



# specialists bulletin



St Vincents & Mercy Private

A newsletter for our Specialists and General Practitioners

## AUTUMN 2010

Issued by the Medical Director's Office

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## Workplace

# Bullying and harassment

The sad case of the young woman who took her life following protracted bullying and harassment by other staff members gained much publicity recently. It highlighted the significant changes in occupational law that have occurred in this area over the last few years. The health sector is not immune from these changes and doctors need to be aware of the nature and effect of these changes.

Bullying and harassment has never been acceptable but has continued to occur in all industries because the victims' story was not given the appropriate weight. I suspect all of us in medicine can look back on our training days and recall episodes of bullying and harassment either to ourselves, other resident colleagues or other staff. In general, nothing was ever done because of the rigid hierarchical nature of the profession, the institution's lack of interest and the trainee's desire not to "rock the boat" for career reasons. Recent evidence suggests that this behaviour still continues in medicine.

The Royal Australasian College of Surgeons had led the other Colleges in developing excellent policies on bullying and harassment in the surgical workplace. The latest Royal Australasian College of Physicians' newsletter noted that the Board of the RACP has endorsed the RACS policy as RACP policy until its own is finalised. I'd like to recommend the document to you <[www.surgeons.org/Content/NavigationMenu/CollegeResources/Publications/BRC\\_2009-12-01\\_Bullying\\_&\\_Harassment.pdf](http://www.surgeons.org/Content/NavigationMenu/CollegeResources/Publications/BRC_2009-12-01_Bullying_&_Harassment.pdf)> as well as the full document *Surgical Competence and Performance* <[www.surgeons.org/Content/ContentFolders/Policies/PUB\\_2008\\_Surgical\\_Competence\\_Guide.pdf](http://www.surgeons.org/Content/ContentFolders/Policies/PUB_2008_Surgical_Competence_Guide.pdf)> The Hospital supports fully the approach that these documents outline on this subject.

I'd like to highlight some points from the RACS "Bullying and Harassment" document. Firstly, I think it is worth defining the terms as there is often some confusion between them:

### Bullying

'To bully is to threaten, oppress or tease, either physically or morally, and can include: public humiliation, persistent criticism, personal insult, professionally undermining a person's professional ability, consistently undervaluing effort and abuse of power. Bullying is not necessarily face to face. It may be by written communication, e-mail or telephone.'

### Harassment

'Unwanted conduct affecting the dignity of men and women in the workplace. It may be related to age, sex,



race, disability, sexual orientation, religion, nationality or any personal characteristic of the individual and may be persistent or an isolated incident.'

The first point of this document I'd like to highlight is that the intention or motive of the alleged bully or harasser is not relevant when determining if the behaviour is unwelcome. The focus is the perception and experience of the recipient. This, in my experience of dealing with cases in this Hospital, is a point that has not occurred to the doctors involved. It is not what you think; it is what the victim thinks.

Secondly, as soon as you find out that you have upset or offended someone, apologise. Fix the problem as soon as you can. Not doing so can lead to permanent harm for the victim and may lead to disciplinary action for the doctor.

Thirdly, excuses such as "He has always been like that..." or "She would have been joking..." or "He's a great surgeon/anaesthetist/physician..." are not excuses. They are evidence that there is a problem.

Examples of inappropriate behaviour by VMP's that have been brought to my attention include swearing and yelling at nursing staff, touching or grabbing staff, persistent hectoring of colleagues and repeated sexual innuendos between VMP's during operating sessions. All of these activities fall squarely into the bullying and harassment area and must not occur. Doctors must be aware that this sort of behaviour exposes them to serious risk. Not only may they be sanctioned by the Hospital, they run the risk of being reported to the Medical Board for unprofessional conduct and being investigated and/or charged by Work Safe. ■

## Good medical practice

As I am sure you all know, the national registration scheme for health professionals comes into effect on 1 July this year. The last bulletin discussed the ramifications of this change. In parallel, the Australian Medical Council has published *Good Medical Practice – A Code of Conduct for Doctors in Australia* <[goodmedicalpractice.org.au](http://goodmedicalpractice.org.au)>. This has been prepared in consultation with the current Medical Boards of the various States and supersedes any existing Codes. I recommend that VMP's download a copy of the publication from the website and read it, particularly in the context of the changes to registration.

## Registration and Insurance

Our By-Laws, like other hospitals, require that VMP's furnish us with their indemnity insurance details annually. Currently, we have about 90% compliance with this requirement with the remaining 10% appearing quite resistant to repeated letters and phone calls. This is a friendly note to this group that their continued credentialing is at risk if they don't provide us with the appropriate details.



### Message from the CEO

## The drive for improved quality of outcomes

The health dollar is very stretched and we are constantly being required to do more with less.

In the USA they are pursuing the Triple Aim objective:

- Better population health outcomes
- Improved experience of care
- Reducing per capita health care costs

Numerous private health care systems in the USA have adopted bold quality objectives to reduce the incidence of harm caused to patients. These objectives are the shared responsibility of the Board, executive, medical practitioners, nurses and clinical support staff.

After five years of concerted effort, significant improvements in reducing events of harm to patients are now being recorded. Lives are being saved and patients spared the harmful side effects of infections, medication errors and falls with injuries. The Triple Aim journey is beginning to bear demonstrable fruit.

In parallel with the 'No Harm' strategies and objectives, private hospitals are now being graded according to the quality of their clinical outcomes

and safe practices. Medicare and Medicaid patient data is processed by an independent agency which, after risk weighted adjustment, is published as scorecards on the internet for all prospective patients to review. Hospitals are awarded anywhere from one (low), to three (average, expected outcomes) to five (high) stars and the payment systems of private insurers are increasingly tied to these grading results.

It is inevitable that the USA experience will be adopted in Australia over the next two to three years and we must prepare now for this eventuality.

There is no doubt that the high performing private hospitals, with the most skilled medical and surgical specialists, producing the best clinical outcomes will be the pacesetters in this new world. They will also be rewarded by private health funds hungry for Triple Aim benefits. ■

*Martin Day*  
Chief Executive Officer

### ■ Workplace

## Improving communication:

### Identify, Situation, Background, Assessment and Recommendation (ISBAR)

SVMPPH has recently undergone an extensive audit of Code Blue events and unplanned admissions to ICU from all three hospitals (St Vincents Private, Mercy Private & Vimy Private) since June 2008. This has been undertaken in the context of a nation-wide hospital focus to recognise and respond appropriately to patients who display signs and symptoms of clinical deterioration.

From the audit and supporting literature, it has been identified that improvement can be made in the areas of:

1. **Early detection of clinical deterioration.**
2. **Communication of changes in patients' conditions**
3. **Development of rapid response systems.**

To facilitate these improvements, a new standard observation chart has been designed that highlights "triggers" to patient's vital signs that fall outside normal parameters which require communication, and possible escalation of treatment.

SVMPPH has also implemented a new phone communication tool based on the ISBAR format to

be used by all nursing staff when communicating with medical staff. ISBAR is an acronym meaning Identify, Situation, Background, Assessment and Recommendation. The purpose of the ISBAR tool is to report any changes in a patient's clinical condition and to clarify orders in a structured and systematic manner. Using a standardised approach such as the ISBAR format promotes the efficient transfer of key information on one form, thereby limiting the risk of missing information. ISBAR provides answers to doctors' three main questions:

- What is the problem?
- What do you need me to do?
- When do I have to respond?

This tool has been adapted from internationally accepted models, where its use has extended to other forms of structured communication such as intra/inter-hospital transfer. ■

*Catherine Pearce*  
Code Blue Project Coordinator

*Simon Plapp*  
Resuscitation Coordinator

## ■ Compliance

# Patient access to medical records

In 1982, the Commonwealth Government passed the Freedom of Information (FOI) Act 1982, providing members of the public the right to obtain information about themselves that is held by Commonwealth governmental agencies such as public hospitals. In the same year, the Victorian Government passed a similar Freedom of Information Act allowing members of the public in Victoria to gain access to official documents of the Government of Victoria and all of its agencies.

The Victorian Health Records Act 2001, on the other hand, provides patients treated in private sectors with regulated access to their medical records. It sets out maximum timeframes for response and charges applicable to the private agency and the individual requesting access to their health information.

The Freedom of Information Act, and the Victorian Health Records Act, should not be confused with the Privacy Act 1988, or its later amended version, the Privacy Amendment (Private Sector) Act 2000. The second two are Commonwealth legislation, designed to protect an individual's right to privacy in the public and private sectors respectively, while the first two regulate the way health information is released while conserving privacy legislation.

Health record requests at SVMPPH are managed by the Health Information Services (HIS) department. All requests are registered, and processed in accordance with the Freedom of Information Act 1982. Some typical types of requests include, but are not limited to:

- Patients requesting to view their medical record
- Patients requesting copies of their medical record
- Patients requesting specific medical information from their medical record.

At any time an inpatient may request medical information to be explained to them.



Inpatients have the right to be informed about their medical conditions and problems and how to manage them. This may involve a medical staff member sitting with them and going through the information in the medical record at ward level.

If, subsequently, a patient requires a copy of the record, the patient will need to either:

- i. Complete and submit a "Release for Personal Health Information" form, which is obtained through HIS, or,
- ii. Submit a request in writing, to HIS. HIS will then send a letter to the patient explaining the process, identification needs and costs involved. Once payment is received, all documents are then sent to the patient within 2 weeks.

The HIS works closely with the Clinical Governance Unit to ensure we are recording what information is being released and to whom which may be pertinent for medico-legal purposes.

If there are any questions about the release of health information, verbal or written, please do not hesitate to contact HIS on 9411 7695. ■

*Alastair Mah*

*Medical Administration Registrar*

## Sugammadex

Sugammadex is a novel agent for the reversal of neuromuscular blockade induced by the amino steroid NMBAs, such as rocuronium and vecuronium. It is a modified gamma cyclodextrin, and is the first selective relaxant binding agent (SRBA) in its class. It has recently been approved for use in the Hospital by the Drug and Therapeutic Committee after representations by the Anaesthetics Committee. It is available at all sites and is located on the difficult intubation trolley.

The indication for its use is in an emergency where a patient cannot be intubated and ventilated. All uses of this drug must be documented and will be reviewed by the relevant committees. This is an agent which must be used appropriately as it is very expensive.

## ■ Administration

# Pharmacy discharge

To avoid unnecessary delays during the discharge process VMP's are requested to:

- Notate by circling on the far right hand side of the drug chart the medications the patient has to continue with on discharge
- When prescribing drugs of addiction, write in "words and figures" the quantity required to be dispensed
- Sign and date the discharge section

- Try and complete discharge section the day before discharge if possible
- Please write authority scripts if patients require increased quantities for long term therapy eg. Antibiotics

All of this will greatly assist our ward pharmacists in providing accurate advice and to produce an up to date "Medication Profile" for the patient on the day of discharge. ■

## Coroners Court reporting

As you all probably know, the rules concerning Coroner's Court reporting changed last November. The important points are that reportable deaths include a death during or following a medical procedure where the death is or may be causally related to the procedure. It includes medical imaging, internal examination and surgical procedures. The responsibility of doctors to report deaths has been strengthened in that there are now penalties for not reporting a death that should have been reported. As I noted in the last Bulletin, VMP's should have a very low threshold for discussing cases with the Coroner because of the potential penalties involved in not doing so. My general impression from reviewing all the deaths in the Hospital is that most VMP's are taking this approach.

### ■ Regulation

## The Coroner's Court: Not just a walk in the park!

The role of the Coroner is to investigate deaths and inquire into fires and disasters. The Coroner also considers matters such as the cause and circumstances of death and the identity of the deceased. While it is not the Coroner's role to establish negligence, he/she can identify persons who are considered to have caused or contributed to a death and accordingly the official findings of a Coroner often serve as the catalyst for relatives of the deceased deciding to commence civil action against a medical practitioner. The Coroner makes no finding of guilt but may, and often does, make recommendations or refer matters for consideration to other bodies, such as the Medical Practitioners Board, the State Health Complaints Commission, relevant government departments and the Director of Public Prosecutions, if he/she believes that this is appropriate.

The rules regarding deaths that must be reported to the Coroner vary a little from State to State but include those that are unexpected, unnatural or violent (including accident and injury) and those occurring in suspicious circumstances. Deaths of persons in care or custody and where the cause is unknown must also be reported.

A Coroner's formal hearing or Inquest is usually open to the public. The Coroner has the discretion to allow any person to appear and to be legally represented. He/she may compel witnesses to give evidence. The Coroner is not bound by rules of evidence and, in general, has discretion to conduct the proceedings as he/

she sees fit, although in practice, the procedure closely resembles a Court hearing. The Coroner is assisted by Counsel who may ask questions of witnesses and legal representatives of the other parties involved may also raise matters that the witness has not previously considered.

Whilst in many cases a Coroner's Court appearance is a relatively benign experience, it may not be so. For this reason doctors called as witnesses to the Coroner's Court should ensure that they are well prepared with the details of the matter at hand and most importantly have legal representation to ensure that their interests are protected. You never know what evidence another witness might introduce and once you are in the witness box it is impossible to control the situation if it starts to go off the rails.

There are some important messages here:

- Before providing a signed statement or entering into detailed conversations with police acting for the Coroner first seek legal support and advice from your medical indemnity provider
- Do contact your medical indemnity provider for support and advice if you receive a request to provide a statement to the Coroner or receive a Summons to attend and give evidence at an inquest. ■

*Jonathan Burdon*  
Respiratory Physician

### ■ Mission

## What are you signing on for?

The process of gaining an appointment and admitting rights in a private hospital is often taken for granted. Accredited VMP's at SVMPH will be aware of revisions last year to update our By-laws and Rules and Regulations. One of the distinctive parts of our process, shared with all Catholic health care facilities, is the commitment to behave at all times consistent with the hospital's Mission, Vision and Values and *The Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*.

*The Code* was published in 2001 after a complex process begun in 1998. It was the first attempt at preparing a set of ethical standards for Catholic health and aged care in Australia and it required a level of cooperation between bishops, clinicians and the religious congregations who ran the 75 health care facilities, including 21 publicly and 54 privately funded hospitals, 7 teaching hospitals, dedicated hospices and palliative care services and approximately 19,000

residential aged care beds. *The Code* was a major and unique work of collaboration.

*The Code* was written to clarify the distinctive meaning and significance of health and health care, and of the appropriate goals of medical interventions affirmed in the Catholic tradition. It is not merely a list of directives or prohibitions but a description of the rationale for Catholic healthcare ethics. It describes how respect for persons is understood and how the goals of health care relate to broader issues of justice and equity. The right to health and well being is fundamental to human life.

All VMP's, irrespective of their personal faith commitment, are expected to respect and abide by the principles and expression of *The Code*. It can be accessed on the hospital's internet and intranet. ■

*Gerard Smith*  
Director of Mission

## Workplace

# Mercy Private embarks on rehabilitation services

Mercy Private will open a new inpatient and outpatient rehabilitation service for post surgical orthopaedic and neurological spinal patients in May 2010.

Dr Penny Smith has accepted the appointment of Director of Rehabilitation Services. Dr Smith is also the Director of Rehabilitation at St Vincent's Health Melbourne and has extensive experience in orthopaedic and neurological rehabilitation.

Dr Smith is looking forward to the new unit opening. "This Unit provides an opportunity for patients to receive rehabilitation services as an integral part of the hospital admission, and in a timely manner. Early engagement in rehabilitation is the key to a good outcome", said Dr Smith.

The 12-bed inpatient rehabilitation unit will be accommodated in the newly renovated Level 3 ward at Mercy Private. The therapy area for both the inpatients and outpatients is located on the ground floor. The centre will include a fully equipped gym, assessment of daily living and facilities, consulting suite and amenities. A purpose built hydro therapy pool and change rooms are located on the lower ground floor, previously housing pharmacy.

Debbie Benger and Pauline Macleod of DP Physiotherapy have been instrumental in the planning of this new service. They are extending their service provisions to include specialised resources in rehabilitation Physiotherapy and Occupational Therapy.

Debbie Benger (DP Physio) said, "We foresee a lot of benefits for the patient in terms of coordinated care across both the acute setting and an in-house dedicated rehabilitation."

SVMPH is a major provider of orthopaedic and neurological surgery in Victoria conducting over 8,500 cases per annum with nearly 1,200 major joint replacements and 750 spinal and neck procedures each year.

Last year, SVMPH generated more than 600 cases requiring inpatient rehabilitation. It is common for orthopaedic patients to be delayed (remain in the acute setting) for 2-3 days before gaining access to a rehabilitation hospital due to lack of beds or coordination.

Janine Loader, Director of Nursing & Chief Nurse, said "Surgeons are looking forward to the introduction of this service at SVMPH. Orthopaedic patients post surgery are normally discharged earlier into in house care settings and, potentially, have an easier road to recovery without the added stress of moving to another external rehabilitation facility".

We look forward to your support to making this new service successful. ■

*Ian Grisold*  
Director of Group Operations"



Dr Penny Smith

## Progress notes

Private hospitals are frequently criticised by ACHS at accreditation for the poor general state of medical documentation. I review all the deaths in the Hospital and it is not unusual for there not to be one entry by the admitting VMP during the final admission. Good admission and progress notes are necessary for safe patient care as they enable other clinicians to get a complete clinical picture. They are obviously essential in an emergency. The absence or paucity of notes in a medico-legal situation leaves the doctor completely exposed. Good medical notes are part of good medical practice <[goodmedicalpractice.org.au](http://goodmedicalpractice.org.au)>.

## Email Addresses

Please keep us up to date with your email address. I sent out a batch email recently and over 30% of the emails bounced because the email address we have is inactive. These days an email address is essential and should change as infrequently as your mobile phone number.

## Research and Development

# National Labelling Project

SVMPH is proud to be chosen as one of the centres involved in trialling the National Labelling Project draft recommendations. This project is developed by the NSW Therapeutic Advisory Group (TAG) and NSW TAG Safer Medicines Group. It is supported by the Australian Commission on Safety and Quality in Healthcare, and is aimed to address patient safety risk management relating to the use of parenteral medicines.

Twelve centres are involved in Australia, and St Vincents Private Hospital is the only hospital chosen in Victoria. Our Day Procedure Unit (DPU) has been selected as one of the clinical areas to roll out the draft recommendations and labels. Visiting Medical Practitioners working in this area might thus find that labels on fluid bags, lines and syringes are different from those previously used. Labels will be colour

coded, and be provided in different sizes to suit all needs. The pilot testing period will take 4 weeks, and final recommendations will be developed shortly after.

We ask all who come in contact with these new labels be patient with staff from the DPU during the trial period. Initially they might be as unfamiliar with the recommendations as you are! We also encourage VMP's to familiarise themselves with the labels as it is likely to be a national recommendation in the near future.

If there are any questions please direct them to the Nurse Unit Manager of the DPU, or to the Medical Administration Registrar. ■

*Alastair Mah*  
Medical Administration Registrar

## X-Rays in the operating room

Chest X-Rays are commonly performed in the operating room or recovery after procedures such as the placement of devices. I would like to remind VMP's that it is the responsibility of the ordering VMP to review the X-Ray or to formally delegate that review to another VMP. It is not appropriate to order the X-Ray then leave the Hospital with a vague instruction to get ICU to look at it. The registrar will almost certainly be less skilled at looking at the X-Ray than the VMP and it raises the likelihood of something being missed. This would place the VMP, the registrar and the Hospital in an invidious position. It's also impolite.

## Workplace

# Staining of surgical instruments

At a recent Anaesthetics and Operating Room meeting, feedback was received from a surgeon that surgical instruments at SVMPH look old and stained, and need replacing.

As many of the instruments were purchased only recently, this came as a surprise to many. The CSSD manager at St Vincents Private, Alison Rose investigated.

Discussions with B. Braun, the main supplier of instruments suppliers, and Ecolab, the company providing chemicals for cleaning and sterilization of instruments, revealed the reason for staining of surgical instruments was the high level of Silica in the water. Reports prepared by both City West Water and Melbourne Water show that water at testing points in Richmond (closest to SVMPH), have a level of Silica between 6.9 to 7.3 ppm.

This level of Silica is a potential source for staining and discolouration of our surgical instruments. A report prepared by B. Braun states that in their experience, stain free results are only guaranteed when Silica levels are below 0.4ppm. Other instrument providers such as AKI also recommend that water used by CSSD have a Silica level of less than 1 ppm to avoid discolouration or staining of steels.

The research and development manager at Ecolab has given us written confirmation that this issue with the Silica is entirely aesthetic, and does not cause or promote corrosion of instrument surfaces, and does not contribute to pitting or rusting. This advice was also substantiated with information from AKI.

The only way to eradicate the staining process is to pre-filter the water coming into CSSD.



This would generate substantial costs without achieving improvements in functionality. Such expense would be difficult to justify.

SVMPH is committed to ensuring all equipment and its maintenance is of the highest quality for practitioners. Our choice of German manufactured Aesculap surgical instruments is a testament to that. Lesser quality stainless steel surgical instruments are readily available at a cheaper price, but it is the hospital's continued decision to supply industry gold-standard quality instrumentation to provide the best working environments for Visiting Medical Practitioners, and to maximise quality care for patients. ■

*Alastair Mah*  
Medical Administration Registrar

## Workplace

# Ruby Red Socks Falls Prevention Program

SVMPH have a strong belief in protecting all patients in our care. Our commitment to achieving excellence in compassionate patient care can be demonstrated through our latest falls prevention program.

The *Ruby Red Sock Falls Prevention Program* is a highly visible and memorable way to identify high risk patients. This program reminds the patient that they need to call for assistance before moving about their room.

It also serves as a bright visual warning to staff and visitors that this patient is at risk of falling and appropriate care should be taken. As the program is rolled out throughout the organisation, you will notice signs to identify these patients.



## Compliance

# Open disclosure

SVMPPH is both proud and excited to have the Health Services Commissioner, Beth Wilson, present to staff at a seminar in March. While Ms Wilson will be discussing patient complaints, ways of dealing with them and conciliation, a large part of her work is mediating and promoting Open Disclosure.

SVMPPH has a policy in support of the Open Disclosure process. We strongly encourage staff and VMP's to embrace this positive culture. In fact, Open Disclosure is not a new concept. Many medical practitioners were practising open disclosure before the term was coined. It is basically a frank discussion between the practitioner, and patient and their support person, about a patient-related incident that may have resulted in harm or injury to the patient.

The key principles of Open Disclosure are:

- Openness and timeliness of communication
- Acknowledgement of the incident
- Expression of regret/apology
- Recognition of the reasonable expectations of the patient and their support person
- Support for staff
- Confidentiality

Open Disclosure encourages health care workers to acknowledge that an adverse event has occurred and to express regret for what has occurred. This is not an admission of liability. However, there is a need to be aware of the risk of making an admission of liability during the open disclosure process. The Standard provides guidance on what to say and what not to say to patients and their families when implementing open disclosure, and highlights related potential legal concerns.

It is possible that open disclosure may provide patients who have suffered an adverse event with information and understanding on which to base a claim, but unless the harm suffered by the patient is serious and permanent, no claims can be made under the tort law reforms anyway. Moreover, evidence suggests that following the principles of open disclosure actually reduces a patient's desire to pursue legal action. Most insurers even advocate Open Disclosure if they are performed correctly!

Staff and VMP's are encouraged to attend the seminar by Beth Wilson on the 24th March at the Lecture Theatre at St Vincents Private to learn and further discuss Open Disclosure.

**Open Disclosure:**  
**'Because it's the right thing to do.'** ■

*Alastair Mah*  
Medical Administration Registrar

For more information, please see:

- National Open Disclosure Standard:  
[http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/3B994EFC1C9C0B22CA25741F0019FDDEE/\\$File/NOD-Std%20reprinted%202008.pdf](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/3B994EFC1C9C0B22CA25741F0019FDDEE/$File/NOD-Std%20reprinted%202008.pdf)
- St Vincents & Mercy Private Hospital Open Disclosure Policy: <http://stvmphpps/PolicyProtocol/Display.asp?ID=FDf1E86B4B5E414BAD891998E1A4E8B1> (via intranet)

## Appropriate use of hospital computers

This Hospital, like all others, has policies on the appropriate use of the computers in the Hospital that all staff and VMP's are expected to comply with. Essentially, the computers are provided to assist staff in the care of their patients and for administrative purposes. We have a web monitoring tool in place that blocks access to sites that are clearly in breach of our policy and also logs the activity of each computer. Sites with pornographic or violent content are obviously automatically blocked. We then have an enormous grey zone where we depend on the common sense of the user. Sometimes this breaks down. We have recently had a case of a person accessing unsuitable sites which got past the web monitor. This type of use is inappropriate on a number of levels and may lead to disciplinary action.

Additionally, patients may be provided with a pair of ruby red, non-slip socks. Safety information will also be given to the patients and their families.

The best approaches to falls prevention are multifactorial and multidisciplinary. VMP's should be alert to factors that may increase the risk of their patients suffering a fall. For example, medications that may cause falls should be reviewed and, if possible, minimised.

As part of our new falls prevention program, if your patients have been assessed as having a high risk of falling, you may be asked to review aspects of their care such as their medication regime. ■

*Sarah Larwill*  
Clinical Risk Manager

Right: One of the RRSFPP awareness posters



## By-Law review

We are in the process of reviewing the Hospital's By-Laws to bring them up to date with changes in legislation and other major private hospitals around Australia. They were last looked at over 5 years ago when Mr John Doyle was the Medical Director. We have engaged Mr Wayne Cahill, a partner at Blake Dawson, to review our documents. He is arguably Australia's leading medical governance lawyer and was involved with the previous review. A significant difference between our By-Laws compared to other hospitals is that we include a linked Rules and Regulations document. I am planning to split this off as its intent is primarily operational and much of the document is covered by existing Hospital policies, protocols and procedures. These latter documents are constantly changing with the potential for the one attached to the By-Laws to be outdated. Areas that are under review include the credentialing process, surgical assistants and the requirement of VMP's to be active in the Hospital for continued credentialing.



From L-R: Kevin Dalton, Nicholas Yule, Vich Keyuranggul and Ian Barabash.

### ■ Staff news

## VMP Golf Day 2010

Our seventh "9 & dine" golf day was held on the 19th February at Greenacres Golf Club in Kew and was a great success. Only 15 minutes from the CBD, Greenacres proved to be a very convenient location for our doctors. Seventeen teams competed in the Ambrose style event. Participants included specialists, members of our Board, sponsors and staff. There was a wide variety of golfing talents on display, some of which have been captured on camera and printed in this newsletter.

All photographs can be found on the website with winners of the day as well as all competition results. [http://www.golfselect.com.au/corporate/archived/dayView.aspx?event\\_id=614](http://www.golfselect.com.au/corporate/archived/dayView.aspx?event_id=614)

Everything about the day was enjoyable. The weather was good for golf, the excellent course condition, good company and tasty food enhanced the day.

The winning team was Nicholas Yule, Ian Barabash, Vich Keyuranggul and Kevin Dalton,

the 'perpetual trophy' returns to delivery suite for the year. Each of our four winners took home a Sure Shot GPS, they will be hard to beat with that attached to their belts or buggies next year.

Green Acres is one of Melbourne's premier Yarra River golf courses, combined with its convenience to our hospitals it is an ideal location and one that we hope to return to on Friday 18 February 2011. Pencil the date in your diary.

The "9 & dine" Ambrose has been a great format, however we have had a great deal of interest in an 18 hole competition so we hope to offer both options Ambrose style in 2011.

This event would not have been possible without the support of our highly valued sponsors St Vincents Pathology, MIA and 3 Points Motors and Taylor Made Golf. ■