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How a partnership in WA is providing opportunities for Indigenous Australians

APHA NATIONAL CONGRESS
What you can expect from this year’s congress

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PATIENTS at our private hospitals are empowered with a choice of doctor, a choice of facilities, timely access to the care they need and high quality care. APHA members across the country are devoted to delivering the best in hospital care to their patients and to providing the latest innovative solutions to patient needs.

Gone are the days of private hospitals being a small cottage industry. Private hospitals in Australia treat 40 percent of all hospital patients in Australia each year. We perform 64 percent of elective surgery and most of this surgery is to treat patients who would not agree that their surgery should be called elective. These are procedures like cardiac valve replacements, hospital-based psychiatric care, hip and knee replacements and the list goes on.

Private hospitals are undeniably evolving with the times. The theme of the 2011 APHA National Congress is Private Hospitals: Evolution through Innovation and this issue of Private Hospital looks at the program for this year’s Congress. I hope the article that starts on page 18 entices you to come along to the Congress and learn from the many experts in their field who will be presenting at the event.

APHA is running a special promotion this year for delegates from hospitals. With our ‘Bring four delegates from your hospital, but only pay for three’ offer, we hope to see many more delegates from various areas of your hospital. We also are running different streams to try to cater for divergent interests among delegates.

This issue also looks at innovation in private hospitals. From the advances in cardiac care services for patients in rural Queensland to advanced reconstruction techniques at Sydney’s Macquarie University Hospital, there are many examples of private hospitals leading the way. And check out our On the Ground feature on page 66 to see how the Wesley Hospital is getting on board with social media too.

APHA is busy using new technologies and social media as well. Our facebook page continues to grow its’ fan base. Have you checked us out at www.facebook.com/valuingprivatehospitals yet? Quite a few people have commented on our No Health Means Test posts and have used the facility to check out how much more they will pay for their private health insurance if means testing of the private health insurance rebate goes ahead. Post a comment on our wall and let us know what you think of our page and what you think about the proposed means testing of the rebate.

If you have comments at any time about anything in Private Hospital magazine, please feel free to contact me at APHA on lisa.ramshaw@apha.org.au or on Twitter at @priv8hospitals.

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Working to stop the means test

APHA has been running an awareness campaign to try to stop the means testing of the private health insurance rebate.

INCE the last edition of Private Hospital, the Federal Government has re-introduced the legislation to means test the 30 percent private health insurance rebate and will debate this legislation when parliament resumes in mid-August. Tasmanian Independent Andrew Wilkie has announced he will support the measure along with Greens MP Adam Bandt, giving the government the support of two of the six lower house crossbenchers and leaving them needing just two more votes to pass this legislation.

At the time of going to print, APHA remains hopeful that the government will not garner the support of the remaining independents – Tony Windsor, Bob Katter, Tony Crook and Rob Oakeshott – some of whom are yet to state their final position. APHA has made a significant effort to convince these independents of the folly of this legislation and the negative impact that it will have on private health insurance and the public hospital system as people drop or reduce their health cover.

We have also undertaken a strong public awareness campaign in Andrew Wilkie’s electorate following his decision to support the rebate. Mr Wilkie has stated that he was convinced by the government’s argument that 83 percent of his electorate will not be affected by the rebate. However this ignores the tens of thousands of people in his electorate who will see their health insurance premiums rise if means testing is introduced. The reality is that everyone will be affected by this legislation through loss of rebate, higher premiums and longer waits on public hospital queues. The government itself has admitted that almost 2.5 million Australians will have to find up to $1000 a year more to pay for their health insurance.

Mr Wilkie’s position is particularly concerning for privately insured patients and private health care providers in rural and regional areas. Doctors in these areas agree that this legislation could have a catastrophic impact on medical and surgical services in regional locations.

Recently, Tamworth surgeon Dr Phil Kennedy was quoted in The Northern Daily Leader saying “the introduction of means testing the rebate will reduce the viability of private hospitals and will lead to significant unemployment in various professional groups as well as precipitating an exodus of surgical proceduralists from these areas.”

The specialists that I have met in rural and regional areas over the past few months have all expressed similar feedback and are very concerned about the negative impact that this legislation will have on their ability to continue to practice in these areas.

Of course, some commentators agree that the changes will actually free up money to invest in public hospitals. But when has investing more money in public hospitals made a huge amount of difference? The revised federal and state government healthcare agreement is set to deliver a further $19.8 billion to the states up to 2019/20, but the reality is that patients will notice very little difference as this money will cover the health system’s growing demand rather than enabling significant improvements.

The Consumers Health Forum agrees that giving more money to the states “has rarely delivered results”.

APHA has worked tirelessly on the means testing issues and, whatever the outcome, I would like to thank the secretariat and members for keeping up the momentum. Let’s hope that common sense prevails and that people are not penalised for doing the right thing and taking out health insurance as well as funding the public health care system through paying taxes.
Some 18,000 needlestick and sharps injuries occur each year in Australian hospitals.¹ Even the smallest skin puncture can expose healthcare professionals to more than 30 potentially life-threatening bloodborne pathogens.²

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References:
The waiting game

How a guarantee changed to a mere target

In my April column I wrote about the ‘revised’ health reform deal agreed at the COAG meeting in February. I commented on the continuation of the National Access Target and National Access Guarantee for elective surgery waiting times and said:

“However, COAG has now stipulated these targets be referred to a committee to consider ‘the effective implementation of these standards’. Don’t be surprised if the committee finds these standards might be a little too tough to implement.”

Sometimes I hate it when I’m right.

APHA provided a submission to the ‘Expert Panel’ appointed to assess these targets (the panel did not include anybody with expertise in the operations of the private hospital sector). We talked about the private sector’s willingness to assist public hospitals meet their targets, but cautioned this needed to be done in a way that did not reduce the value of health insurance. We said:

“In order to build and maintain sustainable capacity in elective surgery, Local Hospital Networks should be able to partner with private hospitals to provide specified surgical services. Not only would this build capacity, it would also significantly improve efficiency.

“If Local Health Networks could enter into arrangements to guarantee patient volumes over an extended period of time, it is likely there would be significant appetite for private sector capital to build new capacity in the system. This could include elective surgery facilities that exclusively treated public patients on contract from the public sector.”

We believed this was consistent with the approach outlined in the COAG deal that said:

“States and territories will endeavour to enter into long term arrangements with private sector providers where this can help ensure hospitals within a Local Hospital Network are better able to meet the National Access Guarantee.”

However, during a face-to-face consultation with the Expert Panel, it became very obvious they were not interested in any solution involving the private hospitals sector, even though it is the ‘engine room’ of elective surgery in this country. Indeed, a member of that panel tried to explain to me afterwards it was just “too hard”.

So it was no surprise that the Health Minister subsequently announced the access target had been ‘strengthened’ from 95 percent to 100 percent of surgical patients being treated within clinically recommended times by 2015. But missing was the requirement for a Local Hospital Network, when it could not meet the target, to pay for a patient to receive treatment in a private hospital. So now there is no guarantee, just a target, and no sanction if that target is not achieved.

The only way these targets were ever going to be met was through cooperative arrangements with the private sector. After all, the COAG Reform Council delivered a report in June that found despite the federal government giving the states $300 million in additional funding since 2008 specifically for elective surgery, waiting times for treatment had actually increased!

One way or another it would cost federal and state governments more money to treat the extra patients they would need to treat to meet the targets. Under the new deal, these extra costs are shared 50-50 between the feds and the states.

Reducing a ‘guarantee’ to a ‘target’ means you never have to meet the target so don’t have to incur the increased costs. And let’s not forget that for health bureaucrats to send someone to a private hospital because they could not treat them in a timely manner is effectively an admission of failure.

The bureaucrats won’t have to worry about that now, unlike the patients who continue to wait.
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Queensland cardiologists rewarded

TWO Queensland cardiologists have been awarded Fellowships by the prestigious international Heart Rhythm Society (HRS), the most pre-eminent cardiology and electrophysiological organisation in the world.

Based at Queensland’s St Andrew’s Memorial Hospital, Dr Wayne Stafford and Dr John Hayes were awarded Fellowships as a result of their efforts spanning 20 years in the field of cardiology and cardiac research.

Dr Stafford and Dr Hayes said they were honoured to be awarded the Fellowship - the only two cardiologists in Queensland to win the award this year.

The cardiologists received the award at the Heart Rhythm Society’s 32nd Annual Scientific Meeting in San Francisco in May.

Both cardiologists are also members of the Royal Australian College of Physicians and the Cardiac Society of Australia and New Zealand.

Code of Practice for the medical technology industry to be reviewed

THE Medical Technology Association of Australia (MTAA) has announced the first three-yearly review of its Code of Practice. The review will be conducted by a panel of independent external stakeholders, chaired by Ms Jan McClelland. The panel will consider if the current Code meets community expectations of medical technology companies’ business practices.

The purpose of the Code is to ensure that high standards of integrity of behaviour apply across the medical technology industry to enable healthcare professionals and consumers to have confidence in dealing with industry. The self-regulated industry Code is mandatory for MTAA members and advisory for all other companies in the medical technology industry.

“The Code has been substantially developed over the past three years with annual updates to clarify language and to reflect Australian and global changes in compliance expectations,” said Anne Trimmer, Chief Executive Officer MTAA.

Ethical interactions with healthcare professionals are important for medical technology companies to identify clinical needs and gain feedback about new innovative technologies. Clinicians are intrinsic to the product development cycle. They provide relevant and often critical feedback to companies on product performance. They often act as advisors and collaborators in product development. These relationships are entirely appropriate, and often essential for the benefit of the patients on whom the technology is used. However the relationships must be transparent and conducted on an ethical basis.

Medical technology companies operate globally and it is therefore important that the codes of ethics or practice that apply in the major economies are reasonably well-aligned. If they are not, and if a company is required to meet divergent requirements, there can be a significant additional cost which ultimately is borne by the healthcare system.

Submissions to the Code review are invited from the healthcare sector, government, consumer groups, the medical technology industry and other interested parties. A submission template and a copy of the MTAA Code are available from the MTAA website www.mtaa.org.au.
Westmead Private CEO to lead Macquarie University Hospital

AUSTRALIA’s most technologically advanced hospital, Macquarie University Hospital, confirmed the appointment of the Chief Executive Officer of Westmead Private Hospital Carol Bryant as its next CEO.

Chairman of the MUH Board, Dr Peter Dodd said that Ms Bryant’s outstanding track record as CEO of Westmead Private over the past nine years amply demonstrated her ability to run a leading private hospital in the Sydney area.

“Those who have worked with Carol over the past decade will agree she has been an outstanding leader, manager and strategist with a clear vision for the future of private health care in Sydney,” Dr Dodd said.

Carol Bryant will take up her new role in early June when founding CEO Robert Glynn steps aside to relocate interstate for family health reasons.

‘‘While I know Robert is disappointed to be leaving Macquarie University Hospital after all that he and his team have achieved, he is very pleased that a CEO of Carol’s standing will build upon that foundation,’’ said Dr Dodd.

DOCTOR Suzanne Hill is to be the new chair of the Pharmaceutical Benefits Advisory Committee (PBAC), the Australian Government’s expert group of technical advisers who recommend listing of medicines on the Pharmaceutical Benefits Scheme (PBS).

The Minister for Health and Ageing, Nicola Roxon, announced that Dr Hill would succeed Professor Lloyd Sansom as chair of PBAC.

Dr Hill is currently works for the World Health Organization in Geneva, in the Department of Medicines Policy and Standards, and was previously Associate Professor, Clinical Pharmacology at the University of Newcastle.

The PBAC is an independent, expert advisory body comprising doctors, other health professionals and a consumer representative and makes recommendations to the Australian Government about PBS listings after considering safety, clinical effectiveness and cost-effectiveness of medicines for intended use compared with other available treatments.

Since 2007, the government has, following PBAC recommendations, listed more than 500 new medicines or brands recommended by PBAC at a cost of more than $4 billion. This includes more than half a billion in the first six months of 2011.

“Dr Hill will bring to her new role a wealth of experience, at a time when rigorous assessments are as important as ever,” Ms Roxon said.

“Professor Sansom has set a high benchmark as PBAC chair over the last decade and I thank him for his excellent leadership and extraordinary hard work.”

Dr Hill will become chair on 9 September 2011.
Mothers and daughters team up to get fit

An Australian first study at the University of Newcastle will examine how mums can help their daughters to get more active by becoming more active themselves.

MADE (Mothers And Daughters Exercising) 4 Life is a program designed to increase physical activity participation, fitness and health in both mothers and daughters by developing physical activity skills and confidence through fun activities performed together.

“Previous studies have found that girls are less active than boys and women less active than men. We also know how important the mother is as a role model for her daughter and this influence extends to the lifestyle a mother leads,” said Alyce Cook, lead researcher.

“There have been no Australian studies that focus on the mother-daughter combination to increase physical activity levels in the family. This research will test if the MADE 4 LIFE program is successful in improving the physical activity behaviours of mothers and daughters.”

MADE 4 Life joint researchers include Professor Philip Morgan, Professor Clare Collins and Professor Ron Plotnikoff from the Priority Research Centre in Physical Activity and Nutrition from the University of Newcastle.
Make your smart phone a wise phone

IF YOUR patient loves their iPhone and regularly takes medicines then they’ll also love the brand new NPS Medicines List iPhone app, now available for free from iTunes.

For those caring for a relative, or those who just can’t remember those long names and impossible strengths, the app will be a game changer. It will allow patients to be MedicineWise by tracking the brand, active ingredient, strength and dosage of their medicines, including prescription, over-the-counter and complementary medicines.

The launch of the app represents the first NPS initiative in the area of smartphone application development and has already been downloaded by more than 2000 people since it went up on the iTunes site in mid June.

NPS clinical adviser Dr Danielle Stowasser says people who take one or more medicines often struggle to keep track of what they are taking and the important details that they need to tell their healthcare providers. Not having this information at hand can sometimes lead to missing a dose, accidentally taking a double dose, interactions with other medicines or forgetting to finish a course of medicines.

“Very few people can remember the name of their active ingredient, regular brand or the number of milligrams they need to take – all essential information for healthcare providers when managing a patient’s care in the long term,” said Dr Stowasser.

“We know that the more people know about their medicines, the more confident they are to talk about their options with their prescriber or pharmacist and that helps people get the most benefit from their medicines.”

The new Medicines List iPhone app provides a way for people to keep this essential information on hand. There are also other features of the app that enable people to:

• Keep photos of medicines, packaging and dispensing labels
• Track any changes to a medicine regimen using the change log
• Export and print or email a copy of their medicine list and change log to discuss with their doctor or pharmacist
• Save personal details and health professionals’ contact details
• Note questions to discuss at the next medical appointment.

“Health professionals can help their patients be MedicineWise by encouraging them to download the Medicines List app and recording their medicine details or those of the person they are caring for,” said Dr Stowasser.

For a link to the app in the iTunes store, tips and videos about how to get the best from the app visit the NPS website www.nps.org.au

New Chair for the AIHW

ACTING Minister for Health and Ageing, Mark Butler has announced that Dr Andrew Refshauge has been appointed as the new Chair of the Australian Institute of Health and Welfare (AIHW) for a three-year term.

Mr Butler said the AIHW is an important part of the Australian Government’s efforts to improve the health and wellbeing of Australians by providing reliable, regular and relevant information and statistics.

“The work of the AIHW provides an important information base for good policy development in health, housing and community services,” he said.

“As a former New South Wales Deputy Premier, Treasurer and Health Minister, and an experienced medical practitioner, Dr Refshauge brings extensive skills to his new role.

“I am delighted Dr Refshauge will be leading the AIHW and am sure he will be a strong and effective advocate and guide for the AIHW in its very important tasks over the next three years.”

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16 August 2011
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The 31st Annual APHA National Congress will be the health industry’s event of the year.

This year’s 31st Annual APHA National Congress will fill a busy two-and-a-half days exploring Private Hospitals: Evolution through Innovation.

The Congress will provide a platform for exploring the essential connections between private hospitals, governments, technology and patient care. It will look at synergies between private hospitals and outside partners: providing practical ideas for hospitals on the ground.

This year’s Congress will be held from 16-18 October at the Hilton Hotel, Sydney. Delegates can look forward to thought-provoking speakers who will stimulate debate throughout the sessions as well as informative knowledge from some of Australia’s best in their field.

With the Federal Government recently reintroducing the means test rebate to parliament, the changes that are proposed will adversely affect private hospitals across the country. All healthcare professionals have noted the potential domino effect. This congress is a ‘must attend’ for everyone involved in private healthcare at any level.

This year’s congress has a streamed approach, which will address Safety and Quality, Mental Health, Community Health Innovation, Health Workforce and Communications and Marketing. The Congress will offer a diverse range of sessions for a variety of hospital staff members. Concurrent to the National Congress is a health sector Trade Expo. Trade Exhibitors and delegates can take the opportunity to build and develop relationships and keep current on the latest developments impacting the industry.

Delegates to the Congress will be provided with sessions that stimulate ideas and promote discussion on the topics of interest to them. The Congress will also provide excellent opportunities for networking among fellow colleagues and industry professionals.
Day One
On Sunday, the Congress will kick off with the Member Forum and AGM, a chance for members to hear about the activities of the association and an outline of the results from this year’s membership survey. Sunday evening will be the Welcome Reception where delegates can meet and network with each other and the exhibitors.

Day Two
The Congress program is filled with high-calibre speakers. The opening keynote address will be given by Professor Guy Maddern, Head, Discipline of Surgery at the University of Adelaide. Prof Maddern will talk about innovations in surgery and the risk of new technologies.

“New technology in surgery does not always have a positive outcome; care and follow up should be part of new surgical innovation,” Mr Maddern said. “Private hospitals have become leaders in introducing new technologies but the pressures of marketing and profile should not allow poorly evaluated interventions and procedures to occur.”

“I plan on talking to the Congress delegates about surgery that must be innovative but also reflective if errors of the past are not to be repeated. These things are crucial to surgeons and other healthcare professionals.”

Following on from Prof Maddern will be Michael Smith, Clinical Director of the Australian Commission on Safety and Quality in Health Care (ACSQHC). Dr Smith will present information on the move to national accreditation.

The concurrent sessions will explore relevant topics such as embracing social media, overseas recruitment and innovations in mental health. Carol Turnbull, CEO, of Ramsay Health Services SA is doing a presentation on Trans Cranial Magnetic Stimulation (TMS) - setting up a service in the private sector.

“We have been running the Trans Cranial Magnetic Stimulation project for two years now under Research protocols and have accumulated substantial data to prove its efficacy,” said Ms Turnbull.

“The TMS machine has recently received TGA approval. I plan on talking about how
APHA National Congress

Day Three

Tuesday begins with a keynote address from Hon Jillian Skinner, NSW Minister for Health, which will no doubt be an engaging discussion. Ms Skinner believes that “there needs to be greater investment in health in Australia, not only to improve access to services, but to add value to medical research and where patients require treatment, they should be able to enjoy the best quality outcomes.”

The concurrent sessions on Tuesday will focus on Patient Innovation and Lean Thinking and its value to private hospitals. Peter Fleming, CEO of NEHTA, will present NEHTA’s vision for Personal Health Records. Evan Rawstron, Chief Operating Officer at Macquarie University Hospital, will then discuss the hospital’s move to become a paper-free hospital.

“I am going to talk about the benefits of an electronic approach for hospitals and the challenges of delivering an electronic medical records in a service-critical environment,” Mr Rawstron said.

“The key link back to the Congress theme is that private hospitals are playing an increasingly important role in driving innovation in health care. This can be clearly seen in investments made in technology by a whole range of private hospitals and is likely to continue into the foreseeable future.”

APHA has been leading private hospitals in social media engagement and this effort will be expanded at the Congress. Twittercamp, run in the morning and afternoon tea sessions, will provide delegates a hands-on learning environment to get involved in this latest communication tool.

APHA welcomes all delegates to this year’s Congress. Registration information and the full program can be accessed at www.apha.consec.com.au.

By Rebecca Angove

By Hon Jillian Skinner, Peter Fleming, Evan Rawstron

this is a great example of the private sector taking the lead and finding new efficient treatments for patients with Mental Illness.”

Monday afternoon delegates will be able to watch the Baxter Awards showcase of presentations. The finalists from each category will be presenting their submissions. This session is a must-see for those attending the Gala Dinner where the winners will be announced.

Rounding out Monday’s sessions will be the pre-dinner cocktail party followed by the Gala Dinner, hosted by the Today Show’s Karl Stefanovic, where the 2011 APHA/Baxter Awards for Quality and Excellence will be presented. APHA received a high standard of applications this year and the judges have had a difficult task in choosing the winner for each category. After the formalities of the evening the night will kick on with live music from Lisa Hunt and Forever Soul, which will keep everyone entertained.
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Plastic surgeons at Macquarie University Hospital have played a key role in enhancing the quality of life of Charlie Abdallah who suffered massive injuries after a car accident in 2003.

Advanced reconstructive surgery techniques at Macquarie University Hospital are improving the quality of life of patients.
WHEN Charlie Abdallah had a car accident almost nine years ago, he suffered multiple and extremely serious injuries. The injuries were primarily internal abdominal injuries – failed kidneys, bowel and bladder, as well as collapsed lungs. Compromised blood supply to the right leg eventually led to a hindquarter amputation.

“Basically, everything stopped working, except my heart and my brain,” said Charlie. “I have no recollection of the accident. I only remember waking up in intensive care after about a month.”

Charlie stayed in Liverpool Hospital for a year and nine months, spending nine months in intensive care and a year on the wards. Since then, he has had twenty additional surgeries. Some have been elective, some emergency. Many of them have involved reconstructive plastic surgery, attempting to close large wounds or lessen the build-up of scar tissue.

Associate Professor Anand Deva, Head of Plastic Surgery at Macquarie University Hospital, has been actively involved in Charlie’s case since the night he was first admitted to hospital. Part of the team who worked hard to get him through those initial weeks, Professor Deva said Charlie is one of the sickest patients he has seen who has gone on to survive so remarkably.

“When I was consulted when he first came in, my first major involvement with Charlie’s recovery was in 2004, when we attempted to heal the abdominal and pelvic wounds that had not closed since the accident,” said Professor Deva. “Because urine and bowel contents were leaking through the wound, it became a matter of priority to look at ways of closing these wounds.

“To accelerate healing, the team used a vacuum sponge dressing, a relatively new technology used to treat chronic, non-healing wounds. This provided a rapid closure and healthy bed on which to place skin grafts, which ultimately achieved complete healing and prevented further loss of blood and body fluids.”

The plastic surgery team later operated to provide padding to Charlie’s pelvic area to allow him to use a wheelchair. Professor Deva also performed a cosmetic nose operation to correct the appearance and function of Charlie’s nose, which was fractured during the accident.

The team’s biggest challenge came with the most recent operation, performed at Macquarie University Hospital this year. The operation involved two procedures simultaneously: an ileostomy reversal and an abdominal reconstruction to address abdominal hernias that had resulted from loss of the majority of Charlie’s abdominal muscle and skin.

To recreate new skin for a reconstruction, a process called tissue expansion was used. Balloons were placed under the skin and from July to November last year, they were gradually expanded by inflation with saline injections. The expansion of tissue generates new healthy skin, which is used to make up for the deficit. During the operation, Professor Deva and Professor Tony Eyers, colorectal surgeon at Macquarie University Hospital, worked together first to reverse the ileostomy, then to reconstruct the abdominal muscles using a new dissolving mesh and, finally, to use the expanded skin to close the abdomen.

“I’m doing a lot better now,” said Charlie. “The surgery at Macquarie University Hospital was the biggest I’ve had since the initial injuries.

“I am very grateful to Professor Deva and also to Professor Tony Eyers. Professor Eyers is known to be one of the best colorectal surgeons, and I was lucky enough to have him assist with the operation.”

Charlie says that having the surgery at Macquarie University Hospital was an amazing experience. “It’s a place where you feel very comfortable. I felt very relaxed in my surroundings. You have enough physical pain in hospital, so it helps if you have a positive attitude and if your physical environment can give you emotional comfort.

“The hospital feels so contemporary. It’s colourful. You want to spend time there. It even has computers over the beds with internet connection; I’ve never been in a hospital with internet connection. These little things mean a lot. You’re still in touch.”

From a doctor’s point of view, the hospital also breaks new ground. “It’s impressive how, in planning the hospital, they looked at a lot of hospital systems – IT systems, the size of rooms, for example – and did a lot of analysis, then applied that information while building the hospital,” noted Professor Deva.

“The concept is unique in Australia. In the US, the top medical institutions – the Mayo Clinic, for example – are private university hospitals. These institutions attract the best doctors and so it is with Macquarie University Hospital. It’s certainly given surgeons access to everything that we love. I’ve done fairly major operations there already and it’s remarkable to work in such a new, clean and technologically advanced environment. I can do all facets of my work there and do them well. I can take on challenging clinical cases; I can pursue my research program; I have access to the newest technologies; I can teach skills and techniques to the next generation of plastic surgeons and I have adequate funding to pursue all these goals.”

“CHARLIE IS ONE OF THE SICKEST PATIENTS I HAVE SEEN WHO HAS GONE ON TO SURVIVE SO REMARKABLY”

Clearly, it’s people like Charlie who benefit from such innovation.

“It’s been a long and hard process but it’s an experience I couldn’t say I wish I had not gone through,” reflected Charlie. “It’s given me a whole new perspective on life and what I want to do. Something like this moulds your personality. I don’t wish it on anyone. The anguish of my family, seeing my parents facing such pain, has been the hardest thing. But, for me, who’s to say, if I hadn’t had this accident, where I would have ended up. I did go through a short period of depression, but you get over it. I’ve never really felt anger. You just accept it. You get much better at facing obstacles in your life after everything you’ve gone through.”

Getting two university degrees – a Bachelor of Software Engineering and a Bachelor of Mathematics – while recovering from his injuries is a sure sign that Charlie hasn’t given up and is able and wanting to face new challenges. He also trains daily and drives a car. PH
John Flynn commences ophthalmology services

Improving services for the Gold Coast, Tweed and Northern Rivers communities

JOHN Flynn Hospital is pleased to announce the commencement of new ophthalmology services at the hospital from 22 June 2011. This long-awaited service for John Flynn will bring ophthalmology back into the hospital setting and patients will be able to have the latest procedures with the new state-of-the-art laser and microscopic equipment both for examinations and surgery.

With suites on the 6th floor of John Flynn Medical Centre, Ophthalmologist Dr Cathryn Edrich of Sea View Eye specialist clinic will provide a wide range of services on site, along with Dr Tony Kwan, situated in Coolangatta, Southport and Brisbane and Dr Elizabeth Hagen, situated at Coolangatta.

The three specialists have been involved in the development of the service, with Dr Edrich providing a great deal of advice and support regarding the purchase of the laser equipment and diagnostics as well as the new operating microscope and faco machine, which will be used for treatment of cataracts.

The specialists will provide comprehensive ophthalmology services treating conditions such as diabetic eye disease and age-related macular degeneration as well as offering cataract, laser, vitreoretinal and oculoplastics surgery.

“We are delighted to provide this new service to the Gold Coast, Tweed and Northern Rivers communities,” said Mr Greg Jenke, hospital CEO. “We have been working on the development of ophthalmology for some time now and with the support of Drs Edridge, Kwan and Hagen and our dedicated nursing staff, we can now provide important access to this service.

“The new services mean we can provide a one-stop shop for ophthalmology care, from consultations through to surgery, all on the one hospital campus.

Now that this service is available at John Flynn, patients requiring vitreoretinal surgery can have their surgery closer to home, rather than travelling out of the local area. PH

By Anne-Marie Teoka
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Bio-absorbable stents

The rationale for new coronary stent technology
BLOCKAGE of coronary arteries (due to atherosclerotic plaque and clot) remains the leading killer in our community and in most Western countries. There have, however, been major advances in the treatment of coronary disease over the last 30 years with the development of truly minimally invasive, key-hole techniques termed percutaneous coronary intervention (PCI).

From its humble beginnings in 1977 with the use of a balloon catheter introduced to the narrowed coronary artery from a groin vessel under local anaesthesia (using X-ray guidance), the technique has evolved rapidly and dramatically expanding the applicability of therapy thus permitting treatment of increasingly complex disease and extending its ability to treat most patients. The balloon catheter (sausage shaped) once at the site of coronary arterial narrowing is expanded allowing dilatation of the diseased vessel and increasing blood flow to heart muscle deprived of sufficient oxygen. The procedure called coronary angioplasty was refined by the 1990s with the routine addition of a metallic coronary stent (sometimes now termed a bare metal stent) implanted at the site of narrowing after initial balloon expansion. These mesh-like stents are expanded on a separate balloon catheter and remain in the coronary artery permanently. By providing a scaffold to an otherwise diseased but elastic artery, they create significant improvements on the results of balloon dilatation alone and lower the rates of re-narrowing at the site of treatment over subsequent months through the prevention of vessel ‘shrinkage’.

Given this excellent performance, coronary stenting still remains the default strategy in PCI treatment of coronary blockages. The stents have evolved highly in the last decade – initially composed of stainless steel, they are now made of a thinner and more flexible alloy (cobalt chromium or platinum chromium) increasing ease and safety of use. The other significant development has been the evolution to a drug coated metallic stent over the last 7-10 years. So-called drug eluting stents, as opposed to a bare metal stent, represent the state-of-the-art device in interventional cardiology in 2011.

“These alloy stents are impregnated with a drug (bound to the stent surface by a polymer) which is released into the artery wall locally at low dose over several months after stent expansion, thus preventing scar tissue in-growth within the stent (leading to a re-narrowing at the site of treatment) that had otherwise plagued bare metal stents (at a rate of 10-20 percent three to six months after stent deployment). The profound improvement in performance of drug eluting stents has significantly altered the overall profile of therapy for blocked coronary arteries – substantially more patients can now be treated effectively with stenting rather than the need for more invasive open-heart bypass surgery without compromise of longer-term clinical outcomes.

The final chapter in this revolution of treatment of blockages is the move to fully bio-absorbable drug eluting stents.

In many ways, this approach represents the Holy Grail of stent technology. Despite the excellent performance and utility of drug eluting metallic stents, they are permanent ‘foreign body’ implants and generally require concomitant long-term double blood thinner (aspirin and an aspirin-like drug called clopidogrel). The advantage of a novel bio-absorbable stent lies in its ability to offer all the early advantages of a metallic stent (scaffolding, improved blood flow and local drug delivery) with the additional benefit of naturally eroding away and being absorbed after 12-18 months, leaving a healthy artery with no residual metal lining.

The advantages are substantial – less need for (costly) ongoing blood thinner therapy with reduced risk of bleeding. Separately, the absence of a metallic casing of the artery allows positive arterial healing and elastic function over months and years from implantation. Similarly the absence of a metallic implant will not impact on other imaging techniques such as MRI and CT scanning of the heart and arteries, which is currently the case with metallic stents. The absorbable scaffold is made of poly-lactic acid (the same compound used in dissolvable suture material) and metabolizes naturally over 12-18 months before complete and total absorption by the body.

The bio-absorbable stent is still under investigational review in Australia, although it has been approved for commercial use in Europe. At the Eastern Heart Clinic Theatres at the Prince of Wales Public Hospital in Randwick, we are using this new technology as part of an international collaborative trial (the only NSW site and only one of a handful in Australasia) confirming device efficacy and safety. Consistent with global results, our experience having treated patients with this new technology is highly exciting and very encouraging and we anticipate the bio-absorbable stent scaffold will become the default tool for the key-hole approach to treating blocked heart arteries in the coming years.

The energy-efficient, green evolution is extending to the human heart! By Dr Nigel Jepson
In focus: Innovation in private hospitals

Dr Bob Ayres demonstrating the new Artis Zee technology in the Cardiac Catheter Laboratory at St Andrew’s Toowoomba Hospital

Advances in Cardiac Care

St Andrew’s Toowoomba Hospital upgrades its cardiac equipment to improve services
ST ANDREW’S Toowoomba Hospital has invested $700,000 in the latest technological equipment to investigate and diagnose cardiovascular conditions and is the first private hospital in Queensland to have the newest technology in CT imaging.

Cardiovascular disease is the leading cause of morbidity and mortality in Queensland and is estimated to affect one in four by 2051. The hospital is committed to establishing a Centre for Cardiac Care for residents of the Toowoomba and Darling Downs region.

The technology allows doctors to perform procedures more accurately.

“We have a number of leading cardiologists who treat patients at St Andrew’s and utilise this equipment on a daily basis,” said Mr Fairweather. “The doctors are delighted with the upgrade to the Cath Lab as the new technology allows them to visualise blood vessels and devices more clearly, increasing their confidence in diagnosis and allowing them to perform procedures more accurately.”

In addition, St Andrew’s Toowoomba Hospital is the first private hospital in Queensland to have the latest technology in CT imaging, a new 256-slice CT machine installed by Queensland X-Ray Service.

The new 256-slice CT machine from Phillips is one of the best available in Australia and has advanced to provide precise imaging of whole organs such as the heart and liver and allows radiologists to diagnose a range of conditions with extreme accuracy.

Toowoomba is very fortunate to have this technology available to patients locally. “A significant number of patients with coronary artery disease are treated every year at St Andrew’s Toowoomba Hospital. Patients come from as far afield as Longreach and Charleville to utilise this advanced technology,” said Mr Fairweather.

St Andrew’s Toowoomba Hospital is renowned for expanding services to meet the needs of the local community. In 2002 the hospital built the only Cancer Care Centre in Toowoomba with medical oncology and radiation oncology services. The Cancer Care Centre is now the largest inland Centre of its kind and due to unprecedented demand is set to double in size in 2012.

“We see a similar need developing in Cardiac Care Services in Toowoomba, as we did with Cancer Care. With our large catchment from rural areas and an ageing population, Toowoomba is well placed to provide a quality cardiac service,” said Mr Fairweather.

As part of the St Andrew’s Cardiac Care Service patients who are recovering from bypass surgery or cardiac conditions can benefit from the St Andrew’s Cardiac Rehabilitation Program. The right rehabilitation program will help most heart patients reduce their risk of further coronary heart disease. The program gives patients information, education, physical activity and a friendly supportive environment.

St Andrew’s Toowoomba Hospital has a very strong reputation in the local community and was recognised through a Medibank Private survey, rating the hospital in the top four in Queensland for patient care.

The hospital prides itself on maintaining this status with members of the community.

St Andrew’s Toowoomba Hospital continues to lead the way in healthcare in Toowoomba, focusing on growth of core services.

By Louise Cuskelly
In focus: Innovation in private hospitals

Robotic leg gives Paralympian a new way to walk

New endo-exo prostheses technology is improving quality of life for users

PARALYMPIAN Brendan Burkett walked out of Macquarie University Hospital just three weeks after being fitted with the newest innovation in orthopaedic surgery – an endo-exo prosthesis. Brendan, who lost his leg in a hit and run accident 25 years ago, is one of only a handful of people in Australia to undergo the procedure so far.

According to Dr Munjed Al Muderis, the orthopaedic surgeon who performed the two-stage operation, although he is in the early stage of recovery, Brendan’s fantastic progress is a promising sign of the operation’s overall success.

The robotic leg is attached to the lower limb by a prosthesis that is inserted into the femur bone in a similar way dental implants are inserted. This revolutionary new approach forms a permanent connection between the prosthesis and the bone, allowing a more natural distribution of weight on the leg and much greater mobility – improving the patient’s overall quality of life.

Different from traditional vacuum prosthetic legs, the procedure removes any contact between the prosthesis and skin, which offers more comfort to the patient and reduces the risk of infection.

“The robotic leg reduces the load on the body. Conventional prostheses take an additional 30 percent of energy from a patient, which can add stress to the heart and other organs,” said Dr Al Muderis.

Though he is realistic about the recovery process ahead, Brendan says that simple achievements like being able to tie his shoe for the first time in 25 years without difficulty gives him hope about what this procedure could mean for the future of prosthesis.

“I know that it’s going to take some time to see the full effects of the operation but I’m already seeing the improvements in the way I sit and my mobility. Things are looking good.”

PH August 2011
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A partnership between Ramsay Health Care WA and Marr Mooditj Training is providing workplace opportunities in healthcare. Ramsay Health Care WA is providing real opportunities for Indigenous Australians to encourage more Indigenous nurses to join the workplace.

The partnership with the Indigenous health training college Marr Mooditj is an innovative approach and representative of Ramsay Health Care’s commitment to its 2010-2013 Reconciliation Action Plan, which includes promoting opportunities for Indigenous Australians within its workplace.

“Ramsay will work to ensure that our workforce is supported, engaged and provided with improved opportunities for career and skill development for Indigenous people,” said Rita Maguire, State HR Manager, Ramsay Health Care WA.

The relationship has already commenced successfully with many nurses receiving practical experience at hospitals in WA with further educational and training opportunities in the pipeline. Several enrolled nurse graduates from Marr Mooditj Training will be commencing employment with Hollywood Private in the August 2011 Gradplus program.

In support of the partnership, Ramsay Health Care sponsored Healing the Spirit Within, which was held at Clontarf Oval on 5 July as part of the celebrations for NAIDOC week. The event, hosted by Marr Mooditj Training and Abmusic, is focused on healing the spirit within: reconnecting with culture, practices, traditional foods and story telling by Elders around a campfire.

Ramsay Health Care’s stall at the event saw health professionals on hand to provide free blood pressure and diabetes tests to the indigenous community. Staff members from the Human Resources team were be available to discuss Indigenous employment opportunities at four WA hospitals; Hollywood Private Hospital, Joondalup Health Campus, Attadale Private Hospital and Glengarry Private Hospital.

“We aim to develop ways for our diverse workforce to gain knowledge of, and respect for, Australia’s Indigenous cultures and history. We will also strive to ensure our trainees are appropriately supported to grow and develop in their career,” Rita Maguire said. PH
Nurse training in the Solomon Islands

UnitingCare Health volunteers are helping to teach nurses from island communities

PATTERSON delivers babies, diagnoses illnesses, performs minor procedures and prescribes medication. Based on a remote island in the Solomon Islands, this nurse is the closest thing to a doctor the small community has.

Patterson lives in the village on Buni Island and runs the rural health clinic like a doctor’s surgery. He completed the three-year Diploma of Nursing in the capital, Honiara, and worked as a graduate nurse for one year before being appointed to the Helena Goldie Hospital remote area staff and taking up his current role.

Director of Clinical Education at Brisbane’s Wesley Hospital and the Helena Goldie Hospital Program Clinical Project Leader, Wendy Zernike, said the level of clinical work Patterson performs is incredible.

“The three-year, diploma level, nurse training programs in the Solomon Islands are helping to improve healthcare outcomes for whole communities,” Ms Zernike said.

“It’s amazing that registered nurses who have trained for three years and are just one year out of training are running clinics. This very capable 23-year-old has a small ward of three general beds plus two maternity beds, delivers babies as well as diagnoses and treats chest pain, gastroenteritis and pneumonia.”
“He also travels to see patients on the surrounding islands, consults with doctors over a two-way radio and is a 20-minute boat ride from the Helena Goldie Hospital.”

The Helena Goldie Hospital in Munda in the Western Province has one of the few Diploma of Nursing programs in the Solomon Islands. Run by the United Church in Solomon Islands, the hospital partners with the Uniting Church of Australia. UnitingCare Health is part of UnitingCare Queensland and operates a number of private hospitals in Queensland.

As part of this partnership, UnitingCare Health is committed to helping the Helena Goldie Hospital and Nursing College as part of UnitingCare Health’s missional work, which is strongly linked to its values of compassion, respect, justice, working together and leading through learning.

Wendy Zernike and up to three clinical volunteers from UnitingCare Health hospitals travel to the Solomon Islands twice a year to teach at the Helena Goldie College of Nursing as well as assist and work in partnership with staff at the Helena Goldie Hospital.

“We go twice a year to coincide with the nursing school program,” Ms Zernike said. “For consistency, we ask our clinical volunteers to commit themselves to the two trips each year to help build relationships with the hospital community.”

In May, Wendy Zernike, accompanied by Annette Bailey, Clinical Nurse Manager from St Andrew’s War Memorial Hospital Emergency Unit in Brisbane and Kathy Johns, Peri-operative Clinical Nurse from St Stephen’s Hospital in Maryborough, spent a week working in partnership with the staff at the Helena Goldie Hospital and Nursing College.

Wearing the “Munda” footwear, a pair of thongs, the team worked in up to 40°C heat and what seemed close to 100 percent humidity throughout their stay. They brought donated medical equipment and supplies from Australia and helped repair some of the broken hospital equipment.

“We spend a lot of the time helping in the hospital wards, gaining an understanding of the conditions that the staff work in, the equipment available and the kind of illnesses and conditions the patients presented with,” Ms Zernike said.

“The students and nurses were keen to learn how to put a nursing care plan together, something we do here in Australia as part of our role that will now have a big impact on nursing care efficiencies in the Helena Goldie Hospital and in remote clinics. Conditions at the 55-bed hospital are basic,” she said. “Other than an old X-ray machine, there were no diagnostic tools or running water and when we were there last year, two out of three of the sterilising machines weren’t working when we arrived. During their stay, the Helena Goldie Hospital team also travelled to some of the surrounding islands with the remote area health clinic to see how care was being provided to the people within their own villages. The remote health clinics occur around every eight weeks when a doctor, specially trained nurses, dentist and pharmacist spend up to a week visiting the local villages and provide medical treatment.

Ms Zernike said she was in awe of the work that was done by the visiting health clinics.
Registered nurse Patterson

Ms Zernike said the continuity of UnitingCare Health staff to train Helena Goldie College of Nursing has seen UnitingCare Health staff accepted into the Helena Goldie Hospital community. “We have learned to adapt teaching styles to accommodate the Helena Goldie College of Nursing,” she said. “It has been a cultural and situation shift compared to the teaching pedagogy we are used to in Australia. However, the Helena Goldie Hospital staff are sharing more of themselves and their experiences and the benefit for us to be part of the Helena Goldie Hospital program is we grow as health professionals and teachers as well as to help with the program.

“At the end of September, we will return to teach both the first year and second year College of Nursing students as they rotate through the college for lectures and the hospital for clinical placements. We will be there again to participate in lectures, assist staff at the hospital and once again we will continue to learn and grow from this incredible experience.”

By Raylee Huggett

THE HEALTHCARE TEAMS INVOLVED DO SO MUCH INCREDIBLE WORK IN THE MOST BASIC CONDITIONS

It's difficult to get supplies and equipment to the hospital and the remote islands,” he said. “It's also difficult to maintain the equipment, so we found the most beneficial way to add value is through education.”

The Helena Goldie Hospital Nurse Aide training school started in the 1960s and continued until 2009, training over 500 Nursing Assistants (similar qualifications as an enrolled nurse in Australia). In 2010, the Helena Goldie College of Nursing upgraded its course to train nurses to Diploma of Nursing level to become Registered Nurses.

“The Wesley Hospital in conjunction with UnitingCare Health offered assistance in training nurses in the three-year Registered Nurses program,” Ms Zernike said. “The aim of the three-year diploma program at Helena Goldie College of Nursing, now in its second year, is to train more registered nurses so they can go out to remote posts around the Solomon Islands.

“The diploma of nursing program includes an obstetric component with a minimum of 20 deliveries at the hospital, which doesn’t happen in Australia, nurses need to be qualified midwives to deliver babies here.” A$5000, she said. “We are looking at opportunities for either sponsorship or fundraising so each Nurses Aide will not be financially disadvantaged while they study for their Diploma.

“We are looking at sponsoring student nurses in a similar way World Vision sponsors children,” she said. “I have already had an inquiry on sponsoring a student nurse from a Department in The Wesley Hospital, so we are now looking at how this can be done.”

Ms Zernike explained that the Solomon Islands had a four-tier health system.

“The first tier of health care for the Solomon Islanders is the nurse aides based on the remote islands, then the second tier is the registered nurses. If the patient's condition cannot be treated by the registered nurses such as Patterson, then the patient is sent to Helena Goldie Hospital, the third tier. “If the condition requires more specialised care than is offered at the Helena Goldie Hospital, the patient is escalated to the forth tier and sent to Honiara Hospital in Honiara, the tiny nation’s capital, and that's only in extreme cases.”
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Improved patient education

The Patient Diary

Improving the delivery of information on chemotherapy
A n increase in day patient numbers and novice oncology staff at Greenslopes Private Hospital has resulted in a prize-winning Patient Education program for oncology nurses Kelly Atkinson and Kerry Phillips-Smith.

After realising a more sustainable approach to patient education was required the Patient Diary was developed to transform the delivery of information about chemotherapy to the patient. The Patient Diary is a research tool that provides a consistent quality script that can be used by anyone from a novice nurse to an experienced oncology nurse.

“Educating patients is crucial for chemotherapy treatments. We wanted the diary to connect to the patient so they could monitor their symptoms for self-assessment,” explained Ms Phillips-Smith.

“The diary is unique and has been in use for about eight months now. We are finding it gets a very positive response from both patients and staff.”

The Patient Diary has information about cancer, helpful insights about dealing with treatments, side effects and advice for chemotherapy. Currently, 97 percent of patients use the diary and 86 percent track their symptoms, including after chemotherapy sessions. This means all the doctors, nurses and patients can communicate in a common language.

The diary has a traffic light colour system that is the Common Terminology Criteria for Adverse Events (CTCAE) Scale. This means that patients can track their results along the different grades from 0-4 and the higher up the scale their symptoms are, the more likely they are reaching a danger zone and need to get in touch with their GP. This has allowed patients to stay safe while receiving treatment. It also has a recording system for patients to track their progress for self-monitoring and self-assessment.

Since introducing the Patient Diary, nurse and patient satisfaction has improved and novices have gained confidence in educating their patients. The use of the diary shows that 40 percent of patients that used the diary made the decision to come to emergency for review, 97 percent of these people used the grading scale to make that decision and only 10 percent required admission to the hospital.

“The use of this tool has been ground-breaking and positive for my patients,” said Ms Phillips-Smith.

“All nurses can educate with this initiative, and all patients can better manage their symptoms at home.”

The program recently won a category first and overall first at the 8th Innovative Practice in the Private Sector Conference. Run by the Private Hospitals Association of Queensland, the conference showcases innovations in the private sector that have demonstrated outcomes in Clinical Innovation; Non-Clinical/Operational Innovation; Innovation in Education and HR Management and Marketing and Community Awareness Initiatives. PH

By Rebecca Angove
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The city of Brisbane was once again painted pink this July, in support of the Think Pink Think Choices Week, the annual awareness and fundraising campaign of the Wesley Hospital Kim Walters Choices Program. The Kim Walters Choices Program is a unique community service offering information, friendship and support for women, men and their families who have been affected by a breast or gynaecological cancer diagnosis. Choices is a free service offered regardless of where surgery and treatment have been received.

The 2011 fundraising campaign was launched on Monday 18 July in Brisbane Square with an outside broadcast from B105 radio station, which raised $23,000. The focus of the launch was the Bras by the Stars fashion parade hosted by B105's Camilla Severi. The parade showcased bras decorated by well-known Australians and modelled by the Brisbane Broncos' cheerleaders. This year's parade featured bras designed by Channel 9 newsreader Melissa Downs; Brisbane Bronco Sam Thaiday; Actor Lincoln Lewis and Channel 7 newsreader Sharyn Ghidella. The bras were auctioned off to raise funds for the campaign.

Another key signature event of Think Pink week was the Pink in the City Tea Party, hosted by Brisbane's Treasury Heritage Hotel and emceed by Camilla of B105. The high tea
Fundraising

IT WAS GREAT THAT EVERYONE RAISED FUNDS TO ENABLE US TO PROVIDE OUR FREE SERVICE TO THOSE AFFECTED BY CANCER

was an opportunity for guests to put on their pinkest outfit and dine out for a good cause. The tea party included a style workshop by stylist Di Cant, as well as a special pamper zone for guests to receive mini massages and hair and make up touch-ups.

Brisbane’s Southbank Precinct was also thinking pink, with the Brisbane Wheel, Stefan’s Needle, the Queensland Performing Arts Complex, the Brisbane Convention and Exhibition Centre dome along with Treasury Heritage Hotel and Casino, City Hall, King George Square and Kurilpa Bridge all lighting up pink for the week.

Choices Funding Development Coordinator, Linda Grieve, said Choices had received tremendous support from the people of Brisbane during Think Pink Week.

“It was fantastic to have the support of the Brisbane community and among all the partying in pink, it was great that everyone raised funds to enable us to provide our free service to those affected by cancer in our community,” she said.

Think Pink Week culminated in the Think Pink Cabaret Charity Ball on Saturday 23 July at the Brisbane Convention and Exhibition Centre. More than 400 people attended the event, which helped raise over $50,000 in funds for the Choices program.

Guests were entertained by emcee Emily-Jade O’Keefe from Brisbane radio station, Triple M and by local Brisbane band, Size Duzz Matter. Various fundraising activities on the night provided many opportunities for people to support the Choices program.

The Wesley’s Hospital’s Acting General Manager, Ann Maguire, said: “The Wesley is proud to be involved with this unique program that makes such a difference to thousands of people in Brisbane each year. Now in its 13th year, Choices continues to provide practical support and information for people affected by breast or gynaecological cancer.”

By Bridget Brown
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Reference:
A new education tool is helping to improve the way operating teams respond to fire evacuation from an operating theatre.

A DVD based on a dramatic fire evacuation incident in an operating theatre in New Zealand is now available for worldwide distribution and should prove a valuable teaching tool. Titled 'I Smell Smoke,' the DVD re-enacts the circumstances of a fire event that happened at the Anglesea Procedure Centre in Hamilton during a laparoscopic gynaecological procedure.

The theatre was evacuated and the patient was removed from the scene safely and uneventfully. But why didn't the alarms go off in a building less than 12 months old that was fully compliant? And why didn't the smoke detector detect the smoke?

The DVD demonstrates how a fully compliant operating theatre does not necessarily provide adequate fire safety systems in the event of a fire in or near the operating theatre. It also shows the realities of evacuating a patient mid-surgery, the more realistic time frames involved in a real fire event and how a real life evacuation can be quite different to what is practised.

On the DVD the fire scenario is recreated by the Procedure Centre in conjunction with the Fire Consultants using hot and cold smoke with the original operating team re-enacting the
operation and subsequent evacuation. The presentation includes the re-enactment plus subsequent findings as well as demonstrating the differences between the theory and what actually happened.

In this incident there was smoke billowing into theatre, the fire alarm had not gone off and there was no idea where the smoke was coming from. Fortunately, there was no one injured in the incident but the outcome could easily have been different.

What happened
A smouldering fire started in the motor switch in the fire rated plantroom above the operating theatres.

The smoke got drawn into the A/C intake and down into the theatre. The plantroom smoke detectors didn’t operate until after the smoke was smelt in theatre 2. Even when they did operate they didn’t sound the alarms and they also did not shut down the A/C. The theatre 2 smoke detectors did not operate and the theatre staff in the middle of a laparoscopy were unaware that smoke was coming into the theatre.

Luckily the surgeon from the adjacent theatre 1 who hadn’t yet started surgery came into theatre 2 and upon entering immediately smelt smoke that the occupants had been completely unaware of.

The lights were turned on and the smoke was seen and the New Zealand Fire Service was called. The theatre 2 team immediately started preparing the patient for evacuation to the recovery fire cell. The theatre 1 patient was removed to a safe place and that team came to help the theatre 2 team.

It took the two theatre teams (two surgeons, two registrars, two anaesthetists, two anaesthetists technicians, four theatre nurses and manager) about 8-10 minutes to prepare the patient who was undergoing ‘minor’ laparoscopic surgery for evacuation. All of this time smoke was filling the theatre.

The staff suffered from smoke inhalation from the time they were in the smoke-filled theatre although luckily not seriously. It could have been a lot worse had there not been so many extra theatre staff on hand to assist.

Spreading the word
Nicky van Praagh, who documented the incident, has been asked to make a presentation at meetings and conferences in New Zealand and Australia and decided the best way to make it available further afield was by making a DVD.

“I have presented it at meetings in New Zealand, at the International Day Surgery Conference in Australia and the Theatre Managers and Educators Conference in Christchurch. In addition there have been several requests for information from hospitals in Australia and a visit from the educator at the Royal Hobart Hospital in Tasmania wanting to use it as a teaching tool for their hospitals,” van Praagh said.

The presentations that the Fire Consultant and van Praagh have delivered have certainly created awareness in the different industries of the realities of evacuating an operating theatre and the effect the air flows have on the smoke detectors in theatre. “In that respect the project has been very successful,” said van Praagh.

Nicky van Praagh was the 2010 National Award Winner of the Leaders in Quality Award, NZ Private Surgical Hospitals Association. The judges were particularly impressed with the innovative approach the hospital took to learning from the incident. The use of re-enactment, videoing and the involvement of external agencies to assist them in improving their processes was quite unique and a thorough process. Their willingness and openness to share their learning and advance operating theatre fire awareness with the New Zealand health sector and overseas is applauded. The judges also commended Anglesea Procedure Centre for their efforts in attempting to influence national fire safety standards, which will have the ultimate benefit of improving patient and staff safety.

An outcome of the re-enactment was that a working party was set up between the Society Of Fire Protection Engineers, the Institution Of Fire Protection Engineers, New Zealand Fire Service and the Department Of Building And Housing. The working party looked at the building code requirements for hospitals and other specialised occupancies and what special requirements were needed for the group. It resulted in changes to the Acceptable Solution to which fire engineers design to.

By Phillip Quay

“When the DVD was released there was a good response,” said van Praagh. “The New Zealand Fire Service were interested in the project and the way we went about it.”

The dvd is available for $95 (plus GST). Contact:
Nicky van Praagh,
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VENOUS thromboembolism (VTE) – the formation of a blood clot in a major vein in the legs (deep vein thrombosis) or lungs (pulmonary embolism) – is a significant and potentially fatal condition that results in an estimated 30,000 hospitalisations and 5000 deaths each year in Australia. There are significant long-term costs and consequences for those who survive VTE.

The majority of VTE cases requiring hospitalisation are related to prior hospitalisation for either surgery or an acute illness and are preventable using safe, efficacious, cost-effective and proven measures. In spite of these measures, the problem persists and best practice guidelines and recommendations continue to be under-used. Fortunately there are effective strategies to increase the uptake of VTE prophylaxis for hospitalised patients.
Recently the Australian Commission on Safety and Quality in Health Care (the Commission) and the National Health and Medical Research Council’s National Institute of Clinical Studies (NHMRC) launched a range of materials designed to assist hospitals and other health services provide the best possible, evidence-based care to patients at risk of VTE. Materials and other support include:

1. **Clinical Practice Guideline for the Prevention of VTE in Patients Admitted to Australian Hospitals (2009);**
2. Clinician and consumer guides to the VTE prophylaxis guidelines;
3. **VTE Prevention Resource Centre,** a dedicated section of the Commission web site which includes all VTE prevention materials and resources developed by the Commission and NHMRC, and links to other resources including:
   a. NPS e-learning module on prescribing for deep venous thrombosis; and
   b. NSW Clinical Excellence Commission’s Medication Safety Self Assessment for Antithrombotic Therapy in Australian Hospitals; and
   c. NSW Therapeutic Advisory Group’s Indicators for Quality Use of Medicines in Australian Hospitals;
4. A template whole-of-hospital VTE prophylaxis policy (with examples of policies and local guidelines provided on the Commission web site);
5. **Stop the Clot** – the third edition of a guide to integrating VTE prevention guideline recommendations into routine hospital care and recently updated by the Commission and the NHMRC;
6. **Preventing Venous Thromboembolism in Hospitalised Patients** – summary of NHMRC activity 2003-2010; and
7. **Summary report on the national VTE Prevention Policy Summit held in 2010** by the NHMRC and the Commission.

All the materials are available for free download from the Commission website at [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au).

The materials reflect the experience of Australian private hospitals including those that participated in the Private Hospital VTE Prevention Program in 2008-2009. Thirty-six private hospitals participated in the Commission-funded program, which was managed by NHMRC. The program resulted in an increase in private hospitals with VTE prevention policies, improved rates of risk assessment, improved use of VTE prevention measures and improvements in sustainable VTE prevention systems. Key outcomes included:

- The proportion of hospitals with a policy governing VTE risk assessment and prophylaxis management increased from 18 percent to 68 percent at the end of the program – seventeen extra hospitals developed policies during the program.
- The average proportion of audited patients for whom VTE risk assessment had been completed and documented increased from 11 percent to 53 percent by the end of the program.
- High-risk patients were significantly more likely to receive appropriate VTE prevention if their risk level had been assessed and documented than if no risk assessment had been documented (68 percent versus 52 percent, p ≤ 0.001).
- The average proportion of patients at high risk of VTE who received appropriate prevention measures increased from 53 percent to 62 percent. Eleven hospitals improved by more than 25 percent. However, the degree of improvement in VTE prevention for high-risk patients varied widely between hospitals.

Private hospitals are encouraged to use the materials developed by the Commission and the NHMRC to reduce the burden of VTE and to improve health outcomes for patients.

*By Graham Bedford*
NEW ZEALANDERS were urged to wear the red and black colours of Canterbury on Friday 15 July to show support for the people of Christchurch.

The National Red and Black Day was organised by Kara Fleming, senior communications advisor with Hamilton-based NZ Transport Agency, as a way for the country to show solidarity and support for Christchurch.

The ultimate goal of Red and Black Day was to raise as much as possible for the Red Cross Earthquake Appeal and people were encouraged to use the day as a platform to arrange other fundraising efforts at their own workplaces and schools.

New Zealand private hospitals got behind the initiative. Nicky van Praagh, Manager at Anglesea Procedure Centre, said supporting the earthquake victims was important to everyone at the facility.

“We were due for new scrubs around the time of the February earthquake. Many of our staff have close ties to Christchurch so chose to get black with red stripes as a tribute to those affected by the earthquake. One of the staff members made the theatre hats to complete the image,” she said.

“These uniforms are worn every day now and we receive many favourable comments from the patients especially those who also have links to Canterbury.”

Many of the hospital’s staff members had friends and family affected by the earthquake and one of the staff members had a friend killed in the CTV building. On 15 July all staff were wearing red and black.

At St George’s Hospital they ran a Red and Black Challenge for their staff. Tony Hunter said it took off like wildfire.

“We ran a competition around the whole site for the best decorated department,” he said. “The winner of the best decorated hospital department and best consulting room got a free morning tea once a week for a month.”

So many New Zealanders, and people around the world, have felt helpless watching the devastation in Christchurch.
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A permanent voice for healthcare safety & quality

New legislation has come into effect giving permanency to the Australian Commission on Safety and Quality in Health Care

The Australian Commission on Safety and Quality in Health Care (the Commission) commenced as an independent, statutory authority on 1 July under the National Health and Hospitals Network Act 2011. The permanent Commission is to lead and coordinate improvements in safety and quality in health care across Australia.

From 1 July 2011 the Commission’s role is to:

• promote, support and encourage the implementation of programs and initiatives relating to healthcare safety and quality matters.
• collect, analyse, interpret and disseminate information and advise Health Ministers on matters relating to healthcare safety and quality matters.
• work with clinicians, the Commonwealth, state and territory governments and the private sector to develop and disseminate national clinical standards and indicators relating to healthcare safety and quality matters.
• promote, support and encourage the implementation of clinical standards and indicators.
• promote, support and encourage training programs and research relating to the Commission’s key work areas.

The full list of Commission functions can be found in Section 9 of the National Health and Hospitals Network Act 2011.

The private sector continues to be a key focus for the Commission and I was very pleased to accept the appointment of interim Board member from 1 July 2011. Richard Bowden, Managing Director of BUPA Australia, will also continue to represent the private insurance sector on the Board.

At its first meeting on 1 July 2011 the interim Board appointed Mr Bill Lawrence, AM, as the Acting Chief Executive Officer for the Commission. Mr Lawrence brings a wealth of knowledge to the role and has previously held the roles of Deputy Chief Executive and Senior Operation Manager for the Commission.

This is an exciting new phase for the Commission. In addition to continuing its current work in driving key national safety and quality initiatives, the Commission now has an expanded role to undertake work relating to clinical standards, guidelines and indicators.

Programs such as healthcare associated infection and medication safety will be ramped up and the Commission will start work on identifying key national goals for safety and quality and developing the work plans to achieve these goals.

Another major focus for the permanent Commission is to continue supporting state and local implementation of safety and quality initiatives. Over the past five years a large range of materials, support and tools for implementation have been developed from Commission programs and projects. Many of the materials are
designed to be flexible so that they can support implementation in many settings or contexts. The development of more targeted implementation support tools will be received with enthusiasm from the private sector.

I look forward to updating you in the coming months on the Commission agenda and highlighting those initiatives that are of particular interest for the private sector. PH

I welcome your feedback on this column and on any matters relating to quality and safety and the Australian Commission on Safety and Quality in Health Care. I can be contacted via the APHA Secretariat – barbara.carney@apha.org.au

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Born on the fourth of July

A ‘new paradigm’ in Australian politics

From Monday 4 July the balance shifted dramatically in federal politics. The Senate elected at the August 2010 election was sworn in and the new line-up gives the balance of power to the Greens in their own right – this is assuming that the Greens vote as a bloc. A combined ALP/Green vote is 40 Senators out of a total of 76 – a clear majority.

From 2007 to 4 July, the balance of power was something of a moving feast with various independents and the Greens presenting themselves as ad hoc supporters of policies and legislation, often with a high level of unpredictability.

So what does this ‘new paradigm’ mean for politics and government in the next 6-12 months? Policy Patter has looked into the crystal ball, and the picture is a bit murky.

For the Government
The Gillard government can take little long-term satisfaction from the new balance of power arrangements. Under the previous Senate, the government had a small level of flexibility in dealing with the independents, but under the new arrangements the Greens have a controlling vote in the House (MP Adam Bandt) and the balance of power in the Senate.

The government will be able to get Bills through on carbon pricing and minerals tax but what is unclear is whether the detail in those Bills will reflect Labor’s or the Greens’ agenda. The government is also facing difficulty over its proposed cuts to the childcare tax rebate, with Greens support uncertain as this column goes to press.

In this climate, the introduction of a deeply unpopular means-test to the PHI rebate may be one battle too many. But as this is written, Health Minister Roxon has just introduced this legislation on the very last day before parliament goes into a five-week recess. This means that the government has the long winter break to try to get the votes it needs on the floor of the House, while escaping being accused of being wimpish over a measure it has tried unsuccessfully to get through the parliament twice before.

There is another issue that is below the radar so far (except for some opinion writers’ commentary) but which is very much occupying the attention of Greens leader Bob Brown. That is, that the nine Green Senators are not a unified team, with common attitudes and philosophical approaches to issues.

Canberra insiders are already chatting about discussions where Senator Brown has expressed concern as to whether the Greens might have split votes on some issues between their ‘moderate’ wing and the far-left ideological Senators. Time will tell but to the extent that the moderate Greens are seen to ‘lose out’ to their more radical colleagues, this in effect creates a very real problem for the government if they are seen to be at the voting mercy of the Greens’ radical wing.

Within the Labor Caucus, there has already been deep concern expressed by members of both Right and Left factions that the Greens are being given credit for proposing traditional Labor policies and that the Greens (and indeed the House Independents) are being given briefings and access not available to even senior
Labor Members and Senators. Strong-minded people such as Senator Doug Cameron have gone public on this concern. It will be difficult for government members to put up with a new regime where the Greens are perceived to be in control of the government agenda.

The other big issue is the very poor polling for both the Prime Minister and for Labor in terms of both its primary vote and the two-party preferred numbers – both of which are at historically low levels. Some pundits say that the patience of the Caucus will only last so long before they move to replace the PM as an act of self-preservation.

For the Opposition
Given this confluence of circumstances, there is probably a big temptation for the opposition to go on the attack immediately against the Greens new power position in the Senate. Policy Potter thinks this could be a mistake.

It would be more strategic for the Coalition to await the detail on the carbon pricing and minerals tax issues and the public reception they receive. Similarly, this applies to decisions on the Malaysian option for asylum seekers and the live cattle exports issue. The government will have their hands full winning outcomes on all these issues that are broadly acceptable to the Australian community – not known for its radical nature. And unless these coming decisions and announcements are ‘broadly acceptable’ and this is reflected in future polling, then the focus will remain on the PM and Labor as being without courage or direction in the face of Green and Independent threats.

In short, the lesson for the opposition could be that Labor and the Greens will be doing a good job of fighting each other on many issues without any help from Mr Abbot or his front bench.

The attacking mode of the first half of 2011 has worked well but it is now time for some positive and dynamic messages to emerge, without giving way to the constant barracking of “show us your detailed policies” from government, Greens or the commentariat. Otherwise, there is a risk of a renewed media focus on tensions within the Liberal Party, which would be a distraction at best, and a disaster at worst.

So, as the politicians get ready to leave the single figure temperatures of Canberra and go back to their electorates, they’ve got a lot to think about in what may be a winter of discontent for some of them at least. PH
Pharmacy Focus with Michael Ryan

Pharmacy Service Agreements

The increasing complexity associated with medicine use means clear pharmacy service agreements are key to managing risk

A pharmacy service agreement typically contains several key elements related to medicine use, including supply and distribution arrangements, clinical and professional pharmacy service provision and reporting and risk management. The following are examples of the components of pharmacy services that an effective agreement should cover.

Supply and distribution arrangements
An agreement should address at least the following:

- frequency of pharmacist visits to wards to review new orders, discharge prescriptions and delivery of medicines back to units/wards;
- responsibilities related to secure storage when medicines are delivered;
- responsibilities in regard to PBS prescription and liaison with medical practitioners including for ‘owing’ prescriptions;
- after hours arrangements;
- total parenteral nutrition (TPN) arrangements;
- processes for the supply of compounded chemotherapy;
- generic medicines interchange;
- management of drugs of addiction;
- clinical drug trial arrangements;
- management of high-cost drugs;
- provision of dose administration aides;
- processes for reviewing the most cost-effective way of supplying medicines (ie via imprest or via dispensing); and
- responsibilities in regard to checking, ordering, delivery, put-away, managing drug recalls, rotation and invoicing of imprest stock.

Clinical and professional pharmacy services
An agreement should address at least the following:

- frequency, location and depth of review of various types of patients’ medicine orders, especially those patients at risk of adverse medication events (which should be defined in the service agreement);
- provision of information and counselling to be provided to patients for discharge medicines;
- type and frequency of medicine-related education to be provided to nurses and medical practitioners;
- the level of participation in the Drug and Therapeutics Committee and medication safety and quality improvement activities; and
- role in drug evaluation/usage reviews, medication incident and error analysis and in producing and updating policies and procedures.

A Pharmacy Services Agreement should define the essential details and scope of the pharmacy services to be provided with an unambiguous fees and charges structure covering each component of the service.

As the safety, quality, cost and reimbursement issues associated with medicine use become more complex, the need for clear and objective pharmacy service agreements becomes greater.

An unambiguous and comprehensive service agreement provides a means to not only agree on the pharmacy’s role in meeting hospital objectives but also to respond to changes in the healthcare environment. The agreement needs to have the flexibility to accommodate changes in legislation and pharmacy remuneration, the requirements of ACHS and the Australian Commission on Safety and Quality in Health Care (ACSQHC), the myriad of changes to the Pharmaceutical Benefits Scheme (PBS) such as impacts on profitability due to price disclosure regulation, S94 remuneration changes, the Revised Arrangements for Efficient Funding of Chemotherapy Drugs and more, yet be firm enough to prevent differences in interpretation and the emergence of mistrust.

Photography: Philip Smith and Thinkstock
Reporting and risk management
An agreement should also address:
• monitoring and reporting on the service (through comparison with performance indicators);
• use of medication-related clinical indicators; and
• reporting and commenting on cost and usage of high-cost or high-volume drugs.

Fees
The agreement should contain a structure for fees for individual services provided (eg a fee for imprest management and for clinical services) which should be based on (but not necessarily equal to) the cost of salaries of pharmacy staff providing the service.

A mark-up on goods, which is an alternative to a fee-based arrangement, is an illogical method for paying for the services provided. It is in interests of both the hospital and pharmacy service provider to have transparency in the method used for determining fees to allow easy and fair adjustment of these as the hospital’s requirements change, which cannot be achieved under a mark-up method.

Key Performance Indicators
Although the inclusion of key performance indicators (KPIs) is common in service agreements, often they are focused on the process rather than the desired outcomes from the delivery of the service. In order to be effective they must provide an objective and meaningful way to measure performance and the achievement of objectives.

A pharmacy service agreement that clearly describes the hospital’s requirements and contains a fee structure for the goods and services provided, with appropriate KPIs, provides both the hospital and pharmacy provider with clarity as to what is to be provided, by whom and by when. If the agreement also describes the outcomes in relation to the use of medicines and a means to measure how successfully these are achieved, there is a good chance the agreement will serve the hospital and the provider well. PH

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**Advance Care Directives**

An update on recent cases involving Advance Care Directives

AdvANCE Care Directives, also known as living wills or advanced care planning, enables a person over the age of 18, who is mentally competent, to express their wishes in relation to future medical care and treatment.

The common law in Australia recognises two relevant but in some cases conflicting interests:
1. a competent adult’s right of autonomy or self-determination: the right to control his or her own body; and
2. the interest of the State in protecting and preserving the lives and health of its citizens.

Legislation and guidelines

Unfortunately, legislation dealing with Advance Care Directives is not uniform in Australia. In 2011 the Clinical, Technical and Ethical Principal Committee of the Australian Health Ministers’ Advisory Council released a Consultation Draft for a National Framework for Advance Care Directives, however, the final version is yet to be released.

In dealing with Advance Care Directives, you must have regard to the relevant legislation in your jurisdiction.

- Australian Capital Territory - *The Medical Treatment (Health Directions) Act 2006 (ACT)*
- New South Wales - *NSW Health has published a Guideline on Using Advance Care Directives (GL2005.056)*
- Northern Territory - *The Natural Death Act 1988 (NT)*
- Queensland - *Guardianship and Administration Act 2000 (Qld)*
- South Australia - *Consent to Medical Treatment and Palliative Care Act 1995 (SA)*
- Victoria - *Medical Treatment Act 1998 (Vic)*
- Western Australia - *Guardianship and Administration Act 1990 (WA)*

In addition to the legislation, there have been a number of recent key cases, including:

- *Hunter and New England Area Health Service v A* (by his Tutor) (2009) 74 NSWLR 88;
- *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84;

**Hunter and New England Case**

This case involved a patient, Mr A, a Jehovah’s witness, who attended a solicitor, Mr N, and made the appointment of an enduring guardian.

In relation to dialysis, Mr A ticked ‘I refuse’. His Honour, McDougall J concluded that the direction represented a considered decision made by Mr A and that when Mr A made that decision (and, to the extent that it may be relevant, when he was admitted to hospital), Mr A was in law capable of making the decision to refuse dialysis. The hospital was entitled to the declaration sought, that is, a valid “Advance Care Directive” given by Mr A, and that it would justify in complying with his wishes as expressed in that directive.

In that case, His Honour gave a summary of the relevant principles with emergency care decisions (while acknowledging that they will not apply in every conceivable circumstance):

1. Except in the case of emergency, where it is not practicable to obtain consent (see para 5 below), it is at common law a battery to administer medical treatment to a person without the person’s consent. There may be a qualification if the treatment is necessary to save the life of a viable unborn child.
2. Consent may be express, or in some cases, implied; and whether a person consents to medical treatment is a question of fact in each case.
3. Consent to medical treatment may be given by the person concerned, if that person is a capable adult; by the person’s guardian (under an instrument of appointment of enduring guardian, if in effect; or by a guardian appointed by the Guardianship Tribunal or a court); by the spouse of the person, if the relationship between the person and the spouse is close and continuing and the spouse is not under guardianship; by a person who has the care of the person; or by a close friend or relative of the person.
4. At common law, next of kin cannot give consent on behalf of the person. However, if they fall into one or other of the categories just listed (and of course they would fall into at least the last) they may do so under the Guardianship Act.
5. Emergency medical treatment that is reasonably necessary in the particular case may be administered to a person without the person’s consent if the
person’s condition is such that it is not possible to obtain his or her consent, and it is not practicable to obtain the consent of someone else authorised to give it, and if the person has not signified that he or she does not wish the treatment, or treatment of that kind, to be carried out.

6. A person may make an ‘Advance Care Directive’: a statement that the person does not wish to receive medical treatment, or medical treatment of specified kinds. If an Advance Care Directive is made by a capable adult, and is clear and unambiguous, and extends to the situation at hand, it must be respected. It would be a battery to administer medical treatment to the person of a kind prohibited by the Advance Care Directive. Again, there may be a qualification if the treatment is necessary to save the life of a viable unborn child.

7. There is a presumption that an adult is capable of deciding whether to consent to or to refuse medical treatment. However, the presumption is rebuttable. In considering the question of capacity, it is necessary to take into account both the importance of the decision and the ability of the individual to receive, retain and process information given to him or her that bears on the decision.

8. If there is a genuine and reasonable doubt as to the validity of an Advance Care Directive, or as to whether it applies in the situation at hand, a hospital or medical practitioner should apply promptly to the court for its aid. The hospital or medical practitioner is justified in acting in accordance with the court’s determination as to the validity and operation of the advance care directive.

9. Where there is a genuine and reasonable doubt as to the validity or operation of an Advance Care Directive, and the hospital or medical practitioner applies promptly to the court for relief, the hospital or practitioner is justified, by the emergency principle, in administering the treatment in question until the court gives its decision.

10. It is not necessary, for there to be a valid Advance Care Directive, that the person giving it should have been informed of the consequences of deciding, in advance, to refuse specified kinds of medical treatment. Nor does it matter that the person’s decision is based on religious, social or moral grounds rather than upon (for example) some balancing act of risk and benefit. Indeed, it does not matter if the decision seems to be unsupported by a discernible reason, as long as it was made voluntarily, and in the absence of any vitiating factor such as misrepresentation, by a capable adult.

11. What appears to be a valid consent given by a capable adult may be ineffective if it does not represent the independent exercise of persons volition: if, by some means, the person’s will has been overborne or the person’s decision is based on religious, social or moral grounds rather than upon (for example) some balancing act of risk and benefit. Indeed, it does not matter if the decision seems to be unsupported by a discernible reason, as long as it was made voluntarily, and in the absence of any vitiating factor such as misrepresentation, by a capable adult.

Brightwater
In Brightwater Care Group (Inc) v Rossiter [2009] WASC 229, the Brightwater Care Group operated a residential aged care facility in Perth for people with disabilities. Mr Rossiter was a quadriplegic who was mentally competent. He was generally unable to move and was only able to talk through a tracheotomy. He directed his medical service provider to discontinue the provision of nutrition and general hydration, to save the life of a viable unborn child. He also requested the prescription of analgesics for the purposes of sedation and pain relief as he approached death.

Mr Rossiter was not terminally ill, nor was he dying. However, he had been advised that there was no prospect that his condition would improve, and in some respects, for example his eyesight, his condition was deteriorating.

Western Australia has specific provisions in its Criminal Code that impose a duty to provide the necessities of life, however, His Honour Martin CJ concluded that the Criminal Code did not impose upon Brightwater a duty to provide the necessities of life to Mr Rossiter against his wishes. His Honour held that it is clear that Mr Rossiter had been provided with full information with respect to the consequences of any decision he might make and has the right to determine and direct the extent of the continuing treatment in the sense that treatment cannot and should not be administered against his wishes. If, after the provision of full advice, he repeats his direction to Brightwater that they discontinue the provision of nutrition and hydration to him, Brightwater is under a legal obligation to comply with that direction.

Such a direction is not irrevocable and while the patient retains his capacities, can be revoked by him at any time.

References
1 Hunter and New England Area Health Service v A (by his Tutor T) (2009) 74 NSWLR 88, McDougall J
2 Note also legislation enabling Enduring Powers of Guardianship

For more information, please contact: Alison Choy Flannigan, Partner Health, Aged Care and Lifesciences Holman Webb Lawyers alison.choyflannigan@holmanwebb.com.au
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Health reform and the PCEHR

INCE the last issue of Private Hospital magazine, APHA has been concentrating its efforts on the legislation currently before the Federal Parliament on means testing the private health insurance rebate. For more information specifically about this, please go to page 60 to see the ad campaign we are running and to find out more.

Elective surgery guarantee removed from health reform agenda

On 2 August, Prime Minister Julia Gillard and Federal Health Minister Nicola Roxon announced the details of the new public hospital funding agreement between the federal and state governments.

As widely predicted, the guarantee that 95 percent of public hospital elective surgery patients would receive their surgery on time has been removed. It has been replaced with a target of 100 percent of patients receiving their surgery on time by 2019-2020. Under the Agreement, a State Health Department or a Local Hospital Network may contract with a private hospital or hospitals to provide services.

The Expert Panel on Elective Surgery, which recommended that the guarantee be done away with, will remain in existence to monitor progress towards the 100 percent target.

To access the text of the National Health Agreement go to www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhra-justreleased

The report of the elective surgery panel may also be found at www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/Expert-Panel-Report

APHA in consultations on PCEHR

On 1 August, APHA’s CEO, Michael Roff and Policy Director, Barbara Carney met with McKinsey and Co for an initial discussion about the work McKinseys are doing on behalf of the Federal Government to develop the National Change and Adoption Strategy for the PCEHR.

The consultants will be looking to engage with private hospitals directly on the impacts of a PCEHR on their operations and also possibly to survey hospitals and hold focus group discussions over the next few months.

APHA appoints Research and Data Manager

APHA has appointed Dr Mehrdad Khodai-Joopari as our new Research and Data Manager. With a PhD in Computer Science, Mehrdad was most recently Analytic Manager at Agrecon, a consultancy providing data analysis and statistical services to the agricultural sector. He has extensive experience in mining, analysing and reporting on complex data and is looking forward to getting to grips with the health sector. Mehrdad has also taught mathematics and computing at the University of NSW. He may be contacted at mehrdad.khodai@apha.org.au.

APHA Council and Board Changes

Following the sale of Healthcare Australia to Australian Hospital Partners Pty Limited, Ben Thynne has resigned from the APHA Board and Council.

The APHA Council has resolved to appoint Mr Geoff Sam (a current APHA Councillor) to fill the casual vacancy on the Board. In addition, the Council has appointed Mr Steve Atkins (CEO of Healthcare) to fill the casual vacancy on Council.

In addition, APHA Director and Chair of Council, John Amery has resigned from Mater Health Services North Queensland and subsequently from the APHA Board and Council. As John was the Queensland representative on the Council, APHA has written to PHAQ requesting they nominate a new representative. The APHA Council has appointed Christine Gee of Toowong Private Hospital to the casual vacancy on the Board created by John’s resignation.

APHA would like to take this opportunity to thank Ben and John for their contribution to the private hospitals sector as Directors of APHA for the past four and eight years respectively. We wish them well in their future endeavours.

Also, Dr Lynleigh Evans of the Skin and Cancer Foundation has been appointed to the casual vacancy on the council in the ‘Not For Profit Small Independent’ electorate.

The Council has also resolved to call for nominations to fill a further two vacancies on Council, in the ‘For Profit Small Independent’ electorate, for the remainder of the term of Council. Members in this electorate will receive further information in the near future.
Fight central line infection with the strength of HARTMANN

Your ICU patients can be at high risk of healthcare associated infections (HAIs), including central line associated bloodstream infections. Yet many of these HAIs are considered preventable.

**HARTMANN would like to join forces with you to help you reduce the risk of central line associated bloodstream infections in your ICU.**

The HARTMANN CVC Custom Procedure Pack is based on a recipe selected from an "ideal pack contents list", ratified by the CLAB-ICU expert group and submitted to NSW Health for procurement via HealthSupport. The pack features a unique customised drape specifically developed by Kimberly-Clark to the exacting requirements of the NSW Clinical Excellence Commission.¹

**Reduce your risk of central line infections**

When you choose HARTMANN CVC Custom Procedure Packs, you can be confident you’ve got the strength of HARTMANN and Kimberly-Clark on your team.

To learn more about HARTMANN CVC Custom Procedure Packs, contact your HARTMANN representative or call 1800 451 681.

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¹ Clinical Excellence Commission May 2011
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In Parliament on 7 July, Federal Minister for Health Nicola Roxon re-introduced legislation to means test the private health insurance rebate. APHA was ready to spring into action immediately and garner support from our member hospitals.

APHA originally developed the Valuing Private Hospitals campaign to:
• build awareness of the value and benefits of private hospitals to the Australian healthcare system;
• garner and mobilise community support for private hospitals; and
• position APHA and our member hospitals to positively contribute to health reform.

Our campaign has been widened to specifically take on the Federal Government on the means test issue. With this in mind, we developed a website, nohealthmeanstest.com.au, where members of the public can see how much more they will pay for private health insurance if means testing begins.

They can also send a personalised message to their local MP asking them to vote against the changes.

Using our network of campaign champions at our member hospitals, APHA was able to quickly get information to all of our members, send out posters and flyer artwork and drive traffic to the nohealthmeanstest.com.au website.

With research showing only 23 percent of Australians are aware of the changes, it has been, and will continue to be, vitally important that hospitals continue to push these messages out. This is particularly true in the electorates of Lyne, New England, Denison, Melbourne, Kennedy and O’Connor where Independent MPs currently hold the seats. APHA has been in discussions with all of these MPs about the issue.

The doctors at Port Macquarie Private Hospital have been very vocal about their opposition to means testing, which would mean longer waits for life-saving treatments. As Dr Dean Pepper, Port Macquarie Private Hospital Advisory Committee chairman, stated in an article in the Port Macquarie News on 15 July: “At present, the system is working adequately well. I think to tamper with it is asking for disaster.”

Port Macquarie Private Hospital Medical Advisory Committee chairman Dr Dean Pepper said doctors and patients were concerned about the proposal. “At present, the system is working adequately well,” Dr Pepper said. “I think to
tamper with it is asking for disaster.”

Dr Pepper said privately insured patients were worried whether they could afford private health cover.

And the plan, if it were passed, would be felt beyond the private health sector, doctors believe. Dr Pepper has also made it clear that a collapse in the private health system in Port Macquarie would result in specialists leaving for Sydney, where they could work in the private and public health systems.

Other APHA hospital staff and doctors have also met with their local Member of Parliament in electorates around the country.

In the electorate of Denison in Tasmania, MP Andrew Wilkie has made it clear that he supports rebate means testing. APHA started a print and radio advertising campaign around the issue in July, which will continue right through the month of August.

With a headline of ‘How long should Gran have to wait for a new hip, Mr Wilkie?’ the ads ask Tasmanians to support the nohealthmeanstest.com.au website and send a message to Mr Wilkie to vote against the legislation. These ads obviously struck a chord with Mr Wilkie as he responded with a press release on 2 August 2011 to stop the ads. APHA responded with our own press release, which can be downloaded at www.apha.org.au.

A direct mail flyer was also designed and sent to more than 43,000 households in the Denison electorate to get them on to the website in support our campaign.

As this issue of Private Hospital goes to press, the next sitting of Federal Parliament is imminent. APHA anticipates the bill will be debated during this sitting and will continue to keep members informed as things progress.

If you have questions on how your hospital can get involved, please contact Lisa Ramshaw, APHA’s Director of Communications and Marketing on lisa.ramshaw@apha.org.au.

By means testing the private health insurance rebate, Andrew Wilkie will create longer queues at public hospitals. Join the long list of Tasmanians telling Mr Wilkie NO at: nohealthmeanstest.com.au

Authorised by the Australian Private Hospitals Association

How long should Gran have to wait for a new hip, Mr Wilkie?

More people in health and community services choose HESTA than any other fund

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Welcome New Members
and Associate Members
Welcome to new hospital member The Oculoplastics Centre, Sydney and Gold Associate member Holman Webb Lawyers. You are both part of the nation’s peak body for private hospitals. Welcome!

Member Benefits
As an employee of an APHA member hospital or associate member organisation you have access to special discounts and benefits! APHA members can take advantage of discounts with Qantas, QBT Travel, The Qantas Club, Accor Hospitality and Hertz rental cars.

For contact information or further details in relation to any of APHA’s member benefits, please contact APHA or log in to the APHA website members-only area and download the information you need. If you don’t know or have a username and password, contact the APHA Secretariat, we are more than happy to get you connected!

National Collections and Reporting of Safety and Quality Indicators
Safety, quality and performance indicators are always at the forefront with private hospitals. Now, through a landmark APHA initiative, private hospitals are able to compare key safety, quality and performance measures with each other for the first time.

APHA has established a national collection of a core suite of safety and quality indicators for private hospitals. The collection is an independent national data collection, analysis and reporting facility for private hospitals. APHA has engaged George Neale and Associates Pty Ltd as project manager and Edgebox Pty Ltd to process the data and produce reports.

APHA is inviting the participation of all private hospitals in this indicator collection. Participation in the project is free for APHA members and at cost for non-members. All private hospitals are urged to get involved and take advantage of this important landmark project. The information brochure and application are available for download on the APHA website, www.apha.org.au.
Take the pulse of the healthcare world

14–15 September 2011, Melbourne

Gain international insights on challenges facing healthcare directors at the inaugural Healthcare Conference:11.

Acquire an international, director perspective on critical issues such as leadership in healthcare, e-Health, regulation and compliance from presenters such as Lorraine King, The King’s Fund.

Register now at companydirectors.com.au/health
New centre delivers better access to cancer treatment

Queensland Treasurer and Minister for State Development and Trade, Andrew Fraser officially opened Fresenius Kabi Australia’s new Oncology Compounding Centre in Brisbane on 2 June 2011. The new $5 million facility equipped with world-leading Robotic Intravenous Automation (RIVA) technology will revolutionise the process of preparing patient specific doses of oncology compounded medication.

Mr Fraser said: “This is a great investment for Queensland, in jobs for the future, for high grade medical services for cancer patients and the health system, both public and private right around Queensland. This new technology, the RIVA system, takes out the risk of human error and ensures there is a high quality to the dosage preparation.

"The rise of cancer is one of our greatest health challenges in Australia and this new technology will provide the dosages, the compounds, the treatments to cancer sufferers to help ensure they have the best chance of recovery. We sincerely welcome the investment by Fresenius Kabi in this facility."

L-R: Mr Iain Rosekilly, Director of Operations for Fresenius Kabi Australia with Queensland Treasurer and Minister for State Development and Trade, Andrew Fraser.

Reach your retirement goals with HESTA

At HESTA, we’re committed to supporting you reach your retirement goals. After all, we’ve had more than 20 years experience in the health and community services sector.

We deliver our finance education and advice services in easy to understand language, using real life examples. Led by CEO, Anne-Marie Corboy, our role is to inform you about your options – so that you can build a better retirement savings balance, whether you’re 25 or 65.

We now have more than 700,000 members, 98,000 employers and $17 billion in assets. Our size means we can offer many benefits to members and employers. These include: low fees; a fully portable account; easy administration; access to low-cost income protection and death insurance; limited financial advice (at no extra cost); super education sessions and transition to retirement options.

In addition, we provide access to a range of great value products and services such as health insurance, banking and financial planning.

HESTA is also at the forefront of super innovation as the first major superannuation fund in Australia to introduce a sustainable investment option and to assess fund managers on their after-tax investment returns.

For more information go to hesta.com.au or free call 1800 813 327.

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Join this year’s conference to debate with the country’s most eminent health experts and government officials and discuss the federal and state agenda for healthcare reform.

The conference will assess whether the government is doing enough to match its aspirations with action and funding. Expect to hear about emerging collaboration between the public and private hospital systems and how it might work, the first successful outcomes of the reform and updates on healthcare research.

The conference will also explore how the health sector and business can work together more effectively to achieve their common interest and deliver world-class healthcare for the country.

**KEY TOPICS:**
- Delivering and implementing health reform
- Budget 2011 impact
- States’ health system - structure and funding
- Major projects report card
- Leveraging E-health technology
- Achieving better collaboration between public and private hospitals
- Pharmaceutical sector outlook
- Primary care update

To register or for further information, call 1800 032 577 or visit www.afr.com/events
Where do you work? What is your role? And how long have you been there?
I have been at The Wesley Hospital in Brisbane, Queensland working as the Marketing Manager since August 2010.

What are the key marketing objectives for the Wesley?
The Wesley Hospital provides the most comprehensive range of clinical services on one campus in Queensland. Our key marketing objectives are focused on raising awareness of these services in the clinical community as well as the broader community where patients can influence their decision to come to our hospital.

What are the future social media plans for the hospital and how will you start encouraging staff and patients to get involved?
Our first step was to develop a social media policy that will be adopted across our other UnitingCare Health hospitals.

The Marketing Department is developing The Wesley Hospital’s Social Media Marketing Plan and any social media activity implemented by the hospital must adhere to the policy and have the same objectives that exist for our other marketing activities.

We have invited staff to be part of social media information forums to ascertain what they are looking for in their employer’s social media presence and for us to gain feedback from staff on what we are proposing to implement.

When our new website is implemented there will be a social media presence on the front page. The Wesley Hospital will have profiles in Twitter, Facebook, YouTube and Foursquare, which will be updated regularly.

New patients will also be notified of The Wesley Hospital’s social media presence and they will be asked if they would like to be invited to join The Wesley Hospital’s Facebook page.

What do you think the biggest challenge will be? How do you plan on overcoming these hurdles?
One of the biggest challenges is the risks and perceived risks associated with using social media in a large organisation. To many, it is a new medium of communication and to help bring staff on board we will hold education sessions. Another challenge is the potential for negative commentary. The key to this will be the proactive positive management of issues.
Reduce the risk of needle-stick injuries

Sandoz have a number of injectable products available with hangers.

Key advantages of using Sandoz products available with bottle or vial hangers

- Removing steps in the production process
  Removing the need for drawing the solution from the vial & injecting into the infusion bag reduces the handling of needles and minimises the risk of needle-stick injuries and administration errors.

- Reducing the preparation time & eliminate the need for infusion bags
  Reducing the preparation time provides efficient healthcare work practices.
  Cost effective solution by minimising waste and materials.

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