Health Education Collaborative

Health Education Collaborative Newsletter

Issue 4
April 2020

A message from the CEO

Bruce Greaves
CEO/Director

Welcome to issue 4

I hope everyone is managing well with the Covid-19 lockdown restrictions. It certainly has changed the way we manage many aspects of our daily work based and social activities. I have done more zoom Friday evening drinks sessions than I ever thought I would.

I was to present at a major international conference in May, with a big course and collaborative partnership launch however, due to COVID-19 this has now been posponed with a new date still to be set.

Has COVID-19 changed the way we will do things in the future, the simple answers is yes.

We have discovered that many of us can work quite effectively from home. Although online learning has been around for many years, the current environment has shown people that have not had exposure to it in the past, that it is a very accessible option for learning. Zoom meetings and classes have become common, they save time and money as there are no travel, accomodation and training rooms expenses and there is no need to sit in peak hour traffic.

But there are the down sides! Internet conections and speeds vary especially in high volume and regional and remote areas. Classroom interactivity is not the same as in a face to face setting which is a very important component of skills based learning programs, where the ability of the facilitator to observe and direct a learner in real time hands on is crucial for the participant's learning.

So, online learning and internet bussiness solutions are going to become much broader in use, our physical contact as it has been will be reduced as these take a more prominent role in our lives.

I believe the best model for the future is to refine the blended model of learning between face to face, online and workbased learning activities and embrace these to suit the new post COVID-19 world which we are about to enter.

Course Development

New partnerships and course releases

Our new collaborative partners have been extremely busy at this time reorganising workflows, surgical operative lists, conferences etc to coincide with the easing of restrictions. As such, we have decided to delay the release of collaborative partner anouncements.

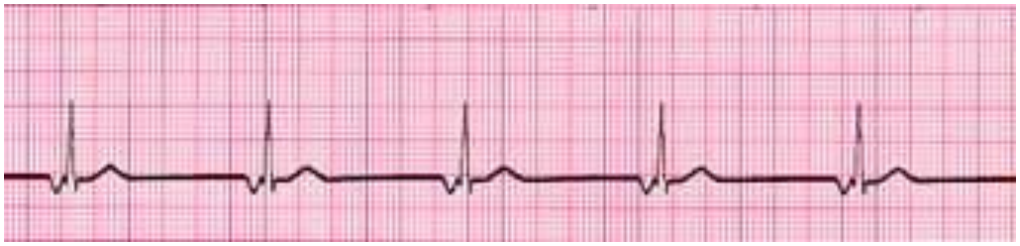
Once life settles in the next few weeks we will post a special edition on our new partnerships and associated courses.

Clinical Update

Margaret Villella
Director/Education Director

Clinical Question/Rhythm

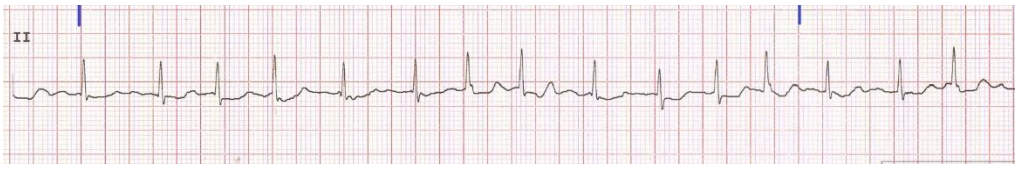
Last month I asked if you could identify this rhythm and I would provide the answer this month.



My systematic interpretation of this rhythm is: the rhythm is regular, rate is 55 bpm, there is a P wave before every QRS but it is inverted, so not sinus, PR interval is quite short 0.12 secs and QRS duration is normal.

Answer: Accelerated junctional rhythm.

See how you go with this one!



Patient Education

I was talking to a friend of mine last week and she told me she had not been well, had a stomach bug for some time and had started some antibiotics. Later in the conversation she said how she had been feeling unwell and nauseated. I asked her if the antibiotics were Flagyl. She went and got the packet and of course they were. I asked her if she had been drinking alcohol (who is not in this current environment). I explained to her that you cannot have ANY alcohol whilst on Flagyl and that is why she is feeling sick. No one had informed her of this – not the GP or the Pharmacist. There was a tiny sticker on the box saying, “avoid alcohol”.

This just highlights to me how important it is that we provide patients with appropriate education. Sometimes we think someone else may have already told them, but it is better to hear it twice than not at all.

Interestingly, the recommendation for Metronidazole is to avoid alcohol whilst taking the antibiotics and for a further 3 days after completion of the antibiotics.

In the Chat Room

This month we interview **Mr. James Brinton** *Hip Fracture CNC, Musculoskeletal, Integumentary and Trauma and Neurosciences Networks NSLHD Royal North Shore Hospital*.

HEC: How long have you been working in this role?

James: I am a naturally motivated, innovative and experienced nurse with over 26 years of clinical experience, augmented with a decade of project management and senior management experience. I started my nursing career in Sydney, spending 13 years as a specialist emergency nurse. I moved into to a Clinical Nurse Consultant role about 5 years ago. I was recently seconded to Northern Sydney Local Health District (Royal North Shore, Ryde and Hornsby Hospitals in the northern suburbs of Sydney). I'm the Clinical Nurse Consultant Hip Fracture, with a focus on the Australian & New Zealand Hip Fracture Registry (ANZHFR).

HEC: So, tell us what your role involves?

James: I work as a CNC across 3 facilities, using the ANZHFR to leverage improvements in the patient experience. I am responsible for collecting, collating and cleansing data and using that data to inform change. Recently I worked with the anaesthetic, orthopaedic, orthogeriatric and emergency teams to improve the time-to-theatre for patients with a hip fracture.

HEC: What is the best part of your job?

James: The job is deeply satisfying because I have the opportunity to inform system-wide change that makes a real difference to patients and their families. Small process changes, driven by data evidence, can make big differences. I also spend time talking to patients and families about their hip fracture journey, a challenging and interesting part of the job.

HEC: What is the worst part of your job?

James: The healthcare system is inherently complex, with multifaceted systems that are difficult for families and patients to navigate. I find the innate complexities challenging and sometimes, inefficient, when they add no value to the patient journey. Think about hip fracture: the patient falls and knows they've probably broken their hip. The ambulance arrives and suspects the patient has broken their hip. They transport the patient to ED where the triage nurse knows the patient has broken their hip and orders an x-ray. The radiographer sees the hip is broken. A junior doctor sees the patient and agrees the hip is broken and talks about the patient with a senior ED doctor, who agrees the hip is broken. They ring the orthopaedic registrar, who knows the hip is broken, and calls the anaesthetic registrar for consult so the patient can have surgery. Finally, usually 7 or 8 hours later, the patient goes to an orthopaedic ward and surgery is planned for the next day. Each step is rate-limiting and rarely patient focused. Image how much better this process could be with improvements in the complexity.

HEC: Why are you so passionate about this role?

James: The ANZHFR sets Clinical Care Standards based on decades of evidence, and I'm passionate about ensuring these Clinical Care Standards are adhered to because to ensure we deliver safe quality care to vulnerable patients. I've looked after hundreds of frail elderly patients with hip fracture, and I know we can do better. Analgesia, early surgery, early mobilisation all improve the patients' outcomes and its part of my job to ensure these standards are met.

HEC: You have worked in Orthopaedics and trauma in your previous roles, what do you like most about Orthopaedics and trauma nursing?

James: Orthopaedic trauma nursing is exciting, interesting and challenging, but it's also predictable and measurable. I like that we can measure and predict to streamline the patient journey and reduce clinical variation. Plus, I really like broken bones!

HEC: How has the current COVID-19 pandemic affected your role?

James: All non-urgent elective surgery has been deferred for now, and resources have been reallocated to prepare for the tsunami of medical respiratory patients. In the coming months, most healthcare systems will be stretched far beyond their usual capacity. With elective orthopaedic wards being repurposed as mixed medical units, the risk is that hip fracture patients will be transferred to outlying wards. It is known that

outlying hip fracture patients have greater chance of unwarranted clinical variation; reduced continuity of care, affecting day-one mobilisation, and increasing the risk of adverse outcomes that evidence shows are reduced on specialist orthopaedic units staffed by specialist orthopaedic teams. In 2019, in line with the guidelines; less than 5% of NSLHD hip fracture patients were transferred to non-orthopaedic wards from Emergency Departments. It will be interesting to see if 2020 ANZHFR figures show a change in this process and if there will also be a subtle change in patient outcomes.

HEC: You have worked extensively in nursing education. From your point of view at this time with COVID-19 affecting us in many ways, do you think the way we deliver education post COVID-19 will change or should change?

James: COVID-19 has given us the opportunity to review and revisit our ways of working. Social distancing will now be the new norm, and we need to structure future learning around the idea that our students will be digital-ready. I see this as an exciting time, a time to think outside of the box, and test blue-sky ideas.

I am passionate about health, education and improving patient outcomes. Please don't hesitate to contact me if you have questions or comments: James.Brinton@health.nsw.gov.au

Until next time, stay safe!

Next Issue: May 2020

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