

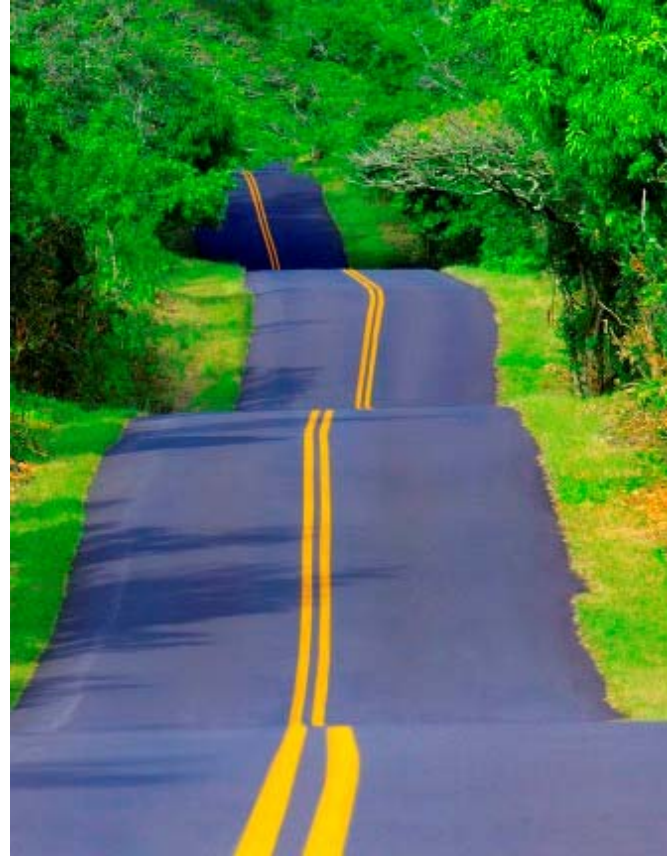


# Putting out spot fires after trailblazing - workshop

Gaby Kavanagh VIHSP

19 June 2015

# Using VIHSP's experience in a workshop



# Workshop overview



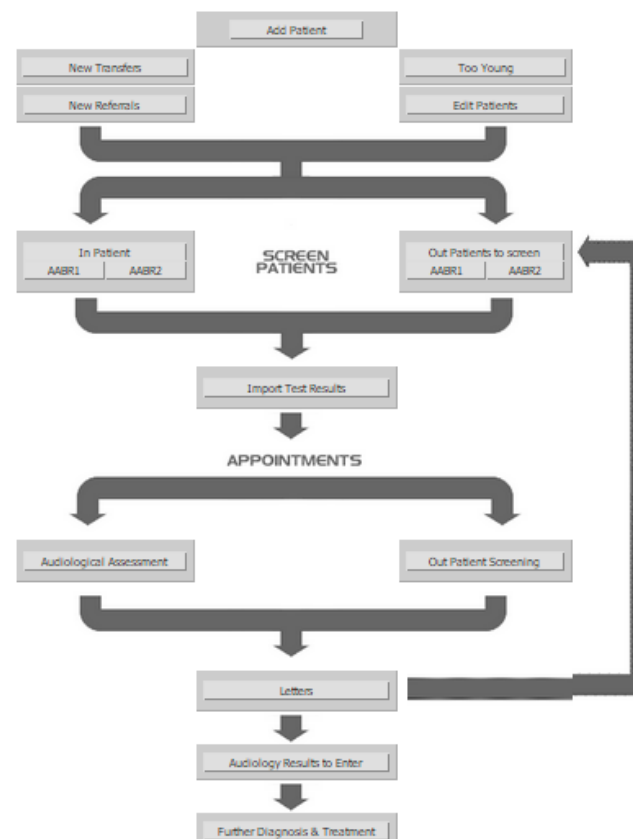
- VIHSP database update 2013 overview
- Issues created following GO LIVE
- Investigation into lingering records
- What should be in an upgrade toolkit?

# How VIHSP use our database



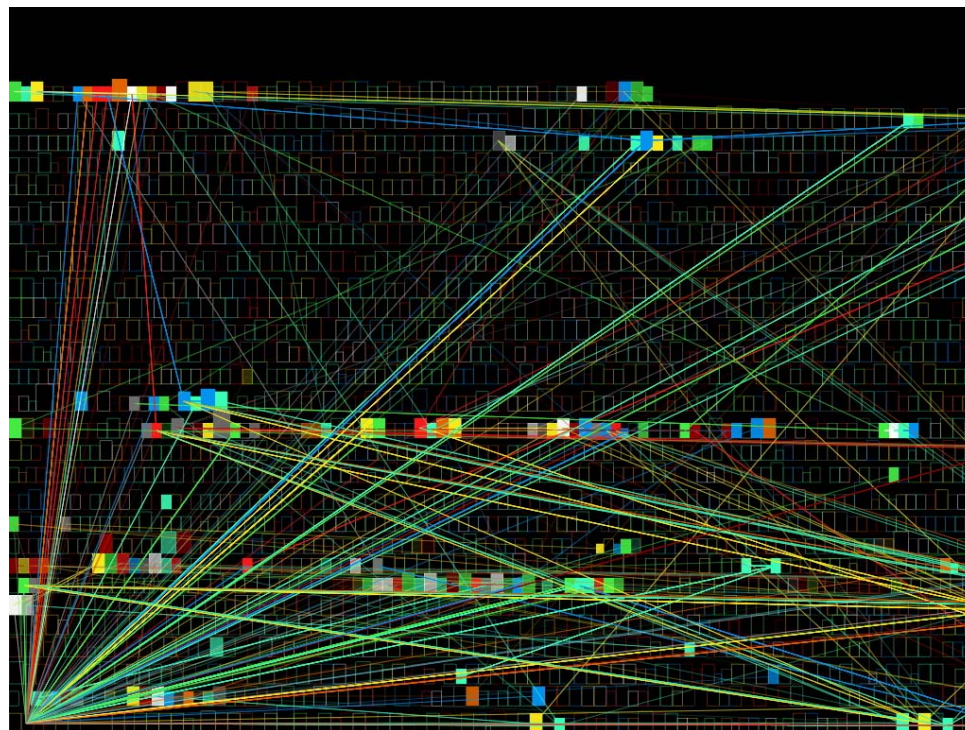
<b>VIHSP To-Do List – In Patients to Screen</b> <a href="#">Print List</a> <a href="#">Close Window</a>									
Date Printed: 11/06/2015 18:57									
Nursery ▼	Ward ▼	Name ▼	Rec# ▼	DOB ▼	Disch ▼	D ▼	C ▼	R ▼	S
Well Baby		sample, baby	092049	13/05/2015		29			
Well Baby		ballarat, boy	1112	30/11/2014		193	C	R	
Well Baby		TEST, BABY	123456	03/06/2000		5486			
Well Baby		INPATIENT BOY, CEPEDEE	145	01/05/2000		5519			
Well Baby		AABR1 ref, IP in process	13	13/01/2000		5628	C	R	

Total patients found: 5





# “Code Merge”





# Receiving and providing information



- What do I need to know?
- How do I find out?
- When to provide it?
- Check that it has been received?
  - Does this need to occur?

# Ready, set, go







What would make a screener's day difficult  
and possibly unmanageable?

# TO DO lists affected



## VIHSP To-Do List – In Patients to Screen

[Print List](#) [Close Window](#)

Date Printed: 11/06/2015 18:57

Nursery ▼	Ward ▼	Name ▼	Rec # ▼	DOB ▼	Disch ▼	D ▼	C ▼	R ▼	S
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# TO DO lists affected



**Decline**

Your baby has  
passed a newborn  
hearing screen



# TO DO lists affected



## VIHSP To-Do List – In Patients to Screen

Date Printed: 11/06/2015 18:57

[Print List](#) [Close Window](#)

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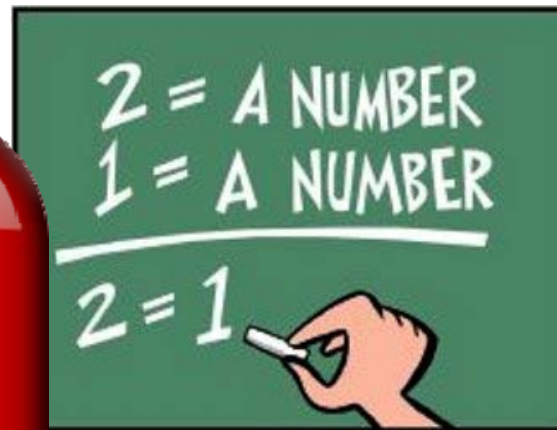


# What did the VIHSP team do?



How did they manage 'random old babies'  
on TO DO lists?

# Creative solutions



# Quick reactions required



# The patch





# The fog was clearing



A number  
of random  
old babies  
loitered on  
lists



What information would you look at in a record?

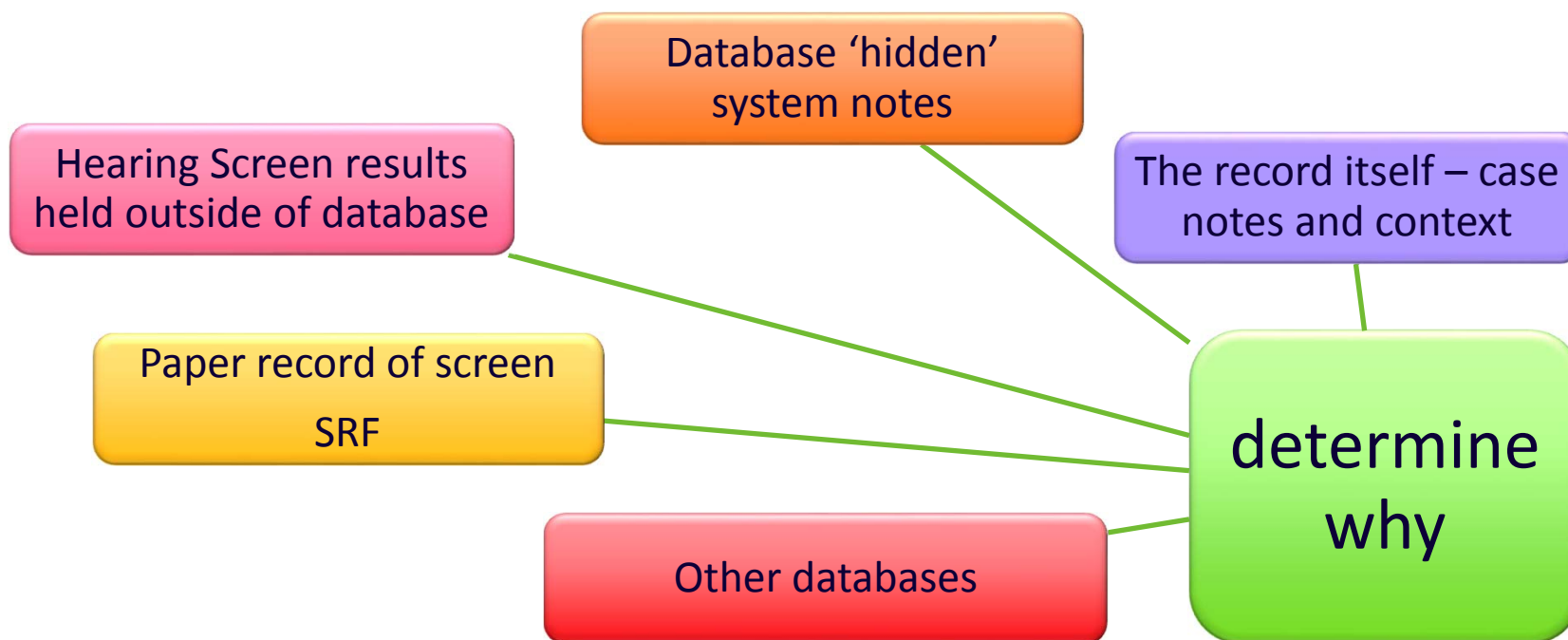
# The 38 'random old babies'



DOB 2005 – 2010

All babies had AABR pass

# Methods used to investigate





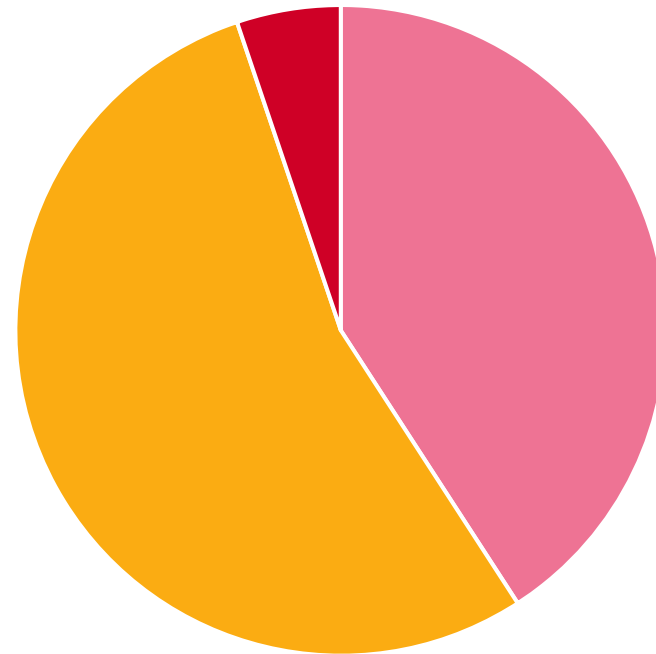
# Pass babies



■ Duplicate pass

■ Over screening

■ Case still open





How do you disseminate findings of investigations without alarming the team?

# Data Management Toolkit





Thanks,

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Images: shutterstock, google images

Melbourne  
Children's

A world leader  
in child and  
adolescent  
health

