

# 附件一

公務出國報告（出國類別：參加國際研討會）

參加第五屆澳洲病人安全和醫療照  
護 品 質 研 討 會  
5th Australasian conference on Safety  
and Quality in Health Care

出國人員：財團法人醫院評鑑暨醫療品質策進會  
林佩儒 專員

出國地點：澳洲 布里斯本

出國期間：96年8月6日至96年8月8日

報告日期：96年9月10日

## 摘要

澳洲 Australasian Association for Quality in Health Care (AAQHC)和 The Australian Council on Healthcare Standards(ACHS), 於 2007 年 8 月 6 日 - 8 日在澳洲布里斯本舉辦之第五屆澳洲病人安全和醫療照護品質研討會(5th Australasian conference on Safety and Quality in Health Care), 大會的主題訂為「The power of us」, 著重在於醫療機構內病人安全文化的建置及醫護團隊的合作以維護病人安全及醫療照護品質。會議主要與會學員大多來自澳洲及紐西蘭, 亦有印尼、香港、新加坡、馬來西亞等國之代表參與, 期望藉由此次會議收集國際病人安全發展之新知與資訊, 使國內病人安全工作之推動可與國際接軌。

第一天開場的專題演講, 是由英國的心理學博士主講, 提出重點為許多高風險的產業都有針對“安全”實行並發展風險管理。所以我們應該可以學習他們的經驗將之應用於醫療業。他以自己與石油產業的工作經驗, 告訴大家, 不管我們是在醫療行業中扮演何種角色, 其實安全文化的建立是非常重要的。第一天分場有一家醫院分享他們如何在急診推展洗手運動及病人辨識的經驗。第一天下午主場會議則提出「The power of E」之概念, 請英國學者說明如何將臨床路徑電子化並應用於病人身上, 澳洲昆士蘭政府部門的專家, 說明如何建立全國性電子病歷, 還有昆士蘭北部的一個城市為提升病人安全及改善醫療品質, 已經先行建立並實施電子病歷。

第二天早上是讓各學員選擇參加工作坊還是參訪技術中心。第二天下午的主題是「The passion and the power of teams」, 提出團隊合作對維護病人安全的重要性。給予病人持續性的醫療照護, 倚賴的並不只是接受完整訓練、具備獨立且高功能工作能力的各個醫療領域的工作人員就可以, 有成效的團隊合作及良好的溝通也是提供良好的醫療的重要因子。

第三天的主題是「Theme-The power of research and evidence」, 其中一位講者

要我們問自己，病人安全的文獻告訴我們什麼訊息，這些訊息要如何應用在醫療照護系統上，讓系統運作，因為，目前的文獻中發現造成傷害的並不是因為個人因素造成的。澳洲衛生部門有一個手術後深部靜脈栓塞的研究，他們將研究計畫成果應用在臨床醫療照護上並修訂臨床指引。

我國在衛生政策、教育及研究應釐訂更具體的主軸，優先以科學的數據證明病安的成效，作為全面推動病人安全的依據。此項工作並非短時間可以預見其成效，必須從文化的改造、領導者的觀念、民眾的參與等議題投入相當精神與時間的，始可見其開花結果。

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## 壹、參加會議目的

病人安全相關議題和研究已成為國際性會議的重點項目與發展趨勢，尤以美國、英國及澳洲等國家較具規模且已累積多年經驗和成果。澳洲在推動民眾參與病人安全之起步甚早，經驗亦值得我們觀摩學習，AAQHC 和 ACHS 於澳洲布里斯本舉辦之第五屆澳洲病人安全和醫療照護品質研討會 (5th Australasian conference on Safety and Quality in Health Care)，該會議為目前世界上對於病人安全議題中，屬於較具規模的國際會議之一，為持續參引國際間病人安全推廣之經驗，作為國內病人安全行動策略之學習標竿，及為使我國病人安全工作能與國際接軌，故本會安排本人參與本次大會。

期許藉由參與國際會議，以瞭解不同國家之病安推廣經驗及國際病人安全發展趨勢，並收集可供學習參考之新知與資訊，以使國內病人安全衛生政策推動之方向與實務工作的推動，可與國際接軌及帶動國內病人安全推動之新思維與行動方案。

## 貳、 會議背景

AAQHC? 澳洲所創立的一個非營利性、會員制的組織，其設立的宗旨在促進病人安全文化的建立及提昇醫療照護品質。；提供一個溝通及標竿學習的平台，推動病人安全相關的研究、促進病人安全的作為，提供持續教育，鼓勵個人及機構為病人尋求改善健康結果，並提供副研究員、研究員的認可證程序等。

自 2003 年起每年該機構均會舉辦一場全國性的會議，提供各項病人安全研究、實務與經驗的發表與交流，可以說是目前國際間以病人安全議題為主軸的會議中最具指標性意義之會議。

大會的主題設定為「The power of us」呼籲全體參與的目標，其精神主要是有感於要促進病人安全，需仰賴於醫療機構內病人安全文化的建立與深化，進而提升醫療品質。病人安全文化的建立是需要團隊的合作及支持，由此可見病人安全文化的營造並非一蹴可及，需要全體參與和投入。

今年為第 5 屆年會，於 8 月 6~8 日在澳洲布里斯本一連舉行三天，與會人員大多為澳洲及紐西蘭之代表亦包含來自其他國家之代表，參加人數將近 1,000 人，其中亞洲地區除本國派員參加之外，印尼、香港、新加坡、馬來西亞亦有代表參加此次會議。此次大會我國指派 2 人出席，係行政院衛生署

醫 事

處 謝

嘉峰、醫策會林佩儒專員，共同前往國外學習他國相關經驗，相信對本國病人安全政策發展與落實應有相當助益，詳細大會議程如附件一。

## 參、研討會重點摘要

### 一、8/6-大會重點

#### 主場會議重點

#### **Patient Safety: Putting it All Together**

許多高風險的產業都有針對“安全”實行並發展風險管理。所以我們應該可以學習他們經驗應用於醫療業。改善安全有三個方法，一是從資訊技術層面，二是從系統面，三是從整各機構的文化，然而最難實行及最有效的方法就是建立整各機構的文化。如何應用三個方法在改善病人安全上，一是三個方法要同時實施，二著重在系統改變及文化的建立，三是“今天系統改善，明天建立文化”。

同時建議醫療機構可以執行安全管理系統(Safety Management System, SMS)，從概念到實施，透過風險管理、加強溝通及醫療倫理，在最根本的層次建立一個完整且整體性的目標去及管理，雖然無法達到零錯誤。但是可提高安全性，建立更強的安全文化。而且經由安全管理系統機構可以建立內部的政策及方針、建立通報系統、更有組織及計畫性、監測及重新檢視機構的安全計畫方案。

#### **The Power of “E”**

英  
國 學

者分享英國的醫院如何運用電腦資訊系統建立 electronic care pathways(ECPs)，來促進醫療照護品質及病人安全。運用 ECPs，可以讓整個醫療領域的專業人員可以共同使用，可以即使獲得病人現況的資料，進而讓病人可以得到最好且即時又適切的治療。ECPs 可使用實證醫學來做跨領域執業。一個成功 ECPs 的建立，可以救更多人的生命，協助醫療人員作對的事情，同時可以立即得到病人的資訊及回饋和結果。ECPs 同時可以用來監測照護過程跟結果是否一致，也可用來作為持續修正及改善臨床治療計畫



(protocol)和路徑的基準,可當 decision support tool, 成為品質改善良性循環。

Authority(NEHTA)的總裁,主講澳洲目前正建置 Electronic health information (or e-health) systems, 這個系統將標準化,以達成建立安全且共享的醫療照護電子系統。此系統可以安全及有效的讓醫護人互相交換訊息和促進行政單位和臨床醫護專業人員交流及溝通。e-health systems 有可能大大提升品質、病人安全和效率的效益,因臨床醫護人員可以從 e-health systems 直接得到病歷紀錄,完整的病人身體評估資料、過去病史、檢查報告和臨床資料及處方,醫療專業人員需要使用同一標準、格式、用語。透過 e-health system 將簡化跨科照護的管理,病人交接將藉由此系統即時的轉介。經由病人病歷的共同分享,臨床醫療人員可獲取最新的臨床醫療意見及病人的過去病史,經由此系統醫療照護提供者彼此之間將可快速又安全的直接交換重要意見訊息。

藉由將記錄在 e-health systems 的某些類型的醫療訊息標準化,將可提高行政效率及改善臨床流程。

澳洲的一家醫院分享,他們如何建立區域性的電子病歷。原先電子病歷只運用在需要開刀的病人上,但是因為實施成效很好,所以現在運用在所有的病人上。成功建立電子病歷的因素是基層診所的醫師非常配合。基層醫師最了解病人的過去病史、家族史及生活型態,所以醫院的醫護人員可以透過電子病歷即時得到這些訊息及病人所有病歷資料,使用在病人醫療照護上,可以做出即時的診斷及提供適切的照護,並可儘早準備出院計畫,病人出院後可以得到持續性的照護。使用電子病歷的優點,減少病人的等候時間,即時取得正確的資訊,節省時間及醫療資源,減少病人不必要的重覆就醫,有助於改

善醫療品質及促進病人安全。

### 分場會議重點

在分場會議中，主要主題則以使用資料改善臨床結果 (Using Data to Improve Clinical)、昆士蘭：Beyond Bundaberg-顧客 (Queensland: Beyond Bundaberg Consumer, Clinician and Corporate Perspectives)，臨床人員和全體的展望、臨床照護品質 (Clinical Quality)、橫跨各醫療層級提供持續性照護 (Primary Health Care Perspectives)、人力資源 (Human Resource)、病人安全及品質 (patient Safety and Quality) 等。

病人安全及品質分場報告，澳洲墨爾本一家醫院分享，如何在急診提高洗手率、病人辨識及醫護人員使用個人防護器材的使用經驗。急診的品質暨病人安全委員會發現一些問題，決定要全體急診人員參與改善計畫。經過與醫護人員及管理者的溝通後，所有的人員 100% 贊成，決定要從改變文化做起，介紹新的手部衛生、病人辨識及個人防護器材使用的標準，因工作人員對這幾個標準流程遵從率低。而且委員會認為“病人安全是為病人及醫療工作人員而做”。病人辨識的改善方法上，建立新的標準，病人沒有戴上手圈，病人就無法離開急診至其他單位，且不可以給任何藥物；增加工作人員對個人防護器材使用率，希望工作人員在工作時能帶手套及護目鏡。同時使用口號“Every patient every time”，並印成海報置放在急診處，來提醒工作人員。

在實施 6

個月後，手部衛生、病人辨識及個人防護器材的使用都有很大的進步。洗手率達到 98%，病人一入急診即戴手圈的比率達 91%，及個人防護器材使用，帶手套比率達 98%，60% 帶護目鏡，同時帶手套及護目鏡 58%。

這個改善方案可以成功的原因是，資深員工對整個改善過程的堅持及支持，並從自己本身做起同時教育其他員工及病人。同時“Every patient every time”的口號是個有效的提醒工具，可以隨時提醒工作人員，但又不具隨時被監督的壓力。經由這個改善方案讓急診重新改造。所以改變要從醫院的文化做起才會達到效果。

## 二、8/7 大會重點

### 主場會議重點

#### **Clinical Indicator Workshop**

澳洲也有監測醫療品質指標，主要是由 Australian Council on Healthcare Standards(ACHS)發展並提供相關服務，ACHS 的指標有 21 類，300 項細項指標。目前提供給參與評鑑的醫院使用，半年提供一次報表給醫院。

這個工作坊主要的目的，是在提醒學員收到季報表時記得要拿出來運用，不要放進櫃子直接存檔。講師給予每組幾張急診指標趨勢圖及一個情況題，請學員分組討論找出改善點及如何進行改善。

### 主場會議重點

#### **The Passion and the Power of Team**

這場主要重點在於團隊合作的重要性，講師主要報告近幾年的所有對病人安全文化研究結果。提出團隊合作對維護病人安全的重要性。給予病人持續性的醫療照護，倚賴的並不只是接受完整訓練、具備獨立且高功能工作能力的各個醫療領域的工作人員就可以，有成效的團隊合作及良好的溝通也是提供良好的醫療的重要因子。其中一篇研究，醫院外科醫師及開刀房護士團隊溝通比較好的團隊，病人死亡率較低。從 1995 年至 2005 年的 RCA 中發現，70% 的異常事件，不管是哪一類的事件，發生原因都是因為團隊溝通有問題。“溝通”是在團隊運作中必須好好加強的，儘管不容易做到。未來病人安全的重點應把如何加強團隊的運作列入發展工作。

另一個講師用同理心跟關懷來做病人安全。光靠科技的方法是無法讓我們改變我們的思想。文化是非實體的，是假定的，價值，信念和行為的。安全文化並不是機構企圖建立就可以成功的，而是機構內部要有強內的動力來參與，同時必須把消費者的價值觀及行為列入在整個文化的建置架構內。

另外香港的學者主要分享香港如何運用資訊系統來促進病人安全。病人安全通報系統和學習文化對病人安全是很重要的，也是一個很普遍且可以找出危險因子的工具。所以香港也建置一個病人通報系統給 43 家公立醫院、45 家特殊診所及 74 家一般診所使用。此通報系統通報事件類別有醫療事件、藥物事件、輸血事件、跌倒、病人失蹤、醫療裝置、工作場所暴力、還有輸液異常事件等。

同時醫院使用 2D-barcode 掃描系統，運用於輸血的流程中，做病人辨識，確保病人輸入正確的血。

### 三、8/8 大會重點

#### 主場會議重點

#### **The Power of Research and Evidence**

第三天的重點，主要談論如何運用研究及實證醫學在臨床實務上以提升醫療品質及病人安全。澳洲 National Health and Medical Research Council 進行預防深部靜脈栓塞的臨床研究，兩年的計畫，目前已經完成並發展成指引應用在臨床上。因為他們發現深部靜脈栓塞在澳洲是一個很嚴重的病人安全議題，因為 55% 的病人在術後出院返家後仍發生深部靜脈栓塞。雖然臨床上有許多預防的指引及建議方法，但是未被充分利用。所以運用深部靜脈栓塞的醫院臨床資料和重新檢視系統及

流程，實施

有效的介入改善方式去改善住院病人的深部靜脈栓塞之預防。改善方式有增加臨床的注意和加強疾病評估的知識、回饋臨床資料給臨床專業人員、使用臨床指引、發展和建立醫院的制度、和定義權責，對機構的臨床專業工作人員(醫師、護士、及藥師)介紹及提醒並衛教病人。改善措施實施之後，79% 的醫院建立相關制度，48% 建立預防深部靜脈栓塞預防措施。

主場會議還討論一個議題，資料運用的部份，在資訊及科技進步的社會，網路資訊可以隨時提供我們生活所需的訊息，例如醫療相關訊息，同時也讓流行病

學專家及行政官員可隨時取得這些訊息。

現在所有的電子資料庫，足以橫跨整個醫療照護去監測和比較過程面和結果面。所以我們必須要小心的使用資料。

基本上，數據和資料皆會改善工作，行政官員也會使數據改善，不然就使得他們失去工作。臨床人員會因要符合行政人員的要求而來改變給予病人的不合理處置。所以我們可以使用臨床監測指標，而醫護人員不做不合理的照護，還是我們可以使用金錢的誘惑進而提升醫療照護品質，這些都是我們使用數據必須好好思考的。

以下幾點是我們使用品質不好的資料或是錯誤解釋所會引起的危險：

1. 醫療院所及臨床專業人員可能會拒絕高危險群病人；
2. 醫療院所及臨床專業人員操控資料，使資料看起來有改善及進步；
3. 優良的醫療院所及臨床專業人員可能會因此而有毀名譽。對外影響大眾對他們的信任，對內影響機構團隊士氣；
4. 可能會模糊焦點，而影響其他的服務；
5. 過程面的成效監測和品質指標也許是無法敘述的。

當我們在收集和提到品質指標必須對不合理的資料有所警覺。所以我們在收集資料時需要注意以下幾點：

1. 使

用可靠的數據和交叉比對包括：(1). 資料來源必須是多方的，(2). 跟結果連結，(3). 避免使用單一資料；

2. 依據使用資料的目的，做風險校正；
3. 不要只監測一個指標。監測同一套裝相關的指標也是不易被信賴的；
4. 臨床的專家必須知道及了解，資料如何分析；
5. 質性及量性的監測同時進行。

現在有像山一樣高的資料可提供給我們，但是不要任意而不負責任的使用數據。需要小心謹慎的分析及使用資料，同時必須告訴大家如果引用錯誤的資

料會所引起的後果。

## 分場會議重點

分場會議，其主要分類為評鑑（Accreditation）、成效量測和結果（Measuring Performance and Outcome）、提升就醫的方便性（Improving Access）、非急性照護（Non Acute Care Setting）、國際現狀（The International Scene）、臨床交接（Clinical Handover）。在會議的發表及討論的過程中，主要可整理以下幾個重點，概述如下：

### 評鑑(Accreditation)

想要了解評鑑是否會有較好的臨床照護品質，或是臨床照護指標是否比較好的病人安全及臨床表現較佳。結果發現臨床指標是用來找出醫療機構需要改善的地方，評鑑是在審視整個機構的服務，並不會幫機構者找出需要改善的臨床點。評鑑委員不應使用臨床指標的數據來做為評值。評鑑及臨床指標是兩個不一樣的工具，但是可用來提升病人安全及促進品質改善，所以必須同時存在，一起實行的。

### 臨床交接(Clinical Handover)

臨

床交接在病人安全中也是一項很重要的議題。目前的交接資料中，只有發展出交接重點摘要單張，所以希望能從系統中改善交接班。目前有醫院自行做內部的調查，找出交接班中最常出現的問題：班別交換時、急性照護轉至社區醫療照護、轉院之間的交接。臨床人員最希望藉由增加臨床人員的教育訓練和溝通技巧、希望提供標準化的工具用在臨床的交接。

目前關於交接班的研究資料不多，不過還是希望機構可以藉由團體工作或是工作坊的方式改善交接，也可以發展出適用所有臨床專業人員且安全的交接班工具。



## 肆、業務相關運用重點

此次年會除了在病人安全觀念上的新知增進，在會場亦有廠商、澳洲各省衛生部門的攤位展覽，提供相當多的病人安全單張、參考手冊及工具，值得醫策會未來在推動病人安全及品質提昇業務實務方面運用參考運用：

- 品質提升病人安全教育訓練及工作手冊：大會有來自澳洲各省衛生部門的展示攤位，針對不同層級及專業背景人員所設計的教育訓練手冊，例如領導統馭、品質管理工具書、預防跌倒改善指引等，國內可發展相關資料，提供所需之醫護人員運用時之參考。
- 確認洗手的正確率之工具：廠商提供機器檢測確定洗手的正確率，洗手前先塗抹具有螢光效果的乳液，塗抹後，請與會者照平常洗手的方式洗手，洗手後將手伸入機器下照射，如洗手不正確，螢光劑將會顯示在未洗乾淨的部位，醫院或許可以使用此機器來稽核醫護人員的洗手是否正確，來確保病人不發生院內感染的情況。
- 會議中工作坊模式的應用：三天的會議中，其中有半天是工作坊，讓與會學員自由選擇，其中品質指標的工作坊進行方式，是由主持人給予一個情況題，請大家分組討論並報告，未來在辦理教育訓練時可以運用此模式。

## 伍、心得與建議

病人安全為一直是國際性所重視之議題，澳洲政府在醫療品質和病人安全的努力皆具備全面性概念，以下乃此次參與此次會議之心得，各面向針對對國內政策研擬與醫療機構品質推動等層面提出相關建議：

在中央主管機關方面：



- 進行國內疾病與病人安全之相關研究：研究調查之重點以瞭解及找出目前國內是否有某項疾病是因其治療方式而有可能影響到病人安全，如有可進行全國性之研究，以減少病人的傷害。
- 媒體營造：經由媒體營造使整體社會環境重視病人安全工作，且讓社會知道這些在醫院發生之病人安全問題，並非歸責於醫院，而是需投入資源做系統性的改善。希望能鼓勵各界從文化層面重新思考病人安全的切入點，而不是只是醫界人士單方面的努力。同時，也要提醒媒體，如要醫院改善，就必須要有數據為依據；醫院品質監測的數據，並不代表醫院的好壞。
- 全國電子病歷的建置：建立安全且共享的醫療照護電子系統，可以安全及有效的讓醫護人互相交換訊息和促進行政單位和臨床醫護專業人員交流及溝通。可提升品質、病人安全和效率的效益，經由病人病歷的共同分享，臨床醫療人員可獲取最新的臨床醫療意見及病人的過去病史，此系統醫療照護提供者彼此之間將可快速又安全的直接交換重要意見訊息。

#### 在醫療機構方面：

- 醫院  
文化塑造與培養：主要工作應要強化國內醫院病人安全文化的建立，醫院從上至下，不同醫療專業領域的人員一起共同參與，病人安全建置在醫院文化中，才是落實病人安全最根本的辦法。
- 專業人員教育訓練：持續不斷的強化各類專業人員之病人安全教育及安全文化環境營造，並加強對病人安全師資培訓與相關教材製作。並加強對現有的資料加以分析，應用在改善上。
- 臨床交接的流程之改善：臨床交接的流程議題在國際間已成為病人安全

主要工作項目之一，醫療人員如何在病人交接時，可以正確、即時的提供正確和完整的資訊給接手的醫療人員。



**AAQHC-ACHS CONFERENCE PROGRAM 2007 Updated 30<sup>th</sup> July 2007**

SUNDAY 5 AUGUST

1500 - 1800

Registration

**DAY ONE Monday 6<sup>th</sup> AUGUST**

0700 – 0845

Registration

0830 -1030	<b>Plenary 1 CONFERENCE OPENING</b>	<i>Great Halls 1 &amp; 2</i>
0830 - 0840	MC: Mr Jim Birch	
0840 - 0850	Welcome Dr Michael Hodgson, ACHS President and Ms Kathleen Ryan, AAQHC President	
0850 - 0905	Indigenous Welcome	
0905 - 0925	Formal Opening Mr Stephen Robertson- Queensland Minister for Health	
0925-0945	Vintage Swiss Cheese	
0945 - 1030	PATIENT SAFETY:PUTTING IT ALL TOGETHER KEYNOTE SPEAKER: PROFESSOR DIANNE PARKER Co-Chairs :Dr Michael Hodgson and Ms Kathleen Ryan	
1030-1100	MORNING TEA	<i>Great Halls 3 &amp; 4</i>

1100-1700

AAQHC Fellowship Exams

*VIP Suites*

1100 -1230	<b>CONCURRENT SESSION ONE</b>					
	THEME 1 <i>P3-5</i>	THEME 2 <i>Great Hall 1 &amp; 2</i>	THEME 3 <i>M4</i>	THEME 4 <i>M1</i>	THEME 5 <i>M2</i>	THEME 6 <i>M3</i>
	USING DATA TO IMPROVE CLINICAL OUTCOMES	QUEENSLAND: BEYOND BUNDABERG <i>CONSUMER, CLINICIAN AND CORPORATE PERSPECTIVES</i>	CLINICAL QUALITY	CARE ACROSS THE CONTINUUM	HUMAN RESOURCES	PATIENT SAFETY AND QUALITY
	Chair: Prof Mike Ward	Chair: Mr Brian Johnston	Chair: Dr Christine Jorm	Chair: Ms Jenny Rance	Chair: Ms Jenny Tuffin	Chair: Dr Annette Pantle

1100 - 1120	Engaging Non Procedural Medical Staff in Quality Improvement Activities: Results of the General Medical Indicator Project (GMIP) <b>Dr Caroline Brand</b>	Reform or rhetoric: Perspectives on changes in QH since the Bundaberg Hospital Commission of Inquiry." <b>Dr Stephen Duckett</b> <b>Mr Keith McNeil</b> <b>Mrs Cheryl Herbert</b> <b>Ms Barbara Kent</b>	Using audit data to develop a predictive model of success for endovascular repair of abdominal aortic aneurysms  <b>Mrs Maggie Boulton</b>	Board of Management reporting on clinical governance in community health  <b>Ms Vicky Mason</b>	Comprehensive Evaluation Of A Simulation Based Undergraduate Medical Course In Patient Safety  <b>Prof Brendan Flanagan</b>	Every Patient Every Time – Improving Hand Hygiene  <b>Mrs Eveline Soon</b>
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1120 - 1140	Chronic Disease Management in the Australian Community Setting: Approaches to evaluation using cross-jurisdictional linkage <b>Dr David Preen</b>		Self Assessment of quality indicators in prescribing and use of medicines across settings <b>Ms Judith Mackson</b>	Coordinated, integrated health care and its implementation vacuum <b>Ms Ann Revell</b>	Consumers A Driving Force <b>Mrs Shirleen Wickham</b>	Credentialing And Clinical Privileging – Protecting Patient Safety <b>Dr Shane McGuire</b>
1140 - 1200	Variable life adjusted display - a new methodology highlighting variation to improve quality of hospital care <b>Miss Kirstine Sketcher-Baker and Mr Chris Hall</b>		Developing a national audit of surgically related deaths with a web based system for data entry linkage <b>Mrs Astrid Cuncins-Hearn</b>	Developing A Quality Framework For A Community Health Setting - A Quality Initiative for Beginners <b>Ms Linda McCrorey</b>	Consumers make a difference to health professional education and accreditation of training courses <b>Mr Antonio Russo</b>	Safer System Saving Lives – What did we find and lessons learnt <b>Ms Alison McMillan</b>
1200 -1230	<b>Q&amp;A with SPEAKER PANEL</b>	<b>Q&amp;A with SPEAKER PANEL</b>	<b>Q&amp;A with SPEAKER PANEL</b>	<b>Q&amp;A with SPEAKER PANEL</b>	<b>Q&amp;A with SPEAKER PANEL</b>	<b>Q&amp;A with SPEAKER PANEL</b>

1230-1330

**LUNCH**

**LUNCHBOX SESSION: *Measuring Patient Safety: Stories or Statistics.***  
QLD HEALTH: Dr John Wakefield

*P3 & 5*

**CONSUMERS LUNCH BOX SESSION**

**CONSUMERS: IT' S ALL ABOUT COMMUNICATION**

Mr Mitch Messer, Chair, Consumers' Health Forum of Australia

*M3*

In this interactive session, Dr Wakefield will explore patient safety measurement, both from the clinician and consumer perspective. Participants will be encouraged to reflect on the 'use' and 'misuse' of current patient safety metrics, in addition to exploring new approaches to patient safety measurement.

1300-1330

**Poster Discussion Session – Theme 1: Measuring Performance to improve patient care**

*Great Halls 3 & 4*

<b>Poster 2</b> - Factors Related To Content Of Antenatal Care In Three Rural Provinces Of Vietnam <b>Dr L Trinh</b>	<b>Poster 3</b> - Antenatal Hospitalisations In New South Wales, Australia 2001-04 <b>Dr L Trinh</b>	<b>Poster 5</b> - Malaria Knowledge And Practice Among Women In An Endemic Area Of Vietnam <b>Dr L Trinh</b>	<b>Poster 10</b> - The Communication Complexity Score- measuring the performance of health care services in communicating with complex non-English-speaking patients <b>Ms P Garrett</b>
<b>Poster 17</b> - Mining the goldmine – using "administrative" databases to monitor quality and improve care <b>Ms M Walker</b>	<b>Poster 20</b> - Pressure Ulcer Point Prevalence Surveys – a call for standardising processes across jurisdictions <b>Mrs B McErlean</b>	<b>Poster 37</b> - Preliminary Insights into the Quality of Data Collected in NSW Intensive Care Units <b>Ms K Hewson</b>	<b>Poster 50</b> - Quality Improvement Through The Introduction Of Routine Audit <b>Ms J Brumby</b>
<b>Poster 51</b> - Consumer Feedback Survey in a Paediatric Physiotherapy Department	<b>Poster 52</b> - Improving Efficiency In Patient Care And Discharge	<b>Poster 54</b> - Indicators For Quality Use Of Medicines In Australian Hospitals	<b>Poster 56</b> - Linking Multiple Information Systems to Collect State Wide Data on Cancer Patient

<b>Ms F Moran</b>	<b>Dr K Tan</b>	<b>Dr J Lowinger</b>	<b>Mr J Harrington</b> Treatment and Outcome
<b>Poster 61</b> - Pilot Project To Evaluate The Effectiveness Of A Falls Minimisation Toolkit	<b>Poster 65</b> - An Evaluation on DOTS Implementation in Indonesian Hospitals Through Clinical Audit: Is The Australian Clinical Governance Model Can Make Improvement?	<b>Poster 75</b> - Overcoming Data Coding Issues To More Effectively Detect Quality of Care	<b>Poster 77</b> - DVT prophylaxis for gastrointestinal surgery/medicine - harder than it looks!!
<b>Ms P McGarrity</b>	<b>Mr H Djasri</b>	<b>Ms K Sketcher-Baker</b>	<b>Ms B Draper</b>
<b>Poster 84</b> - Innovations in Orthopaedic Care - Fast Track Joint Replacement Program	<b>Poster 97</b> - Optimising Procedures to Improve Quality of radiation therapy summary letters and billing - Utilising an oncology information system & Crystal Reports	<b>Poster 100</b> - Developing An Integrated Performance Management System Using Standard IT Software	<b>Poster 103</b> - Improving Clinical Governance in a multi-site Health Service – Implementation of Performance Indicators for Monitoring Patient Safety and Improving care
<b>Ms K Ekberg</b>	<b>Ms N Kadaan</b>	<b>Mrs H Howard</b>	<b>Ms K Morrissy</b>
<b>Poster 105</b> - The Power of a Simple Strategy to reduce MRO infections in hospitals – Hand Hygiene	<b>Poster 117</b> - Electronic bar-code scanning to reduce medication errors associated with dispensing	<b>Poster 128</b> - Laparoscopy in Gynaecology and Surgery: Practice Review Using Audit of Errors for Improving Safety in Rural Australia	<b>Poster 130</b> - Serious Transfusion Incident Reporting: A Pilot Study
<b>Ms A Pantle</b>	<b>Mr M Dooley</b>	<b>Ms V Jenkins</b>	<b>Ms L Stevenson</b>
<b>Poster 134</b> - Linked Hospital Morbidity Data to Evaluate Patterns of Surgery for Ventilation Tube Insertion (Grommets) in WA Children 1981-2004	<b>Poster 136</b> - 'When things go wrong in hospital': the what, why and how of investigating and researching adverse events	<b>Poster 141</b> - Long Term Survival of Stroke Patients Following an Inpatient Rehabilitation Admission	<b>Poster 143</b> - An Evaluation of the Survival Period of Cancer Rehabilitation Patients Following an Inpatient Rehabilitation Admission
<b>Dr K Spilsbury</b>	<b>Dr T Jackson</b>	<b>Dr J Estell</b>	<b>Dr J Estell</b>
<b>Poster 144</b> - An Evaluation of the Survival Period of Patients Following an Inpatient Rehabilitation Admission	<b>Poster 148</b> - From Death We Learn	<b>Poster 165</b> - Digital pen technology use in measuring pathway variances in Queensland	<b>Poster 166</b> - Evaluating Massage Therapy In Palliative Care: Simple Systems, Strong Outcomes
<b>Dr J Estell</b>	<b>Ms A May</b>	<b>Ms K McConochie</b>	<b>Ms N Tyndall</b>
<b>Poster 168</b> - Development of National Guideline for Clinical Indicators and Reporting System to Support Patient Safety in Hospitals	<b>Poster 175</b> - Interprofessional Communication and the Quality of Care for Patients with Upper Gastrointestinal Bleeding	<b>Poster 200</b> - Mental Health Clinical Collaborative - Making Data Meaningful	<b>Poster 209</b> - Smart Tools for Improving Patient Outcomes in Oncology
<b>Mr H Djasri</b>	<b>Dr D Hewett</b>	<b>Ms S Plever</b>	<b>Mr J Harrington</b>
<b>Poster 210</b> - Working Towards Engaging and Supporting Clinicians in Healthcare Delivery, Quality Improvement and Organisational Activities through Standardised and Automated Data Reporting	<b>Poster 211</b> - Multi-disciplinary Team (MDT) Review of Cancer Patients in Hospitals: Do They Make a Difference?	<b>Poster 213</b> - Documentation of Cancer Stage in Public Hospitals: Is There Enough Information to Assess Outcomes and Effectiveness of Treatment?	<b>Poster 215</b> - Patient Journey in Public Hospitals: How Long Do Cancer Patients Wait for Specialist Review, Diagnosis and Treatment?
<b>Dr S Shea</b>	<b>Mr J Harrington</b>	<b>Mr J Harrington</b>	<b>Mr J Harrington</b>

<p><b>Poster 222</b> - Comparing voluntary sentinel event reporting with routinely-coded hospital-acquired diagnoses in Victoria, 2005/06</p> <p><b>Dr T Jackson</b></p>	<p><b>Poster 223</b> - Benchmarking as a Quality Improvement Tool in a local Mental Health Service from participation in a National Project.</p> <p><b>Ms M Hyland</b></p>	<p><b>Poster 224</b> - Efficacy of unit appointed infection control nurses in an Australian intensive care unit with an Acinetobacter outbreak</p> <p><b>Ms L Redl</b></p>	<p><b>Poster 229</b> - Evidence-based multidisciplinary approach to improve patient care: CO2 Retaining Patients Working Group</p> <p><b>Dr A Dwyer</b></p>
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Poster 246 - Quality Improvement in Renal Dialysis: Achievements and Challenges of the Renal Collaborative  Ms J Marshall	Poster 251 - Capability of ambulatory monitoring system in community rehabilitation to quantify physical activity levels in patients  Dr M Karunanithi	Poster 264 - Counting excess lives saved or lost in the care of acute myocardial infarction: Patient selection is more important than method of risk prediction  Prof I Scott
1330-1 5.00	Plenary 2 - The Power of 'E' Proudly Supported by the Australian Commission on Safety & Quality in Health Care Chair: MR JIM BIRCH	
	Presentation : Mr Bill Lawrence- Australian Commission on Safety and Quality in Health Care	
1330 - 1410	TOPIC- ELECTRONIC CARE PATHWAYS Speaker: DR SIMON ECCLES	
14.10-14.45	TOPIC - IMPLEMENTATION OF E- HEALTH IN AUSTRALIA Speaker: DR IAN REINECKE	
14.40-15.00	TOPIC – A CONSUMER VIEW OF QUALITY AND SAFETY THROUGH ELECTRONIC HEALTH RECORDS Speaker: MS CORAL RIZZALI	
15.00-15.15	Question and Answers	

Great Halls 1 & 2

1515-1 545	AFTERNOON TEA	Great Halls 3 & 4
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1545 - 1715	CONCURRENT SESSION TWO					
	THEME 1 <i>GH 1&amp;2</i> REDESIGNING CARE	THEME 2 <i>M3</i> MEASUREING PERFORMANCE: <i>The private sector perspective</i> <i>Sponsored by Medibank Private</i>  Chair: Ms Jenny Rance	THEME 3 <i>M1</i> EDUCATION, SKILLS AND WORKPLACE CULTURE  Chair: Dr George Downward	THEME 4 <i>M2</i> SYSTEMS CHANGE  Chair: Ms Darlene Hennessy	THEME 5 <i>P3-5</i> HUMAN RESOURCES  Chair: Ms Valmae Joyce	THEME 6 <i>M4</i> OPEN DISCLOSURE  Chair: Ms Jannine James
1545 - 1605	SA: Ms Margaret Martin QLD: Prof Mike Ward NSW- Dr Tony O' Connell WA: Ms Tanya Gawthorne	Private Hospital speaker – how the funds measure performance outcomes.  Ms Christine Gee	Use of simulation labs to improve clinical skills  Dr Marcus Watson	Strategic Planning and Change Management  Ms Christine Dennis	Supporting Consumer Participation within a large health service.  Ms Jenny Ashby	Learning from the National Open Disclosure Standard Pilot  Dr John Wakefield, Chair National Open Disclosure Steering Committee, Senior Director, Patient Safety Centre, Queensland Health.
1605 - 1625	VIC: Ms Belinda Rickard Panel Session Facilitated by Dr Simon Eccles	The role of health insurance funds in improving quality and safety in health care	Improving Patient Safety and Outcomes by Changing the Healthcare Culture Using Crisis Resource Management (CRM) Principles.	Building Skills for redesign	Helping Doctors Help Themselves: Organisational Strategies to support poorly performing and 'at risk' junior medical	Cherie Ryan, National and Queensland State Program Manager, Open Disclosure. PhD

		<b>Ms Julie Andrews</b>	<b>Dr Pauline Lyon</b>	<b>Mr Andrew Bryett</b>	staff <b>Dr Alison Dwyer</b>	student, University of Queensland, School of Psychology <b>Dr Luis Prado</b> , Director Medical Services, Wesley Hospital, Brisbane <b>Professor Rick Iedema</b> , Professor of Organizational Communication Associate Dean (Research) Faculty of Humanities and Social Science University of Technology Sydney
1625 - 1645		Measuring Performance - A Private Hospital Perspective.	"Better Workplaces" Staff Opinion Survey – Workplace Culture Improvement	Demonstrating the power of us – the development of the Anaesthetic Crisis Management Manual	Safe Doctors – Fair Systems; supporting clinicians to give safe quality care	
		<b>Sue McKean</b>	<b>Ms Jan Phillips</b>	<b>Mr Peter Hibbert</b>	<b>Dr Craig Margetts</b>	
1645 - 1715	Q&A with SPEAKER PANEL	Q&A with SPEAKER PANEL	Q&A with SPEAKER PANEL	Q&A with SPEAKER PANEL	Q&A with SPEAKER PANEL	Q&A with SPEAKER PANEL

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1715-1 845

Welcome Reception

Great Halls 3 & 4

## DAY TWO Tuesday 7<sup>th</sup> AUGUST

0730-0830 – “Power Speaking” – Breakfast with the Experts <span style="float: right;">P1 &amp; 2</span>			
Chair: Mr Jim Birch			
Speakers: Prof Dianne Parker, Dr Simon Eccles, Prof Sean Clarke, Mr Stephen Duckett, Dr John Youngman, Dr Christine Jorm, Mr Christopher Newell			
<p><b>WORKSHOP 1 A 9.00-10.30am</b> <span style="float: right;"><i>M1</i></span></p> <p>Using Observational Research to Reshape Clinical Practice Professor Rick Iedema, Dr Christine Jorm and Mr Bryce Cassin The National Commission</p>	<p><b>WORKSHOP 2A 9.00-10.30am</b> <span style="float: right;"><i>P3&amp;4</i></span></p> <p>Clinical Indicator Workshop Ms Darlene Hennessy Australian Council on Healthcare Standards Chair: Ms Jenny Tuffin</p>	<p><b>WORKSHOP 3 – Part 1 (200 people)</b> <span style="float: right;"><i>M3</i></span></p> <p><b>9.00-12.30pm</b> Making Change Work Mr Rod Anderson</p>	<p><b>WORKSHOP 4 9.00-10.30am</b> <span style="float: right;"><i>M4</i></span></p> <p>Patient Safety: “The Engagement Party” Dr Peter Lee</p>
<p><b>WORKSHOP 1 B 11.00-12.30pm</b> <span style="float: right;"><i>M1</i></span></p> <p>Using Observational Research to Reshape Clinical Practice Professor Rick Iedema, Dr Christine Jorm and Mr Bryce Cassin The National Commission</p>	<p><b>WORKSHOP 2B 11.00-12.30pm</b> <span style="float: right;"><i>P3&amp;4</i></span></p> <p>Clinical Indicator Workshop Ms Darlene Hennessy Australian Council on Healthcare Standards Chair: Ms Jenny Tuffin</p>	<p><b>Part 2 Follows from previous</b> <span style="float: right;"><i>M3</i></span></p> <p>Making Change Work Mr Rod Anderson</p>	<p><b>WORKSHOP 5 11.00am-12.30pm</b> <span style="float: right;"><i>M4</i></span></p> <p>Human Factors Engineering Dr Shelly Jeffcott, Professor Joseph Ibrahim and Dr Sue Evans.</p>
<p>Off site Visit to Skills Development Centre Session 1</p> <p><b>9.00am-10.30am</b></p>	<p><b>TUTORIAL 1 9am-12.30pm</b> <span style="float: right;"><i>GH1&amp;2</i></span></p> <p>DR SIMON ECCLES TOPIC: Accuracy of IT Records / Health Space Chair: Ms Heather McDonald</p>	<p><b>TUTORIAL 2 9am-12.30pm</b> <span style="float: right;"><i>M2</i></span></p> <p>PROF DIANNE PARKER TOPIC – Understanding and Improving Organisational Culture Chair: Mrs Margaret Marshall</p>	<p><b>TUTORIAL 3 9am-12.30pm</b> <span style="float: right;"><i>P5</i></span></p> <p>PROF SEAN CLARKE TOPIC: Nursing Work Environments and how they promote quality of care Chair: Ms Marilyn Cruickshank</p>
<p>Off site Visit to Skills Development Centre Session 2</p> <p><b>11.00am-12.30pm</b></p>	<p><b>TUTORIAL 1 CONTINUED</b></p> <p>LOCAL SPEAKER: Dr Leonie Katarak Mr Craig Hooper</p> <p>DIALOGUE</p>	<p><b>TUTORIAL 2 CONTINUED</b></p> <p>LOCAL SPEAKER Ms Susan Johnston Mr Christopher Newell</p> <p>DIALOGUE</p>	<p><b>TUTORIAL 3 CONTINUED</b></p> <p>Ms Christine Duffield Ms Michelle Kosky</p> <p>DIALOGUE</p>

1030-1100	<b>MORNING TEA</b>			<i>Great Halls 3 &amp; 4</i>
1230-1330	<b>LUNCH</b>			<i>Great Halls 3 &amp; 4</i>
<b>Posters Discussion Session Theme 2 –Education, Training and Skills Development and Theme 3 – Systems Change and Leadership</b>				<i>Great Halls 3 &amp; 4</i>
<b>Poster 28</b> – Factors that facilitate and hinder the utilization of the medical emergency team: a nursing perspective  <b>Mrs N Santiano</b>	<b>Poster 49</b> –Cancer Services Imaging and training and assessment program  <b>Mr D Sampson</b>	<b>Poster 82</b> – Development of an online safety and quality education package and checklist for all health service staff and an evaluation of its effectiveness  <b>Ms P McGarrity</b>	<b>Poster 91</b> – Co-location in Action  <b>Ms C Foley</b>	
<b>Poster 93</b> – Staff Responsibilities Matrix for Risk Management  <b>Ms C Foley</b>	<b>Poster 106</b> – Model of Care for Prevention & Management of Delirium in the Acute Care Setting  <b>Ms J Sinnott</b>	<b>Poster 107</b> – “Communicating for Clinical Care” – Using Trigger Scenarios to Improve Communication Practices  <b>Ms M Mitchellh ill</b>	<b>Poster 132</b> – An innovative approach to skills development  <b>Ms F Strongylos</b>	
<b>Poster 176</b> – Medical Record Documentation and Interprofessional Communication: An Intergroup Communication Approach  <b>Dr D Hewett</b>	<b>Poster 188</b> – Sharp cat – reducing needlestick injuries & blood exposures and improving reporting  <b>Mrs J Wayland</b>	<b>Poster 197</b> – The Emergency Department Assessment of Patient Medication: A Comedy of Errors  <b>Dr R Bradbear</b>	<b>Poster 198</b> – Clinical Governance knowledge and competencies required by Victorian Public Hospital Medical Administrators – A survey of Medical Administrators currently working in Victorian Public Hospitals  <b>Dr S Shea</b>	
<b>Poster 199</b> – Increasing the safety of enoxaparin therapy in medical inpatients: a combination of guidelines and education is effective.  <b>Dr R Bradbear</b>	<b>Poster 203</b> – Understanding Effective Clinical Handovers: A Multidisciplinary Approach  <b>Dr B Watson</b>	<b>Poster 205</b> – A Model To Ensure Comprehensive Assessment And Treatment Plans Based On Best Practice Guidelines In Dentistry With An Evaluation Tool  <b>Dr D Gold ing</b>	<b>Poster 207</b> – The development of clinical practice guidelines for the management of delirium in older people in Australia  <b>Ms C Brand</b>	
<b>Poster 219</b> – Training for Quality: learning from the VET sector  <b>Dr G Fennessy</b>	<b>Poster 227</b> – Consumer Leadership  <b>Ms K Simons</b>	<b>Poster 232</b> – Medical leaders in Clinical Governance: The Role of a Head of Unit in 2006  <b>Dr A Dwyer</b>	<b>Poster 235</b> – St Vincent’ s Hospital Toowoomba’ s response to a Pandemic Influenza H5N1 Threat: and derived recommendations.  <b>Ms K Hamilton</b>	
<b>Poster 237</b> – Redesigning models of care to meet the needs of people with osteoarthritis (OA) of the hip and knee  <b>Dr C Brand</b>	<b>Poster 247</b> – Improving Patient Safety Through Surgical Simulation: Finding the Evidence to Support the Uptake of the Fundamentals of Laparoscopic Surgery Program by Advanced Surgical Trainees  <b>Ms K Walker</b>	<b>Poster 260</b> – WAASM – Mortality audit extends beyond the data  <b>Ms J Mountain</b>	<b>Poster 262</b> – Quality Approach To Managing Assault Presentations to the Emergency Department  <b>Ms D Wakefield</b>	

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<b>Theme 3- Systems Change and Leadership</b>		<i>Great Halls 3 &amp; 4</i>	
<b>Poster 8</b> – “Better Workplaces” Leadership Development Program  <b>Ms J Phillips</b>	<b>Poster 18</b> - Putting process into action  <b>Ms L Bates</b>	<b>Poster 21</b> - Equal Access s: Health Service Cultural Diversity Plans  <b>Ms L Horvat</b>	<b>Poster 22</b> - The ‘In’ in Interdisciplinary Care  <b>Ms J Exton</b>
<b>Poster 43</b> - The power of bottom up networks as a force for safety and quality  <b>Mr P Hibbert</b>	<b>Poster 53</b> - A Partnership Between An International Law Firm and An Acute Care Hospital - Evaluation Of A Pilot Program To Provide Pro Bono Legal Services For Cancer Patients  <b>Ms E Ballinger</b>	<b>Poster 57</b> - Establishing a Quality Management System; the Catalyst for Redefining an Organisational Culture and Implementing Change  <b>Ms B Knight</b>	<b>Poster 83</b> - Queensland, Stay On Your Feet: A Falls Prevention Collaborative Addressing Falls Injury Prevention Across the Continuum  <b>Ms R Bell</b>
<b>Poster 85</b> - Using functional status outcomes of hospitalised older people as indicators of healthcare quality  <b>Ms L Beddoes</b>	<b>Poster 88</b> - Measuring Program Compliance In Community Health Using Feedback Data And Benchmarking  <b>Ms L McCrorey</b>	<b>Poster 89</b> - Implementing Electronic Medications Management In A Private Hospital  <b>Mr J Evans</b>	<b>Poster 90</b> - Clinical Governance and Peer Review  <b>Ms C Foley</b>
<b>Poster 98</b> - A Staged Approach to Optimising Electronic Billing in LANTIS  <b>Ms S Avery</b>	<b>Poster 109</b> - Clinical Governance: Achieving a Quality Governance Framework From The Bedside to the Board  <b>Ms K Morrissy</b>	<b>Poster 115</b> - An Exploration of Symptom Management Practices to Evaluate Quality of Care in an Oncology Setting  <b>Ms E Cohen</b>	<b>Poster 120</b> – The fall and rise of an outer-metro emergency department  <b>Dr J Farmer</b>
<b>Poster 121</b> - Bridging the Gap – The Orthopaedic Way  <b>Ms C Kimber</b>	<b>Poster 131</b> - Informing Consumers: What Are The Challenges In A Hospital Setting?  <b>Ms L Stevenson</b>	<b>Poster 133</b> - An innovative approach to delivering our goals  <b>Ms C Theobald</b>	<b>Poster 151</b> - Along the road of discovery – facing the challenges of implementing Clinical Governance  <b>Ms F Ciaravella</b>
<b>Poster 179</b> - Public Dental Emergency Demand Management Strategy  <b>Dr S McGuire</b>	<b>Poster 183</b> - The Power Of Change - Role Redesign In An Outpatient Clinic  <b>Ms R Coyne</b>	<b>Poster 187</b> - Patient Perceptions of Obstetric Clinical Handover (Pilot Study)  <b>Dr G Chin</b>	<b>Poster 189</b> - Getting It Right at Night  <b>Ms P Markham</b>
<b>Poster 220</b> - Leadership For Change - The Power Of The People  <b>Ms P Frost</b>	<b>Poster 225</b> - Through the innovation of Discharge Planning System to Reduce the Length of Stay in a Medical Center  <b>Mrs C Shu-Chen</b>	<b>Poster 233</b> - Open Disclosure and leadership- a way forward  <b>Ms B Dougan</b>	<b>Poster 239</b> - Lessons for healthcare from the railways  <b>Dr S Jeffcott</b>
<b>Poster 242</b> - Is Your Head In The Sand?  <b>Mrs H Parsons</b>	<b>Poster 243</b> – Poor concordance with non pharmacological recommendation for osteoarthritis within a chronic disease management program: implications for clinicians, consumers and policy makers  <b>Dr C Brand</b>	<b>Poster 244</b> - Understanding the safety culture of maternity services  <b>Ms S Allen</b>	<b>Poster 245</b> – Application of an evidence based implementation model for supporting service redesign for people with osteoarthritis in ambulatory care settings.  <b>Dr C Brand</b>

Poster 259 - Adopting a transformational change framework to implement a statewide strategy.

Ms M Arblaster

1330-1515	<b>Plenary 3 - The Passion and the Power of Teams</b> Proudly supported by Queensland Health Chair: Mr Jim Birch	<i>Great Halls 1 &amp; 2</i>
1330-1415	Presentation by Queensland Health KEYNOTE ADDRESS – INTERDISCIPLINARY TEAM RESEARCH INTERNATIONAL SPEAKER: PROF SEAN CLARKE	
1415 – 1435	TOPIC – GETTING TO THE HEART OF PATIENT SAFETY-COMPASSION AND CARING SPEAKER: MR ROBIN YOU NGSON	
1435 - 1455	TOPIC – TEAM WORK TO ENHANCE QUALITY PATIENT CARE THROUGH THE USE OF CLINICAL INFORMATION TECHNOLOGY SPEAKER: MR SIU-FAI LUI	
1455 - 1515	Q&A with SPEAKER PANEL	

– 1545 Afternoon tea

1515

*Great Halls 3 & 4*

1545-1715	<b>PLENARY 4 - Research – The Power Behind Practice</b> Chair: Mr Jim Birch	<i>Great Halls 1 &amp; 2</i>
1545 - 1700	TOPIC – PUTTING RESEARCH INTO PRACTICE DR DIANA HORVATH PROFESSOR WARWICK ANDERSON SALLY CROSSING	
1700 - 1715	AWARD PRESENTATIONS: AAQHC	
1900-2300	HESTA SUPERFUND CONFERENCE DINNER	<i>Plaza Terrace Room</i>

# DAY THREE Wednesday 8<sup>th</sup> AUGUST

0730:0830

AAQHC AGM and Breakfast  
Members Only

P1 & 2

0845-1030	<b>Plenary 5 THEME – THE POWER OF RESEARCH AND EVIDENCE</b>	<b>GH 1 &amp; 2</b>
	Chair: PROF MIKE WARD	
0900-0920	TOPIC – BETWEEN THE DEVIL AND THE DEEP BLUE SEA: PATIENT SAFETY AND RISK IN HOSPITALS Speaker: PROF JEFFREY BRAITHWAITE	
0920-0940	TOPIC – NICS 'USING RESEARCH EVIDENCE TO CHANGE CLINICAL PRACTICE Speaker: DR SUE PHILLIPS	
0940-1000	TOPIC – THE DANGERS OF MEASUREMENT Speaker: PROF PETER CAMERON	
1000-10.20	TOPIC – TECHNOLOGY ALLOWS THE RITE OF PASSAGE:THE USE OF RECORD LINKAGE FOR RESEARCH INTO HEALTH Speaker: PROF JAMES SEMMENS	
1020-1 030	QUESTIONS AND ANSWERS	
1030-1100	Morning Tea	<i>GH 3 &amp; 4</i>

1100 - 1230	<b>CONCURRENT SESSION THREE</b>					
	THEME 1 <i>M2</i>	THEME 2 <i>M3</i>	THEME 3 <i>M</i>	THEME 4 <i>P1 &amp; 2</i>	THEME 5 <i>M1</i>	THEME 6 <i>GH 1 &amp; 2</i>
	ACCREDITATION	MEASURING PERFORMANCE AND OUTCOMES	IMPROVING ACCESS	NON ACUTE CARE SETTING	THE INTERNATIONAL SCENE	CLINICAL HANDOVER
	Chair: Mr Bill Lawrence	Chair: Ms Kathleen Ryan	Chair: Ms Kae Martin	Chair: Dr Annette Pantle	Chair: Dr Desmond Yen	Chair: Dr Simon Eccles



1100 - 1120	Review of Accreditation  <b>Prof Margaret Banks</b>	Australian Adaptation of the ISMP Medication Safety Self Assessment Tools  <b>Ms Helen Stark</b>	The Ambulatory Surgery Initiative in a Public Health Service  <b>Ms Pam Tindall</b>	What consumers want from primary healthcare – consistent quality in the non acute care setting  <b>Russell McGowan</b>	Pre operative antibiotics Prophylaxis -Experience from a Taiwanese Medical Centre Setting  <b>Dr Shei-Lin Ku</b>	Improving Clinical Handover – steps taken to support clinicians in the delivery of safe, effective clinical handover  <b>Dr Annie Moulden</b>
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1120 - 1140	The Relationship Between Accreditation Criteria Results and Clinical Indicators  <b>Dr Marjorie Pawsey</b>	Quality Indicators in Trauma" A Study of Validity  <b>Mr Cameron Willis</b>	Managing the Wait: responding to the Consumer  <b>Dr Ken Ooi and Ms Lyn English</b>	Hospital Care of Residents Living in Residential Care Facilities: Profile, Patterns of Utilization and Quality and safety of care  <b>Dr Sanjay Jayasinghe</b>	Improvements In Quality Of Services In Healthcare Organisations Through Accreditation  <b>Dr Bhupendra Rana</b>	Facilitated Discussion:  Bryce Cassin (Doctorate) Clinical Handover Dr Bob Adams TQEH, South Australia Annie Moulden
1140 - 1200	The Accreditation of Australian General Practices – the journey into the electronic age with AccreditationPro.  <b>Ms Marisa Vecchio</b>	Mental Health Outcomes  <b>Dr Aaron Groves</b>	A New Clinical System for Effective Discharge Planning (Improve Access by Reducing Exit Block)  <b>Mrs Cathy Daunt</b>	Grass Roots Quality – A Simple Approach to Implementing a Quality Framework for Health Professionals Working in the Community Setting  <b>Suzanne Corcoran</b>	Successful Implementation of Three Tools for Specialty Based Learning from Incidents  <b>Cathelijne Snijders</b>	
1200 - 1230	<b>Q&amp;A with SPEAKER PANEL</b>	<b>Q&amp;A with SPEAKER PANEL</b>	<b>Q&amp;A with SPEAKER PANEL</b>	<b>Q&amp;A with SPEAKER PANEL</b>	<b>Q&amp;A with SPEAKER PANEL</b>	<b>Q&amp;A with SPEAKER PANEL</b>

1230 - 1330

LUNCH

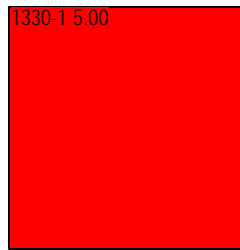
Great Halls 3 &amp; 4

<b>Poster Discussion Session Theme 4 –Human Resources for Health; challenges and opportunities and Theme 5- Patient Safety and Quality</b>			
<b>Poster 74</b> - Application of Balanced Scorecard Methodology to Improve Staff Performance at an Operation Room Setting  <b>Ms S Ku</b>	<b>Poster 127</b> - Facilitation Of Recruitment And Retention Of Allied Health Staff In A Rural Setting Through The Development Of Specialist Skills And Mentoring: A Pilot Project  <b>Ms L McCourt</b>	<b>Poster 156</b> - Introduction Of Perioperative Dedicated Education Unit To Increase Recruitment And Retention Of Nurses  <b>Mrs S Venkataram</b>	
<b>Theme 5- Patient Safety and Quality</b>			
<b>Poster 1</b> - What's an Interpreter? - Giving our Clients a Voice  <b>Ms L Dimopoulos</b>	<b>Poster 6</b> - Risk Minimisation Across Care Settings in a Palliative Care Service Through Shared Documentation and Records  <b>Mrs E Summers</b>	<b>Poster 12</b> - The Happy Migrant Effect- A qualitative study of the perceptions of negative experiences of hospital care by patients with little or no English  <b>Ms P Garrett</b>	<b>Poster 27</b> - The Rapidly Developing Role of the Quality Manager in the Modern Radiation Therapy Department  <b>Ms L Cheetham</b>
<b>Poster 29</b> - Setting up a standardised Medical Emergency Team reporting system across an area health service as a Patient Safety Initiative  <b>Mrs N Santiano</b>	<b>Poster 32</b> - Improving Quality of Care for Patients with Delirium, New Initiatives Following an Audit in Acute Medical Inpatients  <b>Ms Y Smith</b>	<b>Poster 33</b> - Look At Me! Look At Me! My Life Is Back On Track! Maximising Potential Of Clients After A Health Crisis Requiring Allied Health Intervention  <b>Ms S Paul</b>	<b>Poster 42</b> - Inter-Rater Reliability of the Australasian Triage Scale for Mental Health Patients  <b>Dr D Liew</b>
<b>Poster 44</b> - Promoting Clinical Risk Management in Community Health  <b>Ms A Brown</b>	<b>Poster 46</b> – Team Centered Behavior Based Approach to Correct Site Safety System Implementation  <b>Ms J Smith</b>	<b>Poster 55</b> - Talking the Talk: How A Structured Communication Tool Can Improve Patient Safety  <b>Ms M Martin</b>	<b>Poster 60</b> - "Residential Aged Care Coronial Communiqué": providing case studies of deaths reported to the Coroners Office to improve clinical care in Residential Aged Care Facilities  <b>Prof J Ibrahim</b>

<p><b>Poster 64</b> - Lessons Learnt From The Identification And Management Of An Increased Incidence Of Severe Ovarian Hyperstimulation Syndrome At A Tertiary Obstetric Hospital In Melbourne, Australia  <b>Ms M Draper</b></p>	<p><b>Poster 67</b> - Clinical Governance Implementation Using ISO 9000:2000 Quality Management System: A Case Study in Two Public Hospitals in Indonesia  <b>Mr H Djasri</b></p>	<p><b>Poster 70</b> - Formative implementation in multisite piloting of a standardised mental health documentation suite.  <b>Mr A Weller</b></p>	<p><b>Poster 71</b> - Consumer Perceptions Of Using Self Assessment Outcomes In Mental Health To Engage Meaningfully In Care Planning  <b>Mr T Callaly</b></p>
<p><b>Poster 78</b> - Customer Quality In Health Care  <b>Dr J Tabrizi</b></p>	<p><b>Poster 79</b> - Customer Quality And Type 2 Diabetes In Australia  <b>Dr J Tabrizi</b></p>	<p><b>Poster 92</b> - A structured analysis of medication errors: a multi site study  <b>Dr A Gardner</b></p>	<p><b>Poster 95</b> - Preventing Wrong Gas Delivery to Patients  <b>Mr P Mason</b></p>
<p><b>Poster 110</b> – High compliance with a protocol for the management of bleeding peptic ulcer disease improves patient outcomes  <b>Dr P Bampton</b></p>	<p><b>Poster 116</b> - Managing Junior Medical Staff After Hours Workloads with Changes to In and After Hours Practice  <b>Dr T Bright</b></p>	<p><b>Poster 118</b> - Development of a trigger and screening tool to detect medication errors in a quaternary teaching hospital  <b>Ms M Van De Vreede</b></p>	<p><b>Poster 119</b> - Intravenous potassium chloride: Do health professionals in hospitals really know the risks?  <b>Ms M Van De Vreede</b></p>
<p><b>Poster 122</b> - Reality Bites : Coming To Grips With Patient Safety  <b>Ms R Richardson</b></p>	<p><b>Poster 126</b> - Analysis and the subsequent management for intra-operative pressure ulcers  <b>Mrs J Huang</b></p>	<p><b>Poster 135</b> - “Too Many Pills”: Reducing the Risks of Polypharmacy in the Older Patient in the Acute Care Setting  <b>Ms K Stott</b></p>	<p><b>Poster 138</b> - Implementing an Equipment Change to Improve Patient Safety at a Public Hospital  <b>Ms V Wallroth</b></p>
<p><b>Poster 142</b> - Best Quality and Safety Practice in Managing Skin Integrity  <b>Prof A McMurray</b></p>	<p><b>Poster 147</b> - Cleaning Up Narcotic Use – With SOAP...the “ Safe Oxycodone Administration Promotion!  <b>Mrs D Bridgeford</b></p>	<p><b>Poster 150</b> - The Relationship among Knowledge, Attitude and Practice of Physical Restraint  <b>Mrs M Su</b></p>	<p><b>Poster 154</b> - Together Is Better: Providing Multi-Service Drought Relief At The Farm Gate  <b>Ms S Rutherford</b></p>
<p><b>Poster 155</b> - Improved Survival With In House Overnight Neonatal Consultants  <b>Dr S Fraser</b></p>	<p><b>Poster 159</b> - Improving Patient Comfort in Colonoscopy  <b>Ms B Draper</b></p>	<p><b>Poster 161</b> - Implementation Of A Chest Pain Assessment Service  <b>Mrs K O’ Dwyer</b></p>	<p><b>Poster 164</b> - Enhanced Patient Safety with a Web Based Electronic Medication Management System in Two Regional Victorian Hospitals  <b>Mr C Turner</b></p>
<p><b>Poster 178</b> - A Regional Audit of Dosage Administration Aids in Aged Care Facilities  <b>Dr A Carruthers</b></p>	<p><b>Poster 182</b> - Evaluating a Fall Review Program in the Aged Care &amp; Rehab Units  <b>Ms A Ko</b></p>	<p><b>Poster 184</b> - Evaluation Of The Effectiveness Of A Hydration Monitoring Tool In Aged Care Facilities  <b>Ms M Sappupo</b></p>	<p><b>Poster 185</b> - Breaking Down the Levels of Risk Registers and Improving Safety and Quality in Health Care.  <b>Mr R Johnson</b></p>
<p><b>Poster 186</b> - The Role Of Family In Rehabilitation After Stroke  <b>Dr T Barskova</b></p>	<p><b>Poster 193</b> - Early Detection And Management Of Falls Risk In Older Adults: Exploring The Use Of The Quickscreen Tool In Barwon Health Primary Care Clinical Practice Settings  <b>Ms R Smith</b></p>	<p><b>Poster 194</b> - Creating Safety – Addressing Seclusion and Restraint Practices  <b>Mr E Gibbons</b></p>	<p><b>Poster 195</b> - Encouraging Quality Improvement in Aged Care and Rehabilitation Services  <b>Ms J Palmer</b></p>

<p><b>Poster 202</b> - Improving Hand Hygiene – Results of the Victorian Quality Council (VQC) Hand Hygiene Pilot Project 2004 -2006</p> <p>Ms D Quin</p>	<p><b>Poster 214</b> - Health Promotion for Older People – Developing a Lifestyle Option</p> <p>Ms S Daniel</p>	<p><b>Poster 216</b> - Designing programs to reduce risk of Vitamin D deficiency amongst dark skinned and veiled people: community reported barriers to uptake of effective interventions</p> <p>Ms D Couch</p>	<p><b>Poster 217</b> - A National Initiative To Optimise Acute Postoperative Pain Management: The APOP Project</p> <p>Dr K McIntosh</p>
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<b>Poster 226</b> - Fall Reduction in the Cardiac Stepdown Unit  <b>Mrs R Chataway</b>	<b>Poster 231</b> – Communication-an innovative idea to improve safety and quality  <b>Ms R Mach iraju Venkata</b>	<b>Poster 236</b> - Post Anaesthetic Assessment Of "At Risk" Special Needs Patients - Working Collaboratively For Improved Patient Safety  <b>Dr S McGuire</b>	<b>Poster 253</b> - A Socio-cultural-technical Integrated Approach which Involves End-users through the Design and Implementation Process can Develop an Information Communication Technology which Incorporates Patient Safety Initiatives: A Case Study of an Electronic Medical Handover System. <b>Ms M Wong</b>
<b>Poster 254</b> - Fast Track Colorectal Surgery - A Rural Perspective  <b>Ms T Moore</b>	<b>Poster 258</b> - Loads Of Rubbish! One Hospital's Experience Of Waste Management Review And Revision  <b>Mrs I Freeman</b>	<b>Poster 266</b> - Exploring Factors Affecting Inadvertent Perioperative Hypothermia  <b>Ms E Pavlos</b>	<b>Poster 267</b> - Capturing immediate Improvement supports Improvement": One organisation' s recognition of the value of projects designed to improve the quality and safety of health care services.  <b>Ms M Hills</b>



**Great Halls 1 & 2**

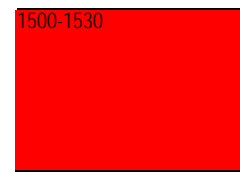
**Plenary 6 DEBATE**  
Proudly supported by Baxter Healthcare  
Presentation by Baxter Healthcare  
Facilitator – Jim Birch

DEBATE: Guests include: Stephen Duckett, Mitch Messer (CHF Chairperson), Joseph Ibrahim, Robin Youngson, Luis Prado, Christine Gee  
**Managing Demand and Addressing Quality: Competing Priorities or Two Sides of the Same Coin?**  
**Have we lost the luxury of quality: Is the focus on activity and targets – at what cost?**

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CLOSE OF CONFERENCE

PROMOTION FOR 2008 CONFERENCE



**BEST POSTER PRIZE**

\*PLEASE NOTE THIS PROGRAM IS SUBJECT TO CHAN

# 附件二