Northeast Health Wangaratta
incorporating:

Wangaratta District Base Hospital

WJ Smith Linen Service

Wangaratta & District Nursing Home

Psychiatric Services - Kerferd Inpatient Unit

Medical Imaging

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Quality of Care Report
Northeast Health Wangaratta
2005-2006

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Our Purpose

To meet the healthcare needs of our community by working collaboratively with individuals, the community, other service providers and funding bodies.

We Value

- Integrity
- Compassion
- Excellence

These are reflected in the following behaviours:

- Caring about what we do
- Caring about those we serve
- Demonstrating professionalism
- Leading by example
- Encouraging innovation
- Supporting each other
- Respecting differences
- Communicating openly and honestly

Welcome

It is with pleasure that we introduce Northeast Health Wangaratta's fifth annual Quality of Care report. As with our previous reports, this publication has been produced with the community of Wangaratta in mind and we hope that this helps you to develop a greater understanding of the diverse organisation that is Northeast Health Wangaratta (NHW).

As always it has been a busy year for NHW. Successful accreditation in both aged care (Aged Care Standards and Accreditation Agency) and the acute, community and mental health service areas (Australian Council on Healthcare Standards) was a major achievement in 2005/2006. Both areas gained the maximum accreditation possible and demonstrated the commitment by our staff to providing excellent patient care and services across the organisation.

The particular projects that have advanced our quality of care this year are highlighted as follows:

- Community Services Intergration Project with Ovens and King Community Health Services and the community services department of the Rural City of Wangaratta. This innovation will hopefully see greater ease of referral and access to the community services patients require, and is more fully discussed later in the report.
- Rural Clinical School (RCS). This year NHW, in collaboration with the University of Melbourne, opened a node of the Rural Clinical School on site in the refurbished former Chalet building in Docker Street. This building also houses the re-located Dr. R.M. Mounsey clinical library, teaching areas for medical students and our mental health services research department. We will now be taking up to 24 advanced medical students per annum who will receive health services education and training. This will offer a wide variety of learning experiences for them with the anticipated advantage, in years to come, being the retention of a viable medical workforce in rural areas.
- Upgrade for our Emergency Department (ED). We were pleased to receive additional funding this year to upgrade the infrastructure and patient amenities in our ED. Refurbishment of the waiting room with improved furnishings and TV entertainment will help to make the patients stay more comfortable. Negative pressure zones have been incorporated into clinical areas so that we can better manage infectious disease epidemics. Staff work areas are also being upgraded. An external decontamination area is in the final planning stages.

Each year production of this report is based on a number of factors. The first is a list of minimum reporting requirements that is set by the Department of Human Services (DHS). These requirements are in areas such as quality and safety, how we meet the health needs of our community and how our community participates in helping to improve our service. The other factor, most importantly, is that of feedback from our community on previous reports. Comments are also provided formally by the experts who assess our report each year.

Generally community feedback has been very positive each year, although a comment has been made in relation to provision of some Italian interpretation of main points. As you will note, in 2006 we have incorporated this suggestion into our report. Generally speaking, feedback from last years report noted that the layout was good (100%), text was easy to understand (96%) and that topics chosen for reporting were relevant and interesting (100%). In order to circulate the information contained within the Quality of Care report more widely, we have started a quarterly hospital community newsletter, 'Health Focus' which will not only contain articles taken from the Quality of Care report but also seasonal health information for the people of Wangaratta and district.

Expert assessment of our 2005 report was positive and NHW was voted 'most improved report' and 'short listed report' in the regional category. Areas for improvement were noted and every effort has been made to make the 2006 edition both informative and interesting.

Geoff Dinning
President
Board of Management

Lis Wilson
Chief Executive Officer

Medical Care

Mr and Mrs Howard are a couple in their eighties who have lived at Whitfield all their lives. Last September they were at home when one Sunday evening after dinner Mrs Howard collapsed with no warning. Mr Howard called an ambulance and his wife was urgently transported to the NHW Emergency Department (ED). Upon arrival she was immediately assessed by medical and nursing staff. Mrs Howard was conscious but unable to speak or move the arm or leg on her left hand side. Clinical staff thought that she may have had a stroke (cerebrovascular accident) but further investigation was required. Blood tests were taken, an intravenous (IV) drip put in her arm and a CT scan was ordered to assess for any signs of injury to Mrs Howard's brain. The radiographer (x-ray technician) was called in and the scan was performed. As it was after hours, the CT scan was reviewed by a specialist doctor in Melbourne via computer, and the results were available to clinical staff in the ED approximately 20 - 30 minutes after the scan was completed.

The test confirmed that Mrs Howard had suffered a stroke and treatment of her condition began as soon as the diagnosis was confirmed. Blood thinning medication was started via the IV drip. The ED staff also referred Mrs Howard to the 'RAS' team (Rapid Assessment Service) and they became involved in her care. This referral was made because her treatment was likely to be complex, and early allied health involvement can make the hospital stay shorter and less traumatic for the patient and their family. The RAS team is comprised of allied health professionals such as Social Workers, Physiotherapists and Occupational Therapists. As Mrs Howard needed hospital admission, and it was late Sunday evening, the RAS team arranged to see her in the ward the next working day.

A bed in the ward was arranged and Mrs Howard was transferred to the Medical Assessment Planning Subunit (MAPS).A full admission was completed by nursing staff and all aspects of risk and her medical condition, past and present, were noted and entered onto the computerised patient record called 'Orion'. Care and management were planned according to Mrs Howard's special needs - for example, because of her decreased ability to move strategies were put in place to reduce the risk of falls and pressure ulcers. Staff ensured that appropriate referrals were made, via 'Orion', to appropriate services such as the Physiotherapist, Occupational Therapist and Speech Pathologist, as well as the Social Worker who was able to arrange travel and accommodation assistance for Mr Howard as he lived out of town.

- Physiotherapists assist people to regain independence with their walking and provide exercises to strengthen muscles and improve balance, particularly after a stroke.
- Occupational Therapists assist people to regain or maintain independence in their day to day activities such as showering, cooking, cleaning, driving, shopping etc. This may include changing how a person completes the activity, providing equipment or modifying the home environment.
- Speech Pathologists not only help people to communicate effectively, but are also experts in assessing swallowing function - essential in stroke patients.

The following morning, and every day thereafter, Mrs Howard was visited by the medical team and the consultant Physician who again carried out a full examination and monitored her medical treatment. All results of blood tests, scans and x-rays were available for clinical staff via the 'Orion' computer system. Mr and Mrs Howard were kept informed of progress and what to expect regarding her recovery. After review by the Speech Pathologist the morning after admission, it was determined that Mrs Howard was able to drink thickened fluids and these were ordered specially through the diet kitchen. The Physiotherapist visited to assess her ability to move and provided staff with a range of activities to promote movement.

Medical Care

After 48 hours in the MAPS unit, Mrs Howard was transferred to Ground West general medical ward. Mrs Howard had made a reasonable recovery and had passed through the acute phase of her illness. She could now speak slowly and walk with assistance, although she was not independent enough to return home. A period of time in the rehabilitation ward was recommended and on her 10th day in hospital Mrs Howard was transferred to the Thomas Hogan Centre.

Within this Centre there was an increased focus on intensive therapy. Clients are encouraged to join others in the dining area for meals and increase their independence as much as possible so that their discharge home is safe. A team meeting involving doctors, nurses and allied health staff was held soon after Mrs Howard transfer to the Centre to discuss the complex care needs of Mrs Howard and ensure that her care was well coordinated. Mr and Mrs Howard were also invited to this meeting to express their desires regarding personal goals for Mrs Howard and her future management.

During her stay in hospital, Mrs Howard's condition and ability was reviewed by the Aged Care Assessment Service (ACAS) from the Ovens and King Community Health Service. Their role is to recommend the care services that may be required by the elderly and it was recommended that Mrs Howard would be eligible for a Community Aged Care Package (see page 18 for further details). After consultation with Community Aged Care Program staff, a package was arranged and this would provide transport from Whitfield to Wangaratta after discharge to allow Mrs Howard to attend the Community Rehabilitation Centre (CRC) for ongoing Physiotherapy. The package also provided personal assistance with showering to help the elderly Mr Howard in caring for his wife.

When Mrs Howard had improved to an acceptable level, a home visit was arranged with the Occupational Therapist to make sure that she could not only cope at home, but that there was suitable access within her home. It was discovered that some bathroom renovation was needed to assist with Mrs Howard's safety - handrails were organised for the shower and a chair for use in the shower was also provided.

After a period of 25 days at NHW Mrs Howard was discharged home in the care of her husband, fully supported by community services provided through NHW.

Follow up appointments and a discharge prescription was arranged and given to Mr and Mrs Howard in a discharge information package. At the NHW Pharmacy the discharge medications were dispensed along with an information sheet about Mrs Howard's medications. The pharmacist explained the medications to ensure both Mr and Mrs Howard understood them.

A comprehensive summary of Mrs Howard diagnosis, pathology and radiology test results, current medications and care plan was electronically sent to Mrs Howard's GP and the Physician who will continue seeing Mrs Howard in his rooms.

In 2005/2006 NHW treated 126 people who had suffered a stroke.

We are a participating hospital in the Rural Organisation of Australian Stroke Teams which has been designed to assist clinicians in rural areas to achieve best practice of stroke care for their patients.

Some of the Key Performance Indicators (KPIs) that are used to determine how well we are managing our stroke patients are:

- Having a CT scan or MRI scan within 12 hours
- Having an initial assessment of swallowing
- Having an Occupational Therapy and Physiotherapy assessment within 24 hours
- Having a speech review within 24 hours of admission

Data provided for the November 2005 to January 2006 time period shows that NHW is achieving approximately 88% compliance with its Key Performance Indicators. This is compared to a Victorian average of 81% for participating organisations.

Safety & Quality

Clinical Governance - providing safe, high quality services

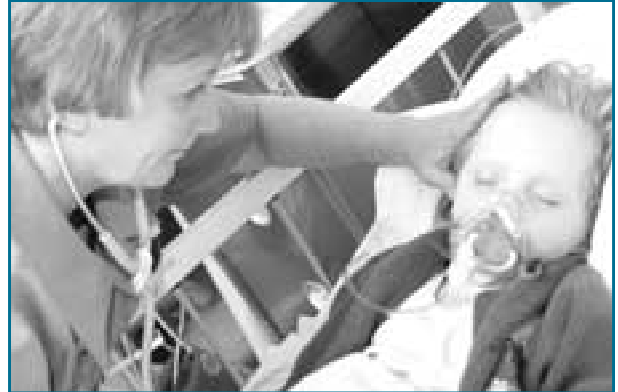
Clinical Governance is about our Board of Management, Executive, Managers and staff all working towards improving the clinical care given to our patients. Ultimately, the Board of Management is responsible for ensuring a certain level of quality & safety is maintained and clinical information that is accurate and appropriate is provided to ensure all clinical services are monitored regularly. Much work has been done in relation to the type of reports that are provided on a monthly basis to the Board of Management so they have a clear overall view of NHW's performance and areas that need improvement. Some of this data includes:

- Numbers of patient falls
- Numbers of medication errors
- Aggression & assault rates
- Complaints and compliments
- Number of pressure ulcers detected by our staff
- How many patient histories are reviewed and the number of recommendations for improvement
- Waiting times for surgery

Significant work has also been undertaken in ensuring that staff in our clinical areas are all aware of Quality & Safety issues across the organisation. Each month the SQuIRM* team, from the Quality & Safety Department, update clinical department notice boards with information relevant to staff and the care they provide. In addition, each month a different theme also forms part of this display to educate staff and raise awareness of clinical risk and quality issues. In 2005/2006 we have had months dedicated to falls prevention, open disclosure, medication administration, risk management, quality activities and fire and evacuation, to name a few.

Some of our major achievements in improving quality & safety in 2005/2006 have been:

- Decreasing falls rates in the acute hospital
- Commencing benchmarking of falls rates/injury rates with an external organisation
- Successful introduction of EACH and CAC packages, allowing elderly clients with high and low care needs to stay longer in their own homes
- Development of a blood transfusion checking chart for use with all blood products to avoid transfusion errors
- Increases in hand hygiene compliance and a corresponding reduction in patient infections as a result of the Hand Hygiene Project
- Facilitating region wide rollout of the Hand Hygiene Project



- Successful accreditation via the Australian Council on Healthcare Standards for the maximum four year period
- Successful aged care accreditation via the Aged Care Standards and Accreditation Agency for the maximum three years
- Implementation of the 'VigilEnt' policy and guideline management system via the hospital intranet for all staff to access
- Overall level of satisfaction of 93.2% for residents of our aged care facility against an average of 88% across other facilities participating in the Moving On audit program.
- Training of diabetes education staff in Dose Adjustment for Normal Eating (DAFNE) to improve patient outcomes for those with diabetes (see page 10 for more information)
- Participation in the Rural Organisation of Australian Stroke Teams - 'ROAST'.
- Commencement of the Cognitive Impairment Identifier Program to help care for those people with dementia or memory problems

*SQuIRM - Safety & Quality, Including Risk Management

Clinical Governance is about providing top quality service and a safe environment for our patients and staff.

Il 'Clinical Governance' é un serrizio diqualita e sicurezza per il nostri pazienti e il personale.

Safety & Quality

Reducing Patient Risks

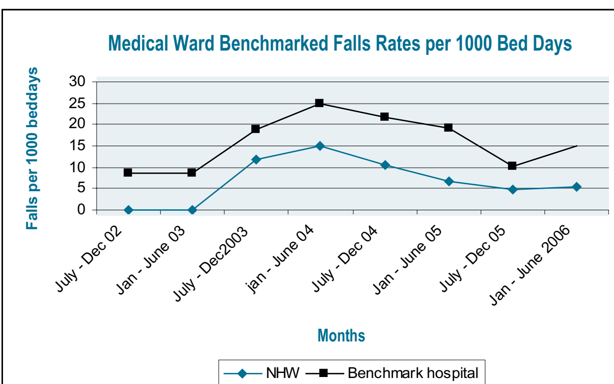
NHW has a comprehensive clinical risk management program that has been in place now since 2001. The reporting of patient incidents helps us to determine areas of greatest risk to our patients so that we can work to reduce the possibility of patient harm in these areas. As with most public hospitals, the largest number of reported patient incidents that occur are in relation to patient falls, medication errors and incidents of aggression and assault.

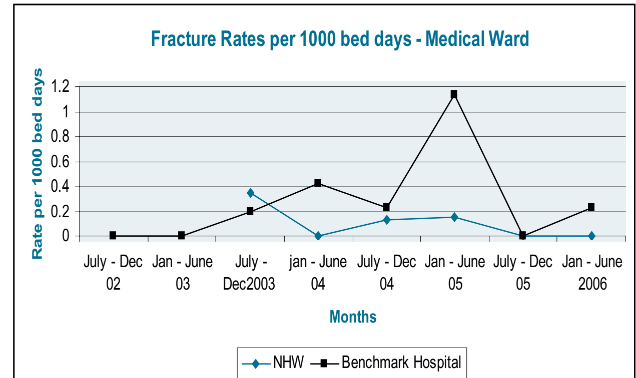
We have a well established system for reporting incidents and staff feel confident in reporting as we work on supporting a fair culture. We understand that no staff member comes to work to intentionally harm patients, therefore we are supportive in our approach to incident management - we focus wherever possible on systems and processes rather than individual staff. Incident reports are reviewed weekly by the Executive staff, with a monthly report also being tabled at the Quality & Safety Committee for review. Each clinical area is provided with monthly data in relation to incidents reported.

Preventing Patient Falls

All patients that are admitted to NHW are assessed for their potential to fall when they are admitted. If patients are determined as having a high or medium risk of falling, our staff implement strategies to reduce this risk. Specific falls prevention equipment is available for use and includes non slip mats, bed sticks and bed/chair alarms that notify staff if a more dependent patient has moved unexpectedly from the bed or chair.

During 2005/2006 the number of falls across NHW (including aged care) has decreased, as have the numbers of injuries resulting from falls. During 2005 we started benchmarking falls rates in our high risk areas (medical and aged care) with another hospital, looking at both falls and fracture rates per 1000 patient bed days. As can be seen in the graphs of our medical areas our rates are favourable. Nevertheless, we will continue to try and reduce patient falls further by auditing the use of the falls risk assessment tool and making sure effective strategies are used.





Decreasing the Risk of Pressure Ulcers

Pressure ulcers can be defined as an injury caused by unrelieved pressure resulting in damage to skin and underlying tissue. They are commonly known as pressure sores or bed sores. Those at high risk of developing pressure ulcers are the elderly and debilitated, especially those with reduced mobility.

Over the past 3 years, as part of a statewide promotion to reduce the incidence of pressure ulcers in hospital patients, NHW has been working to educate staff in both the identification, reporting and documentation of pressure ulcers. Patients are examined on admission to see if they are likely to be at risk of developing pressure ulcers. Care can then be planned ensuring every effort is made to decrease the likelihood of developing ulcers.

Staff are encouraged to report pressure ulcers via the incident reporting system whether they are present on admission or whether they develop during the hospital stay. NHW has participated in the third Pressure Ulcer Point Prevalence Survey (PUPPS) in May 2006. Staff of NHW act as surveyors on this day after completing a comprehensive training program facilitated by the Austin Hospital. We now have 15 staff who are fully trained and act as 'champions' in clinical areas to promote pressure ulcer awareness. Although we are still awaiting results of the 2006 survey, the reporting of pressure ulcers by staff has quadrupled since 2003.

A patient incident is any happening that is not consistent with the routine care of the patient.

Un incidente che succeda a un paziente, non ha niente a redeve con le cure stresse delpaziente.

Safety & Quality

Delivering Medication Safely

The safe delivery of medications to our patients is an essential aspect of patient care. Like falls, staff are encouraged to report any incidents relating to medication or intravenous therapy. It has been a major change in staff thinking to report these types of incidents, without fear of personal repercussion and over the past few years we have seen an encouraging increase in reporting. In 2003/2004 there were only 170 medication incidents reported as opposed to 2005/2006 when 277 were reported by clinical staff. If these incidents are reported then we have the opportunity to take action towards prevention.

The majority of errors reported are linked to administration of medications/intravenous fluids and we continue to examine each incident and make changes for improvement. In 2005/2006 we have:

- Fully reviewed the administration of Drugs of Addiction and have made process changes
- Developed stickers and posters as a checking prompt
- Developed a transfusion checking chart for safer administration of blood products, with associated policy changes.

In high risk areas medication errors are discussed as standing agenda items

Dealing with Adverse and Sentinel Events

Each year NHW treats between 47,000 and 48,500 patients. In the vast majority of cases, care is provided to the satisfaction of these patients, with no untoward effects. Occasionally though, treatment does not go to plan. In these instances we have systems in place that allow appropriate action to be taken to ensure that the patient and their family is fully informed of what has happened and also to ensure, where possible, that this event does not happen to another patient.

Open Disclosure

In 2005 NHW became involved in the National Open Disclosure Program as one of the Victorian Pilot Hospitals. Funding through the Department of Human Services has been provided to help progress this initiative. The term 'Open Disclosure' is used to describe the honest communication of information by medical staff to patients, typically following a serious adverse event. This is not a new concept, as doctors have always relayed information to their patients, however this new project is about making absolutely sure that we are meeting patient and family needs in health care and making sure they are well supported following an unexpected event.

As part of this project, 12 consultant medical staff and 5 senior clinical managers have undergone training by the Cognitive Institute in the open disclosure process and how to communicate effectively with patients and their families following an adverse event. We now have a policy in place that supports the process, it is discussed at medical orientation and it forms part of the medical handbook for new doctors.

Analysing Events

When a more serious adverse event occurs we need to make sure that the likelihood of it occurring again is minimised wherever possible. At NHW these events are analysed using a process widely known as Root Cause Analysis (RCA). This process maps the patient's episode of care, focusing on the critical points in the patients journey that may have contributed to the error. All sentinel events undergo a RCA and at times we may choose to initiate this process when we feel there was a potential for error but no patient injury has occurred (near miss). In 2005/2006 NHW reported no sentinel events, however we did perform a RCA on a near miss situation. By reviewing our current systems it was identified that there were things that we could do to improve safety. To this end, a new checking matrix for blood products was developed as an additional prompt for staff in the safe delivery of blood and blood components. The guideline for medical involvement in the Emergency Department was also altered to encourage improved communication between junior and senior medical staff.

Open Disclosure is about honest communication between clinical staff and patients following an unexpected event.

La rivelazione aperta riguarda la comunicazione onesta tra il personale clinico ed i pazienti in seguito aol un avvenimento imprevisto.

Safety & Quality

Infection Prevention and Control

The two key priorities of the Infection Prevention and Control Team at NHW are improving outcomes for our patients and providing a safe working environment for staff. The combined efforts of the Infection Prevention and Control team and staff working in all clinical areas has contributed to achieving these priorities.

Infection surveillance in a variety of surgical groups is monitored throughout the year and infection rates are benchmarked with other Victorian Hospitals. Considerable effort has been invested into the prevention of surgical wound infections. In the last 12 months there has been a reduction in these infections reported to the Victorian Nosocomial (Hospital Acquired) Infection Surveillance Centre (VICNISS). Improvements in the cleaning of shared equipment, management of sterile stock, skin antisepsis products and hand hygiene awareness have contributed to this outcome.

The Staff Health Service has continued to evolve and diversify with a record 185 staff being vaccinated against Hepatitis A or Hepatitis B, including combination vaccines in the last 12 months. In addition, over 400 staff received the Influenza vaccine this year whilst another 50 staff participated in our tuberculosis screening program, more commonly referred to as mantoux testing. Data from the 2005 vaccination program showed that a total of 43.9% of our staff received influenza vaccines, compared with an average of 37.9% across the state.

Over the last few years, occupational exposures to blood and body fluids have reduced as can be seen in the table below. This is most likely the result of staff adhering to standard precautions (ie wearing of gloves, safety glasses and protective apparel), the introduction of Intravenous safety cannulas and a heightened awareness/understanding of blood borne disease transmission.

Occupational Exposures

Exposure Type	2004	2005	2006 (to August 31)
Needle stick to skin	24	17	6
Splash to eye	3	4	1
Splash to non intact skin	4	3	1
TOTAL	**31**	**24**	**12**

The Victorian Quality Council (VQC) is currently funding two hand hygiene projects at NHW. Firstly, the pilot program based within clinical areas of the hospital has seen an average increase of hand hygiene (hand washing) from 34% to 64% over the course of the project. Results from all six pilot hospitals over the last 18 months indicate that staff at NHW have the highest rates of hand hygiene compliance. The program continues to focus on education and raising awareness for all staff with a clever marketing campaign designed around 'DeBug', the hospitals choice of Alcoholic Hand Rub (AHR). In 2006 all staff are required to complete the Hand Hygiene Credentialing Package and to date 347 of the 527 Nursing staff (66%) have completed this. Similar levels of compliance have been observed within other disciplines at NHW. These significant improvements in hand hygiene are the main contributing factor in the reduction of Methicillin Resistant Staphylococcus Aureus (MRSA) or more commonly referred to as 'Golden Staph'. A reduction of MRSA isolates and clinical infections since the programs inception in October 2004 is an impressive result.

In addition to the 'in house' project, NHW was selected as the coordinating centre for the stage one rollout of the hand hygiene program across the 16 Hume Region public hospitals. This program, funded for 12 months, will provide consultation and resources to assist Infection Control personnel in each hospital to introduce an alcoholic hand rub. Improvements in hand hygiene compliance and a reduction in hospital infections is the key goal. The program will also address issues involving the cleaning of shared equipment and hand care. To date all hospitals have recorded an increase in hand hygiene following the program launch into clinical areas.

Compliance with hand washing at NHW has increased from 34% to 64% due to the Hand Hygiene Project.

Il progetto delle mani igienche é aumenta to dal 34% al 64% per via della nouva legge sull igiene.

Staff Safety

Caring for Our Staff

As well as maintaining a safe environment for our patients at NHW, there is also a commitment to provide a safe workplace for our staff. Occupational Health & Safety now forms part of the Quality & Safety Department so that all safety issues organisation wide are considered in an inclusive manner. As with patient incidents, staff report injuries or 'near misses' via an incident reporting process and preventative actions are taken and documented. Manual handling, risk and housekeeping audits are undertaken regularly and staff attend mandatory training.

In 2005/2006 we have improved the safety of our staff by:

- Training 289 staff in correct manual handling techniques to reduce risk of injury
- Training 394 staff in the use of 'No Lift' equipment and techniques used in the moving or handling of patients
- Training 262 staff in Fire and Evacuation
- Training 12 additional Health & Safety Representatives, giving NHW a total of 44 trained representatives
- Providing Latex Free gloves for all staff to reduce the risk of dermatitis
- Introducing 'Albac' mats for easy evacuation of bed bound patients
- Installing additional duress alarms for staff working in high risk / remote areas
- Providing a new trolley for carrying weights in the Community Rehabilitation Centre
- Implementing new 'No Lift' equipment for Aged Care, Critical Care & Thomas Hogan Centre
- Introducing new work practices in the Linen Service to rotate staff through work stations and reduce risk of exposure to excessive noise
- Introducing a massage/exercise program introduced to the Linen Service to reduce the risk of injury to staff in this high injury risk area
- Introducing 24 hour security surveillance cameras
- Introducing a business visitors sign in books & badges

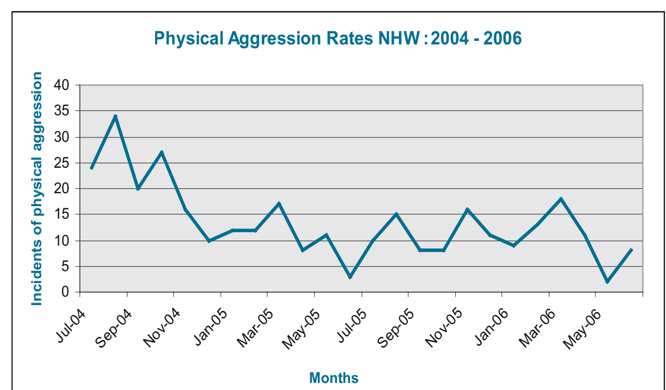
Numbers of staff injuries in 2005/2006 compared to 2004/2005	
2004/2005	284
2005/2006	177

Aggression Prevention & Management Project

As noted on page 5, aggression and assault forms one of our top three reported incidents. These incidents reflect violence, either verbal or physical, towards our staff and therefore demonstrate a high risk to our staff. We have an 'in house' aggression management training package that has been developed, however in May 2005 NHW was successful in joining Melbourne Health and the Victorian Workcover Authority who are funding a three year project which will focus on the prevention and management of aggression in the health workplace. This project is being supported by the Department of Human Services, with the initiatives developed in the project to be made available to all public hospitals in Victoria.

To date the project has focused on developing a 'Tool Kit' that can be used by all hospitals, whether they are a small rural or a large metropolitan hospital. This has been achieved by excellent input from all areas of the health industry, and working parties have been defining best practice techniques for use in the tools developed. The trialling of the completed 'Tool Kit' at Melbourne Health & NHW should start at the end of October 2006.

The graph below shows how a zero tolerance to aggression has reduced physical aggression rates across NHW from July 2004 to June 2006.



Staff injuries have decreased from 284 in 2004/2005 to 177 in 2005/2006.

Le lesioni al personale sono oliminuiete da 284 in 2004/2005 a 177 in 2005/2006.

Appropriate Care

Staff Qualifications

Providing high quality patient care begins with having well qualified clinical staff. At NHW we have systems in place to ensure that not only our staff have appropriate qualifications (credentials) to practice, but also to ensure that this practice is maintained at a high standard during their employment.

Medical staff at NHW have their credentials checked prior to commencement using a method consistent with that mandated by the Victorian Department of Human Services. This process ensures that senior medical staff starting practice at NHW provide management with information and evidence regarding their medical training, qualifications, experience, registration and ongoing professional development, in addition to their insurance status.

As part of this process, referee reports are sought for each applicant and each doctors' application is considered by a Credentialing Committee. This Committee consists of representatives of the senior medical staff at NHW, a representative from the relevant medical college and is chaired by the Director of Medical Services. After a senior doctor's credentials are set and approved by this committee, the doctors application for clinical privileges is considered by the Medical Appointment & Privileging Committee, the membership of which includes members of the NHW Board of Management. Senior medical staff may be given temporary credentialing and clinical privileges by the Director of Medical Services pending the next meeting of the Committees, but only after supplying all the information indicated above.

All senior medical staff at NHW have their credentials and clinical privileges reviewed by the two committees every three years. The Director of Medical Services is currently investigating a process for setting credentials for junior medical staff. It is important to note that junior medical staff are always supervised by more senior doctors, and have access to advice at any time.

As well as medical staff, we also ensure other clinical staff are appropriately qualified. Each year it is a requirement that all nursing staff provide management with evidence that they have renewed their practising certificate through the Nurses Board of Victoria. We now also cross check this with the appropriate Boards via the internet where possible, as it is very important to ensure only registered and properly qualified staff provide care to our community.

Staff working in specialty areas such as Critical Care and Midwifery also need additional qualifications to ensure they have the right skills to care for patients with special needs. All Midwives at NHW are endorsed by the Nurses Board of Victoria to practice Midwifery. Patients who come to our Emergency Department will have their care

managed by doctors and nurses who have extended their knowledge and skills in the emergency medicine area. Over 2005/2006, NHW has developed a comprehensive program to map staff qualifications, to ensure that nurses have access to appropriate education and are able to demonstrate expertise in their area of practice. An example of this is our Basic Life Support (BLS) and Advanced Life Support (ALS) Programs. All nurses in clinical areas must complete the BLS competency annually and all nurses in Critical Care and the Emergency Department must also complete the ALS competency annually.

Participation in various educational placements and programs ensure our staff are kept up to date with the latest advances in clinical care. In 2005/2006 NHW provided education and placement for the Post Graduate Diploma in Midwifery, medical students from the Rural Clinical School (Melbourne University), the Graduate Nurse Program, Acute Respiratory Course, Rural Critical Care Course and the Physical Assessment Course. NHW also has a number of undergraduate students learning at the organisation under the supervision of preceptors and educators.

Annual appraisals of all our clinical staff makes sure that performance is formally evaluated to ensure that acceptable standards are being met. Appraisals also help us determine the educational needs of our staff so that we can plan to meet staff needs.

All clinical staff caring for you at NHW have appropriate qualifications.

Al NHW tutto il personale clinico che si prenole cura di te e appropriatamente qualificato.

Appropriate Care

Planning Services

With a catchment area that covers an approximate area of 42,923 square kilometres and extends from the northern fringes of Melbourne to the Murray River and from the Victorian Alps in the east and the Goulburn Valley in the west, NHW provides health care services to approximately 70,000 people. We are located within the Hume Region of Victoria. With restrictions on the resources available for health care we need to ensure that we are providing the most appropriate services to these people. We do this by evaluating the current use of services by using information such as waiting lists and patient attendances to determine whether services are being used to capacity or if more services are needed. Every month the Board of Management is presented with information surrounding service use. Examples of how information is used to meet community needs and provide adequate service can be seen in the appointment of an additional Consultant Physician, General Surgeon, Paediatrician and Radiologist in 2005/2006.

We plan for future services based on community need and this need is in part determined using demographic data from the Australian Bureau of Statistics so we can identify areas such as age groups which help us to determine what sort of services may be required. Strategic planning (planning for our future) occurs every three years and currently we have a plan from 2005 until 2008. The strategic planning process involves not only our Board of Management and Staff, but also members of other health care organisations and the Department of Human Services to ensure we plan for appropriate service growth.

Meeting Special Needs

The community of Wangaratta and its surrounding catchment is primarily English speaking. Figures from the Australian Bureau of Statistics (2001) have shown that approximately 23,000 people in the Wangaratta area are English speaking with the largest potential non-English speaking group being Italian with 529 people. Despite this small number of people who potentially have limited English, we are mindful of the need to consider cultural diversity in our organisation. To this end we have a cultural diversity plan to ensure that we understand the needs of all clients and provide our staff with education and support to deal with people of different cultural backgrounds or special needs who may present for care here. We have information brochures available in different languages, interpreter services readily available for use if required and we have formed links with the local Goulburn Ovens Institute of TAFE Multi Cultural Consultant, Northeast Multicultural Association and the Shepparton Multicultural Centre. We also have a Cultural Diversity Committee which is structured into three key areas:

- Cultural Diversity
- Work/Life Balance
- Special Needs

Dose Adjustment For Normal Eating (DAFNE)

Another way of ensuring that we provide appropriate services is by making sure our staff are kept up to date with the latest clinical innovations and can offer these to our community. An example of our staff keeping abreast of new treatment methods can be seen within our Diabetes Education Unit. In 2005 the DAFNE approach to managing diabetes was introduced to Australia following great success in the UK and Europe. This method is a way of managing diabetes by working out how much insulin you need based on what you want to eat.

Learning the DAFNE method of managing diabetes involved our Diabetes Educators observing a 5 day patient training course in 2006, followed by a 3 day formal education and assessment. They are now able to teach Wangaratta clients about this new approach. Support has been provided by one of our Consultant Physicians who had previously worked using this method in Europe. The first training course for six patients has been conducted at NHW, with a second being planned.

Appropriate Care

Cognitive Impairment Project

Earlier this year, NHW announced it's participation in the 'Dementia Care in Hospital' Project. In 2003, carers of clients with dementia nationally identified that hospitals were not well equipped to meet the needs of clients with cognitive impairment and their carers. Ballarat Health Service had identified that clients with cognitive impairment were common in the acute wards settings. Clients with cognitive impairment were often not identified and this often resulted in ineffective support of these clients and their carers.

NHW also recognised the need for improvement in this area and commenced the Dementia Care program in January 2006, based on the work pioneered by Ballarat Health Service. A dedicated team was formed. Specific education programs have been developed and delivered to staff throughout the organisation, including those with a 'hands on' role in patient care and those without a direct caring role.

The use of a discrete visual identifier (as can be seen in the accompanying photograph) has been introduced and is designed to trigger an appropriate response from staff in caring appropriately for this specific group of people. Cognitive Impairment posters have been developed and placed throughout the organisation. Cognitive Impairment brochures are available throughout the organisation for clients and their carers.

Linked with the identifier are nine key communication points to assist staff and families to engage with cognitively impaired clients. These simple communication strategies are:

- Introduce yourself
- Make sure you have eye contact at all times
- Remain calm and talk in a matter of fact way
- Involve carers
- Keep sentences short and simple
- Focus on one instruction at a time
- Give time for responses
- Repeat yourself; don't assume you have been understood
- Do not give too many choices

Outcomes of the project so far have been:

> Development of the Abbreviated Mental Test Score and the Confusion Assessment Method forms

> Screening of clients admitted to NHW in May 2006. The criteria for screening (as recommended by Ballarat Health Service) is:

- All clients admitted over the age of 70 years
- All clients admitted over the age of 65 years if undergoing orthopaedic surgery

These patient groups are screened with the Abbreviated Mental Test Score and their management is planned as per the recommendations. If the patient's mental state is altered during their stay in hospital further assessments are attended.

> Introduction of the Cognitive Impairment Identifier. This identifier is introduced if clients have positive assessments. Clients and their families can choose not to have the identifiers placed above their bed. Use of the identifier is documented in the progress notes.

Further evaluation of this project is continuing with satisfaction currently being gauged from those patients and their families that have been part of this initiative.

The Cognitive Impairment Project aims at identifying special needs patients and providing appropriate care.

Il Progetto di Cognitive impairment mira a identificare i pazienti di bisogni speciali e fornescono le cure appropriate.

Services we Provide

- Acute hospital care - specialist medical and surgical
- Critical Care Services
- Medical Imaging (x-ray)
- Emergency
- Pharmacy
- Subacute services - inpatient and outpatient (ambulatory care)
- Midwifery services - CMP (Community Midwife Program), obstetric care
- Psychiatric services - inpatient, community, primary & aged
- Residential Aged Care
- Admission/Day Stay Unit

1. Psychiatric Services encompass acute inpatient, community, aged and primary care. Kerferd acute inpatient unit alone treated 5019 clients.

2. Our Nursing Home (Residential Aged Care) cares for both the frail aged and those with dementia. A new facility will be built in College Street.

3. There were a record 537 babies born at NHW compared to 491last year. A total of 120 mothers chose care through the Community Midwife Program (CMP).

4. Oncology services provided 1281 episodes of treatment with excellent patient satisfaction demonstrated.

Services we Provide

- Oncology
- Palliative care
- Home based nursing and support services - district nursing, hospital in the home, post acute care
- Renal dialysis
- Dental services
- Allied health services
- Patient/client education programs eg: diabetes education and cardiac rehabilitation
- Paediatric - inpatient, home care

1. NHW provides a diverse range of surgical services to the people of Wangaratta. There were 4,640 operations performed, with a total operating time of 174,701 minutes.
2. The Medical Imaging Department provides x-rays, ultrasounds & CT scans. Last year another record number of procedures was performed: 49,253.
3. Pharmacy Department filled 20,990 scripts in 2005/2006. There is currently one Pharmacist and one pre registrant Pharmacist working in this area.
4. The Critical Care unit contains 8 beds and all staff working there are fully trained. Last year the staff cared for 805 patients compared with 673 the previous year.

Surgical Care

Mr Smith had suffered from intermittent knee pain for several years but lately it had become more constant and was affecting his golf game. Something had to be done!

After a visit to his local GP, Mr Smith was referred to an Orthopaedic Surgeon for review where it was discovered that he had osteoarthritis of his knee and that he required a replacement of his knee joint. At the specialist's rooms his condition was assessed for urgency and he was placed on the waiting list at NHW for surgery. (See page 19 to learn more about the waiting list process).

As the time for surgery grew closer, Mr Smith attended NHW for an appointment at the Pre Admission Clinic. While he was there he was assessed by a number of clinical staff including nurses, doctors and physiotherapists who not only checked out his current health, but also helped prepare him for theatre by educating him about what to expect and how long he would be in hospital. Mr Smith was given a letter outlining the exact date of surgery and what time he had to present for admission. He was unsure of a few points, so staff were able to clarify these for him. Risks of surgery were explained by the Orthopaedic medical staff. In addition, he also visited the Anaesthetist in their rooms to make sure he was medically fit for an anaesthetic.

On the day of surgery, Mr Smith knew exactly where to go, because the Pre Admission Clinic is in the same area as the admissions unit. Once he arrived he was admitted by administration staff and prepared for theatre by nurses. He had already showered at home and used the antiseptic scrub solution to reduce the risk of infection. He was again visited by medical staff to make sure he was fit for surgery and before he was taken into the operating theatre he was wrapped in a warming blanket. This blanket stayed on before, during and after surgery to help maintain normal body temperature.

Mr Smith was wheeled to the operating theatre where he was checked in by one of the theatre nurses. They made sure he had a correctly completed and signed consent form, confirmed the correct operation and the correct side and site, checked that he was not wearing any jewellery of other metal objects, he had not had food or drink that day and that all his allergies were listed. It was only after these checks were made that he was taken to the anaesthetic room where and intravenous (IV) drip was inserted and he was prepared for his anaesthetic so his operation could begin.

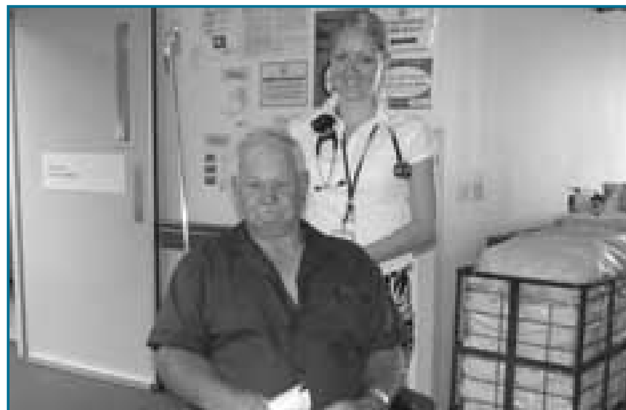
Following surgery, Mr Smith awoke in the recovery room where he initially experienced some pain in his knee, but this was soon controlled using the Patient Controlled Analgesia (PCA) device - patients push a button to control the dose of pain relief they receive via their drip. Once his pain was controlled and his pulse, blood pressure and temperature were considered 'normal' after about half an hour, he was transferred to a high dependency bed in the Critical Care Unit. All joint replacement and major surgical procedures at NHW are admitted to this unit for the first 24 hours post operatively (if there are sufficient beds available) to be closely monitored by nursing staff and receive individual care to assist in a safe and rapid recovery.

Day one after surgery Mr Smith was transferred to the ward. He still had a drain tube, intravenous therapy, PCA and catheter in place and was still confined to bed. To his surprise he found that his pain was well controlled and he could move quite comfortably around his bed. He was advised by the Acute Pain Team to make sure his recovery was not slowed because of unnecessary pain. Over the next couple of days all the attached tubes were removed and after an x-ray to check his knee, the Physiotherapist got him out of bed. His pain was now well controlled with tablets and his mobility increased around the ward, firstly with a walking frame and progressing to a walking stick.

Mr Smith was visited daily by the Orthopaedic medical staff. Half his stitches were taken out on the sixth day with the remaining stitches removed the following day. On the seventh day following surgery, as planned, Mr Smith was discharged home. Follow up appointment times were made and provided to him in a discharge information package that also included information about how to care for his wound at home and a contact number for the ward in case he had any queries.

An electronic summary of Mr Smith's procedure and recovery including medications was sent to Mr Smith's nominated GP to ensure they had up to date information should Mr Smith need to see them in the near future. After he had been home for several weeks Mr Smith received a satisfaction survey in the mail. It was part of a state wide survey looking at how patients feel about the care they received in our public hospitals and Mr Smith was happy to complete this survey and return via reply paid envelope. (Further information regarding this process is available on page 16).

Mr Smith is now back on the golf course and enjoying a pain free life!



Acceptable Services

Accreditation

In 2005/2006, NHW underwent full accreditation surveys in both aged care and the acute, community and psychiatric areas of the hospital. Aged Care services are reviewed by the Aged Care Standards and Accreditation Agency (ACSAA), whilst the remainder of the organisation is reviewed by the Australian Council on Healthcare Standards (ACHS). Undergoing accreditation is mandatory across the entire organisation and is an indication to our community that the care and services provided are of a high standard both in quality and safety.

Aged Care

Wangaratta and District Nursing Home (WDNH) underwent accreditation review on January 31 and February 1 2006 with two external surveyors over two days. This review assessed the care and management of the home across 44 standard outcomes within the following 4 groups:

- Management Systems
- Clinical Care
- Resident Lifestyle
- Emergency and Safety Systems

Nursing homes are awarded a ‘satisfactory’ or ‘not satisfactory’ rating against all of these 44 standards with WDNH scoring ‘satisfactory’ across all 44 outcomes, the best result that we could achieve. The nursing home has therefore been accredited for a further three years. All nursing homes in Australia must be part of the program, and this is the third such survey where WDNH has achieved the maximum standard required.

Organisation Wide

The remainder of the organisation (acute, community and psychiatric services) underwent a full accreditation survey in September 2005 with 5 surveyors from across Australia assessing our organisation for three full days. With ACHS accreditation the surveyors look at a large number of areas under the broad headings of:

- Leadership & Management (how the organisation is managed)
- Safe Practice & Environment (safety of patients, staff & visitors)
- Human Resource Management (people management)
- Continuum of Care (patient care)
- Information management (medical records and computer systems)

Again the result was very positive for NHW and we achieved the maximum accreditation that can be awarded under this system - four years. With all surveys, recommendations for further improvement are made and action plans surrounding these suggestions have been developed to ensure we continue to provide a high standard of service.

Quality Award Winners

Each year NHW awards prizes to individual staff or departments that have made a significant contribution to improving our services. The Quality Award recipients are announced at the Annual General Meeting and are congratulated for outstanding research and innovation in the work place, making the organisation a better place for all internal and external customers, and celebrating excellence. Results of the 2005 Quality Awards were:

Clinical Quality Award was presented to Leesa Milne and the Orion Team for the successful implementation and evaluation of electronic discharge summary information to GPs.

Non Clinical Quality Award was presented to The Supply Department for the successful introduction of the remote ordering requisition system.

Customer Service Award was presented to Jill Castles for her integrity, care, diligence, and for understanding that little touches can make a big difference in dealing with our customers.

Our Nursing Home and hospital were both awarded maximum accreditation status.

La nostra Casa di cura e l'ospedale sono stati entrambi premiati con il Massimo apprezzamento.

Acceptable Services

Involving our Community

At NHW we are keen to make sure our community is involved in decision making surrounding the health care that we provide. There are various ways in which we use the feedback of our consumers in continually improving what we do. Feedback can be formal or informal and includes complaints, compliments and results of satisfaction surveys.

Complaints and Compliments

At NHW we see complaints as an opportunity to improve what we do and all complaints are treated seriously. In 2005/2006 we received a total of 91 complaints, both written and verbal, and ranging in seriousness. A performance target we set for complaints is to have all complaints acknowledged within 7 days and in 100% of cases this was achieved. Another indicator of performance is to have all complaints completely answered with a written response sent to the person making the complaint within 30 days. In 80% of cases this was managed, and we aim to improve on this figure. However, there are sometimes complex complaints that require more in depth investigation, and at times these take us longer to fully investigate and respond to.

As the result of complaints received in 2005/ 2006 we have been able to make some changes to our current practices to improve what we do. In many cases there have been reminders to staff about general customer service and effective communication. Processes surrounding timely information to General Practitioners and Pharmacists as well as discharge processes have been reviewed. We are also considering the production of a brochure for patients with fractures, so they know how to care for plasters at home and what to expect.

Sometimes we receive letters via the Health Services Commissioner, the Aged Care Complaints Resolution Scheme, the Ministers' Office or from the local members offices. In 2005/2006 we received 8 complaints via these avenues. All these complaints were answered to the satisfaction of both the complaint handling bodies and the people making the complaints.

As well as complaints we also receive formal letters of thanks from satisfied customers who are grateful for the care they have received. In 2005/2006 there were a total of 99 formal letters of thanks received.

In 2005/2006 NHW received 91 complaints and 99 compliments.
In 2005/2006 NHW ha ricevuto 91 reclami e 99 complimenti.

Satisfaction

NHW takes part in a State Wide Patient Satisfaction Survey that is commissioned by the Department of Human Services. Participation in this survey is completely voluntary and surveys are sent randomly to patients who have been discharged from hospital. Completed surveys are then collated by an independent company who provide us with results, comparing us to similar hospitals, for each six month period. For the time period September 2005 to February 2006, the satisfaction with overall care at NHW was 79% compared with the average of 78% for hospitals in our similar 'B' group. As well as the overall care category, survey results are divided into 6 main areas for reporting as can be seen in the table below:

Area measured	NHW satisfaction score	Similar hospitals (Group B) satisfaction score
Access and admission	77	77
General patient information	84	83
Treatment and related information	79	79
Complaints management	81	81
Physical environment	76	76
Discharge and follow up	76	77

In addition to this feedback, we also ask aged care residents what they think of the service they receive. The satisfaction in Aged Care is compared through a system called 'Moving On' and in our latest results, overall satisfaction within our facility was 93.2% compared to a benchmark average of 88%.

Acceptable Services

Direct Involvement

Involving community members on committees across the organisation also occurs at various levels. Organisation wide we have a Community Advisory Committee that meets monthly and reports through to the Quality & Safety Committee. Its role is to:

- Ensure that community opinions/thoughts are represented and communicated
- Represent the needs and issues of the community using the health service
- Bring local health issues to the attention of the committee
- Pass on information to the community and provide possible feedback to the working group.
- Attend relevant meetings, activities, training and education days organised by NHW
- Provide advice and review information the hospital will produce regarding its services to the community
- Where appropriate, provide comment on the organisation's strategic and business plans.
- Provide advice and opinions as requested on how programs or services may better meet community needs.

The Community Advisory Committee is heavily involved in the production of the Quality of Care Report and has provided advice on the content and layout as well as the readability of this report.

The Community Advisory Committee ensures the community voice is heard by hospital management.

Il Comitato consultivo di Comunita assicura che la voce olella comunita é ascoltate dalla gestione ospedaliera.

Psychiatric Services have a well developed consumer participation program that involves consumer and carer representatives in policy, planning and strategic direction as well as staff selection and service delivery. There are two consumer consultants and one carer consultant, all who work with their own networks of consumers and carers. They then report back to the facility via the Consumer and Carer Reference Groups. These Reference Groups are comprised of the consumer/carer representatives and Program Managers from across Psychiatric Services as well as the Area Manager for Mental Health Services.

Aged care services also have three community members who sit on the Aged Care Quality Committee. They provide feedback from their perspectives, and are also able to communicate improvements to residents and to the community in general. In addition there is a wonderful volunteer program at the nursing home. The Lifestyle Team within Aged Care will continue working with the Community Relations Department to expand the work of this valued group of people.

Volunteers

Volunteers are utilised throughout NHW and we now have a formal volunteer program that is centrally coordinated via the Community Relations Department. NHW recruits, orientates and trains volunteers to provide help in areas such as palliative care, aged care, visitor and companion programs, psychiatric support, gardening and walking groups, arts and crafts and children's activities. All volunteers attend a volunteer orientation program and attend training updates and meetings, where feedback regarding their roles and the organisation are received. If issues requiring action are identified, these issues are directed to the department involved for action.

Access to Care

Community Aged Care Packages

In 2004 NHW was successful in gaining ongoing funding to provide 15 Extended Aged Care at Home (EACH) and 20 Community Aged Care (CAC) 'packages' to our community. These packages provide care assistance to the elderly to enable them to remain living safely at home with adequate support. To access a CAC or EACH package of care, the client must be:

- Over 65 years of age
- Have complex needs
- Prefer to live at home with support from community services
- Require case management.

EACH packages are distinguished from CAC packages in terms of both complexity and intensity of service provision - CACP clients are those assessed as requiring low level care and EACH are assessed as having high level care needs. Potential clients are assessed according to their requirements by the Aged Care Assessment Service (ACAS). ACAS manages the waiting list and prioritises clients for care assistance as vacant packages become available. It is the NHW program staff who make the final decision to provide an approved person a package. This decision is based on program needs, such as the mix of high and low care clients, geographical location, skill mix of care managers and budget considerations.

The packages provided are flexible and designed for individual care needs. Services provided include:

- Case Management
- After hours contact in the case of emergency
- Personal assistance, which may include bathing, showering, or personal hygiene, toileting, dressing or undressing, mobility, transfer, preparing and eating meals, sensory communication, or fitting sensory communication aids, laundry, home help, gardening
- Transport to help the person shop, visit a medical practitioner or attend social activities
- Temporary respite care in the home and other services to suit.

This new service became fully operational in November 2005 and the current package recipients for NHW are spread across 9 of the 11 municipalities within the Hume Region. The program is staffed by a team leader, two case managers and administration support. The packages have enabled access and coordination of services for all the clients which has resulted in reduced stress on client and carer. Many of the EACH client's have had a great deal of equipment purchased and this has resulted in a better quality of life and, in some cases, greater independence. Access to social activities, allied health and respite services have resulted in an increased ability to remain at home.

Hospital Admission Risk Project / Chronic Disease Management (HARP/CDM)

Another new service funded by the Department of Human Services is the HARP CDM program that was commenced in November 2005. The aim of this service is to:

- Reduce the number of preventable admissions and presentations for clients with chronic cardiac/respiratory conditions and/or complex needs, and to maintain their independence within the community
- Monitor and assess the progress of a client's chronic illness and provide a timely response to enable early management of any exacerbation of their condition, preventing hospital admission
- Increase efficient use of the health system and promote independence through self management education.

The HARP/CDM program has 3 permanent staff (program manager and 2 care coordinators), provides 2 rotations of 3 months duration to the Graduate Nurse Program and 3 days a week support to the District Nursing Service. The program commenced client intake at the end of April 2006 and to date has cared for 165 clients.

Community Aged Care (CAC) and Extended Aged Care at Home (EACH) packages support the elderly to remain at home.

La (CAC) serrizio di cura per glianziani e il servizio esteso ad anzia ni a domialio (EACH) sono dei servizi per il sostegno degli anziani a olomi cilio.

Access to Care

Waiting Lists

Although NHW provides a diverse range of services across the organisation, it is important that we monitor how well people are able to access these services. One way of doing this is by looking at how long people have to wait for treatment. We monitor waiting times in many areas, including our surgical waiting lists and the Emergency Department.

All patients undergoing surgery at NHW are placed on a waiting list according to the urgency of their condition. Urgency classifications are:

Category	Description	Ideal Time to treatment	NHW 2005/2006	NHW 2004/2005
1	Urgent	Within 30 days	100%	100%
2	Semi Urgent	Within 90 days	100%	100%
3	Non Urgent	Within 365 days	83%	80%

It is the surgeon who determines the urgency of treatment and therefore what category a patient is put in to determine waiting time for surgery. In line with the DHS Elective Surgery Access Policy, waiting lists should be reflective of patients who still require surgery and who are currently ready for care. Although doctors determine the priority of care, waiting lists need to be actively managed by NHW.

Routine auditing ensures the Elective Surgery Access Policy is maintained as well as ensuring any patients that are not ready for care can be identified. If patients are found to be unfit for surgery, they can be provided with active management to ensure their surgery can proceed without delay.

In 2005/2006 there has been growth in our waiting lists for Category 3 patients and reasons for this growth are attributed to additional specialists now in the Wangaratta area, as well as an increase in people using our services from outside our catchment area. In the last financial year 19% of people on the total surgery waiting list came from outside our primary and secondary catchments. Despite this growth in people needing surgery, the accompanying table shows that the percentage of people waiting over the maximum recommended waiting times has remained the same - a commendable effort from all our staff.

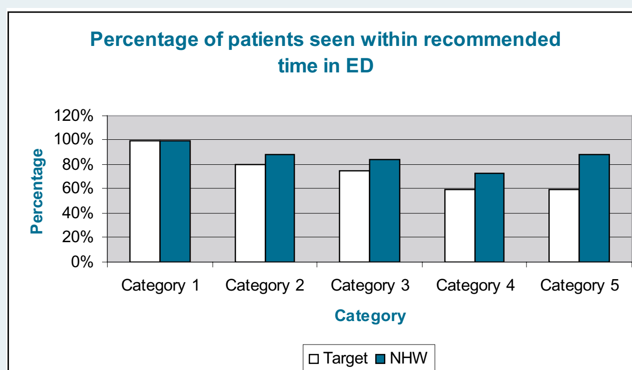
Internal auditing of waiting patients occurs on a routine basis utilising a clinically experienced registered nurse in a limited duties return to work capacity due to injury. All patients waiting for surgery longer than 12 months receive a telephone call at least every 6 months (ideally 3 monthly), to assess if there is any change in their waiting condition. Results are entered onto the electronic waiting list episode for the patient concerned and appropriate health care team members informed of any relevant changes.

Emergency Department

Within our Emergency Department patients are also seen according to priority which at times can mean that patients have to wait for periods of time that can seem lengthy. Priority categories are as follows:

- Category 1 - Urgent cases / medical emergencies - require immediate treatment
- Category 2 - Serious conditions that will deteriorate rapidly without treatment - need treatment within 10 minutes
- Category 3 - Requiring urgent medical attention - require treatment within 30 minutes
- Category 4 - Less urgent complaints - require treatment within 1 hour
- Category 5 - Non urgent complaints - require treatment within 2 hours

As can be seen in the graph, NHW performs well compared to targets set by the Department of Human Services in treatment waiting times.



Patients are placed on waiting lists by surgeons and are treated according to priority.

I pazienti sono collocati sulle liste d'attesa dai chirurghi e sono trattati secondo la priorita.

Effective Care

Clinical Indicators

The term 'clinical indicator' is used to describe data that we collect about our clinical services that help us monitor what we do and how well we do it. By collecting specific data and comparing this with data from other similar health care organisations (benchmarking), we can get an idea of our performance and where we need to improve. NHW currently collects clinical indicators and benchmarks through special programs run through the Australian Council on Healthcare Standards (ACHS) and the Department of Human Services (DHS).

We currently collect indicators for:

- General Surgery
- General Patient Care
- Mental Health Services
- Rehabilitation
- Hospital in the Home
- Emergency Department

Whilst the majority of our clinical indicators show that our rates are comparable or better than other organisations, there are times when expected levels are not met and improvements are then required. An example of this can be seen with the Mental Health Service indicator 'inpatients who assault in an admission'. The rate of assault within the inpatient mental health unit was significantly higher that our peer hospitals as could be seen in the data from 2003. Our rate of inpatients who assault in admission was 13.91% compared with a peer organisation rate of 5.06%. This posed a risk not only to our staff, but to other clients and the clients themselves. Episodes of assault often lead to the client being secluded, or separated, from other clients until their behaviour is more acceptable, and our seclusion rate (36.52%) was also significantly higher than our peers (11.90%).

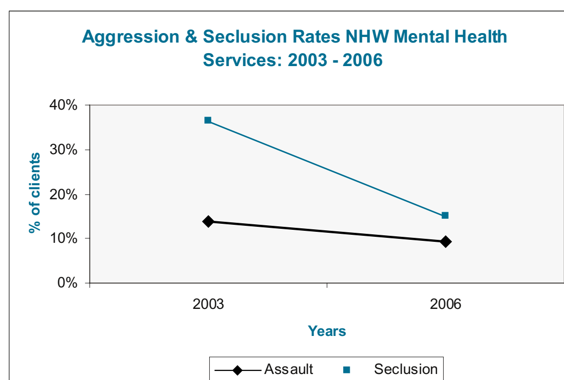
Staff of our Mental Health Services considered this data and in an effort to reduce the rate of aggression and seclusion, a therapeutic program was introduced in 2004, with the results becoming fully evident in 2005/2006.

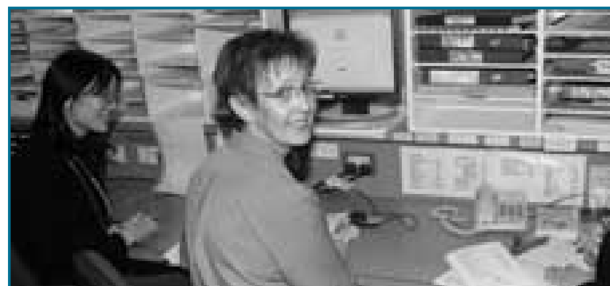
A program coordinator was appointed and a steering committee was formed to guide development of the therapeutic program. A 'morning meeting' was introduced at 10 am each day, with open membership, held in the dining area of the inpatient unit. While this forum provided a voice for clients, it also facilitated a constructive environment to welcome new members and reinforce 'house and safety rules' such as clean air policy and fire and evacuation procedures. Clients can contribute to program planning and can report maintenance issues or raise any concerns they may have.

Program activities have included walking, card making, shopping, cooking, art and crafts and music groups. While some programs are focussed on recreation others are designed to increase the skills of daily living. Some components of the program focus on empowering clients through introduction to the mental health act and client rights, while others facilitate discharge planning and integration into the community.

An innovative part of the program is the client-led group which utilises patient skills (eg. art, dancing, organic gardening and music). This program has been successful in that 50% of this time-slot is planned and facilitated by the client group. This also allows the program co-ordinator time to attend clinical meetings.

As a result of this program being introduced, the consumer consultant reports that patients say that 'the day is shorter' and 'less boring'. Furthermore they enjoy the opportunity to interact, have less time to focus on problems and feel that the program increases their self esteem. In relation to the clinical indicators, our rate of inpatients who assault in an admission has decreased to 9.43% in the first half of 2006. Our seclusion rate has reduced to 15.09% for the same time period, a significant improvement.





Clinical indicators are data used to determine how effective our services are.

Gli indicatori clinici sono dei dati usati per valutare come i nostri servizi sono efficaci.

Effective Care

Community Services Intergration Project

The purpose of the Community Services Integration Project (CSIP) is to assist the three community health providers in Wangaratta - Ovens and King Community Health Service (O&KCHS), the Rural City of Wangaratta (RCoW) and NHW to develop a common purpose and future vision for an incorporated health and community based service system.

A wide range of services are currently provided by the three organisations from three main sites, each individually managed and maintained. In addition, there are several services operating from smaller off-site offices.

A comprehensive five year plan that covers the range of services will provide the organisations with strategic direction for a more collaborative and integrated approach.

Presentation of the final practical strategic plan by the consultant is due in August 2006 and it will then be the responsibility of the three organisations to progress this plan to provide a more streamlined approach to Community Health Services across the City of Wangaratta.

Work completed so far..

Time frame	Outcomes
August 2004	Two project briefs written
Late 2005	Consultant appointed Steering committee formed to oversee the project including representatives from NHW, O&KCHS and the RCoW
	Small design team (9 representatives) developed a process for: • consultation • decision making • consolidation
February 2006	A half day workshop with approximately 30 participants from the three organisations was held to draft a framework for integration. A process to move forward was also developed.
May 2006	Six working groups were formed to develop strategies to progress the way forward. These groups looked at service delivery and planning in relation to: • Community engagement • Information and clever decision making • Quality • Managing the integration • Shared planning • Our people
June 2006	Results discussed with consultant

Integrated Primary Mental Health

The Integrated Primary Mental Health Service (IPMHS) is a service delivery partnership between the North East Victorian Division of General Practice (NEVDGP) and NHW. The IPMHS offers a range of services to both the general community and service providers. It provides both direct clinical service in regional General Practices and a range of health promotion, education and training pertaining to high prevalence mental health disorders. Since commencement in June 2003, the 5 IPMHS co-located clinicians have provided assessment and counselling services for 2,772 clients across the region.

The accessibility (at GP clinics), lack of stigma and focus on early intervention of the IPMHS actively addresses the service gap for people in the region experiencing high prevalence mental health disorders such as anxiety and depression. Initially, the impact on adult mental health services was a 30% reduction in referrals. However, as the IPMHS has grown and waiting lists have developed, this impact has been reduced.

NHW is working with two other community service providers to integrate services.

NHW lavora con due altri fornitori di servizio civile a integrare i servizi.

Efficiency of Services

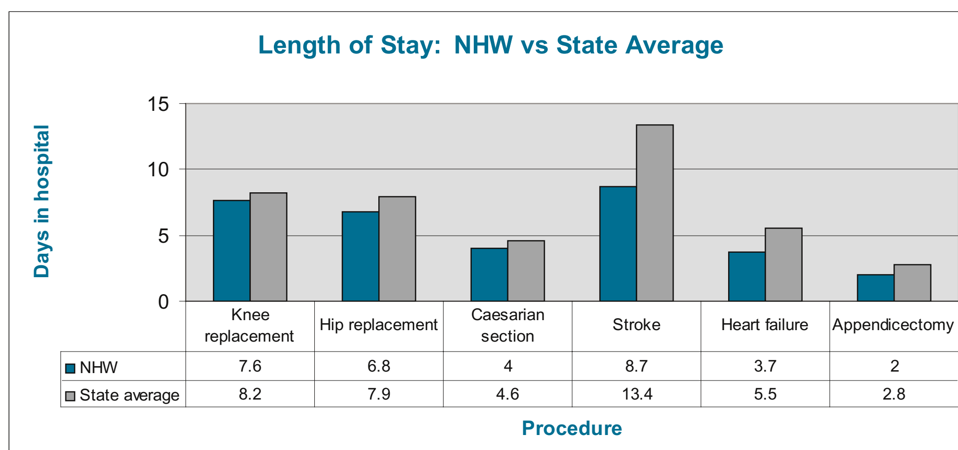
Medical Assessment & Planning Subunit

The Medical Assessment and Planning Subunit (MAPS) was opened in January 2005 as part of Ground West, the acute medical ward. This new sub unit was developed to encourage a streamlined approach to admission, assessment and management of acute medical patients. Part of NHW's policy on acute medical admission and discharge planning is the facilitation of early referral to relevant allied health professionals and timely medical investigations. The aim of MAPS is to:

- Provide efficient bed management
- Focus acute care in a dedicated area
- Co-ordinate discharge planning
- Reduce the length of stay for medical patients
- Complete all relevant allied health assessments within 24 hours

Clinical staff work together with both the patient and carer to plan medical treatment and to commence preparation for the transition from hospital to home. The length of stay in MAPS is 48 hours, and during this time appropriate referrals to inpatient services and external care providers are made to ensure a well planned and supported discharge. At the end of 48 hours, patients will either be discharged, transferred to the most appropriate ward within NHW or transferred back to their referring hospital.

During the first year of operation, 1,193 patients were admitted to MAPS. Referrals to appropriate allied health services have facilitated treatment and early discharge, which is apparent in some of the statistics. The average length of stay in twenty four of the most common medical conditions has decreased (compared to the previous twelve months) and in many cases, is less than the state average length of stay.

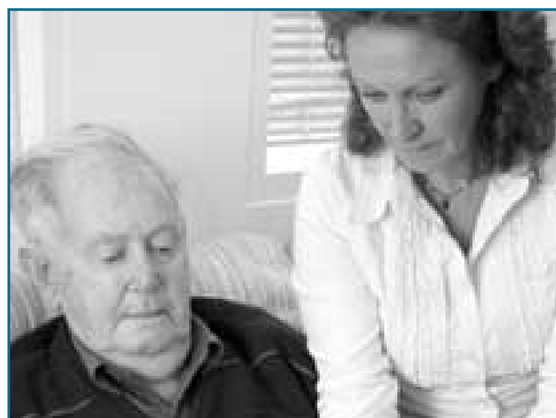


Length of Stay

With advances in medical technology, many procedures that in the past required a lengthy stay in hospital often now see the patient home relatively quickly, even following major surgery. Naturally with the ongoing demand for hospital beds it is of benefit for hospitals to discharge patients efficiently, but in doing so we need to ensure that this is done safely and that the patient is happy to go home. In short, we need to balance efficiency with quality.

In comparing the amount of time our patients stay in hospital with averages for the state of Victoria, we can determine our efficiency. The graph above compares the length of stay of some of our most common procedures at NHW with the state average length of stay.

To balance quality aspects, patient satisfaction from the Victorian Patient Satisfaction Monitor (September 2005 - February 2006) showed 85% of patients thought that the amount of time spent in hospital was about right. We received no complaints from patients in the 2005/2006 year regarding inappropriate length of time spent in hospital.



The Medical Assessment Planning Subunit (MAPS) provides admission and assessment for acute medical patients.

MAPSfornisce l'ammissione e la valutazione per i pazienti con seri problemi disalute.

Efficiency of Services

Day of Surgery Admissions (DOSA)

Day of Surgery Admissions also increase the availability of beds by not admitting patients the evening prior to surgery. All patients who are to undergo major surgery attend the Pre Admission Clinic where they are assessed by the nurses, doctors and allied health staff prior to their hospital stay. If special needs are identified during this visit, plans can be made before admission to meet these needs. Plans and actions can even be put in place for services after discharge, initiated at this first meeting.

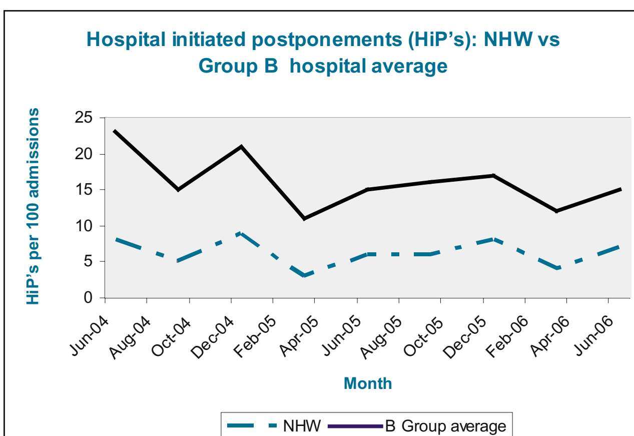
Much of the paperwork required on admission is completed on this visit. The added advantage is that the patient has the chance to meet staff they will see on the day of admission and also have the chance to ask any questions they may have about the procedure or the hospital. Using this streamlined and planned approach to admission, we have been able to increase our DOSA rates to between 96% and 100% for General Surgery, Orthopaedic Surgery, Gynaecology, Urology and Ear Nose and Throat Surgery.

Hospital Initiated Postponements (HiPs)

Hospital Initiated Postponements are the numbers of occasions we have to postpone patients who are scheduled for surgery. Surgery may be postponed for a number of reasons, including:

- Emergencies (for example, trauma cases requiring urgent treatment)
- Lack of available beds
- Unavailability of specialised equipment

If a procedure is postponed, every effort is made to re schedule the operation as soon as possible. As can be seen in the graph, NHW has a favourable rate of Hospital Initiated Postponements compared with the average for similar sized Group B hospitals in Victoria.



Recycling

As one of the largest 'industries' in the Rural City of Wangaratta we have a responsibility to care for our environment, as health care organisations produce enormous amounts of waste. The waste management system that we have in place is of an excellent standard and received special commendation at our Organisation Wide Accreditation survey in September 2005. Information sharing occurs between NHW and other health care organisations keen to see how we have reduced our landfill waste by such a large degree.

In 2005 we became the first hospital in Victoria to start recycling nappies and incontinence pads. These products are recycled by 'My Planet' and are used as heavy duty plastic to make a range of products such as garden seats. As can be seen in the table below, we take recycling seriously and each year the amount of product we recycle becomes larger.

Product	2004 - 2005	2005 - 2006
Plastic bottles & containers	4021kg	4155kg
Tin cans	2980 kg	3289kg
Incontinence pads / nappies	0	33,358kg
Security shredding	11,150kg	12,044kg

We need to balance efficiency with quality.

Abbiamo bisogno di bilanciare l'efficienza con la qualita.

Health Promotion

Health Promotion

Health promotion is defined by the Ottowa Charter (1996) as ‘the process of enabling people to increase control over, and to improve, their health’. Health promotion programs deliver benefits for the community in promoting positive wellbeing, reducing preventable illness and lowering overall health care expenditure. There are many and varied activities at NHW that aim to promote the health of our patients, visitors, volunteers and staff. Some of the health promotion activities offered by NHW include:

- Promotion during specific ‘health weeks’, including the PIT STOP health screening program
- Nutrition sessions for new mothers
- Antenatal programs
- Staff health programs
- World Café evening - open forum to discuss mental health (Target group: hairdressers/barbers in 2006)
- Early Motherhood Program - support & counselling for mothers experiencing difficulties following the birth of a child.

In particular NHW has been involved in a number of projects during 2005/2006. These include:

Community Kitchens

A ‘Community Kitchen’ involves a group of people with similar backgrounds or interests getting together to cook and socialize and encourages all members to participate in the cooking process. Members will generally cook 3-5 delicious and nutritious meals for themselves and their families. The groups are owned and driven by the participants, who are encouraged to use creativity in the development of their individual kitchens. NHW, in partnership with Ovens & King Community Health Centre (O&KCHC), Anglicare, The Centre and Yarrunga Primary School have successfully worked together to implement of Wangaratta’s first Community Kitchen.

Health promotion promotes positive wellbeing and reduces preventable illness.

La promozione sulla salute promuove il benessere in generale e riduce i rishi di malattie.

Rural Health Week ‘Pitstop’ Program

NHW, again in partnership with O&KCHS, the Integrated Primary Mental Health Service and the Rural Clinical School offered a free health screening service for members of the Wangaratta Community. The aim of this program was to provide people with information about their own health status and encourage them to take responsibility for their own health. Health checks covered included eyesight, body mass index, smoking, alcohol, blood pressure, testicle self examination, breast self examination, mental health and bladder/bowel control.

140 individuals participated in the 2 day screening program, reporting it to be a worthwhile community activity. Rural Health Week was May 15th-21st 2006 and our staff were available in King George Gardens to perform this total health check free of charge.

Staff Health and Wellbeing

Workplace health promotion programs aim to support NHW staff to make healthy choices about their lifestyle, to prevent disease as well as reduce workplace absence due to accident, injury or illness. Staff health was identified as a key issue following the organisation wide health promotion audit. To ensure our staff health promotion program addresses issues of concern to staff, a staff health and wellbeing survey was conducted in April/May 2006, with 340 surveys returned - a response rate of 30%.

The results highlighted 4 key areas of concern:

1. Mental health & wellbeing
2. Physical activity & injury prevention
3. Healthy, nutritious food
4. Tobacco smoking

These results will be used to influence the further development of the staff health promotion plan.

Thank you

Every year the production of the Quality of Care report is a major undertaking and there are many people who have helped in its publication. Special thanks must go to the Community Advisory Committee who have not only provided advice on content and layout, but have also been invaluable in their proof reading of this report so it can be easily understood. Special thanks also to those from the community who have helped with the Italian interpretation presented in this edition, as well as others external to the organisation who have been involved in proof reading.

Thanks must also be given to our staff, not only for their assistance with this report, but also for providing the excellent standard of care and service to the patients, clients and residents over the past 12 months. Without our staff we would not have the thriving health service that we have today, that will care for the people of Wangaratta well into the future.

Feedback

This report has been designed primarily to provide our community with information about NHW and the services it provides. To help us to produce a meaningful report each year, we need your comments.

Please let us know what you thought of this years report by completing the enclosed evaluation form. Reply paid envelopes are provided for you to return these completed forms.

Alternatively you can send any comments to:

Quality & Safety Manager
Northeast Health Wangaratta
PO Box 386
WANGARATTA VIC 3676

Feedback via our hospital website at www.nhw.hume.org.au is also encouraged.