Message from the Editor

Winter has arrived…the beaches are emptying just as quickly as the emergency departments are getting busy with chest infections!

And there are things that we can all do to ease the ED load.

There are some fantastic community-based initiatives showcased in this winter edition of ‘Getting better faster’ that are designed to help people to better manage their health outside of the hospital system.

Increasing referrals to these ambulatory care programs will shift demand from the tertiary hospital setting out into the community, effectively reducing ED presentations, inpatient admissions and length of stay in hospital for target populations. At the same time, more equitable access to health-care in the community is resulting in better outcomes for patients and their families.

So read on and refer on!

And in the meantime, keep yourself healthy@home by having your flu jab!

Chronic Disease Management Teams in action - helping people with Diabetes, COPD and Chronic Heart Failure to stay healthy@home and out of hospital this winter (call 1300 855 841).
Getting better faster at KEMH

King Edward Memorial Hospital (KEMH) has been successful in gaining extra funding for several projects including the hospital’s Visiting Midwifery Service (VMS).

The funding ($32,125 until July 2007 and $128,500 recurrent after July) recognises that the number of women choosing to deliver their babies at KEMH has increased from 4,446 in 2004 to 5,512 in 2006.

There is every indication to suggest that this trend will continue with a projected increase of nearly 500 births in 2007.

Acting Executive Director of Nursing and Midwifery, Robyn Collins said in order to absorb the increase in patients KEMH has investigated different models of care to support shorter stays post birth.

“The ability to shorten the length of patients’ stay in hospital is highly dependent upon the ability of the VMS to provide more women with home visits,” she said.

Currently the VMS provides one home visit per day to all women in the catchment area up to day five following birth.

“In 2006 the VMS had an increase of 26.2% in patient numbers and this number is projected to increase to 2,206 home visits in 2007, taking into account increasing numbers of women choosing to birth at KEMH and shorter stays in hospital,” Ms Collins said.

The project’s goals are closely aligned with several of WA Health’s strategic intents:

1. **Healthy Communities** - will assist the support of postnatal women in their community, the implementation and success of breastfeeding and family dynamics.

2. **Healthy Hospital** - the provision of additional midwifery staff for the VMS will enable the hospital to decrease postnatal inpatient length of stay without increasing risk to women and newborns.

3. **Healthy Workforce** - reduced stress levels experienced by midwives working within the hospital as they know that women will be well cared for by experienced and qualified midwives in the community.

4. **Healthy Partnerships** - will assist the support of integration with other community care providers.

5. **Healthy Resources** - the decreased length of stay for postnatal women will increase access to available resources.

Ms Collins said it was well recognised that decreasing length of stay in hospitals and providing increased community based care was a more cost efficient model of care as well as greatly assisting the integration of a new family member.

For more information contact Julie Watson  
 julie.watson@health.wa.gov.au
SCGH Emergency Care Coordination Team

The concept of a patient-focused team of allied health and nursing staff, known as the Care Coordination Team (CCT), was introduced into the emergency department at Sir Charles Gairdner Hospital in September 2005. This was in response to increasing hospital admissions and increasing demands on ED services.

The CCT is comprised of social workers, physiotherapists, occupational therapists, and a nurse discharge coordinator and provides a service to ED patients seven-days-a-week. Services include patient assessment and interventions such as functional assessment, equipment prescription, social support and discharge planning/community referrals.

The primary aims of the CCT are to:

- Provide quality assessment and intervention for safe and effective patient discharge.
- Prevent unnecessary and/or inappropriate hospital admissions.
- Commence early intervention for patients requiring admission.
- Achieve collaborative care with community and hospital outreach services.

Results from the CCT have demonstrated the importance of this ED service for the management of certain patient populations including:

- Falls
- Back pain
- Others such as collapse, inability to manage at home some respiratory problems, musculoskeletal injuries or psycho-social problems.

Follow up of patients once discharged from ED is an essential part of the care program. Patients discharged from the ED may be referred to the following services as appropriate:

- SCGH Occupational Therapy Home Visiting Service
- Domiciliary services (Homelink)
- Department of Rehabilitation and Aged Care (eg. Falls Clinic and Falls Specialist)
- Community services (eg. Silver Chain Personal Enablement Program).

When admission to hospital is required, patients with alternative coverage (eg. Department of Veterans Affairs/private insurance) are offered the choice of admission to a private facility.

Closely linked to the CCT is a ‘Discharge of Elderly from the Emergency Department’ (DEED) nurse who completes a follow-up telephone call for all patients over the age of 70 who are discharged from the ED.

The team’s future directions include:

- Forging strong links with ambulatory care initiatives.
- Encouraging further collaboration between the acute and community health settings including a collaborative falls project with Perth Home Care Services.
- Involvement with the Older Person’s Initiative including risk screening and comprehensive assessment of older persons in ED.

For more information contact Tamala Ranson 9346 7402

Pictures below: Discharge Coordinator and social workers
Getting better faster

A milestone for home rehabilitation program

The Rehabilitation in the home (RITH) program has gone from strength to strength since its launch at Fremantle Hospital in July 2005. Recently RITH has seen its thousandth client.

Mrs Downing was admitted to Fremantle Hospital in March 2007 after falling while playing darts, sustaining a fractured right neck of femur. Following surgery (dynamic hip screw), Mrs Downing was discharged home with RITH services. This enabled her to come home earlier than scheduled and receive the therapy she required at home, rather than in hospital.

RITH team members, including a physiotherapist, occupational therapist, and therapy assistant, visited Mrs Downing in her home intensively for three weeks. During this time, RITH assisted her to improve her mobility and confidence, and return to independence with her personal care and domestic tasks such as cooking, which she now manages well.

Mrs Downing reports she is “so pleased” with the service RITH offered her and the improvements she had made in just three weeks, saying “I thought it would take three months!”

RITH offers a hospital substitution program to provide allied health services at home instead of in hospital. These services include occupational therapy, physiotherapy, speech pathology, social work and dietetics. RITH allows hospital patients to return home sooner, which clients prefer, and also creates additional capacity within the hospital system.

Both clients and therapists have noted that motivation to participate in therapy activities often improves when clients are in their own home and the home environment is a more realistic and relevant setting for therapy programs. The therapists also have better opportunities to involve family members and/or carers as well.

Since July 2006, RITH operates from two bases, Royal Perth Hospital and Fremantle Hospital. The program provides a seven-days-a-week service, and accepts referrals from all hospitals within the South Metropolitan Area Health Service. Between both bases, more than 150 referrals are accepted each month.

More information regarding RITH and referrals to RITH can be made by contacting: Fremantle Hospital 9431 3898 or Royal Perth Hospital 6477 5151.

WoundsWest: Putting WA ahead in wound care

The first ever statewide wound prevalence survey has been completed during the inaugural WoundsWest month. More than 3,000 patients were examined for wounds by over 200 surveyors in 86 hospital sites throughout WA.

A celebration of WoundsWest month took place at Curtin University on June 7. Project partners, the WoundsWest core team and representatives from across the health sector interested in improving wound care in WA gathered to hear preliminary results of the statewide wound prevalence survey.

The survey will establish a baseline in wound epidemiology for WA and will give participating Health Services a better understanding of their wound care management. Keep an eye on the website for updates on the survey and other WoundsWest sub-projects (www.health.wa.gov.au/woundswest).

The survey will be repeated annually over the next three years to track improvements in wound prevention and management.

For more information email woundswest@health.wa.gov.au
Falls and falls injuries are a serious health issue for older people. Australian and overseas studies of community dwelling older people have identified that approximately one in three people aged 65 years and over fall each year, with 10 per cent having multiple falls and more than 30 per cent experiencing injuries requiring medical attention\(^1\). The good news is that falls can be prevented; falls are not a normal part of ageing.

Falls prevention is a “whole of community” issue. Recognising this, a Falls Prevention Health Networks has been established and involves people from diverse backgrounds such as older people over the age of 65 years; carers and families; health professionals such as General Practitioners; staff in various departments within hospitals; non-government organisations such as the Injury Control Council of WA and Council of the Ageing; community home care services; local government services; and residential aged care facilities.

The Falls Prevention Health Network is gaining momentum across the State. In October last year more than 240 participants met to bring together current knowledge and practices in WA for falls prevention.

Getting better faster

Improving community health at the divisions of general practice

Canning Division of General Practice Aboriginal Health Programs

Canning Division’s Aboriginal Primary Health Care Team aim to improve the health of Aboriginal and Torres Strait Islander people living in Perth’s southeast suburbs.

Canning Division of General Practice (CDGP) has two Aboriginal and Torres Strait Islander programs:

- GP Links
- Child and Adult Health Checks (708 and 710).

The GP Links program is designed to assist Aboriginal and Torres Strait Islander (ATSI) patients in Royal Perth Hospital (RPH) who reside in the southeast metropolitan catchment area. Aboriginal Community Liaison Officers (ACLOs) complete daily ward rounds and sign ATSI patients onto the program. The ACLOs link patients to mainstream services such as GPs and the Silver Chain, offer transport to access these services and provide follow-up for three months. This program has reduced the number of ATSI clients being readmitted to RPH.

The Child and Adult Health Checks provide Aboriginal clients living in the southeast metropolitan region, and attending a mainstream GP an opportunity to have their health assessed by an Aboriginal Health Worker. The program promotes good health, offers a three-month follow-up service, and provides the GP with social and medical background information about the client and family aged between 0-54 years.

CDGP has qualified and experienced Aboriginal staff that work closely with the GP to provide an holistic approach to the client’s wellbeing.

For more information please contact Cheryl Phillips at Canning Division of General Practice: 9458 0505

Osborne Division of General Practice - Diabetes Resources and Programs

Osborne Division of General Practice (ODGP) and Osborne Park Hospital have developed a diabetes resource that helps GPs and other providers to quickly find information about accessible diabetes services. This easy-to-use summary of services allows users to find free and affordable services such as education, exercise, dietetics, podiatry and insulin stabilisation for people with diabetes. Developed with the participation of key non-government organisations such as Diabetes Australia and many services in the north metropolitan area, this guide will soon be available on the ODGP website at www.odgp.com.au.

Healthy Families for Happy Futures is a community, family-based behaviour change intervention for 7-15 year olds who are overweight, obese, or at risk. GPs identify suitable patients and complete a baseline assessment. Children and parents attend concurrent workshops covering nutrition, physical activity and goal setting, facilitated by an accredited practising dietitian and a clinical psychologist. Feedback from this program has been overwhelmingly positive.

For more information on these please contact Paulina Montibelier at ODGP on 92089501 or paulinam@odgp.com.au

Perth and Hills Division of General Practice - Chronic Obstructive Pulmonary Disease Programs

The Healthy@Home Chronic Disease Management Team’s COPD program is being actively promoted by Perth and Hills Division of General Practice (PHDGP). This program is designed using self-management and motivational interviewing techniques to help patients to better manage their condition. The aim of the program, by offering advice and support, is to encourage improved lifestyle, improved health and reduce clinical complications thus reducing or shortening COPD hospital admissions.
The program targets people with mild to moderate COPD who are able and motivated to participate in a self-management education and rehabilitation experience related to COPD.

After an initial assessment by a clinical nurse specialist, the individual is involved in group sessions that provide education and detailed pulmonary rehabilitation with a physiotherapist. All patients receive occupational therapy/dietetic/social work/podiatric and nursing expertise via a group program or one-on-one, with staff as appropriate.

The program is completed in eight weeks at community venues with three follow-up phone consultations at monthly intervals. The program finishes with referral to relevant community services as appropriate.

PHDGP has also developed a close collaboration with Community COPD Linkage (profiled in the last newsletter). A table outlining the way the programs can work together is outlined below.

For more information contact
Chronic Disease Teams: 1300 855 841
COPD Linkage: Sean Mulligan 9458 0570

Diabetes Week - July 8-14, 2007

Diabetes WA

How your local Diabetes Educator can help you

With Australia in the grip of a type 2 diabetes epidemic, the pressure is being felt strongly by healthcare professionals. They are required to identify and manage those at risk of diabetes as well as those with complications. The challenge is to source reliable, accessible and quality programs and resources to provide quality care to the patient.

That’s where Diabetes WA (D-WA) can help. Diabetes educators at D-WA provide group education programs for those newly diagnosed, cooking demonstrations and shopping tours, programs to refresh and update those who have been diagnosed for some time as well as a help line, DIAL (D-WA Information and Advice Line).

Rebateable Services

D-WA provides individual appointments with diabetes educators and dietitians. According to D-WA’s Chief Executive Officer Liz Kerrigan Benson explains, a personalised consultation with an expert who deals with diabetes everyday and can offer advice on the finer management details can be extremely beneficial to those living with diabetes.

Table 1: COPD

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate Linkage</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDM Team</td>
<td>COPD Linkage</td>
<td>Multidisciplinary team (nurse and physio)</td>
</tr>
<tr>
<td>Multisdisciplinary team (nurse and allied health)</td>
<td>Multidisciplinary team (nurse and physio)</td>
<td></td>
</tr>
<tr>
<td>■ Confirmed diagnosis COPD and stable.</td>
<td>■ May be undiagnosed and unstable.</td>
<td></td>
</tr>
<tr>
<td>■ Seen within 4 weeks of referral.</td>
<td>■ Seen within 7 days of referral.</td>
<td></td>
</tr>
<tr>
<td>■ Groups education/exercise.</td>
<td>■ Home visits, hospital outpatient.</td>
<td></td>
</tr>
<tr>
<td>■ Self management.</td>
<td>■ 1:1 education, hospital and home based exercise.</td>
<td></td>
</tr>
<tr>
<td>■ 3 to 6 month program.</td>
<td>■ Case MX and self MX.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Ongoing service.</td>
<td></td>
</tr>
</tbody>
</table>
Assessing cardiac risk in diabetes: some limitations

Dr Joey Kaye MBBS FRACP PhD, Endocrinologist, Sir Charles Gairdner Hospital

In people with diabetes, cardiovascular disease (CVD), including ischaemic heart disease and stroke, is the most common cause of death. Most authoritative groups recommend that people with diabetes (without established CVD) be screened for, and treated, with the same intensity as those non-diabetics who have already suffered a CVD event and this is particularly important in women.

Whilst it is well recognised that people with diabetes have a higher CVD risk, this varies considerably within individuals and is dependent on a range of modifiable (smoking, blood pressure, cholesterol) and unmodifiable risk factors (family history, age, gender).

A myriad of medications and treatment strategies are available to try to reduce future CVD events, however, knowing which to use and when to start can be difficult. To aid in this decision-making process several groups have used large population-based studies to create risk assessment tools that estimate an individuals risk of developing CVD. Several research studies have shown that these tools provide clinicians with more accurate predictions of CVD risk, are effective in guiding treatment decisions and tend to reduce the number of people receiving unnecessary therapies. It is important, however, to be aware of their limitations as they may underestimate CVD risk.

Most of the available risk calculators (including the New Zealand Risk Tables) are based on the Framingham Heart Study (a study of over 5,000 Americans aged 30-65 from the town of Framingham, Massachusetts). Only about per cent of individuals had diabetes, and whilst these calculators work well in non-diabetic, middle aged populations they perform less well in diabetics, the young or older individuals or in ethnic minority groups. Another calculator, based on the UK Prospective Diabetes Study (approximately 4,500 adults with type 2 diabetes) may be more valid in the diabetic population, but also has limits as far as minorities, the young and elderly are concerned.

Another limitation of available calculators is that they don’t take into account a number of known risk factors. Weight, family history, LDL-cholesterol, triglycerides, lipoprotein A and C-reactive protein are all potential risk factors whose influence is not considered by existing risk calculators. Microalbuminuria, an important and strong predictor of CVD, is also not accounted for in existing risk calculators. The additional effect of including these risk factors into existing algorithms is not known.

It is important to remember these calculators apply to individuals without existing CVD. Once CVD is present, the future risk of further events is considered extremely high regardless of risk calculator estimates.
The burden of CVD in people with diabetes is very high and aggressive risk factor screening and intervention strategies are strongly recommended. Risk calculators can assist the decision-making process, however, an awareness of their limitations is important particularly in the diabetic where there is a real potential to underestimate CVD risk.

**Framingham Equation:**

**UKPDS Equation:**
www.dtu.ox.ac.uk/index.html?maindoc=/riskengine/index.html

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### What’s happening in WACHS ?

**South West HealthyLink: Chronic disease management program**

In February 2006, the WA Country Health Service-South West introduced a pilot Chronic Disease Management initiative in the Naturaliste locality. SW HealthyLink comprises the following three new programs:

1. **Chronic Disease Self Management (CDSM)**

   Based on the self-management model developed by Stanford University Patient Education Research Centre, the six-week CDSM (Lorig model) courses aim to provide skills in managing a chronic disease as part of a healthy lifestyle. To date, two courses have been run with a total of 20 participants and a third course is proposed to commence soon. Participants have been referred from allied health practitioners, GPs and some have self-referred. Although these courses are not disease-specific, participants’ conditions have included cardiovascular disease, chronic heart failure and type 2 diabetes. Process evaluations indicate very positive responses to course content and format, with participants reporting increased confidence in managing their condition.

2. **HeartMoves**

   HeartMoves is a physical activity program developed by the National Heart Foundation. Strict safety guidelines ensure that leaders specifically offer low to moderate exercise regimes, making the program ideal for people who are managing lifelong health problems, including cardiovascular conditions. In late 2006, WACHS-SW supported two private practitioners - a physiotherapist and a fitness leader - to be trained in this program, both of whom are now offering weekly exercise sessions, the first in rural/regional WA.

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### Table 1: Progress to date at six month re-assessment. Heart failure N=26

<table>
<thead>
<tr>
<th>Key indicator</th>
<th>Initial assessment</th>
<th>6 month re-assessment</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu Vaccine</td>
<td>57%</td>
<td>61%</td>
<td>+4</td>
</tr>
<tr>
<td>Owns a Weight Scale</td>
<td>78%</td>
<td>87%</td>
<td>+9</td>
</tr>
<tr>
<td>Action Plan</td>
<td>23%</td>
<td>89%</td>
<td>+66</td>
</tr>
<tr>
<td>Know Blood Pressure</td>
<td>51%</td>
<td>58%</td>
<td>+7</td>
</tr>
<tr>
<td>Not a Current Smoker</td>
<td>90%</td>
<td>90%</td>
<td>0</td>
</tr>
<tr>
<td>Pneumonia Vaccine</td>
<td>35%</td>
<td>38%</td>
<td>+3</td>
</tr>
<tr>
<td>Own Glucose Monitor</td>
<td>99%</td>
<td>100%</td>
<td>+1</td>
</tr>
<tr>
<td>Know HbA1c Result</td>
<td>35%</td>
<td>35%</td>
<td>0</td>
</tr>
<tr>
<td>HbA1c Below 7</td>
<td>22%</td>
<td>25%</td>
<td>+3</td>
</tr>
<tr>
<td>Lipid Lowering Agent</td>
<td>53%</td>
<td>58%</td>
<td>+5</td>
</tr>
<tr>
<td>LDL Average</td>
<td>2.9</td>
<td>2.6</td>
<td>-0.3mmol/L</td>
</tr>
<tr>
<td>HbA1c Average</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>BMI Average</td>
<td>30.1</td>
<td>29.6</td>
<td>-0.5</td>
</tr>
<tr>
<td>Dilated Eye Exam</td>
<td>82%</td>
<td>89%</td>
<td>+7</td>
</tr>
<tr>
<td>Professional Foot Exam</td>
<td>75%</td>
<td>87%</td>
<td>+12</td>
</tr>
<tr>
<td>Blood Sugar Tested as per GP Instruction</td>
<td>55%</td>
<td>69%</td>
<td>+14</td>
</tr>
</tbody>
</table>
3. Telephone Coaching

A pilot telephone coaching program began in February 2006 with progressive enrolment of participants with chronic heart failure and type 2 diabetes. Referrals were sought from hospital records, physicians, GPs, allied health practitioners and Diabetes WA. Following informed consent, enrolled participants underwent an extensive self-report assessment across a number of disease-specific criteria, allowing for individual and cohort baseline data to be established.

Registered nurses experienced in chronic disease management offer telephone education, counselling and monitoring services to a total of 149 diabetic and 38 heart failure participants who live in, or who have a GP in the Naturaliste locality.

The program monitors behaviour against a series of benchmarks based on clinical evidence to achieve desired outcomes. Participants are encouraged to take an active role in managing their health and to stay in regular contact with their GP, whose advice and management regime is reinforced by the nurses.

In conjunction with the program nurse and GP, participants are encouraged to develop a ‘Stay Healthy Action Plan’. In turn, this plan can assist GPs to acquit a number of management and care planning items.

The tables below detail preliminary summary data from six-month re-assessments on both the heart failure and diabetes programs.

The telephone coaching program will run until 2008, at which time it will be reviewed and evaluated.

For more information about SW HealthyLink contact the program manager, Genevieve Stone ph: 9781 2352 email: genevieve.stone@health.wa.gov.au

### Table 2: Progress to date at six month re-assessment. Diabetes N=114

<table>
<thead>
<tr>
<th>Key indicator</th>
<th>Initial assessment</th>
<th>6 month re-assessment</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu Vaccine</td>
<td>100%</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>Owns a Weight Scale</td>
<td>88%</td>
<td>100%</td>
<td>+12</td>
</tr>
<tr>
<td>Beta Blocker Use</td>
<td>65%</td>
<td>65%</td>
<td>0</td>
</tr>
<tr>
<td>Written Action Plan</td>
<td>8%</td>
<td>77%</td>
<td>+69</td>
</tr>
<tr>
<td>Know Blood Pressure</td>
<td>62%</td>
<td>69%</td>
<td>+7</td>
</tr>
<tr>
<td>Weighs Self Daily</td>
<td>52%</td>
<td>76%</td>
<td>+24</td>
</tr>
<tr>
<td>Maintain Weight Log</td>
<td>43%</td>
<td>43%</td>
<td>0</td>
</tr>
<tr>
<td>Low Sodium Diet</td>
<td>54%</td>
<td>73%</td>
<td>+19</td>
</tr>
<tr>
<td>Read Food Labels For Sodium Content</td>
<td>46%</td>
<td>58%</td>
<td>+12</td>
</tr>
<tr>
<td>ACE/ARB</td>
<td>88%</td>
<td>77%</td>
<td>-11</td>
</tr>
<tr>
<td>Pneumonia Vaccine</td>
<td>81%</td>
<td>92%</td>
<td>+11</td>
</tr>
<tr>
<td>Systolic (90mmHg - 130mmHg)</td>
<td>89%</td>
<td>100%</td>
<td>+11</td>
</tr>
<tr>
<td>Diastolic (50mmHg - 80mmHg)</td>
<td>50%</td>
<td>72%</td>
<td>+22</td>
</tr>
<tr>
<td>Exercise 4+ Per Week</td>
<td>50%</td>
<td>69%</td>
<td>+19</td>
</tr>
<tr>
<td>Not Reporting Problems With Medications</td>
<td>54%</td>
<td>92%</td>
<td>+38</td>
</tr>
<tr>
<td>Method Other Than Memory For Medications</td>
<td>38%</td>
<td>65%</td>
<td>+27</td>
</tr>
<tr>
<td>BMI Average</td>
<td>27</td>
<td>26</td>
<td>-1</td>
</tr>
<tr>
<td>Total Cholesterol Average</td>
<td>3.9</td>
<td>3.5</td>
<td>-0.4mmol/L</td>
</tr>
<tr>
<td>LDL Average</td>
<td>2.6</td>
<td>1.8</td>
<td>-0.8mmol/L</td>
</tr>
</tbody>
</table>
A pilot project assisting general practitioners to initiate systems for diabetes management.

It has been demonstrated that having systems for diabetes care in general practice can improve risk factor status and reduce morbidity, mortality and hospitalisation. General practice staff often recognise the potential benefits of starting a diabetes register, clinics and recall systems, but barriers such as time and access to expert assistance and ongoing support make such a change difficult to achieve.

Three general practices in Perth are taking part in the pilot project. Alison Jones is a clinical nurse specialist and credentialed diabetes educator and works with staff at the practices to develop a diabetes register and recall system. All patients at the practices are offered an appointment with Alison for initial assessment and care planning. Home visits are offered if required and patients can be referred on to services such as the Healthy@Home Chronic Disease Management Teams (CDMT), Living with Diabetes Group, or a Home Medication Review. Practice nurses are assisted to start joint GP/practice nurse clinics for ongoing care including a diabetes protocol and clinic procedure template. The initiative emphasises cardiovascular risk reduction as well as glycaemic control - a noted limitation with some diabetes interventions. An outcome audit will be produced for each practice pre and post intervention. This will record percentages of patients diagnosed and their status regarding blood pressure, HbA1c, lipids, renal function, retinopathy screening, foot screening and smoking status.

Hospital discharge data indicates that diabetes related morbidity is an important factor in hospital admissions. Those patients with diabetes at highest risk of emergency admission are in the lower socio-economic groups who are likely to be less well informed, less engaged and less well managed in the ambulatory setting. This project uses a whole practice approach and actively engages all patients therefore making care accessible for those at highest risk.

This project delivers clear outcomes that support better patient education and increased engagement with GPs and practice nurses. Regular review and referral ensure long-term sustainability and most importantly, it facilitates best practice management of patients with diabetes in the community, thus preventing hospital admission.

Alison Jones, CNS, CDE, BSc (Hons), Ambulatory Care, NMHA. Ph 0433 899870 (references are available on request)

Practice nurse diabetes interest group

As part of the GP Pilot study, Alison Jones launched a diabetes interest group for practice nurses. Prior to immigrating to WA, Alison served on the North East Essex Forum (UK) for Diabetes, helping to organise multidisciplinary meetings on diabetes-related topics. This experience inspired her to embark on a similar initiative for WA.

Alison has worked collaboratively with Jane Butcher, the practice nurse support officer at GP Coastal Division, to get the group started. Funding for venue hire, catering and guest speakers was successfully applied for through the WAGP Network. Jane publicised the meetings through the GP Fax and phone calls to practice nurses. Two Clinical Nurse Education points are granted for each meeting attended.

The meetings will be held bi-monthly, with a different diabetes-related topic each time. Podiatrist Jo Dodds from the Chronic Disease Management Team presented ‘The Diabetic Foot’ at the first meeting.

There is good evidence about the positive benefits to diabetes patients who are seen regularly in a practice nurse assisted diabetes clinic in general practice. The practice nurse role can be isolating at times and the meetings will provide a valuable networking opportunity for practice nurses to meet and exchange ideas and the catering, organised by Jane, is very nice too!

All practice nurses are very welcome to attend - please phone Alison on 0433 899870 or Jane at GP Coastal on 9389 9144 ext 33 for further details.
Silver Chain - supporting people to get up and go again

Silver Chain began over 100 years ago as a small district nursing service. Today, they are one of the largest providers of community, residential and health services to the Western Australian community, assisting over 43,000 people each year.

Their mission ‘to assist people in need to live in the community’ is the foundation of all that they do. Whether you are 6 or 76, Silver Chain’s services can help you maintain or regain your independence, care for you at home or simply enhance your way of life.

Home Independence Program (HIP)
The Home Independence Program (HIP) can assist people aged over 65 years to improve their health and independence. The program encourages different approaches to tasks that have become difficult, preventing or delaying any loss in function.

Home exercise programs, community-based activities and education about healthy ageing are provided by an interdisciplinary team of health professionals and carers over a 12 week period at the client’s home.

Personal Enablement Program (PEP)
The Personal Enablement Program (PEP) assists clients to regain and boost their wellbeing after hospitalisation. PEP employs strategies such as task simplification, trialing aides and equipment, education on self-management for chronic health conditions and exercises to reduce or eliminate the need for ongoing services or readmission to hospital and prevent or delay functional decline.

PEP is provided in the home for up to eight weeks by an interdisciplinary team of health professionals and carers.

To make a referral to HIP or PEP ph: 9242 0347 or 1300 300 122.

hospital@home

The hospital@home program provides acute (short-term) care to people in the comfort of their home, when they would otherwise be in hospital. The program is provided to people living in the metropolitan area, 24 hours a day, seven days a week. Referral to the service may be due to:

- Cellulitis
- Deep vein thrombosis
- Urinary tract infection
- Kidney infection
- Pneumonia
- Or a condition that can be resolved in seven days.

A GP, doctor from an emergency department or medical specialist needs to make the referral. Medical governance is provided by a doctor from the hospital@home program or by the referring hospital specialists. Hospital@home nurses will provide the nursing care prescribed and additional care such as physiotherapy can be organised if requested by the doctor.

Supplies or equipment that are required whilst receiving services through the hospital@home program will be supplied, as well as medications or therapies administered by injection. There is no direct cost to the patient.

For more information about the hospital@home program call 9242 0257.

For more information about Silver Chain’s services, call 9242 0242 or 1300 650 803, 24 hours a day, seven days a week or visit www.silverchain.org.au

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