QUALITY ACCOUNTS 2014/15

HUTT VALLEY DHB

Hutt Hospital's 70th Anniversary Celebrations

St Patrick's day dress ups

Contents

Values

Vision

Whanau Ora ki te Awakairangi

Healthy people, healthy families and healthy communities

Mission

Working together for health and wellbeing

We commit to work cooperatively, as an active part of the health sector and the Hutt Valley community.

Values

Can do – leading, innovating and acting courageously

Hutt Valley DHB leads the New Zealand health sector. We are committed to quality and innovating to improve the health of our people.

Working together with passion, energy and commitment

We are passionate about our work. We direct our energy to doing the best for our clients and the community.

Trust through openness, honesty, respect and integrity

We regard trust as essential to success. The people we serve must have confidence in us. We are open, honest, and respectful. We act with integrity.

Striving for excellence

We aim for excellence, individually and as an organisation. This commitment defines us, the services we provide, the way we work with each other and how we shape our systems.

Introduction

This is the second edition of our Quality Accounts, an important document which highlights some of the work we have done over the last year to improve services and outcomes for Hutt Valley people.

Quality Accounts are 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 document 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.

The year in review

DHBs working together

The merging of two DHBs, Hutt Valley and Wairarapa, 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 Hutt Valley 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 Te Awakairangi Health Network, medical practices, 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 the Hutt Valley 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

Virginia Hope
Board Chair

Have your say

This document has been compiled by the Quality and Communications teams at Hutt Valley DHB, with input from the Executive Leadership Team and staff from throughout the DHB.

We welcome your views on these Quality Accounts.

You can email us:

feedback@huttvalleydhb.org.nz

Or you can write to:

Quality Accounts
Hutt Valley DHB
Private Bag 31907
Lower Hutt 5010

The deadline for feedback is 1 January 2015. All feedback will be collated and published prior to the preparation of the 2014/15 Quality Accounts.

www.huttvalleydhb.org.nz / facebook.com/huttvalleydhb / @huttvalleydhb

Health targets

HEALTH TARGET	Target	2012/13 Performance	2013/14 Performance	Achievement
Shorter stays in Emergency Departments 	95%	92%	94%	✗ Not Achieved
Improved access to elective surgery 	4,946	5,208	5,226	✓ Achieved
Shorter waits for cancer treatment 	100%	100%	100%	✓ Achieved
Increased immunisation 	90%	92%	93%	✓ Achieved
Better help for smokers to quit – hospital 	95%	97%	96%	✓ Achieved
Better help for smokers to quit – primary care 	90%	51%	71%	✗ Not Achieved
Better diabetes and cardiovascular services 	90%	49%	81%	✗ Not Achieved

Quality & Safety Markers

HQSC marker	Goal	July to Sept 2013 (Q1	Oct to Dec 2013 (Q2)	Jan to Mar 2014 (Q3)	Apr to June 2014 (Q4)	NZ average (Q4)	Hutt Valley DHB Comparison with NZ Average
HQSC Reporting has calendar quarters		**Q4 Oct – Dec 13**	**Q1 – Jan – Mar 14**	**Q2 Apr - Jun**	**Q3 Jul – Sep 14**	**NZ Average Q3**	
FALLS: Percentage of patients aged 75 and over (Māori and Pacific Islanders 55 and over) that are given a falls risk assessment.	90	65	76	75	75	89	
FALLS: Percentage of patients assessed as being at risk have an individualised care plan which addresses their falls risk.	90	73		71	78	89	
PERIOPERATIVE HARM: Percentage of operations where all three parts of the surgical checklist were used.		80	93	93	90	94	
CLAB: ICU Central line insertions compliant with good practice		89	93	90	100	95	
HAND HYGIENE: Percentage of opportunities for hand hygiene	70	82	61* *fewer than 50% of required moments	50	60	75	

HQSC Reporting has calendar quarters		Q4 Oct – Dec 13	Q1 – Jan – Mar 14	Q2 Apr - Jun	Q3 Jul – Sep 14	NZ Average Q3	
SURGICAL SITE INFECTIONS : Antibiotic given (0-60 minutes before "knife to skin" (baseline date January to March 2014)	100	99	86	52	86	94	
SURGICAL SITE INFECTIONS : Right antibiotic in the right dose – cefazolin 2g or more	95	0	89	98	97	85	
SURGICAL SITE INFECTIONS : Appropriate skin antisepsis in surgery using alcohol chlorhexidine or alcohol/povidone iodine	100	100	100	98	100	97	

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). Locally we publish our own report. In 2013/14 Hutt Valley DHB reported 8 events and in 2012/13 we reported 11. The local report is available to view at our website www.huttvalleydhb.org.nz

Receiving care closer to home

Thanks to some innovative thinking from staff, Inflammatory Arthritis patients in the Hutt Valley can access high-quality care at home.

Inflammatory arthritis patients need close monitoring over a long period, because the disease progression can be unpredictable and requires multiple medications. In recent years, Hutt's clinical specialists and nurses began to notice that many people coming in for their regular appointments were in a relatively stable condition with no serious complications.

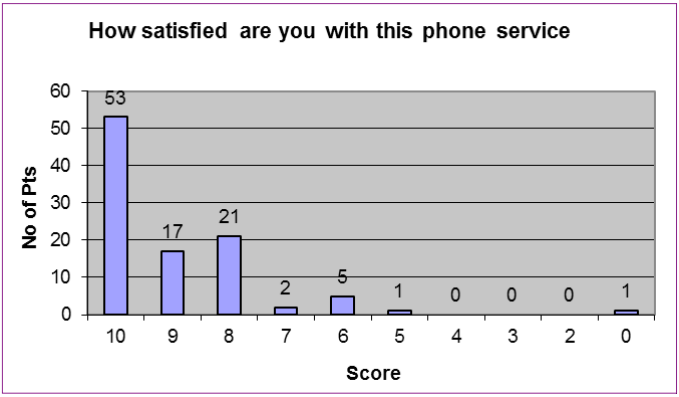
Seeing an opportunity to improve the way these patients are monitored, Rheumatology Clinical Nurse Manager Merie Claridge and the Hutt Valley IT team developed a computer programme that automatically schedules 'virtual clinics' for patients on the long-term inflammatory arthritis management programme.

Now patients are phoned every six months at home to review their condition, following the format of their face-to-face outpatient appointment. If necessary, a hospital appointment can be organised, depending on the person's condition. They can access the computer programme to self-monitor by reporting symptoms of their condition.

400 people have enrolled in the service so far and patients have reported high levels of confidence with the monitoring regime and satisfaction with their access to advice and outpatient appointments.

The change has also created space in the outpatient schedule for patients whose condition has become unstable, meaning more critical cases can be seen face-to-face in a timely way.

"This has been a very successful programme with a high patient satisfaction rate," says Merie. "Patients really enjoy not having to come to a hospital visit. They do not have to take time off work anymore."



Rheumatology Clinical Nurse Manager Merie Claridge with Julie Pope from Hutt Valley DHB's domestic services team. Julie is a participant in the virtual clinic programme.

Podiatry pathway and community care

Diabetes can lead to complications involving the feet, ultimately leading to ulceration or amputation. People at high risk of developing these complications can qualify for funded visits to a community podiatrist – but it involves a hospital visit to assess their eligibility for the service.

Hutt Valley's podiatry team saw an opportunity to remove this unnecessary step by offering screening in the community. They have developed a pathway which will see patients assessed at their GP surgery to determine whether they quality for the funded podiatry visits.

The potential effects of this are a reduction in hospital waiting times for acute cases, because of the reduced number of assessments; plus faster treatment for patients.

The team is currently developing training in line with the NZSSD Diabetes Foot Screening and Risk Stratification Tool and is aiming to roll out the new pathway in 2015.

Getting in shape before joint surgery

'Prehabilitation' classes aim to prepare patients for joint surgery with strengthening and balance exercises.

Research shows that mental and physical preparation before joint surgery leads to better clinical outcomes. With this in mind, a multidisciplinary team at Hutt Hospital set out to improve people's journey through joint replacement surgery and recovery, and possibly reduce the number of days they needed to spend in hospital.

Colleagues from occupational therapy, physiotherapy, nursing social work and the Maori health unit set up a Joint Care Class for patients, with session on what to expect from admission, surgery and after discharge. Demonstrations of exercises and walking aids help prepare patients for the mental and physical challenges ahead.

In the wake of this successful initiative, the team took it one step further. A new series of 'Prehabilitation' classes was started, teaching strengthening and balance exercises to get patients in the best possible shape before surgery.

This 8-week, twice weekly course has been run as a pilot to measure whether patients who undergo 'Prehabilitation' exercises have better physical and functional outcomes, and shorter hospital stays. Next year we'll be reporting back on the results of this trial.

Getting better at home

The Early Supported Discharge Service promotes health, confidence and coping for patients discharged from hospital.

Leaving hospital after an acute stay can be intimidating, but the Early Supported Discharge Service helps patients and their families make the transition.

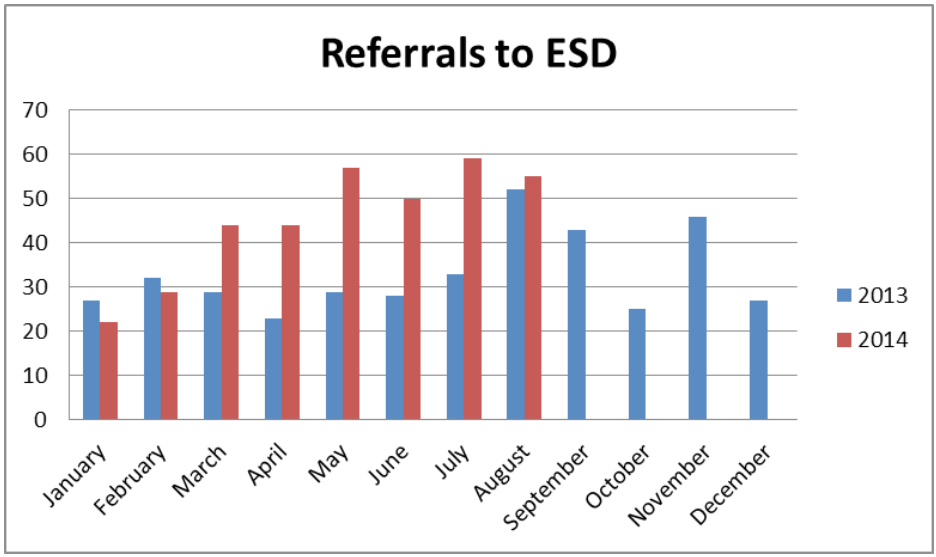
The service originated from a pilot conducted in March 2012, which itself came out of a review showing that Hutt Hospital's average length of acute stay was longer than the national average.

Clinical staff saw an opportunity to improve the experience of patients whose needs would best be met within their own home environment, as well as improving patient flow.

The ESD Service arranges for patients to receive a comprehensive assessment before they're discharged from hospital. They might be seen by the core team, comprising a specialist post-acute nurse and healthcare rehabilitation assistant, as well as other disciplines such as social workers, physiotherapists and occupational therapists.

If it's concluded that the patient could benefit from nursing management in a home-based setting, a plan is put together and the patient can go home to continue their rehabilitation with a programme of support in place.

In-home care might include visits from the ESD team to check on the patient's medication and physical therapy. The team can also use their connections and knowledge of the local community to coordinate for patients to access other relevant services.



The ESD Service has been made part of business as usual with a standard operating procedure developed and referral criteria extended to include more inpatient areas. The hours of the service have also been extended to include Saturday visits, to help facilitate discharges on the weekend. Extra staff have been trained to provide the service so that it can be extended to other areas.

Feedback from surveys of patients and their family members:

"Very much supported on discharge. Very informative and Anna very gentle, stayed for quite a long time and gave information with books etc."

"Very good service that helped me get organised."

"Thought the service was great, gave her the feeling that she was supported once she left hospital."

Helping cancer patients find their way

Since May 2013, Hutt's Cancer Care Coordinators have been establishing themselves as a valuable support for newly diagnosed patients.

Entering the healthcare system for cancer treatment can be a daunting experience. Cancer patients are likely to have multiple appointments with teams at different hospitals or clinics over a period of months.

The role of the Cancer Care Coordinator is twofold. First, they provide advice for patients on how the healthcare system works and what to expect from the cancer journey.

The second major focus for our Cancer Care Coordinators is to review the care pathway for cancer patients and make recommendations on how service gaps or problems can be fixed.

Since patient tracking began, the Cancer Care Coordinators at Hutt have looked at over 700 people with cancer in the Hutt Valley to assess what type of support is needed.

In a recent survey, one Hutt Hospital clinician remarked on how helpful it is to have expert assistance with helping patients and their families.

Cancer Care Coordinators, Lisa Simmons and Monica O'Reilly

"They are very responsive to referrals and have an excellent knowledge of accessing appointments and the necessary tests. I feel confident that when a patient leaves the ward with a cancer diagnosis, they will be followed up."

Patients have fed back that the service provides vital moral support and information during a vulnerable time.

The Cancer Care Coordinator roles were established by the Ministry of Health in 2012 with appointments made for Hutt Valley DHB in May 2013.

As part of a number of projects under the Ministry of Health Faster Cancer Treatment programme the coordinators will be working towards achieving the target of 62 days from referral with a high suspicion of cancer to first treatment.

Encouraging attendance

A missed appointment is a missed opportunity for care. A new intervention has successfully reduced 'Did-Not-Attend' rates by using alternative methods of communication.

Last year, we identified patients missing their scheduled appointments as a key problem for the DHB; and initiated a project to encourage better attendance. This was in light of more than 14,500 missed appointments being recorded in 2012/13 in two of the DHB's four directorates.

This year, the 99% Attendance Project has seen positive progress in improving attendance at scheduled appointments.

Patients from all ethnic groups miss appointments for a number of different reasons. Maori and Pacific people have higher DNA rates nationally for missing scheduled appointments ('DNA' for 'did-not-attend'). A new intervention trialled in the 99% Attendance project involved the Maori Health Advisory Unit and the Pacific Health Unit contacting patients due at an outpatients appointment the following week, using a range of methods to make contact.

These methods were tailored to the individual and included:

- Phone
- Email
- Facebook or other social media
- Community Networks (Church, family contacts)
- Targeted radio station advertising explaining the importance of attending appointments.

Team members initiated contact and explained what would happen when the person came to hospital. In some cases teams were able to offer help with transport, if this was the limiting factor in getting the person to their appointment, or they could give advice on other supports available in the community.

Maori Health Team members – Kerry Hirini, Miriam Coffey, Maria Talia, Diane Kotua

The result of the trials was a significant reduction in DNAs for the four test clinics worked on by each unit.

Maori Health Unit – Reduction in DNA rate		
Trial Clinic	2013 Average	Post Trial
Audiology	22%	14%
Diabetes doctors' appointments	20%	8%
ENT	18%	13%
Paediatrics	18%	13%

PacificHealth Unit – Reduction in DNA rate		
Trial Clinic	2013 Average	Post Trial
Audiology	21%	12%
ENT	20%	9%
Paediatrics	25%	9%
Rheumatology	20%	11%

This approach has now become business as usual for the Maori Health Advisory Unit and Pacific Health Unit and learnings from this trial and other initiatives were collected in the 99% Attendance Project's DNA Toolkit, which gives advice to departments around the DHB on selecting the most appropriate intervention to support people to attend their appointments.

Pacific Health Unit team – Fara Leasuasu, Sarai Matagi, Otila Tefono, Fuaao Stowers, Tofa Gush

HealthPathways

A patient pathway describes the route a person will take through the healthcare system to receive the appropriate care. This might be any combination of GP, hospital and community support services.

3DHealthPathways is a website that provides guidance to clinicians about managing approximately 600 clinical conditions. Aimed primarily at GPs, it helps them diagnose, treat and refer patients to diagnostics, specialist care or community services in the greater Wellington area.

A major benefit for hospital clinicians as well as GPs is clearly stated referral criteria and processes for each localised condition. When GPs follow the pathways and adhere to the referral criteria, patients are more likely to be accepted without delay, thereby increasing effectiveness and satisfaction of all parties.

The HealthPathways concept originated in Canterbury DHB and this year was launched for Wairarapa, Hutt Valley and Capital & Coast DHBs. The 3D (for three DHBs) HealthPathways portal includes the 600 pathways developed for the Canterbury website, a body of work representing 6 years of work. A team of 5 GP Clinical Editors have taken on the major task of localising these pathways to make them relevant and accurate for the 3D Region. The unlocalised pathways are clearly identified as such. Over the course of the next three years the unlocalised pathways will gradually be replaced with localised ones.

"What we've got is a set of about 600 guidelines that contain useful information on clinical best practice although at this stage many of them still contain Canterbury-specific referral information. We encourage our medical community to consult the pathways even if they have not yet been localised because the clinical information will still be relevant," says Clinical Lead Dr Chris Masters.

A total of 60 pathways have been localised so far, with the Clinical Editor team aiming to increase this score to 75 by the end of January 2015.

Members of the HealthPathways team at the 3DHB Quality Awards, where they won the Sub-Regional Collaboration award.

More heart and diabetes checks

We've made serious gains in improving the number of Hutt Valley people who've received these potentially life-saving health checks.

One year ago, Hutt Valley had one of the lowest rates nationally for heart checks, with only 44% of eligible people up to date with their checks. This has been turned around dramatically in the last year, increasing to 79.3% of the target population receiving their heart check - equivalent to an additional 11,500 people receiving an assessment during the year.

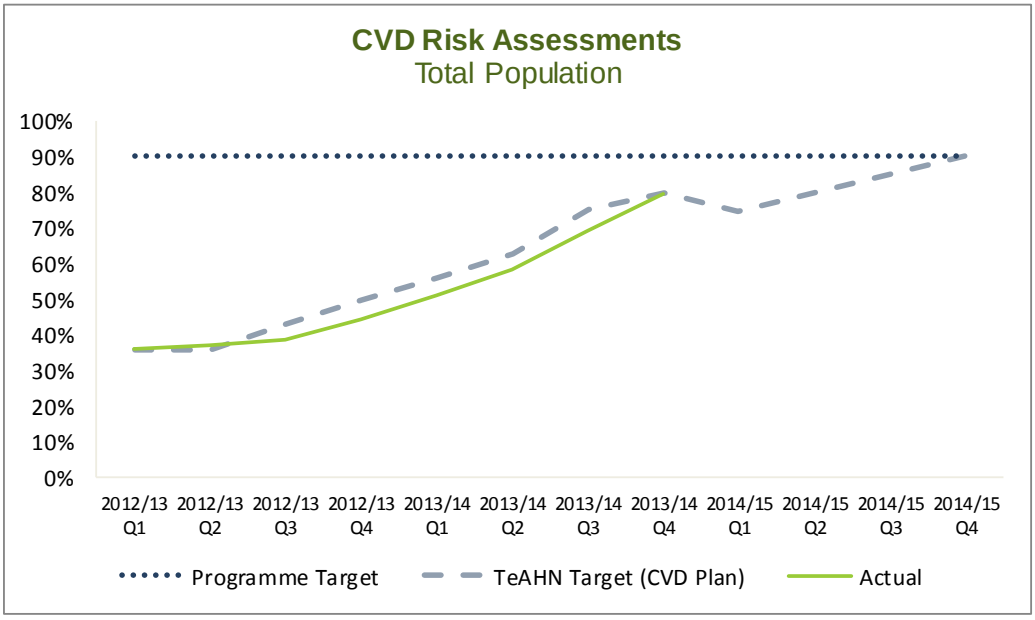
Te Awakairangi Health Network general practices have led the way in making the change. A key element of their success has been arranging for practice teams to call overdue patients at home, inviting them into the practice for an assessment. This allows the nurse or doctor to outline the importance of the check before scheduling the appointment; and reinforces how important it is for the patient to attend.

The Network is actively mobilising the Hutt Valley community to get a check, with the support of All Black legend Buck Shelford, who visited Kokiri Marae, Wainuiomata Marae and the Te Puni Mail Centre in February to promote the heart check message.

Free on-the-spot blood pressure checks have been offered at community events such as the annual festival, Te Ra, and at the Riverbank Markets in the weekend. These events picked up many people who are overdue for a heart check; and many others who were unaware that they had high blood pressure.

There are still over 7,000 eligible people in the Hutt Valley who have not had a heart and diabetes check, and many who are due for their next one. There is still some way to go before the national health target of 90% of the eligible population receiving their check is reached. The Network is committed to continued promotion of heart and diabetes checks and ensuring the current upwards trend continues.


Te Awakairangi
I'm getting a
heart and diabetes check
because:
If you don't know
you can't deal
with it.


CVD Risk Assessments
Total Population
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2012/13 Q1
2012/13 Q2
2012/13 Q3
2012/13 Q4
2013/14 Q1
2013/14 Q2
2013/14 Q3
2013/14 Q4
2014/15 Q1
2014/15 Q2
2014/15 Q3
2014/15 Q4
Programme Target
TeAHN Target (CVD Plan)
Actual

Help to quit smoking

The 'Enjoy' programme takes nicotine replacement therapy direct to smokers - at the shopping mall, in the community or at the office.

Smokers who access support and use nicotine replacement therapy (NRT) have a better chance of staying smokefree. This year, Te Awakairangi Health Network teamed up with Otago University and Kokiri Marae on a trial to make these therapies more accessible to smokers in the Hutt Valley.

The Enjoy trial invited smokers to try NRT as a cheap and safe way to ease cravings. It did this by offering free NRT products to participants who signed up at stalls manned by Enjoy programme workers. These stalls were set up in Queensgate Mall, The Mall in Upper Hutt and community locations and businesses, so that a wide range of people could be offered a chance to quit.

Smokers could take away a week's supply of NRT on the spot – choosing from well-known NRT products such as patches, gum and lozenges; or two innovative forms of NRT, a nicotine mouthspray and an inhalator. They could try as many different products as they like. Smokers were then encouraged and supported by regular follow-up at the mall or over the phone over a four month period.

"Our job is to make quitting as easy as possible", said Arapeta Kamo from Te Awakairangi Health Network. "We know smokers want to quit, but are put off trying because they feel overwhelmed with how hard it is. When we help smokers to use nicotine replacement products in an ideal way and feel their craving evaporate, they become much more confident in their ability to quit."

While the programme still has 6 months to run, as at 29 July, preliminary data shows that the Hutt Valley programme had enrolled 697 smokers, including 234 Maori (33.6%).

The service has also proved very popular with workplaces, with 11 large employers requesting a visit from the Enjoy programme staff.

The trial is also being in run in Porirua and Palmerston North with partners Te Runanga o Toa Rangatira, Te Wahahuia Manawatu and Muaupoko Tribal Authority. The Ministry of Health funded the Enjoy trial as part of its 2025 Smokefree Vision. The principal investigator is Brent Caldwell from Otago University.


0800 778 778
www.quit.org.nz


Smokers
enjoy our
products

Disability services

The work to improve services for people of all ages who have disabilities has stepped up during 2013/14, including a focus on improving the patient journey, from booking an appointment through to discharge.

In December 2013, the first sub-regional New Zealand Disability Strategy Implementation Plan was agreed by the Wairarapa, Hutt Valley, and Capital & Coast DHBs at their first combined meeting. To support this and to provide a voice at governance level, the sub-regional Disability Advisory Group was formed for people with disabilities to give their feedback on the implementation of the sub-regional disability plan.

A Disability Alert Icon was also launched at CCDHB and Hutt Valley DHB. Staff have been trained to use the icon, which alerts them to patients' particular needs when using health services. There are now more than 4,000 people with alerts in the system and at least 10,000 people with health passports.

Other Disability Service highlights include:

- Health Passports can be downloaded from the Health and Disability Commissioner's website www.hdc.org.nz or hard copies are available in most public libraries and some General Practices.
- 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.
- The Champion Network was established. This compromises more than 35 staff members from across the three DHBs who have made themselves available to provide support, navigation and advice to people who have more complex support needs.

Empowering staff

Working together across agencies has resulted in new training and a confidence boost for frontline staff who contribute to suicide prevention.

While collaborating to support the community after some suicide events, Regional Public Health Suicide Postvention Coordinator Jennie Jones, along with Frances Hamilton and her team from Te Awakairangi Health Network's Wellbeing Service, decided to combine efforts on developing suicide prevention training for staff at the frontline of care.

They worked together to commission two suicide prevention workshops for staff based around the QPR methodology (Question, Persuade, Refer). The first session focused on 26 NGO and marae 'gatekeeper' staff, aiming to bust suicide myths and build the confidence needed to support at-risk people to access help. Staff feedback said the course filled a crucial gap.

The second QPR workshop for clinicians and counsellors aimed to strengthen their risk assessment skills and their follow-up of vulnerable individuals.

The Ministry of Health recently supported an online version of the QPR gatekeeper training. Over 100 people have now registered to learn how they could contribute to suicide prevention. Thanks to TeAHN's receptionist spreading the word in her Pacific network, about 40 of these are Pacific people linked in through church and other groups.

The Wellbeing Service also escalated plans for new weekly clinics and additional clinic time in the areas of need such as Stokes Valley and Wainuiomata. Clinic hosts Koraunui Marae and Whai Oranga O Te Iwi Health Centre were generous supporters of the initiative.

Jennie and Frances encouraged as many staff as possible to register for the Ministry of Health-funded Mental Health 101 workshops. These workshops give non-clinical staff (such as general practice receptionists) the confidence to relate and respond to people affected by mental illness. By the end of August, 66 local workers had completed the course.

Frances says collaborating has meant more gains for all the partners involved.

"We've learned that by working together across agencies we can reach a lot of people with an important message," she says.

"Suicide prevention is a complex issue needing long term commitment and wide engagement to turn it around," adds Jennie. "The more we all collaborate, the stronger we are as a community."

Staff feedback from the Suicide Prevention Workshop

"Training normalises the topic and empowered me to ask the 'S' question. No harm from asking, but can cost a life by not asking."

Giving babies the best possible start

This campaign helped Hutt Valley parents-to-be understand what they needed to do in the first ten weeks of pregnancy, as well as introducing them to our dedicated maternity website.

When a woman first finds out she is pregnant, it is both an exciting and daunting time. There are many things to consider and many of these things need to be done within the first 10 weeks of pregnancy. To help raise the profile of these essential things within the region, we ran an awareness campaign that provides newly pregnant women with tips for giving their babies the best start in life.

Building on the '5 things in the first 10 weeks' format developed by MidCentral Health, we produced posters and flyers which were prominently featured on buses and bollards during the week of Mother's Day. The posters and flyers were circulated afterwards to GP surgeries and parent groups. Specialised radio spots pushed the message further out into the community.

The campaign directed prospective parents to the standalone Hutt Maternity website launched in 2013 – www.huttmaternity.org.nz. At this site, local people can access information on the resources available to new parents in the Hutt Valley, including parent groups, nutrition and health information, and details of Hutt Hospital maternity services. The website welcomed an average of 315 users per month before the campaign; following it the average number of users per month grew to 487, representing a 55% increase.

Pregnant?

5 things to do within the first 10 weeks

1. **FIND A LEAD MATERNITY CARER (LMC)**
2. **TAKE FOLIC ACID AND IODINE**
3. **MAKE A DECISION ABOUT SCREENING TESTS**
4. **GIVE YOUR BABY THE BEST POSSIBLE START**
   Avoid smoking, alcohol and recreational drugs.
5. **EAT WELL AND STAY ACTIVE**

HUTT maternity
Hutt Valley Maternity Care

To find a midwife LMC visit:

findyourmidwife.co.nz

for more pregnancy information visit:

huttmaternity.org.nz

Open campaign

HQSC patient safety

Open for better care is a national patient safety campaign launched by the Health Quality & Safety Commission in 2013. The campaign is focused on reducing harm in the areas of:

- Falls
- Healthcare associated infections (surgical site infections [SSIs])
- Perioperative harm
- Medication safety.

In 2012/13, Hutt Valley and other Central Region DHBs participated in the trial of a new traffic light falls signalling system. Following refinement of the tools by HQSC, the signalling system was rolled out in Hutt Valley DHB in September 2014.

Since the OPEN campaign launched, Hutt Valley's medication error and fall rates are significantly lower than they were in 2011/12.

Falls

In July 2014, the DHB implemented the traffic light signalling system which was first developed by central region DHBs. The aim of the system is to enable all staff in contact with patients to easily see what assistance patients need to mobilise safely - ranging from green for patients able to move around freely, orange to indicate that the patient may need some assistance, and red for patients at high risk of falls.

The falls signalling system includes posters, magnets, bedside signs and mobility aid tags. All staff, both clinical and non-clinical, are encouraged to know about the signs.

This system is designed to support staff in focusing on the patient's particular needs and to involve them in how to keep safe when moving about in the ward or unit. Awareness around falls is being addressed both via this system and also through environmental safety audits. Hutt is performing less than optimally in the HQSC's Quality Safety Markers (QSM) and the Falls Committee's focus is to identify and assist staff to address the barriers to good documentation in both assessment and care planning to address individual risk. The key message is that Falls are everyone's business including clinical and non-clinical staff, patients/ whanau and most importantly the patients / clients themselves.

Reducing infection

Hand hygiene is essential within the healthcare environment to reduce the spread of infection and minimise the risk of hospital-acquired infections. Hutt Hospital's Infection Prevention and Control team have gained momentum and frontline ownership with the World Health Organisation's 'Five Moments of Hand Hygiene' this year. In the last quarter for 2013/14, our

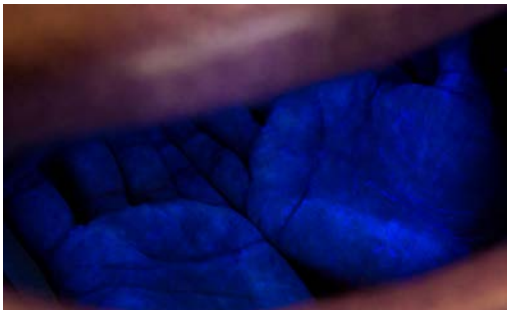
compliance with hand hygiene went from 50% to 60%, with ICU achieving an improvement from 42% to 67%. We remain below the national average of 75%, and the IPC team are working hard to educate the wards about the Five Moments and achieve more frontline ownership.

Our compliance with IV line practice to prevent Central Line Associated Bacteraemia (CLAB) infections remained at 100%. Hutt Valley DHB remains 1094 days CLAB free.

Hutt Valley DHB continues to comply with the Surgical Site Infection Bundle, to prevent surgical site infections. We gave the right antibiotic and the right dose (2g Cefazolin) to the patient 98% of the time and we are 100% compliant with antibiotic prophylaxis post-surgery (three doses) stopped 24 hours post surgery. We provided the appropriate skin disinfectants prior to surgery 98% of the time.

Other key achievements from the IPC service and the Occupational Health service include:

- Staff influenza vaccination rate of 60%
- Isolation signage and provision of additional training and education on isolation practices has been completed.
- The implementation of alcohol-based hand gel at the foot of every bed.



Pictures above from International Hand Hygiene Week – Black box & glow gel display

Improving surgical safety

This year, we adapted a surgical safety checklist from the World Health Organisation's three-phase surgical safety checklist. This is a comprehensive document which acts as a reference for all members of the surgical team.

The checklist has been designed to prevent perioperative harm, which refers to harm caused during or after surgery, for example: surgical tools accidently left inside patients; wrong site of surgery; or accidental punctures or cuts.

Hutt Valley DHB completes a quarterly audit on compliance with the completion of this form, to ensure best practice is being followed.

Safer medication working group

Medication safety is an important patient safety issue. The use of medication is one of the most common interventions in health care. Medication errors have the potential to cause considerable patient harm or even death. It's a national issue recognised by the Health Quality and Safety Commission, and is the subject of a national quality improvement campaign.

This year, Hutt Valley DHB's Clinical Director of Medicine Dr Sisira Jayathissa brought together a small group of clinicians to take an in-depth look at reported medication errors or potential errors. The group quickly expanded to include a Community Pharmacist, recognising that there is considerable opportunity for error after patients leave hospital.

The group has worked throughout the year to identify areas where they can make the biggest difference. While some actions will take longer to implement, some quick and simple process changes are already having positive effects.

Medical Ward Clinical Nurse Manager Andrew Wordsworth created a simple poster and flow chart to ensure all staff, even those who are new to the organisation, can quickly identify the right process for getting non-stocked mediations overnight or during weekends.

Medical House Surgeon Mark Cleghorn worked with fellow RMOs to change their regular shift time from 10am-6pm to 12pm-8pm. The new shift covers the period when patients are arriving in the wards after being assessed in the Emergency Department. This means RMOs have more time to review and chart medications, with fewer delays in the process.

Pharmacy staff have an increased focus on giving feedback to prescribers on charting errors or omissions detected in their routine audits of medication charts. They've also introduced a new high-visibility green bag to store the patient's own medications during admission and transfer, which makes reconciliation a simpler process for staff.

"We still have more to do, because medicines are increasingly complex and there's always new staff to teach," says Chief Pharmacist Chris Jay. "Our next focus will be on improving processes as patients are discharged, to make sure their pharmacist, general practitioner, and most importantly the patient themselves fully understand their medicine regime."

Care capacity demand management

Hutt Valley DHB is committed to safe staffing and healthy workplaces for staff and patients.

As part of this commitment, in October 2013 the DHB health unions NZNO and PSA, along with the Safe Staffing Healthy Workplace Unit (SSHW), signed up to introduce the Care Capacity Demand Management Programme. CCDM gives us the planning tools to identify care requirements to match patient demand and provide quality care for our community. It is the 'science' behind staffing.

The plan is to introduce CCDM to all clinical areas over one to two years. In 2014 one clinical area underwent a data collection pilot which involved staff reporting their activity during a typical workday, over a period of two weeks. The data collected was used to learn and report on the following: type of activity, the roles performing the activity and workload intensity patterns. The results of this study will be used by the staff of the clinical area, who 'own' the results, to see where there is room for improvement in regards to best use of resource, best use of staffing, environmental considerations and workload management.

A second exercise has been performed for most clinical areas using additional information from the DHB's TrendCare system, which manages staffing levels across the DHB. Results from this have been reported through to executive level. As a result of the work on this Hutt Valley DHB has been working with the SSHW Unit to develop a web-based tool to improve the rollout process for other DHBs undertaking CCDM.

Over the next year, the focus of the CCDM project will turn to additional clinical areas and a work plan for modelling unexpected scenarios with a process called 'Variance Response Management'. This means using the science of staffing to plan for times when the unexpected occurs and normal staffing levels need to be changed to accommodate unforeseen circumstances.

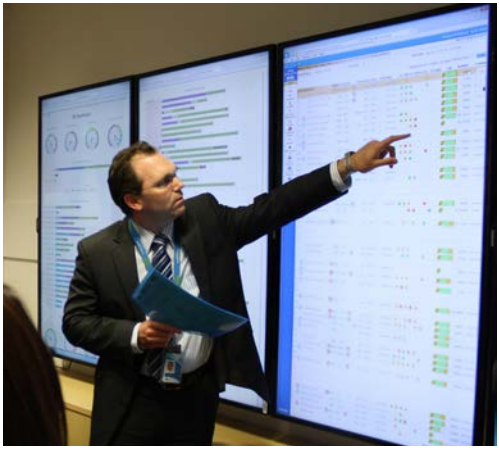
CCDM aims to ensure high quality patient care and also ensures staff go home feeling like they have provided quality care and feel confident about themselves to deliver that care.

Electronic whiteboard

A piece of software designed by Hutt Hospital's clinicians and IT team is helping staff manage their daily workload and provide better care for patients. The 'electronic whiteboard' allows clinicians to log in and see up-to-date information about the flow of patients progressing through the hospital system, including the current status of referrals and lab results, and the staff assigned to a particular patient's care.

In 2013/14 several areas of Hutt Hospital introduced the board, including Medical which is the hospital's largest inpatient ward. The technology is also a key part of the hospital's Operations Centre, from where the daily flow of patients and staffing levels is coordinated.

Before the whiteboard, staff tracked patient information by writing notes on manual whiteboards, logging in to multiple systems to check patient notes or bookings, and phoning around other departments to check on lab results and referrals.



Staff love the ability to see patient information in one place and understand what the team needs to focus on to give the best care.

"It gives me or anyone else a snapshot of where we're at on the ward and how well we're gelling as a team," says Clinical Nurse Manager for the Medical Ward, Andrew Wordsworth.

Physiotherapist Camille McWhirter says a key benefit is the ability for roaming Allied Health staff (such as physiotherapists, dieticians and occupational therapists) to securely view referral information on computers in more than one part of the hospital.

"I work across three wards but can log on anywhere and be aware of what's going on. It helps us collectively manage our whole team's workload even though we're working in different parts of the hospital."

The focus for the coming months will be introducing the whiteboard to more areas of the DHB, as well as sharing the technology with other DHBs across the country.

Newborn hearing screening

Every year, approximately one in one thousand babies in New Zealand are born with a hearing loss. Despite the introduction of free newborn hearing screening in 2009, the team at Hutt Valley continued to experience a small number of babies not screened due to missed appointments.

The Newborn Hearing Screening service at Hutt Valley tackled this in 2013/14 through introducing home visits, which had previously not been offered, and expanding clinic hours to include Saturdays.

The result of these changes was improved engagement with families, and a reduction in the numbers of families missing their scheduled appointments. For the period March to July 2014, there were no incompletes (babies not screened due to lost contact) recorded. The overall rate of families missing their scheduled appointments declined to 2% in March and has remained at this level or below since.

These changes also influenced a culture shift within the team. While there had been initial concerns that home visits would require an increase in screener resource, this was countered by the subsequent reduction of the administration workload involved in missed appointments. Home visits are now able to be accommodated into what would have previously been outpatient clinic time and the team has seen an overall further reduction in the number of babies needing to come back for outpatient appointments due to the increased service coverage on Saturdays. The changes are now business-as-usual.

Screeners Sandra Hoggarth, Laverna Quirk, and Janine Frost celebrating the Newborn Hearing Screening service's fifth birthday in July 2014.

Malnutrition screening & training

A new working group is tackling malnutrition in hospital patients with a common set of guidelines and training for the three DHBs in the Wellington area.

For a variety of reasons, including underlying health conditions, malnutrition is a common problem among people who are admitted to hospital. However, it often goes unrecognised and untreated. A survey of 56 Australasian hospitals (including Hutt) conducted on Australasian Nutrition Care Day in 2010 found that 41% of patients were at risk of malnutrition; with 32% actually malnourished.

Analysis of data from the 2010 study found that malnourished patients stayed an extra five days in hospital, were more likely to be readmitted, and were at greater risk of death in hospital.

The 3DHB Malnutrition Matters Committee was formed in 2013 to address this problem. The Committee has developed a Malnutrition Identification and Management Policy to be adopted in Wairarapa, Hutt Valley and Capital & Coast DHBs. The policy endorses malnutrition screening for most inpatients, and outlines the roles and responsibilities of all staff regarding malnutrition.

Most Hutt Hospital wards now routinely screen patients for malnutrition and an e-learning package is being developed for staff. The screening will be rolled out to remaining inpatient areas over the next year.

Supervisor training

A new training programme seeks to give clinicians the skills to become a more effective professional supervisor.

Health care is hands-on, and supervision by more experienced staff members is an important aspect of practice development. Professional supervision is a routine and required part of practice across the Wairarapa, Hutt Valley and Capital & Coast DHBs.

However, being clinically experienced does not automatically make you a good professional supervisor. Some senior clinicians need specialised training to become proficient in the skills needed by an effective professional supervisor.

At Wairarapa and Hutt Valley DHBs there had been no access to training and development for new supervisors for a number of years. This resulted in inequity of access to supervision and variable quality and outcomes of supervision.

To remedy this, in 2013/14 a 3DHB working party was established to develop a consistent and comprehensive professional supervision policy for allied health and mental health employees. A supervision training team was established for Hutt and Wairarapa DHBs and professional supervision training sessions were run across the three DHBs several times per year.

Since the launch of this training, 75 clinicians have been trained as supervisors. Some of these are new supervisors and some had been supervising without formal training. This represents a huge increase in our pool of available trained supervisors. We are also sharing supervisors across the sub-region to a greater extent.

There are still pockets of professionals and services who find it difficult to establish regular access to professional supervision. We are working on establishing a fuller suite of professional training for the three DHBs and providing follow up training for those seeking advanced skills. This will empower supervisees and supervisors alike by raising the standard for professional supervision across the three DHBs.

Professional supervision encourages staff to review and reflect on their clinical work and effectiveness. It has many functions, including improving patient care, developing and supporting clinicians and encouraging reflective practice and lifelong learning, all of which contribute to the delivery of high quality, safe health services.

Future Focus

Quality of healthcare is at the heart of everything we do. These Quality Accounts are 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 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.

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 three DHBs 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 three DHBs. Work has already started and we look forward to more progress next year.

The 3DHB Health Pathways project is an exciting project 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.

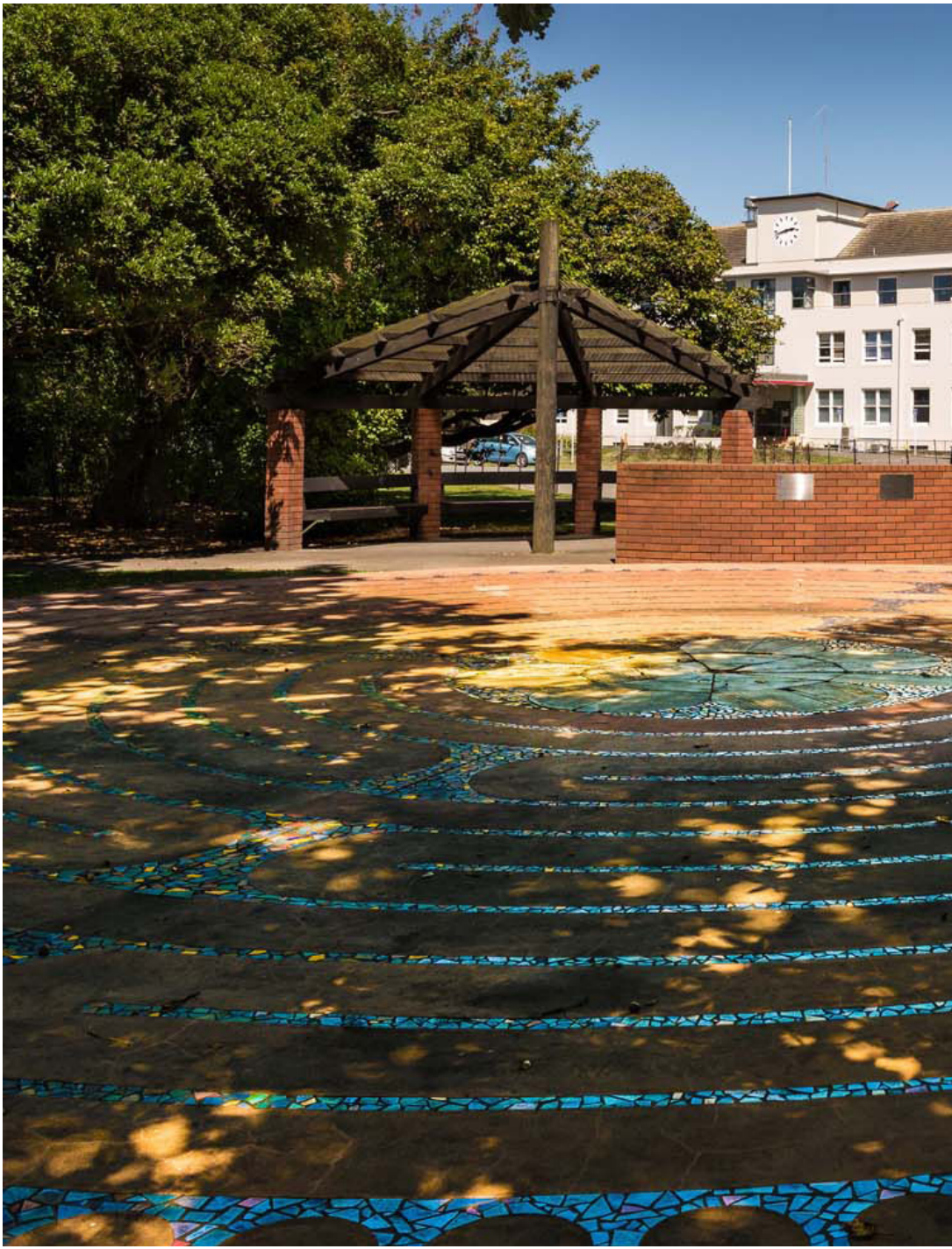
There will be new joint appointments created that will continue to build on the work of the integration programme bringing staff and services closer together.

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

General Manager Safety, Quality & Risk, Wairarapa and Hutt Valley DHB



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