BURNSIDE HOSPITAL

burnsidebulletin

THE OFFICIAL NEWSLETTER OF THE BURNSIDE WAR MEMORIAL HOSPITAL

DECEMBER 2009

NEW SURGICAL PROCEDURE TO TREAT FEMALE INCONTINENCE

Surgical workshops hosted by the Burnside Hospital have enabled gynaecologists to observe a new, minimally invasive procedure to treat female stress urinary incontinence (SUI).

It is estimated that urinary incontinence affects between 20 and 37 per cent of adult women in Australia, with stress urinary incontinence being the most common. SUI is a condition in which physical activities such as coughing, sneezing, or heavy lifting put pressure on the bladder resulting in unintentional loss of urine. More common in women than men, SUI is caused by disruption of the pubo-urethral ligaments and by weakening of pelvic floor muscles often related to tissue and nerve damage resulting from pregnancy, childbirth, radiotherapy, hormone changes or prior surgery.

At the most recent workshop held on 18 November, gynaecologists observed Urogynaecologist, Dr Ian Tucker, perform two procedures using the MiniArc™ single-incision sling system, with attending Gynaecologist Dr Neisha Wratten as operating surgeon, performing the third.

South Australian surgeons first saw the new procedure performed during a teaching session at the hospital in 2008 which featured a presentation by Professor Ajay Rane, Consultant Urogynaecologist and Head of the Department of Obstetrics and Gynaecology, at James Cook University.

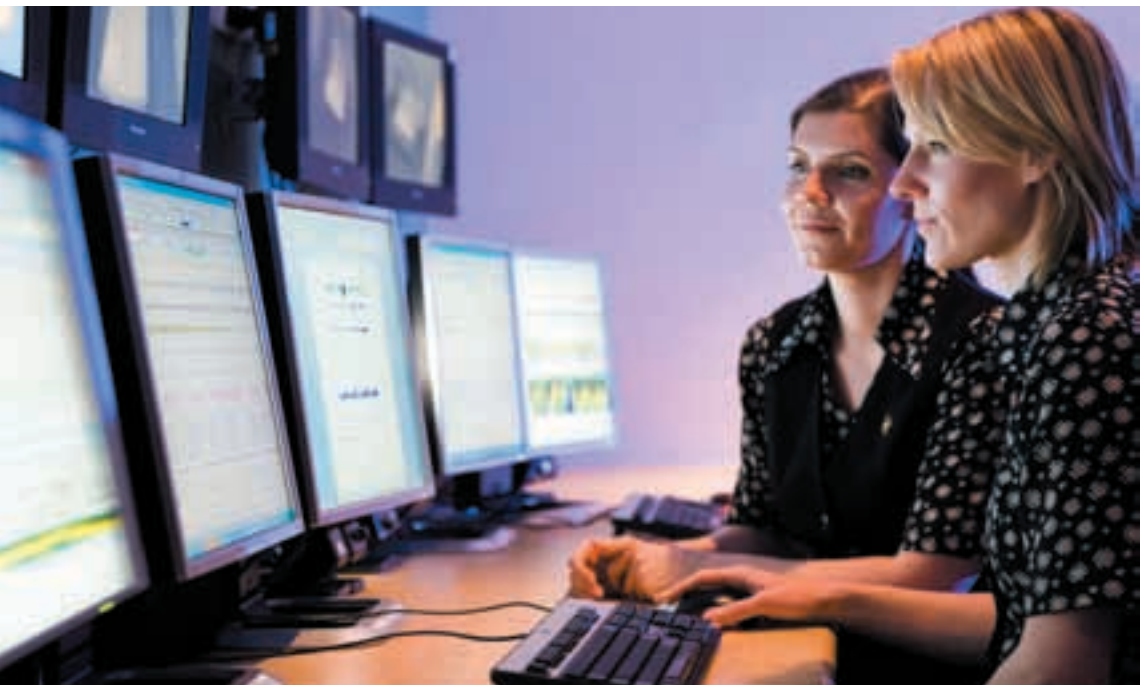
The sling procedure is among a number of surgical approaches used to treat female SUI including retropubic suspension, needle suspension and the anterior repair. Due to their low success rates, needle suspension and anterior repair have long been abandoned to treat this condition. The obturator approach to tensionless vaginal tape sling procedures superseded the 'Burch' colposuspension and retropubic tensionless vaginal tape as the 'gold standard', with equivalent success rates and reduced complication rates. The MiniArc™ is even less invasive and promises a further reduction in complications.

Around 50,000 of the procedures have now been performed worldwide. Early clinical evaluations conducted in the United States have shown promising results, with 94 per cent of women who had the new procedure reporting they were 'dry' at 13 months post-surgery.

"The main benefits of this procedure for women are that as only one incision is needed, there is potentially less tissue and nerve damage and reduced bleeding both during and after surgery. This means a quicker, relatively pain-free recovery with most women able to return to their usual routine within a few days," said Dr Tucker.

The workshops have provided a unique learning opportunity for SA surgeons specialising in female pelvic health and valuable hands-on experience for Burnside's operating theatre staff.

IN PROFILE - THE BURNSIDE SLEEP CENTRE



L - R: Melaura Bradford, Sleep Technician and Renee Galka, Principal Sleep Technician

The Burnside Sleep Centre is a purpose built six-bed facility with large, private, sound-proofed rooms and en suite bathrooms. It is fitted out with state-of-the-art equipment for the diagnosis of sleep disorders. Patients are admitted in the evening for an overnight stay and are discharged the next morning.

Who works there?

A team of Respiratory and Sleep Physicians is responsible for the medical supervision of the Sleep Centre which includes providing clinical consultation and reporting the studies. The main physicians allied with the centre are:

- Dr Peter Robinson (Director)
- Dr Hugh Greville
- Associate Professor Mark Holmes
- Associate Professor Hubertus Jersmann
- Dr Chien-Li Liew
- Associate Professor Paul Reynolds
- Dr Dimitar Sajkov

These studies require considerable technical support both during the overnight study itself and data analysis the following day. The technical team is headed by Renee Galka and Melaura Bradford. We are also fortunate to have Helen Wright and Kurt Lushington, Sleep Psychologists, consulting at the Burnside Sleep Centre on a referral basis.

What does it offer?

The Burnside Sleep Centre is a high level diagnostic facility for a variety of sleep disorders. The most common test performed is an overnight polysomnogram, in which multiple data channels (an average of 20) are recorded simultaneously with technician monitoring throughout the night. Initiation and monitoring of CPAP and other treatment interventions is another common indication – again with full overnight technical support.

Daytime sleep studies, for the investigation of diseases such as narcolepsy, can also be performed.

What are the main sleep disorders?

Snoring and obstructive sleep apnoea (OSA) are the most common reasons for referral. OSA ranges in severity and impact from being a socially disruptive nuisance or embarrassment, to a life threatening problem with implications both for the individual patient and for the community (e.g. increased risk of motor vehicle accidents). The links with other cardiovascular, cerebrovascular and metabolic diseases are still being explored.

Patients are also referred due to insomnia, narcolepsy, restless legs syndrome, excessive daytime sleepiness and abnormal motor behaviour during sleep (parasomnias).

How do I refer a patient?

Patients can be referred either directly to the Burnside Sleep Centre or to one of the physicians listed above. This referral will lead to a consultation (as required by Medicare) and sleep study.

For more information about the Burnside Sleep Centre, please contact the centre direct on 8202 7272 or via the hospital switchboard on 8202 7222.

Dr Peter Robinson
Hon. Director, Burnside Sleep Centre

Dr Peter Robinson, Hon. Director, Burnside Sleep Centre

FROM THE MEDICAL EXECUTIVE COMMITTEE

Dr Clive Hoffmann, Chairman, Medical Executive Committee

Dr Clive Hoffmann was appointed Chairman for the year at the committee's first meeting for 2009 in February. He succeeded Mr Randal Williams who had held the position since February 2001.

The hospital recognised Mr William's contribution, together with that of Dr Lino Scopacasa and Mr Daryl Teague (who both retired from chairing the Perinatal and Operating Suite Committees respectively, over many years), at a dinner in their honour in April.

Pain management protocols

Pain management protocols were updated earlier in the year following a review conducted by an external, independent consultant. A working party was formed to develop an action plan to address the review's findings.

The hospital adopted a new pain protocol incorporating the *Flow Chart for Intermittent Intravenous Analgesia Administration* (based on the Royal Adelaide Hospital's Guidelines for Pain Management) with the inclusion of Pethidine, and the revised Sedation Score.

Following consultation and having reached an agreed position with three major anaesthetic groups, patients who are administered Intrathecal Fentanyl will no longer be routinely admitted to the High Dependency Unit (HDU). Patients receiving Intrathecal Morphine will continue to be managed in the HDU for the first 24 hours. Maternity patients who receive 200 micrograms or less of Intrathecal Morphine may return to the Maternity Unit.

National inpatient medication chart

Medicare Australia has approved the use of the new National Inpatient Medication Chart (NIMC) at the Burnside Hospital. The NIMC was introduced from 1 December 2009. The new style chart has been used in the public sector for more than a year and is also now widely used within the private sector.

Some of you will have received a letter from the hospital about the chart's impending introduction. For any further information, please contact Ms Heather Messenger, Director Clinical Operations, or any of our Clinical Managers.

Pandemic (H1N1) 2009

Following the pandemic (H1N1) 2009 ('Swine' Flu) outbreak in Australia earlier this year, the hospital, in conjunction with its Infectious Diseases Consultant, Dr P C Lee, adopted measures to reduce the risk to patients in vulnerable groups including maternity patients and those undergoing chemotherapy.

Other key matters:

- A review of paediatric surgery is under way. A discussion paper due early in the New Year will examine the age profile of the hospital's paediatric patients and consider whether adequate risk mitigating factors are in place to address any issues identified.
- Introduction of a Placenta Praevia Policy.
- Preliminary consideration by the Perinatal and Operating Suite Committees on patient body mass indices (BMI) and the need for patient screening to identify those considered at particular risk.
- The Clinical Review Committee held its inaugural meeting in November. The committee receives, reviews and analyses clinical adverse event information from each of the hospital's clinical units with the objective of recommending quality improvement initiatives. Previously various medical sub-committees reviewed adverse events.

PROFILE

DR MICHAEL McCLEAVE

Adelaide-trained plastic surgeon, Dr Michael McCleave, has commenced practising at Burnside Hospital. He has recently completed fellowships in the USA and UK in adult and paediatric plastic surgery.

Michael is now available for elective and urgent referrals in general plastic surgery, skin and soft tissue cancers, hand surgery, facial fractures, Workcover injuries and cosmetic surgery. He will also continue as a Consultant at the Royal Adelaide Hospital, the Repatriation General Hospital and Flinders Medical Centre.

For all appointments, Dr McCleave can be contacted at his rooms at 309 Wakefield Street, Adelaide on 8223 1290.

CHIEF EXECUTIVE'S MESSAGE

Reasonably high levels of patient activity and less reliance on agency nursing staff during the 12 months to June 2009 combined to produce the hospital's most favourable financial result in four years.

However, unlike the previous year, the hospital's performance for the five months to November 2009 has been disappointing due to lower than expected patient episodes.

I am pleased to report that despite predictions to the contrary, the number of Australians (and South Australians) covered by private health insurance actually grew in the past year. As a proportion of the national population covered at the end of September 2009, health fund membership is currently 0.1 per cent higher than it was 12 months ago. The level is now at its highest since 1983.

Burnside Hospital has planned a capital expenditure program totalling 1.1 million for the current financial year with a focus on patient and staff-related amenities. Among the high cost items in the budget this year are upgrades to the patient entertainment system (including digital televisions) and the von Rieben South Ward pan room, a new electric operating table, and two additional CTG monitoring machines for our maternity service. We will also undertake significant alterations in the operating theatre associated with removing three decommissioned sterilisers. This work will begin over the Christmas and New Year period to minimise disruption.

This Christmas, as was the case last year, the Burnside Hospital has donated $1,000 to the Australian Red Cross, the Royal Flying Doctor Service and Cancer Council SA, in lieu of sending Christmas cards.

As another year draws to a close, I would like to extend our good wishes to you all for the festive season and look forward to a bright and successful 2010.

Nick Warden

Nick Warden
Chief Executive

CLINICAL PHARMACY SERVICE ENHANCES MEDICATION SAFETY

APHS Pharmacies provide Burnside Hospital's clinical pharmacy service. As part of this service, a pharmacist regularly reviews patient medication charts and records and categorises all clinical interventions.

Between July 2008 and June 2009, APHS pharmacists recorded 1095 medication-related interventions at the hospital - an average of two to three clinical interventions by a pharmacist per day.

These interventions may fall under the following categories:

1	Cessation of a drug	11	Drug interaction
2	Change of dose	12	Therapeutic consultation
3	Addition of a drug	13	Clarification of medication orders
4	Substitution of a drug	14	Drug information
5	Change rate of administration	15	Provision of patient information
6	Change route of administration	16	Drug allergy
7	Change time of administration	17	Drug/Disease interaction
8	Correction of prescription error	18	Change of dosage form
9	Therapeutic drug monitoring	19	Identification of new symptoms
10	Monitoring of efficacy or adverse effect	20	Other

Of the medication-related interventions recorded in the 12 months to June 2009, a majority (68 per cent) were categorised as *Clarification of medication orders*. Examples include clarifying the strength of a medication when it is not recorded on the medication chart or clarifying an illegible medication order.

Other common interventions include recording allergy information which has been omitted from the medication chart, and indicating a maximum dose of paracetamol when the prescriber has not specified a maximum dose for a patient who has been charted for multiple paracetamol-containing medications.

The APHS clinical pharmacy service complements and enhances the hospital's other medication safety initiatives in support of a strong, patient-safety focus.

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120 Kensington Road, Toorak Gardens, South Australia 5065
(08) 8202 7222 /// bwmh@burnsidehospital.asn.au /// www.burnsidehospital.asn.au

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