Townsville Hospital and Health Service

Using a Coaching Framework for PE and Clinical problem solving

Contact:
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Queensland Government

Training

Vs

Coaching

Vs

Mentoring

Training

The acquisition of knowledge, skills, and competencies as a result of the teaching of vocational or practical skills and knowledge that relate to specific useful competencies

Coaching

Aims to enhance the performance and Learning of others by providing feedback, motivation, and effective questioning. It is based on helping the coachee to help her/himself through dynamic interaction – it does not rely on a one way flow of telling and instructing

Mentoring

Informal communication, usually face-to-face, over a sustained period of time, between a person who is perceived to have greater knowledge, wisdom, or experience (the mentor) and a person who is perceived to have less (the protégé)

Coaching Frameworks

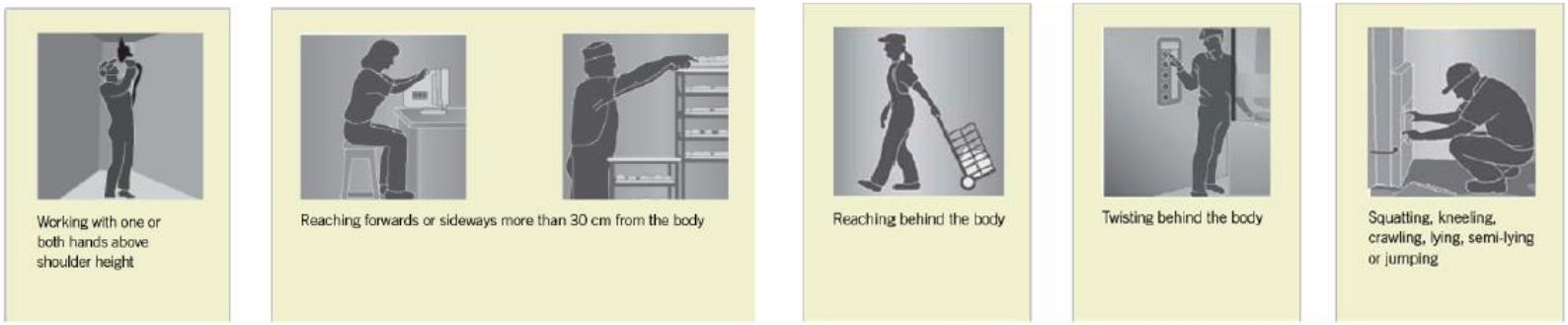
- GROW (Goal, Reality, Options, Way forward)
- WDEP (Wants, Demonstrated behaviour (actions – explored thru feelings, and self-talk,), (Self) Evaluation, Positive plans for improvement)
- 4 Whats (What's Happening? What have you done about it? What could you do about it? What are you going to do about it?)
- EARS (Elicit, Amplify, Reflect, Start over)

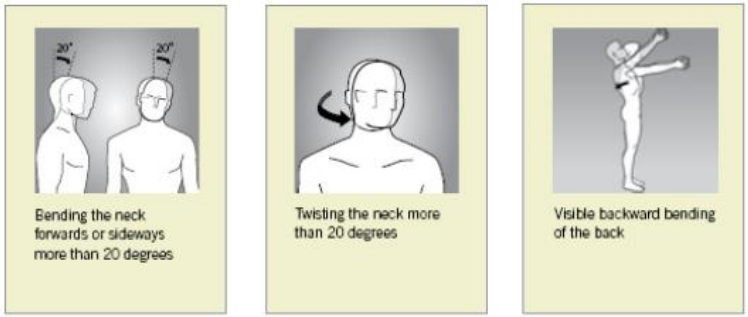
Medical Clinics

- Growing service, Static space
- Numerous Ergonomic and Manual Handling issues
- Historically – looks to units like OHS to solve their problems
- Advice given in the past has not led to action or to changes
- OHS plan – to have issues managed at a work unit level; to build capacity within work units to manage their own risks

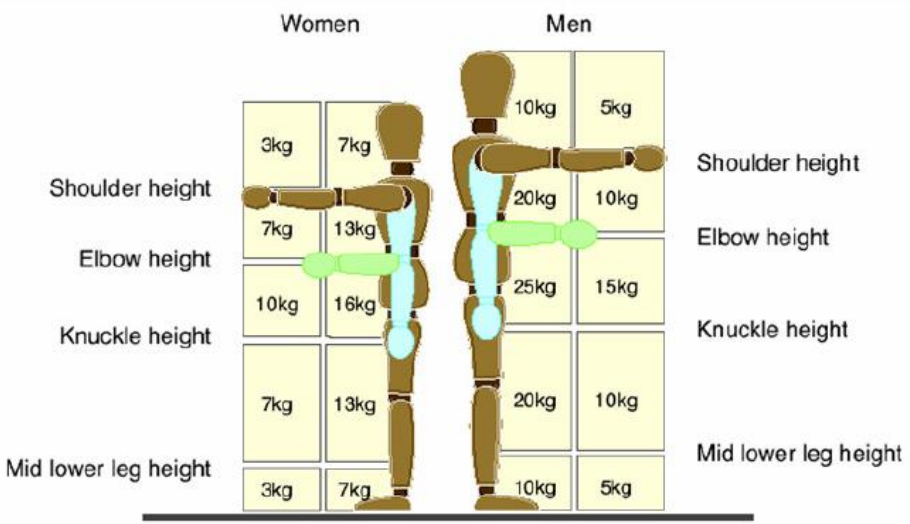
Force, Posture, Time

POSTURE

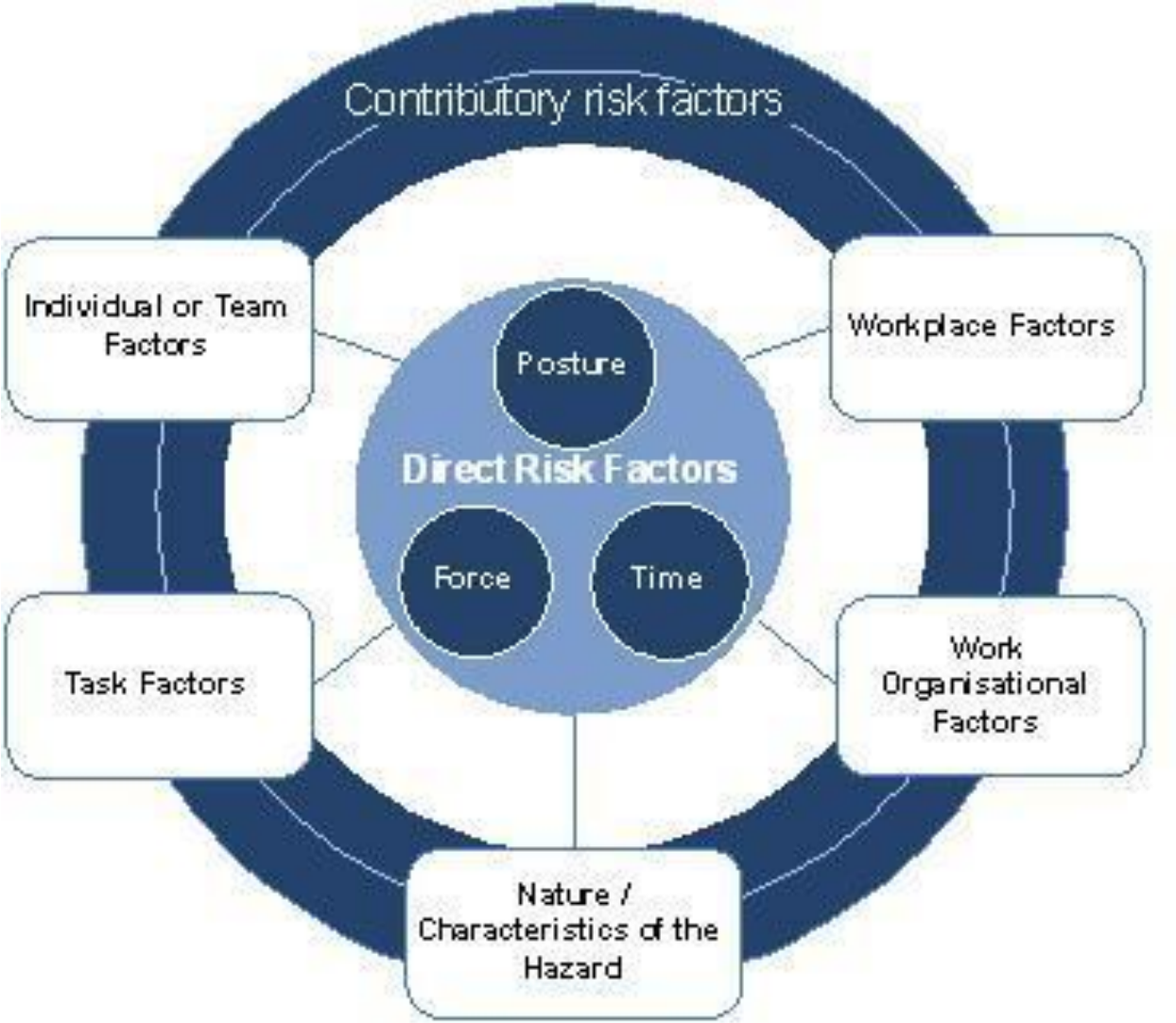




Force



Risk and Hazard identification



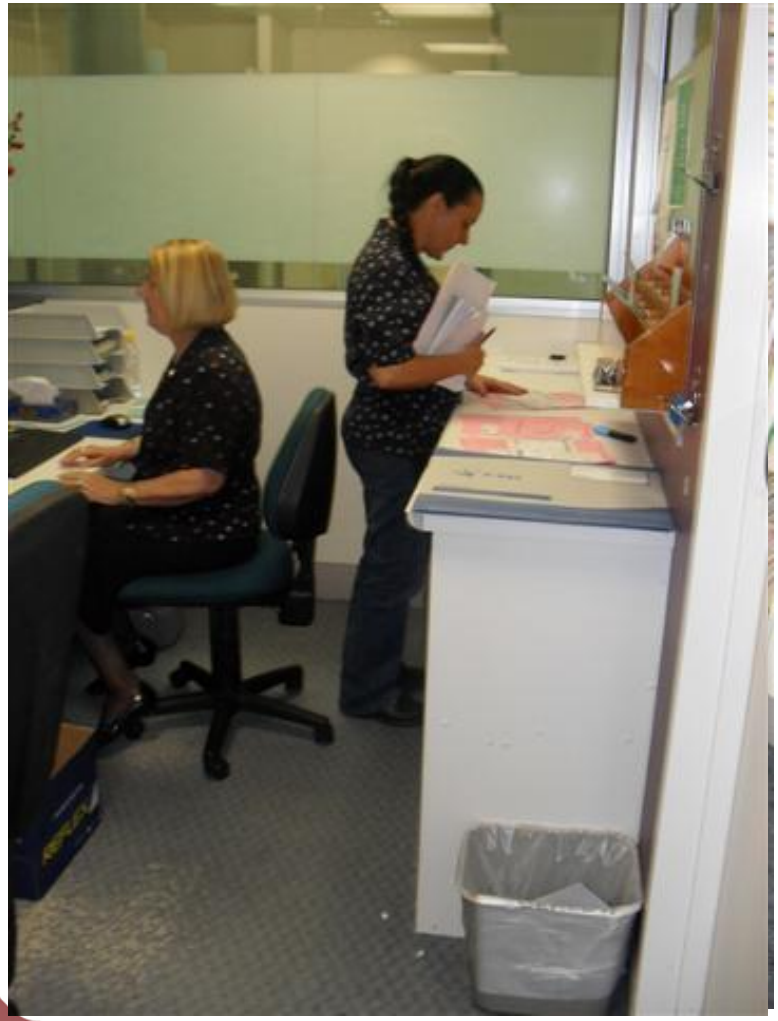
GROW

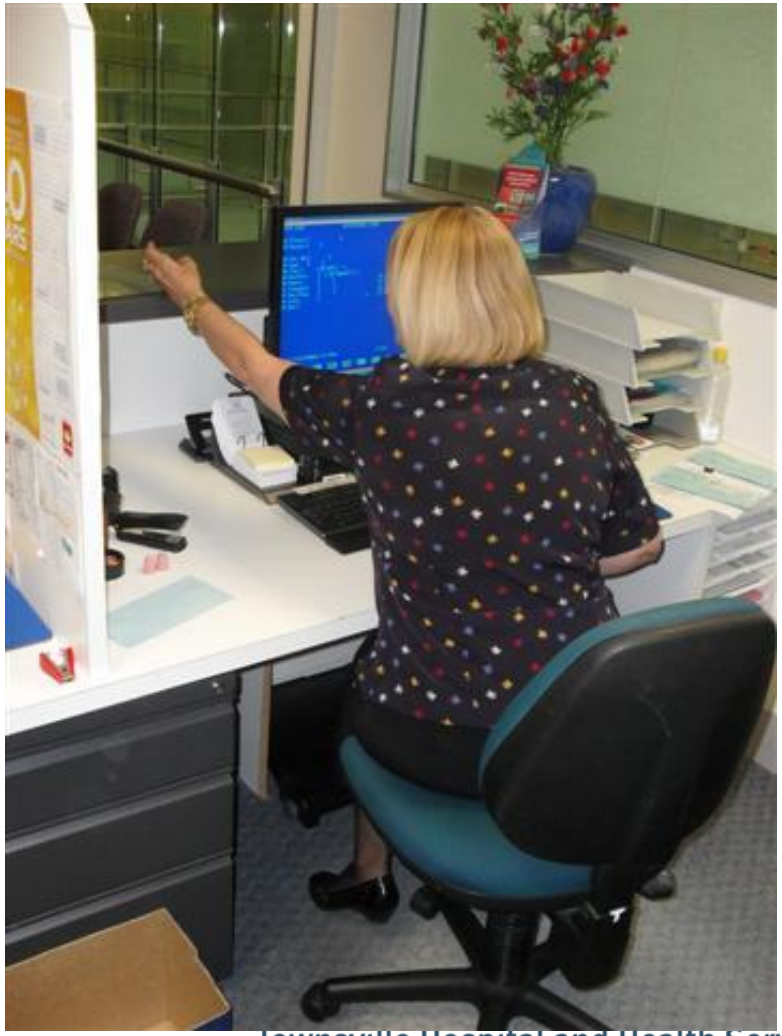
Goal

To identify and assess manual handling and ergonomic risks within Medical clinics, to rank those risks, and to take a methodical and on-going approach to risk management

GROW

Reality





GROW

Options

GROW
Way Forward

Task – 3/10

Problems	Solutions	Proposed completion date	Actual completion
Over-reaching	• Step stool • Avoid using top and bottom shelves, provide enough shelf space at safe heights		
Awkward neck postures	Bluetooth ear piece		
Tasks don't match staff's height	Reconfigure/Modify shelving		
Chart weight	Limit bundle height to 15cm • Instruction to Med Records • Chart height template for Med Records and Med clinic staff		

Task – 7/10

Problems	Solutions	Proposed completion date	Actual completion
Confidentiality	Plastic dividers		
Heavy and hard to steer when fully loaded	• Larger castors • Handle at one end only • Charts positioned closest to pushing end • Limit load size and increase number of trips • 2 person assist when heavy		
Bottom shelf difficult to access	• Raise height with larger castors • Raise shelf heights		
Multiple handling of charts	Additional trolleys to allow for trolley swap (full for empty)		

Experience

Strengths

- More Positive and Engaged staff
- Coaching was a good fit with the Q Health PE program and the new WH&S legislation
- The format was a good fit with the Safety and Quality Cycles
- During Reality and Options phases staff were very good at identifying problems and possible improvements
- The process led to some immediate improvements as well as on-going opportunities to find improvements
- Posting goals, photos and inviting comment and discussion on the staff noticeboard has been effective at ‘maintaining the conversation’ as well as giving staff the sense their issues are still ‘on the radar’.

Challenges

- Staff still needed to be driven from outside (not a self-sustaining process which fell over when I stopped attending)
- Sessions were inconsistent due to work demands and staff availability in Med Clinics
- A number of the significant issues were unable to be addressed from inside the unit – this impacted on the unit’s motivation and their approach to the coaching process

Med 3

- Planned admission of a bariatric patient who was known to be ‘challenging’
- Staff were ‘fearful’ of bariatric patients
- There had been a spate of injuries during previous bariatric admissions
- There was a planned admission of a bariatric patient who staff knew was a challenging personality
- OHS involvement was requested by the NUM

Medical Ward 3
Briefing Session
- Admission of Bariatric Patient -
9/3/2012, 12/3/20012, 14/03/2012 @ 2.30pm

Facilitators: Mark Enders, District Manual Handling Coordinator, OH&S Unit (Ph) 1356
Natalie Simmons, Ergonomic Coordinator, OH&S Unit (Ph) 1732
Leisa Cassidy, CNC BEES Dept (Ph) 1566

Risk	Options / Solutions	Action By
Musculoskeletal injury occurring (back injury)	Equipment, good body posture and techniques, minimise time exposure to task, ensure correct bed height, Rest Pause Breaks (RPB), stretches. Report **ANY INJURIES**	All Staff
Fatigue / Burn out	Rotation of staff, allocation of staff, stretch, ensure enough staff to assist, debrief, employee assistance program available	NUM to facilitate
Patient Related risks Behavioural issues Psychological issues	Above measures, communicate with patient, patient contract, support from Maureen (previous Bariatric patient), reassurance, social workers, co-operation	All Staff
Equipment - availability - capacity - operation	BEES Dept for equipment (Ph) #3594, training from OH&S, check safe working load (SWL) before use	- BEES Dept - OH&S Unit - Ward Unit PH Trainers
Space – lack off	Pre-plan where equipment to be stored, move furniture out of way to create space	All Staff
Lack of staffing	Call OSO for support/assistance, liaise with shift co-ordinator, good team work, schedule tasks, recruit family for appropriate tasks	All Staff
Time	Good communication, start communication book, log how long tasks take	NUM All Staff
Family / Visitors	Allow family to do appropriate tasks, use as information source, develop communication book for family to address any issues/concerns, ask to leave room to perform tasks safely	NUM All Staff
Morale	Regular debriefs, co-workers for support, use and read communication book, raise any issues/concerns as they arise	NUM
Patient morale Possible Litigation Qld Health Reputation	Discuss concerns / issues at handover or briefing sessions, Be mindful of what you say and where you are saying it	All Staff

Outcomes

- 3 staff injured during the first weekend of the patient's admission
- No injuries in the following 10 weeks of managing this patient
- Staff grew to like working with the patient
- Better strategies and more confidence was built in relation to dealing with bariatric patients

Medical Ward 3
Debrief Session
- Discharge of Bariatric Patient -
30th May, 7th June @ 2.30pm

Facilitators: Mark Enders, District Manual Handling Coordinator, OH&S Unit (Ph) 31356
Natalie Simmons, Ergonomic Coordinator, OH&S Unit (Ph) 31732

Positive	Negative
Patient Contract	Failed Discharge – Medical Team insisted
Lessons Learnt	Admitted on Friday – Staff injuries occurred over weekend
Need early Psychology assessment	Initial staffing levels insufficient to provide cares in a safe manner
Failed discharge resulted in behavioural change (motivation) in patient. Progress made in admission and final discharge	Delay in Psychology Assessment
Staff have gained more knowledge around bariatric patients	Limited or no family support/assistance
Approval for additional FTE for ward	Room size – doorways not wide enough to fit equipment
Rostering – only work 2 shifts in a row	No space to store equipment - stored in corridor resulting in trip hazards and fire egress
Weight loss increased patient morale and motivated	Sharing equipment with other patients on floor – Infectious patients
	Staff emotionally/physically exhausted at end of shift
	Casual staff working with patient – limited experience with patient
	Patient had no past times or interests
	Patient morale decreased due to initial sub-optimal care

OHS risk management process