Quality Improvement at Dunmunkle:
Helping people from falling through the cracks of the system

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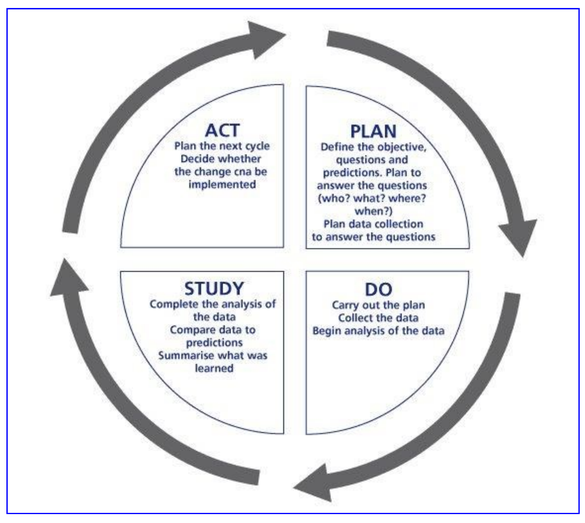
Background

In 2013 the Victorian Department of Health announced that the Community Health Indicators would become a reporting requirement for Community and Women's health funded programs.

This moved from an hours of service reporting method to a set of clinical indicators encompassing the measuring of client experiences, health outcomes, efficiency and effectiveness of health services.

In order to implement these indicators, Dunmunkle Health Services has been working with the Wimmera Primary Care Partnership over the past three years to collect the data, review practices with the aim of improving service delivery to their local population and delivering high quality coordinated care.

Method



Utilising a Plan, Do, Study, Act continuous quality improvement approach to implementing the Department of Health and Human Services Community Health Indicators, a monthly meeting is held with the Dunmunkle hot CHIP (Community Health Indicators Project) team and led by the Wimmera Primary Care Partnership.

Performance of the health service against the indicators is critically reviewed, ideas for improvement are tested, and results are reflected on by the team and then implemented at the Minyip campus.

Results

This quality improvement approach has developed better processes across key indicators for how:

- Clients access services at Dunmunkle
- Needs are identified and services can be delivered to meet these for clients
- There is a consistent process for developing and sharing care plans with clients and other staff and GPs as appropriate
- Care plans are reviewed with clients and changes to their care reflect this

Shared Care Meetings in Action

Dunmunkle have also implemented a regular Shared Care meeting which brings together staff from Community Health and District Nursing departments to discuss any red flags or clients of concern.

This has enabled staff to identify at risk clients, share care plans and work together to assist clients who may be finding it hard to keep well at home.

In December 2015, a client was referred to the Dunmunkle Cancer Resource Nurse. A home visit was conducted and home help was arranged, which was all the client would accept at the time.

The Cancer Resource Nurse kept in regular contact with the client, and was aware that District Nursing service could be needed at any time. This client was subsequently discussed at each Shared Care Meeting.

In May 2016 after returning home from an acute hospital admission, an urgent referral was made to District Nursing, and Hospice also became involved.

Because District Nursing was already aware of the situation they were more able to act quickly and implement strategies to support the client and family.

Conclusions

This work positively demonstrates the power of the PDSA quality improvement process as a successful way to monitor progress and change practice.

Rural clients now have better access to services, improved processes to ensure they receive the care they need and high quality coordinated care.

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