“This is Community and Allied Health – strengthening the way we work”

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The South West Hospital and Health Service Community and Allied Health Division is made up of over 170 staff providing both inpatient and outpatient services to close to 30,000 people in South West Queensland. In late 2015 and early 2016 the Division went through an organisational redesign aligning its organisational architecture to support services delivered at the clinical coalface. Culture and structure are important to establish and maintain clarity of practice. The change in organisational architecture was compelled by the lack of cultural affinity staff felt by a structure that did not support their work practices. There is clear evidence of the link between leadership and a range of important outcomes within health services (West, 2015). It was for this reason reforming services focused on geographic and service wide models to drive a supportive culture of performance. Organisational change is challenging and the key was to establish a clear purpose for change that people could understand. The core components of the change management process were driven by the C^4 Pillars which represent Clients, Clinicians, Clarity and Consistency. Outcomes of the change included cementing workforce performance outcomes, capability and development, strategic plan objectives and government programs into every day work practices to drive a culture of excellence in rural and remote community and allied health services.

Restructure of the model of care in a regional psychology department, in order to increase provision of service to consumers.

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Most Allied Health departments in the public health system adopt one of two models of care: a centralised referral system where all referrals are received through a single point of contact and then triaged and allocated to staff, or an allocation of staff to the various units or areas within the hospital. This latter model was the one initially adopted at the Mackay Base Hospital, which resulted in an inefficient use of very limited resources. A restructure of the model of care was implemented, which included two major changes: 1) A change from allocation of staff to various units, to a central referral system and 2) a change in semantics. These changes resulted in an increase of 100% in the number of patients seen by the psychology department. It is suggested that this model of care is ideal in a regional setting, where limited resources are available.

Background

The Psychology Department at the Mackay Base Hospital comprises 6 staff members, typically allocated to various units such as the Renal unit, Diabetes clinic, Paediatrics etc. This led to an inefficient use of clinician time as staff would for example be allocated to a unit for 2 days a week but only be utilised at 25%. Flexibility to shift the workforce to areas of greater need was limited, due to the fact that they had been allocated to a specific unit. This model also limited access for patients who would only be provided with Psychological Services if they were already receiving services from the units that had an allocated psychologist. It was very conservatively estimated that approximately $67000 in labour was being wasted every year by utilising this model.

Methods

A centralised *request* system was established whereby *requests* were accepted from all areas of the Mackay Hospital and Health Service (both inpatients and outpatients).
A distinction was made between referrals and requests. Whilst a referral implies the patient's care is being handed over, a request allowed us to provide services in a variety of ways: direct service to the patient, consultation with the treating team and occasionally redirection to a more appropriate service.
All requests were actioned.

This model enabled increased flexibility in the allocation of psychological services by allowing the department to move its labour resources according to demand. In some cases, where it was deemed that a single clinician would be more beneficial in order to ensure excellency in patient care, an individual psychologist continued to be allocated. For units that did not have an allocated psychologist, every effort was made to triage referrals from specific units to a single clinician in order to encourage relationship-building within the unit. For example, the majority of the oncology referrals were sent to a specific clinician who also attended oncology clinical reviews. At times of high demand from the oncology department however, we were able to draw upon other psychologists.

Results

The number of Occasions Of Service (OOS) were utilised as a measure of the effectiveness of this model of care.A survey is also currently being developed in order to collect qualitative data regarding satisfaction levels with the use of the service.

As a result of the new model of care, we were able to double the number of Occasions Of Service, resulting in approximately 100 patients receiving psychological services over a period of 3 months, who would not have previously benefited from psychological input.

Discussion

Modelling suggests that our Health System will come under increased pressure with an ageing population. It has also been suggested that the growth required is unsustainable.

It is therefore important that we identify models of service that maximise on our resources, especially in regional, rural and remote areas, where resources can be limited.

This model of service did not require any additional funding, yet resulted in a 100% improvement in efficiency.

Geriatric, Adult Rehabilitation and Stroke Service (GARSS) Day Therapy model of care:

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Background
Day therapy (DT) services have been shown to improve patients' ability to undertake activities of daily living and reduce risk of deterioration post discharge from hospital. The Toowoomba Hospital DT team recently underwent extensive service reform with a number of new initiatives implemented. The goals of the reform were:

- To ensure holistic multi-disciplinary patient-centred care
- To maximise efficiency to cater for increasing demand and patient complexity and acuity;
- To improve patient flow.

The purpose of this project was to evaluate whether these goals were achieved.
Method
A retrospective cross-sectional study was conducted. Effectiveness of service parameters were evaluated and compared for a 3 month period pre (2012) and post (2014) implementation of changes.
Results
A 31% increase in referral numbers post implementation of changes was observed. The proportion of clients who had a multi-disciplinary needs assessment increased 2.5 times. Average waiting times were also reduced with Multi-disciplinary needs assessment completed in 4 days compared to 22, and median waiting time from referral to the first appointment reduced from 40 to 22 days. Whilst patients required a similar number of admissions to hospital in the 6 months following DT service, the median acute length of stay was reduced from 8 to 3 days and the sub-acute length of stay reduced from 13 to 0. This equates to an approximate cost saving of $173,304 in a 3 month period.
Discussion
The introduction of an advanced Trans-disciplinary role, early multidisciplinary screening and streamlining of processes and procedures have resulted in improvements in the efficiency and effectiveness of the DT service. This has allowed for a streamlined respond to the increasing service demand, improved patient-centred practice and timely access to clinically appropriate multidisciplinary care.

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End-of-life essentials: education for Allied Health Professionals

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Background

Many allied health professionals will find they are providing services and care for Australians who are in the last year of life with little training on end-of-life issues. The majority of Australians will die in acute hospitals. Common challenges for any clinician include:

- Not knowing how to respond to patient questions 'such as am I dying?' or 'what will happen to me?'
- Being able to recognise and understand dying patterns
- Negotiating goals of care with patients, families and other professionals
- Working effectively in a team
- Knowing what to do if patient suffering persists

Methods

The *End-of-life Essentials* project provides free e-learning modules and implementation resources for hospital clinicians. Designed for nurses, doctors and allied health professions working in any acute care practice setting, these modules provide specialist e-learning and resources to increase knowledge in end-of-life care. The package has been prepared by the palliative care team at Flinders University in partnership with the Australian Commission on Safety and Quality in Health Care. The resources and e-learning are free to use and can be easily accessed from anywhere in Australia.

Discussion

Dying is a normal part of life and a human experience. Access to appropriate and specialist e-learning and resources will empower and enhance allied health professions to confidently respond to and manage challenging end-of-life care.

Training the next generation of Allied Health professionals in innovative service delivery

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The Telerehabilitation Clinic (TRC) is an innovative teaching and learning clinic for Allied Health students enrolled in the School of Health and Rehabilitation Sciences at the University of Queensland. The aim of the TRC is to provide audiology, occupational therapy, physiotherapy and speech pathology services to people in rural and regional Australia, where access to therapy is diminished.

A key objective of the TRC is to train the next generation of allied health practitioners to be creative and to deliver therapy via alternative modes. While there are challenges in delivering telerehabilitation services across Australia, creative solutions and 'out there' ideas are beginning to change what clinicians believe is possible via telerehabilitation. Research conducted in the TRC is taking these creative ideas and providing the evidence base for their use. There may be controversy when challenging people's beliefs about traditional therapy services, but the health impacts that are possible via telerehabilitation outweigh the difficulties faced.

Students provide valuable input into our clinic through their creative thinking in the use of technology and how services might be delivered. By establishing the TRC and delivering allied health services via telerehabilitation to people in the wider community, we are able to reform services and the role of Allied Health practitioners. Telerehabilitation will become mainstream in health services within Australia in the years to come, and it is imperative that allied health graduates have the education and clinical experience in this innovative mode of service delivery.

An intervention aimed at reducing the number of Frequent Attendances to Hospital Emergency Departments

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Background: A Health and Wellbeing Connection pilot study was undertaken by Richmond Services in partnership with Pegasus Health, Partnership Health, and the Canterbury District Health Board.

Objective: The aim of this study was evaluate an intervention program offered that assisted reduction of the number of frequent attenders to the Emergency Department at Christchurch Hospital.

Methods: The K10 Depression and Anxiety scale and the World Health Organization Quality of Life measure (WHOQOL) were administered to 105 people attending the Emergency Department repeated for the 53 participants who completed the intervention program. Attendance rates at the Emergency Department and general practice were also recorded.

Results: The majority of the participants who completed the program had reduced their attendance at the Emergency Department significantly and all reported a decrease in psychological distress and an increase in their quality of life. There was no real change in their attendance rates at general practice centres.

Conclusion: While the number of participants in this study does not allow for robust analysis of efficacy it does indicate that there is merit in continuing to develop brief intervention case management models to support behaviour change programs for frequent attenders to Emergency Departments.

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An online Allied Health Palliative Care resource

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Background

CareSearch is an online evidence - based palliative care resource. It features an Allied health 'Hub' to recognise their vital role within multidisciplinary care. Hubs consolidate the knowledge base/practice issues for those involved in seeing people with palliative care needs. It provides easily accessible information for Allied Health Professionals that can help empower, motivate and educate in palliative care.

Methods:

An advisory group supports ongoing development, providing feedback on the content, design and organisation of the hub as well as user testing. Pages are created within a knowledge translation framework and include summaries of the issues as well as practical resources that include DVDs, policy documents and weblinks. There are sections on clinical considerations, education, areas of practice, quality policy standards, interdisciplinary teams, and working with patients and consumers. There are also pages for consumers on the roles of allied health professionals. Each page is peer reviewed.

In addition, there are PubMed topic searches specific to Allied Health, each featured discipline and to rural and remote issues.

Results:

The Allied Health hub had 164,000 page views in the 2 years to November 2015.

Each member of the advisory group leads an edition of the bi-monthly newsletter focusing on their discipline. This includes a case story and a profile of someone working in palliative care. There are over 1,000 subscribers to this.

Discussion:

CareSearch contributes to increasing the evidence base for palliative care for those working in Allied health with rigorous developmental processes to ensure currency and appropriateness of information.

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Auditing: death by a thousand paper cuts or the unheard client voice?

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Clinical auditing has long been utilised by health organisations as a tool for quality review in an integrated clinical governance framework. Anecdotally auditing can suffer from an image problem amongst clinicians, despite widespread acknowledgement of usefulness in the quality system. This may include perceptions that auditing is a dry, highly intensive, "big brother", detail driven review process that takes away precious time from direct client services in already stretched and busy teams. Auditing can be seen as an additional impost rather than a core professional activity.

This presentation serves to explore an alternative way to consider and manage attitudes towards auditing; to facilitate a shift from auditing being considered an onerous quality process, to that of liberating the unheard client voice. Auditing can tell us an additional story regarding the quality of our services that we won't hear directly from clients, that we won't receive in consumer surveys and that we won't know if we don't go looking for it. By presenting a change of the lens through which clinicians approach auditing, can this change our experience, our interpretation, our sense of value in the information gained and how we use this to improve services to clients?

The journey of revitalising clinical auditing through a change model that includes attention to this aspect of client centred focus (as giving voice to that which is otherwise unheard) will be shared to broaden this concept in deepening the authentic understanding of the service we provide as we continue our pursuit of excellence.

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Village hopping without a hitch

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The successful implementation of the Country Health South Australia (CHSA) Clinical Supervision Framework and ongoing work to build one cohesive podiatry team has had a significant impact on our ability to provide seamlessly integrated clinical care for Podiatry clients across country South Australia. The Country South Australia regions have come together to create one podiatry 'village' and this in turn has seen better patient outcomes and improved patient satisfaction.

An example of this is when Judith, a client from Mount Gambier, was diagnosed with Charcot Neuroarthropathy (CN). Management of CN requires blood tests, x-rays, weekly foot monitoring and Total Contact Casting (TCC) as gold standard treatment. TCC (generally required for several months) commenced in Mount Gambier but 4 months into her treatment Judith wanted to travel by bus 450kms to visit her daughter in the Barossa Valley for two weeks. Prior to the 'Podiatry Village' Judith would have either needed to cease TCC treatment for 2 weeks, return home after one week to attend an appointment or register as a temporary resident with a Barossa Valley GP to be referred as a new client to the Gawler Podiatry service. Now, because she is a 'podiatry villager', all that is required is a simple phone call and email handover to the Podiatrists in Gawler and Judith is able to travel away from home to visit family without interruption in her therapy. Strengthened networking and communication channels and documentation across CHSA are responsible for this success and is an achievement worth celebrating.

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Understanding nutrition as a patient safety problem: an audit of South Australian practices

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Background:
There is evidence to indicate that poor nutritional care can threaten the safety of people in hospital and community settings leading to increased mortality and morbidity (1). Nutritional care crosses diagnostic, professional and jurisdictional boundaries and can impact a range of health care stakeholders. The aim of this initiative was to provide an overview of, and quantify, the number of nutrition-related patient safety incidents reported in SA Health's Safety Learning System (SLS) and a summary of themes and contributing factors reported in this data.

Methods:
Incidents reported in the SLS as occurring during one calendar year (2015) were searched for nutrition-related keywords using a free text search. Nineteen nutrition-related keywords were used to generate incident reports which were reviewed for nutrition-related incidents against the nutrition-related patient safety incident definition. Nutrition-related incidents were attributed to one or more key themes.

Results:
The findings from this audit indicated that the most commonly reported patient safety nutrition-related incident themes were aspiration/choking, problem with meal or feed preparation and/or delivery, and fasting-related. Contributing factors were poor and lack of timely communication between staff and departments/services, and problems relating to ordering (misinterpretation or incorrect ordering), incorrect/delayed prescription and delivery of feed/food/fluids.

Discussion:
Health care organisations should recognise that poor nutrition care practices can cause unnecessary harm to patients, resulting in poor quality health care. Despite its impact, currently nutrition-related patient safety incidents are under reported and/or hidden in other patient safety incident areas resulting in missed opportunities for improvements.

1. Dietitians of Australia. Evidence based practice guidelines for the nutritional management of malnutrition in adult patients across the continuum of care. *Nutr Diet* 2009; 66(Suppl.): S1-S34.

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How to develop the next generation of Australian Rural and Remote Physiotherapists

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There is a growing number of graduates from Australian universities in Physiotherapy. With fewer opportunities in metropolitan areas, graduates will seek work in sole rural and remote positions. Throughout their training, how do we to ensure that all graduates are ready for the unique demands for rural and remote practice in Australia?
This presentation will describe an “embedded approach” to rural and remote Physiotherapy education. Where challenges and opportunities are explored through a transformative learning approach to teaching – where students are guided through clinical and professional practice but also explore their own values and beliefs to be able to develop partnerships required to negotiate through challenging and changing work location and practices upon graduation.

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Making it up as we go: The tall and true story of Greater Northern Australia Regional Training Network (GNARTN) and Allied Health Rural and Remote Generalist (AHRRG)

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For a new organisation like GNARTN which is by virtue of its structure and funding a radical departure from the way government agencies collaborated, many said for GNARTN to "take on" Allied Health Rural and Remote Generalist was in the words of Humphry from "yes minister" a "Brave Decision". GNARTN was established as a cross-jurisdictional network, established in 2013 to address a range of clinical workforce and clinical placement, education and training issues, via an agreement reached between Western Australia, Northern Territory and Queensland Health Departments through funding provided by the Commonwealth Department of Health Australia. A key objective of GNARTN was to drive innovative pragmatic and sustainable models to address workforce mal-distribution and improve patient outcomes.

This is the story, of GNARTN,as a new entity, and what role the organisation has played in supporting the development of the AHRRG constructs, and the emerging narrative around what this means for the future of the regional, rural and remote allied health workforce in the future.

Sport 4 Rural Health- more than just sport

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Sport 4 Rural Health is a multi-disciplinary physical activity program aimed at improving the physical, social and cognitive health of children and youth with special needs in the Whyalla Community.
Literature suggests that children and youth with cognitive and/or physical impairments are generally less active than children who are considered to be neuro-typical. On top of this, certain conditions such as Autism Spectrum Disorder can cause both behavioural and social impairments. This makes it more difficult for the child living with ASD to engage in conversation, participate in group activities and generally make friends. The literature highlights the importance of physical activity for physical health as well as for the social and psychological benefits it can have for children and youth living with cognitive and/ or physical disabilities.
In 2015, the Whyalla Special Education Centre identified the need for a physical activity program that could help improve motor skills as well as the added social and psychological benefits. The University of South Australia Sport and Development program, The UniSA Department of Rural Health and the Whyalla City Council were approached to partner with the school to develop and facilitate the Sport 4 Rural Health Program.
Into its third term, the program is run by local Health and Education University Students from the Whyalla campus to facilitate physical activity sessions for the students from the Whyalla Special Education Centre. This arrangement is mutually beneficial with the University students gaining valuable experience in working with children with special needs and the school students receiving specialised physical education sessions.

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“Closing the Gap through role-emerging occupational therapy positions”

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Introduction

Kimberley and Tahnee are two Aboriginal new graduate occupational therapists from the University of South Australia, who are working as Aboriginal and Torres Strait Islander Allied Health Officers at the University Department of Rural Health in Whyalla.

Discussion

Occupational therapists work with individuals and groups throughout the lifespan promoting health and wellbeing through the engagement in meaningful occupations. Occupational therapy can offer a unique insight into community-centred practice as we are philosophically, theoretically and practically well situated to work collaboratively with communities. The key values underpinning community-centred approaches parallel client-centred practice, which is intrinsic to occupational therapy philosophy.

If occupational therapists were to work more broadly with communities, there would be greater potential for a larger population impact. Occupational therapists practicing in Australia are perfectly positioned to work together with Aboriginal communities to address the multitude of disadvantages faced by many. By recognising Aboriginal People’s resilience and protective cultural factors occupational therapists can help to support meaningful engagement in life roles at both an individual and community level. Aboriginal holistic views of health and wellbeing, principles of primary health care and occupational therapy share a common comprehensive view of health. A combination of all three within community-centred practice offer an effective approach to addressing broader determinants of health.