associated with lower psychological distress (PR=0.86, 95% CI 0.74-0.96, p=0.01) but higher smoking (PR=1.15, 95% CI.1.02-1.31, p=0.03). Physical activity was nominated by 42% of employees as the behaviour they could change to improve their health, with 78% of these indicating they were currently trying to make the change.

Conclusions

The importance of promoting physical activity was recognised by most departments and was endorsed by employees. This naturalistic evaluation faces challenges in engaging employees with research, accurate assessment of intervention exposure, and attributing change to these interventions.

Outbreak of cholera in Papua New Guinea, 2009–2011 117

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Background

The first cholera outbreak in Papua New Guinea was confirmed by the Port Moresby General Hospital's laboratory in July 2009. Surveillance data through 25 February 2011, provided by the National Department of Health, PNG, indicated that the outbreak had spread to seven provinces. Since the beginning of the outbreak in July 2009, there were 11,888 cases and 483 deaths, with a case fatality ratio of 4.1%. A total of 267 samples were confirmed positive for Vibrio cholera. Male accounted for 53.5% and female for 45.2% of all cases. A majority were older than five years (73%). Oral rehydration solution (ORS) points were established and awareness campaigns were launched in affected provinces. Provinces with early establishment of ORS points, awareness campaign and emphasis on change of funeral practice appeared to control the outbreak more effectively.

Acuity and severity of patients attending 28 Queensland hospitals emergency departments in 2008-09 118

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Background

Overcrowding of hospital Emergency Departments (EDs) in Australia is a complex issue of high public and professional prominence, resulted from a combination of increasing demands, increased complexity of care and Access Block. The aim of this study is to describe the distribution of the acuity and severity of current Queensland ED patients to better understand ED users.

Methods

The Queensland Health Emergency Department Information System (EDIS) collates data from all public hospital EDs in Queensland. Data was extracted to identify the acuity of patients (as measured by Australasia Triage Scale, ATS) and the outcome of those patients following ED care. Hospitals were characterised into three categories: Principal referral & Specialist hospitals, Large major hospitals and regional and Medium and small hospitals.

Multinomial Logistic Regression was applied to analyse if the departure status from three different groups of hospitals varied when controlled the ATS categories.

Results

Data was retrieved on over one million patients attending 28 public hospital Emergency Departments in Queensland in 2008-9. There were 10% of patients triaged into ATS1 Resuscitation & ATS2 Emergency while over half of the total patients into ATS 4 Semi-Urgent & ATS 5 Non-Urgent. Less than a quarter of the patients were admitted to hospitals or observation wards. There were almost 85,000 patients that attended hospital EDs but did not wait for ED service to start or finish and left ED. When controlled for triage acuity, patients are more likely to be admitted, more likely to not-wait, and less likely to die at principal referral and specialist hospitals than other hospital groups.

Conclusion

The majority of current patients attending Emergency Departments in Queensland hospitals are for semi-urgent and non-urgent illness. The differences in ED service outcome may reflect variances in utilisation among hospital groups.

SMRP expression in a cohort of Australian asbestos-exposed power industry workers 119

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Background

The study aims to assess the natural history of serum mesothelin-related protein (SMRP) expression in a cohort of asbestos-exposed power industry workers in the Latrobe Valley of Victoria (Australia). This region has the state's highest rates of mesothelioma from past asbestos use.

Methods

618 persons consented and completed questionnaires on demographics, employment and exposure histories, and self-reported health. Blood samples were collected annually over 36 months for analysis of mesothelin (SMRP) levels. Baseline mesothelin levels were analysed in relation to age, asbestos exposure history and co-morbidities (cross-sectional).