

competence



competence – winner

Improving Quality in Cytology

NSW Cervical Screening Program, Westmead Hospital
Western Sydney Area Health Service

Abstract

The aim of the project was to increase cytology professionals' knowledge of difficult high-grade cervical cytology by 10 percent over a year. Under the guidance of the NSW Cervical Screening Program's Laboratories Task Force, a cytology workshop with accompanying materials was developed specifically to address this complex cytology problem. The development and delivery phases of the project made extensive use of respected peer leaders in the profession. The resulting program has now been delivered to 89 percent of cytology professionals in NSW in less than a year and has achieved a 12 percent increase in knowledge.

Aim

To increase cytology professionals' knowledge of difficult high-grade cervical cytology by 10 percent over a twelve-month period by developing and implementing a peer-led cytology training workshop program, and to deliver this program to 80 percent of cytology professionals in NSW.

Background

The 1997-1998 and 1998-1999 Australian Institute of Health and Welfare Annual Reports for Cervical and Breast Screening indicated that NSW had a relatively low reporting rate of high-grade abnormalities compared with the majority of other states. The NSW Cervical Screening Program has responsibility for assisting laboratories achieve optimal results in cervical cytology and therefore needed to address this issue.

Planning methodology

The NSW Cervical Screening Program took this matter to its stakeholder consultation group, the Laboratory Taskforce, which advises the program on a range of laboratory matters, including cytology-training activities.

The taskforce consists of a selection of highly respected peer leaders in cytology and cervical pathology drawn from both private and public sector laboratories across urban and rural NSW. Analysis of data collated by the NSW Pap Test Register during the three year period from 1 January 1998 to 31 December 2000, showed that between seven and twelve confirmed invasive cancers per year were reported by cytology as mild squamous atypia. Further, 26-27% of pap smears reported as CIN1 were shown on biopsy to be high-grade lesions. The taskforce recommended the development of an educational workshop which would provide a high level and consistent educational experience for all cytologists and cervical pathologists in NSW, and would increase their knowledge, and awareness of difficult high-grade cervical cytology.

The taskforce formed a small working group consisting of cytologists and cyto-pathologists to oversee the development of the training workshop materials. An expert in high-grade cytology training



'The 12 percent increase in knowledge, before and after (the workshop) was statistically significant.'

was contracted to develop the workshop content. Cases of difficult, rare and unusual slides showing high-grade cytological abnormalities, to be used in the workshop, were sought from major laboratories in NSW and these were provided willingly. Laboratories in NSW were asked to provide cases of high-grade cytological abnormalities, which were histologically confirmed, to be used in the workshop. The taskforce itself acted as the expert consultation panel to critically review workshop material for quality of content and delivery method, and to assure learning objectives were met.

The workshops, which use a combination of practical sessions and high quality printed resource materials, were designed to be delivered by peer facilitators using adult learning principles. Sixteen peer facilitators were drawn from a range of laboratories across NSW. Selection of facilitators, both senior cytologists and cytopathologists, was based on their demonstrated skills in peer education and their in-depth understanding of difficult cytology patterns. Training sessions were held to assist facilitators to understand their roles and responsibilities in delivering the workshops. They were also asked to provide input to the structure and content of the workshop. As a result of this input some modifications were made. Because of the need for specialist equipment, various NSW laboratories were asked to host the workshops, which again they willingly did, thus demonstrating the strength of the collaboration between the NSW Cervical Screening Program and the NSW cervical cytology community on this project.

Implementation methodology

The cytology workshop was launched at the Australian Society of Cytology National Conference in September 2002. A short demonstration workshop was run at the conference and cytology professionals throughout NSW were invited to register to attend a workshop. The NSW Cervical Screening Program set up a promotional booth at the conference to answer questions and to garner registrations. The workshop was also promoted through the society's newsletter. On the basis of the high level of registrations, a schedule of workshops in rural and urban locations was developed utilising the trained facilitators on a rotational basis and the available venues. Workshops run from February 2003 to November 2003 to meet demand.

Outcome evaluation

From the outset, the workshop attracted considerable interest and registration numbers. The high level of interest at the ASC conference can only be attributed to the fact that the materials themselves, which were on display and demonstrated, were of sufficient relevance and quality as to generate this level of interest. The involvement of respected peer leaders in the cytology profession in the development, promotion and implementation of the materials was key to this acceptance.

There has continued to be an overwhelming interest in workshop attendance. There are approximately 250 cytology professionals in NSW of which 224 have either attended or registered to attend a workshop. This means that 89 percent of NSW cytology professionals will attend this workshop over a 12-month period. Participants' knowledge before and after participating in the workshop was evaluated by a series of questionnaires and clinical case review. Participants were asked to complete a nine-item pre-session questionnaire prior to attending the workshop, and the same questionnaire was administered after the workshop. The preliminary data suggests that before the workshop the proportion of correct responses was 67 percent while after the workshop it was 75 percent. The 12 percent increase of knowledge, before and after, was statistically significant ($\chi^2 = 15.2, p < 0.001$).

These results confirm the success of a peer-led approach to developing and delivering a complex cervical cytology training workshop.

Future scope

Expressions of interest in the workshops have been received from other states in Australia as well as New Zealand. In addition, the workshop is being developed as an online interactive learning practicum to meet other international demands. This online development supports the NSW government's health IT and health export strategies by developing and promoting potential export markets for Australian health informatics services.

competence – finalist

Mental Health Governance and Quality Indicators

Area Mental Health Services
South East Sydney Area Health Service

“A major objective of any health care system should be the safe progress of consumers through all parts of the system. Harm from their care, by omission or commission, as well as from the environment in which it is carried out, must be avoided and risk minimized in care delivery processes”.

(A Framework for Managing the Quality of Health Services in NSW, NSW Health Department, 1999)

Abstract

Mental health has been excluded from large-scale studies (for example, the Institute of Medicine Reports) that have demonstrated the alarming frequency of error in health care systems. However, it is clear from inquiries into dramatic examples of failure (eg the Chelmsford Inquiry in NSW) and American studies of psychiatric care that error identification, preventable injury and designing systems for patient safety are major challenges for mental health (Herzog et al , 2002).

The development of the Mental Health Program in South East Health as a clinical stream has provided the impetus to re-evaluate organisational and management structures and revitalise processes to support clinical governance.

The Mental Health Program has implemented a framework which assists individual services and the program to improve the level of organisational competence with a particular emphasis on safety within mental health services.

This framework is multifaceted and includes elements like collection of Clinical Indicator data, identification and analysis of Critical Incident Review data, establishment of an appropriate reporting framework for this information and a mechanism for regular feedback to the services and consumers.

Aim

To develop a system of clinical governance within the Area Mental Health Program with an appropriate organisational structure, management processes and Quality reporting processes to “ensure that the clinical care and services provided are safe, effective, appropriate, consumer focussed, accessible and efficient” (Easy Guide to Clinical Practice Improvement, NSW Health Department, 2002, page 1).



Area Mental Health Program team.

Background

The organisational structure of mental health services in South East Health has historically emphasised local management at four sites. This has resulted in a relatively low emphasis on Area-wide consistency in management and reporting of quality and internal benchmarking to review performance.

An organisational re-structure in July 2002 established mental health as a Clinical Stream, strengthening cohesion across the four sites and establishing mental health as an Area Mental Health Program with accountability for service leadership and management

with the Area Director at Mental Health Services. This led to:

- the development of consistent Performance Agreements, which include quality targets, negotiated on an annual basis between the Site Clinical Directors and the Area Director of Mental Health
- a clear point of accountability for performance of mental health services and a clear mandate for a focus on the quality of mental health services
- the establishment of a clear reporting framework for quality via the Area Mental Health Executive and the South East Health Quality Council.

It became clear that the program required a strengthening of its organisational competence and Area wide quality processes to strengthen clinical governance.

Methodology

Firstly, the organisational structure and management processes for quality were reviewed, changes negotiated and implemented. Charts demonstrating the current structure and processes are shown below in Figures 1 and 2.

Secondly, a baseline audit across the Area Mental Health Program demonstrated:

- varying participation in the ACHS accreditation process and quality indicator reporting

- no standard data collection which would allow for Area-wide monitoring of trends over time
- minimal opportunities for internal and external benchmarking
- inconsistent review and analysis of the results of Critical Incident Reviews.

As a result the following was identified as necessary action:

- Review and further development of the conceptual framework used in South East Health Mental Health Services for the management of serious incidents. This framework is strongly based on the concept of a Learning Organisation (Senge, 1990) and the concept that cultural change is necessary to effect improvements in health care (Hindle & Natsagdorj, 2002).
- Development of a framework for quality reporting that is based on the Framework for Management the Quality of Health Services in NSW (NSW Health Department 1999). This conceptual framework has a specific focus on systems to measure competence of the system and ensure patient safety.
- The use of timely, relevant data presented as control charts to enable identification by clinicians and consumers of issues in the quality of care that require further investigation and to enable trend analysis. An example is shown in Figure 3.

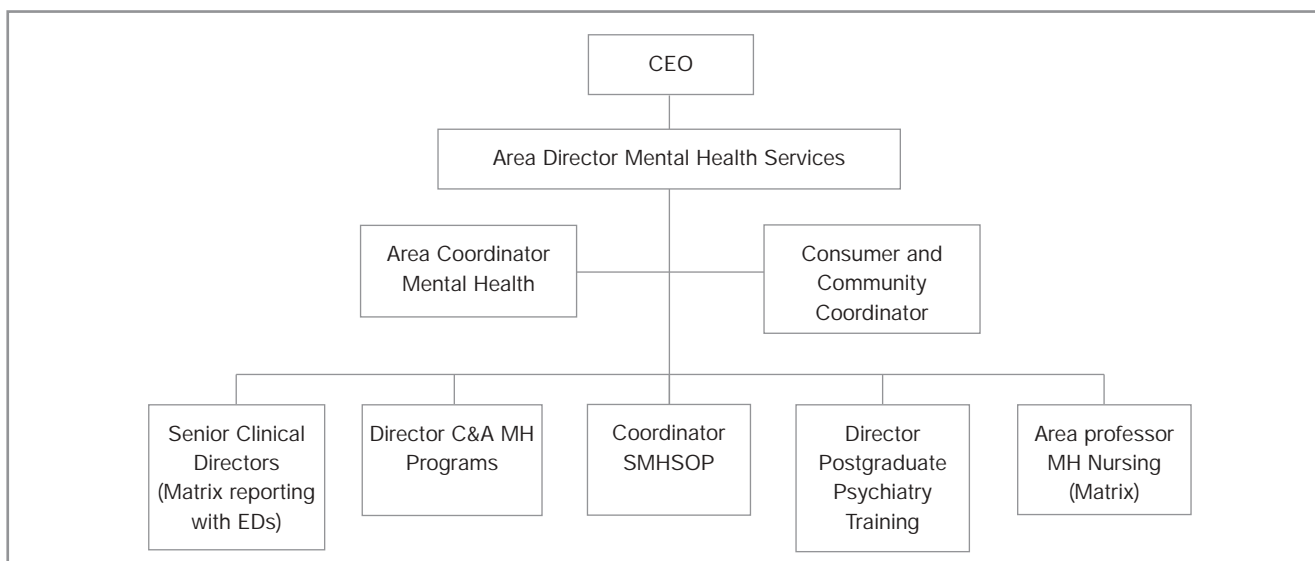


Figure 1. Organisational structure

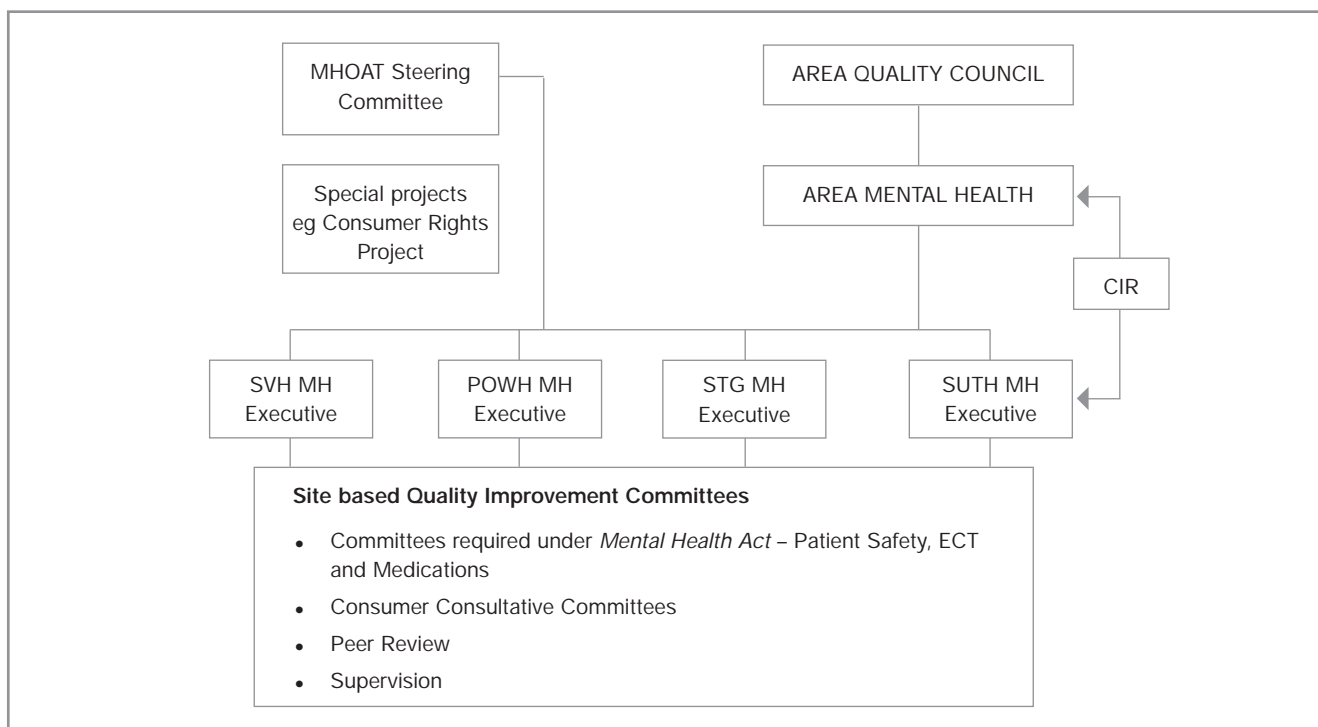


Figure 2. Committee structure

- A strong reporting structure with pathways for feedback to the four mental health sites, consumers, the CEO and Area Quality Council.

It was determined that a Clinical Quality Report would be prepared integrating the conceptual framework with collection of data and reporting across the organisation.

Planning and Implementation

A Clinical Quality Report for Mental Health Services was developed as an iterative process in wide consultation across the organization.

This report includes:

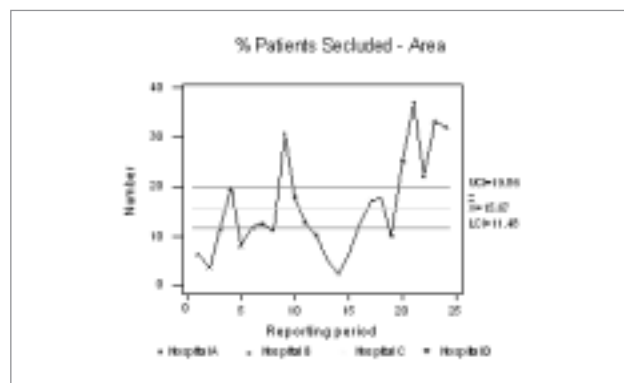
- the NSW Mental Health Quality indicators, with the inclusion of locally developed denominators
- additional indicators that clinicians agreed might be useful in providing feedback on performance
In total, 35 indicators are being reported across 11 dimensions and cross-dimensions
- appropriate benchmarking indicators developed for financial and activity based reporting
- summary reports on analysis of the results of critical incident reviews.

The data used to develop the report is provided from:

- the Area Mental Health database of issues identified and actions required as a result of Critical Incident Reviews. This enables identification of issues at a site level over time, common issues across sites and issues of statewide relevance
- services as part of routine data collection using standard definitions.

Most of the quality indicator items are now entered into a statistical software package and Control Charts for comparison and trends produced. Control Charts have proven to be particularly useful in focussing clinicians and managers on data and stimulating discussion.

Figure 3. Example of an indicator of safety: episodes of seclusion



Select items of data are presented for timely review and discussion at the monthly Area Mental Health Executive. All data is analysed for a six month and an annual quality report that is presented to the Area Quality Committee and the Area Mental Health Executive.

Both the policy framework and the indicator collection system have been viewed as living processes and will be amended to take account of new developments in policy or to respond to issues newly identified by clinicians or consumers as requiring examination.

Outcomes and evaluation

The use of this quality reporting process has strengthened the organisational competence of the Mental Health Program by enabling:

- implementation of an Area-wide quality improvement program
- enhancement of the four site quality programs
- identification of areas for improvement at a site and Area level, including use of seclusion in inpatient units, assaults by inpatients, suicides within 28 days of discharge from inpatient units and rights of community-based consumers
- benchmarking within the Area Health Service and for the future with external benchmarking partner
- improved service planning based on activity data
- identification of trends across all areas of the quality framework
- improved monitoring of the quality of the Incident Management cycle
- a basis for approaching accreditation from an Area wide perspective.

The quality framework has been evaluated against the principles identified in A Framework for

Managing the Quality of Health Services in NSW (NSW Health Department 1999). It demonstrates:

- a systematic and system wide approach to continuous improvement of the quality of care delivered
- an Area Mental Health Service Executive taking responsibility for creating and maintaining a structure and policies for managing the quality of health care
- those practicing within the system taking responsibility for the standard of their own practice and sharing responsibility for creating and maintaining a system which provides safe, high quality health care
- a robust advisory and reporting structure designed to promote the quality improvement of health services and to provide regular information to the CEO and Area Health Council on the quality of service provided.
- the quality of health care being measured systematically with a focus on the minimisation of inappropriate variation in practice
- a system driven by performance in the primary dimensions of quality of health care
- quality information being used in planning and resource allocation decisions within health services.

Future scope

The review of organisational structure and management processes and the development of a comprehensive quality strategy have provided a solid foundation for clinical governance within the South East Health Mental Health Program. The comprehensive quality strategy includes refinement and development of a living conceptual framework, a comprehensive system of Clinical Indicator collection and production of a number of summary reports presented to different levels in the organisation. Quality issues requiring further investigation and action have been identified and are being actively addressed. Quality and Patient Safety have emerged as a unifying vision for the Area Mental Health Program.

Future priorities include:

- further development of Quality Indicators for community based services, child and adolescent and aged care psychiatry services
- ongoing work to improve data quality
- further development of the review of Critical Incident Review reports
- benchmarking with external mental health services
- seeking accreditation with ACHS as an Area Mental Health Program.

This process demonstrates a method for establishing clinical governance in an Area Mental Health Program. It is consistent with the reforms envisaged in the Government Action Plan for Health (NSW Health Council, 2000) in seeking to establish clinical governance as a priority, ensuring the involvement of clinicians and consumers in the management of services and the joint responsibility of clinicians and managers for the quality of services.

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competence – finalist

'I can see clearly now' Clinical Supervision Program

Corrections Health Service

Abstract

A clinical supervision program for corrections Health Service staff was initiated in 1999 in response to the need for staff support and to advance competence. Clinical Supervision is a regular quality activity that contributes toward individual, team and organisational outcomes.

Clinical supervision is a formal arrangement enabling nurses to discuss their work regularly with another professional. It involves reflecting on practice in order to learn from experience and improve competence (Kohner, 1994 as cited in Driscoll, 2000).

Following the improvements to this unique program, there was an overwhelming increase in the number of people accessing supervision (275 percent) and supervisors being retained post training (106 percent).

The CHS executive commitment is evidenced by the allocation of \$100,000 to the program for the current financial year.



'(There is) strong evidence that the changes implemented to the program have resulted in dramatic improvements.'

Aim

The program is based on the belief that, with appropriate support mechanisms, health care professionals will develop to become the best practitioner they are capable of being. Our goal is to promote clinical supervision and train staff to an appropriate level of skill to provide supervision to other staff, therefore resulting in improved patient care.

Background

In 1999, CHS began training its nursing staff as supervisors. Methods of training and delivering supervision changed in October 2001 in response to a needs analysis survey. It was identified that only 47 percent of staff trained were willing to offer their services as supervisors and that there was discontent with the model being taught. It was also identified that there were only 20 people accessing clinical supervision.

In response to the need to provide ongoing management and coordination of the CHS program, staff were appointed to manage the program and implemented a series of strategies to further develop the program.

Method

In October 2001, a CHS learning and development needs analysis was conducted throughout the service. Peter Bazzana, the learning and development coordinator, prepared a report identifying staff responses relating to their failure to access clinical supervision.

At that time only 6.1 percent of CHS staff were receiving clinical supervision. A questionnaire was developed for current supervisors to identify strengths and weakness of the program.

They offered the following:

- Discontent with the model as they thought was better suited to allied health, particularly the expectation of staff being supervised by their line manager.
- That supervisors were not skilled sufficiently to provide quality supervision.
- The need for the program to be promoted and ideas for doing this.
- The importance of being able to choose a clinical supervisor rather than being allocated a supervisor was raised by 90 percent of respondents.
- Potential issues relating to confidentiality.
- Concerns regarding distance as an obstacle to accessing supervision.
- Supervisors reported feeling neglected and were uncertain if they would receive any further training and support.
- Suggestions for improvement such as extending training hours and increasing numbers of staff to be trained.

Planning and implementation

The following changes and innovations for the clinical supervision program were implemented.

- October 2001: Coordinators were appointed to manage the program for 16 hours per week.
- November 2001: Regular in-services on clinical supervision commenced.
- November 2001: Mike Consedine, recognised as the premier trainer of clinical supervision in Australasia, was appointed as the new trainer.

- May 2002: The new training program was commenced.
- May 2003: A clinical supervision register was created to facilitate accountability.
- A code of conduct was created for the practice of clinical supervision.
- The CHS policy on clinical supervision was revised.
- Supervisors trained prior to May 2002 attended the bridging course for the new training.
- The initial training was extended from five days to eight days in the first year with bi-yearly training each year thereafter.
- The new model encouraged staff to choose a supervisor.
- All areas are now sent lists of the current supervisors and their contact details bi-annually.
- A clinical supervision website has been developed on the CHS intranet to improve communication.
- An email link for supervisors has been established.
- Regular submissions of articles are broadcast service-wide via newsletter.
- Evaluation of all training sessions was implemented.

Outcome and evaluation

The following information is supplied as strong evidence that the changes implemented to the program have resulted in dramatic improvements.

The retention of supervisors post training is now 97 percent compared to the previous retention rate of 47 percent (See Table 1).

| 2001 | | 2003 | | % Increase |
|--|---------------|---|---------------|------------|
| Number of trained staff | 66 | Number of trained staff | 32 | NA |
| Number of staff retained as Supervisor post training | 31 | Number of staff retained as Supervisors post training | 31 | 106% |
| Number of staff accessing regular supervision | 20 FTE 328 | Number of staff accessing regular supervision | 75 FTE 378 | 275% |
| Percentage of FTE staff involved | 6.1% | Percentage of FTE staff involved | 19.8% | 225% |
| Initial training days per year | 5 | Initial training days per year | 8 | 60% |

Table 1. Comparison of 2001 and 2003 Clinical Supervision Programs

| Quality surveyed | Percentage |
|-------------------------------|-----------------------------|
| Presentation | 95% rated good to excellent |
| Relevance | 95% rated good to excellent |
| Knowledge | 100% indicated increased |
| Skills | 89% indicated increased |
| Confidence to use skills | 87% indicated increased |
| Recommend to peers | 95% yes |
| Prefer new model to old model | 100% yes |

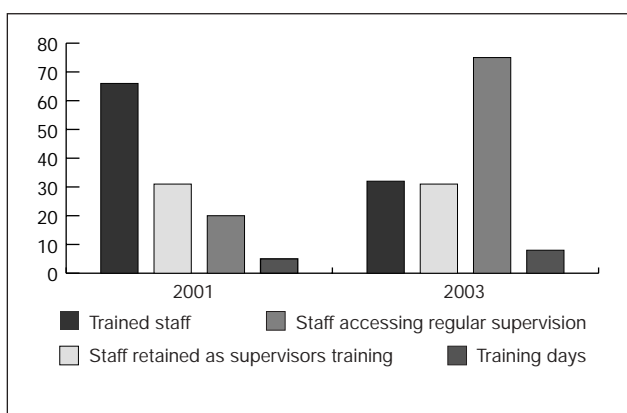
Table 2. Outcome of Clinical Supervision training evaluations

Currently, there are 75 staff receiving regular supervision compared to 20 in 2001, an increase of 275 percent (See Table 1 and Graph 1)

Since October 2001, 66 staff have been trained, including 31 of the staff from the previous program. (See Table 1 and Graph 1)

One hundred percent of the previous program’s participants indicated via evaluation that they preferred the new method of training.

Training has increased from a previous total of five days, to eight in the first year (see Table 1 and Graph 1), four in the second and third years and two days each year thereafter. This is an increase of 13 days over four years. Currently the average training offered throughout other health services is two to six days.



Graph 1. Comparison of 2001 and 2003 clinical supervision program

In November 2002, the coordinators of the program delivered a paper on the success of the innovations adopted in enhancing the clinical supervision program, to the Second International Nursing Forensic Conference in Adelaide.

Evaluation of all training blocks has been overwhelmingly positive (see Table 2).

Future scope

The clinical supervision program is succeeding in CHS. Systems have been implemented which can be transferred to other Area Health Services to assist them in creating a supportive environment for their staff.

Initiatives and strategies for dealing with issues of nurse shortages were discussed in the NSW Health Progress Report Recruitment and Retention Of Nurses, (Oct. 2002). The report highlights the need for developing strategies to create an environment to support staff and that this support should be sustainable.

We submit that a clinical supervision program is supportive, sustainable, and increases and maintains competence.

CHS has undertaken this program to assist in the recruitment and retention of staff and to increase and maintain staff competence.

References

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information management



information management – commended

Organisational Performance Website

Royal North Shore Hospital
Northern Sydney Area Health Service

Abstract

Prior to 2000, less than 5 percent of hospital staff could access information about the performance of Royal North Shore Hospital (RNSH). Now 100 percent of all Northern Sydney Health (NSH) staff with computer access are able to view this information. The organisational performance website was designed to allow all staff to better understand our performance and how their effort impacts on the results we achieve.

Access to information in an easy to understand format was considered essential. Key performance indicator data and patient outcomes are graphed (time series and other analyses), along with commentary and annotations about changes implemented and improvements achieved. The website contains additional resources to complement understanding and enhanced decision-making.

Staff and external health professionals are overwhelmingly positive about the site, particularly the ease of access, quality and utility of the information. User numbers are increasing as the site gains more exposure. The site has reduced costs due to less photocopying and distribution of reports and improved the timeliness and accessibility of information by using an electronic media. The site is continually being enhanced and modified to reflect user needs and wants and has been showcased (oral and poster) at local, national and international conferences.

Aim

The organisational performance website (OPW) aims to improve communication on important areas of our performance, allowing:

- provision of a superior tracking process about our performance over time

- employees to better understand how the organisation operates and how they can contribute to the overall performance
- improved decision-making
- reduced cost, improved timeliness and accessibility of information by using an electronic media



"... the site sets a benchmark for health services in establishing intranet sites for staff to obtain clinical information ..."

Background

Prior to 2000, the vast majority of RNSH staff had minimal or no access to generic performance information, which meant they did not know where we were performing well or otherwise.

We value transparency, which means sharing key statistical information with all of our employees. It is important that staff understand how the organisation operates and how they can contribute to the overall performance. This requires more than simply making and distributing additional copies of monthly statistical reports.

Method

A 1998 committee survey, noted “lots of data – little information”.

A Health Roundtable survey (2000) followed by a more detailed in-house survey (2001) identified problems with corporate performance reporting, including:

- five percent stated that communication about our performance was available to all staff on a regular basis.
- ninety four percent stated that for tabulated data (used exclusively then) it was impossible to see trends over time.

Performance information needs indicated by senior managers, and a consumer, have included:

- easy to access/use/understand method for communicating and deploying information
- need commentary on trends in tabulated data. Comparative – benchmark with like sized facilities
- graphical representation of key safety indicators over time to trigger system analysis and review
- clinical data, eg falls, infections, risk indicators.
- formal training in statistics (requested by 83 percent of all NSH Quality Managers – 2003)

The team comprises the quality manager, director of medical services, waiting list co-ordinator, nursing unit manager, webmaster and area director of clinical services and innovation.

Planning and implementation

Website development began in 1999 and is continually being improved. Major components include:

- Key performance indicators (KPIs) – a visual display of our performance using control charts and other analyses (n=38), updated one-three monthly. Increasingly, these are clinical outcomes, eg falls, pulmonary embolus, unplanned return to theatre, etc. Some KPIs demonstrate ACHS indicator data or sophisticated benchmarking with other facilities (secondary data analysis). Slides include operational definitions and interpretation as well as an introduction to control charts and variation.

- Resources – this page links to various publications (eg Berwick, Pyzdek), QI projects, data display presentations, QI videos, seminars and workshops, STATUM archives (performance-measurement newsletter) and process improvement videos with self-directed learning modules.
- CAST – Computer Assisted Statistics Teaching. A complete course in introductory statistics, CAST is a highly interactive program with dynamic graphics to explain difficult concepts. We recently commissioned a module on control charts, tools (Pareto charts, fishbone etc) and the PDSA cycle.

As the OPW is only available on the NSH intranet, only Area employees can access it, therefore confidentiality is not an issue. The homepage has a confidentiality clause. Site content is provided to the Information Services Department (ISD) in the form of specially formatted MS Word documents and Powerpoint presentations. These are converted to HTML format using Panagon Web Publisher software, or Adobe Acrobat formats.

The OPW is often referenced in Clinical Matters (corporate newsletter), sent to all medical staff, where website graphs are demonstrated and discussed in detail to facilitate wider learning about our performance and appropriate decision making. Website graphs are also used to display statistical concepts and analysis techniques in our MINITAB[®] software computer workshops and STATUM newsletters. Current issues are distributed electronically to registered readers, including our researchers, and staff from Western Sydney and Hunter Area Health Service. The website has been demonstrated to other Area Health Services.

Outcomes and evaluation

All NSH staff with computer access can now easily access and understand our performance, relative to the past and our goals. We have reduced costs and improved the timeliness and accessibility of information by using an electronic media. Many informational problems identified in earlier surveys have been overcome or minimised. Excellent resource pages enhance skills in decision making. Increased site use is demonstrated in Table 1, comparing month to month and year to date usage.

| Report period | 17/3 – 13/4 | 14/4 – 11/5 | 12/5 – 8/6 | Jan – June (24th) |
|--|-------------|-------------|------------|-------------------|
| Total # days | 28 | 28 | 28 | 174 |
| Number of pages viewed | 916 | 921 | 1944 | 7387 |
| Average number of pages viewed per day | 33 | 33 | 69 | 42 |
| Number user sessions | 43 | 53 | 77 | 317 |
| Average user sessions per day | 2 | 2 | 3 | 2 |
| Number of unique users | 28 | 27 | 38 | 152 |

Table 1. Extract from the 2003 Report generated by SurfStats (Reg. trademark of Surfstats Int Ltd)

| | | |
|--|---|--|
| <ul style="list-style-type: none"> Graphical presentation of data over time. Graphs – colour allow easier reading (compared with printed report) – interpretation commentary useful. Ordinary reports of rows and rows of tabulated data comparing this month to last month with the variance tell me little about Design looks great, KPI graphs are good. Great benchmarking with Health Roundtable hospitals shows although we are numerically inferior, we are not statistically different. | <ul style="list-style-type: none"> User friendly. Resource section. Easy to navigate. Excellent. Clear menu. | <ul style="list-style-type: none"> Good idea. Easy to navigate. Well presented. Cartoons are fun. Excellent information |
|--|---|--|

Table 2. Staff evaluation of website.

Site usage was expected to increase dramatically (currently 152 unique users) when the CEO officially launched the site to all NSH staff, in July 2003 (after the close of Baxter application). CAST will be specifically promoted. Prior to July 2003, only senior RNSH staff has been aware of the site. Table 2 shows an internal evaluation of RNSH senior managers who were asked “What did you like about the Website?”.

External evaluations

“I believe that the site sets a benchmark for health services in establishing intranet sites for staff to obtain up to date clinical information on the quality of services provided by the organisation”.

Denise Ward: Quality Systems Manager, Western Sydney Area Mental Health Service. And,

“The web site is an excellent way to present the KPIs” Peter A Reeves – Health Roundtable.

Following the 8th European Forum on Quality Improvement in Healthcare, Norway (2003), the team has been invited to submit a paper, on the OPW, to the *International Journal of Health Care Q.A.*

Future scope

This website has been designed to ensure that it:

- Aligns to the Framework for Managing the Quality of Health Services in NSW by providing the communication avenue related to the performance framework.
- Demonstrates best practice methods for data analysis, interpretation and display as endorsed by the NSW DoH Clinical Practice Improvement Program.
- Links to the Easy Guide to Clinic Practice Improvement – A Guide for Healthcare Professionals.
- Addresses the Health Council Report priority for better use of data.
- Avoids specialised web-publishing techniques, to enable easy adoption, by other healthcare organisations, with existing technology.

information management – commended

Developing the Aged Care Database

St Vincent's Hospital
South Eastern Sydney Area Health Service

Abstract

Development of the aged care database was a joint project between the Quality Improvement Unit and Acute Geriatric Unit. It has been a highly successful quality project that has resulted in genuine change, improvements in clinical care and improved communication with general practitioners on the patients' discharge from hospital. It has enabled accurate and useful data to be easily collated and analysed, which is helping to achieve further improvements in both clinical care and the efficiency of the unit.



'The database has proven that electronic discharge summaries can enhance the effectiveness of a multidisciplinary team ...'

Aim

There were several perceived advantages of using a database to manage our caseload. Most importantly, to develop a genuinely multidisciplinary discharge document that accurately conveyed the team's decisions regarding the patient's multiple and complex problems. We also needed to collect more accurate data to improve clinical key performance indicator reporting.

Background

Older patients may be admitted to the acute care setting with either one or more of the "geriatric syndromes" (acute confusion, incontinence, falls etc) and require the services of multiple health care professionals to ensure that they are discharged into a safe and healthy environment. The assessment of these patients and the mobilising of required services in a timely manner to promote early and safe discharge is often a complex task. The coordination of care within the acute service and across the continuum is essential to ensure positive outcomes are achieved for older people.

Method

The QI Unit conducted interviews with members of the Acute Geriatrics Unit in an effort to identify barriers experienced by the team in the provision of patient care and to identify opportunities for improvement. An analysis of the Acute Geriatric Unit casemix data was undertaken to provide a starting point for review of patient management practices of patient groups outside benchmark targets. Benchmarking with another similar geriatrics unit and detailed analysis of statewide Relative Stay Index (RSI) data was also undertaken.

The review highlighted the desire to reduce the average length of stay, but expressed concern that this could adversely impact on patient outcomes. Some of the findings from the review included:

- fifty-one percent of patients had a length of stay of seven days or less
- that communication and discharge planning were major concerns and there were a number of external barriers impacting upon the discharge process, in particular difficulties in accessing community services for patients
- there was limited data available on patient outcomes

The main recommendations from the review included:

- introduction of a case management model of care with the appointment of a care co-ordinator
- develop and implement the clinical database to ensure it has a multidisciplinary focus
- collect and analyse data to better understand and monitor the barriers faced by the unit
- establish a monitoring system to capture patient outcomes post discharge
- a benchmark of 70 percent of patients to achieve a seven-day or less length of stay should be set

Planning and implementation

As there was no funding for this project, the database was designed by the clinical team with assistance from the QI Unit. There was extensive consultation with a number of departments, including Allied Health and Pharmacy, in order to meet their written and legal requirements. Training in the use of Microsoft Access was provided for all relevant staff and there is ongoing training for new rotating junior medical staff. The database is now used on daily ward rounds and weekly case conferences to assist with the management plan, monitor the outcomes of care, and produce a multidisciplinary discharge summary. Comprehensive geriatric assessments (ADL, MMSE, continence assessment, hearing, falls risk, etc) are completed on the database including home assessment data from occupational therapy and patient outcomes following physiotherapy. The database facilitates the coordination of care, including a telephone follow-up one month post discharge. The database also monitors the barriers to the continuum of care, records the proposed versus the actual discharge plans, and facilitates the collection of the ACHS clinical indicators (previously done manually).

Outcomes and evaluation

The incorporation of the database into our daily ward routine should be acknowledged as a successful outcome in its own right. The system generates patient reports that have proven very useful at nursing hand-over. The discharge summary is completed at team meetings as a team effort using a digital projector and has received favourable feedback from consumer groups (attachment). The summary (including the discharge prescription) is printed, signed and placed in the medical record as the official discharge documentation. Every day we monitor discharge delays. From all collected data, quarterly reports have been generated and presented to the clinical team and the hospital quality committee; we now have useful data that have allowed us:

- to monitor the day to day problems that we encounter in discharge planning
- to accurately monitor key performance indicators and set new indicators for the unit, such as percentage of patients meeting length of stay of 10 days or less, percentage of our patients admitted to our own ward, and percentage of patients undergoing a mini mental state examination (MMSE) test (see clinical indicators 1, 2 and 3 over page)
- to much better understand the complexities of the patients that we treat and have improved outcome data grouped by diagnosis (see below Figure 1)
- to have a better understanding of patient variances (see over page Figure 2).

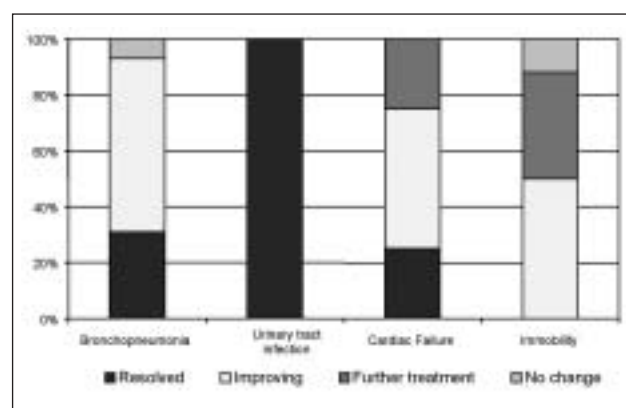


Figure 1. Clinical outcome and data by diagnosis July 2002-April 2003.

Future scope

The database has proven that electronic discharge summaries can enhance the effectiveness of a multidisciplinary team in providing meaningful discharge documentation for patients with complex medical conditions who require a high level of communication to ensure safe and effective hospital discharge. It has highlighted the importance of collaboration between clinical and quality units in achieving accurate data collection regarding performance. Both of these features should be adopted by Health Departments in their planning towards development of electronic medical records.

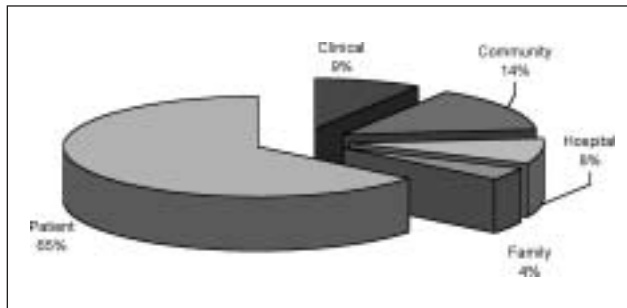
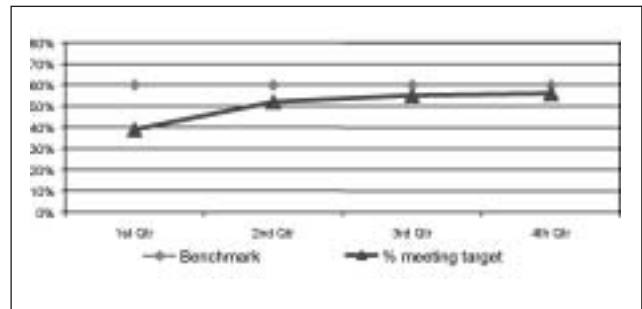
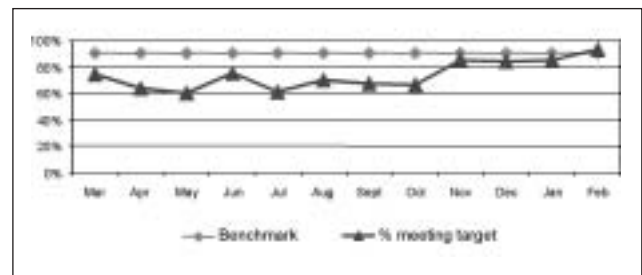


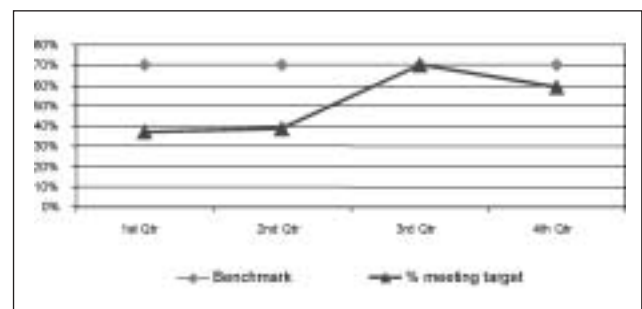
Figure 2. Discharge variance analysis July- December 2002 (ie discharge delays experienced during admission and why they occurred, for example delays in availability of community services etc)



Clinical indicator 1. Percentage of admissions length of stay of 10 days or less for 2002



Clinical indicator 2. Percentage of admissions treated on AGU 2002/2003



Clinical indicator 3. Percentage of patients admitted receiving MMSE

information management – commended

Aiming for a Safer Patient Environment

Clinical Governance Unit
Hunter Area Health Service

Abstract

With the development of the Hunter Health Clinical Risk Framework, a key risk factor for the success of its implementation was identified around the process to assist in the identification, reporting and monitoring of clinical incidents. Current systems utilised throughout NSW do not provide an effective manner to achieve this. After investigation of appropriate systems, the Australian Incident Monitoring System (AIMS), developed by the Australian Patient Safety Foundation in 1996 and continually revised thereafter, was adopted as the system of choice in the Hunter. We believe is the only health service within NSW to have implemented such a comprehensive incident management system on this scale.

After a successful trial in the Lower Hunter Sector in 2001, AIMS was introduced across the rest of Hunter Health in September 2002. Clinicians have embraced the system, reporting 4,446 clinical incidents in the first six months. Both near misses and serious adverse events are being reported allowing managers access to data, which is assisting them to manage clinical risk at a local level and thus improve patient care. Additionally, managers now have ownership of their own data, immediately, while the Area can review overall trends. Reporting has improved by over 500 percent, and a number of key quality improvement projects have been implemented to improve patient safety as a direct result of the improved data management. Key advances in the newer version will enable staff and managers to more readily address patient safety issues with the key components of web-based entry and incident workflow.



'The reporting of incidents has improved dramatically across Hunter Health since the introduction of AIMS.'

Aim

AIMS was introduced as an integral part of the Clinical Risk Management Framework with a number of key objectives:

- A simple tool to report, analyse and monitor clinical incidents.
- To enable managers to timely use data to assist them to prevent future adverse patient outcomes and improve the quality of patient care.
- To provide reports at different organisational levels such as unit, division, hospital, Board, Area Quality Council and senior executive, giving a clear indication of priority areas to target.

Background

Given that harm to patients can potentially result from any type of incident, a cornerstone for safety improvement is incident reporting and management within health services. Incidents provide a valuable source of information to enable health services to identify hazards and actively manage risks at a local level.¹

Many health care facilities have some sort of incident reporting and management system in place as part of risk management or quality assurance programs. Prior to the introduction of AIMS, Hunter Health had a generic system in place, which was used for staff and patient incidents. However this system was not working, with poor reporting level and a lack of detailed information. Doctors saw it as a nursing duty and consequently when things were reported they tended to be limited to falls or, more rarely, medication errors. Because of a fear of retribution, significant incidents were not notified.

Providing an environment that encourages event reporting is a precondition for engaging staff, particularly for reporting near misses² and thus a system was needed that provided for anonymous reporting and confidentiality of information.

Method

As outlined above, the Clinical Governance Unit (CGU) identified as part of its clinical risk strategy that there needed to be a uniform, consistent process across the Area Health Service in order to better share the information and put more system-wide preventative measures in place. The Area established The Area Patient Safety Steering Committee as part of its clinical risk strategy and this team, made up of clinicians and managers, was designated the task of implementing such a system. The problems of poor reporting and a culture of blame were readily identified. It was identified early on that the process also needed to be as simple as possible with a single form that could be used by the reporter, as well as the manager. Medical staff had indicated that they would be more willing to report if the process was privileged.

The Lower Hunter Sector (LHS) in 2001 was requested by the CGU to pilot an identified system that had been used in other areas of Australia. This system was AIMS which had the advantage of privilege of the information for quality improvement process, thereby encouraging the reporting of doctors, as well as a single form that could be used by the reporter and managers, as well as providing the opportunity for staff to identify the system causes of the error and appropriate

remedial action. The pilot in LHS also attempted to identify incidents from a number of different sources, similar to the Wimmera model.³ The aim was to engage the staff to use AIMS as a reporting tool when:

- conducting any audits such as, death, infection control, medication charts or other medical records
- receiving medico-legal claims or TMF reports
- reviewing complaints, patient satisfaction surveys or clinical indicator results
- coding medical records by using “Y Code” as a trigger.

The reporting process and incident form were circulated to a wide range of stakeholders for their input prior to a final model being developed.

Implementation

Following the successful pilot in the LHS, the steering committee rolled out the one incident reporting process across the whole of Hunter Health, incorporating all 19 hospitals, 43 community health services and all clinical services whether in an acute or community setting. This included the same incident form and a shared database for all clinical incidents across the Area. This process was assisted by the creation of specific roles within the Area Health Service that focussed on the safety of patients. These required no additional funding but looked at a restructure of positions to make patients and the safety of services provided to them the key priority. A key component of these roles was to maintain the AIMS database within their units, providing consistency in data input and regular reports to managers and clinicians, as well as following up on recommendations suggested.

Another key stakeholder in the implementation of AIMS was Hunter Health’s Information Technology Department as we were reliant on the software being loaded on the server. For the IT department, this was their first real foray into clinical information systems, which has now seen a dramatic change in their role within the Area Health Service. The department is now working on more than 10 different clinical IT systems.

APSE, the supplier of the software, contributed to the training of the patient safety officers as 'coders' and the education of staff generally about the process. The key to the success of the implementation process was communication with as many clinicians as possible. An awareness campaign was conducted via the use of flyers, mass emails, articles in newsletters, agenda items at meetings, a site on the Hunter Health web address, posters and patient safety staff constantly being in the clinical areas talking about it.

Two weeks prior to the 'go-live' date, a mass education campaign was held in every main site across Hunter Health. Information sessions were held at many times in the day as well as some evening sessions to enable as many staff as possible to attend. These sessions were designed to inform staff of what comprises an incident and the importance of reporting them. They also provided guidelines as to the information required on the AIMS form to assist in the collection of meaningful data.

Over 300 folders containing the AIMS forms, together with clear instructions on how they should be used, were also distributed across the Hunter Health Area and were placed at the clinical workstations to remind staff to report. Signs were attached to current report books to remind staff of the new reporting system for clinical incidents.

The new system commenced on September 1, 2002 and the success of the education program was shown in that only six out of a total of 576 incidents in the first month were reported on the wrong form. Reporting has been made easier recently by the enhancement of a web-based entry system, so that staff can themselves enter the information directly onto the computer if they wish, thereby maintaining confidentiality and more timely use of information.

Outcome and evaluation

The reporting system seems to have been readily accepted. During the first month, there were 576 incidents reported, none were level '8' (serious adverse event). More importantly, 34 percent of incidents were 'near misses', which provide us with the greatest opportunity to correct things before they go wrong. This trend of reporting near misses has continued, with the statistics for the month of March 2003, where there were 631 incidents

reported, 0.005 percent (three) were level '8' and 34.5 percent 'near misses'.

The reporting of incidents has improved dramatically across Hunter Health since the introduction of AIMS, addressing our first objective (Figure 1). This signifies that we have also achieved this with a change in the culture of reporting, with staff feeling comfortable without fear of retribution. Anecdotal evidence indicates that not one staff member has been blamed or disciplined for an incident that did not involve an intentional unsafe act or intentional patient harm.

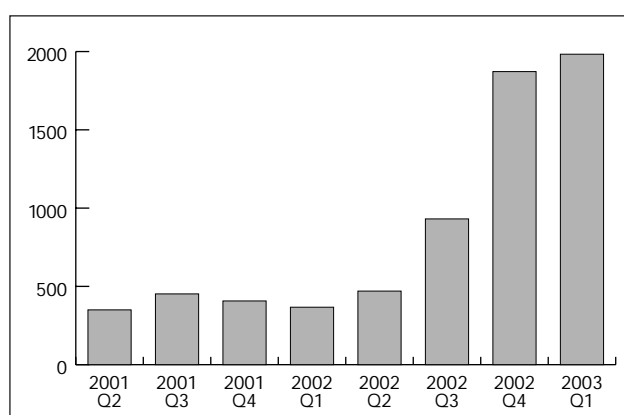


Figure 1. Clinical incidents reported April 2001 – March 2003.

More importantly, making the AIMS data more accessible to managers/committees has resulted in the following improvements to patient care, ultimately making Hunter Health a safer place:

- Red coloured syringes have been introduced to all operating theatres in the Area, following two incidents at separate hospitals, in order to distinguish them from other syringes used by anaesthetists to reduce the risk of muscle relaxants being given prior to induction.
- Advisory signs in Emergency Departments have been erected to alert patients to inform hospital staff if they are pregnant or breastfeeding.
- Standardisation of infusion pumps across hospitals.
- Review of consent checking procedures prior to Occupational Therapy.
- Review of procedures for labelling blood collection tubes for pathology.
- Review of procedures for reporting on X-ray results after hours in Emergency Departments.

- Introduction of falls minimisation programs.
- The trial of new ways to administer medications as part of a strategy to reduce medication errors.

Both these last two projects have utilised the AIMS database to its capacity by using aggregated and trended data, simplifying the diagnostic process for the quality improvement cycle

An added bonus has been the involvement of general practitioners by having them fax any issues on a “GP feedback form”, which are then collated and added to the AIMS database. Reports from AIMS are now provided to all managers, the Area Executive, The Area Quality Council and Board.

Future scope

The success of the implementation, including the ready acceptance of the reporting system by staff, has been recognised by the Department of Health (DOH) and the APSF in that Hunter Health has been asked to conduct a beta test on an advanced version of AIMS. It is due for completion in July 2003.

Advanced AIMS has many functionalities which Hunter Health had recognised were essential for the management of incidents. These include the new module, Workflow. The Workflow module is used for tracking of the implementation of recommendations. This is crucial if AIMS is to be used as a management tool and not just for reporting

and analysing of incidents. This has now resulted in the appropriate person being immediately notified in the event of an adverse event, including email notification of all critical events to the CGU, for notification to the Department of Health under the Reportable Incident Brief. This has also provided the ability to easily follow up on investigations and recommendations for improvement through a specific monthly report of outstanding items.

The AIMS database and the incident management process as part of our larger Clinical Risk Framework has provided the potential for other health services to learn. The Hunter Area Health Service has almost weekly visits from within the state, as well as national and international visitors who wish to use this process themselves and learn from Hunter Health’s experience.

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continuity of care



continuity of care – winner

'Breaks the Cycle' – Correctional Centre Release Treatment Scheme

Corrections health Service

Abstract

Upon release from gaol, many inmates find the transition from incarceration to living in the community a time of great stress and uncertainty. The potential for relapse and resumption of criminogenic behaviour is high during this critical period (Seaman et al., 1998; Harding – Pink, 1990). With 80 percent of NSW's inmates having a prior history of substance misuse, the situation intensifies. International research has found that former inmates with a history of injecting drug use are three to fifteen times more likely to suffer from a drug overdose (Zador et al., 1996) and that their health status in general is poor compared to that of the general public (Harding- Pink, 1990).

For the 18,600 inmates who annually come through the correctional system, Correctional Health Service (CHS) is a rare opportunity for many inmates to access comprehensive health care services. However, upon release many ex-inmates find themselves unable to negotiate the many and varied services available on the outside. The Correctional Centre Release Treatment Scheme (CCRTS) was designed and implemented to act as a bridge between the correctional environment and the community. With project officers located around the state, CCRTS has been able to access inmates prior to release, formulate a needs-based release plan and follow up clients in the community to ensure continuity of care. CCRTS has worked hard to 'break the cycle' in which many clients find themselves trapped.

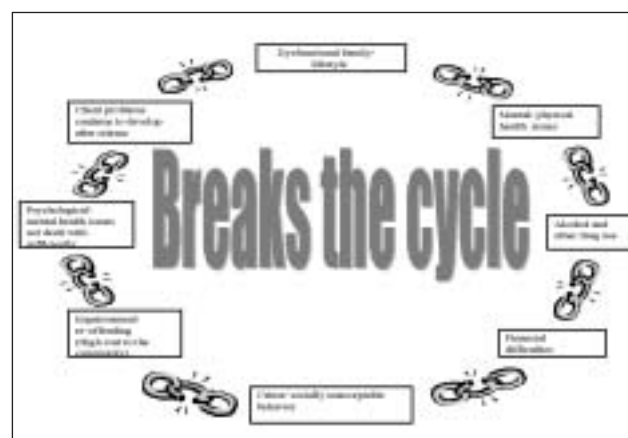


Figure 1. CCRTS cycle

Aim

The Correctional Centre Release Treatment Scheme aimed to provide a continuity of quality health care for recently released inmates, beyond the prison system. This was achievable through a pre-release assessments of inmates' needs, and an intensive three month follow-up, in which clients were assisted in accessing services available in the community. Through the appropriate links made, CCRTS was able to provide clients with a supportive network to ease the transition from prison to community.

Background

The CCRTS project devised its aims and modus operandi on the identified deficits in the current prison correctional release process. Overall it was noted that inmate discharge planning was often inadequate and not tailored to meet individuals' needs. A preliminary survey conducted by the CCRTS project found that inmates experience a number of problems related directly to this lack of comprehensive post release planning.

| | Percentage of CCRTS clients |
|---|-----------------------------|
| Lack of formal identification on release | 88% |
| Resumption of illicit drug use | 76% |
| Finance (debts, Centrelink, Department of Housing) | 76% |
| Untreated health issues (mental health, depression and anxiety) | 58% |
| Return to criminogenic neighborhood | 54% |
| Difficulty in fulfilling requirements of parole | 83%* |
| Legal problems (outstanding warrants, perceived harassment) | 47% |
| Lack of employment | 44% |
| Lack of appropriate housing | 38% |

* 40% of CCRTS clients are released under probation and parole supervision.

Source: CCRTS client self report questionnaire.

Table 1. Self reported barriers to reintegration.

Without holistic planning for release, inmates have found that the return from gaol to the community is fraught with difficulties. Inmates identified accessing community services without assistance and ongoing support, as a main reason for relapsing into drug use, crime and socially unacceptable behaviour. The CCRTS project saw this gap in service delivery, and aimed to bridge it through continuity of care and comprehensive discharge planning.

Method

When the Drug Summit met in 1999, the need for ‘client focused’ health delivery was surmised. These talks acted as the foundation for the development of the CCRTS project. With Corrections Health Services (CHS) recent concerns over prison post release mortality, the NSW Department of Health (DoH) was granted funding for the project, and CHS was nominated as the lead agency. Funding was allocated for a two-year pilot project.

The inmate census of 2001 recorded the Area Health Service of the last known address for NSW prison inmates (Corben, 2002). The results are illustrated in Graph 1.

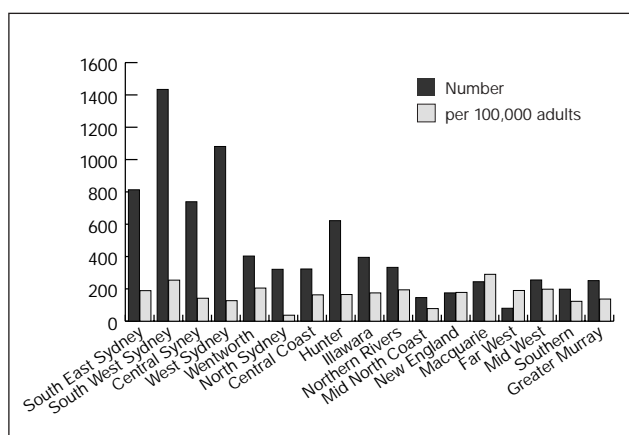
Three areas of note were Central Sydney, West Sydney and Macquarie. Using information from the Bureau

of Crime Statistics And Research (BOCSAR), high crime and recidivism rates were investigated in these three geographical locations. Based on this data, Redfern/ Waterloo, Blacktown and Wellington were nominated as target project areas.

An over-arching steering committee was developed to strategically plan and direct the project. Interested delegates were invited to be a part of the committee, and they included the NSW Department of Health, CHS, Department of Corrective Services, Community Restorative Centre, Aboriginal Medical Services, Area Health Services and non-government agencies. Sub-steering committees were formed to facilitate the project at a local level. Since the project aimed to link clients into community services, local involvement was important in developing geographical specific and supportive networks.

Planning and implementation

Through consultation with the steering committees, an outline for the team was developed. Heading the project was the project manager, assisted by three operational project officers (one in each area), probation and parole officer, and two researchers. In order to assist the transition from prison to community, The project officers would met with



Graph 1. Area Health Service of NSW inmates.

clients one month before release. During this time they would evaluate the clients' needs and assist them in preparing for release. Preparation included arranging formal identification, obtaining clothes for release and making home visits to families where appropriate. On the day of release, project officers met clients at the Correctional Centres and drove them to their pre-arranged accommodation. Over the next three months, the project officers ensured that clients were well supported by community agencies, by linking them into services such as Centrelink, medical services, drug rehabilitation and detoxification facilities and non-government agencies which offer clothing and food vouchers.

Data was collected using the NSW Department of Health's Brief Treatment Outcome Measure. A CCRTS assessment tool was also developed to measure project specific indicators. The Research section of the team was integral in data collection and analysis.

Outcomes and evaluation

The overall aim of the project was to break the cycle of recidivism. One of the major performance indicators was the number of clients who remained out of gaol whilst on the project. Results are illustrated in Graph 2. For many clients, three months in the community was the longest time they had ever been at liberty.

In order to measure the continuity of care for inmates, measures were taken on the number of clients assisted in five key areas; identification,

housing, employment, education and treatment. Since all clients were recidivist, information was gathered on how clients had fared on their previous return to the community, and this was compared to what they achieved under the CCRTS project. Results are shown in Table 2.

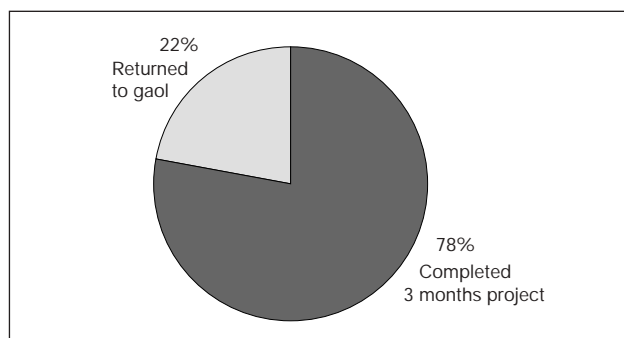
Overall, results indicate an improvement in the quality of care provided to inmates on release from gaol. Through bridging the gap between Corrections and the community, CCRTS has provided clients with a proactive discharge planning process to assist with ensuring the continuum of care from prison to the public.

Future scope

The results from the CCRTS project highlight the need for a more in-depth and individualised approach to inmate discharge planning. Based on empirical evidence, all Correctional Centres around NSW, indeed Australia have the capacity to adopt a more 'client focused' method of post release planning, given the appropriate resources.

Furthermore, pro-active discharge planning is not just relevant to the correctional setting. Post release planning should be an integral part of any patient's contact with the health care system, be it through Corrections Health or in the community

The links forged through the CCRTS steering committees were a fundamental part of the project's success. The need for greater systemic networks to be developed between Area Health Services, community services and Correctional facilities is now evident. For continuum of care to be fully implemented, greater communication is needed



Graph 2. Results at three month follow up.

| | | Identification At least one piece of formal ID | Housing Suitable accommodation arranged; family/friends, public, private rentals | Employment Including volunteer work | Education TAFE, trade and university | Treatment Completed or currently participating in drug treatment program |
|----------------------------|------------|--|--|---|--|--|
| Blacktown (N = 21) | Pre-CCRTS | 9.5% | 47.6% | 9.5% | 0% | 4.7% |
| | With CCRTS | 71.4% | 52.3% | 23.8% | 19% | 100% * |
| Wellington (N= 30) | Pre-CCRTS | 50% | 33.3% | 3.3% | 0% | 3.3% |
| | With CCRTS | 100% | 83.3% | 23.3% | 23.3% | 76.6% |
| Redfern/ Waterloo (N = 20) | Pre-CCRTS | 15% | 10% | 0% | 0% | 0% |
| | With CCRTS | 80% | 75% | 5% | 10% | 30% |

* All clients recruited in Blacktown must be on methadone.

Table 2. Area specific results

between the relevant partners.

An evaluation of the CCRTS project has been produced. Based on these findings, alongside comments and feedback from the steering committee, future directions for the project have been developed. The use of a control group, and project expansion are two possible avenues.

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continuity of care – commended

Diversional Activity Program

Trangie Multi Purpose Health Service
Macquarie Area Health Service

Abstract

Trangie Multi Purpose Health Service (MPHS) is an integrated service of community care, outpatients, inpatients and residential aged care. The MPHS has 20 beds consisting of two acute care, eight high aged care residential and ten low care residential beds.

There was no formal diversional activity program in place for the aged care residents of the MPHS. So a diversional activity team was set up. Potential customers of the program were surveyed and after their feedback interventions were put in place to start diversional activities. Weekly “art classes” were commenced, met with scepticism by the majority of residents. This scepticism related mainly to the level of the residents’ previous abilities with drawing and painting. With this in mind, the team was instrumental in ensuring the classes were responsive to the resident’s abilities, personalities, interests and concerns and fostered self awareness, developed social skills, managed behaviour and increased their self-esteem.

The program began in February 2002 and has now developed into the highlight of the residents’ week. Attended by 66 percent of all residents, the MPHS is now adorned with eye catching, creative works. Clinical care of the residents has been enhanced through the identification of deficits in cognition, motor skills and eyesight.

Aim

To improve the coordination of care for aged care residents of the Trangie MPHS through the provision of a comprehensive diversional activity program with 50 percent attendance, by aged care residents, within six months.



Two residents concentrating on formation of canola plants for mural.

Background

There was no diversional activity for the aged care residents of the MPHS and management of the MPHS experienced difficulty in attracting funding for a designated diversional therapist. The idea of “art therapy” came from an ad hoc suggestion at the residents’ meeting with the health service manager and hostel supervisor. This suggestion was further explored by the identification of customers and their expectations, the activity to be introduced, preparation and sustaining the activity.

The diversional activity project team consisted of the health service manager, hostel supervisor, MAHS manager area quality development and registered nurse. The program was further enhanced by the additional qualifications of the registered nurse, as the art teacher.

Method

Meetings were held with the three designated groups of customers to ascertain their expectations of a diversional activity program (art therapy).

Customers and their expectations included:

- **Health service manager**
 - to provide the program within financial constraints of the MPHS
 - staff for the program to be within existing staff establishments
 - program sessions to be held once per week
 - program to be evaluated
- **Art teacher (registered nurse)**
 - art materials and space provided to conduct the sessions
 - autonomy given for program content
 - program to run within current contact hours
- **Aged care residents of the MPHS**
 - will not cost them any extra money
 - occurs regularly
 - free to 'come and go', depending on individual circumstances

Planning and implementation

Weekly "art classes" have been introduced for aged care residents of the Trangie MPHS. They are coordinated by a registered nurse who is also a qualified art teacher.

The classes are responsive to the residents' abilities, personalities, interests and concerns and foster self-awareness, develop social skills, manage behaviour and increase the self-esteem of residents.

Evaluation mechanisms have been implemented to monitor individual achievements, satisfaction with the program, clinical benefits and attendance numbers.

Outcomes and evaluation

The outcomes of the program were:

- Sixty six percent of aged care residents, low and high care, attend art sessions regularly. (See chart 1 below).
- Enhanced clinical care through the identification of deficits in cognition, motor skills and eye sight among those attending the art sessions.
- Increased mobility and independence of residents attending art sessions.
- A more 'homely environment' for residents with single art works and group productions being displayed throughout the facility.
- Recognition by community members of the achievements of the aged care residents.
- Community members are so impressed with the art works produced that they now raise funds to complement the program.
- The program is delivered within the financial budget of the facility.

Future Scope

- Continue the provision of 'art classes' on a regular basis (weekly) for the aged care residents of Trangie MPHS.
- Continue to utilise evaluation mechanisms to monitor the effectiveness of the program.
- Mechanisms such as resident and staff satisfaction surveys and an assessment scale be developed to measure and evaluate the impact of the program.
- Obtain funding for a designated art room at the Trangie MPHS.
- Conduct an 'art show' for the community of Trangie to say thank you.
- Continue to develop the aged care residents' skills using different mediums.
- Further develop the program for implementation at other MPHSs within the Macquarie Area Health Service.

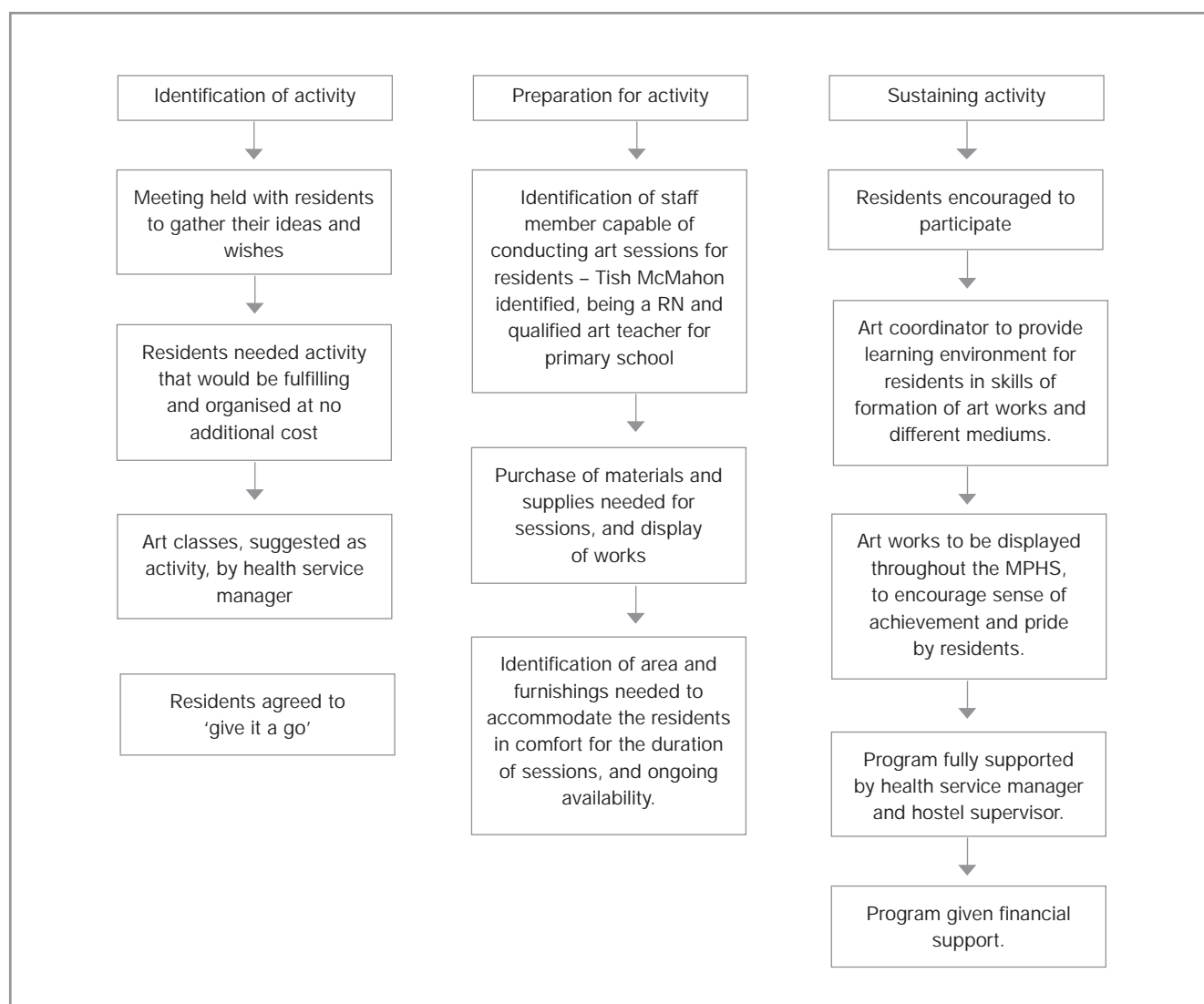
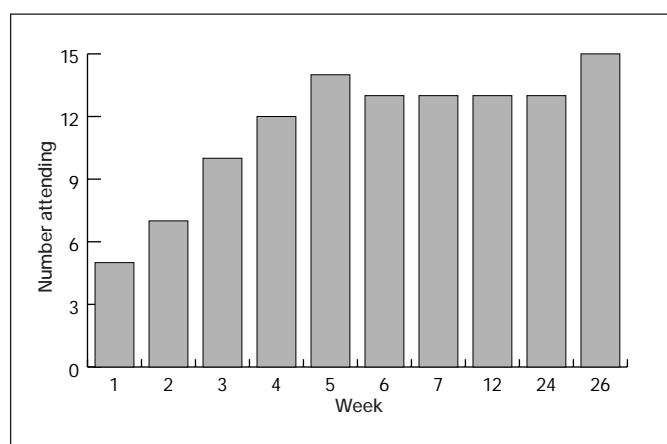


Table 1. Evaluation mechanisms



Graph 1. Total number of aged residents of Trangie MPHS attending sessions

continuity of care – commended

'Play in Partnership'

Paediatric Unit, Dubbo Base Hospital
Macquarie Area Health Service

Abstract

While clinical procedures are a necessary part of clinical practice, the following submission sheds light on the ways to improve the emotional and psychological conditions that impact heavily on children during treatments.



Andrew and the play therapist, Megan.

“Children have immature thoughts and feelings that affect what they believe about what is happening to them and why. Grown ups often violate this understanding in ways which can be accidental, deliberate, or occurring for the sake of expediency. While it is not the intention of the practitioner to commit overt acts of violence (the usual definition of child abuse), children’s vulnerability’s may turn treatment into just that.”

(Lindquist, 1983).

The above extract summarises the familiar concerns of health care workers. The following program has been successful in minimising such violations and is being regarded as a foundation for positive relationships between patients and the health care clinical system.

Mission statement

To optimise the healing experience through respectful attendance to psychosocial and emotional care of children in hospital. This will be achieved through decreasing children’s acute stress reactions as a result of necessary but invasive medical treatments in the Emergency Department and the paediatric treatment room through the implementation of play therapy.

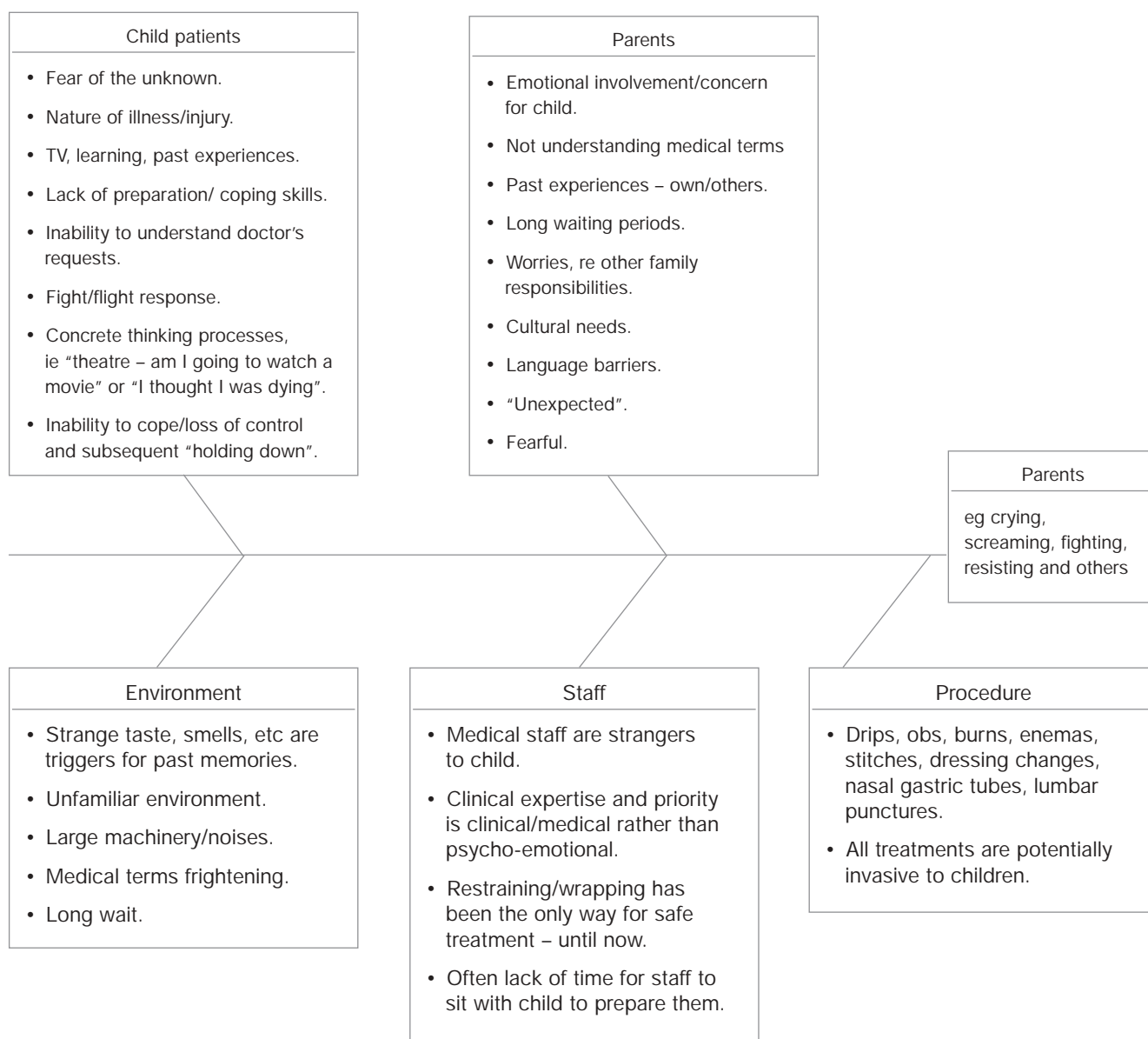
Background

Through observation and discussions with children, parents and staff it became obvious that children’s experiences of treatments were often traumatic for all involved. It was hoped that further investigation might reveal ways to transform stressful treatments into positive experiences.

“Children may react to emotionally unsupported procedures with hysterical symptoms, withdrawing behaviours such as sadness, or aggressive hyper-activity. Children may regress into hostile demanding, provocative or dependent infantile activities. Children reduce cooperation on behalf of their bodies”

(Lindquist, 1983).

Unfortunately children’s reactions have become accepted to be ‘the norm’ and therefore treatments are completed as safely and efficiently as possible – this often means holding the child firmly and wrapping. However it is suggested that play therapy adds a new dimension to treatments where children are actively aware, even participating in treatments to make it a whole and complete experience.



Method

The fish bone chart (figure 1) provides a summary of brainstorming and questionnaires that have taken place. It clearly states the many differing aspects contributing to children's behaviours resulting from their unique stage of development. With further discussion it was agreed that play therapy might change the dynamics of the treatments, as "play" is a child's work, where they learn and have control over their world.

Planning and implementation

Plan – Introducing play therapy into the Emergency Department and the paediatric unit's treatment room.

- Resources have been developed for procedural play and distractional play, with consideration to age ranges (babies – adolescence), presenting problems and necessary treatment. Safety and staff needs have also been considered.
- The procedural and distractional play programs have been implemented into the Emergency Department and paediatric treatment room. The program involves paging the play therapist between half an hour and an hour before any

treatment begins. The Play Therapist finds out necessary information from the parent, child and staff that will help determine the support needed. Preparation and coping skills are practised with the child.

- Staff have been educated in relation to this program and the steps to be taken when a child enters the facility.
- The community has been educated via local media, presentations and promotional materials such as pamphlets and posters.

Outcomes and evaluation

- Eighty seven percent success rate. The results were so positive that the program is now permanently implemented in both departments.
- Reduced patient anxiety.
- Reduced incidence of crying, struggling and other behaviour.
- Absence of regressive behaviours.
- Children were distracted while procedures took place – talking, laughing, participating.
- Effective for all ages, even toddlers benefited from preparation techniques.

Table 1. Outcome study results

| Age | Procedure | Reason for play | Play used | Result | Comments |
|---------|--|--|---|---|---|
| 7 years | Cannulation | Mum mentioned to nurse that child screams / fights every time he has a cannula inserted. | Procedural play distractational play. | Child was relaxed, allowing doctor to cannulate. No tears or fighting. | "It did not hurt much this time" – child. |
| 4 years | Obs to be performed –temp, weight, BP and urine sample needed. | Child very angry and refusing nurses to even begin obs. | Procedural play – playing with equipment. | After 15 mins child allowed staff to do obs; urine collected once child relaxed. | "I didn't think it would work" –parent. |
| 20 mths | Burns dressing to be removed. | Child screaming on entering the ward and bathroom. Refusing removal of dressings, clinging to mum. | Playing with toys –distraction, gradually move into bath. | No tears, played while heavy dressings removed and while ointments dressing re-applied. | "So much easier and she is happy" – parent. |
| 7 years | Removal of stitches from mouth. | Staff could not get near child and anaesthetic was not an option. | Procedural play. Child revealed during play "my mouth will not work if they take them out". | Child remained still and watched Play Therapist during procedure. | "Great stuff" – staff. |
| 2 years | To take oral medication. | Refused to have medication at home or in the ED. | Procedural play Use of puppets, dolls and syringes. | Within 10 minutes the child took the medicine himself. | "I can't believe that" – Grandma. |
| 18 mths | Cannulation | Mum very upset as it was difficult to find vein last time. | Distractational play. | Child played for a long length of time while drip inserted, no tears. | "that was so much better" – mum. |
| 6 years | Enema | Refusal based on previous experience of enemas, tried to leave the ward. | Procedural and Distractational play Relaxation to release muscle tension. | Remained still, played. No holding down, easy for staff to insert enema. | "Play therapy was just great. I know it helped my little girl greatly" – mum. |

- Play produced a calmer atmosphere for all involved.
- Through playing older children were able to ask questions which revealed their elevated fears
- Results of evaluations of treatment incorporating play therapy are included in table 1.

NB. Of the cases that weren't successful, one patient was brought in at the last moment when the procedure was about to begin (children need time to prepare to become relaxed) and the other patients was in so much physical pain (fresh burns) that they could not concentrate.

Future scope

- Maintain the existing program by continually updating skills and inservicing new and visiting staff members.
- Education to those working with children will continue, including expanding to regional hospitals in country NSW area.
- Currently making a video of many differing situations where play therapy helped – for education purposes.
- In the process of researching ways to resource the above vision to meet the needs of country children and their families.

“Seek the wisdom of the ages, but look at the world through the eyes of a child”

Ron Wild.

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continuity of care – finalist

The Clinical Protocol for the Management of Delerium

Kirketon Road Centre
South Eastern Sydney Area Health Service

Abstract

Cocaine and the sequelae of its use were an increasing problem in the Kings Cross area. A survey conducted by the Kirketon Road Centre (KRC) in 2001 (“The Cocaine Project”) among service providers in the Kings Cross/Darlinghurst area reported a 65 percent increase in cocaine use and associated harms, between 2000 and 2001. The NSW Ambulance Service identified that cocaine use had led to an increase in call-outs for acute psychosis, paranoid states, aggression and self-harm. Cocaine induced psychosis was the main concern cited by all the local services consulted.



‘a number of services have used the protocol for use in their services.’

In response, KRC developed a protocol for the clinical management of cocaine induced psychosis. KRC established a working party of representatives from various local agencies, which developed an accessible and easy to use protocol to guide the management of this problem.

The clinical protocol has been successfully integrated into KRC’s services and is now being adapted for inclusion in the NSW Psycho-Stimulant Strategy currently being formulated.

Aim

The aim of this project was to establish a coordinated approach and referral pathway to enhance the assessment and management of cocaine-induced psychosis in the Kings Cross community setting.

Background

The Kirketon Road Centre (KRC) is a primary health care facility of Sydney Hospital, located in Kings Cross. Its target populations are “at risk” youth, sex workers and injecting drug users. KRC provides a comprehensive medical, nursing, counselling and social welfare service, including a methadone access and needle syringe program from premises above the Darlinghurst Fire Station. KRC also has a satellite facility called K2, which provides a needle syringe service, health and social welfare advice and referral to drug treatment and other relevant services. An outreach program also operates from K2, seven days a week in the East Sydney, Darlinghurst and Kings Cross areas.

In July 2000, KRC initiated the Cocaine Project, a 12-month project focusing on the health and social welfare needs of cocaine injecting drug users (CIDUs) in the Kings Cross/Darlinghurst area of Sydney. The Cocaine Project was based at K2, which sees up to 200 clients each day, a significant proportion of these being cocaine injectors.

In early 2001 Australia experienced a heroin shortage. As a result many users in the Kings Cross area substituted cocaine as their injectable drug of choice. This increase in cocaine injection led to a further increase in the occurrence of cocaine-related harms.

The Cocaine Project generated the following information:

- Between 2000 and 2001, 57 percent of the local agencies consulted identified an increase in cocaine use as a result of the recent shortage of heroin and 65 percent identified an increase in cocaine use related harms.
- Ambulance services noticed the increase in cocaine use led to an increase in psychosis, paranoia, aggression and self-harm.
- Cocaine-induced psychosis was the main issue of concern cited by all service providers.
- Cocaine-induced psychosis initially manifests as paranoia, anxiety, agitation, aggression and mood swings.
- Ambulance services recommended the “fast tracking” system that St. Vincent’s Emergency Department had in place for cocaine-affected patients to enable clients’ issues to be addressed quickly with sedation seen as a priority in the initial management.
- Cocaine injectors themselves described significant symptomatology, including fits/seizures 30 percent, moods swings 70 percent, paranoia 37 percent, hallucinations 30 percent, delirium 33 percent.
- Cocaine injectors had no awareness of the possibility of overdose from cocaine use and its possible effects.

The Cocaine Project identified that local agencies did not have clear strategies and guidelines in responding to cocaine-induced psychosis in the community setting.

Method

Having identified a clinical need to develop a more coordinated approach to the clinical management of cocaine-induced psychosis in the Kings Cross community, the Kirketon Road Centre (KRC) sought the input of all relevant agencies. This was to ensure ownership of the protocol’s recommendation, considered essential to the development of an effective and appropriate clinical protocol to assist in the care of these difficult and challenging clients.

The working party was to consist of representatives from KRC (medical, nursing and counselling units), Sydney Hospital (Emergency Department and the Langton Centre), St Vincent’s Hospital (Emergency, psychiatry, community mental health team and drug and alcohol units), the NSW Ambulance Service, the Kings Cross Police Service and the Sydney Medically Supervised Injecting Centre.

Terms of reference for the Working Party were as follows:

- to identify the other causes of delirium, including cocaine-induced psychosis and how to assess these
- to agree on how cocaine psychosis would be best treated in the community setting when it was not possible to refer clients to the Emergency Department for a psychiatric assessment
- to identify the role of the *Mental Health Act* and its application to managing cocaine-induced psychosis
- to develop a clinical protocol that could be adapted and used by all relevant services in the Kings Cross community to ensure a cooperative, coordinated approach to this issue challenging the health system.

Planning and implementation

The Kirketon Road Centre (KRC) invited representatives of the relevant organisations to join a working party to develop a clinical protocol to address this clinical issue.

The working party agreed that cocaine-induced psychosis was a significant problem that would be better managed by all the services if there was a more common coordinated approach. While some services and individuals had developed their own guidelines for treating it, these were often not readily available or formalised and did not usually cater for managing this condition in the community setting. Meanwhile referral to specialist psychiatric and/or emergency hospital-based services was often difficult to achieve, rendering the untreated client with cocaine-induced psychosis a continuing danger to themselves and others in the community. There was general agreement that comprehensive and easy to follow guidelines would be considered highly useful by all the services involved at the meetings.

The working party met on three occasions and copies of the draft protocol were circulated for perusal and input between meetings. While the focus was on drug-induced psychosis, the approach incorporated the need to assess and manage other possible causes of 'acute delirium' (such as organic causes).

The final clinical protocol developed addressed:

- the approach to the presentation of clients with acute delirium
- assessment of other possible causes of delirium
- need for client containment in order to assess delirium and role out involuntary containment under provisions of the *Mental Health Act*
- appropriate referral pathways
- medical and general measures in the management of substance-induced psychosis including the prescription and use of anti-psychotic medication
- discharge planning and outpatient follow-up post-discharge
- advice to prevent and minimise harms associated with substance-induced psychosis.

A flow chart was developed and endorsed by all the interested parties that attended the meetings.

A validated delirium rating scale for nursing and medical staff was included as well as a scale to help non-medical staff assess a distressed person. The scale for non-medical staff was developed in consultation with non-medical staff at KRC and was based on a scale produced for staff working in Emergency Departments. These scales were reviewed and endorsed by all the parties involved in the consultation process.

The protocol also included a copy of the Schedule 2 from the *Mental Health Act*. The clinical protocol was implemented in the various clinical settings of KRC and communicated to other relevant local agencies.

Outcomes and evaluation

The clinical protocol was implemented into the service delivery of Kirketon Road Centre (KRC) over a series of education sessions to ensure that all relevant staff were aware of its content and application. A subsequent survey of clinicians at KRC demonstrated that overall it has been

an effective diagnostic and treatment tool; they specifically reported having greater confidence in dealing with cocaine-induced psychosis and that this has been linked to better outcomes for clients.

The clinical protocol has also been implemented across other relevant services in the South Eastern Sydney Area Health Service; a number of services have adapted the protocol for use in their own services. The services involved in the working party were all contacted subsequently to assess the outcomes of the implementation of the protocol. Very few problems were reported and where necessary, they were addressed and the protocol amended. Likewise, they unanimously reported that the more coordinated and consistent response between services as a result of implementing the protocol had improved clinical outcomes for clients.

While the level of cocaine injecting in the Kings Cross area appears to have decreased in recent months, there has been an increase in the injection of crystal methamphetamine or 'ice'. This psycho-stimulant is particularly potent and may also cause psychosis, which like cocaine induced psychosis, presents as delirium. Therefore this existing protocol has also been able to deal with this new clinical challenge in an appropriate and timely manner.

Future scope

This clinical protocol for the management of acute cocaine-induced psychosis in the community setting is now under consideration to be generically adapted and implemented as part of the state-based Psycho-Stimulant Strategy for NSW. This will represent a significant achievement in working partnerships to improve health care outcomes for those clients with cocaine induced psychosis.

Future plans for this protocol include:

- use as an educational tool for the 10 satellite services of the Kirketon Road Centre (KRC) which also target cocaine injectors
- presentation of this material at relevant scientific conferences and fora
- publication in national and international alcohol and other drug journals to promote better health outcome for the target population.

continuity of care – finalist

'Reach Out' – Rehabilitation and Care of the Elderly at Home

Post acute Care Services, Prince of Wales Hospital
South Eastern Sydney Area Health Service

Abstract

Older patients represent an increasing percentage of inpatients in NSW hospitals. Many have a prolonged length of stay, due to their debility after recovery from the acute illness or complications arising from the initial problem, and require rehabilitation. It has been asserted that rehabilitation at home is preferable, but home rehabilitation has not been used for the frail elderly.

We developed and tested a home rehabilitation service for frail elderly patients which resulted in equivalent rehabilitation outcomes but in a shorter time, greater patient satisfaction, shorter length of stay and lower overall cost compared to inpatient rehabilitation. The service also resulted in greater continuity of care as proven by surveys of general practitioners and hospital staff, and involvement of GPs in case conferences in the patients' homes.

Aims

Our aim was to provide rehabilitation care that best met the frail older patients' needs by truly centring full multidisciplinary care around the patient, and their carer, in their home. It was important to rigorously evaluate whether this new model did meet these aims.

Background

The need to improve health services and their availability for older patients is apparent from the increasing demand for limited facilities. Our experience with home rehabilitation and post acute care in orthopaedics, respiratory medicine and general surgery, amongst others, led us to examine whether there might be a need for home rehabilitation of frail older patients of the



Prince of Wales PACS Team

Geriatric Medicine Department. We saw an increasing demand for subacute care such as geriatric rehabilitation leading to delays in accessing such care because of the limited number of inpatient beds. During this delay period we found some patients deteriorated to the extent that they then required residential care placement.

Method

We examined the inpatient course of patients admitted under geriatric medicine because of acute medical problems and then listed for geriatric rehabilitation. Although there were seasonal variations in demand, we found that patients often waited two weeks or more to access geriatric rehabilitation, and the limited number of places meant some patients who may have benefited from rehabilitation, but were less assured of success, were pushed towards residential care placement. Although over 1,000 patients are admitted each year to geriatric medicine at Prince of Wales Hospital, because the geriatric rehabilitation ward has only 16 beds it must, of necessity, be selective about which patients receive rehabilitation.

A review of the literature revealed no studies aimed at home rehabilitation of frail older patients such as are treated in Geriatric Medicine, but there was some evidence that generally treating older patients at home instead of in hospital may improve health outcomes, patient satisfaction and lower cost. Informal discussions with geriatricians, nurses and allied health skilled in geriatric care suggested that use of home based rehabilitation may allow more patients to access this care, and supported the concept.

Meetings with consumers suggested that, with certain caveats, there would be consumer support for home rehabilitation. But the service had to be at least equivalent to hospital-based rehabilitation, and not a “cut-down” service.

Planning and implementation

A steering committee which included consumers, stakeholders from the geriatric rehabilitation ward, acute geriatric medicine, the post acute care services (PACS) which provided home rehabilitation, general practitioners, hospital administration and community services, overviewed the study.

Formal consultation and promotion to interested stakeholders was implemented by poster, in-service meetings and regular attendance at all discharge planning and monthly program planning meetings. The lack of available literature on this topic determined the need for a rigorous evaluation using a randomised controlled trial, although using a 2:1 randomisation to ensure efficient use of the home rehabilitation service.

Funding to support the project was sought and obtained from the National Demonstration Hospitals Program Phase 3 (Integration).

A project coordinator was appointed who was responsible for daily liaison with the PACS team, geriatric teams, screening and selection of all patients, collection of assessment data, randomisation, family and GP liaison and , discharge facilitation. The coordinator developed, in consultation with the steering committee, instruments for screening and assessment of patients, as well as a dedicated database to monitor the service.

Upskilling of existing home rehabilitation staff through recruitment and training was carried out. Monitoring was supervised by the steering committee, which met regularly (initially monthly) to review the data and progress.

Outcomes and evaluation

The baseline characteristics (Table 1) highlight the frailty and complexity of the patients in the study and that there was no difference between the two groups.

Surveys of patients and general practitioners revealed that they had experienced a significant improvement in continuity of care between the hospital and the GP, compared to controls ($p= 0.019$).

Length of stay in rehabilitation was significantly shorter for the home rehabilitation group (Table 2) but they achieved the same functional improvement in this shorter rehabilitation. That is their rehabilitation was more clinically efficient at home, and therefore more cost efficient as well.

Future scope

Given the increasing numbers of frail older patients admitted to the NSW hospital system and the need for cost-effective subacute options, which improve continuity of care and also increase patient satisfaction without sacrificing clinical efficacy and efficiency, there is a pressing need for models such as the one developed and rigorously tested in the REACH OUT study. This model has wider implications around Australia and the world where similar pressures exist.

| | Home rehabilitation group | Hospital rehabilitation group | P value |
|-----------------------------|---------------------------|-------------------------------|---------|
| Number | 62 | 33 | |
| Age | 83.27 | 80.61 | NS |
| Sex (F:M) | 43:19 (2:1) | 24:9 (3:1) | NS |
| Ischaemic heart disease (%) | 45.16 | 51.52 | NS |
| Diabetes (%) | 12.90 | 12.12 | NS |
| Dementia (%) | 20.97 | 24.24 | NS |
| Number of medications | 5.89 | 5.76 | NS |
| Number of medical problems | 6.97 | 7.15 | NS |
| Baseline FIM* score | 78.27 | 79.09 | NS |
| Baseline MMSE** score | 24.24 | 23.30 | NS |
| Baseline GDS *** | 10.05 | 10.06 | NS |

* FIM Functional independence measure (higher score is better)

** MMSE Mini Mental State Examination (higher score is better)

*** GDS Geriatric Depression Score (lower score is better)

Table 1. Baseline characteristics

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| | Home rehabilitation group | Hospital rehabilitation group | P value |
|----------------------------------|---------------------------|-------------------------------|---------|
| LOS in acute care | 18.7 | 16.9 | NS |
| LOS in rehabilitation | 15.9 | 23.0 | 0.017 |
| FIM* at end of rehabilitation | 100.1 | 104.6 | NS |
| GDS** at end of rehabilitation | 9.0 | 9.4 | NS |
| MMSE*** at end of rehabilitation | 21.4 | 22.2 | NS |
| Overall cost | \$18,482 | \$22,219 | |
| Cost of rehabilitation | \$6,225 | \$12,173 | |

* FIM Functional Independence Measure (higher score is better)

** MMSE Mini Mental State Examination (higher score is better)

*** GDS Geriatric Depression Score (lower score is better)

Table 2. Results

