A REVIEW OF OUR PERFORMANCE

He Arotake o ā Mātou Mahi

2014/15 Quality Account

November 2015
TABLE OF CONTENTS

Our Commitment to Quality and Service Improvement ............................................ 3

Executive summary ........................................................................................................ 4

1.0 Background .................................................................................................................. 6
   Profile of MidCentral District Health Board and Central PHO and our population ... 6
   Some facts about our health services for the year ......................................................... 7

2.0 Introduction .................................................................................................................. 8
   What quality means to us ............................................................................................... 8
   Our Outcomes and Quality Improvement Framework ................................................ 8

3.0 Our Performance in Review ....................................................................................... 10
   3.1 Focusing on our patients and consumers .............................................................. 10
      Improving consumer experience ............................................................................ 10
      Responding to feedback ......................................................................................... 10
      Enabling access and being inclusive ..................................................................... 11
      Reducing serious adverse events .......................................................................... 12
      Minimising hospital acquired infections ................................................................ 13
      Ensuring surgical safety ......................................................................................... 14
      Reducing harm from falls ....................................................................................... 14
      Safer use of medications ....................................................................................... 16

   3.2 Focusing on improving our performance .............................................................. 17
      Breathing easier - Child Asthma Improvement ......................................................... 17
      Scoping sooner - Gastroenterology Services ............................................................ 19
      Recovering quicker - Enhanced Recovery After Surgery ........................................ 21
      Flowing better - Shorter Stays in the Emergency Department .................................. 24
      Flexing on time - Primary Options for Acute Care (POAC) Service ....................... 27
      Reducing barriers - Horowhenua After-hours Service, Levin .............................. 29
      Caring closer to home - Diabetes Specialist Care .................................................... 32

4.0 Our priorities ahead ..................................................................................................... 34

Acknowledgement

Our thanks go to all who have contributed to this Quality Account and for their commitment to improving the quality and safety of services provided to our community by a vast number of staff and range of health care providers throughout our district. We also thank our patients, consumers and families for their contributions through their ongoing participation and provision of feedback that we find useful in our quest for continuous service improvement and work toward our vision of “quality living - healthy lives.”
OUR COMMITMENT TO QUALITY AND SERVICE IMPROVEMENT

From the Chair and Chief Executive, MidCentral District Health Board

Every day, thousands of people access health and disability services in our district. For some, the experience, the care and support they receive exceed their expectations. For others, they feel we have let them down or have fallen short of what they expected.

It is our commitment, alongside our PHO partner, to our communities that the quality of care for all people shall continually improve.

Key to this is open and honest communication and engagement with users of our services. This Quality Account sets out our performance (good and bad) and the work we are doing to further improve the quality and delivery of care. Patient stories are included and we would like to thank all those who shared their experiences with us over the past 12 months. Your feedback is invaluable to shaping our care.

During 2016, we will be engaging with communities about the values they believe MidCentral DHB should stand for, and which every staff member should reflect in everything they do and say. We urge you to take part in shaping your health service.

Phil Sunderland, Chair and Kathryn Cook, Chief Executive

From the Chair and Chief Executive, Central Primary Health Organisation

We are proud of our commitment to working in partnership with MidCentral DHB and the wider sector to improve individuals, families/whānau and communities’ quality of care. We are pleased to be presenting our third combined account that highlights our progress with this and some of the things we are doing to continuously improve the experience of care for our patients, so that the right care is delivered at the right time and place.

Dr Bruce Stewart, Chair and Chiquita Hansen, Chief Executive

From the Chair, Clinical Leadership Council

We have a staff consisting of thousands of dedicated and skilled people working across our district to provide the best possible care for our patients and their families/whānau.

This, our third quality account, highlights several areas where we believe we have done well over the last year and some other areas where we are focusing our activities to ensure improvements are made.

Dr Ken Clark, Chief Medical Officer, Chair

ANY FEEDBACK?? We welcome your feedback on this, our third, Quality Account. Please email your feedback to us at this address: quality@midcentraldhb.govt.nz. Your feedback will be used to help us further develop our quality accounts – your thoughts and comments are appreciated.
EXECUTIVE SUMMARY

We, MidCentral District Health Board (MDHB) and our primary health organisation - Central PHO, are pleased to present our third snapshot account of the quality of services we provide. It relates to the 2014/15 year. We hope this review of our performance provides you with some information that supports your confidence and trust in the quality and safety of services we deliver.

Publication of this Quality Account – A Review of Our Performance – is one way of highlighting our commitment to high quality health care and continuous improvement across our district. It focuses on the results of some of the key performance measures of quality and safety together with some of the feedback and experiences of care we heard about from our patients and consumers of our hospital, community health and primary care services. We have shown where we have done well, and not so well, in meeting our expectations and targets for the quality of care we provide and identified some of the changes we made to further improve those results. This report also profiles some particular service improvement activities that we have undertaken in our hospital and primary health care settings. These improvements are related to:

- child asthma
- gastroenterology services
- enhanced recovery after surgery
- shorter stays in the Emergency Department
- primary options for acute care
- Horowhenua after-hours service
- diabetes specialist care closer to home.

More of our financial and non-financial results for the year can be found in our Annual Reports, and a lot more information about our health system is also available on our respective websites www.midcentraldhb.govt.nz and www.centralpho.org.nz.

Quality improvement is about measuring and monitoring how well we are doing against what is expected, then working together to get better results. Building on “The New Zealand Triple Aim”, we have developed our Quality Improvement Framework as a way to approach our quality and service improvement, focusing on four interconnected elements: being consumer and community-focused, getting it right, being willing and able to learn, and, being up to the job.

The following table summarises the key outcomes we are seeking to achieve through implementing our quality improvement framework.

<table>
<thead>
<tr>
<th>IMPROVED QUALITY, SAFETY AND EXPERIENCE OF CARE</th>
<th>IMPROVED HEALTH AND EQUITY FOR ALL POPULATIONS</th>
<th>BEST VALUE FOR PUBLIC SYSTEM RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased consumer involvement</td>
<td>Increased access to services</td>
<td>Better integration and coordination of services</td>
</tr>
<tr>
<td>Better experiences of care</td>
<td>Reduced waiting times</td>
<td>Resilient community</td>
</tr>
<tr>
<td>Independence enabled</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced risk of harm</td>
<td>Reduced disparities in health status</td>
<td>Better alignment of resources</td>
</tr>
<tr>
<td>Better management of long term health conditions</td>
<td>Reduced avoidable hospitalisations and mortality</td>
<td></td>
</tr>
<tr>
<td>Reduced unplanned, acute events</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced variation in health care practices</td>
<td>Knowledgeable and skilled workforce</td>
<td>Better use of information</td>
</tr>
<tr>
<td></td>
<td>Collaborative partnerships with health and social service providers</td>
<td>Improved system performance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protected healthy environments</td>
<td>Responsive health and disability services</td>
<td>Sound investment and financial management</td>
</tr>
<tr>
<td>High performing teams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fit for purpose services and facilities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Some of our **performance improvements and achievements** during the year include:

- We continued to improve our results against the national quality and safety markers which include a reduction of falls occurring in hospital that result in a fracture, improved surgical safety and a reduction in health care associated infections.
- Attention to our ongoing falls prevention initiatives contributed to there being four fewer serious falls this year compared to last year. Our ‘falls aware ward’ programme has also been taken up by many of our aged residential care providers.
- We achieved better rates of compliance with the ‘5 moments’ for hand hygiene, with 78 percent of the 4,633 observed opportunities for good hand hygiene practices, but not quite achieving the national threshold.
- Staff influenza vaccination rates increased over this year from 44 percent to 60 percent thereby helping to increase the protection of our staff and patients from seasonal influenza.
- We implemented the accessibility self audit tool to support our staff to understand what they need to do to provide an accessible and inclusive health and disability service. This will contribute to improving the experience for all people with access needs.
- We launched our year-long Medication Safety Campaign to help us improve overall patient safety with an emphasis on improving staff knowledge and skill in the safe prescribing and administration of medication.
- We implemented the new national inpatient experience survey as a consistent way of seeking feedback from patients. Our overall results in each of the four domains were not significantly different from those of other hospitals. Our patients generally have trust and confidence in what we do and they highly rated the staff for listening to them. But we need to do better in our overall communications especially consistency of messages, improves the coordination of care with our patients throughout their hospital stay as well as in support of their discharge home.
- Our success with improving patient flows throughout the hospital resulted in a reduced length of stay for medical inpatients by one day on average. This has meant that we can respond to the need for patients to be admitted to a ward more quickly from the Emergency Department and that patients can be transferred or discharged from a medical ward with less time spent ‘just waiting’.
- Attendances at the Emergency Department and acute medical admissions to hospital have reduced for some children with asthma, people living with diabetes and for people living in the Horowhenua district as a result of our service redesign and improvement initiatives.
- A pilot project implementing primary options for acute care packages, showed that promoting a shorter duration of intravenous therapy in the community for people who need treatment for cellulitis was not only delivering effective care, but provided more comfort for the patient and at a lower cost.

We fully acknowledge that we **still have more work to do**. Our commitment to making ongoing improvements to the quality and safety of services delivered across our district is highlighted throughout this report, and in particular, the final section lists our priorities for the year ahead.

Finally, we would welcome any **feedback** you may wish to provide on our Quality Account. Details of how best to do so are included on the earlier page with our Opening Statements.
1.0 BACKGROUND

1.1 PROFILE

WHO ARE WE – MIDCENTRAL DISTRICT HEALTH BOARD AND CENTRAL PRIMARY HEALTH ORGANISATION

MidCentral District Health Board (MDHB), a Crown entity, is one of 20 District Health Boards in New Zealand that plans, manages, provides and purchases publicly-funded health services for the population of our district. This includes contracting for the provision of primary care services, hospital services, public health services, aged care services, and health services provided by non-government organisations and other providers including Māori health providers.

The provision of primary health care services is managed on the DHB’s behalf through the Central Primary Health Organisation (PHO) – an organisation funded by us to support the provision of essential primary health care services through general practitioners (GPs) and general practice teams to people who are enrolled with the PHO. The aim is to ensure GP services are better linked with other primary health services to ensure a seamless continuum of care, in particular to better manage long term conditions, and to support better links with our hospital (MidCentral Health), specialists and associated services.

For more details about who we are and what we do refer to our websites at [www.midcentraldhb.govt.nz](http://www.midcentraldhb.govt.nz) and [www.centralpho.org.nz](http://www.centralpho.org.nz)

WHO ARE YOU – A PROFILE OF OUR POPULATION

- Our district covers the Otaki ward of the Kapiti Coast district, the territorial local authority districts of Horowhenua, Palmerston North City, Manawatu and Tararua located across the mid-lower North Island.

- The 2013 Census revealed our district had a usually resident population of 162,564 people; slightly more females (52 percent) than males, about 35 percent were under the age of 25 years, 48 percent aged between 25 and 64 years, and 17 percent were aged 65 and over. Our population age profile is broadly similar to the national average, but with a higher proportion of older people. The Statistics New Zealand medium projections for the 2014/15 year showed an estimated population of 170,330 people in our district.

- We have a higher proportion of Māori (around 17 percent) and a lower proportion of Pacific people (3.5 percent) than the national average for Māori and Pacific people (14 percent and 7 percent respectively), with a growing proportion of Asian people living here (about 6 percent). There is proportionately more Māori living in the Otaki, Horowhenua and Tararua districts than there is in the Palmerston North and Manawatu districts. The number of residents with refugee status in Palmerston North is also growing.

- We have proportionately more people in the higher levels of the socio-economic deprivation areas (decile 7 – 10) and lower proportions of people living in decile 1 – 4 areas compared to the national average.

- Key statistics show the health status of our population is not significantly different from all of New Zealand, but there are differences.
### 1.2 SOME FACTS ABOUT OUR HEALTH SERVICES FOR THE YEAR

Between July 2014 and June 2015, in our district, there were...

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,371</td>
<td>1,371 people referred to the Green Prescription programme</td>
</tr>
<tr>
<td>1,541</td>
<td>1,541 newborn babies who had a hearing screening test</td>
</tr>
<tr>
<td>1,736</td>
<td>1,736 older people living in an aged residential care facility</td>
</tr>
<tr>
<td>1,857</td>
<td>1,857 babies born at the hospital or health centre</td>
</tr>
<tr>
<td>1,992</td>
<td>1,992 eight month old infants who had had their immunisations</td>
</tr>
<tr>
<td>2,132</td>
<td>2,132 children who had a B4 School Health Check</td>
</tr>
<tr>
<td>3,138</td>
<td>3,138 people who received home based support services</td>
</tr>
<tr>
<td>3,231</td>
<td>3,231 people who had an MRI scan</td>
</tr>
<tr>
<td>4,295</td>
<td>4,295 people seeing community mental health teams</td>
</tr>
<tr>
<td>6,316</td>
<td>6,316 surgical operations at Palmerston North Hospital</td>
</tr>
<tr>
<td>8,835</td>
<td>8,835 adolescents seen by DHB funded dental services</td>
</tr>
<tr>
<td>9,652</td>
<td>9,652 young people seen at the Youth One Stop Shop</td>
</tr>
<tr>
<td>10,037</td>
<td>10,037 consultations after-hours for children aged under six years in primary health care</td>
</tr>
<tr>
<td>25,990</td>
<td>25,990 contacts with Allied Health Services</td>
</tr>
<tr>
<td>38,436</td>
<td>38,436 people discharged from hospital care</td>
</tr>
<tr>
<td>40,369</td>
<td>40,369 attendances at the Emergency Department</td>
</tr>
<tr>
<td>45,705</td>
<td>45,705 people had an x-ray at the hospital</td>
</tr>
<tr>
<td>60,255</td>
<td>60,255 consultations with people who have a long term condition</td>
</tr>
<tr>
<td>73,148</td>
<td>73,148 specialist outpatient appointments</td>
</tr>
<tr>
<td>73,922</td>
<td>73,922 acute ACC consultations with general practice teams</td>
</tr>
<tr>
<td>80,931</td>
<td>80,931 consultations with people being seen by the District Nursing Service</td>
</tr>
<tr>
<td>133,238</td>
<td>133,238 people who had a medicine dispensed from a community pharmacist</td>
</tr>
<tr>
<td>154,825</td>
<td>154,825 people enrolled with the Central PHO</td>
</tr>
<tr>
<td>250,000</td>
<td>250,000 samples taken for laboratory testing in the community</td>
</tr>
</tbody>
</table>
2.0 INTRODUCTION

WHAT QUALITY MEANS TO US

There are many definitions of quality, both in health care and in relation to other areas of work. A working definition of quality guides us in our understanding of the services we deliver and helps us to design and shape the interventions and measures aimed at improving outcomes for the individuals and communities we serve.

New Zealand has adopted a three-pronged approach to quality improvement – the New Zealand Triple Aim – that we are using as a foundation for our work. It has three dimensions:

- improved quality, safety and experience of care
- improved health and equity for all populations
- best value for public health system resources.

The New Zealand Triple Aim, as illustrated in Figure 1, shows that health care improvement is focused not only on individuals (patients, consumers), but also the populations we serve and the broader public health system. We use these three dimensions as goals that we work toward in planning, delivering and improving the health and disability services in our district.

OUR QUALITY IMPROVEMENT FRAMEWORK

Quality improvement is about measuring how well we are doing against what is expected, then working together on ideas to get better results. Building on the NZ Triple Aim, we have developed our Quality Improvement Framework as a way to approach our quality improvement programmes, focusing on four interconnected elements: being consumer and community-focused, getting it right, being willing and able to learn, and, being up to the job. This is illustrated in Figure 4.

By implementing and building on focused improvement activities in these four areas, we aim to progressively move toward achieving the goals and outcomes for our population (see Figure 3), and giving effect to the six outcome domains of our Māori responsiveness framework – Te Anga Whāiti (Figure 2):

Te Kāwai Māori – Being Māori
Te Hā O Te Māramatanga – Good Environment
Ngā Painga Pūmau – Good Services that Fit People
Te Pai Oranga – Wellness and Illness
Te Pū Arataki Whaihua – Leadership and Participation
Te Mana Rangatira – Having a Full and Enjoyable Life
WHAT WE ARE WANTING TO ACHIEVE – OUR INTERMEDIATE OUTCOMES

<table>
<thead>
<tr>
<th>IMPROVED QUALITY, SAFETY AND EXPERIENCE OF CARE</th>
<th>IMPROVED HEALTH AND EQUITY FOR ALL POPULATIONS</th>
<th>BEST VALUE FOR PUBLIC SYSTEM RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEING CONSUMER AND COMMUNITY FOCUSED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased consumer involvement</td>
<td>Increased access to services</td>
<td>Better integration and coordination of services</td>
</tr>
<tr>
<td>Better experiences of care</td>
<td>Reduced waiting times</td>
<td>Resilient community</td>
</tr>
<tr>
<td>Independence enabled</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REDUCED RISK OF HARM</td>
<td>Reduced disparities in health status</td>
<td>Better alignment of resources</td>
</tr>
<tr>
<td>Better management of long term health conditions</td>
<td>Reduced avoidable hospitalisations and mortality</td>
<td></td>
</tr>
<tr>
<td>Reduced unplanned, acute events</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BEING WILLING AND ABLE TO LEARN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced variation in health care practices</td>
<td>Knowledgeable and skilled workforce</td>
<td>Better use of information</td>
</tr>
<tr>
<td></td>
<td>Collaborative partnerships with health and social service providers</td>
<td>Improved system performance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BEING UP TO THE JOB</td>
<td>Responsive health and disability services</td>
<td>Sound investment and financial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>management</td>
</tr>
<tr>
<td>Protected healthy environments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High performing teams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fit for purpose services and facilities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FIGURE 3: INTERMEDIATE OUTCOMES

HOW WE GO ABOUT ACHIEVING OUR OUTCOMES – OUR IMPROVEMENT FRAMEWORK

CLINICAL GOVERNANCE AND QUALITY IMPROVEMENT FRAMEWORK

NZ TRIPLE AIM GOALS
Improved quality, safety and experience of care
Improved health and equity for all populations
Best value for public health system resources

BEING WILLING & ABLE TO LEARN
Continuous improvement
Measuring our performance
Empowering people
Providing feedback
Coaching and supporting each other
Learning from others
Designing for innovation

BEING CONSUMER & COMMUNITY-FOCUSED
Engaging our service users
Communicating effectively
Valuing cultural diversity
Being inclusive
Enabling access
Involving our community
Being informed
Ensuring safe environments
Co-designing services

INDIVIDUALLY AND COLLECTIVELY WE ARE ABOUT...

GETTING IT RIGHT
Achieving outcomes
Aligning resources
Assuring effectiveness
Providing evidence-based practice
Adopting shared standards
Providing services within available funds
Integrating the continuum
Managing risk

BEING UP TO THE JOB
Providing fit for purpose facilities
Being competent
Having clear roles
Engaging in professional development
Collaborating with partners
Being a high performing team
Committing to shared goals
Having healthy work places

FIGURE 4: CLINICAL GOVERNANCE AND QUALITY IMPROVEMENT FRAMEWORK
3.0 OUR PERFORMANCE IN REVIEW

FOCUSING ON OUR PATIENTS AND CONSUMERS

IMPROVING CONSUMER EXPERIENCE

The national inpatient experience survey was introduced this year, replacing the survey tool that had been used for some years. The focus of the survey is on the broader experience that patients have relating to their hospital admission in four key areas – communication, partnership, coordination and physical and emotional needs. Studies have shown that patient/consumer experience is a good indicator of the quality of health services.

There were four surveys during the year. Generally we had a very good response rate of about 45 percent of the 400 surveys sent each quarter. Respondents are asked to rate their experience in each of the four areas, and are invited to answer 20 questions aligned to these areas.

The average scores out of 10 given by the survey respondents for communication, partnership, coordination and physical and emotional needs are shown in the graph. While it is too early to identify a particular trend, it is apparent that we could do better in coordination of care and communications, with our average scores generally lower than our average scores in the areas of partnership and meeting physical and emotional needs. Our ratings in each of the four areas are broadly similar to the average scores given across all District Health Boards.

RESPONDING TO FEEDBACK

In addition to the inpatient experience survey there are several other ways in which we receive feedback from our patients, consumers and families. There is the “on-the-spot” feedback during contact with our services, phone calls to our Customer Relations Coordinator, the “Tell Us What You Think” form that is available across our services for feedback, the anonymised comments voluntarily included with the inpatient experience survey as well as any feedback that may be submitted through the Health and Disability Commission.

Δ Quality, safety and experience of care  Δ Health and equity for all populations  Δ Best value for health system resources
Of the total 508 complaints 75 percent reported over the year related to **staff attitude, communication and clinical treatment**. Interestingly, a positive staff attitude featured as a theme among some of the 494 compliments we received, together with the care and competency of staff encountered by patients, consumers or family members.

We have **paid attention to this feedback** by making improvements in these critical areas – largely through:

- ensuring staff receive the feedback directly
- supporting staff to attend communication or customer service training programmes
- prompts and reminders on the wards
- education about communicating with people who have a hearing impairment or have English as a second language (including access to interpreter services).

**ENABLING ACCESS AND BEING INCLUSIVE**

The accessibility **self audit tool** has been designed to support our staff to understand what they need to do to provide an accessible and inclusive health and disability service. This will contribute to **improving the experience for all people with access needs**.

People with access needs include someone who:

- is an older person
- is vision, hearing or speech impaired
- has a cognitive impairment
- has English as a second language
- is unable to walk easily or uses a wheelchair
- cares for a child or person with access needs.

The first audit was conducted in the Child and Adolescent Oral Health Service. Positive stories from this audit highlighted the **benefits that patients and caregivers experienced** by being more involved in their **own appointment scheduling** and in **decisions about their treatment options**. The self-audit also identified a training need for development of **customer service skills as an area for improvement**.

We will be progressively rolling out the accessibility self-audit tool to other services throughout the 2015/16 year.

“Be aware that complaints are for all of us to manage; we have learned that complaints are really all about communication; we have the opportunity to fix what is wrong before the patient leaves our care, if we recognise the signs of discontent.”

*(Jeanine Willink, Customer Relations Coordinator)*

98 per cent of the recorded complaints were responded to within 15 working days: an increase on the result of 94 per cent in 2013/14.

We receive just about as many compliments as we do complaints from our patients, consumers or families.

“When you have dementia, that does not mean you are unable to understand what treatment you are about to be given, and can't hear the surrounding conversation. Not everyone over 70 is deaf, blind and ignorant of medical matters.”
REducing Serious Adverse Events

We reported 20 serious adverse events\(^1\) over these 12 months – three more than in the 2013/14 year. The slight increase in reported events reflects the ongoing improvement in consistent reporting and our recognition of the value gained from the investigation and learning process which results in opportunities for improvement. These improvements reduce the chance of the same event occurring again.

Of the 20 adverse events reported by the DHB:

- five were falls resulting in a fracture – four fewer than the previous year and shows that the concerted effort with regard to assessing for falls risk and associated care planning is having a positive effect
- five related to diagnosis, treatment and general care
- four resulted from a delayed diagnosis or assessment
- two events of incorrect treatment resulting from incorrect identification of patients
- one each pertaining to documentation error, a piece of surgical equipment not being removed during surgery, self-harm and equipment failure.

Central PHO also reported three serious adverse events that occurred in primary health care settings over the year. These events related to treatment and general care (1), falls (1) and equipment (1).

We review and investigate every serious adverse event to identify the root cause(s) so that we can ensure systems are put in place to try and prevent a similar event happening again. Some examples of the changes we implemented following these reviews included:

- testing of medical equipment
- policy and procedure changes
- developing implementation guides
- targeted clinical education, review and oversight
- information technology system changes
- staff education and training programmes
- patient/consumer information.

---

\(^1\) An "adverse event" means an incident which results in harm to a consumer. New Zealand Health and Disability Services - National Reportable Events Policy, Health Quality and Safety Commission, March 2012.
MINIMISING HOSPITAL ACQUIRED INFECTIONS

While our rates of compliance with the ‘5 moments’ for hand hygiene have been steadily increasing since the baseline rate of 65 percent in the July-October 2012 period, we did not manage to attain the increased national threshold rate of 80 percent – although we were close at 78 percent. Over the year, our auditors observed 4,633 opportunities for staff to undertake good hand hygiene practice on each of the five occasions:

1) directly before patient contact
2) directly before a procedure
3) directly after a procedure or body fluid exposure
4) after patient contact
5) after contact with patient surroundings.

Performing excellent hand hygiene at the right time is the most important measure healthcare staff can take to avoid spreading harmful bacteria and to prevent healthcare associated infections.

Our rate of healthcare associated *Staphylococcus aureus bacteraemia* (blood stream infections) was higher than our longer term average (0.35) but was within the expected variation at 0.43 per 1,000 inpatient bed days for the year. Nine of the total 11 instances of infection occurred between July and December 2014.

We continued to have a zero incidence rate of central line associated bacteraemia in our intensive care unit.

Our strategies for ongoing improvement include: increasing visual and verbal prompts throughout the wards; stimulating a team-based approach; highlighting hand hygiene programme as part of the patient safety week campaign; and targeting areas that are performing least well. It was noted in the latest audit that six departments were exceeding the 80 percent goal, when compared to one area at the end of June 2014.

We are making steady improvements toward excellent hand hygiene practices.
ENSURING SURGICAL SAFETY

This measure is based on how well the team uses the World Health Organisation’s Surgical Safety Checklist at certain points in the patient’s care in the operating theatre. Over the year we audited 523 records of operations to confirm whether or not all three parts of the Surgical Safety Checklist were used by the surgical team. We found that this occurred in 92.5 percent of the cases audited – above the national threshold of 90 percent and an improvement on the result in the 2013/14 year (90.2 percent).

Surgical site infection

The proportion of patients receiving an antibiotic within an hour of “knife to skin” for hip or knee replacement surgery reduced over the last two quarters of the year to 90 percent for the latest period (January – March 2015). This rate was below the national average (96 percent) and the goal of antibiotic prophylaxis occurring for all procedures. We note that not achieving the goal in all cases reflects a failure to record the timing of antibiotic administration rather than recording incorrect times.

The change to include an acceptable alternative to a specific antibiotic for hip and knee replacements meant that we exceeded the national threshold with a slightly higher result of 96 percent of patients receiving the right antibiotic at the right dose.

We maintained achievement of the national threshold for correct skin preparation being undertaken on all occasions.

REDUCING HARM FROM FALLS

We continue to focus on a range of actions to help prevent falls – not just in hospital but across the community.

On 1 April 2015, over 200 health workers attended our falls prevention symposium, which was held as part of ‘April Falls’ activities in the region.
The focus was on the importance of taking an **integrated approach to falls injury prevention** with a spotlight on footwear and care for safe mobility. Topics included: frailty, medication, foot care, activity and exercise.

The interest in the symposium reflected the efforts in the district between the many people who work together to help prevent falls. An outcome of this is the **collaborative clinical pathway** that gives health professionals across the district access to the Falls in Older people pathway.

We have an **in-hospital falls prevention group and a community falls prevention group**. These groups meet separately, and have a combined meeting every quarter which ensures an integrated approach across all care settings.

The symposium also provided an opportunity to showcase our **Falls Aware Ward programme**. The programme, which is in place across Palmerston North Hospital, is now being rolled out to aged residential care. All the aged residential care facilities in the district have signed up to take part.

We also established a **fracture liaison service** that will commence in the 2015/16 year. The aim of this service is to ensure that all patients aged 50 or older with **fragility fractures** receive assessment and the offer of treatment to reduce their risk of subsequent fractures. The service will cover both hospital-based and primary health care services.

**BoneCare 2020: Osteoporosis New Zealand, December 2012.**

A strategy for implementation of a systematic approach to hip fracture care and prevention in New Zealand.


---

Over the year, 90 percent of the 4,321 eligible* older people admitted to hospital had an assessment for their risk of falling, and, 96 percent had an individual care plan to address their falls risk.

The number of in-hospital falls in a year that result in a fractured neck of femur (hip) has reduced over two years from seven to zero over the 2014/15 year.

The chart above (used in statistical quality control), from July 2010 to June 2015, shows a **definite downward shift** in the occurrence rate of in-hospital falls with a fractured neck of femur since the second half of 2014.
SAFER USE OF MEDICINES

We launched our local Medication Safety Campaign in May as part of the national Medication Safety Programme. The campaign aims to “greatly reduce the number of New Zealanders harmed each year by medication errors in our hospitals, general practices, aged care facilities and across the entire health and disability sector”.

Our year-long Medication Safety Campaign will help us improve overall patient safety with an emphasis on improving staff knowledge and skill in the safe prescribing and administration of medication. It includes:

- safely prescribing and using high risk medicines (eg blood thinners, strong pain killers, insulin, oral methotrexate, concentrated potassium)
- establishing medication reconciliation (where a pharmacist checks a patient’s medication between what has been prescribed in the community and hospital admission)
- circulating medication alerts and warnings – adverse drug reactions, allergies
- promoting right dose, right time, right person
- promoting learning and education
- identifying and preventing error and harm
- encouraging and supporting staff to report medication incidents, near misses and other concerns.

A word on medication errors

On average, 52 reports of medication errors were made each month over the 2014/15 year compared to an average of 37 in the previous year. The apparent increase in reports does not necessarily mean an absolute increase in the number of errors. We now have much better supported systems for reporting incidents than we have had in past years. We encourage all staff to report incidents or near misses relating to medication, which includes anything from incorrect medicine prescribed, medication omitted, incorrect timing or dosage, spillage, incorrect count, labelling or storage of medicines. Many of these errors do not result in any harm to our patients however they do provide opportunity to improve our process and systems.

75 percent of all prioritised patients have a clinical pharmacist complete a medication reconciliation within 24 hours of their admission.

Prioritised patients include:

- Māori and Pacific people aged 55 years and over
- all people aged 65 years and over
- all people with a chronic health condition and who have been in hospital within the last year
- all people admitted to hospital with a hip fracture.

“Despite my penicillin allergy being noted and discussed, I was given penicillin on discharge = one week plus of itchiness.”
3.2 FOCUSING ON IMPROVING OUR PERFORMANCE

CHILD ASTHMA IMPROVEMENT

WHAT DID WE WANT TO ACHIEVE?

Getting it right, and, being willing and able to learn

- To improve the health care experience for children with asthma.
- To reduce avoidable hospital admissions and Emergency Department presentations.
- To better enable integrated health care.
- To improve consistency of clinical knowledge.

Outcome: Increased reliability of care in primary health care settings following evidence-based collaborative clinical pathway for child asthma.

WHY DID WE WANT TO ACHIEVE IT?

Asthma is one of the top three reasons for children being admitted to hospital in our district. With better assessment, diagnosis, treatment and care by primary health care practitioners together with patients being more informed and involved in their own care we can help children and their families take control of their asthma and live a stronger, healthier life.

We have implemented a number of Collaborative Clinical Pathways using the Map of Medicine® as a tool to support standardised care. The clinical pathways for Acute and Chronic Asthma in Children are available to general practice teams on the electronic patient information management system or via the internet. Pathways were also developed specifically for patients and their families to use as their own resource.

A baseline audit of child asthma treatment in one large general practice showed that only 27 percent of the evidence-based care described in the Collaborative Clinical Pathway was being followed. Practice leaders wanted to improve this performance.

Successful implementation of clinical pathways depends on the willingness of health professionals to refer to the Collaborative Clinical Pathways and be guided by them. Embedding change to positively influence patient care requires working with health professionals who are willing and able to learn in order to find the best strategies.

HOW DID WE GO ABOUT IT?

A multidisciplinary team was formed comprising members from general practice (medical, nursing and management), the local Primary Health Organisation (quality improvement, pharmacist and information analyst), the hospital (paediatrician) and Community Child Health Services (clinical nurse specialists).

An audit tool was developed based on the key clinical pathway steps for child asthma (1 – 15 years of age) and tested by reviewing 12 consecutive weeks of child asthma consultations.
The team used rapid plan-do-study-act cycles to test changes and learn what worked to enable general practice engagement, improve clinical knowledge and ease use of the pathways. Changes included development of posters demonstrating the pathway steps, peer review education sessions, consumer feedback, clinical records audit and feedback and one-on-one discussions. While patient and family satisfaction with the care provided was high, this project did demonstrate that the Asthma Action Plan was not being used. The most successful changes were the use of the posters in the consulting cubicles, peer review education and targeted feedback to the clinicians.

An electronic form embedded in practice software has been developed that, when worked through, triggers the use of the Asthma Action Plan for patients and their families to take home with them.

WHAT WERE THE RESULTS?

After the improvement project:

- overall performance increased to 43 percent of treatment in line with the Collaborative Clinical Pathway
- when the electronic form was used, over 80 percent of management was in line with the Pathway
- the General Practice reduced Emergency Department presentations for their enrolled children with asthma (52 in 2013 down to 38 in 2014)
- hospital admissions for child asthma remained stable (17 in 2013 to 16 in 2014) even though there was an increase in the practice’s enrolled child population from 4,080 to 4,472 during the project.

The key learning from this project was that it took many small changes to bring about a change in care, rather than one single change.

This project required a long-term commitment and hard work from all the team. This has shown the benefits to be gained from general practice and hospital partnerships in improving health outcomes for the children of our district, with better care at each general practice encounter, reduced presentations to hospital through improved self-management, and better use of the clinical pathways.

The changes and learnings from this project are now to be tested in another general practice, where that team may find even better ways to implement the pathways and further improve the health outcomes and experience of children with asthma.

"It has been fantastic to see an improvement in patient care following the implementation of the asthma project in our practice. This has been a long term goal to improve asthma care at the practice. The help and support from Palmerston North Hospital and the PHO in achieving this has been amazing."

Δ Quality, safety and experience of care  Δ Health and equity for all populations  Δ Best value for health system resources
GASTROENTEROLOGY SERVICES

WHAT DID WE WANT TO ACHIEVE?

Getting it right
- To reduce waiting lists and waiting times
- To improve efficiency and quality of colonoscopy services
- Earlier diagnosis and treatment for cancer
- More patient-focused service
- Better use of resources.

Outcomes: The majority of patients referred for an urgent, diagnostic or planned follow-up colonoscopy have their procedure within expected timeframes.
- Increased utilisation of all available endoscopic sessions.
- Reduced "did not attend" rates for booked appointments.

WHY DID WE WANT TO ACHIEVE IT?

Over the last few years the Gastroenterology Department had been struggling to keep pace with the number of patients being referred, creating long waiting lists for both outpatient endoscopy\(^2\) and clinic services meaning that patients were waiting an unacceptably long time to have their procedure. It was not uncommon for a newly referred patient to have a wait of six months or longer. Patients waiting for a follow-up colonoscopy could be overdue by a year. This situation was typical of Gastroenterology departments across New Zealand at the time.

Appropriate and timely gastroenterology services are an integral part of our bowel cancer services. Bowel cancer is the second highest cause of cancer death in New Zealand. More than 2,800 people are diagnosed with bowel cancer every year and more than 1,200 die from the disease. By 2016 the number of new cases of bowel cancer diagnosed each year is projected to increase by 15 percent for men and 19 percent for women, to 3,302 (for all ages). It was important that we worked to improve our services to ensure that we could better cope with demand, give our patients a better chance of earlier diagnosis and treatment, and use our resources more efficiently.

HOW DID WE GO ABOUT IT?

The National Endoscopy Quality Improvement Programme (NEQIP) was set up with a view to improve efficiency and quality of endoscopic services nationally. A tool called the New Zealand Global Rating Scale (GRS) was rolled out to all endoscopy\(^2\) departments. This provides a set of standards and a quality improvement framework that has four focus areas: clinical quality, quality of patient experience, workforce and training.

A project team was established which provided the oversight and operational management to lead the service improvement initiatives. These focused on teamwork and leadership, planning, better communications and information sharing, and making appointments to better suit patients.

\(^2\) Endoscopy: a non-surgical, diagnostic or therapeutic procedure used to examine a person’s digestive tract. Using an endoscope, a flexible tube with a light and camera attached to it, your doctor can view pictures of your digestive tract on a monitor.
WHAT WERE THE RESULTS?

REDUCING WAITING TIMES FOR A COLONOSCOPY

Since October 2014 we have sustained a high rate of patients prioritised as ‘urgent’ receiving their colonoscopy within 2 weeks (100 percent) and 90 percent of the patients referred for a diagnostic (non-urgent) colonoscopy over the year were seen within six weeks.

Patients scheduled for a follow-up colonoscopy are no longer overdue. Eighty-nine percent of patients in the 2014/15 year had their surveillance colonoscopy within 12 weeks.

The Did Not Attend (DNA) rates have reduced to less than 2.5 percent which is below the national average of 8.9 percent.

These improved performance results were consistently achieved over the year showing that we were able to sustain our system and process improvement efforts. This demonstrates the continued commitment and hard work of the Gastroenterology Department to deliver patient-focused services that are efficient, accountable and sustainable.

We are now confident that we will meet or exceed the increased targets, which take effect from July 2015, for the percentage of patients who have their procedure within the expected timeframes for each of the colonoscopy referral types.

BETTER PATIENT EXPERIENCE

Regular surveys of patients are undertaken on the same day as their procedure (colonoscopy, gastroscopy or sigmoidoscopy). We obtain their views about how well we’ve met their needs throughout their contact with the Gastroenterology Service – from before the appointment to after their procedure. Some of the key results of the survey in June 2015 are summarised below.

- Of all respondents 98% confirmed that the information that was sent to them before their procedure was “about right”. Most (95%) stated that the information provided was either “easy” or “very easy” to understand and 74 percent thought it was “very helpful” (the remainder thought it was “somewhat helpful”).
- The majority (97 percent) of respondents stated that the explanations provided during their procedure and opportunities to ask questions were “about right” and that the explanations were easy or very easy to understand.
- Pain seemed to have been managed adequately during the procedure for most patients. For 91 percent of the patients, the level of pain was about the same or less than they had expected.
- Privacy arrangements were rated highly by all but one of the respondents and the majority (85 percent) were satisfied with the advice, information and after-care arrangements following their procedure.

“The nurses were friendly and informative. The procedure itself was a breeze and interesting. The hardest thing was the 4 day prep. Thanks to all the staff involved.”

“Excellent help before/during /after. Very thoughtful, caring staff. Thanks to you all.”
ENHANCED RECOVERY AFTER SURGERY

WHAT DID WE WANT TO ACHIEVE?

*Being consumer-focused, and, getting it right*

- To ensure patients needing a hip or knee joint replacement are in the best possible condition for surgery.
- That patients are well informed and actively participate in their planned care and rehabilitation.
- That well organised, standardised processes contribute to safe, reliable delivery of care before, during and after surgery.
- That time spent by patients in hospital is as short as safely possible and they return to their normal daily activities as quickly as possible.

*Outcomes:*

- Better patient experience
- Fewer complications of care
- Reduced hospital lengths of stay
- High attendance rate at pre-operative education classes
- Earlier mobilisation of patients post hip and knee replacement surgery
- Increased access to surgery – reduced waiting times and lists.

What is ERAS?

Enhanced Recovery after Surgery (ERAS) is a patient-centred method of ensuring the best possible surgical outcome. This is achieved by looking at each aspect of care from the patient’s experience. The approach starts when it is first decided a person needs surgery and continues through to their rehabilitation in the community.

WHY DID WE WANT TO ACHIEVE IT?

Nearly every day, a hip or knee joint replacement surgery is undertaken at Palmerston North Hospital. In addition to these 350 joint replacements, 120 people a year need surgery to repair a hip fracture, usually following a fall.

*With more people experiencing the normal ageing process and with the prevalence of longer term conditions, including arthritis and osteoporosis, the demand for orthopaedic services is increasing.* This includes planned (elective) hip or knee replacements and revisions and acute surgery to repair fractures – especially hip fractures. There was also a national policy priority to increase access to elective surgery year on year and to reduce the waiting lists and times for specialist assessment and treatment.

We were also keen to *make sure that patients continued to receive the best possible evidence-based treatment, clinical outcomes and delivery of care to enable faster recovery and return to their normal daily routines after surgery.* We needed to make sure we could meet the demand and make the best use of resources.
HOW DID WE GO ABOUT IT?

We joined the National Orthopaedic Enhanced Recovery After Surgery (ERAS) Quality Improvement Collaborative. We then worked on making further improvements to the patient’s experience of care and implemented the principles for hip or knee joint replacements and surgical repair for fractured hips. This was an extension of the work we had already undertaken by having pre-surgical joint replacement clinics and patient information booklets in place. The work covered two phases: implementing the ERAS Collaborative Project through to November 2014, followed by the evaluating and sustaining strategies phase through to June 2015.

A number of new initiatives were introduced. One such initiative was the introduction of a particular medication given during surgery to reduce bleeding and bruising. Providing this evidence-based practice during surgery has reduced the need for the majority of patients to have wound drains or to have a blood transfusion related to blood loss.

Other initiatives included: offering green prescriptions for patients to improve their health and fitness prior to surgery; ensuring notifications were given to multi-disciplinary teams when a patient with a fractured hip was admitted in order to commence pathways earlier; and publishing of the revised information booklets.

WHAT WERE THE RESULTS?

The number of patients having an elective (planned) hip or knee replacement increased by 36 percent to a total of 498 patients over the 12 months to March 2015, compared to 385 patients over the previous 12 months.

- The pre-surgery clinic for elective hip and knee joint replacements now has all patients attending their appointment.
- The average length of stay has reduced to 3 to 4 days from 4 to 5 days in 2011 resulting from patients being more ready for surgery and being able to mobilise earlier after surgery. Not only are patients benefitting from this approach but also our average cost per procedure has reduced by having fewer ‘unnecessary’ overnight stays.
- The percentage of patients requiring a blood transfusion following hip replacement reduced by 57.6 percent and 41.7 percent for knee replacement surgery over the 12 months to March 2015.
- Our rates for acute readmissions to hospital and complications have been lower than the national average since January 2014.
The average proportion of patients receiving all ERAS care components for hip and knee replacements increased from 50 percent to 100 percent by the end of January 2015.

The number of acute patients who had surgery for a fractured neck of femur reduced by 5.6 percent to 152 patients over the same 12 months.

The average proportion of patients receiving ERAS care components for repair to fractured hips was 10 percent, which rose to 50 percent by the end of January 2015.

Our average length of stay for acute patients with a fractured neck of femur has increased on average since September 2014. Also, we have not sustained the higher rate of patients being operated on within 48 hours, so we have more work to do in these areas.

The average time for weight bearing appears to be steadily declining since January 2015. This achieves the desired time to well within 24 hours thereby improving the patient’s recovery process, return to normal activities of daily living and discharge home.

The proportion of patients requiring a blood transfusion reduced by 58.1 percent over the 12 months to March 2015 compared to the previous 12 month period.

While there is still further work to be done for these patients, steady progress is being made.

“Firstly I wish to thank the Surgeons and your nursing staff for the excellent care given during the period of my operation. Wonderful service. Very severe pain for many months before op, very little pain since.”

“Very happy with all facets of stay. Staff were amazing and ward staff were very good.”

“I felt the nursing staff have the pain under control and I thank everyone for their part of the operation.”

“I am so grateful for the care in the hospital and clinic. Thank you.”
SHORFTER STAY AND THE EMERGENCY DEPARTMENT

WHAT DID WE WANT TO ACHIEVE?

Being willing and able to learn, and, getting it right

- Improve the flow of patients throughout the hospital and wider sector.
- Reduce the amount of time patients spent waiting.
- Increase care coordination with patients to achieve expected date of discharge.
- Improve timely transfer of care arrangements for patients and their family.
- Make better use of information and medical leadership to direct change.

Outcomes: More people have shorter stays in the Emergency Department
Reduced average lengths of stay for acute medical services
Sustained or reduced rates of acute readmissions to hospital
Increased acute medical inpatient bed capacity
Reduced transfer time for older patients requiring rehabilitation services
Better experience for patients and their family, overall.

WHY DID WE WANT TO ACHIEVE IT?

We had been struggling to achieve the national health target for shorter stays in Emergency Departments and the hospital was consistently below the national average results for a long time. There was overcrowding at times in the Emergency Department (ED) with more patients attending and staying in the department than could be safely managed. More importantly though, too many patients were waiting too long to be admitted to an inpatient ward or transferred to another facility once the decision for treatment was made, or waiting to go home following their assessment in ED. The average three percent growth in the number of attendances to the ED each year would not slow down either unless we worked more closely with our primary health care partners through the general practice teams.

Not having inpatient beds available for new, unplanned patient admissions was a frequent occurrence with patients moved around the hospital across different wards to accommodate the incoming priority patients. While there have been a number of initiatives introduced aimed at easing the pressure points (like the Medical Assessment and Planning Unit being established, more senior clinical staff being appointed to the ED, having fast track systems and nurse-led clinics in ED, Rapid Rounds on wards) it was evident that these were not enough.

There was a view that achieving shorter stays in the ED was an ED problem that they had to solve. Many clinicians could not believe that small changes that reduced a patient’s unnecessary time waiting for a decision or for a test or for information could have a significant impact not only upon the individual patient journey, but cumulatively upon the whole hospital. If there was a small change that reduced or eradicated an unnecessary wait for the majority of patients then the benefit was potentially significant.
Analyses showed that the average length of stay (ALOS) for General Medicine patients was almost 1.8 days above other DHBs of a similar size. As General Medicine patients also accounted for 50-60 percent of the acute hospital admissions it was believed that focusing on these patients would have the most impact on improving the flow of patients from the Emergency Department and throughout the hospital.

HOW DID WE GO ABOUT IT?

A key improvement initiative that was critical to achieving the objectives of the patient flow programme was reducing the time patients spent waiting throughout the whole of their hospital journey. This became the priority for General Medical Services as the first area of focus.

To ensure medical engagement in the process improvements, assistance was sought from the Medical Head of General Medicine at another hospital that had successfully turned around their results. The Medical Head undertook a high level review of the General Medicine service and on call arrangements. The key message that he fed back was that each area and clinical team had to take ownership of the problem and that senior staff had to become more involved on a daily basis, to support their junior staff and to question why things were or were not happening.

After a visit to the other hospital, our Clinical Director decided to hold quick daily meetings, called Board Rounds, with all the General Medicine registrars. These were in addition to the usual Ward rounds conducted “at the bedside” with the patient, their consultant and others. At the Board Rounds the Clinical Director leads discussion with the medical registrars to confirm the clinical criteria for each patient’s discharge along with the treatment plan and estimated discharge date (EDD). This proactive meeting helped the registrars question what was happening with their patients, seek answers if required and ensure the plan was on track. There were the added benefits of peer review and learning at the same time. These Board Rounds in turn enabled improved communication and coordination of plans with the patient, charge nurse and between other members of the team so together they were better managing expectations and working toward the same goal.

WHAT WERE THE RESULTS?

Although a number of other changes were introduced at this time, it is clear that the impact of these daily Board Rounds has been the most significant in releasing time for patients and subsequently capacity for the hospital. The overall results to end of June 2015 are outlined below.

- A steady reduction in the average length of stay for medical patients.
- No significant change in the rate of acute readmissions to hospital or patient complaints.
- Medical beds are now available earlier in the day when we know the wards need to be ready to manage the inflow of patients from ED.
- Fewer medical patients are having to be placed in other specialty beds thereby assisting other services to manage their patient flow and enabling more consistent, coordinated nursing care.

Acceptance that issues needed to be addressed across the hospital, taking ownership of the problem, communicating better, establishing clear expectations and having clinical leaders take charge of change were all key success factors.
While still not perfect, patients are waiting less time for diagnostic tests or to be seen by other specialist staff.

Generally more patients are mobilising earlier, are more involved in their own care and what’s required to get them discharged as planned.

Older people who are referred to the Assessment, Treatment and Rehabilitation unit following their acute admission are waiting less time to be transferred.

We have consistently achieved the goal of more people having shorter stays in the Emergency Department (since November 2014).

Overall, better communication and coordination of care with patients and their family/whānau, but further improvements can be made.

“My Doctor saw me the 1st day on the ward, after that I saw only his 2nd in charge at least once a day, who was always in touch in discussions with the doctor and myself on deciding what needed to be done. He couldn't [have] been more helpful, he was just fantastic.”

“It almost felt as though different shifts with the doctors were not communicating effectively with each other. I was told two different things by two different doctors.”

“Someone from each department involved came to see me. They explained what help was available from their department after hearing my full “history” I found it most beneficial and was able to take full advantage of what was on offer. A big thank you.”

“I thought the co-ordination was outstanding. Physio, dietitian, IV specialist nurse were all involved with my care and communication between everyone seemed great.”

Medical Service Transfers to STAR2 (AT&R) ALOS
January 2014 - June 2015

Percentage of people presenting to ED who are admitted, transferred or discharged within 6 hours

“While still not perfect, patients are waiting less time for diagnostic tests or to be seen by other specialist staff.”

“Generally more patients are mobilising earlier, are more involved in their own care and what’s required to get them discharged as planned.”

“Older people who are referred to the Assessment, Treatment and Rehabilitation unit following their acute admission are waiting less time to be transferred.”

“We have consistently achieved the goal of more people having shorter stays in the Emergency Department (since November 2014).”

“Overall, better communication and coordination of care with patients and their family/whānau, but further improvements can be made.”

“My Doctor saw me the 1st day on the ward, after that I saw only his 2nd in charge at least once a day, who was always in touch in discussions with the doctor and myself on deciding what needed to be done. He couldn't [have] been more helpful, he was just fantastic.”

“It almost felt as though different shifts with the doctors were not communicating effectively with each other. I was told two different things by two different doctors.”

“Someone from each department involved came to see me. They explained what help was available from their department after hearing my full “history” I found it most beneficial and was able to take full advantage of what was on offer. A big thank you.”

“I thought the co-ordination was outstanding. Physio, dietitian, IV specialist nurse were all involved with my care and communication between everyone seemed great.”

Δ Quality, safety and experience of care  Δ Health and equity for all populations  Δ Best value for health system resources
PRIMARY OPTIONS FOR ACUTE CARE (POAC) SERVICE

WHAT DID WE WANT TO ACHIEVE?

Being consumer and community-focused

- Deliver timely, flexible and coordinated care, meeting the acute health care needs of individual patients in a community setting.
- Avoid transfer to the Emergency Department or admission to hospital.
- Provide patient-centred, cost effective services linked to Collaborative Clinical Pathways.
- Increase capacity and capability for primary health care to provide safe acute care in the community.
- Reduce variation in clinical practice.

Outcomes:
- Reduced total number of medical acute bed days per population
- Improved patient experience
- Reduced attendances at the Emergency Department
- Reduced potentially avoidable hospitalisations
- Best use of available resources with the current workforce

WHY DID WE WANT TO ACHIEVE IT?

We were keen to provide General Practice Teams with more options to treat and care for their patients in their own homes or at their practices. This could be initiated earlier to avoid an escalation of care needs resulting in a presentation to the Emergency Department or hospital admission. We also recognised that we could do better in providing more convenient, coordinated, community-based care overall. Just as importantly we wanted to ensure our patients had a broader range of treatment options available to them and a choice about those services being provided closer to home.

In its most simple form, Primary Options for Acute Care (POAC) may be appropriate if normally the General Practice Team would send the patient to the Emergency Department or hospital for an admission, not because they are very unwell but because the care they require is too difficult to arrange in the community. These difficulties in arranging care may relate to access, funding, timing and co-ordination. POAC aims to simplify and clarify arrangements for acute care in the community, providing funded care options aligned, wherever possible, to Collaborative Clinical Pathways (CCPs).

HOW DID WE GO ABOUT IT?

The POAC service was designed in partnership with eight general practice teams in our district. A pilot ran for a period of seven months, commencing in December 2014 and ceasing in June 2015. Other key stakeholders included St John Ambulance, Supportlinks, Hospital Pharmacy, the Emergency Department and District Nursing services. A number of workshops were held as well as weekly general practice site meetings to monitor the appropriateness of the pilot service.

A number of key activities took place, including but not limited to:

- reviewing existing local clinical guidelines and ensuring these were standardised regardless of the setting in which care was provided
- standardising medicines in accordance with best practice
• supporting better access to, and implementation of, the established Collaborative Clinical Pathways (cellulitis, deep vein thrombosis and chronic obstructive pulmonary disease).
• ensuring all services and tests were able to be accessed in the community and/or by the patient’s General Practice team.

WHAT WERE THE RESULTS?

Over 250 patients received care during the POAC pilot to June 2015 in their General Practice team settings. Patients had a range of conditions that included: cellulitis, suspected deep vein thrombosis, acute on chronic obstructive pulmonary disease, myocardial infarction, acute hypotension, dehydration, oedema, pain and infections.

The majority of the patients in this pilot group were managed in the community – only 10 percent needed to go on to ED for further assessment.

A total of 109 patients presented with cellulitis between 1st December 2014 and 31st May 2015. Of these patients:

• 46 (42.2 percent) were referred to the District Nursing service for intravenous (IV) therapy
• 63 (57.8 percent) were managed by their General Practice team or referred to another POAC provider for IV therapy
• **60 percent of the patients with cellulitis** referred to the District Nursing Service from participating POAC General Practice teams were prescribed IV therapy for two days or less. **In contrast, only 20 percent** of the patients referred to the District Nursing Service from non-POAC General Practice teams were prescribed IV therapy for two days or less. This suggests that **the POAC community IV model is promoting shorter duration of IV therapy**, thereby **promoting effective care for lower costs** and **more comfort for the patient**.

Throughout the pilot there was a high level of feedback which has informed the further development of the service. Feedback was actively sought and responses were extremely positive, indicating an **improved patient experience overall**, notably **continuity of care**, better management of their condition and reduced waiting time for treatment and time spent travelling.

"While it’s still early days, initial indications are that POAC adds value to general practices and has been successful in avoiding patients being referred to the Emergency Department. Our next step is to review the outcomes of the pilot and see if the model, or parts of it, can be implemented across the district.
"We have received good feedback from many of those involved in POAC. St John report quicker turnaround times for their ambulances when they deliver patients to general practice teams. District Nurses are finding it easier to coordinate follow-up for cellulitis patients, and the practices themselves are relishing the opportunity to stretch their wings."
Craig Johnston, Acting General Manager, Funding and Planning

**Primary Options for Acute Care**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cellulitis</td>
<td>39%</td>
</tr>
<tr>
<td>Acute COPD</td>
<td>40%</td>
</tr>
<tr>
<td>DVT</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>13%</td>
</tr>
</tbody>
</table>

"Staff showed excellent knowledge on services available and each service provided comprehensive support and treatment."

"Not having to go to A&E and wait."

"Confident that I will receive the best care possible."

"Seeing my own [GP] team."

"I received numerous follow-ups from each service which aided in my recovery whakawhetai ki a koe (Thank-you)."
HOROWHENUA AFTER-HOURS SERVICE, LEVIN

WHAT DID WE WANT TO ACHIEVE?

*Being up to the job, and, getting it right*

- Improve access to after-hours primary health care services.
- Reduce burden of after-hours rostering arrangements for General Practitioners.
- Increase availability of affordable, fit-for-purpose general practice services after-hours.
- Promote community awareness and utilisation of well-coordinated local services.

**Outcomes:**
- Reduced attendances at the Emergency Department
- Increased equity of access to after-hours services
- Improved experience for patients and their family/whānau
- Better alignment of resources

WHY DID WE WANT TO ACHIEVE IT?

Provision (and community perception) of **after-hours General Practice services** in Horowhenua had a **longstanding history of being problematic**. There had been attempts to form a centralised service which had not come to fruition. The established rostering of a general practice clinic around the **seven Foxton/Levin/Shannon practices on a rotational basis** was considered not to be **working well** by either the providers or the community.

A high level of frustration and **inappropriate use of various urgent care services** by the community combined with the current after-hours arrangements not working from a GP perspective meant that system change was required.

**Feedback from the community** had identified the following issues as **barriers to the community accessing urgent care** appropriately:
- apparent lack of coverage/hours
- confusion about where and when services were available
- frustration by Levin people having to travel to Foxton or Shannon to see an on-call doctor
- 80 percent of Horowhenua residents live in Levin
- difficulties with, or inability to, obtain transport to out-of-town clinics
- high cost of access to General Practice after-hours clinics.

**Feedback from the General Practitioners** and practice owners included:
- the number of patients attending was low at some after-hours clinics
- after-hours can often be “loss making” for practices
- GPs preferred to work from their own practices
- current system failing because the roster demand “on the willing” was excessive.

The objective was to **design and implement a sustainable model of care for after-hours care** that met the health and wellbeing needs of the Horowhenua population.
HOW DID WE GO ABOUT IT?

Horowhenua Community Practice proposed to host a trial of a centralised after-hours clinic service for the district, with hours from 6pm to 8pm weeknights and 9am to 6pm weekends and statutory holidays.

GP representatives from the district attended a number of sessions, facilitated by Central PHO, to discuss a possible solution that would work for all. A project manager led this work from one of the contributing general practice providers.

Relationships with other providers were really important to ensure a complete after-hours service continued to be available such as Healthline, St John Ambulance, the Urgent Community Care service and the local pharmacies. As a result of these discussions other projects have developed between the local pharmacy and Horowhenua Community Practice to support patients during the day.

The Horowhenua Community Practice provided a registered nurse and administrator to support the after-hours service.

The After-hours Service was promoted and publicised widely in order to ensure that the community was confident of where and when the clinic was operating, the type of services they could expect to receive and the cost of those services.

WHAT WERE THE RESULTS?

- The community is very pleased with the service; they know exactly where to go, who to contact and what the processes are. We have also received occasional feedback from patients visiting the area on holiday or travelling through, about how great they found the service.
- General Practitioners feel supported by having a nurse, administrator and security on site while the clinic is open.
- The average number of attendances each month to the Emergency Department from the Horowhenua district has reduced by six to 583 on average per month when compared to the previous 18 months. However, this cannot be solely attributed to the Horowhenua after-hours clinic.
- On average 1,180 patients are seen at the After-hours Clinic for consultations with General Practitioners each quarter.
- About 67 percent of patients are seen during week nights and about a third of patients are seen during the weekends and public holidays.
- The majority of patients seen are over 65 years of age followed by the under six years old. The least frequent attendees are those aged between seven and 14 years.
- The GPs’ allocation of rostered after-hours cover is now largely based on patient identification at the after-hours service. This means that the more patients that attend the after-hours service from a given practice would be the contribution that each practice must provide to the after-hours service roster. This way of allocating the roster is working extremely well.
Patient X said he was extremely happy with the service and it was great that he didn’t have to travel to Palmerston North. He had an accident that required stitches. This was completed at the after-hours service – happy patient who paid and then went home.

A local lady and her husband, Patient Y, phoned the service just after 5pm one evening quite distressed as her husband had cut his hand quite badly. She said she was advised to come straight down and given clear instructions on how to get to the practice. The practice took them in to be seen straight away on arrival, treated his injury to make him comfortable, then the staff co-ordinated his care with the Palmerston North hospital and the Hutt hospital where he ended up. She was so pleased with the treatment, calmness of the team and felt they went the extra mile and was so pleased that this service was available locally.

"I think everyone recognises that a single after-hours centre, with set opening times, is much better from the patient’s perspective and saves patients the difficulty of identifying which practice is on call and what their working hours are. This is particularly relevant for visitors to the area."
DIABETES SPECIALIST CARE CLOSER TO HOME

WHAT DID WE WANT TO ACHIEVE?

Getting it right and Being willing and able to learn

- Increase access to specialised care for people with diabetes in the community.
- Provide a different approach to specialist diabetes service input into general practice teams.
- Build the confidence and capability of general practice teams in the care of patients with diabetes.
- Improve access to specialist diabetes care.
- Provide more ‘team based care’ in the general practice setting.

Outcomes: Reduced utilisation of acute medical beds
Reduced attendances at the Emergency Department
Better patient experience of care
Improved clinical outcomes for patients living with diabetes.

WHY DID WE WANT TO ACHIEVE IT?

More people are living with type 2 diabetes and hospital-based services can no longer meet the demand. This requires a change in the delivery of diabetes care with a stronger approach to integrating health care delivery across primary and secondary services. Such an approach includes: moving services closer to home, building a critical mass in general practice, more collaboration with nursing and allied health professionals and greater engagement of hospital specialists in primary care.

Evidence shows that specialist input into the delivery and co-ordination of out-of-hospital care, coupled with general practice teamwork to co-ordinate services, can improve patient outcomes, patient and staff satisfaction, and can reduce hospital use.

HOW DID WE GO ABOUT IT?

Two specialist diabetes nurses - a Nurse Practitioner (NP) and a Clinical Nurse Specialist (CNS) - were engaged to work in a range of general practices located in Horowhenua, Palmerston North and Feilding.

The specialist nurses were located in thirteen general practice teams across the district to provide care in partnership with the usual General Practitioner/Nurse Practitioner and nursing team. This involved appointments for specialist review being provided in the general practice, the specialist nurse directly discussing care and management with the General Practice Team and entering clinical notes directly into the shared health record. The patient had just one location to visit and could be assured their clinical records and current medication regimes were up-to-date and being monitored by the team.

A project team supported by an advisory group and researcher was established to evaluate the impact and benefits of this approach.
Questionnaires were sent to patients and general practice staff, interviews were undertaken with general practice members and a representative of the Diabetes Endocrinology Service.

Clinical data and routinely collected health information such as data on appointments, hospital admissions, Emergency Department presentations were used for analysis by the specialist nurses.

WHAT WERE THE RESULTS?

The evaluation concluded the following.

- patients were generally satisfied with **being able to access specialist nurses closer to home**.
- a comparison of baseline and follow-up results showed that for **people with diabetes their health status had remained stable and they were more confident** managing their own health.
- patients reported being more satisfied with the diabetes care received from practice staff. The ‘ideal practice’ was described as having specialist management in general practice, with regular and local access to somebody who understands and can explain things clearly, monitor their diabetes and provide follow-up.
- general practice teams expected to be supported to provide care for more complex patients, **assistance with decision making around clinical management and enhancing skills and knowledge** of general practitioners and practice nurses. Most expressed the wish for more time from the specialist nurses and for themselves to fully benefit from their presence in the practice.
- clinical data such as glucose level results, weight, blood pressure and cholesterol, were collected on patients who were directly or indirectly under the specialist nurses’ care with all results remaining stable or showing some improvement.
- fewer people attended the Emergency Department for diabetes-related presentations and fewer were admitted to hospital.
- when people were admitted to hospital **their length of stay was one day less on average**.
- the number of people referred to the Diabetes and Endocrinology Service **decreased by 36 percent** in line with the increased number of people seen at the general practice by the specialist nurses and GP Teams together, enabling secondary care to focus on the more complex patients.

“Supporting General Practice teams with reliable, consistent specialist knowledge and expertise on-site and better local access to clinical management with specialist advice were key success factors.”

“A service that appreciates that I am the only person in a position to manage my own health and that provides me the necessary expert input, advice, medications and medical tests and evaluations (including retinal screening) so I can optimize my health management. I could see that service as able to be delivered via a number of models”

“Since she’s taking care of me 100 percent. Good advice, working with my doctor. Together they make a solid team in whom I can trust and rely on”

“Seeing specialists in general practice, easier to access. Then my GP will become more aware and involved in my diabetes care”

△ Quality, safety and experience of care  △ Health and equity for all populations  △ Best value for health system resources
4.0 OUR PRIORITIES AHEAD

We have made some good progress with our planned improvement programme and initiatives over the 2014/15 year; we have seen some improved results in many instances as a consequence. We are committed to continuing with our quality and service improvement plans, learning from our mistakes, listening to our consumers and focusing on:

- Getting it right
- Being up to the job
- Being consumer and community-focused and
- Being willing and able to learn

Over the next year, our attention will be on the following priorities:

- facilitating implementation of **quality improvement and change programmes in general practices** which ensure their services are structured around the patient

- embedding implementation of the established **Collaborative Clinical Pathways** to increase the standardisation and reliability of patient care with reduced variation on practices

- implementing and monitoring the **Quality Standards for Diabetes Care** across the district, supported by the Diabetes Leadership Group

- continuing to improve the **patient experience and patient flows** throughout the hospital using the results from the “Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care in New Zealand (March 2014)”

- establishing appropriate and sustainable communication and **networks between MidCentral Health and Integrated Family Health Centres** as they further develop

- extending the **“Enhanced Recovery After Surgery” programme** to other surgical specialities

- embedding the **service change programme** across mental health services

- implementing improvements to **address any shortfalls in achieving the Quality and Safety Markers** and other quality performance indicators, including:
  - falls risk reduction strategies to sustain high rates of eligible inpatients having a falls risk assessment and an individual care plan to address their falls risk
  - hand hygiene practices to achieve at least 80 percent compliance with the ’5 moments’
  - adopting the Health Quality and Safety Commission’s “teamwork and communication bundle” for safe surgery
  - surgical site surveillance and infection prevention and control programmes

- strengthening local **mortality and morbidity review** arrangements

- implementing **integrated quality systems** across the district

- ongoing implementation of the **Well Child/Tamariki Ora Quality Improvement Framework** and the **Maternity Quality and Safety** programme.