CI: 69–70%) agreed health professionals involved patients and families in efforts to improve patient care; and 69% (95% CI: 68–70%) agreed it was easy to speak up in their clinical area. Correlations showed links between perceptions of stronger clinical leadership and performances on the three questions, as well as with other survey items. The proportional mixed model also revealed response differences by respondent characteristics.

IMPLICATIONS
The findings suggest positive commitment to quality and safety amongst New Zealand health professionals, albeit with variations by district, profession, gender and age, but also scope for improvement. The study also contributes to the literature indicating that clinical leadership is an important component of quality improvement.

Improving Quality and Safety Through an Evidenced-Based Development Program for Clinical Leaders in Victoria, Australia

Sandra G. Leggat[1], Cathy Balding[1], Anne Smyth[2]

[1]La Trobe University, School of Public Health and Human Biosciences, Bundoora, Victoria 3086; [2]Organisational Consulting

4A.2

OBJECTIVES
The Australasian College of Health Service Management (ACHSM), La Trobe University, Qualityworks and the Australian Centre for Leadership Development collaborated to develop, provide and evaluate an innovative education project funded through by the Victorian Government Department of Health. The aim of the project was to increase the skills of clinical leaders in quality and safety, including a range of health professionals across metropolitan, rural and regional acute, community, long term care and primary care settings.

METHODS
A year-long Clinical Leadership program was developed using the evidence from a detailed literature review, as well as advice from an expert steering committee and interviews and focus groups of relevant organisational stakeholders. A pilot program with 24 health professional participants was provided in 2011/12. A comprehensive process and summative evaluation of the pilot program was completed and provision of the 2013 program with 36 participants has started, with relatively few modifications in the program content and delivery.

LESSONS LEARNED
The pilot program won an international award for Innovation in Health Care Education. The participating clinicians developed a range of leadership skills that enabled them to have a greater impact on quality and safety within their organisations. The most effective program content focused on focused personal and organisational development, which was delivered through an innovative multi-faceted education approach.

IMPLICATIONS
Evidence-based development of clinical leaders can impact quality and safety in care delivery.

Promoting Stakeholder Engagement in the Development of Clinical Policies and Guidelines in a Multi-Site Tertiary Health Care Facility

Aurora Bermudez Ortega, Kathryn Kynoch, Christopher Torpy-Ladd

Mater Health Services, Nursing Research Centre, Clinical Policy

4A.3

OBJECTIVES
This paper will describe the processes employed by Clinical Policy Officers at Mater Health Services (MHS) to promote input from content and context experts in the development of organisational, evidence based clinical policies and guidelines.

METHODS
MHS operates seven co-located, Private and Public Hospitals and provides services up to 500, 000 patients annually. MHS develop evidence based clinical policies and guidelines using a multidisciplinary, consultative approach. This approach is co-ordinated by Clinical Policy Officers and relies on the successful engagement of content and context experts within and outside the organisation.

Engagement of stakeholders in the consultative process has involved a number of key strategies. These strategies include the development and support of Lead Author and Policy Buddy roles which encourage novice clinicians to participate in clinical policy development; the establishment of multidisciplinary, clinical policy governance committees; the administration of an electronic consultation platform and the utilisation of transparent communication practices throughout the development cycle.

LESSONS LEARNED
Consultation through effective engagement of stakeholders takes time and in a large multi-site centre with multiple specialties, disagreement and conflict do emerge. Different service funding arrangements, diverse understandings of the processes involved in clinical policy and guideline development and busy clinical schedules, all contribute to the challenges in facilitating stakeholder engagement.

IMPLICATIONS
Sustainable engagement requires attention to process, a robust visible structure and strong leadership from senior hospital administrators. The strategies employed have been observed to increase understanding, participation and strength in the development of evidence based, multidisciplinary clinical policies and guidelines.

District Health Boards' Public Reporting of Serious and Sentinel Events in New Zealand: Is it Open, Understandable and Meaningful?

Brian Robinson

Graduate School of Nursing, Midwifery & Health, Victoria University of Wellington

4A.4

OBJECTIVES
The objective is to identify how District Health Boards (DHBs) publicly share and convey serious and sentinel event (SSE) information. DHBs are required to report adverse events to the Health Quality & Safety Commission New Zealand (HQSC) within 15 working days of occurring and provide the summary and recommendations within 70 working days. From 2007 through to 2011 the HQSC publicly reported all DHB SSEs. From 2012, the HQSC published summary data only. Public reporting of SSEs occurring from July 2011 to June 2012 became the responsibility of individual DHBs to be published in November 2012.

METHODS
Twenty DHB websites were accessed via the Ministry of Health website and searched using the phrase "serious and sentinel events". Documents, data and information obtained were reviewed and categorised for availability, summary and recommendations and use of clear language.

LESSONS LEARNED
From the 20 New Zealand DHB websites, 19 SSE reports for 2011–2012 were obtained. There was variability regarding presentation of information. Three DHBs reported a summary of SSEs as plain language narratives. Sixteen DHBs provided reports as variations of the HQSC data spreadsheet format. Of these, eleven DHBs predominantly reported with clinical language and medical jargon and six DHBs predominantly used plain language. In several instances, recommendations were still pending indicating the public reports have not been updated since November 2012.

IMPLICATIONS
Gaps and opportunities exist for many DHBs to publicly share information and communicate in clear language, for all to understand, regarding the quality and safety of care provided.

An Evaluation of the 'Preventing Falls and Harm from Falls in Older People Best Practice Guidelines for Australian Hospitals'

Anna Barker[1], Caroline Brand[1], Sandy Brauer[2], Renata Morello[1], Georgie Rose[1]

[1]Monash University; [2]University of Queensland

4A.5

OBJECTIVES
This evaluation aims to undertake a comprehensive review of the 'Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals' and to develop key recommendations for the planned review in 2013–2014.

METHODS
A panel of 18 clinicians, researchers and policy leaders was formed to assess the overall quality of the guidelines and implementability of key