



November 2009

VQHA NEWSLETTER



FROM BRIDGING THE GAP IN SYDNEY—BACK TO THE FUTURE IN PERTH

Following a successful conference in Sydney this year, with more than 650 delegates registered to attend, we move west to Perth for the eighth Australasian Conference in September 2010.

Delegates were provided access to the knowledge and understanding of keynote presenters Beverley Johnson, Richard Davis, David Mayer, Jeffrey Braithwaite and Enrico Coiera.

We look forward to another informative and successful conference in 2010. So mark 6-8 September in your diary and join the AAQHC at the Perth Convention Centre for the 8th Australasian conference on Quality and Safety.

What's Inside?

<i>President's Report</i>	2
<i>New Members Working for you</i>	3-4
<i>Conference Feedback</i>	5
<i>Changes to the Coroner's Act 2008</i>	6
<i>VQC Minimising the Risk of Falls</i>	7

8th Australasian Conference on Safety and Quality in Health Care

6–8 September 2010 Perth Convention Exhibition Centre, Perth



Australasian Association
for Quality in Health Care

www.aaqhc2010.org.au



President's report—November 2009

I will endeavour to keep this as short as possible as there may be more interesting items for the newsletter and you will have received the minutes of the AGM in the last week.

As I have run my 3 year term permissible in our constitution this will be my last report as President. I will continue on committee as past president in support of the new president who will be agreed at our December meeting.

Committee members were excited to have more nominations than positions available on committee which, I believe, is the first time in the history of the association so I am pleased to announce again the addition of Sue Evans, Karina Finch and David Smith to committee and that Jenny Rance and Mary White were re-elected for another 2 years. We look forward to working with those joining the committee. Karina is a new quality manager who will be mentored by one of the more experienced members in her professional as well as committee life.

Executive committee and portfolios will be determined at the December meeting and will be communicated in our Christmas correspondence.

You will also note that there were a couple more constitution changes agreed at the AGM in response to AAQHC changes and current practice.

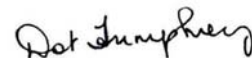
Again we had poor attendance at the October Professional Development forum 'DICS' and there is a report on the feedback elsewhere. We continue to provide relevant forums for quality and risk managers and encourage support of these in future. We would even welcome suggestions that might encourage other colleagues to attend.

I am sure you will have added Perth to you diary for the next AAQHC conference to be held in September 2010. See an advertisement for this elsewhere in the newsletter.

More Victorian members have joined

the association over the last few months which is pleasing given we had reached a low in subscriptions. Encourage all QM colleagues to join the association.

Committee look forward to working on your behalf during 2010.



Dot Humphrey- Lesque,

Outgoing President

Visit the AAQHC website:

www.aaqhc.org.au

It may be hard for an egg to turn into a bird: it would be a jolly sight harder for it to learn to fly while remaining an egg. We are like eggs at present. And you cannot go on indefinitely being just an ordinary, decent egg. We must be hatched or go bad.

C. S. Lewis

Did you know.....this membership fact?

There is a reciprocal membership agreement between VHQA and AAQHC in that a member of VHQA shall have automatic membership of AAQHC and a member of AAQHC who resides in Victoria shall have automatic membership of VHQA?

New Committee Members working for you:

David Smith

B App Sc - Physics
Double Major

Member; Australasian Association for Quality in Health Care

Member; Victorian Healthcare Quality Association

Australian Continuous Improvement Group
203 Drummond Street
Carlton, Vic, 3053
Ph: 61-3-9650 7222

For information about ACIG: www.acig.com.au

David has over 20 years experience in both the private and public sectors as a consultant and organisational change facilitator involved in redesign, service improvement, deliberate improvement and quality management. The primary focus of David's experience had been in health services and local government. Typical assignments require work with team process, team tools and problem analysis, roles in a team, and dealing with change in a practical work environment.

David co-founded the Victorian Healthcare Quality Association (VHQA) in 1988, serving initially as its first Public Officer and then guiding the organisation as chairman, first president and secretary through its establishment and incorporation up until 1994.

In 1997 he wrote the subject material for the Quality Management in Aged Care course at the Victoria University of Technology. He was involved in the delivery of this subject from 1996 - 2007. David has lectured at RMIT, Mayfield Institute, Lincoln School of Health Sciences, and the Northern Melbourne Institute of TAFE. He has also delivered numerous presentations and seminars.

David's relevant experience includes:

✦ Peter James Centre and Eastern Health Services. David has worked with the management of PJC to introduce "Lean Thinking" as an approach to major change; both culture and model of care. The program has included case study based training sessions, management review and priority setting workshops, and ongoing coaching to the project team facilitators. Major changes to the model of care and associated process have resulted. Similar projects completed for Angliss Hospital, Maroondah Hospital and Box Hill Hospital.



✦ The Williamstown Hospital - service improvement team development, facilitation and training. This comprehensive project involved medical, nursing, para-medical and administrative staff in structured projects designed to improve hospital service to the patient. This project resulted in the hospital being recognised by DHS for its achievement with its effective discharge program and a presentation to the national AAQHC conference.

✦ Victorian Department of Human Services – David conducted a series of seminars for the Quality Improvement Unit on continuous improvement concepts, methods and structures.

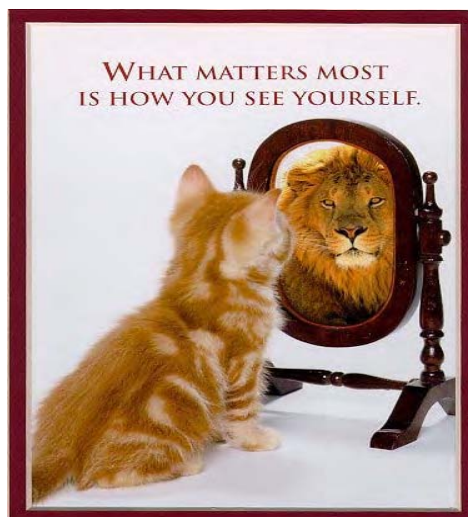
✦ Wimmera Primary Care Partnership. Researched, developed and workshopped a quality assurance framework.

✦ City of Whitehorse – as Organisation Performance Officer David contributed to the achievement of an Australian Quality Award for "Achievement in Business Excellence".

✦ Elsternwick Private Hospital – David facilitated successful preparation for survey under the ACHS EQUiP standards system.

Heidelberg Repatriation Hospital. As quality manager, a significant contribution to HQ-2000, a major 'whole of hospital' redesign and strategic planning process at the former hospital. David also managed four ACHS accreditation cycles for the hospital.

Other clients include ETSA, Sunshine Hospital, Aged Care Accreditation Agency, Malvern Private Hospital, Simplot, Plum Financial Services, Boroondara City Council, Calsonic Industries, Department of Education, Arnott's Biscuits Limited, BHP Temco, Siemens Business Services, Banyule City Council, Cardinia Shire Council, Conzinc Rio Tinto, Automotive Training Australia, Hobson's Bay City Council.



There is one rule for the industrialist and that is: Make the best quality of goods possible at the lowest cost possible, paying the highest wages possible.

Henry Ford

Try to learn something about everything and everything about something

[Thomas Henry](#)

[Huxley](#)

New Committee Members working for you:

Karina Finch
RN Div 1, Grad
Cert Critical Care

Member; Austral-
asian Association
for Quality in
Health Care

Member; Victorian Healthcare Quality
Association

Following a variety of positions as an Enrolled Nurse for almost 15 years, I undertook a Bachelor of Nursing, graduating with Distinction in 2004. I spent my graduate year working in an Intensive Care Unit, where I was successful in my application for a Clinical Nurse position after 2 years. During this time I also undertook a part time Clinical Educator role on the Medical / Oncology ward, before being seconded to the position of Resuscitation Education Coordinator for the entire facility. I completed a Graduate Certificate in Critical Care in 2007, and Certificate IV in Training & Assessment in 2008.

I was appointed to the position of Coordinator of Safety, Quality & Risk at Swan Hill District Health in May this year, having been the Nurse Unit manager of the Acute Ward in this health service for the previous 12 months. I see the provision of safe quality care part of everyday practice, rather than something to be considered as accreditation looms. This is a notion that I will strive to see staff within this health service also adopt. I have applied to commence a Master in Health Management Quality & Leadership at Murdoch University next year, and am in the process of preparing my application for an Associate Fellow Award with AAQHC.

The support and encouragement that I have received since graduating, has been pivotal in shaping me into the professional that I am today. I believe a mentee position on the VHQA committee would be a valuable learning experience whilst providing important networking opportunities that will be beneficial as I develop skills in this new role.



You're in a hospital. What could possibly go wrong?

AAQHC Conference Feedback

My most surprising memory of the conference:

The morning of the first day of the conference saw delegates all hurrying in to register and then re-treat back out into the Sydney morning at Darling Harbour for coffee. Amongst the 650 delegates slowly gathering for three days of stimulation, learning and a little fun were a small group of Victorians. They were desperately in need of coffee after a very early start to fly up from Melbourne.

Brilliant, there was a small coffee shop right outside—already exhibiting a large number of coffee sipping AAQHC conference delegates. We ordered our coffee and stepped back to wait patiently for our names to be called and our desperately needed coffee to be ready. It was just then that we saw the biggest, healthiest looking rat poke its head out of the kitchen and scamper across the front of the waiting queue—closely followed by a rather red-faced café worker. We looked at each other and decided that the temperature that the milk had to be heated to would protect us from food poisoning and proceeded to drink our coffee. I'm pleased to report with no adverse outcomes—I'm not sure whether it was the rat or the coffee that woke us up for the day though!!

Some other feedback from first timers to an

AAQHC conference

What aspects of the Sydney Conference MUST be continued in Perth next year?

- Information Booths
- High level key note speakers & panel
- VQC information
- The friendly interactive atmosphere

What things should be left in Sydney?

- Medial emergency response in rural hospitals (disappointing, no strategies)
- The morning tea biscuits in big open bowls
- The e-posters need to be re-thought

Any suggestions to make Perth our best conference yet?

- **Get the room allocations right so that workshops get appropriate rooms and not lecture theatres that they can't work with**
- **Maximise delegate access to Keynote speakers—more like what was done in Christchurch**

There are some useful suggestions to take with us as we move from "Bridging the Gap" - "Back to the Future"!

*You must
be the
change
you wish
to see in
the world*

Mahatma
Gandhi



VHQA members at the welcome reception, L to R: Susan Joy Shea, Fran Kinnerly, Belinda Westlake, Dot Humphrey-Lesque

You don't have to kick goals to succeed the points add up.

*Graeme A S
Browne*

CHANGES TO THE CORONER'S ACT 2008 (VIC)

How will the changes to the Coroner's Act impact on health services? The Coroners Act 2008 (Vic) will commence on 1 November 2009.

Many of the changes will have an effect on health services. This article is limited to identifying those particular changes that may have an impact on the health services. The definition of a reportable death and reviewable death have altered. The changes for 'reportable death' under s 4(2) includes deaths occurring "during a medical procedure or following a medical procedure where the death is or may be causally related to the medical procedure and a medical practitioner would not immediately before the procedure was undertaken have reasonably expected the death."

This extends the previous obligation of reporting a death, as the definition of a medical procedure has been broadened to include any procedure under the 'general supervision' of a registered medical practitioner and includes imaging, internal examination and surgical procedures. The effect that this change will have, in my opinion, is an increased level of reporting of deaths in health services. The onus will be on the medical practitioner to report the death 'without delay' whether they were present at or after the death. There are no definitions for 'being present at or after the death' or 'without delay'.

Reportable deaths have also been extended to include any deceased person who has been discharged from an approved mental health ser-

vice within the previous three months.

The Coroner will, under the new Act, have a greater role in making recommendations to "any Minister, public statutory authority or entity on any matter connected with a death or fire which the Coroner has investigated..." Where such a recommendation is made the recipient must provide a written response to the recommendation no later than three months after the date of receipt of the recommendations.

The purposes of the new Act requires the Coroner to consider that family members affected by a death should, among other things, be kept informed of the particulars and the progress of the investigation. To that end, the senior next of kin must have access to any reports given to the Coroner as a result of a medical examination performed on the deceased and a copy of the inquest brief. This may expose the documents provided from a variety of sources to greater scrutiny than previously. Health services should continue to be vigilant in the training and education of all staff in relation to their responsibilities to document in a factual and accurate manner.

The decisions of the Coroner following an inquest must be published on the internet. The reporting of such decisions will be consistent with other Courts including the County and Supreme Court decisions.

Another feature of the new Act is the express reference under s70 to an **apology**.

The section defines an apology as an expression of sorrow, regret or sympathy but does not include a clear acknowledgment of fault.

Finally, changes have been made to the privilege against self incrimination. Previously a person could decline to give evidence if there was a risk of being charged with a crime in relation to the death. The new Act narrows the scope of the privilege to against self incrimination by requiring a person to produce a document irrespective of whether that document would tend to incriminate the person.



The new Act places the Coroner in a greater position of making recommendations that must be responded to by the recipient of the recommendations. The changes also have the potential of a greater number of reportable deaths being investigated by the Coroner's office.

Further information regarding these changes is available at:

<http://www.coronerscourt.vic.gov.au/wps/wcm/connect/Coroners+Court/Home/About+Us/Reforms+to+the+Coroners+Act/CORONERS2+-+Coroners+Act+2008+->

Minimising the Risk of Falls and Fall-related Injuries

An online education package for staff working in acute, sub-acute and residential health care services

Falls and fall-related injuries impact significantly on the independence, function, and quality of life for patients and residents.

The magnitude of the negative impact of falls and the costs associated with increased medical intervention and length of stay categorises falls as a significant corporate and clinical risk. Management of that risk is a priority for all health care organisations.

In 2003, the Victorian State Coroner introduced the *Investigation Standard for fall-related deaths in hospital*. This requires all public and private hospitals in Victoria to report specific falls prevention strategies in place within their institution.

In 2005, the Victorian Quality Council (VQC) published *Minimising the Risk of Falls and Fall-related Injuries Guidelines for Acute, Sub-acute and Residential Care Settings*. A comprehensive evaluation of the guidelines suggested that there was limited recognition of the need for falls minimisation strategies to be related to individual risk factors.

To support clinicians in identifying and implementing interven-

tions, the VQC has developed an online falls minimisation education package with modules for acute, sub-acute and residential care settings. The objectives of the package are:

To provide standardised education for falls minimisation for the Victorian health sector.

To improve patient safety by improving understanding of the link between falls risk factors and the implementation of falls prevention strategies.

To utilise internet-based learning modes as a viable method ensuring widespread access and uptake across the sector.

Early in the development of the package the VQC surveyed 25 Victorian quality managers and falls coordinators from rural, regional and metropolitan facilities. The survey aimed to identify the gaps in falls minimisation education and determine priority areas to be included in the package. The National Ageing Research Institute was commissioned to summarise the *Minimising the Risk of Falls and Fall-related Injuries Guidelines* into an Introductory Module. An Expert Working Group was then convened to develop case based scenarios relevant for the various settings. These provide readers with the opportunity to apply learning to practical and relevant examples of

patients they are likely to encounter.

An assessment of the participant's level of understanding is incorporated at the completion of each module. After completing the package, participants are expected to be able to:

Explain why falls are an important safety issue for patients/residents, staff and organisations.

Identify who is at increased risk of falling and the most common risk factors contributing to falls.

Identify appropriate and specific intervention strategies to reduce falls risks for a range of patient characteristics and scenarios.

During the development of this package, feedback from the sector identified the need for organisations to be able to track staff members who had completed the package. In response, the VQC is currently developing a mechanism for returning data from the package to the health services. Participants will be required to log in and a summary of their details will be sent to their hosting health service on completion of the package. This functionality is expected to be available in 2010. All Victorian Health Services will be invited to utilise the package in this way.



Persistence is the twin sister of excellence. One is a matter of quality; the other, a matter of time.

Marabel Morgan,
The Electric Woman

State Government of Victoria, Australia, Department of Human Services
Victorian Government Health Information



Minimising the Risk of Falls
& Fall-Related Injuries
Guidelines for acute, sub-acute and residential care settings

[Return to VQC Website](#) Menu > Index



- 1 Introduction
- 2 Fall Risk Assessment and Minimisation Strategies – For Acute Settings
- 3 Fall Risk Assessment and Minimisation Strategies – For Sub-Acute Settings
- 4 Fall Risk Assessment and Minimisation Strategies – For Residential Care Settings

[top of page](#)

[Links](#) | [Resources](#) | [Help](#)

Last updated: 26 November, 2008
This web site is managed and authorised by the Statewide Quality Branch, Rural & Regional Health & Aged Care Services Division of the Victorian State Government, Department of Human Services, Australia

[Copyright](#) | [Disclaimer](#) | [Privacy statement](#) | [State Government of Victoria home](#) | [Download help](#)



Australasian Association
for Quality in Health Care

8th Australasian Conference on **Safety and Quality** in Health Care



Back to the Future – Unlocking the Potential

Mark the dates in your diary
6 – 8 September 2010

Perth Convention Exhibition Centre, Perth

www.aaqhc2010.org.au

Express your interest now!

Hosted by The Australasian Association for Quality in Health Care (AAQHC)