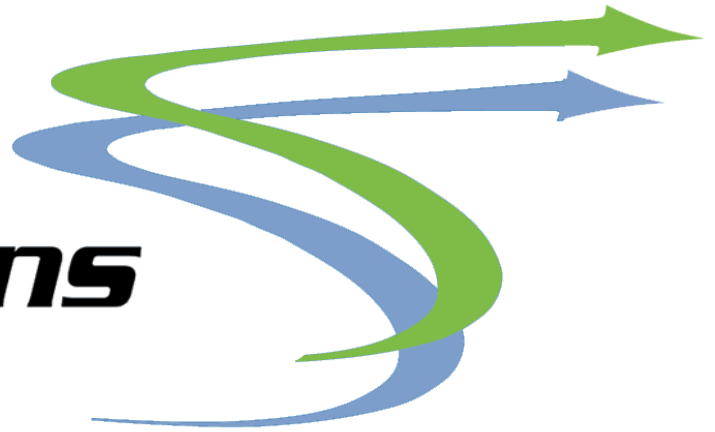


change champions



Newsletter for Innovators
November 2010

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[Check out this new section featuring great innovations in healthcare overseas](#)

Change Champions to become new stakeholder for *CHAIN Australia*

Change Champions P/L is pleased to announce its commitment to facilitating *CHAIN* for Australasia commencing on 1 January 2011. This commitment will be formalised in the coming weeks.

CHAIN (Contact, Help, Advice and Information Networks), established in 1998 in the United Kingdom, is a not for profit, multi-professional online network of more than 9500 people working in the health care family of organisations, research, education and quality improvement in the UK and more than 40 other countries worldwide.

As the new stakeholder for *CHAIN Australia*, Change Champions, an Australian company that produces high quality seminars in the health sector, will become the regional lead for the international

professional network in Health care. Staff at the Change Champions office will field enquiries accessing expertise from the worldwide *CHAIN* network.

“This is a fantastic opportunity to also showcase Australian innovation projects on the world’s stage while encouraging health and social care professionals in Australia, New Zealand and Asia to learn from the achievements in quality, safety and health and social reform overseas,” said Char Weeks, Chief Executive of Change Champions.

“It’s really all about sharing great ideas around the world to foster innovation and improvement with patients being the winners.”

(continued on page 2)

Since 2007 CHAIN has had a national component in Australia and the network has continued to grow significantly over the last two years.

Change Champions will be starting out by producing 4 compendia comprising of Clinical Engagement, Change Management, Creating Sustainable Cultures of Innovation in Healthcare, and Creating Sustainable Cultures of Safety in Healthcare. The compendia will result from a collaborative effort with CHAIN members

encouraged to contribute.

The compendia will be available to CHAIN members for free and non- members at a small fee in order for Change Champions to recover the costs of putting it together.

For more information about CHAIN, visit:

<http://chain.ulcc.ac.uk/chain/index.html>

For more information about Change Champions

visit <http://www.changechampions.com.au> ■

November 2010

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	OH&S Conference		20
21	22	23	24	25	26	27
28	29	30				

Supporting the Healthcare Workforce– Innovations in OH & S

18-19 November 2010

Melbourne, VIC

Keynote Speakers:

Ian Bynon, A/Director Safety & Wellbeing, People and Culture Strategic Services, Queensland Health

Therese Fitzpatrick, Program Manager – National Workplace and Social Enterprise, beyondblue

Katy Fielding, Department of Health Victoria

Dr Robert Grenfell, Public Health Physician, VIC

Dr Ashley Kable, University of Newcastle, NSW

Richard Lizzio, Chief Executive Officer, Greenslopes Private Hospital, QLD

Christian Silvestre, Safetrain, NSW

Prof Pauline Stanton, Victorian Graduate School of Management

Carmen Walker, Southern Health, VIC

Eddie Wood, Manual Handling Co-ordinator, Hunter New England, Area Health Service, NSW

Clementia Yap, Sydney West Area Health Service, NSW

TO REGISTER ONLINE: WWW.CHANGECHAMPIONS.COM.AU

2 WEEKS TO GO: LAST CHANCE TO REGISTER

www.changechampions.com.au

MASTER CLASS: Radical Health Reform under a Minority Government

To be held on 10 November 2010 at the Hilton Hotel,
Adelaide, South Australia

Facilitator: Pippa Bagnall

UK Healthcare Reform Consultant, Chairman Realise Health, UK

Pippa Bagnall is a Health Care Reform Specialist who has held senior positions in the Cabinet office and the Department of Health. She has pioneered many transformational change programs and local projects across emergency, urgent, primary and social care.

2 DAY SEMINAR

BEST CARE

BEST PLACE:

DESIGNING AND IMPROVING PATIENT FLOW

**11-12 November 2010
Hilton Hotel, Victoria Square,
Adelaide, South Australia
Australia**

Hospital at Night

Gerry Bolger

An overview of the *Hospital at Night* initiative— a program designed to support junior clinical staff make the right decisions on night duty



Context

The UK health system is devolved across the countries of the kingdom and provided across four countries England, Wales, Scotland and Northern Ireland. Devolution came into place a number of years ago, and prior to that the NHS was centrally managed being closely aligned to the Department of Health [DH] (now England) in Whitehall.

Prior to devolution many of the reforming change programmes were led by what is now DH England; and one of those far reaching programmes was the *Hospital at Night* initiative. This was an innovative way of supporting the most junior of clinical staff when they needed it most – at night – to help them make the right decisions with the right support.

Hospital at Night [\[H@N\]](#) is well established across England and the most of the UK. Its significance was the fact it has been able to demonstrate effective quality and operational benefits by comparing national data. What Hospital at Night does is it draws the expertise together as a highly effective team to then actively identify those patients at risk and manage them in a multi-professional teamwork.

So rather than having an over-worked junior doctor (which are trainees, that is, they have finished their medical school but working towards their specialist certificates/ expertise) working alone, they would work with other junior doctors and very experienced senior nurses to identify, manage and support ill patients at night, with the ability to call in expertise should this be needed. They would have the key decision makers on site or close to hand if that was necessary.

In fact, where Hospital at Night has worked effectively, they have been able to reduce the number of doctors in training down (especially the very junior doctors) and compliment with trained nurse practitioners who would filter all the calls from the wards and then refer them to the most appropriate clinician, this may not be the medical team treating the patient, or even a doctor at all. Sometimes it would be necessary to refer to the surgical team if a patient had acute abdominal pain to get a definitive diagnosis; or in the case of a patient with chronic respiratory problems, it may be appropriate to call in the respiratory physiotherapist.

What have been the benefits?

Effective teamwork has shown that there is a direct benefit in patient safety, so, where effective [H@N](#) has been in place, there has been a reduction in the number of cardiac arrests at night, a reduction in unnecessary admissions to Intensive Care Units/Therapy Units and a reduction in the movement of patients from ITU at night because the team is working to identify those sick patients and agree a plan to manage those patients at night.

Inter-team handover is a critical factor in the success of [H@N](#). This means that nursing and medical teams come together to handover their patients, rather than seeing it as a 'chore' seeing it as a learning and effective communication approach. As such patients are identified and managed proactively rather than reactively.

What were the drivers for this?

[H@N](#) came from need for improved safety at night, especially for junior medicals staff. However, at the same time the European Union changed legislation that meant the maximum hours any employee in the EU can work was 37.5 hours a week (unless they opted out of the working hours) alongside this was restrictions in the maximum number of hours one could work; these could not be opted out. Evidence shows that clinical staff who are working excessive hours are at risk of making more mistakes and their responsiveness to emergencies is reduced. Medical staff are now treated exactly like all other clinical staff (with the exception of consultants who have a different arrangement). This in itself has created some challenges in the system, especially at night, however [H@N](#) has been a supportive approach to manage these changes.

So H@N work everywhere, right?

No, it doesn't. [H@N](#) is designed to allow transferability of skills, rather than demarcation of roles by speciality. As such it would be totally unsafe to have a junior doctor in respiratory medicine being asked to treat a specialised patient for example, neonates. As such it is about moving the clinicians within the service who have the competences for those patients. As such, paediatrics and neonates are not usually covered by [H@N](#), although, we have a number of hospitals in England who specialise in paediatrics and neonatology where they do move the teams across that service. Likewise in obstetrics there would need to be more traditional models of working.

However, for the majority of services in the acute hospital, there can be one or more Hospital at night teams depending on the size and the 'footprint' of the service. Equally, [H@N](#) can work in psychiatry where there is more cross-cover and the use of specialist nurses who support the initial assessments and responses to either clinical emergencies or crisis intervention. It can be as broad or as narrow as the service you want, but to be effective, it must have the support of your senior management teams, board and clinical leaders; involve all clinical staff, medical nursing and therapy, and must work in a different way, be led by a clinician and coordinated usually by nursing staff who know the service and the clinical staff and have agreed protocols of service to support innovative practice within the legal and regulatory frameworks you have. ■

Gerry Bolger MHM, RN has been a senior Hospital at Night practitioner in two London hospitals. He has developed the roll-out and implementation plan for England and has been the recent lead for quality measurement for the Department of Health in Whitehall.

Hospital at Night has been featured by Change Champions and the former project director is developing a Master Class for Autumn 2011 across Australia and New Zealand.

EG, a 94 year old Tamarama resident had three falls in a week, the last of which resulted in a fracture of her right wrist. In a matter of days she went from being largely independent to being unable to manage the stairs in her split level home. A referral from EG's GP meant the Geriatric Flying Squad (GFS) were on scene a day after her third fall and within the week she was seen at home by every member of the GFS team. Among many things done for EG, Community services were organised, her home was modified to facilitate EG to live on one level for the interim and medical reasons for her falling were identified and treated. EG now continues to remain living independently using both floors of her home and attends the out-patients department of the War Memorial Hospital (WMH) for physiotherapy. EG has not fallen since.

The WMH is a community-based hospital in Waverley. For many years it has provided an integrated model of outpatient geriatric care. With an aim at being "a one stop shop" for community geriatric care, it provides specialist geriatric medical, nursing and allied health treatment and group programs.

The GFS was created because a need for fast community geriatric care was identified. Long waiting times for all community geriatric services meant that elderly clientele who were not necessarily acutely unwell were presenting to A&E departments because they could no longer manage at home.

A multidisciplinary team that responds to community referrals with an inbuilt triage system is able to give priority to urgent cases. This is similar to the community palliative care model and the term "geriatric flying squad" was

previously coined by Professor Tony Broe. The team is based in the outpatients department at WMH but provides both clinic-based and domiciliary assessments and is geared to respond to emergency calls from community care providers and general practitioners. The appointment system is flexible so that patients triaged as urgent are assessed within 24-48 hours of referral. If the flying squad assessment confirms that the patient needs admission to hospital, the integration with the Medical Assessment Unit services (a hospital based geriatric service) ensures a smoother transition of care. Otherwise, the patient can be managed at home, or admission arranged to sub-acute care at WMH, thus avoiding the Emergency Department.



In May 2010 the Geriatric Flying Squad spread its wings and began the assessment and management of elderly clientele in the Northern Network of SESIAHS. The squad consists of a Geriatrician, a Clinical Nurse Consultant (CNC), Social Workers, an Occupational therapist (OT), Physiotherapists and a Clinical Psychologist. Referrals have come from General Practitioners, WMH out-patients department, community care providers, Aged Care Assessment Teams (ACAT), the police, paramedics, neighbours, families and the clients themselves.



(Pictured) Amanda Klahr, Anne Satchell and Andreyka Kelly on the go

Research shows that Geriatric assessment is only beneficial if clients are assisted in carrying out the assessment recommendations; this is what the GFS aims to do. The service provided is individualised; no two clients follow the same pathway of care, as only the required disciplines are involved. Some clients require minimal involvement while others extensive and long term care. To date the GFS has assessed 76 clients.

The GFS is a paperless, mobile service using the CHIME (Community Health Information Management Enterprise) database. The CNC, OT and Geriatrician each have a mobile work station using wireless internet and VPN allowing for efficiency and flexible work practises.

Amanda Klahr
Clinical Nurse Consultant
Geriatric Flying Squad
War Memorial Hospital

In order to measure client outcomes objective client data is being collected. A client and care giver satisfaction measure has just been launched and the first patient follow-up clinic will be held in November.

In the months to come, as with EG, the GFS hopes to service and help many more elderly residents of the Northern Network with an aim to keep them at home, out of A&E and also to give them and their families support, dignity and quality of life. ■



ADVANCE NOTIFICATION: CALL FOR ABSTRACTS

**Medication Safety
for Older People**
1-2 March 2011
Adelaide, SA

**Mental Health
& Medication Safety**
3-4 March 2011
Adelaide, SA

Visit www.changechampions.com.au for more details
or to download the Call for Abstract guidelines



International highlights

Institute for Healthcare Improvement

Technical Report: Options for Large-scale Spread of Simple, High-Impact Interventions

This paper outlines the adoption and spread of high impact interventions, drawing on the experience of those working in large-scale improvement work. It looks at several different approaches for large scale spread, including the collaborative, wave sequence and emergency mobilisation approach.

The online PDF can be found on this link:

http://www.ihl.org/NR/rdonlyres/B37CD455-9F65-422F-878F-3DB1C920A380/0/MassoudDonahueMcCannonLargeScaleSpreadHighImpactInterventions_USAIDURCSept10.pdf

Health Council of Canada

Report: 'Decisions, Decisions: Family Doctors as Gatekeepers to Prescription Drugs and Diagnostic Imaging in Canada'

With an increasing number of written prescriptions and diagnostic tests ordered by family physicians, this fascinating report examines the role of the family physician and the factors that affect their decision making.

The online PDF can be found on this link:

http://healthcouncilcanada.ca/docs/rpts/2010/HSU/DecisionsHSU_Sept2010.pdf

AHRQ: Agency for Healthcare Research and Quality

Improving America's Hospitals: The Joint Commission's Report on Quality and Safety 2010

In this report, The Joint Commission places the spotlight on performance on accountability measures— evidence-based, easily measurable metrics that are strongly linked to patient outcomes and have a minimal potential for harm. The organisation's approach to improving quality and safety in healthcare is discussed by Dr Mark Chassin, the president of the Joint Commission.

The online PDF can be found on this link:

http://www.jointcommission.org/NR/rdonlyres/D60136A2-6A59-4009-A6F3-04E2FF230991/0/2010_Annual_Report.pdf

World's First Transcontinental Anaesthesia

By Allison Flynn
McGill University, Canada

Videoconferences may be known for putting people to sleep, but never like this.

Dr. Thomas Hemmerling and his team of McGill's Department of Anaesthesia achieved a world first on August 30, 2010, when they treated patients undergoing thyroid gland surgery in Italy remotely from Montreal. The approach is part of new technological advancements, known as 'Teleanaesthesia', and it involves a team of engineers, researchers and anaesthesiologists who will ultimately apply the drugs intravenously which are then controlled remotely through an automated system.

This achievement is a product of an on-going scientific collaboration between Dr. Hemmerling's team and the Italian team of Dr. Zaouter of the Department of Anaesthesia of Pisa University (Chairman Prof. Giunta).

"The practice has obvious applications in countries with a significant number of people living in remote areas, like Canada, where specialists may not be available on site," Hemmerling said.

"It could also be used for teaching purposes, allowing the resident to perform tasks without the physical presence of a tutor, thus increasing his or her confidence level."

Four strategically placed video cameras monitored every aspect of patient care in Pisa, Italy, in real time. Ventilation parameters (such as the patient's breathing rate), vital signs (ECG, heart rate, oxygen saturation) and live images of the surgery are monitored by each camera, with the fourth used for special purposes. A remote computer station ('anaesthesia cockpit') is required, as is a workstation that handles the audio-video link between the two centres.



(Above) This anaesthesia cockpit in Montreal is controlling anaesthesia



(Above) This is a preoperative remote patient assessment.



(Above) video-real stream in Montreal from patient monitoring in Pisa

"Obviously, local anaesthesiologists can override the process at any time," Hemmerling explained. Prior to the operation, an assessment of the patient's airway and medical history is also performed via videoconferencing.

The researchers are also looking at the possibility of preoperative assessment of patients at home. It used to be that invasive blood tests or other tests were required in preparation for many surgeries, but that's no longer the case.

Many patients take very long journeys and often wait hours to see an anaesthesiologist who will ask them specific questions, but video-conferencing could eliminate these logistical problems and probably reduce the preoperative stress of the patients coming into the hospital before surgery.

"The next steps will be to confirm the results of this pilot experience with further studies," Hemmerling said. ■

This article was used with permission. Photos courtesy of Dept. of Anaesthesia, McGill University, Montreal.

International highlights

The Nuffield Trust

Briefing Paper: Removing the policy barriers to integrated care in England

This paper uses five case studies of health economics in the English NHS to examine how local clinicians and managers are working together to develop closer service integration and less fragmented care for patients.

For copies of the PDF, please contact Diane Vatinel on +61 (2) 9692 0533 or by email at diane.beyrouthi@changechampions.com.au

PIRAMHIDS

Website: <http://www.piramhids.com>

This website is a fantastic resource created by the NHS Quality Improvement Scotland supported by the Scottish Government. It is a national, multi-disciplinary database of positive and innovative practice in mental health. Toolkits, Forums, Case Studies and a variety of contributions can be found here.

Website: <http://www.piramhids.com/>

IVEY: Centre for Health Innovation and Leadership

Paper: Innovation Takes Leadership: Opportunities and Challenges for Canada's Health Care System

This paper puts forward the case that to ensure Canada's competitive economic future, the country must ensure the sustainability of its health care system by supporting and encouraging innovative adoption.

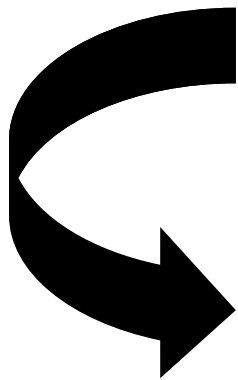
The IVEY Centre's mission is to ensure that developmental process and a system-wide innovation adoption framework (or frameworks) exist to promote new technological innovations and best practices in Canadian health care.

The online PDF of this paper can be found on this link:

<http://blogs.ivey.ca/ichil/files/2010/09/White-Paper.pdf>

Have a suggestion for the International Highlights column?

Contact Diane Vatinel on +61 (2) 9692 0533 or by email: diane.beyrouthi@changechampions.com.au



A New Direction for Change Management?

Facilitated by Pip Robinson and Robin Davis

Learning Objectives and Outcomes:

1. By using the most up to date evidence, such as Kotter's recent refresh of the 8 steps for leading change, and best practice tools and techniques, and through facilitated discussion, delegates will be enthused and mobilised to develop plans of how to initiate and sustain improvements within in their organisation and health system.
2. Participants will explore techniques for spread and adoption of good practice at national and local levels. Reflecting on the experience of the NHS in improving access to elective services and how to support organisations to bridge the gap between theory and practice.
3. Participants will gain an in-depth and practical understanding of how to develop a programme of improvement which takes account of their personal style and unlocks the potential of the wider team.
4. Participants will gain practical ideas and tools on how to understand complex services and develop capacity plans that meet demand, cope with variation and achieve improved access and patient satisfaction.

Audiences: Executives, Managers, Clinicians

Register Now at <http://www.changechampions.com.au>

ALSO AVAILABLE:
In house Master Classes
with Philippa Robinson and Robin Davis
(workshop design is flexible and can be tailored to your organisation)

Topics Covered:

- Quality improvement tools and techniques
- Large scale change
- Human dimensions of change

25 Feb 2011 Wellington NZ

1 March 2011 Brisbane QLD

2 March 2011 Sydney NSW

4 March 2011 Melbourne VIC

8 March 2011 Hobart TAS

10 March 2011 Adelaide SA

11 March 2011 Perth WA

** Change Champions has an exclusive agency agreement with Pip Robinson and Robin Davis. Bookings can only be made via Change Champions. Availability is limited.*

callforabstracts

Medication Safety For Older People

1– 2 March 2011
Adelaide SA
Submissions due: 10 Nov 2010

Mental Health and Medication Safety

3– 4 March 2011
Adelaide SA
Submissions due: 10 Nov 2010

2nd Improving Patient Flows: Diagnostics & Results Reporting

31 March– 1 April 2011
Brisbane, QLD
Submissions due: 15 Dec 2010

Today's Hospital– 24/7 Care Every Day of the Year

25-26 May 2011
Melbourne VIC
Submissions due: 11 Feb 2011

Successful Reform Strategies across the Public Sector

28-29 July 2011
Sydney, NSW
Submissions due: 11 March 2011

Optimising the Management of Pain

18-19 August 2011
Melbourne VIC
Submissions due: 11 April 2011



Download full details at
www.changechampions.com.au

Sponsorship

Sponsorship opportunities are available at ALL Change Champions seminars. Exposure ranges from trade booths, logo appearances in program & learning materials, satchel inserts and much more.

To make an inquiry or to receive a sponsorship kit, please contact:

Jason Amies

Ph: +61 (0) 2 9692 0533

E: Jason.Amies@changechampions.com.au



Leadership and Management for Health Professionals– Sharing the Experience

27 May 2011 in Sydney, NSW
Submissions due: 10 Feb 2011

Change Champions P/L is calling for nominations for inspirational leaders and managers in healthcare to be invited to share their knowledge and expertise at this one day “how to” seminar with an audience that is eager to learn from the voices of experience.

Seminar Aims:

To provide a forum:

- For tomorrow’s rising stars to learn from healthcare leaders and managers who have already trodden the executive path
- For inspirational leaders and managers in health care to share “pearls of wisdom” from their experience working as health care executives and managers

Key Topic Areas:

- Leadership vs Management vs Supervision
- Strategy, Innovation and Performance
- Creating Sustainable Change
- Motivating the Team
- Surviving the Difficult times

Prize Draw:

If your nomination is included in the program for this event, you will receive a prize of a management book plus a complimentary registration to the seminar.

Think your boss is fantastic? Why not nominate them?

masterclasses

The Challenge of Long Term Alcohol Abuse in Older Adults

23 February 2011

Hobart, TAS

Facilitated by Alice Rota Bartelink

Responding to the Behavioural Symptoms of Dementia During Personal Care Activities

19 November 2010

Melbourne, VIC

Facilitated by Robyn Attoe & Alissa Westphal



workshops

Handy Hints for the Novice Conference Presenter

If you are doing great work but never or hardly ever present to a live audience because the thought of it turns your knees to jelly then here is a workshop for you.

10 November 2010

Adelaide, SA

17 November 2010

Melbourne, VIC

10 December 2010

Brisbane, QLD

Facilitated by Char Weeks

'HANDY HINTS FOR THE NOVICE CONFERENCE PRESENTER'

If you are doing great work but never or hardly ever present to a live audience because the thought of it turns your knees to jelly....then this book is for you

Order your copy today for just \$39.95*. 132 pages with some Colour illustrations. Quantity discounts are available for orders: 10-24 copies: \$33.00*; 25-99 copies: \$26.75*

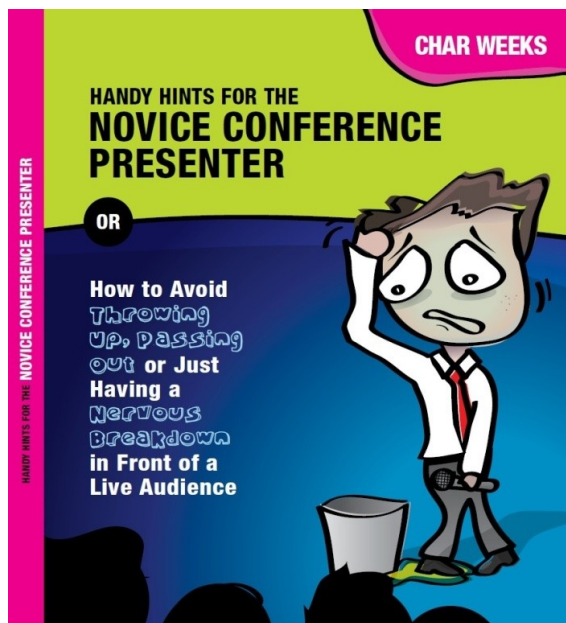
* Prices are in AUD\$ and include GST and P&P (including international)

About the Author: Char Weeks is a Certified Executive Master Coach, change agent and Chief Executive of the Australian change management company, Change Champions P/L.

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Print this page and fax it to Change Champions on: (02) 9518 6898 or: + 61 2 9518 6898(International)



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For more information on the book or on the accompanying workshops, please contact Change Champions:
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Would you like to contribute to this newsletter?

Change Champions are always on the lookout for new innovations, research and workplace achievements in the health sector. If your workplace has been involved in an exciting innovations project, please don't hesitate to send us a summary article of between 250 –300 words.

For newsletter enquiries, to make a submission, or to place an advertisement, please contact:

Diane Vatinel

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