Better health, Better lifestyles, Stronger communities

2010 Quality of Care REPORT

What's inside:

Latrobe Community Health Service
Gippsland Wide

What's in our report

Better health, Better

Foreword

Welcome to our Quality of Care Report for 2009-10. This report documents our achievements, and also looks to the future by reporting on areas in which we can improve. We are committed to providing high quality, safe services to Gippsland.

It has been a very exciting year with the recent completion of our state of the art, custom designed building in Morwell. This building allows us to dramatically extend our programs and service throughout Gippsland.

This report has a wide distribution that has been selected to reach as much of the Gippsland community as possible. Five hundred copies of this report will be printed and provided to our members, key stakeholders as well as copies being sent to all local health community organisations across Gippsland. Additionally this report will be published electronically on our web site at www.lchs.com.au and a report summary will be advertised in the five major regional newspapers across Gippsland. Copies will be made available at all Latrobe Community Health Service sites. Based on community feedback, we will assess the success of this distribution method and make improvements in the future. In our report last year, we asked for feedback either by telephone, email or via our website.

Unfortunately we did not receive any feedback. We value your feedback and would like to hear from you so we invite you to let us know how we can improve this report next year. To provide feedback, please talk to our Quality Staff on 1800 242 696, email feedback@lchs.com.au or click on the link for feedback on our website.

Thank you to the integrated efforts of our staff, volunteers, our valued clients, our community and our key stakeholders in compiling this report. We trust it provides you with a greater understanding of Latrobe Community Health Service. We look forward to working with you and the greater Gippsland community to deliver high quality and safe community health services well into the future.

Ben Leigh
Chief Executive Officer

John Guy
Chairperson

We would like to thank the following people who contributed their photos of Gippsland to this report:
• Amelia Taylor • Barb Ritchie • Bronwyn Pulis • Carina Harris • Jacqueline Eddy • Julie Aitken • Liyin Weckmann • Judy Vanvelzen • Sue Medson

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Section 1

Welcome to Latrobe Community Health Service

1.1

The main issues affecting our community

The following points are some of the major health issues that are affecting the Gippsland community. Each of these health issues are addressed in this report.

1. Providing an integrated community health service.
2. Mental health, in particular dementia and our aged community.
3. Providing quality carer services.
4. Improving Indigenous health.
5. Oral health.
6. Better management of chronic disease.

1.2 Our community at a glance

Latrobe Community Health Service offers services to the whole of Gippsland.

The region covers 41,583 square kilometres and includes large regional cities, smaller regional towns plus rural and remote areas. The population of Gippsland in 2006 was an estimated 250,589 or 5% of Victoria's population. Current trends project that Gippsland's population will grow by 5.7%, or 14,300 people between 2006 and 2016.

The size and remoteness of our region provides barriers when accessing quality health services for some members of our community such as the aged, the young and the mobility impaired. The average age of people in Gippsland is 38.9 years compared with 36 years for Victoria. The percentage of people aged over 65 is expected to increase from 15.3% in 2001 to 24.1% in 2016.

North Gippsland
Noojee

North Gippsland
Thomson Dam

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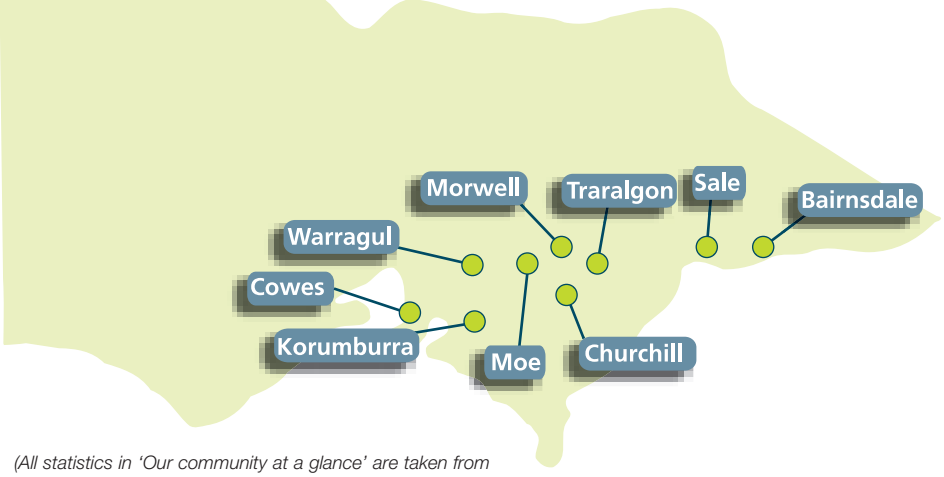
Gippsland experiences high levels of socio economic disadvantage when compared to the rest of Victoria. The Latrobe Local Government Area is ranked the sixth most highly disadvantaged in Victoria, while East Gippsland is ranked 14th and Bass Coast 18th.

Gippsland has residents from a wide mix of cultural backgrounds and is home to the Gunnai/Kurnai people who are the traditional owners and custodians of the land. Aboriginal and Torres Strait Islander communities make up an estimated 1.24% of the Gippsland population which is more than double the Victorian average.

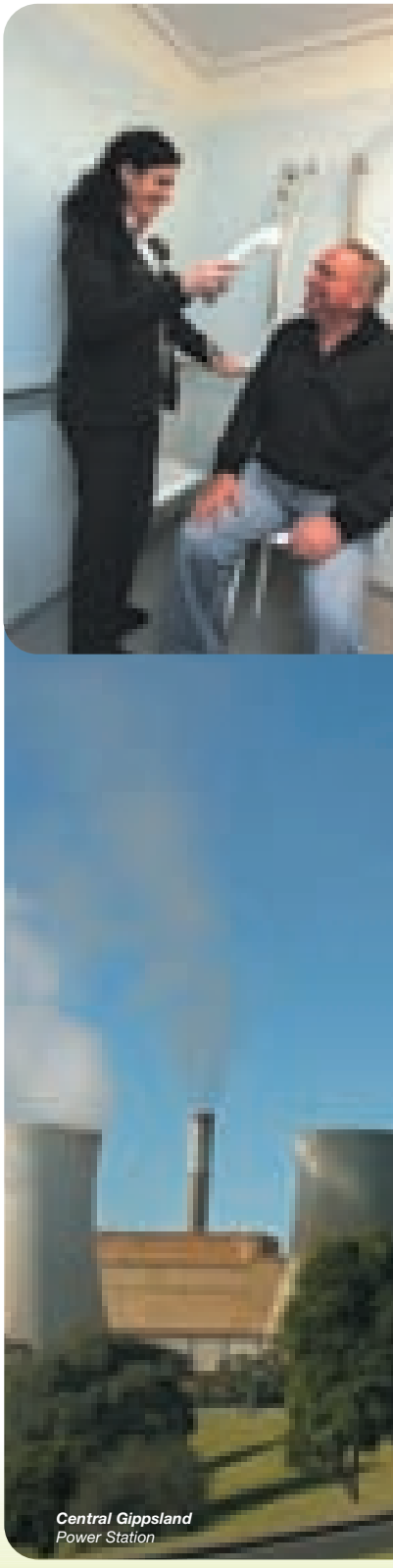
While 85% of our clients speak English we have a significant migrant population. Other community languages spoken include Italian, Greek, Polish, Arabic, Dutch, Maltese and German.

Over the last couple of years there has been a steady increase in the use of our services by Sudanese humanitarian arrivals in our community.

Gippsland has a high degree of health risk due to smoking, obesity and lack of exercise. Alcohol and other drug usage appear to also have a big impact on the health and well being of the community. Mental illness, neurological and sense disorders are the most common cause of 'disability' for most age groups including children under 14 years of age. The rate of dental hospital admissions in Gippsland is 4.40 per 1000 people, which is almost double the state average. The rate for diabetes hospital admissions is also approximately 170% compared with the Victorian average.



(All statistics in 'Our community at a glance' are taken from Latrobe Community Health Service: Facts and Foresight, HDG Consulting Group, June 2007)



Central Gippsland
Power Station

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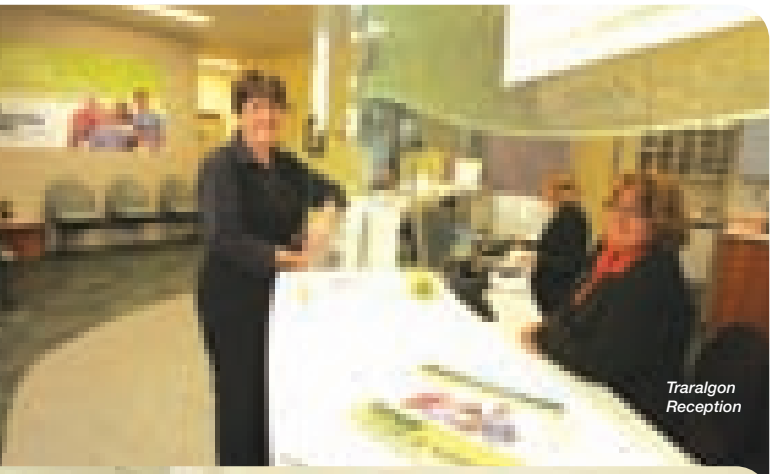

Traralgon Reception

Warragul Reception

Moe Reception

1.3 How we help you

In response to community need and demand, the number of programs we offer continues to grow.

In 2009-10 we:

- responded to 27,193 referrals from Service Access compared with 26,807 in 2008-09. This provided an opening to over 100 services or programs across Gippsland

- answered over 100,000 phone calls, an average of 2,000 calls each week.

When the Australian Government increased its advertising awareness campaign for the Commonwealth Respite and Carelink Centres during 2009-10, our number of referrals followed suit. Additionally we improved our referral process and communications with our local GPs and worked in partnership with the Central West Gippsland Division of General Practice. This created over 3,200 referrals being received and processed by us; that is an increase of 220% on 2008-09.

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Section 2

Involving the whole community

2.1 Working with the Koorie community

Latrobe Community Health Service is committed to improving the health of Koorie people in Gippsland. As the traditional owners and custodians of the land, Koorie people have a significant and special place within the community. We are developing greater cultural understanding within our workplace and becoming increasingly involved with the Koorie community. Together with Indigenous leaders we work to make sure we are a culturally sensitive organisation providing responsive and appropriate services that meet their needs.

Together we are actively developing relationships, strengthening bonds and working to improve Indigenous health as outlined in our 'Engaging Koorie People Plan'. A key focus of this plan is increasing the number of Koorie people accessing our services.

To move forward we have formed partnerships and held joint events with local Indigenous organisations. This ensures our information is readily available and accessible and creates more opportunities to get to know each other.

Of high importance is our relationship with Gippsland and East Gippsland Aboriginal Co-operative, Ramahyuck District Aboriginal Corporation and Wulgunggo Ngalu. Together we continued to develop this important bond throughout 2009-10 to improve Indigenous health.

A year of achievements

We are proud to report on the visible achievements resulting from the 'Engaging Koorie People Plan'. These include:

- flying the Koorie flag at our offices in Morwell and Traralgon
- unveiling plaques at each of our sites recognising the Gunnai/Kurnai people as traditional owners and custodians of our land
- displaying local Koorie artworks at each of our sites
- hosting Koorie Open House Days where we share lunch with the Koorie community and host information sessions on a range of relevant health issues. Examples of these include:
  - 'Stay Healthy Latrobe' – A program that assists in the management of chronic diseases.We have focused on Diabetes, Podiatry and Dietetics.
  - 'Meet, Greet and Eat' – This was held by Gambler's Help Gippsland at Nindedana Quaranook, Ramahyuck District Aboriginal Corporation.
  - Ambulatory Care – Information about our in-home nursing services.

We involved the local Koorie community in the planning of our Morwell office redevelopment, particularly focusing on the outdoor reflective garden and internal courtyard gardens.

'Meet Greet and Eat'
Nina McDonough-Monahan, Central Gippsland Aboriginal Health Services, Ramahyuck District Aboriginal Corporation; Shiralee Hood; Aunty Sarah Morgan and the Gambler's Help Gippsland team at the 'Meet, Greet and Eat' Open House Day.

The 'Koorie Cultural Awareness Program' has been rolled out across Latrobe Community Health Service, with six interactive sessions held throughout 2009-10. Our staff found this a valuable and rewarding experience. Information has been included about Koorie services at orientation sessions.

Reconciliation Week
LCHS staff and Executive Team with Wayne Thorpe and a representative from ANTaR at our Reconciliation Week event.

We actively recognise and celebrate many important dates in the Koorie calendar. Together we celebrated Sorry Day, Close the Gap Day and Reconciliation Week as well as participating in NAIDOC week events locally.

Creating cultural awareness

This year we worked in partnership with the GippsTAFE Koorie Unit and the local Koorie community to develop a 'Cultural Awareness Program'.

This program covers the Gunnai/Kurnai history and provides relevant local information to our staff. The program is developing an understanding of Indigenous people and their rich heritage. Doris Paton, a Gunnai/Monaro/Ngarigo woman with strong family connections to Gippsland worked with us and presents this program.

Reconciliation Week
ANTaR's "Sea of Hands" symbolising the people's movements towards reconciliation.

Reconciliation Week
Kathy Dalton performing a traditional Smoking Ceremony.

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A family day to remember

In partnership with Latrobe City Council Best Start Project, Ramahyuck District Aboriginal Corporation, Gippsland and East Gippsland Aboriginal Co-operative, and Latrobe Valley Aboriginal Community Services Association we celebrated Reconciliation Week with a special Family Day at Kernot Hall. Over 230 people attended and had fun, celebrated together and enjoyed activities and entertainment that brought young and old together to share and teach Koorie culture.

The day featured an opportunity for people to make their own pledge towards reconciliation. They could plant a plastic coloured hand in the earth as part of the ongoing '*Sea of Hands'* campaign run by Australians for Native Title and Reconciliation (ANTaR) to symbolise the people's movement for reconciliation. Kathy Dalton and Ronald Edwards provided 'Welcome to Country', with a highlight of the day being the outstanding performance of the Dedlee Kultya dance group.

Reconciliation Week
Members of 'Dedlee Kultya' talking to the local media about what Reconcilation Week means to them.

Reconciliation Week
'Dedlee Kultya' performing in front of over 250 people at Reconciliation Week.

'Mums and Bubs' tobacco cessation project

This financial year we received funding from the Australian Government for a three year project to reduce tobacco use by pregnant Koorie women. During the year we carried out a literature review and worked alongside a number of local Koorie women to seek advice and input into the development of this important community program.

When completed, this project will deliver a package of information that helps reduce tobacco use in pregnant Koorie women. The package will included a DVD produced by Koorie women as well as a smoking cessation program in conjunction with GippsTAFE.

'Mums and Bubs' artwork
This artwork, created by local artist Alice Pepper, was designed to reflect the concept of the 'Mums and Bubs' cessation project and will be used throughout the project.

lifestyles, Stronger communities

'Bragun Men'
Cliff showing off the catch of the day.

'Bragun Men'
Cliff, Goomy and Jingles fishing at Port Phillip Bay.

Creating healthier lifestyles

We initiated a local Koorie Men's and Women's Group in the Latrobe Valley this year.
This important program is a partnership between our Drug Treatment, Health Promotion and Education staff and the Gippsland and East Gippsland Aboriginal Cooperative.

Together we are providing activities in a culturally safe and substance free environment. The groups are promoting healthy active lifestyles and social links while providing forums for discussion around community issues, cultural strengthening and celebrating culture.

An important part of this program is to identify and support leadership within the local Koorie community by encouraging ownership of the group. All activities and agendas are set by each group.

Introducing the Bragun Men

The term Bragun means 'Brothers on the same track'.
The Bragun Men decided they wanted to focus on:

- physical health
- mind health
- social health
- spiritual health.

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South Gippsland
Port Albert

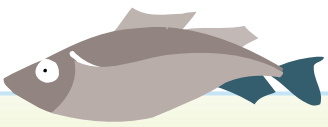
South Gippsland
Cape Woolamai

South Gippsland
Conran

The Bragun Men go fishing

On a cool rainy November day, a minibus and car loaded with 17 men from the local Koorie community went on a fishing trip to Port Phillip Bay. For many this was their first fishing experience on a boat. Salad rolls, fruit and water were the order of the day.

Aged between 12 and 65, the men decided that no alcohol would be involved in these activities. This day was to be about strengthening respectful relationships, having fun and a good laugh without alcohol. This encouraged a culturally appropriate environment where men could talk about issues affecting their community. Once all the fish they could reel in were caught, the catch was distributed amongst the men and taken home to share with their families.



Introducing the 'Deadly Migais'

Comprising local Koorie women, this group calls themselves the 'Deadly Migais' which means 'Deadly Women'.

The 'Deadly Migais' are an active group. This year, they held a series of information days over a six month period. Every two weeks they met and planned healthy lifestyle activities while developing their 'Quilt of Knowledge'. The 'Quilt of Knowledge' encourages women from the community to write, draw or sew some words of advice or wisdom onto squares of fabric. Each square is to be sewn together to form the 'Quilt of Knowledge'. The 'Deadly Migais' are planning to allow the 'Quilt of Knowledge' to be displayed around the community at different locations.

lifestyles, Stronger communities

'Deadly Migais'
Margaret Oates and Karen Mobourne during Sisters Stylin it up.

The 'Deadly Migais'
Members of the Deadly Migais with LCHS staff.

'Sisters Stylin' Up'

'Sisters Stylin' Up' was held by the 'Deadly Migais' at Woolum Bellum - Koorie Open Door Education campus, as part of Gippsland's NAIDOC celebrations. It was a successful day and was attended by 40 women; 15 under the age of 21.

The women participated in activities including:

- applying makeup
- massage
- nail art
- hair styling
- hair removal
- hair colouring
- preparing healthy and nutritious food.

A local beauty therapist and her assistant attended and provided the women with tips on personal beauty care. It was a great opportunity to get advice on managing issues that impact on self confidence, self esteem and personal care in a safe, comfortable environment. A massage therapist was present during the day and was kept extremely busy providing the women with relaxation. The day was filled with sharing of knowledge, stories and interactions with each other in a safe and substance free environment while enjoying nutritious food and some quality pampering.

The feedback received was positive and the women said they enjoyed the day saying the personal skills and increased self confidence was valuable. They enjoyed the chance to sit and have a yarn with other women in the community. The women are planning to hold this event again in the near future.

2.2 Supporting carers

Australia has almost 2.6 million carers, and nearly 500,000 of these are primary carers.

In Gippsland more and more people are providing care and support for their spouse, partner, parent, relative, child with additional needs, neighbour or friend. It generally happens when somebody close can no longer do the things they used to do or look after themselves adequately and have to rely on someone else for their physical and emotional wellbeing.

We provide support services for carers living within our community. This includes providing respite where we help to look after the person they care for, so they can have a well deserved break.

Identifying how we could help carers
To ensure our services continue to meet carers' needs we wanted to find out more about their experiences, including the frustrations, joys and needs. This year we conducted small discussion groups across Gippsland and together carers shared their personal stories and experiences with us.

By listening to their stories we found ways to improve how we provide services to them, and how to reach out to the 'hidden' carers in our community who could really use some support.

Our first step was to bring carers together in small discussion groups across Gippsland so we could develop a greater understanding of their issues and consequently provide a better service to carers. Each person had a unique story to tell us and we discovered some very common themes.

These were:

What caring means
- Caring was seen as a role or a duty, one that you accept and carry out.
- Indentifying yourself as a carer can take time.

Adapting to change
- Carers felt a sense of loneliness and isolation.
- Relationships and social interaction with carers and their social circle change. Many people said their friends dropped off and their life 'just stopped' when their partner required care.
- Women who had a close relationship with their partner before they got ill felt like they lost their 'best friend', as they could no longer rely on their partner, or talk with them in a meaningful way and share their daily thoughts, let alone their longer term hopes, dreams and aspirations.

The GPs role
- The family GP was often the first person to realise that a carer needed support services.
- A good relationship with the GP was seen as vital.

Finding a way through the service maze
- Finding support was seen as an overwhelming task, in particular understanding what is available, who provides it and how to get it.
- Once they do start receiving services, carers feel like they are hit with 'information overload' and they often do not have the time and/or energy to go through it all.

"One carer said, a representative from Carer Support rang me and I nearly dropped the phone when she said she was offering a service for me. For ME! (not my partner) I couldn't believe it! What a Godsend."

East Gippsland
Mallacoota

Making services easier to access and understand

- Helping carers understand that the service is for them, not the person they are looking after was seen as critical as many assume it is the other way around.
- A coordinated approach to the types of Carer Services available was seen as beneficial, so their story did not have to be told over and over again to different people.
- Service providers need to be persistent in trying to make contact as carers are busy and overwhelmed much of the time.
- Service providers should avoid using jargon when dealing with carers.

Breaking down the emotional barriers

- Asking for and receiving services could be a difficult decision. It brought up many emotions, in particular guilt for some people.
- Many carers are simply 'worn out', and are often deprived of sleep. A good night's sleep was on top of their wish list.
- The ideal was to have a service provider who understands their needs and wants and willingly/happily provides the service in a way which enables the carer to feel good about themselves.

Accurate assessment is critical

- Carers said they want people who are experienced and knowledgeable, both about people and the service system.
- It was seen as imperative that when making an assessment to always check with the carer regarding the individuals independence, as the person cared for often puts on their 'best front'.

Social support is necessary

- Being able to talk with other people in similar situations, who are able to understand and empathise with their situation was highly valued.
- Being able to reach out to others, and ask for help when they need it without feeling like they have failed, or feeling guilty was treasured by the participants.

Carer Focus groups
Carers sharing their personal stories and experiences at one of the many small discussion groups held around Gippsland.

The future of carer support

Carers have provided us with great insights into their issues and we are now using this in the planning and delivery of our services to better meet their needs. We have:

- developed new promotional material based on the words and images carers have chosen so we can reach out and connect with more carers in our community

Better health, Better

- become more personalised in our service and we are more persistent when helping people as we have a better understanding of the exact pressures facing carers
- formed a Carers Reference Group for the Gippsland region so we can receive ongoing feedback for planning services and developing new programs. This means we can continue to improve our services to better support carers and ease the burden in caring for loved ones.

Developing strategies for carers of people with dementia

During 2009-10 we ran 'Creative Ways to Care' workshops in Morwell, Wonthaggi, Sale, Warragul and Bairnsdale with 35 carers. We aimed to assist carers who were upset or stressed from behaviours associated with dementia such as wandering, restlessness, repetitive questioning, resistance, withdrawal, boredom and isolation.

The program was developed in 2008 by the Commonwealth Respite and Carelink Centre Southern Region. It comprises six workshops and is a great place for carers to learn about and connect to the many services which are available in their area. We are going to continue to roll this program out across Gippsland over the coming year.

Many carers who were unaware of the services provided by the Commonwealth Respite and Carelink Centre (Carer Services) have now registered for services provided by us and other organisations. Some carers have also accepted Case Management Packages.

"Most of us have skills that we don't realise we have and this course brings them to the forefront. It also exposes you to other people in similar situations."

'Creative Ways to Care'
Stimulating and soothing the senses can affect physical and emotional wellbeing.

Many carers in the workshops have maintained friendships and contact with each other after the workshops have finished. In some cases they have gone on to form their own support groups which continue to meet on a regular basis.

South Gippsland
Thorpdale

"We have gained knowledge, confidence and hope and look forward to the days ahead instead of dreading them."

2.3 Welcoming new arrivals

Welcoming new arrivals
Teny Ngouth, a dedicated Service Access Officer, is the key link between LCHS and the Sudanese community

The number of Sudanese humanitarian arrivals across Gippsland has continued to increase over the last 12 months.

Cultural and language barriers have created difficulties for the newly arrived to access community health services.

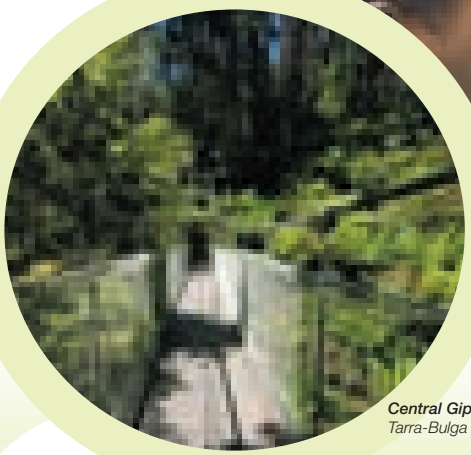
We are dedicated to ensuring help is available for the Sudanese community:

- The number of new Sudanese clients we see increased over 250%, from 19 in 2008 to 49 in 2009. This trend is expected to continue and even double in 2010.
- We have employed Teny Ngouth, a dedicated Service Access Officer to be the key link between our services and the Sudanese community.
- We are building stronger community relations and providing information that is relevant and easy to understand.
- We are making referrals to service providers, interpreting to assist with service provision and providing advocacy within the local community.

Mr Banthon Ayei has experienced first hand the benefit of having a new arrival Service Access Officer available to assist him and his family, and shares his experience with us.

"The number of new Sudanese clients we see increased over 250%, from 19 in 2008 to 49 in 2009. This trend is expected to continue and even double in 2010."

Welcoming new arrivals
Teny Ngouth working with Mr Banthon Ayei explaining what services are available.



Central Gippsland
Tarra-Bulga National Park

Better health, Better

Introducing Mr Banthon Ayei

Welcoming new arrivals
Mr Banthon Ayei

Prior to arriving in Australia, what was your life like in Sudan? Working, studying and family life?

Life in Sudan was very bad, because of the regime or legacy of colonisation that was brought against the Southern Sudanese. During my study at Juba University in Khartoum, the capital city of Sudan, I was forced to join Islam and study Koran at University level. But because I refused to study Koran, I was forced by the military regime to leave my study at University.

When I was in Khartoum, it was difficult to find a job. As a University student who had obtained nursing qualifications and experiences, I was not given a chance to work in any government institution, just because I was not a Muslim. For that reason it was difficult for me and my family to survive while in Khartoum. I was then accepted to do my Bachelor of Medicine. In my fourth year as a medical student, I decided to leave Sudan and go to Egypt where I was given refuge and protection by the UNHCR until I got a chance to come to Australia in 2004.

When you arrived in Australia, what were your biggest challenges?

- The English language.
- Integration to the new system, culture and even new life.
- It was hard to get a job because of the language barrier, my lack of skills and experience.

What difference has it made discovering that Latrobe Community Health Service has a dedicated New Arrivals Service Access Officer?

This new program has contributed very significantly to our community. Since Teny was employed as New Arrivals Service Access Officer everything was very easy for us especially for our community members who are living in four different places in Latrobe Valley which are Moe, Morwell, Traralgon and Churchill.

This New Arrivals program had not only assisted the Sudanese community to cope with financial difficulties, but it has also minimised a lot of stress and trauma for those who are unable to manage their finances.

What benefits have you heard discussed within the Sudanese Community since Teny's arrival?

The benefits discussed when Teny first arrived at Latrobe Community Health Service was that it is important to support Teny and cooperate with him as well as Latrobe Community Health Service so that the relationship between the Sudanese community and Latrobe Community Health Service is built with a strong basis. The community also discussed the important role the Latrobe Community Health Service played in assisting many Sudanese families 'without sending them with empty hands' when they present at any Latrobe Community Health Service sites.

The community is very happy to see Latrobe Community Health Service continuing to support them and they ask Latrobe Community Health Service to continue with that support.

2.4 Improving palliative care

"Thanks to your feedback our nurses are being trained to provide both palliative and district nursing services, resulting in an increase of nurses who are able to provide palliative care on a daily basis."

A significant change to services over the last year was the merger of our Palliative Care and District Nursing teams.

Previously these teams worked separately. Following feedback from carers and GPs and a formal assessment, these teams were combined to create an integrated and coordinated service to provide better care for our clients and the Gippsland community.

Actively listening to the community

We conducted in depth research with carers in order to identify the best outcomes for people who require our palliative care and district nursing service. We interviewed carers about their concerns and complaints and how we could better provide information and support to them.

We interviewed local GPs about our palliative care service, including what they could expect and what services we provide.

We also arranged a palliative care forum with the local Koorie community. We looked at how we could make sure our clients and carers knew what other health services were available and support our staff in referring to other services.

We looked at the structure of our team to make sure that we had more staff who were skilled and better able to communicate with other services. Our specialist team now has a Social Worker and an Occupational Therapist with a Senior Palliative Care Nurse who oversees the program.

Recently we integrated specialist palliative care Doctors as part of our team. These specialist doctors are communicating with us on a weekly basis and once a month they come from Melbourne to work with our team and our local GPs. Their role is to review client care and provide ongoing education and support to our staff and local GPs.

Providing meaningful information

Based on feedback from carers, we have developed two palliative care booklets to support our clients and carers at home. The carers who provided feedback were involved in reviewing the information to ensure it was relevant, understandable and that it met their specific needs. These booklets are now offered to every palliative care carer and are made available to other health services and local GPs.

Palliative Care Booklets
Based on feedback from carers we have developed two palliative care booklets to support our clients and carers at home.

Building relationships with other health care professionals

Together with the Central West Gippsland Division of General Practice, we developed a palliative care information package and visited 42 GPs and their staff. Our aim was to ensure other health care professionals were better informed of the services we provide. Local GPs reported these visits as very successful and informative. To support our visits we now regularly communicate with GPs through a regular newsletter informing them about what is happening in palliative care.

We understand that GPs are busy so we send our nurses out to meet with GPs in order to better discuss individual client care. In many cases, our nurses are now arranging to meet with our clients and their family GP at the same time, making sure client care is planned together. This is a great outcome and a significant improvement to our service.

Developing connections with the Koorie community

In April 2010 we conducted a palliative care forum with the local Koorie community. Thirty local Koorie people and 11 Koorie workers attended. A number of Koorie speakers shared moving stories of their personal experiences with death and dying.

Through this forum we have commenced a group which helps us to provide better palliative care services to the local Koorie community. We have recently employed a new staff member who is a Koorie Allied Health Assistant, to continue to improve communication.

East Gippsland
Mallacoota

Better communication and referrals

Over the past year we have increased the number of other services involved with palliative care clients and their carers. This has included Carer Respite, Occupational Therapy, Physiotherapy and Dietitians. We have actively worked on improving communication with our local hospitals and GPs. An example is our work with Carer Services providing weekend away packages and massage packages for our palliative care clients and their carers. We are also working with Counselling Services to develop better access to grief and bereavement services for clients and their carers.

Koorie Palliative Care Forum
Nicole Steers, Leonie Riddle, Anne-Maree Kaser. Troy McDonald, Sharyn Thompson, Aunty Jenny Solomon, Aunty Sarah Morgan, Kathy Dalton and Aunty Esme Thompson at the Koorie Palliative Care forum held in April.

lifestyles, Stronger communities

2.5 Healthy body, healthy mind

There are many challenges associated with ageing. To address this, we set up a technology program to keep our older clients healthy, happy and active using modern technology.

An innovative exercise environment has been introduced using virtual reality environments to stimulate exercise for Planned Activity Group clients. Video-captured virtual reality provides a way for our Planned Activity Group clients to engage in enjoyable and independent physical activity. Our Planned Activity Group clients take part in activities that are repetitive, safe, motivating and give task-specific feedback to increase mobility.

"I really like singing along to YouTube"

Virtual reality provides clients with the opportunity to experience things that appear and feel similar to real-world objects and events. They interact with displayed images, move and manipulate virtual objects and perform other actions in a way that feels real. Virtual environments like fish tanks or rainforests are displayed on the television during the sessions as a way to calm participants who are suffering from dementia and to stimulate happy memories.

The use of video game consoles and games are helping to keep clients' minds active with many games being used to help stimulate the brain through simple mathematics, drawing on touch screens and reading out loud. We also use the internet to enhance knowledge and foster emotional wellbeing.

They are using Google Earth to visit places of interest and go on virtual holidays and use YouTube to listen to music and watch video clips.

Minds are being expanded and kept active as participants use the internet to research topics they are interested in, such as Van Gogh paintings and NASA and its space shuttles. Clients have even discovered how to find new and healthy recipes to try with their families at home. It has been an outstanding success. Our older clients are learning skills and embracing new technologies to communicate using Skype, Email and social network sites like Facebook and Twitter.

"I need to practice the car game so that I don't crash so much"

"The DS is a lot of fun"

Healthy body, healthy mind
Using the Playstation 3 allows Planned Activity Group clients to experience things that appear and feel similar to real-world objects and events.

Better health, Better

2.6 Breaking down the barriers

We understand that age and mental illness can cause misunderstandings, misconceptions, myths and fear in our community. It is too easy for others to stigmatise older people and people with a mental illness, keeping them on the edge of our society.

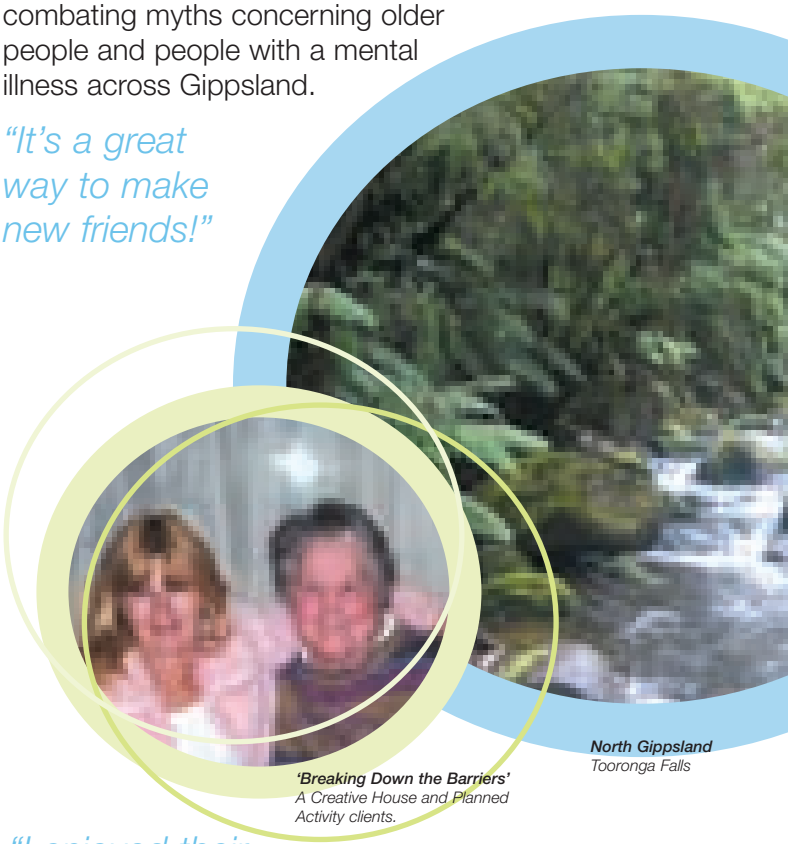
These stigmas often leave people feeling shamed, disgraced, humiliated, ostracised, hopeless, disenfranchised and in a state of 'not belonging'.

Action against stigma and discrimination of older people and people with a mental illness in our community is vital to achieve physical, psychological and social wellbeing.

During this year our Planned Activity Group and Creative House teams began working together to promote positive wellbeing of our older people and people with a mental illness. Together they have focused on activities which foster social inclusion and address myths and stereotypes. Our Creative House clients have been performing music for our Planned Activity Group clients, cooking lunch, helping in the garden and participating in interactive games and discussions. We have created a safe place so participants share experiences with each other. Much of our time is spent talking about the valuable contributions older people and people with a mental illness make to our community.

We understand that age and health problems are just one part of who people are. This unique initiative has promoted positive wellbeing and is combating myths concerning older people and people with a mental illness across Gippsland.

"It's a great way to make new friends!"



North Gippsland
Tooronga Falls

'Breaking Down the Barriers'
A Creative House and Planned Activity clients.

"I enjoyed their company and the music and I'm looking forward to joining them in the future."

"I love it! They say I'm nice for helping. I really like it!"

Healthy body, healthy mind
Cients keeping active using the Nintendo Wii.

2.7 Creative ways to social inclusion

"Looove the twilight social events. Love the new faces, love the door prizes and the raffle".

"It's really good, I enjoy the socialising. Not many clients meet socially of an evening. It gives us the opportunity to get confidence and meet new people."

"It's good. Lets us mingle with other people."

Creative House is a specialist service that operates within our broad range of mental health services. At Creative House we run programs that emphasise the wholeness and wellness of each individual focusing on social inclusion.

We understand social inclusion in our community is closely linked to an individual's recovery. Our emphasis is on clients gaining control of their life by learning to manage their illness and its impacts, while minimising the effect of any relapse. Through our programs we maximise clients' independence and involvement in our community.

Over the year we have expanded our community based activities while providing the opportunity to participate in educational activities, including Certificate 1 in Horticulture.

Together we have hosted many social activities and planned events for clients, carers, staff, family and friends to help our clients gain the confidence to get back out into the community. Many of our activities revolve around music, poetry, gardening and craft.

A popular activity at Creative House was the introduction of our Twilight Social Events in which musicians and music groups from Gippsland donate their time to perform for us. Many of the musicians have been delighted with the interaction from the audience and they are eager to continue to perform for us. Scheduled monthly, our Twilight Social Events provide an opportunity for everyone to share a meal, have a laugh and a fun night out. This is a great event that everyone looks forward to attending together.

These Twilight events are inclusive of other Latrobe Community Health Service programs and other agencies we work with to capture all areas of service and maximise the social benefits. Clients from Respite, Aged and Disability Services, Drug Treatment, Gambler's Help and Community Mental Health Service all attended the events. We are pleased to report the positive improvements in our clients' mood, mobility, and self confidence.

"It feels really good. I liked the music"

Creative House Twilight Social
Creative House clients, LCHS staff, Cooinda Hill clients, students and staff from Monash University Mental Health Winter School and the Strzelecki String busters at the fifth Twilight Social event.

Better health, Better

Section 3

Keeping you safe

3.1 Managing quality and safety

The responsibility for providing high quality care and professional service to our clients and our community in a safe environment is shared by all of us at Latrobe Community Health Service from the staff through to the Board. The safety of our employees is also paramount. This responsibility is ingrained in what we do and is reflected in our day to day practice. The term used to describe this responsibility is 'clinical governance' and we strive for continuous improvement.

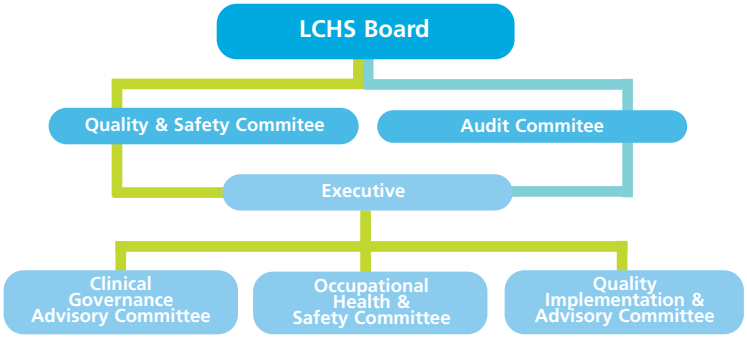
We have a Clinical Governance Advisory Committee meeting each month for senior staff to discuss issues and make recommendations relating to provision of quality care and services. Part of this Committee's responsibility is to review things that have gone wrong (incidents) and assess community feedback including both compliments and complaints.

Complementing the Clinical Governance Advisory Committee is our Quality Implementation and Advisory Committee. This Committee's role is to promote and maintain our culture of continuous improvement. Primarily it ensures that actions are taken to meet the recommendations from our organisational accreditation process that we undertook during 2009. It also has responsibility for the development of this Quality of Care report and how this report relates to you and our community.

Our Occupational Health and Safety Committee plays a key role in ensuring that our work environment continues to be safe for our clients and staff and that we meet our legal obligations under the *Occupational Health and Safety Act (2004)*.

Our Committees report to the Board Quality and Safety Committee. In addition to receiving minutes from these Committees, the Board Quality and Safety Committee members are provided with reports relating to our care and service provision. The basis for this reporting is the Victorian Healthcare Association's Board Governance Reporting Framework.

LCHS Committee Flowchart - Quality, Clinical Governance and Risk



Clinical Governance Advisory Committee
Members of the Clinical Governance Advisory Committee.

Quality Implementation and Advisory Committee
Members of the Quality Implementation and Advisory Committee.

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Meeting our industry standards

In March 2009 we underwent an organisation wide accreditation review as part of our ongoing accreditation cycle. This was conducted by external reviewers from the Quality Improvement and Community Services Accreditation. Forty-three actions have been taken in response and are monitored by the Quality Implementation and Advisory Committee.

From this review a key focus area has been service coordination to improve service delivery to our community and to ensure all relevant services are involved in client care. We have formed a working party to establish organisational responsibility for service coordination and a number of new initiatives have been introduced:

- Our staff now attend forums promoting the benefits of professionals working together and demonstrating the benefits to the client when all relevant services are involved in client care.
- All new staff in our organisation participate in a presentation about the importance of service coordination as part of their employment orientation.
- We have developed a service coordination learning manual and assessment process to ensure that all our employees understand how we coordinate services for the benefit of our clients.

Responding to risk

In everyday life we all take many steps to reduce the 'risk' of something happening to ourselves or to our family. For example, we use pedestrian crossings when we cross the road, we take out insurance on our house and we do not give our bank account information to strangers.

To reduce risk at Latrobe Community Health Service we have adopted a systematic and centralised approach to identifying and managing risks.

This includes the development of an electronic risk register and an incident and community feedback reporting system. Our risk register helps us identify where things may go wrong before they happen. By planning in advance we work to prevent these events occurring and reduce the impact if and when they do. The Committees we have in place are responsible for reviewing our risk register on a regular basis. When things do go wrong we use our incident reporting system to record the details of what happened so that we can investigate and prevent the same type of thing occurring again.

This year we introduced an electronic system for recording incidents which replaced our outdated paper based system. Our new system allows for incidents to be reported immediately to relevant staff members, saving time and enabling an immediate response and corrective action. It records the actions taken in response to an incident and produces reports that are used to monitor incident reporting.

Another vital part of taking care of risk is acting upon and responding to feedback from our clients and the community. The same system we use to record incidents is also used to record both client complaints and compliments. This means that notification to the right staff is immediate.

How we handle your feedback

Compliments are valued by our employees as it provides recognition and appreciation for the services we provide. A total of 164 compliments were received for the 12 month period. Most compliments relate to LCHS providing a valuable service (41%) followed closely by compliments relating to our staff and the way we look after people (34%) and relating to the quality of care received (24%). Our facilities were also complimented (1%).

Complaints are equally important as they provide opportunity for continuous improvement. When we receive a complaint we take it seriously. All complaints undergo investigation. In complex cases we conduct a review through a system called 'Root Cause Analysis', which determines the starting place for what went wrong, where systems failed and the corrective action to prevent it happening again.

Of the 77 complaints we received this year, the majority related to issues about access to service (30%), communication not working as well as it should (29%), with a similar number of complaints received relating to service provided (26%).

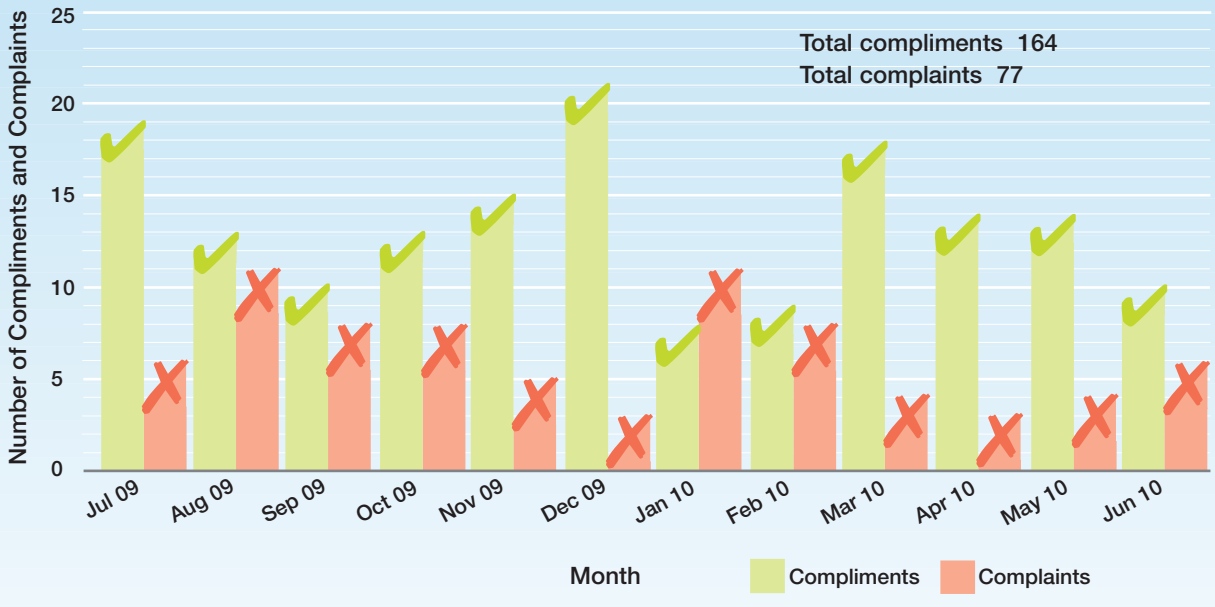
Other complaints received (15%) related to facilities, fees and rights. We treat each complaint as unique and the individual circumstances of each complaint are taken into consideration when following up and taking action.

As an organisation we believe there is no 'one size fits all' response to the complaints we receive.

You can be assured that if you lodge a complaint, we will deal with it promptly and consider your personal situation. We encourage your feedback on your experience with Latrobe Community Health Service as we use this information to improve our services.

"My dental service was fantastic! I had the student dentists. I felt very well looked after. Everything was explained and I feel I've had a complete positive experience. I loved that I was called the day before to remind me too. An all round wonderful service."

Our Client Compliments and Complaints



Graph 1: *Compliments and complaints received from 1 July 2009 - 30 June 2010.*
A total of 164 compliments were received for the 12 month period, in comparison to a total of 77 complaints.

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3.2 Knowing your rights and responsibilities

A new Rights and Responsibilities brochure was developed through the year and is now available for our clients. It informs our clients about what they can expect when receiving our services. It also highlights how you can assist us in providing improved services for you. This brochure was developed with the input of our local community. We held a focus group to provide feedback on our draft document and to suggest extra content they thought was necessary.

Feedback on this process was positive and copies of these brochures are available from all our Latrobe Community Health Service sites. Alternatively copies can be downloaded from our web site at www.lchs.com.au.

Knowing your rights and responsibilities
The new Rights and Responsibilities brochure informs you about what you can expect when you receive services from us.

3.3 We are taking care of your oral health

This year saw a new milestone for dental at Latrobe Community Health Service with the opening of our new 6-chair clinic at our building in Morwell. Our new facility enables further expansion of our dental services along with an expanded partnership with Melbourne University in the provision of a state-of-the-art teaching clinic at Morwell.

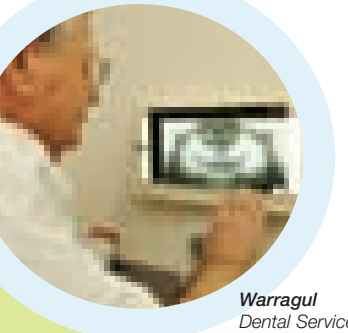
We are very pleased to report that for 2009-10 waiting lists have reduced to their lowest ever having been reduced to 11 months for general dental and 12 months for denture care. This is a significant achievement as in July 2006 our waiting list for Dental Care was around 66 months (5 1/2 years), and the waiting list for Dentures was approximately 40 months (over 3 years).

Over the last 12 months we have increased the staffing levels of Dentists, Dental Therapists and Dental Assistants, which has enabled us to expand our capacity and treat a greater number of clients. For the 2009-10 financial year to May 2010, 8,535 individual clients have been treated with a total of and 20,299 visits for those clients.

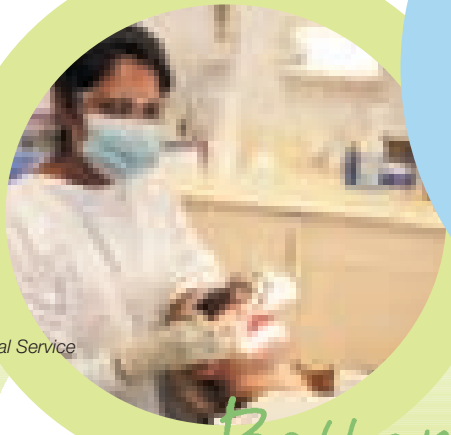
We have taken a strategic approach to waitlist management, increased capacity planning and recruitment to increase our service delivery to our community and improve treatment time.

This has resulted in us achieving:

- reduced dental care waiting list from 27 months to 11 months
- reduced denture care waiting list from 33 months to 12 months
- increased daily emergency treatments/appointments
- created job opportunities for local area.



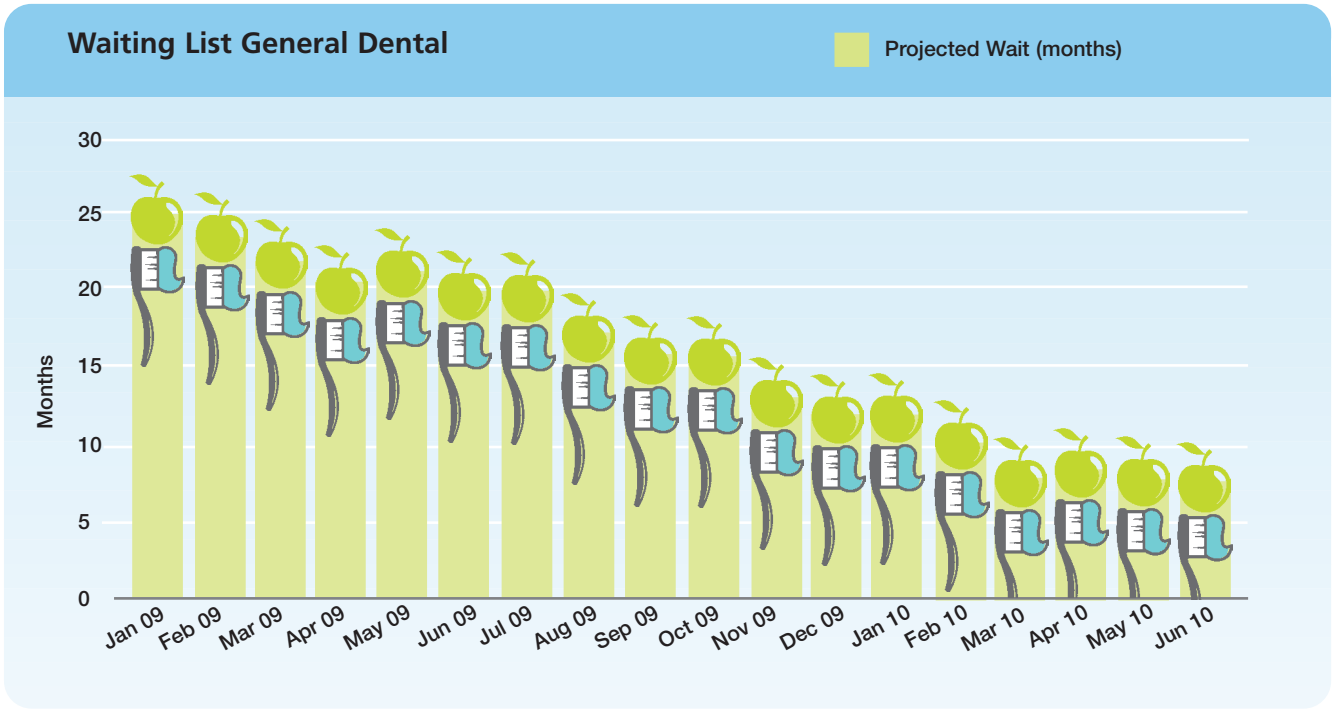
Warragul
Dental Service



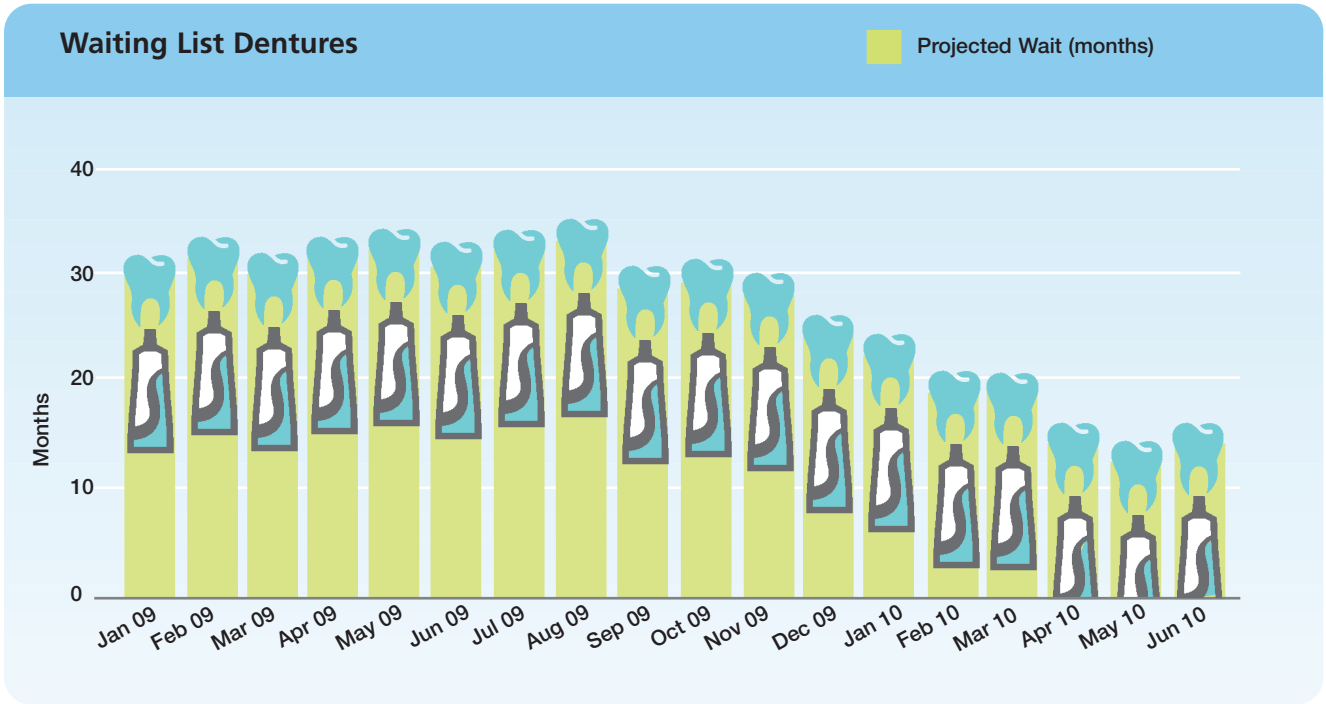
Moe
Dental Service

Churchill
Dental Service

Better health, Better



Graph 1: *Demonstrates the decline in waiting times for patients requiring general dental care which has reduced from 27 months to 11 months in the past 18 months.*



Graph 2: *Demonstrates the decline in waiting times for patients requiring denture care which has reduced from 33 months to 12 months in the past 18 months.*

lifestyles, Stronger communities

3.4 A strong partnership to improve Gippsland's health

MOU Signing
Ben Leigh (LCHS CEO), Prof. Steve Wesselingh and Mollie Burley formally established a Placement, Education and Research Unit which aims to increase the number of clinical student placements at Latrobe Community Health Service.

Providing student placements to future health professionals is an important focus for us. We are committed to staff working together and learning from one another to achieve the best health outcomes for our community now and in the future. As a major health care provider within Gippsland we are committed to undertaking research to ensure that the care we provide is always best practice.

We have formed a partnership with Monash University's Department of Rural and Indigenous Health and established a Placement, Education and Research Unit at Latrobe Community Health Service. This Unit has a number of aims, and in particular we aim to increase the number of clinical student placements within our organisation and improve this experience for students. We place many types of students, including allied health, nursing, medicine, counselling, community care and dental. Students are welcomed and we encourage clients to meet students during their appointment time.

As part of supporting student placements, the Placement, Education and Research Unit organises education for our staff about the benefits of learning about, from and with other professionals. Through working together health professionals can achieve greater outcomes for clients by taking into account their range of needs. From this learning and understanding, the coordination of services provided to our clients is improved.

It shows how services integrate and takes a complete approach to a person's health care.

In addition to student placements and professionals linking together to provide care, a key advantage of our partnership with Monash University is that our staff participate in research courses. This benefits everyone, but most importantly our clients and community. More information about student placements at Latrobe Community Health Service can be obtained by contacting the Placement, Education and Research Unit at Latrobe Community Health Service.

In providing a high quality learning environment we are ensuring that our community continues to be serviced by a quality professional work force.

MOU Signing
Representatives from Latrobe Community Health Service, Monash University and the local community at the signing of the Memorandum of understanding.

3.5 Improving infection control

During 2009-10 Latrobe Community Health Service conducted a comprehensive review of infection control. An external auditor was employed to assess our compliance against the Australian standards and guidelines.

The audit covered all the clinical areas at the Churchill, Moe, Morwell and Traralgon sites. All clinical and storage areas at the sites were inspected as well as the nurses' vehicles, supply bags and briefcases. The Bairnsdale, Korumburra, Sale and Warragul sites were not audited as no clinical treatments occur at these sites.

As a result of the audit a number of recommendations were suggested. A working group has been formed that included staff from all the different clinical areas and their role was to action the recommendations.

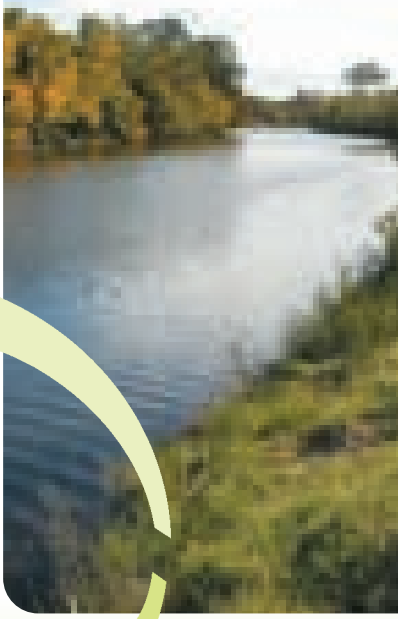
A large number of activities have occurred and changes have been made.

Highlights of this process include:

- The nurses have new bags and a very strict bag cleaning system is in place.
- We have removed a number of sterilisers and changed to single use sterile items instead of re-sterilising in some areas.
- We have fitted all our vehicles with special brackets for the containers which hold used needles and other 'sharps' and we have a very clear process for disposing of the sharps.
- New shelving has been purchased to ensure all sterile goods are stored appropriately and there is a process to make sure that the goods are 'rotated' on the shelves. This prevents the most recently delivered goods being used first.
- Linen and cleaning contracts have all been reviewed to ensure that we are compliant with the standards.
- We have provided hand hygiene education to all of our staff. Special hand wash and hand rubs are made available in the staff bathrooms and personal hand rubs are provided for staff working out in the community.

We will have an infection control audit every year to ensure we remain compliant with the Australian standards.

Improving infection control
Nurses now have new bags and all vehicles have been fitted with brackets for the 'sharps' containers.



Central Gippsland
Latrobe River

lifestyles, Stronger communities

3.6 Judging our performance

A major initiative of our Strategic Plan 2007-12 was to develop an evidence based scorecard that measures selected outcomes in improving population health and well being.

From this we have identified three priority areas as a focus for health promotion activities.

They are:

- physical activity and healthy communities
- healthy and nutritious foods
- social connectedness and mental wellbeing.

The scorecard will report a range of data that aligns with our priority areas which include: Fruit and vegetable intake, alcohol intake, smoking, physical activity, self reported health, overweight and obesity, diabetes, psychological distress, health screening, social networks and participation, chronic disease and social inequalities in health. Our scorecard will be aligned with the Victorian Health Population data collection every three years.

Traralgon Reception

Churchill Reception

North Gippsland
Licola Bridge

Better health, Better

Section 4

Linking you to the right services

4.1 Better management of chronic disease

During 2009-10 we have been improving access for our clients whose chronic conditions are managed by their local GP under a Team Care Arrangement. We have worked with the Central West Gippsland Division of General Practice to implement a new process. As a result, our Diabetes Nurse Educator, a Podiatrist and two Dietitians are now providing services to the community either within a medical clinic or by increasing services available through us. This has been possible because the services are provided under the Medicare Benefits Schedule. We have received positive feedback as there are now more services available and they are easier to access.

4.2 Improving the way we manage wounds in the community

An important role of our Ambulatory Care nurses is helping people across Gippsland manage and heal their wounds. Our Ambulatory Care nurses have been involved in a ground breaking project called the Carepoint Mobile Wound Care Project throughout 2009-10. This is significant as previously there has not been a way of collecting information about how long and how much it costs to heal wounds in our community. This project is supported by the Monash University Department of Rural and Indigenous Health and the Department of Health. It also involves a number of other community nursing, hospital and aged care services across Gippsland.

The Carepoint Mobile Wound Care Project is allowing nurses to collect information about wounds we are treating. The information is entered into a computer system that analyses the information. The aim of this project is to help improve the care of wounds and reduce the amount of time that clients will need to be treated.

By the end of 2010 we will have large amount of information in our system for review. The data will be used to recommend the best ways to look after wounds in our community and to make sure the outcomes occur.

4.3 Michael's Story

My name is Michael de Vent, I have an Acquired Brain Injury and receive a Case Management package through LCHS.


My name is Michael de Vent, I have an Acquired Brain Injury and receive a Case Management package through LCHS.

I was asked by LCHS to write a short history about myself and my contact with the Case Management service at LCHS. I was more than happy to do this because LCHS has been an important part of my life and the support they have provided to me has been crucial. Anyway, this is my story...

Prior to my involvement with LCHS, I lived at Phillip Island and worked as a builder and had eight people working for me. It was a pretty good business and there was lots of work. I had a good social life and a number of strong recreational interests such as fishing and sport. All summed up, life was good.

One of the jobs through my business was to rebuild a restaurant that had been burnt down. It was a very good job to do and the man who owned the restaurant welcomed my staff and I for a free meal when the restaurant reopened. So we did just that. The date of the opening was 6 November. The reason that I remember the date was because it was also my daughter's birthday. It was also the start of Schoolies week and Phillip Island had been planning the event for many months. Phillip Island was very busy with hundreds and hundreds of teenage kids everywhere.

When I went to the restaurant it was about 7pm and all of my workers were there. We had a good feed and the time was getting on, so I said to my workers I would be getting home because I had a small job in the morning. I left them there because they drink and I do not.

When I got outside the streets were filled with teenage kids. I started to walk home and about 100 kids were all around me and I had nowhere to go. Some of the kids asked me for my smokes and I said no to them. So I kept on walking from the restaurant and got to the service station and stopped to buy some milk. The kids followed me there and asked me if I would buy them smokes. I said no because they are too young. When I left the service station the kids had gone so I headed home.

My house was the third house from the service station and when I had turned for home, I noticed quite a few kids were across the road in a car park. They were watching me when I got to my neighbour's fence. Things then got very bad. A young man jumped out and swung a piece of wood and hit me right on my face. My lights went out and I was out for a very long time.

The hit to my head was so bad; the doctors had to put me in a coma. My neck, jaw, skull and cheek bones all had breaks and my brain was described as 'swollen'. I had a Halo Brace placed on my head in an attempt to stop it looking 'caved in'.

The injury to my head gave me mental problems. When I came out of the coma, I could not talk. Every time I tried to talk, the wrong words would come out in my head (I was saying the right thing but that was not happening as my words did not make sense).

My time in hospital was driving me crazy and I had lost the use of the whole right side of my body. The hit to my head was the worst thing that has happened to me. Life was at its worst and I didn't see any way of fixing myself. My time at the hospital in Melbourne was up and there was nothing more that they could do, so they sent me to rehabilitation at a local hospital. This was very hard as the hospital in Melbourne had been my home

for two years and everyone there knew me and I felt safe there. So there I was at a new place and not knowing anyone and not able to talk and make new friends because no one could understand me because of the way I spoke. At the local hospital they were fantastic and after 3 months I had learnt to speak well enough to have a conversation with someone.

My time there was up and I was put in contact with LCHS. I had never had any help from them before and did not know what LCHS was all about.

I had a meeting with a case manager from LCHS and she explained to me what LCHS could do for me. At first I could not believe that she was so good to me. I felt like I had a family behind me and what I needed to be comfortable.

When I left hospital I had nothing except some clothes; nothing for a house, no fridge, table, absolutely nothing. But LCHS came to the rescue and said to me do not worry about anything, they had it all under control.

LCHS assisted with my transition home. They assisted to link me in with services to ensure that I had a roof over my head and assisted to organise me with furniture. Things however were still not right with me. I still had problems talking and putting things together like making something to eat. I could not remember what food I liked and what food to buy at the shops. So once again LCHS supported me and funded a carer to assist me to go shopping and cook. This was the best thing for me because I was not eating properly and I was getting sick.

After a few months I started to get my confidence back. There were many things I needed and had no way of getting them because I was in a wheelchair and the chair had to go back to the hospital. So LCHS came to the rescue once again and got me a new chair.

Things started to look better for me. LCHS put together a chart and put down all of my goals and what I had already achieved and made me look at the things that I had done and the time taken to do it. This made me feel better about myself.

They also assisted me to look at what goals I had for the future.

The good thing about LCHS is that they have always assisted me with things when I have needed it and always reviewed the way they assist me to ensure that they are assisting me appropriately. Over the last year things have gone wrong for me. I burnt myself very bad and needed a skin graft but it did not work. The burn to my leg was getting worse and my health was very bad. I was in and out of hospital many times and however whenever I came home LCHS got carers for me to ensure that when I was home I was comfortable. LCHS also assisted to organise other things, such as equipment for me, so that when I came home I was in a safe environment.

In the end my leg became gangrene and the only thing left to do was to amputate my leg. This is very upsetting and I did not know what to do. I had to start all over again; new way to do things because they are taking my good leg and I need it so I could transfer out of my wheelchair. I needed to know a new way of transferring out of bed and my wheelchair to ensure that I would be able to live independently.

LCHS however gave me the support I needed. They took the lead in my Case Management needs and organised for me to have regular appointments with health professionals. They also organised and assisted with strategies to increase my independence, such as teaching me to use a diary and a whiteboard, which assisted me to remember things.

They also organised additional support for me when I first came home from hospital to ensure that my transition home was successful. They also organised counselling support for me and remained in regular contact to review my needs and place in extra supports as required.

LCHS has provided me with the support services to ensure that I have been able to remain living independently. I have had some major setbacks however without the support of LCHS I would not have been able to recover from them as strongly as I have.

Most importantly, they have always asked me what did I want to do and helped me to set goals to make my life more enriching and fulfilling.

My name is Michael De Vent and this is my story.

4.4 Taking a proactive approach to men's health

A total of 26 health staff attended 'Pit Stop' at Farm World, including workers from Health Promotion, Alcohol and Drug, Community Health Nurses, Work Health Nurses, a Refugee Health Nurse, Councillors, GP's, Nurses, and Peer Educators.

Over the two days at Farm World, 114 men participated in 'Pit Stop', with 46% participants receiving a roadworthy sticker and 53% receiving a yellow/canary sticker, with recommendations to see their GP.

We worked in partnership with a number of other health agencies to find new ways to encourage men to take a proactive approach to their health and foster greater connectivity between men and local health organisations across Gippsland.

Together with the Central West Gippsland Primary Care Partnership, the Central West Gippsland Division of General Practice and Relationships Australia Victoria we identified a project called 'Pit Stop'. 'Pit Stop' was originally developed by the Gascoyne Public Health Unit in Western Australia. Collectively we decided that Farm World at Lardner Park would be the perfect venue to run this men's health program.

Men's Health Program
'Pit Stop' participants.

'Pit Stop' is a program based on the idea that a car needs regular car maintenance, transferring this concept to a person's health. 'Pit Stop' is run as a series of stations that are visited by each participant for a quick and simple health check. Stations can include 'oil pressure' (blood pressure), 'shock absorbers' (mental health and coping skills), 'fuel additives' (alcohol), 'chassis check' (waist measurement),' spark plugs' (testicular cancer) and 'extractors' (bowel cancer).

Men's Health Program
'Pit stop' project at Lardner Park, Farm World.

At the end of the 'Pit Stop' a marshal issues the participant with either a roadworthy or unroadworthy yellow 'canary' sticker. 'Pit Stop' is non-medical and is provided in a comfortable and fun setting that allows participants to overcome any doubt that they have about going to a GP.

The feedback we received from participants was very positive and those that took part said that they would like to see it again at Farm World.

Better health, Better

Section 5

List of services

- Aged Care Assessment Service
- Alcohol and Drug Treatment Service
- Ambulatory Care
  - District Nursing Service
  - Palliative Care
  - Wound Management
- Better Health Self Management
- Carer Services - Commonwealth Respite and Carelink Centre
- Case Management
- Children's Sexual Assault Counselling
- Chronic Disease Management Care Coordination
- Community Health Nursing
- Community Support - Emergency Relief
- Continence Program
- Counselling and Support Services
- Creative House
- Dementia Education and Training for Carers
- Dental Services
- Diabetes Education and Prevention
- Early Parenting Day Stay Program
- Physical Activity/Exercise Programs
- Falls Prevention Program
- Gambler's Help Service
- Gippsland Auslan Interpreter Service
- Gippsland Withdrawal and Rehabilitation Service
- Home and Community Care Response Service
- Health Promotion
- Health Services for Homeless Youth
- Health Hearts Cardiac Exercise and Education Program
- Hydrotherapy
- Kids Life! MEND Program
- Life Skills Group
- Lymphoedema Clinic
- Mayfair House Overnight Respite
- Mental Health Assistance
- Men's Health Clinics
- Moe After Hours Medical Service (MAHMS)
- Men's Behaviour Change Program
- Needle and Syringe Program
- Non Case Managed Packages/Early Intervention
- Nutrition and Dietetics
- Occupational Therapy
- Parent Support Program
- Physiotherapy
- Planned Activity Groups
- Podiatry and Foot Care
- Refugee Health Services
  - Latrobe Valley Sudanese Women's Group
- Relaxation and Stress Management Group
- Support Groups
- Supported Accommodation Program
- Veteran's Home Care
- Women and Children's Family Violence Counselling
- Women's Health Clinics
- Work Health

lifestyles, Stronger communities

Better health, Better lifestyles, Stronger communities

Gippsland wide services

Sale
52 McArthur Street

Morwell
81-87 Buckley Street

Traralgon
Cnr Princes Hwy & Seymour Street

Bairnsdale
5/111 Main Street

Warragul
122 Albert Street

Cowes
164 Thompson Avenue
56-58 Church Street

Korumburra
Gordon Street
at Gippsland Southern Health Service

Moe
42-44 Fowler Street

Churchill
11 Philip Parade

Website: www.lchs.com.au
Free call: 1800 242 696

Latrobe Community Health Service ABN: 74 136 502 022

Latrobe Community Health Service Gippsland Wide

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