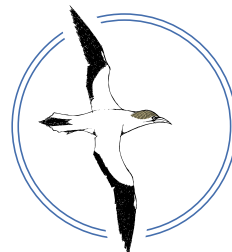


2010-2011

quality of care

• RESPECT • COMPASSION • PARTNERSHIP • EXCELLENCE • EQUITY



PORTLAND
DISTRICT HEALTH



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welcome

On behalf of the Board of Management and our dedicated staff, we are pleased to present our Quality of Care Report for 2010/2011.

This report is developed in line with Department of Health guidelines and minimum reporting requirements. The key areas to report against are:

- a) Consumer, carer and community participation
- b) Quality and safety
- c) Continuity of care

At Portland District Health (PDH) we continue to monitor our performance against other like hospitals to ensure our care is of a high quality. The Quality of Care Report gives us the opportunity to share with our community information about the services, achievements and challenges faced this year.

We take this opportunity to thank the numerous staff members and community members who have contributed to the content of this year's report.

We welcome and value your feedback on our Quality of Care Report and the services provided by PDH. Your views are vital in helping us plan future services and where we need to improve. You are invited to complete and return the feedback form at the end of this report. As a result of feedback received from last year's report, we have endeavoured to ensure this year's report is easy to read, with clear and easy to read graphs.

Clinical Risk Management & Quality Committee

Mr Jim Harpley	Board Member
Mr Ray Gilby	Board Member
Mr John O'Neill	Chief Executive
Ms Jo Lowday	Director of Nursing (resigned)
Ms Anne-Marie Scully	Acting Director of Nursing
Mrs Annette Hinchcliffe	Primary and Community Care Manager
Mrs Jenny Trenorden	Quality Coordinator
Ms Rachel Stoneman	Executive Administration

Distribution

3,000 copies of the Quality of Care Report were printed, with 2,000 copies distributed throughout the Glenelg Shire via the Portland Observer. Copies of the report are also distributed throughout PDH departments and GP and dental clinics. An electronic copy of the report is also available to download at PDH's website www.pdh.net.au

PDH Quality of Care Report is also available by request on audio. Please contact Administration on (03) 5521 0322.

Reports are included in information packages for prospective employees and distributed at the Annual General Meeting.

Contributors

Jenny Trenorden, John O'Neill, Natalie Herbertson, Gaynor DenBoer, Donna Eichler, Carolyn Malseed, Karen Madden, Heather Sayner, Anne Burley, Barb James, Annette Hinchcliffe, Jacki Barnett, Loren Drought, Rick Bayne, Ros Jones

These are an example of key achievements we are proud of:

- PDH receives its second gold star award in risk management - *page 10*
- PDH gains Australian Council on Healthcare Standards accreditation for four years - *page 10*
- PDH confirms its status as one of the cleanest hospitals in Victoria - *page 13*
- Health Minister's Volunteer Awards - Faith Sutterby - *page 8*

Mr Andrew Govanstone
President Board of Management
Portland District Health

Mr John C O'Neill
Chief Executive
Portland District Health



I could not have been in a better place - excellent

Vision, mission and values of PDH

Vision To be a leading rural health service

Mission Portland District Health is dedicated to providing a safe and accessible health service responsive to community needs.

Values

Respect Is a willingness to show consideration to ourselves and others

Compassion Is to acknowledge each other's humanity with understanding and care

Partnership Is working together to achieve a common goal

Excellence Is aiming to exceed expectations in the provision of health care and making best use of our available resources

Equity Is about fairness, justice and endeavouring to do the right thing

Services at PDH

<p>Allied Health Services</p> <ul style="list-style-type: none"> Diabetes Education Dietetics Occupational Therapy Physiotherapy Podiatry Speech Therapy <p>Breast Care</p> <p>Community Health Services</p> <p>Community Nursing</p> <p>CSSD</p> <p>Dental</p> <p>Dialysis</p> <p>Emergency Medicine</p> <p>General Medicine</p> <p>Infection Control</p>	<p>Lymphoedema</p> <p>Maternity Services</p> <p>Operating Suite</p> <ul style="list-style-type: none"> Dental Procedures Ear Nose and Throat Endoscopy General Surgery Gynaecology Obstetrics Ophthalmology Orthopaedic Urology <p>Palliative Care</p> <p>Pharmacy</p> <p>Radiology</p>
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Keynote Improvements

- Portland Aluminium provides \$24,000 to set up an Emergency Transfer Fund to help family members follow younger patients to Melbourne
- Elaine Norton appointed as Cancer Link Nurse
- PDH receives its second gold star award in risk management
- Volunteers clock up more than 1,000 hours per month
- Mr UK Naidoo awarded the Fellowship of the Royal Australian and New Zealand College of Surgeons
- Installation of private patient phones and TV's completed
- Dr Deepti Rampal gains entry into the Fellowship of Royal Australian and New Zealand College of Gynaecologists
- Martin Starrick awarded the Albert Stokes Scholarship for Nursing
- Committee for Portland pledges support for helipad submission
- PDH gains Australian Council on Healthcare Standards accreditation for four years
- The Deakin University/Alcoa of Australia partnership for the Centre for Rural Emergency Medicine agreement is extended, providing \$300,000 over three years ending 31 December 2013
- Ophthalmic Surgery microscope purchased
- Fire panel and EWIS replaced in main hospital block
- PDH confirms its status as one of the cleanest hospitals in Victoria
- New Alaris infusion pump rollout
- Rollout of deteriorating Patient COMPASS Program
- Appointment of new Physician - Dr Anatoli Sobotchouk
- New chiller system installed with \$204,000 grant from Department of Health
- Health Minister's Volunteer Awards - Faith Sutterby joint winner of Outstanding Individual Achievement - Rural Health Service and our Telecare team was awarded joint winner of Outstanding Team - Rural Health Service
- Implementation of Maternity Safety Capacity framework
- Introduction of PEARL and HEARL Early Assessment Referral lines

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our community

Population Profile

The population of the Glenelg Shire in 2008 is estimated to be 20,871, of which 11,061 reside in Glenelg (Portland) Statistical Local Area (SLA) and 6,423 in Glenelg (Heywood) SLA. There has been a moderate population growth in Portland since Census 2006.

The revised estimated resident population (released August 2009), Australian Bureau of Statistics, indicated there were 5,563 males and 5,498 females residing in Portland.

Demographic Profile

The demography of the population is characteristic of rural Victoria in general.

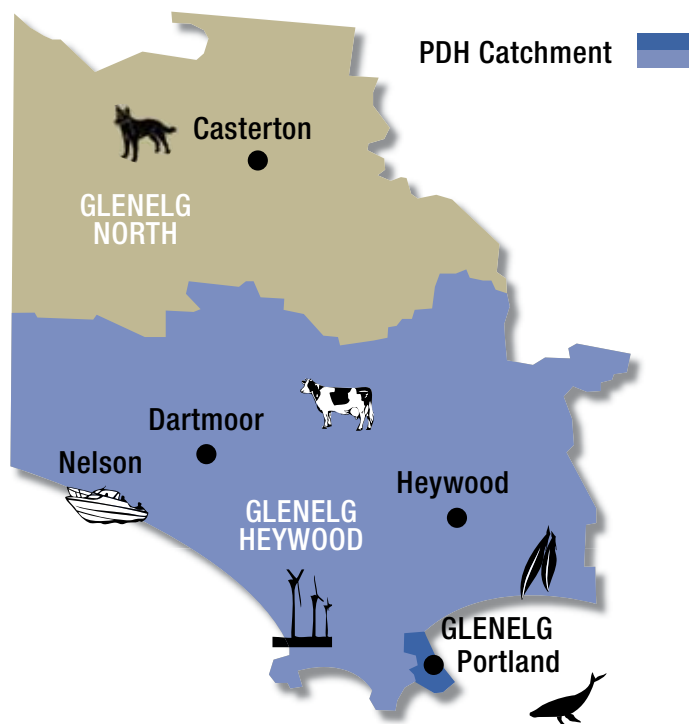
- There is a continuing decline in the number of children in the catchment population.
- Numbers in each age group up to 10 years of age is lower than in 2001.
- There has been a decline in the 15-19 age group and all age groups between 25 and 45 have declined which is a typical trend for rural Victoria as there is generally 'a dip' in the population of younger adults as they tend to move away from rural areas for tertiary study and employment opportunities.
- Conversely, all age groups over 45 years (with the exception of the 70-74 age group) have increased.
- The proportion of the population 70 years and over in 2001 was 9.91%. This is estimated to have increased to 10.9% (1,819 person) in 2006.

The Indigenous population in the Glenelg Shire has increased from 194 to 359 from Census 2001 to Census 2006.

The majority of our population speaks English only at home; Dutch, German and Italian are the most common languages other than English spoken at home. Overall, the population is ageing consistent with the ageing of the population across rural Victoria. This is a significant factor in the expected increase in demand for health services, particularly services that support and maintain the health of the frail elderly in the community.

The 2006 Census saw an increase in manufacturing such as Portland Aluminium, Keppel Prince and the Port of Portland which are among the top employers in Glenelg Shire, but saw a decrease in agriculture, forestry and fishing.

The development of these companies and others will have a significant bearing on the population and future health requirements of the area. Flexibility to meet changing needs will therefore be an important component in planning for our health service in the future.



Portland is located in the Glenelg Shire in South Eastern Victoria



I could not have been treated better anywhere else in the world

consumer, carer and community participation

Consumer Feedback

At PDH we value our community's feedback, as the information provides us with an insight into your experiences whilst in our service and is used to improve the care and services we provide. We monitor our consumer feedback externally through the Department of Health Victorian Patient Satisfaction Monitor (VPSM) and internally by feedback brochures, family meetings, face to face conversations, complaints and compliments received.

As part of her role the Quality Coordinator ensures complaints are managed to the complainant's satisfaction. This may include reviewing processes, practices and procedures at PDH.

During 2010/2011 financial year, 38 formal complaints were received at PDH. An increase of 9% on the previous year.

PDH aims to have all complaints closed within 30 days. As a result of greater emphasis on managing complaints we have seen an increase in response time and we will continue to work with our customers to continually improve our performance. During the 2010/2011 year, 98% of complaints were closed within the 30 day timeframe.

Victorian Patient Satisfaction Monitor (VPSM)

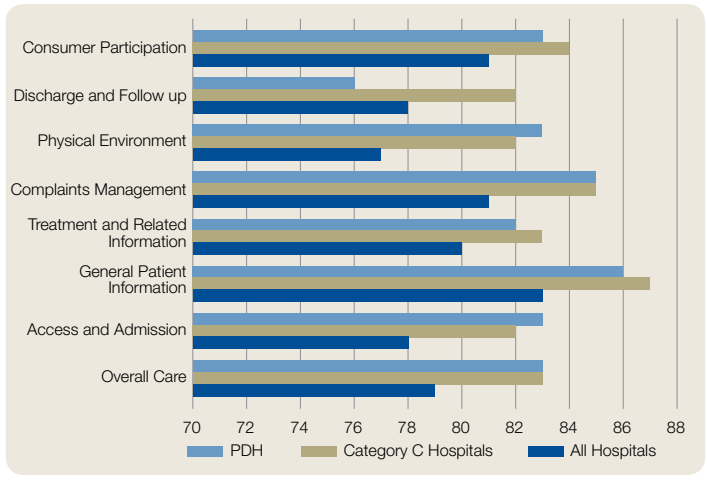
PDH continues to take part in the Victorian Patient Satisfaction Survey (VPSM) conducted by Ultra Feedback for the Department of Health.

Consumers who have been discharged home from hospital are asked a number of questions relating to their experience at PDH including such areas as admission, participation, complaints management, physical environment, general information and overall care.

The purpose of VPSM is to assist hospitals in identifying strategies that can improve services and patient satisfaction. The latest VPSM results have confirmed that PDH is taking good care of patients, with consistent ratings of more than four out of five.

PDH has performed better than the state average in all major categories of physical environment, complaints management, access and administration and overall care.

Once results are collated PDH receives a report comparing us to our peer hospitals and state results. PDH is benchmarked against 16 other Category C hospitals. The table below compares our results against other Category C hospitals and state results in the key performance areas.



Areas identified requiring improvements from this report were discharge and follow up and noise on the wards. These issues have been forwarded to the relevant departments and are currently being reviewed.

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Consumer Participation

The Victorian Government introduced a new comprehensive suite of participation standards. This document is called "Doing it With Us Not For Us" as a result of their commitment to involving people in decision making about health care services. Participation in health is an essential principle of health development, clinical governance and community capacity building.

It is well documented that people who take part in decisions concerning their health care often have:

- An improved quality of life
- Get well faster, and
- Have a better experience of care.

Participation occurs when consumers, carers and community members are meaningfully involved in decision making about health policy and planning, care and treatment and the well being of themselves and the community. Across all areas of PDH, consumers are actively involved in their health care, which may include family meetings and care plans.

In relation to the 'Doing it With Us Not for Us' policy, PDH has commenced working through the policy to address the standards.

Towards the end of 2010 PDH conducted an advertising campaign in an attempt to recruit members to form a community participation committee but there was a poor response and consequently a further recruitment drive is planned 2011-2012.

Cultural Awareness

PDH has a relatively low number of culturally diverse clients. However, PDH has systems in place to ensure all care and services are provided in a culturally sensitive and appropriate manner for all people from culturally and linguistically diverse (CALD) backgrounds.

Raising staff Awareness of Indigenous and Cultural Needs

PDH has in place a Cultural and Linguistic Diversity Plan (CALD) which includes the local Koori people and also is presently looking at the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP). With this in mind a staff member from Dhauwurd-Wurrung Elderly and Community Health Services (DWECHS) attends our monthly Orientation program for new staff providing important and interesting information on Cultural awareness.

In addition to this PDH staff present a one day training session for DWECH staff, this training includes infection control, basic life support, quality systems and fire training. This provides the opportunity to exchange information and share ideas to enhance cultural awareness and develop relationships.

PDH staff and patients have access to telephone interpreting services with supporting policy and procedure documents on how to access the service to ensure communication between all parties is possible.

PDH has a widespread employment of health professionals from a variety of cultures, these include India, Sri Lanka, Lebanon, Jordan, China, Korean, South Africa, Zimbabwe, Indonesia, Philippines, Yugoslavia, Argentina, Syria, Namibia, Ukraine, Canada and Fiji.





I have nothing but praise for all the Hospital staff

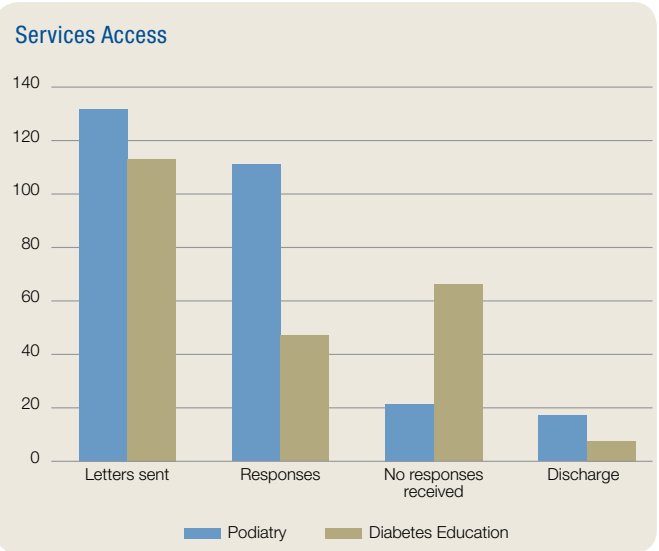
Service Access

Stemming from the appointment last year of a Service Access Coordinator, also referred to as an intake worker, a gap was identified in which there was no recall system for future appointments. For example with the Diabetes Educator, most appointments were when a client was experiencing problems and in some cases they had not made contact with the Diabetes Educator for several years.

Preventative care is very important for people with diabetes. A real need was identified for people with diabetes to return on a more regular basis as treatment and equipment often changes. A reminder letter was drafted which outlines the reason why follow up assessments are important, and recommending an appointment. These visits are in conjunction with the normal check up clients have with their GPs.

Diabetes educators have been delighted with the response because it provides the opportunity to discuss other issues such as foot health, diet and eye appointments on a regular basis.

Podiatry clients also benefit from the recall system. The podiatrist, together with the client, decides on the length of time between appointments and a recall letter is generated at the appropriate time. Response rate is very high for this service.



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Volunteers

PDH volunteers provide invaluable support to a range of programs we offer the community. Currently we have about 250 volunteers registered at PDH who contribute on average 1,273 hours per month; this has been an increase of 100 hours per month from last year's average. We acknowledge and appreciate their considerable contribution to improving the lives of people to whom we provide services.

Awards of Recognition

PDH values the work of our volunteers. The fantastic work contributed by our volunteers was recognised this year at the 2011 Minister of Health Volunteers awards, where Faith Sutterby was awarded joint winner of Outstanding Individual Achievement - Rural Health Services and our Telecare team was awarded joint winner of Outstanding Team Achievement - Rural Health Services.

Hours of Volunteer Service



A number of initiatives have taken place this year:

- Volunteers take part in Palliative care education to support palliative care patients.
- Work is being undertaken on easy identification of your volunteer, all new volunteer identification will be printed on yellow cards.
- Work is currently being undertaken on easy identification of our volunteers, all new volunteer identification is being printed on yellow cards.
- Volunteer pamphlet and information handbook has been developed.

Years of service - Volunteers 2011

20 Years

Dorothy Williams
Selwyn Williams

15 Years

Eunice Brunt
Jill Caldwell
Syd Cuffe
Des Davies[†]
Lynne Newby
Hazel Stevenson
John Taylor
Valerie Taylor
Mick Twomey
Carol Walder
Kyeema Centre Inc
Lions Club
Lions Ladies
St Stephen
Mothers Union

10 Years

Noeleen Flower

5 Years

Lois Bothe
Laurie Duro
Elaine Evans
Neville Gates
Lyn Goodes
Lesley Holmes
Margaret McGregor
Peter McGregor
Dawn Millard
Jeanie Nevin
Monica Saunders
Joy Stiles
Bernie Stiles

[†]Deceased



How lucky are we to have Dr Mario Penta visiting Portland

quality and safety

What is Quality, what does it mean?

Quality of Care is about processes, structures and outcomes in a health care setting. Good quality care is safe, effective, timely, efficient, easily accessed and patient centred.

Community and clinicians may value different aspects of quality care, clinicians focus on results of clinical care and consumers consider aspects relating to timeliness, access, and communication but they all agree that the key to providing quality health care service is about offering skilled and competent staff and a clean, safe and welcoming environment.

Clinical Governance

Clinical governance in Australia has been defined as “the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care” (Australian Council on Healthcare Standards, 2004).

The Department of Health released the Victorian Clinician Governance Policy Framework in 2009 to all public health services to implement. We continue to use this framework as a guide to ensure we have systems and processes in order to ensure safe and effective care to our community.

The Board of Management of PDH has established a number of committees to ensure a safe and effective workplace. The committees are:

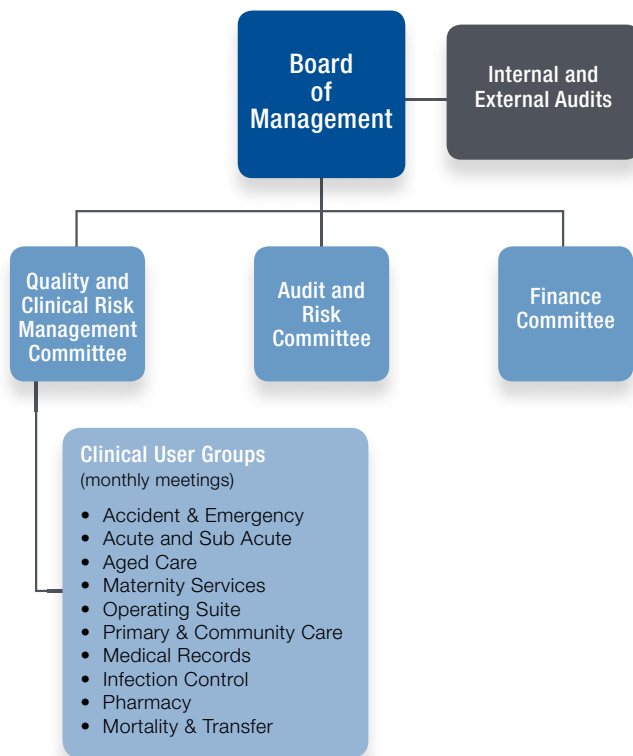
- Audit and Risk
- Finance
- Clinical Quality and Risk Management

The Clinical Quality and Risk Management primary function is to assist the Board of Management to ensure a high standard of health care, a continuous improvement of service delivery and to maintain an environment that supports clinical excellence at PDH.

Limited Adverse Occurrence Screening (LAOS)

PDH continues to be involved in the LAOS program which is an education tool and peer review for medical and nursing staff. This program is specifically for small rural hospitals. De-identified medical records are sent for review by GPs in rural Victoria. In Victoria 71 small rural hospitals sent a total of 1,401 records to the reviewers - 77 learning opportunities and 63 recommendations were finalised. There are six selected criteria and the most records reviewed are for the “transfer to another hospital” followed by “unplanned re-admission within 28 days”.

Across the Otway Division 258 records were received from 12 participating hospitals. PDH reviews the recommendations and uses lessons learned by others to enhance the care we provide. The outcomes are discussed at a monthly meeting to ensure appropriate changes are made and implemented.



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A Safe Workforce

To provide the best possible care to patients and clients, PDH ensures all staff are appropriately trained and qualified for the position for which they are employed. The Human Resources Department verifies the following for all new and existing staff:

- References checked.
- Registration, qualification and skills.
- Police checks undertaken for all new staff, students, volunteers, and every three years for existing staff.
- Staff present current practising certificates or registration annually.
- Yearly staff appraisals.

The Board of Management has the responsibility of overseeing the credentialing, privileging and appointment of medical staff. Credentialing procedures as determined by the Department of Health are used to verify qualifications of all medical staff at PDH and to establish their scope of practice known as privileging, or simply put, ensuring the experience, skills and qualifications stated by any new medical officer is true and correct.

Risk Management

Part of delivering high quality health care for our community is ensuring our staff are appropriately trained and skilled in the process of risk identification and risk management. Reporting incidents that occur and then subsequently learning from them is an important part of risk management. We place great importance on understanding the cause and the impact of a risk and the controls that are documented to reduce the likelihood and the consequences of a risk occurring in the future. Risks are placed on a register as they are identified and accountability is assigned to staff members who are in a position to make effective changes.

VMIA site risk report - Gold Medal Rating Awarded

PDH has been awarded a Gold Medal for risk management procedures for the second successive year. The award was received after a site risk survey was undertaken on behalf of our insurers, the Victorian Managed Insurance Authority. No high priority risk issues were identified. Those identified were of medium to low priority and are systematically being addressed.

Australian Council on Healthcare Standards and Accreditation

The Australian Council on Healthcare Standards is an Independent, not-for-profit organisation dedicated to improving the quality of health care in Australia through the continual review of performance, assessment and accreditation. The principles upon which all programs are developed reflect the characteristics displayed by an improving organisation. These principles are:

- A Consumer Focus
- Effective Leadership
- Continuous Improvement
- Evidence of Outcome
- Striving for Best Practice.

There is a four year Quality Assessment and Improvement program for Health Services. In August 2010 PDH underwent an organisation-wide survey and was awarded a four year accreditation rating. In July 2011 PDH completed a self assessment and in August 2012 there will be a periodic review on site during which PDH will be surveyed against 15 mandatory criteria and progress made on the recommendations that came from the 2010 organisation-wide survey.

There were 13 recommendations for improvement from the last survey most of which have already been acted upon and some continue to be addressed. These recommendations included:

- A policy be developed to prioritise surgical waiting list management - *in progress*.
- Continue with auditing of identification documentation of blood collection samples for pathology appraisal to ensure quality and accuracy of the patient's details on the sample - *addressed*.
- An external security audit is conducted by a qualified person to provide future direction for the security program - *completed*.

Preventing and Controlling Healthcare Associated Infections

The aim of the Infection Control Department at PDH is to provide a safe and healthy environment for patients, visitors and staff. To assist in the provision of quality care the Infection Control Department focuses on preventing transmission of infections, monitoring and investigating spread of infection and continually educating staff on up to date best practices. PDH has achieved favourable results through many areas of the comprehensive Infection Control Program.



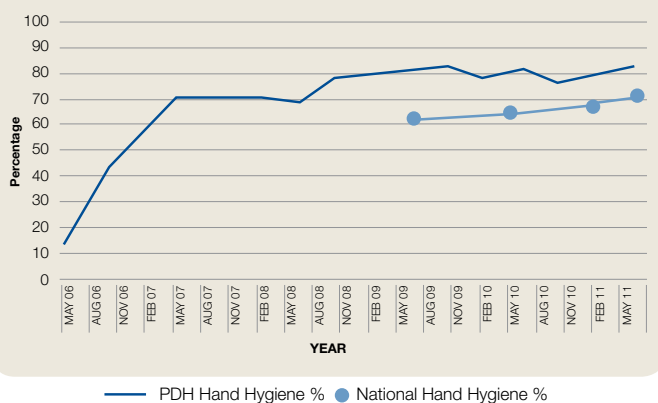
Friendly competent staff made me feel I was getting the best possible treatment

Hand Hygiene

Hand hygiene has been shown to be the most effective method of reducing transmission of infections. PDH has been actively involved in the global hand hygiene initiative called the Five Movements of Hand Hygiene. Staff are observed performing their daily care duties and hand hygiene practices noted. PDH has consistently achieved compliance scores above the national average.

Education and competency needs pertaining to Hand hygiene are provided via the Hand Hygiene Australia Online Learning Package. This package can be accessed by staff at work or at home and is a mandatory learning package for all clinical staff. Visitors to PDH are also assisting in reducing the transmission of micro organisms in the facility. Alcohol hand rub products are available for use at all entrances to the facility with highly visible requests for use. High product usage indicates that this has been a valuable addition to the hand hygiene program.

PDH Hand Hygiene Compliance



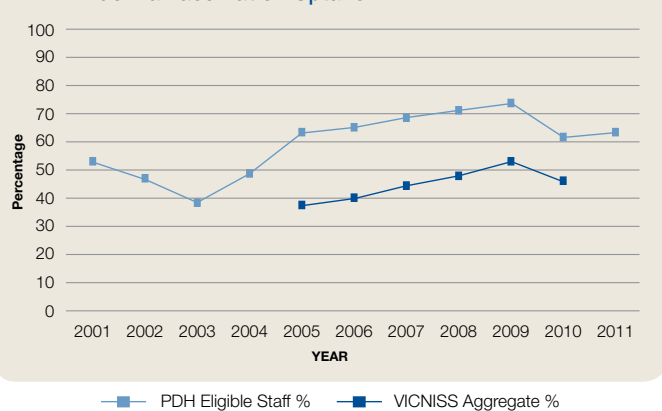
Staff Health

Health care workers are at high risk of exposure to vaccine preventative diseases such as Influenza. Providing vaccines to all staff is one measure used at PDH to prevent the transmission of Influenza to and from health care workers and patients.

PDH provides Staff Influenza Vaccination Clinics and also a mobile vaccination service that this year resulted in PDH having 64% of staff vaccinated.

PDH has consistently achieved compliance greater than the state average in this area.

PDH Influenza Vaccination Uptake



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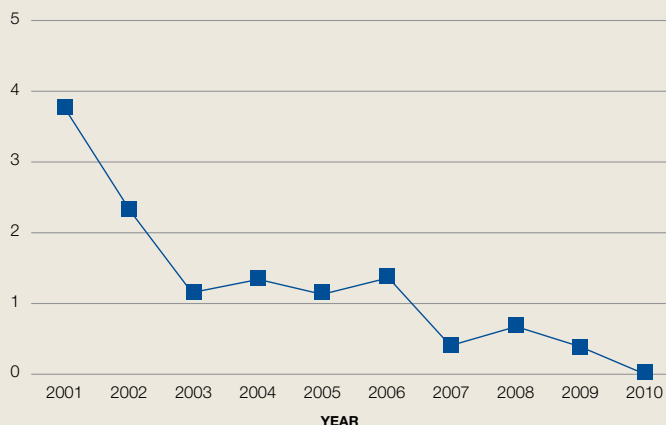


Surgical Site Infection

In Australia surgical site infections are the second most common type of adverse events occurring in hospitalised patients. These infections can cause increased hospitalisation, disfigurement, long term disability and are a financial burden on the health service.

Surgical site infections are reported monthly by health care facilities to VICNISS Healthcare Associated Infection Surveillance Co-ordinating Centre using their surgical site infections guidelines. Portland has not had a reportable surgical site infection since October 2009.

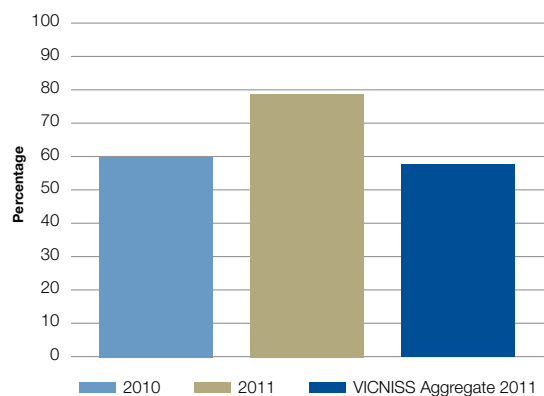
PDH Hospital Acquired Surgical Infections



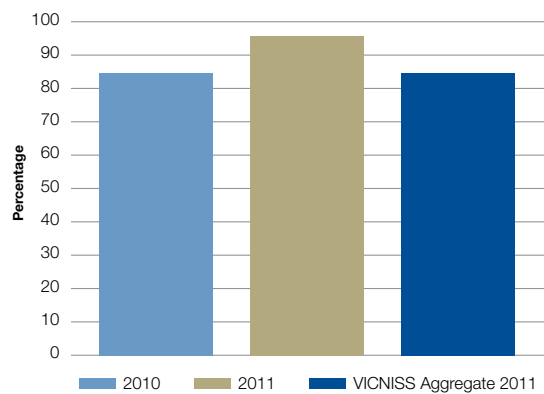
This impressive outcome in the above graph is due to multi-department initiatives that include:

- High level compliance with hand hygiene.
- Appropriate hair removal from surgical site.
- Use of air warmed blanket in theatre department to ensure the patient's temperature is maintained or returned to within normal limits as soon as possible.
- Appropriate use of prophylactic antibiotics (see audit results).
- Prophylactic antibiotics are used to prevent surgical site infections in those procedures deemed to be at high risk. To ensure these antibiotics are most effective the drug of choice, timing of administration and duration of use is critical. PDH audits and reports the appropriateness of prescribing to VICNISS (see audit results below).
- High level compliance with cleaning audits.

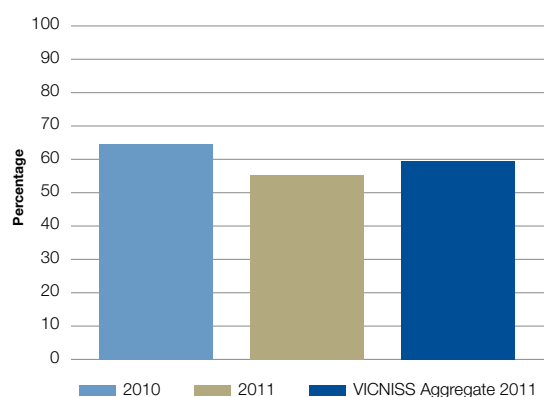
Antibiotic Choice Compliance



Antibiotic Duration Compliance



Antibiotic Timing Compliance





We've really hit a benchmark - it's hard to go much further but we have the challenge ahead of us in trying to maintain this level in the future

Barb James
(Environmental Services Manager)

Safe Food Practices

In August 2010 the Department of Health requested health care facilities to review food safety plans in response to an increase in the number of reported Listeria infections.

Listeria infection is caused by eating contaminated food and those particularly susceptible to this illness are the elderly, those with a weakened immune system from illness such as cancer, leukaemia, diabetes and pregnant women.

An action plan was developed to review processes with input from multiple departments:

- Dietetics reviewed the menu plan for identification and replacement of high risk foods.
- Health Promotion reported that this issue was already a focus of local school and community awareness programs through articles in newsletters and the local newspaper.
- Midwifery department reviewed information on Listeria supplied to pregnant women through the anti natal program.
- Hotel Services reviewed the PDH Food Safety Plan to ensure temperature control evidence could be verified at each step in food processes right through from food transportation to the hospital to delivery of food to the patient.
- Alert stickers were introduced to notify staff and patients of high risk foods that must remain refrigerated.
- All food refrigerators are monitored for temperature control to ensure safe storage of food to make sure patients and staff are not at risk of food borne illnesses.

Cleaning

Not only does PDH look clean - an independent audit has proven that it is clean. PDH recorded a near perfect score for cleanliness when external auditors "Cogent Business Solutions" visited the facility and conducted the audit in 2011.

The audit score recorded by the hospital was 99.5. It is the highest score recorded by the hospital in an external cleaning audit with all credit going to the environmental services working team of 20. It was a fantastic improvement on the impressive 2010 result of 98.9, an achievement that the entire team is very proud of.

The figures confirm that PDH is one of the cleanest hospitals in Victoria. The environmental services team has an excellent cleaning regime that enables the hospital to achieve such a high standard. PDH achieved outstanding scores in all functional area risk categories.

Risk Categories	Score
Very High Risk Areas: <i>e.g. CSSD, Theatre, ICU, Invasive Procedure Areas</i>	99.7
High Risk Areas: <i>e.g. Nursing Units, Treatment Rooms, Emergency Department, Pharmacy</i>	99.4
Moderate Risk Areas: <i>e.g. Pantry, Residential Areas, Pathology, X-ray, Public Areas</i>	99.6
Low Risk Areas: <i>e.g. Administration, Non-sterile Supply, Engineering, External surrounds</i>	n/a

The cleaning standards Acceptable Quality Level (AQL) for all high Very High Risk Departments is a score 90.

The cleaning standards Acceptable Level (AQL) for all other Risk Areas is a score of 85.

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Medication Safety

Medications are one of the most common areas of error in a hospital. Safe delivery of a patient's medication is an extremely important part of any stay in hospital. Our dedicated hospital pharmacists are committed to the safety of patients and accuracy of medication.

The introduction of a Medication Reconciliation Form (M.R.F.) during 2001/2011 has meant that information regarding a patient's medication is compiled upon admission by the clinical pharmacist.

The data recorded includes checking all medications which the patient may have brought from home, obtaining a current list from the patient's community pharmacy (after the patient has given their verbal consent) and clarifying times of administration with the patient or carer. These sources of information are pooled together in the reconciliation process.

The use of complementary medications is also included on the M.R.F. thus a comprehensive, current and accurate medication history is recorded by the clinical pharmacist. The M.R.F. is a valuable communication tool as it is utilised throughout the patient's stay to record any medication changes such as addition of a new drug or cessation of a drug which have been written on the medication chart by the prescribing medical practitioner.

The use of M.R.F. and accurate history taking provides pharmacist's input to the patient's quality of care and safety. If necessary, pharmacists may intervene and they can prevent medication omissions and possible errors during a patient's stay.

By Knowing the '5 - Rights' you can help us reduce errors:

1. Right person
2. Right medication
3. Right dose
4. Right route
5. Right time

Reporting any incidents or near misses can help us develop ways to prevent it happening again. This table compares our four common types of medication incidents.

	Total Number of Incidents Reported	% of total Incidents
Omitted Dose	8	11%
Documentation	10	14%
Wrong Dose	24	35%
Wrong Drug	12	17%

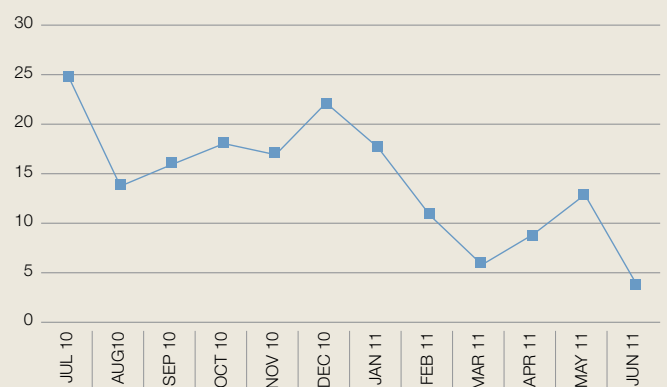
Preventing Falls and Harm from Falls

We monitor falls across the whole organisation. All falls are reported on our incident reporting system VHIMS and these are automatically forwarded to the Department of Health. PDH staff conduct a falls risk assessment. This identifies those at risk and enables staff to take preventative action to reduce the risk with due consideration given to the level of independence of patients and residents.

Preventative actions include:

- Implementation of appropriate equipment such as high/low beds, sensor beams and mats, ID arm bands.
- Referrals are made to allied health professionals (physiotherapy, occupational therapy) where appropriate.
- Appropriate footwear.

Falls across all departments





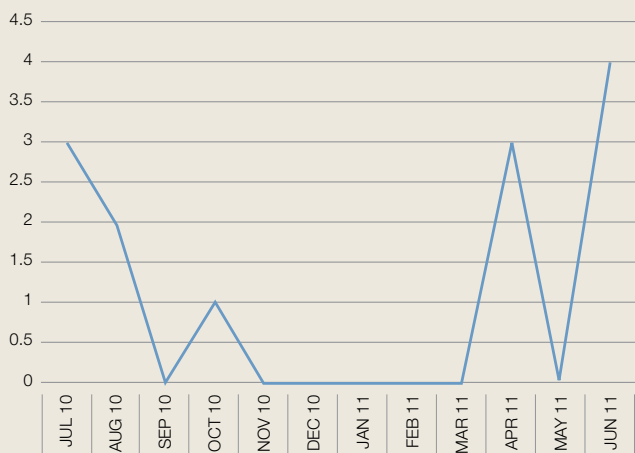
Post operation care was excellent by staff and doctor

Preventing and Managing Pressure Injuries

Pressure ulcers (pressure sores or bed sores) are an area of skin, usually occurring over bone areas such as heels, toes, and buttocks, that has been damaged due to unrelieved pressure. Pressure ulcers or bedsores are a common problem in hospitals, and are internationally recognised as one of the five most common causes of harm to patients. Patients at the greatest risk of developing pressure ulcers are those who are frail, elderly or immobile for long periods.

All pressure ulcers at PDH are monitored using the Waterlow Pressure Ulcer Prevention/Treatment form, located in all patients' bedside folders.

Pressure Ulcers



Safe Use of Blood and Blood Products

Our Transfusion Trainer Nurse continues to be at the forefront of ensuring our Blood Transfusion practices continue along best practice guidelines and ensure all our staff are educated on the taking and administration of blood and blood products.

A recent audit conducted by the Department of Health Blood Matters and Blood Safe program identified three issues requiring consideration.

As a result of recommendations to address the issues we have adopted improved systems across the organization. All fridges are monitored and have a failsafe system, an alarm is fitted to all fridges storing blood products.

The following policies and procedures have been updated:

- Blood and Blood Products Administration
- Blood Transfusion Reaction
- Platelet Transfusion
- Albumin Transfusion, and
- Fresh Frozen Plasma and Cyroprecipitate.

With the introduction of the Deteriorating Patient Program COMPASS, an internal audit has identified that we need to update our Blood Transfusion Medical Form.



Dental Services

Dental Services has seen many challenges over the past year.

Up until April of this year the dental clinic has seen 1,351 individuals equating to 2,760 visits. Our waiting list for general care increased during the year to about 18 months; however with the recruitment of a full time dentist we have reduced the waiting list to 14 months. Our denture waiting list has reduced by two months to 21 months. Both the restorative and denture waiting lists meet the state-wide targets Our denture waiting list has reduced by two months from 23 months as of July 2010 to 21 months in April of this year. Both the restorative and denture waiting lists are below and meeting state-wide targets.

Early in May 2011 two of our dental team undertook mobile dental checkups for pre-school and primary school children in the Heywood community. This was done on a trial basis in collaboration with Heywood Rural Health. A total of 23 children were seen during a day at Heywood Rural Health. Appointments were scheduled at the PDH clinic for any children who required additional dental work. The day was deemed as a success by all parties and an expansion of this type of service is being considered.

The Dental Clinic is continuing to provide a service to all pre-school and primary aged children and anyone above this age group who holds a current Health Care Card or Pension Card.

Dental Clinical Quality Indicators

	No. Treated	No. Returned
Repeat Emergency Care within 28 Days	544	37
Restorative retreatment within 6 months	1,727	48
Unplanned return within 7 days of extraction	491	5
Endodontic retreatment within 6 months (repeat endo treatment)	28	0
Endodontic retreatment within 12 months (by extraction)	39	1
Fissure Sealant retreatment by repeat sealant - within 2 years	745	30
Fissure seal retreatment by multiple treatment modes within 2 years	745	30
Pulpotomy retreatment by extraction within 6 months	66	1

Service Performance

	Actual	Target
Individuals treated	1,612	2,499

Access Performance

	Actual	Target
Adults General Wait List - waiting time (months)	15.9	23.0
Adults Denture Wait List - waiting time (months)	23.2	22.0
Adults Denture Wait List - high priority - waiting time (months)	0.6	3.0



The nursing staff are the best in Australia

Education

Our Education Department continues to support the education and up skilling of our staff. All staff continue to do mandatory training using our on line education program - SOLLE. Learning packages on SOLLE are continually reviewed and updated to reflect current PDH practices.

Clinical Skills Update

A skills update for clinical staff are held monthly. During the year a clinical staff survey was conducted by the educational department, asking staff what areas they would like to receive further education in. As a result of this survey training days have been conducted on respiratory, bowel and neurological assessment.

Learning from Body Parts

A full body mannequin, an arm, a pelvic area and babies of varying descriptions are helping staff at PDH to learn. Thanks to support from local groups several new items have been added in recent months. The mannequins provide realistic simulation opportunities for staff.

A new full body mannequin is allowing full simulated scenario training. The mannequin is connected to a computer, which allows staff to practice all the basic nursing skills along with some more specialised and advanced skills.

Alaris Infusion Pump

Alaris Infusion pump systems were purchased to replace obsolete equipment. This system has an inbuilt "brain" and the most used intravenous drugs are programmed into it to further enhance patient safety. The pumps have a battery backup so if a patient is moved to another area the infusion is not interrupted. The concentration and rate required for IV medications are already stored in the pump, this decreases the incidence of error when administering. The new system has a built in alarm system which indicates problems and has an alerts program, if extra information is needed e.g. blood results prior to the infusion commencing.

The Education Department along with company representatives provided education to relevant clinical staff. A review of paperwork, policies and procedures were undertaken and amended as required.

Roll out was the second week in February, when the pumps were physically changed over.

The Operating Suite is looking at a different system due to different needs required in Theatre.



Deteriorating Patient COMPASS

The aim of the Early Recognition of the Deteriorating Patient Project was to implement a framework that ensured the early recognition of deteriorating patients, the initiation of appropriate medical review and the instigation of timely medical management to reduce the morbidity and mortality of patients.

A number of Australian wide programs were investigated with PDH finally settling on the ACT Health COMPASS program that offered a comprehensive system that has been successfully implemented in both large and small sized hospitals across Australia.

It is based around the patient observation chart with six vital signs (previously four) being:

- Respiratory rate
- Oxygen concentration
- Temperature
- Blood pressure and heart rate
- Sedation score
- Urine output.

These signs were selected as they are most indicative of a deteriorating patient.

All vital signs are given a score 0-3 and then totalled. This is referred to as the MEWS Score (Modified Early Warning Score). The clinicians then develop an action plan depending on the score. This gives increased empowerment to the nurses when contacting medical practitioners who understand quite clearly why they are being contacted and the time frame in which the patient is to be reviewed.

The program was rolled out in June 2011; this included removing all previous observation charts and education of clinical staff. An evaluation of the program will be undertaken in three and six months after commencement. PDH has implemented the COMPASS model with permission from "ACT Health COMPASS".

Specialist areas such as theatre are using the concept of COMPASS to review and update their paperwork, but tailored the concept to their needs. This will still ensure the deteriorating patient is identified quickly, effectively and with notification to medical staff in a timely manner.

The COMPASS program also includes new observation charts for children. this includes 0-3 months, 3-12 months, 1-5, 5-12 and 12-17 years. This grouping of age is due to normal range observations changing over time as we age. The scales on these charts match the age group and allow meaningful observations and timely actions to be taken.



I have had the bad luck to have been in many hospitals and Portland's staff reign supreme



continuity of care

Palliative Care

The Palliative Care Team consists of a Specialist Palliative Care Nurse, a General Practitioner with a special interest and training in palliative care, a Volunteer Co-ordinator and specially trained palliative care volunteers.

This team is supported by a sub regional team in Warrnambool consisting of a Palliative Care Clinical Nurse Consultant, a Palliative Care Physician, a Psychologist and a Palliative Care Counsellor.

These teams work in conjunction with primary care practitioners such as General Practitioners, Nurses, Allied Health and Community Services.

They provide specialist palliative care that includes physical, psychological, social and spiritual assessment and management.

The Portland team has been actively involved in improvement projects such as:

- The Link Nurse provides palliative care education to nurses in Aged Care.
- Completing the National Standards Assessment Program (NSAP) which has rated the local service against the 13 National Standards for the delivery of Palliative Care in Australia.
- The introduction of assessment tools to improve symptom management and patient outcomes.
- The introduction of e-records to replace the existing paper records and improve communications between all health providers.
- The continued support of advance care planning to ensure that patient and family wishes are met.
- The eight week palliative care training of volunteers to assist patient/family support in the community.
- Participation in the annual Victorian palliative care satisfaction survey sent to clients/carers and bereaved carers.



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Health Promotion

Living Safer Sexual Lives

In partnership with the Department of Health and La Trobe University, PDH's - Health Promotion unit delivered the Living Safer Sexual Lives program. The project aimed to use life stories contributed by people with intellectual disabilities to provide the following:

- A contribution to the understanding of the lives of people with intellectual disabilities and the society in which they are living with a particular focus on sexuality and relationships.
- Workshops which are based on real stories and aimed to assist people with intellectual disabilities to live safer sexual lives.
- Workshops for families and service providers which educated them about how people with intellectual disabilities saw their sexuality and relationships.
- Providing resources to people about safe sexual practices and their rights.

The program was very well received, with more than 70 parents, people with disabilities, support staff and health service providers attending.

Food Security

In some areas of the Glenelg Shire finding regular fresh fruit and vegetables isn't always easy.

Food security is a priority area for the Health Promotion Unit at PDH. As the lead agency addressing food insecurity issues across the Glenelg and Southern Grampians Shire, PDH is committed to improving local access to nutritionally adequate food through socially and culturally acceptable means.

In partnership with the Southern Grampians and Glenelg Primary Care Partnership and its member agencies the Food Security Working Group has conducted a 12 month comprehensive research project to investigate the availability and affordability of food across the catchment area and to understand community experiences of food insecurity. Communities across the Glenelg Shire were eager to take part with 293 households completing the food access survey and 41 people attending discussion groups, including local service providers. These findings are detailed in a report available on the PDH website entitled Southern Grampians and Glenelg Community Food Security Needs Assessment.

A range of projects are in the planning stages and are set to roll out from late 2011 to 2012. These initiatives include the development of a local guide to food and nutrition projects and services, group education sessions focusing on budgeting and shopping for healthy food, and setting up social cooking groups such as community kitchens.

The Health Promotion Unit worked in partnership with Loaves & Fishes, the local emergency food relief agency, and Aspire - A Pathway to Mental Health, to successfully pilot the Doorway to the Future program. Participants learnt practical tips to budget and shop for healthy food and cook healthy low cost meals in a social, welcoming environment.



The attention,
level of care
and food were
exceptional

Hospital Admission Risk Program (HARP)

It assists clients to have their health care needs met in the community and receive the right care in the right place at the right time. Clients are assisted to better understand their condition and become involved in monitoring and management.

A number of audits and surveys are conducted throughout the year, highlighting clients' satisfaction from the program. Evidence of the success of the HARP program is shown below which shows a reduction in admissions since the introduction of HARP.

Clients with a Chronic Illness	Pre HARP	Post HARP
ED Presentations	83	31
Hospital Admissions	54	27
Length of Stay	307	139

Longer Stay Older Person (LSOP)

PDH continues to be actively involved in the Department of Health's - Longer Stay Older Person Program. As part of this program a best practice initiative was implemented with a new coloured serviette system.

Patients receive a serviette on their meal tray, a different coloured serviette allows kitchen and nursing staff to identify how much assistance each patient requires.

- White - indicates that the patient is independent
- Yellow - assistance is required setting up the meal and opening small packages
- Blue - patient requires full assistance.

Another initiative implemented is the Cognitive Impairment Identifier (CII). This program was developed by Ballarat Health Service. A symbol is placed at the patient's bedside and notes if the patient has a cognitive impairment. This symbol allows staff to identify immediately if the patient has a cognitive impairment and allows them to communicate efficiently and effectively. All staff have been trained in communication skills to assist those with memory and/or thinking problems.

Emergency Helipad Landing Site

In April 2009, the former State Government announced an upgrade to Victorian ambulance services and the addition of two new medical helicopters including one based at Warrnambool. The cost and construction of emergency helicopter landing pads was left to local communities on the understanding that the landing pad meets Department of Health guidelines.

In December the newly elected Baillieu Government's Minister for Planning amended the Glenelg Planning Scheme to enable the construction of an emergency helipad landing site on the "Ploughed Field" in Portland.

At the time of writing this report, PDH is awaiting formal approval of our development submission and approval from the Department of Sustainability and Environment for coastal management consent to proceed to construction.

PDH is indebted to the Committee for Portland for its assistance and expertise in assisting PDH with the preparation of the formal planning submission and its generous financial support to meet the costs of PDH's submission to the Department of Planning and Community Development.

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GP Super Clinic

In collaboration with our partners, Deakin University, Otway Division of General Practice and Southern GP Training construction on the \$4.9M GP Super Clinic commenced in January 2011 and is scheduled for commissioning in April 2012.

The GP Super Clinic will bring together General Practitioners, nurses, visiting medical specialists, allied health professionals and other health care providers to deliver better health care, tailored to the needs and priorities of the local community. It will bring a greater focus on health promotion and illness prevention and better coordination between privately provided GP services, community health and other state government funded services.

During the year, PDH signed recurrent and capital funding agreements with Health Workforce Australia to expand the footprint of the GP Super Clinic to accommodate additional medical and nursing students. The Deakin Medical School sees the GP Super Clinic as an important teaching site with the capacity to enhance rural general practice. Preparations are underway to receive medical students from Deakin University in 2012.

Chemotherapy Unit

PDH provides support for nearly 200 cancer patients each year and Glenelg Shire experiences a higher than average incidence of cancer in both males and females. Consequently, the development of a day-stay chemotherapy unit at PDH will be a huge relief for an increasing number of local people battling cancer.

The centre will be part of a new cancer infrastructure across Western Victoria being built from \$26.07M funding announced by the Federal Government. The new chemotherapy day unit in Portland will supplement a new integrated cancer centre based in Geelong. The successful submission for funding was coordinated by Barwon South Western Regional Integrated Cancer Service in conjunction with Barwon Health, PDH, South West Healthcare and Western District Health Service.

The chemotherapy day unit will ease the travel burden facing cancer patients and it is planned to commission the unit in the first half of 2012.

PDH Rehabilitation Program

PDH now has 15 staff members both nursing and allied health who have successfully completed the Functional Independence Measure (FIM) training and examination.

The Functional Independence Measure is an outcome measure used within rehabilitation settings. The aim of this assessment is to establish the level of assistance a person requires, if any, to complete activities of daily living.

These activities of daily living include but are not limited to eating, grooming, bathing, walking, social interaction and problem solving. A total of 18 activities of daily living are rated using a 7-point scale. This scale is then used to rate a person's level of function, which can range between fully dependent to independent with no aids required.

This measure has been mandated state-wide for the purpose of standardising outcome measures used in rehabilitation settings.

This program was introduced in February 2011. From February to August 2011, 43 patients have been admitted with all having admittance and discharge FIM scores completed. The majority showed improvement with their scores and those who did not improve also did not show a decline.



our staff

PDH prides itself on the quality of staff committed to providing safe, professional care to all of Portland and the wider community.

The length of service of each individual contributes to the culture of knowledge and experience in the organisation as well as providing support and mentorship to a younger generation of workforce starting at PDH.

As testament to this, we acknowledge staff achieving significant milestones in their careers.

summary

This year's quality of care report demonstrates that quality activities continue at the forefront of all our endeavours.

It is very pleasing to report that the past 12 months has seen many solid advances made on all fronts to strengthen safe patient care. PDH's patient care services have been acknowledged in the results of the recent Victorian Patient Satisfaction Survey and the numerous letters and cards acknowledging the wonderful care received at PDH.

Our achievements this year are a credit to the hard work and commitment of all staff at PDH. Despite increasing patient numbers in many areas we still continue to meet set targets and maintain a high level of patient satisfaction. At the ACHS summation conference, the surveyors provided a very positive report card commending the excellent work undertaken so far and highlighting a demonstrated attitude and commitment to optimal care of patients/consumers.

In that commitment to optimal care, our staff are supported by a large number of community volunteers who dedicate their time freely in support of PDH. Volunteer support is offered in many and varied ways - from supporting patients, families and our staff to participation on the community advisory committee. A huge thank you must be extended to all staff and volunteers for their contribution over the past year.

Years of service

45 Years Marlene Duffy

35 Years Janine Duckmanton
Leanne Stuchbery
Chris Black

30 Years Elizabeth Anderson
Janine McIvor
Beverly Baker
Charlotte Murphy

25 Years Judith Noske
Patricia Cain
Veronica Dowden
Alison Brian
Ivor Graney
Lorraine Hiscock
Sheralee Radley
Myfanwy Maddox
Jennifer Moore

20 Years Catherine Radford
Jenny Matthews

15 Years Jacinta Watson

10 Years Penny Wallis
Gaynor Denboer
Anne Nunn
Anne Polkinghorne
Kevin Treloar
Rae Humphries
Jacki Carmody
Janet Gladwin
Joanne Brewster
Suzanne Hateley

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