

## Public Health to the Fore

**Kerry Chant, Chief Health Officer, Deputy Director-General, Population and Public Health, NSW Ministry for Health** (MoH) visited the Northern NSW Local Health District (NNSW LHD) to promote Public Health Services. Dr Chant was accompanied by Paul Corben, Director of the North Coast Public Health Unit and together they attended an Executive Meeting to discuss some of the key issues relating to Public Health Programs.

### NSW Health HIV Strategy

Dr Chant advised that the new NSW Health HIV Strategy was launched on 1 December 2013. The key elements focus on HIV now being considered a chronic disease, which is best managed in a primary care setting with links to specialist care where appropriate.

Dr Chant said the testing and treatment rates for HIV need to be increased and there is good evidence that early treatment is essential. It is important that the message of maintaining safe sex and condom usage is continued and that there is easy access available to Sexual Health Clinics to respond to a drop in testing of clients. Dr Chant indicated that there may also be some strategies being identified in relation to point of care testing to provide rapid testing of high risk population groups and it may be appropriate for outreach models to be utilised to reach hard to access communities.

A strong focus needs to be undertaken on removing any barriers to treatment and in creating easier access to pharmaceuticals.



At the NNSW LHD Executive Meeting above L-R front: Annette Symes, Executive Director, Nursing & Midwifery; Chris Crawford, Chief Executive; Kerry Chant, Deputy Director General, Population Health & Chief Health Officer, NSW Ministry of Health; Hazel Bridgett, Board Member; Vicki Rose, Acting Executive Director of Allied Health and Manager Chronic & Primary Care; back row: David Hutton, Executive Director, Clinical Governance; Wayne Jones, Acting Executive Director, Richmond Clarence Health Service Group; Paul Corben, Director NNSW & Mid North Coast LHD Public Health; Ian Fielding, Executive Medical Director; Tony Beashel, Acting Chief of Staff, Chief Executive Unit and Richard Buss, Executive Director, Mental Health and Drug and Alcohol Services.

Dr Chant also suggested that Antenatal Clinics may be an area, where HIV testing can be made available. Further, she indicated there may need to be developed some strategies with assistance from the Drug User Groups to create a mixed model for distribution of Needles and Syringes. It is important that the injecting drug use is mapped, so that it is not just targeted towards low risk groups and it is important to include Aboriginal communities.

### Immunisation

Dr Chant noted that immunisation is a key challenge for the North Coast and that there will be an immunisation campaign in 2013, which will focus on issues of timeliness and will try to dispel some of the myths about immunisation.

Dr Chant noted that some Staff also hold strong anti-immunisation views and these views can "rub off" on the community, and it is important to manage this, as it is essential to mitigate as far as possible, the sending of anti-immunisation messages to the community via our own Staff.

### TB Clinics

The MoH has provided some additional funds for TB Clinics in LHDs to engage additional Nursing and Aboriginal Health Worker Staff to work in these TB Clinics.

Paul Corben said the challenge is the late diagnosis of men and removing barriers and building on strengths in the communities to increase the uptake of

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## **A word from the Editor, Susan Walker**



Just when some of us are retiring or reaching retirement age, along comes Jacqueline (known as Jacky) Shaw. Jacky is 71 years old and was one of eight nursing and midwifery graduates celebrating the end of their Transition to Practice internship at Grafton Base Hospital (GBH).

The group, pictured at right are a mix of young and mature women, most of whom have been offered positions on the casual roster at GBH and Maclean Hospital, and one is moving to Adelaide.

Jacky lives in Coffs Harbour and drove each day to GBH and back. I found her really inspiring and so did many others as she created some media interest and made the front page of the Grafton Daily Examiner, resulting in a request from the Coffs ABC Radio Station to interview her. When I called Jacky to see if she would speak on radio, she was working at the computer on her masters. Her special interest is in mental health.

The Nursing Graduate Program would not be successful without the invaluable support of our Management Team, the Nursing Unit Managers and the Clinical Nurse Educators, and particularly the Nursing Staff in general, who take the new graduates under their



*Above some of the Nursing Graduates with their Certificates after completing the "Transition to Practice" year from left: Marianne Taylor, Karlie Little, Deborah Bernard, Jacqueline Shaw, Felicity Drungilas and Belinda Simpson.*

wings and guide them through their Transition to Practice year. During February, across the Local Health District our hospitals have been welcoming the new Nursing & Midwifery Graduates and many of the previous year's graduates are staying on, as second year out Nurses.

In the past month we have farewelled some of our long term Nursing and Allied Health Staff, you will see who those people are when you reach page 12.

## **Lee Rowe, Clinical Nurse Consultant - Quiet Achiever**



*Nominated by Warren Shaw, Network Manager, Richmond Clarence Mental Health Services and Samantha Osborne, Acting Manager, Clarence Valley Mental Health Service.*

Lee relocated to the Clarence Valley and commenced working for Clarence Valley Mental Health Service in 1995. Since then, in her CNC role, Lee has been a remarkable asset and resource. Her commitment to excellence in Nursing is evidenced by the clinical leadership she provides. Her passion for nursing and education has seen her develop and maintain highly successful under graduate and new graduate programs. This passion combined with her sense of social justice and her advocacy for consumers has also seen the development of highly successful multi family education groups in regard to mental health issues.

Her expertise is well recognised across the Clarence Valley and LHD and this sees her contributing to a range of quality and governance activities across the area over many years. At team

level she is regarded as a senior, a mentor and role model, but more importantly a buddy.

Lee Row commenced training as a Psychiatric Nurse in 1969 at North Ryde Psychiatric Centre (now Macquarie Hospital) in Sydney. Twelve months later she was off overseas and around Australia with her film producer husband.

Lee gained registration as a Psychiatric Nurse in 1974 at Gladesville Hospital in Sydney, another Schedule 5 hospital with approx 1,200 patients. The hospital comprised acute, rehabilitation, refractory, geriatric, disability and medical wards along with a piggery, market gardens and a variety of workshops – all of which provided skills development and meaningful activity for the patients.

In the mid-70s Lee accessed tapes from America of what was very early work in Cognitive therapy and relaxation, which interested Lee so much that she quickly incorporated the concept into her practice.

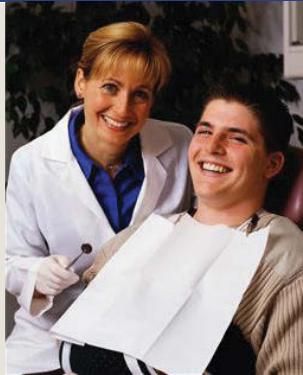
In 1977 Lee relocated to the Dubbo area and joined the newly developed Community Mental Health team. The (then) Orana & Far West area fanned out from Dubbo to cover one third of NSW – north to the Queensland border and west to Broken Hill with a population of around 120,000. Lee's role was to introduce a Community Mental Health Service to this vast area and each had designated towns where they operated as sole practitioners. Health flights were available once a week, rotating through Cobar, Bourke, Brewarrina and Walgett and once a month to Broken Hill.

With the implementation of the Richmond Report in the early 80s, community mental health services began to expand and more closely resemble today's service and practices. In 1991 Lee was appointed to the CNC position (still as a sole practitioner) based in Lightning Ridge and also servicing Walgett, Goodooga and Collarenebri.

# Public Health to the Fore continued

## Dental Health

The NNSW LHD Executive was advised of several important negotiations being undertaken by the MoH including one with the Commonwealth around a Dental National Partnership Agreement (DNPA), which is intended to augment Public Sector Dental Services and Private Sector Dental Services with a view to targeting eligible persons, such as the groups that would normally be on Public Sector Dental Waiting Lists.



Dr Chant said there will be a significant focus on Dental Health Services in 2013 and noted that Dr Greg Davies, Clinical Director of Dental Services, NNSW LHD Oral Health Program, is on a MoH Advisory Committee that is providing input to the MoH on the implementation of this National Dental Program.

Dr Chant indicated that the MoH will be allocating funding for the Dental Program according to the percentage of the eligible

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preventative therapies. The Public Health Unit is undertaking work with the Aboriginal Medical Services on how broader TB Screening can be undertaken.

## Obesity



Dr Chant reported that a whole of government Obesity Plan will be released in 2013, including a strong focus on an Early Childhood Primary School Parental Program, that supports parents and the child, which is more of a mentoring program for children. There is now improved data collection with a survey undertaken of all Early Childhood

Centres and Primary Schools. In line with this data, the targets for LHDs will be more nuanced and will change over time, as better information becomes available.

Better referral pathways to strengthen the "Get Healthy" Coaching Service are being considered, as there is a real opportunity to embed this program. Referrals such as in the Community Health Programs will be encouraged.

## Diabetes

In 2013 a Diabetes focussed model will be developed and a healthy weight in gestation model for pre-pregnancy will also be introduced, so assisting women to go into pregnancy within a healthy weight range.

## Quit for a New Life Program

The MoH needs the support of the LHD in progressing the 'Quit for a New Life Program' that targets Aboriginal Mums who smoke during pregnancy. The new Program focuses on the mother and extended family, but will also work outside the family setting such as via a Maternity Stream, Obstetric Stream or Community Health Stream, according to Dr Chant.

Chris Crawford advised that NNSW LHD has developed some educational resources to assist in promoting a non-smoking message to the Aboriginal community, especially to prospective Aboriginal mothers. Chris Crawford told Dr Chant that NNSW LHD looks forward to working co-operatively with the MoH to promote Public Health Programs

population by LHD and the MoH would like to use the funds to grow the Public Sector Dental Program and is seeking assistance from the LHD to do so.

Using the Commonwealth Funding, NNSW LHD has recruited four additional Dental Teams, of a Dentist and Dental Assistant. These Dentists will assess and treat patients in NNSW LHD Dental Clinics. As well, NNSW LHD has issued a large number of Dental Vouchers, which allow patients to receive services, including Dentures from Private

Dentists.

Dr Chant indicated that in 2013/14 another round of Oral Health initiatives are due to be rolled out, such as the Child Dental Programs and infrastructure funds to upgrade or expand the number of Public Dental Clinics within the LHDs.

## Cover up as Mosquitoes hit after floods



North Coast Public Health Unit is reminding us all to protect ourselves against mosquitoes, which are increasing in numbers as flood waters recede.

Mosquito numbers normally increase in summer but tend to become more of a problem after flooding, when there is water lying around and as the weather warms up. The heavy rains and flooding of recent weeks has produced more mosquito breeding sites and a greater risk of being bitten.

Ross River and Barmah Forest viruses are common on the NSW North Coast and are transmitted by infected mosquitoes that breed in flooded, grassy and swampy areas and around waterways.

On average, in each year over the past decade, about 500 people living on the North Coast were diagnosed with either Ross River virus or Barmah Forest virus - in equal numbers (around 250 cases of each are reported on average each year).

Simple steps to avoid being bitten by mosquitoes include:

- When outside cover up as much as possible with light-coloured, loose-fitting clothing and covered footwear.
- Use an effective repellent on all exposed skin. Re-apply repellent within a few hours, as protection wears off with perspiration. The best mosquito repellents contain Diethyl Toluamide (DEET) or Picaridin.
- Light mosquito coils or use vapourising mats indoors. Devices that use light to attract and electrocute insects are not effective.
- Cover all windows, doors, vents and other entrances with insect screens.
- When camping, use fly screens on caravans and tents or sleep under mosquito nets.

Preventing these viruses depends on avoiding mosquito bites, especially in the warmer months of the year when mosquitoes are most active.

# Welcome to Nursing & Midwifery Graduates



Above L-R: LBH Midwifery Graduates Rachel van Raak-Shine, Tanya Fenwick with Jayne Lawrence, Midwifery Clinical Nurse Educator and Taylor Alexander.



Top right at left: Brian Pezzutti, Chair, NNSW LHD Board with LBH Nursing & Midwifery (N&M) Graduates, was joined by Thomas George - third from left beside Charmaine Crispin, Nurse Educator and centre, Acting Director of N&M Narelle Al- Manro in welcoming the new N&M Graduates to Lismore.

Right: At GBH the new N&M Graduates were welcomed by at right by Allan Tyson, Member of NNSW LHD Board and at rear, Chris Gulaptis, Member for Clarence and far left Paul Schofield, Director of N&M.

Below right: Some of the N&M Graduates at The Tweed Hospital were joined by at left: Denise Harris, Acting Director N&M for Tweed and Murwillumbah Hospitals, Annette Symes, NNSW LHD Executive Director of N&M (kneeling second from right) and Geoff Provest, Member for Tweed.

In early February a total of 62 First Year new graduate Nurses and Midwives commenced working in hospitals across the NNSW LHD.

In the Richmond area there are 18 new fulltime graduate registered nurses, who will undertake three placements of four months each. The rotations include working in specialty areas such as Operating Theatres and Mental Health, as well as rural locations at Nimbin, Kyogle and Urbenville. They will also undertake placements at Ballina and Casino and Lismore Base Hospitals (LBH).

In the Clarence Network, 12 new graduate Nurses and Midwives will rotate between Grafton Base and Maclean Hospitals over the next 12 months. Last year's group recently completed their new graduate contracts and most of them have been successful in gaining employment at Grafton Base Hospital (GBH).

The Tweed Byron Health Service Group has 32 new graduate Nurses and Midwives. This year four will work in the Mental Health Service, while the other 29 will work across The Tweed, Murwillumbah, Byron and Mullumbimby Hospitals.

Annette Symes, NNSW LHD Executive Director of Nursing and Midwifery said Nurses and Midwives are a vital part of the health



system, who deliver a high level of care in a range of situations, which are often challenging. It is essential that graduate Nurses and Midwives are employed to facilitate succession planning of the Nursing and Midwifery Professions.

Our Clinical Nurse Educators and Ward based Staff who mentor nursing graduates play a crucial role in orientating the new graduate Nurses and Midwives to the hospital environment.

These new Nursing and Midwifery positions provide opportunities for talented young health professionals to learn and grow as well as strengthening our health system. It is hoped that these Nurses and Midwives will enjoy their experience working in a rural setting and decide to stay, or consider returning to the area.



# Chief Executive Report

## State Health Plan

The Ministry of Health (MOH) is currently leading a process to develop a State Health Plan, which should be completed by the middle of the year. Already two Think Tank Sessions have been held to initially scope key issues and then develop responses to them. The next step in the wide-ranging consultation process that will be undertaken, will be the holding of four Regional Consultation Forums. One of these will be held in Lismore.

There are two important roles for a State Health Plan. The first of these is to set the direction for the development of Health Policies and Programs for the next five to ten years. Out of the vast array of possible health service responses to the needs of Patients, it has to be determined which ones will be given greater emphasis. The second takes the direction or emphasis contained in the Plan and drills down to the next level. It prioritizes the competing ways of pursuing the chosen direction.

Therefore, it is important that we make our input into the development of the State Health Plan, so we give ourselves the opportunity to influence the directions and priorities it sets.



**Staff attending the Leading Better Patient Outcomes Day held in Coffs Harbour.**

## Quality and Patient Safety

The last meeting of the Senior Executive Forum (SEF) of NSW Health, which comprises senior representations from the MoH, LHDs and the Pillars spent considerable time workshopping the outcomes of the most recent Inquiry into the Patient Care and Safety failings of the Mid Staffordshire Foundation Trust.

This was the second Inquiry Report. The first Report had been into the Foundation Trust itself. This Second Inquiry Report canvassed the failures of the bodies and mechanisms that were in place to monitor the performance of individuals and entities providing health services. The obvious question that the SEF had to grapple with was "Could it happen here?" It was pointed out that we had been through two major reviews of Patients Care and Safety, the

more recent Garling Inquiry and the Inquiry arising from the problems identified at the Campbelltown and Camden Hospitals.

While many positive changes followed on from these Inquiry Reports, the question of whether a "black spot" would be identified and addressed before harm is done to any patient still lingered. Our Director of Clinical Governance, Dr Hutton has written an excellent Paper for the MoH and our Board canvassing the failsafe mechanisms that are now in place and the risks that could cause poor patient care not to be identified. The Board had a good discussion arising from this Paper. A more in-depth discussion of this topic will be undertaken at the next Board Health Care Quality Committee Meeting.

## Whole of Hospital Program

The first wave of the MoH co-ordinated Whole of Hospital Program is underway. This involves seven NSW Hospitals receiving intense support from a group established by the MoH. One of its principle goals is to improve patient flow through Hospitals to unclog Emergency Departments (EDs) and improve the patient's in hospital experience.

It does this not just by examining ED performance and how it can be improved. The Program examines how the whole Hospital performance can better support our EDs.

How can the ED do well itself but do even better by receiving more support from the rest of the Hospital? It involves better discharging to free up ward bed capacity and then "pulling" Patients out of the ED into the Ward rather than waiting for Patients to be "pushed" out of the ED. It is acknowledged that much of this has been tried before. But this Program will give it new impetus and some new techniques that have been utilised successfully in the Western Australian Health System.

Each LHD gets to nominate one hospital to participate in the Program. Then the major learnings and benefits realised by that Hospital are leveraged to other key Hospitals in the LHD. NNSW LHD has nominated LBH to participate in this Program. It wants to leverage the benefits of the Program to The Tweed, Grafton Base, Ballina District and Casino District Hospitals. It is anticipated that this second wave of the Program will commence around May 2013.

## Surgical Success

Congratulations and a big thank you to all our Surgeons and the Teams who work with them – the Anaesthetists, Nurses, Admissions, Booking Office and Support Staff – who have all contributed to our Patients receiving their surgery in a more timely fashion.

The new Surgical target is known as NEST – National Elective Surgery Target. It has been in existence since the beginning of 2012. All Surgery in Australia is assessed against this target. It takes the three existing priority Patient waiting times for Surgery – 30 days, 90 days and 12 months – and applies to them a percentage of Patients who must be treated within these timeframes.

So in 2012, 96.0% of Category One Patients needed to be treated within 30 days. NNSW LHD fell short of that target by 2.0%, achieving a result of 94.0%. This is still a good result. NNSW LHD achieved the Category Two target of 90.0% of Patients being treated in 90 days and the Category Three Target of 92% of Patients being treated within 12 months.

Last year NNSW LHD got off to a slow start, as it took a while to change some of our Operating Theatre List allocation practices to meet the requirements of the new NEST. In contrast NNSW LHD has got off to a much faster start in 2013. So our Patients are benefitting from shorter waiting times starting at the beginning of the year.

As at the end of February 2013, NNSW LHD has improved its performance against each of last year's results. However, the targets have also increased making it tougher to achieve them. For Category One NNSW LHD has treated 99.0% of Patients within 30 days, just shy of the new target of 100.0%.

The new targets for Categories Two and Three are being achieved with 93.0% of Category Two Patients being treated within 90 days and 97.0% of Category Three Patients being treated within 12 months. These are very good results, of which all members of the Surgical teams can be rightly proud.

# Tips for Cleaning Up Safely After Floods



North Coast Public Health Unit is reminding people that from a street drain to a raging river, all flood waters should be considered contaminated.

To avoid illness from potentially contaminated flood waters, it is important to wash hands with soap and clean water after participating in any flood clean-up activities, and before eating or handling food.

First aid should be applied immediately to any scratches or cuts to reduce chances of infection. It is best to avoid all unnecessary contact with mud and floodwaters and to keep children out of flood affected areas.

Other tips for staying healthy during floods and while cleaning up are:

- Wear gloves and suitable foot wear when removing mud or debris from homes or yards.
- Yards can be raked to remove debris and if necessary, hosed down.

- Don't try to check electrical appliances and other equipment yourself, seek professional help.
- Have septic tanks or pipes professionally inspected or serviced if you suspect damage.
- Avoid being bitten by mosquitoes, use roll-on insect repellent on exposed skin and apply every few hours.
- To avoid creating mosquito breeding sites in your yard empty out pot plant bases and remove all water-holding rubbish.
- When cleaning up, consider your personal health, drink plenty of clear fluids. Do not wait until you are thirsty. Take breaks when you can, watch out for heat stress.

Residents and visitors are also reminded to avoid swimming in the ocean, rivers, creeks and lagoons for at least 3 days after the rain has stopped.

If people are concerned about their health they should first seek advice from their General Practitioner.

## Local Nurses Lend a Helping Hand

From Monday 11<sup>th</sup> February, the community of Upper Coopers' Creek was isolated. The only road into this community had been washed away following the recent floods and there was no access for pedestrians or vehicles.

The State Emergency Services visited the community on Friday 15<sup>th</sup> February by Helicopter taking with them Jenny Shaw, Executive Officer/Director of Nursing at Mullumbimby & District Hospital. They provided the residents with medications and a First Aid Kit for the local community.

On Thursday 7<sup>th</sup> March the pedestrian access again became available. Up until that time, Upper Coopers Creek residents Katrina Johnson and Jolita Adema, Registered Nurses, who work at Lismore Base Hospital, had also been stranded along with the rest of the community.



During this time, Katrina and Jolita conducted a Nurse Clinic five days per week and on-call after hours should they be needed, for the Upper Coopers Creek community.

Katrina and Jolita are pictured at right with the First Aid Kit. They also assisted in their new role, as mail sorters for Australia Post – nurses are multi-skilled!!



L-R: Katrina Johnson and Jolita Adema

# Interview with Cathy Adams, Clinical Midwifery Consultant

Cathy has been a midwife for around 30 years. She was a Registered Nurse for two years but her dream job at that time was to work with the Flying Doctor Service. However, to be a nurse with the Flying Doctors, you needed to be a Double Certificate Sister and be trained in Midwifery. Cathy decided if she was going to do another certificate, then she would make it a good experience, so she travelled to Scotland where she trained for 18 months in Midwifery. She then stayed for 18 months longer travelling and working in Europe. After working for two years as a midwife at Westmead Hospital in Sydney she went to Saudi Arabia for two years to fulfil her two passions - midwifery and travel. Cathy said she knew the first day of midwifery training it was what she really wanted to do. She has managed to work in different places all over the world while at the same time learning different models of care.



## ***What does the Clinical Midwifery Consultant role encompass?***

My role is very varied and that is what makes it exciting. Overall I am involved with supporting, overseeing and coordinating the development of Maternity Services. Sometimes this involves education and training and at other times it may be to implement changes to services when there is new evidence for practice change or where the NSW Ministry of Health requires a change. The role is often a mixture of considering the strategic direction of services and the operational side of how to actually implement those new directions as part of clinical practice. The role works alongside the maternity staff as well as the consumers of the service to ensure the services meet all needs.

## ***I asked Cathy what her thoughts were on Homebirth Birthing and was surprised to hear that she had been a practicing Homebirth Midwife for 25 years.***

I had my own private practice in Sydney, supporting women with Homebirths as well as working in the hospital system. But when the insurance ceased being available for midwives to support birth at home I stopped the private practice.

## ***What do you think about the Homebirth Trial in Mullumbimby?***

Obviously I am very supportive of Homebirth as a model of care for families. The Trial for the LHD Publicly Funded Model of Homebirth was one of the first projects I became involved with when I started in this position. The LHD had a working party for two years developing the program. When I started in 2012 the Homebirth Steering Committee had commenced the operational side of the planning and we launched the Homebirth Trial in Mullumbimby in April 2012.

Women are already having their babies at home, therefore it is so very important to have the model aligned to the hospital so women birthing have the support they need. Homebirth is a wonderful option for women, particularly in Northern NSW where many women are choosing to have Homebirths.

If a woman is well and there are no risk factors for her pregnancy, labour and birth, and she is cared for by a skilled birth attendant then it is a very positive experience.

The Homebirth Trial, conducted from Mullumbimby Community Birthing Service, is due for completion in April 2013 and it has been very successful so far. The women and babies have had very positive outcomes from a clinical perspective, as well as a very high

satisfaction rate with the service and care provided. There have been a few transfers from home to hospital during the pilot and these have tested the processes we implemented, so there is now a high level of confidence that everything we have put in place works well. The plan is to request for this model be implemented as an option for more women. We presented our six months data to the Clinical Council and the Health Care Quality Committee, which was part of the Homebirth Trial Agreement and they were very impressed with the results.

## ***How do you feel about the introduction of Birth Rate Plus?***

Birth Rate Plus is a dependency tool developed for maternity care that is a little different to the nursing tool. For many years now NSW Health has been working on how to best develop a dependency tool for maternity, which captures the fact that midwives are actually caring for two patients. When a woman is pregnant, midwives are caring for two patients. Once the baby is born there is a woman and a baby, and there has never been a good maternity tool to capture this. I have been part of the Advisory Committee with NSW Health on Birth Rate Plus from its very inception in Australia. The Committee used a model from the UK to adapt to the Australian context. We have finally, after many years of collecting data from across the LHD, obtained the results at the end of 2012. For the LHD Midwifery Units, we have been able to show our dependency. Some of the results from our Midwifery Units demonstrated the correct staffing establishment. So we had the right number of staff, which reassures us we have the right ratio of women to midwives. In other units, data showed we needed additional staff to complement the activity. So Birth Rate Plus is very good tool to determine the patient to staff ratio.

## ***What are the changes you are making in the Grafton Base Hospital (GBH) maternity service to improve the care of women?***

Currently, I am involved in a project at GBH with the staff of the maternity service which is focused on workforce issues. It is recognised that GBH has a great retention of staff but at times there is a difficulty in recruiting new staff. So I've been exploring the reasons behind the retention of staff. To find out what keeps midwives there and why there is at times, a difficulty in recruitment. It is succession planning really, we know that our long term experienced midwives will one day be retiring so we need to plan ahead and be proactive with strategies to recruit more midwives to the hospital. One of our most successful strategies was to bring some of the midwives working as nurses at Maclean Hospital for some midwifery experience at GBH and they've loved it and stayed. However, we need to support them because they may not have worked as a midwife for many years. These midwives need a structured process of education and supervision, and to be mentored by the very experienced local midwives until they feel confident and capable of undertaking the role as a midwife again. We need to provide the correct supervision and support for them. Another strategy is to encourage more student midwives to come to GBH, and hopefully stay in the area after completing their studies. The official results of Birth Rate Plus showed we had the right number of staff at GBH, which means we need to investigate other ways of providing care and possibly introducing some alternative approaches to care, so it frees the midwives up a little.

# Improving Patient Safety

The NNSWLHD Clinical Governance Unit (CGU) is responsible for investigating serious clinical incidents across the LHD and coordinating RCA investigations. It is the responsibility of the RCA team to prepare a report in writing that contains the following:

- a description of the incident;
- a causation statement, being a statement that indicates the reasons why the RCA team considers the incident concerned occurred; and
- If the RCA team has any recommendations as to the need for changes or improvements in relation to a procedure or practice arising out of the incident—those recommendations are to be identified.

After the RCA report is completed and “signed-off” by the members of the RCA team, the RCA report is sent to relevant managers for their input regarding implementation of the RCA recommendations. The RCA report is then submitted to the Chief Executive together with the managers input. The Chief Executive reviews the recommendations for consideration and endorsement before the Report is submitted to the MoH.

## Feedback to Staff

The success of incident management is dependent on feedback to all staff on the results/outcomes of investigations in a timely manner. Staff involved in the incident need to be informed of the recommendations arising from any investigation. This is provided by local management and supported by the Patient Safety Team.

The final RCA Report provides the basis for feedback on a Clinical SAC 1 clinical incident. The findings of the Clinical SAC 1 RCA Report should be provided to the relevant clinical team and presented at relevant staff meetings. Feedback needs to include the changes made and improvements achieved as a result of these changes.

At a LHD-level, RCA reports/information is provided to the Health Care Quality Committee and other relevant LHD governance committees, such as the Infection Prevention and Control and Drug and Therapeutics Committee.

At a facility or Health Service Group-level, RCA reports/information should be provided to the Safety and Quality Committee and other relevant governance committees. At a Clinical Unit level, RCA reports/information should be provided to a multi-disciplinary clinical review meeting (e.g. Morbidity and Mortality meeting).

## Clinical Governance Unit role

The CGU (Patient Safety and Corporate Risk Manager and Patient Safety Officers) are responsible for:

- Administratively supporting the whole RCA process.
- Facilitating RCA teams, including drafting a report for the RCA team.
- Prepares reports for the Health Care Quality Committee and relevant other LHD-level governance committees.
- Provides copies of final signed RCA reports and Clinical Focus Reports/Patient Safety Reports from the Clinical Excellence Commission to Health Service Groups and facilities.
- Upon request, is able to attend relevant facility and clinical unit-level governance committees to provide feedback regarding RCA reports.

- Following Chief Executive sign-off, the Patient Safety Officers arrange and conduct a feedback session to relevant staff at the site where the clinical incident occurred.

## Patient Safety Watch

Currently the Patient Safety

Team is reviewing its processes and RCA recommendations implementation to ensure that lessons are learnt and our patients are benefiting from all the good work that goes on behind scenes.



## Lessons Learnt from a recent RCA

Lessons learnt from one recent RCA investigation in the Local Health District were as follows:

A 28 year old female patient presented to the Emergency Department (ED) of a local Hospital with abdominal pain, nausea and vomiting. The patient was admitted to the hospital and, upon assessment by a General Surgeon, was diagnosed with acute pancreatitis. The patient deteriorated and was transferred to the High Dependency Unit (HDU). The patient continued to deteriorate and after consultation with the Surgical team and Intensive Care Unit (ICU) of the local referral Hospital, a decision to transfer the patient was arranged via the Aeromedical and Medical Retrieval Service (AMRS). The patient deteriorated further during the flight and upon arrival the patient was in a state of severe shock and suffered a cardiac arrest. The patient was resuscitated and subsequently developed multi-organ failure and died.

On investigation, the RCA team found a number of missed opportunities to escalate the care of this patient and ensure more appropriate clinical management.

- an early opportunity to seek further consultation and possible transfer was missed following the results of biochemistry which indicated a severe metabolic acidosis.
- That patients requiring significant fluid resuscitation and should be managed in an ICU.
- Staff need to be aware of the NSW Health Policy Directive 2011\_077 Recognition and Management of Patients Who are Clinically Deteriorating as the patient moved into the yellow zone of the sago chart several times but was not clinically reviewed. Once reviewed there was a delay in a secondary consultation and initiation of the retrieval process.

## Improving Patient Safety continued



The RCA Team found the severity of the acute pancreatitis – in combination with multiple missed opportunities to escalate the care of this clinically deteriorating patient to an adequate level and ensure more appropriate clinical management led to severe shock, cardiac arrest and her subsequent death.

### What were the main Recommendations?

- All complicated medical patients who need surgical intervention or surgical patients requiring critical care are admitted under a shared care arrangement (i.e. admitted under a physician and a surgeon).
- Further education of staff regarding the Standard Adult General Observation (SAGO) chart and Clinical Emergency Response System (CERS) to ensure a Clinical Review or Rapid Response is called every time it is required.
- Establish a system for LHD governance over the transfers of all critically ill patients (must be coordinated through the AMRS as per policy directive 2010 \_021 Critical Care Tertiary Referral Networks and Transfer of Care Adults).

- Development of an education package for staff across the LHD regarding the transfer of critically ill patients and present this to each ED and ICU/HDU within the LHD.
- Ensure all medical staff including locums are aware of policy and procedure requirements for the transfer of all critically ill patients (VMO, staff specialists, CMO, fellows, registrars, residents, interns).
- As part of their Continuing Professional Development, all VMO and CMO of the C1 Hospitals undertake the BASIC course (Basic Assessment and Support in Intensive Care).
- Review by NSW Ambulance Service of retrieval practices and procedures for minimum safe level of monitoring of critical patients during retrieval (including documentation). This should apply to the inter-hospital transfer of all critically ill patients, regardless of the mode of retrieval.
- Develop a LHD Clinical Guideline for patient assessment and initiating prompt Intravenous fluid therapy of shocked, hypovolemic patients, particularly where aggressive fluid resuscitation is required e.g. patients with severe acute pancreatitis and sepsis.
- Establish a system for an Intensive Care Specialist from a Non-Metropolitan Referral Hospital ICU to undertake “virtual rounds” supported by video-conference technology (ability to visually review the patient and to review patient records, treatment, pathology results and medical imaging results) of patients admitted to the HDU.

## Help for Older Parents Caring for an Adult Child with a Disability

Richmond Community Options can provide support and advice for older parents (over 60, or over 45 if identified as an Aboriginal or Torres Strait Islander), still caring for an adult son or daughter with a physical or psychiatric disability.

This assistance includes:

- Help to make plans in the event of a health crisis that results in the parent being admitted to hospital
- Help to find additional support as they get older and the caring role gets harder
- Equipment and household items, including modifications, to support caring in the home.
- Help to determine realistic plans for the future when the parent is no longer able to be the main carer.

The Staff at Richmond Community Options provide case management support, linking with both formal and informal community supports, as well as planning and preparing for transition from parental care (future's planning).

The service can also fund legal consultations for wills and enduring Power of Attorney and guardianship.

Some parents will want the transition from parental care to start while they are still around, while other parents will just want the comfort of having a plan in place.

“I am amazed that we are hearing from parents in their late 80s who are still the primary carer for their disabled son/daughter, mainly with an intellectual or psychiatric disability, but also acquired brain injury, and quadriplegia. Some do not even have a formal diagnosis; rather the family has been providing care for 50-60 years, because “Joe has never been any different,” said Richmond Community Options Manager, Jan Dilli.



*Above: Michael and Pat Lewis of Lismore with Community Options Case Manager Jennifer Lamrock.*

A number of these people are not known to the service network and the first presentation can be when they are assisted out of the Ambulance, when mum or dad has a health crisis and is being transported to the Emergency Department. This then presents a major management problem for the acute facility, which is not the best place for the disabled son or daughter.

Often the person in the community with the best knowledge of the existence of these carers is the local General Practitioner or Pharmacist. “Hence we are asking for your assistance. Please inform elderly parents of the service,” Jan said.

For more information, please call Jan Dilli at NNSW LHD on 6686 9829. Richmond Community Options covers the Byron, Ballina, Lismore, Richmond Valley and Kyogle local government areas. For Tweed Valley Community Options call 07 5569 3110 and for Clarence Community Options call 6645 3669.

# DonateLife Week make your O&T wish count

NNSW LHD supported DonateLife Week 2013, Australia's national awareness week to promote organ and tissue donation by holding several events during the week.

Dr Mike Lindley Jones, NNSW LHD Medical Specialist said, many people aren't aware that around 1% of hospital deaths occur in specific circumstances where a person can be considered for organ donation, although many more have the opportunity to become a tissue donor.

The rarity of the possibility of organ donation for transplantation is why every Australian needs to ensure their family members know their donation wishes, so that we can optimize every opportunity for Australians to have access to life-transforming transplants, Dr Lindley-Jones said.

It's a conversation we are urging all Australians to have with their family, so that their family can make their wish count, should they ever be asked to confirm a donation wish.



L-R: In Lismore Mike Lindley-Jones, Mary Campbell with Katrina, her mother Nena holding Sarah Carroll (Sarah had a liver transplant at eight months).

Dr Lindley-Jones and Mary Campbell, Clinical Nurse Specialist, Organ and Tissue Donation held Organ and Tissue Awareness events in Lismore and Tweed during the week.

In Lismore Nena Carroll mother of six, including five year old twin girls Katrina and Sarah, said Sarah was diagnosed with liver cancer at two weeks and treated with chemotherapy for seven months until at eight months, she received a liver transplant. Sarah wouldn't be with us today dancing around if not for a transplant.

In Tweed 'Have a Yarn' was held at Minjungbal Aboriginal Health Centre, where Preston Campbell, Indigenous NRL Champion from the Titans attended. Around 80 members of the Aboriginal community came to hear about organ and tissue donation.

For more information go to: [www.donatelife.gov.au](http://www.donatelife.gov.au)



At the 'Have a Yarn' in Tweed with from left: Darlene Rotumah, Auntie Dale Williams, Sue Follent, Preston Campbell and Denise Paulson

## Concerns about possible inappropriate behaviour of Staff

NNSW LHD is committed to working towards a culture that encourages a safe workplace environment that values and respects the contribution of all staff in delivering a quality health care service to our communities.

As effective workplace conduct and performance is essential in developing this culture, it is important to be aware of the mechanism for raising concerns about possible inappropriate behaviour of a member of the NNSW LHD.

***Please be reminded that all staff should raise any concern with their Line Manager in the first instance.*** In order for the line manager to play a role in the assessment of a legitimate concern, the LHD requires an accurate, clear and concise signed statement from the staff member raising the concern. This statement should include details such as who the concern relates to, dates and location of alleged incident/s, as well as explicit details relating to the incident (ie: precise location, specific time/s, what exactly was said/done, identification of any relevant witnesses), as well as any other supporting documentation that may assist in substantiating any concerns. The statement should be signed

and dated by the staff member raising the concern and forwarded to the line manager. This approach enables the NNSW LHD to objectively assess and address legitimate concerns and reduces the opportunity for vexatious activity. In the event that the staff member is unable to raise the concern with their line manager, the appropriate action is to raise the concern with the next most senior manager.

Management will undertake an assessment of the concern and then take the appropriate steps to manage that concern. This may include the immediate notification to relevant authorities. Proven inappropriate behaviour of NNSW LHD employees may result in disciplinary action including dismissal.

Staff wishing to raise concern as a Public Interest Disclosure (PID) should seek relevant information from PID Intranet Webpage: <http://int.nnswlhd.health.nsw.gov.au/chief-executive/public-interest-disclosures/>.

The Employee Assistance Program (EAP) also offers a confidential counselling service to all employees of NNSW LHD.

# Lunchboxes are as easy as 1, 2, 3 plus water



Now that the kids are back at school we're back to the lunchbox routine, a routine that often resembles a pitched battle!

"It's boring, there's nothing to pack, why can't I have a bag of chips?" are common squawks from our much loved nestlings.

Anna Huddy, Healthy Children's Initiative Coordinator from NNSW LHD Health Promotion, has a couple of ideas that might tone down the peeping.

"First, keep it cool and not just with an ice brick. You need to have a clear idea in your head of what's going to happen and you'll be ready to counter the building pressure to pack rubbish," said Anna.

Anna recommends the following Lunchbox Rules that are as easy as 1 + 2 + 3 + water.

#### One, pack a sandwich, wrap, roll or leftover

Sandwiches can be boring – liven it up with different types of breads, rolls and wraps which can be stored in the freezer. Vary the fillings with cold meat, cheese, egg, lettuce, grated carrot, coleslaw, or other salads. Or pack leftovers like fried rice or pasta salad.

#### Two, put in a vegetable or fruit snack

Fresh or canned, whole or pieces, carrot, snowpeas, strawberries, apple, it doesn't matter. Produce in season is cheaper and at its peak. Use small plastic containers for cut up fruit or salad.

#### Three, add a couple of healthy snacks

Variety and interest can be created with snacks like popcorn, low fat fruit yoghurt, a cheese slice and plain biscuits, or go all out with a small sushi or banana bread.

Just keep humming 1 + 2 + 3 + water and it will all fall into place, and into the lunchbox!



## Welcome to new Geriatrician and Rehabilitationist



Dr Alison Semmonds with Mrs Joyce Pepper a patient in LBH.

Dr Alison Semmonds, a Geriatrician joined the Geriatric Team in February. Dr Semmonds will be working with Dr Hugh Fairfull-Smith, who is now working at LBH providing more geriatric services. Dr Semmonds will hold Clinics at LBH and Ballina Hospital, as well as providing an outreach service across the Richmond Network.

Prior to moving to the North Coast Dr Semmonds worked as a Geriatrician and General Physician in a large teaching hospital

and before then, she worked for three years in rural NSW prior to undertaking her specialist training in Sydney.



Dr Cecilia Silva-Withmory, is a Rehabilitationist, who commenced working at Murwillumbah Hospital in February.

Dr Silva-Withmory is a welcome addition to the appointment of Dr Ulla Gerich-McGregor, who commenced as a Rehabilitationist at Ballina Hospital in July 2012.

Dr Gerich-McGregor will also provide clinical governance for the Maclean Rehabilitation service when it commences later this year.

There is significant growth in the demand for Geriatric, Rehabilitation and Dementia services on the North Coast with the demand for Rehabilitation alone estimated to be increasing at 5% per year. Therefore, the appointments of Doctors Semmonds, Gerich-McGregor and Silva-Withmory will help our patients to get their treatments earlier.

# Welcome



**Natalie Parry** has been appointed to the role of Oral Health Coordinator for the Ballina and Clarence Oral Health Network. Natalie was previously the Practice Co-ordinator and had been acting in this role for the past 12 months.

# Farewell



## Farewell



**Helen Lee** commenced as a Dental Therapist with NSW Health working across the Richmond Valley on 8<sup>th</sup> March 1976. During her career, Helen progressed to become the LHD Dental Program Coordinator and ran numerous special projects for Oral Health Services. She retired on the 8<sup>th</sup> February 2013 after providing 37 years of service. Dr Greg Davies, Clinical Director of Dental Services for the NNSW LHD Oral Health Program and Staff held a farewell afternoon tea for Helen and wished her well in retirement.

**Evelyn Robinson** commenced as an Aboriginal Health Worker with NSW Health on the 12<sup>th</sup> May 1987 and joined the Aboriginal Health Service in Lismore on the 14<sup>th</sup> November 1994.

Evelyn was employed across the North Coast in a variety of Aboriginal Health positions and more recently, as the Aboriginal Chronic Care Worker based in Kyogle. Evelyn retired on the 15<sup>th</sup> February 2013 after providing almost 26 years of service in the Public Health System.

At the Farewell held for Aunty Ev (as she is known to many) Jenny Smith, Manager for Aboriginal Health presented her with a Certificate of Appreciation signed by Chief Executive and Chair of the NNSW LHD Board.



Jenny said she will personally miss her kind and compassionate ways. On behalf of all the Aboriginal Health Staff, Jenny acknowledged and congratulated Aunty Ev on her achievements, her career and for a happy retirement.

**Beryl Jordan** retired on 31<sup>st</sup> January 2013 after 40 years of Nursing. Beryl was the Director of Nursing and Midwifery (DoN&M) at LBH and had a long association with the health service. Beryl trained as a Registered Nurse at LBH in 1973 and continued to work until October 1977. She returned in August 1983 specialising in orthopaedics and studied to become a Clinical Nurse Consultant and in 1987 she was appointed the Nurse Unit Manager (NUM) of the Orthopaedic Ward.

Beryl took on other senior positions along her career path and in 1998 Beryl was appointed as the Deputy Director of Nursing at GBH and in 2002 she became the DoN&M. She returned to LBH in 2010 as DoN&M for Lismore and Ballina Hospitals and most recently as LBH DoN&M. Beryl will be missed by her colleagues and the NUMs, many of whom turned up for her farewell at Eltham.

Annette Symes, Executive DoN&M and Wendy Howell, Acting Nurse Manager, Workforce Development and Leadership came from Tweed to Beryl's farewell. Annette presented Beryl with a Certificate of Appreciation signed by the Board Chair and Chief Executive acknowledging her significant contribution to nursing across the area over these many years.



**Martin Gallagher** commenced working in the Lismore Mental Health Acute Care Service on the 27<sup>th</sup> April 1998. In 2008 he transferred to the Lismore Mental Health Inpatient Unit as a Nurse Unit Manager. Since July 2012 Martin has been working as the Mental Health Clinical Nurse Consultant-Clinical Liaison. He retired on the 22<sup>nd</sup> February 2013, after almost 15 years of Nursing with Lismore Mental Health Service.

Martin is pictured above holding a Certificate of Appreciation acknowledging his dedication to mental health services, which was presented to him by Warren Shaw, Manager, Richmond Clarence Mental Health Services at a Farewell Afternoon Tea that the LHD Mental Health Staff held for him.