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Contents

In focus Mental health

18 Transcranial magnetic stimulation
   The Melbourne Clinic utilises new treatment

19 Deep sleep
   Belmont Private Hospital introduces six-week program for insomnia

20 Nourishing the soul
   Perth Clinic’s focus on quality is changing patient perceptions about ‘hospital food’

22 Uniting mental and physical healthcare
   South Coast Private looks at the mind-body connection

23 Pharmaceutical abuse
   St Andrew’s addiction expert raises alarm on the prescription of opioid painkillers

24 Holistic mental health service
   Melbourne’s Epworth Clinic focuses on multifaceted treatment

25 Path to Wellness
   Sunshine Coast encourages recovery through art

26 Resources for Hunter residents
   Redevelopment of Toronto Private Hospital fills need in NSW

27 Addiction and mental health
   Wesley Hospital Ashfield encourages GPs to ask more questions

28 Oral ketamine
   Currumbin Clinic facilitates pilot project for treatment resistant depression

29 Alcohol and depression
   Brisbane Private Hospital takes a multidisciplinary approach

30 Tackling tobacco
   Smoking in mental health facilities

In focus Mental health

27 Addiction and mental health
   Wesley Hospital Ashfield encourages GPs to ask more questions

28 Oral ketamine
   Currumbin Clinic facilitates pilot project for treatment resistant depression

29 Alcohol and depression
   Brisbane Private Hospital takes a multidisciplinary approach

30 Tackling tobacco
   Smoking in mental health facilities

In this issue

14 Michael Roff’s 20th anniversary

16 Mental Health Week Campaign

32 Sydney Adventist redevelopment
   The San builds state-of-the-art facility

34 Dramatic rescue
   Westmead Private patient filmed for Helicopter Heroes

35 Health MoodleMoot
   Sydney Adventist Hospital presents popular open source learning platform

Regulars

06 Editor’s Letter
   With Lisa Ramshaw

08 President’s Report
   With Chris Rex

09 As I See It
   With Michael Roff

10 News
   From APHA and Beyond

36 Since the Last Issue

38 Legal Matters
   With Alison Choy Flannigan

40 Quality in Focus
   With Christine Gee

42 Pharmacy Focus
   With Michael Ryan

46 On the Ground
   With Andrew Butwell
Editor’s Letter

Keeping hospitals and consumers connected

APHA is using social media to not only spread the word about its new Mental Health Week campaign, but also to share news and information on important issues affecting members.

Lisa Ramshaw
Director, Communications & Marketing
Australian Private Hospitals Association

Welcome to the Spring edition of Private Hospital magazine! Spring has definitely sprung here in Canberra and with the advent of spring comes a week very close to my heart – Mental Health Week. This year APHA has launched a new campaign for Mental Health Week – the elephant in the room. You can read all about it on page 16 and see some of the fantastic images that are being promoted across the country for it.

This magazine is going to print just as Mental Health Week kicks off so we’ll have to bring you the news of activities at hospitals in our Summer edition. Or, if you can’t wait that long, go to our Facebook page to check out how everyone marked Mental Health Week and got people talking about mental health.

This edition of the magazine is also packed with articles from hospitals that showcase the excellent work in the private hospital sector around mental health. With one in five Australians suffering from mental illness, it is important that our hospitals are recognised for the services they provide. Did you know that more than 32,000 Australians with mental health disorders are treated in private hospitals each year? For more interesting statistics and information, check out our dedicated website, elephantintheroom.org.au.

And, of course, we are using social media to spread the word about the campaign. Social media is rapidly becoming one of our main ways to communicate with consumers and connect with people. Our Facebook page and Twitter accounts are abuzz with information. If you haven’t checked us out yet, you can find us at Australia’s Private Hospitals on Facebook and @priv8hospitals on Twitter. These accounts are increasingly becoming important for getting our messages out on everything from Mental Health Week to private patients in public hospitals.

Our new PH News Hub is another way we are keeping connected. We are able to post stories from member facilities on our news hub and then share them through social media. If you haven’t seen our news hub yet, visit phnews.org.au.

If you work at a member facility and would like us to feature you in an upcoming edition of the magazine, on the news hub or on social media, let me know. I’m always looking for great story ideas!

Happy spring!
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Signing off

In the words of Heraclitus, “Nothing endures like change”

Chris Rex
President
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This is my final report as president of APHA after six years in this position. Looking back, the years have gone quickly and the challenges have been many. Through this time the association has fought several new policy decisions including changes to the Medicare levy surcharge; the abolition of the means testing of the private health insurance rebate; followed closely by the indexation of the rebate.

Over the last several years we have seen the rise of perverse incentives which drive public hospitals to actively seek out and admit privately insured patients - an unsustainable strategy as time will tell. We have fought and been successful in increasing private hospital representation on government bodies and driving more funds for training into the private sector.

Private Hospital Week and Mental Health Week have been excellent new initiatives by the association that showcase the enormous work the private hospital sector does in Australia and provide the opportunity for us to reflect on our achievements.

Throughout it all, nothing has been too much trouble for the staff of APHA. All of them have worked hard on policies, submissions, communications and public relations, with the aim of improving the position of private hospitals. I would like to thank all of the staff who worked at APHA throughout my tenure as president for their tireless dedication to the work of the association and the industry alike.

As an industry, we will face many challenges ahead. Changes in the private health industry will need to be monitored; state and federal governments will continue to face budgetary pressures in healthcare spending; and ensuring we have a workforce to meet the rapidly ageing and growing population in Australia is potentially one of our greatest challenges over the next decade.

But the future for the industry is also promising. Australia has an excellent balanced healthcare system, one of the best in the world, and one that APHA has fought to maintain. Participation in health insurance remains strong and the demographics of the population will drive further investment and growth in our sector for many decades to come. In the words of Leo Tolstoy, “The strongest of all warriors are these two - Time and Patience”.

Speaking of time and patience, congratulations to Michael Roff, executive director of APHA, on reaching two decades of service - a wonderful achievement that demonstrates his excellent loyalty to the organisation. Personally, I have very much enjoyed working with Michael over these last six years in my time as president. Together, we have faced some difficult challenges and met with some colourful characters, but through it all he has been a great companion and a true friend. We are very fortunate to have someone of Michael’s calibre leading our industry association and I wish him all the best in the future.

Finally, I thank the members of APHA council and board with whom I have worked closely throughout the six years and wish the incoming council and board the very best. I know they will continue the good work of this association and I remind them of the words of Andy Warhol, “They always say time changes things, but you actually have to change them yourself”.

Photography: Cliff Kent
Some very interesting documents recently surfaced on the Department of Health’s Freedom of Information disclosure log. The documents provide insight into the bizarre attitude of state governments and what they think their public hospitals should be doing.

The FOI request was for ‘all correspondence between the health minister and his state and territory counterparts and ministerial briefs, regarding the broad issue of people being treated as private patients in public hospitals.’

One of the documents contains the Commonwealth’s comments on a draft Pricing Framework for Australian Public Hospital Services produced by the Independent Hospital Pricing Authority (IHPA). This highlights the fact that annual growth rates for private patient episodes in public hospitals was 11.4 per cent in 2011-12 and 12.8 per cent in 2012-13, compared with the growth rate of admitted public patient services of just 4.4 per cent.

Nothing new in those figures, but the document goes on to say state governments believe IHPA’s approach to the pricing of private patients was discouraging the treatment of private patients in public hospitals. That’s right, in an environment where growth in private patient episodes was three times higher than public patient episodes, states are worried there is a disincentive to treat even more private patients.

In a number of states, 16 per cent of all public hospital patients are private. What sort of a warped worldview do the operators of these public hospital systems have, that they think this is not enough? The question I would like those operating public hospitals to answer is, if you don’t think you have enough private patients now, what is the right proportion? Fifty per cent? Eighty per cent? One hundred per cent? And where would this leave all those Australians with no health insurance and no choice of treatment location?

Other documents reveal the states are not satisfied with the health fund payments they are getting for all of these private patients (currently running at about $1 billion per annum) and have been lobbying the Commonwealth to increase the mandated minimum health insurance payments by around 20 to 30 per cent. But they want the health funds to pay more, without knowing what they are paying for, with 57 per cent of public hospital HCP records having no principal diagnosis included!

The Commonwealth rightly notes that if it was to agree to the states’ demands, ‘it is expected that the incentives for public hospitals to treat privately insured patients would increase beyond the current 14.1 per cent annual growth rate and that this would have an upward impact on private health insurance premiums and private hospital use.’

Thankfully, the states are not making much headway. In a letter responding to his Victorian counterpart asking for more ‘money for nothing’ the federal Health Minister Peter Dutton responds, ‘In the interests of enhancing private healthcare, my general opinion is that public hospitals should focus on treating public patients and that where appropriate, private patients should be treated by private hospitals.”

He goes on to suggest a solution for public hospitals.

“If the managers of public hospitals are unsatisfied with the rates paid by health insurers, they should be encouraged to engage with insurers to determine appropriate commercial outcomes, the same as managers of private hospitals are required by necessity to do.”

Well said, minister!
The Hollywood Clinic expands to meet demand

In response to an increase in demand for services, The Hollywood Clinic has expanded with purpose-built facilities designed to offer the best possible mental healthcare to the Western Australian community.

The $6.9 million project includes a new 30-bed wing, making The Hollywood Clinic a 70-bed facility.

In addition to the new 30 single rooms with en suite bathrooms, the expansion includes a new dining room with an alfresco area, an additional group therapy room, a patient lounge room, improved staff amenities, and a courtyard with decking.

"Hollywood is pleased to have made a strong commitment to growing our ability to meet this requirement for mental health services. The clinic development allows us not only to care for more patients, but enables us to improve our services and processes to meet patient needs," said Peter Mott, Hollywood Private Hospital’s chief executive officer.

The clinic provides treatment and care for a comprehensive range of mental health conditions including anxiety, depression, bi-polar disorder, personality disorders, trauma, eating disorders and alcohol dependency.

St Andrew’s celebrates 20 years of private emergency care

From small beginnings in 1994, St Andrew’s War Memorial Hospital’s emergency centre has grown to become one of Brisbane’s leading private emergency care providers.

Dr Sean Rothwell, director of St Andrew’s emergency centre, said the centre treats more than 12,000 patients per year for conditions including cardiac, neurological, orthopaedic and surgical emergencies, sports injuries and other urgent conditions.

The emergency centre operates in conjunction with many other specialties at the hospital, including 24-hour access to intensive care, radiology, interventional cardiology, vascular surgery, internal medicine and general surgery. The department also provides a strong link between Brisbane’s sporting clubs and the hospital’s numerous orthopaedic surgeons.

Dr Maree Whitchurch, who started working at St Andrew’s emergency centre in 1997, said the hardworking staff were the reason she had stayed in her role at the hospital.

“Emergency medicine is very much about the team environment, with nurses, doctors, administration and ward staff working closely to ensure safe outcomes for patients. We also have great working relationships with specialists and others outside our department in the hospital,” she said.

To celebrate St Andrew’s emergency centre’s 20th anniversary, Dr Whitchurch, a keen baker, spent almost 24 hours baking and decorating a special eight-kilogram chocolate mud cake. The decadent cake fed more than 200 St Andrew’s staff and incorporated the St Andrew’s tartan theme, as a nod to the hospital’s Scottish heritage.

AllHW report looks at private hospital admissions

The Australian Institute of Health and Welfare (AIHW) recently released a report, Australian hospital statistics 2012-13: Private Hospitals which shows in 2012-13 there were about 3.8 million admissions in private hospitals in Australia, making up 41 per cent of all admissions.

The report can be downloaded from the aihw.gov.au.
Health minister: private patients should be treated by private hospitals

Documents released under the Freedom of Information Act recently confirmed federal Health Minister Peter Dutton has stood by his commitment to take states on regarding the issue of private patients in public hospitals saying that his “general opinion is that public hospitals should focus on treating public patients and that where appropriate, private patients should be treated by private hospitals”. Full details can be viewed at http://bit.ly/1nMp5YT.

Bethesda Hospital recognises staff members’ years of service

Two staff members at Bethesda Hospital in Western Australia were recognised for their long service and dedication to the patients of the hospital. Bethesda also hosted a celebration to mark the official opening of the hospital on the Claremont site in 1944, with this year’s celebrations marking the 70th year of providing care for the WA community.

Clinical Nurse Sonja Paterson and Patient Care Supervisor Anthony Dias were recognised for 25 and 20 years of service respectively.

Ms Paterson, who has worked in all areas of the hospital, said, “The staff are still as supportive and caring today as when the hospital was much smaller and had fewer patients.”

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OzHarvest vision a part of Olympus future

Olympus Australia has established a long-term commitment to OzHarvest, the Australian food charity. OzHarvest was one of the two charities selected by the 310 staff members working for Olympus’ medical, industrial and microscopy divisions in Australia.

The first event supported by the company was the Think.Eat.Save event held in July. Some of the nation’s top chefs, politicians and celebrities assisted at functions held across Sydney, Adelaide, Brisbane, Melbourne and Newcastle to take a stance against food waste.

Founder and CEO of OzHarvest, Ronni Kahn, said the aim of Think.Eat.Save 2014 was to bring attention to the disturbing amount of food wasted in Australia and around the world, where roughly one third of food produced for human consumption (approx. 1.3 billion tonnes) gets wasted along the way.

“Our modern day challenge is to create a sustainable food culture that can be shared by all, where we waste less at all levels of food production and distribution,” Ms Kahn said.

Olympus will be participating in regular team building events with OzHarvest, along with the Think.Eat.Save and CEO Cookout events each year.

Life saving procedure at Lingard Private Hospital

A 40-year-old woman in Newcastle recently became one of the first in Australia to receive a new life changing surgery, when she was implanted with the world’s smallest cardio defibrillator at Lingard Private Hospital.

Dr Brad Wilsomore carried out the revolutionary 45-minute procedure on the morning of September 16. The defibrillator, designed to treat life threatening arrhythmias, is about the size of a watch and less than 10 millimetres thick, and is slipped under the skin on the side of the chest while a small wire passes through a vein into the heart.

The device, which is free and is covered by Medicare, registers if the heart is going fast or slow, charges and shocks after detecting it.

Lingard Private Hospital, a member of the Health Care group, is a 98-bed acute medical and surgical hospital in the Newcastle suburb of Merewether. Lingard’s Cardiology Service was established in August 2013, and in the first year of operation has completed over 1,100 procedures. The two cardiac catherisation labs are supported by a 12-bed coronary care unit and a six-bed intensive care unit, managed by experienced and dedicated nursing and medical staff.

Karen Gallagher, CEO of Lingard Private Hospital, said the entire hospital team was really excited that Dr Brad Wilsomore performed this mini device procedure, one that can save lives, at Lingard Private Hospital.
The Wesley Hospital expands its emergency department

The Wesley Hospital has completed a substantial renovation and expansion of its emergency centre, making it the largest private emergency department in Brisbane.

Dr Gavan Doig, director of emergency medicine at The Wesley Hospital, said the growth in demand for emergency services at the hospital had well and truly outstripped the prediction made two decades ago.

“We now have 19 emergency beds including resuscitation, consultation, paediatric and procedure rooms along with the latest state-of-the-art GE patient monitoring equipment,” Dr Doig said.

“The hospital’s substantial investment to increase capacity is about improving the patient and their relatives’ experience in the centre with increased privacy and greater efficiency.”

St Vincent’s Private Hospital Sydney receives first ever ACHS Group Medal

As part of its 40th birthday anniversary celebrations in 2014, the Australian Council on Healthcare Standards (ACHS) announced St Vincent’s Private Hospital (SVPH) Sydney as the winner of its first ever ACHS Group Medal.

“I am delighted to announce SVPH as the winner, as their entry identified a strong, collective contribution by the hospital to improving quality and safety in Australian health services,” said ACHS President Adj Associate Professor Karen Linegar.

“Congratulations to St Vincent’s Private Hospital Sydney and thank you to all our entries from around Australia, but particularly the other three finalists: Healthscope (VIC), Tasmanian Health Org – North West (TAS) and North Shore Private Hospital, Sydney (NSW). Each has made an important contribution to improving safety and quality in healthcare in Australia.”
APHA CEO Michael Roff recently celebrated 20 years at APHA with a cocktail function at Parliament House, Canberra. The evening provided an opportunity for many who have worked with Michael over the years to congratulate him on his service to the industry. He was congratulated by the Minister for Health, the Hon Peter Dutton on his many achievements throughout the past 20 years.

It was also a chance for many people in the health sector to catch up and see old colleagues and friends.

In his speech on the night, Michael remarked that he had worked with no fewer than eight ministers for health, with one of those going on to become Prime Minister (Tony Abbott). There have also been 11 shadow health ministers, one of whom went on to become Prime Minister (Julia Gillard).

Everyone on the night wished Michael well for his next 20 years with APHA!
Mental Health Week

Mental Health: The elephant in the room

APHA member hospitals across the country marked Mental Health Week from October 5 to 11. This year’s theme was HUGE. APHA deployed a herd of inflatable elephants across the country to illustrate the fact that mental health is often the ‘elephant in the room’ that no one wants to discuss.

Using inflatable elephants, posters, fact cards, videos, a website (elephantintheroom.org.au) and social media, this was literally the largest campaign ever run by APHA. For more photos of activities from hospitals, please see our Facebook page – Australia’s Private Hospitals.
The Melbourne Clinic in Richmond has introduced an innovative program using a number of new treatment tools for patients with psychiatric disorders such as depression.

The treatments, including transcranial magnetic stimulation, are particularly helpful for individuals who have struggled to achieve wellness with traditional therapies alone.

Transcranial magnetic stimulation (TMS) is a potential new treatment for depression and other psychiatric disorders. TMS has been extensively studied for at least 15 years, with a large number of clinical trials establishing that it is an effective treatment for patients with depression.

Research continues to explore its use in other conditions such as schizophrenia, autism and obsessive-compulsive disorder. Notably, TMS has few side effects and is mostly very well tolerated.

TMS is now provided in clinical programs in North America, Asia, Europe and increasingly in Australia – including Healthscope’s Northpark Private Hospital, The Victoria Clinic and The Geelong Clinic.

These treatments are available under the supervision of Dr Nitin Dharwadkar as part of a Melbourne Clinic Research Project – a study of the effect of dose on response to repetitive transcranial magnetic stimulation (rTMS) in major depression.

Dr Dharwadkar explained, “TMS uses a focused magnetic field to activate specific areas of the brain. Repeated TMS stimulation progressively alters brain activity improving depression in some patients. TMS requires no anaesthesia or medication, and generally a patient will be able to go about normal activities immediately following the treatment.”

Most treatment programs involve daily administration of TMS, Monday to Friday for four weeks. Each treatment session typically lasts from 30 to 60 minutes.

General Manager of The Melbourne Clinic, Andrew McKenzie, said the introduction of TMS to the clinic is a welcome one.

“We believe in offering patients a range of treatment options and TMS treatment will complement established therapies and provide patients with a new form of anti-depressant treatment,” Mr McKenzie said.

“Repeated TMS stimulation progressively alters brain activity improving depression in some patients. TMS requires no anaesthesia or medication, and generally a patient will be able to go about normal activities immediately following the treatment.”
A good night’s sleep

Belmont Private Hospital introduces specialised program for insomnia

To service growing demand for therapeutic mental health programs, Queensland’s largest private mental health facility, Belmont Private Hospital (Belmont) in Brisbane’s southeast, has introduced a specialised program for insomnia. The Cognitive Behaviour Therapy for Insomnia (CBT-i) day program is a six-week program held on Tuesday evenings, with booster sessions at strategic intervals after completion.

What is insomnia disorder?
It is classified as disrupted, dissatisfying sleep that occurs at least three nights per week and continues for at least three months despite adequate opportunity for sleep. Long-term patterns of insufficient or unrefreshing sleep can have many causes such as environmental changes, unhealthy sleep habits, shift work, anxiety, depression, pain and medical disorders.

Associate Professor Sandy Sacre, senior programs manager at Belmont and long-standing member of the Australasian Sleep Association, attests that insomnia is one of the most common health problems in the general Australian population and “is certainly the most common sleep disorder”.

Dr Sacre added, ‘It is inextricably linked with mental disorders such as anxiety and depression and in most cases it is difficult to know which came first.’

Why CBT?
According to the 12th annual Bettering the Evaluation and Care of Health (BEACH) report on general practice activity in Australia (2009-2010), insomnia was treated in around 95 per cent of cases by GPs prescribing hypnotic medication.

“This is often efficacious in the short-term,” Dr Sacre said. “However, Cognitive Behaviour Therapy for Insomnia is more efficacious for insomnia than hypnotic medication, and is shown to be the most effective, objectively measured treatment by numerous randomized controlled trials and meta-analyses.”

She added, “Studies demonstrate significant improvement in sleep latency, total sleep time and sleep efficiency, whilst maintaining change over the long term.”

Belmont’s CBT-i program
The program’s facilitator, Kym Barrett, is a psychologist and sleep technologist with a comprehensive understanding of CBT, insomnia and other sleep disorders.

Patients attending the program undergo a comprehensive evaluation of sleep patterns, cognitions and behaviour related to sleep at the start and the end, using sleep diaries and validated questionnaires to measure individual progress and to evaluate the effectiveness of the program as a whole.

Belmont’s program targets maladaptive sleep cognitions and behaviours, and utilises evidence-based therapeutic approaches including relaxation training, stimulus control therapy and cognitive therapy.

“All of these approaches have received the highest ratings in terms of clinical evidence,” said Ms Barrett, citing standards set by the American Academy of Sleep Medicine.

“We also include psycho-education for sleep hygiene. Although we know that sleep hygiene is not useful as a stand-alone treatment for chronic insomnia, some evidence indicates it may be useful as an adjunct to these other therapies.”

All patients are under the care of a hospital-accredited psychiatrist who collaborates with the referring medical practitioner, particularly in relation to any medical conditions that may be contributing to insomnia, as well as prescribed medications. Participants generally maintain their current medications with a gradual tapering of hypnotics as their sleep behaviours and cognitive approaches to sleep improve.

Patients referred may have a primary diagnosis of insomnia disorder with or without co-morbid diagnoses.

“This can include depression, anxiety or obstructive sleep apnea which may have been resolved but left patients with residual sleep loss,” Ms Barrett said.
In focus Mental health

Comfort food

Perth Clinic’s focus on high-quality food is not only meeting patients’ dietary needs, it’s nourishing for the heart and soul

We’re photographing Perth Clinic executive chef Mark Longton in his chef’s whites standing in front of a healthy-looking passionfruit vine in the West Perth hospital’s sunny courtyard when two curious patients wander by. After suggesting the 39-year-old chef should also be photographed without his shirt, the women go on to offer more compliments. “That pasta last night was amazing,” one of them says. “Those meatballs!” says the other. “You’re doing a story on the food at the mental hospital?” she continues. “Take it from me – it is really good.”

Eleven years ago, Mr Longton was pulling late nights and working six-day weeks at e cucina in Perth alongside the likes of Graham Arthur, Herb Faust and Michael Forde. He loved the cut and thrust of the restaurant kitchen, but the father of three craved more family-friendly hours and a deeper level of job satisfaction.

He found out about the vacancy at Perth Clinic, a private mental health facility, through a family member. “I wouldn’t have applied for a hospital job,” he says matter-of-factly. But he was interested in the clinic’s dedication to serving healthy, restaurant-quality food prepared fresh and from scratch. “The only reason I even considered it was I knew we don’t cook and serve to a room. The patients come to us, so at 12.15pm just before lunch we’re trying to do things until the last possible moment to keep the food fresh and at its peak. That was enough to make me go and have a talk.”

Once he signed up, Mr Longton says he had to leave his ego at the door. “When I came here I had to tone down a bit what I was cooking, obviously in a restaurant people might come once a week, once a month or once a year to eat your food. When people are here and staying for 10, 15, 20 days, you can’t have it as rich or really restauranty. You’re cooking for a different kind of clientele, but they still deserve the best you can offer.”

While restaurant chefs are usually hidden away in the kitchen, Mr Longton loves the contact he has with his happy customers. “The customer satisfaction is so rewarding,” he says. “In a restaurant you don’t really know who comes in. To have the contact we do with everyone so frequently and when they do come back you remember their name, that they loved a particular dish. You see people’s faces light up when they’re feeling down. When people give really positive feedback, we joke it’s the only reason you come here.”

Such were the rave reviews that Mr Longton and the clinic published Healthy Food, Healthy Mind, a collection of his favourite recipes to help nourish the body and brain. With instructions for dishes such as roast chicken breast with braised lentils, roast onion and bacon, it provides an insight into the beautiful and “real” food being served. Mr Longton heaps praise on the clinic’s board and chief executive Moira Munro for supporting his passion.

She says good food is integral to her vision for the clinic. “We wanted Perth Clinic to be the place where they would not be ashamed to tell their friends and family to visit but also a place of sanctuary and safety where they could begin to understand the need to care and nurture themselves. Food was essential to this process – being able to invite their family in to have a meal with them and begin the process of enjoying themselves again was so important. I had one patient who I will never forget who had been a patient for 20 years in other facilities. She had never allowed her children to visit her as she was so ashamed to be seen there, but for the very first time invited them to join her for a meal. We can never underestimate the effect of that action on her recovery.”

She says Mr Longton is a “very rare chef”. “Not only is he an absolutely superb chef but he is a people person, he understands our patients, he always treats them with the utmost respect and will do anything. I think Perth Clinic and the demands placed on him have allowed him to flourish not only as a chef but also as a person.”

Mr Longton writes two six-month menus; each has 160-odd dishes and 56 desserts. “There’s always vegetarian and then there is everything from curries, prime cuts, braises, pastas, and risottos.”

Although the dishes boast high-quality ingredients cooked restaurant style, there’s a distinct lack of fussiness. “We don’t head down the molecular gastronomy path,” Mr Longton says with a smile. “What I’m most comfortable with is Italian and European so there’s a bit more of a lean that way.”

He says he always understood the
“I guess people’s perceptions of hospital food or clinical food, institution food, is that it’s just a reheated kind of mush. And it doesn’t have to be”

impact of good food on mental health, but it’s now a central consideration when coming up with his menus. “It was a bit of a battle at the start. Things like lentils, polenta, Persian feta, goat’s cheese: ‘What’s that? I don’t want that. Can I have no lentils?’ But after continually plugging away and keeping those things a little bit more challenging – for cook and client – rather than just doing meat and three veg all the time, now things like a lentil salad are as popular as grilled steak.”

The process was “common sense, or trial and error”.

“You just know what people love. Comfort food is one thing. If you’re feeling crap you don’t want to eat but then if you can see it’s cooked fresh and we serve it with a bit of a smile and a chat ... The nurses and the therapists are all telling them what to do but we’re just here to serve them.”

The key is presenting healthy, appetising food that is “normal – but still a bit of a treat”. “We don’t want them to feel like they’re stuck in an institution.”

On the day we visited, mountains of freshly cooked polenta chips were on offer for an afternoon snack, as well as bowls of fresh fruit. Not your average hospital chow.

“I guess people’s perceptions of hospital food or clinical food, institution food, is that it’s just a reheated kind of mush. And it doesn’t have to be.”

Mr Longton says Perth Clinic sets a benchmark for how other hospitals can augment their medical care with soul and tummy-soothing meals. “The only thing holding them back is money.”

After 11 years, Mr Longton can’t see himself working anywhere else, nor can he imagine more grateful customers.

“That’s what we are here for, to look after these people. Some people say ‘You’re wasted here’. I don’t know about that! I just think I’m exclusive.”

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People living with mental illness suffer higher rates of physical illness, higher mortality rates and people with severe mental illness have significantly lower life expectancies. The Duty to Care\textsuperscript{1} report identified that although death rates from heart disease in the population have declined this is not the case in the mentally ill population, with rates even increasing amongst women living with mental illness. Additionally, despite no higher incidence of cancer in people with a mental illness they have a 30 per cent higher case fatality.

Poorer lifestyle habits, including smoking, alcohol misuse, poor nutritional intake and physical inactivity, coupled with the metabolic effects of antipsychotic, anti depressant and mood stabilizer medications, contribute to compromised physical health and the development of many lifestyle related co-morbidities in this population. People with mental illness are frequently treated for their mental health problems, however their physical health issues are commonly neglected. South Coast Private Hospital is working to unite mental and physical health care treatments to provide holistic care for patients living with mental illness.

Metabolic syndrome, a cluster of risk factors for heart disease and diabetes that often occur together, is a common condition in people with mental illness. A Western Australian study performed by John et al.\textsuperscript{2} concluded that the prevalence of metabolic syndrome in Australians with severe mental illness was close to double that of the general Australian population.

South Coast Private recognises the prevalence of metabolic syndrome amongst mental health patients and has implemented metabolic monitoring of all patients to identify and treat preventable lifestyle diseases. As part of the hospital admission process, all patients undergo a screen for metabolic risk factors performed by a dual qualified dietitian and exercise physiologist. Patients are then offered individual dietary and exercise assessments to develop strategies to improve their lifestyle and consequently, their physical and mental health.

In addition, patients are encouraged to engage in regular physical activity, which has multiple physical and psychological benefits, including improved mood, sleep, reduced stress, anxiety, depression, increased confidence and wellbeing. South Coast Private offers supervised use of a gymnasium by an accredited exercise physiologist, yoga sessions and social walking groups.

Healthy eating is beneficial for both physical and mental health. Patients are provided with nutritious meals, cooked fresh on site. Education sessions about nutrition and local supermarket tours are offered regularly to empower patients with knowledge and skills to continue with healthy lifestyles post discharge.

It is our goal to ensure that the alarmingly poor physical health of people living with mental illness does not go undetected and treated. Through taking an integrated approach to health we are striving to simultaneously improve the physical and mental health to enhance the overall wellbeing and quality of life of our patients.

\textsuperscript{1}Coghlan R, Lawrence D, Holma CDJ, Jablensky AV, 2001, Duty to Care: Physical Illness in People with Mental Illness, Perth: The University of Western Australia
\textsuperscript{2}John AP, Koloth R, Dragovik M, Lim SBC, 2009, Prevalence of Metabolic Syndrome among Australians with severe mental illness, Medical Journal of Australia, vol. 190, no. 4, pp. 176-179
Opioid addiction

Addiction expert Dr Christian Rowan highlights the growing issue of pharmaceutical abuse

The Australian Institute of Health and Welfare National Drug Strategy Household Survey results showed that the misuse of pharmaceuticals is on the rise, from 4.2 per cent in 2010 to 4.7 per cent in 2013.

Addiction Medicine Specialist Dr Christian Rowan confirmed pharmaceutical abuse is a growing problem in Queensland.

Addressing the 2014 Australian Winter School Conference in Brisbane in late July, Dr Rowan said the increased prevalence of chronic pain and growing use of prescription and over-the-counter painkillers is contributing to higher rates of addiction and substance dependency.

Dr Rowan said there was a need for public education and health professional awareness of the dangers of becoming dependent on prescription and over-the-counter medication, and a greater need for multidisciplinary services for chronic pain sufferers, particularly in the public health sector.

“Opioids are often marketed and prescribed as the drug of choice to treat chronic pain. However, there has been a lack of awareness of the risk of addiction with some of these drugs, where their use may be appropriate for short-term pain management, but not as a long-term solution.”

Dr Rowan, who is the medical director of Addiction Sciences Queensland and director of medical services at St Andrew’s War Memorial Hospital, said ‘doctor shopping’ was an ongoing issue, with some patients receiving prescriptions from multiple doctors and gaining access to unsafe quantities of prescription drugs.

“Where possible, GPs should avoid prescribing pain management drugs which contain morphine, and limit the use of benzodiazepines,” Dr Rowan said.

Dr Rowan said 30 per cent of the Australian population will experience chronic pain in their lifetime, and this, coupled with an ageing population, is contributing to the rise in use of prescription opioid painkillers.

Other factors contributing to the issue include increased prevalence of mental health problems, lifestyle-related chronic conditions, and industry marketing of pharmaceutical products.

Dr Rowan said treating co-morbid pain and addiction conditions should focus on use of therapies other than conventional painkiller drugs, such as education, cognitive-behavioural therapy, physiotherapy and occupational therapy.

He suggested better data collection systems, further research at state and federal levels, real time monitoring systems, engagement with the pharmaceutical industry, and enhanced availability of pain and addiction treatment clinics and services could help address the issue.
Holistic mental health

Melbourne’s Epworth Clinic offers an innovative inpatient service and day programs for mental health patients

opened in Camberwell last year but officially launched by Health Minister Peter Dutton in August, the new 63-bed Epworth Clinic focuses on mental health programs across the spectrum of mental health conditions. The clinic offers inpatient and day patient care for people experiencing acute stress disorders, depression, bipolar affective disorder, anxiety disorders, schizophrenia, borderline personality disorder and a range of other mental health conditions.

A suite of day programs for adults includes dialectical behaviour therapy, mindfulness, schema therapy, acceptance and commitment therapy along with programs for bipolar disorder, parent-infant, weight loss and adolescents.

Dr Graham Wong, Epworth Clinic’s director of psychiatry and electroconvulsive therapy (ECT), believes multifaceted treatment options are vital. Thanks to key developments in mental health, the sector as a whole continues to improve.

“We have an extensive therapy program suitable for depressive, bipolar, anxiety and personality difficulties. An inpatient service is available for patients with acute difficulties. A team led by a consultant psychiatrist along with highly experienced mental health nurses and allied health staff help create a management plan which may often involve ongoing care within the day program, post-discharge,” Dr Wong said.

Dr Wong was part of the Mental Health Crisis Assessment and Treatment team for the northwest region of Melbourne over the last decade and acknowledges the challenges faced in general practice with patients who present in crisis.

“Assisting with the establishment of a new holistic mental health service has been very exciting. Likewise, being able to establish an ECT service that will act as a benchmark for all other services, utilising the expertise and collaboration of expert ECT psychiatrists and the ECT nurse coordinator has been great.

“A new Mental Health Act (MHA) for Victoria was introduced in July 2014, which focuses far more on patients’ rights and a recovery model of patient management. Likewise, public mental health services have undergone major redevelopments that also focus on enhanced continuity of care. Epworth is dedicated to establishing contemporary multidisciplinary and recovery-based models of care in the private sector,” Dr Wong said.

An Epworth-wide Consultation Liaison Psychiatry Service has also been established to provide consultation support across Epworth locations and services.
Sunshine Coast artists, who are also mental health consumers or carers of a person who has experienced mental health issues, participated in the Cooinda Mental Health Service’s second annual art exhibition Path to Wellness during Mental Health Week 2014.

At the inaugural art exhibition held at Cooinda Mental Health Service in 2013, more than 100 people attended the event and enjoyed 50 pieces of featured artwork and craft whilst being entertained by local musicians.

Adriana Leonardi, director of support services at The Sunshine Coast Private Hospital, said the event served an important role in helping bring people together to raise the profile of mental health in the community.

“When we opened Cooinda we consciously made the decision to make it accessible – mental health is too often misunderstood and hidden away behind closed doors, and as a result people are made to feel embarrassed or ashamed,” she said.

The art exhibition had its beginnings as a strategy to inspire and re-energise people participating in Cooinda’s group therapy programs. To complement the evidence-based components of its program, the Cooinda Clinic’s group therapy programs utilise diversional craft, physical fitness, relaxation, art and music, all of which can play an important role in relapse prevention – teaching new skills and encouraging socialisation and community connections.

Jo Munday, Cooinda Mental Health Service’s business development manager, said, “It’s amazing to witness the enormous sense of pride and accomplishment the artists experience. It’s also great to see local artists have the opportunity to participate in this program and see their art celebrated.”

The exhibition also affords the hospital an opportunity to promote mental health wellbeing to the community.

“When we are trying to convey through our programs and this exhibition is that mental health is a part of everyone’s wellbeing,” Ms Munday said.

The Cooinda Mental Health Service offers a range of therapeutic programs for patients with emotional, psychological and psychiatric issues such as mood disorders, anxiety disorders, post-traumatic stress disorder/trauma, addictions, obsessive compulsive disorder, anger management issues, and more.

“When we opened Cooinda we consciously made the decision to make it accessible – mental health is too often misunderstood and hidden away behind closed doors, and as a result people are made to feel embarrassed or ashamed.”
A critical shortage of psychiatrists in the NSW Hunter region has created demand for more mental health services and innovative ways to provide them. Toronto Private Hospital, located in Toronto on Lake Macquarie NSW, has introduced a number of mental health services to provide the local community with a variety of options to suit their lifestyles and mental health needs.

Previously, local residents had limited options when considering mental health inpatient treatment. When Lingard Private Hospital, located in Newcastle, introduced a cardiac ward, their large mental health unit, known as the Woodlands Ward, and their out patient programs, needed a new home. Lingard and Toronto Private collaborated with local mental health specialists and their own psychiatric team, leading to the conclusion that in the best interest of the community, the services would be relocated to Toronto Private in October 2013. A $2 million redevelopment project ensured that the new Woodlands Ward would provide patients with a modern, spacious and tranquil facility.

“Mental illness continues to cause considerable distress and disability for individuals, impacting on the entire community. Toronto Private Hospital has been working collaboratively with local psychiatrists and mental health organisations to ensure our services are meeting local needs,” said Andrew Mereau, chief executive officer at Toronto Private Hospital.

“The opening of the inpatient mental health and day therapy units have provided increased capacity and access for patients in the Hunter.”

Now with 25 beds, the voluntary Woodlands Ward is run by specialist psychiatrists, Dr Allan White, Dr Catherine Faehrmann, Dr Ian Fowler and Dr Cynthia Parker, who have developed a variety of well researched therapeutic programs, groups and activities, based on best practice principals.

Toronto Private Hospital recently commenced a new service for patients suffering from treatment resistant anxiety and depression – the Mood and Anxiety Assessment Program.

“The program has been established to support general practitioners by providing a comprehensive clinical assessment service for patients with acute or chronic mood and/or anxiety disorders.

“General practitioners can refer patients with mood or anxiety symptoms where initial treatment has been unsuccessful or hampered by complicating factors,” Mr Mereau said.

“The combination of our services is another step towards ensuring the Hunter community gets the best possible care from a well trained and an appropriately resourced mental health unit.”
Many people with substance dependence do not know where to find help, and GPs—the most likely source of information—often do not have the time, training or resources to be able to explore this issue with patients.

According to the Australian Bureau of Statistics’ national household surveys, five per cent of the population have a dependence on illegal or prescription drugs.

Dr Oliver O’Connell, who heads up the Addiction Recovery Centre at Wesley Hospital Ashfield, said while many doctors are treating people for mental illness, the underlying issue can be addiction.

“Many doctors are aiming to relieve the patient’s anxiety or depression by prescribing anxiolytics like benzodiazepines,” he said. “However, people struggling with addiction will then just become addicted to the prescription drug.”

Dr O’Connell said many doctors were uncomfortable asking questions about the drug or alcohol intake of patients and patients often deny the problem.

“There are ways of identifying the problem such as gamma GTs or facial features,” he said. “However, there are also techniques like motivational interviewing, which can help keep the issue on the table long enough to provide information to the patient about the problem and where they can get help.

“Really it boils down to doctors being comfortable asking patients about substance abuse.”

For most people, conquering an addiction is not something they can do without assistance. Trained staff and the right environment is key.

“People assume that by coming for treatment at a place like Wesley Hospital they will be surrounded by ‘no-hopers’ without jobs, but many patients are actually workaholics,” he said.
Promising treatment program

Owned by HealthCare Australia, Currumbin Clinic on the Gold Coast in collaboration with the Australian Institute for Suicide Research and Prevention will be facilitating a pilot project utilising oral ketamine for treatment resistant depression. The oral ketamine treatment program is scheduled to commence at Currumbin Clinic in October 2014.

According to the Australian Bureau of Statistics 2009, one in seven Australians will experience depression in their lifetime. Depression is the third highest burden of all diseases in Australia at 13.3 per cent.

Treatment resistant depression presents major challenges for both patients and clinicians with the chances of remission decreasing significantly after two failed treatment trials.

Ketamine, a NMDA (N-Methyl-D-aspartate) receptor antagonist, is predominately used for induction and maintenance of anaesthesia, analgesia (including chronic pain management) and procedural sedation. Emerging evidence suggests there is a rapid antidepressant effect at sub-anaesthetic doses in people with bipolar depression, treatment resistant depression and suicidal ideation.

“Most of the research to date has focused on effects when ketamine is administered intravenously on its own. The results to date have been encouraging; however the benefits ketamine offers are consistently reported as short lived,” said Dr De Gioannis, consultant psychiatrist at the Life Promotion Clinic at Griffith University.

The study being introduced at Currumbin Clinic aims to demonstrate that oral ketamine as an augmentation treatment offers significantly higher benefits and greater chances of remission than intravenous ketamine on its own.

The inclusion criteria for the study are:

- Treatment resistant depression; two failed trials on anti-depressant medications from different sub-categories; completion of psychotherapy; participants must be aged 18 to 65 years.

Oral ketamine treatment program

An initial outpatient assessment will be conducted on all patients who are referred to the program to determine suitability for inclusion.

Patients who are eligible will then be offered a three-week planned inpatient admission during which time additional screening will be undertaken and dose titration will commence.

The administration of oral ketamine during both the inpatient and day patient phases of the treatment will be by a psychiatrist.

Patients will then transition to a day patient program for ongoing dosing that will generally require a weekly attendance. In addition to ketamine administration, the patients enrolled in the program will be engaged in emotion modulation therapy.

Emotion modulation therapy

Emotion modulation therapy (EMT) is a mode of psychotherapy developed at the Australian Institute for Suicide Research and Prevention. It is a cognitive behavioural intervention with theoretical underpinnings in performance psychology. To date, EMT has been applied to a range of mental health disorders, including mood, anxiety and personality disorders. EMT is aimed at assisting individuals to improve their ability to cope with the problems they face in life and reduce the discomfort associated with challenges that occur in everyday life.

All patients will be offered up to six months of treatment with the possibility of continuing if clinically appropriate and beneficial. Patients will remain under the care of a hospital-accredited psychiatrist who collaborates with the referring medical practitioner.

Currumbin Clinic is excited to provide this cutting edge treatment alternative for patients who experience this debilitating illness and where other treatments have proven unsuccessful.
Hospitalisation is key in the treatment and rehabilitation of many patients suffering major depression and substance-use disorder, with up to a third of patients suffering both diseases simultaneously.

A quarter of people diagnosed with major depression are shown to have a substance-use disorder, most commonly alcohol abuse or dependence, while one third of patients suffering alcohol dependence have a co-morbid major depression.

According to Brisbane Private Hospital psychiatrist David Storor, the role of inpatient detox and rehabilitation is crucial to the treatment of depression and Alcohol Use Disorder (AUD), aiding greatly in determining which is the primary condition needing treatment.

“Major depression and alcohol abuse and dependence are common disorders that frequently co-occur, however it is important to attempt to establish a chronology because this has significant bearing on treatment,” he said.

“Inpatient detox and rehabilitation within a hospital setting provides a good opportunity to better evaluate the relationship between depression and alcohol excess and safely initiate appropriate treatment.”

Given the relatively frequent occurrence of these problems in society, Dr Storor said it is not surprising that many patients present with depression and a co-morbid alcohol disorder.

At Brisbane Private Hospital’s alcohol and prescription drug unit, Damascus, patients are cared for by a multidisciplinary team including psychiatrists and allied health professionals, as well as physicians and gastroenterologists who can provide assessment and management of poor physical health in relation to drinking.

Dr Storor said the majority of patients at Damascus present with a primary AUD with psychiatric co-morbidity – the most common being depression – and the first step is abstinence.

“Aafter a detox period of about four to five days, the patients enter a two-week, group-based rehabilitation program facilitated by allied health professionals, which focuses on motivational interviewing, relapse prevention, life skills treatment strategies, cognitive behaviour therapy and mindfulness strategies,” he said.

“Post-discharge, patients are seen for day patient sessions on a weekly to fortnightly basis for a period of several months. This gives the psychiatrist an opportunity to review the patient regularly and monitor treatment and medication for both the alcohol problem and depression.”

As with the majority of psychiatric disorders, treatment is focused on three areas: biological, psychological and social.

“Social interventions focus on the family, the workplace and lifestyle factors,” Dr Storor said.

“The main stay of psychological treatment of patients with depression and an AUD is formulating a plan for relapse prevention. Taking the alcohol out of a dependant’s life creates a vacuum that must be filled with more healthy and adaptive behaviours.

“The biological treatment of depression in the setting of alcohol excess is not straightforward, as it is difficult to establish whether someone has had an effective trial of an antidepressant if they continue to drink to excess – this is why our first step at Damascus is detox.”

By Karla Simpson
Few would argue that smoking is a significant issue for people with mental illness. Prevalence is approximately two to four times that of the general population and there is growing evidence that it contributes significantly to increased mortality in this group. Data from the UK, for example, identifies that while people with serious mental illness represent five per cent of the population, they account for 18 per cent of deaths, and almost half of the excess mortality is due to cardiovascular disease, respiratory disease and cancer.

More recently, a large Canadian study found tobacco-related conditions comprised approximately 53 per cent of total deaths in schizophrenia, 48 per cent in bipolar disorder and 50 per cent depression cohorts.

In light of this evidence, there is a growing push to redress the limited attention given to smoking in psychiatric populations and for mental health services to adopt a systematic and integrated approach to managing smoking as part of routine care. A recent Victorian coronial enquiry has included specific recommendations in this regard and various legal opinions have failed to uphold claims of discrimination against health services banning smoking in mental health facilities.

Assisting health services to step up to the challenge, a recent workshop conducted by the Victorian Network of Smokefree Healthcare Services provided an opportunity for mental health clinicians and service managers to discuss the issues and share strategies and resources.

Some of the key challenges identified included:

- the need to manage the attitudes and expectations of both consumers and staff, including the need to turn around a culture in which patients (and staff) expect to be able to smoke;
- the need to focus on ‘care’ of the nicotine dependent patient rather than the smoking ban – if appropriate assessment and treatment is provided, compliance with a ban will be less of an issue;
- the need to ensure staff are well educated and have access to appropriate expertise with respect to smoking and mental health, including motivational interviewing. The issues and management considerations are complex and there needs to be a distinction between managing nicotine withdrawal in the acute situation versus supporting an attempt to quit as part of ongoing care;
- the need to ensure appropriate pharmacotherapy is available, including managing acute withdrawal with fast acting nicotine replacement therapy (NRT), and being alert to the impact of smoking on the metabolism of psychotropic drugs;
- the need for appropriate monitoring and continuity of care, including engagement of the multidisciplinary team (medical, nursing, pharmacy and others) – consider using carbon monoxide monitoring to demonstrate and motivate progress;
- the need to address broader issues such as boredom and social isolation;
- the need to ensure consistency and compliance with a health service smoke-free policy – a total ban is more likely to achieve the goals of protecting staff and patients and providing consistent clinical care.

One of the hot topics was the place of electronic cigarettes in supporting smoking cessation or as a strategy for harm minimisation. This is clearly an evolving area and regular updates are included on the Victorian Network of Smokefree Health Care Services website: smokefreevictoria.com.au.

Fiona Landgren, Victorian Network of Smokefree Healthcare Services
Rachel Ash, The Melbourne Clinic, Richmond, Victoria
Catriona Bastian, Mind + Body Project Coordinator, SANE Australia

1Mental Health Bulletin (Health and Social Care Information Centre, 2013
2Callaghan RC et al. Patterns of tobacco-related mortality among individuals diagnosed with schizophrenia, bipolar disorder or depression. Journal of Psychiatric Research, 2014;102-110
CLAVE™ Oncology is enhancing safety in the workplace with a closed needle-free system from preparation to disposal.

SAFE PREPARATION  
CLAVE bag and vial access spikes

SAFE TRANSPORT  
Spiros™, closed male connector on syringe

SAFE DISPOSAL  
Spiros remains passively closed on disconnection

SAFE ADMINISTRATION  
CLAVE Oncology administration sets

ANOTHER LAYER OF PROTECTION

Total Annual Costs Associated with Implementing Competing CSTDs*:1

<table>
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<th>Product</th>
<th>Cost 2014</th>
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<tr>
<td>PhaSeal®</td>
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* Component cost may vary slightly due to manufacturing price changes, contract pricing, and/or volume discount pricing. Texium/SmartSite is marketed as a closed system, not a CSTD.

1 Barnachea L, Lee T, Gitter J, Saria M. Presented at the California Society of Health System Pharmacists (CSHP), November 4, 2011.
The cornerstone of Sydney Adventist Hospital’s $200 million redevelopment, the new LW Clark Tower, is open.

The 12-story LW Clark Tower is home to a new maternity, women’s health and children’s unit, an integrated cancer centre and healing garden, and provides capacity for up to an extra 200 hospital beds, and 10 extra operating theatres.

With its existing facilities combining to provide the hospital with a total of 550 inpatients beds, another 300 plus day beds, and up to 24 operating theatres, the redevelopment reaffirms Sydney Adventist Hospital (the San) as the largest private and the largest not for profit hospital in NSW.

The LW Clark Tower complements the newly built multi-deck car park, which provides an additional 896 spaces, as well as the hospital’s stunning new arrivals area and clinical education centre.

The redevelopment took almost 10 years of planning and just over three years to construct, and will cater for the 50 per cent increase in patient demand expected by 2026 by a growing and ageing population.

In keeping with other buildings and wards already named in honour of significant figures in the San’s 111-year history the tower was named in honour of Chief Executive Officer Dr Leon Clark, who has been a driving force in the San’s growth and its reputation as a centre of excellence.

“Our vision when we started planning this new facility over 10 years ago was to provide the best facilities to attract the best medical teams to provide the best care,” Dr Clark said.

“The new San – our milestone $200 million redevelopment – is the result. It equips us to care for our community into the 22nd century.”

He added, “We believe it honours the pioneering spirit of the people who first opened a small ‘Sanitarium’ over 111 years ago as a place to care for people and promote healthy lifestyles.”

“We believe it honours the pioneering spirit of the people who first opened a small ‘Sanitarium’ over 111 years ago as a place to care for people and promote healthy lifestyles”

Maternity unit
Level 11 of the new building has been named after former Director of Maternity Wendy Wooller, who worked at the San for 39 years.
“The unit is absolutely fantastic,” Ms Wooller said. “It is better than I could have imagined. The patients are going to love it, and so will the staff.”

The newly opened new maternity unit includes 56 architecturally designed private rooms with ensuites, partner accommodation, a nine-room birthing unit, two birthing pools, and well-baby and special care nurseries, as well as spectacular bushland views to the city.

The first baby in the new maternity unit was Georgia Hogan, daughter of Melannie and John Hogan, and sister to two-year-old Savannah, born in the San's previous unit.

**The cancer centre**

The new integrated cancer centre is designed so that stressed and vulnerable cancer patients have quick and easy access to all the X-ray and other screening or imaging, specialists, surgical and medical treatments, recovery and support services they need.

The San is the largest employer in the Hornsby Ku-ring-gai region with over 2,200 nursing staff and 800 medical specialists. It cares for more than 230,000 patients a year providing diagnostic, acute care, medical and surgical treatments, cutting edge equipment, rehabilitation, education and research facilities.
It was a wing, a prayer and a pair of steady surgeon’s hands that saved Westmead Private patient Sarah Blomfield recently, with her dramatic rescue and operation caught on film by the hit British TV reality show *Helicopter Heroes*.

The Barraba teenager was on a school excursion to the Jenolan Caves when she experienced a sudden severe headache and vomiting.

Thanks to the actions of her teachers, Sarah was quickly transferred by ambulance to Oberon and then onto Bathurst Base Hospital where a CT scan revealed blood on the brain.

It was then that British medic Dr Ben Lakin, in Australia filming the Down Under series of *Helicopter Heroes*, sprinted into action – overseeing the medical care of the 14 year old during the emergency NETS flight to Sydney.

For Dr Lakin, dramatic air rescues – winching souls to safety and jumping hospital trolleys in a single bound - is normal for a flying ER doctor who spends his working day transporting seriously injured patients from far-flung corners of the country.

The other hero of the day was Westmead Private Hospital’s Neurosurgeon Dr Mark Dexter, who seamlessly removed the life-threatening anterior venous malformation (AVM) - a tangle of abnormal blood cells that can cause severe damage with a bleed out.

For Sarah’s mum, Penny, the quick actions of all the staff and doctors involved is something she will be forever grateful for.

“One minute you think you have it all, your child is perfectly healthy and then you get a phone call from a teacher telling you your child is probably very ill and the closest hospital is miles away.”

Sarah spent a week in Westmead Private Hospital, where Dr Lakin visited her to see how she was getting on.

For Sarah and her parents it was a lovely reunion and a time to thank Dr Lakin for his efforts in Sarah’s transfer. Sarah was discharged home back to Barraba where she will shortly return to school in good health and is looking forward to seeing her friends again.
Innovation in healthcare education

Harnessing technology to meet learning expectations in healthcare

The challenges in delivering education in healthcare are complex and diverse. Learning management systems, such as Moodle, as well as mobile devices, multimedia, and the latest digital tools, are enabling healthcare organizations to be innovative and reshape education in a way that builds skills by giving people a compelling, helpful and an authentic learning experience.

Moodle conferences (often referred to as Moots) are held globally all year round. Their intent is to pull educators, learning designers, managers and system administrators together to share their knowledge and passion for all things Moodle – one of the most popular open-source learning platforms, with millions of users all over the world.

The first ever Health MoodleMoot, is proudly presented by Sydney Adventist Hospital and supported by Pukunui Technology. The conference will be held on 27-28 November 2014, at the Clinical Education Centre, Sydney Adventist Hospital.

Why a Health MoodleMoot?
The challenge in healthcare is to develop training programs that meet the needs of individuals, as well as stringent accreditation requirements of the Australian statutory bodies. More than ever before, clinical educators are developing state-of-the-art blended training solutions to support a dynamic landscape in healthcare education. Using the best of eLearning, skills workshops, clinical simulation labs and workplace practice learning, training programs are being specifically tailored for the hospital environment.

This conference will be an opportunity for the healthcare community to network and celebrate emerging approaches, trends and innovative improvements in healthcare education. The event is focused on exploring groundbreaking solutions to compliance and skills training, blended learning, simulation opportunities, collaborative learning, including webinars and social media, and digital resources, including videos and tools that promote learner engagement.

The two-day conference program will consist of master classes, keynote speakers and presentations. Keynote speakers will include Martin Dougiamis, the founder of Moodle, and Dr. Glenn Singleman, Australia’s most experienced expedition doctor.

Inspirational clinical educators, learning designers, multimedia experts, Moodle experts and administrators will present the sessions. Each will share their passion, experience and knowledge on all things related to Moodle, and in doing so, will demonstrate how they embraced new technologies to meet the needs of diverse audiences and developed programs which facilitate the integration of theory and clinical practice.


By Gina Veliotis
Elections and statistics

APHA announces membership of the APHA Council for 2014-2016 and prepares to make another submission to the government’s Competition Policy Review

APHA Council 2014/2016 Elections

APHA recently held bi-annual elections for the APHA Council. Following the recent elections, membership of the APHA Council for 2014-2016 is:

For Profit Large Group
- Steve Atkins (Healthcare)
- Michael Coglin (Healthscope)
- Robert Cooke (Healthscope)
- Andrew Currie (Healthscope)
- Gavin O’Meara (Ramsay Health Care Australia)
- Malcolm Passmore (Ramsay Health Care Australia)
- Geoff Sam (Healthcare)
- Danny Sims (Ramsay Health Care)
- David Wenkart (Macquarie Health Corporation)

For Profit Small Group Large Independent
- Phillipa Blakey (Pulse Health Limited)

For Profit Small Independent
- Denise Thomas (Metropolitan Rehabilitation Hospital)

Not for Profit Large Group
- Philip Currie (Sydney Adventist Hospital)
- Alan Kinkade (Epworth HealthCare)
- Richard Royle (UnitingCare Health Group)

Not for Profit Small Group Large Independent
- Alan Cooper (Friendly Society Private Hospital)

Not for Profit Small Independent
- Allan Boston (The Bays Hospital - Mornington)

Day Hospitals
- Anne Crouch (Cura Day Hospitals Group)

Psychiatry
- Christine Gee (Toowong Private Hospital)

Rehabilitation
- Vincent Borg (Epworth HealthCare)

Regional Representatives
- NSW Robert Cusack (St Vincent’s Private Hospital)
- Queensland Ray Fairweather (St Andrew’s Toowoomba Hospital)
- SA Alan Morrison (Sportsmed SA Hospital)
- Tasmania Amanda Quealy (The Hobart Clinic)
- Victoria Vicki Canning (Western Private Hospital)
- WA Moira Munro (Perth Clinic)

Councillors will take up their seats in early October. APHA office bearers (president, vice-president, chairman of council and treasurer) and additional directors of the APHA Board will be elected at the first meeting of the APHA Council, scheduled for 28 October 2014.

Competition Policy Review

On 22 September, the draft report of the Australian Government’s Competition Policy Review was released. APHA had previously provided a written submission to the review and was subsequently invited to participate in a face-to-face consultation.

In relation to human services (including health, education and community services), the review panel made the following recommendations:

Australian governments should craft an intergovernmental agreement establishing choice and competition principles in the field of human services.

- The guiding principles should include:
  - user choice should be placed at the heart of service delivery;
  - funding, regulation and service delivery should be separate;
  - a diversity of providers should be encouraged, while not crowding out community and voluntary services; and
  - innovation in service provision should be stimulated, while ensuring access to high-quality human services.

Each jurisdiction should develop an implementation plan founded on these principles that reflects the unique characteristics of providing human services in its jurisdiction.

The report also quotes APHA's submission as an example of concerns raised by stakeholders about the application of competitive neutrality. APHA will make a further submission (due by 17 November) to the review.

PHIAC Data – Headlines from June 2014

The Private Health Insurance Administration Council (PHIAC) has released its quarterly statistics for the June 2014 quarter.

Participation in private health insurance hospital cover has increased by 0.2 percentage points since the March quarter to 47.2 per cent. As at 30 June 2014, 11.1 million Australians had hospital cover of some sort. Even though the overall cover has increased (which may be due to seasonal factors), policies that have exclusions have continued to rise. More than one in four (25.5 per cent) policies now have exclusions. APHA members had a full breakdown of the report emailed to them.
Private hospitals make a vital contribution to the delivery of treatment for mental health disorders with more than 32,000 patients treated each year.

one in five Australians will suffer from mental illness this year.

It's time to start talking about mental health.
Man any cases of bullying at work result in psychological and, in some cases, physical injuries to workers. Amendments to the Fair Work Act 2009 (Cth), which commenced on 1 January 2014, give the Fair Work Commission (FWC) jurisdiction over complaints of bullying in workplaces covered by the Fair Work Act. This includes Australian private hospitals operated by companies.

Previously, bullying could only be raised as an example of conduct that may breach adverse action provisions of the Fair Work Act or unfair dismissal laws.

Due to constitutional issues, the provisions do not apply to unincorporated sole traders, partnerships and state public sector departments and authorities.

The commission is able to make orders requiring an individual or group to stop bullying behaviour, or requiring an employer to implement anti-bullying policies and training. However, orders for compensation or reinstatement are not available. Compensation may be available under workers compensation laws.

The amendments introduce a codified definition of workplace bullying describing a situation where an individual or group of individuals exhibit at work ‘repeated, unreasonable behaviour directed towards a worker or a group of workers that creates a risk to health and safety’. The requirement for repeated behaviour means that a worker will not be considered to have been bullied in circumstances where the conduct has only occurred once. However, single instances of unreasonable behaviour may give rise to other rights (such as rights under the general protections provisions of the Fair Work Act), depending upon the reason for the conduct.

Since the legislation commenced, the commission has determined that incidents of bullying that occurred prior to 1 January 2014 may be taken into account if they are part of a pattern of ongoing behaviour.

The definition of ‘workplace bullying’ does not include reasonable management practices. Management practices are not limited to performance management or discipline, and extend to directions to employees generally to perform work. The onus is generally on the employee to show that the management action was unreasonable. The commission has indicated that whilst management action need not be perfect, it must be reasonable in the circumstances. Additionally, expressions of upset and frustration will not necessarily constitute bullying.

Bullying in the workplace can involve subcontractors and third parties. It is unclear whether, in those circumstances, an employer will be able to make submissions as an interested or affected party, particularly, if orders made by the FWC will impact on the way in which the employer deals with its staff. The definition of worker in these provisions also goes much further than “an employee”. It is the same as the definition in the model Work Health Safety Act 2011, which defines a worker as ‘any person who carries out work in any capacity for a person conducting a business or...
“Previously, bullying could only be raised as an example of conduct that may breach adverse action provisions of the Fair Work Act or unfair dismissal laws”

undertaking”. This will include employees, contractors and subcontractors, volunteers, apprentices, trainees and work experience students.

If the FWC considers bullying has occurred, the FWC will be empowered to make any order it considers appropriate to prevent the bullying other than the payment of money. So far there have been more than 150 complaints made, and the overwhelming majority of those complaints have been made by employees against their managers. Many of the complaints have related to issues arising due to workplace change; including restructures, change in reporting lines and asking employees to do additional work (but still within their job description). These types of changes tend to affect the wellness of employees who should be supported through these processes to minimise complaints of bullying.

A contravention of an anti-bullying order can result in a maximum penalty of $51,000 for a corporation and $10,200 for an individual.

It is now even more important for employers to update their anti-bullying policy and complaint procedures. Additionally, employers should appropriately address complaints.

This article was written with the assistance of Robin Young, Rachael Sutton and Tim Smyth.

This article is provided for general information purposes only and should not be relied upon as legal advice.
A coordinated approach

Recognising and responding to deterioration in mental state

The Australian Commission on Safety and Quality in Health Care (the Commission) has a strong commitment to promote, support and encourage safety and quality in the provision of mental health services, and the program around recognising and responding to deterioration in mental state is an exciting element of work currently being progressed.

To date, the Commission’s Recognising and Responding to Clinical Deterioration Program has focused on acute deterioration in a patient’s physical condition. It is known that potentially preventable harm from deterioration in a patient’s mental state also occurs, and that there is room for improvement in the systems and processes for recognising and responding to deterioration in mental state.

The Commission supported a scoping review to explore and report on:

- the current knowledge base for recognising and responding to deterioration in mental state of inpatients in acute settings;
- gaps that could be addressed by the Commission;
- whether, and how, the existing National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration could be applied to deterioration in a person’s mental state.

The scoping review has been completed and has identified a number of gaps in current systems for recognising and responding to deterioration in mental state. These included:

- understanding of the nature, scale and consequences of failures to effectively recognise and respond to deterioration in mental state;
- standardised markers, tools, processes, and systems for recognising deterioration;
- agreement on the key competencies required for clinicians to recognise and respond to deterioration in mental state.

The authors of the scoping review have made seven recommendations for possible action by the Commission. These include working to embed the link between physical and mental health within the consensus statement, identifying key adverse events and markers of deterioration in mental state as well as developing pathways and protocols for responding. Additional recommendations include supporting practice development and research and showcasing best practice.

The scoping review is in the process of being provided to key advisors and experts in order to seek advice guiding the Commission’s next steps. It is also being distributed to a wide range of stakeholders and is available on the Commission’s website.

Next steps

The complexity of the mental health sector means that developing a coordinated approach to recognising and responding to deterioration in mental state is not straightforward. This report provides a starting point to achieve national agreement on some key issues, and potentially a more coordinated approach in this area. This would support actions to provide safe and high-quality care to people with a mental illness in all parts of the health system.

The Commission is currently exploring options to undertake a targeted consultation process. This consultation process would help strengthen the Commission’s understanding of the relevant issues and ensure that key stakeholders are engaged in reaching consensus on two key recommended actions:

- identification of the key potentially preventable adverse outcomes associated with deterioration in mental state and;
- markers of deterioration in mental state.

It is important that the Commission consult in more detail in these two areas to ensure that there is a credible platform from which to proceed with work to improve the recognition and response to deterioration in mental state.

At this stage the Commission is using the information from this review to inform thinking...
about how to better incorporate mental health into the next version of the NSQHS Standards. This work involves mapping the journey for different types of patients in different settings in the health system, to identify where there are safety gaps and issues that could be addressed in the NSQHS Standards. The work is in the very early stages, and the Commission is committed to gaining input from people within the mental health sector as it is progressed.

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 – admin@apha.org.au.

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Benchmarking and hospital pharmacy

If benchmarking is regarded as a worthwhile exercise to improve performance, why isn’t more happening in benchmarking pharmacy and medicine management in hospitals?

Benchmarking has been defined as a technique in which an organisation measures its performance against that of ‘best in class’ organisations, determines how those organisations achieve the levels they do, and uses the information to improve its own performance.

Hospital pharmacy benchmarking activity internationally seems to occur in three forms, these being the comparison of a hospital pharmacy service:

• against best practice standards, as a way of identifying gaps and guiding service development;
• against peers, in order to understand how the performance of a pharmacy department compares with contemporary practices of a similar size or service profile; and
• against itself, as a way of measuring a pharmacy’s own performance over time to track improvement or monitor outcomes of service changes or initiatives.

Best practice standards
The most common form of benchmarking activity occurring in hospital pharmacy appears to be comparison against best practice standards, such as those developed by professional bodies including:

• The Society of Hospital Pharmacists of Australia (SHPA) which has published standards of practice for specific aspects of hospital pharmacy service;
• The Royal Pharmaceutical Society (RPS) in Great Britain which recently developed the Professional Standards for Hospital Pharmacy Practice, Optimising patient outcomes from medicines; and
• The Health Systems Pharmacy Executive Alliance in the USA which developed the High Performance Pharmacy Framework.

Of the ‘best practice’ standards identified in the literature, the High Performance Pharmacy framework (which was described in the Pharmacy Focus section of the February 2014 edition of Private Hospital) is the only one to include financial performance as a key area.

Peer comparison
Very little information is available on benchmarking of pharmacy services against peers in Australia or internationally the most notable exception being the Hospital Pharmacy in Canada 2011/2012 Report which is the report of a comprehensive survey of 176 hospitals representing approximately 68,450 inpatient beds in Canada. It provides the opportunity for individual services to compare themselves with others across the country. The information presented includes data on clinical pharmacy services, drug distribution systems, human resources, pharmacy technicians, evaluating pharmacy services as well as specific benchmarking indicators.

Efforts to establish hospital pharmacy benchmarking activity in Australia via the Health Roundtable forum have largely been unsuccessful although there is renewed interest.
among some public hospital CEOs and directors of pharmacy in Queensland, Victoria and South Australia. The biggest issue in progressing benchmarking in both private and public hospital services appears to be the lack of agreement on definitions for pharmacy services and activities.

Despite this, there have been a number of attempts to identify meaningful ways to affect comparisons using a benchmarking approach. In private hospitals these have included measuring and comparing elements such as:

- total pharmacy revenue per patient day;
- total pharmacy employment cost per patient day;
- operating theatre imprest cost per theatre procedure;
- total operating costs incl. depreciation as a percentage of pharmacy revenue;
- pharmacy stock variation (caused by stock write-off due to expiry or adjustments) in absolute value of write-off and as percentage of total stock purchases;
- gross profit margin on total pharmacy revenue;
- PBS revenue as a percentage of total pharmacy revenue;
- total imprest costs as a percentage of total purchases; and
- PBS prescriptions as a percentage of total prescriptions dispensed.

As the positive impact of the National Safety and Quality Health Service Standards is increasingly felt throughout Australia, some hospitals have begun reporting on and comparing key aspects of Standard 4 (medication safety) such as:

- the percentage of patients receiving a pharmacy review during their inpatient stay;
- the percentage of patients with a documented medication history and medication reconciliation; and
- percentage of patients on discharge with a complete discharge medication record.

A small number of public hospitals have been developing some basic benchmarking criteria by comparing costs and activity per National Weighted Activity Unit (NWAU), in the following ways:

- number of pharmacists and number of pharmacy support staff per 10,000 NWAU;
- inpatient and discharge items dispensed per NWAU;
- total drug expenditure per NWAU; and
- total PBS revenue per NWAU.

There are a number of measures of performance in medicines distribution from relevant SHPA and Royal Pharmaceutical Society practice standards and from Canadian benchmarking activity and include the following:

- average drug cost per acute (and non-acute) patient day;
- turnaround times for inpatient and outpatient prescriptions;
- incidence of omitted medications due to unavailability;
- percentage of prescriptions prepared by support personnel.

**Next steps for benchmarking**

The following are suggested as next steps to consider in progressing meaningful benchmarking for hospital pharmacy:

- decide on the aspects of pharmacy where most insight is required (e.g. financial, clinical, operational) and which most closely align to hospital objectives;
- decide on the outcomes which need to be measured e.g. costs & revenue per patient day or unit of activity, Standard 4 criteria as a surrogate for safety and quality outcomes for patients;
- define the benchmarking elements precisely to ensure that ‘like is being compared with like’ (this is an arduous but essential task);
- decide on the hospitals with which comparison would be of most value (the ‘best of breed’);
- consider using an independent facilitator for the process to ensure confidentiality, accuracy and consistency; and
- make a start!
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Where do you work, what is your role and how long have you been there?
I've worked at Toowong Private Hospital in Brisbane since 2006. I am a Registered Nurse credentialed with the Australian College of Mental Health Nurses (ACMHN). I have a range of roles at the hospital. I manage two community outreach programs namely the Mental Health Nurse Incentive Program (MHNIP) that is federally funded by Medicare Australia and the Assertive Community Treatment Program (ACT) that is funded by a range of Private Health Funds. I have a small case load of 10 patients I see in the community in the MHNIP.

I am the Administrators Delegate for the Queensland Mental Health Act 2000 (MHA2000) overseeing the administrative tasks for involuntary patients at the hospital. I also have a role with auditing controlled drugs and participate in a range of hospital committee meetings and Queensland Health working committees in relation to the MHA2000 on invitation. This keeps me quite challenged and busy.

You were recently named Queensland Father of the Year. Do you have one piece of advice for new fathers out there who are looking for inspiration?
The recent award has been somewhat surreal for me. I believe in being true to yourself and not pretending to be someone you're not. Life is too short to wonder about what you can or can't achieve. There is no harm in striving to achieve what ever goals or inspiration one might have. If you do not succeed initially, there is no shame in persevering or changing tack and trying something else.

You faced a life-changing challenge after you were assaulted in 2006. How did you overcome this adversity?
I was 39 years old, married with four children aged 8 - 15 years when I became a paraplegic in November 2006. I made a conscious decision not to let this life changing experience dull my desire to live a fulfilling life. It was very important to me to provide a strong and stable home both financially, emotionally and socially for my children and wife (now separated) at the time. The support of family, friends and work colleagues was instrumental in my recovery. I decided to treat my rehabilitation in the PAH spinal unit like work and probably set a record for getting out in just over four months. I learnt a lot by merely observing those around me as well as practicing all the new skills I had no choice to learn so I could live as independent a life as possible.

What do your children think of their father being named the Queensland Father of the Year?
My children have been rather proud and slightly embarrassed to a degree. The three youngest children don't really remember me walking and have only known me as dad in a wheelchair. I have not done anything extraordinarily in their view, other than just being dad. They all had a bit of a laugh with me when I was initially nominated as we did not understand the importance of the award. It was not until I won the award that we realised what it meant to others in the community.

What do you hope other people can learn from your experience?
It would be nice to think that anyone who knows what my family and I have gone through since my accident can reflect on their own situation and draw some hope and inspiration when life may not be going that well for them. We will all meet challenges in some form in our lives. Some people are amazed by my ability to have met the challenges I have faced. I have often told people that I was lucky in terms of a spinal injury as I can at least use my arms. I maintain most of my independence and fortunately can do a lot more than some other people with more severe spinal injuries. Never give up I say!
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