SHIRES

(Sutherland Health Improvement, Referral and Education Service):

Increasing clinical placements by introducing an interdisciplinary student led clinic for people with chronic disease.

Submitted by Meredith Pleffer
SHIRES Project Coordinator, 2014
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Patricia Bradd (Director of Allied Health, SESLHD) and later, on her behalf,
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Louise Quiggan (Southcare Community Respiratory Physiotherapist, Pulmonary Rehabilitation Coordinator)

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Executive Summary

The South Eastern Sydney Local Health District (SESLHD) has an estimated population of 838,416; and this is projected to increase by more than 5.08% over the next decade. There are also significant differences in health status and life expectancy between different population groups across the District. The SESLHD Health Care Services Plan 2012-2017 provides direction for the development of services and programs to ensure the health needs of our communities are met. This includes a wide range of population health programs and chronic disease services (including diabetes, heart disease and cancer) which challenge existing resources and place increasing and unsustainable pressure on our health services.

Chronic disease management is a key feature of the strategic plan for the SESLHD, as it is well understood that the number of people living with chronic disease is on the rise with approximately one in three of our residents having at least one chronic disease. As the population ages, the number of people with chronic conditions and multi-morbidities can be expected to rise. It is vital that when addressing chronic disease management the focus must be person centered and directed by the individual who may be suffering from several chronic conditions.

The Sutherland Health Improvement, Referral and Education Service (SHIRES) was funded by the Interdisciplinary Clinical Training Network, under the Health Education Training Institute. It is a collaborative venture between Sutherland Hospital, the University of Sydney and Macquarie University. The purpose of the clinic was to assist clients to identify their health issues and design a Personal Health Improvement Plan, provide referrals to appropriate community based activity/exercise or health professionals, and provide education for lifestyle issues impacting on health. It was envisaged that this approach may prevent future hospital admissions or readmissions for people with risk factors or who currently have chronic disease.

The goal of this project was multifaceted; to establish a primary care clinic, which addressed a service delivery gap in Chronic Disease Management in the Sutherland community; while also providing an innovative, inter-professional clinical placement for senior allied health professional students, which would assist in preparing them for the changing demands of the future health workforce. The participating students were drawn from Physiotherapy, Occupational Therapy and Exercise Physiology disciplines.

Client outcomes and feedback indicates that the SHIRES model of care has been successful with a high retention of clients, substantial achievement of goals and actioning of self-directed health plans. Clients have readily engaged with the program demonstrating commitment to the process of identifying their health issues and taking appropriate actions. This model of care has also shown the potential to be an effective, low cost method for the provision of high volume, low risk client centred community based care.

Students report positive learning experiences and improved understanding of inter-professional learning. The majority of students (75%) felt that the clinic experience had been useful to their future professional development and were satisfied with the level of clinical knowledge they have gained through participation in the project.

Jason Phillips

Head of Department, Physiotherapy

Clinical Lead, Allied Health Department, The Sutherland Hospital
PART 1: INTRODUCTION

1.1 Background

The SHIRES clinic is Stage Three of a project which began at the beginning of last year with ICTN funding. There has been a collaborative effort between The Sutherland Hospital (SESLHD), University of Sydney, and Macquarie University since the beginning of Stage One until now. The main purpose of the project was to establish a student led clinic with senior health professional students working with clients, with or at risk of chronic disease.

Stage One involved the development of a proposed Model of Care, purchase of resources and refurbishment of clinic spaces. Stage Two of the project was a 4 week trial in September last year in which 4 senior students (2x PT and 2xOT) from University of Sydney participated under the supervision of the present Project Coordinator for Stage Three. The outcomes of the pilot drove the many changes which were made to the Model of Care for Stage Three of the project, which became known as the SHIRES clinic.

The SHIRES clinic has run for 20 weeks in the second half of this year. By closure of the clinic for the year on Friday 5th December, there will have been 16 senior students from three Allied Health disciplines who have passed through the programme. The many skills of the student workforce with a “little help” from the Project Coordinator have created a unique service.

1.2 The Strategic Plan for SESLHD

The SESLHD has a strategic plan for the next 5 years in which there has been the recognition of an increase in demand for services. The strategic plan states “the projected increase in demand for health services is only partially driven by population growth. Other factors include more people with chronic conditions, continuing increases in day only activity, additional older patients often with co-morbidities requiring a longer length of stay” (Health Care Services Plan, 2013).

Helping people to avoid hospital admissions requires a number of strategies. The focus, according to the plan must be towards ambulatory and primary care settings (Health Care Services Plan, 2013). Particularly there should be an emphasis on “integration between hospital and primary and community based services as well as “health promotion, protection and disease prevention programs and services … to maintain community health and wellbeing” (Health Care Services Plan, 2013).

According to the Strategic plan there are a number of high priority initiatives including development and funding of chronic care services in conjunction with Medicare Local and securing “a well-trained and appropriate workforce for the future through the ongoing provision of targeted education and training opportunities” (Health Care Services Plan, 2013).
1.3 Inter-professional Clinical Education

An important aspect of training the future workforce is the involvement of students in inter-professional learning. Having students of a variety of health professions learning and working together has been strongly advocated by the World Health Organisation’s “Framework for Action on Inter-professional Collaborative Practice” (Framework for Action on Interprofessional Collaborative Practice, 2013). The argument is that preparing students for collaborative practice by training them inter-professionally will prepare them for working in healthcare teams; where a better understanding of each others’ skills and sharing case management will lead to better services and better health outcomes. According to the World Health Organisation, health and education systems must work collaboratively to coordinate health workforce strategies (WHO, 2013).

The SHIRES project is an example of this collaborative approach to training the future health workforce.

1.4 Primary Care in the Acute Hospital Setting

There are several unique aspects to the SHIRES clinic which are challenging. The concept of inter-professional learning as an important part of student training, is still new to many health professionals working in the hospital setting. Health professional staff work together in multidisciplinary teams on the wards or in outpatient clinics, but do not work “inter-professionally”. Generally each profession works with the patient to assess and provide treatment or intervention individually; but there is close communication between the team members about the patient’s progress or problems; and a team approach to discharge planning often occurs, or when involving clients in outpatient clinics or programmes.

The other aspect of the SHIRES clinic is its focus on primary care i.e. health improvement, referral and education. The particular methodology which was chosen was based on the Health Change Australia (Health Change Australia, 2013) approach. Training in the HCA approach has been offered to health professional staff within the SESLHD, but up to date, only a few staff within the TSH Allied Health department have done the training.

The Model of Care proposed for the SHIRES clinic was new to students as well. It involves team members using the same Health Management Checklist or initial interview tool to work with the client on helping them identify their health issues. Students work in inter-professional pairs to talk with the client. One student takes the lead and the other is the scribe. Students then debrief together about the clients’ story, and through this process, they learn about each others’ particular skill sets, perspectives and knowledge base. When the students meet again with the client they ask and then offer to work with the client on their Personal Health Improvement Plan. The client’s health issues are written in terms of health goals on the plan. The students and the client discuss ideas on how to work towards their larger health goals. Action plans with small achievable goals are developed, with the students researching options for the client and presenting some of them at a follow up session.
Time to practice the different communication style and to become familiar with the Health Management tool is part of the Orientation for the students at the beginning of their placement.

1.5 The Patient Activation Measure (PAM)

At the beginning of a client’s involvement in the SHIRES clinic they are asked to complete the PAM questionnaire. Signed consent is always requested and obtained before proceeding further. After the PAM questionnaire is completed, clients are given a raw score which is then converted into one of four levels: Level One, Two, Three, or Four. A PAM score at Level One represents low patient activation whilst Level Four represents a high level of patient activation.

The PAM (Patient Activation Measure) (Hibbard, Stockard, Mahoney, & Tusler, 2004) was developed as a way of measuring a client’s level of “self-reported knowledge, skill and confidence” (Hibbard, Mahoney, Stockard, & Tusler, 2005) for self-management of their health. In more recent studies, there is evidence to suggest that clients with higher PAM scores are more likely to have better health outcomes (Hibbard & Greene, 2013). According to Hibbard and Greene (2013), interventions which increase activation levels for clients include: “skill development, problem solving and peer support”, or “changing the social environment” or “tailoring the support to the patient’s activation level” or a combination of these.

Further research on how to activate clients at low levels of the PAM have been suggested as these people are less likely to be involved in programmes. This was certainly the case with the one client in SHIRES clinic with a PAM score of Level One. SHIRES clients at Level Two, Three and Four were involved in the process of change however, there were differences in the percentage of goals achieved. Changes of PAM scores overtime with SHIRES clients would be an interesting area for further research.

1.6 CAHP, The Capricornia Project: A guide to setting up SHIRES

An important resource for the Project Coordinator in the preparation phase of the project was the” tool kit” found in the CAHP manual. This provided the Project Coordinator with step by step suggestions on how to plan the clinic. Although the student assisted led clinic which is run in Queensland uses a very different Model of Care, the multiple factors which needed to be taken into account with the SHIRES clinic were very similar in the preparation phase. The Project Coordinator was very grateful to find others who had gone before in this process (Miller, Davies, Swanston, Frakes, & Brownie, 2011).
Part 2: Implementation of the SHIRES Clinic

Development and extension of the Model of Care for the Inter-Professional Student Led Clinic

2.1 Establishment of the Steering Committee

The project coordinator approached people who had been involved in Stage 1 and 2 of the project to become members of the steering committee. These people wore a number of “hats” during Stage 3 of the project, providing consultation, information, involvement and collaboration. Jason Phillips was clinical lead for the project, providing direction, advice and critical feedback to the coordinator. He was the liaison with Physiotherapy managers in the hospital and in Southcare; as well as chairperson for the steering committee meetings. Sharryn Fitzgerald provided weekly supervision sessions with the coordinator; providing guidance, expertise and emotional support; tutoring and support to students; liaison with Jason; and she was minute taker for the steering committee meetings. Dr Gillian Nisbet from University of Sydney was the direct liaison person to WIL regarding any issues with students, university course-related issues and placements. She also provided group mentorship to the coordinator and other discipline specific supervisors; as well as coordinating a briefing session with the coordinator and students before each group began their placement in the SHIRES clinic. Linda Soars, Tom Chapman and Margo Green, who have worked in Chronic Care Management for many years, provided the committee and the coordinator with a deeper understanding of the direction of Chronic Disease Management within the SESLHD and NSW; and they also provided teaching sessions for the various groups of students who moved through the programme. The Chronic Care team members also informed the coordinator of events, and included the coordinator and the SHIRES team in workshops and other activities in which the Chronic Care team were involved.

Terms of Reference for the SHIRES steering committee were defined and agreed upon in the first meetings (see Appendix 1). A detailed communication plan was also developed and acted upon throughout the project; as recommended by the Capricornia report (Miller, Davies, Swanston, Frakes, & Brownie, 2011) (see Appendix 2).

The “SHIRES” acronym (Sutherland Health Improvement, Referral and Education Service) was proposed by the project coordinator, and accepted by the steering committee, as a marketable name for the clinic. This was instead of “The Sutherland Chronic Care Student Led Clinic”, which had been used in Stage 1 in all written material. The name had already been shortened to the Student Led Clinic or SLC by Stage 2. The SHIRES acronym was a helpful aid in explaining the focus of the clinic to students, clients and staff. It helped students to introduce the clinic to clients at the beginning of their Initial Interview.

2.1.1 Development of the TSH Chronic Disease Service Framework

The NSW Agency for Clinical Innovation (ACI) has published the “NSW Chronic Disease Management Program-Connecting Care in the Community Service Model 2013 (ACI Chronic Care Team, 2013). This service model has offered the “core elements and principles that
underpin CDMP” (ACI Chronic Care Team, 2013, p. 1). This service model does not “describe local operational models in NSW” (ACI Chronic Care Team, 2013). Since the clinic was operating out of the acute hospital setting, it was important to understand the approach which was being taken state-wide towards chronic disease management, but also to understand how the clinic, operating out of The Sutherland Hospital might meet a gap in the local operational service model.

After consultation with Tom Chapman and Linda Soars and other members of the Chronic Care Team, the coordinator developed a framework to assist students and staff to understand the “gap in service” which the SHIRES clinic was aiming to fill (see Diagram 2.1.1 below).

Diagram 2.1.1

The Chronic Disease Management Program (CDMP) service model strongly recommends that integration of care across all services and settings (primary, secondary and tertiary care) is required to ensure that people with chronic disease(s) do not fall through the gaps. It warns that unless integration occurs, people with chronic disease(s) will continue to be admitted to their local hospital for “potentially preventable hospitalisations” (ACI Chronic Care Team, 2013).

The person with a chronic disease(s) will have individual needs related to where they are on the continuum from early/newly diagnosed to end stage of that disease(s) (right to left on the framework). This will also be influenced by many other factors, particularly how well the person manages their health. People may have chronic disease, but through careful
management of their condition, (often with family or carer and community support, such as
good relationships with specialists and their GP), as well as a healthy lifestyle, they may
move down the continuum and lessen their risk of admission to hospital.

Across St. George and Sutherland Hospitals, people who are at very high risk of admission
to hospital are targeted for the Connecting Care Program. Each month through the ARC
(Access and Referral Centre), reports are generated from which these people are identified.
They will have had at least 3 admissions to hospital in the last year. They are offered support
through a Connecting Care Coordinator who visits them in their homes and assists them to
access the support they need in the community. These are the Group 3 people in the
framework.

People who come into hospital for their first presentation related to a chronic disease are
also targeted as being at high risk of readmission. They will be offered specialised
programmes such as SHARCS (Cardiac Rehab) or RCCP (Respiratory Chronic Care
Programme) where they receive assessment and a tailored exercise gym programme, plus
education sessions over 8-12 weeks.

The Group 1 people on the framework are people with or at risk of chronic disease that have
never had an admission to hospital related to a chronic disease. According to the ACI report
this latter group represent 70-80% of people with a chronic condition (ACI Chronic Care
Team, 2013). This group are ideally the people the SHIRES clinic will target. They are at low
risk of admission to hospital and they represent a high proportion of people with a chronic
disease.

2.1.2 Proposed Model of Care for SHIRES Clinic

The model of care for the SHIRES clinic was based on the findings of the Stage 2 pilot, in
which the original pathway was trialled. Although client recruitment has changed in Stage 3
steps in the pathway itself are similar. Main inclusion criteria have also been expanded to
encourage anyone who is interested in improving their health.

Inclusion criteria for SHIRES clinic is now:

a) A person interested in thinking about improving their health
b) A person who may have chronic disease(s) or be at risk of Chronic Disease
c) A person who is well and living at home
d) A person who may have attended clinics within the hospital and received
   recommendations from health professionals and is seeking support to follow their
   advice
e) A person over 16 years of age
Exclusion criteria for SHIRES clinic is now:

a) A person who is an inpatient in hospital
b) A person who is acutely unwell
c) A person who lives in a Residential Care Facility
d) A person who is currently attending an Outpatient programme which has an ongoing education component to it (e.g. SHARCS, Mobility clinic, Stepping On, RCCP or Pulmonary Rehab)

The main addition to the model of care is the use of the HCA (Health Change Australia) (Health Change Australia, 2013) approach within the Initial Interview session and subsequent sessions with the client. Students work in interdisciplinary pairs, with one student taking the lead in the interview and the other taking the role as scribe. The lead student builds rapport and trust through a relaxed conversational style of discussion. A therapeutic relationship is built with the client, using a client centred approach. Students do not tell the client what to do, but work with the client on identifying their health issues. If the client agrees, their health issues are written on a Personal Health Improvement Plan and the client is invited to prioritise them in order of importance to them. If the client says they wish to explore their options for making some health changes, possible options for making some changes are discussed. What the client has found helped in the past for a particular issue, what they have thought about doing, or might be interested in trying, are discussed. If the client is already making some changes, these are also noted on the plan.

The students research and discuss options for change with each other and then with the Coordinator. It is during the “debriefing” and collaboration with each other that students learn about each other’s roles and knowledge base. The possible plan is presented to the team during a case conference. Options may include provision of education material, referral to another health professional or service, referral back to the GP or simple steps such as reading a pamphlet, going for a walk to the mailbox, visiting my GP. These options are discussed in the first follow up with the client and again, if the client is committed to making a change, Action Plans with small goals are developed with the client. The client then decides if they want to come back for another follow up session or whether they would prefer a phone follow up, and they also specify the timeframe e.g. 1 week, 2 weeks etc.

In follow up sessions Action Plans are discussed and goals which have been achieved are ticked off. Further goals are added or new health issues addressed through the same process of developing Action Plans and discussion.

A Letter of Notification of Service Provision is sent to the GP after the first follow up session and a Discharge Letter is sent to the GP upon discharge from being an “active client”. This means the client has either decided to discharge themselves from the service or they have attained all their goals and do not need or want the close support they have had from the clinic (see the revised SHIRES Clinical Pathway below).

In Stage 3 of the project it was proposed that clients would be recruited from outside the hospital through GP referral.
SHIRES CLINICAL PATHWAY

Client recruited or referred to clinic
- Client meets inclusion criteria for clinic
- Client consent is obtained
- Students are encouraged to read the client’s medical record to obtain as much information as they can before the interview

Initial Interview with Client
- Client is interviewed by two students of different health disciplines (one interviews, one scribes and Coordinator supervises session)
- Standard Initial Interview tool is used as a guide to exploring client’s health management. Health issues may be identified with the client in this session
- Students document the session

Debrief with student colleague
- Students discuss the session with each other and provide peer feedback
- Students discuss the client and possible options, areas for research with Coordinator
- Students will have the opportunity to self reflect and improve their understanding of the roles of other health disciplines

Student Research and collaboration with student colleague on possible options for plan
- Students work together to investigate options for the client to meet their Personal Health Improvement goals. They may research using the internet for information regarding clinical guidelines, medication, information regarding the clients’ condition or for local groups and activities. They may use the Resource folder the team has been compiling.
- Students will present their ideas to the Coordinator and document any emails, keeping copies in the file if information is sent to the client
- Students keep in mind that these are ideas for options only. The client will decide if any of these will work for them

Team Case Conference
- Team discussion involving all students and clinical supervisor
- Students present their cases and their possible action plans with team or the outcomes of further follow up sessions with clients

Follow up appointment with client and possible Personal Health Improvement Plan developed
- Health issues are identified and prioritised with the client in their order of importance
- Discussion occurs for each health issue and possible options for change
- Action plan(s) with small stepped goals for each health issue are discussed with the client
- Action plans may include referral to community programs and external health care providers
- The client keeps a copy of the plans

Ongoing support via follow up appointments face to face or by phone or email
- Clients are encouraged to show their GP their plans and discuss any changes they are hoping to make.
- Students send a Letter of Notification of Service Provision to the GP after the first follow up session
- Students send a Discharge letter summarising the clients’ achievements and further goals to the GP on discharge from the clinic
- Clients will be followed up at 3, 6 and 12 months
2.2 Project Plan

A detailed plan was developed and a timeline for the plan was produced with key milestones established (see Appendix 3).

A vision statement and objectives to meet the vision were determined. The objectives were matched to KPIs. The project plan was reviewed to ensure that the expected deliverables could be provided to the funding body at the end of the project. Please see the table below for details of the vision, objectives and KPIs.

2.2.1 Vision Statement

<table>
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<th>VISION STATEMENT:</th>
<th>OBJECTIVES</th>
<th>KPIs</th>
<th>Outcome Measures</th>
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<td>To establish a primary care clinic which addresses a service delivery gap in Chronic Disease Management in the Sutherland community and to provide an innovative, interdisciplinary clinical placement for senior health professional students</td>
<td>1. To provide the community of Sutherland Shire with excellent interprofessional client-centred care supporting people with or at risk of chronic disease</td>
<td>1.1 Demographic information of clients shows the group is representative of the wider population with or at risk of chronic disease, in Sutherland Shire</td>
<td>1.1 Rationale: Clients seeking to improve their health by coming to SHIRES will be at risk of, or have chronic disease. Older clients will tend to have more chronic diseases than younger clients as “estimated in the SESLHD resident population with co-morbidity” data. (CDM study) Measures: Breakdown of age and medical conditions or health issues of clients and co-morbidities provides evidence to support above.</td>
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1.2 Majority of clients report positive experiences through written and video feedback

1.2 Rationale: If students have been providing excellent client-centred care, feedback from clients will support this. Students are trained to use a client-centred approach in the SHIRES clinic (HCA approach).

Measures:
(a) Client will score “strongly agree” or “agree” to the question “I am satisfied with the service provided to me by the clinic today”
(b) Clients written comments will support the proposition above
(c) Client video response will reflect positive experiences of “client-centred care” in the clinic

2 To deliver a model of care which supports client identification and prioritisation of health issues and facilitates client goal setting and personal health improvement planning

- Clinical documentation aligns with Model of Care and provides consistent data collection across all clients.
- Documentation tools are used in all clients’ files (Health Management Checklist, Personal Health Improvement Plan, Action Plans, Letter of Notification of Service Provision, Discharge Letter to GP, Feedback questionnaire)

2. Rationale: If the Model of Care is to facilitate clients to be self-activating and improving their health management, then there will be evidence of this process in the clients’ files.

Measures: The designated tools and progress notes will be present in each client’s file and will provide evidence that this process is taking place with all clients who choose to commit to it.
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<th>3.</th>
<th>To consider local community needs, priorities and engagement in the design and sustainability of the clinic</th>
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<td>o Integration of clients by referrals from the clinic to community services occurs regularly</td>
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<tr>
<td>o Referrals to the clinic will continue over the programme and come from a variety of sources</td>
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<td>o Feedback from referral sources is positive regarding the clinic</td>
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**Rationale:** If the SHIRES clinic is meeting the needs of the community and engaging with the community, clients will stay in the programme and there will be evidence of integration of clients into community services and groups. There will also be referrals to the clinic from the community or other services.

**Measures:**
(a) Over 50% of clients will engage in the process of health change over the programme
(b) Breakdown of referrals to the clinic will show a variety of sources and may include referrals from GPs
(c) Breakdown of referrals from the clinic will be to a variety of different services, health providers and groups in the community

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<th>4</th>
<th>To ensure a high standard of patient care through continually monitoring outcomes (both client and service outcomes), ensuring continuum of care, and engaging in quality improvement strategies</th>
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<tr>
<td>o Majority of clients achieve positive clinical outcomes</td>
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<tr>
<td>o Clients demonstrate they are achieving their goals</td>
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<tr>
<td>o Clients action referrals from the clinic to other services as part of their Action Plans</td>
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<tr>
<td>o Clients engage in the programme and are willing to continue until completion</td>
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**Rationale:** If the process used in the Model of Care is successful, then most clients will achieve positive outcomes by achieving their goals and actioning referrals (in action plans). They will engage in the programme and continue until they have reached their goals.

**Measures:**
(a) All clients who are engaged or have been engaged in the programme will achieve > 50% goals
(b) 80% of clients report they are actioning referrals from the clinic to other services as part of their Action plans
(c) Client retention rate is high (> 75%)
(d) Clients will be handed over no more than 3 times in the clinic
(e) Engage in QI projects throughout the 20 week programme
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| 5. To demonstrate efficient, effective use of information technology to support best practice and ongoing clinical research |   | 5. **Rationale:** Students will record the time spent in face to face sessions and other client related activities. A good proportion of their time, other than face to face with clients will be spent on research for the client.  

**Measures:**  
(a) Breakdown of **OOS** into type and over time will show highest number of OOS in face to face and research for all clients  
(b) Breakdown of **time spent** in type of OOS will indicate face to face and research takes high proportion of students’ clinical time  
(c) All students will be given access to EMR and will have access to the T-drive and internet |
|   | Accurate data collection through Cerner reflects an appropriate number of Occasions of Service for case planning (research for client/student education purposes and to provide options for engagement in community activities)  
| Students have access to EMR for the purpose of gathering background medical history of clients  
| Students have access to CIAP, T-drive and Intranet for research purpose |
| 6. To provide an inter-professional clinical placement to student health professionals which prepares them for the changing demands of the future health workforce |   | 6. **Rationale:** Students will report they have had positive learning experiences from being part of SHIRES and may shift their views on inter-professional Learning after being involved in the SHIRES clinic.  

**Measures:**  
(a) Pre and post measures of the RIPLS (Readiness for Inter-Professional Learning) Scale show positive change  
(b) Students written comments in their feedback questionnaires will be mainly positive and there may be a shift in a positive direction on their scores on the RIPLS after the clinic placement. |
|   | Students show a positive attitude towards Inter-professional learning (according to RIPLS written comments and scores)  
| Student written feedback is positive about their experiences in the clinic |
7. To be a key partner with the Chronic Care Team (CCT)

<p>| | |</p>
<table>
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</table>
|   | CCT members sit on the steering committee and provide ongoing updates regarding future developments in Chronic Disease Management in the LHD.  
  |   | CCT members provide education to students and facilitate coordinator and student involvement in functions of the CCT and assist in the evaluation process of the project.  
|

**Rationale:** The SHIRES clinic is involved in providing a service to people with or at risk of chronic disease. Health Improvement, Referral and Education are the main activities of the clinic. As such there must be close liaison with CCT who provide direction and governance in the LHD for CD services. Their understanding of health change and the need for integration of people into community based services and activities to improve their health, will be the driver for sustaining the clinic and developing it further.

**Measure:**

(a) There will be involvement of the CD team at all levels of the clinic (i.e. Steering Committee membership, Student Education and provision of support, information and direction to the Project Coordinator throughout the programme).

(b) CCT will take a significant role in the sustainability plan for the SHIRES clinic.
2.2.2 Evaluation Plan

Various outcome measures had been proposed in Stage 1 of the project. There was much discussion around “Objective Measures”. Considering the outcomes of Stage 2 and the Model of Care to be used in the clinic, it was decided that the “Objective Measures” would not be routinely taken/recorded unless the client themselves had goals related to changing a particular measure and the client themselves requested the measure to be taken. A related rationale was that a client who was working on changing a particular measure may well choose to begin working with a service, gym or trainer who would encourage and wish to take these measures in the course of their assessment. The measures were considered to be intrusive and likely to hinder building rapport, trust and the client-centred, client controlled, client choice, focus of the interactions between the client and the student health professional.

Please see below for the outcome measures, data and data source for the 4 areas of interest for Stage 3 of the clinic: client, student, and supervisor and service outcomes.

<table>
<thead>
<tr>
<th>OUTCOME MEASURES</th>
<th>DATA AND SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client outcomes</strong></td>
<td>Demographic information from client interview and/or EMR regarding:</td>
</tr>
<tr>
<td></td>
<td>1. Client medical conditions</td>
</tr>
<tr>
<td></td>
<td>2. Client Comorbidities</td>
</tr>
<tr>
<td></td>
<td>3. Ages of clients</td>
</tr>
<tr>
<td></td>
<td>Audit of client files regarding:</td>
</tr>
<tr>
<td></td>
<td>1. Consistent use of designated tools, GP letters, client feedback and progress notes present</td>
</tr>
<tr>
<td></td>
<td>Information about client’s progress from client files and database:</td>
</tr>
<tr>
<td></td>
<td>1. Identified Health Improvement goals of clients on Personal Health Improvement Plans</td>
</tr>
<tr>
<td></td>
<td>2. Number of Client Action plan goals</td>
</tr>
<tr>
<td></td>
<td>3. Number of client goals achieved</td>
</tr>
<tr>
<td></td>
<td>4. % goals achieved expressed as % number of achieved goals/total goals</td>
</tr>
<tr>
<td></td>
<td>5. PAM scores of clients matched to goals achieved</td>
</tr>
<tr>
<td></td>
<td>6. Number of referrals made to other services</td>
</tr>
<tr>
<td></td>
<td>7. Number of actioned referrals to other services by clients</td>
</tr>
<tr>
<td></td>
<td>Information about trends from Cerner:</td>
</tr>
<tr>
<td></td>
<td>1. Trends of number of face to face consultations for clients</td>
</tr>
<tr>
<td></td>
<td>2. Trends of length of stay in programme for clients</td>
</tr>
<tr>
<td></td>
<td>Information from client survey and video interviews regarding:</td>
</tr>
<tr>
<td></td>
<td>1. Client satisfaction and feedback</td>
</tr>
<tr>
<td></td>
<td>2. Testimonials from videos</td>
</tr>
</tbody>
</table>
### Student outcomes

1. RIPLS pre and post scores from all students (McFadyen, Webster, & Maclaren, 2006)
2. Midway and Final ICAT assessments performed with all students
3. Student Feedback forms
4. Student testimonials

### Supervisor outcomes

1. Supervisor feedback forms
2. Supervisor testimonials
3. Chronic Care Team feedback

### Service outcomes

Information from client data base regarding:
1. Percentage breakdown of referrals sources to the clinic
2. Numbers of client referrals
3. Numbers of clients in the programme
4. % breakdown of referrals from the clinic
5. Also see “Trends” In Client outcomes

Information from Cerner regarding:
1. Referral trends over time
2. Trends of Client face to face contact
3. OOS type
4. Time in minutes for types of OOS
5. Client numbers and trends over programme

Information from client files regarding:
1. Continuum of Care

### 2.2.3 Project budget

<table>
<thead>
<tr>
<th>Expenditure Direct Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project coordinator</strong></td>
</tr>
<tr>
<td>Level 4 Health Professional (1.0 FTE for 36 weeks – anticipated 24\textsuperscript{th} March 2014 to 30\textsuperscript{th} November 2014 @ $94,134 p.a. plus on costs)</td>
</tr>
<tr>
<td>$76,721</td>
</tr>
<tr>
<td><strong>Administrative including PC costs, access to workstation, phone, electricity</strong></td>
</tr>
<tr>
<td>In-kind SESLHD</td>
</tr>
<tr>
<td><strong>Project support – Education facilities</strong></td>
</tr>
<tr>
<td>In-kind</td>
</tr>
</tbody>
</table>

**Payment Schedule:**

An initial amount of half the project funding was provided to the SESLHD in order to enable the creation of a new position and to assist with recruitment of the Project Coordinator. The second trench of funds was provided at the mid-point of the project, after the Progress Report was submitted showing satisfactory execution of the project deliverables.
Part 3: The SHIRES Clinic Pilot: The 20 week programme

3.1 Preparation Phase for the SHIRES Clinic

3.1.1 Working Parties

Three groups of people were approached to be involved in the planning phase of the clinic. They were the Chronic Care Team, the “Killara group” and the Clinical Academics from the Allied Health professions, which were likely to be involved in the Pilot, from University of Sydney and Macquarie University.

The Project Coordinator had several meetings with the Chronic Care team members at various times before the clinic began and over the course of the project. Discussion around the gap in the service, the Model of Care, the inclusion of the HCA approach within the Model of Care and outcome measures and analysis were topics for discussion.

The “Killara group” were representatives from the various teams who use the gym and clinic rooms at the back of the Killara ward. Their outpatient services related to the SHIRES clinic and they were to be sharing the clinic spaces with the clinic so it was a matter of courtesy and need for consultation with experts which was the driver for the Project Coordinator to meet. Various ideas and ways to solve issues were discussed and most operational barriers were addressed by the start of the clinic including clinic room bookings and key access to the area (see Part 3.1.6 below).

Before the clinic began, a meeting occurred with the Clinical Academics from the disciplines of Exercise Physiology, Occupational Therapy and Physiotherapy, including Dr Gillian Nisbet (Associate Dean Lindy McAllister’s representative on the steering committee). Discussion occurred around such topics as: the learning opportunities available, likelihood of clients being recruited and enough client-student involvement, the Model of Care to be used and relevance to each discipline; as well as the requirements for discipline specific assessment and achievement of competencies.

Phone call contact was made with Macquarie University several times but it was not possible to organise students from Macquarie to be involved in the clinic this year.

3.1.2 Schedule of Interdisciplinary Student Placements

There was capacity to have 16 students over the SHIRES clinic in the 20 week programme. The Project Coordinator was able to develop the Schedule of Student Placements (2014) by consulting the individual calendars for the 3 disciplines involved in the programme, as well as by cross-checking with the Inter-professional Calendar for the year (see Appendix 4). Block placements for all 3 disciplines for senior students occurred over the 20 week programme. By delaying the Occupational Therapy Fieldwork 4 placement by one week, it was possible to start the clinic with a team of two Occupational Therapy GEM students and two Physiotherapy 3rd year students. (Only 3rd year Physiotherapy students were able to be
involved in the programme as the placement could be classed as their “community” placement. In the present UG course at University of Sydney, other Physiotherapy undergraduate years do not have the community placement option).

The breakdown of student numbers from the 3 disciplines involved in the project is shown in Table 3.1.2 below.

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Number of Students</th>
<th>Number and length of placement blocks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise Physiology</td>
<td>4 (2x2 students)</td>
<td>2x5 weeks</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>4 (2x2 students)</td>
<td>2x8 weeks</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>8 (4x2 students)</td>
<td>4x5 weeks</td>
</tr>
</tbody>
</table>

Table 3.1.2

3.1.3 Promotion

Various strategies were undertaken to promote the clinic, to inform staff and recruit clients. The Project Coordinator met with staff who were involved in promotion within the hospital such as Wendy Fyfe (Public Relations Manager) and Janice Oliver (Carer Support Program Manager). Meetings with staff who were already involved in Outpatient Allied Health services were also conducted to discuss links to these services and to learn how they had promoted their service. Meetings with Medicare Local occurred to discuss how to connect with GPs. Meetings with the Chronic Care team also involved discussions around promoting the clinic.

The Project Coordinator also presented the SHIRES clinic twice at the Allied Health Forum and at Allied Health staff meetings and OT Day in OT week; as well as at the Fieldwork Educators Interest Group (FEIG) forum.

A SHIRES flyer was designed by the Project Coordinator’s son and a leaflet was also developed based on the acronym for SHIRES to explain the clinic to potential clients. The wording of the leaflet was checked against an online “grammar level” programme. Janice Oliver, who is the Manager of the Carers Support Programme in the LHD, explained that the level of advertising and pamphlets should be at 5th grade, easily readable by a child of 9-10 years of age (Text Readability Consensus Tool, 2014). The flyer and leaflet were sent to the Local Community Advisory Group (SESLHD) via Wendy Fyfe to have their approval.

To assist in promotion and marketing, a logo was also developed for the clinic. This was used on the flyer, documentation in files, letters to GPs and in presentations. It was also on posters around the Allied Health Department (see Appendix 5).
3.1.4 Patient Recruitment Drive

Beginning the clinic with a client waiting list was seen as imperative to the success of Stage 3 of the project. This was achieved by the Project Coordinator approaching the Volunteer Manager, Linda Vari, regarding whether hospital volunteers would be interested in “volunteering” for the clinic. The Project Coordinator was invited to speak briefly at a number of small meetings for the various groups of volunteers and a short power point was presented. After speaking at 5 volunteer meetings, 11 volunteers had kindly agreed to attend the clinic.

The Communication Plan (Appendix 2) outlines the various people who were consulted and assisted the Project Coordinator in promoting the clinic. The flyer and leaflets were distributed at all community meetings and the Open Day, NAIDOC week celebration and other events. Discussions with Medicare Local took place around how to approach GPs to refer to the clinic.

Patient recruitment was an ongoing theme running throughout the programme. The Quality Improvement Projects conducted by the PT students as a requirement for their Professional Practice Unit of Study often addressed this issue in some way (see Appendix 6).

3.1.5 Review of Spaces

The Killara group assisted the Project Coordinator to gain access to the booking system for the Killara clinic rooms and also pre-booked these rooms for use by the SHIRES clinic every afternoon on the days the clinic operated. The clinic rooms were available from 1.00pm on these days. For morning appointments, the students were able to use the OT Treatment room, working around the Upper Limb group twice a week, a Speech Therapy outpatient group and staff meetings and in-services. The morning appointments challenged the students to find empty managers’ offices or the Dietician clinic room was sometimes available. Most clients wanted morning appointments.

The office space which had been refurbished for the SHIRES students last year was used this year. The office desks allowed for 6 students to sit in the space. This year the Project Coordinator was able to arrange laptop desk locks for the original laptops provided to the clinic, so that during the day the laptops were secured to the desks.

3.1.6 Review of Resources

A number of resources had been purchased during Stage 1 of the project and had yet to be utilised. They were gathered together and a lockable cupboard was found for them in Allied Health. The list of resources and the usage throughout the clinic is listed in Appendix 7.

The Chronic Care Team provided two digital audio recorders which were indispensable to the students. They also uploaded 2 of the 8 iPads with education material to use with clients. This was part of another study they were conducting.
Prior to the clinic, most of the barriers involving resources were overcome. A list of Operational Components (see Appendix 8) which needed to be addressed from Stage Two was made and the Project Coordinator worked through these with the Killara Group. Various strategies were suggested. By the time the first students started at SHIRES the rooms and availability, days of the clinic, reception staff, access to rooms, appointment bookings, equipment to be used, measures to be taken, EMR access, swipes and logins, client files, storage of files, storage of equipment and a PC from Killara clinic rooms for the Project Coordinator had been organised.

3.1.7 Teaching Plan

The Project Coordinator prepared a Teaching Plan prior to the clinic (see Appendix 9). This was presented to the Clinical Educators Working Party at a meeting at the University. The purpose of the Teaching Plan was to address the issues which had arisen during Stage 2 with students regarding assessment and the need for better preparation; and to dispel concerns of Clinical educators around discipline specific competency, accreditation requirements and assessment management.

The plan covered an introduction to all students of any Allied Health disciplines who may be allocated to the SHIRES clinic. This was proposed for early in the year at the university. It also included a Briefing to students who had been allocated to the clinic for their placement just prior to placement and then an Orientation at commencement and training during the placement.

After the meeting with the Clinical Educators the Teaching Plan was modified. This was because an Introduction and Briefings no longer occurred in the courses as they had in the past at the University. Also it was pointed out that PT and EP students’ placements often occurred back to back so there was no time to bring students back to university to hold a briefing. As a compromise, Gillian and the Project Coordinator used a number of strategies to contact the students together to discuss the placement prior to their arrival. Over the programme there were 5 briefings for new students.

(i) Briefings

Gillian was to run the briefings with the students and the Project Coordinator was to be involved. The topics to be covered in the Briefing were the concept of the SHIRES clinic-that it was a primary care clinic and that it was an Inter-professional placement. Also the importance of Inter-professional training for future work readiness and the nature of the placement-working in Inter-professional pairs, peer learning, and Inter-professional assessment, the Inter-professional Capability Assessment Tool (ICAT) (Brewer, Gribble, Robinson, Lloyd, & White, 2009). This includes the competencies of professionalism, communication, collaborative practice and client-centred care. Students are told that the IP competencies have been mapped with discipline specific assessment forms and that there is close liaison between the Project Coordinator and discipline specific supervisors around assessment.
There was also discussion about the workload and that there is direct and indirect client contact and that students are involved in the operations of the clinic. Students were to be told about the Orientation week in which they would learn about the Model of care as well as hear from various staff members about their roles and services in which they are involved. Gillian was also to explain that with their discipline specific assignments students could consider utilising the clinic.

Before students came to SHIRES, the Project Coordinator was to send them an email with a number of attachments for reading and work which needed to be completed prior to placement. Students were expected to read the NSW Health, Code of Conduct and sign and date and print the last page as evidence that they had read it. They also had to log on to the Induct-E website, a mandatory education website for anyone coming to volunteer, work or learn in the hospital. A certificate of completion was issued and printed and brought by the student on the first day. Other reading was the Orientation Manual for students from Stage One and Resource Manual from Stage One, with an explanation from the Project Coordinator that some of the manual was under review during the project. A general summary of the HCA approach was also sent to the students. Students were invited to ring or email the Project Coordinator if they had concerns or questions.

(ii) Orientation Week(s)

Students were to receive an Orientation folder when they arrived on the first day. On the first day when they arrived, students were to have a general orientation to TSH Allied Health. An Orientation checklist in their Orientation folder was to be used. Students and the Project Coordinator were to sign and date this and students and the Project Coordinator were to keep a copy for their records (see Appendix 10). It was in the first session that students were to fill in the RIPLS ((Brewer et al., 2009). Morning tea on the first day was planned to be longer to give the existing team members some time to get to know the newcomers and vice versa. Later on the first day there was to be the Orientation to SHIRES session which covered a history of the project and the roles of Allied health staff in the hospital working with people with Chronic Disease. The TSH Chronic Disease Service Framework was to be presented. Other topics to be covered in this session were: client recruitment, the SHIRES Model of Care, client files and documentation, clinic operations, and learning opportunities whilst at TSH. This session was to take an hour. Students were provided with an HCA manual and the “Chronic Care for Aboriginal People Service Directory, 2010” as learning resources.

Within the Orientation week students would also be able to hear talks by various members of staff such as Margaret Beattie, Physio Manager in the Southcare Community service. Margaret’s talk would explain the roles of the PT staff in the community teams and the various services in which they worked. She also would take the students through the types of assessments the PTs use in these teams. These talks were for all new students. As well, the Student coordinator for OT in Southcare was also asked to present on the role of OT in the various community teams in Southcare. Exercise Physiologists were also involved at various times throughout the programme giving talks on their role in the team they worked with or in one case, providing a Case Study of how the EP used the HCA methodology in her practice.
Other training which was available in the first week was from a variety of sources. The Project Coordinator had been provided with some HCA videos by the HCA peer leaders, which introduced some of the core concepts in the HCA framework. As well, the Project Coordinator had gained permission to video interviews with 3 ex-outpatient clients who were at different stages of chronic disease, with their stories of the impact of chronic disease on their lives and how they were managing their health now.

Another learning opportunity which was discovered to be helpful from feedback from participating students was their first case conference. New students listen whilst the students already working in the clinic present their cases and hand over existing clients to them. The new students also had the opportunity to listen to the audio tapes of these clients who had been handed over. They were able to read their files, becoming familiar with the structure of the SHIRES files and they could learn more about their clients through listening to the tapes and discussing sessions in which other students had scribed.

(iii) Learning Modules

As well as the learning experience above, the Project Coordinator had 3 modules which were called “Model of Care, Part One-Understanding our Approach”, “Model of Care, Part Two-Putting it into Practice” and “Model of Care, Part Three- Taking it to the Community”.

Model of Care, Part One-Understanding our Approach, included discussion about the Initial Interview. We discussed why it was so comprehensive and why the particular questions, areas of interest were being covered during an interview with a client. We discussed how there was no time pressure and that if the client and student felt comfortable and time permitted the interview could go for 1-1 ½ hours There would be discussion about how to ask the questions in an open ended way and how the HCA concepts such as “Wait till 8” or “First ask, then offer” could be utilised.

In Model of Care, Part Two-Putting it into Practice, students practiced using the Initial Interview in a role playing situation with each other. This could include existing members of the team as well as the new students if the other students were free. They would have a scribe (another student) and go through how to begin an interview from offering a cup of tea, to asking permission to use the digital audio taping to asking the client for general information and filling in the PAM questionnaire.

In Model of Care, Part Three-Taking it to the Community, various learning approaches were utilised. This module was usually in the form of a visiting speaker who came to speak about their way of using the HCA approach in their practice. Speakers included, Amy Maclaine, EP from SHARCS, Mick Napoli as a Peer Leader and EP speaking about how to introduce yourself, and Margo Green from Chronic Care Team speaking about Healthways (telephone support service) and Connecting Care.

Another module which was included when it could be arranged was a presentation by Linda Soars and Margo Green from the Chronic Care Team. They presented a background history of Chronic Disease Management in the LHD and discussed the HCA approach and various services connected to Chronic Disease management.
3.1.8 Implementation Plan for Discipline Specific Competency Development

Students were to work in the SHIRES clinic on Mondays, Wednesdays and Thursdays and the other days were to be spent in discipline specific activities (see Appendix 11). For PTs they were to spend Tuesdays and Fridays with the PTs from Southcare, in particular they were to be involved in the Pulmonary Rehab team on Tuesdays and in the Mobility clinic on Friday mornings and they were to go on Home visits with the community PTs on the Friday afternoons. The EP students were to be supervised by the EP working in the SHARCS gym programme both days. The OT students were to go onto the acute wards or Rehab with OT supervision in the mornings on the Tuesday and to run a Stress Management and Relaxation programme for 4 weeks, twice, over the 20 week programme, in the afternoon. This is a discipline-specific activity of the OT department. They were to be supervised by a member of the OT department. The first block of OT students had the opportunity to work on the wards on Friday as well, whereas the second block had coursework at the university on Fridays.

3.1.9 Student Evaluation Plan

Students were to be assessed using their disciplines’ assessment. In the case of OT and PT, the assessments are standardised across all courses throughout Australia (APA (Dalton, Davidson, & Keating, 2011) and SPEF-r (SPEF-Revised Edition Package, 2008), respectively. In the case of the EP students, University of Sydney uses the SPA (Student Placement Assessment (University of Sydney, 2014)). The Project Coordinator was able to assess and report on students’ Inter-professional skills using the ICAT (McFadyen, Webster, & Maclaren, 2006). These skills were mapped by the Clinical Educators at University of Sydney to match the generic skill domains on each of the discipline assessments. The Project Coordinator was able to provide feedback form the ICAT to inform the Discipline Supervisor who was to do the formal assessment of the student in their discipline. Feedback to students was to be given informally throughout the placement and a formal supervision session with the Project Coordinator was to occur each week with each student. Formal feedback sessions at midway and final assessment were to be with the Discipline Supervisor, the Project Coordinator and the student. Each student was expected to rate their own performance prior to attending these sessions. Students were given copies of both the ICAT and the discipline assessment. It was emphasised to students that it was only the discipline assessment which was used for marking and which was sent to the university by the Project Coordinator. Students did appreciate the written feedback at midway and final from the ICAT, however, and always wanted copies for their own benefit.

The Readiness for Inter-Professional Learning Scale (RIPLS) (McFadyen, Webster, & Maclaren, 2006) was administered during the Orientation on the first day and then again at the end of placement on the last day. This survey was recommended for use in the Orientation Manual from Stage One of the project (2013).
3.1.10 Supervisor Training Programme

To prepare all supervisors who were involved with students from the clinic over their placement, University of Sydney provided a ½ day training programme. This was conducted by Dr Gillian Nisbet. For details of the workshop, please contact University of Sydney, Work Integrated Learning, and Dr Gillian Nisbet. The aim of the workshop was to:

a) Explore the principles of Inter-professional supervision and how they may apply to the SHIRES clinic
b) Develop effective strategies to confidently address challenging Inter-professional supervision situations that may arise in the SHIRES clinic
c) Reflect on values, beliefs and attitudes towards IP supervision and facilitation
d) Review operational aspects of the upcoming SHIRES clinic

3.2 Establishment of the SHIRES Clinic

3.2.1 Project Coordinator Recruitment

The recruitment process began in March, 2014 and the Project Coordinator began in the position officially on 1st July which was later than anticipated. The Progress Report for the project was due for submission at the end of July. Fortuitously the preparation phase of the project plan was well underway by this time, and the report was able to be submitted on time. From this point on, whilst establishing the clinic, the Project Coordinator continually reviewed the requirements for each of the groups of people involved in the project; namely the students, clients and supervisors; as well as reviewing and adapting operations as the clinic developed.

3.2.2 Requirements for Students Working in the SHIRES Clinic

(i) Implementation of the Teaching Plan

A variety of strategies were used during the 20 week programme to implement the teaching plan. As already discussed, briefings for students occurred successfully except for the final block of 4 students who were on placement in the week before coming to SHIRES.

Orientation weeks occurred for all students but implementation occurred in various ways. All students underwent the General Orientation to Allied Health and TSH. All students had an Orientation to SHIRES. The way in which the other elements of the Orientation occurred varied, depending on the demands of the clinic on the team; and the availability of the Project Coordinator. At times the speakers were unavailable in the first week so talks occurred in the second week. The modules occurred around the demands of the clinic as it grew and developed. Client appointments, case conferences and the team meeting occurred in every week of the programme, whether it was an Orientation week.
for new students or not. Module 1 and 2 would occur in the first week, and, as already mentioned, existing team members would join in the role playing, if they were free. As the clinic developed and the number of clients grew, balancing the demands of the clinic and existing team members’ needs for supervision with the needs of the new students, required flexibility in the way students learnt the skills required to operate the clinic and work in the team. The existing team members assisted greatly in the process of teaching students the operational side of the clinic. The case conferences assisted new students to understand the process involved in the interactions between the client and their student health professional. New students would listen to the clients’ stories, understand their health issues and the action plans which clients had developed with the help of the students in case conferences.

Over the 20 week programme a SHIRES Operations Manual was gradually developed by the students. Generally, new students found it easier to ask for help from the existing team members rather than consulting the manual. The Project Coordinator endeavoured to encourage students to consult the manual as much as possible to lessen the burden on the existing team as they were “carrying” the clinic in the first couple of weeks of each new students’ placement.

(ii) Other Learning Opportunities

Students were told about the many learning opportunities which were available to them within the environment of the hospital. Some of these were: observing a hip or knee replacement operation, going on Home visits with OTs, attending the FAST SHARCS programme (one day intensive education programme for Cardiac Outpatients), visiting Mobility group, observing and assisting in Knee group or OACCP knee group, observing the Outpatient Physio, observing the Orthopaedic Physio in the plaster room, attending the O.T. Upper Limb group, attending Staff meetings, attending Allied Health Forums, observing Paediatric PT or OT sessions. Students were encouraged to make their interests known and to approach the particular staff member about the possibility of observing. Depending on the person and the situation the Project Coordinator would sometimes organise the session on the student’s behalf.

(iii) Supervision of Students

Supervision was provided to students in a number of different ways throughout the 20 week programme. Initially, the Project Coordinator trialled the use of the audio tapes after students had conducted an Initial Interview, when it was difficult for the Project Coordinator to be present during the interview. Listening to the tapes proved to be time consuming however, and effective feedback and the occasional need to interject during the Initial Interview meant that the Project Coordinator prioritised supervision of students during these sessions. Generally, students were supervised by the Project Coordinator during Initial Interviews with clients. On a rare occasion, another student supervisor would be asked to supervise, if the Project Coordinator was unavailable. This usually occurred if there was a double up of appointments which were generally avoided, if possible. As students developed skills in the HCA framework and after thorough
preparation for follow up sessions, students did not require face to face supervision from the Project Coordinator in follow ups.

There were many other opportunities for feedback to students. Students were able to provide Peer Supervision during follow up sessions, as they were able to focus on the way their peer was interacting with the client, rather than writing down information.

Team meetings and Case Conferences were also an opportunity to provide feedback to students, both from peers and the Project Coordinator.

The Project Coordinator asked the students to ensure they had at least 10-15 minutes of one to one supervision each week and asked them to initiate this time. This was because the Project Coordinator was using another work area down a hallway from the SHIRES clinic office space. Students were encouraged to be responsible for their time and to be proactive about seeking feedback and guidance. The Project Coordinator assured students that they were the priority and if they required more time or there was a matter of urgency that this would always come before other priorities.

The students were often in and out of the Project Coordinator’s office because they were requiring draft documentation checked before entering it into the progress notes for their clients. They would then need to come back to have the entry signed off by the Project Coordinator. These times provided opportunities for informal feedback to students and often led to conversations about how the student was coping with the clinic or what their perceptions were of the work they were doing with clients.

(iv) Liaison with Visiting Speakers from Other Services

As already mentioned there were a number of different speakers who were asked to present to the students over the 20 weeks. Some of these people presented multiple times so that as many students as possible were provided with their knowledge and expertise. The Chronic Care team were one such group who presented their information 3 times over the programme. Also Susie Corby, the Cardiovascular CNC presented twice and Janice Oliver, the Carers Support Programme Manager presented to the students.

(v) Ongoing Liaison with Discipline Supervisors

There was ongoing communication, usually by email to organise midway and final assessment feedback sessions for students. The Project Coordinator and Discipline Supervisors had closer liaison when students were struggling or there were issues with their behaviour. When these situations arose increased support was given to the students concerned, in both the SHIRES clinic and their discipline-specific activities by the relevant supervisor. If the behaviour continued or issues continued then clear expectations of appropriate behaviour and strategies to assist students to improve their performance were discussed in a meeting between the Project Coordinator, Discipline Supervisor and the student. A mediation learning contract was written by the student with help from the Project Coordinator in one case.
3.2.3 Requirements for Operating the SHIRES Clinic

(i) Administration

An appointment diary was used for all client appointments. It was consulted when the team were planning other activities such as Case Conferences or during the team meeting in planning for the next week. Students knew that clients coming for Initial Interviews should not be doubled up so that the Project Coordinator could be present. They were reminded that afternoon bookings were preferred as we had the clinic rooms booked for after 1.00pm each clinic day, throughout the programme. Jenny and Helen (Allied Health Administrative staff) were provided with the appointment diary to book clients in on EMR. This made it easier for Jenny to identify that clients were for the SHIRES clinic, when they arrived in Allied Health reception. Clients were only given a Client number next to their name in the diary and on the database, once they had an appointment booked.

The client data base was set up in a spread sheet in excel on the desktop of one of the laptops only. This was the only place for the data base to ensure students put all data into it alone. The fact that the data base took some time to access, also reminded students of its importance and the care required when using it. There were three data bases created in the clinic: the client data base, Stress Management database and the Resource folder. Each week all three data bases were backed up onto a USB set aside for that purpose alone.

Students created a roster for the various jobs which needed to be done each week. The roster included chairing the team meeting which involved creating the agenda, and being minute taker for the team meeting. There was the role of copying all data bases onto the USB on Thursday afternoons.

Many clients preferred the morning for appointments which required the students to find a suitable meeting room in the Allied Health department, if the OT treatment room was not available. Mostly a manager’s office or the Dieticians’ clinic room was available.

(ii) Caseload Management

As the clinic continued over the 20 weeks and students came and went, it was necessary for new students to receive handover of clients. Managing numbers of clients to ensure equitable caseloads and ensuring students had opportunities to conduct Initial Interviews and follow through with the whole Model of Care process eventually became a task that two of the students were able to manage. They took into account new clients and appointment times as well as where clients were up to in the programme e.g. whether they were only wanting follow up phone calls or still wanted face to face follow up sessions. Some clients only wanted and required follow up phone calls, so the amount of face to face time for certain clients could be limited. Students realised that clients sometimes cancelled appointments or declined to come to SHIRES and so this could impact the number of face to face opportunities they had. Often when this happened we adjusted caseloads to ensure all students had exposure to face to face sessions. The
“lead” student from previous sessions would be present and support the new “lead” student in these sessions.

(iii) Recruitment Strategies

Client recruitment was a standing item on the team meeting agenda. The Project Coordinator and students had discussed strategies to recruit clients who came to Allied Health for various clinics and exercise groups. These were mainly clients attending Physiotherapy or the OACCP (Osteoarthritis Chronic Care Programme). The professionals involved either referred clients to the clinic or allowed students to quickly explain at the end of sessions what the clinic was about and to invite people to express their interest by speaking with the students afterwards.

Another strategy was for the Project Coordinator to present the SHIRES project at community groups. The Project Coordinator presented at the Caringbah Rotary Club, the Lioness club of Sutherland and the Carers and Consumers forum at Sutherland. There were 5 clients recruited from these meetings.

Carers’ health and the need for support in health management was particularly brought to my attention by discussions with Janice Oliver, the Manager of the Carer Support Programme. Through Janice the SHIRES team were given permission to place the SHIRES flyer and leaflet in the Carers packs which were always on display for people to take from a wall near the cafe. This was another job which needed to be done regularly as these packs were taken quickly each week.

Various PT students’ Quality Improvement projects were around the issue of client recruitment. One such project involved a retrospective audit of daily handover sheets from Gunyah ward. This project evolved from discussions between the Project Coordinator, the Acute Neurology CNC, the senior PT and OT working on the ward. It was highlighted that there are several people who are admitted to Gunyah every week with symptoms of TIA or stroke. These people are assessed and their symptoms resolve and they are often discharged within a few days. Often however these people have risk factors for chronic disease or have chronic disease and may be having issues with health management. The QI project involved the students establishing that there were people in this category each week on the wards and a referral system from Gunyah to SHIRES was proposed.

Another QI project which is underway at the moment is implementing a strategy for Allied Health staff on other wards to refer to SHIRES.

The most important recruitment strategy which has yet to be implemented is the referral pathway from GPs. This issue will be addressed in the last section of this report under future directions.

(iv) Presentations to Allied Health and Others

As mentioned, this aspect of the Project Coordinator’s role continued throughout the establishment of the SHIRES clinic. The SHIRES team were often asked by the Project Coordinator to present case studies within other presentations. The team presented at
the Allied Health Forum, Southcare in service, and several times to the steering committee.

(v) Resource Management and Security

Students were provided ID badges and swipe cards from security on their first day. This gave them access to the Allied Health department from any entrance so they were not reliant upon another staff member to let them in if the main doors were still locked early in the morning. Students signed in and out on a department clip board each day. This was mainly for W.H and S requirements in the case of evacuation. Students were provided with their own locker to store valuables. There was a shared locker with shared key access in which the laptops, digital audio recorders, iPads, appointment book and any client “old notes” were kept. Another cupboard with shared key access had other resources that were used frequently, namely the projector and adaptor cable for the monitor. Laptops were able to be locked onto the desks and the key to unlock them was also available to all students. Students were given instructions on “lock up” procedures for each day. Client files were kept in the SHIRES clinic on a shelf with only the Client number to identify the file on the spine, in a similar way to patient files on the wards. A collection of old plastic blue or black two ring binders were found in Allied Health reception to make filing easier and to protect the contents. Manilla folders had been used unsuccessfully to begin with.

(vi) Implementation of Outcome Measurement Framework

There were several ways that outcomes were to be measured as outlined in the evaluation plan (see Part 2.2.2). Outcomes were recorded using several tools. The tools were:

a) Client Database
b) Monthly stats sheets
c) Cerner
d) EMR
e) Client files with tools
f) Student tools
g) Testimonials
h) Project Coordinator Journal

a) Client Database:

When a referral was received to SHIRES the client’s information was recorded in the client data base and in the order of receipt of referrals. In order to keep a record of measures, a client data base was developed over the programme. Each week this data base was saved as a separate document on the backup USB.

b) Monthly Statistic Sheets:

Students were required to keep a record of client contact and client related activities so that this data could be entered into Cerner. Students recorded the type of contact, for example if it was Face to face, phone call follow up or email follow up as well as Case
conferences which included preparation and presentation of their particular cases. Other activities they were to record were debriefing sessions and research and documentation. They recorded the date of these activities and the time taken for the activities against other identifiers for purposes of entering this information into the correct encounter in Cerner such as the client’s name, MRN, DOB and referral date. One issue with the statistic sheet may have been some reticence on the part of students to enter the time taken accurately for tasks such as documentation. Explaining to students that documentation does take a lot of time initially, will ensure more accurate times for this task.

c) Cerber

This system is the section of EMR which is used by Allied Health staff to record “encounters” with clients as well as non-patient related activities. Due to time constraints, the Project Coordinator had to relinquish the usual practice of recording non-patient related statistics. The focus for the project was to record the interventions with clients and the stats sheets ensured students had some responsibility for this process. It was deemed expedient for the Project Coordinator to enter the statistics into the system.

d) EMR

Students used EMR to ascertain MRNs for clients as well as to gather some information regarding past presentations to ED or to read discharge summaries after admissions to hospital. Information from EMR is still limited as wards are not online as yet and so hard files are still used on the wards. Students were encouraged to call up old notes from Medical Records if necessary through Jenny or Helen at the desk.

e) Client Files

The Health Management checklist or Initial Interview was a four page document which was based on the original “Health screening Tool” developed in Stage One of the project. The Project Coordinator adapted the tool to make the questions as open-ended as possible, when appropriate. Students were definitely dissuaded from asking “yes/no” questions as much as possible, to encourage a relaxed conversational style of interview. The lead student was to focus on engaging with the client, whilst the other student was the scribe, writing down information in the Health Management Checklist.

The HCA framework (Health Change Australia, 2013) formed the basis of the other tools which were used with clients during appointment sessions. These were kept in client files and used throughout the client’s programme. Client’s health issues were identified by the client and prioritised in order of importance by the client. The client’s health issues were recorded in the form of goals on their Personal Health Improvement Plan, for example, “Back pain” would become “Managing back pain” or “Improving back pain”. In follow up client appointment sessions, Action Plans were developed. These became the small steps or small goals which the client and student health professional recorded for each of the client’s larger goals on their Personal Health Improvement Plan. In further follow up sessions, clients were able to discuss their progress on their small goals and these were ticked when achieved. Clients and student health professionals worked with the client to find other options or work on other goals depending on the client’s progress and these
were recorded also. Other information which was kept in the client files is listed in the Audit tools section (see Part 3.2.2(vi)).

f) Student Tools

When students started on placement they were asked to fill in the RIPLS. During the placement students had a midway assessment. Students’ performance in the SHIRES clinic was assessed by the Project Coordinator, using the ICAT assessment. This measure was also used at the Final assessment. The ICAT was used to inform the Discipline supervisor about student performance in the domains of Professional behaviour, Communication, Collaborative practice and Client centred care. Students completed the RIPLS again, and a Student Satisfaction and Feedback tool at the end of placement.

g) Testimonials

Statements by people during meetings with the Project Coordinator were recorded in the Project Coordinator’s journal, as an aid to memory around ideas and concepts and ways of thinking about situations. Also students gave cards and sent emails at the end of their placement. Also video recordings of clients’ opinions about the clinic have provided testimonials to their experience of the clinic.

h) Project Coordinator Journal

The journal was used to record ideas, meetings, and notes from articles, reflections of the day or week. The journal was begun some time before the clinic began, the first entry started on 20/5/14. The journal was also used for making “to do” lists and the Project Coordinator ticked and highlighted tasks which were completed or were priorities for completion.

3.2.4 Requirements for Clients of the SHIRES Clinic

(i) Development of Documentation Tools

This has been discussed in Client files in 3.2.3.6. The use of the tools evolved over time as the Model of Care developed with the clients. Earlier client files were less organised and it was harder for new students to understand what client’s goals and action plans were, without reading the progress notes thoroughly. With the inclusion of the Personal Health Improvement Plan and the Action Plan tools, there was easier continuum of care when handover occurred to new students and the tools were used across sessions with clients. The tools were placed in plastic sleeves in the file to make it easier to pull them out during sessions and to protect them from being torn.

(ii) Levels of Supervision in Client Appointment Sessions

Initially the Project Coordinator had thought that students would be able to conduct the Health Management Checklist without the Project Coordinator. Consent for audio recording was given, and it was the intention of the Project Coordinator to listen to the
tapes. Unfortunately this became time consuming, given the other requirements of the clinic. Also, the clients often expected a supervisor to be present during the first session. The in depth nature of the Health management checklist sometimes touched on deep seated emotional issues for clients. Some students said they were glad that the Project Coordinator had been present to help the client through these difficult interactions. Despite the decision for the Project Coordinator to be present for the first session, this was not always required. The decision was based on the maturity and skills of the student and their level of experience in this style of interviewing. It was also dependent on information about the client that we may have already obtained, such as whether they were known to have depression or they had a complicated medical history.

Students did not always need supervision in follow up sessions as they prepared in advance with their partner and the session was likely to be a proactive, empowering session, rather than sometimes reliving difficult past experiences in the initial interview.

If the Project Coordinator was unavailable to supervise the students another member of staff was asked to assist. This was usually Christine Sue (Acting O.T. Student Coordinator) or Christie Russo (OT manager).

(iii) Handover and Case Management

Students were entering and leaving the clinic throughout the 20 week programme as can be seen on the Schedule of Student Placements (see Appendix 4). In the original Schedule of Student Placements there was to be a break halfway through the 20 week programme where a whole new team would start. Soon after the clinic began, the Project Coordinator realised that having overlaps of blocks of placements would be most beneficial to the smooth running of the clinic, both operationally and in managing client caseloads. The university was approached and a block of EP students was able to be included into a new Schedule of Student Placements (see Appendix 12) to provide this overlapping block.

To enable continuum of care for their clients, students had to handover their caseload to continuing students and/or new students. This was done in two ways. Students would prepare their cases for presentation at a longer than usual Case Conference (using the Case Conference tool). They would ensure that the team knew what the main issues were for each client. They would also ensure that all client notes were up to date. Also a list of all “active” clients was made with the activities which still needed to be actioned by the team, such as follow up phone calls, research or face to face appointments.

Case management of all clients to ensure student equity with face to face time with clients and involvement in follow ups was kept in mind, but unfortunately sometimes clients cancelled appointments or declined to continue in the programme, so it was not always possible to control for every contingency.
4.1 Evaluation of Client Outcomes

4.1.1 Demographic Information

Various features of the client group were able to be analysed. For example, it was of interest to know if all clients met the inclusion criteria of having or being at risk of a chronic medical condition. Of the 30 clients who will have been seen when the clinic closes for the year on Friday 5th December, there are 28 clients who have already had initial interviews. **All 28 clients** have more than one chronic medical condition, and 71% have five or more chronic medical conditions each (see Graph 4.1.1a)
Client’s chronic medical conditions were broken into the following groups:

a) Anxiety/depression  
b) Cancer  
c) Cardiac conditions (CAD, CHF, MI, Pacemaker, Stents, AF)  
d) COPD  
e) Diabetes  
f) High Cholesterol  
g) Hypertension  
h) Multiple Sclerosis  
i) Musculoskeletal conditions (OA, RA, OP, THR, TKR, CLBP)  
j) Peripheral Vascular Disease  
k) Others

The proportion of the clients who have any of these chronic medical conditions is represented by Graph 4.1.1b.
The relationship between client's ages and the number of chronic medical conditions was examined and has been depicted in Graph 4.1.1c. Clients across all age groups who have attended the SHIRES clinic have a number of chronic medical conditions. The group are not representative of the proportion of people in the population of SESLHD (Chapman, 2012) where younger people have less chronic diseases than older people.

![Graph 4.1.1c](image)
The age ranges of the clients in the clinic were analysed. The analysis was based on the 30 clients who will have been in the programme by the end of the clinic for this year. The largest group within the clinic were 67% of clients who were in the 65-84 age range. The next largest group represented 23% of the client group who were in the 45-64 age range. 7% of the client group were in the 25-44 age range and there were only 3% of the client group over 85 years old. There were no clients under 25 years of age seen in the clinic. The ages of clients in the categories mentioned and proportion of the clients in each age range is depicted in Graph 4.1.1d.

Graph 4.1.1d
4.1.2 Audit of Client Files

Client files were examined to check whether the following tools were present:

- a) Client cover sheet
- b) PAM questionnaire
- c) Signed consent form
- d) Health Management Checklist
- e) Personal Health Improvement Plan
- f) Action Plan(s)
- g) Letter of Notification of Service Provision to GP
- h) Discharge letter (if applicable)
- i) Client satisfaction and feedback form

Of the 28 files audited, only 4 clients did not have all the tools in their file. The first 3 clients (Client 1, 2 and 3) did not have Action Plans in the format that was to be used later in the clinic. One other client has never come to the clinic due to medical issues but her husband, who is her carer has asked for follow up phone support, so a file with progress notes was commenced for her. Some of the 28 clients have not had their first follow up sessions to discuss their Personal Health Improvement Plans yet so these were not counted as missing from their files.

4.1.3 Audit of Clients’ Health Issues

Of the 28 clients who have been interviewed, 25 of them have gone on to identify their health issues and to develop Personal Health Improvement Plans. Two of the original clients declined to continue in the programme. One client was managing her health issues well and the other client has declined follow up. The third client has not been involved in the clinic directly; SHIRES clinic has been providing support to the client’s husband (i.e. her carer) via phone call. The health issues for the remaining 25 clients were converted to health goals by the clients themselves on their Personal Health Improvement Plans. For the purposes of analysis, the health goals were classified into following 10 categories:

- a) Falls prevention
- b) Improve memory
- c) Improve sleep
- d) Increase exercise
- e) Increase participation in important life roles
- f) Lose weight
- g) Manage diet
- h) Manage medical conditions
- i) Manage mood
- j) Manage symptoms
Graph 4.1.3 shows the breakdown of health goals for the 25 clients who have Personal Health Improvement Plans. The most common health goal was the need to increase exercise with 76% of all clients saying they have this goal. Other common health goals were: 56% of clients wanting to “manage symptoms”. Symptoms to be managed ranged from managing arthritic pain in knees, hips or back; foot care; dry mouth, nose and throat; or incontinence. Under “increase exercise” were such goals as improving endurance, improving strength, improving fitness. Of particular interest is the high proportion of clients (48%) who said they wished to manage their mood which included such things as stress, anxiety, low mood, depression, fear, and anger. Only 9 of these 12 people had a medical diagnosis of anxiety or depression.
4.1.4 Audit of Clients’ Action Plans

Action Plans with small/short-term goals were developed for clients to achieve health goals on their Personal Health Improvement Plans. Of 25 clients who have developed Personal Health Improvement Plans and Action Plans, 18 of them have returned for several follow up sessions so that their progress has been recorded. Progress or achievement is measured by finding the percentage of achieved goals over total goals. The 18 clients have achieved on average 65% of goals on their Action Plans, as shown in the following Table 4.1.4.

<table>
<thead>
<tr>
<th>Client</th>
<th>Number of goals on Action Plans</th>
<th>Number of goals achieved</th>
<th>% of goals achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>2</td>
<td>17</td>
<td>16</td>
<td>94%</td>
</tr>
<tr>
<td>3</td>
<td>17</td>
<td>11</td>
<td>65%</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>6</td>
<td>12</td>
<td>4</td>
<td>33%</td>
</tr>
<tr>
<td>7</td>
<td>25</td>
<td>11</td>
<td>44%</td>
</tr>
<tr>
<td>8</td>
<td>14</td>
<td>14</td>
<td>100%</td>
</tr>
<tr>
<td>9</td>
<td>17</td>
<td>14</td>
<td>82%</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>11</td>
<td>100%</td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>12</td>
<td>13</td>
<td>9</td>
<td>69%</td>
</tr>
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<td>13</td>
<td>12</td>
<td>6</td>
<td>50%</td>
</tr>
<tr>
<td>14</td>
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<td>14</td>
<td>93%</td>
</tr>
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<td>74%</td>
</tr>
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<td>16</td>
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<td>3</td>
<td>38%</td>
</tr>
<tr>
<td>17</td>
<td>14</td>
<td>11</td>
<td>79%</td>
</tr>
<tr>
<td>18</td>
<td>14</td>
<td>9</td>
<td>64%</td>
</tr>
</tbody>
</table>

Average % of goals achieved= 65%

Table 4.1.4

*Only clients who have action plans and returned for 2 or more follow up sessions were included in this table
4.1.5 PAM scores and Goals Achieved

PAM scores from the responses of clients to the PAM questionnaire. The majority of clients were either at Level 3 or 4 of the PAM. Comparing PAM scores with goals achieved revealed that both Level 3 and Level 4 clients achieved a higher % achieved goals on average than the Level 1 and 2 clients, however the Level 2 clients had on average more goals to achieve than either of the Level 3 or 4 clients (see Table 4.1.5).

<table>
<thead>
<tr>
<th>PAM score</th>
<th>% of clients who have this PAM score</th>
<th>Average % of goals achieved</th>
<th>Average number of goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6%</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>22%</td>
<td>62%</td>
<td>15.5</td>
</tr>
<tr>
<td>3</td>
<td>28%</td>
<td>76%</td>
<td>12.8</td>
</tr>
<tr>
<td>4</td>
<td>44%</td>
<td>67%</td>
<td>11.875</td>
</tr>
</tbody>
</table>

Table 4.1.5

There are many variables which can influence the percentage of goals achieved, such as the time clients have had to work on their goals, the difficulty of the goals themselves, level of motivation and confidence, external factors such as health of other family members, vacations, priorities in other areas.

4.1.6 Referrals to Other Services

Recommendations and referrals to other services occurred frequently in the clinic. Clients often had the steps to following through on referrals as goals in their Action Plans. For example, a client may decide they want to have counselling or to see a Clinical Psychologist, so the Action Plan steps may have been:

**Step 1:** “Visit your GP for a referral through a Mental Health Plan” (ATAPs)
**Step 2:** “Ring the Counsellor or Clinical psychologist to make an appointment”
**Step 3:** “See the Clinical Psychologist”
**Step 4:** “See the Clinical Psychologist regularly”

Each client who has had one or more follow up sessions (23 clients) has on average 2.6 referrals made. There have been 63 referrals from SHIRES to a variety of community services, health professionals and groups.
For types of referrals made by SHIRES clinic please see Table 4.1.6.

### DIFFERENT TYPES OF REFERRALS MADE BY SHIRES CLINIC

1. **General Practitioner (GP)**

2. **Psychology:**
   Clinical Psychologist; Counselling Services; Stress Management and Relaxation Group

3. **Exercise:**
   Physiotherapist; Exercise Physiologist; SHARCS; Mobility Group; Stepping On; Exercise Group; Walking Group; GP Referral Scheme; Hydrotherapy; Aqua Group Exercise

4. **Dietician**

5. **Community Services:**
   HACC; Calvary Silver Circle; Hammond Care Caringbah Social Respite Club; Sutherland Wellness Centre

6. **Others**
   Continence Advisor; Wound Care Specialist Nurse

Table 4.1.6

For a breakdown of number of all types of referrals made by SHIRES clinic please see Graph 4.1.6.

![Graph 4.1.6](image)
4.1.7 Audit of Actioned Referrals

The number of actioned referrals has been recorded on the Client Data Base. Of the 63 referrals, 19 of them were to the clients’ GPs for follow up regarding medication, symptom management, to inform the GP of their Personal Health Improvement Plan, or for referrals to other services. Of these 19 GP referrals, 10 clients had met this goal on their Action Plan at the time of writing this report. Others who have yet to be seen in their next follow up session may report they have followed through with their goal of seeing their GP, or that they have made an appointment. GPs will have been sent a Notification of Provision of Service letter after the first follow up session with the client, informing the GP of the clients Personal Health Improvement Plans and Action plans.

The next highest number of referrals was made regarding improving exercise. Referrals in this category ranged from going to an Exercise Physiologist through the GP referral scheme, referral to SHARCS, Mobility group in Southcare, Stepping On, Exercise groups, Walking groups, Hydrotherapy, Aqua classes, and Physiotherapy.

4.1.8 Trends of Length of Stay in Programme

There were 83 face to face Occasions of Service (OOS) with clients over the 20 week programme. Clients differed greatly in their patterns of attendance at the clinic. Approximately 3 face to face consultations on average, per client, occurred over the programme; but the range was from 8 x face to face OOS for one client and only 1x face to face OOS for others.

4.1.9 Client Satisfaction and Feedback Survey

To date there have been 8 feedback forms returned to the SHIRES clinic. Feedback forms were given to clients before discharge. There have only been a few discharges at this point in time. The feedback survey was modified from the proposed Stage One version (see Appendix 13). This was necessary to ask questions which were relevant to the Model of Care used in the SHIRES clinic. Questions around individual consultations by a specific health professional, education classes, referrals were not relevant, as these activities did not take place.

Clients were asked to rate 5 statements on a Likert scale from 1= strongly disagree, 2=disagree, 3= neutral, 4= Agree, 5= strongly agree. The five statements were:

Statement 1: The consultation in the clinic has assisted me to identify my health issues
Statement 2: I have increased my understanding of how to improve my health
Statement 3: The clinic students have adequate knowledge about ways to help me to improve my health
Statement 4: My confidence in being able to make positive changes to my health has increased
Statement 5: Overall, I am satisfied with the service provided to me by the clinic today
The data was entered into “Survey Monkey” to allow for ease of analysis (see Table 4.1.9).

Client rated responses to the five statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither disagree or agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement 1</td>
<td>0%</td>
<td>0%</td>
<td>12.50%</td>
<td>37.50%</td>
<td>62.50%</td>
</tr>
<tr>
<td>Statement 2</td>
<td>0%</td>
<td>0%</td>
<td>12.50%</td>
<td>37.50%</td>
<td>50.00%</td>
</tr>
<tr>
<td>Statement 3</td>
<td>0%</td>
<td>0%</td>
<td>14.29%</td>
<td>28.57%</td>
<td>57.14%</td>
</tr>
<tr>
<td>Statement 4</td>
<td>0%</td>
<td>0%</td>
<td>14.29%</td>
<td>42.86%</td>
<td>42.86%</td>
</tr>
<tr>
<td>Statement 5</td>
<td>0%</td>
<td>0%</td>
<td>12.50%</td>
<td>12.50%</td>
<td>75.00%</td>
</tr>
</tbody>
</table>

Table 4.1.9

Clients were asked to comment on the question:

“What aspect of the clinic did you find most helpful in managing your health?”

The responses are summarised below:

“Making me feel more accountable and motivated to keep my exercise regime going by making a plan. Being given information on Hydrotherapy.”

“Having a conversation about health and aging.”

“I find it very helpful in every way I needed it. The students were absolutely fantastic and help me to understand myself and help myself with all problems.”

“It gave me the opportunity to assess my health needs and to gather information to help me on my way by accessing services made available to me. I think the program is excellent and would not need any improvement to make it better.”

“Supportive in ways to achieve better health e.g. booklet on dietary guidelines, foods to include/exclude for arthritis. Suggestions on treatment e.g. Doctor/Physio.”

“Knee clinic and occupational therapy.”
4.2 Evaluation of Student Outcomes

4.2.1 RIPLS Evaluation

Students were given the RIPLS (McFadyen, Webster, & Maclaren, 2006) to complete at the beginning and end of their placement (see Appendix 14). At this point in time there are only 12 of 16 post RIPLS scores. For ease of analysis, the data was entered into “Survey Monkey” (see Appendix 15).

For the first 9 questions which relate to the subscale of “teamwork and collaboration” the majority of students scored either strongly agree or agree, both before and after their experience of the clinic. Where there may have been a slightly more positive shift was seen in the communication statement (4) where post scores shifted to strongly agree or agree from 75% (pre) to 92% (post). Only one student held a neutral position to the statement, “Communication skills should be learned with other health and social care students/professionals” at the end of their placement, whereas 26% or 4 students had been neutral at the start of placement.

By the end of placement, all students strongly agreed or agreed that “shared learning will help me think positively about other health and social care professionals” (strongly agreed=50%, agreed=50%) whilst at the start of placement, the majority of students agreed but did not strongly agree (strongly agreed=31.25%, agreed=62.50%).

In regard to the next subscale, negative Professional identity (McFadyen, Webster, & Maclaren, 2006), which has three statements worded in the negative, all students had moved to a position of strongly disagreeing or disagreeing at the end of placement (100%) to the statements “I don’t want to waste time learning with other health and social care students/professionals” and “It is not necessary for undergraduate/postgraduate health and social care students/professionals to learn together”; whereas at the beginning of placement their responses were across agree to strongly disagree.

The responses of students to the statements related to the third subscale of positive Professional identity (McFadyen, Webster, & Maclaren, 2006) have all shifted to strongly agree or agree after placement. Over 50% of students said they strongly agreed that they “would welcome the opportunity to work on small group projects” and “share some generic lectures, tutorials or workshops other health and social care students/professionals”. 100% of students at the end of placement also strongly agreed or agreed that “shared learning and practice will help me clarify the nature of patients’ and clients’ problems”.

At the end of placement, 100% of students disagreed or strongly disagreed to the statement “I am not sure what my professional role will be” whereas before placement, students responses had included 31.25% (5 students) who were undecided.
4.2.2 Student Assessments

Students were assessed using their discipline specific assessments as they would be in any other placement. As a tool for the Project Coordinator to provide feedback to the discipline specific supervisor (prior to assessment at midway and end of placement), the Project Coordinator used the ICAT (Inter-professional Capability Assessment Tool) (Brewer, Gribble, Robinson, Lloyd, & White, 2009). Students' inter-professional competencies had been mapped from the ICAT to the discipline specific assessments by the university Clinical Academics, prior to the clinic.

In a joint meeting, between the student, discipline specific supervisor and the Project Coordinator, feedback from the discipline specific assessment would be given. This was an opportunity for students to discuss any issues and the learning opportunities they were being exposed to. Students knew that the marks for the Professional Practice Unit of Study, of which the placement was a part, were based on their discipline specific assessment alone. Students were however, offered a copy of their ICAT assessment, so that they had the comments available as written feedback.

As a matter of interest only, the following table outlines the ICAT scores of 12 students who have completed their placements with the SHIRES clinic. The midway and final scores are provided and mean scores of all students were calculated.

From Table 4.2.2 it can be seen that the mean scores for students at midway

<table>
<thead>
<tr>
<th>Student</th>
<th>Communication</th>
<th>Professionalism</th>
<th>Collaborative Practice</th>
<th>Client Centred Service/Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mid ICAT (Score)</td>
<td>Final ICAT (Score)</td>
<td>Mid ICAT (Score)</td>
<td>Final ICAT (Score)</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Mean Score=</td>
<td>2.83</td>
<td>3.67</td>
<td>3.25</td>
<td>3.58</td>
</tr>
</tbody>
</table>

\( p\text{-value} = 0.00020 \) ** \( 0.019407 \) 0.002293 * 0.001004 *

Table 4.2.2

*p<0.01 (Statistically Significant)  ** p<0.001(Statistically Significant)
A one way paired t-test was used to determine whether the difference between students’ mid and final ICAT scores were statistically significant ($p<0.01$). There was a significant difference in midway and final scores for Communication, Collaborative practice and Client-centred care. In particular the difference in scores for the Communication domain of the ICAT was statistically significant to $p<0.001$. Advanced communication skills were practiced throughout the placement. They were the core skills required by students with clients. These skills plus collaborative practice and client-centred care were all improved from midway to final assessment. Professionalism was a domain in which most students already performed at a high level from the beginning of placement. Since this was the case, it was unlikely that there would be a significant difference between the midway and final scores.
4.2.3 Student Satisfaction and Feedback

Sixteen students will have completed the SHIRES programme by 5\textsuperscript{th} December, 2014. At this point, 12 students have already completed their placements, and were asked to fill out the Student Satisfaction and Feedback Form.

Students were asked to rate their responses from 1= strongly disagree, 2= disagree, 3= Neutral, 4= Agree, 5=strongly agree to the following statements (see Table 4.2.3a).

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither disagree or agree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Total respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>The orientation of the facility was thorough</td>
<td>0%</td>
<td>0%</td>
<td>8.33%</td>
<td>75%</td>
<td>16.67%</td>
<td>12</td>
</tr>
<tr>
<td>The level of supervision during the unit was appropriate</td>
<td>0%</td>
<td>0%</td>
<td>16.67%</td>
<td>50%</td>
<td>33.33%</td>
<td>12</td>
</tr>
<tr>
<td>Sufficient opportunities were provided to cover the learning objectives of the unit</td>
<td>0%</td>
<td>16.67%</td>
<td>33.33%</td>
<td>33.33%</td>
<td>16.67%</td>
<td>12</td>
</tr>
<tr>
<td>I was fully aware of the learning objectives of the unit</td>
<td>0%</td>
<td>0%</td>
<td>9.09%</td>
<td>72.73%</td>
<td>18.18%</td>
<td>11</td>
</tr>
<tr>
<td>During the unit feedback given was constructive</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>33.33%</td>
<td>58.33%</td>
<td>12</td>
</tr>
<tr>
<td>I have improved my understanding of Inter-professional learning</td>
<td>0%</td>
<td>0%</td>
<td>8.33%</td>
<td>41.67%</td>
<td>50.00%</td>
<td>12</td>
</tr>
<tr>
<td>I have improved my understanding of the management of chronic diseases</td>
<td>0%</td>
<td>0%</td>
<td>16.67%</td>
<td>58.33%</td>
<td>25%</td>
<td>12</td>
</tr>
<tr>
<td>The student led clinic is useful to professional development in the future</td>
<td>0%</td>
<td>16.67%</td>
<td>8.33%</td>
<td>58.33%</td>
<td>16.67%</td>
<td>12</td>
</tr>
<tr>
<td>Overall are you satisfied with the clinical knowledge you obtained from the clinic?</td>
<td>0%</td>
<td>16.67%</td>
<td>8.33%</td>
<td>58.33%</td>
<td>16.67%</td>
<td>12</td>
</tr>
</tbody>
</table>

Table 4.2.3a

From the data above it can be seen that the majority of students agreed that orientation was thorough (91.67%), supervision was appropriate (83.33%) and feedback was constructive (91.66%). There were a high proportion of students who said they were aware of the learning objectives of the unit (90.91%) and that they had improved their understanding of Inter-professional learning.

There were 3 statements where students’ responses ranged from disagree to strongly agree. 33.33% of students agreed or were undecided upon whether they had sufficient
opportunities to cover the learning objectives of the unit, respectively. 75% of students strongly agreed or agreed that the student led clinic will be useful to their professional development in the future. 75% of students strongly agreed or agreed that they were satisfied with the clinical knowledge they obtained from the clinic.

Students were also asked to give written comments on a number of aspects of the clinic on their Student Satisfaction and Feedback Form. One student wrote in a comment, “I really see the value of inter-professional education (IPE). It allows me to understand more of each health professionals’ roles. I can see the value of IPE in how it would reduce inappropriate referrals and improve team work”. A summary of student comments is collated (see Appendix 16).

4.2.3 Student Testimonials

Various written statements have been provided to the Project Coordinator by students. One student said in an email after the placement, “I learnt so many unique skills whilst at the clinic, which are beyond what students would usually learn on placement”. Another student said “I feel I have developed a lot of new skills through this placement” and yet another student stated, “I have learnt so much and are grateful for the opportunity to work in SHIRES”.

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### 4.3 Evaluation of Supervisor Outcomes

#### 4.3.1 Supervisor Satisfaction and Feedback Survey

All supervisors who were involved with students from SHIRES, either on the discipline specific days or in intermittent supervision on clinic days, were asked to fill out the Supervisor Satisfaction and Feedback form. Supervisors were asked to rate their responses from 1= strongly disagree, 2= disagree, 3= Neutral, 4= Agree, 5=strongly agree. Please see Table 4.3.1 for the responses expressed in percentages for the 9 supervisors who responded.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither disagree or agree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Total respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand the objectives of the SLC</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>55.56%</td>
<td>44.44%</td>
<td>9</td>
</tr>
<tr>
<td>The orientation material was sufficient for me to provide clinical supervision to students</td>
<td>0%</td>
<td>22%</td>
<td>66.67%</td>
<td>11.11%</td>
<td>0%</td>
<td>9</td>
</tr>
<tr>
<td>I had sufficient time to revise the material in the orientation manual before the commencement of the clinic</td>
<td>0%</td>
<td>22.22%</td>
<td>77.78%</td>
<td>0%</td>
<td>0%</td>
<td>9</td>
</tr>
<tr>
<td>I have increased my understanding of inter-professional learning</td>
<td>11.11%</td>
<td>22.22%</td>
<td>11.11%</td>
<td>44.44%</td>
<td>11.11%</td>
<td>9</td>
</tr>
<tr>
<td>I have increased my understanding of the management of chronic conditions</td>
<td>33.33%</td>
<td>22.22%</td>
<td>33.33%</td>
<td>11.11%</td>
<td>22.22%</td>
<td>9</td>
</tr>
<tr>
<td>The SLC experience is useful to my professional development</td>
<td>22.22%</td>
<td>22.22%</td>
<td>22.22%</td>
<td>22.22%</td>
<td>11.11%</td>
<td>9</td>
</tr>
<tr>
<td>Overall, I am satisfied with the operation of the SLC</td>
<td>0%</td>
<td>22.22%</td>
<td>22.22%</td>
<td>44.44%</td>
<td>11.11%</td>
<td>9</td>
</tr>
</tbody>
</table>

*Numbers in ( ) represent number of respondents*
The Supervisors who were involved with students in SHIRES and responded to the survey were from Physiotherapy (Outpatient and community PTs x4), Occupational Therapy (TSH department x3), and Exercise Physiology (x1) and Nursing (x1).

All supervisors agreed or strongly agreed to “understanding the objectives of the clinic”. The majority of supervisors (66%) rated a neutral response to the second statement regarding the orientation material. This was because many of the supervisors were not supervising the students in the context of the clinic, but in their own area of practice. All supervisors rated the third statement either neutral or disagree because either they had not received the Orientation Manual or they only had the Stage One material available. The statement about whether supervisors had increased their understanding of Interprofessional learning was slightly weighted towards neutral to positive. Again, most supervisors did not work directly with SHIRES students in the clinic, so perhaps the understanding had developed through the presentations given by the Project Coordinator at the Allied Health forum. The professionals already working in community or primary care services may have rated the “increased my understanding of chronic disease” in the negative because they already have a great deal of knowledge and experience in chronic disease management. The statement “The SLC experience is useful to my professional development” evoked responses across the scale. There was concerning variation on the last statement which rated overall satisfaction with the student led clinic.

As well as providing rated responses the 9 supervisors also provided written comments on their feedback forms. There were detailed comments made by several supervisors which will be further analysed and discussed at a planned meeting with the supervisors, the University Clinical academics, the Project Coordinator and the relevant Head of department.

Most dissatisfaction for supervisors surrounded having only 2 discipline specific days a week with students and that Discipline supervisors said they had to teach and assess students over fewer days altogether (10 days out of 25 days). They said they felt this was not enough time to teach and fairly assess students on their discipline specific skills. Significantly, halfway through the project after 2x2 PT students had come through the SHIRES clinic; the Project Coordinator was informed by the Community PT manager that the PT students would only be able to attend ½ days on Tuesdays and Fridays in discipline specific activities. This meant that PT students had less time with discipline specific supervisors, for teaching and assessment purposes in the community. Liaison with the PT manager and Physio HOD occurred in an attempt to involve the PT students in other outpatient PT groups. This occurred sporadically towards the end of the placement as students booked SHIRES clients in on Tuesdays if that was the only day clients could come as a priority.

Unfortunately some of the Discipline supervisors were unable to attend the workshop which had been offered by Dr Gillian Nisbet before the clinic began. This may have contributed to some of the objections the supervisors expressed regarding assessment of students needing to be done by the Discipline specific supervisor with input from the Project Coordinator; as well issues with the structure of Orientation weeks, and the University perspective on the value of Interprofessional placements as well as placements involving supervision with supervisors in a “traditional” role. These were topics which were covered in the workshop.
Some very positive comments were also provided to the Project Coordinator regarding the SHIRES students and the clinic. Some of these were:

“Through the SLC the students have had the opportunity to develop a better understanding when speaking to clients about goals and how to achieve them (compared to other students).” (PT Supervisor)

“The students were always enthusiastic to learn when spending time with clinicians.” (PT supervisor)

“Students are being taught the patient-centred health coaching approach.” (PT supervisor)

“Seeing the students understand and use the HCA approach and have an appreciation for other Allied Health Professionals.” (EP Supervisor)

“Knowing that there is support available for people who want to make lifestyle changes or check that they are doing everything possible to maintain a good quality of health. Although there are other mediums to access this type of support e.g. internet, telephone health coaching, these mediums are not available or suitable for everyone. Many people prefer the face to face approach, for example, if they have a hearing disability.” (Nursing)

“I found that the SHIRES students had a good understanding of how to talk to clients about goals and some independent management strategies, possibly due to the health change concepts.” (PT supervisor)

“I have found working with this alternative model of student placement has provided me with a few new skills for supervising students, e.g. goals, and the way the SHIRES students approached an initial assessment interview for pulmonary rehab gym clients by starting with asking about the client’s current activity, as improving this is often the focus of the gym.” (PT Supervisor)

“I feel this service would be most beneficial as a follow on to SHALT and Cardiac rehab when patients are at a stage of recovery where they are looking at the long-term changes.” (Nursing)
4.4 Evaluation of Service Outcomes

4.4.1 Referrals to the Clinic

There were 10 sources of referrals of clients to the clinic during the 20 week programme (see Table 4.4.1).

<table>
<thead>
<tr>
<th>Data of where patient referred from:</th>
<th>Number of clients referred</th>
<th>% of referral sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Volunteers</td>
<td>13</td>
<td>27%</td>
</tr>
<tr>
<td>Self- Referral</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>OACCP</td>
<td>7</td>
<td>15%</td>
</tr>
<tr>
<td>Stress Management/SHIRES</td>
<td>8</td>
<td>17%</td>
</tr>
<tr>
<td>SHARCS</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Mobility Clinic</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Physiotherapy Knee Group</td>
<td>7</td>
<td>15%</td>
</tr>
<tr>
<td>Allied Health Referral</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Gunyah Ward</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Carers Forum</td>
<td>4</td>
<td>8%</td>
</tr>
</tbody>
</table>

Total Number of Clients= 48

Table 4.4.1

*All clients who had been entered on to the client database were included in this table.
4.4.2 Number of Referrals

There were 48 referrals made to the clinic over the programme. Some clients declined to be involved in the clinic when they were contacted for an appointment. The reason for declining varied. One client had moved away. Others had too many other appointments or did not think they required the service. There are 5 clients who will be on the waiting list for next year.

At this stage of the clinic there have been no referrals from GPs. Graph 4.4.2 shows the proportion of clients referred by the different referral sources.

Graph 4.4.2

4.4.3 Number of Clients Participating in the Programme

As previously mentioned there will have been 30 clients through the SHIRES clinic by the close of the clinic for the year. Clients are at different points along the pathway. Some clients are only requiring follow up phone calls to see how they have been going with their Action Plans. Other clients are at the start of the pathway and have yet to discuss their Personal Health Improvement Plans and formulate Action Plans. These people will require follow up next year as well as face to face appointments before the clinic closes for the year.
4.4.4 Numbers of Clients Attending SHIRES Each Month

The number of clients attending the SHIRES clinic from August 1st until November 21st grew each month. This was despite clients being discharged and despite some clients dropping out of the clinic (x2 clients).

The data for the graphs below has been generated from Cerner, which is the programme in which client-related and non-client related activities must be entered each month by each Allied Health professional working in NSW Health.

Graph 4.4.4 shows the gradual increase in numbers of clients in SHIRES over the programme.

![Graph 4.4.4](image)

4.4.5 Face to Face Occasions of Service (OOS)

On average students were seeing 5 clients a week face to face, over the 3 days that the clinic was running. Each session could take up to 1-1 ½ hours. Over these 3 days as well, students were attending a team meeting and at least one Case Conference, as well as following up other clients by telephone or email. They were also spending considerable time in research, debriefings with each other and documenting in client files. The total number of OOS for all clients in the clinic over the programme is summarised (see Graph 4.4.5).
4.4.6 Time Taken for Different Client Related Activities

The OOS can be further broken down into the different contact types such as face to face, case conferences, case planning sessions, email and phone contact. The information can be expressed in the amount of time taken for each contact type (see Graph 4.4.6).
4.4.7 Trends over time

It is interesting to note that over the months the amount of time for Case planning has increased compared to the time spent in face to face contact. This may be due to the increased numbers of clients SHIRES clinic was managing as time progressed and the number of handovers of clients to students in the second half of the programme. Students needed to spend more time reading client files, listening to previous interviews and follow up sessions on audio tape and talking and researching together on options for clients. The amount of time spent per client in case conferences decreased over the programme but the number of OOS for case conferences was steady, except in November where the time decreased.

Finally the amount of time spent with clients can be seen to have increased over the programme. Thus even though numbers of face to face contacts has not increased per week the amount of time spent in all client related activity has increased. Graph 4.4.7 depicts the time over the programme spent in client related activities, whether they are face to face, debriefing, documentation, case planning or case conferencing OOS.

![Graph 4.4.7](image_url)

4.4.8 Referrals from SHIRES to Other Community Services

Please see Referrals to Other Services (Part 4.1.6) for further details. There were 63 referrals made for SHIRES clients over the programme. 19 clients were referred back to their GP, often to discuss Team Care Arrangements to see another Allied Health professional such as a Physiotherapist, Dietician or Exercise Physiologist, or to discuss a Mental Health plan to see a Clinical Psychologist. There were sometimes several follow up sessions with clients before they made the decision to accept professional help. It was only through the process of trial and error, trying to achieve goals and “failing” with the particular options, that clients came to realise that they had another option which was to have some extra help. Students spent a lot of time researching the best options for their clients in regard to referrals. Each client’s needs were different and it was through the development of therapeutic relationships that clients were able to work through their options and accept referrals to other health professionals or community services.
4.4.9 Client Numbers and Student Caseloads over the Programme

Another feature of the SHIRES clinic was the fact that students were coming and going throughout the 20 week programme. Of concern is the effect on continuum of care, and in particular how many different “lead students” clients may have over this time. The number of changes of lead students that a client had over their time in the clinic is seen in Graph 4.4.9.

Graph 4.4.9

The majority of clients had 3 or less changes in lead students over their time in the clinic. Exceptions were Client 8 and Client 16. Both these clients had been in the programme for over 2 months.

4.4.10 Quality Improvement (QI) and other Projects

QI projects and research was conducted by students throughout the 20 week programme (see Appendix 6). This included QIs which sought to improve the operations of the clinic, client recruitment strategies and referral pathways, and the investigation of client outcomes and clinical targets. All students assisted the Project Coordinator in gathering, recording and analysing data for the purposes of this report.

*Operational QIs* included setting up the Resources Folder. This was kept on the T-drive for easy access to all students and included information which students gathered when researching options for clients. These may have been community services, health professionals, activities and groups or information about individual activities such as meditation. Another important QI involved the development of an Operations Manual for the SHIRES clinic. This had several forms, but has now been updated into a comprehensive manual for students on the “how tos” of running the clinic.

*Client recruitment strategy QIs* covered topics such as determining inclusion/exclusion criteria for outpatients, Knee group recruitment, OACCP recruitment, Gunyah referrals, Allied Health referrals and Carer referrals. These served to make all students aware of the different ways clients could be recruited and kept this high on the priority list in team meetings.
Research was also conducted by students to determine the most up to date information regarding clinical targets for the 5 chronic diseases which are the focus for NSW Health. Another student assisted the Project Coordinator with analysis of the client outcomes for this report. The expertise of the student who had initially set up the Client Data Base and the student who was able to modify and then analyse the Client Data Base is gratefully acknowledged by the Project Coordinator.

4.4.11 Client Admissions before and during SHIRES programme

It is of interest to determine when clients had their most recent admission to TSH and whether this admission was related to their chronic condition(s). Students investigated EMR to determine the SHIRES clients’ most recent admission to TSH. They investigated all 28 clients who have been interviewed but were only able to find information on admissions for 21 of the 28 clients. Graph 4.4.11a gives the proportions of the 21 clients who had admissions to TSH between 0-3 months, 3-6 months, 6-9 months, 9-12 months and over 12 months.

Graph 4.4.11a

From this information it can be seen that 62% (38%+24%) of clients have had an admission within the last 6 months and 81% (62%+19%) have had an admission within the last 12 months.
Based on the limited information on EMR regarding the admission, students were able to group the causes for clients’ admissions into several categories. They were grouped into 6 categories. These were: Musculoskeletal, Cardiac, Planned Surgery, Neurological, Diabetes complication and other (usually an acute illness such as diarrhoea). Graph 4.4.11b depicts the number of clients in each admission category.

Graph 4.4.11b

Whether clients had been admitted whilst they were in the SHIRES programme was another point of interest to this study. Students were able to determine that of the 21 clients; only 3 clients had admissions during the time they were attending the SHIRES clinic (see Graph 4.4.11c).

Graph 4.4.11c
4.5 Review of Objectives of the Project

During the first stage of the current project, soon after the establishment of the steering committee, a detailed project plan was developed which consisted of setting a Vision statement, making objectives and key performance indicators; and linking outcomes. Having done this, an evaluation plan was then developed so that the data which was required was able to be gathered over the programme.

A review of outcome measures, as they relate to the Key Performance Indicators (KPI) for each objective follows in an effort to ascertain whether we have met our ultimate goal:

“To establish a primary care clinic which addresses a service delivery gap in Chronic Disease Management in the Sutherland community and to provide an innovative, interdisciplinary clinical placement for senior health professional students”

<table>
<thead>
<tr>
<th>OBJECTIVE 1:</th>
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<tbody>
<tr>
<td>To provide the community of Sutherland Shire with excellent Inter-professional client-centred care supporting people with or at risk of Chronic disease</td>
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</table>

**Rationale of Objective 1:**

1.1(a) Clients seeking to improve their health by coming to SHIRES will be at risk of or have chronic disease.

**Discussion of Outcome Measures:**

1.1(a) All clients of the SHIRES clinic had at least two chronic diseases and 71% of the group had 5 or more chronic diseases. A large proportion (81%) of the client group had been admitted to hospital in the last year. The client group fits the inclusion criteria for the clinic. Most clients match the profile of the “Group 2” people in the TSH Chronic Disease Service Framework (see Diagram 2.1.1) as the majority have had an admission in the past year and all have two or more chronic diseases.

In Chapman’s (2012) research on co-morbidity, the estimate of people admitted to SESLHD hospitals with 4+ Comorbidities was 79% in 2012. The proportion of people with 4+ Comorbidities in the clinic population was 81% in 2014.
### Rationale of Objective 1:

<table>
<thead>
<tr>
<th>1.1(b)</th>
<th>Older clients will tend to have more chronic diseases than younger clients as “estimated in the SESLHD resident population with co-morbidity” data (Chapman, 2012)</th>
</tr>
</thead>
</table>

### Discussion of Outcome Measures:

| 1.1(b) | The SHIRES client group was not representative of the resident population with co-morbidity in that all clients of all age groups had similar numbers of comorbidities. |

### Rationale of Objective 1:

| 1.2 | If students have been providing excellent client-centred care, feedback from clients will support this. Students are trained to use a client-centred approach in the SHIRES clinic (HCA methodology) |

### Discussion of Outcome Measures:

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<thead>
<tr>
<th>1.2(a)</th>
<th>The majority of clients (87.5%) scored either a strongly agree or agree to the statement “Overall I am satisfied with the service provided to me by the clinic today” on the Client Satisfaction and Feedback Survey.</th>
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<tr>
<td>1.2(b)</td>
<td>Clients made comments such as “making me feel more accountable and motivated”, “The students was absolutely fantastic and help me to understand myself and help myself with all problems”, “Supportive in ways to achieve better health”.</td>
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<tr>
<td>1.2(c)</td>
<td>Video comments were also very positive, in particular “It’s given me direction in managing my health”, “I really do believe in it”, It did make me prioritise what I really needed and it made me realise you do have to take responsibility for your own health”, “To have somebody I can say, ‘How do I go about that?’ and they can give me suggestions”</td>
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### Discussion of Objective 1 – Key Performance Indicators (KPI):

SHIRES clinic has attracted clients who meet the inclusion criteria. Clients have chronic disease, and they are currently well and living at home. They are over the age of 16 years. Some of the clients were attending or had attended other outpatient clinics in the hospital, but none of them were involved in programmes with an ongoing education component when they started in the clinic.

The ages of the SHIRES clients did not cover the 0-24 year age range as in Chapman’s research (Chapman).

The SHIRES clinic has yet to reach the objective of reaching people at risk of chronic disease. The client group have demonstrated and also say that they have benefitted from the service, but there are many more people, particularly people who are younger and newly diagnosed with...
a single chronic disease, who have yet to be referred or recruited to the clinic. Our first KPI was to show that the client group is representative of the wider population of SESLHD with or at risk of chronic disease. We have certainly attracted clients with chronic disease, but our aim is to attract people at risk of chronic disease as well. This will require the connection with GPs and their referral of people with risk factors or people newly diagnosed with chronic disease to the clinic.

<table>
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<tr>
<th>OBJECTIVE 2:</th>
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<tr>
<td><strong>To deliver a Model of Care which supports client identification and prioritisation of health issues and facilitates client goal setting and personal health improvement planning</strong></td>
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<thead>
<tr>
<th>Rationale of Objective 2:</th>
<th>Discussion of Outcome Measures:</th>
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<tr>
<td>If the purpose of the Model of Care is to facilitate clients to improve their health management then there will be evidence of this process in the clients’ files</td>
<td>A documentation audit of all 28 Client Files showed that documentation tools align with the Model of Care and only 3 of 28 clients have Action plans in another format. This has made data collection more difficult in their case as progress notes need to be read in detail.</td>
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**Discussion of Objective 2 – Key Performance Indicators (KPI):**

Overall there has been consistent use of the designated documentation tools since their introduction. They have been an aid in communication between students and clients. The tools assisted the team in data collection regarding client’s progress over their time in the clinic. The 3 files missing “easy to read” Action Plans have made the team aware of the need for using the “standard tools” such as the Client Cover Sheet, Health Management Checklist, Personal Health Improvement Plan, and Action Plans.

The tools used in the client files provide evidence that the Model of Care pathway has been followed by students with clients and Objective 2 is being met.
**OBJECTIVE 3:**
To consider local community needs, priorities and engagement in the design and sustainability of the clinic

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<th>Rationale of Objective 3:</th>
<th>Discussion of Outcome Measures:</th>
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<tr>
<td>If the SHIRES clinic is meeting the needs of the community and engaging with the community, clients will stay in the programme and there will be evidence of integration of clients into community services and groups. There will also be referrals to the clinic from the community or other services</td>
<td>Of the 28 clients who have been interviewed so far in the SHIRES clinic, 25 of them have engaged in the process of health change over the programme. This represents over 89% of the client group. Clients have engaged in the programme, committing to the process of identifying their health issues, prioritising them and working on Action Plans. (See Objective 4 where client outcomes are discussed further).</td>
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Referrals to and from the clinic have been analysed.

Referrals to the clinic continued over the 20 week programme. Over time, referrals included a greater variety of sources which included self-referral by staff and volunteers, referral by Allied Health staff from other clinics, and self-referral from community groups. As yet, SHIRES has not received referrals from GPs. There has been limited contact made directly to GPs at this stage of the project.

(c) Referrals from the clinic to community services occurred frequently but usually during follow up sessions. Clients were actioning referrals as part of their Action plans and required time to decide the referral would be beneficial and then to make appointments and follow through with their appointments. Some clients have yet to have follow up appointments at which time they may report actioning these referrals.

**Discussion of Objective 3 – Key Performance Indicators (KPI):**

89% of clients have engaged in the process of health change over the programme (KPI = >50% clients will engage in the process of health change). Clients’ needs were being met as they had identified what those needs were and they were working to achieve the small goals on their Action Plans, which they had developed, to meet their larger health goals. On average clients achieved 65% of goals on their Action Plans during their time in the clinic this year. A number of clients are now involved with health professionals, with other community services or they have been seeing their GPs to discuss their health issues. Clients, who are still working on their Action Plans, have expressed a desire for follow up next year. There are also at least 5 people on the waiting list for next year. The clinic has been integrating clients into services away
from the hospital into primary care. Engaging GPs will be Stage 4 of the project.

The SHIRES Model of Care has promoted integration of clients into the community. The low number of admissions of clients since involvement in the clinic is heartening; particularly as the majority of SHIRES clients have had admissions over the last year to TSH.

Further work on connecting with GPs, explaining the work of the SHIRES clinic and how the clinic can support their practice, will be a necessary part of increasing the referral of people at risk or newly diagnosed with chronic disease to the programme. Work still needs to be done on this aspect of Objective 3, which is “engagement of the community in the design and sustainability” of the clinic.

**OBJECTIVE 4:**
To ensure a high standard of patient care through continually monitoring outcomes (both client and service outcomes), providing continuum of care, and engaging in quality improvement strategies.

**Rationale of Objective 4:**
If the process used in the Model of Care is successful, then most clients will achieve positive outcomes by achieving their goals and actioning referrals (in Action Plans). They will engage in the programme and continue until they have reached their goals.

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<tr>
<th>Discussion of Outcome Measures:</th>
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<tr>
<td><strong>(a)</strong> There have been 25 clients who have Personal Health Improvement Plans. 18 of these have Action Plans and they have achieved 65% of their goals on these Action Plans at time of writing (KPI = on average, clients will achieve &gt;50% goals on Action Plans). There are still more follow up appointments and phone calls to be made for these people and for those people who have yet to develop Action Plans in their first follow up session. The team ring to remind clients of appointments and rebook appointments with clients who do not attend for some reason.</td>
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<td><strong>(b)</strong> 83.3% of clients have actioned at least one referral (15 out of 18 clients who have had their 2nd follow up session) (KPI = 80% of clients actioned referrals from the clinic to other services as part of their Action Plans). However the time between face to face sessions or follow up phone calls (determined by the client), can mean there is considerable delay in monitoring client outcomes.</td>
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<td><strong>(c)</strong> The retention rate of clients is 93.3% (28 out of 30 clients) (KPI = &gt;75% of client retention rate).</td>
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<td><strong>(d)</strong> Continuum of Care has been ensured through keeping changes of lead students to 3 or less and often the “scribe student” has become the lead when the other student leaves. Also handover occurred at case conferences when students were leaving and the main points for follow up were always</td>
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documented on the Case Conference tool.

Better ways of monitoring clients’ incremental goal achievements (progress over time) with better Action Plan tools and determining the optimal length of time between face to face consultations for clients should be explored further. There has been a wide variation in the number of face to face OOS for clients over their programme.

(e) Quality improvement projects were a feature of the clinic as it was evolving throughout the 20 weeks. It was helpful that the PT students had to do a QI for their Professional Practice Unit of Study. This meant quality improvement was always on the team meeting agenda and all 8x PT students were involved in a QI. Overall students were enthusiastically working on improving the operations of the clinic.

Discussion of Objective 4 – Key Performance Indicators (KPI):

Client outcomes and feedback suggest that the Model of Care has been successful so far. Client engagement has been high. Improvements in monitoring client outcomes could be made, both in the way Action plans are used over time to show goals achieved, changed goals and new goals. Also this could be captured in the client data base in more detail. Another measure which is still to be explored is the PAM score. Only pre intervention scores have been measured at this point. It would be of interest to measure the changes in client’s PAM score over a 3-month, 6-month and 12-month period, as clients continue to work on their health plans.

Within the short timeframe of the project, and the limitations of client numbers; and taking into account the student workforce who have come and gone over the programme, we have achieved one of the major objectives of this stage of the project; which is to see clients working towards improving their health through changing their behaviour.

From the perspective of the client group, the Model of Care has been successful. Some students and supervisors working with students on the “discipline specific days” have provided feedback which will need to be addressed prior to moving forward to the next stage of the project.

The SHIRES clinic has maintained a high standard of patient care, based on client outcomes, continuum of care, and quality improvement involvement. The service outcomes highlight the need for further research into optimal contact points and length of stay in the programme. We have further to go with this objective.
OBJECTIVE 5:
To demonstrate efficient, effective use of information technology to support best practice and ongoing clinical research

Rationale of Objective 5:
Students will record the time spent in face to face sessions and other client related activities. A good proportion of their time, other than face to face with clients will be spent on research for the client.

Discussion of Outcome Measures:
(a) Students developed a statistic sheet to record their Occasion of Service (OOS) for clients in detail. This was used by the Project Coordinator to enter the data into Cerner. The sheet also made it easier for Jenny, one of our administrative staff, to enter the bookings into scheduler. Case Planning (research), face to face OOS, and case conference are the three highest types of OOS (see Appendix 17).
(b) The time spent on research and preparation for clients has been consistently high throughout the 20 weeks of the project and is higher than the time in face to face sessions (see Graph 4.4.6).
(c) Students had access to the T-drive, CIAP and the intranet. The first students who came to SHIRES had to wait for several days for access to these resources as the Project Coordinator had difficulty with the convoluted steps involved in organising this.

Unfortunately students were unable to be given access to the internet. Students also only had 3 laptops between 6 students sometimes. Some students brought their own laptops to do their assignments to free these laptops for use by other students. Most of the students preferred to write their draft notes in typed form for the Project Coordinator to check and then they would write them into the client progress notes. They would bring them back to me to countersign. They used their mobiles to search for information on the internet.

EMR, in its present state still limits students’ ability to track clients’ medical history and admissions at other hospitals. There is also limited information about a clients’ admission to TSH at this stage. Students were however able to retrieve clients’ old notes from Medical Records regarding admissions to TSH.
Discussion of Objective 5 – Key Performance Indicators (KPI):  
The students used their resources effectively. They were able to research and provide information to clients, giving clients details of options for community activities, programmes and services. Efficiency was less achievable, because of the limited number of laptops and access to the internet. Students chose to lessen the impact of these limitations by providing their own resources. Ultimately this should not be necessary, but since staff share the same lack of resources, there is likely to be some difficulty in solving these issues quickly.  
The student workforce was accountable for their client related activities which gave a clear picture of the time spent over the programme. Students were adaptable in the way they solved resource limitations and were not observed to be overly concerned about these issues.

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<th>Objective 6:</th>
<th>Discussion of Outcome Measures:</th>
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| **To provide an inter-professional clinical placement to student health professionals which prepares them for the changing demands of the future health workforce** | (a) Although not tested statistically, there were some clear shifts in students’ opinions regarding some aspects of inter-professional learning, as seen in their post placement RIPLS scores compared to their pre-RIPLS scores (see Part 4.2.1).  
Most students were satisfied that the orientation had been thorough, supervision was appropriate, feedback was constructive and they said they were aware of the learning objectives of the unit. They also agreed that they had improved their understanding of inter-professional learning (91.67% of students).  
The majority of students (75%) agreed that the clinic will be useful to their professional development in the future and they were satisfied with the level of clinical knowledge they had obtained from the clinic (75%).  
(b) Written feedback from students was very positive overall with only a few statements from students expressing some difficulties. The main issues for students surrounded the operational side of running the clinic such as learning and managing administration tasks and computer access. The other issue for some students initially was the difference between the in-depth interviewing and documentation which... |
was used in the clinic compared to their discipline specific area of practice.

There was some dissatisfaction in the number of learning opportunities provided because of low numbers of clients. Students perceived having “new clients” to “do initial interviews with” as the optimum learning experience, whereas the Project Coordinator perceived a students’ ability to gain rapport and work with a client who had been handed over by a departing student; as perhaps more challenging, and therefore of equal or greater value in some ways to the student, as a learning experience.

| **Discussion of Objective 6 – Key Performance Indicators (KPI):**

Students reported many positive learning experiences in the SHIRES clinic, as evidenced by the depth of their written statements on their feedback forms. As the Model of Care was developed and the number of clients grew, students were able to understand the importance of the work they did in research and preparation for face to face sessions with clients and they also understood the importance of working together inter-professionally, to attain the best outcomes for clients. “More opportunities to have face to face appointments” was a theme which some students expressed. The importance of referrals from other sources, such as GPs, is an important goal for the future sustainability of the clinic; to provide enough experiences for all students involved. |
**OBJECTIVE 7:**

To be a key partner with the Chronic Care team

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<th>Rationale of Objective 7:</th>
<th>Discussion of Outcome Measures:</th>
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| The SHIRES clinic is involved in providing a service to people with or at risk of chronic disease. Health Improvement, Referral and Education are the main activities of the clinic. As such there must be close liaison with the Chronic Care Team who provide direction and governance in the LHD for chronic disease services. Students’ understanding of health change and the need for integration of people into community based services and activities to improve their health, will be the driver for sustaining the clinic and developing it further. | (a) The Chronic Care team (CCT) have been involved at all levels of the project. A representative of the team was at each Steering committee meeting either in person or via teleconference. Members of the team gave education sessions to the SHIRES students as part of their orientation, several times over the 20 week programme. The CCT also liaised with the Project Coordinator regarding suitable Continuing Professional Development opportunities for both the students and the Project Coordinator.  
(b) The CCT introduced the Project Coordinator to another Project Officer who has been employed in the HealthOne project. The SHIRES project may move forward alongside this project. This will be an option to be explored further with the CCT when discussing sustainability of the clinic. |
4.5.1 Effectiveness of the Model of Care

The SHIRES project has provided an opportunity to trial a Model of Care which is truly inter-professional in nature. The students use the same Health Management checklist which assists them to understand a person’s health issues from the person’s perspective. The communication style which is used during the in depth interview allows students to develop rapport and build trust with the client. The client is facilitated to identify their health issues and prioritise them. Personal Health Improvement Plans and Action Plans are then developed, usually in the first follow up session in collaboration with the client. The client sets the pace, determining when they think they would like the next follow up session or phone call. Clients are always encouraged and supported in their goals to improve their health. They are encouraged to have confidence that they will achieve their health goals and that trial and error is the way to do this.

New strategies and goals are suggested if clients find they are not meeting their goals. Clients are given as much support as they need. Some clients come regularly each week, others more irregularly.

Students have said that they begin to understand the unique skills of each of their different disciplines as they debrief after the initial interview. They each come from a different knowledge base and as they talk together they gain a broader understanding of the various issues for the client. Together they work on possible options for the client, clients may then choose to make the researched options part of their Action Plans.

Often, over a few sessions with clients, they come to realise that they may need referral to a particular health professional or service to further their goals of health improvement. The clinic plays a vital role in giving clients the control to make these decisions and supports them in following through to completion on their Action plans.

The students come to understand the time it takes to work with people at this level. They realise the uniqueness of having this time with clients in this setting.

The fact that SHIRES is a project with funding for a fixed period has been one of the major limitations to advertising and promoting it widely in the community, especially with GPs. Having now trialled the Model of Care and having been successful, despite this challenge; the Project Coordinator is in a stronger position to promote this service to the community.

The Chronic Care team has a shared understanding of the health change approach and has emphasised the need for integration of people into primary care. The SHIRES clinic has the potential to make a valuable contribution to Chronic Care Management in a cost effective manner, with a student workforce and minimal staffing and resources required.
4.5.2 Evidence to Support the Project has met the Objectives

**Objective One:** Four out of five of the KPIs have been met. Clients fit the inclusion criteria but are not representative of the resident population with co-morbidities. The integration of clients back to GPs, other health professionals and services in the community has occurred also. Incoming referrals from the community, particularly from GPs is still part of this objective which needs to be demonstrated.

**Objective Two:** This has been demonstrated within the limitations of the small client group. The Model of Care process was followed consistently with clients throughout their engagement in the clinic.

**Objective Three:** Two out of three KPIs have been met. There is evidence to suggest that client needs are being met. The engagement of the community in the design and sustainability of the clinic is yet to be attained.

**Objective Four:** All five KPIs have been met. A high standard of client care through monitoring client outcomes and ensuring continuum of care and attention to quality improvement occurred, but monitoring of service outcomes, such as client flow through the clinic and number of contacts face to face will need to be understood and managed well, especially when referrals increase. New KPIs need to be developed around Service Outcomes.

**Objective Five:** Two out of three KPIs were met. Students were able to use technology effectively, but efficiency was likely to be hindered by a lack of computers. This was offset by the resourcefulness of students in using their own laptops at times when demand for computers was high. Resourcing more computers and internet access needs to be prioritised when considering sustainability of the clinic.

**Objective Six:** All KPIs have been met. Students demonstrated a growing understanding of the value of inter-professional learning and practice. They developed core skills in communication, collaboration, client-centred practice and professionalism. An increased caseload through the clinic by increasing referrals will address issues around opportunities to practice face to face interactions.

**Objective Seven:** One out of two KPIs has been met. The Chronic Care team have been involved and informed of the SHIRES progress. Further engagement with the team to discuss the future of the clinic will be required.

The evidence would suggest that many of the KPIs have been met within the limitations of the clinic (i.e. small client group, 20 week programme, new Model of Care).

The vision “To establish a primary care clinic which addresses a service delivery gap in Chronic Disease Management in the Sutherland community and to provide an innovative, interdisciplinary clinical placement for senior health professional students” was a huge undertaking. Over the 20 week programme, the student workforce has been able to achieve admirable steps towards this vision.
4.5.3 Quality of Clinical Placements

How to measure the quality of a placement has been a question which has been raised over many years. Inter-professional placements have been recognised as an important part of training students for the future workforce (World Health Organisation, 2013). The students in the clinic showed an enthusiastic approach to learning and working together, which is a great encouragement. They were respectful of each other and worked well together. There was a great deal of laughter and fun. Peer learning and self-directed learning were features of the placement. Students were supported to expand their knowledge and initiate their own learning opportunities. Some students were more comfortable with this than others. Also some students were more mature and had a broader understanding of the limitations of the clinic in its infancy than others. In the end, most students will reflect back on this placement and hopefully realise the uniqueness of the experience. Their involvement in the clinic will give them another element in their repertoire when seeking employment.

4.5.4 Quantity of Clinical Placements

An analysis of ClinConnect showed the relevant number of days of student placements for both the Occupational Therapy and Physiotherapy disciplines in the Allied Health department of TSH (see Graph 4.5.4).

In terms of increased capacity to the SHIRES clinic (shown as Student Led Clinic on OT and ICTN Student Led Clinic for PT) there has been a marked increase in student placement days. According to ClinConnect, for OT this has been from 32 days in 2013 to 86.4 days in 2014 (60% of the placement) whereas for PT there has been an increase from 50 days (2013) to 120 days (2014) (60% of placement).

Looking at capacity overall for both departments over the two years, Occupational Therapy has increased whereas Physiotherapy has decreased. According to Anna O’Brien, the Student Coordinator for PT, the decrease has been due to staffing issues in various other units.
From data provided by University of Sydney (SONIA), in regards to hours of community placement in Southcare, there were 525 hours in 2012, 735 hours in 2013 (taking away the 60% hours for SLC for 2x PT students) and 560 hours in 2014 (taking away the 60% hours for SLC for 8x PT students).
Part 5: Modifications to the Model

5.1 Areas for Improvement

5.1.1 Preparation Phase

A revised plan will be made in preparation for the next phase of the project. Stakeholders will be invited to presentations of a summary of the report for Stage 3 of the project and the revised plan will be presented for discussion.

A meeting with the Associate Dean of WIL at the University of Sydney has already been organised before the close of the academic year to discuss the outcomes of the clinic and sustainability.

As well, a meeting with the all Clinical Academics from the disciplines involved in the clinic, will be organised before the end of the year to discuss the Model of Care which developed over the clinic, gaps in student knowledge, and strategies for better preparation of students prior to placement. Discussions around direct supervision of students during interviews and better preparation of students in communication skill training will be addressed with the universities. A review of the teaching plan and modules will also be a point for discussion at the meeting.

A meeting between the Clinical academics, discipline-specific supervisors and the Project Coordinator will also be a priority before the end of the year. Issues to be discussed will include: the weekly timetable including clinic and discipline-specific days; expectations of students and supervisors if the current pattern is kept; ways to improve communication between discipline specific supervisors and the Project Coordinator, especially around provisions of student names and contact details, orientation timetabling, dates and times for midway and final assessments; an updated Orientation Manual for staff and students; and also ensuring that all supervisors are able to attend a workshop run by the University of Sydney on inter-professional learning and supervision.

Promotion of the clinic with Allied Health staff, and liaison with the CCT to investigate easier access for training in the HCA courses will occur.

5.1.2 Operation of the Clinic

(i) Student Workforce

The Operations Manual will be revised with additional information. Many of the administrative features of the clinic have evolved and work well. Communication around the administrative tasks and their importance to the smooth operation of the clinic needs to be emphasised and included in the Orientation phase of the placement. Student training on keeping statistics accurate, including time for documentation will be part of orientation as well.
Attention to caseloads and equity in learning opportunities will be a priority.

(ii) Client Outcome Measurement

A better way of using Action Plans over time will be explored. The plans became difficult to read and when new goals were added it was difficult to track people’s goals. A new way of doing this would also assist clearer tracking of client’s achievements over time. The Client data base will require additional columns with Follow up 1, 2, 3 and goals achieved in each column.

Outcome measurement will be easier with the functions which have been built into the data base. Students will be able to monitor outcomes each week and this will make follow up occur more readily. The PAM score for existing clients can be remeasured when clients are followed up next year.

Better follow up regarding Client Satisfaction and Feedback forms will occur and further research into the best questions to ask clients to improve the service will be conducted.

(iii) Promotion and Client Recruitment

Students will be encouraged and expected to assist with promotion of the clinic and to give presentations to staff and the community to facilitate recruitment and improve communication between primary care providers and SHIRES. Continued use of successful recruitment strategies and improving involvement with staff in the acute wards will be imperative. The client data base has clients on the waiting list and appointments have already been made with clients this year for follow up sessions in January. Broader promotion into the community about the SHIRES clinic with particular focus on reaching GPs and community groups will occur.

(iv) Student Supervision

Closer liaison with other supervisors during the clinic will be a priority to allow for best support and understanding of students on placement, and to deal with issues when they arise, rather than after they have impacted on staff.

(v) Resources

Resources such as laptops or PCs and internet access will be sought. Perhaps placing them on the “Wish list” with the volunteers may be a way to provide these tools.

(vi) Spaces

Finding space available in the mornings for appointments with clients has been challenging. Use of clinic rooms in the afternoon will need to be a priority.
5.1.3 Possible Modifications to the Model of Care

Main changes to the Model of Care would involve better tracking of goal achievement on Action plans and possible involvement of students full-time in the clinic. This would be possible if there were sufficient numbers of clients to ensure students had an appropriate level of learning opportunities, both face to face and other client related activities.

Involvement of other Health professional disciplines such as Social Work, Clinical Psychology, Pharmacy, Nursing, Podiatry, Medicine and more will be sought.

Involvement of other universities may also be an advantage in that a continuous flow of students in and out with overlapping of some placements would be guaranteed.

Another element which could be explored is taking the clinic "on the road". The immediate resources required by students when seeing clients are only paper and pen. The actual interview could be conducted in many different settings as long as a comfortable non time-pressured environment could be created. In fact just this week the students and Project Coordinator conducted a follow up session in the hospital cafe at the request of a client.

5.2 Sustainability of the SHIRES Clinic

5.2.1 Project Coordinator

Staffing the clinic with at least one full-time student educator will be necessary to sustain the clinic. Planning for egress, other staff should be encouraged to be involved in the training in the HCA methodology and be involved in direct supervision of students in the clinic. If the clinic was running 5 days a week, it would be necessary for other supervisors to be involved at certain times to provide supervision whilst the Project Coordinator was involved doing other activities related to the position. Having the two days/week to do these activities was a "good balance" for the Project Coordinator.

5.2.2 Student Workforce

With adequate preparation beforehand senior health professional students have demonstrated they are very capable of operating the clinic and developing the in depth communication skills which are required to facilitate the process involved in the Model of Care.

Students are challenged at first with many aspects of the clinic but within a short space of time, usually just over a week, they are able to feel confident in the way the clinic works and in their role.

A high number of clients at low risk are potentially able to come through the SHIRES clinic. A student workforce is an ideal way to efficiently and effectively work with these clients.
5.2.3 Integration of Care

The SHIRES clinic has demonstrated that the purpose of the clinic is to support people to improve their health in practical ways and to encourage them to consider referral to community based health professionals; especially their GP, other community activities and groups and services. As part of the Model of Care, actioning these referrals becomes part of the clients Action Plan. Clients are supported through the process of committing to seeing the person or contacting the service they have decided to investigate. The steps to actioning referrals can take time and there are often stumbling blocks which clients are assisted to overcome. The process is very rewarding to the student health professionals. As one of them stated, “Following clients from initial interview through the whole process and seeing their appreciation with the assistance provided” was very satisfying.

5.2.4 Proposal for Stage 4 and 5 of the SHIRES clinic

The Project Coordinator will be remaining in the position until 15th March next year. At present, negotiations are taking place with the University of Sydney and TSH staff to continue the clinic into next year from the Monday 19th January. This would be Stage 4 of the project. There are clients already booked in for follow up appointments and at least 5 clients on a waiting list. During the time from now until the official end of the position, the Project Coordinator envisages working toward further funding opportunities, through proposal applications and making connections with GPs. Rewriting the Orientation Manual and carrying through the plans for improvement mentioned above will also be a high priority.

Meetings with the University and upper levels of management at the hospital will be scheduled before the end of the year to discuss further options for funding (Stage 5).

The SHIRES clinic has been a rich and rewarding learning experience for students, clients and supervisors. The process of changing behaviour to improve health requires patience and understanding. Students learn that giving recommendations and “telling people what to do” does not always work. Clients require health professionals to be client centred and collaboratively working together to help them. They need them to be genuinely interested, giving them the time they need to explain what is going on in their lives and time to unpack their emotions and other factors such as their carer responsibilities or physical limitations which block them from attaining their health goals.

The SHIRES clinic has challenged students to learn how to communicate deeply with clients. It is at this level that students learn how a therapeutic relationship works. Through students’ strong research skills and team work, they have much to offer clients. Clients value the enthusiasm and genuine care that students can give in a non-threatening, relaxed environment. Together both clients and students learn about the complexity of daily lives. Together in inter-professional partnerships, students find ways to help clients to negotiate the health system, and to be integrated into community services. These services will help to improve and maintain the health changes clients are working towards. Ultimately, by helping people to manage their health better, their daily lives will be more productive and satisfying; and the health system will be optimised to continue to provide services where they are needed.
APPENDIX 1

Terms of Reference (TOR) for the SHIRES Steering Committee

1. MEMBERSHIP
   - Project Coordinator, Meredith Pleffer
   - Director Allied Health, South Eastern Sydney Local Health District (SESLHD), Patricia Bradd
   - Either Chronic Care Services Manager, Ambulatory & Primary Health, SESLHD, Linda Soars OR
   - Chronic Care Redesign Manager, Thomas Chapman
   - Associate Dean, Work Integrated Learning, University of Sydney, Lindy McAllister AND/OR
   - Lecturer, Work Integrated Learning, Faculty of Health Sciences, University of Sydney, Gillian Nisbet
   - Department of Health Professions, Faculty of Human Sciences, Macquarie University, Clinical Educator/coordinator, Angela Stark
   - Physiotherapy Head of Department, St. George and Sutherland Hospitals & Health Service, Jason Phillips
   - Occupational Therapy Head of Department, St. George and Sutherland Hospitals & Health Service, Sharryn Fitzgerald
   - ICTN Project Officer, Cate Dingelstad

2. OFFICERS IN ATTENDANCE
   The Stage 3: Interdisciplinary Clinical Training Network (ICTN) Student Led Clinic Project Steering Committee may request other persons/representatives to attend the meeting to assist in discussions on any particular matter.

3. QUORUM REQUIREMENTS
   50% of membership plus one

4. BACKGROUND
   - Stage 3 of the ICTN Student Led Project (SLC) will see the establishment of a primary care clinic which addresses a service delivery gap in Chronic Disease Management in the Sutherland community. The clinic will provide services to people at risk of or with chronic diseases, who are interested in health improvement, require referral to other services, education on prevention, self-management and health monitoring. The clinic will be staffed by senior health professional students in their clinical placement blocks throughout the year. The clinic will provide an innovative, Inter-professional clinical placement for health professional students.
5. ROLE

- The Stage 3: ICTN Steering committee comprises key stakeholders who will guide and assist the Student Led Clinic Project Officer to establish an Inter-professional student led clinic within South Eastern Sydney Local Health District.
- The Steering Committee will support the Project Officer in the development of a long-term client referral base and recruitment strategy, refinement of the model of care and implementation of the clinic. They will assist with the development of a framework which integrates the clinic into current and future service systems and will review the risk management plan for the delivery of the service.

6. TERMS OF REFERENCE

Provide over-arching governance throughout the project which includes:

6.1 Review and agreement on project milestones and KPIs
6.2 Assistance in development of a patient recruitment strategy
6.3 Assistance in development of a long-term referral base
6.4 Reviewing the teaching plan including the promotion of the SLC, Briefing, Orientation and training package for students and supervisors
6.5 Assistance in promoting and encouraging acceptance of change in use of an Inter-professional Model of Clinical Placement within the culture of the workplace
6.6 Assistance in refining the model of care to be used in the clinic
6.7 Review of revised Screening tool for the clinic
6.8 Review and improve risk management plan
6.9 Ensuring operational barriers are overcome
6.10 Review and agreement upon midway and final report

7. FREQUENCY OF MEETINGS

Meetings to be held as deemed necessary by the Committee.

8. EXECUTIVE SPONSORS

- Associate Dean, Work Integrated Learning, University of Sydney
- Department of Health Professions Head, Director of Physiotherapy Program, Faculty of Human Sciences, Macquarie University

9. SECRETARIAT

- ICTN Project Officer, Cate Dingelstad

10. METHOD OF EVALUATION

- Actions and timelines are established, minuted, and then reviewed to ensure progression.
- A record will be kept of the number of meetings held and the attendance at these meetings.
# APPENDIX 2

## SHIRES CLINIC: COMMUNICATION PLAN

<table>
<thead>
<tr>
<th>Key Stakeholder /Target Audience</th>
<th>Purpose of Communication</th>
<th>Communication Medium</th>
<th>Expected No. of contacts required over project</th>
<th>Actual Meetings to date</th>
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<tbody>
<tr>
<td>Steering Committee</td>
<td>Consult, Inform, Involve, Collaborate</td>
<td>Meetings, emails, phone calls, informal conversations, formal supervision sessions, mentoring sessions, training programme</td>
<td>4x meetings  4-5 emails/week  Daily conversations  1x/month formal supervision with HOD</td>
<td>1x meeting prior to steering committee formation  4x Steering committee meetings (4/6,10/7, 27/8, 24/9, 22/10)</td>
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<tr>
<td>Medicare Local (GPs, Practice nurses, Practice Support officers) Michael Russo (Community Engagement Officer)</td>
<td>Consult, Involve, Inform</td>
<td>Meetings, emails, promotional material package distributed via PSOs</td>
<td>2x meetings  1-2 emails/week  Phone call from Medical Practice  Article in GP enewsletter  Phone call and fax to local GP</td>
<td>2x meetings (11/8,18/6)  20/8  15/9  14/10</td>
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<tr>
<td>University of Sydney/ Macquarie University</td>
<td>Consult, Involve, Inform</td>
<td>Meetings, emails</td>
<td>1x meeting at Sydney Uni  1-2 emails/week  1-4 phone call meetings  1x 4 hour training provided by Uni of Sydney  Weekly emails with Gillian  Mentorship every 3 wks</td>
<td>1x meeting at Uni of Sydney (3/6)  1x phone call meeting with Angela Stark, Macquarie Uni (16/6)  1x phone call meeting with Gillian Nisbet, Uni of Sydney (27/6), Briefing (17/7) and ½ day workshop (18/7)  Mentorship meetings with Gillian (14/8,21/8,24/9,20/10)  Meeting with new PTs and</td>
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<tr>
<td><strong>Name</strong></td>
<td><strong>Consult, Collaborate</strong></td>
<td><strong>Meetings, emails</strong></td>
<td><strong>1x meeting</strong></td>
<td><strong>1x meeting (2/6)</strong></td>
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<tr>
<td>Steve Bowden</td>
<td>Consult, Collaborate</td>
<td>Meetings, emails</td>
<td>1x meeting</td>
<td>1x meeting (2/6)</td>
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<tr>
<td>Matt Webb</td>
<td>Consult, Collaborate</td>
<td>Meetings, emails</td>
<td>1x meeting</td>
<td>1x meeting (2/7)</td>
</tr>
<tr>
<td>Chronic Disease Management Team</td>
<td>Collaborate, Consult, Inform, Involve</td>
<td>Meetings, emails</td>
<td>3-5 meetings</td>
<td>Meeting with Tom Chapman (23/5)</td>
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<td>2-3 emails/week</td>
<td>Meeting with Linda and Tom (2/6)</td>
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<td>Meeting with Linda and &quot;Menu of Options&quot; reps (19/6)-referral pathways discussion</td>
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<td>Meeting with Margo Green re-Outcome Measures (5/9)</td>
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<td>Meetings with Wei-li Hume (Project Officer for HealthOne) (11/7, 11/8)</td>
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<td>Brief sent to Cath Whitehurst (see email)</td>
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<td>Presentations to students during Orientation (21/7, 8/10)</td>
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<tr>
<td>Community service providers both govt, NGOs such as RSLs, Probus, Retirement village management, Community centres, Caring centres</td>
<td>Consult, Involve, Collaborate</td>
<td>Brainstorming groups, meetings, emails</td>
<td>1 meeting/provider 1-2 x phone calls/provider</td>
<td>Meeting with David Tremlett (2/7)</td>
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<td>Emails monthly</td>
<td>Meeting with Janice Oliver (7/7) (22/9)</td>
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<td>Presentation to students</td>
<td>Emails and discussion with Linda Vari (meetings with 5/6x gps of volunteers, 1/6)</td>
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<tr>
<td>Connecting care coordinators</td>
<td>Consult, Involve, Collaborate</td>
<td>Meetings, emails</td>
<td>1-2 meetings 1-2 emails</td>
<td>Impromptu meeting at NAIDOC week celebration, awaiting return email</td>
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<tr>
<td>TSH Allied Health department staff</td>
<td>Consult, Involve, Inform, Collaborate</td>
<td>Allied health forum presentations, meetings, emails, promotional material</td>
<td>1x meeting with AH department 1x meeting/discipline at staff meetings-CASE study presentation?</td>
<td>AH Forum presentation-5 mins (15/7) Presenting SHIRES at November AH Forum (11/11) Meeting organised for Southcare OT/PT on 22/10 Meeting organised for TSH S.W. dept. (13/11)</td>
</tr>
<tr>
<td>Ward staff on Gunyah/Rehab</td>
<td>Inform, Involve, Collaborate</td>
<td>Face to face discussions, emails, daily check with staff, Patient Flow Portal</td>
<td>1-2x Phone calls or Referrals from Staff each week</td>
<td>QI for next PT students, starting 29/9</td>
</tr>
<tr>
<td>Southcare Allied Health Managers of disciplines involved in SHIRES at</td>
<td>Consult, Involve, Inform, Collaborate</td>
<td>Meetings, emails</td>
<td>1-3 meetings 1x email/week</td>
<td>Meetings with Margaret Beattie(4/6, 11/6, 25/6, 15/7, 29/7, 15/9)</td>
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<tr>
<td>present</td>
<td>Catherine Day (8/7, 25/7)</td>
<td>Wendy Mullooly (2/6) Operations Working Party meeting (13/6)- Wendy M, Brendon McDougall, Mick Napoli Amy Maclaine (17/6, 5/9, 22/9)</td>
<td>Amy Maclaine (24/7,22/9)</td>
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<tr>
<td>TSH staff involved in specialised programmes</td>
<td>Consult, Involve, Inform, Collaborate</td>
<td>Meetings, emails</td>
<td>1-2 meetings either individually or in Operations Working Party Case Study Presentation to students x2</td>
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<td>HCA Peer Leaders</td>
<td>Consult, Involve, Inform, Collaborate</td>
<td>Meetings, emails</td>
<td>1x meeting 1-2 emails/week</td>
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<td>1x meeting (24/6)-Cathy Brand, Mick Napoli, Dan Shaw</td>
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<tr>
<td>Michael Tang (Project Officer, Stage One SLC project)</td>
<td>Consult</td>
<td>Meeting</td>
<td>1x meeting 1-2 emails</td>
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<td>1x meeting(13/6)</td>
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<tr>
<td>Students undertaking project placement</td>
<td>Inform, Involve, Consult, Collaborate</td>
<td>Meetings, emails</td>
<td>1-3 phone calls 1-3 emails Webinar Multiple opportunities for communicating with students each week (individually and in team)</td>
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<td>Phone calls to all students made (3/7) Emails with Manuals attached/general info re-TSH Briefings–Gillian Nisbet and Meredith : Webinar 1 (17/7) Meeting with PT students at Sydney Uni (21/8), Phone call meeting with EP students (3/9) occurred with Gillian only Student Team meeting each week, Individual supervision each week, Case Conferences(1-2x/week) with Meredith</td>
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</tr>
<tr>
<td>Supervisors involved in SHIRES clinic</td>
<td>Consult, Involve, Inform, Collaborate</td>
<td>Emails, meetings</td>
<td>See above for individual meetings/multiple emails</td>
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<td>Supervisor Workshop</td>
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<td>Joint midway and final assessments with PT supervisors from Southcare &amp; Clinic Coordinator</td>
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<td></td>
<td>Email from Amy Maclaine Email from Margaret Beattie</td>
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</tbody>
</table>

Meetings with Margaret Beattie, Amy Maclaine, Christine Sue (see above) Amela Salcinovic ½ day workshop (18/7)

Ongoing interdisciplinary involvement via education sessions and joint supervision/assessment meetings with students

Midway and Final axs with Meredith and: Margaret Beattie (6/8) Amela Salcinovic and Louise Quiggin (19/8,10/9)

Regarding changes in commitment of time for discipline-specific experiences and involvement in joint feedback session at midway and final assessment

Stage 3: SLC

Date updated: 14th October, 2014
## APPENDIX 3
### SHIRES Project Timeline

<table>
<thead>
<tr>
<th>TASK STRATEGY</th>
<th>TIMEFRAME</th>
<th>PERFORMANCE MEASURE</th>
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<tbody>
<tr>
<td><strong>What will be done?</strong></td>
<td></td>
<td><strong>Start Date</strong></td>
</tr>
<tr>
<td>Recruit Project coordinator</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; July, 2014</td>
<td>10&lt;sup&gt;th&lt;/sup&gt; March, 2015</td>
</tr>
<tr>
<td>Convene Project Steering Committee</td>
<td>22&lt;sup&gt;nd&lt;/sup&gt; May, 2014</td>
<td>Milestones agreed upon (√)</td>
</tr>
<tr>
<td>Establish Working Parties and convene meetings</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; June(1&lt;sup&gt;st&lt;/sup&gt; meeting with CDM working party)</td>
<td>TOR for committee developed.(√)</td>
</tr>
<tr>
<td>Establish a schedule for Interprofessional student placements across universities and disciplines which integrates with LHD and patient needs</td>
<td>May, 2014</td>
<td>June, 2014</td>
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<tr>
<td>Patient Recruitment Drive</td>
<td>June, 2014</td>
<td>November, 2014</td>
</tr>
<tr>
<td>Review clinic rooms and offices for the SLC in line with determined clinical placement</td>
<td>June, 2014</td>
<td>July, 2014</td>
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<tr>
<td>Task</td>
<td>Start Date</td>
<td>End Date</td>
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<td>----------------------------------------------------------------------</td>
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<tr>
<td>schedule and patient bookings</td>
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<tr>
<td>Review existing SLC resources in light of pilot clinic outcomes</td>
<td>June, 2014</td>
<td>July, 2014</td>
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<tr>
<td>Develop SLC briefing for potential students from all disciplines scheduled for placement blocks in SLC; including working in SLC, Interprofessional learning, peer learning, making the most of the SLC experience</td>
<td>June, 2014</td>
<td>July, 2014</td>
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<tr>
<td>TSH SLC Orientation and Training package reviewed, strengthened and refined including training in Health Change Australia approach and education regarding integrating care and services</td>
<td>June, 2014</td>
<td>July, 2014</td>
</tr>
<tr>
<td>Review/evaluate orientation package for Clinical supervisors and provide training in SLC services and effective ways to provide support to students engaged in the project</td>
<td>June, 2014</td>
<td>July, 2014</td>
</tr>
<tr>
<td>Implementation of strategies to ensure students achieve the core competencies expected in their discipline and IP competencies. Evaluation against project parameters outline from Phase 1</td>
<td>July, 2014</td>
<td>Oct, 2014</td>
</tr>
<tr>
<td>Commence and complete placements</td>
<td>21st July, 2014</td>
<td>12th Dec, 2014</td>
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<tr>
<td>Review resources and equipment utilisation within the program</td>
<td>July, 2014</td>
<td>Oct, 2014</td>
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<tr>
<td>Establishment of sustainability framework which makes the SLC viable in the long term and scaleable to other areas</td>
<td>June, 2014</td>
<td>Nov, 2014</td>
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<tr>
<td>Reporting to ICTN</td>
<td>June, 2014</td>
<td>March, 2015</td>
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</table>

Revised SLC project Milestones and KPIs | 21st October, 2014
## Schedule for Inter-Professional Placements for SHIRES, 2014

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<thead>
<tr>
<th>Week</th>
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<tbody>
<tr>
<td>Start Date</td>
<td>21/7</td>
<td>28/7</td>
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Stage 3/SLC  Date: 2nd July, 2014
APPENDIX 5

SHIRES LEAFLET

SHIRES
(Sutherland Health Improvement, Referral and Education Service)

Shires clinic is a project funded by ICTN (Interdisciplinary Clinical Training Network) under HETI (Health Education Training Institute) and is a collaborative effort between Sutherland Hospital, University of Sydney and Macquarie University.

Shires clinic is in Sutherland hospital, in Sutherland Shire for Sutherland residents. It is your place to come and chat about your health.

Health is something we take for granted. Are you as healthy as you could be? Is your lifestyle good for your health? Are you a carer with little time for yourself, let alone thinking about your health?

Improvement doesn’t have to mean the “biggest loser” approach, even though some people have certainly made huge improvements to their health that way. Coming to Shires clinic is a chance to sit down and talk about your health issues and what you see as your priorities. It is about discussing ways to make small changes that you feel you can handle. You develop your own personal health plan which will work for you, with help from the team.

Referrals to other services may be part of your health plan which is discussed between you and your team. There are many existing programmes and activities which may help you to meet your personal health improvement goals.

Education is part of our role. You may have recently been diagnosed with high blood pressure, high blood sugar or high cholesterol or you may be feeling stressed about life in general. Whatever is going on, we would like to be able to sit down and talk about it and provide you with help to manage and monitor your health.

Service is what we are about, serving Sutherland Shire residents, and helping to improve the health of our community.

FOR FURTHER INFORMATION PLEASE RING: Meredith Pleffer, SHIRES coordinator on 9540-8300 (Allied Health Department, The Sutherland Hospital)

An ICTN (HETI) funded project, with South Eastern Sydney Local Health District (SESLHD) and in partnership with University of Sydney and Macquarie University
SHIREs FLYER

Are you as healthy as you want to be?

SHIREs can help you work out what you want to do about it

Ring Meredith on:
95408300 page 420
## APPENDIX 6

### Quality Improvement and Other Projects

<table>
<thead>
<tr>
<th>PROJECT TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The Referral Data Base (became Resource folder)</td>
</tr>
<tr>
<td>2 Inclusion/Exclusion criteria and pathways for SHIRES</td>
</tr>
<tr>
<td>3 Clinical Targets</td>
</tr>
<tr>
<td>4 Operations Manual (Version1)</td>
</tr>
<tr>
<td>5 Knee group recruitment</td>
</tr>
<tr>
<td>6 OACCP recruitment</td>
</tr>
<tr>
<td>7 Gunyah Referral Pathway</td>
</tr>
<tr>
<td>8 Easy Does It</td>
</tr>
<tr>
<td>9 Recruiting carers from the wards</td>
</tr>
<tr>
<td>10 Increasing referrals from the hospital</td>
</tr>
<tr>
<td>11 Client Outcomes for SHIRES clinic</td>
</tr>
</tbody>
</table>
## APPENDIX 7

### SHIRES EQUIPMENT LIST ON 8/8/14

<table>
<thead>
<tr>
<th>Item</th>
<th>Previous Location</th>
<th>Present Location</th>
<th>Usage</th>
<th>Contact person</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laptops x3</td>
<td>Exec Unit</td>
<td>2x SHIRES clinic area</td>
<td>Daily</td>
<td>Meredith Pleffer</td>
<td>95408300</td>
</tr>
<tr>
<td>iPads x8</td>
<td>Exec Unit</td>
<td>2x SHIRES clinic area</td>
<td>Limited due to no internet SIM cards/no access to wireless. Taped visiting ex-clients interviews for use with upcoming SHIRES students. Have CDM information on iPads</td>
<td>Meredith Pleffer</td>
<td>95408300</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5x CDM team Primrose House</td>
<td>For research project</td>
<td>Thomas Chapman</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1x not known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Label Maker</td>
<td>Exec Unit</td>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Activation Measure Scale and licence(electronic copy)</td>
<td>Exec Unit</td>
<td>Primrose House</td>
<td>Paper copy used with each new client</td>
<td>Thomas Chapman</td>
<td>99479830</td>
</tr>
<tr>
<td>USB flash drives</td>
<td>Exec Unit</td>
<td>2x SHIRES clinic</td>
<td>Daily</td>
<td>Meredith Pleffer</td>
<td>95408300</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2x Meredith Pleffer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Video cameras x 4</td>
<td>Southcare</td>
<td>4x AH</td>
<td>No memory cards supplied with cameras/no stands</td>
<td>Meredith Pleffer</td>
<td>95408300</td>
</tr>
<tr>
<td>Pedometers x10</td>
<td>Southcare</td>
<td>8x AH</td>
<td></td>
<td>Meredith Pleffer</td>
<td>95408300</td>
</tr>
<tr>
<td>Data Projector</td>
<td>Southcare</td>
<td>AH</td>
<td>3-4 x per week at least</td>
<td>Meredith Pleffer</td>
<td>95408300</td>
</tr>
<tr>
<td>Medical scales</td>
<td>Southcare</td>
<td>AH</td>
<td></td>
<td>Meredith Pleffer</td>
<td>95408300</td>
</tr>
<tr>
<td>Portable BP monitors with stands x4</td>
<td>Killara rooms (back of gym)</td>
<td>Killara rooms (back of gym)</td>
<td>SHARCS team use regularly</td>
<td>Wendy Mullooly</td>
<td>95407309</td>
</tr>
<tr>
<td>Item Description</td>
<td>Location/Department</td>
<td>Contact Person</td>
<td>Contact Person Phone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------------</td>
<td>----------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse Oximeters x4</td>
<td>?Southcare</td>
<td>SOS Kylie Ditton</td>
<td>95407047</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood glucose monitors x2</td>
<td>?Southcare</td>
<td>SOS Kylie Ditton</td>
<td>95407047</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood glucose test strips x2</td>
<td>?Southcare</td>
<td>SOS Kylie Ditton</td>
<td>95407047</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tape measures x4</td>
<td>Southcare</td>
<td>3x AH Meredith Pleffer</td>
<td>95408300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wall Height tape measure x2</td>
<td>?Southcare</td>
<td>SOS Kylie Ditton</td>
<td>95407047</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conference phone</td>
<td>Southcare</td>
<td>AH Meredith Pleffer</td>
<td>95408300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cuff Weight 0.5 kg x4</td>
<td>Southcare (EP office)</td>
<td>Southcare (EP office)</td>
<td>Brendon McDougall</td>
<td>95407046</td>
<td></td>
</tr>
<tr>
<td>Cuff Weight 1.0 kg x4</td>
<td>Southcare (EP office)</td>
<td>Southcare (EP office)</td>
<td>Brendon McDougall</td>
<td>95407046</td>
<td></td>
</tr>
<tr>
<td>Cuff Weight 2.0 kg x4</td>
<td>Southcare (EP office)</td>
<td>Southcare (EP office)</td>
<td>Brendon McDougall</td>
<td>95407046</td>
<td></td>
</tr>
<tr>
<td>Cuff Weight 3.0 kg x4</td>
<td>Southcare (EP office)</td>
<td>Southcare (EP office)</td>
<td>Brendon McDougall</td>
<td>95407046</td>
<td></td>
</tr>
<tr>
<td>Dumbbells 0.5 kg x4</td>
<td>Southcare (EP office)</td>
<td>Southcare (EP office)</td>
<td>Brendon McDougall</td>
<td>95407046</td>
<td></td>
</tr>
<tr>
<td>Dumbbells 1.0 kg x4</td>
<td>Southcare (EP office)</td>
<td>Southcare (EP office)</td>
<td>Brendon McDougall</td>
<td>95407046</td>
<td></td>
</tr>
<tr>
<td>Dumbbells 2.0 kg x4</td>
<td>Southcare (EP office)</td>
<td>Southcare (EP office)</td>
<td>Brendon McDougall</td>
<td>95407046</td>
<td></td>
</tr>
<tr>
<td>Dumbbells 3.0 kg x4</td>
<td>Southcare (EP office)</td>
<td>Southcare (EP office)</td>
<td>Brendon McDougall</td>
<td>95407046</td>
<td></td>
</tr>
<tr>
<td>Theraband Red</td>
<td>?Southcare</td>
<td>?Southcare</td>
<td>SOS Kylie Ditton</td>
<td>95407047</td>
<td></td>
</tr>
<tr>
<td>Theraband Yellow</td>
<td>?Southcare</td>
<td>?Southcare</td>
<td>SOS Kylie Ditton</td>
<td>95407047</td>
<td></td>
</tr>
<tr>
<td>Theraband Green</td>
<td>?Southcare</td>
<td>?Southcare</td>
<td>SOS Kylie Ditton</td>
<td>95407047</td>
<td></td>
</tr>
<tr>
<td>Theraband Blue</td>
<td>?Southcare</td>
<td>?Southcare</td>
<td>SOS Kylie Ditton</td>
<td>95407047</td>
<td></td>
</tr>
<tr>
<td>Desktops x4 with keyboard and mouse</td>
<td>Killara rooms (back of gym)</td>
<td>1x AH Daily Meredith Pleffer</td>
<td>95408300</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1x reception in Killara rooms Used during SHARCS programmes by their staff Wendy Mullooly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1x tutorial room and 1x seminar room Used infrequently by staff generally</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pamphlets and booklets</td>
<td>Southcare Exec Unit</td>
<td>AH have one box of each but still more outside Trish’s office? Used as resource for students learning so far Meredith Pleffer</td>
<td>95408300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Location</td>
<td>Status</td>
<td>Contact</td>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------</td>
<td>--------------------------------------------</td>
<td>------------------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>Lever Arch Folders</td>
<td>Southcare</td>
<td>8x in AH</td>
<td>Used for Orientation and resource folders and for files</td>
<td>Meredith Pleffer</td>
<td>95408300</td>
</tr>
<tr>
<td>Interactive TV with stand and CD ROM</td>
<td>Education room off Killara gym</td>
<td>Education room off Killara gym</td>
<td>Not used by SHIRES clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chairs x20</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX 8

#### OPERATIONAL COMPONENTS OF SHIRES CLINIC

<table>
<thead>
<tr>
<th>Aspect/Component</th>
<th>Any issues</th>
<th>Strategies/Suggestions/ Safe Work Practices</th>
<th>What next?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parking</td>
<td>Cost/Distance to walk/ parking vouchers considering the altruistic nature of most client’s involvement and potential barrier to recruitment</td>
<td>Linda Soars to organise this as per offer for last clinic</td>
<td></td>
</tr>
<tr>
<td>Clinic Days- Monday/Weds/Thurs?</td>
<td>Hoping to give students at least 3 days/week of experience in clinic and provide the most amount of time available for client bookings as possible but keep in mind numbers may be slow at the beginning and also student skills will need to be developed over time also.</td>
<td>Meredith developing structured learning programme, including visits and discussions with people from various services connected to SHIRES and some volunteer ex-patients</td>
<td>Meredith to contact ex-patients and work on programme</td>
</tr>
<tr>
<td>Reception staffing</td>
<td>For mornings depends on space to be used for clinic</td>
<td>If using PDU clinic rooms may be able to ask reception there to seat clients</td>
<td>See below (Sharryn investigating)</td>
</tr>
<tr>
<td></td>
<td>For afternoon clinic Rehab clients will not be able to enter the area unless we are there early</td>
<td>Students who are not interviewing will be able to work in other room on projects, contacting clients etc. They can take turns being reception and ensuring they are early to the area</td>
<td>Swipes have been obtained</td>
</tr>
<tr>
<td>Room availability</td>
<td>Rehab rooms only available after 1.00pm on the Mon/Wed/Thurs and not sure what spaces available for mornings any day or times</td>
<td>Can book 2x tut rooms from 1.00pm downstairs and possibly go into the evening to have clinic available to working clients (assured by Gillian that students stay late with Private Practitioners and are still covered by insurance)</td>
<td>Sharryn investigating the PDU clinic rooms which were going to be available for use last year but not refurbished in time for Inpatient clinic last year-NOW Medical Outpatients Clinic?</td>
</tr>
<tr>
<td></td>
<td>For mornings… If PDU clinic rooms not available then use OT Rx room &amp;/or PT outpt spaces?</td>
<td>For mornings… If PDU clinic rooms not available then use OT Rx room &amp;/or PT outpt spaces?</td>
<td>Meredith to find out when various groups run in Outpt PT area from Jenny</td>
</tr>
<tr>
<td>Access to rooms</td>
<td>Key for access to back of Rehab when other groups not there. Tut rooms are not locked and seminar room is locked but not available till later most days so tut rooms will be most used.</td>
<td>Maximo in via Jenny (AH reception) for master key for fire doors which have a lock?, seminar room and education room</td>
<td>Meredith to give Jim names of students so they can generate IDs for them. On first day students need to go to Security after 3.00pm for photo ID and swipe. Swipes are transferable to next students but Meredith to keep a record of student name/swipe</td>
</tr>
<tr>
<td><strong>Appointment Bookings</strong></td>
<td><strong>Equipment</strong></td>
<td><strong>Client files</strong></td>
<td><strong>Storage of client files</strong></td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------</td>
<td>-----------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>AH receptionists may be able to take names and phone numbers or page me so I can take details. Need to consider what information we wish clients to fill out before they come-?Self-management checklist??PAM?? Demographic information?? Other ax or questionnaire. Need to consider how this will be distributed-mail if some time in between referral and appt. or when they come to clinic/factor in time it takes to complete into appt. time.</td>
<td>Training students in use/availability/other clinics usage/ensure use IPADs to tape sessions. Objective measurements and how other clinics use them. Need to decide on objective measurements and why taking them and what doing with them. Had meeting with Steve Bowden to discuss this and how to set up Excel spread sheet D/W Medicare Local re-the measures too-suggested need to look at service measures as well as client measures-thinking about PAM more-measuring improvement in Health Literacy, Activation etc. as could see changes in short time in these. Also look at integration between GPs and service and collaboration-referrals to other services.</td>
<td>Michael Tang said not to call them “forms” but “tools” then not a problem.</td>
<td>Need easy access when not seeing clients for teaching purposes, debriefing, planning Rx. Both tut rooms at back of Rehab have empty lockable filing drawers under desks OR we can use a trolley and take them back and forth and store in filing cabinet in AH set aside for trial using trolley-dependent on how many files we are managing and how much we need to access them in between seeing the client-will be difficult if</td>
</tr>
<tr>
<td><strong>Storage of other resources</strong></td>
<td>Paper based and online resource kept in SLC office area and on laptops. Quite expensive resources bought on behalf of SLC but not being fully utilised by SLC such as TV, PCs, Scales, Sphygmonometer.</td>
<td>List of resources bought for SLC on USB from Michael Tang. Need to discuss with Steering Committee where these are best kept. Also PC required by Meredith in office space.</td>
<td></td>
</tr>
<tr>
<td><strong>Opportunities for learning outside clinic times</strong></td>
<td>Attending Fast SHARCS day. Attending Mobility group on Friday mornings in Southcare. Attending SHALT on Tuesdays/Fridays? Meeting with Connecting Care coordinator(s), Healthways coach(es), HCA Peer Leaders involvement. Meeting Patricia Bradd, Cate Dingelstad &amp;/or other members of Steering committee. Visit to Diabetes clinic.</td>
<td>Meredith liaising with other Supervisors involved with SLC students in discipline specific activities who also are involved in various programmes. Meredith looking at material sent by Gillian regarding format of Simulation programme for PTs at Uni to maximise student learning especially if client numbers are low at the start of the clinic. Also from Gillian encouraged to enhance learning through peer learning from the start and interdisciplinary learning from start.</td>
<td></td>
</tr>
<tr>
<td><strong>Training and mentorship from University being offered</strong></td>
<td>Supervisors and Coordinator would benefit from ½ day training session and ongoing mentorship.</td>
<td>Meredith liaising with Gillian Nisbet and Supervisors about suitable day and times and location of training. ½ day training of Supervisors on 18/7.</td>
<td></td>
</tr>
<tr>
<td><strong>Other clinic related activities</strong></td>
<td>Making f/u appts, Stats in EMR scheduler. Training re-HCA methodology. QI involving summarising SHARCS feedback forms. Sourcing other referrals if needed e.g. f/u ex-SHARCS.</td>
<td>Meeting with Michelle Reed (Tues 1/7/14) regarding possible set up of new book for SLC in stats and then with Matt Webb (Wed 2/7/14) regarding this. Met with HCA Peer leaders to clarify their role. Need to discuss further with Wendy — she has 2 boxes of them — no names on them so can’t f/u using them. Volunteer meetings. Linda Soars following up on EMR-“background mapping of the SHIRES clinic to set up “Webnap and Hero codes” Peer leaders provided USB with lots of resources — YEH! Meredith to use HCA/they will support Meredith in use of HCA and students to learn basic practices—suggest not too much at once.</td>
<td></td>
</tr>
<tr>
<td>IT</td>
<td>Logins</td>
<td>Logins for individual students/Internet access for students/Access to drives</td>
<td>Ask Christie re-forms for computer access for students –Jason says they have to have a name against it so will need to fax off new forms each time get new students throughout the clinic</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>EMR access for each student</td>
<td>As above but need EMR set up first!!!</td>
<td>Clinic set up in Scheduler as Interprofessional clinic</td>
<td>Jenny may do this-need to ask her as per Day Rehab appts but need EMR</td>
</tr>
<tr>
<td>EMR scheduling for clients</td>
<td>Lead student has OOS/time accredited to them but other student has time only</td>
<td>Depends on way we set up structure in EMR</td>
<td></td>
</tr>
<tr>
<td>Stats</td>
<td>T.V flush against wall so needs special plug</td>
<td>Spoke with Natasha from IT –have info on type of cable and where</td>
<td></td>
</tr>
<tr>
<td>Cable to connect TV monitor to laptops (OT Rx room in AH)</td>
<td>Meredith spoke with IT who gave me info re two we could order</td>
<td>Jenny has ordered via AH cost centre (Office Max via iProcurement)</td>
<td></td>
</tr>
<tr>
<td>Laptops to be secured on desks in SLC office area</td>
<td>Swipe cards and pagers for students</td>
<td>Ask Christie or Andrew for form we need to get Student Access Cards (?not time limited) D/W Jason about pagers-:? Expensive so maybe have to use mobiles again and look at pagers in cost of sustainability? He suggests finding out from Christies how much each costs</td>
<td>Organised swipes May use OT mobile phones or our own</td>
</tr>
</tbody>
</table>
## APPENDIX 9

**Proposed Teaching Plan for SLC**

<table>
<thead>
<tr>
<th>SESSION</th>
<th>WHEN</th>
<th>WHERE</th>
<th>WHO TO</th>
<th>WHY</th>
<th>WHAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to Student Led Clinic Placement</td>
<td>Beginning of University year? Each semester?</td>
<td>University</td>
<td>Senior students preferencing in Sonia from any AH discipline</td>
<td>Inform students about nature of this type of placement and why it would be worthwhile preferring it</td>
<td>Explain where the clinic is/info about “The Shire”, the background to the clinic-CDM priority in health, approach is Inter-professional one. Sell the work readiness skills angle and expectations on future workforce. Include one case study and/or Stephen Rue’s videos of students from Pilot?</td>
</tr>
<tr>
<td>Briefing</td>
<td>Prior to Inter-professional placement blocks</td>
<td>University</td>
<td>Students who are allocated to the SLC</td>
<td>Ensure students have a clear understanding of what is expected of them (patient recruitment /building referral base/admin work involved / acute hospital setting with other students on acute placements) /understand the learning objectives of the placement; and give further information regarding the operation of the clinic. Address concerns regarding “traditional community placements” vs SLC e.g. missing out on learning some skills/disadvantaged compared to peers</td>
<td>Explain Inter-professional learning and teamwork and why it is needed when working with CD. Explain expectations of students coming to TSH and working in the SLC particularly. Explain the nature of supervision in the SLC, student assessment, peer learning and peer feedback. Use of technology in SLC. Explain the CDM framework and where the SLC sits within it. Explain the development of the Model of Care for the clinic and how it incorporates Health improvement, Referral, Education and Screening (acronym). Provide case examples from pilot</td>
</tr>
<tr>
<td>Orientation and Training</td>
<td>Week One of placement</td>
<td>TSH</td>
<td>Inter-professional student team</td>
<td>Orient students to the hospital environment, AH department and clinic areas and provide knowledge regarding CDM at TSH. Train students in the processes involved in operating the clinic</td>
<td>Education sessions will involve CDM team, use of case studies and talks by Connecting care coordinators, Healthways personnel, SHARCS team, Diabetic educator, Neurology CNE, Wound CNE. Processes involve administrative, WH&amp;S, client recruitment strategies, client service provision including screening tool, HCA methodology (involve Peer leaders for area)</td>
</tr>
</tbody>
</table>
APPENDIX 10

SHIRES Student Orientation Checklist

The following is a checklist to guide your orientation to the hospital and the SHIRES Student Led Clinic (SCCSLC).

## General Information

### Site Information
- Hospital layout
- Transport and parking
- Placement hours
- Facility information sheet
- Organisational chart

### W,H&S
- Read “Looking out for you” information sheet
- WH&S Policy (see department specific WH&S folder/noticeboards)
- Approach Sarah Dobson to book a time to complete the Sutherland Hospital orientation checklist
- Complete a WHS form (if required by your University)
- Emergency Procedures
- Infection Control (signs outside rooms/hand washing procedure)
- Location of fire exits, fire extinguishers, duress alarms as appropriate

### Medical
- Inform supervisor of immunisation status and any issues which restrict your ability to work in a particular area
- Procedure if sick and/or unable to attend placement
- Procedure if you require medical attention while at placement

### Confidentiality
- Use of medical records
- Maintaining confidentiality with staff, students, relatives or patients

### Security
- ID badge needs to be made and picked up from Security office between 3.00- 3.30pm
- Keys to locker provided and signed for
- Swipes provided and signed for
- Afternoon lock-up procedures for SHIRES clinic
- Sign in/sign out book at front reception of Allied Health

---

**Student Name** ………………………………………………………………………………………………………………………

**Supervisor Name** ………………………………………………………………………………………………………………………

**University** ……………………………………………………………………………………………………………………………

**Year** ……………………………………………………………………………………………………………………………

**Contact Phone Numbers** (emergency use only) ………………………………………………………………………………………

**Date Placement Commenced** / /
Allied Health Department Facilities

- Discipline Head of Department offices
- Discipline Manager Offices
- Discipline offices
- Reception desk
- Location of resources, materials and equipment in offices
- Storage of personal belongings (lockers)
- Toilets
- Lunch area/food outlets/kitchenette
- Library
- Mention other connected services e.g. Southcare, Caringbah Community Centre, equipment hire pool (EHP)
- Student workspaces
- Computer access - log ins to be organised for you by Coordinator and Manager

Telephones

- How to page and make internal and external calls
- Location of internal and external directories
- Personal calls

Clinic Related Facilities

SHIRES Facilities

- Purpose, procedures and operations of clinic
- Location
- Available work areas
- Online room booking system
- Central diary
- Location of resources, materials and equipment in SHIRES office
- Communication system between clinic members (Use of mobile phones)

Student Specific Information

Orientation Folder

- Complete and return by Wednesday of the first week of placement:
  1. Pre-placement questionnaire
  2. Pre-questionnaire for observing surgery
  3. Elective in-services
- Ensure the Feedback form is completed in the last week of placement before final assessment
- Discipline specific assessments
- ICAT
- RIPL

Mandatory Student In-services

- Mandatory in-service timetable
- Check with supervisor for next session details

Items for discussion for SHIRES and also Discipline specific supervisor

Documentation

- Basic policy and procedure for documentation
- Forms for allied health and Tools for SHIRES
- List of abbreviations in student folder
- Location of files

Statistics/EMR

Dependent on whether student will treat patients independently. If so:

- Set time for instructions regarding site specific statistics program and training

Timetable

- Use of diary/planner sheets
- Whiteboard procedure
Meeting with SHIRES Coordinator/Discipline supervisor
- Set weekly (or as appropriate) meeting with supervisor
- Weekly objectives to be discussed at first team meeting in first week

Midway and Final Evaluation
- Set a date for midway and end of placement completion of evaluation forms
- Discuss rating scale and expectations

This orientation checklist must be completed by the end of the first week of the placement and submitted to your student co-ordinator. Please make a copy for your portfolio.

Student signature …………………………………………………….. Date / /

Other Suggested Activities
- Spend time on wards participating in activities not related to SHIRES
- Allied Health forum once/month
- Rehab In service once/month at Kareena Private Hospital
- Observation of treatment session e.g. splinting, Upper Limb group, Breakfast group, Falls group, Rehab gym sessions,
- Attend case conferences and d/c planning meetings
- Attend group sessions e.g. FAST SHARCS programme, Stress management and Relaxation, SHARCS group, Mobility group, SHALT gym sessions
- Sessions/interviews with other Allied Health staff
- Visit to related community services such as Southcare, Mental Health or Child and Family Services
- Operating theatres – observe an orthopaedic operation
## Weekly Timetable for Activities in SHIRES Clinic

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00</td>
<td>SHIRES Clinic client interviews/peer review/phone contact with clients for follow up evaluation</td>
<td>Discipline specific placement or external observation experience</td>
<td>SHIRES Clinic client interviews/peer review/phone contact with clients for follow up evaluation</td>
<td>SHIRES Clinic client interviews/peer review/phone contact with clients for follow up evaluation</td>
<td>Discipline specific placement or external observation experience</td>
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<tr>
<td>08:30</td>
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<td>12:30</td>
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<td>1.00</td>
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<tr>
<td>13:30</td>
<td>SHIRES Clinic client interviews/peer review/phone contact with clients for follow up evaluation</td>
<td>Discipline specific placement or external observation experience</td>
<td>SHIRES Clinic client interviews/peer review/phone contact with clients for follow up evaluation</td>
<td>Team Meeting</td>
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<td>14:00</td>
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<td>15:30</td>
<td>Student Supervision</td>
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<td>16:00</td>
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</tbody>
</table>
## APPENDIX 12

### Updated Schedule for Inter-Professional Placements for SHIRES, 2014

<table>
<thead>
<tr>
<th>Week</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<th>18</th>
<th>19</th>
<th>20</th>
<th>21</th>
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</thead>
<tbody>
<tr>
<td>Start Date</td>
<td>21/7</td>
<td>28/7</td>
<td>4/8</td>
<td>11/8</td>
<td>18/8</td>
<td>25/8</td>
<td>1/9</td>
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<td>29/9</td>
<td>6/10</td>
<td>13/10</td>
<td>20/10</td>
<td>27/10</td>
<td>3/11</td>
<td>10/11</td>
<td>17/11</td>
<td>24/11</td>
<td>1/12</td>
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</tbody>
</table>

Stage 3/SLC

Date: 17th September, 2014
# APPENDIX 13

## Modified Client Satisfaction and Feedback Survey

![SHIRES Logo]

### Sutherland Health Improvement Referral & Educational Service

**Client Satisfaction and Feedback Survey**

<table>
<thead>
<tr>
<th>Client Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Interviewer:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>

Please read each statement carefully, then circle one of the numbers on the right where:
1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree, N/A = not applicable

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>The consultation in the clinic was assisted me to identify my health issues</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>I have increased my understanding of how to improve my health</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The clinic students have adequate knowledge about ways to help me to improve my health</td>
<td></td>
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</tr>
<tr>
<td>My confidence in being able to make positive changes to my health has increased</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Overall, I am satisfied with the service provided to me by the clinic today</td>
<td></td>
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<tr>
<td>What aspect of the clinic did you find most helpful in managing your health?</td>
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<tr>
<td>Question</td>
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<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>What aspect of the clinic did you find least helpful in managing your health?</td>
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</tr>
<tr>
<td>Do you have any suggestions on how to improve our service to you?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Is there any other feedback you are able to give us?</td>
<td></td>
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</tr>
</tbody>
</table>
Appendix 14

Readiness for Inter-Professional Learning Scale (RIPLS)

Readiness for Interprofessional Learning Scale (RIPLS) Questionnaire

The purpose of this questionnaire is to examine the attitude of health and social care students and professionals towards interprofessional learning.

Your name: (develop your own ‘personal code’ by using the following formula):

First 3 letters from your first name:  
Last 3 letters from your last name:

Year of birth:  
Your discipline:  
Gender:  

Have you completed the RIPLS questionnaire before?  
If you answered yes to the previous question please indicate how long ago you last completed the questionnaire:

1 - 3 months  
3 - 6 months  
6 - 12 months  
1 - 2 years  
2-3 years  
3+ years

Have you had previous experience of interprofessional teaching?  
If you answered yes to the previous question please give a very brief statement of what this IPE teaching was and any impact it may have had.

Please complete the following questionnaire.

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Learning with other students / professionals will make me a more effective member of a health and social care team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Patients would ultimately benefit if health and social care students / professionals worked together</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Shared learning with other health and social care students / professionals will increase my ability to understand clinical problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Communications skills should be learned with other health and social care students / professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Team-working skills are vital for all health and social care students / professionals to learn</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Shared learning will help me to understand my own professional limitations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Learning between health and social care students before qualification and for professionals after qualification would improve working relationships after qualification / collaborative practice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Thank you for completing this survey.

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>Shared learning will help me think positively about other health and social care professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>For small-group learning to work, students / professionals need to respect and trust each other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I don’t want to waste time learning with other health and social care students / professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>It is not necessary for undergraduate / postgraduate health and social care students / professionals to learn together</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Clinical problem solving can only be learnt effectively with students / professionals from my own school / organisation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Shared learning with other health and social care professionals will help me to communicate better with patients and other professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>I would welcome the opportunity to work on small group projects with other health and social care students / professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>I would welcome the opportunity to share some generic lectures, tutorials or workshops with other health and social care students / professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Shared learning and practice will help me clarify the nature of patients’ or clients’ problems</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>17.</td>
<td>Shared learning before and after qualification will help me become a better team worker</td>
<td></td>
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</tr>
<tr>
<td>18.</td>
<td>I am not sure what my professional role will be / is</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19.</td>
<td>I have to acquire much more knowledge and skill than other students / professionals in my own faculty / organisation</td>
<td></td>
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</tr>
</tbody>
</table>

If you have any further comments regarding interprofessional education please enter them in the box below

Thank you for completing this survey.
## APPENDIX 15

### Students’ Pre and Post Readiness for Inter-Professional Learning Scale (RIPLS) Responses

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither disagree or agree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Total respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Learning with other students/profs will make me a more effective member of a health and social care team</td>
<td>0.00% 0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>37.50%53.85%</td>
<td>62.50% 46.15%</td>
<td>16 12</td>
</tr>
<tr>
<td>(2) Patient would ultimately benefit if health and social care students/profs worked together</td>
<td>0.00% 0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>12.50%38.46%</td>
<td>81.25% 53.85%</td>
<td>16 12</td>
</tr>
<tr>
<td>(3) Shared learning with other health and social care students/profs will increase my ability to understand clinical problems</td>
<td>0.00% 0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>56.25%46.15%</td>
<td>43.75% 53.85%</td>
<td>16 12</td>
</tr>
<tr>
<td>(4) Communication skills should be learned with other health and social care students/profs</td>
<td>0.00% 0.00%</td>
<td>0.00%</td>
<td>25.00%</td>
<td>37.50%30.77%</td>
<td>37.50% 61.54%</td>
<td>16 12</td>
</tr>
<tr>
<td>(5) Team-working skills are vital for all health and social care students/profs</td>
<td>0.00% 0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>37.50%30.77%</td>
<td>62.50% 69.23%</td>
<td>16 12</td>
</tr>
<tr>
<td>(6) Shared learning will help me to understand my own professional limitations</td>
<td>0.00% 0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>43.75%46.15%</td>
<td>50.00% 53.85%</td>
<td>16 12</td>
</tr>
<tr>
<td>(7) Learning between health and social care students before qualification and for profs after qualification would improve working relationships after qualification/collaborative practice</td>
<td>0.00% 0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>31.25%46.15%</td>
<td>68.75% 46.15%</td>
<td>16 12</td>
</tr>
<tr>
<td>(8) Shared learning will help me think positively about other health and social care professionals</td>
<td>0.00% 0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>62.50%50.00%</td>
<td>31.25% 50.00%</td>
<td>16 12</td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Undecided</td>
<td>Total</td>
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<td></td>
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</tr>
<tr>
<td>(9) For small-group learning to work, students/profs need to respect and trust each other</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
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</tr>
<tr>
<td>(10) I don’t want to waste time learning with other health and social care students/profs</td>
<td>31.25%</td>
<td>54.55%</td>
<td>62.50%</td>
<td>64.29%</td>
<td>6.25%</td>
<td>0.00%</td>
</tr>
<tr>
<td>(11) It is not necessary for undergraduate/postgraduate health and social care students/profs to learn together</td>
<td>31.25%</td>
<td>54.55%</td>
<td>62.50%</td>
<td>64.29%</td>
<td>6.25%</td>
<td>0.00%</td>
</tr>
<tr>
<td>(12) Clinical problem solving can only be learnt effectively with students/profs from my own school/organisation</td>
<td>37.50%</td>
<td>27.27%</td>
<td>54.55%</td>
<td>64.29%</td>
<td>18.75%</td>
<td>18.88%</td>
</tr>
<tr>
<td>(13) Shared learning with other health and social care profs will help me to communicate better with patients and other profs</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>6.25%</td>
<td>0.00%</td>
</tr>
<tr>
<td>(14) I would welcome the opportunity to work on small group projects with other health and social care students/profs</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>12.50%</td>
<td>0.00%</td>
</tr>
<tr>
<td>(15) I would welcome the opportunity to share some generic lectures, tutorials or workshops with other health and social care students/profs</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>(16) Shared learning and practice will help me clarify the nature of patients’ or clients’ problems</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>6.25%</td>
<td>0.00%</td>
</tr>
<tr>
<td>(17) Shared learning before and after qualification will help me become a better team worker</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>(18) I am not sure what my professional role will be/is</td>
<td>12.50%</td>
<td>27.27%</td>
<td>56.25%</td>
<td>64.29%</td>
<td>6.25%</td>
<td>0.00%</td>
</tr>
<tr>
<td>(19) I have to acquire much more knowledge and skill than other students/profs in my own faculty/organisation</td>
<td>6.25%</td>
<td>18.18%</td>
<td>25.00%</td>
<td>50.00%</td>
<td>27.27%</td>
<td>18.75%</td>
</tr>
</tbody>
</table>
## APPENDIX 16

### Summary of Student Satisfaction and Feedback Form (Written Responses)

<table>
<thead>
<tr>
<th>COMMENTS</th>
<th>WRITTEN RESPONSES</th>
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</thead>
</table>
| **What aspect of this placement reinforced your learning?** | 1. Shires values building rapport and communication with clients.  
2. Developing deep communication skills (2)  
3. Client contact  
4. Introduction of HCA approach at beginning of placement and provision of materials regarding this  
5. Practicing interviewing skills with other students  
6. Interviewing using the HCA approach  
7. Being able to watch other health professionals implement the HCA approach  
8. Inter-professional learning. I got so much opportunities to work with the OTs and this really help me to know more about how multidisciplinary works  
9. Case conferences and receiving feedback from my supervisor  
10. The independent learning required on this placement motivated my learning  
11. Learning the types of services in the community setting for clients with/at risk of chronic conditions.  
12. Learning about other professionals  
13. Teamwork  
14. Regular and constructive feedback from supervisor and support which allowed for a comfortable learning environment. Self-directed learning ensured I stayed on top on my workload  
15. Researching services for clients post initial interview  
16. Watching our supervisor interact and engage with patients |
| **Do you have any suggestions for improving the student learning in this unit?** | 1. Mini in-services conducted by team members on discipline specific knowledge (2)  
2. Hands on activities  
3. Structured timetable/schedule (2)  
4. More observation of current practitioners implementing the HCA approach e.g. OACCP staff  
5. The student to educator ratio may be a bit inadequate. Sometimes students can’t get individual supervision time with the educator and can’t get variable feedback to improve  
6. More opportunity to interact with clients (2)  
7. More time spent with patients-being the lead more |
| Do you have any suggestions for improving the operation of the SLC? | 8. Ensure students are well prepared prior to starting at the SLC—be familiar with HCA approach, ensure adequate knowledge of chronic disease management and increased knowledge of the roles of all health professionals in patient care  
9. Clearer orientation to what is expected of me during my time on this placement. Very general overview given—needed more re-objectives |
| --- | --- |
| 1. The data entry process and operation manual needs to be updated (2)  
2. Computer passwords available as soon as possible  
3. More laptops needed. Each student should have one laptop and Internet account  
4. Increase funding and hire an assistant for Meredith so students can have more opportunity to see clients.  
5. Saving time by discussing clients between students instead of in front of the whole team at case conferences  
6. Improve client recruitment sources | |
| What were the most rewarding aspects of the clinic? | 1. Strengthening my communication skills to build rapport with clients (2)  
It was very rewarding seeing clients achieve their goals  
2. The rapport and trust from clients  
3. Being able to work with individuals who would not otherwise receive any help to improve their health and lifestyle and discovering more about the OT profession  
4. Working as a team, being a helpful member to finish the task. Having time to listen to client's story during interview  
5. Working in a multidisciplinary team (2)  
6. Working with clients to help them achieve their goals  
7. Working with other students and the supervisor  
8. Learning new skills that we would probably not learn anywhere else  
9. Being able to spend a long time in individual appointments with patients—getting to know them well to provide the best treatments and care  
10. Clients find the research and the services provided improve their health  
11. Following clients from initial interview through whole process and seeing their appreciation with the assistance provided  
12. SLC allowed more responsibilities and learning opportunities by students |
What were the most difficult aspects of this clinic?

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<td>1.</td>
<td>A lot of administration procedures were not very structured yet, therefore need to spend longer time in doing admin tasks (2)</td>
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<tr>
<td>2.</td>
<td>Setting up the clinic from scratch, having to learn an entirely new method of history taking and interviewing, and balancing this with my days in Southcare in which I was expected to use a different approach</td>
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<td>3.</td>
<td>Figuring out what we were supposed to be doing</td>
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<td>4.</td>
<td>Shortage of computer access at the beginning of the placement</td>
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<td>5.</td>
<td>Keeping busy the first week</td>
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<td>6.</td>
<td>Learning new skills and the operations involved in the clinic</td>
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<td>7.</td>
<td>First week most difficult- getting to know and understand how the clinic operates</td>
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<td>8.</td>
<td>It took me a while to understand our role in patient care however once I was familiar with the service and clinic operations then these aspects were no longer an issue</td>
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<td>9.</td>
<td>The fact there was very limited hands on experience in PT specific areas</td>
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*The numbers in brackets next to comments indicate that more than one student made a similar comment.*
### APPENDIX 17

**SHIRES Statistic Sheet (Template)**

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<tr>
<th>Client #</th>
<th>Client Name</th>
<th>MRN</th>
<th>DOB</th>
<th>Referral date</th>
<th>Referral Source</th>
<th>Initial Contact</th>
<th>Initial Assessment</th>
<th>Debrief + notes</th>
<th>Research + Prep</th>
<th>Case Conference</th>
<th>Follow up Session</th>
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