



Bay of Plenty District Health Board  
**2013 Quality Account**



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# Welcome to Bay of Plenty District Health Board's 2013 Quality Account

*“Health is very much about people – the people who receive care and the people who give that care.” Bay of Plenty District Health Board Chair Sally Webb.*

It is with great pleasure that we present our first annual Quality Account. At Bay of Plenty District Health Board (BOPDHB) patients are at the very heart of everything we do. We work hard to continually improve our health service by collaborating with our staff, patients, family, whanau, carers and community.

This report demonstrates our commitment to providing safe high quality healthcare, shows how we monitor quality and safety, and how changes are made as part of a continuous quality improvement approach.

We have seen significant progress in promoting oral health, helping people to quit smoking, reducing the impact of diabetes and heart disease and increasing the number of older women who undergo a breast screen.

We have also worked hard to meet Ministry of Health targets such as improving access to elective surgery. The achievements, highlighted in this report, have been accomplished through strong leadership with a focus on patient and family participation, risk management and quality improvement systems. Such achievements also rely on building capacity by providing training and support for our staff.

These are only a few of many quality and patient safety initiatives that we continue to support. We are proud of our achievements but acknowledge there are still opportunities for improvement. In this report we also outline some of the priorities for improvement that will provide a focus for our quality and patient safety work in the coming year. These include a number of patient safety programmes that are operating as part of the national Patient Safety Campaign 'Open for better care'.

Others also reflect a growing understanding - at a local national and international level - about the important part that family can play in the ongoing well-being of patients and the medical decisions that may need to be made. Those who have received healthcare also provide a valuable resource in helping to shape our



**Phil Cammish**  
Chief Executive Officer



**Sally Webb**  
Chair

future.

## Our vision and values

### Values

CARE is the acronym of our values.

Compassion

Attitude

Responsiveness

Excellence



### Vision

Healthy, thriving communities  
*Kia Momoho Te Hāpori Ōranga*

# Leadership Statements

The Board and Executive are involved in overseeing the development and implementation of quality and patient safety activities at the BOPDHB, including those described in this Quality Account. We can attest that the content of this account is accurate and represents the quality performance over the past year as well as the improvement goals for the year ahead.

The content for this account has been developed in consultation with members of our staff who work directly within each of the featured programmes as well as with one of our Patient Advisors. We formed a 'Quality Account Working Group' which was responsible for determining the content and priorities. The group was comprised of the following:

- Manager and staff of the Quality and Patient Safety Team
- Patient Advisor
- Nurse Leader for Anaesthesia, Radiology and Surgical Services
- Planning Manager, Planning and Funding Service
- Manager for Decision Support Service
- Planning Manager for Integrated Healthcare
- Communications Advisor.

The account is divided into two main sections. Section One reviews our performance so far and Section Two describes our priorities for the coming year.

We endorse the efforts highlighted in this account, as a reflection of the ways in which we strive to treat you as an individual, to understand your experience and to meet your expectations of receiving expert and compassionate care in a clean, safe, friendly and comfortable environment. By listening to you, we've been able to make significant improvements to the care we give and we're including you in our decision making from the top of the organisation down.

We hope you enjoy reading our 2013 Quality Account and find it informative and interesting.



## Keeping you in the loop

The Quality Account will be published on our website and can be located under: Your DHB > A-Z Publications > Quality Account.

## How to give feedback

Your feedback is essential in helping us make these annual accounts engaging and relevant to our readers. We continue to take on board your ideas, so if you would like to contribute feedback you can do so by contacting the Quality and Patient Safety Team in the following ways:

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**Sally Webb**  
Chair  
Bay of Plenty District Health Board

# Section One: Performance Review

## Child and youth – promoting oral health

### Importance

Good oral health is an important part of lifelong health and impacts on a person’s comfort in eating and quality of life.

### Aim

Dental caries, also known as tooth decay or cavities, is widely accepted as an infectious disease induced by diet. Therefore, the lack of caries in children at five years of age is an early indication of lifelong good dental hygiene.

Improvements will be measured by increasing the percentage of Bay of Plenty children, both Māori and in total, who have no holes or fillings (known as ‘caries-free’) at age five, and decreasing the mean average number of decayed, missing and filled teeth at age 12.

### What are we doing?

- We have achieved significant progress toward targets for both the total population and for Māori.
- 80% of our children (0-4 years of age) have been enrolled in the Community Dental Service.
- The number of children awaiting treatment has been significantly reduced by keeping oral health as a major priority in the Service.



- We provide mobile dental clinics so it is easier for parents and family to have children seen by a dental therapist.

### Targets

We are working on increasing our performance from last year quite significantly, when we did not achieve our target for caries-free at age five in any ethnic group. Our ‘total’ population target of 61% is only being achieved for non-Māori that live in a fluoridated water area such as Whakatane. The pre-school enrolments have improved with earlier intervention opportunities, however results of this may not show for up to five years.

Measure	Baseline 12/13	Target 13/14	Target 14/15 <sup>1</sup>
Increase in the percentage of children who are caries free at age five.			
Māori	40%	64%	64%
Non-Māori	61%	64%	64%
Total	52%	64%	64%

<sup>1</sup> Subject to Ministry of Health approval.

## Primary health – helping people quit smoking

### Importance

Our children and tamariki need to grow up free of the risk of becoming addicted to tobacco and the effects of second-hand smoke. We will reflect the need to achieve the primary and secondary tobacco Health Targets, and contribute towards the wider Government goal of achieving Smokefree Aotearoa 2025.

### Aim

**Primary care** - relates to the professional healthcare received in the community, usually from a general practitioner (GP) or practice nurse.

The aim is that 90% of pregnant women who identify as smokers, when pregnancy is confirmed in general practice/or with their Lead Maternity Carer, are offered advice and support to quit. Also 90% of patients who smoke and are seen by a primary care practitioner are offered similar assistance.

**Secondary care** - healthcare services provided by medical specialists and other health professionals who generally do not have first contact with patients and are provided through the hospital.

The aim is that 95% of patients who smoke, and are seen by a health practitioner in a public hospital, are offered brief advice and support to quit smoking.

### What are we doing?

#### • Active clinical leadership

There continues to be good engagement across the BOPDHB, Primary Health Organisations (PHOs) and GP's practices. Two 'Smokefree Champions'

in the larger PHOs (one a nurse, the other an allied health person) take a strong role in supporting the GP's practices and keeping this particular target at the forefront of their thinking.

#### • Active, dedicated management to support activities in General Practice

The Planning and Funding team meets with the PHOs bi-monthly to discuss the primary tobacco health target. During these meetings, attended by the PHO CEOs, experiences are shared and discussions held on ways to consolidate and improve performance.

#### • Practice support (staff and IT)

Ongoing support is provided by all three PHOs to the general practice staff as a routine activity.

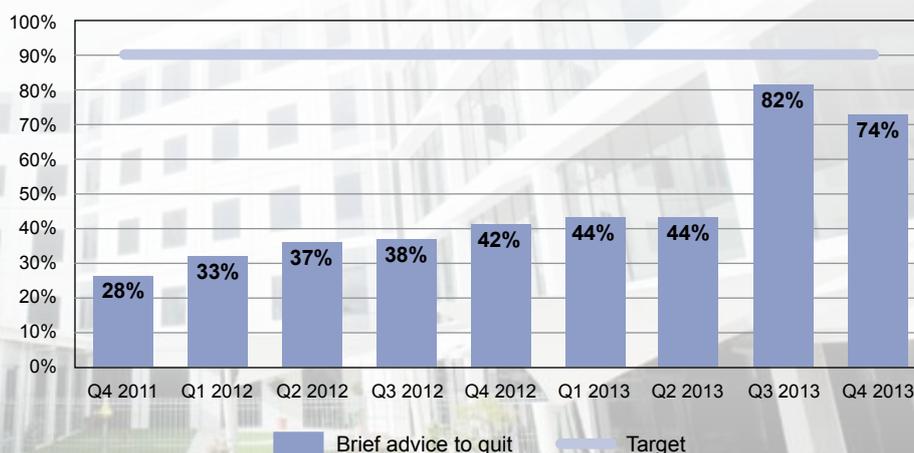
#### • Reminder, prompting and audit tools

The Eastern Bay Primary Health Alliance was funded by the BOPDHB to carry out a one-off project to reach patients who did not have a smoking status recorded, or were recorded as smokers but had not received advice to help them quit.

### Results

The Primary Health Organisations' focus on the ABC (Ask, Brief, offer Cessation support) approach in a primary care setting has resulted in significant improvement in the latter half of the 2012/13 financial year. The Health Target is that 90% of enrolled patients, who smoke and are seen by a health practitioner in general practice, are offered brief advice and support to quit smoking. With a result for the year of 60% we remain below target. However, our result reflects determined efforts to improve our performance from a baseline in 2011/12 of 37%. We compare favourably with the national average of 45%, with our most recent result in Quarter 4 recorded at 74%. The recent performance against this target is charted below.

**Health target: Patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking**



## Chronic conditions – reducing the impact of diabetes and heart disease

### Importance

The focus of this programme is to empower people with chronic conditions to take greater responsibility for their health and to stay well in their homes and communities. Our greatest opportunity to do this is by carrying out Cardiovascular Disease Risk Assessments (CVDRA) so that people can start to manage their diabetes and/or heart disease better. Diabetes and heart disease are two of the largest causes of death in New Zealand, and disproportionately higher for Māori.

### Aim

By helping people with diabetes to manage their condition better, we can reduce complications such as amputation, kidney failure and blindness. This will improve people's quality of life, allowing more to stay well in their homes and communities for longer. We will know we are succeeding if we can increase our CVDRA for the eligible population.

### What are we doing?

We will continue to work with our primary care partners to reduce the impact of cardiovascular disease and diabetes. Our primary care partners are leading development of a Diabetes Care Improvement Package (DCIP), to improve the health outcomes for diabetes sufferers.

We will work with our PHOs and the Ministry of Health to continue delivering Green Prescription programmes, with greater linkages with CVDRA, Health Target interventions and Diabetes Self-Care Management Programmes. The focus will be on high-needs populations. There will also be linkages with smoking cessation activity.

### More heart and diabetes checks

- Identifying eligible populations (including any demographic changes).
- Proactively contact/invite people due for CVDRA.
- Building systems to ensure people attend CVDRA (e.g. efficient recall systems) and fully report performance.
- Ensuring the expertise, training and tools people need to successfully complete the CVDRA to meet clinical guidelines is given.
- Development of effective services tailored to the needs of targeted patients.
- We will support continuing education for service providers as managed through our Primary Nursing Liaison.
- We will evaluate the first year of the DCIP and refine the service as necessary.
- There will be a full integration of diabetes services, with the devolution of retinal screening to complement pre-existing PHO-managed services such as: annual checks, patient self-management programmes and care improvement services.

### Targets

- 90% of the eligible adult population will have had their CVD risk assessed in the last five years.
- We should see an increase in annual checks from 75% of the eligible population to 80%.
- 100% delivery of DCIP volumes.
- Greater than 50% of attendance and completion of self-management programmes.
- Reduction in overall risk factors for all complications related to diabetes.

Measure	Baseline 12/13 <sup>3</sup>	Target 13/14	Target 14/15
Increasing our CVD risk assessment rate:			
Total	67%	90%	90%
Māori	52%	90%	90%

<sup>3</sup> Baseline 2012/13 is to December 2012, with performance against a 2012/13 target of 75%.



## Māori health – reducing disparities in breast cancer

### Importance

Breast cancer is the most common cancer in Māori and non-Māori women. However, breast screening rates for Māori women have lagged behind those of non-Māori in BOPDHB and nationally. Breast screening aims to detect cancers at an early stage; with early treatment ensuring the best chance of a successful outcome. One of the key reasons why breast cancer rates are worse for Māori is that they are more likely to be diagnosed at a later stage.

### Aim

To improve breast screening coverage and reduce the inequalities between Māori and non-Māori screening rates. By carrying out more breast screenings, we increase the chances of being able to help and treat women much earlier. The methods of detection are improving, with the ultimate in early detection known as 'predictive genetic diagnoses'. Survival rates are a reasonable indicator and treatments such as Herceptin may provide a good outcome by treating breast cancer.

### Did you know?

- Māori women have a 14% higher chance of breast cancer than non-Māori; and a 71% higher chance of dying from breast cancer.
- The risk of developing breast cancer increases with age.
- For older women, breast screening using mammography (breast x-rays) followed by appropriate treatment is the best way of reducing the chance of dying from breast cancer.

### What are we doing?

Breast screening rates are trending in the right direction. Implementing key simple strategies that are delivering results will continue to be the focus; such as providing a dedicated resource for women who did not respond (DNR) or did not attend (DNA) follow ups. The two regional Māori Providers who deliver breast and cervical screening services are supporting PHOs when required.

A leadership structure to oversee and monitor performance against the Māori Health Plan is well established. Māori Health Plan champions' leading

activity is one of the key contributors to success. It is equally important however to stress that it is a shared responsibility and it requires a "whole of system" response. We have made some recent changes to our breast screening service delivery model in the Eastern Bay of Plenty and are hoping for some even greater performances over the next 12 months through improving access via extended clinic hours, weekend clinics, and free support to screening services for eligible women.

### Results

In July 2012 our breast screening baseline data was 41% for Māori with a 37% disparity gap between Māori and non-Māori. This can be compared with May 2013 where we increased our rates to 52% for Māori, and reduced our disparity gap to 33% between Māori and non-Māori (compared with a target of 70%).

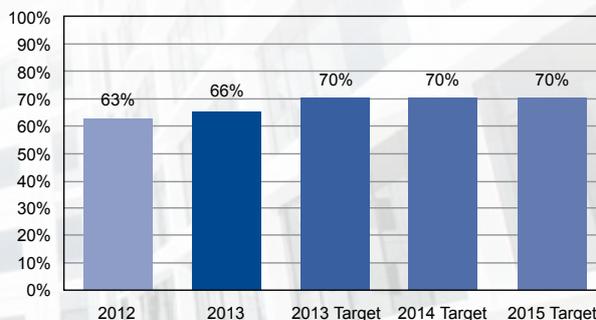
Key strategies contributing to this performance include:

- Enrol and book women for screening at the same time.
- Work with the GP liaison to support with setting targets for GP practices based on eligible women enrolled in the practice.
- Agree monthly GP practice targets - provide monthly data to each practice.
- Short, sharp campaigns with an incentive for women to undertake screening.

An increase in screening rates means more women are reducing their risk of dying from breast cancer. Screening mammograms cannot prevent development of breast cancer, but they do reduce the chance of dying from breast cancer by approximately a third.

### BOPDHB performance and target of increased rate for breast screening for eligible women aged 45-69 years.

Breast screening: Eligible women (45-69) two year period



## Health of older people – pathway for people with dementia

### Importance

More than 43,000 people in New Zealand have dementia and this number is set to double every 20 years. Only 40% of dementia cases are recognized and documented according to the World Alzheimer Report 2011. This means that in Tauranga 1,506 people may have the disease but have not yet been diagnosed. By diagnosing earlier, people can receive the help and advice they need to be able to stay living in their own homes for longer.

Carers and people with dementia have told us they would like to know more about dementia, what to expect and how to support someone they care for who may be developing dementia. GPs and primary care practitioners told us they want to have more access to information and specialist advice so they can diagnose and treat people earlier.

### What are we doing?

We have responded by developing a clinical pathway to support GPs to identify, diagnose and treat people with dementia, particularly in the early stages. The pathway, which was launched in February 2013, was developed with advice and expertise from specialist clinicians from

Health in Ageing and Mental Health Services for Older People, primary care, community providers, Planning and Funding and carers of people with dementia.

Carers of people with dementia have told us they would like to be able to take a break from full-time caring from time to time and be confident their family member with dementia will be cared for and remain safe while they are away.

We have increased the amount of respite care and education available for carers and their families and provided more flexible options for care.

### Goals

We expect the following outcomes from the dementia pathway:

- More GPs will be able to diagnose dementia.
- People will receive the help and support they need earlier.
- More carers can be supported to take a break when they need it.
- People will have access to the information and advice they need to support people with dementia.
- Fewer people will be admitted to hospital or residential care.



## Ministry of Health targets

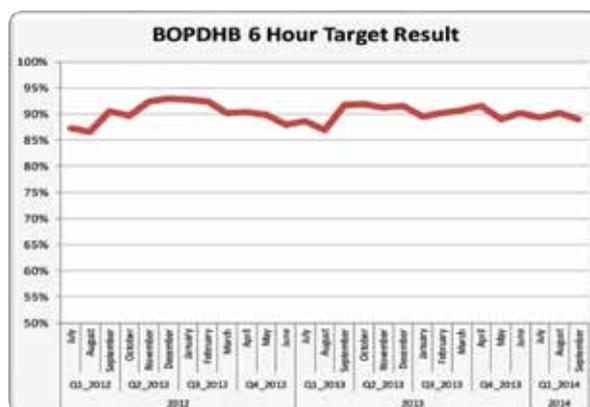
### 1. Shorter stays in emergency departments

#### Overview

- The target is to have 95% of patients admitted, discharged, or transferred from an Emergency Department (ED) within six hours.
- Long stays are linked to overcrowding of the ED, negative clinical outcomes and compromised privacy and dignity for patients.
- The target has been achieved at Whakatane ED but achievement at Tauranga ED has proved more difficult.
- Tauranga Hospital is working across all areas, not just ED, to reduce patient waiting times in the ED as a hospital-wide target.

#### Key initiatives that have been undertaken are:

- Streaming – a process where suitable patients can be seen and treated by a Nurse Practitioner or Specialist Nurse rather than doctors.
- Review of acute patient journey to identify areas where patient care can be improved from ED into and out of the hospital.
- Nurse assessment in ED waiting room (Tauranga) – this allows immediate nurse care, treatment and review for all patients. This also allows for earlier initiation of tests.
- Triage First - patients are reviewed for complexity by a nurse rather than administration on arrival.
- Technology – effective and efficient use of electronic patient information to track patients through the hospital.
- Capacity management – the use of the Transit Lounge to ease discharge of patients and release beds in the hospital for those needing them.
- Model of Medicine – we have changed the way acute medical patients are managed creating a focus on the front door.
- Development of 'Hospital at a Glance' – this is a visual representation of the hospital occupancy, which updates every 12 minutes showing what is happening where – i.e. Are beds available? Is ED busy? Can resources be moved to meet demands?
- Integrated Operations Centre (IOC) – this team meet daily to review the hospital every morning and plan for the day and week ahead.



The graph above shows what percentage of patients, presenting to our Emergency Departments at both Tauranga and Whakatane Hospitals, are treated and discharged or admitted to hospital within six hours of arrival.

### 2. Increased immunisation

#### Overview

After ensuring that people have sufficient food, access to clean water and adequate housing; immunisation is one of the most effective ways of protecting and improving the health of the population. This remains as true today as it has been over the last century. Improving living conditions and health services can reduce the impact of infectious diseases; only immunisation can eradicate them. Examples are the eradication of smallpox and significant progress in eradicating polio.

#### Targets

- 2012-2013 Target achieved – 85% of eight month olds have completed their scheduled vaccinations (six weeks, three months and five months).
- 2013-2014 Target - 95% of eight month olds to have completed their scheduled vaccinations (six weeks, three months and five months). To be achieved in stages by the end of 2014.

#### Purpose of targets

- Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.



- Population benefits only arise with high immunisation rates. New Zealand's current rates are low by international standards and insufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough).
- Immunisation is one of the most effective ways of protecting and improving population health.

Measure	Baseline 12/13 <sup>4</sup>	Target 13/14	Target 14/15
95% of eight month olds have completed their scheduled vaccinations (six weeks, three months and five months) to be achieved in stages by the end of 2014.	85%	95%	95%

### How have we got there?

About 2,700 Bay of Plenty (BOP) children (out of 3,000) are fully vaccinated against childhood diseases at eight months and again at two years. This gives our children the greatest opportunity to thrive. About 2,400 children (out of 3,000) have a free health check at four years to ensure they are as healthy as possible and ready to start school when they turn five.

Through working alongside key service providers, a continued commitment to participation in local District Health Board (DHB)-facilitated Health Target and Immunisation Advisory Groups is ensured. This enables an ongoing opportunity to keep information flowing and identify ways to lift performance further.

There is a collective commitment to strive for achievement against the increased target of 90% from 1 July 2013, while holding the 95% target for December 2014 in sight.

The following graph shows our improvement and increased immunisations of our population by ethnicity. It shows that more and more of our children are being protected against preventable diseases.



4 Forecast 2012/13 is based on YTD achievement for eight months to February 2013

### 3. Improved access to elective surgery

#### Overview

The BOPDHB knows that a patient being able to see a specialist doctor or nurse, and have the right treatment promptly, is important to our community. The Elective Discharge Health Target is published information that tells the community about how patients access treatment that is planned (elective) rather than unplanned (acute).

#### Key initiatives

Actions which have helped achieve the Elective Discharges Health Target:

- We have reduced the time patients wait to see a specialist and have treatment from six months (June 2012), to five months (June 2013), with a scheduled further reduction to four months (December 2014).
- We run different types of operating theatre lists, with procedures being grouped to provide a fast turnaround for patients, allowing more patients to be treated on each list.
- We send weekly reports to our staff that book patient appointments so they are aware of whether they are booking correctly and “on target”. Our booking staff tell us they feel involved in the process and can easily see if more patients are required to be booked each week.
- We hold weekly meetings, between the Booking Team Leader and Theatre Manager, to ensure all theatre sessions are fully booked and equipped over the next two weeks.
- We have documented our booking process so all staff are booking patients using the same method, focusing on appointment times best suited to patients.
- Every month each speciality reviews its “dashboard” of targets including the Ministry of Health’s expectations (contract). They look at how long patients stay in hospital, how many patients come for treatment on the day (and not in the night before), whether patients were cancelled from their treatment and the reason why and at what time patients leave hospital on the day of discharge.

- We run projects to make the pathway easier for patients to access treatment. Examples of this include access to orthopaedics and a quality project called “The Productive Operating Theatre”.



#### Improved access to elective surgery

The target is an increase in the volume of elective surgery by at least 4000 discharges per year. DHBs planned to deliver 38,097 discharges for the year to date, and have delivered 2002 more.

	Quarter one performance (%)	Progress against plan (discharges)
1 Lakes	119	▲
2 Bay of Plenty	117	▲
3 Taranaki	113	▲
4 Waikato	112	▲
5 Northland	110	▲
6 Counties Manukau	110	▲
7 Waikato	108	▲
8 Whanganui	107	▲
9 Canterbury	106	▲
10 Hawke's Bay	106	▲
11 MidCentral	106	▲
12 Nelson Marlborough	105	▲
13 South Canterbury	105	▲
14 Waitemata	105	▲
15 West Coast	104	▲
16 Hutt Valley	103	▲
17 Auckland	99	▼
18 Capital & Coast	98	▼
19 Tairāwhiti	92	▼
20 Southern	90	▼
All DHBs	105	▲

100%

The BOPDHB collects information about the number of patients being discharged from hospital after a surgical procedure. We focus on discharges because this represents the number of people who have actually been treated versus those we plan to treat. These figures are sent to the Ministry of Health which compares our results with other DHBs across the country and publishes those results in our newspapers every three months.

From this example, it can be seen that the BOPDHB is performing well against the target.

## Serious and sentinel events

Reporting serious and sentinel events nationally is an important step to improving health outcomes for New Zealanders through improving safety, and encouraging open and transparent reporting of incidents when something goes wrong.

- A serious adverse event is one that leads to significant additional treatment but is not life-threatening, and has not resulted in a major loss of function.
- A sentinel adverse event is life-threatening or has led to an unexpected death or major loss of function.

The Serious and Sentinel report supports our continuous quality improvement, focusing on shared learning to improve systems and minimise the possibility of future incidents. You can review our latest Serious and Sentinel Report below, or see the Health Quality & Safety Commission's website for the nationwide report, or find more information in our media release. Mental Health Service events are reported separately (see Mental Health Adverse Events HQSC) but are included in our overall numbers.

### Bay of Plenty District Health Board Summary Serious and Sentinel Events - 1 July 2012 to 30 June 2013

16 serious and sentinel events were reported in this period. Of those, 11 were related to a fall in hospital, four were mental health events, and one related to the death of a baby at birth due to an undiagnosed breach.

A significant amount of work has been done to reduce harm caused from falls. Our current focus is on prompt assessment of the individual patients risk of falling and putting the correct intervention in place to manage the

risk of falling. Age is a significant risk factor in relation to falls (as shown in Table 1) and a fractured hip is the most common injury (as shown in Table 2). For further information refer to page 17.

Falls by age group

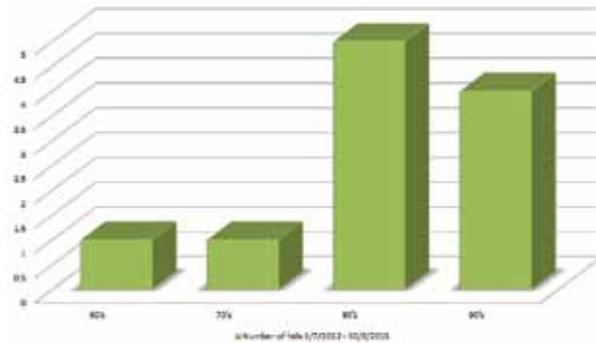


Table 1

Falls by injury

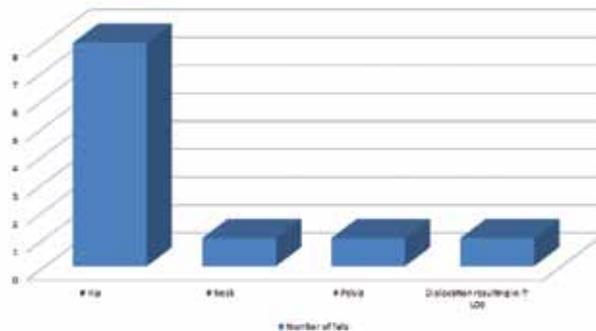
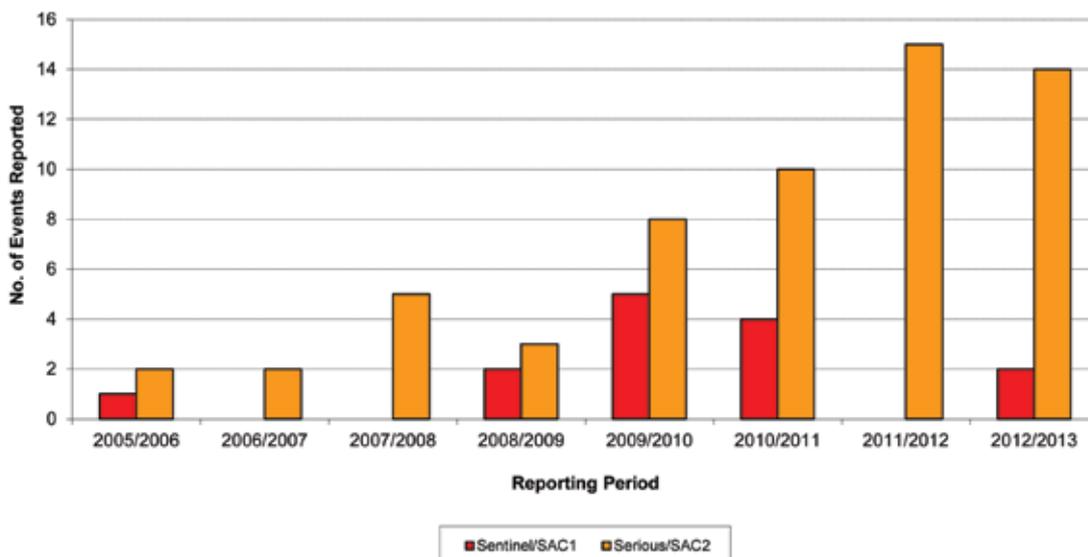


Table 2

National Event reporting 1 July 2005 - 30 June 2013



Reviews and investigations into sentinel events often take time and will appear in the media several years after the event. The following two events were reported in 2013. The purpose of including them is to illustrate the actions taken to ensure similar incidents do not happen again.



HEADLINE: “Hospital Failed Patient Who Died”

*“Tauranga Hospital failed to care for a patient suffering from a hernia who later died a report has found”.*

Source: SunLive May 21, 2013

The Health and Disability Commission (HDC) found: “The Bay of Plenty District Health Board breached the Code of Rights because it failed in its duty to provide an appropriate standard of care to the woman, and because poor documentation and handover by staff resulted in a failure to ensure the woman received quality and continuity of services.”

In the three years since this incident, the BOPDHB has addressed the recommendations made by the HDC and has:

- Introduced a new model of medical management that addresses roster commitments and responsibilities for Senior Medical Officers (SMOs).
- Reviewed and implemented the Early Warning Score (EWS) observation process used to recognise changes in a patient’s condition. Regular audits are completed by staff who monitor their own departments compliance with expected standards.
- Nursing staff have also introduced a new system of shift to shift handover which is completed at the bedside and involves the patient and/or a family member if they are present. Nurses are also increasing their involvement and presence on doctor’s rounds.

HEADLINE: “DHB Criticised Over Death of Patient.”

*“The Bay of Plenty District Health Board has been criticised for serious failings in the care it provided a mental health patient who later committed suicide.”*

Source: Bay of Plenty Times Nov 13, 2012

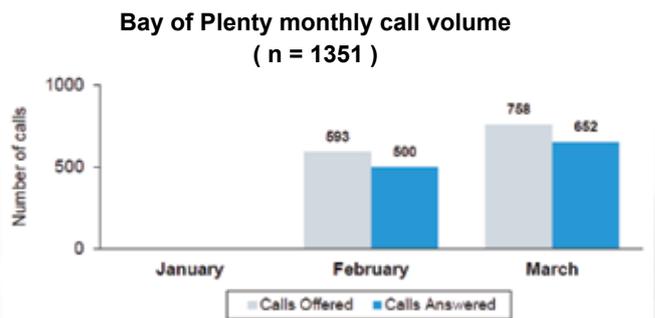
As a result of recommendations received from the HDC and a range of local stakeholders, the BOPDHB implemented a project to Improve Access to Acute Mental Health & Addiction Services.

As well as better access to acute services, improvements were made to referral handling, intake/ triage processes and the allocation of referrals to community case managers.

One significant change has been the use of an out of hours call centre to ensure all calls are responded to in a timely manner.

The first quarterly report of the Mental Health Line service for Bay of Plenty since its launch on February 4, 2013, showed that:

- 1351 calls were made to the Mental Health Line in two months (a monthly breakdown is presented in the table below).
- This quarter 68.6% of calls were answered within 30 seconds, with an average answer time of 44.3 seconds.



## Section Two: Priorities for Improvement

### Reducing harm from falls

#### Overview

The Health Quality & Safety Commission is leading and coordinating a national patient safety campaign, launched in May 2013, focusing initially on reducing harm from falls. However, the BOPDHB has been working on reducing harm from falls since January 2012.

The costs of an inpatient fall causing a minor injury is estimated at \$600, a hip fracture causing a three-week stay in hospital is estimated to cost \$47,000, and a hip fracture with complications and discharge to an aged residential care facility \$135,000. (De Raad, JP – 2012 *Towards a Value Proposition... Scoping the Cost of Falls*. New Zealand Institute of Economic Research).

The Reducing Harm from Falls programme's purpose is to reduce harm from falls by supporting interventions which prevent falls and reduce falls-related injuries.

#### Future focus

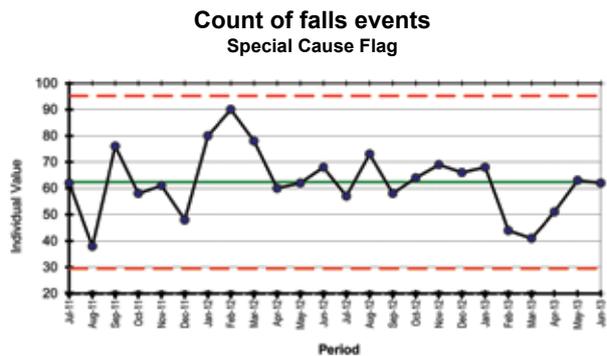
The challenge facing healthcare staff is to balance fall prevention with privacy, dignity, independence and rehabilitation. If we prevent older people from walking, from using the toilet unobserved, and from undertaking any activity without arms' length supervision, we may achieve our aim of fall prevention, but with unacceptable consequences for independence and rehabilitation.

Some successful interventions implemented at BOPDHB are:

- A focus on prevention, detection and treatment of delirium, including dip-testing urine for indications of infection.
- An individualised multi-disciplinary plan of care (rather than solely nursing).
- Review and, where appropriate, discontinuation of 'culprit' medications associated with increased risk of falls.

- Contenance management, including routines of offering frequent assistance to use the toilet.
- Early access to advice, mobility aids and, where appropriate, exercise from physiotherapists.
- Assessment for safe footwear.
- Staff and patient education.

Results of the Reducing Harm from Falls project have been promising and further improvement and sustainability is now the target.



## Reducing harm from surgery

### Overview

A focus for the Health Quality & Safety Commission's patient safety campaign scheduled for 2014 is preventing harm from surgery. The national programme aims to improve the quality and safety of healthcare services provided to patients undergoing surgery in hospital.

The Safe Surgery Checklist is a common sense approach to check that the correct surgery is being carried out on the correct patient.

### Future focus

Improvements can be made when the World Health Organisation's Safe Surgery Checklist is used consistently and where there is a culture of safety, teamwork and good communication in the operating theatres.

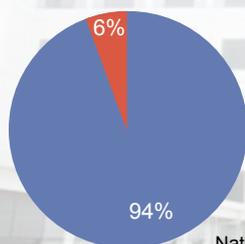
Staff at our DHB have had opportunities to develop a good understanding of how the checklist can be used to reduce harm from surgery. We received funding from the Ministry of Health in 2010 to deliver The Productive Operating Theatre Programme (TPO). The aim of this work has been to focus on improvements rather than productivity gains and so locally the programme was referred to as Building Teams for Safer Care. Over 140 staff were brought together over three training days to deliver an internationally-recognised teamwork programme (TeamSTEPS). This supported staff who already championed the checklist and encouraged others to value teamwork for patient safety.

We look forward to collaborating with others as part of the national programme to continue building on this foundation.

We have started monitoring our performance against HQSC markers. Our first quarter results for 2013 are shown below.

### BOPDHB overall compliance with surgical safety checklist

■ Compliant ■ Non compliant



National threshold = 90%

## Medication safety

### Overview

When complex patients are admitted to hospital, information around their prescribed medications will be collected and checked by medical and pharmacy staff. Information around medication changes during inpatient care will also be communicated to the patient's GP. This process is called Medication Reconciliation.



### Future focus

When patients are admitted to hospital there is the opportunity to review and check their medication usage. This information is important as it gives an insight into the person's current health status and allows for safe prescribing of medicine whilst in hospital. It also allows the transfer of information about medication changes on discharge back to the primary care provider.

Work is being done nationally to identify indicators or triggers which, when present, may mean a person might be at greater risk of an adverse medication event. Examples of these triggers are older adults or people who are on more than five different medicines at a time. By identifying these people on admission to hospital, we can target clinical pharmacy time to ensure their prescribed medication is safe, and that the patient and caregivers understand how to manage this medication on discharge.

Our aim is to identify those people at risk of adverse medication events and establish reconciliation, patient education and communication to ensure the medication is managed safely between community and hospital care.

## Reducing healthcare associated infection

### Overview

Up to 10% of people in hospital develop one or more infections related to their healthcare. These are known as healthcare associated infections (HAIs). Hand hygiene is one of the best actions in the fight against HAIs, making it a key patient safety issue. The World Health Organisation (WHO) developed 'The Five Moments of Hand Hygiene' and these have been adopted by all DHBs across New Zealand.

The risk of serious complications due to HAIs is higher for patients in the Intensive Care Unit (ICU). An infected surgical wound can also have devastating consequences.

A programme to monitor compliance with hand hygiene was introduced in 2009 and we monitor compliance with best practice to reduce infection.

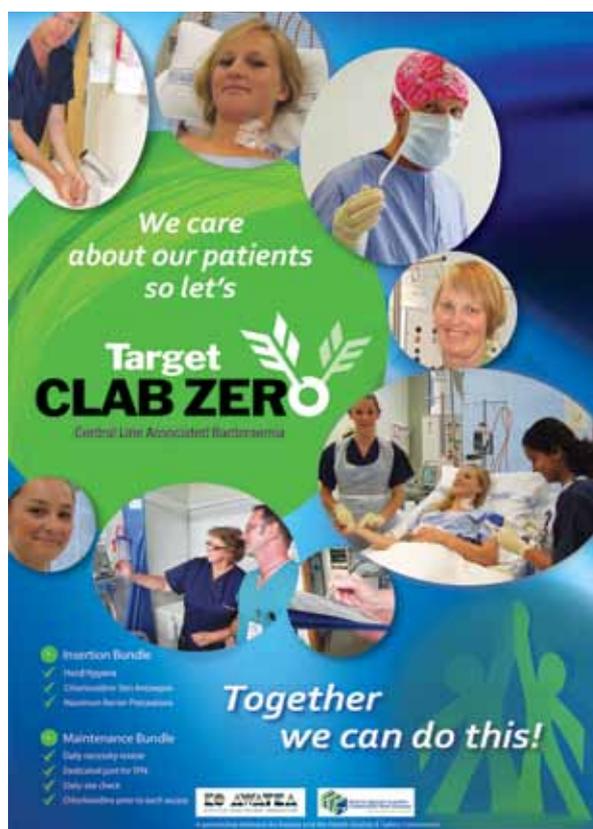
### Future focus

In an effort to improve the compliance with hand hygiene, a reinvigorated communication strategy was launched to coincide with the WHO Hand Hygiene day on 5 May 2013. We used life-sized models of our staff and the slogan "My 5 Moments of Hand Hygiene".

In ICUs, a common way of improving patient care is to insert a fluid line into one of the large blood vessels. These are known as central lines and about half of all ICU patients will need one. They provide many benefits but can also be a way for bacteria to enter the blood stream. These infections are called central line associated bacteraemia (CLAB). We have integrated best practice for the insertion and maintenance of these central lines and we have not had one of these infections for more than three years.

We also monitor surgical site infection (SSI) and promote best practice for preventing SSI. These include correct skin preparation and providing the right preventative antibiotics before surgery. SSI can result in costly prolonged hospitalisation, as well as emotional and financial stress for patients and their families. In severe cases such infections can result in a long-term disability or even death. This year our DHB joined in national efforts to establish an SSI surveillance programme. We were selected as a pilot site to test out the new database and give feedback before it was rolled out across New Zealand in July 2013.

We look forward to continuing to work collaboratively with these national programmes to prevent healthcare associated infection.



## Patient and family-centred care

Patient and family-centred care places an emphasis on working with patients and families of all ages, at all stages of care, and in all health settings. Families are essential to patients' health and well-being and are crucial allies. Patient and family-centred care has four core concepts: Respect and Dignity, Information Sharing, Participation, and Collaboration. At BOPDHB, we are looking to recognise patients and their families as valued members of our healthcare team.

### Patients

When patients are fully involved in their own care they feel confident that care will be of a consistent high quality.

- Dignity and Respect: Patients will be listened to and patient and family perspectives, backgrounds and choices honoured.
- Information Sharing: Staff will communicate and share complete and unbiased information with patients and families in a way they understand.
- Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- Collaboration: Patients, families, staff and organisational leaders collaborate in the planning, implementation and evaluation of the delivery of care.

### Family

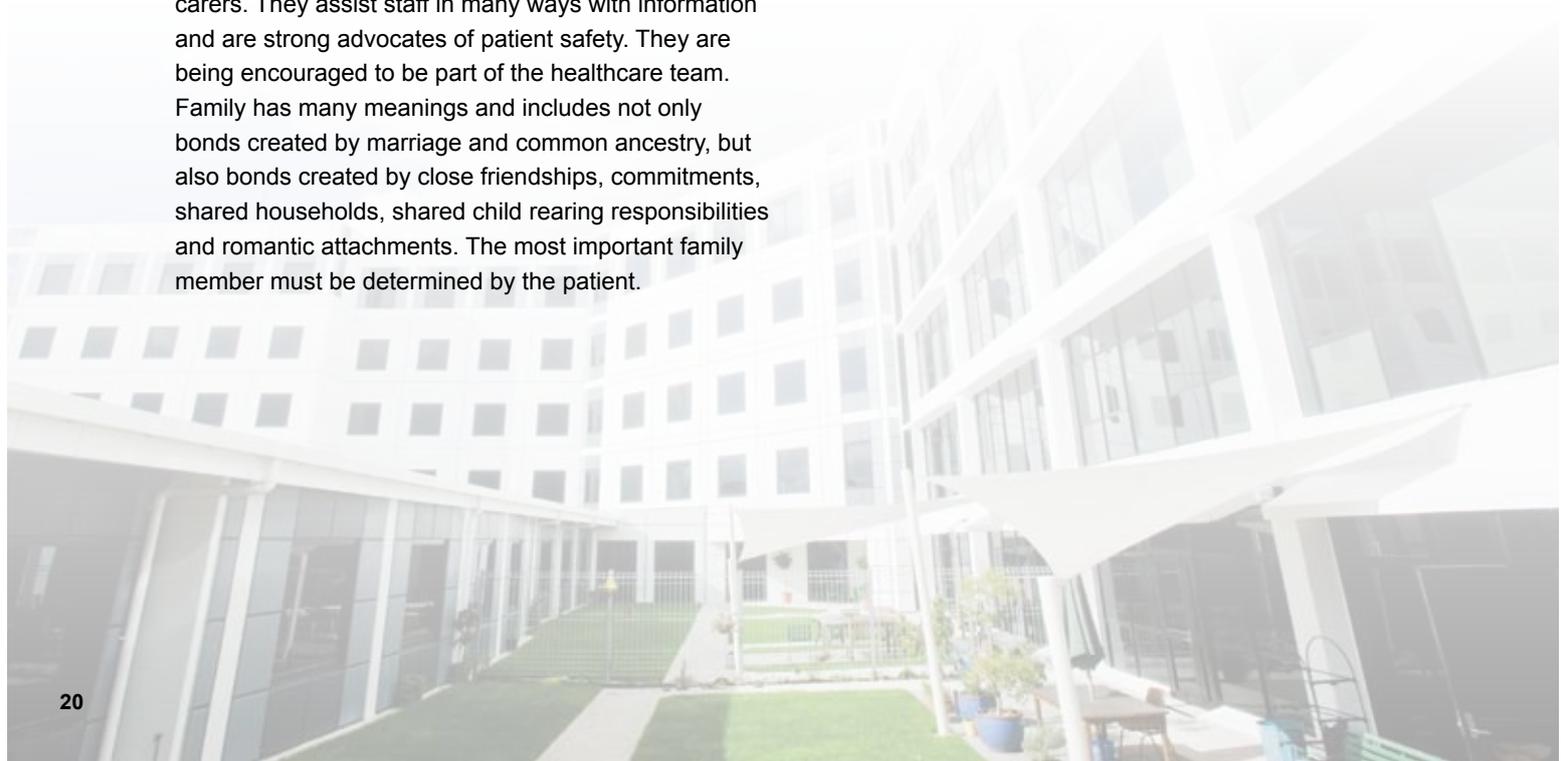
For care to be patient-centred, it must involve the patient and the patient's family. Traditionally, all hospitals have restricted their access to visiting hours, but BOPDHB has recognised that a patient's family members are more than that, they are supporters and carers. They assist staff in many ways with information and are strong advocates of patient safety. They are being encouraged to be part of the healthcare team. Family has many meanings and includes not only bonds created by marriage and common ancestry, but also bonds created by close friendships, commitments, shared households, shared child rearing responsibilities and romantic attachments. The most important family member must be determined by the patient.

## Organisation

When patients feel informed and empowered to participate in their own healthcare, the results can be many for the organisation:

- Improved patient safety with a decreased number of adverse events
- Frequently better clinical outcomes
- People feel they are treated with dignity and respect and report less frustrations with their own healthcare needs
- Patients and staff report an enhanced experience of care, and staff satisfaction, recruitment and retention are likely to show improving trends
- With better clinical outcomes, an added benefit is often reduced costs.

*"I am grateful that the DHB have recognised the important part that the family have in the ongoing well-being of the patient and the medical decisions to be made" - Te Rina, Volunteer Patient Advisor.*



## Capacity development

### Residential care

With an ageing population, the Bay of Plenty will require a strong base of primary care and community support, including residential care, respite and home-based support. If long-term conditions are managed effectively, crises and deterioration can be reduced and health improved. Even where returning to full health is not possible, access to responsive quality services, including residential care where necessary, helps people to live quality lives with dignity.

You have told us you want to have confidence in aged residential care services and in the fact that you, or your family members, will be safe and happy.

We are helping improve quality in aged residential care facilities by providing training for registered nurses to up-skill and implement a comprehensive geriatric assessment process known as the interRAI Long Term Care Tool. This internationally proven clinical assessment system helps nurses better identify and monitor the needs of individual residents. Residents who have been assessed using the tool will have a care plan developed that is informed by the assessment and tailored to meet their individual needs.

The expected outcomes are:

- 100% of aged residential care facilities have implemented the interRAI Long Term Care tool by June 2014.
- Staff in residential care receive training in comprehensive geriatric assessment.
- All residents will receive a comprehensive geriatric assessment and have a care plan developed with them and their families that meets their individual needs.



## Bay Navigator

Launched in 2011, Bay Navigator was established to create a fundamental reorientation of the health system in the Bay of Plenty. Bay Navigator aims to improve collaboration and communication between the community and the hospital services in the pursuit of ensuring that patients receive the very best care, in the timeliest manner, by the most suitable service provider.

A Governance Group assesses conditions identified by cluster groups or primary care for pathway review, to ensure maximum benefit is achieved.

Pathway groups are led by hospital and community-based physicians, and combine healthcare workers from a variety of sectors. They meet over a period of weeks to establish a patient-centred, evidence-based guideline for each medical condition or patient focus. The patient is seen as the centre of the care continuum and is considered an integral part of all decisions.

Resource gaps, inequalities of care and management variance are all addressed. Pathway teams may recommend service restructuring with the transference of some services/procedures from secondary to primary care: the aim being to treat the right person, at the right time, and in the right setting.

Key performance indicators are established for each pathway to assess the impact of pathways on patient care.

## Home and community support services

Illness or exacerbations of chronic disease often have functional consequences in older people. However, they do not necessarily need to be admitted to hospital if they can be assessed in their own home, treated, and temporary additional support put in place. The most common reasons for avoidable hospital admission are falls and minor injuries/fractures; mild exacerbations of a chronic disease; minor infections; gradual (and predictable) inability to cope at home – reaching a crisis point.

Sometimes older people do need to be in hospital and they do have a right to a medical diagnosis. However, access to a GP or nurse out of hours can be difficult and many older people are admitted unnecessarily because of the lack of alternatives. Current home support contracts are not flexible enough to allow for intensive support periods when required, or to provide the kinds of support that really matter to the older person or their family and whanau. This sometimes causes unnecessary delays or an unplanned admission to hospital via the Emergency Department.

Rather than the traditional emphasis on household tasks and personal care, the BOPDHB is moving to a more tailored, integrated response using a goal-orientated restorative, flexible approach, and endorsing a wider variety of interventions/services that support a return to independence. These matter most to service users and have longer term benefits across the health system.



### **Tauranga Community Health Liaison Group**

The Tauranga Community Health Liaison Group, which was set up in March 1999, is a group of representatives from community organisations which have an interest in healthcare.

The members act as a conduit for the free flow of information and comment between the BOPDHB and their respective organisations and observe and monitor the effectiveness of health service delivery in the Bay of Plenty.

The breadth of the Group's membership and interests ensures what is debated at meetings is distributed widely throughout the community.

### **Volunteer Patient Advisory Committee**

The Volunteer Patient Advisory Committee (VPAC) is a partnership of patient and family member advisors and the BOPDHB, dedicated to advancing comprehensive and compassionate patient and family-centred healthcare.

To ensure alignment and integration of patient and family-centred care across BOPDHB, the VPAC will serve as a formal mechanism for involving patients and families in service quality and patient experience improvement.



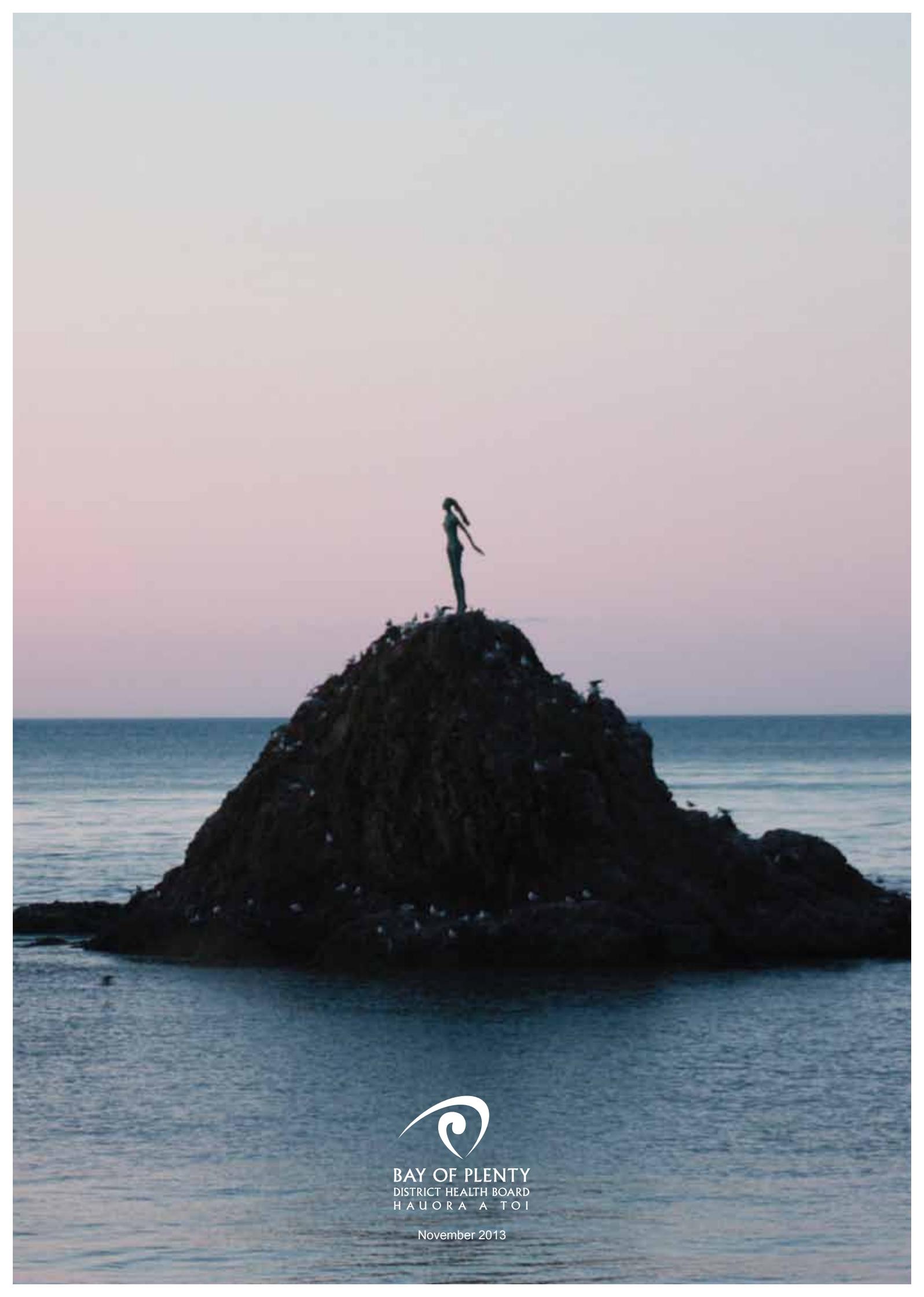
Director of Nursing Julie Robinson, far right, with members of the Tauranga Community Health Liaison Group in Tauranga Hospital's Day Stay Unit.



The Volunteer Patient Advisory Committee (VPAC) meets monthly. From left: Pat Graham, Peter Williams, Jan Polley, Averil Boon (BOPDHB Patient Family Centred Care Coordinator), Te Rina Joseph. Absent: Sarah Faulkner, Kath McInnes, Dianna Scott, Nada Byrne, Jennifer O'Donnell.







BAY OF PLENTY  
DISTRICT HEALTH BOARD  
HAUORA A TOI

November 2013