



BANYULE
Community Health



*A community that values fairness,
health and wellbeing*

2011 QUALITY OF CARE REPORT

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Our cover features decorative garden pavers created by community members for Buna Reserve Community Garden. Standing in the foreground is Lisa and Ian, whose stories feature on pages 30 and 31.

Welcome to this year's *Quality of Care Report*

On behalf of our Board of Directors and dedicated staff of Banyule Community Health, we are delighted to present the Banyule Community Health *Quality of Care Report 2010-11*.

At Banyule Community Health (BCH), we are committed to providing quality and safe health services to our community. The articles and reports in this Quality of Care Report describes some of the exciting work that is occurring at BCH as we strive to meet the health needs of our community.

We also acknowledge that we can always do things better and have identified opportunities for continuous improvement. The introduction of a new risk and incident reporting system has enabled us to better understand and respond to the experience of our clients and carers. Importantly, the development of this Quality of Care Report was overseen by a dedicated group of clients of BCH - their time and contribution is greatly appreciated.

BCH will continue to be a major provider of health and welfare services for the community. We are in the planning stages of developing a new strategic plan for the next three years. The community will be a key stakeholder in the development of this plan and we encourage you to participate in this process as it will enable you to have a say on how health services are delivered for our community.

Your feedback is important to us and we would really like to hear your thoughts on the report.

We commend this report to you.



John Ferraro - Acting Chairperson



Jim Pasinis - Chief Executive Officer

Acting Chairperson

Chief Executive Officer

...► About the Quality of Care Report

'Stories from Home' – an art-research project at Bell Bardia Estate, August 2011.

I've never known a place like this.

Our Quality of Care report is published each year and is used to share important information with the community. It allows us to tell our clients, their carers, our members and our health service community the services we offer, how we maintain safety and how we are working to improve each year.

Consultation and feedback have led to significant changes to the look of our report, including adding more photographs and making sure the data we present is easy to understand. Consumer groups have also

been involved in reviewing this year's report and making sure it is easy to read and useful.

The consumer group identified that stories about staff and clients were well received and allowed a lot of information about the service to be conveyed in an accessible and interesting way. Feedback from the Department of Health has informed us to ensure that the data we present is clear and includes an explanation to help the reader understand it.

Staff at BCH have been actively involved in gathering information and writing articles for this year's publication and we welcome your feedback on the content and presentation. Please fill in and return the postage paid consumer feedback form so we can be sure to use your feedback and suggestions to improve next year.

Some of the interesting comments and suggestions that helped us improve this year's report are included throughout the report.

This year's report will be distributed at the Annual General Meeting and will be available at BCH, and at a variety of community locations including maternal health nurse centres, local libraries, Banyule City Council, local politician's offices and www.bchs.org.au

Vision:

A community that values fairness, health and wellbeing

Mission:

Banyule Community Health will provide health and community services that are accessible and relevant to the needs of our community. We do this by working together with trust and respect.

Values:

Respect
Excellence
Partnerships
Leadership

.....> Participation

“Doing it with us
not for us”

A TIME TO CELEBRATE

BCH and the Gamblers Help Peer Connection Program have more reasons than usual to celebrate lately...

Not only have we recruited seven new Peer Support Workers to join our already expanding team of dedicated volunteers, recently we received a Special Commendation Award from The Hon. David Davis, Minister for Health, at the 2011 Volunteer Awards Ceremony. For those unaware of the volunteer awards, think Logies or Oscars for Volunteers!

It is a huge honour for the Peer Connection Program to be awarded and acknowledged for the pioneering work in the field. This is especially prestigious given the field of worthy programs

At BCH we recognise that to provide the best service we need to know what our community want and need. Consumer participation is facilitated in a number of ways:

- We have a Community/Consumer Participation Policy and a Consumer Participation Working Group
- We use a variety of approaches to report in consumer participation including feedback surveys and this Quality of Care Report
- We have systems in place to involve our consumers including feedback and committee membership
- We are members of a Primary Care Partnership and are actively involved in the implementation of the Integrated Health Promotion Plan

and services also nominated, with some running for thirty years! To be singled out and awarded means so much to the program and the volunteers who make it all happen!

The Peer Connection Program commenced as a small community education activity by BCH in 2006, with an express aim of linking problem gamblers together with ex-gamblers who have successfully managed their issue and to offer confidential telephone peer support. The concept of the peer support was something our clients at the time expressed an interest in, wanting to hear from someone who has 'been there with problem gambling and come through the other end'!

Over time, the program has grown leaps and bounds. We now operate as a fully-funded program delivered by Gamblers Help consortium partnership across the North, West and Metropolitan region. Our volunteers are recruited annually and all offer something truly unique to callers struggling with the effects of problem gambling. They can listen, support and offer hope to those people thinking there is no hope with gambling.



History of Banyule Community Health

BCH has a proud history that dates back to the 1970's. Built and funded as a response to the Henderson Poverty Inquiry, the *West Heidelberg Health and Welfare Centre* was established in the Olympic Village and responded to local community needs and was governed by a community Board of Management. The service started as a modest 5 staff operation with volunteers and a strong vibrant community. In 1985 a review of Community Health led to the establishment of the Diamond Valley Community Health Centre, which provided a range of services with a pediatric and family focus in Greensborough. With changes around councils and municipalities the Board of West Heidelberg and Diamond Valley merged the two services to create Banyule Community Health in 1997. Services grew and responded to new and emerging issues in the community. In 2003 BCH purchased the Diamond Valley Hospital and expanded services in the north of Banyule and in 2006 opened the new purpose built West Heidelberg site in the Olympic Village. BCH is now a leading provider of services in the health and welfare sector, operates with a community governance model and responds to community needs through its 160 staff and 50+ volunteers.

Feedback:

"Very nice people at the main reception desk, very kind and courteous"

"I am so grateful for all the workers of Banyule"

"The staff are very competent"





Consumer group

Banyule Community Health Consumer Group has been central in developing this year's Quality of Care Report. Our members have a wide range of experience and through discussion and decision making have ensured this report contains information that is important to our service users, and is presented in a way that is clear and interesting.

The group has been involved in the consumer group committee meetings to discuss all matters related to the project including formatting, layout, content and distribution of the report.

We gratefully acknowledge the contribution of all members of the Quality of Care Consumer Group:

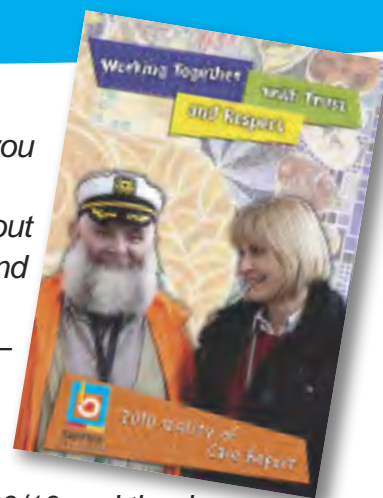
Alan Pearce	Joan Griffiths
Geoff Smith	Julie Watson
Maggie Ryan	Abdi Siad

Feedback on the 2010 Report

This year we received 39 responses about the Quality of Care Report compared to 16 the year before. Clients also used this feedback form as a way of complimenting staff on the services they provide. Feedback specifically about the report included:

- *The report lived up to expectations and beyond, well done*
- *I was very moved and emotionally touched on having my story and photo in this report*
- *Loved the new layout and colours*

- *Visually clear and pleasing. I am glad you didn't tell us how "excited" you are about your services. A sound report*
- *Very reader friendly – attractive publication*
- *Excellent Report on a very good community service 10/10 and thank you BCH*
- *Some sections are verbose: further editing could possibly have been applied*
- *Would be useful to consider the local paper as an avenue for including information about the report*



.....➤ Consumer Feedback Results

At BCH we take your feedback seriously. We receive feedback in a number of ways including verbal and written suggestions and complaints. Clients provide feedback on our services and the clinic environment by completing an *Opportunity for Improvement form*, sending a letter or email, or by providing verbal feedback to a member of staff. From this point, feedback is handled according to type:

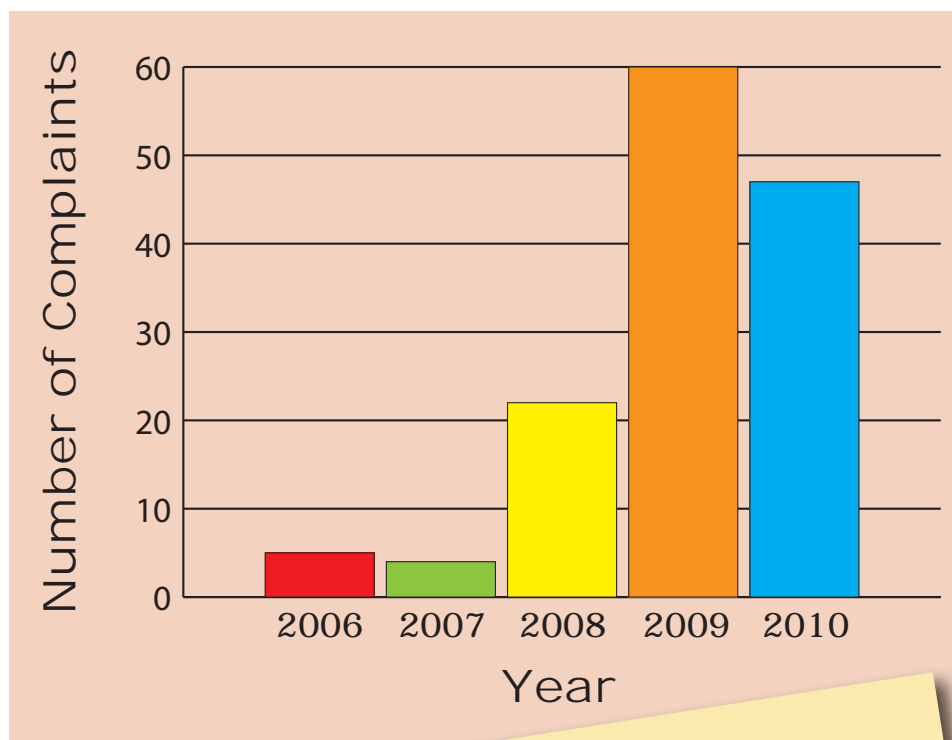
- *Complaints are dealt with by the responsible manager*
- *Compliments and Suggestions are discussed and responded to through the Consumer Participation Working Group.*

BCH is particularly committed to prompt response to complaints from clients. We aim to acknowledge a formal complaint within 48 hours and investigate and respond in writing to the issue within 14 days. Each year we check whether we are achieving these aims by conducting an audit of all consumer feedback. We also use the audit to identify ways in which we can improve the system.

In 2010, system improvements included:

- *Daily clearing of the suggestion box by reception staff*
- *Central coordination of complaints by the Executive Assistant*
- *Moving to recording consumer feedback in the Victorian Health Information Management System (VHIMS)*

Improvements such as these have meant that the collection of consumer feedback data has improved significantly over time. Last year we received 83 episodes of feedback: 46 were recorded as formal complaints, 17 compliments, 14 suggestions and 6 suggestions from staff. The number of formal complaints decreased slightly in 2010 compared to 2009. In 2009, a high number of complaints (23) were recorded in response to the closure of the medical practice at Greensborough.



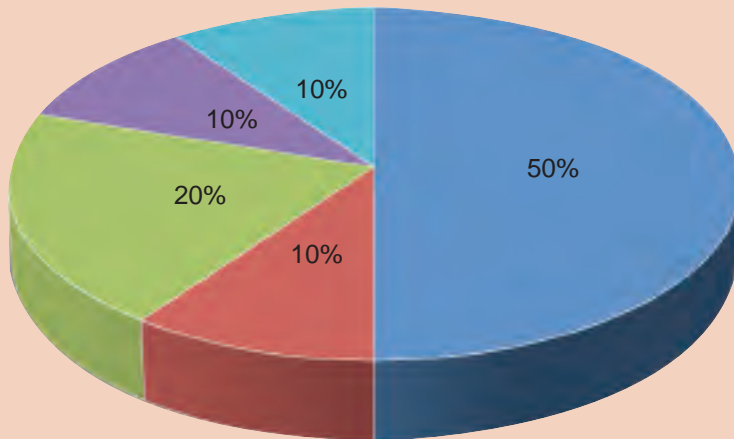
Formal complaints over time

Most of these complaints (45%) related to access issues including long wait times for initial appointment, and waiting time in waiting rooms. The next major issue area for complaints was in Communication (29%), which included complaints about attitude and absence of caring.

Feedback:

"Of more interest would be suggestion: how long for complaints to be acted upon."

Formal complaints by issue area



- Environment / Amenities
- Access / Delay in treatment
- Environment / Car parking
- Other
- Communications / Inadequate information

Consumer Satisfaction Survey 2010

The 2010 Consumer Satisfaction Survey showed that satisfaction levels with the centre environment had decreased between 2007 and 2010. Based on this feedback, a two-year action plan was developed to address identified priorities for improvement. Action now being taken includes:

- Monthly reporting of waiting times to the management team
- Updating and improving the information on the BCH website
- Refurbishment of the waiting area at our Greensborough site
- More car parking available to clients by allocating a section of the car park as client-only parking
- Improving bike parking facilities for staff and clients
- Increasing the number of disabled car parking spaces at our West Heidelberg site.





Diversity

Access and *Equity Plan*

BCH has produced an annual Cultural Action Plan since early 2002, with the aim of improving access to services for culturally and linguistically diverse (CALD) communities. In recognition of the inequality in accessing services and health outcomes experience by other marginalised groups who may not belong to a "cultural" group, in 2010 the plan was broadened to an Access and Equity Plan. The new plan seeks to improve access and equity and diversity within our client population. It identifies strategies to improve access for people with physical and intellectual disabilities, gay, lesbian and transgender people, ATSI people as well as CALD clients.

Over the past 12 months, the Access and Equity Committee has realised the following achievements:

- Investigation into housing issues for international students
- Deaf Society training, Deafness Awareness and the National Relay Service
- Updating the BCH website and brochures to become a National Relay Service friendly organisation
- Increasing Speech Therapy access for Somali children
- Promotion of paediatric dental service to low income families
- Increase counselling staff capacity to deal with clients with a mental illness through rotations with partner agencies

- Dental outreach program to Supported Residential Service
- Recruitment of a care coordinator to work with intellectually disabled in shared supported accommodation
- In-house training for clinical staff by Centre for Culture Ethnicity and Health in Culturally Appropriate Health Assessments
- Recruitment of an ATSI worker (see article on Uncle Phil)

The Committee also completed an investigation and assessment of the access and equity needs of local population groups known to experience inequality. The Committee considered three dimensions of inequity: equality of access, equality of opportunity and equality of health impacts and outcomes. The Committee has identified several groups who remain in need of assertive targeting through this process:

- ATSI
- Children of low income families
- Intellectually Disabled
- Homeless
- Asylum Seekers and Refugees

These groups will become a focus for our new three-year Access and Equity Plan, with specific strategies developed to address access and improve population health.

Clients by Country of Birth

76% of our clients were born in Australia. Of our clients that were born in other countries, the majority were from either Somalia (3.3%) or Italy (3.3%).

The Bilingual Service

Demonstration Project

The Bilingual Service Demonstration Project (BSDP) was a two-year project funded by the Office of Gaming and Racing (OGR) to pilot a new model of bilingual service delivery within the Gambler's Help sector with the Italian and Vietnamese communities.

The aim of the project was to improve problem gambling services and increase access to problem gambling counselling services for culturally and linguistically diverse (CALD) communities. This was achieved through the employment of an Italian speaking Counsellor and Community Educator and a Vietnamese speaking Counsellor with a community education role. The project was implemented via partnership between Gambler's Help Northern, Co.As.It, the Australian Vietnamese

Women's Association (AVWA) and the Multicultural Gambler's Help Program (MGHP). The BSDP project was evaluated by the Multicultural Gambler's Help Program of the Centre for Culture, Ethnicity and Health.

The evaluation found that both programs were successfully implemented, with good service uptake by the relevant communities. Client satisfaction surveys used in the evaluation indicated that clients were very satisfied with the services. The report stated that Gambler's Help Northern had put in an exceptional effort in implementing the new and innovative bilingual service model which demonstrated their strong commitment to improving Gambler's Help services for CALD communities.



Participants from
BCH Japanese
Playgroup

Interpreter Usage

For clients with low proficiency in English, interpreters are essential for the safe and effective delivery of services. BCH seeks to provide an interpreter for every client who needs it, at no cost to the client. This commitment to the use of interpreters has been reflected in a steady increase in the number of interpreter bookings made over the last 6 years. While there were slightly fewer

bookings made in 2010/11, the overall trend is increasing use.

We also use interpreter data as an indicator of access to health services by people from culturally and linguistically diverse (CALD) backgrounds. In 2010/11, the largest number of bookings by language was for Somali interpreters (21%), however Chinese languages (Cantonese, Mandarin and

BETTER HEALTHCARE for People with Intellectual Disabilities

In 2011 a project funded by DHS Disability Services entered its third phase. BCH has been able to further demonstrate its commitment to improving health planning and access to health services for people with intellectual disabilities since the commencement of the project in 2009.

This year the Disability Care Coordinator visited 42 people with intellectual disabilities living in DHS Disability Accommodation Services with the aim to improve their access to quality healthcare services. So far in this phase 68 referrals have been generated for services such as speech pathology, nursing care, podiatry, dental, physiotherapy and occupational therapy among a range of other primary health services. Here is what some of the house supervisors had to say about their experience of being involved in the project:

"Being involved in this project, the residents and house staff gained better access to the range of services available at the local Community Health Centre" (Peter, House Supervisor)

"We were able to use the project to improve the quality of our healthcare planning, by transferring the actions into our quality action plan" (Barry, House Supervisor)

"As a result of the project I feel more empowered to access services for clients" (Jeff, House Supervisor)

"Chinese") accounted for 25% of all bookings. This represents a significantly increased representation in service data of people who prefer to speak in Chinese languages since 2009/10, when these bookings accounted for only 16% of all interpreter bookings.

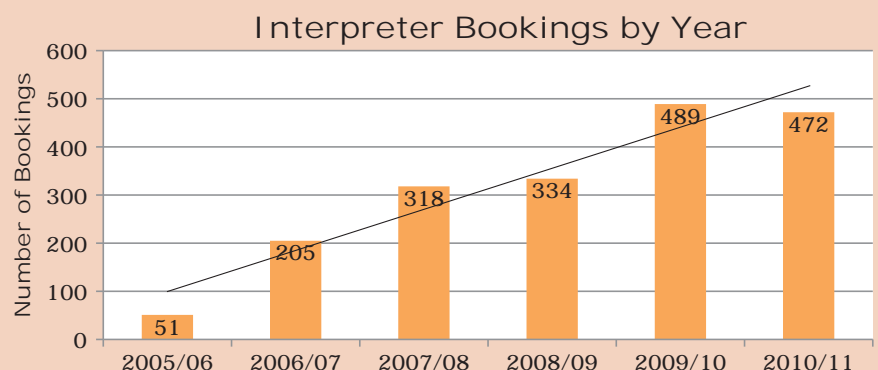
PARTNERSHIP Human Rights

Since the introduction of the Victorian Charter of Human Rights and Responsibilities, BCH has sought to apply these rights to all aspects of our work. This includes using the Charter as a checklist in the development of our organisational policies. Here, we focus on work that has taken place over the last 12 months to further support two of the rights described in the Charter.

Right to protection from torture and cruel, inhuman or degrading treatment, medical or scientific experimentation or treatment without consent

Clinical services at BCH have always sought to collect informed consent from clients when the recommended treatment for a given issue involved a complex or invasive procedure. A working group developed an organisation-wide policy and procedure with the aim to ensure consistent and robust processes in the collection of informed consent, and ensure that clients are actively involved in decision-making about their care. The procedure means that clients and/or their representative will be given enough information (and in a form that they can understand) about their condition and investigation and treatment options, including the option of no treatment, to make a decision about how to manage their health issue. Clients must also have an understanding of the benefits and possible adverse effects of investigations or treatment, and the likely outcome if no treatment is undertaken. While clinical staff at BCH will endeavour to explain all aspects of assessment and care thoroughly, we encourage (and need) our clients to ask questions about their care to make sure that they are fully informed participants in their healthcare management.

Increase in interpreter usage over time



Protection of families and children

BCH prioritises at risk and vulnerable populations within our community. Families who fit this criteria, who are having, or, recently had, a baby are supported by BCH Community Midwives and Maternal & Child Health Nurses. Many families accessing the services experience a range of issues including homelessness, mental health issues, post natal

depression, refugee background, and have involvement with Child Protection.

BCH has established a partnership with Banyule City Council, Maternal and Child Health, to provide a continuous level of care from pregnancy to early childhood. This includes the 10 key appointments for new borns, plus a range of wrap around support to child and family. The trust and relationship that is built between families and the service enables a high quality service to families and their children. Building the capacity of families and ensuring clear access to community supports and specialized care are key features of the partnership.

Clients by Age Group

The majority of the people that we see (41%) are aged between 40 and 59 years. The next largest group is children and young people aged 0-19 years (23%).



.....➤ Governance & Management

Our Board of Directors

The names of the directors in office at any time during or since the end of the financial year are:

John Ferraro
Peter Ogden
Abdalla Ahmed
Bob Dunn
Frances Baum
Bill Barber

David McKenzie
Dr Melissa Russell
Anthony O'Donnell
Melinda Brooks
Larry Stephens

BCH is accredited against the QIC Health and Community Services Standards. At our last accreditation we were awarded a MET for the "Building Quality Organisations" component of the review which includes our Governance processes.

Board Member *Profiles*

Frances Baum

Frances has been a resident of the West Heidelberg and West Ivanhoe area for more than 30 years. Frances taught at St. Pius X Primary School and was later appointed Principal. Some years later she returned to the area to work as a Pastoral Associate at St. Pius X Parish.

Now, living in West Ivanhoe, Frances works as leader of our local community, Missionary Sisters of the Sacred Heart and has also been involved in adult education, counselling and theology and scripture studies. Frances takes an interest in people from all nations and faiths, and with such a mixed community as we have in Banyule, this is very important.



Dr Melissa Russell

Melissa's background is as a physiotherapist and she has worked in a variety of fields of physiotherapy in Australia and overseas. Following many years as a physiotherapist Melissa undertook her PhD through the University of Melbourne and the National Ageing Research Institute and completed it in 2008. She has since worked in public health research, focusing on the areas of healthy ageing, the benefits of physical activity and injury prevention. She is currently employed at the University of Melbourne as a Lecturer in Epidemiology. She joined the board at BCH in July 2011.



Strategic Plan

Our strategic plan for 2009-12 is the main plan providing direction for BCH. From our strategic plan, we develop an annual operational plan and team plans that operationalise the directions and goals that the strategic plan articulates.

The current strategic plan is now in the final year of the strategic plan cycle. Over the past 2 years of the strategic plan, BCH has implemented over 85% of activities outlined in our operational plans. More detail on the outcomes of the Strategic Plan over 2010/11 are provided in the Director's Report in this

year's annual report, however, five key outcomes have been:

- Establishing a new health promotion team, with project officer positions dedicated to specific roles
- Completion of research in problem gambling and family violence
- Recruitment of a project officer to further develop and implement a model of care planning
- Trialling of clinical supervision models in Allied Health
- Development of a Green Action Plan.

Planning is underway for the 2012 – 2017 BCH Strategic Plan. Clients were invited to be involved in the process.

Risk Management

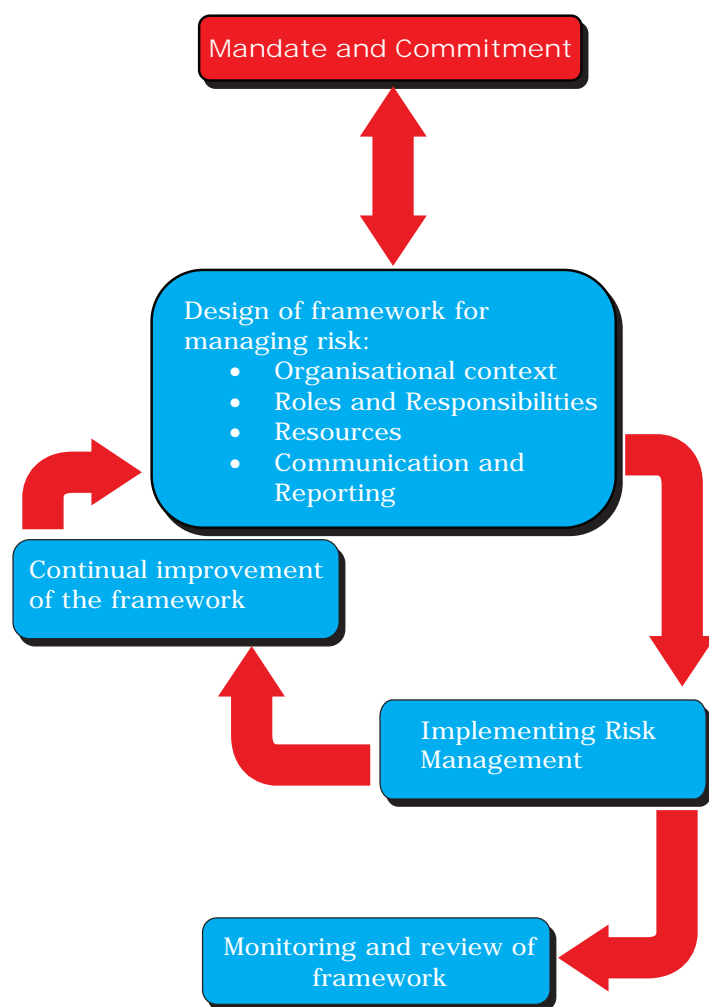
BCH's Risk Management system is based on the international standard for risk management. As the diagram below shows, an important of the system is continual improvement of the framework. In 2010, RSM Bird Cameron was engaged as an external auditor to review the quality of the risk system. The auditor found that while the overall structure and controls over risk management were adequate, further areas for improvement could be identified.

The improvement opportunities and the BCH response included:

- Review of existing risk controls to describe control effectiveness ✓
- Integrate risk management process and coordinate reporting of both financial and non-financial risks ✓
- Investigate options for purchasing risk management software to further centralise and streamline the management of risks ✓
- Place the onus on individual managers to manager risks for their responsibility areas and promote accountability for risk management ✓
- Review all position descriptions to ensure that the responsibility for risk management is clearly articulated in each individual's job function ✓

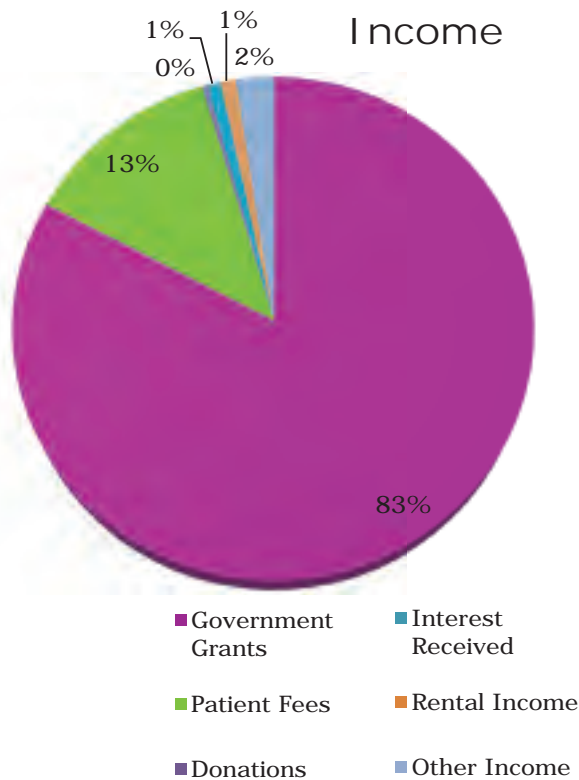
In actioning the improvements, BCH made a substantial investment in purchasing risk management software to support risk documentation. The software provides the

Components of the Risk System



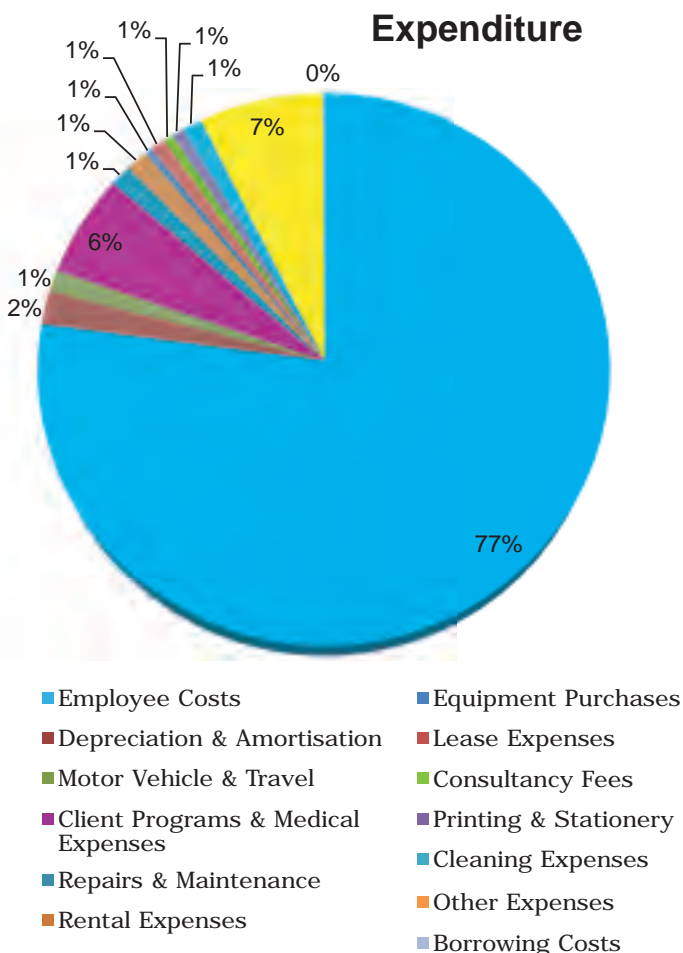
agency with additional benefits as it links to our incident reporting system and can provide us with data on incidents related to our clinical and OHS risks in particular. This helps us monitor the effectiveness of our preventative strategies and provide us with some risk history.

.....➔ Finance Summary



In recognition of positive feedback in 2009 and 2010, we have again produced financial statements separate to our Quality of Care Report. This year, we have made the Banyule Community Health Annual Report & Financial Statements available online at www.bchs.org.au/annualreport as well as providing a printed version to members of Banyule Community Health.

Banyule Community Health is a large and complex organisation, with over 160 staff. Our income and expenditure are both in the order of \$11,000,000 per annum and the table and charts on this page provide a breakdown of where this money comes from and how it is spent.



INCOME	Financial Year 2010/11	
Government Grants	9,292,642	82.8%
Patient Fees	1,420,728	12.7%
Donations	40,301	0.4%
Interest Received	94,054	0.8%
Rental Income	107,453	1.0%
Other Income	273,527	2.4%
TOTAL INCOME	11,228,705	100.0%

EXPENDITURE		
Employee Costs	8,799,375	77.1%
Depreciation & Amortisation	221,053	1.9%
Motor Vehicle & Travel	145,368	1.3%
Client Programs & Medical Expenses	690,306	6.1%
Repairs & Maintenance	142,542	1.2%
Rental Expenses	148,782	1.3%
Equipment Purchases	47,033	0.4%
Lease Expenses	100,808	0.9%
Consultancy Fees	65,124	0.6%
Printing & Stationery	78,378	0.7%
Cleaning Expenses	133,406	1.2%
Other Expenses	824,121	7.2%
Borrowing Costs	13,516	0.1%
TOTAL EXPENSES	11,409,812	100.0%
SURPLUS/(DEFICIT) for the Year	(181,107)	



ATSI

Ngurrungaeta is a health and well being initiative for local Aboriginal and Torres Strait Islander males in the North of Melbourne. The men have identified a holistic model to improving their own health, the health of their families and of their communities. The men are supported by BCH and the Childrens Protection Society.

Ngurrungaeta is a Wurundjeri-willam word that means "leader of the clan". In respect to the Wurundjeri Peoples the Banyule Indigenous Men's Group has adopted the name Ngurrungaeta as a vision for the men to strive towards being better leaders in their own lives, their families and their communities.

The men meet every week to plan activities and events to strengthen both their traditional knowledge and support each other through "yarning" (talking). The men have established their own art studio and meeting place. The men regularly are commissioned to complete art works and provide traditional food catering to local events.

Their work has been widely recognised and recently the South Australian Government

invited the men to represent the state at a state Men's Business Camp. The men recently have been commissioned by the AFL to craft some traditional tools for a cultural exchange to Fiji.

The men self fund their activities and manage all their events.

To date the men have been meeting for some three and half years and in total there are about thirty members.



Everything you wanted to know about

Uncle Phil

How long have you been working at BCH?

I started working here late in 2010, a couple of days a week.

What is your role here?

I am the Aboriginal and Torres Strait Islander community development worker. I support cultural activities with the community of men involved in Ngurrangaeta group. This includes leading the group on cultural exchanges to other mobs' land, making traditional implements such as nulla nulla clubs and boomerangs, and painting artworks. Some of the activities we run help generate income for the group, which is self-funding. The group also provides some community education through traditional catering and dance. Recently the men were asked by the AFL to make some traditional tools for international cultural exchange when they play in other countries.

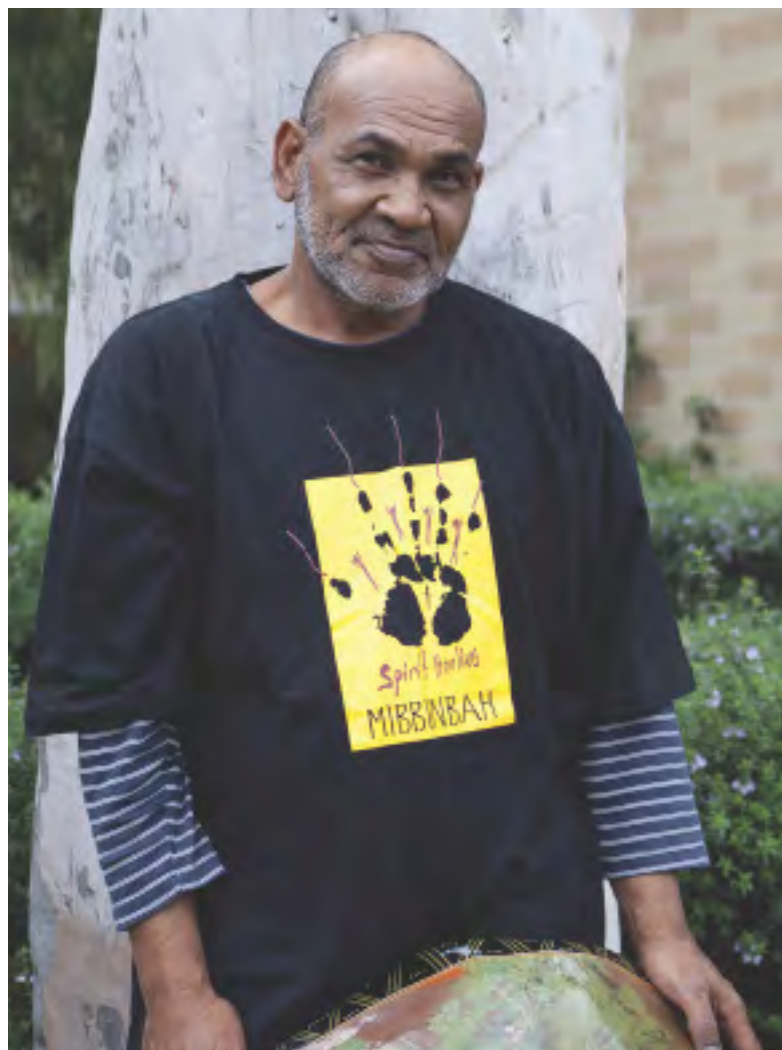
Why do you get called "Uncle Phil"?

I am called Uncle because I have a strong understanding and commitment to the cultural knowledge required to act as an ambassador for my people. In our community people are called "Uncle" and "Aunty" as a measure of respect from the community who recognise these people as their ambassadors. In our culture the terms "Uncle" and "Aunty" don't necessarily refer to kinship, or immediate family, but are a title... a bit like an honorary doctorship... It is something that must be agreed to by the whole community.

You are from the Torres Strait Islands, what can you tell us about this?

My father is from Badu Island and my mother is from Darnley Island in the Torres Strait. I am first generation born on the mainland in Australia.

People who live in the Torres Strait survive from the sea. We eat withe – that's coral trout, sogo (octopus), dungal (dugong or sea cow), waru (green-back turtle). Living on the island is like perpetual paradise! It reminds me of what our islands were called before Torres: Zenith Kes meaning the passage between two lands. We have a different flag to the Aboriginal flag that tells of the islands. The Torres Strait Island flag is blue, green and black. It shows the passage between two lands: the blue is the sea, the green is the land and the black is the people. The white dhari is the symbol that sits around and above the Star of David. The dhari is a traditional head-dress. The Star of David



has 5 points which is used as a navigational tool and represents the 5 provinces of the Torres Strait. The white colour of these two symbols signifies that we come in peace.

Favourite song?

My favourite song is Ngungalpa. When I heard it, it stuck in my mind. I teach it... I sing it. The song tells the story of a grandfather taking his grandson to the sea. Ngungalpa means "grandson". The grandfather explains to the grandson that he needs to get ready... that the sea is coming. When the sea arrives you eat from the sea to survive, and when you die your spirit will return to the sea.

What is the most important thing that people need to understand about Aboriginal and Torres Strait Islander people?

Respect. People need to learn to get along together... just as Aboriginal and Torres Strait Islander people have done since the beginning of time.

.....➤ Accreditation/CQI



At BCH we are always striving to improve and we are proud that we have been successfully accredited against the HACC and Quality Improvement and Community Services Accreditation (QICSA) standards since 2009. Part of the process of accreditation is to identify opportunities for improvement through continuous internal and external review of what we do. We then develop quality journals and implement changes to improve our services.

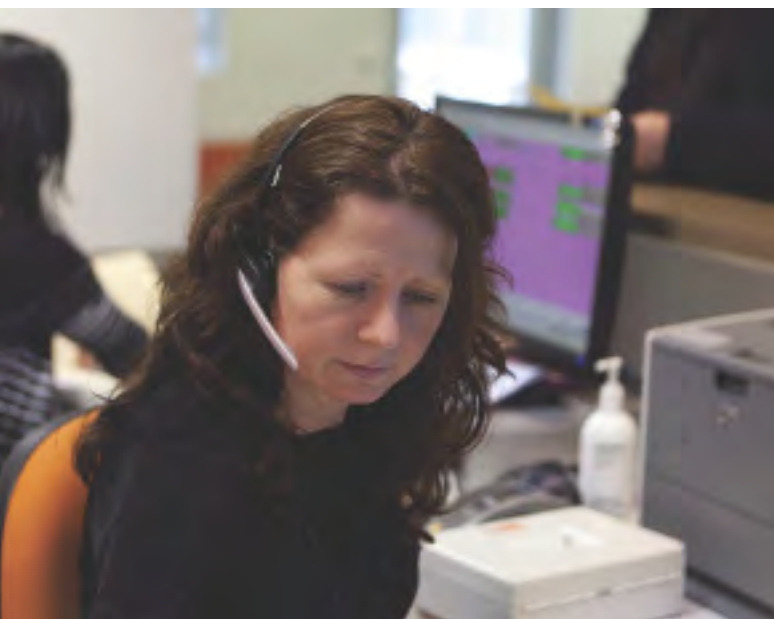
Since our last Quality of Care Report was published we have undergone our external mid cycle QICSA review to see how we are progressing with our action plan. The reviewer was pleased to note that our newly developed documentation to record how we Plan, Do, Check and Act will: "support future quality

initiatives and provide evidence of service coordination both internally and externally." This new system will help us to learn from our experiences and allow us to duplicate successes across a range of programs.

Since our last review our Quality Plan has been implemented with many areas reaching completion.

.....➤ Safety

Client Incidents



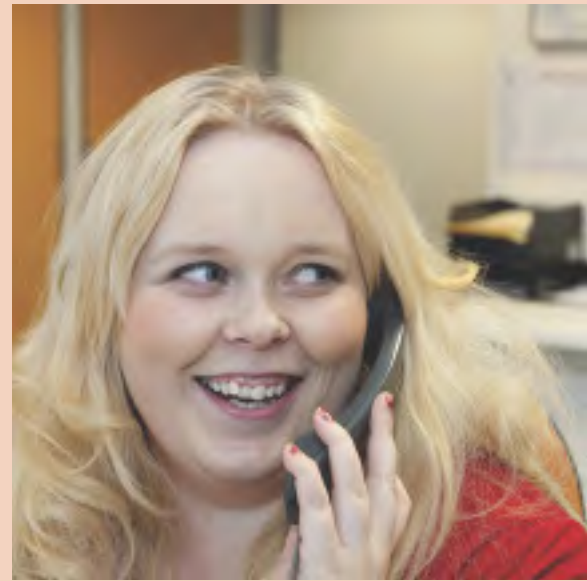
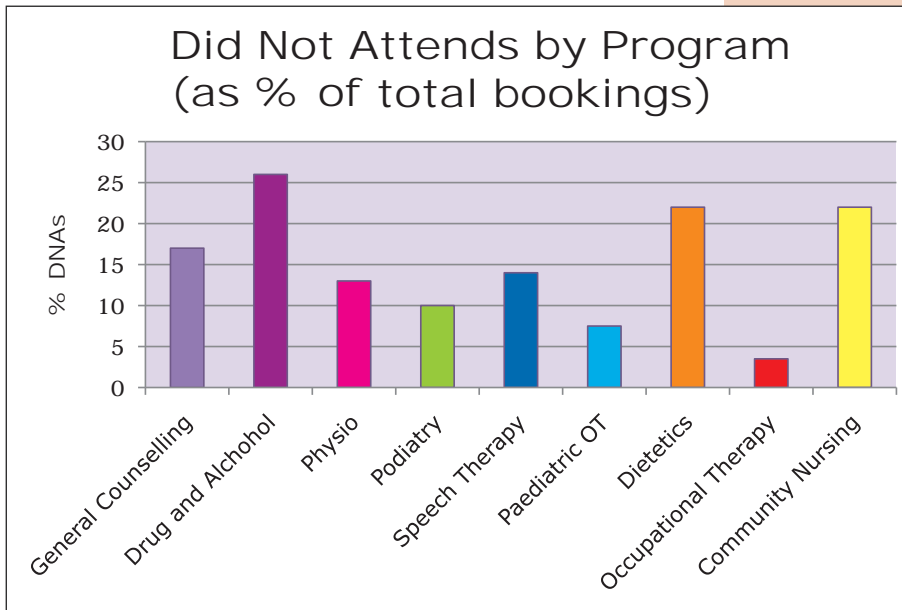
In October 2010, BCH moved to the Victorian Health Information Management System (VHIMS) for incident reporting. With VHIMS came a new system for rating incidents based on a severity rating of 1-4, with 1 being the most severe form of incident.

In the last 12 months, there have been 10 clinical incidents reported. The three incidents rated as Category 1 incidents were deaths offsite of clients of the Drug and Alcohol service, which the service is required to report. The remaining incidents involved:

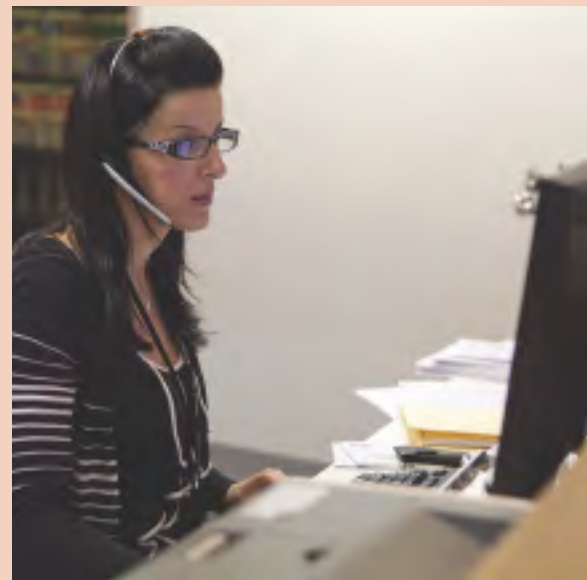
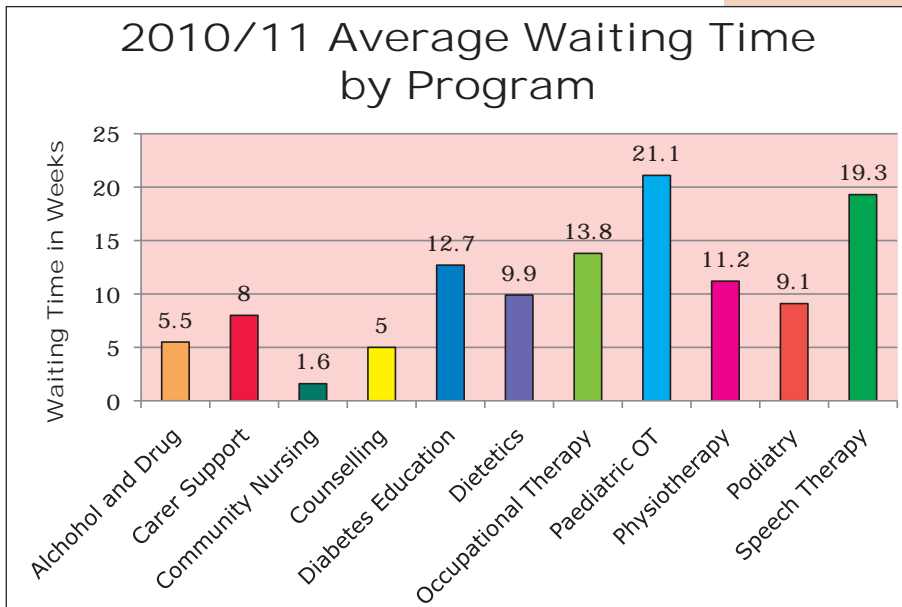
- Client fainting (5)
- Drug overdose in toilets requiring medical attention (1)
- Inappropriate access of medical record (1)

Efficiency

Missed appointments as a percentage of total appointment bookings



Waiting time (weeks) by program



Feedback:
 "Thanks Banyule Community Health for their care of us all"
 "It's very good"
 "Keep up the good work people"



Competence And *Education Of Staff*



Feedback:

"I reckon we are blessed as a community to have the place. Good work to all. The staff I have come across are very professional"

National registration and accreditation for ten health service professions came into operation in Australia on July 1 2010. In preparation for the scheme, BCH undertook to develop a Credentialing Policy and Procedure and Scope of Practice Policy and Procedure for gradual implementation into human resource and management practice.

Credentialing our staff involved ensuring that those clinicians affected were aware of their national registration requirements and implementing a formal process of checking certifications, training and experience on an annual basis.

Scope of Practice has required clinical areas to develop written core scope of practice for all of their clinical roles. These are based on the individual's credentials, competence, performance and professional suitability.

Going forward we will extend the scheme to include individual scope of practices allowing us to ensure staff are trained to do what they do and that they deliver the clinical service expected of their role. Specialist scope of Practice allows clinicians with additional skills to apply for a broader scope of practice.

Both credentialing and scope of practice feeds into supporting the risk management strategies of BCH including clinical governance and training and competence of our staff.

Staff training is offered to all staff and last year we provided 1293 hours of training.



.....➤ Infection Control



Keeping our service clean and minimising cross infection are an important part of what we do. This is particularly significant in our dental service where we regularly audit our clinician's practices and the sterilizing of our instruments. Each year an external assessor from HICMR audits us against a set of standards. This year we achieved an overall score of 90% which was an improvement on last years score of 85%.

The reviewer commented that:

"Overall standards within the sterilizing department were noted to be excellent demonstrated by the high compliance score for this assessment." 2011

The recommendations from the previous year were actioned successfully and we continue to strive for improvements each year.

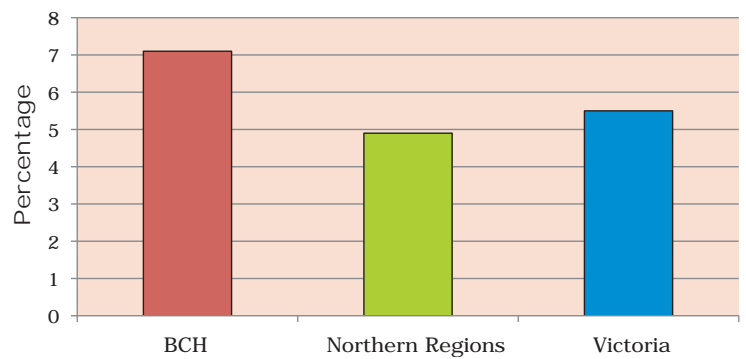
.....➤ Dental Indicators

A client who is assessed as requiring emergency care usually has a single appointment booked for management of their condition. A Repeat Emergency Care appointment may be made by the client within 28 days if the problem has not resolved. Dental staff may also rebook a client for a Repeat Emergency Care appointment at the time of the initial assessment if the client needs further investigations or has other medical problems such as infection that need treating prior to dental treatment. While the dental clinic at BCH has a higher percentage of repeat emergency care, the dentists are often working with complex clients who sometimes need to be seen more than once to gain the best outcome from treatment. The dentists are also committed to providing restorative care as far as possible, rather than quickly moving to an extraction, meaning the additional appointment(s) are necessary.

A client will normally present as an unplanned return after extraction if they are still getting pain or if the area is not healing properly. In this area, BCH is performing better than the Northern Region and the state.

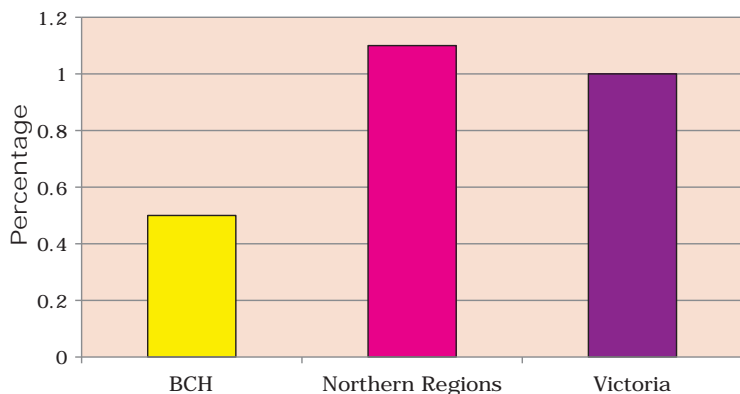
Repeat Emergency Care

% Repeat Emergency Care within 28 days under same course of care



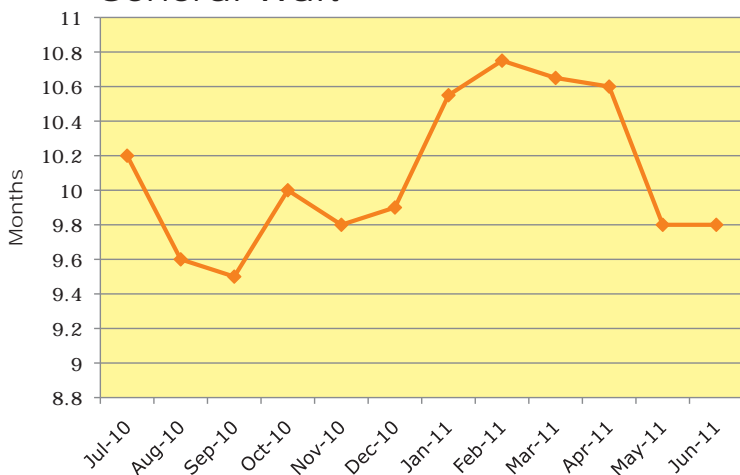
Unplanned return following an extraction

% unplanned return within 7 days subsequent to extraction



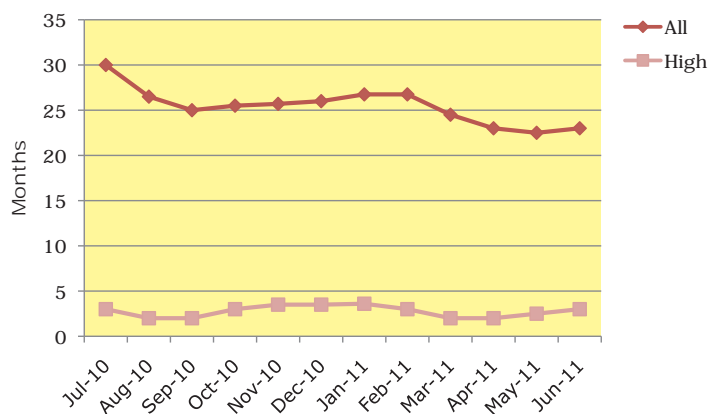
Waiting times

General Wait



The waiting time for dental appointments for general care 10 months averaged over the year.

Denture Wait



The average wait for dentures over 2010/11 was 25.2 months. This has gradually decreased over the 12 month period. The wait for dentures for people assessed as "high" need, averaged 2.4 months.

Providing dental care to clients in Supported Residential Services

Last year Dental Health Services Victoria in partnership with the Department of Health launched a state-wide initiative to improve access to oral health services for residents of pension – level Supported Residential Services (SRS). The Dental program at BCH was successful with their application for non recurrent funding and in August 2010 commenced to develop a new service model to improve the accessibility of oral health services for these clients.

Accessing dental services is often difficult for these clients due to limited income, lack of transport, disability, no family support and chronic health conditions.

In our local area of Banyule we have one pension-level Supported Residential Services (SRS), Chippendale Lodge, which currently has 30 registered beds. Dental staff visited the lodge to provide initial oral health assessments and oral health education. Last financial year, we had 2 residents attend the dental clinic for emergency treatment. Since this project began, 16 residents have attended the dental clinic for general dental treatment (examination, clean, fillings and dentures).

The funding enabled us to build rapport with staff and residents of Chippendale Lodge, prioritise residents for dental services, develop an SRS protocol for future dental care, and improve staff awareness of client needs and the challenges involved in accessing dental treatment.



.....➤ Evidence-based Care

The health promotion team have developed surveys to collect meaningful information for future program development. Two surveys were developed for routine measurement of (a) the impact of health promotion programs in the community and (b) consumer satisfaction with programs. These surveys contribute to a suite of additional measures used for specific projects and activities. The surveys were developed according to feedback from staff, who worked in varying areas of practice and consumers. Each commented on indicators and questions from sources that included: Quality of Care Report Indicators (2010), BCH Consumer Satisfaction Survey (2010) that was based on the Primary Health Care Consumer Opinion survey (LaTrobe University), Neighbourhood Renewal Community Survey (2011), evaluation work plans of the health promotion team and organisational frameworks for consumer participation and volunteering, Annual Community Survey of Maribyrnong City Council (2009), Victorian Population Health Survey (2008), Community Indicators Victoria, annual Australian Unity Wellbeing Index,

Assessment of Quality of Life (2000), survey of Community Cohesion Indicators: Sports, Arts & Cultural Wellbeing Projects and an American National Survey Indicators Database; domain Connection to informal social networks. Following methods of DeVaus (2002, Surveys in social research) some questions and scales of measurement were reframed to reduce bias. In the coming months the surveys will be distributed and thereafter form a process of routine application and review.

Feedback:
"This centre is better than others"
"Men's lunch every Friday great idea keep it up - ta"





.....▶ Health Promotion

What is Healthy & Active at Work?

Healthy & Active @ Work is an exciting new health initiative delivered by BCH. The aim of the project is to support employers in the North East to create workplace environments that foster and enhance employee health and wellbeing.

The project includes a free needs assessment to identify priority issues and wellbeing needs for employees. From the needs assessment strategies relevant to the workplace can be developed to bring about healthy behaviour changes in the workplace, including active transport (riding to work).

To date, the project has been rolled out across two workplaces, with another workplace coming on board in early September 2011. Results are positive with staff already drinking more water (having purchased an onsite water cooler) and implementing onsite health promotion sessions delivered by Allied Health Professionals from BCH.

For further information about Healthy & Active @ Work please contact Sarah Nichols or Irene Pfeiffer on 9450 2641 or via email: Sarah.Nichols@bchs.org.au and Irene.Pfeiffer@bchs.org.au



The Casino Bus Trips Project

In 2009 work by Gamblers Help Northern (GHN) identified that organised bus trips to the Casino by ethnic groups were increasing the vulnerability to problem gambling of some community members. GHN entered a partnership with Primary Care Partnerships to explore ways of addressing this issue.

The partnership began with research that counted actual spending by groups on Casino outings. Using an action research framework, the research effectively challenged the dominant perception that Casino trips are good value. Groups given information on actual outing cost made decisions to stop or reduce future Casino bus trips.

The action research methodology led to the expansion of the project to include a broader community based partnership with ethnic peak bodies, support services and associations. In addition, GHN worked with groups and associations to identify community based alternatives to Casino bus trips. This work led to the publication of the guide *Social Outings: Don't gamble with your group*. This guide is being promoted by way of a free public transport offer to groups interested in undertaking one of the identified outings. Currently, GHN are working with the Primary Care Partnership and local governments to translate a summary of the social outing guide into community languages to increase accessibility to all community members.

.....> Continuity of Care

Ante and post natal support (including share care)



Medical support & Immunisations – GP and clinic nurses
Immunisations - Banyule City Council



BANYULE
Community Health



Paediatric Occupational Therapy

MUMS Group



Paediatric Speech Therapy



School garden



Eat Well Play Well/Paediatric Dietetics



Early Years

"A good start in life means supporting mothers and young children: the health impact of early development and education lasts a lifetime" (World Health Organisation 2003 *Social determinants of health: the solid facts*)
BCH provide a wide range of services to mothers and babies. Targeting those most at risk, as well as services available to all.

Playgroups
- ATSI, Somali, Japanese & CPS Toy Box



Pre school and school dental



Family & Reproductive Rights Program (FARREP)

Feedback:

"Very happy with everything at the centre"
"Reception staff good"

Staff

Amina Hussein

– A Day in the Life of a Somali Community Worker



Amina was born in Somalia. Like so many from her country she fled during the Civil War in the early 1990's. Amina was a lucky one. She had a baby in Egypt and came to Australia to live. Amina is a Vet and has recently finished her Bachelor of Social Work. Her days are busy supporting Somali people in settling into a new country, coming to grips with new ways and systems and dealing with the pain and trauma of the refugee experience.

This is a day in the life of Amina at Banyule Community Health...

9.00am: I walk to work as I live just up the road. It's about a 300metre walk, but it seems to take me 30 minutes as I bump into my community dropping

children at kinder and school. No doubt they will catch me later in the day.

I check my messages. Already there are a few from people with issues. There are many housing issues and many community members worried about the situation back home in Somalia. Everyone has family and friends still over there. I also have emails and faxes to review. My work often involves advocacy for refugee families, so I'm in constant communication with agencies such as Legal Aid, Centrelink, Office of Housing and Department of Immigration.

9.30am: My first appointment is here. A woman who I have been seeing lately. She is a single mother with four young children. She has a range of issues I support her with. It's common for people to have many issues when they see me. We work through some housing issues; some school issues and discuss her own health. I'm worried that she is getting depressed, but Somali people don't really acknowledge this. We talk and I know she has friends and a sister. She attends a playgroup with her youngest, so she is well connected. It's a struggle though.

10.30am: My next appointment is waiting. I don't have bookings, people just drop in...it works best for the Somali people. It's a family who are working through the death of their mother. The death has had a significant impact on the family and I help linking them up with services and discuss arrangements with them. The death of a community member is significant for the community and everybody visits the family immediately after a death. The family now needs to get on top of other areas. It's tough for them and it raises memories of loss and disconnection to their homeland.

1.00pm: This afternoon I have a presentation of the FARREP Program to staff at the Northern Hospital in Epping. FARREP is a program that educates health workers and the community about the practice of Female Genital Mutilation. I have educated people about this practice for over a decade so I am able to talk quite easily about this topic and with great knowledge. I talk to nurses mainly who are all very interested about FGM. We target health professionals to raise awareness of populations of people who may have experienced FGM entering their services. We also target younger women and challenge old cultural beliefs about the practice. This program is an important health promotion program for people who are refugees from

Africa. I am lucky that I can balance the casework with the FARREP work.

I get a chance to talk with some of my colleagues. We are all very isolated in our roles, so we love to share stories and discuss our roles in the community sector.

3.30pm: I have had many missed calls while I'm out. It will be a busy day tomorrow. I have one more client to see. Another young mother with two young children. A three year old and an 18 month old. The baby has an illness that requires ongoing treatment at the Royal Children's Hospital. They are homeless and living with another community member in the lounge room. This type of support from the wider community is normal. I have helped with submitting a priority housing application and putting all of the supporting documents together. My client is desperate and checks twice a week if I have any news. I have to explain to her about the system...it's confusing. I call the Office of Housing and let them know of the urgency. It will be a little longer until this family are settled. Secure and appropriate housing is the key for refugees to have good health.

4.15pm: I write up my notes from the day and make a few calls. I often get asked to talk to groups and advise on cultural specific issues. I am happy to support where I can.

Clients by Postcode
In 2010-11, BCH provided 32,356 appointments. Of these 35% of contacts were with clients who come from postcode 3081: Bellfield, West Heidelberg and Heidelberg Heights. The next highest group by postcode were 11% from 3088: Greensborough.

Breast feeding story by Lara:

In 2008, I accepted a part-time position working at BCH. At the time, I had a little girl aged 6 months. Although I was very excited to accept the position, I was a little anxious about how I would balance motherhood and part-time work. I was particularly concerned about how I would manage the breastfeeding requirements of my baby. I can clearly recall walking to work on my very first day, with baby bottles in my bag and tears in my eyes, hoping it would all work out. I felt very relieved to have been met with the full support from my manager and team members to express breastmilk at the times I would have normally fed my baby at home. At this stage BCH did not have a designated breastfeeding space for staff. Immediately systems were put in place to allow me to have the private space I needed, and it all went smoothly. Importantly



for my family, my daughter was able to wean at her own pace and not forced away from breastmilk due to my work commitments. In 2010, my baby boy was born. I returned to BCH in 2011 when he was 8 months old. Once again I was met with full support to continue breastfeeding my baby. By this time BCH had also put in place a Breastfeeding Friendly Workplace policy and procedure, demonstrating organizational support of a mother's choice to return to work and also a commitment to family friendly workplace practices.

Two of Us Ian's Story

I first met Lisa at Nillumbik Community Health. When she moved to BCH, it suited me because I lived in Bundoora and already attended the Banyule Diabetes Support Group. I was diagnosed with diabetes in 1988. I tend to see Lisa about 3-4 times a year as part of my health care plan. I find her charming and personable and we always have a bit of a laugh and joke. In October 2009, during a regular visit with Lisa she noticed my ankles were swollen. In my typical "head in the sand" approach I told her "they're not swollen". Lisa told me to see my doctor. Thankfully between Lisa and my wife Roslyn, I saw my doctor within a couple of days and the next thing I was sent to the Cardiologist for tests. Before I knew it I was in St Vincent's getting 6 stents put in my heart. The swollen ankles were the early indicator of serious heart problems. Today I have 12 stents in my heart.

Lisa's observation saved my life! I wrote a letter to her CEO and told him that she saved my life. My head in the sand approach to managing my diabetes was going to lead me to

a heart attack or a stroke. Lisa and my health care team were able to give me a second chance. I've made changes to my life – I drink in moderation, eat in moderation (although I still love a sausage roll), I'm more active and manage my diabetes much better. My cholesterol is now 1.9 – it was up to 8. I attribute Lisa to extending my use by date.

I manage my own health by participating in a range of activities. I'm a member of the Banyule Diabetes Support Group where I try and help others understand that diabetes isn't a death sentence. We have a bit of fun, support each other and get education and tips from staff at BCH. I also volunteer with Bundoora Extended Care Centre in their "Settling in Service" as well as a Community Advisor to the Northern Health Board.

I feel in debt to Lisa. She is a very bright, sharp pocket sized hero to me. She starts everything with a smile and it's been a pleasure to see her grow into the talented professional she is today.

Ian Brown

Two of Us Lisa's Story

I started as a Podiatrist in community health as a new graduate at Nillumbik and then took the opportunity to work full time at BCH 5 years ago. I have a particular interest in diabetes. I try to educate my clients around diabetes and their foot health. The more informed people are, the more capable they are to identify any problems and prevent further complications.

I first started seeing Ian and Roslyn at Nillumbik Community Health for routine podiatry care 4-5 times a year and would do his annual diabetes foot assessment and report back to his GP. By having an annual foot assessment it allows the Podiatrist to monitor the progression of diabetes and to prevent any further complications to the feet.

Ian is always bubbly and happy when he comes to see me. He would always ask how I am and want to know what's been happening. Ian would visit regularly, but could be a little too relaxed about his health. He was also involved with the Banyule Diabetes Support Group. I would always remind him when he came to see me the things he should be looking out for and what he needed to do to

keep his feet healthy. I established a good rapport with Ian and his wife and felt they would take on any necessary advice I gave him even if he didn't practice it 100% of the time.

When Ian came to see me for one of his routine appointments in 2010, I notice swelling in his legs. Ian had never had this problem before. Without wanting to alarm Ian, I advised him that he should follow this up with his GP straight away, as this had never presented before. I was confident that Ian would follow through with seeing his GP as he would take on board my advice and I knew his wife Roslyn was also active in keeping Ian's health in check.

When Ian returned for his next podiatry appointment he advised me that his GP had sent him off to see a Cardiologist and he was scheduled to have stress test. Once Ian had the stents put in, he reported how much better he felt, how he did not feel as tired and was motivated more due to having increased energy. Ian was very grateful that I had picked up the swelling in his feet but ultimately Ian should be grateful to himself (and Roslyn) for following through with the recommended care and advice.

Lisa Bell (BCH Podiatrist)



Sharleen Cook:

Francis Baum Fellowship Recipient 2010

I was lucky to be the recipient of the 2010 Francis Baum scholarship. This has allowed me to study for a Certificate in Initiatic Art Therapy over two years. Initiatic, means initiation, the awakening of inner perception. Art therapy uses a range of materials such as crayons, paint, collage and clay to explore and access inner experiences. It does not require any artistic experience by the participants. Art therapy can be used to express, nurture and inspire individuals. So far I have attended two residential weekend workshops. A benefit to me has been to meet other professionals in the health and welfare area who like me are looking at how to incorporate art therapy into their daily practice and being able to support each other. I have been able to apply what I have learnt in a variety of settings. So far I have implemented art therapy into group settings with women whom I work with on a regular basis and another group in which I had never met the clients before around issues of depression, anxiety and domestic violent. Our Mum's Well Being Group has been using art therapy and will hopefully hold an exhibition at the centre later in the year. The feedback from clients has been overwhelmingly positive.

Currently I am also in the process of developing ideas with clients for working on an art therapy project that will allow our clients to tell their story to the community.



Feedback:

"Most helpful, Good service"
"One of the best No 1"



BCH Oxfam Trail Walkers

You may have seen some BCH members walking around the streets with backpack, water packs and headlights on and wondered what on earth they were doing... well, they were in training for the Oxfam 100km trail walk. The event took place on Friday 1st - Sunday 3rd April and the aim was to walk a total of 100km each, in teams of 4, within 48 hours.

BCH had 3 teams take part - 'Banyule A Team' (Leanne, Mia, Karen, Sarah), 'Banyule Bees Knees' (Susan, Rob, Dana, Anna) and 'Banyule on the move' (Rachel, Mary, Lev, Marita) and we're pleased to report that all 3 teams made it across the finish line!

It's been great that other BCH workers joined them in their training - going along for the 'walks'.

Congratulations on your journey, we look forward to seeing who participates in 2012!

Our services, Our groups

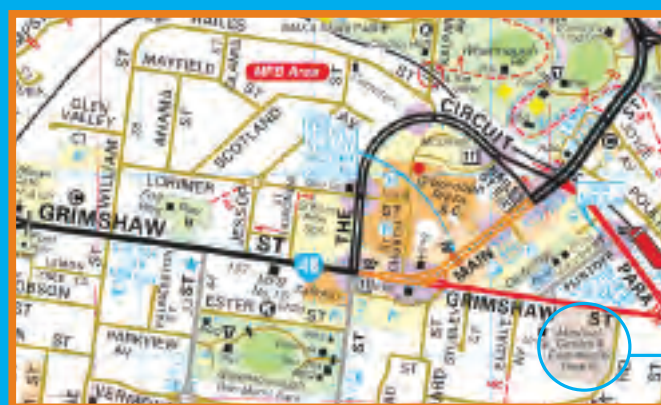
- | | |
|--|--|
| Carer Support Network | Needle & Syringe Program |
| Clinic Nurse | Neighbourhood Renewal |
| Community Choir | NEODAS (Drug & Alcohol) |
| Community Health Nursing | Community Midwifery Service |
| Dietetics | Dental Services |
| Emergency Relief | Northern Region Home & Community Care |
| Family & Reproductive Rights Program (FARREP) | Dietetic Services |
| Financial Counselling | Personal Support Service - Migrant Resource Centre |
| Gambler's Help | Occupational Therapy |
| General Counselling | Olympic Adult Education Program |
| HARP program: Chronic Disease Management Program | Paediatric Occupational Therapy |
| HARP program: North East Diabetes Service | Pharmacotherapy |
| HARP program: Community Link - Rapid Response | Physiotherapy |
| Health For Life | Podiatry |
| Intake | Somali Men's Planned Activity Group (PAG) |
| Medical Service | Speech Pathology |
| Men's Shed | WorkHealth Checks Program |
| Men's Lunch | |

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