

13th International Conference on Health Promoting Hospi- tals (HPH):

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Dublin, Ireland,
May 18-20, 2005

**“Empowering for health –
practicing the principles”**

Book of abstracts

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Letters of Welcome

LETTER OF WELCOME FROM WHO

On behalf of WHO, we have the pleasure of welcoming you to the 13th International Conference on Health Promoting Hospitals (HPH). In the last years the Health Promoting Hospitals Network has made major progress in establishing an evidence-base, clarifying principles and developing tools to implement health promotion activities in hospitals. This is also reflected in the title of this year's conference *Empowering for Health: Practicing the Principles*.

During the conference many important issues in empowering patients, staff and vulnerable groups will be discussed:

- A lot of evidence and models of good practices have become available on the empowerment of patients in clinical interventions. What are the latest experiences in patient education and counseling strategies and how can we place more emphasis in research and implementation on issues such as empowerment of chronic patients to better manage their conditions and develop healthy lifestyles?
- Hospitals are risky working places and health promotion for staff has been an important focus of HPHs from the beginning. Work-related injuries and occupational stress have been recognized as major issues in many hospitals; however, in order to put into practice the principle of empowerment for staff more attention should be drawn on leadership and teamwork issues. How can we put into practice the experiences from other initiatives in creating better and healthier working places?
- Empowerment of vulnerable groups like elderly, migrants, ethnic minorities and persons with mental health problems has become an important issue within HPHs and raises many questions on communication processes, language barriers and cultural differences. How can strategies on empowering these vulnerable groups be developed and what are the implications for the working processes in hospitals?
- As experience has shown in the past, dedication and expertise of individuals are not enough to fully implement health promotion strategies and therefore this conference will finally address financial regulations and quality criteria to support hospitals in putting into practice the principle of empowerment. Can we assess whether empowerment is being practiced in an organization and how can we provide incentives in order to do so?

Different plenary and parallel sessions, workshops and poster presentations will provide opportunities for exchanging ideas and know-how, discussing projects and meeting and networking with colleagues from around the world. For the first time, a summer school was organized by the WHO Collaborating Centre for Evidence-Based Health Promotion and we hope that this exciting event will become a regular feature of the conference programme.

Organizing the HPH conference is a big team effort; therefore, we would like to thank all persons involved for their cooperation and dedication in making this conference a successful event. We would also like to congratulate both hosts of the conference, the Irish HPH Network and the Northern Ireland Regional HPH Network for this very successful collaboration that will hopefully result in an ongoing exchange to promote and improve health.
Looking forward to seeing you in Dublin!

Milagros Garcia-Barbero and Oliver Gröne
WHO Regional Office for Europe

LETTER OF WELCOME BY LOCAL HOST

On behalf of the Mayor of Dublin, the Irish Health Promoting Hospitals Network (HPH) and the Northern Ireland Regional HPH Network - organisers of the 13th International Conference on HPH – we take pleasure in welcoming you to the city of Dublin.

Since the inception of the HPH movement in 1990, involvement and participation from Ireland, both north and south, has been extremely active. While both networks have developed very differently and have their own distinct support and financial structures, both have sought to develop and promote the HPH concept widely throughout the two jurisdictions.

The value of the health service as a setting for the promotion of health is now firmly established, as is the role of the hospital in the promotion of health. It recognizes that health promotion interventions in hospitals need not only to address change in individuals but also the underlying norms, rules and cultures within our organizations. HPH is not simply about doing or having health promotion activities or interventions within our hospitals; it is about affecting decision-making so that organizational changes in both services and structure reflect that *empowering for health* principles are an integral aspect.

The Local Organizing Committee has worked hard to ensure that conditions are in place for an effective and successful conference. We believe that it is a privilege to host this prestigious international health conference in Dublin and believe that the large anticipated international presence at this conference will contribute significantly to the continued development of the HPH movement throughout the island of Ireland.

Welcome to Dublin! We hope that you enjoy your stay and we are looking forward to seeing old friends and meeting new ones!

Ann O'Riordan and Hazel Brown
Irish HPH Network and NI Regional HPH Network

LETTER OF WELCOME BY WHO-COLLABORATING CENTRE, VIENNA

On behalf of the Scientific Committee, we have the pleasure to welcome you at one of the biggest conferences in the history of the WHO-HPH network.

More than 520 visitors from 40 countries have been attracted to attend this event by Dublin and by the topics of this conference. This number of colleagues will work together in four plenary sessions with 10 lectures, 24 parallel sessions with 108 oral presentations, and 2 poster sessions with as many as 246 posters. 55 persons will be active in chairing these sessions.

We would like to thank everybody who contributed to developing the scientific programme of this conference:

- The Irish and Northern Ireland Networks of HPH, who made it all happen and who are providing a very supportive framework for the conference;
- The 47 members of the Scientific Committee for their suggestions for developing the conference program, and for screening a total of 403 abstracts;
- The 9 co-organising organisations of this conference who supported the Scientific Committee and who helped to create visibility and related HPH to a variety of different relevant communities;
- The 10 plenary speakers and the 354 delegates who will present in parallel paper and poster session;
- And all participants in this conference.

Already now, we would like to inform you that a virtual conference publication of this event is planned. Everybody who has an active contribution is invited to send in either slides and / or a written text about the presentation, latest until June 30, 2005, to:

hph.soc-gruwi@univie.ac.at.

And we would like to invite you to support the continuous quality development of the International Conferences on HPH by filling in the evaluation form which is provided in your conference package.

We are happy that "Empowering for health – practicing the principles" motivated so many colleagues and friends to attend, since it is always a risk for a planning committee to decide on conference topics. We hope that the conference will provide you with many ideas and concrete suggestions and thus enable you to further implement empowerment strategies into your own health promotion work, and maybe even into aspects of your personal life. We wish you a lot of mutual learning, fruitful discussions, and networking!

Jürgen M. Pelikan and Christina Dietscher
(Chair and contact, Scientific Committee)

Scope and purpose of the conference

Since WHO defined health promotion as the "process of enabling people to increase control over, and to improve their health" (Ottawa Charter 1986), the use of this approach which is also known as "empowerment", has been widely discussed for health enhancing strategies like the development of communities, healthy workplaces and settings, as well as individual lifestyle changes.

But how effective, acceptable and applicable are empowerment strategies with their focus on self-responsibility, self-determination and participation in the everyday routines of expert organisations like modern hospitals? According to practical experiences and scientific research, empowering interventions offer many potentials for improving health outcomes of patients, as well as health impact on hospital staff. This especially holds true for vulnerable and often rather "powerless" groups of patients and staff.

How then can hospitals implement empowering interventions in their everyday structure and culture, and what would be supportive (financial and quality) frameworks for enabling hospitals to become "empowering organisations" for patients, staff, and citizens? In the last 15 years, a considerable amount of knowledge and experiences around these issues has been developed within the International Network of HPH. These will be presented and discussed at the 13th International Conference on HPH in Dublin, with two Irish Networks of Health Promoting Hospitals as local hosts who have the issue of empowerment high on their agenda.

HOW CAN HOSPITALS USE EMPOWERMENT TO IMPROVE PATIENTS' HEALTH?

Improving the health of patients is the core business of hospitals. For this purpose, what added value can empowerment strategies provide, in addition to the established medical, nursing and therapeutic interventions? There is already a tradition of investing in additional (educative) services for improving patients' ability to live with (chronic) disease, and for developing healthy lifestyles. But hospitals can also use empowerment to enhance the quality of their core services: Enabling patients - and their relatives, or social network - to actively co-operate in diagnostics, therapy and care, as well as to take responsibility for their basic physical, mental and social health needs during hospital stay, can contribute to reduce complications, drug consumption, and length of stay.

Specific issues to be discussed on the basis of models of good practice and research will include:

- Empowerment in clinical interventions: Strategies include patient education, information, training and counselling for informed consent, shared decision-making, enhancing compliance, co-operation and co-production of health;
- Strategies for empowering patients to take care of their basic health needs during hospital stay, e.g. by providing orientation about hospital services, day schedules, opportunities for communication, infrastructures;
- Services for empowering patients to better manage (chronic) diseases: Education, information, training and counselling concerning major chronic conditions (coronary heart disease, stroke, cancer, diabetes mellitus, COPD, ...) but also concerning rehabilitative services;
- Services for empowering patients to develop health promoting life styles: Strategies include education, information, training and counselling concerning smoking, nutrition, exercise and other lifestyle issues.

HOW CAN EMPOWERMENT CONTRIBUTE TO IMPROVE THE HOSPITAL'S IMPACT ON STAFF HEALTH?

As workplaces, hospitals represent a number of considerable health risks for their staff. In addition to the traditional strategies of health protection, disease and accident prevention at the workplace, research shows a considerable positive effect of participatory, empowering management and teamwork styles, including the participatory organisation of work processes, on staff health. Strategies in line with these findings are also enhanced by the European Network of Workplace Health Promotion and by the European Agency for Safety and Health at Work.

Specific issues to be discussed on the basis of models of good practice and research will include:

- How can hospitals (further) develop supportive leadership competencies and health enhancing teamwork, including conflict management, mutual support, mobbing prevention?
- What can be done to enable individual staff members for health promoting work performance, e.g. by providing opportunities for continuous professional education and training; by encouraging staff to suggest ideas on the improvement of work organisation; by providing working hours and recreation periods that fit personal needs (with regard to family life, age); by providing decision-making authority for areas of personal job responsibilities, etc?
- How can staff be empowered and supported to develop health promoting individual strategies for managing health risks or for coping with already existing health problems?

HOW CAN HOSPITALS EMPOWER SPECIFIC VULNERABLE GROUPS LIKE ELDERLY, MIGRANTS AND ETHNIC MINORITIES, AND PERSONS WITH MENTAL HEALTH PROBLEMS?

All issues of empowerment are especially important for members of socially vulnerable groups. Patients - and staff - from these groups have the greatest needs and offer the largest potential for health improvement by empowerment strategies. Based on recent demographic and epidemiological trends, this conference will have a specific focus on empowering the elderly, migrants and ethnic minority groups, and persons with mental health problems - three groups which will be increasingly represented amongst hospital patients (and staff). As patients who belong to these groups offer a considerable risk for additional irritation, conflicts and stress in the hospital, strategies that allow to better adapt to their needs will also contribute to improve the health impact on hospital staff, as well as the efficiency of hospital services.

Specific issues to be discussed on the basis of models of good practice and research will include:

- How can hospitals develop empowering clinical services for vulnerable groups of patients like screening for specific risks and needs already at admission; encouraging patients to communicate expectations concerning professional behaviour; adapting clinical communication to patient expectations, language and hearing problems; adapting existing patient information, training and counselling services and material for vulnerable target groups?
- What can hospitals do to create supportive settings for vulnerable groups, e.g. by enabling them to communicate their specific needs with regard to food, day schedules, religious services, and by adapting hospital routines and infrastructures to meet these needs?
- What information and education do staff need to be enabled to meet the needs of vulnerable groups?
- How can hospitals improve cooperation with other health care and community services in order to support continuous and integrated support of vulnerable patients?

HOW CAN FINANCIAL REGULATIONS AND QUALITY CRITERIA BE ADAPTED TO "EMPOWER HOSPITALS FOR EMPOWERMENT"?

If hospitals are expected to change their structure and culture towards empowerment, they need supportive frameworks to do so: Financial incentives and quality criteria, as formulated in legal regulations, standards of accrediting bodies, and professional organisations, must make it feasible, reasonable and necessary to develop in this direction.

Specific issues to be discussed on the basis of models of good practice and research will include:

- Financial frameworks to allow hospitals to invest in the empowerment of patients, staff and vulnerable groups: How can health promotion and empowerment strategies be introduced in DRGs, in payment systems which are oriented at performance indicators and targets, in payment by results, in fee for service practice, and in other financial frameworks?
- Quality criteria: What experiences do exist in Europe with regard to incorporating health promotion and empowerment as quality criteria for hospital core services into national, regional and professional quality systems like EFQM, balanced score card, standards, guidelines, monitoring, accreditation, and reporting?
- What is the impact of centralising or decentralising strategies (e.g. hospital clusters), and of patient involvement in strategic decision making, on the development of financial frameworks and quality criteria?

Conference partners

Organisers

- WHO-Regional Office for Europe (www.euro.who.int/eprise/main/WHO/progs/HPH/home)
- Irish Network of Health Promoting Hospitals (www.hphallireland.org)
- Northern Ireland Regional Network of Health Promoting Hospitals (www.hphallireland.org)
- Department of Health and Children, Republic of Ireland (www.doh.ie)
- Health Promotion Agency, Northern Ireland (www.healthpromotionagency.org.uk)
- Investing for Health, Northern Ireland (www.investingforhealthni.gov.uk)
- WHO Collaborating Centre for Health Promotion in Hospitals and Health Care (www.hph-hc.cc)

Co-organisers

- EC – European Commission (<http://europa.eu.int>)
- HOPE – Standing Committee of the Hospitals of the European Union (www.hope.be)
- PCN – Standing Committee of the Nurses of the European Union (www.pcn.yucom.be)
- IUHPE – International Union for Health Promotion and Education (www.iuhpe.nyu.edu)
- IAPO – International Alliance of Patients' Organizations (www.patientsorganizations.org)
- EAHM – European Association of Hospital Managers
- PWG – Permanent Working Group of European Junior Doctors (www.pwg-europe.org)
- ENWHP – European Network of Workplace Health Promotion (www.enwhp.org)
- ENSH – European Network of Smoke-Free Hospitals (<http://ensh.free.fr/>)

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Plenary Abstracts

Plenary I: Thursday, May 19, 2005, 09.30 - 10.30 The Hospital - A Staff Empowering Work Place

OCCUPATIONAL SAFETY AND HEALTH ISSUES IN THE HEALTH CARE SECTOR AND STAFF EMPOWERMENT

Sarah COPSEY

The Agency was created by the European Union to provide the technical, scientific and economic information to people with an interest in safety and health at work. It has 3 key areas of activity: networking activities; information services; and carrying out projects resulting in reports on specific topics. The Agency carries out most of its information services via its website, and all its publications can be freely downloaded. The health care sector has been one of the Agency's featured sectors for information services because: there is concern about occupational safety and health in the sector, given the extent of the risks present; Member States themselves have highlighted the sector for future attention; and the risks in the sector are common across Europe

European statistics and studies show the health care sector to be high risk, and demonstrate the extent of risks present. In the Agency study into the State of Occupational Safety and Health in the European Union, the health care sector was the forth most identified sector at risk by the Member States. The report identified high risks in the sector of: violence from the public; stress; bullying; work directed by social demands; reproductive hazards; biological hazards; heavy loads; occupational illnesses; and sickness absence. A report by the European Foundation for the Improvement of Living and Working conditions identified in addition: accidents; chemical substances; shift working; work organisation; and content and forms of work. These risks arise from physical working conditions, organisational restrictions and the social environment. Identified groups most at risk were all nursing staff and the various service and trade workers.

Part of the Agency's work is to identify examples of good practice and analyse the results. The Agency has several cases from the health care sector, particularly in the area of stress and the prevention of violence from members of the public. An analysis of such cases clearly shows the importance of a no-blame approach, staff participation at all parts of the risk prevention cycle, and management commitment to their own-going involvement. In the case of psychosocial risks, the Agency has identified the following key success factors: adequate risk analysis; thorough planning and a stepwise approach; combination of measures covering anticipation, prevention, intervention, support and evaluation with main focus on collective prevention measures; context-specific solutions; experienced practitioners and evidence-based solutions; social dialogue, partnership and workers' involvement.; continuing staff feedback; liaison with external bodies – police, judiciary, local community (in the case of violence); sustained prevention and top management support and resources.

FURTHER INFORMATION

- Health care sector web feature:
http://europe.osha.eu.int/good_practice/sector/healthcare/
- Agency State of OSH report:
<http://agency.osha.eu.int/publications/reports/401/en/index.htm>
- Agency, preventing psychosocial risks in practice:

<http://agency.osha.eu.int/publications/reports/104/en/index.htm>

- Agency good practice publications (practical prevention/prevention in practice series):
http://agency.osha.eu.int/publications/reports/index_en.htm

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MODELS OF GOOD PRACTICE FOR PROMOTING STAFF AUTONOMY: THE MAGNET RECOGNITION PROGRAM®

Karen B. HALLER

The Magnet Award for Excellence in Nursing Service is the highest level of recognition that can be given to a health care organization which provides the services of professional registered nurses. The Magnet Award is the Olympic Gold for Nursing.

The Magnet Recognition Program® is administered by the American Nurses Credentialing Center (ANCC), a subsidiary of The American Nurses Association. Healthcare organizations around the world are using the program's concepts to assess and improve their nursing programs, because the principles are universally applicable. The Magnet designation has been awarded to large and small institutions, urban and rural facilities, and teaching and non-teaching centers.

The Program requires healthcare organizations to document and demonstrate performance on 14 components, known as the "Forces of Magnetism." These are:

- Quality of nursing leadership
- Organizational structure
- Management style
- Personnel policies and programs
- Professional models of care
- Quality of care
- Quality improvement
- Consultation and resources
- Autonomy
- Community and the hospital
- Nurses as teachers
- Image of nursing
- Interdisciplinary relationships
- Professional development

Independent research on the effects of Magnet-related organizational characteristics demonstrates improved recruitment and retention of nurses, greater autonomy in nurses' practice, better relationships with physicians, and even less needlesticks. Better patient outcomes have been identified in Magnet hospitals, including lower mortality rates; lower disease-specific mortality rates; fewer patient falls; and greater patient satisfaction.

In summary, Magnet institutions are characterized by giving high value and status to nursing, granting high levels of staff autonomy, yielding control over their practice to nurses, promoting accountability, and establishing a culture of professionalism.

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Plenary II: Thursday, May 19, 2005, 16.15 - 17.45 Empowering hospital patients for managing their health

EMPOWERING HOSPITAL PATIENTS AS PARTNERS IN THEIR DIAGNOSIS AND TREATMENT – THE EXAMPLE OF BONE MARROW TRANSPLANTATION

Hildegard T. GREINIX (AT)

Although bone marrow and blood stem cell transplantation (SCT) is able to cure many patients with serious haematological and oncologic diseases, the procedure is still associated with significant morbidity and mortality. The high doses of chemotherapy, frequently combined with total body irradiation, cause extended hospitalisations and prolonged recovery periods. Informed consent discussions about the risks and benefits of SCT cover the procedure itself and the probability of disease-free survival. Issues of the long-term side-effects of intensive therapies, return to prior activities and reconstitution of normal levels of functioning are of tremendous importance for patients and their relatives in the decision-making process leading to admittance for or refusal of SCT. To ensure patient compliance with intense diagnostic and therapeutic procedures over lengthy periods of time, an extensive pretransplant work-up including multiple sessions of counselling by physicians, nurses and psychologists, visit of the SCT unit prior to admittance, talks with former patients and distribution of reading material has been established at our facility. In addition, psychosocial support of patients and their relatives during hospitalisation and outpatient care is provided by close cooperation of various health care professionals. To assess quality of life during SCT, prospective studies have been performed revealing elevated levels of anxiety and depression at some point before or during the two years after SCT. Therefore, psychological screening and interventions treating anxiety and depression are started before SCT and continue during the long-term follow-up of our patients.

In prospective studies psychosocial factors like helplessness and hopelessness were associated with lower survival of SCT patients. Thus, psychological diagnostics before SCT to identify patients at risk and long-term psychological treatment of these patients are indicated.

Our studies also revealed that realistic information from the staff about the often lengthy rehabilitation periods before resumption of prior activities is important. Knowing what to expect might help patients to reduce their frustration about shortcomings in the fulfilment of working and social roles until complete recovery.

In summary, intensive counselling and education of patients and their relatives considering transplantation and reasonable expectations for recovery ensures high survival rates and improved quality of life of our patients and also is more satisfying for all health care professionals involved.

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EMPOWERING HOSPITAL PATIENTS FOR DEVELOPING HEALTHY LIFESTYLES – WHAT CAN HOSPITALS CONTRIBUTE? THE EXAMPLE OF THE JYVÄSKYLÄ PEDE-PROJECT

Leena LIIMATAINEN

In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health (Health Promotion Glossary, WHO 1998). Both individual and community empowerment is needed while empowering hospital patients for developing healthy lifestyles. Individual empowerment emphasizes the patients' abilities to make decisions concerning their lifestyles, and controlling their personal lives. Lifestyle counselling, including consultation on how to change one's health behavior, is a vital part of the management and prevention of many chronic diseases. According to the previous studies, nurses recognize that they are ill-prepared for lifestyle counselling, which aims to empower the patients for changing their health behaviors.

To meet the challenge, the Patient Education Development Project (PEDE –project 2002-2004), was started in the internal medicine units of the Central Finland Health Care District. The project involved about 350 nurses and 23 internal medicine units. The aims of the project were: 1. the nursing staff will acquire new empowering patient education skills, 2. the _ounselling practices, material, networks and quality assurance methods are renewed in the working units. Developing a daily routine for lifestyle _ounselling means changes, which presuppose both individual and organizational learning. In the project, an experiential, transformative learning model was used to facilitate both individual and organizational learning, and the processes of change. The project realized the "HPH" –program with a special emphasis on promoting the health of the patients and staff by creating a health-promoting and an empowering nursing culture.

The implementing methods of the project were four different training programs and 19 patient education development projects managed in the working units by 56 change-agent nurses. The benefits of the project include a new empowering patient education competence and the changes in counselling practices in the working units, for example new lifestyle _ounselling material (tobacco withdrawal shelves, a health self-check corner), empowering group _ounselling models for rheumatoid arthritis and dialysis patients, virtual _ounselling folders, and the patient education quality criteria

for the nursing care plan. The successful development work has presupposed focusing on the particular challenges of everyday health promotion practices, working from down to top and in close collaboration with the hospital staff, the managers and the educational project experts from Jyväskylä Polytechnic.

In the PEDE-project, a self evaluation form and a profile to explore the developmental needs of patient education practices were developed. Also an Empowering Speech Practices Scale (ESPS) for assessing the empowerment of dyadic counselling was piloted. The ESPS was constructed by PhD Tarja Kettunen on the basis of the empowerment theory and the foregoing conversation analytic research. According to the preliminary results, the ESPS describes the realization of empowerment directing attention to patient participation.

In the presentation, the results of the PEDE-project and some suggestions for the future will be discussed.

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EMPOWERING HOSPITAL PATIENTS IN THE CONTEXT OF MAJOR HEALTH SERVICES REFORM IN IRELAND

Patrick DOORLEY

The Health Service Executive (HSE) came into being on 1st January 2005. While many countries have had reform of public services, never before has such an ambitious programme of reform been undertaken in the public service in Ireland. What this represents for the hospital community, patients, consumers, contractors, service providers, health service staff, patient support groups and the broader community, is an opportunity to build upon the strengths of our

system and address the weaknesses which detract from a first class service.

Health Promoting Hospitals strive to promote and improve the health and well being of key stakeholders. The concept of well-being is particularly important for hospital patients and their families. Quality of life and a sense of well-being may differ from patient to patient dependant on diagnosis, treatment, expectations and to what extent patients are empowered to participate in all aspects of their care. This is extremely important when we consider vulnerable groups in our community.

The Health Service Executive can make a valuable contribution to models of good practice, which empower patients. Its basic structure supports a population health approach, which underpins service delivery. The establishment of the Health Intelligence and Quality Authority (HIQA), and the Regional Health Offices are but two of the new structures, which support a population health approach and strengthen consumer involvement in health services.

Health Services internationally are facing enormous challenges. Public demands have never been higher. Empowering patients and the public can result in top quality services, developed in a spirit of partnership.

This paper will explore how patients can be empowered to participate in health care services and particularly in their own care. Practical examples from the sharing of data to planning frameworks will illustrate how the developing Health Service Executive can contribute to empowerment.

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Plenary III: Friday, May 20, 2005, 09.30 – 10.30 Empowering vulnerable groups of patients

EMPOWERING VULNERABLE GROUPS OF PATIENTS

MENTAL HEALTH PROMOTION IN THE HOSPITAL SETTING

Eva JANÉ-LLOPIS

Mental and behavioural disorders are found in people of all ages, countries and societies. One in every four persons will develop a mental health problem during their life. In the year 2002, neuropsychiatric conditions accounted for more than 20% of all European disability adjusted life years. Mental ill-health is also common in people with physical illness; for example 22% of people with myocardial infarction and 33% of people with cancer suffer from major depression.

Social and economic costs of mental health problems (estimated at 3-4% of GDP) are wide ranging and long lasting, including health and social service costs, lost employment and reduced productivity, the impact on families and care-

givers, and premature mortality.

Evidence demonstrates that, when properly implemented, mental health promotion and mental disorder prevention interventions lead to a range of positive health, social and economic outcomes. Effective approaches across the life span by health care professionals or involving primary and secondary health care settings in implementation include home-based interventions for infants and families, targeted preventive interventions for groups at risk (e.g., carers, people with chronic illness), prevention of work related stress and depression and mental health promotion for elder populations. Such interventions have led to improvement in positive mental health and quality of life and reductions in aggression, stress, symptoms of anxiety, depression and suicide, with the associated social and economic benefits that these mental health outcomes bring.

Different training opportunities and implementation initiatives can be integrated in health promoting hospitals to support the mental health of its patients and workers. This paper will present the problem of poor mental health in secondary health care, outline some effective interventions to promote mental health and prevent mental disorders and will explore opportunities to integrate mental health promotion components into health promoting hospitals.

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CULTURALLY COMPETENT AND MIGRANT FRIENDLY HOSPITALS: THE SOUTHERNMOST ENTRANCE TO THE EUROPEAN HEALTH SYSTEMS – AN EXAMPLE FOR EMPOWERING MIGRANT PATIENTS

Antonio SALCEDA DE ALBA

Hospital Punta de Europa – HPE - is a small-town community general hospital with a total of 350 beds. Located in the health authority district of Campo de Gibraltar, at Algeciras in the far south of Spain, near the Strait of Gibraltar, it is only 18 km from the African shore.

Clearly enough, the demography of the population we attend to in our hospital is strongly influenced by our geographical situation. Besides, our health coverage area is changing in character from being a transit area to being a settlement area.

HPE is integrated in a publicly owned health service, the Andalusian Public Health System (SSPA), which has a policy of full equality in access to our public service, ensuring free health care to all people, also in cases of undocumented migrants. Through other public organisations like Fundación Progreso y Salud and different agreements with trade unions and NGO's, Andalusia is already making a special effort to integrate migrant communities and improve their health status.

During two years and a half, we have implemented at HPE - in collaboration with other eleven European hospitals, and coordinated by the LBISHM - the EU project "Migrant Friendly Hospitals", aimed at improving accessibility to health resources for migrant populations and ethnic minorities. We will describe why our hospital got involved in this project, what we aim to by being "the southernmost entrance to the European Health systems," and will share some of the lessons learnt in the journey.

Enjoy the experience!

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HOW CAN THE HOSPITAL BECOME A GOOD PLACE FOR OLDER PATIENTS?

Virpi HONKALA

The care for ageing patients sets increasing demands on hospital health promotion due to several reasons, not the least important being the relative growth in the number of senior inhabitants in the population. As it is true that the senior citizens of this day may be "older but fitter", it is as true that there are causes, which appear to "ruin" good ageing. Musculoskeletal disorders, including osteoporosis and e.g. fractures lead easily to diminished mobilization. Diabetes with its cardiovascular, cerebral and neurological complications forms a growing threat of severe disablement. Dementia eventually leaves no alternative but the one suffering from it to be permanently hospitalised. Impairment of hearing and vision causes difficulties in coping with everyday tasks. Loneliness worsens the quality of life.

How to know what we have ahead and how to respond to it? In Raahe area with about 34 000 inhabitants, 14.6 % of the population is over 65 years and 1.4 % over 85 years of age. In 2004 all citizens born in 1939 were invited to attend a study conducted by a registered nurse. 88 % of 357 participated. Only those who already had frequent visits due to chronic diseases or a few who had no previous visits to public health care or suffered from alcoholism showed no interest in taking part. Basic laboratory examinations including blood cell counts, creatinine, TSH, B12 and folate, calcium, fb-glucose, cholesterol and triglycerides were analysed. The nurse carried in her tool kit a laptop, scale and measuring tape, blood pressure apparatus, charts for vision examination, PEF-meter and tests of memory and mood.

The participants' length, weight, hearing and sight were measured. Questions concerning general health, medication, chronic illnesses, physical conditions, sleeping habits, social life including friends and hobbies, living conditions, memory and mood, past working history, security and plans for the future were asked. Blood pressure and PEF were measured. The results of the study showed that the overall physical condition of the participants was fairly good. 95 % had plenty of friends and hobbies and they were happy with life. Most of them had a long continuous history of work and they appeared to be strong individuals despite of hardships in life. They were also quite enthusiastic about changes in life.

However, the study revealed many troubles to be expected in the future. 48 % had medication for hypertension. Despite of that 39 % had blood pressure above 130/85. 28 % were overweight with BMI more than 30 and 9 % undernourished with BMI less than 22. 46 % had fb-glucose level above 5.5 mmol/l and 66 % cholesterol level above 5 mmol/l. Only 39 % had normal bone density. 14 % were smokers, 6 % were former heavy drinkers and 13 % had minimal memory problems.

When an elderly person is hospitalised, many things must be taken into consideration. The symptoms may appear faint or small, there are several illnesses, additional diseases, wrong use or type of medication, poorly understood directions or no cure for the disease. The patient may not be able to describe the illness. A quick deterioration may follow due to delay in treatment. The general condition of the patient may be poor because of unsuitable living surroundings.

The hospital staff faces special demands with a senior patient. Often the condition or situation of the elderly is not known. The resources are limited, everyone is in a hurry, there is no geriatric knowledge and even the attitude may be pessimistic. When the illness is serious, there may also be

overly high expectations or unrealistic goals. Four main points are valuable in dealing with aged patients. Mobilization is of utter importance. A week in bed diminishes one quarter of muscular power. Problems of skin, blood circulation, digestion, drug metabolism, mental condition – just to mention a few – are encountered if the patient is not activated. Nutrition with proper vitamins should be balanced. Since the patients may have difficulties with eating, they should be properly assisted. The relatives or people in close contact with the patient are extremely important to be included into the care process. And finally, a caring and considerate attitude – as it is expected with every patient –

should be emphasized when dealing with an often fragile and sometimes very disoriented senior citizen.

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Plenary IV: Friday, May 20, 2005, 16.15 - 17.15 Frameworks for empowering hospitals to become “empowering organisations”

SUPPORTIVE LEGAL, FINANCIAL, AND QUALITY FRAMEWORKS FOR HPH

Oliver GROENE

More than a decade ago the WHO Health Promoting Hospital project was initiated in order to support hospitals towards placing more emphasis on health promotion and disease prevention, rather than on diagnosis and curative services alone. The network has expanded considerably over the years, however, hospitals and networks in some countries have faced substantial difficulties in supporting the agenda of health promotion in hospitals and convincing new hospitals to join. The presentation will address some of the legal, financial and quality frameworks that can facilitate or obstruct the expansion of health promotion activities in hospitals.

A review of *legal requirements* in health care will yield very restrictive approaches to quality, such as blood safety, nuclear medicine, professional regulation and laboratory standards. Legal requirements may further address certification and possibly, in the most advanced cases, address accreditation of health care institutions or newly established regulations regarding patient safety. Accreditation standards, however, typically make little reference to health promotion activities. And while it is of utmost importance to improve patient safety, most approaches are characterized by their control function and a stronger focus on improvement and health gain is required.

A major obstacle to expanding health promotion in hospitals is the *lack of incentives*. Professionals in hospitals work under a lot of pressure and there is little time and space for health promotion. A number of projects and programmes have identified this issue and demonstrate that, specific investments provided, health promotion is a worthwhile investment for hospitals and for the health system. A task force within the HPH network has started a project to link health promotion to reimbursement in order to institutionalize health promotion in hospitals.

Hospitals are exposed to a great variety of *quality models* most of which focus on the clinical effectiveness of services and hence neglect the focus on groups of stakeholders (e.g. staff) and the benefit of health promotion. What explains this focus? Specific quality standards and indicators for health promotion in hospitals were developed and pilot-implemented in hospitals and show that health promotion can be assessed and the actions for improvement can be identified.

Clinical effectiveness is at the core of the production process in hospitals, but it has become very clear over the last decade that health promotion, too, is an important issue for patients, staff and community issues. In order to institutional-

ize health promotion and reorient hospital services a mix of legal and financial incentives plus implementation tools are required. The presentation will draw on these resources and pinpoint to new and promising developments in this field.

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ENABLING HOSPITALS TO BECOME EMPOWERING ORGANISATIONS

Jürgen M. PELIKAN

HPH is not just a vision, but since 15 years around 1.000 hospitals have been involved and trying to implement the concept, more or less successfully.

But, even 1.000 hospitals is just a small fraction of the estimated 30.000 hospitals in WHO-Europe. Looking at the 1.000 hospitals who have already tried HPH, in most cases only a limited range of the concept has been implemented so far.

Why is HPH not yet implemented in a wider and more comprehensive scale?

As any reform strategy for hospitals, HPH can only be implemented as far as is allowed and supported not only by the internal structure and culture of the hospital, but by the relevant environments as well.

Business plans and everyday practice in hospitals are especially influenced by national and regional legal (organisational, quality regulations, division of labour between hospital and other providers of the health care sector) and financial frameworks and incentives.

Considering the 18 strategies of the WHO working group “Putting HPH policy into action”, supportive or hindering conditions will differ at least for implementing the 9 “quality strategies” or for the 9 strategies for strategic positioning of services offered.

Therefore it makes sense to have a closer look at conditions which have been supportive and hindering for implementation of HPH in Europe so far. What can the international network and the national and regional networks together do

to foster European, national and regional supportive conditions for implementing HPH more successfully in the future?

The input will try to answer these questions on the basis of an analysis of the situation in the European HPH networks.

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Abstracts for parallel paper sessions and conference workshops

Parallel Sessions I: Thursday, May 19, 2005, 11.00-12.30

SESSION I-1: CULTURALLY COMPETENT AND MIGRANT FRIENDLY HOSPITAL

TOWARDS MIGRANT-FRIENDLY AND CULTURALLY COMPETENT HOSPITALS: THE CONTRIBUTION OF THE WHO-HPH TASK FORCE ON MFH

Antonio CHIARENZA

During the last WHO Workshop for the Coordinators of the National / Regional Networks of HPH, which took place in Moscow on 26th May 2004, a new Task Force was launched with the aim of continuing to work on MFH issues after the conclusion of the EU project, and building on the accumulated experience, the primary objective being to better disseminate project outputs and recommendations, to stimulate new forms of cooperation and ideas around these important issues for health care organisations. The WHO-HPH TF on MFH aims to bring together partners in the MFH project, national and regional HPH coordinators, as well as hospitals, health policy actors and experts. The idea is to create a network of organisations interested in intercultural healthcare and a community of professionals with shared principles and beliefs with the common goal of sustaining the Amsterdam Declaration and continuing to disseminate and develop innovative policies and good practices.

In particular, the Task Force wants to become a resource for the development of migrant-friendly and culturally competent health care services by:

- Addressing socio-ethnic inequalities in health.
- Continuing to strengthen the focus on ethno-cultural diversity with a health promotion approach.
- Reinforcing the role of hospitals in health promotion for migrants, members of minority ethnic communities and other disadvantaged groups.
- Promoting good health through sharing of good policies and practices.
- Involving migrants and representative of minorities ethnic groups.
- Driving change through research and developmental activities.
- Providing a means to foster cooperation and alliances between internal and external networks.

To achieve these aims a number of future activities will be planned:

- The diffusion of the MFH project at local level by assisting member organisations in the setting up of new pilot projects.
- The continuation of the MFH project at international level through benchmarking activities and monitoring the effects of changes implemented.
- The organisation of thematic and training workshops in order to support the implementation of the recommendations contained in the Amsterdam Declaration.
- The creation of a base for the development of a new project to submit to the European Commission.
- The participation in national/international conferences to promote continued visibility for the concerns of ethno-cultural diversity in health care.
- The organisation of a bi-annual conference on migrant-friendly and culturally competent health care.
- The development of resources/info/technical material and to make documents and information available on

the web site.

- The dissemination of project outputs and best practices by the MFH web site.

The aim of this communication is to present and discuss the future steps and agenda of the Task force.

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CULTURAL DIVERSITY – OUR REALITY. IMPROVED CULTURAL COMPETENCE – OUR GOAL IN CONNOLLY HOSPITAL, BLANCHARDSTOWN

Angela HUGHES, Fiona MCDAID

INTRODUCTION

The Migrant Friendly Hospital (MFH) project is a European Initiative to promote health and health literacy for migrant patients and ethnic minorities. Twelve hospitals participated across Europe and Connolly Hospital Blanchardstown was the representative for Ireland.

AIM

The aim of this project was to identify, develop and evaluate models of good practice in the participating member states of the EU. More specifically the objectives were to promote the health and health related knowledge and competence of migrants and ethnic minorities and to improve hospital services for these patient groups.

Ireland as a multicultural society is a very recent phenomenon developing over the last 5-10 years. Connolly Hospital serves a catchment population of 270,000 people in North-west Dublin, which has been identified as one of the fastest growing regions in Europe.

METHODOLOGY

Staff and Ethnic Minority Patient needs assessment carried out at baseline identified a need to address communication and cultural barriers in our organisation. Sub Project A: Improving Interpretation in Clinical Communication and Sub Project C : Improving Cultural Competence: Training Hospital Staff for providing Cross-Cultural Health Care were implemented and evaluated during the pilot project.

RESULTS

Project results indicate many gains and improvements as a result of implementing the two sub projects.

Sub project A results illustrate a 9% increase in the use of professional interpreting services either face-to-face or over the phone. Results also indicate an 11% decrease in the

inappropriate use of a child under 18 brought by a patient to interpret. 10% increase in staff satisfaction with the quality of the interpreting service and 28% of staff felt that their work situation had improved through the implementation of the resource file.

Sub project C results highlight that 75 % of participants were very satisfied with the training provided.

An increase in participant's awareness of the influence of culture on people's behaviour and perception of self and others has been illustrated. An increase in participants' self-perceived knowledge on subjects of cultural diversity and improved skills for appropriate, effective, efficient and sustainable handling of diversity as a result of the cultural competence training has also been reported. Finally 91 % of participants stated that the cultural competence training had "quite a lot" or "very significant" impact on their everyday practice.

Participating in the Migrant Friendly Hospital Project has been a very beneficial learning experience for Connolly Hospital, Blanchardstown. It is our intention to extend and build on these interventions throughout the organisation as we continue towards our goal of improved cultural competence.

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INTERCULTURAL HOSPITAL IN THE TUSCANY HPH NETWORK

Alessandra PEDONE, Claudia BEGLIOMINI, Maria José CALDÉS PINILLA, Alessandra D'ALESSANDRO, Chiara NERI, Massimo ROSSI, Claudia RUSSO, Alberto SILVA, Anna ZAPPULLA

The Interculturality Tuscany HPH project involves 8 hospitals. Every Hospital has promoted some specific actions as: cultural and language mediation, operators training, informative leaflets translation. In some experience, the link with community (local) services are very strong. In Prato, one of the most important Chinese community in Italy, the project "L'albero della salute" involves every aspect of the life: family, education, school, work and so on. In Arezzo, the main institutions and organisations of the Province collaborate to run a similar project and the local health unit co-ordinates the health group, connected with Interculturality HPH.

The Interculturality regional group decided to adopt the Italian HPH network proposal about the areas: birth, feeding, cult, pain and death. Every hospital has to guarantee almost 10 requirements, as:

- To include Interculturality in the hospital mission.
- To recognise with formal act the Interculturality HPH group.
- To offer cultural and language mediation.
- To include in planning documents the theme of Interculturality.
- To promote operators training.
- To include Interculturality theme in the education programs.
- To increase the co-operation between south and north countries of the world.
- To improve communication.
- To strengthen the link with local cultural communities.

- To produce an annual report about immigrants health.

For each area (birth, feeding, cult, pain and death) objectives, actions, indicators, standards and evaluation were established. At the end of 2004, every hospital compared the performance level reached to objectives, actions, indicators and standards and defined corrective actions to assure that target has been met within 2005. Within 2005 Hospitals are committed:

- To test and verify standards.
- To propose other hospitals in Tuscany to adopt them.
- To introduce them as certification criteria.

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HOSPITAL DEL MAR, A MIGRANT FRIENDLY HOSPITAL IN BARCELONA

Cristina INIESTA, Ana SANCHO, Maribel PÉREZ, Elvira MÉNDEZ

OBJECTIVES

- To facilitate communication and knowledge between physicians and immigrants and vice versa.
- To promote autonomous behaviour of the immigrant patient by providing written information and support.
- To facilitate access of the immigrant woman to sexual and reproductive education programmes.
- To improve information available to the immigrant regarding the public health care system in Catalonia.

RATIONALE

Given that the reference area of Hospital del Mar in Barcelona (an acute-care 418-bed teaching hospital) includes the districts of Ciutat Vella and Sant Martí with a 36.1% rate of immigrants it was decided to develop an intercultural mediation programme as a new policy targeted to the immigrant population users of hospital. The implementation and development of the programme began in June, 2003.

METHODS

The main tasks included: 1) training activities involving health care professionals, 2) intercultural mediation and translation activities, and 3) information and actions aimed to sensitise the immigrant population of hospital users.

DESIGN

- Weekly availability of intercultural mediations for immigrants from following countries:
 - Arabian countries 20 hours
 - Pakistan 12 hours
 - Romania 12 hours
- Mediation circuit:
 - Emergency department
 - Hospital wards
 - Outpatient clinics
- Target services (Area Percentage):
 - Obstetrics & Gynaecology/Paediatrics 34
 - Emergency department 29
 - Medical services 17
 - Surgical services 13
- Monitorisation, detection of needs and assessment of the programme is coordinated by the head of the helpdesk.

RESULTS

Between June, 2003 to December, 2004

- Users attended 1472
- Mediation actions performed 3148

On the other hand, different publications translated into Catalan, Spanish, English, French, Urdu, Arab, and Romanian have been developed in order to facilitate communication channels between professionals and users.

- Health care and social resources in sex violence
- Paediatric emergencies
- Anaesthesia
- One-day surgery
- Dietary habits
- Postoperative recommendations
- Dietary information for acute and chronic urticaria
- Tractament de la sarna en adults

SESSION I-2: SMOKE FREE HOSPITALS - 1

EUROPEAN NETWORK OF SMOKE FREE HOSPITALS AND MATERNITY SERVICES

Bertrand DAUTZENBERG, Ariadni OURANO, Ann O'RIORDAN, Anne-Marie SCHOELCHER

Changing a hospital that has facilitates for smoking into a totally smoke-free environment is a hard task and one that necessitates long term effort and commitment. Development and implementation of a smoke-free policy and environment requires full management commitment and the active support and involvement of all employees.

The European Network of Smoke Free Hospitals (ENSH) has gathered more than 850 health services committed to the implementation of the European Code of Smoke free hospitals, from fourteen European countries. ENSH aims to provide hospitals with a set of clearly defined standards and a practical supportive instrument that can assist their efforts towards the attainment of a totally smoke-free environment and while also assisting smokers in their smoking cessation process.

The self-audit questionnaire enables hospitals to assess, monitor and review their progress towards implementing a smoke-free policy. It identifies areas that need attention and rewards continuous improvement by categorising the hospitals' progress under four levels, i.e. membership, bronze, silver and gold. Another tool developed by the ENSH is a questionnaire that seeks to measure the smoking habits of all health professionals. Early results from this survey show that although important differences exist between countries, in general, tobacco consumption of health care professionals is decreasing.

A smoke free maternity project has recently been integrated into the overall concept of the smoke free hospitals. Five countries are participating in a survey which aims to report the relationship between maternal and spouses' expired air carbon monoxide (CO) concentrations and the infant's body weight at birth. Emphasis is also given to the impact of this measurement strategy on the behaviour of health professionals regarding tobacco risks.

In 2005, four more European countries, Lithuania, Hungary, Austria and Luxembourg have joined our network. The ENSH process, national activities in tobacco control policies, tools, newsletters, an implementation guide and a training guide for health professionals, the European directory of smoke free healthcare services are available in several

- Digestive endoscopy

CONCLUSIONS

The participation of a professional mediator in the health care system contributes to offer an integral quality care in response to the new social demands.

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EVALUATION OF IMPLEMENTATION OF THE SMOKE-FREE POLICIES IN THE CATALAN NETWORK OF SMOKE-FREE HOSPITALS

Elvira MENDEZ, Cristina MARTÍNEZ, Montse GARCÍA

OBJECTIVE

To validate the self-audit that evaluates the implementation of the tobacco preventive interventions carried out in the Hospitals considering their time of enrollment in the Catalan Network of Smoke-free hospitals (<1 year and >= than 1 year).

METHODOLOGY

The self-audit guide describes 33 items clustered in 9 matters which are: commitment, communication, education, identification and cessation support, tobacco control, environment, health workplace, health promotion, and follow-up.

Obtaining the score of 25 hospitals we have analyzed the grade of implementation of the smoke-free policies in the hospitals. We have compared if there are statistical differences in total punctuation shifting the hospitals in function of the time of their membership (in those which are <1 year and >1 year).

The items have been studied using tendency central measure and the dispersion rate. The median comparison has been done with the Kolmogorow-Smirnow prove and variances similarities, applying the T-test of Student or the U-test of Mann Whitney. We considered the $p < 0.05$ significance level.

RESULTS

The hospitals which have been in the Network for more than 1 year have higher global scores; this means that they have

done more preventive strategies in the tobacco control task.

Regarding the matters that reflect the implementation policy of tobacco control we do not see differences in the scores related to the commitment that show basically the intention of creating a chairperson, a committee and to sign an agreement with the Institute of Oncology.

There are significant differences in the matters related to the information and communication comparing their time in the Network

Finally, the results show us that the ones which are in the network for more time they have improved more health workplaces than the hospitals that have been in the Network for less than one year ($p=0,03$).

CONCLUSION

Higher scores of the self audit are correlated with long time of enrollment in the Network. We observed how some areas of the hospitals evaluated should be reinforced: education and training in tobacco control and promotion of cessation support addressed to the staff and the patients.

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IMPLEMENTING THE CODE AND THE STANDARDS OF THE EUROPEAN NETWORK FOR SMOKE-FREE HOSPITALS ENSH BY REGIONAL WORKING GROUPS IN GERMANY

Christa RUSTLER, Uta-Sophie BEMMANN

The German HPH-Network is organised in five regional working groups. The hospitals of three of them, South Germany, Bavaria and Northrhine-Westfalia, decided to implement the ENSH Standards not as hospitals by themselves but as a regional network and working group. The implementation process is started by a workshop and a joined survey based on the ENSH self audit questionnaire. An interesting result is that those hospitals who work together in that joined survey had a successful experience by starting the implementation of the smoke-free hospital concept. It also strengthens the regional network as a working group. The implementation process and methods will be presented.

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EMPOWERING PSYCHIATRIC SERVICES TO DEAL WITH TOBACCO CONTROL

Göran BOËTHIUS, Barbro Holm IVARSSON, Katarina TÖRNQVIST, Berith BRADSTRÖM

Smoking has devastating effects on health and economy. Smoking is considerably more common in patients with psychiatric disease compared to the general population. Despite this fact smoking cessation support in Sweden available to this group of patients is very limited – an unacceptable inequality issue. Furthermore, it is considered difficult to implement smoking policies in psychiatric clinics. To influence these conditions health professional NGOs are offering expertise support to empower psychiatric care to handle tobacco issues more effectively.

A document for psychiatric care has been produced by the above mentioned organizations including:

- Recommendations for a tobacco policy in psychiatric clinics, harmonizing with recommendations for other health care institutions and aiming at a smoke-free environment and cessation support for staff and patients. The policy regulates where and when smoking is permitted for staff, patients and visitors. The staff should not be permitted to smoke during working hours. Furthermore the staff should be trained to support the cessation process of smoking patients and at discharge refer patients for further qualified support.
- Guidelines for smoking cessation in psychiatric patients, following general recommendations for cessation but focusing on special considerations for the target group. In general, these smokers need more intensive and prolonged support, preferably by specially trained personnel.

To facilitate introduction and implementation of this document representatives from psychiatric clinics in the national HPH network have been invited to contribute in the finalization. The active support of national psychiatric organizations is also sought.

Psychiatric patients seem to be more and more motivated to quit and psychiatric care more interested in dealing with tobacco control.

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IMPLEMENTATION OF SMOKE-FREE MATERNITY WARD ENVIRONMENTS

Michel DELCROIX, Conchita GOMEZ, Pierre MARQUIS

BACKGROUND

In France, it is estimated that 37 % of women smoke before their pregnancy and that 19.5 % of pregnant women continue to smoke during all or part of this pregnancy. It may promote the health professional's that one important part of perinatal professionals smoke. The proposed specific action on smoking cessation training, will build on the recommendation that will emerge from the Consensus Conference "Maternity and tobacco", on the core aspects contained in cessation programmes for maternity services.

The degree of tobacco exposure shall be assessed by

measuring the carbon monoxide (CO) content of the air expired by the person. The CO analyser is an easy-to-use tool during any pre- or post-natal interview. It may promote the health professional's and the pregnant woman's desire to achieve smoking cessation and reinforce their motivation during the actual tobacco cessation period.

A core group, lead by an identified expert in the field of smoking cessation training, will seek to identify what smoking cessation training programmes are provided, to which personnel (disciplines) within hospitals, briefly review of the content of these training programmes and draw up evidence based recommendations on the core aspects or to be contained within the various programmes should be target at which hospital based personnel (disciplines) across Europe. Smoking during pregnancy is associated with reduced birth weight, this relation can be reversed by smoking cessation. The relationship between maternal and spouses' expired air CO concentrations (EACO) on fetal growth has not yet been evaluated.

METHODS

856 smoking and nonsmoking pregnant women were followed during their pregnancy. Their EACO was determined in the first trimester and during delivery. The spouses' EACO were also measured at delivery. The main outcome measures was the infants' birth weight. Secondary measures included head circumference, Apgar score and heart rate at delivery. Cord blood fetal carboxyhemoglobin (FCOHb) served as internal control to determine the characteristics of the population of pregnant women smokers through epidemiologic research, to evaluate the efficiency of a large program to prevent passive smoking of the foetus, to evaluate the efficiency of a large program to prevent active smoking of the women smokers, to increase the rate of smoking by the increase motivation of pregnant women smokers, to reduce about 25 to 30 %, the number of pregnant women smokers, to develop in this domain a policy for training health's professionals who follow the pregnant women and their familial environment, to develop the breastfeeding, to protect relation between the parents and the baby.

RESULTS

Birth weight dose-dependently and significantly decreased

with increasing level of maternal (0-5: 3406 ± 32 ; 6-10: 3048 ± 57 ; 11-20: 2858 ± 54 ; >20 ppm: 2739 ± 34 g ($p < 0.0001$) or spouses' EACO (0-5: 3546 ± 25 ; 6-10: 3484 ± 51 ; 11-20: 3309 ± 47 ; >20 ppm: 3190 ± 57 g, $p < 0.0001$). Even the birth weight of newborns whose mother had EACO between 6 and 10 ppm was significantly lower than the birth weight of newborns whose mother had an EACO between 0 and 5 ppm. Spouses' EACO of delivering women with EACO of 0-5 ppm showed similar effect. Head circumference, Apgar score and normal term gestational age decreased also significantly with increasing maternal or spouses' EACO.

CONCLUSIONS

Expired air CO measured during delivery, a proxy of expired air CO during pregnancy, is dose-dependently and inversely associated with indices of foetal growth, and dose-dependently and positively associated with cord blood FCOHb and anormal foetal heart rate. Even low CO (6 to 10 ppm) may be associated with significantly lower birth weight. Spouses' CO of mothers with CO of 0-5 ppm is also associated with unfavorable indices of foetal growth. A tobacco free environment is essential. The methodology of CO measurement is efficiency for increase the rate of smoking by the increase motivation of pregnant women smokers.

Pregnant women have particular capacity to quit smoking. The professionals trained are able to encourage and help mothers to pay more attention to their pregnancy. Another secondary effect expected is that professionals also give up smoking through the methodology CO measurement.

KEYWORDS

Expired air carbon monoxide, pregnancy, spouses, birth characteristics

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SESSION I-3: HEALTH PROMOTION FOR HOSPITAL STAFF – 1: SUPPORTIVE POLICIES AND PROGRAMS

APPLYING A NATIONAL PROGRAMME TO PROMOTE STAFF HEALTH IN HOSPITAL

James ROBINSON

Various pieces of legislation exist which address staff health and safety but effective health promotion involves consideration of a wider range of issues than is covered by such legislation. To support the development of a health promoting organisation a national scheme exists in Scotland. Scotland's Health at Work (SHAW) is supported by employers' organisations, trade unions and the National Health Service and is used across a wide range of industries. Within Lothian University Hospitals SHAW is being used in five hospitals to promote staff health.

Although separate schemes experience with the Royal Hospital for Sick Children has shown the two programmes complement and support each other. SHAW links very closely with the Health Promoting Hospital philosophy not only addressing staff health but also creating a health promoting culture within the organisation. Building on this cul-

tural development progress to the broader Health Promoting Hospital agenda is more readily achieved.

An important element of SHAW is the involvement of staff in achieving the outcomes. Staff and managers work together to identify health issues and solutions. Staff are therefore not only the beneficiaries but also the leaders of the health promotion effort.

The scheme has three levels of accreditation, Bronze, Silver and Gold. The Royal Hospital for Sick Children was the first of the group to take part in the scheme and having achieved Bronze level is currently working toward the Silver level. The remaining four adult hospitals joined the scheme in 2004 and are currently working for the Bronze level award.

The relationship between the two programmes is illustrated by the reference to work completed to date and currently in progress.

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PROMOTING HEALTH IN THE WORKPLACE: APPLYING THE WHO HPH TOOL IN PUBLIC HOSPITALS IN KWAZULU-NATAL, SOUTH AFRICA

Champak JINABHAI, Rosemary GEDDES, Priscella
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INTRODUCTION

The WHO Health Promoting Hospitals (HPH) project aims to incorporate health promotion into the culture and management of hospitals to improve patient and staff health. The Department of Health, Kwazulu-Natal, piloted the WHO self-assessment tool, in six public hospitals, as part of an international collaboration.

AIMS

This study assessed staff health, staff development and their involvement in hospital management.

METHODS

Data for this cross sectional descriptive study, was obtained through self administered questionnaires from a sample of all health workers and from hospital records in the six selected hospitals. Standardised protocols, questionnaires and field worker training- as specified by WHO were observed. Authorisation to undertake the study, collect data and interview staff was provided by the health authorities.

RESULTS

An analysis of 1610 staff questionnaires established the following:

Staff health:

- 9% of staff were smokers.
- 66% of staff knew their own HIV sero-status.
- An average of 2.1% absenteeism for nursing staff.
- 4.2% needlestick injuries for exposed staff.

Staff development:

- 61% received job descriptions on starting their jobs.
- 51% were aware of a performance appraisal system.
- 78% participated in a Continuing Professional Development (CPD) programme.
- 81% were aware of ongoing audits in their departments.

Hospital management

- 37.7% were involved in hospital policy-making.
- 78.7% were aware of risk management procedures in their hospitals.

DISCUSSION AND CONCLUSION

This pilot study served to deepen staff involvement in health promotion activities, created awareness among health workers of their own health and alerted management to problem areas. It has implications for policy-making at provincial level, improvements at hospital level and potential changes at individual level. It further served to consolidate and im-

prove relationships between staff and management at all levels.

Recommendations were made for the expansion of the project to all hospitals in the Province.

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DESIGNING A CORPORATE CULTURE TO ACHIEVE A "MAGNET HOSPITAL" POSITION: HOW TO EMPOWER PEOPLE TO CREATE A HEALTH PROMOTING ENVIRONMENT?

Wilfried VON EIFF, Kerstin STACHEL

Corporate culture is the most important success factor for a prosper and dynamic corporate development. Designing an excellent and healthy working atmosphere is a precondition to ensure employee satisfaction and as a consequence patient satisfaction as well. A corporate culture can be described by the following criteria: coping with failures; reacting to conflicting opinions, handling suggestions for improvement, importance of waste management

Karasek's "job strain" model states that the greatest risk to physical and mental health from stress occurs to workers facing high psychological workload demands, pressures combined with low control or decision latitude in meeting the demands.

A positive, well structured and strong corporate culture is able to influence and design the mentioned factors and in consequence contributes to reducing stress pressure by increasing employee and patient satisfaction.

In this context the results of the CKM Magnet Hospital Study will be presented. Magnet hospitals are able to attract more patients than other hospitals. At the same time they are known as attractive employers due to an excellent working atmosphere. The key factors to achieve the status of a magnet hospital will be presented.

One way to measure corporate culture is to analyse the social-quality. A CKM-Study on social quality in hospitals depicts the variations among countries concerning the following components of social quality: relative and patient centred organisation, complaint management, human resources development, consciousness of economic factors, communication and dispute culture.

Finally the processes to develop a "mission statement" and continuous development programs for the staff will be demonstrated.

LEARNING PERSPECTIVES

The attendees will:

- Know about the coherence between well-being of the staff, the corporate culture and the patient's satisfaction.
- Be able to design the key factors of a corporate culture.
- Be capable to reduce the risk of physical and mental illness from stress and the patients risk as well.

- Be familiar with the dashboard technique applied to corporate culture issues.

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EMPOWERING FOR HEALTH PROMOTING LEADERSHIP IN HOSPITALS AND NURSING HOMES

Christina DIETSCHER, Peter NOWAK, Susanne HERBEK

CONTEXT

This is a field report from Vienna (Austria) on building a learning environment for hospital management / executive personnel to use health promotion as a resource for themselves, for empowering their staff, and for strategic orientation within the hospital.

BACKGROUND

The empowerment of executive personnel for health promotion is an important way to transport health promotion as a comprehensive approach into a hospital setting. Therefore the training of executive personnel on their role in implementing health promotion is a major strategy of the Viennese information network HEALTH PROMOTION IN HOSPITALS AND NURSING HOMES. But executive personnel are also a major target group for health promotion themselves: 25% of them have symptoms of burnout.

METHOD

This problem was taken up in a workshop which focused on 3 topics:

- Health promoting self management of executive personnel.
- Health promoting working conditions and cooperation with staff.
- Health promoting strategic and organisational development.

In order to create an adequate learning environment that takes into account the expert status of executive personnel as well as health promotion principles, a one-day open space design (Harrison Owen) was chosen. This design has no major inputs or pre-fixed thematic agenda. Supported by a facilitator, topics are raised by participants themselves, and discussion on the raised topics are structured between them.

RESULTS

All directors and top managers of Viennese hospitals and nursing homes were invited to join the workshop (about 1,500 people in total). Of these, almost one tenth actually attended the workshop - which was much more than expected.

The working atmosphere during the workshop was very open and positive, 17 health promotion topics were raised, discussed, and documented. There was enthusiastic feedback to the workshop. Specifically positive feedback was given on the focus the workshop had put on the individual health needs of the target group. In the final evaluation 80 percent of participants stated that they wanted to increase

health promoting activities within their organisation in the future.

SUGGESTIONS FOR PRACTICE

- A good way to engage major stakeholders in implementing health promotion in their organisation is to demonstrate how they can use the concept to improve their own situation.
- The creation of an open learning environment is supportive for transferring health promotion concepts.

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IMPROVING WORKING LIVES FOR CAUSEWAY HEALTH AND SOCIAL SERVICES TRUST STAFF

Anne Marie DOHERTY

Causeway Trust is a statutory health care organisation in Northern Ireland (NI), that provides both acute hospital and community health care and social services. Acute hospital services are provided from the 235 bed Causeway Hospital in Coleraine. Over 3000 staff are employed by Causeway Trust.

The Public Health Strategy for NI 'Investing for Health' (2002), identified the workplace as one of the priority settings for improving the health of the population. In addition, A Long Term Workplace Health Strategy for Northern Ireland (2003) again highlighted the workplace as a priority setting for improving health and well being.

The Senior Management Team (SMT) in Causeway Trust recognised that a healthy workforce is fundamental to an organisation's performance. They acknowledged the need to address social, psychological and physical health issues and consider the effects that organisational as well as individual factors may have on the health of Causeway Trust staff. In November 2002, SMT endorsed the formation of a Health and Well Being steering group, that would comprise representatives from each directorate, occupational health and staffside. The purpose of this group was to develop a Workplace Health and Well being strategy, that would enhance the Trust's role as a health promoting workplace.

As progress continued towards the development of the strategy, it was agreed that an independent evaluation of Causeway Trust should be undertaken to ascertain strengths and weakness of the trust in its efforts to promote the health of its entire staff.

Funding to conduct this research was obtained from the Northern Investing for Health Partnership, and an independent evaluator was commissioned from the University of Ulster to undertake this work in January 2004. The evaluator was a University researcher and academic Health Promotion Specialist, whose principal area of expertise is in the field of workplace health promotion.

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SESSION I-4: HEALTH PROMOTING SERVICE PROVISION FOR OLDER PERSONS

SINGLE ASSESSMENT: A BETTER SYSTEM NOT JUST A NEW FORM

Charlie CLERKE, Margaret ALLEN, Moira SUGDEN, Rabbia KHAN

PURPOSE OF SINGLE ASSESSMENT

To build an understanding of older people's needs, individually and overall, in a way that enhances their choices and control such that appropriate services can be arranged at the right time.

For professionals to work in a flexible and creative way with older people and their carers, putting the person rather than the service first, giving, and sharing information with explanation and for a purpose.

OUTCOMES

- Better co-ordinated and more person centred services for older people leading to better quality of life, the promoting of independence and rehabilitation.
- Professionals contribute to assessments in the most effective way, minimising duplication and sharing information.
- A standardised and outcome centred approach.

SHARED VALUES

- Treat older people, their families and carers with dignity and respect, recognising cultural diversity, promoting choice and control.
- Provide older people with the information they need to inform their full participation in the assessment process, and to maintain full consultation throughout.
- Minimise duplication yet with attention to detail, building a process whereby information can be updated where and when necessary, with attention to confidentiality and consent.
- Build professional skills in assessment, ensuring dialogue with older people takes precedence over form filling, team work is promoted and the process has ownership.
- Promote an holistic approach to service where professionals share and respect each other's assessments in climate of trust and open-ness, resolving boundary and financial issues by putting the older person first.
- Ensure services continue to meet needs and that older people are enabled to comment on their efficacy and quality, that the response is prompt and that services are available before a crisis point is reached.

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ACTIVATING A PERSON'S POTENTIAL FOR COMMUNICATION

Sinead GRENNAN

Sonas aPc is a training organisation founded in 1990 by Sr Mary Threadgold, a Speech and Language Therapist. It aims to activate the potential for communication in older people with communication difficulties associated with Alzheimers Disease and other forms of cognitive impairment, thereby enhancing quality of life.

The Sonas aPc approach is communication focused and involves multi-sensory stimulation, structure, repetition and an appreciation of retained abilities. It is carried out through group and individual sessions. The group sessions involve stimulation of all five senses, gentle exercise and massage; relaxing music, sing-alongs, memory-focused exercises and personal contributions by participants. The individual sessions create a relaxing, interactive environment, which facilitate communication through music and touch.

Our approach has been tailored to the needs of several client groups, all of whom have communication impairment. Sonas is of benefit to those with Alzheimers and other forms of dementia, certain types of stroke, advanced Parkinson's or social isolation. Anam is for adults with intellectual disabilities. Sonas and Anam sessions are carried out in Day and Residential Centres, including nursing homes and long stay geriatric wards.

SIMS (Sonas Individual Multi-sensory Session) is a new adaptation of the Sonas group session for use on an individual basis. It is designed to meet the specific needs of older people with Alzheimers and other forms of dementia who live in their own homes. The first SIMS workshops will be held in Spring 2005.

We are a not-for-profit organisation which provides training and support to healthcare professionals and their teams, and family carers. To date, we have trained more than 5,000 people in Ireland and the UK.

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NUTRITION FOR THE OLDER PERSON IN RESIDENTIAL CARE

Grainne FLANAGAN, Pauline DUNNE, Elizabeth GROGAN, James DWYER, Mairead CAMPBELL, Mary HOOPER; Catherine O'KEEFE, Kay KENNEDY, Ann DOHERTY, Brid McGOLDRICK, Cheryl EARLY, Trudie ROWAN

As a quality initiative, Multidisciplinary Nutrition teams were established in 10 residential care sites for Older people, in the Midland Area, over a 3 year period. Staff were empowered to implement evidence based Food & Nutrition guidelines.

AIM

- To standardise and improve nutrition and feeding practices for the older person.
- To develop and implement nutrition policies for care of the older person.

ACTION PLAN IMPLEMENTED

- Patient & staff satisfaction surveys on food service; mealtimes; nutritional content of meals; food presentation; therapeutic diets; use of Oral Nutritional Supplements were carried out.
- Interventions included: Meal ordering system; Standard Nutritionally balanced menu cycle; Mealtimes addressed; appropriate use of Supplements; Food Fortification methods.
- On site Nutrition training programmes for staff.
- A Nutrition Screening & Assessment Tool was introduced as policy.

OUTCOMES

- Improved nutritional intake among patients, particularly those requiring modified texture diets (from an average 881 kcals to 1878 kcals).
- Improved patient choice on menu cycle.
- Improved awareness of nutrition, feeding positions and feeding techniques among staff.
- Staff equipped to identify patients at risk of malnutrition.
- A Structured referral system to Community Dieticians.
- Development & implementation of Regional Nutrition Policies.

CONCLUSION

There is high risk of malnutrition among older person's in residential care. Structures and systems of practice, often experienced in institutional care, are not always conducive to these client groups nutritional needs. This was challenged in this ongoing project where catering & ward practices were examined. Staff were empowered to make better decisions regarding their clients nutritional status. Assistance was provided at meal times, which were made more flexible and more organised & documented meal ordering systems were implemented. Improving nutritional status has been linked to improved quality of life, is beneficial to the immune system and reduces the risk of nutrition related complications. This all in turn has benefits to length of hospital stay & healthcare costs.

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DESCRIBING THE PROCESS OF ESTABLISHING A DYSPHAGIA SERVICE - TO TARGET INEQUALITIES IN HEALTH

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The term dysphagia is used to describe the total process of eating, drinking and swallowing. The consequences for a child or adult of having an eating, drinking or swallowing difficulty can range from being quite mild to being life threatening and in fact in some cases, death has occurred as a direct consequence of choking or from chest infections caused by food and drink entering the lungs (aspiration).

There is currently no assessment and treatment services for patients with dysphagia available in the Cavan/Monaghan regions, which is putting patient at risk.

As a consequence of this risk the Departments of Nutrition & Dietetics and Speech and Language Therapy with Physiotherapy have been meeting on an on-going basis since 2003 in an effort to highlight the need in this area forming the Dysphagia Working Group. It was agreed that in order to develop such a service, it would be important to target the following areas:

- Increased knowledge about the nature of Dysphagia.
- Increased awareness of the impact of Dysphagia on the patient's quality of life.
- Increased awareness of the impact of Dysphagia on the management of acute sector resources.
- Increased knowledge of the requirements of a dysphagia service.

The Dysphagia Working Group initially sourced information on Best Practice in the field of Dysphagia, and collated this information into a local document.

The group then produced a questionnaire in order to consult with our colleagues, and gain an insight into their perspectives, opinions and needs, regarding Dysphagia.

The questionnaires were circulated to all departments in the hospital and residential units in the area. A separate questionnaire was designed to gain the views of Health Care Assistants and identify what supports (if any) they have when they have a patient with Dysphagia under their care.

The ultimate aim of the Dysphagia Working Group is to set up a multidisciplinary team for the management of patients with dysphagia in the region. It is hoped that by increasing awareness and education among hospital staff the inequality within the region will be addressed. By obtaining this service patients and hospital staff would be empowered to better manage their condition. Ultimately a vulnerable group of patients would be better equipped to deal with their diagnosis.

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DISCHARGE PLANNING FOR OLDER ADULTS

Victoria OLADIMEJI

Every year more than five million older people in Britain experience life as hospital in-patients (Henwood and Wistow 1993; Chiva and Stears 2001). When they are ready for discharge, it is important that the necessary community support is put into place in order to make their journey home as smooth one. A well planned and coordinated discharge reduces the risks of older people being readmitted to hospitals or being unnecessarily placed in long-stay residential care. It also improves survival rates as well as physical and cognitive functioning. However, a plan is good only if it is effectively operationalised.

AIM OF REVIEW

To review current practices in discharge planning in hospital settings and to critically evaluate some of the government strategies for improving the discharge process and the transition from hospital to home for older adults, as well as to review the role of nurses in the process.

Transition from hospital to home should involve:

- Careful assessment, planning, implementation and evaluation of care with full involvement of patient, carers/relatives with particular attention to vulnerable patient.
- A collaborative, and well coordinated approach with multiple professional/agencies approach.

Nurses spend the greatest amount of time with patients than any other professional and therefore should play a pivotal role in enabling patients to regain their independence prior to discharge as well as ensure smooth transition from hospital to home for patients.

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SESSION I-5: DEVELOPING THE HEALTH PROMOTION QUALITY OF HOSPITAL SERVICES

DO PATIENT SURVEYS CONTRIBUTE TO THE EMPOWERMENT OF PATIENTS? THE AUSTRIAN EXPERIENCE: NO, THEY DON'T - BUT THEY COULD

Ursula KARL-TRUMMER, Sonja NOVAK-ZEZULA

Within the last decades, instruments to assess the quality of in-patient care "through the patients eyes" have increasingly gained importance. Conducting patient surveys has become routine for most hospitals, although a systematic use of results for further quality development is less frequent.

Patient surveys can potentially contribute to patients empowerment in various aspects:

- They can raise awareness of the importance of patients views both for patients and providers.
- They can provide a basis for patient centred quality development of services. A precondition for this is that indicators from patient surveys are quality assured and provide useful information. For quality development, they have to be integrated systematically into management decisions.
- They can enable patients to make information-based choices concerning the use of services. To make such choices, indicators from patient surveys have to be comparable between hospitals and hospital units and available for (future) patients.

A feasibility study (conducted in 2004) on how to implement a national quality assessment system of patient orientation in hospitals showed that despite the common use of patient surveys in hospitals, chances to use patients surveys for patient empowerment are limited for several reasons:

- The quality of data collected in hospitals as well as the use of data is often unclear, because undocumented.
- There is only little information given to patients - mainly in formats of hospitals newsletters that point out how satisfied patients are.

As the development of questionnaires and the implementation of patient surveys mainly takes place on local or regional level (single hospitals or hospital boards), results from pa-

tient surveys are comparable only to a very limited extend and therefore do not offer a basis for patient choices.

Nevertheless international experiences as well as results from Austrian model projects source the feasibility and the advantages of the use of a standardized instrument on a national level to conduct data on patient-orientation in a benchmarking design.

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STAFF SURVEYS: AN EMPOWERING INTERVENTION TO IMPROVE STAFF HEALTH AND QUALITY OF PATIENT CARE?

Alf TROJAN, Stefan NICKEL, Silke WERNER

GOAL

Due to new European regulations working time arrangements have to be changed. The German Law was adapted accordingly and requires, that doctors do not work longer than 10 hours without recreation time in between. In one hospital we wanted to find out whether the new working time arrangements (including shift work) could be regarded as improvements or not. A longitudinal study was started in order to generate data which can be used for continuous improvements.

METHOD

A questionnaire was administered to all doctors involved in the new arrangement. The questionnaire comprised: actual working hours and wishes for future working hours, job

satisfaction and socio-demographic information. The core of the instruments were 7 scales: abiding to legal norms, compatibility with "normal" family life, job strain, communication and cooperation, organizational procedures, patient orientation, health complaints of staff.

The T1-survey yielded a response rate of 42% (of N=74 doctors), the T2-survey of 48% (of N=73 doctors). To data were gathered retrospectively during the T1-survey.

FINDINGS

From T0 to T1 (about 7 months after the changes) some improvements were found, but for doctors doing shift work most areas deteriorated. At T2 (about 17 months after T0) the overall situation worsened, particularly the negative impact on "normal" family life and on patient care (according to the staff's view).

DISCUSSION

As intended the survey yielded data suitable to generate action on behalf of the staff's and patients' well-being. These data will be presented in the researched hospital. According to the staff's view the deterioration is a result of too few doctors. The hospital management emphasizes the difficult economic situation of the hospital. At the conference we hope to be able to answer the question posed in the title of our presentation.

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QUALITY DEVELOPMENT AS A HEALTH PROMOTION STRATEGY

Amnach SRIRATANABAN, Krit PONGPIRUL, Santawat ASAVAROENGCHAI, Jinda TANGRUAMSAB, Charuwan THADADEJ

Hospital accreditation (HA) in Thailand has used quality development as a strategy since 1996. This developmental process (HA Process) emphasizes a patient-centered, team-based, and CQI approach. It is, therefore, an action-learning as well as empowering process.

The objective of this study is to utilize the HA Process as a strategy to integrate health promotion into hospital setting.

After studying the situation in a community hospital (A), a model (Model I) was formulated as a learning system, according to the Soft Systems Methodology, based upon the HA Process, the empowering strategies (WHO-EURO 2003. Putting HPH policy into action), and the Thai Department of Health HPH Standards. Model I, a desirable HPH, was used as a tool to explore feasibility in the real world situation in 8 HA-accredited hospitals of various sizes and categories (B). Focus group discussions with 93 key informants and in-depth on-site interviews with 90 hospital staff were conducted. Lessons learned were used to modify Model I into Model II, a desirable and feasible HPH. Model II was fed back to A and B, and introduced to two new groups of hospitals (C and D). C comprises 11 hospitals serving as local

meeting places for other 28 nearby-hospitals (D). A learning network (HAHP network) has thus been formed among A, B, C and D.

Eighteen months after this project was initiated, 121 participants from 37 hospitals joined in a one-day conference on January 13, 2005. Using "Empowerment" as a theme, 34 health promotion programs were submitted for poster presentation, 21 of which were considered empowering by predetermined criteria. Eight programs were selected for group discussion to clarify the concept. Lessons learned would be used to modify Model II into Model III, a desirable and more feasible HPH, for HAHP network members to ponder. This learning process would go on.

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PRIVACY IN HEALTH CARE SYSTEM: PROBLEMS AND POSSIBLE SOLUTIONS

Tautvydas JANKAUSKAS, Darius PETRAITIS, Egle KALINAUSKIENE

Despite patient's privacy rights are regulated by law, which not always known to patients or followed by medical staff.

AIM

To find out about patients and medical staff attitude towards privacy in Kaunas 2nd Clinical Hospital.

METHOD

Questionnaire for patients and staff in general and delicate-to-privacy departments.

RESULTS

Only 16.1% of patients and 35% of medical staff stated "right to privacy" was most important. Priority rights were considered to be a right to quality in health care and accessibility to services. Both, patients and personnel, agree that information must not be made public. 69% of patients and 87% of medical staff think that information contained in medical documents is confidential. Middle age persons with higher education, in high work positions treated due to communicable diseases, tended to avoid publicity. 80% of medical personnel are of opinion that information might be used for education purpose without patient's permission despite it being contrary to law. 8% of patients think that information can be given out on the phone though it contradicts the law.

CONCLUSIONS

Laws do not always reflect patient's and medical personnel' view about privacy in medical care system. Tradition and long established practises should be taken into consideration while new laws are being prepared.

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LISTENING TO THE PATIENT WHEN SOLVING PROBLEMS RELATED TO TREATMENT ERROR

Maria HALLMAN-KEISKOSKI

According to international studies, about 10% of patients experience unexpected problems related to their care, independent of the disease, and about half of these problems could be prevented. A research project concerning this issue was carried out in the emergency room of Central Finland Central Hospital. The aim was to survey the experiences of involving the patient in the follow-up process.

The investigative process of each case consisted of four stages:

- Story by the patient and family member.
- Investigation (Professor Charles Vincent's method).
- Feedback discussion (patient, family member, people involved in care and/or experts).
- Interviews with feedback discussion participants.

Research data comprised stories of three voluntary patients, case-related discussion and interview recordings. Content analysis was used.

The results show that listening has encouraging effects concerning the organization as well as the patient. Listening to the patient helps understand the background of complaints with care and fix shortcomings in the system that can - in the worst case - cause irreparable problems with care. At the same time, listening is an excellent tool in developing the quality of health care. The patients thought that the clarification process was rough, but it helped to cope. They were happy to get proper medical information and felt that the relationship with the staff was mainly appreciative during the study process. The patients thought that it's better to solve things this way than quarrel about the clinical incident.

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SESSION I-6: EMPOWERING PATIENTS IN CLINICAL PRACTICE

CLINICAL PATHWAYS FOR COOPERATION BETWEEN PATIENTS AND STAFF

Danilo ORLANDINI, Antonio CARBOGNANI, Paolo CARRETTI

Clinical pathways are interdisciplinary plans of care set and used by professionals who carry out health care activities. Their aim is to establish the best series of interventions on patients suffering from specific pathologies and to promote the involvement of patients in managing and controlling their own care. All the steps of care should be known and declared, in order to better know the patients' needs and to increase the control over their health.

Check-lists are a means of management of the clinical pathways, they help the staff in guaranteeing that no step is omitted and patients are trained and active in the management of their own health.

In some clinical pathways (e.g. hip-Replacement Pathway) in our organisation, patients are in charge of the check-list: that is they are involved by the staff in what concerns consent, education and outcome evaluation.

Some fields in which it is possible to plan patients empowerment in better managing disease through check lists and other tools are: COPD, Heart failure, Diabetes, Pain, etc.

If the patient is involved in the management of the pathways, the professionals can create tools in order to work in a better way, knowing all the actions linked to the management of a particular disease and not only those carried out by themselves.

The most important characteristic of a clinical pathway is the fact that all the people involved (patients, family and health care staff) are aware of each step of the process (very long when a chronic disease is concerned), it is possible to analyse the patients' changes and how the patients feel about them.

Therefore patients are always happy to agree to the care managed through clinical pathways.

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DEVELOPMENT OF A PATIENT-CENTRED PHILOSOPHY OF CARE DECLARATION AND A COMPREHENSIVE CONSUMER HEALTH INFORMATION SERVICE FOR THE EMPOWERMENT OF PATIENTS AND FAMILIES

Susan HIMEL, Sarah TELFER

Processes of providing care and service to patients and their significant others need a foundation explicitly stating the underlying philosophy of care that will guide community and staff expectations, as well as provide rationale for decisions related to patient/family engagement in the care delivery processes. This declaration must be built in partnership with our community to ensure our philosophy of care reflects the values, beliefs and attitudes of our community at large.

Equally important to the empowerment of, and ability to positively impact the health of individuals, families and the community is the provision of consumer health information delivered at the right time and place, and with the appropriate cultural context, language and literacy level. Consumer health information is defined here as any information that enables individuals to understand their health and make health-related decisions for themselves and their families.

Trillium Health Centre is a large community hospital located in the west end of Toronto, Canada. The hospital's mission is to transform the health care experience through a variety of strategic initiatives that includes the notion of turning the hospital "inside out" through patient, or 'other' focused strategies. This also includes the development of a Philosophy of Care declaration of beliefs, values and attitudes that impact and shape processes associated with the experience of giving and receiving care and service at Trillium.

The hospital has also established a leading-edge, comprehensive Consumer Health Information Service that serves an information seeking public that is becoming increasingly interested in active participation in their care and that of their family members. Access to health information allows patient participation and choice in health care decision-making. Providing consumer health information and community referral and support complements the services of health care practitioners, enhances patient safety and compliance, and leads to greater patient satisfaction and better outcomes along the full continuum of care.

This presentation will document the journey of how a large community hospital is becoming patient-centred through the development of a Philosophy of Care and how Trillium's involvement in health promotion, community development and the provision of consumer health information to empower patients and families contributes to the achievement of a health promoting hospital vision.

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DIRECTIONS FOR THE REALIZATION OF AN INTEGRATED HUMANISED CLINICAL HISTORY

Flora COSCETTI, Roberto ANDREINI, Marcella FILIERI, Piero GHERARDIN, Roberta GIUNTINI, Andrea LENDINI, Giuseppe REMEDI

Six Tuscan health authorities carried out a training process oriented to improve the humanized level of care. Within this framework a team work elaborated a humanized clinical history among procedural tools. The team identified the main principles and the guide lines to point out the humanized clinical history, where information already existing such as personal and clinical data, is integrated with those information concerning personalized healthcare path, patient's needs in his/her social, psychological, cultural and family situation.

The integrated humanized clinical history follows the international HPH standards regarding patient assessment and patient information. It contains a section on the evaluation of psychological and social needs of the patient and his family during hospitalisation and discharge to facilitate the empowerment process, that makes the patient more and more responsible in defining and choosing his own healthcare path. A specific section is focused on the living will, where patients express their own wills on health status, death, prolonged artificial life support, organs donation and how to be buried.

Our indications underline that in the humanized clinical history a blank page is provided, where the patient can write his own impression about the hospitalisation, the stay in the hospital, the reception and comfort levels, the quality of care received, the staff ability to identify, to understand and to interpret his own potential and real needs.

The humanized clinical history is structured in order to guarantee the continuity of care between hospital and primary care. It is systematically delivered both to the general practitioner and to the équipe which is going to take care of patient, his therapeutic, social and cultural needs and his instrumental clinical control. The équipe will involve specific professional profiles, primary care facilities, familiars and care giver.

Next step will be focused on: testing the instrument within specific healthcare paths and units in six Tuscan healthcare authorities; training on the aim and the correct use of the instrument as well as the adoption of the humanized clinical histories by the healthcare authorities members of Tuscan HPH network.

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ADMISSIONS AT THE HOSPITAL EMERGENCY UNIT/ROOM (E.R.): INTEGRATION OF HEALTH WORKERS AND VOLUNTEERS

Teresa ALBERTI, Sonia CAVALLIN, Francesca NOVI

DESCRIPTION

The number of patient admissions in a hospital's emergency unit continues to be on the rise. Such increase is characterised by the growing patients needs and requests that are not merely physical in nature but also interpersonal, emotional and social. This phenomenon stems from a radical ageing of the population, amidst a more consolidated flux of immigration and the public's cultural growth in health information. For this reason, consciousness within the medical circles or the health sector as well as the fulfilment of service offered, even to out-patients, could be immediate and quicker. This high number of access causes patients seeking non-urgent treatment, to wait for 4 to 6 hours. This long wait within the hospital premises produces a high level of stress with strong emotional exposure among patients and health workers. In these cases, it has been agreed that the support given by volunteers in activities such as information release, a task that entails giving guidance, counselling and assistance, will undoubtedly strengthen the interpersonal aspect of the service, making it more friendly, thus promoting a serene and humane environment.

AIMS AND OBJECTIVES

- To assist the patient and his family on how to handle the primary steps in obtaining access to the services. This occurs immediately after the first phase of hospital admission.
- To guarantee emotional support during the wait, fostering the communication of one's anxieties, discomfort and worries.
- To orient, inform and guide the patient and his family in carrying out administrative procedures and require-

ments.

- To accompany the patient with limited mobility in gaining services in the various hospital facilities.
- To help the family and patients in handling interpersonal relations within the hospital world, favouring the humanization of the atmosphere.

METHODOLOGY/ACTIONS

- To define specific functions to be assigned to volunteers with the aim to support waiting patients and the institutional activities of the professionals (medical staff).
- To introduce a training course for volunteers through the supervision of emergency room staff.
- To train and perform tests on experiences.
- To define the instruments for verification.

TARGET

Priority ought to be given to senior citizens, whose tension and anxiety often lead to bewilderment and confusion. These situations could contribute to the worsening of the patient's health condition.

EVALUATION OF THE RESULTS AND CONCLUSION

The project foresees the involvement of the volunteer in safeguarding the patients and their relatives need for information while in the waiting room of the emergency unit, so as to contain anxiety.

The fulfilment of the project requires a strong collaboration between the medical staff of the E.R. and the volunteer. This was made possible thanks to a specific training that promoted the exchange of know-how, the involvement of the worker's and volunteer's capabilities, and the enrichment of their duties.

Specific indicators taken from the continuous monitoring system and periodical meetings (monthly) of the personnel in charge of assistance and the volunteers were identified for purposes of project verification as a whole.

Thanks to the innovative relationship of collaboration with the volunteers, the internal atmosphere within the waiting room of the emergency unit is expected to improve. As a contribution to the general campaign of health promotion, the positive outcome of this experience should bring forth a decrease in the number of complaints and an increase in awareness as regards the correct procedures to having access to E.R. services.

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GIVING ATTENTION TO THE EVALUATION OF PATIENT RECEPTION

Loredana FAUNI, Roberta VINCENZI, Maria FRANCO, Monica MALAGUTI, Alessandra MACCAFERRI

BRIEF DESCRIPTION OF THE PROJECT

By "reception" we mean the first impression, the first encounter that the citizen will have at the entrance to any service such as the porter's desk, a clinic, or in the hospital wards. To make a person at ease, it is fundamental to put oneself in the patient or service users' shoes and find the human envi-

ronmental condition that can help establish a sort of relationship. This shows how the importance of the techno-professional service offered to the public could increase or decrease on an interpersonal level, depending on the assets and added value that each hospital worker gives, whether personal or professional, to interpersonal relations with others, where, he finds himself in a position to be a good listener. This implicates the need to give more attention to aspects related to the RECEPTION, its staff and procedures, so as to be able to make the services more visible and to have a direct access user service or a more user friendly atmosphere within the hospital premises. The reception area of the - Quality Hotel Service (S.Q.A.) is co-ordinated by the Officer In Charge who supervises related projects pertaining to the giving of information to the public, the aspects of interpersonal relations and privacy in the three porter's desk/Front Office of the Hospital Establishments (S.O.) and within the Operative Units (UO)/Services.

Its line of activities can be broken down into 2 sectors:

- Porter's Desk/Front Office
- Operative Unit Sector/Clinical Services

The system of evaluation and verification of the quality of Reception Area implicate some measurements (quantitative and qualitative) and an assessment value. To carry out the assessment, a Check list has been identified as the instrument to be utilized at each functional stage of the service.

AIMS AND OBJECTIVES

To come up with a system of evaluation/assessment of quality of service at the Reception Area that will constantly monitor the effectiveness and the efficiency of the services provided.

METHODOLOGY/PROCEDURE

The Officer-In-Charge/Area Representative will fill up a checklist of quality control to be done monthly and at the same time will complete it, by random sampling, by going to one of the three Hospital Establishments. The rating assigned to each entry is:

- 2 Positive assessment "Yes"
- 1 Partial assessment "Not sure" "in part-NOTE"
- 0 Negative assessment "NO"

The sum of the ratings assigned to each entry allows the possibility to formulate an assessment on the quality of services provided at the Reception Area: "Good" if the total rating is 14; "Satisfactory" if the total rating is between 8 and 13; Poor if the total rating is 7 or less. When the formulated assessment is "Poor", the Officer-In-Charge holds a meeting with the Area Representative of the Porter's Desk to determine the cause of the low level of quality shown and to come up with a plan for an improvement. The Porter's Desk Area Representative will use a checklist to be used monthly. All results will be sent to the Officer-in-Charge of the SQA and to the Management of the P.O.. The assigned ratings to each entry is:

- 2 Positive assessment "YES"
- 1 Partial assessment "in part-NOTE"
- 0 Negative assessment "NO"

The sum of the ratings assigned to each entry allows the possibility to formulate an assessment on the quality of services provided at the Reception Area "Good" if the total rating is between 30 and 32; "Satisfactory" if the total rating is between 13 and 29; "Poor" if the total rating is 12 or less. When the formulated assessment is "Poor" the Area Representative of the Porter's Desk will call a meeting with the Specialized Personnel (O.T.) to be able to evaluate the causes and propose initiatives to be taken to improve the

quality level of the services provided. The Specialized Personnel will use a Chart auto-assessment chart weekly - Daily Work Plan - daily work activities in detail. At the end of the week, the said chart will be submitted to the Area Representative, who, in turn, will evaluate whether the chart has been filled up properly and make an initial evaluation. The Area Representative will include once more such evaluation in the check list for the monthly control. The filled-up charts will be kept at each Reception Point for six months after which they will be eliminated. The rating assigned to each entry is:

- 2 positive assessment "YES"
- 0 negative assessment "NO"

The sum of the ratings assigned to each entry allows the possibility to formulate an assessment on the quality of services provided at the Reception Area: "Good" if the total rating is between 140 and 196; "Satisfactory" if the total rating is between 113 and 114; "Poor" if the total rating is 112 or less.

PRINCIPAL TARGET

Service users and Specialized personnel

EVALUATION OF THE RESULTS AND CONCLUSIONS

The objective has been fully reached. It has been treated

and worked out together with the application of instruments for the assessment/verification of the quality of services provided at the Reception Area. The average overall assessment is found on the band "Good." The fulfilment of such project required a high level of integration and collaboration among the Specialized Personnel (O.T.), the Area Representative and the Officer-in-Charge of the Reception Area, that promoted the exchange of know-how, more involvement of the health operators capabilities and the enrichment of their duties using the auto-assessment charts. According to a survey done where anonymous questionnaires were utilized, 33% of the sampling gave a satisfactory mark of 90.11 thanks to the quality of service received by the users at the hospital entrance.

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Parallel Sessions II: Thursday, May 19, 2005, 13.30-15.00

SESSION II-1: SMOKE FREE HOSPITALS – 2

EMPOWERING THE PROMOTION AND DELIVERY OF EFFECTIVE SMOKING CESSATION SERVICES IN SPECIFIC POPULATIONS

Elaine ROBINSON, Pauline KENT

The Training and Education subgroup of the NW Smoking Forum (HSE NW Donegal, Sligo, Leitrim, & West Cavan) recognised the need to further develop the skills and knowledge around tobacco control, for those persons involved in the delivery of the Smoking Cessation Services. In addition, we acknowledged that given the current climate and our smoke free workplace legislation it was essential to change the public's perception on smoking. That smoking is not just a 'habit' but also a 'dependence' on the drug nicotine, which is a chronic relapsing illness.

The following key areas were identified: Youth, Pregnancy, Mental Health, Relapse, Tobacco Dependence and Personal Behaviour Change. This project was identified as the 'First School in Smoking Cessation. Sourcing experts for each area led our interests to America, Scotland, England and back home to Ireland. These experts included: Danny McGoldrick- Head of Research for Tobacco Free Kids Campaign, US, David Balfour- Scientist in the Neurobiology underlying Nicotine & Tobacco Dependence, UK, Professor Hajek- Head of Psychology and Director of the Tobacco Research Centre Barts & The London, England, Ms. Terry Lawrence- Consultant in Smoking Cessation Training- Pregnancy & Relapse, UK, and Mr. Joe Armstrong- Irish Journalist and Author.

The Project commenced in Spring 2004 and our Programme was delivered in November 2004. Our target audiences were identified as Service Providers, Health Promotion, Public Health, General Practitioners, Consultants, Hospital Doctors, Pharmacists, Teachers, Youth, Youth Workers, Youth Council, Nurses from every discipline, Student Nurses, Learning

Disabilities & Mental Health Services, Addiction Services, Social Workers, Clergy, Gardai, Cardiac and Respiratory Services. The sessions & workshops were delivered over seven days- the feedback from the media, the experts and participants was very positive. We are currently carrying out our project evaluation and planning for our 2nd Winter School for 2005.

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DEVELOPMENT OF A COMPLETE APPROACH FOR SMOKING CONTROL AT THE ERASMUS HOSPITAL (BRUSSELS)

Jacques DUMONT

The Erasmus hospital is an academic institution of 835 beds and with more than 3500 workers. Since 1997 (membership at the HPH network and at the smokefree hospitals network), the Erasmus hospital had developed a lot of steps to support the smoke-control process. Specific work group, strict restriction of smoking area, opening of a "stop-smoke centre", help to stop smoking for inpatients, help to stop smoking for staff, training for staff members, general conferences, annual non-smoking day activities, organisation of research in stop-smoking strategies, taking part at pharmaceutical researches, development of smoking management in outdoor workplaces,...

This communication presents those activities and the evolution of smoking in the Erasmus hospital.

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PREDICTORS OF CONTINUED SMOKING ABSTINENCE AMONG HOSPITALIZED PATIENTS

Cristina MASUET AUMATELL, Josep RAMON TORRELL,
Sergio MORCHON RAMOS, Gilma Lavinia LOPEZ
SALGUERO

OBJECTIVE

To determine the success predictors of continued smoking abstinence among inpatients receiving smoking cessation intervention during hospital stay.

METHODOLOGY

Prospective cohort study of inpatients in a university hospital. A total of 270 smokers admitted in medical and surgical services from October 2003 to May 2004 received health education consisting on verbal advice and standard booklet about smoking cessation and hospital health promotion role from a dedicated nurse counsellor. After discharge, participants received a follow-up by telephone every month from the same counsellor. The main outcome measured was continued abstinence at 6 months after hospital discharge as determined by self-reporting. The covariates studied were analysed by univariate, bivariate and logistic regression to determine the possible factors associated with smoking abstinence: demographics, motivation stage, smoking and medical history.

RESULTS

At 6 months post-discharge, 147 (54.5%) patients remained abstinent. Active motivation stage (adjusted odds ratio, 2.47; 95% CI, 1.21-5.06) was the only independent predictor for success smoking cessation after hospital stay. On the other hand the demographics smoking and medical history

CONCLUSION

Among this cohort of inpatients receiving smoking cessation intervention the motivation stage was the main independent predictor of smoking abstinence at 6 months after hospital discharge.

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IMPLEMENTATION OF MENTORING SMOKE CESSATION PROGRAM

Elvira MÉNDEZ, Montse GARCÍA

BACKGROUND

The Catalan Institute of Oncology (ICO) is a Smoke-Free Center since 1998. This centre which was the first one in Catalonia Region to become free of tobacco smoke, is re-

sponsible for directing, coordinating and promoting the smoke-free initiative to Catalan Health Centres and Institutes.

One of the main objectives is to decrease the number of smokers among the health workers. To achieve this aim we have started in our center a smoke cessation program based in using the Mentoring process. This process allows the person to relearn and mature during the tobacco quitting process.

OBJECTIVE

To implement a smoke cessation program in Hospitals using the Mentoring as methodology.

MATERIAL AND METHOD

Six nurses formed and trained in tobacco cessation give personal support to other health workers of the center during 6 months. They assess the stage of the person according to the change phases of Proshaska and Diclemente model. They determinate the physical dependence (valuated by Fageström test), the social and psychological reliance (tested by Russell text), and they explore the personal tobacco consumption.

Once it is made the diagnostic both, mentor and mentee, appoint a plan to follow for giving up smoking. They establish a minimum of 8 sessions in 24 weeks without a maximum of encounters. They schedule the day "D" and the work in anticipating the weaknesses and enhancing the strong points of the person with the purpose of diminishing prospective difficulties. The mentor is not just the therapist is also the personal support that the smoker has during his process of quitting.

The role of the mentor is to advice and help to choosing the best option for the person to achieve his goal. As well it helps to the person to fix objectives and to plan the steps to reach them. Help to the person to recognize and develop self control capacities such as confidence and self-esteem. And last but not least, the mentor gives a feedback and a critic point to the person.

This project was pilot during 6 months, from May 2002 to December 2003, being offered only to staff nurses (34 % smokers).

RESULTS

16 Nurses where included in our pilot, 4 of them abandon the program before been treated. The rest were followed by one nurse in their smoke cessation process. The profile of the group was: moderated dependence of tobacco, with a media of Fageström of 4.7, and a media of cigarettes smoked of 15.67(D.S= ±5.52). The 41.7% of them they tried to quit before.

In the six months of the program, 5 of the 16 person that started the course did not smoke. This means the 31.25 % of success of the program.

CONCLUSION

The mentoring is a useful methodology to offer support to nurses who is giving up smoking. It has a level of success similar to other smoke cessation interventions.

DISCUSSION

We need more evidence of this research to validate our results.

Moreover, we deem that this kind of program needs to be offered to the rest of staff of our hospital who are also smok-

ers such as administrative and technical staff, for instance.

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HOSPITAL BASED SMOKING CESSATION SERVICE – MORE SMOKERS QUITTING AND STAYING SMOKE-FREE.

Paula CAMPBELL

OBJECTIVES

- To provide all smokers living in the north east region with support for quitting.
- To monitor and evaluate this service on an ongoing basis.

METHODS

Stopping smoking delivers major clinical benefits, and is a highly cost-effective intervention. The north-east region in Ireland covers 4 counties with a population of 345,000 people. The Department of Health Promotion established a Smoking Cessation Service in 2000.

The service is based in 5 acute hospitals, with counsellors providing both one-to-one and group support. Referrals come from hospital/community based staff, self-referrals and the National Smokers Quitline. The service is advertised widely within the region using newspapers and radio.

Quantitative analysis of the data available on all clients who

had received support was undertaken in August 2004. Analysis was completed by the Department of Public Health using JMP statistical package.

RESULTS

The number of smokers accessing the service is increasing each year - from 1557 in 2001, to 2851 in 2004;

Of the total sample in this study (n = 7,253):

- 50.3% of clients were hospital inpatients, 18.4% general public, 15.7% staff members, and 15.5% out-patients.
- 56% of clients had set a Quit Date.
- 35% of those who set a Quit Date were smoke-free at 3 months.
- 12.2% of those who set a Quit Date were smoke-free at 12 months.

Univariate analysis showed being quit at 3 months was significantly related to being older, attending group support and being a staff member.

CONCLUSION

This is an effective service which has helped over 7,253 smokers in their efforts to quit. Although hospital based, the service is reaching smokers in the wider community (the proportion of 'general public' attending has increased from 10% in 2002 to 18% in 2004). In addition, the long term quit rate has increased significantly from 2002 to 2004.

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SESSION II-2: HEALTH PROMOTING PSYCHIATRIC HEALTH CARE SERVICES

COMMUNITY INTEGRATION OF MENTAL HEALTH TEAM

Lorcan MARTIN

Although the focus of mental health service provision has long moved towards the community, stigma and lack of information continue to confound the integration of psychiatry into the community. With this in mind, it was decided to embark on a series of initiatives over a two-year period with the specific aim of increasing public awareness and decreasing stigma.

Within the area covered by the Athlone Community Mental Health Team, four specific issues were identified:

- Lack of knowledge/awareness regarding mental illness and mental health issues
- Difficulty in accessing and reluctance in attending traditional clinic arrangements
- Difficulties related to deaf persons obtaining an equitable mental health service
- Lack of involvement by service users in the Mental Health Service

It was decided to address the issues of information/awareness by delivering a series of interactive mental health awareness evenings. These were organised with the local Mental Health Association and relevant voluntary

group. Each evening was publicised by print & radio media. Additional awareness talks were arranged for staff and students of the local Third Level College.

The second issue was addressed by the development of a Primary Care Consultation Liaison Service which moved the first point of contact with the mental health team into the Primary Care Setting.

It was attempted to overcome the difficulties encountered by deaf service users by the development of sign language skills by the Consultant Psychiatrist and several team members and by the formation of a close alliance with the National Association for Deaf People. Mental Health awareness talks were also provided for this Association.

In order to facilitate greater involvement by service users, a Consultative Group made up of service users and carers was formed. This feeds directly into the management structure of the team.

Further detail of each of these initiatives will be discussed.

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AN APPROACH FOR ENABLING SCHIZOPHRENIC IN-PATIENTS TO BE DISCHARGE WITHIN THREE MONTHS

Yoko NAKAYAMA, Michika TANOUE, Junko NIIMURA, Takako OHKAWA, Mayumi OHTAKE, Naoko CHO

PURPOSE

The purpose of this study is:

- To analyze the categories and timing of nursing care in wards.
- To explore the health promoting approaches, both of which may help patients to remain in communities after discharge.

SUBJECTS AND METHODS

The subjects of this study are 24 nurses who work at psychiatric hospitals in Japan. They were interviewed to recall what kind of care they gave in order to prepare patients for community living. The cases of 26 patients were described by the nurses in the interviews. The interview data was qualitatively analyzed.

RESULTS AND DISCUSSION

All 26 patients remain in the communities for more than 6 months after discharge. Categories of care are following.

- Maintaining a health promoting life style after discharge.
- Coping with problems.
- Spending time outside the hospital on weekends.
- Management of psychiatric symptoms.
- Compliance with medication regimen.
- Re-establishing and re-framing family relationships.
- Developing connections with support professionals in the community.
- Understanding their own mental illness.
- Discussing how to develop interpersonal relationships.
- Motivating patients for the continuation of outpatient treatment.

Many areas of care were given in the context of preparing patients for community living. However, there were differences between first admission patients and re-admission patients. Developing a health promoting life style after discharge began at the week after admission and most of the other areas were being addressed by the fourth week.

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GOOD PRACTICES IN NETWORKING, AN INSTRUMENT FOR BENCHMARKING MENTAL HEALTH ACTIVITIES

Yvonne BONNER, Rosaria RUTA

RESEARCH PROJECT

For 30 years, the Mental Health Service (MHS) of Reggio Emilia endeavoured to maintain patients at home. Recently, before introducing case managers, the MHS organized a quality circle to study the good practices in networking (GPN).

PURPOSE

Study good practices in networking - before developing a course in case management (CCM) - in order to build on team competencies sustaining patient empowerment.

AIMS

- Highlight the GPN
- Promote a Learning Organisation
- Develop a CCM focused on patient empowerment

METHODOLOGY/ACTIONS

Target – 78 persons interviewed

- Severe psychiatric cases, examples of GPN.
- Composition of the sample
- 194 patients were reported, among whom 19 were selected, from different health teams.
- Mapping of the treatment system
- 19 health workers, responsible for 19 patients, mapped the treatment system (TS) to identify 4 persons to be interviewed (patient, health worker responsible of the case, family member, others).

Appreciative Inquiry

- This methodology permits collecting “experienced-based information”, and reinforces the enquiry skills of the health personnel.

Feedback

- The interviewers brought back, to the selected 19 teams, the contents of the 4 interviews, highlighting the diversity in the numerous choices of events and quality indicators.

Seminar

- The GPN were illustrated and discussed with MHS and the families. Following this meeting the content of the CCM was defined.

RESULTS

Interviews revealed:

Diversity in the selection of “key elements” defining GPN

- Users: their status as “person”
- Family members: their “expertise”
- Health worker: their “entrepreneurial” approach
- Other persons: “risk taking”

The consistency of a network

- System of “virtual” networks generated by events.

Emerging interests

- Patient’s point of view monitoring treatment
- Preservation of “differences” in therapeutic alliances
- Support as a network “adhesive”
- Freedom of choice rationale of care

CONCLUSION

These elements were included in the CCM.

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'MEANINGFUL DAY'

Jennifer REYNOLDS, Julie MCILROY

As a nurse led initiative, the Meaningful Day programme was established in response to our concern relating to significant increase in weight and decrease in motivation of patients suffering from severe and enduring mental illness, who were prescribed antipsychotic medication. In response we identified the need to empower patients with the knowledge, skills and support to promote healthier structure and meaning to their day. In order to facilitate this we, in conjunction with community services, formulated an eight week rotational programme framework.

The patient group identified included male and female in-patients who were suffering from a psychotic illness, prescribed antipsychotic medication and had identified a need to make small changes to their current lifestyle. Each week focusses on a different area of concern and time is spent educating and discussing each topic with small achievable goals being set. The initial focus was on weight and healthy lifestyle and although still incorporated into the programme the focus altered to issues surrounding social functioning. This alteration occurred to meet the self-identified needs of the patients. Each week following a group discussion on health issues we accompany and support the patients on a social activity of their choice.

As the programme progresses we have observed a change in the lifestyle and social functioning of the patients involved. For example one female patient has progressed from being housebound due to extreme anxiety, to now jogging approx 5 miles a day and to date has lost 17LBs in weight.

Some patients although discharged from hospital continue to attend the group on a regular basis for ongoing support and friendship.

The programme has surpassed our expectations and has given much personal and professional fulfilment.

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HEALTH PROMOTING MENTAL HEALTH SERVICES: TO EMPOWER THOSE FEELING POWERLESS

Hartmut BERGER

The concept of empowerment gives us a strong orientation towards the patient, we work with. In the field of mental health services we are often confronted with people feeling powerless and helpless. To make them feel and act more powerful may than not only be a work of structural activities, like the setting framework of activities in health promotion may suggest, but must also aim at the individual patient in a more psychotherapeutic way. By doing so it is also necessary to be aware of gaps in the organisation of our work, which may hinder patient and staff to be more empowered.

Mental health disorders require an integrated approach, since disease processes are often long-term and acute and sub-acute phases of illness alternate with phases which are relatively symptom-free. The workshop will offer a forum for sharing experiences in health promotion in psychiatric health care in a broad sense. It is designed to present models of good practice of health promoting mental healthcare and to develop further a conceptual frame for health promotion in mental health care.

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SESSION II-3: HEALTH PROMOTION FOR PATIENTS WITH CHRONIC DISEASES – COPD

HEALTHY LIFESTYLES THROUGH PULMONARY REHABILITATION

Janet SINNERTON

The National Institute for Clinical Excellence (NICE, 2004) recommend that pulmonary rehabilitation programmes should be offered to all patients who consider themselves functionally disabled by Chronic Obstructive Pulmonary Disease (COPD). The main aim of pulmonary rehabilitation is to reduce disability and handicap in people with lung disease, and to improve their quality of life whilst diminishing the health care burden (Morgan et al, 2001).

The Ulster Community & Hospitals Trust (UCHT) deliver a community based pulmonary rehabilitation programme, which is situated in a local leisure centre in order to maximise opportunity for sustainability. A recent audit of con-

sumer questionnaires post pulmonary rehabilitation also highlighted the need for some form of follow on programme (UCHT, 2004).

There is no guidance available as to what is acceptable follow on care for patients who complete the programme. Recommendations following a recent survey by The British Lung Foundation (BLF) and The British Thoracic Society (BTS) are that further research is required to look into the benefits of follow on care/programmes for patients who have completed their pulmonary rehabilitation (BTS & BLF, 2002). The survey also revealed that only 9% of all pulmonary rehabilitation programmes are carried out in a community setting. A UK survey of 287 hospitals revealed that in 91 hospitals with a pulmonary rehabilitation programme refresher courses (n=16) and after-course domiciliary support (n=26) were unusual (Davidson and Morgan, 1998).

The Department of Public Health/Health Development has taken positive steps to address this highlighted need and by working in partnership all clients are invited to attend a chair based exercise class or referral to a twelve-week exercise programme namely "Healthwise". The respiratory nurse and physiotherapist routinely review patients at six months. To date 26% of patients who have completed the programme have been referred to HealthWise and a further 20 % now attend a weekly chair based exercise programme.

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HEALTH PLANS FOR COPD PATIENTS UNDERGOING HOME NON-INVASIVE MECHANICAL VENTILATION (HNIMV): FROM HOSPITAL TO HOME.

Stefano AIOLFI, Vincenzo PATRUNO, Gianfranco BEGHI, Lodovico CHIESA, Ugo ZORZA, Maresca ROTA

The prevalence and impact on public health of chronic obstructive pulmonary disease (COPD) are rising. Individuals living with COPD require skills and information necessary to make changes in their behaviour in order to stay healthy and avoid further deteriorations. We report our experience on the management of Stage IV COPD pts with chronic respiratory failure (CRF) in HNIMV dismissed from our Unit.

METHODS

From April 1999 to December 2004, 48 pts with CRF [M/F: 28/20; mean age 62 yr] had been dismissed from our Unit in HNIMV. All underwent blood gas analysis (BGA) to set the correct parameters of ventilator and to verify the need of supplemental oxygen. Together with their partners, all attended multidisciplinary educational sessions on home management of their condition with emphasis on how to handle and to clean their ventilator, tubes, mask, and oxygen supplier. At discharge, a follow up schedule was set at 1, 3, 6 months, and subsequently every 6 months, if no exacerbations, consisting in clinical visit, BGA, educational reinforcement, and on answering some questions on the no. of requests of technical support; of non scheduled visit; of admissions to other hospitals.

RESULTS

All pts attended the scheduled controls. Till now, 7 pts had died: 4 M, 3 F. At the follow up visit each patient reported to have requested technical assistance more than scheduled in 7% of cases, and non scheduled visit (E.R. or other Respiratory Clinics) in 4%. During the observational period hospital readmissions for respiratory problems were low: mean 0.8/year for each patient.

CONCLUSION

Our multidisciplinary approach to pts in HNIMV shows a low readmission ratio as a consequence of a good health educational approach and a better management of the condition at home.

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PATIENT EMPOWERMENT IN CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Noreen BAXTER, Mary HINDS, Anne Marie MARLEY

Chronic Obstructive Pulmonary Disease (COPD) is a major public health problem. It is the fourth leading cause of chronic morbidity in the UK and the United States and is projected to rank fifth in 2020 as a world-wide burden of disease. Further increases in the prevalence and mortality of the disease can be predicted in the coming decades.

Within north Belfast the prevalence of respiratory disease is exceptionally high with 90% of single parents from inner city housing estates, still smoking. The future rate of COPD suffers can be expected to be 20% of this population, resulting in a major impact on their individual health status and future health care resources. The insidious nature of COPD means that the disease can be moderately severe before it is diagnosed. The breathlessness that occurs restricts activities of living and is known to result in anxiety or depression in up to 50% of sufferers.

A public health approach was adopted in the development of an integrated care-pathway at the Mater Hospital, Belfast for these patients. This local initiative aimed to improve the management and prevention of COPD.

A project over the last year further enhanced this framework by including the primary care teams. This was through collaborative training exercises to increase their skill base and has improved health promotion and prevention strategies, assisting early diagnosis, and pulmonary rehabilitation. Health promotion and education to empower the individual for self-management are central to this approach. Improved palliative care is now in place for those with end stage COPD and this allows the individual to make health choices by recognising deteriorations in their own condition thus enabling them to avoid hospital admissions. Another positive outcome is the reduction in the demand for health care services since the introduction of this project.

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EMPOWERING CHRONIC PATIENTS WITH THE USE OF E-HEALTH, HOME AND COMMUNITY BASED INTEGRATED CARE

Theodore VONTETSIANOS, George KONTOPIRGIAS, Periklis GIOVAS, Theodore KATSARAS, Aris KOSTORIZOS, Aspasia PANAGIOTOU

AIM

The aim of the study was the evaluation of clinical usefulness of an advanced e-health system in home-based rehabilitation, follow up and home hospitalization of patients with advanced stages of COPD.

METHODS

Eighteen subjects (mean FEV1 0.73 L) with at least four admissions for COPD in the previous 2 years were treated at home for 1 year, after an initial out-patient rehabilitation phase. The system consisted of a specially designed electronic health record (HER) and a compilation of advanced telemedicine devices (spirometer, oximetry, ECG) for the transmission of patients' examinations from their homes to the hospital. Through the system the patients were able to undergo home tele-visits, with a real time video connection by the members of the rehabilitation team in the hospital on a regular or on emergency basis.

RESULTS

During the first year, hospital days fell from 17.5 to 4 per patient as compared to the previous year. This was due to

both, reduction of the number of admissions (from 2.1 to 0.4), as well as in the length of stay. Patients had a significant improvement in their quality of life (using CRQ), exercise tolerance (6 min walk test) and emotional status score.

CONCLUSION

It seems that the adoption of such systems in today's clinical practice can offer hospital-quality services at home resulting in improvement in patients' quality of life and significant cost savings.

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KEYWORDS

Home telehealth, integrated care, COPD

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SESSION II-4: ASPECTS OF DEVELOPING HEALTH PROMOTING HOSPITAL ORGANISATIONS – 1

THE HOSPITAL OF THE FUTURE: HEALING AND COMPETITIVE

Tom GUTHKNECHT

FUTURE HOSPITAL, AN HEALING ENVIRONMENT: THE COMPETITION

*With an international competition launched by the Netherlands Board for Hospital Facilities (NBHF) ideas for future health provisions and a 'healing environment' also in the EU Health Property Network. Of the 88 entries received from 28 countries, 35 participating teams were invited to enter the competition.

'CORE HOSPITAL': SMALL IS BEAUTIFUL

The winning entry, named 'Core Hospital', presented a new solution in which only a few of the "classic" functions of a hospital were selected to be included. Instead of the surface area available of 40'000m², the concept requires just 21'000m² to meet the functional requirements specified in the competition.

SERVICES: EMBEDDED INTO THE SURROUNDING ENVIRONMENT

'Core Hospital' connects to an inner city network of services and service partners. Only the highly technical departments of the project need to be newly built. Functions with low technical requirements are placed in surrounding, pre-existing buildings.

HEALING: SUPPORTED BY DESIGN

Good design cannot guarantee high medical performance, but inappropriate design can hinder good practice and reduce performance and quality levels significantly. The task of design and architecture is to balance the different needs of patients and staff with functional requirements.

HUMAN NEEDS: BRINGING THE LIGHT INSIDE

While technological needs change, human needs remain more or less the same. Patients today trust modern healing methods but do not want to be overwhelmed and dominated by technology. In the 'Core Hospital' the focus lies on a balanced environment. An interior landscape of corridors and courtyards with access to natural light is created.

INTEGRAL PROCESS DESIGN: EMPOWERING STAFF AND PATIENTS BY A NEW DIALOGUE

In today's design of hospitals a low degree of user participation is applied. Optimizing processes and workflows with user participation at an early stage will save huge amounts of running costs.

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THE HOSPITAL AS HPH-STRATEGY-FOCUSED ORGANISATION

Elimar BRANDT, Werner SCHMIDT, Rainer HÜBNER

The report will relate to four years of experiences with Strategy-development and - implementation in a Hospital Holding (Immanuel Diakonie Group) based on HPH-core strategies and standards for health promotion in hospitals. In addition to a (HPH) member hospital there are three more hospitals aiming for a membership. The presented results were ex-

tracted in a WHO-pilot-project "HPH/EFQM/BSC" which was accomplished in hospitals of the holding in Brandenburg and Berlin from 2002 to 2005.

It will be described how the HPH concept (Strategy and Standards) was integrated in structure and culture of the Immanuel Diakonie Group. The main focus will be on results, positive experiences and barriers:

- firstly on the implementation of a HPH-concept into basic values of the holding,
- secondly during the self-assessment according to the EFQM-Excellence Model and
- thirdly during the utilization of a Balanced Scorecard as a management tool to develop a strategy - focused organisation.

Concluding there will be a presentation of a combined application of the WHO self assessment tool for HP-standard implementation with a Balanced Scorecard in one of the participating hospitals.

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HOW TO TURN AN ACUTE SERVICES HOSPITAL INTO A HEALTH PROMOTING ORGANISATION IN 12 MONTHS.

Wendy PEACOCK

Tayside is a region in Scotland with a population of 387,420. The largest city is Dundee which has high levels of unemployment and over 50% of children living in social deprivation. Other parts of Tayside are very rural resulting in difficulty in accessing health care services. There are 3 general hospitals across Tayside with a total of 2,526 beds.

With a strong lead from Public Health services, a 12 month health promotion development programme has been implemented within all 3 general hospitals. In addition the CEO for Acute Services has signed the WHO Health Promoting Hospitals Agreement and has accommodated a Senior Manager from Public Health on the Acute Services Senior Management Team.

The approach taken by Public Health staff was to firstly gain senior management support which then led to a middle management requirement to prioritise health promotion. It was recognised that cost pressures, was an issue and so to support this process a small grants award scheme was developed, for the use of all staff interested in taking forward health promotion interventions. This resulted in some short term positive wins and therefore a positive experience of working with Public Health staff and a willingness to engage further.

Clinical services were asked to develop health promotion objectives as part of their strategic plans. Existing staff who had previously shown an interest in health promotion were identified as 'champions' and developed further through training and development and encouraged to lead health promotion interventions in their area.

To increase the health promotion capacity of staff, educa-

tional lunchtime sessions were introduced on a monthly basis with free refreshments to encourage attendance.

The hospital environment was also assessed and a no smoking policy was devised and implemented with plans to address the sales of carbonated drinks as the next priority.

The success to date is mainly due to the awareness by Public Health staff of the barriers to health promotion in an acute setting and the common sense approach to overcoming them.

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SELF-ASSESSMENT TOOL FOR HEALTH PROMOTION ACTIVITIES IN HOSPITALS. RESULTS OF PILOT-IMPLEMENTATION OF STANDARDS AND INDICATORS IN EIGHT COUNTRIES

Oliver GROENE

OBJECTIVE

To assess experience with pilot implementing the WHO self-assessment tool for health promotion in hospitals, including comprehension, applicability and relevance of measurable elements and use of health promotion indicators.

METHODS

On the basis of standards for health promotion developed previously [1, 2] a tool was developed to assess current level of performance on health promotion activities in five domains (management policy, patient assessment, patient information and intervention, promoting a healthy workplace and continuity and cooperation) among hospitals in the international network of Health Promoting Hospitals. An expert working group developed measurable elements to assess compliance with standards and a literature review was carried out to identify performance indicators on health promotion measures currently in use [3]. A self-assessment tool was developed by the lead researcher incorporating measurable elements and indicators, identifying roles and responsibilities, data sources, action plans and assessment procedures [4].

As part of the implementation process participating hospitals established multidisciplinary groups taking responsibility for review of patient records and other data collection issues. Standards' compliance was assessed based on audit of management procedures and patient records. Indicators were computed on the basis of patient records audit, routine surveys on patient satisfaction and staff health and hospital information systems.

In order to gather results from the pilot implementation a meta-evaluation tool was developed to assess hospital quality management structures, to evaluate clarity and relevance of measurable elements and indicators, burden of data collection, current level of compliance with standards, performance on indicators and general experience with implementation.

RESULT

A self-assessment tool for health promotion including 68

measurable elements and 22 complementary performance indicators was developed and pilot implemented in 38 hospitals from 8 countries (Czech Republic, Germany, Ireland, Italy, Lithuania, Slovenia, Sweden and South Africa). Quality teams met on average six times to review patient records and fill in the meta-evaluation tool. Assessed level of compliance with standards is as follows: 40% of standards are fully met, 33% partly met and 27% not met. Regression analysis did not yield significant associations between compliance and hospital quality structures. There was strong agreement with the need and usefulness of assessing health promotion activities in hospitals (94%); 68,5% agreed that the additional workload could be incorporated into current procedures.

CONCLUSIONS

Health promotion activities for patients and staff are important issues to improve quality of care and working conditions in today's hospitals. We developed a tool for hospitals to carry out a self-assessment in this field and piloted it to assess its comprehensibility and usefulness. Hospitals support the use and further implementation of the tool to assess structures, processes and outcome of health promotion actions. Members of the International Network of Health Promoting Hospitals and other quality agencies are encouraged to incorporate assessment of health promotion activities into existing quality tools.

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SESSION II-5: FURTHER DEVELOPING THE HOSPITAL INTO A HEALTH PROMOTING SETTING

'ACTIVE SAFETY' IN THE TUSCANY HEALTH PROMOTING HOSPITALS NETWORK: FROM TRAINING TO PROJECT

Fabrizio SIMONELLI, Lucio COLONNA, Liviana TAVANTI, Maria José CALDÉS PINILLA, Katalin MAJER

THE CONTEXT

The Tuscany HPH Network develops different levels of activities: the implementation of projects on specific health issues shared by the Local Health and Hospital Units is the most outstanding. Among these there is a project on safety in hospital in a health promotion frame, which includes the Local Health Unit of Arezzo (as co-ordinating centre), the Local Hospital Unit of Florence and Pisa, and the Local Health Unit of Siena.

THE WORK DEVELOPED

The intercorporate Working Group has started a specific training programme, composed by five seminars for operators participating to the project. It represented the starting point for a structured intercorporate HPH project because of the hugeness of the issues related to the common project-making and the heterogeneity of the professionals.

The principle aim of the seminars was the presentation of the HPH philosophy and the elaboration of the 'active safety' notion as a reference conceptual frame for the project-making, based on considering health workers and patients as protagonist for the safety in hospital. In fact, the HPH project conceives people (patients, professionals, local community) as active subjects involved directly in the management and improvement of health. This kind of approach needed a more complex idea of safety: there should be a shared distinction between 'passive safety', the one based on adaptation rules, from an 'active' one, acted by people inside the hospital and personally involved in this process.

On this basis, the training process was divided into three

phases:

- Study of the initiatives made by Tuscan hospitals on the safety issue.
- Analyses of the experiences, 'choosing' those in the health promotion field.
- Re-elaboration of the experiences and their synthesis in a shared project based on the 'active safety' concept.

SUB-PROJECT AREAS AND WORK PROGRAMME

The project-making has been characterised by a very innovative approach: the training process as starting point through the synthesis of experiences led to the shared project, adopting the reticular planning method.

Main outcomes of the training process have been:

- Identification of five sub-project areas and elaboration of their work programmes:
 - Prevention of pressure sores
 - Prevention of falls
 - Treatment with central intravenous catheter
 - Safety in the antitubercular therapy
 - Prevention of latex allergies
- Identification of the attended results
- Officialisation of the elaborated intercorporate project

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HOW TO USE THE EFQM EXCELLENCE MODEL TO EMPOWER PATIENTS & STAFF TO CREATE A LATEX-SAFE ENVIRONMENT

Karen CUNNINGHAM

The use of latex gloves and other latex medical products has increased significantly in response to a growing recognition of bodily fluids as a source of transmitting infectious agents. Natural rubber latex offers a high level of protection against infectious agents, but its increased usage has been accompanied by a growing number of people with latex sensitivity. Natural Rubber Latex (NRL) is recognised as a sensitiser or substance hazardous to health.

In addition, particular groups of people who experience frequent or prolonged contact with latex; those with certain food allergies and those with a history of atopic conditions or a history of contact dermatitis are also more likely to exhibit hyper sensitivity to such products.

Green Park Healthcare Trust has a duty to prevent or control exposure to NRL and to provide specific information on latex allergy to all relevant persons. Green Park Healthcare Trust were awarded the EFQM Mark of Excellence by the NI Quality Centre in 2004. We intend to use of EFQM Excellence Model to illustrate how the process of Managing Latex Sensitisation is working in practice.

The Trust has facilitated the development of a latex free environment through the Health & Safety Manager & Directorate Manager in conjunction with a multi-professional group representative of staff throughout the organisation. The Trust has liaised with suppliers/manufacturers and external advisory bodies in developing its policy and creating a latex-safe environment.

Awareness of latex sensitisation has been improved through the use of patient information posters, education programmes and information leaflets for staff, use of risk discs and patient questioning prior to admission / treatment and communication between health professionals. In addition the Trust has developed local protocols in each ward/department to manage latex sensitised individuals and only uses latex-free examination gloves and other medical products (where possible).

This approach is creating a safer working environment by reducing the numbers of reactions from contact with latex containing products and cancelled operations, due to a lack of prior notification to prepare for such.

The Trust organised a Regional conference on the Management of Latex Sensitisation in April 2003 and a further conference is planned for October 2005.

The Trust has also recently revised its Trust policy, local protocols and undertook an internal Audit in the form of a staff survey and observational Audit. In 2004 the Trust was also awarded a Regional Award for European Week of Health & Safety, for their submission on the Management of Latex Sensitisation.

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EMPOWERMENT OF PATIENTS IN A MEDICAL REHABILITATION UNIT THROUGH THE DEVELOPMENT OF A LIVING/WORKING SPACE-A SENSORY GARDEN

Mary KELLY

The Medical Rehabilitation unit opened in 2001. It provides rehabilitation for patients who have suffered a neurological event. Patients range in age from 18 years onwards. The initiative to develop a sensory garden is intended as part of a holistic care approach for patients to enhance the living environment of the unit. A multi-disciplinary team comprising staff from the unit, health promotion staff, consumer, horticultural and gardening 2 staff, physiotherapist and occupational therapist have ensured that this garden has been designed to meet the many needs of patients within rehabilitation programmes. It provides a supportive environment to address not only the treatment of illness but also the promotion of positive health. Early evaluation of the project highlights many advantages of the project:

- Availability of therapeutic gardening activities
- Ease transition from home to hospital and hospital to home
- Privacy to learn to walk on the many different surfaces and levels of the garden
- Enhancement of all the senses
- A private area for practicing car transfer
- A sensory environmentally friendly area in which patients can spend quality time with family and friends

With the gradual unfolding of each season patients will have an opportunity to experience a deep sense of the harmony and continuity of nature. The garden is in its infancy but as the months and years turn new sights will be revealed which constantly serve to raise the spirit, excite the eye and importantly enhance well being.

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ARTS IN HEALTH - THE EMPOWERMENT OF PATIENTS AND STAFF: A COLLABORATIVE PRESENTATION BY ARTS CARE NORTHERN IRELAND

Lorna HASTINGS, Jenny ELLIOTT

This presentation will contain two strands:

- Presentation by Lorna Hastings - Director of Arts Care
- Presentation by Jenny Elliot - Arts Care Dancer in Residence, S&E Belfast Trust

Overview of Arts Care

Lorna HASTINGS

Arts Care is a Charity in Northern Ireland which employs 17 artists in residence as well as many project artists. How it has become part of the hospital and healthcare infrastructure.

Discussion of recent research carried out by Lorna Hastings into the benefits to Older People of involvement in the Arts, i.e.:

- Increased Social inclusion
- Positive Communication between health professionals and patients/residents/clients
- Development of new skills
- Life long learning
- Enhancement of well being
- Empowerment to be involved in improvement of their health environment

How patients and staff can have input into public art in hospitals

Jenny ELLIOTT

This research seeks to explore whether a dance-based programme may contribute to well-being by examining and mapping the personal journeys of service users and staff through the different processes of a dance training programme to a final public performance.

THE AIMS ARE

- To design a creative dance project based on Laban Principles of Movement for use with people with brain injury and the staff who work with them
- To illustrate how a creative dance project can enhance the well-being of persons with enduring brain injury, examining for example, the impact on self-confidence and functional movement

LOCATION OF STUDY

Neuro-Behavioural Rehabilitation Unit, South and East Belfast Health and Social Services Trust, Belfast and Belvoir Community Performance Theatre

RESEARCH CONTEXT

The N.I. based charity ArtsCare has sustained a thirteen-year relationship with Health Trusts, engaging 17 artists-in-residence and many project artists in twenty-two health facilities throughout Northern Ireland. South and East Belfast Health and Social Services Trust has demonstrated its future commitment to the Arts in Health by recently funding the refurbishment of a disused building in Knockbracken Healthcare Park and creating a multi-media arts studio for use by patients and staff.

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FOOD AS TREATMENT- PROMOTING THE 'HEALTHY' FOOD CHOICE IN HOSPITAL.

Niamh FITZPATRICK, Bernadette MALLON, Shelia DONLON

The hospital food service is often regarded as an issue that can be addressed separately to patient treatment, a hotel service. Few hospitals offer patient menus clearly indicating a healthy choice.

On reviewing current practice in Europe regarding hospital food provision, the Council of Europe (Beck et al 2001), outlines 5 major problems:

- Lack of sufficient education
- Lack of influence of the patients
- Lack of co-operation among all staff groups
- Lack of involvement from the hospital management

To solve the problems highlighted a combined team effort was recommended that included national authorities and all staff involved in nutritional care and support, including hospital managers.

The provision of meals should be regarded as an essential part of the treatment and as an opportunity for all staff to promote the appropriate dietary choice.

Every patient should have the opportunity and be encouraged to make the correct healthy choices.

In Cavan General Hospital a multidisciplinary nutritional steering committee was established 2004, with the following aims:

- Enhance the quality of the food service so that patients with varying disease states e.g. (malnutrition, diabetes mellitus) are enabled to become empowered to actively partake in their treatment.
- To encourage staff to health promote correct food choices.
- Improve the hospital menu and ordering system to make the healthier choice the easier choice
- Encourage staff and patients to take responsibility for their dietary treatment while in hospital
- Create a supportive setting for vulnerable groups e.g. (malnourished patients, ethnic minorities) by improving, hospital routines and infrastructures.

The committee divided the process into the following three phases:

- Where we are now? - Review of best practice, Audit, Presentation to management and all hospital staff.
- Where do we want to go? -Create a vision for food service.
- How are we going to get there? -Change management, partnership, monitoring & audit.

This is an example of how evidence based practice can be used to inspire a diverse multidisciplinary team that would not normally work together. Each member of the team will contribute to developing a holistic model for service provision to improve patient care and lead to better health outcomes.

DEFINITIONS

Multidisciplinary team - consisting of- two nominated link people representing the following areas: nursing, medical, nursing management, hospital management, dietetics, patient, auxiliary, catering -kitchen and ward, clinical nurse specialists, physiotherapy, occupational therapy, radiology, speech and language therapy portering, nursing practice development.

Audit - Using the Nobles essence of care document, and the Irish Nutritional guidelines (in press) 3 audit were carried out December 04 - nutritional menu analysis, patient audit, systems audit, observation at meal times.

Foodservice - a system in which meals are produced and service for hospital patients, in professional context. The system includes the food premises, the production and distribution technology and human resources involved in management, production distribution and serving.

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SESSION II-6: MOTHER, PARENT AND BABY FRIENDLY HOSPITALS & COMMUNITY HEALTH ISSUES

EMPOWERING WOMEN, EMPOWERING MIDWIVES: PILOT MIDWIFERY-LED UNITS IN THE REPUBLIC OF IRELAND

Bernadette FLANNAGAN, Helen MURRAY, Declan DEVANE

INTRODUCTION

Subsequent to the recommendations of the 'Report of the Maternity Services Review Group' the first midwifery-led units in the Republic of Ireland were established in the HSE - North Eastern Area on a pilot basis and within the context of a randomised trial known as the 'MidU study'.

BACKGROUND

The care provided in the Midwifery Led Units (MLUs) at Cavan General Hospital and at Our Lady of Lourdes Hospital, Drogheda is based on the philosophy of pregnancy and childbirth as normal, physiological, life-changing events. The care provided by the midwifery-led unit (MLU) is based on the philosophy of pregnancy and birth as normal physiological processes. The unit seeks to promote this philosophy by recognising, respecting and safe-guarding normal processes during normal pregnancy, birth and the postnatal period. The MLU provides a programme of family-centred care within a relaxed, home-like and informal environment for healthy women before, during and after normal pregnancy, labour and birth. The woman is respected as the primary decision maker and midwives assist her in this process through the provision of accurate and unbiased information on which to base informed choices. Recognising the benefits of continuity of care and carer, the MLU seeks to maximise these throughout pregnancy, labour, birth and the postnatal period. This holistic view of birth, which places the woman at the centre of the birth experience, translates into a model of care that empowers both women and midwives.

CONCLUSION

This paper will present details on the innovative midwifery-model of care within the HSE - North Eastern Area highlighting, in particular, how this partnership model of care might empower childbearing women and midwives alike.

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POSITIONING OF 18-HOUR BREASTFEEDING COURSES IN NURSE EDUCATION

Mary HEALY

Breastfeeding is normal. However we live in a world where it is viewed as a key public health measure, which is important to the mother and child (UNICEF, 1998; Sikorski et al., 2002). In this current climate, promotion of breastfeeding requires the active involvement of everyone in the health services. Health workers can play a key role in the protection, promotion and support of breastfeeding. The critical role of breastfeeding knowledge, skills, and education for health care workers is stressed in the interim report (Dept of Health 2003). There have been significant changes in breastfeeding education in Ireland over the past ten years. This thesis endeavours to explore nurse training in breastfeeding from the perspective of experienced trainers of the 18-hour breastfeeding course. The exploration is carried out through the lens of adult education and from a systems perspective. A qualitative research design was employed, using semi-structured interviews as a means of gathering data from five trainers.

The research project elicited qualitative data and a thematic, grounded analysis was conducted as described by Burnard (1991). Findings revealed that trainers on the 18-hour Breastfeeding course around the country face many challenges. There is no standardized course. Only one formal audit of an 18-hour Breastfeeding course has been done over the past ten years. All trainers, while being qualified and practicing midwives, are also International Board Certified Lactation Consultants. Trainers who are in Clinical Midwife Specialist posts seem to have a more formal, supported structure where the role of trainer is incorporated into their job description. Other trainers do not seem to have that structure and support, particularly those in the community. Findings also reveal serious concerns related to secretarial support and training in the use of audio-visual equipment.

There needs to be an urgent review of the course structure and delivery at national and regional levels. This review should be done in partnership with representatives from third level institutions involved in midwifery training and representatives from the Nursing Midwifery Planning Development Units. This curriculum content review should consider the development of modules based on adult education theories. This would allow for a more participatory and reflective type of learning to occur.

The trainers are, despite the current challenges, all very aware of the learning needs of the course participants and because they are all involved in clinical practice, very in tune with the needs of the Irish breastfeeding mother.

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ACHIEVING BABY FRIENDLY STATUS – ONE ASPECT

Margaret O'LEARY

St. Munchin's Regional Maternity Hospital, Limerick has reached the standard of a Baby Friendly Hospital under the WHO/UNICEF Baby Friendly Hospital Initiative. This initiative was launched in 1991, by WHO/UNICEF to counteract the worldwide decline in breastfeeding.

The Hospital has been involved in the initiative since 1998. Following a certificate of membership, the hospital received a certificate of commitment in 2000 & renewed it in 2002.

In order to receive the award in 2004, the Hospital had to adhere to the 10 steps to successful Breastfeeding as outlined by WHO & UNICEF & adhere to the International Code of Marketing of Breast Milk Substitutes & its subsequent resolutions. The award followed a number of very rigorous assessments by a team of external assessors.

SPECIFIC TASKS

As it would not be possible to discuss all aspects of BFHI we are specifically focusing on Skin to Skin contact. How this was achieved?

Staff Education:

- 18 hours training in Lactation Management became mandatory for all midwives.
- 4 hour refresher courses offered to staff who had previously attended 18 hour course (more than 5 years).
- Video tapes on wards outlining the medical benefits of skin to skin contact.

Client Education:

- One to one advice in Ante Natal Clinic
- Ante Natal classes
- Breastfeeding skills workshop
- Written information

Change in Practise:

- Aim to initiate skin to skin contact immediately as part of uncomplicated birth.
- Skin to skin contact initiated as soon as possible in other births.
- Skin to skin contact offered to mother on transfer to postnatal wards.
- Skin to skin contact offered following baby's bath.

EVALUATION

The Regional Maternity Hospital is now a Baby Friendly Hospital. In order to audit our care in January 2005 we commenced a research project to audit skin to skin contact.

This involves

- A questionnaire to be completed by 100 randomly selected pregnant (37 weeks +) women.
- A questionnaire to be completed by 100 randomly selected mothers (day 3).

- Qualitative analysis, involving in depth interviews with 5 breastfeeding mothers.

This will summarise clients' perceptions & experiences of skin to skin contact. This study is in progress & results will be available in March 2005.

CONCLUSION

The WHO/UNICEF Baby Friendly Hospital Initiative has been integral to virtually every Breastfeeding Strategy since its inception in 1991. Its implementation has been proven time & time again to result in a marked improvement the breastfeeding initiation & duration rates in both developed & underdeveloped countries across the world.

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MINIMIZING HEALTH RISKS OF EXPECTANT MOTHERS: EMPOWERMENT OF STAFF AND PATIENTS

Keith CERNAK

Partners For A Healthier Community (Partners) is a collaboration of Seattle health systems that has created continuum of care initiatives to address two high risk health issues of expectant mothers i.e. domestic violence and smoking during pregnancy. These initiatives involve a multi-tiered strategy of empowerment including: training hospital/clinic staff, counseling patients and reinforcing health promotion messages on a broad based community level.

Partners has found expectant mothers to be at "key teachable moments" making them more receptive to interventions and messages to protect themselves and their unborn child. To leverage from this Partners has created a training program for obstetricians and prenatal care nurses/staff who are the "critical front line" to be empowered in recognizing the earliest warning signs of and counseling for domestic violence. To empower expectant mothers to overcome the fear and stigma of domestic violence, Partners has extended critical community supports along a continuum of services while simultaneously reinforcing the need to take action through a broad based community message campaign. Partners' hospitals have created an early warning and support system for one of our community's most vulnerable populations.

This multi-tiered approach is also applied to expectant mothers who are smoking in our community. Partners has created smoking cessation workshops for health professionals to counsel expectant mothers at "gateway" office and hospital visits. To further reinforce this effort Partners has simultaneously implemented a major community awareness campaign called "Weigh The Risks".

In a community where nearly one third of women will be domestic violence victims and more than 25% of expectant mothers smoked, this presentation will highlight how these initiatives significantly reduced smoking during pregnancy and significantly increased requests/referrals for help for domestic violence among pregnant women by empowering

health system staff and patients alike.

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**EMPOWERING FOR HEALTH: BRIDGING
THE GAP BETWEEN HEALTH PROMOTION
THEORY AND CARE FOR CHRONIC ILLNESS**

Carol MCWILLIAM, Evelyn VINGILIS, Moira STEWART,
Gina BROWNE, Catherine WARD-GRIFFIN, Jeffrey HOCH,
Allan DONNER, Peter COYTE, Sandra GOLDING, Sandra
COLEMAN, Mary WILSON

Prolonged and intensive care management makes promoting health as a resource for everyday living challenging. Patients requiring chronic care often adopt the health care system's focus on their chronic conditions and related problems, overlooking their own potential for health, despite chronic illness.

The purpose of this quasi-experimental research was to evaluate an evidence-based approach to a health-oriented flexible client-driven approach to care management. The intervention was designed to empower chronically ill people as partners in their health care management by engaging their equitable exercise of personal knowledge of their health status and needs, skills for self-care, and decision-making abilities to promote their health.

Researchers obtained a stratified random sample of a total of 1813 clients, including three groups of clients over 65

years with primary diagnoses of arthritis, cardiovascular disease or respiratory disease, and a fourth group of clients aged 18 to 64 years with chronic functional limitations classified as disabling. Half of this sample received care through a home-care organization using the empowering partnering approach to care management, and half through a comparable organization approximately 200 miles away, that managed care in the usual way.

Care outcomes were compared using data obtained from organization records and client surveys. While mediating policy changes during the two year observational period precluded conclusive evidence, comparisons of mean health status, quality of life, independence, health-promoting effort, service utilization and costs of care supported the appropriateness of the empowering partnership approach.

Both these and qualitative evaluative findings suggest the importance of prolonged intervention implementation, longer longitudinal study periods, controlled policy contexts and transformative change strategies. All might enhance efforts to bridge the gap between health promotion theory and care for chronic illness.

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Parallel Sessions III: Friday, May 20, 2005, 11.45-13.15

SESSION III-1: HEALTH PROMOTION FOR CHILDREN AND ADOLESCENTS IN HOSPITALS

**HEALTH PROMOTION FOR CHILDREN AND
ADOLESCENTS IN HOSPITALS (HPH-CA):
UPDATE ON THE PROJECT DEVELOPMENT
AND THE ACTIVITIES OF THE SPECIFIC HPH
WORKING GROUP**

Fabrizio SIMONELLI, Maria José CALDÉS PINILLA, Katalin
MAJER, Paolo Morello MARCHESE

BACKGROUND AND PRECEDING WORK

On the occasion of the 11th International Conference on Health Promoting Hospitals (HPH) in Florence, May 2003, the WHO European Office for Integrated Health Care Services has welcomed the proposal of the HPH Network of Tuscany to develop a project on the theme of 'Health Promotion for Children and Adolescents in Hospitals'. A mandate was given to the A. Meyer University Children's Hospital of Florence to define the draft of the project. Successively, a specific working group has been constituted for the development of the project, with the task of the development of the planning and scientific aspects of this topic.

The most important milestones were represented by:

- The 1st WHO Workshop on this issue (29-30 April

2004, Barcelona, Spain), with the discussion of the project elaborated and the identification of the operational perspectives.

- The 12th International Conference on HPH (26-28 May, 2004, Moscow, Russian Federation) where the programme elaborated by the Working Group has been officially presented in the 10th Workshop of the National/Regional Network Co-ordinators, and a specific parallel session has been organised.
- The 2nd WHO Workshop on 'Health promotion for children and adolescents in hospitals' (8 December 2004, Amsterdam, The Netherlands), with the presentation of the development level of the project and the definition of the next steps of it.

**DEVELOPMENT LEVEL OF THE PROJECT AND
WORKING PERSPECTIVES**

During the specific parallel session an overview on the project development has been presented, including the outcomes of the Amsterdam workshop and the first results of the HPH-CA Background Survey (which has involved 114 children's hospitals and paediatric departments of general hospitals from the WHO European Region). Key concepts on the theme of health promotion for children and adolescents

in hospitals have been illustrated. Also, precise organisational references regarding the development of the activities and indications on the new work perspectives have been provided.

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TELETEACHING PROJECT: A SCHOOL FOR FRIEND

Maria Cristina ALESSANDRELLI

WHAT IS TELETEACHING?

Teleteaching is for children who for one reason or another are unable to participate in the conventional education system, normally due to hospitalization. Teleteaching offers the opportunity to integrate and learn from the hospital bed, not only with a teacher but with other groups of children, using the technology of video communication.

PARTNERS

- Marche Region
- Presidio Ospedaliero di Alta Specializzazione "G. Salesi"
- Institute Comprensivo Ancona Centro
- Aethra - Telecommunication Society
- Telecom Italia
- Voluntary Association

In October 2001 the partners subscribed to a Project agreement and later renewed in October 2004.

TECHNOLOGICAL EQUIPMENT

- N.° 3 Video Conference System
- Easy use and Transport to schools
- Specialized hospital units such as post operative and cancer wards
- ISDN line.

TARGETS

This videoconferencing equipment is designed to target children recovering in hospital between the ages of 10 and fourteen.

OBJECTIVES

- Enable students to utilise their "Right to Education" using "Distance Learning".
- Help to alleviate isolation from schooling by integrating the student with others of a similar condition, providing company and an opportunity to exchange thoughts and ideas.
- To heighten Scholastic interest/motivation and to maintain interests and contact out with the hospital.
- To advance the emotional, social and learning capacity of the individual.
- Strengthen the assistance to child.

OPERATIONAL PHASES

- Education of personnel and interaction with the system.
- Organise participation with the children concerned.
- Create and agree a learning program with the external

schools.

TEACHER/STUDENT TRAINING

- How to use Video Communications
- Psychologic/Emotional aspects
- Communication Techniques
- Hospital Visits

POSITIVE ASPECTS

- The teacher directs the lessons outwith the conventional learning environment.
- Lessons are organised by the external schools
- The patient increases motivational, concentration and emotional skills

THE OUTCOME

To realise a positive learning situation for the parents, teacher, doctors and above all, the student.

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MUSIC IN HOSPITAL: ACTION AND RESEARCH

Andrea MESSERI

"Music in Hospital" is a European project for the humanization of the hospital which involves cultural, musical and health institutions. The experience was born in France fifteen years ago and it extends now to others countries such as Italy, Portugal, Germany and Greece. The AEMH - European Association for Music in Hospital - promotes every year occasions of exchange and workshop.

The primary objectives of this project are:

- The humanization of the hospital
- Improvement in the quality of life
- Redefinition of the perception of the hospital's social image
- Promotion of culture

In Italy the project started in 2002 with a partnership between Anna Meyer Pediatric Hospital, Anna Meyer Hospital Foundation and Athenaeum Musicale Fiorentino. Training professional action, musical action, research and evaluation's projects are carried on together.

In one year 2652 hours of musical action have been scheduled with the sponsorship of Anna Meyer Hospital Foundation and Athenaeum Musicale Fiorentino as a partner.

The evaluation project is conducted by an inter-professional group which has already worked on four researches.

The first one was a questionnaire which purpose was to measure the impact of the musical activity on the subjects involved. The result was an unanimous positive opinion of the project and a request it should continue.

The objective of the second research was to quantify the number of people involved in the musical action who were 756 in 2 weeks (98 hours). Spontaneous evidence were also

collected from the people present during the interventions.

The last two researches proved a significant reduction in the distress of the children during the drawing of blood and the medication of burns compared to the control group of children without music. The scales used were the OSBD and one for the musical relationship evaluation.

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IMPROVING THE ORAL HEALTH OF CHILDREN

James ROBINSON, Alison FENWICK

Oral health in children is a major public health problem in Scotland. By the age of 3 years over 60% of children from deprived areas have dental disease while by the age 5 years over 56% of all school children have some degree of dental disease. Over 67% of school children have dental caries in their adult teeth by age 14 years. A national target has been set to reduce the percentage of 5 years who have had any degree of dental disease to 40% by 2010. A number of initiatives have been put in place to address this health issue. Since many causal factors are related to lifestyle and socio-economics circumstances these have all been based within community and primary care settings.

While oral health in hospital is already a focus for children with specific illnesses, such as cardiac disease or those undergoing chemotherapy the role of the hospital service in dental health has largely been confined to one of treatment and restoration. However hospitals can also contribute to the wider health improvement strategy in other ways. Recognising this the children's hospitals in Scotland have come together to improve and maintain oral health for all children in hospital. A working group of nurses, dental surgeons and health promotion specialists is developing best practice guidance. The work programme includes:

- An audit of current practice in hospital
- A literature review
- Sharing of existing good practice
- Developing a 'tooth friendly' environment
- Developing care standards
- Development of screening programmes
- Improving oral hygiene practices
- Improving utilisation of dental health services

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NOTICE THE CHILDREN PROJECT 2003 - 2005

M. SAARINEN, Hilikka RÄISÄNEN, H. LEIJALA

OBJECTIVE

Parental mental illness overloads the whole family and is a risk for children's mental health. This project continues (since 1992) the long-term development and collaboration between the child and adult psychiatric units. The aims of the current project are to notice the children and families at risk; to prevent the social withdrawal; to give support and follow-up services; to develop applicable clinical assessment methods; to improve training, supervision and consultation and to introduce the child psychiatric viewpoint in adult psychiatry.

METHODS

The families are referred on a voluntary basis by the specialist in charge of the parent's psychiatric care. The child's and the family's situation is assessed by using the CBCL, TRF and YSR forms, home visits, family interviews and multiprofessional collaboration. Beardslee's Family and Mini Interventions are also employed. Appropriate forms of support and care are provided to the family. In addition, training, consultation and supervision are arranged for the staff in collaboration between the child and adult psychiatric units.

RESULTS

According to the preliminary results the project has received referrals concerning 42 families and 112 (0-22-year-old) home living children. To date, 46 % of 90 children and adolescents in 34 families have been referred to further examinations and support in primary health care or in child, adolescent or adult psychiatry. Secondly, every fifth of the healthy parents have been referred to psychiatric care or to treatment for alcoholic or medical abuse. Sixty-one (61) % of the families have been under the surveillance of child protection authorities, and 44 % have received support services. The final results will be published later.

CONCLUSIONS

According to preliminary findings the model of this project was successful. The training programme involving Beardslee's Family Intervention for basic level staff has been started. Both the families and the collaborating partners have experienced the project positively. Further development of this activity is one of the main focuses in our hospital.

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SESSION III-2: WORKSHOP: HOW CAN WE INTEGRATE MENTAL HEALTH PROMOTION ACTION IN HEALTH PROMOTING HOSPITALS?

HOW CAN WE INTEGRATE MENTAL HEALTH PROMOTION ACTION IN HEALTH PROMOTING HOSPITALS?

Eva JANÉ-LLOPIS, Christina DIETSCHER, Jürgen M. PELIKAN

Mental health problems and mental disorders are common in people with physical illness and present in secondary health care, although unfortunately many times are unrecognized. For example it is estimated that up to 22% of people with myocardial infarction and 33% of people with cancer suffer from major depression. But many more, while not fulfilling the diagnostic criteria for a full-blown mental disorder, suffer from the mental health strain associated with the stress of chronic conditions or of being in hospital. In addition, stress, anxiety and associated mental health problems are also common in secondary health care workers, who are particularly at risk for mental disorders when exposed to the stressful working conditions that secondary health care setting can bring.

THIS WORKSHOP AIMS TO

- Identify the perceived groups at risk in the hospital setting that could benefit from mental health promotion.
- Identify existing health promotion practices in the hospital setting that could integrate a mental health promotion component, and what could be done.
- Explore how best mental health promotion could be accepted and taken on board in hospital settings.
- Link possibilities for action with the 18 core strategies of

the Health Promoting Hospital concept.

THE WORKSHOP WILL BE DIVIDED INTO

- 10 minutes introduction
- 10 minutes input on mental health promotion in the 18 core strategies of the Health Promoting Hospitals concept
- separation into groups and 40 minutes active group discussion on some of the identified aims
- 30 minutes feedback and discussion on how to integrate mental health promotion in secondary health care settings

It is aimed to use the outcomes and conclusions of this workshop to explore possibilities for setting up a mental health promotion initiative in the hospital setting.

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SESSION III-3: PAIN-FREE HOSPITALS

PAIN FREE HOSPITALS: THE EDUCATIONAL TRAINING OF HPH ITALIAN VENETO REGION NETWORK

Sabrina MARCONATO, Simone TASSO, Marco VISENTIN, Renata FERRARI

INTRODUCTION

In the Italian HPH Veneto Region Network a Pain Free Hospitals Project started in 2002 involving 12 Hospitals with a polycentric study on 1325 inpatients and 1636 hospital workers (nurses and physicians), showing a high pain prevalence (51.5% of patients) and a poor knowledge about pain management in the personnel : 51.2 % were the right answers in a 21 items questionnaire. Starting from these observations, a Regional Working Group (RWG) on pain management decided that the first step of the Project should be an educational training for the staff.

EDUCATIONAL TRAINING

RWG realized that the premise for a useful educational training was to adopt a same pain scale in all the hospitals. Numerical Rating Scale (NRS) for adult patients and Bieri Scale (for paediatric patients) were adopted by all the hospitals. This is important since it permits to compare the pain measurement made in the different hospitals and, consequently, a uniform educational training was prepared for the staff.

It was carried out with the following main contents on pain management:

- Health Promotion and its relationship with pain man-

agement

- Theoretical aspects (Physio-pathology and pain treatment)
- Practical aspects (right skills toward the patient with pain)

To help the work of educational trainer, RWG realized a video-cassette (and DVD) having the above mentioned contents. The video-cassette contains theoretical descriptions of pain management followed by scenes performed by actors in the roles of nurses and doctors who have wrong behaviours (first scene) and right behaviours (second scene) to face pain patients. In this way it was realized a sort of standardized role-playing.

Moreover, a hand-book was prepared, having the texts of the videocassette, including the scripts of the scenes performed by the actors, and telling about the right and wrong skills they had.

Educational Training started in may 2004 and it is still running. As long as today more than 700 persons were trained in our hospitals all over Veneto Region.

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DEVELOPMENT OF PROTOCOL FOR MANAGEMENT OF POSTOPERATIVE PAIN IN KAUNAS 2ND CLINICAL HOSPITAL

Grazvyde MASILIUNIENE, MACIJAIUSKIENE

The patient's well-being and quality of care in the hospitals are influenced by many factors, including pain control as well.

With the aim to increase compliance with pain management in surgical departments an initial evaluation of monitoring and treatment of pain was performed.

METHOD

Retrospective analysis of case histories from surgical and gynaecological departments had been performed.

RESULTS

Analysis revealed that 56.4% of patients in both departments experienced pain, although the reports on pain in case histories were incomplete and uninformative. Quantitative evaluation of pain was not reported; qualitative assessment of pain was not extensive and comprehensive. The given medications were reported in all cases of reported pain. Although the rationale use of pain killers was not assessed due to inappropriate documentation.

A team of specialists including surgeon, anaesthesiologist, gynaecologist, and nurse had developed the tool for postoperative pain management. The tool for reporting postoperative pain contains information on type of surgery, localization, time of onset and severity of pain. The prescribed medication according the established algorithm and their effectiveness are documented in the tool. Careful documentation of pain will allow close observation of pain and assure timely analgesia. The monitoring of pain with data analysis is performed based on the data from the pain tool.

CONCLUSIONS

- Pain is not well documented in the case histories.
- Development of new policy regarding pain contributes to quality assurance in the hospital.

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BONE PAIN PALLIATION: SUPPORTING ROLE OF STAFF DURING THE RADIONUCLIDE TREATMENT.

Galina SHAMARINA, Eve PALOTU

Recently, the health care community has recognised the importance of using Quality-of-life (QoL) measurement as an essential component of a treatment. QoL assessment can be helpful in weighting the risks and benefits of treatment options. Goal in treatment of bone metastases - relief of pain, thus improving patient mobility, function and QoL.

The aim of the study was to describe and analyse the aspects of the activities of nuclear medicine staff taking care of patients during the pain palliation with radioisotopes.

From the qualitative assessment on the patients' questionnaires it became evident that the patients want to participate in their treatment to get a sense of control over their disease. The study was approved by the hospital's ethics committee.

MATERIALS AND METHODS

Clinical experience gained during the period of 1995-2004 in 82 patients with bone pain due to metastatic cancer.

Methods for evaluation of QoL: pain descriptor scale, patient's analgetic use, physician's global assessment, questionnaires. The questionnaires examine the QoL specifically in a palliative care setting. The most important aspect is to pay attention to staff quality in pharmacological management.

RESULTS

58 of the evaluated patients (71%) experienced complete or substantial relief of pain due to the therapy. There was minimal improvement in 12% and no change in 17% of patients. Pain relief usually occurred within one week, the maximum response experienced approximately 4-5 weeks after the therapy. Duration of pain relief varied from 4 to 24 weeks.

CONCLUSIONS

Treatment with radioisotopes is an effective method for the palliation of metastatic pain providing relief in majority of our patients. As the therapy affects the site of pain without affecting central nervous system the patients really feel the improvement of their QoL. It is highly depended of staff management quality.

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ROLE OF A DEDICATED PAIN - NURSE IN THE PAIN FREE HOSPITAL PROJECT

Andrea VENEZIANI, Antonio MOLOSSO, Luisa GAROFOLINI, Brunella LIBRANDI, Vincenza FUSARI, Franca PICCA, Alberto APPICCIAFUOCO

The greatest difficulty of a project involving a big cultural and aptitude changeover to patient pain relief, is to take care that the initial investment on hospital health staff training doesn't remain fruitless. Basically the applicative phase of which the nursing pain evaluation in the wards is the key element, to guarantee an optimal (pain score <3) and steady analgesia even with therapy adjustments, must be promptly carried out as soon as possible. For this purpose, just from the beginning, nurses were stimulated and supported in pain scores recording and solving any problem by an applied dedicated nurse co-ordinating the postoperative pain control into an Acute Pain Service, according to a model proposed by Prof Rawal (Rawal N.10 years of acute pain services- achievements and challenges. Reg Anesth Pain Med. 1999; 24:68-73.Review). She also set up a data base for monitoring the service and pick up problems hindering the system implementation. Patients are enlisted in the theatre into a specially created program operating on a handled PC where

kind of operation, anaesthetic treatment and analgesic prescriptions are input.

Postoperatively several parameters monitoring the patient condition, the quality of analgesia and any side effect are recorded. A pain measure to implement the ward nurses recordings is assured facilitate the therapy correction and its efficacy control. One year data, concerning 1078 patients, (about one half of patients treatments), show that average surgical pain score after 3-5 hours from the term of operation, significant of the efficacy of the planned analgesic therapy (analgesia) changed from 3.36 to 2.57 in the second observational semester. Thanks to the dedicated nurse 576 times a therapy correction, sometimes a simple adjustment, generally successful was possible. The impact on the hospital of this new leading figure was absolutely positive. A more

complete evaluation of its efficacy over the time will be carried out analyzing some clinical prefixed indicators concerning the improving of pain relief in the hospital.

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SESSION III-4: EMPOWERING PATIENTS FOR HEALTHY LIFESTYLES

EFFECTS OF AN EXERCISE AND EDUCATION PROGRAMME ON PAEDIATRIC OBESITY

Edna ROCHE, Niamh CROASDELL, Elaine HERATY, Aishling BRENNAN, John GORMLEY, Christopher BELL, Hilary HOEY

Ireland, along with other European Countries, is experiencing increasing levels of childhood obesity. Obesity in childhood and adolescence is associated with cardiovascular risk factors such as low activity levels, low fitness levels, hypertension and hyperlipidemia. A previous study has demonstrated that 2/3 of children attending the weight reduction clinic have at least 2 of these risk factors.

The aim of this study was to evaluate the effect of an eight week exercise and education programme on cardiovascular risk factors. Children along with their parents attended the Physiotherapy Department weekly where the children had an hour of exercise and the parents received education in the areas of healthy nutrition and physical activity.

Nine children entered the programme (5 girls and 4 boys) with a mean age (SD) of 10 ± 1.1 years. Mean data before and after the programme and the difference were as follows. BMI: 29.2 ± 3.3 to 28.8 ± 3.6 (NS), waist circumference: 95.5 ± 8.8 to 93.7 ± 9.1 ($P < 0.05$) reported energy expended in regular activity in METs: 14.4 ± 12.7 to 36.3 ± 31.1 ($P < 0.01$, estimated exercise tolerance (VO₂): 33.8 ± 4.6 to 36.5 ± 6.9 (NS) and systolic blood pressure (mmHg): 121.4 ± 12.8 to 115 ± 10.3 (NS)

This eight week programme resulted in a significant increase in reported energy expenditure in regular activity as measured by METs and a significant decrease in waist circumference. These short term effects may be followed by longer lasting changes if activity levels are maintained.

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INVESTIGATING HEALTH PROMOTION PRACTICE AT A NHS FOUNDATION TRUST HOSPITALS - CURRENT PRACTICE AND IMPLICATIONS FOR THE FUTURE

Gary COOK, Richard EDWARDS

Current health policy in the UK emphasises the need for hospitals to move away from a "sickness service" to a "health-driven service" which enables the population to avoid disease through effective public health measures. While death from chronic diseases such as coronary heart disease and cancer is decreasing, the number of individuals living with these conditions is increasing. There is a wealth of evidence that changing certain behaviours such as smoking, alcohol intake, diet, and exercise reduces the incidence of these diseases. The fundamental issue is how can individuals achieve these changes? One route by which the NHS can assist individuals, is through hospitals providing health promotion ("the process of enabling people to increase control over, and to improve, their health").

This paper discusses the results of a series of research which investigated, through interviews, questionnaires, and a review of case notes, the current provision of health promotion to patients at Stockport NHS Foundation Trust Hospitals, and the attitudes of patients and staff toward health promotion at secondary care level. We will also discuss the impact on health promotion practice of a scheme (the Healthy Wards Scheme) developed to facilitate nursing staff in assessing patients' needs for health promotion and provide relevant advice and interventions to patients. These findings provide an insight into how hospitals can appropriately assess patients' needs for health promotion and provide all patients with information on significant factors and/or interventions concerning their disease and health condition.

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A MODEL FOR LIFESTYLE INTERVENTION IN THE HOSPITAL SETTING - EMPOWERING THE PATIENT THROUGH MOTIVATIONAL INTERVIEWING

Beth HAMMARSTROM

BACKGROUND

The hospital in Enköping, Sweden is a health promoting hospital where extensive work has been done to improve the health of the staff. This focus has increased the standard of health awareness among the personnel. The next focus was to improve the health of patients.

A national public health objective for Sweden is "a health and medical service that more actively promotes good health". The hospital leadership decided to work towards this objective by establishing a model for lifestyle intervention as a form of treatment within the hospital setting. The work was done as a project from 030901 - 041231.

PURPOSE

The purpose of the project was to establish an infrastructure for working with non-medical methods of treatment, stimulate the use of measurement of health results, educate the personnel and increase interaction within the community and public health care system.

RESULT

A concrete model was developed to establish lifestyle interventions as a form of treatment. A co-ordinator receives a referral from the treating doctor, she meets the patient for a motivational interview with the goal of empowering the patient to take steps towards changes in life style. The co-ordinator helps the patient come in contact with support groups in the community and the public health care system. This can involve help in stopping smoking, increasing physical activity, stress management and losing weight. Routines for systematic documentation of lifestyle were established in the computer based patient journal. The infrastructure for working with physical activity as a prescription has been developed in co-operation with the community and public health care. Further, the project has increased awareness and understanding of the relation of lifestyle to health for patients and personnel, educated personnel in motivational interviewing techniques and intensified the use of health measurement with SF36.

CONCLUSIONS

A model was developed to support the professionals responsible for patient care in empowering the patient to take responsibility for lifestyle changes. Lifestyle intervention was accepted as a form of treatment within the hospital setting. This has improved the quality of patient care and made it possible to increase general health in the community.

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"HOW DO YOU MEASURE UP?" AN ALCOHOL AWARENESS PROGRAMME FOR STAFF AND CLIENTS AND MEMBERS OF THE PUBLIC EMPOWERING THOSE WHO DRINK WITH SKILLS TO REDUCE THE HARM FROM ALCOHOL CONSUMPTION.

Tara ALEXANDER, Susan KENNY

RATIONALE

The aim of this alcohol awareness programme is to provide information about the harms and benefits of drinking so as those empower staff, clients and members of the public who choose to drink, with the skills and knowledge to enable them to reduce the risk of harm to their health. Also "Euridice" is a project currently being implemented in the North Eastern Health Board which aims to increase awareness among staff of substance Misuse and dependencies.

OBJECTIVES

- To provide clients, staff and members of the public with information on what constitutes low risk and high risk drinking levels.
- To provide those who choose to drink with the relevant information on how to avoid or minimize alcohol related harm.
- To increase knowledge and awareness of standard drinks and the factors to take into account when monitoring consumption of alcohol.
- To ascertain the baseline level of knowledge and awareness among this target group and put in place an information campaign to address any relevant deficits highlighted.

METHODS

- An awareness day was held in the Louth County Hospital facilitated by the HPH coordinator, the Regional Alcohol Misuse Prevention Officer and the hospital Euridice link person.
- Information stands were manned by the facilitators who challenged the hospital population to pour what they deemed to be a standard pub measure of spirits and then demonstrated the correct amount.
- Measures were then distributed to all for home use and information booklets gave relevant information on alcohol consumption.
- A quiz was disseminated to the target group with a separate prize for the winner among the staff and members of the public/clients.

RESULTS

- Evaluation of the "Awareness quiz" and "Measure Challenge" highlighted many areas where there was a knowledge deficit among staff and clients about low and high risk alcohol consumption.
- An information campaign is now ongoing which will address this deficit and its effectiveness will be evaluated in six months time when the awareness quiz will be repeated and the results compared with the baseline data.

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MAINTAINING ALCOHOL POLICY - A NEVER-ENDING STORY

Vibeke THYGESEN, Karin BIRTØ, Ulrik BECKER, Hanne TØNNESEN

INTRODUCTION

Since 1998 Bispebjerg University Hospital has been an alcohol-free hospital with an alcohol policy concerning staff-members. The aim of the policy is:

- To keep the hospital a healthy and attractive working place.
- To help staff-members to manage alcohol problems.
- To empower alcohol key persons (special educated staff-members) to discover development of alcohol problems among staff-members.

The purpose of the study was to evaluate the effect among staff-members of implementing an alcohol-free hospital policy.

MATERIAL AND METHODS

An anonymised questionnaire was sent to 3,606 staff-members during the period May to June 2003. The response rate was 75%.

RESULTS

6 % of staff-members compared to 10% of the general Danish population exceed the upper limit of alcohol intake. 83% of the staff-members knew about the hospital alcohol policy (64% in 1997), however only one third (35%) knew, who their alcohol key person was (31% in 1997).

The proportion of staff-members who exceeded the upper

limit of alcohol intake was highest among males 9.8% (4.3% for women), physicians (11.2%) and nonhealth care workers (11.1%) and among the medical departments (5.6%). 5% of all staff-members wanted to change their drinking habits.

CONCLUSION

Fewer in Bispebjerg University Hospital have an alcohol intake higher than the national recommendations compared to the Danish population.

Wishes from the staff-members have been discovered through the survey and seen in connection with, that 5% of the staff wanted to change their drinking habits there is a basis and potential for intervention. A number of activities were carried out to empower staff-members.

85% knew the policy however only 35% knew their alcohol key person. There is a need for more and different information and visibility to fulfil the policy. Maintaining alcohol policy is still a challenge - a never-ending story.

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SESSION III-5: EMPOWERING PATIENTS FOR CHRONIC DISEASES – CARDIO-VASCULAR PROBLEMS, AIDS

PATHWAYS OF INTEGRATED CARE FOR PATIENTS AFFECTED BY HEART FAILURE

Mariella MARTINI, Rosanna CARBOGNANI, Maria Giulia CALZARI, Stefano BENDINELLI, Paolo PIETRANERA

Until now chronicity has been regarded as a series of acute events in a fragmented and non-organised process. Operators think it is scarcely efficient and it does not allow any integration/communication with other professionals, whereas the feeling of users emerging from histories of disease, is one of abandonment. Based on new epidemiological evidence, which indicates growing numbers of users with chronic pathologies linked to the increase in life expectancy and the possibilities of treatment, the Health Board decided to create an integrated pathway for hospital-local care for one of the most frequent chronic pathologies. This aims at improving the organisation and quality of life of patients, patient empowerment (considered as responsibility for the co-management of pathology, knowledge of individual pathway, aware access to services), guaranteeing the continuity of treatment and reducing or preventing inappropriate hospital admission. In 2003 there have been 2268 admissions to hospitals in the province for heart failure, corresponding to 1892 patients.

The pathway was constructed around the individual requiring treatment, who becomes the protagonist of his/her own health project through a therapeutic alliance with the medical system. The phase of promoting health becomes therefore fundamental. This is understood as education to promote suitable lifestyles, the interpretation of early symptoms, the

efficient management of treatment. The pathway normally starts with admission to hospital or a specialist outpatient appointment, after which two main aspects develop: the diagnostic-therapeutic aspect and that of health promotion. The latter is extended through the local health service using shared protocols, which allow access to the general practitioner, the area specialist, the hospital, as integrated and communicating points of the same network.

PURPOSE AND AIMS

To realise an effective and measurable model for the integration of treatment.

METHODOLOGY/ACTIONS

The working group is divided into three sub-groups: the first worked on drawing up valid diagnostic and therapeutic guidelines for all the operators in the province; the second worked on setting up four different pathways depending on the patient's NYHA class and on deciding the expertise of the various professionals; the third group was responsible for designing a training pathway for professionals and creating an educational project for the patient and the family (ongoing education offered by professionals, in particular General Practitioners; annual meetings with dieticians, rehabilitation therapists, psychologists; delivery of information leaflets and a recipe book containing suitable diets; delivery and instructions for filling in self-monitoring forms on weight, pressure, physical activities and pharmacological compliance).

MAIN TARGET

Patient and family, medical and nursing team.

EVALUATION OF RESULTS AND CONCLUSIONS

We have identified two types of indicators: indicators of process (use of instruments created by the working group: follow-up form, self-monitoring forms, delivery of information leaflets, etc.; appropriateness of treatment; appropriateness of admissions; etc.) and indicators of outcome (number of patients followed with the designed pathway; etc.).

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A SUSTAINABLE CARDIAC REHAB STRESS MANAGEMENT PROGRAMME WHICH ENABLES CLIENTS TO TAKE CONTROL OF THEIR STRESS LEVELS.

Nuala McKEOWN

OBJECTIVE

To provide patients with an overall package to help them reduce the effects of stress on their heart that would be sustainable and could extend to family members. Also to empower these clients to take responsibility for their own stress management on the completion of the programme.

METHODS

An information pack was designed containing information on how to recognise stress with simple techniques on how to deal with it and how to recognise successful coping with stress and thus empowering patients to manage life stressors. Also a relaxation CD was developed and produced for the patients by the coordinator of the unit and Nuala McKeown B.Sc. (Hons) Psych who is the narrator on the C.D. The C.D., or audio tape if appropriate, is then made available for purchase at the nominal sum of five euro for home use. This charge is waived if necessary which makes the programme equitable and accessible to all clients.

EVALUATION

A Hospital and Anxiety and Depression Score (HADS) was recorded on commencement of the programme and at its completion in order to evaluate the programme. An evaluation questionnaire was also completed by patients on completion of the programme.

RESULTS

HADS scores on completion of the programme were greatly reduced. In all cases HADS scores were less on completion of the programme. Some of the qualitative comments on the evaluation of the CD included 'It's the first time I've had a decent nights sleep in years'.

CONCLUSIONS

This programme has now been extended to include sessions for staff with the option to purchase the C.D. Feedback from staff has been positive and the C.D. has gone for reprint.

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WAYS PROMOTING QUALITY OF CARDIOLOGIC CARE

Leonid BARBARASH, Galina ARTAMONOVA, Sergey MAKAROV

To create high-quality medical service we need to find out its necessity. The requirements of patients, hospital doctors and healthcare managers are different. Thus, major quality characteristics for patients are conformity with expected needs, attentive and polite staff, alleviating disease symptoms. Hospital doctors need, first of all, compliance of assistance rendered by them with modern technical equipment. Healthcare managers require maximal reduce of population's invalidization and effective usage of medical resources.

How can we combine such different needs? What should we do to satisfy all the requirements, or in other words, to promote healthcare quality? Success of this work mostly depends on system-like thinking of people organizing medical care. Natural development of a system approach in management is a situation analysis. It determines inner and outer factors more exactly and evaluates their influence on a healthcare organization. State of population's health is characterized by high level of circulatory system pathology during the last few years. That is the main reason for mortality and limited ability to work. That leads to economic losses for the society and for the patient himself. Creating continuous cyclic cardiology care in the context of one legal entity in such a large industrial city as Kemerovo really provides continuity of ambulatory, hospital and sanatorium-and-rehabilitation steps. The united structure of a cardiology centre is unique for Russia. Our experience shows that there is a growth of cardiology care accessibility for the population. That provides consolidation of conservative and surgical ways of treatment of cardiovascular diseases, helps to carry out qualified patients' screening for the cardio surgical treatment, and stimulates medical technology and staff professionalism development. Timely diagnostics and treatment raise clinical and economic efficiency of the whole cardiology care system.

Thus, these are the results achieved during the ten-year development of the cardiology centre in Kemerovo:

- The average duration of acute myocardial infarction treatment was reduced by 11.3 days, and on the whole by 3.8 days in the profile.
- The level of cardio surgical activity has grown twice with the same level of reduction in death after surgery.
- Patients' stay in a hospital is 3 days less before the operation and 2.6 days less after it.
- Cardiovascular death growth rate among the population in Kemerovo region decreased from 30% to 15%.

This way cardiology care quality mostly depends on effective integration of cardiologists, neurologists and cardiovascular surgeons on the basis of united organization and methodological approaches in prevention, diagnostics, treatment and rehabilitation, and promotes better life quality for patients from the social point of view.

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MAINTAINING COUNSELLING NURSES FOR AIDS PATIENTS TREATED AT NICE UNIVERSITY HOSPITAL: THEORY VERSUS PRACTICE.

Laurence BENTZ, Nathalie ORAN, Jean Noël MAZZA, Michèle RUBOLINI, Maryline REBILLON, Pierre DELLAMONICA, Jean Gabriel FUZIBET, Jill Patrice CASSUTO, Catherine TOURETTE TURGIS, Christian PRADIER

A supportive care program for treated HIV-infected patients was implemented between 1999 and 2004 in 3 care units at Nice University Hospital, France. These counselling consultations were provided by specially trained nurses. Counselling, like most patient-centred approaches, calls upon the patient's personal skills and resources, and is in line with the patient empowerment trend developed in the health field. We have shown the beneficial impact of these consultations on treatment adherence as well as on laboratory results (HIV viral load).

The major aim of our study is to describe quantitative trends for this particular aspect of health care over the years 1999 -

2004. During this period more than 3500 nurse-conducted consultations took place in addition to medical consultations. The activity increased regularly between 2000 and 2002, then decreased by 20 % between 2003 and 2004. This downward trend was explained by difficulties in nurse recruitment, which penalized the entire organization of all hospital care units. The success factors were the proven beneficial impact on the health of treated HIV-infected patients, the acknowledgement of their importance by the institution (hospital management, physicians), the registered nurse's motivation for counselling practices and of course the patients' satisfaction. The main difficulty lies in maintaining or even developing this activity.

Our study shows the importance of this aspect of care but also its precariousness with regard to the financial difficulties prevailing in French hospitals and the lack of financial support for counselling activities in France to date.

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SESSION III-6: CULTURALLY COMPETENT AND MIGRANT FRIENDLY HOSPITALS – 2

ASSESSING “MIGRANT FRIENDLINESS” OF HOSPITALS – EXPERIENCES AND RESULTS FROM A EUROPEAN PROJECT

Ursula KARL-TRUMMER, Karl KRAJIC, Sonja NOVAK-ZEZULA, Jürgen M. PELIKAN

The European project “Migrant-friendly hospitals” (MFH), financially supported by the European Commission, (DG SANCO) brought together hospitals from 12 member states of the European Union who worked on the issue of migrant friendly hospital services.

Supported by a scientific organisation, the LBISHM, as coordinator, an international group of experts and supporting international organisations, the hospitals set up an overall project of developing migrant friendliness along with three thematically focussed subprojects (improving clinical communication, training and information in mother and child care, cultural competence training for staff) selected on basis of a needs assessment.

Sustainable improvements of complex organisations, like hospitals, can be achieved only within the framework of an overall organisational development process.

In line with quality management procedures, this process was initiated by defining core principles of migrant friendliness as follows:

- valuing diversity by accepting people with diverse backgrounds as principally equal members of society;
- identifying the needs of people with diverse backgrounds and monitoring and developing services with regard to these needs;
- and finally, compensating for disadvantages arising from diverse backgrounds.

Local overall projects were implemented to establish a framework for organisational development. To define and assess “Migrant Friendliness” an assessment instrument was developed. The “Migrant Friendly Quality Questionnaire” (MFQQ) monitors the status quo of overall “migrant-friendliness” concerning services and (quality) management structures. The MFQQ proved useful in systematically assessing migrant-friendly structures such as interpreting services, information material for migrant patients, culturally sensitive services (religion, food), as well as components of a (quality) management system to enable and assure the migrant-friendliness of services.

The MFQQ was used for two assessments (2003 and 2004) within the 12 European Partner Hospitals and – additionally – for 5 observer hospitals in Germany and Ireland, all locally organised within the Health Promoting Hospitals network. It proved to be feasible and informative, but experiences also indicate areas for further improvement.

The presentation gives an overview of the main results of the project with a focus on results from the two MFQQ assessments.

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EMPOWERING STAFF THROUGH CULTURAL COMPETENCY TRAINING, AS PART OF THE MIGRANT FRIENDLY HOSPITAL INITIATIVE PILOT PROJECT.

Fiona FALVEY, Catherine SHERLOCK

AIM

To increase staffs' understanding of cultural issues affecting our clients.

OBJECTIVES

- To improve participants' knowledge in relation to the health/social/economic status of migrants.
- Participants to identify the ways in which fear and prejudice can affect the way services are delivered.
- Participants to identify the main barriers to accessing the health services experienced by migrants.

METHOD

The overall Migrant Friendly Hospital Initiative Steering committee, chaired by the Health Promotion Officer and Social Worker, included representatives from:

- Senior Management
- Social Work Dept
- Health Promotion Dept, Psychiatry
- Galway Refugee Support Group
- Irish Refugee Trust
- Accreditation Dept
- Obstetrics-Gynaecology Division
- Accident & Emergency Dept
- Medical Records Dept
- Human Resources

A subcommittee was formed to develop a training pack. We were provided with best practice guidelines from the European MFHI project. We also used a Traveller Friendly Training Pack which had previously been developed, and successfully evaluated, by the Western Health Board Health Promotion Team. The training was 10 hours in length and was delivered over 3 days (approximately 3.5 hours each day) to staff in 2 pilots areas of the hospital: Maternity Outpatients' Dept and Ward Clerks.

The training pack included modules on:

- Relevant reading material
- What is Culture?
- Myths and Beliefs about migrants
- Health service providers' experiences of working with migrants
- Barriers to accessing our services
- A reflection on privilege
- Culturally sensitive work
- An audit of good practice

RESULTS

2 10-hour training programmes were delivered to ward clerks and staff in Maternity Outpatients' Dept. Evaluations have found the training programme to be very informative and useful.

CONCLUSIONS

Promoting a migrant friendly culture is an ongoing process. This pilot initiative has evaluated positively, and we are currently continuing beyond the pilot phase and expanding the training to the rest of the hospital. Much support came from the co-ordinating centre of the Initiative and from the other hospital involved in the initiative (James Connolly Memorial Hospital).

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CROSS CULTURAL MEDIATION AS ENABLER OF CARE. THE EXPERIENCE OF TRENTO HOSPITAL

Daniela CHIUSOLE, Enrico BALDANTONI, Elisabetta MON, Michela MONTEROSSO, Adriano PASSERINI, Carlo FAVARETTI

OBJECTIVE

The increasing number of foreign nationals using health care services make effective communication a key issue in the process of care since patients from different cultural areas usually experience difficulties in comprehension of the linguistic code and the rules of the Hospital. The purpose of this paper is to describe how cultural mediation could be a valuable tool for:

- Improving understanding of language and correct use of hospital services.
- Facilitating the connection between patients and health care workers.

METHODS

The service of cultural mediation in the Hospital of Trento has been offered since September 2004 thorough an agreement with AMIC Association (more than 30 mediators fluent overall in 11 languages) based on the relevance of the migratory drift.

- Preliminary Phase
 - Orientation course to Hospital rules targeted to mediators information needs (7 hours of training each)
 - Application forms for
 - Pledge of secrecy on personal data of patients (confidentiality of information)
 - Patient consensus to mediator intervention
 - Gathering of data
- Practical issues
 - Procedure for 24/7 mediator intervention on demand by units.
 - Written sheets with details of each intervention.
 - Monitoring of the activity supervised by customer satisfaction unit.

RESULT

- Preliminary data (4 months) show that:
 - The number of interventions (61) is according to the hours planned.
 - The service has been used by the units more accessed by foreign immigrants (16 out of 35; i.e. OBGYN, ED).
 - No particular problem has been documented.
- Evaluation of the intervention:
 - Has enabled mutual understanding (100 %)
 - Has facilitated relationship between workers and patients (82 %)

- Underuse of service (18 %)
- Has facilitated the comprehension of aspects connected to the ethnic-cultural belonging (41 %)

CONCLUSIONS

Assuming the rate of calls of intervention as a proxy indicator of the perceived utility by the employees, preliminary data show that usefulness of the service has been understood both by workers and patients, mainly during key steps of the process of care (i.e. plan of care, p&h., patient education, patient family rights, discharge). Cultural mediation is part of the compliance to Joint Commission International standards for Accreditation of the Hospital of Trento.

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THE DRAGON AND THE PHOENIX: THE CHILDBIRTH EXPERIENCE BETWEEN CHINESE COMMUNITY AND HEALTHCARE SERVICES

Piera BEVOLO, Marina SPARANO, Mara MANGHI, Sun SHUYAN, Laura PANNA

In the context of practical experience in working with Chinese women, the first childbirth preparation course aimed at expectant mothers of Chinese nationality was held at the Centre for Immigrant Family Health.

In our area, there is a sizable number of pregnant women and newborns from the Chinese ethnic group, yet healthcare workers are not very familiar with the birth and childcare conditions in the Chinese community. The members of this community are often living in conditions of illegality, in buildings which often also double as their workplace.

We are aware that families face difficulties in raising children in Italy. Child raising is often delegated to relatives who have remained in China, with periods of separation and reunion which create problems and risks for the process of parent-child bonding, and for the integration of Chinese children into our social context. Moreover, children often cannot be breast-fed because they are separated too soon from their mothers.

Language barriers, combined with the migration pattern of this ethnic group, that is apparently not inclined to integration, have meant that up until now health care services have played only a marginal role in prenatal care and delivery for

Chinese children and their parents.

PURPOSE AND AIMS

The above described observations resulted in a project to initiate a childbirth pathway especially built to meet Chinese women's needs.

METHODS/ACTIONS

Based on the experience acquired in previous pathways for immigrant women, in particular the one addressed to Arab women, we proposed open group meetings dealing with issues of pregnancy, birth, contraception, childcare, and child development.

The cultural-linguistic mediator has been a fundamental go-between in meetings with women and in the interpretation of their needs. In the multi-professional working group there was ongoing discussion of the proposals submitted to the group along the way, and of possible ways of management.

A strong point which aided participation in the experiment was dedicating part of the meeting to teaching language skills and Italian words related to birth. Moreover (as in other childbirth preparation courses), a visit was made to hospital facilities, allowing concrete visualisation of the pathway and direct knowledge with the healthcare workers women might encounter at the time of delivery.

PRIMARY TARGET

Pregnant Chinese women, the Chinese community, healthcare workers

RESULTS EVALUATION AND CONCLUSIONS

The number of participants has been quite satisfactory. As is always the case, participation has already corrected some operative stereotypes and those of the cultural approach of services; women had many requests; the level of trust and interest in knowing about the services was very high.

Though the situation is still experimental, the positive results are encouraging us to continue along this path and work on further improvements.

A questionnaire has been administered.

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SESSION IV-1: EMPOWERING PATIENTS AND CARERS TO COPE WITH CHRONIC CONDITIONS

THE LUCA DE NIGRIS AWAKENING HOME IN BOLOGNA (ITALY)

Fulvio DE NIGRIS, Alberto BATTISTINI, Teresa MONTELLA, Emanuela DALL'OLMI, Roberto PIPERNO, Maria VACCARI

Loneliness, fear and exceeding burden of care are perceived by the family when a young patient with severe brain injury (BI) is going to be discharged from rehab facilities. This often arouses the search for new chances of inpatient rehabilitation with an unrealistic hope of improvement. The lack of family information and their empowerment represent the critical factors.

The "Luca De Nigris Awakening Home" is aimed to empower the family during the post-acute rehab phase and to lead to the best home living. The project started in 1988 when an association of volunteers, "Gli Amici di Luca", began to cooperate together with the Local Health Service.

This facility is part of the Bologna system of care for severe BI. This system takes care of about 200 people per year, 40 among them needing long term care and at least 10 with a vegetative (VS) or minimally conscious state (MCS).

GOALS

- To offer a post-acute facility for VS, MCS or slow to recover survivors in an integrated pathway of care.
- To empower the family with special programs aimed to perceive a continuum with the home care.
- To test a setting for long term rehabilitation with a social ecology differing from a traditional hospital-based one.
- To pursue the best outcome by the appropriate observation for the whole post-acute phase.

METHODS

Formal information such as handbooks, lectures and multimedia tools, personal counselling and training, group opportunities and leisure events are aimed to accomplish a family-based model of care with a strong involvement of the family in decision making.

10 mini apartments allow one relative to live together with the patient and avail some facts and events that synchronize the familiar and the personal daily rhythms. Wide spaces for community activities, diagnostic and therapeutic laboratories complete the facility.

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HOW PATIENTS' EXPERIENCES HELP INSTITUTIONS TO IMPROVE CARE IN ONCOLOGICAL PATHWAY.

Sabina NUTI, Milena VAINIERI, Linda MARCACCI, Enrico DESIDERI

INTRODUCTION

To improve services, institutions need to listen the patients voice. The patient experience through the health care pathway can help institutions to point out the problems and to learn to design the organization putting the patient at the center of the service.

METHODS

Focus groups were performed on a group of patients affected by colon rectum neoplasia who had an operation during June-September 2003 in the hospitals located in three geographical districts. It was performed a focus group per district in the period between June and July 2004.

RESULTS

Overall patient were interviewed in district A, B and C, respectively. District C included a University Hospital and a Community Hospital. We choose the focus group technics because of the peculiarity of the studied disease. By a crossed reading of patients' experience we obtained two type of informations: how CORD is working (CORD is the structure which has the role of coordination of oncological pathway, according to the regional guidelines) and which are the strength ness and the weakness of the services delivered by each healthcare unit participating at the study.

The patient experience in benchmarking through out different institutions, has been useful for managers to start an internal process of reviewing critical points regarding above all humanization and care coordination along the health care pathway.

Particularly interesting is the case of the University Hospital of Pisa, where the patients indications allowed the institution to reengineering the process, to improve services and empower the communication skills of the physicians and nurses involved in the clinical pathway.

CONCLUSIONS

Patient point of view in oncological care was an easy tool for improving the health care pathway. It gives to health managers a simple method that allows the organization to evaluate services through the patients eyes.

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A CONTROLLED STUDY INVESTIGATING THE EFFECTS OF AEROBIC TRAINING ON PATIENTS WITH MULTIPLE SCLEROSIS (MS).

Ruth O'CONNELL

PURPOSE

Trials examining effects of aerobic training have found positive effects both physically and psychosocially, including fatigue and continence. This trial aimed to assess physical and psychosocial effects on those with mild disability.

RELEVANCE

Literature states that there is a wider gap between levels of ability and activity in the MS population than in any other studied group with chronic disability. The majority of patients are diagnosed young and lead sedentary lives, predisposing them to osteoporosis and cardiovascular problems. Lack of confidence regarding exercise is known to limit patients' social outlet. With deeper understanding, exercise could be encouraged and adapted as necessary.

SUBJECTS

24 patients were recruited in the South Dublin region. All patients were in relapse-remission stage of MS, independently mobile and neurologically stable for three months. They were allocated to the exercise (n=12) or non-exercise group (n=12).

METHODS

All participants were assessed before, after a three-month training programme and followed up at six months. Fitness, using a Modified Graded Exercise Test (MGET) and Borg's Perception of Exertion (RPE), ambulation, using the 50 Metre Walk Test (50MWT), and Quality of Life (QOL) were measured, using the Multiple Sclerosis Impact Scale-29 (MSIS) and Functional Assessment of Multiple Sclerosis (FAMS). The exercise group attended circuit style, hour-long classes, twice weekly and exercised once weekly independently. Heart rate was monitored during training.

ANALYSES

Changes from baseline were compared using the Kruskal-Wallis rank sum test at three and six months. Results show that, at 3 months, the Ex group had significantly improved scores for HR, RPE, FAMS, MFIS and the 50 MW (time). At 6 months, the Ex group maintained significant improvements for FAMS and MFIS while fitness had returned to near baseline.

CONCLUSION

Fitness training had beneficial effects on fatigue and QOL patients with MS. There was no association between fitness and fatigue or QOL at six months.

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LIFESTYLE, LIFE GOAL AND SOCIAL NETWORK ANALYSIS: TOOL FOR EMPOWERING CHRONIC DISEASE PATIENT

Chanuantong TANASUGARN

Bhuddhachinaras hospital is a regional health promoting hospital in the northern lower part of Thailand. It is a Medical Center which provides training for medical professional and also health services for people from Pitsanulok province and the province nearby. Therefore, the hospital needs to offer health promoting intervention for chronic and terminally ill patients who are referred from the health care network. Empowering intervention included tools such as the lifestyle analysis, life goal and social network analysis has been developed and tested. Empowering outcome indicators include patients and family member participation levels in health care plan, and patient's life satisfaction levels. Results indicated that the tools developed in this study can be applied in cancer patients, heart disease and diabetic patients with a positive empowering outcome on the patients and family members. High level of behavior change was also reported. Moreover, the tools have also empowered the patient care team.

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SESSION IV-2: STRATEGIES FOR EMPOWERING OLDER PERSONS

UNDERSTANDING WELL-BEING AS A MEANS OF EMPOWERING OLDER PEOPLE

Phil NOONE

People are living longer in this ageing society and the balance of life is changing. To facilitate older people to live independently in their own homes in accordance with their own wishes and that of government policy (Department of Health and Children 2001) it is necessary to understand from the lay perspective of older people the concept of well-being and its influencing factors. It is only with this new understanding that the process of enabling older people to increase control over and improve their health can take place.

This qualitative study was undertaken in the West of Ireland,

utilising in-depth interviews with a purposeful sample of 23 people over the age of 65 years. Its aim was to uncover the meaning of well-being for older people and its facilitating and inhibiting factors. Findings indicate that well-being is a complex, interrelated concept with many layers of influence. Well-being, in this study, emerged as a sense of 'connectedness': 'connectedness to place', 'connectedness to people' and 'connectedness to life'.

Multiple, cumulative influences on well-being were identified. Adaptability, resilience and strong supportive networks promoted well-being. Vulnerability in terms of poverty, inequality, inequity, lack of access to services, loss, loneliness and isolation depleted well-being for this vulnerable group in society. Vulnerability factors were unevenly distributed within

older people in this study, highlighting the fact that older people are not a homogenous group, but indeed a very diverse group with very different needs.

For health promotion, this study reiterates the need to build healthy public policy, strengthen community action and increase the personal skills of older people to enable them to continue to live in their own communities and in their own homes. It also stresses the need to reorient the health services so that issues of access and inequity are addressed. It highlights the need to explore ways to build supportive environments that accommodate the needs of older people as they advance in years. Change and adaptability to change, both at societal and individual level were identified as challenges facing older people in this study. All of this points to a need for a holistic, intersectoral, multistrategy approach to addressing the health promotion needs of this group in a manner that facilitates their participation and empowerment in the process.

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THE STUDY ON EMPOWERING THE ELDERLY IN 4 ACCREDITED HEALTH PROMOTING HOSPITAL IN THAILAND

Jaruwan JONGVANICH, Chuen TEECHAMAHACHAI, Srivipa LIENGPAKSAKUL

Based on the standard of the Health Promoting Hospital (HPH) the qualitative standard on the empowering the aging people for health was launched in four accredited HPH in Thailand during 2004-2005. Structured interviews and direct observation of operations were employed among health personnel, key stakeholders and the aging people. The tools were designed to elicit information regarding key variables of visionary leadership, strategic plan, human resource development, service system, information system, empowering process, physical and social environment, social responsibility and the community action.

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EMPOWERMENT AS A TOOL FOR SHIFTING VULNERABLE PERSONS FROM A BURDEN TO A RESOURCE

Luigi RESEGOTTI, Mario CARZANA, Antonella GIANESIN

Vulnerable groups include two categories for which many actions have been implemented in recent years for providing assistance to them but little has been done so far for empowering them so as to shift them from a burden to a re-

source for a community.

Most elderly patients would prefer remaining at home in their family and social context rather than being attended by professional nurse in old people homes. Likely many migrants women seek a job in taking care of elderly patients at home, but lacking education and training are underpaid and have no legal tutelage. This results in loss of self-esteem and disvaluation.

We planned to offers adequate training, legal tutelage to migrant women who take care of elderly patients thus making it possible to keep them at home.

The project consists of three steps:

- Assessment of a number of elderly patients needing assistance and migrant women willing to assist them.
- Activation of free training courses on basic principles of care for migrant women and free substitution of them when necessary with professional nurses until the attainment of the licence.
- Establishment of an agency for keeping into contact families of elderly people and migrant women.

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HEALTH AGEING RESIDENTIAL CARE INITIATIVE

Patricia JAYCOCK

As the average age of the population worldwide is rising, the number of older people in residential care is on the increase and the necessity to focus on the quality and effectiveness of long-term care services, rather than the provision of those services to a minimum standard is a key setting for future development.

The Irish HPH Network and Irish National Council for Ageing and Older People have in partnership developed an initiative to support best practice towards Healthy Ageing Status in residential care facilities caring for older people.

This presentation will describe that the initiative was developed in a holistic way by involving experts for many agencies. That the initiative is based on the ten steps to healthy ageing. It will explain how it will operate and the advantages to the facilities taking part. The initiative will be evaluated in a qualitative and quantitative manner but as it is a new initiative no results are available as yet.

Both organisations have long recognised that supporting best practice in residential facilities is crucial to the promotion of healthy ageing. The goals of the initiative are to support residential care facilities in realising and acting upon their health promoting capacity, to assist residential care facilities to adopt a health promotion aspect to their daily work and to achieve the above through supporting facilities in completion of the Ten Steps to Healthy Ageing.

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PROCESSES IN ACTION: DESCRIPTION AND ANALYSIS OF PROCESSES USED TO IMPLEMENT PERSON CENTRED PLANNING IN A RESIDENTIAL CENTRE

Eileen CAREY

This study described and analysed processes used to implement a person-centred approach to care devised by staff in a residential service in the Mid-Western region of Ireland. The degree to which the spiritual needs of the person are realised was also examined. The research design was mainly quantitative informed by a qualitative component. From a population of 250 the defined sampling frame was N=168 health care employees. A focus group interview and a pilot study enabled the adaptation of an instrument devised by Holburn et al (2000) and development of the Indicators of

Processes of Person-Centred Planning Scale (IPPCPS). The final draft of the IPPCPS was distributed to N=147 health care employees. The findings demonstrate core systematic processes, which are conducive to person-centred planning are operating in the residential centre. Systematic processes are in place to meet some of the spiritual needs of the service user.

However, this study found a substantial lack of consideration for identifying the preferences and perspectives of the service user in relation to quality of life issues. This residential centre is challenged to move beyond the traditional approach to care of 'protection' and 'mothering' and to develop good practice guidelines ensuring person-centred care. In providing a holistic approach to care, staff must move beyond the care plan and understand the service user in the context of living.

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SESSION IV-3: DEVELOPING HEALTH PROMOTING PROGRAMS AND SERVICES IN HPH ORGANISATIONS

DEVELOPING STANDARDS FOR HEALTH PROMOTING HOSPITALS IN PUBLIC HOSPITALS IN SOUTH AFRICA

Priscella RAMDAS, Mohamed CASSIMJEE, Rosemary GEDDES

Public hospitals in South Africa use both formal systems of hospital accreditation as well informal strategies such as "Batho Pele" to promote health. Recognising that hospital accreditation does not comprehensively consider health promotion activities, the WHO European office has developed five standards and complementary performance indicators to support health promotion activities in hospitals. This paper describes the development and process of this pilot undertaken by the KwaZulu-Natal Department of Health (DOH).

METHODS

The following standards were assessed in six public hospitals during 2004: hospital management policy; patients' assessment, information and intervention; a healthy workplace; and continuity and cooperation with other providers of health promotion services. A self-assessment tool with measurable elements to assess the compliance with standards was administered. Health professionals carried out their own internal quality evaluation against these set of standards.

RESULTS

Specific outcomes were compliance with the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of an action plan, implementation and subsequent evaluation. Positive outcomes were that Quality Improvement Teams in the hospitals reported having acquired knowledge and new skills.

Team leaders also reported positive attitudes and an improvement in morale among staff as interest had been shown in their health and their views. Staff capacity was enhanced, although regular inputs would be required for sustainability. Action plans addressed management commitment to the development of a Health Promotion policy; specific staff related issues to reduce needlestick injuries and smoking and increased resource allocations.

CONCLUSION

Hospitals were encouraged to use the adapted self-assessment tool to improve health promotion activities, accelerate continuous quality improvement for improved quality of care; and expand the scope for participatory research.

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EMPOWERMENT OF PATIENTS AND STAFF AND IMPROVEMENTS IN THE QUALITY OF SERVICES.

Angela CONNOLLY

INTRODUCTION

Entering into the role of a patient very often brings on a

sense of powerlessness, vulnerability and dependency on others. However, all of us who become a patient should have a sense that we are engaging into a partnership of trust, mutual understanding and respect.

Beaumont Hospital recognised both the importance and desirability of empowerment and have we believe that we have succeeded in this through the establishment of a Patient Representative Programme. However, we must also be aware that not all patients wish to be empowered and this must be respected and requires ongoing and continuous education.

Beaumont hospital has embraced an ethos of patient centred care and regards all patient's comments or complaints positively and as a means of highlighting the need for some quality initiatives. Listening to the views of our clients is of paramount importance and being proactive and providing a voice to our users assists us in the management of services. Patients have moved from being recipients of healthcare to becoming collaborators within the Health Service.

AIMS AND OBJECTIVES

- To create a partnership of mutual trust and understanding between our patients and staff.
- To enhance dialogue between those giving and receiving health care.
- To listen to and learn from our patients and clients.
- To enable patients to obtain solutions to problems.
- To provide patient centred care.
- To enable our Patient Focus Group to act as a consultative body for the CEO and senior management
- To support and train staff in complaint resolution.
- To initiate change through the analyses of information and data received from our clients.

METHODOLOGY

- Draft and development of a Patient Representative Programme.
- Secured the co-operation of management, staff & patients in order to implement same.
- Installed a customised software package, which provides management reports for analysis.
- Agreed on a phased introduction.
- Promoted the programme throughout all disciplines within the hospital.
- Introduction of a Hospital Complaints Policy.
- Recruitment of motivated patients to participate on the Patient Focus Group.

RESULTS AND CONCLUSIONS

- Empowerment of patients and staff.
- Introduction of training programmes for staff in conflict negotiation.
- Improved information and support for patients and staff.
- Reduction of official complaints and increased interaction between our patients and staff.
- Patient representation on committees.
- Patients now have a voice in the decision making process.

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FORENSIC HEALTH IMPROVEMENT TEAM

Thomas HARRISON

The Forensic Health Improvement Team in Glasgow are keen to share their experiences of implementing health improvement activity within their in-patient facilities by utilising the Scottish Health Promoting Health Service Framework.

Participants will gain:

- Forewarning of the potential pitfalls
- Knowledge of how we planned our programme
- Implementing the HPHS Framework
- Understanding of the need for evaluation and measurement tools

This 20 minute talk will explain clearly how a low secure forensic unit in Glasgow set up and established a programme of health promoting activities. We will give an account of our step by step set up process - warts and all. In particular, we will highlight the problems experienced, both practical and attitudinal, and how we overcame them. We will show how we turned adversaries into ambassadors amongst the staff team.

With regard to user involvement, we are able to provide pointers on how to involve the patient group and to give them ownership of their activities and consequently their health - and how to keep them involved.

We will also give a frank overview of the lessons we have learned along the way and how we may have done things differently. The on-going evaluation of our health promotion activities will also be addressed briefly.

In summary, we will share our failures and successes in going from a standing start to a patient-led programme of health promoting activities. Give brief descriptions of our projects especially the Acorn Project (horticultural) and Work it Out (Gymnasium) last years winners of the Scottish Health Awards for Mental Health and runners up in the Nursing Times Mental Health Category Awards.

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COMFORT MANAGEMENT: A COMPREHENSIVE APPROACH TO IMPROVE HOSPITAL COMFORT

Simone TASSO, Carlo FAVARETTI

INTRODUCTION

The aim of this paper is to elaborate the methodological bases to manage the comfort in hospital following the HPH principles.

Comfort can be defined as "state of physical well-being" and/or "things that make life easy or pleasant". Following the Budapest Declaration, a HPH approach has to address its actions towards these main different categories: patients, staff, communities.

COMFORT MANAGEMENT IN HPH: WHAT DOES IT MEAN?

Considering Budapest Declaration and starting from the above mentioned definition, comfort management can be defined as "the process to control and direct comfort of patients, staff and communities (visitors) with the aim to make easy their presence in hospital". As regards patients, comfort does not concern the clinical interventions (which are addressed to patient disease). In other words, comfort management is addressed to positive health.

Empowerment appears a fundamental condition in Comfort Management. For instance, strategies for empowering patients to take care of their basic health needs during the hospital stay (e.g. opportunities for communication, for information, by providing orientation about hospitals services). Empowering is also a fundamental element for the visitors comfort to make life easy during their stay in hospital (e.g. information, bed/armchair for assistance, other facilities). At last, in other way and for other reason it is important the empowerment for the staff to get a healthy workplace.

CONCLUSION

Starting from these matters a HPH Project is in progress and it tries to deal with the comfort in a comprehensive approach that has to consider the different levels in which comfort works:

- Structure (i.e. hospital architecture, common areas, rooms characteristics)
- Services (Hospital Facilities, staff manners)

The complete structure of the Projects can be presented.

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SESSION IV-4: HEALTH PROMOTION FOR HOSPITAL STAFF – 2: COPING WITH WORK RELATED RISKS AND DEVELOPING HEALTH PROMOTING LIFESTYLES

EMPOWERING HEALTH SERVICE MANAGERS IN RELATION TO MANAGEMENT OF LOW BACK PAIN IN THE WORKPLACE

Caitriona CUNNINGHAM, Catherine BLAKE

BACKGROUND

Current evidence emphasises the need for workplace managers to be involved in health promotion strategies aimed at reducing back related disability in the workplace (UK Guidelines, 2000). As part of a strategy aimed at empowering managers to better manage occupational low back pain (LBP) their needs must be identified.

PURPOSE

To establish health service managers' needs in relation to the management of the worker with low back pain.

METHODS

A self administered questionnaire was distributed to all departmental managers (n =63) at a major Irish teaching hospital. The questionnaire was comprised of a series of quantitative and qualitative questions, relating to aspects of management of the worker with LBP, including facilitation of return to work, providing a supportive environment for the worker with LBP and organisational support for managers.

Quantitative data were summarised using descriptive statistics. Qualitative data were transcribed, coded and analysed using the qualitative data analysis approach of Miles and Huberman (1994).

RESULTS

A response rate of 76% (n =48) was achieved. Of these 63% (n=30) had experience of managing LBP related sick leave among staff. Common themes which emerged from the qualitative data included lack of staff resources to accommodate return to work of a worker at less than full physical work capacity, lack of specific guidance from the occupational health department regarding expected work capacity of the worker with LBP and difficulty dealing with attitudes of

colleagues towards the worker with LBP.

CONCLUSION

Strategies aimed at improving the management of the worker with LBP and facilitating earlier return to work need to give consideration to improving staff resources, provision of clear guidelines from occupational health departments and guidance for managers regarding ways of supporting both the worker with LBP and his/her colleagues.

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THE EFFECT OF A PHYSICAL ACTIVITY EDUCATION PROGRAMME IN THE HOSPITAL WORKPLACE SETTING

Rhoda SOHUN, Ciaran MACDONNCHA, Ann BREEN, Brian NEESON

The WHO contends that access to physical activity education and information is essential to empower individuals and communities to be more physically active.

PURPOSE

To examine the effectiveness of a ten-week educational intervention on the physical activity behaviour of sedentary female staff (n=23, 32.9±5.4 years) in the hospital setting.

METHODOLOGY

The intervention group received 10 weekly one-hour educational sessions during work time, which was supported by hospital management. Educational sessions addressed various topics each week, and participants were assisted in planning their physical activity on a week-by-week basis. Participants received a pedometer as a motivational tool. Body mass index (BMI), stage of change and various mediators of physical activity were assessed at pre, post, and six-month post intervention. The stage of change model proposes five stages of readiness for change. A control group (n=9, 29.4±5.4 years) received no intervention.

RESULTS

At post intervention, 78% of the intervention group increased physical activity participation by one or two stages of change. In the control group 45% moved positively by one stage. Repeated measures analysis demonstrated an improvement ($p=0.05$) in the experimental group on 8 of the 10 processes of change, decisional balance, self-efficacy, outcome expectation for exercise and enjoyment for physical activity post intervention. No significant differences were observed in the control group. At 6-months follow up, 14% of the intervention group moved positively by one or two stages, 29% remained unchanged, and 57% regressed by either one or two stages. Additionally, an improvement ($p=0.05$) occurred in exercise self-efficacy, and on two processes of change. A regression ($p=0.05$) occurred in the intervention group scores on eight processes of change, decisional balance and enjoyment of physical activity.

CONCLUSIONS

The intervention was successful at changing the physical activity behaviour of sedentary female hospital employees. To maintain change additional support may be required.

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AN EXPLORATION OF THE PREVALENCE OF BULLYING WITHIN AN IRISH MATERNITY HOSPITAL SETTING.

Maria GIBBONS, Patricia MANNIX-MCNAMARA

Bullying is internationally well documented as a problem within workplaces. The past decade has seen research into bullying focusing on prevalence, cause and effect and strategies for eradication. Professions such as teaching and nursing have been documented in literatures as areas where bullying unfortunately prevails. Clearly, bullying has a negative impact on workplace culture and the health of employees. Health Promoting Hospitals draw heavily on the value of empowerment as a key principle for working life. This is in keeping with the principles of the Ottawa Charter (1986). The HPH Network prioritises the promotion of policies and structures that impact positively on well-being and quality of working life. Workplace bullying, if it continues unchecked denies the values of the HPH initiative in practice most

particularly as the HPH network prioritises the staff of an organisation as being its greatest asset.

AIM

The aim of this study is to explore the experiences of bullying as experienced by staff in a Maternity Hospital setting. It aims to document prevalence, and to explore the relevance of grade to either experiencing or engaging in bullying behaviour. It also explores the link between gender, age and employment status as variables in the bullying dynamic. The research is a collaborative project between the HPH Coordinator of the hospital setting and health promotion Course Director, University of Limerick.

METHODOLOGY

The methodology of the study is quantitative in nature. The study is conducted utilising Einerssen's internationally tested standardised survey (permissions granted), the Negative Acts Questionnaire NAQ. Utilising a convenience sample of a maternity hospital setting the NAQ was distributed via internal post to all hospital employees.

As this is a study in progress data analysis is currently being conducted utilising SPSS (Statistical Package for the Social Sciences), this will be completed and results will be available March 2005.

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COUNSELING AND SUPPORT TEAM FOR EMPLOYEES

Svava THORKEÐSDÓTTIR, Ema EINARSDÓTTIR

The potential for health promotion in the workplace has gained increased attention in recent years. The slogan "healthy employees in healthy organizations" refers to the claim that the success of any organization depends on motivated and healthy workers, working in a healthy work environment. Logically, the key to all health promoting activities within a workplace is that the executive team or the company's management fosters the idea of workplace health promotion. Health-promoting behavior is thus encouraged and health-promoting measures are properly integrated into the existing structures and processes of the organization.

Research has shown that work related stress, inability to control work load and lack of support has an impact on the health and well - being of employees. In 2003 a counseling and support team for employees was established at the Office of Human Resources at Landspítali – University Hospital in Reykjavík. The aim of the team is to support employees who are experiencing work related stress or critical incidents that affect or can affect their well - being at work.

The team consists of 12 specialists, nurses, social workers, psychologists, priests and a physician. All the team members have different work responsibilities within various divisions in the organization but are allowed to devote a certain amount of their time to the counseling and support team.

In this presentation the establishment and focus of the team will be addressed as well as an overview of the incidents that the team has dealt with.

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DIET, ALCOHOL AND TOBACCO USE AMONG FEMALE STUDENT NURSES AND THE IMPLICATIONS FOR THEIR FUTURE ROLE AS HEALTH PROMOTERS.

Anna M. O'LEARY

Obesity is becoming one of the fastest growing health problems in Ireland and female students are no exception. Female college students are a unique group, and their lifestyle habits and circumstances are the focus of many studies. The aim of this study was to examine the diet of female college students. The study was a descriptive survey using a convenience sample of 200 female student nurses. A structured questionnaire and a modified food frequency questionnaire were used to obtain information on the dietary intake, alcohol and smoking habits of female student nurses. The average

age of female student nurses was 20 years. 2.8% of the female student nurses were underweight, 35.2% were overweight and 11.7% were in the obese category. 96.8% of the female student nurses consumed alcohol and an alarming 20.1% of the student nurses consumed greater than the recommended intake of alcohol (14 units) per week for females. Nearly a quarter of the student nurses were current smokers. The uptake of folic acid, vitamins and other supplements was poor.

Compliance with the recommended servings from the food pyramid was not evident in this study, with 60-90% consuming below the recommended servings in the five food groups. The findings were staggering, half the group were overweight and obese (47%). This data suggests that students have inadequate health behaviours in relation to diet, alcohol and smoking and this will have implications for their future role as health promoters.

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SESSION IV-5: SUPPORTIVE FRAMEWORKS & NETWORKING FOR HPH

CATALYSTS AND CONSTRAINTS OF HPH NETWORK DEVELOPMENT

Denise MORRIS

England has been involved in the HPH network since 1995. However, in all that time, the national network has repeatedly failed to attract sufficient funding to enable its full potential to be realised.

This presentation will look at a new model of national network development, and will highlight a number of current national priorities which may point to very positive opportunities for the expansion of English HPH's in the coming year.

Changes in both the delivery and commissioning of health care, has signalled a new approach to the promotion of health across all settings.

This presentation will report on the developments so far, and discuss why the attainment of HPH status could still be considered a desirable achievement by English hospitals.

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TOWARDS A MORE HEALTH ORIENTED HEALTH SERVICE

Lars WEINEHALL, Margareta KRISTENSSON, Ingrid STRÖM

Public health policy in Sweden has, until 2003, not been subject to any comprehensive national policy. According to the Swedish constitution, health care has mainly been a regional responsibility. However, as the perspective has widened, there has been an increased request in the Parliament for a coherent national public health policy. In 1997 the Swedish government appointed a National Committee to formulate national goals for public health and to suggest strategies for achieving these goals and, finally, in 2003 the Swedish Parliament the first National Public Health Objectives Bill. Contrary to many other national health policies, the Swedish health objectives mainly address determinants of health. The new policy specifies eleven domains, where Domain 6 specifies "A health and medical service that more actively promotes good health" is one of them. By that the Swedish Parliament emphasized a more health oriented health service to be a significant structural determinant for public health.

According to the Bill, a medical service plays a key role in public health work due to its specific competence, broad knowledge, authority and extensive contact with the population. It should integrate relevant health promotion and disease prevention aspects into its daily work in a more systematic fashion. The Bill underlines that the health and medical services responsibility for good health also implies a responsibility on the individual, group and population level.

Based on the Bill, the National Institute of Public Health has proposed four new specific objectives (regarding the patient, the population, the own staff and the management policy)

and specific indicators for evaluation of each of the four Domain 6 specific objectives. The presentation will focus on the Domain 6 development process, and also present efforts to implement the National Policy on regional levels.

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EMPOWERMENT AND HEALTH PROMOTING NETWORKS IN QUEBEC?

Nicole DEDOBBELEER, André-Pierre CONTANDRIOPOULOS, Hung NGUYEN, Martin BEAUMONT, Louise ROUSSEAU, Lise LAMOTHE

In Canada, the Quebec government restructured the organization of health care and social services by establishing local health and social services network development agencies (ADRLSSSS). Each ADRLSSSS is responsible for developing local health and social services networks in its area. A Board of Directors appointed by the Minister of Health and Social Services administer it. The Board includes the President and Executive Director of the ADRLSSSS, and members of the regional medical, nursing and multidisciplinary commissions. The Board must also appoint 15 to 20 members of the public to serve on the "People's Forum". Each local health and social services network is related to a local authority, a health and social services centre (CSSS), merging establishments identified by the agency.

These establishments are in most cases local hospitals, community health centers (CLSCs), residential and long-term care centres. Each CSSS will work in partnership with physicians, pharmacists, community organizations, social economy enterprises and private resources available within the jurisdiction of the ADRLSSSS. It will also be expected to coordinate activities and services with hospitals providing more specialized medical services, child and youth protection centres and rehabilitation centres, through agreements and other terms.

The first objective of this presentation will be to discuss how the WHO concept of health promoting hospital and the concept of empowerment can be incorporated in the establishment of health and social services centres and health promoting networks in one of the Quebec regions, the Montérégie. The second objective will be to assess how the standards of the Canadian Council on Health Facilities Accreditation will support this incorporation. The Montérégie region of near to 1.5 million people living in an area of 11,074 km² is the second region in terms of population in Quebec.

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EMPOWERING THE HEALTH SYSTEM: WHAT NEW CHALLENGES AND OPPORTUNITIES FOR HEALTH SYSTEMS IN EUROPE?

Carole-Juliette Maignan

How can we produce health in today's societies? Can the public service promote the health of the population in a sustainable and equitable manner? Could an intersectoral development strategy provide added value to economic and social results, in addition to bringing about population health gains? These are questions that national, regional and local governments will increasingly be confronted with in both the developed and developing countries.

A thorough understanding of the social and economic determinants of health will increasingly play a major role in addressing the questions above. In particular, employment or rather non- or under-employment has been identified as one of the determinants of health, as well as one of its outcome.

In this paper, we first explain the social and economic determinants of health. Secondly, we highlight the characteristics of the European labour market and in particular review the evidence linking long-term and temporary employment, and health. Thirdly, we provide examples and evidences of the opportunities lying within European health systems, as well as underlying their challenges in dealing with precarious work and persistent unemployment.

The role of public health system can make a difference by acting on the labour supply and demand, by using genuine intersectoral strategies and be a role model employer for its staff and health promoter.

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CENTRED PATIENTS HOSPITAL ADMISSION: THE HPH PROJECT OF VENETO REGION NETWORK

Anna Maria RINOLFI, Simone TASSO, Paola MELINA, Graziano COSARO, Prisca PERENZIN, Daniela MAGGIO, Pino CALDANA, Claudio BALBONI, Massimo CAPPELLIN, Maria Luisa MIGLIORINO

INTRODUCTION

The admission in hospital is an important and particular moment for inpatients because they have the first impact with the hospital both as structure and as organization and they should be informed in a prompt and appropriate way about their health state and hospital/unit logistics and organization.

With the aim to get a better service during the admission, in the Italian HPH Veneto Region Network a Project started in 2002 involving the hospitals of 6 Health Local Units (Health Trusts: Bussolengo, Chioggia, Este, Feltre, Rovigo, Thiene). A HPH Regional Working Group (RWG) was created and its first step was the realization of Polycentric Study, using a questionnaire for inpatients to receive information about their admissions. A specific questionnaire was made and it was formed by 15 items regarding the following main issues:

- Information
- Organization
- Staff behaviour
- Patients expectation

POLYCENTRIC STUDY

A Polycentric study was realized, involving 1684 inpatients who answered to as many questionnaires. Important matters emerged, and the most important results can be summarized: 1404 (83.4 %) patients said to have a positive impression about admission organization; more than 90 % received health information in respect of their own privacy and in an understandable way. The 69.4% of patients expressed the importance of having a relative or a neighbour close to them, according to the ward rules, while the 28% of them declared "they didn't need it". Study showed important problems, too. For instance, within the first day only 822 patients (48.8%) received information about the unit/hospital organization and only 407 (24.2%) said to have received complete information. Furthermore, only the 35.2% stated they were "quiet" when admitted, while the other patients declared to be rather worried.

CONCLUSION

Questionnaire was useful to have a global vision of patients admission, showing the main problems of organization, information and permitting to evaluate the most important patients expectations. Specific studies were realized for each hospital and even for each unit. This was important for the beginning of the second step of the Project: specific interventions with different units and results discussion with patients organizations with the aim to get a better service through the empowerment of staff and patients.

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SESSION IV-6: ASPECTS OF DEVELOPING HEALTH PROMOTING HOSPITAL ORGANISATIONS – 2

THE ART AND SCIENCE OF CHANGING CULTURE IN A MEDICAL ORGANIZATION

Ted MAVOR

The hospital, despite its emphasis on specialized techniques and equipment, is basically an organization of human beings. The health care system is shifting on its axis on a regular basis - a permanent white water situation. The new reality to be successful in creating organizational change is comparable to a white water kayaker, who must think and act independently to adapt to the changes around him/her.

Health promotion practitioners must understand how power is distributed (plumbing principle), how decisions are made and how changes affect other elements of the organization. They must proceed in a systematic way to develop and apply power (organizational judo) in order that health promotion knowledge and values may have their appropriate effect on the delivery and deployment of medical services.

What are the requirements of a change agent? Review the importance of the formation of alliances, the development of conceptual and verbal skills, the organizational equilibrium, use of crisis theory and group processes.

The onrushing changes in health care present not only dangers, but also many opportunities to improve the health of all. It is to these opportunities that health promotion practitioners must address themselves.

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HEALTH PROMOTION, ECONOMY AND PROTECTION OF THE ENVIRONMENT IN LINE WITH THE HOSPITAL FOOD SERVICES PROJECT

Carlo LESI, Augusta ALBERTINI, Patrizia BELTRAMI, Ruggero BORGOGNO, Corrado GIANNONE, Emilia GUBERTI, Pietro MAGNAVITA, Luciana PRETE

DESCRIPTION

Due to the construction of the Local Health Unit and the approval of the three public health utilities/establishments there is the need to analyse and improve the quality of service given by a hospital's food services department, not only to achieve a higher level of efficiency and quality in general, but also to develop operating procedures that will aim to promote the health of the patients, of the personnel and the community.

The set of standard operating procedures used by the food services department represents the institution's strategic objective within its own undertaking for social responsibility since it is instrumental to health promotion and the safeguard of the environment and bio-diversity. In this context, a high lever of importance is given not only to sanitary hygiene and nutritional factors, but also to the choices made connected with cultural aspects and the promotion of well-being that should be emphasized when aiming for the improvement of the quality of service.

AIMS AND OBJECTIVES

- To analyse the hospital food services department through a unitary project that aims to make its operating procedures contribute to health promotion particularly in the field of food and nutrition.
- To develop a territorial experimentation that will favour the synergy and sharing of the responsibility to promote health between the Local Health Services and the Local entities. Special emphasis must be given to the determining environmental aspects of health by maximizing the sector's potentials and at the same time by improving the efficiency and the sustainability of the output of said sector.
- To implement a project, correlated to the steps to be followed pertaining to hospital food services, with a par-

tical social impact, specifically directed to the group of underprivileged in the local community.

METHODOLOGY/ACTIONS

- To analyse the existing situation at the nine leading hospitals within the area and determine the factors that influence the productive aspects of the service, its problematic state and find possible alternatives that can quantitatively improve the service itself.
- To review and redefine new and quantitative shared parameters, the instruments on health promotion and the communication to be included on the risk, which added value, on the unitary management of the service.
- To perform experiments in the highlands and decentralized hospitals, comparing them to the normal area of responsibility of the public utility. This serves as a combined project of local authorities on hospital and school food services, where food is prepared in loco. The contracting firm will privilege the local producers on this relationship, based on the potentiality of the assessment on the area. The methods of environmental plausibility is defined as "short chain" or rather the reduction of the foreseen long passage between the producer and the consumer.
- To test a combined project between the local authorities and associations within the territory that favours the recovery of the foodstuffs not consumed within the hospital food department's premises for its distribution to the underprivileged part of the community while maintaining at the same time the nutritional needs and the safety of the product.

TARGET

The service users or patients, the personnel, the families, the voluntary associations, the authorities and the local producers

EVALUATION OF THE RESULTS AND CONCLUSIONS

The project highlights the complex defence of the aspects of compatibility between economic management through specific indicators such as the cost of the supply of service production, and the hygienic nutritional aspect, through the adoption criteria that guarantees the standard quality of the service.

But the peculiar element and the innovative aspect of the project are to be found in the instruments of health promotion, (particularly the adoption of methodology and communication instruments used on patients and their families), and in the personnel and communities oriented to construct in time a food culture that is more suitable for health maintenance and a cultural growth of the personnel in charge of the foodstuffs. Furthermore, a particular attention on the environmental determining factors on health was noted, in a vulnerable territorial context, through economic support from the area with the purchase of local products, the re-utilization of organic waste in composting, produced by the food services department and finally the support given to biodiversity with the adoption of food said to be on risk of extinction.

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GIVING STRUCTURE TO HEALTH PROMOTION: THREE INNOVATIONS FOR COMPLEX ENVIRONMENTS

Robert PERREAULT

Consistency and coherence are fundamental principles of health promotion. It is suggested that there can be no Health Promoting Hospitals without strong organic links to community-wide visions of health. This presentation puts forward three structuring elements that can empower hospitals to become amplifiers of community health promotion initiatives.

The first is Harmonized Programming. If empowerment is the process by which people take control over their own health, it is incumbent upon professional organizations to provide coherent and consistent messages and action plans throughout their healthcare system, including hospitals. The Province of Quebec's smoking cessation initiative will serve to illustrate this point emphasizing coherence and continuity in its community, primary care and hospital deployment.

The second structuring element is that of Multi-strategy Coverage. Ultimately, health education needs to find its target in the individuals who may move toward the adoption of healthy lifestyles and behaviours. Diversity in learning and cognitive styles as well as evolving cultural trends need to be taken into account. This is illustrated by the creation of Multi-media Centers for Health Education as part of the Montreal region's new integrated health networks that now include community outpatient health and social services, long and short term-care hospitals under a single administrative structure. The Centers act as core sources for health education content harmonizing programs at all levels of health care from primary care to specialty hospital settings. They are responsible for presenting the same core messages in video, Web, print and educator mediated formats.

The third structuring element is the necessity to use Contextualized decision making. When it comes to promoting health, no hospital is a black box. Decisions need to be taken in context with access to all necessary information. The MOXXI program of integrated computerized chronic disease management will serve to illustrate how a managed flow of information increases the odds of favourable outcomes both in primary and secondary prevention.

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DEVELOPMENT OF INTERNATIONAL CODES FOR DRG AND HEALTH PROMOTION

Hanne TØNNESEN, Oliver GROENE, Poul-Erik HANSEN, Thomas Lund SØRENSEN

BACKGROUND

Last year an international HPH workshop regarding quality-based reimbursement took place in WHO Barcelona. The conclusion of the workshop was to perform an international pilot test of the new systematic codes for HP procedures in hospitals based upon the registration codes developed by the Danish Network. The interest for the pilot test has been

high, and we would therefore present the pilot test in details.

AIM

To evaluate the new group of HP codes in an international pilot test.

METHODS

3 member hospitals or departments from 5-8 different countries will participate. The test consists of two parts:

- All participants should code the same 20 standardised medical records (in English) for evaluating the interobservational variance.
- All participants should code 20 different local medical records from their own department for evaluating the usefulness of the codes in clinical day life.

RESULTS

The results will be presented for the HPH Network and published in an international journal

CONCLUSION

We are looking forward to perform the international pilot test

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Abstracts for conference poster sessions

Poster Sessions I: Thursday, May 19, 2004, 15.00-15.45

SESSION I-1: HEALTH PROMOTION IN CLINICAL PRACTICE

P 1: THE INFORMATION AND WELCOME TO CITIZEN: CONSTRUCTION OF RECEPTION SECTOR TO GUARANTEE A LISTENING AND INTEGRATED COMMUNICATION CIRCUIT

Fosco FOGLIETTA, Carla LANFRANCHI

PROJECT ABSTRACT

From citizens and operators signals and from organization analysis made after this announcements, our company have been evidenced some difficult of the operators allocated in the information point, in the switchboard and in public relation office; the causes of difficulties are due for a management not equal, for a not correct connection of information point, for a shortage of informatics technologies. So our firm decided to construction a welcome sector with a joint management that can connect all the organization structures.

PURPOSE AND TARGET

Improve the access to our services and the access to charity work (especially for needy people like elderly persons).

METHODOLOGY ACTIONS

- Organization analysis in specific contests.
- Definition of a company and a district coordination with all the responsibility.
- Plan and realize a specific formation and a specific intervention for maintenance the operators skills.
- Create some team work for construct the correct operational instruments.
- Computerization of all the activities necessary to supply data base and electronic mail. This is necessary to have information in real time.

PRINCIPAL TARGET: Operators assigned to welcome.

CONCLUSION

The actions above are be realized in this period have, already, generated some results like a more motivation by the operators.

The process will be nearly concluded.

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P 2: THE GOOD ACCEPTANCE OF THE CUSTOMER IN THE UNIT

Giuseppe REMEDI

With the word welcome we do not only mean the first welcome we offer to the customer, but the whole cycle of hospital service, from the pre-admission to post-hospitalisation and the Other preliminary contact with the structure, the admission, the stay in the ward, the discharge, to the follow-up.

GENERAL OBJECTS OF THE PROJECT

- Conform the way we answer to the customers in order to realize the objectives of health promotion.
- Realize some opportunities of comparison and exchange among the operating units.
- Introduce a system for the measurement of the staff's satisfaction.

SPECIFIC OBJECTS OF THE PROJECT

For the nurse:

- Adhesion to the plan
- Motivation

IT'S IMPORTANT GUARANTEE IN THE CUSTOMER RELATION

- Professionalism and competence
- Information, participation, listen and self-cure
- Privacy

PARTICULARLY

- The promotion of the citizen's health with actions that fulfil them selves in the welcome process.
- The re-orientation of the environment dedicated to the welcome towards the health promotion.
- The improvement of the citizen's knowledge of the hospital service in order to assure the access, the appropriate use and participation.
- The facility of the empowerment for health in the relationship between operators/operators and operators/customers

Protagonists of this plan are in principle the nurses who maintain a continuous relationship from the moment of the welcome to the resignations.

FORSEEN STANDARD

- Operative protocols
- Delivery of welcome paper
- A nurse dedicate to the welcome
- Place for guarantee privacy
- Every nurse must be recognizable
- The presence of the patients at the direction of his illness

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P 3: MILLIONS 'ILLITERATE' ABOUT HEALTH!: EDUCATIONALISTS SUPPORTING HPH'S TO PROVIDE 'LIFELONG EMPOWERING HEALTH EDUCATION PROGRAMMES FOR PUBLIC HEALTH IMPROVEMENT

Denise RICHARDSON, Margaret BORSEY

There is a huge gap in "health literacy" between the richest and poorest sections of society, fuelling widening inequalities in health care. One in five people – as many as seven million across the country – had problems with basic skills, are unable to understand and interpret basic information that could lead to better health."

IMPROVING HEALTH LITERACY THROUGH EMPOWERING HEALTHY PUBLIC POLICY:

Health literacy: being able to make the most of health, looks at people's capacity to obtain, interpret and understand basic health information in order to enhance their health. "...need to consider how best to stimulate the supply side of the engagement relationship by supporting public demand ... to raise levels of 'health literacy' in the population, including awareness of public health issues. "... 'health literacy means 'the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.'

EMPOWERMENT HEALTH EDUCATION IN PRACTICE

Choosing Health: Making healthy choices easier' ensuring that the daily contacts people have with HPH's become "opportunities for improving and promoting health and developing systematic approaches to health improvement and disease prevention. Green Light Pharmacy has transformed its basement into a local health education meeting centre providing regular health education sessions.

EXPERT PATIENT PROGRAMMES : HPH'S AND ACADEMIES AS PUBLIC HEALTH EDUCATORS

everyone working in the NHS, must help educate patients and support them in their decisions. HPH's in partnership with local education facilities can deliver flexible face to face, CD's and e-learning based health education programmes and life long (enhancing) health education opportunities. Evidence based lay epidemiological research must also be carried out measuring the impact of poor health literacy on access to healthcare and effectiveness of innovative health education to improve health of 'for all' in the 21st century.

LITERATURE:

- <http://www.literacytrust.org.uk/database/health.html#Millions>
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P 4: RELATIONSHIP BETWEEN PHYSICIANS AND PATIENTS: CHANGES OF VALUES

Ryte GIEDRIKAITE. Irayda JAKUSOVAITE, Irena MISEVICIENE

PROBLEMS

Processes of globalization and democratization of the society are influencing the growing reliance of physician and patient relationship on the functional culture of organizations and institutions. Today the ethical foundations of the training of health care professionals have become very important. It is not any more possible to judge them in the content of traditional ethics.

AIM

To reveal the value changes among the physicians and patient relationship.

RESULTS

Medical ethics has become the dynamic area, the dialog of various different opinions and attitudes, which are seeking for methods of procedures helping to deal with outstanding ethical dilemmas. The key changes which have occurred in methodology of medical ethics could be described as shifting from the norms and ethical codes towards the ethics of principles. The new conception of physician and patient relationship evaluation is necessary and it should include the levels of both individual (micro) and social (macro) ethics. Not only the personal characteristics of patients, physicians and other health professionals (awareness, compassionateness, etc.), but also the organization of work in order to ensure the high quality of services in the health care institutions play a crucial role in changing the physician / patient relationships. It's essential, that health care institutions should pay more attention to the culture of clinical practice, i.e. shifting the solution of problems from discussions and moralizations towards management and decision making.

CONCLUSION

The analysis of scientific references and the pilot study in Health Promoting Hospitals in order to evaluate the aspects of medical ethics are being performed. The final results will be presented during the conference.

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P 5: IMPROVEMENT OF PATIENTS HEALTH LITERACY - THE PREREQUISITE FOR THEIR EMPOWERMENT

Irena MISEVICIENE, Juozas PUNDZIUS, Zemyna MILASauskiene, Daiva ZAGURSKIENE

BACKGROUND

Health literacy skills are important for both health and health care. Studies have shown an association between limited health literacy and worse health outcomes, such as poorer knowledge of health conditions, lower use of preventive services, lower use of medication nonadherence, higher hospitalization rates, and poorer self-reported health.

AIM

To assess the health literacy among adult patients in University hospital.

METHODS

Patients (n=200) were recruited from eight clinical departments in Kaunas Medical University Hospital. A questionnaire (developed by L. D. Chew and all, 2004) consisting of 16 health literacy screening questions was used. Clinical nurses asked the patients to fill in questionnaires. The pilot survey was performed in eight clinical departments in one day. The response rate was 93.5%.

RESULTS

The preliminary analysis of health literacy questions showed that more than a third of the patients answered that appointment slips and medical forms are written in a way that is always or often easy to read and understand (39%), but for every fifth it is difficult to understand hospital or clinical signs (20%), the appointment slips (22%) and to fill out medical forms (21%). The majority of patients agree that medication labels and educational materials are written in a way that easy to read and understand, i.e. "Always or often" answered correspondingly 73% and 67% of patients. Every fourth patient (25%) was complaining that he often has difficulties to find out his medical condition because of the problems in understanding written information. Men and older patients answered that the appointment slips, medical forms, medication labels and written information given by health provider is difficult to read and understand more often.

CONCLUSION

The preliminary findings reported here suggest that there are different aspects of patients health literacy and these aspects must be taken into account for the empowerment of patients in their own health condition control.

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operative instrument to analyse ordinary hospitalization. Normally questionnaire was given to each in-patient at the end of stay, asking to return it compiled.

In 2003 (the last year having this questionnaire) only 1107 questionnaires returned compiled (8.5% of total discharges). A main problem appeared from their data analysis: very low frequency of returned questionnaires for several units (range 0-28 %). At the same time, the necessity of an up-date emerged after the presentation of the questionnaire items to patients representatives.

ACTIONS

Starting from the above mentioned problems, in 2004 Hospital Medical Direction decided to elaborate a new questionnaire following the HPH principles, trying to improve the empowering both of staff and of patients.

Following the Ottawa Charter principles, Direction acted as intermediary, with the aim to involve the following different actors:

- 1) Patients Committees
- 2) Head nurses of the different units
- 3) Central Nursing Office
- 4) Quality Office
- 5) Migrant Patients Intermediaries
- 6) University of Padua

A work was initiated to create a new questionnaire, following the suggestions of the different actors: custom, religion, privacy, human relationship and dignity were matters pointed out. Special attention was given for the patient who lives in a condition of fragility (i.e. elderly). Suggestions came also to have an easily understandable form.

CONCLUSION

A new questionnaire was realized, trying to get a simple operative tool. It was not simply well accepted by the different stakeholders but it was constructed with them. For instance, involving Quality Office was important for methodological aspects; staff involving (and in particular Head nurses) was important for getting their good acceptance of the questionnaire and for presenting it to patients in an adduced way, trying to have a higher frequency of returned questionnaires.

Last but not least, it was important - of course- to involve the patients committees, for getting a new text better representing their own values and needs (i.e. special items were added for the migrant patients).

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P 6: PATHWAY TOWARDS A PATIENT CENTRED TOOL

Maria Luisa MIGLIORINO, Simone TASSO

INTRODUCTION

Since 1995 in the Italian Castelfranco Veneto Hospital it has been used an anonymous patients questionnaire, as an

P 7: THE ATTITUDES OF IRISH PHYSIOTHERAPISTS AND PHYSIOTHERAPY CLIENTS TOWARDS CLIENT-CENTREDNESS: CHALLENGES AND POTENTIALS.

Eva DEVANEY, Patricia MANNIX-MCNAMARA

PURPOSE

The principle of client-centredness in the health services means that individual needs are identified and responded to, and that participation in decision-making is encouraged and facilitated. This is a core principle in Irish health policy and also in national physiotherapy guidelines. Previous research indicates that while physiotherapists embrace the concept, it is less evident in practice (Baker et al. 2001, Allison 2002). This study aimed to investigate the attitudes towards client-centredness among Irish physiotherapists and users of physiotherapy services.

METHODOLOGY

A multi-method research approach was chosen. Two surveys were administered, one using a purposive sample of 207 physiotherapists (response rate 54%, N=112) in primary care, and one using a convenience sample of 102 consecutive patients (response rate 36%, N=37) attending a physiotherapy clinic. Semi-structured interviews were conducted with five therapists and four clients. Combined scores were calculated for attitudinal statements, and analysis included frequency distributions and Mann-Whitney U tests. Interpretive content analysis was used with qualitative data.

RESULTS

Physiotherapists held positive attitudes towards client-centredness; the mean combined score was 22.5 (S.D.=2.5), where scores could range from 7-28. The positive attitudes were stronger among those qualified ten years or less ($U=558$, $p<0.05$), and those with postgraduate training in communication skills ($U=1030$, $p=0.005$), facilitation skills ($U=617$, $p<0.05$), and health promotion theory ($U=664$, $p<0.05$). Over 95% of physiotherapists agreed that respecting and understanding their clients' perspectives, and collaborating in goal setting and decision-making were important. Clients held preferences for active involvement in their care, with a mean score of 12.4 (S.D.=1.5), where scores could range from 4-16. Both physiotherapists and clients agreed that adherence to the professional's advice was important.

CONCLUSIONS

Findings indicate that Irish physiotherapists in this study held positive attitudes towards client-centredness and that the clients in this study preferred being actively involved in their care. It is recommended that undergraduate and postgraduate education for physiotherapists address the humanistic and affective domains of knowledge and skills to facilitate the development of positive attitudes towards client-centredness. Further research should address the challenge of health practitioners' accepting client autonomy.

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P 8: STRATEGIES OF CO-OPERATION AND CO-PRODUCTION OF HEALTH- CLINICAL PATHWAY IMPROVEMENT THE: PATIENT ROLE

Antonio DI SANTO, Luciana LAZZARINO, Maurizio MELLANA, Renza SANTANGELO, Domenico TANGOLO, Alberto BIGLINO, Roberto GERBI, Donatella CIACERI, Andrea MORRA, Roberto RUSSO

Promoting modality of involvement and active participation of the patient in the process of improvement of the quality care, has the objective to construct a clinical pathway to answer to real needs of the "client". This is a quality strategies of enabling patients to actively co-operate in diagnostics, therapy and care, as well as to take responsibility for their health and contribute to reduce complications.

The aim of this study was to understand the role of patient in the clinical pathways design. Patient's illness representation, which include cognitive and emotional aspects, along with patient suggestions, are considered as vital data in order to design effective clinical pathways. Direct outcome related to health care professional-patient relationship and service re-organisation can be widely found in literature and observed in daily clinical practice.

In this study, a multidisciplinary group interviewer in order to figure out expectation and relational needs which raised during the routine clinical pathway in a sample of chronic liver disease patients recovered in the ASL 19 Infective Disease Unit.

AIM OF THE QUALITATIVE STUDY WAS TO:

- Figure out which aspect of health care professional behaviour and/or language ("killer words") could reduce the perception of the trauma from the patient point of view.
- Give back the results of the study to all the Infective Disease Unit health care professionals, in order to promote a higher consciousness of the power of the health care professional-patient relationship in the clinical pathways.

The results will be discussed in relation to the increasing need to shift the clinical pathways design from a merely disease centred point of view to a illness centred point a view (Engel, 1977). We found out confirm that "Illness" contains the "Disease" but not vice versa and the way a patient can represent the disease is related with quality perception and with doctor shopping phenomena (Beckman, 1994).

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P 9: CLEAN SELF-CATHETERISATION - CSC

Riina TIIDO, Ylle MUSTALLIKAS

The videofilm "Clean self-catheterisation" was prepared within the study proceeding from the data of specialist literature and the need for patients education.

The aim of the study was to describe clean self-catheterisation and to make a film on the basis of it. Proceeding from the aim of the study the following tasks were set:

- To describe nursing activities in the case of the neurological patient with urination disturbance on the basis of the fundamentals of contemporary nursing science.
- To draw up a scenario of a study videofilm for introducing self-catheterisation on the basis of the analysis of specialist literature.
- To obtain an expert evaluation of the necessity, comprehensibility and informativeness of the videofilm.

When studying and analysing specialist articles by different authors an author came to the conclusion that CSC as a method of care is widespread and recommended worldwide. In Estonia, patients education is at the initial stage and Estonian-language study materials for patients and for nurses who instruct them are limited.

While compiling the study material I proceeded from the assumption that it will be used as an aid in teaching patients. A videofilm creates a positive mood for teaching and gives better possibilities for learning of the procedure. Also, it helps prepare and plan teaching process and makes invisible visible. Using the videofilm it is easier to give explanations to patients who have difficulties with hearing or understanding.

Regarding the future, I consider it important to prepare new study films and study materials. Through this it is possible to improve the quality of nursing activities and to improve also the wellbeing of patients.

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P 10: CARE PLANNING IN PARTNERSHIP WITH PATIENTS/CLIENTS

Geraldine KIRK, Eamon MCGRATH, Declan MANGAN

This project developed as a result of a client satisfaction survey whereby clients expressed a desire to be more involved in decisions around their care and to have specific time allocated to spending with their key nurse.

GOAL STATEMENT

Our aim is to promote and foster a culture, which improves client participation in the management of their own health care.

OBJECTIVES

- To establish a client/patient to nurse allocation system which supports continuity in care.
- To develop a care planning process which supports an individualised care planning approach.
- To establish a recognised forum which facilitates shared decision making with the patient/client on their health care needs.
- To seek the views of patients/clients in relation to how to improve the system of care planning.
- To show clear evidence of patient/client participation in their own care planning.
- To improve satisfaction rating with patient/client involvement in own health care.

involvement in own health care.

RESULTS

This is a list of the improvements that have occurred since commencing this process:

- Monthly meeting by appointment for patient/client with identified key nurse.
- New nursing records.
- Provision for patients/clients to sign off on their own care plan and evaluation of care.
- Direct participation by patients/clients in identifying their own health care needs and care plan.
- Improved identification of Key Nurse.

CHANGES MADE

- Re-organising the client to nurse allocation system, thus improving identification of key nurses.
- Introducing new nursing care documentation and education of staff on its use.
- Introducing choice of nursing model or approach to appropriately reflect the needs of the client group.
- Establishing a forum for client and key nurse meeting to be held at least monthly.
- Seeking client and staff views on how to improve the care planning process.

CONCLUSIONS

The development of this approach to care planning has empowered clients to take a more active role in the management of their own health care. The service has a more client centred focus because of the partnership approach. Nursing staff are exploring new ways to give clients more choice and involve them more in their own care.

FUTURE PLANS

- We expect to further build on client involvement, and that the partnership approach becomes integral part of culture.
- We expect an improvement in satisfaction ratings in a number of areas, e.g. time spent with key nurse, range of activities for clients to engage in, and client involvement in own care planning.
- We expect to explore further, models and approaches, which more appropriately reflect the health care needs of our client group, and adapt these approaches to implement in our services.

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P 11: THE COOPERATION BETWEEN MEDICAL PERSONNEL AND PATIENTS AIMING TO REDUCE THE PREOPERATION STRESS

Loreta-Rasute REZGIENE

INTRODUCTION

Any illness provokes the stress situation demanding both from patient and medical personnel maximum concentration of skills and competences. A patient, who is ready to undergo the operation, cannot avoid the stress. Medical personnel has to identify the patient's reaction to illness - anxiety.

ety, fear, anger, feeling of guilty,- and to help to cope with these reactions.

THE AIM

To evaluate the aspects of cooperation between medical personnel and patients in order to reduce the preoperation stress.

OBJECTIVES

- To analyse the patients preoperation stress.
- To foresee stress reduction measures.

RESULTS

The data of anonymous questionnaire of patients showed that the experient stress depends on time, left before operation - the shorter is interval before operation, the stronger is stress: 3 days before operation 40% of respondents indicated that they didn't feel any stress, 52% of respondents indicated low stress, none felt any moderate , high or very high stress.

On the day of operation even 50% of respondents suffered high stress, 7 % - very high stress, 43%- the moderate stress. Almost all respondents indicated that stress was caused because of fear: respondents indicated, that 90% of fear was caused of inability to look after themselves in post operation period, 80% - of loosing job, 70% - of post operation pain, 80% - of changes in life style, 60%- of changes of the role in family, 40% - of lack of information about illness and after effects, 30%- of anesthesia "to get asleep and not to be able to wake up", 20% - of any intervention.

50% of respondents indicated that communication with medical personnel helps to overcome the stress. Patients most of all are apt to communicate with doctors (52%) and nurses (52%), while 7% of them indicated that before operation they had no possibilities to communicate with doctor, and 8% - that they had no possibilities to communicate with surgeon before operation.

90% of respondents stated that the stress reduces possibility to discuss health related issues with doctor, but only 30% of respondents pointed out that they took part in the decision making concerning their treatment process. Others respondents (70%) claimed that all health and treatment related decisions were made by doctors or surgeons.

In opinion of 80% of respondents the stress reduction is possible by providing the additional information about illness, operation and post operation period. The importance of talking with priest indicated 30% of respondents, while 60% of respondents indicated the stress reducing effect of smoking.

CONCLUSIONS

The respondents endure with the stress differently as well as they have different attitude towards the stress reduction ways. Most of respondents get stressed because of lack of information. According to them communication with medical staff, sufficient information about illness and its treatment , active participation in decision making would reduce the preoperation stress. The communication between patients and medical personnel should be based on principles of cooperation: the patients should be provided possibility to take part in health related decision making, be informed on illness, treatment and future perspectives.

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P 12: QUALITY AND CONTINUITY OF CARE IN DAY SURGERY

Federico GIBERTONI, Franca GOLINELLI, Anne Marie PIETRANTONIO, Stefano CENCETTI, Iolanda PO

With the rapid advance in technology and the onset of minimally invasive surgery over 60% of the surgical procedures, is provided on an out patient basis.

In Carpi Hospital from 1999 was carried out a project to realise a Day Surgery Unit in the aim, to assure efficiency and effectiveness of care, in surgical treatment.

The realisation of a dedicated Day Surgery Unit, allowed a re-engineering of the work organisation and of the patient approach, in surgical care.

Patients enrolled to day-surgery treatment, are admitted as outpatients to the pre-admission clinic two weeks prior to their scheduled surgery date, for the execution of all pre-admission testing, anesthesiological visit and any consultation that are required at this time. At the same time the surgeon, the anaesthesiologist and the nurses, give instructions to the patient and their family about preoperative needs in the aim to enhance competence, physical and psychological well-being, relates to the surgical experience.

At the discharge patient, and patient's family, receive written information's about pain management postoperatively at home, and about follow up visits.

The program set up in Carpi Hospital, that emphasis patient teaching, care planning and discharge planning at home, allowed:

- Increased accuracy of the patient information and compliance.
- Improved quality of care.
- Positive image for the hospital and of public's perception of profession quality.
- Increased job satisfaction for medical staff and nurses.
- Improved continuity of care.

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P 13: EMPOWERING PATIENTS IN CLINICAL INTERVENTIONS – EXPERIENCE OF RUSSIAN HOSPITALS

Izolda CHEREPANOVA, Anzhela BAKHOVA, George GOLUKHOV

OBJECTIVES

Level of hospitalisation, forms and types of informed consent

to medical intervention, patients' evaluation on the results of their stay in hospitals.

METHODOLOGY

- Statistics
- Social and psychological
- Sociological monitoring

EVALUATION

During the last years the level of hospitalization in the Russian Federation is 20.7 - 21.9 for 100 people. Every fifth citizen of Russia stays in a hospital more than 15 days annually.

Informing patients of forthcoming clinical interventions is an integral right of a patient, though it isn't stipulated in the legislation of the Russian Federation.

In connection with peculiarities of hospitalization patients are divided into three groups: about 30.1% of patients are admitted to hospitals for elective surgeries or treatment; 59.6% - emergency cases; 10.3% for consultation without hospitalization.

We developed variants for receiving patients' consent to different interventions. For example, patient's consent to medical intervention; patient's consent to surgery; patient's application for medical intervention using expensive materials; consent to anesthetic management of a medical intervention; patient's consent to transfusion of blood components and substitutes; renunciation of hospitalization.

A study of patients' opinion on discharge from the hospital showed the following. 321 patients were interviewed. 303 patients (94.4%) were satisfied with the treatment, 28 patients (5.6%) were dissatisfied.

51.2% of patients evaluated medical assistance rendered by physicians as an excellent one, 37.7% as a good one, the remaining 11.5% evaluated it as a satisfactory one. Paramedical personnel's activity was evaluated in the following way: 64.8% - excellent, 22.6% - good, 12.6% - satisfactory.

Patients make suggestions for a quicker way of contacting their families and relatives; modes of communication; about how to have more time for communicating with chief doctors – heads of departments, deputies head physician. These suggestions also concern the way of behaviour after a medical intervention, methods and means of health resumption and rehabilitation.

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P 14: USING COUNSELLING SKILLS IN NURSING CARE AND EMPOWERING PATIENTS TO TAKE SELF RESPONSIBILITY FOR HEALTH: DEVELOPING AN HPH CULTURE

Michael JACKSON, Denise RICHARDSON

EQUIPPING THE HPH NURSES OF THE FUTURE

Training in the use of counselling skills can improve communication, clarify understanding, challenge dysfunctional perceptions, empower and promote empathy and emotional support (Hetherington 2001). However, 'counselling skills' do not usually form part of modern nurse education, instead students learn and master basic 'interpersonal skills'. In acute hospitals nurses spend time 'doing' practical tasks and due to staff shortages little time can be allocated for talking with patients. However to develop a HPH culture nurses need to take time to consider or utilise counselling skills to provide develop an empowering therapeutic alliance between nurse and patient.

COUNSELLING SKILLS IN NURSING: EMPOWERED PATIENTS TAKE RESPONSIBILITY FOR THEIR OWN HEALTH

As an experienced counsellor entering nurse education I have found the use of counselling skills an advantage. When Nurse meets Patient a 'social encounter' (Goffman 1972) is presented before us and strangers meet. The patient is presented with people in uniform and experiences an unfriendly and dis-empowering experience, a strange environment creating stress and anxiety. Certain characteristics have been recognised as fundamental for the positive use of counselling skills, congruence, empathy, regard, concreteness, immediacy and considered as core skills in establishing a rapport with a patient (Rogers 1980) empowering them to take self-responsibility for their own health:

NURSE COUNSELLORS (Freshwater 2002) - IMPROVING NURSE AND PATIENT HEALTH LITERACY AND DEVELOPING A HPH CULTURE

'Nurse counsellors' assist in the process of relieving stress and anxiety for both service provider and user, improving health literacy of nurse and patient, creating a positive impact of the health promoting hospital service and contributing to an overall health promoting hospital culture. Evidence of patient 'health literacy' in action includes comments: "I really appreciated talking to someone prior to my procedure" "I felt reassured" "He gave me an opportunity to express how I felt" "I felt much better after talking to someone".

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SESSION I-2: MOTHER AND BABY FRIENDLY HOSPITALS – FOR PATIENTS, STAFF AND COMMUNITY

P 15: BREASTFEEDING SUPPORT, A DROP-IN CLINIC

Geraldine HANLEY

ABSTRACT

In August 2003 a hospital based, weekly drop- in breastfeeding support clinic was established in Letterkenny Maternity Unit to promote, protect and support breastfeeding. The Unit currently has a breastfeeding initiation rate of 48% with an approximate 10% discontinuation rate on discharge from hospital.

CONTEXT

This project was established in support of the regional breastfeeding policy and the "Baby Friendly Hospital Initiative" (BFHI).

AIM

To provide professional, practical and peer support for breastfeeding mothers and to increase the current breastfeeding initiation and duration rates.

CONCLUSION

Breastfeeding mothers attending the clinic with their babies enjoy professional, practical and peer support in a relaxed, social environment. Partners and siblings are welcome and play toys, refreshments and changing facilities are provided.

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P 16: BREAST FEEDING – THE WEST LOTHIAN WAY

Diane LOUGHLIN, Linda MIDDLEMIST

BACKGROUND

West Lothian Healthcare Division has an active programme of health promotion activities within its integrated primary and secondary care settings. The organisation works closely in partnership with the Local Authority through jointly funded Health Improvement Programmes. The idea for the production of a calendar came from members of the Breast Feeding Implementation Group and the Health Improvement Funded Food and Health Project and with local mothers in West Lothian.

AIM

To produce a calendar with local mothers breast feeding in local settings to challenge the cultural norm of formula feeding and promote positive imaging of breast feeding.

METHOD

The calendar was developed in partnership with all agencies and parents. Health Visitors and Midwives supported recruitment of breast feeding mothers. Local communities and businesses were approached to identify locations.

New and previous breast feeding mothers were identified and matched with locations for photographs.

Evaluation of the calendar will include monitoring of breast feeding rates, qualitative data from midwives and health visitors at visits as well as monitoring of requests from other agencies.

RESULTS

2500 calendars were produced and positively promotes breast feeding in a variety of settings such as the local football club, shops, home, sport centres, clubs and even the Scottish Parliament. It was launched at Livingston Football Club in December 2004. Local MSP representatives, Scottish Executive speakers and 120 staff, breastfeeding mothers and relatives attended.

OUTCOMES

- Widely displayed within health, local authority, school and library settings.
- Increased awareness of breastfeeding benefits.
- Monitoring of Breast Feeding Rates.
- Qualitative data collection.
- Cultural change in attitudes.

CONCLUSION

Although a recently developed project, some evidence suggests the calendar has started to make a difference through raising awareness of the benefits especially with the quotes of local breast feeding mothers.

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P 17: KNOWLEDGE OF THE FATHERS ABOUT BREASTFEEDING

Rasa TAMELIENE, Giedra LEVINIENE, Rita BANEVICIENE

Support of the family, especially of the newborn father, is very important for the successful breastfeeding.

Kaunas 2nd Clinical Hospital achieved Baby Friendly status in December 2004. 80% of men took part in the delivery and half of them (50%) stayed with the newborn and mother in the same room until the time of their discharge from the hospital.

AIM

To evaluate the knowledge about breastfeeding of the fathers of the newborns, born in the Kaunas 2nd Clinical Hospital Obstetrics Department.

RESULTS

100 of the fathers answered to the questionnaire with 15 questions about breastfeeding management:

2% of respondents were up to 20 years old, 66% - 21-30

years old, 25% - 31-40 years old, 7% of respondents were older than 40 years. Education of the fathers was: secondary - 34%, special secondary - 23%, high - 43%. 82% of parents were married, 18% - were partners.

Self-evaluation of the knowledge about breastfeeding was as follows: excellent - 4% of men, good - 32%, satisfactory - 57%, bad - 7%. Only 14% of fathers attended education classes together with mothers. The sources of knowledge were indicated as follows: 25% mass media and TV, 38% - special literature, 49% - wife's, 39% - medical workers. All fathers wanted their newborns to be breastfed. 3% of them answered, that the newborn must be breastfed till first month of age, 18% - till 3 months, 54% - till 6 months, 2% - till one year of age. 3% of respondents answered that complementary feeding of infant must be started at 1 months of age, 25% - 3 month, 75% - 6 months, 2% - at one year of age. 80% of fathers knew that infant doesn't need other drink, than mother's milk. 72% of respondents answered, that breastfeeding should be initiated during first 30 minutes after birth, 18% - during 2 hours, 10% - during 24 hours after birth. 66% of fathers knew, that infant should be breastfed on demand.

CONCLUSION

Father's knowledge about breastfeeding was evaluated as insufficient. Fathers must be given more information about breastfeeding.

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P 18: HEALTH BEHAVIOUR OF PREGNANT WOMEN IN ESTONIA AND ROLE OF FAMILY SCHOOLS IN HEALTH PROMOTION ACTIVITIES

Maarike HARRO

Considering the marked role of a pregnant woman's lifestyle on health of both a woman and a future child and assumingly impact of this period of life to be more open to lifestyle changes, information on relations between pregnancy and health behaviour is of high importance in Estonia.

OBJECTIVES OF STUDY

- Describe health state evaluation and behaviour connected to health state of women newly given a birth, 6 month before pregnancy, during and after it. Describe awareness and attitude towards physical activity during pregnancy and before it.
- Evaluate attendance of family schools trainings and satisfaction with their job.

CHOICE AND METHODICS

Data were collected on the basis of the special questionnaire during the period of December 10. 2002 up to April 15. 2003.

All the maternity hospitals and -departments in Estonia were asked to participate. Questionnaires were delivered to each mother after the 2nd or 3rd day after the living child was born. 565 filled questionnaires were got vback. Three (3) women refused to fulfil. The used questionnaire as the method had been worked out by author of the paper Marge Grauberg

and Maarike Harro (University of Tartu Institute of Health Care).

RESULTS

- In connection with pregnancy estimation 'very good' on general health state decreased mainly on the account of increase of estimation 'good'.
- Increasing part of these women were complaining sleeping problems, higher blood-pressure, worrying too much, or being too tired, easily irritative, problems with joints-bones.
- Most part of women changed their way of life more healthy. Especially concerning eating habits, smoking less or dropping it, and less alcohol consumption. More attention was paid to work and rest regime and women tried to spend more time in the open air.
- Physical activity got a positive attitude and it was claimed that they tried to move more and be more active but it did not come out from their behaviour estimations.
- 5. More information about physical activity during pregnancy was got from books and journals, via internet, from mother, friends, relatives, then followed TV/radio, medical sister,. Family school and gynecologue hold the last place in the list .Most of the women (74.6%) did not get instructions about the first physical exercises in marital departments, yet 25.4%, confirmed this kind of training had taken place there.
- Majority of women who attended family schools found it very useful or useful to some extent. Yet only 31% of pregnant women attend the school and 1/4 of them goes there 3 or more times. At the same time 45% of women admitted that their knowledge are average or low how to take care of a newborn or about their healthcare. Evidently it is necessary to think how to change family schools activity so that what they are offering would reach bigger part of the pregnant women.

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P 19: BABY FRIENDLY HOSPITAL INITIATIVE – WORKPLACE, GALWAY REGIONAL HOSPITALS

Fiona FALVEY

The Baby Friendly Hospital Initiative Working Group developed Guidelines on Lactation Breaks for all staff who are breastfeeding mothers, which aims to support and meet the needs of our employees who want to continue to breastfeed their babies for the first 6 months of the infants life after returning to work.

We also developed an information leaflet for all staff who apply for maternity leave "Combining Breast-feeding & Employment", covering areas such as:

- Why Breastfeed?
- Why Breastfeeding is best for your baby?
- Why Breastfeeding is best for you?
- Details of the initiative, and the facilities and resources available (20 minutes per 4 hours work sessions are available in addition to normal breaks to express milk.;

Lactation breaks have to be taken within rostered working hours and not at the start or end of the working shift; This break is forfeited if not taken within your rostered duty on that day or night.; This 20 minutes lactation time cannot be accumulate; A suitable room is available for expressing so that there is privacy.

- Before going on maternity leave, interested staff should discuss lactation breaks with their line manager

Signs for Lactation Room, a new fridge, kettle, chair, changing mat and activity centre were obtained for Breastfeeding Room.

A Lactation Survey/comment card, comment card holder and box for completed cards were placed in breastfeeding room. The comment card asked questions, as follows:

- Did you receive an information leaflet?
- Were you made aware of the Lactation Breaks?
- Did you avail of the Lactation Breaks?
- Did you use the designated Lactation Room?
- Was your work environment supportive?

The Ten Steps towards Successful Breastfeeding document was framed, along with our Certificate of Commitment, and hung on walls in all areas.

A summary of the Breastfeeding Guidelines in on the Intranet for all staff, and a copy is also in all manuals in all areas of the General Hospital.

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P 20: IS THE ROTUNDA HOSPITAL A BREASTFEEDING SUPPORTIVE WORKPLACE

Maura LAVERY

This is a poster presentation outlining the practices that are in place in the Rotunda hospital to be a breastfeeding supportive workplace. For example it outlines:

- Paid lactation breaks.
- Education to all staff.
- Space - The provision of a designated room for a staff member to express milk for/feed her baby.

It also outlines why the hospital should support its staff in this way, for example:

- It reduces absenteeism
- Reduces costs
- Supports a family friendly work culture

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SESSION I-3: HEALTH PROMOTION FOR CHILDREN AND ADOLESCENTS IN HOSPITALS (I)

P 21: RESULTS OF THE STUDY FOR THE IMPLEMENTATION OF THE CONVENTION ON THE RIGHTS OF THE CHILDREN

Lagle SUURORG

INTRODUCTION

One important aim of Health Promotion for Children and Adolescents in Hospitals (HPH-CA) should be improvement a hospital culture and practice based on the respect of the rights of children and adolescents in hospital.

Aim of the project was to study the opinion and practice of health care workers on adoption of the Rights of Children in Hospital.

- Setting: tertiary level children's hospital.
- Study time: year 2004.
- Study instrument: questionnaire for the implementation of the Convention on the Rights of the Children in the Hospital from department of Social Medicine "P & A. Kyriakoy" Children's Hospital.

RESULTS

Altogether 61 persons filled the questionnaire, among them 49% physicians, 38% -nurses and 13% - other professionals. 71% of respondents were aware of the Convention on the Child's Rights and main source of information was the media. Only 1.6% of respondents got some information about Convention from the university. Hospital environment, facili-

ties and space for confidential discussion with children/adolescents were assessed as children-friendly in 70-94% of cases. There was mentioned the lack of sensitivity of the personnel in the care and in communication and only 2/3 of workers had enough information material for patients. Only 54% of respondents mentioned that child encouraged to take active part in his/ her treatment and 58% asked children about needed services.

CONCLUSION

Information about UN Convention on the Rights of the Children should be transmitted to undergraduate students in university and there was the need of the postgraduate training on this topic. Sensitivity of the personnel in the care and communication with children need to improvement. Further studies on sick children's/ adolescents need should be done in hospital.

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P 22: SICK NEWBORN AND HIS FAMILY. COOPERATION OF PARENTS AND PERSONNEL

Rita BALCIUNIENE, Dalia STONIENE

GOAL

To examine parents' opinion, whose newborns has been treated in KMHU Clinic of Neonatology, about personnel's work.

METHOD

Conducting anonymous surveys using questionnaires.

RESULTS

Most parents (61.3%) noted that doctors were aware of their needs, however a part of them (13%) affirmed that they attained it only sometimes. The dialog between parents and doctors determined that quite a few parents (64.5%) always relied upon doctors, one-third did it most of the time, and only a small part (6.0%) did it seldom. There was not relation with number of children in a family; however has statistically coherency with marital status: single or married mothers relied upon doctors more than divorced mothers did.

Often doctors consort with troubled parents too little, excusing themselves by saying that they are very busy. Perhaps that is why only 38.7 % of respondents claimed, that doctors always spared them enough time and 58.1 % of parents indicated having attained proper attention. Nevertheless, nearly two-thirds of parents rated doctors' work positively.

Namely the nurse spends most of the time near sick newborn. Almost two-thirds of respondents commented that nurse paid not enough attention to their sick newborn, one-third of them felt that nurse understood them only sometimes. Most of the parents (96.8%) were on good terms with nurses. Most parents (74.5%) thought that staff really helped them emotionally, still 25.5% of responders felt misunderstood.

CONCLUSIONS

The proficiency of doctors ensures the quality of work, even so personnel needs to be prompted to consort with parents of sick newborn more. Doing so would improve opinion of parents about the quality of personnel work.

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P 23: "MANAGEMENT TO TWO" OF THE PREMATURE BABY: INTEGRATED APPROACH AMONG HOSPITAL'S CENTER OF REFERENCE AND PEDIATRICIAN FOR THE WELFARE CONTINUITY OF THE PATHOLOGICAL NEW-BORN BABY THEN THE DISCHARGE.

Camelia Gaby TIRON, Laura DECEMBRINO, Vania MONTALDI, Giovanni COMPAGNONI, Alberto RIGO

INTRODUCTION

The quality of the connection among pediatrician one and neonatologist depicts a central element to optimize the

welfare continuity and to guarantee taking by suitable loading of the new-born premature baby then the discharge by the neonatal intensive care unit (UTIN). This one himself realizes across a report of narrow collaboration among neonatologist and paediatrician where last one gains the coprotagonist's roll. With the activation of constituted team from neonatologists and paediatricians himself intends to offer to the paediatrician the possibility to put clinical problems, where to reconcile the necessities of the formation, to programme visits and checks together with the objective that a neonatologist and paediatrician use the same language. Thanks to this one the fathers will be able to exceed at best all the anxieties of family bound for the birth of a new-born baby pretermine and to benefit by an adequate follow up that can last years and be studded of problems and difficulty.

OBJECTIVES

- To establish a collaboration report with hospital's pediatricians and pediatricians.
- To promote the communication by hospital and territory.
- To improve one's the assistance and the life quality with the pathological new-born babies and some families of theirs.

APPROACH TO THE PLAN

- Cognitive research among the paediatricians basic - talking-group's founding.
- Definition of guideline and shareable path through welfare.
- Activation a consulting service 24/24 hours.
- Implementation at the presence at the paediatricians by the neonatology.

SPECIFIC TARGETS

- The creation of a communication network (paper, telephone and computer science).
- Elaboration cards of registration of the new-born baby from the admission, to the discharge, to the checks in follow up.
- Drawing up of operating and sharing protocols.
- Implementation of the knowledge of the prematurity's epidemiology and the correlativeness problems across the organization of formation courses.

EXPECTED RESULTS

- Gaining awareness of the correlativeness problems by the prematurity.
- Behaviour uniformity among hospital and territory - simplification of the patient's access to the hospital structures.
- Acquisition of an intimacy attitude and trust of family towards the health professional.

INNOVATIVE ELEMENTS OF THE PLAN

- Team work among paediatrician one and at the same level hospital practitioner.
- New way of procedure management of the premature new-born babies either in hospital or territory.

TRANSFERABILITY ELEMENTS OF THE PLAN:

- Simplicity of the selected resources
- Common problem in a lot of districts.

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P 24: TREATMENT AND PROMOTION OF CHILDREN AND ADOLESCENTS' HEALTH IN PSKOV REGION (RUSSIAN FEDERATION)

Vladimir GNATOVSKYI, Elena GNATOVSKAYA

At the present stage of healthcare system development a transition of a system oriented at treatment to the one aimed at health promotion is a priority in improvement of rendering medical care. Use of hydrotherapy and biologic feedback method, exercise therapy as well as other methods of non-drug therapy gives more noticeable results only in combination with other components such as rational nutrition, active life style, regular exercises and sports, giving-up bad habits. Taking into account complex social and economic situation in Russia, better results in children and adolescents' treatment and health promotion are obtained in hospitals. Comprehensive medical and non-medical assistance to children can be rendered only in hospitals so far.

Three years ago in 2003 a regional children's hospital was opened in Pskov. The hospital is fit with modern equipment purchased with funds allocated by instructions of the President of the Russian Federation Vladimir Putin.

It's no secret that hospitalization is a strong stressor for adults and children. That's why it's necessary to bring hospital environment near a family one as far as possible.

The first impression of a hospital is produced by its interior. That's why while painting walls in the hospital white colour was avoided, as in big quantities it depresses children. And all the walls on different floors were painted in various colours. Warm tints were selected. There are pictures, vases with house plants and big aquariums in the halls. Furniture for small children is of appropriate dimensions.

There are curtains in canteens, tissue papers on tables. Plates and dishes are also selected according to patients' age.

The hospital has a playing room with plenty of toys. There is a gymnasium and a "dry" swimming pool for patients who need exercise therapy.

We specially focused our attention on the hospital's interiors and furniture as on non-drug methods of treatment. Of course such a big hospital as this one has well equipped surgery and rehabilitation departments; there are filter and ventilation installations with air conditioning. But any good hospital is equipped like that but interiors which are designed inventively are new for Russian hospitals.

All this gives children an opportunity to feel at home which leads to more rapid recovery. As a result children and adolescents' health indices have improved considerably for the last two years.

It's reasonable that neither most modern medical equipment only nor beautiful interiors can cure or promote children's health. Qualified medical staff is required.

A physician is often called a teacher and a mentor. No profession but medicine is so closely connected with human fate. Relations between people depend very much on culture and way of behaving: ability to get in touch with a person, understand and establish relations, delve into a person's inner world. There are different kinds of a communication

process: gestures, mimicry, intonation, but the most important of them is talk.

It's necessary to consider that a patient in a hospital is far from the way of communication with relatives and friends he is accustomed to. He finds himself in an unaccustomed world and doesn't adapt himself to it at once. A patient feels lost, lonely and unhappy. Many patients have a hard time during their stay in hospital due to mental sufferings rather than physical ones. That's why it's necessary to lavish care upon a sick child.

Specific character reveals more vividly among younger children. A child has much vital energy and force. Fear is a dominant in children's relations with a doctor even if they are well brought-up and courageous by nature. Children have rather unpleasant associations with a doctor's smock and specific scents. Environment for a small child is either fine or terrible. While getting in touch a young patient can trust a doctor and it helps a treatment process.

Young patients' parents are to be treated in a special way. They are confused, alarmed and impatient. A doctor's duty is to show maximum understanding and patience.

Much attention is paid now to improving mutual relations between a doctor and a patient and his relatives. Healthcare reform in Russia has only been announced but where to go and how to work isn't very clear so far. We believe that only the initiative "from the bottom" will lead healthcare management and the branch itself to the right track. So whatever to begin with but with the up-to-date, modern and new regional children's hospital?

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P 25: AN UNEXPECTED VISIT

Edwige GOMBACH, Giulio Andrea ZANAZZO, Stefano RUSSIAN

Accreditation is the process of external self-assessment among peers used by health organisations to carefully evaluate levels of performance in relation to set standards and identify ways of continuous improvement of the health system (1).

This work deals with the quality perceived by the staff of a department (Pediatric Oncology) that received an accreditation visit in the framework of the project "Charter on the Rights of Children in the Hospital and identification of assessment criteria for the respect of the mentioned rights"(2, 3, 4).

When the staff was informed of a sudden visit to the Department, reactions were:

- Nuisance
- Annoyance
- Anger
- Inadequacy.

In light of these feelings, in October 2000, three department delegates took part in a training course on perceived quality and accreditation. At the end of the course, the feelings had

radically changed.

The department manager, once he received the check list, summoned the three delegates to analyse together articles, statements and the criteria for evaluation standards.

A feverish period followed in which department documentation was evaluated, and in an excess of zeal, a negative judgement was expressed on criteria which the visiting Commission later judged as satisfactory.

Evaluation, therefore, had changed from self-assessment of the work done to more objective criticism which was leading to an overall revision of procedures based on the human, instrumental and structural resources of the department.

It was a very rewarding experience for the department representatives because of the benefits achieved mainly for the hospitalised children, but also for the organisation of routine activities.

CONCLUSIONS

- The team felt they could interact at the same level with the visiting commission because they had gained command of the accreditation procedures;
- Meeting the members of the commission represented a cultural enrichment for everyone;
- The team did not feel they were being "judged".

The only negative mark was the low involvement of the majority of operators in the department.

It is, in fact, desirable that ad hoc instruments are put in place (department meetings, spreading of written reports) to achieve greater success and involve all the operators from the first stages of the project.

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P 26: THE "POLLICINO" PROJECT - "A GLOBAL, COMBINED, MULTIDISCIPLINARY PROJECT WITH PEDIATRIC ONCOLOGICAL PATIENTS"

Mariano GIACCHI, Anna GRASSO, Lucia RAPPUOLI, Giada MACINAI, Antonella SECCO, Daniela URILLI, Chiara GIUDONI

The strong impact that a neoplasia illness has on the young patients and his or her family heavily influences both the psycho-social development of the child and the progress of the family concentrated on the ill child and his or her disease.

It's necessary to guarantee the oncologic child and his or her family a "GLOBAL CARE" for both their physical and psychological well-being.

GENERAL OBJECTIVES

This project aims to establish in advance to help parents process and overcome the diagnosis, which operates on the phases of welcome, treatment and discharge.

SPECIFIC OBJECTIVES

- The welcome phase, is based on the idea that "a positive welcome is the first step of treatment". The communication must be clear and effective, focusing on the comprehension of the illness and appealing to each family member's resources.
- In the treatment phase the care program is outlined, including the therapy protocol, the length of the period of hospitalisation, tests to be done, and any eventual changes of the initial treatment program based on incoming test results.
- In the discharge phase, the project aims to offer continuous social assistance by activating and involving territorial health services.

WORKING METHODS AND CONCLUSION

In order to attain these goals, the project intends to activate the following infrastructure:

- A multidisciplinary work group that will meet periodically for case evaluation and agreement upon individual projects.
- Organization of a competent service that can adequately respond to needs of the patient's parents.
- Psycho-social counselling.
- Improvement of the setting actions.

The project has developed from the consciousness of the various health professionals of an urgent need for a multidisciplinary cooperation in which all are involved, especially the parents.

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P 27: THE CLINICAL PEDAGOGICAL LABORATORY IN ORDER TO AMELIORATE THE MANAGEMENT OF CHRONIC DISEASE IN THE PEDIATRIC AGE

Daniela MANFREDI, Emanuele D'AGATA, Antonello BALDI, Antonietta SILINI, Enrico COMBERTI, Rosaria AVISANI, Alfonso CASTELLANI, Luigi Daniele NOTARANGELO, Raffaele SPIAZZI

SCOPES/OBJECTIVES

- To structure, around the child and his/her family, a network of intervention in terms of self-management, health and prevention, intended as the elimination

and/or reduction of anxiety and fear towards the acute and/or chronic events, the hospitalization.

- To configure the Clinical Pedagogical Laboratory as a center of communication/education, and as a sanitary formation, which acts as a promoter of:
 - The institution and its health operators
 - The users, intended as the child and his/her family
 - The institutions outside of the hospital, for example the pharmacy, the school and educational and recreational centers used by the children
 - Other hospital institutions
 - Scientific societies
 - Sanitary and social institutions
- To concentrate in a single, recognizable, operative structure the following activities: obtaining and analyzing statistics, providing a benchmark for instruments used for communication, the sharing of project proposals at the national and international level, and the certification of procedures and protocols for the promotion of collaboration.

METHODS/ACTIVITIES

The Laboratory is oriented towards the development and the promotion of this educational project, mainly across:

- Informative and Formative initiatives (ECM courses, seminars, scientific publications...) of the "actors" (medical doctors, nurses, pharmacists, teachers...).
- Sanitary education courses for the children, the adolescents, and their parents.
- Planning/Production/Popularization of educational material characterized by a unique style composed of:
 - Multimedia products, CD-ROM, internet.
 - Educational materials such as booklets with stories to color, interactive worksheets...
 - Materials for games such as: dominos, puzzles, bingo...
- Research activities/surveys.
- Scientific activities/cultural.

RESULTS/CONCLUSIONS

The Clinical Pedagogical Laboratory qualifies as a center which supports and encourages communication, education, and the professional formation of its users, and of all the center's actors. Furthermore, the center improves the management of pediatric assistance and it promotes the quality of the institution.

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P 28: RESULTS ON INPATIENT SATISFACTION STUDY IN TALLINN CHILDREN'S HOSPITAL

Lagle SUURORG

Study on patient satisfaction has been carried out every year according to total quality management program.

AIM

To assess the parents' satisfaction with children's health care in one of Health Promoting Hospital of Estonia - Tallinn Children's Hospital.

SUBJECTS AND METHOD

At the time of hospitalization with child 464 mothers filled out the 26-item questionnaire addressing overall satisfaction, loyalty to hospital, satisfaction with accessibility of inpatient care, given information about process of care, trustiness to professionals and watchfulness to children and mothers' needs. A 5-point satisfaction scale ranging from "dissatisfied" to "very satisfied". Statistical package SPSS 8.0 for Windows was used for the data analysis.

RESULTS

Among of respondents 90.5% were mothers of children younger than four years. The overall satisfaction with inpatient care was high-96.5%. The same amount of respondents expressed loyalty to hospital. Six percent of mothers have had problems with accessibility of inpatient care. Very satisfied and rather satisfied with given information before health care process were 83.3% of mothers. A little less was satisfaction with explanation about used medicine (65.5%). More than eighty percent of mothers got clear explanation from nurses about planned procedures. Every tenth mother was not satisfied with explanation on care after discharging from hospital. Trustworthiness of physicians and nurses was high (95.3% and 88.8% accordingly). The difference in satisfaction with children's health care between different departments was drawn out.

CONCLUSION

There was found the need of improvement of information about medicine use and planned procedures. Better information is a tool of empowerment mothers to avoid preventable adverse event rate by medical management and to diminish quality problems in children's hospital.

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SESSION I-4: CHRONIC DISEASES (I): HEALTH PROMOTION FOR PATIENTS WITH DIABETES AND METABOLIC DISORDERS

P 29: MULTIPLE DAILY INJECTION PROGRAMME IN UNIVERSITY COLLEGE HOSPITAL, GALWAY.

Fiona FALVEY

Empowerment and the education of people with diabetes is the foundation and cornerstone towards which we strive in modern diabetes care. The enhancing of self-care of diabetes through education is our greatest challenge.

In UCHG we set up a multiple daily injection programme in January 2002. It involves all members of the multi-disciplinary diabetes team:

- Doctors
- Diabetes nurses
- Dieticians
- Chiropodists

The aim of the programme is to educate the patient on all aspects of 4 daily injections.

The programme covers all aspects, such as:

- Insulin dose adjustments
- Insulin dose supplements
- Hypoglycaemia
- Hyperglycaemia
- Sick day guidelines
- Foot care
- Dietetic input

Initially we covered the sessions on 2 consecutive information days.

However on patient satisfaction questionnaire replies, concerns were raised on overload of information and confusion regarding insulin dose supplements and insulin dose adjustments.

As a result we decided, in conjunction with our patients, to do the conversion to 4 injections per day (i.e. demonstrate the pen devices, rationale behind 4 injections and insulin dose supplements) on a one-to-one session. This session usually lasted 2 hours. We continued to keep phone support for three weeks. If any problem arose in the meantime we would see the patient again.

After this period of time we invited the patients back again to a group session for further education on their regime.

Overall, the results have been positive. We continually strive to improve and evaluate the programme in conjunction with our patients. We are currently in the process of adapting this course again with further emphasis on empowering the patient living on a day-to-day basis with diabetes.

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P 30: EMPOWERING YOUNG DIABETIC WOMAN TO GIVE THE BIRTH TO A CHILD

Evalda DANYTE, Vladimiras PETRENKO

THE GOAL

Through the diabetes education improve the quality of life of diabetic patients empowering them to manage their disease and its treatment, restoring normal social life.

THE ACTIVITIES

- The five day structured organized diabetes education program.
- Pregnancy planning.
- Organization of care of pregnant diabetic women.
- Diabetic mothers' day.

The staff involved consists of physicians-endocrinologists, gynecologist, nurses.

SUBJECTS AND ORGANIZATION OF ACTIVITIES

All young women who are referred to our unit get information about pregnancy planning during the regular educational courses and are informed about high possibility or positive outcomes of pregnancy. The care for pregnant diabetic women is organized uniting the members of diabetes care unit and obstetrics unit working as a team. Most the pregnant diabetic women from whole Lithuania are observed in our hospital and almost all have deliveries in obstetrics unit of our hospital. The outcomes of diabetic deliveries are similar to those of healthy women.

Once per year we organize the Diabetic mothers' day - a meeting where all the diabetic women who gave birth to a child are invited to participate together with their children and meet the team involved in the diabetic pregnancy care. Usually the meeting consists of discussion about diabetes care problems and little concert for children. Parallel consultations of specialists are available. TV and press cover the meeting, the publicity encourages more diabetic women not to be afraid of pregnancies and help up to countervail the belief that pregnancy can hurt both diabetic mother and child.

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P 31: EMPOWERING PATIENTS WITH DIABETES - NURSE'S ROLE IN PROMOTING HEALTHY DIET FOR PATIENTS WITH DIABETES.

Victoria OLADIMEJI

Education about diet is essential to delay the onset, or even prevent diabetes in those at risk of Type 2 diabetes and for the effective management of the condition in those with Types 1 and 2 diabetes.

Nurses, in collaboration with dieticians are uniquely placed to provide this input and to ensure the integration of accurate

and consistent dietary messages throughout hospital and community care teams.

The aim is to empower patients living with diabetes by providing them with the information required to make appropriate choices on the type and quantity of the food which they eat as well as their lifestyles.

The advice must take account of the individual's personal and cultural preferences, beliefs and lifestyle, and must respect the individual's wishes and willingness to change. The nurse should aim to facilitate self-care and help the patient acquire new knowledge and skills to make informed choices and facilitate behaviour change.

Dietary education should be a resource for life, an on-going interactive process between patient and the professional, not a standard package which can be delivered to a patient in a single session. In the initial stages after diagnosis, people may only be able to assimilate limited amount of information. The process of dietary assessment provides an opportunity to explain the types of dietary changes needed and to explore how these may be met.

MONITORING PROGRESS

Follow-up and review of progress is essential. The frequency of follow-up depends on the type of treatment, the patient's ability, level of confidence, and diabetic control. All patients should have at least one follow-up review and the opportunity of an annual dietetic review. Patients with special problems such as renal disease, pregnancy or perceived poor practice or knowledge should be seen more frequently.

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P 32: PROMOTING MEDICATION COMPLIANCE IN PATIENTS WITH DIABETES

Victoria OLADIMEJI

The aim of this paper is to explore ways of increasing medication compliance for patients with Diabetes.

Promoting Medication Compliance in patients with diabetes is an important aspect of holistic care. Non-compliance could lead to lack of response to treatment or worsening of the existing medical and nursing problems. It could also lead to unnecessary lengthening of patient's stay in hospital. In the current atmosphere of cost-cutting and waste minimization, hospitals and ward managers are looking for ways of improving the quality of care provision for patient in order to ensure successful rehabilitation at home. Medication compliance by patients is one way of improving the quality of treatment regimes in hospital as well as ensuring effective rehabilitation and prevention of re-admission of patients to hospitals. One of the ways of improving medication compliance in hospital setting is through patient education.

Although some of the factors contributing lack of medication compliance in hospitalized patients have been identified in a variety of research studies (Bassett 1992; Hancock 1994), little has been done in practice to improve the situation. This

paper explores strategy for improving medication compliance. An educational approach with emphasis on empowerment forms the basis of the overall approach.

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P 33: PROJECTING THE WHO STANDARD FOR HEALTH PROMOTION IN HOSPITALS ONTO THE TREATMENT OF DIABETIC'S

Nils UNDRITZ

An interdisciplinary working party of the Swiss HPH-Network tried to answer following questions:

Does the standard support health promotion for diabetic's' by using

- The management tools (standard 1)
- The patient tools (standard 2 & 3)
- The human resources tools (standard 4)
- The cooperation tools (standard 5)

The presentation will reflect the first results of deliberation, which is mainly that the treatment for diabetic's is improving, but is not yet well structured between the different health actors, so that the patient may get "lost".

Need is felt for developing teaching, coding of interventions, indicators and patient card.

We're looking forward to hearing from participants to this workshop their best practise solutions!

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P 34: EMPOWERMENT OF THE DIABETIC INPATIENT THROUGH NURSING CONSULTANCY

Marco GANASSI, Enrica MANICARDI, Maria Paola LINCE, Cristiano CARBONELLI, Loredana CERULLO

The analysis of the social context of the users of our hospital has underlined the necessity of an educational intervention during the ordinary admission of diabetic patients treated with insulin for the first time in the various operative units, through a regular and coordinated intervention during the time before the territorial diabetic service of reference takes care of the patient. Admission in hospital may become an ideal moment to catch the patient's attention and to give him significant lessons in the self-managing of the disease. In this context the critic points of the basic diabetic education, concerning diet, insulin, glycaemia control, may find a

greater attention, as an acute complication changes a chronic disease, usually silent, in something concrete.

The aim of this project is to assure that every inpatient affected by 1st type diabetes recently diagnosed or by 2nd type diabetes undergoing a new insuline therapy has confidence in therapeutic continuity from the discharge to the moment the anti-diabetes centre of reference takes care of him.

The project was studied in a joined way by physicians and nurses. All the staff of the ordinary admission and of the day hospital units of S. Maria Nuova hospital has to report the necessity of an educational intervention for the diabetic inpatients of the various units to the referencing nurse. Consultancy will be carried in the patient room or in the diabetes ambulatory, it takes 90 minutes and aims to give information and techniques for the 'survival' after discharge from the hospital. It helps to avoid complications associated with a grave hypoglycaemia or an acute hyperglycaemia.

The information concerns basic physio-pathology of the diabetic disease and possible treatment. Starting the insulin therapy needs to educate the patient in some abilities (to make a self-injection, to use the blood glucose meter), that can let the patient to adapt the therapy to his life style instead of adapting his life stile to the therapy.

Tests will be carried out in order to verify what the patient has learned, and nutritional education will be conducted by a dietician.

Illustrative material that permits to better remember what thought and to increase the knowledge will be handed out. It's also handed out to the patient a kit consisting in: pens for insulin or syringes for a two weeks treatment, insulin for a therapy cycle, blood glucose meter and reactive stripes and adjustable lancing device for two weeks self-monitoring, glycaemia diary.

The consultancy ends with the delivery to the patient of a nursing letter of discharge containing the information collected and a list of the material delivered.

We are sure that this highly structured intervention, made by the diabetic team and especially by an experienced nurse, is an educational and important instrument for the diabetic patient treated with insulin in hospital for the first time, and that this instrument is useful in all the hospital units, its usefulness lasts later than the foreseen safe discharge.

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P 35: ORGANISED PATIENT EDUCATION ENHANCES EMPOWERMENT OF PATIENT'S OF METABOLIC SYNDROME TOWARDS HEALTH RESTORATION

Tamas HALMOS, László KAUTZKY

Treatment of metabolic syndrome, as a main risk factor for fatal cardiovascular events, depends on successful change

of life-style and additional drug therapy.

Aims

To test the changes in compliance of metabolic patients regarding metabolic parameters and educational level, prior and after organised training course.

PATIENTS

- 58 males, 15 females, average age: 53.3 year
- 45 white-collar, 15 physical worker

All of them fit the criteria of the syndrome (elevated blood sugar, dyslipidemia, increased body weight, and high blood-pressure as well).

METHODS

We constructed a detailed questionnaire, including their attitude towards organic diseases, life-style (exercise), diet, knowledge-level, acceptance of the disease, compliance. We introduced a five-day course in small groups, maximum 7 patients/group adapting the curriculum of Teaching Letters written by professor Assal. During the course we informed them about the important instructions, concerning life-style, daily exercise, healthy nutrition, and necessary drugs. Written exams were carried out before and after training course, and after one-year follow-up period.

RESULTS

Knowledge level, compliance were improved after the course. Prior the training average score number was 53 (max: 100), post training score: 88. After one year score was 76. Organic metabolic parameters significantly improved after one year. Evaluating the questionnaires, it became clear, that worst problem seemed to be radically change of life-style, doing regular exercise, and keeping healthy diet. Instead of that, they preferred rather taking even many kind of drugs.

CONCLUSION

Our results gave evidences, that patient education, regular dealing with our patients by giving them detailed informations, keeping their motivational level, and self responsibility high, improves significantly both organic and mental well-being. In this kind of chronic diseases drug therapy alone is less sufficient than holistic approach

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P 36: COMPLEX REHABILITATION STRATEGIES IN PATIENTS WITH CHRONIC RENAL FAILURE (CRF).

Liidia KIISK, Ülle PECHTER, Mai OTS

Most chronic nephropathies lack a specific treatment and progress relentlessly to end-stage renal disease which prevalence is increasing worldwide posing a large morbidity, mortality and financial burden. Protective therapy may have the greatest impact if initiated early in the course of renal failure development. In addition of medication therapy, non-medicament strategies preventing progression of renal disease could be used in complex care strategies in patients with CRF.

Nutritional counselling, cessation of smoking and good blood pressure control should be integrated to the complex of combined nephroprotective and cardioprotective therapy for CRF patients to achieve the positive results. The progression of kidney disease could be influenced by dietary measures that support protein digestion. A care plan for nutritional management should be developed early in the course of CRF and modified frequently, based on the patient's medical and social conditions. The patients with CRF need to undergo nutritional assessment and their nutritional status should be followed at frequent intervals. Timely involvement of specialized rehabilitation team could be really beneficial.

In addition to pharmacological renoprotective therapies, beneficial rehabilitation strategies could be included, especially encouraging patients with CRF of participation in an exercise-conditioning programme. Aquatic environment is an ideal one for exercising for chronic renal patients. Regular, long-time provided exercising, even 2-3 times per week, produces a beneficial effect. The intensity of exercise should be low, with a prolonged warm-up and exercise adaptation period and time allowance for adequate cool-down.

Vocational counselling as an important part of non-pharmacological treatment could especially not remain under-valued. Psychotherapy and education offer potential benefits for patients including improved treatment outcomes. Each patient's condition should be taken into account individually when suggesting complex therapies. Patient-based management in the pre-dialysis period, in the most appropriate setting for the individual patient's needs, would best achieve the progression prevention in CRF.

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P 37: ANTHROPOMETRICAL MONITORING IN PATIENTS WITH CHRONIC RENAL FAILURE

Liidia KIISK, Mart LINTSI, Siiri MESIKEPP, Elviira SEPPET, Maie PIKKMAA, Mai OTS

Body composition, anthropometrical monitoring and nutritional status in chronic renal failure (CRF) patients (pts) including transplant pts. is necessary.

AIM

Was to systematize anthropometric data:
Body structure, food intake and biochemical analysis and dietician systematic reviews.

MATERIAL AND METHODS

40 kidney transplant pts were studied: 15 males (mean age 41.9 ± 8.6) and 25 females (mean age 49.5 ± 14.3). Diagnoses of patients were the following: pyelonephritis chronica – 8 pts, glomerulonephritis chronica – 25 pts, diabetes mellitus 7 pts. Studied biochemical indices were the following: serum albumin, creatinine, calculated GFR and lipid profile.

RESULTS

Pts height ranged from 150 to 182 cm, weight from 56 to 134.1 kg. 85% of pts had normal nutritional status and 15% of studied pts had overweight. Only one pts had severe undernutrition (BMI 16.2). Waist/ Hip Ratio (cm) was males

mean 0.89 ± 0.05 and females mean 0.86 ± 0.09 .

CONCLUSION

Anthropometrics is central to the study of body composition and physical fitness in transplant patients beside other methods. Studied pts were generally in good nutritional status. Systematized anthropometrics should become an obligatory procedure in everyday medical practice. The patient's nutrition has been of interest to investigators in the praxis of clinical medicine, health promotion and physical education many years.

In the clinical study of Tartu University Hospital there were assessed the role body composition during rapid weight loss in obese persons with the metabolic syndrome. The role of food habits and nutrient intake in patients with chronic renal failure considering their association with psychosocial factors.

Therefore, many aspects should be taken into account like patient age, gender, diagnosis, also functional status and cognitive function. Management guidelines for nutritional status are effective to the quality hospital care and was used in medical and nursing practice in hospitals.

Dietary management guidelines for nutrition and all data of diet nutrition has been linked to the clinic's integrated computer system. Example menus and recipes were published in Estonian as a handbook for doctors, nurses and dietitians (Kiisk L. Diet Nutrition. Tartu, 2002). Information for patients on fruits, vegetables and protein intake in foods were report in Estonian a handbook (Maser M, Varava L. For Good Healthy Eating. Tallinn, 2004).

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P 38: EMPOWERING PATIENTS FOR CHRONIC DISEASE IN THE NSGD HOSPITAL NEPHROLOGY AND DIALYSIS DEPARTMENT

Alberto APPICCIAFUOCO, Pier Luigi TOSI, Gabriela KUHN, Vania CORTI, Giorgio MONZANI, Cristina GRIMALDI, Laura GRAZIANI, Serena DEL PUGLIA, Marco QUERCIOLO, Vincenzo FUSARI

As a part of the HPH Program of the Nuovo San Giovanni di Dio Hospital in Florence, our Nephrology and Dialysis Department is providing an additional educational service for patients with End Stage Renal Disease that will soon need Renal Replacement Therapy (RRT).

Dialysis patients not only suffer from a chronic disease with all the physical, psychological and social consequences of their pathology, but are also often elderly, frail people who need support in collaboration with their families, to cope with a new and potentially stressful reality.

Patients and their relatives are followed by a group of dedicated nurses that provide them, before they start their treatment, with information and emotional support in order to:

- Learn to cope better with the important and often diffi-

- cult changes in their life.
- Help them choose the most suitable dialysis (Haemodialysis or Peritonealdialysis)

During various meetings they are given information and written material about the different kinds of treatment, changes in diet and lifestyle, and be encouraged to communicate their expectations, fears and difficulties with the help of a specially chosen nursing staff and, when necessary in collaboration with psychologists and dieticians. This enables them, to reduce stressful situations and suffering, cope better with their chronic disease, their life quality, improve compliance with the treatment and pharmaceutical therapy.

By educational, informative and psychological support patients have improved their lifestyle quality obtaining the following results:

- Reduction in hospital emergency admissions for acute pulmonary oedema and hyperpotassium cases.
- Decrease in the use of central venous temporary catheter closing arteriovenous fistula.

- Better compliance in treatment assuring a major psychic and physical health.

Patients that have had the opportunity to approach RRT followed by this program are better prepared to the new environment and their treatment, feel more participant and co-operating adapting better to their new situation.

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SESSION I-5: CHRONIC DISEASES (II): HEALTH PROMOTION FOR CANCER PATIENTS

P 39: CONTINUITY OF CARE FOR ONCOLOGICAL PATHWAY: PROMOTION OF A MULTIDISCIPLINARY APPROACH AND OF THE SECOND OPINION

Marcella FILIERI, Orlando GOLETTI, Luca CIONINI, Andrea FERRARI

RATIONALE

The peculiarity of the Pisan area, in which both the Local Health Service (USL 5) and the University Health Service (AOUP) operate, makes it necessary for health providers to pay particular attention to issues of continuity in care for each treatment profile.

The target of the project is to plan a route of treatment for each and every oncological illness - within and between the services (USL 5 and AOUP) - in order to ensure the right of choice between the different therapies available, and therefore to promote the participation of the patient within a framework of empowerment for health.

SPECIFIC OBJECTIVES

To prepare the following for each and every illness with oncological diagnoses related to cancer in the mammary glands and the digestive system:

- Multi-professional consultation
- Organisation of a way to obtain complementary professional opinions

The first point is to be carried out toward organising something of a "planned multidisciplinary consultation" between the professionals concerned in the case (oncologists, radiotherapists, family GPs, specialists in various disciplines, etc.).

The second point demands, at first, indicating to the patient all hospital, university and scientific research facilities in order to provide consultation in relation to the specific pathology, then arrangements for the visit to the facility chosen by the patient, and, finally, the transfer - possibly electronically - of the clinical data.

METHODS

In making the project a reality, action is to be carried out in three fields:

- Interactive relationships: professional training of the personnel of the two Health Services (in "inter-service team-building" or in "meaning of second opinion and relations between health workers and patients") and the publication of informational material ("a commitments charter").
- Organisation: revision of the work procedures within each service and the definition of procedures between the services.
- Equipment: software and hardware for the transmission of patients' clinical data between the health structures involved.

MEASURE OF SUCCESS

An improvement in the satisfaction of the clients demonstrated through the focus group on the oncological patients.

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P 40: ORGANIZATION OF CANCER PREVENTION AMONG THE POPULATION IN HEALTHCARE SERVICE OF THE REPUBLIC OF TATARSTAN (RUSSIAN FEDERATION)

Elena KHAFIZOVA

The most effective method of preventing development of malignant neoplasms is active detection of neoplasms at early stages and, hence, preexposure and postexposure.

First of all, importance of self-control, significance of preventive medical examination and timely visits to medical institu-

tions are explained to the population with the help of mass media.

Besides oncologic dispensaries existing within the Republic's healthcare system regional oncologists' service is organized in 41 territories. Gynecologists and obstetricians play an important role in detecting cancer of visual sites. Women are examined in antenatal clinics, gynecologic consulting rooms and rooms for patients' examination in city clinics, clinics of central regional hospitals, regional and district hospitals, medical outpatient departments, doctor's assistant and obstetric stations.

Cytologic laboratories on the basis of medical institutions including oncologic dispensaries are set up in 11 territories. Laboratory doctors and doctor's assistants trained on cytology work in clinical laboratories of 10 regions.

A cytological screening is introduced among women above 18 and older. It's aimed at timely detection of cervical pre-cancerous changes and carcinoma as well as at patients' sanitation. Cytological smear sampling is contemplated by the Programme of state guarantees on rendering free of charge medical care to citizens of the Republic of Tatarstan.

A number of detected cancer patients during preventive medical examinations has increased. In 2003 this index on average in the Republic was higher than a federative one.

Preventive actions called "Pink ribbon on the lapel", aimed at preventing breast and genitals cancer, have become traditional. During 11 actions medical specialists gave lectures to the population, 6020 women were examined by oncologists.

A special working commission responsible for studying healthcare service in respect of early cancer detection in regions and cities of the Republic was established in July of 2003 at the Ministry of Health of the Republic of Tatarstan on the initiative of the preventive department. Analysis of cancer statistics and basic indices of the Republic healthcare service is carried out. A comprehensive assessment of work organization at all stages of outpatient medical care is realized in different territories.

An established order of work in the Republic allowed achieving some positive dynamics during the last years. Cancer neglect and one-year mortality from malignant neoplasms reduced.

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P 41: FACILITATING CHOICE ABOUT CANCER SCREENING FOR WOMEN WITH LEARNING DIFFICULTIES

Adrian MAIRS, Maire CAREY

The aim of this project was to provide additional support to women with learning difficulties to enable them to make an informed choice about breast screening and to facilitate their attendance.

A number of information sources were used to identify 47

women in one area who were due for mammography within a six-month period. Sixteen of these women were due for their first mammogram or had previously declined an invitation to attend. These women were offered a personal invitation from a learning disability nurse and an enhanced package of care. This included a programme of information, education and support for themselves, their carers and the learning disability nurses, as well as the option of attending the local health service screening clinic or a special clinic, provided in partnership with a local cancer charity (Action Cancer). Transportation was offered to both sites. The special clinic also offered cervical screening.

In total 39 women attended for breast screening and 30 had a mammogram. Of the 16 women offered the enhanced package of care 5 attended the special clinic and had a mammogram, 7 attended the health service facility and had a mammogram, and 4 did not attend either. Seven women who had previously declined screening had a mammogram and each of the five women invited for the first time had a mammogram. None of the women who attended the special clinics accepted the offer of cervical screening.

There was positive feedback from the learning disability nurses on the programme. The individually tailored approach of pre-attendance preparation, pre-arranged personal transportation, supported attendance and provision of special clinics meant that it was possible to better meet the needs of these women and improve their uptake of mammography screening.

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P 42: BREAST CARE UNIT: FINDING OUT MORE

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A large body of international research evidence supports the view that health outcomes for breast disease can be maximised through a specialist multidisciplinary approach to treatment and ongoing care. Our Breast Unit provides diagnosis and management of benign and malignant breast disease for inpatients and outpatients.

The Breast Clinic is staffed by surgeons, medical oncologists and breast care nurses, with consultative radiotherapy services, integrated with pathology, nuclear medicine and radiology and psychologist. Approximately 100 women each year have breast cancer diagnosed and taken care by the Our Breast Cancer Care Unit, where women undergo diagnosis either treatment.

WE OFFER:

- A prompt referral to a multidisciplinary team specialising in the diagnosis and treatment of breast cancer, including a consultant from within the team.
- A firm diagnosis within three weeks of being referred to a hospital.
- The opportunity of a confirmed diagnosis before con-

senting to treatment, including surgery.

- Access to a specialist breast care nurse trained to give information and psychological support.
- Full information about types of surgery (including breast reconstruction, where appropriate), and the role of medical treatments (this includes radiotherapy, chemotherapy and drugs such as tamoxifen).
- A full explanation about the aims of the treatments proposed and their benefits and possible side effects.
- Information on all support services available to patients with breast cancer and their families.
- The Familial Breast Cancer Clinic provides women with a familial history of breast cancer with advice re assessment of risk, genetic testing where appropriate, and development of appropriate follow up and early detection methods.

Developing models of multidisciplinary care was studied and improved, and the implementation and/or enhancement of multidisciplinary care was an important feature of our Breast Care Unit and that it is possible with our project of clinical research

- Development of breast specific multidisciplinary meetings.
- Expansion of the multidisciplinary team.
- Increased consideration of psychosocial aspects of patient care in multidisciplinary meeting discussions.
- Provision of formalised opportunities for professional development and education among multidisciplinary team members.
- Development of improved information management systems for assessment and management of women presenting with breast systems.
- Establishment of protocols and clinical pathways to enhance specialist breast care.

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P 43: USER'S CENTRALITY IN THE ASSISTANCE PATHWAY OF THE LUNG TUMOUR

Cristiano CARBONELLI, Loredana CERULLO, Luca SIRCANA, Giorgio GARDINI, Francesca ZANELLI, Francesco FALCO, Maria RAVELLI

In the S. Maria Nuova hospital of Reggio Emilia in order to increasingly satisfy the user's needs and in order to get transversal results it has started to work and to structure in assistance pathways.

The analysis of the pathway of the lung tumour is one of the first experimentation that aims to put in comparison all professionals who act together in this proceeding and to create synergies in order to have the patient and his family as the centre of the process.

Assistance pathways are the more suitable instrument for a comprehensive analysis, an analysis that embraces both clinical and organizational-managerial point of view developing dimensions of professional, organizational-managerial and relational quality.

THEREFORE THE TARGETS TO PURSUE WITH THIS PATHWAY ARE:

- Create clear and well defined pathways for users.
- Create the conditions in order to the structure and the professionals organize themselves to guarantee coordinate and univocal answers.
- Guarantee to the user a clinician of reference (a pulmonologist) who takes care of the patient during all the pathway.
- Structure a group that takes care of the patient affected by lung cancer in a collegial and multidisciplinary way.
- Structure educational pathways in order to have an effective communication both with user and his family to manage an unfavourable diagnosis.
- Structure links with GPs in order to manage in a joined way problems of user and his family that can be medical or not

EXPECTED RESULTS

- Create a group of professionals including a pulmonologist, an oncologist, a radiotherapist and a thoracic surgeon to discuss cases. Discussions occur weekly.
- Collect indicators, decided by the group, information regarding both the services quantity and above all the quality services and the results achieved in terms of "health" of the patient in the clinical-assistance pathway.
- Know the patient's opinion and whether the structured pathway has satisfied his needs or not.

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P 44: HPH PROJECT OF THE TUSCANY REGION HEALTH SYSTEM: HUMANITIES AND SOCIAL ACTIONS FOR TREATMENT OF CANCER PATIENTS

Alberto ZANOBINI, Anna Maria GIANNONI, Silvia SICAMACCA

The Istituto Toscano Tumori (Tuscany Cancer Institute) - a body of the regional health government - is promoting a series of projects to re-orient the system of cancer health-care towards humanities and social actions inside the Tuscany HPH program. The overall aims of the projects developed by the local health agencies are the respect of the human dignity, the fight to the social exclusion, the active participation of different health professional. Equality, treatment continuity, information, involvement / empowerment, privacy, individual health service, hospitalisation, counselling and social care are the most relevant aspects and strategies. Projects are addressed particularly to the patients and their families, involving volunteer associations and local social, cultural, artistic resources as well.

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P 45: ORGANIZATION OF CONDITIONS FOR EARLY CANCER DETECTION IN WOMEN OF MATURE AGE

Natalia KRASNOVA, Galina ARTAMONOVA

Highly insufficient use of modern diagnostic methods, ineffectiveness of preventive examinations among the population, lack of regular medical check-up of patients with chronic and pseudotumor diseases, inadequate oncologic alarm among doctors of basic clinical specialties are the reasons for late cancer detection.

The index of primary cancer detection during preventive examinations in Kemerovo region is $9.2 \pm 0.3\%$ on average. Weight of cervical carcinoma detected during preventive examination is $22.4 \pm 2.6\%$, and uterine carcinoma – $6.4 \pm 1.4\%$. The portion of malignant neoplasms detected at I-II developmental stages is 38.0 – 69.7%.

The portion of female breeding organs, mammary and thyroid glands diseases is 36.5- 41.7% among all cancer diseases. Cervical and uterine carcinomas rank second and third in the structure of malignant neoplasms. There is a considerable increase (4 - 6 times more) in cervical and uterine carcinomas cases at the age of 40 - 49, in the age group above 50.

546 women of above 40 were questioned, comprehensive ultrasound examination was carried out for the purpose of early detection of endometrium hyperplasia. It's ascertained that weight indices of risk factors were more than one and, therefore they are important in endometrium hyperplasia development.

From the first to the forth ranks in respect of weight index the following factors have priority: absence of labor, liver pathology, breast diseases, body of uterus fibromyoma with indices from 2.2 to 1.5. Such factors as age and diabetes mellitus have a weight index of 1.4. Weight indices for such factors as increased body weight, arterial hypertension, thyroid gland pathology are 1.3. On the basis of social and sanitary study results algorithm of prenatal endometrium cancer screening was developed.

It consists of three stages. The first stage is detection of risk factors of endometrium hyperplasia and endometrium cancer development in women above 40 on their first visit to any doctor in a hospital. As a result an endometrium hyperplasia and endometrium cancer development risk group is formed, individual risk is evaluated. The second stage includes ultrasound examination of pelvis minor organs, mammary and thyroid glands. Depending on the results of the ultrasound examination all patients are divided into 4 risk groups and individual screening programme is made up for each of them. The third screening stage is case monitoring in antenatal clinic. A gynaecologist determines policy of further patient's treatment including regular medical check-up. As a result of screening the number of ultrasound examination of pelvis minor organs increased by 2.6 times, the number of detected and taken for regular check-up cases of cancer diseases has increased by 2.7 times during the last 5 years, the structure of regular check-up group nosologies has changed.

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P 46: A MULTIDISCIPLINARY APPROACH FOR DIAGNOSIS, TREATMENT, FOLLOW UP AND PREVENTION OF PROSTATIC DISEASES THE PRELIMINARY EXPERIENCE OF A PROSTATE CENTER AT B. RAMAZZINI HOSPITAL – CARPI (MODENA – ITALY).

Maurizio BRAUSI, Anne Marie PIETRANTONIO, Stefano CENCETTI, Alfonso ANANIA

From October 2004 the Department of Urology in B. Ramazzini Hospital set up a "Prostate Center" with a multidisciplinary approach.

THE AIM OF THE CENTER IS:

- To optimize the diagnosis and treatment of patients with low urinary tract SYMPTOMS (luts) who are referred from the out – patient clinic or emergency room.
- To set up a follow up program .
- To improve health awareness and health behaviour by a prevention program aiming to improve health status.
- To up - date hospital staff and general practitioners about diagnosis, treatment, care and health promotion by an educational program coordinated by the director of the urological department.

PATIENT PATHWAY STEPS IN THE CENTER ARE:

- Urological examination and evaluation
- Lab tests (and PSA) in the same day
- Scheduled surgical treatment or other medical therapy
- Counseling for care assistance and prevention (Diet)

The prostate center also supplies a detailed information booklet for patients. This is divided into 3 parts and is composed of guidelines to help in the correct follow up, counseling for:

- Care
- Treatment
- Prevention (Diet)

The center is an important step for Carpi hospital on the road to a more patient, centered health care unit. The goal is to support the development of health awareness (patients ability to obtain, interpret and understand basic health informations, and the competence to use such information to enhance health).

This multidisciplinary approach also consents to redesign a model of patient care where the hospital staff, general practitioners and patients work together to improve the efficacy of medical hospital care but also to improve health and preventive behaviours.

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SESSION I-6: EMPOWERING PATIENTS FOR HEALTHY LIFESTYLES

P 47: THE HOSPITAL BEYOND THE WALL ("TAKE CARE OF YOUR HEART")

Maurizio FILICE, Alberto APPICCIAFUOCO, Claudia RUSSO, Giovanni Maria SANTORO, Rina BRUNETTI

Cardiovascular diseases are the leading causes of death, disability and costs in the western world. Risk factors can explain 60% to 80% of coronary heart disease. Randomized trials have proven that interventions to modify these risk factors can prevent disease. Application of effective preventive therapies has been disappointing because numerous barriers exist. The optimal model must involve groups of population traditionally excluded: young people, women, patients at risk.

AIMS

N.S.G.D. Hospital's goal is the provision of a complete package of health related activities for cardiovascular patients. Its aims are the improvement of the population's health status by those measures which delay or avoid the onset of cardiovascular illness.

We have planned specific actions of education on health and cardiovascular prevention in a context of integration between hospital and territorial services.

OUR PLAN

- To make the population aware of the gravity of cardiovascular risks.
- To promote the culture of prevention.
- To diffuse the chart of cardiovascular risk.

METHODS

Three phases

Phase I

- Promotion of correct lifestyles targeted on young people and women.
 - Instruments
 - Education programs in the schools
- Involvement of women, through the spread of educational material, in hospitals, pharmacies, supermarkets, offices of general practitioners and gynaecologists.

Phase II

- Education programs and cardiovascular prevention for the general population
- Instruments
- Manifestations of sanitary education and screening of risk factors.

Cardiovascular prevention directed towards patients who have had an event.

Phase III

- Distribution to all the population of the Italian edition of the "risk chart".

CONCLUSIONS

In order to attain these objectives it is necessary to involve selected groups of population. This action demands the cooperation of the hospitals, of the sanitary structures of the territory, the administrators.

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P 48: EMPOWERING CLIENTS WITH HEART DISEASE THROUGH A CARDIAC REHABILITATION PROGRAMME

Valerie FLATTERY, CARDIAC REHABILITATION TEAM
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Cardiac Rehabilitation has been defined by WHO as a programme that favourably influences the underlying causes of the disease and ensures that an individual's physical, mental and social conditions are addressed so that they may resume their place in the life of the community. Cardiac Rehabilitation is an integrated component of the client's whole treatment process. A multidisciplinary team has been functioning at University College Hospital Galway (UCHG) since January 2001 delivering an eight week programme of Cardiac Rehabilitation. Team members are: Cardiac Rehabilitation Nurse; Community Liaison Nurse; Physiotherapist; Occupational Therapist; Medical Social Worker; Dietician; Doctors and directed by Consultant Cardiologists.

The aims of Cardiac Rehabilitation at UCHG include: to educate the client about their heart disease; to improve the quality of life of the client; to bridge the gap between hospital and home; to teach the client skills to cope with and overcome their condition; to assist and empower the client to return to optimal physiological, psychological and social status so they can return to previous life roles.

The eight week structured Cardiac Rehabilitation Programme consists of exercise and educational sessions. The topics covered in the informational sessions include: risk factors; heart disease; nutrition; medication; stress management; activity guidelines; work issues; emotional aspect of illness. Family members are encouraged to take an active part in the client's rehabilitation. All members of the multidisciplinary team are involved in delivering the educational component. The exercise sessions are planned and supervised by the Cardiac Rehabilitation Nurse and Physiotherapist.

Outcome measurement is an integral part of the programme with clients scored on the Canadian Occupational Performance Measure and Hospital Anxiety and Depression Scale. Blood pressure, cholesterol and weight are monitored throughout the eight weeks and pre and post exercise tests take place. Client satisfaction questionnaires are completed at exit.

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P 49: THE EFFECTIVENESS OF THE HEART MANUAL ON PATIENTS QUALITY OF LIFE, EXERCISE LEVELS, RISK FACTOR KNOWLEDGE AND SMOKING STATUS THREE MONTHS POST MYOCARDIAL INFARCTION

Kay KARIM, John GORMLEY

Cardiac Rehabilitation programmes have been shown to improve mortality and quality of life in patients post myocardial infarction. Phase two of cardiac rehabilitation is the convalescent period following discharge from hospital. It is a crucial time for the patients as they adjust to change in their lives. The Heart Manual (Lothian Primary Care 2001) was developed to fill a recognised gap in patient care during this period following discharge from hospital. The aim of this study is to determine the effectiveness of the Heart manual as a home-based cardiac rehabilitation programme on risk factor knowledge, exercise levels, smoking status and health-related quality of life in patients three months post myocardial infarction.

A comparative study was carried out on 36 patients who had a myocardial infarction. They were randomly assigned to a control group (n=15) (mean age 61.5+/- 7.1years) receiving standard care or the intervention group (n=16) (mean age 59.3+/- 8.7years) who received the heart manual. All patients received usual education and advice from the multidisciplinary team but in addition the intervention group received the heart manual. Three months post discharge Quality of Life was examined using the SF-36 questionnaire and a second questionnaire was designed to examine patients exercise levels, knowledge and smoking status.

The patients who received the Heart Manual scored significantly higher on the Physical Functioning (p=0.0001), general health (p=0.019) and mental health (p=0.012) items of the SF-36. The Heart manual group reported greater frequency and greater duration of exercise and demonstrated a greater knowledge of the benefits of exercise in risk factor modification.

The results of this study demonstrate the beneficial effects of the Heart Manual to patients post myocardial infarction in empowering them to make lifestyle changes.

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P 50: EMPOWERING PSYCHIATRIC PATIENTS TO DEVELOP HEALTH PROMOTING LIFE STYLES; EATING, EXERCISE, AND EXPERIENCE

Karl MATHISEN, Karen Marie GAARDSHOLT

Over the years attention has been drawn to the fact that psychiatric patients develop diseases resulting from their lifestyle both owing the psychiatric disease and the medical treatment.

It is a main issue for hospital staff to promote prevention of disease resulting from lifestyle, to motivate patients to eat healthy food, and to engage in sport. We have found that the promotion depends on an active co-operation between the

staff in the psychiatric hospital, the psychiatric patients, and their families.

Our idea of an active co-operation was a multifarious arrangement about - eating, exercise, and experience - for psychiatric patients, their families, and the staff.

We held a "Day of Inspiration" co-operating with interest groups of service users and their families, staff, kitchen staff, physiotherapists, and occupational therapists - all of them from the psychiatric hospital.

On the "Day of Inspiration" there were activities such as:

- Lectures on - how to change eating habits, a project on healthier food for people suffering from schizophrenia, and the incidence of physical disease in psychiatric patients.
- Different displays - for instance of psychiatry in general and of many different interest groups such as the group of people with cardiovascular diseases and the group of people with diabetes.
- Different activities - for instance spinning, exercises, jogging, cycle race, and light music played by a band of service users.
- Food - throughout the day the hospital canteen served healthy food as an inspiration.

The "Day of Inspiration" has contributed to patients actively co-operating in taking responsibility for their nutrition and life styles. Thus the arrangement is now a continual event at our hospital and everyone looks forward to participating.

The "Day of Inspiration" May 2005 focus on "walking with staffs".

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P 51: THE EVALUATION OF A WEIGHT REDUCTION PROGRAMME IN MONAGHAN GENERAL HOSPITAL.

Darina CURRAN

RATIONALE

According to the North/South Ireland Food Consumption Survey 2001, 18% of the population is obese (20% of men and 16% of women), while 39% were overweight (46% men and 33% women). Obesity is associated with increased risk of a number of diseases, cardiovascular, hypertension, diabetes (type 2), bladder diseases and certain cancers.

The Government in 2004 set up The National Taskforce on obesity, with the purpose of developing a strategy to halt the rise and reverse the prevalence of this condition.

METHOD

At present there are many different views on how to deal with and tackle the problem of obesity, however treatment strategies have been poorly developed on evidence based models. A programme was designed to assist an adult group of patients to lose weight using a multi-disciplinary team approach this included a Dietician, a Physiotherapist, a

Psychologist.

Subjects: 50 completed the programme; 19 patients male and 31 female.

CONCLUSIONS AND RECOMMENDATIONS

These findings indicate that the programme was successful, ten women lost weight. The highest was in the age group 50-69, six in total, range of weight loss 0.8Kg- 4.7Kg. Three lost weight in age group 26-49, range 5.2Kg -8.3Kg. One lady in age group 70 plus lost 3.4Kg. A total of nine men lost weight. Six in age group 50-69, range 1.0Kg- 9.0Kg. In the 26-49 age group, three lost weight, range 3.5Kg- 6.3Kg.

Recommendation would suggest more work in this area with emphasis on multi-disciplinary approach.

SUMMARY

In the women, the most successful age group was 26-49, with weight loss of 24.1Kg, yet the 50-69 age group lost 11.7Kg. Women's total weight loss, 39.2Kg (6stone 2 Lbs). In the men, the most successful age group was 50-69, weight loss, 25.1Kg, yet 26-49 age group lost of 13.5Kg. Total weight loss for men 38.6Kg (6 stone 1 Lbs).

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P 52: EVALUATION AND TREATMENT OF DISABLED PEOPLE INVOLVED IN SPORTS ACTIVITY

Luciano BISSOLOTTI, Carla CALABRETTO, Walter PASSERI

Disabled people involved in sports activity need a careful clinical pre-participation screening to identify the presence of cardiovascular risk factors and/or the arousal of occult metabolic or musculoskeletal trouble derived by physical activity. A comprehensive analysis of needs in Brescia and surroundings showed that the patients' clinical documentation was fairly incomplete and, if far from the beginning, even lacunose. Often there were not recent data about pulmonary and cardiovascular function, as well precise references about maximal tolerance to physical strain.

The intervention has been directed to disabled people doing wheelchair sports activity (SCI, spina bifida, cerebral palsy, post-polio, amputation).

We decided record:

- Residual motor functions through a clinical, nutritional and sports anamnesis, joined to a kinesiological examination and classification according to ASIA score.
- Ventilatory tests (MIP, MEP, FVC, FEV1).
- Multistage incremental test on handgrip ergometer to assess VO2max.
- Isokinetic test for upper limbs.
- Biomechanical evaluation of upper limb during handcycling (recording surface EMG and metabolic effort).
- If necessary cardiology and heart ultrasound screening.

The evaluation time has been followed by the proposal of proper rehabilitation (occupational therapy, manual and instrumental physiotherapy, ergonomics, etc) if present any functional or organic persistent impairment, tertiary problems and/or overuse injuries of upper limb.

We proceeded to propose educational meetings on nutritional and sports issues giving a counselling about empowerment of good life styles habits. Cooperation produced adapted training programs according to metabolic parameters derived from maximal cardio-respiratory test (VO2max, real maximal heart rate and anaerobic threshold). This part of the work was thought to be able reducing cardio-metabolic hazards during sports participation and selecting the best kind of sports activity for patients.

The described approach empowered primary, or sometimes secondary, prevention of cardiovascular illnesses and, at the same time, optimized sports participation and independence during ADL.

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P 53: FACILITATING INDIVIDUAL BEHAVIOUR CHANGE IN THE CLINICAL SETTING - WHICH STRATEGIES DO IRISH PHYSIOTHERAPISTS USE?

Eva DEVANEY, Patricia MANNIX-MCNAMARA

PURPOSE

The World Health Organization, through the Ottawa Charter (1986), has envisioned that all health workers have a health promoting role. One aspect of promoting health involves the enabling and facilitation of individual behaviour change with clients who have identified such a need. To understand how health practitioners do this in clinical practice, this study aimed to illuminate Irish physiotherapists' self-reported use of behaviour change strategies.

METHODOLOGY

Postal survey of 207 physiotherapists (response rate 54%, N=112) in a primary care setting. Respondents were asked to select any strategies that they used to facilitate behaviour change with their clients from a prepared list, generated from theories of individual behaviour change. Data analysis involved frequency distributions and Mann-Whitney U tests.

RESULTS

The most frequently reported strategies included providing verbal information (99%), encouraging self-management (95%), having a supportive, non-judgemental and empathetic relationship (94%), facilitating skills development (89%), using persuasive encouragement (88%), referring to other professionals (87%), and providing written information (86%). The least utilised strategies included referring to self-help groups (59%), using role modelling (48%), using behavioural contracts (34%) and working with groups (14%). Those more likely to draw on a wider repertoire of strategies included those qualified ten years or less (U=691, p<0.05), and those with postgraduate training in health promotion theory (U=658, p<0.01), communication skills (U=1005, p<0.005), facilitation skills (U=692, p=0.05), and behaviour change management (U=510, p<0.005).

CONCLUSIONS

Even though a large variety in use of strategies was reported, opportunities exist to increase the use of group work

and behavioural contracts in the physiotherapy clinical setting. Health promotion theory and skills can be addressed at undergraduate and postgraduate levels to extend physiotherapists' confidence in using a variety of strategies when enabling lifestyle changes with their clients.

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P 54: MATER CARDIAC SERVICES, "THE HEART OF THE TROPICS"

Heather GINARD; Claire DOUGHERTY

The catchment area for Cardiac Services at the Mater Hospital in Townsville, Queensland, Australia, comprises approximately 1,260,000 square kilometres, with an approximate population of 363,189. On a comparative basis, the U.K. has an area of 244,101 square km, and a population of 60,178,000. The provision of holistic and equitable care within this vast geographical area (given the remote nature of the population) offers special challenges, and the Cardiac Services Team has addressed these in various ways.

'Cardiac Outreach Services' offers participatory programmes aimed at primary and secondary heart disease prevention, and all are accessible in person, electronically via e-mail, or by post:

- The Cardiac Risk Assessment Clinic, a free community service held at a local shopping centre offering cholesterol and blood pressure monitoring along with lifestyle advice and information.
- The HYPE Programme for obese children and adolescents, which educates and encourages young people to become more active through modified exercise, and offers advice on healthy eating.
- The Lifestyle Programme is aimed at people with known cardiac risk factors, offering supervised exercise sessions, diet and weight management advice, and offers advice on healthy eating.
- The Cardiac Rehabilitation Programme has evolved into a more proactive programme, where individual advice and support is now given to those with a cardiac history.
- The Chronic Heart Disease Programme targets clients with long standing cardiac problems, assisting them with their basic activities of daily living and empowering them to take control of their heart disease through living life to the fullest.

Cardiac Outreach Services has demonstrated positive health outcomes and empowerment of individuals through innovative and locally appropriate health promotion initiatives, not constrained by geographical location and/or physical access to a regional centre. The programmes offered also target all ages and not just those with pre-existing cardiac conditions.

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P 55: HEALTH TECHNOLOGY ASSESSMENT (HTA) OF A SCHOOL STUDY FOR PATIENTS WITH TYPE 2-DIABETES AT ODENSE UNIVERSITY HOSPITAL IN DENMARK

Else-Marie LØNVIG, Jan Erik HENRIKSEN, Kristian KIDHOLM, Ane Friis BENDIX, Inge Skov ANDERSEN, Henning BECK-NIELSEN

BACKGROUND

In 2003 Odense University Hospital's top management decided to boost the hospital's prevention- and health promotion effort by establishing three research-based projects, part of the hospital's prevention- and health promotion strategy.

With the massive increase of type 2-diabetes in Denmark the illness was singled out for action, and the research and HTA department established a multi-disciplinary collaboration with the Endocrinology Department on a joint project in the Department's diabetes school.

The study is based on the results of a recently published HTA-report on type 2-diabetes concluding that the existing level offers no convincing documented effect of established teaching programmes for type 2-diabetes patients.

AIM

The aim of the project is to examine the effects of a school study for newly discovered type 2-patients. The 1-year course is run on the conclusion of the established teaching programme in the Diabetes school and aims at minimising the negative effects of the risk factors tobacco, alcohol, diet and inactivity. The clinical, patient-related, organisational and economic consequences of the course will be examined.

SETTING

OUH is the largest hospital in Denmark. Every year abt. 250 diabetics complete a basic course in the hospital diabetes school.

MATERIAL

400 patients with recently discovered type 2-diabetes will be included in the study during a 2-year period starting April 1st 2005.

METHOD

The survey will be randomised, the intervention based on literature study. The effect of one year's intervention to be measured on clinical variables, medicine consumption, life style factors, self-reported state of health and use of the health system. The organisational aspects and the post-school costs and efficiency will be described.

RESULTS

We expect that a differentiated one-year programme will induce durable life style changes with resulting improvements in the patients' health and life quality. The effort should also entail savings in the health sector through better health control, fewer referrals and (re)admissions.

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P 56: STREETWISE – HEALTHY LIFESTYLES PROGRAMME

Anthea SAVAGE; Marise DAMARY

INTRODUCTION/PURPOSE

Establishment of a hospital-based programme to promote healthy lifestyles in children who are overweight and obese.

METHODS

Eight-week programme for both children and parents. Participants referred from Outpatient Department clinics by Consultant Paediatrician. Programme focuses on three principles: exercise promotion, diet modification and behavioural education.

COURSE OUTLINE:

- Week 1: Introduction / Meeting members of multidisciplinary team (parents only)
- Week 2: Dietician - practical advice / Physiotherapist - exercise demonstrations
- Week 3: Dietician - practical advice / Physiotherapist - exercise demonstrations
- Week 4: Children's psychiatric nurse - self-esteem, bullying talk
- Week 5: Field-trip - grocery tour / shopping - alternatives
- Week 6: Child psychologist - motivation, breaking habits, emotions
- Week 7: Physiotherapist - exercise demonstrations / Healthy lunches, eating out
- Week 8: Meeting members of multidisciplinary team /

Evaluation form completion

RESULTS

Eight participants enrolled - five participants completed course - one participant failed to attend following initial assessment, two participants postponed and enrolled to attend next course. Age range 10 to 14 years. Average attendance 59%.

Body mass indices (BMI)

- Participant 1: 35.7 - 33.9
- Participant 2: 34.4 - 35.7
- Participant 3: 30.2 - 31.1
- Participant 4: 32.4 - 30.2
- Participant 5: 33.3 - 32.4

Participant 2 & 3 – Reduction in BMI is not an aim of the StreetWise programme.

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SESSION I-7: HEALTH PROMOTING PSYCHIATRIC HEALTH CARE SERVICES & MENTAL HEALTH PROMOTION IN HOSPITALS (I)

P 57: EMPOWERMENT AND MENTAL HEALTH SERVICES - THE TRENTO EXPERIENCE.

Giovanni LUTTERI, Francesca GIRARDELLI, Matteo VEZZOLI

The purpose of this study is to explore critically the impact of empowerment processes within the context of mental health services in the Province of Trento (Northern Italy): this area (6,233 km²) has 485,000 inhabitants and a special legislative autonomy in several sectors, including welfare and health (7 Central Departments, 13 Sanitary Districts, 2 General Hospitals, and 5 County Hospitals).

The Psychiatric Department is divided into 5 Mental Health Services that provide community psychiatric care to the resident population (ambulatory and home visits, day-hospital, group therapy, and rehabilitation activities, long-term residential facilities).

The 1978 Italian Mental Health Law was designed to prevent further mental hospital admissions, replacing them with treatment in short-term Diagnosis and Cure Units and alternative structures. When hospitalization is needed, our community-oriented services refer to 3 Diagnosis and Cure Unit in the General Hospital (16 beds each).

The psychiatry department has begun in 2004 a three - year project, providing a work group consisting of a representative for each operations unit and a student in psychology, having as commitment to enquire on a clinical empowerment formulation about mental health and to assess the empowerment

activities carried out in each unit.

The work group used a tool of estimation specially developed and based on the qualitative research features.

This instrument is consisting of 30 open questions and subordinate to 30 operators identified like meaningful for the knowledge and the application of the empowerment concept inside the varied services.

The results highlight that the concept of empowerment in psychiatry still collide with the "guard" and the strict control of the patient.

It appear the difference in the use of the empowerment instruments inner the territory and as it is steady the risk that this tools thought to increase the patient's empowerment become an unempowerment function.

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P 58: EMPOWERING PEOPLE IN NEED OF HEALTH AND SOCIAL CARE THROUGH USING A MULTI AGENCY ADULT PROTECTION POLICY

Chrissie PEARCE, Kostakis CHRISTODOULOU, Charlie CLERKE, Margaret ALLEN

"YOU HAVE THE RIGHT NOT TO BE ABUSED."

The Enfield Multi Agency Protection Policy was produced in line with guidance issued by the Department of Health in the "No Secrets" document.

All adults have a fundamental human right to choose how they live even if this appears in the view of others to involve levels of risk. This human right is afforded to vulnerable adults as well.

All vulnerable adults have the right to be protected from harm. In the reporting of a suspected case of harm, neglect or abuse, the emphasis must be on the shared responsibility and immediate communication with senior managers and in some cases the police.

WORKING PRINCIPLES

Enfield NHS Trusts, Social Services, Voluntary Organisations, Independent Sector Providers and Metropolitan Police (Enfield Division), brought together through the London Borough of Enfield Social Services Group to develop and implement the policy.

- Better relationships built between professionals and community.
- All agencies take as a priority their duty to protect vulnerable adults from abuse.
- All agencies understand the complexities of Adult protection work and the requirement for interagency multidisciplinary working
- All investigations to be dealt with in a timely and efficient way acknowledging a well planned investigation is of paramount importance.
- Agencies work together on the prevention, identification, investigation and monitoring of abuse, and plan services to meet the needs of those who have been abused and provide strategies to protect vulnerable adults from abuse.

The presentation will expand on how a local general hospitals trust has worked towards the empowerment of their patients through the use of the Adult Protections Policy.

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P 59: PROVISION OF MENTAL HEALTH SERVICE FOR DEAF USERS

Lorcan MARTIN

There are several difficulties encountered by people suffering from deafness in relation to access to health care. The absence of verbal communication, of course, renders any consultation difficult but makes the interaction even less

satisfying in the area of mental health where successful communication assumes more importance. Even if an interpreter is available, this is an unsatisfactory way to conduct such an assessment and the deaf person may not want a third party present for the discussion of potentially sensitive information. This may often act as a deterrent when help is needed. A further difficulty is the lack of information available to deaf people regarding mental health issues. Additionally, there are a number of cultural issues related to the deaf community which must be understood in relation to mental health care.

It is estimated that there are approximately 300 deaf people in the four counties covered by the Longford/Westmeath Mental Health Service. Their main point of access for services, advice and support is the National Association for Deaf People (NAD). However, if mental health care is required, then these people are scattered in small numbers, attending several different mental health teams, none of which have specific expertise in this area.

In order to address these difficulties, a partnership was formed between the Athlone Community Mental Health Team and the NAD, specifically the Social Worker with responsibility for the area. The consultant psychiatrist and three members of nursing staff underwent training in Sign Language and the cultural issues related to deaf people. Liaison was established with an existing service in the United Kingdom. Additionally, a series of mental health awareness evenings were arranged in conjunction with the NAD.

Further detail regarding the development of this service and specifics of its delivery will be discussed.

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P 60: A HEALTHY EATING APPROACH FOR CLIENTS IN ST. VINCENT'S HOSPITAL, FAIRVIEW, DUBLIN 3

Christina MCDERMOTT, Deirdre MCADAMS

BACKGROUND

The physical health of psychiatric patients can be adversely affected by their poor diet and at times excessive weight gain.

AIMS

- That healthy food is provided.
- That staff and clients have an awareness of healthy eating and the food pyramid.

METHODOLOGY

- A dietician audited the menu cycle.
- A dietician talked to staff and clients regarding current food provision and identifying dietary needs.
- Findings disseminated to management, staff and clients with a view to negotiating appropriate changes.
- Healthy eating policy devised.
- Education provided for staff by:
 - A dietician in relation to the food pyramid and healthy eating.

- A physical activity co-ordinator in relation to exercise regimes for clients.

The poster will highlight the findings and changes to date, some of which include:

- Findings
 - The timing of the evening meal is very early (1645hrs) thus encouraging clients to snack.
 - Two wards are using the same dining facility thus creating a tendency to 'eat up quickly'.
 - Food portions are over sized.
 - Clients are virtually inactive.
- Changes
 - Clients have agreed to opt for fruit and yoghurt as a dessert option Monday to Friday and avail of traditional dessert at weekends only.
 - The evidence generated has increased the Catering Manager's ability to negotiate with staff and client expectations.
 - Introduction of 'Baked Potatoes' and a reduction in the provision of Chips.
 - Introduction of healthy drinks and juices, Homemade vegetable soups, Soya milk, low-fat spreads and reduced sodium salt as alternatives.
 - Less white bread is supplied and the provision of brown bread has increased.

CONCLUSION

The healthy eating programme has highlighted areas for change. In order to provide a holistic approach many other areas such as lifestyle, fitness and smoking cessation need to be addressed.

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P 61: A HEALTH EDUCATION PROGRAMME FOR FEMALE CLIENTS WITH MENTAL ILLNESS

Christina MCDERMOTT

AIM

- To provide women with mental illness with basic education on a wide range of health issues. It is hoped that this will:
 - Strengthen their understanding of what affects health.
 - Empower them to take responsibility for their health.
 - Improve their quality of life.

OBJECTIVES

- To provide education regarding women's autonomy and physiology along with information regarding common physical health problems.
- To facilitate interactive discussion regarding client's personal health difficulties and promote the positive coping abilities they have adapted to their problems.

- To provide them with information which they can use to help them gain access to appropriate local services.

METHODOLOGY

- To deliver an education course within an informal group setting.
- To plan a group which will be held for one hour a week on eight consecutive weeks.
- Invite guest speakers to give relevant talks e.g. dental health.
- Delivery of the programme will be in a formal but creative and fun atmosphere to encourage full participation of all members.
- Administer a pre group questionnaire to assess participant's knowledge on health matters and their quality of life.
- To administer a post group questionnaire to establish information uptake and changes to quality of life.

The poster will outline the content of each group session, pre and post questionnaire results and will contain some personal communications by clients regarding the whole programme.

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P 62: DEPRESSION - WHAT'S IN A NAME - EXPERIENCE AND CARE - THE CHOICES PROGRAMME

Malachy FEELY

SUMMARY EXPLANATION

The development and delivery of an interactive and responsive educational programme (Choices Programme) that promotes and fosters decision-making and choice for people who experience depression is the scope of this initiative.

Depression, what it means, how it is experienced and responses have been central to this work.

KEY LEARNING OUTCOMES

Client feedback and experience in the initial process has identified that the development, delivery and participation in the Choices Programme has empowered clients to take a more active role in their care relative to their experience of depression. Additional learning, in relation to programme development, delivery, participation and initial review include:

- Identifying what it means "I'm depressed".
- Identifying what to include in developing the programme.
- Delivery of Choices Programme - the facilitators' experience.
- Client participation in Choices Programme - client experience.
- Review of Choices Programme - what it really meant to be there.

Another key initial learning outcome in examining such a complex phenomena was identifying a responsive and ethi-

cal approach that adequately captures the multifarious experience a.k.a. 'depression'.

Further, depression was found to be an individually lived multifaceted, disconnecting and imprisoning experience. The application of the label is simultaneously helpful and unhelpful. Those who experience it have difficulty in responding to the enormity of actual experience. It is concurrently individualised and collectivised in context and experience.

IMPLICATIONS FOR PRACTICE

Care experience and depression are inextricably linked, with relational responses of caregiver significant both in what is said and the manner in which it is delivered. The changing nature of depression knowledge and experience as an individually based occurrence requires internal and external personal reflective responses. The use of educationally and experientially focussed approaches to care has the potential to positively facilitate this journey - a process that requires further examination in the context of care and experience.

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P 63: EMPOWERMENT THROUGH KNOWLEDGE

Susan ALLAN, Henrik MADSEN

Psychoeducation is an important part of treatment for some of the most seriously ill patients in psychiatry. In Aalborg, Denmark we have several years experience in the use of Psychoeducation on our Forensic Psychiatric Unit.

OUR PATIENTS

The group of inpatients for whom Psychoeducation is relevant are those sentenced to psychiatric treatment and those with a restriction order. They are all schizophrenics and almost all are male with a history of substance-abuse. It is typical for this group that they are difficult to treat, are very volatile and have a poor level of function.

THE AIMS OF PSYCHOEDUCATION

- To provide the patients with a knowledge and understanding of the illness schizophrenia.
- To improve compliance particularly in relation to anti-psychotic drug treatment.
- To help patients to recognise their personal "early-warning" signs and find strategies to cope with their symptoms.

PLANNING A COURSE OF PSYCHOEDUCATION

The planning of a course is all important if it is to succeed. The carefully selected group of patients does not exceed four in number. It is of primary importance that those responsible for teaching are experienced in psychiatry and have an experienced supervisor. Older members of staff - one male and one female (myself) - with whom the patients feel secure, are a vital ingredient in our recipe for success. Each session is held at the same venue and on the same day each week. Our chosen venue is a "Conference Room" which has all the necessary teaching aids. We believe that it is important that our patients move off the ward to receive

Psychoeducation but at the same time the room that we use lives up to the necessary security standard.

THE COURSE

The course involves ten teaching sessions, an evaluation and a social touch to mark the conclusion of the course.

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P 64: SUPPORTED HOME AND EMPLOYMENT OF PEOPLE WITH SPECIAL NEEDS IN VIJANDI COUNTY, ESTONIA

Kyllike HEIDE

Due to statistics there are about 7000 people with psychical special needs in Estonia today, 70 % of them are in working-age.

The basis of psychosocial rehabilitation: people with special needs need abilities and supporting environment to fulfil the roles required by their living, learning, social and working environment.

Supported home and supported employment in Viljandi County (total population 57 000 people): 4 supported home and employment service offering institutions, which altogether provide supported home service for 31 people and supported employment service also for 31 people including 13 supported home and 5 supported employment places in the Viljandi Hospital Foundation.

THE MAIN PURPOSE OF SUPPORTED HOME

- The independent coping with everyday life in the living environment as similar to the conventional as possible.

THE COLLABORATION PARTNERS OF THE SUPPORTED HOME SERVICE OFFERING INSTITUTIONS

- Local governments
- Rehabilitation institutions / rehabilitation teams
- Physician, general practitioner
- Other institutions offering same services
- Client's family and relatives
- The state

THE MAIN PURPOSE OF SUPPORTED EMPLOYMENT

- Persons with psychical special needs working in the conventional working relations.

THE MAIN WORKING AREAS OF SUPPORTED EMPLOYMENT SERVICE

- Handicraft
- Woodwork
- Unskilled work
- Building

THE COLLABORATION PARTNERS OF THE SUPPORTED EMPLOYMENT SERVICE OFFERING INSTITUTIONS

- Local governments
- Other institutions offering same services
- Local enterprises

- The case manager of local public employment service

THE MAIN TENDENCIES IN SUPPORTED HOME / SUPPORTED EMPLOYMENT IN BASIS OF VILJANDI COUNTY

- Not all people with special treatment need outside help for 24 hours in day to manage - that's why it is better to use supported home service.
- People with special needs are interested from work but they are not capable to compete in open labor market. Through supported employment their working habit and presumption to return to the labor market enhance.
- The main problem concerning supported employment is finding proper working places.
- It's hard to assume the concrete number of people who need supported home and employment service but definitely there is bigger need for those services than today's offering.

EXPECTED FUTURE ACTIVITIES

- To specify the amount of the people who need supported home or employment service.
- To create supported home places in local governments including the co-financing from them.
- The preparedness of the local enterprises to employ people with special needs.
- The regular informing through the media and other channels in order to raise the people's awareness of people with special needs, including informing at the local level.

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SESSION I-8: CULTURALLY COMPETENT AND MIGRANT FRIENDLY HOSPITALS

P 65: A PRACTICAL GUIDE TO CULTURAL COMPETENCE IN HEALTHCARE

Fiona FALVEY, Catherine SHERLOCK

AIM

- To assist staff in their work with patients who are from different cultures
- To promote a migrant-friendly culture within UCHG

BACKGROUND

A pack was originally developed by the Social Work Dept of UCHG, specifically for asylum seekers and refugees, including information on legal issues, rights, and contact details for useful organisations. Arising out of the Migrant Friendly Hospital Pilot Initiative this pack was expanded into a guide for staff for dealing with the many issues which may arise when working with people from other cultures, including language barriers, racism, misunderstandings.

METHOD

The guide was developed by the MFHI steering committee which includes representatives from Senior Management, Social Work Dept, Health Promotion Dept, Psychiatry, Galway Refugee Support Group, Irish Refugee Trust, Clinical Audit, Obstetrics-Gynaecology Dept, Accident & Emergency Dept, Medical Records, Human Resources.

THE GUIDE INCLUDES INFORMATION ON:

- Culture and cultural identity
- Culturally competent care and its relevance
- How to access and work with interpreters
- How to work without an interpreter
- Rights and entitlements of migrants, including asylum seekers and refugees
- Contact details for government and NGO support agencies and churches
- Notes on racism, inter-culturalism and equality

RESULTS

Evaluation has shown that the information and tips included in the pack are useful to staff.

CONCLUSIONS

Developing good Intercultural Communication is a constant learning process.

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P 66: DEVELOPING A CULTURALLY COMPETENT HOSPITAL - WORKING WITH LOCAL MINORITY ETHNIC COMMUNITIES

James ROBINSON

The city of Edinburgh is the local authority with the second highest minority ethnic population in Scotland. As a university city and a popular tourist centre the settled population is added to by a large body of overseas students and visitors. This means that Lothian University Hospitals must be able to meet the needs of a wide variety of ethnic groups. The local population is the obvious source of information as to how this can best be achieved. While a valuable source of information local populations, in common with similar communities across the United Kingdom, have complained of "consultation fatigue". That is a variety of service providers, local and national government departments and university research departments approach the same groups on a too frequent basis. Added to this communities complain that although consulted they rarely see their needs being met.

Lothian University Hospitals therefore decided to move beyond consultation to active involvement of the local communities in service planning and development. The first measure taken was to involve minority ethnic groups in staff cultural awareness training. Staff were able to learn directly from community members about the issues they faced, the needs of the community and how these could be met by hospital staff. Building on this a wider involvement was developed through the formation of a Multi-Cultural Health Action Group. This group, composed of clinical staff, hospital managers and community members, has set about the process of finding solutions to service problems and minority

ethnic care needs.

Through this changed approach minority ethnic communities are able to directly influence service planning and development. Staff also benefit by increasing their understanding of the local communities and their health and social needs.

The role of the group is becoming increasingly important and influential in developing culturally competent hospitals in Edinburgh.

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P 67: TO IMPROVE ACCESS TO SERVICES FOR MARGINALIZED GROUPS BY DEVELOPING CULTURALLY APPROPRIATE SIGNAGE IN HOSPITAL OPD'S AND COMMUNITY CARE CLINICS

Richard PHELAN, Ann MORAN

To improve access to services for marginalized groups by developing culturally appropriate signage in hospital OPD's and community care clinics

RATIONALE

Recent reports (Task force on the travelling community report, 1995, UCG Mc Carthy report, Travellers health Strategy, 2002, & Quality & Fairness, 2001) recognised the need to improve access to services for disadvantaged groups including members of ethnic minorities and persons with learning disabilities. IALAS 1997, states that 25% of the general Irish population are at the lowest level of literacy.

One of the contributing factors influencing access to services are low literacy rates among those groups and many amongst the general population.

As a result of improved signage and way-finding; services will be more effective and cost efficient leading to reduced anxiety and confusion for services users; fewer DNA's (did not attend) and time wasted by service providers.

AIM

To improve access to services for marginalized and disadvantaged groups by developing culturally appropriate and literacy friendly signage and way-finding in hospital OPD's and community care clinics.

OBJECTIVES

- To convene a steering group to develop a proposal to achieve this aim.
- To identify existing good practice and evidence on signage and way finding.
- To consult with key stakeholders including service providers and service users.
- To present an action plan on the proposal for consideration by the health service executive (HSE).

METHODOLOGY:

- Scope out the principal issues identified in the proposal

including literature review, site audits, briefings with key stakeholders.

- Organised a focus group to determine key priorities for the proposal.
- Develop a consultative forum of key stakeholders.
- Establish a steering group and terms of reference.
- Identify and consult with commercial design and manufacturing companies.
- Develop an action plan including costs
- Elicit the support of key stakeholders in the development of a multi -agency project management team.
- Engage with service users.
- Agree action plan.
- Source materials & design team.
- Agree budget for project.
- Pilot signage in appropriate settings.

EVALUATION

- Agree milestones for the action plan.
- Report regularly to the consultative forum.
- Final action plan approved by the consultative forum.

EXPECTED OUTCOME

To present a proposal to the HSE which will include:

- A detailed analysis of the information currently available on signage and way-finding to support the aims of the proposal.
- An audit of existing signage and way-finding in selected sites.
- A report on the consultation with service users and providers.
- The identification of commercial partners who can deliver on the aims of the proposal.
- A fully costed pilot project in a designated pilot site.

OUTCOME/CONCLUSION TO DATE

- Steering group established.
- Consultative Forum convened.
- Scoping of key issues completed.

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P 68: A GUIDE FOR ASYLUM SEEKERS AND REFUGEES

Kostakis CHRISTODOULOU

A new publication "A Guide for Asylum Seekers and Refugees" has been produced by Enfield Primary Care Trust and the London Borough of Enfield, United Kingdom.

AUDIENCE

The guide is suitable for everyone requiring information on services in Enfield. It is particularly helpful for a wide variety of people. For example:

- Refugee and asylum seekers
- Socially excluded
- Black and ethnic minorities
- People with learning difficulties or reading problems
- Children and young people
- Voluntary and community groups

- Professionals and the public

KEY FEATURES

- One of the key features is that most of the guide is in pictures and does not require people to read.
- Language guide to services in fourteen languages
- Picture guide using maps, photographs, illustrations, graphs, clocks, flags, and numbers
- Enfield postal area map
- Translation and interpreting services
- Over 70 maps showing location of services, opening times and languages
- Over 250 services

HEALTH SERVICES

- Children's health
- Children and Young People
- Complaints about health services
- Dentists
- Doctors
- Enfield Primary Care Trust
- Eye Services
- Family Planning and Contraception Services
- Hospitals
- Mental Health
- Sexual Health and HIV
- Smoking - Quitting
- Translation and Interpreting Services
- Walk-in Centre

OTHER SERVICES

- Alcohol and Drug Services
- Asylum and Immigration Advice and Services
- Benefits
- Citizens Advice Bureaux
- Education, training and employment
- English classes
- First Stop Information Points
- Healthy Living Centre
- Housing
- Independent Complaints Advocacy Service
- Legal rights
- Leisure Centres
- Libraries
- Social ServicesYouth Services

REFUGEE AND ASYLUM POPULATION

- Refugee and asylum groups in Enfield
- Helpful organisations
- Useful resources and websites

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P 69: TRAVELLER FRIENDLY WORKSHOPS

Fiona FALVEY

Travellers' health status is far less than that of settled people. Travellers have a low uptake of preventative and outpatient services, and on average, Traveller women live 11.9 years less than their settled counterparts, and Traveller men 9.9 years less. To attempt to redress this imbalance, Health

Promotion Services and the Traveller Health Unit devised a 2-day intercultural training programme for WHB staff.

AIM

To increase the uptake of our services by Travellers.

OBJECTIVES

- Improved knowledge re: health status of Travellers.
- Identify ways in which fear and prejudice can affect service delivery.
- Identified the main barriers to accessing services experienced by Travellers.
- Identified one worthwhile way of making their particular service more Traveller-friendly (A quality initiative for implementation on return to the workplace).

METHODS

Through a series of sessions, including exploring myths and beliefs about Travellers, examining service providers' "frustrations" when dealing with Travellers, staff learned about Traveller culture and were able to highlight barriers preventing Travellers (and other minority groups) accessing health services.

RESULTS/CONCLUSION

5 Traveller Friendly workshops were held, and 49 members of staff attended and came up with a number of initiatives to make their own department/ward more Traveller-friendly. Facilitation of the workshops was a partnership between Health Promotion Services and the Galway Traveller Support Group. The workshops were evaluated very well by staff, in no small measure due to the co-facilitation by a member of the Travelling community.

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P 70: CROSSING BOUNDARIES

Cristiano CARBONELLI, Piergiuseppina FAGANDINI, Maria RAVELLI, Loredana CERULLO

Foreigners living in Reggio Emilia at 31/12/02 are 25,815 (5.6% of resident population). Following a context analysis, you can notice a difficult situation of the operators in the clinical-assistance daily activity addressed to foreigners and you can also notice a foreigners' vision of hospital as the first and unique access point to the health services.

The project, started in January 2004, has seen and still sees both the operators and the immigrant patients of Paediatrics, Obstetrics and Gynaecology and Nursery involved in a research that has deepened the knowledge of both operators' and users' experiences.

THE METHODOLOGY HAS FORESEEN THE USE OF QUALITATIVE INSTRUMENTS SUCH AS:

- Semi-structured interviews addressed to immigrant users (50 interviews).
- Focus groups with sanitary operators (5 focus groups that have involved about 30 professionals among clinicians, nurses and mid-wives).

RESULTS

In the focus groups it was noticed that the operators have a complex and contradictory vision of immigrants that ranges from a "sense of intolerance" to a feeling of identification with them.

A feeling of "strong uneasiness" is prevalent in operators and it's due to an unexpected increase of immigration that has seen the sanitary structures unready, to a lack of time and to the linguistic and cultural incomprehension.

According to these interviews the first clear fact is that migration changes the cultural traditions regarding pregnancy, childbirth and mother-child bond. As for the operators, the main difficulty noticed even for immigrants is the lack of linguistic comprehension, above all because women know only their native language and in order to communicate they must ask help to their husband, son or to a fellow-countryman. All the women interviewed pointed out the importance of a cultural mediator. They have noticed an attitude of kindness, courtesy and availability of the operators even trying to communicate with gestures.

Operators suggest a deep training on the other prevalent cultures, a higher presence of cultural mediators, a reorganization of the hospital structure and of the territorial services even according to immigrants needs and the development of an integrated socio-sanitary-assistance net.

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P 71: HOW TO CELEBRATE YOUR CHRISTMAS DAY?!

Bernhard F. HENNING, Ingrid PALIK, MROGENDA

The Marienhospital, seen as a multi-cultural institution and a meeting place in the health care sector, is a daily central contact point of an enormous number of employees, patients and visitors from different nations, religions and cultures. Just the employees are forming an area of nearly 200 different nations.

In order to develop the feeling and to strengthen thereby togetherness and mutual understanding that there are holidays being important as significant for other nations' and religions' people, besides the high holidays of the Christian Church, there must be taken the chance of laying them open inside the institution, describing their features and presenting their specifics as well as determining their common characters of a spiritual background.

METHODS OF REALIZATION:

- Calendar 'holidays in foreign and own cultures' as a poster to fix on the wards and departments.
- Booklet about the backgrounds respectively the contents of the special holidays.
- Offering specific meals on the occasion of these holidays.
- Hinting at the actual data/events in Marienhospital media.
- Celebrating together as far as possible.

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P 72: FOOD AND DRINK KEEP BODY AND SOUL TOGETHER

Bernhard F. HENNING

Inadequate behaviour in the interaction between migrants and hospital staff is often caused by unsureness and fear. One way of lessening these irrational feelings can be found in emphasizing the positive aspects of the foreign culture.

The migrant should be able to feel more secure, more familiar in a foreign environment. The hospital staffer should experience a more positive view on the migrant's culture.

This might be achieved by the use of food and drink. These are fundamental needs of every human being and are regarded as a positive in all cultures. Moreover they are often associated with agreeable situations such as hosting parties etc. Arranging the food in a pleasing way can also in creating a more positive mindset, thus improving the interaction between the two parties.

METHOD

- Migrant orientated approach: a multilingual menu mentions that it is allowed to bring familiar home-made food to the hospital, if so desired. If necessary the food can be heated on the ward by the hospital staff (microwave). Nursing staff and dieticians are available to provide consultations if needed.
- Hospital staff orientated approach: unusual things are often met with fear and unsureness, whereas they are experienced as exciting and interesting while on holidays. Serving foreign meals from different countries in the staff canteen on a regular basis can be used to change the way hospital staffers view a foreign culture e.g. every two weeks foreign meals from different countries will be offered in the staff canteen for one day.

RESULT

- The serving of familiar food will provide a daily fixed point for the migrant to counteract the unusual hospital environment he might experience as disagreeable. Diet training on the home-made meals by the hospital staff can enable a much easier transition to the family home after hospital treatment has ended.
- Special actions at the canteen can be used to show the extent to which migrants and their cultures have already enriched our day-to-day lives.

Curiosity about all things foreign will be increased. Some dishes we do not regard as being foreign originally came from different countries. This already shows that we are gathering something positive from foreign countries all the time.

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P 73: COMPARISON FOR IMPROVING: THE INTERCULTURAL WORK OF HPH VENETO REGION NETWORK

Simone TASSO, Maurizia BORDINI, Maria Caterina DE MARCO, Sabrina MARCONATO

INTRODUCTION

During 2002 a HPH Intercultural Project started in the Italian Veneto Region, involving 13 Hospitals and the Social Sanitary Services of 6 Health Local Units (Social Sanitary Trusts).

The first step of the Project was to collect the different experiences of the different Trusts with the general aims of enabling migrant patients to control better their health and enabling staff to manage better the problem of migrant patients. It was decided :1) to know the main sanitary needs of our migrant patients; 2) to census the several organizations which were working with migrants all over our communities; 3) to create common archives to share the documents already made; 4) to create common actions for migrants patients.

RESULTS:

Common archives were realized collecting the document translated in different languages. Census of organizations for migrants was realized. It was also realized a Regional Conference having as audience the migrants and the main actors who were working with them : municipalities, schools,

liaison officers, hospital staff ; it had as speakers experts from Migrant Friendly Hospitals International Project. The conference was a key action for the project: it was important to show examples of good practice all over Europe; to strength alliances with different stakeholders; to strength the visibility HPH Project towards our Regional Government. Then it facilitated the beginning of a work with municipalities, schools and liaison officers so that special workshops with these actors were realized. There were some problems ,too. For instance, it was difficult (or not possible) to find direct answers about some migrants groups, because they do not have any formal representatives.

CONCLUSION

This sharing work suggested several actions for the future: it would be important to open special services for migrants patients, sharing them with the different stakeholders and in particular with municipalities and schools. For instance, a shared service of telephone interpreting could be a solution for some problems, because it would permit to contain the costs and , at the same time, it would help migrants in many problems of their every day life in integrated way. The correct education of liaison officers was another important matter that emerged.

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SESSION I-9: SMOKE-FREE HOSPITALS (I)

P 74: ESTONIAN HEALTH PROMOTING HOSPITALS UNITING AS A COMMON FRONT AGAINST TOBACCO

Tiiu HÄRM

The National Strategy for Cardiovascular Disease (CVD) prevention for 2005-2020 is being implemented in Estonia.

CVD mortality in Estonia is the highest in Europe. Ischemic Heart Disease claims two and half more lives in Estonia than in Finland.

Characteristic feature of Estonia is a stable high level of early CVD incidence, loss of work capacity and mortality in middle-age group. Out of 100 000 people at least 250 men and 80 women under the age of 65 die of heart diseases per year. CVD prevention strategy has been developed for 15 years. By 2020 the CVD mortality of men and women under 65 should be reduced by 40 and 30 percent respectively.

The aim of CVD prevention strategy is to raise the number of physically active people, reduce unhealthy nutrition practices and smoking prevalence. Priority for the year 2005 is reducing smoking prevalence with help of new Tobacco Law. The tasks of the Estonian HPH Network in this area include:

- To join the European Network for Smoke-free Hospitals (ENSH) in 2005 and to develop relevant cooperation with other hospitals in WHO HPH and ENSH networks (exchange of experiences, implementation of motivation

strategies, comparing research results on smoking prevalence etc).

- To open more smoking cessation counselling cabinets and to train smoking cessation counsellors in health promotion hospitals. In 2004 the counselling service was provided by 5 hospitals in 4 counties. In the beginning of 2006 there should be 15 counselling cabinets (in 13 hospitals, in 12 counties).
- To pay more attention to tobacco-related problems while training medical staff (appropriate legislation, prevention, health risk factors, passive smoking, motivation to stop smoking etc.) with the aim to reduce smoking prevalence among medical staff and the population.
- To adopt European Standards for Smoke-free Hospital Policy and to launch smoke-free hospitals movement in 5 hospitals.
- To develop cooperation with community institutions (other health care service providers, patient unions, local municipalities, media etc) in organizing World Heart Week, Heart Day and smoking cessations campaigns.

The efficient implementation of the national strategy for CVD prevention requires working as a united front at all levels. It is the only way the expected results for 2005-2020 can be achieved.

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P 75: SMOKING CESSATION IN THE UNIVERSITY HOSPITAL OF TURKU

Leena JÄRVI, Maritta KILPELÄINEN, Päivi GRÖNROOS, Eva NORDMAN

Smoking cessation is necessary for successful treatment of pulmonary- and heart- and circulation diseases. Individual guidance of smoking cessation was commenced already 1994 for patients with cancer. In 1998 a proper unit for cessation of smoking was established at the Department of Pulmonary Diseases. A counsellor (a nurse) familiar with the cessation methods was engaged.

A web of nurses acquainted with the nation-wide recommendations of smoking was developed for all departments of the hospital.

THE CESSATION PROGRAM

The basic activity in the cessation program unit is discussion in a group of 5-10 patients. The group consists of 5-10 patients of the same age. The group meets during five weeks six times, or more if needed.

- 1. Meeting: The smoking habits are discussed and the earlier cessation attempts are analysed, the Fagerstöm test for nicotine dependence and 15D for quality of life.
- 2. Meeting: The nicotine replacement products are demonstrated, the day of cessation is determined.
- 3. Meeting: Information of tobacco effects.
- 4. Meeting: Lecture concerning the diseases induced by smoking.
- 5. Meeting: The dieticians lecture.
- 6. Meeting: The motivation of permanent smoking cessation.

After six months a final meeting is held and the positive and negative effects of smoking cessation are discussed. After one year a new 15D quality of life form is sent.

RESULTS

54.3% of the participants are smokeless at the end of the course and 21.3 % of the patients are non-smoking at 24 months.

CONCLUSION

The aim with the cessation program is to improve the condition of the patient and to enhance the prognosis. The aim is to find different cessation methods and to compare them, too. The knowledge of smoking and cessation of smoking among the staff is increased.

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P 76: MAPPING THE CHANGES - EMPOWERING BEAUMONT HOSPITAL'S STAFF, PATIENTS AND VISITORS TO ADAPT TO THE SMOKE FREE WORKPLACE LEGISLATION.

Olive GIBSON

AIM

To implement the Smoke Free Workplace Legislation with maximum impact and with a view to empowering staff and patients to adapt to the changes.

OBJECTIVES

- Develop and Implement Smoke Free Hospital Policy.
- Set up Multi-disciplinary Team, 'Smoke Free at Work Committee' to assist in Implementation and Evaluation of the Policy.
- Empower and assist Staff in the implementation of the policy through education, in-service training and development of appropriate supportive materials.
- Empower patients with information about the legislation and develop support systems to assist them through the legislative changes.
- Ensure the hospital is conducive to sustaining a smoke free environment.

METHODOLOGY

General Staff:

- Develop and Implement Smoke Free at Work Policy.
- Hold in-service education sessions regarding the policy.
- Develop and distribute documentation regarding staff role in relation to the policy.
- Set up Confidential phone number for breaches in legislation.
- Set up Smoke Free at Work Committee.
- Develop spot-check monitoring tool to assess compliance.
- Support Staff to quit smoking e.g. stop smoking challenge, NRT free to staff for one week etc.

Clinical Staff:

- Improve Smoking Cessation referral service by changing referrals from postal to I.T.
- Availability of Fagerstorm Questionnaire in each ward to assess for Nicotine Dependence.
- Development of NRT Poster with dosage, method of use, side effects etc.
- In-service education regarding the Stages of Change Model and NRT (one hour).
- Training in Brief Motivation Intervention skills (one day).

Patients:

- Develop an admission patient information leaflet about the policy and smoking cessation support available.
- Continuation one to one smoking cessation counselling service.
- Availability of all NRT products in hospital.

Environment:

- Close down smoking rooms on each floor of hospital.
- Display appropriate no smoking signage.
- Alteration of public address tannoy system and structure of smoking gazebos to comply with legislative requirements.
- Provision of secure gazebo for night staff.

EVALUATION

- The Smoke Free at Work Policy has been implemented

- successfully with minimum disruptions.
- Staff and patients are aware of their role in the policy.
- Through the Smoke Free at Work Committee; Staff feel validated as they have a forum to discuss issues arising.
- Compliance is monitored via 'spot check' forms.
- Managers are supported in the event of non-compliance to the legislation.
- Smoking cessation support service improvements have benefited staff and patients.
- Increase in referrals to smoking cessation service and requests for NRT.

RECOMMENDATIONS

- Continuation of Smoke Free at Work Group.
- Annual audit of Smoke Free Policy for more in-depth evaluation on it's effectiveness and smoking rates.

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P 77: EMPOWERING HOSPITALS TO ENGAGE IN TOBACCO CONTROL - AN EDUCATIONAL PROJECT

Göran BOËTHIUS, Gunnel LÖÖW, Siv KARLSSON

Health care services have important roles in tobacco control. Primary care institutions are believed to support the smoking patient, although several surveys have indicated that there is much room for improvement... Hospitals in general have been slower in the tobacco control process - with due respect for many members of the Health Promoting Hospitals' network.

The aim of this information project was to make hospital doctors and nurses more knowledgeable about the tobacco issue and willing to engage in cessation support and other tobacco control activities in the hospitals.

All Swedish hospitals were invited to send, free of charge, a team consisting of a doctor and a nurse to a two days seminar. The programme covered an overview of the tobacco issue, the broad tobacco control strategy needed at all levels in society as well as the basics regarding cessation support including useful information materials.

Recruiting teams to the seminars proved to be more difficult than expected, mostly due to the hesitance of doctors to participate, contrasting to the willingness of nurses to join. However, two thirds of the hospitals accepted the invitation. Immediate evaluations of the seminars have been very positive, not least among doctors having realized the extent of the health problem and their responsibility to act.

An evaluation of the project is now underway and will be presented, comparing the tobacco control status in hospitals participating in the seminars with that of hospitals that did not participate.

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P 78: PROTECTION OF NON-SMOKERS AND SMOKING CESSATION AT THE WORKPLACE IN THE HOSPITAL SETTING WITH AN EMPHASIS ON EDUCATION AND TRAINING FOR NURSES

Christa RUSTLER, Christoph KRÖGER, Sibylle FLEITMANN

In February 2005 a baseline study to assess non-smoking policy and smoking cessation programs for staff and patients in about 3.600 German hospitals, rehabilitation clinics and nursing schools was conducted. Among others the self audit questionnaire of the European Network for Smoke-free Hospitals ENSH was used in this survey, that shall provide data for the implementation of measures to enhance protection of non-smokers and of curricula for teaching nurses in smoking cessation intervention.. The Institute for therapy research, Munich, and the German HPH Network, as the national co-ordinator for the ENSH, are partners in this project. The results of the survey will be presented.

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P 79: FOUR DECADES OF SMOKING CESSATION IN ST. VINCENT'S UNIVERSITY HOSPITAL

Kirsten DOHERTY, Denise COMERFORD, Cecily KELLEHER, Patricia FITZPATRICK, Leslie DALY, Anna CLARKE, Carol PYE, Brenda WHITESIDE, Jacinta BARNWELL, Hilda GALLAGHER, Veronica O'NEILL, Vivien REID

This presentation describes the development of smoking cessation by a hospital Dept of Preventive Medicine, in the context of national smoking trends and tobacco control initiatives. Three data sources are quoted: national smoking rates, figures from departmental cardiovascular epidemiological studies, and surveys of smoking rates in this hospital.

Smoking cessation has been an interest of this department since the outset. By the 1990s, this work had expanded into the community, providing training courses, stop smoking courses and a schools programme.

Many publications on effects of smoking and smoking cessation in cardiology patients have ensued. Current research includes regular surveys of hospital smoking prevalence, an EU-funded evaluation of the smoking cessation service, and a cohort study of hospital smoking patients.

National initiatives impacted on hospital policy with the set-

ting up of the Irish HPH network in 1997, leading to involvement with the European Smoke-free Hospital initiative and a silver-level award, and the launch of the hospital's Smoke-free Policy in 2002.

The Cardiovascular Health Strategy started funding a comprehensive smoking cessation service in 2001. Tobacco control legislation culminated in March 2004 with a complete ban on smoking in the workplace, including hospitals, with resulting policy implications, requiring changes within the hospital.

In 1973/74, the national smoking prevalence was 43%, in 1978/79 it was 36%, and by 2002 it had dropped to 27%.

Our most recent survey of smoking prevalence showed that 24% of inpatients smoke, and that consistently 70% express interest in stopping. In July 2004, 21% of current smokers stated that the effect of the ban in hospitals had caused them to stop smoking. Referral rates last year were only 20% of the potential need, and the ongoing work in awareness-raising and lobbying continues, with meetings with general, medical and nursing management.

We describe a highly innovative smoking cessation programme over thirty years, underpinned by robust epidemiological data, which will be of major value to hospitals in the future.

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P 80: HOSPITAL WITHOUT TOBACCO

Stasys GENDVILIS, Daina SUSINSKIENE

AIMS

- Improve patients' health by decreasing morbidity and death rate of illnesses of respiratory and blood circulation systems (especially chronic obstructive pulmonary disease and lung cancer) by implementing the integrated prophylaxis of risk factor-smoking.
- Ensure regular provision with information to hospital personnel and patients about the activity "Hospital Without Tobacco" being carried out in hospital as well as prepare a patient to be ready to adopt decisions related to the mentioned activity.

TASKS

- Decrease of smoking spread among medical personnel and patients by evaluating the smoking spread in Kaunas Regional hospital.
- Anticipate anti-smoking measures.
- Evaluate the effectiveness of anti-smoking measures.
- Create healthy environment without tobacco.
- Organize anti-smoking events.

METHODS AND MEASURES

- Training of the qualified staff participating in the programme.
- Implementation of anonymous questionnaire for patients and medical staff on smoking, their knowledge and attitude to health. Analysis of the collected data.
- Lectures, reports, preparation of visual aids (posters,

brochures for patients, methodical guidelines and their application).

- Discussions with patients and medical personnel carried out individually and in groups.
- Aiming to create a healthy atmosphere without tobacco, special premises for smoking are planned to be equipped and smoking prohibitive signs to be positioned in hospital and its territory.
- In case signs of dependence to nicotine are present organize consultations of psychotherapist.
- Organizing of different events and actions against smoking like "International Non-smoking Day", "Day of Chronic Obstructive Pulmonary Disease", contest "Give up and Win". Patients are provided a possibility to examine the functioning of their respiratory system (spirogram performance) and receive qualified consultation of a pulmonary specialist.

RESULTS

In February 2004 a project of anti-smoking prevention was started. Smoking prohibitive signs were positioned in hospital and its territory and brochures on damage caused by smoking are being delivered.

Anonymous questionnaire of the personnel was carried out in order to evaluate the smoking spread rate in our hospital. 50.3 per cent of employees were inquired, 17.3 per cent of whom smoke. The questionnaire is also planned to be carried out among patients by the random selection method.

Special premises for smoking are being equipped for the purpose to create healthy environment without tobacco. The hospital personnel who smoke participated in the contest "Give up and Win".

In November 2004 the Day of COPD and International Non-smoking Day were commemorated. The possibility to examine the functioning of the respiratory system was available for everyone upon request and especially for those who smoke and in case of changes in spirogram - bronchia obstruction, people were directed for the consultation of a pulmonary specialist. New patients ill with chronic obstructive pulmonary disease were diagnosed, treatment and qualified assistance while giving up smoking were recommended to them.

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P 81: WHO DOESN'T SMOKE ...WINS ! THE POINT AFTER THE THIRD REGIONAL EDITION

Simone TASSO, Maria Luisa MIGLIORINO, Sabrina MARCONATO

INTRODUCTION

Since 1997 HPH Italian Veneto Region Network has been organized a anti-smoking campaign for young generation called "WHO doesn't smoke...WINS !" (WDSW). It is formed by a homonymous Contest and by the several actions linked to it.

THE PROJECT

The Contest was addressed to students 11-14 years old: they had to create short advertising videos against tobacco and usually, with the help of their teachers, students are the actors, directors, script-writers of the videos. Medical doctors, psychologists, experts in educations and experts in communication went to the schools to introduce the Contest and, above all, to talk about tabagism to students and their teachers. To support this campaign, posters were made with the images of well-know persons who accepted to support our initiative. For instance, we had Deborah Compagnoni, Manuela Di Centa (skiers - Olympic champions), Alessandro Del Piero, Paolo Maldini, Aldo Serena (football players of Italian National Team). Their posters were sent to the schools, Hospitals, Social and Sanitary Services all over Veneto Region. This campaign had the support of local municipalities, other local institutions. and voluntary associations (in particular the "Italian League against Tumors").

Each Hospital (or group of hospitals) organized a local part of the Contest, designating its own local winner, organizing a local celebration, creating a very important capillary work. Each local winner had the right of access to the regional finals which took place for the World No Tobacco Day and designs the Regional Winner, at the presence of important personalities of Veneto Region (mayors, artists, journalists, politicians, focus persons of voluntary organizations). During the finals a champion of ours is the guest of honour and he hands out best prizes to the Regional Winner. The best videos are passed on Regional TV Networks so that winner students (and their communities) can watch themselves - as actors - at the television.

EVALUATION

An evaluation trial was also realized in 2001: an anonymous questionnaire was filled by a sample of 647 students of 2 different groups: a first one was formed by the students participating to the contest (and its linked actions) and the second one was formed by students who didn't participate. The frequency of students who quitted to smoke was higher in the participating group vs. control (20.8 % vs. 16.2 %).

CONCLUSION

By means this HPH anti-smoking campaign, more than 15.000 students have already participated to the first 3 regional editions of the Contest and linked actions, knowing the HPH principles of Budapest Declaration and Ottawa Charter, presented into their classes and into their communities. At last since 2001 WDSW has been realized also outside Veneto and it is now a reality in Trentino, Liguria and Valle d'Aosta

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P 82: EVALUATION OF ANTI SMOKING PROJECTS IN 77 ITALIAN HOSPITALS USING E.N.S.H. QUESTIONNAIRE

Simone TASSO, Marina BONFANTI, Lucia OCCHIONERO, Cristina AGUZZOLI, Giorgio GALLI, Roberto PREDONZANI, Paolo DE PIERI, Carlo FAVARETTI

INTRODUCTION

The European Network of Smoke Free Hospitals (ENSH) realized a Self Audit Questionnaire (SAQ) for the performance evaluation of a smoke-free organization. SAQ is formed both by dichotomic question (yes-no) and by graduated answers (from 0 to 3). Moreover, in each question, it is possible to answer also "not applicable" and/or to write suggestions.

In the 7th National Italian Conference (November 2003) , it was decided to test SAQ in the HPH Italian Regional Networks, using its version 2003, published on the 8th ENSH Newsletter of November 2003.

RESULTS

During 2004 SAQ was tested in 77 Italian Hospitals of 7 Regional Networks: Liguria, Lombardia, Friuli Venezia Giulia, Piemonte, Trentino, Valle d'Aosta, Veneto. In general, the questionnaire appeared useful to describe the most important aspects of the Italian Hospitals anti-smoking projects. Some difficulties were observed with the question having the highest frequency of "not applicable" (36.4%) or the question without any answer (11.7%). It was due to the Italian legislation that doesn't permit to have smoking area into the hospitals. So it was not possible to answer in questions concerning this matter. Observations arrived with suggestions to introduce some modifications into the SAQ, and above all to make clearer some questions (and/or their translation) and score system.

CONCLUSION

SAQ was a valid instrument to describe a anti-smoking Project and to focus the most important aspects of a smoke-free organization. It appeared useful to support the work of peer-review.

Important considerations emerged about the score system: the attribution of the score to each answer should take in account the different importance of the different questions. At the moment, the most appropriate way to elaborate the data appears the frequency distribution.

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P 83: SMOKING CESSATION SPECIALIST SERVICE IN THE ACUTE HOSPITAL SETTING.

Nikki CINNAMOND

INTRODUCTION

Smoking is a major cause of disease, killing around 3000 people in Northern Ireland each year, it remains the single most dangerous threat to public health.

In Northern Ireland 28% of the population are current smokers and 60 individuals are hospitalised daily with smoking related illness. Evidence would suggest that smoking cessation specialist services improve cessation rates and so improve outcomes.

METHOD

The development of a smoking cessation specialist service in the acute hospital ward setting. The service (provided by myself, a smoking cessation specialist nurse), has three main objectives.

- To identify currently smoking patients on admission to the hospital.
- To offer counselling on a one to one basis throughout the patients hospital stay and to offer Nicotine replacement therapy or Zyban.
- To arrange follow-up support at outpatient hospital Smoking Cessation Clinic, referral to community smoking cessation service in their area or via hospital telephone counselling service.

RESULTS

Over 500 patients have used the service since it began in October 2001. The service is audited in accordance with current guidelines from the Department of Health for Northern Ireland and has showed a 45% smoking cessation "Quit" rate at 4-6 week follow-up.

CONCLUSIONS

This smoking cessation specialist service in an acute hospital setting showed an increase in cessation rates well above national averages. This was the first inpatient smoking cessation service in Northern Ireland and is being implemented in other acute hospitals throughout the province.

The service is continually growing, we now also provide:

- Outpatient referral service
- "Drop-in-clinic" once a week
- Midwife Led Clinic for ante-natal and post-natal
- Smoking Cessation Clinic for staff
- Brief awareness training for staff

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P 84: NURSE LED SMOKING CESSATION CLINIC - ST JAMES'S HOSPITAL, DUBLIN

Carmel DOHERTY

INTRODUCTION

Smoking is the largest single cause of preventable mortality and morbidity in Ireland. The enormous health benefits of stopping smoking are now well established. The nurse-led smoking cessation clinic was established May 2001. Hospitalisation provides an ideal opportunity to help people stop smoking.

AIM

To adopt a non-judgemental, supportive and flexible approach to assist clients to give up smoking, based on the 'readiness to change' model.

MODEL OF SERVICE PROVISION : (REFERRALS TAKEN FROM ALL HEALTH -CARE PROFESSIONALS)

- Low intensity with high coverage - This takes the form of brief interventions, which usually take place when the client is an inpatient. Clients are then followed up by

phone on discharge.

- High intensity with low coverage - Intensive support for 6 weeks. Clients are seen for 1 hour each week on a one to one basis. Follow up is self -reported by phone at 3.6 and 12 months.

RESOURCES

One trained smoking cessation Nurse Specialist.

OUTCOMES

417 smokers have enrolled on the 6 -week programme since May 2001 and 44% (183) of this cohort has completed the programme. During the period 2001- 2004 the average abstinence rates at 3.6 and 12 months were 40.4%, 33.4% and 26.7% respectively. Of those Clients attending the 6-week programme during 2004 - 23% had never attempted to stop previously. 38% had made 1 attempt to stop and the remaining 38% had made more than 1 attempt. 93% of this group smoked for more than 20 years. Results at 6 weeks showed age-related quit rate of 20% (<40 age group) 46% (40-60 age group) and 53% (>60 age group) quitting. 42% of the clients were highly dependant smokers (Fagerstrom test). 64% smoked >20 cigarettes daily. Clients who smoked <30 cigarettes daily had higher success rates than heavier smokers.

CONCLUSION

The results indicate the effectiveness of current evidence based interventions. However, the challenge remains to develop a systematic plan that will promptly identify ALL smokers admitted to hospital and co-ordinate an intervention pathway that will offer assistance and/or treatment to ALL smokers.

A dedicated specialist smoking cessation service should back up this pathway.

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P 85: SMOKING CESSATION SUPPORT: CHANGING THE HABITS OF A LIFETIME

Jackie MEREDITH-LYNCH

The Smoking Cessation service was set up to support patients, staff and the public in their effort to stop smoking. The service in Our Lady's is supported by the Nursing Department and the Health Promotion Department.

It consists of dedicated 33 hrs per week, Monday to Thursday, & includes 2 six week night time support groups per year. The service is free of charge.

An holistic approach is taken whereby the smoking cessation staff assess the clients' attitude to smoking, intention to quit and determination to stay smoke free. The Prochaska & Clemente stage of change model is used to establish the clients' position in relation to cessation, guide the cessation staff in client assessment and in advice offered. The overall aim is to support the client in his present stage and encourage him/her to move on to the next stage towards quitting.

Any member of staff may refer a client to the service. Self referrals are welcome. Clients who make a quit attempt /who give a quit date receive telephone follow-up at 2 weeks, 3 months and 1 year post quit date (relapsed clients do not routinely receive the next timed telephone call).

THIS POSTER DEMONSTRATES:

- The organization of the service
- The referral systems
- The contents of the night group programme
- Gives a picture of the support available to in-patients, out-patients and staff.
- Gives detailed audit results on the impact advice has on those who made a committed quit attempt, and those who received advice but did not make a quit attempt.

In-patient referrals were chiefly made by nursing staff and not initiated by the client. Clients were pleased with the information given and the knowledge that a support service was available should they wish to avail in the future.

Many who did not give a commitment to quit on their first interview would consider quitting after speaking with the smoking cessation staff.

The poster shows that although quit rates are important we also need to consider the positive effect that can be achieved through communicating with our clients, providing suitable verbal /written information, and offering timely support and advice.

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P 86: TOBACCO DEPENDENCE AND WILLINGNESS TO QUIT AMONG HOSPITAL PATIENTS

Reetta-Maija LUHTA, Kati KOPONEN

Despite sustained tobacco control activities, 19% of women and 26% of men continue to use tobacco in Finland. Hospitals provide a conducive environment for smoking cessation since many patients are being treated for smoking-related illnesses. We assessed tobacco use and dependence, willingness to quit, and attitudes towards smoke-free hospitals among patients in two central hospitals: North Karelia Central Hospital and Seinäjoki Central Hospital.

2861 general hospital (GH) and 399 mental hospital (MH) patients completed a tobacco survey. More women (55%) than men answered the survey. Forty-two percent of respondents were 41-64 years old, and 22% reported tobacco use (19% in GH and 40% in MH). Six percent were recent quitters (i.e., < 12 months), 22% were former smokers and 48% never smokers. The duration of smoking was over 20 years among 41% of the smokers. The majority were pack-a-day smokers who smoked their first cigarette within 30 minutes of awakening. Over half of the smokers had high nicotine dependence (48% in GH, 66% in MH). The smoking rate was 12% among pregnant women. Eighty-three percent of patients in GH, and 68% in MH reported willingness to quit. Nearly half of the smokers supported a smoke-free hospital.

To capitalize on the smoking cessation motivation, a systematic treatment of smoking patients was started in several subspecialties. Results obtained 3 months after a hospital visit from patients with acute cardiac event show that 14% continued to smoke at the pre-hospitalisation level, while others had either quit (38%) or reduced. Clearly there is a need for secondary prevention among hospital patients.

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P 87: "THE MAN WHO GAVE UP SMOKING" - A THEATRE EXPERIENCE AT THE HOSPITAL

Claudia RUSSO, Alberto APPICCIAFUOCO, Patrizia DE MARCO, Fabrizio GEMMI, Daniela MAZZOTTA, Giovanni TAVANTI

Health Education Office of Florence Health Care, O.S.M.A-Direzione Sanitaria, the Italian League against Tumours of Florence, Pie Fiorentina School Theatre Group - AGESC - have recently presented in S.M. Annunziata Hospital Front office, "The Man Who Gave Up Smoking" (L'uomo che smise di fumare), a comedy inspired by a P.G. Wodehouse's tale. School students, as actors, exploited a theatre play as an innovative means for young people to debate about important health matters with adults, such as hospital patients, their families, and hospital operators.

In Europe, in 2001, almost 38% of men and 23% of women used to smoke, with some differences among different countries. The use of tobacco among young people was estimated between 27% and 30% with a slight tendency upwards. The 20% of young people under twenty used to smoke.

One of the aims of the O.S.M.A. HPH. project is to establish a network among all subjects who wish to commit themselves against smoke by cooperating with young people and "the world of Education". The idea is to create, by good models, persuasive actions and respect for law, a spread and shared "no-smoking culture".

The HPH project is based on the idea that bringing up smoke-free life styles requires to create alliances and synergies between young people and all people who work for education, health, politics, economy, voluntary associations and medias. For such reasons, the project successfully experimented theatre as a new technique, alternative to traditional systems of lessons, based on a communication and education pattern which helps students to make a direct elaboration of contents. The apprehension process is based on the tested approach of "peer education" and forced the students to focus on the best way to communicate their knowledge to the attendance, which in turn can gather people of any sort. This experience gave the students the opportunity to address the message to adults and debate on the variety of interpretations a theatre text could give, and to all people involved the chance to wonder about important mat-

ters in an "entertaining way" and the place for cooperative dialogue and reflection. The impact of the experimentation was considerable, and showed how Hospitals can promote larger diffusion of information, involvement of people and subjects interested to community health.

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P 88: DON'T LET OUR CHILDREN GROW UP IN SMOKE

Bridie CLARKE

A new baby! A new life! The joy and wonder of parents as they gaze upon their new arrival.

Everything must be special and just perfect for this baby. A new cot, buggy, a car seat. Please ensure baby is strapped in at all times. This baby will be cared for so well. Plan ahead for the best schools, the best of everything. Feeding, well breast is best of course.

Mum is trying to do all the right things during her pregnancy. She has not taken any alcohol. She has taken the correct dose of iron and folic acid. Attended all her hospital visits and ante natal classes. She had chosen not to smoke. But now baby is here and she is no longer pregnant, a cigarette might be nice?

After all Gran said she smoked and it never harmed any of her children. The asthma, well that was in the family, it must be hereditary. And her younger sister, she did get a lot of

chesty colds, but that was normal in every family.

Expecting a baby is the ideal time for health professionals to encourage new parents to give up smoking. Advice and support is best offered at Ante Natal visits and classes. The use of smoking cessation services is an added advantage to initiate positive behavioural changes.

The importance of fathers giving up smoking should be emphasised. The benefits of quitting should be mentioned continuously. Health professionals should not make parents feel guilty about smoking as it is an addiction and help is needed to quit.

When baby arrives and joins the family circle it is also another ideal opportunity to encourage the extended family to stop smoking, and ensure new mums do not return to smoking once pregnancy is over. All of the family want the very best for this new arrival and are often ready and eager to make changes.

Smoking is as addictive as heroine. It is an epidemic in slow motion and it kills. Smoking brings disease and death. One young person in every two has a parent who smokes. Usually only one in ten smokers begin as adults, so it is essential that ongoing support and advice is given early.

So to work with new parents is a great opportunity to meet the goal of smoke free families. Support and encouragement for smokers is beneficial at any time, but can be of extra benefit to families before and after baby is born.

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SESSION I-10: STAFF HEALTH ISSUES (I): TACKLING SPECIFIC RISKS

P 89: RISK PROFILE OF NURSES: EXPERIENCE FROM LITHUANIA

Zemyna MILASauskiene, Irena MISEVICIENE

BACKGROUND

The large body of evidence from cross-sectional studies points clearly and consistently to association between nurses' health behaviours and their role in health promotion. It is known that non-compliance of patients with health promoting behaviour may be influenced by the non-compliance of those caring for them. Therefore, it is very important for health promotion policy implementation in hospital to know the risk profile of nurses that is the largest group of health professionals in hospitals.

The aim of this study was evaluate Lithuanian head nurses risk profile.

METHODS

A cross-sectional survey with a self-administrated health behaviour survey (HBS) questionnaire was conducted among 200 head nurses, working indifferent Lithuanian hospitals. The response rate was 94.5%. The HBS questionnaire contained 18 questions on use of preventive health care, smoking, dietary habits, alcohol consumption, and

physical activity. In order to estimate health related behaviour according to nurses' age we divided respondents into four groups: 20-30, 31-40, 41-50, and 51-65.

RESULTS

The study results indicated that 13.8 % of nurses are regular smoker; half (52.4%) of respondents do not take regular exercise; in the period of the last 12 months 23.1% of nurses indicated that they felt depressed more often than other people did; only 12.7% of nurses sought consultation of psychologist; the majority (85.3 %) of nurses brush their teeth twice or more per day; every second (56 %) of head nurses try to maintain their body weight within a "normal" range; 52.3% of nurses noted avoiding foods contain fats and cholesterol; 57.3 % reported eating fruits and vegetables every day. Statistical significant associations were detected between physical exercise, smoking and nurses' age.

CONCLUSIONS

The results of study suggest the need for health promotion programs addressing the health behaviour of hospital personnel.

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P 90: 'WORKING BACKS PROGRAMME' - PROMOTING ACTIVE MANAGEMENT OF LOW BACK PAIN IN THE WORKPLACE

Caitriona CUNNINGHAM, Siobhan BULFIN, Theresa FLYNN, Catherine TOOLE, Ann O'REILLY, Nuala GANNON, Justine MCGRANE, Aisling PURCELL, Orla SEALE, Paul GUERET. Catherine BLAKE

BACKGROUND

Low back pain (LBP) and disability continue to be a major problem among health service workers. Current evidence indicates the need for a more active approach to the management of LBP with the emphasis on self management in the majority of cases. When clinical intervention is necessary, evidence based clinical guidelines are available to direct practice. However, successful translation of research into practice is contingent upon a supportive organisational environment.

AIMS

To develop an organisational structure which:

- Empowers workers to self manage most episodes of LBP.
- Gives workers easy access to a multidisciplinary back management programme when self management is not sufficient.
- Improves communication between clinicians and managers involved in the case management of a worker with LBP.

METHODOLOGY

A multidisciplinary 'Working Backs Programme' team was established with clearly defined roles and lines of communication. The team included Occupational Health, Physiotherapy, Human Resources, Emergency Department, Occupational Psychology, Orthopaedics as well as line managers. A new occupational health data base was devised.

Specific written health promotion packages were developed for the key stakeholders: staff, line managers and back clinicians, in accordance with the UK guidelines for the management of LBP in the workplace (UK guidelines, 2000). Information was disseminated using hospital management structures and a series of health promotion events.

PROGRAMME EVALUATION

The programme is now five months in progress. Programme audit is ongoing using both quantitative and qualitative methods. Outcome measures include: health service utilisation data, sick leave data and staff and managers' satisfaction with the working backs programme.

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P 91: EVALUATION OF THE PILOT PHASE OF A NEEDLESTICK INJURY PREVENTION PROGRAMME

Nuala GANNON, Paul GUERET, Justine MCGRANE, Ann O'REILLY, Anne MCFADDEN, Siobhan BULFIN, Orla SEALE, Aishling PURCELL

A needlestick injury prevention workshop was designed to improve knowledge, attitudes and behaviour of healthcare workers in the management of needlestick injuries (NSI's).

OBJECTIVES OF WORKSHOPS

- To increase staff knowledge on the causes, consequences and management of needlestick injuries.
- To promote the benefits of safe work practices.

METHOD

- The development of a hospital-wide needlestick injury prevention workshop.
- A pre- and post-intervention survey.
- Monitoring of needlestick injury rates over a 9-month period post-workshop.

Participants were provided with information and training. Knowledge of the needlestick injuries programme was examined pre- and post-workshop using a 6-item self-report questionnaire.

PILOT PROGRAMME RESULTS

281 (14.5%) staff members have attended the workshops to date. There was no significant improvement in knowledge pre- and post- workshop. There has, however, been a change in behaviour as evidenced by the 19% reduction in the reported incidence of needlestick injury rates post-workshop (101 pre-programme period; 82 post-programme period). Attendance at workshops was higher among nurses than doctors; this may have contributed to the outcome (55% of NSI's to nurses pre-programme reduced to 44% post-programme; 27% of NSI's to doctors pre-programme increased to 35% post-programme). Positive information was recorded for all parts of the workshop.

CONCLUSIONS

Notwithstanding a 19% decrease, the current levels of needlestick injuries underlines the importance of providing an ongoing focus on the prevention and management of such injuries. While the workshop content will be reviewed and modified accordingly, there is sufficient evidence to support the continuing provision of the NSI prevention workshops.

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P 92: STRESS AND EMOTIONAL TIREDNESS - RISK FACTORS FOR HEALTH CARE WORKERS.

Vidmantas JANUSKEVICIUS, Paulius VASILAVICIUS, Audrius SPIRGYS

Stress is human mental and physiological health status that is caused by the influence of outside and inside factors (stressors). Physicians and other medical staff are under the sway of stress. Health care staff mental tiredness is caused by the time that is spared in contact with patients or as reaction to patient's death.

We questioned 2665 nurses in one of Kaunas city hospitals. Questionnaire was given during daily meetings. Respond rate was 89.9 %. So we analyzed 2279 questionnaires. The average age of the entire subjects was 40.02 yr. The biggest group of respondents had further medical education (37.6 %), special secondary education had 32.9 %, secondary education had 16.4 %, and high medical education- 9.8 % of respondents. 67.9 % of respondents maintained that their work is going together with emotion strain and that strain conducts on the average of 6.5 hour.

The rates of those who had stress situations in the group who worked 7-8 hours were significantly higher than in the group who worked 1-3 hours. The rates of those who were very emotionally tired after work in the group who worked 7-8 hours were significantly higher than in the group who worked 1-3 hours.

We found out that more than half (62.9 %) of respondents were under psychological pressure and aggression from patients and their household. 89.1 % of respondents who are under the psychological pressure and aggression at work significantly more frequently stated that their work goes together with emotion strain.

Significant associations were observed between being under the psychological pressure and the representations about health conditions over the past 12 months.

Growing number of night work goes together with growing number of respondents who complained about emotional pressure. About 80 % of respondents who worked 6-7 nights per month state that their work goes together with emotion strain.

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P 93: THE FEELINGS' NARRATION OF WORKERS IN SANITARY AREA AS A PROFESSIONAL INSTRUMENT IN SANITARY WORK IN NEONATOLOGY AND PEDIATRICS

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Education and training for sanitary professionals are still based on getting knowledge about objectivity, procedures, operability. Subjectivity, feelings and personal meanings are most of the times considered in contrast with "professionalism" and for this reason are exonerated from standard training paths.

This project began in 1993 in neonatology and in 2000 in pediatrics and it's still carried on. The main project aim is to build a training path to make health professionals able to implement the following issues: to manage stress and relation conflicts, to give support and counseling as concern emotional handling of pain, traumas and mourning.

OBJECTIVES

- Leading professionals to consider feelings as a source, a chance.
- Giving professionals training and managing instruments to help them to identify their and other people's feelings, to name, educate and manage them to not rise them up disorderly but to be instruments to humanize professional contests.

METHODOLOGICAL-QUALITATIVE INSTRUMENTS

- In Neonatology ward, since 1993, there is a monthly meeting group with doctors and nurses according to Bion model; in pediatrics ward focus group is used. In both situations it became clear that finding the time to think, observe and discuss inside the group has the function to handle and modulate the persecutory potential of emotions raised up in every day work.
- Narration: such strong emotions, usually hidden or neglected, can be expressed and shared only without fear of judging and if there are other ways, other than the group, to express them (poetry, stories, dreams, theatre representation, photos, draws...). First parents started to narrate their experience in the ward through letters. Professionals first shared children and parents' stories and later they narrate themselves.

Narration can be a gift of personal experience and can become a contest/instrument to "listen" feelings and have the opportunity to re-consider sanitary job in its complex relational meanings. We think to implement a new culture of Sanitary Hospital Services, where emotional life is considered as a part of professional life. It became clear that hospital can't be just a place for medical care, illness, death. It has to offer a space for mind too, where is possible to think life, illness and death.

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P 94: HOW TO RECONCILE TIME, FAMILY, JOB, HEALTH

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INTRODUCTION

In these years we often speak about "complexity, stress and runs against time", as social factors and elements influencing the quality of life and the serenity of everyone, even if with different intensity and relevance.

Even sharing every aspect of these analysis, is furthermore difficult to act on stress factors in the sanitary sector and in

the management of our hospital firms. Our sector lives, in fact, a well known and extremely high stress level, but our strategic managements have to measure themselves with the balancing of budgets, the integration of different professional profiles and the organizational improvement and the attainment of strategic objectives. All of this trying to improve the quality of life of the single sanitary operator, basic element for a better organizational quality and sanitary performance.

The starting points that have lead the firm to a project that can reconcile Family Time, Job Time and Health Time, are:

- The intensity of work pace
- The high feminization
- Shift work
- The difficulty in winning the confidence of the professional figures
- The fiduciary relation between the Management of the Firm and the Operators
- The effects of the firm transformations
- The social-economic troubles
- From the humanization to the personalization of the assistance

OBJECTIVES

- Improvement of the wealth of the employees-citizens
- Scientific validation of the model of Firm Day Nursery
- Improvement of the organizational firm climate and of the treatment model, towards the personalization of the assistance
- Reiterability of the model

TARGET

Employees of the Firm and their children and sons of patients

EVALUATION

- Improvement of the wealth of employees- citizens
- Scientific validation of the model
- Improvement of the firm organizational climate and of the treatment model, towards the personalization of the assistance
- Reiterability of the model

CONCLUSION

This project appears as a wide project of cultural change that involves even the assistential dimension.

Accompanying in a non traumatic way the passage in process from a "Health Service as government microcosm" to that of "Firm Health Service" and progressively, to that of "Health Service person microcosm", centered on the citizen.

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P 95: IS THERE A PLACE FOR CARDIOVASCULAR RISK ASSESSMENT IN THE WORKPLACE?

Irene GIBSON

AIM

To reduce the cardiovascular risk of employees of the Health Service Executive in the Western Area, by empowering them to gain control over their own health through comprehensive risk factor profiling within the workplace.

BACKGROUND

As part of its primary prevention programme, Croi the West of Ireland Cardiology Foundation became involved in the staff wellness day initiative. Some of the key services involved in the wellness day initiative are Health Promotion, Community Nutrition, Smoking Cessation, Employee Assistance and Cardiac Rehabilitation. At the wellness days Croi offered employee's a free cardiac risk assessment.

OBJECTIVES

- To raise awareness of cardiovascular disease among employee's.
- To target and identify high risk individuals for heart disease.
- Use motivational interviewing to enable employee's explore ways in which they can improve and take control over their health.
- Provide lifestyle and behavioural counselling as appropriate to each individual with the support of educational booklets.
- Refer individuals to community nutrition, smoking cessation, physical activity personal and doctor as appropriate.
- Maintain follow up of each individual identified at a high risk after 6 months.

METHOD

A total of 194 staff members availed of the cardiac risk assessment service. The staff profile included 43 males and 151 females. The age range was between 22 - 64.

The cardiac risk assessment included an assessment of both the modifiable and non modifiable risk factors for heart disease. All results were explained and discussed with each individual and each individual was given a personal record of their results. Individuals that were identified as being high risk were encouraged to attend their doctor and received a follow up phone call.

RESULTS

53% of males and 51% of females were identified with raised total cholesterol as well as having a number of other risk factors such as hypertension, smoking, family history, physical inactivity and being overweight. Follow up was in accordance with a protocol approved by the Department of Cardiology University College Hospital Galway.

CONCLUSION

The settings approach to health promotion proved to be very successful with large numbers of staff attending the days. Feedback from employee's who had a cardiac risk assessment was very positive. Comments in relation to improved staff morale were reported. Many employee's were identified as having risk factors for heart disease. While the follow up sessions have not taken place yet, it is hoped that these employee's made the appropriate lifestyle changes and attended the doctor as advised.

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SESSION I-11: STAFF HEALTH ISSUES (II): STAFF SURVEYS & TRAINING FOR HEALTH PROMOTING WORK PERFORMANCE

P 96: SELF- REPORTED JOB SATISFACTION AND HEALTH STATUS OF THE EMPLOYEES IN THE H.P. HOSPITALS IN GREECE.

Yannis TOUNTAS, Alexander Stamatios ANTONIOU, Xara TZAVARA, Eleni MORETI

METHOD

A stratified random sample consisted of 345 personnel of seven Health Promoting Hospitals in the major area of Athens, was used. The SF-36 questionnaire and a series of five questions concerning job satisfaction were administered to the employees. The scores obtained from each question for the estimation of job satisfaction were summarized and the median of the total score was used to discriminate employees into two groups, those with high levels of job satisfaction and those with low levels of job satisfaction. In order to check the differences of the scores of SF-36 scales t-test were used. Logistic regression models were used to estimate the relation of job satisfaction with other factors. Statistical significance was set at $p=0.05$.

RESULTS

The differences of the scores derived by the scales: Role Physical, General Health, Vitality, Social Functioning, Role Emotional, Mental Health except from Physical Functioning between the two groups concerning job satisfaction, were significant ($p<0.05$), while the difference of the scores of Bodily Pain tends to be significant ($p=0.09$). Additionally, significant differences were found for the scores of the two main dimensions of SF-36 Physical Health and Mental Health with $p=0.038$ and $p<0.001$ respectively. For all the scales of SF-36 the score is greater when the employees indicate more satisfaction with their job. When logistic regression models were used, females were found to be more satisfied with their job than males, in a significant degree (odds ratio=1.78, $p=0.024$). Furthermore, differences were found between the professions, with employees belong to auxiliary personnel to be more likely to have high levels of job satisfaction compared to administrative personnel, medical doctors, nurses and technical personnel. Older employees were found to be more satisfied with their job than the younger ones. No significant differences were found for job satisfaction according to workplace. The total score of SF-36 was significantly correlated with job satisfaction (odds ratio=1.28, $p=0.01$).

CONCLUSIONS

There is a significant relation between job satisfaction and health related quality of life providing the need for intervention to groups with low job satisfaction.

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P 97: STAFF MATTERS

Kathleen COOPER

AIM

Establish and develop a health promoting culture for staff within the workplace using the Health Promoting Health Service Framework.

METHODOLOGY

A literature review was carried out of health promotion activities in the workplace. Locally, a mapping exercise established current health promotion programmes. A questionnaire was developed and analysed. The formal evaluation of the Staff Health Needs Assessment and development of links to strategic groups have been achieved.

The methods of staff consultation included a quantitative questionnaire. In total 545 questionnaires were distributed, of which 322 were returned giving an overall response rate of 59%.

RESULTS

The main issues identified from the questionnaires were stress at work, policy development and physical activity. Similar results were obtained from a national survey of staff within the Trust. Staff requested provision of, or further development of health checks, access to sport's facilities, information about managing stress, confidential counselling and staff exercise classes. These areas have been progressed and staff empowerment encouraged through the Staff Governance Group and Staff Fora. A Staff Forum has been established to discuss issues relating to provision of food for staff.

Additional links have also been made with, for example, the Occupational Health and Safety Group who successfully bid for finance from the Scottish Executive to improve mental health and well being. Future plans centre around developing and maintaining the portfolio for the Gold SHAW Award and Health Promoting Hospital development.

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P 98: AN INVESTIGATION INTO IRISH PHYSIOTHERAPISTS' PERCEPTIONS OF HEALTH PROMOTION: BELIEFS AND SELF-REPORTED PRACTICE.

Eva DEVANEY, Patricia MANNIX-MCNAMARA

PURPOSE

A pre-requisite for working towards a shared understanding of the concept of health promotion in the health services is the understanding of how different groups of health practitioners perceive and practice health promotion. This study aimed to investigate Irish physiotherapists' beliefs of the effectiveness of different approaches, comparing those with self-reported practice.

METHODOLOGY

Postal survey, using a purposive sample of 207 Irish physiotherapists (response rate 54%, N=112 in the primary care setting. Respondents were asked to rank five approaches - social change, education, medical, empowerment and behaviour change (Ewles & Simnett 1999) - according to their belief in the most effective approach for promoting health and for best fitting description of their own practice. Data analysis included frequency distributions and Mann-Whitney U tests.

RESULTS

An empowerment approach was ranked first most frequently (51%) by respondents for belief in its effectiveness, while 39% ranked this first for their own practice. While only 24% of respondents ranked an educational approach first for belief in effectiveness, it was the approach ranked first most frequently for practice (40%). A social change approach was ranked first by only 14% of respondents, while a fraction (1%) ranked this approach first for their own practice.

CONCLUSIONS

The study found a discrepancy between the respondents' beliefs and self-reported practices; while just over half of respondents believed an empowerment approach was most effective, an educational approach was most frequently reported being used in practice. Individual approaches were ranked higher than collective health promotion strategies; consequently, an opportunity exists to raise awareness of using social change approaches in health promotion within this professional group.

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P 99: AN EXPLORATION OF NURSES' PERCEPTIONS OF THE ROLE HEALTH PROMOTION PLAYS IN THEIR WORK WITH SUBSTANCE MISUSERS.

Therese HENNESSY

Research has documented the role that health promotion can play within nursing generally, with some studies focusing on specific areas such as mental health nursing (see Deasy 2004) and public health nursing (see Gibson 2004). Little research has emerged examining the role of health promotion within nursing focusing on the area of substance misuse. This study attempts to address this gap in the knowledge base.

The research objectives were to explore nurses' attitudes towards chemical substance misusers and to establish if their attitudes varied according to the type of chemical substance used, to ascertain nurse's level of training in the area of chemical substance misuse issues and to explore nurses' perceived competencies with regard to health promotion strategies when working with this population.

The study was mixed method in approach with both quantitative and qualitative methods employed these were focus group, survey and interviews. A focus group was employed to inform the survey design. The survey was an anonymous postal survey to a stratified random sample of 354 nurses within the Mid Western Region and yielded a response rate of 44%. This was followed by interview with five practicing nurses who self selected to be interviewed.

The findings of the study indicate that nurses working in the area of substance misuse within hospitals felt that they needed support and training with regard to substance misuse. Participants also found it difficult to differentiate between health promotion and health education, as there was a poor understanding of health promotion. The majority of participants saw health promotion as health education. Participants identified the need for professional development in areas such as stages of change and its relevance to substance misusers, communications, and self-awareness training.

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P 100: AN EXAMINATION OF A STAFF SUPPORT SERVICE IN AN ACUTE HEALTHCARE SETTING.

Nuala GANNON

The paper describes a Staff Support service for health care workers in an Irish hospital setting. An overview is provided of its history, development and extent of the work involved. The report provides a limited evaluation of the effectiveness, outcomes and benefits reported by users. Barriers to implementation and strategies for overcoming them are discussed.

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P 101: EMPOWERING HEALTH PROFESSIONALS IN IMPLEMENTING HEALTH PROMOTION BY STRENGTHENING THE EDUCATION AT BACHELOR LEVEL

Karin BIRTØ

PURPOSE

To increase and coordinate knowledge and skills in clinical health promotion by using Problem Based Learning (PBL) in a multi disciplinary educational setting.

BACKGROUND

By legislation, and an expectation of an increase in teaching/learning quality a number of health care teaching institutions at bachelor level established a common management in 2002. This gave the opportunity to start up new multi-disciplinary approaches in teaching health care professionals at bachelor level. The topic clinical health promotion was prioritized differently at the various schools, now was the chance for coordination of the efforts.

METHOD

Students from four schools participate: Copenhagen School of Nursing, School of Physiotherapy, School of Occupational health and School of Medical Laboratory Technology, all members of the CVU-Oeresund. Since 2003, one week in each semester has been allocated to a obligatory multi-disciplinary course in Clinical health promotion. Approximately 250 students participate, the majority being student nurses. A modification of PBL is used as teaching methodology. Four relevant paper based clinical scenarios are used as trigger material. Further more, a lecture providing the students with basic background knowledge is given as a kick-off at the beginning of the course. During the course, a panel of experts in clinical health promotion is answering questions and chairing a focused workshop session with discussions of the learning objectives. Finally the groups share their results and the tutor checks the learning. The week is finalized by a plenary lecture on future perspectives of clinical health promotion.

RESULTS

The students evaluate each course.. In general they find the multi-disciplinary approach challenging as they have already adapted the behavior and thinking of their own health care profession. *

CONCLUSION

A multi-disciplinary approach when teaching clinical health promotion using problem based learning can be implemented at bachelor level in health care educations.

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P 102: EMPOWERING STAFF OF MODERN HOSPITALS FOR HEALTHY WORK PERFORMANCE (EXPERIENCE OF RUSSIAN HOSPITALS)

Izolda CHEREPANOVA, Tatiana RODIONTSEVA, George GOLUKHOV

OBJECTIVES

Ministry of Health of the Russian Federation, hospital's staff, allocation of financing weight, staff's opinion.

METHODOLOGY

- Statistics
- Social and psychological, sociological monitoring

EVALUATION

About 9 thousand hospitals function in the system of Ministry of Health of the Russian Federation.

As a whole more than 3 million people work in Russian healthcare system, about 2 million of them are medical staff including 613 thousand physicians.

The analysis showed that about 30% of financial resources are spent on pre-admission assistance, 10% on acute care and 60% on hospital assistance at the present time. Reforming of national healthcare system plans re-allocation of financial flows.

In spite of certain progress in allocating financial resources in favour of primary care, taking place at the present time, hospitals remain an important source of work places.

Sociological monitoring, a study of modern hospitals' needs, which we carry out, give interesting results. A part of the data obtained by us is presented in this report.

The following suggestions were made while the staff answered the question: "What would you like to change in the hospital and suggest living and working better in it?" 25% of the staff suggested making changes in the process of work organization in the hospital itself; 18% would like to improve mutual relations between the hospital's management and the staff working there; 14% offered particular acts on improving comfort of working conditions (to increase a number of flowers in the rooms, to have rest rooms and dining rooms for the staff, to expand opportunities for the staff, to enlarge opportunities for advanced training, to set up and use a library); 18% would like to get assistance in spending free time with their families and children.

The hospital staff made suggestions protecting occupational safety and health: almost one third (30.9%) would like to get pecuniary aid to reimburse their transport expenses, 26% would like to go in for sports, 69.1% responded that they observe healthy life style, 33% reported that obsolete equipment and facilities can be hazardous for health and additional sanitary measures are required.

43.6% of physicians and nurses smoke in hospitals (data obtained in Moscow and Moscow region).

41.5% stated that they aren't satisfied with the level of their salary at all and 35.1% of the respondents answered that they are not quite satisfied with it.

About 20% of the staff wishes to have support in housing issues, extension of vacation duration, and assistance in medical and social care, in adequate provision of specialists accordingly. And only 1% of the respondents were satisfied with everything.

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P 103: EMPOWERING PHYSICIANS' HEALTH PROMOTION IN A HOSPITAL

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Physicians' health depends not only on their lifestyles but also on workloads. Due to health reforms in Lithuania and other countries of economical changes the amount of physicians' work and responsibilities has increased.

The aim of the survey was to investigate physicians' opinion on their workplace improvement opportunities, find out concern about personal health and measure their burnout.

METHODS

Physicians (n=55) from 5 departments in Kaunas'2nd Clinical hospital were asked to fill out the questionnaire. The burnout rate was assessed according to Freudbergs' scale.

RESULTS

The majority (94.5%) of respondents were aware of their blood pressure, body mass index (80.0%), less respondents were aware of their cholesterol level (43.6%). There were much more smokers among surgeons if compare with other specialists (36.4% vs. 6.8%, p=0.02). Despite cardiologists' most healthy lifestyles their burnout level was the same as surgeons' and in these two departments it was 38.9 ± 18.8 versus 26.5 ± 16.6 in other departments, p=0.01. More than 80% of cardiologists and surgeons were tend to work over-times and felt the lack of time for profession related knowledge improvement. Only 23.6% of all respondents noted that in case of ailment they undergo a professional examination. The majority of respondents approved of implementation of certain measures to decrease workload.

CONCLUSIONS

Despite cardiologists' most healthy lifestyles their and surgeons' burnout level was the biggest. According to the results of survey a room for rest in the Department of Cardiology was established. The implementation of requested changes in work procedure has started.

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P 104: COMPLEMENTARY THERAPIES FOR NURSES AND MIDWIVES AT UNIVERSITY COLLEGE HOSPITAL GALWAY

Hannah KENT

AIM

To provide an onsite complementary therapy service for nurses and midwives in UCHG.

METHOD

A working group that included nurses, midwives, the Health Promotion Officer, a member of the hospital finance department and the Nursing Practice Development Coordinator, advanced this positive health promotion project. Two service providers were contracted to deliver therapies on two half days per week. Their qualifications and insurance cover were verified and authenticated. St Valentine's Day 2003 saw the launch of the new initiative. The launch day provided an opportunity to advertise the service and the balloon and heart be-decked stand in the main foyer got much attention. 200 information leaflets were distributed on the day and posters were mailed to each clinical area highlighting the service and phone booking details. Reflexology, Indian head and neck massage and holistic massage were some of the therapies offered. Therapies were provided at a reduced cost to participants and subsidised by the Nurses/Midwives Forum through the National Partnership Forum.

RESULTS

Over 600 therapies have been provided to 200 nurses.

CONCLUSION

Evaluation of the service indicates that participants perceived that the availability of the service made them feel that the organisation valued them as employees. Staff identified complementary therapies helped them to deal with physical and psychological stress and participants tended to use the service on a recurring basis. The collaborative approach supported its successful implementation and it was not without its difficulties and challenges. The main difficulties were in relation to securing a designated venue suitable for such a therapeutic service.

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P 105: TEAM-BASED SELF-ROSTERING

Geraldine MCDONAGH, Edel SHIELDS

AIM

To introduce self-rostering to Unit 5, Merlin Park

METHOD

- In November 2003, the ward manager attended a study day on modernizing rostering.
- Feedback to staff was given outlining the advantages of self-rostering:
 - Staff control the process
 - Staff become more accountable
 - It maximises flexibility
 - Good way to build co-operation, negotiation

and teamwork.

- Areas of concern were identified by staff and addressed (e.g. weekends, bank holidays).
- Guidelines for rostering were developed in the unit (Patient and service comes first; Appropriate staffing levels and skill mix) and distributed to each staff member.
- Several meetings were held with staff in November and December.
- After reaching a consensus, it was decided that self-rostering would begin in January 2004 and would be reviewed after 6 months.
- In March 2004 some staff expressed concern and difficulties with self-rostering. Some staff found it difficult to negotiate with other members of staff.
- Further meetings were held with staff and by the end of June there was a marked improvement in self-rostering.

RESULTS

Rosters are prepared by staff using agreed guidelines. Staff negotiate with each other and agree work schedules and ward cover. The negotiation process has improved markedly in the year since introduction. The process is over-seen by the Ward Manager.

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P 106: ENTERING A NEW HOSPITAL: HOW TO EMPOWER HEALTH PROFESSIONALS

Maurizio MELLANA

In the mid of '90 Asti began to build a new hospital. We have planned a way to help health care professionals to discover the new hospital and reduce the risks of resistances resulting from the impact of new technologies, spaces and innovative methodologies.

We simulated a standard health care professional working day (park the car, enter the hospital, dress change, enter a standard medical division, have lunch, goes out from the division, take the car and leave the parking), trained a group of nurses and MD of 30 and lead 1250 health care professionals to do this path inside the new structure. After a three hours long visit, we have given a half-structured questionnaire to each person, before starting a question time session where every one had the time to ask questions to experts (engineers, medical doctors etc).

Questionnaire asked people to:

- Rate themselves on a Likert scale according to their post-tour feelings.
- Rate which was the main source of anxiety among three change dimensions stated (new spaces, new technologies, new organisational models) and why.
- Write an adjective or a metaphor related to the hospital's image they had after the tour.
- Write up to three questions or suggestions.

767 questionnaires have been evaluated: quantitative and qualitative datas will be discussed.

In order to manage questions and suggestion, we start an open forum on the company intranet: a trained pool of expert start to give answers to the question the climate survey raised up. Moreover, every health care professional had the chance to give the contribution to the change process simply e-mailing answers or suggestion to the forum: we collected 25 individual answers and suggestions and 1500 contacts in two months. Qualitative datas will be presented.

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P 107: PATIENT EDUCATION FOR NURSING EXECUTIVE LEVEL IN BELGIUM

Genevieve THOMAS

To contribute at the development of patient education programs in hospitals, the Health Promoting Hospital Network of the French community of Belgium organise in 2004-2005 a 4-days training in patient education management. 20 persons took part at this training (December 2004 - April 2005)

TARGET

Nursing executive level

CONTENTS

- Comprehensive PE approach
- Analysis of the factors who influence the PE relation
- PE individual strategies
- PE group strategies
- Who to develop PE institutional strategies?

TRAINERS

- Geneviève Thomas (nursing chief in patient education CHR Citadelle - Liège Belgium)
- Jacques Dumont (co-ordinator of the HPH Network - French Community in Belgium)

TOOLS USED IN THE TRAINING

- Theoretical and practical talk
- Practical exercises
- Video
- etc

Evaluation (will be available for the HPH conference in May 2005) based on the subjective opinion of the participants, the evolution of PE perception and the ability to build a PE project.

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P 108: USING E-LEARNING COURSE ON PATIENT HANDLING IN HOSPITAL EMERGENCY UNIT

Lucia BERNARDONI, Stefano SASSI, Paola APPRESSI, Daniele TOVOLI

Patient lifting and transfer is the first cause of injuries, loss of workdays and loss of work ability in Italian Hospitals. Training courses on good practices in patient handling proved effectiveness to control risk. Often training is a time consuming activity, and in Italian hospital some factors limit its efficacy like shortage and high turnover of nurse staff. To overcome the problems, to have more flexibility, to control the costs, we experimented a e-learning training course.

The training course is organized in three parts: the first one is a short meeting for general information, the second one is a theory based e-learning course with three intermediate check tests; and tutor support. The third one is a practical training activity lasting three ours and half, made by physiotherapists. The course end with a learning test and course evaluation questionnaire. After six months has been made a follow up to control the nurses acquired good practice.

Sixty-five nurses attended the course in three months from points of access into the hospital; during working shift, working pause, night shift, and sometimes from home. They completed the e-learning course with a medium time of one hour and half instead of an estimated time of two hours and half. Nurses passed the e-learning tests with a medium percentage of 88.7 of correct answers. During the practical training activities nurses made simulations to identify critical tasks in patient handling, revised procedure and got hints to acquire new type of aids for patients handling in Emergency Unit. Follow up evaluation after six months showed a compliance to correct procedure above 80% of items.

The use of e-learning system proved a significant decrease of course length and overall control of costs too. It helps to overcome some factors affecting the attendance of hospital staff and it has had a good appreciation score. Because of the effectiveness, e-learning course for hospital staff maybe a good investment either for basic training than for specific one too, and a useful option to traditional training courses.

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P 109: COMMUNICATION STUDIES AND THE RELEVANCE OF HEALTH LITERACY FOR PATIENTS AND STAFF CHOOSING HEALTH IN A HPH

Margaret KELLEY, Denise RICHARDSON

Professional practice in a HPH culture: developing communicative / interactive health literacy

"Communication is talking to one another" (Fiske 1990). Importance of effective interpersonal communication in professional contexts is now widely recognised (Hagie 1994). The ability to communicate is a vital part of the role for doctors, nurses, health visitors and social workers and essential "together with social skills.." as: "those kinds of behaviour which are basic to effective face-to-face commu-

nications between individuals" (McGuire 1981) and "...to actively participate... in developing communicative/interactive health literacy..." (Nutbeam 2000) essential for developing a HPH culture and environment.

EMPOWERING EDUCATION FOR DEVELOPING CRITICAL HEALTH LITERACY SKILLS IN A HPH ENVIRONMENT

Many young people entering the health profession lack the very basic skills to communicate with patients, relatives and staff and other carers. Communication studies as an essential part of the curriculum, enables students to develop knowledge and transferable skills thus empowering them and increasing confidence. "Communication studies provide knowledge, skills and attitudes that are central to caring work" (Balzer-Riley 2004) and a prerequisite for critical health literacy for staff in a HPH environment "...to exert greater control" (Nutbeam 2000) in enabling patients to take responsibility for self - health improvement.

'EMPOWERING COMMUNICATIVE/INTERACTIVE HEALTH LITERACY IN ACTION: PRACTICAL RELEVANCE FOR MAKING HEALTHY CHOICES IN HPHS

Building skills for clear communication will continue to increase effectiveness in professional and personal interactions and important for evidence based HPH practice. It is essential that communicative/interactive health literacy skills are taught, understood and used as part of a health professionals training, allowing empowerment to become a cultural norm for patients, relatives and health professionals. "...Everyone working in the NHS, must help educate patients and support them in their decisions" when Choosing Health: and Making healthy choices easier' (DoH 2004).

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P 110: EMPOWERING CURRICULUM IN PRACTICE: THE FUTURE GENERATION OF HEALTH PROMOTING HOSPITALS ADVOCATES IN ACTION

Vilma SMITH-YATES, Jason WALDRON, Denise RICHARDSON,

EMPOWERING HEALTH EDUCATION PROGRAMMES FOR FUTURE GENERATION OF HOSPITAL STAFF:

Preston College offers health education programmes in partnership with UCLan (University of Central Lancashire), designed to meet the needs of students, employers (e.g. local hospitals and PCT's (Primary Care Trusts)), their families, social networks and wider community. The Health, Social Care and Early Years Academy delivers a BTEC National Diploma in Health Studies course including a health promotion module providing empowerment health education as key to effective health promotion strategies and action whereby individuals take control of their own health and empower others. Located next to Royal Preston Hospital the College is a signatory to the Lancashire Tertiary Education Drug Prevention and Education Charter, interacting with and using professional advice from the Health Promotion Unit, HPH, community health services, Drug Agencies and the Police.

RECOMMENDATIONS

- Identify and document best practice and outcomes of 'empowering health education programmes for a variety of audiences and environments in education;
- Ensure through partnerships in education, HPHs and other settings, continued delivery of learner-centred 'health promotion' education to enable health literacy development throughout the learning experiences.

EMPOWERING HEALTH PROMOTION IN ACTION: YOUNG STUDENT ADVOCATES FOR SOCIALLY VULNERABLE YOUNG PEOPLE

Through collegiate empowering partnerships with colleagues in the LSHPGM (The Lancashire School of Health and Postgraduate Medicine) UCLan the module ensures that WHO's HPH values and messages stand out in the learning experience of students. Empowering learning and teaching experience assists students to act as health promotion advocates in planning and evaluating a 'Health Fair' - Drugs 4 Slugs' held in the college refectory. Carefully designed posters, NHS supported leaflets, college mass media promotion, information and active empowering dialogue was made accessible to various audience groups (students, staff, visi-

tors and partners in health promotion). This example of empowerment in action aims to support existing infrastructure, create and sustain environments that can effectively promote health of potentially vulnerable young people in college and wider community. 'Skilled for Health' ("Skilled for Health, has been launched to help more people improve their basic skills and to link learning to health - for example, some seven million people living in the UK today have difficulty reading the label on a medicine bottle." <http://www.dfes.gov.uk/readwriteplus/bank/ACFEE55.pdf>) enables young people to manage health hazard risks, thereby challenging and combating the negative influences of health 'hazard merchants' such as drugs and alcohol.

RECOMMENDATIONS

- Support 'health literacy' as an indispensable human right to education, enabling each person to be a knowledgeable, empowered community member, skilled and critical health worker.
- Support by multilevel stakeholders (WHO HPHs, governmental and educational players) to 'Skilled for Health' programme (<http://www.dfes.gov.uk/readwriteplus/bank/ACFEE55.pdf>) requiring 'health literacy' (via health promotion modules) to be a fundamental and documented learning outcome in primary, secondary, tertiary, and life-long education.

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SESSION I-12: DEVELOPING HEALTH PROMOTING HOSPITAL ORGANISATIONS

P 111: INTEGRATING HEALTH PROMOTION IN AN HOSPITAL STRATEGY WITHIN THE FRAMEWORK OF THE PUBLIC HOSPITAL MANAGEMENT REFORM. DREUX HOSPITAL, FRANCE.

Florence DA SILVA, François MARTIN

The hospital Victor Jousselin (Dreux - France) is member of the Health promoting hospitals network since 1997.

The purpose of this poster is to illustrate how in practical terms a French local hospital carries out prevention, health promotion and patient education in the new frameworks of the public hospital management reform ("New governance").

In 1995 this hospital were one of the first to implement a Prevention and health education unit. In 2004 it is one of the first to experiment the new concept of management "les pôles d'activités" and to applicate it to health promotion. Since the team of the Prevention and health education Unit pooled their activities with others into the "Addictology, Prevention, Education resources center", including:

- Addictology
- Alcoholology
- Tabacology

PREVENTION

- Anonymous and free screening for Aids and hepatitis
- Health Center for Tuberculosis
- Medical and social consultation for vulnerable populations*
- City/hospital network "Health and precariousness"

PATIENT EDUCATION

- Asthma
- Cardio-vascular diseases

To perpetuate the financing of this Center will be what is at stake in the coming battle.

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P 112: HEALTH - WHAT HAVE HOSPITALS GOT TO DO WITH IT?

John WRIGHT, Jane WEST

For too long promoting health has been seen as a primary care issue and hospitals have neglected their role as centres for health and health promotion. Yet English National Health Service (NHS) hospital trusts consume over half the total NHS budget and treat 25% of the population every year. Many hospital patients will be suffering from cancer, heart disease, diabetes and lung disease - the public health epidemics that the UK is facing. These hospital contacts provide an opportunity to target advice at a time when patients already have concerns about their health. Hospitals are also big employers and can take on an exemplar role by creating healthier workplaces and investing in their local community.

In 2004 Bradford Teaching Hospitals NHS Trust acknowledged the importance of its role as a centre for health and developed the UK's first public health strategy for a hospital. Bradford has a diverse population of around 500,000 and includes some of the most deprived communities in the country. Infant mortality is well above the national average and life expectancy below average. We wanted a strategy that would offer a clear and radical framework to tackle poor health and health inequalities in Bradford.

The strategy sets out three key areas for action: creating a healthy place to work and visit; reducing inequalities and partnerships and regeneration. It recommends a radical approach to tackling smoking, obesity, physical inactivity, inequalities in health, regeneration and sustainability.

Hospital trusts have a great opportunity to review their efforts to prevent disease as well as treating disease, and promote a healthier workplace for staff. The time is right to start building fences at the top of the cliff and stop people falling off, rather than waiting to treat them at the bottom.

This presentation will outline the development and progress of our strategy.

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P 113: INTERMEDIATE EVALUATION OF THE HEALTH PROMOTING HOSPITALS - PROGRAMME IN THE CENTRAL FINLAND HEALTH CARE DISTRICT

Maria HALLMAN-KEISKOSKI, Eeva HÄKKINEN, Johanna KOSKENKORVA

Central Finland Health Care District is carrying out Finland's first Health Promoting Hospital -programme in 2001 - 2006. The programme's intermediate evaluation was completed in 2003 as management interviews, analyses of the operational plans of responsible units and employee questionnaires.

According to the management interviewees (N=10), upper management's support has been significant and health awareness and positive attitudes towards health topics have increased. The most crucial issues in the future are manag-

ers as role models, positive attitudes, healthy lifestyles and vision and insight about health promotion.

The content analysis of operational plans (N=30) clearly brought out the frame of reference of health promotion. According to the researcher, all professional groups should be included in preparing the operational plans, and it would be best to have named persons in charge of different activities. Communication within and between units should be improved and the significance of the ageing population and staff should be discussed.

Respondents to the employee questionnaires (N=794) felt that health promotion had been discussed in the units but it was also visible as part of operational practices. The employees hoped that the district would direct resources for supporting ageing employees, recognising depression and developing care guidelines. The three most important development areas were supporting the coping of patients and staff, increasing cooperation between units and agents and increasing the amount of preventive work.

Health Promotion Committee evaluated the results of the intermediate evaluation by coming up with concrete ways to improve the intelligibility of the programme's concepts and its visibility in daily practice. In the future, resources will be directed towards recognising depression, development of care guidelines and prevention of Type 2 Diabetes. The immediate goals include establishing a health information centre, prevention of problems with care, preparing a sexual health promotion -project and expanding the forthcoming programme to become a regional project in 2007 -2012.

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P 114: EMPOWERING FOR HEALTH: PATIENTS AND STAFF IN UPPER SILESIAN REHABILITATION CENTER "REPTY"

Krystian OLESZCZYK, Anna ZIELINSKA-MEUS, Marlena SZASTOK

Upper Silesian Rehabilitation Center "REPTY" in Tarnowskie Gory is specialist rehabilitation hospital. There are 560 beds in cardiac, neurological and orthopedic wards, 8200 patients are treated yearly. The Center is the member of National and European Health Promoting Network. 498 persons are employed there (medical staff: 76%, other staff and administration: 24%).

The aim of this paper is to present how our hospital implements empowerment to improve patients' and staff health. There are many strategies implemented in the Center which have been constructed to reach this target. We have special services for empowering patients in clinical intervention and to better manage chronic diseases. There are some programs as: education, information, culture in the hospital and communication (better stress manage), patients' satisfaction monitoring, patients' needs analysis (empowering in clinical intervention).

The group of active rehabilitation exists in our hospital as

subproject of empowering patients in healthy lifestyle: sport for disabled on wheelchairs and swimming and for paraplegia patients. Another strategy is the program of continuous quality improvement. The Hospital has its own and professional quality systems: the national hospital accreditation program (160 standards, 100 instructions), international certificate on quality management: ISO 9001 : 2001, and international certificate on environment management 14001:1998. This program confirms our professional quality.

There are also some strategies implemented for improving the hospital's impact on staff health: teamwork style (in all departments), professional education, psychological support, sport in the hospital. The special program for environment has been also implemented: energy consumption reduction, pollution reduction and recycling. All this project were implemented for improving patients, and staff health and to support professional quality.

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P 115: PILOT OF STANDARDS FOR HEALTH PROMOTION IN HOSPITALS: THE HEALTH SERVICE EXECUTIVE MIDLAND REGION EXPERIENCE IN ORTHOPAEDICS AND MATERNITY SERVICES

Kathleen MCLOUGHLIN, Dolores BOOTH, Mai TORMEY, Fiona MCMAHON, Dorothy NIALL

BACKGROUND

The Health Service Executive, Midland Area, agreed to pilot the Standards for Health Promotion in Hospitals in the orthopaedic and maternity services in 2004. Multidisciplinary groups were established to collect evidence and assess both disciplines in relation to the standards provided examining the organisational culture in relation to health promotion, patients assessment, patients information and intervention, workplace health promotion and continuity and co-operation.

OBJECTIVES

- To pilot the standards and submit feedback on them to the World Health Organisation.
- To form multidisciplinary groups to self assess current practice against the standards.
- To collect evidence to support each standard.
- To devise an action plan for each area in relation to each of the 5 standards.

METHODS

Each group met 6 times and was facilitated by the Regional Co-ordinator for HPH. Groups consisted of Consultants, nursing staff, physios, OTs, admin staff and the Co-ordinator for the Community Rehabilitation unit attended the group for Orthopaedic staff.

RESULTS

From the self assessment both groups have developed detailed action plans for the year ahead, these actions include the development of a health promotion policy for the hospital, a review of food provision for cultural groups, development of a patients satisfaction measure, an audit of

health promotion materials available and various plans for workplace health promotion.

CONCLUSION

Participation in the pilot has been a positive experience allowing for the sharing of information and knowledge and the development of actions for the future. For the maternity group the pilot also resulted in the opening of the staff lactation room at the Mullingar site during the pilot period. The groups felt that the majority of standards presented in the pilot study were understandable, applicable and important and have recommended that other disciplines within the hospital engage in this valuable activity.

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P 116: ACTION PLANS FOR APPLICATION OF HEALTH PROMOTION STANDARDS IN HOSPITALS

Daniilo ORLANDINI

At the Local Health Board of Reggio Emilia, health promotion is one of the main aims in planning patient pathways. They take into account the issues of ensuring effectiveness, getting professional staff involved, safeguarding patient rights, and promoting patient participation in managing the treatment plan.

The project's primary aim is to improve the care provided to patients, ensuring effectiveness of services and technical competence of staff, also promoting correct behaviour which can serve as an example.

As part of the project, the organisation is committed to participation in an interdisciplinary working group with the head of quality department and the HPH project manager; the management provide support in the formulation and implementation of action plans; the quality and accreditation department contributes to the guidance and training of personnel in carrying out self-evaluation, and assists in the collection and correct interpretation of data.

The project's primary target is the patient: rather than passively subject to treatment of a pathology, he/she becomes an active player in the process of planning and supervising a treatment programme. In part, this aim is to be achieved through staff involvement in training and personal and professional development activities, so that a greater awareness of health promotion issues leads to concrete patients empowerment.

Specific action plans have been outlined and are under implementation in the five areas identified by health promotion standards in hospitals.

- Organisation policy: Widespread information about HPH projects among the entire staff of the Montecchio hospital.
- Patient evaluation: Modification of nurse records for data collection.
- Patient information and involvement: Creation of a guide for patients regarding the clinical care programme for surgical hip replacement treatment, enabling the patient to check his/her progress.

- Promoting a healthy work environment: Reducing the number of staff members who smoke.
- Continuity and cooperation: Improving the methods of transmitting discharge letters.

The aim of this presentation is to present and discuss the experience carried out in one of the hospitals run by the Health Board of Reggio Emilia, aimed at implementing health promotion standards and related indicators involving the hospital's primary stakeholders. Five working groups have been established for this purpose, one for each standard, with the task of carrying out self-evaluation activities, gathering data on indicators, and outlining a quality improvement plan based on the compliance data to standards and performance data measured by indicators. Up until now, the indicators identified for comparison of the current situation with that of the project's end date (December 2005) have been measured.

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P 117: OUR FIRST EXPERIENCE AND OUTCOMES FROM IMPLEMENTATION OF STANDARDS FOR HEALTH PROMOTION HOSPITALS IN THE CZECH REPUBLIC

Ivana KORINKOVA, Milena KALVACHOVA

The five hospitals, different size, greatness and specialization were engaged in the work on pilot implementation of standards for Health Promotion Hospitals and Self-Assessment tool in the Czech Republic. This pilot implementation started in February 2004. This work has brought the new important information which can be used for improving health promotion activities and for continuous quality improvement of care in our country.

- The new view of the hospitals on themselves showed that many activities are provided but not recorded.
- The best outcomes were achieved in the standards Patient Assessment and Patient Information and Intervention. Nurses are the main strength for implementation of health promotion activities in the hospitals. They are very interested in the new direction of development in the improving quality of health care.
- The most work will stay on the standards Management Policy and Continuity and Cooperation. Our program has support in new oncoming legislative and in the conception of health care.
- It is needful to prepare the conditions for better understanding of hospitals management for the significance of health promotion, for the better using of the possibilities for presentation of our experiences and international dialogue about good praxis.

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P 118: NATIONAL INSTITUTE OF CARDIOLOGY-HEALTH PROMOTION HOSPITAL ACTIVITY

Malgorzata MISIUNA, Jaroslav PINKAS

Health Promotion Hospital Programme is realized in the National Institute of Cardiology since 1998. It is addressed to whole society of the hospital: personnel staff, patients, their families and local community. In recent years our main aims were:

- elimination of health risk factors among patients, their families and local communities, such as: improper nutrition, tobacco smoking and lack of adequate health status control,
- increasing quality of diet and proper composition of diet in the hospital canteen.
- improving selfcare skills of cardiological patients and health lifestyle implementations.

To achieve these goals our activities were focused on: Founding of Anti-Tobacco Service providing comprehensive diagnostic therapy for personal staff, patients and their families. Implementation of special anti-tobacco treatment among cardilogic patients. Implementing in regular medical practice Minimal Antitobacco Intervention Programme. Health promotion in the local community through education and primary prevention. Providing Nutrition Counselling for patients and their families. Implementing in hospital canteen diet recommended in heart diseases. Realization of special educational programmes addressed to different group of cardilogic patients, for example heart failure patients.

CONCLUSION:

It was estimated that in a consequence of our activities: A number of smokers among cardilogic patients decreased about 30%. Personnel staff and patients got constant access to proper nutrition and healthy lifestyle knowledge. There was change for health diet in hospital canteen. Patients selfcare skills and knowledge increased. Health Promotion Hospital cooperates with medical institutions, schools and representatives of local community on the realization of many health promotion programmes.

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P 119: EXPERIENCES OF A HPH CO-ORDINATOR IN A PILOT PROJECT

Maria GIBBONS, Kate BRICKLEY, Joe WHELAN, Imelda LAMBERT, Michael KEARNS

The Mid-Western Regional Maternity was randomly selected as one of three hospitals in Ireland to take part in a three-year pilot project for the Health Promoting Hospital Network. The Aim of the project was to demonstrate the efficacy of the Health Promotion co-ordinators role in implementing strategic health promotion goals within the hospital setting.

METHODOLOGY

A HPH co-ordinator was appointed to the Mid-Western

Regional Maternity in March 2002 for a three-year pilot project. The funding for the initiative was inspired by the cardiovascular strategy and therefore issues related to cardiovascular health such as smoking, physical activity and healthy eating were considered priority areas for attention.

STEERING COMMITTEE

Realistically steering committee meetings held twice yearly were more likely to guarantee maximum attendance. This is certainly the case in any clinical setting due to constraints of other meetings and workload in general.

PATIENT REPRESENTATION

On hindsight a patient/client perspective would have enabled and guided the practical introduction of a health promotion culture within the clinical setting.

MANAGEMENT LINKS

On discussion with management at the end of the pilot phase, senior management regretted not having drawn up a hospital strategy for health promotion for the pilot phase. **

HEALTH PROMOTION DEPT*

In the Mid-Western area, there has been very defined links between the Health Promotion Department and the Health promoting hospitals. This proved invaluable in terms of sharing resources, opportunities for training and networking through a forum with other health promotion professionals in the region.*

REGIONAL CO-ORDINATOR

For the initial stages of the pilot programme, a Regional HPH Co-ordinator was in place which strengthened links among co-ordinators in the mid-western region.

LEGISLATION (STRENGTH)

Undoubtedly the introduction of the smoking ban in the workplace was assisted by legislation in March 2004.

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P 120: OPTIMISING PATIENT'S LIFE CYCLE IN THE MARIENHOSPITAL HERNE

Bernhard F. HENNING, Holger RAPHAEL

The project should achieve the optimisation of each stage of patient's treatment in hospital. Especially are focused the interferences between the different stages the patient has to pass in hospital. Starting with administrative registration the patient passes basic diagnostics in the same area. The discharge of the patient is planned. After that the patient has to go to his ward where the special diagnostics have to be planned and a therapy decision is made. Special units are formed for each step in the Marienhospital Herne to prove an effective proceeding and shorten the waiting periods. Therefore e.g. planning the capacity of the beds like in hotels takes place. The process as a whole shall be optimised, the focus is on the patient's requirements.

The project is planned in close relationship to the PDCA-

Cyclus of TQM.

- All involved processes are documented in an electronic tool and analysed, changes are planned.
- The different projects must be established. New units have to be built. Clinical pathways must be developed as a base to control the single processes.
- The projects are improved by using different tools like process cost analyses for each step to identify possible cost drivers.
- By using the results of the 3rd phase business process optimisation takes place. The results of the 1st and 2nd phase will be revised if necessary.

With this complex project we want to enlarge the satisfaction of our patients and employees with the procedures and system of the hospital as a whole by using business tools that are improved outside the hospitals.

We want to connect and use the knowledge of the medical experts with those of other businesses and industry to achieve an optimal result for all persons involved in the system.

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P 121: INVESTING IN STAFF, HEALTH PROMOTION IN FOUNDATION TRUST HOSPITALS

Catherine BOYCE, Sally PEARSON

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) is one of the first Foundation Trusts in England. This has changed the management arrangements of the organisation and given it a Gloucestershire Community focus, through the election of a Council of Governors from a base of over 10,000 staff and public members.

GHNHSFT's Strategy - Our vision is excellence in the delivery of acute hospital-based services to the local population through partnership with patients, the public and other organisations.

Underpinning the strategy are three key themes:

- Defining the scope of our services.
- Delivering excellence in care through challenging delays and attending to the personal aspects of care.
- Extending our role through partnership.

*Exploration of these themes with the board and governors has led to the identification of Health Promotion as a principle element of the Partnership theme. This is reinforced by publication of the Public Health White Paper "Choosing Health", and the Public Health Domain of the Healthcare Commission Standards for Better Health.

Using "Putting HPH Policy into Action, Draft Version 23.03.2004" the Foundation Trust will focus on staff in the first instance. The Staff Oriented Core Strategies identified are:

- STA-1 Health Promoting Work Life in the Hospital for Staff.
- STA-3 Health Promoting Hospital Setting for Staff.

- STA-5 Health Promoting Lifestyle Development for Staff.

The organisation felt that by targeting these Core Strategies with short life high profile projects it will instil in the organisation enthusiasm to change lifestyle and lead by example. This will in turn have a knock on effect when the 6,427 employees interact with the patients at work and the public outside of work.

We propose to present at the conference:

- The approach taken to pursue this agenda.
- Progress to date.
- An assessment of the extent to which this could have

been achieved without Foundation Trust status.

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Poster Sessions II: Friday, May 28, 2004, 10.30-11.15

SESSION II-1: HEALTH PROMOTION FOR CHILDREN AND ADOLESCENTS IN HOSPITALS (II)

P 122: HPH MATERNAL-CHILDLIKE RECEPTION: MULTICULTURAL REALITY

Alberto APPICCIAFUOCO, Arianna MARTINI, Stefania MASTROPASQUA, Daniela PINTO, Monica RASPINI, Barbara ROSADONI, Rina TONETTI, Isabella FRATI

FOREWORD

The Maternal-Childlike Department of the New Hospital "San Giovanni di Dio in Florence can boast a very important number of users (up to about 1700/year) coming from a wide region of growing multi-ethnic communities (mostly Chinese, Albanian Arabic and "Rom").

Consequently, a dedicated service network has been set up allowing multi-ethnic women to communicate with the medical staff so taking benefit of services delivered by the hospital.

METHODS

To facilitate the organizational change of the multi-ethnic women reception process, a Maternal-Childlike Group (HPH) has been so established.

RESULTS

The HPH Group has been operating using several training tools to make the obstetric, nursery and labor room personnel aware of project and of its importance.

Chinese-, Albanian-, Arabic- and "Rom" translated brochures, available even on-line, were published and spread over the territory to make the foreign women aware of services provided by the hospital as well as the way to gain access to them.

A linguistic-cultural mediator has been introduced to facilitate the verbal communication and get acquainted with foreign women customs (e.g., food, cult, etc.) so as to comply with them as much as possible.

CONCLUSIONS

The important influx of foreign citizens into our hospital has made impellent as well as necessary the development and the consolidation of a sort of "inter-cultural culture".

The Maternal-Childlike Department of the New Hospital "San Giovanni di Dio" strong in the results obtained so far, will be continuing to commit itself to the reception project being conscious that a better integration will make the birth-course safer and more comfortable, so encouraging the Health

Promoting.

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P 123: BECOMING WOMEN, BECOMING MEN: HOSPITAL OPEN FOR THE NOWDAYS TEENAGERS

Umberto BIANCHI, Linda FRUGONI, Rosaria AVISANI, Giuliano FILIPPINI

INTRODUCTION

The passage from infancy to adolescence and then to full maturity is one of the most important moments of the life of every person (man or woman), both for the extraordinary importance of the physical changes and for the deriving psychological and sociological implications. There are a lot of important ingredients that permit a serene development: family, affective and social relations and, among these, as much fundamental is the knowledge of the own body and of those phenomenons that characterize that development. These reflections have lead some high schools to ask the A.O. to develop interventions of Health education for their students.

OBJECTIVES

Sensitize, through school, teenagers and their families to the importance to face the development phase and the beginning of adult life through the fully knowledge of the own body and of the important psychological changes which follow, besides specific objectives as:

- Spreading the culture of health and of activating for the own health.
- Spreading the attention to prevention of illness.
- Spreading correct life styles.
- Soliciting teenagers to the knowledge of the services and of the operators for eventual advices.
- Pulling down the teenagers psychical barriers about sanitary structures.

TARGET

Teenagers attending high schools in Brescia

Adolescence is variable, unforeseeable and uncertain, it is a border age with even more unstable bounds. Anchored to an everlasting present that tends to renege the past even keeping a secret, unconfessed longing, the adolescent is projected towards a future from which he unconsciously steps back. Today both for the family and the society it becomes more difficult to transmit the adolescents their model of life and thought. For the adolescents it becomes difficult to become "adults" without this generational comparison. The project wants to bring into action resources and skills in order to support this generational "changing of the guard".

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P 124: RE-DISCOVER ONESELF NATURALLY

Luigina CENCI

The project configures as a multisensorial laboratory for neuropsychic disabled children in which playful-interactive approach stimulates the relationship between the environment and children to improve the perception of space and time as dynamic factors. It follows educational-qualifying experiences through different kinds of activity (sensorial perception, bodily contact and communication, visual and manipulating arts).

METHODS/ACTIVITIES

Multisensorial group laboratory had been directed to 8 children, aged between 7-14yrs affected by different neuropsychic disabilities (mental delay, developmental disorders). The period of realization of experience had been February-July 2002, weekly meetings two hours each in two natural places in Marche Region -Italy named Oasis Ripa Bianca Jesi - Ancona, managed by Italian WWF and CEA WWF Villa Colloredo in Recanati -Macerata.

Operating model derived from our Diurnal Therapeutic Hospital, which consists in a rehabilitative, neurocognitive, teamwork, intensive, integrated multimodale service for children with troubles of the development in pre-school age it, approach according to which it's possible to develop new forms of communicative and symbolic space within the Group stimulating reciprocal competences to get a more harmonious process of development.

RESULTS/CONCLUSIONS

all the subjects have experienced a more integrated "one-self" through the relationship with nature which favours a vast range of hedonistic gratifications (sense-perceptive, emotional-affective, aesthetics, entertaining/amusing) independently from different factors (age, sex, culture, ability).

The ubiquity of the various protected areas into and out our Country pushes us to seek the diffusion of our experience to

encourage multi-professional exchanges and comparisons.

For the hospital it had been an experience "beyond the clinic", an example of clinic good practice and an opposite way from the practice to the research.

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P 125: THE PLAY AND CHILD'S LIFE PROGRAM IN THE PEDIATRIC CLINICAL SETTING: ROLE AND FUNCTIONS OF A PROFESSIONAL SERVICE

Elena BERTOCCO, Elisa SALATA, Claudia SCHIVO, Carlo MORETTI

Admission into the hospital may represent a dramatic experience for children and adolescents.

Losing normal points of reference of their every-day life(home, toys, relationships, friends etc.), unavoidable violation of privacy, painful procedures, poor informations, apathy due to the lack of interesting activities, are relevant factors contributing to the psycho-relational status of pediatric patients and, as a consequence, to the global positive result of the project of care.

To help pediatric patients to cope with the experience of illness and hospital admission, our Institution has realized that an important role can be represented by a play and child's life program.

ITS OBJECTIVES ARE:

- To create into the Hospital an "affectively warm" environment.
- To involve children and adolescents into activities that help them to re-improve their own self-esteem, previously decreased by the illness.
- To give to the patients chances to elaborate the trauma of disease and hospital admission.
- To mobilize positive energies, contributing to the recovery and to the global care of the pediatric patients.

THE OPERATIVE METHODS ARE:

- Psycho-relational and playing profile of every patient made by the staff of the Service, soon after admission.
- Programs of playing activities, laboratories, individual and group activities, scheduled during the day and the week.
- School classes every day.
- Individualized program of playing and recreational activities for special patients (psychiatric, handicapped, isolated, etc.).
- Group discussions, with physicians and nurses, about the progress of the patients and the future strategies to improve their care.

THE HUMAN RESOURCES UTILIZED ARE:

- The Staff Operators, who are professionals graduated in Educational Sciences, coordinated by a Child Psy-

chiatrist.

- The Staff Volunteers, specifically formed (by the Staff Operators) in animation and recreational activities.
- University students of psychological and educational sciences, who attend their internship into our Pediatric Hospital.
- Other volunteer associations who realize specific activities.

The range of ACTIVITIES offered to children are: laboratories of cooking, gardening, bonsai, handworking with many different material, decoration, painting, photography; activities of music, cinema, cineforum, dedicated to adolescents; "round the wards" library and animated reading of books; writing and printing of the "Hospital Children Gazette"; internet and computing; twice a week visits of hospital clowns; pet therapy; relaxing massages; comical and music shows and many others.

AFTER 15 YEARS FROM THE BEGINNING OF THIS PROGRAM THE MAIN RESULTS ARE:

- The Hospital has got an original "smiling" style, in welcoming its patients.
- Children demonstrate to cope much more better with the trauma of hospitalization and do not fear any more the Hospital, in case of future admissions.
- Often they keep in contact with the staff of the Service after dismission, establishing intense friendships.
- Parents revealed a high degree of satisfaction when they see children completely cared, also in their emotional dimension.
- Physicians and nurses feel helped in their busy job, because the psycho-relational needs of the patients are cared by dedicated professionals.
- Associations and privates outside the hospital, anxious to do something to help hospitalized children, can refer to the Service to be addressed and involved in the project.

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P 126: CROSSWORDS PUZZLES AND REBUSES AS EDUCATIONAL DIALOGUE FOR SELF-CONTROL CHILDREN AND ADOLESCENTS WITH DIABETES

Alicja SZEWCZYK, Bogumila ROZYCKA, Grazyna PIEGDON

Teaching self-control in diabetes is very important, integral part of therapeutic proceeding regarded child as his(her) family.

The main goal of therapeutic education is providing sick child and his family with knowledge about desired health behaviours.

Educational nurse who undertake process of teaching child with diabetes and his family, achieve this by:

- Setting diagnosis of nurse with:

- physical condition
- emotional adaption to the hospital
- the level of cognitived and perceived development
- social and financial condition of the family

- Setting goals for therapeutic education.
- Introducing educational programme according to the model of selfcare for children with diabetes

Our aim was to estimate the influence of therapeutic education of children and adolescents through crosswords puzzles and rebuses on the level of their self-control of the disease.

METHOD:

Pilot study using observation as a way of gathering data was conducted at Departament of Diabetology, Pediatric Clinic The Children's Memorial Health Institute.

CONCLUSIONS:

This research confirmed the efficiency of crosswords puzzles and rebuses as a method of educating childrens and adolescents how to perform self-control of their diabetes.

SUMMARY:

- Efficient self-control of diabetes can be achieved only through therapeutic education based on a verified programme.
- Education should be organised and provided only in specialised centers for diabetes.
- Therapeutic goals should always be child-tailored.
- Active methods, as crosswords puzzles and rebuses are very efficient methods of educational dialogue.

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P 127: AN UNHS IN LOMBARDY – A HOSPITAL TO SUPPORT DEAF CHILDREN

Giancarlo PASTORINO, Paola SERGI, Fabio MOSCA, Tommaso REDAELLI, Pierangelo SARCHI, Marisa ARPESELLA, Antonio CESARANI

In newborns, the prevalence of hearing impairment is in the range of 1 to 3/1000 (Jennifer S, Martyn H Hearing screening – Pediatrics in Review p. 155-161 vol. 23 – 2002). Hearing loss is not detectable in time by routine clinical procedures (Joint Committee on infant Hearing. Year 2000 Position Statement: principles and guidelines for early hearing detection and intention programs www.asha.org). Without hearing screening the average age of identification of hearing impairment is about 30 months. While only if detected before 6 months, intervention is believed able to improve speech and language development and cognitive outcome, due to the importance of the problem and to increase the opportunities offered to patients and their parents

"La Fondazione Policlinico Mangiagalli", reference point for maternal infantile diseases in Lombardy, introduced Early hearing screening of newborns in 1997 to anticipate identification of hearing impairment and possibility of intervention. Universal Newborn Hearing Screening was organized ac-

cording to the Joint Committee on Infant Hearing Screening Assessment protocol. To do this, all the personnel of the interested wards take part into the screening of all newborns before their discharge. In addition the ward responsible for the screening takes care of the post-discharge controls, if necessary. In case of deafness or hearing impairment a counselling activity for parents is carried out a team of deaf child's parents, in accord with Health Staff, created a guide for child/parents relationship. Parents organized a mutual-help group with great satisfaction for all.

To further improve the support towards parents an external network, consisting of family doctors, paediatricians, ear specialists, nurses, social workers, was created. From the beginning a database of all related data was organized, which, together with improvement of the organization brought to efficacy goals. From 01.01.2003 to 30.06.2004 9430 newborns were screened: 92.7 % before the discharge from hospital, 7.3 % in the next thirty days. The loss at the follow-up was of 18 infants. The UNHS reach the goal of early diagnosis. The organization of the screen allows to reduce the discomfort of the family. This model is going to be adopted by different Hospitals in Lombardy coordinated by the Mangiagalli's team.

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P 128: HPH / SOCIAL PERSONAL HEALTH EDUCATION SUPPORT

Sarah GIBBONS, Kate BRICKLEY, Joe WHELAN, Imelda LAMBERT, Michael KEARNS

OBJECTIVES

- To promote closer links between a post primary school and the general hospital in the catchment area.
- To develop a support structure that engages the Midland Regional Hospital Mullingar, Loreto College Mullingar and a regional team from the SPHE support service.

METHODS

The implementation has been broken into the following phases.

- Phase 1: Baseline questionnaire.
- Phase 2: Links to be maintained between the consultative group.
- Phase 3: To develop and promote a teen friendly holistic health service at the Midland Regional Hospital Mullingar.

RESULTS

- Phase 1: The baseline questionnaire has been completed by the HPH co-ordinator, the school principal and the SPHE regional team. The questionnaire measured current levels of satisfaction with contact between the school, hospital and SPHE team within the Midland Health Board.
- Phase 2: Several meetings have taken place between the consultative group. As a result there is a greater understanding of the needs of young people.
- Phase 3: A literature review and research in relation to best practice in teenage sexual health has been conducted.

An education programme has been delivered in a school setting by the consultant paediatrician and the programme was evaluated. A teen clinic has commenced on a once weekly outpatient basis and is led by a consultant paediatrician with specialist training in teen health.

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P 129: EMPOWERING AND SUPPORTING CHILDREN WITH COMPLEX CARE NEEDS AND THEIR FAMILIES.

Chris RIDLEY, James ROBINSON

Medical advances mean a growing number of children with complex needs are surviving into later life. These children require an ever-increasing number of professionals involved in their care over a much longer time span and into adulthood. It is vital that families of these children are well-supported, empowered and enabled to work in partnership with healthcare and other professionals. Families have said for many years that they wished professionals would work in a more 'joined-up' way. They have also expressed a wish to have a 'keyworker' assigned to them who could offer emotional support and liaise with all professionals involved in their child's care.

Care co-ordination with keyworking is a model of practice, which involves working with children/young people and their families. It can be applied to any group of children who require input from two or more services in addition to core services (e.g. general practitioner, health visitor, teacher, school nurse). It encompasses individual tailoring of services based on assessment of need, inter-agency collaboration at strategic and practice levels, and a named key worker for the child and family.

Following a Community & Therapies Redesign project at the Royal Hospital for Sick Children funding was allocated to appoint a full-time Care Co-ordination Facilitator and Administrative Assistant. The remit of the Care Co-ordination Facilitator is to develop the model of Care Co-ordination across the City of Edinburgh, East Lothian and Midlothian.

THE MODEL PROVIDES

- Advocacy and works in partnership with the family.
- A link between all professionals/agencies involved in the child/young person's care.
- A pro-active, emotionally supportive relationship with families.
- Empowerment, rather than creating dependency, whilst recognising that the family's capacity to care will vary over time.
- Better co-ordination for families and professionals working together and planning in partnership.

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P 130: CHILDREN WITH MENTALLY ILL PARENTS - TIME OUT

Jan SANDBERG

It has been clear for many years that we have overlooked children with mentally ill parents in our work to promote mental health.

When one member of a family develops a mental illness, the whole family is affected, not least the children. The children often live in ignorance and doubt as to what mother or father is suffering from. This confusion can result in the child feeling insecure and guilty.

Growing up with a mentally ill mother or father can result in low self-esteem, anxiety or depression and thus have consequences for child's development and quality of life.

In November 2003 Aalborg Psychiatric Hospital established "The Team Concerned With Children Of Mentally Ill Parents". The Team has started groups for these children aged between six and eighteen years.

Fifty four children have taken part in Time Out since November 2003. Here they have the chance to meet and share experience with other children of the same age and similar backgrounds. The children can learn about mental illness, and are given support in coming to terms with their feelings of guilt and responsibility.

The Team Concerned With Children Of Mentally Ill Parents "have also a consultative and educational function; communicating knowledge to the network of professional collaborators and thus preparing this network to provide a better and more qualified service to children and their families.

The Team is a health promoting initiative working to give the child a better grasp of situation and peace of mind.

These children are vulnerable and can be exposed to pressure and unexpected situations. In Time-out the children can, through expression and reflection, be helped to see ways to react to their parents illness and their own situation.

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P 131: TRACING AND CONCERTED ACTION BY ODENSE UNIVERSITY HOSPITAL (OUH) CONCERNING CHILDREN AND ADOLESCENTS OF PARENTS WITH ALCOHOL ABUSE

Lene SJØBERG, Else-Marie LØNVIG, Ane Friis BENDIX

BACKGROUND

Approximately 500,000 adults - corresponding to abt. 10% of the Danish population - consume alcohol in excess of the limits recommended by the Danish Health Board. Alcohol overconsumption is related to increased ill health; hence an estimated 20% of Danish hospital admissions are alcohol-related.

The assumption is that 60,000 - 70,000 children aged 0 - 18 live in families with drink problems. Children and adolescents from these families have excessive psychosomatic problems, need more medical attention and are often hospitalised. The experience is that these children get no help or that the help is initiated too late. So a great potential for alcohol prevention in the field of Health Promoting Hospitals exists in this area.

AIM

The aim of the project is to develop a method for hospitals to identify children living in families with alcohol abuse and discover how to remedy the problem among the children and their parents.

HYPOTHESIS

The developed method will empower the patients to take more responsibility for their own health, and give the staff knowledge and a tool so they will become better prepared for handling children and parents with alcohol problems.

MATERIAL

The project has three target groups:

- Hospitalised children from families with alcohol abuse
- Adults admitted to somatic wards because of excessive alcohol consumption
- Hospital staff in paediatric and adult somatic wards

METHOD

Initially a systematic literature study about empowerment and the motivational interview will be carried out. The evidence generated from this study will be the basis for development of the method and interventions in the project. The fundamental issue is based on educational efforts for patients and staff. The alcohol consultant will implement motivational interviewing courses for the hospital staff. The evaluation will be carried out as a Health Technology Assessment.

RESULTS

It is anticipated that by taking concerted action the adults' alcohol intake can be reduced, and well-being - mentally and socially - will be improved in the family in general. It is also expected that development of the model will improve staff qualifications and cause better care for both children and adults.

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P 132: INFORMATIVE PAMPHLET FOR THE PREVENTION OF PEDIATRIC SCALDS IN A DOMESTIC ENVIRONMENT

Gloria CAMINATI

Informative pamphlet for the prevention of pediatric scalds in a domestic environment

Scalds are extremely dramatic events, especially during the pediatric age, for both, the young patients and their families. This is due to long stays in hospital in intensive care, to painful medication on affected areas, to the frequent need of surgery and to the long recovery process.

In Italy every year there are about 10.000 scalded patients who need hospitalization; 70% of the accidents occur in a domestic environment, while work injuries represent 15% of the cases, road accidents 10% and scalds from different causes are 5%

Patients who burn themselves during the pediatric age represent about 20% of that population and the most affected are children between the age of 1 and 4 years old.

Epidemiological data from the centre for burns in Cesena (to join with those of the major national centres for burns):

- Hot liquids represent the main cause of burns in pre-school age (60% of the patients).
- Flames represent the main cause of burns in school age.
- The inappropriate use of alcohol is the main cause of scalds by flames.

AIM

- To promote a culture of security and adequate first aid in a domestic environment.
- To start a process of behavioural change by educating and sensitizing parents and relatives in order to avoid risky behaviour.

METHODOLOGY/ACTION:

- To form a project group for the prevention of burns.
- Analysis of the epidemiological data.
- To choose a strategy.
- To involve pediatric staff from the community and health.
- Education
- To realize two informative pamphlets that will be given to parents at the moment of the child vaccination (3 months and 3 years).
- To involve nurseries and teachers.
- To translate the text in Arab, Chinese and Albanian.

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P 133: CAPACITY BUILDING IN COOPERATION WITH THE HOSPITAL AND NON-GOVERNMENTAL ORGANIZATION TO IMPROVE HEALTH SERVICES FOR CHILDREN

Lagle SUURORG, Pille KALDMÄE, Inna KRAMER

RATIONALE

In-service training is crucial for strengthening the knowledge and skills of professionals who practice with children and adolescents with chronic illnesses. To find resources for in-service training and health promoting activities in partnership with Tallinn Children's Hospital Foundation (TCHF) and Tallinn Children's Hospital (TCH) a common grant application to PHARE was prepared. The grant application was successful and the project was started in December 2004.

MAIN OBJECTIVES OF THE PROJECT

- To empower non-governmental organization- TCHF as initiator of philanthropic approach in Estonia.
- To prevent the development of social exclusion of disabled and chronically ill children and their parents, to support their socialisation and well-being.

TO ACHIEVE THESE OBJECTIVES THE AIMS OF THE PROJECT ARE:

- Improve of the professional's knowledge and skills in patient assessment and intervention in according to the WHO Standards of HPH through in-service training.
- Increase the professional abilities of specialists to empower disabled and chronically ill children and their parents.
- Enhance of patient-centered health services.
- Increase of self-esteem of children and their parents by increasing health literacy and scoping skills.

THE TARGET GROUPS OF THE PROJECT WERE:

- Children with disabilities and chronic diseases and their parents
- Rehabilitation specialists from TCH - physiotherapists, speech therapists, rehabilitation nurses and physicians.

THE MAIN ACTIVITIES WERE PLANNED AS NEXT:

- Role-play activities for disabled children, their parents and professionals and creation of partnership in health care.
- Role-play leadership trainings for specialist and training of team-work methods; summer- camps for disabled children, their parents with professionals.
- Continuous evaluation of the project and development of TCHF.
- Round-table meeting "Healthy life for children" among representatives of Estonian, Swedish and Finnish charity foundations.

EXPECTED OUTCOMES

To increase the role of an NGO, TCHF, in Estonian society.

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SESSION II-2: CHRONIC DISEASES (III): HEALTH PROMOTION FOR PATIENTS WITH BREATHING DISORDERS AND FOR PATIENTS WITH CARDIO-VASCULAR PROBLEMS

P 134: AN INTEGRATED CARE PATHWAY FOR THE PATIENT WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Anne BUCKLEY

RATIONALE

Chronic Obstructive Airways Disease ranks among the leading causes of adult morbidity and mortality worldwide especially among smokers. It affects over 110,000 Irish people and is estimated to account for a quarter of deaths in Ireland.

AIM

Explore and develop a model of evidence based care which provides continuous improvement in the quality of care for patients with C.O.P.D.

OBJECTIVES

- Develop an integrated care pathway to diagnose and treat patients with Chronic Obstructive Pulmonary Disease.
- Involve patients in designing and implementing their own pathway of care.
- Improve collaboration between hospital and primary/community care services.

METHOD

- Identify relevant stakeholders.
- Establish a multidisciplinary team.
- Conduct a literature review to establish the most up to date guidelines for the management of Chronic Obstructive Pulmonary Disease.
- Establish a Consumer Panel of patients to ensure public and patient involvement in developing the pathway.
- Use the clinical audit process to review the quality of everyday care provided to patients with C.O.P.D. and to highlight the need for improvement.
- Agree the elements of the pathway for the patient and each discipline involved.
- Regularly review the process to ensure continuous improvement.

CONCLUSION

This is an ongoing process resulting in continuous improved patient care. A better response to the needs of patients and carers through the use of the consumer panel and increased knowledge and expertise in all disciplines involved in providing care. It provides more and better information for patients and improves communication between all staff and patients. The clinical audit process assists in identifying what needs to be done to improve patient care, why we are not achieving it, re-designing the process to improve care and monitoring the outcome.

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P 135: PATIENTS' EMPOWERMENT IN MANAGING A LIQUID OXYGEN DELIVERY SYSTEM INCLUDING PORTABLE CANISTER.

Stefano AIOLFI, Gianfranco BEGHI, Vincenzo PATRUNO, Lodovico CHIESA, Ugo ZORZA, Silvia ZIBETTI

Supplemental oxygen improves exercise tolerance of hypoxemic chronic obstructive pulmonary disease (COPD) patients. We report our experience on how to empower patients in managing liquid oxygen delivery systems at home

METHODS

In the last 5 years, 200 pts with chronic respiratory failure (CRF) from COPD underwent long term oxygen therapy (LTOT): 70 pts are still alive. The prescription of LTOT was based on national and international guidelines and on the patient's acceptance. During hospital stay, all patients received a comprehensive educational program and a practical approach on the management of oxygen devices, to reduce risks and misuse, and to lower the health costs.

The educational sessions consisted of an individual approach during which the nurse explained the principles of oxygen therapy, taught how to fill the portable tank, pointed out the possibility for users to be mobile, promoting an active lifestyle. A subsequent 30 min group session was held to reinforce the messages given individually, to confront with the difficulties encountered and to answer the questions that patients and/or relatives asked. It was stressed the importance of the cleaning and hygiene of the stationary unit, the portable canister, the nasal prongs and/or Venturi mask.

RESULTS

The efficacy of our program was regularly controlled during the follow up visits, in order to elicit the correctness of the manoeuvres learned. We could verify a good adherence to the messages given: 85% of patients reported to strictly use the O₂-flow prescribed at discharge, to comply with information received on the hygiene and cleaning of the device and to regularly fill up a register of these activities.

CONCLUSION

Our educational efforts produced a good compliance to the prescribed LTOT and to the manoeuvres needed to maintain in good performance the delivery devices. These good results must be positively considered in a cost/benefit analysis of health costs.

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P 136: COPD EDUCATION SESSIONS FOR HOSPITAL IN-PATIENTS

Hope FISHER

Chronic obstructive pulmonary disease (COPD) is a disease state characterised by airflow limitation that is not fully re-

versible. The airflow limitation is usually both progressive and associated with abnormal inflammatory response of the lungs to noxious particles or gases (GOLD guidelines 2004). Currently in Ireland, it is estimated that 110,000 people have COPD, with nearly 2000 deaths a year attributed to the disease. The most important risk factor for COPD is cigarette smoking.

In December 2004, St. James's Hospital Physiotherapy Department set up a new initiative for patient's with COPD to promote better awareness regarding their condition. This involves weekly education sessions for patients admitted to the hospital who have a medical history of COPD. The session is run by the Clinical Specialist in Respiratory Physiotherapy, with groups of no more than 4 patients, for a duration of 1 hour.

TOPICS INCLUDED ARE:

- Understanding COPD.
- Understanding the medical management of COPD.
- Inhaler technique.
- Smoking cessation.
- Recognising the early warning signs of an exacerbation.

Patients are given time to practice inhaler technique, as well as activities such as breathing control (for breathlessness) and airway clearance (for sputum retention), as well as time to discuss symptom issues amongst themselves.

It is hoped that through a better understanding of the disease, the medications that can control it and the benefits of smoking cessation, patients will have more control of not only their symptom management but also their disease progression. Patients are also provided with information leaflets specifically designed for the education session for family members and carers.

By April 2005, over 30 patients will have been assessed pre and post the education session. Results regarding knowledge of their condition and symptom improvement will then be available.

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P 137: "ALL ROADS LEAD TO ROME". PATIENT EDUCATION AS PART OF THE REHABILITATION PROGRAMME FOR PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONAL DISEASE

Karin BIRTØ

BACKGROUND

Patients with chronic disease are increasing in numbers causing frequent hospital admissions and a demand for rehabilitation programs. It is essential to focus on patient education as a tool for self - management and empowerment in the rehabilitation concept.

The patient with chronic obstructive pulmonary disease (COPD) will be in focus.

OBJECTIVE

To determine the various characteristics of formal patient-education programmes for patients with COPD, which can show evidence for effect. And to complement with patient experiences from a rehabilitation programme including education in a Danish hospital.

METHOD

- A systematic review in the databases Medline, Cinahl and Cochrane combined with manual searching focusing on randomised clinical trials and controlled clinical trials from 1995-2003, metanalysis as well as reviews. Search words: Patienteducation or Self-management or Decision support technique and COPD.
- A focus group interview with 7 patients at the end of their 7 weeks rehabilitation programme
- The theoretical frame is rehabilitation and educational theory.

RESULTS

Even though structure, content and theoretical background seemed very different, several of the studies provided evidence for effect on identical outcome.

The educational programmes included many different elements but the theoretically based dimension was in general poorly described.

The patients regard education as part of a rehabilitation programme and called for more time for dialog and follow-up in order to maintain acquired skills. They reported, among other things, self-efficacy managing stress situations and increased quality of life, motivation and knowledge as result of the rehabilitation program.

CONCLUSION

"All roads lead to Rome". In other words patienteducation can successfully be conducted and organised in different ways. The discussion emphasised theory of rehabilitation and education as essential parameters.

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P 138: A RETROSPECTIVE STUDY LOOKING AT THE INCIDENCE OF HEALTHCARE SERVICES UTILIZATION AMONG PEDIATRIC AGE GROUP ASTHMA PATIENTS AND CORRELATION TO THEIR PRESCRIPTION REFILL

Judith FLORES, Mani K.C VINDHYA, Ana NIETO, Diana VILLANUEVA, Naveena VINDHYA

OBJECTIVE

Despite national initiatives to improve asthma medical treatment, the pattern of use of health care services remains high. The primary objective is to study the incidence of Inpatient hospitalisations, ER visits and unscheduled office visits by paediatric age group patients and its correlation to pharmacy visits and the class of medication refill in patients with mild to moderate asthma and identifying potential points of

intervention for increasing patient compliance.

METHODS

Subjects were children 0 to 18 years of age enrolled continuously over one year ($n = 375$) in a community based setting. Percent of enrollees filling prescriptions for asthma medications and fill rates by medication class and its correlation to their subsequent healthcare services utilization were measured. Medication class was broadly divided into two classes (beta agonists and steroids/anti-inflammatory). Each beta agonist refill was scored as one negative point and each steroid refill as one positive point thus a total score derived for each subject, thus categorizing subjects into three groups a negative, positive and a zero group.

RESULTS

Between 2002 Jan to 2002 Dec, of 1219 pharmacy visits, 878 visits were by the high beta-agonist users (negative group) ($n=278$) as compared to 230 pharmacy visits by the combined inhaled anti-inflammatory and beta-agonist users (zero group) ($n=66$) ($p=0.04$). The total primary care physician visits between the negative group and zero groups were 588 and 186 ($p=0.01$) respectively. There was a strong inverse correlation between number of pharmacy visits by each subject and their total score ($p=0.0001$).

CONCLUSION

The proportion of children using asthma medications increased substantially during the study period, but the use of inhaled anti-inflammatory medication per patient remained low even for those using large amounts of inhaled beta-agonists. Subsequently their pharmacy visits and visits to primary care physician increased substantially. These findings suggest that inhaled anti-inflammatory medication use in children with asthma fell short of national guidelines resulting in significant rise in healthcare services utilization and thus healthcare costs.

Tackling an epidemic like asthma needs multi modal approach. As evidenced from the study and from day to day experience pharmacies form a crucial point in the cross roads between physicians, hospitals and patients. The conventional role of pharmacies should expand towards specially trained community pharmacies to involve active patient education and increase patient compliance and adherence to see a positive change in the clinical and economic outcome measures in asthma patients.

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P 139: IS A PROGRAM FOR PREVENTIVE HEALTH MEASURES EXPERIENCED AS MORALISTIC? A PROSPECTIVE COHORT-STUDY OF PATIENTS WITH CORONARY HEART DISEASE.

Else Karin KOGSTAD

Preventive medicine has been accused of acting unethical or paternalistic. Why not ask the patients themselves? How do they react to our information about their unhealthy lifestyles, and our recommendations for improvements? This is the subject of this study.

Patients from a coronary-care-rehabilitation project were interviewed. The 139 patients were divided into a control group, attaining conventional follow-up, and an intervention group who received more intense secondary preventive measures, smoking cessation, diet and an individual training program. After a response-rate of 91% (127 of 139), the results allow the conclusion that the great majority of our patients were very satisfied with both information and advice, and it was no real difference between the two groups.

A qualitative interview was also done in 10 patients. A few patients had in previous contacts with medical profession experienced a behavior of paternalistic attitude. I got the strong impression that these coronary patients regarded good information together with detailed recommendations for improvement in unhealthy habits as necessary and mandatory. The patients did not experience our intervention as unethical or paternalistic. The discussion contains a short moral-philosophical part.

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P 140: PORTIUNCULA STROKE SUPPORT GROUP

Mary DISKIN

Portiuncula Hospital is a Health Promoting Hospital. The hospital is situated in the HSE Western Region.

The Stroke Support Group was initiated in September 2004 due to an expressed need from patients/carers who had experienced stroke. Meetings take place at the local health centre once per month for approximately one hour.

The group was developed using the Partnership model, and involved patients' representatives and healthcare staff.

Stroke patients enter the hospital in the acute phase, and receive treatment and therapy before being discharged. On average Portiuncula has 3 acute stroke admissions per week.

All patients/carers are offered access to the Stroke Support Group on discharge.

The patients/carers were asked to suggest what they wanted from the support group meetings. These are some of the issues highlighted for information and education.

RISK FACTORS

- Prevention - Primary and Secondary
- Hobbies
- Community Support
- Benefits of exercise
- Equipment
- Nutrition
- Links to Voluntary and Community Groups
- Driving post-stroke
- Speech Therapy
- Pendant Alarms/Security
- Falls/Safety in the Home Environment

Feedback from the group would indicate that both patients

and their carers value the provision of this service. Usual attendance to our meets averages at 30 persons per meeting.

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P 141: TEAM TEACHING OF PATIENTS – MODERN TECHNOLOGY OF PREVENTIVE CARDIOLOGY

Sergey MAKAROV, Leonid BARBARASH

Nowadays, one of the most important health care issues is prevention and treatment of cardiovascular diseases. It is determined by great losses concerned with patients' mortality and disability caused by these diseases. It should become an axiom that prevention takes the leading role in this fight against cardiovascular diseases. World medical practice shows that one of the most progressive approaches to treatment of cardiovascular diseases including arterial hypertension is the system of team teaching of patients both on inpatient and outpatient steps. There is no similar structure in our native health care system. Schools for patients with arterial hypertension, where outpatient cardiologists play the key role in teaching, function on the basis of Kemerovo Cardiology Dispensary during the last three years.

OBJECTIVES

To evaluate efficiency of these preventive programs while teaching patients with arterial hypertension on an outpatient basis.

MATERIALS AND METHODS

Work of eight schools during 2003-2004 years has been studied. 1138 trained patients, 195 examined patients, average examination period is 8.2 ± 1.2 months.

RESULTS

Before introduction of these training programs there were only 27% of patients who knew about risk factors of arterial hypertension. Only 33.3% of them were treated regularly, and only 11% - effectively. All blood pressure indices were higher in women than in men.

During examination in the distant period the following results were obtained: the number of informed patients grew to 98% ($p < 0.001$); 92.6% of patients received regular drug treatment ($p < 0.05$); 64% - underwent treatment effectively ($p < 0.001$). Besides, data in favour of cost-efficiency of such schools was obtained: frequency of hypertension crisis decreased from 32.2% to 5.9% of cases; frequency of emergency calls decreased from 28.5% to 2.3%; frequency of urgent hospitalization dropped from 21.4% to 1.2%.

Thus, the results prove the necessity of introducing arterial hypertension schools in clinical practice. This research shows that after such team teaching patients become more informed than after individual contacts with the doctor. Team teaching saves the time and minimizes work expenses that economically compare favourably with individual preventive consultations.

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P 142: PILOT PROJECT OF PRIMARY PREVENTION IN PATIENTS WITH HIGH CARDIO-CEREBRO - VASCULAR RISK

Maria Cristiana BRUNAZZI, Maurizio NEGRELLI, Carla CALANCA, Diego PADOVANI, Camelia Gaby TIRON

BACKGROUND

The atherosclerotic process begins many years before its clinical manifestations, such as sudden death, myocardial infarction, or stroke in 50% of patients (PTS). The cost for each year of life saved by prevention is nearly always lower than any pharmacological and/or interventional cardiovascular treatment.

A positive family history for cardio-cerebro-vascular disease is an important risk factor for relatives and it is synergistic with other risk factors (because similar genes and lifestyles run in families). The screening and early identification of high risk relatives of PTS with cardiovascular disease (CVD) by hospital specialists (HS) and general practitioners (GPs) is crucial. A family centered approach to cardiovascular prevention is an opportunity and challenge for promoting cardiovascular health and needs collaboration between specialists and general practitioners.

For effective primary cardiovascular prevention in high risk subjects the cornerstone is a knowledge of their own cardiovascular risk and this knowledge may be influenced by the interaction with a health service which is well informed about atherosclerotic diseases's pathogenesis and well motivated to CVD risk factor management.

MATERIALS AND METHODS

The program has been developed in 4 phases:

- Training
 - Hospital staff (doctors and nurses) and general practitioners attended educational courses on CVD prevention, in order to create well motivate counsellors (Health promoting Hospital).
- Information
 - Patients with cardiovascular diseases, both out- PTS and in-PTS, are informed by H.S and /or their GPs about CVD prevention and are actively involved as regards the importance of risk evaluation among other family members, thus creating an information network.
 - In-PTS and out-PTS are given clear educational leaflets / booklets.
 - In-PTS are also given weekly counselling sessions.
- Risk assessment
 - The family GP estimate risk factors in relatives using the Italian reference risk chart.
- Individual primary prevention strategy
 - On the basis of cardiovascular risk estimation

in relatives are choosed therapeutic and diagnostic strategies according to the degree of risk:

- Subjects with absolute CVD risk <10% (low risk): dietary and lifestyle changes and GP follow up
- Subjects with absolute CVD risk 10-20 % (medium risk): dietary and lifestyle changes as above + specialistic evaluation with echo doppler
- Subjects with absolute CVD risk > 20% (high risk): dietary and life style changes as above + specialist evaluation with echo doppler and ergometry

RESULTS

- From December 2002 to February 2004 GPS took a census of 277 subjects (first degree relatives of PTS with cardiovascular diseases); 113 female and 164 males with median age 53.2 +/- 8.8 years.
- 61.9 % of female were in medium or high CVD risk level, with median age 58.1 +/- 7.3 years, while the remaining 38.1% with absolute CVD risk <10% had a lower median age (49.3 +/-9.2 years).
- 65.8 % of males had an absolute CVD risk > 10 % with median age 53 +/- 8.3 years, and the remaining 34.2 % with CVD risk <10 % had a median age of 49.5 +/- 7.3 years.
- Altogether results with medium-high CVD risk were 64.2 % of the census subjects.
- 65.7 % of females presented medium CVD risk: of these 59% presented organ damage such as carotid atherosclerosis and/or left ventricular hypertrophy; 34,3 % presented high CVD risk and in this group the prevalence of organ damage was about 83,4 %.
- 62 % of males presented medium CVD risk: of these 58.3 % had organ damage.
- 38 % of males presented high CVD risk and in this group the prevalence of organ damage was 95.2 %.

All census subjects were informed by GP ad HS about the probability of developing a future cardiovascular events and about intensive non -pharmacological and/or pharmacological therapy to avoid them.

CONCLUSIONS

In first degree relatives of PTS affected by CVD with high or medium CVD risk the prevalence of asymptomatic organ lesions is very high and in this class of subjects more aggressive strategies of CVD primary prevention are warranted. As shows in our pilot project a systematic well programmed family - centered approach (which starts from In-and/or Out-Hospital PTS) may lead to the evaluation and adequate treatment of the majority of the target population within a few years.

This programme stems by developing an Health promoting Hospital which improves health literacy of patients and their relatives with the creation of an effective information network, since a proper knowledge of CVD risk is the first step toward avoiding it.

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P 143: EMPOWERING FAMILY MEMBERS FOR SUPPORTING A PERSON WITH HEART FAILURE

Laima JANKAUSKIENE, Dale CECHANAVICIENE, Rita BANEVICIENE, Tautvydas JANKAUSKAS, Egle KALINAUSKIENE

There is already a tradition of investing in additional (educative) services for improving patients' ability to live with (chronic) disease, and for developing healthy lifestyles. But hospitals can also use empowerment to enhance the quality of their core services: Enabling patients - and their relatives, or social network - to actively co-operate in diagnostics, therapy and care, as well as to take responsibility for their basic physical, mental and social health needs during hospital stay, can contribute to reduce complications, drug consumption, and length of stay. Our aim was to teach patients' relatives to actively co-operate in diagnostics, therapy and care, as well as to take responsibility for patients' basic physical, mental and social health needs during hospital stay and later at home and to investigate whether it improves patients' ability to live with chronic heart failure and whether it can contribute to reduce the length of stay in a hospital.

Methods. The relatives of sixty patients with chronic heart failure filled out the questionnaire prepared in accordance with the Educational Modules on Heart Failure of the Heart Failure Society of America in the Cardiology Unit of the Kaunas 2nd Clinical Hospital, member of the International Network of Health Promoting Hospitals. They were asked to follow these recommendations. The mean +/- SD length of stay in the hospital was compared between these patients and such patients of the Unit until the education. After 1 month these patients were asked by phone whether improved their ability to live with chronic heart failure. Results. After 1 month, 66.7% of patients indicated the improvement of their ability to live with chronic heart failure: mostly - by relatives' helping with daily activities (more relatives have discussed with patients topic such as living arrangements and providing assistance as necessary - 64.7 vs. 41.7%, p = 0.0007). The length of stay in the hospital have decreased: 13.3 +/- 2.1 vs. 10.9 +/- 1.7, p = 0.0001.

Conclusions. The education of patients' relatives in the Cardiology Unit have improved patients' ability to live with chronic heart failure and it can contribute to reduce the length of stay in a hospital.

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P 144: QUALITY IMPROVEMENT IN STROKE CARE

Gabriele GRECO, Mario SANTANGELO, Anna Maria PIETRANTONIO, Stefano CENCETTI, Iolanda PO

Many clinical surveys carried out to investigate correlations between different possible levels of assistance and methods of stroke patient care demonstrate that recovery and treatment in units dedicated to stroke care backed by a multidisciplinary team trained and oriented by medical associations guidelines can reduce mortality, disability, length of stay improving quality of life after hospital discharge.

In the local health service of Modena (Italy) in 2004 there were about 1.500 stroke patients admitted in eight hospitals of different sizes that provided hospital treatment for stroke patients. Within these hospitals there were nine general medicine available, two geriatrics units and one neurological unit in where in 2005 a stroke unit with six beds will be activated.

In 1998, with the aim to optimize the treatment of stroke and to assure homogeneity in stroke care, the neurological unit constituted a work team composed of specialists and nurses of all the general medicine, geriatric and neurological units of the 8 hospitals and the local area general practitioners.

The team provided:

- The implementation of stroke guidelines with the consequent standardisation of knowledge in the field of stroke treatment and care.
- An agreement and definition about clinical treatment and patient care protocol for general practitioners and care givers.
- A creation of operative teams dedicated to stroke care

in each of the 8 hospitals of the local health services.

- A map of the network and the telematic connections between all the units that provide hospital care to stroke patients, the stroke units and the emergency services.

As a part of the program there was set up a special hospital training for patients and/or care givers about patient rehabilitation and correct life style to follow after discharge. In this way patients and family members were urged to be more informed, more responsible and more enabled to cope with the disease before and after hospital treatment.

The participation of general practitioners and care givers in the care process of the stroke patient facilitated continuity of care by the use of a uniform and common standard protocol during the hospital treatment and the follow up of this mutual collaboration after discharge in the home.

The program inevitably contributed to enrich the cultural web between hospital. Out patients facilities and home care allowing a better intercommunication between the different roles and different functions within the hospital care community and social care community.

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SESSION II-3: CHRONIC DISEASES (IV): HEALTH PROMOTION FOR DIVERSE CHRONIC CONDITIONS

P 145: PATIENTS' ASSOCIATIONS NEED OF EMPOWERMENT IN HOSPITAL CARE ORGANIZATION FOR CHRONIC DISEASE.

Laurence BENTZ, Christian PRADIER

In order to involve patients in the decisions and actions taken concerning their health, a survey by semi-directive interviews was conducted in 2004 by the Public Health Department of Nice University Hospital, France. Eight different associations of patients suffering from chronic disease were contacted, representing about 1000 members and almost 1600 patients followed every year (breast cancer, ENT cancer with laryngectomy, digestive ostomy, HIV, stroke, Alzheimer's disease).

The aim of this study was to collect the opinions of representatives from these associations concerning patients' and their families' problems and needs during hospital care to enable us to justify and conceptualize the implementation of accompaniment strategies, with a strong empowerment aspect, for patients with chronic disease.

Several common problems emerged from the survey which concerned the conditions and circumstances of announcement of the diagnosis, the quality of communication and of the information delivered by the health professionals, the organization of the return home including help with social, financial and legal problems as well as knowledge about existing health care networks. The needs are correlated with these problems and require adapted organization and type

of care. Particular attention should be paid to preparation for returning home, as well as anticipation of psychological and practical difficulties in everyday life and how to resolve them. Associations concerned with very dependent patients (cranial trauma, stroke, Alzheimer's disease) suggest that these problems should be considered by the patient's family in order to avoid burn-out and resulting health problems.

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P 146: PATIENTS WITH CHRONIC DISEASES AND ELDERLY PEOPLE NEED MORE ATTENTION

Helle MAELTSEMEES

INTRODUCTION

The network of health promoting hospitals in Estonia was set up five years ago and Tallinn Järve hospital was the first

health promoting hospital in Estonia. Health promotion became as an integral part of the daily work at this hospital. Estonian population is aging extremely quickly. For example in the capital of Estonia - Tallinn, the % of elderly people (older than 65 years) is 16.7%. At the moment the purpose of our health policy is to retain the old persons independent as long as possible, in their own environment. There is need to reduce the number of hospital beds for acute treatment in the Tallinn hospitals, the same time is demand for special institution for long term patients (day hospitals, medical rehabilitation help for elderly people).

The HPH East- Tallinn Central Hospitals Medical rehabilitation and long-term care Clinic (the late Järve Hospital) is until now as a leader of the reorganization the hospital care system in Tallinn for chronically ill patients and for frail elderly people.

AIM

- To create a common vision of the future health care system for elderly people, and consequently to define approaches for acceleration of the progress to that direction.
- To develop a toolkit for the management and performance evaluation of health and social care services for elderly people.
- To implement and evaluate various model solutions according to the actual needs of patients: community care services (home care); counseling by social workers in local social care; social care homes (with very basic nursing only); social departments; two day-care centers for demented persons in Tallinn; no-assisted or group living houses for elderly persons; etc.

METHODOLOGY

East-Tallinn Central Hospital is providing now the adaptation of comprehensive geriatric assessment on the basis of the program of project CARMA (Care for the Aged at the Risk of Marginalization) together with the Internal Clinic of Tartu University and Estonian Association of Gerontology and Geriatrics, associated professor of the Tartu University Dr. Med. Kai Saks.

EXPECTED OUTCOMES

The old people are better prepared for coping in later stages of life: the capability of elderly people be active and ensure that their acceptable standard of living and status is equal with the other group in society.

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P 147: HEALTH PROMOTION PROJECT "BEYOND THE BARRIER": A REFLECTION BETWEEN EQUALITY ON THE ACQUIRED DISABILITY

Dora BOLOGNESI, Maddalena DEGLI ESPOSTI, Lorena CONSOLI, Licia COVONI, Federica MATULLI

DESCRIPTION OF THE PROJECT

A consistent increase of acquired disability of the young population caused by road accidents, emerged from the

analysis of the statistic and epidemiological Data. To acquire a disability takes to find oneself live with limited movements, and must look over again ones life project, to encounter daily discomfort and relational difficulties.

An unfavourable social environment, uninformed or exclusion, diffused presence of architectonic and psychological barrier. The environment and socio-cultural are in itself the cause of disability and the social re-integration after a hospital recovery caused by a serious trauma is usually difficult both for the patient and for his family.

This critical context represents the motivation of the project processing which is aimed to promote and sustain the communication and the reflection on the "group equality" within the school surroundings, the relative thematic on the acquired disability.

GENERAL OBJECTIVES

- Promote health and develop the culture of integration within the community of "the equals".
- Improve the quality of life of the person with acquired disability, promoting the potentials of health and the integration within the community.
- Specific Objectives.
- Let the students buy reading materials that consent an adequate comprehension of the rehabilitative process.
- To favour moments of comparisons and reflections among the young.
- Individualise analytical experiences on the "accessibility" within the territory. This should be done in collaboration with the teachers and the students.

METHODOLOGY

The project proposes a didactics methodology that tends to favour the active participation of the present students and the disabled children. The aim is to use frontal lessons, simulation games, creative games that suggests the students the use of wheel chairs for the disabled and inviting them to carry out daily life activities.

TARGET

Students of the mid-high school of the city of Bologna and its provinces.

EVALUATION OF THE RESULTS

At the end of the course: written exercises in which the boys are invited to express their feelings, emotions and questions.

Successively, in collaboration with the academic staff, the boys will elaborate agreed on exercises (ex. mapping of places connected to the daily lives where in the accessibility or less, also for a disabled boy is verified) that will be published on the web site of the Hospital Association called "rehanet" where an appropriate space for dialogue among the boys is foreseen.

CONCLUSION

The project aimed to promote the culture of integration and of communication of the disability, and on the 3° year of accomplishments, it is undertaking the continuity of its didactic programming as the result of interest and appreciation by the involved scholastic structure.

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P 148: HOME CARE CLINICAL PATHS AND GUIDELINES DIRECTED TO PARENTS

Carla BERNARDINI

Education and responsibility in chronic patients and parents are fundamental to shorten and simplify hospital stay and to facilitate the return inside the home environment after hospital stay.

An effective "Learning about your health" process within a hospital can though be structured only if physicians and nurses learn how to participate in the selection of the information to be given and how to use effective communication techniques to make them understandable.

Considering this, the Nutritional Department of the Meyer Hospital of Florence produced in 2004 2 handbooks with guidelines on enteral and parenteral artificial nutrition probes management within the domestic environment. The contents were shared with physicians and nurses in order to make them coherent with what is everyday done and said by the hospital personnel to patients during their hospital stay and then were transferred in a simple form to be easily understood.

In the meanwhile interventions on the nursing personnel were conducted to encourage them to share and confront information with physicians. This resulted in a more effective teamwork that gave patients the impression of a good and reassuring climate around them and strengthened the concept of perceived good quality towards the hospital.

Two were the main outcomes of the project: first of all the shared contents production increased the willingness of patients and parents to accept the information given on home caring in a written form since the contents were easy to comprehend and perfectly coherent to what they experienced within the hospital. The effective support made them more independent from professionals and able to manage at home small problems and inconveniences.

Secondly, the shared responsibility between hospital personnel and patients in managing the caring process reduced the costs related to the employ and maintenance of the tubes used for enteral feeding and catheters used for parenteral nutrition.

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P 149: REGIONAL HPH PROJECT FOR ARTIFICIAL NUTRITIONAL SUPPORT: 1999-2004 REPORT.

Lorella MOZZONI, Mariano BARBERINI

In these years, the role of Home Artificial Nutrition (HAN) has gained great importance in clinical practice, for covering the nutritional needs of patients who can not eat (orally or enter-

ally) and for reducing the length of hospitalization and its cost, when it is not strictly required. At home, the nutritional support can be equally efficient, improving the life expectancy and also the quality of patients' life.

Our group was born with the objective of promoting health and well-being in patients undergoing treatment and to ease the therapeutic activity of implicated professionals. We developed some suggestions for the home practice of enteral and parenteral nutrition, as composition of the nutrition team, criteria for selection of patients, methods of self-training, routes of access, follow-up, treatment of complications, materials.

We treated 415 patients in Home Enteral and Parenteral Nutrition (1999-2004). It was mainly used in patients with cancer (37%) or brain pathologies (35%).

In enteral nutrition, the most commonly access route is the nasogastric tube, although there is an observed increase in the application of percutaneous gastrostomy (32%). In parenteral nutrition, we treated mainly cancer and mesenteric ischemia: the majority of patients had central non-tunneled or periferic vein cath (66%), 34% of this group had tunneled cath.

There was an observed complication index of 0.57 episodes/patient-year and our index of rehospitalization was 0.26 hospitalization/ patient-year. These values are like those found in many other studies.

Anyway, it is necessary to underline that better education and greater awareness are necessary to improve the quality of care and the clinical outcome in this group of home-treated patients.

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P 150: EMPOWERING STAFF TO PROMOTE CONTINENCE AND MANAGE INCONTINENCE IN THE OLDER PERSON

Olivia FLATTERY

Due to a product change within the organisation issues surrounding knowledge and appropriate usage of products was identified. A continence promotion-working group was established to support best practice, within the care of the older persons wards. The group consisted of a Link Nurse and Clinical Nurse Manager from each area, Nursing Practice Development and a Clinical Nurse Specialist.

The aim of the group was to heighten continence awareness among nurses and health care staff. This was achieved by offering in house education sessions on the principles of continence assessment and products. Staff were also encouraged to attend the 'Continence Promotion and Management of Incontinence' course which is run by the Continence Promotion Unit in Dr. Steeven's Hospital.

The group developed an appropriate assessment chart and introduced this to the clinical area. All patients with incontinence are to be assessed using this chart. The effectiveness

of the assessment chart will be audited this year.

The group reviewed their impact and identified that there still appeared to be a knowledge deficit among the nurses and health care assistants in relation to continence assessment and promotion. The group decided to identify this among the staff by developing a training needs questionnaire and they audited the awareness among the staff, which will guide the future training needs of the staff within the care of the older persons wards.

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P 151: EMPOWERING PATIENTS AND RELATIVES TOWARDS A HEALTH PROMOTING PRO-ACTIVE INVOLVEMENT IN THEIR TREATMENT, CARE AND MAINTENANCE OF GENETIC ACQUIRED HAEMOCHROMATOSIS

Niall FRIEL

RATIONALE

Haemochromatosis is a genetic (family inherited) disorder in which too much iron is taken into the body over and above the needs of the body. One in three people have the disease Haemochromatosis, and it is widely recognised as one of the commonest genetic diseases in our society. According to Reyes et al (2003) identifying people with evidence of Haemochromatosis represents a major chronic disease prevention opportunity. If detected it is easily treated. In the last two years over sixty individuals have attended Day Unit Monaghan General Hospital, or are in attendance for treatment of this disorder. It has been observed that there is a need to build healthy alliances with the National Irish Haemochromatosis Society and to empower fellow sufferers to develop a link with the wider organisation.

AIM

To empower individuals to take responsibility for their own disease management and prevention strategies.

OBJECTIVES

- To create an awareness of the disease and how it impact on the individual involved and family.
- To build a network structure between the National Haemochromatosis Society and local agencies to provide support and information for those suffering from Haemochromatosis.
- To promote and develop relationships with the National Haemochromatosis Society and medical experts working in the field to advance the knowledge and treatment of Haemochromatosis.
- To empower local sufferers to affiliate to the National Haemochromatosis Society and self manage.

METHODOLOGY

- Initial contact with Irish Haemochromatosis Society.
- Set up affiliated branch of National Association Conclusion.

Agreement has been reached with the National Haemochromatosis Society to set up local branch in Monaghan region. Committee has been elected. Fund raising has commenced to support individual sufferers to attend AGM in May. This will empower all clients to participate fully and to learn about their illness and how to live with it.

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P 152: CONTINUITY OF CARE AND REHABILITATION OF HEMIPLEGIC PATIENTS

Cristiano CARBONELLI, Loredana CERULLO, Donatella PROCICCHIANI, Gianbattista CAMURRI, Giovanna TESTONI

In our Rehabilitation unit, of 300 inpatients treated each year, 40% are hemiplegics after a recent stroke. These hemiplegics are our most severe cases, stay for a long time, and consume most of our resources. Among the problems our staff used to experience were burnout and conflict with families at discharge time.

Our project, started in 2001, was aimed at improving autonomy and quality of life of our patients, and making the discharge smoother. To that extent, we start discussing and solving early, with patients and families, the difficulties they are going to experience after discharge. The major organizational intervention was setting up an interdisciplinary team, sharing values, objectives and working style. The team also makes and disclose a prognosis on the achievable autonomy. To measure targets and results, and to exchange information, we have adopted standard measurement scales.

OUR MOST IMPORTANT RESULTS, MEASURED AGAINST THE BASELINE YEAR 2000, ARE:

- Reduction of length of stay.
- Increase of number of patients discharged at home.
- Reduction of conflict with the families.

Measured in terms of reduction of length of stay, costs, and number of patients discharged at home, positive results were already visible in 2001. They have continued to improve in the following years. We now have a more serene environment for patients and staff and better collaboration and satisfaction of families. The number of complaints, already small, after the project, has decreased to nil.

As a follow-up of the project, we are planning a qualitative analysis, aiming at improving our understanding of needs, difficulties and expectations of families and patients, and assessing their satisfaction about the work done by the team.

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P 153: CULTURAL DANCE TEAM AS CLINIC INTERVENTION TO EMPOWER HIA/AIDS PATIENT

Chanuantong TANASUGARN, Pissamai JARUCHAOWALIT, Kwanjai AMNAJSUTSUE

HIV/AIDS patient in developing countries are not only suffered from physical conditions but also psychological and social condition. Hospital staff also found themselves helpless in provide wholistic care. Therefore, staff needs to include People living with AIDS as a team in the clinic. Intervention to empower PWA, HIV/AIDS patient include not only professional care such as counselling, home visit, but also cultural traditional dance team and participation in clinic service design by the PWA. Quality of life perception and ARV drug compliance has been increased significantly.

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P 154: SUCCESSIVE SOCIALIZING OF PERSONS, WHO HAVE SUFFERED SPINAL CORD INJURY

Romualdas MIKELSKAS, Judita DARATIENE, Virginijus BISKYS, Violeta VALVONIENE

BACKGROUND

Patients, who have suffered spinal cord injury, are subjected to multiple derangements of biosocial functions. The acquired disability, psychological and social changes substantially affect both, the patients and their families. It takes time to bring such people back into society. An analysis of 314 cases of patients (1997-2003) with spinal cord injury was carried out in Palanga Rehabilitation hospital. It appeared that the most specific features were as follows: the patients were of the best working capacity (72% were aged 15-44); high level spinal cord disorders were dominant (55% out of which were neck area disorders); male patients constituted 81%.

GOAL

To create a system of rehabilitation stages, that would ensure the greatest quality improvement of life for patients with spinal cord disorders, while using joint efforts of medical personnel, families and non governmental organizations (NGO).

TASKS

- To make the utmost use of means of rehabilitation and time to achieve the improvement of patients' physical condition.
- To supply those people and their families with the necessary means for social adaptation using the efforts and support of non governmental organizations.
- To give the patients treated at the hospital the opportunity of professional rehabilitation.

TARGET GROUP

Patients at Palanga Rehabilitation hospital (2003-2004) who

have suffered spinal cord trauma.

METHODS

A program of medical, social and professional rehabilitation was compiled at the hospital. On the basis of this program all the patients with spinal cord disorders at Palanga Rehabilitation hospital are not only provided with the usual medical and social rehabilitation, but they are also granted an opportunity of professional rehabilitation. Barthel and FIM tests are used to evaluate the alteration of physical condition of the patients; SF 36 question test is used to evaluate the quality of life. Active rehabilitation camps at the hospital are run by instructors who are disabled themselves. They are trained by non governmental organizations. Patients are involved in social activities under the guidance of these organizations. After being through with the course of professional rehabilitation the patients receive new chances of employment. Cooperation with employers and labor exchange is very helpful.

CONCLUSION

Patients who take an active part in this project are sooner incorporated into society; they improve their physical condition; and enjoy higher quality of life. The project will be continued; the collected data will be studied; and a more detailed analysis will be presented.

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P 155: SPEECH AND LANGUAGE THERAPY AND PULMONARY REHABILITATION; A MULTIDISCIPLINARY PERSPECTIVE

Ruth O'RIORDAN

The speech & language therapist's role is in educating COPD participants regarding "safe swallowing" and the risks of aspiration associated with the disease. Prevention and safe swallowing guidelines are outlined which heightens the participants awareness of the prevalence of swallowing difficulties in the COPD population.

The Pulmonary rehabilitation program is head by a physiotherapist and includes members from all the multidisciplinary team; medical, nursing, occupational therapy, social work and nutrition & dietetics. The pulmonary rehabilitation programs includes medical management, education, emotional support, exercise, breathing retraining and nutritional counselling. The purpose of pulmonary rehabilitation is to help people to lead a full, satisfying life and restore them to their highest possible functional capacity.

The specific goals of pulmonary rehabilitation are to improve quality of life by decreasing respiratory symptoms and complications, encouraging self management and control over daily functioning, improving physical and emotional well being and reducing hospitalisation. As this program is in the initial stages, it is hoped that this initiative will result in earlier detection of swallowing difficulties and a decrease in admissions for aspiration pneumonia and COPD exacerbations.

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P 156: GAIA PROJECT (ORAL HEALTH IMPROVEMENT FOR DISABLED PEOPLE)

Christian BACCI, Ettore VALESI-PENSO

GAIA is bi-annual project to promote oral health by improving hygienic and alimentary habits.

Scope of this paper is to explain this project and to evaluate some results achieved in those two years.

Since 1992 Operative Unit of Dentistry and Stomatology of Saint Lorenzo Hospital, Borgo Valsugana (Trento, North-Eastern Italy), follows the customers of residential and stay-in daily centers for handicapped people of the province of Trento.

TARGET OF THIS PROJECT ARE:

- The disabled subjects entertained in centers of province of Trento, theirs parents and/or legal tutors, operators of those centers.
- Scope of the plan is to improve hygienic and alimentary habits and to reduce the incidence the oral pathologies of those subjects.

MATERIALS AND METHODS

We have taken in examination 40 center of residency for a total of 553 handicapped people. For everyone of those centers: a visit was performed noting: presence of caries, dental plaque index, teeth needed to be extracted. We have taken note in a score scale from 1 to 3 (good, intermediate, poor oral hygiene) as plaque index (PI); Decayed Missed Filled Theet international score (DMFT), initial caries lesions, gingivitis, periodontitis, dento-facial anomalies and oral lesions were also noted.

A meeting with operators of the center were articulated on two days: in the first one, with aids of multimedial and practical exercises, they were trained about oral pathologies and their systemic implications, correct feeding habit, why and how oral hygiene.

The second day was dedicated to a workshop for the operators and for parents or legal tutor and the more cooperatives of handicapped people. They were trained about oral hygiene procedures for cooperative, mild uncooperative and total uncooperative patients. Those visits to the centers were realized yearly and so plaque index were taken at least yearly.

RESULTS

At the first visit baseline PI was 67 score 1 (good oral hygiene), 142 score 2 (intermediate), 344 score 3 (poor); after the first year, in 2003, PI becomes 329 score 1, 108 score 2, 116 score 3, at the end of the training (2004) PI were: 398 score 1, 123 score 2 and 29 score 3.

DISCUSSION

Oral health have great improvement, but it is to underline the importance of a continuous formation, of the reinforcement of the motivations for customers and operators. In fact the

best results we have gotten after the second formative cycle.

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P 157: A BETTER LIFE FOR RHEUMATIC PATIENTS LEARNING AND UNDERSTANDING IN PATIENT CARE HEALTH EDUCATION - A VITAL ELEMENT IN DISEASE TREATMENT

Alessandra MATUCCI, Alberto APPICCIAFUOCO, Gabriella MARIN, Leila MAGARÒ, Vincenza FUSARI, Simonetta DURETTO, Mauro DAVENIA, Luana BACCETTI, Paola REZOAGLI

The N.S.G.D. hospital rheumatology unit, working within the HPH project, at the Nuovo San Giovanni Di Dio Hospital, Florence, has as its goal the provision of all health related activities aimed at rheumatic patients through the implementation of a global approach to care.

During the first phase of the project a Rheumatology Unit with appropriate in-patient facilities meeting specific structural requirements, rheumatology out-patient services and specific activities aimed at improving patient comfort and care were set up.

The project is now in its second phase. This involves the establishment of functional hospital-community links to guarantee an uninterrupted flow in patient care and the provision of activities aimed at patient education, through health education procedures.

A patient education project aiming to improve patients' health status implies first of all a certain of knowledge of the disease on the patient's behalf. The transmission of accurate and clearly comprehensible scientific data is essential in an approach to treatment based on patient awareness and working towards prevention. During the past year, in this context, we have organized a series of patients-physician meetings following specific requests of the rheumatic patients' associations:

- Rheumatologist and gastroenterologist: easy endoscopy and drug induced GI lesions - how to avoid them.
- Rheumatologist and radiologist working together for the patients' benefit: the importance of imaging techniques in rheumatic diseases.
- Rheumatologist, orthopedic surgeon e physiotherapist cooperating for the patients' benefit: joint prosthesis, giving joints a new life.
- Women to Women (rheumatology, gynecology, physiotherapy, dietary medicine) - Speaking of osteoporosis: information, awareness and prevention.

At the end of each meeting ample question time was allowed for extended discussion between the various participants (physicians, nursing-staff, therapists and patients) to enrich this cultural experience.

The Rheumatology Centre thus acquires a reference standing in patient care, psychological and moral support - an important pivotal role in patients' lives and their future.

Caring for a rheumatic patient requires time: Patient-carer communication is a vital part of the care giving process.

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P 158: MANAGING JUVENILE ARTHRITIS: EMPOWERING ADOLESCENTS AND THEIR FAMILIES

Mary O'HARA

Juvenile idiopathic arthritis (JIA) is a heterogeneous group of conditions which begin in childhood and involve persistent inflammation in one or more joints. This review explores the impact of juvenile idiopathic arthritis on affected adolescents and their families and how they can be supported and empowered to manage this condition.

The incidence of JIA is approximately 10 per 100 000 (Davidson, 2000; Cassidy & Petty 1995). Andersson Garre, (1999) suggests the incidence rate is 6-19 per 100 000 with a prevalence of approximately 1-1000, comparable to that of childhood diabetes. The detection, treatment and monitoring of juvenile idiopathic arthritis are of great significance as this condition can be seriously disabling. Impaired function, joint destruction, growth disturbances, pulmonary, ocular and cardiac problems are potential complications. Chronic pain and loss of education can impact on career choices and prospects (Johnson & Gardner-Medwin 2002). Reducing the psychosocial impact of this condition is of critical importance to strengthen social inclusion and avoid marginalisation.

Lack of specialist knowledge and appropriate treatment can cause a delay in treatment. Classification of childhood arthritis continues to be an evolving process which is yet to be clearly delineated with predictable outcomes and responses to treatment (Hofer, M. 2002). In some cases the condition arrests in late childhood, however the course of the disease is unpredictable. The Chief Medical Officer's Report (2000) acknowledges that issues in relation to prognosis and long term implications of a disability create high levels of distress and anxiety in families. Currently, there is no dedicated paediatric rheumatology service in Ireland (ISR 2003). Cuneo and Schiaffino (2002) examine adolescent self-perceptions of adjustment to childhood arthritis with particular interest in the influence of disease activity, family resources and adjustment. This presentation focuses on quality of life issues and interventions utilized to reduce the impact of this condition.

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P 159: OSTEOPOROSIS PREVENTION AND HEALTHY AGEING

Dalibor PETRAS, Stefan PETRICEK, Zora BRUCHACOVA

After finishing the programme "Health for Everybody by 2000", the World Health Organisation (WHO) published another perspective programme "Health 21 - Health in the twenty-first century", which includes 21 objectives. For old people care it is of great importance that for the first time WHO identified unambiguously population's ageing as one of the central world-wide problems and healthy ageing was denoted as objective no. 5 in this programme. Among twelve cardinal medical problems of ageing persons, osteoporosis prevention and treatment is one of the top priorities.

This work reports on and analyses the results of and approach to osteoporosis prevention in the community by Specialised Institute of Tuberculosis and Respiration Diseases (VOÚ TaRCH) Nitra - Zobor - Osteocentrum over 2000-2003. Over 7,000 people with a potential risk of osteopeny or osteoporosis were examined, using a USG mobile osteodensitometer or, in selected cases, a DEXA osteodensitometer for both sexes. Data were retrospectively analysed and evaluated. T-score ranging from -1 to -2.5 was evaluated as osteopeny, while T-score higher than -2.5 was regarded as osteoporosis. Seven groups (without interference) were studied: residents from old people's homes, standard population, working population, chemical industry employees, food industry employees, health service employees, and citizens of Nitra region. Examination showed normal values in 44.66% persons, osteopeny in 42.31% and osteoporosis in 13.03%. There was a significant difference between the sexes, with a higher occurrence of pathologic values for females compared to males (43.44% vs. 35.79% in osteopeny, 13.67% vs. 9.26% in osteoporosis). The study has confirmed a high prevalence of osteopeny and osteoporosis in risk groups and thus the need for a complex preventative and therapeutic treatment on all levels.

Finally, the case is presented of an 85-year old patient with immobilization syndrome (4 years) due to repeated fractures of lower left leg due to osteoporosis known for 9 years but not treated.

KEY WORDS

Healthy ageing, osteoporosis, osteopeny, prevention

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SESSION II-4: HEALTH PROMOTION FOR OLDER PATIENTS

P 160: VAUGIRARD-GABRIEL-PALLEZ: AN INNOVATIVE HEALTH CARE PROJECT

Sophie JAMMES

The Vaugirard-Gabriel-Pallez Hospital, in its global hospital project, is initiating a new approach of care for the aged. Health cares are provided by professionals whose objectives are to bring back a sense of well-being to elder patients, to encourage communication, to reinforce self-esteem, to be more present to life.

TWO PROJECTS ARE BEING DEVELOPED:

- Through the intermediary of thymotactile contact (to affectively confirm the patient's existence through tactile contact), a nurse specialized in Haptonomic Accompaniment tends to restore a feeling of security inwardly. The nurse strengthens the elder patient in his desire to live. She helps out the patient to use his inner resources.
- A partnership between the Vaugirard-Gabriel-Pallez Hospital and the Institut Supérieur d'esthétique JUVENTHURA in Paris allows the elder patients to receive esthetical care by students who are undertaking work-experience at the hospital. In the long run, an alternative training course will allow the esthetical care students to specialize in social-esthetical care.

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P 161: VAUGIRARD-GABRIEL-PALLEZ: MEMORY AND MUSIC AT THE HOSPITAL

Sophie JAMMES

The cultural project maintains the social link of the elder patient, gives him back the initiative, the act and the voice. More, it strengthens the link with the community, including the hospital network as a whole. The cultural network City-Hospital that was introduced at the Vaugirard-Gabriel-Pallez hospital makes it a place for creating in the patients' every day life. All year round, 22 artistic troops create and rehearse their shows at the hospital. In return, they organise manual workgroups, concerts, reading workgroups and evening gatherings for the elder patients.

The workgroups made up by the university centres on the motion, of handicap and the old age, as well as the workgroups composed by doctors, physiotherapists and artists have converted the hospitals into a place for research in complementarity with health care.

An opening towards the city has begun with the creation of

cultural workgroups reserved to the district elder people (tai-chi-chuan classes, tango, choral, yoga and so on).

The cultural policy is implemented around music (through concert programming, musical conferences, creation of a singing centre) and around memory (through collecting the memory of the local elder people and promoting inter-generation gatherings).

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P 162: AN INTERACTIVE THEATRE AND MUSIC PROGRAMME FOR ELDERLY PATIENTS

Geraldine MCDONAGH

AIM

To promote the increased quality of life for older people through the delivery of high quality arts activities

METHOD

This project uses the arts - including music, story telling, costume and improvisation to provide an interactive playful experience that is tailored to each individual. Through the co-operation of the nursing staff, the project practitioners are taught a basic understanding of the clients' various illnesses. With regular informative meetings with staff members, both the practitioners and the nursing staff develop an understanding of each other's work and approach to the caring of clients. The project practitioners worked in the day room full of both long term and respite patients. All patients were greeted individually, and some had requests - a story, a poem, or an old time waltz. The atmosphere was very jovial and nurses were also involved. The practitioners then circulated through the wards to visit those patients who stay in their beds. Sometimes a nurse proposes a certain type of art activity for a particular client. The practitioners also performed individual concerts that sometimes involved a patient joining in.

RESULTS

Both patients and staff warmed to the work of the artists and participated in the project.

CONCLUSION

This type of intervention allows clients to express themselves in ways that side step their disabilities. The playful interaction motivates verbal and non-verbal communication with expression, thereby promoting social inclusion. The nursing staff and the practitioners combined to create an overall

lighter atmosphere.

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P 163: INJURY AS A HEALTH PROBLEM AMONGST ELDERLY AT HOSPITAL AND DWELLING PLACE

Jerzy B. KARSKI

Every year over 130,000 EU-citizens lose their lives as a result of an unintentional injury and over 40 million are required to seek medical treatment (ECOSA report, 2001). The toll of intentional injuries is reported to be over 15,000 deaths each year. Total injury morbidity accounts for more than 10% of overall health care utilisation. Especially unintentional injuries (other than traffic injuries) are resisting the overall trend of declining mortality (CVI Report, IPP 2000).

However the number of death and disabling injuries as a result of home and leisure injury is now in fact on the increase. This places a still greater burden on society in terms of the costs of treatment, rehabilitation and coping with disability and therefore presents an important public health problem. The actual burden of unintentional injury for society is estimated at 400 billion Euros, a sum four times the total budget of the European Union.

Injury amongst elderly is a specific issue to be more and more important due to general rise of life expectancy. Another question is the general safety at hospital and injury prevention at the hospital environment, including safety of elderly.

Safety measures concerning elderly at the hospital require specific approach to the issue. It concerns both the patients and their families, as well as hospital staff in advanced age.

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P 164: FALL IN OLDER ADULT POPULATION OF THE MIDLAND HEALTH BOARD: EXPLORATION OF CIRCUMSTANCES AND BELIEVES.

Anna DE SUIN

BACKGROUND

Falls are among the most serious problems facing older people. While a great deal of research has been carried out on falls, information on patient's views, compliance with and acceptability of falls prevention programmes is lacking within trials and systematic reviews, (NICE Clinical Practice Guide-

line 2004.). The Midland Health Board (MHB) formed a falls prevention committee in 2003 with a remit to design and implement a Board wide falls prevention programme. In order to ensure that such a programme would be appropriate and acceptable to the older adult population of the MHB, a piece of qualitative research exploring circumstances and beliefs of people who had fallen was carried out.

METHODOLOGY

A semi-structured interview schedule designed to explore the circumstances of each persons fall, beliefs held around falls, and the acceptability of interventions (exercise, home modification and equipment), was administered to 13 people over the age of 65 who had fallen.

RESULTS

It was found that while the circumstances of each persons fall differed widely, a number of similar attitudes to falls were expressed. The majority of people had experienced more than one fall, but tended to dismiss previous falls as unimportant. Few were able to give an explanation for their fall, and few believed that future falls could be prevented. The most dominant underlying theme was a belief in the inevitability of falling.

No-one interviewed was aware of the beneficial role exercise could play in the prevention of falls. Those who had never had Occupational Therapy intervention rejected the idea of 'change' in the home, while those who had previously had OT intervention were happy with modifications made. For many people, maintaining independence was linked to not needing to use special equipment such as hip protectors and personal alarms.

KEYWORDS

Older person, falls, circumstances, beliefs, falls prevention, qualitative.

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P 165: IDENTIFICATION OF ENVIRONMENTAL RISK FACTORS FOR FALLS IN ELDERLY INPATIENTS

Grazvyde MASILIUNIENE, Jurate MACIJASKIENE

Kaunas 2nd Clinical hospital has arranged a program for prevention of the risk of the falls in the elderly inpatients. The aim of this study was to evaluate the environmental risk factors.

METHODS

The nurses of 16 departments fulfilled questionnaire about environmental risk factors for falls in the hospital.

RESULTS

Secure handrails were documented in 14 departments. The corridors clear of clutter and obstacles with adequate resting seats and adequate width for mobility aids were noted in nearly all departments. The rooms and corridors were well lit without glare in 12 departments. The provision for night lighting and switches easy to reach were adequate in nine

departments. Lack of individual switches beside beds was noted. Only one department had light switches with luminous tape for night visibility. The toilets with adequate space for persons with walking aids were noticed in 11 departments. The grabrails in the toilets were missing or not easily reached in seven departments. Only three departments had call bells in the toilets.

CONCLUSIONS

- The corridors in the hospital are safe.
- Light switches in the departments should be more visible during night and easier to reach.
- The toilets should be installed with call bells.

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P 166: IDENTIFICATION OF THE NURSE'S NEEDS FOR INFORMATION ON FALLS IN THE ELDERLY

Jurate MACIJAIUSKIENE, Grazvyde MASILIUNIENE, Rita BANEVICIENE

Kaunas 2nd Clinical hospital has arranged multi-step program for prevention of the risk factors for the elderly inpatients. One of the tasks of the program and the aim of this study were to evaluate the needs for information of falls among the nurses.

METHODS

The 109 nurses of 12 departments in the hospital fulfilled questionnaire containing nine questions about the major factors for falls in the elderly and about the needs for more information on this subject.

RESULTS

The main risk factors mentioned by nurses were slippery floors, changes in blood pressure and circulation, impaired vision, and inappropriate footwear among other 53 answers. 38.5% of nurses correctly noticed that the patients for risk falls should be evaluated on admission to the hospital. The consequences of the falls were listed giving the priority to fractures and major injuries, less than third of nurses noticing fear of falls. More than 50% of nurses answered that during last five years did not get new knowledge on the falls.

CONCLUSIONS

- The information, knowledge possessed by nurses are unsystematic.
- There is a need for up-to-date information on the falls for the nurses.

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P 167: AN INVESTIGATION OF THE EFFECTIVENESS OF A PHYSIOTHERAPY LED GROUP EXERCISE CLASS IN IMPROVING BALANCE IN OLDER PEOPLE

Maura O'SULLIVAN

AIM

To assess the effectiveness of a high-level physiotherapy balance class (HLBC) in improving balance in older people and to ascertain which patients benefit the most from the HLBC.

RELEVANCE

*Muscle weakness and impaired balance, both of which are targeted in the balance class, have been shown to be key risk factors of falls in older people (Tinetti et al 1988). Falls are common among older people and result in both injuries and an increase in fear of falling which has a detrimental effect on the independence of community dwelling older people. The effectiveness of group delivered exercise interventions in preventing falls in older people is unknown and further research into the subject has been recommended (Powers et al, 2002).

METHOD

The Berg Balance Scale, a well validated outcome measure for assessing balance in older people (Berg et al, 1992) was used to assess patients on initial assessment and on discharge from the physiotherapy class. The scores of 38 older people who attended at least 6 high level balance physiotherapy classes between July and December 2004 were compared. The balance class consisted of a warm up, limb strengthening and high level balance activities. The subject group was then divided in to those whose initial Berg scores were < 45/56 (n=13) and those whose scores were ≥ 45 (n=25) and the analysis was repeated. A Berg score of 45 or greater indicates that a patient is less likely to fall. Statistical analysis was carried out using Wilcoxin Signed Rank test on Datadesk software.

RESULTS

For the total group, mean pre-HLBC Berg score was 46.68 (+ 5.47) and mean post- Balance class score was 49.63 (+ 4.96). This was statistically significant (p<0.05).

The mean percentage improvement for the <45/56 group was 8.2% (range 1.8-10.7%) and for the ≥ 45/56 was 3.7% (range 1.8-14.3%). The difference in % improvements was not statistically significant.

CONCLUSIONS

All Patients who participated in the high level physiotherapy balance class showed significant improvements in Berg Balance Scale score. Patients with initial scores less than 45 showing the greatest improvements. From these results it could be suggested that the balance class should be targeted at patients with lower Berg scores on initial assessment.

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P 168: SPECIAL NEEDS ROOM FOR OLDER PEOPLE IN RESIDENTIAL CARE

Geraldine MCDONAGH

AIM

That the residents who live in continued care in Unit 5 may have a peaceful, dignified and comfortable death at the end of their stay.

METHODS

The staff of Unit 5 identified a need for a special needs room. This room could be used for: Residents who become critically ill, so their relatives and loved ones can be with them, and they can enjoy respect, dignity and privacy at the end of their life; Residents who need to conduct private business; Staff who need to talk with relatives.

All staff in Unit 5 were consulted, the idea was discussed, and all staff felt it was a good idea. A room was identified and set aside. It was painted in blue and lemon, the colours conveying a sense of calm and tranquillity, peace, along with a sense of warmth and well-being. The room has scented burning candles, soft lighting, relaxing music, pictures with nature scenes and a water feature. Gifts have been received including a 3 piece suite of furniture from a past staff member of Unit 5.

RESULTS

The feedback from relatives has been very positive. Some relatives felt "they were allowed the time and privacy to grieve". Others felt "having that unhurried special time with their loved one had helped them a lot".

CONCLUSIONS

Working along side a patient in silence or meeting practical needs is essential and life-supporting, and many patients will find within themselves all they need to give them assurance and peace. In creating a caring and supportive environment, both patients and families can find peace and strength for themselves. The way care is given can reach the most hidden places and give space for unexpected development. By creating this special needs room, we are trying to help the patient to find a meaningful death with dignity.

During the time approaching death, we need to attend not just to the outer, but also to the inner aspects of the process of dying. As death approaches, the quality of the time that remains becomes the most important issue. Family and staff feel this quality time is allowed by the special needs room. Families feel privacy is very important while they are with their loved one on his/her final journey to everlasting peace.

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P 169: OLDER ADULT'S PARTICIPATION IN HEALTH -CARE DECISION MAKING

Bernadette POWER

This study was concerned with the ability of the older adult to participate in health-care decisions within the context of current health policies. The aim of the study was to uncover older people's views and experiences of participation in health care decision-making while in acute and community hospitals and in receipt of community care services.

The study was carried out using an interpretive, grounded theory approach. This approach would appear to support the espoused aims of contemporary health policies which emphasises the importance of considering the needs, rights and expectations of older people. It could also be considered as empowering older people as it gives a voice to research participants.

The core theme to emerge in the study is the ability of health care professionals and significant others to facilitate or inhibit older peoples' involvement in autonomous decision-making.

Findings to emerge are, although clinical decisions are made at an individual level, the older person needs adequate and pertinent information about treatments in order to make informed decisions in relation to their treatment and future care needs.

Paternalistic attitudes were found to impact on the older person as often well-meaning staff and families considered older people to be incompetent to make decisions. Older people were found to be pre-occupied with physiological needs which may have impacted on their awareness of their right to make decisions about their care.

Issues of dignity and respect within social interaction and verbal and non-verbal communication between staff and older patients secures or threatens the older person's sense of self. A new finding is the perception that recent financial cutbacks negatively impacts on the older adults' ability to remain living at home. Possession of private health insurance is felt to ensure rapid access to health services, particularly non-emergency services.

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P 170: SUPPORT FOR CAREGIVERS OF PEOPLE WITH DEMENTIA - A MULTIDISCIPLINARY APPROACH

Susan LAWSON, Emma KILLIAN

In Ireland it has been estimated that there are over 33000 people with dementia. Reports indicate that some interventions can reduce caregiver psychological morbidity and help people with dementia stay at home longer (Brodaty et al,

JAGS 2003:51:657-62). We report on an education and support group for caregivers run by a multidisciplinary team in an acute hospital setting. Post group evaluation indicates that providing support and education had an immediate positive impact for caregivers of people with dementia.

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P 171: HOMEFIRST SERVICE

Gretta THOMPSON

HOMEFIRST SERVICE

HOMEFIRST was established by the ERHA to examine how services for older people could be developed and improved. This service incorporated elements of case and care management and developed as a model of care for older people. It was a collaborative service between Beaumont Hospital and the Northern area Health Board funded by the board.

THE MAIN AIMS OF THE SERVICE ARE:

- To enable older people to return home after discharge.
- To improve levels of home based services to enable older people to remain at home where this is their choice.
- To develop a seamless and integrated partnership between the primary care team, other agencies and the acute hospital to ensure the delivery of quality care for older people.

At present there are 33 older people who are at home with the support of the Home First service. It would be accurate to say that the majority of these would be in hospital or nursing home without the input of the service. Two older people are currently being assessed for the service with a further waiting list of 14. The home first service can facilitate 35 people at home at any one time.

A vital part of the service is the MDT approach of 8 different health professionals. This ensures that the clients involved get a needs led, person centred service that addresses the needs identified.

It also encourages the older person to maximise their independence and promotes self determination in making decisions about their health and the care provided. HOMEFIRST has been an established service for older people at home for the last four years and is continually being used as a blue print for the development of other services for older people in the community. The postal or oral presentation will indicate the strengths/weaknesses of the service and the challenges that were faced in the last 4 years since its beginning.

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P 172: SOCIAL HEALTH KEEPER

Gianbattista MARTINELLI, Sonia MOISO, Achille LEX, Ivana PISONI

OBJECTIVES

In Milan suburbs is evident an isolation status and a fault or weakness in relationships of elderly people (family and/or friendship). Don Gnocchi Foundation (Palazzolo Institute) belongs to an Italian chain of more than 25 research, care and rehabilitation hospitals. We begun an experimental project, with a private-public partnership (Health Ministry, Lombardy Region, City of Milan, Milan health territorial organization-ASL, Lombardy housing company-ALER and other voluntary associations), whose main objectives are: to empower fragile senior citizens by offering them a service of nearness in risky demographic and social environmental contexts, including "training on field" about how to move towards institutions; to improve institution link capability towards elderly people, by developing a map of frailty; to facilitate warning and activation of local existing services and re-activation of human/social networks to prevent admissions in protected structures.

ACTIVITIES

Social Health Keeper is a new job profile coordinated and trained by a team of experts (medicals, psychologists, social assistants, administratives). The Keepers locally detect the needs of the senior citizens, enable services, organize the supportive local net, supply well timed interventions and focused training. The foremost Keeper's tools are social health screening file of the senior citizens and electronic data base about the subjects and the territorial services.

RESULTS

In the first year of activity ten new locations of Keepers have been set up, with a target of 12.000 seniors: 1970 seniors contacted, more than 26.000 supplied activities (home visit, direct assistance, meetings with social health services and other care givers). From a representative sample (464 seniors), the needs detected were: solitude (55.82%), loss of physical-psychic autonomy (41.81%), family discomfort (15.09%), enable housing (6.68%).

CONCLUSIONS

The needs mapping and the human feedback we received demonstrates the necessity of a local, permanent and qualified reference person, assisting the senior at home, planning effective assistance, helping integration between social health public utility, fostering networks of relationships. The Social Health Keeper seems to match several of these goals on the field, even though more experience is needed.

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P 173: PEER-CONDUCTED TRAINING "BY ELDERLY FOR ELDERLY", AN EMPOWERMENT APPROACH TO THE RETIREMENT PERIOD.

Pia TOUBOUL, Laurence BENTZ, Albert BENZAKEN, Christian PRADIER

BACKGROUND

The aging of the population is a fact in France, as in most occidental countries. The south-eastern part of France, Alps - Maritimes (population: 1.040 million) has a particularly high proportion of retired people. (21 % are over 65).

The spare time of the retirement could be used in a creative and productive purpose, aiming the solution by the elderly of specific problems in this period of life. Contrary to previous parts of life, there is no adapted training in the retirement period. Classical pedagogic methods are not adapted to elderly; new methods based on gerontology could be more efficient. Retired people clearly express their saturation of classical medical information; they prefer information from their peers.

METHODOLOGICAL PROPOSAL OF PROJECT

A project of peer-conducted adapted training "by elderly for elderly" is planned in the Alps - Maritimes area, based on a unique experience between 1983 - 1997, lead by a retired moderator, Mr Albert Benzaken. The creator of the concept was Dr Vellas in Toulouse 1973. The Public Health Department, University Hospital of Nice, in collaboration with CODERPA (a local organization of retired people), propose

the implementation in the community of this empowerment approach, using interactive research groups (small units of 8-10 persons with a trained moderator leading and stimulating the group in a positive and encouraging way).

All participants, including the moderator, are retired and take part actively in the researches, in their individual way. The explored themes, chosen by the participants in order of concerns in daily life, could treat physical and mental health as well as spiritual, financial or cultural concerns. To encourage exchange, a yearly meeting with presentations from each group will be organized. An ongoing quantitative and qualitative evaluation of the project is planned, in the perspective to conduct large scale community based interventions promoted and coordinated by Health Promoting Hospitals in their geographic territory.

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SESSION II-5: HEALTH PROMOTING PSYCHIATRIC HEALTH CARE SERVICES & MENTAL HEALTH PROMOTION IN HOSPITALS (II)

P 174: EMPOWERING FOR MENTAL HEALTH

Mari-Ann JÜRS

Health promoting attempts have been focusing on physical issues such as anti-smoking campaigns, healthy eating campaigns etc. The issue of empowering people on mental health care has never been addressed in the same way. However, today's approach to the psychiatric work gives us the means to not only increase the quality of life for the patients, but it also provides us with the ability to enable the public to take care of their own mental health.

Earlier there was a pretty pessimistic approach to psychiatric disease, since prognoses were mostly bad. Due to this lack of effectiveness psychiatry was low priority and little was spent on promoting mental health. Today, however new methods like cognitive therapy and recovery provides a basis for optimism.

The patient is an active co-player and not just a chronically ill person. Now we can actually provide an operational approach that can empower patients as well as the rest of the public.

In doing so we had to challenge a lot of taboo and deal with many years of stigmatization. We made alliances with non-governmental organizations and planned the approach together. This collaboration has been priceless.

Politicians and other prominent citizens have been forming a steering committee. These have been able to change the agenda and put some positive focus on psychological disease and promote preventative efforts on public mental health.

In challenging the taboo and stigmatization we decided that the only way was to be open-minded, extremely honest, sometimes provocative and serve our messages with a good sense of humour.

How? Get their attention! Ask questions they can relate to and give answers in an open and forward manner. Get respected citizens to tell about their own mental health or illness. Be focused, there's a differences between approaching a 50 year old doctor and a teenager.

Where? Schools, work places, education centres, media etc. We keep focused on trends, read papers, watch TV and follow up on stories that give us an opportunity to go and tell about mental health.

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P 175: THE TASK OF TAKING CARE OF CHILDREN OF PARENTS WITH PSYCHIATRIC DISORDER, NETWORK OF HEALTH PROMOTING HOSPITALS IN DENMARK

Søren BLINKENBERG

The Task of Taking Care of Children of Parents with Psychiatric Disorder

Network of Health Promoting Hospitals in Denmark

BACKGROUND

The last years there has been a developing attention concerning children of parents with psychiatric disorders. The ministry of social affairs has during more than ten years supported projects that focused on these families. The psychiatric hospitals have not yet elaborated a systematic strategy to assure that the children of psychiatric patients do not suffer unnecessarily. Re-searches have found that about 25% of psychiatric patients are parents to children below the age of 18 years. Researches have also shown that 50% of the children later in their lives will get problems related to the consequences of their parents psychiatric illness.

In 2003 HPH-Denmark decided to focus on this issue in the strategies of health promoting. A working group drew up the following tasks which were confirmed by the council:

THE PURPOSE

- To prevent physical and psychological failure of care of the children.
- To prevent that the children develop psychiatric disorders and/or psychosocial difficulties.
- To ensure that the correct psychiatric treatment is given in a perspective of parenting and family life.
- To ensure that the different efforts form different treatment-sectors work as a whole.
- To prevent stigmatisation by information.

The target and the commission is further outlined and discussed in the 3 working-groups. The three working-groups were established in September 2004. The product will be ready primo 2007, contents and strategies of implementing have not yet been developed as well as the product only has been approved in a framework.

The work is coordinated with

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P 176: PREPARATION FOR IMPLEMENTATION AND CO-ORDINATION OF THE MENTAL HEALTH ACT 2001 WITHIN THE HSE MIDLANDS REGION

Amelia COX

BACKGROUND

The Mental Health Act 2001 was signed into law in July 8th 2001. Implementation of this legislation will introduce new and comprehensive procedures to protect the interests of those involuntarily admitted for treatment and care. Through its quality aspiration, the legislation will promote the interests of all persons availing of Mental Health Services along with persons admitted under provisions of the Act.

Preparation within the HSE Midlands Region has been ongoing since 2002 with a change management approach being utilised and implemented.

OBJECTIVES

- To promote, encourage and foster maintenance of high standards and good practices for both service users and staff in the delivery of the Mental Health Services.
- To train and equip all relevant staff with the necessary knowledge to follow correct procedures for involuntary admissions.
- To nominate staff from a multidisciplinary background within the HSE Midlands Region to join a national "train the trainers" programme with the aim of being a resource to service users and providing a continuing in-service training programme for staff locally.

METHODS

- A Project Manager was appointed to co-ordinate the implementation of the Mental Health Act 2001 in May 2002.
- A Needs Analysis was carried out to identify staff training needs from within a range of disciplines.
- Liaison and participation was established with both local stakeholders and the National Mental Health Act Steering Group re scoping out a state of local and National readiness.

RESULTS

- Training has being ongoing and updated as per phased implementation of the Act from October 2002 to 2005.
- All grades of staff i.e. medical, nursing, administration, disability services and child psychiatry have attended, with training tailored to individual needs.
- Links have been established with voluntary and advocacy groups for service user information dissemination.

CONCLUSION

Within the HSE Midlands Region, the change management approach that we have adopted has endeavoured to prepare staff for implementation of the Mental Health Act 2001. It has therefore helped to create an environment that is ready to embrace and implement the changes that it will bring for the dignity, protection and empowerment of patients who are involuntarily detained. Resistance and fear have been replaced by information and training.

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P 177: THE ROLE OF CASE MANAGER IN THE MENTAL HEALTH DEPARTMENT

Dorella COSTI

SHORT DESCRIPTION OF PROJECT

The Department of Mental Health of Reggio Emilia is structured at the local level, made up of Mental Health Centres for outpatient treatment, semi-residential facilities for daytime treatment related to specific projects, residential facilities for intensive, long-term hospitalization and social rehabilitation, and a diagnosis and treatment service for acute cases. The Mental Health Services provide care for people who suffer from psychic disorders; they seek to move beyond a limited, traditional approach to treating disorders or diseases, focusing on the person as a whole and working to foster the patient's capabilities and potential; what's more, the Services provide assistance not only for users, but for their family members and community.

PURPOSE AND AIMS

The project goal is to improve the quality of treatment for patients in the care of the department, by developing new methods of providing care which are aimed at ensuring greater continuity.

The case manager is a highly specialized and qualified professional figure who oversees the treatment programme, with the task of assessing patient needs, ensuring treatment functionality by improving application of the care programme, and providing information and direct assistance to patients and their families.

In Reggio Emilia, case managers are nurses and educators who have undergone specific training and have professional experience acquired by working in the field; they are responsible for guiding serious, long-term patients through the course of their treatment and re-socialization programmes, while coordinating all the various healthcare and social services in order to maintain a coherent outlook on life and on treatment which is shared by patients and their families.

An equally important factor is the empowerment of non-medical personnel, fostering their professional skills and the necessary professional autonomy. Case managers coordinate the complex treatment which the psychiatric service offers patients in its care. They are directly responsible for overseeing that the entire network of services functions properly as a whole, for laying out the treatment programme along with the doctor, and for taking care of the patient in the course of this programme, providing guidance and support and acting as an interface with the service.

METHODS/ACTIONS

- Identification of patients in need of a high level of care.
- Identification of staff members already involved in activities similar to the case management model.
- Training program for these staff members.
- In the field experimentation for 6 months (October 2004-March 2005).
- Outlining a specific admittance procedure for target patients of Mental Health Centres, identification of such patients, and transition to the new procedure; use of the case manager file.

PRIMARY TARGET

Patients of the Centres for Mental Health, residential, and semi-residential facilities who have complex therapeutic and support problems, combined with a sufficient degree of stability in their clinical conditions. Moreover, as regards patients of residential and semi-residential facilities, a strong therapeutic bond and an in-depth knowledge of the case by

the staff within long-term therapeutic plans.

RESULTS EVALUATION AND CONCLUSIONS

At the end of the trial period, an overall evaluation of the project will be carried out, critical elements will be redefined, and the project will then be extended by identifying other staff members and assigning new cases.

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P 178: IMPLEMENTING THE RECOMMENDATIONS OF THE "INITIATIVE TO ADDRESS THE ISSUE OF SUICIDE & PARASUICIDE FOR STAFF WORKING IN THE EMERGENCY DEPARTMENT OF JAMES CONNOLLY MEMORIAL HOSPITAL"

Fiona MCDAID

The initial research was developed following an identified need by staff for training following an increase in the number of completed suicides & parasuicide presenting to the Emergency Department.

A multidisciplinary committee was established to implement the recommendations of research performed previously in the emergency department. The committee reviewed the findings of the initial report to establish progress to date on the issues identified which were subdivided into the following groups:

- The service
- Client group
- Personal
- Training & information
- Future development

Progress has been made on all aspects of the project with some being fully implemented (staff training) and others nearing completion (information leaflets).

A review of the project is now in progress to determine the next steps future developments.

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P 179: A STUDY EXPLORING THE RELATIONSHIP BETWEEN SELF REPORTED STRESS AND SELF REPORTED SMOKING BEHAVIOUR IN A SAMPLE OF STUDENT MENTAL HEALTH NURSES.

Christine DEASY

A study exploring the relationship between self reported stress and self reported smoking behaviour in a sample of student mental health nurses.

The aim of this research was to explore the relationship, if any, between self reported stress and smoking behaviour in a convenience sample of fifty-one student mental health nurses and to explore their perceptions regarding the factors influencing their stress and smoking behaviour.

Data collection involved a survey (using the GHQ 28 and a smoking behaviour questionnaire), followed by a focus group comprised of six self-selected volunteers from the original sample, the purpose of which was to explore student's perceptions regarding the factors influencing their stress and smoking behaviour.

The results indicated that 39% of the respondents (N=49) were current smokers (higher than the general population) and 33% reported being significantly psychologically distressed (probable psychiatric cases, unlikely to remit without intervention). Statistical analysis verified that there was no statistically significant association between smoking status and probable psychiatric cases. Interestingly, all the probable psychiatric cases were female aged 18-35 years, two thirds of whom were current or past smokers. These findings may have implications for the student's health, the health service and service users.

Recommendations include:

- Brief intervention upskilling should be made available to all staff.
- Stress management and smoking cessation advice and support should be accessible to students to facilitate healthy choices.
- Nurses should consider the impact of their modelling behaviour on student learning and take an active role in promoting health, preventing smoking and reducing stress in student nurses. They need to be supported in their own roles to allow this to happen.
- The practice of nurses smoking in clinical learning environments must be addressed; the exemption from the smoking ban was created to allow patients (not nurses) to smoke. The area of exemption needs further exploration and research.
- Resources should be focused specifically in capacity building with regard to stress and smoking prevention.

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P 180: HEALTH PROMOTION IN MENTAL HEALTH NURSING: AN EXPLORATORY STUDY OF THE PERCEPTIONS OF MENTAL HEALTH NURSES IN ONE GEOGRAPHICAL REGION.

Christine DEASY

Mental health nurses have a recognised role in promoting mental health however; their perception of a broader health promotion role does not appear to have been formally researched.

The aim of this qualitative study was to explore mental health nurses understanding of health promotion and the role it currently plays in their professional practice. A stratified random sample of mental health nurses employed by the mental health service in one Irish county was invited to participate in the study.

Data collection involved two phases; focus group and interview. The focus group allowed the participants to highlight the health promotion issues in their practice; which were followed up in nine semi structured individual interviews.

The findings underlined that while mental health nurses perceived that they had a role in health promotion they had difficulty differentiating it from health education. Health promotion practice for this group encompassed education regarding lifestyle behaviour, client empowerment and advocacy. The participants considered that they should role model lifestyle behaviours but acknowledged the difficulties of this for them personally.

Their work presented them with opportunities to promote health; conversely, barriers and challenges existed. These included lack of time, staff shortages, access to information, motivation, the stigma of mental illness, the client group, institutionalisation and a lack of training in health promotion. Participants articulated a holistic view towards clients yet some focused exclusively on promoting mental health and sexual health promotion specifically was not engaged in. The participants identified the nurse client relationship, advocacy and empowerment as processes for promoting health.

Clearly, while mental health nurses perceive that they have a role in health promotion the role is underdeveloped. The articulated barriers and challenges must be addressed to ensure health promotion becomes a reality in everyday mental health nursing practice.

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P 181: A VOICE TO BE HEARD - SERVICE USER INVOLVEMENT IN MENTAL HEALTH SERVICES

Lorcan MARTIN

Historically, mental health services have adopted a somewhat paternalistic approach, the professional deciding what is best for the patient and the patient duly following the advice, taking the medication, etc. (or not). There was little evidence of those using the service having any input into how the service was delivered or developed. Although there

may be times of acute illness when others must take responsibility for the welfare of the patient, generally individuals with mental health problems are not only capable of but enthusiastic in taking part in both their individual care plan and also in the delivery of service in a wider perspective.

In recent times, focus groups and consumer panels have been used in other branches of health care and are gradually being used in the Mental Health area. However, these groups sometimes have limited usefulness as they are often formed to address a particular issue or area of service development. With this in mind, Athlone Community Mental Health Team decided to form a Consultative Group comprised of service users and carers who would advise on service development, raise issues related to patient care both in the hospital and community environment and also feed back to service users regarding new service development, policies, etc.

A number of clients and carers were invited to take part in this group and ultimately twelve agreed to do so. They represented both genders, wide age ranges, different social backgrounds and a variety of mental health difficulties. Training was given to the group in general and more specific training to the elected Chairperson and Secretary (with emphasis on minute-taking, Freedom-of-Information legislation, etc). It was decided that, to allow more freedom of discussion, a member of the Mental Health Team would not attend but would be available at the end of the meeting to answer queries, etc. Formal feedback from the Group to the Mental Health Team would take place by the Chairperson attending the regular management meetings of the Team.

Further explanation of development of the group and issues raised will be discussed.

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P 182: CLIENT INTEREST GROUP

Geraldine KIRK, Eamon McGRATH

This project developed as a result of a client satisfaction survey whereby clients expressed an interest to be more involved in decisions around developments and improvements in their unit. This aim complements the concepts of health promoting in so far as it empowers patients to be have a greater responsibility for meeting their own health needs.

GOAL STATEMENT

Our aim is to promote and foster a culture, which improves client participation in decision-making through a partnership approach.

OBJECTIVES

- To establish a recognised forum which supports open and frank discussion on day centre issues.

- To facilitate identified clients to train in the role as advocate or facilitator to the client group.
- To encourage and facilitate clients in voicing their ideas and participating in discussion, through a recognised forum.
- To identify a communication pathway to enable the free flow of information between service users and service providers.
- To establish a process whereby ideas generated, decisions made and actions agreed can be implemented and evaluated.

QUANTIFIABLE RESULTS

This is a list of the improvements that have occurred since commencing the client interest group:

- Monthly client staff meetings to discuss day-to-day issues and improvements.
- Establishing a suggestion board.
- Improvement in meals.
- Establishment of daily activities board.
- Establishment of health information board.
- Commencement of separate men and women groups.
- Improved identification of Key Nurse.

CHANGES MADE

- Setting up of a suggestion board whereby any client can record any idea or issue the want discussed at the next meeting. This board allows for other clients to add their views or ideas to those already made.
- Identifying a client who is interested in facilitating the group meetings.
- Facilitating training for that client with Advocacy Network of Ireland.
- Establishing a forum for meetings to be held and conducted monthly.
- Client representative involvement in the Quality Steering Group.

CONCLUSIONS

The establishment of this group has empowered clients to take a more active role in the delivery of service in the day centre. The service has a more client centred focus because of the partnership approach. Clients are encouraged to have a more responsible role in their own health care needs

FUTURE PLANS

We expect to further build on the partnership approach, and that client involvement in service planning becomes integral part of culture. We expect to replicate this approach in other areas of the Louth Meath Mental Health Service. We expect an improvement in satisfaction ratings in a number of areas, e.g. time spent with key nurse, house keeping issues, range of activities for clients, and client involvement in own care planning.

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SESSION II-6: PAIN FREE HOSPITALS

P 183: PAIN FREE HOSPITAL: FROM THEORY TO PRACTISE

Andrea VENEZIANI, Antonio MOLOSSO, Luisa GAROFOLINI, Brunella LIBRANDI, Isabella FRATI, Franca PICCA, Alberto APPICCIAFUOCO

Two years after our hospital's adhesion to the Pain Free Hospital project PFH, we can define the fundamental elements to build up an itinerary which gave concrete and encouraging results.

- Joining the PFHP into an group of initiatives of Health Promoting Hospitals network HPH supported by Tuscany Region, empowered an additional authority to this plan.
- Constituting the PFHP Committee, different leading professional figures, belonging to several distinct areas are been involved, choosing elements greatly motivated, with a pivotal role in their environment to strengthen the initiative.
- Training, fundamental element to obtain a cultural and attitude change toward the patient's pain, was structured on these essential points:
 - Planning strictly specific objectives related (improving of the interdisciplinary communication, patient's needs anticipation, pain measure and treatment anywhere the pain score is >3, safety care of the patient).
 - Multi-professional involvement of all sanitary staff participating to the process of pain assistance, with a mainly participating didactic approach to improve the team spirit and motivation of any different competence.
- Applicative phase: it has been carried out following the educational program so that it could not remain fruitless.

Thanks to the greater sensibility to the problem, pain began to be considered and systematically measured like a vital sign in any surgical ward. Significant was the role, likewise in an Acute Pain service already tested model (Rawal N, Berggren L. Organization of acute pain services: a low-cost model. *Pain*. 1994; 57:117-23), carried out by an assigned and dedicated nurse co-ordinating the pain control, with an educational role and facilitating the application of the therapy and the pain measurement. The obtained data show that by means of a progressive and now systemic pain recording pain score has been reduced significantly in any surgical ward with a considerable increase of analgesic drugs consumption.

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P 184: PAIN FREE HOSPITAL PROJECT: HOSPITAL EXPERIENCE IN EASTERN EMILIA-ROMAGNA

Lorella MOZZONI, F. RUGGERI, Mariano BARBERINI

Taking care of patients who need assistance means to consider illness not only as a biological event but as an experience of life too, with aspects of physical and psychological pain, often not correctly evaluated.

In these years, the improvement of pain treatment has acquired great importance in clinical practice, although it is clear that pain control in suffering patients is poor in many hospitals and at home. Therefore, many projects have been developed for improving the approach to the problem of pain.

Some years ago, the American Pain Society published guidelines that emphasized the need of recognizing and treating pain immediately, spreading information on the use of pain drugs and informing patients on the importance and chances of the treatment of it.

Acute pain is not only a postoperative problem: it is a real situation in many clinical situations. Our target is to create a team in our hospitals for treating pain in accordance with international guidelines. The management of acute and chronic pain is based on systematic reviews of the most important randomised trials.

THE PROJECT IS DIVIDED IN THREE PARTS:

The first objective is to improve the comprehension, the valuation and the treatment of pain in patients admitted in our hospital, in order to create a favourable climate of opinion and involve clinical staff with the help of refresher courses.

The second point is the creation of the "painless hospital" team, the elaboration of well-accepted protocols of therapy, the evaluation of pain and pain trends by scales, the monitoring of pain (with the use of VAS or other indexes) and the report of collateral pharmacological effects of drugs.

The third time is used to plan periodic meeting for studying data and identifying mistakes (technical and administrative). It is important to correct them and then it is necessary to choose a model, extending it to all operative units.

This operative work began only few months ago and the first results are encouraging. Our opinion is that the basis of successful pain management is education, not new drugs or high-tech delivery systems. However it will be necessary a long way to get good results (in ethical and cultural sense), founded on strong guide lines.

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P 185: DATA SHARING ON THE USE OF ANALGESICS AS A TOOL FOR EFFECTIVE PAIN MANAGEMENT. THE EXPERIENCE OF THE HEALTH CARE TRUST OF TRENTO-ITALY

Maria Grazia ALLEGRETTI, Enrico BALDANTONI, Giovanni Maria GUARRERA, Michela MONTEROSSO

INTRODUCTION

Despite the fact that the World Health Organization has long acknowledged the importance of pain management as a key factor in the quality of care, there are still many barriers and inequities regarding the access to effective treatment of pain. The European Network of Health Promoting Hospital encourages the use of effective assessment tools to achieve greater empowerment of individuals, including professionals.

OBJECTIVE

Describe No Pain Hospital Committee-NPHC intervention to enable networking for appropriate pain management in the 7 Hospitals of the Health Care Trust of Trento using the ATC/DDD system for drug utilization studies and results from patient satisfaction survey, with sharing of data from both tools.

METHODS

Pain is defined as an unpleasant experience that reflects a combination of sensory, affective and cognitive responses. The use of effective analgesics (i.e. opioids) can be seen as a proxy indicator of good clinical practice. In the time frame 2002-2004 NPHC has undergone a survey on analgesics use through the implementation of the Defined Daily Dose-DDD model. The DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults. The DDD model allows to make comparisons and benchmarking with and within different settings of care. Patient satisfaction was assessed with self administered ad hoc questionnaires. Data and knowledge sharing to improve professional awareness and overcome sectoral and fragmented approaches was achieved with multimedia tools such as: media exposure (television interviews, press conferences, press articles, seminars), NPHC web site, outreach visits of NPHC committee to all District hospitals, guidelines on pain management.

RESULTS

In the time interval 2002-2003 the consumption of analgesics was 1.94 DDD/100 patients/die in the medical area and raised to 6.32 DDD in the year 2004. In the surgical field the DDD was 1.84 in 2002-2003 and 3.23 DDD in the year 2004. The key factor in promoting the use of analgesics through NPHC guidelines on pain assessment/management and the utilization of Visual Analogic Scale, was the role of the network of Trust Hospitals in the circulation and sharing of information (IT) considering a range of potential strategies. The survey has also showed an improvement up to 20% in patient satisfaction measured with a qualitative scale.

CONCLUSIONS

Clinical governance can be seen as a framework whose contents, looking inside, should allow to see a series of processes for improving quality and ensuring that professionals are accountable for their practices and support what works with dissemination of successful innovations. In this respect, the process of pain management can be seen as a key issue because inadequate pain assessment represents a highly prevalent barrier to effective care. Although individualization of the dose is the key principle in pain therapy, the network strategy of sharing of information seems to be effective in improving pain management through the use of

the same system for drug utilization survey, benchmarking and NPHC guidelines and recommendations. NPHC guidelines on pain management and information from DDD model and patient satisfaction survey show a complex relationship between professionals. Overall the Organization has gained knowledge on such an important issue with a more explicit and shared concern and aim for the achievement of better health outcomes.

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P 186: HOW CAN WE IMPROVE PAIN MANAGEMENT IN A GENERAL HOSPITAL? THE UTILITY OF A FOCUS GROUP

Luciana BEVILACQUA

Four years ago in our general Hospital we started a project to improve pain management: we implemented methods and instruments to measure the pain in our patients; in our clinical records pain was considered as important as other clinical parameters; the guidelines for management of surgical pain were implemented.

Last year the commission for a Hospital-Without-Pain has addressed the necessity of continuing the project and involving health operators to improve the approach to pain management. Four Focus Groups turned to 65 participants between doctors and nurses, divided for acute pain and chronic pain area. The focus group is an audit technique with a pathway that foresees: guided questions, identification of a conductor and finally tape-recording of the discussions.

The results of this experience have been analysed with a series of critical states. The more important question is the different point of view of nurses and doctors. Firstly, nurses are always closer to the patient and make no difference between pain and suffering. Doctors have a more technical approach and are able to answer to pain preferably with drugs. Another important question is the lack of communication between patients and health providers regarding the issue of pain and the organisational structure to solve this issue.

Lastly, the ethical question regarding the management of the dying patients affected by chronic illnesses as cancer, dementia or cardiac or neurovascular diseases. The Focus has allowed us to understand what are the staff's true educational needs and to plan aimed interventions.

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P 187: PAIN-FREE HOSPITAL: IMPROVING THE EXPERIENCE

Sandro SOTTILI

"Pain-Free Hospital" program started in 1999 in San Carlo Clinic, a general private hospital near Milan. This program is continuously updated.

When the program started up the acute pain treatment was the main goal; chronic not malignant pain was the second step, and cancer pain was the final one. Treatment methods are improved and we started with intravenous infusions or peridural continuous infusions pump controlled, then we added more aids as the electric peridural stimulation, and the spinal catheter implants, both devices connected to subcutaneous stimulators or infusional pumps.

Clinic activity was carried on with the organization of clinical courses named "No Pain Hospital". Those CME courses reached the third edition, with a great attendance even from hospitals of Milan and hinterland. Last edition (2004) was addressed to doctor, nurses, physiotherapists and hospital chemists. Last categories were added in compliance with National Guidelines for a "Free Pain Hospital" and Application Manual of Lombardia Region.

In the same point of view the Clinic organizes public meetings about "Pain", in collaboration with municipalities near the Clinic.

The program is done mirroring the HPH spirit, and results will be collected at the end of 2005, in accord with suggestions of a national program named "the Relief Day", controlling the prevalence of pain in the hospital.

The purpose of our program "Fighting the Pain" is the involvement as much as possible of people contacting the pain, in order to fight a common battle against a physical sign who, when not necessary, quickly becomes useless and dangerous.

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P 188: IMPROVED MANAGEMENT OF POST-OPERATION PAIN WITHIN THE LOCAL HEALTH BOARD OF REGGIO EMILIA BETWEEN CULTURAL CHANGES BY HEALTH CARE OPERATORS AND PATIENT EMPOWERMENT

Antonella MESSORI

The Emilia Romagna Region launched the "Pain-free Hospital" project being aware of the delay and shortcomings related to such an important health issue from an ethical point of view and in terms of quality of service. The Local Health Board of Reggio Emilia participated by developing a project to improve post-operation pain management.

PURPOSE AND AIMS

To draw up and implement a model of best practice based on "EBM", capable of changing the cultural approach of operators and implementing patient empowerment meas-

ures.

METHODOLOGY/ACTIONS

The Health Board set up a "Pain-free Hospital Committee", a multi-professional working group composed by medical doctors and nurses, which drew up a guideline, protocols for pharmacological treatment, an operating procedure, and instruments used to manage the nursing process and to inform and involve the patient. The latter consisted in an information leaflet to be explained and given to patients before being admitted to hospital and a questionnaire to be compiled before discharge that was used to evaluate the results from the patient's point of view.

Initially, the opinion leaders of the 5 hospitals in the Region were informed, and then a training course was held for all doctors and nurses in the surgical departments. The course was attended by 334 operators. Training was provided in small groups using interactive methods, with frontal interventions, the use of films, talks given by experts and by a psychologist, focusing not only on technical contents but, above all, on increasing awareness of operators and on relational methods of active involvement of patients as an essential element for guaranteeing the efficacy of results. The implementation process started in December 2004.

MAIN TARGET

- Final target: patients who underwent an operation (to minimise post-operation pain as much as possible, making patients active and aware).
- Intermediate target: health care operators (to achieve a cultural as well as technical change, prior to adopting measures of best practice and patient empowerment).

RESULTS EVALUATION AND CONCLUSIONS

An evaluation of the training process was carried out with positive results. Evaluation of implementation results of the project has been planned by making a sample study of medical records and patient empowerment through questionnaires filled in by patients before discharge.

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P 189: NON NEOPLASTIC CHRONIC PAIN: AN ORGANIZATION PROPOSAL

Caterina AMADUCCI, Tiziana FRATTI, Tiziana FARAONI, Lucia TURCO, Maurizio PIERI

Non neoplastic chronic pain is for most synonymous of musculoskeletal pain representing a pervasive and debilitating condition in our culture, causing untold pain, disability, and just downright inconvenience. Possibly because low back pain, migraine, or a sore neck are not life-threatening, we tend to think that they are just a fact of life for which we expect no cure, and only little relief.

Furthermore pain lasting for years leads the patient to depression creating a vicious circle. This conditions have enormous economical and social costs.

In our hospital have created service for outpatient to treat-

ment of non neoplastic chronic pain. The ambulatory is open 12 hour weekly. About 80% of people that referring to us are affected by low back pain, the others present cervical pain, headache, polyarthritis (rheumatoid arthritis, LES, ankylosant arthritis), herpes zoster or neuralgia.

The most of our patients are aged and with many concomitant pathology (diabetes, obesity, hypertension, etc) and have a great pharmacological load (anticoagulant, antiarrhythmic drug, antidiabetic etc.) that don't permit the common invasive or pharmacological therapy. In many cases the musculoskeletal pathology is long lasting treated by every pharmacologic and non pharmacological means with many side effects.

For these reasons we have preferred a soft approach based on mesotherapy with diluted local anesthetic and homeopathy associated with physical therapy. Our aim is not only a temporary relief of pain also cure the disease. In three years of activity we treated 312 patients with good results both in pain reduction than in psychophysical wellbeing. In many patients concomitant pathology showed improvement because homeopathic treatment has direct to patient and no to disease, we can define a "side effect" of therapy. The service has become a point of reference for many patients suffering of musculoskeletal pathology.

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P 190: NURSE'S ATTITUDES AND APPROACHES TO PAEDIATRIC PAIN MANAGEMENT.

Jennifer CRENNAN

The objective of the study was to explore the attitudes and approaches used by nurse's to assess and effectively manage paediatric pain.

Effective pain management involves the use of an appropriate assessment tool, reflecting the cognitive, developmental and psychosocial needs of the age group been cared for.

A review of the literature clearly identified that the majority of nurse's do not use an assessment tool to assess paediatric pain, instead they rely on their own judgement, professional and personal experiences to determine their patient's level of pain.

A likert type questionnaire adapted from a previous study was used to assess nurse's attitudes and approaches to paediatric pain management for this research proposal.

The findings of the literature review and the authors previous experience clearly indicated the need to introduce a paediatric pain assessment tool into clinical practice.

In August 2004, the author introduced the Wong&Baker FACE assessment tool. This chart was successfully piloted and evaluated in one clinical area over a six week period.

It resulted in paediatric pain been effectively assessed and treated.

As a result of these findings, The Wong&Baker FACE pain assessment chart is now used in all clinical settings involved in caring for children in this health care Institute.

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P 191: PAIN-FREE HOSPITALS AND HOSPICE: A NEW DIMENSION OF CARE IN THE EMILIA ROMAGNA REGION

Stefano LIVERANI

The Palliative Care and Pain-Free Hospital programmes have now become an established part of the Region's social and healthcare policies for health promotion. Pain control represents an important aspect of care, and an essential value for a healthcare system committed to promoting quality of life, including, above all, those who are facing the final stage of their existence.

Increasingly effective therapies and techniques are now available, thanks to progress in the social and medical fields. Nevertheless, the success of these programmes is tied to cultural change, granting "visibility" to the pain that paradoxically, though it constitutes the most frequent motive for access to outpatient clinics, is at times underestimated due to enduring myths about morphine and qualms and difficulties in facing the overall issue of pain in all its psychological, social, and spiritual aspects.

The goal of this report is to present the programme and the early results that have already been attained. To summarize, in Emilia-Romagna there are already 10 Hospices in operation, working to complement home care services (ADI) and healthcare and social service facilities.

The work of the Pain-Free Hospital Committees (COSD) is planned, coordinated, and monitored (through indicators) to support the organisational changes needed in order to apply the Guidelines and Recommendations regarding postoperative pain and oncologic and non-oncologic chronic pain. Moreover, recommendations have been outlined for controlling pain from medical and surgical procedures at the paediatric age.

The results of the second epidemiological survey, conducted on 9/6/2004 on the occasion of the National Pain Relief Day in order to assess how pain is perceived by patients in public and private hospitals, provides useful data for evaluating early results and the problematic issues that have emerged, enabling to implement improvements. Continuous training for healthcare personnel and volunteers, along with information aimed at patients and at the general public, are changing patient expectations regarding improvements in pain control procedures, towards healthcare offering more technical and professional skills, and greater humanity

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P 192: BENCHMARKING STUDY CONDUCTED IN MORE THAN 100 PAIN THERAPY CENTRES IN ITALY, IN ORDER TO FACILITATE THE PATIENT FLOW

Giancarlo CARUSO, Angela CASTELLARI, Giovanni PENNA, William RAFFAELI

DESCRIPTION

As far as pain culture and its treatment in our country is concerned, there are many critical points.

Many of these are due both to a lack of connection and sharing of the protocols and guidelines between the different centres involved in this therapy field, and to a medical behaviour that considers the pain only as a symptom.

The pain treatment is not a pitiful act to address only to patients without any hope, but it is a patient right and a must for the people taking care, at all level, of them. It has been proved that chronic pain must not be considered only a symptom but an illness by itself related to modifications at neurophysiological level as happens under certain circumstances when acute pain is not properly treated.

Pain must be considered as the Fifth Sign of life, together with blood pressure, cardiac activity, breath and temperature because it represents one of the major problem of the public welfare both for the paediatric and adult population with invalidity and high disability costs.

AIM AND OBJECTIVES

Detect and give a better welfare flow for the patient in the Pain Therapy Centre.

METHODOLOGY

At the end of 2003 a Benchmarking study started involving 111 Centres of Pain Therapy from different Italian regions. The main aim was to analyse different aspects in order to create, according to a welfare promotion of the Italian Hospitals, synergy, collaboration and interface between the different Centres of Pain Therapy in Italy. These Centres, already engaged in COSD flow (Hospital Without Pain Committee), created an association named FederDolore. During 2004 many evaluation studies have been carried out and at the end of 2004 the results have been approved by SIAARTI. This study investigated different items such as:

- Centre structure
- Organization
- Equipment
- Type of treated patients
- Quality of cure and respect of the Guidelines
- Identification of Centres of Excellence.

TARGET

- Patients with pain
- Specialists in Pain Therapy

RESULTS

The collected data allowed to create a "mapping" of the activity status of the Pain Therapy Centres, creating a Net, and shared objectives and protocols.

A few improvement flows have been detected for the patient:

- Creation of a list of Reference Centres and sharing of

the common protocols.

- Send the patient for treatment at a Pain Therapy Centre close to its house, after communication to the reference people of the structure of the patient status and treatment;
- Detect the centres where particular techniques are carried out with experience and in a proper way. Send the patient, if so agreed, in this Centre after the necessary agreements, communication and sharing to apply the methodology.
- Connection between the different centres to handle and control implanted medical devices (e.g. permanent venous central catheters, peridurals, subarachnoid and all medulla stimulators when adequate technological equipment is available) in order to avoid patient referral to different structures or centres.

This flow will assure high quality management of the patient and quality improvement also for the pain therapist in terms of:

- Consciousness and awareness, potential or limits.
- Constant check of the actions flow, definition of needs and adoption of improvement processes.
- Constant benchmark with identified centres of excellence.
- Cultural and experience exchange not only during the periodical meetings but also during stages in different centres.

EVALUATION OF THE RESULTS

The data collection provided a large amount of information showing several differences within centres.

Improvement processes have been designed according to priorities to face the identified critical areas in order to grant a better cure to the patient suffering from pain.

The most important step was to have all the Centres in network, following a common cultural approach.

CONCLUSIONS

The study highlighted the patient unmet needs despite the previous treatment. The study supported the creation of a network aimed to applying agreed procedures and developing constant communication flow among the centres during daily practice and as well as during periodical meetings.

Next steps, at least for some centres, include the interaction with GP's and others Specialists to share a multidisciplinary approach to the suffering patient.

As matter stands it will be necessary to detect the proper actions to complete the network and make it effective

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SESSION II-7: HEALTH PROMOTING INTEGRATED CARE

P 193: COORDINATION OF HOSPITAL DEL MAR OF BARCELONA WITH PRIMARY CARE

Marisol LOPEZ JIMENEZ, Rancho GOMEZ DE TRAVESEDO, Juliana Esquerro RIBAS, Cristina INIESTA

OBJECTIVES

To improve coordination and continuity between health care levels as well as accessibility and resolutive capacity in the primary care setting.

RATIONALE

To provide hospital-dependent specialised care to seven primary care centres in order to improve efficiency and to rationalise the process of care.

METHODS

A total of 10 specialties from our hospital (Cardiology, Rheumatology, Trauma, Digestive, Endocrinology, Urology, Gynaecology, ETN, Pneumology, and Surgery) and three from other centres (Dermatology, Ophthalmology and Mental Health) are becoming integrated in a step-by-step process. Specialists physicians visit the primary care centres for the care of patients and to provide advice to family physicians.

DESIGN

Hospital-primary care team work in order to identify the needs of specialised outpatient care and prioritising according to the following criteria: possibility to increase the problem-solving capacity of primary care physicians, high demand for particular specialties, possibility to introduce specialists as consulting professionals for general practitioners.

RESULTS

Two periods are evaluated and data regarding pre-implementation (1997) and post-implementation (2001) activities are compared. A total of 1075 patients/day were attended in the outpatient clinic of the hospital. Specialists attended 533 patients/day in the different primary care centres.

- As a result of the implementation of the process, family physicians' referrals to specialised care decrease by 16%.
- On the other hand, the frequency of repeated visits for specialists decreased by 21%.
- Referrals to hospital care decreased by 31%.
- The hospital has fidelised the population with an increase of discharge rates of 23%.

CONCLUSIONS

The availability of specialists in the primary care setting has allowed re-designing more efficient patients' circuits for the hospital, protocolise with the family physician the care of the most frequent conditions. As a result, primary care indicators improved as well as the quality of referrals to in-patient care.

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P 194: PROTECTED DISCHARGES IN INFECTIOUS DISEASES OPERATIVE UNIT

Cristiano CARBONELLI, Loredana CERULLO, Annamaria GIAMPIETRI

The Infectious diseases unit, finding evident difficulties of a safe re-insertion of the patient at home, has studied as other hospital structures a pathway of protected discharge addressed to the problematic patients showing:

- A worsening of self-sufficiency or the loss of self-sufficiency.
- Rehabilitative needs that couldn't be born by the family.
- Problems in linguistic and cultural comprehension.
- Patients without a home or in clandestine conditions.

THE PROJECT, STARTED IN 2001 AND STILL IN PROGRESS, FORESEES:

- To guarantee the therapeutic and assistance continuity between Hospital and Structure.
- To provide to the operators an homogeneous way of managing.
- To create pathways that better answer to citizens/users needs.
- To increase the filtering capacity of the improper hospital admission (consequently the reduction of admissions and of hospital expenses) and a better use of beds availability).
- To spread "good health" practices to live at best in one's own environment reducing uneasiness of admission.

INDICATORS AND RESULTS

- Record of the inefficiencies by patients/families/operators involved in the discharge
 - The gold standard, meaning the lack of signals, has been achieved 100%
- Users' satisfaction in protected discharges, was studied by an hospital satisfaction questionnaire
 - The gold standard was the achievement of 100% of satisfied users, against 96.2%
- Number of re-hospitalization in 3 months from the last admission in hospital.
 - The gold standard was the reduction of 90% of the rehospitalization. In 2001 it was recorded a positive shift of 3.1% from the standard, while in 2002 and in 2003 it was recorded a negative shift respectively of 5.8% and of 16.2%.

The first data collected show an increase in the use of the protected discharges procedure: in 2001 the discharged patients following this procedure were 29, in 2002, 57 and in 2003, 61.

The protected discharges procedure, every time that it's has been used, has given a high users' satisfaction and has permitted a better management of the patients with a high medical complexity.

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P 195: INTERDISCIPLINARY PATIENT-FOCUSED DISCHARGE PLANNING: BRINGING THE PIECES TOGETHER

Marie KEHOE

Discharge planning should commence at time of admission yet many factors inhibit effective planning and a positive patient experience. Often this is because of the "conveyor belt" approach to health care. This project focused on looking at the patient journey from home to hospital and back to home or continued care, from the patient's perspective. Based on that perspective, the project was initiated to enhance interdisciplinary and interagency working for better patient outcomes.

The aim of the project was to develop a comprehensive co-ordinated patient-driven interdisciplinary process for discharge planning between the Kerry area acute hospitals and the Community.

THE OBJECTIVES WERE TO

- Identify current practice, deficits and appropriate models of discharge planning.
- Ensure the key involvement of the patient in planning his/her discharge.
- Facilitate collaborative working across the hospital community interface.
- Establish appropriate tiered criteria for referral to appropriate services.

A steering group representative of Patients, Carers, Health Board, Private, and Community Hospital Management, nursing, medical, allied health professionals, public health, IT, discharge coordinators and community care services was established. Criteria for referral to discharge coordinator and community care services were developed. The admission tool was modified to incorporate a holistic risk management questionnaire for discharge planning.

To date the results have shown an increased awareness by hospital/community service policy groups of the discharge planning function; increased communication and understanding between involved health care professionals; a decrease in inappropriate referrals to discharge coordinators, and earlier identification of post acute hospital discharge needs.

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P 196: EMPOWERING PATIENTS AND FAMILY MEMBERS DURING THEIR HOSPITAL STAY

Dolors JUVINYÀ, Neus BRUGADA, Rosa SUÑER, Carme BERTRAN, Alicia BALTASAR, David BALLESTER

Admittance to a hospital typically represents a situation of stress and uncertainty for patients and their relatives. In the knowledge that tension can be reduced by receiving the patient well on admission, the hospital implemented an admissions protocol in 1998.

OBJECTIVE

To evaluate the degree of compliance with the admissions protocol and the level of patient and family satisfaction.

METHOD

A transversal study evaluating the admissions protocol on patients admitted to the hospital during 2004. Data was collected twice at six months intervals through a questionnaire administered to the patient or relative in the first 24 hours after admission.

The protocol evaluated both the conditions of the hospital, including the basic elements of the room necessary for their comfort, and the level of satisfaction with and quality of the information given by the nursing professionals to patient and family members.

RESULTS

- Sixty-nine 2004 admissions protocols were studied, 65.7% corresponding to emergency admissions and 34.3% to programmed admissions. Fifty-three percent of the admissions were received by registered nurses and 47% by assistant nurses.
- The degree of compliance with the admissions protocol was 98.6%. The overall compliance with the admissions protocol was 83.1%. One-hundred percent of those surveyed evaluated the treatment received on admission positively.
- Comparison of the typology and the level of dependency of the patients with satisfaction at the information received on admission revealed no significant differences.

CONCLUSIONS

Although the results are satisfactory, the elements with the poorest evaluation related to the information and communication with patients and family members, which while having been observed in other studies, deserve special attention and revision in order to advance in the quality of care provided.

This study has received the support of the Nursing Management Team of the Doctor Josep Trueta University Hospital & Group of Sanitary Care and Health of Nursing Department, University of Girona.

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P 197: TERRITORY AND HOSPITAL, TOGETHER TO QUALITY IMPROVE.

Humberto PONTONI, Ida RAMPONI

The aim of this project is to establish a relevant relationship, in term of patient's follow-up, between Hospital and Territory in order to guarantee the best care for the patient.

- Scientific project manager: dr. Humberto Pontoni
- Project Manager: dott.ssa Ida Ramponi

STRUCTURE

Hospital Medical Management and Heads of Internal Medicine, Pneumology and Cardiology Units; the Medical Management will take care of the planning of the project, while the Heads of the Medical Units will realize it.

EXTERNAL CONSULTANTS

Local Health Unit and GPs (general practitioners) with their Association

PROJECT LENGTH: 30 months

CONTEXT

We find in the literature that the best approach to the patients affected by a chronic disease is to be treated, for a short period as inpatient (in hospital setting) and after the discharge from the hospital followed in terms of medical treatment and nursing at home. This is true for chronic diseases as heart failure, COPD (Chronic Obstructive Pulmonary Disease) and diabetes. The Hospital, the Local Health Unit and the GPs have planned and are performing this project in order to implement the integration between all the involved structures from one side and to the other to respond to patient's needs.

With the aim to respond to the needs of the patients affected by these diseases all the structure above mentioned are working on 3 protocols for diagnosis and treatment of these chronic diseases. In this way we think it is possible to make aware between inpatient, doctors and territory in order to the necessity of an important integration to guarantee medical treatment continuity. With the collaboration of all professional in and out of the Hospital we won't to activate a team to further the health as a precious gift, all things considered, as the financial resources, energy resources and professional resources.

SESSION II-8: SMOKE-FREE HOSPITALS (II)

P 198: "SMOKE-FREE HOSPITALS IN GERMANY - A GUIDE FOR IMPLEMENTATION"

Michaela GOECKE, Peter LANG

Published by the Federal Centre for Health Education (BZgA), 2004

In Germany there are 2,240 hospitals - many of which already have non-smoking regulations in place but only few of them are actually smoke-free.

In October 2002 a stricter regulation regarding the protection of non-smokers at the workplace came into force. Through this new law employers are forced to protect all non-smoking employees from passive smoking at the workplace. This has also to be enforced in hospitals.

In December 2004 the Federal Centre for Health Education presented a new implementation guide for smoke-free hospitals based on existing material. The publication was developed by the Federal Association for Health in Bonn which used its comprehensive experience of consulting companies in their effort to become smoke-free.

The new manual comprises important background information on health risks of smoking and passive smoking, on laws concerning the protection of non-smokers and on recent methods of smoking cessation. The focus of the manual is on a strategy for the implementation of non-smoking regu-

TARGET

Patients with chronic disease (heart failure, COPD and diabetes); the selection will be done according to the severity of the disease.

TYPOLOGY OF PROJECT: Educational

OBJECTIVE

Prepare the protocols for the treatment of diabetes, heart failure, COPD.

INDICATORS

N. of patients treated according to the protocols / total patients n. protocols prepared / n. protocols in preparation.

PLANNING

- Project's stage 1-10-2003 / 30-05-2004
- Implementation (start): 1-06-2004 / 31-10-2004
- End: 1-1-2006 / 31-03-2006
- Means of communication: Consensus Conference with all the structures involved.
- Costs and baching: Euro 39.000,00
- Illustrative materials: CD ROM and others.

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lations in hospitals.

IT RECOMMENDS THE FOLLOWING 8 STEPS:

- Set up a work group.
- Record the smoking situation in the hospital.
- Define a non-smoking policy.
- Offer smoking cessation training programmes for hospital staff.
- Organize an information day in the hospital.
- Offer indoor smoking cessation courses for hospital staff and patients.
- Communicate the activities to the local media (PR).
- Build a network with other hospitals.

The manual addresses employers and employees, i.e. medical, technical and administrative staff. It has been developed for practical work and comprises also model samples for presentations, surveys, letters and articles that can be used by the work group.

With the new manual the Federal Centre for Health Education is promoting smoke-free hospitals. The implementation guide should motivate many hospitals in taking action and should support them in becoming smoke-free.

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P 199: HEALTH PROMOTION IN A SMOKE-FREE HOSPITAL (SMOKING CESSATION, TRAINING, HEALTH EDUCATION). DREUX HOSPITAL - FRANCE.

Florence DA SILVA, Béatrice DECELLE, François MARTIN, Didier DONNEAU

The hospital Victor Jousselin (Dreux - France) is member of the two networks, Health promoting hospitals and European Non Smoking Hospitals since 1997. The purpose of this poster is to demonstrate the complementarity of the two networks by connecting values, methods and actions.

The smoking prevention strategy of Victor Jousselin Hospital is totally based on a health promotion architecture: actions are designed by a multidisciplinary staff at the same time for

- Patients and families (tobacco cessation intervention based on patient education methods, free nicotine substitutes during hospitalization, events for the 31th of may, ...)
- Hospital staff (tobacco cessation intervention during working time, free nicotine substitutes, tobacco survey, training in tobacco counselling)
- Community (health education in schools-social centers-firms; training teachers and nurses in schools).

In 2004, Victor Jousselin Hospital won the national price of the French Non Smoking Hospitals network for its action of training teachers and nurses in using pedagogical tools for addictions prevention based on psychosocial skills development/empowerment.

Moreover, the institutional dimension of health promotion is integrated in the strategy thanks to the implementation of a smoking prevention committee.

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P 200: PLAN OF ACTION FOR A SMOKE-FREE HOSPITAL

David CHALOM

It is essential to keep in mind that the most effective efforts are those aimed at the health-care personnel, parent and teacher target groups. In accordance with the goals of the National Health Institute (Statens Folkhälsoinstitut), the HPH and the guidelines for "Scanian vitality" the hospital hopes to improve health, reduce morbidity and decrease the economic burden that smoking places on it and on the community by the following measures:

- Present the plan of action for approval to hospital management.
- Install clear signs forbidding smoking, including reference to smoking areas, as well as information about a smoke-free hospital, before March 2005. Smoking ar-

reas will be indicated on the hospital maps.

- Present this work to the local and regional press and media during the annual "smoke-free week".
- Plan to stop the sale of cigarettes and other tobacco products in the hospital cafeteria.
- Provide information about a smoke-free hospital on the website and in job advertisements.
- When recruiting, inform smokers about a smoke-free-hospital and nicotine addiction treatment.
- Inform all hospital employees about nicotine's negative effects and treatment for nicotine addiction, the guidelines for an HPH with reference to a smoke-free hospital. This information is also found on the Intranet.
- Physicians:
 - Receive a letter from the hospital's chief consultant, with a brochure and simple tools for helping patients.
 - Report nicotine addiction in the journal system.
 - Register the diagnosis F172 (nicotine addiction) during consultation.
 - Sign standard referrals to the tobacco-prevention group.
- The "stop-smoking doctor" informs expectant parents about the dangers of smoking and available treatment during their social insurance meetings every other month.
- The "stop-smoking doctor" co-operates with the municipality to inform teachers at the beginning of every term about the consequences of smoking.
- Improve co-operation with primary care.
- Extend the plan of action to the rest of Scania through the HPH management.
- Evaluate the work annually.

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P 201: TREATING OF SMOKING ADDICTION IN CARDIOLOGIC PATIENTS IN HEALTH PROMOTION HOSPITAL

Aleksander PREJBISZ, Malgorzata MISIUNA, Jaroslaw PINKAS

INTRODUCTION:

Smoking is the strongest single risk factor of cancer and cardiovascular disease. Unfortunately it is a part of Polish style of life. Due to undertaken in 90's health campaigns and chronic diseases prevention programs, awareness of harmful effects of smoking has risen. According to studies conducted by Institute of Cardiology, Warsaw, Poland in years 1984-2001 the number of smoking men and women practically remained unchanged (50-47% for men and 33% for women). The rise of number of anti-smoking medical advises was observed. They resulted in smoking cessation in only 2.7% of patients. Taken these data together there is rising and urgent need for more complex and efficacious actions to promote smoking cessation in greater number of patients.

AIM

Complex program of treating of smoking addiction in cardiological patients.

METHODS

In 2003, there was a complex program of treating of smoking addiction in cardiologic patients carried out in Institute of Cardiology, Warsaw, Poland. 732 patients were included into the program (54% males, 48% females) based on medical interview, history of smoking addiction, measurement of carbon oxide and strength of addiction and willingness to stop smoking, both assessed by means of questionnaires. In 54% of patients psychological type of smoking addiction was observed. The rest of patients were characterized by pharmacological type of smoking addiction. Among the reasons for cessation, most frequently mentioned were: concern for own's health (71%), financial pressure (41%) and environmental pressure (36%).

After providing with detail medical advice, all patients were treated with bupropion for 7 weeks. During these period patients were secured with psychological support.

RESULTS

In one year follow-up, 31% of patients did not smoke. Among patients who received whole 7-weeks bupropion treatment 47.5% of patient quitted smoking.

Our results indicato that complex programs encompassing medical advice, psychological support as well as pharmacological treatment are effective and purposeful.

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P 202: EMPOWERING STAFF AND PATIENTS TO ACCESS SMOKING CESSATION SERVICE

Jacinta MC AREE-MURPHY

Smoking is the leading cause of illness and death. 50% of all smokers will die from smoking related illness. The Smoke Free Workplace legislation has highlighted the need to support and provide information to empower smokers to quit. Health Status surveys has show that 27% of the population smoke and 80% wish to quit. (The National Health and Lifestyle Surveys: 2003) (North Eastern Health Board. Health Status 2003). World Health Organisation Recommendations 2001 show that smokers should have access to individual and group support to assist them to quit smoking.

AIM

The aim of the service was to provide co-ordinated evidence based information and support to all who accessed or worked in the hospital.

OBJECTIVES

- To recruit a smoking cessation facilitator and provide appropriate training.
- To design a efficient referral system.
- To inform all internal and external stakeholders of the new service.
- To provide brief intervention training to colleagues.
- To ensure that all patient documentation includes clients smoking status and intervention offered.
- To work in partnership with the regional health promotion department.

METHODOLOGY

Information recorded includes date seen age sex has client a medical card pregnant Stage of change the client is at. (Prochaska J, DiCLEMENTE et al 1993) If a quit date set. Minimum follow up is recorded at 2 weeks 3 months and one year. Support is provided as the client requires. Phone contact is provided but where possible follow ups are validated by recording carbon monoxide levels.

This intensive facilitation and follow up has produced the following results:

CLIENTS WHO SET A QUIT DATE

On a regional level each acute hospital in the region has a smoking cessation facilitator with varying hours and the Regional Smoking Rates are (Health Status of the People of the North East 2004):

- National level 2002 Overall rate 27% Male 28% Female 26%
- North East Region 2002 Overall Rate 23% Male 25% Female 23%

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P 203: DEVELOPING AND SUSTAINING A SUPPORTIVE SMOKE FREE ENVIRONMENT IN THE ACUTE HOSPITAL SETTING

Elaine ROBINSON

This comprehensive Smoke-Free Hospital project focuses on Sensitiation, Engendering Support, Informing & Assisting Cessation Efforts, Staff Training in Brief Intervention, Intensive Support, Awareness Campaigns to support local, national, and international events and an incremental approach to creating a smoke free environment.

METHODOLOGY

Area managers and staff were invited to join working groups: to develop action plans and local policies to creating a smoke-free environment, supported by the Smoking Cessation CNS. Group members identified their needs to providing and sustaining a smoke free environment. These included appropriate signage, admission policy changes, patient information, staff training in raising and recording smoking status with patients, information on rationale and workings of a smoke-free policy and referral process: self & patients to Smoking Cessation Service.

The General Hospital Setting went Smoke-Free in Nov. 2003, and the exception to our policy included the Acute and Long Stay Mental Health Units. Our National Smoke Free Workplace Legislation, March 2004, presently lists these services as 'exemptions' for patients or residents of these 'dwellings'.

This project is ongoing, in order to sustain this smoke-free environment the HSFWG have created the following documents: Campus Smoke-Free Policy, Policy Support Leaflet, Policy Audit Tool, and a Non Compliance Tool. Smoking Cessation Services have extended to the wider community. Staff programme has been extended to December 2005.

The Smoking Cessation CNS supports the co-ordination, development and co-facilitates three levels of training in Smoking Cessation regionally, supports the Mental Health Team in developing their comprehensive Smoke-Free project, supports Awareness/ Media Campaigns regionally and works in partnership with relevant stakeholders to promote at every opportunity the prevention, education and cessation of tobacco.

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P 204: DEVELOPING AND SUSTAINING A SMOKE FREE ENVIRONMENT ACROSS A MENTAL HEALTH SETTING

John McCARDLE

INTRODUCTION

The Donegal Mental Health Service recognized the need for the clients of the mental health service to be afforded the same rights as every other citizen in availing of a smoke free environment. The local HPH steering group created a project to achieve a smoke free environment for all staff users and visitors of the Donegal Mental Health Service.

AIMS:

To ensure that the workplace remains smoke free. To promote an awareness amongst staff, patients and visitors of the smoke-free workplace objective. To protect all employees, service users, and visitors from exposure to ETS.

METHODOLOGIES

*Working group - Identification of key personnel in all areas. Awareness campaign; legislation, health effects, policy, plans. Signage. Incremental steps; using progressively restricted smoking areas. External shelters; provided to reduce the effects of winter weather. Communication with patients; meetings and health promotion activities. Staff training; key staff trained in brief interventions. Psychological and pharmaceutical support structures. Policy development and implementation. Audit tool built into the policy document.

ONGOING PROGRESS

The project is ongoing and many of the supportive aspects of the methodology are now in maintenance mode to sustain this smoke free environment. The working group meets every three months to review priorities and create action plans as situations develop or re-develop. Staff trained in supportive brief interventions create individualised programmes for clients. Poster campaigns are renewed regularly. Emphasis is placed on naturally occurring cues e.g. new year, lent etc to pick up on people in the motivation phase of quitting. An ongoing effort is made to create a culture wherein everyone has ownership of a smoke free environment.

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P 205: ROLE OF THE TOBACCO FREE HOSPITALS IN DEVELOPMENT IN KAZAKHSTAN

Kazbek TULEBAYEV, Alma ZHYLKAI DAROVA, Maiya JANGOZINA, Zhanna KALMATAEVA

According to the data of the 2001 National study of behavioural risk factors, 23 % of men and women in Kazakhstan were smoking tobacco, 7.5 % of them were women. There are a homogenous spreading of tobacco smoking in all regions of Kazakhstan, regardless of social status and adherence to national traditions. The problem of smoking among medical professionals becomes important now in Kazakhstan due to the expansion of tobacco smoking epidemic which can be detected from data collected by sociological research on prevalence of smoking among medical workers, their knowledge and the attitude to smoking and an antitobacco policy.

Survey has been lead among physicians and students of medical colleges and academies in pilot regions. 740 respondents were interviewed. There was noted rather high level of the knowledges that tobacco use has casual role in the developing of several fatal diseases. Kazakhstan' professionals have negative attitude to passive smoking, positive attitude to smoking ban and tobacco policy. However, behaviour of medical professionals did not correspond to their knowledges and tobacco attitude. It is established that 28.3 % respondents are regular smokers, including 80.3% men and 6.3% women. Approximately 60% would like to quit smoking. Other situation was marked among tobacco smoking of medical students of 5-6 courses: regular smokers among men was 51.1%, women - 34.1%. Only 55% of students would like to quit smoking.

By support of ACS/UICC Tobacco Control Seed Grant some actions were conducted on reinforcement of the activities of doctors and medical students in involvement them to antitobacco movement

According to legislation, the smoking in many public places is ban, including the public health organizations. For reasons this Law, the Order on amplification of antitobacco activity of medical workers has been developed by us and signed by Minister of Health on April, 5, 2004. It provides smoking ban on territories of the medical organizations, increase of knowledge, development of the help wishing to refuse smoking, expansion of the international projects "Tobacco free hospitals" and "Hospitals promoting health", attraction of international experts in activity on tobacco control in Kazakhstan.

Seminars-trainings on tobacco control and treatment of tobacco dependence, debates and round tables "Medical professionals support the National legislation and the WHO Framework Convention on Tobacco Control in all regions of Kazakhstan", actions of medical students "Realization of smoking ban in public places" were organized. 2500 of medical workers were participants of international competition Quit&Win-2004.

The first National scientific-practical conference "Tobacco or Health" among "Tobacco free hospitals" and "Hospitals promoting health" was held on October 27-28, Almaty. One of the conference outcomes was a declaration signing of National coalition "For smoke free Kazakhstan" creation. This event had got the broad resonance in seal and in medical society.

The first experience of involvement of medical professionals and students in antitobacco activity shows need of the further development of network of the Smoke free Hospitals.

Many of them are a scholastic base for medical colleges and academies. Exactly these hospitals most often are leaders in antitobacco movement.

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P 206: SMOKING PREVALENCE IN MEDICAL INSTITUTIONS OF KRASNOYARSK TERRITORY (RUSSIAN FEDERATION)

Olga KUTUMOVA, Boris GORNYI, Vladimir MAZHAROV

Physicians' role in smoking prevention is great. At the same time they can be in earnest about this process only if they don't smoke themselves. For some last ten years smoking prevalence among doctors has been considerably reduced in the world. Yet, studies conducted in Russia testify to substantial smoking prevalence among physicians of different specialties.

A survey of 500 physicians working in different medical institutions of Krasnoyarsk Territory showed that about 40% of them do smoke.

Almost half of smokers (49.8%) smoke more than 20 cigarettes a day, 26.7% from 5 to 20 and only 23.5% smoke less than 5 cigarettes. Smoking prevalence considerably varies depending on specialty. Surgeons smoke more often (14.3%) than therapists (7.7%) and pediatricians (2.4%).

Smoking physicians deny influence of their behavior on patients. It turned out that 12.5% of doctors never discuss smoking with patients and 34.2% do it only from time to time. Whereas 8.7% of non-smoking physicians never discuss the issues of smoking, 32% do it from time to time and 48% do it permanently.

The majority of smoking physicians (59.4%) wish to stop smoking. People with apparent smoking dependence prevail among them (78.7% against 49.5%). 64.8% of smokers think that giving-up smoking is realizable and confidence of success is in feed-back with the degree of dependence (72.6% against 48.9%).

Thus, the conducted survey showed high level of smoking prevalence among physicians of Krasnoyarsk Territory. It's obvious that prohibition of smoking in medical institutions is insufficient. First of all doctors themselves should realize a complex problem of smoking. It can be achieved by realization of training programmes which illustrate not only scientific evidence of health hazard from smoking but also policy and economics of smoking industry, means of smoking promotion to the market and other issues. Another important direction of activity is rendering assistance to physicians-smokers in giving up this bad habit.

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P 207: PREFERENCES FOR "SHARED DECISION MAKING" AND SMOKING CESSATION IN YOUNG TRAUMA PATIENTS

Bruno NEUNER, Edith WEISS-GERLACH, Tim NEUMANN, Gerda SIEBERT, Claudia SPIES

BACKGROUND

There is a high prevalence of substance use in patients in emergency departments (1). Emergency departments are suitable places for screening and brief intervention in harmful alcohol consumption (2) and smoking, too (3). The outcome of interventions depends on patients preferences for "shared decision making" (4).

Aim of this investigation was to evaluate the „decision making preference scale" (DMP-S) of the "Autonomy Preference Index" (API) (5) in young patients with minor trauma in association with the smoking status.

METHODS

After approval of the local Ethical Committee and written informed consent 527 smokers answered the DMP-S. Patients were additionally evaluated for substance use (smoking ["Heaviness of smoking index", HSI-d (6)], alcohol use ["hazardous alcohol consumption": > 8 points in the Alcohol Use Disorder Identification Test (7)] as well as illicit drug use), and socioeconomic status (8). Half of the patients were randomized to a written brief intervention. After 12 months the smoking status was re-evaluated.

STATISTIC

- χ^2 -Statistic
- Mann-Whitney-U-Test
- Binary logistics regression model

RESULTS

504 (96%) API-questionnaires were analysed, 260 patients (49%) were reachable after 12 months. Of these 208 continued to smoke, whereas 52 quitted smoking. The preferences for "Shared Decision Making" were significantly lower in patients who stopped smoking within 12 months in comparison to patients who continued to smoke. (DMP-S at baseline: 52 (13-92) vs. 46 (12-100), $p = 0.024$). With each higher API-SDM-quartile, a significant increase in degree of smoking cessation was found, independently of the written brief intervention, age, gender, additional substance use, nicotine dependence but not independently from school education.

CONCLUSION

Patients preferences for "shared decision making" are a significant predictor for a change in smoking status, independently from a written intervention, age, gender, nicotine dependency, but not independently from school education. Patients preferences for SDM do not seem to be a relevant confounding factor regarding outcome after screening and intervention.

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P 208: EVALUATION OF A SELF-AUDIT TOBACCO QUESTIONNAIRE IN ALL DEPARTMENTS OF A GENERAL UNIVERSITY HOSPITAL

Bertrand DAUTZENBERG, François BOURDILLON

BACKGROUND

The European self-audit questionnaire enables hospitals to monitor and to review their smoke free policy and to assess the progress towards the achievement of a totally smoke free environment (gold level). A pilot study is conducted to assess the feasibility of a more precise assessment by department.

METHODS

A review of the 34 questions of the one page self-audit questionnaire of European Network of Smoke Free Hospital has been made so as to facilitate the assessment by department. Each question is coded 0, 1, 2 or 3 according to the indications or NA if "non applicable". A pilot questionnaire has been fulfilled during a meeting by the head-nurses and other managers of each department of the hospital.

RESULTS

38 head directors have answered the questionnaire, corresponding to 35 different departments or units.

- We received two answers for three departments, with a 90% concordance of score of individual question. The 5 discrepancies are due to unclear formulation of the question (about tobacco sale inside the hospital), a different perception of the passive smoking exposure and to poor wording of the question. Consequently, there has been a new wording for 3 questions.
- The total score of each department has been expressed as absolute (maximum 102) and as a proportion of the maximum theoretical score after removing of the item "non applicable" in the department. The mean of absolute score is 26/102. The mean of relative score is 33 (because on average of 14 questions is "non applicable"). The rate of "non applicable" is low in clinical department (5%) but high in administrative departments (25%). For a better comparison, all results are expressed as relative (in comparison to maximum applicable score of the department).
- The mean relative score vary with department's specialization from 47% (administrative departments) to 41% (medical departments), 38% for surgical department, 35% for laboratories and technical departments and 12% for psychiatry.
- Data centralisation has showed important variation by department. As an example, minimal and maximal score are 4 and 84 in administrative departments and 11 and 55 in medical departments.
- Analysing individual question (maximum score = 3 for a question), the higher score being in the good availability of smoking cessation facilities for health staff (score 2.1) and in the prohibition of tobacco sale inside the hospital. On the other hand, a lower score has being

noticed in the monitoring (0.03) and in review of smoke free policies. The score on the health staff training is also very low (0.5).

CONCLUSIONS

Minor modifications in the wording of the questionnaire might be necessary. The self audit of tobacco control in hospital's departments is a promising way to increase implementation of smoke free policies and to further implicate and sensibilise the health staff.

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P 209: I LEARNT HOW TO QUIT SMOKING IN THE HOSPITAL

Anna Maria FERRARI, Antonio CHIARENZA, Sandra BOSI, Alessandro VOLTA, Paola BRUNAZZI, Mauro GROSSI, Fabrizio BONI, Massimo PEDRONI

For several years, the HPH project "Smoke-Free Hospital" has been under implementation at the Local Health Board of Reggio Emilia, linked with the Region's anti-smoking project. Its aim is to create smoke-free environments and a community encouraging people not to smoke, using various opportunities for this purpose (school, workplace, hospital). The approach to the tobacco problem during hospital stays is fundamental, not only for patients affected by pathologies that are negatively influenced by this habit, but also for other categories of patients, for visitors, and for staff. More specifically, hospital stays should be used as an occasion for information, education, counselling and start of a giving up pathway, addressed to patients with pathologies that are negatively affected by this habit (patients with heart and lung diseases)

PURPOSE AND AIMS

To awaken patients to the consequences of smoking and the benefits of quitting. To implement an information, education and counselling programme for patients and hospital staff, aimed at encouraging the adoption of healthy lifestyles, in a perspective of partnership with local institutions, schools, primary care services, and volunteer associations (anti-cancer league). To use the hospital stay as a special opportunity for highlighting the smoking problem, and, through the coordinated efforts of hospital doctors and general practitioners, for offering smoking cessation centres and useful recommendations for quitting, in context where the non-smoking attitude is promoted in schools, at work and during free time activities. Finally, to evaluate the results of this combined initiative.

METHODS/ACTION

This project has three main points. The first regards the training of healthcare staff, the second the establishment of healthy environments, and the third the creation of specific health promotion initiatives- "Baby No Smoke" , "Smoke-Free Hospital", and "Community Counselling"-in one of the districts of the province of Reggio Emilia.

- Actions undertaken in the "Baby No Smoke" project addresses to pregnant women: Training courses for midwives, information and education for pregnant women, counselling for smoking pregnant women, cultural change towards smoking addiction, organizational

changes.

- Actions undertaken as part of the HPH "Smoke-Free Hospital" project: Non-smoking signposting and provision of appropriate informational/educational materials in waiting rooms (posters, leaflets, self-help booklets); surveys on smoking habits of healthcare staff; sensitization of department heads in order to supervise the enforcement of the smoking ban and promote complementary educational initiatives in the areas they are in charge of; information and education for patients and staff, training/sensitization course for hospital personnel, identification of tobacco addiction in the medical history of patients with heart and lung conditions and pregnant women, writing it in the medical record.
- Activities undertaken in the "Community Counselling" project: collaboration among all institutions active in the social and healthcare context of the district (Scandiano): schools, workplaces, and healthcare services. Agreement between hospital physicians and general practitioners on a procedure for dealing with patients who smoke. Report the tobacco problem by the hospital doctor to the general practitioner in the discharge letter, referral the patient to a no-smoking centre, recommendation of individual or group counselling to the smoking patient.

PRIMARY TARGETS

Patients who smoke, especially pregnant women, young people, and patients with heart, lung, and artery pathologies.

EVALUATION OF RESULTS AND CONCLUSIONS

The sub-projects are in the implementation phase, and for each of them specific evaluation measures are foreseen.

- Baby No Smoke - percentage of pregnant women identified as smokers in their medical record; percentage of pregnant smokers who quit.
- Smoke-Free Hospital - structural indicators: organizational quality of the project, number of training hours for staff, availability of information material, respect for smoking ban.
- Counselling in Scandiano - percentage of patients with heart, lung, and artery identified as smokers in their medical records; percentage of patients with heart, lung, and artery pathologies whose smoking habit has been reported in the discharge letter for the general practitioners; percentage of patients identified as smokers who enrol in anti-smoking centres or courses to quit smoking.

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P 210: A SMOKING PHYSICIAN. IMPACT ON A HOSPITAL'S REPUTATION

Olga KUTUMOVA, Boris GORNYI, Vladimir MAZHAROV

In conditions of severe competition of goods and services when their quality and cost don't practically differ, reputation becomes an important factor ensuring priority at the market.

One of significant elements of a hospital's reputation is its

personnel. Confidence in the staff and in the hospital as a whole depends in many respects on appearance and behavior of a medical man.

We conducted an anonymous survey among patients of two dentistry offices of Krasnoyarsk, a private and a municipal one. The respondents were to express their attitude towards smoking of the staff.

46% of the respondents from the private dentistry reacted negatively to the staff's smoking, 23% of them were indifferent. At the same time patients of a municipal institution were more loyal to the personnel's smoking. Only 27% of the respondents gave a negative reaction, 38% were indifferent ($p < 0.05$).

Essential differences between the patients from medical institutions of different forms of ownership were noticed while responding to the following question: "Will you entrust your health to a smoking physician?" It turned out that a physician's smoking won't affect the choice only for 17% of the patients of the private dentistry, 41% of the respondents will try to find some other doctor or go to some other clinic. The patients of the municipal clinic who could confide in a smoking doctor were 48%. 19% ($p < 0.05$) reacted negatively.

Thus, a physician's smoking as an important factor for patients. It determines attitude towards staff and the hospital as a whole.

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P 211: SMOKING, PREGNANCY AND THE NEWBORN - TRAINING FOR HEALTH PROFESSIONALS

Maria GIBBONS

BACKGROUND

The European Smoke free maternity initiative is a sub-project of the European smoke-free initiative with specific focus on the maternity setting.

AIM

To deliver a one-day training to health professionals on the skills necessary to assist pregnant women in quitting smoking

OBJECTIVES

- To consolidate participants' understanding of the risks of smoking, particularly passive smoking.
- To explore participants personal values/beliefs regarding smoking/passive smoking.
- To train participants in skills required to facilitate behaviour change among their clients and/or partners.
- To consolidate participants awareness of effective communication skills.
- To follow up trained health professionals and ensure that they are practicing the skills and making appropriate referrals for smoking cessation support.

METHODOLOGY

The HPH Network and the smoke-free hospitals initiative, Ireland, provided training of trainers by an external facilitator on smoking, pregnancy and the newborn. As a result of this training and the resources provided, a one-day training programme for health professionals within the maternity services was designed.

Midwifery management support was vital to this training. A commitment was given by midwifery management to release 6-8 midwives every six months for training.

Commitment has also been given by the School of Midwifery to allow the trainer access to train groups of student midwives while they are in block

EVALUATION

An evaluation of the first two training days has been carried out, exploring issues of content of training day, participants understanding and confidence of facilitating behaviour change and overall participants' views/suggestions on training programme.

RESULTS

Participants considered content, clarity of training, organisation of training, theoretical input, skills practice either excellent or good. Due to parking restrictions, all participants would have preferred a different venue or an earlier start time to ensure parking. The pace of content delivery was considered 'just right'.

Confidence level in facilitating behaviour change had changed in the case of all participants from fair-good to good-excellent.

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SESSION II-9: STAFF HEALTH ISSUES (III): EMPOWERING STAFF FOR HEALTH PROMOTING LIFE STYLES & FURTHER DEVELOPING THE HOSPITAL SETTING INTO A HEALTH PROMOTING WORKING ENVIRONMENT

P 212: COMPLEMENTARY THERAPIES FOR STAFF: EMPOWERING STAFF FOR HEALTHY LIFESTYLES

Jo O'ROURKE, Michele MCGETTIGAN

INTRODUCTION

The management of stress levels was identified as a great need for staff in Beaumont Hospital "Staff Turnover and Retention survey" (Boyle et al 2000). Yoga and massage were introduced into the hospital for staff in 2000. This was in response to an expression of interest by a number of staff.

AIM

To equip and empower staff to manage their stress levels by introducing massage and yoga as methods of relaxation which in turn will bring about a healthier lifestyle.

METHODOLOGY

Participants were given a pre and post questionnaire in order to determine what their exact needs were from these sessions. Greater flexibility, relaxation, stress reduction were some of the wishes stated. Post questionnaires indicated that staff was more than happy with the effects of bringing yoga and massage into their lives. The response was so positive and due to the success of this pilot phase 6 hours of massage therapy (15-30minutes per client) for staff was introduced and a series of regular classes in yoga. The yoga classes run at 5.30p.m. and 6.30p.m. one evening a week. The first class is for beginners and the second for those more advanced. The hospital accommodates the sessions within the hospital building. All sessions are subsidised by the hospital.

RESULTS

The massage sessions are booked out 3-4months in advance. 20-25 participants' sign up for the yoga classes and attendance throughout the sessions is generally good. Feedback after the sessions would suggest that people's expectations were met. The feedback would also indicate

that staff views this initiative as a tool to assist them in maintaining a healthier lifestyle.

RECOMMENDATIONS

Further in depth evaluation.

Staff requested the introduction of Pilates as another form of exercise to help maintain a healthy lifestyle.

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P 213: EURIDICE FUN QUIZ

Roisin DRUGIN, Maria PEEL, Elizabeth MCARDLE

RATIONAL

The role of the Euridice link person is to support their colleagues to understand more about dependencies, and addictions. Addiction can affect work performance. The lunch time fun quiz highlights the profile of the link person based in St. Brigid's Complex and support structures available for staff.

AIM

To raise awareness of addiction facts associated with alcohol, smoking and drugs, in a social setting conducive to networking.

OBJECTIVE

- To raise the profile of the Euridice link person on campus.
- To raise awareness of support structures available to staff re dependencies and addictions.

- To raise awareness of addiction facts associated with alcohol, smoking, and drugs.
- Encourage networking in a social setting.
- Provide staff education in a fun, non threatening setting.

METHOD

The Euridice Lunchtime Fun Quiz was identified as a novel approach to achieve the above aims and objectives. An organising committee was formed to support the link person and ensure maximum participation by staff. Lunch break was identified as the ideal time to engage staff, however the organising committee had to plan the event schedule precisely. The format of the quiz created a learning and social environment. Prizes were sponsored by Health Promotion Department, Primary Care, and Mental Health Services. Each participant was provided with health promotional literature. Teams were mixed and had a cross section of disciplines within the complex. Everyone was a winner on the day with prizes for all.

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P 214: LIFE IS MEANT FOR LIVING: HPH PHYSICAL ACTIVITY STAFF CHALLENGE

Mary Killeen MCCARTHY

AIMS OF PROJECT

- To improve physical activity levels among staff
- To enhance interdisciplinary communication.

METHOD

- Weekly team activity table for nine consecutive weeks.
- Weekly team football league for same time period.

PROCESS

The HPH summer staff challenge extended the concept of the National HPH challenge day to a more meaningful venture. A Physiotherapist had the idea of running a weekly indoor football challenge over a nine week period. Participants also completed an activity record over the same period charting their other physical activities e.g. walking, swimming, gym etc. The idea was enthusiastically embraced by up to eighty staff across many disciplines. An energetic member of the portering staff displayed effective project leadership. Indoor football matches were scheduled on a league basis with ten teams participating, finishing with semi-finals and a fiercely contested final.

The same ten teams also completed an activity record over the same period. Points were awarded according to length of time spent on physical activity. At the end of the challenge winners in the football league and the activity challenge emerged. Prizes were presented on the final night and a barbeque was enjoyed by all. Proceeds were donated to Friends of Nenagh General Hospital an organisation which helps to fund equipment for patient care.

EVALUATION

- A pre and post challenge questionnaire was conducted with a sample group of seven participants by the Cardiac Rehab Co- Ordinator. Increased physical activity levels were maintained up to six months post project.
- A post project evaluation was carried out by the HPH CO-ordinator with clear guidelines emerging for a smoother run next time. The following benefits were listed by participants, improved morale at work, weight loss, fun and fitness, social interaction, friendship and feel good factor.

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P 215: A PROGRAMME FOR IMPLEMENTING A HEALTHY LIFESTYLE IN THE WORKPLACE, AND EXPERIENCES FROM A TRAINING PROGRAMME FOR MEMBERS OF STAFF.

Marit NÄÄS

The programme is a result of research with the aim of promoting health, preventing ill health and motivating employees to change an aspect of their lifestyle and take personal responsibility for their health. The overall goal is to reduce the sick leave for the staff in the local Swedish Health Care.

The method consists of three phases starting with a questionnaire to investigate the staff's state of health, lifestyle and psychosocial work environment. This produces a result at both individual and group level. The next phase is to draw up a plan on preventive measures and finally work with improvements for the working environment. The individual is provided with opportunities to receive support in order to improve their health and lifestyle through the company health service.

A training project, derived from among other things the result of the questionnaire was carried out for staff in an organisation working with rehabilitation.

A training course, comprising five days, was planned, implemented and evaluated by an intra-disciplinary group, which was recruited internally.

The programme covered lectures and practical training/solution of problems. Training was effected mainly by internal members of staff. The actual training highlighted current issues in such subjects as participation, communication and team-work. Opportunities were provided to share knowledge, feelings and experiences.

This training project has been developed in conjunction with the work force, focusing on lifestyle, work conditions and physical elements of risk. It was seen as the beginning of a more open dialogue in the team, and encouraged interest to further develop team-work and learn more from each other. The way this training programme was designed and implemented is an example of how to take advantage of the available skills and forces found in an organisation.

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P 216: AN ADDICTION AWARENESS CAMPAIGN FOR STAFF AIMED AT EMPOWERING STAFF TO TAKE RESPONSIBILITY FOR THEIR OWN ACTIONS.

Jacinta MC AREE-MURPHY

RATIONALE

As part of the criteria for participation as a link person in the 'Euridice' project an undertaking was given to carry out a piece of research with regard to the creation of an awareness culture about addictions in all spheres.

From our interactions with staff in Cavan General Hospital it was clear that many were not aware of the services available to people with alcohol/addiction problems. Many who were aware did not know how to access the services.

AIM

- Primary aim to help staff understand more about dependencies.
- To increase staff awareness of the facts relating to alcohol.
- To increase staff awareness of the services and supports that are available to people with alcohol/addiction problems.
- To get staff "thinking" about their own drinking patterns.

METHOD/ACTION

A questionnaire was drawn up consisting of 15 questions in total. First five questions related to recommended standards in relation to alcohol. The next eight questions related to facts and myths in relation to alcohol. Last two questions asked staff if they knew where to go if they or someone they knew had an alcohol/addiction problem. And who or where they would go to get help.

A "measure up" initiative was also held where staff were asked to pour what they considered to be a recommended measure/unit of alcohol.

RESULTS

- 64% were aware of how much a standard drink measured.
- 70% did not know the recommended maximum number of standard drinks per week.
- 90% thought the maximum number of standard drinks as higher than the recommended level.
- 55% considered binge drinking to be higher than the considered level of 4 - 6 standard drinks at a time.
- 41% did not know where or who to go to for help or what services were available.

CONCLUSION

- Areas for action have been identified.
- Need to increase awareness among staff of recommended low risk weekly drinking limits.
- Need to increase awareness of dependency services.

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P 217: IMPLEMENTATION OF PHYSICAL ACTIVITY FOR EMPLOYEES IN HOSPITAL: TRAINING PROGRAM FOR EMPLOYEES AT RISK OF ACQUIRING WORK RELATED MUSCULO-SKELETAL DISEASES.

Dorte HØST, Thomas LUND-SØRENSEN

INTRODUCTION

Bispebjerg Hospital carried out a study of job satisfaction and health promotion among employees with the purpose of being able to document the most important development areas in relation to job satisfaction and health promotion on the hospital. The study showed, that many employees were physical active in their leisure time, but a significant number wanted help from the hospital to become more physical active. In addition the study showed, that many employees had physical problems from their musculo-skeletal system. Occasionally some employees were absent from work for this reason. One third of employees had many lift- and carry situations during a working day, in particular nurses and their assistants.

Since it is well documented that many lifts and carry situations can result in strain problems in the muscle-skeletal system all employees at risk were offered an exercise program with the purpose of improving their physical baseline capacity and stimulating continuous training.

METHODS

In total, 72 employees completed a 10 weeks training program. The duration of the weekly session were 90 min. 8 - 10 persons attended each class. A condition for attending was, that the employees were willing to do home exercises or other relevant fitness activities twice a week in addition to the scheduled programme. Each class covered fitness training, muscle strengthening and finally a supervised group discussion on health promotion and physical activity.

FITNESS TRAINING

Fitness training was on an exercise bike. The employees trained 30 min. with 75 - 80 % of the individual maximum pulse capacity.

MUSCLE STRENGTH TRAINING

The training program had 5 basics elements (leg exercises, press and pull exercises for the torso, exercises for the low back, the abdominal muscles and shoulder/arm muscles). The training goal was to increase strain aiming at 8RM in set of 3. The exercises were carried out in training machines.

CLOSING SESSIONS

The employee's knowledge with physical inactivity as a risks factor is important and the employees must know the relation between lifestyle and an optimal health. Each training session ended with a discussion of how our body is build up, its function, why and how to train, pain after training, sign of overloading and instruction in ways at reducing strain damaging lift- and carry situation.

OUTCOME MEASURES

The participants self reported pain, sick leave, changes in working capacity with Åstrands "1 point test", muscle strengthen test with strain gauge were monitored. The measures were done before start of the program, at the end, and 2 and 8 month after finishing, respectively.

DISCUSSION

The result of the measurement will be presented on the poster at the conference.

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P 218: WALKING @ WORK

Fiona FALVEY

AIM

To increase the levels of physical activity of staff within working hours

OBJECTIVES

To provide staff with detailed information on:

- Types of walks which can be taken around the 2 sites of Galway Regional Hospitals.
- Information about warm up and wind down techniques

METHOD

- 2 Health Promotion Officers, in consultation with staff from UCHG and Merlin Park devised 6 walks around 3 sites including NUI Galway (which is adjacent to UCHG)
- Staff member drew maps of the walks.

The booklet included:

- Warm up exercises.
- Benefits of walking.
- Diary of exercise (to be photocopied by users).

Launch of the booklet was on Hospital Challenge Day, 2004 and a walking club began soon after in UCHG. (Merlin Park already has an established walking club)

RESULTS

Approximately 20 people are involved in the walking club. The group meets once a week at lunchtime and walk for 20-30 minutes (approx 2km)

CONCLUSIONS

Support comes from the incentive of meeting others.

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P 219: ART @ WORK, GALWAY REGIONAL HOSPITALS

Margaret FLANNERY

Galway Regional Hospitals Arts Committee's aim is to explore the role of the arts in the promotion of healing and well-being through a multi-disciplinary arts programme and through this to promote greater links between the hospital and the community. A first for Galway Regional Hospitals occurred in 2003 when Dr. Sheelah Ryan, CEO, Western Health Board launched the first staff art exhibition, "Art at Work," just one of the many arts initiatives organised by Galway Regional Hospitals Arts Committee. 42 staff members exhibited over ninety pieces in a variety of media - oils, water colour, acrylic, and photography. This was the first of what has become an annual exhibition by staff in both University College Hospital Galway and Merlin Park Regional Hospital in Galway. This is a move by Galway Arts Committee to involve staff of Galway Regional Hospitals in Arts Activities.

OBJECTIVES

- Establishment of an annual Employees Art Exhibition in Galway Regional Hospitals which will allow staff to engage in creative artistic activities which will improve the quality of life in their working environment.
- To enable the staff to work on creative projects that would also improve the hospital environment and make it more attractive to patients, visitors and staff alike.

METHODS

Staff are invited four months in advance to submit a maximum of three works for exhibition in University College Hospital Galway and Merlin Park. Work is then hung for six weeks in each hospital.

RESULTS

- Enhancement of hospital environment.
- Improved working relations among staff.
- Artistic activity among the hospital community.

CONCLUSIONS

This project which now takes place annually was a huge success. Staff were interested in buying each other's paintings and encouraged colleagues to submit work who may never have exhibited before. A questionnaire was circulated and the feedback was very positive. Patients also commented on the improvement to the hospital interior

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P 220: NEW APPROACHES TO REMUNERATION OF LABOR IN THE SYSTEM OF COMPULSORY MEDICAL INSURANCE

Alexander NIKISHIN, Izolda CHEREPANOVA, Sergey SHKADOV, Vladimir MOCHALOV, Alexei VEREMEENKO

Modern conditions of healthcare system stipulate for establishing direct relation of remuneration of labor of medical staff's to final outcomes of their activity.

At the present time introduction of a team labor contract is possible. It's when a team of medical staff allocates the money they earned on their own in accordance with the volume of work which was in fact carried out.

Introduction of a team labor contract follows a preparatory stage which includes:

- Development of a Statute on Intra-corporate Payment and a Statute on a Team.
- Concluding labor contracts between a team and an institution's administration.
- Assessment of team members' labor activity.
- Organization of remuneration of labor in a team.
- Control of volume and quality of team members' work.

Wages fund, planned performance, cost of 1 day in a hospital and cost of 1 visit to an out-patient clinic are determined for each team beforehand.

An average duration of treatment is determined in a hospital. While comparing actual duration of treatment deviations of treatment periods towards reduction by 15% and towards increase by 10% are conceded. Penalty provisions are applied for deviations which exceed the above-mentioned limits.

Cost of a unit of medical services is determined by a special

procedure. The money which the team earned is determined depending on the number of discharged patients and visits to a hospital. After calculating the money for actual time of work the volume of additional financing is fixed. In order to insure non-fulfilment of planned performance a reserve of 10% from the additional volume is formed. After that additional wages fund for allocation is calculated. Additional wages fund is allocated according to three factors: 1) intensity; 2) interchangeability; 3) quality.

After calculating payment it's necessary to verify if the sum of payments for actual time of work and additional wages fund don't exceed the sum of earned money.

The above-mentioned systematic approaches are steps in the process of taking decisions in respect of the number of posts and beds.

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SESSION II-10: HEALTH PROMOTION AS A QUALITY ISSUE & FURTHER DEVELOPING THE HOSPITAL INTO A HEALTH PROMOTING SETTING

P 221: MANAGERS' ATTITUDE ON HEALTH PROMOTION INITIATIVES IN UNIVERSITY HOSPITAL

Lina TOLEIKYTE, Irena MISEVICIENE, Juozas PUNDZIUS, Zemyna MILASAUSKIENE

Health Promotion (HP) is an integral part of all services offered to patients and hospitals have to take an active role in promoting the health of staff, to attract and retain high qualified specialists and improve the productivity and quality of care provided.

The aim of survey was to evaluate managers' attitude on HP initiatives, partnership and demands for HP structures.

METHODS

The study was carried out in Kaunas Medical University Hospital (KMUH). A standard questionnaire was distributed to managers (n=33) of all departments in KMUH. The response rate was 87.7%. The respondents were asked to express their attitudes towards promotion and implementation of HP initiatives in their departments and within hospital.

RESULTS

The majority of managers define HP initiatives as a very wide spectrum of activities including health education programs both for staff and patients, support in creating healthy workplace, continuous quality improvement plans and efficient management of financial and human resources. Although level of awareness of Health promoting hospitals' goals is not sufficient: 64.3% are only partly acquainted. The majority of the respondents (88.9%) noted that specific structure responsible for coordination of HP activities in hospital should be established. A public health specialist was considered the

most relevant person for implementation of HP initiatives but the role of physicians and nurses in HP was acknowledged too. Other hospitals, rehabilitation centers, municipalities, NGO's of patients', physicians' and governmental institutions were marked as important partners for collaboration and implementation of HP initiatives.

CONCLUSION

Managers of all KMUH departments approved the necessity of implementation of HP initiatives, development of health promoting management structures within hospital and involvement of significant partners. These activities would lead to a better health of staff and patients and better quality of services in hospital.

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P 222: HANDHYGIENE - BACK TO BASICS

Teresa SEXTON

Hand hygiene often previously referred to as handwashing, is critical in the prevention of health-care associated infections by reducing the incidence of cross -infection. The hands of

Health care workers (HCWs) become heavily contaminated with organisms whilst caring for patients. These organisms may survive for several hours thereby allowing transfer to other patients or contamination of the environment and invariably causes a hospital acquired infection (HAI). These infections are a cause of significant mortality, morbidity and financial cost the healthcare system.

Handhygiene is the single most important measure in preventing a HAI however, poor compliance has been repeatedly acknowledged (Larson 1999, Pittet 1999). Scientific evidence supports the use of alcohol hand gels as effective tools to overcome the obstacles associated with poor hand hygiene compliance. To improve compliance of hand hygiene among HCWs, a handhygiene campaign was put in place focusing on the promotion of alcohol hand gels. Successfully incorporating alcohol hand gels into routine clinical practice will positively impact hand hygiene behavior, thereby improving patient safety and quality of care and reducing the financial and human costs associated with hospital-acquired infections.

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P 223: RISKS COMMUNICATION FOR STAKEHOLDERS

Giovanni MORINI, Dorella COSTI

SHORT DESCRIPTION OF PROJECT

Due to its size and content, the current risk assessment document is not easy to consult, and in any case, is not suitable for widespread distribution.

Therefore, in order to respond adequately to new regulatory requirements, a tool had to be developed to communicate the risks and preventive measures adopted by the Health Board, addressed to new employees, external people working at the Health Board, and the general public.

PURPOSE AND AIMS

Get workers involved in the development of strategies and the practical implementation of procedures aimed at improving workplace safety, through familiarity with the primary risks present in the many different work environments of the agency. A brief memorandum about workplace risks emphasizes the importance of taking measures to reduce some risks by encouraging appropriate behaviour; moreover, it allows what has been developed to be compared with what is objectively needed. It is essential to foster worker empowerment through an information programme which facilitates change and participation, focusing on risk factors which can be effectively acted on, and emphasizing the role of protection factors such as safety equipment, training, health monitoring, and appropriate behaviour.

METHODS/ACTIONS

A document has been created in order to communicate risks and containment measures adopted, and is supplied to each new external company working at the Health Board and to each temporary worker. Newly hired employees are provided with the information brochure during the training course included in the personnel orientation programme, which explains the organization, activities, risks, rights, and responsibilities. The staff is also kept involved through the prevention

and protection service, which accepts suggestions and acts in regard to specific reports, as well as through periodic information and training initiatives.

PRIMARY TARGET

New employees, employees of external companies operating at the Local Health Board of Reggio Emilia.

RESULTS EVALUATION AND CONCLUSIONS

The information document on "job risk management", containing information about general risks related to health board activities, containment measures, telephone numbers, and the e-mail address for contacting the agency's safety technicians, is included as an integral part of contractor agreements, ensuring that this information is circulated. When necessary, a meeting is held to emphasize specific elements.

Each newly hired employee receives a copy of this document, as an initial guide to the risks and safety procedures adopted at the health board.

The transition from a weighty technical document, with a risk assessment focused on facilities and plant systems, to an information tool aimed at developing communication and collaboration between workers and the prevention service, has led to reciprocal cultural enrichment and the development of a common language

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P 224: BLOOD DONOR'S RECEPTION PROCEDURE IN THE NUOVO SAN GIOVANNI DI DIO HOSPITAL IMMUNE-HAEMATOLOGY AND TRANSFUSION MEDICINE SERVICE

Alberto APPICCIAFUOCO, Silvana ARISTODEMO, Maria Loredana LORNO, Franco VOCIONI, Brunella LIBRANDI, Isabella FRATI, Rosalba GUADAGNO

Azienda Sanitaria di Firenze has been taking part in the HPH network since 2002. A Sub Group supporting HPH policy in "Blood Donor Reception and Care" was created within NSGD Hospital, Immunoematology and Transfusional Medicine Service (ITMS).

One of the main objectives of the HPH Group is to communicate and inform the community about blood donations process in the ITMS, making people aware of blood donation steps and procedures through printed leaflets and posters.

The following is the blood donor's reception procedure which includes common actions as well as diversified steps both for the periodical donor and the new donor.

NEW BLOOD DONOR'S RECEPTION

The new donor goes to the Immune-haematology and Transfusion Service (ITMS)

- ITMS's secretarial staff give the new donor a printed leaflet about blood donation.
- A ITMS's physician explains donation procedures and aims to the donor.

- The donor reads educational materials describing AIDS and other infectious diseases that could be transmitted by transfusion.

PERIODICAL BLOOD DONOR'S RECEPTION

The periodical donor receives the ITMS invitation or spontaneously goes to the ITMS

COMMON PROCEDURE

- The donor fills in the case history form.
- A drop of blood is taken from the prospective donor's finger to measure the level of haemoglobin (if a low haemoglobin is found the donor is temporarily deferred).
- An ITMS's physician visits the donor and evaluates the case history form (possible further specific diagnostic exams - i.e. ECG etc. - in case of temporarily deferred donation).
- If the donor is qualified for blood or plasma donation he/she goes to the donation area.
- The blood draw is executed by a skilled specially trained medical staff-person.
- After donation the donor is asked to take to rest and receives important advice on post-donation behaviour.
- Donors will be given a formal document in order to justify the time take off at work.
- Donors will be provided with refreshments at the local hospital café.
- Exams results are mailed to the donor's main address by first class mail (in case of abnormal levels, donors will be alerted by phone by a member of medical staff).

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P 225: METHODOLOGICAL FRAMEWORK FOR EVALUATION RELATIONSHIP BETWEEN HOSPITAL VOLUME AND OUTCOMES

N. DUCINSKAS, D. PAVALKIS, Irena MISEVICIENE, Juozas PUNDZIUS

An increasing number of studies suggest that patients who have surgery at hospitals or by surgeons performing a high number of the particular procedure they need (high-volume providers) do better than patients who have surgery at hospitals or by surgeons doing fewer procedures (low-volume providers). Hospital volume can be considered as expression of the hospital experience in particular surgical procedure. Hospitals that treat a relatively high volume of patients report lower surgical in-hospital mortality rates than hospitals with low volume of the procedures.

Objective was to analyze recent literature dealing with relationship between hospital volume and outcomes and to estimate the methodological framework for evaluation volume and outcomes.

Recent literature was studied in the way most published volume-outcome studies have done. 57 studies from January 1999 to December 2004 for English-language have been

searched (Medline). Population-based studies examined the independent relationship between hospital volume and clinical outcomes. 71% of all studies reported statistically significant associations between higher volume and better outcomes. The strongest associations were found for surgery on pancreatic cancer, esophageal cancer, abdominal aortic aneurysms, and pediatric cardiac problems (a median of 3.3 to 13 excess deaths per 100 cases were attributed to low volume).

Although statistically significant, the volume-outcome relationship for coronary artery bypass surgery, coronary angioplasty, carotid endarterectomy, other cancer surgery, and orthopedic procedures was of much smaller magnitude. Highest differences in postoperative mortality rates reaching 5 times increase were found in pancreatic resection and esophageal resection groups. The volume-outcome measures of the studies varied. Despite differences in outcome in all high-risk surgical procedures, methodological framework estimated mainly on significant strongest association in pancreatotomy, esophageal resection, non-ruptured abdominal aorta repair and in main cardio surgical procedures, nevertheless hospital volume has influence not only on mortality rates, but to other indicators of the surgical quality of performance, namely on postoperative morbidity, functional outcome and in cancer surgery - long term survival etc.

Estimates should be adjusted for age, sex, and co-morbidity and accounted for hospital level clustering. Policymakers should focus on common procedures before less-common, high-risk operations. With the designated referral center approach, policymakers would select a single or limited number of hospitals allowed to perform specific procedures within each referral area. This approach focuses on high-volume centers and on which hospitals can do selected procedures. Publicly reported volume outcomes data will help to improve quality of hospital care and health literacy of future patients. The patients will find out which hospital to chose and they will know how to evaluate hospital volume outcome.

CONCLUSIONS

High volume is associated with better outcomes across a wide range of procedures and conditions, but the magnitude of the association varies greatly. The clinical and policy significance of these findings is complicated by the methodological shortcomings of many studies. For selected cardio surgical, vascular and surgical oncology procedures volume standards - methodological framework have been estimated and proposed way for implementation of this frame as pilot study Hospital of Kaunas University of Medicine and later transferring to Lithuanian Health Promoting Hospitals Network.

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P 226: PATIENTS' ASSESSMENT OF THE QUALITY OF HEALTH CARE IN KAUNAS MEDICAL UNIVERSITY HOSPITAL

Odeta BALTIKAUSKAITE

High quality of health care services is one of the main aims of the organizations and includes many aspects of services provided. The opinion of clients is very important in the process of quality improvement. Patient's satisfaction is used as an indicator of quality of health care in the hospital.

THE AIM

The aim of this survey was to investigate patient's satisfaction with the quality of health care services in Kaunas Medical University Hospital (KMUH).

MATERIALS AND METHODS

The survey was conducted among the patients treated in 31 department of KMUH. The questionnaires were distributed in all the departments at the same time and when they were filled out, the same administrative workers of the departments collected them. Questionnaires were not given to the patients who were hospitalized on that day. Out of 1426 questionnaires, 872 were filled out; that is 61.15% of the patients responded. According to the standard questionnaire the patients were asked to evaluate the quality of health services: physical and internal environment in hospital as well as nurses and physicians' performance of their duties.

RESULTS

Most (93%) of the patients were introduced to the hospital's rules. Every third patient (38%) evaluated neatness and physical environment in the ward as excellent. Every second patient (50%) noted that the quality of food is good, but almost every third patient pointed out insufficient food supply and every fourth – that hospital food lacks vegetables. While analyzing patients' satisfaction with doctors' (95%) and nurses (96%) behavior, the majority of the patients were found to evaluate it as very good or excellent, but every second patient noted that want to know more about their health and illness and want to help more themselves.

The majority of patients indicated that doctors and nurses always or frequently communicated with patients and explained them about medical and nursing procedures. Most (87%) of patients evaluate internal atmosphere of hospital positively because they feel safe in the hospital, medical staff is serviceable for the patients and their visitors.

CONCLUSION AND OUTCOME

- Majority of patients treated in KMUH assessed quality of health care positively.
- To develop the patient information about their diet, health, illness and procedures.
- To provide nutritional information and health education to the users, their family members and the health care workers.
- To increase the role of medical staff in health promoting hospital: to show confidence to the patient, to interact respectfully with the patient, to contribute to patient empowerment, to talk about health in every meeting with the patient.
- Meeting with staff, patients and their relatives to discuss actions that could be taken to improve care.
- Training course for health care staff for the education of peculiarity of communication of patients.
- Analysis on patients' evaluations is a simple partial analysis of quality of health services and is also an objective premise to improve quality of health services.

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P 227: METHODOLOGY AND EXPERIENCE OF CLINICAL AND ECONOMIC RESEARCH IN RUSSIAN HOSPITALS

George GOLUKHOV, Izolda CHEREPANOVA

Conducting of clinical and economic research and using their results while observing the rules of documentary registration and submission from the results serve as a guarantee of reliability and safety of patients' health, protection of patients' and researchers' rights.

METHODOLOGY OF CLINICAL AND ECONOMIC RESEARCH INCLUDES SOLUTION OF THE FOLLOWING TASKS

- Unification of approaches to conducting and utilization of the results of clinical and economic research.
- Ensuring safety, rights and health of people taking part in clinical and economic research.
- Protection of researchers' rights.
- Substantiation of choosing drugs and medical techniques to develop regulations ensuring their efficient application.
- Unification of drafts of basic programs for compulsory medical insurance.
- Development of interconnected clinical and economic requirements for efficiency, safety, compatibility and interchangeability of medical interventions and their assessment criteria.
- Scientific substantiation of developing a unified system of interconnected assessment of clinical and economic indices of medical services' efficiency, determination of science-based requirements for their nomenclature and scope.
- Economic substantiation of updating regulations for the system of standardization in subjects of the Russian Federation, healthcare and medical institutions.

The essence of clinical and economic analysis methodology lies in comparative quality assessment of two or more methods of prevention, diagnostics, drug and non-drug treatment on the basis of a comprehensive interconnected registration of medical intervention results and expenses for its execution. Clinical and economic analysis methodology is applicable to any medical interventions, e.g. drug (pharmacoeconomics) and non-drug methods of treatment, diagnostics, prevention and rehabilitation, in order to determine cost efficiency of their utilization.

Basic methods of the proper clinical and economic analysis include:

- "Expenses - Efficiency" analysis
- "Minimization of expenses" analysis
- "Expenses - Utility"
- "Expenses - Profit"

Subsidiary kinds of clinical and economic analysis include:

- "Illness cost" analysis
- "Modeling"
- "Sensitivity analysis"
- "Discounting"
- "Clinical and economic research"
- "Clinical and economic monitoring" and others

Results of clinical and economic research are aimed at solving the issue of expediency of including theses or those medicines or non-drug methods of treatment in relative regulations for the system of standardization in healthcare. In hospitals of the Russian Federation clinical and economic substantiations of drug or non-drug treatment expediency are taken into account while developing patients' records, list of vitally important medicines, official lists, other kinds of regula-

tions governing scope and structure of medical assistance rendered to the population. Clinical and economic substantiations of these or those medical interventions expediency are carried out while developing methodic recommendations, guidelines, reference books, manuals describing approaches to diagnostics, treatment, illnesses prevention and rehabilitation.

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P 228: NUTRITIONAL EDUCATION AND FIGHT AGAINST HOSPITAL MALNUTRITION.

Carla BERNARDINI

One of Paediatricians' primary tasks is to promote healthy dietary habits in children thus preventing secondary diseases related to incorrect nutrition to appear in adulthood.

Inside a hospital, though, managers, physicians and nurses often fail to pay enough attention to hospital foodage.

Considering this, the Nutritional Department of Meyer Hospital of Florence started in 2003 an educational program on nutrition and correct food habits.

A survey was first conducted to verify the knowledge on dietary habits and common incorrect beliefs. 486 questionnaires were distributed to all staff members, including administrative personnel and 368 were completed. Results showing a fairly good knowledge on basic nutritional facts were publicly discussed during a hospital meeting. Correct answers were published on the hospital intranet for consultation.

A training course was then directed to all staff members who participated massively feeling it as a mean to acquire more knowledge about nutrition principles and thus be able to give competent advices to friends, relatives and patients.

Thematic meetings then followed on topics like Food allergies, Gastroesophageal Reflux, Acute Diarrhoea and Osteoporosis in paediatric age, presented by multidisciplinary professional teams of Radiologists, Ecographists, Surgeons, Dietists, Gastroenterologists. Family paediatricians were invited to attend to reinforce an operative network between the hospital and the territory.

Consensus papers were produced at the end of every discussion and given the audience as a mean of consultation when facing different problems. The same papers will soon be published in a less technical version to be distributed inside the hospital to all patients' parents.

As a first result inside the hospital the meetings produced a deeper awareness on dietary matters and a careful attention on young patients' nutritional status.

Thematic meetings will continue in 2005, since the attention perceived by the hospital personnel upon themselves solicited participation and more themes to be examined.

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P 229: SUPPORT CARERS IN IMPROVING NUTRITION OF THEIR CLIENTS

Pauline DUNNE, Marion DELANEY-HYNES, Grainne FLANAGAN

INTRODUCTION

In accordance with the National Health Strategy, programmes to support caregivers through the provision of informal networks, provision of basic training, and the greater availability of short-term respite care are to be developed and implemented. A nutrition education session, as part of a training programme established in conjunction with Services for Carers Longford/Westmeath and the Carer's Association, has been developed and delivered to Carers.

AIM

To improve nutritional status of clients in their home by supporting care-givers in provision of adequate meals.

OBJECTIVES

- To plan, develop and deliver a nutrition education session to carers attending a carer training programme.
- To evaluate the nutrition education session by use of a questionnaire.
- To incorporate nutrition into ongoing training to carers.

METHOD

The course runs over 10 consecutive weeks, with each module being two hours in duration. By completing the diet and nutrition module, participants receive training in:

- The role of food and nutrition in promoting and maintaining health.
- The specific nutritional needs of the older adult.
- The importance of adequate hydration and adverse effects of dehydration.
- Procedures necessary for the prevention of cross contamination in the kitchen area.

A Community Dietitian delivers the nutrition training, and candidates are encouraged to actively participate. Each session is evaluated by means of a questionnaire.

RESULTS

Qualitative information collated from evaluation questionnaires shows similar themes arising from each cohort of candidates. All evaluations have been extremely positive and participants have expressed great satisfaction with the module. Additional condition-specific nutritional information, and training for specific care groups e.g. dementia, children, disabilities, continues to be requested.

DISCUSSION

The National Policy for older people advocates maintaining individuals in the home. Provision of adequate nutrition is a cornerstone in maintaining the health of an individual. The constant demand for further nutrition interventions from both carer's and health professionals alike displays the need for training programmes such as this to be maintained and indeed expanded into specific care groups.

CONCLUSION

Provision of nutrition training such as that provided in this module enhances the carer's care-giving role thus instilling confidence and competence in provision of adequate nutrition to their clients.

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P 230: "FOOD FOR THOUGHT"-THE DEVELOPMENT OF A TRAINING PROGRAMME FOR SUPPORT SERVICE STAFF IN THE ACUTE HOSPITAL

Bernadette MALLON, Niamh FITZPATRICK, Gwen RICE, Darina CURRAN, Orla DUFFY, Joan EARLEY, Grainne BOGUE

It is increasingly recognized within the acute hospital sector that there is insufficient education about nutrition amongst all staff groups, and in particular, key non-clinical staff (support services - catering attendants and care staff) whom sometimes have no training at all. In addition, this staff group may not be aware of their potential positive influence on the food choices a patient makes during their hospital stay, and therefore may not recognize their own value as "health-promoters" within the health services.

Individual Departments of Nutrition & Dietetics within the former North Eastern Health Board (NEHB) area identified this need as a priority for 2005. The Clinical Dietitian's Steering Group (hospital dietitians, former NEHB) then decided to produce a comprehensive training pack, in a coordinated and structured way, so that any dietitian, at any site, could deliver the programme.

THE PROCESS OF PREPARING THE TRAINING PACK INCLUDED

- An initial meeting of representative dietitians.
- A meeting with a Training & Education Coordinator from the NEHB Regional Education Centre.
- Agreement on the content of the programme, with allocation of initial preparation work.
- Training for all presenters on the most appropriate training methods for the target audience.
- Final and inclusive agreement on the content and a number of "practice-runs".

THE ULTIMATE AIMS OF THE PROJECT ARE

- To provide appropriate and specific nutrition to a staff group who are, in direct and influencing contact with patients.
- To empower this staff group to realize that they can impact on health outcomes of patients and therefore add a health promoting value to their work.
- To produce the programme in such a way that it is evidence based, consistent and reliable.

The programme has a strong focus on practical learning & uses a combination of presentations, prop-based activities and group interaction. It will be piloted and evaluated on one site in early 2005, and then extend to all other acute hospital

sites. It will also be provided in the Regional Education Centre so that staff in other units e.g. long stay elderly, may access it.

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P 231: MUSIC AS A RELAXATION AID FOR HOSPITAL PATIENTS

Rose BYRNE

RATIONALE

The Irish Slan Survey cites "Less Stress" as the most important factor in achieving or improving health among all groups, by introducing this stress management initiative we hoped to empower our clients and extended family to become more proactive in managing their stress levels.

OBJECTIVE

- To facilitate relaxation and stress management for patients attending for day surgery/procedures.
- To reduce the levels of anxiety among this target group.
- To improve the mood and environment of this group.
- To encourage self management of stress in these clients by using a sustainable aid.

METHODOLOGY

- By offering "walkmans" with music/guided imagery and comedy audio tapes to relevant clients whose mood has been identified as anxious by staff.
- By securing staff support and co-operation for the pilot project.
- By applying and receiving a small grant from the health promotion unit for the purchase of the equipment.
- By ensuring that tapes were offered in addition to reassurance from staff about their procedure and not instead.

EVALUATION

- Level of usage was monitored.
- Feedback from clients via an evaluation form.
- Feedback from staff through observation of anxiety and mood levels among clients.
- Pilot scheme to be evaluated after six months, interim process evaluation ongoing.

OUTCOME

- Patients empowered to take control over their own stress management.
- Initial feedback from staff indicates a more relaxed clientele when using the aids.
- Aids may be purchased and used at home by family and friends and is therefore a more sustainable method of relaxation.
- Scheme has now been extended to pre and post operative clients in theatre.

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P 232: DISPOSAL OF UNUSED MEDICATIONS PROPERLY (DUMP), A SERVICE TO EMPOWER

Catherine BROGAN

The DUMP project was piloted and then launched as a Health Promoting Initiative in the Health Service Executive (SWA) as a potential way of reducing access to means for suicide and parasuicide, both problems of significant concern in the Irish context. Added benefit included reducing accidental poisoning in children, and environmental pollution.

This project empowered individuals through the provision of a service to dispose of unused medicines in a safe and appropriate manner via local community pharmacies, and through making available health promotion literature on safe storage and use of medications.

The National Task Force Report on Suicide (1998) under the area of prevention of suicide and parasuicide made specific recommendations relating to the control, availability and supply of medicines. D.U.M.P has helped strengthen community development by enabling people take control of reducing access to means, preventing accidental poisoning in children and reducing the amount of hazardous waste in the community and thus improving their health.

The pilot (Oct / Nov 2002) involved 6 community pharmacies (rural and urban) and now through community need has 162 pharmacies involved. The pharmacists' were provided with leaflets and information outlining the campaign, 'Knowledge is the Best Medicine' (Irish Pharmaceutical Healthcare Association), and a template for recording the returns. The campaign is now in its second year, with data from the initial pilot and study of the first year being presented, and with the results demonstrating:

- Significant quantities of unused or unwanted medications were returned.
- Qualitative data suggests that there was a huge public interest.
- A correlation was noted between the medication of choice as a method of overdose and medication type being returned (National Parasuicide Registry Annual 2002).

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P 233: HEALTH PROMOTING HOSPITAL BELONGS TO COMMUNITY INFRASTRUCTURE

Mari PÖLD, Liis-Mail MOORA, Aili LAASNER

The Health Promoting Hospital (HPH) concept includes three main targets, and accordingly, relevant strategies to tackle those targets. The patient and staff oriented strategies are quite well-known and implemented in Estonian HPH-s. Pro-

moting the health of the population in the community remains still a challenge.

BACKGROUND

Rapla county has about 37000 inhabitants and includes 10 municipalities. The county hospital - the only one for those 10 municipalities, is a member of Estonian HPH Network since 2000.

Community people, hospital staff and county level decision-makers succeeded in proving the necessity of the hospital as a crucial part of community infrastructure.

DEVELOPMENTS

Following to that, county people are able to access and use general hospital level services appropriately and timely. The hospital is seeking for best solutions for enabling different medical services and good care on the spot and avoiding by that waiting hours elsewhere and long distances to go to another hospital. Thus, for many members of the community, the Rapla county hospital is primarily a potential provider of medical care and other health services as well.

The hospital has initiated self-help groups for diabetics, and cholesterol program and trainings for young families, i.e. "family school".

Hospital doctors belong to county level health promoting intersectoral workgroups on safety promotion and drugs prevention. They have also been invited to participate in an elaboration of the long-term development plan of the county.

For better communication and information change, we work in very tight contacts with municipal social specialists and social workers.

We highlight healthy life styles for all - for hospital patients and staff and to community people in local media, as much as possible. There is a special focus on primary and secondary prevention of cardiovascular diseases. We try to ensure that people are well informed and able to make suitable health choices.

CONCLUSIONS

- Active participation of doctors and nurses on different health promoting attempts remarkably contributes to the healthy lifestyle of local population.
- Interpersonal relations as regards to patient-nurse-doctor has been improved (results of surveys, regularly carried out in our hospital). Patient' role in the treatment process should not be underestimated.
- The importance of health promotion has been increased and more thoroughly understood among the county population while many nurses and doctors of Rapla HPH are in real collaboration with the county level health promotion network.

HPH - Rapla county hospital is at the very heart of the community infrastructure and decision-making process. Community empowerment, one of main HPH strategies has to be a process that sustains and continues.

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SESSION II-11: CONTRIBUTIONS OF HPH TO COMMUNITY HEALTH – HEALTH PROMOTION IN THE COMMUNITY

P 234: THE GERMAN COOPERATION PROJECT „HEALTH PROMOTION FOR THE SOCIALLY DIS-ADVANTAGED“

Raimund GEENE

Epidemiologic studies show the close connection between a low social status and ill health – in Germany as well as in the EU countries. People with low occupational status, low income and a low education die earlier, get sick more often and more seriously than people that are better off. The necessity for health promoting efforts is unquestioned. The German project “Health Promotion of the Socially Disadvantaged” wants to enhance transparency in this multi-methodological and often unstructured field of action and to improve communication between the players. The project involves partners like the Federal Center for Health Education (BZgA), the federal and regional associations for health promotion and the Federal Association of Company Health Insurance Funds (BKK Bundesverband). An online project-database with more than 2,600 entries provides an overview of health promotion practice with socially disadvantaged groups and is integrated in a website that concentrates on the same topic (www.datenbank-gesundheitsprojekte.de). In 2005 the central aim of the project will be to systematically identify and present examples of “good practice” to support quality-oriented project-development.

Hospitals are an important setting to reach people in (socially) problematic life situations by participatory and activating health promoting efforts – especially on the background of the new Prevention Law in Germany, which is currently in parliamentary consultation. This may allow to set the foundations for a healthy environment in cooperation with patients and their relatives as well as hospital employees. The setting approach is very promising for hospitals when the social, institutional and ecological environments are incorporated in all health promoting activities. An aim should be to develop the hospital from an “island” into a bridge towards a healthy future. Our presentation introduces the activities of the German cooperation project as well as promising examples for health promoting interventions and activities in hospitals.

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P 235: ENVIRONMENTAL MANAGEMENT STRATEGIES IN GERMAN HOSPITALS - RESULTS OF A SURVEY

Ulrich STOESSEL, Matthias NUEBLING, Martin SCHERRER, Manuela BAUER

OBJECTIVES

Hospitals not only in Germany are facing a lot of challenges in nowadays: Progress in medical science, changes in budgeting systems, introduction of new structures, procedures, last but not least the necessity to improve quality and outcome by means of quality management, have made

hospitals to (sometimes unwilling) learning organisations. Furthermore European strategies like the EMAS (European Management Audit System) shall be implemented in quality assurance systems and integrated in environmental management systems.

Our project, funded by the federal foundation for environment, aims at the detection of barriers and chances for the sustainable implementation of an environmental management system in hospitals.

METHODS

Different methods were chosen for the investigation. Main part was a mainly standardised questionnaire for physicians, nurses, administrators and environmental experts in hospitals. This questionnaire was addressed to 200 hospitals (10% sample of all German hospitals). Additionally phone-interviews with 10 experts were conducted. Random samples of medical and nursing students too were questioned with a short form of the mainly standardised questionnaire. All results were fed back to an expert group to discuss practical consequences and transfer strategies.

RESULTS

Results from the survey can be reported for a sample of 193 hospitals, which sent back 2 questionnaires on average (=ca. 400 respondents). The relevance of environmental management issues is judged relatively high. On the other hand a lot of action still is needed to promote a sustainable protection of the environment, esp. by reducing waste, electric power and water consumption. Personal factors on the sides of possible stakeholders are assumed to be more important than structural matters.

CONCLUSIONS

Our results show a great need for pushing forward the environmental issue in the context of a health promoting hospital- and quality development both in professional education and in the organisational context.

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P 236: DETERMINATION OF RADON CONCENTRATIONS IN HOSPITALS

A. SCHIAVI, G. SCARPINI, V. BUCCOLIERO

INTRODUCTION

Radon is a noble, radio-active, inert gas which penetrates buildings through ground infiltration. IARC classifies it as Group One: a substance with definite carcinogenic effects on man. The reference value limits established by the European Community are: 400 Bq/m³ for residences and 500 – 1.000 Bq/m³ for the workplace. The risk of pulmonary neoplasma onset appears negligible for annual effective quantities

below 3 mSv/year. The 241/00 decree (put into effect following the 96/29/EURATOM guideline) sets out some workplace activities (underground level) in which it is mandatory to take samples and set some "action levels" which, if exceeded, require intervention.

AIM

The aim of the work carried out by the Safety and Prevention Service and the Qualified Expert in agreement with the AO general administration was: 1) to inform hospital staff working in underground areas of environmental risks which may go undetected unless appropriate measurements are taken, 2) to promote the transmission of a behaviour-related culture suited to risk prevention, 3) to measure the entity of the risk in compliance with D. Lgs. (legislative decree) 230/95 and D. Lgs. 241/200, 4) to inform the workers involved of the results obtained.

MATERIALS AND METHODS

Introductory instruction and basic training was set up for all staff involved in work in underground conditions. Steps were taken to calculate the effective amount; the determining value was set as the maximum exposure time equal to 2000 hours/year for the average annual concentration of radon revealed by nuclear-trace detectors PADC (LR-115), hung, on the qualified expert's instructions, at altitudes lower than 2.5 m on foot-accessible floors. The results obtained were explained in a subsequent meeting.

RESULTS

Limits of 500 Bq/m³ are never exceeded. The maximum value of average annual concentration is equal to 194 Bq/m³ in only one of the hospitals. The distribution of the frequencies of measured concentrations is:

Frequencies	Classes (Bq/ m3)
10	<10
49	10-50
14	50-100
6	100-150
1	150-200
2	200-250
1	250-300

The distribution of the concentration values in the range 0-250 Bq/m³ is:

Frequencies %	Classes (Bq/ m3)
12,0	<10
59,0	10-50
16,9	50-100
7,2	100-150
1,2	150-200
2,4	200-250
1,2	250-300

CONCLUSIONS:

Effective quantities potentially accumulated by staff are greatly inferior to 1,5 mSv/year. Since the risk derived from exposure to radon is negligible and concentrations are much lower than 400 Bq/m³ (0.8*S) corrective measures are neither required nor recommended nor are further samplings recommended unless following major structural modifications in the underground floors.

The awareness of working in safe environments certainly reassured the workers and rendered the administration of their duties more amenable.

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P 237: THE ABUSE PROJECT: RECEPTION INTO THE GENERAL HOSPITAL

Alessandra BERTI, Roberto PREDONZANNI

CONTEXT

During the annual planning for interhospital projects, many coordinators have expressed the necessity to create a working group on sexual abuse phenomenon and its management within the general hospital.

This project came up from the evidence of an increasing amount of requests to the First Aid for assistance related to sexual abuse problems and from the fact that most caregivers (doctors and nurses of First Aid structures, particularly) are not provided yet with adequate skills to manage such emergencies; moreover, it is often missing a good connection between the hospital and other territorial structures for assistance and above all it is still lacking an information network, which could give users a chance to know whom to ask for help and for which problems, from the very beginning.

OBJECTIVES

the project in discussion sets the following objectives:

- to estimate the extent of this problem, even though we are facing a hardly measurable context (there are no accurate statistics about this fact, in Italy) and to take a census of public and private structures of our area that usually deal with this problem
- to generate common flow charts of operations to be used in hospitals
- to carry out an intervention of education/information for the staff of First Aid structures of the area
- to plan the realization of a booklet on abuse, providing useful information and an address list of the main prevention, reception and cure structures available, to be handed out at every Health Service in the area.

TARGET

victims of sexual abuse

RESULTS ASSESSMENT

we are now checking out the flow chart and preparing the booklet. This phase will be ended by December 2004 and an education course is being activated, that should be given by the end of 2005.

CONCLUSIONS

the project presents some aspects difficult to be carried out, especially since there is still very little experience in this field in other hospitals; the presentation of this work itself wants to be a way to verify if other structures are dealing with the same problem.

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P 238: AN EDUCATIONAL INTERVENTION OF FIRST AID IN THE PRIMARY SCHOOL

Roberto PREDONZANI, M. ANFOSSO

The doctors and nurses of "Operative Central 118" for territorial emergency has been watched in their experiences a scanty knowledge in the people of basic life support and of local structural of emergency (no knowledge of telephone number for example). This poor knowledge have been caused:

- wrong requests of help
- there isn't possible to have necessary informations to coordinate the emergency interventions
- often there are wrong supports on patient
- Objects: We want teaching to teachers and students: 1) simple and good interventions of help; 2) we do make the operative Central 2118 and his utilization.

We realized a Compact Disc in collaboration with Firemen and Red Cross. We realized a first aid's course to teachers (during ten hours in three days). We administered pre test questionnaires and a final evaluation of test. In the final, we delivered a licence of aid's assistant at teachers.

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P 239: FRIENDLY RUBBISH: CHILDREN HELP THE HOSPITAL

Rita GAGNO, Roberto PREDONZANI; Cristina MAGLIO

INTRODUCTION

The project was born in the Saint Charles Hospital, at Bordighera, to persuade visitors, patients and employees to use a proper behaviour when they eliminate waste (paper, bottles, ...).

OBJECTIVE

We wanted to realize a promotional campaign turn out in the community; it's necessary to keep the hospital clean. For this reason we have been involving primary school's students to produce with them posters of good civil practice.

We described in several lessons to the students that it is very important to collect waste goods for recycling to live in a clean world.

Together with the children we developed posters with slogans and sketches to display in Bordighera's Hospital.

TARGET

Visitors, patients, doctors and nurses, students and teachers of primary schools

The project started in 2004; in the first phase, the principal premises where posters have to be displayed were identified. In the second phase children developed 70 posters (dimension:100 x 70 cm) with several claims and different comics (so as speaking flowers, butterflies and other animals). They used equipment like felt-tip pens, tempera colours, water colours, collage. In May 2005 there were presentation of this work during a show in the hospital. The "Azienda Sanitaria Localae 1 Imperiese" will print a book with the children's works.

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P 240: PUBLIC RELATION PROJECT - PERFORMANCE DEDICATED TO WORLD HEALTH DAY

Jurate VAIDELIENE, Jolita LINKEVICIUTE

The World Health Day in 2004 year was dedicated to safe traffic. Every year almost 700 people die on Lithuania's roads, more than 10% of them children. In the last 13 years almost 30 000 people were disabled due to car accidents. According to World Health Organization (WHO), car accidents caused 94-106 million EUR loss to Lithuanian economics.

PARTICIPANTS

KMU Children surgery hospital orthopedists-traumatologists, laureate of national prize sculptor R. Antinis, I. Mikulis art school students, children surgery patients.

Aim. To get public attention about child traumas. To inform society what security measures must be taken to avoid such disasters.

IMPLEMENTATION

Two weeks before the competition there was a radio announcement on one of the radio stations. Wish concerts were broadcasted each Sunday. Children from children surgery department have reported how they got an accident, how they were cured, they sent greeting to their doctors, nurses, parents, friends.

During the presentation students from I. Mikuličiūtės Art School had painted on the children's plaster of Paris. Orthopedists-traumatologists from the Children's Surgery Department and sculptor R. Antinis, the laureate of the National prize, plastered hands and legs of healthy children, who had participated in the event. At the same time traffic control specialist from Kaunas police head-quarters had explained to children and journalists about safe traffic. Several sculptures which were created during the event were exhibited at KMH.

RESULTS

Many national newspapers and journals had described the event. There were several interviews in radio stations and television as well.

CONCLUSIONS

According to the achieved results we may conclude that unique projects are useful. Nontraditional event, where the problem is shown in original form attracts national and regional mass media.

RECOMMENDATIONS

In future it is necessary to find nontraditional relation forms with society also drawing in representatives of different professions.

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P 241: DEPARTMENT FOR WOMEN AND CHILDREN WHO ARE VICTIMS OF SEXUAL ABUSE

Silvia DONADIO, Valentina DONVITO, Giuseppina POPPA, Fulvia NEGRO, Gemma ISAIA

On the 1st of May 2003 we opened a new department for women (over 14 years old) and children, who are victim of sexual abuses, at Sant'Anna hospital. At the department we assist the patients in the emergency, it means immediately after the abuse, and then we take care of them during the following period of time. There are several professional people working for the department:

- Gynaecologist (24 h per day)
- Police surgeon (24 h per day)
- Midwife
- Psychologist
- Social worker
- Member of Voluntary Service

When the victim arrives at the department, she finds a gynaecologist who takes care of her. The physician examines the woman, prescribes blood tests, gives her a therapy, and collects all the evidence that will be useful for the legal trial. The gynecologist must also report the crime to the police, as required by the law.

At the department we perform "long-term" assistance, as well. It means that we perform periodical check and examination, and we offer some conversation with our psychologist to help the women to overcome the trauma. From 1st May to 31st December we took care of 100 women, who were victim of sexual abuses.

In 2002 at Pediatric Hospital Regina Margherita we opened an outpatient department for children who are victim of sexual abuse and maltreatment. The treatment of childrens' sexual abuses and maltreatment is a very difficult problem that involves medical, psychological, social and legal aspects; it's necessary to have different professional people working all together to help the child and his family to overcome the trauma.

In our outpatient department work a pediatrician and a nurse specialist who have time to listen the child and his parents, so the child trusts them and has the chance to explain them all the details of the fact. Also the cooperation with the GP and the social service are very important.

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P 242: 'SPEAKING UP FOR TEACHERS' VOICE CARE PROJECT

Jan STANIER, Claire GOODHEIR

A project to promote appropriate voice care in the classroom for teachers has been developed in Paisley, Scotland as part of the Health Promoting Health Service framework. It was undertaken by the Speech & Language Therapy (SLT) Department in a hospital and local health promotion department. It aims to promote vocal health to teaching and teaching-related staff in the area and ultimately to reduce referrals of voice disordered patients to the joint ENT/SLT "Voice Clinic".

It was previously observed that by the time some teaching staff were referred to the SLT clinic, many of the behaviors that damage vocal health had become established and were therefore more complex to treat. By targeting staff currently teaching but not experiencing any long-term vocal difficulties, it was felt that early health promotion advice might prevent long-term vocal damage and resultant emotional pressures on these groups.

The course programme includes both theoretical and practical elements as well as long-term strategies to encourage teachers to use their voices correctly. Specialist SLT staff deliver the programme from the Royal Alexandra Hospital in Renfrewshire.

An accompanying booklet is provided with the course that details extensive advice and sources of further information and support that will last beyond the initial intervention. An initial pilot course was undertaken in 2004 and evaluated to develop the structure and content of this preventative health promotion intervention. It has since been run twice with another two sessions organised for spring 2005 and has evaluated well on a short-term basis. However, the next phase of the course will be evaluated over a longer timescale to identify if the participants have adopted changes in voice usage. Ultimately in the long-term, it is hoped that future audits of teacher numbers within voice clinic referrals will reflect this preventative work.

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P 243: CARING FOR OUR BEREAVED BACKGROUND

Aine CANNY, Eileen O'DONNELL, Victoria RICHARDSON, Kieran BUCKLEY

The Medical Social Work Department in St. Vincent's University Hospital (SVUH) is committed to the support of relatives who have been bereaved. There is strong evidence indicating the benefits of supporting the bereaved in the prevention of secondary health complications. A bereavement programme advances the ethos of health promotion in the hospital.

OBJECTIVE

To normalise the process of grief for families whose relative died in SVUH

METHOD

Needs assessment carried out. Liaison with other hospital bereavement services to establish the best model of prac-

tice. Based on this evaluation the team developed a four-week bereavement support programme. Four evening talks on different aspects of bereavement are followed by a short tea/coffee break. The relatives are grouped according to the nature of their loss and discussion is facilitated by a medical social worker. The programme is offered twice yearly.

EVALUATION

All bereaved next of kin were notified (1,419 relatives). In past two years, 165 attended one of four programmes. Evaluation forms completed each evening. Recent evaluation (74 responses) indicated: 74% found the group discussion "very helpful". 74.5% found the speakers to be excellent. The supportive connections are the greatest evidence of the programme's effectiveness. One participant stated, "Listening to others loss has helped me understand my own". The success of the programme was acknowledged with the receipt of an Innovation Award by the SVUH Health Care Group in November 2004.

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P 244: DEVELOPMENT OF A PHARMACY LED ANTICOAGULATION CLINIC AT PORTIUNCULA HOSPITAL

Geraldine COLOHAN

OBJECTIVES

Weekly clinic management. Maintain patients within INR range. Reduce the incidences of problems occurring in patient care. Identify problems which need referral to a physician.

Ensure a regular point of contact for patients who may have concerns about their treatment.

Interview patients and assess factors which may affect their anticoagulation e.g. disease states and drug interactions.

Introduce a counselling protocol.

Documentation format review.

Education of physicians and pharmacists.

Assess available computer predictive packages.

METHOD

Review current practices and documentation standards at our anticoagulation clinic.

Ensure there is a clear and effective system for referring patients to the clinic or to their GP.

Ensure there are clear relevant guidelines for patient treatment.

Introduce patient documentation that includes patient demographics, target INR range countersigned by the prescriber, any relevant diseases, a drug profile and a record of attendance with relevant comments and INR results.

Implement procedures for follow up of non-attendees at clinics and procedures for regular medical review.

Review existing software packages for data management.

Undertake a comprehensive review of our current in-patient anticoagulation service including referral for counselling, review of counselling tools used, referral for further management either by GP or Out patient clinic, dosage loading regimens.

Work closely with medical and nursing staff to ensure a

comprehensive in/out-patient anticoagulation service at Portiuncula.

Liase closely with General Practitioners Review Indemnity Insurance required for Pharmacist led anticoagulation clinics.

Implement protocols for patient management. Establish accredited training programme for clinic personnel.

Set appropriate clinic standards.

FOLLOW-UP

Audit of the following. Percentage of results in range / time in range-Haemorrhagic or Thrombotic events-INR < 1.5 or > 6.0-Completeness of records-Appropriateness of indications, range and duration of treatment. Patient questionnaire-Publish audit results detailing quality, effectiveness and efficiency of the service.

Identify and initiate action to rectify shortcomings of the anticoagulation clinic

DISCUSSION

Our pharmacy led warfarin clinic has been established since October 2003.

Audit has shown better control of patient treatment. A patient satisfaction survey has revealed that patients find that the pharmacy led clinic is an improvement.

Other benefits include better communication and data sharing with GPs, audit, ongoing counselling of patients by pharmacist and provision of information leaflets. The core benefits have been a regular point of contact for warfarin patients with someone who is familiar with their treatment in addition to patients receiving more information and hopefully a better understanding of their treatment.

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P 245: EMPOWERING PHARMACISTS FOR SMOKING CESSATION: APPLYING THE PRINCIPLES OF HEALTH PROMOTION

Miriam GUNNING, Jean MOLLOY

RATIONALE

Pharmacists play an important role in disease prevention by promoting healthy lifestyles. Ideally placed in many communities they have opportunities to intervene directly with clients on a number of health topics. They have particular opportunities in the area of smoking cessation as many smokers will ask for advice from a pharmacist when considering purchasing smoking cessation aids.

PROJECT AIMS

The Ottawa Charter provides a useful framework for developing health promotion within the community. With this particular project it was possible to apply a number of health promotion principles. The project aims included: To develop a partnership between the HSE Northern Area and Boots towards a common goal of encouraging more smokers to stop.

To develop the pharmacy environment as a supportive setting for smoking cessation.

To re-orient pharmacy staff towards a health promotion focus by encouraging a stronger focus on smoking cessation within the pharmacy.

To strengthen community action on smoking cessation.

To empower pharmacy staff by developing their brief intervention skills.

METHODOLOGY

The time frame for the project was one year June 2004-June 2005. The HSE Northern Area and Boots worked together to agree a process for introducing smoking cessation into the pharmacy setting taking into account the impact on service, client confidentiality and ethics. This entailed the development of

- An internal and external communication process
- A training programme for pharmacy staff
- Specific resources for clients
- Recording methods
- Referral systems
- Systems for staff support
- Monitoring and evaluation methods

RESULT

At the end of the programme, it will be possible to evaluate the project according to process, impact and outcome. Preliminary results indicate that the project has been successful in identifying and supporting smokers. There were significant learnings relating to the process and the importance of maintaining staff interest and motivation for this type of initiative.

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P 246: THE HEALTH PROMOTING ACTIVITIES INTEGRATION: FROM HPH TO A LOCAL HEALTH PROMOTION SYSTEM. THE EXPERIENCE OF THE LOCAL HEALTH UNIT NO. 3 OF PISTOIA (ITALY)

Vairo CONTINI, Maria José CALDÉS PINILLA

RATIONALE

The new conception of 'health' is more and more revealing the heterogeneity of its determinants, the relative impact of the health systems on the global health, the need of finding out new policies and strategies to protect both the individual and the collective health. The health promotion is to be considered as a cultural, political and economical investment made by community to affect health determinants.

The latest Regional Health Plan (RHP) 2005-2007 by Tuscany Region (Italy) aims to carry out health policies fit to compare the idea of the people's Health Promotion with their centrality, sense of responsibility, values of solidarity and social participation, moral and cultural assets of the Community. In this sense, the RHP identifies two important tools to be implemented at the local level: the "Health Societies" and the 'Integrated Health Plan'. Moreover, the RHP conceives the HPH network a very strong tool for the Hospital's HP strategies.

THE PROJECT

The Local Health Unit no. 3 of Pistoia has individuated as HPH project core strategy the integration of some Health Promotion activities carried out by hospital's through the primary health care services. The project aims to develop a significant and progressive growing-up of the HPH activities, through a qualification, strengthening of initiatives, and fundamentally a connection with the HP activities realised by the local primary health care services. At the moment, the Local Health Unit no. 3 of Pistoia is involved in five HPH projects:

- Smoke-free hospital;
- Pain-free hospital;
- multicultural hospital;
- breast feeding in hospital;
- continuous health care hospital.

All this projects see health professionals, participating from hospitals and from health care and preventive services, working together in a co-ordinated and integrated way. Hence, hospitals and primary health care services common objectives should be:

- the achievement of concrete and documented outcomes related to a growing control and an improvement of the health of the target population;
- the improving of job methodologies, re-used in the context of HPH activities and in the HP in general;
- the spreading of HP culture among health staff, patients and community.

This is the context in which the strategy and the philosophy of the HPH project of the Local Health Unit no. 3 of Pistoia has been thus implemented.

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Past HPH conferences:

"Investing in health for the future: Positioning health promotion in health care provision & supporting effective implementation"

12th International Conference on Health Promoting Hospitals (HPH), Moscow, Russia, May 26-May 28, 2004

www.univie.ac.at/hph/moscow2004

"Reorienting hospitals for better health in Europe: New governance, patient orientation and cultural diversity in hospitals"

11th International Conference on Health Promoting Hospitals, Florence, Italy, May 18-20, 2003

www.univie.ac.at/hph/florence2003

"The contribution of HPH to reorient health services: Improving health gain by developing partnerships and quality"

10th International Conference on Health Promoting Hospitals, Bratislava, Slovakia, May 15-17, 2002

www.univie.ac.at/hph/reports.html#10ic

www.univie.ac.at/hph/10ic/programm.html

"Health Promoting Hospitals in a National Health Policy Perspective – Evidence in Health Promotion"

9th International Conference on Health Promoting Hospitals, Copenhagen, Denmark, May 16 -18, 2001

www.univie.ac.at/hph/9ic/proc9ic.html

"The Health Promoting Hospital in the 21st Century - Challenges and Opportunities, Strategies and Scenarios for Patients, Staff, Communities and the Hospital as an Organisation"

8th International Conference on Health Promoting Hospitals

Athens, Greece, June 14 - 16, 2000

www.univie.ac.at/hph/8ic/programm.html

"Health Promotion and Quality: Challenges and Opportunities for Health Promoting Hospitals"

7th International Conference on Health Promoting Hospitals

Swansea, Wales, April 21-23, 1999

www.univie.ac.at/hph/reports.html#7ic

www.univie.ac.at/hph/proc7ic.html

"Health Promoting Hospitals: Healthy Workplace, Clinical Centre of Excellence, Partner for Comprehensive Care, Ally for Public Health + Health Promoting Psychiatric Hospitals"

6th International Conference on Health Promoting Hospitals

Darmstadt, Germany, April 29-May 2, 1998

www.univie.ac.at/hph/reports.html#6ic

www.univie.ac.at/hph/proc6ic.html/p>

"From Projects to Networks: Effectiveness, Quality Assurance and Sustainability of Health Promoting Hospitals Projects"

5th International Conference on Health Promoting Hospitals

Vienna, Austria, April 16-April 19, 1997

"Health Promoting Hospitals: A Vision for Development in Times of Change"

4th International Conference on Health Promoting Hospitals

Londonderry, UK - Northern Ireland, April 18-April 19, 1996

"Health gain Measurements as a Tool for Hospital Management and Health Policy"

3rd International Conference on Health Promoting Hospitals

Linköping, Sweden, June 1-June 2, 1995

"Developing Health Promoting Organizations by Strengthening Intersectoral and Community Action. Healthy Nutrition Policies for Hospitals"

2nd International Conference on Health Promoting Hospitals

Padova, Italy, April 15-16, 1994

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"Establishing New Structure of the Network: The European Pilot Hospital Project & Tobacco-Free Hospitals"

1st International Conference on Health Promoting Hospitals

Warsaw, Poland, April 30-May 02, 1993

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