



Accreditation – it gets to us all in the end!!

The Division recently went through the process of re-accreditation – something for which most of you will feel some sympathy! Happily, we achieved or exceeded all the standards required to retain our QICSA accreditation thanks to the team effort of all staff and especially Janet Conroy, our Quality Coordinator.

So what does it mean to us to be accredited? In its most simple terms it means that, as an organisation, we have effective and systematic management processes that the documented and that support accountability. And why is that important? Because, mostly, people working in the organisation know “how we do things around here”- or at the very least, where to find information. And it means they are actually part of and contribute to the continuous quality improvement cycle in the organisation, taking personal responsibility for organisational actions and objectives. (oh, and it means we fulfil one of the requirements of our primary funding body...which is no small thing!)

As most of you know, there is a lot of time and effort put in to the accreditation process and we can often wonder if it is really worth it. While a lot of that effort can be seen as simply fulfilling some bureaucratic paper chasing, the underlying principles are important. No matter how well we think we are doing, we can always do many things better. Having an external assessment process also means that we don't fool ourselves into complacency. Being guided through a 'check list' we can ensure that we are looking at areas of our operation that can be validated against other benchmarks. We get objective feedback on strengths and weaknesses, and we have to commit to make improvements where they can actually make a difference to our workplace.

As noted in the RACGP Standards, “quality and safety in general practice depends on more than the performance of each GP working in isolation. Efforts to assess and enhance quality need to also include attention to the structure and organisation of practices”.

Accreditation in general practice is one part of the broader evolution of the profession. Growing from being a GP-centred 'cottage industry' to a provider of multi-disciplinary, community-based primary health care means that practices must be serious about implementing efficient systems that can

improve both health outcomes and the patient experience. While the clinical expertise and autonomy of GPs remains at the heart of the practice, it needs to be supported by effective administrative systems, accessible 'patient-friendly' services and strong links with a range of allied and specialist health providers.

Consistent practice-wide systems are crucial to this whole process – from appointments and bookings, recall and reminder systems and billing through to common or standardised patient records and consultation notes, infection control, cold chain management, OH&S and risk management. It IS all about quality – and knowing that when a patient comes to your practice they are receiving the best care and service you can offer.

And what is the Division doing well and where can it improve? Here are just a few commendations from the review:

- There is an effective and committed COM which keeps current with local health issues and issues impacting the future of Divisions and primary health care.
- The organisation has established a systematic approach to OH&S that is well embedded into practice.
- The outstanding program for Integrated Disease Management for people with diabetes involves several service partners and delivers effective and timely assessment and referral for people with diabetes.
- DDDGP is recognised as a lead agency in establishing partnerships to promote better health service delivery so that is strategically positioned for sustainability.
- The organisation is attentive and responsive to community health issues (note: particular note was made of the work the Division has done with the Aboriginal Health Service, the Asylum Seekers Clinic and Refugee Clinic established in collaboration with other health services).

In our first accreditation assessment, we identified a range of OH&S matters that required attention. Advances in this area were noted and commended this time around. Our next quality improvement area will be around some of our human resources processes and strategies to better record our “corporate history and knowledge”. All to ensure that our services best fulfil the needs of our membership and, ultimately, the needs of our wider community!

Graeme Fletcher, Acting CEO

Dandenong District Division of General Practice

314B Thomas Street, Dandenong, 3175
Phone: 9706 7311 Fax: 9793 4050
Email: dandiv@dddgp.com.au
Website: www.dddgp.com.au
Office hours: 8.00a.m. – 5.00p.m.

COMMITTEE OF MANAGEMENT

Chair: *Dr Nicholas Demediuk*
Vice Chair: *Dr Graeme Downe*
Treasurer: *Dr Greg Wyatt*
Secretary: *Dr Roger Smith*
Committee Members: *Dr Sally McDonald*
Dr John Meaney
Dr Cely Goeltom
Dr Jacob Dessauer
Dr Jacqui Barry
Dr Craig Mulligan
Dr Brett Ogilvie

Chief Executive Officer: *Anne Peek*
Senior Program Officer: *Graeme Fletcher*
Program Officers: *Kate Russo*
Rose Griffiths
Graham Sweet
Michelle Guille
Christine Crosbie
Janet Conroy
Christine Prendergast
Julie Sutherland
Monica Bensberg
Jo Ong

Business Coordinator: *Julie Shanahan*
Events Coordinator: *Stephanie Edmonds*
Administrative Support: *Alison Killin*
Heather Simpson
Marg Toon
Karen Knaus
Margaret Ham
Angela Watson
Editorial Subcommittee: *Dr. Wes Jame*
Dr. Cely Goeltom

To email staff directly: *initial.surname@dddgp.com.au*
pki@dddgp.com.au

Deadline for newsletter articles is 10th of each month. Dandenong District Division of General Practice reserves the right to accept or reject all material submitted for publication. For further information please call the Division.

DISCLAIMER

The views expressed in this newsletter are those of the authors and do not necessarily reflect the official position of the Dandenong District Division of General Practice

BRAIN INJURY AWARENESS WEEK **Monday 17th – Sunday 23rd September 2007**

An Acquired Brain Injury (ABI) or head injury is a term used to describe all types of brain injury that occur after birth. There is often little understanding in the community about brain injury and the impact that this type of injury can have on individuals and families.

Acquired brain injury can happen to anyone at anytime through:

- accidents
- brain tumours
- lack of oxygen (hypoxia)
- drug and/or alcohol abuse
- stroke
- infections
- assaults
- falls

The number of people with an ABI in Victoria is approximately 73,000 of which 31,000 need personal assistance or supervision sometimes or always. (Source: www.brainlink.com.au/resources)

Brain Injury Awareness Week is designed to inform and educate the community on the effects of ABI and to highlight services that are available to someone with an ABI.

A group of people who live daily with an ABI have come together from Southern Health, Bunurong Community Care, Disability Services Programs to help educate and inform the community on ABI during Brain Injury Awareness Week.

This group will be setting up a stall on Monday 17th September at Fountain Gate Shopping Centre and will be located on Level 2 outside Angus & Robertson Bookstore from 9am to 5.30pm. Please come along and have a chat about ABI and you will receive a show bag that will hold relevant information about services of support for people with disabilities and ABI.

For more information please contact the Community Development Worker, Diane Denton, on: 8792 2322.



Fathers' Day Activities for men and their children

Sunday 2nd September
Palm Plaza (Dandenong)

Loads of activities, entertainment etc.
Great family day.

Organised by Southern Health
(Community Health), City of Greater Dandenong
and Mission Australia.

Further information: 8792 2200



Dementia Awareness Week 17th – 22nd September

Dementia Awareness Month

Five years ago Ellen mentioned memory loss to our loved and respected GP. He took her concern seriously and referred us to a neurologist. The neurologist prescribed Exelon, Aricept and suggested Ellen contact Alzheimer's Association but she did not retain this information (we were talking memory loss) and she declined to make contact.

Three years went by, memory slipping, early dementia signs, (which I tended to emotionally deny!) and as a first time carer learning "on the job", **professional 'hand holding' is life saving**. Read on to find how we have been blessed.

We went to Alzheimer's Association, it would be exaggerating to say Ellen came kicking and screaming, but it was certainly not her idea. Our interviewer gave us useful, sympathetic advice, "travelled" with us all the way. **The first of my 'hand holders'**.

We moved to a retirement village and shortly before we moved our GP died. Circumstances drew us to a young professionally excellent GP who has also proved to be "beyond the call of duty" in her sympathetic approach to our needs. **Another 'hand holder'**.

Our Alzheimer's contact provided other helpful information. First, and most important, a Carer Support Worker, from the Commonwealth Carer Respite Centre - Dandenong. Here I gained **another 'hand holder'**. She provided advice regarding strategies to help cope with changing dementia patterns.

Other avenues of help included:

1. **Cardinia Care** provided in-home respite. Prior to this service, Ellen had to come with me for my dentist, dermatologist and business appointments in the city where she found the bustle stressful;
2. **Villa Maria** (Avebury House) provided weekly day care centre respite;
3. **Commonwealth Carer Respite Centre (CCRC)** provided advice about residential respite.

2006 was an eventful year. Ellen had two 14 day stays in a secure low level hostel. These stays were organised by CCRC and would have been impossible without their advice, encouragement, information and support. **My most recent 'hand holders'**.

It became clear to "the head" not "the heart" that eventually permanent residential care would happen and I made use of the second respite stay to enter Ellen's name on multiple lists at hostels. When a room became available, we

accepted, and now my new journey of love and care is under way.

Thank you to the many 'hand holders' who assisted in our journey so far.

The Commonwealth Carer Respite Centre Southern Metropolitan Region (CCRCSMR) is a regional contact point for carers who may be parents, partners, family members or friends in the community. The CCRCSMR operate Careline and Carelink. Carer Support Workers - Dementia and Behaviour aim to help carers find the balance between caring for themselves and caring for someone with dementia by providing information, support and respite.

Careline - 1800 059 059 - Available 24 hours for carer information, support and urgent or short term respite needs.

Carelink - 1800 052 222 - Available 9-5 for information on aged and disability services. Doctor's enquiries welcome. Information packs available.

Cognitive Dementia and Memory Service is a specialist diagnostic service for people who are concerned about memory loss or changes in thinking. For referral to CDAMS call Kingston Centre on 9265 1291.

Alzheimer's Australia Victoria is a statewide service, providing information, education, support and advice to families, carers and people living with Dementia. This is a free service and can be accessed by calling the National Dementia Helpline on 1800 100 500. Information about Dementia is also available in a number of community languages.

Refugee Health Small Group Learning Activity

We were recently contacted by the Monash Medical Centre Thalassaemia Clinic to advise us of the services they provide and seeking opportunities to contribute to educational activities for GPs. At this stage it is probably unlikely that we would conduct a CPD activity on this condition alone but, following the recent refugee health forum, we are aware that a number of GPs would be interested in learning more about some of the specific conditions affecting refugee patients (including infectious diseases, vitamin deficiencies, etc). The Division is keen to establish a Small Group Learning activity which could address a range of issues in some detail. This could operate as a lunchtime or evening clinical discussion group and would have links through the Dandenong Hospital Refugee Health Clinic to relevant specialist services. If you are interested in joining such a group please contact Graeme Fletcher at the Division.

If you want information about the Thalassaemia Clinic please contact Vicki Petrou on 9594 2756.



Important information for GPs: Cardio-respiratory arrest following excessive ingestion of morphine. This article has been supplied by DHS following the recommendation by Coroner Saines that his findings from a recent inquest into the death of a man following excessive ingestion of morphine prescribed in liquid mixture form, be disseminated widely throughout the general practice and pharmacy community for education and discussion.

“One of the State Coroners recently investigated a death involving the excessive consumption of morphine provided as a liquid (Ordine 5mg/mL). For reasons of cost and convenience, the deceased’s GP increased the amount supplied on prescription (including repeats) to 600mL about 11 months prior to the patient’s death. The general practitioner described that he had counselled the patient about measuring doses and complying with suggested frequency of dosing, and the pharmacist had provided the patient with appropriate information and a consumer medication information sheet and labelled containers with appropriate warnings about side effects.

Despite this counselling, it was observed by his family that the deceased took the medication “straight from the bottle”. Death was attributed to cardio-respiratory arrest following morphine administration.

The Coroner considered that the GP had acted in a conscientious and careful manner in this case, but was misled by the deceased about the level of care and safety in his use of the liquid morphine.

The Coroner has recommended that narcotic analgesics should be dispensed in tablet form in blister packs, to avoid or reduce the risk of overdosing, unless clinical reasons dictate otherwise. Proper counselling, advice and warnings should routinely be given by both doctors and pharmacists with respect to accurate measurement of dose, and risks of misuse and overdose, for all narcotic analgesics, but particularly for liquid forms.” GPDV E-Bulletin 14/07

Quick Quiz

1. The use of antibiotics is associated with an increased risk of incident and fatal breast cancer. True or false?
2. A small daily ration of dark chocolate may further increase blood pressure by a few mm Hg in otherwise healthy people with above-optimum blood pressure. True or false?
3. Black cohosh is a herb predominantly used for relieving the symptoms of menopause.

4
ADRAC reports that there is an association between black cohosh and liver toxicity. 16 cases have been reported, 5 were the association was listed as certain and 3 requiring liver transplants. eMIMs lists 17 products containing black cohosh. List 3 of them.

4. Which of the following drugs may be implicated in anticholinergic adverse effects? Oxybutyn, nifedipine, amitriptyline, warfarin, carbamazepine, prednisolone, ranitidine, gentamycin, isosorbide and tramadol.

“Have you ever had a reaction to an antibiotic?”

Story number 1. “Yes” she said as she presented the ‘script for Ialex®*.

“Oh” said the pharmacist (thinking, probably a just bit of mild diarrhoea), “what happened?”

“I spent 3 days in Maroondah hospital with St. John’s Wort syndrome after taking some Keflex®*” she said. (*Brand names of cephalexin)

This exchange happened in a pharmacy recently and the customer then gave a classic description of Stevens-Johnson Syndrome. The prescribing GP immediately recognized SJS and changed the script. QUM news had heard of SJS but never run across it before. However the next day while visiting a customer for a Home Medication Review SJS came up again. Again cephalexin was the cause and Maroondah hospital the place that the customer ended up in (where it was apparently diagnosed by a nurse who “looked it up in her book”). This was a bit like lightning striking twice in the one place.

Story number 2. (From the same pharmacy but 14 days later.) “Yes” she said as she presented the script for amoxicillin.

“Oh” said the pharmacist (thinking, probably a just bit of mild diarrhoea), “what happened?”

“My lips and tongue puffed up like a balloon” she said.

The prescribing doctor was very happy to change the penicillin to a macrolide under the circumstances!

And the moral to these little stories is one that all doctors know, but for which a reminder never hurts. Always ask the question, “Have you ever had a reaction to an antibiotic?”

NPS visits on antibiotics. These are continuing and creating great interest. If you have not had your visit yet, call Graham Sweet at the Division on 9706 7311 to arrange it. (Qualifies for RACGP CPD points and as a QPI PIP activity.)

Have you read the latest NPS RADAR yet? If not amongst other things you will have missed the following summary on Budesonide with eformoterol dry powder inhaler (Symbicort

Turbuhaler) regarding its use as both a maintenance and reliever regimen for asthma.

- Replacing the usual short-acting beta₂ agonist reliever with extra, on-demand use of budesonide with eformoterol is a substantial change in asthma treatment. Though supported by clinical trial evidence, the new regimen's place in routine practice is not established.
- The extended PBS listing allows people who experience frequent asthma symptoms while receiving combination therapy or corticosteroids alone to use the alternative budesonide with eformoterol maintenance and reliever regimen.
- People with good asthma control should not switch to the new maintenance and reliever regimen. Some people with poor symptom control on combination therapy may benefit from the maintenance and reliever regimen as an alternative to increasing their maintenance doses.
- The new regimen may not be suitable for people who are poor perceivers of airway obstruction or who overuse relievers.
- Ensure that people:
 - have a suitable asthma action plan for the maintenance and reliever regimen
 - know to always use the combination inhaler for symptom relief rather than a blue reliever inhaler
 - know to monitor how often they use the inhaler
 - know not to take more than 6 inhalations on a single occasion, and no more than 12 inhalations per day.
- Eformoterol is a long-acting beta₂ agonist but has a rapid onset of action. Fluticasone with salmeterol (Seretide) cannot be used as a reliever because salmeterol has too slow an onset.
- Do not use the budesonide with eformoterol 400/12 strength inhaler for the maintenance and reliever regimen, because it can easily lead to overdosing.

These summaries are great because they answer the questions that GPs want asked rather than just give information from the drug companies which may be highly selective. NPS RADAR also gives more details to back up the summaries. It is available on www.npsradar.org.au and can be mailed free on request.

Home Medicines Reviews / HMRs – potential help with “nightmare patients”. Think of your “nightmare patient”. Is this the person who may benefit from an experienced pharmacist visiting their house and finding out what they actually do with their medications? Why not order a HMR for them? Not sure how to get involved? Call Graham Sweet at the Division on 9706 7311 for details.

Lumiracoxib: Cancellation of registration

Australia's medicines regulator, the Therapeutic Goods Administration (TGA) has cancelled the registration of the COX-2 selective nonsteroidal anti-inflammatory drug (NSAID) lumiracoxib (*Prexige*) (see [link http://www.tga.gov.au/alerts/index.htm](http://www.tga.gov.au/alerts/index.htm))

According to the TGA's Principal Medical Advisor, Dr Rohan Hammett, as of 10th August 2007 the TGA had received 8 reports of serious liver adverse reactions to the drug, including two deaths and two liver transplants. All these reports have been received since March 2007, with 6 reports received in the last 6 weeks. It is for that reason that the TGA, on advice from Adverse Drug Reactions Advisory Committee (ADRAC), has cancelled the registration of lumiracoxib in order to prevent further cases of severe liver damage.

The TGA are advising people to stop taking the lumiracoxib immediately and to discuss alternative treatments with their doctor. They are also recommending that all people taking lumiracoxib are assessed by their doctor for any clinical or biochemical evidence of liver damage. Patients found with liver abnormalities should be referred for specialist hepatologist review and further investigated.

Further information for patients and health professionals can be obtained by contacting the TGA Info Line on 1800 004 599 (8.30 am - 8.30 pm seven days a week), or Novartis Pharmaceuticals on 1800 671 203.

For your information is the following links:

- The National Prescribing Service has issued a media release, aimed at consumers at www.nps.org.au
- Novartis Pharmaceuticals media release <http://www.novartis.com.au/Prexige%20press%20release%2011%20August.pdf>
- RACGP fax sent to GPs <http://www.racgp.org.au/fridayfax/18052>

The key points when we last discussed use of NSAIDs were

- Paracetamol is preferred as first line analgesic to nonsteroidal anti-inflammatory agents (NSAIDs) - both conventional and COX-2 selective - because it is an effective analgesic and has a much lower risk of adverse effects. Consider adding an NSAID when paracetamol (and non-drug therapy) does not provide adequate pain relief
- When considering starting or switching NSAIDs, bear in mind the patient's risk of all adverse effects, including cardiovascular, gastrointestinal and renal complications
- People at high risk of cardiovascular, gastrointestinal and renal adverse effects should avoid using an NSAID if possible

If an NSAID is used, it should be at the **lowest effective** dose for the **shortest possible duration** to minimise the risk of adverse effects

Quick Quiz Answers

1. True. See “antibiotic use in relation to the risk of breast cancer” JAMA February 18, 2004. However the article also states that “It cannot be determined whether antibiotic use is causally associated with breast cancer or whether indication for use, overall weakened immune system or other factors are pertinent....” and “these findings reinforce the need for prudent long-term use of antibiotics”. To which it would be pertinent to add that for those women who obtain frequent antibiotic prescriptions it might be a good idea to be even more vigilant regarding screening for breast cancer.
2. False. It’s liquorice* that puts blood pressure up not chocolate and small amounts of dark chocolate may actually lower blood pressure. Taubert, D. Roesen, R. et al. 2007, 'Effects of low habitual cocoa intake on blood pressure and bioactive nitric oxide: A randomized controlled trial' JAMA vol. 298, pp. 49-60. *Glycyrrhetic acid, the active constituent of liquorice, inhibits renal 11beta-hydroxysteroid dehydrogenase. This allows cortisol to stimulate mineralocorticoid receptors, which can result in hypertension and hypokalaemia.
3. Bioglan (medinat) esten, Blackmores for women 45+, Celery complex, Dong quai 1000 complex, Emmugen, Extra life PMS plus, Femex dong quai complex, Fem-nan, Greenridge femi tone, Herron naturo-pause for menopause, Isofem natural isoflavones, Mega potency women’s multi vitamins, meno-eze, Menopause support, Phylla, Remifemin and Women’s choice for menopause and bone health. ADRAC also states “Drug-induced liver injury should be suspected in all cases without a clear cause of abnormal liver enzymes. A full review of all medicines that a patient has been taking, including complimentary medicines, is essential.” Were you able to name any of the medications? Just another reason for involving a pharmacist in a Home Medicines Review.
4. All of them – effects may be additive. From the anticholinergic drugs scale oxybutyn and amitriptyline are “markedly” anticholinergic. Ranitidine and carbamazepine are “sometimes” anticholinergic. The rest are listed as “potentially” anticholinergic. So it is important to assess “anticholinergic load” as, amongst other things, this may worsen dementia symptoms and promote falls.

The Northern Division of General Practice warmly invites you to their **GP Refugee Health Forum**

Saturday 8th September, 10.00am – 5.30pm
at the Bishops Parlour, Abbotsford Convent.
(Melway Map 44 F5)

This forum is an opportunity for GPs from across Melbourne who work with refugees together with guests from the health sector to take part in a day that has a particular focus on refugee health issues. There will be talks and lots of interactive discussion, and opportunities to meet others and share experiences over a lunch of tasty food catered by the Lentil as Anything Café. Your family is welcome to join in at the end of the day for celebration and refreshments (from 4.00pm)! NB: The Collingwood Children’s Farm next to the convent is a great afternoon outing for families!

Topics covered include: Infectious Diseases and Screening, Dermatology of Dark Skin, Refugee Mental Health, Chronic Pain in the refugee population.

Category Two CPD points apply for GPs.

Details and registration forms are available from Kay Duffy, Northern Division of General Practice. Phone: 8480 4609, Mobile: 0408 340 692 or email: kay.duffy@ndgp.org.au



Why are we concerned about vaccine storage management? It’s a professional obligation.

(Taken from Strive for 5 - page 2)

1. As health professional we need to ensure people receive an effective health product. (i.e. a vaccine that has not been adversely affected by heat or cold)
2. It is important to carefully manage resources and be accountable. Vaccines are expensive (privately purchased conjugate pneumococcal vaccine can cost up to \$180) and can be in short supply.
3. It is professionally unacceptable as well as uncomfortable to be in a position where you have to inform people that they or their child may have received ineffective vaccine and will require revaccination. Cold chain breaches can occur even in well designed and well-managed systems as a result of technical malfunctions but if there are good procedures in place, problems will be detected and effectively managed before ineffective vaccine is used.
4. Efficient vaccine storage management is a good quality assurance measure of a vaccine service provider.



Immunisation Tip

If we don't protect our vaccines they won't protect our community.

Vaccines must be stored between 2-8 degrees at all times!!

Human Resource Issues



Wage Increase

The Division has had many calls enquiring about

Workplace Relations Fact Sheets

It is a legal requirement for employers in the federal system to supply the Workplace Relations Fact sheet to their employees. This obligation takes effect from the 20/7/07 and you have until 30/10/07 to do this. For new employees, they must be provided with this sheet within 7 days of commencing employment. The fact sheet can be obtained by phoning Workplace Infoline on 1300 363 264 or from one of the following websites:

www.dddgp.com.au

www.oea.gov.au

www.workplaceauthority.gov.au

Please note this sheet will soon be available in languages other than English and in an audio version.

Recent decision by the Fair Pay Commission

The Commission has granted a general pay increase for minimum wage earners and this will come into effect on 1/10/07. The increase is approximately \$10.25 per week (27c per hr) for all adult pay scales that currently provide for a basic period rate of pay up to the level of \$700 per week. Over \$700 per week the increase will be approximately \$5.30 per week (14c per hr)

Exact amounts will hopefully be published in next month's newsletter and on the Division's website.

Please note this increase is not applicable if an AWA or Certified Agreement is in place.

The last pay increase was in December 2006 and the next increase will be July next year. Increases are expected to be annually from then on and will be handed down in July of each year.

The rationalisation of pay scales is expected to commence in September this year. Further information will be provided when information comes to hand.

Tax Tips

It's that time of year again when consideration should be given around tax issues. Below are some helpful tips –

- SGC Superannuation rate remains at 9% for the coming financial year

- Ensure sufficient superannuation contributions have been submitted to the relevant superannuation funds.
- A superannuation fund can accept contributions made on behalf of a child up to the age of 18 to a maximum of \$3000 over 3 years. They are not taxed in the superfund and are not deductible.
- Any BAS activity statements which are outstanding should be submitted to avoid penalties. The tax office has made it clear that penalties will apply.
- Ensure all employees have completed TFN declarations and that they have been lodged.
- Review your tax invoices that you send or receive and ensure they are compliant with tax office requirements. That is "are they valid?"
- Review asset ownership in light of potential risks of being sued!
- Review business strategies and visions
- Be cautious of tax schemes
- Review investments and revisit retirement options
- Records should be kept for 5 years however some documents are required to be kept longer ie capital gains tax and superfunds.
- Business travel expenses for self employed people must be supported with written documentation
- Motor vehicle expenses should be substantiated whether incurred by employees or non employees

OH&S Legislation – Risk Management

Further changes to the OH&S Act came into effect on 1/7/07. Further information can be found on the Division's website or from Worksafe.

October's Practice Managers lunch briefing will cover OH&S so watch out for the flyer!

Industrial Relations / Human Resources

Do you need help with industrial relations or human resource issues? If so, give me a call. If we don't have the answer we will try to point you in the right direction of where to get the right advice. Contact Julie Shanahan at the Division.

Advertising Scam

Beware of scams occurring seeking practices to advertise in their community based magazines supporting various groups like veterans, underprivileged children etc. We have been advised that some practices are being contacted seeking advertising for a substantial cost. They appear to know the practice managers names and are quite persuasive. So be cautious with calls like this as they seem to be well thought out scams!

Julie Shanahan
Business Coordinator

Curly Cases in Palliative Care



Back row: Dr Irene Wagner, Mr Michael Wells, Mr Robert Molenaar. Front Row: Dr Mike Fitzgerald, Dr Brian McDonald, Dr Sally McDonald.

A very successful and interactive Curly Cases CPD evening was held on 1st August and attended by 16 GPs and 20 staff from residential aged care facilities.

The evening involved case presentations from Dr Sally McDonald and Dr Mike Fitzgerald, with input and discussion from a panel of experts including Dr Irene Wagner, Geriatrician, Dr Brian McDonald, Palliative Care Physician, Mr Michael Wells Office of Public Advocate and Mr Robert Molenaar from South East Palliative Care.

There was much discussion around the difficulties when family members don't agree on treatment and the patient does not have capacity to make the decision.

Resource material was also made available to participants, in particular two new posters launched by the Office of the Public Advocate. These are designed to assist health care providers in identifying issues of disability, medical consent, guardianship and administration. These posters were made available to participants.

The first poster "Can your patient consent" is designed to be a quick guide to the steps involved in obtaining consent when a person may not have capacity.

The second poster "Guardianship and Administration" has been produced to assist professionals to identify situations in which an application to the Victorian Civil and Administration Tribunal may be needed for an individual. Particularly where you are unsure whether a person has capacity to make decisions, it provides an overview of the different substitute decision makers i.e. Enduring Powers of attorney (medical, financial) and an outline of the process.

Both posters have received endorsements from the Victorian branches of peak bodies including the AMA, Australian College of Emergency Medicine, Australian Association of Social

Workers and the Australian Nurses Federation. These are also available on the Office of the Public Advocate (OPA) website - www.publicadvocate.vic.gov.au.

Copies of the poster/s can be obtained by contacting the Division or alternatively calling the OPA on 1300 309 337.



FREE DVD Smoking Cessation Program available to General Practitioners from Quit Victoria

Quit Victoria is offering a **FREE** copy of Quit's DVD and booklet "Just say A-A-A-A", the smoking cessation intervention program for general practitioners.

In Victoria around 3950 deaths are caused by smoking each year. Most of these could have been prevented. As a GP you are in a unique position to offer quitting advice to your patients. Research consistently shows that advice from a GP is the major motivating factor in the decision to quit smoking.

Quit recognises that time constraints often make it difficult for you to provide ongoing cessation support to patients. The 5As framework enables an effective brief intervention in as little as three minutes, in combination with a referral to the Quitline (13 7848), the professional research-based telephone information, advice and support service for people who want to quit smoking. This is shown clearly on the free DVD. The 5As framework forms the basis of the *Australian Smoking Cessation Guidelines for General Practice, 2004*.

The Australian Smoking Cessation Guidelines recommends fax-based referrals to the Quitline helping to provide a practical approach in the general practice setting. Quit Victoria encourages you to ask about smoking as part of your consultation, and where appropriate fax-refer to the Quitline. This is a good way for you to further increase your patient's chances of success without taking additional time from your consultation.

To order a **FREE copy of Quit's smoking cessation program for GPs**, or to find out more about Quit Victoria's professional development programs, please fill out the order form enclosed and fax to Stavroula Zandes on 9635 5510 by **Friday 17 September** or email your request to Stavroula.Zandes@cancervic.org.au.

Further information also available at www.quit.org.au.

Government Scholarships for 1 in 12 practice nurses

The Australian Government has committed to educating 1 in 12 practice nurses over the next 12 months. Applications for the 2007 Practice Nurse scholarship and postgraduate scholarship schemes are now open.

The Department of Health and Ageing's commitment to the program means that over 520 practice nurses have the opportunity to be awarded a scholarship, a record number for any practice nurse education program.

Administered by the Australian Practice Nurse Association (APNA), the scholarships are open to all practice nurses. Belinda Caldwell, APNA CEO said, "Nurses in general practice are providing a key clinical role in the primary care setting with almost 60% of Australian general practices employing at least one practice nurse. Many are the first nurse in their practice and for many it may be their first role as a practice nurse. For the more established practice nurse, the role is constantly changing to accommodate new health priorities and initiatives. The result is a significant need for professional development in order to deliver high quality care".

Applications are open to all practice nurses and Aboriginal health workers currently working in a general practice environment and past recipients can apply again. Applicants must be an Australian or New Zealand citizen living in Australia and for those nurses and Aboriginal health workers in rural and remote locations, accommodation and travel expenses will be provided as part of the scholarship.

Scholarships range in value up to \$1,500 for continuing education and \$10,000 for a postgraduate program with the duration between one and four years and courses that have already been paid for in this financial year can also be applied for.

Scholarships cover courses in the following areas:

- Immunisation training/education
- Wound management training/education
- Women's health*, including Pap smear training/education
- Diabetes management training/education
- Chronic disease management and illness training/education
- Mental health training/education
- Asthma training/education
- Cardiovascular care including cholesterol management training/education
- Obesity, food and nutrition training/education
- Clinical assessment training/education
- Sexual and reproductive health training/education*

- Clinical skills competency based training/education e.g. suturing, plastering*

*New areas, just released

Applications open on Wednesday 15th August and close at 5pm on **Friday 28th September**. Scholarships can also be awarded retrospectively for courses commenced from 1st July 2007.

Application forms and supplementary information is available from the Australian Practice Nurse Association website www.apna.asn.au or the APNA on 03 9614 7777.



Changes to the "Go for your Life" Diabetes Prevention Program

- The trial component of the DPP ended on the 30th June 2007 and Swinburne University will now undertake the evaluation of the trial program.
- The program will now transition to an integrated service, continuing to deliver a community-based intervention to prevent Type 2 diabetes.
- Eligibility for referral to the program no longer requires participants to undergo an oral glucose tolerance test (OGTT), however the *exclusion of Type 2 diabetes* based on best practice is recommended.
- National Evidence Based Guidelines recommend that plasma glucose, preferably fasting and performed by a laboratory, be measured as the screening test in people with risk factors and interpreted as follows:

Fasting level	Random level	Interpretation
< 5.5mmol/l		Diabetes unlikely
5.5-6.9mmol/l	5.5-11mmol/l	Perform an oral glucose tolerance test*
≥7.0mmol/l	≥11.1mmol/l	Diabetes likely**

*The oral glucose tolerance test should be performed and interpreted according to the 1999 WHO criteria

**All asymptomatic individuals will need a confirmatory test, on a separate day, to confirm the diagnosis of diabetes

Reference: National Evidence Based Guidelines for the Management of Type 2 Diabetes Mellitus (www.nhmrc.gov.au)



Are you caring for scleroderma patients who may have lung disease?

Systemic sclerosis (SSc) is a connective tissue disease characterised by vascular, inflammatory and fibrotic dysfunction affecting multiple organ systems. It occurs more commonly in women than in men and is often under-recognized. The condition is typically characterised by skin thickening and tightening involving the face and hands with proximal extension to variable degrees.

Raynaud's phenomenon is also common and frequently leads to painful digital ulceration and ischaemia. Multiple facial telangiectasias are often present on the face, trunk or extremities. ANA antibodies with a centromere pattern and SCL70 or anti-topo-isomerase antibodies are often found in patients with SSc. Life threatening involvement of the cardiopulmonary, renal and gastrointestinal systems is also seen.

Now that the mortality associated with SSc renal crisis has improved with ACE-inhibition, SSc pulmonary disease has become the leading cause of disease-related mortality in this population.

There are two major causes of pulmonary disease in Scleroderma:

- ◆ **Pulmonary Arterial Hypertension (PAH)** occurs in approximately 15 per cent of patients with SSc and typically affects those with limited scleroderma of at least 10 years duration.
- ◆ **Interstitial Lung Disease (ILD)** occurs early in the course of diffuse and limited SSc and is present in 30-40 per cent of patients with SSc.

Recently, new, safe and effective treatment for SSc-related PAH has become available. Effective treatment is also available for ILD in SSc.

Earlier treatment of both of these conditions is associated with improved patient outcomes.

Both PAH and ILD can be associated with non-specific symptoms such as exertional dyspnoea, fatigue and in patients with ILD, cough. However, many patients have few or no symptoms in the early stages of disease.

To enable timely intervention, it is important that all patients with known or suspected SSc be screened with regular pulmonary function tests and echocardiography. When indicated, further investigation with right heart catheterization for PAH and high resolution chest CT for ILD are necessary.

A specialist centre with experience in the investigation and treatment of these conditions has been established at Monash Medical Centre through which PBS-funded therapy can be prescribed.

Early referral of patients with scleroderma to this service is recommended. Referrals can be made by contacting Kathleen Elford, Scleroderma Nurse Consultant, Department Rheumatology, Monash Medical Centre, Block E, Level 3, 246 Clayton Rd, Clayton 3168. Ph: (03) 9594 3565. Fax: (03) 95946512.

Lifescrpts

Dandenong Division in conjunction with Central Bayside Division of General Practice has been successful in obtaining a grant from the Department of Health and Aging for a significant Lifescrpts project. The Division is now seeking expressions of interest from practices that would like to be involved in the project. The project will provide intense support to practices to implement the Lifescrpts tools.

If you would like to be involved or for more information please phone: Sylvia Pomeroy or Michelle Guille at the Division on: 9706 7311.

Request for Assistance in Cambodia

On her recent trip to Cambodia, Division Administrative Assistant, Margaret Ham, visited the Children's Surgical Centre in Phnom Penh. The CSC is an international NGO with no political or religious affiliation and provides a range of specialised rehabilitation surgical services and support directly to the disabled and poor people of Cambodia. A friend of Margaret's will be working as a theatre nurse at the centre for 3 months commencing in October. Prior to her departure she hopes to collect a range of items including excess surgical stock, dressing materials, eye pads, etc. If you are able to help, please contact Margaret Ham at the Division on 9706 7311.



Surgical Team at work in Children's Surgical Centre, Cambodia



Keep this date free!

DDDGP Annual General Meeting
Wednesday 21st November, 2007

Southern Golf Course, Lower Dandenong Road, Keysborough. Stay tuned for further details.