The Satisfaction Snapshot is a monthly electronic bulletin freely available to all those involved or interested in improving the patient/client experience. Each month the Snapshot showcases issues and ideas which relate to improving patient satisfaction and customer service, improving workplace culture and improving the way we go about our work in the health care industry.

The Satisfaction Snapshot features:
- relevant articles from health care industry experts
- case study success stories
- tips and tools for quality improvement
- patient satisfaction and other industry research findings
- articles with ideas to help achieve success in your role

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Each year Press Ganey recognises the success stories of health care organisations Australia-wide. This years entrants were so strong that we decided to bring you the stories of success from the five other finalists in the 2006 Success Story competition. The two winners were featured in the October issue of Satisfaction Snapshot. These stories are a testimony to the commitment to quality care and improvement of service to communities everywhere. Celebrate with us as we share the success stories of Children, Youth and Women’s Health Service, Hawkesbury District Health Service, Mercy Hospital - Mount Lawley, St. John of God Hospital - Murdoch and Beleura Private Hospital.
Children, Youth and Women’s Health Service

“Putting the Patient First When Redesigning Care”

We, the Children Youth and Women’s Health Service commenced a redesigning care framework in the form of ‘Patient First’ in July 2005. This encompassed four streams of care:

- After Hours Hospital Care
- Paediatric Emergency Care
- Surgical Booking processes
- Uncomplicated Vaginal Birth

Prior to commencing the care streams, Press Ganey Associates was engaged to perform staff and consumer satisfaction surveys in the Paediatric Emergency area and the Postnatal area. The results were far from complementary. The Press Ganey report for Paediatric Emergency patients in September 2005 showed that only 7% of all facilities had scores lower than ours. The staff survey for the same period reflected that 18% of all facilities had scores lower than ours. We were the lowest performer nationally in Postnatal in the inpatient survey and 21% of all hospitals had scores lower than ours when the Postnatal Staff were surveyed. The only way to go was up.

From there the four teams began their process of redesigning care under the Continuous Practice Improvement model which consists of analysing the problem using:

- Mapping the current process;
- Brainstorming the issues;
- Analyses and implementing;
- Plan Do Study Act cycles to improve the process to make gains. The key to this is measuring prior and post initiative, so some sense of achievement can be measured.

In the Paediatric Emergency area, we initiated the ‘See and Treat model’, which is a streamlining model that has been utilised throughout the world in key institutions using the redesigning care framework. The principles of this initiative are to have dedicated, experienced, senior staff to run the service. Usually a senior Nurse works with a senior Doctor and they are allocated a specific group of patients, which includes patients presenting with common conditions such as simple fractures, lacerations treatable with tissue glue, sprains, pulled elbows, foreign bodies, mild croup and upper respiratory tract infections. These patients can be seen quickly and efficiently and it has been shown that this model does not interfere with the waiting times of the patients with more acute conditions. This leads to a high degree of patient satisfaction; as they are seen and treated quickly, with a more timely discharge. The survey performed Post Implementation of the “See and Treat Model” was an exceptional increase in Patient satisfaction. For example ‘The care your child received while in PED’ improved from 79% rated as good to very good to 95%. Other initiatives in the Paediatric Emergency were many and varied.

- A clinical Pathway for Diarrhoea and Vomiting for children following best practice, hoping to reduce admissions by 25%;
- An escort to ward without the Nurse utilising a Patient Service Attendant (following a strict criteria), saving 20 minutes per transfer of nurse time that can be spent elsewhere;
- Instigating an automated phone streamlining service, which directs calls to the appropriate staff, e.g. poisons information directed to the Pharmacy, allowing the Triage nurse more time to assess the waiting patients at the triage desk;
- Conducting consumer workshops to tease out the top Ten Press Ganey Priority Index issues, gained from our consumer survey. This consisted of formulating an action plan to address the issues raised at the forum.

Some initiatives from the action plan were:

- Developing communication in-services utilising role-plays, group norms and scripting as per Press Ganey Solution Starter for customer service;
- Developing a brochure to give to Patients at the triage desk which explains who will treat you, why you may be seen out of turn and location of amenities such as rest rooms etc.;
- Providing consumer feedback forms in strategic places with return envelopes, to try and encourage constructive feedback.
Staff formed a focus group and strategically and systematically worked on strategies from the top ten Priority Index reported by Press Ganey. They also were keen to explore the lowest percentage scores as well. Initiatives include:

- Re-instigating a multidisciplinary ward meeting weekly with a preset agenda. The rotating chair was instigated to try and improve communication between levels one, two and three staff in nursing and all levels of the multidisciplinary staff;
- Commencing dialogue with the Acting Nursing Unit Head regarding the roster system and how it could be adjusted to please more staff and therefore improve staff satisfaction;
- A multidisciplinary newsletter was commenced and circulation increased to improve communication.

All the initiatives occurred during a major redevelopment of the Paediatric Emergency Department.

Following the Continuous Practice Improvement methodology the Postnatal team instigated many initiatives to improve their consumer and staff satisfaction as well as trying to reduce length of stay and allow for increased capacity, e.g. the anticipated births for the next year was 500 more than the year before i.e. 4500.

Patient First is an initiative which brings together a number of projects aimed at improving care for our clients and patients. The program aims to improve patient satisfaction, the safety and quality of care, and staff satisfaction.

Patient First will initially focus on improving:
- Paediatric emergency services
- Normal (vaginal) births
- After hours hospital care
- Booking processes for children’s surgery

We will:
- Redesign the way we provide care to meet the needs of patients/clients and their families
- Involve consumers and staff
- Reduce waiting time and delays for patients/clients
- Trial small changes (cycles of plan, do, study, act) and measure the impact
- Move quickly (to try new ideas, and to do away with those not working)
Initiatives included:

- Creating a discharge lounge, to reduce bed block;
- A pharmacy trial which required the ward pharmacist to facilitate the Discharge Medication the day prior to Discharge, so that this did not cause delays;
- Streamlining the Neonatal checks for the newborns;
- Promoting and credentialing midwives to discharge well women following strict criteria;
- Developing a postnatal brochure, which facilitates consumers to communicate to the staff the information they require prior to discharge, rather than teach all families the same information;
- Revising a Multidisciplinary clinical pathway so all staff will know what the patient requires and not repeat information;
- Running a consumer workshop to tease out the Top Ten Press Ganey Priority Index was held and a strategic plan developed from this.

The action plan included a full day workshop for all permanent Postnatal Staff was organised to review the Press Ganey results, concentrating on the top Ten Priority Index, identify strategies to improve teamwork, group norms and prioritising care needed and given to mothers and babies in the first forty-eight hours after birth. The staff workshop also addressed issues brought up in the consumer workshop such as visiting hours, customer service and communication skills.

The After Hours Team instigated improvement programmes such as:

- Developing a Respiratory Status chart, which enables all levels of nursing staff to recognise Respiratory Distress and report using the same tool and instigating help depending on score;
- Developing a template for daily entries for medical staff to improve communication especially for overnight problems;
- Trial a Consultant led handover in the evening, reviewing sick patients and planning strategies overnight;
- Surveying families and adolescents regarding communication when your child is sick.

We subsequently engaged Press Ganey Associates to repeat the survey in July 2006 in both Paediatric Emergency Department and in the Postnatal Ward, to measure the status of patient and staff satisfaction in light of these initiatives. We envisage an improvement and hope to share the positive outcomes with the staff and consumers.

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To achieve this aim, objectives were defined from issues identified:

- Facilitate a coordinated organisational approach to early and appropriate patient care interventions;
- Increase clinical staff awareness of “at-risk” patients;
- Increase staff awareness of HDHS protocols to call for emergent or urgent assistance where they had serious concerns for a patient;
- Establishment of a data collection system to assist in measuring performance, strategies and outcomes, which would then remain ongoing.

**Planning Methods**

Hospital executive set up a Critical Care Review Committee (CCR), meeting bimonthly, led by the Clinical Nurse Consultant Critical Care to oversee the GMR review. This Committee reported directly, and was supported by recommendations from the Medical Management Committee, Director of Inpatient Services and Quality and Risk Departments. Senior leadership was critical in driving the project.

The first stage of planning involved the creation of a framework tool, which enabled capture of objectives, strategies, time frames, outcomes and evaluations. Evaluations could then be examined, and further quality initiatives introduced where required on an ongoing basis. The “Quality Action Plan” was created, intentionally cyclic in design.

Baseline qualitative and quantitative data from 2000 - 2004 was found to be limited, thus staff surveys and knowledge questionnaires were implemented organisational wide. Baseline measurement was essential for issue identification to meet outlined objectives, and outcome performance measurement. On evaluation, 5 areas for improvement of the GMR system were identified:

- Criteria
- Data Collection
- Communication
- Processes
- Education

Specific goals were set to meet the issues identified in each area (Code Action Plan 2004-2006 HDHS).

Underpinning the Quality Action Plan, were the Equip standards of:

- Customer Focus
- Leadership
- Continuous Improvement
- Striving for best practice
- Innovation
- Applicability to other settings
Programs and Initiatives

In April 2004, CCR recognised that all the goals identified in the 5 subcategories were interrelated and that initiatives would only succeed if staff were allowed the opportunity of ownership of the project through open reporting, feedback and education. Staff were provided with outcomes of initiatives within their areas, and an opportunity to conceptualise improvements.

By increasing staff awareness of the reasons for introducing an initiative, through nurse managers, team meetings, memos and reports, only one episode with difficulty was experienced, and positive feedback for improvement was generated. Introduction of a backup Code Green pager in 2005 to improve response times in case of battery failure, produced a low compliance in shift handovers despite 4 months of education to medical officers. The Action Plan enabled a second strategy to be implemented, with slight increase in benchmark response times and if unanswered an escalation to a Code Blue for response. Data in 2006 shows, response times have markedly improved (Jan - May report summary 2006).

Initiatives under the 5 sub categories in 2004-2006 were:

1. Criteria
   - Standardised Code Blue criteria with Area policies 2004
   - 100% display of Code Blue and Green criteria 2004
   - Code Blue criteria and parameters displayed on all graphic observation charts 2005, 2006
   - Code Blue criteria displayed on laminated staff badges 2005
   - Criteria for specialised units 2004, 2005
   - Education on criteria location 2004, 2005

2. Data Collection
   - Statistical database designed 2004, 2006
   - Revision and implementation of Code Blue/Green reporting forms for Adults and Paediatrics 2004, 2005, 2006

3. Communication
   - New Code Green pathways for Emergency, Maternity, Theatre and pathology. 2004
   - Code Green reporting information to switch, available on Graphic Observation Charts, Staff Badges and signage’s in all wards 2005
   - New communication pathways established for Pastoral Care and Social Worker for Code Blue resuscitation calls. 2004

4. Process
   - HDHS Policy and Procedures for GMR revised 2005 and again 2006, and incorporated into educational programs.

5. Education
   - May 2004 Training program revision and schedule developed for clinical staff for BLS and ALS.
   - In-services on recognition, activation and reporting Code Blue and Green Organisational wide ongoing
   - 2005/06 – Reinforcement education program through audits, team meetings and memos to staff
   - Mandatory BLS training extended to include Code Green and Blue training from March 05
   - Skills and competency package developed 2005, revised 2006
   - Staff education database developed to track participation in Code Blue workshops 2004
   - ALS training time extended to include Nurse Managers and senior clinicians, Career Medical Officers 2005, 2006
   - Competencies revised 2005, 2006

Result Reports

Evidence from statistical data collated (Report summaries, 2004, 2005 and 2006), quality department audits of documentation and staff feedback indicate achievements to date are:

1. Criteria
   - Diversity of criteria utilised- increased recognition of “high risk patients”
   - 100% of patients who have had a Code Green called, not requiring a Code Blue response within 24hrs
   - Reduction in resources required i.e. only 14.8% of code calls required a full team response in 2005.
2. Data Collection

- Implementation of a central data system for evaluation has resulted in the ability to performance measure:
  1. Amount and type of Codes per month
  2. Criteria utilised – common trends
  3. Response times and treatments
  4. In hour and after hour code calls
  5. Code Green reporting via Switch
  6. Up to date management of education for ALS

3. Communication

- Increased compliance with Code notifications
- Inclusion of Social worker and Pastoral Care Services for Code Blue has resulted in positive feedback from relatives and staff for timely support and information
- Improved response times due to new pathways for ED, OT, Maternity and Pathology
- Increased staff resources after-hours to manage Codes

4. Process

- Improved access to Policy and procedures via HDHS intranet
- Increased awareness of clinical parameters and documentation due to introduction and trial of new forms.

5. Education

- Code Blue Workshop (ALS) evaluations excellent (Summary report 2005 and 2006)
- Code training introduced to all orientation and mandatory days to capture all staff
- Revision of all BLS, ALS programs in line with ARC guidelines Feb, 2006. 74% of staff have completed ALS training utilising new guidelines since inception in February, 2006
- BLS and ALS programs have resulted in 100% competency achievement by all staff attending
- Increased education to staff reflected in:
  1. increased Codes reported
  2. increased diversity of codes called
  3. increased compliance using correct communication pathways
  4. improved reporting from individual wards
- Staff satisfaction surveys reflect increased staff confidence in managing a Code situation 2005, 2006.

Conclusion

Presently our goals from 2004 have been met, are sustainable, with no budgetary implications, as it has been internally driven. We are achieving our aim of improving patient outcomes and staff satisfaction by early recognition and intervention for our patients. HDHS is proud to have achieved 100% of Code Green calls not resulting in Code Blue call in the first 24hrs, recognised by a High Commendation from the Quality Baxter Awards in 2005.

In 2006, HDHS continues to challenge the boundaries of the Medical Emergency Team response to improve and provide quality outcomes for both patients and staff. Successful strategies reflected by positive outcomes has meant the journey from conception in 2000 to revision in 2004 and adaptation and implementation in 2005 – 06, has provided valuable lessons. Perhaps the most valuable lesson of all, is that to overcome perceived obstacles and resistance to change, leaders must empower their customers to attain ownership of the goals, so that everyone feels the tangibility of the outcomes. Success lies in the fact that this is not a one-person project, but an organisational wide initiative that has led to overall improvement of the quality of healthcare provided.

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Mercy Hospital Mount Lawley
“Developing an Inpatient Discharge Summary Policy”

I commenced employment at Mercy Hospital Mount Lawley (MHML) at the end of April 2005 as the Acting Health Information Manager, and was dismayed to find that there was no Inpatient Discharge Summary Policy. From enquiries regarding the lack of such policy, I gained the impression that private hospitals are dependent on doctors for their clinical activities and the business this brings, and therefore are reluctant to bring pressure to bear on these clinicians, fearing potential loss of business.

Despite the requirements and the usefulness of a discharge summary, hospitals throughout still struggle to gain compliance from doctors regarding this documentation. Common objections range from duplication of information already within the patient record, inappropriate or complex formats, to lack of time.

A completed discharge summary in the patient medical record enables access to information regarding the episode of care in a summary format. The detail in the summary allows care delivery to be tracked, monitored and evaluated by authorized internal and external health care providers at a glance. Clinical Coders rely on the discharge summary to enable accurate coding for statistical purposes and ultimately for correct Diagnosis Related Group (DRG) allocation for reimbursement by health funds.

For nearly a decade, MHML had indicated a desire for the introduction of inpatient discharge summaries, however it had been deemed impossible to achieve due to the reasons cited above. I decided that this was a significant problem and became determined to try to change this culture. There was a need to introduce awareness of the relevance, the requirements, and the financial and clinical advantages of discharge summaries to the clinicians at MHML.
Positive feedback and comments were received when presentation was made to the doctors at the MAC and during individual visits to many key doctors; During a visit to a key obstetrician to discuss the reformatted obstetric discharge summary, the Obstetrician suggested that this new format should be presented to the Maternity Services Committee; Feedback from this committee was unsupportive due to the carbon copy nature of the format with questions regarding the legality of the carbon copy signature. In - house lawyer’s opinion was sought to ensure meeting of legal requirements; With approval from the Director Medical Services on behalf of the MAC and the chair obstetrician of the Maternity Services Committee, the reformatted discharge summaries were introduced on February 1st, 2006.

Results of Initiatives:

One-month post implementation, an audit of 909 discharged medical records showed 97% completion rates. A number of issues including legibility, overwriting of the carbon discharge summaries, non-completed discharge summaries for antenatal patients, missing diagnoses and non-completion of complications of stay were identified. These issues were presented and discussed at the SQRM Committee, MAC, Nursing Governance Committee and Maternity Services Committee and also with specific doctors to increase awareness and decide actions to overcome issues. Audited records from April 2006 showed 100% attempted completion of discharge summaries within 14 days. Ongoing encouragement is given to the small number of clinicians who only partially completed the summary. Discharge Summary implementation, which included diagnoses and procedures, undoubtedly...
enhanced accuracy of coding and improved coders’ job satisfaction levels. The ability of the Medical Records Department to provide copies of discharge summaries to other health professionals sustained the improvement of patient care standards. We also continue to meet the recommendation of the ACHS post survey.

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In 2000 the shortage of midwives in WA was addressed in part, by moving post graduate midwifery students back into hospitals as employees. This recruitment and retention strategy meant that student midwives were provided with an income for the duration of their course and were able to develop a relationship with one hospital. St John of God Hospital Murdoch (SJGHM) recruited four of these students. A Clinical Support Midwife (CSM) was designated to co-ordinate their orientation and clinical practice in the hospital. The CSM is a clinical midwife with 15 years midwifery experience in tertiary and private hospitals. As a result of recruiting these students, and the increase in risk factors present in pregnant women, the current midwives felt they needed some education to meet the expectations of a changing workforce and to update on current midwifery evidence based practise. These midwives had an extensive amount of experience collectively but each individual felt they needed to increase their own knowledge and skills and be ‘up to date’.

The Identified Problem

In response to the concerns of the midwifery group, a clinical skills survey was undertaken to prioritise which areas required educational support. The survey was distributed to 62 midwives. The midwives indicated that there were three main areas that they required education in, these were:

- Neonatal Resuscitation;
- Obstetric Emergencies; and
- Electronic Fetal Monitoring (EFM).

The results of this survey were interesting in that at the same time the Douglas Inquiry, an investigation of the Obstetric Services at King Edward Memorial Hospital for Women (KEMH) released their report into investigations in obstetric practices at KEMH. The recommendations correlated with our own findings and recommended that every midwife in WA undergo annual education in neonatal emergencies, obstetric emergencies and EFM.

A Midwifery Education Plan was designed to address these three areas identified in the survey and outlined learning components and objectives, resources and associated costs. The Midwifery Education Plan received the support of the Hospital Executive. The plan was viewed as a priority initiative in the development of quality practices and outcomes in a Hospital with a delivery rate of 1440 babies a year.

Introduction

Although maternal mortality has reduced significantly over the last 30 years, in Australia, women still die in childbirth. Obstetric haemorrhage is the major cause of death at the time of birth of the newborn. Other deaths occur post birth as a result of pulmonary embolus, haemorrhage and septicaemia. In our Western society there is an increase in the childbearing age, people requiring fertility treatments, obesity, greater intervention in labouring women with epidurals and augmentation of labour, all of which increase the risk of emergencies occurring. There is an increasing caesarean section rate and associated abnormal placental implantation which in turn compounds the risk for obstetric emergency. Although the mortality rate is low 5.3 per 1000 live births it is the morbidity that is also of concern; for every one maternal death there are 50 other women who experience a life threatening complication with varying degrees of short and long term health effects. Risk management strategies in obstetrics and midwifery care require a team approach with simulation of the emergency to improve skills and behavioural performance as one key strategy. Midwives throughout their careers may only witness or be involved in obstetric emergencies once or twice, therefore practicing the ‘what to do’ is imperative to improve and maintain skills to successfully manage an obstetric emergency.
The Midwifery Education Plan for Management of Obstetric Emergencies

A Review of the Literature

A literature review of articles was undertaken from 1998 onwards using Ovid, Medline and the Cochrane Database relating to models of practice in delivering adult education in emergencies. In the past, this type of education has been by lecture format with the participant then applying theory to practice. However, real life situations are often complex and multifactorial requiring critical thinking analysis. A problem solving approach allows critical thinking and analytical skills to be developed, therefore a program that focuses on the way health care practitioners think and act in real life situations was designed. The literature indicates that the retention of skills and knowledge quickly deteriorates if not used regularly or updated, however, if the program involves critical thinking skills and promotes life long learning, knowledge and understanding is retained longer. This program was designed to ensure a 'hands on' approach, utilizing modern training manikins and real life scenarios.

The Study Day Program

Participant Preparation

Advertisements were placed in the ward area to announce the study day and objectives. On registration of their intent to attend, midwives were given a questionnaire to assess their current knowledge of risk factors and treatment of each emergency. Participants were asked to rate their knowledge, using a Likert scale of 1-5, ie little knowledge to extensive knowledge. They were also asked their perception of being able to apply skills to treat the emergency using the same scale of 1 – 5, ie few skills to expert skills. Participants then completed a pre-course test of 20 multiple choice questions to ascertain their current level of knowledge on each of the obstetric emergencies in the clinical program.

Obstetric emergencies addressed in this program included the following:

- Cord Prolapse;
- Antepartum Haemorrhage;
- Post partum Haemorrhage;
- Ruptured Uterus;
- Eclampsia; and
- Shoulder Dystocia.

These clinical situations and presentations are common emergencies in the antepartum, intrapartum and post partum periods. A literature review on each of these topics was undertaken using Ovid and Medline with the intent of compiling a resource of the current literature and evidence based practice from 1998 onwards for each emergency. The literature was summarised and written up as course notes for the participants to use to prepare for the study day and keep as a reference for ongoing learning.

Following the literature review several current articles on each topic were copied and distributed amongst the participants as pre reading 2 weeks prior to the course, 14 articles in all were expected to be read and were provided to each participant as background to the current body of knowledge for each emergency.

Study Day Objectives

Participants were provided with the learning objectives for the study day at the commencement of the first sessions. The learning objectives were:

- Midwives will have a greater understanding of the risk factors that may cause conditions leading to an obstetric emergency;
- Midwives will develop an action plan that is able to be used in the unit;
- Midwives will be able to respond to an emergency with a systematic plan based on best practice to implement emergency procedures;
- Harm to mother and baby will be minimised because of the effective management of the emergency.

The study day was based on the following adult learning principles. Adult learners want to learn; respond positively to an effective learning environment; learn by doing; want to have fun; and prefer variety in teaching styles and methods. Using these premises the group of participants were divided into learning groups of six. Each group was given an emergency topic and they were asked to devise an action plan based on a critical thinking model of ‘predict’, ‘prevent’, ‘manage’ and ‘promote’.

Participants were provided with relevant literature and course notes to assist in the completion of this learning task. Each group was required to present their plan to the class. Other groups were then able to contribute or question their suggested actions. The groups then swapped topics and were each given a scenario based on an obstetric emergency. The participants were required to role play the scenario using props such as the bed, mannequin, resuscitation equipment, monitoring...
equipment and intravenous equipment in ‘real time’. One participant kept time, while the others watched on. Participants were encouraged to ask questions or offer advice at the end of the role play. This contributed to the reflective practice analysis of the role play in a ‘blame free’ approach. Participants watching the role play contributed constructively by providing input from similar emergency situations that they had been involved in, or brought other information to the conversation that they had read. It is important to practice critique in a non-threatening, ‘blame free’ context, as this is what would be required if evaluating a real life emergency. Midwives must feel comfortable to receive constructive comments from peers and supervisors and in turn be able to confidently provide constructive feedback.

**Evaluation**

At the end of the study day, each participant was asked to share with the group what they had learnt from participating in the day. Many of the responses were that they learnt how better to manage an obstetric emergency; that role play was fun, not scary; and that their colleagues had valuable experiences that they enjoyed sharing. They also commented that midwifery can be ‘risky business’ and although these emergencies don’t happen often it is good to practise and have a plan in place for when they do. An evaluation form was also provided to participants. Comments were sought to a range of questions.

A qualitative analysis of these evaluations produced 4 distinct themes. These are now listed:

- An increase in confidence in acting appropriately in an emergency;
- Less fearful of the consequences of actions in an emergency;
- Recognition for a team approach to training for obstetric emergencies, including the need for medical staff to attend;
- A realisation of ‘what I didn’t know.

The content learned was evaluated by an assessment of the participants’ knowledge and skills with a post-course test using the same Likert score as in the pre-course test. The self perceived scores, showed an improvement in both the knowledge and skills for all participants. The multiple choice test showed a marked increase in the level of knowledge gained.

The post-course test was again completed after six months to measure the self-perceived retention of knowledge and skills and the actual knowledge. Test results after 6 months indicated that there was the same result or slight decrease in ‘skill confidence’ but the retention of knowledge had remained. In summary, the pre-course test revealed an average of 79% and an average post course score of 95%. At this six month period the average score was 83% (2005 results).

**The Following Year**

The study day was repeated 3 times in one year to enable all midwives to attend. The following year the scenarios were changed slightly, allowing for participants to use their critical thinking skills. It was clear that participants responded faster when required to obtain resuscitation equipment and were increasingly coordinated with their approach to managing the simulated emergency. Midwives were encouraged to attend these study days as often as they felt they needed, but attendance at one study day a year was mandatory.
The Way Forward

Since the introduction of this program at SJGHM, midwives from other hospitals have enquired about attending the study day. In order for the program to be successful in their hospital, a small group were encouraged to participate and then take the framework back to their hospital to set up a similar scenario based study day based on our model but specific to their environment.

Conclusion

Obstetric emergencies although not common place are a reality for health care practitioners. This program is aimed at increasing the knowledge, skill and confidence of one group of midwives employed in an acute maternity unit. As a risk management and quality initiative this program in the form of structured study days using real life scenarios is proving extremely effective in meeting the learning needs of midwives. The success of the program to date has meant that our midwives are more confident in both recognising and managing an obstetric emergency.

Further quality outcomes from this program include the development and implementation of action plans for obstetric emergencies. These are evidenced based, have been laminated and position in key areas of the maternity unit, including the birth suite. Furthermore, in the event of an emergency we are confident that there will be a more coordinated approach, with each person being a part of the systematic plan and the outcome for the mother and baby will be risk managed appropriately.

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The overall aim of the interventions was to prevent any further staff from developing musculoskeletal problems from wearing lead. The above risk controls reduced the staff injury rate to zero for 6 months in 2004–2005. However in March 2005 another staff member was injured due to wearing lead. Following this, Theatre staff, OH&S staff and Executive management reviewed the problem and in August 2005 developed a new initiative unique to Beleura Private Hospital, the Posture Perfect – Workplace Exercise Injury Prevention program for Theatre Staff which was to be run over six weeks.

All theatre nurses participated in a postural awareness campaign while six nurses who wore lead regularly completed a 6 week individual posture correction exercise program. The key program criteria goals were:

- Restore muscle balance;
- Restore muscle function and optimal range of motion;
- Improve cardiovascular fitness;
- Increase health and energy;
- Educate on movement strategies and the key aspects of injury prevention.

A Post program assessment was completed with the following results;

- Increased awareness of posture and movement strategies;
- Reduced self ratings of pain (40% no longer using medication post program);
- Improved functional activation of important postural muscles;
- Improved posture and function;

Many of the Beleura Theatre and Angiography suite staff who wear lead gowns (which forms part of their personal protective equipment when working with different types of X ray and radiation producing equipment) had reported severe shoulder and neck pain which increased exponentially with the amount of time they wear lead.

A number of staff have had workcover claims for musculoskeletal injuries related specifically to wearing lead. To date there are now a number of staff whose medical practitioners have certified them unable to wear lead at any stage whilst at work. This has impacted significantly on the remaining staff who have to cover the many Theatre lists where lead is required to be worn.

A number of strategies were employed to address the problem. Theatre staff worked closely with Executive management and OH&S staff on an individual and committee basis to investigate the problem and to determine ideas for improvement and controlling the risk. Initially a lead survey was undertaken to determine staff problems injuries, and identify who could/could not wear lead. Theatre and OH&S staff then contacted multiple hospital sites and companies who supply the personal protective equipment to determine best practice initiatives across the industry.

Over a 2 year period several risk control solutions were developed and run concurrently. Most of the solutions were initiated and developed by Beleura staff. Initially the solutions centred on changes to work practices. These included:

1. Rotation of staff through the areas, ie have more staff trained in the specialties where they are required to wear lead;
2. Surgeons contacted via memo in relation to injuries related to lead, that staff were to stop and have proper meal breaks and to stop for morning and afternoon tea;
3. Only do one list per day wearing lead;
4. Remove the lead in between cases;
5. Rest staff from those areas if problem persists;
6. Provide Massage Vouchers for some Cath Lab staff who wear lead frequently;
7. Adequate seating, specific stools for Cath Lab staff;
8. Specific exercises for lead wearing staff. Posters showing exercises were placed in the Cath Lab and theatre.

The overall aim of the interventions was to prevent any further staff from developing musculoskeletal problems from wearing lead. The above risk controls reduced the staff injury rate to zero for 6 months in 2004–2005.

However in March 2005 another staff member was injured due to wearing lead. Following this, Theatre staff, OH&S staff and Executive management reviewed the problem and in August 2005 developed a new initiative unique to Beleura Private Hospital, the Posture Perfect – Workplace Exercise Injury Prevention program for Theatre Staff which was to be run over six weeks.
3. Buy light weight lead and the 2 piece variety if preferred, but all lead garments to have the capacity of taking the weight off the shoulders, with a cummerbund that is part of the garment;

4. Purchase some lead garments that can be removed without un-scrubbing when the Image Intensifier is finished with. (The lead has cross-over shoulder straps that can be released by another staff member, hence minimising the time the lead is worn;

5. Teach staff the correct method of putting their lead on, to effectively take the weight off their shoulders. This is to be followed up with charts attached to the rack where the lead is stored.

The outcomes of the two latest initiatives have been;

1. No staff injuries or incidents related to the wearing of lead since March 2005;
2. No verbal or written complaints of pain by staff when wearing lead;
3. A further decrease in workcover costs and premium incurred as there have been no claims for theatre staff in 12 months;
4. Staff are more aware of their posture and continue to do their exercises as measured recently in a staff survey;
5. Staff continue to be available to wear lead when required;
6. An increase in staff morale as measured in a recent staff survey.

Overall the work completed by the staff involved in developing these initiatives and the commitment by staff to implement and follow through with the programs has been exemplary. The goal to reduce the staff injury rate has been sustained for 12 months and with the added improvements to the garments worn by staff it is strongly anticipated that this should continue.

For more information on this success story please contact:

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Exercises specifically chosen for the staff at Beleura Private Hospital are shown on page 4.

The Work Cover insurer was contacted in early 2006 to see if other hospitals were reporting similar problems in their Angiography suites or theatres. They put us in touch with staff at the Alfred Hospital in Prahan, who had formed a working party to address the same problem and to find the lightest lead available, while providing adequate protection against radiation according to the standards. The Alfred gave us the names of the suppliers of lead theatre garments which fit the above criteria.

In May 2006 the Hospital held a lead expo to demonstrate to all theatre staff the latest lead gown designs. The results of the expo have been:

1. The final determining of two preferred suppliers for the lead gowns and collars;
2. To have staff individually fitted for their own lead garments;

In conjunction with this initiative, it was decided to further research the type of personal protective equipment staff were wearing to determine if the risk of injury could be reduced by changing the garments.

To end May 2006, another 2 rounds of exercise and Pilates sessions have been completed for 16 staff in the evenings. The opportunity provided by the hospital has now reached 30 theatre staff and all those staff who wear lead have attended.

The results achieved by the participants reflect their commitment, compliance and enthusiasm for the program. The program was so well received that it was extended to more theatre staff. The program was modified due to the difficulty of releasing the staff to attend at the same time during working hours and the cost associated with the pre and post assessment documentation. The decision was to reach more staff, but to carry it out without the documentation pre and post exercise of each of the participant as a cost reduction strategy.

The final determining of two preferred suppliers for the lead gowns and collars;

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Beleura Private Hospital sought out an Exercise Physiologist with Post Graduate studies in Exercise for Rehabilitation at Victoria University to implement the program. Pictured is exercise physiologist Ashley Gardner who has done all of the assessment and exercise sessions for the staff of Beleura Private Hospital. He is demonstrating the specific exercises that the staff perform.