April 2015

CQI: EVERYBODY'S BUSINESS

Northern Territory Continuous Quality Improvement Strategy

COMMUNIQUE IN QUALITY

WELCOME TO THIS EDITION

The first Communique in Quality newsletter for 2015

After a well-deserved break over Christmas and New Year for many of the NT CQI team, we are certainly back to work.

Just some of the CQI activities that have already happened or are in the planning phase:

- The CQI Steering Committee met in Darwin and used the CQI Program Logic to evaluate how effectively the CQI Strategy is achieving the intended outcomes
- Training for 40 more clinicians in the one21seventy CQI cycle – Darwin and Alice Springs
- Health promotion audit at Anyinginyi health service – see photo of the team at work
- Attended the East Arnhem CPHAG
- The CQI Program Coordinators attended a High Performance Leadership Skills workshop in Adelaide
- Orientation for new members of the NT CQI team – see photos and bios of the new CQI Facilitators in this issue
- The Congress CQI team are busy preparing for their Regional CQI Collaborative. Being held on Tuesday 19th May, the themes for the day will cover antenatal care and child health. An exciting program is being led by Carli and her team
- A CQI Workshop is being held up in Darwin on 14th and 15th May in response to requests from health promotion workers for further information on CQI. Joanna Schwarzman, AMSANT Indigenous Health Project Officer, is helping to organise this workshop for the Tackling Smoking Healthy Lifestyle, AOD and SEWB workforce.
- The Commonwealth has commissioned the development of a National CQI Framework. This project is being led by Lowitja in partnership with NACCHO and Affiliates. The purpose of this National Framework is to support a coordinated approach to CQI in primary health care for Aboriginal and Torres Strait Islander people, wherever they live and seek care. The work happening across Australia and in the NT over the last 5 years by ACCHS and NT Government PHC services through the NT CQI Strategy is informing the development of this framework.
- In parallel to the development of a National CQI Framework, the Commonwealth is funding CQI workshops in each State or Territory Jurisdiction to provide the opportunity to hear about and discuss progress on the development of the National CQI Framework. A Jurisdictional CQI Workshop is being held at the Alice Springs Convention Centre on Wednesday 10th June. We plan to bring NT PHC staff together to showcase their CQI activities and to discuss the National CQI Framework. Invitations have been extended to all PHC services – DoH and ACCHS are attending.

So as you can see, there is plenty to keep the NT CQI team busy.

As always, we want to hear from you about quality initiatives taking place in your health service. Share the good news with all of us!

Enjoy this edition of the Communique.

2015

CQI- Calendar

Health Promotion Team CQI Workshop 14th and 15th May in Darwin

Congress Regional CQI Collaborative 19th May in Alice Spring

Jurisdictional CQI Workshop 10th June in Alice Springs

NT Wide CQI Collaborative 2015 10th and 11th November in Darwin

Communicare and Ehealth Forum 12th and 13th November in Darwin

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April 2015

CommuniQue In Quality

Welcome New CQI Facilitators...

Monica Ostigh is the new CQI Facilitator for Borroloola, Robinson River, Pine Creek and Katherine Urban. Monica has a long history in the NT. She came to the Territory in 1998, the day Katherine flooded. She has worked in Gunbalanya, Jabiru, Adelaide River and Belyuen. Monica also worked for Air Med for 4 years. Monica was the first Area Service Manager for Maningrida. She has a long association with CRANA Plus and was a Remote Emergency Care (REC) and Maternity Emergency Care (MEC) Coordinator for AHP's. Her most recent role has been at Wurruminyga on the beautiful Tiwi Islands working as a midwife.

Continuous quality improvement has always been embedded formally and informally in the different roles that Monica has undertaken. She is looking forward to catching up with a lot of "old mates" out bush and supporting PHC managers and staff with their quality improvement priorities.

Monica's contact details are: monica.ostigh@nt.gov.au
Phone: 08 89858123 M 0475953409

"Every action is an opportunity to improve."
~Mark Graban

Catherine Lombord is a South African born Australian Citizen and has lived in Australia for seven years.

Catherine has a wide range of experience in many fields, including sales and marketing and has worked as a Service Co-ordinator. She loves working with people and organising events.

So even though CQI is new for her, she is looking forward to the challenges and acknowledges that she has great mentors to learn from.

Darwin - One21Seventy on 14th -15th April 2015

Alice Spring - One21Seventy on 28th - 29th April 2015

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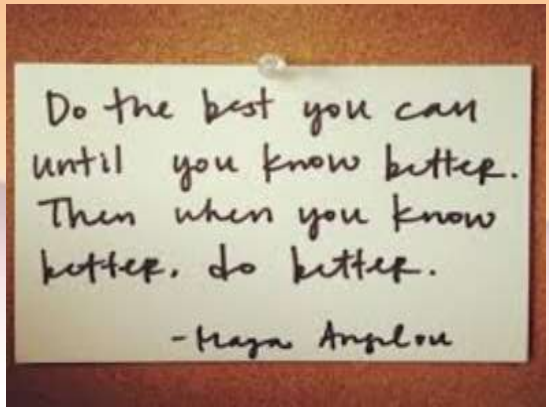
Pauline Reynolds, Congress CQI Facilitator, is English and has lived in Alice Springs for 4 years. Pauline is an Emergency Nurse by background and has also worked in Alcohol and Other Drugs sector and Prison Service.
"Having participated in several audits and data collection over the past few years I have developed a keen interest in data analysis and looking at best practice / accreditation / service delivery improvement."
Pauline has been with Congress for two months and is really enjoying her new role.

Annie Power is one of the new CQI Facilitators at Congress. She has a long history with Congress, predominately working within the Maternal and Child Health area. Annie has been at Congress since December 2005 and thoroughly enjoys the diversity and the challenge and the growth of Congress during that time.
Her interests include travel, family and friends, literature, art, in all forms, beautiful things, activism, food and wine. She's currently studying Interior design and French (two separate courses), to feed her passion in both these areas. She has a beautiful daughter who is an inspiration to her every day.



Central Australia Health Outreach Data Session

On February 17th 2015, a group of staff at Primary Health Care Outreach participated in an One21Seventy Audit Tool training workshop led by Estrella Munoz.

The session was designed to assist remote outreach staff to identify the importance and relevance of implementing continuous quality improvement (CQI) processes within primary health care centres. The session further developed participants' skills and confidence to engage with remote-based staff to complete important One21Seventy audits. Working in small groups, time was spent familiarising ourselves with and completing an audit tool relevant to our area of expertise, for example child health or chronic disease. With these new (or revised!) skills, the next step will be completing the audit within remote health clinics. The One21seventy clinical audit tools will collect data about the health centre's delivery of recommended services to prevent or manage chronic conditions and provide maternal and child health care.

"Eventually everything connects - people, ideas, objects. The quality of the connections is the key to quality per se". Charles Eames

The results from the clinical audits will assist remote health centre staff to collect demographic information about their population group, while also gaining information about service access by their clients and the overall coverage of their programs.

Thank you to Estrella for an engaging morning – now off to the communities we must go to immerse ourselves in audits…

Katherine Cacavas

Miwatj – Accreditation Success

Miwatj is proud to announce we have been successful in gaining full AGPAL accreditation for its Nhulunbuy and Gunyangara clinics. This success ensures standards of patient care are met and we are continuing on our quality journey. The RACGP standards support all aspects of care provided by the clinics to ensure high quality and safe care. This includes attention to services provided, education processes, quality improvement, the rights and needs of patients, practice management and physical resources.

We are proud to have achieved accreditation for all our 4 clinics. This is a huge achievement and ensures high standards of care for the people of East Arnhem.

We also were the first organisation in Australia to undergo dual Accreditation, AGPAL and QIC at the same time. This was a pilot to map how both accreditations can be done together in the future and lessen the costs and burden on the organisation. It was refreshing to involve our business partners, board members, stakeholders, clients and funding bodies participate in this quality process. This allows them to have their say in how our organisation moves forward and continues to improve our systems and relationships.

This process enabled us to make the improvements required to ensure our organisation is accountable, efficient, effective, legal, participatory and reflective. By joining forces within the organisation, RACGP focusing on clinical services combined with QIC which featured a systems thinking on building a quality organisation providing quality services and sustaining quality relationships. The QIC standards cover: governance, management, human resources, physical resources, finances, knowledge management and so forth. The accreditation process is a major contributor to health services to ensure safety and quality in health care provided to our clients.

We are very privileged and proud to be part of an innovative, supportive and wonderful organisation which supports us on our quality journey.

The Miwatj Team

Chronic Illness Care for Aboriginal and Torres Strait Islander People: Final Report

Many of your organisations have participated in and contributed your One21seventy data to the ABCD Research Partnership Project over the last 5 years and have had significant input into the Engaging Stakeholders in Identifying Priority Evidence-Practice Gaps and Strategies for Improvement in Primary Health Care (ESP) Project.

This report provides up-to date and comprehensive data on the quality of chronic illness care for Aboriginal and Torres Strait Islander people from 160 primary health centres. It incorporates perspectives of a wide range of stakeholders on priority evidence-practice gaps and barriers, enablers and strategies for achieving improvement. It should be useful for stimulating discussion and action for improving quality of chronic illness care for Aboriginal and Torres Strait Islander people at local, regional, and national levels. We encourage you to pass this report to others who may have an interest in improving chronic illness care for Aboriginal and Torres Strait Islander people. To access the Final Report click here and the accompanying Data Supplement click here.

A similar report on the quality of Aboriginal and Torres Strait Islander child health has been produced, and we are going through the same collaborative process for mental health, preventive health, maternal health and rheumatic heart disease. We encourage you to engage in the process for these aspects of care and to provide suggestions on how we can make the process and the reports more useful for the purpose of improving the quality of primary health care. For more information about the ESP Project click here or email Jodie Bailie on jodie.bailie@menzies.edu.au.

Anyinginyi Health Promotion audit team

The one21seventy Health Promotion audit was facilitated by Marcel Clark and Catherine Lombard (CQI team) at Anyinginyi Health Service in Tennant Creek in February this year. Clare Anderson and Josh Southwell audited the Smoking in Pregnancy health promotion package.

KEY PERFORMANCE INDICATORS

NORTHERN TERRITORY ABORIGINAL HEALTH KEY PERFORMANCE INDICATOR (NT AHKPIs)

There are three changed indicators and three new indicators in the next round of NT- AHKPIs.

Changed indicators

KPI 1.6 Anaemic Children

This indicator has been disaggregated by age using the following categories

- 6-12 months,
- 12-24 months, and
- 24-60 months.

Disaggregation by age will allow services to target those at highest risk (likely to be the youngest age groups).

KPI 1.8.1 HbA1c Tests

This indicator will now include a reporting period of 12 months as well as six months. It will align this indicator with indicator1.82 on the results of testing. It also aligns with the nkpi for diabetes testing and results.

KPI 1.15 RHD

This indicator has been updated to include additional numerators to provide more information on the proportion of injections received by clients. The additional numerators will show injection breakdown as less than 50% and 50-80% injections received by clients. It is important to be aware that clients are largely unprotected if they receive a low (<50%) of scheduled injections. However, providing more information will allow clinics to ascertain what proportion of regular clients are poorly engaged in care and have less than 50 % of injections and how many are more engaged but require more support to receive a higher proportion of injections.

New indicators

There are three new indicators in the area of renal disease, STI testing and smoking

KPI 1.14 Chronic Kidney Disease

A new Indicator has been introduced that measures the proportion of Aboriginal clients aged 31 and over , who have been screened for renal disease according to CARPA guidelines (ACR & eGFR) during the previous two year period and the number and proportion of those screen who have results suggestive of kidney disease. Please note that to diagnose chronic kidney disease for the first time, two tests at least three months apart (either an abnormal eGFR and /or an abnormal ACR) are required so clinics will need to review those who are picked up by this indicator as being at risk of CKD for the first time to ascertain if they have had the required tests before a definitive diagnosis is made. The sixth edition of CARPA now recommends urine ACR for renal screening from age 30 instead of urinalysis and eGFR from 15 years. Therefore, the proportion of people screened according to guidelines will initially be low given this recent change but it will increase over the next 2 years.

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KPI 1.16 Tobacco Use

This is a new Indicator that measures the number and proportion of Aboriginal clients aged 15 years and over whose smoking status has been recorded as current, ex-smokers and never smokers. Ex-smokers are further classified as those who have quit for less than or more than twelve months. This distinction was made because it aligns with the definition of smoking used to determine cardiovascular risk and also those smokers who have quit more recently should be provided with more intensive support given a higher risk of relapse.

KPI 1.17 Sexually Transmissible Infection

New Indicator to measure the number and proportion of regular clients who are aged between 15 and 35 years and who have received a test for chlamydia and gonorrhea. Trichomonas has not been included as the role of population based screening for this infection is not clearly defined due to uncertainties around prevalence and adverse health outcomes. (Source: NACCHO/RACGP. National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people. 2nd end. South Melbourne: The RACGP, 2012.)

Indicators under development

Indicators under development include one on staff turnover and a possible indicator on the use of spirometry in respiratory disease. An indicator on retinal screening in people with diabetes has also been proposed

Feedback

We welcome any feedback on new or existing indicators which can be provided to either the data unit for primary health care within the Department (ahkpi.communications@nt.gov.au) or to Liz Moore who is the chair of the Clinical Reference Group for the NTAHF Key Performance indicators.

NATIONAL KEY PERFORMANCE INDICATORS (nKPIS)

There are no national key performance indicators in this reporting round. It is expected that there will be two national key performance indicators introduced in December.

Proportion of people at high risk from alcohol

This indicator follows on from the alcohol screening indicator to give the results of the screening – particularly the proportion of people who are at high risk. This indicator will probably require the Audit C to be used but there are indications that the IRIS indicator will also be acceptable

Proportion of adults screened for absolute cardiovascular risk

This indicator (proportion of adults screened for absolute cardiovascular risk) will start from age 35 although CARPA recommends starting from age 20. Communicare is currently implementing an absolute cardiovascular risk calculator using the CARPA definition and also a calculator using the national definition developed by the National Vascular Prevention Alliance. The national definition of absolute cardiovascular risk does not include a 5% loading for Aboriginal people whereas the CARPA

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definition does include this loading. It is not clear whether the NT will be able to report on the NT CARPA definition or whether the nKPI will mandate the national definition.

Indicators under development

There are no other national key performance indicators that have been developed and agreed to that are yet to be implemented. We understand that the Department may wish to implement indicators in the area of Social and Emotional Wellbeing as a priority but do not know what this indicator may be.

Feedback regarding the national key performance indicators

If you have any concerns or feedback regarding the national key performance indicators, you can provide feedback to Margaret Cotter or Liz Moore at AMSANT if you are in the community controlled sector or to your CQI facilitator or manager within the Department

"Be a yardstick of quality. Some people aren't used to an environment where excellence is expected." ~Steve Jobs

The Congress CQI Team,

Annie Power, Pauline Reynolds and Eloise Cook at the one21seventy foundation training in Alice Springs.

Pharmacotherapeutics for RANs - Online Developments

Nurses in the remote context practise at an advanced level often with limited or distant medical support. The advanced scope of practice requires Remote Area Nurses (RANs) to have a broad knowledge base in relation to disease management, including the administration, monitoring, supply and storage of medications. In 2003, recognising the dearth of training for RANs, staff at the Centre for Remote Health (CRH) and the Council of Remote Area Nurses of Australia (CRANAplus) developed a course in the practical use of medicines in disease management called *Pharmacotherapeutics for RANs*. The pharmacotherapeutics course is designed to assist nurses in developing knowledge and skills in the use of medications, the risks associated with them, and strategies to increase the benefits and minimise the risks of treatments.

Over the past 12 years, hundreds of nurses have completed the pharmacotherapeutics course. And while the course has been updated regularly to ensure currency, we are aware that more significant changes are essential if the course is to remain relevant and responsive to needs of nurses and employing organisations. In response to an identified need, staff at CRH are in the process of developing an online pharmacotherapeutics course. The online course will allow greater access to education and provide flexibility in upskilling options for nurses in remote areas. The course will be delivered utilising a variety of learning methods, including reading materials, clinical scenarios, personal reflection, multiple choice quiz, short answer questions, case studies, discussion boards and online tutorials. However, for those who prefer the face to face contact, or wonder if they have the skills to tackle an online course, the standard 2 day workshop will continue to be offered.

Through the development of an online option, CRH is continuing to ensure the delivery of quality training that is affordable and accessible, and supporting the health and livelihood of people living in remote areas. Further information on the implementation of the online course will be added to the CRH website (https://www.crh.org.au/) over the next few months.

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