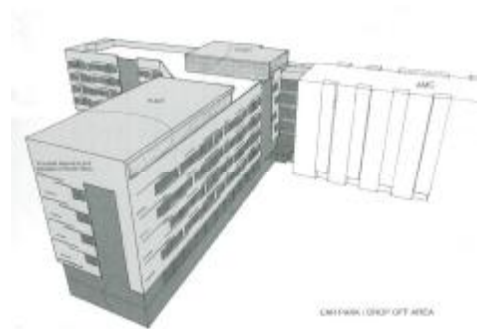


**February 2007**

## **New ward block planned for Middlemore Hospital**

Construction of a new 6 storey ward block (plus basement) will be one of the larger building projects on the Middlemore site.

The multi-million dollar project has been approved by the National Capital Committee and is awaiting formal sign off by the Minister of Health.



The 6 level L-shaped building, beside the existing Adult Medical Centre (AMC) will provide an additional 240 inpatient beds when fully completed.

The initial stage of the project, for which funding has been approved, will fit out two floors of wards totalling 120 beds on Levels 2 and 3, and a new Cardiac Investigation Unit in the North Wing on Level 1. Further stages of development will include two more floors of wards on Levels 4 and 5, and the fit-out of the East wing and central core area of Level 1. A future ground floor podium and basement will accommodate Clinical Support Services.

Construction is due to commence in early 2008, with a target date of June 2009 for opening the first of the new wards. It has not yet been determined which services will occupy the new wards, however a lot of work has been done with Managers, Clinicians, Nurses and Support Services around the concept design.

"The design is patient focussed," says Process Improvement Manager, Gill Cossey. "There is an emphasis on allowing maximum light and sunshine into the bedrooms and improving patient privacy by having a greater number of single rooms (20 per floor) - double the number in the AMC. There will be internal bathrooms in each room, as opposed to the existing AMC which has bathrooms on the outside of the building. This enables larger windows and therefore more light and a feeling of spaciousness."

Another design feature is the single rooms situated across an angle in the apex of the L shape, which enables ward beds to be flexed where necessary. For example, rather than having two 30 bed wards, it may be more practical, at certain times of the year to have one ward expand to 32 beds and the other 28 beds. The "flexing" of bed spaces and the centralised staff stations also creates an opportunity to look at gaining efficiencies across the floor, rather than having two separate wings functioning independently.

"Environmentally sustainable design features are also being considered for the wards," says Klein Architect Rachael Rush. Options being looked at include: collection of rainwater and use for toilet flushing or air-conditioning cooling towers, low flow water usage fixtures, low energy lighting design, increased insulation, easy access to and visibility of stairs to encourage staff stair use and provisions to encourage cycle usage such as bike stands.

## New Orthopaedic Wards up and running

It's been over a month since staff and patients made the move to the Orthopaedic Floor on Level 5, Adult Medical Centre.

In December Wards 10 and 11 were officially opened and blessed.

"It's taken a lot of hard work to reach this stage," says Chris Fleming, General Manager Surgical and Ambulatory Care.



*Wards 10 and 11 are officially opened*

"We couldn't have done it without the input from the staff, project and construction teams. It's a wonderful achievement."

The opening was a special occasion, well attended by more than 50 staff.

Following the speeches and ribbon cutting, both wards were blessed by the Chaplains and Kaumatua.

For those who hadn't had a chance to see the new facility, many were impressed with the new and improved facilities.

The new wards feature:

- Central reception and shared write-up area.
- The design of the new wards is patient focused, with enlarged patient day rooms and facilities such as dining rooms and kitchen's.
- The plaster room, physiotherapy room and patient dining areas are located on the same floor.
- Integrated Casting unit within the Orthopaedic floor.
- An Allied Health Assessment and Treatment Gym for ease of access for patients from the wards.
- A full 'domestic' kitchen in the lounge/dining area allows assessment of patients before they return home.
- The new wards use a silent call bell system with pagers that will reduce the amount of unnecessary noise within the wards.
- All patient notes will be stored in locked cupboards outside each of the rooms for easy access.

"We are very happy with the new facilities," says Orthopaedic Service Manager, Michelle McCallum Jones. "The central reception area improves the meeting and greeting of visitors while the shared write up area for the multi-disciplinary team will improve communication between the two wards.

"We have such a wealth of knowledge and skills between the wards. This new concept encourages staff to work together and more importantly support each other."

## No job too big or too small



*Tom, Tui, Bill, Mahammad and Sao*

Tui, Bill, Sao, Mahammad and Tom, make up the Carpentry team at Middlemore Hospital.

“There is a wide range of experience among the team,” says senior Carpenter, Tui Kaivelata.

Bill has been working at Middlemore the longest (22 years), while the youngest member Sao is undergoing his apprenticeship in carpentry.

“It’s a great learning environment,” says Sao. “We usually work in pairs, which means there is always someone who can give you a hand.”

Tui says his team can average 25 jobs a day, ranging from maintenance work plastering and painting. “It’s my job to assess each request and give a priority rating,” he says.

Clinical areas tend to get top priority, followed by health and safety (e.g. a hole in the floor), security (locks) and jobs that could cause further damage if left until later. The rest are classified as non-urgent jobs.

“We recognise that each job is important and will try and give people an estimate of when we will be carrying out the work,” says Tui. “This may however change if other jobs take preference.

“For this reason we ask people to be patient. We will get to you as soon as possible.”

Engineers work from 7.30 am – 4 pm and can be found at the back of Building 27 (Engineering). If you need work done, log a job via the Engineering web site or call the Help Desk on extension 9770.



*Tom in the carpentry workshop*

## The Intensive Care Unit (ICU) is on the move

On Sunday 17 February 2007 the Intensive Care Unit will move temporarily (for approx 4 weeks) to the NEW Coronary Care Unit (CCU), Level 1, Adult Medical Centre.

### Why is ICU moving?

So that building works can progress for the Assessment and Birthing Unit on Level 2, Galbraith Building.

Builders need access to ICU's ceiling, which is located on Level 1 Galbraith.

For health and safety reasons, ICU staff and patients were required to relocate.



*The new CCU*

**NB:** The existing CCU will move into the new Unit March 2007

## Demolition Month

The catch phrase this month is down with the old and up with the new.

Three wards (15, 18 and 19) are undergoing demolition.

All of the wards are located in the Galbraith Building.

Ward 15 on Level 2 is being demolished in preparation for the new Assessment and Birthing Unit.

Wards 18 and 19 on Level 4 will be demolished early February 2007 in preparation for Antenatal, postnatal and transitional care.

We will keep you posted on progress.



*Ward 15 is being demolished in the Galbraith Building.*

## Praise for Middlemore's Mobility Carparks

Disabled staff and visitors to the Middlemore site will notice a change in the location and amount of mobility carparks.

Approximately 6 months ago Disability Advisor Gaylene Gaffney, CMDHB Communications Co-ordinator Janet Haley and Engineers Harrison and Grierson, assessed the situation and concluded improvements were needed to the location and size of some parks as well as work to roadside kerbs.



***Mobility carparks can now be found by the AMC main entrance.***

As a result extra mobility parks have been created at Assessment, Treatment and Rehabilitation (AT & R), the Adult Medical Centre (AMC) and mental health services. Some parks have been relocated closer to the main entrances.

Other mobility parks have been remarked and kerbs fixed, ensuring wheelchair users have an uninterrupted journey to entrances.

People are already starting to notice the difference.

"It's great to find a park next to the main entrance," says a wheelchair visitor to the Hospital. "I usually have to park miles away."

"The mobility parks near AT & R always seem to be full," says rehab patient, Bob Dunsbury. "The 3 extra spaces will hopefully mean I can now find a park."

Middlemore's carparking Manager, Ross Harlick says his team will be closely monitoring these spaces and will take a tough stance if people park illegally.

"My team has no hesitation in getting cars removed, if they don't display the appropriate permit," says Ross.



***Uneven kerbs are a thing of the past.***

## 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.*

### A General Physician in the 1990's – by Roger Reynolds

On day one at Otago Medical School we were told that the characteristic of our professional careers would be "Change", and so it has proved.

In the twenty odd years since I graduated we have had to learn new diseases e.g. HIV as well as re-emergence of older diseases such as Tb and changing disease patterns. There have been a plethora of new diagnostic techniques from imaging gross anatomy via CT and MRI, to characterisation at the molecular level of hormones, receptors, antibodies and genes. A host of powerful new drugs and new combinations have emerged, as well as a range of less invasive techniques.



*Part of the medical team in 1984, outside Ward 4.*

With these medical advances have come increasing expectation of the health service by the public at large. Patients and whanau have greater involvement in management decisions, based on an understanding of illness and treatment options. At Middlemore there have been major changes of the ethnic mix of our communities, requiring sensitivity to the differing cultural practices and belief systems and there has been a heavy reliance on the translating staff. Ever increasing financial constraints have impacted on treatment options along with a dramatic increase in the workload.

Today's general physician operates under very different conditions to meet the challenges described above. The physician must be present on the ward most days of the week, ensuring as far as possible that all new cases are seen by a consultant within twenty-four hours of admission and that progress is reviewed at least once before discharge. Post acute ward rounds may take six hours, especially on Sundays when 25 to 30 cases admitted on Saturday must be seen. Required physician skills to achieve this are the ability to maintain concentration for hours at a time, to extract essential details from the registrars' and house surgeons already abbreviated case presentations, to review old case notes in minimal time and to make five minutes of listening to the patient appear like twenty-five.

We need to explain to the patient the disease and its treatment in two minutes. We go on to explain to the patient the need for major behavioural changes in one minute and throughout we need to maintain a sense of humour. In the back of the physicians mind is the threat of medico-legal action for errors of commission or omission, or worse a wayward outcome when cases are audited and compared with those of local or distant colleagues. When not physically present on the ward, the physician must be available for consultation by the junior staff – discussions with the registrar being the minimal expectation after a day on call.

Relationships with other staff have also evolved from the hierarchial days of old when the consultant was third in line to God, behind the ward sister.

Today's team acknowledges the unique contribution of each member to the patient's care and welfare.

## Historical beginnings - continued

The team recognises that allied health professionals have essential skills in evaluation and treatment and that junior staff may – and often do – have more up-to-date knowledge than their senior colleagues. Any member of the team may question another's point of view. For the consultant, the challenge is to provide clear leadership and exercise the authority that must accompany the ultimate responsibility for the patient care, without suppressing the ideas and efforts of other team members.

Compared to the 1960's, a quantum change has occurred in the range, power and specificity of treatments available to the physician. In infectious diseases these range from powerful new antibiotics to the much awaited range of antiviral agents.

In cardiovascular diseases equally spectacular advances have occurred, with early thrombolysis saving lives in acute myocardial infarction. For treatment of acute gastrointestinal diseases the advent of endoscopy has revolutionised the ease and accuracy of diagnosis.

Of the common respiratory diseases in the medical ward, asthma has almost been tamed with the advent of inhaled steroids and bronchodilators. However, it has required a major educational programme for patients, their GP's and specialists before the potential of these agents could be fully realised.

Of the many advances progress in the management of diabetes must be noted, especially the now ubiquitous home blood glucose monitor which has put patients back in control of the disease and their lives, if they choose to commit themselves.

Against these many advances, it is the phoenix-like rise of one of the oldest drugs of all, aspirin – reincarnated in its enteric-coated mini-dose form. It has found a new array of life-prolonging stroke-preventing indications appealing to the patient, physician and service manager alike for its cost benefits and performance.

For the general physician the changes described above have led to a sense of greater fulfilment and perhaps, greater frustration.



*The Coronary Care Unit prior to opening.*

Fulfilment, because we can witness dramatic improvement in patients well-being in life threatening conditions. Frustration, because the increasing patient numbers, the burgeoning cost of care and the growing burden of lifestyle in the community we serve.

Over the last 25 years the Division of Medicine has grown in stature to take an equal place alongside the foundation specialties of the hospital.

The present physicians acknowledge a debt to their forerunners who set the stage for this process.



## Contact

Communications Coordinator  
 Janet Haley  
 PROJECT EXCEL – TOWARDS 20.20  
 Counties Manukau District Health Board.  
 C/- Projects Office, Building 25  
 Private Bag 94052  
 South Auckland Mail Centre  
 Auckland  
 Ph: (09) 262-9500  
 Fax: (09) 270 9714  
 Mobile: 021 443 731  
 Email: [haleyj@middlemore.co.nz](mailto:haleyj@middlemore.co.nz)  
 Web: [www.cmdhb.org.nz](http://www.cmdhb.org.nz)

## Project Excel Web Site

In the internet explorer address bar type: <http://www.cmdhb.org.nz>.

Click onto PROJECT EXCEL.

The PROJECT EXCEL web site has been designed to inform staff about the modernisation and redevelopment projects occurring across the CMDHB sites.

You'll find background information and regular updates on the various projects, along with updated photographs of construction activities, floor plans, copies of PROJECT EXCEL NEWS and much more.

## Welcome

Project Excel would like to welcome Patrick Long to the team.

Patrick has been appointed Process Improvement Manager (PIM) and will be responsible for:

Women's Health Redevelopment Projects (Assessment and Birthing Unit, Postnatal, Antenatal and Transitional Care)

Mental Health Redevelopment Projects.

Patrick was at the Auckland District Health Board for over 12 years in roles ranging from Orthopaedic and Emergency Department Nurse, Emergency Management Coordinator, Migration Co-ordinator for the Building Programme and Duty Manager.

