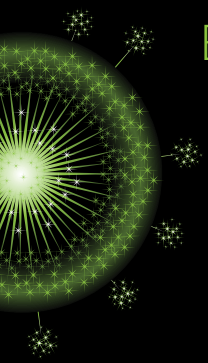
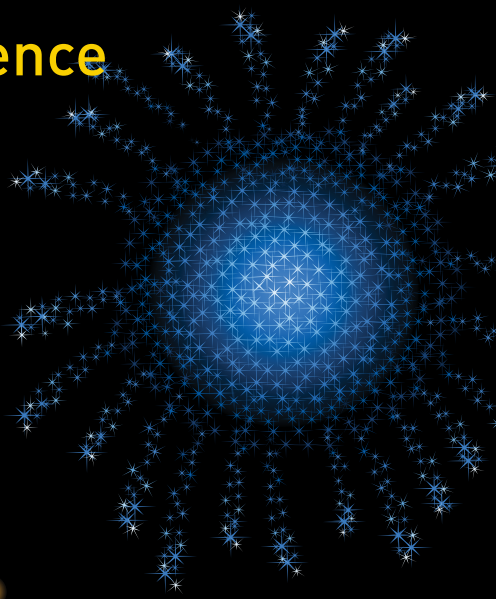
10th National Allied Health Conference

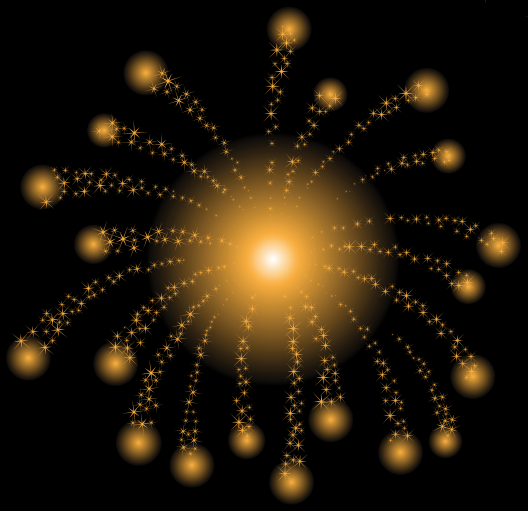
16–18 October 2013

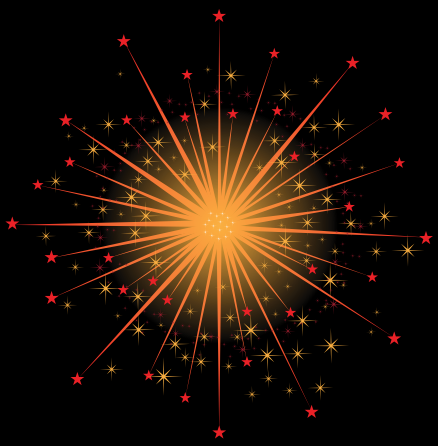
BRISBANE CONVENTION AND EXHIBITION CENTRE

Educate, Motivate, Innovate, *Celebrate*









2013

CONFERENCE HANDBOOK

Welcome

It is with great pleasure the conference committee welcomes you to attend Allied Health's premier event, the 10th National Allied Health Conference, at the Brisbane Convention and Exhibition Centre, October 2013.

Showcasing national and international speakers, the conference will discuss innovations in service delivery, clinical education and health research. Educate, Motivate, Innovate, Celebrate promises to be engaging and informative and will be of interest to allied health clinicians, researchers, educators and managers.

The conference provides a forum for the allied health workforce, educators and researchers to showcase innovations in service delivery and education relevant to the allied health professions share, their latest research findings, network with colleagues and celebrate allied health professionals' achievements.

2013 Conference Theme

Educate, Motivate, Innovate, *Celebrate*

The aim of the conference is to celebrate innovation in allied health education, clinical service delivery and research, and the contribution of this to patient care and the health of the community.

2013 Organising Committee

Julie Hulcombe
Andrea Hurwood
Ilsa Nielsen
Judith Catherwood
Kathy Stapley
Lujuana Abernathy
Matthew Molineux
Tania Hobson
Ans Van Erp
Amanda Greaves
Gail Gordon
Nicole Ralston
Julie Connell
Ling Lee
Mark Butterworth
Nicky Haron
Vanessa Richardson
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NAHC 2013 is supported by financial assistance from the Australian Government.

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Pocket Program

Facilitating Organisations

The conference is a collaborative of Allied Health Professions Australia (AHPA), Indigenous Allied Health Australia (IAHA), Services for Australian Rural and Remote Allied Health (SARRAH) and the National Allied Health Advisory Committee (NAHAC), with coordination overseen by the Queensland Department of Health.

Allied Health Professions Australia

Services for Australian Rural and Remote Allied Health

Indigenous Allied Health Australia

National Allied Health Advisory Committee

Continuing Professional Development (CPD)

Most attendees can earn Continuing Professional Development Hours at this event. Contact your governing association to determine the exact number of hours you can earn.

2013 Scientific Committee

Kim Bulkeley
Anna Farrell
Fiona Hinchcliffe
Tanya Lehmann
Bradley Lloyd
Lee McGovern
Brenda McLeod
Shirley Milligan
Marianna Milosavlijevic
Renae Moore
Janet Richmond
David Schmidt
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Karl Winckel
Shelley Wilkinson
Gretchen Young

Brisbane Convention and Exhibition Centre

The BCEC is Australia's most flexible meeting and events venue. From private business meetings to major conventions and exhibitions, social and charity functions to sporting and entertainment events, no matter what the event, our broad expertise, extensive resources and meticulous attention to detail helps ensure success for our clients and deliver outcomes beyond expectations for their guests.

Social Functions

WELCOME RECEPTION

Date Wednesday 16 October 2013
Time 1730-1900 Exhibition Area, Plaza Level, Brisbane Convention and Exhibition Centre
Cost Inclusive for full registrants.
$40 for additional tickets
Dress Smart casual

Welcome to the Conference! The Welcome Reception is an ideal opportunity to catch up with your interstate and international colleagues and to meet delegates who are attending the conference for the first time.

NETWORKING RECEPTION

Date Thursday 17 October 2013
Time 1730-1930
Venue Exhibition Area, Plaza Level, Brisbane Convention and Exhibition Centre
Cost Inclusive of full registrations
$70 for additional tickets
Dress Smart casual

Join us at the close of sessions on the first day for a selection of fine food and wine among the exhibitors, our valuable supporters. Take this opportunity to relax and unwind with friends and colleagues to the cool tunes of acoustic duo The Redsell Brothers.

Keynote Speakers

THE HONOURABLE LAWRENCE SPRINGBORG MP

Minister for Health, Member for Southern Downs

At twenty-one years of age, Lawrence Springborg became the youngest person ever elected to the Queensland Parliament.

He was first elected as the Member for Carnarvon in 1989. Subsequent electoral redistributions saw him elected as the Member for Warwick and then as the Member for Southern Downs, the seat he represents today.

At 29, Lawrence became Queensland's youngest ever member of Cabinet when he was sworn-in as Minister for Natural Resources in 1998 by then Premier Rob Borbidge. The following year, after the Coalition lost government, Lawrence was elected Deputy Leader of the Opposition and in February 2003 his parliamentary colleagues elected him as Leader of the Opposition.

Aged 34, he became the youngest political leader in Queensland since 'Red' Ted Theodore became Premier in 1919. Lawrence resigned as the Leader of The Nationals, Leader of the Opposition and Leader of the Queensland Coalition following the 2006 State Election. However, he was re-elected to the positions on 21 January 2008. Lawrence was determined to bring together the National and Liberal Parties as a united force. A plebiscite of all members of both Parties was conducted. A resounding 97% of National and 86% of Liberal Party members participating in the plebiscite voted in favour of the proposed merger.

Lawrence's determination and hard work came to fruition on 26 July, 2008 with the merge of the two conservative parties to create the LNP. Following the resounding win of government by the LNP in the March election, Lawrence Springborg was sworn in as Queensland's Minister of Health on 3 April 2012.

Lawrence enjoys spending time with his family on their Yelarbon property. He is married to Linda and is the father of four children. Lawrence has a strong interest in reading, political history and astronomy - an interest that drove him to build his own observatory. He is also a keen beekeeper.

MR DAVID BUTT

Deputy Secretary, Head of Rural and Regional Health Australia, Chief Allied Health Officer, Commonwealth Department of Health and Ageing

David Butt is Deputy Secretary of the Commonwealth Department of Health and Ageing with responsibility for national primary health care reform, population health, and regulatory policy and governance. Prior to commencing in this position in August 2011, David spent three years as CEO of the Australian General Practice Network, the peak national body for Australia's Divisions of General Practice and state-based organisations. David also has worked as National CEO of Little Company of Mary Health Care (the Calvary group of public and private hospitals, aged care and home care services) and CEO of ACT Health and Community Care, including two years as Chair of the Australian Health Ministers Advisory Council (AHMAC).

DR GEOFF GARRETT AO

Office of the Queensland Chief Scientist

Dr Geoff Garrett was appointed Queensland Chief Scientist to the Queensland Government in January 2011, following the retirement of Professor Peter Andrews AO.

A Cambridge graduate in metallurgy and an academic for 13 years, Geoff led two of the world's major national research institutions - CSIR in South Africa (1995-2000) and CSIRO in Australia (2001-2008). A former South African 'Engineer of the Year' (1999), he is a recipient of the Centenary Medal for service to Australian society through science. In June 2008 he was appointed as an Officer of the Order of Australia (AO) in the Queen's Birthday Honours List.

MS TANIA MAJOR

Acclaimed Indigenous advocate, former Young Australian of the Year

Tania Major is a Kokoberra woman from the remote community of Kowanyama in Cape York, Queensland. She holds a degree in Criminology from Griffith University and has also completed a Master's degree in Public Policy at Sydney University. Since 2002 Tania has addressed many national and international forums, speaking on Indigenous and youth affairs as these relate to remote communities, particularly those in Cape York. After 4 years with the Cape York Institute for Policy and Leadership, Tania established her own private consultancy and advocacy business. In 2010, Tania was both delighted and proud to accept an invitation from business leader and philanthropist Andrew Forrest to become the spokesperson for GenerationOne. As Managing Director of her own company, Tania is currently leading a project in Cape York communities to support young women who have, for many reasons, become disengaged from education, training or employment. The Cape York Super Sisters project aims to empower up to 100 young women to re-engage in these vital activities through a holistic approach and a focus on individual needs.

MS BERNIE HARRISON

Executive Director Hospital Performance, National Health Performance Authority

Ms Bernie Harrison has over 30 years' experience in healthcare including: clinical practice, research, health improvement, leadership and policy roles. In December 2012 she was appointed as the Executive Director Hospital Performance to the National Health Performance Authority. In this role she is responsible for the Hospital Performance Group who will prepare public reports on public and private hospitals, as well as local hospital networks. The purpose of these reports is to provide transparent public reporting across a range of performance indicators to increase accountability and drive continuous improvement.

In her most recent role Bernie was a Director at the NSW Clinical Excellence Commission, where she led the development of the Quality Systems Assessment program and directed the Blood Watch program, the Clinical Leadership and Clinical Practice Improvement programs. She has extensive experience in leadership and management at senior levels in the health system. She has over 20 years experience in academic and policy research in quality and safety, including co-authoring the seminal Quality in Australian Health Care Study (MJA 1995). She has been an international advisor to over ten countries on the measurement of patient safety at both a research and policy level. She was a Fulbright Scholar in 2001 and during that time focussed on healthcare improvement methods, prospective payment and comparative measurement approaches. She is a strong advocate of transparency in reporting to drive improvement in healthcare. Her clinical background is in intensive care nursing and midwifery in the UK.

Invited Speakers

MS PAULA BOWMAN

Lecturer, Health Management, School of Public Health and Social Work, Queensland University of Technology

Paula lectures in the Master of Health Management program at QUT. She also teaches clinical risk management in China for the Flinders University of SA. She has a special interest in healthcare quality and safety and leadership. She has also recently been an Australian Business Volunteer working with a community rehabilitation NGO in the Philippines.

Paula has 27 years experience in the healthcare sector - 16 years working as a Speech Pathologist in rehabilitation, acute hospital services and private practice, as a clinical manager and more recently 11 years working as a senior executive in Queensland Health. She moved to Queensland from South Australia in 1997 to take up the inaugural position of Principal Allied Health Adviser which she held until 2002.

She has extensive experience in direct service provision, operational management, program and project management, workforce and clinical service planning and in leading and managing clinical practice and health service reform.

PROFESSOR SUSAN NANCARROW

Professor of Health Sciences, Director of Research in the School of Health and Human Science, Southern Cross University

Susan is Professor of Health Sciences and Director of Research in the School of Health and Human Science at Southern Cross University. She joined SCU in March 2011, returning to Australia following 10 years in the United Kingdom where she worked as a health services researcher examining workforce change and capacity building in the National Health Service.

Susan trained as a podiatrist at the Queensland University of Technology and completed a PhD in public health at the National Centre for Epidemiology and Population Health, Australian National University. Prior to moving to England in 2001, Susan worked in Australia a range of clinical and management roles, including aboriginal health, multidisciplinary team leader for a community health service and as part of a primary care team in northern India. Susan's evaluation approach is underpinned by the principles of capacity building and user-focused engagement to ensure that the findings are relevant and meaningful to the end users, and contribute to organisational capacity and skill development where it fits the objectives of the evaluation. She has led research projects worth more than $2 million, and is a collaborator on projects worth more than $30 million.

MR DANIEL MAHONY

Services for Australian Rural and Remote Allied Health (SARRAH), Co-Chair of Future Health Leaders and the Rural Representative, Australian Physiotherapy Association (APA) National Advisory Council

Daniel is a young physiotherapist working in rural Western Australia making waves in Australia's healthcare system. At the age of 22, he became the youngest person ever elected to the board of Services for Australian Rural and Remote Allied Health (SARRAH) and is also currently Co-Chair of Future Health Leaders and the Rural Representative on the Australian Physiotherapy Association (APA) National Advisory Council.

Upon graduating from The University of Notre Dame Australia in 2010, Daniel was awarded the SARRAH Student Leadership Award, the Rural Health Workforce Award for Outstanding Leadership and the APA National Board of Directors Student Award for work achieved with the National Rural Health Students' Network (NRHSN) Allied Health Portfolio and his rural health club in promoting and advocating for rural health careers and better healthcare in the bush.

Daniel is passionate about improving the healthcare system for all Australians. On top of his part time postgraduate studies in Health Services Management, Daniel is working with Future Health Leaders to provide leadership development and mentoring opportunities for the future health workforce and facilitating the conversations we need to have to create a workforce that will work together for the benefit of the patient and their community. In his spare time he is a Volunteer Fire and Rescue Officer and enjoys rowing, gardening, camping and fishing.

MR BEN WALLACE

Executive Director Clinical Training Reform, Health Workforce Australia

In his role he is responsible for the Clinical Training Funding Program, The Clinical Supervision Support Program, The Simulated Learning Environments Program and funding for Integrated Regional Clinical Training Networks as well as advice to the HWA Board and the Australian Health Ministers Conference in relation to clinical training reform.

Prior to joining HWA Ben held a range of senior executive positions in the Commonwealth Government, primarily in the Department for Families, Housing, Community Services and Indigenous Affairs as well as serving in taskforce arrangements in the Department of the Prime Minister and Cabinet.

Ben's experience includes policy development, program implementation and management, and direct service delivery.

Ben's academic qualifications are in psychology, social work and public policy.

PROFESSOR LINDY MCALLISTER

Professor and Associate Dean for Work Integrated Learning (WIL), Faculty of Health Sciences, University of Sydney

In this role she has responsibility for leading the clinical education and work integrated learning (WIL) staff in all of the faculty's nine allied health disciplines. A major component of this role is innovation in WIL placements, education for practice, and assisting staff to develop their research and scholarship in clinical education and WIL.

Lindy has a PhD in clinical education and supervision. Her academic background is in the discipline of speech pathology where she has served as a Clinical Coordinator and later Head of Program in different urban and rural universities. She has worked across the health professions in various leadership and capacity building roles in Australia and in Vietnam. She was Deputy Head at the UQ Medical School from 2009-11. Her research activities in the clinical education and WIL space encompass workplace-based assessment of clinical competence (The COMPASS™ project - 2006 Carrick Institute Citation for Outstanding Contributions to Student Learning; 2008 Australian Learning and Teaching Council Award for Programs that Enhance Learning); preparation of students for placement including for international and intercultural practice; interprofessional education; education of clinical supervisors.

Professor McAllister's research has been supported by more than $1.5 million in major external research grants in recent years, including funds from the Carrick Institute, Australian Learning and Teaching Council, HWA (through ClinEdQ and HETI), and the Australian Research Council. She was part of two successful applications for funding to the Australian Learning and Teaching Council for 2011-2012. In the past seven years Prof. McAllister has published 5 books, 10 invited chapters and more than 30 peer-reviewed journal publications, in teaching and learning, and clinical education. She has developed clinical supervisor development programs for a range of health professions, most recently online programs for the UQ Medical School and ClinEdQ. Professor McAllister has also maintained a clinical research stream and publication profile in children's speech sound disorders, adults with traumatic brain injury and rural speech pathology service delivery issues.

Invited Speakers

MR JOHN MERRICK

Director of Allied Health, Health Education and Training Institute, New South Wales

John Merrick has worked in the public sector for 30 years, working at numerous teaching hospitals, in Allied Health. John has joined HETI from South Eastern Sydney where he worked as Head of the Social Work Department. John has extensive experience in counselling, particularly in bereavement and trauma. John worked in Forensic Medicine and the Office of the NSW State Coroner for close to twenty years. He has extensive experience in disaster work, having worked on disasters such as the Grafton and Kempsey bus crashes, the Bali Bombings and many others. He also has experience working as an investigator at the Healthcare Complaints Commission. John currently is the Director of Allied Health at the Health Education and Training Institute at Gladesville in New South Wales. John's passion is to assist in the development of a world class Allied Health workforce.

DR ADAM BIRD

Head of Podiatry, La Trobe University

Dr Adam Bird is the Head of Podiatry at La Trobe University, and the Deputy Chair of the Australian and New Zealand Podiatry Accreditation Council. He has experience in the development of the educational elements of the Endorsement for Scheduled Medicines in Podiatry in Australia, and in developing the accreditation standard for theoretical and supervised practice for this endorsement.

MS KATHLEEN PHILIP

Chief Allied Health Advisor Department of Health, Victoria

Kathleen was appointed to the newly created role of Chief Allied Health Advisor of Victoria in 2013. She continues in her role as the Manager, Workforce Innovation and Allied Health team, in the Health Workforce Unit of the Department of Health Victoria, a position she has held since 2008. Kathleen completed qualifications in Public Health and Health Economics in 2005 and joined the department in 2007. She is responsible for Victoria's new workforce reform implementation agenda (2012-16) as well as providing leadership and strategic direction to Victoria's allied health workforce policy. Prior to joining the department she practised as a specialist musculoskeletal physiotherapist and was involved in the establishing new service models and advanced practice physiotherapy roles in orthopaedics, neurosurgery and Emergency.

MS ILSA NIELSEN

Principal Workforce Officer, Allied Health Professions' Office of Queensland, Department of Health

Ilsa has worked in a number of roles in the Queensland public health system since 2007. She is currently Principal Workforce Officer in the Allied Health Professions Office of Queensland, Department of Health. This role is focussed on workforce policy, planning, development and support for the rural and remote Allied Health workforce. Ilsa has recently commenced work with the Greater Northern Regional Training Network on the Rural & Remote Generalist: Allied Health project.

Ilsa trained as a physiotherapist at the University of Sydney and has worked in New South Wales, Queensland and the United Kingdom in a range of clinical areas. In 2004, Ilsa was appointed Lecturer and foundation Physiotherapy Program Coordinator at James Cook University, Townsville. At JCU she also completed postgraduate studies in Public Health and Education. She remains an adjunct Senior Lecturer in the School of Public Health, Tropical Medicine and Rehabilitation Sciences. Ilsa is a current member of the Northern Queensland Regional Training Network and is the representative for the Services for Australian Rural and Remote Allied Health (SARRAH) on the Queensland Primary Health Care Network.

MS JULIE CONNELL

Executive Director Clinical Support Services, Princess Alexandra Hospital, Metro South Health, Queensland

Julie Connell is the Executive Director Clinical Support Services, Princess Alexandra Hospital, Metro South Health, Queensland. This is a position that Julie has held since 2002 and during this time has experienced many organisational changes and restructuring at local and state level.

Julie has been involved for many years at a state and national level in allied health activity data collection and benchmarking, and PAH has been a member of the National Allied Health Benchmarking Consortium since the late 90's.

More recently Julie has become a member of the Clinical Advisory and Teaching, Training and Research Committees to the Independent Hospital Pricing Authority and a surveyor with the Australian Council on Healthcare Standards.

MR DAVID STOKES

Executive Manager, Professional Practice, Australian Psychological Society (APS)

Mr David L. Stokes is the Executive Manager, Professional Practice, for the Australian Psychological Society (APS). Prior to this role with the Society, David has a long history of working in the health system in teaching hospitals, and as a Clinical Neuropsychologist has provided services in collaboration with specialists in psychiatry, paediatrics, geriatrics, neurology and general medicine. In his private practice he provides diagnostic work up for patients with a variety of conditions but specialising in aged care and developmental psychology.

While working with the APS, David has been closely involved with government-funded initiatives in primary care such as Better Outcomes in MHC, Better Access in MHC, Mental Health Professions Network and the current eHealth reforms. This has involved working closely with other primary care organisations like RACGP, RANZCP, MHNA, ACNP, NEHTA and AHPA.

In addition, David has an extensive history of working in the area of allied health activity data set development and particularly the creation of performance indicators in both primary and tertiary care for allied health practitioners.

Invited Speakers

MS ERICA KNEIPP

Assistant Secretary, Commonwealth Department of Health & Ageing

Erica Kneipp is an Assistant Secretary in the Commonwealth Department of Health & Ageing. She currently has responsibility for the Medicare Locals Branch in the Primary and Ambulatory Care Division. She has worked with the Department since 2009 implementing the National Partnership Agreement on Preventive Health and activity-based hospital funding under the National Health Reform Agreement.

Prior to this, Erica worked with the George Institute for International Health on a variety of strategic health service planning frameworks within Australasia. She worked for over a decade at the state government and local health service level in Western Australia, including in the Kimberley. While in WA, she was instrumental in establishing first time satellite dialysis models involving partnerships with Aboriginal Community Controlled Health Services and the private sector.

Erica commenced in the Medicare Locals Branch in August 2012 and is overseeing the development of Medicare Locals as regional primary health care organisations across the country.

MS ROBYN SMITH

Northern Health Learning and Research, Victoria
Director, Allied Health Learning and Research, Northern Health, Melbourne

Robyn is Director of Allied Health Learning and Research at Northern Health – a major public health service in Melbourne's northern metropolitan suburbs. Robyn is an experienced allied health clinician, researcher and facilitator. She has postgraduate qualifications in Gerontology and Public Health, and over her career (including during her role as Director, Public Health Division at the National Ageing Research Institute) has completed a wide range of funded projects, publications and reports that have influenced practice and policy.

Since commencing at Northern Health in 2003 Robyn's role has developed as an integral part of the senior leadership group of allied health and the wider health service. Her role at Northern Health is focused on developing allied health staff capacity in research and evidence based practice, and on fostering excellence in clinical education and staff learning across all disciplines.

In recent years, Robyn has lead a range of projects and programs aimed at developing interprofessional approaches to education and practice in the clinical setting. These include an innovative interprofessional graduate program supporting the transition from student to professional and a number of collaborative programs fostering interprofessional learning opportunities for health professional students and their supervisors.

MR RUSSELL BOOTH

Chief Nuclear Medicine Technologist, St Vincent's Hospital, Melbourne

Russell is a graduate of RMIT University in Medical Radiations (Nuclear Medicine). He initially worked at the Peter MacCallum Cancer Centre and then moved to take the position of Chief Nuclear Medicine Technologist at St Vincent's Hospital, Melbourne.

His principal interests include undergraduate and graduate clinical training and Quality Improvement. He has worked in partnership with the Victorian Health Department to develop a course in diagnostic CT for nuclear medicine technologists. He is chair of the Victorian Society of Nuclear Medicine Technologists Education Committee who have recently introduced a new intern model for graduate technologists.

Russell completed a Masters in Quality Improvement in Healthcare from the Centre for Clinical Epidemiology and Biostatistics at the University of Newcastle. This background has led to an interest in the evaluation of supervised practice programs.

Russell is a member of the Victorian Radiation Advisory Committee and RMIT Universities Program Advisory Committee in Medical Radiations.

MS FRANCES MILLAR

Project Manager, University of Queensland Health Care, Ipswich Aged and Chronic Disease Clinic

Frances completed a Bachelor of Applied Science - Occupational Therapy at Curtin University in Western Australia in 1986; has clinical and management experience in community and mental health, including rural and remote services; and held project management and service development roles for the Health Department of Western Australia. Interest in mental health continues through her role as a member of the Queensland Mental Health Review Tribunal.

Having previously completed a Graduate Diploma of Business; Frances has recently undertaken an HWA National Clinical Supervision Fellowship in partnership with the University of the Sunshine Coast.

Whilst working in Clinical Education with the OT Program at the University of Queensland, Frances was involved in the development of iQIPP, a guide for Improving Quality in Practice Placements.

Frances is currently in a project management role with UQ Health Care, working with stakeholders to develop sustainable, student-assisted service delivery programs, using an interprofessional education framework.

MR DARRYL GRUNDY

CEO, University of Queensland Health Care

Darryl completed his Bachelor of Pharmacy at the University of Queensland in 1987. Since then he has gained extensive experience within public and private hospitals, in metropolitan and rural settings across Australia and the UK. He holds a Master of Science degree in Clinical Pharmacy from The Queen's University, Belfast, with a research focus on the control of terminal pain. Since then he has developed extensive management experience, ranging from pharmacy ownership, to General Manager of a national pharmacy company. Darryl conceived and established a community based hospital-in-the-home nursing company, which achieved the prevention or shortening of hospital admission of over 14,000 patients. As CEO of UQ Health Care, he converted vision to reality in establishing 3 GP Super Clinics. Darryl has successfully implemented a best-practice, integrated and multidisciplinary model of healthcare, striving for excellence in clinical service, research and education, establishing UQ Health Care as a key link between the hospital and community health sectors in the health reform process.

Program

	WEDNESDAY 16 OCTOBER 2013		
0800	Registration Open		
	Plaza 1	**Plaza 2**	
0830-1000	*The added value of allied health management and leadership in challenging times - Enter the dragon's den* Robert Jones, Fiona Jenkins, Janice Mueller, Rosalie Boyce	Commences 0900 *Aligning your personal and business life* Michelle Tate-Lovery	
1000	Morning Tea		Plaza Foyer
1020-1230	*The added value of allied health management and leadership in challenging times - Enter the dragon's den* continued	*Aligning your personal and business life* continued	
1215-1315	Lunch		Plaza Foyer
	Plaza 1	**Plaza 2**	**Plaza 3**
1300-1430	*The added value of allied health management and leadership in challenging times - Enter the dragon's den* Robert Jones, Fiona Jenkins, Janice Mueller, Rosalie Boyce	*Calderdale Framework - Implementation in Australia* Rachel Duffy, Jayne Smith, Alison Pighills, Annette Scott, Ilsa Nielsen, Sarah Patterson, Michelle Bradford	*A beginner's guide to cost effectiveness analysis* Nicholas Graves
1430	Afternoon Tea		Plaza Foyer
1450-1720	*The added value of allied health management and leadership in challenging times–Enter the dragon's den* continued	*Calderdale Framework - Implementation in Australia* continued	*A beginner's guide to cost effectiveness analysis* continued
1730-1900	**Welcome Reception**		Plaza Foyer, Brisbane Convention and Exhibition Centre

	THURSDAY 17 OCTOBER 2013
0800	Registration Open
	Plenary Session — Plaza Terrace Room
0830	**Welcome to Delegates** Mr David Butt, Deputy Secretary, Head of Rural and Regional Health Australia, Chief Allied Health Officer, Commonwealth Department of Health and Ageing
0840	**Welcome to Country** Uncle Eddie Ruska, Traditional Custodian of the Brisbane Region
0845	**Opening Address** The Honourable Lawrence Springborg MP, Minister for Health, Member for Southern Downs
0900	**Keynote Address: Australian Chief Allied Health Office - The Future** Mr David Butt, Commonwealth Department of Health and Ageing
0915	**Keynote Address: INNOVATE** Dr Geoff Garrett, Chief Scientist, Office of the Queensland Chief Scientist

1000	Morning Tea in the Exhibition			Plaza Foyer
	Concurrent Sessions: Plaza Level			
	Workforce Innovation Plaza Terrace Room Chair: Mark Butterworth	**Clinical Education** Plaza 1 Chair: Matthew Molineux	**Indigenous Health** Plaza 2 Chair: Craig Dukes	**Coordination of Care** Plaza 3 Chair: Ling Lee
1020-1035	*Allied health redesign: Applying lean thinking to an acute allied health service* Derryn Cashmore	*Putting the best foot forward - Use of clinical simulation to support teaching and training in undergraduate podiatry* Shan Bergin	*Institute for Urban Indigenous Health Paediatric Allied Health Assessment Model* Tara Lewis, Chrisdell McLaren, Alison Nelson	*'Someone was there for me': Using experience-based co-design to improve clients experience of care coordination services* Mark Murray, Jacinta Roberton
1040-1055	*Evaluation of the Queensland Health Practitioners Models of Care Project: Lessons for successful workforce change* Susan Nancarrow	*A comparative study of paired and single clinical placement models: An activity level analysis* Marita Plunkett	*A multidisciplinary allied health partnership approach to improving chronic disease self-management in an urban Indigenous population: Let's 'Work It Out'!* Emma Campbell, Samara Dargan	*From muddle of care to model of care in rehabilitation teams: Results of a system-wide change program* Susan Fone
1100-1115	*An RCT to evaluate the clinical effectiveness of trans-professional skill sharing* Alison Pighills	*Creating new placement opportunities by overcoming barriers for assessment: Results of a Delphi* Sandra Capra	*'If you don't have that knowledge you don't ask that question.' Staff readiness for conducting assessments in remote Indigenous community contexts* Melissa Lindeman	*Improving hospital to community handover: Implementing an electronic dietetics discharge summary* Lauren Rogers
1120-1135	*Advanced allied health assistants in the ACT* Claire Pearce	*How does the 'Teaching on the Run' program affect motivation, confidence and the effectiveness of allied health professionals involved in student clinical supervision?* Margaret Potter	*You can lead the way – Educate, motivate, innovate and then celebrate being culturally responsive* Keona Wilson	*Care of the elder inpatient - 'When everyone is responsible, no one is responsible' - Solving the problem with a multi-professional allied health assistant* Mark Cruickshank
1140-1155	*Creating a foundation for delegation to Allied Health Assistants in a Medical Assessment and Planning Unit* Julie-Anne Ross	*Educating and motivating rural and remote allied health professionals: Learnings from experience and evidence* Wendy Ducat	*Partnership outcome: Brain injury training and support program for Aboriginal and Torres Strait Islander health workers* Susan Gauld, Sharon Smith	*The role of allied health in advance care planning - Our time to shine!* Liz Crowe

1200-1300	Lunch & Poster Viewing in the Exhibition (odd numbered posters)			Plaza Foyer
1300-1400	**CELEBRATE - Allied Health Past, Present, Future** Chair: Gretchen Young, Young Futures Ms Paula Bowman, Queensland University of Technology Professor Susan Nancarrow, Southern Cross University Mr Daniel Mahony, SARRAH			Plaza Terrace Room
	Concurrent Sessions: Plaza Level			
	Workforce Innovation Plaza Terrace Room Chair: Gail Gordon	**Research & Evidence Based Practice** Plaza 1 Chair: Ilsa Nielsen	**Innovations in Client Care** Plaza 2 Chair: Amanda Greaves	**Professional Support** Plaza 3 Chair: Lujvana Abernathy
1400-1415	*Flexible, capable, adaptable: A dynamic allied health workforce* Kerry May	*Allied health research at Royal Melbourne Hospital: The first year of a new approach* Julia Blackshaw	*Improving patient access: Redesigning the allied health cancer care model of care at Cairns Base Hospital* Cara Johnstone	*Celebrating innovative research collaboration with outcomes: Professional support in Queensland* Karen Bell, Fiona Hall
1420-1435	*Allied health staffing factor: Are we underestimating the cost of staffing required?* Lyndell Keating	*Influencing EBP use by allied health professionals through education, motivation and innovation* Shelley Wilkinson	*Engaging allied health in cancer survivorship - The positive change for Life Survivorship Project* Sharon Avery	*Positive psychology proving itself in retention* Christine Franklin
1440-1455	*Implementing an expanded scope of practise physiotherapy service in the emergency department at Robina Hospital* Deb Lenaghan	*Understanding allied health professionals' use of research evidence using the theory of planned behaviour* Marlena Klaic	*Trial of a computer-based program that provides length of stay benchmark figures at a rehabilitation centre: Its ability to identify and impact on prolonged lengths of stay and staff perceptions of its use* Kate Roberts	*Does clinical supervision lead to better outcomes? Findings from a study of allied health professionals* Christine Saxby
1500-1515	*Evaluation of an advanced allied health assistant role in ACT Health* Therese Edwards, Claire Pearce	*A recursive model for capacity-building in the learning and sustainability of evidence-based treatment* Ingrid Wagner	*Multisite investigation of weekend allied health services on acute medical/surgical wards* Donna Markham	*Celebrating the innovative use of telehealth technologies to educate, mentor and motivate best practice* Desleigh De Jonge
1520-1535	*Change sweet change: Improving equity for staff and clients through change management* Andrea Whitehead	*Comparison of GAS and Lawton Scale for measuring outcomes in a rural Ambulatory Rehabilitation Service* Louis Baggio	*Clinical allied health dashboard - by clinicians for clinicians* Leah Thompson	*Raising the bar - Governance, education and training for the Allied Health Assistant (AHA) workforce in NSW Health* Sue Steel-Smith, Danijela Radovanovic
1535	Afternoon Tea in the Exhibition			Plaza Foyer

1600-1730	**EDUCATE - Supply and demand clinical training for the future** Chair: Susan Nancarrow **HWA Perspective** Mr Ben Wallace, Health Workforce Australia **University Perspective** Professor Lindy McAllister, University of Sydney **Public Health Employer Perception** Mr John Merrick, Health Education and Training Institute (HETI) NSW Panel Discussion	Plaza Terrace Room
1730	**Sessions End**	
1730-1930	**CELEBRATE - Networking Reception** Plaza Foyer, Brisbane Convention and Exhibition Centre	

FRIDAY 18 OCTOBER 2013

0800	Registration Open			
0830	**Plenary Session** Chairs: Julie Hulcombe, Department of Heath, Queensland and Lyn Littlefield, Allied Health Professionals Australia			Plaza Terrace Room
0830	**Keynote Address: Two way thinking on building a healthy nation one person at a time** Ms Tania Major, acclaimed Indigenous advocate and former Young Australian of the Year			
0930	**Keynote Address: Performance and accountability and implications for allied health** Ms Bernie Harrison, Executive Director Hospital Performance, National Health Performance Authority			
1030	Morning Tea in the Exhibition			Plaza Foyer
	Concurrent Sessions: Plaza Level			
	Workforce Innovation Plaza Terrace Room Chair: Lee McGovern	**Rural & Remote** Plaza 1 Chair: Renae Moore	**Interprofessional Education & Practice** Plaza 2 Chair: Nicky Haron	**Paediatrics** Plaza 3 Chair: Tania Hobson
1050-1105	*Benchmarking in allied health services - If you can't measure it you can't manage it!* Fiona Jenkins, Robert Jones	*WA Country Health Service allied health transition to Practice Graduate Program* Katherine Lamont	*Preparing pre-graduate students for the workplace - Proving the worth of an Interprofessional competency-based education program* Rebecca Black	*Paediatric allied health drop-in clinics improve accessibility and efficiency* Lisa Sandaver, Timothy Effeney
1110-1125	*Securing the allied health workforce - Evaluation of subacute models of care, including fiscal modelling* Steven Wood	*Educate, articulate, motivate: More 'transition to remote practice' training tools* Annie Farthing	*Inter-professional education and the first year experience: Ongoing developments in a core health sciences course* Melanie Hayes	*Feeding difficulties in children with autism spectrum disorders and so-called 'fussy eaters': Baseline information from the HELP Study* Jeanne Marshall

1130-1145	*Doing things differently: Extending the scope of allied health assistants in speech pathology* Simone Williams	*Maximising our Remote Professional Health (MORPH) workforce project* Kathy Relihan, Tanya Lehmann	*An innovative model of interprofessional paediatric education for allied health professionals* Alexandra Little	*Simulated Learning in Paediatric Allied Health (SLIPAH): Making the SLIPAH fit!* Kristine Kelly
1150-1205	*Using The Calderdale Framework to develop employer led higher education* Rachael Smith, Jayne Duffy	*Rural private therapy framework: Delivering high quality, sustainable and accessible services to people with disability* Jo Ragen	*Flying Start Queensland Health: International innovation for inter-professional education* Peter Fuelling	*How can parents educate health professionals about their experiences in child development services: A grounded theory model for goal setting* Shareen Forsingdal
1205-1300	Lunch & Poster Viewing in the Exhibition (even numbered posters)			Plaza Foyer
	Concurrent Sessions: Plaza Level			
1300-1415	Plaza Terrace Room Chair: Tanya Lehmann	Plaza 1 Chair: Lin Oke	Plaza 2 Chair: Lindy McAllister	
	Expanding scope to improve services *Implementing prescribing in allied health - the journey* Dr Adam Bird, La Trobe University, Victoria *Renewing the workforce - the challenges* Ms Kathleen Philip, Department of Human Services, Victoria *Rural and remote allied health generalist* Ms Ilsa Nielsen, Department of Health, Queensland	**National Health Reform - The new environment and reform** *Health reform - What does it mean for allied health?* Ms Julie Connell, Metro South Health, Queensland *National health reform: AH input into IHPA and NHPA and what's next* Mr David Stokes, Australian Psychological Society (APS) *Implementation of medicare locals and primary care reform* Ms Erica Kneipp, Commonwealth Department of Health & Ageing Medicare Locals Branch	**Clinical Education Showcase** *Getting 'interprofessional' into the every day!* Ms Robyn Smith, Northern Health Learning and Research, Victoria *Simulation within medical imaging* Mr Russell Booth, St Vincent's Hospital, Melbourne, Victoria *Creating opportunities through identified need: Development of primary care based student assisted program using a collaborative model of service development* Ms Frances Millar, University of Queensland Health Care Ipswich Aged and Chronic Disease Clinic Mr Darryl Grundy, CEO UQ Health Care	
	Group discussion	Group discussion	Group discussion	
1415-1435	Afternoon Tea in the Exhibition			Plaza Foyer

	Concurrent Sessions: Plaza Level			
	Clinical Education Plaza Terrace Room Chair: Julie Hulcombe	**Workforce Innovation** Plaza 1 Chair: Julie Connell	**Clinical Practice** Plaza 2 Chair: Judith Catherwood	**Community & Primary Care** Plaza 3 Chair: Amanda Greaves
1440-1455	*Innovative solutions for traditional problems: Development of new student placement models at the University of the Sunshine Coast* Heidi Miller	*Resourcing allied health managers for activity-based funding and workforce planning* Steven Bowden	*Poor nutrition and function after acute hospitalisation: Opportunity for innovative post-discharge care* Adrienne Young	*Development and implementation of a community palliative care equipment service* Geraldine Hodson
1500-1515	*Fostering and Inspiring Research Engagement (FIRE): A research incubator scheme for undergraduate allied health students* Jenny Ziviani	*Restructuring allied health for quality: Effective, efficient and economical service provision* Gail Gordon	*Education and motivation in clinical handover at a tertiary hospital. A model for allied health disciplines* Therese Dodds	*Allied health and its role in reducing chronic disease complications impacting the homeless population* Rebecca Mannix
1520-1535	*NSW Health ClinConnect - Innovation in clinical placement management* Brenda McLeod	*Innovation in models of care: Implementation of an allied health clinical leader in a medical assessment and planning unit* Marguerite Bennetts, Doug Murtagh	*Connecting practice: A dynamic framework for implementing workplace supervision and support* Susan Nancarrow	*Early and intensive allied health rehabilitation programs improve patient outcomes and drive financial efficiencies* Steven Bowden
1540-1555	*'Learn, feel inspired, creative and affirmed' - Mixed methods findings in professional music therapy supervision* Jeanette Kennelly	*Allied Health Assistant Implementation Program - Taking delegation to task* Andrea Elliott, Annette Davis,	*Utilising allied health assistants to implement a new model of occupational therapy service delivery on the medical wards at the Townsville Hospital* Kym Murphy	*Community pharmacy - Leading innovation in primary health care* Kathleen Moorby
1600-1615	*Intercontinental nutrition and dietetic practice placements: A collaborative and innovative partnership between London and Melbourne* Sophia Lee	*Leading the future for allied health - A governance perspective* Joanne Travaglia, Patricia Bradd	*Multidisciplinary action research improves nutrition-related outcomes post acute hip fracture* Jack Bell	*Allied health enabling the development of health localities* Martin Chadwick
1620-1630	**Conference Close and Handover to NAHC 2015**			Plaza Terrace Room

Posters

Posters will be displayed for the duration of the conference. Attending authors are asked to attend their poster during the lunch on Thursday 17th October or Friday 18th October to discuss with other delegates.

ODD numbered posters will be presented during lunch on Thursday 17th October
EVEN numbered posters will be presented during lunch on Friday 18th October

1 *Students' perceptions of regional and rural allied health clinical placement quality*
Veronique Anderson, Dominic Mawn, Jayne Kirkpatrick, Karen Bruggemann, Yvonne Watts, Linda Furness

2 *Striving for health equity in small regional hospitals using telehealth to deliver dietetic services*
Rhonda Anderson

3 *Are generic resources for Allied Health Assistants in rural settings possible?*
Lauren Arthurson, Merrin Prictor, Alicia Cunningham

4 *Establishing a palliative music therapy service in the hospital: Personalising end of life care for oncology patients and families*
Belinda Ayres

5 *Clinical handover - From policy to practice*
Sarah Bailey, Samara Phillips, Ruth Cox

6 *AHPEP - educating the allied health workforce through clinical placements since 2000*
Katie Bauer, Melinda Stone

7 *Development of an occupational therapy needs assessment tool*
Michelle Bennett, Kym Murphy, Michelle Watson, Daniel Lowrie, Tilley Pain

8 *Fast-tracking sustainable discharge from the emergency department: Implementation of a subacute allied health service*
Marguerite Bennetts, Doug Murtagh

9 *Innovating outcomes for adults attending alternative to employment programmes: A role for occupational therapy*
Carly Bloomfield, Janet Richmond, Ruth Marquis

10 Withdrawn

11 *Validity of malnutrition screening tools for adult rehabilitation patients*
Loretta Bufalino, Joanne McKinstry, Maria Apostolides, Jennifer Sequeira, Elizabeth Few, Catherine Higgin

12 *Pilot speech pathology telehealth service for head and neck cancer patient support*
Clare Burns, Elizabeth Ward, Anne Hill, Karen Malcolm, Lynell Bassett, Lizbeth Kenny, Phillip Greenup

13 *Celebrating increased food service patient satisfaction with the Queensland health nutrition standards for meals and menus*
Clare Byrne, Michelle Palmer

14 *'Tools of Trade' TOT a non-traditional approach to men's shed development. Featuring health: as a contemporary new partner*
Bruce Campbell, Melissa Koch

15 *Development of ePET (ePharmacy Education and Training): A statewide pharmacy specific online training site*
Ann Carter, Shelley Crowther

16 *Store Walk'n'Talks: an innovative approach to nutrition education in a remote Aboriginal community*
Erin Cassells, Hilary Jimmieson, Judith Aliakbari, Derlene Gray, Carolyn Keogh

17 *Allied health within a complex adaptive system*
Martin Chadwick

18 *Improving health literacy for parents accessing child development services: A model for information use*
Winnie Cheung, Jeanette Davey, Carmen Bydeveldt, Winsome St John

19 *Exploring the benefits and challenges of an innovative fee-for-service program within a not-for-profit organisation*
Karen Bolger

20 *Evaluating the effectiveness of the oncology needs assessment tool in identification of outpatient needs for multidisciplinary health services*
Amy Chiu, Vanessa Cobham

21 *The challenges and enablers for implementing experienced based co-design as a quality improvement approach*
Kate Cranwell, Jacinta Roberton

22 *The development of a mentorship role for occupational therapists within an acute setting*
Rebecca Donnelly, Meagan Elder

23 *Nutrition assistant delegation: An innovative model for increasing nutrition surveillance and management of 'at risk' patients*
Kristen Demedio, Jennifer Hall, Rebecca Moore

24 *One fine day for paediatric pharmacists - A time and motion study*
Anna Durance, Heidi Wong, Nicolette Graham

25 *TeamUp educational intervention: Development of an educational resource for educators to teach teamwork skills*
Alaina Evanson, Jennieffer Barr

26 *Sensory sensitivities in children with feeding difficulties: An interdisciplinary team approach*
Nadine Frederiksen, Pamela Dodrill, Jeanne Marshall, Jenny Ziviani

27 *Motivating new graduate professional learning: Pilot of a clinical learning framework*
Cate Fitzgerald

28 *Motivating learning and innovation with assistive technology for people with progressive neurological diseases*
Millissa Fromer, Janet Mostovoy, Orla Foster, Rosanne Gibb

29 *Queensland physiotherapy placement collaborative and the Queensland central allocation process*
Mark Gooding, Linda Blackwell, Ruth Dunwoodie, Garry Kirwan, Paul Miller, Nikki Milne, Meg Moller, Aya Pellatt, Rod Stuart

30 *A 3D virtual medical imaging CT suite: Innovation in education*
Therese Gunn, Pete Bridge, Clare Berry, Vicki Braithwaite, Gaynor Mahoney, Pam Rowntree, Debbie Starkey, Kelly Wilson-Stewart

31 *Better prepared, better placement: An online resource to prepare allied health students and supervisors for clinical placement*
Sandra Grace, Keri Moore

32 *Development and trial of a 12-month multidisciplinary clinical measurements graduate training framework*
Megan Harbourne, Stephanie Van Ballegooyen, Chris Brown, Tilley Pain

33 *Challenges faced in developing a validated satisfaction survey for students completing nutrition and dietetics (N&D) clinical placements*
Nicky Haron, Angela Vivanti, Rhiannon Barnes

34 *Kickstarting your research: a one day workshop for aspiring practitioner researchers*
Desley Harvey, Alison Pighills

35 *An interprofessional education program for allied health new graduates*
Jacinta Hayes, Samantha Sevenhuysen

36 Withdrawn

37 *Innovative approaches to clinical education in Evolve Therapeutic Services*
Linda Furness, Kaylee Venter, Jackie Wright

38 *Can involvement in a store badging program increase engagement of indigenous youth?*
Hilary Jimmieson, Erin Cassells, Judith Aliakbari, Derlene Gray, Carolyn Keogh

39 *Mealtimes on the oncology ward: Identifying opportunities to eat, walk and engage*
Lisa Jolliffe, Adrienne Young, Prue McRae, Alison Mudge, Kelli Malone

40 *Supervision, Training and Readiness (STAR) Program; an interdisciplinary approach to building clinical supervision capacity*
Phillippa James, Grainne O'Loughlin

41 *Clinical placements in a telesupervision model: Student and educators views*
Yvonne Kane, Anne Hill, Lucinda Chipchase, Ruth Dunwoodie

42 *Growing a simulated learning framework for paediatric allied health*
Kristine Kelly, Meg Moller, Allison Mandrusiak, Sarah Wright

43 *Are we there yet? A journey towards clinical governance in rural and remote allied health*
Tanya Lehmann, Elaine Ashworth, Saravana Kumar

44 *Interdisciplinary persistent pain management program - A twelve-month review*
Hannah Kennedy, Melissa Hatty

45 *The disappearing waiting list: Improving access to services through complete service redesign*
Alexandra Little

46 *Innovation in service models for eating disorders in child and youth mental health*
Richard Litster, Karen Dawson, Tania Withington, Ingrid Wagner

47 *Improving the care of the elderly through an oral health education program for nursing staff*
Christine Mamo, Louisa Lunn, Nicholas Brennan

48 *Governance framework for professional practice in allied health*
Donna Markham, Kathleen Phillip, Jill Walsh

49 *Leisure therapy - A new service in the Queensland spinal injuries unit*
Kate Martin, Glenda Price, Ruth Cox

50 *Challenging risk appetite in allied health*
Kerry May, Deb Mitchell, Fiona McAlinden

51 *Developing an interdisciplinary model of care in rehabilitation and aged care services: New building, new opportunities*
Fiona McAlinden, Michelle O'Rourke

52 *Knowledge exchange, primary health care and allied health - The role of the primary health care research and information service*
Ellen McIntyre, Jodie Oliver-Baxter, Lynsey Brown

53 *Clinical supervision models used in allied health at a regional health service*
Narelle McPhee, Marcus Gardner, Angela Crombie

54 *Problem based learning - The real life experience*
Kerstin McPherson

55 *Eat walk engage: Working together for better care of elders*
Prue McRae, Alison Mudge, Mark Cruickshank

56 *What is the evidence around how to best support new graduates?*
Nadine Ninness, Mary Whitehead

57 *Design of a quality improvement framework to revolutionise quality in a busy occupational therapy department*
Katherine O'Shea, Jenny Nel

58 *Discovering performance skills for motorised mobility scooter use*
Casey Overste, Lois Moir, Janet Richmond, Jeannine Millsteed

59 *Your online colleague - Evidence-based subject guides*
Christopher Parker

60 *Innovation: Working in partnerships to provide perinatal mental health treatment and support to families in rural communities*
Katie Peterson, Amanda Finn, Fiona Little

61 *Education model for palliative care: An interdisciplinary approach*
Linh Pham, Renae Majcen

62 *Patient's experiences of receiving an Allied Health professional skill sharing model of care: A qualitative study*
Alison Pighills, Michelle Bradford, Desley Harvey, David Plummer

63 *Hunter Medicare Local- Delivering multidisciplinary education to meet local health providers' needs*
Aimee Prosser, Rick Naylor, Lisa Craig

64 *Client-led visual goal-setting in a sub-acute rehabilitation unit*
Sarah Raffell

65 *Video-based telehealth: Current and potential use of videoconsultation by allied health professionals*
Melissa Raven, Petra Bywood

66 *Students attitudes towards working with older people - The Placement Rotation in Aged Care (PRAC) project*
Helen Redfern, Suzette Fox

67 *Adults with disabilities - A cross sector collaboration*
Helen Redfern, Christine Cotter, Mary Fenn

68 *Celebrate collaboration! Implementation of new standardised new standardised parenteral nutrition formulas in a tertiary paediatric hospital*
Lana Steward-Harrison, Ashlee Aitken, Lyn Robinson, Julia Fox, Looi Ee

69 *Engaging our workforce early*
Julie-Anne Ross, Julie Connell, Cate Fitzgerald, Gail Gordon

70 *Supporting allied health professionals to contribute to better patient outcomes through an interprofessional capability development framework*
Julie-Anne Ross, Cate Fitzgerald, Julie Connell, Gail Gordon, Angela Wood, Kim Walder

71 *QH spirometry training program - Promoting lung health in Queensland*
Irene Schneider, Andrew Coates

72 *High risk foot training in Western Australia: Making a difference*
Deborah Schoen, Sandra Thompson

73 *Evaluating inpatients' satisfaction with allied health services: a series of surveys at a rehabilitation centre*
Kate Roberts

74 *A journey in self management and sustainability for communication impaired stroke survivors*
Susan Scholtz

75 *Exploring the impact of mealtime assistance and interruptions on nutritional intake of vascular surgical inpatients*
Amy Scott, Adrienne Young, Lisa Joliffe, Prue McRae, Alison Mudge

76 *Developing an interprofessional curriculum from the ground up - The process*
Cindy Sealey, Beverly Raasch

77 *An investigation into the enablers and barriers to physiotherapy clinical placements within Queensland's public health system*
Kassie Shardlow, Peter Tonks, Mark Gooding, Rod Stuart

78 *Well equipped for palliative care. A review and evaluation of the aids and equipment utilised and accessed by the clinicians at Calvary Health Care Bethlehem (CHCB) to best support individuals with palliative and neuropalliative conditions*
Ruth Skene, Sarah Solomon, Jill Loveland

79 *Exercise and the treatment of depression - A critical analysis of recent reviews*
Robert Stanton, Peter Reaburn, Brenda Happell

80 *Is more intensive better? Intensive versus standard therapy for functional dysphonia*
Penny Stabler, Rachel Wenke, Leah Coman, Chloe Walton, Melissa Lawrie, John O'Neill, Elizabeth Cardell, Deborah Theodoros

81 *The value of workforce profiling*
Catherine Stephens, Julie Hulcomb

82 *The smart assistive technology revolution*
Wendy Stevens

83 *The implementation of a sustainable student led role in an acute care setting: A review*
Vicky Stirling

84 *Education targeted at developing managerial skills within our senior allied health workforce*
Tamica Sturgess

85 Withdrawn

86 *Assessment, management and support of people living in situations of domestic squalor in regional Queensland*
Rebecca Torkington, Alison Maynard, Jennie Whitely, Angela Atherton, Leianne Elms

87 *Pillar pain post open carpal tunnel release: characteristics, assessment, and occupational implications*
Alta-Mari van Huyssteen, Janet Richmond, Rachel McKay

88 *The causes of their death appear (unto our shame perpetual)*
Lil Vrklevski, Leanne McKechnie

89 *A mapping of allied health service capacity for maternity and neonatal services across southern Queensland*
Shelley Wilkinson, Leyanne Duncan, Catherine Barrett, Robin Turnbull, Sally McCray

90 *Participatory action research of knowledge translation in occupational therapy*
Mary Whitehead, Elizabeth Caldwell, Sally Bennett, Jennifer Fleming

Exhibitors

01	Department of Health is a dynamic organisation committed to providing a range of services aimed at achieving good health and well-being for all Queenslanders. Through a network of 17 Hospital and Health Services and the Mater Hospitals, Queensland Health delivers a range of integrated services including hospital inpatient, outpatient and emergency services, community and mental health services, aged care services and public health and health promotion programs. W: www.health.qld.gov.au	Queensland Government
02	Healthdirect Australia manages telephone and online services providing Australians with access to health information and the right advice on the appropriate care for their health issue, when and where they need it. Services include: healthdirect Australia, after hours GP helpline, healthinsite, Pregnancy, Birth and Baby, mindhealthconnect, National Health Services Directory. Contact: Sharon Lum Ph: 02 9263 9037 W: http://www.healthdirect.org.au/	HEALTHDIRECT AUSTRALIA
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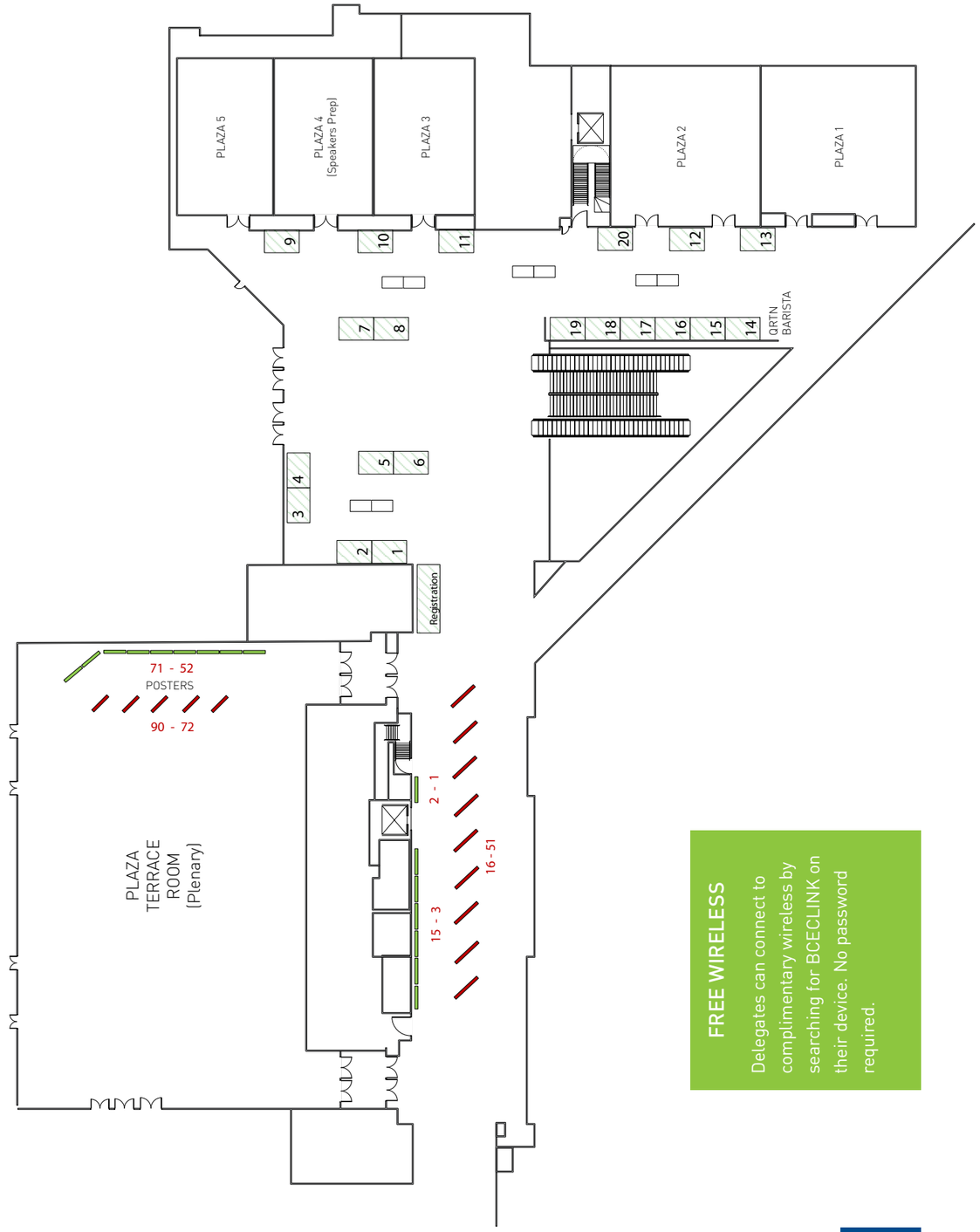
05	CheckUP is an independent, not-for-profit industry body dedicated to advancing primary health care. CheckUP fosters innovation, integration and collaboration through a range of business services, products and events. Contact LIbby to discuss how CheckUP can assist your organisation. Contact: Libby Dunstan (Business Manager) Ph: 07 3105 8300 E: ldunstan@checkup.org.au W: www.checkup.org.au	CHECKUP advancing primary healthcare
06	The National Relay Service is a government-sponsored phone service for people who are deaf or have a hearing or speech impairment. The service uses relay officers who are the central link in every call, relaying exactly what is said or typed. NRS users can ring anyone from anywhere in Australia, anytime. Contact: NRS Helpdesk Contact: 1800 555 660 E: helpdesk@relayservice.com.au	A phone solution for people who are deaf or have a hearing or speech impairment. NATIONAL RELAY SERVICE. An Australian Government Initiative
07	Research Nutrition globally sources the highest quality nutritional supplements and functional testing services for healthcare practitioners to promote optimal ageing, improved clinical efficacy and personalised test results. The successful combination of functional diagnostic testing with evidence-based supplementation represents a preventive approach to health management. Contact: Allissa Collier Ph: 1800 110 158 E: support@researchnutrition.com.au W: www.researchnutrition.com.au	researchnutrition
08	Eden Ritchie - Health Recruitment is focused on providing professional and individually tailored recruitment services. The team consists of experienced Consultants and Talent Resourcers, sourcing outstanding talent for leading employers in the Public and Private Health Sectors, including NFP and NGO, as well as Allied Health, Life Sciences and Academia. Contact: Sue or Kylene on 07 3230 0033 W: www.edenritchie.com.au	ER Health Health Recruitment

09	Greater Metro South Brisbane Medicare Local (GMSBML) assists our community to have better access to local health services. GMSBML works with local healthcare providers including allied health, general practice, hospitals, community-based health organisations and government to better connect the people in our communities with healthcare services where and when they need them. Ph: 1300 467 265 E: info@gmsbml.org.au W: www.gmsbml.org.au	medicare local GREATER METRO SOUTH BRISBANE Connecting health to meet local needs
10	Do you care for patients with a life-limiting illness? Enhance your practice by undertaking professional development opportunities in palliative care (3-5 day supervised placements in specialist palliative care services or palliative approach workshops). There are no fees for attendance. Some backfill and travel funding is available. Visit: www.pepaeducation.com.	PEPA Program of Experience in the Palliative Approach. Funded by the Australian Government Department of Health and Ageing
11	Health Services Union is the union for all Health Professionals. Our members work in aged care, disability services, community health, mental health, private practices and hospitals; practising in Dietetics, Imaging, Radiation Science, Social Work, Counselling, Optometry, Pharmacy, Physical Therapy, Prosthetics, Language, Hearing and Dentistry. Contact: HSU National Ph: 02 8203 6066 E: hsu@hsu.net.au W: www.hsu.net.au mailto:hsu@hsu.net.au	HSU Health Services Union
12	The Primary Health Care Research & Information Service is a national organisation based at Flinders University. PHCRIS generates, manages and shares information and knowledge which informs, influences and enhances PHC practice, policy and research. PHCRIS resources, publications and data are accessible through the website which promotes the sharing of information and knowledge. Contact: Prof Ellen McIntyre Ph: 1800 025 882 E: phcris@flinders.edu.au W: www.phcris.org.au	PHCRIS Primary Health Care Research & Information Service
13	LifeTec is the leading provider of specialist information, consultation and education and training services for Assistive Technologies. Services include a telephone and video enquiries line, home visits, online training and support and regional visits throughout Queensland. Visit www.lifetec.org.au for further details. P: 07 3552 9000 or 07 4759 5600 E: mail@lifetec.org.au W: www.lifetec.org.au	LifeTec towards easier living
14	Health Workforce Australia is supporting all states and territories to establish and maintain Regional Clinical Training Networks to build collaborations between education and clinical placement providers to support the delivery of clinical education and to build the future health workforce. QRTNs aim to facilitate locally driven, stakeholder-led clinical placement initiatives. Contact: Moina Lettice Ph: 07 4781 4042, 0419 327 683 E: QCETC.Sec@jcu.edu.au	QRTN
15	Locum support made easy. NO fees or charges apply. The Nursing and Allied Health Rural Locum Scheme (NAHRLS) is an Australian Government funded programme offering locum support for nurses and midwives in rural and remote Australia to relieve staff while they are away on leave up to 14 days (per request). NAHRLS Enquiries 1300NAHRLS (1300 624 757)	NAHRLS

16	Austraining International is a specialist project management and international development organisation delivering projects worldwide. We have over 10 years experience in volunteering, having managed more than 4000 volunteers across Asia, the Pacific, Africa, Latin America and the Caribbean. Volunteer programs provide Australian organisations the opportunity to develop and strengthen international relationships. Contact: Marijke Fotia Ph: 08 8634 8500 E: partnerships@austraining.com.au	
17	The Centre for Remote Health (CRH) is a joint centre of Flinders University and Charles Darwin University. CRH aims to contribute to the improved health outcomes of people in remote communities of the Northern Territory and Australia, through the provision of high quality tertiary education, training and research focusing on the discipline of Remote Health. The Remote Health Practice Program (RHPP) has been designed by remote practitioners for remote practitioners in the Australian context. Contact: Annie Farthing P: 08 89514 752 E: annie.farthing@flinders.edu.au W: www.crh.org.au	
18	Dementia Training Study Centres offer a range of professional development opportunities that translate current knowledge and research into practical, effective approaches to help people living with dementia and their families. Find out more about our courses, workshops, seminars, scholarships, UG/PG curriculum development and access resources and online learning at www.dtsc.com.au	
19	Diabetes Queensland is the peak body for people with diabetes in Queensland - providing a single, powerful and collective voice for the diabetes community. In addition, Diabetes Queensland also offers a variety of resources and education programs to assist health professionals in their treatment and management of people with diabetes. To find out more, contact us on 1300 136 588 or visit www.diabeteqld.org.au.	
20	Computers, software and technology in general must ensure that businesses do less and gain more. By following this simple rule, REND Tech Associates implements IT solutions for Allied Health professionals that make their job easier and make their business more productive. REND Tech Associates is an eHealth IT firm specialising in delivering IT solutions for the health industry. We ensure that the solutions implemented are tailored for your business so you can reap the benefits from day one. Whether it's a Cloud solution so you can work from multiple sites that you need or a local IT infrastructure to safely host your patient data and run your day to day clinical applications. We do it all. Ph: 02 8005 0583 E: mail@rendta.com W: www.rendta.com	
	Health Workforce Australia (HWA) is a Commonwealth statutory authority established to build a sustainable health workforce that meets Australia's healthcare needs. HWA leads the implementation of national and large-scale reform, working in collaboration with health and higher education sectors to address priorities of planning, training and reforming Australia's health workforce. W: www.hwa.gov.au	

Exhibition



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Indigenous Allied Health Australia (IAHA)

IAHA Indigenous Allied Health Australia 2013 2nd National Conference

Healthy Footprints Leading Generational Change

26-27 November 2013, Hilton Adelaide

It is with great pleasure that Indigenous Allied Health Australia (IAHA), the national peak body representing Aboriginal and Torres Strait Islander allied health professionals and students, invites you to attend the second Indigenous Allied Health Australia (IAHA) national conference to be held in Adelaide 26-27 November 2013. IAHA welcomes attendees from Indigenous health, education and research sectors, community organisations, university students, health service providers and policy makers.

Registrations now open! See more at: http://iaha.com.au/events/2013-conference.

Health Workforce Australia 2013 Conference

18-20 November 2013, Adelaide Convention Centre

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Dietitians Association of Australia (DAA) 31st National Conference

15-17 May 2014, Brisbane Convention Centre

www.daa.asn.au

Australian Association of Practice Managers National Conference 2014

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11th National Conference for Rural and Remote Allied Health Professionals (SARRAH)

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Services for Australian Rural and Remote Allied Health

Surf's Up: Ride the Waves

17-20 September 2014, Mantra on Salt Beach, NSW

Get ready to wax your surfboard for the 2014 National SARRAH Conference Surf's Up! Ride the Waves, held by Services for Australian Rural and Remote Allied Health (SARRAH).

The highly-anticipated event will be held in Kingscliff, northern New South Wales, from 17-20 September 2014. The packed speaker program focuses on the latest research and projects impacting on Australia's allied health sector.

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Occupational Therapy Australia State Conferences
(some dates and locations to be confirmed)

- **Australian Capital Territory / New South Wales**
  28-29 March 2014, Australian Technology Park, Redfern NSW
- **Victoria "Moving with the Times"**
  2-3 May 2014, The Event Centre, Flemington Racecourse
- **Western Australia 'Breaking Down Barriers Through Occupation'**
  16-17 May 2014
- **Northern Territory**
  Early July 2014
- **South Australia**
  23-24 October 2014
- **Queensland**
  23-25 October 2014, Noosa, Sunshine Coast
- **Tasmania**
  November 2014


10th National Allied Health Conference
ORAL ABSTRACTS

The Future

Mr David Butt

Deputy Secretary, Head of Rural and Regional Health Australia, Chief Allied Health Officer, Commonwealth Department of Health and Ageing

INNOVATE

Dr Geoff Garrett

Chief Scientist, Office of the Queensland Chief Scientist

Allied Health redesign: Applying lean thinking to an Acute Allied Health Service

Karen Brown[1], **Derryn Cashmore**[1], Stephen Basso[1], Lauri O'Brien[2] , Mel Lewis[2]

[1] Repatriation General Hospital, Daw Park, SA
[2] Flinders Medical Centre, Bedford Park, SA

Allied Health Departments across Australia are facing the same challenge of how to manage increasing demand within existing resources. The Allied Health Department at the Repatriation General Hospital (RGH) in Adelaide have applied lean thinking principles to redesign their service to meet this challenge.

Staff in each department (Physiotherapy, Social Work, Occupational Therapy, Dietetics, Speech Pathology and Podiatry) participated in a detailed diagnostic phase where they mapped their processes and also self-tracked their work day. This analysis showed that allied health staff spent between 10-40% of their time in direct patient care. Data was also collected on response times, referral patterns, workload and leave patterns. Surveys were completed by patients, allied health, nursing and medical staff. This data showed that patients could not always identify who allied health staff were, that allied health staff felt they were not providing the best quality treatment, and that all staff believed communication could improve.

From this analysis it became clear that allied health needed to redesign:

- Staff allocation
- Work Flow
- Guidelines and Management of Referrals
- Management of planned and unplanned leave
- Communication processes with each other and the rest of the care team

Process outcomes include a standard approach to allocation, the development of user-friendly referral guidelines and clinical priorities, a leave management policy, visual management of allied health staff and the implementation of 'allied health hub boards'.

Initial outcomes show a 26% reduction in inappropriate referrals, enhanced communication within the multidisciplinary team and improved staff satisfaction.

Evaluation of the Queensland Health Practitioners Models of Care Project: Lessons for successful workforce change

Susan A Nancarrow[1], Alison Roots[1], Anna M Moran[1], Sandra Grace[1], Kerry Lyons[1, 2]

[1] Southern Cross University, Bilinga, Qld
[2] Formerly Queensland Health

Background: Increasingly, health workforces are undergoing high level 're-engineering' to help them better meet the needs of the population, the workforce and services. Queensland Health implemented a large-scale, 5 year program involving 54 workforce redesign projects across 15 different disciplines. The aim of this study was to synthesise the finding from the projects to identify and codify the mechanisms associated with successful workforce redesign.

Methods: The research drew on primary and secondary data sources including a systematic review, documentary analysis, a survey and interviews. Concept analysis was used to develop an overarching taxonomy of workforce redesign projects; logic models were used to extract and organise data according to the headings contexts, barriers, facilitators, outputs, outcomes; the logic model was then used to develop propositions which causally link the contexts and mechanisms associated with successful workforce redesign, which were then re-tested empirically against the data.

Findings: The study identified three overarching principles to optimise the success of workforce redesign:

(1) Drivers for change which are close to practice
(2) Contexts which are supportive both locally and legislatively
(3) Mechanisms which include; appropriate engagement; appropriate resources, facilitated change management; appropriate governance and support structures.

Attending to these factors was uniformly associated with the success of the project.

Conclusions: Despite the heterogeneity of projects, professions and approaches, a consistent set of overarching principles underpins the success of workforce change approaches. These have been further developed into a validated workforce change checklist.

An RCT to evaluate the clinical effectiveness of trans-professional skill sharing

Alison Pighills, Michelle Bradford, Danielle Hornsby

Mackay Hospital and Health Service, Mackay Mail Centre, Qld

Increasing pressures on Allied Health (AH) services indicate that the skill mix of the workforce needs to be reviewed and re configured to improve efficiency and meet the needs of the patient, rather than reflecting historical roles. Trans-professional skill sharing is widely accepted as a means of providing efficient services in a healthcare environment facing increasing demands and skills shortages. This is particularly the case in rural/remote areas where clinicians work in isolation.

The Calderdale Framework (CF) is a robust, systematic, risk managed approach to skill mix review and identifies clinical tasks that can be safely skill shared between professionals. It has been widely implemented in the UK and momentum is increasing in Australia. However, the clinical effectiveness of the framework has never been evaluated.

Aim: To establish a model of trans-professional skill sharing using the CF and evaluate its clinical effectiveness Research question: Is trans-professional skill sharing clinically effective in enhancing patients' functional independence, in a regional setting, as compared to usual care?

Methods: The CF was implemented in the Mackay Hospital and Health Services. AH clinicians were trained in tasks that were historically the domain of other disciplines. A RCT was carried out to investigate clinical effectiveness. The primary outcome was functional independence measured by the WHO-DAS, secondary outcomes included: EuroQol, Short Form-12, Barthel and Timed Up and Go.

Results: 152 participants were recruited to a RCT and randomised to receive usual uni-disciplinary AH care or the trans-disciplinary skill sharing model. The results of this RCT will be outlined in this presentation.

Discussion: The presentation will discuss the CF implementation process, the research methods and results.

Advanced allied health assistants in the ACT

Claire Pearce

Senior Project Officer, ACT Health Directorate, Canberra, ACT

The ACT Government employs approximately fifty allied health assistants (AHA) across acute, rehabilitation, community and developmental delay services. This number reflects a quadrupling in positions since the introduction of the Certificate IV in Allied Health Assistance in 2006. Over 70% of ACT AHAs have or are enrolled in the Certificate IV or have a higher qualification in a health related field.

To support an innovative approach to the continued development of the AHA workforce, the ACT has undertaken a project to explore the concept of an Advanced AHA. The project aimed to describe the advanced role and its potential to contribute to the delivery of quality client care whilst also exploring an educational pathway that provides skills escalation and career development for this growing workforce.

A literature review was commissioned from the International Centre for Allied Health Evidence (iCAHE). Interviews were conducted with managers and AHAs from occupational therapy, physiotherapy, podiatry, nutrition, speech pathology and exercise physiology with the purpose of establishing the current scope of AHA roles and to review perceptions of an advanced role. This was supplemented by reviewing the duty statements of current positions to identify the core skills and roles of an AHA.

This paper will describe the outcomes of the project, highlighting:

- the definition and description of an advanced AHA role
- evidence to support the role
- potential areas where the role may be utilised
- barriers and enablers to implementing an advanced role
- examples of advanced roles.

It will conclude by outlining how the ACT plans to support the development of further advanced roles including plans to develop an educational pathway to a diploma level.

This paper links to "Evaluation of an Advanced Allied Health Assistant Role in ACT Health' which describes the implementation and evaluation of the advanced Discharge Support AHA role in aged care services.

Creating a foundation for delegation to Allied Health Assistants in a Medical Assessment and Planning Unit

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[1] Metro South Hospital and Health Service, c/o Nutrition & Dietetics, Ground floor, Building 15, Princess Alexandra Hospital, Woolloongabba, QLD

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Aims: This presentation will describe the process that was used in one tertiary hospital to implement delegation practices to Allied Health Assistants (AHAs) from allied health professionals (AHPs) within a Medical Assessment and Planning Unit (MAPU).

Content: In health, where there is ever increasing demand on services due to people living longer, increasing health costs with an aging and shrinking workforce, it is imperative that we ensure AHPs are free to undertake tasks that require their valuable skills.

A strategic approach to implementing delegation practices is essential to ensure that AHPs, AHAs and other hospital staff are confident in the delegation practices and to ensure that patient care is optimised and risk is mitigated. Benefits of fully utilising our AHA workforce are numerous. Patient benefits include more timely and comprehensive assessment, intervention and follow up; enhanced continuity of care; reduced duplication of assessment and intervention; and an increased number of patients receiving allied health services for longer periods of time. Both AHPs and AHAs report increased job satisfaction; increased work at full scope; and increased confidence in delegation. Organisational benefits include improved utilisation of skills; skill mix aligns with the direction of the organisation; and increased efficiencies. For this reason, delegation practices within a Medical Assessment and Planning Unit for AH staff was seen as a priority.

The Calderdale Framework and methodology provided a systematic approach to implementing delegation practices that were coordinated, sustained and governed. It involved mapping services, identifying appropriate tasks for delegation, establishing competencies for tasks, developing governance strategies, undertaking training and implementing strategies for sustaining practices.

Putting the best foot forward – Use of Clinical simulation to support teaching and training in undergraduate podiatry

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[2] Monash University, Clayton, VIC
[3] Monash Health, Dandenong Hospital, Dandenong, VIC

Traditional teaching models for Victorian undergraduate podiatry students combine theoretical and onsite university clinic based practice with observational and practical placements within designated public health institution clinical schools. In both environments, there are difficulties ensuring undergraduate students get sufficient hands on clinical training to gain an appropriate level of 'readiness to practice'. Conversely, Podiatrists working within the clinical school model are under growing pressure to support an increasing number of students. Small staffing numbers, the requirement for placements to provide sufficient opportunity to demonstrate competency across key learning areas and the provision of an environment for students to safely exercise risk free higher acuity clinical tasks continue to challenge the podiatry discipline.

A Health Workforce Australia grant enabled Podiatry at Monash Health, to purchase simulation equipment resulting in; an increased capacity to accept higher numbers of students, a risk averse training environment for student learning and reduced pressure on Monash Health Podiatry staff.

The use of clinical simulation training has been used previously to up-skill qualified Podiatrists in the area of diabetes related foot ulcers. The Foot Ulcer Simulation Training (FUST) developed and evaluated by Queensland Health resulted in a 42% increase in clinician confidence when assessing and managing diabetes related foot ulcers and a significantly increased ability to differentiate between wound types.

The teaching models developed by Monash Health podiatrists enabled third and fourth year Podiatry students to simulate clinical activities such as wound debridement, injection techniques, nail surgery and lower limb casting. This presentation will describe the theory behind the use of simulation and its potential application to multidisciplinary assessment within allied health. It will also discuss the development of the different simulation models used, tasks covered during 'SIM' labs and perceptions of the shift along the confidence/competence continuum following "SIM".

A comparative study of paired and single clinical placement models: An activity level analysis

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[2] The Prince Charles Hospital, Speech Pathology Department, Chermside, QLD
[3] Statistics Unit, Queensland Institute of Medical Research, Herston, QLD
[4] The University of Queensland, School of Health and Rehabilitation Sciences, QLD
[5] Metro South Hospital and Health Service, Eight Mile Plains, QLD
[6] Cunningham Centre, Darling Downs Hospital and Health Service, Toowoomba, QLD
[7] Queensland Paediatric Rehabilitation Service, The Royal Children's Hospital, Herston, QLD

Background: In order to meet rising clinical placement demand caused by increasing health student numbers, the use of paired (2 students) rather than single (1 student) placements has been proposed. There is, however, limited research available to inform placement providers about the relative effects of both models on patient and non-patient related activities. This study therefore investigates a key clinical question: does clinician and student activity differ during paired placements, compared to single placements?

Methods: Queensland Health speech pathologists (N=44) and speech pathology students (N=32) involved in paired or single clinical placements in 2011-2012 participated. Clinical educators (CEs) and students completed time use surveys for 3 days during placements; CEs also completed surveys for 3 days during a non-placement period for comparative purposes. Paired and single CE and student groups were compared on their time use and satisfaction levels using Fisher's exact tests (categorical variables) and Mann-Whitney tests (continuous variables). A thematic analysis was undertaken on qualitative data.

Summary of results: Occasions of service was not affected by placement type, for students (p=0.77) or CEs (p=0.93). Placement type also had no effect on percentage of time students and CEs engaged in patient-related activities (p=0.18; p=0.56) and non-patient related activities (p=0.18; p=0.56). CEs spent a median 10 minutes longer at work regardless of whether it was a paired or single placement, compared with non-placement days (p=0.50). Clinicians and students who had been involved in a paired placement reported the same high levels of placement satisfaction (various measures) as those who had been involved in a single placement.

Conclusions: The paired placement model has the capacity to increase student placement offers without negatively impacting on occasions of service, clinical or non-clinical activities or overall CE time spent at work.

Creating new placement opportunities by overcoming barriers for assessment: Results of a Delphi

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[5] Queensland University of Technology, Kelvin Grove, QLD

The demands on clinical placement capacity for allied health students are well documented. Ensuring only appropriate assessment of relevant competencies occurs in this setting is vital to reduce burden on clinical educators and supervisors and therefore increase capacity. This study aimed to determine the appropriate setting for assessment of the competence of entry-level dietitians in Australia. Seventy-five experienced assessors, academics and practitioners, were invited to participate in an electronic Delphi survey. The Delphi study aimed to reach consensus as to which of the 166 entry-level performance criteria can only be assessed in the practice/placement environment, compared to those which can be assessed in a classroom/university setting or through simulation and those where either setting can be used. Forty-two assessors responded to the first round of the survey. A second round of the survey was conducted with the participants with 34 responding. Consensus was achieved for the setting for many of the performance criteria. However, where no consensus was reached it became clear that practitioners perceived the setting differently to academics who saw more potential pre-placement skill assessment. The results showed the need for clinical placement setting only to assess individual patient care and professionalism. Competencies in communication and information assessment were the areas in which practitioners differed from academics. For any growth and innovation in clinical placements the barrier of the different perceptions needs to be addressed. There is an opportunity to skill assessors to better understand the preparation of students prior to commencing work-based placement experiences. Developing the confidence of those involved in educating health professionals on alternative valid and reliable assessment prior to placement to reduce time required in the healthcare system is required. Although this study was conducted in dietetics we believe the results are transferable to other allied health professions.

How does the 'Teaching on the Run' program affect motivation, confidence and the effectiveness of allied health professionals involved in student clinical supervision?

Margaret Potter, Fiona Lake

University of Western Australia, WA

Introduction: There has been considerable growth in the number of training places across all health professions in recent years, increasing demand for clinical placements. Consequently, placements are being sought in previously underutilised areas such as in aged care, mental health, rural and remote areas, as well as in non-traditional places such as private practice and other community-based settings. In addition, staff are being asked to supervise students much earlier in their career, often immediately upon graduation.

For clinical supervisors responsible for increased numbers of students from multiple training institutions, with few if any breaks from students throughout the year the role can be very challenging. This results in increased pressure on staff who may lack the fundamental skills and confidence, or lose motivation due to burn out making it difficult to maintain interest and be highly effective.

Methods: As part of an initiative to provide student clinical supervisors with support, an education program known as 'Teaching on the Run' was utilised to train and accredit allied health facilitators at various sites across Australia who then rolled out workshops in their own clinical setting. Data from every workshop delivered during the first half of 2013 were collected and analysed to evaluate the value of the program and to measure changes in levels of motivation, confidence and effectiveness pre and post-training.

Results and Discussion: Regardless of profession or level of experience, the vast majority of participants who attended workshops delivered by any of the trained facilitators rated the value of the information provided as 4 (good) to 5 (excellent). In addition, there were some significant changes in the pre- and post-training measures suggesting the program was beneficial in supporting the professional development needs of allied health professionals. The key elements of the program that were found to be most useful will be highlighted.

Educating and motivating rural and remote allied health professionals: Learnings from experience and evidence

Wendy Ducat[1], Vanessa Richardson[1], Saravana Kumar[2]

[1] Cunningham Centre, Darling Downs Hospital and Health Service, QLD
[2] International Centre for Allied Health Evidence, University of South Australia, Adelaide, SA

It is widely acknowledged that healthcare delivery should be underpinned by principles of safety, effectiveness, patient centeredness, timeliness, efficiency and equity. In recent times though, workforce shortages have had a significant impact on the quality and safety of healthcare despite increasing demand for healthcare services. The impact of health workforce shortages, including allied health, is nowhere more evident than in rural and remote Australia. In addition to these workforce issues, historically, these allied health professionals (AHPs) were supported in an ad hoc and opportunistic manner.

The innovative Allied Health Rural and Remote Training and Support (AHRRTS) program aimed to provide an integrated program of education and professional support activities for AHPs working within Queensland Health in rural and remote locations. By doing so, it aimed to increase and support the participation in education and professional support activities which would ultimately positively impact on clinical governance, clinical and professional capability and health outcomes in rural and remote areas of Queensland.

Evaluation of the AHRRTS program utilised a mixed-methods approach. Qualitative data in the form of semi-structured interviews were collected from allied health stakeholders. Quantitative data originated from surveys conducted at various time periods throughout the duration of the AHRRTS program and evaluations of workshops and training programs.

Overall, there was universal recognition of the positive impact of the AHRRTS program. Evidence from evaluation indicated that AHPs in rural and remote locations participated in more education and professional support activities which met their expectations and learning goals, had improved confidence, knowledge and skills for supervision and retention was stable. While participants did report barriers to access and participation in education and professional support activities, they also reported enablers which acted as facilitators. The learnings from experience and evidence from the AHRRTS initiative provide a valuable blue print for success for similar initiatives elsewhere.

Institute for Urban Indigenous Health Paediatric Allied Health Assessment Model

Tara J Lewis, Chrisdell McLaren, Dr Alison L Nelson

Institute for Urban Indigenous Health, West End, QLD

Allied health professionals are becoming increasingly aware of the difficulties associated with assessing Aboriginal and/or Torres Strait Islander children's developmental abilities. Standardised assessments are rarely normed for Aboriginal and Torres Strait Islander children and seldom provide accurate and reliable assessment results. However, allied health professionals continue to use standardised assessments as they feel there are no other methods to guide their practice.

Recent research has been conducted to support culturally safe methods of assessing Aboriginal and Torres Strait Islander children. Judy Gould, Speech Pathologist, conducted research in a remote Aboriginal community and identified three principles when assessing rural Aboriginal children: make modifications to existing assessment tasks, create new assessments that reflect the communication style of Aboriginal children and collect natural language samples. Additionally, Dr Alison Nelson, Occupational Therapist, has emphasised the importance of building a relationship with a child, using a strengths-based approach and using informal assessment and observations to gain a more accurate understanding of the child's developmental abilities. Whilst there is ample literature evidencing culturally safe assessment principles, there is no literature that coherently links it all together to guide allied health professionals in their assessment of urban Aboriginal and Torres Strait Islander children.

The Institute for Urban Indigenous Health has drawn on this literature and developed a Paediatric Allied Health Assessment Model to guide allied health professionals in the safe assessment of urban Aboriginal and Torres Strait Islander children. This presentation will discuss how this Assessment Model is considered best practice when assessing Urban Aboriginal children's developmental abilities through the consideration of the child's culture, ensuring a strengths-based approach, understanding the child and their story and developing purposeful and meaningful assessment activities.

A multidisciplinary allied health partnership approach to improving chronic disease self-management in an urban Indigenous population: Let's 'Work It Out'!

Emma Campbell, Samara Dargan, Kyly Mills, Alison Nelson, Chantal Roder, Tabinda Basit, Katherine Munce, David McLaughlin, Katrina Rae

The Institute for Urban Indigenous Health, Bowen Hills, QLD

Chronic diseases disproportionately contribute to the burden of disease in Australia experienced by Aboriginal and Torres Strait Islander populations. Effective management of these conditions is elemental in closing the life expectancy gap between Indigenous and non-Indigenous Australians within a generation. Moreover, there is a need to design and implement programs which meet the unique needs of urban Aboriginal and Torres Strait Islander people.

The Work It Out (WIO) Program has been implemented by the Institute for Urban Indigenous health across five Indigenous Community Controlled Medical Services in urban south-east Queensland. This innovative program adopts the holistic view of Indigenous health and utilises a multidisciplinary partnership approach to aid in chronic disease self-management within an urban Indigenous population. Multiple weekly 45-minute education sessions are delivered by allied health professionals from fields of exercise physiology, occupational therapy, nutrition, psychology, nursing or pharmacy. This is followed by a one hour individually tailored exercise program in a group setting. Independent of the group sessions, clients have the opportunity to meet one-on-one with allied health professionals to aid in self-management strategies which are unique to their chronic condition.

Fostering a mixed-methodology approach, evaluation of the Work It Out program is ongoing. Physiological health data and quality of life measures are collected at baseline and at 6 weeks. In addition, semi-structured qualitative interviews are undertaken to provide more in-depth client and staff perspectives on the contribution of the program to chronic disease self-management. Preliminary evaluations have shown promising results in increasing client knowledge of chronic conditions and motivation to empower self-management, as well as self-reported improvements in social and emotional well-being and general quality of life. Changes in some physiological measures are also emerging. This presentation will outline the project in detail and report on outcomes from preliminary evaluations.

'If you don't have that knowledge you don't ask that question.' Staff readiness for conducting assessments in remote Indigenous community contexts

Melissa A Lindeman[1], Kylie M Dingwall[2], Di Bell[1]

[1] Centre for Remote Health, a partner in the Centre for Research Excellence in Rural and Remote Primary Health Care, Flinders University, Alice Springs, NT
[2] Menzies School of Health Research, Alice Springs, NT

In the aged care sector assessments enable access to appropriate community and residential care services. Identified needs should be incorporated into a care plan which should determine how identified needs are to be actioned. Similarly, when a cognitive assessment is required of a client of correctional services, youth services or family and child welfare, the assessment should lead to appropriate service or therapy responses.

This paper combines the results of two studies to report on similar themes arising in both. Study one was concerned with aged care assessment practices within the remote Aboriginal context of Central Australia, and involved 11 in-depth interviews with personnel responsible for the needs assessment of older Aboriginal people, and two focus groups with service users in remote Aboriginal communities. Study two aimed to review the current state of practice for assessing cognition among Aboriginal Australians in diverse settings across the NT and involved 22 in-depth interviews with psychologists, speech pathologists, occupational therapists, aged care nurses and doctors. In both studies, data were analysed thematically using NVIVO to manage the data. Themes were agreed by all authors by consensus.

We report on themes related to staff readiness to undertake assessments in remote and/or Indigenous settings. We found diverse staff backgrounds and a lack of specific preparation for assessment in remote and Aboriginal contexts. On-the-job and 'ad hoc' learning was common. With little publicly available knowledge about what constitutes best practice, staff are resourceful in how they develop the necessary 'know-how' to undertake the work. This can lead to inequities and inconsistencies in assessment outcomes, and can also result in highly skilled and reflective individual practitioners. By reporting staff views on their and their colleagues' readiness to undertake assessments, better approaches to workforce development and preparation can be planned.

Thursday 17 October
Concurrent Session – Indigenous Health

You can Lead the Way - Educate, Motivate, Innovate and then Celebrate being Culturally Responsive

Keona Wilson

Indigenous Allied Health Australia, 6b Thesiger Court Deakin West ACT

Be culturally responsive – it's easier than you think! This presentation will explore practical solutions around how allied health professionals, organisations and education providers can successfully work with and deliver culturally responsive care to Aboriginal and Torres Strait Islander people.
The definition of cultural responsiveness will be explored, as well as the rationale from an Aboriginal and Torres Strait Islander allied health perspective for why it is essential for the current and future allied health workforce to take ownership of the way in which they meet the unique needs of Aboriginal and Torres Strait Islander people, families and communities.

There are multiple layers of responsibility to ensure that Aboriginal and Torres Strait Islander people receive culturally responsive healthcare.

1. It is the responsibility of the allied health professional to deliver culturally responsive healthcare. Being culturally responsive places the onus back onto the health professional to appropriately respond to the unique attributes of the person, family or community they are working with.
2. It is the responsibility of the allied health service provider to demonstrate culturally responsive leadership and build governance structures and environments that ensure health professionals are encouraged, expected and able to respond to the needs of Aboriginal and Torres Strait Islander people effectively.
3. It is the responsibility of the allied health education providers to ensure their graduates attain the necessary skills, knowledge and attitudes that will enable them to deliver culturally responsive care.

IAHA challenges all health professionals, organisations and health education providers to be motivated to celebrate diversity and find innovative ways to be culturally responsive. If we work together we can positively impact and improve the health and wellbeing of Aboriginal and Torres Strait Islander people.

Partnership outcome: Brain injury training and support program for Aboriginal and Torres Strait Islander health workers

Sharon E Smith[1], **Susan L Gauld**[1], Melissa B Kendall[2]

[1] Acquired Brain Injury Outreach Service (ABIOS), Buranda, QLD
[2] Acquired Brain Injury Outreach Service (ABIOS) and Griffith University, Buranda, QLD

Nationally, acquired brain injury (ABI) is a significant health and disability issue. In Queensland, the prevalence rate is 2.5% compared with the national average of 1.8%. More than one in three (34%) people with ABI reported five or more health conditions, compared with about one in eight (13%) of all people with disability (Australian Institute of Health and Welfare, 2007). The rate of brain injury for Aboriginal Queenslanders is three times higher than for non-indigenous people.

Previous research (2006-09) conducted by our service in partnership with two Aboriginal and Torres Strait Islander communities in Far North Queensland resulted in the development of a service model which is supported by key Aboriginal and Torres Strait Islander health and disability service providers in Queensland. The model identifies a local worker/s with brain injury knowledge as being the key link between communities and mainstream health services, and as being a key support within communities for people with brain injury and their families.

ABIOS has developed a pilot brain injury training program in partnership with colleagues from an Aboriginal community in southern Queensland. This program aims to deliver brain injury education in the context of a Community Based Rehabilitation (CBR) model (WHO, 2004) to Aboriginal Health Workers, whilst establishing relationships and partnerships with and amongst program participants to facilitate ongoing support after training. The program aims to build capacity within communities by having a number of people trained, who become a link within the community for people with brain injury and their families.

This paper will discuss the partnership that has fostered the development of this training program, as well as the unique relationship that has evolved with this community to further develop a CBR model for people with ABI and their families. Components of this culturally relevant and interactive training program will be presented.

‘Someone was there for me’: Using experience-based co-design to improve clients’ experience of care coordination services

Kate Cranwell, **Mark Murray,** Jacinta Roberton

Western Health, St Albans, VIC

Background: There is increasing emphasis on the need to engage consumers, carers and community members in the evaluation and development of services to create a more responsive service and workforce, designed to meet the needs of consumers and the community.

Experience-based co-design (EBCD) is a quality improvement approach that enables staff and clients (or other service users) to co-design services, together in partnership, going beyond traditional client satisfaction surveys. The approach was developed by the King’s Trust UK for the NHS (The Kings Fund 2012).

The EBCD project was made possible due to funding from Health Workforce Australia.

Objective: The objective of the EBCD project was to understand client/carer experience of care coordination service provision and utilise the information to:

- understand what clients value and what is working well
- develop and improve how care coordination services are delivered
- inform and educate staff
- increase consumer involvement in care coordination service redesign.

Method: 18 clients/carers and 13 staff participated in interviews. Client/carer video recorded interviews and transcribed data from staff interviews were then analysed to identify key touch points (emotionally significant points) and common themes. Edited data from client interviews together with quotations from staff audio recorded interviews were then used to produce a short video to convey in an impactful way how clients experience the service. Staff and clients participated in a focus group to identify priority areas for re design.

Results: The following priority areas were identified in the staff/client re-design focus group:

- access: need to market care coordination services to GPs, acute to ensure early referral
- client feedback: Increase opportunities for informal client feedback through establishment of a clear client feedback process and routine information provision to clients
- knowledge base: need to support development of care coordinator workforce broad knowledge and skill base which is highly valued by clients
- re design initiatives focused on these areas are currently being implemented and evaluated.

From muddle of care to model of care in rehabilitation teams: Results of a system-wide change program

Susan Fone MOT [1], Peteris Darziņš PhD FRACP FRCPC [2], Christopher King PhD [3]

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Background: In 2004, hospital managers and senior clinicians in Geriatric Evaluation and Management (GEM) and Rehabilitation Units questioned practices in their units. A review showed non-standard, ad hoc, highly variable care. A project was designed to change culture, team processes and practices through implementing an explicit Model of Care. This paper describes the implementation of the chosen model of care in four GEM and three Rehabilitation units of a large health service in Melbourne. The deliberate use of various change management strategies to achieve innovation is presented.

Methods: Qualitative methods were used to describe the views and practices of clinicians prior to the change. A comprehensive change program using the Diffusion of Innovation model was designed and implemented over two years. Clinical staff and managers participated in the re design of processes, practices and documentation. The program was adjusted after a mid-way evaluation. Three years after commencement of the project the qualitative study was repeated.

Results: The ‘pre’ study found highly variable, discipline-based approaches driven by individual preferences with no apparent adherence to any models of care. The mid-way evaluation showed staff were stressed and challenged by the changes and that the pace and extent of change was too great. After changes were made, clinician engagement with the project manager increased; while some continued to view the project with scepticism and distaste, most moved ahead with it.

The final evaluation showed clear evidence of sustained change. Staff described:

- consistent team processes and documentation
- use of Models of Care
- standard and consistent involvement of patients and families in decision-making
- patient-centred, measurable team goals set for all patients
- a formal leadership structure
- shared responsibility for outcomes.

Conclusion: The deliberate use of various change management strategies did achieve the desired change. Tenacity, clarity, time and persistent organisational support are required for profound system change.

Improving hospital to community handover: Implementing an electronic dietetics discharge summary

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Timely communication between hospital and community is needed to facilitate provision of healthcare after acute hospitalisation. At present, all general practitioners (and community nurses, where applicable) receive a nursing and medical electronic discharge summary (Enterprise Discharge Summary, EDS) when patients are discharged from Royal Brisbane and Women's Hospital (RBWH). Literature suggests that allied health staff should contribute to an integrated electronic discharge summary. The aim of this study was to integrate and evaluate use of a dietetic discharge summary into the current RBWH EDS.

Departments of Nutrition and Dietetics, Safety and Quality and Health Information Services at RBWH designed and implemented the dietetic discharge summary to sit within the existing EDS. Dietitians and community nurses were involved in designing and trialling the dietetic dataset within the EDS to ensure that it was relevant and user-friendly. Dietitians were trained in the use of EDS and dietetic summary, which was implemented in November 2012. A satisfaction survey was conducted with RBWH dietitians and compliance audit of 41 electronic discharge summaries was completed in April 2013.

All dietitians (n=12) reported that the integrated EDS facilitated better communication and increased efficiency and timeliness of handover to community service providers. Over 90% of dietitians reported that it was easy to use and an improvement on previous systems. The compliance audit identified three fields within the dietetic summary that were commonly not completed, with some fields attracting repetitive information (e.g. "reason for referral" and "nutritional diagnosis").

The integrated electronic dietetic discharge summary ensures a more efficient and timely handover of information to GPs and community nurses, which may facilitate monitoring of nutrition related issues after acute hospital admission. The process of introducing the integrated dietetics discharge summary has informed a similar project for all allied health disciplines across the hospital and health service.

Care of the elder inpatient – 'When everyone is responsible, no one is responsible' – Solving the problem with a Multi-Professional Allied Health Assistant

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Aim: Older hospitalised patients are at risk of preventable complications including delirium deconditioning and malnutrition. Eat Walk Engage (EWE) program aims to prevent these complications and enhance functional recovery by ensuring adequate nutritional intake, early mobilisation and cognitive stimulation. During implementation of EWE on a general medical ward, it was identified that several strategies and tasks were seen as a shared responsibility. In practice, ownership was unclear and when clinical priorities intervened, these tasks were not completed. To provide support to program and its strategies, particularly in relation to more generic strategies and tasks, a novel approach was taken of developing a multi-professional Allied Health Assistant (AHA) role to assist in meeting the goals of the program.

Method: Utilising the existing knowledge and skills of the multi-professional EWE program group and resources from the Allied Health Workforce Advice and Coordination Unit (AHWACU), a scope of practice for the AHA role was developed, including a defined task/duties statement; a guideline for the governance and delegation; and a training package for the position. Following a period of education for both the AHA and the multi-professional team, the position commenced in the ward environment. The specific impact of the AHA role was evaluated using a satisfaction survey for the AHA position and the multi-professional team (n=17).

Outcomes: Evaluation of the impact of the AHA role demonstrated improved job satisfaction experienced by the multi-professional team. Allied health team members perceived greater time to complete more quality activities, therapy interventions and patient education. There was a perceived positive influence of the AHA role on the multi-professional team and patients, and a high degree of commitment to the continuation. The AHA performing the role reported a high level of job satisfaction, a perception of inclusion in the multi-professional team and sense of achievement through knowledge growth.

The role of allied health in advance care planning – Our time to shine!

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Background: Advance Care Planning (ACP) is high on the Federal Health agenda as our population continues to age and health issues become more chronic. Allied health professionals frequently have relational understanding of older consumers and multiple opportunities to engage during multiple interventions. Allied health are currently not routinely involved in ACP training and provision. An aim of this study was to promote the strategic leadership and clinical role that allied health professionals can take in the expanding field of Advance Care Planning for people over 60 years and those with chronic illness.

Method: A 3-hour educational workshop was piloted with 178 consumers and 186 health professionals in Queensland. Impact was evaluated immediately pre and post-training and 6 months post-training using questionnaires on knowledge, attitudes and skills and 20 semi-structured qualitative interviews.

Findings: The 3-hour education workshop increased health professional's knowledge and confidence in the area of ACP. Barriers to engaging in ACP included no time to engage, unsure who has responsibility for the discussion and fear of communicating about ACP. Key strategies for health professionals to resolve ACP barriers include knowledge and understanding of the individuals' life and stresses and the ability to approach the topic over several visits. Allied health staff are well positioned to lead this important health strategy and found the workshop to be empowering and positive.

Conclusions: Our research confirms that the ideal time to engage older people in ACP conversations is when they are in good health and during outpatient visits. This population require ACP to be a process, explored over time with health professionals they know and trust. Allied health professionals have a psychosocial approach to health and strong communication skills can potentially position them to provide leadership and innovative outcomes in the area of Advance Care Planning in the future.

CELEBRATE - Allied Health Past, Present, Future

Ms Paula Bowman, Lecturer, Health Management, School of Public Health and Social Work, Queensland University of Technology, the first Allied Health Advisor in Australia
Professor Susan Nancarrow, Director of Research in the School of Health and Human Science, Southern Cross University
Mr Daniel Mahony, SARRAH, Co-Chair of Future Health Leaders and the Rural Representative, Australian Physiotherapy Association (APA) National Advisory Council.

Flexible, capable, adaptable: A dynamic allied health workforce

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The allied health workforce is experiencing an increasing number of requests from staff, including senior clinicians and managers, for flexible work arrangements. This is mainly in the setting of returning to work after having children, but may also occur when staff desire to meet work/life balance challenges for a variety reasons, including, but not limited to, caring responsibilities, recreational interests (e.g. travel), study and private practice. The Allied Health Executive is keen to consider strategies support the retention of our highly skilled clinicians and managers.

In order to be proactive and innovative in managing these requests utilising a consistent manner in line with organisational as well as legislative requirements, the authors completed a root cause analysis that identified three main causes of the current, adhoc approach to flexible work requests as a lack of consistent information from human resources as to how to manage and set up a flexible work request, historical Executive approach and previous individual experiences of flexible work arrangements. The authors also surveyed current and past flexible work participants, their managers and the Nurse Unit Managers of the areas they worked in. A literature review regarding frameworks for supporting flexible work requests was undertaken. This data was then utilised to develop a framework to support decision making around whether a role could function under a flexible work arrangement, and how to best support the staff in these arrangements to ensure all the benefits of a flexible work arrangement are realised and many of the challenges minimised.

Allied health staffing factor: Are we underestimating the cost of staffing required?

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Education of funding providers and stakeholders is required regarding the components of allied health costs in a hospital setting. A consistent framework is essential to define the link between the direct clinical hours provided to a patient group and the staffing resources or Equivalent Full Time (EFT), which has a direct relationship to costs.

Decisions about allied health hospital staffing requirements are often based on statistics that staff enter regarding their activity. Benchmarking of casemix groupings also relies on Individual Patient Attributable (IPA) time per Diagnosis Related Group (DRG), as per the National Allied Health Classification Committee's standardised methods for recording activity in Australian public hospitals. Initial drafts for the Independent Hospital Pricing Authority (IHPA) allied health costings have only included IPA hours. There is a risk that the national efficient prices established for allied health will significantly underestimate the true costs.

An Allied Health Staffing Factor (AHSF) has been established which allows the translation of clinical activity into the EFT staffing resources required. To determine the total hours required, the clinical hours need to be multiplied by the AHSF of 1.818 for weekday activity and 1.17 for weekend activity. To determine the required EFT, this result is then divided by the total work hours in a year (52 weeks x 40 hours per week).

The AHSF has been determined through long term data collection at a tertiary hospital, and testing of EFT modelling using the factor against real EFT. The AHSF takes into consideration an IPA ratio (the IPA proportion of total statistics time), paid breaks, public holidays, and various leave entitlements.

The AHSF can be modified to reflect any local or jurisdictional changes to the elements of the factor, such as award entitlements.

Implementing an expanded scope of practise physiotherapy service in the emergency department at Robina Hospital

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Advance Physiotherapist, ESP Physiotherapy in ED Project, Robina Hospital, QLD

The Expanded Scope of Practise (ESP) Physiotherapist in ED Project

The Physiotherapy Department at the Gold Coast Hospital secured funding over 18 months from HWA (Health Workforce Australia) in June 2012, as part of a national program to develop and implement programs to expand the scope of work of physiotherapists in emergency departments.

The primary objective of the project is to successfully implement and evaluate a locally adapted model of the ESP Physiotherapist working within the ED at Robina Hospital by Jan 2014.

Secondary objectives include demonstrating:

- increased productivity.
- workforce reform.
- transferability/sustainability.

Expanded scope of Practise activities that are being undertaken by the Physiotherapist include:

- imaging request and interpretation
- fracture management.

Activities being implemented dependent on legislative adjustments:

- joint relocation including local anaesthetic injections
- medicine prescriptions (simple analgesics).

Progress to date: The project has completed set-up (including governance structures) and implementation phases and is currently imbedding an ESP Physiotherapy Service into the ED at Robina Hospital.

Early evaluation (3 months) of the role has demonstrated improvements in time, cost and quality:

- 98% of patients managed by the ESP Physiotherapist discharged from the ED within 4 hours (NEAT)
- patients managed by the ESP Physiotherapist have a length of stay on average 1 hour 53 minutes less than a similar patient managed by other Health Professionals
- through-put is high with the Physiotherapist seeing the equal or more patients than any other treating clinician in the ED
- many written compliments from staff and patients.

Evaluation of an advanced allied health assistant role in ACT Health

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The role of an allied health assistant (AHA) in many clinical areas has long been established. Role definitions and the concept of an advance AHA role have been an interest area in ACT Health for some time. An advanced AHA role was piloted as part of a Health Workforce Australia (HWA) project in 2010, to look at innovative models of practice for AHA's. This project focused on the role of an AHA working in discharge support for older adults transitioning from an acute hospital to home. On the success of this pilot project, ACT Health has adopted the permanent position of Discharge Support AHA working on an acute aged care ward.

The Discharge Support AHA role works with clients in the inpatient setting to formulate a meaningful discharge plan, based on identified need from the client and multi-disciplinary team (MDT). The AHA then follows up clients once they have been discharged home to ensure the discharge plan is fully implemented and client transition home has been successful. A role such as this has traditionally been fulfilled by a health professional and it was found that with achievements of skill-based competencies, the AHA is able to provide appropriate level of support for discharge needs, ability to feedback to the hospital treating team and deal with issues as they arise. This AHA role is unique in the ACT Health Directorate in its scope and is an innovative way to address an identified gap in service.

This paper will describe the outcomes of the 12 month evaluation of the role, which highlighted that both staff and clients had high levels of satisfaction with the role and believed it to be beneficial. Statistical data and readmission impacts will also be highlighted as part of the evaluation.

Note: This paper links to "Advanced Allied Health Assistants in the ACT" which describes a current project looking at existing AHA roles and recognition of the breadth of skills in this workforce in the ACT.

Change sweet change: Improving equity for staff and clients through change management

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With the implementation of an activity based funding (ABF) model across Australian public hospitals, it has been imperative that all healthcare providers, including allied health departments, plan for this change of management in terms of how best they can provide the most appropriate healthcare to the most appropriate patients at the most clinically relevant time in the right clinical environment.

The speech pathology department of Mater Health Services (MHS) South Brisbane implemented a change management project with the key aim of ensuring the provision of an accessible and equitable speech pathology service to all patients (neonates, children and adults) across all MHS facilities. Through completion of a thorough activity based audit and inter-facility benchmarking process, we are moving towards changing the way we allocate clinical resources, with the ultimate outcome of improved patient access and satisfaction, and increased staff satisfaction, particularly in relation to perceived equity of load and stress.

This paper will outline the key components of the project, including:

- the methodology of the activity-based audit
- the development of Service Profiles across all clinical areas which are based on best and evidence based practice information and are integral in providing clarity around work practices, and ensuring work practice is commensurate with benchmarked standards
- examples of caseload specific projects which have arisen as a result of the audit analysis, including "Audit of the Accuracy and Effectiveness of a Patient Prioritisation Tool".

Finally, we will discuss future directions of the project, including how we will utilise the above information to inform ongoing service change and development within the strategic goals of both the speech pathology department and the MHS organisation.

Allied health research at Royal Melbourne Hospital: The first year of a new approach

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Despite the rewards of research for both clinicians and organisations, few hospital allied health departments are exactly where they would like to be when it comes to research. In hospital environments, staff are increasingly expert yet face barriers to translating their clinical expertise into research activities.

This presentation will explore a new approach to supporting clinicians research efforts, exploring the outcomes of the first year of new research leadership roles embedded in the physiotherapy and social work departments. As RMH explores innovative approaches to student clinical education, these non-clinical dedicated research roles have a complementary focus on creating a culture that supports clinician research.

The roles have led the consolidation of research and quality assurance activities within their respective departments, providing a dedicated resource to increase clinicians confidence in formulating ideas, deciding on study methods, navigating ethical approval processes and achieving research output. Outcomes from the first year of this approach demonstrate that despite the difficulties, clinician researchers can flourish if modest resources are available to support them to engage in research activities that are integrated into their clinical position.

This presentation will consider the issues, priorities, barriers and enablers surrounding clinician research from the perspective of two very different disciplines. It will highlight the features of this particular approach, examining the associated challenges and opportunities. It will demonstrate how clinician research can align with organisational priorities, lead to improved services for clients and how cultural change can be delivered and sustained. It will demonstrate how clinician research can keep staff engaged and thinking about clinical issues and services, and showcase examples of successful clinician research projects.

Influencing EBP use by allied health professionals through education, motivation and innovation

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Factors affecting the evidence-based practice (EBP) capabilities of allied health professionals (AHPs) are not simply the result of a gap in knowledge, but are more complex and linked with institutional culture and barriers, personal self-belief, individual experience and ability. This study aimed to measure change in the level of EBP self-efficacy, outcome expectancy, knowledge and use amongst AHPs at a health service following an innovative approach to support and motivate clinicians to engage principles of EBP. The approach was informed by emerging implementation science theory and frameworks.

In 2011 66.3% (201/303) AH staff employed across the campus completed an online survey consisting of a battery of validated and reliable survey tools measuring EBP constructs. Additional information on professional background, knowledge and previous training in EBP and research processes was collected. Results were compared with those from a previous survey conducted in 2010, with a response rate of 72.2% (182/252). Eighty staff completed the survey at both time points. Independent and repeated measures ANOVAs were used to compare levels of self-efficacy, outcome expectancy, knowledge and use, according to AH discipline over time.

A significant increase in EBP self-efficacy was observed over time between groups *(p=0.03)*, as well as amongst staff who completed the survey at both time points *(p=0.013)*. Significant differences were observed over time for specific professional groups for EBP use (occupational therapy, cross sectional *p=0.049;* repeated measures *p=0.013)*, and EBP outcome expectancy (speech pathology, repeated measures *p=0.032*; psychology, repeated measures *p = 0.008)*. Significant differences existed between professions at time 2 in EBP -outcome expectancy *(p=0.002)* and EBP-use *(p=0.016)*.

Targeted within-department and general AH workplace evidence-based interventions to improve EBP constructs have been effective at improving overall AH EBP self-efficacy. Different departments have demonstrated individual improvements in EBP constructs, potentially reflecting different training opportunities and organisational changes implemented across departments.

Understanding allied health professionals' use of research evidence using the theory of planned behaviour

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Background: There is a significant body of research which suggests that allied health professionals agree with the philosophy of evidence based practice (EBP), and believe that research evidence can improve patient care. However, actual implementation of research findings into clinical practice is poor with numerous barriers cited. The aim of this study was to identify and describe the factors that influence allied health professionals implementation of research evidence in clinical practice, using the theory of planned behavior.

Methods: Allied health professionals from dietetics/nutrition, occupational therapy, physiotherapy, psychology, social work, speech pathology and other were invited to complete an on-line survey (n=496). The survey measured attitudes, confidence and skills towards EBP and participation in EBP activities. Results were analysed using the theory of planned behaviour.

Results: A total of 288 allied health clinicians completed the survey, indicating a response rate of 58%. The study revealed that allied health clinicians have a positive attitude towards EBP (behavioural belief) and believe they should be implementing research evidence into clinical practice (subjective norms). However, allied health clinicians from all disciplines reported difficulties in most EBP behaviours, such as appraising research evidence (perceived behavioural control). The theory of planned behaviour proposes that perceived behavioural control is an important determinant of a clinician's likelihood to change his/her behavior.

Conclusion: This study demonstrates that the theory of planned behaviour can provide a framework in which to understand allied health clinicians' current experience of EBP. Strategies to enhance allied health clinicians' use of research evidence in clinical practice should focus on perceived behavioural control.

A recursive model for capacity-building in the learning and sustainability of evidence-based treatment

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In 2010 the Child and Youth Mental Health Services and the Queensland University of Technology formalised a partnership through the appointment of a Clinical Academic Fellow. The objectives of this Fellowship are to disseminate evidence-based family level treatments and encourage research in this field by allied health disciplines across Queensland. In this presentation we describe the development of a recursive model of training to support the sustainability of treatment. The model utilises the resources of both the University and the CYMHS to provide stepped learning, and two clinics developed in tandem within each sector, which introduce students to this specialist field, and provide support to clinic sites providing this treatment across Queensland. It supports capacity building from undergraduate studies to postgraduate research, and continuing professional education for the field linking education to research.

To develop this model we have collaborated across the disciplines of social work, nursing, dietetics/nutrition and psychology, and formed a collaborative partnership with the internationally recognised Training Institute for the Treatment of Adolescent Eating Disorders. Our next phase of this project is forming collaborations for research with the Training Institute and other national clinician groups that are providing this evidence-based model of treatment to support and encourage opportunities for allied health engagement in innovative research.

Comparison of GAS and Lawton Scale for measuring outcomes in a rural Ambulatory Rehabilitation Service

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Background: The Modified Australian Lawton's Instrumental Activities of Daily Living Scale (Lawton Scale) is used to measure disability of patients, track changes during rehabilitation and is used by the Australasian Rehabilitation Outcome Centre as a measure of the relative effectiveness of ambulatory rehabilitation services. Clinicians in the Wagga Wagga Ambulatory Rehabilitation Service felt the Lawton Scale was insensitive to clinical outcomes. This paper reports the performance of the Lawton and Goal Attainment Scale (GAS) measured concomitantly on rehabilitation patients in a diverse community population.

Method: Over a three year period, 110 programs involving 83 patients were assessed with the Lawton Scale and GAS. Score changes following treatment were examined using Wilcox matched-pairs signed-ranks test, responsiveness was measured using Cohen's D statistic and the correlation using Spearman's Correlation Coefficient.

Results: The mean Lawton Score increased significantly (Wilcox matched-pair Z=6.63, P←0.001) from 23.98 (95%CI 22.9 to 25.1) to 26.0 (95%CI 25.1 to 27.0) following treatment. The GAS also increased significantly (Wilcox matched-pair Z=6.63, P←0.001) from 39.8 (95%CI 38.8 to 40.8) to 55.2 (95%CI 53.0 to 57.5). The Lawton Scale was invariant in 45.8% of patients (95%CI 35.0 to 57.1%) and 6.0% of patients with GAS (95%CI 2.0 to 13.5%). Responsiveness of the Lawton Scale (Cohen's D=0.34) was less that than of the GAS (1.73). The correlation between changes in the two scales was poor (Spearman's Rho=0.27).

Conclusion: The Lawton Scale's lack of responsiveness limits its value as a rehabilitation outcome measure. Whilst the Lawton Scale might be a useful tool for assessing comparative disability, its invariance to functional improvement raises questions on its value as a measure of rehabilitation outcomes or the effectiveness of service delivery. The authors offer the GAS as a more responsive tool for measuring the functional improvement in patients undertaking goal specific rehabilitation in an ambulatory setting.

Improving patient access: Redesigning the allied health cancer care model of care at Cairns Base Hospital

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Allied Health Cancer Care (AHCC) services have the challenge of continuing to provide high quality patient care despite increasing demand, an ageing population, and fiscal constraints. The Cairns Base Hospital AHCC service is redesigning their model of care through a detailed review process which includes use of the Calderdale Framework. This paper will describe preliminary outcomes from the model of care re design project.

The service analysis described a total of 213 clinical tasks currently undertaken by the AHCC team. Of these tasks, 175 were analysed in detail with regard to their component activities, risk and potential for either skill sharing with another profession or delegation to an Allied Health Assistant (AHA). Preliminary findings showed that:

- 41% of tasks should remain with the current allied health profession (AHP) due to the skill, knowledge and training requirements or negligible efficiency gained by delegating/sharing the task
- 38% can be delegated to a trained AHA
- 7% can be skill shared with another AHP
- 9% have both delegation and skill sharing components.

Seventy-one delegation tasks are identified for inclusion in the redesigned model of care and associated AHA training and competency assessment process. Delegation tasks are clustered in the areas of screening, mobility and exercise, lymphoedema, nutrition, and swallowing and communication. Spread across a range of clinical areas, approximately two-thirds of skill-share tasks included in the new model of care are assessment tasks, supporting timely intervention and appropriate referrals. A concurrent service review identified opportunities to improve referral and intake processes, care co-ordination and administration, which were addressed through process re design with a focus on quality patient experience and service efficiency. Expected outcomes from the re designed model of care include reduced duplication of clinical tasks resulting in improved clinical service efficiencies and enhanced access to allied healthcare for patients.

Engaging allied health in cancer survivorship – The positive change for Life Survivorship Project

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Introduction: Lifestyle modification is an increasingly important component of cancer survivorship to ameliorate the effects of treatment, minimise co-morbidities and promote long-term wellness. Engagement of allied health in lifestyle modification programs has the potential to substantially improve the health and wellbeing of blood cancer survivors who have been cured by stem cell transplantation (SCT).

Aim: To provide a range of community-based physical activities, support and education opportunities to enable survivors to develop lifelong healthy eating and physical activity patterns.

Method: Long-term SCT survivors (↗2 years in ongoing remission) enter a 12 month program integrating the key components of dietary advice, tailored individual and group physical activity, motivational strategies and GP support. A range of patient-reported outcomes including FACIT fatigue, Godin Leisure-Time Activity and Rapid Eating and Activity Assessment (REAP) questionnaires were administered at baseline and following 6 and 12 months of participation.

Results: 45 participants (22 female) with a median age of 48 years (range, 25-67) are enrolled. Median time since either autologous (27%) or allogeneic (73%) transplantation was 5.5 years (range, 2-15.4). Significant improvements in physical activity levels at 6 months were achieved with 60% reporting sufficient activity to achieve substantial health benefits compared with only 15% at baseline (p←0.001). 25% of participants reported improved fatigue levels and 80% of participants reported a reduction in 27 unhealthy eating behaviours included in the REAP with the average number of undesirable nutrition behaviours reducing from 5 (range 1-9) to 3 (range 1-3) over the first 6 months.

Conclusion: The completion of cancer treatment represents an opportunity for survivors to undertake lifestyle modification programs to reduce future health concerns. Allied health plays a critical role to support the uptake of regular exercise, good nutrition and healthy weight maintenance to improve health, wellbeing and quality of life for long-term survivors of curative SCT.

Trial of a computer-based program that provides length of stay benchmark figures at a rehabilitation centre: Its ability to identify and impact on prolonged lengths of stay and staff perceptions of its use

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Background: Length of stay (LOS) is an increasingly important consideration for healthcare practitioners because of the growing burden on healthcare facilities. LOS benchmark figures can be used to guide clinical practice in a rehabilitation setting. We trialled a computer-based program that provided real time LOS benchmark figures and alerted staff of patients who were approaching or exceeding LOS benchmark figures.

Aims: To trial the computer-based program and evaluate:

(1) its ability, in real-time, to identify patients whose LOS exceeded benchmark figures and reasons for these delays

(2) whether the use of the computer-based program affected LOS

(3) staff perceptions of the usefulness of the program.

Methods: A prospective observational study was undertaken. Data were collected regarding LOS, reasons for delay if LOS was beyond benchmark figures, and staff perceptions of the computer-based program's usefulness. The patient sample comprised 202 inpatients in a stroke or brain injury rehabilitation unit. Twenty-eight staff completed a pre-trial survey and 13 completed a post-trial survey.

Results: LOS in excess of benchmark figures was found for 48 (44%) stroke and 44 (47%) brain injury unit participants, resulting in a total discharge delay of 6311 days. Reasons for discharge delay were diverse. Using the computer-based program did not consistently decrease LOS compared to data from the previous year. Staff perceptions regarding the usefulness of the computer-based program were mixed.

Conclusion: A computer-based program that provided LOS benchmark figures successfully identified patients whose LOS exceeded benchmark figures and reasons for these delays. However it did not consistently decrease LOS and, overall, the use of this program was negatively perceived by staff.

Multisite investigation of weekend allied health services on acute medical/ surgical wards

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This project describes an innovative project model undertaken across three health services to compare:

- the effectiveness and cost-effectiveness of current weekend Allied Health (AH) services to no weekend AH services
- the effectiveness and cost-effectiveness of a stakeholder-driven model of weekend AH services to no weekend AH services
- to develop a dose-response identifying the optimal amount of AH service provided that maximises patient safety, effectiveness and cost-effectiveness.

Design: Stepped-wedge cluster randomised control trial

Phase 1: In this phase, the current model of weekend AH service delivery will be rolled back from across six acute medical and surgical units from each participating hospital. One ward, selected at random, will transition from current weekend AH service delivery to no weekend AH service delivery model per month.

Phase 2: A stakeholder-driven model of weekend AH service delivery will be rolled out to these same wards. One ward, selected at random, will transition per month.

Participants / setting: Monash Health, Melbourne Health and Western Health.

Key outcomes:

The primary outcome measures will be:

i. the proportion of patients who stay longer than their Australian Refined Diagnosis Related Group average "inlier" length of stay according to data published from the previous year
ii. cost per patient treated
iii. rate of unplanned hospital readmission within 28 days.

Secondary outcome measures include:
Patient adverse event, number of complaints and compliments, patient discharge destination and patient satisfaction with overall care

Qualitative evaluation:
Group interviews will be conducted with staff members from each ward at the end each phase to explore their experiences of the different weekend AH service delivery models, focussing on workplace pressures.

The presentation will describe the innovative model being used to assess the effectiveness and cost-effectiveness of existing weekend AH services and compare it to a unit level stakeholder-driven model providing AH weekend services that maximise patient safety, effectiveness and cost-effectiveness.

Clinical allied health dashboard – by clinicians for clinicians

Rebecca Moore, **Leah Thompson**, Mark Butterworth

The Prince Charles Hospital, Chermside, QLD

The current healthcare climate demands an agile and efficient workforce accountable for delivering a safe and quality service matched to current demand. The aim of a clinical dashboard is to improve staff efficiency, accelerate decisions, streamline workflow processes and reduce errors in operational practice. Dashboards provide high visual impact, relevant, real time information as an alternative to traditional reports or scorecards that are retrospective in nature. It is recognised that good quality and timely information is a driver of performance for clinical teams. There is currently very little information available for allied health clinicians that is easily understood, accessible and presented in real time. To meet this need and improve transparency and accountability The Prince Charles Hospital has developed a prototype clinical allied health dashboard that displays locally relevant information to inform and prioritise clinical decision making. The pilot key performance indicators and thresholds were created by clinicians through focus groups in consultation with the local Business Solutions Unit. The data reported is sourced from the electronic patient journey board (EPJB) and is displayed on a single screen so information can be monitored at a glance. The clinical dashboard extracts data from existing local electronic data sources therefore visually displaying information that is already being collected, not duplicating or adding layers of extra work. The dashboard metrics are flexible to meet clinical needs and add value to patient care. Allied health referrals incomplete (orange or red on the EPJB) within 48 hours of the expected date of discharge is one example of the metrics developed to date. Clinicians have the ability to parameterise their individual dashboard display for their personal login and determine individual notifications when thresholds have been reached. The dashboard has significant benefits for clinicians and managers as a tool for workload recognition and prioritisation.

Celebrating innovative research collaboration with outcomes: Professional support in Queensland

Karen E. Bell[1], Fiona Hall[2], Pim Kuipers[3], Sue Pager[4],

[1] Darling Downs Hospital and Health Service, Taroom, QLD
[2] Allied Health Professional Leader (Workforce) Allied Health Professions Office & Cape York Hospital and Health Service
[3] Metro South Hospital and Health Service, Loganholme DC, QLD
[4] CFAHR, Metro South H&HS and Population and Social Health Research Program, Griffith Health Institute, Griffith University, Buranda, QLD

This paper describes how a diverse group of allied health professionals established a successful research collaborative around the theme of 'professional support'. Members differed in profession, role, employment type, location and research experience but shared related research. The innovative collaborative produced four papers for publication, a report and conference presentations. This paper describes the research collaborative, results of the four studies outcomes for Queensland Health.

Study 1: broad evaluation of Queensland Health's Professional Support Program (PSP) provided an overarching piece of work to link the other studies. This program sought to support professionals who may not previously have had optimal professional support. Findings indicate the PSP has facilitated access, participation and improved the quality of professional support activities.

Study 2: evaluation of the Peer Group Supervision (PGS) program, one component of the PSP. Descriptive methods provided insights into professionals' experience of the PGS model and identified the challenges and benefits of operationalising PGS in a large, dispersed, diverse and mobile health workforce.

Study 3: used a validated measure of satisfaction with PGS, the Clinical Supervision Evaluation Questionnaire (CSEQ). Statistical analyses examined differences in *CSEQ scores* across four group variables; geography, multiple professions, work setting and formal arrangements. No significant differences were found between groups except groups with formal arrangements (documentation, evaluation, use of tools provided in training) were rated more highly.

Study 4: evaluated Queensland Health's organisation wide approach to supporting professionals through a Professional Support Policy and Evaluation Framework. Findings indicate that an evidence based policy that is structured, collaborative and evaluated has benefits for allied health that do not exist in professional support provided without an overarching policy.

This collaborative enabled productive research partnerships across professions, health districts and sectors. Outcomes provide further empirical data of the efficacy of this work in supporting allied health professionals.

Positive psychology proving itself in retention

Christine J Franklin

Sybellamentoring Services, Cannonvale, QLD

The fact that a move to regional Australia can be one of the best career decisions an allied health professional can make, belies the difficulties employers face when filling vacancies. Then, once a vacancy is filled, the challenge becomes one of retention. This paper presents an overview of an innovative mentoring program specifically designed to address the support and retention of staff in rural and remote regions.

Structured transition mentoring, informed by the research around Positive Psychology, is demonstrating its usefulness in retaining staff in otherwise challenging environments. Support is provided for a 12 month period by an experienced rural psychologist in the form of directed reading, structured conversations and email correspondence. The program builds on the existing strengths of the individual in a one-on-one program that supports new employees to adapt to the challenges of both a new workplace and home town.

The program has two aims. The first is to increase the tenure of employees making a move to regional Australia, and the second is to challenge the existing negative narrative about rural practice. The goal being to ensure that if/ when people return to metropolitan Australia they will not only report exciting adventures but also demonstrate psychological wellbeing. Such that more people – particularly new graduates, will want to spend some time in the Bush, also.

Both qualitative and quantitative data will be presented to demonstrate that people who complete the transition support program register higher levels of psychological well-being, greater levels of professional confidence and an increased likelihood of staying in their role longer. Other applications for transition support will be suggested.

Does clinical supervision lead to better outcomes? Findings from a study of allied health professionals

Christine Saxby[1, 2], Jill Wilson[1], Peter Newcombe[1]

[1] School of Social Work and Human Services, The University of QLD
[2] Subacute & Ambulatory Service, Metro North Hospital & Health Service, QLD

Introduction: Clinical supervision is widely recognised as a key strategy for providing professional development, support, and clinical governance for health workers. Despite this, there has been limited empirical evidence about outcomes or what elements make clinical supervision effective. This study sought to identify whether clinical supervision was perceived to be effective but uniquely, it also sought to identify procedural components that contributed to effectiveness.

Method: A cross-sectional quantitative study was conducted with 82 community allied health workers, comprising seven professions. Effectiveness was measured using the MCSS-26© (Manchester Clinical Supervision Scale). Participants completed an on-line questionnaire, eight months post-implementation of a structured clinical supervision program.

Results: Participant's MCSS-26© scores ranged between 32 and 100 (M=73.23, SD=14.70). The published benchmark for allied health staff is M=74.7. A "best practice" group was defined as: receiving clinical supervision, attending clinical supervision training, having some choice in selection of clinical supervisor, having a completed clinical supervision agreement and having a clear understanding about the boundaries of confidentiality. The 'best practice' group (n=21, M=78.81, SD=12.34) rated the effectiveness of clinical supervision significantly more highly than did the 'less than best practice' group (n=44, M=70.57, SD=15.12), t (63) =2.17, p=.033. In addition, those in the 'best practice' group rated the effectiveness of the Restorative domain more highly than the published benchmark although this difference represented only a trend towards significance (p=.052).

Conclusion: The study's findings make an important contribution to the emerging evidence base for clinical supervision. The results demonstrate that best practice clinical supervision can provide professional support and facilitate reflective practice for allied health workers. The difference in outcomes between the best practice group and the less than best practice group is notable given the short period of implementation. The findings will be discussed in relation to having appropriate infrastructure to support effective clinical supervision.

Celebrating the website: Innovative use of telehealth technologies to educate, mentor and motivate best practice

Desleigh de Jonge, Wendy Stevens

LifeTec, Newmarket, QLD

Health professionals in regional and remote areas constantly struggle to keep abreast of the many areas of practice they need to work across. Similarly, new graduate and sole therapists in metropolitan and non-metropolitan areas are often challenged by complex clients who require specialist input. Access to education, expert advice and support can be invaluable in ensuring quality service delivery and is becoming increasingly easier to access with the advent of telehealth technologies. The successful utilisation of these exciting but challenging technologies requires a systematic analysis of education and service events and careful selection of technology. Whilst it is critical that these technologies are effective and reliable, it is also necessary to build practitioner capacity to translate face to face events into more remote modes of delivery. This requires practitioners to learn new ways to develop relationships, gather and present information. It requires a deep understanding of the goals of the education or service event, a dedication to working through the technical challenges, capacity to support the person at the other end to make best use of the event and an ability to share expertise and relinquish control.

This presentation will detail the journey of LifeTec over the last five years in using mainstream web-based and portable videoconsultation technologies to provide education, expert advice and support to our own staff when working with clients in regional and remote areas. It will also describe the ways in which these technologies have been used to educate and mentor regional and remote health practitioners and promote best practice in a specialist areas of practice. Despite the challenges involved in moving to telehealth education and service events, the potential benefits afforded by these technologies are cause for much celebration.

Raising the bar – Governance, education and training for the allied health assistant (AHA) workforce in NSW Health

Sue Steele-Smith, Danijela Radovanovic

NSW Ministry of Health, North Sydney, NSW

In 2012 NSW Health initiated a project to develop a robust, rigorous and consistent approach to clinical governance of AHAs to build on outcomes achieved over the last 5 years in the area of training and employment of AHAs.

The project initially involved a state-wide survey to identify, numbers, locations, disciplines, award classification and qualifications of AHAs employed in NSW Health. The results included identifying 34 different qualifications held by AHAs along with identifying that a third of the workforce had no formal training.

A governance framework was developed to provide guidelines for the creation of new AHA positions in the workplace and for enhancing the utilisation of AHAs currently employed in NSW Health.

The framework describes appropriate education and training programs for AHA roles and includes the recommendation that the future AHA workforce in NSW will either hold a relevant qualification or be prepared to undertake a qualification on commencement of employment.

The final part of the project involved the development of an implementation strategy for the framework. The main priority was to assist the unqualified AHA workforce in gaining a relevant qualification if desired. Funding and access to appropriate training providers were identified as barriers for this group. The survey provided the information about where the unqualified assistants were employed, which then allowed the Ministry of Health to target individuals interested in obtaining a formal qualification, to identify appropriate training providers and to obtain funding specifically for this group.

This presentation will describe both the process and the results of this initiative along with a report on NSW Health's progress towards achieving an allied health assistant workforce that is utilised at maximum efficiency to deliver a safe, cost-effective and sustainable service in the NSW public health system.

EDUCATE - Supply and demand clinical training for the future

HWA Perspective

Mr Ben Wallace, Executive Director, Clinical Training Reform, Health Workforce Australia

In 2010 HWA was established to deliver a national coordinated approach to health workforce reform to meet Australia's future needs by building capacity, boosting productivity and improving distribution of the health workforce.

HWA is working towards these objectives through statistical collection, evidence-based planning, and practical, targeted reform in higher education and health sectors. Early HWA priorities have been funding growth in clinical training capacity across professions, setting out a national strategic framework for workforce innovation and reform, and developing models of support such as standard clinical placement assessment tools for clinical supervisors and studying embedding simulation into health professions curriculum.

HWA's current priorities include profiling the supply and demand for allied health workforces. HWA is using this workforce intelligence to improve alignment of training supply and workforce demand, identify opportunities for clinical training innovation and address barriers to necessary workforce reform.

University Perspective

Lindy McAllister, Professor & Associate Dean Work Integrated Learning, Faculty of Health Sciences, The University of Sydney

Uncapping of student enrolments in universities, increasing numbers of allied health degrees, possibly decreasing numbers of available placements due to workplace pressures including loss of positions and increasing numbers of part-time positions have all placed significant pressure on the demand and supply of clinical placements. The important work of HWA has done much to increase placement capacity and innovation in clinical education, and raised awareness of issues affecting quality of placements. However, the investment in placements by HWA has skewed the economics of placements. Placement sites often will only take students from universities who will pay for placements (in HWA $ or other funding sources); in effect – a price has been set on placements. In many of not most cases, the intended outcome of HWA funding – to promote sustainability of placements – will not be achieved. Placement sites are ceasing to take students when the HWA funds cease. So while capacity for placements has increased, this presentation suggests that innovation, quality and sustainability of palcements have not. In addition, the debate around costs and benefits of having students on placements is accelerating. Placement sites often argue, in the absence of data, that students take away time from the core business of seeing patients. This may be so if outdated models of clinical education are used. This presentation outlines placements models that increase productivity and provides preliminary data suggesting the amount and scope of patient services increases when students are on placement. The presentation also considers other benefits that flow to placement sites.

Public Health Employer's Perception

Mr John Merrick, Health Education and Training Institute (HETI) NSW

Two way thinking on building a healthy nation one person at a time

Ms Tania Major, acclaimed Indigenous advocate and former Young Australian of the Year

Tania Major will be speaking on issues and the reality of delivering effective and efficient community engagement programs. Often government programs are developed with limited knowledge of the needs and capacity of remote clients. A good health program is dependent upon the quality of the connection between the health provider and the individual client. Tania will be talking about ways to build this connection by sharing both her personal and professional experiences whilst on the ground.

Performance and accountability and implications for allied health

Ms Bernie Harrison, Executive Director Hospital Performance, National Health Performance Authority

Benchmarking in allied health services – If you can't measure it you can't manage it!

Fiona Jenkins[1], **Robert Jones**[2]

[1] JJ Consulting Healthcare Management Ltd. Cardiff and Vale University Health Board
[2] JJ Consulting Healthcare Management Ltd. Moorfields Eye Hospital NHS Foundation Trust

Benchmarking is an invaluable means of enhancing understanding of your service's performance, achieved through making comparisons with other organisations and services or between different areas of your own service. Benchmarking indicates whether the full potential of workforce and other resources is being fully realised. The information obtained through using this process has a wide range of applications such as:

- developing new clinical services
- improving existing provision
- developing business cases
- service redesign and innovation
- enhancing service user experience.

If as allied health professionals we have little idea what the metrics for a wide range of parameters are, we cannot compare to establish the relationship between ourselves and others.

Benchmarking may be used as part of service review and for quality improvement initiatives and the technique which has its origins in industry, is increasingly used in healthcare.

Recognising that a basic evidence-based benchmarking methodology was needed, we developed this straightforward process to help set and monitor services to evaluate whether these are being met in terms of workforce, resources and their use, activity, service availability and scope, access etc. We have piloted this approach and incorporated advice from heads of Allied Health and clinicians who have used our technique. We use it ourselves as an element in our service reviews and have also designed a set of assessment charts.

The process is designed to be objective and straightforward. It can be used to review your own service in 'isolation' or to make comparisons with other services.

The process has five sections:

- your organisation
- your professional group
- in-patient services
- outpatient services
- community services

The purpose of our presentation is to explain the background, introduce the methodology, demonstrate how it works and show how it can be used. We will demonstrate the paperwork system which we have designed to support the process.

Securing the allied health workforce – Evaluation of subacute models of care, including fiscal modelling

Steven Wood, Steven Bowden, Patricia Bradd, Tish Bruce

South Eastern Sydney Local Health District, Taren Point, NSW

Aim: To develop an evaluation methodology to determine the effectiveness of subacute models of care (MoC), including increasing the Allied Health workforce, to the healthcare system in relation to capacity; efficiency; patient outcomes; and fiscal efficiencies.

Background: Council of Australian Governments (COAG) provided funding to enhance subacute services under two National Partnership Agreements (NPA), including Hospital and Health Workforce Reform (HHWR). South Eastern Sydney Local Health District (SESLHD) utilised NPA-HHWR funding over four years to implement over twenty new or enhanced MoC. Notably, over 25 full time equivalent (FTE) Allied Health positions were recruited to rehabilitation services.

Results: A methodology was developed to investigate:

- fiscal efficiency savings derived from:
  - decreased subacute inpatient length of stay
  - avoided admissions to acute and subacute settings
  - avoided emergency department presentations
  - avoided ambulance journeys
- increased capacity
- improved patient outcomes in rehabilitation, primarily resulting from the enhanced Allied Health workforce affording additional therapy.

Overall:

- Rehabilitation enhancements generated an annual efficiency of **$11,398,274** for an investment of **$5,649,258**
- Aged care enhancements generated an annual efficiency of **$905,369** for an investment of **$760,758**
- Palliative care enhancements generated an annual efficiency of **$1,122,452** for an investment of **$508,197**

Conclusions: This evaluation methodology successfully enabled investigation of efficiency and effectiveness measures across a multi-site, multi-strategy program. The methodology addressed the key levers of healthcare decision making - cost, quantity and quality and was successfully utilised to inform investment and disinvestment determinations. The impact of targeted Allied Health investment was described resulting in permanent appointment of over 25 FTE new Allied Health positions across SESLHD. This methodology can be applied with the implementation of future acute and subacute models of care, including Allied Health specific initiatives, to demonstrate benefits realised to the healthcare system.

Doing things differently: Extending the scope of allied health assistants in speech pathology

Simone Williams, Julieanne Coyle, Rebecca Downes

Monash Health, Melbourne, VIC

Monash Health Speech Pathology Service recruited to a Grade 3 Allied Health Assistant Nutrition and Communication position, based in general medicine, at Dandenong Hospital. Development of the role included implementation of core business and extension of scope of practise for allied health assistants in the acute speech pathology setting. Evaluation of the role substitute was undertaken in terms of patient outcomes and risk and time savings for speech pathology staff.

In order to define areas of extended scope of practise, competency standards were developed in the areas of general medicine dysphagia screening, dysphagia tolerating reviews, communication support for clients with dementia, and assisting feeding clients in videofluroscopy. Competencies were supported by assessment resources and learning materials.

Six months of data was collected focusing on general medicine dysphagia screening, dysphagia tolerating checks and participating in videofluroscopy. Occasions of service over the data collection period was approximately 200. Number of days of service included in the analysis is 52 days.

Analysis of the data indicated that 44% of new referrals received from the general medical wards passed the initial dysphagia screen and where placed on their premorbid diet and fluids by the allied health assistant. 68% of these patients were placed on their premorbid diet and fluids modification due to longstanding dysphagia. The remaining 32% had no indicators for requiring texture modified diet and fluids and where placed on a regular diet and fluids. Auditing of the validity of these dysphagia screens was performed and results where in 100% agreeance. Analysis of the 110 dysphagia tolerating reviews revealed 76% patients passed, with only 17% of patients who failed requiring immediate speech pathology review and downgrade of texture modified diet or fluids. The remaining "failed data" was due to patient not being present, medical reasons, or refusing oral intake trials. Evaluation of the time saved by the speech pathology service through the introduction of the Allied Health Assistant indicated a saving of over one and half hours per day based on the introduction of extended scope of practise roles.

Evaluation of adverse risks following allied health assistant review, increased scope and complexity of service delivery by the speech pathologist enabled introducing an allied health assistant, validity of the screening tools and mealtime reviews was also undertaken and will be discussed within the presentation. Discussion will also include the areas of change management processes introduced during this role introduction, introduction of extended scope of practise for allied health assistants and implementation tools.

Friday 18 October
Concurrent Session – Workforce Innovation

Using The Calderdale Framework to develop employer led higher education

Rachael Smith, **Jayne Duffy**

Effective Workforce Solutions Ltd, Brighouse. HD6 1EJ UK

The Calderdale Framework (CF) is a seven stage transformational workforce development tool[1], providing a systematic method of reviewing skill, role and service design, ensuring safe, effective and productive patient centred care.

Challenges posed by demographic change mean that demand for rehabilitation in the UK will rise significantly - services and education providers must innovate in order to meet this. Development of Assistant Practitioners (AP) and skill sharing between AHP's with new educational routes are vital.

CF was implemented across Allied Health services over a 12 month period, with the aims of improving productivity, improving quality and developing talent. The focus of this CF implementation was to develop AP roles and advance skill sharing, with appropriate higher education provision.

The scope of roles was defined and protocols and competencies were developed, forming a robust work based training programme. In order to add rigour and gain academic credit a partnership was formed with the University of Bradford (UoB). Consultation with staff and service users ensured the academic offer met service and learner needs. This resulted in the development of a 120 credit Certificate in Higher Education (professional support)[2] for AP's and post graduate education for AHPs[3].

The AP competency portfolio was accredited by UoB, gaining prior standing of 40 credits. This course is now part of the University of Bradford's portfolio.

Progression with skill sharing training has led UoB to develop postgraduate study programs (up to Masters level) dedicated to advancing transdisciplinary practice, incorporating and crediting work based competencies and learning.

This flexible employer-led development resulted in less time out of the workplace, less duplication of learning and learner specific progression. Both sets of learners embraced this patient-focussed professional development.

WA Country Health Service allied health transition to Practice Graduate Program

Katherine Lamont, Suzanne Spitz

WA Country Health Service, East Perth Business Centre, WA

The transition to rural and remote practice can be a highly stressful time both personally and professionally, and even more so for graduate allied health professionals (AHP). They are often leaving their long time home and moving to a new unfamiliar community, leaving behind their family and friends, as well as their usual professional support networks. On arrival, they may be met with large caseloads and workloads, must learn new policies and procedures and provide services in new and unfamiliar work-models and geographical contexts. Furthermore, working in small teams, or even as a sole practitioner often means support on the ground is limited. These circumstances leave many AHPs feeling under-prepared for the unique culture of remote and rural health. In response to this identified need and following consultation with relevant stakeholders, WA Country Health Service has established the Allied Health Transition to Practice (T2P) Graduate Program. The T2P Program assists allied health professionals make the transition from a graduate to a confident and competent rural and remote health professional. The program is designed to provide additional strategies and supports, to complement local orientation, support and development of graduate allied health professionals. It utilises a flexible self directed approach to learning and provides graduates with the opportunity to consolidate and apply skills gained in their university education program, as well as the opportunity to acquire new skills and knowledge. Key components of the program include: orientation and induction, professional supervision, graduate networking, manager support, individual learning planning and continuing professional development. The program does not involve 'dedicated' graduate positions, but rather works to flexibly to support any graduate employed at any location within WA Country Health Service. A review of relevant literature determined it is one of the few inter-professional, rural and remote allied health graduate programs in operation.

Educate, articulate, motivate: More 'transition to remote practice' training tools

Annie Farthing[1], Nicole Beattie, Renae Moore, Shelagh Lowe[2], Lois McCullagh

[1] Centre for Remote Health, Alice Springs, NT
[2] Services for Australian Rural and Remote Allied Health, Deakin, ACT

This presentation highlights the development of interactive online learning modules for delivery via an online learning management system. The development process utilised a virtual team of rural and remote allied health professionals from every Australian state and territory.

Since 2009, Services for Rural and Remote Allied Health (SARRAH) has hosted an online training resource entitled Supporting the Transition of Allied Health Professionals to Remote & Rural Practice training package. In July 2012 a total of 19,238 distinct visits were made to the site, demonstrating its value. The package included five interactive eLearning modules with the Cultural Security Module averaging 680 visits per month. The online nature of the modules has allowed for flexible access to learning opportunities which is critical for rural and remote workforce support. The content had been written by rural and remote AHPs with an understanding of the challenges and joys of work in rural and remote locations, including barriers to Professional Development.

In late 2012, SARRAH received a Rural Health Continuing Education (RHCE2) grant to review and update the existing training package and to expand it to include a further four online learning modules, in collaboration with the Centre for Remote Health (CRH).

The project steering committee reviewed the existing SARRAH resource and identified four priority areas for rural and remote practice: workload management and prioritisation; working together in a team; remote and rural outreach; and service evaluation and planning. Working groups of rural and remote AHPs established learning objectives and appropriate content. A learning design consultant guided the design process and converted the modules into an online format using Articulate Storyline. The modules were piloted throughout Australia and feedback incorporated into the final package.

The presentation will showcase the updated resource including the new modules and provide insight into the virtual development process.

Maximising Our Remote Professional Health (MORPH) workforce project

Kathy Relihan, Tanya Lehmann

County Health South Australia Local Health Network, c/- Port Augusta Hospital, Port Augusta, SA

Country Health South Australia Local Health Network (CHSALHN) has been granted funding from Health Workforce Australia (HWA) under the Aged Care Workforce Reform (ACWR) project for the Maximising Our Remote Professional Health (MORPH) workforce project. The MORPH project seeks to prevent functional decline in older people living in remote communities by maximising the local and visiting health professional workforce, through the development and expansion of new Health Service Assistant (HSA) roles.

Allied health assistants employed by CHSALHN have tended to be discipline specific and not based locally within remote communities. The MORPH project has involved the employment of locally based HSAs in 2 remote South Australian communities (Ceduna and Coober Pedy). They are working as 'generalist' assistants, providing assistance to all health professional disciplines (Allied Health Professionals, Registered/Enrolled Nurses, General Practitioners and Medical Specialists). The HSAs play a vital role in supporting clients at risk of or currently experiencing functional decline. They act as the conduit between the client and visiting/local health professionals. The new workforce model sees the HSAs playing a significant role in the coordination of 'fly in/fly out' health professional services and interface with local providers.

Key findings from the project will be presented, including barriers and enablers to workforce innovation and redesign, which have been identified thus far. We will also be presenting a tool developed by CHSALHN in collaboration with other national Workforce Innovation Group (WIG) project teams called PREVENT. The PREVENT tool has been designed to facilitate discussion with clients and improve their understanding about the Indicators of Functional Decline.

Rural private therapy framework: Delivering high quality, sustainable and accessible services to people with disability

Jo Ragen[1], Rebecca Barton[2], Angela, Dew[3]

Faculty of Health Sciences, University of Sydney, NSW

Therapy service provision to people with disability living in rural areas is challenging due to a shortage of therapy workforce and unique geographic constraints resulting in a high level of unmet need. The introduction of the National Disability Insurance Scheme (NDIS) is likely to increase the demand for therapy services but not necessarily result in an increased rural therapy workforce. Previous work by the Wobbly Hub and Double Spokes project team highlighted the potential of rural private therapists to help meet the increased therapy demand. The Wobbly Hub team received Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) Practical Design Funds to develop a framework to enhance the capacity of rural private therapists to provide high quality, sustainable and accessible services to people with disability under the NDIS. Focus groups and telephone interviews were conducted with 28 private therapists working in western New South Wales. Data were analysed using thematic analysis and a draft framework was developed. The draft framework was refined through an online modified Delphi process and national consultations with key stakeholders. The resulting framework identifies the means by which a therapist and a person with disability work together within their community, drawing on existing networks, resources and processes to meet the needs and goals of the person. The framework identifies barriers, facilitators, drivers and potential solutions that limit or enhance the capacity of private therapists within rural communities to provide high quality services. The use of this framework to guide policy and service provision will result in high quality, sustainable and accessible therapy services for people with a disability in rural areas. Furthermore, the framework highlights the importance of drawing and building on the networks, resources and processes within rural communities to support the participation of people with disability.

Preparing pre-graduate students for the workplace – Proving the worth of an Interprofessional competency-based education program

Rebecca Black

Aim: To design, implement and evaluate a competency-based, multimodal, Interprofessional Education (IPE) program for medical, nursing and allied health students in a Sydney teaching hospital.

Background: Interprofessional education is acknowledged as a fundamental means for equipping health students and professionals for multidisciplinary team work in the health environment and consequently to be better prepared to respond to local health needs (World Health Organisation, 2010). *Get Ready!* is a one week interprofessional educational program developed at St Vincents and Mater Health Services in 2011 following a successful grant application through the CETI Team Health Right Start initiative. The content of the course was developed on the basis of interprofessional education competencies and includes interdisciplinary learning across a range of training modalities to maximise practical application and embedding of skills.

Methods: Students participated in a one week interprofessional program in their last semester of study. The program was initially run in 2011 and then repeated in 2012. IPE competency models were reviewed and the Canadian Interprofessional Health Collaborative (CIHC) Competency Framework was selected. Didactic and interactive classes, encompassing core interprofessional competencies of role clarification, team building, leadership, interpersonal communication skills and conflict resolution were included in the program design. Multi-modal educational strategies included: team participation, simulation activities, structured lectures, use of DVD's and role playing.

Comprehensive repeated measure evaluation tools were used, including the Work Self-Efficacy Inventory Survey (WSEIS), Interprofessional Socialisation and Valuing Scale (ISVS), and two other tools – one locally developed and the other an adaptation of a self-assessment tool which accompanies the CIHC competency framework.

Results: Paired t-test analysis for the repeat measure evaluations showed a high number of statistically significant results across all competency domains assessed for both the 2011 and 2012 programs. The qualitative feedback supported these findings with the students strongly endorsing *Get Ready!* as a valuable learning experience. Results will be presented.

Conclusion: Further IPE programs such as *Get Ready!* are recommended as part of the undergraduate experience in preparation for workplace readiness.

Interprofessional education and the first year experience: Ongoing developments in a core health sciences course

Melanie J. Hayes

The University of Newcastle, Ourimbah, NSW

Interprofessional education has been recognised as an innovative approach to cultivating collaborative healthcare practitioners, with the aim of improving health outcomes. This paper will provide an overview of the ongoing developments of an interprofessional course for all first year health science students at the University of Newcastle. The course, now in its seventh year of offer, has undergone significant developments in response to student feedback and the changing face of healthcare in Australia.

The curriculum comprises of three key modules: academic literacy, fitness to practice and concepts in health. This foundational knowledge prepares students from all health science programs, including podiatry, oral health, nutrition and dietetics, occupational therapy, physiotherapy and medical radiation science, with the skills required for academic success, as well as those required to practise safely and ethically in patient clinics. The course focuses on collaboration, with lectures delivered from a range of experts within the Health Sciences faculty, while students participate in early teamwork exercises in manual handling.

In response to student feedback, the key development in the current offering was to adopt a more flexible delivery approach. Determining how to achieve this goal, while still engaging and supporting students across several disciplines, and continuing to promote collaboration was challenging. The course moved towards a blended learning model, with the replacement of face-to-face tutorials, which caused significant burden on staff and students, with interactive online activities. The online activities developed supported the lecture content, and also helped to increase the 'challenge' associated with the course, as well as appealing to the Generation Y cohort with popular culture references and YouTube clips.

This paper will conclude by discussing future directions for this first year interprofessional course based on current student and staff feedback, including embedding summative assessment in the online modules, and further condensing the face-to-face requirements.

An innovative model of interprofessional paediatric education for allied health professionals

Alexandra Little, Luke Wakely, Elesa Crowley, Katrina Wakely

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Interprofessional education is considered to be an effective way for health professionals to learn, providing opportunity to gain a deeper understanding of professional roles and practices. Education provided in this manner is designed to support participants to engage in a more interdisciplinary approach to clinical practice. The speciality area of paediatrics often requires the management of complex issues which is best delivered by a number of different health disciplines. However, the provision of specialised paediatric training, with an interprofessional approach, is limited in rural areas. Maintaining skills and knowledge in specialised areas of practice can be difficult for rural clinicians. This paper describes an innovative model of delivering interprofessional education in the practice area of paediatrics to allied and other health professionals and will report on quantitative and qualitative evaluation responses from the workshops. Funding obtained though National Rural Health Continuing Education (Stream 2) facilitated the creation and delivery of six interdisciplinary workshops for rural allied health, nursing and medical professionals across northern NSW. The workshops were based around a paediatric case study and aimed to provide health professionals with the knowledge and skills to incorporate an interdisciplinary framework into their clinical practice. Participants were required to problem solve issues within the case study in interdisciplinary teams. These activities provided an opportunity to network with and learn from and alongside health professionals from other disciplines. The workshops were also designed to enhance participants' understanding of the management of paediatric developmental issues within and beyond their own discipline. Eleven disciplines were represented across the 118 workshop participants. Feedback was positive and emphasised the need for further interprofessional education to support clinicians in their delivery of holistic services to children and families, with a 97% satisfaction rating of workshop content. Factors influencing attendance were largely related to the rural location of the workshops (80%) and the need for paediatric specific education (50%). Evaluation results strongly supported the delivery of education via a model of interdisciplinary case-based learning as an effective way for health professionals to learn.

Flying Start Queensland Health: international innovation for inter-professional education

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Introduction: Flying Start Queensland Health is a web-based program designed to increase the confidence and competence of new starter allied health professionals (AHPs). It is learner-directed, with an emphasis on building a progressive portfolio of professional development evidence through reflective learning activities. The resource has been developed to complement professional support practices such as supervision and mentoring.

Purpose: The purpose of this presentation is to provide a demonstration of Flying Start Queensland Health and describe the process of acquiring, contextualising and implementing the resource. Preliminary usage data will also be presented which demonstrates the extent and trends of the early uptake phase.

Resource Development: The need to support the inter-professional learning and development of new starter AHPs was recently identified in Queensland Health across a range of disciplines. The Flying Start NHS website was originally developed by NHS Education for Scotland. This website was identified as a structured learning and development program that could potentially meet the identified needs. Flying Start NHS was an existing resource that was currently in use in the United Kingdom and had been favourably evaluated. An Intellectual Property Licensing Agreement was established between NHS Education for Scotland and Queensland Health to enable the resource to be contextualised to the local context and released as Flying Start Queensland Health. The website (http://www.flyingstart.health.qld.gov.au) was launched on 18 June 2012.

Organisational Context: A number of workforce factors within Queensland Health provided the impetus for the development of Flying Start Queensland Health:

- Implementation of the Credentialing and Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals Policy (http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-375.pdf)
- Identification of a need to support new starter AHPs arising from the Ministerial Taskforce on Clinical Education and Training (2007)

Demonstration: A demonstration of the features of the resource will be presented including the learning program, online portfolio and learner guides.

Preliminary usage data: Data which demonstrates the extent and trends of the early uptake phase of the resource will be presented.

Conclusions: Flying Start Queensland Health is an example of as existing resource that was acquired and contextualised to meet an identified learning and development need.

Flying Start Queensland Health is available to support the learning and development of all Queensland Health AHPs.

Professional Support practices such as supervision and mentoring have been key to the implementation of Flying Start Queensland Health.

Education, Innovation, Inter-professional, Early Career, New Graduate, Professional Support, Supervision, Mentoring, eLearning

Paediatric allied health drop-in clinics improve accessibility and efficiency

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Therapy and Support Service for Children (TASSC) - West Moreton Hospital and Health Service, Ipswich, QLD

Therapy and Support Service for Children (TASSC; a child development service), provides allied health developmental services to the West Moreton Hospital and Health Service. Driven by pressures of high service demand, long wait lists and limited resources, this service has developed a novel approach of using multidisciplinary drop-in clinics as a process of intake and triage to improve service accessibility and efficiency.

A review of this service change has been conducted. This review aimed to assess and report the outcomes of this service model change in respect to its impact on the clinical service, the local community and the service staff.

Methods: This review consisted of a statistical review of the database of a 12 month clinic period, a parental questionnaire and a staff questionnaire.

Results: The multidisciplinary drop-in clinic has demonstrated high attendance (n=748); a low to moderate referral rate for further assessment or intervention (34% Physiotherapy, 67% Occupational Therapy, 54% Speech Pathology) and reduced clinical time spent for an initial contact, saving approximately $32000 in labour. The clinic has positively influenced staff's clinical skills and workplace culture and a parental questionnaire (n=91), demonstrated 100% of responders would return to drop-in for any future concerns and 95% would recommend the service to family and friends. Utilising this model also enabled further review and redesign of discipline clinical pathways leading to improved service flow and reduced wait times for assessment and/or intervention for clients.

Conclusions: This review showed that using multidisciplinary drop-in clinics in this allied health developmental paediatrics team has been a successful service innovation and has led to positive changes to clinical processes, community access and staff perceptions. We would recommend that other services consider a similar model as a cost-effective way of improving client access, efficiency of intake processes and clinical flow.

Feeding difficulties in children with autism spectrum disorders and so-called 'fussy eaters': Baseline information from the HELP Study

Jeanne Marshall, Pamela Dodrill

Queensland Children's Medical Research Institute, The University of Queensland and The Royal Children's Hospital, Herston, Brisbane, QLD

Background: Childhood feeding difficulties are characterised by inadequate volume or range of food intake, often accompanied by behavioural, sensory processing, and/or oral-motor difficulties. Feeding difficulties have been linked to nutrient deficiencies, which may have short and long-term health impacts, as well as increased parental stress, which can impact the parent-child relationship.

Aims: This study describes baseline data on children presenting to a research clinic for intervention to treat feeding difficulties, and aimed to evaluate the relationship between child feeding skills and behaviours, diet, growth, and developmental status, as well as parent stress.

Content: Data is presented on 72 children aged 2–6 years who attended the clinic over a 12 month period – 36 children with ASD and 36 children with no significant medical history. Background information was collected through parent questionnaires and direct clinical assessment.

Analysis revealed that, of the two groups of children with feeding difficulties, those with ASD presented with more developmental delays, and significantly higher weight/height percentiles than the non-medically complex group. Children with ASD were also reported to have a significantly greater number of mealtime and general behaviour difficulties ($p < 0.05$). Parental stress accompanying mealtimes, however, was high in both groups. There was considerable variability in nutrient intake across the groups but, in general, children from both groups demonstrated inadequate intake of iron, iodine, and fibre. Age was negatively correlated with inadequate intake of many key nutrients. Children who had been identified with oral sensory sensitivities were significantly more likely to have food-related behavioural difficulties ($p < 0.05$), and higher parent stress reported during mealtimes ($p < 0.05$).

Conclusions: Children with feeding difficulties may not present as underweight, but nutrient intake generally worsens with age. The significant relationship between oral sensory sensitivities, difficult mealtime behaviours, and parent stress suggests that a multidisciplinary approach is required to effectively identify and treat feeding difficulties.

Simulated Learning in Paediatric Allied Health(SLIPAH): Making the SLIPAH fit!

Kris Kelly, Meg Moller, Sarah Wright

Physiotherapy Department, Royal Children's Hospital, Herston, QLD

Aims:To deliver a flexible SLE(simulated learning environment) model to integrate into Queensland university allied health(AH) curricula, providing a framework to access resources thus enhancing paediatric clinical capability for workforce entry.

Background: SLE use in AH has increased due to its educational benefits and challenges in providing sufficient, standardised clinical experiences for increasing student numbers. Integrating SLE into curriculum ensures maximal uptake, however barriers exist due to lack of infrastructure, facilities, transportability and sustainability, compounded by differing curricula, course scheduling, varied learning needs, discipline specific requirements and large cohorts requiring direct clinical participation.

Method: Using an action research methodology, a flexible model for delivery of paediatric SLE–SLIPAH, was developed to be delivered across 3 university campuses and professions (physiotherapy, speech pathology and occupational therapy). Core paediatric principles and key clinical training were identified and specific paediatric course content within each curriculum established. Five key elements were identified and formed the basis of the multi-modal SLIPAH model: infrastructure needs, androgogy/academic requirements, student population/demographics, clinical consultation and logistics & monitoring.

Results: Barriers identified to SLE included: 3 campuses without dedicated space/facilities, 11 differing curricula with significant variation in timing and level of exposure to paediatrics with up to 150 students per course and student/educator ratio from 1:1 to 1:120. All demonstrated a lack of paediatric specific resources and poor clinical exposure. SLIPAH provided interdisciplinary, portable simulation units to each campus. E-learning packages were developed in combination with a library of scenarios in consultation with clinical experts based on core paediatric experiences. Planning and logistical procedures accommodate shared use and scheduling into curricula as determined by faculty.

Conclusion: SLIPAH provides a coordinated and cohesive approach to discipline specific and interdisciplinary SLE. It is a model which can be adapted to provide equitable, standardised clinical experience for all AH students across Queensland.

This program is supported by HWA

How can parents educate health professionals about their experiences in child development services: A grounded theory model for goal setting

Shareen L. Forsingdal[1], Winsome St John[2], Vanessa Miller[1], Anna Harvey[1], Penny Wearne[1]

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[2] Associate Professor, Population and Social Health Research Group, Griffith Health Institute, Griffith University, QLD

This presentation will report on the findings of a recent qualitative research study on goal setting in child development services. The grounded theory study explored mothers' perspectives of the processes of collaborative goal setting in multidisciplinary child development services involving follow up home therapy.

Collaborative goal setting is a core component of family centred practice and requires high levels of partnership and collaboration between therapist and parent/carer (Novak & Cusick 2006[1]; Piggot, ***et al***. 2003[2]). However there is little available knowledge and research into the processes of collaboration during goal setting, particularly from a parent's perspective. Studies that have investigated parent perspectives about goal setting have either focussed on the types of goals parents want for their child (Knox, 2008[3]) or have highlighted the importance of making goals realistic and applicable to daily activities (Siebes ***et al***. 2007). Findings have also highlighted that parents actually wanted less responsibility for identifying goals, particularly early in the therapy process (Wiart ***et al***. 2010[4]). These studies did not explore when parents were ready to engage in collaborative goal setting.

This grounded theory study used semi-structured interviews (Strauss & Corbin, 1998[5]) as part of a larger research study investigating home therapy programs for children with developmental delay. The present study focused specifically on developing a theoretical understanding of the parents' and therapists' processes of goal setting for children's development needs.

The Maternal Roles in Goal Setting (M-RIGS) Model was developed from analysis of the data. The presentation will explore components of this model. It will focus on parental roles and influencing factors in the goal setting process to inform clinicians on how best to work with families accessing multidisciplinary child development services.

Implementing prescribing in allied health – the journey

Dr Adam Bird

Head of Podiatry, La Trobe University, VIC

Adam will describe the journey of the podiatry profession in Australia, in obtaining a pathway for independent prescribing endorsements, from the early 1990's to the present day. He will also reflect on some of the lessons learnt from this process.

Renewing the workforce – the challenges

Ms Kathleen Philip

Chief Allied Health Adivor, Department of Human Services, VIC

There is significant momentum at national and jurisdictional levels to reform the health workforce and the way health care is delivered to increase the system's ability to meet increasing demand efficiently and cost –effectively while maintaining high quality of care. This presentation outlines the Victorian approach, and experience of health workforce innovation and reform and implementing 'contemporary' allied health practice; and the challenges of renewing the workforce in the current environment.

Rural and remote allied health generalist

Ms Ilsa Nielsen

Principal Workforce Officer, Allied Health Professions' Office of Queensland, Department of Health, QLD

The need for rural and remote allied health practitioners to be 'generalists' has been widely proposed in the professional literature. Generalism is often discussed as a logical consequence of working with limited access to health professionals of the same and other disciplines, and across a wide range of clinical conditions and client groups. Generalist practice has recently been identified by national and jurisdiction governments as a key strategy for rural and remote health workforce sustainability, service efficiency and outcomes. But what does generalism mean for the allied health professions in rural and remote areas?

This paper will contribute to the current discourse by presenting a working model of rural and remote generalism which spans professional entry through to new models of practice. It will examine opportunities for enhanced healthcare access for rural and remote consumers through expanded breadth and depth of allied health practice. An overview of recent project findings related to skill sharing will be presented.

Health reform – What does it mean for allied health?

Ms Julie Connell

Executive Director Clinical Support Services, Princess Alexandra Hospital, Metro South Health, QLD

National Health Reform: AH input into IHPA and NHPA and what's next

Mr David L Stokes

Executive Manager, Professional Practice, Australian Psychological Society (APS)

One of the initiatives in the Rudd Health Reform program was the creation of two national authorities to oversee the funding and evaluation of government health services. The first was the Independent Hospital Pricing Authority (IHPA), the second the National Health Performance Authority (NHPA). Allied health was invited to participate by membership on a number of committees in each authority. IHPA is currently focused on establishing activity-based funding (ABF) models in areas not previously funded that way and so has established the Clinical Advisory Group (new), and working groups for Subacute Care, Mental Health and Teacher, Training and Research. Their major work has involved conducting reviews, environmental scans here and overseas, establishing definitions, analysing cost drivers and proposing draft models and classifications including data sets. The paper will provide a brief summary of such work in each area from an allied health perspective. The work of NHPA has been much broader and encompasses primary and tertiary care. Their major objectives and tasks are to monitor and report on the performance of bodies that provide healthcare services. Two major committees have requested allied health involvement: Primary Healthcare Advisory Committee and the Healthy Communities project. Major themes and tasks will be identified and reported on in this paper highlighting allied health aspects.

Allied Health Representatives:

IHPA
Clinical Advisory – Jan Erven
Subacute Care – Mary Haire, Jan Erven
Mental Health – David Stokes
Teacher, Training and Research – Michael Dooley

NHPA:
PHAC – David Stokes
Healthy Communities Project – David Stokes

Implementation of medicare locals and primary care reform

Ms Erica Kneipp

Assistant Secretary Commonwealth Department of Health & Ageing Medicare Locals Branch

Getting 'interprofessional' into the every day!

Ms Robyn Smith BAppSc (OT), Grad Dip Geront, MPH.

Director, Allied Health Learning and Research, Northern Health, Melbourne.
Adjunct Associate Professor, Faculty of Health Sciences, LaTrobe University.

The World Health Organisation has endorsed interprofessional education (IPE) as the way forward for fostering collaborative practice and effective healthcare. Training providers in Australia are gradually introducing opportunities for students from different disciplines to learn with, from and about one another in the academic setting. But what happens in the clinical setting? How can we structure the clinical education experience in a healthcare setting so that students are actively encouraged to develop collaborative practice skills during clinical placements? This presentation will provide examples of successful interprofessional education programs in the clinical setting and propose some key 'next steps' to enable wider integration of interprofessional approaches in clinical placements.

Simulation within medical imaging

Mr Russell Booth

Chief Nuclear Medicine Technologist, St Vincent's Hospital, Melbourne, VIC

The healthcare professions are heavily task and performance based and traditionally these skills have been taught in the clinical environment. However, this environment has changed significantly over the last decade. Increasing demand on teaching hospital placements coupled with a decrease in resources has placed enormous stresses on the system. In addition, access to sophisticated and expensive imaging technology has meant the only training sites are the teaching hospitals as universities cannot justify the purchase of high end technology.

These factors are driving the development of new models for the delivery of training without compromising patient safety. Increasing time spent by students under supervision alone is no longer possible. New models that combine supervised practice with simulation may provide a viable alternative.

Most non-technical skills and attributes are difficult to teach in the classroom. Simulation based learning can be employed to enhance the teaching of attributes to healthcare professionals in a safe, controlled environment without compromising patient safety.

Technical skills are taught, for the most part, in the classroom. However the high cost of imaging equipment means high end image processing cannot be adequately taught in the universities.

My presentation will focus on two current projects and how we could use simulation to teach both technical and non-technical skills in the future.

Creating opportunities through identified need: Development of primary care based student assisted programs using a collaborative model of service development

From Vision to Reality

Ms Frances Millar[1], Mr Darryl Grundy[2]

[1] University of Queensland Health Care Ipswich Aged and Chronic Disease Clinic
[2] CEO UQ Health Care

UQ Health Care (UQHC) utilised HWA QRTN CTP funding to establish student assisted aged and chronic disease management programs, and child wellbeing programs at its clinics. UQHC, a primary care group, focuses on clinical service delivery, education and research. This funding enabled program development centred on student involvement in service delivery.

The key strategy was collaboration with stakeholders ensuring programs targeted identified areas of need and addressed unmet demand including existing waiting lists for services.

An inter-professional education framework underpins all student placements. A comprehensive health coaching approach has been supported by orientation materials and tutorials to develop students' understanding and application of this approach across all discipline groups, providing a consistent approach to assessment, intervention and case conferencing.

We will describe the development and implementation the UQ Health Care inter-professional student assisted programs and placement models; report on the outcomes of research into the experiences of clients, students, and supervisors; and explore implications for future practice.

Sharing our experiences will facilitate understanding of the benefits of this approach and its capacity to extend student knowledge, skills and experience and expand opportunities for health professionals to combine clinical expertise with student learning, while providing effective client interventions.

The development of sustainable student assisted service delivery models extends opportunities for students to access clinical placements in primary care environments. This inter- professional framework provides experiences for students of a range of health disciplines whilst enabling a holistic service delivery model for clients with complex needs.

Innovative solutions for traditional problems: Development of new student placement models

Heidi Miller, Penny Taylor, Frances Millar, Davin Lloyd

University of the Sunshine Coast, Maroochydore DC, QLD

Introduction: The University of the Sunshine Coast (USC) occupational therapy program commenced in 2008. A rapid increase in the number of occupational therapy programs across Queensland, combined with a steady increase in cohort sizes at USC, has created pressure on traditional 'apprenticeship' student placement models.

Placement shortages are a global issue and have led to increased use of alternate models of student placement; however these models are usually limited to one-off trials, or only available to certain students. Using HWA funding, USC has successfully piloted capacity building projects plus a range of alternate placement options (in facilities where occupational therapy services do not currently exist) for students in years 2–4 of the program. As well as addressing placement shortages, we have found these placement models to provide unique student learning and skill development opportunities which complement those found in apprenticeship model placements; and provide benefits to the organisations hosting the students.

Aim: We will describe the processes used to develop and implement the USC Occupational Therapy student placement models, report on the outcomes of research into the experiences of students, supervisors and organisations, and explore implications for future practice.

Method: An action-research method was employed. This included grounding in the literature, development of a trial model, student and facility preparation, piloting different placement models, and evaluating outcomes through research into the experience of key stakeholders.

Practice implications: By sharing our experiences we will facilitate understanding about the benefits of our approach and its capacity to extend student knowledge, skills and experience and expand opportunities for our profession.

Conclusion: The new USC OT placement models are an excellent way to provide sustainable placements that enhance engagement of the community, and equip students for increasingly diverse employment opportunities now, and in the future.

Fostering and Inspiring Research Engagement (FIRE): A research incubator scheme for undergraduate allied health students

Jenny M. Ziviani[1], Rachel Feeney[2], Siobhan Schabrun[2], David Copeland[2], Paul Hodges[2]

[1] Children's Allied Health Research, Queensland Health, Conjoint Professor, School of Health and Rehabilitation Sciences, Level 3 Foundation Building Royal Children's Hospital, Herston, Brisbane QLD
[2] School of Health and Rehabilitation Sciences, The University of Queensland, St Lucia, QLD

Research evidence supports the notion that active engagement of students in undergraduate research experience early in their training may better prepare students to pursue a research career commencing with an honours degree. In 2008 the Research Committee of the School of Health and Rehabilitation Sciences within The University of Queensland commenced a 'research incubator program' to introduce academically capable occupational therapy, physiotherapy and speech pathology students to the idea of research, early in their undergraduate/graduate entry training. The current presentation outlines a program logic model for the research incubator scheme as a means of facilitating subsequent evaluation of the effectiveness of this initiative. Program logic is a form of program description which provides a means of depicting the theory of how a program, scheme or intervention works. It is commonly used by evaluators, either as an adjunct to an impact evaluation or as a stand-alone tool for summarising a complex program. In this presentation we aim to describe the application of program logic in depicting the way in which the scheme was designed to enhance student autonomy, provide a connection to the research community and build a sense of competence in relation to research processes. We will also identify the underlying assumptions and external/environmental factors that could potentially impact on the delivery and success of the scheme. The major components of the logic model will be described as inputs and resources, activities/outputs and outcomes (immediate/learning, intermediate/action and longer term/impacts). While immediate and intermediate outcomes chiefly pertained to students' participation in honours programs, longer term (impacts) concerned their subsequent participation in research higher degree programs and engagement in research careers. Program logic was an effective tool for clarifying program objectives and detailing, from a theoretical perspective, how the research incubator scheme was designed to achieve its intended outcomes and impacts.

NSW Health ClinConnect – Innovation in clinical placement management

Brenda McLeod[1], **Elizabeth Schlossberger**[2]

[1] Central Coast Local Health District, Gosford, NSW
[2] NSW Health Education & Training Institute, Gladesville, NSW

In 2009, NSW Health provided 3.2 million hours of clinical placements to healthcare students and it is recognised this number needs to grow significantly in order to meet future workforce needs. The NSW Health ClinConnect Interdisciplinary Clinical Placement Booking System is a web-based application developed to support the management of clinical training demand and improve training capacity. This presentation will provide a 'live' demonstration of the ClinConnect system online, show what the different allied health profession modules look like and provide an overview of the reporting function.

ClinConnect provides a single portal to search and book clinical placements offered across NSW public health facilities and records placement activity for Allied Health, Nursing and Midwifery, Dental and Oral Health and Medicine. The system has extensive reporting and tracking capabilities and will assist with reporting requirements to Health Workforce Australia (HWA) on placements undertaken in NSW Health facilities.

After a two-year consultation and build phase, ClinConnect was implemented in 2012 following state-wide user training for clinicians and education users. Within the Allied Health module, the system design provides allied health profession users the ability to enter discipline specific descriptors for the type of placement being offered as well as clinician supervisor details when required.

From conception to development until implementation, this innovation in clinical placement management challenged clinicians and educators alike to reflect on historical ways of booking placements. ClinConnect offers an opportunity to reengineer how placements are organised and managed, improve efficiency and meet growing demand. The system also provides enhanced visibility and fairness around clinical placement allocation by enabling greater transparency during the request and approval processes, while reducing the manual effort and workload involved in arranging and tracking clinical placements. The system is still being refined and inclusion of additional allied health professions is planned.

'Learn, feel inspired, creative and affirmed' – Mixed methods findings in professional music therapy supervision

Jeanette D. Kennelly

Lecturer in Music Therapy, PhD Candidate, School of Music, University of Queensland, St Lucia, QLD

The strive to clearly identify the role and purpose of supervision in promoting best practice in allied health professions has been discussed widely in the literature (Davys & Beddoe, 2010). Articulating the different roles supervision can play, whether focused on clinical, professional or administrative agenda, is impacted by professional and organisational policy; professional competency standards; the workplace context and importantly, each professional's individual definition and understanding of supervision (Beddoe, 2010). Therefore, the supervisory experience for all participants can be viewed as complex and multilayered.

This paper will present the mixed methods findings on the views, experiences and practices of professional supervision for Australian-based Registered Music Therapists. The study used a sequential explanatory design:

1) an online survey
2) a narrative analysis of supervision experiences
3) a narrative synthesis of the evidence regarding music therapy supervision and
4) an integration of all findings.

The final results reported there are significant discrepancies between the importance of supervision presented in music therapy professional guidelines and what occurs in practice. A key finding included the supervisory relationship as a core factor of the supervision experience. Additional themes from this study were difficulties with supervisor access, dual role relationships, external supervision and the complexities surrounding supervision and accountable practice.

Implications for this study's findings will be discussed in relation to the different roles of supervision in allied health and the need to promote reflective practice as a core element of professional supervision. While maintaining balance between the requirements and needs of all stakeholders in supervision (employees, line managers, internal/external supervisors and the professional association or accrediting body) is important, this study's findings will highlight the need for clear defined supervisory guidelines. In doing so, it is hoped that innovative ways of understanding and practicing supervision within allied health can be explored and encouraged.

Intercontinental nutrition and dietetic practice placements: A collaborative and innovative partnership between London and Melbourne

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In the context of increasing global mutual recognition for dietetic practice, international student practice placements provide a key learning opportunity to broaden understanding of international health systems and professional competencies. In July 2012, six dietetics students from the United Kingdom (UK) undertook an approved Placement B program (equivalent to the individual case management placement in Australia), for nine weeks at St Vincent's Hospital, Melbourne. This unique programme offered by King's College London (KCL), the first UK University to offer students approved pre-registration practice placements in Australia, followed from an innovative pilot project in 2008 between the two sites. A formal student selection process developed by KCL was based on academic record and a personal statement from the applicant summarising the differences between healthcare provision in the UK and Australia. The learning outcomes and assessment tools used were those set by the British Dietetic Association. The assessment portfolio consisted of five assessment tools. In addition, the portfolio provides evidence of proficiency development for a range of settings, client groups and assessment and intervention skills. Regular meetings between the Student Lead at St Vincent's and KCL link tutor ensured a forum to provide support to the students and the practice educators. All six students achieved the appropriate learning outcomes for Placement B. The placement was formally evaluated using the London Placement Evaluation Form, which is completed by all students and practice educators after Placement B. Students were positive about the placement structure (variety, opportunity for observation) and educator feedback. These all rated at 80% or above. All six students viewed the experience favourably and recommended the program to be continued in the future. The sustainability of the collaboration requires consideration of academic and pastoral support for students and placement providers, budget considerations and capacity of Australian practice placement sites.

Resourcing allied health managers for activity-based funding and workforce planning

Steven Bowden, Patricia Bradd

South Eastern Sydney Local Health District, Taren Point, NSW

Aim: To capacity build data management skills and knowledge of Activity Based Funding (ABF) requirements for allied health managers.
Background: The implementation of ABF for health has wide reaching implications for all areas of the health workforce, including allied health. The requirement for relevant, accurate, standardised, patient level activity and outcome data is crucial for allied health to lobby effectively in an ABF data dependent environment.

In 2011, the former South Eastern Sydney Area Health Service (SESIAHS) implemented an allied health data capture system within the Cerner eMR suite of products. Minimum data sets were developed for 12 allied health disciplines and the successful rollout provided standardised data capture for over 1,000 allied health clinicians from 15 hospitals in both inpatient and outpatient settings.

Despite a well executed change management strategy and high level of staff engagement, it was found that allied health managers were generally poorly resourced or prepared for handling, interpreting and applying the vast amount of information available from the system. Additionally, despite the common system a significant degree of date definition interpretation was observed between disciplines and geographic locations.

Discussion: A multi-faceted approach was taken to address these shortfalls, including:

- creation of regular allied health data management meetings and governance structures
- development of standardised data definitions across allied health departments, including practical examples
- data management training programs for senior allied health clinicians and managers
- centralised monthly reporting governance and feedback
- regular communication via newsletters.

Conclusion: Implementing the above strategies has reduced data error rates by over 85%. Allied health managers report improved confidence in handling data and an increase in knowledge about how their data is used for ABF. There is a high need for ongoing training and education for allied health in understanding how data systems inform ABF.

Restructuring allied health for quality: Effective, efficient and economical service provision

Gail Gordon, Sue Pager

Metro South Hospital and Health Service, PO Box 4096 Loganholme DC, QLD

This paper describes the impact and outcomes of an intense five year period of restructure and reform for the allied health workforce in Metro South. Metro South Health is now governed by a hospital and health board and services approximately one million people through six hospitals and a collection of community, mental and oral health services.

A timeline of significant events from 2008–2013 will provide the context; implementation of a new health practitioner award, district amalgamations, introduction of activity based funding, widespread clinical redesign and increasing fiscal restraint. A description will follow of the actions taken to form a united model for allied health within the Chief Executive Officer's vision of facility based service delivery connected by integrated clinical governance.

The *Assessment Tool* for Evaluating AHP Management Structures (Jones & Jenkins, 2006) and interviews with key stakeholders are used to evaluate the changes across domains including strategic management, clinical governance, professional requirements, resource management, education and research. Significant successes are identified such as new roles, improved leadership and supervision and changes in culture resulting in increased accountability through research and data systems. Initiatives that failed to meet expectations are also described, in particular workforce and resource alignment, some persistent allied health silos and limitations in our ability to contribute to and influence whole of business budget processes.

These reflections challenge allied health, particularly our leaders to remain relevant, adaptable and integral to the reform agenda. Principles are proposed to guide more effective, efficient and economical ways of working. At the same time we identify the hard won and critical elements to retain; true points of integration (that are not just re-siloing in a different way), a culture of collegiality and the right to self-determination.

Innovation in models of care: Implementation of an allied health clinical leader role in a medical assessment and planning unit

Doug Murtagh, **Marguerite Bennetts**

Darling Downs Hospital and Health Service, Toowoomba, QLD

Background: The traditional allied health model of care in the acute medical units of Toowoomba Hospital lacks efficiency. The intention of the Acute Medical Services Model of Care – Toowoomba Project was to analyse existing allied health service delivery, identify and implement changes to practice through the development of a skill sharing role, and evaluate efficacy.

Implementation: The Allied Health Clinical Leader (AHCL) role was introduced into the Medical Admission and Planning Unit (MAPU) at Toowoomba Hospital in October 2012. The MAPU is utilised by medical patients with a predicted length of stay of less than 48 hours. Traditionally the MAPU has been serviced by multiple allied health clinicians, based on medical and nursing referral.

The AHCL role was developed in order to enhance allied health assessment and care coordination processes and to improve the patient experience by providing a single point of allied health involvement. The key feature of the AHCL role involves early, comprehensive trans-disciplinary assessment and discharge planning for patients who are identified for imminent discharge and who have multiple allied health needs. Development and acceptance of an assessment tool with links to ongoing management pathways was a crucial process in the implementation. Performance of assessment and intervention tasks that extended beyond traditional professional boundaries was facilitated through use of the Calderdale Framework.

Results: A randomised controlled trial evaluation of the AHCL role is currently being conducted. Preliminary data will be presented, alongside description of the challenges faced, strategies employed, and future directions is envisaged. Staff surveys, focus groups, and analysis of process data will also aid the evaluation.

Conclusions: Novel approaches to allied health service delivery are necessary to meet growing service demand. The practical implementation experience overviewed in this presentation will serve to inform innovative allied health service delivery models.

Allied Health Assistant Implementation Program – Taking delegation to task

Lisa Somerville[1], **Andrea Elliott[1]** , **Annette Davis[2]**, Claire Brett[3]

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The Allied Health Assistant Implementation Program (the program) is a statewide implementation program that scopes, quantifies and introduces new allied health assistant (AHA) roles and allied health service models. The aim of the program is to increase the number, and utilise the full scope, of AHAs to increase allied health workforce capacity, improve the efficacy of highly skilled clinicians, improve access to allied health services and grow a sustainable allied health workforce. This will ensure that future services continue to meet increased community demand and support best health outcomes. The methodology underpinning the program combines change management principles with data collection and analysis, business case development, and promotes ownership and motivation for the change driving the process. It is based on the AHA methodology developed, piloted and evaluated by Alfred Health in 2009-2011.

The successful implementation of the AHA methodology at Alfred Health included a cost-neutral increase in the number of AHAs and the proportion of AHAs across acute campuses. The evaluation conducted by Alfred Health indicated that allied health professions had an increased understanding of AHA roles and delegatable tasks, which corresponded with an increase in the utilisation of these roles and increased job satisfaction for allied health professionals and AHAs.

The program is currently being delivered in 3 stages across Victoria. Preliminary results from stage one, within health and community services across rural-regional Victoria, have included planning for the introduction of new and amended allied health assistant roles within and across rural and regional settings that utilise the full scope of practice and include remote supervision models and the establishment of regional strategic plans to provide the framework to action this process. Other incidental outcomes of the project have included positive culture change, increased regional service collaboration, and improved communication linkages and resource sharing.

Leading the future for allied health – A governance perspective

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At the core of educating, motivating, innovating and celebrating the work of healthcare are leaders. Leadership, in all its manifestations, has increasingly come to the fore in healthcare, forming one of the five domains of the National Health Workforce Innovation and Reform Strategy (Health Workforce Australia 2011).[1]

This presentation we will explore the cutting edge research on the link between leadership and governance in the context of allied health service provision in the public health system. Drawing on the presenters' research, practice and leadership experience over the last decade, it will consider the way in which allied health training prepares individuals for the role of leaders, and why and how allied health leadership needs to come to the fore if the 'wicked problems' facing healthcare in Australia and internationally are to be addressed.

The presentation will explore the question of the role of allied health in clinical governance as one response to the wicked problem of errors and adverse events.[2] The presentation will explore two relatively under-studied aspects of allied health as a field: whether allied health workers really can 'do no harm' including our current knowledge of the nature of errors made by allied health workers in what is a complex, challenging environment. Then, drawing on primary data from error reports, we will discuss the evidence of errors which occur across the health system because the professional advice of allied health personnel is not taken.

In concluding, the presenters will reflect on the epistemological and ontological factors which precipitate this continued lack of voice in the professional decision making process. We will then propose a model for allied health leadership, across professional disciplines, which will support and enable critical reflection, learning and innovation in response to the quality and safety agenda.

Poor nutrition and function after acute hospitalisation: Opportunity for innovative post-discharge care

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Malnutrition is common in older hospital patients. Efforts to treat malnutrition focus on inpatient stay; however acute illness and decreasing length of stay limit the effectiveness of hospital-only interventions. Multifaceted inter-disciplinary nutrition interventions at the hospital–community interface may improve patient outcomes. The purpose of this study is to inform an innovative post-hospital nutrition model-of-care. The aim was to observe nutrition-related discharge planning and follow-up after hospital discharge, and describe nutritional and functional status of older people six weeks after acute hospitalisation.

A prospective cohort study of 22 medical inpatients aged 65 years or older (mean age 81±8, 50% male) who were either malnourished or at risk of malnutrition and discharged home to the community. Data were collected prior to discharge and in-home at six weeks: nutrition-related care provided, weight, nutritional status (Mini Nutritional Assessment), activities of daily living (Modified Barthel Index), grip strength, walk speed.

Limited nutrition discharge planning and post-discharge follow-up was provided: 41% received no education to improve nutrition at home, one participant was referred for practical nutrition support (meal delivery), and no participants received any dietetic follow-up (community or hospital-based). At six weeks, 44% experienced further weight loss and 47% had deterioration or no improvement in nutritional status. While most were independent with activities of daily living at 6 weeks (median MBI 100), 90% had weak grip strength (males: ←33kg, females: ←22kg) and 41% had slow walk speed (←1 m/sec), suggesting high levels of frailty.

These data confirm that limited nutrition intervention and follow-up is provided to recently-discharged frail elders. Consequently, nutritional and functional status does not improve under current models of care, highlighting the need for enhanced discharge planning and innovative models of hospital-to-home care. Our team is currently implementing the Hospital to Home Outreach for Malnourished Elders program to improve outcomes for recently discharged elders.

Education and motivation in clinical handover at a tertiary hospital: A model for allied health disciplines

Therese A. Dodds

St Vincent's Hospital, Speech Pathology Department, Darlinghurst, NSW

Clinical handover has been a target for improvement at St Vincent's Hospital Sydney, in response to the Final Report of the NSW Special Commission of Inquiry: Acute Care in NSW Public Hospitals and subsequent Caring Together initiatives. This paper will present a description of the processes utilised to educate and motivate clinicians and the outcomes achieved in improving clinical handover for allied health at our facility.

Allied health clinicians participate in a range of clinical handover scenarios, many of which are considered high risk. Clinician engagement and structured participation in clinical handover is therefore imperative if we are to comply with The Caring Together Initiative and ultimately provide best possible care for our patients.

An Allied Health clinical handover working party was formed at our facility to identify allied health handover occurrences and to address the issues of clinician engagement and participation in clinical handover across disciplines. The key objectives of the working party included: (i) review of current handover practice (ii) development of an allied health clinical handover education video and training package (iii) implementation of guidelines regarding the standard key principles of handover and (iv) implementation of a handover process – ISBAR.

The objectives of the working party were evaluated following a 12 month implementation period. Methods of evaluation including focus groups and documentation audits were utilised. Key outcomes including 80-100% compliance rates with the ISBAR and the consistent utilisation of discipline specific handover forms across Allied Health were achieved. The active inclusion of patients in clinical handover was identified as an area for further improvement. These outcomes suggest that the processes utilised at St Vincent's Hospital Sydney, have been effective in improving key areas of clinical handover for allied health disciplines and may provide a model to support improvements in this area across other healthcare facilities.

Connecting Practice: A dynamic framework for implementing workplace supervision and support

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Aim: This paper describes the development and pilot outcomes of Connecting Practice, a model which was designed to provide supervision and support for rural and remote health care practitioners.

Background: Connecting Practice redefines supervision as a fluid concept which is part of a broader context of change management. It recognises that there are multiple different supervision and support relationships, and these are contextually dependent. In other words, individuals are likely to require multiple different supervision and support relationships according to different needs, and these needs will change over time. Unlike the organisational focus of existing tools, Connecting Practice focuses on linking the needs and goals of the individual with those of the organisation and creating support structures that can address these goals.

Methods: Connecting Practice engages teams using structured facilitation action research methodology. For the pilot, three teams (16 staff) participated in four Action Work Group events which were facilitated by a trained facilitator. Data were collected systematically through team reports, and additional data were collected for the purpose of the pilot through key stakeholder interviews.

Results: Staff were positive about their involvement in Connecting Practice. Some of the outputs included active involvement of staff in the development of a governance framework for allied health; establishment of feedback loops between teams and executive; mechanisms and resources to enable a review of supervision processes; development of facilitation and leadership capacity.

Conclusions: Connecting Practice supports practitioners through the creation of dynamic, peer supported networks that are appropriate to their needs, while providing mechanisms for them to inform and influence organisational change at a strategic level.

Utilising allied health assistants to implement a new model of occupational therapy service delivery on the medical wards at the Townsville Hospital

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Introduction and aims: It is essential to consider the most effective and efficient use of available resources in order to ensure that services are provided by the right professional, in the right environment for individual patient needs.

One of the key occupational therapy roles on the acute medical wards is to facilitate a safe and timely discharge home from hospital. Traditionally this has involved assessment of a patient's 'safety for discharge' with limited capacity to provide therapeutic interventions to assist a patient's return to optimal sustainable functional performance.

Traditionally occupational therapy (OT) services are predominantly delivered in the acute hospital setting, with occasional post discharge home visiting provided within a two week follow up period where outstanding issues need finalising. In Townsville, an alternate model of care is being trialled which entails provision of a ward based therapy program delivered by an allied health assistant (AHA) in addition to post acute OT follow-up in patients homes for up to 4 weeks following discharge. In-reach OT services are available as required.

Method: Funding was received as part of the Queensland Health Models of Care/Workforce Redesign Project to fund a project officer, allied health assistant and car. All other expenses were funded through usual business.

Implementation of this model was enabled through use of the Calderdale Framework in supporting the identification of delegable OT tasks and subsequent development of AHA competencies by the TTH OT team. AHA recruitment, training and competency assessment occurred from October 2012. Implementation of the service commenced in December 2012.

Research data collection commenced February 2013 to determine if a post acute model of care produces:

- better patient outcomes (primary outcome measure World Health Organisation Disability Assessment Schedule 2.0)
- a more cost effective service
- greater work satisfaction for staff involved than the traditional pre-discharge OT service model.

Results and discussion: Research is still in the early stages with 50 of the 160 required participants recruited. Patient specific outcomes are being analysed through measures of participation, function and quality of life on recruitment to the study, discharge from hospital and at 3 months post recruitment. A number of organisational and health economic outcomes are also being examined including length of stay, community service use, readmission rates and occasion of service data.

Qualitative exploration of the thoughts and experiences of staff involved in delivering the alternate model of care is also being undertaken as part of the service evaluation, with data gathered through weekly written reflections and minuted debriefing sessions. Preliminary analysis of this data has revealed three key findings:

- greater work satisfaction experienced by both the OT and AHA
- perceived improvements regarding the understanding and appreciation of the OT role among patients, coupled with an increased receptiveness to OT recommendations
- a recognition of the critical importance of a strong and trusting working relationship and effective communication processes between the OT and AHA.

Conclusion: The new model of occupational therapy service being trialled at the Townsville Hospital aims to evaluate the appropriateness of providing a post acute occupational therapy service in a contextually appropriate environment to make best use of available resources. Research into the patient, organisational and health economic outcomes will give a broad evaluation of the overall impact of the service from all perspectives.

Multidisciplinary action research improves nutrition-related outcomes post acute hip fracture

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Malnutrition is highly prevalent and costly post hip fracture; nutritional intervention studies have met with limited success. This study aimed to investigate whether a multidisciplinary action research approach improves outcomes in patients admitted to a metropolitan hospital hip fracture unit. A controlled before and after comparative interventional method was applied aligning to the CONSORT guidelines for pragmatic clinical trials. Clinical practice improvements identified by multidisciplinary focus groups included medicalisation of nutrition, delegation of nutritional care, enhancing the foodservice system, and improving knowledge. A random selection of all patients for surgical intervention targeted 120 24-hour weighed food records. On admission and discharge malnutrition status was assessed using the Academy of Nutrition and Dietetics diagnostic criteria by a single senior dietitian. Group demographics were not significantly different demonstrating predominantly community dwelling (72%), elderly (82.2 years), female (70%), malnourished (51.0%) patients prone to co-morbidities (median 5) with early surgical intervention (median D1). Fifty-eight weighed food records were available for each group. Practice improvements and reduced barriers to intake significantly increased total 24-hour energy (2957 v 6224kJ) and protein (33.8 v 69.0g) intakes, reduced nutritional deterioration over admission (20.5 v 5.4%), and increased discharge directly back to the community setting (17.6 v 48.0%). Trends suggested a reduction in median length of stay (D14 v D13). Inpatient mortality remained low across groups (2.3%, 5.2%). A multidisciplinary action research approach improves nutrition related outcomes in acute hip fracture inpatients. Results are considered highly relevant to routine clinical practice. Similar pragmatic study designs should be considered in other elderly inpatient populations perceived resistant to nutritional intervention.

Development and implementation of a community palliative care equipment service

Geraldine Hodson

Metro South Palliative Care Service, Eight Mile Plains, QLD

Introduction: Palliative patients need access to affordable specialised equipment to remain safely in their own homes and participate in valued activities.

Aim: To develop, implement and evaluate an equitable, accessible and sustainable palliative care equipment loan service operating across numerous palliative care services in Brisbane.

Method: Stakeholder services were consulted to establish desired components of a future equipment loan service. A service framework inclusive of those components was developed and implemented for a trial of 6 months. The trial was evaluated across patient access, cost and stakeholder satisfaction measures. Questionnaires and an online survey were completed by professionals using the service.

Results: Desired service components included objective criteria for eligibility and defined length of equipment loan and charging practices. A service with patient eligibility based on prognosis, RUG ADL and AKPS scoring, a usual length of loan of 3 months and consistent charging practices was implemented. Over 6 months all eligible patients were able to access equipment. 70% of equipment was returned within 3 months. A system of shared charging enabled targeting of financial support for those in hardship. 36% of the budget was self-funded by patients. 92% of clinicians (23 /25) were satisfied with the service, and found the framework to be efficient and responsive to patient needs. Respondents highlighted an ongoing need for increased equipment stocks, OT staffing, financial resources, and education about the service.

Conclusion: A service framework with defined criteria improves equity of access to specialised equipment. A shared funding model supports service sustainability.

Allied health and its role in reducing chronic disease complications impacting the homeless population

Rebecca Mannix

Podiatrist, Complex needs team, Doutta Galla Community Health service, Melbourne

People who are homeless face many issues, including being at higher risk of chronic disease and mental illness. They often do not prioritise their healthcare because they are in crisis and they have difficulty accessing mainstream services due to their situation.

This presentation aims to explore the challenges of an allied health professional working with people experiencing homelessness as presented within the literature and through personal experiences in two busy clinics within Melbourne CBD.

Literature indicates the challenges of homelessness on health. Stress, long term social disadvantage, increased rates of smoking chronic disease (including diabetes), and skin conditions have all been reported as common challenges. It is also discussed that clients experiencing homelessness are less likely to access timely treatment. These physical risk factors, combined with social and economic factors, mental health and poor health literacy make traditional Allied health approaches challenging.

Healthcare research has identified client-centred care, health coaching and motivational interviewing as systems to assist clients to play an active role in heath change. Using these approaches the Doutta Galla Complex Needs Team have partnered with Youth Projects and Anglicare in collaborating to improve client's overall health and meet their personal goals.

By partnering with organisations it has been allowed barriers to be broken down for clients at high risk of poor health outcomes. These partnerships involve staff working in different environments, including off-site at outreach centres and where our clients gather. This enables conversations about health and chronic disease to be initiated in a safe and comfortable environment.

Holistic collaborative care that involves more flexible practices and less conventional work places that may take us out of our comfort zone as workers can lead to better outcomes for vulnerable and disadvantaged clients.

Early and intensive allied health rehabilitation programs improve patient outcomes and drive financial efficiencies

Steven Bowden, Steven Wood, Tish Bruce, Patricia Bradd

South Eastern Sydney Local Health District, Taren Point, NSW

Aim: To improve patient outcomes, capacity and efficiency in inpatient rehabilitation through implementing and enhancing allied health models of care.

Background: South Eastern Sydney Local Health District (SESLHD) was allocated $18.25M over four years commencing 2009/10 to enhance subacute services under the Council of Australian Governments (COAG) National Partnership Agreement (NPA) on Hospital and Health Workforce Reform (HHWR). As part of the funding allocation, approximately 25 full time equivalent (FTE) allied health staff were employed to implement early rehabilitation through inreach to acute wards (Acute Rehabilitation Therapy [ART]) and increase intensity of therapy (ITP) in inpatient rehabilitation wards.

Method: Programs were evaluated to ascertain the effect that enhanced allied health services had on rehabilitation patient outcome measures including Functional Independence Measure (FIM), length of stay (LoS) and discharge destination. Increased capacity in terms of throughput was also reported. Fiscal modelling was conducted to quantify efficiencies generated by the programs.

Results: Inpatient rehabilitation wards decreased average LoS by 20% (4.9 days) in comparison to baseline year (2007/08). Patient admission and discharge FIM scores were maintained within the shortened LoS, resulting in improved FIM efficiency. Increased capacity was illustrated through a 48% increase in the number of rehabilitation episodes of care across SESLHD against baseline year. Additionally, inreach rehabilitation services prevented 132 admissions to inpatient rehabilitation units annually.

Discussion: At the conclusion of the NPA, inpatient rehabilitation programs required an annual investment of $2.9M . SESLHD has driven increased capacity of rehabilitation services by decreased LOS and avoided admissions. These improvements have produced an annual fiscal efficiency of $11.4M worth of activity compared with baseline. Importantly, the rate of patient functional improvement increased by up to 75%.

Conclusion: Patient functional outcomes are improved through the investing in innovative allied health rehabilitation programs, consequently driving increased capacity and fiscal efficiencies to the health service.

Community pharmacy – Leading innovation in primary health care

Kathleen Moorby, Andrew Matthews

The Pharmacy Guild of Australia, Canberra Business Centre, ACT

Community pharmacies as primary health care providers are involved in health promotion, early intervention, prevention, minor ailments and chronic conditions management, and are often the first point of contact between the public and the healthcare system.

With more than 400,000 people visiting Australia's 5200 community pharmacies each day, their role is integral to the delivery of healthcare services to the community. Over 90% of the population visit community pharmacies each year, providing the opportunity for pharmacies to engage with people along the health spectrum and in hard-to-reach communities, who may not utilise other health services.

Community pharmacies are in a unique position to work with allied health professionals in the delivery of health education and awareness raising activities, providing referral pathways and improving access to health advice and information. For example, working with diabetes educators and dietitians to assist patients with diabetes.

The Pharmacy Practice Incentive (PPI) Program funded under the Fifth Community Pharmacy Agreement is supporting innovation in the delivery of health services and providing motivation for these services to be developed and delivered in collaboration with allied health professionals.

The services within the PPI Program are to be delivered within a quality framework and are focused on six priority areas, to support pharmacists as valuable members of the primary health care team and improve patient safety and health outcomes.

In May 2013, 4,825 (92%) community pharmacies were actively participating in the PPI Program. This demonstrates, the majority of community pharmacies are motivated to deliver innovative and collaborative health services, providing the opportunity for allied health professionals to work with their local community pharmacy in the delivery of these services.

This presentation will showcase how the PPI Program is motivating community pharmacies to deliver innovative health services, in collaboration with other healthcare professionals.

Allied health enabling the development of health localities

Martin Chadwick

Director Allied Health, Counties Manukau Health, Middlemore Hospital, Otahuhu, Auckland 1640, New Zealand

Counties Manukau Health is embarking on an ambitious four year program to deliver services more conveniently and sustainably by breaking down the barriers between primary, secondary and tertiary services. This has led to the establishment of four distinct geographic and demographic localities within its catchment area. Allied health (AH) has been identified as a key enabler in this development.

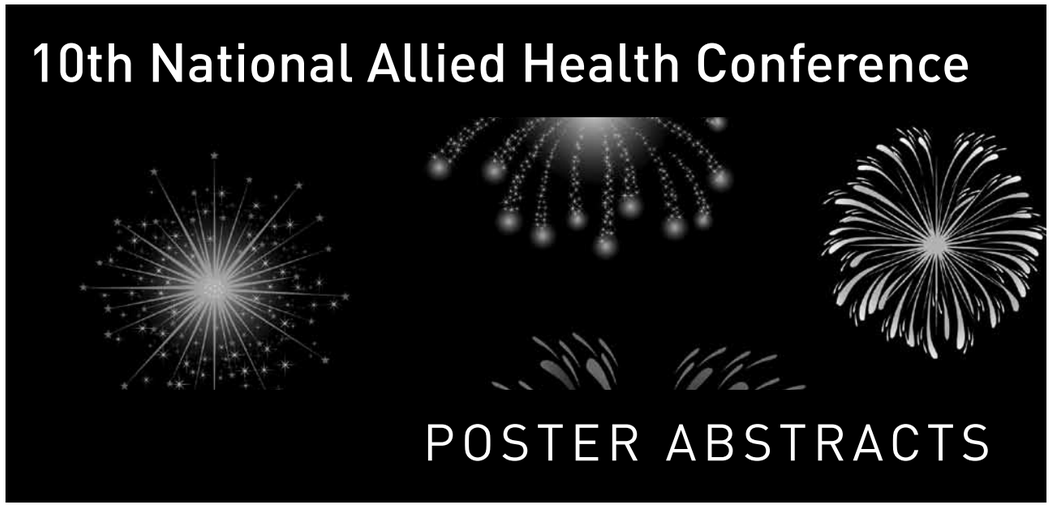
As an enabler there is a need to determine the AH resources required to provide the service delivery models to meet population health needs, as opposed to historical resource allocation. Much of the work undertaken to date with primary care colleagues has highlighted a lack of awareness of the services that can be provided by AH professionals, how to access these services, and in turn who should be providing these services. This has led to a specific project to address these concerns which will deliver:

- workforce models aligned to health needs
- a defined Model of Care for Allied Health in an outpatient and community setting
- a defined role and scope for AH Professionals within the community setting to maximise scopes of practice
- the utilisation of a competency based framework to support skill sharing across disciplines within AH and across the Counties Manukau district by using the principles that underpin the Calderdale Framework as a methodology to engage front-line staff.

The goal of the project is to improve health outcomes for the community through:

- more streamlined coordination/multidisciplinary care
- more timely access to relevant allied health services
- increased efficiencies for health service through better utilisation of workforce skills and roles.

As a project in situ, there have been multiple opportunities to collate lessons learnt in how to raise awareness and engage the multiple partners that make up the complex landscape that is healthcare.



1.

Students' perceptions of regional and rural allied health clinical placement quality

Veronique Anderson, Dominic Mawn, Jayne Kirkpatrick, Karen Bruggemann, Yvonne Watts, Linda Furness

Background: The Clinical Education Workload Management Initiative was established in 2009 with the aim of enhancing the quality and capacity of allied health clinical education in Queensland Health. Clinical Educator Support positions were created in most allied health disciplines to enhance the quality of clinical education, and to build the capability of allied health professionals to provide clinical education. Numerous studies have shown a link between rural clinical placements and future employment in rural areas, however few studies have investigated the quality of clinical placements in regional and rural areas. Research into the quality of placements across allied health disciplines in regional and rural locations is even more limited, despite the need to examine this area to address recruitment and retention issues in regional and rural areas.

Aim: To investigate student perception around the quality of clinical placements within six allied health disciplines in the regional and rural areas of the Darling Downs and South West Hospital and Health Services.

Method: A survey tool was developed through the Survey Monkey website to determine students' perceptions of the quality of their clinical placement and to identify the challenges and advantages of placements in regional and rural areas. Students completing clinical placements during 2012 in the allied health disciplines of physiotherapy, occupational therapy, psychology, social work, speech pathology and dietetics in the Darling Downs and South West Hospital & Health Services were invited to participate. Results were collated across all disciplines in order to establish trends within a larger sample, with descriptive analysis of data undertaken.

Results: Ninety-six students responded to the survey. Several key results include:

- 98% of students reported their rural/regional placement developed their skills for entering their profession
- with respect to their specific regional/rural placement, 96% of students reported feeling confident to assume the role of new graduate clinician in this field
- 90% of students indicated they would be interested in working in a rural/regional setting in the future
- 90% of students were satisfied with the teaching and supervision received during their placement
- Common challenges identified were financial pressures and isolation from family and friends, suggesting areas of investment need in order to increase staffing in regional and rural areas.

Contribution to the field: This paper develops understanding of student perceptions on the elements of a quality clinical education placement, with particular emphasis on rural and regional placements. It also highlights the link between high quality clinical placement experiences and 'work ready' new graduates with a willingness to consider future work in regional and rural areas.

These results inform allied health clinical education in regional and remote areas and highlight the need for further investigation around financial support for regional and rural student placements.

2.

Striving for health equity in small regional hospitals using telehealth to deliver dietetic services

Rhonda M. Anderson

Mackay Base Hospital, Mackay, QLD

Mackay Hospital and Health Service (MHHS) is a geographically challenging area in which to provide health services due to its regional status and the substantial distances between facilities. Mackay Base Hospital serves as a hub for the eight public hospitals within this Hospital and Health Service (HHS). The only Queensland Health dietitians in this HHS are located at Mackay Base Hospital and provide limited, ad hoc dietetic support to all of the MHHS facilities. A recent audit of the MHHS hospitals with no onsite dietetic service indicated that less than 34 per cent of inpatient admissions were screened for nutritional risk and up to 30 per cent of the inpatient admissions required dietitian intervention.

In striving for equity in the provision of dietetic services and increasing the focus on clinical nutrition (including but not limited to the identification and treatment of malnutrition) across the HHS, a dietetic telehealth service using existing videoconference facilities was established for both inpatients and outpatients across MHHS.

Formal evaluation of the use of the Telehealth in delivering dietetic services across MHHS has not yet been completed, however anecdotal reports indicated some initial difficulties in uptake of this service which have resolved as systems and processes have become more embedded. A formal evaluation evaluation of the service is in progress. Preliminary results indicate that telehealth is a successful model for delivering dietetic services for both inpatients and outpatients. It is envisaged that the use of this new technology will contribute to health equity for the residents of the Mackay Hospital and Health Service.

3.

Are generic resources for allied health assistants in rural settings possible?

Lauren G. Arthurson[1], Merrin Prictor[1], Alicia Cunningham[2]

[1] Echuca Regional Health, Echuca, VIC
[2] Rochester and Elmore District Health Service, Rochester, VIC

Introduction: The Echuca regional cluster established a long term strategic plan to develop the allied health assistant (AHA) workforce. A combined group of seven health services in regional Victoria identified the value of expansion and support of allied health roles to address the increasing demand for allied health services. The cluster identified the need to develop generic resources for the network managers and to develop a peer support network for AHAs.

Method: Completion of focus groups and an AHA staff survey informed the development of the AHA peer support network and education and training content. 1:1 interviews and meetings were held with key stakeholders to discuss AHA workforce development. A literature review as well as collation and reviewing of AHA core documents was completed. These were integrated into a generic AHA toolkit. Continuous collaboration with the key stakeholders occurred throughout the project.

Results: An AHA peer support network and a network-wide professional development calendar for the AHA group was established, as well as a resource toolkit for managers and clinicians. In addition to these outcomes, the partnerships formed have strengthened beyond the boundaries of the project bringing additional benefits to health services in the cluster.

The challenges identified during the project include:

- effectively addressing the historical AHA workforce challenges
- meeting significantly different needs of the 7 health services
- challenges faced by training organisations to provide adequate clinical training for AHAs
- balancing AHA workforce expansion, ensuring allied health professional EFT is not compromised.

Discussion: This project successfully utilised a partnership approach to develop the AHA workforce in the cluster. Sharing information, resources and creating the AHA peer support network has ensured this valuable work will continue beyond the life of the current project.

The authors would like to thank the Department of Health, Victoria for providing funding for the project and acknowledge the support of the AHA Implementation Program Steering Committee.

4.

Establishing a palliative music therapy service in the hospital: Personalising end of life care for oncology patients and families

Belinda Ayres, BComm, MMusThrpy, RMT

Royal Children's Hospital, Brisbane

Music therapy palliative care services in Australia are often delivered via the community respite setting. The introduction of a new funding structure through the Paediatric Palliative Care Service (PPCS) has provided the music therapy team at Royal Children's Hospital (Brisbane) with the opportunity to develop a unique and personalised model of service for children and their families to support symptom management and enhance quality of life. This newly developed music therapy service is rare in Australia, as it is solely dedicated to paediatric hospital palliative care.

This presentation will explore the literature in relation to best practice within paediatric palliative care music therapy, and outline the process of establishing a new model of service to paediatric oncology patients receiving palliative care in the hospital environment.

Practical aspects in regards to varying clinical presentations of patients and families, and the impact of these factors on informing clinical service delivery, will be discussed. Data in regards to the service provided to paediatric oncology patients will be presented, as well as the challenges and highlights involved in establishing the new service.

Several music therapy modules focused on personalising palliative care for paediatric oncology patients and their families will be demonstrated. In particular, the elements of music as a creative-based therapy that contribute to enhancing quality of life and facilitating positive memory-making will be shared.

5.

Clinical handover – from policy to practice

Ruth Cox[1], Samara Phillips[2], Sarah Bailey[3]

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[2] Metro South Health and Hospital Service, Brisbane Technology Park, Eight Mile Plains, QLD
[3] Allied Health Workforce Development Metro South Health and Hospital Service, Princess Alexandra Hospital, Woolloongabba QLD

Introduction: Clinical handover is a high risk scenario for patient safety because of the dangers of discontinuity of care, increased chance of adverse events, and higher likelihood of legal action due to malpractice (Wong, Yee and Turner, 2008). The new mandatory National Safety and Quality Health Service Standards include clinical handover, highlighting its importance and elevating it as a priority for allied health staff.

The aims of this presentation are to:

- raise awareness of the National Safety and Quality Health Service Standard 6 – Clinical Handover
- share how Metro South Allied Health have contextualised Standard 6
- detail implementation of new and improved clinical handover processes
- discuss future directions including audit and other evaluation initiatives.

Contextualisation: Whilst a Queensland Health clinical handover policy existed, it was identified that the focus was mainly medically and nursing oriented including shift to shift and bed side handover. The nuances of allied health models of care needed to be taken into account. This presentation will discuss the creation of a Metro South Allied health Clinical Handover Guideline. The guideline includes key principles and key criteria for clinical handover as well as responsibilities of staff at different levels in the organisation.

Implementation: The use of SBAR (Situation, Background, Assessment, Recommendation) was widely seen by Metro South allied health staff as the most appropriate communication tool to use in clinical handover. Departments were encouraged to share their resources, approaches and experiences. This presentation will include examples of clinical handover tools developed. Strategies to facilitate the change process and training support will also be discussed.

Future Directions: An evaluation process was established to ensure that allied health clinical handovers are effective, efficient and compliant with Standard 6. The evaluation framework which includes audit tools, incident monitoring and reporting requirements will be detailed in the presentation.

6.

AHPEP – educating the allied health workforce through clinical placements since 2000

Melinda Stone, Katie Bauer

Cunningham Centre, Toowoomba, QLD

Introduction: The Allied Health Professional Enhancement Program (AHPEP) provides eligible allied health professionals and assistants with access to placement opportunities which focus on improving services and health outcomes for their clients. Data collected to date suggests that the program can be an effective mechanism for increasing knowledge and skills, improving professional networks and validating current work practices in the regional and rural workforce.

Objective: The objectives of the program are to provide allied health professionals and assistants working in regional, rural and remote areas with a placement opportunity to gain knowledge and skills in clinical practice areas relevant to their rural and remote client and caseload needs, in particular those areas identified as Hospital and Health Service or Department of Health priorities; to gather ideas and information to support the implementation of genuine improvements to service delivery for rural and remote clients and communities and to promote the sharing of relevant knowledge, skills, ideas and expertise between remote, rural, regional and metropolitan allied health professionals and assistants, in order to facilitate positive changes in service delivery and health outcomes for rural and remote clients and communities.

Description: This presentation will describe the evolution of the program over the last thirteen years, the rewards, challenges and lessons learnt.

Discussion: Eighty-eight placements were completed in 2011/12 program year from 12 different allied health disciplines. Evaluation of the program has demonstrated clear benefits for clinicians, their service and the organisation. Over 80% of line managers reported that placements had assisted to meet local Health Service or Department of Health priorities.

Conclusion: Evaluation outcomes indicate that these placements have been highly beneficial especially to the regional, rural and remote allied health workforce in Queensland. Lessons learnt from implementing hundreds of successful outcome focussed placements may be applicable to similar programs in other healthcare settings.

7.

Development of an occupational therapy needs assessment tool

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Background: In developing a comparative study, researchers found the use of diagnostic related groups (DRGs) to have limitations for analysing the impact of an occupational therapy service within the diversity of an acute medical ward. An alternate way of analysing occupational therapy impact was, therefore, required. Service analysis determined that medical ward patients appear to require either, no, low, medium or high levels of occupational therapy intervention, with the level of need influenced by many variables. These variables appear to significantly influence function, levels of participation in activities of daily living, and a person's ability to manage at home. In the absence of any existing formal method to identify the level of Occupational Therapy required by a patient, the Occupational Therapy Needs Assessment Tool was developed.

Aim: To develop a tool to support the classification of occupational therapy service need for clinical research and prioritisation. In a comparison study investigating alternate models of occupational therapy service delivery, randomisation was unable to be implemented. Thus a matching process was required to ensure the recruitment of an equal sample of patients from all occupational therapy needs levels in both the intervention and control groups. The tool continues to be used prospectively to determine the level of occupational therapy service required by patients of the medical wards at The Townsville Hospital which are involved in the Occupational Therapy New Models of Care/ Workforce Redesign Project. The tool may also have a future role in assisting with service prioritisation.

Method: Senior clinicians were consulted to identify the variable believed to influence the need for occupational therapy. Each variable was assigned a weighting score. In a pilot study, ward clinicians were provided training in applying the tool and used it with all patients. This determined each patient's projected level of occupational therapy service need. Following completion of each patient's admission (or episode of care), their actual level of service need was established by the ward clinician, using statistical data and clinical opinion. This clinician was blinded to the initially projected level of service need. A cross-referencing analysis of the projected and actual levels was completed to determine accuracy of the tool. A number of trials were conducted, and variables and weightings revised to improve the accuracy of the tool.

Findings & Discussion: Within the pilot, 70% of patients were accurately categorised into their actual level of service need. Where error occurred, the tool was more likely to project a patient into a category higher than their actual level of need, indicating greater service need than patients actually required. This was deemed an acceptable accuracy rate and risk, and the tool is currently being used to enable stratified recruitment of participants from each of the arms in the comparison study. As the model of care research continues to be undertaken, the final evaluation of the needs assessment tool is yet to be conducted. It is anticipated that a larger study following the same evaluation undertaken in the pilot study will be conducted.

Conclusion: The development of an occupational therapy needs assessment tool has the capacity to improve the robustness of clinically driven occupational therapy research. Furthermore, it has the ability to assist with improved workload planning for occupational therapists in acute medical services.

8.

Fast-tracking sustainable discharge from the Emergency Department: Implementation of a subacute allied health service

Doug Murtagh, Marguerite Bennetts

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Background: Comprehensive management of subacute patients presenting to the Emergency Department (ED) must consider underlying function beyond the acute medical presentation. It was anticipated that the implementation of an allied health (AH) team stationed in the ED would enhance subacute patient function and wellbeing, thereby reducing re-presentation.

Methods: The implementation of a coordinated multidisciplinary care team included: (a) screening of subacute patients presenting to the ED; (b) early trans-disciplinary AH assessment and management planning across the continuum of care, and; (c) immediate service in the community setting. Prior to this innovation, AH referrals were identified by medical and nursing staff, and actioned by individual AH therapists on an 'on-call' basis, only within the ED. Subacute patients were defined as older adults with significant chronic co-morbidities and/or underlying functional deficits.

Retrospective reviews of databases and medical records three months before and after implementation were used to describe service utilisation and examine changes.

Results: In the three-month period post-implementation, 101 patients were seen by the subacute ED AH service (compared to 23 prior to implementation). The most common presenting health conditions were falls (59%) and pain (15%). In total, 229 AH Occasions of Service were provided, with a mean treatment time per patient of 155 minutes. For patients seen in the ED, the median time delay from presentation to AH assessment was 4:27 hours (compared to 7:12 hours pre-implementation). Overall, 38.6% of patients re-presented to the ED within the following 6-month period (compared to 52.2% pre-implementation).

Conclusions: The evaluation provides preliminary evidence of the utility of a subacute AH service stationed in the ED. It highlights the unmet need inherent in the pre-existing service delivery model, the capacity to reduce delays in management, and the potential to reduce rates of re-presentation.

9.

Innovating outcomes for adults attending alternative to employment programs: A role for occupational therapy

Carly Bloomfield, Janet Richmond, Ruth Marquis

Edith Cowan University, WA

Background: The Alternative to Employment Programs; funded by the Western Australian Disability Services Commission, support adults with disabilities unable to participate in education or supported employment in excess of twenty hours per week. Currently support workers are primarily responsible for ensuring the achievement of client outcomes in support services through person centred practice and questionnaires enabling client's to have input into their desired activities. Support workers facilitate innovative community participation through leisure and educational activities to develop client's occupational skills and enhance independence for participation in daily activities. In addition Occupational Therapists are not involved within the setting and could positively impact the individual and the program as the professional values support the facilitation and enhancement of client's occupational performance. Limited research is available regarding the effectiveness of these programs in achieving the client's goals, this research aimed at identifying the innovative practices support workers implement to assist goal attainment and determine a potential role for Occupational Therapy.

Method: An Ethnographic approach involving semi structured interviews with twelve support workers across three Alternative to Employment organisations provided data for thematic analysis. In addition observational data of support workers facilitating an activity in the program were collected to identify whether the findings from the analysis of the interview data were reinforced by the observations.

Findings: This research identifies strengths and limitations of the current service provided to adults with disabilities attending Alternative to Employment Programs. The contribution of Occupational Therapy to assist support workers in skill advancement through education and training will further enrich client outcomes. Recommendations are suggested for future program innovations. The Occupational Therapy role will intensify the outcomes for adults with disabilities attending the Alternative to Employment Programme through education, training, and supervision, including the requirements of support workers for skill development will be discussed.

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11.

Validity of malnutrition screening tools for adult rehabilitation patients

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Nutritional status has been shown to deteriorate in patients during hospital admission due to poor recognition of their nutritional risk. Early identification of patients at risk of malnutrition is therefore important so that appropriate nutrition therapy can be initiated. Various screening tools have been validated in the inpatient rehabilitation setting, but have been focused on older patients and/or are very time consuming to complete. The aim of this study was to validate a simple screening tool suitable for use across the full adult age span in rehabilitation inpatients, so a consistent tool could be used across acute and sub-acute wards in our health service. A prospective validation study using a convenience sample of 250 adults admitted to the rehabilitation wards of two Victorian metropolitan public hospitals (Dandenong and Casey) was conducted. Participants were screened by a nutrition assistant for malnutrition risk using two tools previously validated in the acute setting - the Malnutrition Screening Tool (MST) and Malnutrition Universal Screening Tool (MUST). To assess the specificity and sensitivity of the screening tools, an assessment of each patient's nutritional status was undertaken by a dietitian using the Subjective Global Assessment (SGA). Convergent validity was assessed by comparing the MST and MUST to anthropometric (Body Mass Index, mid-arm circumference) and biochemical measure (serum albumin protein). Predictive validity was determined by comparing the screening tools' scores to length of hospital stay and mortality. Inter-rater reliability of the screening tools and SGA was completed by clinicians independently of one another and compared. A cost analysis will be undertaken to assess the cost-effectiveness of the nutrition screening tool. Results and conclusion are pending.

12.

Pilot speech pathology telehealth service for head and neck cancer patient support

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Speech pathologists have a key role in the management of the swallowing and communication difficulties experienced by patients with head and neck (H&N) cancer. Within Queensland Health, the majority of H&N cancer treatment is based at metropolitan Cancer Centres, such as the Royal Brisbane and Women's Hospital (RBWH). For patients living outside of Brisbane, there are significant issues and costs associated with ongoing access to specialist services such as speech pathology. Utilising telehealth to link specialist clinicians in metropolitan Cancer Centres with speech pathologists and patients in regional and rural locations is one solution to enhance patient access to quality clinical services locally and achieve best practice.

Research by members of the current team has demonstrated the potential for telehealth in speech pathology management1-4 . The current project evaluates a 5 month pilot telehealth service for patients with H&N cancer between the speech pathology departments of a metropolitan health service (RBWH) and a regional health service (Nambour General Hospital). A dedicated weekly telehealth clinic provided a range of services including pre-treatment counselling, early intervention and post treatment handover and complex case management. Along with service data, satisfaction questionnaires were completed by patients, and clinicians and any workforce training benefits were recorded.

Fifty telehealth sessions were conducted for 18 patients incorporating 38 patient consultations, 9 case discussions and 3 clinical training sessions. Overall patients were satisfied with the service, stating a preference for attending the telehealth session and reporting financial and time benefits. Clinicians reported the purpose built telehealth system with enhanced network support facilitated the clinical assessment and generally, telehealth would be a more efficient means of service. Significant workforce training benefits were also achieved.

A coordinated telehealth service improves patient access to specialist speech pathology services, enhances patient and clinician satisfaction and provides strategic staff training.

13.

Celebrating increased foodservice patient satisfaction with the Queensland Health Nutrition Standards for meals and menus

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Queensland Health Nutrition Standards for Meals and Menus were developed to assist healthcare facilities to meet the nutritional requirements of patient groups. We aimed to evaluate patient satisfaction before and after menu changes consistent with the new standards were implemented in a 20 bed rural hospital with a cook fresh menu.

Menu changes over 2011 and 2012 included an additional soup at midday, additional dessert at evening meal, extending menu cycle from 1 to 4 weeks to increase hot meals choices, high energy and protein mid-meals and offering choice of meal size. Additionally quality audits were used to improve food quality, portion control practices and nutrition specifications as outlined in the standards. The validated Acute Care Hospital Foodservice Patient Satisfaction Questionnaire was administered to inpatients prior to (2011) and after (2013) menu changes occurred. A score of one for each statement meant 'very dissatisfied' and five 'very satisfied'. Chi-squared and non-parametric independent samples t-tests were used to compare 2011 and 2013 demographic and satisfaction data.

Forty-three respondents completed surveys in 2011 and 49 in 2013. Respondent demographics were similar across years (2011: 70±14yrs, 47%F, 53% LOS→1wk, 83% standard diets; 2013: 70±15yrs, 43%F, 41% LOS→1wk, 67% standard diets; p→0.05). Respondents reported high, but unchanged, scores in most dimensions, including overall satisfaction (Overall: 2011: 5(2-5) median (range), 2013: 5(1-5), p→0.05). Several of these dimensions including physical environment, meal service quality, staff/service issues and temperature of hot foods were not expected to increase from the changes implemented. Food quality and meal size dimensions, however, increased post-implementation (2011: 4.3(2.7-5.0), 5(1-5); 2013: 4.7(3.3-5.0), 5(2-5), respectively, p=0.002).

Increased patient satisfaction occurred after menu changes were implemented, suggesting that compliance with nutrition standards and patient satisfaction is positively linked. Future research is planned to assess satisfaction following the implementation of a patient dining room.

14.

'Tools of Trade' (TOT) a non-traditional approach to men's shed development. Featuring Health: As a contemporary new partner

Bruce Campbell, Melissa Koch

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The Rural Health Team (RHT) situated in the Yorke & Northern Rural Region of South Australia is well known for its innovative grassroots approach to Primary Health Care. The conjunctive need for older men in rural communities within Australia to access programs that promote successful aging is well established and is of vital importance for an aging population. It is also well established that men's sheds in Australia generally, are an excellent forum to engage older men in social and practical activities that meet this requirement.

Over the last 4 years, the RHT has developed a men's shed-program model: 'Tools of Trade' (TOT) that specifically aims to target the needs of older socially isolated men, by creating innovative men's shed programs in their regions. Although TOT sounds conventional it seeks to incorporate both traditional and non-traditional approaches to men's shed activities for older men in rural Australia. This is evidenced in the three distinctly unique men's shed programs that have been developed in the Mid North townships of Jamestown, Peterborough and Booleroo Centre. Although each shed differs in practical aspects of engagement, management and implementation, each program holds strongly to principles of community development in the following ways:

- highly valuing the thoughts and contribution of local people
- creative community consultation and ongoing liaison
- forming, valuing and utilising local partnerships
- the inclusion of socially disadvantaged and handicapped people in all aspects of planning/implementation
- working together to provide an ideal environment for reaching these ends
- health as a contemporary and innovative new partner.

In conclusion: The Theme: Educate, Motivate, Innovate, and Celebrate from The 10th National Allied Health Conference strikes a resounding chord with RHT project managers Occupational Therapists Bruce Campbell, and Melissa Koch. It represents the commensurate familiar pathway in the development of the TOT model.

15.

Development of ePET (ePharmacy Education and Training): A Statewide Pharmacy Specific Online Training Site

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Aim: To develop a central site for access to pharmacy specific and general e-learning resources relevant to public hospital practice. To develop e-learning modules to introduce hospital practice to interns and pharmacists new to hospital and reduce duplication of effort in instructional design.

Method: A pharmacy specific e-learning web page providing links to existing relevant e-learning packages (internal and external to the organisation) is being developed to add to the state health elearning platform due July 2013.

Learning modules to introduce hospital pharmacy practice were developed: an introduction to the state healthcare system, the roles of hospital pharmacy staff and other healthcare providers and an introduction to the role of the pharmacist (as part of the multidisciplinary team) throughout the patient journey.

Users are encouraged to think about their provision of service to the patient as an individual and as part of the population. They are shown the range of knowledge and skills required to practice competently and independently as a hospital pharmacist. Preceptors and line managers provide onsite assistance and monitoring where necessary.

Results: The interactive, problem-based format encourages independent learning. The modules are designed to demonstrate how to identify relevant information about current best practice and local policies and procedures and encourage participants to evaluate it themselves. This allows the modules to be used at different sites across the state and ensures the modules remain current for longer.

Participation rates, results and feedback will be monitored through the state learner management system (LMS).

Conclusion: The format reduces duplication of effort in instructional design, emphasises independent learning and provides easy access to continued professional development. It is expandable for more advanced practice and could include technician relevant material. It could be used as a model for other allied health professions.

16.

Store Walk'n'Talks: An innovative approach to nutrition education in a remote Aboriginal community

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The 'Healthy Choice' store badging program was implemented in a remote Aboriginal community in May 2013. Evaluation of previous store badging programs identified shelf label maintenance as an issue that could potentially influence the feasibility of stores taking full ownership and future control of the program. The literature has identified that program messages should be reinforced and complemented by other nutrition promotion activities in the wider community. In order to reinforce program messages and develop capacity of store management and staff to improve shelf label maintenance, a store Walk'n'Talk providing basic nutrition education was designed for community members and store employees.

The store Walk'n'Talk was developed through trialling and modification of the *Remote Indigenous Stores and Takeaway Nutrition Training Manual* (Queensland Government). Eleven store employees and two community members participated in four pilot tours. Findings of these tours guided development of the store badging and Walk'n'Talk guide.

Key learnings from the store Walk'n'Talks included length of tour, group size, age distribution of group, gender mix of group, key nutritional messages and delivery format. The content of the original RIST training and format of delivery was significantly altered based on time constraints, varying demographic profile and literacy levels of participating groups, and key health issues within the remote Indigenous community. The store badging and Walk'n'Talk guide included a section on the localized store Walk'n'Talk and a section on how to badge in a remote community store.

The store Walk'n'Talk seeks to reinforce program messages within the wider community by developing the knowledge and skills of store employees. The store badging and Walk'n'Talk guide provides the community with a resource to facilitate future store Walk'n'Talks. Further localised store badging and Walk'n'Talk guides are planned for development in other Cape stores.

17.

Allied health within a complex adaptive system

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As publically funded systems, the New Zealand and Australian healthcare systems are always open to changing policy direction and the focus of the government of the time. There is not the ability to predict with accuracy the outcome of policy change and the subsequent impact on service delivery, but it is possible to gain a greater understanding. The science of complexity and the construct of a complex adaptive system (CAS) provide a methodology to gain this understanding.

There is a unique language used to define a CAS such as 'fitness landscapes', 'strong influence string construct' and 'agents'. Allied Health (AH) can be defined as an 'agent' within this language. An 'agent' operates using a short list of simple rules, which drive action and generate behaviour. These rules are often not shared, or explicit, or even logical when viewed by others. Understanding these concepts can provide an insight as to why within healthcare there is often conflict or cross-purposes between groups, be they professional groups or organisations. There is also the concept of an 'attractor', which doesn't explicitly draw agents to it, but rather it recognises the pattern into which a system settles. One of the primary attractors within Australia and New Zealand are how services are funded.

Understanding provides a means to influence and drive change. Within this methodology, it is argued that there lies the ability to understand the multiple tensions that influence the healthcare landscape. And it is by recognising these patterns that AH can be better placed to influence the attractors in the system, be more agile in how it responds collectively, and look to influence or in some instances re write the 'short list of simple rules' that agents within the system operate by.

18.

Improving health literacy for parents accessing child development services: A model for information use

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This presentation will report on the findings of a recent qualitative research study on Information Use in paediatric home therapy programs (HTP). Most studies to date have focussed on parental compliance with home programs (Mayo, 1981[1]; Law & King, 1993[2]; Schreiber et al, 1995[3]), attitudes and beliefs around participation HTP (Bazyk, 1989[4]; Piggot et al, 2003[5]), effectiveness of HTP (Novak, 2006[6]; Novak 2007[7]) and parents' views on implementation of HTP (Hinojosa & Anderson, 1989[8]; Tetreault, 2003[9]; Novak, 2011[10]). The present study explored parent perceptions around the information used in HTP within a health literacy context. Health literacy in child development services has not yet been explored. The presentation will outline a Model of Information Use relevant to parents of children presenting with developmental delay.

The Comprehensive Parent Assessment Model of Information Use (ComPAss Model) outlines a process of how parents Assess, Apply, Review and Acquire information. It also highlights how contextual factors including information characteristics, environment, personal characteristics and relationships influence how parents use information at these stages.

This presentation will also explore practical use of the model and implications for practice. As the model is based on parent perceptions of their experiences with child development services, it is important that health professionals consider such outcomes as a way of helping to improve health literacy for this population.

19.

Exploring the benefits and challenges of an innovative fee-for-service program within a not-for-profit organisation

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Calvary Health Care Bethlehem, Caulfield, VIC

In a climate of scarce resources, public healthcare organisations are increasingly required to employ innovative strategies to supplement government funding. The music therapy department at Calvary Health Care Bethlehem has been providing an innovative and successful fee-for-service program for over 15 years. Revenue generated from this program has enabled the provision of additional music therapy services as well as investment in research and staff development. This paper will outline the benefits and challenges of delivering a commercial initiative within a not-for-profit organisation. In particular, tension between conflicting philosophies of commercial business practices and public healthcare will be explored. These issues include enabling collaboration within a competitive business model, managing power imbalances during marketing, maintaining equity while rewarding performance and avoiding concealment of shortfalls in government funding. Implications for human resource management and accounting practices will also be presented. While this presentation will describe a music therapy program, the issues explored will have relevance for other revenue generating ventures including fee-for-service education programs, consultancy services and fundraising.

20.

Evaluating the effectiveness of the Oncology Needs Assessment Tool in identification of outpatient needs for multidisciplinary health services

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The Oncology Needs Assessment Tool (ONAT) was developed by the Allied Health Team at the Mater Adult Hospital, Brisbane to assist them in being able to recognise patients who needed support whilst undergoing chemotherapy. It was developed as a result of the lack of multidisciplinary and multidimensional items (as well as other limitations) in existing screening tools. Patients are asked to identify and rate the severity of each symptom/problem. Clinicians use the ONAT to identify and prioritise patients who need support. Interventions and services are then able to be provided to ensure that patients remain well-supported throughout their chemotherapy.

A field trial involving 47 males and 154 females was conducted focusing on the feasibility and patient acceptability of the ONAT. The study examined how the ONAT performed against the widely accepted criteria of an effective screening tool. The ONAT was deemed to:

1) include patients' needs from a cancer-related multidimensional aspect
2) assess patients' subjective needs
3) be patient friendly
4) be system friendly
5) have referral guidelines in place to link support services to risk factors
6) assess needs for clinical purposes.

The trial identified strengths and limitations associated with the ONAT. This has provided clinicians at the MAH with important directions for the next phase of development, which will incorporate a consumer-informed refinement of the tool. The updated version of the ONAT will be disseminated to all patients undertaking chemotherapy. It is believed that changes made will enhance the effectiveness of the assessment tool, improving allied health clinician's ability to identify and subsequently, provide an efficient service. The ONAT and its referral processes are considered innovative as no other tools are able to offer the same multidisciplinary focus.

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21.

The challenges and enablers for implementing experienced based co-design as a quality improvement approach

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Background: Quality improvement approaches that engage consumers, carers and community members in the evaluation and development of services to create a more responsive service and workforce are gaining in popularity. Experience Based Co-Design (EBCD) (The Kings Fund 2012), is one such approach that seeks to understand the consumers experience as the starting point for service and workforce redesign going beyond traditional client satisfaction surveys to enable staff and clients (or other service users) to co-design, together in partnership.

Objective: The objective of the, EBCD project was to understand client/carer experience of care coordination service provision at Western Health and utilise the information to:

- understand what clients value and what is working well
- develop and improve how care coordination services are delivered
- iInform and educate staff
- increase consumer involvement in care coordination service and workforce redesign.

Evaluation of the EBCD process and outcomes has been conducted to determine the effectiveness, sustainability and transferability of the approach.

The EBCD project was made possible due to funding from Health Workforce Australia.

Method: Interviews with staff involved in implementation of EBCD together with feedback from clients have been conducted to evaluate the EBCD process to identify key challenges and enablers. The number and outcome of redesign projects initiated as part of the EBCD process is being used to evaluate the effectiveness of the approach.

Results: Challenges identified include:

- resource requirements
- time
- focus on positive experiences
- farticipant attrition.

Enablers identified include:

- clinical champions to engage staff in EBCD process
- harnessing the power of the client experience
- celebrating successes.

22.

The development of a mentorship role for occupational therapists within an acute setting

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A review of the acute team structure at Campbelltown Hospital highlighted two areas for change: retaining and enhancing skills of level 2 OTs as well as improving access for new graduates to supervision via varied informal means. It was identified that new staff frequently sought time and guidance from experienced Level 2 staff without formal structures in place. The mentorship program was aimed at enhancing job satisfaction of the cohort of level 2 OTs with promoting opportunities to gain experience in supervisory skills often required for higher level positions. As well as ensuring high quality of supervision and skill development was accessible for new staff members.

Using models of mentorship from the private sector and nursing, we developed a mentorship programme that was trialled over the duration of 9 months, equivalent to one clinical rotation in the acute hospital setting.

Qualitative data of the mentorship program was collated at the commencement and end of program, identifying expectations and perceptions of a mentor/mentorship programme, staffs current/previous experiences, and advantages/disadvantages of the program.

Quantitative data was collated throughout the 9 month rotation, identifying how much time was used in mentorship activities and if the mentorship provided, related to clinical, professional or administrative tasks.

The data demonstrated the majority of mentorship time was directed to clinical activities followed by administrative and professional skills. Analysis of the data in relation to staffing establishment demonstrated more mentorship time was utilised when there were a greater proportion of new staff.

Future directions from the project indicate that a model of clinical supervision that includes mentorship and coaching will be created for Campbelltown Hospital in collaboration with the existing formal supervision processes.

23.

Nutrition assistant delegation: An innovative model for increasing nutrition surveillance and management of 'at risk' patients

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The Prince Charles Hospital, Chermside, QLD

In response to increasing workforce demands and the need to optimise skill mix within allied health departments, a delegation model for Nutrition Assistants (NA) was developed at The Prince Charles Hospital (TPCH) for acute and sub acute services. Previously, NAs (2.5 Full-Time Equivalent) were responsible for malnutrition screening, weight monitoring, meal audits/preference checks and oral nutrition support (ONS) under dietitian supervision.

The model was developed by a working party of dietitians via a series of focus groups.

From this, a Nutrition Care Plan (NCP) was developed in conjunction with delegation and escalation criteria to maintain safe practice. Identification of training needs and upskilling of NA staff was completed prior to implementation.

Delegation criteria for NA referral includes a Malnutrition Screening Tool score of 2 or, a patient who after dietitian assessment, is considered nutritionally stable and would benefit from monitoring and ongoing optimisation of ONS. Patients are triaged according to NA Priority Guidelines. Once referred, the NA NCP incorporates assessment of clinical data incorporating biochemistry, nutrition impact symptoms, weight /weight change and the evaluation of oral intake. Following assessment, NAs complete a range of interventions including the delivery of nutrition care via optimisation of food-based ONS and the provision of simple discharge education materials for home or discharge summary for residential aged care facilities. An escalation criterion was developed to identify deteriorating patients and/or capture a patient who requires Dietitian documentation of a malnutrition diagnosis. A communication plan includes documentation in the patient's medical chart and input into the shared NA/ Dietitian handover spread sheet.

Outcomes include an enhanced capacity for the monitoring and optimisation of nutritional status for inpatients and increased scope of practice for Nutrition Assistants at TPCH. Evaluation via focus groups is continuing and future directions include potential for patient education as part of the NCP.

24.

One fine day for paediatric pharmacists – A time and motion study

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Aim: To quantify the time spent on clinical, administrative and other activites by pharmacists working in a tertiary paediatric hospital and to identify potential strategies to improve efficiency.

Methods: An observer observed and documented participating pharmacists' inpatient activities in paediatric surgical, medical, oncology and critical care wards. The data collection form was adapted from the 'NHS Institute for Innovation and Improvement – A Productive Ward Releasing Time to Care' activity follow sheet. Descriptive statistical analysis was performed to summarize and contrast time spending patterns.

Results: A total of 3821 minutes of pharmacists' activities were observed between the hours of 9:00am and 4:00pm over a 9-day observation period. Overall, pharmacists spent 62.9% of observed time on clinical tasks, 12.8% on administration tasks and 24.3% on other tasks. Surgical pharmacists spent the most time on clinical activities whereas oncology and critical care pharmacists spent more time on administrative activities. Direct care time was mostly spent on medication chart reviews. 'Walking' time is strongly related to the co-locations of wards serviced by the same pharmacists and their proximities to pharmacy department. Medical pharmacists spend noticeable amount of time 'looking' for misplaced charts which reduced their efficiency.

Conclusion: The study pharmacists spent similar proportion of work hours in clinical tasks as those who work in adult hospitals. Assistants/technicians' support in administrative tasks allow pharmacists to focus on clinical tasks. Team-based model of care, satellite pharmacy, electronic prescribing and reliable internal courier system (i.e. Lamson tubes) may improve pharmacists' efficiency by reducing unnecessary motion time.

25.

TeamUp educational intervention: Development of an educational resource for educators to teach teamwork skills

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The aim of this educational project is to develop one section of a suite of teaching and learning resources to assist educators to develop the graduate attribute of learning and working collaboratively, or teamwork skills, in their students. This educational project is part of a larger research project called 'TeamUp Teachers'. Students need teamwork skills to work within multidisciplinary healthcare teams. Teachers need resources and specific education to facilitate the development of students' learning to work effectively and collaboratively in teams.

The educational resource will consist of a self-paced online learning module. The module sub-title or theme is called 'Facilitating the Contributions of Others'. The expected benefit of this educational resource is that teacher training could lead to increased educator knowledge and an improvement of the teaching and learning of teamwork skills for students undertaking tertiary education.

If teachers are provided with innovative research based resources they will be better able to teach students how to work effectively in teams during their educational experiences within higher education and this should assist with students obtaining the desired graduate attributes.

26.

Sensory sensitivities in children with feeding difficulties: An interdisciplinary team approach

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Background: Feeding difficulties occur when a child is unable or unwilling to eat an age-appropriate range or volume of food, often as a result of poorly developed feeding skills. Speech pathologists and occupational therapists bring differing perspectives into the clinical management of these children. Traditionally, speech pathologists play a primary role in assessing and treating oral motor skills for feeding, while occupational therapists direct assessment and treatment of sensory processing difficulties.

Aims: This study aimed to investigate: (a) the proportion of children with feeding difficulties that presented with sensory sensitivities, and (b) the extent to which any sensory sensitivities were associated with severity of feeding difficulties.

Methods: Cross-sectional data were collected over a 12-month period from children attending an outpatient feeding clinic. Data on 72 children aged 3-6 years with feeding difficulties (36 children with autism spectrum disorder and 36 non-medically complex children) are reported. Parents completed the *Sensory Profile*, as well as the *Behavioural Paediatric Feeding Assessment Scale* and the *Children's Picky Eating Questionnaire*.

Results: Over 80% of children attending the feeding clinic presented with either probable or definite sensory differences. There were no significant differences between the sensory profiles of the autism spectrum disorder group and the non-medically complex group, with the majority of children showing some sensory difference in the areas of tactile, olfactory, and gustatory input, as well as visual and auditory input, sensory responsiveness, and body tone. Across the whole group, the degree of sensory sensitivity was positively correlated with the degree of feeding difficulty ($p \leftarrow 0.05$).

Conclusion: A large proportion of children with feeding difficulties have sensory sensitivities. Sensory sensitivities compound the complexity of feeding problems and justify the need for multi-disciplinary allied health input for this population. These findings highlight the key role of both speech pathologists and occupational therapists in this caseload.

27.

Motivating new graduate professional learning: Pilot of a clinical learning framework

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Background: In 2012 the Statewide Occupational Therapy Clinical Education Program within Queensland Health commenced a research project exploring the extent to which the Occupational Therapy Clinical Learning Framework (OT CLF) supported the clinical learning and professional development for new graduate occupational therapists (OT's). The OTCLF provides a process to support new graduate learning aimed at strengthening their contribution to the healthcare of the facility. The framework enables the development of learning objectives, learning strategies and promotes the discussion of, and engagement in, actions enabling clinical learning and professional development within a continuous review cycle.

Aim: The OTCLF promotes independent learning, reflective practice and a planned approach to utilising professional learning resources available for newly graduated professionals. The presentation will report on the outcomes of the research project.

Methods and Results: The perspectives of new graduates, their clinical supervisors and their local Clinical Eduction Support Officers (CESO) informed the research outcomes. Qualitative data outcomes from pre and post pilot surveys will be presented alongside discussion of literature findings examining the benefits and challenges of post graduate professional learning strategies and frameworks. Preliminary results indicate the OTCLF successfully supports new graduate engagement in professional learning actions as well as the potential utility of the OT CLF for a diverse range of allied health practitioners across a range of healthcare settings. Areas requiring further investigation will be proposed.

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28.

Motivating learning and innovation with assistive technology for people with progressive neurological diseases

Janet Mostovoy, Orla Foster, Rosanne Gibb, Melissa Fromer

Calvary Health Care Bethlehem, Caulfield

With the rapidly growing number of assistive technologies available for people living with Progressive Neurological Diseases such as Motor Neurone Disease, it is challenging for even the most established clinical team to keep informed and updated about the full range of technology options available to support this patient cohort.

Calvary Health Care Bethlehem is a level 5 State-wide provider of service and support for people living with Progressive Neurological Diseases (PND). As a specialist provider, use of integrated technologies is a core component of clinical practice. A service gap was identified whereby the specialist service was lacking both a clinical leader to provide education and coordination of assistive technologies, and access to an appropriate environmental setting that facilitated innovative integration (e.g. environmental control units, scanners used with powered wheelchairs and electronic communication devices).

To address this service gap, the integrated assistive technology project was commenced with the following aims:

- creation of a coordinator of Integrated Technologies for a 6 months trial period to support the team with learning current and new technologies that aim to assist people with PND with limited mobility, communication issues and lack of access to their environment
- development of an allied health assistive technology room was designed to foster learning and innovation, increase knowledge across the team, and enhance interdisciplinary and inter-organisational practice.

The following will be discussed in relation to the integrated assistive technology project:

- the challenges of addressing the ever changing needs of people with PND and their families in a timely manner.
- presentation of survey results identifying variability of knowledge and experience amongst clinical team; and the education sessions that followed
- outline the development of the integrated assistive technology room, highlighting challenges and innovative outcomes
- discuss development of inclusive interdisciplinary work practice resulting in motivating and educating staff in the field of assistive technology
- provide clinical examples of successful integrated assistive technologies through case studies.

29.

Queensland physiotherapy placement collaborative and the Queensland central allocation process

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[6] Bond University, Faculty of Health Science and Medicine, Bond University, QLD
[7] Royal Children's Hospital, Physiotherapy Department, Herston, QLD
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It is well recognised and accepted within the Queensland physiotherapy profession that the responsibility for provision of student clinical education should be a shared one, with tertiary education institutions and placement providers acting in a partnership. To facilitate this, the Queensland Physiotherapy Placement Collaborative (QPPC) was established in 2008 (originally termed the Physiotherapy Clinical Education Placement Working Party) with representative membership from the Universities' Schools of Physiotherapy and the Queensland public health system. The role of the QPPC is to ensure that Queensland public health system physiotherapy services work towards providing a sustainable capacity for quality placements for pre-entry physiotherapy students, and that these placements are provided to Queensland universities in a fair, efficient way, to optimise clinical education opportunities.

A key achievement of the QPPC is the development and implementation of the Queensland Central Allocation Process (CAP) as a strategy for the allocation of physiotherapy clinical placements within the Queensland public health system. The QPPC provides oversight of the CAP and facilitates communication between the physiotherapy services and the Universities regarding these placements, as well as managing and reporting on the current state of Physiotherapy placement capacity and demand at any point in time. This has resulted in a coordinated, equitable and collaborative approach to building sustainable physiotherapy student placement capacity and quality across the state.

Since the inaugural CAP meeting in 2008, each year has seen the implementation and refinement of the:

- processes around managing supply and demand
- evaluation and reporting of quality data relating to clinical placements to continually build capacity and refine the CAP methodology
- principles and procedures of placement allocation
- role of Queensland Physiotherapy Placement and Development Coordinator.

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30.

A 3D virtual medical imaging CT suite: Innovation in education

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Aims: The Medical Imaging Training Immersive Environment (MITIE) Computed Tomography (CT) system is an innovative virtual reality (VR) platform that allows students to practice a range of CT techniques. The aim of this pilot study was to harvest user feedback about the educational value of the application and inform future pedagogical development. This presentation explores the use of this technology for skills training and blurring the boundaries between academic learning and clinical skills training.

Background: MITIE CT is a 3D VR environment that allows students to position a patient and, - set CT technical parameters including IV contrast dose and dose rate. As with VR initiatives in other health disciplines (1-6) the software mimics clinical practice as much as possible and uses 3D technology to enhance immersion and realism. The software is new and was developed by the Medical Imaging Course Team at a provider University with funding from a Health Workforce Australia 'Simulated Learning Environments' grant.

Methods: Current third year medical imaging students were provided with additional 1 hour MITIE laboratory tutorials and student feedback was collated with regard to educational value and performance. Ethical approval for the project was provided by the university ethics panel.

Results: This presentation provides qualitative analysis of student perceptions relating to satisfaction, usability and educational value. Students reported high levels of satisfaction and both feedback and assessment results confirmed the application's significance as a pre-clinical training tool. There was a clear emerging theme that MITIE could be a useful learning tool that students could access to consolidate their clinical learning, either on campus or during their clinical placement.

Conclusion: Student feedback indicates that MITIE CT has a valuable role to play in the clinical skills training for medical imaging students both in the academic and the clinical environment. Future work will establish a framework for an appropriate supporting pedagogy that can cross the boundary between the two environments.

31.

Better prepared, better placement: An online resource to prepare allied health students and their supervisors for clinical placement

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Better Prepared, Better Placement is a multidisciplinary online resource comprising a suite of innovative tools including self-assessments, guides, surveys, a template for individual learning plans, and video, audio and second life scenarios. The resource is designed to help prepare allied health students and their supervisors for placements.

This paper will present the development and evaluation of the resource. In the first phase of the project, an online survey and a series of interviews and focus groups were conducted with third and fourth year students and their supervisors to find out how well they felt they had been prepared for previous placements and to identify strengths and deficiencies in their preparation. Findings from this phase of the project, and an extensive literature review, informed the development of the resource.

In the second phase of the project the resource was piloted in five health disciplines (nursing, occupational therapy, clinical exercise physiology, osteopathy and midwifery), each in two host organisations. The resource was evaluated using Kirkpatrick's evaluation model. According to our participants, the resource was instrumental in preparing students and supervisors for placement: students and supervisors got to know each other, students learned about where they were going, clarified their learning goals, and set realistic strategies for achieving them. Supervisors learned about their students' level of skills and knowledge, about their assessment requirements, and used the resource for their own professional development. The resource could be further developed and adapted for a particular focus (e.g. aged care or interdisciplinary placements). This paper summarises key findings from the evaluation data and presents a snapshot of the resource.

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32.

Development and trial of a 12-month multidisciplinary clinical measurements graduate training framework

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Summary:

- educate using a multidisciplinary framework.
- motivate new graduates with the opportunity of a generalist role.
- innovate our service to improve workforce sustainability and operational flexibility.
- celebrate the potential application of this training.

Introduction/background: 'Clinical Measurements' at the Townsville Hospital refers to scientists in the cardiac, respiratory, sleep and neurophysiology disciplines. Entry to the profession is via an undergraduate human sciences degree and on-the-job training. Traditionally, single discipline training occurs after entering the workforce with some regional facilities having clinicians skilled in a second discipline. The innovation of this framework lies in skilling clinicians across all four clinical measurement disciplines.

Objective: Develop and trial a generalist, graduate training framework to support sustainable regional clinical measurement services.

Ideas for discussion: The 12-month framework, trialled by two graduates in 2012, included four 10-week single discipline training blocks and one 8-week multidisciplinary block. Success was measured by the trainee's ability to support relief in core business services. One aspect of evaluation included: (1) trainer's perception of trainee clinical competence; and (2) trainee's self-reported confidence for providing base-level clinical service relief, measured on a five-point Likert scale. Qualitative data were also collected.

Results: Quantitative data showed the training model increased graduate's capability, competence and confidence to enable core-business service relief. Qualitative data demonstrated comprehensive and complementary clinical learnings across the four disciplines.

Discussion: Utilising the 12-month framework, graduates developed skills across a range of base-level investigations. An unexpected benefit was the trainee's ability to support core business relief for non-complex patients. The scope of relief varied with each discipline. A graduate generalist role may be applicable to all regional clinical measurement services enabling workforce sustainability and increased operational flexibility.

Conclusions: A multidisciplinary graduate training framework is a viable option to support regional clinical measurement services within the respiratory, cardiac, neurophysiology and sleep sciences.

33.

Challenges faced in developing a validated satisfaction survey for students completing nutrition and dietetics (N&D) clinical placements

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Introduction/background: The assessment of student perceptions of clinical placements is fundamental to the provision of quality educational experiences, particularly in the current environment of increasing demand for placements and limited resources. (Roberts et al., 2009; Rodger et al., 2008)

Purpose/Objective: To discuss the challenges that arose in the development of a single, validated electronic student satisfaction survey for use across a wide range of Queensland Health hospitals providing N&D placements to students.

Issues/Questions for exploration or ideas for discussion: Issues associated with the development of this validated survey, such as confidentiality, recruitment and other considerations within the context of a state-wide program with multiple sites and limited resources, will be the focus of the presentation.

Results: The survey was implemented in 2012 and the initial reports distributed to clinical educators in participating sites. The results from this survey will form the subject of a subsequent paper.

Conclusion: A validated tool was developed for measuring student satisfaction within N&D student placement sites across Queensland. Since this tool has potential applicability to alternate sites and professions, the lessons learnt in this process may be useful to other health professionals.

34.

Kickstarting your research: A one-day workshop for aspiring practitioner researchers

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Background: Research capacity building initiatives are being implemented in Australia, the UK and elsewhere to strengthen the evidence base for allied health. Practitioners find the prospect of conducting research to be unnerving where there is not a strong research culture and this may prevent or delay research capacity building. There are very few practical examples of how to initially engage practitioners in research, demystify the research process and develop research literacy.

HPResearchNQ is a team of four research fellows, appointed to increase health practitioner research capacity in northern Queensland. This paper describes the Kick-starting Your Research workshops instigated by two of the HPResearchNQ research fellows.

Methods: A baseline survey of research capacity was conducted to assess research experience and need for support in research activities, confidence in conducting research and perceived barriers and enablers to conducting research. The results informed the choice of workshop topics. The research fellows developed a one-day workshop focusing on turning an interest in a topic into a research question, an introduction to literature searching and research design. The methods were a mixture of didactic presentations, small group work, guest speakers, group discussion and independent work. The workshop structure provided the scaffolding for each participant to develop a research question and design a research project on a topic relevant to practice. Each workshop was evaluated using a questionnaire based on five evaluation criteria.

Results: Four Kick-starting Your Research workshops have been conducted. The workshop plan, course materials, resources and examples of research questions developed by participants will be presented. A total of 40 allied health staff participated in the workshops. Response to the workshops was positive. Participants reported the workshop was relevant, stimulated interest, increased understanding, was of practical use and would be recommended to others. Three funding bids were developed as a direct consequence of the workshops.

35.

An interprofessional education program for allied health new graduates

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This project established an education program to support the professional development of allied health graduates in their first year of clinical practice. As it is the largest health service in metropolitan Melbourne, it is important Monash Health provide a program to meet the needs of the allied health new graduate workforce.

The strategy to develop this program included a lead project role and an advisory group that comprised of representatives from allied health teams across bed based, community and mental health services. Focus groups were conducted with departmental and team managers and the allied health executive team was also engaged to support this initiative.

Recent new graduates and their clinical supervisors were invited to participate in surveys for the program. The survey results showed 67% of supervisors felt graduates are 'somewhat well prepared' and 17% felt graduates are 'very well prepared' for clinical practice. Compared to 65% of new graduates, 53% of supervisors felt graduates work 'quite well' in an interdisciplinary team. When asked if a graduate program would be beneficial to them, 95% of supervisors reported the program would be 'extremely' or 'quite' beneficial, compared to 43% of graduates who felt the program would be 'extremely' or 'quite beneficial'. Majority (47%) of graduates reported the program would be 'somewhat beneficial'.

Feedback from key stakeholders was collated to design the program and create behavioural learning objectives to meet needs specific to new graduates. These learning objectives reflect Monash Health's capability framework. The resultant blended education program comprises of interprofessional face to face learning, online learning, self-directed learning and reflective practice.

This project illustrates the processes by which an interprofessional education program can deliver professional development specific to allied health new graduates, that is aligned with organisational objectives and stakeholder requirements.

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37.

Innovative approaches to clinical education in evolve therapeutic services

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[2] Occupational Therapy Student, University of Queensland, St Lucia, QLD

Background: The increasing numbers of students enrolling in occupational therapy courses has precipitated the need for innovative clinical placement approaches to build placement capacity and manage the demand for placements. Developing placements in specialised community services can be challenging and calls for novel approaches to ensure the clinical care undertaken by students is appropriate to their level of expertise whilst supporting their clinical learning. A project placement approach was undertaken within Evolve Therapeutic Services (ETS) Toowoomba that provides therapeutic and behaviour support need of children and young people in the care of the Department of Child Safety Services. This placement provided significant learning opportunities for occupational therapy students whilst contributing to service evaluation and resource development.

Aims: This poster will report on the process of implementing a professional practice placement with a project focus at Evolve Therapeutic Services Toowoomba, highlighting the contribution of an occupational therapy student to benchmarking, team engagement and resource development.

Outcomes: Required outcomes of the placement included a literature review, completion of site visits to other ETS and mental health services in SE QLD and support to the clinical team on the implementation of sensory processing strategies for client care. This student placement has provided the ETS Toowoomba with a collation of resource material on sensory processing, approaches being utilised in other areas and the opportunity to consider the potential contribution of future students through similar placement models. Verbal feedback from both the student and members of the ETS Toowoomba multidisciplinary team indicated benefits of the project placement model to the student, ETS Toowoomba and clients and their carers.

Contribution to field: This presentation will highlight resources compiled by an occupational therapy student on clinical placement for the implementation of sensory processing in the context of ETS Toowoomba service delivery. The contribution made by this student highlights the potential benefits of project placements for teams with complex client needs.

38.

Can involvement in a store badging program increase engagement of indigenous youth?

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Opportunities for education and employment in remote indigenous communities in Cape York are limited, and resultantly contribute to the many healthy inequities of these populations today. Students are often sent away to boarding school for secondary education, however only 9% of Aboriginal and Torres Strait Islander people in Cape York achieve year 12 or equivalent schooling. The Alternative Secondary Pathways (ASP) program provides education opportunities for students who return prematurely to community from boarding school. An opportunity for these students to participate in the implementation of a 'Healthy Choices' badging project was negotiated with the local supermarket; with the long term view of work experience. A nutrition tour was provided to the ASP students as part of the 'Healthy Choices' badging project.

The store tour aimed to increase nutrition knowledge and develop the personal skills of the ASP students through their participation in the badging. Based on the supermarket tour concept, the 'Store Walk'n'Talk' was designed as a 30- minute guided walk around the store during which basic nutrition education, products badging rationale and practical skills for product badging were shared with students. The tour was based on the constructs of Bandura's Social Cognitive Theory (SCT) to accommodate for the kinaesthetic and visual learning styles of the target group. Several key findings from the trial were identified — optimum tour length, group size (i.e. no more than 5 students) and support from teachers (i.e. at least one teacher/teacher aide participating). The general format of the walk should include ice-breaker games, nutrition education provided in 5 minutes theory blocks followed by hands-on activities, and conclude with a summary of key nutrition messages. Findings identified in this trial are proposed for use in the design of other education activities for this target group.

39.

Mealtimes on the oncology ward: Identifying opportunities to Eat, Walk and Engage

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Eat, Walk and Engage (EWE) is an interdisciplinary program to prevent deconditioning, delirium, and malnutrition in older people. This program has been implemented in a medical ward at Royal Brisbane and Women's Hospital (RBWH) and is yet to be implemented in oncology, where malnutrition rates are high and mealtime assistance needs are unknown. The aim of this study was to observe nutritional intake and mealtime care of oncology inpatients to inform design of innovative mealtime strategies for EWE.

Six meals (two breakfasts, lunches and dinners) were observed by two dietitians for 45 minutes. A total of 131 observations were conducted, after excluding patients who were nil by mouth (n=20), palliative (n=3), away from the ward (n=5) or where beds were empty (n=21). Data was collected on patient positioning for meals, need for assistance, assistance received and proportion of meal consumed, which was estimated by visually estimating plate waste.

Almost half of all patients ate ↖50% of their meal. Eating meals out of bed may influence nutritional intake, as only 19% of people sitting out of bed had poor intake compared with 53% of those lying in bed (p←0.01). No patients needed full feeding assistance, but 64 patients (49%) required set-up assistance (e.g. opening packages, and positioning of meal trays). 78% of patients received the mealtime assistance they required. Assistance was most frequently provided by nurses (61% of the time), followed by other staff (31%) and visitors (8%).

These observations suggest that half of our oncology patients eat poorly while in hospital, and a large proportion require mealtime assistance. The results have facilitated implementation of EWE by celebrating areas of good mealtime care and highlighting opportunities for improvement, which has led to the introduction of shared dining areas on the ward and innovative mealtime training for staff at the patient bed-side.

40.

Supervision, Training and Readiness (STAR) Program; an interdisciplinary approach to building clinical supervision capacity

Philippa James, Grainne O'Loughlin

St Vincent's Hospital, Darlinghurst, NSW

St Vincent's Hospital Sydney received funding from Health Workforce Australia (HWA) to expand clinical supervision capacity and competency. The Supervision, Training and Readiness (STAR) Program, which embraces the theme of this year's conference **'Educate, Motivate, Innovate, Celebrate'**, was developed, implemented and evaluated for its effectiveness in meeting these deliverables.

The STAR program collaboratively ***educates*** staff from Allied Health, Medicine and Nursing in theoretical and practical aspects of clinical supervision through a series of education modules and educational activities. These educational topics and activities were identified and developed from recurrent themes that arose from a literature search, and a widely circulated online survey of supervisee's experiences and perceptions of clinical supervision.

The STAR program ***motivates*** experienced clinical supervisors by enhancing their existing skills enabling them to reflect and develop their knowledge and abilities in an interprofessional forum. It also inspires and motivates new supervisors by using educational activities that foster collaborative discussion, confidence building and exploration of the challenges that are faced. The program also identifies strategies that can be utilised effectively in practice.

The STAR Program ***innovates*** the training of clinical supervisors with an interprofessional approach that utilises ***innovative*** educational activities and resources including scenarios, vignettes, reflective practice, role-playing, group discussion/presentation and simulation.

Research shows that this ***innovative*** and collaborative approach to building competent Clinical Supervisors improves clinical outcomes for patients and contributes to a proficient and sustainable health workforce by increasing staff satisfaction, well-being and retention.

The outstanding efforts of our clinical supervisors will be recognised and ***celebrated*** through a yearly award, a positive, supportive organisational culture and structured peer mentoring groups.

We will describe the research and design of the program, the implementation process, the obstacles we faced, what we did well, how it was delivered and the evaluative data sets, thus demonstrating how interprofessional clinical supervision and educational collaboration of the disciplines can succeed.

Comprehensive evaluations of the STAR Program, including session content, ability to apply in practice and perceptions of self-efficacy pre and post the course are being conducted and these results will be available in full for the presentation.

41.

Clinical placements in a telesupervision model: Student and educators' views

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Background: Telesupervision, using an established telehealth system, has potential to increase capacity for work-based learning in rural and regional placements. This study aimed to determine student and clinical educator views on placement experiences provided within a telesupervision model.
Summary of work: Students from physiotherapy and speech pathology were remotely supervised for one session per week using eHAB®, a videoconferencing system, while on placement in a regional town in Queensland, Australia and three sessions in a rural setting. Two on-site and two remote clinical educators shared the student supervision. All participants were interviewed following the placements to seek their views on the delivery of telesupervision. Interviews were transcribed verbatim and inductive content analysis was undertaken to establish themes.

Summary of results: Themes identified in this study included the user-friendliness, comfort and accessibility of the eHAB® equipment, connectivity issues, acceptance of the modality by all participants and patients, and the need for additional communication between remote and on site supervisors.

Conclusions: Participants reported that telesupervision had potential for expansion of student placements and increased support for graduates in rural and remote areas. Improvements in the applications of eHAB® were suggested.

Take-home messages: Telesupervision is accepted by students, clinical educators and patients. Communication between on site and remote educators is essential to facilitate student learning.

42.

Growing a simulated learning framework for paediatric allied health

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Aims: To develop an innovative strategy to deliver SLEs (Simulated Learning Environment) in paediatric allied health (AH) curriculums across Queensland.

Background: Educational approaches within universities are disconnected from clinical environments particularly in paediatrics, where use of "representative" children poses ethical dilemas. E-learning and simulation provide solutions with potential to exceed traditional approaches if developed according to best practice. Guidelines for ensuring effective design and delivery of e-learning environments and simulation have been well described. Barriers to uptake of these methodologies of education include lack of adequate training, technical support and understanding of SLE.

Method: Using an action research methodology, literature reviews were conducted to establish best practice in development of e-learning, simulation and adult learning principles. Core paediatric principles(CPP) and key clinical experiences(KCE) were identified based on curriculum content, professional standards/competencies for graduates across three university campuses and professions (physiotherapy, speech pathology and occupational therapy). Progressive case studies (including medical notes/imaging/investigations, socio-cultural issues) were developed based on commonly encountered paediatric cases that demonstrated theoretical principles, and applied to e-learning and simulation. Educators modified scenarios for discipline specific and interdisciplinary simulation.

Results: Uptake has occurred across 3 universities within 11 curricula, with increased involvement of clinical experts ensuring current evidence based experiential learning. E-learning case studies blended seamlessly with simulation to 'scaffold' learning. To date, 100% of scheduled students have completed the e-learning package and directly participated in simulation using multiple low fidelity-high realism mannequins and one high fidelity mannequin.

Conclusions: No simulation had previously been used within paediatric AH curricula. Framework provided by this model has provided the necessary support to improve paediatric exposure and engagement. Synchronous use of a targeted e-learning package with simulation provides an ideal platform for learning CPP and providing KCE. It is an effective and innovative model of andragogy which melds clinical expertise with educational requirements.

This program is supported by HWA

43.

Are we there yet? A journey towards clinical governance in rural and remote allied health

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In 2011, responding to complex workforce and service issues confronting the organisation, and to ameliorate a 'very flat structure' for allied health professionals (AHPs), Country Health SA Local Health Network (CHSALHN) developed an AHP clinical governance structure (AHPCGS). While the evidence to support clinical governance as a tool to deliver quality improvement in healthcare is equivocal (predominantly originating from medicine), there is a limited evidence base for clinical governance for allied health in rural and remote contexts. So the development of the AHPCGS was informed by the available evidence, and significantly shaped through iterative development, consultation, refinement and Executive approval (or disapproval!) cycles spanning an 18-month period.

The final approved structure involved creation of Advanced Clinical Lead and Clinical Senior roles in each profession, the establishment of an AHP Clinical Governance Committee, and a range of other systems and processes. The structure aimed to facilitate the implementation of a new Clinical Support Framework and Policy; provide profession specific clinical leadership and governance; improve the quality and safety of services; and improve the retention, recruitment and support of AHPs.

The next challenge was to design an evaluation framework to determine if the structure was making a difference. Following a review of the literature, and in partnership with the International Centre for Allied Health Evidence (iCAHE), CHSALHN arrived at a mixed methods, realist, iterative approach to the evaluation that ran for the first 18 months of structure implementation. Evaluation tools included an on-line clinical supervision survey, focus groups, semi-structured interviews, and collection of a range of quantitative and qualitative data against a Structure-Process-Outcomes framework.

A brief description of the AHPCGS and Evaluation framework will be presented, along with evaluation results. The authors will highlight the major challenges and critical success factors, and seek to answer the question, 'are we there yet?'

44.

Interdisciplinary persistent pain management program – A twelve month review

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Introduction: Group programs have been established as one treatment option for clients with chronic disease. The use of an interdisciplinary approach is strongly supported in the literature to effectively treat persistent pain conditions. The National Strategy for Persistent Pain recommends access to interdisciplinary group programs as a key treatment strategy. The Gold Coast Interdisciplinary Persistent Pain Centre's eight week Pain Management Program (PMP) aims to increase the use of active self-management strategies, including exercise, activity pacing, activity adaptation, cognitive strategies, and understanding of persistent pain.

Objective: To review combined client evaluation and outcomes from the Pain Management Programs completed in 2012 at the Gold Coast Interdisciplinary Persistent Pain Centre.

Method: Data was collected from clients at commencement of the program, conclusion of the program, one-month and three-months post group completion. Clients completed evaluation questionnaires at program conclusion. In addition to demographic and clinical characteristics, outcome measures included the Pain Self Efficacy Scale, Pain Catastrophising Scale, Tampa Scale of Kinesiophobia, Pain Stages of Change Questionnaire, and the Depression and Anxiety Scale (DASS).

Results: Six Pain Management Programs were completed in 2012. Forty-two clients commenced the program, however three programs did not complete a three-month follow up, impacting full data collection. Baseline, program completion, and one-month follow up data was collected from 20 clients, with three-month follow-up data only available for 13 clients. Descriptive data of demographic and clinical characteristics, program evaluation, as well as from each outcome measure, will be presented for these 20 clients.

Practice Implications: Results from the outcome measures and evaluation will be reflected upon, and used to revise program content if required. Suitability of each outcome measure will also be explored. A quality of life outcome measure is required to ensure self-management strategies are positively impacting on overall life skills. Inconsistent follow up at one and three-month post group completion impacted on data collection, and may indicate a need for individual follow up and data collection.

45.

The disappearing waiting list: Improving access to services through complete service redesign

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The impacts of delayed access to assessment and treatment in paediatric speech pathology can be stressful for the child and their family, and frustrating for the clinicians who battle lengthy waiting lists and resort to the provision of limited therapy services as a demand management strategy. The benefits of accessing intervention early in life have been well documented, but how do you facilitate this when the demand for service exceeds the capacity of existing staffing?

Long affected by recruitment and retention difficulties, the speech pathology department at Tamworth Community Health Service adopted a caseload management model designed to improve client flow from intake to discharge, cut waiting times for assessment and therapy, and deliver family-centred intervention to all clients. The model known as ESSENCe, necessitated the complete re-design of service provision across the entire client journey and a shift in the way therapy services were delivered. The challenges and the inner workings of the model will be the focus of this paper.

Extensive planning and ongoing re design of the model was required to ensure it aligned with the needs of the community, the capacity of the department, and the values of the local health district. ESSENCe now offers clients and their families a more flexible service with fewer barriers to accessing the service, and no limit on the amount of therapy that can be received.

Trialling the model proved successful with a substantial reduction in waiting times for both assessment and therapy appointments. The real challenge of this process was in the continual restructuring of ESSENCe in order to maintain and improve its capacity as a caseload management model and develop an optimal service design.

46.

Innovation in service models for eating disorders in child and youth mental health

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Anorexia Nervosa (AN) and restrictive eating disorders present a significant burden of disease within the Australian Community with AN having the highest mortality rate of all psychiatric disorders. Family Based Treatment for Adolescent Anorexia Nervosa (FBT) has the best evidence worldwide for successful treatment outcome and sustained recovery.

In October 2012, The Children Health Services District established a specialised weekly clinic to provide FBT for community based treatment of AN. Multidisciplinary staff with a background in family therapy were trained in FBT. The aim was to develop a specialist service targeted at a high risk and resource-intensive population.

Prior to establishing the clinic in this form Family Based Treatment was provided at three separate community clinics. The intention of establishing a single clinic was to facilitate greater access to supervision and increase model fidelity, increase the capacity of the service, enhance the sense of team cohesion and increase the overall number of referrals.

The presentation will consider the innovations required to move from a disparate 'as needed' service to an established specialist clinic. Benefits to date include greater team cohesion and multidisciplinary support in this high risk work; increased opportunities to provide education and training on treating AN; improved continuity of care for patients and increased rates of referrals for FBT. Challenges included establishing a clinic with no budget; sustaining the clinic through staff and greater organisational changes; supporting patients and families to adjust to changes; and working within the confines of a one day clinic. The specialist clinic is now well-established and continues to grow and develop with further innovations on the horizon.

47.

Improving the care of the elderly through an oral health education program for nursing staff

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Aims:

- Investigate the effectiveness of nursing staff education on the oral health of patients admitted under Geriatrics to the Aged Care Ward and Medical Assessment Unit (MAU) of St Vincent's Hospital Darlinghurst (SVH)
- Highlight the importance of a multidisciplinary approach to the management of oral care

Methods: The study took place on the Geriatrics Unit and MAU. Nursing staff were surveyed pre-education to ascertain their knowledge of oral care. The information from the survey was used to develop an education package delivered to nursing staff. Nursing staff then completed a post-survey to re assess their knowledge and give them an opportunity to evaluate the education. To determine whether the education could potentially have an impact on oral health patients admitted under geriatrics also underwent a screening of their oral health pre- and post-education.

Results: The post-education survey results indicate that the majority of nursing staff educated felt the education was useful and that it should be done on an annual basis. The number of nursing staff educated was not as high as originally intended, which has implications for delivery of this type of education in the future.

There were no significant differences on the scores on the oral health screening tool which was administered to the cohort of patients on admission.

Conclusions:

- The nursing staff who completed the education found it valuable and a majority thought it should be completed annually.
- Some of the barriers to delivering the education included:
  - timetabling of education sessions to fit in with the existing nursing education timetable
  - capturing nursing staff that had changed from day shift to night shift
  - the investigators timeline for the project.

The type of education provided and method of delivery would need to be reviewed if the project were to be replicated.

- The literature supports the use of the oral health screening tool in residential care facilities. This project has shown that the tool can be used in an acute setting to assess oral health. Therefore, there is potential for nursing staff to be trained in using a similar tool to assess the oral health of their patients.
- There is scope within the study plan to develop an e-learning tool, with the aim of making the education available to all nursing staff at St Vincent's Hospital.

48.

Governance Framework for professional Practice in Allied Health

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The purpose of the *Governance Framework for Professional Practice in Allied Health* is to ensure that care is provided by appropriately qualified Allied Health Practitioners (AHPs) and Allied Health Assistants (AHAs) who perform at an appropriate level for quality and safety. Allied Health Professionals are constituted by a range of registered and non-registered (self-regulated) health professions.

The governance framework is being developed by Monash Health in partnership with the Victorian Department of Health as a statewide framework and incorporates credentialing and scope of practice processes, work place competencies and capabilities, and the supervision requirements to support the framework's implementation and ongoing functioning of the framework.

Credentialing is the process of verification and evaluation of the qualifications, experience, professional standards and professional attributes of a health practitioner. Scope of Practice continues on from credentialing and determines the type of work that the AHP or AHA may safely undertake based on what they are educated, authorised or competent to perform.

'Advanced' and 'Extended' roles move the AHP beyond the core practices of the discipline to take on more challenging and often substituted/delegated roles within the health workforce. Advanced and Extended scope roles may require further training in addition to significant professional experience and competency development.

Competencies provide a basis for verification of clinical competence using competence-based training and assessment processes. A competency framework provides a focus on the knowledge and skills needed to support clinical competence for clinical practices as well as Advanced or Extended roles and translation of skills across occupational groups.

Capabilities specify the expected behaviours and attributes of AHPs as they progress through grading structures. They reflect the expanding sphere of influence and control expected of individuals of a higher grading. This ensures consistency of expectation across grading's and disciplines and provides a basis for performance development plans and position descriptions.

The role of supervision underpins the success of many of these elements in supporting safe practice. During this process, professional governance of the AHP is monitored and reviewed.

The *Governance Framework for Professional Practice in Allied Health* will ensure the future growth and advancement of a contemporary Allied Health Workforce as an integral part of the patient care workforce.

49.

Leisure therapy – A new service in the Queensland spinal injuries unit

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Leisure Therapy (LT) involves the application of recreational and experiential interventions that assist in maintaining or improving the health status, functional capabilities, and the quality of life of patients in the Spinal Injuries Unit (SIU).

Commencing in October 2011 and funded until June 2014, the LT position is part of the National Health Partnerships initiative. Various data collection methods have indicated the following in terms of service delivery outcomes:

- 113 referrals have been received from members of the multidisciplinary team in the past 14 months
- 66% of referrals have been received within the first month of patients' SIU admissions (27% within first week)
- average of 136 occasions of patient service occurring each month
- 70% of patients have at least 2 leisure-specific goals recorded in their individual rehabilitation goal plan
- LT position has assisted with the re-establishment of patients' identities, has enhanced cultural connections for patients, has been strongly linked to the goal setting process in the SIU and has had a positive impact on patient adjustment to injury
- patients' reported levels of participation in desired leisure activities on admission are an average of 2.4/10 with repeat scoring on discharge indicating a considerable increase to an average of 6.8/10
- levels of patient satisfaction with LT services sit at an average of 8.6/10
- qualitative data collection has further indicated positive results.

To date, the implementation of the LT position has been successful. An ongoing goal is to complete a research project titled *'Leisure Therapy in the SIU – Using Goal Attainment as a Measure of Service Delivery Outcomes during Rehabilitation'* which commenced in February 2013. Preliminary findings will assess the performance and satisfaction with attainment of leisure-specific goals using the Modified Canadian Occupational Performance Measure. Possible future research aims would also include linking with the Transitional Rehabilitation and Spinal Outreach Programs to review leisure participation for SIU patients post discharge.

50.

Challenging risk appetite in allied health

Deb Mitchell, Kerry May, Fiona McAlinden

Monash Health, Clayton, VIC

From 2012, the Monash Health Allied Health (AH) executive noted feedback from medical and nursing staff that 'Allied Health hold up discharge'. Examples were cited where a patient was medically ready to be discharged but AH staff disputed the patient's discharge as 'unsafe" resulting in conflict in the multidisciplinary team.

The concept of a series of 'Appetite for risk' presentations was developed to challenge the concepts of 'safe for discharge' and the perception that patients are safer in hospital than at home, and to motivate AH staff to rethink patient discharge. They aligned with the Monash Health priority of meeting the four hour emergency department target. The presentations focussed on the concepts of risk appetite and perception, and drew on evidence of the risks for patients of being at home compared to in hospital, and research into patient falls.

When discharge planning, it encouraged AH staff to:

- place the patient at the centre of their own care and decision making
- have conversations about their clinical reasoning with the multidisciplinary team
- if in doubt or disagreement – escalate to a more experienced clinician.

We began working toward a change in language — instead of 'Safe for discharge' we asked clinicians to document 'Ready for discharge as per team decision' and what they had seen the patient do and what activities the patient needed to be able to do at home.

The presentation was delivered to the AH managers and staff at four Monash Health sites and was successful in encouraging conversation around risk appetite between AH clinicians. AH clinicians highlighted examples of changes that were needed in other areas of the health service as impediments to patient flow.

Work is also underway in other areas of the organisation to clarify role expectations in discharge decision-making.

51.

Developing an interdisciplinary model of care in rehabilitation and aged care services: New building, new opportunities

Fiona McAlinden, Michelle O'Rourke

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This presentation discusses the unique journey of allied health in the development of an interdisciplinary model of care within the rehabilitation and aged care services in Monash Health.*

In 2011- 2012, Monash Health, Kingston Centre, underwent a major redevelopment which offered the opportunity to redesign the model of care offered to patients in the rehabilitation setting.

Medical, nursing and allied health staff joined together to examine the model of care with the aim of supporting the highest standard of sub acute care delivery to allow patients to achieve their highest level of function in the most effective, efficient and personalised way.

The four objectives set were to develop:

- strong organisational and frontline interdisciplinary leadership
- high performing interdisciplinary teams to deliver patient centred care
- service configurations to support safe, high quality and cost effective care that makes the best use of available resources
- sustainable and ongoing service improvement
- an extensive collaborative change process commenced
- allied health staffing were reconfigured across all units to best meet patient needs
- workforce profiles and capabilities were examined
- leadership groups consisting of medical, nursing and allied health were formed on each unit
- the executive team and all of the leadership team members underwent an assessment and learning centre process to identify strengths and opportunities to leverage performance improvements
- multiple processes were redesigned to improve efficiencies and patient flow
- twelve months on we are evaluating our experiences and improvements.

* Monash Health was formerly known as Southern Health

52.

Knowledge exchange, primary health care and allied health - The role of the primary health care research and information service

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PHC RIS, Discipline of General Practice, Flinders University, Adelaide, SA

Knowledge Exchange (KE) is a process that aims to get research knowledge into action; knowledge is translated into either decision-making or practice settings. KE involves synthesis, exchange, and application of knowledge by relevant stakeholders to accelerate benefits of global and local innovation to strengthen health systems and improve people's health (WHO, 2005). This presentation outlines innovative ways a KE organisation, the Primary Health Care Research and Information Service (PHC RIS), operates.

PHC RIS works in partnership with stakeholders in the PHC sector to inform and influence policy, practice, research and evaluation. It offers a diverse range of online products, developed according to stakeholders' needs, which promote knowledge exchange. Resources provided by PHC RIS relevant to allied health include: 1) the PHC Search Filter enabling quick and easy access to PHC literature using real-time searches of PubMed; 2) weekly (eBulletin) and bi-monthly (Infonet) newsletters delivering the latest PHC research, reports, news and opportunities; 3) Infobytes to introduce topics and build capacity; 4) the Roadmap of Australian PHC Research (ROAR) providing information about research projects and researchers; and 5) synthesised research reports (short RESEARCH ROUNDups and longer Policy Issue Reviews) addressing topical policy matters.

Evidence of uptake and benefit is provided, with emphasis on the value of KE tools for educating, motivating and innovating professionals working in primary health care.

53.

Clinical supervision models used in allied health at a regional health service

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Introduction: Health services are facing an unprecedented demand for clinical placements. Students require quality clinical placements so they can contextualise their tertiary learning within clinical care settings. The ability to provide quality clinical placements in an environment of rapidly increasing demand requires careful thought and planning. This study aimed to investigate and inform clinical supervision models used in dietetics, physiotherapy, occupational therapy, social work, speech pathology and podiatry departments at a large regional health service.

Methods: A rapid review of the literature was conducted using electronic databases and manual search of studies published from January 2005 until March 2013. In addition qualitative data was collected by interviewing key stakeholders to profile current student supervision models in place.

Results: The review of the literature identified 21 articles that met the inclusion criteria. The literature supports increasing the number of students per supervisor. This promotes peer learning, reduces the number of supervision hours per student and increases the productivity of the placement. Six interviews were conducted to profile supervision models used. The one student to one supervisor ratio remains the dominant supervision model for the allied health disciplines represented. The one student to two supervisors model is the next most frequent model used and allows part-time staff and smaller departments to be involved in student supervision.

Conclusion: The traditional one student to one supervisor model of supervision remains dominant in this regional health service. This is not sustainable. Alternative models of supervision should be encouraged and supported to meet increasing demand and ensure the quality of clinical placements. Whichever approach is utilised, preparation and time are required to ensure a successful placement. A clinical educator could be considered to facilitate and support this process.

54.

Problem Based Learning – The real life experience

Kerstin McPherson

Charles Sturt University, Leeds Parade, Orange

The Problem Based Learning approach was introduced to the new curriculum of the physiotherapy program at Charles Sturt University in 2010 to the Albury and newly established Orange campus.

Within the physiotherapy program the PBL approach is designed to teach content in a way to that allows students to work in small groups to solve clinical problems and professional dilemmas within clinical cases. It involves a tutor whose role is to facilitate rather than teach and it also allows the students within their groups to gain confidence in communicating ideas and concepts, to justify their clinical reasoning ideas, and to gain skills in professionalism and reflective practice.

Over the last three years the approach to how cases are developed and delivered has been developed and progressed and scaffolded for complexity. The assessments within the subjects have been also scaffolded from content specific to authentic case based written and practical examinations.

The problem based learning approach has great potential in postgraduate education with students across disciples exploring clinical and professional issues and with new technology with online tutorials, such as wiki, enhancing access to professional development for allied health professionals in rural and metropolitan locations.

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55.

Eat Walk Engage: Working together for better care of elders

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Aim: Older hospitalised patients are vulnerable to complications such as delirium, de-conditioning, falls and malnutrition. These common interrelated conditions are predictors of poor outcomes, including increased dependency and longer length of stay. Eat Walk Engage aimed to support adequate nutritional intake, promote early exercise and ambulation, and provide orientation and cognitive stimulation, in order to enhance functional recovery and reduce complications.

Method: This ward-based quality improvement intervention was undertaken on a general medical ward over a 15 month period at Royal Brisbane and Women's Hospital in order to improve processes of care and outcomes for acute medical patients aged 65 and older. Two experienced project leaders (a physician and physiotherapist) worked with the interdisciplinary team to identify and implement strategies to support the aims, while adopting an integrated approach to care. Implementation included engagement of local allied health champions, cyclical measurement and feedback on care processes, identification of barriers and solutions, interdisciplinary education sessions and an innovative multi-professional allied health assistant (AHA) role. Data sources included nursing documentation, patient report, observation, and routine reporting of falls and length of stay.

Results: Sequential audits of observation and patient-reported feedback showed sustained improvements in nursing documentation, patient mobility levels and availability of cognitive activities. The proportion of patients having walked recently increased from 63% to 100%, while bedside availability of cognitive activities increased from 27% to 60%. There was no increase in falls events and a 3 day reduction in length of stay was observed.

Conclusions and implications for practice: This holistic approach to care shows promise for improving a range of care processes and outcomes. Important elements included strong allied health engagement and leadership, collaborative problem solving and explicit systems for task assignment and delegation.

56.

What is the evidence around how to best support new graduates?

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Aim: This project aims to report on an approach to new graduate support within an Occupational Therapy department of a tertiary teaching hospital informed by appraisal of literature evidence.

Method: Literature was reviewed with the aim of investigating the most effective way to support new graduate occupational therapists to acquire professional skills for proficient practice. Comparison of the current practice of support and that recommended by the literature was undertaken. The department's new graduate support program was modified to translate the new evidence into practice.

Results: The following seven themes emerged from the literature:

1) the importance of supervision/ mentoring for new graduates
2) more than clinical care skills are required for new graduate development
3) a time of transition and stress during the first year of practice
4) the importance of peer support for new graduates
5) the importance of feedback for new graduates
6) the need for role clarity
7) the need for ongoing professional development.

The findings from the literature identified the need for changes to the existing program. These were then compared to what support the department was currently providing new graduates. Changes were then made to the program to incorporate the themes identified. One of the primary changes was holding more frequent new graduate meetings with an emphasis on peer group supervision and peer feedback. These meetings provide one hour of supervision to all first and second year new graduates in the department, therefore reducing the amount of supervision time required of clinical supervisors.

Conclusions: The revised approach to new graduate support reduced the amount of supervision time required by new graduate clinical supervisors with positive feedback on how the approach supported the professional learning of the graduates. It is currently being trialled for a second year with a formal evaluation planned following a two year trial.

57.

Design of a quality improvement framework to revolutionise quality in a busy occupational therapy department

Katherine O'Shea, Jenny Nel

Assistant Director, Occupational Therapy Department, Gold Coast Hospital & Health Service, Gold Coast

Introduction: Queensland Health 2011 reports that 'optimal healthcare will be achieved through a system that promotes safety and quality as the key drivers' for the delivery of optimum healthcare. The OT Department at Gold Coast Hospital and Health Services identified a need to change the way quality was coordinated, delivered and evaluated. An audit of Quality Activities within the department identified the following key issues included: fluctuating accountability, a lack of consistency and coordination of quality projects, nil evaluation of outcomes, repetition of topics, and a lack of collaboration between sites.

In the move towards becoming a tertiary facility, the OT Department has identified a need to change and be innovative in the way quality outcomes are achieved. It is also paramount in the current economic environment to demonstrate outcomes through service reporting on KPIs and consistent auditing.

Objectives: This presentation explores an innovative quality management framework:

- to present a new framework that improved the clinical governance and changed the quality culture of an Occupational Therapy service
- to demonstrate the efficacy of the framework in producing quality evaluated projects

Methodology: The Quality Improvement Framework will be explored.

Change Management processes that were successfully implemented will also be reported on.

Results: The Quality Improvement Framework presents an innovative and effective method to coordinate the quality initiatives of a busy and complex OT Department. These strategies have revolutionised the management of quality projects and enabled a strong and coordinated direction for quality improvement and evaluation of clinical effectiveness.

58.

Discovering Performance Skills for Motorised Mobility Scooter Use

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Motorised mobility scooters ('scooters') enable people with mobility difficulties to engage in community participation, however scooter use has lead to many accidents resulting in injury or death to the user and others. At present there are few assessments available to screen people for scooter use. Additionally, formal assessment is not required prior to commencement of scooter use. Thirty participants were sourced from the occupational therapy course at Edith Cowan University, using convenience sampling. Due to the experimental design, participants were required to have knowledge of performance skills. Participants drove two models of scooter (three and four wheel models) around a course designed by the researchers to simulate community based scooter driving tasks. Following the completion of the course on both models of scooter, participants rated the frequency of their performance skill use on a survey. Data were analysed using SPSS statistical software. This study identified performance skills required to drive a scooter, which provides guidance for allied health practitioners. The results will be presented relating to the implications for occupational therapy practice; with emphasis on which performance skills are used more frequently when operating a scooter. These results should be distributed widely to educate allied health practitioners about the multiple facets of scooter use that must be continuously reviewed with clients considering scooter use. This study is the first contribution toward innovation of practice in this area. Further research could lead to the development of a performance skills based screening tool specific to scooter use. A screening tool would be particularly useful for clinical reasoning for clinicians who have limited time and funding available to conduct the current motorised mobility assessments. This innovative screening will assist clients and their families to make informed decisions regarding responsible scooter use.

59.

Your online colleague—Evidence-based subject guides

Christopher R. Parker

The Prince Charles Hospital Library, Qld

We are all aware of the importance of evidence-based practice, but most clinical practitioners do not have the appropriate information searching skills (ie. the skills of a medical librarian) to adequately search the literature for new and updated clinical information. There have been many studies that show that the first place a clinician goes to for information is another (normally trusted) colleague.

The Prince Charles Hospital Library has long recognised the need to provide evidence-based information to support clinical practice—and this has been done by providing Literature Searches to clinicians when they have asked for a search. Recognising that waiting for a question from clinicians is of limited value, we created subject speciality guides that provide the busy clinician with single click completed and continuously updated literature searches that are evidenced-based—using the pyramid of evidence (Systematic Reviews, RCTs, Clinical Trials and Guidelines). Created by medical librarians, each topic has a minimum of 40 completed literature searches using the Ovid and PubMed versions of Medline.

These searches are available to health professionals throughout the world—making them a valuable resource for keeping clinicians current in evidence-based practice without them needing to have the specialist searching skills of a medical librarian. As an added bonus, the guides are also mobile device ready. At the time of writing, 12 clinically focussed specialist guides have been created—more are in the pipeline. They can be found at: <http://tpch.qld.libguides.com>.

60.

Innovation: Working in partnerships to provide perinatal mental health treatment and support to families in rural communities

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The National Perinatal Depression Initiative has recently identified the scarcity of care models for perinatal mental health in Australia. Additionally the challenge of implementing such models in rural and remote communities has been highlighted to exist due to a lack of services within these communities.

Following recommendations from this initiative a partnership was formed between the New England Medicare Local, Tamworth NSW and St John of God, Sydney NSW. This partnership, called the Early Years Outreach Clinic provided a perinatal mental health service to rural families that previously had limited access. Based on The National Perinatal Depression Initiative guidelines for best practice Phase One of the EYOC model involved scoping local needs, building partnerships with existing local services, increasing access to specialised services, providing specialised education and supervision, clarifying care pathways and developing community support groups.

Following positive feedback from health professionals regarding Phase One, Phase Two of the model has been implemented into other rural and remote communities in need of additional perinatal mental health services. In accordance with the guidelines, Phase Two will aim to educate and support professionals to work interprofessionally and use contemporary approaches to care pathways through the utilisation of telehealth. Additionally, culturally appropriate services will need to be considered in rural and remote communities with larger Aboriginal populations.

The overall aim of Phase Two is to fill the gap for models in perinatal mental health, particularly in rural communities. It is expected that the model will be implemented and then become self-supporting within the community with some ongoing support from specialised services. Key stages of the development and implementation of the model will be highlighted for both phases with the intention for the model to be easily adaptable to a variety of rural and remote communities requiring specialised perinatal mental healthcare.

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61.

Education model for palliative care: An interdisciplinary approach

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Patients who are receiving 'end of life' care in an acute hospital benefit from a holistic, multidisciplinary approach that addresses: control of symptoms, psychological, social and spiritual concerns providing opportunity for a 'good death'. Specialised patient focused palliative care reduces the risk of existential concerns for patients around impending death and elevated psychological, physiological distress and complicated grief for the bereaved family after death. Research highlights the complex clinical, ethical and legal issues that arise in 'end of life' care, highlighting the integral role that the multidisciplinary team (MDT) has in ensuring a palliative approach is implemented in a timely way. Integrating such approaches into everyday practice across clinical settings can be a challenge for MDTs. Specialised education and training is required to champion the palliative approach within acute settings which raises awareness and benefits for clients and their family.

An interdisciplinary education model in palliative care was trialled at Royal Brisbane and Women's Hospital (RBWH) in 2012. This was a collaborative partnership between social work and the RBWH palliative care team to raise awareness of the palliative care approach in MDTs through a series of five workshops delivered over a one year period. As an innovative approach it provided opportunity to share practice wisdom, upskill in areas including; communication skills, legal documentation, facilitating family meetings, advocacy and liaising with external services to ensure continuity of care as well as examining the best evidence for practice. Social workers, nursing and other allied health staff attended these workshops. Initial evaluation of the program indicated that attendees felt motivated to continue education in this speciality area, follow up evaluation is planned.

It is anticipated that this model can be applied within a MDT context in all clinical settings to motivate staff to recognise patients and families needs and respond appropriately, utilising best practice model.

62.

Patients' experiences of receiving an allied health professional skill sharing model of care: A qualitative study

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A randomised control trial (RCT) was undertaken in the Mackay Hospital and Health Service to establish the clinical and cost effectiveness of an Allied Health (AH) skill sharing model of practice. A qualitative research study was carried out alongside the RCT to elicit patients' experiences of receiving healthcare, including both conventional AH care and the AH skill sharing model. The research question was: what are patients' experiences of contact with the health system?

A cohort of 16 patients, participating in the broader study, were interviewed using individual, in-depth interviews in which they shared their thoughts and experiences about the care they received. Interviews were conducted in patients' homes and timeframes ranged from 45 minutes to 1 ¾ hours. Theoretical sampling was used to recruit patients with particular experiences, characteristics and health criteria who could contribute to an in-depth understanding of patient experiences with the health system. Sampling was considered to be complete when saturation of themes was reached. Ten participants were female and 6 were male (mean age 74.9, range 66-92yrs). Four participants had acute and 12 had chronic conditions, with 9 participants living in rural locations and 7 urban.

The analysis used a grounded theory approach which involved transcribing interviews, open coding, selective coding, identification of key themes and writing an interpretive account of patient experience, using quotes from patients as evidence. The main themes that emerged were:

1. communication with individuals in the health system
2. participation in decision making and care planning
3. holistic care
4. personal agency
5. being stuck in the system.

This presentation will describe the grounded theory methods used and outline the findings of the study. Findings highlight patients' high expectations of healthcare services and the central importance of interpersonal communication and relationship with the health practitioner to patients' assessment of quality healthcare.

63.

Hunter Medicare Local - Delivering multidisciplinary education to meet local health providers needs

Aimee Prosser, Rick Naylor, Lisa Craig

Hunter Medicare Local, Newcastle, NSW

The Hunter Medicare Local was established in July 2011 and we have actively sought individual members from all allied health disciplines. By engaging at an individual practice level, through local discipline support groups, and via local area focus groups, we identified a number of allied health professional issues. These included: reduced understanding of others' roles, GPs not understanding what allied health do, desire for local CPD, and a need for multidisciplinary education.

The Hunter Medicare Local also undertook local health needs surveys, determining our regions' most prevalent chronic conditions, as well as the populations' health behaviours and service use. From the local intelligence gathered, it was determined that we could best meet members needs by providing local multidisciplinary education, based on the most prevalent health issues in each area. We would like to share what we have learnt and talk about the education model we have developed.

During May to July 2013, we have conducted 3 multidisciplinary dinners where GPs, Pharmacy, Podiatry, Dietetics, Exercise Physiology, Occupational Therapy, Physiotherapy, Chiropractors and Psychology each presented. Presenters were provided with a case study and each discipline had 4-5 mins to discuss their role with this patient. This increased awareness of what each profession offers, promoting cross referrals, and strengthening local networks. We have had a tremendous response to these events with 139 participants attending from 15 different disciplines.

Participants and presenters reported the evenings were extremely valuable from both an educational and networking perspective. Outcomes and lessons learnt from this series of multidisciplinary evenings will now be applied with varying case study topics throughout the year, forming part of the Medicare Locals ongoing education calendar.

64.

Client-Led Visual Goal-Setting in a Sub-Acute Rehabilitation Unit

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Metro South Hospital and Health Services, Queensland, Centre for Neuroscience, Recovery and Mental Health, Diamantina Health Partners

Involving a client in goal formulation, planning and decision making increases the potential for active engagement in the rehabilitation process. The purpose of this study was to change the goal setting process in a sub-acute rehabilitation unit from a clinician driven approach to a collaborative, clinician assisted approach using innovative techniques to integrate personally negotiated goals. Traditional goal setting methods were adapted for this population due to cognitive and communicative changes.

Method: Structured qualitative interviews were conducted with clients from a sub-acute rehabilitation unit for acquired brain injury and mental health disorders to ascertain their levels of motivation to engage in rehabilitation. The Satisfaction With Life Scale (SWLS) was administered. The Activity and Participation domains from the World Health Organisation's International Classification of Functioning were used as a basis for client-led, clinician assisted goal formulation. An individualised visual goal map was developed with the client's input which was the basis for rehabilitation interventions. Interviews and the SWLS were re-administered two weeks after the visual goal maps were in place.

Results: Clients reported increased motivation after the goal setting method was changed. Recall of goals improved and there was increased engagement in the rehabilitation process. Clients reported they felt more empowered and satisfied.

Conclusions: Innovative collaborative goal setting can integrate personal identity into rehabilitation and can result in greater motivation and engagement. This model of delivery reflects the needs of the clients rather than clinicians. The use of visual goal setting in a sub-acute rehabilitation unit with clients with cognitive and communication impairments was successful in increasing active participation. Clients felt empowered rather than passive and were able to lead the rehabilitation process to meet their individual goals.

65.

Video-Based Telehealth: Current and potential use of videoconsultation by allied health professionals

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Primary Health Care Research & Information Service, Flinders University, Adelaide SA

Many Australians have limited access to healthcare because of barriers including geographic distance and restricted mobility. Telehealth is recognised worldwide as an important approach to reducing access inequalities. Video-based telehealth (videoconsultation, a form of videoconferencing) seems particularly useful and appropriate for the Australian geography and healthcare system, and it is being used innovatively by allied health professionals (AHPs). This paper reviews its use and its evidence base.

Despite a substantial literature on videoconsultation, there is relatively little published research about its use by AHPs. Most research has focused on medical specialist consultations, particularly between specialists in tertiary hospitals and doctors in regional hospitals. The evidence for AHP videoconsultation is sparser and weaker, often focusing on feasibility and/or performance of technologies (e.g. commercial videoconferencing systems, with or without peripheral devices), or validation of video-based assessment compared with established face-to-face assessment. Outcome measures are often limited to patient and/or health professional satisfaction.
Few studies have rigorously investigated clinical effectiveness, and even fewer have investigated cost-effectiveness. Evidence has generally been limited by short follow-up periods and reliance on surrogate outcomes (e.g. blood glucose levels rather than diabetes complications). Other methodological problems include small sample sizes, non-randomisation and lack of control groups/conditions. There is better evidence for some AHPs (e.g. speech pathologists) than others (e.g. chiropractors).

Overall, studies have revealed few significant differences compared with face-to-face consultations. Patient satisfaction has been relatively high. There is some evidence of cost savings, particularly for patients and their families. Practical problems identified include prohibitive equipment costs and inadequate internet bandwidth, but new technologies and infrastructure are improving feasibility and affordability.

Videoconsultation is generally intended to improve access, not replace face-to-face consultation across the board. Consequently, despite the weak evidence base, there are grounds for optimism about the potential value of AHP videoconsultation, particularly in rural/remote regions.

66.

Students' attitudes towards working with older people – The Placement Rotation in Aged Care (PRAC) Project

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Core to clinical work in the health sector is the care of older people. As Australia's population continues to age, rising levels of disability, chronic illness, dementia and mental illness in older people presents significant challenges to quality healthcare. Moreover, the negative image of older people and of aged care has been found to be a major obstacle in attracting healthcare personnel. In the allied health professions this is highlighted by the reluctance of students to seek field placements in aged care.

Funded by Health Workforce Australia as part of the Queensland Regional Training Network (QRTN) Clinical Innovation initiative, Social Work Services at Royal Brisbane and Women's Hospital (RBWH) are trialling a clinical rotational model for final year social work students in aged care across both acute and subacute clinical settings. Students have been purposively selected for the trial with key selection criteria specific to the placement requirements. Outcomes from this placement model focus on knowledge, skills and the development of positive attitudes towards working with older people. It is expected that engaging with older people in acute and subacute clinical settings, and participation in a specially designed curriculum for learning about ageing, will increase students' positive attitudes towards older people.

A research study using a mixed methods approach examines students' attitudes both prior to and at the conclusion of the field placement to determine whether the placement experience makes a difference to their attitudes towards older people. This consists of a pre-test post-test attitudinal questionnaire, content analysis of a reflective writing task and in-depth interviews undertaken at the close of the placement. Findings from this study will inform the future delivery of clinical education in aged care and contribute to discussions about equipping emerging clinicians to work in the sector as a viable employment option.

67.

Adults with disabilities – A cross sector collaboration

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Adults with disabilities under the age of 65 years in acute hospital settings who are unable to return to their previous living situation often face complex discharges involving systems (health, disability and aged care) interface issues resulting in extended length of hospital stay. At Royal Brisbane and Women's Hospital, a large tertiary hospital, this is a diverse patient group dispersed across the hospital, with a range of medical conditions and disabilities. To reduce length of extended stay for this group an articulated Pathway was established in 2009 as a collaborative between the hospital and Disability Services which identified these patients as a single cohort and monitored patients' discharge planning processes and discharge outcomes. To inform clinical improvement, a descriptive research study commenced in 2012, examining the nature of this patient group, and the social and economic factors contributing to their extended length of stay. Phase 1 involved an analysis of a clinical data set (N=80: Pathway data from 2009–2012) and qualitative data from interviews with clinicians involved with this patient group are currently being analysed.

The Federal reforms resulted in further collaboration between the hospital and Disability Services in 2012 with the development of a cross sector Systems Interface Protocol (including patient discharge pathways; raising awareness at both the clinical and strategic organisational levels through data reporting, and cross sector case conferencing and escalation processes). Through the Metro North Hospital and Health Service (MNHHS) SEED Innovation funding this is currently being trialled across the MNHHS involving 4 acute hospitals (RBWH, The Prince Charles Hospital, Redcliffe and Caboolture Hospitals), the local Aged Care Assessment Team and Disability Service offices (North Coast and Brisbane regions). This project will complete in June 2013 and success and sustainability of this innovation and lessons learnt will be outlined in this presentation.

68.

Celebrate collaboration! Implementation of new standardised parenteral nutrition formulas in a tertiary paediatric hospital

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Background: Existing standard paediatric parenteral nutrition (PN) formulations in the hospital have not been updated for many years and no longer comply with the latest international standards set by the American Society of Parenteral and Enteral Nutrition (ASPEN). Frequent modifications were required to meet the patients' clinical status which has led to significant wastage and cost to the healthcare system.

Aim: To describe the collaborative work among pharmacy, medical, nursing and dietetic professionals in the development and implementation of new standardised paediatric parenteral nutrition (PN) formulas in a children's hospital.

Method: A multidisciplinary working party was formed to investigate and develop new PN formulas by literature review, patient review, discussion with benchmarking hospitals, and internal consultation.

Results: New formulas were developed with increased macronutrients (amino acid and carbohydrate). The micronutrient contents were also rationalised. The final formulas are more chemically and physically stable and suitable for the dynamic needs of the PN patient. The new solutions were rolled out in July 2012 and since then, a total of 244 patients have received the new PN formula. There was a marked reduction in the number of modifications required to these new standard solutions.

Conclusion: This venture demonstated the advantage of a multidisciplinary approach in improving patient safety and quality of care.

69.

Engaging our workforce early

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Aims: This presentation aims to report on a consumer and professional engagement strategy to inform high school students and their teachers/counsellors of the depth and breadth of allied health professions. It will highlight the benefits of an allied healthcareers forum as a creative and engaging alternative to providing work experience placements for high school students.

Content: Metro South Hospital and Health Service (MSHHS) hosts an annual allied healthcareers forum for high school students. The forum increases awareness of the allied health professions, profiles the professions and training requirements and importantly provides students with insight into what life as a professional entails. The event supports the Health Service consumer engagement strategy and enables prioritisation of university student placements over high school work experience programs.

The Allied Healthcareers Forum has been running for 4 years. In 2013 this event was attended by 400 high school students and 50 school representatives from 36 schools within the geographical boundaries of MSHHS. In addition, 7 higher education institutes (e.g. TAFE and universities) plus 1 organisation that links schools and industry, School Community Industry Partnerships (SCIPS), hosted stalls at the event. The high school students engage with 18 different allied health professions in one place at one time and have the unique opportunity to speak directly with both clinicians and university students. The half-day forum includes brief presentations and interactive stalls for each profession, and stalls for each tertiary institution.

Evaluations and informal feedback from Allied Health Executive, Clinical Educators, clinical staff, schools and higher education institutes indicate the positive impact of the event in informing school leavers of careers in allied health. Attendees from schools reported gaining a better understanding of allied health professions and their training pathways.

Continued evaluation of this forum ensures that MSHHS continue to engage and attract the future allied health workforce early.

70.

Supporting allied health professionals to contribute to better patient outcomes through an interprofessional capability development framework

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Aims: This presentation will outline the development, implementation and evaluation of an allied health capability development framework within a health service.

Content: Capability refers to the skills, knowledge and attitudes that each person brings to their work. While clinical capabilities are critical, the importance of non-clinical capabilities such as leadership, team work and strategic thinking are critical to success as a health professional. Ongoing learning linked with these capabilities is essential to ensure contemporary practice and skill refinement to meet the needs of our patients, the organisation and career goals. Whilst work level statements existed in the Health Service and a capability framework was previously developed, they did not clearly identify the interprofessional expectations required of health professionals at each role level. To this end, Metro South Hospital and Health Service developed an interprofessional capability development framework to clearly articulate expectations of allied health staff at various levels of employment.

The capability development framework includes expectations at various levels and learning and development opportunities to support achievement of these capabilities. It:

- promotes consistency of skills, knowledge and attitudes across practice areas, facilities and professions
- facilitates quality patient care
- supports staff, managers and supervisors to understand and describe expectations, and
- provides a career development pathway.

The development of the framework included extensive consultation and literature review. The framework was then disseminated widely with support mechanisms to assist implementation. An evaluation strategy was also developed.

Critical success factors for the development and implementation of the framework included extensive consultation, a comprehensive communication and marketing strategy, and user friendly and practical tools for implementation.

Clearly defined capabilities and expectations for allied health professionals, with aligned learning and development opportunities, helps to establish a workforce that is best placed to achieve best patient outcomes.

71.

QH Spirometry Training Program – Promoting lung health in Queensland

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Introduction: Queensland Health (QH) has developed an accessible, high quality spirometry training program for health professionals including allied health, addressing the inequitable access to spirometry education that meets international recommendations. Spirometry is the best objective and repeatable test for diagnosis and assessment of COPD and asthma. COPD affects about one in seven Australians over 40 and is the second leading cause of avoidable hospital admissions. Early diagnosis and management of COPD has shown to improve quality of life, slow progression of the disease and keep people out of hospital, thus reducing costs to the public and private health sectors. Limited access to respiratory services, in all but metropolitan and larger regional health services, has resulted in poor, if any, quality spirometry practice across the state.

Evaluation: The Spirometry Training Program, comprising an Australia-first online learning component (OLC) and a practical workshop component (PWC), has been evaluated by 60 health professionals in six pilot workshops across SEQ. Participants reported significant improvements in confidence after training in all aspects of spirometry practice ($p \rightarrow 0.0001$; test performance, interpretation of results, equipment quality assurance) and high satisfaction (97% of participants) for program structure and content. Competency is awarded after the completion of a Workplace Portfolio Assessment (WPA)**.**

Sustainability: The Spirometry Training Program competencies have been mapped to the Industry Skills Council Spirometry Unit of Competency and as such the program will be delivered through a registered training organisation. Flexible delivery options and processes for endorsing trainers from regional, rural and remote areas will enable access to training across the state and nationally.

Conclusion: An innovative spirometry-training program for health professionals is ready for statewide implementation. Strategies for sustainable and equitable access to training have been developed, potentially leading to improvements in patient care through quality spirometry practice.

72.

High Risk Foot training in rural Western Australia: Making a difference

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Combined Universities Centre for Rural Health, University of Western Australia, Geraldton WA

Aim: To deliver multidisciplinary high risk foot workshops to educate and determine high risk foot knowledge, attitude and practice of health professionals in the Midwest and Pilbara of Western Australia (WA).

Method: Sixteen Multidisciplinary high risk foot workshops were delivered between June 2012 and February 2013 in the Midwest and Pilbara regions of WA. Participants were trained in High Risk Foot assessment, the 2011 National Health and Medical Research Council Guidelines (NHMRC Guidelines) on Prevention, Identification and Management of Foot Complications and use of the MMEx Diabetes Foot Check with a risk calculator. A knowledge, attitude and practice survey was completed at the beginning and end of each workshop with the TurningPoint® audience response system. This innovative system integrates with Microsoft® PowerPoint® presentations and allowed participants to enter survey responses on hand held keypads. The results are quickly translated into charts or graphs to provide instant feedback to the participants and presenter.

Results: A total of 143 health professionals (84.6% female and 11.9% Aboriginal people) were trained in 13 towns in WA. In the pre-test, only 15% correctly stratified a person as intermediate risk when there was one foot risk factor compared to 48% in the post test. Only 19% in the pre-test correctly stratified a person as high risk when there were two foot risk factors present compared to 62% in the post test.

Discussion: A significant change was demonstrated in participating health practitioners' ability to correctly stratify foot risk according to the 2011 NHMRC guidelines. The TurningPoint® audience response system is a useful and engaging means to assess increases in participants' knowledge as a result of education.

73.

Evaluating inpatients' satisfaction with allied health services: A series of surveys at a rehabilitation centre

Kate Roberts
Hampstead Rehabilitation Centre, Northfield, SA

Aims: Patient satisfaction is an integral component of rehabilitation. The evaluation of patient satisfaction is an important outcome in its own right and needs to be measured formally. The aim of this study was to determine inpatients' levels of satisfaction with the physiotherapy, occupational therapy, physical education, social work and speech pathology services at one rehabilitation centre.

Methods: A series of 5 prospective observational studies were performed over a 4 year period from 2009-2012. 273 inpatients completed purpose designed surveys. Analyses were mainly descriptive in nature.

Findings: High levels of satisfaction with all the allied health services were reported for the common themes identified in each survey; namely the quality and access to the service and the interpersonal relationships between the allied health staff and the patients. Responses were not significantly influenced by demographic characteristics.

Conclusions: These findings confirm that a high standard of allied health services are provided to inpatients at the rehabilitation centre studied. The survey was relatively straightforward to conduct and has demonstrated that the services are effective from the patients' perspective. Importantly, it has identified areas where each service can be improved. These findings will be of interest to other providers of allied health rehabilitation services who wish to evaluate their patients' levels of satisfaction. Future research using a qualitative approach may be worthwhile to enable a more in-depth understanding of factors influencing patient satisfaction.

74.

A journey in self management and sustainability for communication impaired stroke survivors

Susan Scholtz

The Community Based Rehabilitation Team, Queensland Health, Metro North, aims to improve people's wellbeing, independence, and quality of life. It has an additional goal to empower clients to work towards self-management of their health condition. In late 2011 and early 2012, Queensland Health funded a pilot Stroke Self Management Program – *Dream, Believe, Achieve* - developed by the National Stroke Foundation. Stroke survivors with communication disability are often perceived as unsuitable for self-management programs. This program and a group facilitated by the Speech Pathologist and an Allied Health Assistant from the Caboolture Community Based Rehabilitation Team (February and March, 2012) challenged this concept. Two volunteer facilitators, who had had strokes themselves, and nine stroke survivors met over an eight week period as detailed in the *Dream, Believe, Achieve* self management program. The volunteers and stroke survivors all had a communication disability ranging from moderate to severe aphasia and dyspraxia. At the end of the eight weeks, the stroke survivors had a goal to meet on a monthly basis for ongoing support. A coffee group was organised and is still running 15 months later. This paper discusses the concepts behind the stroke self-management program, the process this group underwent and the communication challenges faced while facilitating the program. It further explores the sustainability and transfer of skills by the group members and the journey of those both during the program and to this day.

75.

Exploring the impact of mealtime assistance and interruptions on nutritional intake of vascular surgical inpatients

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Poor nutritional intake during hospital admission is common and has many contributing factors. Eat Walk Engage (EWE) is an innovative, interdisciplinary program to address malnutrition (alongside deconditioning and delirium) in older people at Royal Brisbane and Women's Hospital. The aim of this study was to identify factors associated with poor nutritional intake of vascular surgical patients to inform implementation of nutritional strategies for EWE.

Patients on the 23-bed vascular ward were observed by two dietitians over six meals (two breakfasts, lunches and dinners). Patients were excluded if nil by mouth (n=14), away from the ward (n=4) or where beds were empty (n=14), resulting in a total of 106 patient observations. Data were collected on patient positioning for meals, need for assistance, assistance received and nutritional intake, which was estimated by visually estimating plate waste. Patients were classified as having 'poor' intake (↖50% of their meal) or 'good' intake (→50%). Bivariate comparisons were made using Fisher's exact x^2 tests.

Over a third of patients (37%) had poor intake. Significantly more of these patients needed mealtime assistance compared with those with good intake (46% vs. 20%, p←0.01). Overall, high levels of mealtime assistance were observed (94% received the assistance they required), and spare meal packs for fasting/absent patients were used appropriately. Mealtime interruptions were frequent (36%) although no difference was observed in the frequency between those with poor and good intake (32% vs 36%, p=0.67). Patients who ate meals in bed had a higher frequency of poor oral intake than those sitting in a chair (41% vs 29%, p=0.26).

This study confirms that a high proportion of vascular surgical patients have poor nutritional intake despite receiving adequate mealtime support. Mealtime interruptions were frequent and mealtime positioning was a factor affecting intake. EWE strategies will need to be tailored to address these barriers.

76.

Developing an interprofessional curriculum from the ground up - The process

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Aim of presentation: This presentation aims to describe one University's approach to developing an interprofessional curriculum across health and social disciplines.

Content: A parallel approach with academics, clinicians and students has been taken in developing an interprofessional curriculum at James Cook University (JCU). The drivers for change were the development of a partnership between JCU and the Medicare Local to provide a neurological community rehabilitation service, and the new Clinical Practice Building in the health precinct at JCU that will provide a variety of clinical experiences, including interprofessional placements.

An initial search of the literature was followed by a workshop with University and community staff to establish a model suitable to for all disciplines involved. An Interprofessional Education (IPE) Working Group has also been established to support cultural change within the University. A standing agenda item on IPE on the Faculty Teaching and Learning committee will ensure the process for implementing the curriculum is accepted and agreed by the Faculty.

Action research is being used to establish the readiness of the University's clinical staff, academics and students for IPE and to provide the basis for development initiatives. An analysis of early year health and social care students, clinicians has been conducted (using surveys and focus groups). Students' attitudes regarding IPE are also being evaluated pre- and post clinical placement, in both uniprofessional and interprofessional settings. Preliminary data from early year students (N = 525) surveyed using the RIPL survey, indicates a high degree of readiness to engage in IPL. Across all three subscales, students appeared to recognise the benefits of IPL and collaboration. At present, where students are already involved in work integrated learning, both students (N=26) and staff (N=8) have been uniformly positive about aspects of interprofessional learning and practice.

The development of the curriculum is still in progress.

77.

An investigation into the enablers and barriers to physiotherapy clinical placements within Queensland's public health system

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In 2010/11 the Queensland Health and Mater Health Services Brisbane (QH&MHSB) Physiotherapy Placement Collaborative successfully submitted a proposal for Health Workforce Australia Clinical Training Funds (HWA CTF). These funds were intended to support growth in clinical training capacity for physiotherapy students for the years 2011-2013. This coincided with an expected substantial growth in university requirements for clinical placements, particularly with the initial cohort of students from the Australian Catholic University requiring placements in 2013.

Two project officers were employed from January 2012 for a period of six months to establish the potential capacity for growth in clinical placement provision in QH&MHSB for 2013. The main objectives of this project were to:

1. investigate and analyse the enablers and barriers to the provision of physiotherapy clinical placements
2. establish what facilities and services across the state could offer additional physiotherapy placements in 2013.

The objectives were met through a process of state-wide consultation with stakeholders and the results are outlined below.

- Enablers and Barriers: Investigation and analysis of the key enablers and barriers to clinical education placement provision has highlighted a number of trends across the state. Top enablers to providing placements were having an appropriate number and desirable varieties of patients using a suitable student to educator ratio. Top barriers were: lack of availability of appropriate staff to perform educator roles, lack of non-clinical space, lack of clinical space, lack of resources and lack of available workload. Other notable trends were that extra resourcing would most likely help provide extra placements in metropolitan areas; and that accommodation and travel were also key barriers to the provision of placements in regional, rural and remote areas.
- Placement growth: At the completion of the project in June 2012 it was estimated that, without the provision of additional resourcing, there would be a 22% growth in placement offers compared to the number of placements offered in 2012.

This presentation will provide an overview of the methodology of the Queensland Physiotherapy Placement Collaborative Project; discuss enablers and barriers to physiotherapy clinical placements; outline the project recommendations related to building the quality and capacity of Queensland physiotherapy clinical placements.

78.

Well-equipped for palliative care: A review and evaluation of the aides and equipment utilised and accessed by the clinicians at Calvary Health Care Bethlehem (CHCB) to best support individuals with palliative and neuropalliative conditions

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Calvary Health Care Bethlehem

The provision of aides and equipment is often a maligned task for the Allied Health professional, clinicians can be concerned that their role is viewed as a 'store person' and not valued within the health team. At CHCB we find that access to a broad range of equipment options and timely equipment prescription can maximise the quality of life for those with life limiting conditions. Such resources are needed to provide comfort, sustain independence and dignity for individuals with palliative and neuropalliative conditions. It is never a simple one size fits all proposition and the clinical team at CHCB are regularly challenged by the changing needs of those who have palliative conditions. Clinicians must be adaptable, flexible and timely in the provision of equipment for this population. Standard issue equipment may be suitable but this is not always the case and has led to some ***innovative*** and ***creative*** practices within the CHCB service.

In this paper we will review our provision of equipment for:

- End of life Care, within the final weeks to hours. Including the importance of dignity of risk and individual choice:
- Rapidly changing technology and what is normal occupational engagement in relation to IT access
- The benefits, costs and alternatives to an in-house equipment loan pool. Is this an expense or a cost saving measure to the health service – a creative viewpoint?
- Describe and outline how we manage the inpatient experience for those with progressive neurological conditions who may have limited hand movement or communication impairment
- Outline feedback from carers regarding their experience of aides, equipment and modifications in their home, in essence what worked for them. It sometimes is the small things that make the most impact.
- Our provision of equipment is innovative and creative and we hope to educate and motivate others by example.

79.

Exercise and the treatment of depression – A critical analysis of recent reviews

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Depression is a chronic and disabling condition which adversely affects the quality of life for millions of people worldwide and is predicted to become the largest burden of disease by 2020. One in five Australians experience depression and often suffer the additional symptom burden associated with comorbidities such as diabetes, cardiovascular disease and hypertension. Pharmacotherapy and psychotherapy remains the first line of treatment for depression however pharmacotherapy may be associated with adverse cardiometabolic consequences such as weight gain. One strategy to simultaneously treat depression, the associated comorbidities, *and* ameliorate the adverse consequences of pharmacotherapy is exercise. There are a growing number of randomised controlled trials, systematic reviews and meta-analyses supporting the efficacy of exercise in the treatment of depression across a range of populations, and severity levels. Despite the plethora of literature on exercise and depression, the optimal program design for successful mental health outcomes for people with depression remains controversial. A number of recent reviews have attempted to describe the exercise program variables associated with successful mental health outcomes for people with depression with contradictory recommendations. This presentation will undertake a critical analysis of these reviews in order to inform allied health professionals of the limitations associated with recently published guidelines. Such information is vital to clinicians involved in the multidisciplinary treatment of people with depression. In addition to this critical analysis of the literature, the exercise program recommendations for people with depression will be compared to those recommended for healthy populations, and other clinical conditions. Despite contrasting recommendations in the literature, prescription of exercise for people with depression is not vastly different to other populations. Clinicians should encourage people with depression to commence, maintain and gradually progress toward individualised exercise targets.

NAHC 2013 Poster Abstracts

80.

Is more intensive better? Intensive versus standard therapy for functional dysphonia

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Background: Functional dysphonia is the most common voice disorder seen by speech pathologists and can result in reduced wellbeing and impaired capacity to fulfil employment and/or social roles. While voice therapy has the best evidence for positive treatment outcomes, poor attendance rates are commonly reported. Emerging research has indicated that intensive treatment models may potentially improve client outcomes and treatment adherence in functional dysphonia; however, further research into the application of such models is warranted.

Aims: The current study evaluated the impact of intensive and standard treatment on client and service outcome measures in clients with functional dysphonia.

Methods: Fourteen participants with a functional dysphonia (13 females and one male, mean age 54.9 years, SD=12.34), were randomly allocated to one of two treatment groups: (1) intensive treatment (n=7) and (2) standard treatment (n=7). A battery of assessments was completed prior to treatment, immediately post-treatment, and four weeks post-treatment. Participants completed the Voice Handicap Index (VHI), the AusTOMS voice assessment, and perceptual analyses (conducted by a blinded assessor). Satisfaction questionnaires were completed following treatment, and data pertaining to attendance and duration of intervention were collected. Treatment comprised a one hour vocal hygiene education session, and a total of eight hours of treatment. The intensive group consisted of four 1-hour treatment sessions per week over 2 weeks, while the standard group received one 1-hour treatment session per week over 8 weeks.

Results and Outcomes: Clinically significant changes on the VHI and AusTOMs were found for both groups, with a trend of more consistent participant attendance in the intensive group. Satisfaction ratings and perceptual analyses will also be presented, as well as clinical implications of findings on service provision and future directions for research.

81.

The value of workforce profiling

Catherine Stephens, Julie Hulcombe

Department of Health, Queensland

Introduction: A series of allied health workforce profiles has been developed by the Allied Health Professions' Office of Queensland in response to a commitment under the Health Practitioner (Queensland Health) Certified Agreement (No.1) 2007 and demand for workforce planning guidelines to inform allied health resourcing of new capital builds. The initial document, the Profile of Allied Health Workforce (PAHW), describes and analyses the allied health staffing levels for seven allied health professions across 27 case-mix funded Queensland hospitals in 2009. Subsequent papers were developed to examine allied health staffing in six high growth specialty areas: Emergency, Intensive Care, General Medicine, Oncology, Renal and Rehabilitation services.

Method: Data for the PAHW was collected and verified by Directors of Allied Health at a facility level and statewide medication and radiology units in 2010. Full time equivalent allied health staffing was collected across acute and sub-acute services in each of the identified facilities. Data for the specialty areas was collected in 2011. FTE were correlated to various denominators depending on the health service delivery model, e.g. bed numbers, dialysis patients, Emergency Department presentations.

Results: Staffing profiles are presented in each paper together with recommendations for staffing based on current levels and/or benchmarks. One of the major limitations included the lack of existing benchmarks for allied health services and the validity of those that did exist. Stakeholder feedback on the documents has been considerable and a survey was created to gauge the level to which these profiles have met the needs of allied health managers.

Conclusion: Seven papers have been developed to profile the allied health workforce and assist workforce planning to meet the needs of healthcare delivery in the Queensland public health system. While delivering a snapshot of staffing levels at a point in time and developing recommendations to inform models of service delivery, feedback from stakeholders has often been critical and the value of these documents, questioned. A survey was developed to determine their worth.

82.

The smart assistive technology revolution

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While Assistive Technology (AT) has always included high and low tech applications, there has been a recent trend towards smart AT has created a range of new solutions (and possible confusion) to solving an individual's functional independence requirements.

As Australia's (and the world's) population ages and the complexity of demands increase, it is necessary to continue to advance the adoption of smart assistive technologies (AT) to encourage and support independent living, access to care, improved outcomes and reduced costs. With the current healthcare system under ever increasing pressure, Smart AT is the way of the future. It allows people to be where they want to be, in their own home while reducing costs on the system.

Australia is embracing the Smart AT revolution, through areas such as telecare, teleheath and GPS monitoring. Telecare is providing person-centred technologies to support the individual or their carers to remain independent in their own homes. Telehealth is the use of telecommunications technologies to provide distance care to clients.

Whilst this technology has the potential to revolutionise the way in which community services is provided, there are unique considerations that need to be taken into account as with any AT prescription.

This presentation will outline what is now commonly available in the Telecare and Telehealth area of practice and outline some of the clinical considerations to ensure effective uptake and implementation of Smart AT. Some of these considerations including clinical considerations, cost and access, education and support and the role of the healthcare provider.

83.

The implementation of a sustainable student-led role in an acute care setting: A review

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Aim: The presentation will report on the outcomes of a review into the implementation of a sustainable student-led role and its perceived impact on clinical care and pre-entry student learning. Areas requiring further investigation will be discussed.

Background: In 2012 a sustainable student-led role of an Occupational Therapy Health Promotion Educator was introduced within the acute wards of Southport Hospital (part of the Gold Coast public Hospital and Health Service). The role was developed to meet client and service demands as well as enable the provision of continuous work integrated pre-entry collaborative Occupational Therapy (OT) student placements. The review of the implementation of the role across three consecutive block placements was undertaken to determine if the sustainable student role improved the consistency of the health promotion program; assisted the workload management of acute OT care staff; and, enabled students to contribute to the facility client care outcomes.

Methods and Results: Qualitative data was collected through semi-structured interviews with OT staff and pre-entry students. Data outcomes indicate that the anticipated benefits were attained along with others. This supports the positive impact the sustainable student role has on clients of the acute wards within the health service.

84.

Education targeted at developing managerial skills within our senior allied health workforce

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Background: Aside from formal university post graduate study, there is limited opportunity for Allied Health clinicians to undertake training and education targeting managerial skills, despite this being a potential career pathway for these individuals. Development and enhancement of such skills is of benefit at both an individual and organisational level. A quality assurance project was undertaken, whereby the Physiotherapy Manager developed and delivered a series of workshops targeting managerial skills.

Design: A series of four workshops were conducted over a three month period, including: monthly manager reports and KPIs, monthly budget performance, understanding the budget (introductory level) and understanding the budget (intermediate level). Workshops were designed to be as interactive as possible, with practical activities to consolidate learning.

Participants: Senior Physiotherapy staff members within the Monash Medical Centre Physiotherapy Department were eligible to apply for each of the workshops. Between 5and 10 participants attended the various workshops.

Outcome measures: Attendees rated their confidence/knowledge in key learning objective areas pre and post workshop. They also rated their interest level in the workshop and the usefulness of the information presented. All attendees were invited to make open comments regarding what they liked and any areas for improvement.

Results: There was improvement in staff confidence/knowledge within each of the key learning objective areas for all workshops. All attendees either agreed or strongly agreed that they found each workshop interesting.

Conclusions: Senior Physiotherapy clinical staff have a keen interest in developing managerial skills, and similar workshop series would be equally applicable across allied health. There was overwhelming positive feedback regarding practical activities within the workshops.

86.

Assessment, management and support of people living in situations of domestic squalor in regional Queensland

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What is domestic squalor?

The term domestic squalor is specific to the Australian experience and is used to describe living conditions, not people. A squalid dwelling or living place (as opposed to clothing or appearance) refers to somewhere that is filthy, unclean or foul indicating extreme self-neglect through a lack of care, cleanliness or general neglect. (Halliday et al, 2000)

Referrals to Government and NGOs in regional Queensland (Hervey Bay, Maryborough and Bundaberg) of people living in situations of domestic squalor have increased in recent years.

Referrals are received from community organisations, hospitals, neighbours, family and friends.

The increase in referrals and the complexity of managing such clients promoted us to review how we assess, support and manage clients living in such situations.

Often there are a number of complex factors that need to be considered including mental and physical health, selfneglect, trauma, substance abuse, dependants, inadequate living conditions, lack of available support networks, hoarding behaviours, animals and the impact on family and the community.

There is also the issue of decision-making capacity and rights versus risk. Clients may refuse intervention, minimise concerns or reluctantly agree. They may feel embarrassed or ashamed and in some cases lack insight into their situation and the impact on their own health and wellbeing.

In 2011 community-based social workers from both the public and private sector across the Fraser Coast/ Wide Bay set up a working group to review current responses to such referrals and develop a consistent, collaborative community response to these at-risk clients.

The working group has undertaken research of existing services from Victoria, NSW, the UK and the USA to develop a pathway and booklet that will enhance the Wide Bay and Fraser Coast response to people living in situations of squalor.

This initiative outlines a decision-making pathway for management of clients living in squalor on the Fraser Coast/ Wide Bay and has been well received by the community. The innovative approach engages key stakeholders from Government departments and NGO's to work cooperatively and in a multidisciplinary /multisectoral model to achieve positive outcomes for clients.

87.

Pillar pain post open carpal tunnel release: Characteristics, assessment, and occupational implications

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Pillar pain is a common postoperative complication following carpal tunnel release (CTR), the most frequently performed surgery of the upper limb. Pillar pain is pain at the site of the thenar and/or hypothenar eminences, following CTR. Carpal tunnel syndrome (CTS) accounts for 40.8% of all upper limb disorders reported in the workplace and can be related to repetitive movement. Many individuals with CTS require surgical release of the carpal tunnel to relieve symptoms. Estimated incidence of pillar pain post CTR ranges from 12-48%, however minimal research has examined the demographics of individuals with pillar pain and its influence on return to work. This study outlines the characteristics, assessment, and occupational implications of pillar pain following open CTR. The study consisted of two parts: a cross sectional survey questionnaire and a retrospective patient file review. Forty hand therapists and orthopaedic surgeons participated in an online survey questionnaire. Sixty files were reviewed, of which thirty met the inclusion criteria. Results indicated the main methods used to assess pillar pain; however no standardised assessment is consistently implemented. The characteristics of pillar pain and the population affected were also investigated. The occupational implications, presence and duration of pillar pain and its effect on return to work rates were explored. Individuals who reported pillar pain took longer to return to work compared to those without pillar pain post open CTR. The occupational implications of pillar pain highlight the need for a standardised assessment, and the importance of the subsequent treatment of pillar pain. The information from this study may be used to educate health professionals treating pillar pain, and may contribute to an innovative formulation of a standardised assessment tool for pillar pain.

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88.

The causes of their death appear (unto our shame perpetual)- root cause analysis: Evaluating the implementation of recommendations

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Background: Root Cause Analysis (RCA) is the model of accident investigation mandated by the NSW Ministry of Health. It is used to review all serious incidents that occur across the Health Service. Anecdotal evidence suggests that the RCA model is not always suitable for reviewing adverse events in mental health such as suicides and homicides.

Objectives: The aim of the research was to evaluate the impact of RCA on improving patient outcomes in a regional service and to discover whether the RCA model is the most appropriate model in mental health.

Methods: The literature on RCA was reviewed. The effectiveness of implementation of RCA recommendations was evaluated using quantitative and qualitative data.

Findings: Suicides and homicides which constitute 90% of SAC 1 events in mental health do not lend themselves well to identification of a root cause. There is evidence for low clinician engagement in the recommendations that arise from RCAs and a poor level of evidence that implementation of RCA recommendations result in safer patient care. Most troubling is the finding that RCAs frequently make recommendations which repeat existing policy or previous recommendations.

Conclusions: While the RCA model offers a formal and systematic approach to the review of SAC 1 events in Mental Health it is not the model of best fit.

89.

A mapping of allied health service capacity for maternity and neonatal services across southern Queensland

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Allied health professionals (AHPs) in Maternity and Neonatology Services (MNS) are essential for quality care and outcomes, reflected in the minimum service delivery requirements in the Queensland Health Clinical Services Capability Framework (CSCF). However, AH capacity across the (former) Southern Queensland Health Service Districts (SQHSD) is not known. This project aimed to redress this knowledge gap to inform ongoing service planning and delivery.

Maternity and neonatal AH clinicians in all birthing facilities in the (former) SQHSD were surveyed between October and December 2011 to investigate AHP staffing, practices, and models of care. Results were grouped per question, with stratification by CSCF and/or profession.

Fifty-five valid surveys from the 16 facilities were received. All professions were represented. Gaps in maternity AH services were identified. Awareness and use of evidence-based practices were more likely to be reported where higher FTEs were allocated.

Very low staffing levels have been recorded in all MNS AHPs in the (former) SQHSD. Gaps exist between actual and recommended CSCF staffing standards across all levels and professions. The results indicate that profession-specific support networks for AHPs have positive effects in the spreading of information and continued promotion, support, and involvement in these profession-specific networks is suggested for all facilities.

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90.

Participatory action research of knowledge translation in occupational therapy

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Introduction: Knowledge translation (KT) is a systematic and iterative approach to help implement research in clinical practice, in order to improve healthcare. It is a complex process involving change in attitudes, systems and behaviours. The Princess Alexandra Hospital Occupational Therapy Department (PAHOT) has been active in developing a Research and Evidence in Practice Program (REP) since 2001. Staff have made substantial efforts to locate, appraise and implement research evidence into their clinical practice, however attitudinal, knowledge and resource barriers remain. Despite its importance, very little research exists about organisational initiatives designed to build KT capacity and close research-practice gaps.

Objectives: To introduce and evaluate organisational initiatives for KT within the PAHOT Department (such as training, support and resources), to facilitate closure of research-practice gaps in core clinical practices and ultimately improve patient outcomes.

Method or Approach: Participatory Action Research (PAR) design proceeding through a number of stages, each informing the following stage. Participants include 20-30 occupational therapists with data collected by online survey and focus groups at repeated time points over a 1 year period.

Practice Implications: We report a strategy to develop, implement and evaluate an initiative to build capacity for KT. Findings will assist management to implement organisational initiatives to support KT.

Conclusion: A multifaceted organisational initiative may support KT by enhancing the knowledge, skills and reported behaviours of occupational therapists, ultimately leading to improved patient outcomes, as well as judicious use of healthcare resources.

NOTES

NOTES

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Jackie	Moon	Mater Health Services	QLD
Kathleen	Moorby	The Pharmacy Guild Of Australia	ACT
Renae	Moore	NT Department of Health	NT
Callie	Moran	Western Sydney Medicare Local	NSW
Janice	Mueller	Waipiata Consulting Ltd	NEW ZEALAND
Liz	Murdoch	Mercy Public Hospitals Inc.	VIC
Kym	Murphy	The Townsville Hospital	QLD
Mark	Murray	Western Health	VIC
Doug	Murtagh	Darling Downs Hospital and Health Service	QLD
Susan	Nancarrow	Southern Cross University	QLD
Jenny	Nel	Gold Coast Health and Hospital Service	QLD
Alison	Nelson	Institute For Urban Indigenous Health	QLD
Antony	Nicholas	Australian Osteopathic Association	NSW
Lauren	Nichols	Department of Health and Human Services	TAS
Ilsa	Nielsen	Allied Health Professions' Office of QLD	QLD
Jacqueline	Nix	Department of Health - MNHHS	QLD
Lin	Oke	Allied Health Professions Australia	VIC
Grainne	O'Loughlin	St Vincent's Hospital	NSW

Delegate List

Maria	O'Reilly	QLD Dtsc (Qut)	QLD
Michelle	O'Rourke	Monash Health	VIC
Stuart	Orr	Queensland Health	QLD
Casey	Overste	Edith Cowan University	WA
Leanne	Pagett	ACT Health Directorate	ACT
Amanda	Parker	Metro South Hospital Health Service	QLD
Christopher	Parker	The Prince Charles Hospital	QLD
Nissa	Parsons	QH Gold Coast Hospital and Health Service	QLD
Juanine	Passfield	Queensland Health	QLD
Claire	Pearce	ACT Health Directorate	ACT
Leonie	Pearce	Austin Health	VIC
Ratha	Pen	Flinders University	SA
Carmel	Perrett	Children's Health Queensland	QLD
Kiley	Pershouse	Metro South Health	QLD
Katie	Peterson	New England Medicare Local	NSW
Linh	Pham	Royal Brisbane and Women's Hospital	QLD
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Sam	Pilling	La Trobe University	VIC
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Nicola	Pollard	H&F Rehab	QLD
Lindsay	Pooley	Waikato District Health Board	NEW ZEALAND
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Sarah	Raffell	Queensland Health	QLD
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Cindy	Ranger	National Relay Service	NSW
Jane	Ransome	St Vincent's Hospital Melbourne	VIC
Alison	Ray	Alere	VIC
Helen	Redfern	Royal Brisbane and Women's Hospital, Queensland Health	QLD
Kathy	Relihan	Country Health SA	SA
Vanessa	Richardson	Darling Downs Hospital and Health Service	QLD
Jacinta	Roberton	Western Aged Care Assessment Service	VIC
Kate	Roberts	Hampstead Rehabilitation Centre	SA
Cecile	Roberts	Older Person's Mental Health Services	TAS
Susan	Roberts	Pivotal Point Consulting Services	VIC
Ben	Robertson	Nambour Selangor Private Hospital	QLD
Emma	Robinson	Medicare Local	QLD
Dane	Robinson	Queensland Health	QLD
Gail	Rogers	Far North Queensland Medicare Local	QLD
Lauren	Rogers	Royal Brisbane and Women's Hospital	QLD
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Julie-Anne	Ross	Department of Health	QLD
Karen	Salata	James Cook University	QLD

Lisa	Sandaver	Move Play Learn	QLD
Sally	Sanderson	Podiatry Service	WA
Christine	Saxby	Subacute & Ambulatory Service, Metro North Hospital & Health Service	QLD
Michael	Scanlon	HESTA	QLD
Irene	Schneider	Queensland Health	QLD
Deborah	Schoen	University of WA / CUCRH	WA
Susan	Scholtz	Queensland Health	QLD
Amy	Scott	Royal Brisbane and Women's Hospital	QLD
Cindy	Sealey	James Cook University	QLD
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Shae	Seymour	Fiona Stanley Hospital	WA
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Natalie	Simmance	St Vincent's Hospital Melbourne	VIC
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Stacey	Small		QLD
Sharon	Smith	Acquired Brain Injury Outreach Service	QLD
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Margaret	Smythe	HACC Allied Health Team - DDHHS	QLD
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Penelope	Stabler	Queensland Health	QLD
Robert	Stanton	CQ University	QLD
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Lana	Steward-Harrison	Royal Children's Hospital Pharmacy	QLD
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Melinda	Stone	Cunningham Centre	QLD
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Tamica	Sturgess	Monash Health	VIC
Michelle	Stute	The Prince Charles Hospital	QLD
Natalie	Sullivan	Cabrini Health	VIC
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Gayle	Sutherland	Redcliffe Hospital	QLD
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Meredith	Swaby	Western Health	VIC
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Penny	Taylor	University of the Sunshine Coast	QLD
Patricia	Thomas	Australian Osteopathic Association	NSW
Leah	Thompson	The Prince Charles Hospital	QLD
Helen	Titmuss	Occupational Therapy Launceston General Hospital	TAS

Delegate List

Rachael	Tong	Physiotherapy Royal Hobart Hospital, Tasmanian Health Organisation	TAS
Natasha	Toohey	Sunshine Hospital	
Rebecca	Torkington	Queensland Health	QLD
Tanya	Trevena	CQHHS	QLD
Catherine	Turnbull	Department for Health and Ageing	SA
Varuges	V.M Abraham	Allied Health Sciences Division, Ministry of Health	MALAYSIA
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Kaylee	Venter	University of Queensland	QLD
Krystle	Volgyesi	Department of Health and Ageing	ACT
Lil	Vrklevski	Sydney Local Health District	NSW
Ingrid	Wagner	Queensland University of Technology	QLD
Ben	Wallace	Health Workforce Australia	
C F (Tina)	Wallace	Wide Bay HHS	QLD
Jo	Walters	Queensland Health	QLD
Paul	Ward	NCI Tafe	NSW
Helen	Wassman	Healthy Ageing Community & Allied Health at Queensland Health	QLD
Christopher	Wear	Grafton Base Hospital	NSW
Marea	Webb	Darling Downs Hospital and Health Service	QLD
Ruth	Wedd	Queanbeyan Health Service	NSW
Jenny	Wheeler	Dubbo Base Hospital	NSW
John	Whellum	Australian Medicare Local Alliance	ACT
Andrea	Whitehead	Mater Health Services	QLD
Mary	Whitehead	Princess Alexandra Hospital	QLD
Jennie	Whitley	Ozcare	QLD
Zac	Wilkins	ME Bank	QLD
Shelley	Wilkinson	Mater Health Services	QLD
Kimberley	Williams	Eastern Health	VIC
Lauren	Williams	Griffith University	QLD
Simone	Williams	Monash Health	VIC
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Keona	Wilson	Indigenous Allied Health Australia	ACT
Judith	Wilson	Queensland Health	QLD
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Margaret	Woodhouse	Julia Creek Hospital	QLD
Ian	Wronski	QLD Regional Training Network	QLD
Costa	Wrout	ME Bank	QLD
Kim	Wyllie	Tablelands Health Service	QLD
Adel	Wynd	Kyogle Memorial Health	NSW
Gretchen	Young	Department of Health	QLD
Adrienne	Young	Royal Brisbane and Women's Hospital	QLD
Julie	Yule	Wesley Mission Brisbane	QLD
Lynne	Zeldenryk	Australian Council of PVCs and Deans of Health Sciences	QLD
Wendy	Zernike	QLD Regional Training Network	QLD
Jenny	Ziviani	Queensland Health	QLD

NOTES

NOTES

Survey of the Conference

The National Allied Health Committee can only make the annual conferences more valuable through your input.
We will use the information gained from the following survey to assess the Brisbane Conference and plan for the next.
All information will be treated in the strictest confidence.

You can return the evaluation by:

- Dropping it in the designated box on the Registration Desk,
- Facsimile on 03 6231 1522,
- Scan/Email to hannah@conferencedesign.com.au, or
- Post to Conference Design, 228 Liverpool St, Hobart Tasmania 7000.

If you do not feel you can answer the question meaningfully then please leave blank.

Please indicate (✓) ...

❑ Standard Registration ❑ Early Registration ❑ Exhibitor/Sponsor
❑ Student Registration ❑ Day Registration ❑ Complimentary/Invited Speakers
❑ Other .....

Please rate the following components of the Conference (circle the appropriate value) ...

Poor = 1, Appropriate = 3, Very good = 5

1. Quality of the Plenary Sessions:	1	2	3	4	5	N/A
2. Quality of the Concurrent Sessions:	1	2	3	4	5	N/A
3. Quality of the Posters:	1	2	3	4	5	N/A
4. Pre-conference Workshops:	1	2	3	4	5	N/A
5. Pre-conference Organisation:	1	2	3	4	5	N/A
6. Organisation at Conference:	1	2	3	4	5	N/A
7. Venue:	1	2	3	4	5	N/A
8. Social Functions:	1	2	3	4	5	N/A
9. Catering:	1	2	3	4	5	N/A
10. Registration Cost:	1	2	3	4	5	N/A

Do you think (please circle)...

11. There should be more or less Plenary Speakers:	More	Same	Less
12. There should be more or less Concurrent Sessions:	More	Same	Less
13. There should be more or less Posters:	More	Same	Less
14. There should be more or less Panel Sessions:	More	Same	Less
15. There should be more or less free time:	More	Same	Less

16. The web-based registration was useful:	Yes	No
17. You would recommend the Conference to others:	Yes	No
18. Have you attended a previous Conference:	Yes	No
19. Based on this year's Conference would you attend the next Conference:	Yes	No
20. Did you find the Conference relevant:	Yes	No
21. How often do you think the Conference should be held (in years):	.....	

Please rate the following Keynote Speakers (circle the appropriate value) ...

Poor = 1, Appropriate = 3, Very good = 5 (Leave blank if you did not attend the session)

22. Mr David Butt	1	2	3	4	5
23. The Honourable Lawrence Springborg MP	1	2	3	4	5
24. Dr Geoff Garrett	1	2	3	4	5
25. Ms Tania Major	1	2	3	4	5
26. Ms Bernie Harrison	1	2	3	4	5

In general ...

27. What was your favourite part of the Conference?

28. What was your least favourite part of the Conference?

28. Do you have any suggestions to improve future Conferences?

HealthWorkforce AUSTRALIA

Health Workforce Australia (HWA) is a Commonwealth statutory authority established to build a sustainable health workforce that meets Australia's healthcare needs. HWA leads the implementation of national and large-scale reform, working in collaboration with health and higher education sectors to address the critical priorities of planning, training and reforming Australia's health workforce.

HWA supports health professional educators through a range of programs including those with a focus on Aboriginal and Torres Strait Islander health workers, simulation learning, clinical supervision support and clinical training reform.

Visit us at **hwa.gov.au** to learn more.

An Australian Government Initiative

Health Workforce Australia 2013 conference

Skilled & flexible

The health workforce for Australia's future

18 – 20 November 2013
Adelaide Convention Centre,
Adelaide, South Australia

Health Workforce Australia's 2013 conference *Skilled and flexible – the health workforce for Australia's future* explores new and exciting opportunities for reform, bringing together local and international leaders to share best practice, their knowledge and expertise in workforce innovation and reform. This is your opportunity to learn from some of the world's brightest minds, collaborate with like-minded individuals over an intensive three-day program and gain the skills you need to drive change in healthcare settings across Australia.

This includes the following topics:

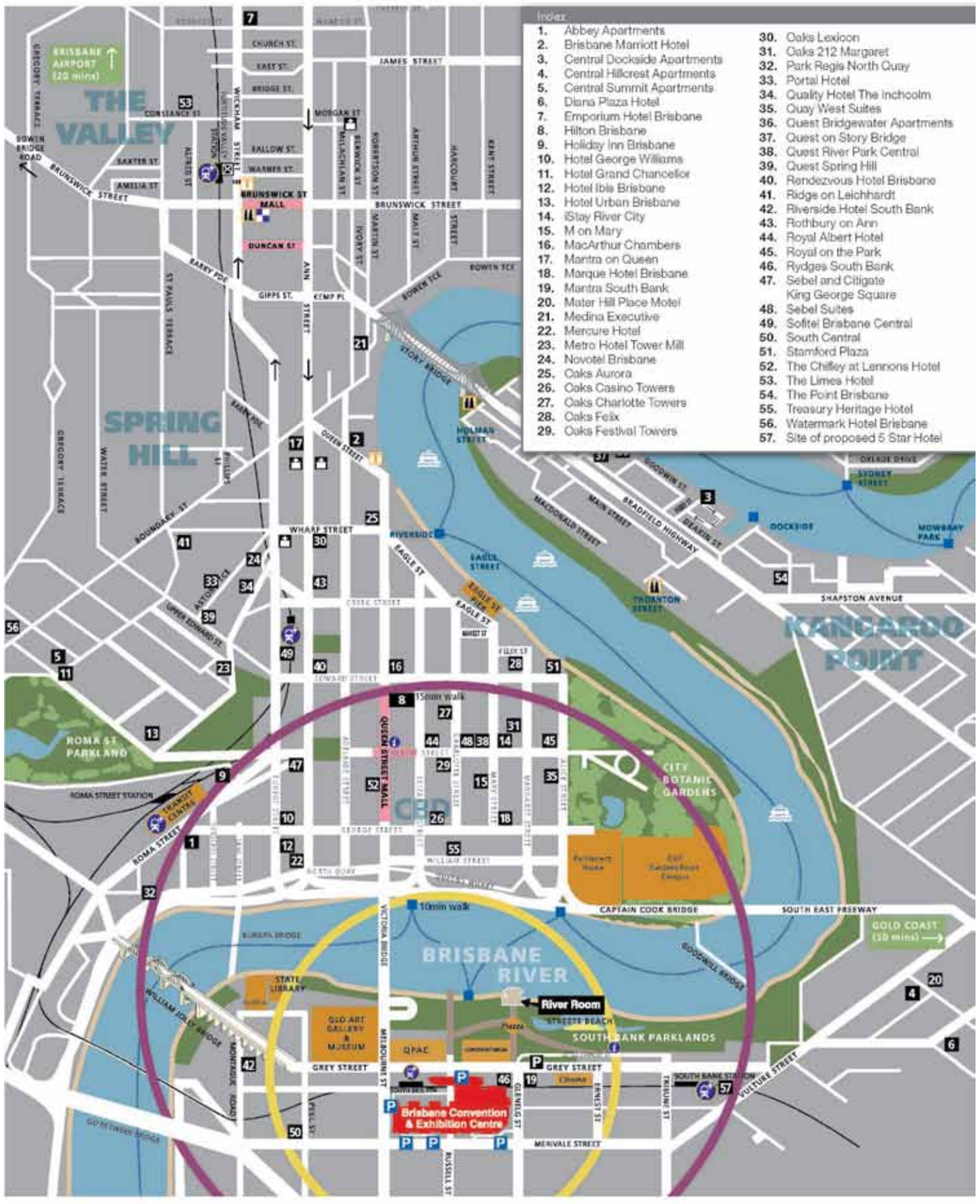
- How Australia can get enough health professionals to provide the care our communities need.
- Using the skills and expertise of health workers in a smarter way to improve job satisfaction, retention, recruitment and overall productivity.
- Improving distribution across health professions, specialties, jurisdictions and geographic locations so Australians can get the care they need, no matter where they are.
- Building an evidence base for national health workforce innovation and reform through the use of research, data analysis and evaluation.

For more information or to register to attend please visit: **www.hwa.gov.au/2013conference**
Rates: Early bird: $500 (before 30 September 2013) | Standard: $600 | Concession: $350

HWA13CM034 08/13

BCEC Location & Accommodation Map

BRISBANE convention & exhibition CENTRE



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9. Holiday Inn Brisbane
10. Hotel George Williams
11. Hotel Grand Chancellor
12. Hotel Ibis Brisbane
13. Hotel Urban Brisbane
14. iStay River City
15. M on Mary
16. MacArthur Chambers
17. Mantra on Queen
18. Marque Hotel Brisbane
19. Mantra South Bank
20. Mater Hill Place Motel
21. Medina Executive
22. Mercure Hotel
23. Metro Hotel Tower Mill
24. Novotel Brisbane
25. Oaks Aurora
26. Oaks Casino Towers
27. Oaks Charlotte Towers
28. Oaks Felix
29. Oaks Festival Towers
30. Oaks Lexicon
31. Oaks 212 Margaret
32. Park Regis North Quay
33. Portal Hotel
34. Quality Hotel The Inchcolm
35. Quay West Suites
36. Quest Bridgewater Apartments
37. Quest on Story Bridge
38. Quest River Park Central
39. Quest Spring Hill
40. Rendezvous Hotel Brisbane
41. Ridge on Leichhardt
42. Riverside Hotel South Bank
43. Rothbury on Ann
44. Royal Albert Hotel
45. Royal on the Park
46. Rydges South Bank
47. Sebel and Citigate King George Square
48. Sebel Suites
49. Sofitel Brisbane Central
50. South Central
51. Stamford Plaza
52. The Chifley at Lennons Hotel
53. The Limes Hotel
54. The Point Brisbane
55. Treasury Heritage Hotel
56. Watermark Hotel Brisbane
57. Site of proposed 5 Star Hotel

more personal - more choice

Allied Health Professions' Office of Queensland



Queensland Health is a dynamic organisation committed to providing a range of services aimed at achieving good health and well-being for all Queenslanders. Through a network of 17 Hospital and Health Services and the Mater hospitals, Queensland Health delivers a range of integrated services including hospital inpatient, outpatient and emergency services, community and mental health services, aged care services and public health and health promotion programs.

Queenslanders have access to more than 5000 allied health professionals who work alongside doctors and nurses to provide optimum healthcare.

The Allied Health Professions' Office of Queensland plays a key role in the development, implementation and evaluation of strategies to ensure there is an appropriately skilled allied health workforce designed to meet current and future health service needs.

In February 2013 the Queensland Government released the *Blueprint for better healthcare in Queensland* as the action plan to transform the Queensland healthcare system.

The blueprint has four principal themes:

1. **Health services focused on patients and people.**
2. **Empowering the community and our health workforce.**
3. **Providing Queenslanders with value in health services.**
4. **Investing, innovating and planning for the future.**

In alignment with these four themes, the Allied Health Professions' Office of Queensland has developed a number of initiatives aimed at:

- implementing new models of care, including maximising full and extended scope of practice to improve patient access, efficiency and effectiveness in healthcare delivery
- supporting a diverse range of approaches in the provision of clinical education placements (e.g. student-led clinics)
- supporting allied health research initiatives which lead to better healthcare practices and clinical outcomes.

Allied Health Professions' Office of Queensland

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