出國報告（出國類別:開會）

國際醫療品質與安全論壇（International Forum on Quality and Safety in Healthcare）之學習

28 October ~4 November 2023, Melbourne, Australia

服務機關：國立台灣大學醫學院附設醫院新竹臺大分院

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派赴國家：澳大利亞-墨爾本

出國期間：2023年10月28日~11月4日

報告日期：2023年12月1日

摘要

國際醫療保健品質與安全論壇(International Forum on Quality and Safety in Healthcare)由醫療保健改進研究所(Institute for Healthcare Improvement, IHI) 和 英國醫學雜誌(BMJ) 共同舉辦。2023年BMJ國際會議於澳洲墨爾本舉行，自10月30日至11月1日為期3天，在墨爾本國際論壇上的會議主題是〝以人為本的變革——更健康的生活、更公平的制度、可持續的未來〞。8大項議題包括：(1)多元化、公平和包容性、(2)整個組織文化、勞動力、福祉和員工敬業度、 (3)與服務使用者共同創造病人安全、(4)持續性氣候變化和環境對健康的影響、(5)新興科技和數位健康、 (6)病人流與安全、(7) 健康創新、 (8)以人為本的變革與流程。

以人為本的醫療保健變革和流程在使個人能夠控制自己的健康和預防保健。鼓勵人們積極參與自己的醫療保健決策，而不是僅僅依賴醫療專業人員。包括宣導獲得更好地醫療保健，更好的護理品質，以及更好的病人權利。尋求建立一個更公平的醫療保健系統，讓每個人都能獲得相同品質的照護。

目錄

一、目的：

(一) 國際醫療保健品質與安全論壇(International Forum on Quality and Safety in Healthcare)由醫療保健改進研究所(Institute for Healthcare Improvement, IHI) 和英國醫學雜誌(BMJ) 共同舉辦。兩個組織的目標都是改善病患和社區的醫療保健和結果。

1. 醫療保健改善研究所 (IHI)：醫療保健改善研究所 (IHI) 是一家獨立的非營利組織，總部位於美國麻薩諸塞州波士頓。25 年來，IHI 一直利用科學化的改進方式來推動和維持世界各地衛生和衛生系統的更好成果。IHI 為數百萬人帶來了安全和品質資訊，促進學習和系統性的照護改善，為以前棘手的挑戰制定解決方案，並動員衛生系統、社區、地區和國家來減少傷害和死亡。IHI 與不斷壯大的 IHI 社群合作，激發大膽、創新的方法來改善個人和人群的健康。IHI 激發樂觀情緒，收穫各種新想法，並為任何想要徹底改變健康和醫療保健、改善健康狀況的任何人、任何地方的人提供支持。

2. 英國醫學雜誌(BMJ)：作為全球醫療保健知識提供者，BMJ 出版世界上被引用最多的一般醫學期刊之一《BMJ》以及 70 多種專業期刊。該機構還提供數位專業發展課程和臨床決策支援工具，以幫助衛生專業人員提高醫療保健服務的品質。

(二) 國際論壇擁有超過 25 年的歷史，透過引入為全球最優質的計畫和實踐轉型提供資訊的知識、想法和專業，支持並激勵病人安全和醫療保健改善運動。每年有來自 80 多個國家的 4,700 多名參與者參加國際論壇，以應對當今和未來關鍵的健康議題和面對醫療保健挑戰。透過相互聯繫，形成長期合作關係，並考量醫療保健的新思維方式。**展示區域視角，引入國際專業知識**：每個國際論壇的議程都是與區域策略夥伴密切合作制定的。每次會議都展示了當地專家和國際社會的策略，滿足了區域需求，並將最好的全球學習帶到了該地區。

(三) 本次派員參加國際醫療保健品質與安全論壇，主要因應醫學中心評鑑及醫中任務評鑑條文3.2. 展現符合國際趨勢的卓越醫療品質與病人安全成果，其中條文第4點更明確表示醫療品質與病人安全成果，提供國外專業人員雙向交流學習情形，由新竹醫院品管中心同仁參與ePoster 海報發表(如下表)並學習國際醫療品質及病人安全新趨勢。

112年	第一作者	節錄醫品病安改善主題	類別	醫學中心任務條文
BMJ	余佳穗	建造醫院組織復原力，以提高員工在 COVID-19 流行期間的復原力 Building hospital organizational resilience to promote staff resilience during the COVID-19 pandemic	復原力	3.1.1 3.1.2
BMJ	李幸容	運用資訊系統提升醫病決策共享管理效率 Improving the efficiency of sharing decision-making management with information system model	SDM	3.3.2
BMJ	林佳儀	利用品管圈提高缺血性腦中風再灌注治療的執行率 Using Quality Control Circle to improve execution rate of ischemic stroke reperfusion therapy	QCC	3.2.1
BMJ	謝明芫	使用人工智慧建智儀表板用於安全事件分析和管理 Using artificial intelligence to create a dashboard for safety incident analysis and management	智能分析病安事件	3.2.1 3.2.2
BMJ	謝明芫	利用電子交班提高新生兒疫苗及時接種率 Improving the rate of timely administration of neonatal vaccines by using electronic shifts	病安事件改善	3.2.1

二、過程：

(一)活動規劃：

1、主會場主題：

2023年BMJ國際會議於澳洲墨爾本舉行，自10月30日至11月1日為期3天，在墨爾本國際論壇上的會議主題是〝**以人為本的變革——更健康的生活、更公平的制度、可持續的未來**〞。

計劃展示，只有當每個人都齊心協力推動變革時，才有可能實現醫療保健轉型。

(1) 瞭解如何跨國界和組織參與、激勵和創新

(2) 探索高層領導者如何支持人員、場所和系統動員變革

(3) 瞭解如何讓最貼近問題的人具備發展可持續、可傳播創新的能力

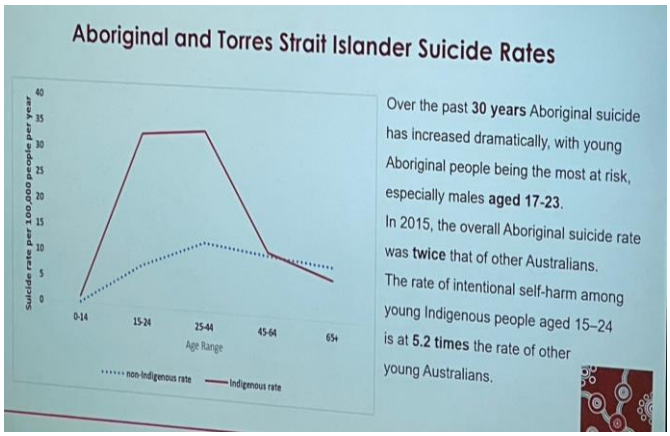
(4) 創造適合每個人現在和未來生活需求的持久改進。

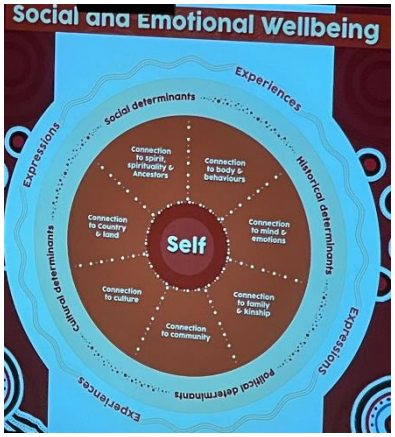
圖1、墨爾本會展中心 (MCEC)外部景觀

圖2、會場報到處

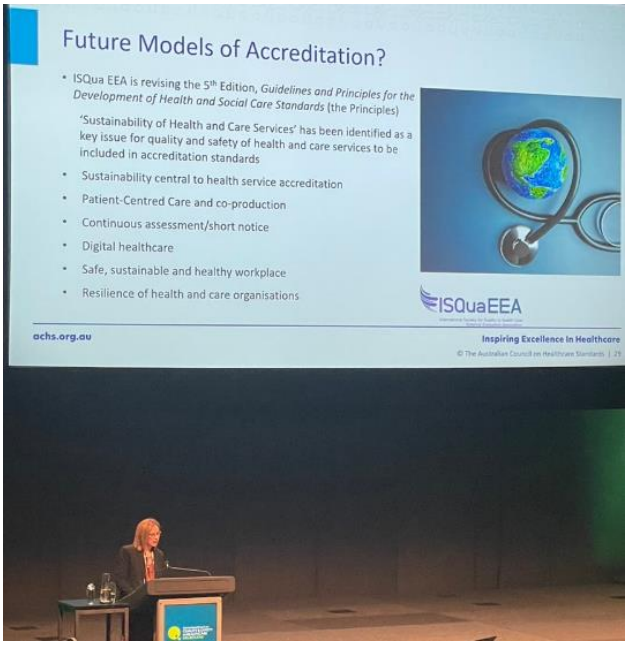
圖3、此次會議發表之會議廳

其中印象較深的幾場大會場演講，第一場講者Pat Dudgeon，是西澳大學波切原住民健康中心和原住民研究學院的心理學家和教授。研究領域包括原住民社會和情感健康以及自殺預防。她是西澳大學原住民和托雷斯海峽島民自殺預防最佳實踐中心的主任，也是國家研究專案“改變土著心理健康和福祉”的首席研究員，依據研究顯示**當地的青少年自殺率高於其他區，該專案旨在開發促進文化價值觀和優勢並賦予權力的心理健康服務方法**。

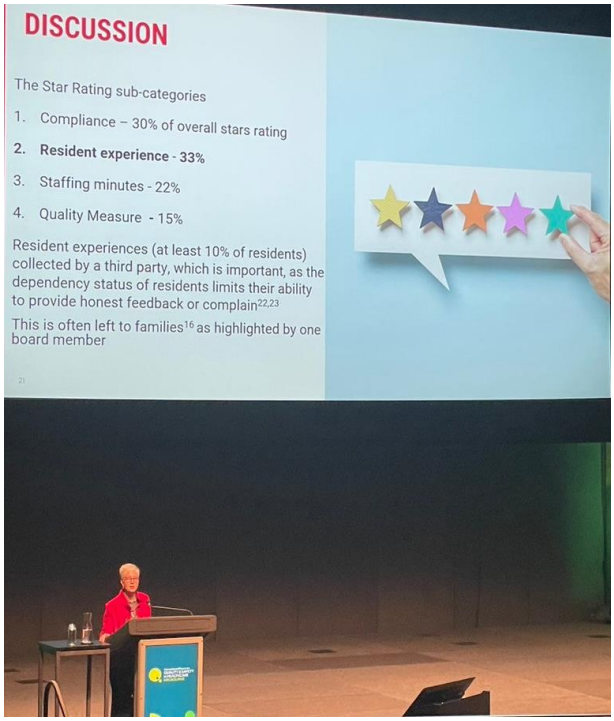




Louise Cuskelly是澳大利亞醫療保健標準委員會（ACHS）國際和諮詢公司的執行董事，該委員會是醫療保健品質和安全領域組織。Cuskelly在臨床風險管理、醫療保健品質改進、治理、策略規劃、安全和品質、專業制度和文化變革方面擁有豐富的經驗。作為一名臨床醫生和衛生部門經驗豐富的高級管理人員，在超過 25 年的職業生涯中致力於領導國際團隊，在中東和亞太地區提供品質改進計劃、認證服務、教育計劃和諮詢服務。通過衡量病人品質指標改善、培養專業責任制度和培養安全文化來推動高績效的品質管理。演講內容包含：了解目



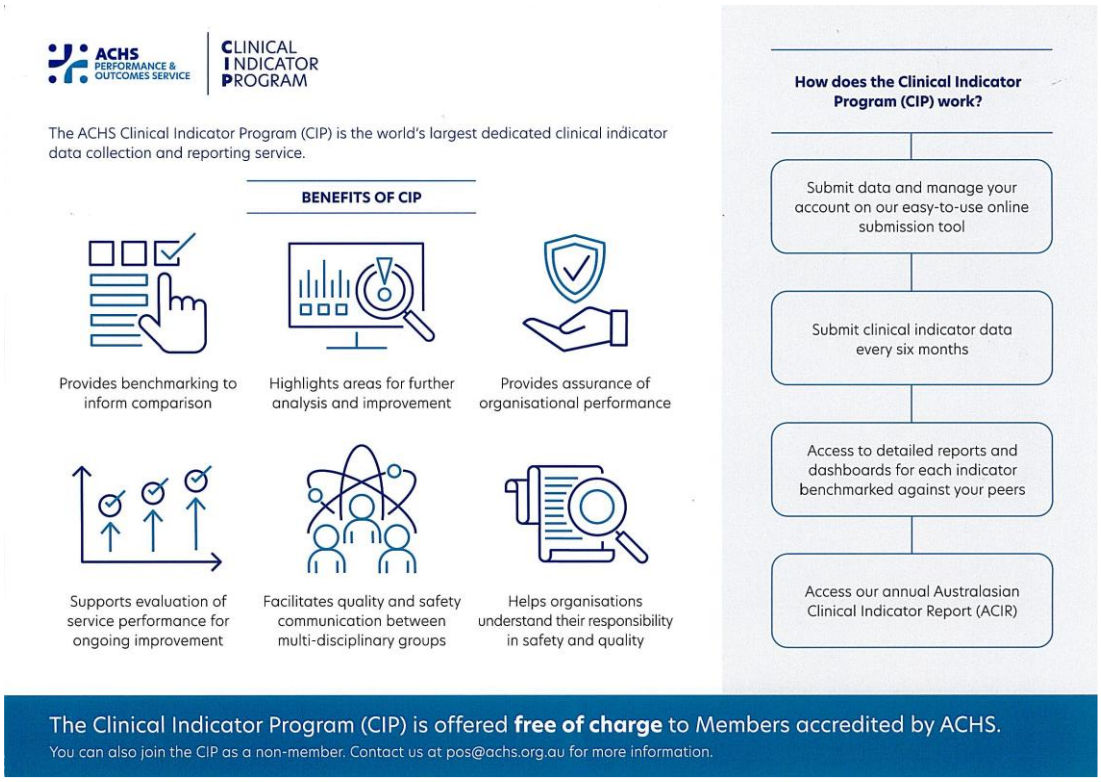
前安全和品質外部評估的方法、品質改進評估的全球趨勢、反思轉向以「結果」作為焦點的證據。**未來的認證模式會是持續性的評估機構服務品質、以病人為中心、智慧醫療、安全的工作環境和組織復原力**。



Jo-Anne Rayner博士是拉籌伯大學澳大利亞循證老年護理中心的高級研究員。研究重點是：將研究證據轉化為實踐;在養老院照顧老年人，特別是失智患者。Jo擁有豐富的專業知識和經驗，擔任定性方法研究員，並指導高等教育部門和衛生部的初級研究人員。老年人應該期望獲得安全、高品質的居家老年照護。然而，澳洲皇家老年護理品質和安全委員會的調查結果顯示並非如此。本次會議介紹負責治理 **15 個公共部門住宅老年護理服務 (PSRACS)、擁有 857 張床位的 6 個維多利亞州公共衛生服務委員會成員的訪談結果**。這些訪談是一項大規模研究，幫助發展和支持老年人在這些環境中茁壯成長的概念模型。

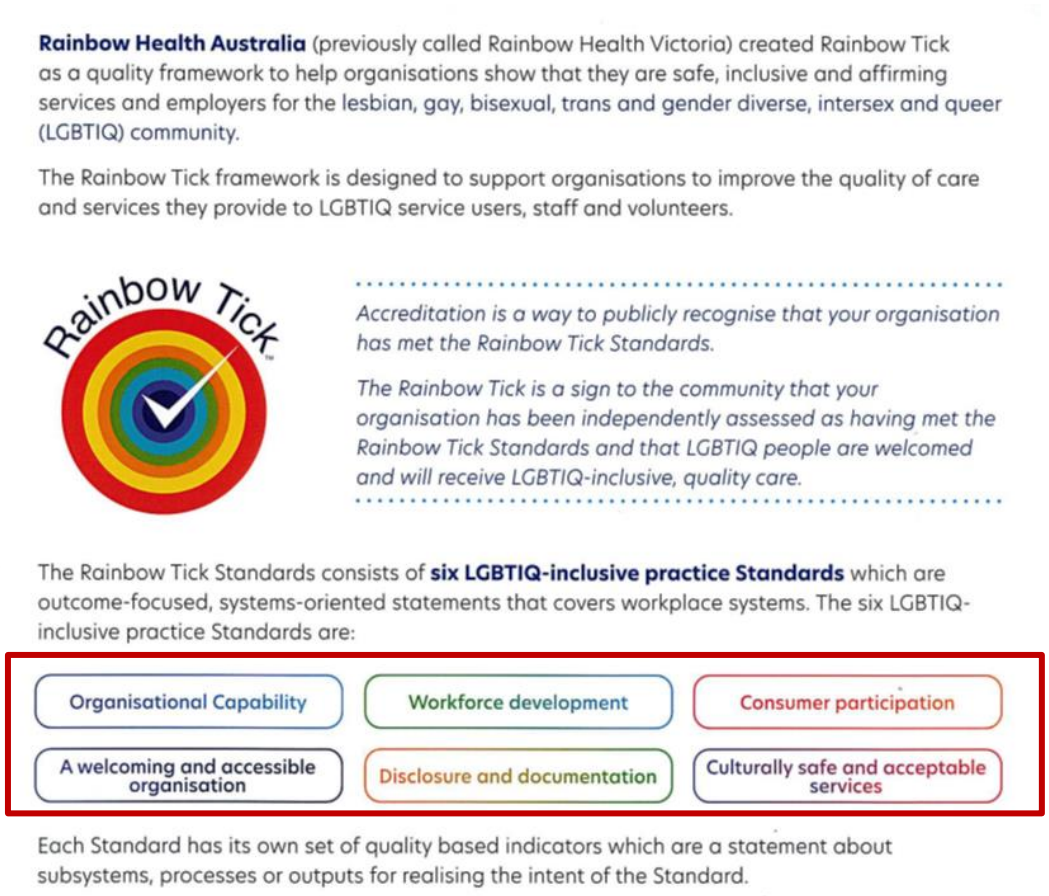
2、展場主題：

現場共有14個贊助廠商擺攤，提供各類醫療品質相關宣傳品資訊供與會者參觀取用。



澳洲醫療保健標準委員會 (ACHS) 是一個獨立的非營利組織，致力於提高醫療保健質量，代表澳洲各地的政府、消費者和最高衛生機構。臨床指標計劃(CIP)是世界上最大的專用臨床指標資料收集和報告服務。成立於 1989 年，旨在

支援 ACHS 會員追蹤、測量和分析他們的數據，從而推動品質計劃並改善患者安全和護理。目前有 22 個專業醫學學科的 650 多家醫療機構定期向該計劃提交數據。ACHS使用Metrik數據分析軟體進行數據測量和分析，提供所有醫療保健組織衡量績效並與澳洲和世界各地的機構進行比較。除了基準測試、透明度和易用性之外，每六個月提交一次資料，即可對數據進行分析，並以一般報告和同儕比較報告的形式提供結果。醫療保健組織還可以獲得其結果的年度分析，以及幾年來的趨勢。



Rainbow Health Australia (previously called Rainbow Health Victoria) created Rainbow Tick as a quality framework to help organisations show that they are safe, inclusive and affirming services and employers for the lesbian, gay, bisexual, trans and gender diverse, intersex and queer (LGBTIQ) community.

The Rainbow Tick framework is designed to support organisations to improve the quality of care and services they provide to LGBTIQ service users, staff and volunteers.

Rainbow Tick

Accreditation is a way to publicly recognise that your organisation has met the Rainbow Tick Standards.

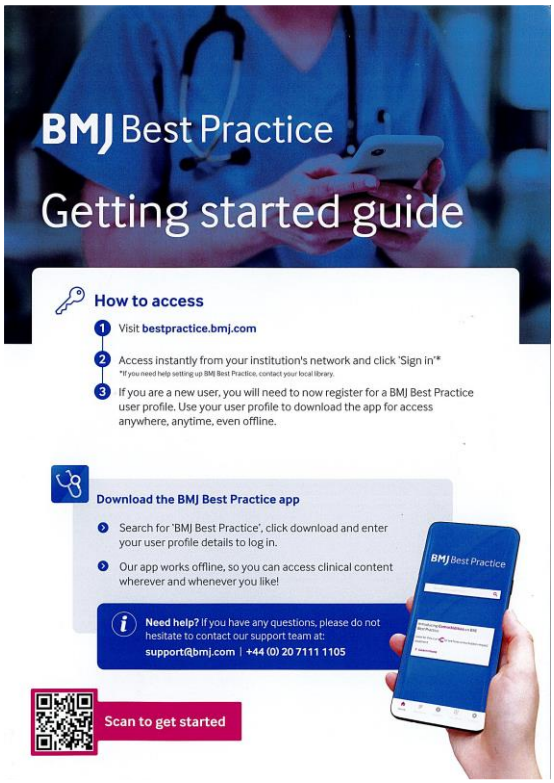
The Rainbow Tick is a sign to the community that your organisation has been independently assessed as having met the Rainbow Tick Standards and that LGBTIQ people are welcomed and will receive LGBTIQ-inclusive, quality care.

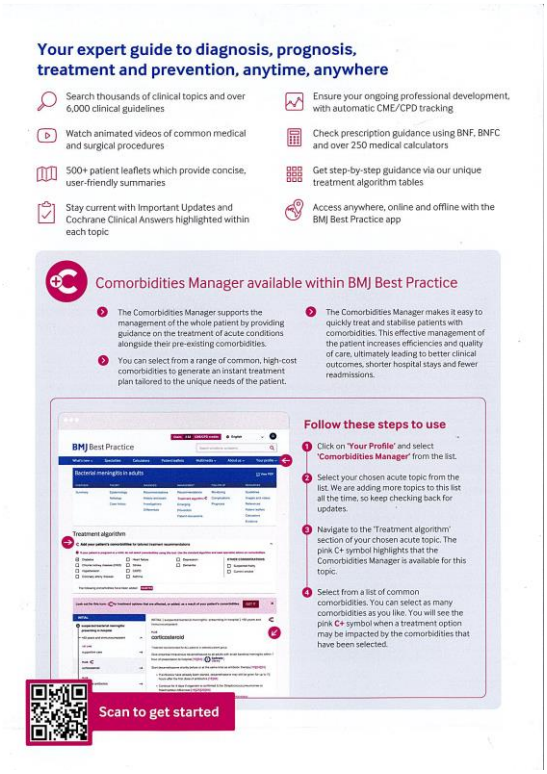
The Rainbow Tick Standards consists of **six LGBTIQ-inclusive practice Standards** which are outcome-focused, systems-oriented statements that covers workplace systems. The six LGBTIQ-inclusive practice Standards are:

- Organisational Capability
- Workforce development
- Consumer participation
- A welcoming and accessible organisation
- Disclosure and documentation
- Culturally safe and acceptable services

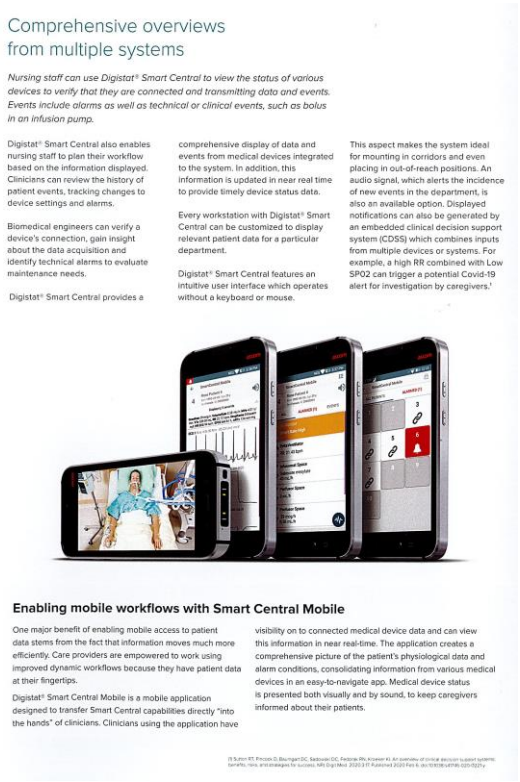
Each Standard has its own set of quality based indicators which are a statement about subsystems, processes or outputs for realising the intent of the Standard.

Rainbow Tick 彩虹旗認證適用於為性別友善團體提供安全、包容的工作場所和健康的服務。包含六個標準旨在供整個組織使用，可以應用於特定服務或機構。透過獲得 Rainbow Tick 認證，表明了組織對多元化和包容性價值觀的承諾。為群體提供更積極的服務，促進心理健康和福祉的提升。





BMJ Best Practice最佳實踐被評為全球健康專業人員的最佳臨床決策支援工具之一，提供診斷、治療和預防的逐步指導。是一種基於實證的臨床決策支援工具，可為醫療保健專業人員提供有關醫療狀況的診斷、治療和管理的可靠資訊。旨在透過為醫療機構從業者提供輕鬆存取最新醫療資訊的方式來提高護理品質和病人治療效果。BMJ Best Practice被 100 多個國家的醫療保健專業人員使用，大量研究表示可以提高護理品質和病人治療效果。目前可掃描QR-Code或是透過線上收聽podcast獲得最佳實施方案的相關資訊。



Comprehensive overviews from multiple systems

Nursing staff can use Digistat® Smart Central to view the status of various devices to verify that they are connected and transmitting data and events. Events include alarms as well as technical or clinical events, such as bolus in an infusion pump.

Digistat® Smart Central also enables nursing staff to plan their workflow based on the information displayed. Clinicians can review the history of patient events, tracking changes to device settings and alarms.

Biomedical engineers can verify a device's connection, gain insight about the data acquisition and identify technical alarms to evaluate maintenance needs.

Digistat® Smart Central provides a comprehensive display of data and events from medical devices integrated to the system. In addition, this information is updated in near real time to provide timely device status data.

Every workstation with Digistat® Smart Central can be customized to display relevant patient data for a particular department.

Digistat® Smart Central features an intuitive user interface which operates without a keyboard or mouse.

This aspect makes the system ideal for mounting in corridors and even placing in out-of-reach positions. An audio signal, which alerts the incidence of new events in the department, is also an available option. Displayed notifications can also be generated by an embedded clinical decision support system (CDSS) which combines inputs from multiple devices or systems. For example, a high RR combined with Low SPO2 can trigger a potential Covid-19 alert for investigation by caregivers.[1]

Enabling mobile workflows with Smart Central Mobile

One major benefit of enabling mobile access to patient data stems from the fact that information moves much more efficiently. Care providers are empowered to work using improved dynamic workflows because they have patient data at their fingertips.

Digistat® Smart Central Mobile is a mobile application designed to transfer Smart Central capabilities directly "into the hands" of clinicians. Clinicians using the application have visibility on to connected medical device data and can view this information in near real-time. The application creates a comprehensive picture of the patient's physiological data and alarm conditions, consolidating information from various medical devices in an easy-to-navigate app. Medical device status is presented both visually and by sound, to keep caregivers informed about their patients.

Enhancing patient dashboards using waveforms

Visual information, including waveforms, provide caregivers with a better understanding of the patient condition and produce accurate contextual data which helps them to evaluate alarms.

Smart Central can display waveforms collected from medical devices either in near real time, or as snapshots synchronized with alarms. waveforms can be displayed both in dashboard or mobile view to help support the workflows of caregivers.

The capability to view waveforms when away from the unit in near real time helps to streamline patient care whenever coordination with colleagues is required, to evaluate a patient's condition and decide on the best course of action. The automatic capture and synching of waveforms snapshots with events helps to provide valuable context to alerts, which supports alarm management workflow.

Smart central live waveforms view

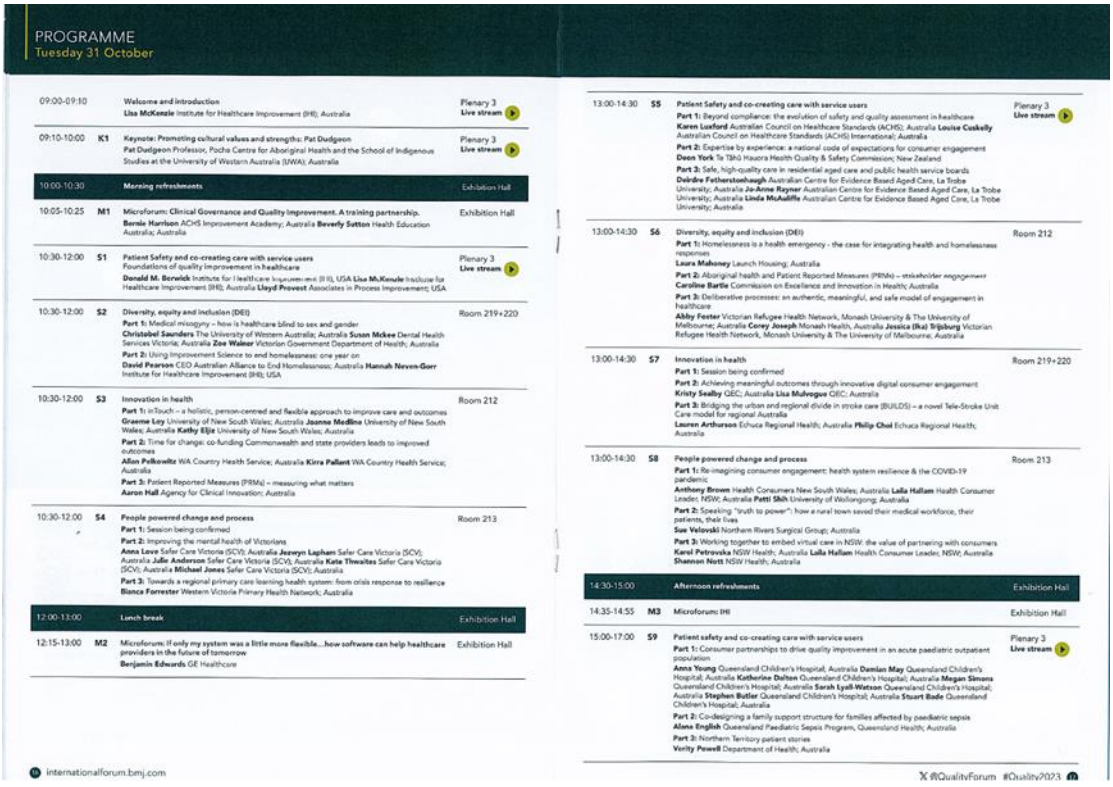
Smart central live webcam view

Supporting video streams

Live video footage of a patient provides additional support when monitoring his or her condition because it generates information which is not always visible within clinical data. Digistat® Smart Central can be configured to support the provision of video stream via a webcam. This functionality enables visual monitoring of the patient area, so that when an alarm condition occurs, the images for each patient can provide important contextual information. Caregivers and clinicians gain a complete view of the situation, with video views enabled via desktop and mobile.

Ascom 醫療保健平台是來自臨床通訊和協作的智能化系統。這些解決方案旨在幫助醫院實現「四個目標」：降低成本、改善病人健康、增強病人體驗和醫療團隊福祉。以臨床資訊系統為例，透過重症監護流程的數位化，安全有效地管理高風險護理中的複雜工作流程。警報通知管理系統可以收集和顯示事件資訊和及時波形，以提供病人狀態的清晰且情境化的圖片。這些資訊可以顯示在大型壁掛式顯示器、個人電腦和/或智慧型手機上。行動警報可以被過濾，有助於使工作人員和病人的環境更安靜、更舒適。

10月31日及11月1日大會議程如附圖，各參與研討會者可免費下載大會APP，可事先預訂有興趣的演講主題，當天APP會主動提醒報名場次的時間和地點，部分講者的演講更開放實況線上直播，供與會者參閱。



PROGRAMME
Tuesday 31 October

09:00-09:10		**Welcome and introduction** **Lisa McKenzie** Institute for Healthcare Improvement (IHI); Australia	Plenary 3 Live stream
09:10-10:00	K1	**Keynote: Promoting cultural values and strengths: Pat Dudgeon** **Pat Dudgeon** Professor, Pocha Centre for Aboriginal Health and the School of Indigenous Studies at the University of Western Australia (UWA); Australia	Plenary 3 Live stream
10:00-10:30		**Morning refreshments**	Exhibition Hall
10:05-10:25	M1	**Microforum: Clinical Governance and Quality Improvement. A training partnership.** **Bernie Harrison** ACHS Improvement Academy; Australia **Beverly Sutton** Health Education Australia; Australia	Exhibition Hall
10:30-12:00	S1	**Patient Safety and co-creating care with service users** Foundations of quality improvement in healthcare **Donald M. Berwick** Institute for Healthcare Improvement (IHI), USA **Lisa McKenzie** Institute for Healthcare Improvement (IHI); Australia **Lloyd Provost** Associates in Process Improvement; USA	Plenary 3 Live stream
10:30-12:00	S2	**Diversity, equity and inclusion (DEI)** **Part 1:** Medical misogyny – how is healthcare blind to sex and gender **Christobel Saunders** The University of Western Australia; Australia **Susan Mckee** Dental Health Services Victoria; Australia **Zoe Walker** Victorian Government Department of Health; Australia **Part 2:** Using Improvement Science to end homelessness: one year on **David Pearson** CEO Australian Alliance to End Homelessness; Australia **Hannah Neven-Gorr** Institute for Healthcare Improvement (IHI); USA	Room 219+220
10:30-12:00	S3	**Innovation in health** **Part 1:** inTouch – a holistic, person-centred and flexible approach to improve care and outcomes **Graeme Ley** University of New South Wales; Australia **Joanne Medina** University of New South Wales; Australia **Kathy Eljiz** University of New South Wales; Australia **Part 2:** Time for change: co-funding Commonwealth and state providers leads to improved outcomes **Allan Pelkowitz** WA Country Health Service; Australia **Kirra Pallant** WA Country Health Service; Australia **Part 3:** Patient Reported Measures (PRMs) – measuring what matters **Aaron Hall** Agency for Clinical Innovation; Australia	Room 212
10:30-12:00	S4	**People powered change and process** **Part 1:** Session being confirmed **Part 2:** Improving the mental health of Victorians **Anna Love** Safer Care Victoria (SCV); Australia **Jazwyn Lapham** Safer Care Victoria (SCV); Australia **Julie Anderson** Safer Care Victoria (SCV); Australia **Kate Thwaites** Safer Care Victoria (SCV); Australia **Michael Jones** Safer Care Victoria (SCV); Australia **Part 3:** Towards a regional primary care learning health system: from crisis response to resilience **Bianca Forrester** Western Victoria Primary Health Network; Australia	Room 213
12:00-13:00		**Lunch break**	Exhibition Hall
12:15-13:00	M2	**Microforum: If only my system was a little more flexible...how software can help healthcare providers in the future of tomorrow** **Benjamin Edwards** GE Healthcare	Exhibition Hall
13:00-14:30	S5	**Patient Safety and co-creating care with service users** **Part 1:** Beyond compliance: the evolution of safety and quality assessment in healthcare **Karen Luxford** Australian Council on Healthcare Standards (ACHS); Australia **Louise Coskelly** Australian Council on Healthcare Standards (ACHS) International; Australia **Part 2:** Expertise by experience: a national code of expectations for consumer engagement **Deon York** Te Tāhū Hauora Health Quality & Safety Commission; New Zealand **Part 3:** Safe, high-quality care in residential aged care and public health service boards **Deirdre Fetherstonhaugh** Australian Centre for Evidence Based Aged Care, La Trobe University; Australia **Jo-Anne Rayner** Australian Centre for Evidence Based Aged Care, La Trobe University; Australia **Linda McAuliffe** Australian Centre for Evidence Based Aged Care, La Trobe University; Australia	Plenary 3 Live stream
13:00-14:30	S6	**Diversity, equity and inclusion (DEI)** **Part 1:** Homelessness is a health emergency - the case for integrating health and homelessness responses **Laura Mahoney** Launch Housing; Australia **Part 2:** Aboriginal health and Patient Reported Measures (PRMs) – stakeholder engagement **Caroline Bartle** Commission on Excellence and Innovation in Health; Australia **Part 3:** Deliberative processes: an authentic, meaningful, and safe model of engagement in healthcare **Abby Foster** Victorian Refugee Health Network, Monash University & The University of Melbourne; Australia **Corey Joseph** Monash Health, Australia **Jessica (Ika) Trijsburg** Victorian Refugee Health Network, Monash University & The University of Melbourne; Australia	Room 212
13:00-14:30	S7	**Innovation in health** **Part 1:** Session being confirmed **Part 2:** Achieving meaningful outcomes through innovative digital consumer engagement **Kristy Sealby** QEC; Australia **Lisa Mulvogue** QEC; Australia **Part 3:** Bridging the urban and regional divide in stroke care (BUILDS) – a novel Tele-Stroke Unit Care model for regional Australia **Lauren Arthurson** Echuca Regional Health; Australia **Philip Choi** Echuca Regional Health; Australia	Room 219+220
13:00-14:30	S8	**People powered change and process** **Part 1:** Re-imagining consumer engagement: health system resilience & the COVID-19 pandemic **Anthony Brown** Health Consumers New South Wales; Australia **Laila Hallam** Health Consumer Leader, NSW; Australia **Patti Shih** University of Wollongong; Australia **Part 2:** Speaking "truth to power": how a rural town saved their medical workforce, their patients, their lives **Sue Velovski** Northern Rivers Surgical Group; Australia **Part 3:** Working together to embed virtual care in NSW: the value of partnering with consumers **Karol Petrovska** NSW Health; Australia **Laila Hallam** Health Consumer Leader, NSW; Australia **Shannon Nott** NSW Health; Australia	Room 213
14:30-15:00		**Afternoon refreshments**	Exhibition Hall
14:35-14:55	M3	**Microforum: IHI**	Exhibition Hall
15:00-17:00	S9	**Patient safety and co-creating care with service users** **Part 1:** Consumer partnerships to drive quality improvement in an acute paediatric outpatient population **Anna Young** Queensland Children's Hospital; Australia **Damian May** Queensland Children's Hospital; Australia **Katherine Dalton** Queensland Children's Hospital; Australia **Megan Simons** Queensland Children's Hospital; Australia **Sarah Lyall-Watson** Queensland Children's Hospital; Australia **Stephen Butler** Queensland Children's Hospital; Australia **Stuart Bade** Queensland Children's Hospital; Australia **Part 2:** Co-designing a family support structure for families affected by paediatric sepsis **Alana English** Queensland Paediatric Sepsis Program, Queensland Health; Australia **Part 3:** Northern Territory patient stories **Verity Powell** Department of Health; Australia	Plenary 3 Live stream

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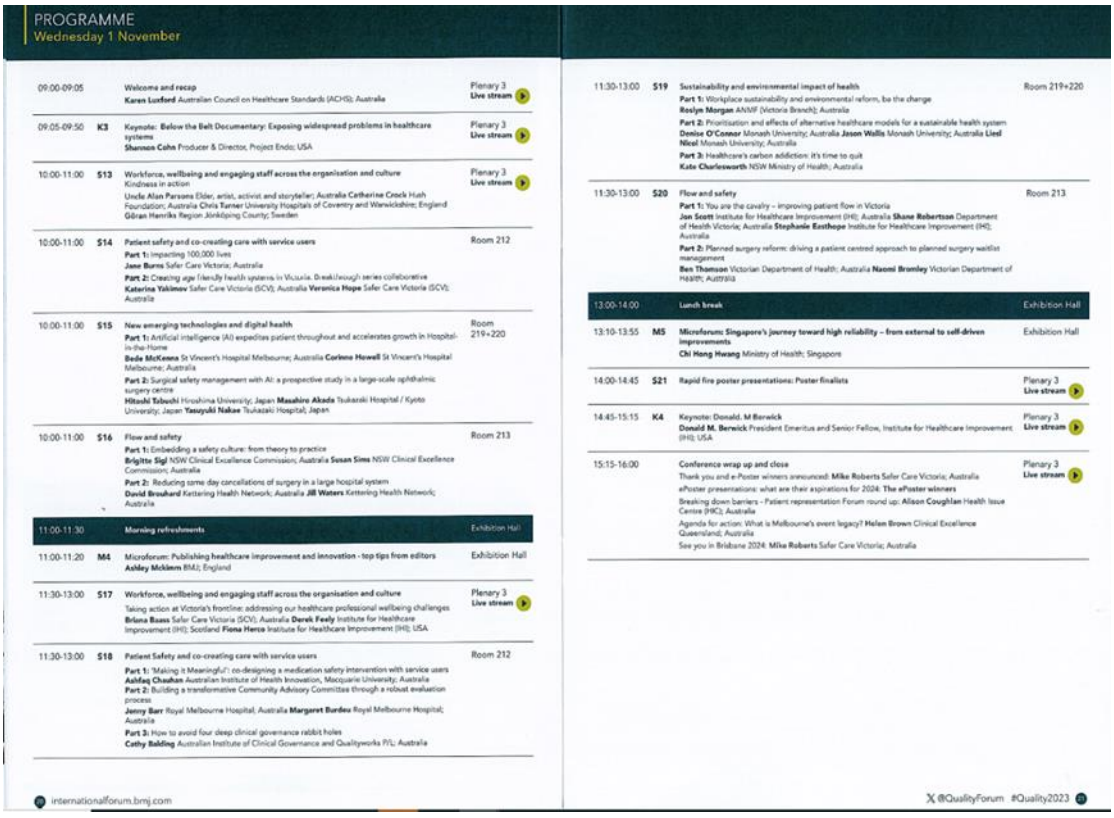

PROGRAMME
Wednesday 1 November

09:00-09:05		**Welcome and recap** **Karen Luxford** Australian Council on Healthcare Standards (ACHS); Australia	Plenary 3 Live stream
09:05-09:50	K3	**Keynote: Below the Belt Documentary: Exposing widespread problems in healthcare systems** **Shannon Cohn** Producer & Director, Project Endo; USA	Plenary 3 Live stream
10:00-11:00	S13	**Workforce, wellbeing and engaging staff across the organisation and culture** Kindness in action **Uncle Alan Parsons** Elder, artist, activist and storyteller; Australia **Catherine Crock** Hush Foundation; Australia **Chris Turner** University Hospitals of Coventry and Warwickshire; England **Göran Henriks** Region Jönköping County; Sweden	Plenary 3 Live stream
10:00-11:00	S14	**Patient safety and co-creating care with service users** **Part 1:** Impacting 100,000 lives **Jane Burns** Safer Care Victoria; Australia **Part 2:** Creating age friendly health systems in Victoria. Breakthrough series collaborative **Katerina Yakimov** Safer Care Victoria (SCV); Australia **Veronica Hope** Safer Care Victoria (SCV); Australia	Room 212
10:00-11:00	S15	**New emerging technologies and digital health** **Part 1:** Artificial intelligence (AI) expedites patient throughput and accelerates growth in Hospital-in-the-Home **Bede McKenna** St Vincent's Hospital Melbourne; Australia **Corinne Howell** St Vincent's Hospital Melbourne; Australia **Part 2:** Surgical safety management with AI: a prospective study in a large-scale ophthalmic surgery centre **Hitoshi Tabuchi** Hiroshima University; Japan **Masahiro Akada** Tsukazaki Hospital / Kyoto University; Japan **Yasuyuki Nakae** Tsukazaki Hospital; Japan	Room 219+220
10:00-11:00	S16	**Flow and safety** **Part 1:** Embedding a safety culture: from theory to practice **Brigitte Sigl** NSW Clinical Excellence Commission; Australia **Susan Sims** NSW Clinical Excellence Commission; Australia **Part 2:** Reducing same day cancellations of surgery in a large hospital system **David Brouhard** Kettering Health Network; Australia **Jill Waters** Kettering Health Network; Australia	Room 213
11:00-11:30		**Morning refreshments**	Exhibition Hall
11:00-11:20	M4	**Microforum: Publishing healthcare improvement and innovation - top tips from editors** **Ashley Mckimm** BMJ; England	Exhibition Hall
11:30-13:00	S17	**Workforce, wellbeing and engaging staff across the organisation and culture** Taking action at Victoria's frontline: addressing our healthcare professional wellbeing challenges **Briana Boass** Safer Care Victoria (SCV); Australia **Derek Feely** Institute for Healthcare Improvement (IHI); Scotland **Fiona Herco** Institute for Healthcare Improvement (IHI); USA	Plenary 3 Live stream
11:30-13:00	S18	**Patient Safety and co-creating care with service users** **Part 1:** 'Making It Meaningful': co-designing a medication safety intervention with service users **Ashfaq Chauhan** Australian Institute of Health Innovation, Macquarie University; Australia **Part 2:** Building a transformative Community Advisory Committee through a robust evaluation process **Jenny Barr** Royal Melbourne Hospital; Australia **Margaret Burdeu** Royal Melbourne Hospital; Australia **Part 3:** How to avoid four deep clinical governance rabbit holes **Cathy Balding** Australian Institute of Clinical Governance and Qualityworks P/L; Australia	Room 212
11:30-13:00	S19	**Sustainability and environmental impact of health** **Part 1:** Workplace sustainability and environmental reform, be the change **Roslyn Morgan** ANMF (Victoria Branch); Australia **Part 2:** Prioritisation and effects of alternative healthcare models for a sustainable health system **Denise O'Connor** Monash University; Australia **Jason Wallis** Monash University; Australia **Liesl Nicol** Monash University; Australia **Part 3:** Healthcare's carbon addiction: it's time to quit **Kate Charlesworth** NSW Ministry of Health; Australia	Room 219+220
11:30-13:00	S20	**Flow and safety** **Part 1:** You are the cavalry – improving patient flow in Victoria **Jon Scott** Institute for Healthcare Improvement (IHI); Australia **Shane Robertson** Department of Health Victoria; Australia **Stephanie Easthope** Institute for Healthcare Improvement (IHI); Australia **Part 2:** Planned surgery reform: driving a patient centred approach to planned surgery waitlist management **Ben Thomson** Victorian Department of Health; Australia **Naomi Bromley** Victorian Department of Health; Australia	Room 213
13:00-14:00		**Lunch break**	Exhibition Hall
13:10-13:55	M5	**Microforum: Singapore's journey toward high reliability – from external to self-driven improvements** **Chi Hong Hwang** Ministry of Health; Singapore	Exhibition Hall
14:00-14:45	S21	**Rapid fire poster presentations: Poster finalists**	Plenary 3 Live stream
14:45-15:15	K4	Keynote: Donald. M Berwick **Donald M. Berwick** President Emeritus and Senior Fellow, Institute for Healthcare Improvement (IHI); USA	Plenary 3 Live stream
15:15-16:00		**Conference wrap up and close** Thank you and e-Poster winners announced: **Mike Roberts** Safer Care Victoria; Australia ePoster presentations: what are their aspirations for 2024: **The ePoster winners** Breaking down barriers - Patient representation Forum round up: **Alison Coughlan** Health Issue Centre (HIC); Australia Agenda for action: What is Melbourne's event legacy? **Helen Brown** Clinical Excellence Queensland; Australia See you in Brisbane 2024: **Mike Roberts** Safer Care Victoria; Australia	Plenary 3 Live stream

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3、海報發表：

電子海報展示是一個寶貴的機會，來自世界各地的同事和專家可以分享他們的改善和安全項目，其他人可以從這些策略和經驗中學習。

今年電子海報的8大項議題包括：

(1) 多元化、公平和包容性Diversity, equity and inclusion (DEI)

這一主題著重於公平、多樣性和包容性原則的定義，以及需要採取哪些步驟來統一各級的包容性和品質改善實踐。如何實現人人享有健康公平？如何學會更有效地與地方和社區合作，基於有價值的照護結果改善？探討如何確保在醫療保健所有領域實施EDI，以及如何使品質改善系統中的員工、病人、家庭和關鍵利益相關者受益。

(2) 整個組織和文化中的勞動力、福祉和員工敬業度Workforce, wellbeing and engaging staff across the organization and culture

有證據表明在組織內實施的員工健康和福祉計劃可以改善健康、生產力並減少病假，但採用這些服務仍然是一個挑戰。這一主題將探討策略，以需求為導向的方法來實施和啟動福利計劃;以及如何建立支持員工、健康和福祉的組織文化。

(3) 與服務使用者共同創造病人安全Patient safety and co-creating care with service users

病人和醫療保健專業人員之間的平等夥伴關係可幫助推動了良好生活和維持關係的能力，這種夥伴關係從病人、社區和網路需要與醫療保健專業人員、社區和志工部門合作，以支持病人安全。如何通過創建新的模型、流程和改善來提高病人安全和照護的效率，著重對病人而言最重要的事情。

(4) 可持續性、氣候變化和環境對健康的影響Sustainability, climate change and environmental impact on health

如何處理對大環境不同種類的干擾，衛生系統與社區之間的平衡；以及可以為改善提供哪些支援。討論如何從社區和消費者的角度以及周圍的病人

的角度提供更好的學習和成長。最重要的是衛生系統如何應對氣候變化？

(5) 新興科技和數位健康Emerging technologies and digital health

改善和轉型正在以非凡的規模和速度發生。如何利用技術帶來的機會來提供更好的健康？如何創建更敏捷的系統？如何才能充分利用現在可以蒐集到的數據？能否快速生成證據並與臨床的專業知識結合？如何評估數位健康創新在健康和安全方面的表現？並提供基於證據的建議來支持結果。

(6) 病人流與安全Flow and safety

如何透過一次又一次地提供安全的照護來使醫療保健系統順利運行？快節奏的醫療保健系統對工作產能有何影響，照護模式有哪些變化？如何應對新冠病毒對醫療保健系統的品質和安全的影響？探討病人流和安全主題，並提供系統化改善的專案範例。

(7) 健康創新Innovation in health

品質改善活動依靠創新來改變。著重於在全面化的改善健康結果的創新方法，以及新方法如何惠及社區中最脆弱的人群。創新不一定是高科技，可以是社交、數位、流程或設備創新—與未來相比，現在是什麼樣子的？

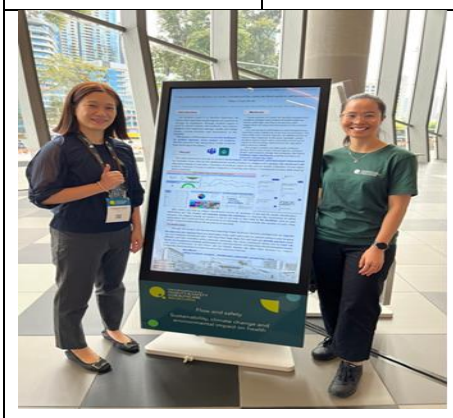
(8) 以人為本的變革與流程People powered change and process

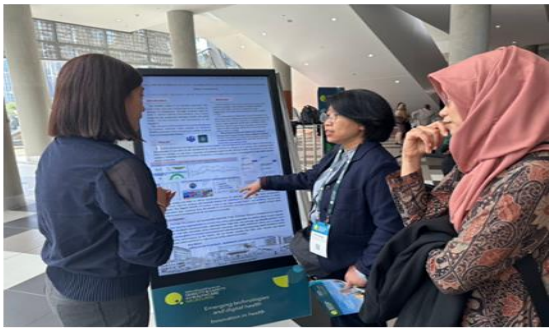
以人為本的醫療保健變革和流程在使個人能夠控制自己的健康和預防保健。鼓勵人們積極參與自己的醫療保健決策，而不是僅僅依賴醫療專業人員。包括宣導獲得更好地醫療保健，更好的護理品質，以及更好的病人權利。尋求建立一個更公平的醫療保健系統，讓每個人都能獲得相同品質的照護，無論其經濟或社會地位如何。提供如何解決這些問題的實際範例，並展示如何在社區中創造積極的變化，特別是：

- 訪問服務
- 照護的品質和成本，像是缺乏實證方法和提供不合標準的照護
- 工作力短缺
- 人口老齡化

4、參與報告主題：

報告者	主題
謝明芫護理師	Using artificial intelligence to create a dashboard for safety incident analysis and management





摘要：

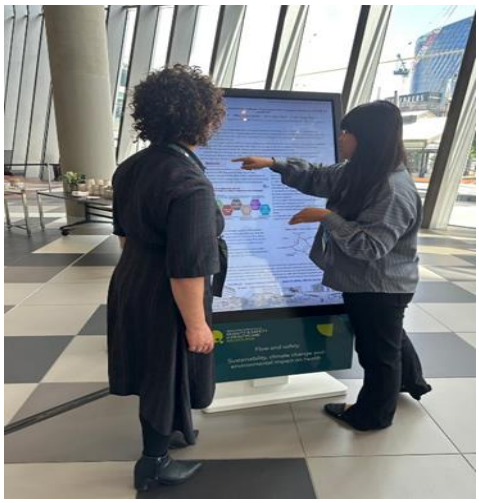
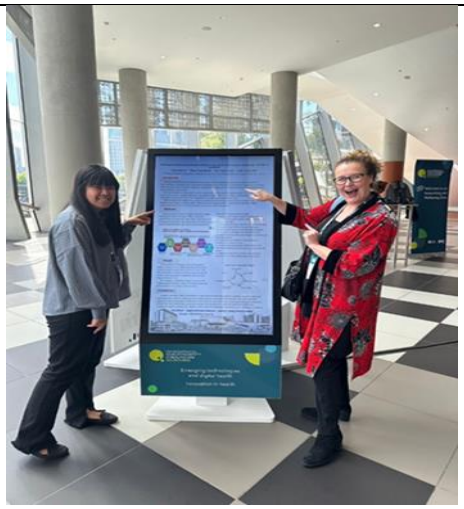
專案的核心目標是利用儀表板對異常事件進行即時趨勢分析。這種方法使我們能夠識別潛在風險，更重要的是，可以防止將來發生類似事件。我們的專案使用 Microsoft 軟體， Power BI、Teams Power Virtual Agents 和 Power Automate來開發兩個主要專案：安全事件報告儀表板和自動問答機器人。

事件報告儀表板使我們能夠進行趨勢分析、風險管理並追蹤專案改進。例如透過按月份、發生單位或類別點擊儀表板，它可以提供以下內容的即時互動顯示：1.當月事件報告數量。2.根本原因分析的數量。3.各類別案件數。4. 追蹤案件狀態。5. 追蹤嚴重程度高於中度案件清單。

問答機器人有助於減少分類錯誤。使用者若詢問事件分類定義，聊天機器人會立即提供定義以增強安全事件的一致性。聊天機器人的主要優點在於其節省時間，例如減少解釋時間（從28秒減少到13秒）以及即時提供單位通報安全事件的數量（將搜尋時間從99秒減少到22秒）。

匯入Power BI（Power Business Intelligence）可以在短時間內有效地將資料繪製成所需的樣式。醫院內負責病人安全的同仁使用智能化儀表板將帶來巨大的好處。它簡化了識別問題時間以利及時採取改善措施。安全儀表板提供了風險因素的全面概述，使我們能夠監控績效、減少傷害並提高整體工作場所健康和安全。

余佳穗護理師	Building hospital organizational resilience to promote staff resilience during the COVID-19 pandemic

摘要：

由於2020年開始爆發COVID-19疫情，根據本院2021年的患者安全文化調查結果顯示復原力正向百分比為9.1%；單位的安全氛圍為42.2%，其分數均低於區域醫院復原力正向百分比為20.1%，以及單位安全氛圍為55.5%。此外，員工滿意度調查的所有方面得分都下降了，其中在COVID-19流行期間，“組織認同”方面的得分從76.39下降到75.74。

本院通過組建“組織韌性促進小組”來促進人員韌性，介入措施包括：

1.盤點目前促進員工韌性的活動。

2.舉辦復原力課程。

3.建立員工關懷機制，為員工提供心理諮詢和精神支持。

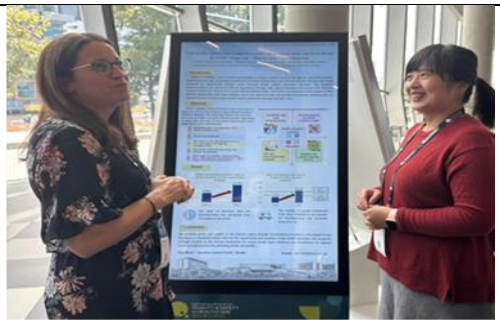
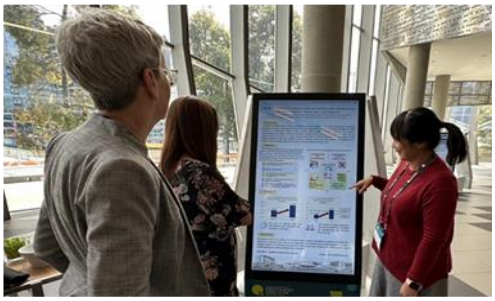
4.鼓勵單位成員參加與正念相關的課程。

5.進行員工年度健康檢查，制定超時工作和壓力的健康保護計劃。

2021年和2022年患者安全文化調查的積極百分比結果顯示，復原力從9.1%增加至2022年的11.7%；單位安全風氣將從42.2%增加至47%；對管理感受從42.1%增加至45.1%；2021年和2022年員工滿意度報告顯示，“組織認同”方面的總體滿意度得分將從77.3提高至2022年的78.7。

雖然透過專案改善的效果仍然低於區域醫院，通過長期規劃促進組織韌性，持續培養和加深人員韌性，對員工進行個別關懷以及主管的支持，在COVID流行期間幫助員工發展韌性，持續積極思考並避免工作疲憊。

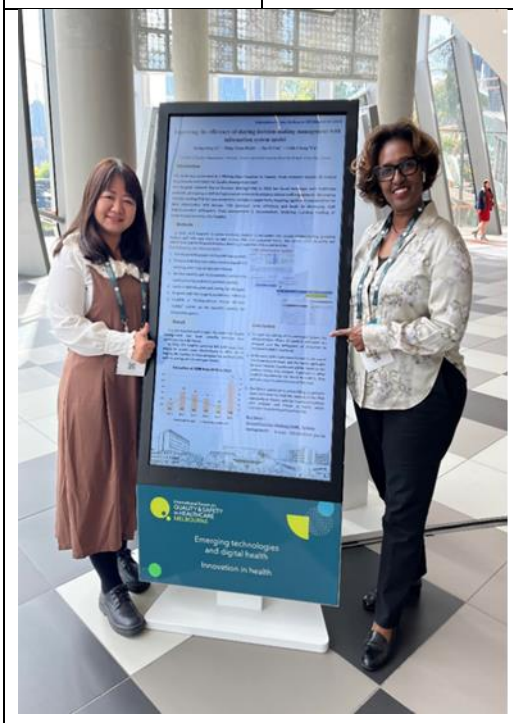
林佳儀副管理師	Using Quality Control Circle to improve execution rate of ischemic stroke reperfusion therapy

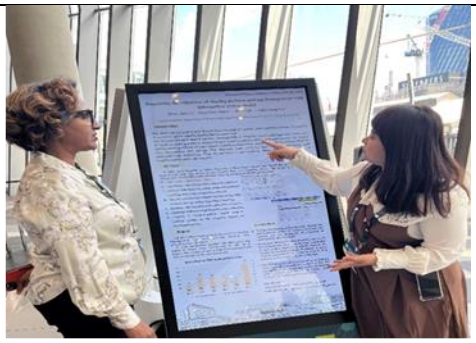




摘要：

中風在臺灣是十大死因中位居第四，會導致病人死亡和殘疾的重大疾病。本院急性缺血性中風病人實施再灌流治療率為9.4%，其中動脈取栓實施率為5.5%。為提升中風病人照護品質，跨單位合作組成品管圈進行改善，使用頭腦激盪和魚骨圖篩選出12個根因。並找出五個真因：人手不足，團隊協作差，空間和實時影像設備不足，轉診流程不明確，以及公眾意識不足。擬訂對策實施：全面人員培訓、促進跨團隊合作、優化轉診流程、建置與急診救護員溝通管道及推廣中風健康教育倡議。再灌流治療率從9.4%提升至17.7%，動脈取栓實施率由5.5%提升至12.6%。值得一提，本院於區域醫院及醫學中心中表現優異。動脈血栓切除時間從173分鐘大幅減少到155分鐘，而動脈血栓切除病人轉診則從10例增加到15例。藉著品管圈的改善，將有效的改善措施列為標準化、並優化與EMS反饋系統，以大幅提升竹苗地區中風病人照護品質。

李幸容副管理師	Improving the efficiency of sharing decision-making management with information system model





摘要：醫病共享決策(Shared Decision Making,SDM)是醫病溝通及治療選擇之重要手法。本院於2018年即開始推動SDM，然傳統紙本執行方式及2019年之COVID-19 疫情因素，SDM推行成效不佳，以及紙本資料由各執行SDM團隊自行管理，缺乏統一整合全院資料單位，醫院管理階層及科部主管無法即時掌握當前執行狀況，故透過SDM資訊化的導入以提升臨床人員執行率及有效管理全院執行情形。本院2022年將電子病歷線上系統導入醫病共享決策資訊化功能於2023年正式啟用；品質管理中心為全院統籌單位，負責制訂全院SMD作業流程與管理，並制訂以下介入措施(1)醫療科部會議宣導SDM系統功能及製作系統操作手冊供同仁使用(2)每月追蹤各單位執行情況，回饋醫療科部主管與院層會議報告(3)辦理SDM教育訓練課程(4)SDM推動納入院層級平衡計分績效指標(5) 官網設立「醫病共享決策專區」，提供病人與家屬有多元管道查詢相關資訊。以全院每年執行量進行評量，以2018年收案數304位，平均每月收案25位；進行SDM資訊化後，截至2023年8月收案數為1060位，平均每月收案133位，大幅提升全院執行成效。由此可知，有效運用資訊科技輔助，減少醫療人員在行政事務處理，提升人員對於SDM執行意願。

四、心得及建議：

(1)　會議主軸為以人為本的變革與流程：面對COVID-19 大流行，醫療機構在採取應變措施後，引發反思「復原力」的概念，在於衛生系統如何調適以抵禦疫情危機的擾亂。組織內實施的員工健康和福利計劃來改善員工生、心理健康、提高生產力並減少病假，甚至降低員工離職率以減少醫療體系缺工的問題，包括要有單位主管的支持、同儕間的互助夥伴關係、足夠的資源系統，並且藉由有效的量測方式來發現高風險員工，提供心理精神諮詢服務，建立支持員工健康和福祉的組織文化。

(2)　學習型醫療系統(LHS) 的概念已在全球發酵，將研究和政策轉化為實踐，共同設計據實證基礎的照護模型，提高醫療品質，利用激勵措施，定期收集的健康數據衡量結果，建立支持改善流程。 BMJ Best Practice為醫療保健專業人員提供有關醫療狀況的診斷、治療和管理的可靠資訊。透過輕鬆存取最新醫療資訊的方式來提高照護品質和病人治療效果。未來若有相關的醫療品質相關改善也可以利用這個工具來查詢最佳化的實踐改善措施。

(3)　ACHS使用Metrik進行數據測量和分析，提供所有醫療保健組織衡量績效並與澳洲和世界各地的機構進行比較。除了基準測試、透明度和易用性之外，每六個月提交一次資料，即可對數據進行分析。此次，醫學中心需要提供大量的數據和同儕值比較，若醫院能利用資訊化軟體建立大數據資料庫，並進行智能化的分析比較，將有助於評鑑日常化的管理。

(4)　Ascom 醫療保健平台利用臨床資訊系統，進行重症監護流程的數位化，若病人出現危急的生命徵象，可進行警報通知，管理系統可以收集和顯示事件資訊和及時波形，以提供病人狀態的清晰且情境化的圖片 。這些資訊可以顯示在大型壁掛式顯示器、個人電腦和/或智慧型手機上提醒醫療人員留意病人狀況。此外，各種不同疾病的病人可以由臨床醫療專業者設定符合該疾病類型的病人生理參數，達到個別化的照護，以提升病人的照護品質。

五、攜回資料名稱與內容：

(一)發表證明4張：(如圖4~15)

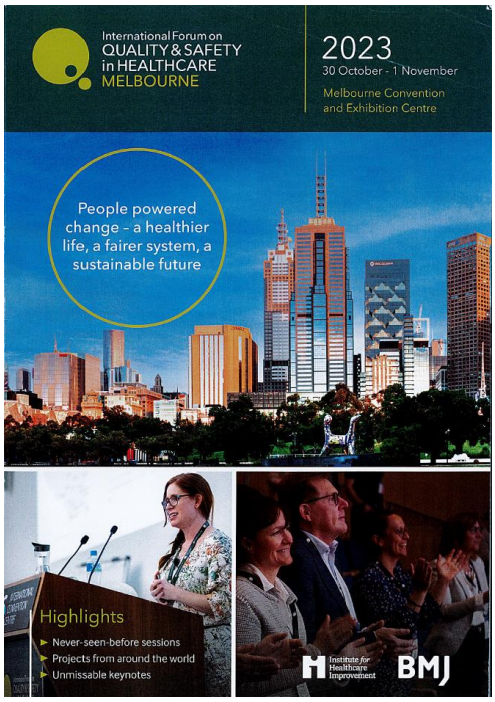


圖4、會議手冊

圖5、大會APP

圖6、謝明芫護理師出席證明

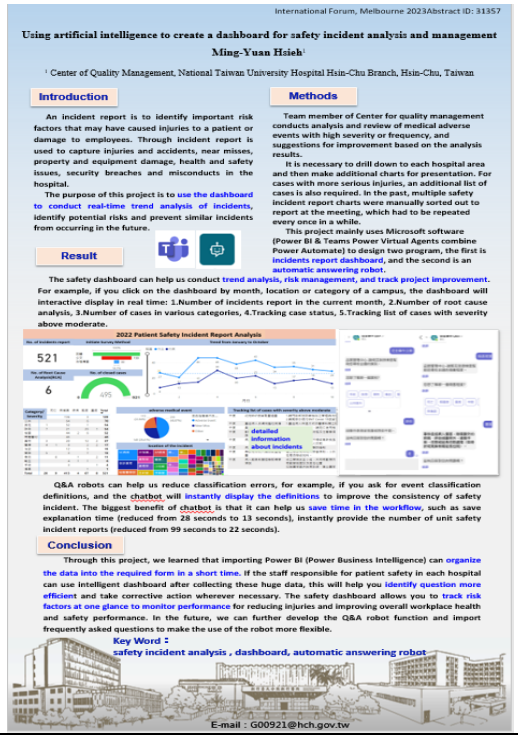


圖7、謝明芫護理師海報展示

International Forum on QUALITY & SAFETY in HEALTHCARE MELBOURNE 30 Oct - 1 Nov 2023 Melbourne Convention and Exhibition Centre (MCEC)

BMJ

Certificate of Attendance

I certify that

CHIA SUI YU

attended the

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held at the Melbourne Convention and Exhibition Centre

Tuesday 31 October 2023 ☐

Wednesday 1 November 2023 ☐

The International Forum in Melbourne has been approved for a total of 24 CPD credits by the Federation of the Royal Colleges of Physicians of the United Kingdom (event code 146053).

Dr Ashley McKimm
Director of Partnership Development
on behalf of BMJ and Institute for Healthcare Improvement

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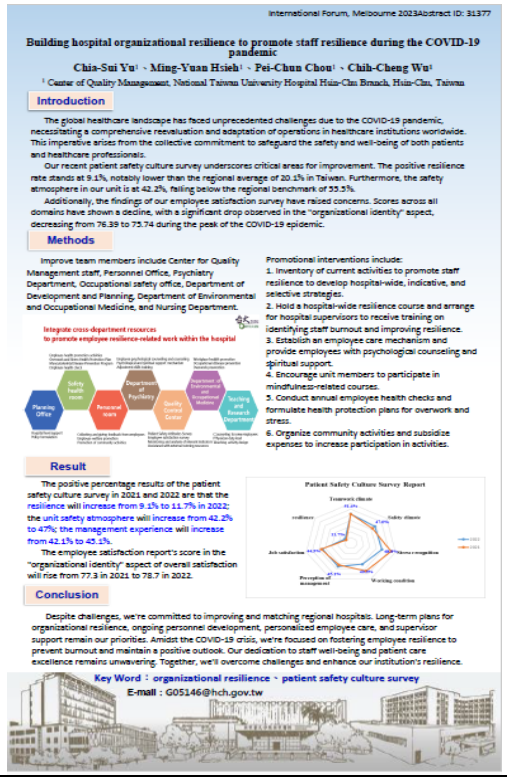
圖8、余佳穗護理師出席證明



International Forum, Melbourne 2023Abstract ID: 31377

Building hospital organizational resilience to promote staff resilience during the COVID-19 pandemic

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Introduction

The global healthcare landscape has faced unprecedented challenges due to the COVID-19 pandemic, necessitating a comprehensive reevaluation and adaptation of operations in healthcare institutions worldwide. This imperative arises from the collective commitment to safeguard the safety and well-being of both patients and healthcare professionals.

Our recent patient safety culture survey underscores critical areas for improvement. The positive resilience rate stands at 9.1%, notably lower than the regional average of 20.1% in Taiwan. Furthermore, the safety atmosphere in our unit is at 42.2%, falling below the regional benchmark of 55.5%.

Additionally, the findings of our employee satisfaction survey have raised concerns. Scores across all domains have shown a decline, with a significant drop observed in the "organizational identity" aspect, decreasing from 76.39 to 73.74 during the peak of the COVID-19 epidemic.

Methods

Improve team members include Center for Quality Management staff, Personnel Office, Psychiatry Department, Occupational safety office, Department of Development and Planning, Department of Environmental and Occupational Medicine, and Nursing Department.

Integrate cross-department resources to promote employee resilience-related work within the hospital

Promotional interventions include:
1. Inventory of current activities to promote staff resilience to develop hospital-wide, indicative, and selective strategies.
2. Hold a hospital-wide resilience course and arrange for hospital supervisors to receive training on identifying staff burnout and improving resilience.
3. Establish an employee care mechanism and provide employees with psychological counseling and spiritual support.
4. Encourage unit members to participate in mindfulness-related courses.
5. Conduct annual employee health checks and formulate health protection plans for overwork and stress.
6. Organize community activities and subsidize expenses to increase participation in activities.

Result

The positive percentage results of the patient safety culture survey in 2021 and 2022 are that the resilience will increase from 9.1% to 11.7% in 2022; the unit safety atmosphere will increase from 42.2% to 47%; the management experience will increase from 42.1% to 42.1%.

The employee satisfaction report's score in the "organizational identity" aspect of overall satisfaction will rise from 77.3 in 2021 to 78.7 in 2022.

Patient Safety Culture Survey Report

Conclusion

Despite challenges, we're committed to improving and matching regional hospitals. Long-term plans for organizational resilience, ongoing personnel development, personalized employee care, and supervisor support remain our priorities. Amidst the COVID-19 crisis, we're focused on fostering employee resilience to prevent burnout and maintain a positive outlook. Our dedication to staff well-being and patient care excellence remains unwavering. Together, we'll overcome challenges and enhance our institution's resilience.

Key Word：organizational resilience、patient safety culture survey
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圖9、余佳穗護理師海報展示

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Dr Ashley McKimm
Director of Partnership Development
on behalf of BMJ and Institute for Healthcare Improvement

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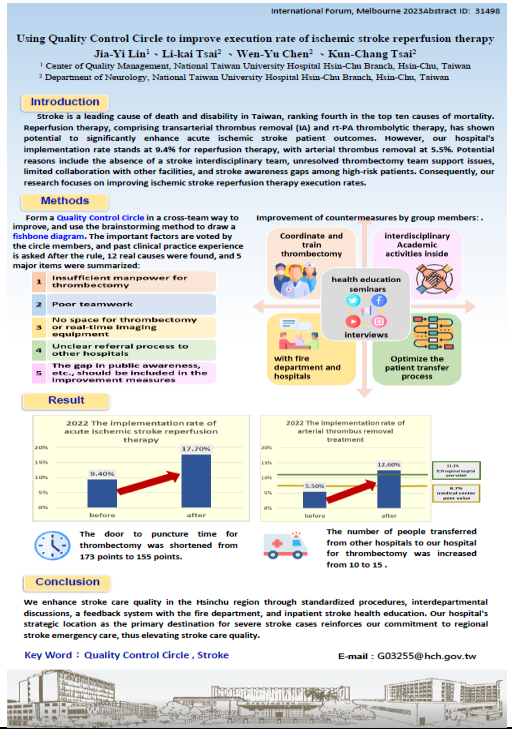
圖10、林佳儀副管理師出席證明



International Forum, Melbourne 2023Abstract ID: 31498

Using Quality Control Circle to improve execution rate of ischemic stroke reperfusion therapy

Jia-Yi Lin[1]、Li-kai Tsai[2]、Wen-Yu Chen[2]、Kun-Chang Tsai[2]
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Introduction

Stroke is a leading cause of death and disability in Taiwan, ranking fourth in the top ten causes of mortality. Reperfusion therapy, comprising transarterial thrombus removal (IA) and rt-PA thrombolytic therapy, has shown potential to significantly enhance acute ischemic stroke patient outcomes. However, our hospital's implementation rate stands at 9.4% for reperfusion therapy, with arterial thrombus removal at 5.5%. Potential reasons include the absence of a stroke interdisciplinary team, unresolved thrombectomy team support issues, limited collaboration with other facilities, and stroke awareness gaps among high-risk patients. Consequently, our research focuses on improving ischemic stroke reperfusion therapy execution rates.

Methods

Form a Quality Control Circle in a cross-team way to improve, and use the brainstorming method to draw a fishbone diagram. The important factors are voted by the circle members, and past clinical practice experience is asked After the rule, 12 real causes were found, and 5 major items were summarized:

1. Insufficient manpower for thrombectomy
2. Poor teamwork
3. No space for thrombectomy or real-time imaging equipment
4. Unclear referral process to other hospitals
5. The gap in public awareness, etc., should be included in the improvement measures

Improvement of countermeasures by group members: .

Coordinate and train thrombectomy
interdisciplinary Academic activities inside
health education seminars
interviews
with fire department and hospitals
Optimize the patient transfer process

Result

2022 The implementation rate of acute ischemic stroke reperfusion therapy

2022 The implementation rate of arterial thrombus removal treatment

The door to puncture time for thrombectomy was shortened from 173 points to 155 points.

The number of people transferred from other hospitals to our hospital for thrombectomy was increased from 10 to 15 .

Conclusion

We enhance stroke care quality in the Hsinchu region through standardized procedures, interdepartmental discussions, a feedback system with the fire department, and inpatient stroke health education. Our hospital's strategic location as the primary destination for severe stroke cases reinforces our commitment to regional stroke emergency care, thus elevating stroke care quality.

Key Word：Quality Control Circle , Stroke
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圖11、林佳儀副管理師海報展示

International Forum on QUALITY & SAFETY in HEALTHCARE MELBOURNE 30 Oct - 1 Nov 2023 Melbourne Convention and Exhibition Centre (MCEC)

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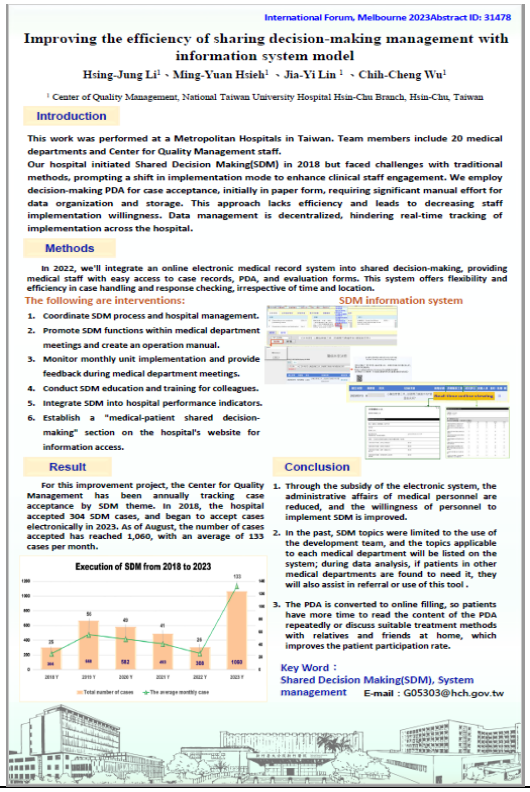
Dr Ashley McGimm
Director of Partnership Development
on behalf of BMJ and Institute for Healthcare Improvement

Institute for Healthcare Improvement BMJ

圖12、李幸容副管理師出席證明



International Forum, Melbourne 2023Abstract ID: 31478

Improving the efficiency of sharing decision-making management with information system model

Hsing-Jung Li[1]、Ming-Yuan Hsieh[1]、Jia-Yi Lin[1]、Chih-Cheng Wu[1]

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Introduction

This work was performed at a Metropolitan Hospitals in Taiwan. Team members include 20 medical departments and Center for Quality Management staff.
Our hospital initiated Shared Decision Making(SDM) in 2018 but faced challenges with traditional methods, prompting a shift in implementation mode to enhance clinical staff engagement. We employ decision-making PDA for case acceptance, initially in paper form, requiring significant manual effort for data organization and storage. This approach lacks efficiency and leads to decreasing staff implementation willingness. Data management is decentralized, hindering real-time tracking of implementation across the hospital.

Methods

In 2022, we'll integrate an online electronic medical record system into shared decision-making, providing medical staff with easy access to case records, PDA, and evaluation forms. This system offers flexibility and efficiency in case handling and response checking, irrespective of time and location.

The following are interventions:

1. Coordinate SDM process and hospital management.
2. Promote SDM functions within medical department meetings and create an operation manual.
3. Monitor monthly unit implementation and provide feedback during medical department meetings.
4. Conduct SDM education and training for colleagues.
5. Integrate SDM into hospital performance indicators.
6. Establish a "medical-patient shared decision-making" section on the hospital's website for information access.

SDM information system

Result

For this improvement project, the Center for Quality Management has been annually tracking case acceptance by SDM theme. In 2018, the hospital accepted 304 SDM cases, and began to accept cases electronically in 2023. As of August, the number of cases accepted has reached 1,060, with an average of 133 cases per month.

Execution of SDM from 2018 to 2023

Conclusion

1. Through the subsidy of the electronic system, the administrative affairs of medical personnel are reduced, and the willingness of personnel to implement SDM is improved.
2. In the past, SDM topics were limited to the use of the development team, and the topics applicable to each medical department will be listed on the system; during data analysis, if patients in other medical departments are found to need it, they will also assist in referral or use of this tool .
3. The PDA is converted to online filling, so patients have more time to read the content of the PDA repeatedly or discuss suitable treatment methods with relatives and friends at home, which improves the patient participation rate.

Key Word：
Shared Decision Making(SDM), System management
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圖13、李幸容副管理師海報展示

圖14、與台大體系醫院共同合影

圖15、與台大總院、彰基共同合影