QUALITY ACCOUNTS 2014

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Quality Accounts

Putting patients first: a report on the safety and quality of healthcare in Wairarapa

Welcome to this year's Quality Accounts for Wairarapa District Health Board. It gives you a snapshot of how we support the health needs of our people in our community. This Quality Account is an annual report about the quality of services we deliver. We aim to deliver a first class servicce which is patient focused and provides the right care and support when and where it is needed.

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Putting Patients First

Introduction

This is Wairarapa's second Quality Account which highlights some of the work we have done over the last year to improve services and outcomes for Wairarapa people. We look back at some of the initiatives we have implemented both in the hospital and in the community to improve services with patient safety and involvement in mind.

The Quality Account is a way of openly reflecting on the care we provide for our patients, describing what we do well and highlighting where there are opportunities for improvement. Our job is to understand what patients want from us, to truly listen to what they tell us about their experience and see things from a range of perspectives. We realise for patients it is about receiving the right care, at the right time and in the right place.

This Account focuses on the quality of services we provided during 2013/2014. We demonstrate our achievements, our progress in improving the patient/consumer experience and our desire to continuously improve our health services.

DHBs working together

The integration of Hutt Valley and Wairarapa DHBs under one management structure has created many opportunities for sharing information, expertise and improving services. The achievements of this year are a firm foundation for the 2014/15 year as we move towards more streamlined services across Wairarapa, Hutt Valley and Capital & Coast DHBs. We recognise that our future lies in forging strong subregional and regional relationships and implementing sustainable arrangements to continue to deliver safe, high quality affordable services in the Wairarapa over the forthcoming years.

This year has also seen the coming together of three DHBs in the larger Wellington region (Wairarapa, Hutt Valley and Capital & Coast). We are working together to ensure that change initiatives are focused on quality and safety. Through the sub-regional (3DHB) programme, Service Level Alliances have been set up in areas such as Child Health and Health of the Older Person where we have identified that by working collaboratively, we can deliver better and more timely services to our patients.

Hospital and community

The increased pace of integration can be seen not just with our neighbouring DHBs but also with local health providers. We work in partnership with medical practices, Compass Health, community health providers, support groups, aged residential care and NGOs to deliver high quality care. Together we work to support healthy lifestyles, improve population health and care for those who are sick.

We acknowledge the commitment and professionalism of our staff and those of other DHBs and in community care who have developed partnerships across teams and services, to enable gains for patients. The DHB works in partnership with many community groups and health providers in Wairarapa and beyond.

Health promotion

We continue to support and promote the Health Quality & Safety Commission campaigns, which have targeted key areas including inpatient falls, healthcare associated infections and hand-hygiene compliance as well as surgical safety checks.

Recognising staff

Acknowledging the value of improvement work by individuals and teams is important and alongside our annual local Nursing and Midwifery Awards, this year we launched the inaugural 3DHB Allied Health, Technical & Scientific Awards. The awards recognise the key role Allied Health professions play in healthcare delivery. This year we are also holding our inaugural 3DHB Quality Awards, which celebrate innovation and recognise the achievements of staff across all three DHBs.

The on-going commitment to training our workforce; both present and future, remains a key driver to our success. We continue to encourage innovation and practice improvement to benefit our combined populations.

We value and appreciate the array of involvement from clinical staff at all levels across the DHBS and primary and community care to ensure we all practice safe, high quality, and effective healthcare.

Learning from our mistakes

The strength of an organisation is measured not by counting the number of successes, but by its response to failure.

This Quality Account does not just highlight our achievements – sometimes mistakes are made or things are not as good as we would like. We learn from those mistakes and they help us plan for the future. In this Account we set out our priorities for improving quality over the coming year and the ways in which we will achieve these improvements.

Consumer feedback

Our vision for the future has been shaped by listening to the opinions and experiences of our patients and their families, along with the views and priorities of our staff and other key stakeholders. We encourage feedback from consumers of healthcare and we receive great feedback and in many cases high satisfaction with services provided. This feedback helps us continually improve the patient experience. We want our patients to feel cared for and confident in our services.

Thanks

We would like to thank all our staff across our hospital and community services for their continuing hard work and commitment.

We also thank our patients, our volunteers and all those with an interest in our services who have offered their time, support and feedback over the past 12 months. We look forward to working with all our teams, and with our key stakeholders, to deliver our vision for top quality and safe services over the year ahead.

Graham Dyer
Chief Executive

Derek Milne
Board Chair

Values

Vision

Well Wairarapa – Better health for all

Wairarapa ora – Hauora pai mo to katoa

Mission

Our Mission is to improve, promote, and protect the health status of the people of the Wairarapa, and the independent living of those with disabilities, by supporting and encouraging healthy choices.

Values

Respect – whakamana tangata

According respect, courtesy and support to all

Integrity – mana tu

Being inclusive, open, honest and ethical

Self Determination – rangatiratanga

Determining and taking responsibility for ones actions

Co-operation – whakawhanaungatanga

Working collaboratively with other individuals and organisations

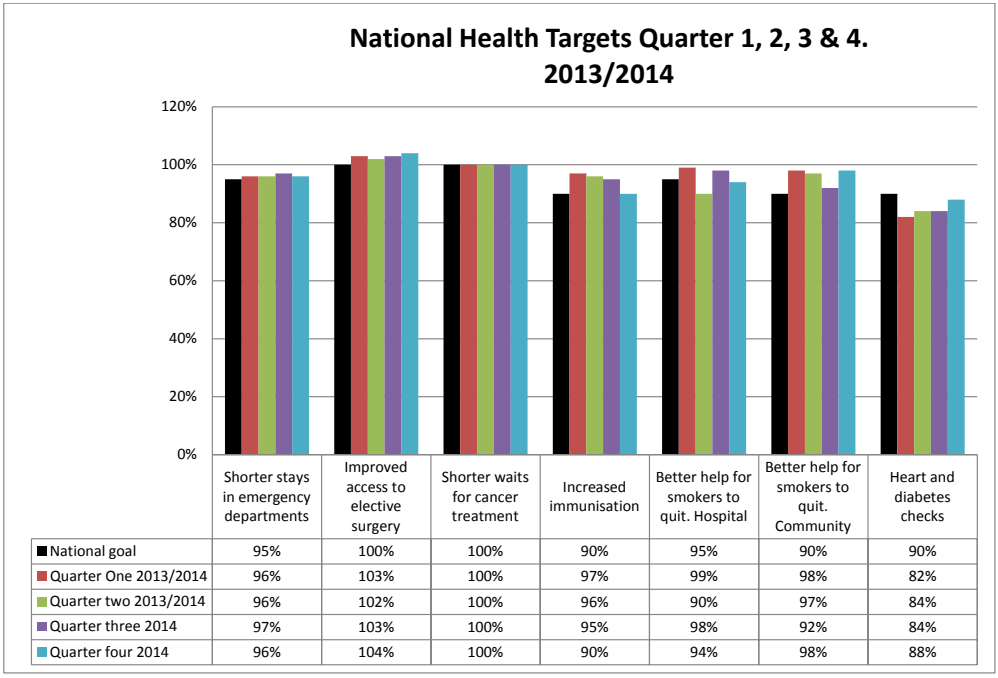
Excellence – taumatatanga

Striving for the highest standards in all that we do

Health Targets

The national health targets compare Zealand's 20 health boards across six categories each quarter. They are a set of six national performance measures specifically designed to improve the performance of health services. The targets are determined by the Minister of Health and reviewed annually to ensure they align with government's health priorities. Wairarapa has consistently performed well against the National Targets this year, only just falling short in two of the six targets in the last quarter of 2014. On six occasions during the year Wairarapa DHB ranked first in New Zealand when measured against all DHBs.

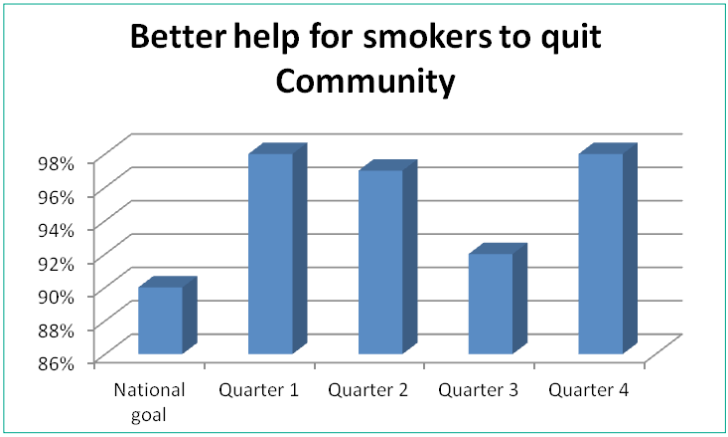
Wairarapa DHB Health Target Performance 2013/2014



	Shorter stays in emergency departments	Improved access to elective surgery	Shorter waits for cancer treatment	Increased immunisation	Better help for smokers to quit. Hospital	Better help for smokers to quit. Community	Heart and diabetes checks
National goal	95%	100%	100%	90%	95%	90%	90%
Quarter One 2013/2014	96%	103%	100%	97%	99%	98%	82%
Quarter two 2013/2014	96%	102%	100%	96%	90%	97%	84%
Quarter three 2014	97%	103%	100%	95%	98%	92%	84%
Quarter four 2014	96%	104%	100%	90%	94%	98%	88%

Helping Smokers Quit

The Government is determined to reduce the burden of death and disease caused by smoking and its goal is for a Smokefree Aotearoa by 2025. The aim is to protect children from exposure to tobacco marketing and promotion, reduce the demand for tobacco and provide the best possible support for quitting. In Wairarapa, the DHB and Compass Health Wairarapa have introduced several innovative programmes to stamp out smoking. Results show that in National Health Targets Wairarapa DHB is leading the country for helping smokers to quit.



In medical practices

Wairarapa medical practices are top achievers in New Zealand with their support for smokers to quit smoking. Since January 2013 Wairarapa medical practices have continually exceeded the primary health care target of offering smokers brief advice and support to quit smoking. The national target is 90%: in the April to June 2014 quarter Wairarapa practices achieved 98%.

Practice staff, nurses and doctors ask patients when they come into the practice if they would like cessation support and contact those who have not come to the practice by phone or text.

Brief advice provided to practice patients has resulted in successful quit attempts, and a decrease in smokers. 10% of those who smoked two years ago, and were given brief advice, have quit. Census data has also shown a substantial drop in smokers. The 2006 census showed that 23% of the Wairarapa population smoked and by 2013 this had dropped to 17%.

Compass Health works closely with Wairarapa practices to encourage them to continue their excellent work of providing brief advice and cessation support to smokers. They provide medical practices with weekly statistics showing how many of their patients need to be given brief advice to meet the target by the end of each quarter. Numbers of patients to contact is divided into weekly figures and it is calculated how many hours it will take to contact this number of patients. This means practices can allocate time and resources appropriately. Practices find this a very motivating and supportive strategy as it allows them to track progress.

In the community

Spreading the Smokefree message within the wider Wairarapa community has also had an impact with more people making more quit attempts.

The Wairarapa Smokefree Network is a collective of health organisations including Compass Health, Whaiora, the DHB and the National Heart Foundation. This network works together providing regular communications and media releases and promoting smokefree events and promotions in an ongoing manner to de-normalise smoking and to encourage people to quit.

This year the Network supported World Smokefree Day, Smokefree Sport, and Smokefree events such as Wairarapa Wearable arts and the Golden Shears.

Golden Shears

The Golden Shears committee this year made a commitment to hold the annual Golden Shears event as a smokefree event. Their vision was to have no smoking outside the stadium venue or on the surrounding footpath areas. The Wairarapa Smokefree Network joined forces with the Golden Shears organising committee to promote the smokefree message and support it as a smokefree event.

Quit Coaches from Whaiora, Quitline and the DHB were at the event. A smokefree stand was erected at the stadium entrance. The Golden Shears commentators made frequent smokefree announcements during the event, and the Maori Wardens encouraged any smokers outside the venue to abstain from smoking in the vicinity.

The smokefree stand outside the stadium at the Golden Shears, February 2014.

This event was a great success, Whaiora and Quit Line received many quit referrals and participants, spectators and the Golden Shears committee were happy to have smokefree air at their event.

The Golden Shears committee had a vision for this year's event to be smokefree and they succeeded beyond their expectations with the public, including smokers, supporting their smokefree stance with grace and respect.

"People were so keen to talk about their experience with smoking and to chat about how we might help them. Even some of the shearers raced out to see us after they had finished a competition. The Shears commentators in good humour were 'ribbing' the shearers who weren't winning that they better give up smoking if they wanted to be fitter and faster. These comments obviously got to them."

Whaiora Quit Coach

Next steps

Compass Health will continue to work with practices to ensure they maintain their high level of brief advice to patients. Practices will continue to receive weekly notifications of their progress to meet the target.

Think Right, Dream Big

St Teresa's School in Featherston wished to support their senior boys (Year 7-8) with a programme to build resilience, develop confidence and build self–esteem. Such a programme would support the boys to learn skills and techniques to cope with feelings of peer pressure, fear and anxiety.

Tiran O'Hagan, Public Health Advisor, working with senior school staff designed and developed a programme to support the school. The parents and Board endorsed 'The Think Right, Dream Big Programme' which aimed to equip the boys to better deal with life's challenges during their remaining primary school days, and onto college and beyond.

The key tenet for the programme was the acronym LEADER: leadership, equipper, attitude, dreamer, excellence and relationships. This provided a maxim for the boys to work through any issues or problems and provided guidance in everyday activities. The programme was delivered weekly for seven weeks. Discussions included: dreams and aspirations, understanding how thoughts and feelings affect behaviour, developing confidence and self-esteem, dealing with conflict bullying and peer pressure, and leadership. Each week, Tiran returned to the office progressively more excited about the increased enthusiasm and engagement experienced with the boys.

He particularly noted the importance and impact of building a rapport with the group as they learned to trust him and value his input.

A key component of the programme was the inclusion of Tu Tama Toa led by Ronnie Wairau, Public Health Advisor. Tu Tama Toa is a wānanga for young teenage boys designed to encourage, empower and instil self-worth through the medium of Mau Rākau. Through exploration of karakia, purākau (story), movement and imitations of nature it depicts messages for self control, discipline and self esteem.

Since the programme began, Senior Teacher Carrie Watson has observed a change in behaviours of the boys. "The boys have begun to show some great thinking in situations with their peers, both in the classroom and the playground, speaking up for others and reminding others what they should be doing. One student who finds social situations difficult is now relating better with his peers. Comments from the parents are that the boys are talking about 'Think Right, Dream Big' at home and they have enjoyed working with Tiran. I have found the programme a really positive initiative, especially as we have no male teachers at St Teresa's. I would be really keen to be a part of something like this again.

The boys have learnt not to belittle anyone, and to accept everyone. Being aware rather than to beware (important when rākau are flying), I stress continuously the importance of teamwork or working as a team. We have learnt that this means moving to the beat of one heart and watching their brothers' back. Their acceptance of one another is also demonstrated at the end of our lessons where we hongi each other; a transformation clearly evident where all of the boys now are comfortable with this tikanga and even better demonstrating it with one another. So their acceptance of one another is vital and is a form of encouragement hence empowering each and every one. The empowerment in our boys, especially in our Māori, is seen clearly through their efforts. One of the parents is even making them a rākau matarua (taiaha). It has also created a window for them to see a taonga that truly belongs to them and they have responded. They are inspired in what is shown and modelled but I tell them 'you cannot and never will swing a stick like me but you are the only one who can swing a stick like you'.

Ronnie Wairau, Public Health Advisor

Nurturing Baby

Breastfeeding Wairarapa (formerly the Baby Friendly Community Initiative) aims "to promote, increase and maintain high breastfeeding rates for all and encourage greater public awareness and community engagement in supporting families to breastfeed for at least six months."

Breastfeeding Wairarapa organises community-based health promotion events such as *Nurturing Baby* and *the Big Latch On.* Events are a key part of public health practice and focuses on changing community norms, attitudes, awareness, practices, and behaviours.

The Breastfeeding Wairarapa committee includes Regional Public Health - Wairarapa, the Wairarapa DHB Maternity Service, Whaiora, Parents Centre, Plunket and Parents As First Teachers (PAFT).

The Big Latch On

At the Big Latch On in August, mums and babies from across Wairarapa showed their support by latching on to promote breastfeeding and to break last year's record. 64 babies latched on successfully breaking the record in a fantastic turnout at the Carterton Events Centre! Last year 48 mums and babies latched on.

Clare McLennan-Kissel, Breastfeeding Wairarapa Coordinator from Regional Public Health - Wairarapa, was delighted with how many people came to the event in Carterton, the first time it has been held outside of Masterton.

"The community in Carterton really got behind the Big Latch On with the Events Centre donating the venue and other local businesses providing morning tea, goody bags and spot prizes".

It was a really positive community event supporting local mums to continue their breastfeeding effort.

A local breastfeeding health promotion

This year Breastfeeding Wairarapa held Nurturing Baby, a free event outside Countdown. This inaugural event primarily targeted mums with plenty of information for dads, grandmothers and extended whānau. It promoted the idea that everyone can have a role in breastfeeding by helping around the house, preparing meals for mum, making sure she gets enough sleep, for example. The event supplied free sausages, free fruit and a free raffle for all those who participated to emphasise that one key benefit to breastfeeding is that it is free.

Breastfeeding health promotion is a key part of work for Regional Public Health – Wairarapa. Increasing breastfeeding rates helps contribute to the Regional Public Health bold goal of "halving the rate of avoidable hospital admissions for Māori, Pacific and children by 2021".

Gaining community and whānau support for breastfeeding is extremely important to the success of mothers being able to breastfeeding for at least six months. Breastfeeding will give a child the best possible start in life. The benefits for the mother are also enormously important - the longer she breastfeeds, the better the protection.

Maternity Matters

The Maternity Quality & Safety Programme

The Maternity Quality & Safety Programme brings community and hospital maternity professionals together to discuss how they can lead and implement a programme to improve the quality and safety of maternity services in our region. It guides the development and delivery of integrated maternity services and monitors agreed quality performance indicators to ensure effective service delivery and the best possible outcomes for women and their babies.

Annual Report

The Maternity Quality and Safety Programme's second Annual Report highlights some great achievements that have occurred for maternity over the past year:

Pregnancy Information Packs

We developed these packs for GP practices so pregnant women who attend the clinic are given a pack containing up-to-date information about being healthy in pregnancy, smokefree advice, how to find a midwife as well as local midwives' leaflets. This ensures streamlined information is shared with women throughout the community. Maternity DHB staff visited all Wairarapa GP practices providing them with the Pregnancy Information Packs and introducing them to the Maternity Quality & Safety Programme.

New Wairarapa Maternity Website

A new website designed for parents and health professionals is now online. It is a hub of information relevant to Wairarapa and links into alternative sites to help keep women well informed.

www.wairarapamaternity.org.nz

Consumer feedback survey

We developed a maternity services consumer feedback form for women to complete following their inpatient stay. Survey results are now being collated. Responses so far have been very positive and reassuring.

Newsletter

A quarterly newsletter providing up-to-date information, changes in the service, new members of the team, new campaigns and reminders of the website, smokefree, SUDI and education is sent to health professionals and the wider community.

5:10 Campaign

This campaign took a regional approach promoting five of the most important things to do in the first 10 weeks of pregnancy.

Wairarapa DHB Pregnancy and Parenting Education

Wairarapa DHB recommenced Pregnancy and Parenting classes in October 2013. Previously antenatal education was contracted out to Wairarapa Parents Centre. Initially each course was 12 hours of education over 6 weeks, but this was extended to 15 hours in April 2014.

The courses are run by two DHB midwives, both with current practising certificates.

On site Hospital classes

Since October 2013:

- 66 women have been booked into the classes with 51 completing the full course.
- Most women are around 31 weeks pregnant when they join a class.
- The age range of attendees was 19 years to 37 years
- The ethnic mix included 1% Indian, 1% Asian, 2% Pacific Island, 5% NZ Maori, 5% European, 86% NZ European.

Teen parenting unit classes

- Community education at the Wairarapa Teen Parenting Unit began in February 2014 at the start of the school year. Midwife educators provide ongoing pregnancy and parenting information for pregnant teens.
- 13 enrolled students have attended classes this year.

Whaiora drop-in classes

Drop-in classes of two hours per week began at Whaiora in February 2014, with the support of Whānau Ora and Whaiora services. These were designed to target high-risk women who may not otherwise be able to access pregnancy and parenting education.

Unfortunately, despite support from Whaiora, these classes had a poor uptake and were cancelled in June 2014. The intention is to set up regular, concentrated weekend satellite classes in outlying rural areas.

Targeting

The goal for the remainder of 2014 is to establish regular satellite classes, targeting high risk groups such as teens, Maori and Pacific island women and low socioeconomic groups. This has been initiated with classes starting in Featherston.

Improving Cancer Treatment

At Wairarapa DHB the Cancer Nurse Coordinator has been working with the clinicians who deliver oncology services to audit and review the DHB's performance against the draft national tumour standards. Two Standards (bowel cancer and lung cancer) were completed in 2013/14.

National tumour standards

New National Tumour Standards will improve consistency of care for cancer patients in New Zealand. The new standards have been developed by health professionals from across the cancer pathway and are based on established national and international evidence-based guidelines, or expert opinion.

All tumour standard documents cover timely access to services, referral and communication, data collection, investigations, diagnosis and staging, multidisciplinary care, supportive care coordination, palliative care, treatment, follow-up and surveillance.

Jacinta Buchanan,MDM coordinator at WDHB, praises the commitment of WDHB General Surgeons and physicians for introducing this standard.

General surgeons, Mr Ian Thirsk and Mr Bob Saharkian

"Our patients will be supported through their journey and we will be able to monitor and measure our performance against the standards. If we are consistently able to meet these standards we can be confident our patients will be getting timely, high quality care.

The Government has confirmed funding of $11.2m over four years for a new Service Improvement Fund to support DHBs to make sustainable cancer service improvements. The introduction of National Tumour Standards should improve consistency of care across all DHBs, and particularly improve outcomes for patients living away from the main centres."

Jacinta Buchanan, Cancer Nurse Coordinator.

Multidisciplinary care

Multidisciplinary care is the hallmark of high-quality cancer management. Presenting cases diagnosed with cancer to multidisciplinary treatment planning meetings (MDMs) is an important aspect of the Faster Cancer Treatment Programme and one of the National Tumour Standards that Wairarapa DHB is implementing.

MDMs represent an important step in the cancer treatment pathway, in which all core disciplines regularly attend meetings to provide input to diagnosis and treatment plans. Wairarapa DHB introduced these early in 2013.

Introducing MDMs has produced good results for patients diagnosed with colorectal cancer. They are brought to MDM clinical discussion typically within one week of a diagnosis and can be treated within 31 days. These patients are 6% more likely to receive timely treatment compared to the regional average.

All patients with complex cancers are discussed at multidisciplinary forums often hosted by a DHB video conferencing link-up between smaller DHBs and the larger DHB treatment teams. Each team has a pathologist radiologist, oncologist and any other specialty clinician required to make treatment decisions and plans. It is an efficient use of time and resource with all interested clinical staff able to discuss the diagnostic findings and make a recommendation about treatment. Using video conferencing unites clinical expertise in one room, makes organising treatment plans easier, and saves the patient time to move straight into their treatment regime. It is the way of the future using technology to bring teams together and to effectively reduce travel for the patient out of the area to appointments. Recommendations from MDMs clearly give patients and clinicians a pathway for best practice treatment.

Jacinta Buchanan, Fiona Terry – faster cancer treatment tracker, and Dr Tim Matthews triage cancer patients.

Advance Care Planning

The elephant in the room is that we are reluctant to talk about death and dying and the type of treatment and care we want at the end of our lives, whether death is expected or sudden. For some communities talking about death is taboo. Often discussions do not happen in families until someone is very unwell and may be in hospital. When people get sick, families and healthcare providers are often left to make difficult decisions without knowing what the person wants. Advance Care planning can help with this.

Advance Care Planning (ACP) was a concept introduced internationally in the late 1980s but has only gained momentum in NZ in recent years. ACP assists in the provision of quality health care and is becoming increasingly important, due to the growing range of medical treatment options at the end of life. ACP is a tool to use to enhance recognition of shared decision making.

Advance Care Planning is a process of discussion and shared planning for future health care. It involves patient and whānau and health care professionals. Advance Care Planning gives patients the opportunity to develop and express preferences for end of life care based on their personal views and values, a better understanding of their current and likely future health or the treatment and care options available.

Advance care planning can be many things, such as having a conversation about illness, prognosis and treatment, having a discussion about death and dying, talking about treatment preferences, now and in the future, writing down values and beliefs to inform treatment decisions now, or for a time when a person is no longer capable.

Advance Care planning will not resolve all difficulties related to care decisions for an incapable patient. It may not be possible to fulfill all of an individual's care wishes. For example, a person may express a wish to die at home but the material and emotional resources of the family and the resources of the health care system may not be able to sustain care at home until the end of life.

Advance Care Planning - A guide for the New Zealand Health Care Workforce, 2011.)

At Wairarapa DHB

In 2013 I was selected to join the working party to develop a framework for the Central region around Advance Care Planning. The final document was released this year. A group of health workers came together to see how we were able to engage the public/ healthcare colleagues about Advance Care Planning using the concept of "conversations count".

Raising awareness of this issue is not an easy undertaking and achieving lasting behavioural change is challenging. To raise public awareness of a topic is an attempt to inform the behaviours, attitudes and beliefs of a community. We need to be mindful that ACP is not exclusive to older people but to everyone who wishes to put in place a plan for themselves.

We need to keep this project very focused and be brave about having these discussions with our patients, especially with life limiting conditions, complex needs, the physically and/or intellectually disabled people.

We want the general public to raise ACP with our own families, friends, whānau and colleagues. It is a great opportunity to think about and share what is important. It helps us to think about and plan what treatments we do and don't want and it helps us to clarify how we want to be cared for as we approach the end of our lives.

Anne Savage, Palliative Care Nurse Educator

Quotes from local patients interviewed:

- ***I feel in control, not leaving my family to guess what is to happen to me if I have a big health event.***
- ***It was good to talk this over with my wife as she had some good ideas too and then she did hers – what a relief.***
- ***I have made a will and EPOA but writing my wishes that I want before my death is reassuring.***
- ***I don't want life support. I want to die gracefully, naturally and not with lots of machinery. I want my family to get on with their lives - not mourn me for too long.***

Falls

Falls Prevention

Health Quality & Safety Commission New Zealand continues to identify falls as the leading cause of injuries to older people and a significant factor in the loss of their independence. The impact of a fall, even if there is no physical injury, can cause a loss of confidence and lead to a restriction of activity. This in turn can cause a loss of physical conditioning which then leads to an increase in the risk of falling.

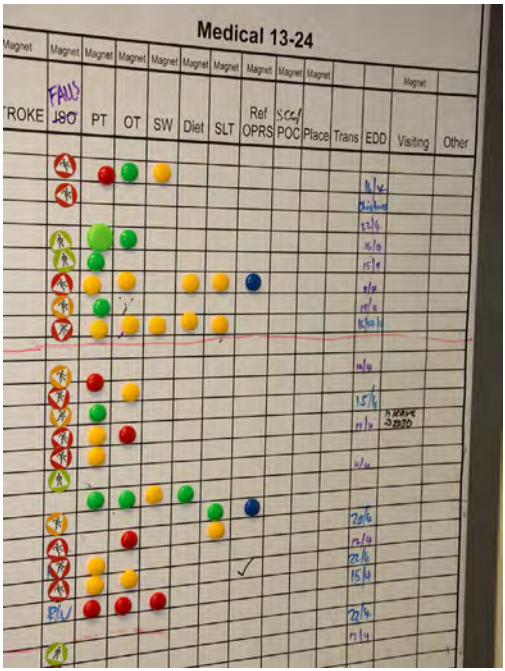
Hospital Initiatives

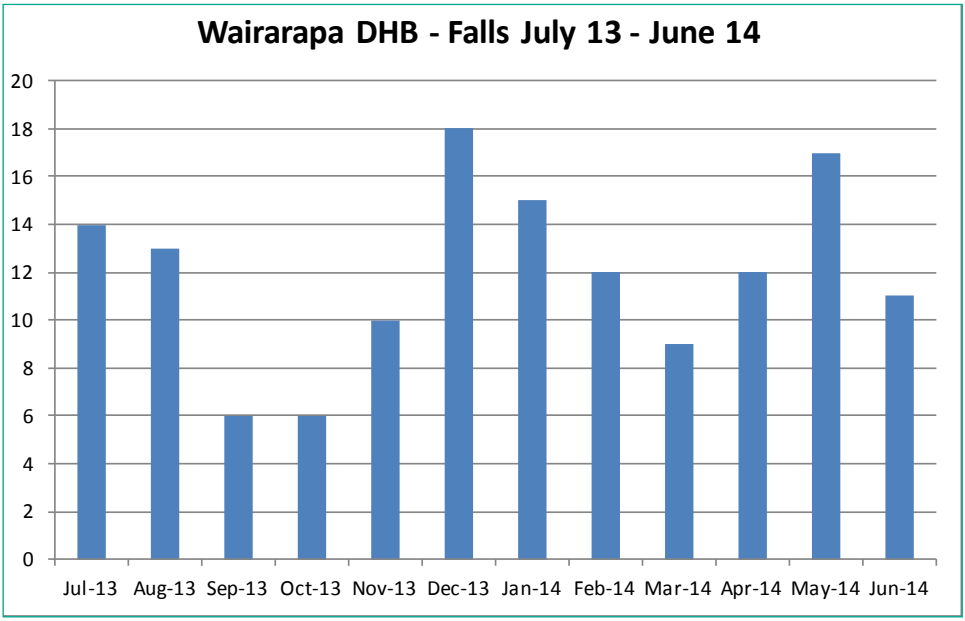
Falls in hospitals often lead to patients needing longer hospital stays, with further medical tests and treatment. Wairarapa DHB has routinely asked all adult patients admitted into the hospital if they have had a fall in the last year as part of the 'Ask, Assess, Act' National Falls Prevention campaign which aims to reduce the number of inpatient falls.

A few simple questions have identified a number of patients targeted for further assessment and interventions. It is important we continue to ask the question "Have you had any fall including a slip or trip in which you lost your balance and landed on the floor or ground or lower level?" The importance of using words such as 'slip, trip, stumble and losing balance' in regard to falls will ensure people are aware that a fall is more than a person hitting the ground.

Over the last year as part of the National Campaign the DHB's Falls Prevention team introduced a 'Traffic Light System' in the wards.There are flip charts above the beds that highlight risk levels to indicate if patients need help. This has helped staff implement appropriate strategies to reduce the risk of patients falling. The Traffic Light System gives visual cues that identify a patient's level of risk. Red = high, amber = medium, green = low risk.

Also on the wards the traffic light system uses red, amber and green magnets on the patient identification boards; this identifies the risk status of patients at a glance in the staff offices.





"It helps you to quickly signal a change in the level of help needed if the patient's status and risk changes – the magnet can be swapped, or the bedside sign can be flipped over, and a new note particular to the patient's changed risk or need can be added. A patient's risk level may change through the day – for instance, someone who is unsteady on their feet, taking night sedation and having diuretics, may need more help with getting to the toilet in the morning than they do in the afternoon. The April Falls activities will complement the strong focus all DHBs place on reducing falls and harm from falls throughout the year."

Vivienne Petersen, Team Leader of Wairarapa DHB's Falls Prevention Group

Occupation Therapy intervention after discharge from ED

The Wairarapa DHB Falls Prevention Initiative has kept its momentum. The initiative screens all people over the age of 65 who have been discharged from the Emergency Department following a fall. They are contacted by telephone and asked a series of questions in order to determine their risk of falling and further injury in the home environment.

Since July 2012 more than 300 people over the age of 65 have been contacted following discharge from ED. Most consider their falls to be “one offs” but they are still asked if they live alone, whether handrails are in place and whether they struggle with transfers. If the client admits to struggling, our occupational therapists can do a home visit with the view to providing information, equipment or housing alterations such as a ramp.

A small number of these patients required further intervention from an Occupational Therapist. A high indicator of need is whether a patient has fallen more than once in the last year.

Letting in the sunshine

A new development as part of the falls prevention initiative is to gauge the extent to which people are using Vitamin D as well as their exposure to sunlight. This query is now included in the questionnaire used to interview people. Vitamin D can improve muscle function and reduce falls in older people with low Vitamin D levels. When it appears that the person has little exposure to sunlight the suggestion is made to ask their GP for advice on whether Vitamin D use is appropriate.

A general guideline is that walking or outdoor activities should take place in the early morning or late afternoon from September to April to prevent exposure to harmful rays and sunburn. Between May and August walks should take place in the middle of the day with arms, hands and face uncovered. However, the older we become the less our skin is able to produce Vitamin D from sunlight, which highlights the importance of considering Vitamin D supplements. ACC is very much involved in encouraging the use of Vitamin D in residential care facilities. A target of 75% has been set for implementation of Vitamin D therapy in these facilities.

Best practice in the community

Falls prevention in Glenwood Masonic Hospital

Falls in the elderly can have fatal consequences. Unfortunately the majority of elderly residents coming into our care have multiple co-morbidities and are entering our service older and frailer with a higher risk of falls. We wanted to develop a coordinated approach and systems within the facility to assist in reducing the number of monthly falls.

Our wish at Glenwood is to be proactive and to have a smorgasbord of resources from which to choose the most appropriate intervention for each individual. This required us to develop our knowledge, to network with others, to tap into relevant training and available resources and to commit the time and energy to get it right and embed an appropriate and lasting falls prevention programme.

What we have learnt is there is no one correct answer that will meet every individual resident's need. Sometimes patterns of behaviour can be hard to change, especially if there are elements of dementia involved.

A multipronged approach

We have addressed the problem in many different ways:

- Gained support and networked with other health services.
- Set up a Falls Prevention Committee to drive the project.
- Attended training: Regional 3DHB Reducing Harm from Falls workshops and local Wairarapa Falls Collaborative meetings.
- Linked into the Vitamin D Supplement Programme run by ACC.
- Increased RN awareness of pharmacology-related falls risks.
- Reviewed educational material from HQSC.
- Developed data collection and display resources eg. Falls wheel, improved incident report for data collection, daily falls record and falls map to heighten falls awareness of staff.
- Reviewed collected data and identified residents with high falls numbers and times of falls; targeted high fallers and initiated a PDSA Cycle/model for improvement.
- Notified GP and families of high fallers to gain their support – families were asked to visit relatives at high falls times (changes to visit routines) which assisted with increased monitoring.
- Outlined initiatives in the Glenwood newsletter to heighten awareness.
- Changed staff roster to increase staff hours around identified high falls times.

- Involved private physio in targeted client review and exercise planning including exercise and walking programmes to strengthen muscles. Initiated walk charts and increased monitoring as needed. Doubled the physio budget in the 2014 financial year. Introduced Tai Chi twice monthly and increased exercises in the monthly programme.
- Falls coordinator completes a summary of each resident's progress.
- Reviewed equipment and purchase of new equipment as needs were identified eg. sensor mats, cocoon mattress, personal alarm, industrial non-slip mats for bathroom, wall rails, double sided socks, trial of swivel board and new hoist.
- System is now embedded with follow-up of individual suggestions for care improvement, walking and exercise charts and feedback outlining effectiveness of interventions. Full care team involved – management, GP, care staff and support staff.

Results

We significantly reduced numbers of monthly falls and in doing so improved patient safety. Residents, families and staff are satisfied and staff knowledge and collaboration has improved. We have better understanding of what to do next, i.e., if this doesn't work we will try....and there is better use of equipment. In addition we have an excellent documentation trail for audit purposes.

Overall the Falls Project has created a sense of "community" for the project participants, working together for the good of the residents, both internal and external to the facility.

What have we learnt?

We realize there will never be 'no falls'. Because of the complexity of our residents, interventions need to be based on individual need and must include a partnership approach with family and significant others. Any approach must have the backing and support of the full team to ensure it is seamless and integrated into the system. This requires excellent communication, motivating leadership and support, dedicated time, persistence, clear guidelines and putting the patient first.

"It's easy to give up and state 'old people fall'. We say... an ounce of prevention is worth a ton of cure! So don't give up and make it someone else's issue. Get in behind making positive outcomes for your residents/clients/patients, as every contribution, no matter how small, helps make positive outcomes happen. Think outside the box, pull from a smorgasbord of resources when developing new ways of working. Look outside what you know in your organisation if you are stuck for ideas. Work round hurdles and don't give up."

Danielle Farmer, Manager, Glenwood Masonic Hospital

Mental health

Wairarapa Mental Health Services and community mental health providers working together

Integration and collaboration is happening. Wairarapa mental health and addiction service leaders are working together to improve access and treatment responses for people and their whānau.

Our focus remains 'Any door is the right door', improving access to mental health and addictions services in Wairarapa. We want to make sure that no matter which service a person approaches they are supported to have their needs met.

What we have done

We have improved knowledge about mental health and addiction, and how to access those services in our community. Over the past year we have introduced a number of initiatives to make it easy to access our services:

- One brochure, 'Wairarapa Mental Health & Addiction Services', has brought all information about MHA services together.There has been good feedback from the community.
- Primary Mental Health Nurses are in place and work across six medical centres in Wairarapa providing mental health and addiction assessment and brief interventions as well as education/information for GPs and Practice Nurses.
- Te Hauora Runanga O Wairarapa – Kaupapa Maori Addictions and Mental Health Support services work collaboratively with Carterton Medical. This has increased access to information and treatment options for Maori patients.
- Oasis Network Inc, a Peer Advocacy service, provides services for tangata whaiora/service users one day a week in Masterton. This provides people using mental health services with support from people who have experienced mental health problems – 'Nothing about us without us'.
- Pathways and Workwise support people with mental health and addiction problems to maintain their independence through housing and work opportunities.
- King Street Artworks provides a free creative space for people who use, or have used, mental health and addiction services. A great friendly environment
- 'What's Working, What's Not?' is a forum for service users/family/others to express a concern or ask questions about mental health and addiction services. MHA providers meet with the person to answer questions and to resolve any issues. This is working well.

- Supporting Families Wairarapa provides support for family/whānau and friends of people with a mental health or addiction problem.

COPMIA programme facilitators – Jill from SF Wairarapa; Jo from CAMHS and Manawai from Te Hauora

SF facilitates a programme for children of parents with a mental illness or addiction

COPMIA is a 7 week programme for children living in the presence of mental illness and addiction. Children attending this programme will know they are not alone, have opportunities to discuss feelings, develop coping skills to deal with stressful events, be able to share concerns, explore myths about mental illness, and have access to ongoing support by a family/whānau support worker. Supporting Families has teamed up with Child Adolescent Mental Health (CAMHS) and Te Hauora to provide skilled staff to co-facilitate this programme.

Feedback:

- *'E was so relieved to realise her family wasn't the only family to deal with these sorts of issues.'*
- *My daughter 'learnt skills to keep herself safe when her Dad is unwell'*
- *'The children have learned it's not their fault when parents are unwell'*

CAMHS – Child & Adolescent Mental Health Service

Improving the process of new referrals to CAMHS team meetings

Before

Each day CAMHS has a morning meeting. Before we revised the process new referrals/enquiries were presented, and where a referral required more information, the duty person followed it up and presented it again the next morning. If the duty person was not able to obtain the required information or contact the family/whānau then the duty person for that day took over. This went on until the appropriate person/ people had been contacted, with the referral being brought back to the meeting every morning.

One of the main problems was that the referral never had a clinician who was solely responsible for it, which created a risk of it getting lost in the system. Another problem was that the same referral was taking up time at more than one meeting - on some occasions up to two weeks. This was a waste of clinical time involving up to 10 clinicians at any one meeting.

After

When a referral is received now it is discussed at the morning meeting. If further information is required the referral is allocated to the duty person on that day who follows it through until sufficient information has been obtained. It is then brought back to the morning meeting for allocation.

Result

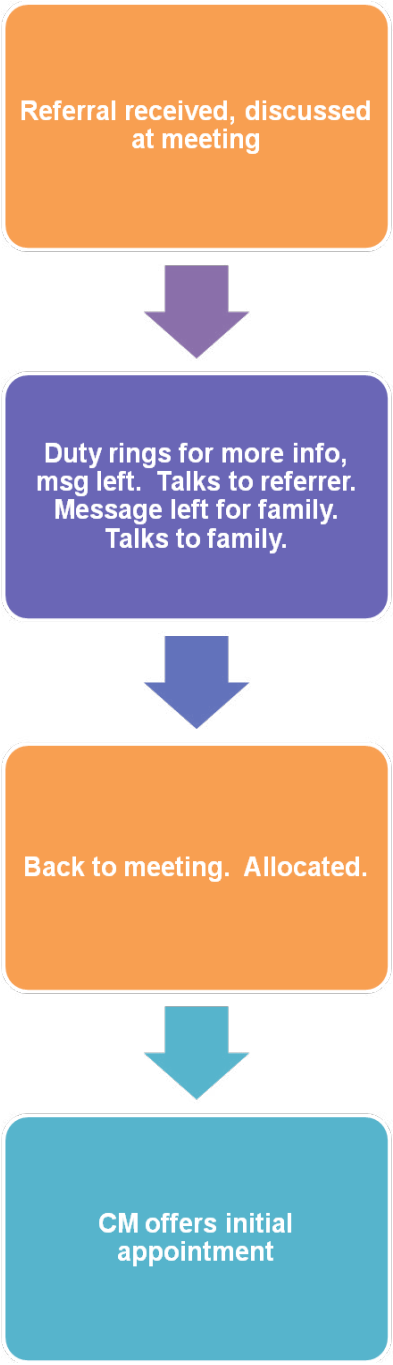
Revising the referrals process has reduced the length of time taken in the morning meetings by an average of 10 minutes each day. There has been an estimated savings of $350 per week in staff time = $18,200 per year. Staff have time to attend to other duties such as client appointments and phone calls in that time. The risk of a referral getting lost in the system has reduced because only one person is responsible for following it through.

Next steps

We can continue to look at how this process can be applied to other areas of our work to improve work flow and reduce waste. Lean thinking is an ongoing process across the service. By looking at how lean thinking can be applied to all areas of our work we can develop a calmer, safer, more organised work environment

CAMHS staff will continue to evaluate team processes. This will improve work flow, and reduce waste. An uncluttered our workplace and systems can also remove stress.


Referral received, discussed at meeting
Duty rings for more info. Msg left
Back to meeting, handed to next Duty person
Duty talks to referrer. Message left for family
Back to meeting, handed to next Duty person.
Duty reads notes, talks to family
Back to meeting, allocated
CM offers initial appointment


Referral received, discussed at meeting
Duty rings for more info, msg left. Talks to referrer. Message left for family. Talks to family.
Back to meeting. Allocated.
CM offers initial appointment

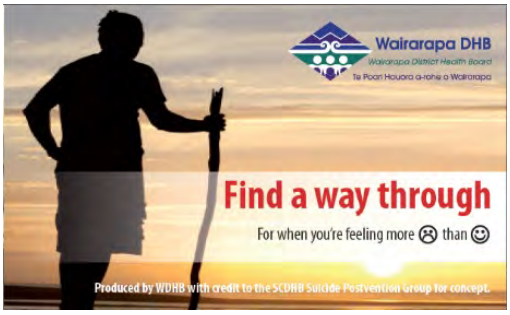
Suicide prevention

A variety of cross sector agencies involved in suicide prevention have worked more together over the last three years. This group has now moved much more into suicide prevention, rather than postvention, and has Bereaved Families working with the group. A smaller postvention group still responds confidentially in the event of a suicide death.

Online Tools

An information sheet has been developed and distributed summarizing the online tools available to help equip people with skills to manage depression. Health workers and the community are more aware of online tools available.

Men



The 'Find A Way Through' pocket foldout resource was developed targeting men. 2000 were printed and distributed through agency networks. This promotes www.wairarapasocialservices.org.nz and the depression line and mental health services.

The Wairarapa Blokes Book has been updated and reprinted. This is being delivered to rural addresses and through rural networks.

In conjunction with the East Coast Rural Support Trust the "Down on the Farm" newspaper supplement about mental health in rural Wairarapa was released during Mental Health Awareness Week.

For Youth

The Suicide Prevention Group organised a high profile positive event with Pio Terei from the 'Parenting Place' speaking at Masterton Town Hall

in June. Approximately 300 people attended. As they arrived there was a power point display of local services. Pio presented stories of resilience to about 200 Kuranui College (South Wairarapa) students during the afternoon. There were media and radio articles about the event and these helped promote local services.

'Connecting Communities' is developing a youth film project that will showcase youth's creative response/ interpretation of three challenges they have identified relating to bullying and violence, drugs and alcohol and mental health. They will showcase their individual uniqueness, affirmation of diversity, positive self-esteem, inclusiveness and resilience.

Young people in schools are receiving early support and skills for resilience building. 'Skylight' provided facilitator training to the three co-ed public colleges in Wairarapa. This course aims to build resilience in young people and the three schools now have this available.

Parents are more aware of services available in the community.

Bereavement support

WAVES, a bereaved-by-suicide facilitated group, was an 8 week group taken by two trained facilitators. Those bereaved by suicide are at a greater risk of suicide and this programme aims to support them and decrease that risk.

GP information

GPs were notified that July, August and September have been the months when most of the suicide deaths occurred in the Wairarapa over the last three years. They were encouraged to attend Advanced Suicide Risk management training.

Best practice research and information disseminated:

- Suicide Facts 2011 from the Ministry of Health was released in January. For the five year period 2007-2011 Wairarapa DHB had 16.8/100,000 population suicides. This is the fourth highest DHB (the national average is 11.3 for the period); however because of confidence levels it is not statistically significant.
- The Law Commission produced a report on media and suicide. Relevant information was distributed to the Suicide Prevention Group.
- www.sparx.org.nz and other good online sites were promoted through networks.
- Bullying prevention and response: 'A guide for schools' was emailed to schools. Also a US resources "Bullying and Suicide" distributed.
- Information was sent to local media around reporting suicides and best practice.

Training

- Gatekeeper Training was promoted to community organisations, schools and individuals.
- Advanced Risk Assessment and Triage one day training was delivered to health professionals. Attendees included GPs, counsellors and mental health workers.
- Victoria University of Wellington ran a two hour education session on Self Harm. 32 people attended including mental health workers, GP, Focus Health, Social Workers, Whanua Ora Wairarapa and Whaiora.
- 'Bluepint for Learning' ran two courses in Wairarapa - one for the rural community and another for the general community. It aims to get people to recognise, relate and respond to people with a mental illness. It also has a suicide awareness component to the training.

ED and Self Harm

An online on-going audit of people self-harming and attending at the Emergency Department has been established.

For the period 1 January 2013 to 30 August 2014 (20 months) no teenagers have died by suicide in the Wairarapa. Sadly two people under 25 have died in that period but this is significantly fewer than the previous two years. To date this year, there have been fewer deaths during 2014 than in that period during 2011, 2012 or 2013.

Hand Hygiene

There is convincing evidence that rates of healthcare-associated infections can be lowered with improved hand hygiene by health care workers. By adopting World Health Organisation's programme, 'the 5 Moments of Hand Hygiene' we have been able to show an improvement in hand hygiene compliance rates at Wairarapa DHB through staff education and auditing.

The most simple and effective means of avoiding infections is good hand hygiene. Failure to comply with hand hygiene is a leading cause of healthcare associated infections, contributes to the spread of multi-resistant organisms and is a significant contributor to infection outbreaks.

Five Moments of Hand Hygiene

In 2009 the World Health Organisation's Five Moments of Hand Hygiene programme was rolled out nationwide to all DHBs. This involves staff education and auditing against the Five Moments of Hand Hygiene, checking that hand hygiene has been done at the appropriate moments:

1. Before patient contact
2. Before a procedure
3. After a procedure or a body fluid exposure risk
4. After patient contact
5. After contact with patient surroundings

Auditing

Three times per year Wairarapa DHB submits our Hand Hygiene auditing results nationally.

5 Moments of Hand Hygiene		
Audit Date	**% Compliant to 5 Moments of Hand Hygiene out of 20 DHBs in NZ**	
October 2012	70.5%	3rd
March 2013	68.1%	8th
June 2013	76.8%	2nd
October 2013	78.2%	1st
March 2014	81.7%	1st
June 2014	80.7%	1st

Next steps

We need to sustain and improve our hand hygiene compliance rates among staff. But it doesn't just involve the staff at Wairarapa Hospital. We also need our patients and visitors to support us in this by cleaning their hands on arrival and departure of the hospital, after coughing and sneezing, after toileting, before eating. Reducing healthcare-associated infections by improving hand hygiene goes beyond the hospital door. We all need to encourage and practise good hand hygiene in our community to prevent the transmission of disease.

"Good Hand Hygiene involves us all – patients, staff, visitors at Wairarapa Hospital and the Wairarapa community."

Lizzie Daniell, CNS Infection Control

Surgical Site Infections

International evidence tells us that healthcare-associated infections are a significant risk to patients, with surgical site infections being one of the highest proportions of these. The consequence of these include prolonged hospital stays and additional treatment and can result in increased death rates.

Surgical Site Infection Improvement Programme (SSII)

Previously surveillance of surgical site infections was done by each DHB in NZ using their own methodology which was not consistent. The National Surgical Site Infection Surveillance Programme was rolled out in July and will standardise data collection across NZ. The application of this data to infection prevention will improve patient safety and experience, free up bed days and reduce costs associated with surgical site infections.

Wairarapa DHB has joined the national programme. We provide surveillance data to the Health Quality & Safety Commission on all hip and knee replacement surgeries (including replacements)that occur. HQSC gave five educational webinars and Wairarapa staff were invited to attend.
HQSC have produced three guidelines:

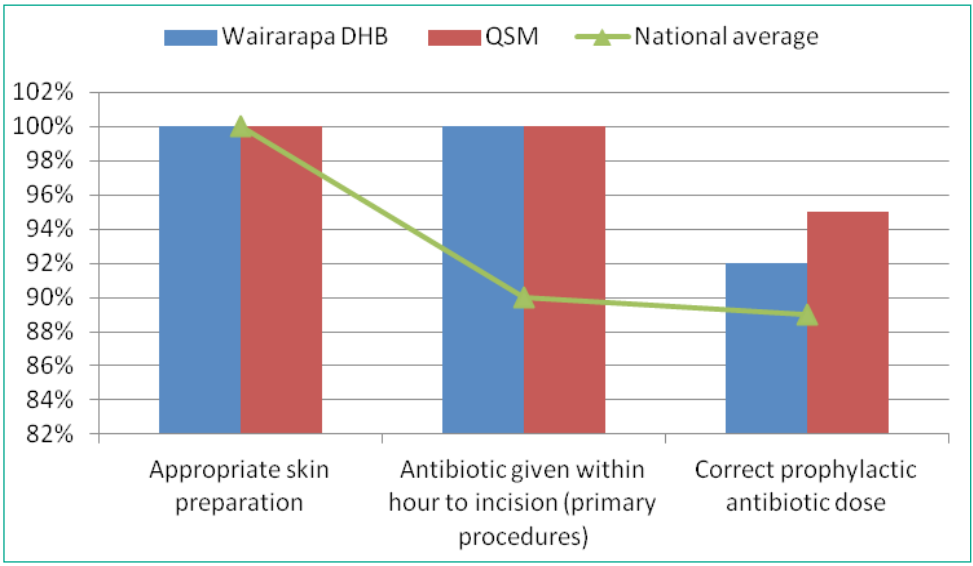
- Surgical Antimicrobial Prophylaxis Intervention Guideline
- Surgical Skin Antisepsis Preparation Intervention Guideline
- Clipping not Shaving Intervention Guidelines

The national SSII baseline quarterly report gives a national SSII rate against which to measure future performance and chart improvement.

Positive results

In the National Orthopaedic Report from the second quarter (October – December 2013) Wairarapa DHB achieved excellent results:

- Wairarapa DHB was preparing skin at the site of surgery appropriately in 100% of cases. The Quality Safety Marker (QSM) for skin antisepsis is for use of an alcohol based skin preparation in 100% of cases.
- Wairarapa DHB achieved 100% for the giving of antibiotic within the hour before the incision is made in primary procedures. The national average is 90%.
- Wairarapa DHB is using the correct antibiotic in 100% of cases. The correct dose was given in 92% of cases. The national average is 89%.
- Process and outcome measures will continue to be reported quarterly to the Health Quality Safety Commission. The focus of the SSII Programme will be expanded to include selected cardiac procedures over the next year.



Serious Adverse Events

A serious adverse event is one where patient care has an unintended consequence resulting in significant harm or death. All serious adverse events are investigated. This enables us to find out what went wrong, learn from them, and put in place measures to prevent harm occurring again.

The Health Quality and Safety Commission (HQSC) produces a report each year detailing the events which occurred in all DHBs (available at hqsc.govt.nz).

As part of Wairarapa DHB's commitment to providing safe care for patients, we have a process in place for investigating serious and adverse events that occur in our hospitals. The purpose of investigating serious and adverse events is to determine the underlying causes of the event so that improvements can be made to the systems of care to reduce the likelihood of such events occurring again.

Wairarapa reported events

In 2013/14 Wairarapa DHB reported 7 serious and adverse events.

3 were the result of errors in clinical process, 1 was a patient fall, 1 was a medication error, 1 was a concern about an item of medical equipment and 1 was concerned with a patient transfer.

These events were investigated through our reportable event system and reported to the Health Quality and Safety Commission. Our DHB is committed to providing the highest quality care for all patients, but the reality is that even with the best people, processes and systems, errors can occur. When they do, we need to find out what went wrong, whether it could have been prevented, and what improvements or changes should be made.

New Zealand incidents

Most reported incidents across all DHBs were the result of serious harm from falls. In 2013/14 falls were the most frequent cause of harm reported by DHBs, making up 55 percent of all cases. In Wairarapa considerable effort is going into reducing harm from falls and the Falls Group has put in place several initiatives to prevent falls in hospital.

Clinical management incidents were the next most frequently-reported events nationally. Reported cases included delays in treatment, assessment, diagnosis and observation, medication prescribing, dispensing or administration.

The HQSC says the slight increase in SAEs nationally is likely to reflect the health sector's increasing commitment to improved reporting of cases.

Patients who are harmed during health care have a right to understand what happened and to expect that everything possible will be done to prevent the same thing from happening to someone else in the future.

Medical Services Ward

The clinicians and nursing teams in the Medical Surgical Ward (MSW) have been working together to appropriately reduce the average length of stay for patients.

Average length of stay (ALOS) describes the duration of a single episode of hospitalisation and its usefulness in predicting a patient's expected length of stay.

The table below shows a decline in the average length of stay during the first four months of 2014, compared with 2013. Overall total ward admissions have increased but length of stay has declined.

	2012	2013	First 4 months 2012	First 4 months 2013	First 4 months 2014	Difference between first 4 months 2013 and 2014
Medical admissions	1538	1601	438	489	544	55 patients ↑
Medical ALOS	4.23	4.24	4.29	4.11	3.52	0.59 days ↓
General surgical admissions	856	858	284	279	249	30 patients ↓
General surgical ALOS	3.86	2.99	3.95	3.02	2.77	0.25 days ↓
Orthopaedic admissions	598	682	190	224	216	8 patients ↓
Orthopaedic ALOS	3.41	3.71	2.76	3.43	3.14	0.29 days ↓
Total ward admissions	3288	3458	1025	1083	1118	35 patients ↑

Service Improvement

Creating an environment for wellness at Glenwood Masonic Hospital

At Glenwood "best of care" is our aim every day. To achieve this goal we use a holistic health approach, which requires us to consider all aspects of our residents' wellness, including the environment in which they live.

Glenwood opened its new purpose-built facility in April 2010. Even though it was a nice new facility, it was clinical and did not have a welcome homely feel. We wanted to create a warm, welcoming environment to live and work in and to encourage families and friends to come in and visit and to feel welcome to continue to be part of our residents' lives.

Over time we noticed inconsistency in our standard of presentation and build up of clutter and storage issues for resident-related equipment. There was no set standard for keeping the living environment fresh and homely.

The WOW factor

We asked the residents and the staff for feedback. We also asked an independent "mystery guest" to come in to tell us what they saw and how they felt. The feedback was valuable and provided us with direction and purpose.

The responsibility for keeping the environment beautiful, clear of clutter, odour-free, warm, comfortable and welcoming sits with the staff. So we considered what we would like for our own families and developed clear guidelines to maintain the standard we wished to achieve on a daily basis. For new residents coming in we set a standard including a comprehensive welcome/information pack to assist their transition into Glenwood's Care environment and we have set up clear guidelines for staff related to room presentation. This includes nice fluffy towels on the bed with a welcome gift.

We revamped the presentation of the facility in general to give it the wow factor. We change the painting on the walls regularly (thanks Wai Art), we have photo canvases for empty rooms and common rooms, and we have introduced orchids throughout the facility and fresh flowers for the dining tables, library and front foyer.

We regrouped furniture to encourage socialisation and family gatherings. We encouraged families to share a meal with their loved ones at minimal cost. We de-cluttered lounges and created a purpose-built equipment room to reduce hazards and staff time searching for equipment.

All this has reduced staff frustration and saved time searching, creating more time for resident care and improving the workplace and general satisfaction for all.

Continuous quality improvement calls for all of us to take off our rose-tinted glasses and really look at the service we provide. We strive to keep open communication with residents, families and staff and to work together to provide the "Best of Care".

A clean, warm and welcoming environment links to our emphasis on "Best of Care" and helps us achieve a Holistic Health Approach at Glenwood

Danielle Farmer, Manager Glenwood Masonic Hospital

Health Passport

The Health Passport was launched in Wairarapa in December 2013. It enables patients to hand over their full history at whatever medical centre they attend without lengthy or repetitive explanations of their conditions. It is aimed at assisting nursing and medical staff to understand the care and support needs of people with disabilities. The passport belongs to the person, is kept and updated by him or her and comes with the person to hospital and medical centre.

It can be hard to let health workers know what patients need, especially if they have complex needs related to a disability or long-term condition. The Health Passport is a booklet people carry with them when they go to hospital or when they use other health and disability services, such as a GP or a new carer. It contains information about how to support and communicate with them. It is designed to ensure people have a better voice when accessing health services.

Heath passports are available at GP practices, within the hospital or by contacting Gillian Malton, Quality Co-ordinator. They are also available online.

"This initiative is a huge step forward for the rights of people with disabilities. It provides a voice for those people who, for whatever reason, can't speak for themselves. It's a way for people to tell their story without telling it 50 times a year."

Ruth Carter

Integration of Regional Public Health Patient Information

The problem

Patients' clinical information used by Regional Public Health did not include public health activity and storage systems used were inadequate, representing risk to the patient as well as RPH and the DHB. There was a variety of storage formats (electronic and paper)and information was not stored in the DHB centralized clinical records department. Neither primary nor secondary care clinicians could identify when Regional Public Health was providing services to individuals. The electronic Regional Health Surveillance System (RHSS) personal health database did not have an audit trail, information could be restricted and information can be permanently deleted.

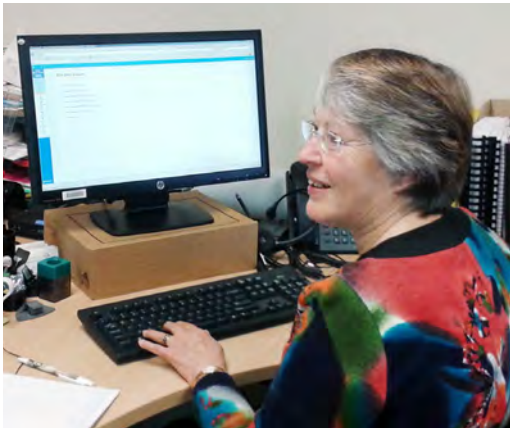
The solution

Public Health information is now being added to Concerto, the patient information IT system. There are now relevant patient modules that clinicians can access.

The new RPH Concerto system provides staff with the ability to access and update electronic personal health information as required. It provides a centralised solution for RPH to efficiently capture information electronically. Concerto can then be accessed by other authorised health agencies and internal departments to ensure a complete overview of referrals and events for patients and provides easily accessible and updateable information enabling staff to provide safe clinical practice in the community.

The School Public Health Nurses moved to using Concerto for personal health information in August 2013. The Disease Control Team moved to concerto in June 2014 and are now recording all communicable diseases, follow-up patient and contact information.

RPH Concerto provids clear visibility of all patient contacts and outcomes. Access to good care becomes safer and easier with the ability to easily share patient information among Public Health Nurses, clinicians, emergency department staff, primary care and others.



Collabor8

> *"The training highlighted for me, the financial benefits to be gained from streamlining processes."*
>
> *Libby Trafford, Office Manager, Whaiora*

Collabor8 is designed to improve systems with a key focus on a whole health system approach. The two one-day workshops introduce lean principles which are tools and techniques to help us improve the patient flow through our DHB and health system. The reduction of waste, leads to efficiencies and savings for the DHB. Following the first workshop staff complete a project which is presented to the second workshop two months later. The second day also involves further learning to continue building skills and knowledge.

Staff from across the DHB, from several Aged Care Facilities and from Community Health have taken up this training opportunity facilitated by Brian Dolan, Director of Service Improvement at Canterbury DHB. He has been running Collabor8 at Canterbury DHB for the last 5 years.

Changes

Examples of changes implemented due to the workshops included:

- The paperless office
- Reducing referral steps in Dietetic Services and in CAMHS
- Streamlining file tracking in FOCUS
- Reorganising office space in Paediatrics, Health Records, MSW and Rehab to create efficiencies
- Making efficiencies to the coding process
- Creating a pathway to deal with gastro illness in childcare centres
- Rebranding and reorganising in an aged care facility
- Auditing the District Nursing referral process
- Continually improving the discharge process
- Reducing double handling and stock sent back to suppliers in Pharmacy
- Simple changes in Emergency Department resulting in improvements for patients and efficiencies for clinical staff.

"This training was invaluable, not only from a professional development point of view but because the benefits to patients and to the organization are unquestionable."

Michelle Gibbons

"Many staff from the department have attended this training and we are seeing ongoing benefits. This has resulted in positive changes to the work environment and has produced a culture where team members are continuously looking for ways to improve."

Karen Carter, Senior Administrator

"We found the facilitator engaging, the project challenge a useful process for 'lean thinking' outside the box and within budget. In fact we saved thousands! Our projects also helped us build on collaborative practice within our workplace and develop a stream of interrelated initiatives that have improved quality service provision for our residents and better ways of working for our staff. Having the time to step back and think about the big picture was invaluable. Thanks go to our WDHB for supporting a local Aged Care service provider and positive change in this sector."

Danielle Farmer, Facility Manager and Stefanie Porten, Administration Coordinator, Glenwood Masonic Hospital.

Shared Care Record

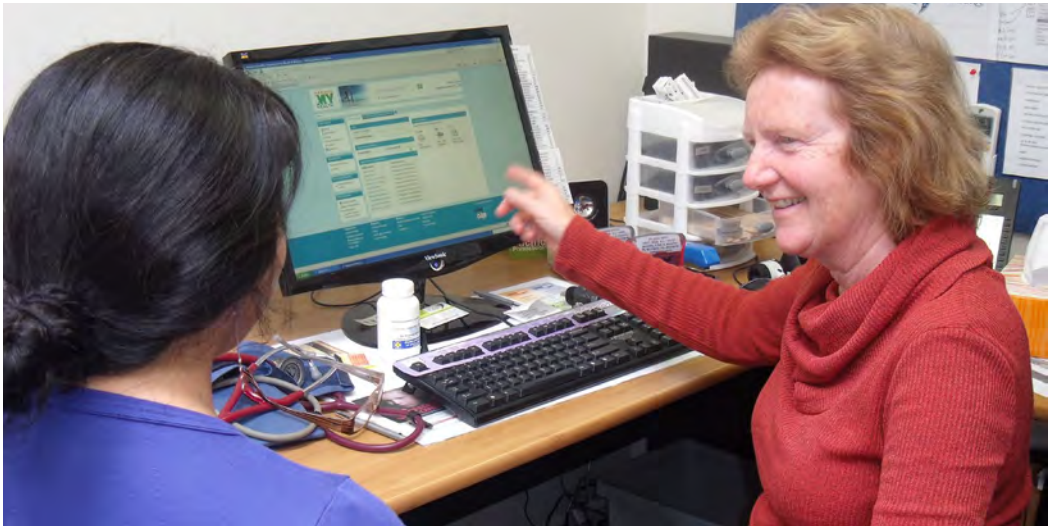
In 2011 a new way of sharing health information between GPs, pharmacy, after- hours and the hospital was launched in Wairarapa. The electronic Shared Care Record (SCR) lets authorised health care providers, such as after-hours GPs, hospital doctors and pharmacists, access a summary of information from your GP. Information such as medical conditions, allergies and prescribed medications can be shared. The information will be available at any time, even if a medical practice is closed.

Since its implementation, the major reported benefit to the patient has been the ease in which medical professionals, other than their family doctor, can access vital information if needed in the hospital or after hours setting. The information is stored securely in New Zealand and all access to the information is recorded and routinely audited.

Medical Centres onboard

Masterton Medical Centre, Carterton Medical Centre, Martinborough Medical Centre and Whaiora were the first medical centres to use the new electronic system and over the last year Featherston Medical Centre and Greytown Medical Centre joined the project. Now 95% of people living in Wairarapa will benefit from this online health record.

The Shared Care Record is not a complete clinical record, nor is it a complete record of all the information the GP holds for the patient. In Wairarapa participating General Practices hold records of all long term medications prescribed by the GP, all allergies (warnings), all future recalls and all immunisations.



An asset to ED

The outcomes are very positive particularly with reducing clinical risk for the patient accessing Emergency Department. The SRC increases safe practice and ensures that clinicians are comfortable with their clinical assessment of the patient.

From an ED perspective the problem was accessing information on the presenting patient in a timely manner during the day. Obtaining the information from General Practice can be time consuming because the GP and nurses were often very busy themselves. Sometimes the patients are unable to speak for themselves because they are very unwell or just cannot recall their medication. At night and afterhours the patients are often older, may have dementia or may present at ED confused and disoriented, and so access to the Shared Care Record can give the clinicians the information that the patient and their families cannot give. The SCR provides vital clinical information that gives clinicians a bigger picture of what is going on for the patient. It acts as a patient advocate when patients are unable to speak for themselves and keeps everybody safe.

Carterton Integrated Family Health Centre

Carterton Medical Centre created an Integrated Family Health Centre (IFHC) to meet the health needs of its community and deliver quality care services from its hub. Recognising the difficulties the community has when needing to access health services that require travel across a semi-rural district, CMC directors took the bold path to approach and attract health services to work with and be based from the medical centre.

This has resulted in a wide range of services now able to be accessed in Carterton saving people the burden of travelling outside the district. Services include laboratory, midwifery, physiotherapy, podiatry, counselling, audiology, mole map, optometry, DHB specialist diabetes and respiratory nurses, Before School Checks and Maori massage/ Mirimiri.

Delivering integrated health care for our community

Before

Prior to Carterton IFHC, there was limited physio, optometry, podiatry or counselling based in Carterton, so clients often had to travel out of the area to access services, resulting in delays for treatment. This was problematic owing to a limited public transport system and the cost involved. High needs and elderly clients were hit the hardest and often meant appointments were not kept or followed up.

Laboratory services were located at the far end of town which meant many clients faced barriers: too far to walk from the medical centre, no car to drive or parking issues resulting in poor uptake of blood testing & screening.

Patient health information was disjointed and often not shared in a timely manner amongst health providers.

Now

The directors of CMIFHC undertook major financial investment in purchasing and completely renovating the existing building and linking this with a newly purchased building. It has been completed this year. The director's investment in the community has been large and with over 30 years of service, they were well placed to understand the needs of the community and how they could be met.

By acquiring more space CMIFHC was able to attract services to the medical centre. The Medlab service arrived first and a new physio was attracted to the area. The optometry service brought equipment such a slit lamp which stays at the medical centre providing better service to clients. The optometrist is able to share knowledge and learning with GPs. Podiatry services are now offered - the podiatrist holds the diabetes foot care contract and works closely with diabetic patients and clinical staff and is able to write directly into patient records at the practice.

There is now a midwife based at CMIFHC two mornings per week. Carterton Medical is the only practice in Wairarapa to have a midwife working onsite with mutual clients. This is a huge achievement for the practice as midwives are in short supply in Wairarapa and the communication flow between GPs and midwives had previously been limited.

Results

We have reduced barriers to access for clients by adding additional health providers to the medical centre.

We have:

- improved the multi-disciplinary approach for health providers resulting in better patient health outcomes. Our physio is able to discuss and refer with the GPs any problematic clients. Information sharing occurs which enables quicker health outcomes to be achieved for clients with a sooner return to the workforce.
- improved the flow of communication between health providers through direct access to patient notes for clinicians, referrals and corridor conversations.
- provided greater learning opportunities for medical students such as trainee intern doctors, registrars, rural immersion medical trainees and nursing students. They are placed regularly with CMIFHC. Having trainee interns and registrars in the practice and area, makes the region more attractive to younger doctors looking for employment opportunities.

There has been knowledge sharing and better utilisation of resources among clinicians using a collaborative approach to sourcing and using equipment. Also patients are able to have tests done immediately after seeing their clinician with no additional travel or time delay. A now established midwife/GP relationship has improved the patient journey from conception to adulthood.

Next steps

We will continue to attract health services that improve patient health outcomes, such as a dietician onsite, and improve communication and collaboration between clinicians.

We will maintain and continue to build relationships with our community to reflect their healthcare needs. Links are already being established with local council and community groups.

3DHB

Working together across three DHBs

The past year has seen a continued commitment to partnership between Wairarapa, Hutt Valley and Capital & Coast DHBs as we focus on providing sustainable services, both clinically and financially.

The 3DHB Health Service Delivery programme has continued to focus on specific clinical service projects identified as critical services for integration. Integrated service design continues with Child Health, Radiology, and Gastroenterology services.

A pathway to good health

The 3DHB Health Pathways project was launched in February 2014. This collaboration between General Practice and DHBs sees care pathways developed to take the uncertainty out of patient care by ensuring a clear and consistent treatment regime for patients to be referred along. In doing so, health professionals from across different sectors and organisations must agree upon best practice treatment guidelines, and discuss any existing barriers to implementation.

The new general practice model recognises that long-term conditions require coordinated care from different health services. Practice nurses and community health providers such as physiotherapists are seen as key to this.

While the project is still in its initial stages it is seen as a priority for the coming year. Pathways in development include: diabetes nutrition, frail elderly patients, gastroenterology, cellulitis, Older Persons Health, orthopaedics, haematology, General Surgery and Rheumatic Fever.

Appointments

In the past year new joint appointments have been created that will continue to build on the work of the integration programme. The first clinical service position across the three DHBs is General Manager of Mental Health and Addiction Services. The appointment of this position will enable the general manager to lead the staff involved in the delivery of Mental Health and Addictions Services across the sub-region to develop a single approach to service design and delivery.

Corporate Service appointments have progressed with the appointment of a 3DHB Executive Director Corporate Services Group, a 3DHB Chief Information Officer and a 3DHB Facilities

Management structure. The focus of these positions in the short-term is to support the 3DHB development to keep us on the pathway toward sustainability and strengthening the back office systems and functions that underpin the way we do business.

These positions will provide strategic advice and direction for Wairarapa, Hutt Valley and Capital & Coast DHBs in relation to financial management, information communications technology, facilities management and payroll and to ensure that the strategic direction translates into tactical and operational activity supporting all DHBs wider goals as well as individual service goals.

Disability services

Great progress has been made during 2013/14 in improving health services for people who experience long-term impairments/disability in the wider Wellington region.

Highlights include:

- The launch of the Health Passport in Wairarapa, Hutt Valley and Capital & Coast DHBs. The Health Passport will assist health providers to better understand the care and communication needs of people who experience long-term impairments/ disability.
- A disability champion/facilitator network made up of staff across all three Sub-Regional District Health Boards and community services was launched to help improve services and information to health staff and people with disabilities.

Wellington Free Ambulance provides ambulance services to the greater Wellington region which includes Wairarapa, Hutt Valley and Capital & Coast DHBs.

3DHBs working together

No boundaries for cancer

Vicki Duffy, a fit and active Wairarapa vineyard worker and ex-farmer, received a body blow when she was diagnosed with breast cancer in 2011.

"I discovered a breast lump and went to my GP in Masterton. I was then referred for a mammogram and ultrasound in the Hutt. I could tell from the look on the radiographer's face it was not good and when she wished me luck, I knew. The surgeon at Wairarapa Hospital did a biopsy and I was expecting a general conversation until we got the results the following week. However I got the lot – I would need a mastectomy, lymph nodes removed, chemo, radiotherapy and maybe reconstruction. It was a bombshell and I was not prepared for it."

After diagnosis at Wairarapa Hospital Vicki was referred to a specialist breast surgeon in Hutt Hospital's Breast Centre where she had a mastectomy with sentinel node biopsy to remove just a few lymph nodes. Unfortunately cancer was found in two of the five removed lymph nodes and so it was back to Hutt Hospital three weeks later for a second operation to remove more lymph nodes. The gruelling journey involving up to 20 health professionals in three DHBs had begun.

Back in Masterton after her initial mastectomy, the District Nurses visited Vicki at home every day for 10 days after both operations to check on drains, fluid retention, monitor pain relief and the healing of the scar. Later they followed up with phone calls and occasional visits.

"Life as you know it stops. I was told I would need a year of chemo, radiotherapy and herceptin in Wellington Hospital. I had to wait 12 weeks before it started and as I wasn't looking forward to the effects of chemo the waiting began to get me down."

Wellington Hospital provides oncology services for our region and so Vicki was passed from the Hutt to Wellington Hospital for oncology.

"Every three weeks for six months, I had chemotherapy intravenously and after the first three months herceptin as well. The herceptin continued for a further nine months. Each treatment required a day trip to Wellington Hospital. You get used to the cycle of treatment and

seeing health professionals regularly. The whole year was mapped out for me and all I had to do was follow directions and meet appointments. I was off work for a year and then it took time to adjust back to self reliance and a daily routine."

The effects of chemo were unpleasant. Vicki says she could hardly get out of bed at first, she didn't feel like eating or drinking and she felt nauseous. Support kicked in quickly with the oncology nurses in Masterton providing ongoing assistance with symptom control and advice about hair loss, nausea, vomiting and risk of infection. Cancer Society Wairarapa offered information, workshops such as 'Look Good, Feel Better" and transport. Their volunteers drove Vicki over the hill for her treatment regularly. When radiotherapy started three weeks following chemotherapy Vicki stayed at Margaret Stewart House, the Cancer Society facility opposite Wellington Hospital in Newtown. "The accommodation was excellent - you're right beside the hospital, you have your own room and you can share stories with others in the same boat."

18 months after her mastectomy Vicki finished her oncology treatment in Wellington and her care was passed back to the surgeon at the Hutt Breast Centre.

"He keeps an eye on me and I will see him once a year for the next five years. I'll also see the radiologist once a year in Masterton and continue to have mammograms at Breast screen in the Hutt.

"It all seemed a maze at first but once you're in the system you are passed from one health professional to another and it happens seamlessly. There is a lot of information to digest but the journey is mapped out for you. I have had fantastic support from doctors, nurses, the Cancer Society and allied health professionals and I'm very grateful."

Vicki is back at work in the vineyard, feeling fine and looking fit and healthy again. Her story is a fine example of the way health professionals and support agencies work closely together across the three DHBs in the greater Wellington area to give the patient the best possible care and clinical support.

Wairarapa's Cancer Coordinator Jacinta Buchanan says, "From diagnosis to treatment, cancer patients see on average 22 health professionals and they are not always local. Coordinated care is important, particularly when services are provided over time and between DHBs. Cancer treatment is a really good example of how our three DHBs and community partners work together to provide coordinated services ensuring continuity of care both in the community and hospital."

Future Focus

Quality of healthcare is at the heart of everything we do. This Quality Account is a record of our progress over the past year and a public commitment to our future priorities. The accounts represent not only what we do well but also areas where we are striving for improvement, We aim to deliver high quality care and have robust systems and processes in place to ensure we can maintain and continually improve both the quality and experience of the care we provide while being informed early of potential risks.

In 2013/14 Wairarapa DHB met and exceeded many of the expectations that have been placed on it, and continued to deliver and fund high quality care. We are particularly proud of our achievements against the health targets, where our small size and ability to respond quickly to changing circumstances aided our consistently good ratings.

A strong safety culture

Continually strengthening our culture of patient safety and quality is a top priority for us. A strong safety culture means that patients and their families, other health providers like family doctors, primary health nurses, and our own staff tell us when an incident has occurred and raise concerns so that we can look into what happened.

Our practice is to communicate openly with patients and families at all times including when adverse events occur, to acknowledge what has happened and to apologise where we have got things wrong. We will listen to concerns, provide support, involve patients and families to the degree they prefer, and where possible answer their questions and address any concerns that they have.

Further integration

The past year has seen a continued commitment to partnership between Wairarapa, Hutt Valley and Capital & Coast DHBs as we focus on providing sustainable services, both clinically and financially. The 3DHBs believe that the best health gains for patients can be achieved through a joined-up approach to service delivery across the sub-region, and that by removing artificial boundaries decisions can be made in the collective interest of the sub-region's population.

Building a common IT environment is key to this. A 3DHB approach to information technology will support integration activities and enable both effectiveness and efficiency gains across the 3DHBs. Work has already started and we look forward to more progress next year.

The 3DHB Health Pathways project is an exciting project that will expand in the future. This collaboration between General Practice and DHBs sees care pathways developed to take the uncertainty out of patient care by ensuring a clear and consistent treatment regime for patients. While the project is still in its initial stages it is seen as a priority for the coming year.

There will be new joint appointments created that will continue to build on the work of the integration programme bringing staff and services closer together.

Vision

Our vision is to deliver quality services and improvements with, for and in the community in order to deliver the best care possible.

Amber O'Callaghan
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