

Second Report on the Models of Care Project: Workshops and Seminars

February-December 2006



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Executive Summary

The 2006 Models of Care workshops and seminars formed part of the Models of Nursing Care Project established by the Nursing and Midwifery Office of NSW Health (NaMO) in 2004.

The content was developed as a result of feedback from participants in the 2005 Models of Care Roadshow. These participants identified a range of skills and information required to enable them to review and implement changes to nursing care delivery and organisation practices (models of care work).

Workshops were offered at 20 sites across NSW and over 900 clinical nurses and midwives participated, with about 2/3 being metropolitan nurses and 1/3 being rural or remote. A wide range of clinical specialties were represented at both workshops and seminars.

The workshops and seminars were positively evaluated and there was strong consensus that they met their stated aims. Thirty eight of thirty-nine seminar presenters gave permission for their presentations to be made available through the NaMO Models of Care website.

The themes that emerge are discussed in detail in the Report and are:

- Growing synergies across the State
- Change and development in nursing roles
- Growth of Practice Development
- Identification of cultural and practical challenges
- Lack of clarity around role delineation and expectations

A key recommendation is the proposal to establish a statewide Modelling Care (MoC) Reference Group comprising those key personnel who have been involved in coordinating the work to date and representatives from each of the Faculties of Nursing and Midwifery who are currently engaged in issues relating to clinical practice and thus shaping future clinical environments. This group would then interact with a wider group of clinical leaders and practice developers to build capacity within the broader nursing workforce on the investment by NaMO in these areas.

In discussion and feedback from nurses and midwives in the workshops, five key areas of challenge can be identified to drive the ongoing MoC work: These are Sustainability, Synergy, Synchronicity, Spread and Self-belief. The recommendations for 2007/08 are set out under these headings. In addition to the five areas of challenge, a strong and coherent overarching evaluation strategy must be developed in order to:

- Conduct evaluations of the existing work they have already undertaken
- Implement and evaluate new projects in line with the five key areas of challenge
- Generate new theory around models of care work and develop empirical evidence about how the five key areas of challenge can be implemented within the nursing and midwifery professions.

It is envisaged that this work will be ongoing over 2007 and 2008.

Recommendations

There is a clear need to move towards sustainability of the models of care work so that the measurement, review, innovation, re-measurement and publication of outcomes, in relation to work concerning organisation and delivery of patient care, become part of the culture.

A range of synergies, recommendations and suggestions has emerged from the workshop evaluations that can be progressed across Area Health Services.

Key Recommendations:

- That a State-wide Modelling of Care Reference Group be established comprising clinical and academic nurses and midwives.
- That an overarching evaluation strategy is adopted in order to evaluate current and future models of care projects and to generate new theory around models of care and supportive empirical evidence.

Recommendations:

Sustainability

- That NaMO continues to support the development of new and improved models of nursing and midwifery care delivery and organisation through scholarships and strong and visible leadership and infrastructure.
- Continue Statewide support for the implementation of Practice Development in nursing and midwifery practice to promote a culture where innovation and best practice can flourish through a person-centred approach.
- Engage patients in changes to care delivery practices and organisation to ensure person-centred care while enabling realistic expectations from both staff and patients.

Spread

- Continue and where possible increase financial support through scholarships for innovations in models of care in order to meet demand and to encourage further work.
- Facilitate at an AHS level the attendance of RNs, ENS, AINs at seminars that showcase and share models of care activities.

- Nursing and midwifery leaders in Universities and AHSs to encourage and promote strong links between universities and clinical areas in relation to Models of Care implementation and evaluation.
- Develop further statewide and local strategies to spread information about models of care activities and to encourage links within AHSs as well as between other AHSs and between AHSs and universities.
- Support nurses and midwives to present and publish their clinical innovations, change processes and research.
- Develop an action plan to identify ongoing and further communication strategies to ensure dissemination of activity across NSW.

Synergy

- Promote and encourage synergies between academics and clinicians in making scholarship and grant applications.
- Ensure synergies with other state-wide initiatives through information sharing at both state and local levels to guarantee maximum efficiencies.
- Nursing and midwifery clinical and academic leaders to provide strong support for new and existing strategies to improve links and communication strategies across hospital/community boundaries.

Synchronicity

- Academics and clinicians to work more closely together to ensure maximum uptake of grant and scholarship application opportunities.
- NaMO to continue to coordinate and disseminate information about models of care activity regularly in order to ensure that corporate knowledge and memory will not be lost.

Self-belief

- Support strategies to encourage nurses and midwives to develop cultures of lifelong learning such as action learning sets and Practice Development.
- Facilitate formal assistance and education in relation to working in teams to support the development of new models of care.

Background

1.1 History of Nursing Models of Care project

In 2004 the then Chief Nursing Officer (CNO), A/ Professor Kathy Baker, asked Professor Mary Chiarella to set up a four year program to assist clinical nurses to:

- a) explore and develop innovative models of nursing care delivery and organisation that would facilitate best clinical practice
- b) develop new and emerging roles and partnerships within nursing and health care.

The need to develop clinical nursing and midwifery leadership to be both proactive in relation to improving safety and quality in health care and responsive to changes in the health care landscape had been identified initially by the Ministerial Standing Committee on the Nursing Workforce (2000)¹ and later by the Joint Strategic Reference Group for Nursing and Midwifery (JSRGNM) (2003). Issues identified that led to the need for such a program included, but were not limited to, the following:

- The much-needed increases in nursing undergraduates, trainee enrolled nurses, enrolled nurses and new graduates being recruited to meet the projected shortfall of nurses in the future will mean significantly greater numbers of staff in the workplace, who in their early days will require education and support
- The introduction of nurse practitioner and other specialist advanced practice roles will mean greater numbers of highly specialised staff across the workforce
- Changes to care delivery patterns -eg clinical streaming, outreach and in-reach programs will mean geographical and structural shifts to the nature and location of teams

- The growing focus on multidisciplinary workforce development may mean changes to the allocation and ownership of work and will certainly require a more interdisciplinary approach to problem-solving (NSW Health, 2006).

It was agreed that the project would be a four-year action research project, with the emphasis being on the development of leadership and innovation at a clinical level, supported by nursing management and integrated into the wider health care improvement and academic environment. It is critical to understand that the project recognises the need for cultural change and development at a local level if readiness and aptitude for clinical improvement is to be embedded into the fabric of health care. For this reason, the project set out to learn from local successes, in order to identify what strategies could then be spread across NSW to improve the sustainability of such cultures and to develop synergies between interest groups.

¹ Ministerial Standing Committee on the Nursing Workforce Action Plan (2001) http://www.health.nsw.gov.au/nursing/pdf/action_plan.pdf Accessed on 15th March 2007

1.2 Year One (2005)

Activity for the first year focussed on investigating and collecting current developments in relation to the review and development of Models of Nursing Care; providing literature and information for nurses who were unfamiliar with the existing debates about nursing care delivery and organisation; and affording opportunities for the exchange of ideas between nurses across NSW. The objectives for the 2005 Models of Care Roadshow were to provide:

- the first step in an iterative process to assist clinical and academic nurses to benefit and profit from the changes that are occurring due to increased recruitment of staff
- exemplars of best practice and to workshop difficult issues in relation to models of nursing and midwifery care and practice
- a forum for exploring ideas and generating discussion
- clinical and academic nurses with opportunities to think about analysing practice
- clinical and academic nurses with a range of tools to help them to evaluate the effectiveness of existing practices.
- support and stimulate questions.

The Roadshow was positively evaluated and generally agreed to be highly successful in meeting its objectives. In addition to the evaluation of the Roadshow per se, further questions were asked of the participants in terms of identifying key issues emerging from the workshops that were in need of further exploration. These issues were mapped and analysed for inclusion in the report and to guide the next round of the action research cycle. The Report from the Roadshow has been published² and a website established³ to disseminate nursing and midwifery innovations and to provide opportunities for networking and identification of synergies among NSW nurses. Following the Roadshow, presentations were also made to Faculties of Nursing and Midwifery in NSW universities to encourage greater synergies between academic and clinical staff in terms of development of research, publications and joint funding applications. This work to increase synergies between nursing and midwifery faculties and the clinical areas is an integral part of the Models of Care Project.

² 2 NSW Health (2006) First Report on the Models of Care Project http://www.health.nsw.gov.au/pubs/2005/pdf/models_of_care.pdf

³ http://www.health.nsw.gov.au/pubs/2006/models_of_care.html

Overview of Year Two (2006) Work

2.1 Issues and needs identified

Year Two (2006) built on both the work undertaken and issues identified through the evaluations in Year One (2005). The issues and needs identified in the evaluations are set out below:

- a) Engage more RNs, ENs and AINs in the discussions around modelling care (the nurses who had attended the first year workshops were predominantly more senior clinical nurses)
- b) Ensure that the outcomes of the workshops are both analysed and publicised
- c) Provide senior clinical nurses with more information about how to access support, both in terms of funding and skills to implement change
- d) Foster greater mentorship and clinical supervision;
- e) Foster greater collaborative practice with other health care professionals
- f) Improve clinical education skills for nurses;
- g) Develop stronger collaboration between hospital and community staff.

2.2 Scholarship announcements

Year Two began with the release of the *2005 First Models of Care Report*, which ensured publication and dissemination of the work relating to models of care being undertaken by NSW nurses, and the announcement by the Minister for Health of Nursing Innovations Scholarships. Nine \$10,000 scholarships were awarded on International Nurses Day in 2006. The first round of scholarship recipients are listed in Appendix A. A second round of scholarships was offered in 2006, with a closing date of 31st December 2006. In addition, funding was granted for Innovations Scholarships for mental health nurses. These will be reported on in the 2008 Report. It is of note that, in the second round and the Mental Health round, the overall quality of the scholarship applications was much

improved, the number of scholarship applications had more than doubled and the combined applications from academics and clinicians was more noticeable. Joint applications were often, although not exclusively, of a higher quality, probably due to the expertise of the academics in developing grant applications.

Support for innovations in models of care needs to be ongoing and, given the number of applications, could increase to meet demand and to encourage further work.

Joint applications from academics and clinicians are to be promoted and encouraged.

2.3 Workshop and seminar format

The workshops and seminars were provided at 20 venues over the year. In addition to the workshops organised and offered through the Nursing and Midwifery Office, some organisations specifically requested assistance in exploring new models of care and this was provided. The Renal Services Network of the Greater Metropolitan Clinical Taskforce (GMCT) and Justice Health were two such organisations. Venues and dates are listed in Appendix B.

2.3.1 Morning workshops

The format for the education program in Year Two has been a series of half-day workshops and seminars across NSW. The morning workshops were designed for senior clinical nurses who attended in 2005 to build on existing knowledge in a range of areas. The objectives for the morning workshop were derived from the issues identified by respondents in the *2005 Roadshow* (see Section 2.1) as follows:

- To provide an overview of Clinical Services Redesign and Patient (CSRP) safety projects and their relationships to changing models of patient care delivery
- To stimulate thought and discussion about developing new care delivery models
- To apply these new ideas in practical exercises about developing and resourcing new models
- To harness collective knowledge and enthusiasm for future implementation.

The participants were introduced to the CSRP and any nurses and midwives currently involved in CSRP work were encouraged to share their experiences and discuss their work so that networks of interest could be established. The same process was undertaken for the Clinical Excellence Commission's (CEC) suite of safety and quality activities. An overview of the outcomes and activities from the first year's Models of Care work was shared with the participants and information was provided about both fiscal and human resources that can be accessed to facilitate models of care delivery and organisation development and review. An introduction was provided to the value of practice development as a means of engaging clinical nurses and midwives in innovation and review. The participants then worked in groups to share innovations across their own Area Health Service (AHS). This information has also been collected on their evaluation forms so that for Year Three an activities directory can be established on the NaMO Models of Care website so that nurses and midwives across NSW can see at a glance who is undertaking activities similar to theirs. A series of activity tables derived from this work are set out in Appendix C. Workshop participants consistently found the networking to be both inspirational and enlightening. Many had no idea of the extent of activity occurring "on their own doorstep".

Further state-wide and local strategies are required to provide information about models of care activities and to encourage links within AHSs as well as between other AHSs and between AHSs and universities.

2.3.2 Afternoon seminars

The Year Two afternoon seminar was a short program designed to a) address the need to engage more nurses in MoC discussions issues, and b) introduce more clinical nurses (RNs, ENs, AINs) to the concepts of nursing care improvements across the models of care spectrum. The focus of this year's presentations was on work undertaken through the growing synergies between clinical and academic nurses and midwives, the clinical work undertaken by participants in the Clinical Leadership Program (CLP) funded by NaMO in 2004-2005, and some introductory presentations later in the year from the Innovations Scholarship recipients.

The afternoon seminars were poorly attended by clinical nurses initially. This was due to two discrete factors: in metropolitan hospitals, the difficulties in releasing clinical staff from surrounding wards and units to attend; and for rural staff, the problem that those who had travelled to attend the morning workshop were unable to return in time to cover for clinical staff to attend the afternoon seminar. Two strategies were used to address the problems. The rural workshops were simply offered as an all-day attendance with both experienced and less experienced clinical staff being able to attend both. In metropolitan hospitals, by shortening the length of the afternoon seminars from 3 hours to 1.5 hours, and focussing solely on the presentations, larger numbers of clinical nurses were able to be released to attend or rotate through the afternoon seminars. The evaluations for the afternoon seminars were uniformly positive and many attendees verbally reported becoming aware of the work of their peers (sometimes for the first time) as inspirational and motivating. Feedback from the afternoon seminars is provided in section 2.8.

AHSs to continue to develop strategies to allow clinical grades of nurses eg RNs, ENs, AINs to attend seminars that showcase and share models of care activities, as this is highly motivational and affirming

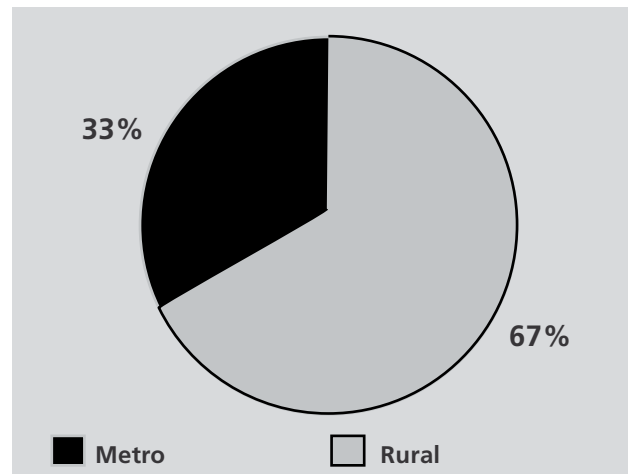
2.4 Integrative projects

In addition to the activities around the workshops, Year Two has seen the commencement of a range of projects, generated within the AHSs, aimed at further support for review and development of new care delivery models and publication and dissemination of improvements. Credit for much of this initiative must go to those coordinators who were involved both in the Models of Care project and also in the original CLP. Several of these CLP graduates have sought synergies with universities to further develop the models of care work by obtaining funding for project grants and to develop partnerships for publication (eg SESIAHS, HNEAHS, SSWAHS). Other AHSs have funded individuals to undertake more extensive local work on developing new models of care (eg GWAHS) and still others have joined up with research organizations who were seeking opportunities to facilitate larger scale research projects (eg JH, SESIAHS and Hospital Alliance for Research Collaboration). One AHS has also introduced a "Writing for Publication" program to assist clinical nurses to team up with academic writing coaches (SEIAHS). This program is continuing in 2007.

Support for nurses and midwives to publish their work is essential. The writing for publication workshops introduced by SESIAHS provides an example that could be implemented in every AHS and supported by academics to develop joint publications with clinicians and to ensure spread of information.

2.5 Profile of workshop attendees

Accurate participation data are not available for a range of reasons, as clinical staff were free to come and go during the workshops (and even more so during the seminars) as their workload enabled. Data provided are from numbers of people returning questionnaires, rather than total numbers attending. Thus for the workshops it is possible to say that at least 566 clinical nurses and midwives attended and for the seminars at least 361 nurses and midwives attended (although we know that more rotated through and neither registered or completed evaluations). In the workshops 66.6% of the attendees were from metropolitan facilities and 33.4% from rural.



The vast majority of the respondents at the workshops were senior clinical nurses and midwives, with 25% being Nursing Unit Managers (NUMs), 21% being Clinical Nurse Consultants (CNCs), 13% being Clinical Nurse Educators (CNEs) and a further 12% being Clinical Nurse Specialists (CNSs). Only 12% identified as Nurse Managers (NMs).

Although the intent of the second year of workshops was to provide ongoing education to the senior clinical nurses that had attended the Roadshow in 2005, there was a significant proportion of each audience who were becoming involved with the Models of Care project for the first time in 2006.

It will be important to continue to provide information about models of care activity regularly to ensure that new staff understand the aims of the project and the context in which clinical changes are arising.

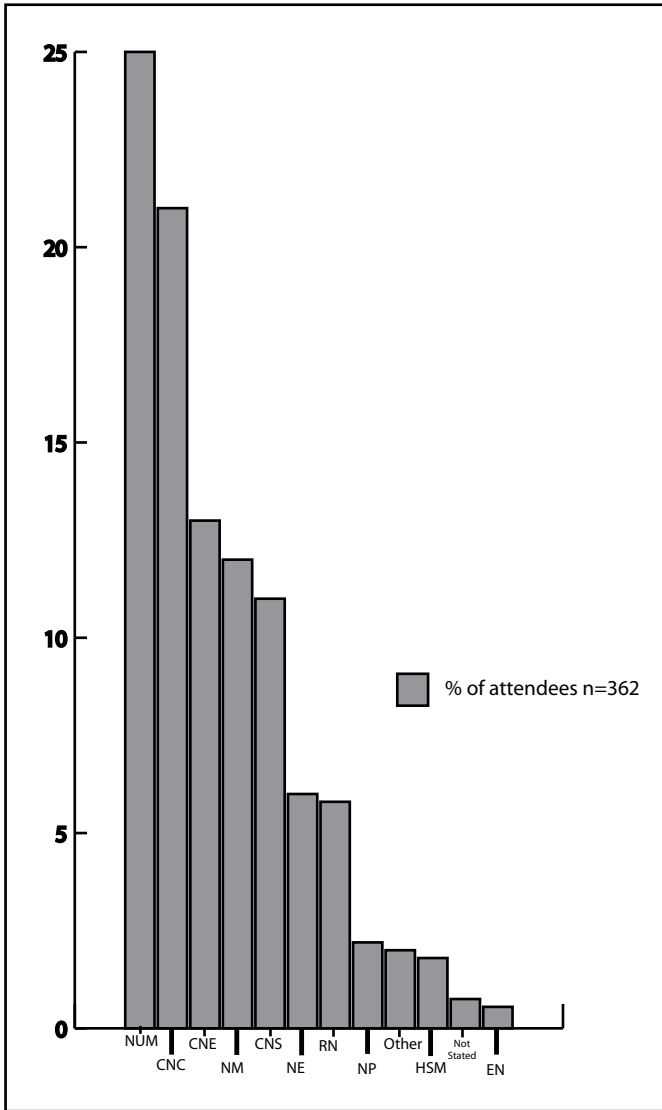


Figure 2: Breakdown of respondents by role

There was a wide range of specialist nurses and midwives represented. These are set out in Table 1. Medical and mixed medical/surgical accounted for over 17% with Critical Care and Emergency representing a further 11%. Overall a broad cross-section of specialties was represented, which was gratifying.

Specialty	Frequency	Percent
Medical	44	12.2
CC-Emergency	40	11.0
Management	35	9.7
Surgical	34	9.4
Other	33	9.1
Community Health	28	7.7
Aged care	25	6.9
Midwifery	23	6.4
Mix med/surg	20	5.5
Family & Child Health	13	3.6
Mental Health	11	3.0
Nursingf Education	11	3.0
Rehab	11	3.0
Periop	10	2.8
Oncology/ Haematology	8	2.2
Paediatrics	6	1.7
Palliative care	3	0.8
Neonatology	2	0.6
Policy	2	0.6
Not stated	1	0.3
OPD	1	0.3
Research	1	0.3
Total	362	100

Table 1: Specialty mix of responding nurses and midwives attending workshops

2.6 Profile of seminar attendees

Seminar evaluations were collected from 229 participants from 60 facilities around NSW. This is not representative of all attendees as the invitation was extended to any clinical nurse for as long as they were able to attend, in order to obtain maximum coverage of clinical staff. Some wards and units had clinical staff rotating through the afternoon seminar, with a cohort attending and then returning to the ward to relieve other staff to enable them to attend. Although attendees who were present at the commencement of the seminar signed the attendance sheet, as did most of those who were still there at the end of the seminar, those who came in and out during the seminar usually entered and left quietly, often without registering their attendance or completing an evaluation form. Thus all afternoon seminar evaluation data is presented with the caveat that it does not necessarily reflect the views of all attendees. However 361 participants registered and of those, 229 completed evaluations, giving a response rate of 63.4%.

There is an ongoing need to develop strategies to enable less experienced clinicians to attend models of care workshops as they will be the group most affected and implicated in clinical practice change.

The breakdown of attendees is set out in Table 2. At first, there was some reluctance to release registered nurses to attend the seminars due to reported workload demands and time constraints on busy wards. It is therefore gratifying to note that overall 33% of respondents were registered nurses, as this is indicative of the significantly increased attendance once the seminars were shortened from 3 hours to 1.5 hours. However, AINs (n=1) and ENs (n=15) are still poorly represented in the respondents. Although there are only 6 undergraduate respondents identified, there were a number of seminars where undergraduates attended and their verbal feedback and interaction during the seminars was both thoughtful and positive

Designation	Frequency	Percent
AIN	1	0.4
NUM	29	12.7
NM	24	10.5
HSM	4	1.7
Other	8	3.5
EN	15	6.6
RN	75	32.8
CNS	15	6.6
CNE	18	7.9
Undergrad	6	2.6
NE	8	3.5
CNC	24	10.5
NP	2	0.9
Total	229	100

Table 2. Designation of seminar respondents

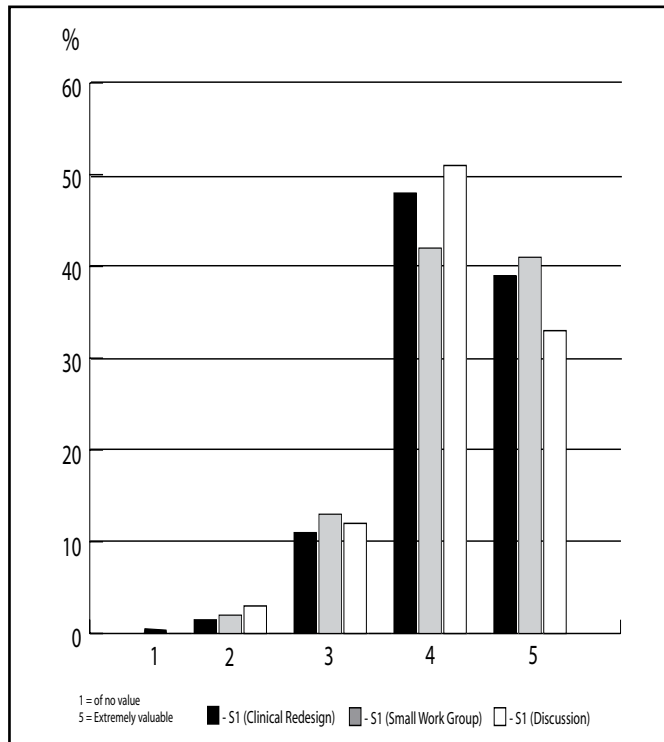
The seminar attendees also came from a wide range of specialty areas and these are set out in Table 3. The fact that managers were strongly represented in the afternoon seminars (14%) is due to the decision to integrate the workshops and seminars in rural areas (see 2.3.2). Almost 32% of respondents worked in general medical/surgical units, 8.7% in emergency or critical care and a further 8.3% in community or family community health.

Specialty area	Frequency	Percent
Medical	43	18.8
Management	32	14.0
Surgical	22	9.6
CC-Emergency	20	8.7
Other	20	8.7
Com H	17	7.4
Midwifery	13	5.7
Aged care	12	5.2
Periop	11	4.8
Rehab	10	4.4
Mix med/surg	8	3.5
Education	7	3.1
Mental H	6	2.6
Not stated	5	2.2
Family CH	2	0.9
Paediatrics	1	0.4
Total	229	100

Table 3 Area of specialty of seminar respondents

2.7 Workshop Evaluation

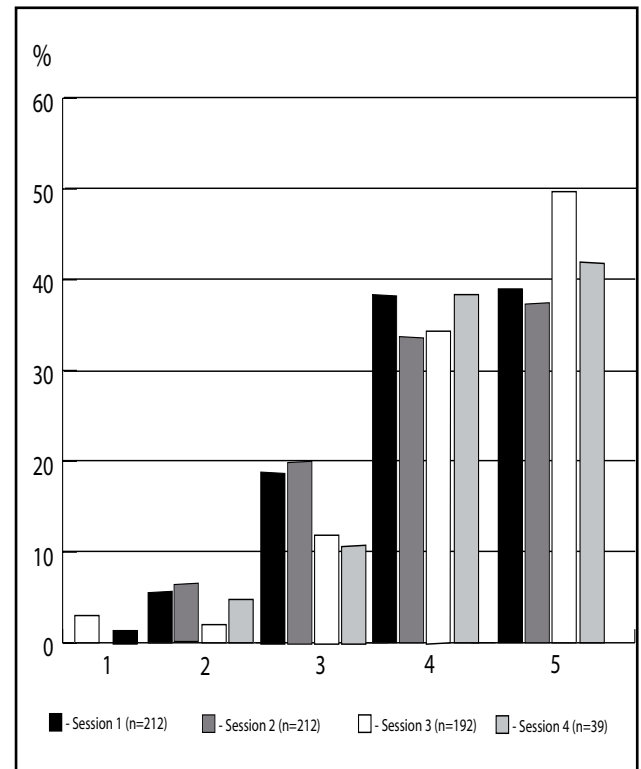
Respondents found the workshops valuable and rated them highly on a Likert scale with between 80% and 90% of participants scoring 4 or 5 for all sessions. [5 being extremely valuable and 1 being of no value.]



Other comments relating to the day from workshop participants (n=94) included that it was “a very useful and informative day” and “a purposeful and productive project” (n=16) and there were ongoing requests for more information and more dissemination of information about the project (n=48). The workshop questionnaires also requested evaluation feedback. They sought information about involvement in work relating to patient care organisation and delivery. Most significantly, in terms of the action research element of this project, the questionnaires sought advice about what further resources and support nurses needed to move this work forward. These data will be presented in Section 4.

2.8 Seminar evaluation

Seminar evaluations were collected from those participants who were present at the end of the seminar. The evaluations are extremely positive overall, with between 70-80% scoring the seminar either 4 or 5 (with 5 being extremely valuable and 1 of no value) in meeting its stated aims.



General comments included that the seminar was inspiring or good work and that the participants learnt a lot and had received food for thought (n=50). The seminar participants were also asked to identify two or three issues that had arisen for them from the seminars and asked for comments on future ideas. There was a lot of overlap between these two areas so they will be treated as one for the purposes of reporting. Comments included the need for further information about reflective practice and Practice Development (n=26), and the Clinical Leadership Program (n=20). Many of the comments related directly to the presentations they had seen e.g. comments about returning to their clinical areas with ideas to implement new wound management or aged care practices. Other recurrent comments revolved around the enthusiasm they had witnessed and would now take back to their own areas. A few comments are set out in Box 2.1. as examples of the tone of feedback.

Box 2.1. Examples of comments from seminar respondents

- “Restored my faith in nursing after 40 years of service” (Gosford)
- “Many of the innovative ideas seem so obvious at least after their implementation, it is hard to believe they are only now being put forward” (Ballina)
- “The sharing of information between clusters/ health services is essential as there are many innovative ideas out there” (Pambula)
- Rekindled enthusiasm to make relevant meaningful changes within the health unit ...” (West Wyalong)
- “All very interesting - amazing what’s going on around you that you don’t know about” (Nepean)
- “Very inspirational - gave me hope for our unit” (Royal Hospital for Women)
- “Very informative and impressed with work ethic of presenters”; “Will inspire me to get through last semester” (undergraduate students)
- “The workshop enabled me to see that the “great divide” between hospital and community can be bridged. Stimulated to make improvements in my area”. (Community health, GSAHS)

The Presentations

A number of the presentations for 2006 were those providing updates and extensions from projects initially presented during 2005. The quality of presentations was once again outstanding. The criteria for inclusion in the seminars were the same as in Year One (2005): nurses or midwives must have taken baseline measurements, implemented a change and then re-measured. In order to maximise synergies with and promote awareness of existing activities in the NSW Health CSRP⁴ and the Patient Safety and Clinical Quality Program⁵, presentations were sought from nurses who were leading these projects. Nurses were specifically asked to share tools and resources and to address areas of challenge as well as successes, so that participants could learn from each other's challenges, in addition to their successes. We had also called for presentations that involved community nursing, as this was an area of work that participants in 2005 had identified as requiring further work.

This year a decision was made not to bring external speakers to the AHSs, but rather to encourage nurses to learn more about the activities occurring in their own AHS, given the restructure and the need to develop greater information sharing within the new AHSs. The only exception to this was where AHSs requested external presenters. Thirty eight (38) of the presenters gave permission for their PowerPoint presentations to be shared through the NaMO website.⁶ A list of the presentations is provided In Appendix D

In order to identify trends in nursing practice and organisational development the presentations have been thematically analysed and the key themes and challenges identified. The work of this Models of Care Project has had a key diagnostic element, in that it set out to identify what projects nurses and midwives were initiating at the "grass roots" level to bring about changes in their clinical practice and organisation. The purpose of this strategy was then to be able to identify strengths and challenges in that work and to support the work and disseminate the

findings to increase spread and sustainability. In addition, it was anticipated that dissemination of the findings would spark synergies with other similar work occurring across NSW. The analysis of the presentations is discussed under the following headings:

- Growing synergies through the NaMO Models of Care Project
- Growing synergies through other state-wide initiatives
- Changing and developing nursing roles; focus on clinical specialities
- Growth in Practice Development
- Identified and ongoing challenges.

3.1 Growing synergies through the NaMO Models of Care Project

A significant number of the presenters demonstrated that not only had they progressed their own local work since 2005, but they had also taken steps to link up with others to develop improved synergies across NSW and to obtain funds and other resources. There was also growing evidence of the development of teamwork, including multidisciplinary links, another factor that was highlighted in the 2005 Roadshow.

3.1.1 Ongoing progress of local work

In terms of progressing their own local work, Davis, Murray & Rivas, (2006, Prince of Wales) who had presented their work in introducing 12 hour shifts on a Respiratory and Infectious Diseases ward in 2005, described how they were now developing action learning sets among the clinical nursing staff in order to develop an ongoing culture of improvement in patient care. They described action learning as "learning through reflection, questioning, critique of own and others' clinical practice, work[ing] on real clinical issues, with the intention of getting things

⁴ NSW Health (2005) Clinical Services Redesign Program Redesigning a better patient journey Program Overview October 2005 http://www.health.nsw.gov.au/nursing/pdf/action_plan.pdf Accessed on 25th March 2007

⁵ NSW Health (2006) Patient Safety and Clinical Quality Program http://www.health.nsw.gov.au/policies/pd/2005/PD2005_608.html Accessed on 25th March 2007

⁶ NSW Health Department (2007) Models of Care 2006 presentations <http://www.health.nsw.gov.au/nursing/moc.html#2006pres> Accessed on 25th March 2007.

done-given ownership". They described the process as "Someone presents an 'issue' and the group helps them to understand it, come up with solutions & set achievable goals" and went on to state that the process was "empowering nurses to speak up about their practice and take action towards positive change".⁷ This development was part of an ongoing growth in Practice Development, which will be discussed later in Section 3.4. Dempsey and Mangone (2006, Gosford), who had reported on their work in developing new models of care in medical wards at Gosford and Woy Woy in 2005, have now gone on to do further work around patient stories and observations of care, using ideas generated through the Clinical Leadership Program⁸ and applied to Dempsey's work over the past ten years.⁹

3.1.2 Developing synergies across NSW

Strategies to encourage nurses to develop cultures of lifelong learning such as action learning sets and Practice Development need strong support and dissemination.

A heartening aspect of the presentations was the numbers of clinicians who were developing strong and ongoing links with academics to assist in the development of robust methods to design and evaluate patient care organisation and delivery practices. This was occurring in a range of specialty areas and locations. For example, Harman (2006, HNEAHS Community Mental Health) reported on the establishment of a Professional Development of Community Mental Health Nurses (CMHN) Working Group whose aim is "to develop a consistent and comprehensive model of care based on the developing models of integrated mental health care".¹⁰ The project has been established in consultation with Professor Mike Hazelton at the University of Newcastle and is designed to encourage improved community liaison between CMHNs and General Practitioners and to develop an integrated case management model using evidence-based interventions.

Donna Hartz described the introduction of a midwifery model of care in the Ryde Group Midwifery Practice and

the extensive risk assessment and evaluation process that was established as part of its implementation. The risk assessment process was Highly Commended in the NSW State Treasury Managed Funds Risk Management Awards in 2004. The summary of the extensive risk management controls put in place for this program are set out in Box 3.1

- ACMI National Midwifery Consultation and Referral Guidelines
- NSWNA annualized salary agreement
- NSWMA Credential
- Early antenatal record review and ad hoc clinical review by RNSH obstetrician (NICE)
- 24 hour on-call telephone liaison/consultation: midwifery; obstetric; paediatric
- Antenatal/ intrapartum /Neonatal consultation and referral pathway/algorithms and guidelines
- Ryde ED Maternity consultation and referral pathway
- Peer review: prospective audit using specific clinical indicators
- Clinical networking with RNSH for antenatal women in moderate and high risk groups
- Underpinning these quality measures are tools and guidelines of the Safety Improvement Program of NSW Health

Box 3.1: Risk management controls in place for Ryde Group Midwifery Practice (RMGP)

The evaluation of this project was undertaken with Professor Sally Tracy from the University of Technology, Sydney. Two significant outcomes from this study as compared with NSW data overall are that normal vaginal birth rates for the RMGP were 83.7% as compared with a NSW rate of 62.8% and the length of stay for the RMGP was 2.5 days as compared with a NSW rate of 3.5 days.¹¹

Other projects that will be discussed later but that had developed links with universities for design and evaluation purposes include Bevan (2006, John Hunter,

⁷ Davis J, Murray S and Rivas K, (2006) 12 Hour Shift a Possibility in an Acute Ward- http://www.health.nsw.gov.au/nursing/pdf/12hr_shift_acute_ward.pdf Accessed on 25th March 2007

⁸ Nursing and Midwifery Office (2005) Clinical Leadership Program <http://www.health.nsw.gov.au/nursing/clp.html> Accessed on 25th March 2007

⁹ Dempsey, J. (2004). Falls prevention revisited: a call for a new approach. *Journal of Clinical Nursing*, 13, 479-485., Dempsey J (2006), The elusive indicator: A search for a nurse sensitive outcome measure for patient falls DNur Thesis <http://www.nmh.uts.edu.au/research/theses.html>

¹⁰ Harmon, K., Carr V.J. & Lewin T.J. (2000) Comparison of integrated and consultation-liaison models for providing mental health care in general practice. *Journal of Advanced Nursing*, Vol 32 (6). 1459-1466; Shannon-Jones, S., Surrledge, A.& Boden, J. (2003). Developing an integrated mental health nursing team. *Nursing Standard*.Vol 17, (27), 41-44.

¹¹ Tracy SK & Hartz D (2006) The Quality Review of Ryde Midwifery Group Practice, September 2004 to October 2005. Final Report. Northern Sydney and Central Coast Health

University of Newcastle); Wand (2006, Royal Prince Alfred Hospital, University of Sydney); Crisp & Ind, (2006, Bloomfield, Charles Sturt University) and Coote, (2006, POW, University of New South Wales). It is also heartening to note that a number of the nurses presenting had already published in relation to their work and are continuing to do so.

Excellent examples of working together across AHS boundaries were provided through the strong relationships developed through the NaMO Clinical Leadership Program (Cutler, SESIAHS & Griffin, JH, 2006). These will be discussed in more detail in Section 3.2. Other networks were also used as learning groups - for example, the nursing limb of the Renal Services Network of the Greater Metropolitan Clinical Taskforce (GMCT) enabled Lucas (2006, Griffith) to learn from the experiences of Josephine Chow at Liverpool Hospital in order to introduce medication Endorsed Enrolled Nurses (EENs) into a new haemodialysis unit at Griffith and subsequently into an existing unit at Wagga Wagga.

Nursing leaders in universities and AHSs must encourage and promote strong links between universities and clinical areas to produce robust implementation and evaluation designs in relation to Models of care work.

3.1.3 Accessing funds and other resources

Several presenters outlined their success in obtaining funds and/or support through major statewide initiatives such as the CSRP and these will be discussed further in Section 3.2. In addition, at the request of HNEAHS, two of the presenters later in the year were Innovations Scholarship recipients who presented their project designs in order to provide guidance for future scholarship applicants (Bevan, 2006, John Hunter; Hurt, 2006, John Hunter). This strategy was clearly successful as 17 of the 45 scholarship applications in December 2006 came from the HNEAHS. Bevan had been particularly successful in accessing not only a scholarship but also all her equipment for the trial from the company whose technology she wished to trial. Coote (2006, Prince of Wales) enlisted the support of the Australian Graduate School of Management

(UNSW) who assisted him to develop a business case to access further funds for evaluation and expansion of the service. An example of using pre-existing resources differently was provided by Ronald (2006, RNSH) who used the Employee Assistance Program to help her analyse team dynamics in a ward that formerly had a high turnover and anecdotally low morale.

3.1.4 Growth of and emphasis on teamwork

In the 2005 presentations there was much discussion and debate about the change in hospital based settings from a predominantly patient allocation model of nursing care to a range of team nursing models. These changes had been made to accommodate both the increase in new graduates into the system and also the changes in skill mix. Changes in skill mix included the introduction into clinical areas of endorsed enrolled nurses, more trainee enrolled nurses and assistants in nursing to address staffing shortages and improve workforce stability, rather than relying on casual or agency staffing. In 2006 there were a number of presentations about skill mix changes, which will be discussed in Section 3.3, but in many of the presentations where changes to care delivery practices were occurring, there was still significant emphasis put on the development of team work and the engagement of multidisciplinary stakeholders.

Marshall (2006, Wagga Wagga), describing the introduction of a 23hour ward, emphasised the need to engage all nurses in the process and to ensure that there was a consistently held belief about the need for the change. In addition, she described working closely with surgeons, anaesthetists, patients and carers in introducing the service. Wand (2006, RPAH) in a presentation aptly titled "Evolution, not revolution" described how the Mental Health Nurse Practitioner (NP) role in the Emergency Department (ED) at Royal Prince Alfred Hospital had been in progress since 1998, beginning with a Mental Health liaison nurse pilot project,¹² then moving onto a Clinical Nurse Consultant position in 2000 and later a NP role in 2003, with guidelines authorised in 2005. Wand reports having the support of the Nurse Unit Manager (NUM), the Director of the Emergency

¹² Wand T & Happell B (2001) The Mental Health Nurse: Contributing to improved outcomes for patients in the emergency department Accident and Emergency Nursing 9, 1-11

Department and the head of Psychiatry Clinical Liaison, in addition to his nursing peers in order to ensure the effective roll-out of his position. The role will be described in more detail in Section 3.3.

De Cressac (2006, Woy Woy) in describing the Proactive Team model developed in the sub-acute care unit, identified the need to engage all staff in the planning and development process. The staff began their changes with a team planning day and developed an agreed set of principles on which to base their new model. They identified a range of strategies in the implementation phase that they considered critical to maintain the involvement and commitment of the team. These included regular debriefing in the initial phases every 1-2 days, regular trouble shooting sessions as problems arose in addition to regular formal meetings, the ability to provide verbal feedback to NUM or Clinical facilitator and an ideas box for those who preferred to feedback anonymously. They also sought feedback from the multidisciplinary team and provided a formal evaluation questionnaire at three months. Performance management was also considered essential for ongoing team growth. They provided clear descriptions and expectations of roles to provide clarity on what could be expected of the nursing team.

Crameri (2006, Orange) also identified the need for a clear set of principles and values on which to base future team work. This concept will be discussed in more detail in the section on Practice Development (PD), as it is central to the development of a PD culture. Crameri also engaged the team in diagnosing the issues they had identified as problematic through activities such as process mapping and patient review. These were reported to be powerful tools in identifying common problems and developing shared goals. Ronald (2006, RNSH) identified understanding the strength of the team as being one of the key factors in affecting change. She provides a range of advice within her presentation

Formal assistance and education in relation to working in teams is essential for new models of care to develop. This includes aspects such as communication, challenge, peer review and support, performance management, craft transfer, mentoring and reflective practice.

in relation to team dynamics. Harmon (2006, HNEAHS MH Community), Coote (2006, POWH), Samuels (2006, Nepean) and McPhail (2006, Bulli) all emphasise the need for involvement of the multi-disciplinary team.

3.2 Growing synergies with other state-wide initiatives

As was requested, a number of the presentations were from statewide initiatives, such as the CSRP, specifically in relation to aged care and patient access, the Towards a Safer Culture (TASC) Project being coordinated through the CEC and the initiatives arising from the five year plan identified under *New South Wales: A New Direction for Mental Health*.¹³ In addition, there were a number of presentations generated by the work of participants in the Clinical Leadership Program¹⁴ sponsored by NaMO over 2005/2006. The purpose of requesting presentations by nurses involved in some of the state-wide initiatives was to highlight the synergies and shared concerns between the work that nurses initiated at grass roots level and the work that was being coordinated at state level.

Presentations relating to patient access included the introduction of the 23 hour ward at Wagga Wagga Hospital (Marshall, 2006), the project to reduce the long elective orthopaedic waiting list at Mount Druitt Hospital (Cort, 2006) and the introduction of Advanced Practice Nurses at Prince of Wales Hospital to provide after hours support for Junior Medical Officers (Coote, 2006). Presentations relating to aged care initiatives under CSRP included the Acute Care of the Elderly (ACE) model (King, 2006, Ryde), a shared care model between admitting physicians, geriatric specialists and the multidisciplinary team, which included "Nurses (-NUM, CNE, RNs, EENs, ENs, AINs and undergraduate nurses), Physiotherapist, Occupational therapists, Social worker, Mobility Enhancement person (physiotherapist or physiotherapist assistant), Pharmacist and Speech pathologist (as requested)".

The outcomes for this project include decreased readmissions within 28 days for ACE patients from 12.4% to 3%. This is significant for both patient care and budget as the average cost saving of 10 ACE patients who are NOT re-admitted is approximately \$23,300.

¹³ NSW Health (2006): *New South Wales A New Direction for Mental Health* http://www.health.nsw.gov.au/pubs/2006/pdf/mental_health.pdf Accessed on 25th March 2007

¹⁴ This program has now been discontinued and nursing and midwifery clinical leaders are now encouraged to apply for the multidisciplinary Clinical Excellence Clinical Leadership Program <http://www.cec.health.nsw.gov.au/currentprojects.html#clp>

Another aged care project initiated as a result of the CSRP is the Older Persons Evaluation Review and Assessment Project (OPERA) (Gradidge, 2006, Nepean). The project is designed to "facilitate best practice care through a mixture of inpatient outpatient, ambulatory and community care options capable of delivering acute, post acute, sub acute and chronic maintenance and management as required". Yet another was the change in status from what had previously been a 16 bed, general medical, surgical and paediatric ward into an Acute Geriatric Unit at Bulli District Hospital (McPhail, 2006). Whilst these projects will in all probability be reported as part of the state-wide initiatives from which they were generated, the presentations by these nurses are available on the NaMO website as they provide valuable information on implementing and evaluating change.

The TASC Project was sponsored through the CEC initially with the purpose of introducing evidence-based clinical pathways for the management of acute cardiac and stroke patients. Part of the pilot project was the introduction of the Cardiac Assessment Nurse (CAN) and this has now been recommended as a state-wide initiative. The CAN has a liaison role both emergency department and all other aspects of cardiac care from intensive care unit to cardiac catheter laboratory to ensure that "the cardiac patient's journey is rapid, accurate and safe" (Samuels, 2006, Nepean).

There were a number of presentations relating to mental health innovations and these will be discussed further in Section 3.3. However, it is important to acknowledge that mental health nursing has been given significant support through the increased emphasis on mental health in New South Wales A New Direction for Mental Health. By March 2007, an extra ten nursing innovations scholarships were advertised and awarded for mental health innovations and models of care, in addition to those advertised and awarded for other nursing models of care innovations.

Another statewide initiative that created significant changes to nursing practice was the NaMO sponsored CLP. The program was introduced in 2005 and completed in 2006, with the transfer to a multidisciplinary program sponsored by the CEC. The CLP (UK) was designed to be a two tiered professional development program to meet the needs of clinicians and local facilitators who were usually senior nurse leaders with a focus on the person receiving the care. This provided a valuable platform particularly for work relating to changes to models of care delivery. The activities focusing on patient care delivery revolved

around undertaking observations of patient care and taking and acting upon patient stories. In addition, the CLP grew and developed excellent networks among nursing and midwifery clinical facilitators and leaders that continue to deliver dividends in terms of the preparedness of the participants to take on leadership roles (Rivas, 2006, POW; Jones, 2006, St Vincent's; Cutler & Griffin, 2006, St George/NaMO, JH).

The observations of care exercise required the local clinical leader to spend thirty minutes with an external peer in their own clinical environment both simultaneously observing and recording their observations of patient care, which they then compared and contrasted. As a result of this exercise Hamilton (2006, RPAH) made improvements to privacy and confidentiality, space and environment and hand-washing and infection control in the unit where she was the NUM.

Bristow (2006, Armidale/Tamworth) reported that the patient stories taught staff a great deal about the patient's feelings and needs. Staff learnt that the relationship between staff and patients was very important to the patients' care, with one patient proudly stating "even when I'm off they worry about me". However, equally important was for the patients to be able to trust the staff professionally and feel confident about their clinical skills with another saying that "staff are efficient, effective and have a fine spirit". The observations of care were also undertaken from the patient's perspective by giving one of the patients a video camera to record their "view".

The nurses learnt from both these exercises that things that mattered to the patients included time spent waiting, including time when the machines break down and the time spent on the machine. They learnt that the environment was boring, the patients asked them "What do you do for five hours?" They also learnt that there was no personal space as the unit was designed to be an open plan unit so that the nurses could see all the patients. In terms of the environment, the patients spoke of the noise, in terms of the machines and the staff; the smells of coffee, of clinical solutions and of food and of the colour of the walls. As a result of these patient stories and experiences Bristow and her team made extensive changes to the environment in the haemodialysis unit that included a major diversional therapy program, including movies, magazines, poetry readings, music programs, socialization during treatment, visitors and guests into the unit, and celebrations of events such as birthdays, Easter and

Anzac Day. They also developed feature walls, displayed patients' art works and photographs and now actively encourage conversation and sharing between patients, many of whom attend the units for years.

Synergies with other statewide initiatives is critical and information sharing at both state and local levels needs to continue to ensure maximum effectiveness.

3.3 Changing and developing nursing roles

There were a number of presentations that focussed on the introduction of new nursing roles, at a senior clinical level, also endorsed enrolled nurses and the introduction of Assistants in Nursing (AINs) in acute care. There was also some focus on the development of new roles within specialties and descriptions which, in some cases were quite detailed outlines of the education provided to equip nurses and midwives for new roles, were also shared. This information is provided on the NaMO website but all presenters offered to provide further information directly on request.

3.3.1 Development of senior clinical nursing roles

A number of the presentations focused on the introduction of new nursing roles. These provided valuable advice about the need to carefully plan their introduction and to identify exactly how these roles impact existing roles. Unless the new roles are to introduce a completely new aspect of patient care, it is highly likely that all existing roles will require some revision in order to ensure clarity of role expectation and performance and avoid work overlap. A number of presenters described the introduction of advanced nursing roles, both Award and non-Award. Wand (2006, RPAH) describes in some detail his daily practice, which is set out in Box 3.2.

Box 3.2 Daily practice of MH Liaison NP in ED (Wand, 2006, RPAH)

- Provides advanced MHN care through direct contact with patients, family and significant others and through support, education, and advice to other healthcare professionals
- Provides a link between mental health services, community organisations, General Practitioners, and mainstream medical services
- Actively promotes mental health awareness and primary prevention
- Facilitates access to medical care for people with mental health concerns
- Incorporates an expanded, autonomous clinical role in decision making, medication prescribing and in advising on or interpreting pathology tests and results
- Utilises a repertoire of psychotherapeutic and psycho educational interventions with individuals to promote greater personal understanding and self-mastery
- Demonstrates a high standard of professional practice and clinical leadership that incorporates education and research
- Maintains involvement in organisational and professional matters such as regular meetings between the ED and mental health services, providing input on working parties and into training programs, as well as providing clinical supervision for MHNs.¹⁵

Asimus (2006, Greater Newcastle Cluster Community Care) reported on the introduction of a Nurse Practitioner (Wound Management) position. Following a clinical audit she identified 233 patients with classified chronic wounds that had remained unhealed for longer than 12 months. Her strategies to address this problem, described in detail in her presentation, included the implementation of clinical practice guidelines and competencies for wound management across the Greater Newcastle Cluster. This raft of strategies resulted in the number of patients with a wound opened longer than 12 months being reduced by 61.4%. Similarly Puckett, Hallam and Leaver (2006, Goulburn Community

¹⁵ Wand T (2004) Mental health liaison nurses in the emergency department: on-site expertise and enhanced coordination of care Australian Journal of Advanced Nursing 22(2) 25-31.

Nursing Service) reported significant improvement in patient outcomes as a result of the introduction of a Clinical Nurse Consultant (CNC) role “to support clinicians’ professional skill and confidence in applying evidence-based practice processes ensuring optimum client outcomes and consistent clinical practices”. Puckett, Hallam and Leaver were of the view that “education alone is not enough” and that staff needed “power points to plug into” in the form of local clinical leaders to provide support and reflection on practice. The CNC introduced a comprehensive and in-depth reflective practice program that will be described in Section 3.4.

Samuel’s role as CAN (2006, Nepean) and Coote’s role as Advanced Practice Nurse (APN) (2006, POW) are both examples of positions that were developed to address gaps in services. The CAN role was described earlier and Coote describes the APN role as “A clinical nursing position created to

- Provide support to junior medical officers
- Improve After Hours continuity of care
- Improve & Promote a safer patient care culture
- Improve patient access/ flow After Hours and
- Provide a transitional training platform for NPs”.

These roles are obviously highly rewarding for the nurses undertaking them and provide significant job satisfaction as nurses are really able to make a difference to patient outcomes. The ability to develop positions that provide transitional roles for nurses into NP career development is a positive aspect of the APN role, as a proliferation of non-award positions in order to address specific care delivery problems has the potential to create career uncertainty or even stasis for clinical nurses.

3.3.2 Emerging roles for enrolled nurses

The introduction of medication endorsement for enrolled nurses (ENs) in NSW has seen a proliferation of changes to their role, as they are now able to be more flexible in the range of care they are able to provide. This has opened up new career opportunities for ENs, and it is anticipated that this will enhance enrolled nursing as a career path in its own right, but also as a pathway to registration, given the potential for recognition of prior learning. Endorsed ENs (i.e. ENs who are able to administer medications following a Nursing and Midwifery Board (NMB) approved course of study) were successfully introduced into the operating room (Sutherland-Fraser, 2006, POW), the haemodialysis unit

(Lucas, 2006, Griffith, Wagga Wagga) and the neonatal nursery (Mulhearn, 2006, Westmead). Despite initial misgivings about the way in which these new roles would be accepted by registered nurses and midwives, all three programs reported acceptance overall.

3.3.3 Introduction of Assistants in Nursing (AINs) (Cert III)

Two presentations focussed on the introduction of AINs (Cert III Aged Care) into the workforce. Both wards (Ronald, 2006, RNSH; Jones, 2006, St Vincent’s) were acute aged care units where there was significant difficulty in recruiting permanent registered nursing staff. Both wards were concerned about continuity and quality of care due to high levels of casual and agency staff use. In terms of cost, Jones calculated his use of agency AINs plus his overtime payments from June 1st to September 1st 2004 as the equivalent of 4.2 FTEs, due to the use of undergraduate agency AINs on 58 shifts, other agency AINs on 115 shifts and paid overtime to the equivalent of 70 shifts. Agency shift payments were significantly reduced following the introduction of permanent AIN (Cert III Aged Care) staff. On both wards the introduction also resulted in improved patient outcomes, including reduction in falls and medication incidents.

Clear agreement on and dissemination of the scope and expectations of new roles is essential to prevent disharmony, communication breakdown, over-servicing and under-servicing.

3.3.4 Changes within specialty practice and midwifery

Although there is some overlap with previous sections, there was significant focus in the 2006 seminars on three key areas of specialty nursing practice and midwifery. These were mental health, aged care, and community nursing. To some extent, mental health and aged care were to be anticipated, as both are priority areas for NSW Health. However, community nursing had been identified in the 2005 feedback as an area where further focus was required and midwifery was an area the MoC project had chosen not to focus on, as midwifery models of care were being addressed through a range of other strategies within the Department of Health. Therefore it was both surprising and gratifying to see them showcased to some extent within the presentations.

Mental health

There were some real changes made to models of mental health nursing care. Harman's (2006, HNEAHS Community MH) developed an integrated "stepped" model of community mental health case management, whereby community mental health nurses work in concert with general practitioners. The aim of the project is "to improve communication and collaboration between the services in an effort to maximise resources". It is anticipated that "improved collaboration from the CMHN could ensure GPs are able to manage patients through a sequence of referred treatments options, such as Cognitive Behavioural Therapy, whilst monitoring outcome as well as the appropriateness and timing of pharmacological therapy"

Three in-patient models of care for mental health patients were also presented. Wand's work (2006, RPAH) has already been described in some detail in Section 4.3. Two other presentations address access, entry and exit to acute inpatient mental health services (Crisp and Ind, 2006, Bloomfield) and a medication self-administration program on a mental health rehabilitation unit (Coates, 2006, Prince of Wales). Both these projects are highly innovative and produce excellent outcomes. Crisp and Ind describe an extensive audit and review of both the telephone triage service provided and the work of the acute admissions clinic. The extent and rigour of the review undertaken is to be commended and the quite radical changes made as a result of the review were based on the best available quantitative data and research literature. As a result of this review the team changed from a task orientated model of care to a team focussed model of care with the following attributes:

- A small group of nurses working together
- Guided by a team leader
- Consisting of staff who have a diversity in education and skills
- Focusing on working collaboratively and co-operatively
- Sharing responsibility
- Having accountability for assessment planning delivery and evaluation of patient care
- Including continuity of care along the patient journey

- Providing greater communication and interaction between nurses, patients and community stakeholders
- Improving quality of care due to responsibility and accountability
- Allowing greater access to clinical supervision.

This work is currently being evaluated by the team at Bloomfield in conjunction with Charles Sturt University. The third of the in-patient models is the introduction of a self-medication program to the Mental Health Rehabilitation Unit (MHRU) at Prince of Wales Hospital. The MHRU is a medium stay non gazetted clinical rehabilitation facility opened in September 2004. The model of care is based on the recovery model and the 'Framework for rehabilitation for mental health'.¹⁶ The MHRU is built within the hospital campus, has 24hr nursing staff and an On-Campus Pharmacy. The self-medication program is set out in three stages and has a strong research base. As with each of these presentations, it contains considerable detail regarding the implementation and is thus a valuable educational and information tool for interested readers.

Aged care

Three of the aged care models presented in the 2006 seminars have already been described as they originated from the work of the CSRP (King, 2006, Ryde; Gradidge, 2006, Nepean & McPhail, 2006, Bulli). The development of an Older Persons Acute Care Model has been central to the work of Peek and Higgins (2006, John Hunter), both individually and more recently collectively, for many years. This work has recently merged with work on Person-Centred Care emanating from the PD movement¹⁷. The model is both theoretical and practical and has been implemented in parts of the HNEAHS where, since its introduction, there have been significant reductions in falls, hospital acquired pressure areas and use of restraints.

Community nursing

A number of highly successful community nursing projects have already been described earlier, with a NP in wound management (Asimus, 2006) and changes to community mental health nurse practice (Harman, 2006) both being successfully introduced in HNEAHS. Hallam's outstanding work (2006, Goulburn

¹⁶ NSW Health (2002) Government Action Plan: Framework for Rehabilitation for Mental Health <http://www.health.nsw.gov.au/policy/cmnh/publications/pdf/rehabilitation.pdf> Accessed on 31st March 2007

¹⁷ Garbett, R. & McCormack, B. (2002) A concept analysis of practice development. *Nursing Times Research*, 7(2), 87-100

Community) in improving wound outcomes through the introduction of a CNC position to provide mentoring and ongoing support and peer review has also been highlighted and will be discussed further in Section 4.4. A project that introduced a home visiting service for palliative care from an in-patient setting identifies the reduction of traditional hospital/community barriers. This is anticipated to be the hallmark of future models of care. Baddock (2006, Mount Druitt) described the introduction of a collaborative after hours home based visiting program between Mount Druitt Palliative Care Unit and the local primary health network. The service provides a crisis after hours phone support service to palliative care patients between 17.00 and 08.00 hours, seven days per week, backed up with a crisis home visiting service offered by the Palliative Care Unit.

Midwifery models of care

Three successful midwifery models of care were presented at the seminars and have been described earlier. These were the introduction of an early pregnancy assessment clinic at Auburn, Westmead & Blacktown Hospitals (Carlyon, 2006); the Ryde Midwifery Group Practice (Hartz, 2006), and the program that received an innovations scholarship to support women with antenatal and postnatal depression in the Newcastle, Port Stephens and Lake Macquarie areas (Hurt, 2006).¹⁸

3.3.5 Presentations describing in-house education programs

A significant feature of the Models of Care project has been the generosity people have demonstrated in their willingness to share both research tools and educational resources of all kinds. Whilst it is beyond the scope of this report to go into these in any detail, there is rich information about the educational programs available in the power point presentations on the NaMO website and all presenters were agreeable to being contacted directly for further information and discussion. It is hoped that readers will take up those offers and minimise unnecessary repetition. Detailed breakdown of educational programs is provided in relation to in-house management training (Stead and Hamilton, 2006, GSAHS); orientation and mandatory training (Toft and Johnson, 2006, Pambula); dementia education (McPhail,

2006, Bulli); EEN scrub program (Sutherland-Fraser, 2006, SESIAHS); and EN neonatal nursing (Mulhearn, 2006, Westmead).

3.4 The growth of Practice Development

Perhaps one of the most significant developments in the models of care presentations in 2006 was the uptake of PD as a means of achieving cultural and practice change. A need for further understanding of and support for PD was identified as a key recommendation in the 2005 Models of Care Report.¹⁹ PD can be simply Technical or Emancipatory. Emancipatory PD has an impact on the clinical culture and environment. There was much agreement amongst presenters about the value of Emancipatory PD as an important underpinning to supportive and challenging cultures in which nursing aspirations could be realised, and in which innovation and improvement could flourish.

In terms of identifying modes of PD, there is significant overlap between organisation and delivery of patient care. Furthermore, changes to these aspects of nursing work impact on both patient and staff outcomes. Examples from the presentations of changes to the organisation of nursing care include nursing care delivery patterns (such as team nursing and patient-managed care); rostering; skill mix; location of care; and, handover. Examples of changes to delivery of patient care include the prevention of adverse events (such as falls and medication errors); clinical interventions (such as measurement of INR levels on the ward, wound care management and cognitive behavioural therapy); and developing new care delivery strategies with patients and relatives. Much of this work would fall within the definition of Technical PD. The way in which this work has been introduced may or may not fall within the ambit of Emancipatory PD (Garbett & McCormack, 2002).²⁰ Knowing more about the PD movement is helpful for people wishing to learn more about how best to sustain a culture of inquiry and readiness for improvement and change. What is apparent from the presentations and feedback (over the past two years, but particularly in 2006) is that engaging in PD activities is deeply satisfying for nurses and contributes to improved staff and patient outcomes.

¹⁸Significant focused work is also being undertaken in NaMO in relation to midwifery models of care. For more information see <http://www.health.nsw.gov.au/nursing/maternity.html>

¹⁹ NSW Health (2006) First Report on the Models of Care Project P. 6. http://www.health.nsw.gov.au/pubs/2005/pdf/models_of_care.pdf

²⁰ Garbett R. & McCormack B. (2002) A concept analysis of practice development. *NT Research* 7(2),87-100.

NSW has been fortunate in early 2007 to have Professor Brendan McCormack, as a Visiting Professor to the Prince of Wales Hospital and the University of Sydney. He has been principally responsible for the development of the research and literature around PD. This visit is drawing to a close, but there is now a strong cohort of experienced nursing staff who have worked with him, some over several years, to develop skills in PD., Their impact is evident in some of the most significant and sustained changes that have occurred in clinical nursing culture over the past few years. PD is defined as:

A continuous process of improvement designed to promote increased effectiveness in person-centred care. It is brought about by enabling health care teams to develop their knowledge and skills and in doing so, transform the culture and context of care. It is enabled and supported by facilitators who are committed to systematic, rigorous and continuous processes of change that will free practitioners to act in new ways that better reflect the perspectives of both service users and service providers. ²¹

One of the key components of implementing Emancipatory PD is the need to engage in values clarification. Clarkson and Hook (2006, Children's Hospital, Westmead) describe the use of a Values Clarification Tool to establish the agreed culture on their unit that asks a number of key questions, set out below in Box 3.3:

Box 3.3 Key questions for values clarification²²

- I believe our purpose in this ward is
- I believe we can achieve this purpose by
- I believe my role in the team is
- I feel valued when
- Factors that enable this purpose to be achieved are
- Factors that inhibit the achievement of this purpose are
- Other important values and beliefs I hold are

De Cressac (2006, Woy Woy) also reported that beginning their change to their nursing model of care with a values clarification exercise was essential for the introduction of their Proactive Team model. However, it is important to recognise that such an exercise may take time to reach consensus on the values, especially if they are to underpin the new culture required to make changes in the workplace. De Cressac reports commencing the values clarification work in February 2004 and not completing until August 2004. Dempsey and Mangone (2006, Gosford) also undertook extensive values clarification work across two facilities and used a set of four questions to drive their work.

- What do you want nursing to look like in this stream?
- What makes you proud to be a nurse in this stream?
- If you were a transient nurse how would you expect to be treated?
- What would you need to function effectively?

As a result of the values clarification work Dempsey & Mangone were able to identify a set of principles that underpinned the model of care they adopted. These are set out below in Box 3.4.

Box 3.4 Principles underpinning the model of care developed at Gosford Hospital

- Person centred care that encourages patient independence by professional and caring nurses.
- A team approach to work that supports, plans and guides care with clear roles identified and communicated.
- A culture that embraces learning, professional growth and innovation.
- Clear and inclusive communication for nurses and patients that commences with orientation and continues.
- All staff are valued for their knowledge and skills and decision making is transparent and participatory.

²¹ Ibid, p.87

Cramer (2006, Orange Hospital) also undertook values clarification exercises prior to introducing a patient-centred model of nursing care. This was clearly important to the nursing staff, as prior to the change to the model of care, 52% of staff surveyed were dissatisfied with the quality of patient care and “knew they could do better”. In one ward 80% of staff were dissatisfied with current practice. Following major review and revision of care delivery organization and practices, this changed to 80% of staff being satisfied with the new practices.

Another key element in PD is the concept of person-centred care. Person-centredness has been defined as:

- The right to have values and beliefs as an individual respected (personhood) and knowing that these values and beliefs are what makes each individual unique and authentic
- It requires us to know the values of another in order to treat them as a person
- It requires us to work with individual’s beliefs, values, wants, needs and desires and adopt approaches to work that enable flexibility, mutuality, respect, care and being with another as an interconnected relationship.²³

Peek and Higgins (2006, John Hunter) have used the person-centred approach as the basis for the development of an Older Persons Acute Care Model that has been introduced into the Divisions of Medicine and Surgery at the John Hunter Hospital. A set of principles in relation to Older Person care were developed and agreed among the staff and standards were identified and introduced across the multidisciplinary team. The introduction of this model has resulted in reduction in the number of falls, hospital acquired pressure areas and application of restraints since its introduction.

Other aspects of PD include the need to critique practice (in order to be able to develop constructive solutions for change) and concepts such as team building, mentoring and clinical supervision are also allied to the process. The concept of a “critical companion” who provides high challenge accompanied by high support is central to PD²⁴ and was also central to activities such

as observations of care in the CLP program. Central to all these processes is the requirement for reflection on practice. In one of the seminal texts on reflective practice, it is defined as:

*The throwing back of thoughts and memories, in cognitive acts such as thinking, contemplation, meditation and any other form of attentive consideration, in order to make sense of them, and to make contextually appropriate changes if they are required.*²⁵

Puckett, Hallam and Leaver (2006, Goulburn) identified that reflection on practice was the key to improving patient care in community nursing, that education alone was not sufficient. Analysis of previous mechanisms for supporting professional practice had identified that they did not allow for the in-depth exploration of professional roles, values and strategies that underpin the individual nurse’s practice. Reflective practice has been introduced through a process of clinical support (a term the staff preferred to clinical supervision). In the process the nursing staff participate in a weekly meeting whereby staff, in rotation, present a case that demonstrates the nursing process of referral, assessment and care planning pathway.

The CNC works with each nurse preparing and presenting the case study. The nurses are encouraged to reflect on the on the efficacy of their nursing practice against the evidence based standards. The template for the case study preparation is provided in their presentation. Another form of collegial support was implemented by Mulhearn (2006, Westmead) who described the establishment of a mentoring program to allow for “a shared supportive and encouraging relationship with an experienced person which is built on mutual attraction and shared values and supports personal and professional development and socialization into the workforce”²⁶

Statewide support for the implementation of Practice Development in nursing and midwifery practice would ensure strong synergies and support and promote a culture where innovation and best practice can flourish through a person-centred approach.

²² Manley K (1992) Quality Assurance: The Pathway To Excellence in Nursing (Chapter 7) In Bryzinska G & Jolley M (Eds) Nursing Care: the challenge to change. Edward Arnold London

²³ McCormack B (2001) Negotiating Partnerships with Older People - A Person-Centred Approach. Ashgate, Basingstoke.

²⁴ Manley K, Hardy S, Titchen A, Garbett R & McCormack B (2005) Changing patients’ worlds through nursing practice expertise: Exploring nursing practice expertise through emancipatory action research and fourth generation evaluation. A Royal College of Nursing Research Report, 1998 - 2004 Royal College of Nursing: London <http://www.rcn.org.uk/publications/pdf/Nursingpracticeexpertise.pdf>

²⁵ Taylor B (2000) Reflective practice: a guide for nurses and midwives Allen & Unwin: Sydney, p.3

3.5 The identification of ongoing challenges

A specific request this year was that presenters were to reflect not only on what was successful, but also on what aspects of change had been particularly challenging for them and required ongoing work, in order to direct nurses who might be experiencing difficulties for support and advice towards other clinicians who had encountered and managed similar problems. It is a reflection of the growing confidence in and robustness of the MoC work that many nurses generously shared their areas of challenge and where available discussed strategies they had used. The challenges identified were both cultural and practical and related both to staff and patients.

The cultural challenges fundamentally related to comfort with change, confidence to try out new ideas, and concepts of professionalism and trust. How these matters were managed created the need for a range of practical skills.

In terms of comfort with change, the Emancipatory PD work specifically identifies the need for staff to own the change process and to feel empowered to take control of the change. Understanding this need to own the process, presenters still reported the difficulty nurses encountered letting go of old practices and rituals, even though the nurses may themselves have identified them as outdated (Puckett, Hallam & Leaver, 2006, Goulburn Community). Nurses recognised that some of their practices might be nurse centred, rather than patient centred, but they were entrenched practices and a practical challenge related to the cultural issue was that there was a tendency to default to them, especially in times of stress (Dempsey & Mangone, 2006, Gosford). From the patients' perspectives too, some changes to nurses' roles and ways of working can create similar resistance to change. Moving to an acute care rehabilitation unit presented a range of challenges for patients, who had predetermined views about what might happen to them in hospital. King (2006, Ryde) reported "the patients like to be pampered and expected that traditionally they would stay in bed, eat their meals in bed and get showered on a commode chair because 'this is what happens when you are in hospital'". Thus managing expectations for patients as

well as staff in times of change is critical and engaging them in the change process is central to successful change and improved patient outcomes.

A commitment to the goals and values identified was considered to be essential, as was the recognition that this was a lengthy process, not a short-term fix (Puckett, Hallam & Leaver). Notwithstanding this recognition, sustaining memory about what the aim was in a rapidly changing clinical workforce was an essential component of the project and regular updates and reminders of the goals and values are required (Dempsey & Mangone). Dempsey & Mangone also pointed out that it was important to understand change theory and to recognise vocal resistors and to determine whether they were a minority or majority group. Skills in conflict resolution were an essential practical tool to sort out differences of opinion.

The confidence to try out new ideas and to hold work up for scrutiny was also significant cultural and practical challenges. Whilst placing work into a public forum was recognized as encouraging reflection, rigour and clarity, it was acknowledged that in the short term it may well increase the sense of discomfort and strain that staff might initially feel. Practically such an exercise required reciprocal and regular support (Puckett, Hallam and Leaver, 2006, Goulburn Community).

Engagement of patients in changes to care delivery practices and organization will ensure patient-centred care but will also enable realistic expectations from both staff and patients.

²⁶ Morton-Cooper, A and Palmer, A. (2000). *Mentoring, Preceptorship and Clinical Supervision*: Blackwell Sciences Ltd. Oxford

²⁷ This vision arose initially from the discussions of the MoC Working Group established in 2004 under the Joint Strategic Reference Group on Nursing and Midwifery.

Workshop Feedback and Outcomes

At the workshops participants were asked to complete a lengthy questionnaire with the purpose of identifying the level and types of models of care activity in which nurses were involved; their intention to undertake further activities; the ways in which they were measuring and evaluating their activities; the type of support they might require and the type of networking they might undertake.

4.1 Existing MoC activity

Eighty six percent of those present had been involved in some work relating to changing models of care, and 71% planned to undertake more MoC work in the future, which was extremely heartening. When asked what had motivated them to undertake MoC work, over 50% of the respondents cited a desire to improve patient experiences (e.g. 16% expressed a desire to improve patient outcomes, 12% to improve patient care, 13.5% stated they wished to align their care with patient needs and 6% wished to improve patient safety). 48% of respondents cited a desire to address staffing issues: with 12% of those stating they wished to improve job satisfaction, 11.5% to improve recruitment and retention, 7% to address skill mix changes and a further 7% to address reasonable workload issues. A smaller number cited management initiatives as the stimulus for change: with 5.6% of those identifying bed shortage/access block as a motivator, 5.3% wishing to reduce the number of incidents reported through IIMS and 3% identifying that the stimulus arose because of an expansion of their existing service. These overall responses are heartening, as they suggest intrinsic motivation based on a desire to improve care of patients and staff as being the primary drivers for change.

Participants were asked what types of measurement they were using currently and what types of changes they were involved with. 273 respondents answered this question and, although some of the responses about

the types of changes are quite vague, the diversity of clinical change that nurses are involved with is vast and provides valuable information into the level of activity in terms of safety and quality review and improvement that is occurring across NSW. One of the most valuable outcomes of the 2006 data collection is that we have been able to map the reported activities to specific hospital and community sites and plan to establish a directory on the NaMO MoC website that links specific activity to facilities. The activity reports are tabled as Appendix A (there is some overlap between activities) and have been divided up into the following categories:

- Work practice changes (41 sites - often more than one report per site)
- Maggie project (A Hunter New England AHS major health reform program about re-orienting healthcare processes to truly focus on the patient.) (19 sites)
- Skill mix changes (38 sites)
- Introduction of team nursing (54 sites)
- Improving communication and handover (11 sites)
- Introduction of clinical pathways and guidelines (16 sites)
- Ongoing and further communication strategies to ensure dissemination of activity across NSW are required.

4.2 Future MoC activity

Nurses were also asked what types of issues they would like to address in the future and these are set out in Table 4.1. Some are rather vague (for example, 87 wanted to review their model of care, staffing or practice and a further 37 wished to improve patient care or patient satisfaction) but others are quite specific. In addition, there is a good degree of synergy across some areas, identifying the potential for larger groups to form to undertake more substantial projects.

4a. What sorts of issues would you like to address?	Metro	Rural	Total
Review MOC, practice and staffing	58	29	87
Improve quality of patient care, patient satisfaction with care	24	13	37
Continual professional development, clinically-based education self-directed learning, tele-health, broadband - for permanent staff & new grads	31	20	51
Effective handover, improved documentation	16	9	25
Discharge planning, nurse initiated discharge, post discharge follow up and review	11	5	16
Improve ward environment to recruit and retain staff, flexible rostering	15	8	23
Clinical supervision, journaling, reflective practice, action learning, PD	9	2	11
Wound & leg ulcer management	4	2	6
Community based care: e.g. HITH, chronic care Mx	6	3	9
Improve referral system across the spectrum, in-hospital, hosp-com, comm-hosp	3	4	7
Skill mix changes ENs, EENs, AINs, students	4	6	10
Patient flow, process mapping	6	2	8
NP Guidelines, other clinical guidelines, pathways	3	3	6
Fast track ED pts to ward, transitional care, 23 hour wards	7	1	8
Support of research initiatives- aged care, MH, continence, aggression	5	4	9
Improved support and mentorship for each other	1	3	4
On call system for VMOs or other staff	2		2
Amalgamation of Community Health	1	1	2
Relief from admin. Duty		2	2
Improve care in rehabilitation, diversion therapy, nursing care	2		2
Patient education, self-help	3		3
Total responses	152	90	242

Table 4.1 Types of issues relating to models of care nurses would like to address

4.3 Assistance required to undertake further MoC activity

However, of specific interest for ongoing work over the next two years is the type of assistance participants require to progress their work. 33% identified a need for funding/ scholarships/or grants with 12% identifying that they needed assistance not only to write the proposals, but also to collect and analyse their data and to design their evaluation framework. 26% identified the need for support from management and human resources and 23% stated they needed support from networking with other nurses. 17% needed extra time to undertake the project and a further 17% needed assistance with educational resources such as searching journals and reviewing the literature.

More in-depth information about what this help and support might look like was gleaned through discussion within the workshops and the challenges identified in section 3.5, and this information formed the basis of the goals set for the Project Coordinator for 2007. The help and support included the need to develop a range of activities around:

- Additional strategies for disseminating information about existing and proposed activities
- Analysis of practice, including skills (inter alia) such as process mapping, audit, patients' stories
- Ongoing education for clinicians, managers, educators and academics on models of care development
- Support for and extension of Practice Development, both technical and emancipatory
- The development and piloting of strategies to address issues of delegation, scope of practice and challenges of peer performance experienced by many clinical nurses
- The canvassing of strategies to develop skills for clinical nurses to share their craft with less experienced nurses
- Support and education in writing for publication.

From the workshop discussions there emerged an obvious need to provide networking and support for nurses working on local projects. This identified need is supported by the data. Thirty eight percent of nurses wishing to undertake projects identified that they would need to seek assistance and support from other specialty units and a further 45% identified other nurse clinicians and managers. 10.5% stated they would contact nurse educators for support, 8% academics and universities, 7% specialty groups, 6% Clinical Nurse Consultants, plus a wide range of others including external agencies, local government councils, General Practitioners, Learning and Development Units and the Joanna Briggs Institute.

The workshops demonstrated that nurses were often unaware of others undertaking similar work in their own AHS, and certainly the data on existing MoC activity demonstrates that key activities are occurring across the state with little or no linkage between the nurses undertaking the work at different sites. However, enthusiasm and support for linking up and undertaking more wide-ranging projects was evident. Respondents (n=143) suggested a range of strategies to make stronger links with peers including email (n=59), workshops and networking face-to-face (n=71), meetings in work and through specialist groups (n=38), phones, teleconferences (n=39), websites, discussion boards (n=25) and site visits (n=3).

4.4 Improving hospital and community integration

A specific focus area that was identified in the 2005 evaluations was the need to improve communications and links between community staff and hospital based staff. In both years of presentations there were a number of impressive and innovative projects from the community. These generated a good deal of discussion about the need for better integration. In the 2006 evaluations the question was posed "How could community staff be further integrated into models of care and innovations work?" Although some of the overall responses (n=218) are rather vague e.g. "improve communications with community health nurses", there were many concrete and achievable suggestions and these are set out below in Table 4.2.

A number of the comments from both workshop and seminar respondents indicated that the very process of raising the question in workshop discussions and evaluations had stimulated valuable communication and prompted people to commit to find strategies to work better together in future. However, the need for improved synergies across all groups is an area for ongoing intensive work.

There is an ongoing need to provide strong support for the strategies to improve links and communication strategies across hospital/community boundaries.

Q6	Metro	Rural	Total
Involve community health & hospital staff in committees/meetings	58	23	69
Improve communication with community health nurses	34	32	66
Involve community health nurse in discharge planning, case conferences, MoC development/ introduce community nurse to patient prior to discharge	30	22	52
Nurses and midwives practise across hospital and community	11	7	18
Educate community and hospital staff (medical & nursing) re each other's roles	21	13	34
Links with Division of GPs, CH Nurses network & acute care staff	6	3	9
Formal "follow up" visits/phone calls for staff into hospital and/or community	4		4
Establish self-supporting groups/Educate pt to self care	3		3
Exchange programs rotations between hospital and community nurses	2	1	3
Automatic electronic referral of pts (to CH) on discharge	1	1	2
Through "communities of practice" framework	1		1
Total responses	135	83	218

Table 4.2. Suggestions for integrating community and hospital staff

Where to from here?

5.1 The need for a state-wide reference group

There is a clear need to move towards sustainability of the models of care work so that the measurement, review, innovation, re-measurement and publication of outcomes, in relation to work concerning organization and delivery of patient care, become part of the culture. With the new roles emerging from the AHS restructures, both in terms of practice development co-ordination and clinical leadership, there is an opportunity to build capacity to support the dissemination and adoption of new models of care.

A range of synergies, recommendations and suggestions has emerged from the evaluations that can be progressed across the AHSs. It will therefore be critical to ensure links between the AHSs that will facilitate funding applications and coordinated programs of evaluation and innovation. Furthermore, the respective AHS nominees can benefit from professional development through the support and mentorship by the Project Coordinator, Professor Chiarella, to assist them with networking and developing sustainability. In addition, links between innovative clinicians and universities whilst strong in places are not universal and need to be fostered.

It is therefore proposed to establish a state-wide MoC Reference Group comprising those key personnel who have been involved in coordinating the work to date and representatives from each of the Faculties of Nursing and Midwifery who are currently engaged in issues relating to clinical practice and \shaping future clinical environments. This group would then interact with a wider group of clinical leaders and practice developers to build capacity within the broader nursing workforce.

5.2 The vision

The ongoing vision for this project, which has been exemplified in discussions with the clinical nurses involved in models of care work, is that clinical nurses:

- Are both competent and curious
- Are confident of their own achievements and potential
- Live with a willingness to change and explore
- Are positioned to maximise opportunities as they present.

5.3 The key areas of challenge

In discussion and feedback from nurses in the workshops, five key areas of challenge can be identified to drive the ongoing MoC work:

- Sustainability - to ensure that no one person carries the project;
- Synergy - to maximise resources through linkages between clinicians and academics;
- Synchronicity - to coordinate work in care delivery practices and organisation with research grant rounds/ scholarship applications in order to obtain funding support;
- Spread - to publish the work, and to enable people to know or at least be able to find out who is doing what;
- Self-belief -to feel that they have the ability to improve their environment or the patient's environment.

The recommendations for 2007/08 are set out under these headings.

5.4 Future work

Future work that needs to be done falls into 3 main areas, all of which overlap to some degree. An agreed plan of action to ensure that the current level of activity and self-belief in relation to work around MoC is sustained, to spread the level of activity and the knowledge of the work, and to improve synergy and synchronicity in relation to the work across NSW (and even beyond).

A. Ongoing support at AHS and also now university level for clinicians to:

- Conduct evaluations of the existing work they have already undertaken;
- Implement and evaluate new projects in line with the five key areas of challenge.

It is envisaged that this work will be ongoing over 2007 and 2008.

B. The work to date and any future work needs to be part of an overarching evaluation strategy in order to generate new theory around models of care and to develop empirical evidence about how the five key areas of challenge can be effectively addressed.

Conclusion

The 2006 program of workshop and seminars was designed to address the needs and issues identified by nurses in the 2005 Roadshow. The program was enthusiastically received and identified a wide range of work relating to nursing care organisation and delivery that is occurring across NSW. It was clear that the 2005 Models of Care Roadshow had generated significant interest in developing models of care and had encouraged clinicians to apply for the Innovations Scholarships.

The 2006 workshops provided information on how to access resources, both in terms of skills and funding, to enable clinical staff to review and develop their models of clinical care delivery and organization. This information was considered to be highly relevant and valuable, as was the networking and information sharing that was encouraged between participants working across AHSs. It was clear from the written and verbal feedback that there was much activity that people were unaware of, even within their own AHS and the need for much greater synergy to prevent duplication and maximize gains from effort was apparent.

At the workshops participants were asked to complete a lengthy questionnaire with the purpose of identifying the level and types of models of care activity in which nurses were involved; their intention to undertake further activities; the ways in which they were measuring and evaluating their activities; the type of support they might require and the type of networking they might undertake. This information has been collated and will inform the work for 2007.

38 out of the 39 seminar presentations were about activities to improve care delivery and copies were provided for publication on the NaMO website. These presentations were thematically analysed to provide an overview of issues and activities across NSW in relation to MoC development. The themes that emerged were that synergies are growing across NSW partly as a result of the NaMO MoC Project and partly as a result of other statewide initiatives such as the work of CSRP and the CEC. Significant changes and development are occurring

in nursing roles and there is an increasing focus on how clinical specialties should develop and what the nurses need to know. Of particular note in 2006 was the growth in both Technical and Emancipatory PD as a means of changing the clinical culture and developing sustainability of a supportive and inquisitive clinical culture that is open to change.

The analysis also identified some ongoing cultural and practical challenges. The cultural challenges fundamentally related to comfort with change, confidence to try out new ideas, and concepts of professionalism and trust. These challenges created the need for a range of practical skills that included behaviours to develop an environment of high challenge and high support, performance management, clinical coaching, clinical skills development (through craft transfer). Other challenges identified also included the need for additional work around clear role delineation and expectations, so that nurses feel confident in their work and are able to clarify the expectations of their peers and managers. Future directions have been set out in this report to address those challenges and to ensure sustainability and spread of current developments.

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Appendix A

Round 1 Innovation Scholarship recipients May 12th 2006

AHS	Name	Topic
HNEAHS	Dianne Hurt	Getting it right from the start for mothers and babies
HNEAHS	Eileen Guest	Introducing Practice Standards in Child and Family Health Nursing
HNEAHS	Mike Hazelton	Implementation and Evaluation of a Nursing-Delivered Anti-Absconding Intervention for Acute Mental Health Inpatient Services
HNEAHS	Heather Bevan	Clinical Re-Design of International Normalised Ratio Testing for Patients - Determine Accuracy of Point of Care Finger Prick Testing Using CoagChek(r) XS Versus Venipuncture Laboratory Testing, Particularly in Patient Population Receiving Heparin Therapy
SESIAHS	Kim Reid	Nurses Clinical Decision Making Process in the Administration of PRN Psychotropic Medications: A Prospective Study
SESIAHS	Scott Brunero	The Hand Held Health Record Card for Mental Health Consumers
SESIAHS	Julie Smith	Supporting Overseas Recruited Nurses Through the Adjustment Phase of Working in Australia: Can We Impact on Retention Rates?
SSWAHS	Tim Wand	Improving Access and Continuity of Care for Mental Health Clients in the Emergency Department: Exploration of a Mental Health Nurse Practitioner Follow-Up Service
SSWAHS	Michelle Cleary	Patient and Carer Perceptions of Need and Caregiver Burden: Working in Partnership to Facilitate Community-Based Interventions

Appendix B

Workshop venues 2006

Date	Site	Metro/Rural
7-Mar-06	Gosford	Metro
14-Mar-06	Concord	Metro
20-Mar-06	Queanbeyan	Metro
23-Mar-06	St George	Metro
18-Apr-06	Tamworth	Rural
26/27 Apr 06	Justice Health	Statewide
2 May 06	Campbelltown	Metro
9 May 06	Dubbo	Rural
27-Jun-06	Wollongong	Metro
11-Jul-06	POW	Metro
25-Jul-06	Forbes	Rural
24-Aug-06	Maitland	Metro
4-Sep-06	Coraki	Rural
4 Oct 06	Wagga Wagga	Rural
23-Oct-06	Blacktown	Metro
26-Oct-06	CHW	Metro
2-Nov-06	Westmead	Metro
9-Nov-06	Port Macquarie	Rural
13-Dec-06	Nepean	Metro
14 Dec 06	GMCT Renal	Statewide
		12 Metro

Total

20

**6 rural
2 Statewide**

Appendix C

Activities reported by workshop respondents

NB: 1. Please note where more than one activity reported there is overlap between tables

1 Work practice changes

Facility	Specialty	Work practice changes
RHW	Not stated	1. Interviewing women who are at the end of treatment phase to establish gaps in service
Area position GWAHS	Agedcare	1. Redesign of Coonamble HS - processes, rosters, work practices. 2. Rehab Satellite Program (Research Project). 3. KMPG Aged Care redesign. 4. DBH Area Transitional Care Program. 5. Com Packs Project 6. Area SOP, Area AC CSPing.
Goulburn Base	Midwifery	community Outreach Clinics - for bookings / ante natal post natal care in liaison with community nurses.
Forbes CH	FamilyCH	1. Reviewing MOC.2. Clinical supervision. 3. Families first guidelines.
Tullamore	Management	1. Changing work practices.
Orange	Surgical	1. Change our practice to patient centered care.
Sutherland	ComH	1. Introduced a flow chart for the treatment of clients following Palinodes Sinus. 2. Developed patient education pamphlet and plan for maintenance.
Lismore Base	Midwifery	1. Continuity of care - midwifery.
Grafton CH	Agedcare	1. Clinical redesign.
Lismore Base	Surgical	1. MOC
Lismore Base	Mixmedsurg	1. Implementation of new MOC on all general wards.
Ballina	ComH	1. Introduction of a diabetes resource nurse within the generalist community nurse team. 2. Flexible work hours for nurses.
Ballina	CC-Emergency	1. Transitional care in general ward.
Bulli	Agedcare	1.Reviewing patient falls. Little success in greater supervision of the patients. Need to look at injury minimization.
Blacktown Mount Druitt Hospital (BMDH)	Other	1. Vital care work group (communication, handover, documentation). 2. EEN medication
BMDH	Other	1. National medication chart implementation. 2. Vital care
JHH	Mixmedsurg	1. Team leader project
RPC	Rehab	1. Falls working party. 2. Revision of code black procedure.
HNEAHS	Surgical	1. Wound management model.
Maitland	Family CH	1. Implementation baby friendly hospital - community initiative.

CHW	paed	1. Medical short stay - interdisciplinary care plans.
SWAHS	Management	1. Patient mapping and clinical care.
CHW	Periop	1. Wellness checks pre-operatively.
PMBH	Surgical	1. Mentorship program for junior staff. 2. Introduced undergraduate AINs.
Community Health	ComH	Monthly and bimonthly diabetes with the local paediatricians for children with type 1 diabetes.
Singleton	Mixmedsurg	1. Screening inpatients for sleep disorder.
Westmead	Midwifery	1. Looking at MOC for midwifery to improve care for women.
Tresillian	FamilyCH	1. Identifying & documenting MOC underpinning work practice. 2. Currently involved in research project Mothering at a Distance.
Nepean	Agedcare	1. Introduction of the falls package.
Nepean	Midwifery	1. Developing midwifery "all risk" model of care.
Westmead	NurEdu	1. Medication errors amongst senior and junior nursing staff.
Forbes	ComH	1. To improve discharge planning.
St. George	CC-Emergency	1. Practice development - Vascular/urology, fast tract ED pt. 2. Pain scale for all patients.
PMHC	ComH	1. Education for RNs. 2. Exploring our MOC - moving to a more sustainable model.
Singleton	Management	1. Discharge planning. 2. Medication working party.
Cessnock CH	ComH	1. Staff mix. 2. New post acute care program.
JHH	Medical	1. Clinical care planning forum. Introducing older person model - pt. Center care. 3. Bowel management working party.
Westmead	CC-Emergency	1. Handover. 2. Documentation. 3. Practice development. 4. Wound care.
Coffs Harbour	Management	1. 23- hour surgical unit. 2. Home based IV therapy program. 3. Medication safety review.
PMBH	NurEdu	1. Medication chart/medication errors. 2. Undergraduate and post graduate support.
Nepean	Midwifery	1. Outreach antenatal clinics in conjunction with CC & FH nurse. 2. Pink Link - Mental Health program for antenatal women through GPs. 3. Electronic antenatal records.

2 Maggie and Patient flow work

Facility	Specialty	Maggie and Patient Flow work
TRRH	Other	Currently employed as implementation officer for 'Maggie' transfer of care project (area wide project).
Tamworth	CC-Emergency	Maggie projects - access. Patient care - streamline process transfer to ward.
Tamworth	Onc/Hae	1. Maggie style project - acute care setting - workflows. 2. Project in schools - diabetes / fitness.
Manning Base	CC-Emergency	Various changes implemented via Maggie Program in ED locally and transfer of care area wide.
Manning Base	CC-Emergency	We are in the transfer o care phase with a Maggie Project.
Tamworth	NurEdu	Maggie Project - Area wide - transfer of care.
JHH	Periop	1. Maggie program in 2005. 2. AINs in work force.
Concord	Other	1. Proactive D/C Planning - patient flow commence - June 05. Roll out of occupancy management program. 2. Expected dates of discharge (EDD) and Clinical codes for RN for early D/C planning assessment proactively.

WWBH	Other	1. Establishment of 23 hour care unit. 2. Development and implementation of modified HITH.
St George	Agedcare	1. Development of the Aged Care precinct - involving expansion of wards, remodeling environment, introduction of AIN Cert III's, introduction of a rapid assessment unit and to improve communication. 2. Introduction of general assessment tool and facilitator
Sydney Hospital	CC-Emergency	1. Roster. 2. Upskilling of staff. 3. Transfer of critically ill patient - protocol.
JHH	Surgical	3rd yr undergrad AINs. and EN becoming "endorsed". 2. Use of discharge lounge to free up beds. 3. Flexible working hours. 4. Ward based discharge facilitators.
CHW	Medical	1. Discharge planning & case management of chronic/complex patients. 2. Revised appraisal / mentoring system.
Nepean	Midwifery	1. Caseload management of women (antenatal/postnatal). 2. "DAWN" - discharge assessment of well neonate by midwife.
GGRM	Agedcare	1. Electronic prescribing of medications. 2. CVC project - re-accrediting RNs. 3. Producing assessment tools for the 10 GGRM skills. 4. Put into practice the CNC projects. 5. Hospital and Nursing Home focus groups - discharge planning.
JHH	Surgical	1. Rostering - 12 and 10-hr shifts. 2. Third year nursing students to work on ward as AINs. 3. Maggie programme and patient transfer forms.
NMMH	Surgical	1. Discharge planning. 2. Rostering changes. 3. Implementation of pain assessment tool. 4. Staffing changes implementation of ENN.
Westmead	FamilyCH	1. Skill mix. 2. Introduction of EN into Unit. 3. Rostering. 4. Discharge and Home Care.

3 Skill mix changes

Facility	Specialty	Skill Mix changes
Westmead	FamilyCH	1. Skill mix. 2. Introduction of EN into Unit. 3. Rostering. 4. Discharge and Home Care.
Balmain	Management	We are in the early stages of changing our models of care to introduce AIN's with Cert III to take on personal care and simple ob tasks. This will enable RN's and med endorsed ENM's to have more direct patient involvement, job satisfaction, boost nursing
Balmain	Agedcare	MoC for introducing AINs to skillmix on wards - supporting all designations in expanding.
Blayney MPS	Management	1. Changing staffing models with short shifts to cover increased workload.
Sutherland	Surgical	1. Staff retention. 2. Skill mix. 3. Bedside handovers.
St Vincent's	Onc/Hae	Increased utilisation of AINs on an Acute Geriatric Ward - increased utilisation of Ens endorsed.
St George	Agedcare	Development of the Aged Care precinct - involving expansion of wards, remodeling environment, introduction of AIN Cert III's, introduction of a rapid assessment unit and to improve communication. 2. Introduction of general assessment tool and facilitat

TTH	CC-Emergency	1. Team nursing. 2. Flexible working hours. 3. Nurse educator in ward.
Ballina	Mixedmedsurg	1. Hospital In Charge (HIC).
Ballina	Management	1. Introduction of a nurse education
Tweed	Agedcare	1. Team nursing
MDH	Rehab	1. Different roles in the dept and how they contribute to the team.
Blacktown	Midwifery	1. Model of care surround PN care, BF2. Team nursing, skill mix issues and workforce review.
CHW	NurEdu	1. New graduate program structure, ward rotations, education, expectations, skill requirement, length of program and preceptorship.
Cessnock CH	ComH	1. Staff mix. 2. New post acute care program.
CHW	Management	1. AINs in ED. 2. Framework for application review - CNS, NP application. 3. Kids Outreach Liaison Service review.
JHH	CC-Emergency	1. Ain into NICU - a completely new role for this area.
JHH	FamilyCH	1. Introduction of AIN in unit. 2. Pilot CNE
JHH	Periop	1. 3-yr undergrads employed as AINs
JHH	Surgical	1. 3rd yr undergrad AINs. and EN becoming "endorsed". 2. Use of discharge lounge to free up beds. 3. Flexible working hours. 4. Ward based discharge facilitators.
TMH	NurEdu	1. Increase TEN intake.
Westmead	Medical	1. Skill mix. 2. Rostering for 23-hour ward.
Westmead	CC-Emergency	1. PACC service in ED. 2. Physiotherapist placed in ED from point of triage. 3. NP in Fast Track area.
Westmead	FamilyCH	1. Skill mix. 2. Introduction of EN into Unit. 3. Rostering. 4. Discharge and Home Care.
Westmead	Neonatology	1. Introduction of EN in unit. Amalgamation of SCN with NNIC, increase staff knowledge base from working in level 2 to level 3.
Westmead	NurEdu	1. "Hospital at night" project - across whole hospital - medical unit focus.
JHH	Medical	1. RN/EN rotation through specialty areas. 2. Changing shift hours. 3. Team leader project to up skill team leaders (medical division).
JHH	Surgical	1. Introduction of undergraduate AINs. 2. Scoping up nurse practitioner role. 3. Opportunity to support NUM and floor staff.
CHW	paed	1. Recently went through a values clarification process and developed a ward vision document. 2. Skill mix and allocation. 3. Reasonable workload survey.
CHW	Medical	1. Skill mix initiatives.
CHW	paed	1. Restructuring of roster system.
Westmead	CC-Emergency	1. 23- hour cardiology intervention unit. Cardiac assessment unit (2-bed) to try to reduce waiting times in ED. 2. Outpatient CCF program to try to decrease hospitalisation. 3. Different staffing levels.
Grafton Base	Management	1. Processing mapping - introduction of team nursing. 2. Conversion of 2 RN positions to EN.
JHH	Periop	1. Maggie program in 2005. 2. AINs in work force.

JHH	Surgical	1. Rostering - 12 and 10-hr shifts. 2. Third year nursing students to work on ward as AINs. 3. Maggie programme and patient transfer forms.
PMBH	Surgical	1. Mentorship program for junior staff. 2. Introduced undergraduate AINs.
PMBH	Surgical	1. Mentorship programs. 2. Rotation of surgical RNs through another surgical area. 3. Employment of undergraduate AINs.
RPAH	CC-Emergency	1. Clinical support through a team approach. 2. Professional development for EN through waiting room clinical redesign. 3. Professional development through Communities of Practice.
GBH	Medical	Encouraging ENs to complete the endorsement course.
NED	Other	1. EN in tracheotomy suctioning.
BMDH	Other	1. EN to perform tracheotomy care.
JHH	CC-Emergency	1. Pilot study EN into ICU workforce.
JHH	CC-Emergency	1. ENs in ICU. 2. Changing role for NUMs. Nurse practitioner. 3. Rostering - 12-hr shifts. 4. Succession planning
NMMH	Surgical	1. Training of enrolled nurses - greater EN to RN ratios.
BMDH	Other	1. EEN medication administration work group. 2. Handover documentation
NMMH	Surgical	1. Discharge planning. 2. Rostering changes. 3. Implementation of pain assessment tool. 4. Staffing changes implementation of ENN.
Westmead	FamilyCH	1. Skill mix. 2. Introduction of EN into Unit. 3. Rostering. 4. Discharge and Home Care.

4 Introduction of team nursing

Facility	Specialty	Q1desc
POW	Policy	1. Team nursing in several wards. 2. 12 hour shifts which frees up 4 hours/month for professional development. 3. PD and professional Model of Care being developed over past 2 years. 4. At stage to now engage clinical nurses through Action Learning an
Rehabilitation	Rehab	1. Models of Nursing. 2. Team nursing. 3. Pain Management 4. QA
POW	ComH	We are constantly looking at our Models of Care in our service. It is a multidisciplinary team - need to frequently discuss roles and responsibilities.
Concord	Onc/Hae	1. Moving staff from patient allocation to team nursing approach. 2. Re-education of staff to move along with the times.
Queanbeyan	Midwifery	Changing models of care around midwifery eg team midwifery.
War Memorial	Rehab	1. Patient allocation vs. team nursing.
Goulburn Base	Management	1. Currently reviewing support practices for post grads and students. 2. Performance development plans competency programs and orientation under review.
Grenfell	Mixmedsurg	1. Morbidity & mortality meetings.
Mullum	Midwifery	1. New MOC - midwifery
Casino CH	Management	1. Implemented diabetes assessment clinic.
POW	Medical	1. MoC team and shift co-coordinator - in place and ongoing. 2. Action learning sets (AHL). 3. Clinical rounds - 1 to 1 or 1 to 2, CNC or NE with team. 4. Education provided/support/documentation received.
MRRH	CC-Emergency	Change to new care models for nurses from allocation of staff to team care implementation and integration of nurse practitioner into model.
Byron Hospital	Management	1. Shared care - antenatal care.
Community Health	ComH	1. A collaborative approach between Division GP, community health and allied health to provide care to cancer patients.
Grafton Base	Management	1. Processing mapping - introduction of team nursing. 2. Conversion of 2 RN positions to EN.
Mental Health (Richmond clinic)	MentalH	1. Changing from an institutional style of care to group nursing approach that is responsive to client needs.
Lismore Base	Medical	1. Team nursing
Lismore Base	Medical	1. Team nursing on acute medical/oncology unit.
Nowra Mental Health	MentalH	1. We have split our case-management team into 3 areas.
CHW	Medical	1. Twice weekly meetings with families and BMT team to review patient care as well as survey by BMT CNC's effectiveness of these sessions for parents and staff.
PMCH	ComH	1. Wound clinic that runs 7 days.
JHH	Management	1. Re-introduction of RN/EN rotation through unit
Integrated health - SW	Management	1. Integrated primary health project - model of care.

CHW	CC-Emergency	1. Changing skill mix - team nursing.
CHW	Medical	1. Team nursing. 2. Clinical coordinator
CHW	Surgical	1. Team nursing. 2. Clinical outreach. 3. TNP appointment and implication. 4. Short shifts.
CHW	Surgical	Trialling team nursing with the new graduate nurses to give better support to them.
CHW	Medical	1. Discharge planning & case management of chronic/complex patients. 2. Revised appraisal / mentoring system.
Community Health	FamilyCH	1. Realign of services to best meet client demand.
CHW	Mixmedsurg	1. Team nursing. 2.12-hour shifts.
CHW	Medical	1. Introducing team nursing into the unit.
St George	Medical	1. Nurses Practice Development in developing ward culture. 2. Team nursing - Team 1 & 2 to support junior staff and improve a.m. and p.m. shifts. 3. End of Life Pathway for Renal and Gastro patients - designated area in the ward.
Forbes CH	FamilyCH	1. Reviewing MOC. 2. Clinical supervision. 3. Families first guidelines.
War Memorial	Rehab	1. Pain project. 2. Team nursing. 3. Accreditation. 4. Falls project.
TTH	CC-Emergency	1. Team nursing. 2. Flexible working hours. 3. Nurse educator in ward.
CHHC	ComH	1. Redesign/restructure of community nursing role. 2. Case management MOC
Blacktown	Midwifery	1. Model of care surround PN care, BF 2. Team nursing, skill mix issues and workforce review.
Mitland/Dungoong	FamilyCH	1. Breast feeding "Drop in" support. 2. Collaboration with population health on ETS screening by CHN to smoking.
RPAH	CC-Emergency	1. Clinical support through a team approach. 2. Professional development for EN through waiting room clinical redesign. 3. Professional development through Communities of Practice.
POW	Policy	1. Team nursing in several wards. 2. 12 hour shifts which frees up 4 hours/month for professional development. 3. PD and professional Model of Care being developed over past 2 years. 4. At stage to now engage clinical nurses through Action Learning an
POW	Medical	12 hour shifts leading to successful team nursing.
Ballina	ComH	1. Introduction of a diabetes resource nurse within the generalist community nurse team. 2. Flexible work hours for nurses.
Sydney Hospital	CC-Emergency	1. Roster. 2. Upskilling of staff. 3. Transfer of critically ill patient - protocol.
JHH	Surgical	1. Flexible shift times. 2. Secondment programs throughout the area.
Singleton	Mixmedsurg	1. Sleep apnoea research project. 2. Roster in in OT incorporating 10-hr shifts.
JHH	Surgical	1. Rostering - 12 and 10-hr shifts. 2. Third year nursing students to work on ward as AINs. 3. Maggie programme and patient transfer forms.

CHW	Mixmedsurg	1. Team nursing 2. 12-hour shifts
TTH	CC-Emergency	1. Team nursing. 2. Flexible working hours. 3. Nurse educator in ward.
JHH	CC-Emergency	1. ENs in ICU. 2. Changing role for NUMs. Nurse practitioner. 3. Rostering - 12-hr shifts. 4. Succession planning
NMMH	Surgical	1. Discharge planning. 2. Rostering changes. 3. Implementation of pain assessment tool. 4. Staffing changes implementation of ENN.
JHH	Surgical	1. 3rd yr undergrad AINs. and EN becoming "endorsed". 2. Use of discharge lounge to free up beds. 3. Flexible working hours. 4. Ward based discharge facilitators.
CHW	Surgical	1. Team nursing. 2. Clinical outreach. 3. TNP appointment and implication. 4. Short shifts.
Westmead	FamilyCH	1. Skill mix. 2. Introduction of EN into Unit. 3. Rostering. 4. Discharge and Home Care.

5 Communication and handover

Facility	Specialty	Q1desc
Blacktown	Surgical	1.Communication - staff/pt, staff/staff.
Blacktown	CC-Emergency	1. Communication package developed on communication skills.
Blacktown	Midwifery	1. Team leader role development. 2. CNS working group. 3. Documentation - audits.
Blacktown	Policy	1. Documentation and handover
Blacktown	Midwifery	1. Looking at documentation - to educate new grads and students. 2. Reflective practice
Mater	palliative care	1. Terminal care pathway review. 2. Communication - liaising with external care providers.
Community Mental Health	MentalH	1. Improving understanding of MH in ED through education. 2. Six sigma project in reviewing communication pathways, in service and other agencies.
Westmead	CC-Emergency	1. Handover. 2. Documentation. 3. Practice development. 4. Wound care.
Sutherland	Surgical	1. Staff retention. 2. Skill mix. 3. Bedside handovers.
Sutherland	Surgical	Bedside handovers.

6: Implementation of clinical pathways

Facility	Specialty	Q1desc
SVH	Medical	1.Developing protocols for managing hyperglycemia within the stroke unit.
PACS	Rehab	1. Practice development issues. 2. New protocols/pathways.
POW	ComH	1. Implementation of clinical pathways.
Sutherland	CC-Emergency	Implementation of clinical pathways for paediatric and adult patients.
	MentalH	Involved in statewide project (I am one of 4 care group and leader of nursing) for the development of clinical practice guidelines for the management of children and adolescents with eating disorders in paediatric units.
Mater	palliative care	1. Terminal care pathway review. 2. Communication - liaising with external care providers.
Nepean	Periop	1. Evidenced based practice
St George	CC-Emergency	1. Proposal for cannulations / venepuncture training for ENs which are part of our ED Nursing core staff. 2. C/N in ED. 3. NP proposal. 4. Clinical pathway implementation.
HNEAHS	CC-Emergency	1. Patient assessment days for RNs. 2. Triage days for RNs 3. TASC project for Acute Coronary Syndrome, Stroke pathways.
Forbes CH	FamilyCH	1. Reviewing MOC.2. Clinical supervision. 3. Families first guidelines.
Lismore Base	Other	1. Set up NP peritoneal dialysis service - scope of practice/ guidelines. 2. Set up communication lines, pt involvement, contact with GP & community. 3. Develop pathways of care.
Parkes	Other	1. Providing a palliative care service across the AHS.
St George	Medical	End of Life Pathways.
St George	Medical	1. PD on the haemo unit - diabetic, fluid management, self care, Ca & Po4 management. 2. End of Life care.
St George	Medical	1. Nurses Practice Development in developing ward culture. 2. Team nursing - Team 1 & 2 to support junior staff and improve a.m. and p.m. shifts. 3. End of Life Pathway for Renal and Gastro patients - designated area in the ward.

Appendix D

List of Powerpoint presentations

- Asimus M (2006) *Introducing an Evidence-Based Wound Management Model to Improve People's Care.*
- Baddock P (2006) *Cancer Network and Primary Health Network - SWAHS.*
- Bevan H (2006) *INR Comparison Trial.*
- Bristow S (2006) *The Wise Owl.*
- Carlyon C (2006) *Early Pregnancy Assessment Clinic - Blacktown Hospital.*
- Clarkson E & Hooke N (2006) *Creating a Shared Vision - The Experience of Edgar Stephen Ward.*
- Coates M (2006) *Developing the MHRU Medication Self-Administration Programme.*
- Cootes S (2006) *The Advanced Practice Nurse - Pilot Project - "Changing Patient Care Culture".*
- Cort J (2006) *Mt Druitt Hospital - Long Waitlist Project for Elective Orthopaedic Surgery.*
- Cutler N & Griffin A (2006) *Correcting Ourselves: Nursing in a Non-Standard Setting.*
- Creameri D (2006) *Patient Centred Care.*
- Davis J, Murray S & Rivas K (2006) *12 Hour Shift a Possibility in an Acute Ward*
- De Cressac J (2006) *Proactive Team Model - Model of Care in a Sub Acute Unit*
- Dempsey J & Mangone N (2006) *"Why Fix What's Not Broken"*
- Gradidge K (2006) *Older Persons Evaluation Review and Assessment*
- Hamilton J (2006) *Observations of Care - A Nursing Unit Managers Perspective*
- Harmon K (2006) *Community Mental Health Nursing - Developing an Integrated Model of Nursing Case Management*
- Hartz D (2006) *Ryde Midwifery Group Practice*
- Hurt D (2006) *Getting it Right from the Start for Mothers and Babies*
- Ind A & Crisp J (2006) *Access, Entry and Exit; Acute Inpatient Mental Health Services (GWAHS)*
- Jones A (2006) *Xavier 9 North 3 Tier Nursing Model Trial - Evaluation Report - 3 Cheers for 3 Tiers.*
- King C (2006) *The ACE (Acute Care of the Elderly) Model of Care*
- Lucas A (2006) *Introduction of Endorsed Enrolled Nurses in Haemodialysis Units*
- Marshall S (2006) *Establishment of a 23 Hour Ward*
- McPhail C (2006) *Improving Outcomes for Patients with Dementia in an Acute Geriatric Unit*
- Mulhearn L (2006) *The Introduction of Enrolled Nurses to Neonatal Nursing*
- Peek C & Higgins I (2006) *Older Person Acute Care Model*
- Puckett C, Hallam J & Leaver D (2006) *Bringing the Pieces Together - Supporting Evidence-Based Community Nursing Practice*
- Ronald T (2006) *Team Nursing - The Highs and Not So Lows*
- Samuels S (2006) *If We Can, You CAN - The Role of the Cardiac Assessment Nurse Nepean Hospital in the Delivery of Models of Care*
- Stead D & Hamilton R (2006) *Management Training on a Shoestring*
- Sutherland-Fraser S (2006) *Scrubbing up on their Skills*
- Toft R & Johnson C (2006) *Models of Care - Staff Development - What We Have Done at Pambula Hospital*
- Wand T (2006) *Evolution Not Revolution: Development of the Mental Health Nurse Practitioner Role at Royal Prince Alfred Hospital - Progress Report*

