

Transforming Healthcare Research & Innovation Symposium

Foreword

Executive Director Medical Services Dr Nicola Murdock

Welcome to West Moreton Health's *Research and Innovation Symposium: Transforming Healthcare*.



Our annual symposium celebrates the people, partnerships and ideas that are shaping the future of healthcare across West Moreton. It showcases the outstanding research, service improvement and innovation being led by our staff, alongside the valuable contributions of our academic, industry and community partners.

Research and innovation are essential to delivering safe, effective and person-centred care. Through the work highlighted in this year's symposium, we are strengthening our ability to respond to emerging challenges, improve patient outcomes and deliver better healthcare for the communities we serve.

This year's program features a diverse range of oral presentations and posters spanning clinical research, quality improvement and, for the first time, a dedicated clinical innovation stream. The addition of this stream reflects our growing commitment to developing and implementing new models of care, technologies and solutions that improve healthcare delivery and meet the changing needs of our population.

We are also pleased to welcome Professor Jeffrey Dunn AO, University of Southern Queensland, as our plenary speaker. Professor Dunn is internationally recognised for his leadership in health research and cancer survivorship, and we look forward to the valuable insights he will share with delegates.

The symposium provides an important opportunity to recognise excellence through the Research Excellence Awards and Research to Practice Awards, celebrating individuals and teams whose work is generating new knowledge and translating evidence into meaningful improvements in patient care.

I would also like to acknowledge the ongoing support of our symposium sponsors, the West Moreton Health Foundation and National Australia Bank (Riverlink Branch). Their partnership helps foster a culture where research, improvement and innovation can thrive.

I encourage you to connect with colleagues, explore new ideas and take the opportunity to learn from the exceptional work being undertaken across our health service.

Together, we are building a stronger culture of inquiry, innovation and continuous improvement that will help transform healthcare for our communities now and into the future.

Research and Innovation Symposium agenda

	Session	Speaker
8.30–9am	Registration	
9–10.10am	Welcome and plenary	Chair: West Moreton Health (WMH) Executive Director Medical Services Dr Nicola Murdock
	Event information	WMH Director Research Christopher Hicks
	Acknowledgement of Country	WMH Director Aboriginal and Torres Strait Islander Health Unit Maurice Woodley
	Official welcome	WMH Chief Executive Hannah Bloch
	Sponsor welcome	West Moreton Health Foundation (WMHF) Chief Executive Officer Scott Young and National Australia Bank (NAB) Riverlink representative Melissa Rogaloff
	Plenary speaker	University of Southern Queensland (UniSQ) Professor of Social and Behavioural Science and Chair Cancer Survivorship Professor Jeffrey Dunn AO
	Awards: Research Excellence and Research to Practice	WMH Director Research Christopher Hicks, WMHF Chief Executive Officer Scott Young, and NAB representative Melissa Rogaloff
10.10–10.35am	Morning tea	
10.35–11.45am	Research session	Chair: Queensland Centre for Mental Health Research (QCMHR) Assistant Director Dr Duncan McLean
Standard	Core components and implementation outcomes of the Preventative Integrated Care Service – first three years	Darling Downs and West Moreton Primary Health Network Regional Planning Lead and Queensland University of Technology PhD Candidate, Ashleigh Earnshaw
Rapid	New ROTEM FIBTEM: should the fibrinogen replacement threshold change for critical bleeding?	WMH Emergency Specialist Dr Akmez Latona
Rapid	Developing trauma-informed care guidelines for the emergency department context	QCMHR, Principal Research Officer Olivia Miller
Standard	Nurse-led transitional and aftercare program for adult burn survivors: development and preliminary effects	UniSQ, Associate Professor Jonathan Bayuo

Rapid	Breast cancer, brain health and exercise: insights from novel clinical studies	UniSQ Lecturer Tahnee Downs
Standard	Delayed discharge beyond medical clearance in gastrointestinal surgery: a qualitative study of workflow, system misalignment, and operational normalised delay	UniSQ Lecturer and University of Technology Sydney PhD Candidate Mathulada Chaimee
Rapid	When ADHD runs in families: impacts of unrecognised maternal ADHD	WMH Registered Nurse Tamara Taione
Rapid	Computed Tomography Coronary Angiography-first evaluation in an Australian regional chest pain assessment service: real-world outcomes	WMH and Metro South Health Basic Physician Trainee Dr Krishnaa Sivapalan
11.30–11.35am	Question time	
11.35–11.40am	Vote break / 5 mins stretch time	
11.40–11.45am	Award: Best Research presentation	WMH Director Research Christopher Hicks, WMHF Chief Executive Officer Scott Young, and NAB representative Melissa Rogaloff
11.45am–12.45pm	Lunch and poster display	
12.45–1.55pm	Quality Improvement session	Chair: Senior Director Patient Safety and Quality Erin Finn
Rapid	Beyond keywords: semantic NLP for auditing narrative clinical documentation in mental health electronic health records	WMH Director of Service Evaluation and Research Unit, Professor Niall Higgins
Standard	Empowered nurses, improved patient journeys: implementing Extended Practice Authority RN in the Ripley Minor Injury and Illness Clinic	WMH Assistant Nursing Director Marissa Alexander and WMH Nurse Unit Manager James Want
Rapid	Charting the unknown: establishing pathways for supporting dysphagia post electroconvulsive therapy	WMH Speech Pathologist Alison McGann
Standard	Safer transfusions for rural communities: strengthening blood product traceability and	WMH Clinical Nurse Consultant (CNC) Bronwen Pauli

	stewardship across rural hospitals	
Rapid	Implementing room service on demand and electronic menu management in a greenfield sub-acute facility: the critical role of the senior nutrition assistant	WMH Senior Dietetic Assistant Cheryl Grulke
Rapid	Cellulitis: what is the scope of OT intervention in an acute hospital setting?	WMH Senior Occupational Therapist and Lymphoedema Practitioner Julia Douglas
Standard	Improving pneumococcal vaccination uptake among dialysis patients with chronic kidney disease: a quality improvement study in Queensland, Australia	WMH Clinical Nurse Alison Kenny
Rapid	More than a screening tool: changing dysphagia referral practice across four rural hospitals	WMH Speech Pathologist Olivia Jones
1.40–1.45pm	Question time	
1.45–1.50pm	Vote break / 5 mins stretch time	
1.50–1.55pm	Award: Best Poster and Best Quality Improvement presentation	WMH Director Research Christopher Hicks, WMHF Chief Executive Officer Scott Young, and NAB representative Melissa Rogaloff
1.55–2.15pm	Afternoon tea	
2.15–3.25pm	Clinical Innovation session	Chair: Executive Director of Mental Health, Addictions, Custodial Health and Statewide Services Professor Luke Butcher
Rapid	Breaking down barriers to Hepatitis C testing	WMH Clinical Nurse Lisa Ball and WMH CNC Grace O'Donoghue
Rapid	Implementation of SOSI compliant SMS confirmation process for appointment bookings in paediatric dietitian clinic	WMH Senior Paediatric Dietitian Ainsley Galton
Standard	Improving patient access and flow for general medicine through the implementation of the Rapid Assessment Intervention and Discharge (RAID) model of care at Ipswich Hospital	WMH Project Lead General Medicine Redesign Kate Atkinson

Rapid	Implementing an OT cadet in mental health residential rehabilitation	WMH A/Occupational Therapy Discipline Lead and Allied Health Workforce Lead Jessica Warner
2.40–2.45pm	Question time – session one	
Rapid	Evaluation of cancer treatment diary card (PROMs tool) for the monitoring of treatment related toxicity	WMH Pharmacist Advanced Lesley Dawson
Standard	Systems approach to health intelligence: identifying opportunities for patient-centred models of care	WMH Health Intelligence Lead John Marquess
Rapid	Rural palliative care outreach and in-reach model: developing an integrated specialist rural palliative care service	WMH Senior Staff Specialist Dr Trish Kahawita and WMH Nurse Navigator / Nurse Practitioner Candidate Ela Thompson
Standard	Time is tissue: redesigning rural wound care to improve access	WMH Acting Senior Planning Officer Elle Goodwin and WMH Clinical Nurse Melissa Jackson
3.15–3.20pm	Question time – session two	
3.20–3.25pm	Award: Best Clinical Innovation presentation	WMH Executive Director Mental Health, Addictions, Custodial Health and Statewide Services Professor Luke Butcher, WMHF Chief Executive Officer Scott Young, and NAB representative Melissa Rogaloff
3.25–3.30pm	Closing remarks	WMH Director Research Christopher Hicks

Research and Innovation Symposium posters

	Title	Presenter	
1	Intranasal delivery of nanoparticle-encapsulated Clozapine as a lysosome-targeting therapy for treatment-resistant Glioblastoma	Queensland Centre for Mental Health Research (QCMHR) Senior Researcher Dr Xiaoying Cui	Res
2	Using waiting time to capture the patient story: a prospective evaluation of VitalStory in the emergency department	The University of Queensland (UQ) PhD Candidate Anton Cush	Res
3	A co-designed resistance training-based physical activity intervention to improve cognition in overweight or obese older adults independently living in regional Australia	University of Southern Queensland (UniSQ) PhD Candidate Thilini Herath Pathirana	Res
4	Identifying the components of research frameworks in health services: a scoping review	West Moreton Health (WMH) Director Research Christopher Hicks	Res
5	Evaluating rural telepractice dysphagia care at West Moreton Health: a nine-year review	WMH Senior Speech Pathologist Chaerim Kim	Res
6	Outcomes of implantation of totally implanted vascular access devices for oncology patients in interventional radiological suites or operating rooms: a systematic review	WMH Nurse Educator Trudie Lawson	Res
7	Feasibility, acceptability and effectiveness of a tailored exercise-based rehabilitation program for postural orthostatic tachycardia syndrome (POTS): a Queensland Health pilot program	WMH Exercise Physiologist and UQ PhD Candidate Olivia Powrie	Res
8	Real-world intravascular imaging use in left main percutaneous coronary intervention: contemporary adoption patterns and clinical outcomes in a large multicentre registry	WMH and Metro South Health (MSH) Basic Physician Trainee Dr Krishnaa Sivapalan	Res
9	The prevalence, risk factors and interventions for dysphagia in adults with a severe mental illness: a scoping review	UniSQ Student (Honours) Ruby Strasser and UniSQ Student (Honours) Alice Foster	Res
10	Thriving at work: improving support and retention of early career nurses at West Moreton Health	UniSQ Professor Daniel Terry and WMH Nurse Educator Robert Winstone	Res
11	Bridging the gap in chronic pain management: a translational research program empowering healthcare professionals and consumers	UniSQ Lecturer Dr Emily Wang	Res
12	Improving multidisciplinary team communication through the implementation of rapid rounds in general medicine at Ipswich Hospital	WMH Project Lead SAFEST Kate Atkinson, WMH Executive Director Allied Health Philip Juffs, WMH Director of Physiotherapy Justin Jacob, and Clinical Director Acute	QI

		Medicine and Older Persons Dr Connor O'Neill	
13	The long road home: expanding hospital in the home for rural communities	WMH Staff Specialist Dr Nicholas Duong	QI
14	Improving dietetic documentation in ieMR through transition from PowerForms to progress notes: a quality improvement initiative	WMH Senior Paediatric Dietitian Ainsley Galton and Team Leader Dietitian Danielle McLaren	QI
15	Evaluation of acute coronary syndrome management at Ipswich Hospital against national clinical care standards: a clinical audit	WMH Medical Registrar Dr Hope Kinloch	QI
16	Are we monitoring the right patients? Evaluating telemetry utilisation and guideline compliance in medical wards	WMH Medical Registrar Dr Hope Kinloch, and MSH Registrar Dr Anusha Natani	QI
17	Streamlining gastrostomy management and follow up processes to improve patient experience at Ipswich Hospital	WMH Dietitian Riya Master	QI
18	Sudden unexpected death in infancy project: implementation of recommendations for WMH following the Queensland Paediatric Quality Council (QPQC) summary report	WMH Clinical Nurse Consultant Sheree Murray	QI
19	Improving physiotherapy management of COPD to align with clinical care standards	WMH Senior Physiotherapist Sarah Williams	QI
20	Audit of CT-guided percutaneous lung biopsies: complications, diagnostic yield and specimen adequacy prior to biopsy device change	WMH Registrar Dr Yuze Zhai	QI
21	Pregnancy care in WMH correctional centres	WMH Principal Project Manager Sarah Sorensen	CI
22	Co-design and engagement for improved interpreter services delivery	WMH Principal Project Officer Nicole Burns and WMH Interpreter Coordinator Anna Price	CI
23	Tiny transitions: supporting big outcomes for small patients	WMH Clinical Nurse Sally Denkel	CI
24	Applying implementation science to guide quality improvement recommendations for conducting a population health needs assessment	WMH Principal Planning Advisor Ashleigh Earnshaw	CI
25	Implementing exercise physiology within an acute mental health service	WMH Senior Exercise Physiologist Matthew Wall	CI
26	FISM flow improvement	WMH Project Lead General Medicine Redesign Kate Atkinson and the Flow Improvement Services Medical (FISM) team	CI

Professor Jeffrey Dunn AO

Professor Jeffrey Dunn AO is the Professor of Social and Behavioural Science and Chair of Cancer Survivorship at the University of Southern Queensland.

An internationally recognised leader in cancer survivorship, quality of life research and patient-centred care, he has spent more than 30 years influencing cancer control policy, research and practice in Australia and around the world.

Professor Dunn serves as Global Advocacy Companion for the Prostate Cancer Foundation of Australia and Chair-elect of the Translational Research Institute of Australia.

He is also a former Deputy Board Chair of West Moreton Health and former Chair of its Research Committee, maintaining a strong connection with the organisation's research community.

A past president of the Union for International Cancer Control and the Asia Pacific Organisation for Cancer Prevention, Professor Dunn served for many years as secretary of the International Psycho-oncology Society.

Throughout his career, he has worked across disciplines to build community capacity in cancer control and influence health policy, programs and practice at local, national and international levels.

Recognised by Stanford University among the world's top 2 per cent of scientists in oncology and clinical medicine, Professor Dunn is ranked by SciVal among the world's leading researchers in prostate cancer survivorship and quality-of-life research.

He has authored more than 200 publications, including peer-reviewed journal articles, books, book chapters and government reports.

In 2014, he was appointed an Officer of the Order of Australia for distinguished service to medical administration, cancer control and the promotion of innovative, integrated cancer care.

More recently, he was recognised as a Queensland Great and named University of Queensland Colleges Alumnus of the Year in 2025.

Drawing on his extensive leadership experience and personal experience as a cancer survivor, Professor Dunn continues to champion research, innovation and improved outcomes for people affected by cancer, both nationally and internationally.

Diagnosed with a rare form of mantle cell lymphoma in 2022, he remains a powerful advocate for cancer survivorship.

Although still undergoing treatment, he continues to champion the needs of cancer survivors in representations to government, the cancer control sector, learned societies and academia, both in Australia and globally.



Oral abstracts

Core components and implementation outcomes of the Preventative Integrated Care Service – first three years

- Darling Downs and West Moreton PHN and Queensland University of Technology: Ashleigh Earnshaw
- Queensland University of Technology: Hannah E. Carter, Steven M. McPhail, Sundresan Naicker
- West Moreton Health: Kelly McGowan, Shannon Wallis
- Metro South Health: Steven M. McPhail

Research

Introduction

Chronic conditions are burdensome to individuals, families, societies, and health systems. Novel approaches to address patient deterioration are required to provide care outside of the hospital environment. Such novel approaches include rapid access clinics, such as the Preventative Integrated Care Service at West Moreton Health.

Aim

To examine the core components and implementation outcomes (adoption, fidelity, and sustainability) of the Preventative Integrated Care Service.

Method

A theoretically informed, mixed methods approach was employed across three phases. Phase one undertook a context assessment, informed by the Consolidated Framework for Implementation Research (CFIR) and the Nonadoption, Abandonment, Scale-Up, Spread, and Sustainability (NASSS) Framework. Semi-structured interviews were undertaken with service delivery staff (n=13), implementation leaders (n=6), and consumers (n=33). Implementation outcomes (adoption, fidelity, and sustainability) and core components were examined in phase two. Phase three undertook a solution co-design workshop to address prioritised barriers, and a sustainability assessment including interviews with referrers (n=6).

Results

Five core components were identified – 1) rapid access to a prescriber, 2) rapid interdisciplinary team access, 3) adaptive fidelity guided by a patient-safety first approach to clinical care, 4) specialist clinical capacity addressing medical and psychosocial needs, and 5) embeddedness within the acute care sector. Four attributes of fidelity were examined, showing moderate adherence to service metrics (referral to assessment and length of stay in service), and strong uptake of multidisciplinary care approach and multimodal service delivery. Sustainability was influenced by workforce, and tensions between financial efficiency and clinical integrity. Adoption was strong relative to other outpatient services.

Conclusions and clinical implications

This research offers insights into minimum essential criteria to the establishment, scale-up, and spread of rapid access clinics for complex care needs. This highlights the need for empowerment of staff to make clinical decisions and space to engage in non-clinical but critical work. Fidelity to service parameters must be guided by patients' medical and psychosocial needs, placing safety above arbitrary performance measures.

New ROTEM FIBTEM: should the fibrinogen replacement threshold change for critical bleeding?

West Moreton Health: Akmez Latona

Research

Introduction

The FIBTEM assay in Rotational Thromboelastometry (ROTEM®) measures fibrin-based clot formation. The reagent transitioned from single to dual-platelet inhibition with addition of tirofiban to cytochalasin D, offering more complete platelet suppression.

Aim

The aim of this study was to assess the impact of this change on transfusion thresholds in trauma.

Method

In this retrospective cohort study, we included adult patients with major trauma across Queensland who presented between 2022 and 2025 and had results available for paired ROTEM and conventional coagulation tests on arrival. Patients were sub-grouped into single and dual-platelet inhibition assay groups. Correlations between FIBTEM-A5 and Clauss fibrinogen were analysed, comparing correlation strength and diagnostic accuracy for fibrinogen levels of < 2.0 g/L.

Results

The relationship between FIBTEM-A5 and Clauss fibrinogen was similar using single platelet inhibition assays (R^2 0.61;95%CI: 0.51–0.70) and dual-platelet inhibition assays (R^2 0.70;95%CI: 0.62–0.77; $p = 0.94$). Predicted FIBTEM-A5 amplitudes at 2 g/L fibrinogen were 7.83 mm (95%CI: 7.42–8.23) and 7.54 mm (95%CI: 7.22–7.87). Diagnostic performance for detecting fibrinogen < 2.0 g/L was comparable between assays, for both FIBTEM-A5 ≤ 10 mm and FIBTEM-A5 ≤ 8 mm (all $p > 0.05$). For the dual-platelet inhibition assay, sensitivity and specificity were 97.8% and 48.1% at ≤ 10 mm, and 92.1% and 74.7% at ≤ 8 mm.

Conclusions and clinical implications

Dual-platelet inhibition did not alter the relationship between FIBTEM-A5 and Clauss fibrinogen or the diagnostic accuracy of FIBTEM thresholds for identifying hypofibrinogenemia. FIBTEM-A5 ≤ 10 mm maintained high sensitivity, while ≤ 8 mm demonstrated greater specificity. Recalibration of established FIBTEM thresholds is not required following transition to dual-platelet inhibition.

- West Moreton Health and University of Queensland: Olivia Miller
- Queensland University of Technology: Danielle Villoresi

Research

Introduction

Exposure to potentially psychologically traumatic events is extremely common. Trauma-exposed people are more likely to access emergency care than their non-trauma-exposed counterparts, and they risk symptom exacerbation and re-traumatisation during the care process. Trauma-informed care (TIC) practices – which aim to recognise and respond to the effects of psychological trauma, prevent re-traumatisation, and promote a sense of safety – may provide better experiences for these patients. However, TIC understanding and implementation in emergency settings remains limited and there are no publicly available TIC guidelines for the emergency context where patients are likely to be in a heightened emotional state due to the emergency nature of their injury or illness.

Aim

This research aimed to explore how emergency department clinicians understand and implement TIC and use the results to develop TIC guidelines for the emergency context.

Method

Qualitative semi-structured interviews were conducted with 20 nurses and doctors working in a Brisbane emergency department about their understanding and use of TIC. The data were analysed using reflexive thematic analysis, with the findings used to contextualise TIC guidelines to the emergency setting.

Results

Three themes were generated: (1) 'treat the person not the problem'; (2) 'we're not mental health'; and (3) 'systemic factors that we can't fix'. Together, these themes suggested that emergency clinicians perceived TIC to be a holistic, person-centred practice designed to treat psychological trauma, with responsibility for TIC placed with mental health clinicians. Adoption of TIC practices was further impeded by perceived systemic barriers like competing priorities and working conditions fostering burnout. These findings were used to contextualise TIC guidelines to the emergency context which will be briefly presented and are available upon request.

Conclusions and clinical implications

While the emergency context presents unique challenges, TIC is possible in this context with organisational support, shared understanding, and clear guidelines. We hope that the guidelines developed will support emergency clinicians' confidence and comfort in using trauma-informed practices, which may then have positive flow-on effects for patients and staff alike.

University of Southern Queensland: Jonathan Bayuo

Research

Introduction

Burn survivors frequently face persistent and complex post-burn needs after discharge, including physical, psychological, and social challenges. The transition from specialised inpatient burn care to the home environment is a particularly vulnerable period, often marked by uncertainty, stress, and difficulty navigating self-management demands. Although early post-discharge support is critical for recovery, aftercare services are often fragmented or limited, leaving many survivors without adequate guidance or continuity of care. Current evidence shows that these gaps in transitional support contribute to suboptimal outcomes, including pain, poor sleep, psychological issues, limited physical role functioning, and poor quality of life.

Aim

This study aimed to develop and implement a nurse-led transitional and after-care program and examine its effects on quality of life, psychological functioning, sleep, pain, itchiness, scarring, and physical role functioning of adult burn survivors.

Method

Guided by the MRC Framework, the development phase of the study involved in-depth review of existing literature and a qualitative phase involving adult burn survivors and burn care staff. Following the development, a pilot randomised approach was employed to ascertain the preliminary effects of the intervention. A sample of 60 burn survivors, aged ≥ 18 years were randomly allocated to either the control or treatment group with 30 participants per arm. Participants in the intervention group received an 8-week comprehensive transitional-aftercare program. The program comprised of two phases: predischARGE and active follow-up phase. Data was collected over three time points. A generalised estimating equation (GEE) was employed to ascertain group changes.

Results

Using Bonferroni corrected p value (0.017), statistically significant improvements were observed regarding simple abilities, affect, interpersonal relationships, overall quality of life, physical role functioning, psychological functioning, and pain interference. No statistically significant improvements were observed regarding sleep and scarring.

Conclusions and clinical implications

The transitional aftercare program demonstrates potential in improving post-burn recovery outcomes which warrants further large-scale randomised trials to refine and test the intervention further. The mean scores observed on the outcome measures however highlight a need to extend the program in the long-term considering the chronicity associated with the post-burn needs.

- University of Southern Queensland: Tahnee Downs, Eliza Whiteside, Dean Mills, Edward Bliss
- The FitLab Toowoomba: Steve Nance, Naomi Vogler, Lauren Taylor
- Blush Cancer Care: Gaye Foot

Research

Introduction

In Australia, breast cancer is the most diagnosed cancer and the second leading cause of cancer death in women. Although incidence continues to rise, so too has short- and long-term survival. The current 5-year survival rate in Australia is 93%. As a result, Australia now has a large survivor population, many of whom experience chronic adverse effects due to their cancer and treatment. One such adverse effect is cancer-related cognitive impairment (CRCI). Up to 75% of breast cancer patients report CRCI, which significantly reduces quality of life in this population.

Aim

We investigated the impact of breast cancer and breast cancer treatment on cerebrovascular function and cognition, and whether an eight-week supervised multimodal exercise intervention could provide a protective mechanism in maintaining these outcomes during active treatment, as well as whether it could provide a reversive mechanism in survivors post-active treatment.

Method

We used transcranial Doppler ultrasonography (TCD) to measure cerebrovascular responsiveness (CVR) to a physical stimulus (5% CO₂ hypercapnia) and a psychological stimulus (NIH Toolbox cognitive battery), as well as anthropomorphic, cardiovascular and quality of life measures.

We first compared breast cancer survivors (n=15) to non-cancer controls (n=15), to compare the baseline differences in cerebrovascular function and cognition. We then compared the effects of a supervised eight-week multimodal exercise intervention on cerebrovascular function and cognition in breast cancer patients undergoing active treatment (n=8) and breast cancer patients post-active treatment (n=24), compared to non-exercising controls.

Results

We found that breast cancer patients had lower CVR to hypercapnia ($P < 0.001$), CVR to cognitive stimuli ($P < 0.001$) and total composite cognitive score ($P = 0.003$) than age and body mass index matched cancer-free women.

In breast cancer patients undergoing active treatment, exercise training improved CVR to hypercapnia ($P < 0.05$) and cognitive stimuli ($P < 0.005$). In breast cancer survivors post-active treatment, exercise improved CVR to hypercapnia ($P < 0.005$) and cognitive stimuli ($P < 0.005$). No between-group differences in total cognition were observed in either intervention study.

Conclusions and clinical implications

The findings of these studies have important clinical and regional implications. Clinically, the results demonstrate cerebrovascular function, and cognition is impaired in women with breast cancer and cerebrovascular function can be improved through multimodal exercise training. These results support the integration of supervised multimodal exercise as a supportive care strategy for women with breast cancer, particularly from the time of diagnosis and during active treatment.

These studies were conducted within a regional breast cancer care context and developed through collaboration with local clinical and community partners. Women in regional areas may face additional barriers to accessing supportive care, including travel burden, limited specialist services, financial strain, and reduced availability of tailored exercise oncology programs. By demonstrating a supervised multimodal exercise training intervention can be delivered in a regional setting and can improve outcomes, this finding provides a foundation for locally relevant supportive care models that are both clinically meaningful and feasible.

Delayed discharge beyond medical clearance in gastrointestinal surgery: a qualitative study of workflow, system misalignment, and operational normalised delay

- University of Technology: Mathulada Chaimee, Jutharat Attawet, Yunjing QIU, Pauline Murray-Parahi, Amanda Wilson
- University of Southern Queensland: Mathulada Chaimee
- The University of Sydney: Thomas J Hugh
- Royal North Shore Hospital Thomas: J Hugh
- Swinburne University of Technology: Jutharat Attawet
- Edith Cowan University: Pauline Murray-Parahi
- Newcastle University: Amanda Wilson

Research

Introduction

Delayed hospital discharge after medical clearance is a growing challenge that can expose patients to avoidable harm, reduce hospital capacity, and increase healthcare costs. Although delayed discharge has been widely recognised across healthcare settings, most research has focused on broad hospital populations, with limited evidence specific to gastrointestinal surgery. Surgical patients often experience complex discharge pathways involving multidisciplinary coordination, postoperative recovery, and access to appropriate post-acute services. A better understanding of how workflow, communication, and system processes contribute to delayed discharge is needed to inform effective improvement strategies and support safe, timely transitions from hospital to home or ongoing care.

Aim

To explore factors contributing to delayed discharge following medical clearance in gastrointestinal surgery and develop a process-based understanding of how delays occur.

Method

Semi-structured interviews were conducted between September 2025 and April 2026 with 19 participants: seven delayed-discharge gastrointestinal surgery patients and 12 healthcare professionals involved in discharge planning and coordination. Data were analysed using reflexive thematic analysis, supported by NVivo 14.

Results

Delayed discharge resulted from misalignment across patient, workflow, and system processes after medical clearance. Four mechanisms explained how delays were produced and sustained: fragmented surgical workflow, including delayed decision-making, documentation and medication preparation; misalignment between medical clearance and patient discharge readiness; operational normalisation of delayed discharge within routine acute care priorities; and mismatch between patient complexity and post-acute care capability. Delays affected patients, families, healthcare professionals, and the healthcare system through uncertainty and distress, functional decline, increased workload, and reduced acute bed availability. Enablers included early planning, clearer discharge pathways, stronger accountability, coordinated communication, patient and family preparation, use of digital and AI tools, and improved post-acute pathways.

Conclusions and clinical implications

Delayed discharge after medical clearance reflects a failure of post-clearance care transition rather than a simple consequence of patient complexity or limited resources. It should therefore be recognised as an active phase of care requiring early, proactive discharge

planning. Anticipatory workflows should include timely medical decision-making, documentation, medication reconciliation, multidisciplinary referrals and escalation of unresolved barriers. Nurses play a central coordinating role, but accountability for discharge progression should be shared across the multidisciplinary team. Health systems should strengthen integration among acute, rehabilitation, and community services while ensuring that post-acute care can meet complex postoperative needs. Digital solutions, including integrated health records and AI-supported documentation, may improve discharge efficiency when appropriately governed. Future research should evaluate implementation-focused discharge strategies, structured readiness assessments and coordinated care pathways to reduce post-clearance delays and improve patient outcomes.

- West Moreton Health and University of Otago: Tamara Taione
- University of Otago: Dr Mandy Wilkinson, Dr Kelly Tikao

Research

Introduction

Attention deficit hyperactivity disorder (ADHD) is highly heritable, meaning mothers of children with ADHD may also experience ADHD themselves. Yet ADHD care remains predominantly child-centred and often assumes caregivers can consistently organise appointments, implement behavioural strategies, regulate emotions and model executive functioning. Women have historically been under-recognised because diagnostic knowledge developed around male presentations, leaving many to enter motherhood without an explanation for lifelong difficulties. When maternal ADHD remains unidentified, parenting challenges can be misinterpreted as poor motivation, inconsistency or disengagement, while the mother's own support needs remain overlooked. Understanding these experiences is necessary to develop neuro-affirming, family-responsive models of care that support both the child and the caregiver responsible for implementing treatment recommendations.

Aim

To synthesise evidence on the experiences and impacts of undiagnosed ADHD in mothers of children with ADHD, and identify implications for clinical practice, family-centred care and health service delivery.

Method

An integrative review was undertaken using Whitemore and Knafl's five-stage framework. Literature was searched across electronic databases and authoritative organisational sources from 2022 to early 2023, with no publication date restriction. The search identified 214 records; 34 remained after duplicate removal and initial exclusions, 20 full texts were assessed, and 13 papers were included. Methodological quality was appraised using relevant Joanna Briggs Institute checklists. Study characteristics and findings were organised in a data matrix. Braun and Clarke's six-phase thematic analysis was then used to code, refine and synthesise findings, with study selection reported using PRISMA 2020.

Results

Thirteen papers from six countries were included, comprising quantitative, qualitative, review, consensus and grey-literature evidence. Three themes emerged: impact of ADHD; screening and effective assessment; and outcomes. ADHD affected activities of daily living, finances, socioeconomic participation, communication, relationships, parenting and family functioning, while stigma and gendered symptom presentation contributed to delayed recognition. Screening was complicated by diagnostic bias, limited cultural responsiveness and restricted access to adult services. Untreated parental ADHD could impede engagement with parent behavioural interventions. Conversely, identification and treatment were associated with improved wellbeing, relationships, employment and quality of life, with potential benefits for children, families and communities.

Conclusions and clinical implications

ADHD is highly familial, yet clinical care often focuses on the diagnosed child while overlooking the possibility that a mother may also have unrecognised and untreated ADHD. Delayed recognition can affect maternal wellbeing, relationships, parenting capacity and engagement with a child's treatment. Clinical practice should therefore move beyond reliance on self-identification and strengthen clinicians' awareness of female ADHD

presentations. When clinically indicated, assessment of a child should prompt sensitive enquiry about parental symptoms, supported by culturally responsive screening, clear referral pathways and family-focused care. Greater access to affordable adult assessment and evidence-based treatment is also required. Recognising and supporting maternal ADHD may improve treatment engagement and outcomes for mothers, children and families, while reducing avoidable social, economic and service impacts.

Computed tomography coronary angiography-first evaluation in an Australian regional chest pain assessment service: real-world outcomes

- West Moreton Health: Krishnaa Sivapalan, Shaun Prior, Sheen Mathew, Charlotte Gregory, Jacqueline Masters, James Robinson, Johanne Neill
- Metro South Health: Krishnaa Sivapalan, Sheen Mathew
- The University of Queensland: Shaun Prior, Farah Zahir, Johanne Neill
- Queensland Cyber Infrastructure Foundation: Farah Zahir

Research

Introduction

Rapid-access chest pain assessment services (CPAS) enable outpatient evaluation of suspected stable coronary artery disease, reducing hospital admission and unnecessary invasive investigation. Contemporary evidence supports a coronary computed tomography angiography (CTCA)-first strategy, but real-world Australian data remain limited.

Aim

This study aimed to evaluate the clinical outcomes of patients managed through the Ipswich Hospital CPAS following transition toward a CTCA-first investigative strategy.

Method

We retrospectively audited consecutive referrals to the Ipswich Hospital CPAS (2024-2025). Service timelines, demographics, investigations, disposition, revascularisation, major adverse cardiovascular events (MACE), and statin prescription after CPAS assessment were recorded. Outcomes were compared between CTCA-first and non-CTCA pathways using chi-squared/Fisher tests and logistic regression.

Results

Among 911 patients (median age 57 years; 46.3% female), median referral-to-contact time was 12 days (IQR 8-20). Initial testing occurred in 66.6%, most commonly exercise stress testing (32.2%) or CTCA (22.9%), while 33.4% required no investigation. Following CPAS assessment, 75.1% were discharged and 8.1% referred for outpatient follow-up. Only 3.3% underwent invasive angiography, with revascularisation in 1.9%. One acute coronary syndrome occurred during three-month follow-up. Compared with alternative investigations, CTCA-first evaluation was associated with lower failure-to-attend rates (1.0% vs 17.2%, $p<0.001$), higher angiography (7.7% vs 2.0%, $p<0.001$) and revascularisation (3.3% vs 0.3%, $p<0.001$), and greater statin initiation (OR 6.19, $p<0.001$).

Conclusions and clinical implications

In a regional CPAS, most patients avoided invasive investigation with excellent short-term safety. CTCA-first evaluation improved pathway completion, diagnostic yield, and preventive therapy uptake compared with functional testing. This real-world data supports CTCA-first CPAS models as the preferred outpatient chest pain pathway and justifies broader guideline adoption.

Beyond keywords: semantic NLP for auditing narrative clinical documentation in mental health electronic health records

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- West Moreton Health: [Niall Higgins](#), Terry Stedman
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Quality Improvement

Introduction

Unstructured narrative documentation within mental health electronic health records (EHRs) contains clinically important information for patient care, quality improvement, and service governance. However, variation in clinical language, documentation practices, and record structure makes systematic review of narrative content difficult. Most mental health services rely on manual audits or keyword searches, both of which are resource-intensive and may overlook clinically meaningful information expressed using alternative language. Natural language processing (NLP) offers opportunities to analyse narrative documentation at scale by identifying conceptually related content rather than exact terms. Suicide risk formulation was used as an illustrative example because it is commonly documented in narrative form and rarely captured in structured datasets. This project explored whether semantic NLP techniques could support automated documentation review and auditing within routine mental health services.

Aim

To evaluate the feasibility of using semantic NLP methods to identify clinically meaningful concepts within unstructured mental health EHR documentation and determine whether semantic matching provides broader and more accurate documentation coverage than traditional keyword-based auditing approaches.

Method

A quality improvement project was undertaken using de-identified narrative clinical documentation extracted from a metropolitan mental health service EHR. An intermediate processing layer standardised heterogeneous data sources, including scanned documents processed through optical character recognition and free-text normalisation. Semantic text-matching methods were applied to identify formulation-related constructs within narrative documentation. Two independent datasets containing real-world clinical formulations were analysed. Performance of semantic matching was compared with predefined keyword searches using an expanded clinically informed reference standard. Precision and recall were calculated to evaluate each method's ability to identify clinically relevant concepts documented within free-text records.

Results

Semantic analysis identified clinically meaningful narrative content that was frequently missed by keyword-only approaches. Comparative validation demonstrated improved retrieval performance using semantic matching. The keyword-based method achieved a precision of 0.96 and recall of 0.75, indicating that relevant content was often overlooked when predefined terminology was absent. The semantic NLP approach achieved a precision of 1.00 and recall of 0.93. Improvements were observed across all formulation construct categories, particularly for Predisposing, Perpetuating, and Integrated factors, which are commonly described using varied narrative language. Findings demonstrated superior capture of conceptually relevant information within routine clinical documentation.

Conclusions and clinical implications

This project demonstrates the feasibility of applying semantic NLP techniques to analyse unstructured mental health EHR documentation for quality improvement and audit purposes. Compared with keyword-based approaches, semantic matching more effectively identified clinically relevant concepts expressed using varied clinical language while maintaining high precision. The approach supports large-scale review of documentation practices and may assist services to better understand the content recorded within narrative clinical notes without requiring extensive manual auditing. Importantly, the method is intended to support documentation review and service-level quality improvement rather than individual clinical decision-making or risk prediction. Further work is required using clinician-annotated datasets and multiple health services to establish validity, reproducibility, and generalisability. Semantic NLP may provide a scalable tool for improving governance, documentation review, and quality monitoring within mental health services.

- West Moreton Health: Marissa Alexander, James Want

Quality improvement

Introduction

A three-week Extended Practice Authority (EPA) registered nurse (RN) Part A pilot enabled nurse-led minor injury care, boosting capacity, improving timeliness, and becoming sustainable routine practice.

Aim

To determine whether an EPA RN Part A model could safely expand nursing scope to deliver timely minor injury care, increase capacity during peak periods, and strengthen a flexible, sustainable workforce at Minor Injury and Illness Clinic.

Method

The EPA RN Part A pilot was implemented over three weeks at the Minor Injury and Illness Clinic to assess feasibility, safety, and operational fit in routine clinical practice. Five registered and clinical nurses completed mandatory training, competency assessment, and local credentialing, practising under authorised health management protocols. Credentialed nurses independently managed eligible minor injury and illness presentations, including assessment, treatment, documentation, and discharge, with escalation pathways ensuring patient safety. Oversight was provided by a multidisciplinary governance group. Data demonstrated safe and effective care, appropriate escalation, positive consumer experiences, and high nurse satisfaction. Following governance review, the model was endorsed and transitioned into routine daily practice.

Results

The EPA RN Part A pilot demonstrated safe, effective, and sustainable implementation within the Minor Injury and Illness Clinic. Success was supported by strong alignment between clinic workflows, PCCM-based protocols, and EPA RN requirements, enabling nurses to deliver consistent protocol-led care. Multidisciplinary support from medical officers, nurse practitioners, pharmacists, and extended-scope physiotherapists strengthened clinical governance and confidence in decision-making. Consumer feedback was overwhelmingly positive, with patients reporting timely, professional, and reassuring care experiences. The model improved patient flow by enabling nurses to complete full episodes of care, allowing other clinicians to focus on more complex presentations. Nurse satisfaction, engagement, and professional development opportunities also increased significantly.

Conclusions and clinical implications

The EPA RN Part A pilot demonstrated that expanded scope nursing can safely improve access, patient flow, and workforce capability within a minor injuries and illness setting. The findings have had a lasting impact at the Minor Injury and Illness Clinic, where the model has transitioned from pilot to standard daily practice. Consumers benefited from timely, high-quality care, while nurses were empowered to work to their full scope, improving job satisfaction and supporting workforce retention. Challenges included the short implementation period, reliance on a highly motivated nursing cohort, and the need to establish strong governance and stakeholder engagement. Key learnings highlighted the importance of multidisciplinary collaboration, pharmacist support, and structured escalation pathways.

Charting the unknown: establishing pathways for supporting dysphagia post electroconvulsive therapy

- West Moreton Health: [Alison McGann](#)

Quality improvement

Introduction

Dysphagia post- electroconvulsive therapy (ECT) is not documented in the evidence base. However, it is frequently reported by nursing and speech pathology staff at sites offering ECT. Clinical reasoning suggests that an intersection may exist between post-ictal state, post-anaesthetic recovery, post-extubation symptoms and antipsychotic medication side effects, particularly for patients with pre-existing dysphagia or saliva management difficulties or with risk factors such as advanced age. Current statewide and local ECT guidelines do not include dysphagia monitoring or management recommendations. A gap therefore exists whereby vulnerable patients may be at risk of choking or aspiration, which could be prevented with appropriate guidelines and procedures.

Aim

This project sought to examine the current evidence base, gather local data, provide education to psychiatry and nursing staff, and establish a pathway to monitor and manage post-ECT dysphagia. Desired outcomes of this project were to increase staff knowledge and confidence in identifying and referring patients exhibiting dysphagia symptoms post-ECT.

Method

A literature review and Riskman data audit were completed. In-services were delivered to ECT clinic staff, psychiatry registrars and nursing staff across all wards on post-ECT dysphagia considerations. In-service attendees were invited to complete a survey which probed observations of post-ECT dysphagia and measured post-in-service knowledge shifts and practice changes. Informal benchmarking was completed with statewide and national mental health speech pathology colleagues.

Results

The majority of survey and benchmarking respondents reported observing dysphagia symptoms post-ECT. All survey respondents reported an increase in both knowledge of dysphagia post-ECT and confidence in identifying patients requiring referral to speech pathology for swallow assessment post-ECT after attending a speech pathology dysphagia in-service which included a section discussing post-ECT dysphagia.

Conclusions and clinical implications

This project has highlighted a gap in whole-of-service knowledge regarding risks of dysphagia post-ECT. Following this project, work will commence to include dysphagia monitoring and management in the local ECT workplace instruction, and to develop a dysphagia escalation pathway to ensure that patients are appropriately identified and screened in a timely manner if swallowing difficulties are observed post-ECT. There is scope to complete a prevalence study at this site or across multiple sites, and/or a prevalence study targeting adolescent ECT populations in the future. Research outcomes may lead to future inclusion of dysphagia in statewide ECT guidelines. Challenges likely to be experienced as this body of work progresses will relate to cultural shifts amongst nursing and psychiatry staff regarding scope of practice.

Safer transfusions for rural communities: strengthening blood product traceability and stewardship across rural hospitals

- West Moreton Health: Bronwen Pauli, Patrick McGarry, Rhys Doble, Satyan Chari
- Pathology Queensland: Greg Dulley

Quality improvement

Introduction

Safe storage and traceability of blood products are essential components of transfusion safety. An audit of blood management processes across four rural hospitals serviced by the Ipswich Hospital Blood Bank identified opportunities to strengthen documentation of blood product receipt, storage monitoring and utilisation. Maintaining reliable blood management processes in rural healthcare settings can be challenging due to geographical separation from central laboratory services, competing clinical priorities and variation in workforce availability. A review of existing processes highlighted the need for systems that better support staff to demonstrate compliance with national safety and quality requirements. Improving traceability and stewardship is critical to protecting patients, preserving a scarce community resource and supporting equitable access to transfusion services for growing rural populations.

Aim

To improve transfusion safety and blood stewardship across four rural hospitals by achieving at least 95% accuracy in documentation of blood product receipt, storage and utilisation, and eliminating storage related blood product wastage by October 2026 through implementation of streamlined, technology-enabled monitoring processes.

Method

A multidisciplinary project team undertook a quality improvement initiative using audit data, process mapping, staff consultation and root cause analysis. Particular emphasis was placed on understanding how blood management processes were performed in day-to-day clinical practice within diverse rural environments. Staff feedback was used to identify barriers and enablers to safe blood storage and traceability. A driver diagram was developed to guide improvement strategies, including QR code-enabled electronic documentation, real-time monitoring dashboards and enhanced visibility of blood product tracking information. Interventions are being tested through iterative Plan-Do-Study-Act cycles, with evaluation focusing on documentation accuracy, timeliness and user experience.

Results

Baseline audits demonstrated variability in the completion and accessibility of blood management documentation across participating sites. Diagnostic work identified several system-level factors influencing compliance, including reliance on paper-based processes, limited visibility of documentation requirements, workforce turnover, competing clinical demands and environmental constraints associated with older healthcare facilities. Staff consultation revealed strong engagement with transfusion safety and valuable insights into opportunities for improvement. Early outcomes include strengthened collaboration between rural sites, pathology services and patient safety teams, greater awareness of blood stewardship requirements, and development of interventions ready for implementation and testing. Formal outcome measures will continue to be evaluated throughout subsequent PDSA cycles.

Conclusions and clinical implications

This project highlights the importance of designing safety systems that align with the realities of rural healthcare delivery. Early findings suggest that opportunities for improvement are primarily related to process design, accessibility of documentation systems and visibility of safety requirements, rather than individual performance. Co-designed digital solutions such as QR code-enabled documentation and live monitoring dashboards have the potential to improve traceability, reduce administrative burden and strengthen compliance with blood stewardship standards. Improved monitoring processes will support safer transfusion practice, reduce avoidable wastage and provide a foundation for future enhancement of rural transfusion services. Key lessons include the value of engaging frontline staff, understanding work as performed in practice and ensuring improvement initiatives remain adaptable to local contexts.

Implementing room service on demand and electronic menu management in a greenfield sub-acute facility: the critical role of the senior nutrition assistant

- West Moreton Health: Cheryl Grulke, Jessica Fry, Kate Morgan, Kylie Bruce, Jillian Ross, Shelley Smith

Quality improvement

Introduction

The Nutrition and Food Services department at West Moreton Health had an opportunity to implement a new model of service, Room Service on Demand, supported by an electronic menu management system for a greenfield 90 bed sub-acute facility. This was the first implementation of this model within our health service and a key milestone in its digital transformation journey. Early planning identified significant workflow, workforce, and operational changes – the leadership team identified that dedicated Nutrition Assistant expertise would be invaluable in this change process.

Aim

To provide operational leadership, develop new nutrition assistant and senior nutrition assistant role structures, and support staff capability to enable a safe, efficient transition to electronic menu management at the new sub-acute facility.

Method

Working as a project officer, the senior nutrition assistant developed expertise in the electronic system, developed rosters and duty statements across six shift types, created operational guidelines, coordinated uniforms, and supported workforce preparation. Site visits to other hospitals informed best practice strategies. Collaboration with the project team ensured all deliverables were achievable within the three-month timeframe.

Results

The project delivered improved efficiency, enhanced patient meal choice, and a successful transition to electronic menu management. Strong collaboration and team support were critical to success, particularly as staff adapted to new systems and workflows. Having a Senior Nutrition Assistant with existing Food Services experience and nutrition assistant expertise provided valuable operational insight throughout implementation and supported ongoing sustainability.

Conclusions and clinical implications

The project clearly illustrates the impact of embedding nutrition assistant expertise within large scale service transitions. Key lessons emphasise the essential role experienced Nutrition Assistants play in ensuring the sustainability and ongoing success of future service improvements and expansion projects.

- West Moreton Health: Julia Douglas
- The University of Queensland: Bailey Ostrofski, Hannah Khoo, Sophie Whiteside, Yena Lee-Kang

Quality improvement

Introduction

Ipswich Hospital (IH) experiences high readmission rates for lower limb cellulitis. Management of recurrent cellulitis varies across IH and other Australian hospitals, particularly occupational therapy (OT) referrals for interventions such as education, compression therapy as well as discharge follow-up protocols. This inconsistency increases the risk of readmissions, adding financial and healthcare burdens. The aim of this retrospective review was to improve cellulitis management at IH by establishing a clinical pathway focused on promoting OT input within the multidisciplinary team (MDT) in the Medical Assessment and Planning Unit (MAPU).

Aim

The aim of the project is to improve management of patients presenting with lower limb cellulitis at IH through establishing a clinical pathway, specifically relating to OT input as part of a MDT in the MAPU.

Method

An evidence-based clinical pathway was developed using multiple information sources: a literature review on cellulitis management, analysis of IH data on lower limb cellulitis readmissions, chart audits of MAPU patients with lower limb cellulitis, benchmarking IH cellulitis management protocols against interstate hospitals, and stakeholder interviews with the IH MDT working in MAPU.

Results

Analysis revealed gaps in cellulitis management at MAPU, especially inconsistent OT involvement and follow-up care. These findings guided the proposal of a new acute hospital clinical pathway and recommendations for implementation, including self-directed learning guides for OT and MDT working in acute and sub-acute settings to standardise evidence-based treatment and management of all cellulitis presentations.

Conclusions and clinical implications

The development of a clinical pathway defines a clear OT referral process, related interventions and follow-up options at IH to ensure consistent, evidence-based cellulitis care. It also emphasises the importance of educating stakeholders to improve patient access to appropriate post admission follow-up and how to address modifiable risk factors, particularly through monitoring of affected limbs, as well as prescription of conservative management strategies and medical-grade compression therapy for chronic oedema where clinically indicated. Implementing this pathway may help reduce hospital readmissions.

Improving pneumococcal vaccination uptake among dialysis patients with chronic kidney disease: a quality improvement study in Queensland, Australia

- West Moreton Health: Alison Kenny, Catherine Quagliotto, Penny Hutchinson, Sree Venuthurupalli, Janet Farmer

Quality improvement

Introduction

Invasive pneumococcal disease (IPD) causes significant morbidity and mortality among people with chronic kidney disease (CKD), despite funded vaccination under Australia's National Immunisation Program (NIP). In March 2023, two cases of IPD occurred in unvaccinated dialysis patients at the West Moreton Kidney Health Service (WMKHS), Queensland, prompting a manual review of pneumococcal immunisation coverage and a targeted quality improvement intervention.

Aim

Improving pneumococcal vaccinations in patients with CKD.

Method

A quality improvement study assessed pneumococcal vaccination status among dialysis patients with CKD using the integrated electronic medical record (ieMR) and Australian Immunisation Register (AIR). The intervention included patient education materials, vaccine service provider letters, posters, and healthcare worker education sessions. Vaccination status was reassessed seven months post-intervention.

Results

Of 107 eligible patients, 23 (21.5%) received at least one pneumococcal vaccine dose during the study period, with most administered within the first two months. Nineteen patients (17.7%) died during follow-up and were retained in the analysis. Vaccination coverage remained low, with 47 (43.9%) patients unvaccinated at final review. A further 32 patients (29.9%) were partially vaccinated, and 47 (43.9%) remained unvaccinated. Uptake was highest among those aged 70+ years and lowest among those aged 18-49 years. No vaccinations were recorded among patients receiving care at the private facility.

Conclusions and clinical implications

Targeted education and healthcare worker engagement were associated with a modest short-term increase in pneumococcal vaccine uptake; however, substantial under-vaccination persisted. Specialist health services represent an important opportunity for systematic vaccine promotion and delivery. Embedding vaccination assessment into routine dialysis care, supported by healthcare worker engagement, may improve vaccination coverage in this high-risk population.

More than a screening tool: changing dysphagia referral practice across four rural hospitals

- West Moreton Health: [Olivia Jones](#)

Quality improvement

Introduction

Dysphagia is common in older inpatients. If unrecognised, it can lead to aspiration pneumonia, malnutrition and death. Early recognition and timely referral to speech pathology (SP) reduce these risks. In rural hospitals, where SP is delivered predominantly by telehealth, nursing staff are usually the first clinicians to observe swallowing concerns, making their recognition and escalation critical. Across four West Moreton Health rural hospitals, audits found inconsistent recognition and escalation of dysphagia. Clinical signs of dysphagia did not always prompt SP referral, and oral intake was modified before assessment. This variability suggested a gap between evidence-based dysphagia management and current practice in rural settings, where limited on-site SP reduces opportunities for education and shared understanding of referral processes.

Aim

To improve the timely and appropriate recognition and escalation of dysphagia by nursing staff across four rural West Moreton hospitals, through implementation of the validated Royal Brisbane and Women's Hospital Dysphagia Screening Tool (DST) and supporting education.

Method

Guided by the Knowledge-to-Action framework, implementation included SP-led education, online DST training, a recorded in-service, a lanyard reference card, electronic medical record prompts, a consumer-reviewed patient handout, and a co-designed, iteratively refined escalation pathway. Resources were refined iteratively through feedback from nursing staff, clinical nurses, medical staff and the SP team across the rollout period. Rollout was sequential across Gatton, Esk, Laidley and Boonah, with lessons learned applied to later sites (January to May 2026). Evaluation involved pre/post nurse surveys, focus groups, referral audits, and DST screening audits.

Results

Inappropriate referrals decreased from 54% to 28%, improving across all four sites. The most common pre-implementation problem – nurses modifying diet or fluids before SP assessment – fell from 19% of referrals to none. Referral volume increased at three of four sites, confirming that improvements in referral quality were not simply explained by a reduction in overall referral activity. Nurse-reported confidence improved across all three comparable survey items pre to post implementation. Barrier analysis using the COM-B framework indicated a shift from knowledge and capability barriers pre-implementation to workload and infrequent use post-implementation, suggesting education successfully addressed initial gaps but practical barriers require ongoing attention. Across 110 audited charts, no patient requiring review was missed.

Conclusions and clinical implications

Implementation of the validated DST with SP-led education and an escalation pathway improved referral quality and confidence across four rural hospitals. Nurses referred readily but used the DST infrequently, reflecting limited opportunities for practice and some hesitancy. Sustaining DST use over time emerged as the central challenge, with staff turnover and infrequent use identified as key risks in low-volume rural settings. Without a comparison site, improvements cannot be attributed to the intervention alone. For services

considering similar implementation, face-to-face education, sequential rollout with site-specific adaptation, and early engagement of nursing leadership were critical enablers. Next steps include case-based education to sustain DST use, embedding the DST in orientation, a dedicated SharePoint site for ongoing resource access, and building on medical engagement through education.

- West Moreton Health: Lisa Ball, Grace O'Donoghue

Clinical innovation

Introduction

Since February 2024, Ipswich Alcohol Other Drug Service (AODS) has been providing Hepatitis C testing as part of The National Australian HCV Point-of-Care Testing Program.

Aim

The Liver Health Roadshow was established to improve access to Hepatitis C testing for people not reached through traditional service models. The project aimed to reduce barriers to screening, increase early detection and diagnosis, strengthen linkage to care, and support Australia's goal of eliminating Hepatitis C as a public health threat by 2030.

Method

Ipswich AODS implemented the Liver Health Roadshow to address barriers that prevent people from accessing Hepatitis C testing, treatment, and follow-up care. The project adopted a flexible, mobile, and person-centred approach by delivering testing, education, and health promotion directly within community and healthcare settings. Partnerships were established with West Moreton Health services and community organisations to create accessible one-stop health events that included screening, referral, and treatment pathways. Hepatitis C testing was also integrated into mental health inpatient and community services. This approach reduced stigma, improved access and engagement, increased health literacy, and strengthened early intervention opportunities.

Results

The Liver Health Roadshow improved access to Hepatitis C testing by delivering services directly to people in community, rural, mental health, and outreach settings. Our outreach model successfully identified critical gaps in rural and mental health services, driving a significant shift in testing activity. By redirecting resources to previously underserved environments, we expanded our diagnostic reach and identified substantial unmet patient need. Increasing requests from services across West Moreton to host Roadshow events demonstrated strong demand and engagement. Promotion through partner organisations, flyers, social media, internal communications, and word-of-mouth increased awareness. Overall, the Roadshow reduced barriers, improved health literacy, and strengthened pathways to care.

Conclusions and clinical implications

The Liver Health Roadshow has demonstrated the value of a flexible, community-based approach to Hepatitis C care by bringing testing, education, and health promotion directly to people who may otherwise face barriers to accessing services. Through strong partnerships across health, mental health, and community organisations, the Roadshow has reduced barriers to care, increased engagement with priority populations, and strengthened pathways for early intervention and treatment. By meeting people where they are, the initiative has improved access, reduced stigma, and enhanced health literacy across the West Moreton region.

Implementation of a SOSIS compliant SMS confirmation process for appointment bookings in a paediatric dietitian clinic

- West Moreton Health: [Ainsley Galton](#)

Clinical innovation

Introduction

Rapid population growth within the service catchment has resulted in demand for outpatient paediatric dietetic services exceeding available capacity. Consequently, patients across all triage categories experienced delays beyond recommended timeframes for first appointments, with Category 3 referrals unlikely to be seen. Service review identified clinic inefficiencies, including high failure-to-attend (FTA) rates and suboptimal utilisation of available appointments, as contributing factors. The existing booking process relied on a confirmation letter issued six weeks before the appointment, followed by SMS reminders seven days and one day prior to attendance. This approach assumed successful receipt of written and electronic communications. Evidence suggests that appointment confirmation systems improve attendance rates, reduce administrative burden, minimise lost treatment opportunities, support rescheduling, and enhance healthcare resource utilisation.

Aim

To implement and evaluate a SOSIS-compliant SMS appointment confirmation process within a paediatric dietitian outpatient clinic to improve attendance and service efficiency.

Method

A multidisciplinary working group established a SOSIS-compliant SMS confirmation process, implemented in December 2025. Patients with appointments booked 28 days in advance were required to confirm attendance via SMS. Patients declining appointments were contacted to reschedule. Non-responders received a reminder at 15 days; if no response was received by 14 days, appointments were cancelled and reviewed by the treating clinician. Patients booked within 28 days received verbal confirmation. Administrative processes were redesigned to enable proactive filling of vacant appointments from the waitlist. In March 2026, appointment templates were changed to flexible 45-minute consultations. Pre- and post-implementation data were compared.

Results

The process was considered acceptable by administrative and clinical staff. Overall FTA rates decreased from 17.1% to 10.1%. FTA rates for new patients reduced from 24.8% to 11.3%, while review appointments decreased from 14.7% to 10.3%. The proportion of patients seen within recommended timeframes increased from 14.6% to 45.5%, including improvements from 22.5% to 50% for Category 1 patients and from 12.5% to 50% for Category 2 patients. Average clinic utilisation increased from 60% to 74%. The outpatient waitlist was completely cleared, and no unplanned appointment attendances occurred.

Conclusions and clinical implications

Implementation of a SOSIS-compliant SMS confirmation process substantially improved clinic efficiency, attendance rates, appointment utilisation, and timely access to paediatric dietetic services. The combination of early appointment confirmation, proactive management of non-responses, and rapid reallocation of vacant appointments enabled more effective use of limited clinical resources and contributed to complete waitlist clearance. Flexible appointment scheduling further enhanced the ability to maximise clinic utilisation optimising finite clinical resources. Improvements in seen-in-time rates across all urgency categories demonstrate the potential for confirmation processes to support equitable access to care.

The intervention was acceptable to both administrative and clinical staff and has been sustained within routine practice. These findings support wider implementation of automated confirmation systems in outpatient services facing increasing demand and capacity constraints.

Improving patient access and flow for general medicine through the implementation of the Rapid Assessment Intervention and Discharge (RAID) model of care at Ipswich Hospital

- West Moreton Health: Dr Connor O'Neill, Dr Lauren Rodwell, Kate Atkinson

Clinical innovation

Introduction

General Medicine is recognised as the largest admitting unit with 26% of inpatient separations at Ipswich Hospital departing via the General Medicine department in 2025. General Medicine accounted for 68% of all patients with an extended Emergency Department (ED) length of stay between February 2024 - January 2025, with the highest number of general medicine overnight admitted care events recorded in the state when compared with peer sites for the same reporting period.

Aim

To implement a General Medical Physician-led, multidisciplinary team based in the ED, to rapidly assess patients awaiting general medical admission, providing senior clinical decision making. The RAID model aims to reduce avoidable admissions, link patients to appropriate alternative care pathways and to direct patients to their next suitable care environment in a streamlined and timely way.

Method

The RAID model commenced in December 2025 with the team primarily based in the ED to direct referrals, enabling consultation with ED staff and facilitating rapid senior clinical decision making around the most appropriate care pathway for general medical patients referred to the service. This may include referral to alternative care pathways, discharge home, referral to outpatient services such as the Rapid Access Clinic or other outpatient clinics, or inpatient admission, as clinically indicated. RAID operates seven days a week with 10-hour service coverage Monday to Friday and eight-hour coverage on weekends. The RAID team consists of Medical Officers, Clinical Nurse Consultant, Collaborative Pharmacist Medication Prescriber (CPMP), Physiotherapy and Occupational Therapy. Service activity has been captured through ieMR consult orders and via patient records in ieMR.

Results

1,295 patient consults have been completed by the RAID team between December 2025 - June 2026. A total of 704 patients have avoided inpatient admission under General Medicine at Ipswich Hospital following RAID consult between December 2025 - June 2026. That equates to an average of 54% of patients avoiding an admission following RAID consult between December 2025 - June 2026. Median Emergency length of stay (ELOS) was reduced by an average of five hours for patients with a RAID consult vs those without from February 2026 - June 2026. A significant reduction in 24-hour stays in the ED was seen from >400 patients staying >24 hours in the ED between September 2025 - December 2025, to a total of 18 patients staying >24 hours in the ED between March 2026 - June 2026.

Conclusions and clinical implications

The RAID model has improved patient access and flow for General Medical patients at Ipswich Hospital. Close collaboration with the ED has strengthened relationships and clinical partnerships. RAID has demonstrated through early, senior clinical decision making, a total of 704 patients have avoided an overnight inpatient admission under General Medicine at Ipswich Hospital between December 2025 - June 2026, and more importantly, more patients at Ipswich Hospital are receiving the right care in the right setting at the right time.

Implementing an Occupational Therapist Cadet role in a mental health residential rehabilitation

- West Moreton Health: Jessica Warner, Hannah Bennett

Clinical innovation

Introduction

Mental health residential rehabilitation services play a key role in supporting people with severe and complex mental health conditions. Occupational therapists are often inundated with clinical work, leaving significantly reduced capacity to address all occupational issues for residents. An emerging role within mental health is an occupational therapy cadet. This role is designed for third- or fourth-year occupational therapy students to contribute to or engage in discipline-specific tasks under the supervision of an experienced occupational therapist. A pilot was conducted to explore the benefits of implementing an occupational therapy cadet role into the service.

Aim

The aim of this project is to explore how introducing an occupational therapy cadet role in a mental health residential rehabilitation environment would impact the experiences of residents, clinicians, and the cadet.

Method

Clinicians and residents within the mental health residential rehabilitation service where the cadet was implemented were provided with an anonymous survey that included statements on a five-point Likert scale and free-text questions to collect qualitative data. The cadet was excluded from quantitative data collection and included in qualitative datasets only. Descriptive quantitative analysis was used to analyse Likert scale data. Thematic analysis was used to uncover themes in the qualitative data, focusing on exploration of how the cadet role has contributed to professional development of the cadet, the recovery journey of the residents and the effectiveness of the service overall.

Results

Through analysis of quantitative data provided by 15 survey respondents, it was found that 100% of respondents indicated that the occupational therapy cadet role had a significantly positive impact on the mental health residential rehabilitation service and would like the role to continue. Qualitative data revealed four overarching themes outlining the impacts the occupational cadet role has had within the mental health residential rehabilitation service: enhanced resident engagement and capacity, improved staff support and service capacity, cadet learning and growth and scope uncertainty.

Conclusions and clinical implications

This project found that implementing an OT cadet role in a mental health residential rehabilitation setting has positive impacts on resident engagement, clinician capacity, and cadet learning. It has also highlighted opportunities for further success through refining the occupational therapy cadet role scope and developing a more robust implementation structure. Due to the small scale of this study, findings are unable to be generalised to other settings outside of the mental health residential rehabilitation. Further exploration of implementing cadet roles amongst other allied health professions and within other mental health services would be a valuable contribution to the currently limited available evidence on this emerging role within healthcare.

Evaluation of the introduction of a cancer treatment diary card (PROMs tool) for the monitoring of treatment related toxicity

- West Moreton Health: Lesley Dawson, Gurunath Sule, Olivia Sanderson

Clinical innovation

Introduction

Patients with cancer frequently experience symptoms related to their disease or cancer treatment related side effects, however research has shown that healthcare professionals often under detect or underestimate the severity of symptoms being experienced by patients.

Aim

Evaluate the effectiveness of a PROMs tool in the monitoring of toxicities experienced by cancer patients undergoing treatment, with the aim of improving symptom management and patient outcomes.

Method

A paper PROMs tool previously used overseas was modified based on recommendations in the European Society of Medical Oncology (ESMO) Clinical Practice Guideline and adapted to include colour coded triage (eviQ DoT tool).

Results

Implementation of the diary card resulted in high patient engagement, with most participants completing the diary throughout their treatment cycle. Patient-reported symptoms enabled earlier recognition of common toxicities, including fatigue, nausea and vomiting, diarrhoea, mucositis, and peripheral neuropathy.

Conclusions and clinical implications

The introduction of a PROMs tool appears feasible and acceptable in routine oncology practice. The tool promotes patient involvement in symptom monitoring and facilitates timely identification of treatment-related toxicity, which could contribute to more proactive symptom management and potentially reduce avoidable hospital admissions.

- Regional Health Collaborative: [John Marquess](#)

Clinical innovation

Introduction

The Regional Health Collaborative (RHC) is a formal partnership between Darling Downs Health, West Moreton Health, Darling Downs and West Moreton Primary Health Network, five local Aboriginal Community Controlled Health Organisations, Queensland Ambulance Service, and Health Consumers Queensland. The RHC is supported by a health intelligence function that provides an evidence-based approach to planning and prioritisation using data from the hospital and health services and GP data systems to ensure that rich health intelligence drives decision-making across the region.

Aim

The RHC aims are to achieve patient-centred approaches to healthcare service delivery through the integrated models of care, delivery of care in the right place at the right time with the outcome of reducing duplication and gaps in provision of services across the region. Since the RHC was established in November 2024 there has been a focus on generating health intelligence about older persons' health use to investigate patterns of frequent emergency department presentations, hospital readmissions, extended lengths of stay, and potentially preventable hospitalisations. This intelligence is used to identify specific opportunities for new models of care.

Method

Health service utilisation was examined across chronic disease distribution from GP data, and hospital and health service emergency department and admitted-patient data covering frequent presentation, potentially preventable hospitalisation and 28-day readmission. Each signal was expressed as a rate by SA2, and the overlap between them was treated as a proxy for concentrated demand and gaps in access. Admitted-patient records were stratified by frailty using a Hospital Frailty Risk Score (Gilbert et al., Lancet 2018), from cumulative ICD-10-AM scores categorised as low, intermediate and high, matching each cohort to a suitable response. Potentially preventable hospitalisations reproduced the Queensland Health definitions using ePADT data. Australian Bureau of Statistics population and SEIFA data, and Australian Institute of Health and Welfare residential care aged care information, were added to locate the SA2 areas where place-based intervention would have most effect.

Results

Across older persons, frailty ordered both readmission and length of stay: 28-day readmissions rose from 14.4% at low frailty to 26.1% at high and mean stay from 2.3 to 5.9 days. The same lens split conditions that look alike on volume. Older COPD admissions were mostly not frail (68% low frailty), an upstream primary-care opportunity, whereas older urinary tract infections were over three-quarters intermediate-to-high frailty and drove 85% of their bed days, a post-acute and flow opportunity. Geography separated the signals rather than uniting them: frequent presentation and readmission rates per head were highest in rural Darling Downs, whereas readmission proportion was highest in urban Ipswich, indicating a discharge and follow-up pattern distinct from the rural access signal.

Conclusions and clinical implications

What is novel about our approach is taking a system-level view, stratified by risk of frailty, on existing data to generate insights. Frailty ordered readmission and length of stay consistently

and split preventable admissions into an upstream primary-care group and a frail post-acute group. The signals did not share one geography: rural areas of Darling Downs showed higher emergency demand, urban Ipswich a high readmission proportion, each pointing to a different model of care. Models can now be aimed at a place and a cohort and quantified in acute utilisation before commissioning.

The West Moreton rural palliative care outreach and in-reach model: developing an integrated specialist rural palliative care service

- West Moreton Health: [Trish Kahawita](#), [Ela Thompson](#)

Clinical innovation

Introduction

The West Moreton region spans over 10,000 square kilometres and is one of Queensland's fastest growing health districts, with demand for specialist palliative care projected to increase by more than 50% over the coming decade. Rural communities across the Somerset, Lockyer Valley and Scenic Rim face additional challenges due to geography, workforce and reduced access to specialist services. Historically, specialist palliative care outside Ipswich was sparse and fragmented, relying largely on reactive telephone advice. This resulted in delayed referrals, inconsistent symptom management, unnecessary transfers to Ipswich Hospital and many patients receiving end-of-life care away from their families and communities. A dedicated rural specialist palliative care model was therefore required to provide equitable, coordinated and holistic care tailored to the unique needs of rural West Moreton.

Aim

The project aimed to develop an integrated rural specialist palliative care model that is proactive, flexible and responsive across community and inpatient settings. The objectives were to improve timely access to specialist care, deliver holistic multidisciplinary support, strengthen local clinical capability and enable more patients to receive high-quality end-of-life care within their own communities and place of choice.

Method

The rural palliative care service evolved from a predominantly telephone support model into an integrated outreach and in-reach service across four rural hospitals. The service sits within the Ipswich Outreach Palliative Care Service and is staffed by a Specialist Medical Officer, Nurse Navigator, Clinical Nurse and a part-time rural generalist registrar undertaking advanced skills in palliative care. The team has access to outreach pharmacists, occupational therapists, physiotherapists, psychologists, social workers, advance care planners and Aboriginal and Torres Strait Islander Liaison Officers and works closely with the Community Health Nurses across each rural hospital. Monthly outreach clinics commenced in September 2023, increasing to fortnightly from November 2024 and expanding to concurrent consultant and registrar clinics from August 2025, as well as weekly registrar telehealth clinics for urgent reviews. The service provides triage, phone support, telehealth, home visits, outpatient clinics, inpatient reviews, family meetings, discharge planning, education and daily specialist support.

Results

Routine outcome data has been collected over the last six months, demonstrating the impact of the integrated rural model. The service supported an average of 114 patients each month (range 107–122), including an average of 18 rural inpatients at any time. An average of 16 patients died each month, with 73% achieving their documented preferred place of death; only 4 had preferences that were not met. During this period, 14 patients died at home, supported through our daily review through palliative care hospital in the home. Average time to first specialist review remained between 3–6 days for most months.

Conclusions and clinical implications

The West Moreton Rural Palliative Care Outreach and In-reach integrated Model demonstrates that specialist palliative care can be successfully integrated across community and rural hospital settings to improve access, continuity and holistic patient-centred care. Six months of routine outcome data demonstrate high rates of preference achievement, timely specialist review and increasing service capacity despite rising demand. The model has also strengthened the confidence and capability of rural clinicians through education and shared care. The inpatient component, however, has evolved without dedicated funding, creating sustainability challenges. These results highlight the critical role of the service in managing increasingly complex rural palliative cases and meeting patient goals.

- West Moreton Health: Madeleine Van Hunnik, Melissa Jackson, Elle Goodwin

Clinical innovation

Introduction

The Lockyer Valley is one of Queensland's fastest growing rural regions, placing increasing pressure on local health services. At Laidley Hospital, rising demand for wound care, post-COVID health system pressures and limited access to primary care had created a growing mismatch between service demand and capacity. Patients experienced delays accessing specialist wound care, while staff identified variability in referral pathways, inconsistent clinical processes and communication challenges that impacted service efficiency. As a priority initiative within West Moreton Health's Rural Health Services Plan, the Laidley Wound Care Clinic was selected for healthcare redesign to improve patient access, optimise service delivery and support a more sustainable model of care. A structured, evidence-informed diagnostic process was undertaken to identify opportunities for improvement through a co-designed quality improvement approach.

Aim

This project aimed to redesign the Laidley Wound Care Clinic to improve timely access to care, optimise service delivery and enhance staff confidence and capability through a co-designed, evidence-informed approach. Key goals included reducing referral-to-first-appointment time from 18 to 5 days and improving staff confidence in wound care best practice.

Method

A structured healthcare redesign methodology underpinned by Lean Six Sigma principles was used to investigate and redesign the Laidley Wound Care Clinic. Diagnostic activities included stakeholder interviews, staff surveys, root cause analysis, process mapping, patient case review, literature review, benchmarking, population projections and chart audits to understand patient, staff and organisational perspectives. Findings informed a multidisciplinary co-design workshop where issues were prioritised using dot voting and evidence-informed solutions were developed. Proposed interventions focused on standardising referral pathways, strengthening communication, improving staff confidence and capability and optimising patient flow. A detailed implementation, communication, risk and evaluation plan was developed to support sustainable change.

Results

The diagnostic identified five key system issues contributing to delays in patient access and service inefficiencies. Early implementation has improved referral processing times through the introduction of standardised referral criteria, redesigned administrative workflows, referral tracking tools, and targeted education for clinicians and administrative staff. These changes have increased consistency in referral management and streamlined administrative processes. A revised model of care has been developed and is awaiting governance approval, while opportunities to enhance referral pathways through Smart Referrals have been escalated for future implementation. Formal evaluation will measure the impact of these changes on referral-to-first-appointment time and staff confidence.

Conclusions and clinical implications

This project demonstrates how structured healthcare redesign can translate diagnostic findings into practical, sustainable service improvements within a rural healthcare setting. Early implementation has strengthened referral standardisation, streamlined administrative

processes and established a foundation for improved patient access and workforce capability. The co-design approach fostered stakeholder ownership and produced solutions that were both evidence-informed and operationally feasible. Key challenges included balancing competing clinical priorities, securing consistent stakeholder engagement and progressing digital solutions within existing system constraints. Future implementation would benefit from non-clinical time dedicated to implementation, staff training and continuous improvement activities to build confidence and capability, reduce single-point dependencies and support sustainable change. The principles and methodology applied are transferable across rural and outpatient services seeking to improve access, efficiency and quality of care.

Poster abstracts

Intranasal delivery of nanoparticle-encapsulated Clozapine as a lysosome-targeting therapy for treatment-resistant Glioblastoma

- West Moreton Health and The University of Queensland: [Xiaoying Cui](#)
- The University of Queensland: Ruirui Qiao

Research

Introduction

Glioblastoma (GBM) is the most aggressive primary brain cancer, with a five-year survival rate of approximately 5%. Despite standard treatment of surgical resection, radiotherapy and temozolomide (TMZ) chemotherapy, median survival remains only 12 to 15 months because of rapid tumour progression and treatment resistance. Novel therapies are urgently needed for recurrent and TMZ-resistant GBM. These tumours display a distinctive metabolic vulnerability: a strong dependence on hyper-acidic, hyper-functional lysosomes that drive growth and invasion, making lysosomal dysfunction an exploitable therapeutic target. Drug repurposing offers a rapid, cost-effective pathway to clinical translation. Clozapine, an established antipsychotic with lysosome-modulating properties, may therefore represent a novel strategy for resistant GBM. To enhance brain and tumour targeting and avoid peripheral side effects, we encapsulated clozapine within nanoparticles and delivered it intranasally.

Aim

To investigate the anti-GBM effects and lysosome-targeting mechanisms of nanoparticle-encapsulated clozapine in TMZ-sensitive and TMZ-resistant GBM models, and to evaluate intranasal nanoparticle delivery as a strategy to enhance brain and tumour targeting while minimising systemic adverse effects.

Method

Human GBM cell lines U87MG and TMZ-resistant T98G were treated with increasing concentrations of clozapine. Cell proliferation was assessed using EdU incorporation assays. Lysosomal and autophagic responses were evaluated by Western blot analysis of LC3-II, immunofluorescence staining and confocal microscopy, with LC3-II and LAMP2 co-localisation used to assess lysosomal function. Preclinical studies measured clozapine concentration in the rat brain and compared the peripheral side effects of intranasal clozapine nanoparticle delivery versus oral clozapine, including liver weight, glucose tolerance testing and gut microbiome composition.

Results

Clozapine inhibited the proliferation of both U87MG and TMZ-resistant T98G cells in a dose-dependent manner. EdU incorporation was markedly reduced following treatment. Western blot analysis showed increased LC3-II accumulation, while immunofluorescence revealed dose-dependent lysosomal enlargement and trapping of LC3-II within LAMP2-positive lysosomes, indicating impaired lysosomal processing and dysfunction. Intranasal delivery of nanoparticle-encapsulated clozapine achieved a high brain concentration in preclinical models, sufficient to inhibit GBM growth in vitro. Compared with oral administration, intranasal delivery substantially reduced systemic exposure and associated adverse effects, including hepatomegaly, glucose intolerance and gut microbiome disruption.

Conclusions and clinical implications

These findings identify clozapine as a promising repurposed therapy for treatment-resistant glioblastoma, acting through disruption of lysosomal function. Intranasal nanoparticle delivery enables efficient nose-to-brain transport and reduced peripheral toxicity. By integrating drug repurposing, nanomedicine and intranasal delivery, this approach addresses major barriers to glioblastoma therapy and offers a novel strategy for recurrent and TMZ-resistant disease. As clozapine is already clinically approved with a well-characterised safety profile, translation to early-phase clinical studies may be accelerated. These findings support further preclinical development and clinical evaluation of intranasal nanoparticle-based clozapine therapy for patients with glioblastoma.

Using waiting time to capture the patient story: a prospective evaluation of VitalStory in the emergency department

- The University of Queensland: [Anton Cush](#), Sisira Edirippulige, Anton Pak
- CSIRO: Sankalp Khanna
- West Moreton Health: Minna Grahvendy

Research

Introduction

Emergency department history-taking occurs under time pressure, interruptions, patient distress and variable waiting periods. These conditions can affect recall and contribute to incomplete or inconsistent documentation, particularly for lower-acuity patients who often experience a long wait. VitalStory is a patient-facing, artificial intelligence-assisted tool that guides patients through their presenting problem and relevant medical history after triage, then produces a structured history for clinician review. Before such a system can be considered for practice, it must be evaluated in a live emergency department to determine whether it captures comparable history content to routine clinician documentation and whether patients can use it successfully and acceptably while awaiting care.

Aim

To compare the documented completeness of VitalStory-generated and routine-care clinician histories and evaluate the usability and acceptability of VitalStory among adult Australian Triage Scale (ATS) category 4 and 5 emergency department patients.

Method

A prospective, single-site evaluation was conducted at Ipswich Hospital Emergency Department. Ninety consenting adult ATS category 4 and 5 patients used VitalStory while awaiting routine care. Clinicians completed usual history-taking without access to the VitalStory report. De-identified paired histories are being independently scored by two trained, source-blinded clinical raters using a pre-specified 16-item subset derived from the MAAS-R history-taking domain. Paired source comparisons will occur only after ratings are locked. Inter-rater reliability will be reported separately. Patient usability was assessed using the Post-Study System Usability Questionnaire.

Results

Recruitment and patient data collection are complete, with 90 participants enrolled under routine emergency department conditions. VitalStory was successfully implemented without replacing triage, clinician assessment or clinical decision-making. Some participants did not produce an eligible routine-care clinician history because they left before a suitable consultation, or their clinical pathway did not yield a comparable record, reducing the final paired dataset. Blinded scoring and paired analysis are underway. Final reporting will include analysable pairs, overall and domain-level completeness, item-level omissions, paired differences with 95% confidence intervals, inter-rater reliability, and PSSUQ overall and subscale scores.

Conclusions and clinical implications

This study provides a real-world evaluation of patient-entered AI-assisted history capture within routine emergency care. VitalStory is intended to structure the patient story for subsequent verification, not to replace clinician history-taking, diagnosis or judgement. The final analysis will determine whether its documented history content is comparable with routine clinician documentation and whether patients find the system usable. Potential clinical value lies in using otherwise unproductive waiting time to prepare more structured

information before consultation. Implementation would require clinician review, secure data governance, accessible alternatives and workflow integration. The single-site design and loss of some paired records will limit precision and generalisability and will be explicitly considered when interpreting the findings.

A co-designed resistance training-based physical activity intervention to improve cognition in overweight or obese older adults independently living in regional Australia

- University of Southern Queensland: Thilini Herath Pathiranage, A/Prof Edward Bliss, Prof Tracy Kolbe-Alexander, A/Prof Dean Mills
- The University of Queensland: A/Prof Edward Bliss
- University of Cape Town: Prof Tracy Kolbe-Alexander

Research

Introduction

Ageing is accompanied by cerebrovascular dysfunction and cognitive decline which can be further exacerbated by insufficient physical activity and obesity, increasing the risk of dementia. Regular exercise, particularly resistance training, can reduce this risk and support cerebrovascular function and cognition. Despite these benefits, participation in resistance training is low, especially among older adults living in regional Australia due to geographic, socioeconomic and access barriers. Co-design is a participatory research method that can improve the acceptability, feasibility, and effectiveness of interventions.

Aim

The aim of this study was to co-design a resistance training-based physical activity intervention to improve cerebrovascular function and cognition in overweight/ obese older adults who are insufficiently physically active, living independently in regional Australia.

Method

Sixteen older adults (≥ 65 years) at risk of dementia and/or living with early-onset dementia were purposively recruited to participate in three World Café co-design workshops at the University of Southern Queensland (UniSQ), Toowoomba. The workshops aimed to; explore perceptions, barriers, and preferences related to physical activity and resistance training; identify key intervention components; and collaboratively design and refine the intervention. Following this, healthcare professionals ($n=9$; exercise physiologists, physiotherapists, occupational therapists, and nurses) participated in semi-structured online interviews to provide their perspectives on physical activity and resistance training and validate and refine the co-developed intervention. All the participants were invited to complete a process evaluation survey after each workshop and interview. Qualitative data, including workshop discussions, interview transcripts, and artefacts, were analysed thematically using NVivo software. Ethical approval was obtained from the UniSQ Human Research Ethics Committee (ETH2025-0241).

Results

Preliminary findings from co-design workshops and interviews with older adults and healthcare professionals in regional Australia identified three key themes: the need for supportive, qualified instructors and safe exercise environments; preferred programme components, including social interaction, clear goals, and functional resistance exercises; and barriers to participation, including medical concerns, low confidence, transport, and cost. The co-developed program consists of a 16-week hybrid intervention involving supervised gym-based sessions, unsupervised home-based sessions, and social group-based activities, delivered three to four times per week. Key features of this program included: a progressive resistance training approach using bodyweight, resistance bands, machines, and free weights; circuit-based sessions incorporating whole-body exercises; and individually prescribed home-based exercise supported by written exercise information. All co-designers reported satisfaction with the co-design workshops and provided no negative feedback.

Conclusions and clinical implications

A contextually relevant, co-designed resistance training-based physical activity intervention was developed with the collaboration of end-users and key healthcare stakeholders responsive to end-user needs. The intervention will be assessed for its feasibility and efficacy on cerebrovascular function and cognition in independent-living overweight/obese older adults in regional Australia. This study will generate preliminary efficacy data and a scalable intervention model to support larger studies targeting dementia risk and brain health. If found to be feasible and effective, this intervention has the potential to inform person-centred approaches to promote resistance training in clinical practice and community-based healthy ageing programs, supporting dementia risk reduction in regional Australia.

- The University of Queensland: Christopher Hicks, Dr Rebekah Eden, Dr Gemma McKeon, Dr Duncan McLean, Prof Anthony Smith
- West Moreton Health: Christopher Hicks, Dr Gemma McKeon, Dr Duncan McLean, Penelope Ganzenmuller

Research

Introduction

Health services make substantial investments into developing research frameworks with the aim of supporting clinical staff, consumers and academic partners to undertake research as part of their professional practice and to improve clinical care.

Aim

This scoping review sought to provide a synopsis of the literature describing research frameworks adopted by health services with a view to identifying the broad range of components of these frameworks.

Method

A scoping review was undertaken to identify peer-reviewed publications and grey literature related to research frameworks, strategies or models adopted by health services published from high-income countries, in English language and from January 2014. Editorials, opinion pieces and research protocols were excluded. Data charting was undertaken according to study design, study type and study setting and if the articles were derived from peer-reviewed journal databases or grey literature. A qualitative synthesis, using reflexive thematic analysis was undertaken to develop a list of components of research frameworks.

Results

A total of 87 publications were included in the review, with 54% of articles from electronic databases and 46% sourced from grey literature. Of the 47 databased derived articles, 42% were descriptive studies, 19% qualitative studies, 19% mix method studies, and 19% were scoping or systematic reviews. All the grey literature pertained to a hospital, health service, health network or government health research strategy. The following framework components were identified: research collaborations and partnerships; consumer and First Nations involvement in research; research capacity, capability and workforce strengthening; research culture, leadership and research ethics and governance arrangements; research design, dissemination and translation; research funding, resources and infrastructure; research strategy, planning, governance and implementation; research ecosystem: enablers, challenges and value.

Conclusions and clinical implications

This scoping review has enabled the development of a coherent, overarching catalogue of research framework elements in health services. It has identified framework components that are variously described in the literature but not previously included in research framework descriptions. These include consumer involvement in research and research priority setting, health equity approaches in research, including First Nations research, data access considerations and a full understanding of the ecosystem in which research in health services is conducted. Further work in validating this framework as a comprehensive descriptor of health service research programs, and in evaluating the effectiveness of research programs, particularly First Nations research programs, in improving health service performance and outcomes for consumers is suggested by this scoping review.

- West Moreton Health: Chaerim Kim, Kylie Ferguson, Natasha Vaughan, Emma Finch
- Metro North Health: Katrina Dunn
- Consumer representative Belinda Barrie

Research

Introduction

Rural and remote inpatients often have limited direct access to speech pathology services, and dysphagia identified in this population carries risks of aspiration, malnutrition and prolonged hospital stay if not assessed promptly. Telepractice has been proposed as a solution to this access gap, with prior studies supporting its feasibility for swallowing assessment. However, most existing evidence is drawn from short-term evaluations, with limited understanding of how telepractice services perform when embedded into routine care over extended periods and how they are experienced by patients, carers and clinicians.

Aim

To evaluate the efficiency, effectiveness and safety of the current telepractice dysphagia service for rural inpatients within West Moreton Health and to explore stakeholder expectations and satisfaction to help inform future service planning.

Method

A retrospective audit of clinical records was conducted for 189 patients referred to the service across four rural hospital sites within West Moreton Health between 2015 and 2024, with data analysed descriptively to evaluate service performance across efficiency, effectiveness and safety measures. This was combined with semi-structured interviews with patients, family members and carers (n=10) and healthcare staff (n=11) to capture first-hand experience of the service. Interview data were analysed using the Theoretical Domains Framework and Capability, Opportunity, Motivation - Behaviour model to identify behavioural and implementation factors influencing service delivery.

Results

The service met its 24-hour contact target in 94% of referrals, with delays generally linked to weekend referrals or coordination across health services. Of patients referred, 95% were considered suitable for telepractice, with 95% of suitable patients completing telepractice dysphagia assessment. Oropharyngeal dysphagia was confirmed in 53% of the cohort, and clinical recommendations followed for the large majority of patients. Sixteen safety incidents were recorded across the nine-year period, providing evidence to support safe delivery of telepractice across geographically dispersed sites. Interviews identified consistent enablers and barriers relating to environmental and resourcing factors, social influences and clinical knowledge, with experiences differing between rural sites and the central hub. Stakeholders supported the ongoing role of telepractice while identifying opportunities to strengthen service delivery through more structured training, clearer scheduling processes and the implementation of a hybrid service model incorporating both in-person and telepractice approaches.

Conclusions and clinical implications

Overall, this evaluation demonstrates that the rural hospital telepractice dysphagia service is meeting key efficiency and safety benchmarks while supporting clinical decision-making across rural sites within West Moreton Health. Findings also highlight opportunities to further optimise the service model in response to stakeholder experiences and expectations. These

results provide evidence to guide future service planning and support the ongoing development of sustainable, hybrid models of rural dysphagia care.

- West Moreton Health: Trudie Lawson
- University of Southern Queensland: Melissa Taylor, Julie Flynn, Ashlee Sterling, Snezana Stolic

Research

Introduction

Patients with cancer may receive long-term intravenous systemic anticancer therapies (SACTs). Totally implanted venous access devices (TIVADs) are favoured devices for this purpose. Many health services insert TIVADs via interventional radiology suites (IRS). Some utilise operating rooms (OR), resulting in greater risk/delays.

Aim

This systematic review investigates outcomes of IRS TIVAD insertion compared to OR TIVAD insertion.

Method

Five databases were searched systematically: EBSCO, Health Source, ProQuest, Scopus, and Web of Science (date limitations: 2015– 2024). Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) was used. Search terms: “cancer” OR “oncology” OR “neoplasm” AND “totally implanted venous access device” OR “Portacath” OR “Infusion port” AND “surgical*” OR “surger*” OR “radiolog*” AND “adult”. 972 citations were imported into EndNote, and 53 duplicates were removed. Two independent reviewers screened records, and conflicts were resolved by a third. 912 were excluded. Seven full-text papers remained. A hand search of each reference list elicited five papers. A total of 12 papers were reviewed. Narrative synthesis was generated from the extracted data.

Results

High-income (Australia, Greece, Italy, Korea, Taiwan) [2-6] and low-income countries (China and Iraq) [7-13] were discussed. Sample sizes: 4480 – 55. No Randomised Control Trials (RCT) were found. Two studies investigated both settings [2,5]. Eight studies reviewed OR only [7-13]. Two discussed IRS only [3,4]. Reported outcomes: success rates, complications, procedural duration, and patient satisfaction. Procedural success: OR -100 – 99.9%; IRS - 100 - 99.6%. Complications: OR - 13.4- 3.74%; IR - 24.1-4%. Procedural time: OR - 46 ± 14 to 26.59 ± 6.18; IRS - 36.5 ± 15 – 28 minutes. Patient satisfaction was discussed in OR context only.

Conclusions and clinical implications

IRS TIVAD insertion is non-inferior to OR insertion. Patient satisfaction requires research in IRS. While procedural time was equivalent, perioperative time is not quantified. Success/low complication rates are consistent across settings. IRS and OR TIVAD insertions have comparable safety profiles. Patient voice is largely absent from the literature.

Feasibility, acceptability and effectiveness of a tailored exercise-based rehabilitation program for postural orthostatic tachycardia syndrome (POTS):
a Queensland Health pilot program

- West Moreton Health: Olivia Powrie
- The University of Queensland: Olivia Powrie, A/Prof David Holland, Prof Jeff Coombes, Dr Jenna Taylor
- Sunshine Coast University Hospital: A/Prof David Holland
- Griffith University: A/Prof David Holland

Research

Introduction

In recent years, there has been a notable increase in the prevalence of Postural Orthostatic Tachycardia Syndrome (POTS). Despite this increase in prevalence, access to tailored care for POTS in the Australian public health-care system remains limited.

Integrating a tailored POTS program into an existing chronic conditions service was conceptualised as an approach to address this gap in access to tailored care. The integration of a tailored program will provide individuals with POTS the opportunity to receive education and engage with an individualised exercise program delivered by an exercise physiologist.

The approach of integrating a tailored POTS program into an existing service was successfully trialled for an individual with POTS in 2023 with positive patient outcomes achieved. Integration of this program on a larger scale has not yet been trialled. This pilot study will trial and evaluate this approach.

Aim

The aim of this study is to investigate the feasibility, acceptability and preliminary effectiveness of integrating a tailored POTS rehabilitation program into an existing chronic conditions service.

Method

Three lived-experience consumers were recruited to review the proposed rehabilitation program design. Consumer feedback was used to finalise the design involving two phases: three months of supervised exercise (Phase One) and three months of home-based exercise training (Phase Two).

Primary outcomes were feasibility and acceptability. Secondary outcomes included effectiveness on quality of life, symptom severity, heart rate and exercise capacity. Participants completed an individualised exercise prescription with progressions guided by participant feedback received during sessions (eg rating of perceived exertion) and between sessions (eg symptom trends). Participants were also provided with education on self-management strategies (eg pacing) during the program.

Results

Thirty-six participants have been enrolled in this pilot study (35 females, mean $\pm$ SD; age=27.2 $\pm$ 10.0years). At baseline, mean quality of life was low (EQ-VAS=44.5 $\pm$ 16.7/100) and symptom severity was high (Fatigue Severity Score (FSS)=55.3 $\pm$ 6.4/63, Malmo POTS Symptom Score (MAPS)=78.2 $\pm$ 20.8/120).

Five participants (13%) have withdrawn from the program and 3% of available sessions (17/600) have been missed due to POTS symptoms, indicating high program feasibility and acceptability.

Preliminary analysis of available phase one effectiveness data (n=14) demonstrates a mean reduction in FSS(-8.5 ± 7.0 , $p=0.002$), MAPS(-14.0 ± 18.0 , $p=0.041$), and improvement in EQ-VAS($+20.9 \pm 18.6$, $p=0.003$) and six-minute walk distance ($+95.4 \pm 61.2$ m, $p<0.001$). Full results will be available at the conference.

Conclusions and clinical implications

In conclusion, preliminary results from this pilot study suggest that a tailored POTS rehabilitation program integrated into an existing chronic conditions service is feasible, acceptable and effective at improving quality of life, symptom severity, orthostatic heart rate and exercise capacity in individuals with POTS.

Limitations of this pilot study include the single-site and uncontrolled design, opt-in recruitment method and lack of control group. To address these limitations, next steps will involve a multi-site randomized controlled trial to expand on the findings of this pilot study.

Real-world intravascular imaging use in left main percutaneous coronary intervention: contemporary adoption patterns and clinical outcomes in a large multicentre registry

- West Moreton Health: Krishnaa Sivapalan, Sheen Mathew, Anitha Lakshmanan, Yohan Chacko
- Metro South Health: Krishnaa Sivapalan, Sheen Mathew, Anthony Camuglia, Yash Singbal, Yohan Chacko
- Gold Coast Health: Vineel Lal, Thomas Koh, Kuljit Singh
- Queensland Statewide Cardiac Clinical Network: Marcus Prior, Michael Mallouhi, William Vollbon, Ian Smith
- St Andrew's War Memorial Hospital: Ian Smith
- Mackay Health: Zhihua Zhang
- The University of Queensland: Yohan Chacko

Research

Introduction

Intravascular imaging (IVI) is guideline-endorsed for complex percutaneous coronary intervention, especially left main disease (LM-PCI). However, contemporary real-world adoption patterns and associations with outcomes remain incompletely characterised.

Aim

Our study aims to characterise temporal trends and patterns of IVI use and their association with procedural and clinical outcomes, providing high-quality real-world insight into operator and system-level drivers of imaging adoption.

Method

We performed a retrospective multicentre cohort study of LM-PCI utilising the Queensland Cardiac Outcomes Registry between January 2016 and December 2024. Multivariable logistic regression identified patient, procedural, operator and institutional factors associated with IVI use. Multivariable Cox regression evaluated all-cause mortality and major adverse cardiac and cerebrovascular events (MACCE) between IVI-guided and angiography-guided PCI. Adjusted long-term survival and 30-day landmark analyses were derived from fitted Cox models.

Results

Among 44,265 PCI procedures, 1,535 involved the left main coronary artery. IVI was used in 50.6%, increasing from 30.2% in 2016 to 62.7% in 2024. IVI use was associated with calcium modification and was less frequent in ST-elevation myocardial infarction, left ventricular dysfunction, and prior coronary artery bypass grafting. IVI-guided PCI was associated with lower in-hospital, 30-day and 1-year mortality and MACCE (all $p < 0.001$). After multivariable adjustment, IVI guidance remained independently associated with lower all-cause mortality (aHR 0.61, $p < 0.001$) and MACCE (aHR 0.67, $p < 0.001$), with sustained separation of adjusted survival curves.

Conclusions and clinical implications

In contemporary Australian practice, IVI adoption has increased substantially but remains under-utilised in high acuity presentations. IVI-guided PCI was consistently associated with lower mortality, MACCE, and improved long-term survival, supporting routine adoption in LM-PCI.

The prevalence, risk factors and interventions for dysphagia in adults with a severe mental illness: a scoping review

- University of Southern Queensland: [Ruby Strasser](#), [Alice Foster](#)

Research

Introduction

Dysphagia is associated with an increased morbidity and mortality rate in our general population. New evidence shows that those with a severe mental illness are disproportionately affected. Previous research has shown that approximately 30% of adults with a severe mental illness will also display symptoms of dysphagia and that there is a bidirectional link between severe mental illness and dysphagia. Therefore, understanding the evidence of prevalence rates, the factors of heightened risk, the screening and diagnostic procedures used as well as what interventions have been identified for this population, what outcomes have been reported and what have been barriers or facilitators to providing this intervention is crucial to providing effective treatment within this population.

Aim

The purpose of our project is to inform and prioritise dysphagia screening, assessment and intervention practices in the adult SMI population by mapping the existing evidence, and in doing so provide a foundation for; practice and procedural improvements in the highest risk settings; and larger epidemiological studies.

Method

For our scoping review we utilized the Arksey and O'Malley scoping review methodological framework and the PRISMA-SCR checklist for reporting. Alice investigated prevalence, risk factors screening and assessment methods utilized in this population, whilst Ruby researched the interventions, outcomes, and barriers and facilitators. Using a developed search string, a singular search was used across four different electronic databases. This search was conducted in March 2026. No research published since has been included in the review.

Results

From the 590 studies that Alice screened and 684 articles Ruby screened a total of 19 studies for prevalence and risk factors and 22 for interventions and outcomes were identified as having met the eligibility criteria. The scoping review has identified considerable gaps on this topic and highlights the weakness in procedures of reporting, screening and assessment as well as lack of documented evidence of interventions used, other than psychotropic medication.

Conclusions and clinical implications

The scoping review highlights the need for robust epidemiological studies, and the necessity for explicit, uniform and contextually appropriate screening and assessment protocols for dysphagia in the adult SMI population. The results also indicate the need for a more comprehensive clinical reporting of risk factors for dysphagia in this population as well as an analysis of the current swallowing interventions provided and whether these are appropriate and effective for this population. If not, there should be further research on what evidence-based practices there are that consider the associated factors of severe mental illnesses in adults. This research will help improve how we consider treatment and effectively provide dysphagia screening, assessment and intervention within this population.

Thriving at work: improving support and retention of early career nurses at West Moreton Health

- University of Southern Queensland: Daniel Terry, Jessica Elliott, Leah East, Liz Ryan, Tracey Tulleners, Stephen Jacobs
- West Moreton Health: Robert Winstone

Research

Introduction

Early career nurses (ECNs) are particularly vulnerable to burnout, workplace stress, and attrition, with approximately one-quarter leaving the nursing profession within their first five years. Workforce shortages and retention challenges have increased the need to better understand factors that support nurse wellbeing and professional sustainability. Thriving at work, characterised by vitality and learning, is associated with improved health, workplace engagement, and performance. Organisational resources, including leadership, colleague support, workplace culture, and opportunities for professional development, are critical determinants of thriving. However, there is limited evidence regarding these factors within local health service contexts.

Aim

To examine factors associated with thriving, burnout, and retention among ECNs at West Moreton Health (WMH) and evaluate changes in workplace support, wellbeing, and turnover intentions between 2025 and 2026. The study seeks to inform workforce strategies that strengthen thriving, enhance retention, and support sustainable nursing careers.

Method

This research forms part of an international longitudinal mixed-methods study investigating thriving among ECNs. Annual survey data were collected in partnership with WMH among graduate nurses in 2025 and 2026 using measures informed by the Thriving at Work model and the Institute for Healthcare Improvement Joy in Work framework. Variables included vitality, learning, authenticity at work, burnout, quality of care, leadership support, colleague support, organisational support, and intention to leave. Statistical analyses examined relationships between workplace support measures and workforce outcomes, as well as differences between survey years. Qualitative feedback provided additional insights into workplace experiences and support needs.

Results

In 2025, vitality and colleague support were significantly associated with reduced burnout, while colleague support positively influenced thriving. Leadership support was significantly associated with lower intention to leave nursing. In 2026, vitality remained associated with reduced burnout and lower intention to leave the organisation. Both colleague support and leadership support were significant contributors to thriving. Comparison of survey years demonstrated significantly higher organisational support and leadership support scores in 2026, alongside significantly lower intention to leave nursing. Qualitative findings highlighted the importance of visible leadership, supportive workplace relationships, effective communication, structured learning opportunities, and staff wellbeing initiatives.

Conclusions and clinical implications

Thriving among ECNs is strongly influenced by workplace factors, particularly leadership, organisational support, and positive collegial relationships. Improved organisational and leadership at WMH was accompanied by lower intention to leave nursing, highlighting the importance of supportive practice environments for workforce retention. Visible leadership,

positive workplace culture, effective communication, and structured learning opportunities are critical enablers of thriving, which WMH exemplifies. These results provide an evidence-informed foundation for developing and evaluating co-designed workforce strategies that enhance wellbeing, retention, and the long-term sustainability of the nursing workforce.

Bridging the gap in chronic pain management: a translational research program empowering healthcare professionals and consumers

- University of Southern Queensland: [Dr Emily Wang](#)

Research

Introduction

Chronic pain affects one in five Australians and is one of the leading causes of disability, costing the Australian economy over \$140 billion annually. Despite substantial advances in contemporary pain science, many people living with chronic pain continue to experience fragmented care, repeated healthcare encounters and poor outcomes. Healthcare professionals feel constrained by limited education in modern pain management, time-pressured consultations and a health system traditionally focused on biomedical treatments. At the same time, people living with chronic pain frequently report feeling misunderstood, dismissed or unsupported. Consequently, consultations often end with both parties frustrated; the clinician perceiving a 'difficult patient', and the person living with chronic pain believing the clinician has little to offer. These perceptions reflect a broader gap between contemporary pain science and routine clinical practice. Addressing this gap requires more than new treatments; it requires improving understanding, communication and partnerships between healthcare professionals and consumers.

Aim

To present a coordinated program of research that aims to bridge the gap between healthcare professionals and people living with chronic pain by translating contemporary pain science into education, workforce capability, self-management support and practical models of care that strengthen therapeutic partnerships and improve chronic pain management.

Method

This research program employs a mixed-methods and translational research approach across multiple interconnected projects. These include systematic reviews, intervention development and evaluation, clinical trials, national workforce surveys, qualitative research, co-design methodologies and implementation science. The program investigates healthcare professionals' knowledge, confidence and educational needs, while developing and evaluating consumer education and self-management strategies. Current work extends to primary care workforce capability, rural health service delivery and implementation of evidence-based chronic pain management within routine clinical practice. Together, these projects generate complementary evidence addressing both clinician and consumer perspectives.

Results

Completed studies have demonstrated the benefits of evidence-based pain education and non-pharmacological interventions for improving pain-related outcomes and informed the development of practical educational resources. Current national research is identifying knowledge gaps, challenges and support needs among primary care nurses, while ongoing work focuses on co-designing workforce capability strategies and implementation approaches for primary care settings. Collectively, these projects demonstrate that improving chronic pain management requires supporting both healthcare professionals and consumers rather than focusing solely on new clinical treatments. The emerging evidence supports education and capability building as key enablers of person-centred, evidence-based chronic pain care.

Conclusions and clinical implications

This research program proposes a shift in how chronic pain management is approached, from treating persistent pain as an isolated clinical problem to strengthening the relationship between healthcare professionals and people living with chronic pain. Education provides the foundation, empowerment creates capability, and partnership enables sustainable change. By translating contemporary pain science into practical clinical strategies, the program seeks to improve healthcare professionals' confidence, enhance consumers' understanding of pain, and support meaningful self-management within everyday healthcare. Ultimately, the goal is not simply to improve pain management, but to bridge the gap between evidence and practice, and between healthcare professionals and consumers. Collaboration with clinicians, consumers, health services and researchers will be essential to achieving this vision and transforming chronic pain care.

Improving multidisciplinary team communication through the implementation of rapid rounds in general medicine at Ipswich Hospital

- West Moreton Health Kate Atkinson, Justin Jacob, Philip Juffs, Dr Connor O'Neill

Quality improvement

Introduction

Through a collaborative multidisciplinary team (MDT) workshop, it was identified that communication within the MDT in General Medicine was challenging, resulting in both clinical and operational delays in patient progress and discharge planning.

Aim

Optimise patient flow within General Medicine by bringing the full MDT together through short, sharp, scripted daily morning huddles.

Method

Five-minute flow focussed discussions per treating team with an emphasis on patients flagged for discharge with an EDD within the next 24 hours, high priority allied health referrals for new patients, reconciliation of outstanding referrals required for existing patients, highlighting any resourcing or capacity constraints identified for the day. Data was collected through staff feedback surveys, local data dashboards and ieMR consult orders.

Results

- Time to identification of allied health input and consult order generation has significantly improved; moving to earlier identification in the patient's journey from an average of 9.63 days to 3.88 days.
- Time to completion of allied health consults have also improved with earlier identification of need. Improving from 5 days to 1 day on average to complete, following initial consult.
- Discharge patterns shifted earlier in the day from 1pm - 4pm being the highest discharging hours for general medical patients, to 10am – 1.59pm post implementation.
- 61% of staff reported that they agree or strongly agree that rapid rounds help to identify and address patient issues early.
- 77% of staff who participated in a staff feedback survey reported that they either agreed or strongly agreed that the Rapid Rounds improve communication between disciplines.
- 65% of staff reported to either agree or strongly agree that overall, rapid rounds are a successful improvement.

Conclusions and clinical implications

The implementation of daily MDT rapid rounds improved communication, early identification of patient issues and discharge planning. Staff reported improved communication between disciplines, with discharge patterns shifting to earlier by time-of-day post implementation. Time to allied health input and consult order generation significantly improved with the model largely embedded into routine practice.

- West Moreton Health: Nicholas Duong, Mohammed Soofi Hussain Phakeer, Min Fong, Brent Simkus

Quality improvement

Introduction

West Moreton Health (WMH) provides care across the Ipswich City, Somerset, Scenic Rim, and Lockyer Valley regions. Geographic distance remains a barrier to timely hospital care for many rural Australians, increasing travel challenges for patients and families.

Hospital in the Home (HITH) delivers hospital-level care, including intravenous therapies, allied health interventions, and Geriatric Evaluation and Management in the Home (GEMHITH), within a patient's usual place of residence as an alternative to inpatient admission when clinically appropriate.

Aligned with Queensland Health's commitment to delivering care closer to home, WMH has expanded its HITH service model to improve equitable access to responsive, connected hospital-level care for patients across metropolitan and rural communities.

Aim

This audit evaluated the impact of expanding HITH eligibility and operational capacity to include patients residing more than 50 minutes' drive from the service base, comparing rural patient access before and after implementation.

Method

In July 2025, the HITH service implemented a staged expansion of its rural catchment area, supported by collaborative referral pathways, operational redesign, and partnerships with rural healthcare providers.

A retrospective before-and-after audit was conducted using electronic medical records to identify HITH admissions and residential locations for the 12-month periods before and after implementation (7/7/2024 - 6/7/2025 and 7/7/2025 - 6/7/2026). Residential locations were classified using the Modified Monash Model (MMM), and rural patient admissions were compared. Patients were invited to provide feedback on their HITH experience.

Results

Non-metropolitan (MMM ≥ 2) HITH admissions increased from 206 patients in the 12-month pre-implementation period to 352 patients in the 12-month post-implementation period, representing a 71% increase following expansion of the service footprint. Rural (MMM ≥ 4) HITH admissions increased from 88 to 235 patients, with the proportion of total HITH admissions from rural locations doubling from 6% to 12%.

The expanded model extended the full scope of HITH services across three major rural regions. Informal patient feedback was consistently positive, highlighting satisfaction with receiving care closer to home and avoiding travel to metropolitan facilities.

Conclusions and clinical implications

Geographic distance should not determine access to hospital-level care. Expanding the WMH HITH into rural communities demonstrates that established models of care can be successfully implemented across large and diverse catchments, improving equity, reducing the burden of travel and bringing contemporary healthcare closer to where patients live. As demand for healthcare continues to grow, rural HITH offers a scalable model for delivering high-quality, patient-centred care beyond traditional hospital walls.

Improving dietetic documentation in ieMR through transition from PowerForms to progress notes: a quality improvement initiative

- West Moreton Health: [Ainsley Galton](#), [Danielle McLaren](#)

Quality improvement

Introduction

Accurate, accessible, and efficient clinical documentation is essential for communication, continuity of care, and medico-legal record keeping. Despite this, documentation burden is strongly associated with job dissatisfaction and professional burnout, with excessive time devoted to documentation reducing time available for direct patient care. Historically, dietitians at West Moreton Health used PowerForms for all clinical documentation within ieMR. Clinician feedback identified several limitations, including poor readability, inefficient documentation practices such as double handling (i.e. handwritten notes or word documents, needing to be documented after the appointment), character limits, and limited functionality for shortcuts or templates. These issues impacted multidisciplinary communication, clinician efficiency, and the visibility of dietetic care. Previous literature highlights the value of structured, standardised documentation systems in improving information accessibility and supporting clinical decision-making. In response, a quality improvement initiative transitioned dietetic documentation from PowerForms to standardised Progress Notes.

Aim

To improve the usability, readability, efficiency, and accessibility of dietetic documentation within ieMR through implementation of a standardised Progress Note template and to evaluate its impact on clinician satisfaction and perceptions of documentation quality within the dietetics service.

Method

A dietetic working group was established to review existing documentation practices and develop a standardised Progress Note template aligned with clinical and organisational requirements. Consultation was undertaken with key stakeholders, including dietitians and digital health representatives, to inform template design and implementation planning. Education sessions, written resources, and implementation support were provided prior to implementation. The Progress Note template was then introduced across the dietetics service, replacing routine use of PowerForms. Pre- and post-implementation surveys assessed clinician perceptions of documentation usability, readability, efficiency, accessibility, consistency, and overall satisfaction. Survey responses were analysed descriptively to compare clinician experience before and after implementation.

Results

Following implementation, clinicians reported improvements across multiple domains of documentation practice. Progress Notes were perceived as more time-efficient, supporting point-of-care documentation through the use of smart templates and shortcuts, while also being more user-friendly and easier to read than PowerForms. Clinicians reported more timely completion of documentation, improved consistency in recording clinical care, and greater confidence in the accuracy and completeness of documentation due to contemporaneous documentation and use of standardised templates. Additional perceived benefits included greater compatibility with emerging technologies, including AI-assisted documentation tools. A reported limitation was the reduced ability to filter and easily locate dietetic documentation compared with PowerForms.

Conclusions and clinical implications

Transitioning dietetic documentation from PowerForms to standardised Progress Notes improved clinician satisfaction and perceived documentation quality within the dietetics service. Improved readability and accessibility of documentation support effective multidisciplinary communication and increase the visibility of nutrition care within the electronic medical record. The project demonstrates the value of clinician-led digital workflow redesign in improving documentation processes while maintaining alignment with organisational requirements and governance standards. Key enablers of success included stakeholder engagement, clinician consultation, and the provision of education and implementation support. Challenges included managing change across a diverse clinical workforce and balancing differing preferences regarding documentation style. Future evaluation will focus on the sustainability of improvements, objective measures of documentation quality and efficiency, and the impact of documentation changes on clinical and patient outcomes.

- West Moreton Health: Hope Kinloch, Johanne Neill

Quality improvement

Introduction

Acute coronary syndrome (ACS) remains a leading cause of morbidity and mortality in Australia, requiring timely diagnosis and evidence-based management to optimise patient outcomes. The Acute Coronary Syndromes Clinical Care Standard, developed by the Australian Commission on Safety and Quality in Health Care, outlines key quality indicators to support the delivery of timely, appropriate, and consistent care across the patient journey. Despite the availability of these national standards, variation in clinical practice may result in delays to treatment, incomplete implementation of guideline-directed therapies, and missed opportunities for secondary prevention. Clinical audit is an important quality improvement strategy for evaluating adherence to evidence-based care, identifying gaps in practice, and informing targeted interventions to improve the quality and consistency of ACS management.

Aim

This clinical audit aimed to assess whether the management of patients presenting with acute coronary syndrome (ACS) at Ipswich Hospital aligned with the key indicators for local monitoring outlined in the Acute Coronary Syndromes Clinical Care Standard. The audit sought to identify variations in practice and opportunities to improve adherence to evidence-based care.

Method

A retrospective clinical audit was conducted of adult patients presenting to Ipswich Hospital with Acute Coronary Syndrome (ACS) over a defined six-month period. Information was collected from patients' electronic medical records and compared with the Acute Coronary Syndromes Clinical Care Standard. Variables assessed included timing of ECG acquisition, risk stratification, left ventricular ejection fraction assessment, discharge planning, secondary prevention prescribing, cardiac rehabilitation referral, and completion of discharge summaries. Compliance with the Clinical Care Standard was evaluated to identify areas of practice that aligned with, or differed from, national quality indicators.

Results

A total of 102 patients were included in the audit (mean age 65.3 years; 70% male), with NSTEMI accounting for 90.2% of presentations and STEMI accounting for 9.8%. Of the 10 patients presenting with STEMI, five did not receive reperfusion therapy (PCI or fibrinolysis). Among those who underwent reperfusion, only 20% achieved the recommended time-to-treatment target. Guideline-recommended secondary prevention prescription rate was high, with lipid-lowering therapy prescribed at discharge in 96% of patients. Left ventricular ejection fraction was assessed before discharge in 89.2%. Cardiac rehabilitation referral occurred in 76.5% of cases. However, only 10.8% of patients underwent an ECG within 10 minutes of first clinical contact, and discharge summaries were completed within 48 hours in 50% of cases. Documentation of assessment using the ADAPT risk stratification pathway was not identified in the electronic medical records, and TIMI / GRACE risk scores were not documented for admitted patients, highlighting key areas for quality improvement.

Conclusions and clinical implications

This audit demonstrated strong adherence to guideline-recommended secondary prevention strategies following ACS, while identifying important opportunities to improve early assessment processes and clinical documentation. In particular, the low rate of ECG completion within 10 minutes of first clinical contact, alongside delays in achieving recommended time-to-reperfusion targets, highlights potential areas for improving timely diagnosis and management of ACS. The findings will inform targeted quality improvement initiatives at Ipswich Hospital, including education on time-critical ACS assessment, integration of structured chest pain pathways and risk stratification tools into the electronic medical record, and promotion of standardised documentation practices. Other, more practical initiatives may include a designated area for ECGs at triage or more immediate access to ECG machines. Future audit cycles will assess the impact of these interventions, with a focus on improving compliance with evidence-based standards and optimising patient outcomes.

Are we monitoring the right patients? Evaluating telemetry utilisation and guideline compliance in medical wards

- West Moreton Health: Hope Kinloch, Anusha Natani, James Robinson

Quality improvement

Introduction

Continuous cardiac telemetry is an important monitoring tool for patients at risk of clinically significant arrhythmias. However, prolonged or inappropriate telemetry use contributes to alarm fatigue, unnecessary resource utilisation, and increased healthcare costs. Telemetry beds are often capped at limited numbers on certain wards, potentially creating issues with patient flow. Current guidelines recommend that telemetry should only be used for appropriate indications and reviewed daily to determine ongoing need. This audit evaluated telemetry prescribing practices across four general medical wards in a major regional hospital.

Aim

The aim of this audit was to assess current telemetry utilisation on selected medical wards, evaluate adherence to local telemetry guidelines, and identify opportunities to optimise patient monitoring and resource utilisation.

Method

A retrospective audit of 118 consecutive telemetry episodes was performed across four inpatient wards at Ipswich Hospital (6B, 7A, 7B and 7D). Data collected included documented indication for telemetry, duration of monitoring, and evidence of documented daily medical review. Descriptive statistics were used to evaluate compliance with local best-practice standards.

Results

A documented indication for telemetry was present in 85 of 118 episodes (72%), while 33 episodes (28%) lacked a documented indication. Evidence of documented daily review was identified in only 37 episodes (31.4%), with 81 episodes (68.6%) having no documented reassessment of ongoing telemetry requirements. The mean duration of telemetry monitoring was 3.8 days (median 3 days). Ward variation was observed, with Ward 7D demonstrating the highest compliance with indication documentation (82.5%), whereas Ward 7B demonstrated the lowest compliance for both indication documentation (41.2%) and daily review (5.9%).

Conclusions and clinical implications

This audit identified substantial opportunities to improve telemetry stewardship, particularly regarding documentation of daily medical review and ongoing clinical indication for monitoring. The introduction of a standardised telemetry order on ieMR would allow medical staff to prescribe telemetry monitoring for patients according to a refined list of indications with a recommended duration. Once prescribed, electronic prompts may improve adherence to best-practice recommendations, reduce unnecessary telemetry utilisation, and optimise patient care.

Streamlining gastrostomy management and follow up processes to improve patient experience at Ipswich Hospital

- West Moreton Health: Riya Master, Danielle McLaren, Kelly Carmont

Quality improvement

Introduction

Gastrostomy tubes provide long-term enteral nutrition support for patients requiring nutritional management. Following gastrostomy insertion, multidisciplinary team (MDT) members, including dietitians and nursing staff, provide education regarding nutrition, tube care, complication management, and follow up requirements. A review of the gastrostomy services at Ipswich Hospital (IH) identified several gaps in care, including inconsistent knowledge and confidence in gastrostomy management, inconsistent referrals to stomal therapy services, avoidable emergency department (ED) presentations for gastrostomy-related complications, and limited long-term follow-up processes. These gaps contribute to fragmented care, with uncertainty regarding ongoing care and follow up pathways, reduced access to care closer to home, increased risk of gastrostomy-related complications, and potentially avoidable ED presentations and hospital admissions, negatively impacting patient experience and outcomes.

Aim

This project aims to improve MDT knowledge and confidence in gastrostomy management to work to full scope of practice, establish streamlined and evidence-based follow-up processes, enhance access to timely care closer to home, and improve patient experience through coordinated, high-quality gastrostomy support across the continuum of care.

Method

A quality improvement project, guided by the Model for Improvement using Plan-Do-Study-Act cycles, was undertaken to evaluate gastrostomy management practices and implement service improvements at IH. A gap analysis comparing current practice at IH against evidence-based guidelines informed the development of education resources and MDT training. Pre- and post-implementation surveys were used to evaluate changes in staff knowledge and confidence. Retrospective audits of gastrostomy service activity data, ED presentations, gastrostomy-related Riskmans, and referral pathway reviews identified key service gaps. Findings, alongside stakeholder consultations, informed revision of local gastrostomy management guidelines and implementation of standardised discharge care plans with routine follow-ups. Prospective patient experience surveys were conducted to evaluate the impact of these initiatives.

Results

Preliminary evaluation identified significant variation in gastrostomy follow-up processes. No routine system existed for scheduling gastrostomy replacement within recommended timeframes or for routine stomal therapy outpatient review following insertion to support ongoing monitoring, complication prevention and tube care. Patients requiring gastrostomy support in the community were identified who were not known to local stomal therapy services, highlighting gaps in care coordination. Dietitians reported variable confidence in managing gastrostomies within their scope of practice. Evaluation of ED presentations, post-implementation staff confidence and patient experience is currently underway.

Conclusions and clinical implications

This project identified important opportunities to improve gastrostomy management within West Moreton Health. Gaps in routine follow-up, monitoring and care coordination have the

potential to contribute to delayed identification of complications, fragmented care pathways and reduced access to care closer to home. The implementation of standardised referral processes, evidence-based follow-up pathways and multidisciplinary education aims to improve clinician capability, strengthen continuity of care and enhance patient experience. Ongoing evaluation will assess the impact of these changes on service delivery, ED presentations, complication management and patient outcomes, with findings informing future service development and sustainability.

SUDI project: implementation of recommendations for West Moreton Health (WMH) following the Queensland Paediatric Quality Council (QPQC) summary report

- West Moreton Health: Sheree Murray

Quality improvement

Introduction

Sudden unexpected death in infancy (SUDI) remains the leading cause of post-neonatal deaths in Queensland with rates exceeding the national average. The West Moreton region was identified to have a larger than average number of SUDI in the community, between January and June 2025, which prompted a review to be undertaken by the QPQC. These deaths occurred in the home environment and babies were aged between 10 weeks and 10 months old. Key prevention opportunities and 24 recommendations arising from the review were provided to WMH, with the aim of reducing the risk of these preventable deaths.

Aim

The purpose of the project was to address the 24 recommendations from the QPQC within WMH with an aim to improve safe sleeping education to staff and families and the community and with an overall aim to see a reduction in the rates of SUDI in the West Moreton region.

Method

Changes implemented were; an increase in staff and medical education around SUDI, more visual safe sleeping prompts for families in maternity and child health settings, enhanced engagement from maternity to child health, phone calls to all women who birthed at Ipswich Hospital and introduction to child health services, improved documentation in child health charts to ensure safe sleeping discussion at every encounter, engagement with GPs through a podcast to reinforce safe sleeping messaging, Pēpi-Pods roll out in August to further promote safe sleeping environments alongside education, audit of consumers at drop-in clinics at Ipswich and Goodna to gain understanding of parents' knowledge of safe sleeping, audit of child health charts to check if screening tools were being done. Follow up audits of compliance is planned to be done in three months.

Results

Consumer audit revealed 100% of families had received safe sleeping information in pregnancy and after birth from midwives and child health nurses, however documentation did not always reflect that these discussions were occurring. Implementation of updated templates with safer sleeping prompts is now in place, capturing the information shared with families at a child health drop-in clinics and home visiting encounters. Poor compliance was noted with screening tools postnatally, with these findings shared with Child Health Nurses and repeat audits planned in three months to review.

Conclusions and clinical implications

This was a three-month project funded by the Putting Queensland Kids First plan. Poor engagement with and an understanding of Child Health services was a major finding in this project. This was an opportunity to increase education around SUDI as well as the role of Child Health for families with staff in all areas of maternity, Children's ward and Paediatric Emergency Department, and to ensure the continuum of care from postnatal to child health occurred for families. Several outstanding actions were provided as well as statewide implementation of packages to further support the recommendations from QPQC.

- West Moreton Health: Sarah Williams, Samuel Donaldson, Thomas King Koi

Quality improvement

Introduction

Chronic obstructive pulmonary disease (COPD) places a significant burden on West Moreton Health services. Respiratory medicine is one of the highest-volume service groups, and demand and complexity of acute respiratory care is projected to double leading up to 2032. The physiotherapy management of patients presenting to hospital with an exacerbation of COPD is anecdotally variable and is likely not aligned with current clinical guidelines. The Darling Downs and West Moreton Joint Regional Needs Assessment identified priorities of Preventative Health and Chronic Conditions – aiming to optimise and enhance care for people with chronic respiratory conditions like COPD across the region.

Aim

To improve physiotherapy management of patients presenting to hospital with an exacerbation of COPD to align with clinical guidelines and recommendations. Goal is to standardise physiotherapy care in acute inpatients at Ipswich Hospital to improve care for this patient population.

Method

A survey was sent out to physiotherapists working in acute inpatient areas to understand their current management of patients presenting with an exacerbation of COPD, to see whether their current practice aligned with clinical practice guidelines. It also aimed to gather feedback on barriers to providing better patient care and provided an opportunity to raise questions. The charts of 20 patients who had a hospital admission for N/IECOPD were audited against the clinical care guidelines relevant to physiotherapy from January – March 2026. The audit and survey results were compared.

Results

There were significant discrepancies found between what staff reported and what was found in chart audits, and it was found that current physiotherapy care does not align with Clinical Care Standards for COPD. An in-service was delivered to the acute physiotherapy team providing feedback on survey results compared to audit outcomes, outlined how our care could be improved to align with Clinical Care Standards, and introduced tools to aid in improving care. These tools included a patient handout, awaiting consumer feedback and approval, and an ieMR template used for every patient in every chart entry to prompt providing education and completing follow-up referrals. The in-service also outlined the referral process to Lung Health CCS and discussed the importance of pulmonary rehabilitation following COPD exacerbations.

Conclusions and clinical implications

The changes implemented aim to standardise physiotherapy care across acute inpatient services at Ipswich Hospital and contribute to more effective management of patients presenting with COPD exacerbations. We plan to re-audit in September to evaluate whether the changes made have resulted in more effective management. We also plan to evaluate whether changes in practice have resulted in any changes to readmission rates, noting we have a small sample size.

Challenges included:

- Large acute physiotherapy team, including a high percentage of new or recent graduate staff members, and ECOPD patients are found across all wards.

- Difficulty implementing practice changes to a large group across multiple clinical areas.
 - Prolonged time period awaiting handout feedback and approvals.
- Learnings:
- Prioritise handout creation earlier in project timeline due to approval process.

Audit of CT-guided percutaneous lung biopsies: complications, diagnostic yield and specimen adequacy prior to biopsy device change

- West Moreton Health: Yuze Zhai, Charles Beams

Quality improvement

Introduction

CT-guided percutaneous lung biopsy is an established minimally invasive technique for obtaining tissue diagnosis of pulmonary lesions. It is critical in the work-up of suspected pulmonary malignancies, metastatic disease and other benign pulmonary pathologies. This procedure carries recognised risks including pneumothorax, haemoptysis, requiring chest drain insertion or hospital admission. Procedural outcomes are influenced by patient risk factors, lesion characteristics, and technical factors, making ongoing quality assurance essential. The Medical Imaging department at Ipswich Hospital performs approximately 100-120 CT-guided percutaneous lung biopsies annually, making this a high-volume procedure within the service. The department has recently introduced a new biopsy device for CT-guided lung biopsies. This audit establishes baseline departmental performance prior to its implementation, providing a benchmark for a planned re-audit to evaluate the impact of the new device on procedural safety, diagnostic yield, and specimen adequacy.

Aim

To evaluate the safety, diagnostic performance, and specimen adequacy of CT-guided percutaneous lung biopsies performed at Ipswich Hospital, establishing baseline departmental performance before the introduction of a new biopsy device.

Method

A retrospective clinical audit was conducted on adult patients who underwent CT-guided percutaneous lung biopsy at Ipswich Hospital between July 2025 and June 2026. Clinical, radiological, procedural, and pathological data were collected from electronic medical records (ieMR), PACS, and AUSLAB. Outcomes assessed included procedural complications, diagnostic yield, and specimen adequacy for histopathological diagnosis and molecular testing. Findings will be compared with published benchmarks and used to inform future quality improvement.

Results

Data collection and analysis are still ongoing. Final analysis will report complication rates, diagnostic yield, specimen adequacy for molecular testing, and factors associated with procedural outcomes.

Conclusions and clinical implications

This audit will establish the baseline performance metrics for recent CT-guided lung biopsies at Ipswich Hospital. The findings will support a repeat audit following implementation of the new biopsy device to assess its impact on complication rates, diagnostic yield, and tissue adequacy, guiding ongoing quality improvement within the department.

- West Moreton Health: Sarah Sorensen

Clinical innovation

Introduction

Delivery of pregnancy care to women in correctional centres can be complicated due to the nature of custodial environments and the various organisations involved in the custody and care of these women. Pregnant women in custody do not currently have access to the same breadth of services available to women in the community.

Aim

The purpose of this improvement was to bring together key stakeholders in a workshop format to map the existing healthcare journey for pregnant women who are incarcerated to create greater visibility of service provision, barriers and the opportunities to improve the equitable access of care for these women.

Method

Service representatives and leaders attended the workshop, including Director of Offender Health and Wellbeing (Department of Health); West Moreton Health (WMH) Allied Health executives, Nursing, Mental Health and Specialised Services, and Family, Surgery and Diagnostic Imaging; staff from Prison and Youth Detention Health, First Nations Health, Jaghu Maternity, Child Health, Perinatal Infant Mental Health, Social Work and other services. A series of large discussions and small group facilitated activities were conducted to gather the information.

Results

The workshop resulted in a single-page patient journey that summarises a woman's pregnancy journey while in custody, in either Brisbane Women's Correctional Centre or Southern Queensland Correctional Centre, including healthcare services external to WMH care. An accompanying workshop summary document provides additional detail about specific care delivery and an action plan based on identified opportunities.

Conclusions and clinical implications

Following the findings from the workshop, a temporary clinical midwife consultant role with project support from the Clinical Planning and Multicultural Services teams has been stood up to develop a maternity model of care for women in custody. Given the over-representation of First Nations women in custody, the model will be co-designed and clinically led by an identified midwife to ensure the care delivered meets the needs of all women – aligning with the Queensland Health's First Nations First health equity approach.

- West Moreton Health: Nicole Burns, Anna Price

Clinical innovation

Introduction

West Moreton Health (WMH) Interpreter Services was identified as an opportunity area for improvement and financial efficiency following a cost optimisation program undertaken in 2025. Subsequent review within language services identified opportunities for improvement and optimisation with savings estimated to be between \$140,000 - \$294,000 across the health service.

Aim

The objective of the project was to improve patient access to care, reduce costs and wastage, improve booking processes and provide transparency of interpreter bookings WMH wide, commencing with piloted site engagement and co-design.

Method

- Exploration: staff were engaged to define the issue. Pilot sites were determined from quantitative interpreter usage data.
- Preparation: digital booking portal was developed replacing the paper-based booking form, a usage data dashboard was built to provide visibility, Digital Assignment Sheets introduced to reduce paper-based waste and tailored virtual delivery plans were developed in conjunction with pilot sites.
- Implementation: training provided on new systems and processes. Benefits and reiteration of the change communicated via internal channels.
- Sustainment: the average person needs to hear a new process message five to seven times before it changes behaviour, because of this education was and continues to be a focus.

Results

Face-to-face bookings transitioned to virtual delivery have reduced the cost of appointments, associated travel and wastage fees (via on demand).

Conclusions and clinical implications

This project highlights the benefits of engagement and co-design for successful implementation of service improvement initiatives and change management processes within a large organisation.

- West Moreton Health: Sally Denkel

Clinical innovation

Introduction

Families of infants leaving the Special Care Nursery (SCN) are experiencing inconsistent discharge processes, unclear referral pathways, and fragmented communication between hospital, community, and primary care services, leading to gaps in continuity of care and reduced confidence for families transitioning home. Retrospective data suggests there are numerous infants that have been lost to medical, allied health and nursing follow-up post discharge from the Ipswich Hospital SCN.

Aim

The Tiny Transitions Project is a neonatal–paediatric quality improvement initiative designed to strengthen the transition from hospital to home, including discharge home from the Special Care Nursery. The project focuses on improving discharge consistency, enhancing families' understanding of available supports, streamlining referrals, and strengthening communication across hospital and community care services. It also modernises discharge processes and equips staff with the confidence and tools to guide families toward appropriate, community-based care following discharge.

Method

Development of clear discharge checklists to support consistency.

Results

The Tiny Transitions Secondary Project has successfully identified and addressed key gaps in discharge planning, referral processes, family education, and digital systems within the Special Care Nursery. Implementation of standardised tools, including the Admission to Discharge Record and Electronic Discharge Summary (EDS) templates, alongside the development of health literacy–appropriate consumer resources, has established a strong foundation for safer, more consistent discharge practices, strengthened referral pathways and improved communication.

Conclusions and clinical implications

To further strengthen discharge processes and continuity of care, it is recommended that the role of a SCN Discharge Coordinator be considered.

Applying implementation science to guide quality improvement recommendations for conducting a population health needs assessment

- Darling Downs and West Moreton PHN, Australian Centre for Health Services Innovation, Queensland University of Technology, West Moreton Health: Ashleigh Earnshaw

Clinical innovation

Introduction

Population health needs assessments (HNA) are a tool to systematically identify, validate, and prioritise the health and service needs of a specific population. The identification of needs is intrinsically complex, informing health and social care planning and promoting improvements in health inequities. The conduct of a population HNA must therefore balance complexities with pragmatism, to facilitate a robust and accessible process for all stakeholders. Following the delivery of its population HNA, West Moreton Health (WMH) undertook a quality improvement project to review the HNA process and provide recommendations for future HNAs. Improvement Science and Implementation Science share common desired outcomes yet differ slightly in their approach and academic perspectives. This project used the Consolidated Framework for Implementation Research (CFIR) and Expert Recommendations for Implementing Change (ERIC) Framework.

Aim

This project aimed to identify barriers and enablers to the development of *WMH RANA 2025-28* and develop a set of strategies for improvement in future HNA processes.

Method

A qualitative, cross-sectional design was used. Qualitative data was generated from semi-structured interviews. Recruitment was open to all individuals who participated in governance, project delivery, or the prioritisation process, resulting in 17 participants. Inductive analyses were conducted using reflexive thematic analysis to develop barriers and enablers, which were mapped to CFIR. A workshop was held with the project team using the CFIR-ERIC Implementation Strategy Matching Tool to formulate strategies for improvement in the HNA process.

Results

Seven barriers were identified including the relative priority of engaging in the needs assessment process compared to clinical and administrative responsibilities in a healthcare setting (Inner setting – relative advantage), short timeframe for completion (Outer setting – external policy and incentives), and high resourcing costs (Intervention characteristics – cost). Thirteen strategies for improvement were developed. These included seeking out medical champions to be involved in needs assessment processes (identify and prepare champions), meet with clinical leaders to discuss benefits of needs assessment involvement to facilitate engagement (inform local opinion leaders), and embed needs assessment in budget builds, staff operational planning, and identify opportunities for leveraging existing resources (alter incentive/allowance structures).

Conclusions and clinical implications

This project highlights the complexities of conducting a HNA, underscoring the importance of effective professional relationships and engagement to facilitate a cohesive and robust process that is embedded into a healthcare organisations' workings.

- West Moreton Health: Matthew Wall

Clinical innovation

Introduction

It is well established that exercise interventions have been demonstrated to be effective in improving health and wellbeing outcomes for a wide variety of physical health conditions. There is also growing evidence for the role of exercise interventions in the treatment of mental health conditions such as depression, anxiety and psychosis. However, access to exercise interventions within Acute Inpatient Mental Health Services (AIMHS) has historically been very limited, largely due to a lack of qualified clinicians and environmental restrictions. The Mental Health Acute Inpatient Service (MHAIS) integrated a permanent full-time Exercise Physiologist and well-equipped gymnasium space to address these historical barriers. As this position represented a Queensland AIMHS first, the feasibility and efficacy of implementing an Exercise Physiology (EP) service within this setting was poorly understood.

Aim

The aim of this project was to conduct a comprehensive evaluation of the feasibility and efficacy of the implementation of the MHAIS EP service over a 2-year period to guide future service development and develop implementation recommendations for EP services with Queensland AIMHSs.

Method

The MHAIS EP service provided individual and group-based clinical EP services that support the mental health recovery of MHAIS consumers and help to address physical health conditions that might be negatively affecting their recovery. The EP service additionally supported consumer care through conducting physical health and functioning assessments to guide treatment planning and advocate for the physical health needs of consumers.

Results

With a staffing profile of 1.0 HP4 FTE for 14 months and additional 1.0 HP3 FTE for 10 months, the EP service received 794 referrals (age range of 16-93 years) where 57.2% reported having a physical health condition.

Conclusions and clinical implications

The EP service activity data, clinical outcomes and consumer feedback indicate that the EP service was highly utilised and positively influenced the recovery journeys of consumers. The EP service was perceived as highly valuable by MHAIS staff which exceeded their expectations. Exercise Physiologists provide safe, effective and highly valuable therapeutic services for AIMHS consumers and should be integrated as a core service provider into existing and service planning for new AIMHSs statewide. The integration of Exercise Physiologists offers a unique opportunity for AIMHSs to demonstrate innovation, expand workforce capability and increase access to evidence-based service delivery. The inclusion of EP into Mental Health Allied Health new graduate programs is feasible, significantly increases workforce development pathways and increases service capacity.

- West Moreton Health: Kate Atkinson and the FISM team

Clinical innovation

Introduction

West Moreton Health (WMH) is experiencing increasing pressure on inpatient capacity due to a growing and ageing population, with future bed expansion projects still some time away. As demand continues to rise, maintaining patient flow and timely access to care has become a significant operational challenge. Emergency Department (ED) overcrowding and prolonged wait times are exacerbated by limited inpatient bed availability, resulting in access block and delayed admissions. General Medical teams manage high patient volumes, often with patients dispersed across multiple wards, extending ward rounds and impacting efficiency. In addition, stranded patients frequently require intensive nursing and allied health input to facilitate discharge. A small cohort of patients with recurrent presentations also accounts for a disproportionate share of inpatient bed utilisation, further increasing demand on hospital resources and services.

Aim

The Flow Improvement Services Medicine (FISM) team was established to reduce discharge delays, improve multidisciplinary coordination, and embed Criteria Led Discharge (CLD) across WMH. Operating seven days per week, FISM supports timely patient discharge through early escalation of barriers, collaboration with key partners, discharge delay monitoring, and increased weekend discharges.

Method

The Flow Improvement Services Medicine (FISM) team was established to embed senior nursing and allied health clinicians within existing General Medical teams at Ipswich Hospital. The service supports timely discharge and improved patient flow through coordination of Criteria Led Discharge (CLD), complex discharge planning, rapid rounds, and facilitation of transfers to the Transit Lounge. FISM attends ward rounds and multidisciplinary team meetings, identifies and escalates discharge barriers, provides clinical support when required, and collaborates with community partners to ensure safe transitions of care. The team also supports weekend discharges, monitors key performance indicators, drives continuous improvement, and promotes utilisation of CLD across medical services.

Results

FISM has delivered measurable improvements in patient flow and discharge outcomes across General Medicine. The service supports an average of 86 CLD discharges per month and completed 291 occasions of service in June 2026. General medicine discharges via the Transit Lounge increased from 84 to 129 patients per month, while support expanded to all five General Medical teams. Discharge activity has shifted earlier in the day, improving bed availability and patient flow. Staff satisfaction has also improved significantly, with positive feedback regarding FISM increasing from 56% to 80%, demonstrating the service's growing value and effectiveness. (Data source: FISM Dashboard, OPD Power BI Dashboard, FISM evaluation staff survey).

Conclusions and clinical implications

FISM's success has been driven by strong clinical leadership, stakeholder support, and an experienced multidisciplinary team with established networks across hospital and community services. Early results indicate improved communication, reduced discharge delays, shorter

lengths of stay, and reduced readmission rates, supported by positive feedback from staff and consumers. Key learnings highlighted the importance of early stakeholder engagement, ongoing education, robust planning, and collaboration with digital and data teams to support service evaluation. Regular review has enabled continuous refinement of processes and data collection. Future opportunities include further expansion across General Medicine, increased utilisation of Transit Lounge and rural facilities, and targeted strategies to address common discharge barriers and further improve patient flow.

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