Striving For Excellence

2016 Quality Accounts FROM HUTT VALLEY DHB

HUTT VALLEY DHB

Our Vision

Whānau Ora ki te Awakairangi

Healthy people, healthy families and healthy communities

Our promise

Hutt Valley District Health Board meets the health needs of around 145,000 people who live in the Hutt Valley. We aim to do this by:

- ✓ Leading, innovating and acting courageously
- ✓ Working together with passion, energy, and commitment
- ✓ Building trust through openness, honesty, respect and integrity
- ✓ Striving for excellence.

On the following pages you can read about the things we are doing, in partnership with other health care providers, to provide better quality healthcare for our community.

145,000

people live in the Hutt Valley

WHAT DID WE DO TODAY?

a day in the life...

900 PATIENTS WERE SEEN BY THEIR GP

6970 PRESCRIPTION ITEMS FILLED BY COMMUNITY PHARMACIES

20 People had heart and diabetes CHECKS

5 8 MONTH OLD CHILDREN WERE IMMUNISED

34 People received advice to QUIT SMOKING - Primary Care & hospital

1,160 People cared for in subsidised aged residential care

Contents

Big Man, a 2.7 metre high bronze polar bear wearing a hooded sweatshirt, was gifted to Hutt Valley District Health Board by E Tu Awakairangi Hutt Public Art Trust who hoped the sculpture would be a source of hope and comfort for visitors to Hutt Hospital. He was officially welcomed to his new home in front of the hospital by, from left, DHB Chair Dr Virginia Hope, artist Lucy Bucknall and Trust Chair Greg Thomas.

Building a quality and safety culture

Quality and safety is a core part of the way we do things at Hutt Valley District Health Board.

Our aim is to ensure that all preventable harm is eliminated and our patients have improved experiences. To do this we engage the help of our staff, patients and the public.

One of the things we're doing to support quality and safety is the introduction of Quality and Safety Walk Rounds. These walk rounds involve senior District Health Board leaders making regular structured visits to clinical and non-clinical areas of the DHB. The aims of the walk rounds are to:

- demonstrate our commitment to quality and safety for patients, staff and the public
- increase staff engagement and develop a culture of open communication
- identify, acknowledge and share good practice
- take a proactive approach to minimising risk, timely reporting and receiving feedback.

The walk rounds began in June 2016 with a visit by the executive leadership team to the Orthopaedic ward where they spoke to staff and patients about what was working well and what needed to improve, from both staff and patients' perspectives.

DHB managers share a light moment with Orthopaedics staff during a Quality and Safety Walk Round

The team also undertook the *15 Steps Challenge*. This is a UK programme based on a comment from a parent's first impressions of her experience: "I can tell what kind of care my daughter is going to get within 15 steps of walking onto a ward".

The DHB's Quality team agrees that first impressions count; first impressions give us our initial feeling about any situation. *The 15 Steps Challenge* helps staff, patients and others work together to identify improvements that can be made to enhance the patient experience. It provides a way of understanding the first impressions of patients and their families/whānau more clearly, supports the sharing of good practice and helps identify improvements.

Patients in the Orthopaedic ward said they felt well cared for and well informed. In the words of one patient: "Just appreciate your staff. They carry themselves well and even when they are busy they have time for us". Feedback from staff was that they rated the DHB highly for its friendliness, great people and support. They said they love their jobs and are pretty happy with the way things are run.

> **"I can tell what kind of care my daughter is going to get within 15 steps of walking onto a ward."**

The team found the Orthopaedic ward was clean, tidy, calm and ordered, with great quality and safety material easily available for staff and the public. The feedback from staff and patients, including things that could be improved, was discussed with the ward leadership team in a post-visit debrief.

Quality and Safety Walk Rounds are now a regular monthly activity that demonstrates the DHB's commitment to staff engagement, building relationships, trust and patient safety.

Co-design

Another new quality and safety initiative involves the DHB consulting people who use our services in one way or another ('consumers'). The programme, called co-design, involves clinicians working alongside consumers on a specific improvement project over a six month period to make our services safer and improve the patient's experience.

Co-design is a fairly new improvement methodology, and the DHB is pleased to be building capability in this area. Many service improvement projects have patient involvement; co-design is different in that it focuses on understanding and improving patients' experiences of services as well as the services themselves. This engagement helps to ensure that improvements are successful.

Training was provided to a group of health professionals from Hutt Valley DHB and Te Awakairangi Health Network, as well as consumers. The workshop, run by Dr Lynne Maher, Ko Awatea's Director for Innovation, and supported by the HQSC's Partners in Care programme, marked the start of the DHB's involvement in the programme. We plan to continue using this approach to ensure we are making improvements that meet the needs of our community, improving the patient's experience and making our services safer.

Clinical and consumer councils

Clinical governance refers to the systems and processes in place across the organisation to ensure accountability for quality and safety. A number of activities are underway to strengthen clinical governance at the DHB. One significant development is the establishment of a Clinical Council in April 2016.

The Clinical Council is a group of experienced multidisciplinary clinicians from across primary and secondary care in the Hutt Valley. They meet monthly, advising on a range of issues that span improved quality, safety and experience of care, improved health and equity for all populations, and best value for public health system resources.

In the next few months we will begin establishing a Consumer Council – a group of people who contribute to policy and governance within the Hutt Valley Health System. We will be letting members of our community know how they might get involved in this exciting opportunity in the next few months.

Both the clinical and consumer councils further enhance the DHB's commitment to fostering a healthy quality and safety culture.

Patient Safety Week

We highlighted Patient Safety Week in a number of ways, including the display of posters, distribution of patient information sheets, and walk rounds focused on patient safety.

We asked patients, their families and staff, "What matters to you?" We asked people to write on speech bubbles about what matters to them in a hospital setting. The information that was provided will be put into themes by the Quality, Service Improvement and Innovation Group, and improvement projects will follow. The theme was 'Let's Talk', emphasising that communication with patients and between staff members, is key to keeping patients safe.

Patient Safety Week is one way we show that patients and their families/whānau are at the centre of what we do, and gives us a chance to highlight our drive to provide the best and safest care possible, every time.

Hutt Valley DHB Quality Awards – Striving for Excellence

The 2016 Hutt Valley DHB Quality Awards – Striving for Excellence ceremony was held in November 2016. The awards have been designed to encourage, recognise and celebrate innovative quality improvements within the DHB and primary healthcare across the Hutt Valley Health System. It is a privilege to have the opportunity to formally acknowledge the work that supports the continued advancement of a positive quality and safety culture.

Partnership delivers great results for patients, community and hospital

A new, coordinated approach to how and where primary and community-based health services and resources are delivered in the Hutt Valley is paying off for everyone involved.

The Person-centred Acute Care Coordination service (PACC) is a 'one stop shop' for GPs to call and arrange for urgent services to be delivered to patients closer to their own homes. This means patients don't have to spend hours waiting in the emergency department and GPs don't have to ring around to organise the right services for their patients.

PACC isn't about keeping seriously ill patients out of hospital. It's about getting short term support for patients whose conditions can be safely treated at home. Examples include flu, urinary tract and skin infections such as cellulitis. These patients often have other conditions or are elderly, so being able to stay home and get well is a real bonus for them and their families.

PACC is a joint initiative between Hutt Valley DHB and local Primary Health Organisation (PHO) Te Awakairangi Health Network (TeAHN). Paul Abernethy, TeAHN's General Manager, says it's a great concept that's already been proven in other parts of New Zealand.

Between January and June 2016
PACC handled 81 referrals, avoided 76 hospital admissions and saved more than an estimated $200,000.
Services include nursing, equipment supply and referral for x-rays and scans. There is no cost to patients apart from the initial doctor's visit.

"When we started looking at introducing the PACC approach to Hutt Valley we said, 'let's get people right back into the centre of the picture – what do people want?' The reality is that most people prefer not to go to hospital and would much rather stay at home with a bit of extra help, if that's appropriate.

"PACC is a flexible, nimble approach that saves people and their families valuable time and reduces their stress. It helps GPs do their job and patients get access to quality care closer to home."

Karen Blair from the DHB's Community Health Service says PACC is not a new service – it's a new coordination point for existing services. "PACC has been working well and gaining support for more than a year now and we're doing a lot of work to keep it growing."

John Quinn says his needs were met quickly.

Quick work reassures patient

Wainuiomata man John Quinn had a sore knee for some time and when it suddenly got a lot worse he went to see his Hutt City Health Centre GP who immediately considered the possibility of a blood clot (deep vein thrombosis or DVT) in his lower leg.

The GP quickly phoned PACC Coordinator Bernadine Coddington who organised an ultrasound scan for the next day. In the meantime, John needed an urgent blood thinner injection to keep him stable overnight so Bernadine also arranged an appointment at the After Hours Medical Centre that evening for him to have the shot. She sorted out the appropriate paperwork to ensure the cost of treatment would be covered and assured John there would be no charge.

The good news is that the ultrasound confirmed the problem was a burst cyst and not DVT. John is feeling better and he's impressed by how quickly everything was set up for him.

"It all happened really fast and everything was taken care of for me so I just had to turn up. And I still can't believe it all cost me nothing."

Assessment tool aids rehab

Tracking patients' progress during rehabilitation following a severe illness such as stroke is an important part of ensuring they get the appropriate level of rehabilitation for their stage of recovery.

To do this, Hutt Valley DHB's Older Persons Rehabilitation Services (OPRS) team uses a tool known as a Functional Independence Measure (FIM). The FIM is a basic indicator of the severity of a disability. A person's functional ability changes during rehabilitation and the FIM helps track those changes.

Occupational therapists, physiotherapists, speech language therapists, social workers and nurses in OPRS are trained to use the tool and their competency is reassessed every two years. Every patient is assessed using FIM within 24 hours of admission and another assessment is given on discharge to measure improvements in functionality over the course of their rehabilitation.

All FIM scores and other patient data such as demographics, comorbidities (all their conditions), and length of stay are submitted to The Australasian Rehabilitation Outcomes Centre (AROC) which is the national rehabilitation medicine clinical registry of Australia and New Zealand. AROC is a benchmarking system that provides reports and measurement against the rest of New Zealand and Australia. This enables OPRS to ensure their rehabilitation programmes achieve outcomes that line up with those of other facilities providing a similar service in New Zealand and Australia.

AROC has developed a data set which uses a patient's admission FIM score to estimate how long they will need to stay in hospital for rehabilitation.

New tools provide certainty around timing for patients' rehabilitation and discharge from hospital.

> **"This information also assists us to plan any onward referrals needed to other services so patients can continue their recovery in the community."**

Allied Health Rehabilitation Coordinator Shannon McRae says the majority of a patient's rehabilitation happens in the community "However while they are on the ward with us we can monitor their functional gains which then helps us measure the effectiveness of our rehabilitation. It also assists our clinical reasoning and decision-making."
"The data that's used to develop these data sets comes from information gathered by AROC from rehabilitation centres throughout New Zealand, so we know it's relevant to our patient population," Shannon says.

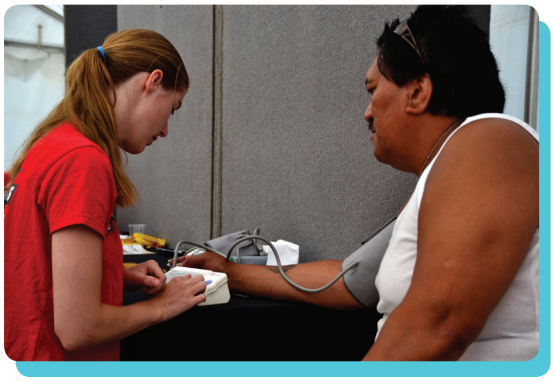
"Within the next few months we will start using estimated discharge dates generated by this data to give our patients, their families and other services, such as care agencies and funders, realistic timeframes for people to achieve a level of independence that will enable their discharge from the ward.

"This information also assists us to plan any referrals needed to other services so patients can continue their recovery in the community."

Working together to manage diabetes

A partnership between Hutt Hospital's diabetes specialist services and local Primary Health Organisations Cosine and Te Awakairangi Health Network to improve the health of people with diabetes has been recognised as best practice by the Ministry of Health.

There is also hard evidence that this shared approach contributes significantly to improving the health of people with diabetes. Monitoring of HbA1c (patients' average blood sugar levels) shows Hutt Valley DHB is performing very well against national criteria.



Over time diabetes can damage the heart, blood vessels, eyes, kidneys, and nerves so prevention, early detection and management are important.

It's a patient-centred approach in which general practice and hospital diabetes nursing teams use best-practice evidence and guidelines to support people to manage their own care. They monitor patients' progress and work in partnership with other health care providers in the community.

This shared approach helps ensure patients get improved quality diabetes management closer to where they live. This reduces their anxiety, helps them understand their condition, how to manage it and avoid hospitalisation. Getting more specialised diabetes management skills into primary health care is also important.

Having a relationship with a skilled nurse gives patients confidence that they are being well cared for by their practices.

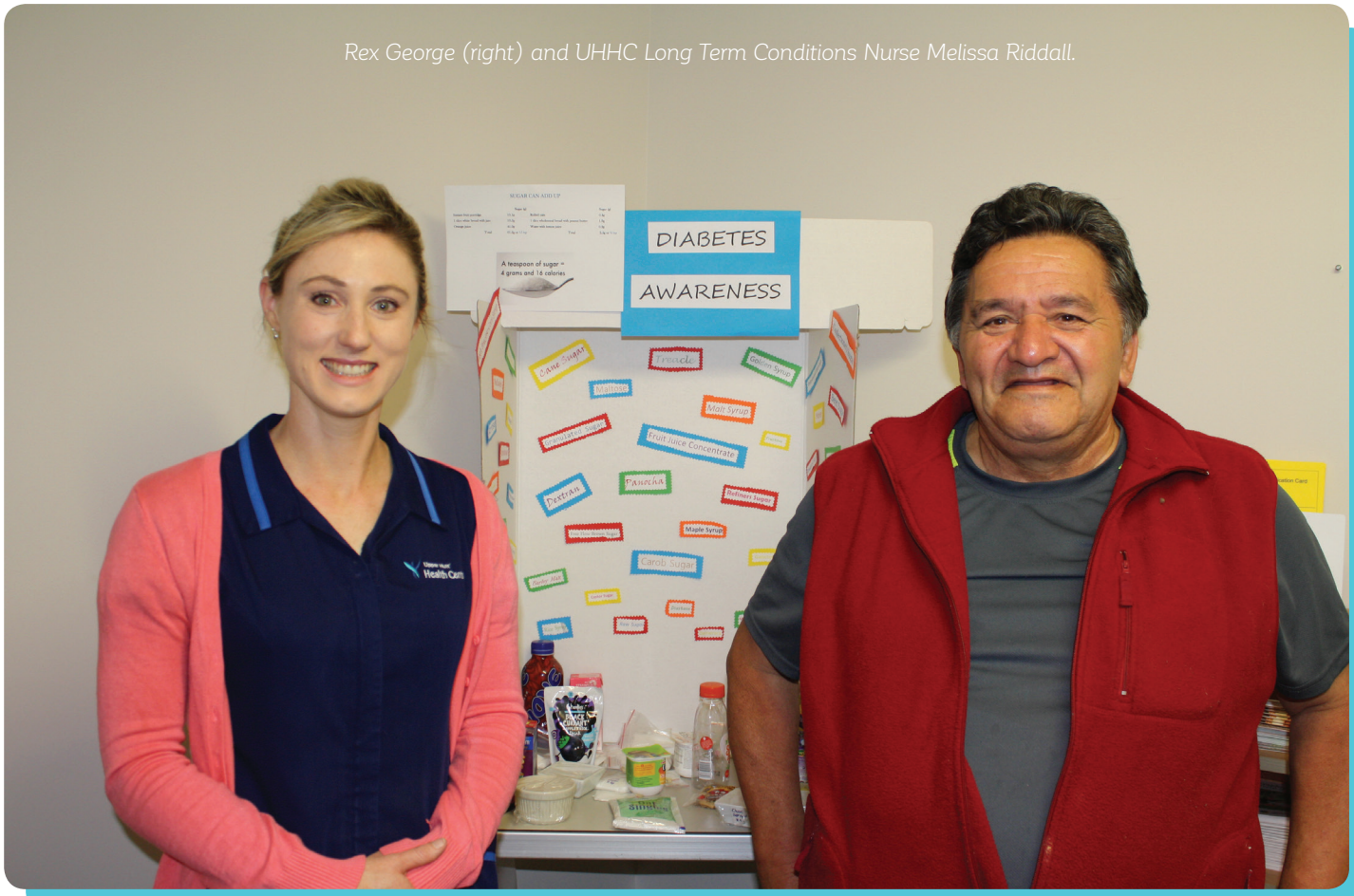
How we're fighting diabetes

- **We've developed a primary care diabetes nurse education pathway (or programme) delivered in partnership by hospital and PHO staff.**
- **47 practice nurses have completed the online component of the pathway.**
- **29 nurses have now completed the entire diabetes training programme.**
- **New workshops are being added, with a focus on pre-diabetes, sexual health and pregnancy, mental health, dental health and insulin intensification.**

Diabetes clinics are held every two to six weeks in seven Hutt Valley general practices, and at Kōkiri Marae and Pacific Health Service, with practice nurses working alongside hospital diabetes clinical nurse specialists. Four diabetes nurse prescribers work across the Hutt Valley. Diabetes physicians from the hospital also go out to primary care with the diabetes nurse specialists. Every three to six months seven out of 22 practices carry out clinical reviews.

Public engagement and visibility of the importance of checks for diabetes, blood pressure and heart health includes community events such as Te Rā o te Raukura community festival and regular community blood pressure awareness campaigns.

- **More than 200,000 people in New Zealand have diabetes (mostly type 2).**
- **As many as 100,000 people nationally may also have undiagnosed diabetes.**
- **Māori and Pacific people have around three times the rate of diabetes of other New Zealanders. People from South Asia are also disproportionately affected.**
- **In the Hutt Valley (as at December 2015) there were a total of 8,281 enrolled people in PHOs on the Virtual Diabetes Register (VDR) Prevalence. Of these 1,094 were Pacific, 1,208 were Māori and 5,979 were of other ethnicities.**



Rex George (right) and UHHC Long Term Conditions Nurse Melissa Riddall.

Diabetes team does great job, says patient

Seamless care, delivered close to home, is very important for diabetes patient Rex George.

Mr George, who was diagnosed with type 2 diabetes by his GP more than 20 years ago, says the Hutt Hospital, Upper Hutt Health Centre, community nursing and allied health professionals who work in partnership to deliver the long term conditions programme look after him well.

When he was first diagnosed he was seeing doctors at Hutt Hospital and, while his care there was always good, he finds it much easier to go to the clinic just five minutes from home and get all his health needs met in one place, by the people who he's got to know well over the years. It's a bonus having a pharmacy right next door.

"The nurses at the centre look after me really well – I have no complaints," he says. "The district nurses and podiatrist do a great job too."

Caring for the whole patient is extremely important for people with diabetes as the illness can lead to or exacerbate other conditions.

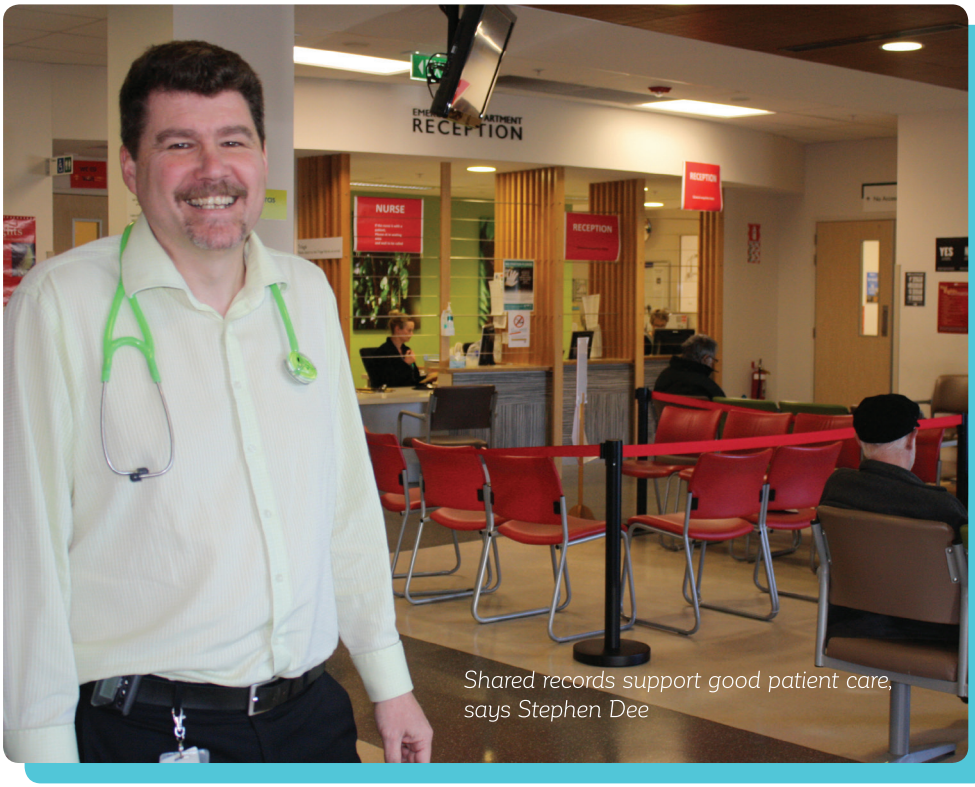
> **"The nurses at the centre look after me really well – I have no complaints. The district nurses and podiatrist do a great job too."** *– patient Rex George*

Mr George's goal is to continue living well for as long as possible. At 66 he was working until he got a painful leg ulcer in February and he plans to get back to being active as soon as he can.

His wellness routine includes daily self-monitoring and recording of insulin levels and fortnightly visits to the team for blood pressure checks, blood tests and general monitoring of his overall health. He also visits regularly to get his ulcer dressings changed.

Shared patient records improves safety and efficiency

Sharing of patient records between Hutt Valley DHB clinical staff and local GPs is improving patient safety and saving time for everyone.



Shared records support good patient care, says Stephen Dee

The Shared Care Record (SCR) includes information about a patient's existing medical conditions, test results including those ordered by specialists, medicines and any allergies, but not the GP's consultation notes.

Dr Stephen Dee, Acting Clinical Head of Hutt Hospital's emergency department (ED), says 19 of 22 Hutt Valley practices are now sharing records with the hospital, and recently surveyed ED staff all said they had used the SCR at least twice during the previous shift.

The SCR helps by providing information about things like previous treatments, current medications and allergies. This means that if an ED patient can't recall the name of a medication they are taking, or a recent treatment they have had, a quick check of the SCR will provide it.

"The SCR is proving to be incredibly valuable," says Stephen Dee. "Many patients who come in don't know the names of medication they are taking. Without access to their records there would be a lot of chasing around to contact their GP or specialist, or the local pharmacy.

"Having details of recent diagnoses also helps us trigger a patient's memory so they recall details which can help us ensure they get the most appropriate care."

The initiative, introduced in 2015, was spearheaded by local PHO Te Awakairangi Health Network.

> **"Having details of recent diagnoses also helps us trigger a patient's memory so they recall details which can help us ensure they get the most appropriate care."** – *Dr Stephen Dee*

CEO Bridget Allan says GPs know how important accurate clinical information is for good patient care. So they have been pleased to have a tool like the SCR that makes the patient's key information readily available to other clinical staff looking after that person.

"It is great to know that hospital staff are finding the SCR so valuable," says Bridget Allan. "The next step is assisting all our practices to implement a patient portal, so that patients can easily see their own health information. This will help patients to understand and manage their own health conditions better."

Helping people breathe easier

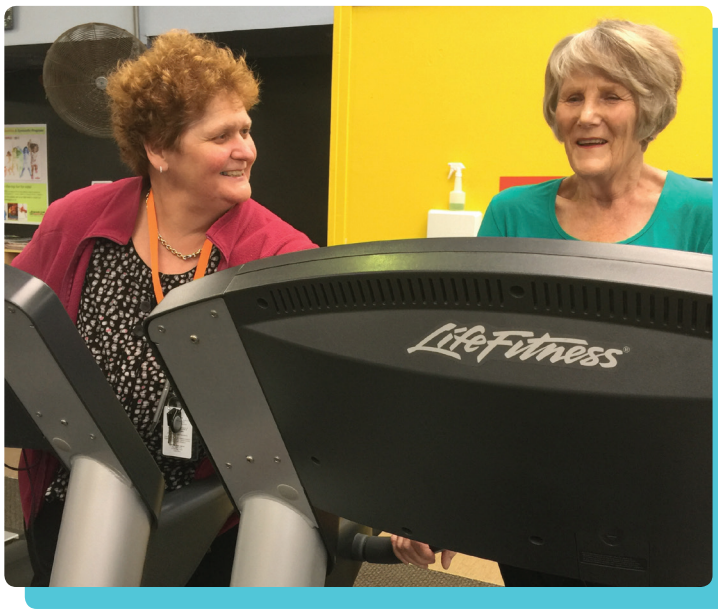
Helping people live well with respiratory illness is a key priority for Hutt Valley DHB.

Respiratory illness is a major contributor to poor health for children and their families in the Hutt Valley. Demand for acute care is growing faster than elsewhere in New Zealand and respiratory illness contributes to this. This means larger numbers of people with respiratory problems are attending Hutt Hospital's ED or being admitted to hospital.

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented through appropriate and timely health treatment in a primary care or community setting.

ASH rates for respiratory conditions are 7% higher in the Hutt Valley than elsewhere in New Zealand. This problem especially affects Māori and Pacific people.

Improving the patient journey



Respiratory Services Physiotherapist Colleen Stevens (left) assists Pam Truscott with her exercise programme at a local gym.

The DHB and the Alliance Leadership Team (known as Hutt INC) have responded to the local ASH issue with a project designed to improve the health outcomes and experiences of our respiratory patients as they move through the health system.

The respiratory patient journey project involved patients, nurses, doctors, allied health professionals and managers from across the health system working together to improve how we keep people with respiratory illness well and care for them if they become ill.

The project team used a range of techniques to evaluate how services were being delivered, looked at best practice in other DHBs and developed recommendations for approval by Hutt INC.

They will become part of a large respiratory work programme, to begin delivery in November 2017.

Respiratory clinics popular

Patients over the age of 15 with bronchiectasis, a condition in which parts of the lungs are permanently enlarged, are being treated and supported at a specialised Hutt Hospital clinic. Hutt Valley has a higher that average rate of bronchiectasis in the community and people with the condition can experience poor outcomes, which affects their quality of life.

The majority of patients who come to the clinic are seen by a nurse practitioner and a respiratory physiotherapist, with two physicians on call for more complex cases. Each patient gets a written self-management plan and regular follow up that is appropriate to their condition.

Additional benefits include education, advice and support (often over the phone) and the ability to contact the clinic to arrange an earlier-than-scheduled appointment if they have any concerns.

There are three clinics each month which have seen more than 100 people in the past year. Patients say they appreciate the support they receive and most people keep their appointments, which also indicates the clinics are valued.

People aged under **5** and over **65** are the highest users of health services for respiratory illness and have different service use characteristics.

ASH rates for respiratory conditions are **7%** **higher in the Hutt Valley** than elsewhere in New Zealand.

35% of all ASH admissions in the Hutt Valley are for respiratory illness.

The average length of stay for patients admitted to Hutt Hospital for respiratory illness was **3.4 DAYS** (1.7 days in 0-14 years and 4.3 days in 15+years).

IN 2014-15 respiratory-related ASH rates for Hutt Valley children were:

MĀORI	PACIFIC	OTHER ETHNICITIES
44 per 1,000	**68** per 1,000	**26** per 1,000

More **Māori** and **Pacific** adults have respiratory-related ASH events than other ethnicities; this is highest for people aged **45–64 YEARS.**

Helping families/whānau close to home

A range of clinical supports and services are available for people with respiratory conditions provided through Hutt Hospital's respiratory specialist service, general practices, community based respiratory nurses and other agencies. This includes the nurses from Tu Kōtahi Māori Asthma Trust which is based at Kōkiri Marae.

Tu Kōtahi Māori Asthma Trust specialist respiratory nurses visit whānau in their own homes, helping them understand and manage their own condition. They have developed an educational booklet with help from Starship Hospital which whānau have found very helpful.

Nurses also provide holistic care and wraparound services such as referrals for housing insulation, link and connect with whānau's general practices, Hutt Hospital's specialist nurses and other community agencies as required.

WHAT OUR PATIENTS SAID

A key part of the respiratory patient journey project was group and individual interviews with whānau and community members at Kōkiri Marae and the Pacific Health Service. These were done to find out what people feel has worked well, what has not worked well and what could change to improve the patient journey.

Some of their feedback was:

- "**Give me early access to information and explain** so I understand what to do to keep well; give me a simple, easy to follow management plan"
- "**Give me access to health care close to where I live** so I can get advice early and be seen when I am really unwell"
- "**Provide culturally appropriate support** as early as possible when I am in hospital or have an appointment; someone to help with support, communication and understanding"

Boosting nursing skills improves older people's health

A desire to improve the health of older people, especially those in aged residential care (ARC), has prompted nurse practitioners from the Hutt Hospital's OPRS to support their colleagues in ARC settings through introducing a mentoring programme for clinical staff.

The programme was set up following a study that showed nurses wanted additional skills in the specialised care of older people with long term conditions. Themes that emerged from the study included the need for health professionals to be good communicators, work collaboratively and take a 'whole person' approach. Timely assessment and follow-up were also important especially for people working in aged residential care.

The programme, which combines mentoring with regular review of cases, has been underway since 2012. It has grown steadily and is now being used in nine out of a possible 15 facilities. More than 500 nurses took part in the programme in 2015 including health care assistants and allied health professionals.

The increasing demand for care makes it more important to support and develop the skills of health professionals working with older people and to keep those skills current. Working innovatively and together as one team to improve the quality of care, with the patient firmly at the centre of care, will help build a sustainable workforce.

Nurse Practitioner Mary Daly, who works in OPRS alongside colleague Elaine Burn, says, "this programme is a great example of how we are doing that and, in the process, it's ensuring we can continue to meet the on-going and increasingly complex needs of older people in our community."

New GP-specialist hotline a big success

Linking GPs with hospital geriatricians for quick specialist advice via mobile phone is a genius idea that's paying off for doctors and patients alike.

Dr Andrew Linton, Senior Medical Officer OPRS, and colleagues Teresa Thompson and Jo Rodwell, came up with the idea as part of an overall move to improve access to specialist advice for doctors working in primary care.

A three month trial was set up to test the value of an acute access mobile phone, with specialists available for phone consultation between 8am and 4pm Monday to Friday. There were 40 calls during the trial period of which 25% resulted in reduced referrals and admissions.

A follow-up survey of GPs showed they all found the service useful, wanted it to continue and hoped the hours could be extended.

Andrew Linton says the hotline is good news for patients.

Andrew Linton says finding ways for the DHB and GPs to work more closely together is a key priority for Hutt Valley's Clinical Council and clinical networks.

"There is clear evidence that early access to specialist advice for GPs can avoid hospital admissions and reduce unnecessary referrals of patients to specialist services," he says.

Seamless care for stroke patients

Stroke patients are being fast-tracked from Hutt Hospital's acute unit into rehabilitation thanks to seamless coordination between the hospital's OPRS teams.

Research shows stroke patients do better with continuous care.

The DHB's Comprehensive Stroke Unit is an integrated team of stroke professionals who provide patient-dedicated, continuous care to people who have experienced a stroke.

The team follows the patient's journey from hospital admission and acute care, to rehabilitation and discharge. People who have spent less than five days in acute care can go home and be rehabilitated in the community. Others will have in-patient rehabilitation. Regardless of the setting, all their clinical notes follow patients through the system, ensuring continuity of care.

Before this approach was introduced in January 2016, stroke patients were cared for in a multi-step process involving multiple teams and different people. Now one team, made up of a stroke specialist physician, a stroke nurse and a stroke house surgeon, works directly with rehabilitation professionals such as physiotherapists to provide continuous care for the patient.

About 240 patients a year come through the DHB's stroke unit and more than one third of them are transferred to rehabilitation.

> **"Experiencing a stroke is a very traumatic time for the patient and their family. It can also mean adjustment to a new disability. Research shows that there are better outcomes for patients with a continuous model of care and having a single team to provide care helps the patient and their family feel more secure and confident. It avoids duplication and improves the experience for both patients and their families. Staff also experience greater work satisfaction from getting to see a person's full recovery process."** *– Dr Marianne Falconer, Senior Medical Officer, HVDHB*

Local hearing tests reduce stress for sick patients

Ototoxicity, or ear poisoning, is a serious side effect of some medications, including chemotherapy drugs. They can sometimes cause hearing loss, dizziness and/or tinnitus (ringing in the ears). These effects may last only a while or be permanent.

Before starting treatment with chemotherapy drugs that could be ototoxic, people need to get a hearing test to determine the current state of their hearing, which can then be monitored for any effects during treatment.

Before 1 July 2016 Hutt Valley patients had to travel to Wellington Regional Hospital for testing. Now this can be done at Hutt Hospital, thanks to new test equipment and processes.

It's early days for the new regime with only seven patients involved to date, but all have been tested within 10 days of being referred.

This is good news for sick patients and their families/whānau who are being seen more quickly and don't have to travel. This reduces stress, which is especially important for people who are already unwell.

Newborns now need fewer hearing tests

Smart thinking by Hutt Valley DHB's newborn hearing screening staff has reduced the need for extra hearing tests for many new babies.

The team had noticed that, following earlier introduction of a new, national screening regime and use of new screening equipment, the numbers of new babies being referred for further hearing tests after their two initial screenings increased significantly and stayed high for longer than expected. However, at the end of the process the majority of these babies were found to have good hearing.

Babies had been routinely screened up to two times after birth to check their hearing. The time gap between the two screens was shortened to less than a week as part of the new screening regime.

Fluid in the middle ear takes a few days to clear after birth. After they noticed the pattern of increased referrals, the screening team wondered if it could be related to the two screens now being closer together.

They decided to try having a longer gap between the two initial tests to see if the numbers of referrals would drop again. They were right – numbers dropped and from now on there will always be at least a week between session one and two.

> **"Since we began delaying the second screen for a week the diagnostic referral rate has dropped from around 5% to less than 2%"** *– Newborn Hearing Service Coordinator Sandra Hoggarth*

Newborn Hearing Service Coordinator Sandra Hoggarth says that while the goal is to detect and begin addressing any permanent hearing loss early, it's also important to keep stress to a minimum for new parents. So results of the trial are good news for parents, she says.

"Since we began delaying the second screen for a week the diagnostic referral rate has dropped from around 5% to less than 2%," she says.

"This means fewer families will have to go through a period of uncertainty, followed by an up-to-two-hour appointment, only to find out their baby's hearing is good."

Health Targets

There are six national health targets set by the Ministry of Health to track how well district health boards are providing services to their communities. The targets include both preventative health and hospital service measures and are publicly reported each quarter. In 2016 the More heart and diabetes checks target has been removed and a new Raising healthy kids target added.

HEALTH TARGET	Target	2015/16 results	Achievement
 **INCREASED IMMUNISATION** The target is 95% of eight month olds have their primary course of immunisation at six weeks, three months and five months on time	95%	95%	✓ Achieved
 **IMPROVED ACCESS TO ELECTIVE SURGERY** The target is an increase in the volume of elective surgery by at least 4000 discharges per year	100%	105%	✓ Achieved
 **FASTER CANCER TREATMENT** The target is 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	85%	73%	Making good progress
 **SHORTER STAYS IN EMERGENCY DEPARTMENTS** The target is 95% of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours	95%	93%	Making good progress
 **BETTER HELP FOR SMOKERS TO QUIT** The target is 95% of patients who smoke and are seen by a health practitioner in **public hospitals** are offered brief advice and support to quit smoking	95%	95%	✓ Achieved
The target is 90% of patients who smoke and are seen by a health practitioner in **primary care** are offered brief advice and support to quit smoking	90%	81%	Making good progress
 **MORE HEART AND DIABETES CHECKS** The target is 90% of the eligible population will have had their cardiovascular risk assessed in the last five years	90%	88%	Making good progress

Quality and Safety Markers

The Health Quality & Safety Commission is driving improvement of New Zealand's health care through the national patient safety campaign Open for better care. The quality and safety markers below help evaluate the success of the campaign nationally.

MARKER DEFINITION	NZ Goal	Jul to Sep 2015	Oct to Dec 2015	Jan to Mar 2016	Apr to Jun 2016	Compared with NZ goal
PREVENTING PATIENT FALLS: Percentage of patients aged 75 and over (Maori and Pacific Islanders 55 and over) that are given a falls risk assessment	90%	72%	66%	72%	86%	Making good progress
PREVENTING PATIENT FALLS: Percentage of patients assessed as being at risk have an individualised care plan which addresses their falls risk	90%	62%	60%	73%	82%	Making good progess
REDUCING SURGICAL SITE INFECTIONS Right antibiotic in the right dose – 2 grams or more cefazolin given	95%	99%	97%	97%	**	✓ Target met
REDUCING SURGICAL SITE INFECTIONS Appropriate skin antisepsis in surgery using alcohol/chlorhex or alcohol/providone iodine	100%	100%	100%	100%	**	✓ Target met
REDUCING SURGICAL SITE INFECTIONS Antibiotics given (O-60 minutes before "knife to skin" – baseline data January to March 2015)	100%	98%	94%	96%	**	time recording issue, no process concerns
IMPROVING HAND HYGIENE Percentage of opportunities for hand hygiene for health professionals	80%	78%	*	80%	80%	✓ Target met

*National compliance data for hand hygiene is reported three times a year.

**These results run one quarter behind other measures and were not available at time of publication.

HUTT VALLEY DHB

Tell us what you think...

We welcome feedback from patients, clients, families/whānau and visitors on things that have gone well and ways we can improve the quality of our services.

Please send us your feedback by:

EMAIL: feedback@huttvalleydhb.org.nz

PHONE: (04) 587 2613

POST TO: Hutt Valley Quality Team
Hutt Valley DHB
Private Bag 31907
Lower Hutt 5040

View online at **www.huttvalleydhb.org.nz/about-us/reports-and-publications/**