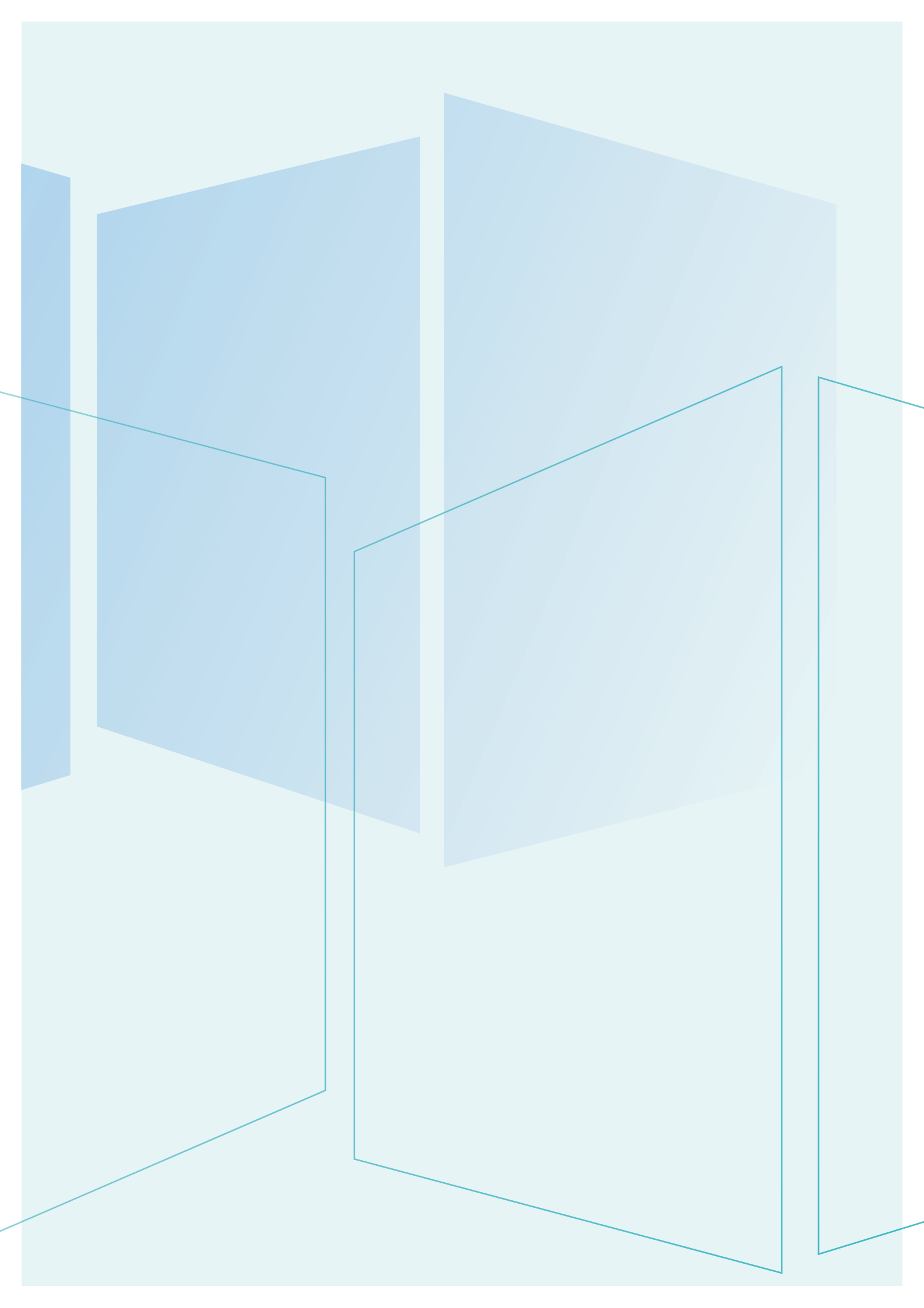




Innovations in
Models of care for the
Health Practitioner Workforce
in Queensland Health



Contents

	Acknowledgements	2
1	Overview	3
2	Project Supports	5
3	Learnings	7
4	Checklist for a successful project	9
5	Project Summaries	11
	Capricornia Allied Health Partnership (CAHP) – Student-assisted chronic disease clinic	12
	Allied Health Coordinated Respiratory Outpatient Support Service (ACROSS)	13
	Allied Health Supportive Care Initiative (palliative care)	14
	Use of an Allied Health Assistant to improve Allied Health Service Provision in a Rural Area	15
	Designing and implementing an innovative Model of care in Mental Health	16
	New Oral Health Service for Adults with Diabetes Mellitus	17
	eHAB (Telerehabilitation) Project	18
	Developing Partnerships to improve the patient journey from isolated sites	19
	Orthopaedic Podiatry Triage Clinic (OPodTC)	20
	Redesigned Paediatric Outpatient Service Delivery	21
	New Models of Pharmacy Practice: Pharmacy	22
	Radiographer Abnormality Description (RAD) Project	23
	Pathology Queensland and Queensland Health Forensic and Scientific Services (QHFSS)	24
	Neurological Screening Clinic for Spinal Pain	25
	Advanced Allied Health Practitioner Trial – Emergency and Aged Care	26
	Advanced Allied Health Practitioner – Aged Care	27
	Allied Health Assistant Project – Metro North HSD	28
	Social Work Assistant (SWA) Trial Project	29
	Medical Imaging Assistant Project	30
	Allied Health Assistant project - Princess Alexandra Hospital	31
	Rural Assistant Project	32
	Advanced Allied Health Assistant in management of diabetes and renal disease	33

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- the members of the multiple project steering committees around the state for their participation and hard work.

1

Overview

1

Overview

Real efficiencies in outcomes for clients can be achieved through workforce reform that maximises partnerships, uses existing workforce skills, develops desirable and attainable advanced skills and uses appropriate delegation of tasks. In tandem, satisfaction in work roles can be increased for health practitioners when they are able to employ the full scope of their practice.

The health practitioner workforce faces a number of challenges to delivering effective, efficient and responsive services to Queenslanders. These challenges include: high and escalating demand for services; limited published evidence about effective workforce utilisation and ongoing system and process changes in Queensland Health.

The health practitioner Models of Care (MOC) projects sought to promote sustainable allied health services to satisfy future service demands as well as:

- optimising client outcomes through delivering high quality, safe and best practice services
- improving service productivity and patient flow
- managing increasing demands within finite resources
- developing and retaining a sustainable, highly skilled workforce
- minimising duplication of tasks/roles.

Queensland Health's Allied Health Workforce Advice and Coordination Unit (AHWACU) provided oversight to the implementation of a number of workforce redesign and reform innovation projects. The projects were provided with support to trial models of care that:

- used full allied health scope of professional practice
- advanced or extended scope of practice
- better utilised support staff (assistant staff)
- partnered with internal and/or external services
- used multidisciplinary approaches, and integrated health services across the continuum.

Two significant projects with shared methodologies ran concurrently. The Models of Care Project commenced in January 2009 and concluded in June 2011. The Allied Health Assistant Project commenced in 2008 and concluded in December 2010. Both are covered in this integrated report.

The projects were authorised in the Health Practitioners (Queensland Health) Certified Agreement (No1) 2007 and Queensland Public Health Sector Certified Agreement (No7) 2008. Funding for the projects came from a combination of sources including funding allocated to implement the industrial agreement, district resources, AHWACU and AHCETU.

This publication summarises the aims, governance, process, project outcomes and critical success factors from these significant workforce reform initiatives. Specifically, this report documents the outcomes from individual projects and from the process as a whole to inform ongoing reform work in health practitioner fields of practice in Queensland Health.

A "top-down" approach to identifying suitable projects was used so as to respond to the strategic direction for Queensland Health service needs. High population growth areas and new capital works build sites were targeted due to both the expected increase in demand and because of the opportunities these sites offered through growth funding and a fresh start in new facilities. Other priority areas were mental health, elective surgery, emergency and ambulatory care, chronic disease and rural and remote services. Additionally some health service districts had been considering changes in models of service in response to particular local needs and these projects originated from a 'bottom-up' approach. The eventual cohort of projects sponsored and supported were variable in scope and timeline.

2



Project supports

2 | Project supports

Each project was integrated at the health service district level and was supported throughout the process by a number of key strategies:

1. funding – to enable scoping, consultation and change management for the project
2. sponsorship – each project had a district or corporate office sponsor and was overseen by a steering committee of relevant stakeholders
3. dedicated project officer time – allocated to each project
4. education and training specific to projects – to ensure staff confidence and skill in change management, leadership and/or clinical skills required
5. evaluation framework – developed specifically to measure outcomes of the projects
6. engagement with industrial partners – AHA projects reported regularly to a steering committee and to the Public Hospitals Oversight Committee (PHOC). MOC projects were regularly updated at the Health Practitioner Interest Based Bargaining Group (HPIBB).

Criteria for selection of proposals to participate as part of the MOC project were:

1. evidence of strong leadership and sponsorship for the project locally
2. innovation in design of service delivery
3. alignment with Queensland Health strategic direction and service priorities
4. evidence of patient focus, improved patient care or enhanced patient outcomes and consumer engagement
5. multidisciplinary approach
6. partnership with other stakeholders including registered training organisations, universities, non-government organisations and general practitioners
7. strong project design, realistic budget and resource utilisation
8. evaluation plan to adequately measure outcomes
9. transferability of model, or major components of model, to other centres
10. commitment to training and education of staff to support clinical skill development, process redesign and supervision
11. sustainability of model
12. commitment to share new knowledge and project learnings.

3 | Learnings

3

Learnings

The overall learnings from the MOC projects are outlined below.

Engagement:

- Staff selection and training in change management is critical to success.
- Ongoing workforce education is required to address the skills and attitudes for change.
- Following full change management and consultation process is more important and effective than adhering to timelines to achieve successful outcomes.
- The service or facility has to be ready for change, especially if it requires a change in practice and in process – a ‘readiness for change survey’ may be beneficial.
- A steering committee has to be committed to assist in making the change happen. Select the members carefully and purposely, but inclusive of the spokespeople for the most critical objectives.
- To ensure ongoing success changes must include strategies to enable sustainability.
- Professional boundaries are difficult to cross.
- Delegating tasks and conceptualising new roles are difficult in practice.

Organisation:

- Commitment and support from a dedicated sponsor, and in some cases a medical champion, is fundamental for effective change.
- Where a change involves new technology, regular use of the device promotes retention of knowledge, reduces fear and increases confidence in use.
- In rural and remote settings the fluctuations in staffing levels have a direct effect on workload and the amount of time clinicians have available to spend on professional development activities.
- Many health professionals and managers, regardless of classification and experience, have an aversion to risk and accountability. Plan for this.
- Training needs to be conducted on a regular basis for staff to refresh their knowledge and to account for staff turnover and recruitment.

Project management:

- Scope the project accurately. Do less and get better results. Concentrate on smaller sections to achieve slow but deliberate change. Set objectives with local staff.
- Consultation with site staff to ensure staff feel they have been heard greatly increases staff participation and motivation and instils a sense of project ownership.
- The aims and objectives of the project, along with the specific outcomes, need to be made clear to staff. Understanding and participation should be monitored throughout the duration of the project and not just at commencement.
- Time constraints can have unexpected influence on projects. There needs to be realistic rather than hopeful timeframes included in the initial project plan. Allow time to plan for training and education.
- A feedback process to committed supporters of the project, including referrers, should be integral to the project.
- For assistant roles in particular, time and resources for “on the job” training should be factored in to the project plan.
- Recruitment can be slow, especially in non-metropolitan sites, and this can impact significantly on project outcomes.

Evaluation

- Rigorous evaluation methods are required to ensure valid outcomes and to enable the findings to be used by others.
- Allocate time to plan your evaluation framework, including identification of data that will provide meaningful information about your project. Collect only this information but do it from the start.
- The need for an ethics review and clearance should be determined and acted on early to allow research outcomes.

4

Checklist for a Successful Project

4

Checklist for a Successful Project

- **Innovation**
 - The model of care should be truly innovative. It should not simply replicate a service delivery model in operation elsewhere.
- **Patient/Client focus**
 - Outcomes should focus on improved patient care, enhanced patient outcomes and consumer engagement.
- **Leadership**
 - Strong leadership is critical for success. Leadership includes executive sponsorship, skilled project management and change champions.
- **Local Support**
 - There needs to be widespread local support for a project, particularly within the immediate team. Local medical, nursing and allied health champions should be identified.
 - A multidisciplinary team approach needs to be taken for project/model development.
- **Governance**
 - Accountabilities and responsibilities must be clearly defined with appropriate supervision in place.
- **Research**
 - Research and the collection of data (including ethics approval) should commence at the outset of the project. Research support should also be identified.
 - A commitment must be made to share new knowledge and project learnings.
- **Sustainability**
 - The service must be sustainable at the end of the formal project period. Funding of the model should therefore include a local team resource contribution ensuring commitment to the model and embedding of it into the core business of the service.
 - The project should take into consideration the transferability of the model to other centres and how this can be facilitated.
- **Strategic alignment**
 - The model of care should align with Queensland Health and national strategic directions and service priorities.
- **Project Management**
 - The project should have a realistic budget and identify how to achieve outcomes within the project period.
 - The project manager should either have project experience or have ready access to a skilled mentor in project management.
- **Change Management**
 - Take time to engage the team and include them in all steps of the process.

5

Project Summaries

Capricornia Allied Health Partnership (CAHP) – Student-assisted chronic disease clinic

Central Queensland Health Service District (CQHSD) – Rockhampton

How the Need Was Identified

CAHP was formed to address challenges in health service provision in the region. CAHP identified many issues and those specifically targeted were the high numbers of patients with chronic diseases who were not being treated; the difficulty with health employment shown by the high number of vacancies in both allied health and medical cohorts; and the low numbers of students from health disciplines who attended clinical placements in Rockhampton.

CAHP determined that a stronger partnership between general practice and other public and private health providers to support a student assisted clinic for patients with chronic diseases was feasible and likely to have beneficial effects on these issues.

How the Service was Developed

At the beginning of 2010 the clinic was established, following lengthy and meticulous planning by a Project Manager and committee. The clinic consists of pre-entry allied health students that work in an inter-professional clinical environment. The students deliver individual and group-based outpatient services under the supervision of experienced clinical staff of relevant disciplines.

A full review and evaluation of the CAHP Project is underway and will be reported publicly. Additionally a 'How-To Guide and Toolkit' is under construction and will be available online for interested persons and service areas.

Outcomes

Some of the outcomes of the clinic are presented here in brief form. Perusal of the full report is recommended to understand the clinic and its achievements in total.

- Provision on average of 46.5 clinical contact hours with clients per week per full time equivalent clinical supervisor position was provided.
- Over 12 months there were 73 completed student placements from two to ten weeks in length, from eight universities across three states. 52% were from regional universities. 77% were final (fourth) year students.
- Students have been from dietetics, exercise physiology, occupational therapy, podiatry, pharmacy, and social work.
- In 2010 a total of 1004 referrals were accepted. 73.5% were from general practitioners, 13.4% from cardiac rehabilitation team, 8.6% from Rockhampton Hospital and 4.5% others.
- Patients have significantly reduced wait times to receive a service.
- Students experience an inter-professional clinic with high levels of responsibility for service provision and 97.5% would recommend it to other students.
- Students report feeling confident in teamwork and 63% improved communication skills at the end of placement. 78% reported improved discipline specific knowledge and 70% improved inter-professional knowledge.

Contact

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Allied Health Coordinated Respiratory Outpatient Support Service (ACROSS)

Mater Children's Hospital & Royal Children's Hospital

How the need was identified

A key driver of the design and implementation of the ACROSS project was the objective to improve health outcomes for children with a chronic respiratory condition. It was hoped to also reduce the number of hospital admissions, particularly those that were unplanned. It was hypothesised that the number of unplanned hospital admissions may be reduced by delivering a more proactive and coordinated model of care within the ambulatory care setting, thereby demonstrating clear cost benefits for the organisation.

How the service was developed

The target group for the project was children and young people (aged 0–16 years) with chronic, complex respiratory conditions who have frequent tertiary paediatric hospital admissions each year and the families of these clients. The model of care was therefore aimed at a small cohort of children at a high risk of multiple hospital admissions where potentially significant cost efficiency improvements could be achieved. The model of care included core allied health disciplines of nutrition and dietetics, occupational therapy, physiotherapy, pharmacy and social work. The demonstration phase of ACROSS project ran for six months between January and June 2010. There were three distinct phases including an initial multi-disciplinary review phase, a coordinated assessment and planning phase and a final phase of targeted interventions.

Outcomes

Increases in allied health activity in the ambulatory care setting including the provision of joint treatment sessions and coordinated assessment and treatment plans did not achieve a model of care required by patients and did not provide increased satisfaction levels or improved health outcomes.

The project did, however, provide evidence to support a coordinated model of care for children with a chronic health condition and outlines valuable lessons that can be used to inform future project selection and design.

- Future project selection should be precipitated by a period of well structured patient consultation and the identification of a 'patient centred' problem.
- The redesign initiative must aim to specifically address an issue identified by service users and the multi-disciplinary clinical team.
- Project objectives must be supported by key strategic objectives of the organisation.
- The necessary and valuable periods of multi-disciplinary consultation must not be truncated to meet project timelines and deadlines.
- The steering committee should be established early in the project life-cycle and be afforded full decision making responsibilities.

Contact

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Allied Health Supportive Care Initiative (palliative care)

Gold Coast Health Service District (GCHSD)

How the need was identified

A need to improve Allied Health support for Advance Care Planning processes for patients approaching end of life was identified. In particular the palliative care service showed a high number of clients with cancer (83%) compared to other life limiting conditions. A comprehensive chart audit of 50 deceased patients with chronic disease showed very low levels of documented discussions about advance care planning or referral to palliative care for these clients.

How the service was developed

A Steering Committee was established with relevant membership and project governance identified for sustainability within the District. A Literature Review was conducted which showed a shared model of care between different internal and external services to be most effective.

Service Mapping found that the patients' General Practitioner (GP) and non-Queensland Health service provider were the common links between Palliative Care and Chronic Disease services. GPs were essential to case management and thus included in the pathway for patients with chronic disease.

Education and awareness-raising about the allied health professionals role in Advance Care Planning for people with life limiting illness was conducted through inservice presentations to most allied health teams.

Outcomes

- The Multidisciplinary Team for this service included physiotherapy, occupational therapy, social work, pharmacy, dietetic and allied health assistant roles. The service was run part-time with 59 patients registered by the service over the project life.
- There was an increase in the number of patients with a non-cancer diagnosis from 17% to 37% referred to Palliative Care services over the project life. Patients had renal, cardiac, respiratory and neurodegenerative conditions.
- Review of the Palliative Care Phase score indicated patients were being referred earlier in their illness trajectory. There was a significant increase in the number of patients who were offered discussion about Enduring Power of Attorney and Advance Health Directive.
- Key learnings about managing a part-time service, and the challenging nature of working with end of life discussions were found.

Contact

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Gold Coast Health Service District.
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Use of an Allied Health Assistant to improve Allied Health Service Provision in a Rural Area

Central Queensland Health Service District – Central Highlands Health Hub (Emerald)

How the need was identified

Allied health staff in the Central Highlands Health Hub were feeling overwhelmed by increasing workloads and staff turnover. The primary intention of this project was for a rural Allied Health team to trial a Model of Care that utilised an Allied Health Assistant (AHA) across the professional group to improve current service provision.

How the service was developed

Development of a multidisciplinary allied health screening tool for inpatients which could be implemented by an AHA, or by a nurse, and serve as a referral. This would then enable more timely service through improved management of the triage process.

In addition, a more streamlined, time efficient and reliable method for consumable stock ordering was needed to free up allied health professional (AHP) time for service delivery.

Outcomes

- Implementation of a generic allied health screening tool.
- Increased number of new and appropriate referrals per month.
- Creation of streamlined stock ordering process.
- 46% decrease in average waiting times for consumers to access allied health service.
- 69% increase in number of consumers accessing allied health services.
- 40% increase in hospital generated referrals.
- 90% decrease in time spent managing stores by allied health professionals.
- Improved awareness of allied health services by medical and nursing staff within the Central Highlands health care facilities.
- Staff retention, staff experience and project management experience impacted the implementation of this project.

Contact

Central Highlands Allied Health Team
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Designing and implementing an innovative Model of care in Mental Health

Central Queensland Health Service District

How the need was identified

A Consumer Survey demonstrated mental health clients had a positive service experience overall however only 22% of respondents received therapy from their case manager. In addition, an Employee Satisfaction Questionnaire showed low levels of job satisfaction for allied health professionals and a desire to perform more discipline specific interventions.

Consumer flow had been mapped using Lean Thinking methodology to identify occasions of service per activity type; length of stay; and referrals to Brief Intervention.

How the service was developed

Consultation and planning with involved clinicians and managers was used to develop a service delivery model based on a Recovery framework. Education was provided to mental health clinicians in Queensland Health and in Non-Government Organisations to enhance skill base and to support an increase in provision of short-term and medium-term therapy interventions to consumers.

A Recovery Consultant was employed to train and advise the service teams and clinicians on the implementation of a Recovery approach to client care. An holistic approach was established in the Case Management Team by refining the case review process to include individual and group therapies in case management and establish a referral pathway for Brief Intervention.

Outcomes

- Establishment of Brief Intervention Roles within two teams in Central Queensland Mental Health Service (CQMHS).
- Establishment of Recovery oriented approach to mental health case management.
- Redesign and review of the Case Review process.
- Skill audit and sourcing of training to enhance clinical skills, enabling clinicians to provide discipline specific therapy within mental health case management.
- Future planning for service delivery changes in alignment with the Mental Health Reform project.
- Change management skill development for managers and senior clinicians within the CQMHS.

Contact

Director, Central Queensland Mental Health Service. Ph (07) 4920 6100

New Oral Health Service for Adults with Diabetes Mellitus

Metro North Health Service District

How the need was identified

The oral-systemic interface and the impact oral diseases have on general health are not well understood by many health professionals. Increased demand on the limited physical and human resources available and growing concern regarding best management of public sector oral health patients made the need for new models of oral health care imperative.

Diabetes Mellitus is prevalent in 7.5% of the population 25 years and older, and in Queensland contributes to a significant proportion of morbidity. Research has confirmed a strong bilateral relationship between diabetic health and oral health. Periodontal disease (gum disease) is more prevalent and severe in people with diabetes and treatment of periodontitis can positively influence glycaemic control. Thus an alternative model of oral health service was developed and trialled to provide effective oral health care to patients with diabetes.

How the service was developed

Current service delivery in dentistry is provided largely in isolation from other health services. Existing staffing and resources were reoriented so that patients with diabetes were given prioritised access to oral health care through a direct referral pathway from GP's, Community Health Centres, Indigenous Chronic Disease Teams, Metro North Community Health Centre and Metro North Oral Health Services. Initial assessment and preventive oral health care was provided by an oral health therapist (OHT), and standard dental treatment, supportive periodontal therapy, and prosthodontic services were delivered by dentists and dental specialists as needed to eligible adult patients with diabetes.

Key strategies involved:

- establishment of partnerships and referral pathways with other health service providers
- professional development specific to the model of care
- patient and carer education
- utilisation of the full scope of practice of all members of the dental team.

Outcomes

- Improved access and reduced waiting list time for targeted patients with diabetes.
- Improved oral health status for targeted diabetic patients.
- Improved patient knowledge of the links between Diabetes and Oral Health.
- Cost effective delivery by utilising the oral health therapist as the first point of contact in the provision of an initial risk assessment and preventive care.
- Sustainable partnerships and integration of oral health into general health referral and clinical pathways.
- Professional development for health practitioners.

Contact

Metro North Health Service District Oral Health Services. Ph (07) 3257 3533

eHAB (Telerehabilitation) Project

Cairns and Hinterland Health Service District (CHHSD)

How the need was identified

Availability of new technology has been identified as one driver for the emergence of new models of care. Patients' expectations about ease of access to services and quality of services are rising. eHAB telerehabilitation technology has potential to provide a means for rural and remote patients to access rehabilitation services without the need to travel long distances or incur associated travel costs.

The eHAB devices are portable, sturdy and contain a suite of calibrated assessment tools that allow Allied Health Professionals to undertake clinical measurements such as balance, gait analysis, speech and communication assessments and height and depth measurements over the internet from a remote location.

The aim of the eHAB Models of Care Project was to integrate the use of eHAB in allied health services across the CHHSD in an effective and sustainable manner. Specifically this project sought to:

- trial the delivery of specialist allied health services to rural clients in CHHSD utilising eHAB technology
- determine whether the provision of services via eHAB enhances client care and improves access in a cost effective and timely manner
- examine the effectiveness of using eHAB technology to provide clinical support and supervision for staff in rural and remote areas.

How the service was developed

Six sites across CHHSD were selected for participation in the trial, which was conducted as a descriptive study in a Quality Assurance project. The study used convenience samples of patients, clinicians and supervisees from the allied health disciplines of occupational therapy, physiotherapy and speech pathology.

Outcomes

- Professional development activities conducted via eHAB were rated moderately positively on Likert scales by both providing and receiving clinicians.
- Most clinicians who participated in eHAB consultations reported they would participate in an eHAB session again.
- A number of technical issues, particularly poor audio and video quality, served as barriers to use.
- The number of vacant allied health positions across the district contributed to difficulties with adequately trialling the devices in this project.

Contact

Director of Allied Health, Cairns Hospital.
Ph (07) 4226 466

Developing Partnerships to improve the patient journey from isolated sites

Mt Isa Health Service District

How the need was identified

Several service provider organisations held the view they have capacity to sustain a critical mass of well supported staff and provide clear, well linked care for patients by working in partnership. The need for better partnerships was identified by the Aurora Report 2007 and confirmed by district baseline research. Thus the aim of this project was to build district partnerships to streamline the patient journey for people with chronic diseases from isolated sites.

District staff were consulted and their 'on the ground' ideas for change explored. Specific good processes and practice were identified as well as issues and concerns. This data was thematically compiled to identify focus areas for implementation.

How the service was developed

Seeds of change were sown amongst all service providers to streamline the patient care journey by working in partnerships to implement consistent systems and processes and prevent duplication. Management focussed on stabilising and supporting staff in the various organisations to implement consistent systems and processes across the district. With the clear support of management on site, staff were empowered to identify partnership implications at their site and prioritise and set the pace for change. Redesign implications for Allied Health were then reviewed to support these changes.

Outcomes

- Queensland Health staff efforts were concentrated on hospital based service delivery and outreach service was provided by other organisations in the main.
- Clear service provision, communication protocols, identified gaps in care and focus for improvement.
- Connected discharge process with a clear pathway now in use.
- Stabilised staff – critical mass across provider organisations using role redesign and introducing Health Practitioner trainer/mentor role and rural generalist allied health assistant role.
- Pooling of Queensland Health and other organisations' part positions to recruit one full time person and determine the scope of service provision accordingly.
- Increased staff development, mentoring and support.
- Improved efficiency in use of district resources.

Contact

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Mt Isa Health Service District.
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Orthopaedic Podiatry Triage Clinic (OPodTC)

Logan Hospital, Ipswich Hospital and Townsville Hospital

How the need was identified

Waiting times to see an orthopaedic surgeon for foot and ankle problems have extended to unacceptably long periods in many QH Districts. Patients can wait for many months for an appointment, and for some, surgery is not always the only or the best option. Many non-urgent foot problems can be successfully managed with conservative podiatry interventions including footwear prescription, foot orthoses and exercises.

How the service was developed

The OPodTC was piloted at Logan, Ipswich and Townsville Hospitals to investigate the impact of this new service on waiting lists for foot and ankle surgery. A podiatrist screened all non-urgent (category 3) patients to determine whether they were suitable for conservative podiatric treatment. If these treatments were beneficial to the patient they were then discharged from the surgical waiting list. Patients who the Podiatrist assessed as still needing to see the orthopaedic surgeon were placed back on the waiting list. Those patients who returned onto the surgical waiting list were also provided with relevant podiatry treatment as a measure to alleviate or reduce the severity of their impairment.

Outcomes

- Since the implementation of the OPodTC in July 2009 at Logan Hospital, the orthopaedic foot and ankle waiting list has been reduced by 49.7%. 150 patients have been screened by the OPodTC podiatrist. Of these, 69 patients (46%) were identified as suitable for conservative podiatry treatments and discharged from the surgical waiting list. A further 65 patients (43%) had a foot problem that required surgical intervention, and these patients were returned to the waiting list.
- At Ipswich Hospital, the waiting list has been reduced by 23.3% since October 2009, with 13 of the 63 patients (20.6%) seen by the podiatrist discharged from the waiting list.
- Townsville Hospital also achieved a reduction of 25.5% for category 3 waiting list, and 38% of patients seen by the podiatrist were discharged.
- Increase in conversion to surgery rates: the orthopaedic surgeon at Logan Hospital is now seeing patients who need and want surgery, with the number of new patients seen progressing to surgery increasing from between 29-35% to between 41-51%.
- Improved foot health outcomes for patients who have been screened and treated by the OPodTC podiatrist. The projects demonstrated an average of 20% improvement in foot pain, foot function, footwear problems and general foot health.
- In the Staff Opinion Survey all indicators of Individual Outcome and Organisational Climate moved to level 4 'commendable' except Training and Career Development which finished at level 5 'outstanding'.

Contact

Orthopaedic Podiatry Triage Clinic Project
Manager. Ph (07) 3299 8383

Redesigned Paediatric Outpatient Service Delivery

Sunshine Coast Health Service District

How the need was identified

Sunshine Coast demographic data shows increases in numbers of children (up to age 14) of 2.3% a year. Currently there is a mismatch between existing demand and provision of early intervention to children with developmental delay. Literature suggests the use of family-centred, outcomes focused intervention using direct and indirect service delivery is more effective than traditional child-centred intervention.

Fragmented services with convoluted access and service pathways were identified as issues at stakeholder forums that included government and non government services.

Service analysis was therefore undertaken using Lean Thinking Methodology.

How the service was developed

Current mapping of service delivery and a SWOT analysis were used to draft a service delivery model based on local priorities, benchmarking with like services, state-wide trends and evidence.

The primary objectives were to improve the patient journey by reducing wait, simplifying referral process, enhancing information flow, and reducing duplication and redundancies.

Outcomes

A redesigned model of service has demonstrated significant improvements in the patient journey for children and their families and enhanced skills and job satisfaction for staff. Successful components include:

- Centralised Intake System - decreased client waiting time from referral to contact from 81.3 days to 31 days.
- The Advanced Paediatric Health Practitioner facilitated access to referral pathways and provided high level assessment and other services to complex patients so that they required less time from the specialist paediatrician. This had a positive effect on both clients and waiting lists.
- Increased average numbers of referrals received per month from 6.75 to 30.5.
- Simplification of journey by reduction of entry process steps from 15 to 3.
- New Complex Case stream: 58.3% of clients achieving target of 6 week service turnaround time during first 4 months of trial.
- Embedded service sustainability, succession planning, evaluation processes (developed and learnt through practical application).
- Enhanced clinician skill base was supported with training opportunities, development of clinical pathways and weekly multidisciplinary case feedback/discussion meetings.
- Strengthened and newly created clinical networks and partnerships are ongoing.
- Improved information flow by development of standardized suite of letters and report proformas.

Contact

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New Models of Pharmacy Practice: Pharmacy Assistants' Roles

How the need was identified

In July 2008 pharmacy stakeholders identified the need for the role and scope of practice of pharmacy assistants/technicians to be expanded as a strategy to cope with service demand. Pharmacists were performing tasks which, in line with overseas workforce trends, could be safely and legally delegated to pharmacy assistants/technicians.

How the service was developed

Current roles being performed by the pharmacy assistant workforce in Queensland Health facilities were established through informal workforce surveys and observational audits that provided time-and-motion data to define daily tasks. The data obtained informed the development of role descriptions and the underpinning duties statements, contextualized for pharmacy, which mapped to the generic allied health assistant role descriptions developed for the allied health assistant project.

These redesigned roles were then successfully trialled at a large metropolitan site (Princess Alexandra Hospital) and a rural site (Emerald hospital). A generic business case was developed for the establishment of permanent full scope and advanced scope pharmacy assistant roles in Queensland Health facilities.

Outcomes

Trial data demonstrated that optimising and expanding the roles and scope of practice of pharmacy assistants:

- allowed pharmacists to spend more time performing clinical activities
- substantially increased the percentage of patients receiving a Discharge Medication Record
- led to reported improvement in inpatient medication management
- improved timeliness of medication supply to patients
- increased nurses satisfaction with medication supply
- reduced pharmacists' workload and stress, and improved job satisfaction
- provided costs savings on the ward due to improved inventory management.

Contact

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Radiographer Abnormality Description (RAD) Project

How the need was identified

A number of key factors within the Queensland Health Medical Imaging working environment were identified that suggested the need for this project:

- There are ongoing statewide access difficulties to a timely diagnostic report. In 2008/09 only 39% of all radiographic diagnostic reports were available within 24 hours and thus most were unable to inform patient outcome in the Emergency Department setting.
- Radiographers are routinely approached in the clinical setting for image interpretation opinions. There are currently no short relevant courses to accredit radiographers to provide image interpretation opinions.
- Junior doctors in QH facilities have usually had minimal training in image interpretation which can result in inaccurate diagnoses and undetected injuries.

How the service was developed

Baseline data of current reporting timelines were gathered. Alternative existing national and international models of care for radiography services that included provision of an opinion were investigated.

A Radiographer Abnormality Description (RAD) worksheet to communicate radiographer findings with Emergency Department clinicians was designed and trialled in this project.

Outcomes

- Significant improvements in radiographer image interpretation sensitivity were achieved (87.1% to 93.1%) during the pilot study following delivery of a short course in image interpretation.
- Trained radiographers' opinions had almost perfect agreement with the radiologist report when statistical analysis was applied.
- A completed RAD worksheet could be provided to Emergency physicians within an average of 16 minutes, which is a clinically useful timeframe. Combining the radiographer comment with the Emergency Department physician assessment provides a very high level of accuracy in a clinically appropriate timeframe.
- The use of a RAD worksheet reduced the incidence of missed abnormalities in the Emergency Department setting for examinations within the scope of the project. The 22 day project trial identified 8 cases where the radiographer identified an abnormality missed by the Emergency clinician.
- Access to the patient and additional clinical information is a key component of the worksheet model with accuracy rates increasing from 88.3% to 95.8% when the radiographers had direct access to the patient.
- Recommendations were made for the development of relevant education and a QH policy framework to support future implementation of RAD more extensively.

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Pathology Queensland and Queensland Health Forensic and Scientific Services (QHFSS)

How the need was identified

Pathology Queensland and QHFSS face a number of the challenges in delivering effective, efficient and responsive services to Queenslanders. These challenges include:

- demand for services from an ageing population with an increasing disease burden
- workforce challenges including staff shortages and increased cost of services
- systems and process changes, including staff spending significant time on tasks not requiring their full level of expertise.

This Models of Care Project attempted to address some of these challenges. A review of the Pathology Queensland and QHFSS workforces during Phase I identified a number of new and redesigned Operational Officer roles which were subsequently trialled during Phase II of the project at various demonstration sites.

How the service was developed

Three roles were trialled with extended scope -

1. Analytical assistant
2. Cross-trained specimen collection and reception officer
3. Operational staff supervisor.

Trialling of the roles involved the application of a number of change management strategies to support each project task. Role implementation toolkits were developed.

Outcomes

The comprehensive trial and analysis of two new and one redesigned Operational Officer roles within Pathology Queensland and Queensland Health Forensic and Scientific Services (QHFSS) has found:

- An Analytical Assistant role was effective and could be progressed as a new Operational role(004) within Pathology Queensland laboratories.
- The Cross-trained Specimen Collection and Reception Officer (003) would require sufficient flexibility of staff deployment to provide organizational benefits.
- An Operational Staff Supervisor role (004) within the QHFSS DNA Analysis Laboratory was effective at this site.
- Industrial implications of the new or redesigned roles need to be considered early in any change process.
- At the final Staff Opinion Survey all indicators of Individual Outcome and Organisational Climate reached the 'commendable' level.

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Neurological Screening Clinic for Spinal Pain

Gold Coast Health Service District (GCHSD)

How the need was identified

Within the GCHSD the category 3 neurosurgical waiting time, which includes the numerous General Practitioner referrals for spinal pain, is over three years. The Department of Neurosurgery identified a need for an alternative approach.

There is published evidence to support the use of physiotherapy screening of spinal referrals. Thus a Neurological Screening Clinic (NSC) was developed to deliver screening and multi-disciplinary allied health non-surgical care for spinal patients referred by their GP to the GCHSD Department of Neurosurgery. The approach involves assessment by a clinical lead physiotherapist and non-surgical treatment by a team including pharmacist, dietitian, occupational therapist, psychologist and physiotherapist.

How the service was developed

The NSC was supported by the establishment of an Advisory Committee and by funding for a twelve month project.

The aims of the project were:

1. to provide timely, evidence based, patient focused multidisciplinary management for patients with spinal pain
2. to decrease neurosurgical waiting lists by providing a non-surgical alternate pathway
3. to increase the proportion of spinal patients assessed by the neurosurgeon that require surgical management
4. to improve satisfaction for the patient, the referring GP, the consultant neurosurgeon and the range of GCHSD clinicians in the Neurosurgery department.

Outcomes

- NSC activity has resulted in a 70% average monthly increase in new patient throughput in the Neurosurgery Outpatient Clinics.
- 58% of NSC patients assessed in the first nine months have been discharged following multidisciplinary allied health care without the need for review by the medical neurosurgical team. This rate increased in the next three months.
- In house surveys distributed showed high levels of patient, GP referrer, neurosurgical consultant and clinical staff satisfaction with the service as an alternative model of care for patients with spinal pain.
- Patients have received earlier management from the allied health multidisciplinary team than would otherwise have been provided.

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Advanced Allied Health Practitioner Trial – Emergency Department and Acute Aged Care

Gold Coast Health Service District

How the need was identified

External review of Gold Coast allied health services identified a need to improve the quality and timeliness of allied health care and referrals for patients presenting through Emergency Department and the Acute Medical Wards and to enhance patient flow and process design for service efficiencies. Within this context there was an opportunity to trial and evaluate a model of Advanced Allied Health Practice in the Emergency Department (ED) and Acute Medical Wards of both Southport and Robina Hospitals.

How the service was developed

To trial advanced roles there was a need to explore and define the concept of advanced practice and to more broadly review current service delivery. As well, delegation could be explored through an Advanced Allied Health Assistant role.

Consultation with key stakeholders, a literature review of current trends, and analysis of Decision Support Service (DSS) Data shaped the service model.

The Gold Coast Health Service District Advanced Allied Health Practitioner Advisory Committee has overseen the development and implementation of the trial project.

Outcomes

- Projects to develop the advanced allied health practitioner role are ongoing.
- Allied health professionals have found it difficult to conceptualise an advanced role. Clear vision and articulation of role scope is required to pursue a new role.
- Allied health professionals are not pushing the boundaries of their potential scope.
- The Emergency Department is a difficult environment for a new role given the time and flow pressures.
- Commitment and support from a medical champion is fundamental for effective change in scope of roles.
- Staff selection and training is critical to success.
- Ongoing workforce education is required to address the stigma, fear and attitudes about shared competencies, skill mixing and exploring professional boundaries.

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Advanced Allied Health Practitioner – Aged Care

Sunshine Coast Health Service District (SCHSD)

How the need was identified

The SCHSD is expected to experience a 77% increase in total population within two decades (2001 – 2021). This represents the second largest growth within Queensland, approximately 190,000 people. The highest proportional increase is predicted to occur within the age group 65 years and over. This increase is consistent with many other areas of the state. Specialist services within the aged care sector have been identified as a key “flash point” in demand for services. Health capital works expansions in the SCHSD will also provide opportunity for new models of care to be implemented.

How the service was developed

The primary aim was to trial a model for aged care service which utilised an Advanced Allied Health Practitioner (AdAHP) role supported by an Advanced Allied Health Assistant role to improve patient access to earlier intervention and specialist services. Decreasing hospital readmissions was a further goal.

The two new roles were developed with the support of targeted training and development of criteria-based decision-making processes and implemented in the outpatient geriatric clinic.

Outcomes

This project is continuing with the following desired outcomes:

- use of the AdAHP role to enable more targeted geriatrician time for both simple and complex cases
- reduced waiting time to specialist geriatrician services as more appointment times available due to reduced time required per patient post implementation of role
- use of an advanced assistant role for screening, patient follow-up and care coordination, health promotion and falls prevention programs
- reduced waiting times for face to face interventions (AdAHPs <3 weeks category 1; 25% of current category 2 wait list seen)
- targeted earlier referral to appropriate community based allied health services
- reduced hospital admissions
- improvements in patient function and/or functional maintenance
- improved information flow across service groups
- development of a specialist resource for skills transfer within allied health.

Analysis of data to date indicates a trend towards the desired outcomes. The project will continue and collect relevant data to fully investigate the effect of the advanced health practitioner role in this context.

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Allied Health Assistant Project

Metro North HSD

How the need was identified

Service demand and capacity to provide it were increasingly mismatched and trials were proposed to test potential for service delivery gains through use of assistant / support staff across the extensive Metro North District.

At each trial site the organisational redesign approach started with a detailed mapping of the local patient journey. This 'map' informed the subsequent redesign work within the team.

How the service was developed

Six individual trials of allied health assistant roles, across diverse settings, were established. This was achieved by:

- a close partnership between the Project Team (comprising two health practitioners and one experienced allied health assistant) and multidisciplinary teams at each trial site
- direct project involvement in critical aspects of trials such as design of duty statements and monitoring of progress
- generous commitment of time from local allied health and nursing staff to coordinate each trial, provide training, assess competency training and supervise assistants.

Outcomes

- Successes were seen in components of each of the six trials of a new model for Allied Health Assistant service delivery in diverse clinical settings.
- The majority of the trial sites were community settings. All important aspects of the assistant model (profession specific / multidisciplinary / aide / full scope / advanced) were trialled using twelve different assistant roles.
- A 'bottom-up' organisational approach for redesigning roles and change management was tested in a range of workplaces and found to be effective. Essential elements were – engaging the team, identification of specific tasks for role transfer, good quality documentation, competency assessment process aligned to duty statement, practical training plan and regular feedback to site team.
- A 'measurement for improvement' approach, based on NHS experience in the U.K. was used to evaluate the trials. The approach showed the required changes occurred at five trial sites, and that the change was an improvement in productivity at two sites. These two sites represent best practice, for the profession-specific assistant in a hospital setting (Redcliffe), and the multidisciplinary assistant in a community setting (Transition Care Program).
- A dedicated outcome study at Redcliffe Hospital stroke service, both in acute and rehabilitation contexts, has provided important evidence of the contribution of the new AHA model to improving client health outcomes.

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Social Work Assistant (SWA) Trial Project

Mater Health Services

How the need was identified

Most Social Workers employed in health settings in Queensland do not have access to a support worker. This misalignment with trends in other allied health professions has potential to negatively impact levels of Social Work service provision, and contribute to possible job dissatisfaction.

Social Workers are key professionals in facilitating timely and appropriate patient discharge from adult medical beds into residential aged care facilities and into the community. They also provide high level assessment, counselling and crisis intervention for patients and families. The assistant role was seen as potentially helpful in maintaining effective patient flow.

How the service was developed

The aims of the Social Work Assistant (SWA) project were to increase social work productivity, optimise social work service through more efficient alignment of skill to task, improve staff satisfaction and enhance the quality of the patient journey.

The project Initiation phase developed and validated a contextualised and discipline specific SWA position description using Lean®-based mapping processes. The Implementation phase saw the establishment of a new SWA role within the Mater Adult Hospital Social Work team. The Sustainability phase included the effective roll-out of Implementation Workshops to Social Work teams across Queensland.

Outcomes

- An innovative SWA model has been developed within Mater Allied Health Services, using a workforce redesign framework and methodology.
- Clear productivity and cost-effectiveness benefit with a 20% increase in number of new patients seen, and an 11% reduction in cost per occasion of service.
- Documentation developed for how the role functions (within the Mater Hospital) in terms of operational and reporting structures, clinical service delivery, clinical governance and quality and safety.
- The SWA role operates within a delegation model which enables Social Workers to operate at full scope with increased job satisfaction.
- The new model allows Social Workers time to carry out more complex tasks, whilst ensuring patient safety, quality and consistency of service.
- The Social Work Task Complexity Hierarchy was developed during the project and this could be developed further through validation research.

There was strong agreement in the need for, and appropriateness of the proposed SWA model. Consultation with the relevant national peak body, Community Service Health Industry Skills Council (CSHISC), secured commitment to scope the creation of a SWA qualification.

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Medical Imaging Assistant Project

Logan Hospital and Toowoomba Hospital

How the need was identified

There was general recognition that a trial of medical imaging assistants was needed to develop data to inform the following objectives:

- creation of a career pathway for medical imaging assistants
- identification of specific tasks that could be performed at two assistant levels
- identification of training and education packages appropriate for medical imaging assistants.

How the service was developed

A project approach was taken with the following aims -

- identify duties that are appropriate for delegation at an Aide (trainee) and full scope assistant level
- create orientation packages, work instructions and a governance framework for use during implementation of assistant roles
- medical imaging assistant role trialled in both computed tomography and general radiography
- evaluate the outcomes of the roles and work with the Medical Imaging Assistant steering committee for resolution of issues identified.

Outcomes

Major outcomes for the project included:

- role description developed for the Medical Imaging Aide (trainee) and Full Scope Medical Imaging Assistant
- task List created for the two assistant levels however the Aide (trainee) level was minimally effective
- contextualised governance guidelines for the role of Medical Imaging Assistant
- the medical imaging workforce found conceptualisation of the role and the tasks which could be performed to be very difficult
- explored availability of existing education and training and found there is no suitable training package available at present.

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Allied Health Assistant project

Princess Alexandra Hospital

How the need was identified

The Princess Alexandra Hospital was a demonstration site for AHA trials in a tertiary, metropolitan hospital setting. A review was undertaken of the local AHA workforce and existing training/support frameworks and subsequently trial work areas across a range of services with state-wide applicability were selected. Work groups with an identified need or committed change agents were recruited. Eleven teams from four professions participated in the trials – nutrition and dietetics, occupational therapy, physiotherapy and speech pathology.

How the service was developed

Trial roles were developed through the application of service redesign methodology. The 17 roles included in the trials equated to 15.7 full time equivalents (FTE). Some trials utilised redesigned existing roles, with new or higher level tasks incorporated to align the role with the trial role descriptions. Some roles were redesigned from full scope AHA roles to Advanced AHA roles.

The impact of the trial roles was evaluated using standardised Key Performance Indicators as well as trial specific measures. Contact between trial groups and the Project Manager helped identify the enabling and limiting factors.

Outcomes

- Allied health assistant roles were trialled at aide (trainee), full scope, and advanced assistant. Successful role implementation requires appropriate staff skill mix, team commitment, management support, clearly defined duties and well integrated processes of delegation, supervision and communication.
- AHA roles containing clinical tasks were safely implemented in four professions.
- HP and AHA time commitment to train AHAs for new roles is substantial.
- Effective clinical AHA roles increase service productivity and have the capacity to reduce relative cost of therapy services:
 - 34% increase group attendances in spinal injuries wheelchair skills group; 29% decrease in cost per patient attendance, 64% decrease in Health Practitioner (HP) time required to run the group (Physiotherapy)
 - 23% increase in occasions of service in orthopaedic ward; 15% increase in HP attendances, 6% decrease in cost per occasion of service (Physio)
 - 24% increase in review attendances in rehabilitation; 13% decrease in cost per occasion of service (Speech Pathology)
 - 31% increase in review occasions of service for acute wards; 24% increase in HP attendances; 19% decrease in cost per occasion of service
 - Estimated 33% cost reduction for Home Enteral Nutrition Service; “Eat Well and Live Well” Program over 50% reduction in HP time required, 33% decrease in clinic cost (Nutrition and Dietetics).

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Rural Assistant Project

South West Health Service District

How the need was identified

The South West Health Service District covers a large geographical area. Allied health services are based on a 'hub and spoke' model, where allied health professionals provide regular visits to outreach sites. The model has inherent limitations in quantity and quality of service provided to clients in outreach communities. Potential for the Allied Health Assistant (AHA) role to make significant improvements in the existing service delivery gap was identified.

The Rural Assistant project aimed to determine how the AHA role could be implemented to support professional staff, and provide a more consistent and cost-effective allied health service to all communities in a dispersed rural health service district.

How the service was developed

Existing AHA roles within the allied health team in St George were redesigned - one to full and one to advanced scope. The team worked to develop roles with a strong clinical focus which extended to the full scope as defined by generic state wide role descriptions. In addition, two new temporary part-time full scope AHA positions were created in Augathella and Dirranbandi. These positions were integrated with allied health teams in 'hub' sites but located in 'spoke' sites, with the aim of maximising service provision and community engagement through a delegated model.

Outcomes

The Rural Assistant project has demonstrated that the use of AHAs improves the efficiency and effectiveness of allied health services provided in rural and remote communities. The major outcomes and results of the project include:

- Duties statements created and tested for multidisciplinary full and advanced scope AHA roles in a rural setting, aligned to generic state wide role descriptions.
- A multidisciplinary advanced assistant role in the rural setting was effective.
- A new model for allied health services to clients in outreach areas using locally situated AHAs, demonstrated benefits of increased service throughput and reduced cost per occasion of service in one site (Augathella), with maintenance or improvement of client health outcomes and satisfaction.
- Enhanced profile of the AHA role within the broader health workforce was accepted and members of local community groups supported the role.
- The clinical tasks delegated to AHAs within scope of practice were increased and appropriate supervision provided from hub site one hour away.
- Demonstrated that specific competency based training and continuing professional development for assistants allows supervising therapists to be confident in delegation.
- Podiatry screening clinic and walking group have been implemented and managed by therapy assistants with appropriate supervision.
- Time spent to train assistants is economical as they often constitute a more stable long term workforce in rural areas than do allied health professionals.

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Advanced Allied Health Assistant in management of diabetes and renal disease

Townsville Health Service Districts (THSD) and supported sites

How the need was identified

Indications for the project trial included the relatively high local incidence of chronic disease particularly diabetes and renal disease in the Aboriginal and Torres Strait Islander population; workforce shortages in rural, regional and remote areas and in community based services; the capacity of small disciplines to respond to growing service demands; and the potential for regional settings to provide service and workforce support to rural and remote settings.

The objectives were to develop a model of care that enhances allied health service delivery in diabetes and renal disease, and trial an advanced AHA role that provided the opportunity for full scope practice for health practitioners.

How the service was developed

Key stakeholders oversaw four distinct project phases including:

1. Development Phase: conceptual design of service to address stakeholder identified issues.
2. Workforce and Service Development Phase: developed advanced allied health assistant role descriptions; facilitated training and competency acquisition in chronic disease skill sets.
3. Advanced AHA Role Phase: upon achieving required competencies the advanced AHA provided foot screening for the clients attending the haemodialysis units.
4. Four month trial of an advanced AHA intake role: this phase of the project aimed to enhance consumer engagement in managing their chronic disease.

Outcomes

- Development of an advanced Allied Health Assistant role in chronic disease. The advanced AHA screening with dialysis clients using a foot screening protocol showed 98% correlation with screening by the podiatrist.
- Demonstration of a role for advanced allied health assistant in foot screening within a dialysis unit. Audit in Townsville found a significant level of high risk feet in the unit – 16% peripheral arterial disease, 42% peripheral neuropathy, 71% foot deformity, 18% lower limb amputations, 29% poor foot care practices.
- Advanced AHA role in community based intake team is to screen each client using an agreed multi-disciplinary tool; establish the client's stage of change; support client to act on services offered. The role resulted in 33% increase in referral uptake for clients with chronic disease.
- Resources to support competency acquisition and assessment are available for use by other similar services. These include Foot Screening Clinic protocol, Diabetes Group Education, Engagement Clinic One-on-One, Foot Care and Nutrition Self Management Group Clinic, and the Enhancing Client Engagement (multi-disciplinary intake) screening clinic.

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