

# Victorian Travelling Fellowship Program

Creating innovation and improvement in patient care

2005-06 Report



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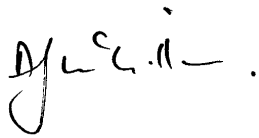
## Foreword

We are pleased to provide the third report of the Victorian Travelling Fellowship Program.

The Victorian Travelling Fellowship Program was established in 2003 to increase innovation and improvement in patient care in Victoria by encouraging international learning and information sharing among health professionals. The program is a joint initiative between The Victorian Quality Council and the Victorian Department of Human Services.

Recognised as 'leaders of change' in their workplace and champions for quality improvement and innovation, the successful fellows looked at international best-practice, improvements and innovative responses to issues and challenges in their own workplace. Their overseas learnings will advance and improve the patient's journey through the Victorian health sector.

This report is a summary of the lessons and experiences gained by the successful applicants in the third year of this program. For more information contact the Victorian Travelling Fellowship web site at: [www.health.vic.gov.au/travelfellowships](http://www.health.vic.gov.au/travelfellowships).



**Alison J McMillan**  
Director, Quality and Safety Branch  
Rural and Regional Health  
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**Christine Kilpatrick**  
Chair, Victorian Quality Council





Creating innovation and improvement in patient care

## Victorian Travelling Fellowship Program

# Introduction and background

The Victorian Government, along with other jurisdictions, has recognised and supported the need to continually improve the quality and safety of our health system and its capacity to meet the increasing expectations and demands of our society<sup>1,2</sup>. Clinicians, managers and health department officers are instrumental in leading and implementing change in our health system. Conferences, publications and peer contact are three of the major ways of accessing information about improvements and innovation in health care, both locally and internationally. The first two methods are readily accessible to the healthcare workforce, however, establishing peer networks and exchanging knowledge and experiences face-to-face with colleagues in the local and international arena are often less practical.

The Victorian Travelling Fellowship is a program for health professionals, clinicians and managers presently working within the Victorian public health system. It aims to build capacity in the sector to improve the quality and safety of the Victorian health system by encouraging international learning and information sharing — assisting and leading the implementation of improved patient care.

## Aims of the Victorian Travelling Fellowship Program

- To create a program that focuses on enhancing healthcare in Victoria so that it continues to meet and exceed community expectations.
- To improve the quality and safety of the Victorian health system by encouraging international learning and information sharing among clinicians and managers.
- To support the exchange of interventions, methodologies and learning with health professionals outside usual networks for greater understanding and professional development.
- To ensure the wide dissemination of lessons to benefit the Victorian healthcare system.
- To develop and maintain contacts with international agencies and individuals demonstrating leading edge practice in health systems and healthcare, for the purpose of improving public health care in Victoria and informing the development of the Victorian Travelling Fellowship Program.

<sup>1</sup> ACSQHC (2001). National Action Plan 2001. The Australian Council for Safety and Quality in Health Care

<sup>2</sup> Patient Management Task Force Paper No: 5 Improving Hospital Care for Older Victorians. May 2001

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## Approved study areas 2005-06

All successful applicants to the Victorian Travelling Fellowship Program must base their proposed project on one of the specified study areas provided by the program annually and incorporate an existing workplace need or situation. Fellows compare the Victorian health system response with those of leading international health providers through the investigation and exchange of interventions, methodologies and experiences.

The approved study areas are aligned with the strategic priorities of the Department of Human Services, the Victorian Quality Council and the Australian Council for Safety and Quality in Health Care.

The specified study areas for the 2005-06 fellowships were:

1. **Quality improvement:** ensuring the ongoing improvement of quality in healthcare through the implementation of innovative strategies, methodologies and practices.
2. **Workforce redesign:** the delivery of effective healthcare services in Victoria depends upon the sustainability of an appropriately skilled and available workforce. Vital for the continuous improvement of quality and safe patient care is the ongoing development of a workplace culture that values teamwork and individual competencies, workforce redesign seeks to address these challenges.
3. **System measurement:** improving healthcare practices by developing tools and techniques to aid in the evaluation of improvement programs and activities by the collection of meaningful, targeted data.
4. **Patient safety:** improving patient safety by minimising the risk of harm. To reduce harm in areas of known risk through the promotion of safe and appropriate care and by developing strategies that enable implementation of innovations in healthcare.

## Applications

There were 64 applications received for the 2005-06 round and independent experts assessed each application. Eight applications – seven individuals, and one team of two - were successful. Subsequently, one fellow (Margaret Fould) withdrew from the team application, with the remaining fellow, Fiona Whitecross, continuing with their project, and the department withdrew the offer of a fellowship to one applicant (Justin Walter).

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## 2005-06 Victorian Travelling Fellows



From left to right: Sandra Davis, Frances Wise, Felicity Lawrence, Susan Brumby, Fiona Whitecross, Melita Van de Vreede, Margaret Foulds, Angela Murray and Justin Walter.

### 2005-06 Victorian Travelling Fellows

The following section contains a summary report from each fellow. If you would like to contact a fellow or view more detailed information about the Victorian Travelling Fellowship Program or the fellow's reports, please visit the program's web site: [www.health.vic.gov.au/travelfellowships](http://www.health.vic.gov.au/travelfellowships) or contact the Victorian Travelling Fellowship Program Project Officer on (03) 9096 7742, or email [vtfp@dhs.vic.gov.au](mailto:vtfp@dhs.vic.gov.au).



## Susan Brumby

*Director, Community Services*

### Western District Health Service

## Travel summary

### Dates

19 May to 29 June 2006

### Places visited

- Agrisafe Network Incorporated, Washington DC, USA
- United States Department Agriculture, Washington DC, USA
- University of Kentucky, Kentucky, USA
- Montgomery County Health Department, Kentucky, USA
- College of Public Health, University of Iowa, Iowa, USA
- Great Plains Center for Agricultural and Occupational Health, Iowa, USA
- National Education Center for Agricultural Safety, Peosta, Iowa, USA
- National Farm Medicine Center, Marshfield, Wisconsin, USA
- Rural Cancer Research Center, Marshfield, Wisconsin, USA
- High Peak and Dales Primary Care Trust, West Derbyshire, UK
- Farm Out Citizens Advice Bureaus, Derbyshire, UK
- Farm Life Centre, Derbyshire, UK
- Independent Research Centres, Peak District, Wales
- Institute of Rural Health, Powys, Wales
- ADAS Pwllpeiran, Cwmystwyth, Wales
- University of Wales, Bangor, Wales
- International congress of Agricultural Medicine and Rural Health Conference, Lodi, Italy.
- Directorate General for Health and Consumer Affairs, Brussels, Belgium.

## Study area

Ms Susan Brumby investigated healthcare practises, strategies and tools that are used in successful farmer engagement projects in the United States of America, United Kingdom, Italy and Belgium. Ms Brumby was particularly interested in the triggers and opportunities for improving farming family health, minimising poor health outcomes, decreasing the risk of harm and how the international learnings could inform the Western District Health Service Sustainable Farm Family Project.

Ms Brumby undertook site visits to universities, research centres, health services or agencies specialising in agricultural health or innovative service delivery models. She also attended and presented at the plenary session of the 16<sup>th</sup> International Congress of Agricultural Medicine and Rural Health Conference in Lodi, Italy and participated in the Agricultural and Occupational Health Training Program at the University of Iowa, USA.

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## Study lessons

### Top three outcomes

1. Increased vision to drive improvements in agricultural and farmer health, wellbeing and safety across Victoria and clarity regarding agricultural health being a high priority area.
2. New knowledge and skills in agricultural health and the importance of this knowledge and skills in the Victorian healthcare system and economy.
3. The partnerships and collaboration across the countries visited to continue to build a further body of evidence for farmer health globally.

### Major learnings

- Farmers and farming families under-access services and have worse health outcomes across a myriad of conditions across the globe and require specific targeted strategies.
- Agricultural health issues are usually poorly recognised by health professionals (nurses, doctors, physicians, veterinary surgeons, physiotherapists) because they don't know what they are looking for.
- Agricultural health is different from:
  - farm health and safety
  - rural health.
- Respiratory exposures are poorly understood in farming families and Australia has undertaken little research work on bioaerosols, endotoxins and safe levels.
- The Agrisafe model, with modification, could suit the Victorian health system.
- Poor differentiation exists between farmer health and rural health and as a result specific data on farmer and farming family health is lacking globally.

### Lessons for the Victorian health system

- Establish a framework and Centre for Agricultural Health as a matter of urgency which would include:
  - Department of Human Services, Primary Industries, Victorian Communities, WorkSafe.
  - Development of an agricultural health program that is multidisciplinary and intersectoral and is recognised as an academic subject in public health and delivered to rural health professionals, veterinary surgeons and WorkSafe/ Farmsafe staff.
  - Expansion of Sustainable Farm Families (SFF) Program by training more rural nurses to deliver the program and inclusion of SFF in rural services health promotion plans.
  - Development of Agrisafe Clinics (USA) with accreditation system of properly qualified nurses.
  - Commencement of centralised data collection from the above to further inform practice.

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- Explore reduction in insurance premiums or WorkCover premiums if farmers have undertaken Sustainable Farm Families Program, satisfactory farm-place audit and an occupational history.
  - Consider the implementation of models such as the UK Farm Out model to provide access for farming populations in high-density areas as a point of first contact.



## Sandra Davis

*Deputy Director, Centre for Applied Gerontology, Bundoora Extended Care Centre*

**Northern Health**

### Travel summary

#### Dates

22 June to 19 August 2006

#### Places visited

- South West Peninsula Strategic Health Authority (Expert Patient Program), Plymouth, UK
- South East London Strategic Health Authority (Expert Patient Program, Greenwich Primary Care Trust, Lewisham Patient as Teacher Program, Patient Advise and Liaison Service, Guys & St Tomas Hospital NHS Trust, Connect), London, UK
- Royal Liverpool and Broadgreen University Hospitals Trust (Older Peoples Skills Team Project, Older People's Champion Network), Liverpool, UK
- University of Dundee, Aberdeen, Scotland
- Veteran's Affairs Canada Research Directorate, Montreal, Canada
- St Anne's Veteran's Hospital (Reconstituted Food Program), Montreal, Canada
- Univeritaire de Gériatrie de Montréal, Canada
- St Catharines (T. Roy Adams Regional Centre for Dementia Care), Ontario, Canada
- Green House Project, New York City, New York and Tupelo, Mississippi, USA
- NorthWest Senior and Disability Services (Senior Advisory Council, Senior Peer Mental Health Counselling Program), Salem (Portland), Oregon, USA

### Study area

Dr Sandra Davis investigated international practises and innovations that emphasised and facilitated consumer involvement and strong person-centred approaches across care settings in the United Kingdom, Canada and the United States of America.

Dr Davis reviewed the implementation and management of programs relating to the self-management of chronic disease, consumer involvement programs specific to enhancing person centred care across care settings, care of older persons in relation to service planning, dementia friendly physical and social environments in large hospitals, day respite centres and complex care settings and explored models of community participation involving statewide operational policy, service planning and development for older people.

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## Study lessons

### Top three outcomes

1. Identified key strategic actions beneficial in the Victorian context for improving community and consumer participation to enhance person centred care for older people in health services.
2. Documented successful change management approach to improving person centred care across care settings.
3. Discovered specialised food that provides a significant improvement in the eating experience and outcomes for people with dysphagia.

### Major learnings

- Successful consumer and community participation in health service settings requires significant organisational commitment and action to realise the benefits and break down system and ideological barriers.
- The implementation of person centred care in any health care setting requires a quality improvement framework that focuses on practical educational approaches that directly and clearly address identified issues and challenges.
- The sustainability of person centred care in any health care setting requires management commitment and strong leadership to foster the empowerment of direct care staff to address the needs of the older person and provide ongoing support and engagement within the quality improvement framework.
- The successful recruitment and retention of consumers in active participatory roles within health care settings is related to three key elements: a clearly defined role, role value and visible, positive outcomes.
- The physical environment is very important in creating the right environment for providing information and encouraging clients to provide their views about the care they receive in a health care setting.
- To maximise the benefits of research evidence, the translation of research to practice to improve the care of older people requires innovative thinking, risk-taking and a commitment of resources at all levels of the organisation.
- Overseas models of dementia friendly physical and social environments that are financially comparable to traditional residential care facilities have been inextricably linked to existing infrastructure that provides either clinical or administrative support.
- Person centred care can be seriously undermined in all health care settings by a lack of understanding about the role of food.

### Lessons for the Victorian health system

- Consumer participation in Victorian healthcare organisations is at a crucial stage where immediate benefits of a few key short term actions can set the foundation for moving forward in partnership.
- To increase consumer and community participation at the policy and planning level, the Victorian Government could involve older consumers through an advisory committee structure that links to health service community advisory committees.

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- Lay led programs in health care management can contribute to the Victorian healthcare system significantly and should be considered a fundamental component within all health service organisations, providing sustainable benefits to consumers and to the healthcare system.
  - Dieticians should hold management positions in kitchens responsible for feeding people in health care settings to ensure that food plays an appropriate role in the quality of care provided.
  - People experiencing dysphagia in Victoria could benefit significantly from reconstituted food that increases appetite and has better nutrition than traditional, pureed and minced diets available currently. Health care organisations are likely to find it cost effective given that the high cost of supplements is significantly reduced with this food as part of the treatment for dysphagia.
  - Person centred care in a dementia friendly environment can be facilitated in residential care settings without significant cost differentiations to more traditional care environments – State facilities could be pilot sites for the implementation of Department of Human Services resources currently under development, providing information on creating such environments.
  - Person centred care in any health care setting can be successfully implemented and sustained with a practical educational approach that provides training and ongoing support.



## Felicity Lawrence

*Manager, Victorian Dual Disability Service*

**St Vincent's Health**

### Travel summary

#### Dates

23 June to 14 July 2006

#### Places visited

- Fraser and WestCoast Mental Health Support Teams, Vancouver, Canada
- StageDoor, Vancouver, Canada
- Provincial Assessment Centre, Vancouver, Canada
- Centre for Addiction and Mental Health, Toronto, Canada
- Quality of Life Research Centre, University of Toronto, Canada
- Surrey Place, Toronto, Canada
- Griffin Centre, North York, Canada
- Department of Psychiatry, University of Toronto, Canada
- George Brown College, Toronto, Canada
- Department of Mental Health, Columbus, Ohio, USA
- Nisonger Centre, Ohio State University, Columbus, Ohio, USA
- Coordinating Centre of Excellence, Ohio, USA
- Cincinnati Mental Health Services, Cincinnati, Ohio, USA
- Montgomery County Mental Health Services, Ohio, USA
- SouthEast Inc Recovery and Mental Health Care Services, Columbus, Ohio, USA
- Department of Mental Health, New York City, USA
- LifeSpire, New York City, USA
- Earn and Learn, Staten Island, New York City, USA
- Prevocational and Supported Employment Programs, Staten Island, New York City, USA
- Specialist Program for Assessing Need, Queens, New York City, USA
- National Associate for Dual Disability, Kingston, New York, USA

### Study area

Ms Felicity Lawrence's project looked at quality improvement, workforce redesign and system measurement in relation to models of service and indicators of organisational effectiveness in the specialist field of dual disability.

Visiting services in Canada and the United States of America, Ms Lawrence met with key stakeholders in the field of multiple mental disorders – co-occurring intellectual disability with another mental disorder – to undertake a comparative analysis,

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across a number of performance indicators, of the efficacy of such services in comparison to the Victorian Dual Disability Service.

## Study lessons

### Top three outcomes

1. Relationships have been established with managerial and clinical staff working in specialist dual disability services in Canada and the USA.
2. My working knowledge and familiarisation with alternative models of service delivery and care has been enhanced and meaningful comparisons have been made to systems and processes employed in Victoria and by the Victorian Dual Disability Service (VDDS). Informed by these comparisons it is now possible to conceptualise the VDDS along a spectrum of 'care models' that have evolved since deinstitutionalisation.
3. A framework for ascertaining and operationalising organisational effectiveness within dual disability services has been developed. The framework enables comparisons to be made between the VDDS, Victoria's specialist mental health services and the services visited. It includes comparisons between models of care, strategies to improve workforce sustainability and processes to collect and report clinical outcomes and quality of life.

### Major learnings

- **Quality improvement/models of care**

There is an international trend toward establishing mental health services tailored to meet the mental health needs of people with an intellectual disability. These services are referred to as specialist dual disability services. Many of the services have been established to provide the same continuum of mental health care provided by the specialist mental health services in Victoria. The reported benefits of specialist dual disability services include improvements on a number of outcome measures including psychiatric symptoms, overall level of functioning, severity of mental health problem and behavioural disturbance. Cascading benefits for the service system are also reported and include, but are not limited to, reducing the length of time that consumers with an intellectual disability spend in acute inpatient facilities.
- **Workforce sustainability**

Specialist dual disability services are well positioned to make a significant contribution to enhancing and maintaining a sustainable workforce that is competent in meeting the needs of consumers with a dual disability. Partnerships between service providers, academic institutions and professional organisations smooth the progress of:

  - Dual disability courses that provide competency-based training at the certificate, diploma, graduate and postgraduate level, being developed and delivered by industry experts.
  - Creating opportunities for students to demonstrate their competence through student placements across the disciplines of medicine, nursing, psychology, physiotherapy, social work and occupational therapy.

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- Creating opportunities for industry experts to have joint clinical and academic positions.
  - Creating incentives for the workforce to attend training events dedicated to dual disability. Many professional bodies and registration boards make it mandatory that ongoing registration is conditional on professionals accruing a predetermined number of professional development points on an annual basis. Having the training activities delivered by accredited dual disability services improves the sustainability of the workforce two ways; staff are more likely to attend training if there is the opportunity to accrue mandatory professional development points as well as improving their competence to fulfil their duty of care in assessing and managing the mental health needs of consumers with a dual disability.
  - **Outcome measurement**

There are a range of formal and informal, tailored and generic instruments used to monitor clinical outcomes and the quality of life of for consumers with a dual disability. Expanding the range of indicators the VDDS uses to trial some of the measures used internationally would enable the VDDS to contribute to collaborative, multi-site research and evaluation activities. At the same time, it would be possible for the VDDS to contribute to establishing a 'critical mass' database, which is necessary to ensure the reliability and validity of any conclusions drawn from such endeavours.

### Lessons for the Victorian health system

- From an international perspective, Victoria remains characteristic of health care systems that manage the mental health needs of people with an intellectual disability in mainstreamed (generic) mental health services. There are indisputable advantages to this approach including lack of discrimination and stigma. It is important that such advantages are weighed up against the likelihood that care within the generic mental health service system may be sub-optimal because the parameters of care (purpose of admission and length of stay) are often inconsistent with the priority and focus of care provided to the non-disabled population.
- The insights gained from the fellowship will be useful should Victoria at some point include in its service continuum specialist dual disability services for people with a dual disability. Independent of such developments, the VDDS is now well positioned to develop partnerships and strategies that will improve the sustainability of a competent workforce as well as having the service positioned as a stakeholder in international research and evaluation activities.



## Angela Murray

*Research Assistant, Emergency and Trauma Centre, The Alfred Hospital*

**Bayside Health**

### Travel summary

#### Dates

31 March to 19 May 2006

#### Places visited

- Institute for Safe Medication Practice, Philadelphia, USA
- University of Maryland Medical System (R Adams Cowley Shock Trauma Center), Baltimore, USA
- MedSTAR, Washington Hospital Center, Northwest Washington, USA
- Duke University Health System (Duke Patient Safety Center), Durham, USA
- Veteran's Affairs National Center for Patient Safety, Ann Arbor, USA
- University of Michigan Health System, Ann Arbor, USA
- 8<sup>th</sup> Annual NPSF Patient Safety Congress, San Francisco, USA

### Study area

Ms Angela Murray's project explored patient safety systems in emergency healthcare, benchmarking and evaluating emergency department and trauma centre protocols in the United States of America. The objective of Ms Murray's project was to raise awareness of the key elements required to develop a patient safety program in emergency health care and the need for a systems approach to patient safety.

Ms Murray sought to identify innovative practise and leading edge research in patient safety systems and establish international networks to inform work being undertaken for the Trauma Reception and Resuscitation Project at The Alfred Hospital.

### Study lessons

#### Top three outcomes

1. Leadership in collaboration with all healthcare professionals is the key to the promotion and successful implementation of a culture of patient safety.
2. Dedicated infrastructure and ongoing financial and policy support are required to empower healthcare professionals at all levels to make ongoing changes to improve patient safety.

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3. Education to improve patient safety needs to be multidisciplinary and needs to begin at the undergraduate level.

### Major learnings

- The emergency department is a working environment that poses unique barriers to the development of a systems approach to safety.
- Barriers to implementing a culture of safety in the emergency department can be overcome.
- Developing a culture of safety is a complicated and lengthy process, which requires commitment and cooperation from all staff, beginning with the leadership of the hospital.
- Patient safety initiatives need to be aligned with ongoing performance management of staff members.
- Transparency and open disclosure is a challenge for healthcare professionals: this can be overcome with comprehensive training and a culture of safety in which healthcare workers support each other through this process.
- Patient safety systems are in varying stages of development in the USA, which is reflected by different levels of infrastructure and program development to support patient safety. A major challenge to the development of a successful patient safety system identified through this study was the difficulty of disseminating high-level safety initiatives to frontline staff.
- Initiatives that have been presented as solutions for medication errors, such as computerised physician order entry and bar code medication administration need to be implemented with caution. It has been reported that unforeseen complications from these systems can impair patient safety.

### Lessons for the Victorian health system

- Further research needs to be conducted to more clearly define causes of error in the emergency department. Once causes of errors have been identified systems and strategies can be developed to mitigate them.
- Patient safety principles and practices need to be included as a core part of the undergraduate curriculum for all healthcare workers.
- The development of multidisciplinary patient safety curriculum for healthcare workers is more likely to enhance communication and collaboration between disciplines.
- Funding and resources to implement Crew Resource Management training is required throughout the healthcare system. It has shown to be an effective tool to improve communication between healthcare disciplines and reduce errors caused by poor communication.
- A well-structured and coordinated approach to programs of patient safety would benefit the Victorian healthcare system. Frontline staff should be included in the identification and development of patient safety initiatives.
- Patient safety outcome measures need to be standardised to assess improvement across the healthcare system.



## Melita Van de Vreede

*Senior Pharmacist, The Alfred  
Hospital*

**Bayside Health**

### Travel summary

#### Dates

30 March to 5 May 2006

#### Places visited

- Kings College Hospital, South London, UK
- National Patient Safety Agency, London, UK
- Charing Cross Hospital, Hammersmith Trust, London, UK
- Craigavon Hospital Trust, Craigavon, Northern Ireland
- Brigham and Women's Hospital, Boston, USA
- Dana Farber Cancer Institute, Boston, USA
- University of Massachusetts Medical Center, Worcester, USA
- Massachusetts College of Pharmacy, Boston, USA
- Northeastern University, Boston, USA
- American Health-System Pharmacists Association, Bethesda Maryland, USA
- Institute of Safe Medication Practices, Huntingdon Valley, USA
- Abington Memorial Hospital, Philadelphia, USA
- St Josephs Medical Center, Reading, USA

### Study area

Ms Melita Van de Vreede's project studied ways to improve medication safety and reduce risk of harm in hospitals as well as exploring innovative ideas, techniques and initiatives that could further improve patient safety in the Victorian context.

Visiting some of the leading international organisations in medication safety and quality improvement in the United Kingdom and the United States of America, as well as a range of hospitals that have introduced some of these initiatives, Ms Van de Vreede sought a practical knowledge of the American medication use system in order to be able to understand which initiatives could be translated for use in Victoria.

### Study lessons

#### Top three outcomes

1. A culture of safety led from the top-down in organisations, which could be promoted by the Department Of Human Services. In USA the Joint Commission Accreditation of Health Care Organisations (JCAHO) patient safety goals are widely promoted and visible to staff, patients and visitors in all the hospitals.

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Medication safety could be promoted through the Department of Human Services via the Victorian Medicines Advisory Committee (VMAC) on a statewide basis similar to the model that I viewed in Northern Ireland, which would facilitate safer systems and standardisation across Victorian healthcare networks. This includes a statewide medication safety program managed by pharmacists at each network, which could be facilitated by the Department of Human Services.

2. New initiatives for the Victorian health system to improve medication safety in hospitals:
  - a) Specific initiatives that could be implemented in the short term. These include chemotherapy safety, pharmacist prescribing models, the introduction of oral dispensers to prevent 'wrong route' errors and executive safety walkarounds.
  - b) A practical knowledge of the American medication delivery system has enabled me to better understand which American initiatives could be used here. Initiatives that could be introduced, but would require a feasibility study and substantial funding, are computer prescription order entry (CPOE), patient and medication barcoding, linked dispensing and automated dispensing cabinets on wards and 'smart' technology infusion pumps.
3. International collaboration to facilitate improved labelling and packaging on medications to prevent errors. Work with the National Patient Safety Agency (NPSA) and the Institute for Safe Medication Practices (ISMP) who are leaders in this field and with whom we have common goals.

### Major learnings

- The UK prescribing, dispensing and administration of medications follows a similar model to that used in Australia and they are experiencing many of the same issues and at a similar stage in introducing systems to improve medication safety as we are in Australia.
- The UK has recently commenced a countrywide medication error reporting system, which has made it possible to analyse trends and develop strategies to address system problems across the country.
- Northern Ireland has introduced a territory wide, top down coordinated system for medication safety, managed across all hospital trusts by Medicines Governance Pharmacists (similar to Medication Safety and Quality Use of Medicines pharmacists). This has enabled standardisation of medication error reporting systems, the implementation of new strategies and a standard approach to all medication safety activities across Northern Ireland.
- The USA system has historically progressed from more discrete prescribing, dispensing and administration systems and has therefore developed differently. They are further advanced with respect to technology, for example CPOE and pharmacy dispensing and medication supply systems, but less advanced with respect to clinical services and discharge prescription dispensing and patient counselling.
- Another fundamental difference between the USA and Australia is the funding mechanisms for hospitals and the medical insurance system which has one been one of the drivers for the USA's unit dose medication system, (the patient can be charged electronically for each drug dose dispensed). In addition,

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- confidentiality relating to error reporting is affected by the different funding of hospitals and insurance schemes, which makes them less willing to share data.
- The Joint Commission for Accreditation of Healthcare Organisations (JCAHO) patient safety goals has led a top-down safety approach that was visible in all hospitals I visited and ensured the organisational compliance with the safety goals was the main driver for Medication and Patient Safety Officers.

### Lessons for the Victorian health system

- **Improving the safety culture across the state:**
  - A safety culture promoted across all organisations led by the Department of Human Services would progress safety in hospitals and give the public positive messages about safety in hospitals.
  - A top-down coordinated approach across all healthcare networks with a core group of medication safety pharmacists and patient safety officers working together – as in the Northern Ireland model. This would enable standardisation and prevent errors, including extension to primary care through general practitioners and community pharmacist safety standards mandated by a government or an affiliated organisation (for example, JCAHO safety goals) as an effective way of giving organisations the capability to raise their standards and improve safety.
- **Lessons from the USA medication system:**
  - A thorough understanding of the USA medication management system is necessary to be able to determine whether system improvements, for example, barcoding and automated dispensing machines available in the USA, can be translated for use in our healthcare system.
  - It is not necessary to wait until all elements of technology are ready to commence an electronic prescribing system. The USA commenced with separate sections, such as CPOE first, then linked them together. If we wait for the whole system to be planned, we may never start. Australia should work towards implementing one section at a time.
  - Systems of unit dosing and linkage to pharmacy dispensing systems in the USA could be a way to reduce medication administration system errors in Australia.
  - Medication error reduction for administration needs to consider the capital outlay for electronic communication between prescribing, dispensing and administration. Capital outlay to do this will be major and needs to be built into future budget calculations.
  - CPOE and barcoding also reduce errors but are very expensive to implement.
  - Labelling and packaging of medications needs a global approach, by working together with NPSA in the UK and ISMP in the USA this could be progressed.



## Fiona Whitecross

*Nurse Manager, The Alfred  
Hospital Psychiatry*

**Bayside Health**

### Travel summary

#### Dates

18 March to 26 April 2006

#### Places visited

- National Association of State Mental Health Program Directors Technical Assistance Center, Boston, Massachusetts, USA
- Cambridge Health Alliance, Cambridge, Massachusetts, USA
- Faulkner Hospital Centre, Boston, Massachusetts, USA
- Cooley Dickinson Hospital, Northampton, Massachusetts, USA
- Goodmeys Hospital, Pathways PICU, Essex, UK
- St Georges Hospital, Newcastle, UK
- Wotton Lawn Hospital, Grey Friars PICU, Gloucestershire, UK
- The Tarn PICU, Oxleas Mental Health Trust, Dartford, UK
- Northumberland, Tyne and Wear NHS Trust, Newcastle, UK
- Amersham Hospital, Buckinghamshire Mental Health Trust, Buckinghamshire, UK
- Ladywell Unit, South London, UK
- The Maudsley Hospital, Lewisham, South London, UK
- Huntercombe Hospital, Roehampton, UK

### Study area

Ms Fiona Whitecross' fellowship project investigated best practice models of psychiatric intensive care from the perspective of systems improvement. Ms Whitecross was particularly interested in seclusion reduction techniques and initiatives, and also with 'least restraint' models of care.

Visiting psychiatric services in the United Kingdom and the United States of America that specialise in psychiatric intensive care and have demonstrated achievements in caring for people with acute psychiatric illness in the least restrictive way, Ms Whitecross also undertook a training module titled 'Creating violence free and coercion free mental health treatment environments for the reduction of seclusion and restraint' with the National Association of State Mental Health Program Directors in Boston.

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## Study lessons

### Top three outcomes

1. The inspirational efforts and achievements of mental health programs in the USA and UK in the area of seclusion and restraint reduction in acute psychiatric care settings has shown that better outcomes can be achieved in Victoria.
2. That opportunity exists to learn from other programs' success and barriers in seclusion reduction. The learnings from these initiatives have identified six-core strategies fundamental in achieving least restrictive treatment environments for patients with severe mental illness.
3. Development of an appreciation for strategies/prevention tools that assist the workforce in creating alternatives to restrictive interventions and observation of these approaches being translated/operationalised into the treatment environment.

### Major learnings

- That it is possible to transform restrictive, coercive and rules orientated mental health treatment environments without significant additional resources.
- Reducing seclusion within an acute mental health treatment setting is possible.
- Successful seclusion reduction initiatives have in common six key success factors:
  - leadership towards organisational change
  - using data to inform practice
  - workforce development
  - use of seclusion reduction tool
  - involving consumers in inpatient units
  - debriefing techniques.
- Use of sensory modulation approaches in acute psychiatric settings is a useful intervention in the acute care context as one part of a seclusion reduction strategy.
- More emphasis should be placed on prevention of violence and aggression in order to reduce it.
- A public health prevention model is a useful framework to consider seclusion reduction initiatives.

### Lessons for the Victorian health system

- The Victorian Travelling Fellowship is a very worthwhile activity on a variety of levels. It allows people to see first hand clinical innovation in practice. Things might not always be as they seem in an article or circumstances change rapidly from the time of writing the article and publication; what people perceive as being a key success factor in services might not necessarily be captured in an article; or perhaps the articles are not yet written. The fellowship gives the opportunity to consider service context, external factors such as policy, law, funding, workforce and other variables that may influence a program's success or otherwise.

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- The recent identification of seclusion reduction in the Commonwealth National Safety priorities in *Mental Health: A plan for reducing harm, 2005*, underlines an increasing need for mental health services to 'reduce use of seclusion and restraint wherever possible'. If system change is at the core of a project, it is important to start small, set realistic goals, have frequent review of the data, strong leadership, and allow at least three years to see meaningful results.
  - The North American seclusion reduction experiences and six key success factors could be used as a framework for change for services in Victoria.
  - The Victorian healthcare system would benefit from the development of statewide standards and policy for the management and prevention of aggression in inpatient psychiatric settings. The National Institute for Clinical Excellence (NICE) Guidelines on the short-term management of disturbed/violent behaviour developed in the UK could be used as a reference.
  - The development of comprehensive data systems could collect quality seclusion and restraint data from mental health services across Victoria.
  - Further research activity into seclusion practices across Victoria is desperately needed to better understand its use.
  - That the public health prevention model is a useful framework to consider seclusion reduction initiatives.
  - Patients who have experienced seclusion and restraint are an influential force and have important testimonies regarding their experiences of these interventions. Their stories need to inform the treatment system, guide policy, and be part of training to staff in aggression management.



## Frances Wise

*Senior Rehabilitation Physician,  
Caulfield General Medical  
Centre*

**Bayside Health**

### Travel summary

#### Dates

18 September 2006 to 12 October 2006

#### Places visited

- Duke University and Duke University Medical Center, Durham, USA
- University of Vermont and Fletcher Allen Health Care Center, Burlington, Vermont, USA
- Boston Medical Center, Boston, USA
- Charing Cross Hospital and the National Heart and Lung Institute, London, UK
- International Centre for Circulatory Health, London, UK
- St Mary's Hospital Campus, London, UK
- East Riding and Hull Cardiac Rehabilitation Service, East Yorkshire Primary Care Trust, York, UK
- University of York, York, UK
- University Department of Human Nutrition, Glasgow Royal Infirmary, Glasgow, UK
- Royal Alexandra Hospital, Paisley, UK
- Astley Ainslie Hospital, Edinburgh, UK

### Study area

Dr Frances Wise's project involved the study of innovative models of cardiac rehabilitation to reduce a major and preventable cardiac risk factor – obesity – and involved quality improvement and workforce redesign investigation.

Dr Wise's study was conducted in the United States of America and the United Kingdom in facilities that have reported success with a variety of interventions, including behavioural and dietary interventions, internet case management and home-based therapies.

### Study lessons

#### Top three outcomes

1. A better understanding of new and appropriate methods that we aim to introduce in our own Caulfield General Medical Centre Cardiac Rehabilitation Unit, using existing resources, to reduce and prevent obesity in our cardiac patients.

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2. Obtaining materials that will be invaluable in the cardiac rehabilitation setting for weight loss, for example, patient education literature, copies of the Heart Manual, angina plan, and relevant questionnaires, for example, the 'rate your plate'.
  3. Establishing links with facilities abroad, particularly in the UK, which may lead to valuable collaborative study in the area of cardiac rehabilitation and obesity.

### Major learnings

- High calorie exercise is a successful strategy for weight loss in cardiac patients.
- Cognitive Behavioural Therapy (CBT) techniques are effective in helping patients lose weight and adopt healthier diet and exercise habits, and can be successfully conducted in group settings within cardiac rehabilitation programmes. Often this is in the setting of cardiac rehabilitation programmes run over three to four months, however, which is significantly longer than the six weeks run at Caulfield General Medical Centre (CGMC).
- Long-term support is advised to maximise the chances that patients will maintain gains.
- Weight loss strategies can be offered to cardiac patients and the wider population via innovative community-based programmes including:
  - mobile programmes allowing patients to access affordable, high-quality food
  - groups offering cookery lessons, healthy lunches, and physical activity
  - health coaching.

### Lessons for the Victorian health system

The programmes and interventions observed during this study are eminently suitable for the Victorian healthcare system. Some strategies could be introduced to many cardiac rehabilitation units without increased resources, for example weekly weighing of patients; however, others would require longer programme duration, increased staffing and/or training, for example:

- weekly dietician review and use of patient self-monitoring sheets
- high calorie exercise
- cooking demonstrations
- cognitive-behavioural weight loss strategies in a group setting
- clear protocols for screening, recruitment and follow-up of patients
- the use of the internet for weight loss in cardiac patients
- longer post-discharge follow-up to evaluate maintenance of gains.

The main outcome of this study was obtaining new and appropriate methods that reduce and prevent obesity in our cardiac patients, most of whom are at risk of increased morbidity and mortality due to obesity-related illness. Ultimately, we hope to better inform clinical practice in Victoria in the areas of primary and secondary cardiac prevention and health promotion, improve Victorians' quality of life, and alleviate the strain on our health system by reducing avoidable illness.

