PROJECT TOWARDS EXCEL 2020
Supporting our community into the future
COUNTIES MANUKAU DISTRICT HEALTH BOARD
A Community Partnership
NEWS
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Whirinaki opens its doors to the community

A new community mental health care facility called 'Whirinaki' was officially opened by the Counties Manukau District Health Board (CMDHB) on Thursday 27 July 2006.

Whirinaki (meaning to support) will provide better access and care to patients living with mental illness.

Its location at 7 Springs road, East Tamaki is ideally situated to its client-base in South Auckland and to cover future growth in the Flat Bush area.

Staff from Child and Adolescent Mental Health Services (CAMHS) and the Early Psychosis Intervention Team (EPIT) relocated to Whirinaki in May 2006.

The facility, covers two floors (2nd & 3rd) which includes 12 interview rooms and accommodation for up to 80 staff as well as a meeting room / seminar area.

The site is beautifully landscaped and includes a generous number of car parks.

Board member, Arthur Anae officially opens "Whirinaki"

Maori Cultural Advisor, Heemi Witehira guided the afternoon's proceedings, which began with a welcoming Karakia and song from Whirinaki staff.

Ian McKenzie, General Manager Mental Health and Intermediary Care, thanked everyone for their commitment to the Project, and Clinical Head Dr Hugh Clarkson talked about a challenging new phase of growth and development for Child and Adolescent Mental Health Services.

EPIT Team Leader, Aaron O'Connell spoke of the improved facilities, and said it was the first time both services (EPIT and CAMHS) had been together under one roof.

Other speakers included Moaseni Sioli, who spoke on behalf of the Pacific Island community, adolescent service users Doreen Whittaker and Paul Harvey, who gave their personal stories and Rawiri Wharemate who explained the history behind the name Whirinaki.

CMDHB Board member, Arthur Anae spoke of the Boards ongoing support for mental health services for children and young people, before cutting the cake to officially open the new facility.

The refurbishment of the building was undertaken by Projects Facilities and Engineering and was completed in an extraordinarily short time - less than ten weeks from the signing of the lease to the relocation of staff.

Behind the scenes - Tunnels and Corridors Redevelopment Project

Work is progressing on the Tunnels and Corridors Redevelopment Project with consultation underway with Management Groups and services directly affected by the first stage of building works.

User Groups for Stage 2 will commence shortly (September 2006) followed by the ongoing release of information and updates to the wider organisation.

"We have left no stone unturned when planning this project," says RCP Project Manager, Matt Allen. "The potential impact of each stage of construction on clinical operations is the "single most important factor" we take into account when planning construction methodology."

Mr Allen says that everyone (staff, patients and visitors) will be affected in some degree by the building works. For example many will notice way-finding and access changes, some departments may be affected by construction noise and dust, while others will be required to relocate to allow building works to progress.

Strategies are in place to manage planned and unplanned disruptions to the Hospital. An important part of this strategy is keeping you informed every step of the way.

Meet the Project Team:

Project Managers, RCP/CMDHB	→	Project Managers provide project leadership and co-ordinate the design and construction elements.
Communication Co-ordinator	→	Provides project updates and information
CMDHB Engineers	→	Carry out the services design review and services connection.
CMDHB Process Improvement Managers	→	Responsible for change management. Will work closely with relocating services.
Architects – Peddle Thorp	→	Incorporates spatial design and functional planning. Co-ordinates the other design consultants requirements and integrates with the User Group.
Beca Engineers	→	Responsible for the design and integration of new and existing building services eg lighting, fire protection, ventilation etc.
Holmes Consulting Structural Engineers	→	Analyse the structural components of buildings and non-building structures. This involves calculating the stresses and forces that affect or arise within a structure.
Health Alliance	→	Responsible for the data and communication requirements, including getting the best results from the network during the building works.
Other: Contractor, Vertrans, LA4 Landscape Architects and Harrison and Grierson	→	The Contractor will carry out the construction work, Vertran Engineers are responsible for managing the lifts. LA4 Landscape Architects are involved in the design of the courtyards and Harrison and Grierson are responsible for Civil Engineering and drainage.

The design process

Architects Haitham Alrubayee (Peddle Thorp), Rachel Rush (Klein) and Health Planner Debbie Nichols have been involved with many of Middlemore's redevelopment projects, which include the Neonatal Unit, National Burn Centre Facility and the Adult Medical Centre.

All agree there are specific guidelines to follow when designing any new facility and that Users need to be involved in each step of the design process to ensure their needs are met.

"The first step is to ensure User Groups understand the design process and the proposals being tabled for discussion, says Haitham Alrubayee. "We do not expect Users to understand architectural plans and elevations, so where possible we relate space to existing known areas."

Interaction between Architects and User Groups are at their busiest during the first three phases of the design process (concept, preliminary and developed design). "A lot of detail is covered during these phases," says Rachael Rush. "By the end of Phase 3 all key design decisions are made and agreed upon.

"During the latter phases User Group members can tour the facility during construction to see how their ideas have been translated into reality and confirm they have been correctly implemented."

Phase 1 – Concept Design

Provides User Groups with a "big picture" of what is planned for their areas. A scaled drawing is presented to the User Group for sign-off.

Phase 2 – Preliminary Design

Provides more detail, including elevations, sketches and a selection of materials and finishes. These designs are assessed for their ability to provide future growth and flexibility of use, easily identifiable circulation and way finding, disabled accessibility, a variety of settings to meet different client's needs, security i.e. the ability to zone off areas and provide an environment that is supportive and therapeutic of its users.

Phase 3 – Developed Design

Refines rather than changes the preliminary drawings, increasing accuracy and definition of detail. Further information is also added at this stage, including room datasheets, which outline:

- Detailed written description of each space
- Furniture, fittings and equipment
- Services e.g. electrical outlets
- Doors and windows
- Finishes e.g. wall, floor, carpet, vinyl, paint.

Phase 4 – Detailed Design and Documentation

Includes all the documentation required for builders to price the work. It also includes structural, mechanical, electrical, plumbing and fire engineering specifications.

The final stages of the process are tender and construction and then the commissioning of the project.

Settling into the National Burn Centre - A personal perspective from Occupational Therapist, Tracey Perrett

The National Burn Centre Facility has been open for six weeks and overall the transition of our team to the new environment has been very smooth.

The orientation was particularly helpful. It helped to have people on hand who were familiar with the new equipment and who could answer our questions.

The Change Management Workshop was also useful as it helped put our minds at ease and remind us that people cope with change in different ways.

The new facility far exceeds the previous one in terms of health and safety, infection control, access to computers, not to mention the obvious improvements in appearance!

I have been involved in the design plan for over five years – and the real thing is far better than the paper plans we have poured over for years!

Occupational Therapist - Tracey Perrett

Since opening we have treated approximately 80 patients a week, with many commenting on how much nicer the outpatient facilities are. We also had a visiting Rep who was very impressed with our splinting room. It was the first time he had seen a dedicated splinting area.

If I had any lessons to pass on regarding the move I would say effective communication is vital to a successful move.

The move to a new area should also be a team event and not the responsibility of one particular staff group. I recommend involving the whole multi-disciplinary team in the actual move as well as the plan.

Outpatient Clinic Corridor

Located on the first floor of the Acute Hub at Middlemore Hospital, the National Burn Centre is directly above Emergency Care and flanked by the Kidz First Children's Hospital, acute theatres and the planned Intensive Care Unit (ICU).

Although the new Centre is now being utilised, it will not be fully operational until 2008, when the Intensive Care Unit is co-located.

National Burn Centre a delight to work in – by Staff Nurse Bunna Eng-Tusitala

How are you settling into your new facility?

We have been waiting for this new facility for a long time and it has definitely met my expectations. Of course there are always teething problems with any new unit and everyone has an opinion on where 'equipment' could be better placed.

We've all learnt to think 'laterally' thanks to our Charge Nurse and everyone is working well to identify issues that need to be addressed, in comparison to things we need to 'adapt' to.

Staff Nurse Bunna Eng-Tusitala

What are some of the things that helped you settle in?

The orientation day was definitely useful. It covered a wide range of information ranging from the new call bell system to how to operate the curtain remotes!

What are some of the advantages of the new facility in comparison to the one you have left?

The new unit gives us the ability to provide quality care in a quality facility. Having the High Dependency Unit (HDU) rooms for our complex care patients provides them with the appropriate environment to maintain infection control and to be closely monitored via the wonderful CASS Medical Monitors. Our complex burn patients are provided with televisions in their own rooms and X-Box's to play games, watch movies or play music CD's.

Since opening how many patients have you treated?

We were very busy on our second day of operation, admitting two serious burns patients, one of which was an 18 month old. Since then we have had a steady flow of smaller percentage burns and have taken in plastics patients when we haven't been at full capacity. Once the full 'burns service' is up and running we expect we will run at full capacity for a majority of the time.

What have been some of the comments from patients?

The majority of patients have been extremely impressed with the facility and the attention to detail. The fact they all have their own TV and X-Box console's definitely helps. We have only had a couple of negative comments, one being the HDU rooms can get quite hot due to the controlled heating and another patient felt a bit 'confined' in his room but otherwise loved the facility.

What lessons or tips would you pass on to others moving to new facilities?

Formulating a 'move' plan early on definitely helps and I suggest you have a decisive list of all the items/equipment you need to take with you and what can be left behind. We found it extremely useful that we were able to start bringing equipment/items to the new unit the weekend before we opened. That way we weren't having to move absolutely everything over on ‘opening’ day. Not having to take admissions during the move was definitely helpful.

We anticipated that the move would require 'all hands on deck' and rostered as many of our staff on as possible. Staff were divided into two teams – one team provided care for the patients while the other facilitated the move. Moving a ward is always going to be a little chaotic, but planning your move can make it a little easier.

Construction Photo's - Levels 4 & 5 Adult Medical Centre

Level 4 - General Surgical Wards

The box marks the Reception area. The photo also shows a Ward corridor.

The shared write-up area will be located behind Reception.

Single patient bedroom with ensuite

4-beded room with ensuite

Dayroom with view of golf course

Most patient rooms have views of the golf course

Level 5 - Orthopaedic Wards

Reception

Ward Corridor

Day Room

Wide patient doors

The new ward layouts encourage a unit rather than ward approach.

Ward clerks will move into a central core area (Reception), immediately opposite the wards main entry. This will improve the meeting and greeting of visitors.

Both wards on each floor(4 & 5) will share a write-up area improving communication between the wards.

The design of the new wards will be patient focused, with enlarged patient day rooms and facilities such as dining rooms and kitchen's, providing patients with some interdependence around meals.

Orthopaedics on the 5th floor will have improved facilities with the plaster room, physiotherapy room and patient dining areas incorporated into the structure.

The 5th floor has an allied health gym space with a sliding door connection to a patient lounge dining area.

A full 'domestic' kitchen in the lounge/dining area allows assessment of patients before they return home.

Glazed walls behind the ward clerks, reflect light into the wards.

The majority of patient bedrooms have large windows and fabulous views of the golf course.

Orthopaedic wards on the 5th floor have wide patient doors to accommodate traction beds.

Historical beginnings

As we enter into a period of growth and redevelopment it's important to understand our historical beginnings. Each issue of Project EXCEL will take you on a journey through the past 59 years.

An Orthopaedic Nurse's personal and selective perspective. This article was published in 'Middlemore Memories' and was written by retired Nurse Joan Williams. Collins.

In 1960 Middlemore had 300 beds and working there was almost a family affair. Everyone knew everyone else, and this was not just in one's department.

Years later, when the size of the hospital increased, Middlemore continued to behave like an small hospital and maintained its friendly atmosphere. Staff went away, but also came back and were greeted as if they had been on holiday for a while, even if they had been away for years.

The corridor between the old and the new blocks was the best place to see and be seen.

Professor Harley Gray talks to a young girl in traction

In those days, the old block plaster room was part of the theatre block (now gastroenterology and haematology). It certainly put a new face on orthopaedics. There was plastering, splinting, manipulations, anaesthetics and lots of people, which all went on in a two-bedded room, with only one curtain! These days the lack of privacy would probably not have been tolerated but looking back I can't see how we could have managed to get through the workload any other way.

There was constant to-ing and fro-ing through the plaster room as many of the surgeons parked their cars just outside and this was the quickest access to the theatre block. Under the plaster room there was what can only be described as a 'hole'. Access was from the outside via a few steps and contained an array of spider webs, Thomas splints, Braun frames, tin boots and sundry other devices that fortunately would mean nothing to a current orthopaedic nurse. Thankfully, the light was so poor that we probably couldn't see the other livestock down there.

There were some advantages. Those were the days when the kitchen, handily positioned next door to the theatre block sent around sandwiches and scones for morning tea and scones and cakes for afternoon tea … such luxury!

In 1964 the Galbraith Block opened and we transferred to the theatre suite. Our new surroundings were much appreciated. We had more room and even a store room with a window, which was next door instead of underneath. The workload was increasing and with it the staffing level. There were six full time nurses and we took it in turns to go to the Accident and Emergency Department and outpatient plaster rooms as needed. Each orthopaedic team's plaster room lists ran concurrently with the theatre lists.

It was a busy and frequently chaotic, department and we loved it. Orthopaedic Surgeon Tim Astley summed it up when he presented us with a lovely daisy-laden poster stating "BLESS THIS MESS". It hung on our wall until it fell apart.

The information provided is courtesy of Middlemore Memories – the first 50 years of Middlemore Hospital by David Scott

Did we really do that then?

Casting* in the early sixties was often a complex affair. Internal fixation of fractures, with the exception of hip fractures, was uncommon and external fixation unknown. So in fracture treatment good casting was essential. Open fractures presented a special challenge.

Orthopaedic Surgeon Mr Nicholson treated patients who had scoliosis (curvature of the spine). Some pre-operative correction was achieved by means of body casts, which were fitted with hinges and turnbuckle devices to position the patient into a corrected position before spinal fusion. The jackets were applied with the children on a distraction frame, which any medieval torturer would be proud to own. Once they were in their jackets the ward nurses did a magnificent job in preventing the casts causing pressure as the turnbuckles or distraction devices were lengthened each day.

Cervical fractures were treated primarily with skull tongs. Then a Minerva cast would be applied so that the patient could start mobilising.

I think that the thing all our staff really enjoyed was making a plaster bed. This was no one-day event and we didn't use commercial plaster. The patient was measured and muslin cut to shape and stitched. When everything was ready the patient was positioned, oiled and then it was all systems go.

There needed to be five nurses, one at each corner of the patient, and a mixer. This was the job we all vied for. The recipe was ten pints of water and fourteen pounds of plaster. The bucket was filled, the plaster added and vigourously stirred. Then it was in with the layers of muslin and on to the patient. Speed was essential if you were to get all the muslin soaked, and not be left with a bucket of set plaster. When set the cast was quickly lifted off the patient and then, when completely dry it was trimmed, sent to the splint department for a frame to be made, then lined. It would take four days to complete. A fancy arrangement of pulleys attached to the frame enabled the patient to raise and lower the whole contraption and it looked most impressive.

Now, when even a hip spica is almost a thing of the past, these casts seem like something from another century but they were a challenge and we did enjoy ourselves.

In the plaster room five nurses are making a plaster bed.

Like everything else, the orthopaedic nurse's work was changing. New procedures, more complicated surgery, external fixation for many fractures, much more internal fixation, joint replacement surgery, earlier ambulation and a quicker turnover of patients. The ward nurse's work was certainly no lighter. It was much more complex and demanding, although the casts were less complex.

* The act or process of making casts or moulds

Women's Health Projects

Thank You

The **Assessment and Birthing, and Antenatal Postnatal Transitional Care Teams** would like to thank all those who have welcomed us in to their areas to study such things as:

- Medical service panels - gas, suction and other services delivered from wall outlets
- Clean and dirty utility rooms
- Procedure lights
- Storage ideas
- Ensuites
- Window treatments - blinds, drapes etc
- Clever administration ideas and ward clerk office layouts
- Staff hubs and workstations etc

We appreciate being able to "see before we buy or design" and may wish to visit again with more questions! Thank you.

Gynaecology Care Unit Project

Work is underway in preparing a Business Case for the National Capital Committee to approve funding for this Unit which will be located where Ward 20 is currently.

This Unit will be a combination of Inpatient beds, and an Early Pregnancy Service which includes Ultrasound Assessment.

The Gynaecology Care Unit will need to move from its current location off the Rainbow Corridor so that construction of the next ward block similar to the Adult Medical Centre can begin in 2007.

PROJECT EXCEL TOWARDS 20:20

Supporting our community into the future

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Coming up in the next issue ..

- **Project updates**

We would love to hear your feedback regarding the newsletter and ideas for future articles.

Please email Janet Haley with your suggestions: haleyj@middlemore.co.nz