NEWLY UPGRADED TRAUMA UNIT

Making your hospital experience **BETTER TOGETHER.**

The Trauma Unit is a high-volume unit where sometimes up to 20 000 patients are seen per annum. It is self-evident that where you have such a high volume of patients going through the unit, it needs to be maintained on a regular basis. Since the last upgrade many years ago, the unit has slowly but steadily deteriorated up to a point where we had a continuous flood of complaints about the state of the unit. About five years ago, the then Medical Superintendent responsible for Trauma, Dr Richard Muller, started a process negotiation for a complete upgrade of the unit. After many planning sessions and numerous plans, the final plans were approved at the end of 2012 and a process started to do a serious infrastructure upgrade of the unit.

Initially it was only going to be a building upgrade and nothing more. The building upgrade also was selective with some parts not being upgraded. After intense negotiations a decision was made to do a total building infrastructure upgrade. Whilst plans were a foot to do the building upgrade, officials from Metro Clinical Engineering visited us and asked question of whether we need equipment. The outcome of this visit was an allocation of an equipment budget of R13 million for the unit.

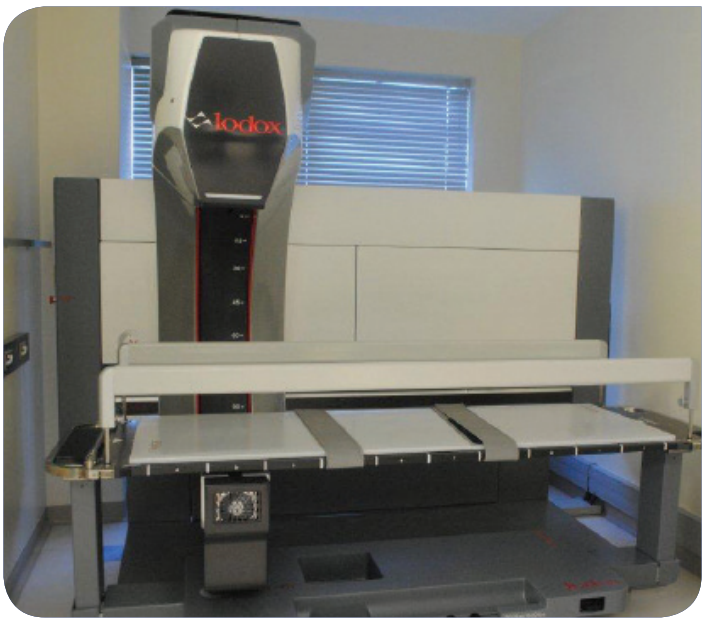
With the equipment budget the then head of the Unit, Dr L. Taylor, advocated strongly for a Lodox (Low Dosage X-ray) machine. This piece of equipment then had to be worked into the existing unit. Today the unit has this piece of modern equipment that will allow Radiographers to do a total body scan within 30 seconds. This, of course, will give doctors access to a very quick assessment of a politrauma patient.

The outcome of all of this is a brand new unit equipped with brand new equipment and with brand new facilities for the Nursing staff.

The staff of the Trauma Unit at Tygerberg Hospital is truly grateful for the Management, Department of Health Western Cape, as well as Public Works, for making a new Trauma Unit a reality.

The unit will be officially opened by the Western Cape Minister of Health, Mr Theuns Botha, at an opportune time.

Dr AJA Müller



CONGRATULATIONS

Thank you for your hard work.

Above Left: Professor Simon Schaaf who received the National Order of Mapungubwe from President Jacob Zuma on 27 April 2014 for his excellent contribution in the field of medical sciences, specifically his ground-breaking focus on drug-resistant tuberculosis.

Above Right: Professional Nurse Edma de Kock (Unit Manager of Ward J3) received the Achievers Award, 2nd Academic Place, for Post Graduate Diploma in Nursing Management from the University of Stellenbosch – Nursing Division, at a function held on 22 April 2014.

WELLDONE!

TEENAGE SUBSTANCE ABUSE

Substance abuse among teenagers is a significant problem in the Western Cape. Experimentation with drugs sometimes starts as early as ten years old, and drug dealers are increasingly targeting schools, even primary schools. Substance use during early adolescence almost always starts among friends and typically involves substances that are easily available. Many young people discontinue use after a period of experimentation, but others progress to psychological and/or physical addiction, moving from alcohol and cigarette use, which is illegal in those under 18 years, to other drugs which are illegal under any circumstances. Prevention of early alcohol and tobacco use does reduce the risk of other drug use. The most common substances used by teenagers in the Western Cape are methamphetamine ("tik"), alcohol, cannabis ("dagga") and heroin.

What is addiction?

Addiction (dependence) happens when a person who is using a substance becomes unable to cope without it. Not all substance users are dependent, but the risk of developing dependence is higher with certain substances, and in persons with a history of mental illness or a family history of addiction.

How serious is the problem among Western Cape youth?

In one study, 32% of males and 17% of females between 15 and 19 years old were found to have consumed alcohol, and in another, one in eight high school students reported drinking alcohol before the age of 13 years. Most substance abusers do not use only one drug, and often tik users will use other drugs to deal with the "coming down" phase. Many adolescent drug users do not seek treatment on their own, and the figures for drug use are undoubtedly higher than school surveys can show.

What does this mean for our communities?

Drug use carries significant risks, both to the physical and mental health of the user and to society as a whole. In the short term, individual users may develop psychosis, anxiety or depression, poor school performance and social or legal difficulties, but in the longer term, there are potentially devastating consequences, including criminality, violence, accidents, injuries and risky sexual behaviour resulting in unwanted pregnancies and/or sexually transmitted diseases. Drug use generally impairs one's judgement and decreases one's social and academic skills.

Is my child at risk for substance use?

Some children are at higher risk for drug use, including those with poor self-esteem, learning difficulties, defiant behaviour, inherited vulnerability (family members with addiction problems) or mental health problems. Some adolescents may use drugs as an expression of anger or in an exploratory way.

Family issues may also increase the risk. When parents are poor role models or do not monitor their children's lives, drug use may develop without anyone being aware of it. Homes with harsh or inconsistent/"unfair" discipline, high levels of conflict and poor support are also breeding grounds for drug use in teenagers.

In schools and wider communities, exposure to discrimination/bullying, violence and crime is associated with adolescent substance use, and peer pressure combined with easy access to drugs becomes a slippery slope for vulnerable teenagers.

How do I know if my child is using drugs?

There are no signs that are absolute proof of drug use except catching the child in the act of using drugs. Most of the signs are non-specific, and include unexplained mood swings, lying, stealing, unusual aggression or laziness, a decline in school performance and/or attendance, sleeping in class, lack of interest in hobbies, sport and school work, poor personal hygiene, an undesirable change of friends, poor or increased appetite, social isolation, and mental health problems (hearing voices or appearing confused). However, drug use is only one possible cause for a change in behaviour, and it is important that the alternatives causes be investigated.

There are some more specific signs found with drug use, but again, there are other possible causes, and parents should not jump to conclusions without a health professional examining the child. These signs include enlarged or small pupils of the eyes, bloodshot eyes, runny nose and unexplained weight loss.

How do we stop our children from becoming drug users?

This is a difficult question to answer. Perhaps the strongest protection a child can have against substance use is a strong, open, positive relationship with a parent or other helpful adult, but even this is no guarantee against drug use in otherwise vulnerable adolescents, and additional resources are needed to strengthen the resilience of our youth. The most important aspects of successful individual prevention programmes seem to be teaching life skills, dealing with learning difficulties and poor school performance, and detecting and treating mental health problems such as depression.

Prevention programmes consisting only of information and instruction have not been found to be very effective. Some programmes focus only on those at high risk, but the strongest evidence is for a multifaceted, holistic strategy, targeting all children in primary school and dealing with substances in general, not just illegal drugs. Those programmes found to be most effective are the ones that focus on conflict resolution, self-image, social competence, resilience building and promoting healthy life choices. In addition, running parent and community information groups with regular follow up sessions, combined with positive community activities has been found to help a great deal.

For communities in general, part of the solution lies in law enforcement, so that drugs are not easily available, and also in how the media represent drug use (including tobacco and alcohol advertisements). In addition, many parents seek help to improve their positive parenting skills, such as how to nurture children's self-esteem, set firm and clear rules, apply consistent appropriate discipline, improve communication, monitor compliance with rules and achieve quality family time.

For at-risk children, drug screening at school or a local clinic may be useful. If there is a likelihood that a particular child is using substances, then a visit to the local health facility for physical and mental health screening is needed, following which an interview to motivate the child (and parents) to make use of available treatment options must be carried out. Sometimes a brief intervention at community level may be sufficient to change the child's behaviour, but there are also some specialised in patient treatment programmes offering services for children for whom diversion programs and school/community based counselling are insufficient.

What must I do if my child is using drugs?

If there is a crisis, (the child is intoxicated, in withdrawal or has taken an overdose), the emergency department at the nearest health facility will be the first port of call. These situations almost always involve confused and sometimes aggressive behaviour, and help may be needed in getting the child to the facility.

If detoxification is required, arrangements can be made through the social worker or the mental health team at the local clinic or district hospital for this to be done either as an inpatient or as an outpatient.

Rehabilitation is offered by several facilities, and organisations such as the Western Cape Rehabilitation Centre, BADISA, SANCA, Teen Challenge, ACVV, Child Line, Life line, Cape Town Drug Counselling Centre, CASE and the Department of Education district offices will usually be able to provide telephonic advice on how to go about having a child admitted. Admission to a rehabilitation centre may be voluntary or court ordered. The treatment process is generally a long term one with outpatient follow-up, and success depends on sustained motivation.

Substance dependence treatment programmes are overseen by the Department of Social Development, and your local social worker should be able to provide specific information on request. If the child has a diagnosis of another mental illness in addition to substance abuse, more specialised treatment may be required, and the Department of Health has a role to play in this.

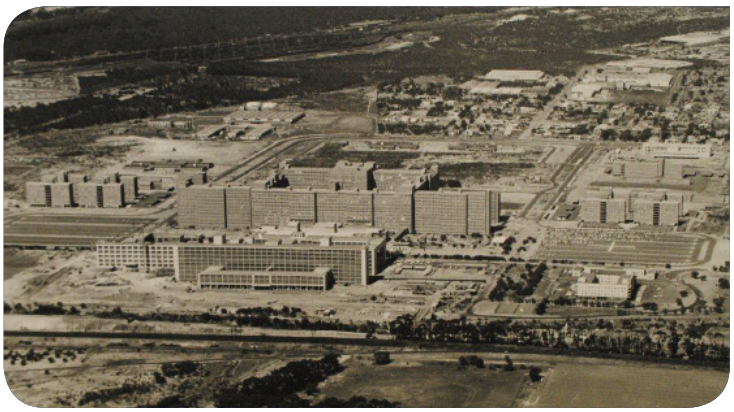
Dr Fiona Schulte & Dr Sue Hawkridge

REDEVELOPMENT NEWS

The redevelopment project of Tygerberg Hospital is well in its feasibility study. The project office has established various task t comprising staff members from Western Cape Government Health, the hospital as well as other government departments. The focus of the last few months was on clinical issues. All clinical departments and divisions had dedicated user-group meetings, during which respective teams were able to give inputs into the redevelopment project. The appointed Clinical Advisor collates the inputs and translates these into brief documents, aiming to encapsulate needs. Further a Clinical Review team, comprising of the senior medical managers, senior nursing management, Information Management and the CEO, are in weekly engagements, aiming to vet any inputs received and clarifying issues with regards to expected operation theatre times, numbers of day-surgery patients, outpatient workloads, etc. The redevelopment project of Tygerberg Hospital is well in its feasibility study. The project office has established various task t comprising staff members from Western Cape Government Health, the hospital as well as other government departments. The focus of the last few months was on clinical issues. All clinical departments and divisions had dedicated user-group meetings, during which respective teams were able to give inputs into the redevelopment project. The appointed Clinical Advisor collates the inputs and translates these into brief documents, aiming to encapsulate needs. Further a Clinical Review team, comprising of the senior medical managers, senior nursing management, Information Management and the CEO, are in weekly engagements, aiming to vet any inputs received and clarifying issues with regards to expected operation theatre times, numbers of day-surgery patients, outpatient workloads, etc.

The next step is to establish the needs for the Support, Admin and Facility Management services. Here the input from respective task teams is solicited, aiming to understand better what their needs would be in a new hospital. This process runs in parallel with higher-level discussions on future service provision in the Metro and the Western Cape. The overall work on the feasibility study is slightly behind schedule. The Project Office is however still confident to finalise the feasibility study in 2014.

Dr Ludwig Martin , Director, Project Office-Tygerberg Hospital



INTERNATIONAL NURSES DAY

On 28 May 2014, Tygerberg Hospital celebrated International Nurses Day to commemorate the hardworking and dedicated Florence Nightingales who work tirelessly at the hospital. Lucky draws were part of the programme sponsored by various stakeholders. Our future leaders of the Tygerberg Hospital crèche surprised the nurses in song as well as Ms Lizette Heyns and Realta Pienaar. At the end of the programme nurses recommitted themselves to the service by saying the nursing pledge. Nurses, we salute you for your commitment towards the patients of Tygerberg Hospital!

Above: From left to right: Ms Priscilla Cupido (Professional Nurse), Ms Melissa Hendricks (Enrolled Nurse) and Ms Emelda Williams (Enrolled Nursing Assistant) with their Liberty prize.

Far Right: Ms Anneline Beukes (Enrolled Nursing Assistant) who received a picnic hamper from Ms Liezel Bonthuys from Metropolitan.

Above: Mr Cobie Beukes and Stacey from Capitec with Ms Rene Rossouw (Professional Nurse, middle), who won the Capitec hamper at the second session.

Above: These nurses won the Metropolitan caps.

FAREWELLS

Above: Mr Christo Odendaal, who was appointed on 14 January 2013 as Chief Engineer, bid farewell to the Department of Health on 31 March 2014 and will commence duty at the University of Cape Town. He expressed his thanks and support to Management and the support of the Engineering Department, as well as their willingness to always assist and keeping the infrastructure in such a good condition.

Bo: Ná 40 jaar van getroue diens as 'n Administratiewe klerk sê mev. Kathleen Slabbert, ook bekend as aunty Mina, vaarwel vir haar kollegas. Geniet die aftrede terdeë.

Above: Tygerberg Hospital bids farewell to the Florence Nightingale of Ward A9, Ms Louise Cloete, after 41 years of dedicated service. Colleagues said that Ms Cloete was a real inspiration and mentor to them and wished her all of the best with her future.

Above: Ms Natasha Frazer who was an Administration Clerk at the Procurement department has transferred to Groote Schuur Hospital as an Administration Officer Procurement with effect from 1 May 2014. Congratulations on your promotion!

NEW APPOINTMENTS

Above: Dr Granville Marinus, who was the previous CEO of Lentegeur Psychiatric Hospital, was appointed as Manager: Medical Services with effect from 1 April 2014. His main portfolios are Paediatrics, Psychiatry, Pharmacy, Research and Antibiotics Stewardship.

Above: Ms Lesley Paterson who was a Lecturer at the University of Stellenbosch commenced duty as the new Assistant Manager Nursing services for the Internal Medicine Module on 1 April 2014.

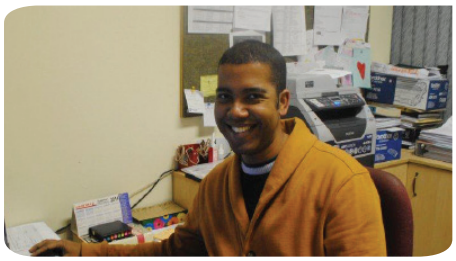
Above: Ms Rhoda Keyser was appointed as Assistant Director: Food Services with effect from 1 February 2014.

Above: Congratulations to Ms Shamla Le Kay who was appointed as Assistant Manager Pharmacy: Operations and Mr Mogamat Waleed Isaacs appointed as Assistant Manager Pharmacy: Finance & Supply Chain.

HR MATTERS

Far left: Ms Linda Zimele transferred from Khayelitsha Eastern Substructure: Facility-based Services to commence duty at Tygerberg Hospital on 1 April 2014 as a Labour Relations Clerk. Welcome to the Tygerberg Hospital family

Far Left: The Finance Department bid farewell to Mr Rouan Reid after 21 years of service. Mr Reid joined the team at Stikland Hospital as State Accountant with effect from 1 April 2014. Congratulations on your promotion, we wish you well with your future endeavours.



Far Left: Mr Kyle Brookes will be joining the Human Resource Management team at Valkenberg Hospital as an Administration Clerk with effect from 1 July 2014. We wish him all of the best with his future.

HAEMOPHILLIA

What is Haemophilia?

Haemophilia is a rare hereditary disorder in which a blood clotting factor is missing or reduced. The most common type of haemophilia is factor VIII deficiency (haemophilia A). The second most common type is factor IX deficiency (haemophilia B). When a person with haemophilia is injured, he will have prolonged bleeding because a firm blood clot cannot be formed. Depending on the level of factor VIII or IX, the condition is classified as severe (<1%), moderate (1-5%) or mild (6-39%). Patients with severe haemophilia have multiple bleeding episodes, which often occur spontaneously. Moderate haemophilia results in less bleeding episodes, occurring only after trauma or procedures. Many patients with mild haemophilia remain undiagnosed since the bleeding episodes are very few and occur only after significant trauma or medical procedures.

How Does Someone Get Haemophilia?

Haemophilia is a sex-linked hereditary bleeding disorder transmitted on a gene of the X chromosome. The condition occurs almost exclusively in men, since women have two X chromosomes and it is quite unlikely for both of the chromosomes to have the haemophilia gene. In most cases there is a family history of male relatives on the maternal side of the family who were born with haemophilia. A spontaneous mutation is also possible, in which case there will be no family history. Very rarely a female with haemophilia is born if her mother is a carrier and her father has haemophilia.

Symptoms and Treatment of Bleeding Episodes

Bruises: Newborns with haemophilia may develop complications due to intracranial haemorrhage and circumcision usually produces prolonged bleeding. Intramuscular injections should be avoided. During the first few months of life, a baby with haemophilia has few problems because of limited mobility. As he learns to walk, he will fall and sustain many small, superficial bumps and muscle bruises (haematomas) which usually are not serious. **Deep Muscle Bleeding (Haematoma)**: As a child with haemophilia matures, he becomes more active and will have more bleeding episodes. Joint bleeding occurs most frequently in the knee, ankle and elbow joints. Bleeding from the gums or teeth, nose bleeds and haematuria (blood in the urine) may also occur. **Joint Bleeding (Haemarthrosis):** An early sign of bleeding is the reluctance to use the painful affected limb, as well as mild swelling. As more blood accumulates in the joint, it feels warmer and the swelling worsens. Later the limb is held in a flexed position to ease the pain, which can be quite severe. If untreated, the bleeding continues until the area feels hot and hard. Usually there is no bruising associated with a joint bleed. Early treatment with the missing clotting factor will stop the bleeding and prevent the pain from worsening. Recovery will be quick, although the joint will sustain some permanent damage. Inadequately treated bleeding irritates the joint surface, which eventually leads to arthritis and joint deformities. **Major bleeding episodes** include intracranial haemorrhage, bleeding around the airway (neck), hip or iliopsoas muscle bleeding, major trauma, gastrointestinal bleeding, severe joint bleeding and forearm compartment. It is crucial not to delay treatment especially in the case of major bleeding episodes.

How is Haemophilia Treated?

There is currently no cure for haemophilia, but ongoing gene therapy trials are promising. Products used to treat haemophilia in South Africa are mostly plasma-derived factor VIII and IX concentrates (made from donated human blood plasma). Newer recombinant products (manufactured in a laboratory) are unfortunately too expensive for our setting. All treatment products are given intravenously and patients are taught from a young age how to prepare the products and administer it themselves (home therapy). Primary prophylaxis (regular administration of treatment in order to prevent bleeding) is the standard of care. When uncomplicated bleeding occurs, treatment is usually required for three to five days. Surgery can be performed with great success, provided factor is given before, during and after surgery.

Physiotherapy is very important for joint rehabilitation and prevention of complications. Contact sport should be avoided, but swimming is an excellent sport to partake in. Patients should be educated about their condition and should always wear a Medical Alert bracelet. Medications to avoid include aspirin and non-steroidal anti-inflammatory drugs. Patients should attend a Haemophilia clinic at least annually for integrated care. Currently 87 patients with Haemophilia attend the Tygerberg adult and paediatric clinics, along with 32 patients with other bleeding conditions.For further information contact Judy Butler (South African Haemophilia Foundation) on 021 785 7140 or Sr. Anne-Louise Cruickshank (Haemophilia Nurse Coordinator Western Cape) on 082 788 1038. **(Adapted from a general information leaflet from the South African Haemophilia Foundation)**

Dr Anel van Zyl

HOPE TO HOME
INITIATIVE LAUNCHED

HOPE Cape Town recently launched the HOPE to Home initiative as an extension of its current programme of intervention. Rev. Fr. Stefan Hippler, founding member of HOPE Cape Town and Chairperson of the board of trustees of the HOPE Cape Town Trust, said: “The biggest emerging threat to HIV positive patients receiving ARVs is the lack of compliance and the resulting resistance to available antiretroviral drugs. At HOPE Cape Town we recognise the importance of addressing the obstacles to adherence. Retaining patients in care in the community, after being discharged from hospital, remains a challenge and initial integration of paediatric patients into their community healthcare facilities plays a major role in this retention.”

He continued: “We plan to facilitate the smooth transition between admission to Tygerberg Children Hospital and reporting for care at the local community health facility. Our HOPE to home team, based at the hospital, will provide counselling and practical support while the child is admitted to hospital. We will be preparing our little patients and caregivers for discharge, confirming follow-up appointments, visiting them at home and accompanying them to the local facility, where possible. We estimate that 150 to 200 children will require this service per month.”

HOPE Cape Town, located at the Medical School of the University of Stellenbosch – Tygerberg Campus, is a non-profit organisation providing outreach, education and counselling at community level, focusing on HIV/AIDS and TB in the Western Cape. HOPE Cape Town is linked to the University of Stellenbosch and cooperates with the Department of Paediatrics and “KID-CRU”, the Tygerberg Hospital research unit for paediatric infectious diseases.

HOPE Cape Town began their work in 2001 with its mission to impact the communities they work in and have been very successful to date. Having expanded their services to address the increasing need, they are now more reliant on the generosity of businesses and individuals to help fund their programmes.

To support HOPE or find out more about the work they do, please visit www.hopecapetown.com or phone 021 938 9930.

Above: HOPE doctor, Dr Jayne Cunningham with a patient at Delft Clinic

Above: Outreach Facilitator, Pauline Jooste on a home visit

Western Cape Government

Health

BETTER TOGETHER.