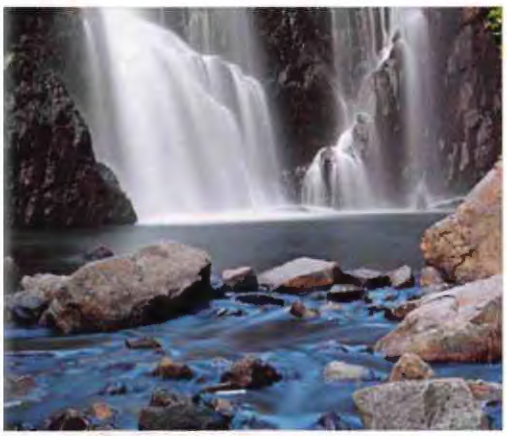
STAWELL
REGIONAL HEALTH

Caring for our Community






Annual Quality of Care Report 2007

Caring for our community

Our Mission

Stawell Regional Health provides a complete continuum of integrated health and related services, by providing the highest quality facilities and skills delivered in a personalised and caring environment.

Our Values and accompanying behaviours form a basic set of beliefs by which our people at Stawell Regional Health function:

Effectiveness

- Display attention to detail when carrying out their role
- Plan work practice and is outcome focused
- Use problem solving strategies to achieve maximum results
- Perform their role to ensure appropriate service delivery

Openness

- Share information and ideas readily
- Value new ideas and innovation
- Apply new ideas and embrace change when appropriate
- Ensures patients, families and staff have access to appropriate services

Integrity

- Respect the unique nature of each person to assure dignity for all is maintained
- Display attributes of truth and honesty
- Ensure confidentiality and privacy is assured at all times
- Exhibit reliability and punctuality at work

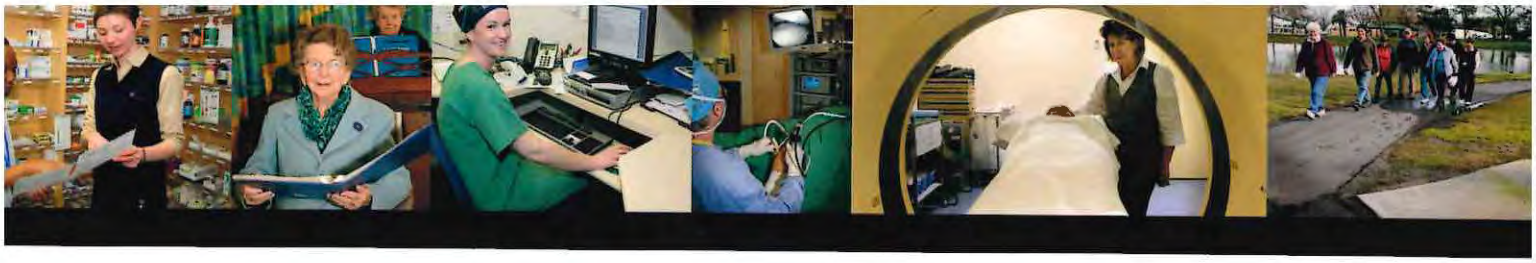
Accountability

- Provide services that are patient centred
- Display commitment to continuous quality improvement
- Use the theory of evidence based practice to ensure best possible outcomes
- Demonstrate best practice through clinical excellence and professional conduct
- Commit to the integration of best technology, systems and processes to manage and record relevant methods of work
- Accept the consequences of their actions

Flexibility

- Willing to participate in new initiatives
- Contribute ideas when setting new directions
- Strive for best outcomes for all stakeholders and the Stawell community
- Display a willingness to consider other's goals and priorities when making decisions

03/2006



Contents

Quality of Care
Board of Management

On behalf of the Board it is once again our pleasure to present the combined Quality of Care/Annual Report for the year ended June 30, 2007.

This report has been continually developed and we appreciate the feedback we receive from the people who read the report and from the Quality and Safety Branch of the Department of Human Services which enables us to adopt changes to enable its continuous improvements.

The Health Precinct

In May 2007 the State Budget brought an allocation of funds to redevelop the old Technical School in Patrick Street. Once completed this site will provide an opportunity to co-locate a broad range of primary and community care personnel.

The development of one physical site for this group of health care workers will enhance the continuum of integrated health care for the residents of Stawell and district. Work on the detailed planning of the site is now underway and it is hoped construction will commence during the 2007/2008 financial year.

Board Members

During the year the Board welcomed Mr. Martin Dorman to the Board, having been appointed to that role by the Minister of Health in October 2006. Mr. Gary Thomas resigned from the Board in May 2007 due to work commitments. Gary's experience and expertise will be greatly missed as his contributions during the rebuilding programmes and financial advice were significant factors in the Stawell community being able to enjoy the fine facilities it has today.

Grampians Health Alliance (GHA)

The membership of the GHA includes Stawell Regional Health (SRH), East Wimmera Health Service (EWHS), Beaufort and Skipton Health Service (BSHS), and East Grampians Health Service (EGHS).

The GHA continues to meet bi-monthly and rotates its meeting venue between the four services. In addition to the services SRH already shares with EGHS a recent innovation has been a shared payroll service auspiced by East Wimmera Health Service.

The outcome of the shared service has been extremely positive and its success has ensured further initiatives of a similar kind will be developed between these services. In late 2006/2007 the services agreed to pursue the development of an initiative to secure the services of a Regional Director of Medical Services as well as a joint tender proposal for the purchase of linen services.

Hospital Redevelopment and Capital Works Programme

The redevelopment programme was concluded last year and the official opening was undertaken in September by the Hon. Bronwyn Pike, Minister for Health.

The most significant project in 2006/2007 was the acquisition of a CT Scanner for Radiology which was purchased with funds from the Hospital Foundation. We are extremely grateful the Foundation saw fit to fund this project. The relationship between the Hospital and the Trustees is strong and we value their support and commitment to Stawell Regional Health.

There were other major works undertaken this year under the Statewide Infrastructure Renewal Programme.

The hospital kitchen cooling and heating plant was replaced for $35,000 and the hospital wide chiller plant was replaced for $186,000. This latter project is of significance to the hospital as it regulates heating and cooling services to the whole hospital including the theatre.

Aged Care Accreditation

During the past year staff at the Macpherson Smith Nursing Home have worked extensively to prepare for Commonwealth Accreditation Surveys by the Aged Care and Accreditation Agency. We are pleased to report that the facility gained its 3 year Accreditation in November 2006 and further visits during 2007 have reinforced that the care within the facility is of an optimal standard. Congratulations to Jason Laverack and his team on this achievement.

Quality of Care
Board of Management

Resignation of Chief Executive Officer

During the year our long serving CEO Mr. Michael Delahunty left Stawell to take up a similar position at Echuca Health Service. Michael had been at SRH for 24 years and had made a significant contribution to the development of the Health Service over that period. The Board and staff congratulate Michael on his achievements and wish him the very best in his new role.

The Board were indebted to Mrs. Claire Letts, Director of Clinical Services who acted in the role for a significant part of the year and capably enabled the service to move forward.

In May 2007 the Board appointed Mr. Peter Edwards to the position of CEO.

Peter has a strong background in Health Services and we look forward to his input into Stawell Regional Health.

Radiology Services

The introduction of a new 6 slice Scanner in August 2006 has greatly enhanced the quality of CT services available through the joint radiology service with EGHS.
The purchase of software in January 2007 has also enhanced the transmission of images for review by the Radiologist. Images can also be viewed at each of the Stawell and Ararat Medical Clinics via desktop PC's.

Stawell Regional Health as a leader in Innovation

We are pleased to report that your health service continues to pursue opportunities for the development of Best Practice Health Care. During the year SRH participated in several projects which are examples of Stawell leading the way in health. These are mentioned elsewhere in this report and the commitment of our staff to programmes which are not our 'core business' is to be commended. The range of 'pilots' and 'trials' conducted at SRH is truly commendable work.

Peter Edwards : Chief Executive Officer Peter Martin : President

Quality of Care
Board of Management

Peter Martin, Retired School Principal

Board Representation on Executive, Quality Improvement, Grampians Alliance, Audit, Governance, Risk Management Committees

Howard Cooper, Primary Producer

Board Representation on Audit/Finance, Project Control Group(Health Precinct) Committees.

Karen Douglas, Primary Producer

Board Representation on Executive, Quality Improvement, Grampians Alliance, Governance and Risk Management Committees

Joan Brilliant, General Manager Coach Tour Company

Board Representation on Fundraising and Foundation Committees.

Graeme McDonough, Retired

Board Representation on Quality Improvement, Governance and O.H.& S Committees

Neville Dunn, Branch Real Estate Manager

Board Representation on Audit/Finance, Fundraising and Project Control Group (Health Precinct) Committees.

Martin Dorman, Police Inspector

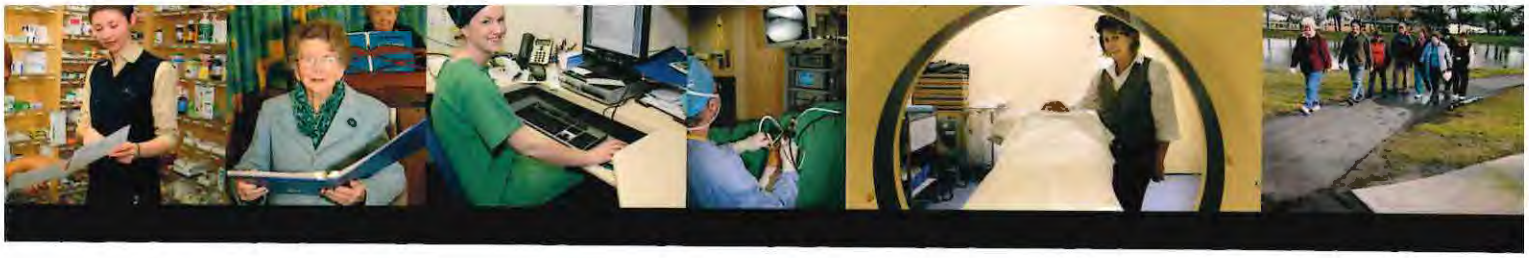
Board Representation on Executive, Quality Improvement, Grampians Alliance, Audit, Governance, Risk Management Committees

David Stanes, Business Manager

Board Representation on Quality Improvement and Project Control Group (Health Precinct) Committees

Kay Harris, Business Manager

Board Representation on Governance and Fundraising Committees



STAWELL REGIONAL HEALTH

Organisational Structure

Board of Management
President: Peter Martin

Sub-Committees
Executive
Governance
Quality Improvement
Grampians Health Alliance
Audit
Risk Management
Occupational Health & Safety
Fundraising

Chief Executive
Peter Edwards

Secretary
Medical Library
Quality Manager
Radiology
Health Information
Reception/Clerical
Public Relations/Fundraising
Sessional Medical Director
Medical Services
Engineering Services
Human Resources

Director of Clinical Services
Claire Letts

Aged Care
Nursing Home
Acute Services
Medical/Surgical
Nurse Education
Infection Control
Midwifery
Pre-Admission Clinic
Pharmacy
Operating Suite/CSSD
Community Services
Hospital in the Home
District Nursing
Post Acute Care
Day Centre
Primary Care Services
Physiotherapy
Occupational Therapy
Podiatry
Speech Therapy
Audiology
Social Worker
Diabetes Educator
Dietitian
Secretary

Deputy Director of Clinical Services
Risk Management/Projects
Enid Smith

Occupational Health & Safety

Director of Finance
Mark Knights

Finance Officer
Accounts Officer
Information Technology
Purchasing
Payroll

Director of Support Services
Stuart Kerr

Catering Services
Environmental Services

Issued Date: 09/2003 :: Latest Revision: 01-06-2007

Caring for our community

Awards

Each year the Board of Management presents either a Life Governorship or Certificate of Appreciation to community members for their valued support to the health service and to long serving staff members in excess of thirty years service.

This year's recipients are:

Life Governership

Mr Garry Thomas
Mrs Betty Gust
Mrs Betty Jackson
Mrs Betty Smith

Certificate of Appreciation

Mr Don Murphy

Staff Long Service Awards

Each year, in recognition of long and valued service to the health service, the Board of Management presents long service awards to staff members. The following are recipients of this years awards:

25 Years Gold Watch

Lynette Healy

20 Years

Fiona Wynd
Paul Tangey
Lowell Waller

10 Years

Wayne Bannister

Vale

Mabel Josephine **Evans** passed away
18th September, 2006

Jack Henry (John) **Glover** passed away
22nd April, 2007

Marjory Claire **Delahunty** passed away
14th June, 2007

Evaluation & Distribution

Distribution

As in previous year's Stawell Regional Health's (SRH) Quality of Care Report is combined with the organisations Annual General Report.

The report was officially launched at the Annual General meeting in October and copies were also provided to key stakeholders.

In addition to this, the report could be accessed from the hospital website, in waiting areas throughout the organisation or in person by request. Copies have also been distributed to local hairdressers/ barbers, medical centres, dentist, bakeries, coffee lounges, restaurants, library, employment agencies, Centrelink and the Northern Grampians Shire Council office waiting area.

To increase distribution of this year's report the above avenues will again be utilised with exerts from the report published as part of the ongoing 'Caring for your Community' article that is featured on a **weekly** basis in the local newspaper. This distribution process was selected as it provides a multi faceted approach and reaches a broad cross section of the community.

The effectiveness of the distribution strategies of this years report will be assessed by consumer feedback through a focus group to be held later in the year. A group of multidisciplinary staff developed this year's report.

Evaluation

Report evaluation is two fold.
Firstly from consumers through the Consumer Feedback Questionnaire and secondly by an independent panel auspiced by the Department of Human Services who review the report against guidelines and minimum reporting requirements.

Even though a small number of responses were received from the questionnaire, suggestions have been incorporated into this years report.

All who returned the questionnaire "strongly agreed" or "agreed" the report was:

Well presented, easy to read/understand/ interpret and helped them understand how SRH is responding to Quality and Safety issues.

The feedback will provide us with an opportunity to improve our report.

What will we try to improve:

The size and the amount of information in the report.

Feedback from the independent panel was generally positive.

Some general suggestions for improving this years report included:

- Clearer explanation of medical/technical terms
- Improve readability by using less text on top of watermarked photos
- Provide more information about consultations that have occurred with Culturally and Linguistically Diverse (CALD) and Indigenous groups
- More consumer involvement.

Partnerships - working together

Rural Patient Initiative Project between Stawell Regional Health and East Grampians Health

During 2006 funding was received from DHS as part of the Rural Patient Initiative. Two collaborative projects were conducted. One was the upskilling of nurses in Emergency Care including Obstetric Emergencies to achieve the necessary levels of competence. A series of education sessions and skill stations were conducted including:

- Advanced Life Support (28 staff)
- Advanced Life Support for Obstetrics (7 staff)
- Neonatal Emergency Transfers (13 staff)
- Clinical Assessment (28 staff)
- Intrapartum Surveillance of mothers using Cardio Toco Graph (CTG) (9 staff).

Education and skills provided within the Emergency Care Project link closely to the clinical management and up skilling required for the Shared on Call Project.

The Shared Maternity Service Model

This project focused on the alternating surgical and obstetric service between Stawell Regional Health and East Grampians Health. To enable efficient functioning of GP Obstetricians, surgeons, anaesthetists and nursing staff on the on call weekend the framework was refined and formalized between the health services. This included rostering and circulation of information for medical officers, nursing staff and the community. This shared service has provided medical officers and theatre nurses with improved working hours and quality of life. Satisfaction surveys conducted with mothers indicated a 90% satisfaction rate with most aspects of this alternating weekend service. Where mothers have birthed at the alternate service, 90% were happy to stay.

The key factor to this success was evaluating and acting on the information received between agencies. As a result, effective and efficient communication systems have been developed to ensure that this occurs.

Rural Emergency Collaborative Practice Model

Stawell Regional Health is one of 6 pilot sites to participate in a research study. The aim of the project is to introduce a practice model of care into rural hospitals to deliver sustainable and safe emergency care by more efficient use and access to medical and nursing staff in the provision of emergency care to the community. This is particularly important when recruitment and retention of professionals in rural areas is a priority for rural health.

Eight of our staff are participating in the research study. It is hoped that the current emergency care being provided will be enhanced by improving call back arrangements for medical officers, improve timely assessment and treatment for patients, improve communication between professionals and maintain clinicians competence in emergency care. A training program for four nurses at SRH will occur as well as for nurses at the other pilot sites. Clinical guidelines will be reviewed by nurses and medical officers at a local level and provide a guide for treatment on a wide range of clinical conditions.

Partnerships – working together

Working in partnership with other health care providers assists us to sustain services and bring new services to you. The alternating weekend on call arrangement for Obstetrics and Emergency surgery between Stawell and Ararat hospitals is an example of this. This service was formally reviewed over the past twelve months and continues to help retain our medical and surgical services.

The **Grampians Health Alliance**, consisting of four organisations, Stawell Regional Health, East Wimmera Health Services, East Grampians Health Service and Beaufort-Skipton Health Service continues to evolve, offering staff opportunities to develop strategically and use high level skills more effectively. In 2007 the GHA payroll services unit was developed to ensure ongoing capacity to meet payroll demands. The ability to utilise the knowledge of one highly trained payroll manager across three organisations in a mentoring and supervisory role, with excellent outcomes demonstrates what can be achieved when we work together.

The health service works closely with Grampians Community Health Centre, Budja Budja Aboriginal Cooperative, Northern Grampians Shire Council, West Vic. Division of GP's and many other organisations.

The **After Hours Telephone** advice service was implemented in 1998 in partnership with the West Vic Division of GP's to relieve the burden of after hours telephone calls to medical staff and assist their retention in the area. This service has now expanded to include 13 medical clinics which divert their telephone to a 1800 number between 6 p.m and 8.30 a.m. 7 days per week. Stawell Regional Health plays a vital part in this system providing all night time cover after 10.30 p.m. plus dedicated shifts to take calls, provide advice and ensure care co-ordination with hospitals and GP's. Nursing staff use local knowledge and local services to provide this service to rural communities.

Private Inpatient Billing Service

The private inpatient billing service allows patients to utilise their private health insurance whilst being treated in a public hospital. In the past you were often reluctant to be treated as private in a public hospital as you would receive numerous accounts from a wide range of service providers (doctors and diagnostic services) and were often left with out of pocket expenses after receiving the health fund contribution.

The billing service acts as an agent for you and administers the claims from both Medicare and the health funds. The monies are then paid into a trust account and distributed to the service providers. You will now receive one invoice from the billing service which details all the services provided and will have no balance to pay.

The benefit to the hospital is **significant** as the Department of Human Services sets an annual private patient fee target for each hospital. Once the hospital achieves that target any additional fees generated are kept by the organisation.

These funds are then reinvested in the hospital as either increased services or new equipment.

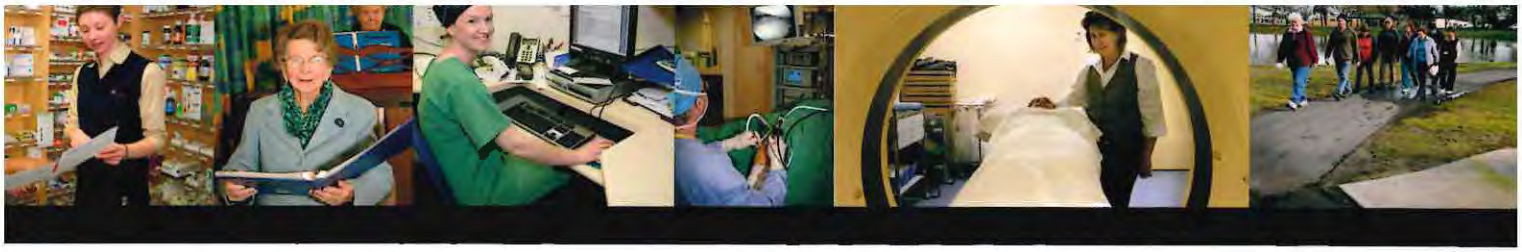
Stawell Regional Health established the private inpatient billing service in December 2005. The first six months were spent bedding down the billing software, promoting the service within the community and educating staff on how the service works.

As a private patient at Stawell Regional Health you will receive a wide range of benefits including:

- a personalised menu
- a single room
- transport to and from hospital and
- an individual gift pack.

Stawell Regional Health would like to take this opportunity to thank you the members of the community for utilising your private health insurance whilst being a patient.

This is one significant way you can assist in ensuring the future of our health service.



Consumer involvement in improving our Health Service

Resident Feedback

Macpherson Smith Nursing Home residents/relatives provide feedback at meetings which are held monthly.
The meeting is chaired by a resident's relative and a number of the organisation's executive staff attend the meeting.

General Feedback

- At some stage after using a hospital service you may be contacted to complete a satisfaction survey.
We encourage you to provide this feedback, as this tells us how we can improve our service and how you rate our care/service.
SRH conducts a number of surveys and is also involved in a statewide survey called the 'Victorian Patient Satisfaction Monitor'. (Please see page 12.)

Client Feedback

Bennett Centre for Community Activities holds a Client/Carer meeting second monthly.
Feedback from this meeting provides information about what direction future activities should take.

Suggestions

Suggestions are also collected on the Suggestion, Complaint and Compliment Form. A small number (8) of formal suggestions were received last year which is comparable to previous years.

In response to suggestions we have:

- Increased the variety of summer desserts for nursing home residents
- Reviewed the layout of patient accounts
- Increased the number of hooks on inpatient bathroom doors
- Increased the number of 'current' magazines in waiting areas and
- Utilised phone call reminders to improve outpatient attendances in some allied health areas.

Outreach Customers

A variety of allied health services are offered in surrounding towns. Feedback from customers is provided to the visiting Community Health Nurse and other members of the Outreach Team. Team Members liaise with the Primary Care Manager on a regular basis to address concerns and improve service provision.

Future Directions

- To hold a focus group to evaluate the impact of 'Caring for Our Community' newspaper article
- To develop a Cultural Diversity and Consumer Participation Committee, which will:
    - Monitor and review the Cultural Diversity Plan
    - Develop/ review patient information brochures and
    - Aid in development of future Quality of Care Reports.

Monitoring Patient Satisfaction

We encourage your feedback'

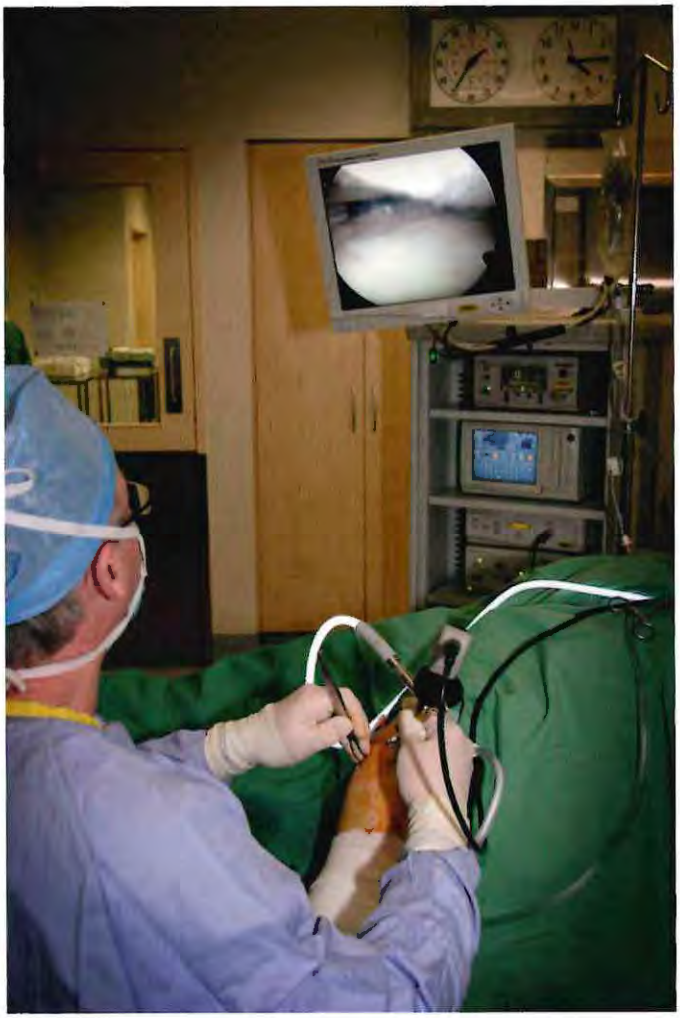
Stawell Regional Health monitors patient satisfaction through a number of internal and external surveys and is involved in a statewide survey called the 'Victorian Patient Satisfaction Monitor'.

This survey is conducted twice a year, over six month periods by an external source.

All patients who stay overnight in a Victorian Public Hospital are eligible to participate. A 'Refusal to Participate' form along with a'Participant Information Sheet' and brochure is given to every patient at each admission contact. Results are provided to SRH on a regular basis and we are able to compare them against organisations of the same size and the Statewide mean.

Our latest results (six months ended February 2007) indicate that 87% of patients were very satisfied overall with their hospital stay.

Patient Feedback:
"Everyone was very helpful and listened to any concerns and made suggestions on how to solve them" "The feeling of security and that I received the best treatment available"



Patient responses have told us we are good at:

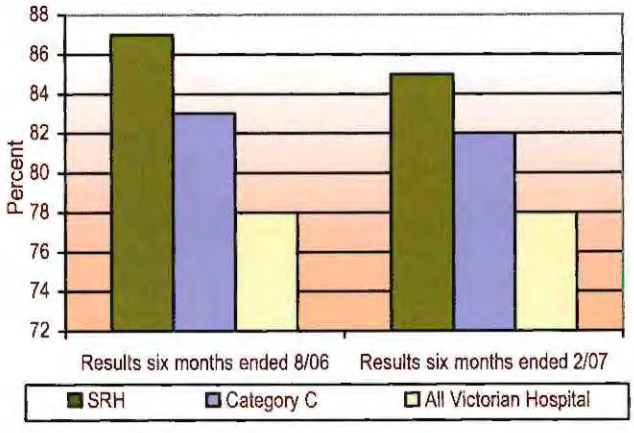
- Courtesy of nurses – 98%
- Courtesy of doctors – 100%
- Explanation of treatment – 93%
- Respect for privacy – 99%
- Personal Safety (patient) - 99%
- Cleanliness toilets/showers/ patients rooms – 100%
- Quality of food – 96%

We need to improve:

- Waiting Time – 90%

Patient Feedback:
"Staff and their courtesy, respect and friendliness and help in recovery and rehabilitation"

Figure 1 'Overall Care Index'
Illustrates how patients rated their overall care compared to Category C and Statewide Hospital Benchmark.



Consumer Participation and Decision Making

Our staff aim to involve you in decisions about your care. This is achieved on an individual basis through the Pre Admission Clinic, Day Procedure Unit, Antenatal Booking or when admitted as a medical or surgical patient to the acute ward – Simpson Wing.

At times a family conference involving a multidisciplinary group of staff may also assist in planning your care.

To encourage you to become more knowledgeable and active about your health we provide you with the following written information:-

1. **'Tips for Safer Healthcare'** – leaflet available on all inpatient bedside lockers and
2. **'10 Tips for Safer Healthcare'** - leaflet (developed by the Australian Council for Safety and Quality in Healthcare) available in all patient admission packs and in waiting/reception areas throughout the organisation.

Through the Victorian Patient Satisfaction Monitor (VPSM) (as described on page 12) we are now able to compare consumer participation against Category C Hospitals (those approximately the same size as SRH) and Statewide Hospital Benchmarks.

The Consumer Participation Indicator (CPI) is a measure that is collected from a combination of results of three VPSM questions.

These questions are:

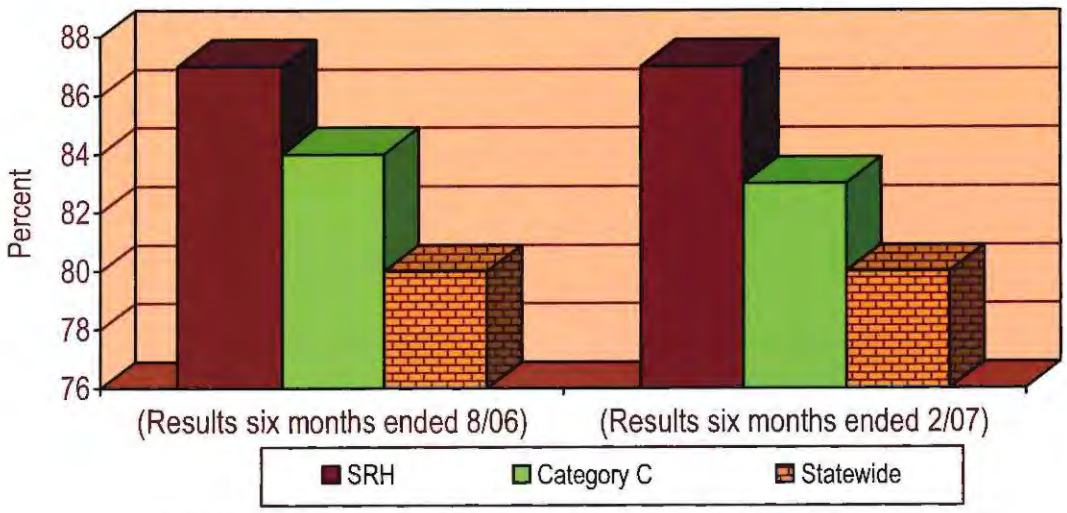
- The opportunity to ask questions about your condition or treatment
- The way staff involved you in decisions about your care
- The willingness of hospital staff to listen to your health concerns.

The indicator which is highlighted in the following graph provides us with a measure of how you rated your involvement in your health care during your hospital stay.

Figure 2 compares the average overall rating over two six month periods.

Patient Feedback: *"Information given at Pre Admission Clinic before hospital stay. Meeting anaesthetists/ doctors and discussing treatment etc.*

Figure 2 Consumer Participation Indicator



Data Source: Ultrafeedback. Victorian Patient Satisfaction Monitor.

Cultural Diversity

SRH CEO Peter Edwards with the Chairman of Budja Budja Aboriginal Cooperative Tim Chatfield.

Stawell Regional Health (SRH) provides health services to the township of Stawell and its' surrounding areas. The Local Government Areas (LGAs) serviced in order of proportion are Northern Grampians Shire, Pyrenees Shire and Ararat Rural City.

Outreach health services are provided to the small towns of Glenorchy, Halls Gap, Marnoo, Landsborough (Pyrenees Shire), Navarre and Great Western. Residents of Pomonal (Ararat Rural City) also access health services provided by Stawell Regional Health.

There are a limited number of people from culturally diverse backgrounds in our main catchment areas of Northern Grampians Shire and the small portion of Pyrenees Shire that access our health services.

Cultural Diversity in our catchment:

Australian Bureau of Statistics (ABS) data obtained in the 2006 Census indicates the following cultural roots for our residents:

Northern Grampians LGA – Country of Birth:
88.7 percent of residents of Northern Grampians Shire were born in Australia. Only 1.6% spoke a language other than English at home.

Of those born overseas, 42% of residents were born in the following countries: United Kingdom (61.6%), New Zealand (13.7%), Netherlands (7.8%), Germany (5.7%), China (4.1%), Ireland (3.5%) and South Africa (3.3%).

Pyrenees LGA – Country of Birth:
84.6 percent of residents of Pyrenees Shire were born in Australia.

Of those born overseas, 45% of residents were born in the following countries: United Kingdom (63.8%), Netherlands (8.5%), New Zealand (8.31%), Germany (6.5%), Malta (3.2%), South Eastern Europe (3.2%), Phillipines (3%) and USA (3%).

It is important to note that the township of Landsborough, in the Pyrenees Shire, is almost an equal distance from both Ararat and Stawell. As a result, residents access health services in both towns. The predominant non-English-speaking country of birth in Landsborough is Croatia. All residents speak fluent English.

Cultural Diversity

Indigenous Population:

0.7% of residents (86 people) of the Northern Grampians Shire (NGS) are of Aboriginal or Torres Strait Islander descent.

0.5% of residents (35 people) of the Pyrenees Shire are of Aboriginal or Torres Strait Islander descent.

The majority of indigenous people in our catchment live in Halls Gap (NGS), Pomonal (Ararat Rural City), and Stawell (NGS).

Chinese Population:

The 2006 census data identifies 32 people born in China and Hong Kong living in the Northern Grampians and Pyrenees Shires. For the last 2-3 years Stawell Secondary College have had a program in years 10, 11 and 12 that caters for students from China. There are approximately 30 Chinese students at Stawell Secondary College per year. The students are billeted out with host families in the district. When these students arrive, many of them do not speak English and there are health issues associated with dietary changes.

Religious Groups:

There is a significant population of people of the Exclusive Brethren living in Stawell. This group has different cultural beliefs to the majority of residents in our sub-region, which can impact on culturally safe access to, and delivery, of health services.

Tourists:

The Grampians region attracts many tourists each year. As Stawell Regional Health does not have a funded Accident and Emergency (A & E) department, we have no data on presentations to A & E by the tourist population.

In terms of total hospital admissions, 3% of patients were from non-English speaking countries of birth. Of those, only 0.17% were from a non-English speaking country of birth. Unfortunately, we cannot verify if these people were residents of Australia or visitors from another country.

Cultural Diversity

Understanding clients and their needs

Stawell Regional Health has engaged in mapping the current client profile against the demographics of the service catchment area to determine whether there are any trends.

In the past year, there has been a measurable improvement in identification of people of Aboriginal and Torres Strait Islander (ATSI) descent who access mainstream outpatient services at SRH and mainstream health services at Budja Budja Aboriginal Co-Operative.

- In 2005-2006, only 0.69% of outpatients were identified as of ATSI descent, and these people accessed 0.5% of services
- In 2006-2007, 0.85% of outpatients were identified as of ATSI descent, and these people accessed 0.59% of services.

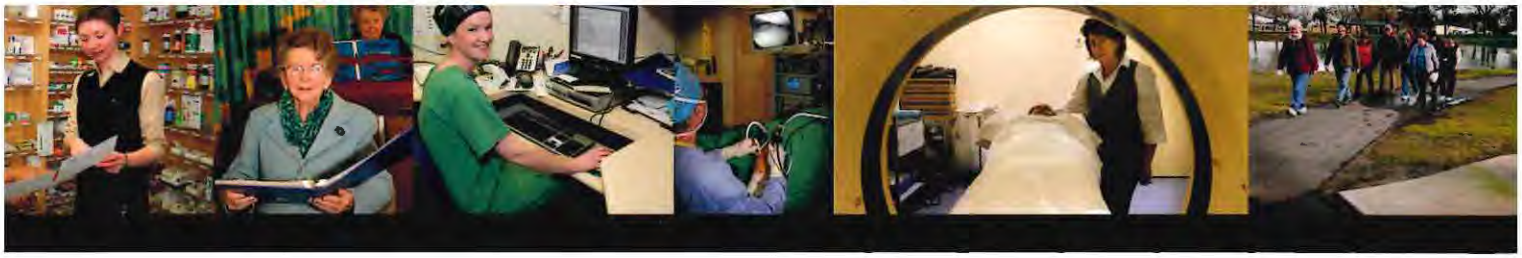
The percentage of indigenous people accessing outpatient services closely corresponds with the demographic information provided. It is hoped that these numbers will increase as people become more comfortable accessing services, especially given that ATSI health outcomes are significantly worse than that of the general population.

It is clear that access to mainstream health services has improved significantly with the involvement of the male Indigenous Community Health Development Worker in the past ten months.

New programs that have been commenced by the male Indigenous Community Health Development Worker and

- a Healthy Lifestyles program for indigenous men, and
- a group that meets around Respect, Responsibility and Relationships.

In the next twelve months, further work with members of Budja Budja Aboriginal Co-Operative, including changes to the physical environment at Stawell Regional Health to increase cultural safety and sensitivity, may impact positively both on individuals' willingness to identify as an indigenous person, and to access mainstream health services.



Cultural Diversity

Partnerships with multicultural and ethno-specific agencies

Our organization has undertaken to work in partnership with the appropriate ethno-specific and multi-cultural agencies to assist in obtaining a better understanding of our local Culturally and Linguistically Diverse (CALD) communities.

A tailored staff orientation program is being developed with the assistance of the male Indigenous Community Health Development Worker to assist with indigenous issues.

Following appointment of the Cultural Diversity Committee members, the cultural safety of the other identified CALD groups will be explored.

This information will be disseminated to the staff of Stawell Regional Health to enable the provision of culturally safe care.

A workforce with skills in cultural diversity

Stawell Regional Health actively seeks to engage new employees who are from different backgrounds, or who have different experiences or perspectives. The employment application process identifies people from culturally and linguistically diverse backgrounds. A general register is currently being developed as part of the new Human Resources Information System.

Using languages to best effect

Timely and effective interpreting and translation services improve both access to services, and the quality of the service provided. There has been significant education of staff to ensure they are trained and proficient in accessing the new Department of Human Services interpreting and translation services.

SRH provides surgical services to a number of Arabic-speaking people. Appropriate Pre-Admission information has been translated into Arabic to assist safe and comfortable access to SRH services.

Encouraging participation in decision-making

Better health outcomes should be attainable if service planning strategies are developed that involve members of CALD communities. The development of a suitable Cultural Diversity Committee structure, and consultation with CALD clients on the development of health promotion or health education programs should have a significant effect on increasing the reach and impact of programs on their health.

Over the past twelve months, SRH has been working towards the development of an appropriate structure, with clear terms of reference and position descriptions for participants of our Cultural Diversity Committee. We are currently in the final draft phase. It is anticipated that notices for Expressions of Interest, and specific invitations to identified cultural groups, such as the indigenous community and the Chinese community, will be sent out early in the 2007-2008 financial year.

Promoting the benefits of a culturally diverse community

Whilst there is limited cultural diversity in the Stawell Regional Health catchment area, assisting in promoting and sustaining cultural diversity should result in positive benefits to health and well-being. Acknowledgment of cultural diversity does not necessarily require special events, but can be through enduring initiatives such as displaying artwork that is culturally important to a particular CALD group.

Improvement in Indigenous Health Services

Improving the health status of indigenous people in our catchment has been a specific objective of Stawell Regional Health for many years. In 2002, we commenced delivery of primary care services such as physiotherapy, dietetics and podiatry directly in the Budja Budja Aboriginal Co-Operative in Halls Gap. Despite the location, the 2005 evaluation of the Commonwealth program "Strengthening Rural Communities" supported our concerns that the program was not having the desired impact on indigenous health issues in our local region.

Significant effort in partnership with Budja Budja Aboriginal Co-Operative, the Commonwealth Department of Health and Ageing and the Office of Aboriginal and Torres Strait Islander Health over the last two years has resulted in the appointment of a male Indigenous Community Health Development Worker in August 2006. The three days per week position is jointly funded through the Commonwealth Regional Health Services Program and the Office of Aboriginal and Torres Strait Islander Health.

Key activities being performed by the male Indigenous Community Health Development Worker are:

1. Needs assessment and development of a new Health Plan for the indigenous community.
2. Development of an 'access plan' that will include direction for mainstream health service providers to provide culturally safe access to services.
3. Organisation of services and activities that support local indigenous men and their communities to improve their health status. This may mean working on areas such as education, housing, family violence and justice provision.
4. Act as a resource and referral person to appropriate health and welfare services, such as counselling, dental services and medical services.

The impacts of this position have been immediate and positive, with the development of a:

- Men's Counselling & Support Group and
- Men's Healthy Lifestyles Group.

There has also been a significant increase in the number of indigenous people who have been assisted to attend mainstream health appointments such as dental appointments, and appointments with both general practitioners and medical specialists.

Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP):

Key result areas	Achievements
Key result area 1 Establish and maintain relationships with Aboriginal communities and services.	Stawell Regional Health and Budja Budja Co-Operative have enjoyed a positive working relationship for many years, with the joint auspice of the Commonwealth program "Strengthening Rural Communities." Progress towards development of a Cultural Diversity / Consumer Participation Committee that will have indigenous representation. Employment of a male Indigenous Community Health Development worker to assist with improving access to mainstream health services for local indigenous people.
Key result area 2 Provide or coordinate cross-cultural training for hospital staff.	Involvement of local indigenous people in planning for cross cultural training of hospital staff. Development of a comprehensive cross-cultural training plan for all hospital staff.
Key result area 3 Set up and maintain service planning and evaluation processes that ensure the cultural needs of Aboriginal people are addressed when referrals and service needs are being considered, particularly in regard to discharge planning.	Budja Budja Health Plan was developed following extensive consultation with the local indigenous community and service providers. Regular meetings with the male Indigenous Community Health Development Worker, Budja Budja Co-Operative Board member and key parties at SRH eg Chief Executive Officer, Director of Clinical Services and Primary Care Manager.
Key result area 4 Establish referral arrangements to support all hospital staff to make effective primary care referrals and seek the involvement of Aboriginal workers and agencies.	Progress towards involvement of aboriginal staff in development, review and refinement of referral to primary care. Progress towards obtaining the views of Aboriginal service users through development of a Cultural Diversity Committee.

Clinical Governance

"Quality is consistently meeting the negotiated expectations of our customers and optimising their health outcomes in a cost effective manner"

Stawell Regional Health (SRH) has an ongoing commitment to improving the quality of its services.
We do this through our Clinical Governance Framework, Quality Improvement Programme and maintaining Accreditation.

The Board of Management has ultimate accountability for ensuring the health service is effectively and efficiently managed.

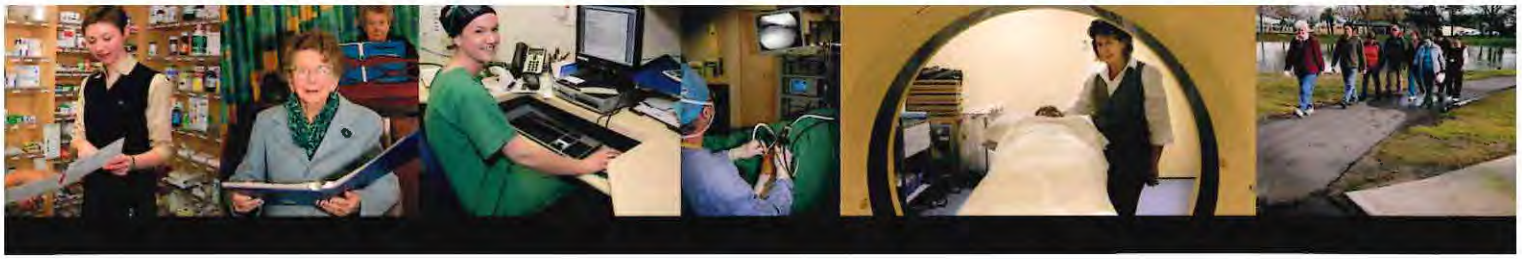
The framework of Clinical Governance ensures systems are in place to continuously improve the quality of health care through reducing risk and creating a culture in which best practice clinical care flourishes.

Some of the components of clinical governance include:

- Collection and trending of complaints
- Ensuring external reviews such as accreditation are achieved
- Monitoring of medication errors
- Staff credentialing and privileging (what they are allowed to do)
- Clinical Risk Management Programme.

A number of Board Members have received education through the Board of Management training sessions conducted on behalf of the Department of Human Services.

At this organisation, the Quality Improvement Committee is a sub-committee of the Board of Management. It is chaired by a Board Member and comprises clinicians, nurses, allied health and executive staff. This committee ensures clinical systems are well designed and their performance is monitored with identified issues actioned through systems improvements.



Complaints Management

Complaints indicate your dissatisfaction with care and provide us with information about the service we provide.

We use complaints as 'a window of opportunity for improvement'.

All formal complaints to SRH can be made on the 'Suggestion, Complaint and Compliment (SCC) Form. These forms are found in all reception areas across the facility. In addition to this complaints can also be made by phone or in person.The complaints are initially referred to the CEO, and investigation is managed by a member of the Executive.

The complaints are reviewed at the bi-monthly Quality Improvement Committee (QIC) meeting.

They are also reported to the Health Complaints Commissioner on a three monthly basis. Information is de-identified to protect privacy.

Recent changes to the complaints process include:

1. Rolling out the availability of the SCC form to the radiology reception area, and

2. Increasing the amount of data to the QIC members to monitor trends in complaints by trending information on a quarterly basis.

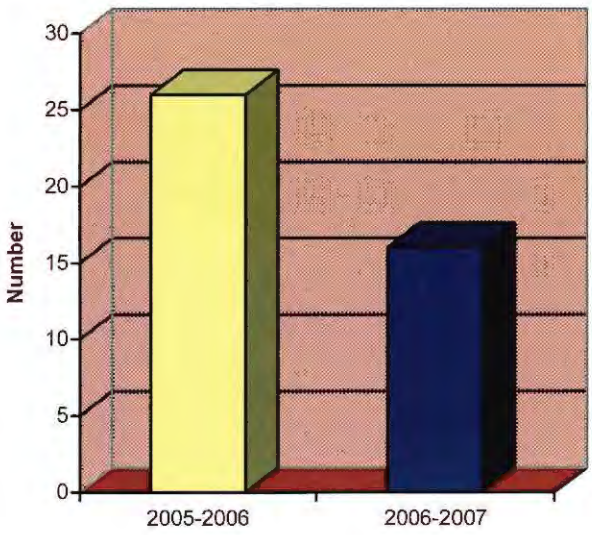
In response to complaints we have made changes to policy, provided staff education/counselling and improved service provision through revision of appointment making processes.

No complaints resulted in an adverse outcome for patients.

Performance Measures
In 2005-06 80% of complaints were closed within 30 days compared to 75% this year.

Figure 3 illustrates the total number of formal complaints received over the past two financial years.

Figure 3 Formal Complaints Received



External Monitoring

Accreditation is a process that requires external monitoring of our performance.

We are independently reviewed by a number of accrediting bodies. This is a requirement of the Victorian and Commonwealth Governments for all health and aged care services.

The accreditation process enables us to compare and benchmark ourselves against set standards. This comparison ensures the quality and standard of care we provide is comparable with other health services. It also provides us with the opportunity to identify areas for improvement.

We are continually looking at how we do things to improve our standard of care.

We have achieved and maintained accreditation with:

- **Australian Council on Healthcare Standards (ACHS)**

  Accredited until June 2010. As part of the 4 year accreditation cycle, we will be assessed through an on site review in April 2008. At this review we must achieve a minimum rating of 'Moderate Achievement' for the fourteen Mandatory Criteria. We must also show significant progress on the two recommendations we received at the Organisational Wide Survey in March 2006.

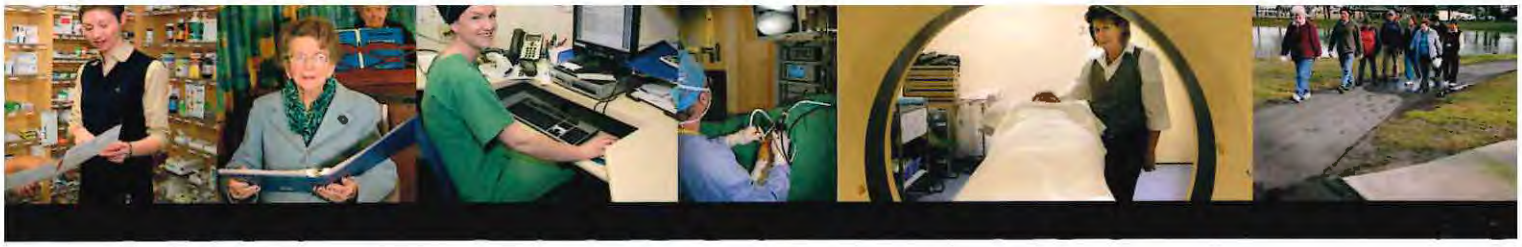
Compliance with these standards means we have process/systems in place to meet, monitor and evaluate Clinical Governance, Credentialing and Certification of Staff, Risk Management and Complaints. Improved outcomes against these areas can be found throughout the report.

- **Aged Care Standards and Accreditation Agency (ACAA)**

  Macpherson Smith Nursing Home is accredited until November 2009. The nursing home underwent an on site survey in September 2006.
  Two support contacts have taken place in January and March this year. No areas of 'non compliance' have been found. As part of the review process, all visits leading up to the survey in 2009 will be 'un-announced' (no notification of when surveyors will arrive). We expect at least one unannounced support contact per year until survey.

- **Home and Community Care (HACC)**
  Successful review in 2003. No review offered since, however the HACC review will be incorporated into the ACHS review in the future

- **Department of Veterans Affairs (DVA)**
  Preliminary audit in 2005, no review offered since.



Staff Skills and Credentials

Patient safety and quality of care are important for you as a customer of our services and Stawell Regional Health. To assist in meeting your expectations and our goals, we have a number of systems and processes in place involving our staff.

Medical Practitioners whether employed by SRH or contracted (Visiting Medical Officers) are registered by the Medical Board of Victoria and are subject to Credentialing (registration) and Privileging, (what they are allowed to do), on commencement and at defined periods thereafter. Patient care episodes are reviewed to identify areas for improvement and if necessary to review the Privileging rights. These processes assist in ensuring patients are not receiving treatment/care that is outside the scope of this organisation or its' medical practitioners.

Nursing staff must provide evidence of annual registration which can be verified via the internet on the Nurses Board of Victoria website. Nurses practicing in specialist fields such as Midwifery must ensure they have recency of practice within the last five years. Whilst continuing education is not mandatory the Nurses Board can request evidence of ongoing education from nurses and it is considered an important component of professional development.

Stawell Regional Health provides a comprehensive range of education for nursing staff to assist them to remain up to date across the broad range of fields required for rural nursing. Sessions include Infection Control, Basic Life Support, Epidural Management, Medication Management and Intravenous Cannulation.

Allied Health staff also participate in ongoing education and an annual registration process. The mentoring program conducted in partnership with Ballarat Health Services provides exposure to expert practitioners and provides opportunities for advanced skill development which may not be available in Stawell. This additional knowledge helps to ensure our customers are receiving up to date treatments.

Quality, Safety and Risk Management

Risk Management Process

If risks are identified staff are required to complete an incident form stating the risk or incident.

Following this, the circumstances that occurred at the time which may have contributed to the incident are identified. This helps determine what needs to be looked at in more detail. Any action or equipment that is used prior to the incident is included in the investigation. This assists the Department Head and Risk Manager when review of the incident occurs.
All incidents are reviewed by the Department Head and then forwarded to the Risk Manager to determine if adequate action has occurred or further investigation or action needs to be taken.
Incidents are trended to look for: -

- Common causes
- Frequency and
- Severity of events.

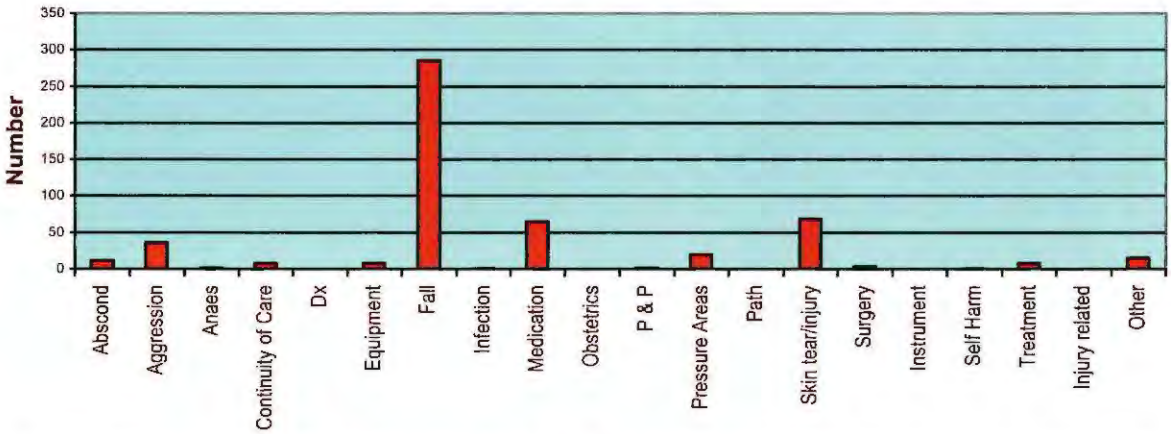
Incidents are classified depending on whether it has been a near miss, a minor injury or major injury. All significant risks are entered onto a central risk register. Information is collated on a monthly basis and presented to our Risk Management Committee, which has Board representation.

During 2005 a staff survey on the culture of Patient Safety was conducted following education on the importance of reporting incidents. This was repeated in 2006 to see if there had been any significant changes.
Some major improvements and strengths were identified.
These included:-

- When a lot of work needs to be done we work together as a team – 83% (2005) compared to 87% (2006)
- Our procedures and systems are good at preventing errors 78% (2005) compared to – 79% (2006)
- Hospital management provides a climate that promotes patient safety 88% (2005) compared to 93% (2006).

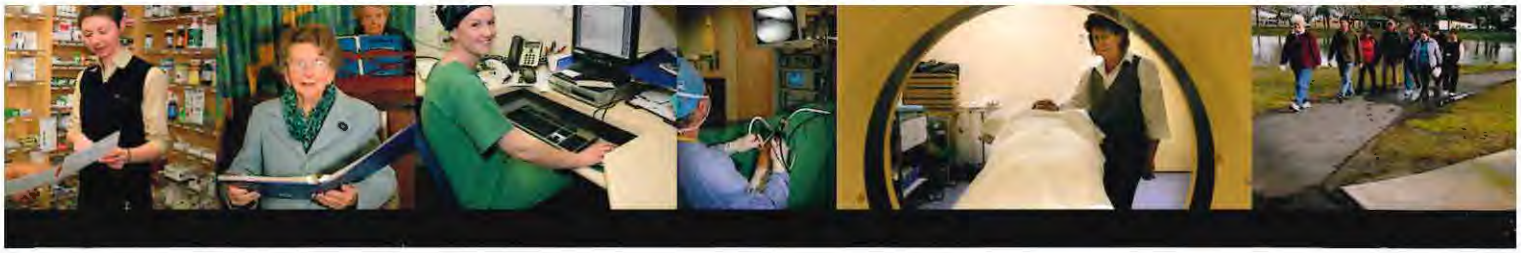
Figure 4 illustrates the number and types of incidents over the last twelve months.

Figure 4 Incidents



Some of the improvements to the systems and processes resulting from incidents include:

- Education on requirements for collection and labelling of blood specimens
- Adding the age and gender of patients on patient identification labels
- Review of all security measures, including installation of locks to areas which were considered to need more security
- Review of the security contract and
- Review of lock down procedures and access to areas of the organisation.



Quality, Safety and Risk Management

Falls Monitoring and Prevention

Falls has been identified as one of the major factors for hospital admission, particularly in persons over the age of 65 yrs. Falls are in the most part preventable and our health service has initiated a Falls Prevention Programme.

When patients or residents are admitted and are over 65 years of age or have a history of a previous fall a risk assessment is undertaken. Once this is completed prevention strategies are put into place eg. walking frame. Falls are monitored on an ongoing basis and incident reports are completed as part of our risk management programme to enable information to be trended over time. These reports identify strategies in place for patients or residents and include additional interventions that have been added should a fall occur.

The prevention programme involves consultation between nurses and allied health staff to identify the best possible prevention strategies.

Some of these strategies include:

- Use of alarm sensor mats
- Hip protectors
- Non slip socks
- Review of the environment and
- Location of furniture.

Strategies are documented on care plans.

Whilst the rate of falls in Aged Care has increased several factors need to be considered.
The culture of willingness of staff to report any trip, slip or fall has improved as has the identification of some resident's who have had multiple falls.
Whilst every effort is made to minimize falls our focus has also been on reducing harm.

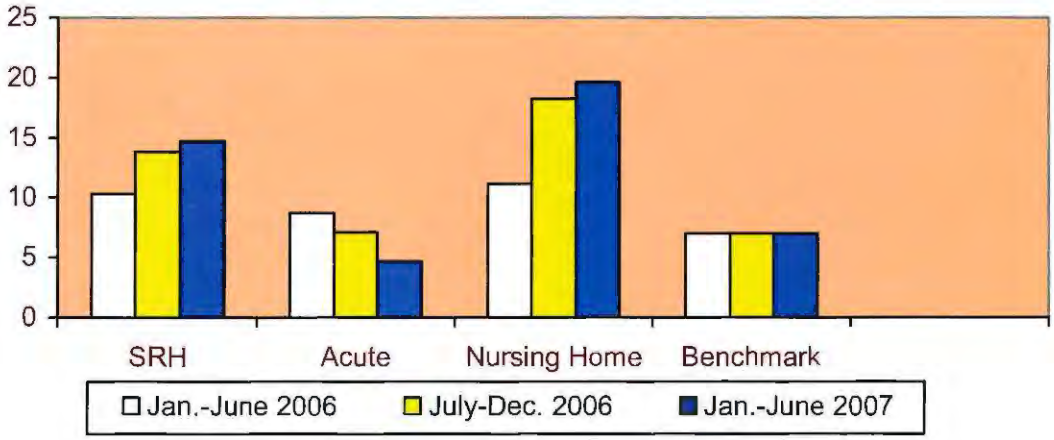
This year Aged Care received funding and have recently installed new technology called "Invisibeam". This equipment uses an invisible electric beam that alarms when a resident crosses the beam. This alarm is relayed back to alert nursing staff. We will be evaluating the use of this new technology to see what impact it has on our falls rate.

In acute care, walking frames have been color coded to identify those patients who require supervision, observation or are independent. This provides an alert for staff when observing patients to ensure their safety whilst walking.

Falls have been measured by the number that have occurred within 1000 days that a bed is occupied. This method is used as it provides a consistent measure for each time frame.
Falls in acute care have reduced and this has mainly been due to the type of patient admitted.

Falls have been monitored and benchmarked within acute and aged care comparing six month timeframes. This is depicted in Figure 5.

Figure 5 Falls/1000 bed days



Quality, Safety and Risk Management

Food Safety

Over the past three years, the food services department infection control practices have been assessed against externally set standards.

We have been assessed against the following criteria:

- Cleaning equipment and chemicals
- Control of food borne listeriosis (infection caused by a bacteria)
- Environment
- Food protection
- Food safety plan
- Food storage
- Personal hygiene and education.

Figure 6
Compliance with Food Safety Standards

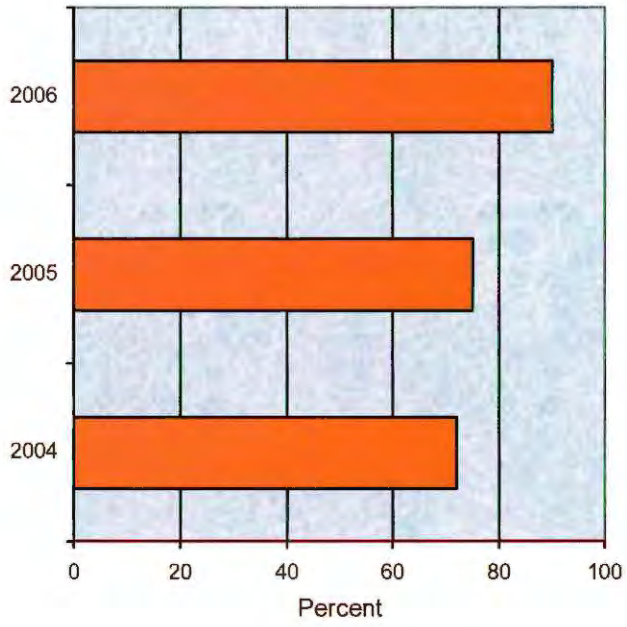
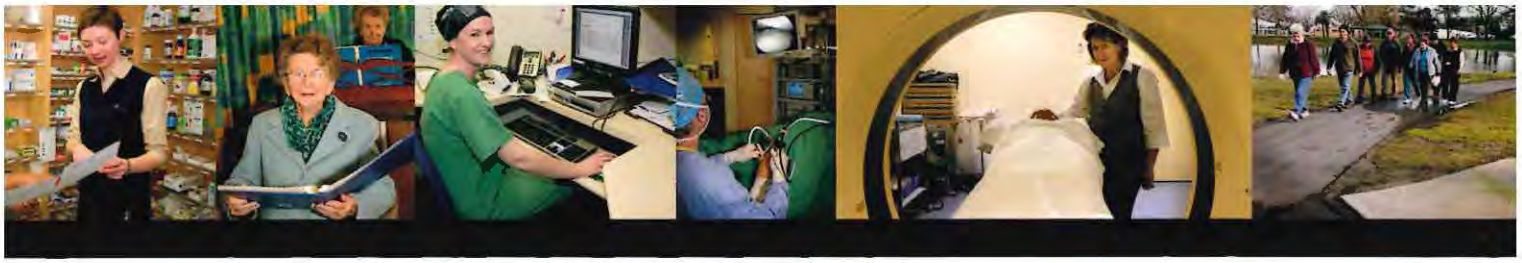


Figure 6 compares our scores from 2004 to 2006. An 18% improvement over three years is demonstrated.

Introduction of the following practices resulted in the improved score:-

- Improved food storage/labelling practices
- Improved storage practices of empty containers
- Placing patient's cutlery in paper cutlery bags on meal trays
- Recording food temperature of a plated 'dummy' (mock) meal
- Including all food fridges in a temperature monitoring program
- Change in delivery times of fresh food to the kitchen
- Discussion/education of food safety matters at monthly staff meeting
- Recording dishwasher temperatures and
- The size of the food storage area was increased.

In addition to this a Food Services Review by an external company was undertaken in May. A summary report was presented to the Board of Management in June.



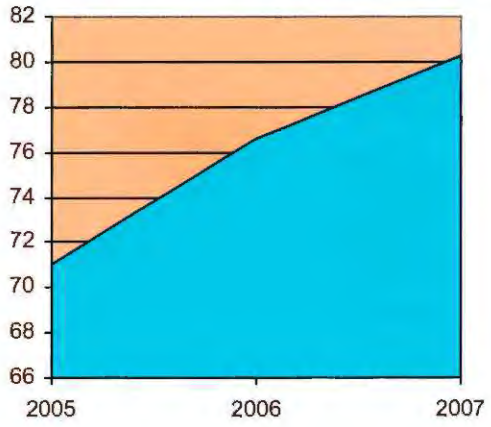
Quality, Safety and Risk Management

Infection Control

Education

In our hospital it is the staff's knowledge and understanding of how infections occur and how diseases are spread that minimises the risk of you acquiring an infection during your hospital stay. For the past seven years, it has been compulsory for all nurses to participate in the computer based "Infection Control Challenge Exam". From 2007 it has also become compulsory for all Personal Care Assistants (PCA's) and Patient Services Assistants (PSA's) to participate in this exam. The purpose of the exam is to identify staff knowledge deficits, so that an education program can be developed to meet staff needs. Figure 7 shows the average score of all staff participating in the challenge exam over the last three years.

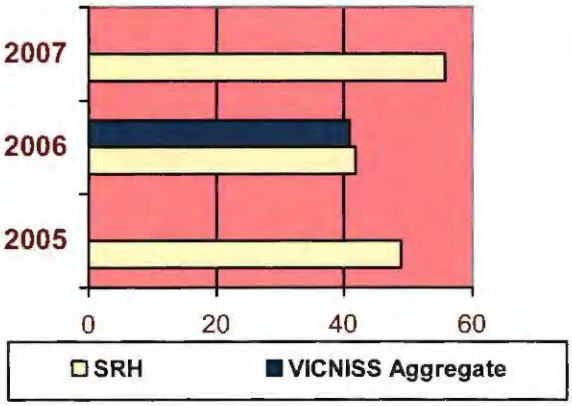
Figure 7
Infection Control Challenge Exam



Preventing the spread of Infections

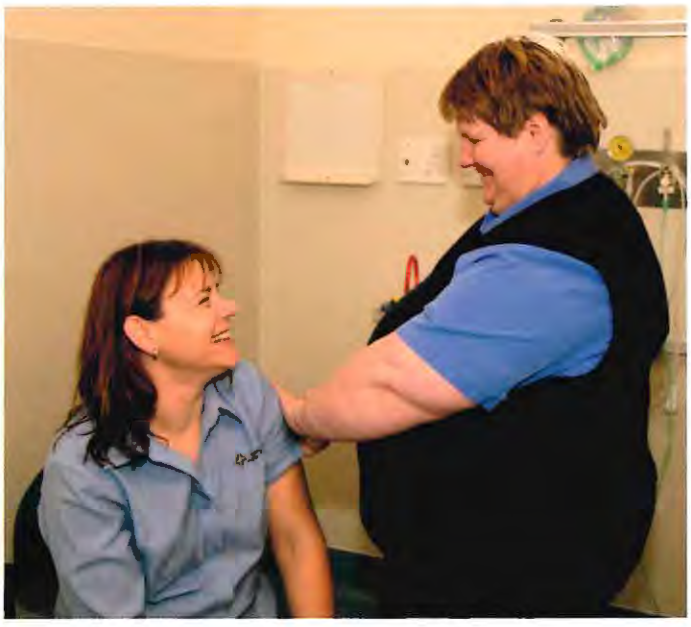
By immunising yourself against preventable diseases such as influenza, measles, mumps, rubella and chickenpox, not only are you protecting yourself, but by being immunised you will not spread these diseases onto your family, friends and work colleagues. Immunised health care workers also prevent spreading these diseases to you the patient who are already ill and less able to fight off diseases. We provide and encourage all staff to participate in this free immunisation program.

Figure 8
Influenza Immunisation Program



The Victorian Nosocomial Infection Surveillance System (VICNISS) aggregate is the average of eligible staff, accepting the influenza vaccine in Victorian hospitals that participate in the VICNISS surveillance program.

The influenza immunisation program results as depicted in Figure 8 show the percentage of eligible staff (nominated by DHS) that have accepted the vaccine over the past three years.



Quality, Safety and Risk Management

Infection Control

'Clean' hands are 'healthy' hands

For the past twelve months, we have been participating in the Victorian Quality Council (VQC) Hand Hygiene Project. The aim of the project was to implement this 'best practice' program across Victorian hospitals to reduce the transmission of MRSA (Methicillin Resistant Staphylococcus aureus). *Staphylococcus aureus* is a microbe that is usually found on your skin. It is called **MRSA,** commonly called "Golden Staph." when this microbe becomes resistant to certain antibiotics.

The program involved changes to aspects of hand hygiene practices in our facility. An alcoholic-chorhexidine hand rub has been placed at the end of each patient's bed, so all staff are able to clean their hands before and after attending to patients or contact with objects/equipment. This reduces the risk of transferring 'bugs' from one patient to another. The hand rub is also found at hospital entrances and waiting rooms. Outpatient and visitors are encouraged to use the hand rub before and after visiting sick friends and relatives. In addition to the hand rub a moisturising product is available that will minimise skin irritation and dryness. The effectiveness of this project will be monitored by the following three indicators suggested by the VQC.

These indicators are:

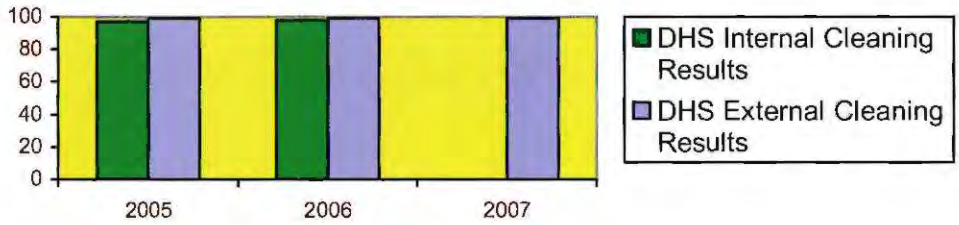
- rates of compliance
- the amounts of hand hygiene product used and
- the rates of hospital acquired infections.

Maintaining Cleaning Standards

Stawell Regional Health has exceeded the minimum cleaning standards set by the Department of Human Services (DHS) for the past seven years. Figure 9 illustrates DHS internal/external cleaning results compared to the set DHS minimal acceptable standard.

In addition to maintaining our high standard, we introduced a low chemical cleaning system in September 2002. This has reduced the number of microbes (bugs) on different surfaces by up to 85%. This system is used throughout the organisation.

Figure 9 Cleaning Audit Results



Quality, Safety and Risk Management

Infection Control

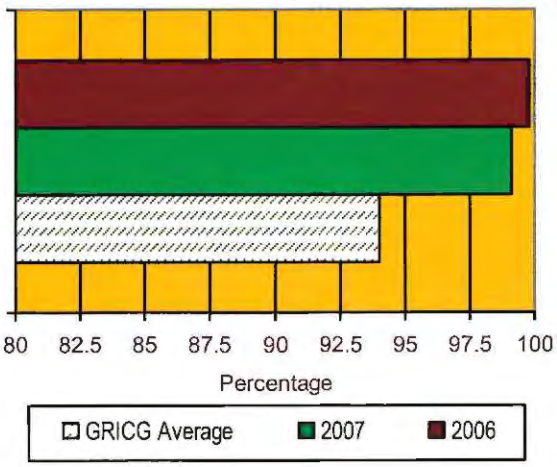
Maintaining Cleaning Standards

In addition to reducing the number of chemicals used for cleaning other flow-on benefits have been:

- reduction in cost
- eliminating the odour of chemicals from the environment
- reducing OH&S issues (manual handling)
- reducing the number of chemicals containers to be stored/disposed of and
- reducing the risk of microbes becoming resistant to chemicals used for cleaning.

In addition to these results, we have maintained the highest scores for external cleaning audits over the last two years (2006 and 2007) compared to eleven other health facilities in the Grampians region (Grampians Region Infection Control Group). Our results for 2006 were 99.8% and 2007 results were 99.1% compared to the GRICG Average which is shown in Figure 10.

Figure 10
External Cleaning Audit Comparisons. SRH results compared to Grampians Region Infection Control Group (GRICG) Average.



Quality, Safety and Risk Management

Medication Safety

Safe management of medication is a priority at Stawell Regional Health. A medication error may cause an adverse event which is defined as:

> *'an unintended injury or complications that result in disability, death or prolonged hospital stay and is caused by health care management (in this case medication management) rather than the patient's disease'.*

It may include prescribing, dispensing and administration errors. Detection of such errors may occur through self-reporting, direct observation or through review of the medication chart. So that it is possible to maintain safety and quality, and prevent future occurrences, staff are encouraged to report near misses and incidents which result in no harm.

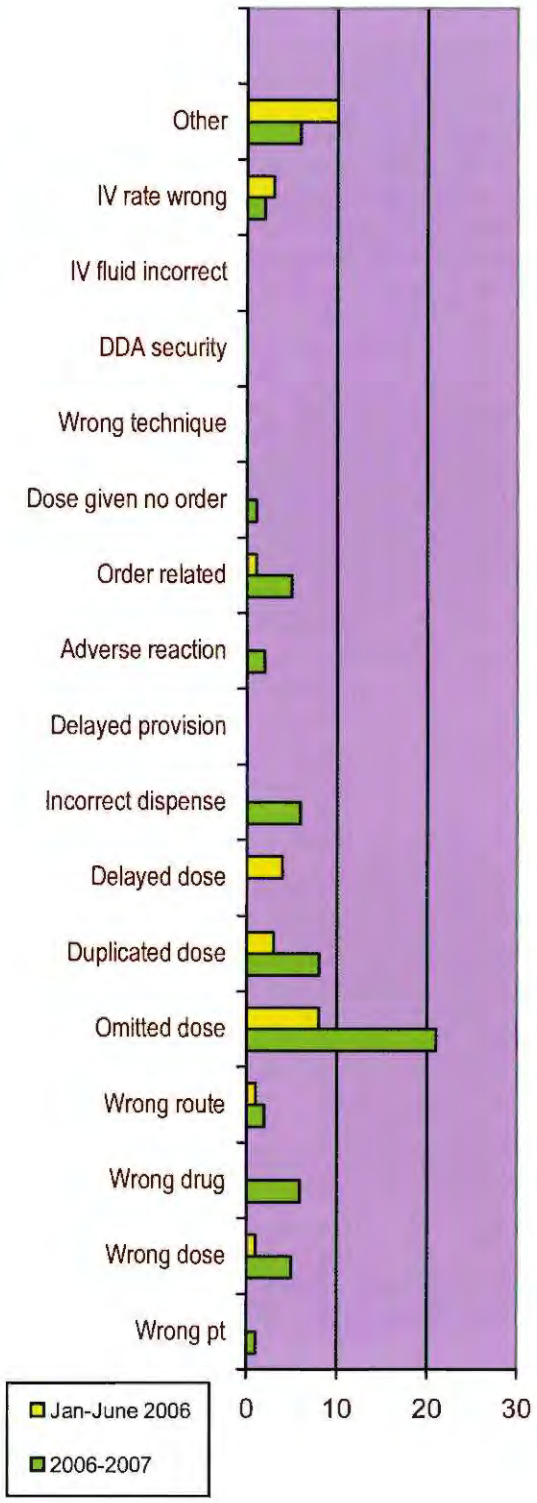
Medication incident reports are received and collated from all areas of the organisation, including the aged care facility and the Radiology Department.

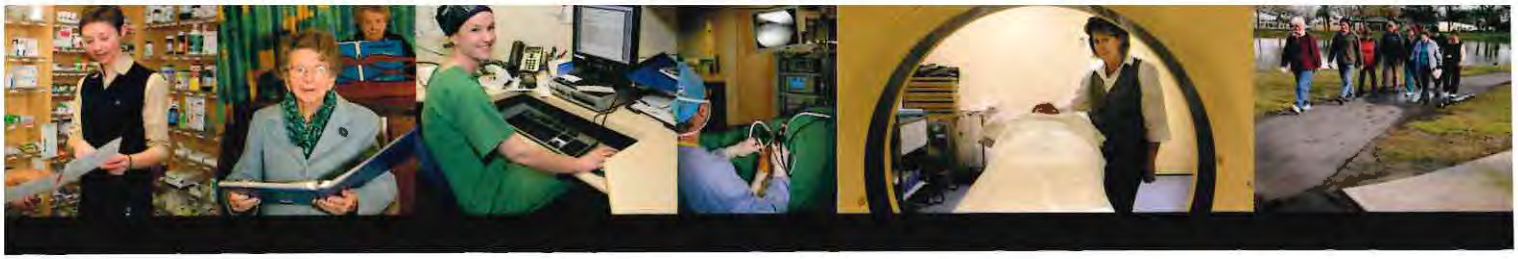
Last year there were 65 medication-related incident reports submitted. No incidents resulted in patient harm.

Figure 11 illustrates medication errors by type over the last eighteen months.

Whilst omitted doses were the highest rated error this included where drugs may have been administered but not signed as given.

Figure 11 Medication Errors (2006 compared to 2007)





Quality, Safety and Risk Management

Medication Safety (Continued)

In order to reduce the occurrence of medication errors, and the resultant possibility of harm, it is necessary to know which drug products, medication categories and work processes are involved. Error prevention in SRH is based around the analysis of incident reports, review of current practices and processes in place and the subsequent development of staff education, protocols or policies as appropriate. In addition, communication with other healthcare facilities and project teams and the availability of literature allows for comparison and early identification of risks.

A major step in the promotion of quality and safety at Stawell Regional Health was the introduction of the National Inpatient Medication Chart (NIMC) into the acute care facility in July 2006. The chart was developed as a result of a communiqué released by the Australian Health Ministers in 2004, suggesting a commitment to the implementation of a standard medication chart to reduce harm from medication errors. Collaboration between SRH and a project team from DHS-funded Victorian Medicines Advisory Committee (VMAC) has allowed the development of a chart specific for our use. Further developments for ancillary charts are in process and will be adopted by SRH when available.

In order to identify areas of possible improvement and potential for harm or error, audits have been conducted prior to, and 3 months after, the introduction of the NIMC. The audit tool which is utilised encompasses the survey of prescribing, administration and documentation, in addition to patient's personal identifiers and information.

Results of our process of implementation and findings will be forwarded to DHS for others to share lessons learnt. A major improvement is the addition of patient admission drugs onto the chart – all patient medication information is now contained in one place in the record.

Since the introduction of the NIMC there has been demonstrated improvement in the following areas:

- Prescription and administration; prescribers (doctors) name clear and if drug not given indicated by an approved code eg (F) Fasting
- Patient identification and information; presence of patient identification labels, patient weight and documentation of patient adverse drug reactions
- Regular orders; administration times entered by the doctor and orders ceased correctly.

As part of the cycle of continuous improvement, the use of the chart will continue to be audited on an annual basis.

Quality, Safety and Risk Management

Skin Integrity
Pressure Ulcer Prevention and Monitoring

Patients who are admitted to hospital are at risk of developing pressure ulcers, particularly if pressure is applied to a body part from lack of movement. This may potentially occur when patients are immobile in bed or even under an anaesthetic.

A Pressure Ulcer Prevention Program has been introduced on a statewide level which requires health services to screen for risk of pressure ulcers. This may be by assessing continence, nutrition, mobility and the type of surgery to be undertaken.

Interventions are put into place and may include:

- pressure relieving mattresses
- heel wedges or
- regular repositioning of patients.

Our staff are educated in how to assess patients for risk, determine the grade of any pressure ulcer that may occur and initiate appropriate treatment.

Frequently residents and patients may be admitted with pre-existing pressure areas. This has occurred within our health service. Over the last twelve months **22** pressure ulcers were identified, **10** of which were pre-existing.

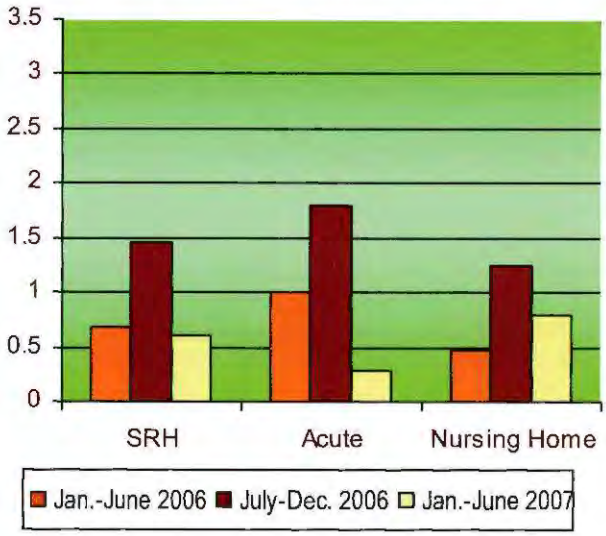
Our policy on Pressure Area Prevention has been updated and provides current best practice information for staff and patients.

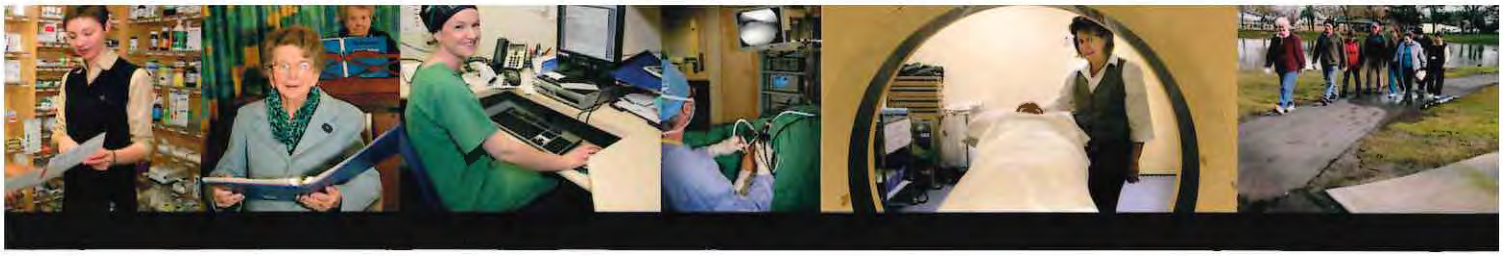
In addition to these strategies the Operating Theatre has also included risk screening on the intra-operative assessment. Prevention Strategies are included on care plans and a quick reference wound product guide has been developed and is available in all clinical areas.

In September 2006 new mattresses of a higher standard were purchased for the nursing home. This replacement programme was funded by DHS.

Figure 12 compares six monthly benchmarked data, measuring the number of pressure areas that have occurred within 1000 bed days that a bed is occupied. Both acute and aged care show a significant reduction in rate over the last six months.

Figure 12 Pressure Areas





Quality, Safety and Risk Management

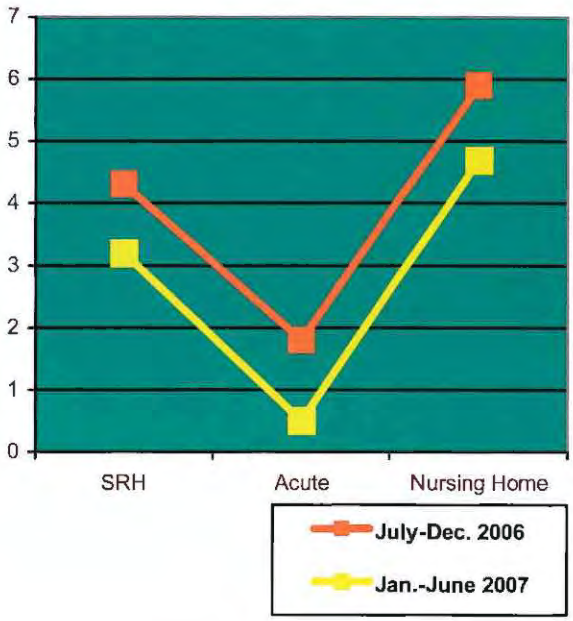
Skin Tears

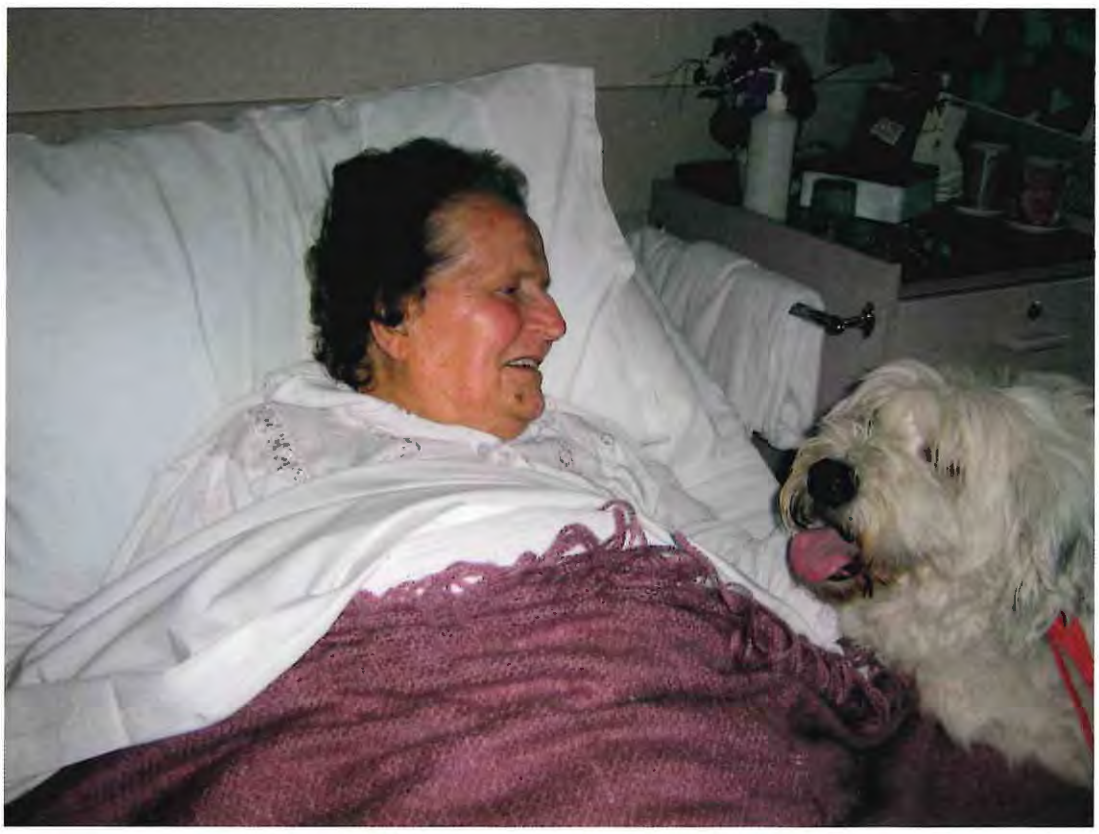
Skin tears are also monitored across the organization and reported through the Incident Reporting Program. Skin tears may be prevented by ensuring adequate and appropriate skin hydration and nutrition. Factors contributing to the development of skin tears are collected. These include whether they occur as a result of transferring a patient/resident, whether it may be self caused or caused by equipment or products. Skin tears may also have resulted from a fall.

Patients/Residents may be referred to the dietitian for nutritional assessment. Some patients/residents have benefited from the use of limb protectors where their skin may be very fragile.

Figure 13 illustrates skin tears per 1000 bed days over two six month periods across the organisation compared to the acute and aged care facility.

Figure 13 Skin Tears/1000 Bed Days





Caring for our community

Ladies Auxiliary

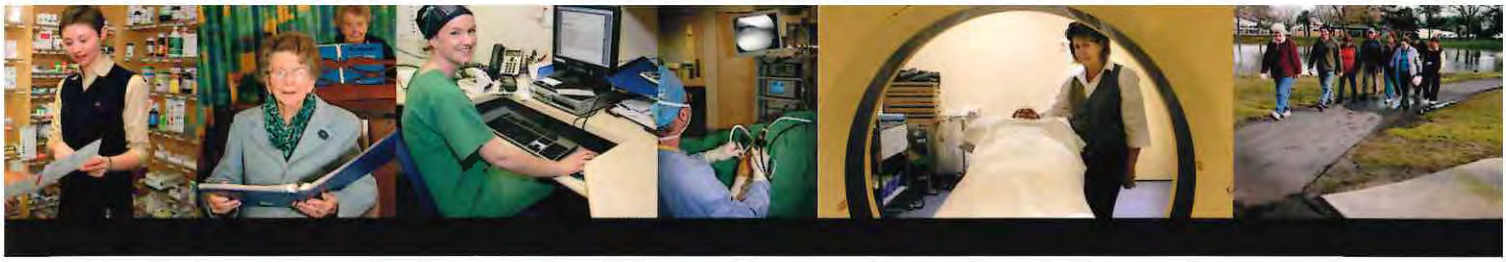
This year has once again been successful financially, providing equipment for our hospital.

Thankyou for the dedication and commitment of volunteers and the generosity of our community.

We acknowledge the generosity of private donors who support the Auxiliary with donations of money, gifts and items throughout the year.

Through donations and fundraising this year we have been able to purchase a –

- Palliative chair for the Nursing Home
- Hi Lo Trolley for the Visiting Specialist Rooms
- Thermometer for Simpson Wing
- 12 Heat Bags for the John Bowen Oncology Unit and a
- Syringe Driver for Accident & Emergency.



Y-Zetts

The Stawell Regional Health Y-Zetts are a fundraising committee that raise money to assist Stawell Regional Health purchase equipment. This committee does a great job organising and running functions such as the Annual Rotary Club Convention Luncheon, the annual Stawell Traders Shopping Spree and other fundraisers such as 'Save your Garden' survival information day.

In the 2006/2007 financial year, the Stawell Regional Health Y-Zett Committee pledged $16,000 in funding for the Stawell Hospital, as well as purchasing much needed equipment for the hospital. This included a joint donation with the Murray to Moyne Sprockets for the new Vital Signs Monitor for the Accident & Emergency Department at Stawell Regional Health. (See below)

Our community benefits greatly from these fundraisers which allows the hospital to acquire new equipment, hence improving our already fantastic hospital and services.

Are you at risk of developing Type 2 Diabetes?

One person in Australia is diagnosed with diabetes every seven minutes. Diabetes is Australia's fastest growing chronic disease.

Over 75,000 people were diagnosed between May 2006-May 2007.

What is Diabetes?
In people with diabetes blood glucose levels are higher than normal, because the body does not produce enough insulin and is unable to use insulin properly. Insulin is a hormone. It is needed for glucose to enter the body cells and be converted to energy. There are two types of diabetes, Type 1 and Type 2.

Type 2 Diabetes
This is the form of diabetes that is related to lifestyle factors.

It occurs when the pancreas is not producing enough insulin and often the insulin is not working effectively.

Who is most at risk of developing Type 2 Diabetes?

People with one or more of the following risk factors:

- People over 35 years of age from:
  - Aboriginal or Torres Strait Islander background
  - Pacific Island, Indian subcontinent or Chinese cultural background.
- People over 45 years of age who are:
  - overweight
  - have immediate family members with Type 2 Diabetes and
  - have high blood pressure.
- People over 55 years of age
- People who have impaired fasting glucose or impaired glucose tolerance
- People who have heart disease or have had a heart attack
- Women who have had gestational diabetes
- Women who have polycystic ovarian syndrome and are overweight.

If you think you are at risk what should you do?

Symptoms are not often recognised or noticed.

Know the risk factors so you can reduce your risk.

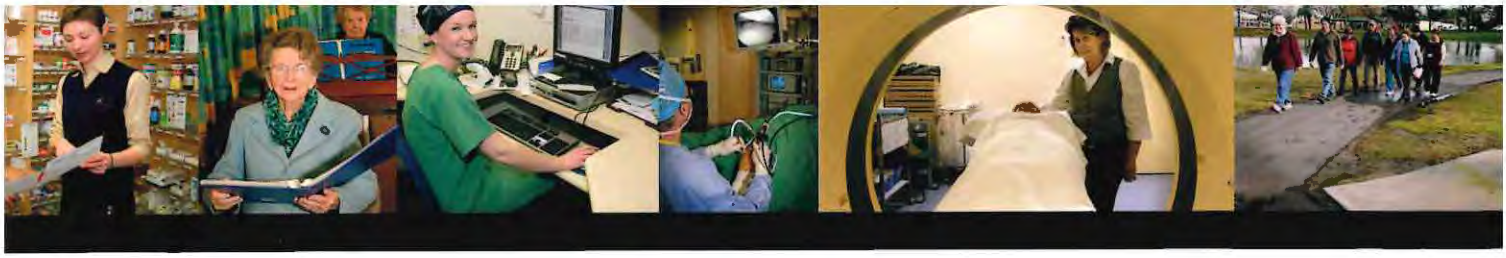
Diagnosis: Visit your doctor and have a simple blood test – a fasting plasma glucose test.

Prevent Type 2 Diabetes by:

- maintaining a healthy weight
- being physically active
- following a healthy eating plan.

These preventative measures can reduce a persons risk by up to 60%

(Reference: Diabetes Australia)



Are you at risk of developing Type 2 Diabetes?

Our Numbers:
As the number of people being diagnosed with diabetes have increased so have the number of contacts to our Diabetes Education Department over the past four years.

The departments hours were increased to six (6) days per fortnight in June 2007 to meet the demand.

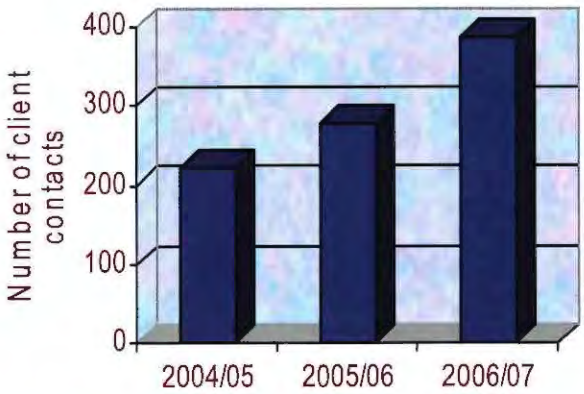
These days are flexible depending on community needs in the outreach program, health promotion activities and inpatient/outpatient appointments.

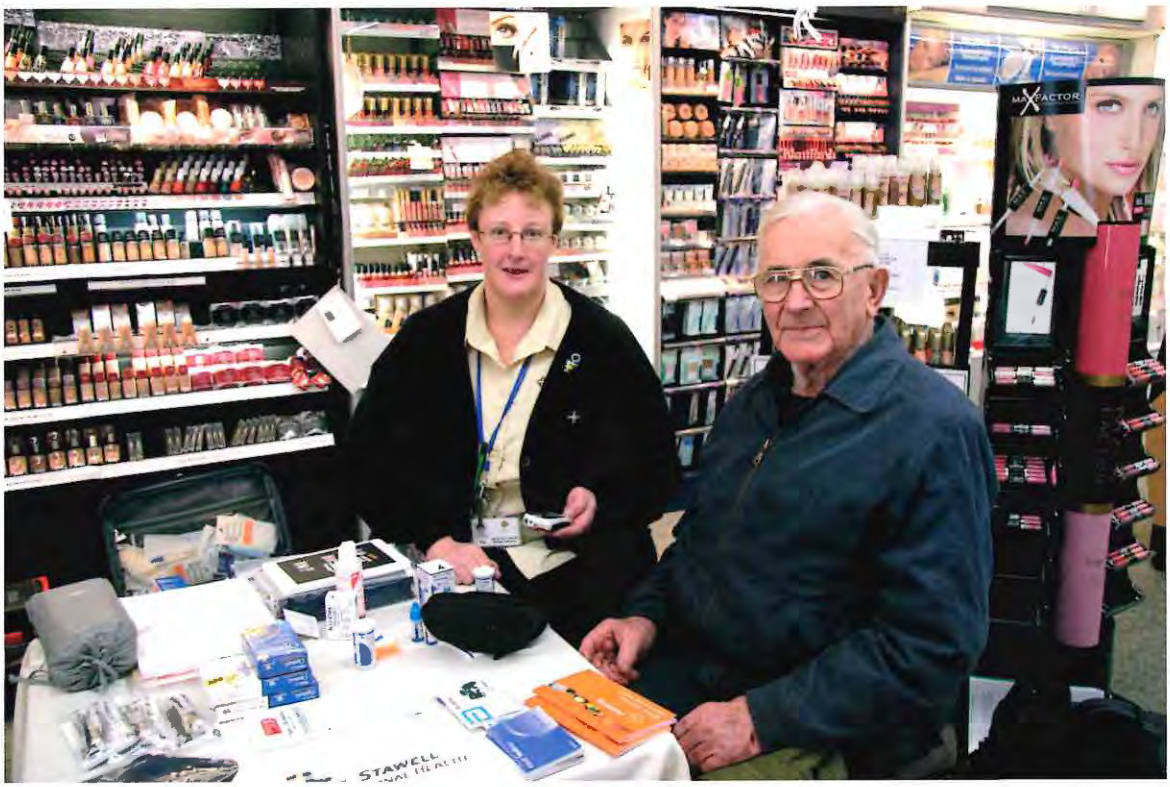
Figure 14 illustrates the increase in number of patient contacts to the Diabetes Education Department over the last three financial years.

In 2006, SRH became a fund holder (DHS funded) for the Grampians Health Alliance for a Self Management Program for people newly diagnosed with Type 2 Diabetes.

In 2006/07 and 2008 this will provide newly diagnosed diabetics with three core components: - client assessment, self management intervention and client services and monitoring through our Primary Health Care Department.

Figure 14 Diabetes Education Patient Contact





Continuum of Care

Caring for you because of either a medical illness or an operation commences from the time we first have contact with you. The discharge planning process involving you and/ or your carer, hospital and other relevant personnel including your General Practitioner commences at this time. This process will ensure that supports, if needed, are organised prior to your discharge or put in place as soon as the need arises.

Upon discharge there may be a need for Post Acute Care (PAC) and/or District Nursing involvement. If this is the case then a referral would be received from the hospital during your hospital stay. Referrals to PAC may also be made after discharge.

This referral may come from Community Services, Local Councils, General Practitioners or individuals.

Post Acute Care links you to services you need that you may not have accessed before your admission. The PAC Service streamlines the support process for you. Support may only be needed short term, but if this changes then appropriate referrals will be made with your input and agreement. PAC is only available to public hospital patients and to be eligible you must meet certain PAC criteria.

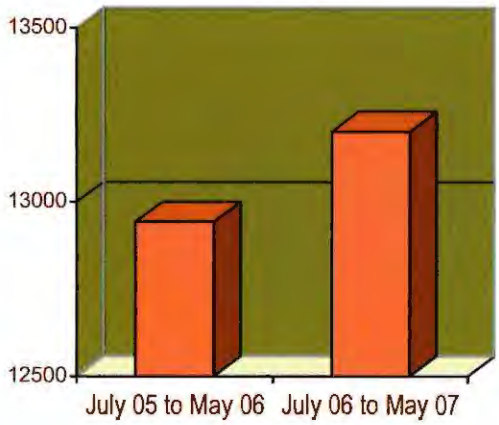
Since 1998, SRH has managed two of the three subregions in the Grampians DHS region; from Beaufort to the Victorian/South Australian border.

District Nursing is a service provided by the hospital. Referrals may be made during a hospital admission or because support is required unrelated to a hospital admission. This support may include wound care/ management, incontinence advice, medication and hygiene support. This year episodes of care have been steadily increasing within the service.

From July 2005 to May 2006 there were 12,943 episodes of care and from July 2006 to May 2007 there were 13,202 episodes of care which shows an increase of 259 visits this year. Figure 15 illustrates this.

Hospital in the Home (HITH) is another program provided through the hospital by the district nurses. This program allows some people to receive treatment in their home instead of having to remain in hospital. There are conditions to this service which are decided by the hospital and the medical staff. Types of care that can be delivered to you through this program are giving intravenous antibiotics (medication for an infection given into a vein) or anti coagulant medication (medication that thins the blood).

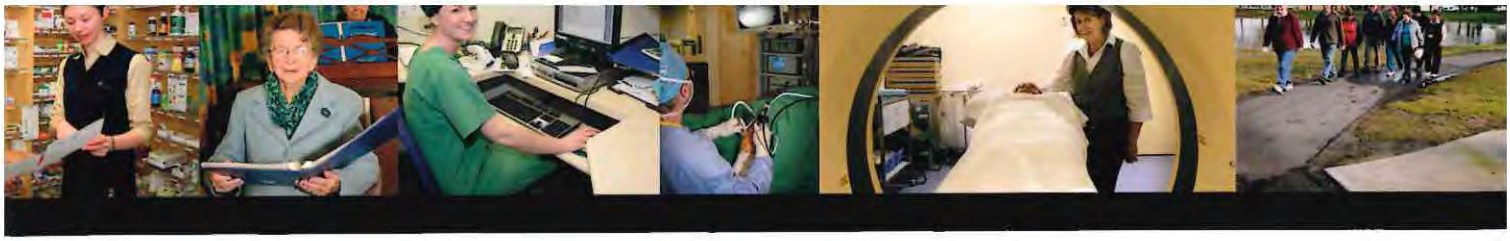
Figure 15
Episodes of Care



District Nurses have to complete specific competencies each year for their roles (HITH duties). This ensures that staff maintain a certain standard of safe practice required to care for and support their patients.

Should support through District Nursing or Hospital in the Home no longer be required, staff will discuss with the patient/carer the date the service will cease. If other support/s are required then these will continue. This may include a referral to the local council for ongoing hygiene support with a personal care worker. This will be discussed with you first. If ongoing support is required with District Nursing then this also will be discussed with you.

Sometimes during your hospital stay it may be identified that you may benefit from visiting the Bennett Centre for Community Activities. Staff will discuss this option with you and if you are well enough and agree, it may be arranged that you visit prior to discharge from hospital. Bennett Centre staff may also call you after discharge to discuss attendance.



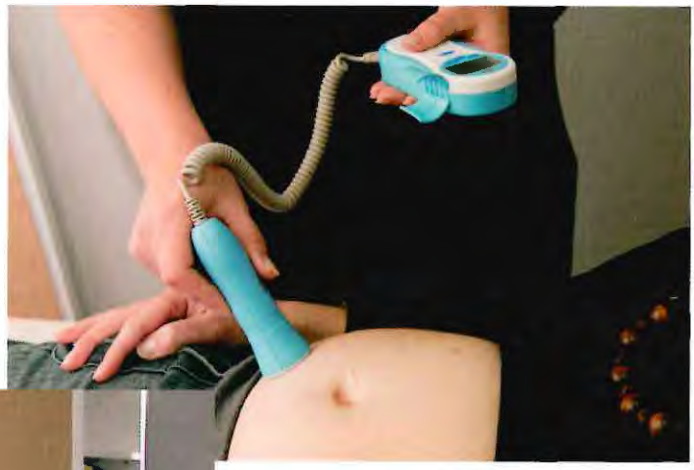
Continuum of Care

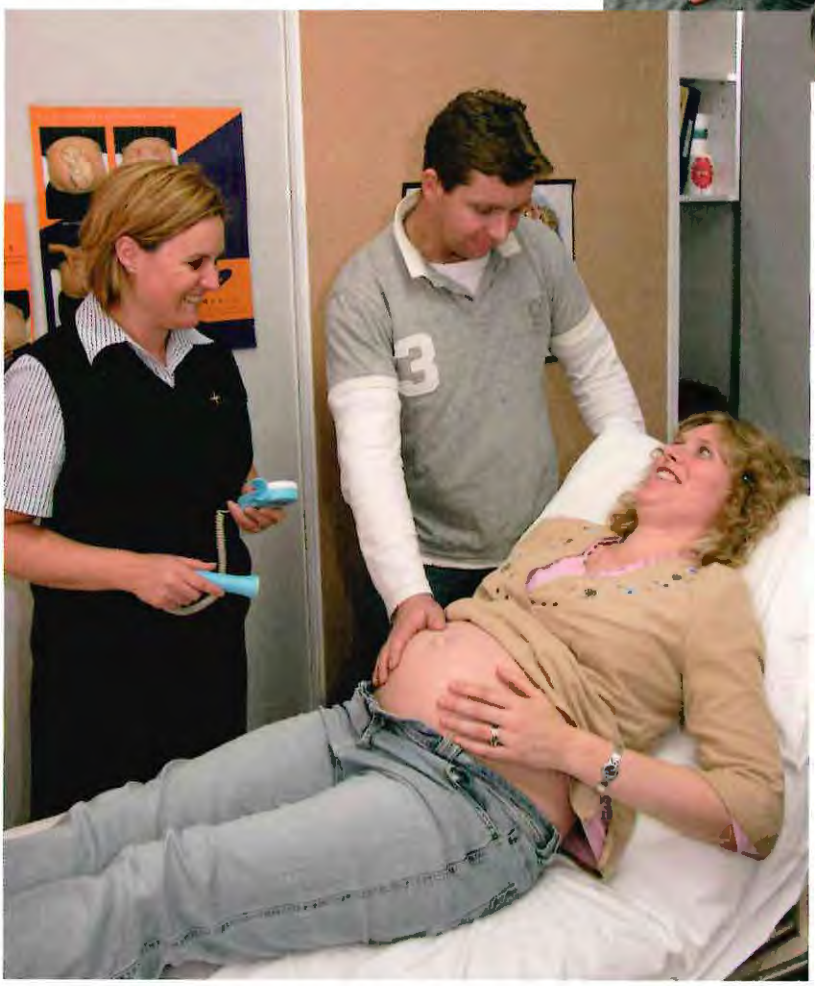
Attendance may be anything from one day to five days per week. Transport to and from the centre can be arranged if needed. The types of activities that are happening on a day by day basis will allow you to decide what days you might like to attend. It is very beneficial for those who are socially isolated, or whose carers may need an occasional break. It is also of benefit for those who would enjoy a gentle supervised exercise program. There are many activities to choose from and a midday meal is provided. You do not have to have had a hospital admission to attend the centre, but this is often when such a need is identified.

We strive to ensure your discharge from the hospital is streamlined and supported. We meet regularly with other regional hospitals to ensure the same high standard of care for discharge is achieved across the region. This also includes standardising and streamlining documentation for inter-hospital transfers. This ensures we all receive the same type of information. This process is currently a regional project with the prospect of it being computer based in the near future to further streamline the transfer process between hospitals when needed.

Birthing Services

The birthing service has undergone some changes this year to meet the changing demands of maternity care at Stawell Regional Health. Maternity care is provided to women and their family during their pregnancy and birth by a highly skilled team of midwives, in close collaboration with local GP obstetricians. This care provides women with the opportunity to have increased access to the midwives in the antenatal period. The care is extended beyond their hospital stay to provide support and education within the home environment.

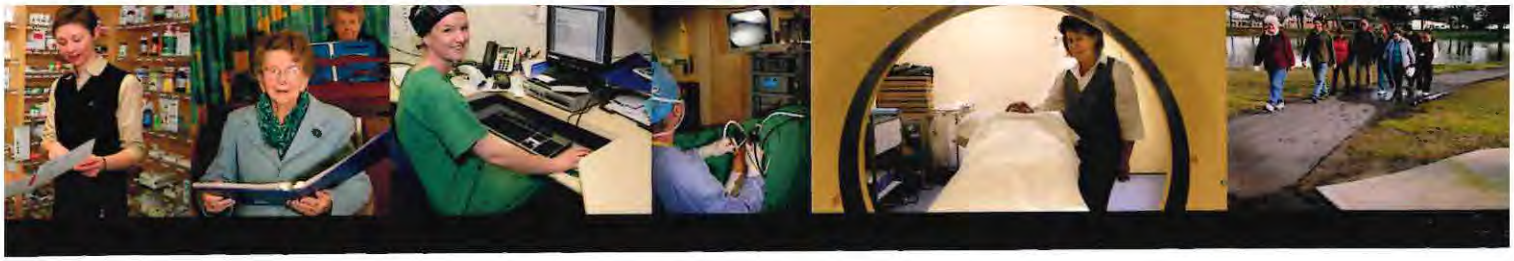




In January 2007 our Shared Care Program was implemented and has given women a choice of care options during their pregnancy. Joint pregnancy care is now available with midwives working in conjunction with the womens' choice of GP. As community awareness of this service has increased many women have made this their preferred choice of care. This program has been initially funded by the Department of Health Services Rural Maternity Initiative and is part of the 'Future directions for Victoria's maternity services'.

The midwives working as a team provide the full continuum of care- antenatal, birthing, postnatal and visit at home after discharge. This enables women to develop a trusting relationship with the midwives throughout their pregnancy and beyond. The midwives are able to practice in all areas of maternity care.

This year at discharge 87% of our mothers were exclusively breast feeding compared to 82.5% last year.



Birthing Services

Guidelines have been developed as a part of the organizations Risk Management Plan to ensure births within this health service are appropriate and without complication. The exciting and sometimes challenging journey through pregnancy and early parenthood is supported through education and a comprehensive domiciliary program (midwifery care within the home).

Our staff attend education sessions to ensure their skills are maintained in all areas, and to reflect best practice:

> Three midwives attended and successfully completed the Advanced Life Support in Obstetrics (ALSO) course. More midwives will be attending this course in the future to ensure they are further prepared to manage emergencies that may arise in maternity care.

Seven midwives participated in a Pregnancy Care workshop. This is the second part of the Pregnancy and Maternity Emergency Education Program which staff attended last year. The knowledge gained from this education session upskilled midwives in many aspects of pregnancy assessment and care. These skills will be enhanced while working more closely with women and their families in the new Shared Care Program.

In addition to education, the funding from the Shared Care Program also contributed to upgrading the facilities and equipment for antenatal services.

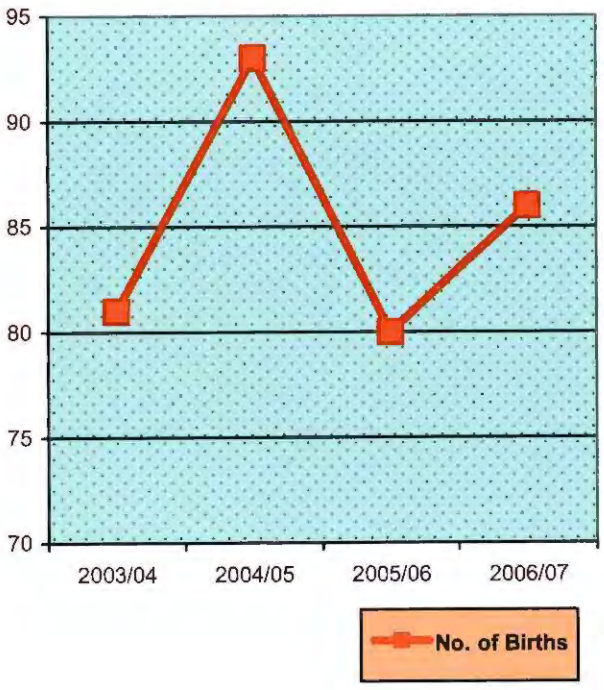
Satisfaction of the midwifery service is continually monitored through internal customer satisfaction surveys. The results of these surveys indicate a continually high level of satisfaction. Results and comments are evaluated so our service can be improved.

The sharing of weekend on-call services with East Grampians Health Service (EGHS) continues. The small amount of women who birth in their "non-booked" hospital have been happy with their experience. When they return to their home town, women continue to receive domicillary care as planned.

Midwives and doctors from both hospitals (SRH and EGHS) have been involved in benchmarking processes to ensure the support and education provided is consistent. Women and their partners are given an opportunity to view birthing suites in both hospitals and meet some midwives to familiarize themselves with both hospital environments.

Figure 16 depicts birthing trends over the last four financial years.

Figure 16 Birthing Trends



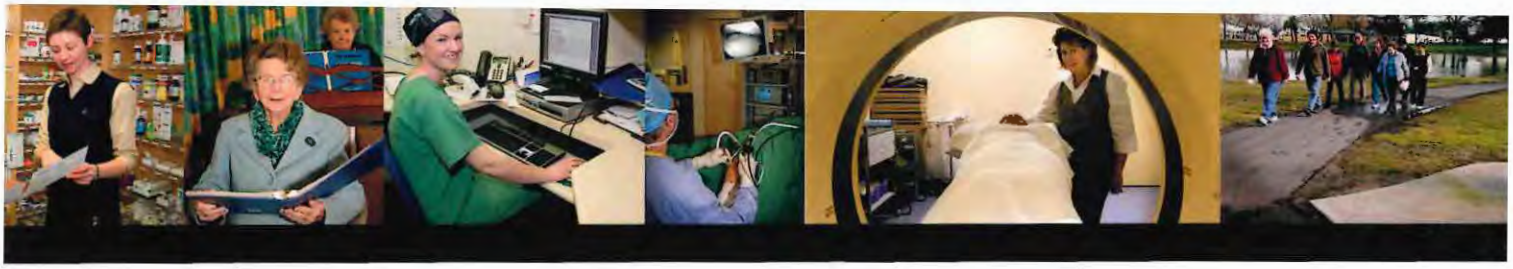
Macpherson Smith Nursing Home

Macpherson Smith Nursing Home is home to 35 residents who require a high level of nursing care around the clock including: frail aged, dementia and those with a psychiatric illness. Accommodation includes 8 shared rooms and 19 single rooms. The nursing home has a 3 year accreditation status which extends to November 2009. Continuous monitoring by the Aged Care Standards Agency ensures the service meets the Commonwealth accreditation standards in line with the Aged Care Act 1997.

Staff at the nursing home includes registered nurses, personal care workers, kitchen and laundry personnel. All staff involve themselves in the accreditation process and contribute to quality improvements.

Macpherson Smith Nursing Home is regularly serviced by allied health staff from the hospital.Resident's needs are assessed by a designated case manager (Registered Nurse Division 1 or 3). Families are invited to attend case conference meetings to discuss and contribute to the care planning and changing needs of their loved one.

Residents and relatives have a dedicated committee which is supported by the Aged Care Manager, Chief Executive Officer and Director of Clinical Services. All quality activities are tabled at this meeting for discussion and action. This committee acts as a focus group, advocates for residents and provides a venue for information sharing between residents, relatives and staff.



Macpherson Smith Nursing Home

Some of the projects that the committee has endorsed are:

- Mural for the resident courtyard that was completed by Stawell Secondary College (SCC) students
- Purchase of indoor plants for the nursing home to enhance its home-like qualities
- Introduction of 'doll therapy' as part of the resident complementary therapy program
- Securing of funding for the introduction of a 'multi sensory' room
- Commencement of a volunteer program at the nursing home, including student volunteers from the local secondary school.

In addition to this, specialized equipment including 'invisibeam' (falls prevention devices) have been purchased and are in use.

The future is full of promise with a strong focus on resident lifestyle. Our Leisure and Lifestyle Coordinator is included in care planning of the resident and is pivotal to the ongoing success of the volunteer program. The Leisure and Lifestyle Program is tailored to the needs of the individual with the emphasis on community access. An extensive range of regular and special activities are offered.

Some of the regular activities are bingo, football tipping, billiards, hookey, golf, quoits, draughts, cards, singing, quizzes, trivia, BBQ's, happy hour, cooking, reading the newspaper and low impact exercises.

Special activities have included : Mothers Day afternoon tea, football, fishing, dancing, morning tea and coffee parties, ladies pamper days, SCC students project, primary school choir and dancers.

In addition to offering care to residents we recognize that accessing high level respite care is an issue for the Stawell community. To ease the burden SRH have submitted an application for a respite bed licence with DHS. If successful, this should allow one bed to become available for short term respite to someone in the community needing high level care.

How long will I have to wait.....

Elective Surgery
Stawell Regional Health offers services provided by a number of visiting specialists and General Practitioners.

These providers come from the Stawell area and from other areas in the Grampians Region. The following table illustrates the speciality and waiting times for elective surgery

Table 1 Elective Surgery Waiting Time

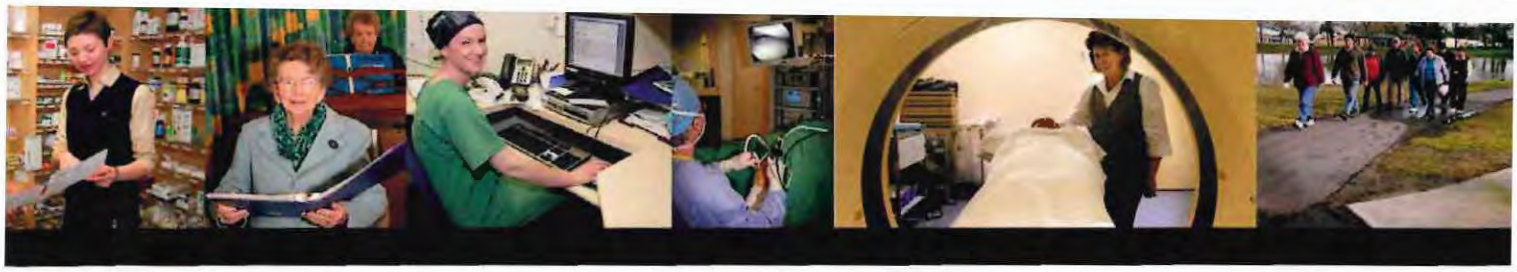
Surgeon	Type of Surgery	Waiting Times (WT)
Local Surgeon	General Surgery	1-6 months
Local Surgeon	Gastroscopy} Colonoscopy}	Urgent less than 28 days Otherwise within 3 months
2 Local Surgeons	General Surgery	Minimal Waiting Time
2 Visiting Specialists	Opthalmology	Both have waiting times of 6 months
1 Visiting Specialist	Gynaecology	1 month
1 Visiting Specialist	Urology	1 month
2 Visiting Specialists	Orthopaedics	1 has a WT for joint replacements of 18 months; the other 4 months. For both; WT's for minor procedures is 3-4 weeks.
1 Visiting Specialist	Ear, Nose and Throat	3 months

Who manages the Waiting times/Lists?

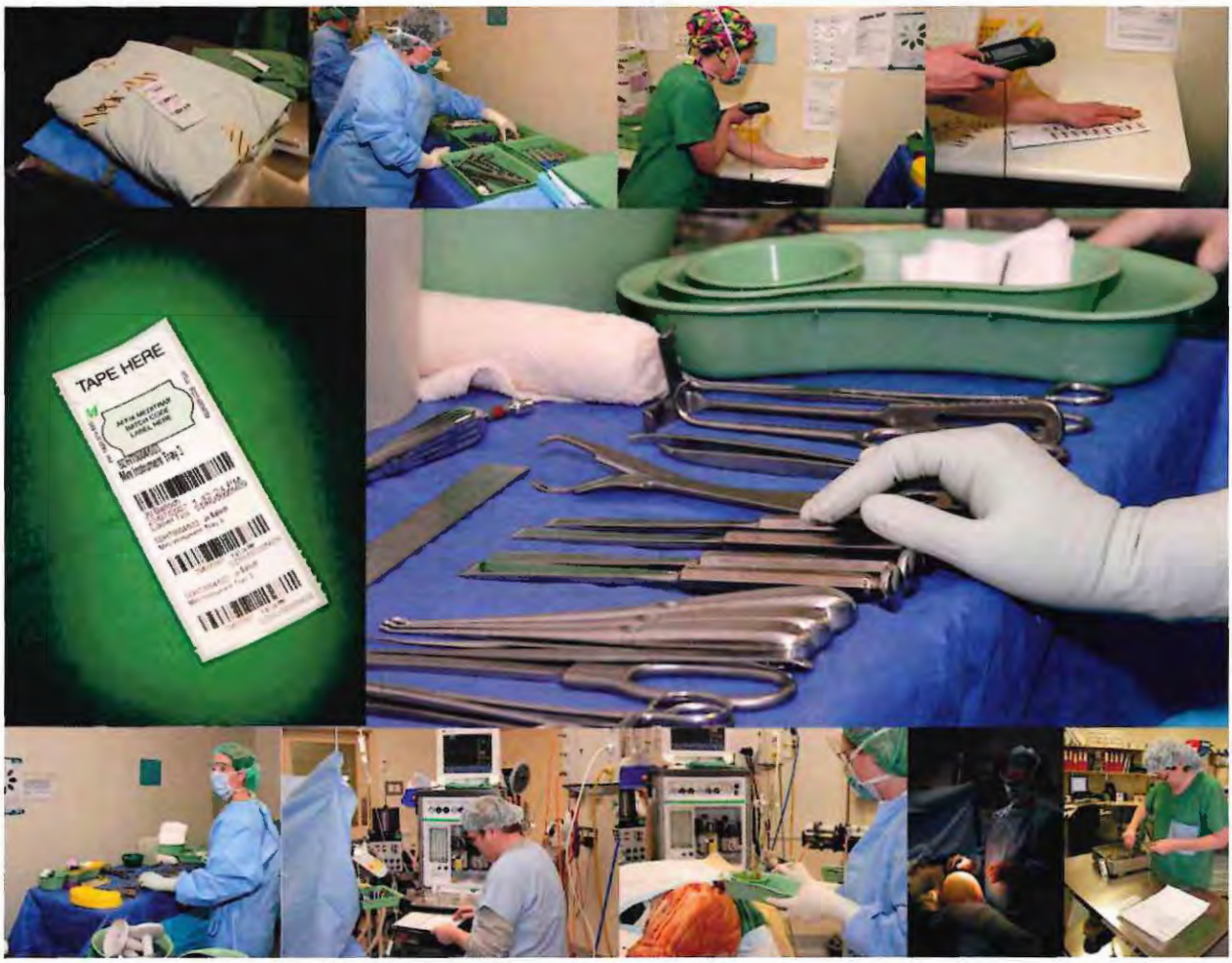
Your

- allocation to an operating list
- the scheduling of lists and
- the management of patients on waiting lists is managed by the hospital, and

is the responsibility of the Peri-operative Nurse Manager in consultation with the Pre-Admission Clinic Co-ordinator based on the information on your consent provided by the surgeon. Should your surgeon or General Practitioner feel your surgery needs to be done sooner, then it is acted upon as soon as possible.



Stawell Theatre goes Hi Tech.....



During the year funds were allocated form the Department of Human Services Targeted Equipment Program which enabled Stawell Regional Health to introduce a bar coding system within its theatres to track instruments. The grant was for a sum of $72,000 however SRH has used some of its own funds to provide supplementary scanners.

The tracking of theatre instruments has always been a labour intensive task relying on manual systems. This is an exciting and innovative project demonstrating the commitment of SRH to best practice.

The Electronic Instrument Tracking System
The move from a manual to an electronic instrument tracking system commenced in February 2007 and concluded in April 2007. A week long comprehensive training schedule was implemented and yes we do all have our own unique bar code! The system purchased is the **TRAYBAX** Sterility Management System, supplied by Austmel, a 100% Australian owned company.

TRAYBAX has been designed to provide a comprehensive materials management system as mandated by Australian Standard AS/NZ 4187:2003 section 8.5 through the use of bar coding, integration with Washer and Sterilizers, identification of staff conducting the process, staff productivity and tracking of items used to the individual patient.

Sterilization is a specialised process under this standard and as it cannot be verified by visual inspection the entire process must be Validated, Monitored and Controlled, requiring that instrument/tray tracking records be kept. The system has a comprehensive reporting module and all aspects of the complex requirements are clearly and easily followed using the system centered around the **TRAYBAX** database.

A Patient's Journey .....

Follow the journey of a local patient who is to undergo a Colonoscopy (a visual examination of the large bowel with an endoscope to identify sites of bleeding, inflammation, irregular or abnormal tissue) performed by a local surgeon.

Symptoms develop
- Change in bowel habits
- Pain

Family history of bowel disease
Recall
Procedure

See local GP for assessment and referral

Referral to local surgeon (if urgent will be seen within 1 month, if non urgent will be seen within 2 months).

Visit surgeon for explanation :
- Alternative treatment
- Complications and
- Signing of consent.

- Completes Admission/Booking In details
- Understands: procedure/consent/complications
- Medical/surgical/anaesthetic/allergy/ medical history taken.
- Vital signs/ECG/height/weight/Body Mass Index taken.
- Risk explained, assessment attended.
- BT's (if taken) reviewed.
- If using Community Services continue, not cancelled.
- Education – (written/verbal) – given on surgery/pain/fasting/medication/ clothing/bowel preparation/what to bring and access to DPU.
- Confirm date of procedure.

Patient attends appointment (usually sees nurse only). If other medical conditions (such as – heart disease, diabetes, lung/chest problems) present; patient will see anaesthetist as well.

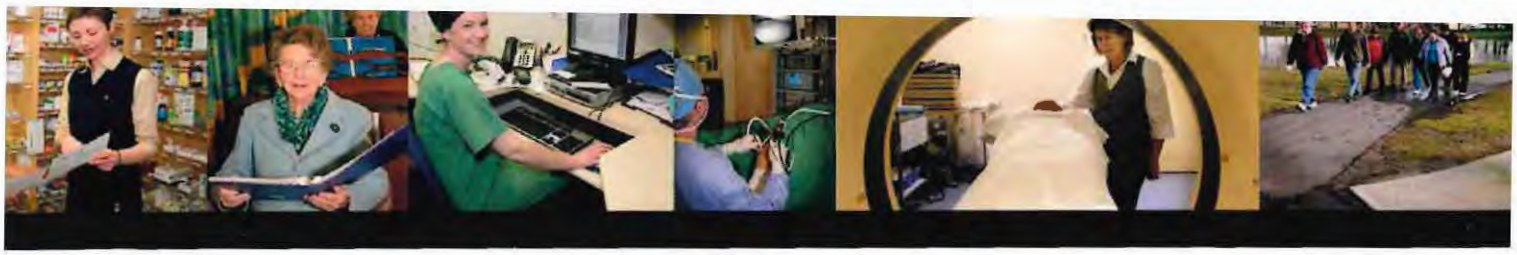
If well, pronounced 'fit' for procedure, if 'unfit' referred back and managed by own GP until 'well'.

Phone SRH the afternoon the day before the day of procedure to confirm the time of arrival.

Once you are on the database the process recommences with a call from SMC staff to come for an appointment.

Patient information retained on 'Patient Endoscopy Data Base' for a recall procedure. Date identified by surgeon.

Review appointment with surgeon 2 weeks after the procedure for 'results'.



Consent forwarded next working day to the Theatre Manager.

Patient information entered onto 'Patient Endoscopy Data Base' developed 1/07 as a result of consultation between the surgeon, Pre AC Staff, Theatre Manager, HIM and Practice Manager of SMC to reduce duplication of information. Resulted in an organised patient recall process for this procedure.

Theatre Manager and Pre ACC check availability of time for the colonoscopy.

Date of procedure is allocated depending on urgency. (Within 2-28 days if urgent) (Procedure may be earlier if cancellations occur).

Patient contacted by phone or letter by Pre ACC to attend Pre AC appointment (appointment at hospital or clinic).

To Recovery Room until fully awake

To theatre all details confirmed. Procedure attended. Photos of your bowel may be taken by using the 'Stryber Image Capture System' camera.

Since 5/07 all instruments used for surgical procedures are tracked through the 'Electronic Instrument Tracking System'.

Day of procedure admitted to DPU at scheduled time. All details confirmed.

- To DPU
- Recover from anaesthesia
- Monitored and observed
- Verbal/written information re managing your condition discussed when you are fully awake.

HOME

'24 hour phone call follow up' by DPU nurse to see how you are recovering and progressing. Any concerns, questions or problems are answered .

LEGEND: DPU=Day Procedure Unit; ECG=Electrocardiograph; GP = General Practitioner; HIM = Health Information Manager; PreAC = Pre Admission Clinic; PreACC = Pre Admission Clinic Coordinator; SMC = Stawell Medical Centre; SRH = Stawell Regional Health ; BT= Blood Tests; PAC=Post Acute Care.

Strengthening Rural Communities

Commonwealth Regional Health Services Program

The "Strengthening Rural Communities" Program seeks to reduce the social inequalities in the health of people living in rural areas and to reduce the need for secondary and tertiary medical interventions.

During the past five years, the programme has progressively developed and provides a broad range of services to the outlying communities. The services include:

- Family & Relationship Counselling
- Community Health Nursing
- Podiatry
- Speech Pathology
- Diabetes Education
- Nutrition and Dietetics
- Occupational Therapy
- Physiotherapy.

These services are delivered out of Budja Budja Aboriginal Co-Operative in Halls Gap, the Marnoo Hall, the Landsborough and District Community Recreation Centre and the Navarre Football/Netball Clubrooms.

Customer Service:

The staff members of the outreach team have sought to provide greater customer service this year by travelling out in multi-disciplinary teams of 3 or 4 clinicians.

This has resulted in more efficient service delivery and greater cross-disciplinary collaboration. Clients with diabetes are benefiting from access to the team of the diabetes educator, dietitian, podiatrist and community health nurse; whilst clients with gait issues can benefit from joint consultations with both the physiotherapist and the podiatrist.

Indigenous Health

A major achievement for the program has been the appointment of an Indigenous Health and Community Development Worker in August 2006. The three days per week position is jointly funded through the Commonwealth Regional Health Services Program and the Office of Aboriginal and Torres Strait Islander Health.

A key objective of the Worker is to improve access to mainstream health services such as dental services, general practitioners, and primary care services such as dietetics, physiotherapy, podiatry, diabetes education and counselling for local indigenous people.

The Commonwealth Regional Health Services Program is auspiced by Stawell Regional Health, Grampians Community Health Centre, Budja Budja Aboriginal Co-Operative and Northern Grampians Shire Council.

Occupational Health, Safety and Environmental Surveys have been conducted at each of the program locations of Landsborough, Navarre and Marnoo.

The Budja Budja Aboriginal Co-Operative was not surveyed, as the health services are delivered in a purpose-built clinical room at the Co-Operative.

Strengthening Rural Communities

The surveys were conducted by the Stawell Regional Health Safety Officer in conjunction with the outreach staff present at each location.

Minimal harm was identified for the public and / or clients, with slips, trips or falls being the most likely source of injury.

Privacy was identified as an issue for staff and clients alike as conversations could be heard from adjoining rooms in some locations. This has been addressed by ensuring a radio is playing to mute conversations.

Hazards were identified for staff traveling to and from the service's locations, in setting up and packing away equipment, and there were certain demographic exposures.

Table 2 **Staff Hazard Exposures**

Identified Hazard	Action
Lack of comprehensive telecommunications across the area.	Procedures in place for notifying SRH Reception of movements and travel plans. Communications equipment is updated as technology advances become available.
Vehicular Breakdown, adverse occurrence (collision / rollover).	Advanced driver training skills (Safe driving techniques).
Potential threats from disturbed or drug / intoxicated persons.	Procedures in place for dealing with personal threat.
Emergency Occurrences - fire, personal threat.	Procedures in place for dealing with emergency occurrences.
Use of facilities' electrical supply without proper safety switches (RCDs) or boards being connected to the power circuits.	RCD boards supplied for all outreach electrical equipment.
Storage and transfer (carrying) of treatment bench.	Provision of trolley to transfer treatment table from storage to treatment area.
Use of alternative equipment leading to ergonomic hazards (i.e. use of chair instead of treatment table).	Purchase of two additional treatment tables with a grant.

In summary the report advised "Overall, properly managed, the services create a minimal hazard exposure to all those who provide or attend."

Allied Health Waiting Times

Diabetes Educator

Generally the waiting period for an outpatient appointment is one week.

The Diabetes Education Department is currently operational six (6) days per fortnight.

The Dietitian

Currently the dietitian has 4 hours per day allocated for outpatients.

Numbers attending the outpatient service have been similar to the past financial year with a total of 1,185 contacts, which is 55 contacts more than the previous financial year. The current average waiting time for a new appointment has remained at 11.1 days, however urgent referrals are treated as a priority, usually within 3-5 days. The receptionist will communicate with the dietitian if an urgent referral is received and the dietitian will make an appointment for these outpatients at the earliest possible convenience. The receptionist keeps a log to record the initial day of contact with the client and the first available time slot that is appropriate for that client, to determine the waiting period. The dietitian is currently considering ways to decrease the waiting times for outpatients.

Possible future directions include a weight loss group or a multi-disciplinary diabetes education group to reduce the number of single appointments for weight loss and diabetes outpatients, as these appointments currently occupy a large proportion of dedicated outpatient time.

The Occupational Therapist

The effective management of the Occupational Therapists outpatient waitlist requires clients to be prioritized according to need.
This ensures people who have:

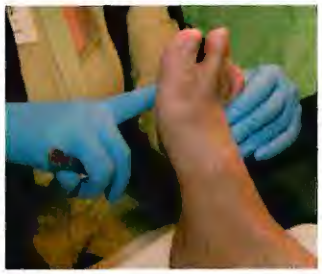
- experienced a sudden and unexpected decrease in their ability to cope at home
- people whose carer is unable to care for them
- people at high falls risk and people with acute and severe hand conditions.

- are seen urgently.

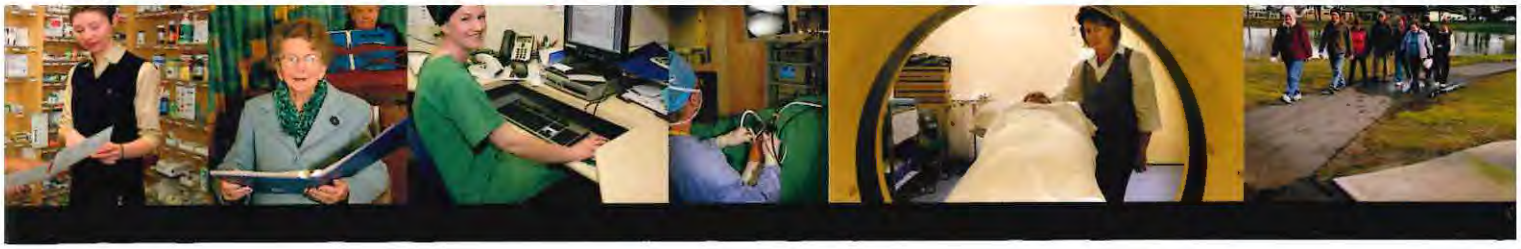
A snap shot of the quarter Feb –May 2007 was taken with the following average waiting times.

- Priority 1: (High Priority – Initial assessment within 2 working days of referral) : Average waiting time = 1.75 days
- Priority 2: (Medium Priority – Initial assessment within 2 weeks of referral) : Average waiting time = 7.5 days
- Priority 3: (Low Priority – Initial assessment within 6 weeks of referral) : Average waiting time = 14.6 days. (2 weeks).

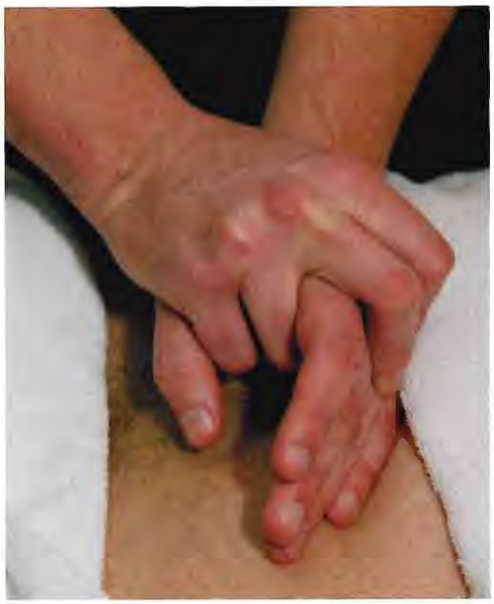
The Podiatrist



The Podiatry Service is available to all members of the community.
However priority is given to those members of the community who are considered to have "at risk" feet, eg, Diabetics. The average waiting time for an outpatient appointment is seven weeks, but can be as early as three weeks. This is a significant improvement from a minimum waiting time of 10 weeks in September 2006.
An Allied Health Assistant (Podiatry specific) has been employed and is now fully trained. The aim of this appointment is to reduce waiting times in the near future to approximately 4 weeks.



Allied Health Waiting Times



The Physiotherapist

The Physiotherapy Department works across a wide spectrum of health areas. To ensure appropriate and reasonable access to physiotherapy services staff need to prioritise which areas of care they attend to. Outpatient physiotherapy services are always in high demand by the community and the department regularly monitors the waiting times for outpatient appointments. After reviewing the data from these evaluations the department looks at its operations to see where if possible procedures can be modified to reduce waiting times for those with an urgent need for outpatient physiotherapy services.

Waiting times for outpatient physiotherapy services were measured between February and April 2007.

The average waiting time for an outpatient appointment was 4.73 days in 2006 and 4.84 days in 2007. These figures represent the average wait for appointments and in some cases patients are seen much earlier than these figures indicate. Appointments late in the day are very popular so some patients will elect to wait longer for their appointment to have a chosen time, which does alter the waiting time data.

A strategy that the Physiotherapy Department has in place to minimise wait times is the operation of a cancellation waiting list where we attempt to fill any cancellations with patients requiring urgent appointments. To facilitate this we ask that patients unable to attend an appointment give us 24 hours notice so that we can rebook their appointment. Late notice of cancellation of an appointment, or just not attending, means other patients miss out on the opportunity of an earlier appointment. The department also attempts to prioritise if an appointment is urgent because of the nature of the condition or whether it is reasonable that a patient with a more long standing condition waits a few days longer to ensure urgent cases can be seen promptly. Such an approach helps those patients who may have acute pain that otherwise may be forced to wait longer for treatment.

The Physiotherapy Department also has a range of classes that patients may be encouraged to attend as an alternative to, or as an adjunct to one on one treatment with the physiotherapist. There is much evidence to suggest that people that remain active and maintain or improve body strength require less physiotherapy, have less pain and have a better quality of life. The use of class based care also assists in reduction of people seeking one on one physiotherapy care.

Speech Pathology

Current waiting times for an outpatient appointment are minimal.

There was a cessation to services for a three month period mid 2007, but a new service commenced in August 2007, with the successful appointment of a Speech Pathologist.

Allied Health Waiting Times

Social Work Department

At last survey 40% of outpatients were seen within one week of contacting the department. All were seen within three weeks of contacting the department.

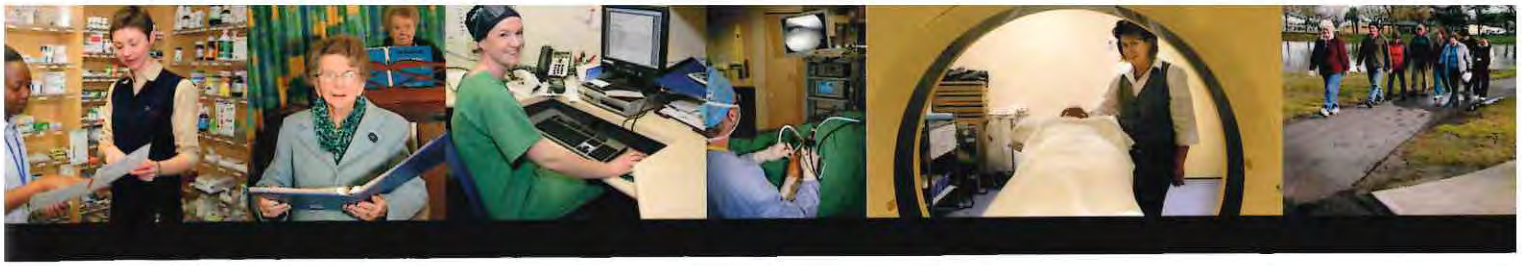
Outpatients can contact the Social Worker for an appointment by phone. A waiting list is kept for outpatient appointments.

Aged Care Assessment Service (ACAS) referral is prioritized in categories of:
(1) most urgent (seen in 3 days)
(2) 3-14 days and
(3) more than 14 days.

Sometimes these referrals can be delayed due to the patient/client being away or still under treatment in hospital or the patient/client is not ready or appropriate to be assessed for ACAS.

How do I contact Allied Health Services....

Service	Contact Details
Diabetes Educator Dietitian Speech Pathologist	Ring the Visiting Specialist Reception on 5358 8507, Monday to Friday (except public holidays), or visit Building C reception area in person.
Physiotherapist Podiatrist	Ring Allied Health Reception on 5358 8531, Monday to Friday (except public holidays), or visit Building B reception area in person.
Occupational Therapist	Ring directly on 5358 8564, Monday to Friday (except public holidays).
Social Worker/ Counsellor and Family Therapist	Ring directly on 5358 8518, Monday to Friday (except public holidays)



Health Promotion

Physical Activity Challenges

Each year, SRH runs a 6-week challenge to motivate and support Stawell and district residents to increase their physical activity levels.

The **'Walking Challenge'** is a community-wide program that involves teams of six competing for the most time spent walking and greatest improvement in health. A similar 'Team Challenge' is run with SRH employees. In this challenge, a variety of physical activities are included in addition to walking. As shown in Figure 17, participation in both these challenges increased markedly in 2006 compared with previous years, which demonstrates that the program is becoming more established within the community.

Figure 17 Participation in the Walking Challenge and Team Challenge

Health Promotion

In 2006, a third Challenge was added in response to the declining levels of physical activity in children. The 'Kids Challenge' involved primary schools competing against each other for the most time spent walking or running during school hours. Ten out of 12 local schools (or 708 students) participated.

Outcomes
To evaluate the success of the Team and Walking Challenges, the physical activity levels of participants were measured through a questionnaire before and after the programs.

The following positive outcomes were found:

- Walking Challenge participants, on average, increased the number of days they walked by 1.8 days per week and walked 32 more minutes per day
- Team Challenge participants increased their level of vigorous activity by 21 minutes per day and moderate activity by 27 minutes per day. A small increase in walking was also shown.

A survey conducted three months after the Challenges revealed that this level of physical activity was maintained or increased in 44.7% of participants (Walking Challenge) and 57% of participants (Team Challenge). In 2007, the health service will aim to increase these figures to over 60%.

Health benefits were also demonstrated through participation in the Team Challenge and Walking Challenge, with participants collectively losing 11.78 metres from their waist and hips and 208kgs in weight.

By surveying staff of the participating schools, a number of positive outcomes of the Kids Challenge were revealed:

- The majority of schools felt that students' physical activity levels at school increased
- Other benefits included parent participation in the walking, increased concentration and increased social interaction
- All schools reported they would continue to keep walking regularly after the Challenge ended and also participate again in 2007.

Areas for improvement
The evaluation of the Team and Walking Challenge revealed that most people were already exercising enough to achieve health benefits prior to competing in the Challenges. This means that people who are most in need of motivation and support to become physically active are not, in general, getting involved in the program. Encouraging greater participation of those who are inactive will be a specific focus for the 2007 Challenges.

Suggestions for improvement from Walking and Team Challenge participants that will be implemented in 2007 include:

- extending the challenges to 8 weeks
- having an earlier launch event and
- providing information about how the data collected will be used.

With these improvements, the health service looks forward to further increasing participation in physical activity across all members of the community.

Walking Group

The Stawell Regional Health **Community Walking Group** continues to provide a fun and supportive exercise option for people who are just starting a walking program or who wish to walk with others.

This year has seen a number of new faces joining in the walks around Cato Lake, some of whom also attend the hospital Gait and Balance Program. There are currently 15 people who regularly attend the group, with an average of 7 or 8 participating per week. Staff have observed that all members have either increased the number of laps they can complete or have increased the amount of time they spend walking. A number of members now walk for the full 60 minutes that the group meets.

The group has enabled some strong friendships to form and the walkers often comment that they lose track of how many laps they've done because they're too busy chatting! A particular strength of the group is that newcomers are always made to feel

Health Promotion

Walking Group

welcome and included. An allied health staff member is present each week to provide additional assistance, especially to those who have limited mobility or other medical conditions.

In October last year, SRH worked with the local Primary Care Partnership to run an event celebrating the benefits of walking. Ninety community members joined the Walking Group on its walk around Cato Lake. Polewalking lessons were offered to anyone who wanted to give it a try, and a healthy morning tea followed. The event was successful in raising awareness of the Walking Group to the wider community.

Earlier this year, members of the Walking Group were asked if there was any way that the Walking Group could be improved. One of the suggestions was to try and re-engage with people who have previously attended the group by inviting them to a "welcome back" morning tea with current members. It is hoped that this will provide an opportunity for previous members to get to know newer members and feel welcome to return to the group, should they wish to.

'Well for Life' Project

In 2006, Stawell Regional Health (SRH) received a Government grant under the **'Go For Your Life'** initiative to increase nutrition, physical activity and overall quality of life in older adults.

The **'Well for Life'** Project is a collaboration between the Hospital, Macpherson Smith Nursing Home and Bennett Centre for Community Activities, and is designed to impact the health and wellbeing of aged care residents, Bennett Centre clients and older community members who live alone or are reliant on Meals on Wheels.

As part of this project, SRH ran an intergenerational picnic during Seniors Week, 2006. The purpose of this picnic was to facilitate communication and interaction between older adults and local primary school children and to re-create childhood memories through 'old-fashioned' games and food.

At the end of the day, participants were asked what they thought of the picnic. The responses indicated that there was a high level of enjoyment among the older adults, particularly in meeting and mixing with the school children.

The children similarly enjoyed the day, with all stating they would like to do something like it again in the future. As one child summed up *"We talked to the older people. We played egg and spoon race, tag, quoits 'pin the tail on the donkey' and line dancing. I had a great time at the picnic."*

Given the success of the picnic, Stawell Regional Health will look at running future intergenerational events as a way to foster positive social outcomes in both older adults and children.

A primary focus of the **'Well for Life'** Project is to develop skills and knowledge in staff members so that they can provide opportunities for improved nutrition and increased physical activity in aged care residents and clients of the Bennett Centre.

Health Promotion

'Well For Life' Project

Through this approach, a Division 2 Nurse has been trained as the Aged Care Nutrition and Hydration Ambassador. This role will support the Dietitian in monitoring nutrition and hydration practices as well as increasing opportunities for healthy eating in residents. As a result of the training, the ambassador has reported increased knowledge, skills, confidence and job satisfaction. To facilitate long-term changes in physical activity, four staff members are currently being trained in Certificate III in Fitness, with a focus on older adults. An Oral Health Ambassador will also be implemented in the Nursing Home.

Another initiative currently underway to encourage healthy eating is the provision of dietitian-led 'Cooking for One' classes. These 'hands-on' classes are designed for people living on their own who may lack the skills or knowledge to cook well-balanced meals for themselves.

The **'Well for Life Project'** has already made some important gains in promoting the health of older adults. It is anticipated that the infrastructure and organisational culture developed by the end of the project will ensure that activities to increase physical activity and nutrition in older adults continue beyond the funded period.

Strength Training Group

The **Strength Training Group** began in August 2006 as a way of introducing the physical and social aspects of resistance work to individuals who may not normally participate in this sort of exercise, for example, by attending a gym. The initial group consisted of 13 people, all of whom were older adults or had chronic conditions which required ongoing physiotherapy. The strength training sessions were held once a week at the Bennett Centre for Community Activities.

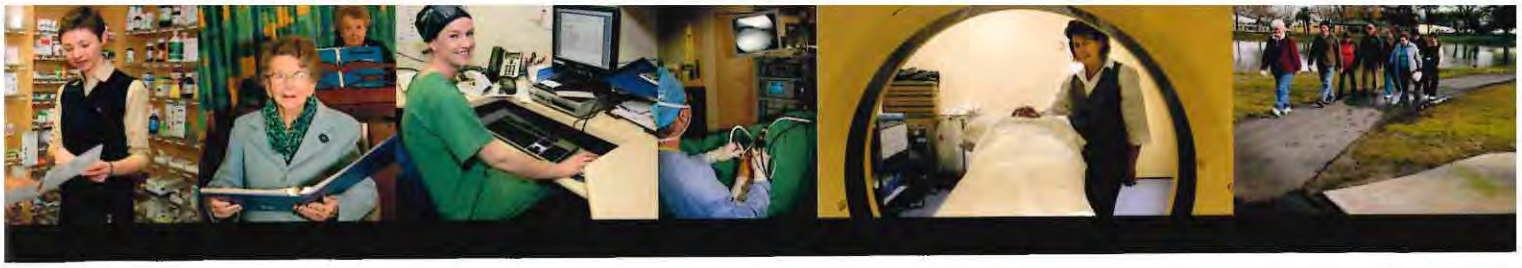
The group was evaluated over a 6 month period to determine how effective it was in increasing the strength of participants, as well as their overall physical activity levels and social wellbeing.

The following outcomes were found:

- Grip strength increased by 18.5% for left and right hands combined
- There was a reduction of 30% in the time taken to sit and stand 10 times
- Three participants stated that they were more active since participating in the group and two stated that their physical activity level was the same.

In addition, most participants stated that they wanted to continue training and all enjoyed the social aspects of the program.

The program has continued in 2007, with 3 – 6 people attending each week. The aim for this year will be to increase attendance through greater promotion of the program. Another area for improvement of the program is to combine the Strength Training Group with the Community Walking Group, as both run on a Thursday morning. This would provide the added benefit of increasing fitness as well as strength.



Cardiac Rehabilitation

A Cardiac Rehabilitation Program (CRP) is conducted on site at the hospital to assist people:

- to recover from heart surgery and heart attacks and
- for people with heart disease.

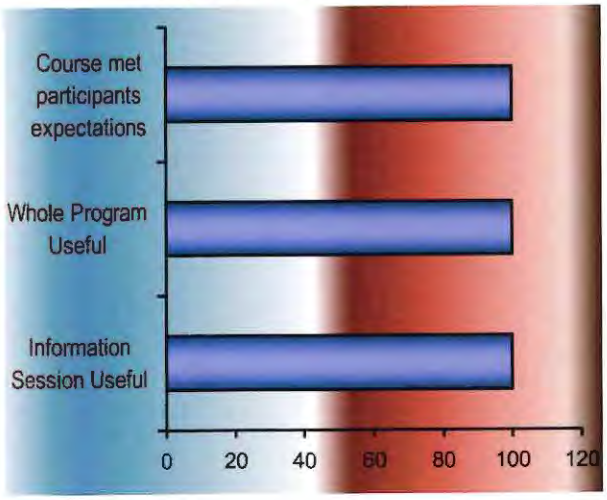
The program consists of eight two hour sessions conducted once a week over eight weeks. A Doctor's referral is necessary. People must be:

- well enough to be able to exercise and
- have no unstable medical conditions.

The program is ongoing throughout the year with a break over Christmas.

A team of health professionals including a cardiac nurse, allied health assistant, physiotherapist, dietician, occupational therapist, pharmacist, paramedic and representative from Heartbeat Victoria work together to provide information, advice, guidance and support. Also included is a personal exercise program aimed at making exercise a part of the participant's daily life.

Figure 18 Cardiac Rehabilitation Questionnaire results (n=10) July 2006-June 2007



Over the last year twenty five (25) patient referrals were received from doctors, rural, regional and metropolitan hospitals.
Fifteen (15) people attended the program with eleven (11) completing it. A number of people still plan to complete the program whilst a few are waiting to start.

The reasons for people not attending the program were because they were:-
medically unwell

- not interested or
- were unable to attend due to work commitments.

Feedback through a questionnaire, from those that completed the program (10) was positive.

- 100% felt all the information sessions were useful
- 100% felt the whole program was useful and would recommend it to other people
- 100% of participants felt the course met their expectations
- 90% of participants had changed either the amount/type of exercise and/or their diet since commencing the program.

Some of these results are shown in Figure 18
Participants were asked to rate on a scale of 0 (no change) to 6 (distinct change) how much their health had improved after the program compared to before they participated in the program.
The average health improvement was rated at 4.25.

In the past, difficulties were encountered with receiving patient referrals in a timely way from regional and metropolitan health services. This problem was addressed by networking with coordinators at referring health services to increase their knowledge of our local CRP. Now referrals come through without difficulty.

Gait and Balance Programme

Stawell Regional Health conducts a monthly Gait & Balance Programme. This programme is an assessment session which helps to address the risk factors associated with falling and the aging population. The Gait and Balance programme is open to all people in the community who have experienced recent falls or are at high risk of falling.

Referrals for this programme are received largely from doctors and from other health professionals within the hospital. Referrals can also be made by family, community services or by directly contacting the Allied Health Department.

During the last year 48 people were referred to the Gait and Balance Programme.

Of these, 26 attended and were assessed by the multidisciplinary team.

This team includes the dietitian, occupational therapist, pharmacist, physiotherapist and podiatrist.

The most common falls risk factors identified in this group were:

- Unsteady balance
- Poor muscle strength
- Loss of confidence/fear of falling
- Poor dietary intake
- Lack of hand rails in the shower and toilet and by steps at home
- Medication interactions, dosages and related issues including blood pressure changes.

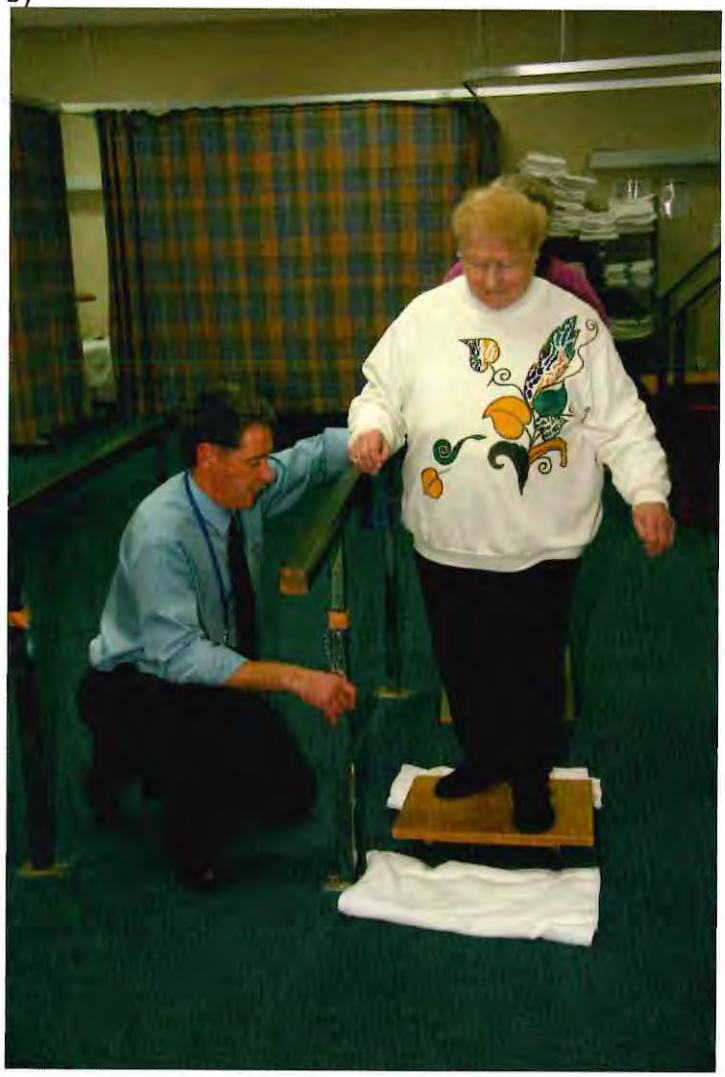
The major outcomes as a result of the programme include:

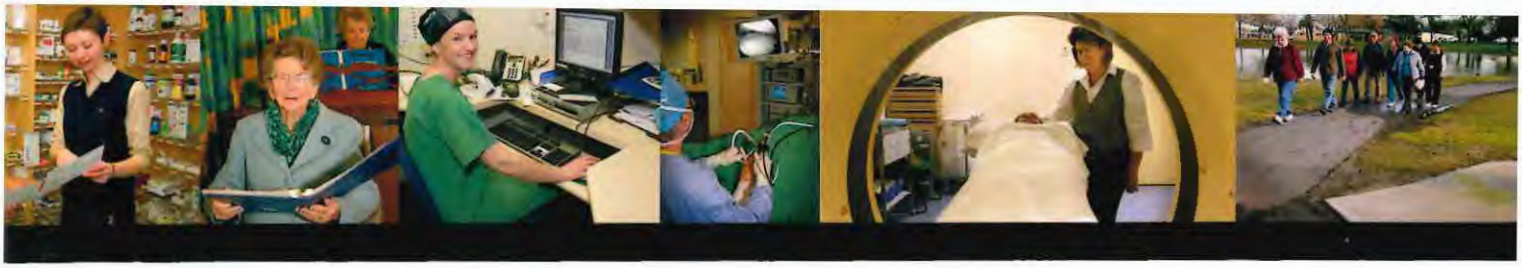
- Gait and Balance Exercise Class (over 15 weeks) – 69% of patients attended
- Medication changes/advise to GP – 57% of patients
- Professional foot care - 30% of patients
- Home modifications – 26% of patients
- Dietary changes – 26% of patients.

Follow-up telephone interviews are conducted approximately one month after attending the programme. Information from the interviews revealed that:

- 66% of respondents had experienced no further falls compared to 71% last year
- 71% of respondents found the programme worthwhile (some found the programme too difficult whilst others found it did not positively alter anything for them)
- 71% of respondents found the Gait and Balance Programme helped them to identify the risk factors associated with falling (comparable to last years results).

Social interaction, motivation and confidence were identified by respondents as positive benefits of the programme.





Orthopaedic Exercise Class

The physiotherapy department has operated an orthopaedic exercise class over several years to provide rehabilitation care for patients who have undergone orthopaedic surgery at SRH or at another hospital. The service was established initially in 2004 when it was recognised that the department had difficulty providing timely follow up outpatient care for patients due to a very busy outpatient workload.

The provision of the orthopaedic exercise class each week ensures that patients are able to see a physiotherapist within a week of discharge from hospital. Prompt care enables the therapist to have an early check on the progress of the patient following surgery and provide early feedback to the general practitioner or surgeon if necessary. An early appointment also allows the physiotherapist to check that the patient is ambulating safely and carrying out the required exercise program.

At the orthopaedic exercise class each patient is assessed by a physiotherapist and given an appropriate exercise program to perform at home. The Allied Health Assistant also supervises each patients exercise program during the orthopaedic class to ensure exercises are carried out correctly. At the initial appointment patients who have undergone knee or hip replacement procedures are also required to complete a survey about their current degree of recovery after the surgery. Patients also perform a couple of specific activities that are also used as a measure of recovery. On discharge from the orthopaedic class both the survey and the specific activities are reassessed to measure the recovery over the time of attendance at the class. Use of such measures enables the department to review the success of the treatment in the orthopaedic class. The department also monitors the types of surgeries that are seen in the orthopaedic exercise class. Monitoring of the types of surgery coming to the class assists us in being able to provide appropriate staffing according to demand. The types of surgery seen in classes in 2006 and 2007 are shown in figures 19 & 20.

Figure 19 Surgery seen in Orthopaedic Exercise Class 2007

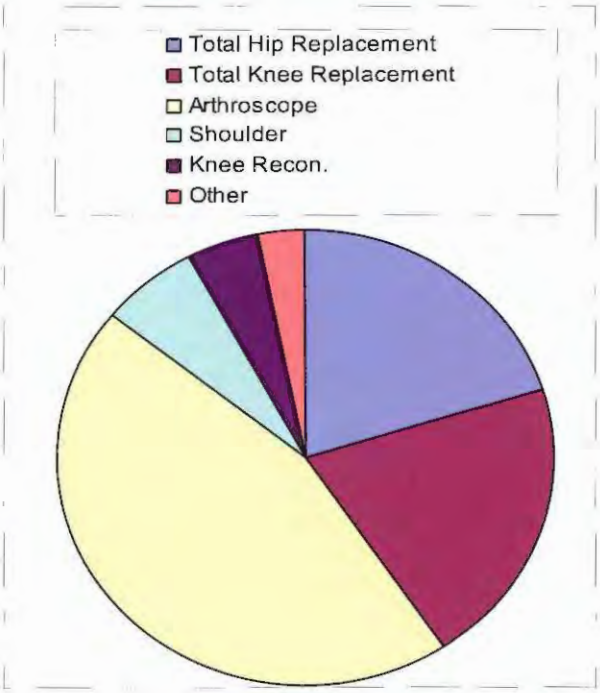
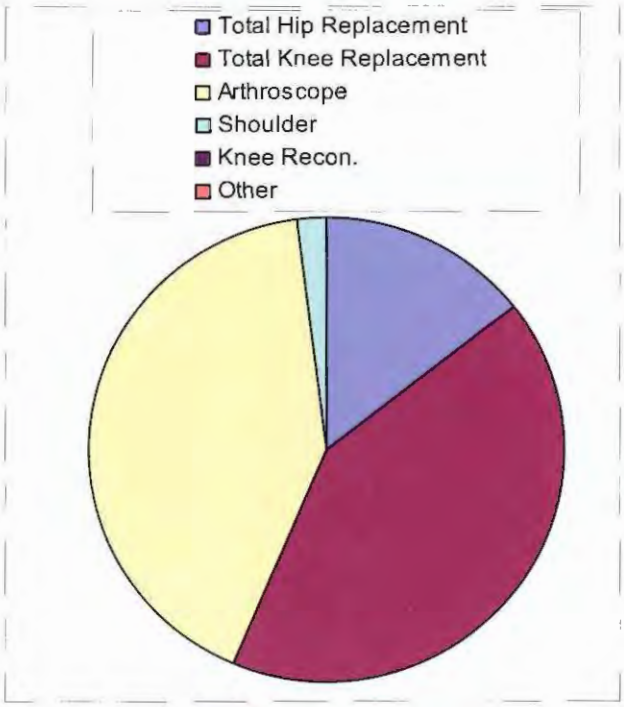


Figure 20 Surgery seen in Orthopaedic Exercise Class 2006



Occupational Health and Safety

The Occupational Health and Safety (OH&S) Program continues to improve the environment for employees, visitors and patients. SRH employs an external consultant to manage the OH&S Program.

SRH conducts all OH&S programs with reference to the relevant Acts, Regulations, Industry Standards and Guidelines.

Programs including 'No lift', Manual Handling, falls prevention, safety inspections, injured/ ill employee rehabilitation, return to work and risk assessments, continue to improve the wellbeing of all who work at and access our facilities.

This year we have auspiced the services of the regional DHS OH&S officer from the Health Services Unit in the Grampians Region. Her expertise has been utilised by educating and training our OH&S representatives in risk assessments and their OH&S responsibilities.

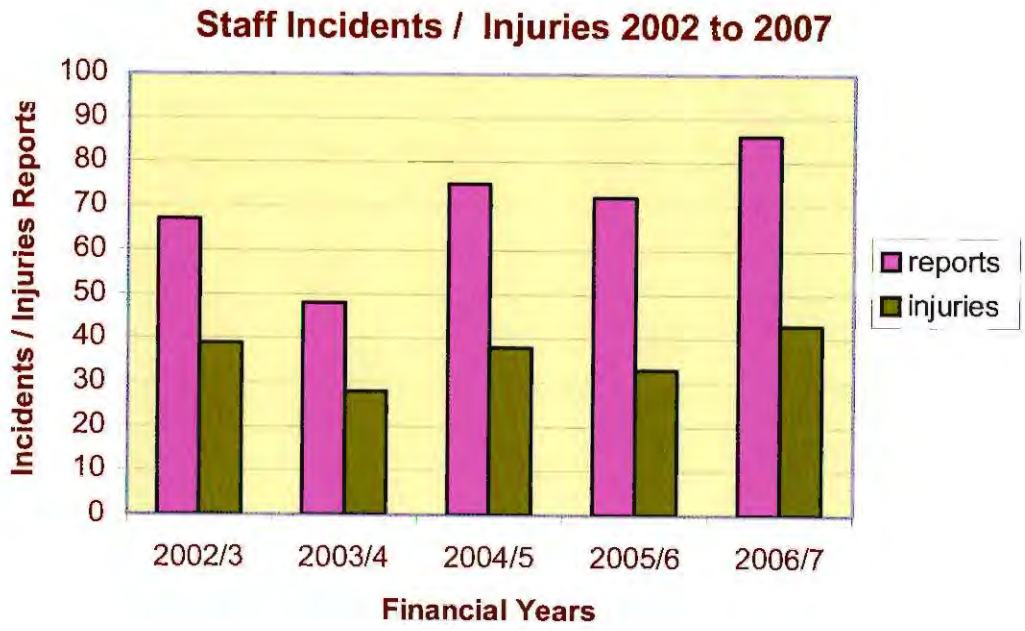
Incident Reporting

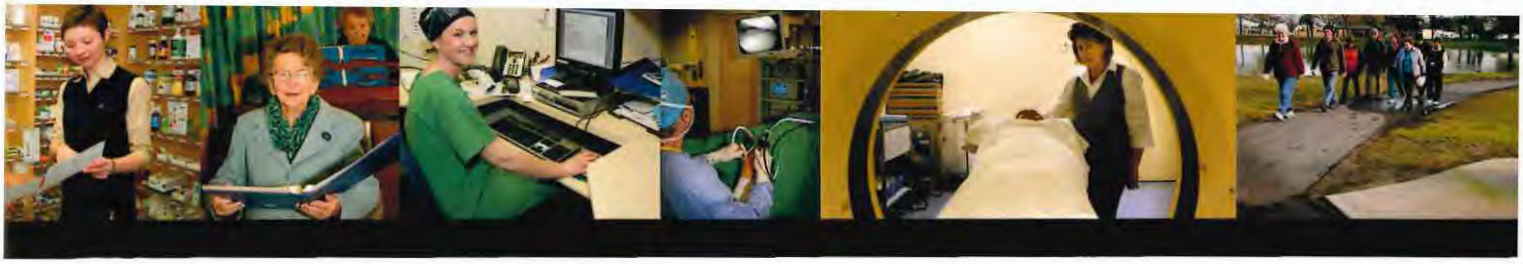
The report of an incident/ injury is followed up as soon as possible by the department heads and the OH&S coordinator and/or Risk Manager. Strategies are put in place to reduce a recurrence of the incident.

During the last year the number of staff reported incident occurrences was 86 of which 50%(43) resulted in minor injury. This is an increase of 10 injuries from the previous year. Overall the number of staff injury occurrences has remained within 46% to 58% of reported incidents over 5 years. The dominant 2006/07 injury occurrences equated to abuse and assault (13), contact with / by, caught by/ between (12), manual handling (9) and needle stick (4). Figure 21 shows staff incident/injury numbers for the past 5 years.

The number of staff lost time injuries of 2 (2006-7) is similar to the previous year. The total time off work for these injuries equated to 32 days compared to 80 days the previous year.

Figure 21





Occupational Health and Safety

Safety Initiatives

Throughout the facility many OH&S programs operate for the improvement of employee, patient and visitor well being.

These include:

Employee rehabilitation

An Employee Rehabilitation Program is provided to employees injured at work and those recovering from injury & illness that occurred away from work.

Over the last year, there were three full 'return to work', two rehabilitation cases with 38 days total lost.

Safety/environmental inspections

Ongoing safety and environmental inspections were conducted for the nursing home, and other sections of the hospital. New inspections were conducted for allied health at their three outreach locations. Remedial action against these inspections can be found in the 'Strengthening Rural Communities' report on page 48.

Risk assessments

Risk assessments have been a high priority, mostly flagged by incident reports and / or staff concerns of the work environment, equipment and processes. Risk assessments included theatre Central Sterile Supply Department (CSSD) processes, maintenance workshop plant and equipment, meals on wheels food container handling, vacuum cleaner use and patient lifter handling at the nursing home.

Issues indicated by the risk assessments have been addressed. Eg through the installation of a new ultrasonic cleaner in the CSSD decontamination room and reinforcement of CSSD work procedures. The handling of bulk and heavy items in the supply department and about the organization have been addressed by the acquisition of a small forklift.

Risk assessments of equipment (proposed and in current use) are conducted as part of new equipment acquisitions.

Hazardous substances

The annual review of the storage, handling and disposal of hazardous substance was conducted. The register of substances was reviewed, and our intranet Hazardous Substance Database was updated during the first half of 2006. A comprehensive review of hazardous substance management during August 2006 indicated a 91% compliance with legislative requirements.

One hazardous substance incident was recorded for the year, this being exposure to biological wastes on food containers.

External audits

WorkSafe Victoria visited our organisation six times during 2006/7. The visits were part of the Authorities programs on "Patient handling in Hospitals (acute and aged care)" and "Occupational Violence in Mental Health / Hospital in the Home". The inspectorate concluded that the processes in place 'are generally in line with the Authorities'. Two improvement notices were issued of which one is currently being addressed, and relates to patient handling during orthopaedic surgery.

Fire & evacuation training

Annual fire and evacuation training was provided for staff across the facility, 98.0% of staff participated in the training.

A number of emergency exercises relating to fire, evacuation, internal, personal threat and medical were conducted throughout the year. These exercises required staff to respond to 'mock' codes. The exercises highlighted how well staff comprehend what is expected of them.

Occupational Health and Safety

Orientation

All new employees are required to attend an orientation of the organization. The program covers a wide range of topics including OH&S employer and employee responsibilities, emergency procedures, infection control and manual handling.

Contractor management

Contractors (eg services, trades) are required to complete a contractor OH&S Plan before starting work at SRH and are regularly supervised by the respective SRH person whom the contractor reports to. There was one report of a contractor injury for the year.

OH&S Committee

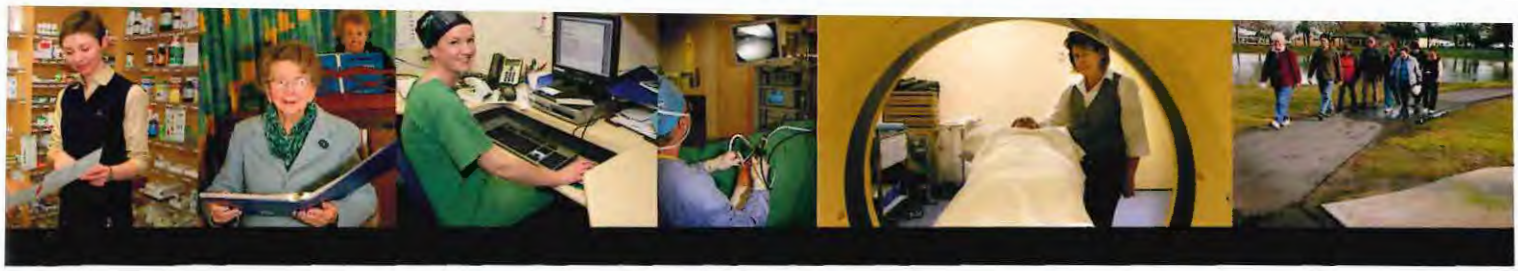
The OH&S committee is very active and meets bi-monthly. Members represent the various work sections/areas and stakeholders of SRH and are trained to the required Victorian WorkCover Authority competency.

The committee's brief is to develop and /or endorse strategic OH&S programs, monitor future trends and recommend the instigation of appropriate action in line with the organizations goals.

Security management

During the first six months of 2006, two external security reviews were undertaken; one by an external consultant against Australian and ACHS Standards and one by the Victorian Police to review hospital security.
In addition to this there was a security breach on the acute hospital site.

The reviews and security breach resulted in an extensive Action Plan to address the areas of non/poor compliance. Of the eighteen recommendations, sixteen have been completed over a twelve month period.



Activity Indicators

Hospital Inpatient Activity	2004	2005	2006	2007
Inpatients treated	3,093	2,904	2,692	2,891
Casemix adjusted (WIES)	2,171	2,058	2,112	2,075
Average Length of Stay (days)	2.74	2.70	2.94	2.61
Total Bed Days	8,477	7,519	7,927	7,535
"Hospital in the Home" Bed Days	248	198	125	153
Nursing Home Type Bed Days	228	133	223	131
Operations	1,316	1,277	1,237	1,278
Births	81	93	80	78
Occupancy Rate	75%	60%	61.07%	57.78%

Nursing Home Activity	2004	2005	2006	2007
Residents Accommodated	56	54	46	56
Resident Bed Days	12,729	12,684	12,710	12,629
Occupancy Rate	99.4%	99.3%	99.49%	98.82%

Outpatient (non-admitted) Occasions of Service	2004	2005	2006	2007
Casualty	4,539	4,356	3,554	3,254
Pre-Admission Clinic	1,145	1,167	1,090	1,195
Ante-Natal Classes	425	450	490	570
Podiatry	3,446	2,974	2,851	3,576
Occupational Therapy	952	1,241	1,264	981
Physiotherapy	6,424	7,992	7,493	5,761
Speech Therapy	644	537	727	686
Dietetic	922	1,277	1,151	1,253
Social Work	773	968	682	394
Day Centre	4,631	3,168	3,363	3,442
District Nursing	13,525	14,039	13,973	14,301
Radiology	4,934	5,295	5,620	6,060
Meals on Wheels	13,489	13,058	12,447	17,507

Pecuniary Interests
Members of the Board of Governance are required under the Hospital By-Laws to declare their pecuniary interest in any matter that may be discussed by the Board or Board Sub-Committees.

Publications
A review is regularly undertaken to update information in publications such as, the Patient Information Brochure. The Annual/Quality Care Report is presented each year at Stawell Regional Health's annual meeting.

Activity Indicators

Freedom of Information
There were thirteen (13) requests under the Freedom of Information Act 1982 regulations and access to information was granted in all instances.

Freedom of Information requests should be in writing and addressed to the Chief Executive, Stawell Regional Health, Sloane Street, Stawell Victoria 3380.

The Protected Disclosure Co-Ordinator for Stawell Regional Health is Liz McCourt. She has the central clearinghouse role for managing disclosures: Tel: 5358 8506
email: lmccourt@srh.org.au

Disclosures of improper conduct by Stawell Regional Health or its employees may be made to:

- The Protected Disclosure Officer, Meg Blake, Tel: 5358 8513
  email: mblake@srh.org.au
  Stawell Regional Health, Sloane Street, Stawell 3380

  Or

- The Ombudsman Victoria
  Level 22,
  459 Collins Street, Melbourne 2000
  Tel: 9613 6222 Toll free: 1800 806 314

No disclosures under the Act were received during 2006/07.

Hospital Fees
The Hospital charges fees in accordance with the Department of Human Services Victoria directives.

Consultants Engaged and Their Cost
Thirteen (13) separate Consultants : total cost $118,213.

Whistleblowers Protection Act
The Whistleblowers Protection Act 2001 came into effect on January 1, 2002. The Act is designed to protect people who disclose information about serious wrongdoings within the Victorian Public Sector and to provide a framework for the investigation of these matters.

Public Authorities Equal Employment Opportunity Act 1990
Stawell Regional Health has an ongoing commitment to eliminate discrimination and inefficient work practices, and to promote Equal Employment Opportunities in its workplace, in accordance with the Public Authorities (Equal Employment Opportunity) Act of 1990. Responsibility for the Equal Employment Opportunity programmes has been conferred upon the Pay Officer.

Staffing Profile
A total of 246 persons were employed by Stawell Regional Health : full time 67; part time 111; casual 68.

Building and Maintenance
All building works have been designed in accordance with the Department of Human Service's Guidelines and comply with the Building Act 1993 and the Building Code of Australia 1996

Stawell Regional Health incorporates Macpherson Smith Nursing Home and
Bennett Centre for Community Activities
Sloane Street, Stawell Victoria 3380
Phone (03) 5358 8500 Fax (03) 5358 3553 Email info@srh.org.au Web www.srh.org.au

The **front cover** features a series of photographs demonstrating the nature features of the Northern Grampians landscape.

The production of a Quality of Care Report is an annual reporting requirement, initiated by the Department of Human Services. The management and staff of Stawell Regional Health want to make this report interesting and useful for our valued community.

Suggestions of what to include in the next report can be forwarded to:

Quality Manager
Stawell Regional Health
Stawell Vic 3380

The Quality Improvement Department can also be contacted on 5358 8576 or via email at info@srh.org.au

We value your comments

Acknowledgements

Compiled by Jane Kibble with assistance from Lynette Healy, various staff members and IT Department
Main Photography : John Tiddy

Thank You
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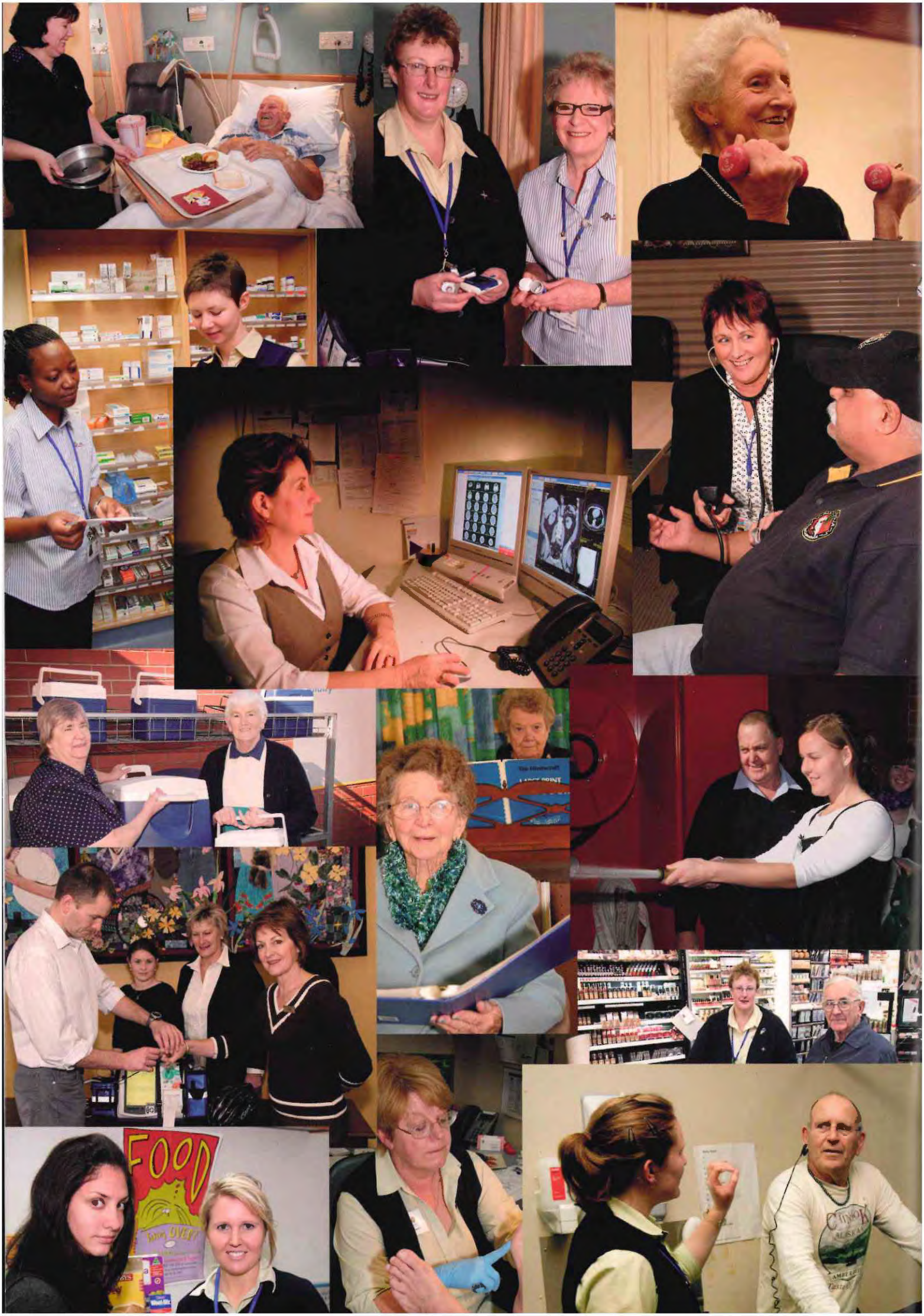
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