

A new approach to managing and delivering clinical services

It's important to ACC that our staff and the health practitioners with whom we work have the best clinical support they need to be able to provide the right advice to our clients. As part of that drive, the Clinical Services Directorate team (CSD) has been making some changes, and from 1 July a new structure will officially come into play.

The team's being led by newly appointed Peter Robinson, and has set a new strategic direction based on visible clinical leadership, enhanced clinical knowledge management and strengthened accountability for clinical performance.

We're placing client experience and outcomes at the centre of what we do, while providing a mechanism for sharing lessons learned and best practice. What that boils down to is health practitioners supporting each other.

We have health practitioners coming on board to join the existing team. They'll be providing a wide range of expertise, from allied health, dental and pharmacy to mental health, rehabilitation and surgery.

It's all about quality

Underpinning the new structure are mechanisms to ensure quality every step of the way.

A range of reference and review tactics will be used to monitor and improve communication, consistency and the use of clinical knowledge.

We want health practitioners to feel supported in what they do.

We can't do it alone

How we engage with health practitioners around the country is really important to us.

We'll continue to build on our existing relationships and work at identifying and developing new links in the clinical community.

We want to really understand how we can better support practitioners with the issues we all face in the health sector in New Zealand. That means carrying on our work with health practitioners to bring evidence-based medicine to the fore and to capitalise on areas of common ground.

This will mean working with a wider range of health practitioners collaboratively on strategic thinking.



Meet the man leading the new focus for clinical services at ACC

Doctor Peter Robinson recently took up the role of ACC's Chief Clinical Advisor, managing and leading the new structure of the Clinical Services Directorate.

He's supported by an experienced and energetic team and says he's looking forward to the challenges ahead:

“When I was first approached about the role of Chief Clinical Advisor, it was the vision and the direction ACC was taking that really caught my interest. ACC's focus is on those who've been injured and the rehabilitation that goes into getting them back to their everyday lives, or supporting them on the way to their new ways of life.

“As the new Clinical Services Directorate takes shape, I believe we'll bring change through a new approach to managing and delivering clinical services – both internally and externally.

“My team has already done a lot of work in developing a new structure that allows us to be more focused on engaging in a productive way with our clinicians. It's a more structured approach to knowledge management and I believe it'll cement our role as a thought leader in the clinical space. The results of this change will be faster and more consistent advice, positive rehabilitation outcomes, increased return-to-work rates and an improved overall client experience.

“I believe the team and the structure we are putting in place allow us to deliver best-practice guidelines and expert clinical advice and support modern clinical practices in a timely way. This will allow us to work together to deliver the vision of getting those who've had injuries back to their everyday lives as soon as possible.”

Peter has a strong background in advisory and consultancy roles to organisations including the *Medical Council of New Zealand, New Zealand Police, New Zealand Fire Service, Maritime Safety Authority, Ministry of Defence and Civil Aviation Authority.*

Changes to hearing loss regulations mean more benefits for more people

From 1 July 2014 a number of changes will be made to the way ACC manages hearing loss regulations.

The new regulations are the result of a close collaboration and public consultation with New Zealand's hearing loss sector and community groups.



There'll be more benefits to more people with hearing loss, from device purchase and fitting through to repairs.

Changes include:

Increased ACC payments for hearing aids

The current 10-band pricing model for hearing aid subsidies will move to a simpler three-band model – with ACC increasing its contribution.

A new flat fitting fee

A new flat fitting fee is being introduced to help reduce clients' overall costs. A fitting consultation allowance is also being introduced.

New funding for ear moulds

New contributions are being introduced for ear moulds – devices worn inserted into the ear for sound conduction/ear protection.

Introduction of multiple repairs

Clients will be able to take advantage of multiple repairs for their hearing devices.

Better access to services for children

A new ACC policy has been developed to meet the unique hearing loss needs of children under 18.

For more information, visit: acc.co.nz

Self-management design going strong

ACC's innovative Self-management pilot to give seriously injured clients more decision-making power and greater independence has reached an important milestone.

Since its launch in August last year, the pilot has quickly grown from a small group of clients in the Wellington region, with 33 now taking part throughout the North Island.

Most of those piloting Self-management have spinal injuries; they have all been ACC clients for more than five years and have 'stable needs'. That means they're able to predict what day-to-day supports they'll need in the next 12 months.

The Self-management pilot sees clients set up dedicated bank accounts, which they use to buy their own supports and services – things like prescriptions and general medical and equipment consumables. They make their own decisions about the services and supports they need.

Right from the beginning ACC's Self-management project team has been working really closely in partnership with our clients to make sure the service we're piloting is hitting the mark in meeting



their needs. We haven't just left our clients to manage completely alone. We've talked continually to find out how it's going and whether we need to make changes.

We've also been researching to gain insights from the pilot group. The feedback has helped us to reshape some aspects of the pilot. We've made some small changes and modified the process, and the consensus of our Self-management clients is that it's working well for them so far.

Self-management will be rolled out branch by branch throughout the rest of the year.

e is for 'everyone'

While more and more providers are seeing the benefits of working electronically with us, we know there's still a few of you that may need a little encouragement.

That's why, behind the computer screens and file servers, there's a team of people who can help make your shift to 'e' easy. Our e-business team is here to help get you confident with the technology, provide support along the way and basically make your job a little easier.

One of the easiest things to get started with is invoicing, because you've probably already got everything you need to get up and running. All it takes is one call to us and a computer with the right amount of grunt.

Smarter, faster, easier

Once you're up and running with e-billing you'll find invoicing:

- *more efficient* – invoices will get to us more quickly
- *more reliable* – data only gets entered once
- *more timely* – you'll be able to see all your transactions online
- *faster* – you'll save time as it's all done online
- *cheaper* – you won't have to pay for stationery or postage and it's free.

Why wait?

If you need a little encouragement to get up and running, we're here to make it easy. All you need to do is pick up the phone and give us a call on 0800 222 994 option 1 or email us at ebusinessinfo@acc.co.nz.

Elective Services Review completes first stage

The first phase of the Elective Services Review has wound up and we've been hugely appreciative of the involvement of the hundreds of stakeholders we've been working with through workshops and working groups.



Around 80 sector representatives and ACC staff attended a full day's session in April.

It was an opportunity for everyone to talk through the findings of the four working groups tasked with looking at patient outcomes, support services and delivery and the implementation of Elective Services.

The working groups have identified a number of key themes, including access, service integration, outcomes, communication, funding and workforce capability and capacity.

The review's considering the whole treatment pathway for patients, from the time they injure themselves to when they need surgery.

ACC will continue to work closely with the sector throughout the next phase of the review, leading up to implementation beginning in July 2015.

If you'd like more information, please email electivesurgerypathwayreview@acc.co.nz or contact ACC Review Manager Jane Kelley on 04 816 6224 or 027 497 4600.

ACC provider on the ground in Sochi – a Paralympics experience

As the spotlight fell on some of the world's elite athletes at the Sochi 2014 Paralympics Winter Games, ACC was helping to lead a charge back home to highlight the achievements of the Kiwi contingent.

ACC partnered with AttitudeLive to bring New Zealand extensive, live, free coverage of the Games.

Among those in Sochi providing support to the Kiwi team was physiotherapist Andrew Duff, who is no stranger to working in a high-paced environment to help our top disabled athletes reach their dreams.

Fresh from the success of the Games, where Corey Peters achieved great heights in his new sport of alpine skiing – clinching a silver medal in the giant slalom – Andrew talks of his involvement with our team to Russia.

It's all about preparation

With more than eight years' experience working with Olympic athletes and travelling the many corners of the globe with the New Zealand Winter Performance Programme, Andrew was part of the seven-person support crew for our athletes.



His role was to help the athletes with physical fine-tuning on the snow, in the gym and on the treatment table. No two days were the same. The schedule changed every day, depending on snow conditions, access to training areas, the timing of events and the physical condition of the athletes.

Each of the three athletes in the New Zealand team has different impairments to contend with. Corey Peters has a spinal cord injury that has left him paralysed from the waist down. A Vancouver 2010 Paralympic gold medallist, alpine ski racer Adam Hall has spina bifida that affects the strength and control he has over his legs. Snowboarder Carl Murphy is a below-the-knee amputee.

For Andrew, the most challenging part of the job is adapting to each athlete's unique needs, and dealing with the unexpected injuries that can happen at crucial times in competition, he says.

“Dealing with any events can at times put the therapist under the pump in regard to key decisions affecting participation, the dreams of the individual and the ultimate outcome.

“I enjoy the challenges of the high-performance environment and find them stimulating and rewarding to address, adapt to and overcome in conjunction with the athletes and support team.”

He says working with athletes in the Paralympic team is fantastically rewarding, because they are hungry for success and put in the hard yards on and off the snow.

“They are great guys to spend time with. It's always a pleasure to be involved with athletes and the management team, who have a passion that is so palpable.”

Golden moments

The Paralympic Games have provided Andrew with some golden moments.

“Working with Adam Hall when he won gold in 2010 was incredibly special and something I'll always remember. When Corey Peters skied himself into contention for a silver medal on his very first run at Sochi, I felt enormous pride at being associated with New Zealand athletes who achieve such greatness through study, grit and determination,” he says.

Even with the high-intensity and challenging demands of being an on-site treatment provider, it was a moment early in his career that Andrew holds dear as a highlight so far.

“From all my experiences, one of the most memorable career highlights was helping a lady who had had a stroke to learn to walk again as a fourth-year student in Wellington.

“Words can't explain just quite how incredible it felt to witness the amazing effect that physiotherapy can have in helping someone regain their independence and mobility.”

ACC is a proud partner of disability website [AttitudeLive](#) and of its Paralympic coverage. Visit [AttitudeLive](#).

Spotlight on injury prevention in the forestry sector

ACC has begun work on developing a new injury prevention programme aimed at encouraging safer practices in the forestry sector.

It's a joint approach, with the programme being developed and implemented in collaboration with WorkSafe New Zealand, the New Zealand Forest Owners Association (FOA), the Forest Industry Contractors Association (FICA) and the Council of Trade Unions.

Forestry workers Wiremu Edmonds and Neil Thomas will be the worker representatives in the new injury prevention programme.

Both are experienced forestry workers and passionate, experienced health and safety advocates – and in Wiremu's case, his passion is strengthened by the personal tragedy of having lost a son to the industry.

Figures show that, in the past 18 months, the safety record of New Zealand's forestry industry has lagged behind those of other New Zealand industries, as well as forestry sectors globally. Recent fatalities, 11 since January 2013, have highlighted ongoing safety concerns.

ACC's head of Insurance Products and Injury Prevention, David Simpson, says the new initiative represented a concerted, collaborative approach by key sector players to address the concerns.

The programme will involve eight separate streams of work, aimed at developing clearer, effective guides for workers on the ground, to influence them to make safer choices in their day-to-day actions.

Likely outputs of the programme include workshops and educational resources, such as assessment tools, videos and case studies, designed to address the range of tasks and situations that workers face on the job.

It's intended to complement the independent review of forestry safety, launched in January by FICA and FOA, which will address a broader palette of issues affecting safety in the sector.

“ACC's programme will focus on how we can help workers and employers to make safer decisions, minute by minute, on the job. The FICA and FOA review may address these factors, but it's also likely to explore bigger-picture issues such as how the sector is organised, how compliance is enforced and more,” says David.



Moving and handling people safely in a health care setting

In the health sector, one of the main contributors to ACC claims results from the moving and handling of people, and many carers suffer serious injuries over time in their various roles.

Presentations to numerous groups of health providers throughout New Zealand in 2013 indicated the need for a Post-Graduate International Certificate in the Moving and Handling of people in a variety of health care settings. ACC, the Auckland University of Technology (AUT) and Loughborough University in the United Kingdom have initiated a programme that will begin in August 2014.

The course is largely extramural with short periods of on-site block courses. The course will cover Health Ergonomics, Organisational Ergonomics: Concepts of Moving and Handling and a negotiated research project related to moving and handling people in a particular health care situation.

Details are available from:

- Dr Fiona Trevelyan, senior lecturer, Faculty of Health and Environmental Sciences, AUT, fiona.trevelyan@aut.ac.nz or phone 09 921 9999
- Dr John Wallaart, ACC Corporate Office, john.wallaart@acc.co.nz or phone 04 816 5409.

Case study – sharing information to enhance patient safety

This is an overview of ACC's treatment injury claims, with a focus on the patterns of accepted injuries. As always, our intention is to inform as well as promote learning and discussion.

EVENT: ACC treatment injury data patterns and learning

Did you know?

Between July 2005 and December 2013 ACC made almost 65,000 treatment injury decisions and provided cover for almost 41,000 clients whose injuries had been caused by treatment.

Who is lodging these claims?

In relation to lodging provider practice, between July 2005 and December 2013 43% of all claims were lodged from GP practices, 34% by staff working within district health boards (DHBs), 13% by practitioners at private hospitals or clinics and 10% from other types of practice.



Where did the treatment injury events occur?

48% of all the treatment injury claims lodged occurred at public facilities (DHBs), 45% at private facilities and 7% at individual private practices (where the facilities could not be identified).

What was the volume trend of these claims?

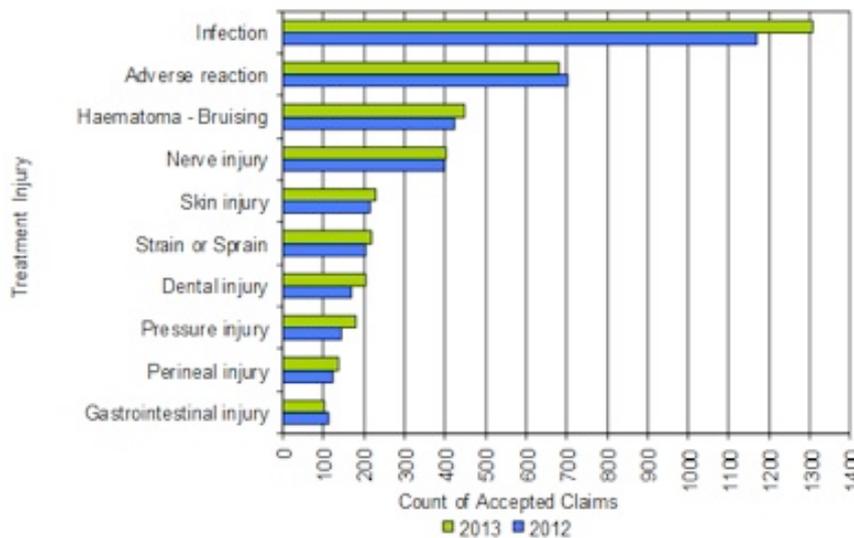
Treatment injury claims grew rapidly in comparison with medical misadventure claims in the first four years of the scheme, after July 2005. Much of this growth was in high-volume, low-cost injuries, such as allergic reactions. There was some growth in more serious treatment injury claims from 2005, but these were lodged under the previous medical misadventure legislation.

In the following three years (July 2009 – June 2012) claim growth levelled at between 8,000 and 8,500 claims, with growth from July 2012 to June 2013 reaching almost 10,000 claims.

What were the most commonly accepted treatment injuries nationally?

Although the top 10 treatment injuries were generally high-volume, low-cost injuries, each injury category contained a small number of high-cost and serious injury claims.

National top-10 accepted treatment injuries 2013 vs 2012



Learning from treatment injuries and what’s happening regarding the prevention of these injuries:

Infection:

These claims were most commonly associated with the orthopaedic context, with 26% of all accepted wound infection claims arising from orthopaedic treatment. The most common event categories resulting in infection were removal of skin lesion and knee and hip surgery/replacement.



Surgical site infections (SSIs) are a significant problem worldwide, and although some of these infections are minor, they can still cause emotional and financial stress, long hospital stays, long-term disabilities etc. The consequences for health services, and more importantly patients, mean that preventing SSIs is extremely important. To address this, in 2012 the Health Quality and Safety Commission launched the Surgical Site Infection Improvement Programme – New Zealand’s first national quality improvement programme to reduce the incidence of SSIs. For further information, please follow the link: www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/projects/surgical-site-infection-improvement.

Adverse reaction:

These claims commonly related to the more routinely prescribed antibiotics, such as amoxicillin, Augmentin and flucloxacillin. The number of these claims decreased in 2013 compared with 2012. There were some major adverse drug reaction claims (e.g. involving warfarin and trimethoprim) that were accepted.

ACC has published interesting case studies on alerted major drug reactions; the latest case study on medication adverse reaction can be found at the following link: www.acc.co.nz/for-providers/clinical-best-practice/case-studies/index.htmw.

Pressure injury:

There has been a general pattern of increased pressure injury claims over the years. These claims have mostly related to nursing care. Pressure injuries are usually preventable when certain steps are taken. Accepted claims for pressure injuries normally relate to inadequate pressure area prevention or management, for example no risk assessment, no prevention plan or a lack of pressure area care.

The Clinical Practice Guideline for the Prevention and Management of Pressure Injury presents a comprehensive review of the assessment, diagnosis, management and prevention of pressure injuries within the Australian, New Zealand, Hong Kong and Singapore health care contexts, based on the best evidence available up to August 2011. The Guideline is designed to provide information to assist in decision-making and is based on the best information available at the date of compilation.

The Guideline was developed by the Australian Wound Management Association and its subcommittee the Australian Pressure Injury Advisory Panel, in partnership with independent, multidisciplinary experts throughout Australia and the New Zealand Wound Care Society, the New Zealand Nursing Service, the Singapore Ministry of Health and the Hong Kong Enterostomal Therapists Association.

Other treatment injuries:

The following are the other treatment injuries in our top-10 list by volume. If you are aware of any useful information or learning, please send your feedback to Ti.info@acc.co.nz.

Haematoma – bruising:

These claims were most often lodged in relation to vascular access failure (with IV cannulation and venous puncture the most common). There was a smaller proportion of claims relating to major surgical haematomas, and a very small group of serious injuries to the spinal cord secondary to haematomas.



Nerve injury:

These claims most commonly related to vascular access, spinal surgery, hip/knee surgery/ replacement and dental treatment.

Skin injury:

These claims were most commonly associated with nursing events, with 27% of all accepted skin injury claims associated with nursing treatment. The most common event categories resulting in skin injury were wound care and more specifically removal of dressings. Patient transfer was the next most common, shared with vascular access failure and strapping, tape or bandage.

Strain or sprain:

These claims most commonly related to positioning, manual therapy involving spinal and neck manipulation, dental treatment and interventional delivery leading with ventouse. Strain or sprain was most commonly associated with the maternity, radiology, dental, orthopaedics and physiotherapy contexts.

Dental injury:

These claims related most commonly to general anaesthetic, endotracheal intubation and intubation – other, and to dental treatment including tooth extraction and root canal treatment.

Perineal injury:

These claims related most commonly to interventional delivery with forceps delivery leading. The next most common event category was vaginal repair relating to the gynaecology and urology treatment contexts.

Gastrointestinal injury:

These injuries related most commonly to gastrointestinal injury scoping procedures and bowel surgery. Perforations of bowel and oesophagus were the most commonly accepted injuries.

The ACC website contains further information on treatment injury, along with all previously published treatment injury case studies (www.acc.co.nz/for-providers/clinical-best-practice/case-studies/index.htm).

Key messages:

- Consent from the client is always required to lodge a treatment injury claim
- It is important to send the treatment injury claim form (ACC2152) and all the relevant medical information at the time of lodgement to ensure timely rehabilitation support and assistance to the client
- ACC covers only injuries, not underlying health conditions; hence if there is no injury as a result of treatment there is no need to lodge a claim
- ACC provided cover for rehabilitation and assistance for almost 41,000 treatment injury claims between July 2005 and December 2013
- Treatment injury claims relating to infections, nerve injuries and pressure injuries have increased over the years and some of these are preventable.



Claims information:

Between July 2005 and December 2013, 65,230 treatment injury claims were lodged, of which 64,812 were decided.

Of the 64,812 decided treatment injury claims, 40,762 (63%) were accepted and 24,050 (37%) were declined.

The most common reasons for declining claims were that no physical injury could be identified (45%), there was no causal link between treatment and the injury (31%), the injury was an ordinary consequence of treatment (12%) and the injury was wholly or substantially caused by an underlying health condition (7%).

***Only claims attributed to the Treatment Injury Fund are included.*

Endometrial thermal ablation

In this case study we give an overview of 'Endometrial thermal ablation' and feature expert commentary on how similar injuries might be avoided.

EVENT: Endometrial thermal ablation

INJURY: Endometrial ablation burns

Case study

Janine, a 37-year-old woman with two children, had suffered from menorrhagia for many years.

Her other medical problems included hypertension and depression, for which she took citalopram. She also took iron tablets. Janine's menorrhagia had previously been treated with a Mirena® Intrauterine System, as well as oral contraceptives. These had not been fully effective, so Janine and her gynaecologist agreed to surgical treatment in the form of endometrial thermal ablation.

Janine had a thermal ablation and post-operatively was in a lot of pain. This continued to worsen over the following two days and she developed abdominal distension. A computerised tomography (CT) scan was performed, which showed a full-thickness endometrial burn, as well as burns to the sigmoid colon and rectum. Janine was taken to theatre for a washout and was treated with intravenous antibiotics. She fortunately improved and was discharged.

Some days later Janine came to hospital after developing worsening abdominal pain. She had been passing flatus and blood vaginally, and had some rectal bleeding. Janine was taken to theatre where a necrotic cavity was found between her uterus and rectum. An en-bloc hysterectomy and bowel resection with anastomosis was performed, leaving Janine with an ileostomy.

Following this procedure Janine became septic and needed intensive care. A peripherally inserted central catheter (PICC) line was inserted for antibiotics and parenteral nutrition. She made a slow recovery and was discharged three weeks later with ongoing support at home.

A treatment injury claim was made for Janine's rectal and uterine burns with necrosis leading to rectal resection and ileostomy, hysterectomy and sepsis. ACC accepted the claim as the



complications were due to the failure of the equipment used during the thermal endometrial ablation treatment. ACC was able to assist with the costs of Janine's treatment for the injuries and provide support at home while she was recovering and extra time off work.

Expert commentary:

Sylvia Rosevear, obstetrician and gynaecologist

This case illustrates the very severe consequences for a patient who has consented to a minimally invasive procedure – the effects of which are usually assessed in terms of the primary outcome measures of amenorrhea, heavy bleeding, patient satisfaction (generally 80%) and hysterectomy rates. The management of this case involved not only the local complications, but also the severe intra-abdominal complications relating to the bowel burn. The patient required multidisciplinary treatment. Thermal bowel injury is the most commonly reported life-threatening injury (86% due to radiofrequency endometrial ablation and 5% due to thermal balloon); 80% of the injured required bowel resection. Creating a false passage is a risk with ablation that potentiates thermal damage.

Endometrial ablation is done by second-generation devices in order to minimise the risk of severe injury and the technical difficulties of the procedure (related to hysteroscopic techniques), and to give a more uniform clinical result.^{1,2} It is simpler to perform, has a shorter operating time and can be done under local anaesthetic. This particular case used MenoTreat™, which is now not available in New Zealand. The severe complication was a problem of probable endometrial cavity perforation. In order to cause the bowel burns, perforation was likely to have occurred as more fluid added with the pressure drop outside the uterus.

Additional adverse events from endometrial ablation include pelvic cramping (from prostaglandin release), nausea and vomiting, rupture of the uterus, infection, post-ablation tubal sterilisation syndrome and haematometra.

There are three second-generation devices generally available in New Zealand. Two are balloon-type devices – Thermachoice™ (Johnson & Johnson), Thermablate EAS™ (Idoman) and Nova Sure®, which is radio frequency ablation. Thermachoice™ is a water-based system that takes longer. Thermablate™ uses glycerine, which is heated to 173 degrees outside the uterus. It only allows a maximum 28ml of fluid – on average 4-12ml to pressurise an average-size uterus – and the machine controls the fluid volume and pressure. A larger uterus can be treated with Thermablate™, which takes two minutes and six seconds. Nova Sure® (Hologic) uses bipolar radiofrequency electrical energy to ablate, and has a higher amenorrhea rate. It can only ablate an endometrial cavity measuring 8-10cm. Nova Sure™ checks endometrial cavity integrity with carbon dioxide into the cavity. It is a proactive test of endometrial integrity before starting the procedure, whereas balloon methods alarm if the pressure goes down. It will detect a perforation equivalent to an 18-gauge needle. It vaporises the endometrium down to the myometrium. The results therefore are not affected by endometrial thickness. It ablates 5-7mm in the fundus and 2-3mm at each cornua. It draws the endometrial cavity down onto the device. Microsulis™ (microwave ablation) is now not available in New Zealand.

Consent should be clear and some reference made to the instrument being used and potential risks.³ The MAUDE (Manufacturer and User Facility Device Experience) database is a source of updated



information on complications of devices. It includes medical device reports submitted to the United States Food and Drug Administration by mandatory reporters (manufacturers, importers and device user facilities) and voluntary reporters such as health care professionals, patients and consumers. In general, complication rates can be up to three times what might be stated by a company.

Key points:

Contraindications to ablative procedures:

- Myomectomy (no previous surgery)
- No intrauterine pathology e.g. fibroids
- No previous pelvic inflammatory disease/abdominal surgery
- Classical caesarean section
- Previous endometrial ablation
- Myometrial thickness of caesarean section scar less than 8-10mm
- Uterine cavity less than 4cm
- Uterine length (cervix to fundus) no more than 12cm
- Abnormal uterine shape

Consider cervical softening agents if dilatation is anticipated to be difficult

Abandon procedure if any concern about possibility of perforation of the uterus

Inform patient to expect rapid to normal recovery post-procedure, and ask them to seek treatment if they deteriorate – ensuring that adverse events related to the device can be notified to regulatory authorities.⁵

References/Websites:

1. Daniels J.P., Middleton L.J., Champaneria R., Khan K.S., Cooper K., Mol, B.W.J., Bhattacharya S., on behalf of the International Heavy Menstrual Bleeding IPD Meta-analysis Collaborative Group. Second generation endometrial ablation techniques for heavy menstrual bleeding: network meta-analysis. *BMJ* 2012;344:e2564 doi:10.1136/bmj.e2564 (published 23 April 2012).
2. The Cochrane Collaboration, The Cochrane Library, 2013, Issue 8. Endometrial resection and ablation techniques for heavy menstrual bleeding (Review). Lethaby A., Penninx J., Hickey M., Garry R., Marjoribanks J.
3. Brown J., Blank K. Minimally invasive endometrial ablation device complications and use outside of the manufacturer's instructions. *Obstetrics and Gynecology* 2012; 120 (4) 865-870.
4. Guidance on the responsibilities of manufacturers, the regulator and clinicians with respect to endometrial ablation. The recommendations of a joint workshop February 2011. Medicines and Healthcare Products Regulatory Agency. RCOG. British Society for Gynaecological Endoscopy.
5. To report incidents: www.medsafe.govt.nz/regulatory/devicesnew/9adverseevent.asp



Claims information:

Between July 2005 and March 2014 ACC received 3174 claims relating to the gynaecology treatment context. Of these, 70% were accepted and 30% were declined. Of the 3174 decided claims 18 were ablation-related injuries, of which 14 were accepted and four were declined.

The most common reason for declining a claim was no injury identified or that there was no causal link between the treatment provided and the injury claimed.

Working towards even better outcomes for clients returning to work after injury

ACC's Clinical Review for Fitness for Work (CRFW) service is being reviewed to make sure it's doing what it was designed for – helping injured clients to return to work safely and quickly.

ACC Research is evaluating the service, which was launched nationally in October 2012, to better understand what works and whether there's scope for any improvement.

While we're inviting a small number of GPs and CRFW providers to be part of the review, we're interested in hearing from anyone who has used the service. You can email your thoughts and experiences of the service to sarah.trevethick@acc.co.nz.

Leptospirosis in New Zealand – ACC Review

Recent publications in the New Zealand Medical Journal highlighted that leptospirosis remains an important zoonotic disease, and its occurrence is significantly under-reported¹.

ACC has published an updated overview of best clinical practice which can be found here: www.acc.co.nz/=leptospirosis+best+clinical+practice.

The ACC Review was developed in collaboration with the infectious diseases specialist, Wellington Regional Public Health, WorkSafe New Zealand and a group of subject matter experts that included GPs and occupational medicine specialists. Although the article is aimed primarily at rural GPs, it can be used by all health practitioners to gain a better understanding of leptospirosis and its management.

¹ Mansell C, Benschop J. Leptospirosis is an important multi-species zoonotic disease in New Zealand 2014; 127(1388):5-8.



Treatment injury claims – the right information at the right time

This is a reminder to treatment providers to lodge treatment injury claims as soon as possible after an incident. It's important to make sure you've sent in the ACC45, an ACC2152 treatment injury claim form and all relevant clinical records, reports and investigation results.

It's also important to remember to send us any new relevant information as it becomes available.

We're changing the way we help people with hearing loss

ACC has been working with the hearing sector and the Ministry of Health to improve services for people with hearing loss.

From 1 July 2014 we're increasing funding across a wide range of services, including hearing aids, fittings and repairs. We're also changing the way we help children with hearing loss through injury – making it much easier for them to access services as their needs change.

Find out more about what's changing with hearing loss services by visiting www.acc.co.nz/hearingloss.

Funding decision on prolotherapy treatment

The Purchasing Guidance Advisory Group has decided not to fund prolotherapy treatment, or any variation of it, as a pain management option.

The recommendation was that due to limited evidence of the treatment's clinical effectiveness, ACC won't be purchasing or endorsing the use of prolotherapy for any indication.