Passion for Caring

Melbourne Health Quality of Care Report 2013/14

respect, caring, unity, integrity, discovery
Our Vision
Passion for Caring – Achieving the Extraordinary

Our Mission
Melbourne Health’s Mission is to provide world-class health care for our community. We will embrace discovery and learning, build collaborative relationships and engage our patients in their care.

Our Values
Underpinning our behaviour and practice, informing all that we do:

→ **Respect** for the dignity beliefs and abilities of every individual
→ **Caring** and compassion
→ **Unity** as a team and in embracing our communities
→ **Discovery** through passion for innovation
→ **Integrity** by being open, honest and fair

Our Goals
Supporting us to achieve, guiding our direction:

→ **Develop** our workforce
→ **Improve** the quality and safety of our services
→ **Develop** and encourage strategic relationships
→ **Foster** a culture of research and innovation
→ **Build** a sustainable organisation

If you have any compliments, complaints or suggestions about your experience at Melbourne Health, please contact our Consumer Liaison Unit on 9342 7806 or email: consumerliaison@mh.org.au
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We are so much more than the sum of our parts, from the small-scale innovations on our wards through to the international medical research collaborations, ours is a truly great health service thanks to the contributions of every individual who works or volunteers here.

It can sometimes be hard to see how so many small ideas can have such a significant impact, which is why the Quality of Care Report is such an important document. It also gives us the opportunity to acknowledge our partners in the community health setting and highlight the good work they do in making sure your care is seamless.

Through this report we can share the stories about the research we are undertaking that will save lives and transform healthcare, and the changes we are making to our services to better meet your needs.

This report also gives us a forum to have an honest conversation about whether we are meeting your expectations and where we need to do better. The key quality and safety measures which we use to track our safety performance are shared with you in this document and we are open about those areas where we need to do better. Not every story is a good news story, but you deserve to know where we are turning things around.

At the heart of healthcare is you – the patient, the consumer, the client, the carer – the person who relies on us to help you live well. Our most important collaboration is the one we have with you. We are making efforts to make sure you are an active participant in your care, and that we are taking into account your cultural background, language, faith and history to provide whole-of-person care and not just technically proficient treatment.

This report has some inspiring examples from around the organisation of where we are leading the field in person-centred care: from early recovery to end-of-life, our staff are working hard to engage with you.

Once you have finished reading this report, please get in touch and let us know what you would like to see us doing to improve our service and meet your needs. We would also like to know what you think of this report and what sorts of information we should be sharing with you.
We have an obligation to raise awareness, engage the community, create a welcoming environment, and develop inclusive workforce practices, communication and cultural safety. We need to respect your cultural background and language needs each and every time you receive care. This is person-centred care.

To do this, we developed our Respecting our Community (ROC) Action Plan in 2010, to drive an organisation wide improvement process around cultural responsiveness.

The committee that oversees the implementation of this plan has representation from every level of the organisation, including members of our Community Advisory Committee. The plan covers Aboriginal health, our culturally and linguistically diverse communities and people living with a disability. Each meeting starts with a patient story which keeps the needs of those who use our services at the forefront.

Patient experience data and patient feedback from each of these three cohorts is reported at Respecting Our Community meetings and is used to guide the committee’s activities. We know we still have work to do: from January to December 2013 we received 103 complaints relating to these specific areas. Nearly half related to disability, 23% to interpreting and 30% to cultural issues.

We are using this data to plan improvements to our services. To keep you informed, we have a dedicated page on our website, “You said. We did.” where we highlight the areas of greatest concern to you and what we are doing to fix them.

Some problems can be fixed quickly and easily: lowering the taxi telephone in the hospital’s main entrance so it can be reached by people in a wheelchair; including welcome signage in the new Outpatients Department and foyer in many languages other than English.

Others involve changes to our practices which can take longer to take effect. We are working to achieve a better quality of care and support for those who use our services by having you represented at a governance and management level. For example: Consumer and Carer Advisors facilitate consumer and carer participation and leadership activities across all levels of service at NorthWestern Mental Health, and provide leadership and support to the consumer and carer workforce.
The power of language

Clear communication is vital in a health setting, and in 2013/14, we identified 13,009 people, or 16% of those admitted to The Royal Melbourne Hospital who needed an interpreter. In our Outpatients, 26,914 people, or 13% of those attending, needed an interpreter and were provided with a service. In our Emergency Department, it was about 6% of those presenting, or 2,221 cases.

We had people speaking 82 different community languages other than English attend The Royal Melbourne Hospital. Most fall into our top seven language groups: Italian, Greek, Arabic, Vietnamese, Turkish, Cantonese and Mandarin, for whom we can offer in-house interpreting.

To meet everyone’s language needs, we trialled a telephone interpreting service with four Outpatient clinics from July to December 2013. Clinicians and consumers helped develop the criteria for when to use telephone interpreting. We saw improvements in quality of the service with connection times and sound quality, and extra handsets allowed our clinicians, interpreters and patients to speak with one another easily.

At the same time, we asked you to tell us what you thought of our signage on how to contact an interpreter. As a result, we have rolled out improved signage that includes information in the top seven languages about how to contact an interpreter at the City and Royal Park campuses.

Working together to be communication-accessible

One in five hundred people in Victoria need some form of help communicating. Communication difficulties can be a result of a stroke, cancer of the head and neck, or progressive diseases such as Parkinson’s Disease and it often isn’t obvious they need help.

Our Community Therapy Service understands how important it is to give every person a voice and have partnered with Scope, an organisation that works alongside people with disabilities, to make the service communication friendly.

The Community Therapy Service (CTS) covers a broad range of rehabilitation including physiotherapy, occupational therapy, speech pathology, audiology, dietetics, podiatry, orthotics and nursing; many patients see more than one discipline. The CTS staff wanted the start of their patients’ therapy journey to be a stress-free process, and with the reception as their first point of call, that was where they started.

They trained the reception staff on how to support people with any communication difficulties. Signage and written materials are being reviewed to make sure they are clear and easy to follow, and they are developing picture boards to help the reception staff communicate with people who have difficulty speaking or getting out their message. Finally, they are asking those who use the service how they would like to be supported and are engaging with people from a non-English speaking background.

Once the Community Therapy Service has made the changes, the communication-friendliness of the reception will be tested by a ‘mystery shopper’ from Scope. If successful, the site will be awarded with a communication access symbol. This symbol, similar to the wheelchair-accessible symbol, shows you that our service is aware and supportive of people who have communication difficulties.
Caring for all of you

Excellent healthcare takes into consideration your personal situation, cultural background, and your religious or spiritual needs.

We know that religious identity is important to many of you, and we need to record this when you are admitted to hospital, so amongst other things, we can provide Kosher, Halal or other meals that are appropriate to your religious or cultural needs. It also means our Pastoral Care team can respond appropriately as part of your holistic care.

From July to December 2013, the Pastoral Care team investigated whether this important information was being recorded and found that 17% of patients’ religion was recorded as ‘not specified’ or ‘unknown’, but on closer examination, 97% of these patients did have a religious identification. They are now looking at how to train staff to address this.

Pastoral Care is there whenever you or your family need it.

We have a palliative care chaplain, as well as faith chaplains from several Christian churches, the Islamic and Buddhist councils. The Sacred Space at The Royal Melbourne Hospital City Campus is a quiet area for reflection and prayer that is available for everyone to use, and has texts from the seven main faiths in our community.
Gender sensitivity and safety is another critically important aspect of person-centred care. Our services in NorthWestern Mental Health have been working hard to improve awareness and practices in relation to gender sensitivity and safety for all consumers and carers. Gender sensitivity and safety is being added to staff training and is discussed at staff meetings. Wherever possible, we have made changes to the physical spaces to introduce secure women-only wards, corridors, and safe family spaces. Gender sensitivity and safety is now routinely taken into account when allocating beds across the NorthWestern Mental Health services.

Having a voice and being heard is central to person-centred care. You have the right to make decisions about how you would like to be cared for, and have those decisions respected by your loved ones and medical team. One of the ways we can make sure we know exactly what your wishes are and how to follow them, is through an advance care plan.

Above:
In May 2014, Orygen Youth Health had a Rainbow Pedestrian Crossing day to support International Day against Homophobia and Transphobia, to get people talking about these issues. Their inpatient unit is currently changing their physical environment to support more gender sensitive practices and Transgender Victoria has been in to talk to staff.
Nowhere is person-centred care more important than at the end of a person’s life. Our Palliative and Supportive Care service looks after people with serious illness, and aims to care for the patient as well as their families and carers.

Since 2010, the team has strived to provide truly person-centred care. They regularly ask each patient about their experience of care. Any issue a patient may have, including symptoms like pain, they respond to immediately.

Just by listening, recording and responding, each and every time, this specialist team has been able to give care that targets the key issues their patients have, such as pain, nausea, breathlessness and constipation. And they are doing it better than the national average.

Mrs C had advanced lung cancer. She was fiercely independent but was too breathless to manage on her own any longer.

Initially she was cared for in a private hospital, but needed ongoing care in our Palliative and Supportive Care Unit. She hated this and was angry towards the staff and the whole world.

Our team listened to her concerns, hopes and dreams. They treated her with respect and responded to her needs. Eventually her fear evaporated, she settled in, and her lovely personality came out.

When her son came from overseas to be with her, the team saw this as a chance to get Mrs C home for a while. When she eventually needed hospital care again, Mrs C insisted she return to the team she trusted at the Palliative and Supportive Care Unit, refusing to go anywhere else.
Advance care planning is a process of planning for your future health and personal care needs. By talking to your family, friends and doctors about your health; your life-goals, values and beliefs; and your health care preferences, you establish what is important to you so if you become too unwell to speak for yourself, your loved ones and health professionals will have a plan for making decisions that are right for you.

Anyone over the age of 18 can have an Advance Care Plan but it is especially important for people who are living with a chronic illness, such as heart, lung, and kidney disease, or dementia.

Once you have decided what is important to you, you can write it down in a document that describes your plan and the types of treatment you would or would not want to have. At Melbourne Health, we call this document a Statement of Choices. If you do complete a Statement of Choices, it’s very important to keep the original document for yourself and provide a certified copy to: your GP; the hospital you normally attend; and your loved ones – so that everyone is on the same page.

You may also want to appoint an Enduring Power of Attorney (Medical Treatment). This is a legal document that allows another person to make medical decisions for you if you are unable to speak for yourself. That person should be someone you trust, who will listen carefully to your plans and goals for future health care, and will faithfully represent you. They can, but don’t have to be, a family member.

We are running training sessions with our staff, so our doctors, nurses and allied health staff have the knowledge, skills and understanding of advance care planning to help you with the process and give you the opportunity to complete a Statement of Choices.

You can find more information and obtain copies of all the documents on the Patient Information page on our website. You can also speak to a member of staff or email rmh-advancecareplanning@mh.org.au

According to Simon, about every five years a new challenge crops up. He doesn’t let it get him down, but he’s realistic.

He has a positive attitude to life and takes his chronic health problems in his stride, but knows that one day his health will deteriorate to the point where he will lose the independence he values so highly.

As a long-term patient, the hospital has been a big part of Simon’s life and his medical team have got to know him well. He trusts and respects them, and they know what he wants. So, Simon’s social worker spoke to him about creating an Advance Care Plan that reflected his wishes to live all of his life with dignity and autonomy.

He made it clear he didn’t want any of his family to feel the burden of responsibility; he knew exactly what he wanted from his advance care plan.

His social worker gave Simon all the advance care planning paperwork, which he shared with his older sister who he nominated as his enduring power of attorney. She was comfortable with this important role, and together they filled in the forms, with their local Justice of the Peace completing and certifying the paperwork.

His family respects and understands his choices – they all know what has motivated him to make them, and why he has created his advance care plan. A copy is with his GP, another with his sister.

“I’m one of eight – So nobody had to make the choice, I made the choice. If I’m not the same as I am, don’t revive me. Everyone knows what I want and I’ve no plans to review it,” he said.

Some days Simon’s illnesses are overwhelming, but other days they are manageable. Living in supported housing, he’s enjoying reconnecting with the community and running his own home. He can look back on an exciting life lived with panache, and know that when the day comes, his wishes will be respected.
Developing our skills

Cultural responsiveness isn’t always innate, so we need to make sure that our staff, at all levels of the organisation, are given professional development opportunities to enhance their cultural responsiveness.

We have introduced mandatory training for all our staff and volunteers. Partnering with Consumers includes information on our Aboriginal Health Program, interpreting services and cultural diversity awareness. It is delivered face-to-face at staff and volunteer orientation, and is also available on-line for those who want a refresher. Since the training was introduced in August 2013, 72% of staff have completed online training and 714 new staff attended orientation.

Our staff now have a greater understanding of how important it is to ask someone whether they are of Aboriginal or Torres Strait Islander descent and are becoming more comfortable asking. We have seen a drop in “unable to be asked” from 2% of all presentations (February 2013) to 1.4% (June 2013).

We are planning extra training on diversity and Aboriginal health, and improvements to the online training package will be finalised in the second half of 2014.

Once again, we celebrated Cultural Diversity Week in March, with more than 16 departments across the organisation enjoying A Taste of Harmony lunches with food from around the world. We held African drumming workshops for staff, and an Italian women’s choir sang for patients on wards at both the City and Royal Park campuses. During Cultural Diversity week Pastoral Care also facilitated a number of different religious activities in the Sacred Space including a Zen Buddhist meditation, an ecumenical Christian celebration and Ju’maa (guided Muslim prayers). All these activities help remind us of how rich and diverse our community is, and that cultural understanding is an integral part of our care.
Improving care for Aboriginal and Torres Strait Islander patients

We know that Aboriginal and Torres Strait Islander people experience poorer health than others in the community. Many live with chronic illnesses which are entirely preventable and overall have a lower life expectancy than the rest of the community.

Aboriginal and Torres Strait Islander health is not solely focused on the physical wellbeing of the individual. It involves the emotional, social and cultural wellbeing of the whole community, so it is vitally important that we establish and maintain relationships with Aboriginal communities and services.

In 2013 we developed two educational films to educate staff on how they can improve the care and health outcomes of Aboriginal and Torres Strait Islander patients, and empower this community to become active participants in their care.

Dean Heta, our Aboriginal Service Development Worker has visited eighteen Aboriginal Community Controlled Organisations to promote the films, which have been well received across the state. Feedback from the community has indicated that the film has helped them to know what to expect when they come to hospital, and to feel confident they will get a good service.

Producing the films has not only created an ongoing training and education resource, but has raised the profile of our efforts to close the healthcare gap, and highlighted the importance of our relationships with Aboriginal Community Controlled Organisations.

The films were funded by the Department of Health and the team who ran the project were highly commended in The Secretary’s Award for improving patient outcomes and patient experience at the Victorian Public Healthcare Awards 2013.

The Aboriginal Service Development Worker is an important link in the chain of providing appropriate care to patients as they arrive in hospital, during their stay, and then when they return to their communities. Dean works directly with the families, assisting them to access and navigate the health service. The help can be as practical as organising accommodation and meals for families, through to alerting the treating team of a patient’s particular issues, needs and preferences. Importantly, he has built strong relationships in the broader community so he can work with the patient’s local Aboriginal Community Controlled Health Organisations and support workers on longer-term care plans.

In late 2013, he revised the way that his notes in patients’ clinical files were identified. A coloured sticker with the Aboriginal and the Torres Strait Islander flags is now used in the clinical notes so that his input is easily identified.

To support this work, we developed a procedure, Meeting the Specific Needs of Self Identified Aboriginal and Torres Strait Islander patients, which will help staff across the organisation understand and meet the specific needs of Aboriginal and Torres Strait Islander patients. It covers information about correct procedure of asking the question about and correctly recording Aboriginal or Torres Strait Islander status; the specific health needs and life expectancy of this patient group, advice on provision of culturally safe care, and accessing training about improving care of Aboriginal and Torres Strait Islander patients. It was launched during NAIDOC Week 2014.
Changing the face of our workforce

One of the ways we can improve the care we give to Aboriginal and Torres Strait Islander patients is for them to have greater representation in our workforce. In partnership with the Royal Women’s Hospital, the Royal Children’s Hospital and the Peter MacCallum Cancer Centre, we have developed the Parkville Precinct Aboriginal Employment Partnership Framework to increase the number of Aboriginal and Torres Strait Islander people working in the health sector. We also launched our own Aboriginal employment plan in May 2014, during Reconciliation Week. This plan translates the strategy into action and we are proud of what we have already achieved.

We have secured funding for a part-time Aboriginal and Torres Strait Islander Employment Project Officer with the Department of Health and produced two short films featuring two members of staff who are Aboriginal.

In Together We Care, Dean Heta and Dr Glenn Harrison, an Emergency Department senior physician, share the importance of their cultural heritage and how this informs their professional lives. This film is being shown at all the management committees across the organisation. Join my Mob promotes us as an employer of choice for the Aboriginal and Torres Strait Islander community.

Inspiring the next generation of healthcare professionals is one way we can increase Aboriginal and Torres Strait Islander participation in the sector. On 25 March 2014, we hosted a visit from Yiramalay Wesley Studio School in Arnhem Land. Nineteen students had the chance to discover for themselves the different employment opportunities available throughout our organisation.
Every year we celebrate NAIDOC Week, where the nation recognises the significant contributions that Indigenous Australians make to our country and our society. During NAIDOC Week, we hosted the signing of a landmark agreement between Australian Indigenous Doctors’ Association and the Committee of Presidents of Medical Colleges. Aboriginal and Torres Strait Islander doctors are significantly under-represented in the medical workforce and as a major teaching hospital; we have an important role in supporting this agreement and ensuring its success.

Our Acknowledgement of Country procedure has continued to gain momentum, with departments such as Allied Health making sure that at staff forums, an Acknowledgment of Country is undertaken by someone from each discipline. Our Chief Executive, Dr Gareth Goodier acknowledges the traditional owners every month at the start of the orientation session for new employees. We also have a formal welcome to country at all major events including our Annual General Meeting, Community Board Meeting and official openings.
Local initiatives
Care in the community

Managing your health can be complicated. You might have a brief illness or injury, or you could be living with a medical or mental health condition that needs regular, ongoing care. The right care in the right environment is important for your health and wellbeing, so we have built relationships with primary health services, general practitioners and other organisations. Our Hospital Admission Risk Program, HARP, coordinates and integrates care between us and these community services, helping you to manage whatever chronic illness or condition you live with, and live as independently as possible.

The Diabetic Foot Service developed a very successful model of care with HARP for vulnerable clients with complex, diabetes-related foot conditions that took into account social, psychological and other issues that could affect their condition.

A care facilitator joined the Diabetes Foot Service for three days a week, to help the team to identify and engage with those clients with potentially unidentified psychosocial issues. Our clinicians learned how to incorporate questions designed to identify those issues into their conversations, and to use language which normalised the stress and psychosocial effects of chronic disease for the client and their carers.

The care facilitator and a psychologist also attended the Foot Service case conferences where clients’ issues were discussed, so their expertise could help shape the care plans and support the clinicians in their decisions.

Now, patients who may be anxious about moving from hospital to community services (or vice versa) will see the clinician they know at each venue, and be confident that the whole team is well informed about their history, care plan and special needs.

Another recent HARP innovation was the Chest Pain Service, developed with Emergency and Cardiology departments, which has successfully coached patients to manage their chest pain so they don’t need to come to hospital.
Of the people who frequently come to our Emergency Department suffering chest pain, around a quarter who stay between 12 and 24 hours are back within a month. We found that in most cases they didn’t have enough information about their condition to manage it independently or allay their concerns, and they hadn’t been linked to any care in their community.

A Cardiac Coach nurse now schedules in four phone calls over six months to talk them through their chest pain management plan; check they’re taking their medication; discuss smoking and other lifestyle changes that could reduce their chest pain; offer referrals to other services to manage other medical or psychosocial issues. They also visit patients in their home, as well as make sure their local doctor is kept informed and up-to-date.

As a result, the rate of people coming back to the Emergency Department within 30 days from chest pain has fallen from 25% to 14%, as people feel more confident and better able to cope on their own.

Adult community program redesign

In late 2013, we made major changes to how NorthWestern Mental Health delivered its community-based services to consumers and their families and carers. We needed to make sure our consumers, their families and carers were being heard and understood the information we had given them about their care. There was a growing need for our services which were becoming fragmented, limiting our ability to change practices in line with new evidence. The ‘Adult Community Program Redesign’, responded to these challenges in the traditional system and aimed to improve the clinical outcomes and the experiences of our consumers, their families and carers.

We have now integrated Community Teams which combine the functions of the traditional Crisis Assessment and Treatment Teams, Continuing Care Teams, Primary Mental Health Teams and Mobile Support and Treatment Teams. We are focussing on refining the content of the care we deliver, enhancing our recovery-oriented approaches, broadening workforce capability and establishing stronger partnerships with primary care and Mental Health Community Support Services. We believe this means we will be able to give our consumers and their families and carers consistent, evidence-based care; seamless, appropriate and acceptable services; and make best use of the expertise, skill and experience of our staff and those of other clinical and non-clinical service providers.

We surveyed more than 450 people, just under half who spoke a language other than English at home, to find out what they thought about the quality of care they receive and about our community mental health services in general. Overall, we received some very positive feedback about our services, and some constructive criticism that we can immediately use to make improvements.
The Multiple Family Group

It can be easy for others to forget that you are not your medical condition, and this is especially true when it comes to mental health. Separating the person from the condition lies at the heart of a highly successful program run by the Inner West Area Mental Health Service.

Widely recognised as one of the most effective clinical interventions a service can offer, the multiple family group, MFG, is a program for clients and their families and carers that meets fortnightly for 10 to 12 months. It uses people's experiences in a safe, staff-facilitated setting to promote peer support, understanding of serious psychiatric conditions and treatment options, and the impact the condition can have on the individual, their family and their relationships.

Because difficulties experienced by clients and their families are work-shopped by the group using a problem-solving approach, we have seen participants improve their coping skills, increase their confidence and independence, as well as improve communication and relationships within their families.

We are proud of our most recent MFG graduates and all that they have achieved. Some have returned to full or part time work. Others have retrained and are now members of the Inner West Consumer Advisory Group, sitting on committees, co-presenting in staff training and at conferences; and making a valuable contribution to the growing peer support and consumer/carer representative workforce.

All the graduates have increased their awareness of their mental health conditions and recognise the early warning signs. They are much more willing and able to address long-standing alcohol and substance abuse issues and have a greater understanding of the impact of gambling on themselves and their loved ones. They can all cope better with difficult feelings and conversations including grief and loss, disappointment and frustration.

Everyone is finding more of a voice and strength that comes from honouring the expertise that comes from the personal experience of living with mental illness.
The Works

Like anyone else in our community, people living with a severe mental illness want to participate in the workforce. Unfortunately, many miss out on further education and employment, or have their careers disrupted as a result of the impact of their mental illness. A recent survey by NorthWestern Mental Health reported unemployment rates as high as 85%. The Occupational Therapy service at Inner West Area Mental Health is tackling this issue through The WORKS.

The WORKS is a six-week program that supports people with severe mental illness to rebuild their career aspirations. Topics include an introduction, what work means to me, personal qualities, overcoming challenges, fitting work into my day, and where to from here? Each session includes worksheets, independent tasks, small and large group activities, preparation tasks and opportunities to give feedback.

The program is delivered by a team of occupational therapists and peer support workers: clinicians and consumers work in an equal partnership.

There have been three rounds of The WORKS and all the participants were willing to try the tasks even when they found them daunting or difficult. More importantly, they came back the following week even after saying the session had been emotionally draining and challenging.

We can see The WORKS is working. Half of the workshops had a 100% attendance rate, no client actively dropped out and just over half attended all six sessions. Everyone was willing to have a go, contribute during the sessions and complete their homework tasks.

Overall, people attending The WORKS felt they had learnt a lot about themselves as individuals. In their own words, they found the program “positive, practical, relevant and useful” “rewarding and fulfilling”, and “a good way of sorting out my goals and preparing to take the next steps in looking for work”.

One of the graduates now has regular work in a local coffee shop, another volunteers in a local op shop, and a third has joined local committees in his housing estate and is spending more time with family and friends.

We plan to expand The WORKS to all other adult mental health services in NorthWestern Mental Health and offer mentorship and consultation to other services wanting to set up The WORKS.
We have always encouraged courageous thinking to explore how we can give you the care you need more quickly, safely and efficiently. Nowhere is this more important than in those parts of the organisation where our patients are at their most vulnerable, most unwell and most in need of world-class care.

Intensive Care is one such place, and they have been doing what they can to keep you as safe as possible.

Breathing easy
What does the airline industry and intensive care have in common? They both use safety checklists to keep you safe.

Over the past 18 months, our Intensive Care team has developed a comprehensive safety program including standard operating procedures, mandatory staff training, and safety checklists to increase patient safety. One particularly high-risk area they have been focusing on is endotracheal intubation.

Endotracheal intubation is when a breathing tube is put into a patient’s windpipe to help them breathe. When it is removed, it is called extubation. Both procedures are common in our Intensive Care Unit, but there are still risks and even minor errors can have serious consequences.

Now, a pre-intubation checklist must be completed before putting a patient off to sleep. Our doctors and nurses check the equipment, drugs and monitoring before going ahead with the intubation. When the patient is able to breathe on their own without mechanical ventilation, the medical team completes the pre-extubation checklist before removing the patient’s breathing tube.

Along with having a standardised approach to endotracheal intubations, they have developed a step-by-step process to managing an airway where the placement of a breathing tube is challenging or impossible. This went hand in hand with testing and selecting key equipment based on current best practice.

All our Intensive Care doctors undergo a mandatory 5-hour training course in the hospital’s Simulation Centre at the beginning of their employment in the unit. The main focus is hands-on training using lifelike mannequin simulators. The course is also open to our Intensive Care nurses, as training doctors and nurses together builds strong teams, which improves patient safety. By the end of 2014, more than 100 ICU staff will be trained in the new standard operating procedure for endotracheal intubation.

These checklists help everyone follow the standard operating procedures and act as a trigger to increase vigilance. Using checklists in medicine is still fairly uncommon, but given the strong culture of safety in our Intensive Care Unit, they are now very much part of daily practice.
Right Food, Right Patient, Every Time

Eating and drinking isn’t as straight-forward as you might think when you’re in hospital. Delivering the right kind of food and drink to the right patient is a complex process and there are things that can go wrong and at times have gone wrong at Melbourne Health.

So in February 2013, we pulled together a team: Right Food, Right Patient, Every Time. The team developed an education program for clinical and non-clinical staff to build understanding of how complex providing patients with the right kind of food and drink in hospital can be.

They developed dysphagia guidelines for staff to follow when treating patients with swallowing disorders, a training package using real patient stories, and in June 2014, they launched an electronic nutrition toolkit to help staff order food and fluids that are safe for their patients.

Having monthly tracking and reporting of food and fluid incidents has raised awareness and has given us a way to classify these incidents by cause, so we know exactly where we need to make improvements to our system.

We now have a report listing a patient’s food and fluid orders before they move from the City to the Royal Park Campus, so staff can check previous meal orders, and our Assistant Nurse Unit Managers now cross-check the patient name, bed number and diet code. It is also mandatory for wards to display food and fluid diet codes on the front screen of our electronic patient management system, with high-risk diet codes highlighted in yellow; food and fluids are only given to patients with a valid diet code.

Cut-off times for ordering have been brought closer to actual patient mealtimes, so if a patient’s condition changes, their meal order can be adjusted accordingly.

Thanks to all these changes and a renewed focus on safety, the number of incidents from Royal Park has gone down, from 62% in 2012 to 25% in 2014, of the organisation’s total food and fluid incidents.
The patient experience

We are developing new ways for patients to tell us about their experiences. From 1 July 2013, every patient who stays overnight at The Royal Melbourne Hospital and gives us an email address has been sent an online patient experience survey. Since then, more than 2000 patients and their families have responded. The survey includes questions developed by experts in patient experience, and focuses on aspects of care that matter most to patients and families.

Overall, the survey feedback has been very positive: 82% report that they would recommend the hospital to a relative or friend – this is a solid starting point but we can do even better.

We have also had a 40% increase in the amount of feedback received via our complaints compliments and suggestions pathways. This represents contact from over 2500 people. The growth in feedback has been driven by an increase of almost 70% in compliments. More than 1000 patients and their families have specifically written or called to express their gratitude for our care. We have resolved more than 90% of our complaints within 35 days.

We are working hard to understand how you experience our services in order to make changes that matter to patients, and to demonstrate this commitment to you.

In response to your feedback we are working on our discharge processes and how we can involve patients, family and carers in decisions about care.

We have developed an e-Discharge system which will allow us to more quickly and easily provide you, your family and GP with a discharge summary about your stay. We are exploring ways of providing you with easy to understand information about the important side effects of new medications.

In response to your feedback we are also reviewing our cleaning processes.

You can find information on our website about the changes we have made based on your feedback: “You Said. We Did.”

Advanced physiotherapy

Adam de Gruchy is an Advance Practice Physiotherapist who works in our Emergency Department.

Advance Practice Physiotherapists look after patients with minor fractures, dislocations, ligament injuries, tendinopathies and spinal problems. Around half of these conditions they manage independently, as they are skilled in assessing and diagnosing musculoskeletal issues, and are trained in evidence-based treatments such as splinting, plastering, exercise and education.

Adam, and advance practice physiotherapists like him, look after their patients safely and effectively, helping free our emergency doctors to manage more acutely ill patients.

We also have advanced practice physiotherapists making a positive difference in our orthopaedic and neurosurgery services, and we are working with the Victorian Department of Health to help introduce these roles to other health services.
Living well, beyond the cancer

Thanks to early detection and improved treatments, more women than ever before are beating their breast cancer.

But the path of diagnosis, treatment and follow-up care isn't straightforward. Our Breast Cancer Survivorship Project aimed to improve the quality of care for women completing treatment for early breast cancer at The Royal Melbourne/Royal Women's Breast Service and Western Health Breast Service.

The project team wanted to make sure all their patients received the best possible ongoing care once their hospital-based treatment was over. These women needed to be kept informed about their diagnosis, treatment and follow-up care. They needed to know their care and information about their health was being properly shared between the Breast Service and their GPs, and they could quickly and easily get access to advice, referrals and other support.

A total of 184 women participated in a nurse-led clinic as part of the project, and 40 of these women took part in a telephone consultation with the Breast Care Nurse.

During their appointment, they would get an individual follow-up care plan, referrals to support networks and healthcare providers, and the chance to talk about their mental wellbeing as well as any physical or other issues.

The project team asked the GPs and the women who participated in the project what they thought of the shared care model. The GPs said the care plan and shared care arrangement has helped with communication and care coordination between the two services, and women have shown that they feel better supported at the end of their treatment thanks to the nurse-led consultation, and health and wellbeing management plan.

Finally, by moving a woman's care safely into the community when she's ready, our Breast Service staff can see more new patients at the hospital, and spend more time dealing with new referrals and complex cases.

Room to recover

More and more people are moving to Melbourne’s outer western suburbs. As the population in this area grows, so too does the demand on medical and mental health facilities. To meet the increasing demand for specialist mental health services, we extended the Sunshine Adult Acute Psychiatric Unit at Sunshine Hospital to include a four-bed assessment and planning unit.

The inpatient unit at Sunshine now has 29 beds: 20 Low Dependency unit (LDU), five Intensive Care Area (ICA) and four Psychiatric Assessment and Planning (PAPU) beds. We worked in partnership with Western Health to provide this secure environment that has flexibility to manage a varying mix of high and medium risk consumers.

After only an eight month build, the Sunshine Psychiatric Assessment and Planning Unit (PAPU) was officially opened on Tuesday 3 December 2013 by Mr Bernie Finn MLC, Member for the Western Metropolitan Region.

The PAPU was designed to reduce the waiting time in the Sunshine Emergency Department for people needing acute inpatient beds. By allowing direct admissions from the community, we can provide a greater standard of care in a more appropriate setting without needing an admission to the Sunshine Emergency Department.

The proposed length of stay in PAPU is 48 hours; during that time staff work with you to manage your immediate physical and mental health issues, as well as develop a personalised management plan in consultation with family, loved ones or carers that will help you receive treatment, recovery support and other health services in the community.

The PAPU means we can offer support that is informed by your unique strengths, preferences, needs, experiences and cultural background in a less restrictive environment than an inpatient unit.
Light, airy spaces help with recovery.

To meet the increasing demand for specialist mental health services, we extended the Sunshine Adult Acute Psychiatric Unit at Sunshine Hospital to include a four-bed assessment and planning unit.
Living better through moving more

Lung cancer is the second most common cancer in Australia. Two of the most debilitating symptoms are breathlessness and fatigue, making it hard for people living with this disease to remain physically active and stay as well as possible during, and after, their treatment.

We know that people living with cancer should do around 30 minutes of moderate physical activity at least five times a week, as exercise improves their fitness, quality of life and mental wellbeing. In fact, with some types of cancer, being more active is associated with improved survival.

Despite this, there is a gap between the evidence and practice. So we have partnered with the University of Melbourne to investigate how to bridge this evidence-practice gap for our patients living with lung cancer. Part of the project will look at what helps doctors encourage physical activity to their patients and what are the barriers. They will also measure how many patients are becoming active and by how much.

The aim is to empower our doctors to routinely encourage their patients living with lung cancer to follow the physical activity guidelines, and to help them to make that change. The research team hopes to learn what strategies work and develop new models that can be used by other hospitals and healthcare services in the future.

Currently the burden of lung cancer for both the patient and the community is substantial. Our team hopes that through their research they will help to improve the quality of survival of people with lung cancer.

Social Media and Chronic Pain

Many feel the burden of chronic pain. It costs Australia over $34 billion every year, but the human cost is incalculable, with patients, their carers and loved ones all feeling the strain. Those living with chronic pain feel misunderstood and stigmatised by the public perception of their condition.

Mark Merolli, a PhD candidate at the Health and Biomedical Informatics Centre (HaBIC), Melbourne Medical School asked people living with chronic pain what they thought about using social media as part of managing their pain. Survey participants reported using social network sites, blogs and forums, and most felt that through the ability to share experiences with others, social media could have a positive impact on their social, mental and cognitive well-being.

Building on this research, our chronic pain clinic at The Royal Melbourne Hospital Royal Park Campus has teamed up with Mark and HaBIC to look at how effective social media resources are for people living with pain. He is running a pilot study with people on the clinic’s waiting list, to measure acceptability, uptake and use, and pain health outcomes.

There is a very high demand for the services of the chronic pain clinic and the clinic staff routinely review the waiting list and seek ways to assist patients waiting for appointments. If social media access and resources can assist patients with chronic pain it may provide another useful tool for patients and potentially expand the reach of service beyond the conventional clinic setting.
Redesigning care

The Broadmeadows Adult Psychiatric Inpatient Unit (BIPU) is a 25 bed unit providing short-term care to people in an acute phase of mental illness. Following some concerning complaints from BIPU consumers and carers, the team went about improving experience of care.

They found out that the amount of time the nurses spent in direct care was low and that they weren’t well engaged with those they were meant to be looking after. The consumers said they struggled to get access to staff, didn’t feel like they were being listened to or involved in the planning for when they left the facility.

The more formal communication wasn’t working either: lots of meetings were interrupted; what should have been formal, clinical consultation became informal and ad-hoc; and there was no clear care pathway, which resulted in lots of duplication and gaps.

They now have a daily multidisciplinary handover to improve communication between the shifts, clearly allocate tasks and plan for every consumer’s care. The clinical review was redesigned to put the focus on the consumer, enhance the nurses’ role in care and make the whole process more efficient. Finally the new primary nursing model allocated nurses to medical teams to provide holistic and continuous care.

By working from the bottom up – letting the consumers, carers and staff define the problems and find the solutions, the changes have been dramatic. The BIPU nurses have much more time to care: ‘high’ engagement time with consumers has gone from 36% to 94%. Our consumers are now more involved in their discharge planning, have better access to their BIPU nurses and are feeling respected, safe and comfortable.

The BIPU staff are finding things better too, as they are interrupted less often, the multidisciplinary care pathways for their consumers are better defined and easier to use, and there are formal channels for communication in place.

Most importantly, complaints about the quality of care have dropped and compliments are the highest they have ever been.
Falls

In 2013 there were 2,055 reported patient falls across all areas of the organisation, compared with 1,957 reported falls in 2012. Injuries from falling have also increased, with 47 falls resulting in fracture reported in 2013, compared to 26 in 2012.

We are very concerned about the increase in falls and committed to reversing the trend. In response we recruited a Falls Prevention and Improvement Coordinator, Hayley Murphy in May 2014. Hayley is leading the push to prevent falls through education and communication and as part of this process, review all falls as they are reported.

By reviewing the data we collect on who is falling, where and when, we can identify areas where an intervention is likely to have impact and work out ways to prevent falls. As an example, we know that our patients are much more likely to fall in the bathroom or on their way to the bathroom, so that is one area where we have increased our focus.

Hourly rounding (nurse checks on the patient) to anticipate and assist with toileting and other needs has been implemented across all wards. We have reviewed the published research on falls prevention and are using data to compare ourselves to other similar healthcare facilities and share information and approaches to improve our care.

We are in the process of reviewing our assessment tools and purchasing suitable equipment such as low beds, to prevent harm from falling. In 2014, we are spending $1.2 million on additional equipment to prevent falls.

A recently introduced initiative on every ward is the Falls Champion; a recognised leader, passionate about improving patient care and an advocate for falls prevention. The Falls Champion assists their colleagues develop their knowledge of best practice in relation to falls prevention and make sure it is being practiced and regularly evaluated.

We have made progress and achieved some successes. The aged care ward AC2 on the Royal Park campus and neurosciences Ward 4 South have both achieved significant reductions in the number of falls. We are assessing how to replicate the changes they have made in other wards and across Melbourne Health.

By reviewing the data we collect on who is falling and where, we can identify those areas where you are at the greatest risk of falling, and work out ways to stop this from happening.
Preventing the spread of infection

One of the easiest ways to stop the spread of infection is by washing your hands. Because good hand hygiene is so important, we have extended our hand hygiene auditing program to all departments and areas at our City and Royal Park campuses, our satellite dialysis centres, and NorthWestern Mental Health facilities. We now have 180 trained auditors including a consumer auditor who report on hand hygiene compliance for their area every month, with the results shared amongst staff through a league table on our intranet.

Three times a year, every hospital in Australia submits their hand hygiene compliance for high risk areas such as Intensive Care, operating theatres and cancer care. We submit our data at the end of March (National Audit 1), end of June (National Audit 2) and end of October (National Audit 3), with the national results published on the www.myhospitals.com.au website.

The national benchmark is 70% hand hygiene compliance. Our compliance for 2013/14, was consistently above the national benchmark, with an overall average compliance of 77%. This reflects our ongoing education and audits which have improved awareness and compliance with hand hygiene.

One way we monitor whether our staff are practicing hand hygiene is through a patient survey. In May 2014, patients said that 70% of the time, doctors cleaned their hands before treating or seeing them and 80% of the time they saw our nurses clean their hands.

Falls, and the injuries that can come from having a fall, can be devastating when you’re an older person.

You just don’t “bounce back” like you did when you were younger.

The team on our aged care ward, AC2, were determined to keep the patients they cared for safe by preventing falls and the harm they cause.

Over the last 12 months, they have increased formal and informal staff education on awareness of falls. During clinical handover and in informal patient safety ‘huddles’, they discuss how best to manage those patients who are at high risk of falling. Patients at greatest risk of falling are checked every half hour instead of an hour, with extra time allocated to observe their behaviour and keep them from harm. The falls champions are making sure everyone knows how to use the falls risk assessment tool and that it is being used for every patient, every time.

The ward introduced more beds that can be lowered to floor level to prevent patients from falling out of bed and bought six pairs of hip protectors. This caring team take the time to explain to the patients and their families how to use the hip protectors and the low-low beds, and how the bed sensors work.

Their efforts are paying off: from 21 June 2014, for 36 consecutive days, not one patient had a fall.
Many patients in hospital, especially in our Intensive Care Unit, have an intravenous line put in, commonly known as a drip. Sometimes they might have more than one intravenous line, or it might be in there for a long time. This increases the risk of infection, particularly bloodstream infections.

By tracking these infection rates, we can see whether our infection prevention procedures are working, and it has proved effective in our Intensive Care Unit. We have now expanded this monitoring to other wards where patients need intravenous lines for long periods of time, and those areas now apply the same strict protocols used in Intensive Care. We have a standardised line insertion technique and a standardised way of caring for the patient’s line once it is in. For each line inserted, there must be a plan to remove it as soon as possible when it is no longer needed.

One of the most common types of bacteria associated with intravenous line infections is Staphylococcus aureus – known as “Golden Staph”. When Staph gets into your blood, we call this Staphylococcus aureus bacteraemia, or SAB. This can make you very unwell, and can be life threatening. We closely monitor for SAB so it can be treated appropriately as soon as possible. We also send a comprehensive review of the infection to the medical head of the patient’s ward to help them investigate the most likely cause of the SAB.

We report our SAB infections at a national level so we can compare infection rates with other hospitals of similar size across the nation. During 2013/14 our rate of 1.3 was well below the National Standard of 2; and our own target of 1.5 infections per 1000 bed days.

Since 2003, we have been tracking surgical site infections following hip and knee replacement and cardiothoracic bypass surgery. For each infection, an in-depth review is reported back to the medical head of the unit where the patient was staying, so they can use that information to change practices at a ward level.

We report surgical site infection to the Victorian Healthcare Associated Infection Surveillance Service (VicNISS) so we can compare our infection data with other Victorian public hospitals. Overall, our infection rates compare favourably with other hospitals that perform the same surgery; we sit close or below the average Victorian hospital infection rate for hip, knee and cardiothoracic infections.
Pressure injuries

Did you know you can get hurt from lying or sitting for a long time? You can develop a pressure injury from being on an operating table, or from sitting on a chair where the blood flow to your skin has been restricted. They most commonly form on the heels, lower back, hips and elbows.

Not everyone is at risk of developing a pressure injury; older patients with fragile skin are more likely to develop them than younger people. People with mobility issues, or who use a wheelchair are also at greater risk, and if you have heart disease or diabetes, you are more likely to develop a pressure injury.

Pressure injuries are categorised on a four-point scale, based on how deep the injury goes: 1 is superficial and 4 is deep damage.

We have a Skin Integrity Committee and Wound Resource Education Nurses (WReN’s) whose responsibility it is to provide education and practical support on the wards to make sure every nurse knows how to identify patients at risk, what to look for and how to prevent pressure injuries. We regularly audit our pressure injury prevention activities and in our most recent audit of 784 patients, 86.8% were identified as high risk. Of those, 69.3% were lying on air mattresses and 67.4% had the pressure on their heels relieved by a pillow. This shows our staff understand the minimum provision for pressure area care and current preventive practices.

Our research focuses on how best to prevent pressure injuries and we have developed new ways to protect our most vulnerable patients. For example we reduced pressure injuries in ICU patients by 76% through the use of specialised dressings to prevent these wounds occurring.

We also focus on ongoing education to keep staff informed of the latest evidence of how to prevent pressure injuries and will continue our research in this important area of patient safety.

Number of pressure injuries per 1000 bed days at Melbourne Health
Medication safety

The National Safety and Quality Health Service Standard for Medication Safety outlines what we need to do as an organisation to make sure that your medications are prescribed, dispensed, administered and explained in a safe and appropriate way. Our Medication Safety Committee is responsible for overseeing compliance with this standard and continues to lead improvement activities in this area. In partnership with the Pharmacy Department, some of these improvements are outlined below.

The process of matching up the medications you take at home with the medications that you are prescribed when you are admitted to hospital is very important. This process is called ‘medication reconciliation’. It helps to prevent unintended changes to your medications while you are in hospital and prevent harm by reducing the opportunity for medication errors. A key part of this process involves a pharmacist recording what medications you were taking before you came into hospital. We have started to measure this process every month, with our June 2014 result showing that 84% of our patients have a medication history completed by a pharmacist within 24 hours of hospital admission.

We are committed to making sure that you understand the medications you are taking. In May 2014, we worked with a group of patients and carers to find out what medication information matters most to you, and to get feedback on how we can improve the way that pharmacists explain your medications while you are in hospital. We are now focusing on how we can make sure that your preferences for receiving education are met, and looking to new ways to help you understand your medications and be informed of changes during your hospital stay.

Over the last year, the Pharmacy Department has been working with medical and nursing staff to develop new organisation-wide medication guidelines. We are concentrating on the medications that are thought to be ‘high-risk’ and can cause harm if used in error, such as intravenous (IV) potassium. These guidelines will help make sure the medications you require during your hospital stay are safely prescribed, administered, dispensed and monitored in a standard way.

The Medication Safety Committee encourages all staff to report medication incidents and “near misses”. We want to know as much as possible about who, what, where, when and why medication errors occur. In the last 12 months, we saw a rise in the number of incidents reported compared to last year. We use this information in order to improve the awareness and know more about the medication risks at Melbourne Health. The more we know about medication risks, the more we can focus our efforts to make improvements to make medications safer for all of our patients.
**Blood safety**

Blood and products made from blood are used throughout the hospital. Their distribution and storage is managed by the Transfusion Laboratory team.

The clinical team giving the transfusion share the responsibility with the Transfusion Laboratory team of making sure it’s the right product for the right patient and that it’s been given appropriately. But the Transfusion Laboratory team are the ones who have to make sure the blood is safe to give.

They do this by making sure it is kept at the right temperature, 4°C, but when it leaves their laboratory they can’t guarantee the storage conditions. So, any unused blood returned to them is thrown away if they don’t know how it has been stored, as it can be dangerous to transfuse blood that has been stored incorrectly.

To reduce the amount of blood we are wasting without putting you at risk, we have changed the way blood is requested and issued to the operating theatre – one of the places where the most blood is used. Unless it’s an emergency, or some other pre-arranged special case, blood is issued one unit at a time.

In May 2014, we introduced a new blood tracking system, *Blood 360*, which is used throughout the United Kingdom. A central hub sitting in the Transfusion Laboratory talks to the remote blood fridge, so the Laboratory team knows whether there has been a break in the cold-chain for a particular unit of blood and for how long. This means they can return the unused blood back into the inventory rather than wasting it.

With *Blood 360*, our wastage has dropped considerably; in June 2014, we reached our target of less than 4% waste in our operating theatres. Our haematology ward, another area that uses a lot of blood and blood products, is now working towards the purchase of the *Blood 360* tracking system.

We will continue to teach staff how to use and store blood safely, so everyone understands the role they play in reducing waste.
Residential aged care services

We operate eight residential aged care services in northern and western Melbourne:

- Gardenview House, Parkville
- Boyne Russell House, Moreland
- Cyril Jewel House, Keilor East
- McLellan House Hostel, Jacana
- Merv Irvine Nursing Home, Bundoora
- South Stone Lodge, Werribee
- Westside Lodge Nursing Home, St Albans

The facilities provide residential, high care services with the exception of McLellan House Hostel which is a low care facility.

Gardenview House is a facility for residents with acquired brain injuries and Cyril Jewel House provides care for residents with multiple sclerosis and neurological disorders, in addition to residential aged care.

Falls and fall related fractures

At MH the number of falls and falls related fractures in the residential aged care services remains under the statewide average excluding the 3rd quarter for falls with fracture. Analysis of the incidents involving a fall and fall related fracture provides valuable information on which to develop increased staff awareness of the circumstances that contribute to falls and standard precautions that can reduce the risk of falls.
Physical restraints

Physical restraint devices are used in circumstances where there is a direct risk of the patient injuring themselves or others and is kept to a minimum wherever possible. The Melbourne Health results for 2013/14 unfortunately remain above the statewide average and continue to reflect the complex needs of the patient population in specific Melbourne Health high care residential services; particularly Gardenview House. The use of physical restraints which includes a range of devices including tilt chairs, bed rails and seat belts, is regularly monitored and reviewed to determine both appropriateness and the requirement for ongoing restraint.

Residents prescribed nine or more medications

The number of MH residents prescribed nine or more medications reflects the high care and complex needs of residents across the range of residential services. As a result MH records higher numbers when compared to the statewide average. An increased number of medications for an individual resident can increase the risk of medication errors and subsequent harm. Regular review of all prescribed medications is required to ensure prescribing follows best practice guidelines.
Weight loss
Weight loss experienced by elderly patients in residential aged care services is an area of increased focus in terms of monitoring and prevention. The weight loss can be due to a combination of the patient’s medical conditions and the type and quantity of food available. MH numbers were above the statewide average in 2013/14. Ongoing initiatives include identification of residents who require assistance at mealtimes and a focus on providing more time to finish meals.

Pressure Injuries
Pressure injuries most commonly form on the heels, lower back, hips and elbows and older patients and residents are at a higher risk of developing pressure injuries due to a combination of factors such as fragile skin, mobility issues and prolonged periods sitting or lying in the same position. The number of pressure injuries recorded in 2013/14 were above the statewide average and although the numbers overall are low, an ongoing education program ensures staff are kept up to date with the latest evidence on how to prevent pressure injuries.
Governance and accountability

Accreditation

From January 2013, all Australian health service organisations must be accredited against new National Safety and Quality Health Service Standards (NSQHSS). Standards 1 and 2 cover health service governance and partnering with consumers, while Standards 3 to 10 reflect the key clinical risks to patient safety.

We have also chosen to participate in EQuIPNational, which has five additional Standards addressing service delivery, provision of care, workforce management and planning, information management, and corporate systems and safety.

In November 2013, as part of the four yearly accreditation cycle under the EQuIPNational program, Melbourne Health undertook a Periodic Review, accreditation survey. As we were fully accredited in 2011, this review was to address elements of NSQHSS which are considered to be critical in maintaining quality and safety standards. This Periodic Review survey was against Standards 1 to 3 plus critical elements of Standards 11-15.

The new accreditation process is a compliance-based model. We are rated against specific action items with the possible ratings being:

- **MM** – Met with merit
- **SM** – Satisfactorily met
- **NM** – Not met

To achieve or maintain full accreditation, all action items must achieve at least a **SM** rating in all core action items. From the 133 actions reviewed in November, we achieved **SM** for all core actions and 31 actions were upgraded to **MM**, an outstanding achievement for the first review under the new NSQHSS program.

Standards in Action

To prepare for the next Organisation-Wide Survey in 2015, we introduced “Standards in Action”, a program of training, audit and information for the 15 EQuIPNational Standards, so staff understand them and know how to incorporate the requirements into everything they do.

In April 2014 we commenced the “Standards in Action” program and have covered a different National Standard every month, featuring a review of relevant policies and procedures; completing relevant mandatory training, and any improvement activities to make sure we are ready for a full Accreditation Survey in 2015.
Melbourne Health

Quality of Care Report 2013/14

Standard 1
Governance for Safety & Quality in Health Service Organisations

Standard 2
Partnering with Consumers

Standard 3
Healthcare Associated Infections

Standard 4
Medication Safety

Standard 5
Patient Identification & Procedure Matching

Standard 6
Clinical Handover

Standard 7
Blood & Blood Products

Standard 8
Preventing & Managing Pressure Injuries

Standard 9
Recognising & Responding to Clinical Deterioration in Acute Health Care

Standard 10
Preventing Falls & Harm from Falls

Left: The National Safety and Quality Health Service Standards.
We are one of Victoria’s leading public healthcare services, serving more than 1 million Melbournians as well as regional and rural Victorians and interstate patients.

Melbourne Health is made up of The Royal Melbourne Hospital City and Royal Park Campuses, NorthWestern Mental Health and the Victorian Infectious Diseases Reference Laboratory.
Tell us what you think

Thank you for reading our Quality of Care Report
To help us improve this report, please take a moment to fill in this feedback form.
Please tick the answer that matches your response.

### How do you rate the presentation of this report?

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<th>Poor</th>
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<th>2</th>
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<th>5</th>
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### Was the report easy to understand?

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### Do you think the report was:

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### Would you like to see more information about:

(Tick as many that apply)

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<tr>
<th>Melbourne Health services</th>
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<tr>
<td>How consumers/volunteers contribute to the organisation</td>
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<td>Preventing and managing pressure injuries</td>
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<td>Preventing falls and harm from falls</td>
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<td>Safe use of blood and blood products</td>
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<td>Preventing and controlling healthcare associated infections</td>
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<tr>
<td>Use of physical restraint on patients and residents</td>
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<td>Medication safety</td>
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<td>Quality and Patient Safety related policies</td>
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<td>Hospital accreditation</td>
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<td>Research projects and how the findings have been applied</td>
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### Other

### What would you like to see more of?

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<th>More patient stories</th>
<th>☐</th>
<th>Staff profiles</th>
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### General comments:

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Thank you for your feedback

**Please return this survey to:**
Transformation and Quality
Level 2, Materials Handling Building. The Royal Melbourne Hospital, Parkville 3050,
or drop it into the feedback boxes found on every ward.
This report is a snapshot of our work in 2013-14. It describes how we measure and monitor the quality and safety of the care we provide and what we are doing to improve our services. Community representatives, medical, nursing and allied health staff all helped develop it. We used feedback from people who received last year’s report, input from our Community Advisory Committee and staff to shape its content and look, as well as making sure we followed the guidelines, comments and instructions on content from the Department of Health.

You told us you wanted a more conversational, easy to read report and that you wanted more patient and staff stories. This year we’ve used stories where possible to illustrate the areas we are reporting on. These stories cover:

- Doing it with us not for us – strategic direction 2010-13
- Cultural Responsiveness Framework
- Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) program, key result areas 1 to 4
- Preventing and controlling healthcare associated infections
- Medication safety
- Preventing falls and harm from falls
- Preventing and managing pressure injuries
- Safe use of blood and blood products
- Quality indicators in public sector residential aged care
  - Pressure ulcers
  - Falls and fractures
  - Use of physical restraint
  - Multiple medication use
  - Unplanned weight loss
- Clinical governance
- Accreditation
- Quality improvement
- Applied research projects.

Last year the report was available to patients and families in our outpatients clinics, at pre-admission, in the Emergency Department, hospital cafeteria and patient waiting areas. It was also on our website: www.mh.org.au. We advertised in our local newspapers and invited people to either download it or contact us for a copy.

This year, we will distribute the report across our services so as many people as possible can read and comment on it and we are partnering with our Community Advisory Committee and volunteers for their feedback through focus groups and surveys. Our top 50 local GPs and the Medicare Locals we partner with will get a link to the online version of the report to share with their staff and local communities.

To give your feedback, there is a form on the back page of this report and on our website. We welcome your comments. By sharing your thoughts, you will help us make sure this report and our services meet your needs.