HUTT VALLEY DHB

Hutt Valley DHB Quality Accounts

2013

Quality Accounts

Getting better: a report on the safety and quality of healthcare in Hutt Valley

Welcome to the first Quality Account for Hutt Valley DHB. 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 service which is patient-focused and provides the right care and support when and where it is needed.

This is probably the most important document we will produce this year. It is a way of openly reflecting the care we provide for our patients, describing what we do well and where there are opportunities for improvement. It focuses on the reasons that health care professionals enter into the profession - to strive for safe, effective care that patients, staff and the wider community can be proud of. In the health care service we often draw on our own personal and family experience of health, and use the measure of "would I be happy for my mum to receive this standard of service?" 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.

This report focuses on the quality of services we provided during 2012/2013. Through this Quality Account we will demonstrate our achievements, our progress in improving the patient/consumer experience and our desire to continuously improve our health services.

'Healthy People, Healthy Families, Healthy Communities'

Our vision is to deliver quality improvements and quality services with, for, and in the community. This Quality Account focuses on three aims: to reduce and contain cost, to improve the patient experience, and to improve the overall health of the population. The DHB's Board and the Senior Leadership team are acutely conscious of the financial restraints that the DHB will face in the coming year, and the importance of safeguarding the quality of care through these times. The essence of how we will achieve this is through service transformation, service redesign and both regional and sub-regional collaboration. The last year has seen us committed to achieving the initiatives laid down by the Health Quality Safety Commission (HQSC), and refining our measuring, monitoring and reporting processes.

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.

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. The DHB works in partnership with many community groups and health providers in the Hutt Valley and beyond. Together we work to support healthy lifestyles, improve population health and care for those who are sick.

Key priorities

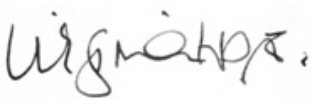
- Encourage feedback from consumers of healthcare and continually improve the patient experience resulting in high satisfaction with all our services. We want our patients to feel cared for and confident in our services.
- Ensure that our patients experience consistently safe and high quality services.
- Ensure that we have high quality systems and processes in place for quality, safety and risk.
- Ensure that our hospital and community services are based around patients' needs.

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.

Chief Executive
Graham Dyer



Board Chair
Virginia Hope

Our Vision, Mission & Values

Our vision, mission and values are part of the Hutt Valley District Health Board strategic plan and lie at the heart of our organisation.

Our Vision

Whanau Ora ki te Awakairangi

Healthy people, healthy families and healthy communities are so interlinked that it is impossible to identify which one comes first and then leads to another.

Our Mission

Working together for health and wellbeing

Our mission demonstrates the Hutt Valley DHB's commitment to a cooperative way of working. This includes staff working cooperatively, working in collaboration with the people and organisations we fund, working with organisations from other sectors and working within our community.

Our Values

"Can do": leading, innovating and acting courageously

Hutt Valley DHB is already acknowledged by the NZ health sector as an organisation that will try new things in order to make a difference. We will continue to do that and to be ever more innovative in order to improve the health of people in the Hutt Valley.

Working together with passion, energy and commitment

People at Hutt Valley DHB work with passion, energy and commitment: to each other, to our clients and the community.

Trust through openness, honesty, respect and integrity

The trust of those we work with and those we work for is fundamental to achieving positive results. To be trusted we will be open, honest, respectful and act with integrity in everything we do.

Striving for excellence

Striving for excellence is a key Hutt Valley DHB value. We look for excellence in ourselves as individuals and collectively as an organisation. We expect it of the services we provide, the way we treat each other, the systems we put in place and the achievements we make.

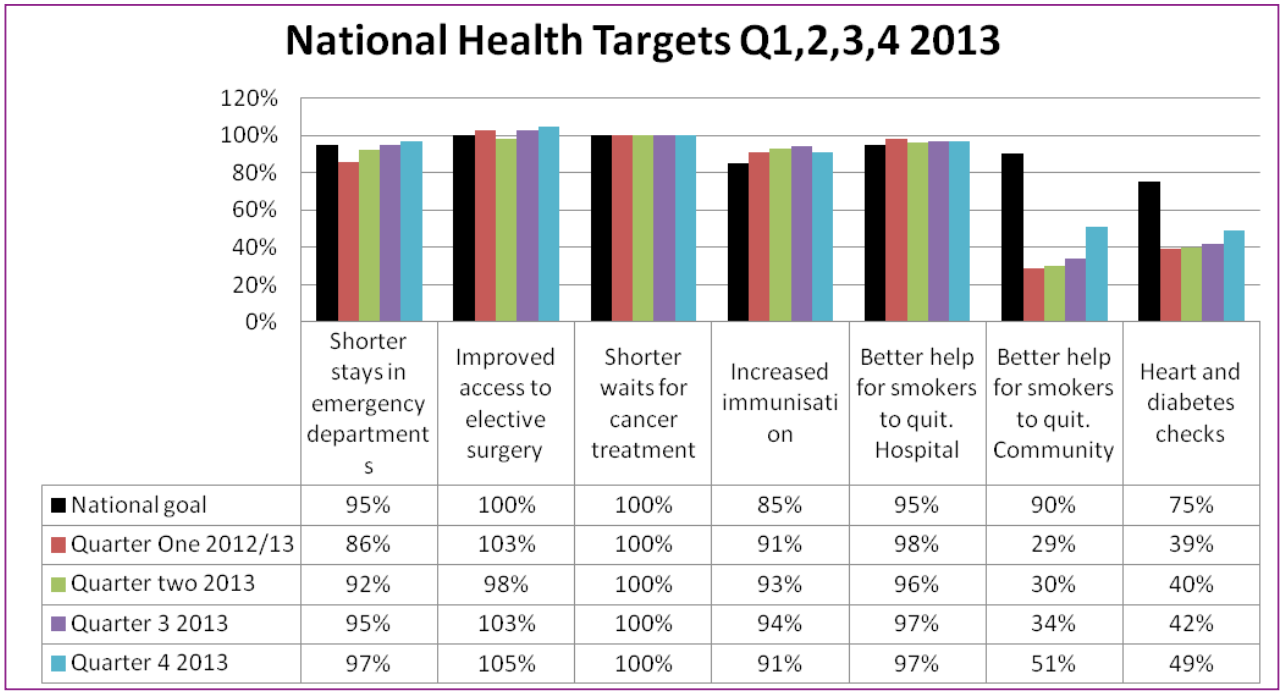
Contents

Healthcare Goals

Health Targets

The national health targets compare New 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 the government's health priorities.

Hutt Valley DHB Health Target Performance 2012/2013



	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%	85%	95%	90%	75%
Quarter One 2012/13	86%	103%	100%	91%	98%	29%	39%
Quarter two 2013	92%	98%	100%	93%	96%	30%	40%
Quarter 3 2013	95%	103%	100%	94%	97%	34%	42%
Quarter 4 2013	97%	105%	100%	91%	97%	51%	49%

The National Health Targets

Shorter stays in emergency departments

95 percent of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals and home again.

Improved access to elective surgery

The rate of growth of elective surgery needs to increase, which in turn, will increase patients' access to this important service, and should achieve genuine reductions in waiting times for patients.

Shorter waits for cancer treatment

All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.

Increased immunisation

By July 2013, 85 percent of eight-month-olds will have their primary course of immunisation (at six weeks, three months and five months) on time, increasing to 90 percent by July 2014 and 95 percent by December 2014.

Better help for smokers to quit

95 percent of patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.

More heart and diabetes checks

90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years to be achieved in stages by 1 July 2014. The first stage was to achieve 60 percent by July 2012, and then 75 percent by July 2013.

Reducing Cellulitis Through Collaboration

Since 2011 the number of people admitted to Hutt Hospital with cellulitis has reduced and when admitted, their stay is shorter thanks to a new multipronged approach.

In June 2012 cellulitis was the number one avoidable hospitalisation condition in the Hutt Valley for the 0-74 year age group. There were 590 admissions staying a total of 1,715 days in hospital.

The rate of cellulitis admissions was significantly higher than the national average overall in the 45-64 age group but not in the 0-4 year age group.

The model of care for managing cellulitis conditions often required hospital admission for the provision of intravenous treatment. This was inconvenient for the patient and their family/whānau.

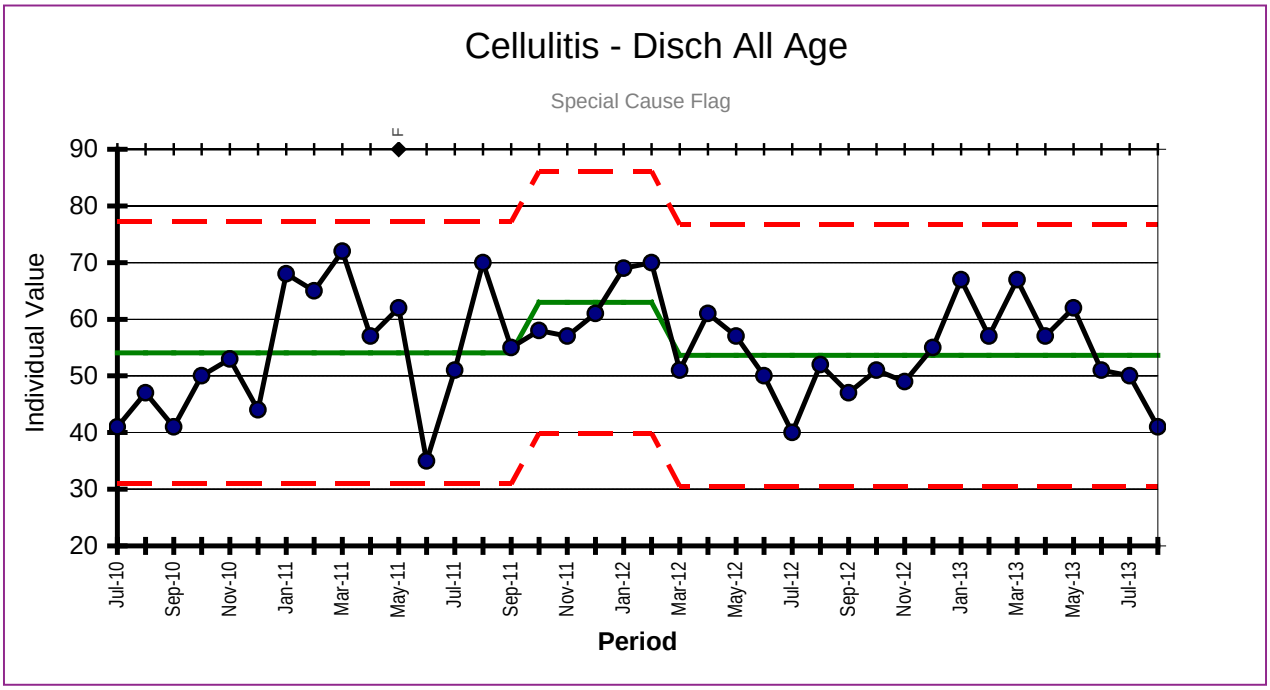
A new approach was needed and this was how the Silverstream Health Centre Cellulitis IV pilot was born. This project aimed to improve access to an acute primary health care service for patients with cellulitis and to decrease the number of hospital admissions.

This new innovation offered a nurse-led service that provided intravenous antibiotic therapy in a community-based setting. The nurses were educated and upskilled which ensured the efficient clinical management of referred patients with cellulitis.

The pilot project also provided:

- a 24 hour/7 days a week referral service
- each patient who met the criteria received three intravenous infusions over three consecutive days and received individualised education
- the service was open to patients from across the Hutt Valley region
- no cost to the patients
- transport provided by the PHO to the Practice if necessary
- collaborative arrangement by which Silverstream Health Centre delivered the intravenous service for Ropata Medical Centre in exchange for access to the newly developed toolkit by Ropata Medical Centre staff

Cellulitis – Discharge All Ages



- GPs able to refer their patients for acute treatment and be kept up to date about this.
- clinical oversight was available at Silverstream through dedicated GP 24/7
- duty of Care transferred to Silverstream Health Centre for the duration of the treatment procedure (i.e. 3 x IV procedures) then discharged back to personal/family GP
- improved relationships with secondary care, achieved through agreement over protocols, and education provided to medical registrars, ED/Medical Assessment and Planning Unit (MAPU) registrars and consultants. This led to secondary care clinician confidence to refer patients to the Pilot for treatment

Apart from this pilot programme, there were a number of other projects across primary and secondary care in the Hutt Valley that specifically targeted cellulitis.

The combined work over the last 18 months has contributed to reducing the impact of avoidable hospitalisation for patients with cellulitis.

Fewer patients have been admitted, with bed days reducing from 5.88 to 3.85 and they have shorter stays with the average length of stay from 3.52 to 2.60 days.

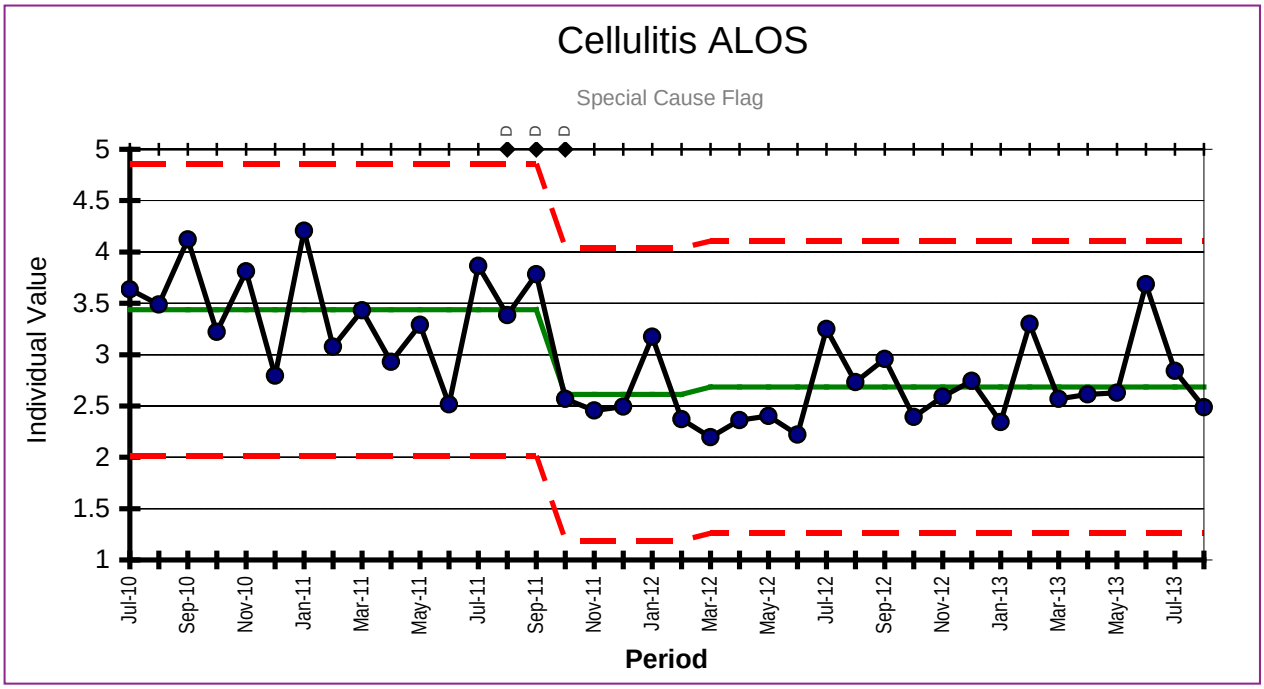
This has resulted in a total savings of two beds (730 bed days) by the end of May 2013, thus freeing up admissions and beds for patients with other conditions.

The Silverstream Health Centre Pilot demonstrated a 94% treatment success rate with zero adverse reactions or defaulters. Patients rated their experiences extremely positively, and preferred to avoid going into hospital.

Success has been due to a multipronged approach with primary and secondary care clinicians working together to address preventable admissions for cellulitis at many levels.

This has improved the patient experience and access to primary health care for treatment and prevention. Clinical integration has improved care and health outcomes for patients.

Cellulitis Average Length of Stay



Healthcare Outcomes

Putting Patients First

People with mental health needs in the Hutt Valley now have better access to an important therapy known as Cognitive Behavioural Therapy (CBT).

CBT is internationally recognised as one of the best practice therapies for depression and anxiety, and efforts are underway nationally to increase its availability.

Like all talk therapies it is relatively expensive and resource intensive to deliver, so few free or low cost CBT providers are available to people with mild to moderate mental health needs.

Hutt Valley residents are fortunate to have access to CBT through Te Awakairangi Health Network's Wellbeing Service.

The PHO sent two staff on an eight month training course because it recognised that more access to CBT would be helpful for people with mild to moderate mental illness.

With two staff away, a huge commitment was needed from the remaining four staff, to ensure client needs were met.

However the Network says it was short term pain for medium and longer term gains.

Most of the team can now offer simpler CBT interventions and skills training to people with milder conditions, freeing the more experienced practitioners, including the psychologists, to work with those with more enduring or challenging presentations.

Feedback received from a client of one of our newly CBT trained staff, said it all :

The new skills she taught me have enabled me to change my life. The skills have allowed me to gain a balance that I had been unable to achieve on my own. I can now do anything I wish to and am getting enjoyment from my life with family and friends whereas I once felt overwhelmed by life and now I can't wait for life to begin.

Primary Mental Health Nurse Nikki Foster working with a client using a CBT approach.

Dietetic Clinics–Better Access for Patients

Attending appointments at the hospital is often difficult for patients, particularly patients from high deprivation areas, where transport is an issue or where cultural barriers to attending appointments at the hospital exist. The Dietetic service at Hutt Hospital has tried to address this by providing an outpatient service located in the community.

Patients often find it difficult or undesirable to attend clinic appointments at the hospital for financial, transport, and cultural reasons. As a consequence patients will often fail to attend, or cancel their hospital appointments.

Maori and Pacific Island communities have some of the poorest health outcomes in New Zealand particularly in the areas of obesity and diabetes.

With advice from the Maori and Pacific Health Units, the dietetic service started to provide clinics in communities with high deprivation, and high Maori and Pacific populations to try and improve the access to their service.

These community clinics are being run at Pomare health centre in Farmers Crescent, and Whai Oranga health centre, in Wainuiomata. The team noticed that they were seeing more patients through these community based clinics because of the convenient location.

The clinics have proved to be also useful to GPs, who can now refer their patients to a dietitian who runs a weekly clinic at these locations. In addition, these clinics can also be used for hospital referrals if the location is more convenient for the patient.

Other benefits include sharing of the workload between dieticians at the DHB and within Te Awakairangi Health Network and quicker communication between the dietitian and other health care professionals at the medical centres.

These clinics fit in with the Te Awakairangi Health Network's healthy lifestyle programmes, and the clinician also provides support to other programmes such as the Green Prescription programme, and supporting Arthritis NZ.

The community based clinics are a win win for all.

Improving Housing to Reduce Hospital Admissions

Many admissions to hospital could be avoided if houses were warm, dry and not crowded. In particular skin and chest infections, meningococcal disease and rheumatic fever would decrease if housing improved. Reducing hospitalisations is a priority for the Hutt Valley DHB.

Health care providers are aware of the link between housing and health but often find it too hard to get the right support for families.

Housing links to Health

Overcrowding → Infectious diseases

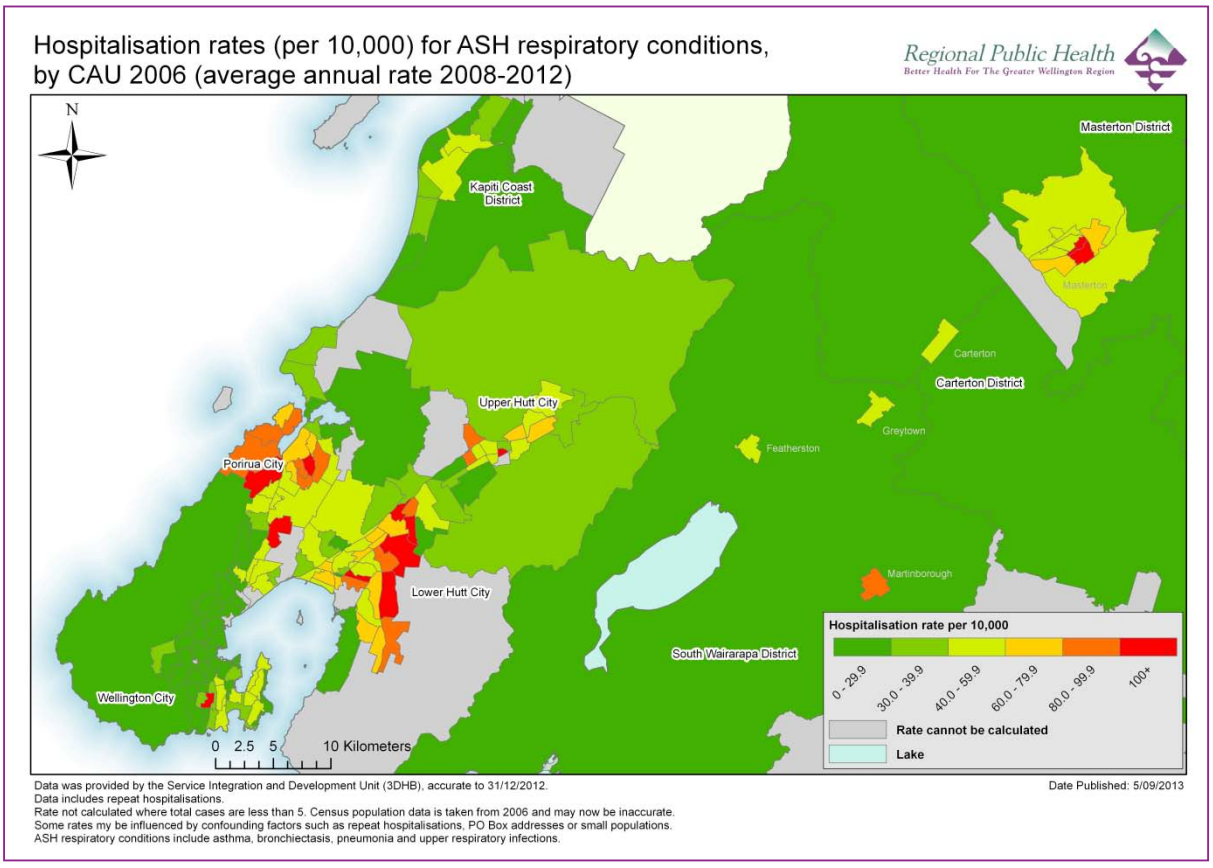
Cold, damp, mould → Respiratory illness

Unsuitable housing → Range of health and social issues

In partnership with Housing New Zealand (HNZ), Regional Public Health completed health and social assessments of 203 homes in the Naenae area with 544 clients assessed and 210 health and social referrals made.

Naenae was chosen for the Healthy Housing Programme based on hospitalisation rates for respiratory illness, rheumatic fever notifications, meningococcal notifications, skin infection data and the deprivation index.

At a strategic level, Regional Public Health also has a co-ordination role of the Wellington Regional Healthy Housing Coalition. The coalition brings together 30 organisations who are involved with health or housing, to identify solutions to improve housing conditions for our population.



Recently the group has developed a common referral pathway to link people who are at risk of illness to housing insulation programmes. This is currently being promoted across the region, and will make it much easier for community and health care workers to support their patients.

With the Healthy Housing Programme, households with high health needs were provided with health and social assessments, which help by linking families to primary care and other health and social services. The nurses providing the assessments also make recommendations to HNZ for housing interventions such as heating, safety or ventilation.

An action plan is then completed by HNZ.

The Regional Healthy Housing Coalition referral system aims to ensure priority households receive free insulation. This new pathway has been introduced to primary and secondary health care providers in the district. This is now being promoted across the Wellington region.

The actions of the health sector alone will not be able to address housing related health conditions. To address crowding, housing quality issues and improve access to affordable heating and other healthy housing interventions, RPH will work alongside the wider health services, housing and social sectors to improve services responsiveness to at risk families.

To improve health and wellbeing, housing conditions for people in our region need to improve.

Case Study One

A visit was made to a father living with his two adult sons in a three bedroom HNZ property. One of the sons had autism spectrum disorder and was unable to manage his own daily cares and his care package appeared inadequate. The father had pre-existing medical conditions including: uncontrolled diabetes, sleep apnoea, hypertension and decreased mobility.

A number of housing issues were identified including:

- significant mould issues in two of the bedrooms (and in household curtains), which held significant health risk for the father
- poor ventilation and heating that was unable to be used
- inadequate bathroom facilities for the autistic son to manage his daily needs
- insufficient power outlets in the bedroom for medical machines to operate safely

With the consent of the family Housing NZ were told that this family urgently needed:

- adequate heating
- improved ventilation systems in the kitchen
- mould treatment for the bedrooms
- bathroom modifications

- further power outlets so that medical machines could operate safely

Health and Social Providers were also informed including:

- a primary health outreach provider to assist the father with his health needs
- disability Support Service to review the son's care package
- occupational Therapy to review the son's needs
- a curtain bank referral

As a result, this family received a full house upgrade including, painting, mould treatment, ventilation in the kitchen, a heating solution, and power outlets in the bedroom.

The family also received Primary Health Outreach support (which is ongoing), a review of the Disability Support care package and Occupational Therapy support for the bathroom modification. Curtains were also provided for this family.

Case Study Two

– from a Regional Healthy Housing Coalition insulation provider participating in the new Referral System

Before the insulation, our house was bitterly cold in the mornings and in the night times. At times it would feel warmer outside than in for a comparison of temperature. We are a household of three people, two adults and one child aged two years old. At various times of the year, our health would suffer and our main concern was providing a healthier, warmer home for our daughter to recover from her ailments. She suffers with earache and eczema and has had many a trip to the doctors and hospitals for this.

A carer, at our daughter's day care, referred us through the Tu Kotahi Maori Asthma Trust to an insulation provider to arrange a visit to our house for an overview of our property and a meet and greet.

A time was arranged for a fit out of insulation for under floor and in our roof top some days later.

We noticed the difference in temperature immediately! We use less power to heat our house now; this will definitely keep the energy bills down in cost and keep us warmer in the cooler months.

Our house is now a home!

Focus for the Future

Regional Public Health and the Coalition are developing an enhanced programme that may include the following components:

- ongoing improvement of pathways between health, housing and social sectors for at risk households
- healthy Housing - Health & social assessments and referrals
- health, housing and social sector workforce development
- ongoing access to free insulation for people living with high health needs and limited financial means
- access to healthy housing information
- access to curtains
- maintenance
- healthy & affordable heating
- house assessments for efficiency measures

Increasing childhood immunisation rates to meet Government Health Targets

"Be Wise - Immunise"

Increasing the number of children immunised has resulted in lower numbers of children presenting with vaccine preventable diseases.

Children were not being enrolled at General Practices in a prompt and timely manner which resulted in immunisations being delayed. This increases the potential number of children being at risk of contracting vaccine preventable disease.

General Practices are encouraged to have good processes around welcoming a new-born to the practice, including a letter to advise of the first immunisation due.

There is also an National Immunisation Register (NIR) welcome letter outlining the parent's responsibility to enrol the baby and organise the six week immunisation. If they don't have a GP the NIR administrator will attempt to obtain a GP for them. If this is not possible the child is referred to the Outreach Immunisation Service for timely immunisation.

Hutt Valley DHB Immunisation Coordinator Tracey Green says they have various people within the community who can be contacted if a child has not been immunised. These include the Maori Breast Feeding Co-ordinator, Paediatric wards, Special Care Baby Unit (SCBU) and at times the Emergency Department.

General Practices also use Community Health Workers to locate these at-risk children and provide transport and any other social help that the child or family require.

As a result of these collaborative efforts, more children are now receiving timely immunisations. This is reflected in an increase in the number of children aged at eight months who are fully immunised.

Tracey says the team needs to keep building and maintaining positive relationships with key stakeholders and increase immunisation rates in Maori children by working with Maori Providers.

Case study

Several babies are born with Talipes, which means they spent the first few months of their lives with their legs in plaster. This makes it very difficult for them to receive their vaccinations, as the area of the thigh where they are normally given the vaccines is covered up.

Often the practice nurse will ring asking if the NIR Administrator and the Immunisation Coordinator can help facilitate this, when the child is brought into the hospital's fracture clinic.

"We liaise with the family and fracture clinic. We check that the fracture clinic can accommodate the vaccination during the appointment, and then meet the family in the clinic," Hutt Valley DHB Immunisation Coordinator Tracey Green says.

The Immunisation Coordinator provides the vaccines and when the plaster has been removed, can vaccinate the baby before the new plaster is applied.

Sometimes this means the plaster length is adjusted to allow for observation of the vaccine site.

Tracey says, "Vaccinations are very important and we will do as much as we can to ensure the child receives vaccines when they are due".

"Vaccinations are very important and we will do as much as we can to ensure the child receives vaccines when they are due."

Celebrating Two Years CLAB Free

Executive officer Richard Schmidt, Infection, Prevention & Control nurse specialist Jane Pryer, ICU Clinical Nurse Manager Teresa Thompson, Director of Operations Carolyn Braddock, CLAB Project leader Sarah Harris, Director of Operations Sarah Boyes, Chief Operating Officer Pete Chandler and Board member John Terris celebrating the success of the CLAB project.

Central Line Associated Bacteraemia (CLAB) prevention is an important measure in the fight against healthcare acquired infection. Central line infections are an issue throughout hospitals, but particularly in intensive care units (ICU) where they are most commonly used.

Throughout NZ there are approximately 19,000 ICU admissions each year. In these vulnerable patients, there is a serious risk of central line infection and with it a mortality rate of 10-50%.

The Hutt Valley DHBs CLAB programme is part of the Health Quality & Safety Commission's (HQSC) Infection Prevention and Control Programme (along with other initiatives including Hand Hygiene and Surgical Site Infection Surveillance).

The main goal was to reduce the rate of CLAB as close to zero as possible by implementing best practice care for insertion and maintenance of central lines.

Hutt Valley DHB is one of 10 DHBs who achieved zero CLAB for the duration of the project, which is being continued through the HQSC Quality & Safety Marker ongoing reporting requirements.

The successful project was rolled out to include central lines inserted in theatres and recovery, who have also achieved zero CLAB since the roll out in August 2012.

This success equates to over 730 days in ICU without a CLAB infection - theatres/recovery celebrated one year CLAB free in August.

Nationally, there has been a 90% overall improvement in the rate of CLAB since starting the programme in 2010 from 3.32 per 1000 line days to 0.4 per 1000.

This equates to prevention of 50-74 CLAB infections in patients, saving approximately 1.5 million dollars and 5 to 7 lives.

The CLAB project is a significant achievement which Hutt Valley DHB has fully participated in.

Oral Health Services

The reorientation of child dental services across the country has seen some great successes. Bee Healthy Regional Dental Service in Wellington explains how it is working closer than ever before with its local communities and Primary Health Organisations (PHO).

Since the recent transformation of free publicly funded child dental services across the country, Bee Healthy has been working hard at reorienting its service and improving oral health for its community.

A public meeting held in Porirua East last year, enabled both local community members, representatives from local health and social agencies to share both their expectations and concerns for their children's oral health across their community.

Bee Healthy embraced the opportunity and developed a stakeholders group to assist with shaping its existing service and supporting the development of community-based collaborative programmes and actions.

The combined approaches of the stakeholder group have seen the development of an activity plan aimed at increasing preschool dental enrolment, improving access to oral health services and ensuring that cross sector initiatives include oral health suited to their community's needs.

Bee Healthy is currently establishing a project with a local PHO aimed at increasing preschool dental enrolments across its general practices. It will be in place by early 2014 and will include oral health training such as 'Lift the Lip' for PHO staff and Practice Nurses.

The project aims to combine the newly implemented "Patient Dashboard" system to inform GPs and Practice Nurses of the dental enrolment status of each preschool child. An electronic enrolment form will be automatically generated if parents wish their child to be enrolled.

Further integrated work with PHOs across the community is expected to follow, ensuring oral health is firmly embedded across both community and population based child health focused initiatives.

Achieving 99% attendance at our clinics

A patient not attending their appointment is a big problem at hospitals and a project has been launched to reduce this in the Hutt Valley. Last year more than 13,000 people did not attend their appointments. Hutt Valley DHB, Wairarapa DHB and Capital and Coast DHB have identified this as an important issue with an initial target of getting to 6% DNA (did not attend) rate as an average across services.

The project as proposed by the Te Awakairangi is aimed at getting a 99% attendance by working towards an attendance goal rather than to address a perceived failure.

This widens the scope to consider high (and potentially unnecessary) follow-up rates or non-essential appointments, as well as focussing on 'enabling' people to attend appointments – considering timing, location and travel factors.

Public Health Registrar Saira Dayal says the campaign was kicked off by speaking with a range of interested people who work at Hutt outpatient services and Te Awakairangi Health Network.

"So far we've heard that there are a range of perspectives on why patients come and don't come and that no two clinics are alike. Each person we've spoken to also has ideas on how we can do things differently."

"Getting the right people to their appointments means patients get the care they need, and the outpatients system will move more smoothly," Saira says.

Children, young adults, Maori and Pacific people were found to have higher rates of non-attendance than others.

Case Study

"Earlier this year the Maori Health Unit received a referral from one of our clinics regarding a young woman who hadn't been attending a number of her appointments at the Maternity Assessment Unit. Our clinic staff were concerned for the health of the woman and her baby as they knew she had health and social concerns and was living in difficult circumstances.

The woman was difficult to get hold of or engage with, but the Maori Health Unit using their local connections, knowledge, Primary care Community health Workers, a student social worker, text messages and Facebook and managed to get in touch with the woman to help with getting her to the MAU appointments. Maori Health Unit staff have since formed a relationship with the woman and her whanau and assisted her to attend, which has included picking her up and bringing her to her appointments.

The pregnancy went well and the baby was delivered here at Hutt Hospital. She hasn't missed her appointments since the Maori Health Unit have been involved and at the next appointment for her baby in a couple of months time she knows who to contact if she requires further help to attend. She is also now connected to the Trentham Community House who provide ongoing activities and support for her and the whānau."

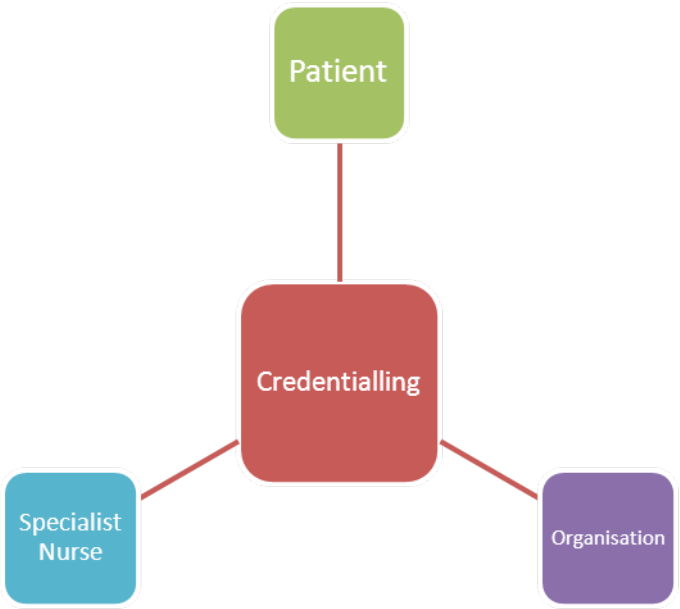
Credentialling

Credentialling is defined as the process by which health service providers assign specific clinical responsibilities to health practitioners on the basis of their training, qualifications, experience and fitness to practise within a defined context. The prime focus of credentialling is patient safety.

In New Zealand the credentialling process has been active for the past decade but has only focussed on medical practitioners, however many nurses have an expanded practice and also should be appropriately assessed as competent to undertake the expanded role.

The credentialling process focuses on quality improvement rather than discipline, and it has evolved over the years. The Ministry of Health recommends that practitioners whose practice is in some way specialised and who are not subject to routine supervision need to be credentialled.

Under the Health Practitioner's Competency Assurance (HPCA) Act of 2003, regulatory authorities such as the New Zealand Medical Council define scopes of practice, ensure practitioners are competent and fit to practise, and manage recertification. This includes statements that each practitioner takes part in a continued professional development (CPD) programme through their College. This information also informs part of credentialling through the formal documentation of external evidence.



Credentialling is delegated to the medical staff by the Chief Executive. It is a proactive process that commences on appointment with an initial credentialling, and continues on an annual basis with the Clinical Head of Department (CHOD) and then through service departmental credentialling every three to five years.

Each health practitioner should also be credentialled to work in an organisational scope of practice.

An organisational scope of practice takes into account, a practitioner's qualifications, experience, performance; and the organisational environment, including clinical support and available resources.

- Initial Credentialling – on commencement of employment. It is a process to review job description, confirmation of qualifications, registration, defines scope of practice (this includes locums), professional development needs and appropriate support.
- Annual Credentialling – paper exercise to ascertain if any changes have taken place since the last credentialling. Focus is on scope of practice, competence, continuing medical education and clinician's health and well being. Form is completed and given to CHOD for comment. Forms are reviewed by chief medical officer and followed up if necessary.
- Senior Medical Officer (SMO)/ Service Credentialling – Completed every 3-5 years for each service within the DHB.
- Visiting SMO credentialling - Confirmation of qualifications, registration, annual practising certificate. Defines scope of practice and appropriate support.

As an example of credentialling, an orthopaedic specialist may be trained in spinal surgery. However, as Hutt Hospital does not have intensive care unit (ICU) and theatre supports for this type of surgery, the surgeon would be credentialled to do general orthopaedics here, but not spinal surgery. The surgeon could be credentialled to perform this surgery in neighbouring hospitals with higher levels of support.

Case Study

Clinical nurse manager (CNM) Jennie Dean was the first nurse in New Zealand to be credentialled to run a nurse-led atrial fibrillation (AF) clinic.

She works in conjunction with and under the supervision of the cardiologists. This AF nurse-led clinic is unique in Australasia and probably internationally.

Because of the unique nature of this clinic, there is no formal training pathway.

Jenny has done Masters level papers in clinical decision-making through Massey University.

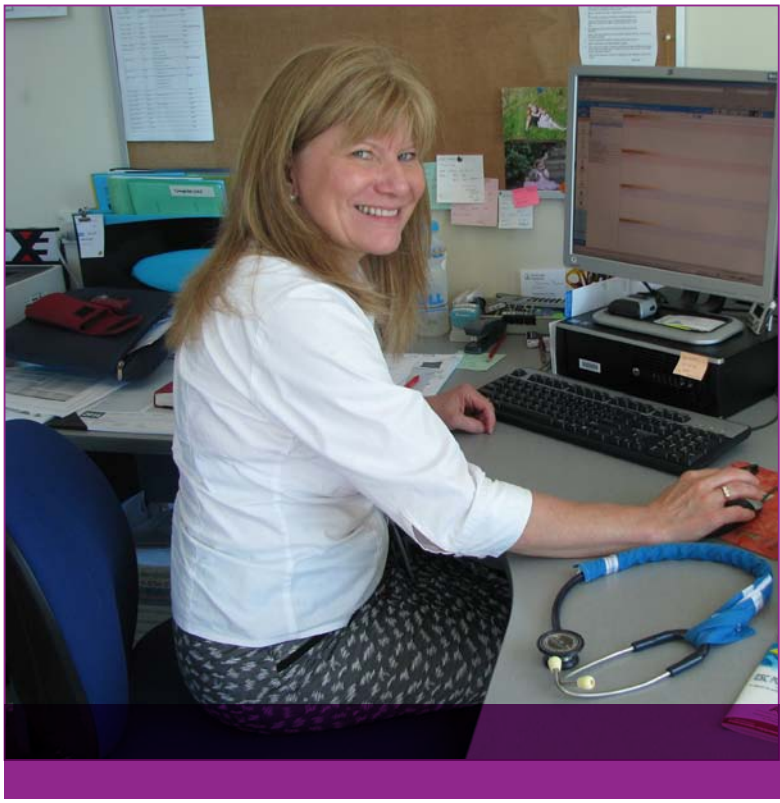
She had subsequently been identified by senior cardiologists as a good candidate for further clinical training to run the new unit.

She underwent extensive clinical training including patient examination technique under Chief Medical Officer Iwona Stolarek.

This ran concurrently with the AF clinic until such time as it was considered appropriate for her to work alone.

In making this decision, Iwona was able to call on her extensive experience in teaching clinical skills to medical undergraduates as well as her experience with postgraduate education.

The clinic is run efficiently with excellent recorded results.



Shorter Stays in the Emergency Department

ED staff with CE Graham Dyer and Board Chair Virginia Hope after receiving the Spirit of Quality Award for achieving the shorter stays in ED health target.

Hutt Hospital achieved the 95% Health Target for Shorter stays in Emergency Departments (ED) in October.

The shorter stays in ED is one of the Ministry of Health's priorities introduced in 2009.

The health target is defined as '95% of patients presenting to the Emergency Departments will be admitted, discharged or transferred within 6 hours of presentation'

It not only measures patients through the department, but reflects the performance of the entire acute patient flow, from primary services through to secondary, tertiary services and discharge.

The specialists believe a six-hour timeframe is a reasonable amount of time in which to treat and admit patients – long enough for good clinical care but not unjustifiably long.

Hutt hospital introduced a suite of computer tools to monitor demand and capacity within the organisation.

This enabled staff to know who was waiting in ED, how long they had been waiting, what their needs were and how busy the rest of the hospital was.

Hutt hospital manager Peng Voon says this enables them to allocate resources accordingly.

A Patient Flow Coordinator was appointed last year to assist with the new system and provide 'live' data and timely reports to key staff in the organisation.

"We only introduced the electronic whiteboard only late last year and this has made a huge difference to the timeliness of our service. Patients now receive a more efficient service from ED, i.e. they are spending less time there. For the first time, Hutt DHB met the Shorter Stay ED Target in Quarter 3 of 2013."

"The buy-in from the whole hospital is also important," Peng Voon says.

She says the hospital still needs to work with primary services to better manage lower acuity patients in the community like gastroenteritis, bronchiolitis and asthma.

The hospital has also introduced the Care Capacity and Demand program which matches the number of nurses to match patient demand.

Supporting Smokers to Quit

Staff from Upper Hutt Medical Centre - Championing Smoking Cessation.

Hutt Valley DHB has shot up in the Health Target rankings for better help for smokers to quit, with an increase in the primary care "brief advice" rate from 28% in the first quarter of 2012/13 to 64% in the most recent quarter (September 2013).

This is a reflection of the hard work by Te Awakairangi Health Network general practices, staff, and Regional Public Health staff to improve the health of our communities. One practice (Upper Hutt Health Centre) has now achieved the 90% target.

Te Awakairangi Health Network Health Promotion Team Leader Tanya Radford says encouraging and supporting people to quit smoking is often the most effective intervention GPs and practice nurses can do to improve the health of their patients.

She says evidence shows that even a brief discussion about smoking and offering cessation support is effective in generating successful quit attempts.

The Network wanted to ensure more of these conversations were happening in general practices so they rolled out a range of interventions to increase smokefree brief advice.

One of the interventions was the implementation of a patient dashboard that pops up on the computer screen when the patient is with a GP or nurse, so that the GPs and nurses are reminded to undertake various checks.

"The traffic light system is an easy and effective way to remind us to talk about smoking in each consultation," Tanya says.

Practices were encouraged and supported to telephone smokers to discuss quitting support.

Where practices were not able to do this, smokers were contacted through a pilot project where Quitline contacted smokers on behalf of the practice.

The Network also offered regular training to its own staff and DHB nurses and midwives.

As a result of these interventions, 3100 smokers were contacted by their practice or Quitline over three months and offered cessation advice and support.

Tanya says, "On the whole patients have been really open to the calls. We know that the majority of smokers want to quit and about half have attempted to quit in the last year. This project has been about making sure smokers are aware of the help that is available to them and supporting them on their journey to quit".

The challenge for the months to come is to maintain the focus and enthusiasm for smokefree brief advice amid the competing pressures of a busy primary care practice.

"We know that the majority of smokers want to quit and about half have attempted to do this in the last year. This project has been about making sure smokers are aware of the help that is available to them and supporting them on their journey to quit."

Wainuiomata Smokefree Car Campaign

A University of Otago study shows that smoking in cars in Wainuiomata is 11 times greater than in Karori. Researchers observed almost 150,000 cars in Karori and Wainuiomata, during February to April 2011. These results were the first ever to show the differences between two areas for smoking in cars with children. The results also suggested that the current educational approach to smoking in cars is not working well for children in poorer areas.

Following the results of the survey, Regional Public Health consulted and collaborated with community stakeholders, residents, local businesses and high school students to develop a campaign to reduce smoking in cars in Wainuiomata.

The Wainuiomata Smokefree Cars 'That's How We Roll' campaign was launched in February this year to encourage the people of Wainuiomata to make their cars smokefree, especially when children are passengers.

The working group youth members known as the #TAGs are the face of this smokefree car "That's How We Roll" campaign. They are working alongside several Wainuiomata community groups and Regional Public Health promoting the smoke free car message.

Following the introduction of the campaign, the University of Otago this year repeated the 2011 observational study of smoking in cars and observed 57,672 vehicles. Their findings show there was a significant decline of smoking in vehicles with children during 2011-13, compared to the 2006–2011 period.

Case Study

My son was 4 years old when he began asking me and his kaiako (kohanga teacher) to 'stop smoking'. He would say that I was 'bleeding on the inside' or that my 'eyes were going to fall out'. This was my young son's take on what he was seeing on the TV ads; all he knew for sure was that he didn't want his daddy getting sick. Every time my 3 year old son saw the 'Smokefree Car' billboard at the bottom of Wainuiomata hill he would start singing the Wiggles big red car song. It was simple for him to understand that the Wiggles car is auahi kore (smokefree), I'm not sure if the big red car on the billboard was intended to promote smokefree cars in that manner.

In November 2012 my journey began towards becoming a non-smoker; at this time I was smoking three or four packets a week. In April 2013, I began coaching a junior rugby league team and part of my commitment to the team was encouraging parents not to smoke in cars and on the side-lines. We began to see parents walk off the fields to have a smoke away from the children and we didn't once need to remind the parents not to smoke in their cars to and from the games.

The urge not to pick up a cigarette is an ongoing battle for me and I still have the odd slip up but I know I need to keep trying for the sake of my family.

First 3DHB Allied Health Awards a Success

Helen Topham receiving the Innovation Award on behalf of RPH, Carrie Henderson receiving the Hand Therapy Award on behalf of the 2DHB Hand Therapy team and Natalie Richardson receiving the 2DHB Allied Health Director award.

Hutt Valley DHB scooped three out of eight awards at the inaugural 2013 Allied Health Technical and Scientific Awards in August.

The Healthy Environments Team at Regional Public Health won the Innovation Award, Natalie Richardson the 2DHB Allied Health Director won the Leadership Award and the Hand Therapy Team at Hutt and Wairarapa DHBs won the Across DHB Collaboration Award.

About 200 staff from the Hutt, Wairarapa and Capital and Coast DHBs, attended the awards, held at the Horne Lecture Theatre at Wellington Hospital.

The awards were noted to be the first to bring staff from the three DHBs together at an event.

2DHB Allied Health Director Health Director, Natalie Richardson, says the idea for the awards came about a year ago during a monthly meeting between the teams across the three DHBs.

"We know that there are quality awards and nursing awards and we felt that it was important to acknowledge allied health workers as well."

Natalie says they received over a hundred nominations for the eight categories, which is a good number considering it is the first awards for allied workers.

The panel of judges were made up of eight directors from Wairarapa, Hutt and Capital Coast DHBs.

Natalie says the awards are the first and certainly not the last.

The sponsors of the event were: Wellington Hospitals Health Foundation, Medical and Cardiac Trust Hutt Valley DHB and Active Healthcare.

"We know that there are quality awards and nursing awards and we felt that it was important to acknowledge allied health workers as well."

The wait is over!

The Infant Child Adolescent and Family Service (ICAFS) has experienced a steady increase in referrals over the past 4 years leading to increased wait-times for clients. To address this problem they implemented the Choice and Partnership Approach, smashing their waiting list after a six week blitz.

Over the past four years ICAFS has experienced a 60% increase in referrals but only a 15% increase in staffing. This has led to longer wait-times for an initial assessment for children and young people.

They wanted to see clients faster and get them into treatment quicker, consistent with the Ministry of Health targets for similar services across the country.

The first step was to share their demand and capacity calculations with the Directorate Leadership Team and convince them that they needed extra resourcing.

The second step was to apply the Choice and Partnership Approach (CAPA), currently used by other child & adolescent mental health services in the country.

ICAFS then calculated how many new assessments they would need to provide each week to ensure 80% of clients were seen within three weeks of referral.

Then they calculated how many of those clients went on to receive further treatment and how to spread this load across clinicians so that everyone was working to full capacity and clients could be given a definite date that their treatment would begin.

"Our final step was to focus on reducing our waitlists. Across the service, every clinician offered up some extra assessments, resulting in approximately 100 assessments in a 6 week period. This allowed us to clear our waitlists and book everyone into treatment," says Clinical Manager Dougal Sutherland.

"Although we are still in the process of completing our waitlist reduction process, we are confident that by the start of November every new referral will be seen for an assessment within 1-2 weeks of being referred and be given a definite date for treatment to begin."

Dougal says ICAFS still need to review their demand and capacity each quarter to ensure that they can put resources 'where we need them and to flex our service to best meet the demands on it'.

"We analysed the demand on the service and focused our resources on reducing our waitlist, allowing us to see people sooner and give them a clear date for treatment to start."

Reducing the impact of patient falls

Having a fall can be devastating. Falls in hospital have a major impact not only on the person who falls but also the individual's family/ whanau, those caring for them and the health care system. Falls are the leading cause of injuries to older people – one out of three older people has a fall each year, and the likelihood of falling increases with age.

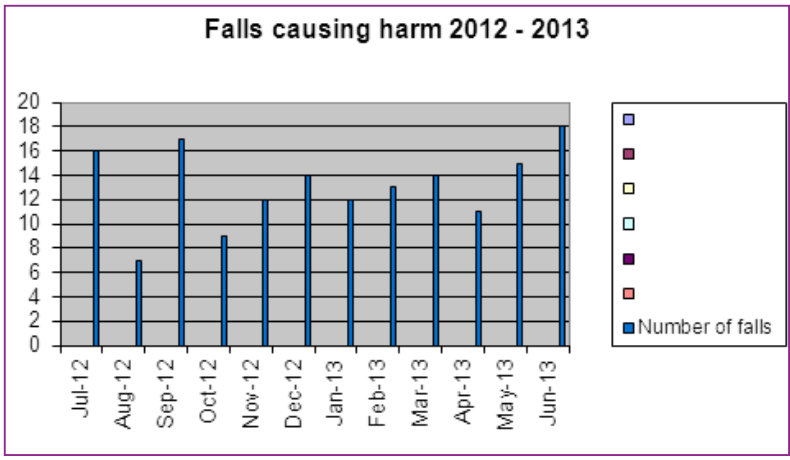
Falls in hospital carry both a human and financial cost. The financial cost of a fall may vary between $600 (minor injuries sustained) to $47,000 associated with a 3 week stay in hospital for a fall resulting in a hip fracture (HQSC).

From the beginning of this year until 30 September, 382 falls were recorded in the Hutt Valley. One hundred and thirty-eight resulted in minor harm, only three resulted in a fracture or temporary significant harm and 241 resulted in no harm to the patient.

The human and physiological cost is less easy to measure but often results in loss of independence and associated loss of confidence and social isolation (HQSC). In recognition of this the Health Quality and Safety Commission (HQSC) has identified "Falls" as one of its priorities as part of its "Open for Better Care" patient safety campaign.

Hutt Valley DHB has played an active role in the HQSC campaign. This included taking part in the Central Region DHBs trial of a 'signalling system" – a series of mobility assistance symbols (equipment tags, bedside signs, posters and magnets) designed to act as a signal to health care providers, support staff, families/whānau and friends that a person may require help to ensure they are safe when walking. The HQSC have refined the tools as a result of feedback from the Central Region and are entering into a procurement process.

Two clinical areas trialled the signaling system and found the tools useful even though they used the tools in slightly different ways due to their patient population (this was found throughout the region). Once the tools are available for wider use the Falls Committee will look at rolling out their use throughout the DHB.



The HQSC undertook a national review of falls risk assessment tools and care plans in use in DHBs. The review identified that falls assessment tools and care plans varied across the DHBs and they often lacked an individualised approach. The DHB Falls Committee has commenced a process of reviewing and standardizing falls documentation currently in use based on the review's recommendations.

Claire Jennings, the Nursing Director, Practice Development Unit, Hutt Valley DHB says, "Meeting the tension of reducing falls and harm for those who do fall whilst maintaining confidence and independence is the overall aim of the Falls Committee work."

Falls prevention is everybody's business, so let's all do what we can to prevent the pain and harm caused by falls.

Pressure Injuries

Pressure injuries are largely preventable adverse events. It is imperative that 'at risk' people have regular top to toe assessment especially of skin integrity; receive basic cares such as regular turns; that turning schedules and wound charts are documented, and pressure injuries reported.

At Hutt Valley DHB there have been inconsistent practices around pressure injuries, with the focus more on treatment rather than prevention. Recommendations from annual prevalence studies have been slow to be implemented. However, some progress is now underway and a range of initiatives are being implemented to help address these issues.

This includes a drive to implement international best practice guidelines and improve practice and raise awareness about this issue. Collaboration with our neighbours in Capital and Coast DHB and Wairarapa DHB has been occurring along the way; a pilot prevalence study with our colleagues in aged residential care has been implemented with positive outcomes, and a link with a dermatologist has been established to facilitate earlier access to a specialist for patients with severe skin problems.

People who have a history of falls, declining health and consequent admission to hospital are 'at risk' of developing pressure injuries. Our aging population is increasing and they are also at risk so we must look at how we can best manage the problem of pressure injuries through preventative strategies.

In New Zealand, national data indicates that pressure injury events have been reported to be twice as high as the number of falls recorded in the same period.

"Previously we have collected data by an annual 'snap shot' of inpatients with pressure injuries on one day (prevalence studies). A gap analysis provided recommendations following prevalence studies but these have been slow to be implemented. Education of staff about the prevention, management and treatment of pressure injuries and providing consistent care is vital," says Guideline Implementation Pressure Injury (GIPI) Group chair, Kate Gray.

The GIPI group formed in September 2012 to implement best practice by using the Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury.

Kate says staff have been educated through provision of three pressure injury study days annually.

A pilot prevalence study for patients with pressure injuries in aged care has been implemented for the first time, and a research report on this has been completed.

A link with a dermatologist has been established to facilitate earlier access to a specialist for patients with severe skin problems.

Kate says communication and education of health professionals about the importance of establishing consistent preventative measures and treatment for pressure injuries both in secondary and in aged residential care has been implemented and continues to be crucial.

The importance of skin integrity assessment, the use of prevention strategies and event reporting has been communicated. A current focus is to gain support for and establish the recommended 'link' roles.

"The clinical audit from the pilot prevalence study in aged care had very positive outcomes. The staff from the Aged Care residence who participated 'learnt so much' with a clinical audit as data was not only collected but education around pressure injuries/equipment was provided at the same time. We identified and made recommendations around assessment and documentation."

"Our focus should be not on collecting numbers of pressure injuries but looking at the 'enablers' and 'disablers' in the prevention of pressure injuries working within an interdisciplinary collaborative practice model," Kate says.

A further clinical audit will be carried out in December 2013 (18 months post study) in the Aged Care residence on a smaller sample of patients to see if there is evidence of improved documentation, processes and prevention strategies.

Surgical Site Infections

Surgical Site Infection Surveillance Programme

International evidence tells us that healthcare-associated infections are a significant risk to patients, with surgical site infections (SSI) being one of the most prevalent. About two to five percent of patients who have inpatient surgery will develop an SSI. SSIs are the second most commonly-reported healthcare associated infection.

SSIs can develop when bacteria enter a surgical incision and multiply in the tissues. Symptoms may include pain and redness around the surgical site, drainage of cloudy fluid from the surgical wound, and fever. The consequence of these infections include prolonged hospital stays and additional treatment and can result in increased death rates. Patients with an SSI have a two to 11-fold increased risk of death compared to postoperative patients without an SSI.

Before this year each DHB in NZ did its own surveillance of surgical site infections which led to inconsistencies. The National Surgical Site Infection Surveillance Programme was rolled out this year and will standardise data collection and reporting 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. Year One of the national surveillance programme will focus on surveillance of hip and knee surgeries. National data shows that a site infection following hip or knee replacement can cost three to four times as much as the original surgery. Patients who develop an SSI after hip replacement surgery stay at least two or three times as long in hospital as expected.

To help minimise the risk of surgical site infections patients need to present for surgery in the best condition possible. This may include stopping smoking, reducing obesity, pre-operative showering and presenting in a good nutritional state.

Next steps

Hutt Valley DHB joined the Open for Better Care campaign to prevent and improve the numbers of surgical site infections occurring. Important SSI prevention and improvement work is already underway via the Surgical Site Infections Surveillance (SSIS) Programme. The Programme will continue its work to ensure the New Zealand health and disability sector has the resources, capability and support required to improve clinical practice and reduce the harm incurred from surgical site infections.

Some specific campaign actions include raising awareness of the scale of the issue and the benefits to be gained from a national improvement programme. Another focus is to improve data quality and increase teamwork to ensure streamlined measurement for improvement within units. The campaign will also highlight the importance of appropriate prophylactic antibiotic use, the importance of appropriate skin preparation and the importance of clipping and not shaving the surgical site.

Serious and Sentinel Events 2012/13

Hutt Valley DHB has a well established review process to ensure the needs of family and whānau are addressed.

What is a serious or sentinel event?

A serious or sentinel event is an adverse event which has generally resulted in harm to patients not related to the natural course of the patient's illness or underlying condition. A serious event is one which has led to significant additional treatment and a sentinel event is life threatening or has led to an unexpected death or major loss of function.

As part of Hutt Valley DHB's commitment to providing safe care for patients, we have a process in place for investigating serious and sentinel events that occur in our hospitals. The purpose of investigating serious and sentinel 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.

Serious & sentinel events reporting

Serious and sentinel events must be reported to the Health Quality and Safety Commission (HQSC) so that lessons can be shared about how to prevent similar events in the future. The Health Quality and Safety Commission produces a national report on serious and sentinel events each year, based on information provided by DHBs. Each DHB produces a report providing further detail on its serious and sentinel events for that reporting year. Each of the reported SSE events involves a patient suffering harm or death while in our care.

Hutt Valley DHB serious & sentinel events report for 2012/2013

In 2012/2013 Hutt Valley DHB reported 11 serious and sentinel events.

- colonoscopy
- skin tear
- undiagnosed fracture of femur
- delay in cancer diagnosis
- undiagnosed fracture in foot
- patient falls x6

General Manager Quality, Safety & Risk, Cate Tyrer, says, "These events were investigated through our reportable event system and reported to the Health Quality and Safety Commission. While adverse events are of great concern, they are relatively rare. Our DHB is actively learning from these events and we have a falls management group set up to look at the management and reporting of falls to ensure systems and processes are in place that will reduce the likelihood of such events occurring again. 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."

Learning from our mistakes

"We consider one event is one too many, and apologise unreservedly to the patients and families involved. We acknowledge the distress and grief that result when things go wrong in healthcare. We always seek to learn from these incidents and improve safety. We can't do this if we don't know about them happening. 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," says Cate Tyrer.

Continually strengthening our culture of patient safety and quality is a top priority for Hutt Valley DHBs. We are committed to working with patients and families when things go wrong to ensure that their concerns and needs are addressed and supported, and that they are included in the process of the review.

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.

This commitment is emphasized through our strategic quality direction with our three clear objectives being

- Improving the Healthcare Experience
- Improving Healthcare Outcomes (effectiveness)
- Improving Healthcare Safety

"We consider one event is one too many, and apologise unreservedly to the patients and families involved. We acknowledge the distress and grief that result when things go wrong in healthcare. We always seek to learn from these incidents and improve safety."

Cate Tyrer, General Manager Safety, Quality & Risk, Wairarapa and Hutt valley DHBs

Future Focus

This has been an extraordinary year for Hutt Valley DHB, as we have moved from vision to reality on our journey towards more streamlined services across Wairarapa, Hutt Valley and Capital & Coast DHBs. The achievements of this year are a firm foundation for the 2013/14 year, as we move from a 2DHB to an increasingly 3DHB model for service planning and delivery. 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 Hutt Valley over the forthcoming years.

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 general practices, Te Awakairangi Health Network, community health providers, support groups, aged residential care and Non Governmental Organisations (NGO) to deliver high quality care.

At the heart of it

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 2012/13 Hutt Valley 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.

While we have made significant progress in reducing patient harm from falls and pressure injuries these will continue a focus for the coming year.

The DHBs overall strategic quality objectives will be

- Improving the healthcare experience
- Improving healthcare outcomes
- Improving healthcare safety

We will achieve these goals through continued participation in the HQSC ‘Open for better care’ programme. This national campaign focuses on reducing harm in the areas of falls, surgery, healthcare associated infections and medication. It is about providing the best care possible. “It starts here, it starts with me.”

Cate Tyrer, General Manager Safety, Quality & Risk, Wairarapa and Hutt Valley DHBs

Tell us what you think

If you have any feedback or comments about our first Quality Accounts we want to hear from you.

Email us: Quality.email@huttvalleydhb.org.nz

Quality Accounts

Our first Quality Accounts for 2012/2013 was compiled by the Communications Unit on behalf of Hutt Valley DHB. DHB staff and health providers in the community were invited to look back over their achievements and quality initiatives over the previous year and contribute their stories.