THE AUSTRALIAN

HOSPITAL HEALTHCARE

BULLETIN SPRING 2016

GOING VIRAL

Focus on Infection Control

Credentialling, Culture Change & Cytoxic T Cells

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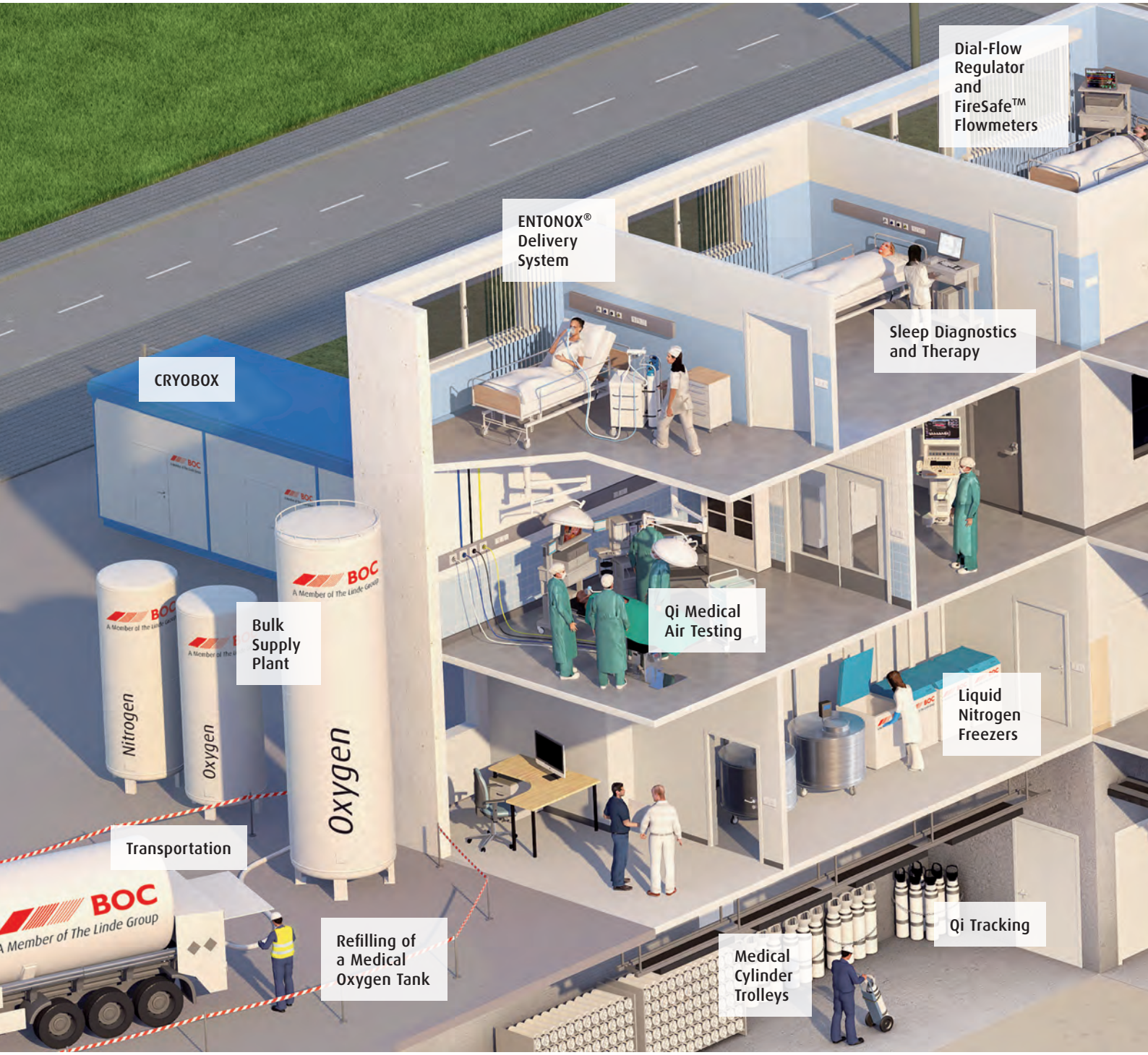

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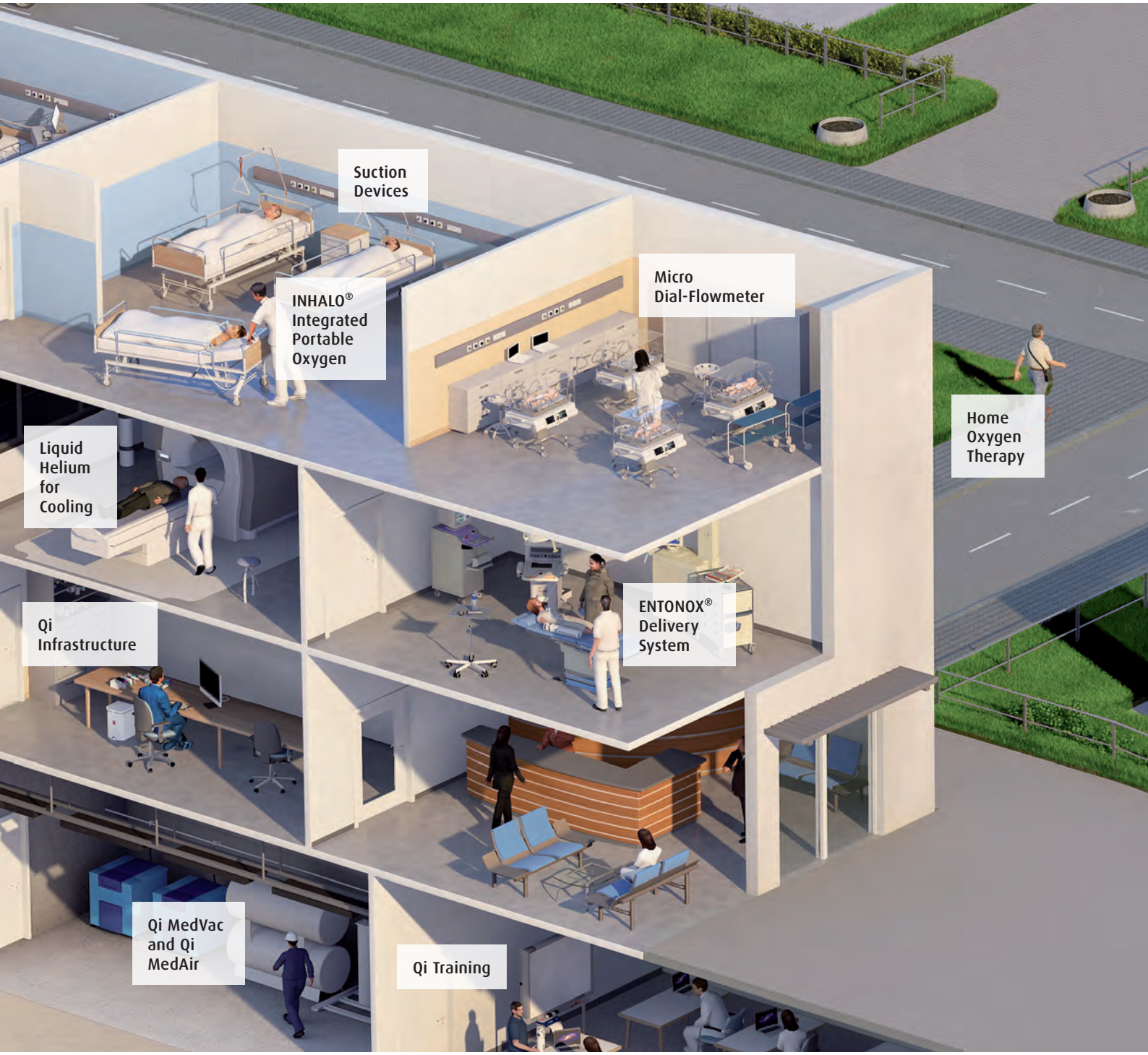

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McQuoin Park - Promoting Wellness in Aged Care

In May 2016, Catholic Healthcare commenced construction of a $120 million development project at McQuoin Park in Waitara, New South Wales.

Friendly Vs. Functional

Aaron Fertjowski and *Shawn Godwin* of Base Craft Medical, share their views on why hospital design and build has never been more challenging.

IN FOCUS

Panel of Experts

In this issue our expert panel weighs in on the question - *'What are the implications for patients and healthcare workers in a culture of open disclosure and why do we still find it hard to say sorry?'*

EMERGENCY MEDICINE

Emergency Medicine in Rural Mali

Dr Lisa Umphrey describes how Médecins Sans Frontières is working to prevent infant mortality in southern Mali where opportunistic infections are creating havoc.

FEATURES Food Services

Dysphagia in Head and Neck Cancer
– the role of the speech pathologist

Professor Liz Ward is a leading clinician and researcher in dysphagia management and head and neck cancer (HNC) care.

Enjoying a meal 'experience' makes all the difference

Jacquie Krassie (APD), explains why a positive meal experience is vital for older people to remain living independently.

Identifying malnutrition and boosting nutritional intake in aged care

Liz Purcell (APD), is presenting at the Institute of Hospitality in HealthCare Conference (IHHC) in Tasmania, 17-19 October.

Building Capacity through Collaboration

John Kirwan takes a progressive look at the future of food security for health services.

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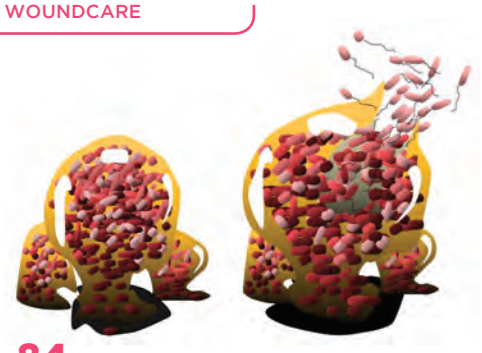

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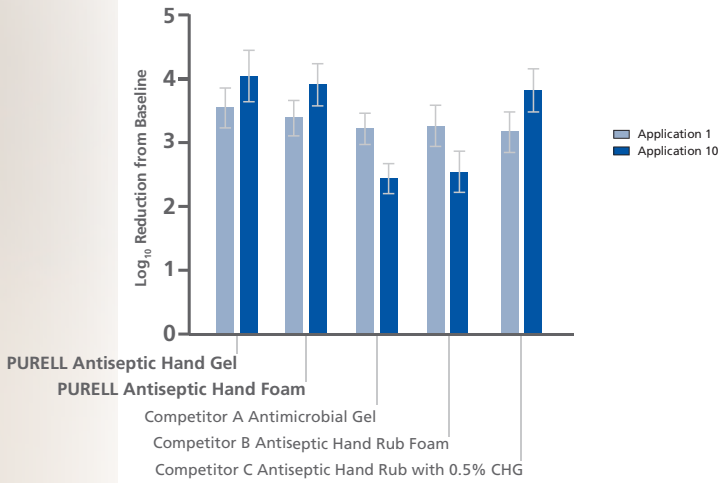
Published quarterly, The Australian Hospital and Healthcare Bulletin is an independent voice for the hospital, health and aged care professional containing regular features on major projects, healthcare disciplines, eHealth, Government updates, news, conferences and events.

One touch – the best way to kill germs in one pump

- Breakthrough entire hospital formulations with exceptional antimicrobial efficacy.[1]
- Feels great to use and clinically proven to maintain skin health.[2]

Efficacy Test Results for
PURELL Antiseptic Hand Gel and PURELL Antiseptic Hand Foam
vs. Competitive Products Commonly used in Australian Hospitals[3]



1. EN12791, Studies SN13045, SN14886, HygCen Schwerin, Germany. EN1500, Studies SN1086, SN 13912. HygCen Schwerin, Germany.
2. 4-Week Clinical Field Studies #2011-F10232, #2011-F10233. Akron, OH, USA. February – March, 2011; 21-Day Cumulative Irritation Assay, Studies 2866, 3024, RCTS, Irving, TX, USA
3. ASTM E1174 HCPHW study with 2 ml application. Studies #110103-101, April 5, 2011; 111209-101, March 8, 2012; BioScience Laboratories, Bozeman, MT, USA

8 out of 10 Australian nurses prefer PURELL® Antiseptic Hand Rubs[4]

4. Stancombe Research and Planning, Australian Nurse User Preference Test, 2013, Australia.

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EDITOR
Corin Kelly 07 3218 6537
ckelly@aprs.com.au

PUBLICATION MANAGER
Nicky Stanley 07 3229 5022
nstanley@aprs.com.au

ART DIRECTION
Dan Hancock 07 3012 7400
dhancock@aprs.com.au

Aaron Sammut 07 3229 5344
asammut@aprs.com.au

DIGITAL DEVELOPER
Elnaz Gharaee
egharaee@aprs.com.au

CONTRIBUTORS
Aaron Fertjowski, Andrew Stewardson, Carol Trevor, Charlie Farah, Colin Thompson, Debora Picone AM, Dorothy Kamaker, Jacquie Krassie, John Kirwan, Kate Ryan, Kristen Michaels, Dr Lisa Umphrey, Liz Purcell, Dr Mark O'Brien, Prof Liz Ward, Prof Nick Santamaria, Prof Ramon Shaban, Dr Sarah Maddocks, Sean Rooney, Shawn Godwin, Prof Tina Cockburn

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GOING VIRAL
COVER FEATURE

"If anything kills over 10 million people in the next few decades, it's most likely to be a highly infectious virus rather than a war. Not missiles, but microbes."

This observation comes from Bill Gates, speaking on behalf of his Global Health Program in 2015.

GOING VIRAL
Infection Control

Are we ready for the next epidemic? In Bill Gates' opinion, one that is shared by many leading infection control experts, we are not.

Having invested heavily in military defence, we have invested very little in a system to stop an epidemic. The Hollywood crack team of highly funded and mobile epidemiologists, ready to respond to an international microbial threat, do not exist.

In the lead up to the ACIPC Conference in Melbourne, November 20-23, President, Ramon Shaban, explains how ACIPC is tackling this issue through a revised credentialling framework that provides a formalised career pathway for infection control professionals. Credentialling recognises experts in the field of infection control and is a vital step towards organising an effective response to infectious threats.

Médecins Sans Frontières (MSF) was a vital part of the response to Ebola, mobilising and orchestrating volunteers to contain the spread. In this Spring issue of AHHB we hear from *Dr Lisa Umphrey*, MSF Australia Medical Advisor about opportunistic infections wreaking havoc on the child population of Koutiala, southern Mali.

Design in Health takes a look at the integrated design applied to the McQuoin Park aged care development in Sydney and the challenges hospital design faces in the 'push for plush'.

In Food Services, *John Kirwan* encourages us to take a peek outside the box at potential partnerships with non-health organisations to ensure food security and address the rise in co-morbidity.

Dr Elizabeth Marsden takes us into the world of the GEDI nurses, bringing geriatric care to the front line while *Dr Sarah Maddocks* investigates biofilms and the strategies being developed to combat them.

Over the years we have benefited greatly from Professor Colin Thomson's insights in his regular Ethics column. We say farewell to Colin in this issue and thank him for sharing with us his knowledge and passion for ethics in medicine.

Our team strives to deliver inspiring and solution-based stories from around Australia and the globe. I hope you enjoy reading this issue of Spring AHHB as much as we have enjoyed bringing it to you.

Corin Kelly
Editor, AHHB
ckelly@aprs.com.au

WANT TO CONTRIBUTE?

We welcome articles and research reports from health professionals across Australia for review for the quarterly print publication and our daily web page. If you have a story you think would be of interest, please send an email to **ckelly@aprs.com.au.**

Registered nurses

Increase your scope of practice and sphere of professional influence through these higher education options

Immunisation Courses

Have you considered becoming a **Nurse Immuniser**?

ACN offers an online Immunisation course that is designed for registered nurses working in health areas where administration of immunisation is part of their role.

It is also suitable for registered nurses who wish to enhance their career opportunities by becoming a **Nurse Immuniser**.

Delivered online over 12 weeks. Completing this course will help you develop the knowledge and skills to confidently and competently deliver an immunisation service that is safe, timely and appropriate.

- Enrolments are monthly (excluding January)
- This course has been approved by the Health Departments in NSW, VIC, TAS, SA and ACT*

*Successful completion of this course is one of the requirements necessary for RNs to administer vaccinations without the direction of a medical officer (ACT legislation differs, please refer to course information for details)

Principles of Emergency Care Course

Do you have the knowledge and skills to make decisions when lives hang in the balance?

ACN offers an online course in **Principles of Emergency Care**, designed for RNs and ENs working in any clinical setting in metropolitan, regional, rural and remote areas. It equips you with the knowledge and skills needed to render first-line emergency care in emergency/critical situations.

It will also enhance your critical thinking and problem-solving skills, and your confidence in decision-making when providing care to patients during emergency situations.

- Build on existing knowledge and understanding of principles of emergency nursing care
- Demonstrate assessment skills in prioritising care of critically ill patients
- Apply problem solving and clinical decision making skills in the management of deteriorating patient conditions
- Implement communication strategies that support interdisciplinary collaboration and patient-centred care
- Plan and evaluate patient management using clinical practice guidelines and current evidence

The Rounds
Updates in Healthcare

EDUCATION

Medicine's Clever Dummies

Professor Harry Owen of the School of Medicine at Flinders University has been using high-tech mannequins and models to teach medical students the elements of anatomy and to learn a range of medical and surgical procedures for the past 20 years. His interest in the technology has led him to write an illustrated history, Simulation in Health Care Education.

Professor Owen, a clinician, researcher and teacher in the Department of Anaesthesia and Pain Medicine, said the inventors and manufacturers of models and simulators have displayed extraordinary imagination and ingenuity in creating their imitations of human anatomy and physiology.

He says there has been a strong resurgence in the past 25 years in the use of simulation in the early stages of medical training. "Medical schools are once again realising the benefits of allowing students to learn the basics of risky and invasive procedures without putting real patients at risk."

"Now", he says, "the dummies are back, and better than ever."

Simulation in Health Care Education: An Extensive History is published by Springer.

INFECTION CONTROL

Boosting our response to infectious disease outbreaks

Infectious diseases can disrupt health and society, globally and locally. University of Sydney researchers will partner with other leading national experts in clinical, laboratory and public health research on a new $5m initiative to boost Australia's capacity to respond rapidly to infectious disease outbreaks.

Funded by the National Health and Medical Research Council, the Australian Partnership for Preparedness Research on Infectious Disease Emergencies (APPRISE) initiative will focus on major infectious disease threats such as influenza, coronaviruses, haemorrhagic viral diseases, arboviruses, novel pathogens and antimicrobial resistance.

DIGITAL

Monash Health begins major digital upgrade to standardise care and improve patient safety

Monash Health, the largest public health service in Victoria, is embarking on the first step of its major digital transformation with the integration of an electronic medical record (EMR) system with Order Sets, a solution from Elsevier.

Order Sets will be rolled out as a key part of the first stage of the EMR system. They provide clinical decision support by delivering real-time, evidence-based prompts and make it easier for clinicians to do "the right thing." This move to digitise patients' medical records along with providing medical staff quick access to evidence-based content with Order Sets will help to standardise clinical practice, reduce medical errors and streamline workflows, all of which ultimately result in safer and better quality care outcomes for patients.

RESEARCH

Mount Kilimanjaro trek looks for answers to pulmonary hypertension

Improving our understanding of pulmonary hypertension and heart failure by measuring the effects of increased altitude is the aim of Griffith's Professor Norm Morris as he climbs Mount Kilimanjaro with the Heartclimb medical research expedition.

Professor Morris will trek with 30 climbers from base camp in Mount Kilimanjaro at 7,380ft to the summit at 19,340ft.

"We will be studying the responses to exercise of between 20 and 26 healthy climbers aged over 60, measuring how much they breathe along with their oxygen consumption and carbon dioxide gas production as we increase in altitude up the mountain. In addition, we will examine how much they desaturate during exercise," says Professor Morris.

"This is a unique model to study and it will also provide us with novel data related to the acute onset of pulmonary hypertension and heart failure in a large group of older individuals, who may be more susceptible."

Pulmonary hypertension is complex. Whilst relatively rare, patients often develop symptoms quite suddenly and often without any known cause.

Griffith University

DIAGNOSTICS

WA launches world first initiative to diagnose rare diseases in aboriginal children

"Pilbara Faces" will build the world's first resource of 3-D photographs of Aboriginal children's faces - a unique knowledge-base to assist in medical diagnosis, treatment monitoring and clinical research. The initiative will be funded by Roy Hill Community Foundation has partnered with Perth Children's Hospital Foundation

The facial imaging project is led by Perth's Dr Gareth Baynam, of Genetic Services Western Australia (GSWA), who uses 3D images to identify subtle variations in facial contours, often imperceptible to the naked eye.

He says, "Our face is a biological billboard that advertises our physical and mental wellness, our aging and our disease. Approximately one third of genetic and rare diseases are thought to have subtle facial clues, so harnessing these through 3D facial analysis will provide a new way to improve diagnosis and treatment."

The non-invasive test and analysis only takes 20 minutes and will give families a new way to find answers for children with long-standing, very complex, usually multi-system disorders that were previously undiagnosed.

PUBLIC AWARENESS

Australian attitudes costing lung cancer patients' lives

A new report released from Lung Foundation Australia (LFA) highlights how despite being Australia's biggest cancer killer, responsible for more deaths than breast, prostate and ovarian cancer combined, lung cancer gets the least empathy from Australians, largely due to its association with smoking.

The stereotyping is impacting diagnosis and access to treatment and is contributing to a disturbing 15% survival rate five years after diagnosis, compared to the 90% survival rate for breast cancer and 94% for prostate cancer.

LFA CEO Heather Allan says "Unlike other cancers, lung cancer patients face constant questioning around their earlier life choices that may or may not have contributed to the disease."

One in three women diagnosed with lung cancer has never smoked and occupational exposure contributes to 29% of lung cancer in men.

"Lung cancer doesn't discriminate and neither should we," she says.

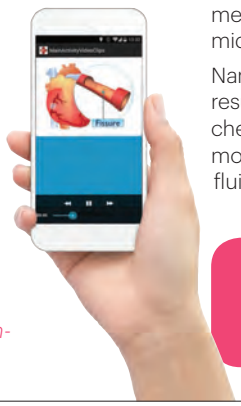
People can show their support for "Improving outcomes for Australians with Lung Cancer – A Call to Action" at www.lungfoundation.com.au/lung-cancer-call-to-action and make lung cancer a key priority in Australia.

REHABILITATION

Lifesaving app for cardiac patients

Cardiac rehab saves lives, but unfortunately take-up amongst heart attack survivors is low. That's why CSIRO developed CardiHab, an app that brings the hospital rehabilitation program to the patient's home, offering a more flexible option for eligible patients and reducing reliance on health centre visits. CardiHab is taking part in the Slingshot HCF Catalyst accelerator, a program focused on innovation in the health tech sector – which will help put this technology directly into the hands of heart attack patients.

www.startupdaily.net/2016/02/slingshot-announces-intake-for-its-first-hcf-catalyst-healthtech-accelerator-program/



NUTRITION

Offer 'biscuits and cheese' to increase nutrition at mid-meals

Addressing hospital malnutrition is an ongoing challenge and it turns out that being specific when communicating mid-meal options helps boost nutrition provided. A recent study at Epworth, VIC, found that when Food Service Assistants (FSAs) offered between meal services to patients, mentioning the actual food on offer increased mid-meal uptake and thus energy provided.

Naming just one or two food items produces results - for example, offering 'biscuits and cheese' as opposed to offering 'morning tea' more than doubled the energy, protein and fluid consumed.

"Allocating adequate time for service delivery and training food service staff to name two food and beverage items when offering between meal services to patients, could significantly improve the nutritional contribution of the service," says Judy Appleton, Accredited Practising Dietitian and co-author of the study.

COVER FEATURE

GOING VIRAL
Infection Control

FEATURES

GOING VIRAL
COVER FEATURE

Credentialling and the future of infection prevention and control

There is a growing body of evidence demonstrating a direct correlation between patient outcomes and the implementation of infection prevention and control programs led and staffed by infection control professionals who hold professional certification or credentialling and have a combination of comprehensive experience and formal training.

Put simply, patient outcomes are better in health services where infection control programs are led by infection control professionals who hold specialist certification or credentialling.

Credentialling is a self-regulatory process instituted by a professional body to determine and acknowledge that an individual has demonstrated the prescribed competence of the relevant specialist role in infection prevention in control.

Credentialling has been with the Australasian College for Infection Prevention and Control (ACIPC) and our predecessor associations now for decades. As Australian infection control professionals, we were early adopters of credentialling as a professional group and the current process has served us well for many years by identifying and recognising experts in our field.

But times change, and along with it do the demands of everyday practice. Fundamental to our College's work is to establish and articulate professional pathways and standards for practice for the changing environment of infection control. ACIPC recognises this evidence and has moved it into practice. Our existing single-tier credentialling framework for expert infection control professionals has been revised in light of the growing evidence and expanded to all infection control professionals across three new tiers.

In July this year, ACIPC launched our new Credentialling Framework that combines the requirements for experience, formal education and training together with peer review. The ACIPC Credentialling Framework comprises of three levels:

The ***Primary Credentialled Infection Control Professional (CICP-P)*** demonstrates the knowledge, attributes and behaviours in infection control at a basic level. They have participatory responsibility for infection control in their setting. They defer to the expertise of an Advanced or Expert ICP and/or fulfil some infection control responsibility in accordance with specific legislation and standards of practice. This may include hand hygiene auditing, acting as a link nurse, or a person who is involved in reprocessing reusable equipment. It is expected that they will routinely practice in accordance with

Credentialling:

"A key underpinning philosophy of the new framework is to provide a formalised career pathway for infection control professionals..."

relevant guidelines and the best available evidence, and actively seek the advice of Advanced and Expert CICPs in applying core principles to new, unfamiliar or challenging circumstances.

The ***Advanced Credentialled Infection Control Professional (CICP-A)*** demonstrates the knowledge, attributes and behaviours in infection control at an advanced level. They have leadership responsibility for one or more elements of an infection control program in their setting. They would defer to an Expert ICP for guidance and oversight in co-ordinating an entire program. It is expected that they will act as role models to Primary ICPs and practise in accordance with relevant guidelines and the best available evidence, and actively seek the advice of Expert CICPs in applying core principles to new, unfamiliar or challenging circumstances.

The ***Expert Credentialled Infection Control Professional (CICP-E)*** demonstrates the knowledge, attributes and behaviours at an expert level. They plan, implement, review and evaluate comprehensive infection control programs. They take a leadership role in terms of research and knowledge generation and contribute to the evolution of the discipline of infection control. They act as role model and mentor to Primary and Advanced ICPs and in accordance with relevant guidelines and the best available evidence, and work collaboratively with other Expert CICPs in applying core principles to challenging circumstances and generating new evidence for practice.

Importantly, the new ACIPC Credentialling Framework has something for everybody. A key underpinning philosophy of the new framework is to provide a formalised career pathway for infection control professionals that is open to everyone working in infection control.

This includes a vast array of professional groups, including nursing, midwifery, medicine, surgery, pharmacy, health and medical sciences, veterinary sciences, environmental health, paramedicine etc,.

ACIPC is of the view that for infection control to be everyone's business it needs to be accessible and relevant to, and be formally recognised within, multiple professions. The ACIPC Credentialling Framework comprises professional practice pathways and frameworks that support and recognise the vital role we all play. Whether you are new to the profession or have been practising for some time, there is something for you in the new ACIPC Credentialling Framework.

For more information, please visit the College website at: www.acipc.org.au/Credentialling

Ramon Shaban

Professor Ramon Shaban is Clinical Chair of Infection Prevention and Control at Griffith University and the Gold Coast Hospital and Health Service, Australia. He is President of the Australasian College for Infection Prevention and Control (ACIPC), Editor-in-Chief of the *Australasian Emergency Nursing Journal*, Senior Editor of *Infection, Disease and Health*, and Temporary Advisor to the World Health Organization on Antimicrobial Resistance.

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The INHALO® features a high volume gas package which is light, easy to use and versatile. It eliminates the need for regulators, and with its plug-and-go functionality will make cylinder changeovers quicker, safer and easier – allowing you to concentrate on patient care.

BOC was the first company to develop and introduce the integrated valve cylinder to the healthcare sector. Its popularity has gone from strength to strength as customers have discovered how more efficient and convenient it is to use. These lightweight, ready-to-use cylinders have a built in pressure regulator, easy on/off handwheel and integral flow selector.

It is designed to make cylinder operation and the task of medical oxygen administration easier for healthcare staff, as there is no need to attach a regulator. With a wide range of flow settings, you can accurately select the treatment to meet the patient's prescription. With the integrated valve cylinder, you get constant outlet pressure and flow settings to match your requirements. The cylinder has a "live" contents gauge, giving you a clear indication of contents at all times, even when the cylinder is turned off. The INHALO® is constructed from lightweight materials, making it easier and safer to handle than conventional cylinders. Using a medical oxygen integrated valve cylinder, ensures that therapy can be started right away, without any complex set-up or unnecessary manual handling for the operator.

Integral valve

- Integrated valve/regulator/flowmeter
- Enables simple multi-functional use and eliminates the need for external regulators and flow meters
- Enables easier, safer and faster cylinder changeovers saving precious time
- Inhalo is completely maintained by BOC saving you costly equipment inventory & maintenance
- A wide selection of accurate flow settings (1-15 lpm) provides for a wide range of oxygen therapies

Live contents gauge

- Easy to read gauge instantly provides a clear indication of gas level at all times
- Prevents waste as cylinder doesn't need to be opened to determine contents

Design

- Ergonomic carry handle is designed to provide a balanced and safe carry point
- Robust design ensures a secure supply of oxygen
- Fibre-wrapped cylinder provides high capacity but light weight making handling easy
- Tamper evident seal provides assurance of quality and safety
- Ease of use simplifies training

High capacity package

- The high gas capacity (630 litres) of the INHALO means less cylinder changes saving you time
- With significantly more gas than a standard C sized cylinder the INHALO saves you space, and cost on stock holdings and delivery

Multiple oxygen outlets

- The 'plug & go' functionality make the INHALO versatile & easy to use
- Allows multiple therapies from the same cylinder, e.g. oxygen supply &/or suction device (from DIO connection)
- The multiple outlets mean the INHALO acts like a cylinder & a wall outlet at the same time

Appearance

- The INHALO has a smart, clinical look that reassures patients and enhances compliance
- Clear plastic finish allows easy cleaning and provides for better hygiene

Registration

- Medical device, AUST R 135358, 187646
- Medical oxygen AUST R 34468

Inhalo specifications

Gas code	400CD
Gas type	Medical Oxygen E.P. Grade
Gas volume	630 litres
Empty weight	3.5 kg
Full weight	4.4 kg
Height	555mm
Diameter	105mm
Outlets	400 kPa outlet pressure (g)
- Firtree	Also known as 'barbed tail' Tubing diameters 6-8 mm Flow rates 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 15 lpm
- Diameter Indexed Outlet (D.I.O)	Also known as Sleeve Index System (S.I.S.) refer AS2896 300 ipm (max)

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Evidence-based training helps meet IPC targets

Within the healthcare sector there is growing pressure to reduce the rates of Health Care Associated Infections (HCAI).Infection Prevention and Control (IPC) teams have increasingly stringent targets to aim for with tighter budgets and larger penalties in place if they fail.

Public scrutiny and media coverage on hospital cleanliness is consistently growing, placing additional pressure on IPC teams. What can an IPC team do in 2014 to address these concerns and hit their targets?

It is accepted practice that improved infection control practices, such as good hand hygiene, routine cleaning and disinfection of surfaces, can help break the chain of transmission and therefore reduce HCAI rates.[1,2,3]

There have been many initiatives from both the Government and individual Trusts that target hand hygiene, however compliance and product effectiveness can vary. Environmental surfaces can serve as a reservoir for microorganisms, which can be transferred to the hands of healthcare workers, visitors and patients. Good environmental cleaning practices help to reduce bacterial load, preventing the cross transmission of potentially harmful microorganisms. Studies have shown the positive impact of effective environmental cleaning on reducing the bioburden of MRSA, *C. difficile* and norovirus.[1,2,3,4,5,6,7,8]

In many Health Services there is a confusing division of labour and responsibility between nursing and cleaning staff regarding environmental cleaning, with some equipment being missed altogether from the cleaning schedule and some items, such as beds having a shared responsibility. Over 70% of the most common patient touch points are not effectively cleaned. [9,10,11]

Clinical equipment should be cleaned after each use, placing the responsibility of cleanliness on medical staff. However, according to a *Nursing Times*, 75% of nurses had not received adequate training in environmental cleaning and only 16% of senior doctors received any training at all. A recent internet-based survey of 98 nurses confirmed that nurses were regularly expected to clean, yet two-thirds of respondents had no formal training in cleaning a commode, mattress or the general hospital environment. [7,12,13]

Reducing HCAIs

Education and training are proven to reduce HCAIs. It doesn't matter how powerful the disinfectant or how effective the delivery mechanism is, it will never achieve its stated claims if it is not used correctly due to insufficient understanding and training. An accessible, comprehensive and universal training scheme should be available to all staff. This should cover the basic tenets of infection control, such as why cleaning is important; how to clean in the most efficient manner; transference and high touch points. Easy-to-understand videos and step-by-step diagrams on the most effective way to clean surfaces and equipment within the healthcare environment would be an invaluable tool for all staff. [14,15]

Infection Control teams are required to create reports on training interventions and results, these can be time consuming and complicated. The ability to monitor and measure results and then generate comprehensive reports should be intrinsic within a new media based delivery system simplifying the whole process.

Studies have shown that monitoring cleaning efficacy has a positive impact on the thoroughness and level of cleaning that is attained. Ultra Violet marking is a common and cost-efficient solution to assist with monitoring and training good environmental cleaning practices. [16]

GAMA Healthcare, the manufacturer of Clinell (the leading supplier of infection control products to the NHS), invited over 20 senior Infection Prevention and Control professionals, including several past and present members of the IPS board, to join an advisory board. The board was tasked with creating the most flexible and accessible training package for the UK. Their advice, experience and research undertaken on over 130 of the most up-to-date and relevant journals and studies have enabled GAMA to create a package outlining a practical and scientific approach to effective cleaning practices within a healthcare setting.
The resulting training package cost over £350,000 to develop, took nearly two years to produce, and is widely considered the most comprehensive educational guide to environmental cleaning available to healthcare professionals.

Training Application

Delivered primarily on a 10in Android powered tablet, the Clinell Training Application is both accessible and enjoyable. Featuring fun and engaging games which help to emphasise key learning points and measure understanding. The application is designed to be used individually, in a small or large group and to assist staff in performing bespoke ward-based training. The videos and instructional diagram sheets explain simply and clearly the most effective way to reduce microorganisms on the most common items found within a hospital.

Included within the Clinell Training Package is the UV Torch Kit: One UV torch, water-soluble UV pens, UV powder and evidence based guidance booklet on where best to mark ward rooms and bathrooms, making monitoring simple and effective.

Resources:

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Understanding the variables that determine ABHR efficacy

Author: Christine Claighen, Regulatory and Scientific Manager, GOJO Australasia

For 70 years, GOJO has been a leader in infection control and skin science. We are your single source provider to help increase hand hygiene compliance, reduce infections and improve patient outcomes. We offer a wide range of comprehensive, science-based solutions to increase hand hygiene compliance – including revolutionary, skin-friendly formulations in PURELL® and GOJO® brands; with smart, easy-to-use touch free and manual dispensing platforms.

Our reputation is based on formulations that provide advanced germ kill, improved skin health and skin feel that make healthcare workers want to use our products. PURELL® Antiseptic Hand formulations (Gel and Foam) and GOJO® skin care formulations are tested to ensure the health and safety of staff, patients and visitors.

PURELL Antiseptic Hand gel and foam are both approved in Australia as hand sanitisers with a 1.1ml efficacious dose[1,2]. PURELL Antiseptic Hand gel is also approved for dual function as a waterless surgical scrub when sufficient product to keep hands and forearms wet for 120 seconds is applied. PURELL® Antiseptic Hand Gel and Foam are effective against a broad spectrum of organisms, including viruses and antibiotic resistant organisms.

Both the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) agree that hand hygiene is the single most important step a caregiver can take to prevent the spread of infections in the healthcare setting.[3,4] The CDC and WHO Hand Hygiene Guidelines recommend that soap and water should be used when hands are visibly soiled or after contact with spores such as *Clostridium difficile*. For all other moments or opportunities for hand hygiene in the healthcare setting, both guidelines state that alcohol based hand rub (ABHR) is recommended. ABHR is preferred because it offers superior antimicrobial efficacy, better skin tolerability under high frequency use, greater convenience and time savings, all of which contribute to better end user acceptability and higher compliance.

Because product dry time is directly proportional to the amount of product applied to the hands, there is a practical limit to the volume of product that can be used without disrupting healthcare workflow. If healthcare workers (HCWs) must use 5 mL of product to achieve efficacy, they will not have the time to rub it in until dry. The ideal product application quantity is one that minimizes workflow disruption while maintaining maximum antimicrobial efficacy.[5] Therefore, product literature should be examined to compare the quantity of product used in Healthcare Personal Hand Wash (ASTM E1174) or EN 1500 tests, the in vivo efficacy methods to evaluate ABHRs, to realistic in-use volumes. It is important to know how much product a HCW would need to rub in to achieve transient bacteria kill and how that corresponds to the volume of product that is dispensed during each actuation from your facility's dispensers.

Total product formulation and product application volume, not alcohol concentration or product form, are the key determinants of the in vivo antimicrobial efficacy of an ABHR[6,7]. Because formulation plays an important role in ABHR antimicrobial efficacy, critical examination of *in vivo* efficacy data along with the quantity of product applied to hands in the test should be conducted when comparing antimicrobial efficacy of products. Finally, hand hygiene compliance is perhaps the most critical element to achieving clinical outcomes. For this reason, the most effective ABHRs are those that balance antimicrobial efficacy with skin performance and healthcare worker acceptability to ensure maximal compliance to hand hygiene practices.

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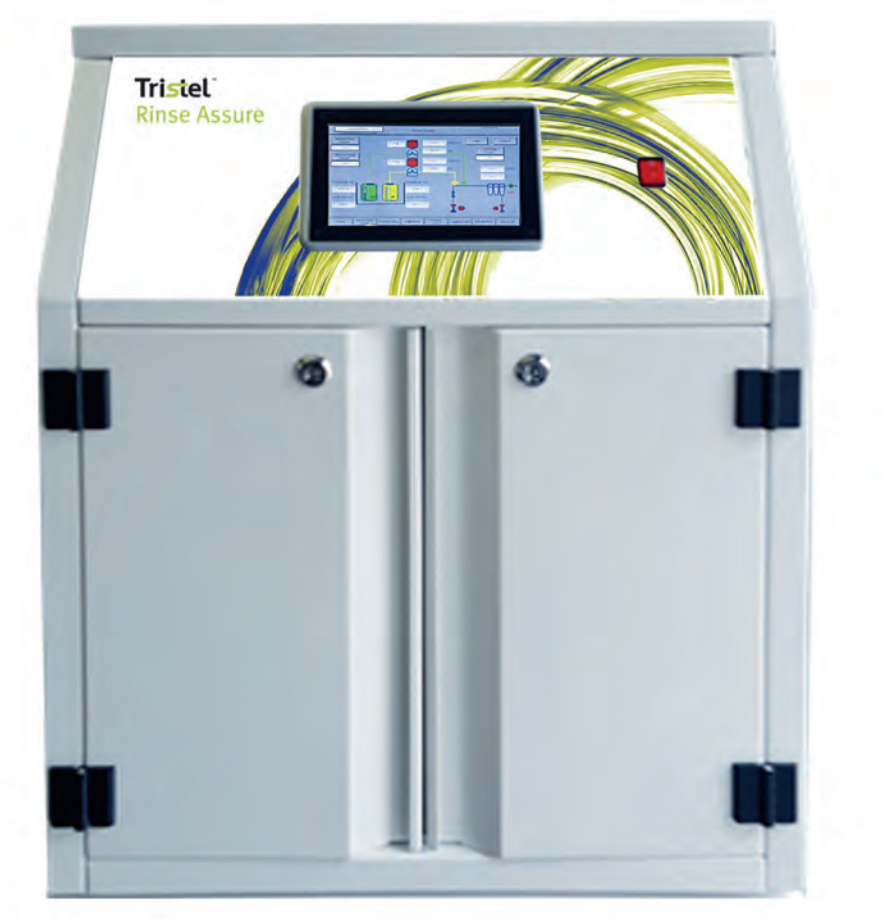
Engineered for protection

Tristel Rinse Assure

Reducing TVCs down to zero at Neath & Port Talbot Hospital

The Endoscopy Outreach Department at Neath & Port Talbot Hospital uses four QED Washer Disinfectors (WDs) to disinfect medical devices including bronchoscopes, gastroscopes, colonoscopes, cystoscopes and duodenoscopes. The quality of the water going into the washers had been tested in accordance with HTM2030.



In September 2013 a review of rinse water quality testing found endoscopy final rinse water issues. As a result of testing changes in February 2013 – from a three-day testing regime to the new five-day regime – the department was regularly exceeding the acceptable levels for rinse water. The average was in excess of 100 TVC's (Total Viable Count) per 100ml of sample water.

Decontamination Manager Shirley Kivi explains: "A lot of remedial work had been done such as changing filters, using new flexible tubing and self-disinfecting the WDs with double doses of chlorine tablets, but water testing results did not improve. All the practical changes we could make, we made, but with no resolution." After a chance meeting with Tristel, the hospital decided to trial their new Rinse Assure System.

Tristel Rinse Assure is a management system for rinse water in WDs. It provides a continuous supply of HTM 01-06 and EN15883 compliant rinse water. Tristel Rinse Assure doses low levels of Tristel's patented chlorine dioxide chemistry into the water used during a WDs decontamination process, ensuring that all water delivered is of the highest quality.

Prior to the installation of Tristel Rinse Assure, full water samples were taken to three labs to independently assess the quality of the water that was supplied to the four QED WDs. All results showed high TVCs. On 11 April 2014, T.E.S.T. engineers installed one Tristel Rinse Assure to dose two of the four QED WDs, while the other two bays continued to operate with the existing filtered mains water configuration to act as control bays. Once the installation of Tristel Rinse Assure was complete, several high dose cycles were run to purge the WDs. Daily samples were taken by the hospital and sent to the three laboratories.

By 16 April and up to 13 May 2014, all T.E.S.T. water sample test results from the units using Rinse Assure showed zero TVCs. One of the labs took water samples from all four bays during the same period; these results showed that the non-Rinse Assure bays had high TVCs in excess of 100cfu. The Tristel Rinse Assure bays passed with no growth detected. Only five days after installation, Tristel Rinse Assure had reduced TVCs to zero.

The results continued to show the success of Rinse Assure – so much so that the hospital purchased a system before the trial had even finished. While the hospital also considered UV disinfection, eventually they decided against it as they were unsure how efficient it would be, and the installation and use of Tristel's Rinse Assure was so simple.

Soon after, a second Rinse Assure unit was installed at a new site, replacing an RO Water System. Most recently, a third Tristel Rinse Assure system was installed at Moriston Hospital; three hours after installation, water sample test results showed zero TVCs. Chlorine dioxide was dosed at 0.5ml/L.

This article was originallly published as **http://bit.ly/RinseAssure**

Tristel™ Rinse Assure

A more effective, more reliable and more economical alternative to systems such as reverse osmosis.

- An automated management system for rinse water in washer disinfectors
- Provides a continuous supply of chemically dosed rinse water that is compliant with CFPP 01-06, HTM 01-06 and EN 15883.
- Meets AS/NZS-4187 Standards for rinse water
- TGA approved
- Doses low levels of Tristel's proprietary chlorine dioxide chemistry
- Effective in reducing high levels of microbiological contamination
- Designed for minimal user input and easy to operate

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Tristel Rinse Assure provides a constant supply of water chemically dosed with a low level of chlorine dioxide before a final 0.2µm filter. It prevents bacterial proliferation and protects the filter and rinse water from contamination.

Tristel Rinse Assure features an integrated track and trace system which enables the operator to constantly monitor the process via the Operator Interface Touch Screen.

Tristel Rinse Assure Series III

Tristel Rinse Assure Series III provides all the benefits of Series II, plus an integrated Reverse Osmosis (RO) system. A water tank, which features a self-decontamination cycle, holds up to 50L of chemically dosed water. Therefore, Tristel Rinse Assure Series III can cope with high demand for bacteria-free rinse water.

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GOING VIRAL
COVER FEATURE

Killer T Cells – marching towards a viral cure

New research has taken us a step closer to finding a cure for human immunodeficiency virus (HIV), as well as other infections including the glandular fever virus, which is associated with the development of lymphoma. Some infections, such as HIV, cannot be cured with antiviral therapy because the virus effectively hides from the immune system.

An international team of scientists, led by Monash Biomedicine Discovery Institute researcher Dr Di Yu, and Dr Axel Kallies from the Walter and Eliza Hall Institute, have discovered that killer T cells, a specialised type of white blood cell, can find these "hidden" infected cells in tissue and destroy them. This discovery[1] could provide new insights into finding a lifelong cure for chronic infections such as HIV.

Dr Yu said this type of killer T cell was naturally found in the body during infection, but their numbers and killing function needed to be boosted to allow them to eradicate chronic infections.

"We've shown for the first time that there are specialised killer T cells that can migrate into a part of the lymphoid tissue and control hidden infection," Dr Yu said.

Although treatments for HIV with antiretroviral drugs are highly effective, treatment is lifelong and there is no cure. Other infections such as Epstein-Barr virus, the cause of glandular fever, may also hide and persist for many years, but become active when the immune system is compromised.

The researchers discovered that these specialised killer T cells, called follicular cytotoxic T cells, can enter hiding spots inside lymphoid tissue, where viruses can hide on treatment. These hiding spots are called B cell follicles.

Dr Yu's PhD student Mr Yew Ann Leong, who conducted a large portion of the research, also from the Monash Biomedicine Discovery Institute, said that although some infections including HIV could hide within B cell follicles, these killer T cells are specialised to eradicate this hidden virus pool.

"This discovery will help us to design new therapies that could eventually treat many different infections, including HIV," Mr Leong said.

Dr Axel Kallies, fellow lead researcher on the study from the Walter and Eliza Hall Institute, said he was excited to have co-led this exciting piece of international research.

"The potential of this discovery is huge. It helps us to understand how we may be able to treat diseases that affect the immune system itself, such as HIV or B cell lymphoma," Dr Kallies said.

Professor Sharon Lewin, the Director of the Peter Doherty Institute for Infection and Immunity, a joint venture of the University of Melbourne and Royal Melbourne Hospital and a co-author on the study, said there were a few ways this discovery could be translated into a treatment for people with chronic infections.

"We could potentially transfer these specialised super potent killer T cells into patients, or we could treat patients with proteins that can drag these specialised killer T-cells into the right spots, specifically to the hot spots where HIV can hide on antiviral treatment," Professor Lewin said.

Dr Yu said he hoped human trials of such treatments would begin within the next five years.

The researchers' work was supported by several international funding bodies, including the Australian National Health and Medical Research Council, the Sylvia and Charles Viertel Foundation, the amfAR Research Consortium on HIV eradication, the National Institutes of Health, the International AIDS Society and the Creative and Novel Ideas in HIV Research Program.

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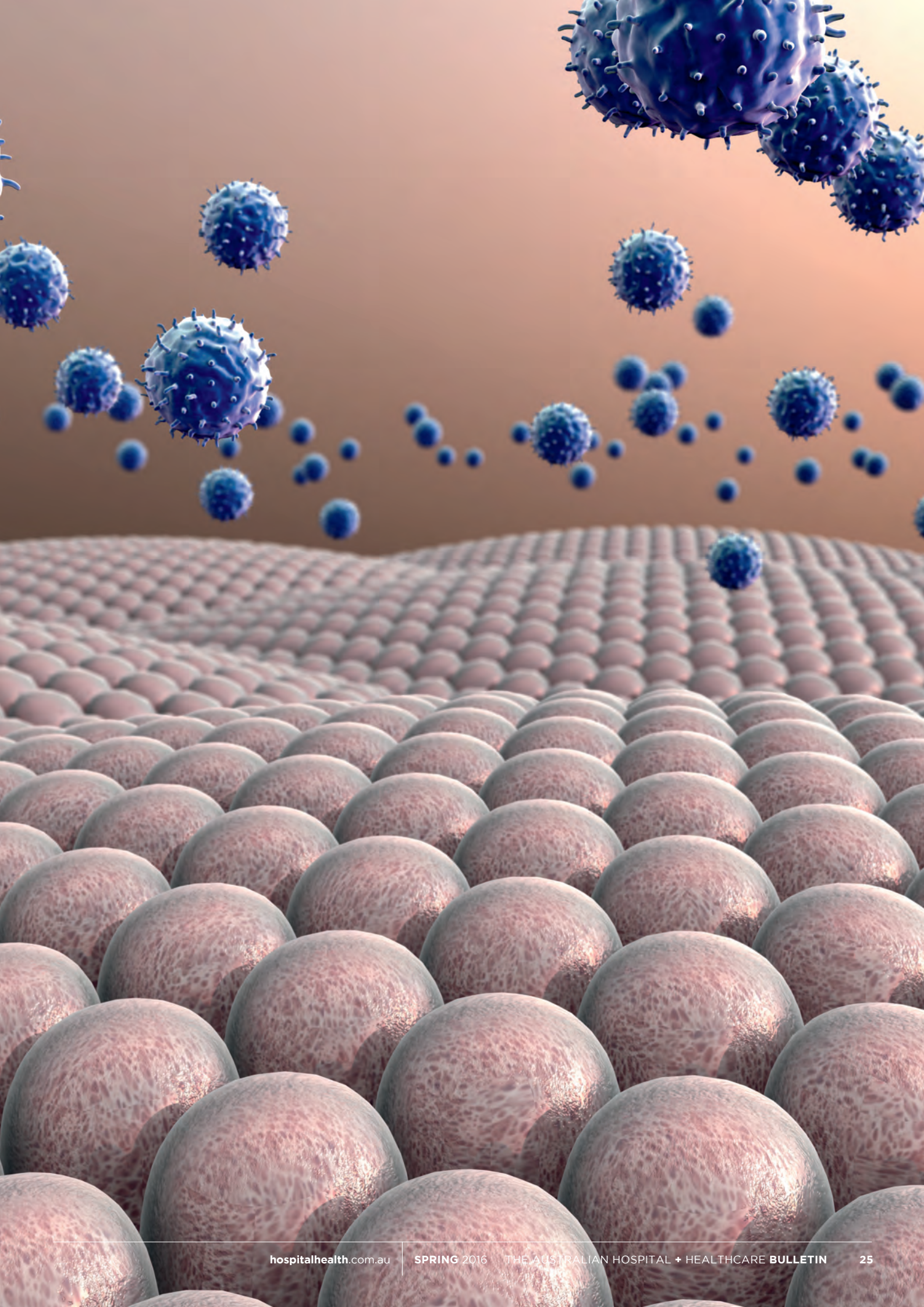
"The potential of this discovery is huge. It helps us to understand how we may be able to treat diseases that affect the immune system itself..."



Miele Professional launches a new end-to-end solution for Australian CSSD's

Full state of the art instrument reprocessing to meet the new standards arrives.

Hospital management and Central Sterile Supply Department's (CSSD) grappling with the challenges faced by refurbishments or complying with the new version of AS/NZS 4187 now have a proven new solution.

Thanks to Miele Professional Australian hospitals can overcome common challenges, such as maintaining the perfect flow of cleaning, disinfecting and sterilising the instruments and materials by renting an entire Mobile CSSD, including the facility and all technical equipment required for reprocessing.

Miele Professional has ramped up its investment in Australia to bring its 50 years' experience in the medical field in Europe to Australian hospitals, offering a direct manufacturer to customer, full design, equipment and maintenance solution.

Australia's first Mobile CSSD Unit will be installed in Brisbane to coincide with the WFHSS allowing attendees to learn how this unique innovation is transforming how hospitals plan and manage CSSD upgrades.

Sjaak Brouwer, Managing Director of Miele Australia and New Zealand, said that for the past 50 years Miele has attached great significance to working closely with both medical specialists and instrument manufacturers.

"Until now, Australia's 1300 plus hospitals faced seemingly unsurmountable challenges when a new CSSD was built or an existing one needed refurbishing or replacing," Mr Brouwer said.

"Now there is a fast and simple fix. Miele can supply three fully equipped modules, which are combined on a site in a few days to give a fully functioning and operational CSSD.

"As a rental option, it is a unique innovation, offering a full set up for reprocessing instruments which is the perfect solution for hospitals needing a fast and cost effective way to maintain the quality of production during construction works."

The Miele Mobile CSSD meets the new Australian standards and guarantees world's best reliability.

"It offers the full setup for reprocessing instruments with separate areas for washing and disinfection, packaging and sterile supplies," he explained.

Mr Brouwer said that one of the key benefits of the Mobile CSSD from Miele Professional is that the quality of reprocessing remains under a hospital's control.

"Existing staff can also continue to do their job in a positive working environment, without exposure to the strains of a building site.

"Finally, the effort on the part of the hospital is less than for all other options as this approach avoids the construction and dismantling of a provisional CSSD and is a more cost effective solution than outsourcing."

Covering an area of 68m^2, the module includes washer-disinfectors, sterilisers, packing tables, steam generating equipment, water pre-treatment and air conditioning.

Mr Brouwer said that in Europe the Miele Mobile CSSD was already being rented by hospitals in Belgium and Switzerland.

It was first used at the Sacred Heart Hospital in Belgium last year, and was described as 'a perfect solution', by Leon Jackers, Manager of the Sacred Heart Hospital Apothecary and responsible for sterile supplies.

"Throughout the world, hospitals having to renovate existing CSSD facilities are up against the same problem as we were. Hospitals can rarely find another stop-gap location on their own premises, which is suitable for providing sterile supplies.

"The only other alternative for our hospital would have been to work with a third-party service provider some 100 kilometres away which would have meant investing in additional instruments to compensate for longer turnaround times."

Jackers was 'extremely pleased' with the solution Miele proposed as it did not involve any interruption to supplies and worked smoothly. After relocating back to the new premises, members of staff were already highly familiar with many aspects of their work, as the new CSSD was also fitted with medical technology from Miele Professional.

"Along with the Mobile CSSD, Miele Professional will have a local team of dedicated specialists and technicians delivering a complete instrument reprocessing solution - from the planning phase, installation, operation and on-going maintenance - to hospital and medical customers," Mr Brouwer announced.

He said that Miele Professional was excited to be a major sponsor of WFHSS and exhibiting its new range of economic and ergonomic product solutions at such an important event.

"The combination of choice materials, perfect workmanship and mature and sophisticated technology has earned Miele its exceptional reputation in the field of medical technology.

"A wide range of products, inserts, specially designed programmes and efficient water pre-treatment ensure thorough, effective and material-friendly cleaning, offering great flexibility in hospitals and CSSD units."

With Miele Professional as your partner, you can not only benefit from this new cost effective, fast and streamlined solution for complying with the CSSD standards, but also feel comfortable that you are dealing with professionals with extensive experience in the field.

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This is your opportunity to see the Mobile CSSD in Australia and we'd like to invite you on a guided tour. Places are strictly limited.

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Miele
PROFESSIONAL

Wipe away the risk of infection with Microfibre

With around 200,000* healthcare associated infections in Australian acute healthcare facilities each year, prevention and control of infection is a top priority for hospital and healthcare facilities.

Often hospital and healthcare staff rely heavily on chemicals to guarantee a hygienic environment, yet the sole use of chemicals is quickly being side-lined by the new concept of 'sustainable cleaning'. Staff also may not be aware that outbreaks often occur because microbes become resistant to certain chemicals which reduce their effectiveness, opening a facility up to the risk of potential outbreaks.

There is a growing movement in the healthcare industry towards sustainable cleaning practises, using microfibre to control and prevent infections. Microfibre is effective due to its ability to remove fine particles, bacteria, microbes and oils sitting on surfaces and hidden in crevices, that cotton sponges and cloths typically cannot reach. Microfibre products have the ability to remove 99.9 per cent of microbes, with less water, and without the need to use harsh chemicals that kill but don't remove bacteria.

An important step in the prevention of infection is to ensure all bacteria and particles are completely removed from the surface areas to prevent the bacteria spreading and eliminating the food source for other bacteria to grow. The Rubbermaid HYGEN Disposable Microfibre System, in conjunction with chemicals or steam, effectively kills the bacteria while the microfibre removes it from the surface, providing a thorough clean. Described as an industry first, the Rubbermaid

HYGEN Disposable Microfibre System features innovative technology that offers optimal infection preventions, superior cleaning performance and improved productivity. It is the only Disposable product line in the healthcare industry proven to remove 99.9 per cent of microbes, including C. diff, which helps stop the chain of infection.

Suitable for any surface, the HYGEN Microfibre system also provides streak free cleaning for mirrors, glass and stainless steel and can be used for dusting or wet cleaning. To clean larger areas, the disposable microfibre mop can be used wet or dry and is compatible with Rubbermaid Pulse or Rubbermaid Charging Bucket.

With more coverage than leading disposable cloths, the HYGEN microfibre system also features built-in scrubbers that enable complete dirt removal without smearing.

In a hospital environment, reaching a higher level of cleanliness is an important goal. Areas where microfibre products can be used to effectively prevent infection include occupied and discharged patient rooms; emergency, ICU and isolation rooms; nurses' stations; MRI and X-ray machines; and other public areas. As patients and staff come into contact with these areas regularly it's important that they remain clean to prevent the spread of disease from person to person.

The superior cleaning power of microfibre allows staff to do more with less by removing almost all bacteria in a sustainable way. By reducing the need for chemicals it takes away previously required steps in the cleaning process, providing increased productivity and cost savings. This creates a secondary benefit for hospital and healthcare facilities by preventing the cost associated from outbreaks or ongoing infections.

References

*Australian Guidelines for the Prevention and Control of Infections in Healthcare 2010

IT'S NOT CLEAN UNLESS YOU WIPE IT ALL AWAY

REMOVE MICROBES TO ENSURE SUPERIOR CLEANING.
Rubbermaid HYGEN™ Disposable Microfibre System removes microbes, the food source for live pathogens.

Removes

99.9%

of microorganisms*

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*BASED ON THIRD PARTY TESTING WITH WATER ONLY. THE PRODUCT CAN BE USED WITH A WIDE ARRAY OF CLEANING SOLUTIONS.

BioClad® Antimicrobial Products offer Lifetime Armor in the War against Micro-Organisms

BioClad® is the world's first proven antimicrobial PVC hygienic wall cladding. Antimicrobial silver ion is impregnated into the hygienic cladding panels at the time of manufacture. This helps stop the growth of bacteria and mould which works continuously for the lifetime of the panels, reducing levels of bacteria such as MRSA, E Coli, Legionella, Salmonella and mould (including Aspergillus Niger) by up to 99.99%.

Utilising Antimicrobial Technology, BioClad® products have been Proven to inhibit growth and control bacteria 24/7, not for a few years but guarantee protection for the expected lifetime of the BioClad antimicrobial products.

BioClad® incorporates BioCote® silver ion antimicrobial technology. Silver ion technology is a safe, natural antimicrobial that is added at our point of manufacture ensuring it is present throughout our virgin PVC sheets. This manufacturing process is not, just a surface treatment needing to be revitalised, it is not a mere disinfectant cleaning solution whipped over during the cleaning process, BioClad® Antimicrobial products ensure continued protection guaranteed for its lifetime.

BioClad® has been proven to work in real-world environments.

An independent study was undertaken in a UK Aged Care facility kitchen where 35 surfaces were tested for their bacteria levels. The BioClad hygienic wall cladding registered a 0 level of bacteria.

Date of study: October 2012

Study conducted and report written by Dr Richard Hastings, Microbiologist, Affiliate Microbiology Department, Life Sciences Department, University of Warwick, CV4 7AL. Study and report reviewed and audited by Dr Pamela Simpson, Independent Consultant Microbiologist, Whitewater Technologies Ltd, DY8 2GB.

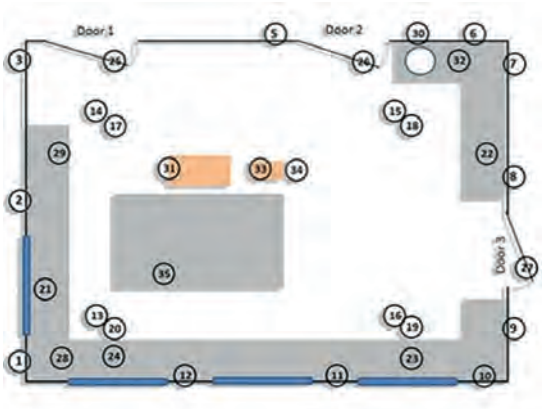
Study Aim

This study aimed to compare levels of bacterial contamination isolated from surfaces in a busy kitchen situated in a UK Aged Care facility. The study's main objective was to compare bacterial contamination on the antimicrobial wall cladding with other surfaces in the kitchen. The care home kitchen had been fitted with BioClad® PVC wall cladding (Advanced Hygienic Cladding Ltd, Harrogate, UK) at the time of construction in 2011. All walls in the rectangular-shaped room were fitted with BioClad® from ceiling to floor. The antimicrobial performance of the wall cladding was to be appraised according to the findings of the study.

Methods

Transport medium swabs were collected from various surfaces situated in a working kitchen (Fig. 1) of a recently commissioned (2011) care home for the elderly located in the UK. Swabbing was performed by rubbing an object's surface area of 25cm² (typically 5cm by 5cm) with the cotton tip of a pre-moistened bacterial transport swab. Objects swabbed from the kitchen are identified in Figure 1. Swabs were transported to the microbiology laboratory for processing but kept at 4°c during transport. Bacteria collected on the swabs were transferred to two types of solid growth media; plate count agar and brain heart infusion agar containing 5% horse blood. Cultures were incubated in an aerobic environment at 36°c for 48 hours. After incubation, the amount of bacterial growth isolated from each swab was quantified by colony counting and the diversity of growth estimated by inspection of colony types. Isolates presenting a colonial appearance suggestive of a pathogen were Gram stained and presumptively identified.

1: Floor plan of kitchen swabbed in study. Numbers indicate approximate positions of swabbing points and correspond with Swab No listed in Table 1.



Concluding Statement

This study revealed a variety of bacterial counts on different kitchen surfaces. Numbers of bacteria isolated from the surfaces ranged from none (zero) detected to over 1000 colony forming units from 25cm² sampling area. Only two surface types did not produce bacterial growth upon swab culture – BioClad® wall cladding and a suspended plastic

ceiling tile. It does not follow that these surfaces were sterile (i.e. totally free from microorganisms), as bacteria may have been present on these surfaces that were not able to grow as colonies on the media used in this study, or the bacteria were present in such low numbers per unit surface area that the sensitivity limit of the isolation techniques used was exceeded. Given the ease of demonstrating the presence of diverse bacteria from all other surfaces examined in the kitchen, it is reasonable to suppose those surfaces that yielded no bacterial growth on culture were not solely contaminated by non-cultivable bacteria rather numbers of bacteria on them were very low or, indeed, were absent. Thirteen swabs yielded no bacterial growth. Twelve of the thirteen surfaces swabbed were BioClad® wall cladding. A strong explanation for this observation must be the activity of BioClad's® antimicrobial feature. Previous laboratory analysis of BioCote® treated BioClad® wall cladding according to the ISO22196:2011 protocol (Measurement of antibacterial activity on plastics and other non-porous surfaces) demonstrated this material to possess a potent antimicrobial property under laboratory conditions. This study suggests BioClad's® antimicrobial efficacy is transferable to the working environment.

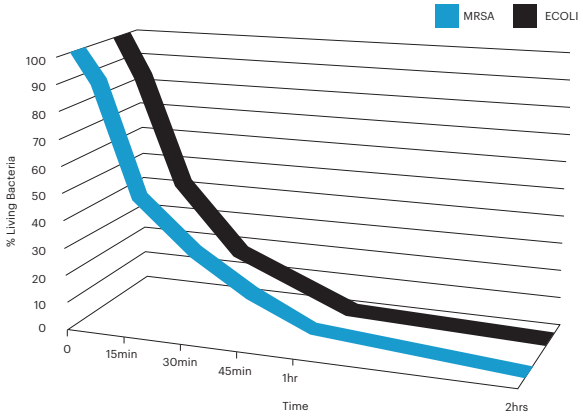
Bioclad's 2-Hour Benchmark

BioClad panels offer antimicrobial protection. They do not only protect against incidences of bacteria. BioClad offers protection against protozoans, fungi, mould, and a range of other potentially harmful microbes, including bacteria. With BioClad you get a superior second defence barrier for those hygiene-critical areas, and this chart demonstrates just how effective it is. Please don't just take our word for it. Every batch of BioClad is independently tested, and data from field testing has also been obtained independently.

The silver ion technology BioClad uses interrupts the breeding cycle of surface microbes, and leads to their eradication in well-maintained critical areas such as operating theatres, kitchens, shower rooms etc. that would otherwise provide excellent breeding conditions for micro-organisms.

Typical results for BioClad tested to ISO 22196:2007 standards are a reduction in overall bacteria load of over 99%. Environmental tests ensure BioCote technology performs equally in real life as in a lab.

The graph shows that even after only 15 minutes the reduction in living bacteria is over 50% and after 2 hours over 99%



Results

Table 1: Comparison of abundance and diversity of bacteria isolated from surfaces in a working kitchen located in a UK care home.

Fig. 2: Bacterial isolates from swabs taken from surfaces in kitchen used for study.

Swab No	Kitchen Surface Swabbed	Bacterial Count	Bacterial Diversity	Presumptive Bacterial Identification
1	BioClad® wall cladding position 1 north wall	0	-	-
2	BioClad® wall cladding position 2 north wall	0	-	-
3	BioClad® wall cladding position 3 north wall	0	-	-
4	BioClad® wall cladding position 1 east wall	0	-	-
5	BioClad® wall cladding position 2 east wall	0	-	-
6	BioClad® wall cladding position 3 east wall	0	-	-
7	BioClad® wall cladding position 1 south wall	0	-	-
8	BioClad® wall cladding position 2 south wall	0	-	-
9	BioClad® wall cladding position 3 south wall	0	-	-
10	BioClad® wall cladding position 1 west wall	0	-	-
11	BioClad® wall cladding position 2 west wall	0	-	-
12	BioClad® wall cladding position 3 west wall	0	-	-
13	Rubberised flooring 1	51	4 different colony types	CNS, Bacillus, 2 unidentified species
14	Rubberised flooring 2	12	1 colony type	Unidentified species
15	Rubberised flooring 3	83	6 different colony types	CNS x2, Bacillus, coliform-like, 2 unidentified species
16	Rubberised flooring 4	107	4 different colony types	CPS, CNS x2, 1 unidentified species
17	Suspended plastic ceiling tile 1	8	2 different colony types	Unidentified species
18	Suspended plastic ceiling tile 2	1	1 colony type	Unidentified species
19	Suspended plastic ceiling tile 3	3	1 colony type	Bacillus
20	Suspended plastic ceiling tile 4	0	-	-
21	Stainless steel work surface 1	17	2 different colony types	CNS, unidentified species
22	Stainless steel work surface 2	3	2 different colony types	CNS, unidentified species
23	Stainless steel work surface 3	10	3 different colony types	Bacillus, fungus, unidentified species
24	Stainless steel work surface 4	1	1 colony type	Bacillus
25	Stainless steel handle, door 1	16	3 different colony types	CNS x2, unidentified species
26	Stainless steel handle, door 2	2	2 different colony types	CNS x2
27	Stainless steel handle, door 3	237	> 6 different colony types	CPS, Pseudomonas, CNS x2, fungus, > 2 unidentified species
28	Grilling machine plastic handle	14	3 different colony types	CNS x2, unidentified species
29	Water heater dispens-ing plastic handle	60	4 different colony types	CPS, CNS x2, 1 unidentified species
30	Liquid hand soap dispenser plastic casing	9	2 different colony types	CNS x2
31	Food warning trolley plastic handle	31	4 different colony types	CNS, Bacillus, 2 unidentified species
32	Waste collection unit casing	> 1000	> 4 different colony types	Pseudomonas, > 3 unidentified species
33	Plastic refuse bin lid	28	3 different colony types	CPS, CNS, unidentified species
34	Plastic refuse bin pedal	375	> 6 different colony types	CNS x3, Bacillus, fungus, > 1 unidentified species
35	Plastic oven handle	2	I colony type	CNS

GOING VIRAL
COVER FEATURE

HHA Launches New Learning Management System

By *Kate Ryan*, Project Officer, Hand Hygiene Australia and *Andrew Stewardson*, National Program Manager, Hand Hygiene Australia

The National Hand Hygiene Initiative (NNHI) is a culture change program to reduce the rate of healthcare associated infections in Australia.

- provision of alcohol-based handrub at the point of care
- monitoring and feedback of hand hygiene performance according to the WHO '5 Moments for Hand Hygiene'
- education of healthcare workers about hand hygiene and infection control.

To assist with education of healthcare workers, Hand Hygiene Australia (HHA) developed online learning modules about hand hygiene during the initial phases of the national program. In addition to a standard module, there are profession-specific learning modules for nurses and midwives, medical practitioners, allied health practitioners, non-clinical staff and student health practitioners.

HHA has recently launched a new learning management system to host these learning modules. The new system represents an improvement over the previous system in a number of ways, including a modern interface with added functionality and improved reporting capabilities for administrators at each health organisation. But most importantly, the system offers an improved learner experience, with learners being able to save and return to modules and access historical records and certificates.

The new system also allows HHA to support other learning modules. The first additional learning module is a general introduction to infection control for healthcare workers developed by the Australian Commission in Quality and Safety in Health Care, called the 'Infection Control Orientation'.

This module is designed to be used by health service organisations as part of their workforce orientation program in infection prevention and control. It provides an overview of the key areas of infection prevention and control that should be used as a starting point for ongoing education of both clinical and non-clinical health care workers.

It aims to help all healthcare workers minimise the risk and prevent the spread of infection and infectious agents. This module contains three levels that reflect the variation in risk of exposure to blood and body substances that different roles may have. Users should choose the content that best reflects that level of risk e.g., direct contact, indirect contact or no contact with blood or body substances.

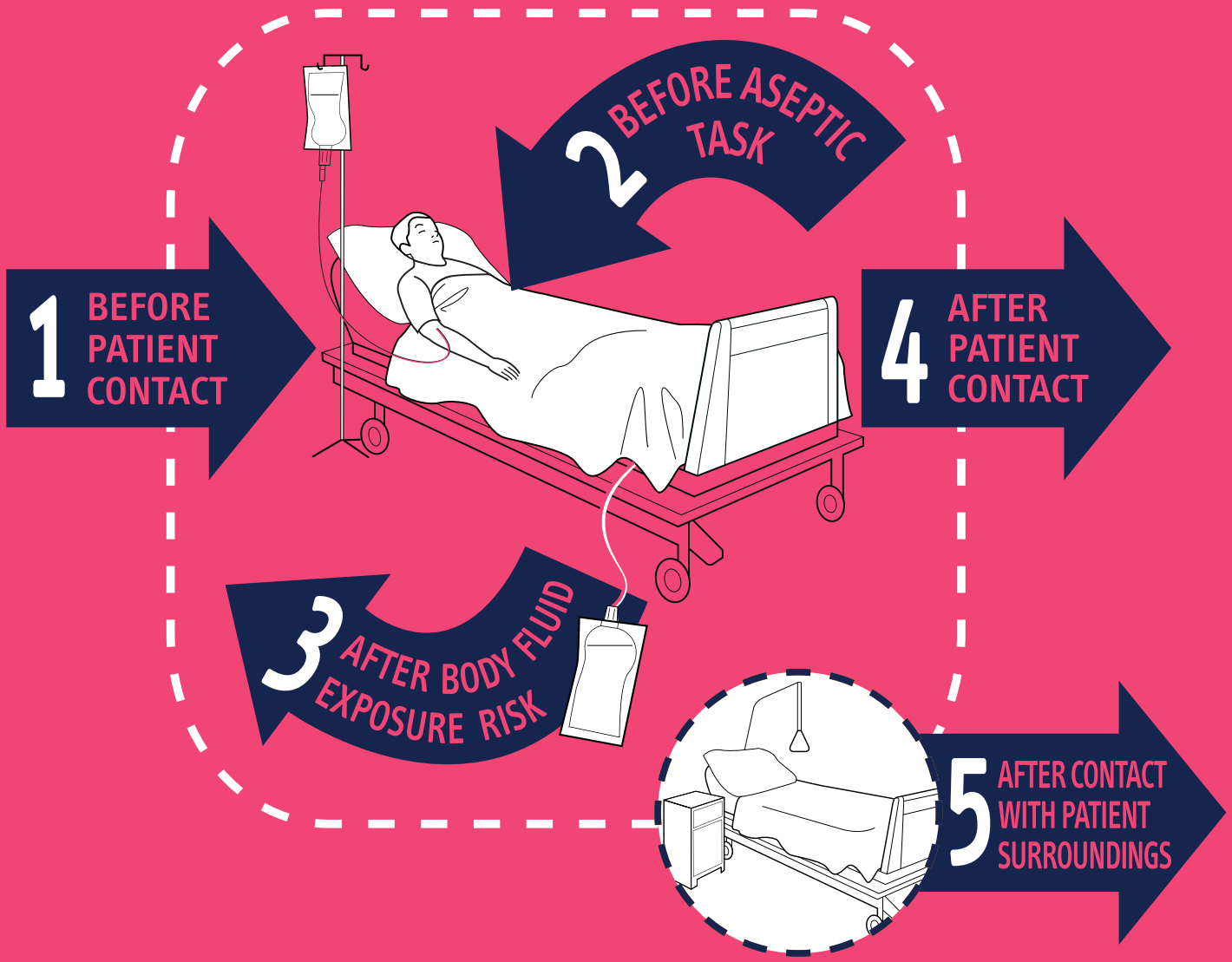
"The new system represents an improvement over the previous system in a number of ways..."

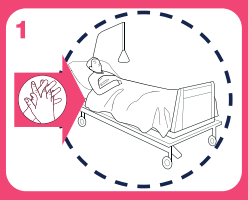
The HHA learning management system can be accessed here: www.hha.org.au/LearningPackage/olp-home.aspx

For queries related to the system, please email hhalearning@austin.org.au

Your 5 moments for HAND HYGIENE

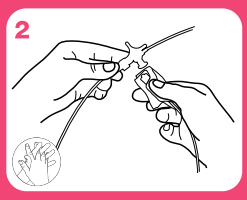
Design: mondofragilis network





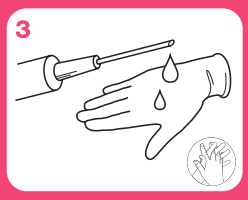
1 BEFORE PATIENT CONTACT

Clean your hands before touching a patient when approaching him or her



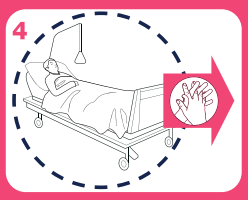
2 BEFORE AN ASEPTIC TASK

Clean your hands immediately before any aseptic task



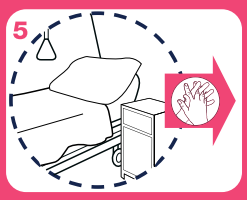
3 AFTER BODY FLUID EXPOSURE RISK

Clean your hands immediately after an exposure risk to body fluids (and after glove removal)



4 AFTER PATIENT CONTACT

Clean your hands after touching a patient and his or her immediate surroundings when leaving



5 AFTER CONTACT WITH PATIENT SURROUNDINGS

Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving - even without touching the patient

World Health Organization

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

Human Factors and Safety Improvements for Infection Prevention

There are around 200,000 healthcare-associated infections (HAIs) in Australian acute healthcare facilities each year. This makes HAIs the most common complication affecting patients in hospital. As well as causing unnecessary pain and suffering for patients and their families, these adverse events prolong hospital stays and are costly to the health system.[1]

However, a significant number of these infections can be reduced or prevented and the first step, according to Professor Jane Reid, is introducing a safety culture in the hospital and healthcare setting and being more open to doing things 'differently'.

Professor Jane Reid is a Registered Nurse, Researcher and Independent Healthcare Advisor with the NHS and a Non-Executive Director. Earlier this year, Professor Reid presented at the ACORN Conference on a topic she's extremely passionate about - human factors and patient & staff safety. While she was in town, Professor Reid also presented to the Clinical Excellence Commission (New South Wales).

Infections can have serious consequences, especially in the most vulnerable of hospital patients. It can result in surgical wounds not healing and respiratory and urinary tract infections.[2] These complications are not only dangerous for the patient but drain valuable healthcare resources.

What may be surprising however, is that at least half of healthcare associated infections are preventable.[3] The science of Human Factors and Ergonomics and a positive Safety Culture can make a significant contribution.

Human Factors refers to environmental, organisational and job factors, and the human and individual characteristics which influence behaviour at work in a way that can affect health and safety.[4]

"People might know what is the right thing to do but whether they actually do it is another matter.", said Professor Reid.

"The science of Human Factors has a lot to offer. Consider hospital acquired infections. We can consider the lapses that may have contributed to that infection – lapses in systems, lapses in processes and lapses in our attention. It invites us to look at the pathway of care and think about all of the elements that we need to put right to ensure that patients get the best care possible."

"The greatest challenge to compliance with infection prevention measures is the concept of compliance itself," says Professor Reid. "The way I view safety is that compliance is about good enough, and I don't want good enough for my family, or my loved ones – I want excellence."

"I would like the healthcare industry to get to a place where people understand that their individual contribution makes a huge difference. We also need to look at advances in technology that reduce the potential for harm – products like BD ChloraPrep™ cutaneous solution, which has been available in the UK since 2006, are helpful in reducing the incidence of infection."

"Regularly when I'm working with clinical staff I talk about a pledge - a commitment to delivering the very best of care. We need to instil a passion and a sense of 'not on my watch'. To ensure that we're attentive to potential lapses and we absolutely commit to doing the right thing at the right time for every patient.", Professor Reid concluded.

Six Steps to Help Minimise the Risk of Hospital Acquired Infections:

1. Ensure you have the right procedure and facilities in place for your healthcare setting.
2. Get the right up-to-date training for the procedures that keep everyone safe.
3. Understand all the reasons behind why each procedure must be performed to keep everyone safe.
4. Lead by example and encourage others adherence to procedures.
5. Speak up and suggest changes if a procedure is difficult to adhere to or if you can see anything that can be done more optimally. This will not only be helpful for you, but may benefit the entire team or premises.
6. Choose products / services that help optimise human well-being and overall system performance in day-to-day activities.

References

1. Australian Guidelines for the Prevention and Control of Infection in Healthcare, 2010. National Health and Medical Research Council. Accessed August 9, 2016 at https://www.nhmrc.gov.au/book/html-australian-guidelines-prevention-and-control-infection-healthcare-2010
2. Spelman DW. Hospital Aquired Infections. *Med J Aust.* 2002;176(6):286-29.
3. Australian Commission on Safety and Quality in Health Care, 2012. *NSQHS Standards fact sheet – Standard 3: Preventing and controlling healthcare associated infections.* Accessed on July 25, 2016, at http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/NSQHS-Standards-Fact-Sheet-Standard-3.pdf.
4. Health and Safety Executive, 1999. *Reducing error and influencing behaviour.* Accessed August 9, 2016, at http://www.mewpsafety.co.uk/app/download/5794850745/HSG48+Second+Edition.pdf

*Professor Jane Reid's visit to Australia was sponsored by BD Medical.

THE DIFFERENCE OF ONE PARTNER

MAKING AN IMPACT ON HEALTHCARE-ASSOCIATED INFECTIONS. Across the world, BD works closely with healthcare organisations to combat healthcare-associated infections (HAIs). HAIs, or infections acquired in healthcare settings, are the most frequent adverse events in healthcare delivery worldwide.[1] In Australian healthcare facilities, the impact of HAIs is significant—ranging from needless patient suffering to strained resources and related costs. **Our broad portfolio of solutions and global insights combine products, education, screening, diagnosis and surveillance,** helping you minimise the risk of HAIs, deliver improved patient outcomes and control costs. Discover the difference one company can make. **Discover the new BD.**

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1 World Health Organisation. Patient Safety: *Healthcare-associated Infections Fact Sheet.* Accessed on August 5, 2016 at http://www.who.int/gpsc/country_work/gpsc_ccisc_fact_sheet_en.pdf

The S-Monovette® is the revolution in blood collection.

The S-Monovette® is an innovative enclosed blood collection system that allows the user to draw blood from the patient using the syringe or vacuum method, uniting the advantages of both techniques in a single product.

When used as a syringe, the phlebotomist has full control over the speed at which the blood is drawn into the tube. This is particularly useful for patients with fragile veins, such as the very young or elderly, where the use of the aspiration technique prevents even the most fragile veins from collapsing. When the tube has been filled, the plunger is simply snapped off to leave a primary sample tube which can be centrifuged and is compatible with all major analysers.

The S-Monovette® can also be used as an evacuated tube by drawing the plunger fully down and snapping it off immediately prior to blood collection. This creates a fresh vacuum and ensures a precise filling volume, ensuring a correct dilution ratio.

The reduced vacuum pressure in the S-Monovette® drastically reduces the rate of haemolysis and vein collapse, meaning increased sample quality and reduced costs associated with repeat collections. Furthermore, unlike pre-evacuated tubes, the S-Monovette® does not have to hold a vacuum for many months after manufacture, which allows the membrane stopper to be thinner and more easily penetrated by the needle sheath. This minimises the movement of the needle in the vein when attaching the tube, ensuring optimum patient comfort.

The S-Monovette® needle is ready to use so that there is no need for assembly to a holder. The needle is of a compact, low profile design, which reduces the chance of haematoma by allowing for a reduced angle of puncture and eliminates the possibility of needle stick injury caused by assembly of the needle and holder. The compact design also results in approximately one sixth of the sharps volume caused by using a pre-evacuated system, giving significant cost savings.

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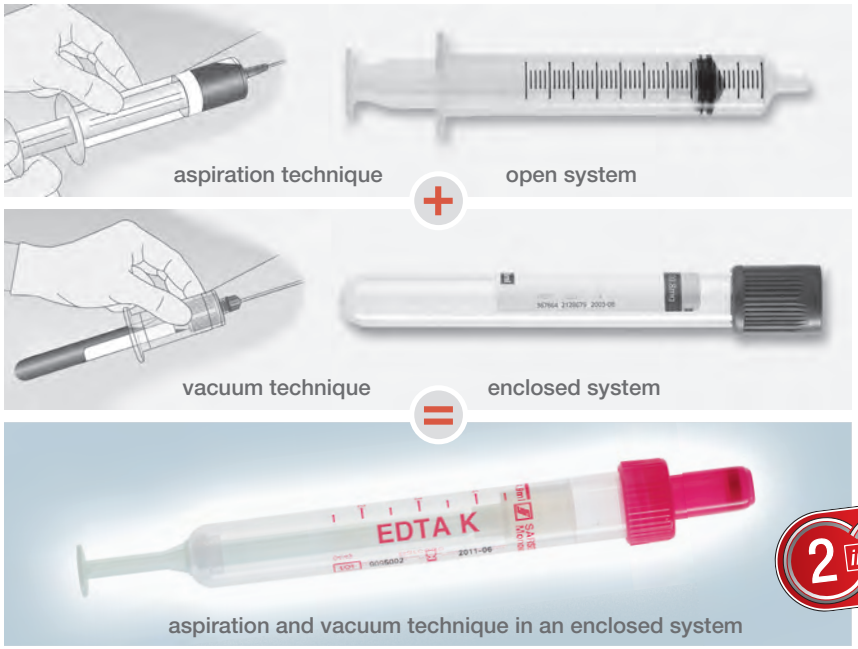

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To meet your laundry requirements, Richard Jay offers a wide range of durable industrial Electrolux laundry machinery Australia wide and has Infection Control solutions to suit all laundries. In addition we can provide you with guaranteed service response on every machine.

With a long history of in-house laundry we are a specialised company that is constantly improving to give the best service to our customers. We understand that your core business is not laundry, fortunately it is ours. Infection control and potential cross infection in laundries is important so we work closely with the Australian laundry standard AS4146. As such the Electrolux machinery we offer for your laundry is the only one of its kind certified worldwide for the Risk Analysis Bio-contamination Control method (R.A.B.C).

We have Infection control solutions to suit all laundries. From a 5.5kg front load washer for mops and Microfibre all the way through to 110kg Barrier Washer Technology for full On Premise Laundry. For maximum infection control whether you choose Thermal disinfection or Low temperature laundering through the use of Ozone Technology, we are able to provide you validation of your wash process with information on whether your load has passed or failed disinfection.

The wide range of Electrolux professional washers, dryers and ironers are known globally for the best quality and high durability with low running costs; you can still have the best quality results in your laundry with the lowest cost per wash. The use of Power Balance™ on the high spin washers creates real time monitoring of unbalance and adjustment of G-force throughout the entire extraction sequence.

Is capital investment in laundry machinery an issue? Richard Jay Capital Plus allows you to benefit from new machinery installed with no capital outlay and free breakdown service. Capital Plus is company owned with no third financial party involved. Across Australia, the entire process is managed by the Richard Jay team.

Richard Jay Laundry Matters

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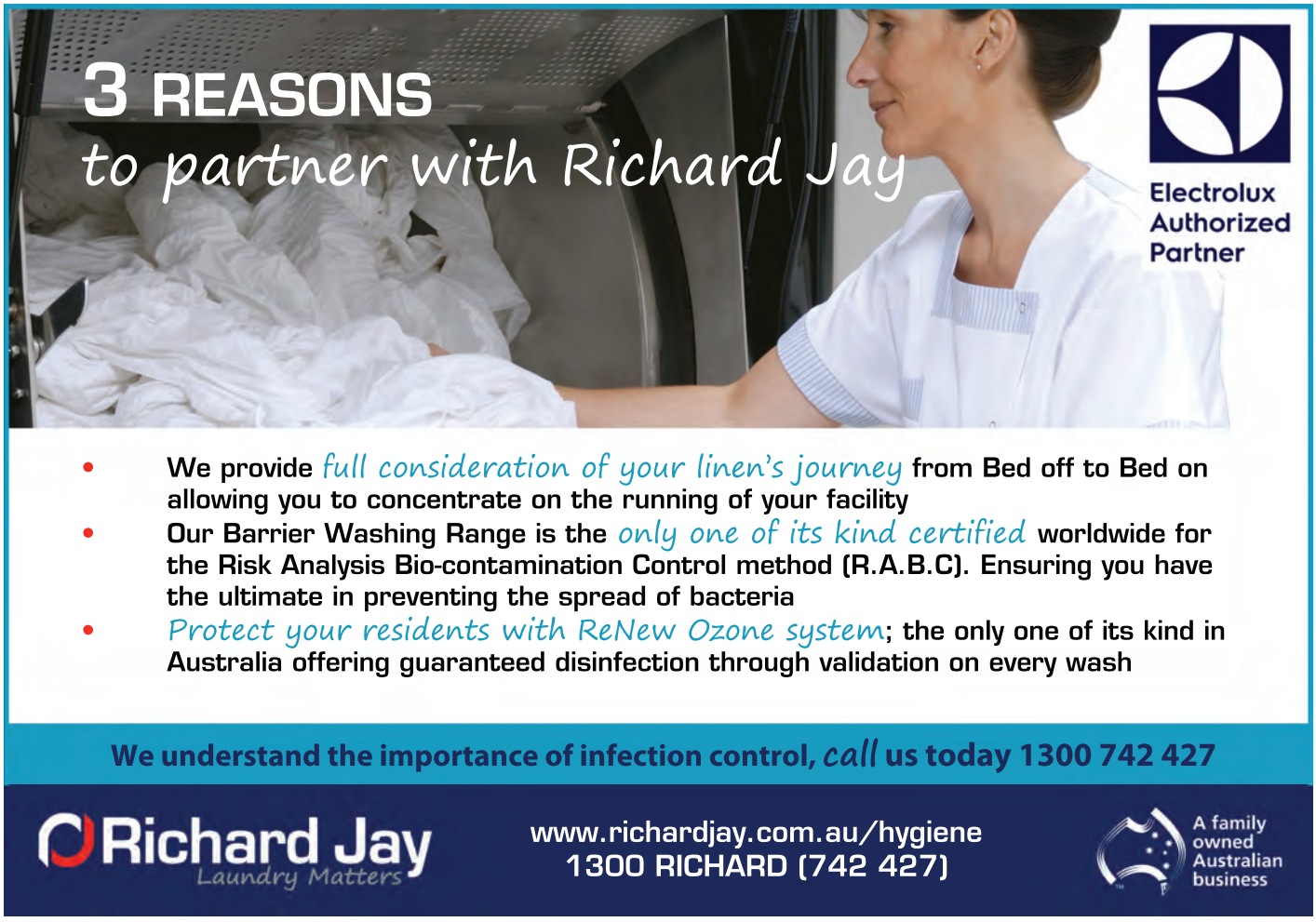

Fabric that's good for you

Hi-tech fibres for the high demands of infection prevention and control.

Hospitals, clinics, medical practices, retirement homes and mental health institutions, to name a few, all provide perfect breeding grounds for bacteria. In fact, anywhere textiles require frequent washing there are also questions raised about factors like easy care and economy.

That's where Trevira CS Bioactive textiles are consequently ideal for use in areas where there is a strong emphasis on cleanliness and freshness. It goes without saying that having both flame retardant and antimicrobial fibres that hold the Oeko-Tex Standard 100 certificate are thus free from toxic substances.

Trevira CS is perfect for the Healthcare sector, not only being an eco-friendly material but as an antimicrobial fabric with permanent bioactive properties that prevent bacteria from multiplying in or on the fibre to meet the highest requirements of cleanliness.

We proudly offer these innovative and dimensionally stable Trevira CS® fabrics in plain, printed and reversible ranges which are suitable for use as bedscreens, curtains and bedspreads. Additionally, they work well with our curtain track systems for a total healthcare solution and can be coordinated to suit your interior furnishings.

Vertilux is Australia's leading supplier of cutting edge Curtain Tracks.

Our Healthcare Curtain Track Systems used for separating areas such as hospital beds are also suitable for showers and work exceptionally well in both professional and hospital environments. 'Mottura by Vertilux' offers you Italian design and excellence that is proving to be a winner against its rivals.

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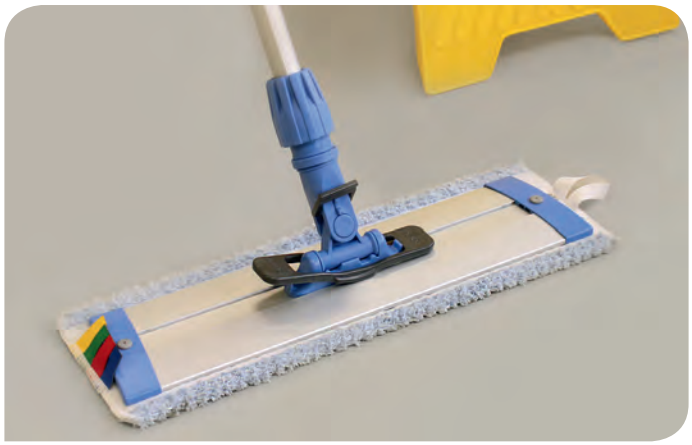
Sabco Bleach Resistant Microfibre Flat Mop

Sabco is proud to announce the ultimate innovation in microfibre: the new MicroFX flat mops range. Thanks to the latest research into yarn development, the next generation microfibre from Sabco is not only the finest microfibre ever, but it also guarantees the longest life performance due to its resistance to strong chemicals, in particular bleach.

Microfibre is notorious for losing its effectiveness after use with highly alkaline chemicals such as chlorine. The most evident effect is often a change of colour, but less evident to the naked eye is the deterioration of the fibre and consequently, loss of strength.

The **MicroFX Hygiene** mop is bleach resistant and can be pre-prepared for use and even laundered with chlorine chemicals. It is the ideal mop for cleaning Hospitals, Clinics, Aged Care Homes and general cleaning activities where chlorine based chemicals are mandatory and hygiene is paramount.

The **MicroFX Xtreme** mop is the ideal solution for effective cleaning of Hospital bathroom floors. The majority of floors installed in a healthcare environment offer anti-slip/safety solutions that prevent most of the existing mops from gliding easily. Thankfully, the unique yarn composition of the MicroFX Xtreme alleviates this issue.



The MicroFX flat mop range is certified by SGS, the world's leading inspection, verification, testing and certification's company. After undergoing several tests to measure the chemical resistance and longevity of the MicroFX flat mops, results concluded that these mops can be laundered up to 600 times. Moreover, the no-filling construction of the mops guarantees the highest level of hygiene, avoiding dirt residue to remain in the mop after laundering.

The mops have been designed to match any cleaning need and floor type with colour tags to help distinguish between the different environments of usage. They are available with two attachment options: velcro or pockets with universal flaps, making them compatible with any mop base on the market. Their ability to be used with a damp pre-prepared system or a wet flat wringer bucket offers great versatility for a variety of applications.

»

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Register now for ACIPC 2016

20 – 23 November 2016, Melbourne Victoria.

About the Conference

The ACIPC Annual Conference is Australasia's pre-eminent conference for Infection Prevention & Control professionals.

Building on the success of arguably our most successful conference last year in Hobart, ACIPC 2016 promises a wealth of interest as we tackle the challenges and embrace the opportunities for the future of our profession.

Program

The full conference program including pre-conference workshops, invited speakers and peer reviewed free papers is now available online at **www.acipcconference.com.au/program**

Registration

Registration is now open for the ACIPC 2016 Annual Conference being held at the Pullman Melbourne Albert Park, 20 - 23 November.

- ACIPC & Editorial Board Members – Early bird: AUD$765
- Non-Member – Early bird: AUD$865
- Student – Early bird: AUD$550

All full registrations include:
- All conference sessions (excluding pre conference workshops)
- Welcome Reception
- Poster Reception
- Presidents Breakfast
- Morning tea each day
- Lunch each day
- Afternoon tea each day

Early bird registration closes 9 October 2016.

Visit **www.acipcconference.com.au/registration** to register

Pre-Conference Workshops

Sunday 20 November, Pullman Melbourne, Albert Park
- New Initiatives in Hand Hygiene
- Antimicrobial stewardship (AMS) for nurses
- Implementing change: a focus on infection prevention and control
- An introduction to understanding and using epidemiology
- Credentialing
- Australian Premiere Screening of 'Clean Hands', followed by Q&A with Professor Didier Pittet

*Space is limited for some workshops and we recommend registering early to secure your spot.

Invited Speakers

- Dr Jennie Wilson
- Professor Mary Dixon-Woods
- Professor Patricia Stone
- Professor Dale Fisher
- Professor Didier Pittet
- Martin Kiernan
- Professor Heather Loveday
- Professor Tom Riley
- Professor Peter Collignon
- Dr Becky Freeman
- Professor Marianne Wallis
- Professor Alison Kitson
- Dr Peta-Anne Zimmerman
- Dr Deborough MacBeth
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- Greg Whitely
- Professor Karin Thursky
- Cate Quoyle
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3 minute research

The ACIPC 2016 Scientific Committee is now accepting submissions for 3 minute research presentations from interested researchers who are proposing a project or are about to commence or have recently commenced a project.

In this session, included as part of the main scientific program, selected researchers will have 3 minutes to discuss their research project.

This call for participation opens 1st September and closes 7th October.

For more information, visit **www.acipcconference.com.au/3-minute-research**

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- Professor Mary Dixon-Woods
- Professor Dale Fisher
- Martin Kiernan
- Professor Heather Loveday
- Professor Didier Pittet
- Professor Patricia Stone
- Dr Jennie Wilson

Benefits of attending ACIPC 2016

- Opportunities to see how knowledge and research is translated into practice
- Access to international, national and local Infection control and prevention and infectious disease expertise
- Access to the latest evidence based research
- Networking
- Information about products and product experts
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Panel of Experts - Open Disclosure

Panel of Experts is a forum for industry professionals to share their opinion on a topical issue relevant to healthcare. In this issue our expert panel weighs in on the question

What are the implications for patients and healthcare workers in a culture of open disclosure and why do we still find it hard to say sorry?

MS CAROL TREVOR

Director Safety, Quality and Innovation,
Sunshine Coast Hospital and Health Service

Responding to and supporting patients, families, carers, and staff after an adverse event can be a complex process.

The Australian Open Disclosure Framework (2013) and the Queensland Health Best Practice Guide to Clinical Incident Management (2014) identify that good skills in communicating with patients, families and carers, and staff, are critical to achieving good clinical outcomes and meeting patient expectations. Open Disclosure facilitates open and effective communication; supporting patients, families, carers, and staff after an adverse event. Healing can be facilitated and restoration of therapeutic relationships can occur.

Unfortunately, many clinicians still find it hard to say sorry or express regret. Until recently the misconception it was necessary to protect individuals or organisations from expressions of regret was common. This, along with anxiety and guilt all influenced how clinicians approached disclosing information after an adverse event.

Saying SORRY is an important, powerful way to show empathy and respect. Research shows genuine open disclosure protects clinicians and leads to patients, their families and staff feeling supported.

Open and transparent communication also reduces suspicion, restores trust and fosters an environment that delivers responsive and respectful care that meets individual needs. This lessens, not increases, the risk of liability and litigation. It is OK to say sorry.

DR MARK O'BRIEN

Medical Director and co-founder
of the Cognitive Institute.

Even when a patient suffers the most serious, preventable adverse outcome it is extraordinarily rare to find that the clinicians providing care deliberately set out to do harm. As a result, good clinicians can be deeply disappointed or feel guilt when such an event occurs. No one looks forward to discussing circumstances where their actions may have contributed to a sub-optimal outcome; clinicians are no exception.

However, we have known for many years that an important prerequisite for patients to come to terms with a serious adverse outcome is a full understanding of how the harm occurred, what is being done to repair the harm where possible and how such harm will be prevented in the future.

As challenging as it is, providing an open and honest explanation and an apology for suffering caused are the hallmarks of good clinical care after an adverse outcome. Patients who have suffered harm deserve the same quality communication after an adverse outcome. The great news is that experience from across the world shows that when clinicians provide this open and honest communication they are helping patients to heal psychologically and are setting up an environment where, despite disappointment, there is the highest chance of a functional relationship continuing with their patient.

ADJUNCT PROFESSOR DEBORA PICONE AM

Chief Executive Officer, Australian Commission on Safety and Quality in Healthcare

In my experience, the best health services and clinicians, as a matter of routine, do have a culture of open disclosure, do let patients and families know when something goes wrong and do apologise.

Open disclosure has been around for twenty years and the Commission did publish a framework document in 2013 that covers how to prepare your organisation; the conditions under which you need to engage in open disclosure, the legal aspects, patient considerations and very importantly - how to educate staff in the open disclosure process and have the conversation with a patient and family.

All state and territory governments have legislation that protects staff in the open disclosure process and medical defence funds support the policy. So education in this area is critical in dispelling fears about medico-legal consequences of disclosure. Many of Australia's leading hospitals, particularly in the private sector, have embraced the National Patient Safety Standards. With the new Standards scheduled for release in 2017, we will see the open disclosure standard made mandatory.

I am very confident that by this time, the vast majority of hospitals and health facilities will have no trouble in meeting this standard.

My belief is that the vast majority of hospitals believe in and practice open disclosure, thus acknowledging the basic ethical right for a patient, family or carer to be told if something goes wrong.

ASSOCIATE PROFESSOR TINA COCKBURN

Australian Centre for Health Law Research, QUT.

Open disclosure[1] aims to foster an environment where patients and healthcare professionals feel supported and encouraged to identify and report adverse events. Timely communication to patients enables them to understand what happened, receive proper treatment and, where appropriate, compensation. Health care professionals, the "second victims," receive support from colleagues and the health service organisation. The health system also benefits where system issues are identified and addressed to improve patient safety, restore trust in the system and minimise unnecessary litigation.

Barriers to open disclosure include concerns about personal, professional and legal consequences of disclosure, as well as adequacy of communication skills[2], which may result in an "incident disclosure gap."[3] While some overseas jurisdictions have responded by enacting a statutory duty of candour, in Australia, the focus has been on developing a culture within health service organisations that values transparency, openness and patient-centredness through education of health care professionals and patients.

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Emergency Medicine in Rural Mali

Three-year-old Fatoumata receives a blood transfusion.

In Koutiala, in southern Mali, severe acute malnutrition, malaria, diarrhoea, respiratory tract diseases and other so-called opportunistic infections are creating havoc in children aged six months to five years. Dr Lisa Umphrey describes how Médecins Sans Frontières/Doctors Without Borders (MSF) is working to prevent infant mortality in a region that has very few health professionals.

Five years ago MSF approached the Ministry of Health (MoH) in Mali with a plan to combat endemic illness and mortality in children under five in the southern Mali. The key was to integrate community-level care and high-quality hospital services, via a continuum from prevention through to treatment for even the sickest children.

Early diagnosis and treatment by skilled staff in the community are essential to preventing severe sickness. The closer the healthcare, the earlier the contact, the better the results. But inevitably some children will become severely sick or develop complications, so it's important that the approach be networked, spreading primary care as widely as possible but linking it in with secondary-level care in the hospital.

Emergency Care in Koutiala Hospital

The Koutiala Reference Hospital paediatric department has emergency and resuscitation rooms; a newborn unit; an intensive care unit (ICU) and general ward for non-malnourished children; and an ICU and intensive therapeutic feeding centre for acutely malnourished patients. We sometimes describe this 210-bed facility as "the accordion hospital", because it has to almost double in capacity to respond to the malaria peak which results in a sudden rise in cases from the middle of each year.

When sick kids arrive at the admission area of the hospital we need to assess quickly to identify those patients with life-threatening conditions.

We use a system called ETAT (Emergency Triage Assessment and Treatment), one of several systems which forms the backbone of training for the Malian nursing and medical staff working with MSF. If a child is a "red" or critical case, this means they have a life-threatening condition or are in need of emergency resuscitation.

These patients are taken next door to the resuscitation room. Here they receive life-saving treatment, like cardiopulmonary resuscitation or rapid IV infusions to treat shock. If they survive, which unfortunately despite our best efforts not all do, they will remain in this resuscitation room until they are "stable" enough to move to the ICU.

If the child is critical but not in need of resuscitation, they receive initial care, such as IV placement, first dose of medications and lab tests in the emergency room before being transferred to the ICU.

Tiemoko – Severe Acute Malnutrition

Acute malnutrition can easily and rapidly develop into a medical emergency. One-year-old Tiemoko is such a case. He weighed just 5.5kg when he presented at the community health centre. His health had deteriorated after a bout of diarrhoea followed by the onset of vomiting and fever.

He was in shock, with his body in semi-shutdown mode to protect his most vital organs. He had lost an extreme amount of fluid, and this is was interlinked with his severe state of acute malnutrition.

Under the outreach doctor's supervision, Tiemoko was stabilised on IV fluids before he could be moved to Koutiala hospital.

Kids with severe acute malnutrition are incredibly sensitive to fluid shifts and cannot receive too much fluid at one time. Giving them too much can quickly push them into heart failure. In "normal" kids, you would often see a quick and positive response to your fluids, but for the malnourished child, they will decompensate in front of you with no apparent reason. Therefore critical management of these kids, in addition to the usual treatments, includes painfully slow and restricted fluid resuscitation or blood transfusions, very close glucose monitoring, and prevention/treatment of hypothermia.

On admission in the hospital Tiemoko's shock and malnutrition category classified him as 'red'.

In severe acute malnutrition you can see any type of shock and treatment will depend on correctly identifying the type of shock, which can be incredibly difficult in the MSF setting. Life-saving treatment for one type of shock can have an adverse affect for another type. The first step is to check and recheck that you understand what is happening to the child to cause the shock. The second step is to go slowly ahead with your treatment plan, changing immediately if the child starts to decompensate. Support would include (careful) IV fluids, antibiotics and/or antimalarials, oxygen therapy, control of blood sugar and haemoglobin and reintroduction of therapeutic milk as soon as possible after the child has stabilised.

Tiemoko needed to start therapeutic feeding but was too sick to feed orally. So a naso-gastric tube was inserted. On his second

One-year-old Tiemoko in the ICU at the Koutiala Hospital. He is too sick to feed orally so a naso-gastric tube was inserted.

General paediatrics ward, Koutiala Reference Hospital.

day at Koutiala, Tiemoko was able to move out of ICU into the next two phases of the therapeutic feeding program.

Into his second week, Tiemoko was much closer to recovery. He eventually made the transition from milk to therapeutic peanut paste, started breastfeeding, and gained weight. He could hold his head up, and sit upright— which were key milestones. A few days later he was able to be discharged back to the community nutrition program so that he could complete treatment for full nutritional recovery.

Fatoumata – Severe Malaria and Severe Anaemia

Simple malaria is treatable at community level here in southern Mali. But left untreated, or in severe form, malaria is nothing less than the number one killer of under-fives. Three-year-old Fatoumata first started showing signs of malaria at home, including fever, vomiting and diarrhoea.

At the community health centre Fatoumata tested positive for malaria, but had many of the indications of the severe malaria associated with this disease, such as panting when breathing, a fast pulse rate, and extreme pallor. Unsurprisingly she was very anaemic. Without a transfusion, she had only a few hours to live.

We immediately classified Fatoumata as an urgent case at hospital admissions. Most patients who present to the hospital with severe malaria will need rapid checks of their haemoglobin and blood glucose levels (and appropriate responses such as glucose boluses, transfusions and IV fluids), oxygen support, urgent administration of antimalarial and antibiotic medications, and close observation in the hospital. These patients can decompensate quickly and die from preventable complications even in the hospital.

Fatoumata was examined in ER and started on IV artesunate for her malaria. For her anaemia, she was blood matched via the lab, and then taken into ICU where we began her transfusion.

Blood transfusions are often the difference between surviving malaria and not. It doesn't take long before it's too late even for a transfusion. I've had too many patients die during the first hour of a blood transfusion despite doing everything right simply because the anaemia was too advanced by the time they reached the hospital. But the transformation for the many patients that survive is exemplified by Fatoumata—full of three-year-old personality and energy again, and on the cusp of discharge, within two days.

A Comprehensive Paediatrics Program

While emergency cases in Koutiala are inevitable, thanks to the integrated community and hospital care with vaccination, regular health monitoring and the focus on preventing malnutrition and malaria, mortality has been halved.

Life-threatening emergencies in Koutiala

- Cerebral Malaria with Seizures
- Severe or Cerebral Malaria with Severe Anaemia
- Hypovolemic Shock from severe dehydration caused by Gastroenteritis
- Sepsis and Septic Shock
- Meningitis
- Neonatal Sepsis
- Severe Malnutrition
- Severe Pneumonia with Respiratory Distress

You can read more about Médecins Sans Frontières' paediatric program in Koutiala here: http://childhealthmali.msf.org/

Dr Lisa Umphrey, MD.

Medical Advisor - Paediatrics,
Médecins Sans Frontières

Dr Lisa Umphrey, MD. Medical Advisor - Paediatrics, Médecins Sans Frontières Australia. Having qualified as a paediatrician in the US, Dr Umphrey moved to Uganda for three years where she worked with a number of international NGOs in roles including medical director, running their health clinics. Dr Umphrey joined Médecins Sans Frontières in 2013 and has completed two field placements in large hospital projects in southern Mali and in northwestern South Sudan. Lisa currently advises on paediatric, and particularly neonatal care, in projects in countries including Haiti, Mali, Nigeria and Papua New Guinea, as well as for emergencies.

McQuoin Park

Promoting Wellness in Aged Care

In May 2016, Catholic Healthcare commenced construction of a $120 million development project at McQuoin Park in Waitara, New South Wales.

FAST FACTS

- Catholic Healthcare is undertaking a $120 million development of their McQuoin Park aged care campus in Waitara, Sydney.
- It will integrate retirement living, aged care services and a state of the art health and wellness centre.
- Residents will have access to wellness programs that promote independence, links to the community and a high standard of clinical care.
- The design will incorporate energy efficient products and will retain the leafy character of the surrounding area and streetscape.

The first stage of construction is scheduled for completion in mid 2017, with the overall project being completed by 2020. The first stage of the development being built by Grindley Construction, will replace existing buildings onsite dating back to the 1980's that are struggling to meet the needs of the local ageing community of Sydney's upper north shore.

About Catholic Healthcare

Since 1994, Catholic Healthcare has grown to offer a range of residential aged care services, retirement living communities, healthcare services and home community services to over 6,500 persons in New South Wales and South East Queensland.

Once complete, the McQuoin Park integrated campus will offer state-of-the-art retirement living alongside residential aged care services, a health and wellness centre, onsite respite and community support for seniors. The new development will provide a range of options and benefit-geared solutions for all stages of ageing, offering a coordinated design, one that is tailored to individual needs and connects with the local community.

Catholic Healthcare's General Manager of Residential Care, Anne Maree Hodgson says, "At the heart of the development is Catholic Healthcare's determination to build a residential service and retirement living village offering community spaces such as a café, playground, chapel and lifestyle spaces for locals and the wider community."

Catholic Healthcare is challenging the idea that ageing is intrinsically linked to functional decline. McQuion Park will support ageing in place care and promote independence

Features of the Residential Aged Care Service include:

- **60kW Photovoltaic System (solar panels)**
- **Solar hot water system boost**
- **Rainwater reuse for landscaping**
- **Energy efficient lighting and use of sustainable environmentally responsible products**
- **Leading construction techniques such as use of pre-fabricated bathrooms**

through a new suite of evidence-based health and wellness programs. These are aimed at empowering residents to stay out of hospital by keeping physically and mentally active, eating well, staying socially connected and having access to a high standard of clinical care.

Residential Aged Care Service

McQuoin Park will offer 122 private, ensuite rooms to accommodate existing and potential residents. There will be two dementia specific wings for long term specialised care for residents, along with palliative care options to help achieve the best quality of life and comfort, offering support for residents, loved ones and their carers. Other types of care will include respite and transitional care.

"The private bedrooms with ensuites will be spacious enough for families to gather, plus there will also be lounge and sitting rooms, activities areas and a chapel for communal gatherings," says Anne Maree Hodgson

Retirement Living

168 units housed in five retirement living buildings will provide a range of communal living services including a therapy pool, gymnasium, cinema, library, hair and beauty salon, men's shed, activity rooms, dining and living spaces. Lift and ramp access will be available throughout the village.

Health and Wellness Centre

The health and wellness centre will expand upon the services currently offered to carers and their loved ones. The centre will provide an additional space for more specialised programs, such as dementia respite services, restorative care programs and engagement activities for seniors living independently in the local area.

Cafe and Playground

Designed as a public link between the site and the surrounding areas, the café will provide a meeting place for residents, visitors and families together with the local Waitara community. This café will provide social experiences which is integral to seniors living well.

Site Ecology and the Environment

McQuoin Park will be nestled around portions of the remnant Sydney Blue Gum High Forest. The scale of the existing trees helped inform the design and height of the proposed development. The height of the buildings is set to be below the tree canopy height, thus retaining the leafy character of the surrounding area and streetscape along the Pacific Highway.

Catholic Healthcare's, General Manager of Property, Michael Lockwood says, "This is an exciting time for the expansion of Catholic Healthcare's portfolio. Our McQuoin Park development will provide a modern, integrated aged care service to Sydney's upper north shore region. The development is currently progressing well and we look forward to the completion of the first stage."


Image credit: LGH Specialist Clinic by Artas Architects

The Role of Textiles in Healthcare

Considered design choices play a key role in building or refurbishing a healthcare facility. Research has shown that a well-designed nurturing and therapeutic environment contributes greatly to how a patient and family perceive their quality of care and their overall experience.

Healthcare facilities that are designed in a less clinical way have better patient outcomes and recovery times, thereby reducing the patient's length of stay. Design positively affects staff satisfaction, thereby enabling the facility to attract and retain quality staff with an improvement in morale. Design can also reflect a sense of the facility's image, reinforcing its strategic goals and point of difference.

Healthcare furnishings provide the scope to achieve this. Textiles can also play a key role in creating a healing environment, adding colour and texture to areas that otherwise would look quite hard, cold and clinical.

Australian healthcare textile supplier Instyle offers a wide range of coordinating drapery textiles, upholstery vinyls, Cryptons, wallcoverings and acoustic solutions that reflect this design philosophy.

For designers and healthcare facilities that prefer a more customised solution, Instyle's design studio can also work closely with clients to best interpret their vision.

Instyle's experienced designers are problem solvers combining design expertise with technical knowledge to create functional yet individual solutions for specific projects.. Carol Debono, a textile designer with Instyle, says "The client's brief can be met with a new design, a re-colouration of one of our existing healthcare products or fulfil a more complex technical brief of creating designs for specific budgets, weights, widths, finishes and performance requirements."

A recent project wanted to include a connection to the local area and the surrounding landscape into the design to define specific areas. By customising the colours in the privacy curtaining to coordinate with the company's extensive range of vinyl and Crypton upholstery, Instyle was able to support the designer's vision of natural themes throughout the facility.

In the case of Royal North Shore Hospital, the designer wanted the privacy curtains to echo the colours used in the wayfinding graphics and external façade of the building. Debono says "we developed a construction that allowed the same intensity of colour to be seen on both the face and back of the privacy fabric. The result was a fully reversible dynamic and colourful textile that became the focal point of the room."

A solution can also be derived to meet established design standards. "We have customised widths ranging from 186cm for medical centres that require shorter curtaining to 280cm for a full hospital length curtain with no track, particularly suitable for mental health areas."

With most healthcare furnishings refreshed every 7-10 years, Instyle can design a highly durable product that has a long lasting design aesthetic.

Instyle has developed numerous custom designs including Prince of Wales Private, La Trobe, Queen Elizabeth and Greenslopes hospitals to name a few.

Instyle's design studio can provide computer aided simulations and samples to assist the designer and healthcare facility in their decision making. Through its strong relationships with leading textiles mills in Australia and overseas, Instyle can organise prototype lengths and production. The result is a consistent and high quality product to create a healing environment.

INSTYLE HEALTH

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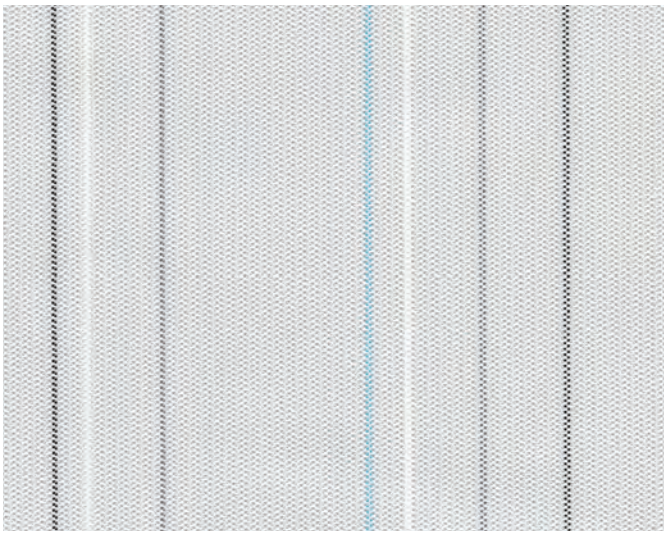
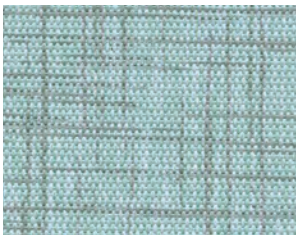
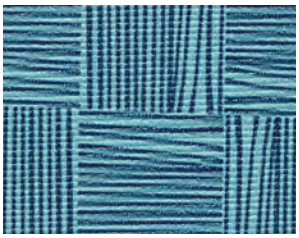


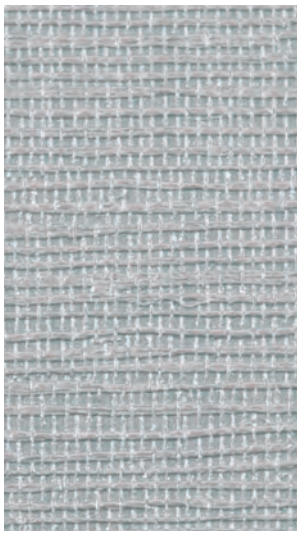
ONLINE Surf - curtain, privacy screen, bedspread



TEX Glass - vinyl



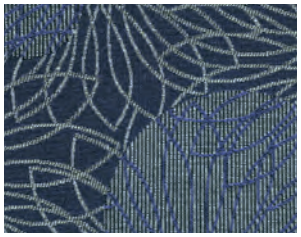
HATCH Thought - vinyl



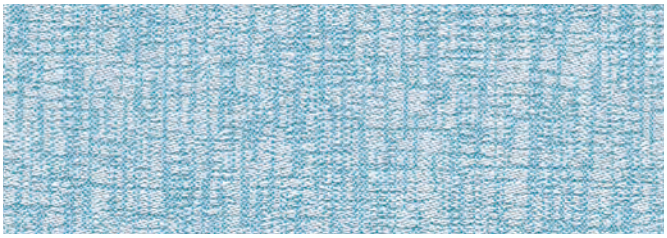
SAIGON Aqua - wallcovering

REFLECT Wave - curtain, privacy screen, bedspread

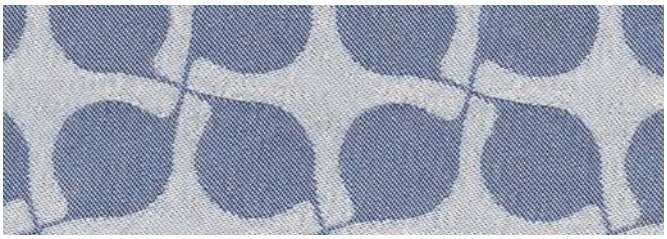
BUZZ Electric - vinyl



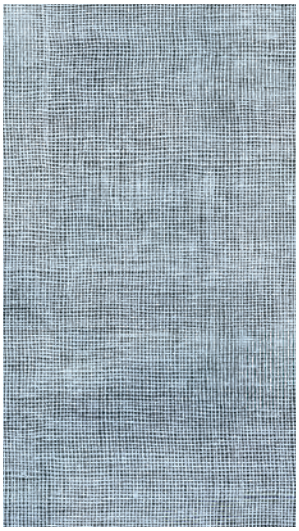
AVENGER Indigo - Crypton®



SKETCH Freestyle - curtain, privacy screen, bedspread

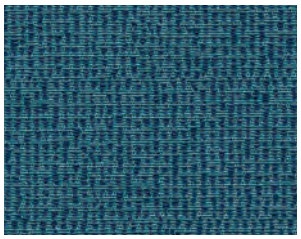


EDITION Relax - curtain, privacy screen, bedspread



TOBAGO Horizon - wallcovering

MAVERICK Paradise - Crypton®



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INSTYLE HEALTH

Florabella Lounge Chair.

Designed by Martin Linder for Herman Miller.

It would be safe to assume the majority of us would conscientiously avoid spending time in hospital waiting rooms. When designer Martin Linder was engaged to design a new line of healthcare furniture however, he spent six months in waiting rooms gathering information to discover exactly how he could improve what is rarely an inviting space for its users.

Linder sat and talked with people and observed their emotional states. He made notes of well-worn, uncomfortable seating with a tendency to entrap materials like food, hair and liquids. He observed the constant traffic, frequent cleaning and particular habits that caused the furniture to deteriorate more quickly.

Linder's unique insights from this intensive research helped him to set forth three priorities for the design of the Florabella Lounge Chair:

1. Limiting dirt and pathogen build up;
2. Maximising durability in key areas; and
3. Creating a chair that is comfortable for long periods of sitting, and provides emotional comfort for those in crisis.

The Florabella Lounge Seating Collection, manufactured by Brandrud (a Herman Miller company) tackles each of these issues.

To combat the growth of pathogens in difficult to clean areas, Linder introduced an innovative floating seat. Florabella's contoured seat and back are separated by a continuous, wipeable gap that allows residual dirt to fall to the floor, where it can be easily and thoroughly cleaned.

Infection control is also supported by reusable contact points on the arm rest and legs, which are durable enough to withstand constant cleaning. Elbow pads, reminiscent of patches on the sleeves of a suit, are a considered response to a habit Linder observed in waiting room users, who would pick and pull at the fabric in this place.

Florabella's barrelback design 'hugs' the user and allows patients to either sit upright or slouch deep into the chair. Emotional comfort is built in too — the shape creates a feeling of privacy that is often lost in waiting rooms.

The chair's frame is crafted from steel, suspending the seat and providing sturdy support. The urethane seat pad is highly durable and cleanable, yet also soft to the touch. Replaceable components ensure lasting performance in demanding healthcare environments, while multiple fabric options and coordinated tables enable harmonious design.

The Florabella range is GREENGUARD Gold certified, and comes backed by a 12-year warranty.

Stylish, comfortable and easy to clean, the Florabella Lounge Seating Collection sets new standards for seating in demanding healthcare environments. Martin Linder's work was recognised by Contract Magazine and the Center for Healthcare Design (US) with a prestigious Nightingale Award—considered the Oscar of Healthcare design.

"I love design projects that are grounded in performance, rather than aesthetics," says Linder. "Where there's research and a search for problems to solve and innovation to occur."

HermanMiller Healthcare

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HermanMiller Healthcare

Slim Jim™ Step-On an efficient, hands free waste management system

Storage and disposal of refuse is a necessary process in the hospital and healthcare workplace. In an environment that is notoriously busy, staff shouldn't have to worry about where waste must be stored, or about the safety risk of tripping over a large bulky bin. It is important that the process of storage and removal is streamlined to ensure a clean and efficient workplace.

The Slim Jim™ Step-On refuse container by Rubbermaid Commercial Products® is designed to address issues of workplace safety and cleanliness. The container has a slender design and small footprint, meaning it can fit in tight spaces while not compromising on the ability to hold a large amount of waste. The durable construction allows for a hands-free operation, to ensure the user does not have to risk potential contamination.

"The Slim Jim Step-On is designed with a slimmer profile and fills the gap in the market for a smarter and safer refuse container. Healthcare and hospital environments demand hands-free waste management solutions to stay aligned with the Waste Management Guidelines provided by the NSW State Government regarding the risk associated with waste," said Alicia Fenwick, Senior Manager, Brand Marketing at Rubbermaid Commercial Products. "Slim Jim Step-On containers intuitive design helps minimise the risk of cross infection between patients and staff, helping to provide a safe and healthy working environment."

The availability of the Slim Jim Step-On in five sizes and eight different colours allows for easy refuse management as state based regulations require all waste to be stored in colour coded containers indicating its contents. Through the use of the colour coded system productivity is heightened by reducing the minutes needed to find the correct bin for the refuse on hand.

The ability to thoroughly clean refuse containers in hospital and healthcare facilities is enhanced by the smooth surface of the Slim Jim Step-On and the round edges that are incorporated into its design. This ease of maintaining a hygienic bin results in the decreased opportunity for pathogens to breed.

The Slim Jim Step-On design not only has safety, time efficiency and functionality in mind, the built in lid dampener ensures a quiet and controlled lid closure that minimises noise; allowing patients and patrons to be undisturbed. The commercial grade foot pedal is engineered for extreme durability, significantly extending the product life and reducing the cost outlay for the business in repurchasing equipment in the future. It also has an internally hinged lid, preventing wall damage when placed flush against the wall.

The Slim Jim Step-On is not only available in five sizes and eight colours, it is also produced in resin and stainless steel with two pedal placements options, (front and side) depending on the space in which it will be stored.

This collection also includes containers with dual liner options to facilitate recycling.

Rubbermaid Commercial Products HYGEN

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The Slim Jim Step-On line can be purchased through distributors nationwide. For more information about the containers or to find an RCP distributor or wholesaler, please visit **www.rubbermaidcommercial.com.au**

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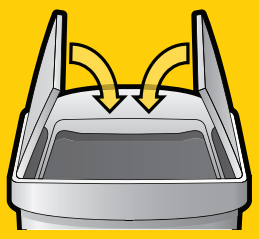

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Friendly Vs. Functional

Aaron Fertjowski and *Shawn Godwin* of Base Craft Medical, share their views on why hospital design and build has never been more challenging.

A surge in contemporary, patient-focused design in medical centres and specialist rooms is creating major challenges for hospitals that are being swept up in the luxury trend, according to experts in the field.

With research now indicating that patient and staff-friendly environments can have a positive impact on the treatment and healing process, hospitals are increasingly taking note.

But Aaron says hospitals present an entirely new set of challenges when the 'push for plush' is on.

"From a building perspective, unlike a medical centre for example, we are faced with a space that has 24/7 activity," he explains.

"This means access is an issue and noise needs to be carefully considered. Not to mention the incorporation of highly technical diagnostic equipment and treatment facilities."

"This then brings into play considerations about costs and efficiency, which we regularly encounter with projects that involve redeveloping or refurbishing hospital spaces," Aaron says.

"The key for us is to determine exactly what the client's requirements are in terms of noise minimisation, because there is definitely not a 'one size fits all' approach to this aspect of building work," he explains.

"Noise insulation technology has come ahead in leaps and bounds over recent years to deliver better outcomes in noise sensitive environments like hospitals," he says.

"One of the major trends we have identified is the move towards a more 'holistic' approach to patient treatment and care," he says.

Shawn Godwin, director, shares, "We're seeing more primary health care facilities wanting to adopt a 'wellness' approach to patient care."

"This has some exciting and challenging consequences from a design perspective when you're confronted with a project that demands some vital functional elements that are critical to the treatment process," says Shawn.

"To then overlay that functional design brief with a plush aesthetic, that's where experience comes into play because many designers will simply see the two requirements in constant competition," he says.

"It is important to take a less binary approach and find those happy mediums where the 'function' and the 'friendly' can work together," Shawn says.

"For example, medical spaces have key functional requirements like non-slip surfaces, minimum access widths for wheelchairs and gurneys, and hygiene control measures that, with a bit of thought and creativity, you can implement without making the space visually 'sterile'," he shares.

"Use of colour is very important in a hospital environment. There is no hard and fast rule to

Springwood Medical Centre - a dedicated corner for kids to play

Grey Street Medical blending function and comfort

say that if you need a non-slip surface, it has to be black," he says.

Shawn continues, "Hygiene and disease control points can be an eyesore if you apply purely functional thinking. It is possible to make these spaces appear more inviting with the use of contemporary fittings, smooth textures and the right colour scheme."

"Play spaces for children are a good example where you can be too 'functional' in your approach. Often you want the space to be separated from patients, but not segregated. Clever design can find that happy medium," he says.

"It can even come down to the way you display reading material in hospital areas which many people perceive as being a haven for germs. Consider fresh ways to display brochures, books and magazines so that people don't have to rifle through items," Shawn says.

Shawn advises, "Applying a 'people focused' approach to your medical projects requires a deep understanding of the patients, doctors and staff who'll be utilising the clinical space you are creating."

"And," he adds, "those who inhabit hospital environments have ever-changing needs and desires."

"We've found patients want to be more educated about their conditions and families want to be more involved in the process of caring for their loved ones," Shawn says.

"So designing spaces like mini-libraries for patients is something that has been proposed to us, as well as providing food preparation areas for the families of patients so that they can all dine together," he says.

"While there is a constant push and pull between functionality and a pleasing 'look and feel' in designing hospital spaces, I find that natural tension a catalyst to some real creativity."

"That's where my passion for these projects lies," he says.

"It is important to take a less binary approach and find those happy mediums where the 'function' and the 'friendly' can work together."

Automated Bedlifts Provide More Hospital Floor Space

Materials Handling's Bedlift Vertical Storage solution aims to meet one main goal: maximizing hospital floor space in the most efficient way possible. The Bedlift is a space saving vertical storage solution and a cost effective way to remove unused "hallway beds" from hospital corridors as pictured above and store them in a neat and easy to access fashion.

Stacking unused beds vertically in a secure storage system will recover valuable floor space by reducing hallway clutter and removing potential fire hazards from hospital corridors. By using Bedlift, hospital maintenance departments will see a dramatic increase in storage capacity, organization and product flow, which will reduce down time and increase the number of beds available to patients.

In addition to increasing space and efficiency, removing unused beds from hallways reduces hazards, which will allow hospitals to meet or continue to meet standards regarding the storage of hospital beds.

These unique vertical stackers will also improve hospital's maintenance departments' capacity, organisation and product flow whilst reducing down time. This critically increases the number of beds available for patient use at any given moment.

Bedlifts are simple to use, and can be operated by a single person with the push of a button. Operating on the last in first out (LIFO) picking concept, the first bed is loaded onto the lift and raised vertically, which opens up space below the bed for the next unit. Available in heights of up to 3.8metres, you can select the height that fits your need best. Choose from models that can hold three, four or five beds with optional security gate to prohibit unauthorized use in public spaces. The Bedlift can store up to 5 hospitals beds vertically in a footprint slightly larger than a single bed for savings in excess of 70% of your existing floor space.

There are two configurations, end or side (lateral) loading and 11 models to suit from large beds to stretchers and are optionally available with Anti-Microbial Paint.

The six major benefits by installing Bedlifts are More Floor Space, Safe Handling, Easy Access, Maximum Storage, Fast Retrieval & Small Footprint.

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About Faraday

The accuracy and scope of MRI practice is rapidly increasing and the field has become increasingly competitive. New practices are opening and established practices are expanding continually, but at the same time, the demand for MRI scanning as a diagnostic tool is growing exponentially.

Advanced diagnostic techniques are routinely requested for an increasing number of procedures and MRI scanning is now being integrated into the operating theatre environment. This places more pressure on both privately owned and publically funded MRI facilities and many are working double shifts to cope with the demand and reduce waiting lists for urgent and everyday scans.

In short, MRI suite design is no longer just a matter of physical shielding, but also of human psychology and workplace productivity. The requirement is to engineer a patient- and staff friendly environment within the exacting physical demands of MRI cage engineering, yet still produce an efficient MRI suite at a realistic cost. This is the challenge we continually explore at Faraday P/L.

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A turn for the better

– for patients and staff

The way in which a Critical Care or ICU Bed turns, is not only absolutely critical to the safety of the patient, but the Nurses, Surgeons and Care staff that attend to the patient.

The Multicare critical care bed, when used in the critical care setting can provide a number of clinical and manual handling benefits. The clinical features include advantages for fine tuned patient positioning prior to clinical procedures and a reduction in preventable patient complications (such as respiratory and pressure related tissue injuries). Additionally, the safety and well being of the care staff, not only to aid the patient, but to protect against back injury is an integral feature of the MutiCare Critical Care Bed. The following article will outline the advantages for nursing and other operational support staff, as the Multicare bed can achieve a true lying surface lateral tilt without physical exertion. There are 2 key factors as to how the Multicare provides maximum safety of the patient and Care Staff

- The Multicare is a unique and intelligent bed capable of finely tuned patient posturing for critical care invasive procedures whilst still providing pressure area care and metrics such as weight trends etc
- The Multicare has a number of clinical, safety and logistical benefits for patients, staff and management

Patient Benefits

- **Automatic Lateral Therapy (ALT**) Lack of movement puts patients in critical and intensive care units in danger of a number of medical complications. Reduction of the residual pulmonary capacity, atelectasis and pneumonia are serious medical complications that affect the respiratory tract of longterm immobile patients. The positioning of the patient plays an important preventative role here.
- **Ergoframe enables** Easier breathing, eating & torso wound healing without additional complications are key benefits (diaphragmatic splinting & additional pain). The orthopneic chair® position created by the Ergoframe® mattress platform is intended mainly for patients with resting dyspnea, facilitating respiration. It combines a high Fowler's position, pressure reduction in the abdominal area for easier deep breathing and foot support, allowing the use of additional breathing muscles.
- **Platform Based True lateral tilt** will reduce inherent risks of manual handling (shearing/uncontrolled musculoskeletal movement), procedures & repositioning made easier & include pressure reduction
- **Side rail/Bed Exit Alarm/iBrake** reduced falls risk, tilt inactivated when side rail down

Surgeon, Nurse and Staff Benefits

Nursing is one of the professions with the highest risk of back pain. This is usually caused by the strain endured during positioning of heavy patients while providing care. Lateral tilt of the bed can help significantly in these situations. Work becomes much easier with automatic bed function, which also reduces the potential risk of human error.

- **Lateral tilt** reduced physical manual handling for procedures & Pressure Injury prevention (Refer to figure 1.0)
- **iDrive** safer, easier & quicker transport
- **Ergoframe** reduced manual repositioning
- **Digital data display** simple & accurate tilt measurement

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The Multicare is an ICU and Crtical Care Bed which is widely used across the world. More information can be obtained via **sales@acigroupaustralia.com.au** or phone on **1800 429 117**.

A Genuine Tilt for Nurse Safety

Designed to be ergonomically friendly, the tilt function, utilised in one easy touch, allows for the patient to be managed and handled with significantly less strain. With Genuine Lateral Tilt, the requirement for nurses to bend their back while reaching over to attend to the patient, is entirely removed. The benefits for patient recovery will exceed the expectations of your ward with the following features:

- Easier breathing
- Pressure injury prevention
- Falls prevention
- Prevention of pulmonary complications
- Safe X-Raying

The Multicare's innovative design has incorporated Staff Safety and patient recovery to create an optimal Critical Bed for your hospital.

BACK INJURIES

ERGONOMICALLY CORRECT

The Multicare bed with the lateral tilt.

ERGONOMICALLY INCORRECT

A bed without the lateral tilt. A huge risk of back injury in the lumbar area.

Nurses and care staff are highly susceptible to back injuries. With Patient Handling a key factor in the increased risk of injury, the Multicare's genuine lateral tilt is an ergonomic function that significantly reduces the physical strain when handling a patient.

The Multicare is specifically designed to care for both patient and staff - ask us for more information via sales@acigroupaustralia.com.au or call us on 1800 429 117.

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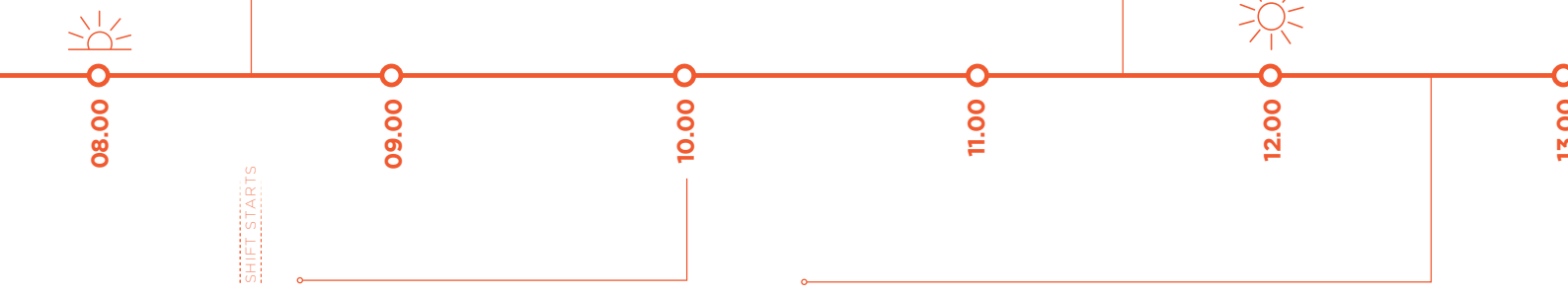
A Day in the Life

Dorothy Kamaker is the founder of Patient Advocates Australia. After decades working in ICU and ED as a clinician and academic she has trained as an independent patient advocate and supports clients with a broad range of health related issues. Patient advocates support patients to understand, navigate and negotiate the health and aged care systems.

There are 3 streams to her work: • face to face patient time • patient and provider related research/ administration and • teaching/mentoring and community workDorothy balances her time between these streams, but there are times where a sick patient can require 6 hours in a flash. What follows is a 24 hour period in her practice in March 2016 with reference to the case notes behind each of her diary entries.



08:30

CLIENT: Cecilia with mother Rosi's consent. Rosi had been deteriorating in hospital and shuttling between ICU and ward "without a clear diagnosis or plan" for 6 weeks and now her physicians are "contradicting each other about what is causing her problems and how to treat her." Cecilia and her brother Carlo are exhausted and losing confidence in Rosi's medical team. Rosi is becoming paranoid and combative and was refusing treatment.

Call from Cecilia. "Can you arrange a meeting with Mum's haematologist? Both my parents have had life threatening leukaemia. I have 2 teenage daughters, a sister and a brother. I have heard some blood disorders are hereditary. I want to know what are the implications of those diagnoses for me, my siblings and for my girls. Please ask him to obtain my father's medical records from 2006." Rosi has been given a prognosis from possibly imminent to between 3-30 months. Scheduled meetings with further specialists (haematologist and geriatrician) to clarify discrepancies in diagnosis/prognosis

10:00

CLIENT: Anne's great aunt Pip is in a nursing home and she is concerned about her management. In particular, Anne is concerned about an unexpected deterioration in Pip's condition, the adequacy of the nursing and GP care and her own availability and expertise to be responsible for monitoring and guiding Pip's care.

I accompany Pip to a consultation with a gynaecologist for assessment of vaginal prolapse and review of management options. I Arrange for ultrasound and laboratory results to be available. Review and revise nursing care plan with NUM.

11:30

Stop to grab a coffee and receive text from client, Jan, regarding her phone conversations with the two carer's I had short-listed for her to provide 4 hours/week of respite care/companionship for her husband Jon who was developing dementia.
"I agree. Of the two, Judy sounds absolutely perfect.
I have reviewed the care plan you emailed me and it looks fine."
I call the care agency to obtain Judy's police check, professional indemnity insurance and reference details and to arrange her engagement.

12:30

Attend workshop with community group to discuss understanding wills, guardianship, "enduring" instructions, living wills, advanced care planning, DNR orders, palliative care and the importance of having sensitive discussions with family members.

Patient Advocate, Dorothy Kamaker

"I have heard some blood disorders are hereditary. I want to know what are the implications of those diagnoses for me, my siblings and for my girls."

16:00

CLIENT: Elaine is concerned for her 74yo husband, Tim, who has fallen from a ladder and is hospitalised awaiting surgery on the neck of his femur. There is a possibility of a head injury. His level of consciousness is fluctuating. Elaine has enduring guardianship for Tim whose legal capacity is temporarily in doubt. Her mobility is restricted and she is unable to be at the hospital. Her daughter lives interstate and her son in London. Elaine needs me to be with Tim during urgent investigations and monitor his condition/care.

14.00 15.00 16.00 17.00 18.00 SHIFT ENDS

14:00

CLIENT: Deirdre's 93yo mother Helen has been deteriorating in hospital for 10 days with end stage COPD. Both mother and daughter accept the terminal nature of the illness but Deirdre feels their wishes about treatment are not being sought or respected.

Meet with Deirdre and Helen and her physicians and nurses to clarify Helen's wishes and devise a suitable direction and plan for her care with the view to negotiating a palliative care regime that I can monitor.

15:30

Phone conference Continuing Education session exploring Patient Advocacy Issues and Elder Law.

CLIENT: Chris, 57 year old male, referred by specialist who believes he requires thyroid surgery for a tumour. Chris is experiencing emotional and behavioural symptoms (consistent with hyperthyroidism) and is not accepting advice about the necessity for surgery. Initially received voicemail from Chris. I return his call but encourage face to face meeting rather than phone consultation to establish more personal contact.

Accompany Chris to consultation with his specialist to discuss proposed thyroid surgery. Provide Chris (and specialist with Chris's permission) with written report of Chris' thoughts about the consultation.

16:45

Time for a 15 minute break then a drive to Tim's hospital where I speak with Tim's neuro surgeon regarding a scheduling of surgery to evacuate subdural haematoma. I relay this discussion to Elaine and arrange a time to speak with Tim's son in London.

A Day in the Life is a regular column opening the door into the life of a person working in their field of healthcare. If you would like to share a day in your working life, please drop me an email: **ckelly@aprs.com.au**.

Dysphagia in Head and Neck Cancer

– the role of the speech pathologist

Professor *Liz Ward* has been a leading clinician and researcher in dysphagia management and head and neck cancer (HNC) care for over two decades. Professor Ward joins us to discuss the role of the speech pathologist in managing dysphagia in individuals with HNC.

What causes swallowing problems (dysphagia) in HNC cancer patients?

There are two main causes. The first is the cancer itself because if you have a cancer that has formed in your mouth, larynx or pharynx, its physical presence will disrupt the normal pattern of how we use those structures to control foods/fluids to swallow safely, placing the person at greater risk of aspirating the food/fluid.

The second cause is the management of the cancer. Management can involve surgery, nonsurgical techniques such as radiotherapy/chemotherapy, or a combination of these. Surgical excision and removal of some of the surrounding tissue around a HNC can result in removal of, or damage to, important structures critical to swallowing.

For those patients who require radiotherapy or chemoradiotherapy, the early stages of radiation treatment can cause painful ulceration in the mouth, leading to tender and sore tissues which make eating difficult. Swelling of the oral pharyngeal and laryngeal structures also impacts on how these structures work, leading to unsafe swallowing.

Furthermore other effects such as taste changes and feelings of nausea and fatigue (if chemotherapy is part of treatment), also impact desire/ability to eat and drink. Patients may need to receive non oral feeding to maintain their nutrition during their chemo/radiotherapy. After treatment, many patients are left with persistent swallowing problems which can be worsened by long term negative effects (neurological damage or hardening or swelling of the tissues) caused by the radiation.

Promising new advances in surgery and radiotherapy techniques target tumours more precisely and spare the healthy tissue around it. It is hoped these may help to reduce the side effects of radiotherapy and improve the swallowing outcomes for patients.

What does it mean to have swallowing problems?

The most common impact for most people with HNC is the damage radiation can do to the production of saliva resulting in chronic dry mouth and this can interfere with swallow. For others, surgery on the tongue, floor of the mouth, pharynx and larynx can make it difficult for a patient to control the food in their mouth - to hold it and then make sure that it goes into their oesophagus and not their airway. Swallowing safely, without aspirating, is the challenge for these patients postoperatively.

How is a patient's diet managed after treatment?

A diet for a person with HNC is different to other patient groups. Each patient needs to be individually assessed. A speech pathologist's role is to determine the type of food and drink that is easiest to consume based on the remaining structures and the impacts of radiation on that patient.

Once they start their radiotherapy, a speech pathologist will see most patients weekly to assess their pain and swallowing and see what is needed (eg., pain relief) to make it easier to continue eating.

Most patients will require some modification to the texture of their foods during and after treatment. Soft foods and those with more sauce/gravy/moisture content are easier for people with HNC to manage due to the lack of saliva. Some patients, though fewer than in other clinical groups such as post stroke, may also require modified or thickened fluids. Thickened fluids help slow the movement of the fluid in the mouth so the fluid is easier to control. This is useful if someone has had part of their tongue removed for example.

If a patient is too unsafe or unwell to eat orally, a nasogastric or PEG (percutaneous endoscopic gastrostomy) tube may be necessary to ensure their nutritional needs are met while they are receiving their radiotherapy treatment.

Can you describe your role in the management of these patients?

The speech pathologist's care of a patient begins at the time of diagnosis. A

FAST FACTS

- The 2 main causes of dysphagia in HNC are; the tumour itself interfering with swallow and treatment that can remove or damage important structures critical to swallowing.
- Postoperatively the challenge for HNC patients is to achieve a safe swallow without aspirating.
- Swallowing therapy with a speech pathologist begins before treatment and rehabilitation can continue for months or years.
- A speech pathologist will assess each patient individually and determine their diet depending on remaining structures and damage caused by radiation.
- The ScreenIT program at the PA streamlines services and reduces the burden on HNC patients.
- A Telehealth program run through The Royal Brisbane Hospital allows rural patients to return home and access their specialist cancer centre in the city remotely.

"In Australia we have a multi-disciplinary approach to cancer management that is recognised around the world as being best practice."

third of all patients will already be having trouble swallowing due to the presence of their tumour.

Prophylactic swallowing therapy begins prior to and during chemoradiotherapy. Patients are encouraged to do daily exercises to strengthen the muscles of the mouth and throat and teach them how to do a 'safe swallow'. It's all about not letting those vital muscles weaken and lose their function during the discomfort of radiotherapy. These exercises are modified during and post treatment. Post treatment, speech pathologists continue to work with patients for months or years to help them rehabilitate and optimise their swallow.

Do you work as part of a team?

In Australia we have a multi-disciplinary approach to cancer management that is recognised around the world as being best practice. HNC patients need care from a range of disciplines including specialist nursing, surgical and allied health. As part of that team, speech pathologists work most closely with the dietician to ensure that we are maximising our patient's nutrition and swallow safety.

Where are the innovations and solutions coming from in this area?

One of the challenges we are facing is to match the needs of the patients in rehabilitation with the services they need. Following HNC treatment, a patient will have extensive appointments booked with their care team. This can mean long hours spent at the hospital. Today, for example, Mr Jones may be coping well with swallowing but he really needs to see his physical therapist. So how can we prioritise him into the service he needs and allow him to spend more time with family?

At the Princess Alexandra (PA) Hospital the "ScreenIT" computerised screening project is underway.[1] This project, lead by Dr Benna Cartmill and Laurelie Wall, involves the patient answering a range of questions designed to take one or two minutes. A report is immediately sent to the allied health team who prioritise appointments for this patient. Our research into using ScreenIT shows this is an effective way to identify people who are experiencing difficulties and get them referred into the services they need in a timely manner. At the PA hospital, we are building up to full scale implementation of ScreenIT with the aim of streamlining our services and reducing the burden on patients.

The other challenge for patients is accessing specialist services. Most specialist cancer centres are located in capital cities. For our regional and rural patients - this presents another challenge. Where do they access services when they return home? At the Royal Brisbane and Women's Hospital we are running a telehealth project lead by speech pathologist Claire Burns.[2] With this post discharge ongoing support, patients can return home and, along with their local clinician, link in with the specialist cancer centre in Brisbane. This helps to ensure their local clinician is also well supported to provide rehabilitation locally, and helps to limit the need for frequent long distance trips for the patient.

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2. Burns CL et at. A pilot trial of a speech pathology telehealth service for head and neck cancer patients. Journal of Telemedicine and Telecare. Vol 18. No. 8 (2012).

Liz Ward

Professor Liz Ward is the Professor of the Centre for Functioning and Health Research in Metro South Hospital and Health Service in Queensland, and a Professor in the School of Health and Rehabilitation Sciences at The University of Queensland. Prof Ward's primary research area is the investigation of speech and swallowing outcomes for patients undergoing Head and Neck Cancer (HNC) management. Prof Ward has been published in over 200 peer reviewed publications. Her textbook, Head and Neck Cancer: Treatment Rehabilitation and Outcomes, Plural Publishing, is used internationally as the training textbook for this area of clinical practice in speech pathology.

Meal delivery Systems that adapt to the changing dynamic in Health and Aged Care.

Moffat reputation in the Healthcare market has been well earned. The Company's success in this market sector has come about due to the focus this market receives. Moffat has a healthcare division made up of a dedicated team of people experienced in the logistic challenges and day to day operations within this sector. Their brief is to supply what the customer needs and wants and to support that customer after the sale and beyond.

This personal focus when matched to a stable of traditional and innovative products affords the customer a diverse choice of meal delivery systems and operational procedures from:.

- Hospital tray assembly systems - traditional belt lines to smaller assembly stations using single individual operators in an ergonomic model called Blean.
- Traditional passive meal temperature maintenance systems from Aladdin Temp-Rite, such as insulated tray ware and plate covers.
- New active temperature maintenance options for both individual meals such as Heat on Demand and ready Chill from Aladdin Temp-Rite, to bulk (multi portion) food temperature retention for both hot and cold foods from SDX Thermobox.
- Meal delivery equipment for the Cook-Serve, Cook-Chill or Cook-Freeze operator. From single tray systems to multiportion trolleys with on board technology that records all operational events and can offer semi automation such as automatic turn on and program activation, from Burlodge.

Our Brands:

Aladdin Temp-Rite

A leader in the international market place for over 30 years Aladdin Temp-Rite and Moffat have built a strong reputation in being able to offer solutions for meal delivery and presentation. Aladdin has developed solutions for every food service application. And with a strong concentration on research and development is able to keep pace with the industry ever changing demands. The latest offering from Aladdin is the new Heat on Demand plate base activator: a 10 Kilowatt induction activator that can heat the special base in 12 seconds. This base when used in conjunction with the insulated plate cover can maintain the hot food portions for in excess of one hour, couple this with the Aladdin Ready-Chill base and cover and cold food can be maintained as well on the same tray.

While getting a hot and cold presentable meal is paramount we need to also address the issues associated with meal assembly and equipment storage, these issues can also be addressed with the Aladdin Supply solutions range of equipment. Items such as Bain Marie, cold wells, air curtain refrigerators, plating line conveyors, starter stations as well as tray, bowl, plate and plate cover storage equipment.

For the full range of Aladdin Temp-Rite solutions visit **www.moffat.com.au/brands/aladdin-temp-rite**

Burlodge

An international manufacturer that specialises in meal delivery equipment for: Hospitals, Prisons, aged care facilities and schools. With reputation for innovation, development, service and operational support.

The Moffat-Burlodge reputation is well established here in Australia. The key is the versatility of the equipment which can satisfy the needs of the Cook-Serve, Cook –Chill or Cook-Freeze operator. The equipment is built to give value for money over the long term and is constantly being improved via the heavy investment the company has in research and development. It is this very investment that enables us to be the number one meal delivery equipment brand in Australia.

With several different models for tray service and multi portion (bulk) meal delivery, finding the best fit for the customer needs is made easier with very little compromise. From large hospital delivery systems that are AGV (Automatic guided vehicles) compatible to the smaller multi-purpose aged care centres we are able to offer value in both the equipment and support.

For more information and the full range of products go to: **www.moffat.com.au/brands/burlodge**

SDX Thermobox

A Swedish manufacturer that specialises in equipment for temperature retention of food both hot and cold in mobile trolleys. Simplicity is the foundation of this company's success. The Moffat-SDX Thermobox has again been a successful partnership and delivers uncomplicated solution for food transport for both large and small facilities alike. From Meals On Wheels transport boxes to Major banquet carts used by the Hotel industry the SDX offering can contribute to our customers food transport and safety requirement.

Simple one touch controls with digital temperature display, the seamless internal stainless steel pressed tray guides allows cleaning to be as uncomplicated as possible. With CFC free foam injected insulation and solid base frame this product is built to last.

As with all the Moffat brands research and development play a key role in our ability to keep pace with the industry requirement, and SDX is no exception, we can if required have tailor made transport boxes manufactured to meet a specific need. Which is not as uncommon as one might think, we often have requests for specific configurations to address a particular logistic challenge.

MOFFAT

»

For more information and the full range of products go to **www.moffat.com.au**

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Hakuna Matata Frittata – it means no worries for hospitals

Flinders Private Hospital Adelaide and Healthscope Campbelltown Private Hospital are among a host of Australian hospitals enjoying cracking success in the kitchen with reduced contamination risks, as well as reduced overhead costs in preparation and cooking time.

The secret to their success is in the pre-prepared egg meals from Sunny Queen Meal Solutions – which offer increased efficiency in the kitchen and faster, nutritious meals for patients, with food solutions such as poached eggs, smashed egg, fritters, omelettes and more.

In response to industry demand, the range has just expanded to include Frittatas, with the hearty Vegetable and unique Asian Chicken and Corn varieties which make for a delicious lunch or a meal for any time of day.

Sunny Queen Meal Solutions' Frittatas are a powerhouse of nutritious vegetables and real eggs, and their texture is suitable for many patients. With a vegetarian option and another with chicken to satisfy all palates, hospital kitchens can serve up tasty meals with chunky ingredients in a delicate egg base that will ensure patients remain nourished during their hospital visit.

Mark Shevlin of Flinders Private Hospital Adelaide, first considered Sunny Queen Meal Solutions as a way of reducing contamination risks in the kitchen.

"In a hospital environment we are dealing with a vulnerable population, so having a safer product like Sunny Queen Meal Solutions is really valuable as it reduces the risk of infection and illness associated with using raw egg," he said.

"When you're responsible for ordering food for thousands of sick and injured people, you need to ensure you're considering taste, food safety, texture, how it's prepared and so much more,"

John O'Hara, Managing Director of Sunny Queen Meal Solutions, said Sunny Queen Meal Solutions understands the balance between chefs wanting the best eggs and kitchen managers needing to streamline expenses.

"We know that Australian hospitals serve around 33 million meals each year - that's a lot of preparation and cooking going on, and a lot of mouths to feed," he said.

"Under the food safety plan, raw egg is a hazardous product and a lot of effort goes into the storage and handling of eggs in a commercial kitchen to reduce any risk of contamination. Pre-prepared frozen egg meals remove the need for powdered or raw eggs, so real eggs can be served with confidence," he said.

Sunny Queen Meal Solutions products are cooked fresh and snap frozen, and are ideal for heating in microwaves and combi or conventional ovens. With no added artificial colours or flavours and HACCP certified, it's the smart decision for cooking in large quantities.

"When you're responsible for ordering food for thousands of sick and injured people, you need to ensure you're considering taste, food safety, texture, how it's prepared and so much more".

»
The full Sunny Queen Meal Solutions range along with images and nutrition facts is available to review at **www.sunnyqueenmealsolutions.com.au.**

Frittatas just got a little more fabulous.

Available in two new irresistible varieties: Vegetable and Asian Chicken & Corn.

Our new Frittatas will add a touch of fun and flair to your lunch menu. The inspired combination of Asian Chicken & Corn and vibrant Vegetable topped with quinoa Frittatas are the first two varieties our chefs have created for this brand new range. All Frittatas in the Meal Solutions range are made with real eggs in our state of the art kitchen. Then they're snap-frozen and delivered, ready to be heated and served. **For more information call Sunny Queen Customer Service on 1300 834 703 or visit sunnyqueenmealsolutions.com.au**

Real eggs. Real easy.

Sunny Queen® Meal Solutions

Enjoying a meal 'experience' makes all the difference

As we get older, we all want to remain in our home where life is familiar, comfortable and we are close to our memories. To remain in our home, we need to remain healthy, which includes eating well. But this isn't always as easy as it sounds. To really enjoy a meal and maximise nutrition, we need to have a positive meal experience.

We all know nutrition is important, however this knowledge doesn't always drive our meal choices. Each time we eat, our unique, complex collection of backgrounds, experiences and circumstances influence our 'food mood' and choices. As we age, our appetite declines and health issues, including limited manual dexterity, can further limit our ability to consume a variety of foods. Even if our meal meets energy and protein needs but doesn't suit our mood at the time, part of the meal may be shared with a friend, a pet or the bin. The result is less consumption, and reduced nutritional benefit.

These are only some of the challenges faced by Meals on Wheels services focused on providing nutritional support for individuals to remain in their homes.

Enjoying the taste, smell, appearance and texture is only part of the meal experience. When wait staff, friends and family chat and share the moment, there is a sense of 'connection' with the food, the company and the environment. This meal 'experience' is much more positive compared to eating a meal we prepared ourselves, at home, alone.

Manufacturers and suppliers of meals can easily become absorbed in the latest production and delivery technology. However, people eating the meal only experience the 'front of house' such as meal choice, the food, meal presentation and the service. Today's older population are diverse and 'food conscious'. They know about and

are used to choice, cultural variety and desire a responsive service that meets individual needs.

For Meals on Wheels clients, a friendly exchange on the phone, a timely follow-through on a request for a meal choice, or clarifying a delivery time can create that positive, personal connection to the meal service.

"Even if our meal meets energy and protein needs but doesn't suit our mood at the time, part of the meal may be shared with a friend, a pet or the bin."

There has been considerable discussion within the industry, including a recent review of food services[1] provided under the Commonwealth Home Support Programme (CHSP), and initiatives are underway that could support services in meeting these complex needs.

The Australian Meals on Wheels Association (AMOWA) received Australian government funding to develop national 'meal' guidelines. The change of wording from 'nutritional' to 'meal' guidelines could be the first step forward in developing guidelines that acknowledge the importance of a 'food focused, individualised' approach.

The successful tenderer, Smart Foods Centre from the University of Wollongong, is undertaking a broad consultation process to inform the development of these guidelines, due to be released later this year.

Congratulations to AMOWA for taking the lead on this strategy to further encourage independence by helping people to stay living in their own homes and connected within their communities. Follow the progress of this project at http://mealsonwheels.org.au.

Jacquie Krassie

Jacquie Krassie is an Accredited Practising Dietitian (APD) and food service consultant. Jacquie's work with Meals on Wheels began in the mid-1990s as she undertook a series of projects developing guidelines for the NSW Meals on Wheels Association. Subsequent projects in the Hunter, Central Coast and Southern Highlands focused on developing sustainable meal distribution models. In addition to lecturing and research at Victoria University, as the principal of *J Krassie & Associates*, Jacquie consults to private and public health care facilities in acute, residential aged care and community nutrition programs across Australia. Jacquie takes a holistic approach to the development of efficient and effective food service and nutrition operations, addressing food quality, safety and cost issues while acknowledging the impact of the meal 'experience' on intake and nutritional health.

Accredited Practising Dietitian APD

References

1 Wells, Y. (2013). Review of Meal Services under the Home and Community Care (HACC) Program: Final report – Implications for Meal Services in the Commonwealth Home Support Program. Project report prepared by the Australian Institute for Primary Care & Ageing, La Trobe University, Melbourne, for the Australian Department of Health and Ageing.

Healthy Solutions

Suited to all meal times, throughout the day

Nestlé Professional is the perfect partner to offer healthy food and beverage options, suited for all meal times throughout the day. With brands you can trust, our unrivalled expertise in foodservice is perfectly aligned to the demanding needs of hospitals and aged care.

Coffee is one of life's little pleasures and not surprisingly one of the most consumed beverages in the world, with about 5,500 cups of NESCAFÉ drunk around the world every second.

Contrary to the common assumption that coffee contains additives and is highly processed, Australia's favourite coffee[1], NESCAFÉ Blend 43 is reassuringly in fact made from nothing but 100% high-quality natural coffee beans.

What's more, everyone's #1 coffee is produced sustainably and ethically right here in Australia at our NESCAFÉ production plant in Gympie, Queensland, where 70% of onsite energy consumption comes from renewable resources.

Our beans are slow roasted and ground, freshly brewed and then dried into granules, for a delicious, full flavour with an irresistible aroma. From bean to cup, with NESCAFÉ Blend 43 you can be assured of serving up simply great coffee to your patients and residents.

To remove the potential frustration that hard-to-open packaging can trigger in hospital and aged care environments, NESCAFÉ Blend 43 also comes in an easy to open, portion controlled stick pack format.

When you need to serve copious amounts of coffee and fast throughout the day, the NESCAFÉ ALEGRIA V-Café will deliver great tasting hot beverages, cup after cup.

But it's not just about being able to consistently serve up a lot of coffee, on demand, 24/7, at any hour of the day.

Variety in menu choice is just as important to meet your patients' needs and at the touch of a button NESCAFÉ ALEGRIA allows you to provide just that with delicious café-style menu selections like long black, flat white, cappuccino, espresso, latte, mocha and a classic comforting treat - hot chocolate.

So whether you want to offer patients and residents a stimulating start to the day with their breakfast meal, a refreshing recharge at lunchtime and later in the day as an afternoon snack accompaniment, or to give comfort and relaxation towards the end of the day, the NESCAFÉ ALEGRIA system is the perfect choice.

Ensuring that your patients and residents are getting good nutrition and enjoying their meals is often a balancing act. At Nestlé Professional, we are passionate about healthy, convenient additions to your menu range that work for all meal times, throughout the day.

Our latest addition to this commitment is the NESTLÉ Docello® Protein Enriched Dessert Mixes. Specifically developed to meet menu standards for hospitals and aged care[2] they provide a vital source of protein and calcium in every serve when prepared as directed.

"This versatile, cost-effective protein enriched range is gluten free and also meets Texture C requirements, allowing better menu integration and offering increased variety for patients and residents with special diet needs," says Karen Kingham, Accredited Practising Dietitian & Brand Nutritionist at Nestlé Professional.

Our Protein Enriched dessert mixes offer calculated nutrition per serve for measurable dietary planning, giving you the confidence of knowing nutritional content when developing nourishing recipes or including desserts as part of your complete menu.

NESTLÉ Docello® Protein Enriched Desserts deliver on taste as well as nutrition. Your patients and residents will love the variety, the flavour and texture of these desserts.

With menu variety in mind, the tasty range of dessert flavours includes Protein Enriched Butterscotch, Protein Enriched Lemon and Protein Enriched Strawberry.

With a 10-year track record, our MAGGI range has pioneered in the gluten free arena and today we have developed an extensive range of gluten free options for hospitals and aged care.

"With menu planning in mind, the MAGGI Gluten Free range gives you absolute flexibility for effortless menu integration. The great tasting range of sauces, soups, boosters, mash and gravy mixes considerably reduce menu complexity and enable greater patient and resident choice across menus, so you can offer varied meal options to support appetite appeal," adds Karen.

References

1 Volume and Value Sales AC Nielsen Scan Data MAT 01/03/2016

2 BIS Shrapnel 2013

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All Natural Kitchen

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Would you like to focus more on your patrons, patients and residents and add value to their dining experience? LOOK NO FURTHER... than All Natural Kitchen.

We provide freshly cooked, healthy and delicious menu items that allow your chef to do what they do best; adding special touches and taking away the strain of the day to day.

Founded in 1994, All Natural Kitchen is a Food Manufacturing and Food Processing kitchen situated in the heart of the Sutherland Shire, Sydney NSW. Our flexible team of skilled chefs and personnel has been supplying NSW Health and Aged Care Facilities for nearly 20 years.

As the name suggests, we pride ourselves on providing quality cost driven vegetable products, using natural, fresh ingredients, delivered fresh daily. We also make Soups, Sauces, Dips and a High Cling and Gourmet Mayonnaises.

Our qualified chefs can create items to your individual specifications and nutritional profiles or, recreate your favourite recipes in our traditional kitchen facility. We are small enough to be very versatile and large enough to handle the largest of jobs. This means better taste, quality, price, personalised service and customer satisfaction. Inventory management and waste is also a benefit in outsourcing your needs to All Natural Kitchen.

We offer Solutions not just great products!

Using a HACCP and NSW Food Authority approved *Cook Chill System*, we can offer extended shelf life on most fresh products from 16 to 42 days. Most of our products are available frozen, ensuring you have enough product to meet all of your catering, manufacturing, meal preparation and food service needs.

Our own fleet of refrigerated trucks and vans, can deliver directly to your door, within 100kms of the Sydney CBD or by one of our

trusted distributors.

"We provide a proven quality product coupled with great personalised service. We can tailor-make food products to the customer's individual needs, specifications and nutritional profile and we are continuously evolving our catalogue, increasing our product range, so that we can provide you with innovative and seasonal menu suggestions to enhance your customers dining pleasure." says Colin Hart, General Manager.

"All Natural Kitchen offers a range of catering solutions from Breakfast (Fresh, Scrambled Eggs or Rolled Oats), Lunch and Dinner (Steamed Rice, Mashed Potato, Mash Sweet Potato, Mash Pumpkin, Steamed Vegetables and Sauces) through to Desserts (Custards and Mousse) and all in between."

"Our scrambled eggs are made from real eggs and milk. The milk is sourced from a local dairy in New South Wales, which supports local industry and ensures the highest quality. Vegetables are prepared as ordered, from an independent local provider, and delivered ''Just in Time'' this ensures that our products are as fresh as can be, maximising shelf life and providing employment for the local communities," Colin says.

Colin understands how costly it is to run a kitchen. "Labor and cost-per-portion are the two main expenses that a kitchen deals with on a daily basis, "I have recently done costings on what I believe it would cost to produce fresh product like our Real Mash Potato, in-house. I believe we can save you up to 70% per serve, and you are still providing a fresh, great tasting nutritionally guaranteed meal," he says.

"I also understand that the chef still wants to have creative control, that's why I believe our "staples" can free up some of the chef's time, so that they can add their touches to make the dish their own."

"We can assist with waste too. Providing products in convenient sized packaging, so you only need to use what you need to satisfy your service. And if needed additional cooked, ready to go product, is right there where you need it to be!"

"At All Natural Kitchen we conduct regular in-house organoleptic panels, with the staff responsible for the end product," says Colin.

"This ensures our products are as good as they can be! The team discusses the products and ways to improve the taste or process, if required. This gives the team skin in the game and ownership. It's that level of care, passion and commitment that I believe working with a small dedicated Company provides, which may be lost with some of the larger players."

"With our focus on fresh quality products and customer satisfaction, All Natural Kitchen is Your Second Chef...Naturally!"

»
For more information please visit **www.allnaturalkitchen.com.au** email **Admin@allnaturalkitchen.com.au** or call **(02) 9524 6511**

Identifying malnutrition and boosting nutritional intake in aged care

Undetected malnutrition affects every system in the body. It is directly associated with increasing complex clinical needs, increased vulnerability to illness with associated functional decline, increased dependency and subsequent increased health care costs. Even when underlying illness and age are taken into account, it predicts a greater than threefold risk of death within 12 to 18 months in older Australians.

FAST FACTS

- Malnutrition is a problem in aged care that can affect people of all weights.
- Unintentional weight loss should always be investigated.
- The effects of malnutrition can be prevented or successfully treated when detected early.
- Malnutrition places a significant burden on the economy.
- Dieticians need to be front and centre at handovers, meetings, activities, audits etc.
- Collaboration with all medical staff, GPs, Practice nurses and food service staff is key to battling malnutrition in aged care.

The major cause of malnutrition in developed countries is disease, but the condition is strongly compounded by factors such as:

- lack of awareness,
- lack of recognition of its debilitating consequences,
- lack of nutritional screening within aged care facilities,
- minimal regard for nutrition as a vital component of care,
- failure to refer onto a Dietitian
- failure to utilise appropriate nutrition support.

Malnutrition is not weight discriminatory and can occur across a spectrum of shapes and sizes. Unintentional weight loss at any size justifies further investigation and intervention.

Nutrition & unintentional weight loss in aged care results in:

Increased

- **Risk** of falls and fractures
- **Risk** of osteoporosis
- **Risk** of infection and pressure ulcers
- **Risk** of depression
- **Frequency** of hospital admissions, with prolonged length of stays

Decreased

- **Mobility**
- **Independence**
- **Morbidity** and **mortality**
- **Wound healing**
- **Quality of life**

Costs

Malnutrition undoubtedly places a considerable burden on our economy. Based on recent health economic figures, the cost of identifying and managing malnutrition is estimated to be £13 billion per annum in the UK and €9 billion in Germany alone.

Although similar Australian data is not available, we know that direct consequences of malnutrition such as pressure injuries are estimated to cost the Australian economy $3 billion per annum (~$10,000 per patient per year). A similar picture presents for falls, their estimated cost ranging from $1- $2 billion per year, with a particular prevalence in aged care facilities as up to half of all residents fall at least once a year. Cangelosi MJ reported in her 2014 study that the requirements for residential care placement contributed the most to overall long term costs in Australia.

This, coupled with the fact that several key reports identify the over 65's as being the most 'at risk' of malnutrition and with 8.5 million Australians or ~21% of our population estimated to fill this age bracket by 2053, this is something which demands immediate attention.

How can we create sustainable change?

Dietitians specialise in nutrition/disease relationships and are trained to diagnose and treat malnutrition which can be prevented or successfully treated when detected early. Despite this, we too are forced to work within the realms of limited resources. With facility visits routinely limited to 'ad hoc' and so many other demands placed on ever decreasing budgets, nutrition is a resource which is frequently shelved for "another day".

Never has it been so crucial to work smartly and innovatively.

In order to boost our profile and bring nutrition to the table, we need to collaborate with all professions across the continuum of care and engage with all levels from the ground up. Guiding and motivating ground floor staff to actively participate in nutrition care, while also building credible cases for executive support.

Investing time in cultivating relationships and reputations, imparting knowledge and educating on the added value dietetics can offer, is time well spent. Dietitians need a visible presence at staff handovers, medical and resident/relative meetings, as well as active participation in quality improvement facility activities, audits etc.

Enlisting the support of medical staff, GP's and Practice nurses through nutrition training is vital. We need to raise awareness about malnutrition and put it on everyone's agenda.

Creating, Cultivating, Collaborating

Interested and dedicated food service staff are integral to the successful implementation and provision of nutritionally adequate meals.

Building a culture that promotes optimum nutritional intake can be achieved through;

- Collaborating with chefs and cooks on menu design and reviews and the provision of fortified and special diets needs to be standard practice.
- Listening to their needs and providing appropriate training and resources on various aspects of nutrition to instil motivation and confidence at every level.
- Identifying care staff with a particular interest in nutrition and enriching this through one to one training of basic and essential nutrition skills i.e., nutrition screening, meal environment assessments and assistance with meals.
- Liaising directly with these front line staff, imparting knowledge passionately and rewarding effort to improve job satisfaction and staff morale. This is fundamental to sustainable advances in institutional settings.

The dietitian plays a pivotal role in building momentum and ultimately achieving a greater nutrition profile within aged care but we need your support to achieve optimal, collaborative person-centred improvements.

"Optimising nutrition intake and providing adequate nutrition support for older adults within the aged care setting is fundamental to their functional outcomes."

Liz Purcell

Liz Purcell, Accredited Practising Dietitian, has a particular interest and advanced clinical knowledge in gastroenterology, intensive care and aged care. Liz has held positions with the NHS, UK, Director of Dietetics at Bundaberg Hospital QLD and is currently Lead Dietitian with OSCAR Hospitality. Liz is presenting at the Institute of Hospitality in HealthCare Conference (IHHC) in Tasmania, 17-19 October.

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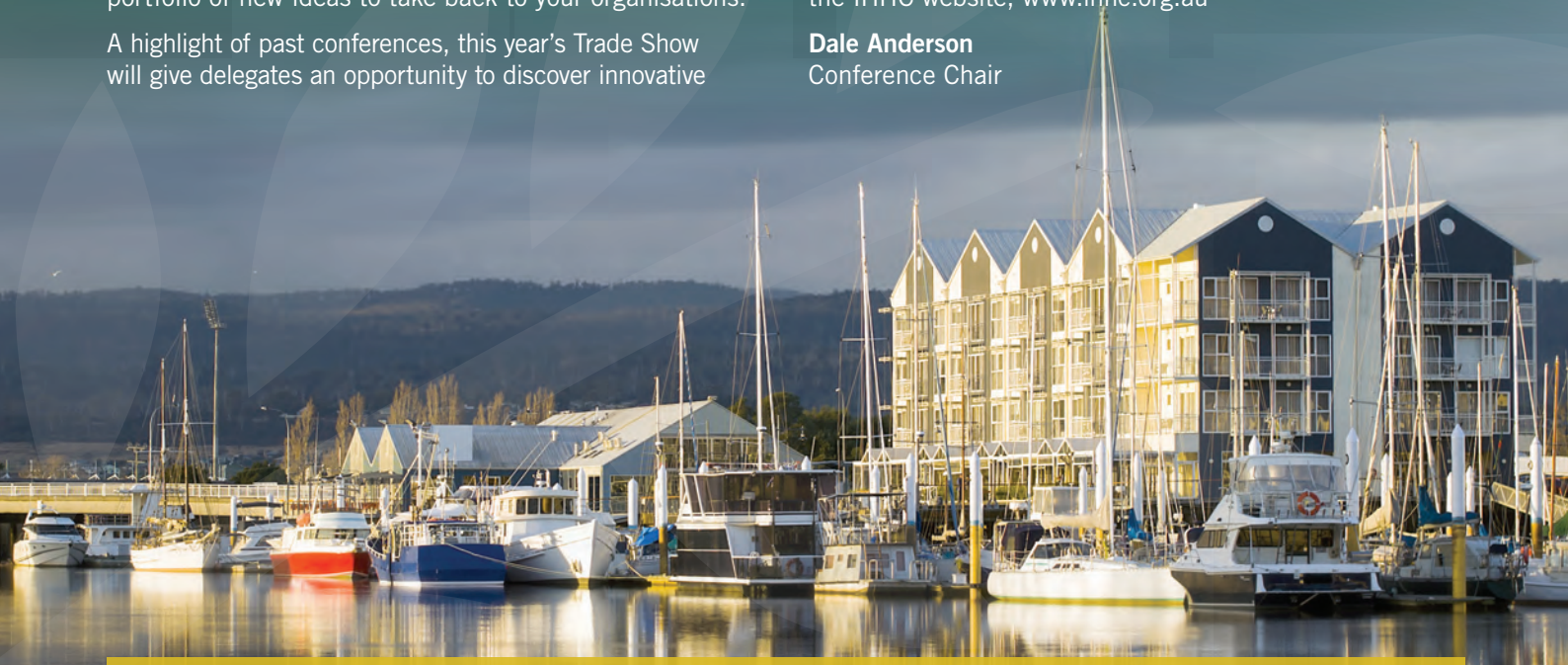
The conference will inform, motivate, inspire and entertain as you are taken on a journey that spans all aspects of support services in the health and aged care industry.

A well balanced program allows for ample networking, a great opportunity to learn from each other and collate a portfolio of new ideas to take back to your organisations.

A highlight of past conferences, this year's Trade Show will give delegates an opportunity to discover innovative products and services whilst having your questions answered by representatives from our various industry supporters.

Join us for this exceptional three day learning experience and, if time allows, extend your stay to enjoy the magnificent surrounds of Launceston. All conference, accommodation and tourist information can be found on the IHHC website, www.ihhc.org.au

Dale Anderson
Conference Chair



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- Retail Outlet Managers
- Food Safety Managers
- Dietitians
- Meals on Wheels Coordinators
- Professionals engaged in delivering a variety of services to the Health and Aged Care sectors.

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SPEAKERS

JOHN KIRWAN

CEO, Royal Flying Doctor Service, Tasmania

THE ROYAL FLYING DOCTOR SERVICE

John Kirwan was appointed as the inaugural CEO of the Royal Flying Doctor Service Tasmania in January 2015. Prior to this appointment, he was the CEO of the Launceston General Hospital, CEO of the Northern Area Health Service and from 2012-2014 the CEO of the Tasmanian Health Organisation – North. John has almost 40 years of IR, HR and operational health experience. He has been the Commissioner for Public Employment in the Northern Territory, the Executive General Manager responsible for the Acute, Community, Public and Aboriginal Health areas of the Health Department of Western Australia (HDWA), and the General Manager responsible for Health Workforce Reform in HDWA. He was a full-time union Official in Western Australia for 14 years.

DR KAREN WALTON

Associate Professor, Smart Foods Centre
University of Wollongong

THE DEVELOPMENT OF NATIONAL MEAL GUIDELINES FOR THE COMMONWEALTH HOME SUPPORT PROGRAMME

Dr Karen Walton has a wealth of experience in health service based nutrition and dietetics (1994-2005); combined with an academic career (2005-current); national and developing international reputation in the areas of food service dietetics and nutrition support for older adults. Karen's dietetics experience is broad and includes: hospital based practice; private practice; group education; food service dietetics; quality and food safety management. She is now working as an Associate Professor within the Smart Foods Centre and the School of Medicine at the University of Wollongong.

DR GARY FETTKE

M.B.,B.S. (University NSW), F.R.A.C.S. (Orthopaedic Surgery), F.A.Orth.A.

HOSPITAL FOOD – VALUE FOR MONEY?

Dr Garry Fettke is an Orthopaedic Surgeon and Senior Lecturer of the University of Tasmania actively practising in Launceston, Tasmania, Australia. He mentors the staff at Nutrition for Life – Diabetes and Health Research Centre. A significant part of his surgical practice is working with people suffering the complications of Diabetes and Obesity – both of which are out of control in society. He has a major interest in the preventative aspects of health and particularly weight loss before operating on patients. The last few years in particular have been dedicated to reconsidering the role of diet in the cause of Diabetes, Obesity and Cancer. He has recently helped reverse Type 2 Diabetes for one patient on the Channel 7 Sunday Night program in their 'Saving Australia Diet' series.

BRIAN CLARK

CEO, FM Contract Solutions

PERFORMANCE MANAGEMENT OF SOFT SERVICE CONTRACTS

Brian Clark is the CEO & Senior Consultant for FM Contract Solutions. He has tertiary qualifications in business management and is a specialist consultant in cleaning procedures, cleaning specifications, equipment and chemical selection, training, scope development and cleaning audit systems. With over 25 years' experience in senior management roles in the cleaning and laundry industries he has extensive knowledge and insight into cleaning and laundry practices gained from Industry experience in Australia, New Zealand, Asia, Europe and USA. Brian has worked on numerous technical committees in the cleaning, chemical and healthcare arena and was a committee member of Standards Australia Technical Committee TX/9/3 providing technical input towards the development of the Australian Standard for maintenance of Commercial and Residential Textile Floor Coverings. His experience and expertise includes cleaning to minimise infection transmission, green cleaning, cleaning management, scope development, maintenance of commercial floor coverings and has industry achievement awards. In 2007, he was the recipient of an Eminence Award of Excellence from the Rotary Club of Southport for his distinctive flair and point of difference in his approach to business philosophy.

CONFERENCE FORUM

HOW THE STATES AND TERRITORIES COMPARE ON THE VARIOUS NUTRITIONAL STANDARDS

Hosted by Mr. Gary Kennedy, the forum will discuss how the states and territories compare on the various standards. It is an opportunity to discuss how operators, users, manufacturers and suppliers could move toward a common goal of a National Nutritional Standard which would enable economies of scale.

There will also be a focus on food safety standards across the nation; where are we up to and why do we differ from state to state? Eggs are one of the hot topics at present – can we or can`t we serve eggs? Which parts of our organisation are inspected and by whom, how often and for what?

John Patison (ex-National IHHC President) will join the panel, as will Associate Professor Dr Karen Walton and Roslyn Norrie from New Zealand, to give their take on standards both here in Australia and New Zealand.

INDUSTRY TOURS

MASONIC HOMES LAUNCESTON

Masonic Peace Haven home is a retirement village consisting of 76 Independent Living Units (ILU`s) and a 96 high and low bed care facility including a 48 bed dementia specific area. Simon Neep, Services Manager for the home will be our host for this tour.

GLENARA LAKES RETIREMENT VILLAGE, (PART OF THE SOUTHERN CROSS CARE GROUP)

Glenara Lakes Retirement Village consists of a spacious 88 bed Residential Aged Care Facility and 93 Independent Living Villas built in a picturesque environment on land which includes three man-made lakes. In keeping with their philosophy of ageing in place, the variety of accommodation options allows residents to remain on one site despite changes in their health status. Phillip Stott, Northern Services Manager will be our host.

THE LAUNCESTON GENERAL HOSPITAL (LGH)

The Launceston General Hospital (LGH) is a 300-bed public hospital that provides acute care facilities for residents of Launceston and the northern region of Tasmania. Every year the hospital treats over 24,000 inpatients and over 225,000 outpatients. David Webb, our host, will take this opportunity to provide our delegates with information across all streams of service including Food Services, Cleaning Department, Waste Management, Security and Contract Linen Delivery.

Building Capacity through Collaboration

In the lead up to the Institute of Hospitality in HealthCare conference, 17-19 October, *John Kirwan* reflects on almost 40 years' experience in the healthcare industry. He urges us to look closely at the potential of working with the broader health community and organisations outside health to ensure food security and address the rise in co-morbidity.

I describe health as a unique industry because it is a labour, capital and transactional, 24 hour service. We are a complex, inter-relational industry that is constantly aiming to run more efficiently, minimise costs, maintain and improve quality and fulfil social responsibilities.

The areas of catering, cleaning and supply are often seen as costs of doing business in healthcare and an easy target when savings need to be found. Trying to maintain cost efficiency by cutting staff hours, however and reducing catering down to the bare bones, in my experience, does not translate to real, long term savings. It also restricts our capacity to meet the individual nutritional needs of patients which is an important factor in healing and preventing readmission.

Beyond Hospital

Figures from the Dieticians Association of Australia indicate that up to one third of elderly patients admitted to hospital in Australia are malnourished and we now have the disturbing paradox of obesity and malnourishment. Acutely ill patients with comorbidities who are also malnourished present an extra problem in terms of their response to treatment.

Our success in short stay surgery, new drugs that allow us to get patients out of hospital quicker and pressure to clear beds are all reducing the average length of stay. A patient who would have been in a bed for 7 to 10 days where they would see the dietician, the podiatrist and the physio and OT is now in and out in a much shorter time and this brings with it a range of other issues.

We have a responsibility to our patient's beyond hospital. On discharge, a patient's ability to feed themselves adequately should be considered. In Tasmania we are seeing a growth in the demographic of single people living at home in small communities. The local clubs that used to provide a hot meal during the day have closed and we need to be clear about how to provide services to these people.

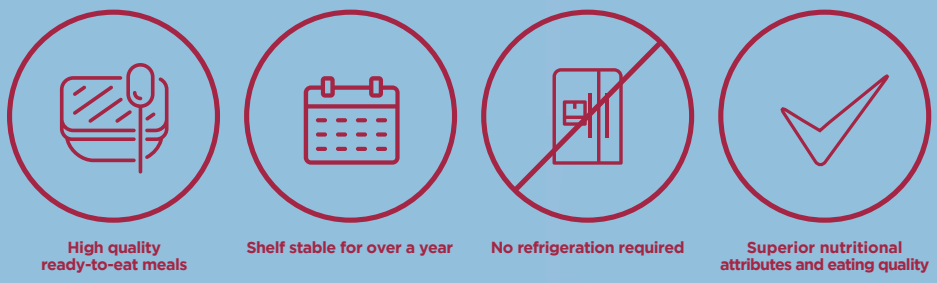
I'm thinking of the 80 year old bloke, discharged from hospital, living on acreage at the back of Lilydale that's a 40 minute drive from Launceston with limited public transport options. For this man to know that he has a week's or month's supply of pre-cooked, nutritious meals on hand has got to be a positive in terms of recovery and prevention.

Collaboration

Moving forward, it seems to me that we need to be thinking outside the box. With health often being the largest employer

"We should look to building our capacity through collaboration and reach out to form partnerships with other organisations."

MATS food processing system



Australia's world class clean food, farming industries and research capability has the opportunity to transform the food service and ready-meal consumer landscape.

and consumer, particularly in rural areas, we should look to building our capacity through collaboration and reach out to form partnerships with other organisations like agri-business and those with similar aims like defence and emergency services.

When I look at my time as the CEO of Launceston General Hospital, we supplied patient meals plus we did Meals on Wheels and products for smaller regional hospitals. If there was an emergency like bush fires, with the physical capacity of a big production area, our kitchens would be making sandwiches etc.

If health is already a large supplier of food to patients and staff, surely there is a critical mass there we can leverage from to ensure food security to a wider portion of our community by working with other organisations. Finding innovative ways to managing costs, efficiency and quality are the same solutions being sought by defence and emergency relief services.

In Tasmania, our defence technology site at Scottsdale is invested in developing food ration products for the army. They are bringing in new innovations like their Microwave Assisted Thermal Sterilisation MATS technology. MATS is a significant advancement in food processing that could revolutionise ready-to-eat meal production for the defence force and other sectors such as healthcare.

MATS enables pasteurisation and sterilisation of food produces ready-to-eat packaged meals that are shelf stable for over 12 months without freezing or refrigeration. MATS can be used for fish, meat, vegetables, fruit and grain/pasta. Using this technology, food retains more nutritional value than canning or retort processing.

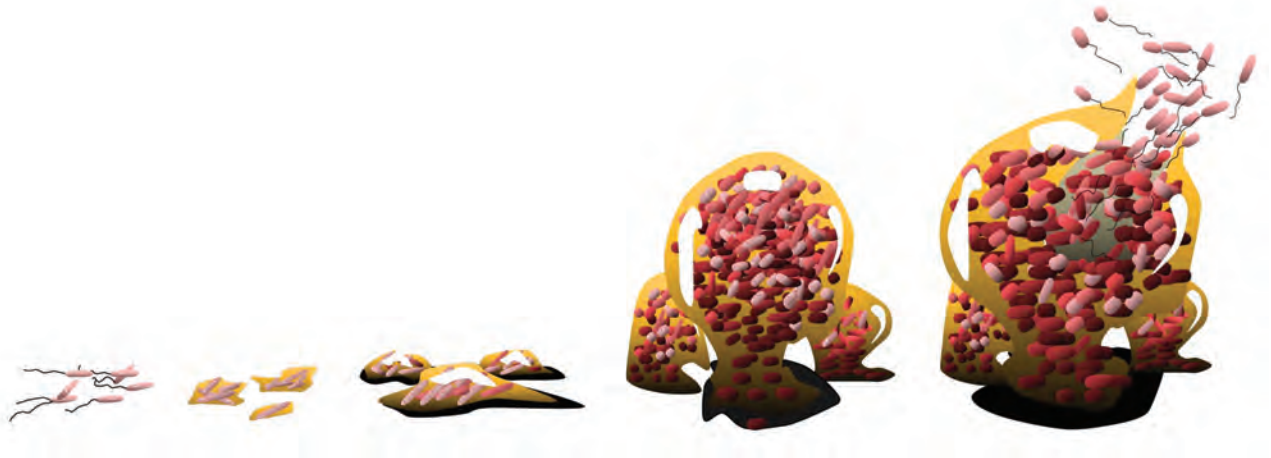
So the questions I can see that we need to answer are; where are the opportunities to build partnerships with allied organisations and the broader health community? How are we addressing the new developments enabling ageing in place that is seeing more people living independently for longer? And how do we meet our responsibility for the nutritional needs of our patients with increasing comorbidities in hospital and on discharge?

I don't have the answers to these questions but it is vital that we start to have the conversation.

John Kirwan

CEO, Royal Flying Doctor Service Tasmania

John Kirwan was appointed CEO of the Royal Flying Doctor Service Tasmania in Jan, 2015. He was formerly the CEO of the Launceston General Hospital (LGH), CEO of the Northern Area Health Service (NAHS) and from 2012 – 2014 the CEO of the Tasmanian Health Organisation – North (THO-N). John has almost 40 years of IR, HR and operational health experience. He has been the Commissioner for Public Employment in the Northern Territory, the Executive General Manager responsible for the Acute, Community, Public and Aboriginal Health areas of the Health Department of Western Australia (HDWA), and the General Manager responsible for Health Workforce Reform in HDWA. He was a full time union Official in Western Australia for 14 years.



Biofilms and Wound Infection

Wounds provide an ideal environment for bacterial growth and are readily colonised by microorganisms of indigenous, human origin and in many cases by environmental contaminants. Bacteria attach to a coating known as the extracellular matrix, a mesh of proteins that encompasses the cells of the wound bed. Once attached, bacteria proliferate to form micro-colonies, secreting a thick polysaccharide layer that protects against environmental challenges such as the host immune system or antimicrobial treatments. Micro-colonies eventually develop into a biofilm, which is a dynamic microbial community comprised of diverse bacterial species.

Biofilm is common within infected wounds being found in 4 percent of acute and 40 percent of chronic wounds. It is difficult to see by eye and presents challenges to the clinical microbiologist; bacteria can be exceptionally difficult to culture from wound swabs with a proportion of the population failing to be recovered. Therefore, treatment of biofilm-infected wounds can be problematic resulting in persistent or recurrent infection. Furthermore it is estimated that bacteria residing within a biofilm are up to 1000 times more resistant to antimicrobial treatment, a characteristic conferred in part by the polysaccharide layer surrounding the biofilm.

Topical antimicrobials in the form of impregnated dressings are often applied to infected wounds. The efficacy of such dressings is dependent on continued release of the antimicrobial component, sufficient to provide a sustained inhibitory, or lethal dose. The polysaccharide layer of the biofilm impairs diffusion of antimicrobials through the biofilm, meaning that not all bacteria are exposed to an appropriate treatment dose. Consequently upon cessation of antimicrobial treatment, infection can recur because bacteria still remain within the wound.

Despite this, research continues to aid scientists' understanding of the biofilm lifestyle and how best to tackle these resilient microbial communities. New strategies to prevent and treat biofilms in wounds include the use of anti-adhesive (or anti-biofilm) compounds to prevent attachment of bacteria to the wound, or anti-virulence compounds which diminish the damage that infecting bacteria cause and give the immune system a chance to clear the infection. Other alternatives include the use of bacteria-specific viruses which target and kill biofilm bacteria without infecting or damaging the host. At present many of these are still in early investigative or developmental stages and so traditional antimicrobial treatments are still widely utilised.

Biofilm is not just problematic in wound infection. Bacteria can grow as a biofilm on almost any surface meaning that in humans, biofilm can be found in the lungs of patients with chronic pulmonary infection, on the heart valves of patients with infective endocarditis, within the urethra of patients with persistent or recurrent urinary tract infection, and - the most well known biofilm - on the teeth as dental plaque. Therefore understanding the biofilm lifestyle in infection and the challenges posed to effective eradication is imperative, and as more is understood the better equipped clinical practitioners will be to overcome the biofilm burden.

"Micro-colonies eventually develop into a biofilm, which is a dynamic microbial community comprised of diverse bacterial species."

FAST FACTS

- Biofilms develop from micro-colonies of bacteria that secrete a thick polysaccharide layer.
- Biofilms are found in 4 percent of acute and 40 percent of chronic wounds.
- Wounds infected with biofilm are resistant to treatment resulting in recurrent infections.
- Treatment options in development include anti-adhesive and anti-virulence compounds and bacteria-specific viruses which target and kill biofilm bacteria.

Sarah Maddocks

Dr Sarah Maddocks works as a lecturer in Microbiology at Cardiff Metropolitan University (UK), where her work focuses on the host-pathogen interaction and biofilm development during infection.

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- Stress Response & Health Breakdown
- Wound Management

For the full list of subjects available please go to our website www.acn.edu.au/units-of-study

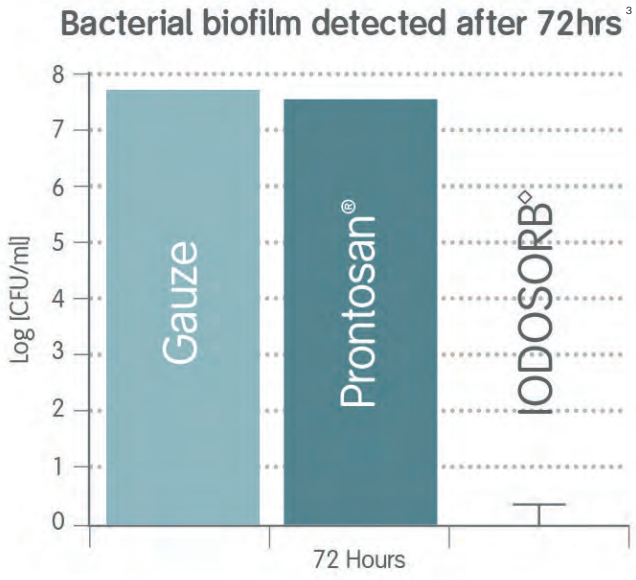
Cadexomer Iodine and Biofilms

Anyone managing a chronic wound will know that some wounds take longer to heal than expected, and one reason for this may be the presence of biofilm bacteria, which prolongs the inflammatory response and thus prolongs healing.[1] Biofilms present several practical problems: they are not visible to the naked eye, swab results are unhelpful, and because the bacteria are protected by an extracellular matrix antibiotics and antiseptics are generally unhelpful in removing them.

The most effective way of removing biofilms is surgical debridement, however, in many cases surgical debridement is not a practical option, either because the clinician is not authorised, or because the patient is unsuitable.

In these situations, cadexomer iodine (IODOSORB) can be used as an effective alternative. Cadexomer has a unique polysaccharide structure which means that in the presence of exudate it is able to absorb debris and cellular material. As it does this, the beads swell and release the iodine in a sustained manner maintaining antibacterial levels (0.9%) over a prolonged period, while not impairing epithelialisation.[2]

In a recent study[3] cadexomer iodine has been shown to be very effective against biofilms, in comparison to other antimicrobial agents such as povidone-iodine and PHMB, where a similar effect was not observed. It is easy to use, and well tolerated[4], and a recent systematic review concluded that there is evidence to show cadexomer iodine is effective in promoting healing.[5]



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IODOSORB 0.9% Cadexomer Iodine overcomes multiple barriers to healing, allowing you to take control of chronic ulcers:

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Recommendations for Wound Biofilm Management: Results of a Global Consensus Panel

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Join us at the Inaugural Wounds Australia Conference

The inaugural Wounds Australia Conference will be held from 9-12 November 2016 at the Melbourne Convention and Exhibition Centre. The 2016 theme, 'State of Play', will not only acknowledge the major achievements impacting clinical practice in wound management, but will explore the state of play in current wound management, research and clinical application. Delegates will see a strong focus on collaboration between disciplines, the translation of research into clinical practice and fantastic networking opportunities.

Join us at the conference dinner amongst the 'Glitz and Glam' of the Grand Hyatt Melbourne. Featuring live music and entertainment the dinner is sure to impress and delight. A great way to relax, have some fun and enjoy making some 'glitz and glam' memories at our photo booth!

The 2016 conference program is certainly exciting, with an array of highly regarded international and national speakers and is loaded with opportunities to network, learn and above all enjoy the 'State of Play!'

International invited speakers include:

- Prof David Armstrong, Director, Southern Arizona Limb Salvage Alliance, USA
- Prof Amit Gefen, Department of Biomedical Engineering, Tel Aviv University, Israel
- Dr David Keast, Chair of the International Wound Infection Institute, Canada
- Prof David Margolis, Director Cutaneous Ulcer Program, Professor of Biostatistics and Epidemiology, Professor of Dermatology, USA

Presentations from Australian speakers including;

- Dr Claire Campbell, Honorary Fellow, University of Melbourne, VIC
- Prof Keryln Carville, Silver Chain and Curtin University, WA
- Dr Phillip Clarke, Chair in Health Economics, School of Population and Global Health, University of Melbourne, VIC
- Dr John Crozier, Chair at National Trauma Committee Royal Australasian College of Surgeons, NSW
- Prof John Funder, Professor, Department of Medicine, Monash

University, Professorial Associate, Centre for Neuroscience, University of Melbourne, Honorary Professor, Institute of Molecular Biosciences, University of Queensland, QLD
- Assoc Prof Mark Jackson, Griffith University, QLD
- Dr Bill McGuiness, Head of School, School of Nursing and Midwifery, La Trobe University and Head of the La Trobe Alfred Clinical School, Alfred Health, VIC
- Dr Rosana Norman, Senior Research Fellow, Queensland University of Technology, QLD
- Assoc Prof Jonathan Shaw, Head, Clinical Diabetes and Epidemiology Group, Baker IDI, VIC
- Assoc Prof Geoff Sussman OAM, Wound Consultant at Monash University, VIC
- Terry Swanson, Nurse Practitioner, South West Healthcare, VIC
- Dr Geoff Tymms, Orthopaedic Surgeon OPSMC, VIC
- Dr Carolina Weller, Senior Research Fellow, Department of Epidemiology & Preventive Medicine, Monash University, VIC
- Prof Fiona Wood, Head of Unit/Professor, Burn Injury Research Unit, University of Western Australia, WA

This will be an amazing opportunity for you to update your knowledge, mix with international and national speakers, industry trade and delegates and what better place to enjoy this experience than in Melbourne? The gateway to Victoria's world class wineries, natural springs and spectacular coastline. Discover Melbourne's secret laneways and rooftops, experience the cultural hub of Federation Square, the iconic MCG and the nation stopping excitement of the Spring racing carnival. Join us to experience Melbourne's playful side from its creative exciting city centre, world class arts and cultural heritage and indulge in the richness and diversity of Melbourne's food and wine.

Registration to attend the conference is open and can be completed at www.woundsaust2016.com.au. Registration prices start at $895 for Wounds Australia members. Non member, student and day registration prices are also available.

The conference is proudly supported by our sponsors,

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» For more information on the Conference please visit **www.woundsaust2016.com.au**.

Science Vs. snake oil in pressure injury prevention

- why you must use evidence when making pressure injury prevention decisions

In this article, Professor *Nick Santamaria* highlights the need for clinicians and managers to always base their decisions about pressure injury prevention strategies on sound scientific and clinical evidence.

There is a compelling need for us to challenge the wound care industry to provide high quality evidence of not only the clinical efficacy but also the cost effectiveness of their products rather than marketing materials.

Our ultimate goal is to provide the best care and protection to our patients who are vulnerable to developing a pressure injury whilst in care.

Silicone Foam

An instructive example of this need for evidence is in the area of the use of silicone foam wound dressings for the prevention of pressure injuries. The use of wound dressings as a potential additional intervention for the prevention of pressure injuries has been investigated intermittently over the past 20 years.

More recently, however, work by Tod Brindle[1,2] in the USA and by our own group in Melbourne,[3,4] has clearly demonstrated that one particular dressing can reduce the incidence of hospital acquire pressure injuries by 80 percent when used prophylactically in large randomised controlled trials. Additionally our work showed that there was a 3.6 times cost benefit to using these dressings than not using them because wounds are much more costly to treat than to prevent.

These dressings have also undergone extensive laboratory based investigation [5,6] that support and elucidate our clinical findings. One of the outcomes of our research is that more than 1000 hospitals around the world are using our approach to protect their patients using these dressings.

The disturbing trend emerging is that we are now seeing unsubstantiated claims being made by other manufacturers of silicone foam dressings that their products can provide the same level of protection. These claims are generally based on small case studies or case series that are mostly not published in the peer reviewed scientific literature.

Voodoo Science

I recently attended the European Wound Management Association meeting where one manufacturer was demonstrating the pressure redistribution capacity of their dressing by placing a large steel ball on the dressing and measuring the change in pressure under the dressing with a pressure mapping device. This is completely misleading with no clinical relevance (unless you are looking after steel balls at your facility) yet looks good on a display stand. We now refer to these displays as Voodoo science.

There is no way in the world that the pharmaceutical industry could get away with claims of comparable clinical efficacy without any meaningful data, yet the wound care industry does just that.

Whilst we may lack the necessary legislative controls to prevent the use of voodoo science in wound care marketing, we do have an even more powerful approach and that power resides in the wound care clinicians and their managers.

We need to ask for the evidence of clinical efficacy and cost benefit before committing to using a particular product. In the case of prophylactic dressings, ask for copies of the publications of the large well designed randomised controlled trials showing the effectiveness of the dressing in preventing pressure injuries. It's simple, if this is not available don't buy the dressing.

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"We need to ask for the evidence of clinical efficacy and cost benefit before committing to using a particular product."

Nick Santamaria

Nick Santamaria RN. B.App.Sc. M.Ed. St. Grad Dip Health ED. PhD, is the Professor of Nursing Research, Translational Research at the University of Melbourne. He has a long history of wound research and has published extensively. Nick has received more than $12 million in research funding. He is currently chief investigator in a number of pressure injury prevention clinical trials in Australia and the USA.

A New Hope

GEDI Nurses - bringing geriatric care to the front line

Dr Elizabeth Marsden, Consultant Physician, Nambour Emergency Department (ED), saw a need for a new model to better support older people and residential aged care residents presenting to ED and the health professionals managing their care.

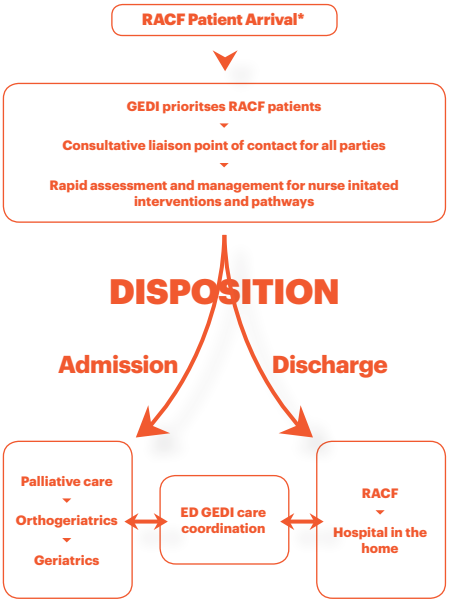
The journey began when Dr Marsden met with Amanda Glenwright from Sunshine Coast Medicare Local who had just concluded a pilot project into reducing non-urgent transfers of elders to the ED after hours. In mid-2014, with the help of a passionate team, Dr Marsden saw the launch of the CEDRiC (Care Coordination through Emergency Department, Residential Aged Care and Primary Health Collaboration) research project.

"I put an idea out there and that's how this started," shares Dr Marsden. "I wanted to implement this nursing model so I asked Clinical Nurse Consultant, Andrea Taylor, if it was feasible. She gave me an extensive critique and the idea developed from there. CEDRiC has come about through the efforts of an engaged and enthusiastic team," she says.

CEDRiC has evolved through a partnership between Nambour General Hospital, The University of the Sunshine Coast (USC), Sundale Residential Aged Care Facility (RACF) and Central Queensland, Wide Bay, Sunshine Coast PHN, which replaced Sunshine Coast Medicare Local in 2015.

FAST FACTS

- CEDRiC evolved through a partnership between Nambour General Hospital, The University of the Sunshine Coast (USC), Sundale Residential Aged Care Facility (RACF) and Central Queensland, Wide Bay, Sunshine Coast PHN.
- CEDRiC encompasses two streams of care; a Nurse Practitioner within the RACF and specialist clinical nurses (GEDIs) on the ED floor for all patients over 70 years of age and from all RACFs.
- CEDRiC aims to:
  - reduce inappropriate transfer of RACF residents to ED
  - improve resident and family satisfaction with care
  - minimise hospital access block and
  - provide a better level of care to older Australians while providing net reduction in or cost neutral Government expenditure.



The early gains demonstrated in the CEDRiC pilot project provided a strong evidence base to support a successful grant application to the Department of Social Services, resulting in a two-year $1.15million research grant. This funding has provided specialist nursing staff in the ED and the RACF, project research staff and access to research specialists including health economists and statisticians.

Key Elements

The CEDRiC model establishes an effective process of communication and liaison with multiple personnel involved in the care of older patients. CEDRiC promotes the flow of information between a patient, ED, the RACF, their GP and family.

CEDRiC encompasses two streams of care;

1 **HIPS** (Health Intervention Projects for Seniors) that includes provision of a Nurse Practitioner within the RACFs whose role it is to develop advanced care plans for residents, coordinate with GPs in care delivery and deliver training programs for staff.

2 **GEDI** (Geriatric Emergency Department Innovation), pronounced Jedi, provides specialist clinical nurses on the ED floor for all patients over 70 years of age and from all RACFs. The GEDI nurses provide a dedicated, single point of contact within the ED for the patient's RACF and other hospital departments and rapid, comprehensive geriatric assessment and management on presentation.

Kaye Coates, HIPS Nurse Practitioner based at Sundale RACF on the Sunshine Coast, says, "If a patient does need to be transferred to hospital from the nursing home, I prepare a summary of the findings for the GEDI nurses. This includes the aims of the hospital transfer highlighting that this person is presenting differently to their usual healthy baseline and this helps the hospital team determine the best management pathway."

"If an elderly person with comorbidities presents at ED without this information, devising a management plan can be a long process for emergency staff and for the person concerned," she says.

"CEDRiC has come about through the efforts of an engaged and enthusiastic team."

GEDI CNC Andrea Taylor with an elder presenting to ED.

NP Kaye Coates from Sundale LTD with CN assisting resident of aged care.

"CEDRiC Practitioner Nurses in nursing homes reviews complex health issues and advanced health directives or care plans while a patient is stable. This, along with providing support and liaison to the staff, GPs and the patients' families will, I believe, lead to a reduction in unnecessary hospital admissions," Kaye says.

"An example of how this process works would be the case of a 93 year old man, presenting with sudden onset shortness of breath and lots of frothy white sputum. His notes outlined a past history of heart failure that I determined was not the cause of his current situation which was acute pulmonary oedema secondary to aspiration pneumonia," says Kaye.

"So the steps are;

- Assess the person
- Consult their advanced care plan or health directive
- Liaise with family, nurses and doctors
- Summarise the findings and use that information to determine if the patient will be managed in the residential setting or go to hospital."

"If the patient is transferred to hospital, my assessment may help to guide the appropriate investigations and facilitate his safe discharge and palliation," Kaye says.

The Gedi Order

On the role of the GEDI nurses, Dr Marsden says, "They assess an elderly patient when they arrive, streamline their stay and improve communications between hospital departments and the nursing home."

"The GEDIs streamline patient flow and can refer directly to geriatrics and orthogeriatrics when appropriate, bypassing delays in ED. They promote communication between departments and facilitate discharge planning and education/training of health professionals," she explains.

Staffing

"Feedback from recent qualitative data collected has suggested the ED staff would prefer 24 hour GEDI nurses, 7 days a week when funding allows. We feel this would be the gold standard, however as a bare minimum, we need to extend the GEDI team's current hours coverage and have two GEDIs on the weekend," Dr Marsden says.

Outcomes

It is anticipated that CEDRiC will reduce inappropriate transfer of RACF residents to ED, improve resident and family satisfaction with care, minimise hospital access block and provide a better level of care to older Australians while providing net reduction in or cost neutral Government expenditure.

Dr Marsden says, "The results of our research based on GEDI's impact in the hospital, nursing home and community settings are still to be published but the preliminary numbers are extremely positive in terms of saving and return on investment."

"And the cost savings figures do not take into account the patient benefits such as decreased mortality and morbidity from hospital acquired complications," she says.

Central Queensland, Wide Bay, Sunshine Coast PHN Board Chair, Dr Peter Dobson states, "Our PHN has been involved with the CEDRiC project since its inception, and we are very proud of the team's achievements to date. Our PHN contributed innovation funding to the pilot study period, and we were thrilled to hear that the project was reducing avoidable hospitalisations of the elders in our community. 2017 will be an exciting time as we will be able to share the evidence of this successful project."

Professor Marianne Wallis, Chief Investigator, USC , shares her insights into the project. "Even from the preliminary model we are seeing a reduced length of ED stay and cost savings. So we are really optimistic about the outcomes from this project," she says.

Next Step

Dr Marsden reflects on whether this model will be transferrable to other hospitals. "We will be implementing the GEDI model into SCUH, the Sunshine Coast University public hospital, when it opens," she says.

"We are expanding the model to include a Geriatrician who will provide ED with access to specialist geriatric care. We will be bringing the Geriatrician to the front line."

"The GEDIs streamline patient flow and can refer directly to geriatrics and orthogeriatrics when appropriate, bypassing delays in ED..."

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Leading Age Services Australia **Feature**

Taking a collaborative approach to hospitals, health and aged care

Collaboration is a word that is often used but not often enough put into practice.

Having joined Leading Age Services Australia (LASA) and the aged care industry in June from health and more recently the ACT Government, it is clear to me there are many opportunities for aged care and health to be working more collaboratively. Doing so will not only benefit health service and age service providers, but most importantly, it will benefit Australians.

A number of the issues aged care is facing are applicable to health, and will require cross-sector solutions. These include funding, workforce shortages, e-health and other technologies, and population health planning to inform future services.

Over the next 12 months the Government must deliver an independent review of the "Living Longer, Living Better" reforms, which is legislated to occur five years into the 10-year program. The review will show whether we are on the right track to achieving the reform goals, and what – if anything needs to change.

This review will be critical for both industry and Government, and absolutely must involve providers. The ongoing issue of funding cuts and their impact on service sustainability will undoubtedly be a central theme.

The primary concern for aged care right now is funding. In May, the Commonwealth Government announced a further $1.8 billion in savings to its Budget through changes to the aged care funding instrument, known as ACFI. The changes relate to how scoring is determined and effectively raises the bar so as to reduce the number of clients that are assessed as requiring the highest level of care, which in turn attracts higher levels of funding.

The specific changes will be implemented in two waves – the first came into effect on 1 July and impact indexation as well as new clients and reappraisals (for example, if a client returns to an aged care facility after being in hospital for more than 30 days their ACFI status is reassessed). The second wave of changes, yet to pass in Parliament, are due to come into effect on 1 January 2017 and will see a new scoring matrix with different eligibility requirements for certain complex health care procedures.

Independent analysts have calculated that these changes will save $350 million over and above what the Government has publicly said. Two independent industry consultancies, Stewart Brown and Ansell Strategic, believe the cuts to aged care will exceed $4 billion by 2020.There are concerns the ACFI changes could impact on access to aged care and create a disincentive for providers to admit people with high care needs.

In rural and remote areas, where there are fewer service options, this is likely to ultimately result in increased hospitalisations. The inevitable outcome of increased pressure on local health services, if aged care providers are unable to continue delivering vital services in the community through home care and residential aged care, will be disastrous.

What the Government calls 'savings' are not only excessive cuts to the vital funding age service providers receive to deliver care to clients, but a shifting of costs from the Commonwealth budget to State budgets.

As leaders in our industry, we cannot allow this to be the outcome. The solution

"The primary concern for aged care right now is funding."

requires genuine collaboration between health and aged care services, peak bodies, and Commonwealth and State Governments.

Appropriate funding and delivery of aged care services is a vital issue in every community, particularly in rural and remote areas. Workforce training, enhanced dementia care, and continuous improvement to achieve quality service provision require funding and investment into the industry.

As well as delivering critical care services for older people, aged care providers enable people to remain in their communities with family and friends; they create jobs and generate opportunities for other service providers in the area; and they alleviate some of the pressure on the public health system by delivering healthcare services to clients who do not need hospitalisation but who do need higher levels of care. Imagine if those services did not exist in your local area.

Off the back of our election campaign, LASA was pleased to gain the support of Independent Senator, Nick Xenophon, who committed to blocking the funding cuts in Parliament, as well as The Australian Greens, Andrew Wilkie and Jackie Lambie.

We need your support too. The more that hospital and health care industry leaders understand aged care and the issues facing aged care providers and older Australians, the more we can work together to solving our mutual problems. As such, I encourage you to attend our National Congress in October and learn more about aged care, meet the industry's leaders and participate in debate and discussion for the future of our industry.

LASA will continue to keep you informed about the issues in our industry, and finding ways in which we can actively collaborate at the highest levels right down to grass roots. Together we can create a strong, viable and supported aged care industry that works in sync with health, rather than fragmented services.

Collaboration is the only way we can ensure accessible, affordable, quality aged care services for older Australians, that are delivered by viable and sustainable aged care service providers.

Sean Rooney
CEO, LASA

Sean Rooney joined LASA as its inaugural national CEO in June 2016. He has held several Chief Executive/ Senior Executive roles in public, private, and not-for-profit sector organisations including the CSIRO, Medicare Local Alliance and in the ACT Government.

Q&A

Continence Care and Dementia

Continence expert, *Dr Joan Ostaszkiewicz*, in consultation with the Continence Foundation of Australia, presents this Q&A relating to the management of incontinence in dementia patients in aged care.

Q We have many residents with dementia in our facility. How do we assess the best methods of toileting assistance for them?

The diagnosis of dementia complicates the management of incontinence. For example, it can be difficult to obtain accurate information about the frequency of incontinence or continence. In addition, people with dementia may not always understand or appreciate a health worker's efforts to help them wash, use the toilet, or change a pad.

However, residents with dementia may have incontinence for the same reasons as residents without dementia. They should receive the same assessment as residents without dementia.

The Continence Tools for Residential Aged Care, available from www.bladderbowel.gov.au, provides a structured process to help staff conduct an individualised assessment of any resident's continence status and implement a targeted management plan.

Q Often, the staff/residents ratio in residential aged care facilities are blamed for inadequate toileting assistance programs. At the hands-on level how can we best work within our staffing capacity to identify which residents are most likely to respond to a toileting assistance program?

According to research conducted in the US, up to 50 percent of residents living in aged care homes can maintain continence if they receive toileting assistance up to four times during a 12-hour day, particularly if they also participate in a program to improve their functional abilities. This includes residents with mild cognitive impairment.

However, providing such assistance requires one staff member to five residents. This explains why many staff find it difficult to implement and sustain toileting assistance programs at rates that improve residents' continence.

It's important to note that all residents will derive benefit from a toileting assistance program. For example, a distressed response to toileting assistance should always be regarded as a desire to maintain independent bladder or bowel control.

A realistic response to workforce constraints involves targeting those residents most likely to respond to a toileting assistance program.

In the first instance, residents should receive a multidisciplinary continence assessment in order to identify and address potentially reversible causes of incontinence, and to inform the development of an individualised continence care plan. The plan may or may not include the use of toileting assistance programs.

The Continence Tools for Residential Aged Care, provides an evidence-based set of resources to assist staff working in residential aged care facilities to conduct this assessment and determine the most appropriate individualised intervention.

Q What steps would you suggest to take before prescribing a laxative to a frail older adult?

The key to good bowel management is regular and ongoing assessment. Assess the frail older adult to identify and treat reversible causes of constipation including side effects of medication.

Conservative treatment of constipation can include exercise, abdominal massage, increased fluids, fruit and fibre. This can be tailored according to the frail older adult's individual needs.

A recent study undertaken by a Victorian regional health service showed it was possible to substantially reduce the need for suppositories to manage constipation in frail older adults in a dementia unit by introducing new assessment guidelines to individualise residents' care, and by increasing the use of non-laxative agents.

Vigilant daily bowel charting was carried out using a stool form scale. Other measurements were also noted, including behavioural response of resident, and if any laxatives were administered, type and dose.

Before administering laxatives to the frail older adult, consideration is given to the presenting symptoms, the individual's fluid intake, swallowing ability, diet and potential side effects of any current medications.

In choosing a laxative, it is important to know how they work. Selection is also dependent of goals; for example to prevent constipation, increase bulk, to soften or push stool or a combination of these.

Q I am a physiotherapist in an acute Older Adult Mental Health facility and have noted that quite a number of our older female patients get recurrent UTIs. The increase in their confusion adds significantly to their already present dementia-related confusion and side-effects from further medications to treat the UTIs. What is "best practice" management of this population?

This is a big topic and there is considerable debate about diagnosis and treatment. The signs and symptoms of UTI in older adults may include altered mental status, fever, haematuria, dysuria, urgency and suprapubic pain. UTIs can also cause frail older adults, particularly those with pre-existing dementia, to develop delirium. Once they have delirium they are at greater risk of falling.

The question is one of treatment; the clinical assessment of people with dementia and living in care homes is challenging because of their limited verbal communication, and the difficulty of obtaining a clean catch specimen of urine.

Moreover, frail older persons are at higher risk for unintended adverse effects from treatment (eg., fulminant Clostridium difficile colitis from antibiotics used to treat otherwise asymptomatic bacteriuria in the presence of urinary incontinence). Asymptomatic bacteriuria should not be treated as it may increase antimicrobial resistance.

The Society for Healthcare Epidemiology of America (SHEA) developed a set of minimum criteria to help clinicians determine the appropriateness of antimicrobial therapy for individuals with advanced dementia. The clinical indicators include: acute dysuria OR fever, and at least one of the following symptoms: i) new or worse urinary frequency, (ii) urinary urgency, (iii) gross haematuria, (iv) suprapubic pain, (v) costovertebral tenderness, (vi) rigours, and (vii) changes in mental status.

"We should look to building our capacity through collaboration and reach out to form partnerships with other organisations."

Joan Ostaszkiewicz

Dr Joan Ostaszkiewicz is a registered nurse with a clinical and academic background in the management of incontinence in frail older adults. Dr Ostaszkiewicz is a Postdoctoral Research Fellow in the Centre for Quality and Patient Safety Research at Deakin University.

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Ethics and Aged Care

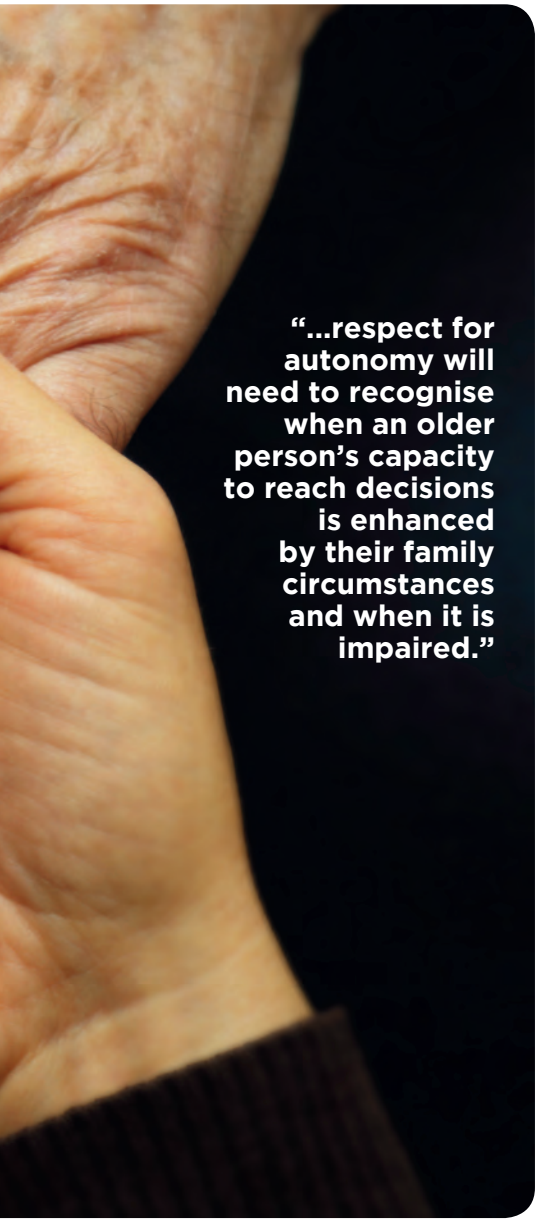
The proportion of people aged 65 and over in the Australian population is increasing. The number has more than tripled over the last fifty years and was 3.4 million in 2014, while the number of people aged 85 and over increased nine fold to 456,600. The Australian Bureau of Statistics predicts that there will be 9.6 million people aged 65 and over and 1.9 million people aged 85 and over by 2064.

Although these statistics reveal that older people are living longer and healthier lives, there is likely to be an increase in demand for care; not necessarily intensive medical care but ongoing care for health and lifestyle needs.

Care for the aged resembles healthcare in some respects so that the familiar principles of medical ethics – respect for autonomy, beneficence (acting for the good of the patient), nonmaleficence (avoiding harm) and justice (treating like people alike) - would also apply to ethics in aged care.

There are however some significant differences. The principles of medical ethics have emerged primarily in the context of the healthcare treatment of individual patients, so that, for example, the focus of respect for autonomy is on the capacity and the freedom of individual patients to make decisions about their own health care. Certainly, there are occasions when partners or family members may be involved in those decisions, but the ethical focus has been on the individual patient.

To an important degree, this is recognised in formal statements of the ethics of aged care that, while recognising some features of an older person's situation, whether in a residential facility or at home, retain that individual focus. One variation to the conventional focus on autonomy is the added recognition of respect for dignity. Similar patterns of individual emphasis can be seen in the development of proposed national codes of ethics for residential aged care.



Aged Care and Healthcare

This individualist ethical focus can mask the reality that aged care has a wider frame of reference than healthcare: it is concerned with promoting an older person's welfare. Decisions around welfare include not only healthcare but also living arrangements, family and business affairs, financial and estate planning - all of which commonly intimately involve partners and family members. Accordingly, ethics in aged care operates in a far more complex decision-making environment in which multiple influences, both beneficial and supportive and also potentially manipulative and debilitating, will need to be taken into account.

The other two constant considerations are the older person's reduced independence (in all respects) and the fact that he or she is living his or her last years.

Even if there remains a primary focus on the individual older person, their age brings to the fore not only their declining physical and intellectual capacities, but the legacy of their family life. Complex intersecting relationships can lie at the base of obligations or perceived obligations within and beyond the generation of the older person.

Advocacy - it's not always family first

As a result, respect for autonomy will need to recognise when an older person's capacity to reach decisions is enhanced by their family circumstances and when it is impaired. Acting for their benefit will need to take into account the influence of family history and family relationships so as to avoid inadvertently and indirectly causing harm by supporting decisions that run counter to established family understandings.

Lastly, the intergenerational complexity for the consideration of justice in relation to an older person's care and support will merit careful and ongoing attention. For aged care workers, whether in residential facilities or in supported housing, these complexities are likely to present difficulties in role definition.

For example, nurses have often adopted the role of advocacy for patients in their care. The value for patients is that such advocates have a clear audience for their advocacy, namely the healthcare system, which nurses usually know intimately.

In aged care, although the role of an advocate is equally available to nurses and other health care professionals, the audience for the advocacy is much more disparate in ways that are likely to complicate the expression of that advocacy and mitigate its value and effect.

Adding to the complexity of aged care are competing obligations that can arise from the discovery of abuse or neglect, not only in the provision of aged care, but in the conduct and decision-making of family members and even guardians.

As a result, it may be more difficult for healthcare workers in aged care to establish and exercise a clear advocacy role that can confidently contribute to the welfare of an older person. Some healthcare workers in aged care describe themselves as being 'the meat in the sandwich' between the resident and his/her family, the resident and other residents, the resident and multiple health and aged care providers or a combination of all of these.

This complexity merits careful attention to the development of a compassionate, holistic and realistic account of the competing ethical obligations of healthcare workers in aged care.

Colin Thomson

BA, LLB, LLM (Sydney) www.ehealthinfo.gov.au

Colin Thomson, BA, LLM (Sydney) is Professor of Law at the University of Wollongong and Academic Leader for Health Law and Ethics in the Graduate School of Medicine. He also works as a consultant.

He was a member of the Medical Research Ethics Committee (1988-91) of the National Health and Medical Research Council and, from 1998-2002 a member, and from 2006-2009, chair of the Australian Health Ethics Committee. As a consultant, he has advised NHMRC, FaHCSIA, Health Departments of NSW, Qld and Vic and several universities. He is a Senior Consultant with Australasian Human Research Ethics Consultancy Services (www.ahrecs.com).

Colin has provided training to human research ethics committees, chairs the CSIRO Social Science HREC and is a member of HRECs at Department of Health and Ageing and University of Wollongong/ Illawarra Shoalhaven LHD.

He is a joint author of Good Medical Practice: professionalism, ethics and law, 2010, Cambridge University Press.

One machine for all people

From chaotic emergency rooms to quiet waiting rooms, the healthcare industry relies on technology to perform its tasks reliably so carers can focus on the health of patients rather than the health of their IT equipment. The day-to-day operations of most healthcare facilities produces a great number of printed documents so having printers that can be relied on to handle rigorous use is paramount. When your equipment works well, it is almost invisible, faithfully plugging away and producing prints day in, day out with ease. As a result, it is easy to dismiss the impact a quality machine can have in a healthcare environment.

For care professionals, they need tools that help them do their job quickly, efficiently and reliably. Just as you wouldn't consider an MRI or X-Ray machine that didn't perform flawlessly, the same level of quality must also be demanded from your administrative equipment as well. This is the primary design goal of the latest series of scalable, modular monochrome laser printers. The range is built from the ground up with flexibility in mind allowing you to create the type of system you want. In essence, it is one machine to all people.

Flexible to your needs

Whether it is a smaller two tray printer in a GP office or a high volume floor standing-model in a hospital, the latest range can be modularly adapted to fit your workflow. Brother understands that every healthcare professional is different and that the needs of an environment can change over time. There are seven base models in the range starting at the HL-5100DN three tray system running at 40 pages per minute through to the larger Multi-Function MFC-L6900DW which sports five trays, a slew of productivity features and a blistering 50 pages per minute speed. Depending on budget and feature set, a base model can be selected then expanded in the future with extra paper trays and various optional accessories. Even the trays themselves come in multiple sizes so you can choose between 250 page or 520 page capacity.

Adding a new paper try isn't only so you can increase the capacity of paper on the printer but is rather a way to provide extra functionality to the printer as well. By specifying which print jobs use which tray, you can have all your scripts in one tray, pathology slips in another, have one tray for radiology slips and fourth tray for administration/ letterheads etc. In a larger environment and combined with networking and workgroup features, a single machine can service an entire ward or medical centre.

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By taking advantage of the modular design and having dedicated trays for different types of jobs, there is never a need to switch paper types, therefore saving administration time. With the latest range of Brother Printers you are also able to share critical patient information while maintaining HIPAA compliance, facilitate electronic health records interoperability, and improve record keeping while enhancing the quality of care and streamlining your workflow.

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Understanding the Range

The range are monochrome laser printers available at different price points and feature sets. The range is comprised of Multi-Function printers as part of the MFC series and dedicated printers in the HL series. The MFC series has three models namely the MFC-L5755DW, MFC-L6700DW and the MFC-L6900DW in ascending order of price. The Printer series has four models being the HL-L5100DN, HL-L5200DW, HL-L6200DW and the HL-L6400DW, again, in ascending order of price. Starting from a base machine, each new model has additional features, faster speeds and different connectivity options. The top tier machines for the Multi-Function and the Printer Monochrome Laser ranges contain the highest level of innovation on offer with unique technologies perfectly suited to the healthcare industry.

The top of the range Multi-Function printer is the MFC-L6900DW which clocks in at a blistering 50ppm and has an RRP of $1799. It can be built as a floor standing model with 6 optional trays, a 12.3cm touchscreen and 80 page document feeder. It has 1GB of memory and comes with the added connectivity of Near Field Communication which allows for extra security features and copy tracking. It uses ultra-high yield toner at up to 20,000 pages and has optional extras available like a mailbox stacker/sorter. This unit would be ideal for a workgroup environment or printing room but will also work brilliantly in a smaller practice or nursing home office.

The HL-L6400DW can also be built as a floor standing workhorse which can pump out prints at a rate of 50 pages per minute and has USB host functionality to be used in conjunction with card readers. It has a user-friendly 4.6cm touchscreen and fast processing thanks to its 512MB of memory. When it comes to connectivity, it has both wired and wireless Ethernet and Near Field Communication compatibility. Like its Multi-Function cousin, it takes advantage of an ultra-high yield toner, can use up to five paper trays (520 input/ 250 output) and is compatible with mailbox stacker/sorter attachments.

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Reducing Healthcare Wastage with Data Analytics

Healthcare providers are unknowingly pouring funds down the drain – and that's because they can't keep track of all the spillage. That's where analytics plugs the gaps.

Visual analytics allow healthcare providers to see the whole story within their data. By knowing where resources are allocated and products/services consumed, facilities can see trends and uncover inefficiencies, empowering them to seize opportunities to limit and ultimately prevent wastage.

The government's Health Safety and Quality Commission found that healthcare waste costs taxpayers $20 billion a year and if this was eliminated it would cut 15 percent off the national health bill[1]. This is money that could be reinvested into the healthcare ecospace to support wider innovation, quality improvement and increased service offerings. Clearly, there is great potential for analytics to improve Australia's current state of healthcare waste.

More data for more improvement

With vast reams of data being created by the Internet of Things (IoT), Big Data and wearable tech, healthcare organisations can leverage data from an ever-expanding range of sources to have a more complete view of their consumers in order to make data driven decisions. Removing the all too common 'gut' from decision-making to a more evidence-based approach is the fundamental aim of analytics.

The range of data is only set to increase. IDC found that total shipments of wearable devices will reach 214.6 million units by 2019[2]. It predicts there will be 28.1 billion IoT units by 2020[3]. Incorporating data from these devices, both from its staff and its patients, will lead to many more exciting opportunities for insight and optimal service delivery as well as improved communication e.g., alerting, messaging, reminders, etc.

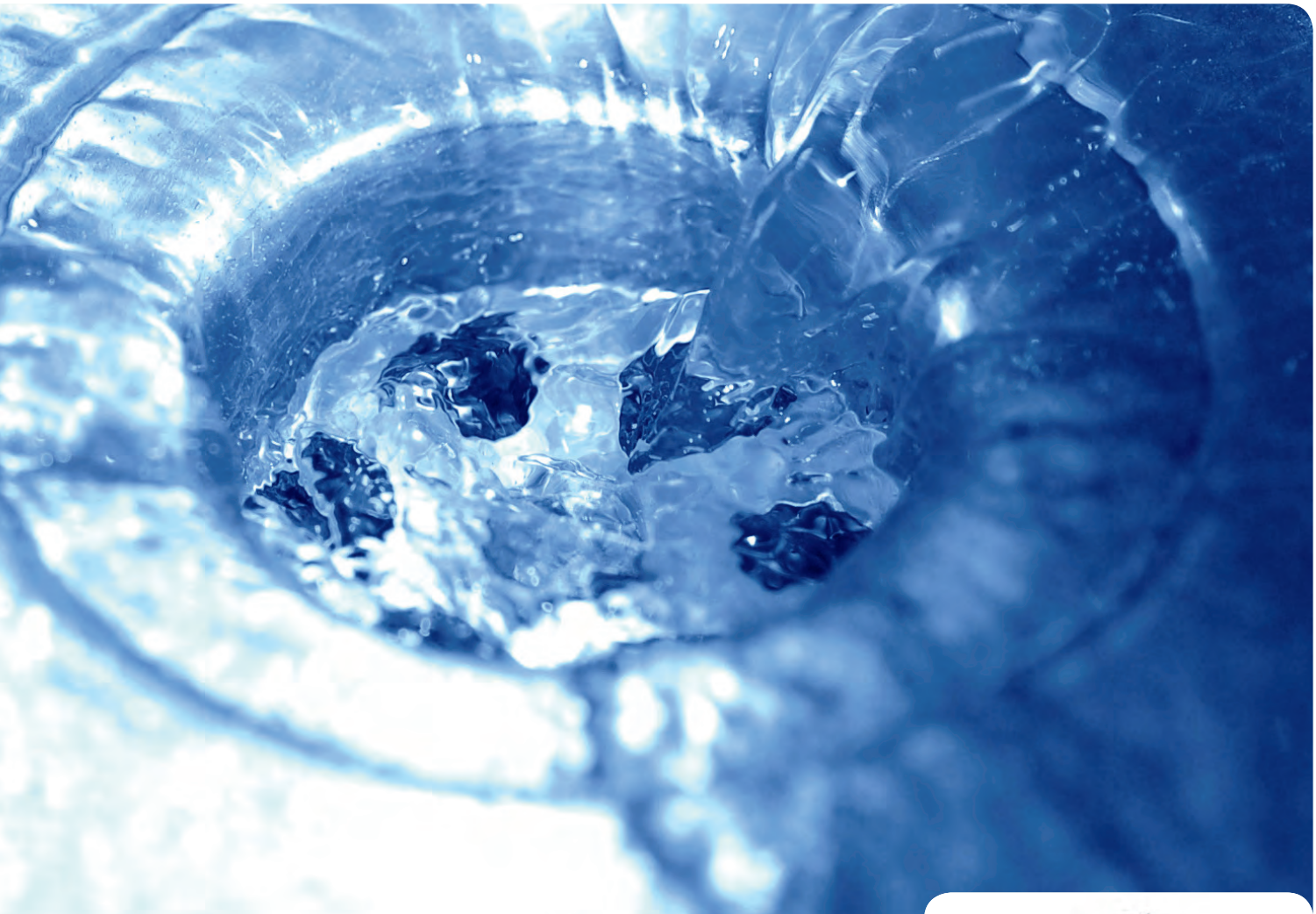
Qlik's and HIMSS Analytics' recent study of 400 healthcare organisations into data analytics found that many are using data to cut waste in patient care delivery. The study found 56% of healthcare organisations, the early adopters of BI platforms, improved patient care and greatly cut healthcare costs, while 48% could make faster and more accurate operational and clinical decisions.

Harnessing the platform effectively

The HIMSS Analytics Study also revealed that while data analytics has the potential to greatly reduce waste, the analytics strategy must be aligned with the healthcare organisation's goals to be most effective. Complete organisational buy-in will ensure strong adoption and recognised accountability.

Robust data governance, product agility and scalability, merging of disparate internal and external data systems and an intuitive user interface are essential add-ons to ensure complete value is derived from the organisation's investment; both of time and finances.

The user interface however, is most crucial to harnessing the business intelligence (BI) platform effectively. Healthcare



organisations must appreciate that although important to an analytics culture, data is still just a piece to their puzzle. It's the people who make decisions, and harness the value of that data. And simply mandating a tool will not force users to adopt it. A lack of user adoption is the primary cause for 70 percent of failed projects, according to a study by Forrester Research so selecting a tool that encourages self-service and interactive use of the data is paramount.

The possibilities of data

Digital healthcare leverages the changing capacities of technology to offer more information than ever before. Healthcare providers can analyse vast amounts of patient data from multiple sources in order to make better decisions around patient care and treatment plans leading to improved outcomes.

By seeing the whole story in their data, healthcare organisations can identify and eliminate inefficiencies in their processes, from unnecessary diagnostics, to changing prescription patterns or reducing length of stay, thereby achieving greater cost and operational efficiencies, and ensuring patients get the right care the first time. And as a country, we'll take a big step towards reducing healthcare wastage and improving the overall wellbeing of our population.

Charlie Farah

Charlie Farah is Director of Market Development, Healthcare & Public Sector for Qlik Asia Pacific covering public and private hospitals and Government agencies. Charlie has 14 years' experience working within the New South Wales health system. As Director of Performance Monitoring and Systems Improvement and Innovation for NSW Health, Charlie built new business intelligence solutions to address evolving opportunities and challenges facing the industries.

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- Simple, versatile functionality makes it convenient to use.

Contents gauge

- Clearly displays gas contents in real time with no need to touch the open/close valve
- High capacity cylinder
- Increased gas capacity of 0.639 m^3 (639 litres) saves time with less cylinder changeovers
- Potentially lower stock holdings
- User-friendly design
- Two ergonomic carry handles
- Tamper proof seal provides quality assurance
- Lightweight cylinder package makes handling easier
- Plastic coating makes it easy to clean
- Staff training in 6 easy steps
- Sleek, professional appearance ensures patient confidence

Specifications

Product code	202178 Gas Medical oxygen
Gas content	0.639 m^3 (~639 litres) at 15°C and 101kPa
Cylinder fill pressure	20 000 kPa at 15°C
Diameter	115 mm
Height	524 mm
Weight (empty)	3.5 kg
Weight (full)	4.4 kg
Outlets – Firtree	Tubing diameter: 6-8 mm
(Therapy tubing connection)	Flow rates: 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 15 lpm
– Diameter index outlet (D.I.O.)	Maximum outlet pressure (g): 400 kPa
Also referred to as sleeve index system (S.I.S)	Flow rates: up to 300 lpm as per AS 2902-2005

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Hill-Rom is a leading global medical technology company partnering with health care providers in more than 100 countries, with over 10,000 staff and 7 million patients touched by Hill-Rom® products every day.

Hill-Rom achieves this by focusing on patient care solutions that improve clinical and economic outcomes in five core areas:

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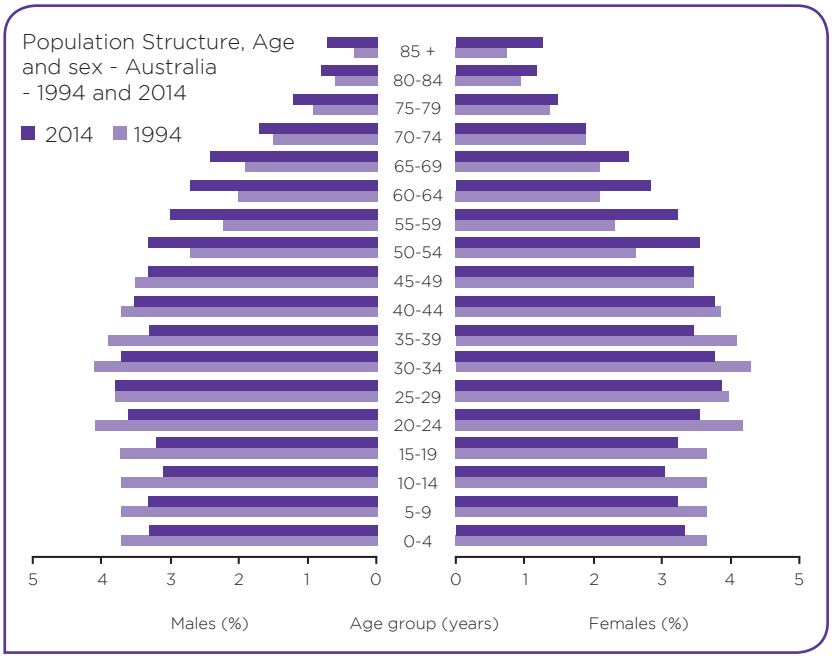
Tackling Healthcare for an Ageing Population

SHPA has long called for improving access to pharmacist led medication reviews, especially amongst vulnerable patient groups at risk of medication misadventure, with older and elderly patients being one of them.

While the Home Medicines Review and Residential Medication Management Review Programs have had some impact, their restrictive funding and access rules mean not all patients are able to receive the best possible care in the setting that best suits their needs.

Our ageing population is a key issue for Australia's future. Solutions for managing the impact of our ageing community need to consider health, economic and social perspectives.

Like other OECD countries, the median age of Australians has been increasing year on year. The figure below from the Australian Bureau of Statistics paints a realistic depiction of our times.



As life expectancy worldwide has been increasing since the end of World War II, so has the emergence and incidence of non-communicable diseases. There aren't many of us that have not been personally affected by a friend or family member with Type 2 Diabetes, cardiovascular disease, or dementia.

Because of this, unnecessary medicine use and polypharmacy amongst elderly patients is significant.

As clinicians, it is imperative to put patients first. We need to remember that we are treating people, and not a set of biological markers. When it comes to elderly patients and their medicines, sometimes, less is more.

In Australian hospitals, the average number of prescribed medicines for older inpatients is nine to ten medicines. Frail, elderly patients are more susceptible to the adverse effects of medicines. There is limited evidence to support the use of many medicines in elderly patients as they are typically excluded from clinical trials.

One study has estimated the cost to the Pharmaceutical Benefits Scheme of potentially inappropriate medication in older patients is between $240 and $450 million each year.

The use of medicines used to prevent a condition, or disease, or those with a long 'time to benefit' profile may not be consistent with the life expectancy of the patient and their goals of care, and thus proactive deprescribing of medicines is encouraged where appropriate.

That is why SHPA's first listed recommendation for the Choosing Wisely Australia (www.choosingwisely.org.au) initiative is:

'Don't initiate and continue medicines for primary prevention in individuals who have a limited life expectancy'.

Hospital pharmacists have valuable expertise in managing the quality use of medicines and can help members of the healthcare team to achieve better outcomes not only for the patient's health, but also the healthcare system and the patient's (and their carers) overall satisfaction and engagement with their health and wellbeing.

In the June 2016 edition of SHPA's Journal of Pharmacy Practice and Research, the Hospital Outreach Medication Review (HOMR) study[1] at Monash Health demonstrated pharmacist-led medication reviews, can reduce hospital readmissions by up to 25% in people aged between 51 and 65 years.

With the Federal election behind us, SHPA will continue to advocate for pharmacists providing more clinical services to older and elderly Australians as the government continues to review the Medicare Benefits Schedule and plan the pilot trial for Health Care Homes.

Kristin Michaels
CEO Society of Hospital Pharmacists of Australia

Kristin Michaels is the Chief Executive Officer of The Society of Hospital Pharmacists of Australia, with a keen interest and experience in health system design. She is a seasoned Board Director in both the primary, acute and aged care sectors. Kristin holds qualifications in Arts, Organisational Leadership, Governance and Health Service Management. She is a Fellow of the Australian Institute of Company Directors and is accredited as an International Partnership Broker.

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TAKEO_2 The Innovative Solution for enhanced Patient Safety and Cost Savings in Healthcare Facilities

Air Liquide *Healthcare* is proud to introduce TAKEO_2™, one of the world's first digital integrated cylinders. Australia is one of the first countries outside of Europe to implement this new technology.

About Air Liquide *Healthcare*

Air Liquide *Healthcare* is a world leader in medical gases, home healthcare, hygiene products and healthcare specialty ingredients. Air Liquide *Healthcare* aims to provide customers in the continuum of care from hospital to home with medical products, specialty ingredients and services that contribute to protecting vulnerable lives.

We serve over 7,500 hospitals and 1,000,000 patients throughout the world, supplying medical gases, hygiene products and equipment to hospital customers, and providing Home Healthcare services to patients in the community.

TAKEO_2™ is a major innovation in the Medical Oxygen field. This new generation cylinder combines a built in pressure regulator, an ergonomic cap and a patented digital gauge, to provide healthcare professionals with the industry's safest and most cost effective medical oxygen delivery system.

This new technology allows caregivers to better manage the administration of medical oxygen, by viewing the remaining time and volume available at a glance.

What does TAKEO_2™ mean for me?

This solution provides major benefits to healthcare providers:

Greater patient safety by reducing the risk of oxygen supply interruption:

- Staff can safely plan oxygen dependent transfers having immediate and accurate cylinders duration time.
- The permanent display of the remaining time and available volume as well as the safety alerts indicate when the cylinder needs to be replaced
- The integrated valve with built in pressure regulator provides a higher level of safety as it reduces the possibility of adiabatic compression associated with detachable pressure regulators.

Improved ease of use and faster oxygen set ups:

- With an ergonomic cap, a comfortable handle and a straightforward flow selector, patient care is significantly facilitated.
- The time-related data provides an unprecedented comfort level to caregivers who can better focus on their primary responsibility, the patient.

Cost efficiency through an effective use of the cylinder content and reduced equipment cost:

- With direct and exact information on remaining time, staff members are more confident to use most of the cylinder contents as they have a better control of the autonomy of the cylinder.
- Featuring an integrated valve, **TAKEO_2**™ does not require a separate regulator to be attached. This eliminates the need to purchase regulators for medical oxygen cylinders, or to manage their maintenance and repair.

The use of the integrated **TAKEO_2**™ cylinders reduces redundant and inefficient activities, enables caregivers to reallocate their time on the patients and delivers significant cost savings for the healthcare facilities.

It was demonstrated with several case studies in Europe and Canada that hospitals were returning about 50% of their medical oxygen cylinders for refill (considered as empty) when cylinders were actually over 1/4 full. With the new digital integrated cylinders, over 90% of the cylinders were returned completely empty by the hospital. As a focus on lean management and waste reduction practices in the healthcare sector continues, **TAKEO_2**™ is the innovative solution for cost savings.

How does it work?

When the cylinder is in use, the patented digital pressure gauge calculates and displays the time remaining in hours and minutes. No more estimations or calculations of the remaining content are required as **TAKEO_2**™ cylinder provides direct intelligible information to medical staff with the remaining treatment time at the selected flow.

When the cylinder is not in use, it displays the available volume in litres. The device also features visual and audible warning alerts which indicate when critical levels are reached.

Remaining time displayed in hours:minutes

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In Conversation

In Conversation gives a glimpse into the life of an 'outlier' - an exceptional person going above and beyond to innovate in their field and improve patient outcomes. In this issue we talk to *Maggie Beer* about why she established the Maggie Beer Foundation and the impact it is having on the food experience of aged care residents.

Thank you for joining us In Conversation Maggie. You are one of Australia's most well known food personalities, you have owned an award winning restaurant and successful gourmet food company and appeared on the ABC programme The Cook & The Chef. What prompted you to launch the Maggie Beer Foundation?

The nutritional welfare of those in aged care facilities has been an ongoing concern of mine for a long time and I'm so happy to finally have found the time and people to support my passion. In 2014 I established the Maggie Beer Foundation to provide the pleasure of a good food life for all, regardless of age or health restrictions. In fellowship with my board of industry leaders, professors and health advisors, I've made it my personal mission to link the latest research of nutrition's impact on brain health and general well being, with my personal knowledge of what good food can do for everyone's state of mind.

In 2010 you were named Senior Australian of the Year and as one of your many engagements you were asked to speak to 1000 CEOs of aged care. What impact did this experience have on you personally?

It was then that I realised just how many passionate people there are involved in this industry; all of them trying to do what they can with limited resources to bring every part of the puzzle together to impact change in aged care but it is a very complex tapestry to manage. It was my hope to pull all of the various specialist aspects of science, research, nutrition and management under the one umbrella to support this ever growing industry in providing nutrient dense, flavoursome food to everyone, regardless of age or dietary requirements. The vision of the Maggie Beer Foundation is to educate and facilitate the food we all deserve, and I truly believe everyone deserves to enjoy good food.

Do you feel that it's possible for aged care providers to give their residents quality food at a reasonable cost?

There are many stumbling blocks in relation to cooking in aged care homes, but my purpose with the Foundation is not to focus on the negatives but rather to put some fresh thinking around nutritious ingredients, food budgeting, supplier relationships, aged care specific recipes, menus and dining room management. This was never going to be an easy road and so there have most certainly be challenges along the way, but the common denominator is that everyone involved can agree that change needs to happen, so we start from there.

Some of the difficulties have been in impeding food safety rules, an inadequate budget for meals in aged care, and attitudes of staff that were either resistant to change and/or acknowledged that change was required but felt disempowered. Finally the skill level of cooks, chefs and food providers in aged care homes was identified as a constraint. The need for menus with variety, that included cultural diversity but were familiar, flavorsome and within budget constraints has been highlighted as requiring considerable skills to plan and execute and that these skills were lacking in the residential aged care setting. By addressing these issues, one by one, very real change can be achieved on a daily basis.

Would you share the story behind the Flinders University Evaluation Report, 'Creating an appetite for life'? What do you hope this report will achieve?

Throughout our most recent 2 day education program in Sydney, students from Flinders University sat in to gain feedback from the chefs and cooks who joined us for 'Creating An Appetite For Life'. We're hoping this will add to the exchange of information everyone shared throughout the program, especially in troubleshooting the stumbling blocks of cooking in aged care homes, putting some fresh thinking around nutritious ingredients, food budgeting, supplier relationships, aged care specific recipes, menus and dining room management.

In your experience, when the variety and quality of food is improved, what are the benefits to older people?

We have had a steady stream of success based on the goals we set out as our overall plan when we began. Focussed on the objectives of establishing a vibrant, influential and authoritative charitable foundation we are on this journey to improve the quality of life of the current and future generations of older people by working in conjunction with governments, institutions, non-government organisations and the community. We believe that enhanced food experiences from all meals have a measurable and positive impact on the quality of life of older people and the Maggie Beer Foundation seeks to prove that enjoyment from food equals increased emotional well being equals increased nutrition and physical well being equals increased quality of life.

We also encourage all to be involved, where practical, in one, some or all phases of a great meal - including the growing of food, shopping/ordering, preparing, cooking, table setting, serving, eating, table clearing and washing up. I have seen so many wonderful

changes take place, but perhaps a stand out was the addition of a veggie garden in one of the homes, which encouraged a man, who hadn't left his room for many months, to venture outside and plant some vegetables. I couldn't get the smile off my face when I read the thank you letter from the staff. Really wonderful.

You have said that "old age is a wonderful time of life if we have choices." How does this apply to the food we have access to?

It has everything to do with the food we have access to but for many in their later years, the food itself needs to be altered according to dietary restrictions, pureed etc, and this is when I think it's especially important to recognise the choice to enjoy the social aspect of eating as much as the choice of nutritionally dense foods. We have noticed in our visits with the aged care homes that the social aspect of eating is a major influence on the enjoyment of food.

When I think about the importance I place on my environment when I eat, or when I'm sharing a meal with people I care about, it makes absolute sense that the way food is prepared and brought to the table should be taken into consideration as a natural part of any meal. It is so important; equal to the food itself. And I see no reason for anyone to miss out on this aspect of pleasure when it comes to sharing the table, especially those in the later stages of their lives.

What is on the horizon for the Maggie Beer Foundation?

We'll continue to be focussed on all the things we have as our objectives and work to make them manifest in the lives of the residents - things like making mealtimes more social, starting gardens to grow fresh vegetables and herbs on site and allowing more autonomy of choice for residents when deciding on their meals.

With the staff, we are now providing hands on cooking demonstrations to share new recipe ideas and ways of incorporating simple things like fresh stock, real butter and fresh rather than frozen veggies. We will also continue to troubleshoot the inevitable challenges both the kitchen staff and management are dealing with on a day to day basis. Last month we completed the first ever aged care focussed presentation at Tasting Australia, and it's made me especially keen to continue to bring an awareness to aged care cooking and nutrition in the greater food world.

"We have noticed in our visits with the aged care homes that the social aspect of eating is a major influence on the enjoyment of food."

How would an aged care facility access the Maggie Beer Foundation's resources?

There are many providers and many cooks and chefs who do have a love of food and an understanding of how vital that joy of looking forward to a meal is, and there are others wanting to do more but frustrated by the many complex issues which can overload management. This can easily result in expedient decisions being made instead of the basic premise where the kitchen is the heart of the home. By coming together and sharing the positive stories and ideas, we can make change together.

Our website, newsletters and Facebook page provide a space for this food interested group to come together and you can also show your support, and stay connected with the Foundation's work by joining the supporters register at www.maggiebeerfoundation.org.au/subscribe

For chefs and cooks working in aged care, the Maggie Beer Foundation Education Programs offer an opportunity for a selected number of attendees to participate in 2 or 3 day workshops with Maggie and aged care industry experts. These education programs are aimed at those who are committed to making a difference in their aged care home kitchens and who can influence those controlling food budgets, supplier relationships, menus and dining room management.

For more information on the upcoming programs you can email us at info@maggiebeerfoundation.org.au.

Key Issues with IV Connectors

Catheter Occlusions

- Catheter occlusion is the most common noninfectious complication in the long-term use of central venous catheters (CVCs) and occurs in 33% of these catheters.[1]
- A common cause for catheter occlusion is clotting of blood refluxed into the catheter. Blood reflux occurs when an administration set or syringe is connected to a positive displacement connector or disconnected from a negative displacement connector.[1]
- Occlusions increase the risk of procedural complications, risk of infections and costs in hospital time and money. Maintaining the patency of the catheter is a high priority.[2]

Bloodstream Infections

- Facilities and governments have increased pressure to reduce hospital-acquired infections (HAis).
- It is estimated that central vascular catheters are associated with 248,000 bloodstream infection per year in the US.[4]
- Development of a catheter-related bloodstream infection (CR-BSI) can increase hospital length of stay by an average of 23 days, and mortality rate by 21.6% which increases total cost of care.[5]
- As an additional reference the FDA has expressed concern about multiple clinical reports regarding the association of BSIs with positive displacement devices.[6]

Connector Failure

- Connectors not designed to tolerate pressures used for power injection can fail and harm the patient.[3]
- Failure can delay treatment of patient.[7]

Training Requirements

- Multiple connectors with varied techniques can cause confusion and increased potential for errors.[8]
- Ongoing staff turnover requires increased training.[9]

Key Features and Benefits of the One-Link Needle-free IV Connector

Features	Clinical Benefits
Withstands a maximum of 325 psi with a pressure power injector[1]	Compatible with most contrast media power injectors
Can be used for up to 200 actuations and over a period of 7 days. Replace device whichever comes first.	Aligns with CDC 2011 guidelines and may provide flexibility for longer use
Smooth top surface with gland tightly fitted to housing	Provides an easy-to-cleanse device that helps the clinician disinfect the surface
Clear housing	Allows the visualization of the fluid path, thereby helping the clinician to verify that the device has been flushed
Finger-grip surface	May reduce likelihood of touch contamination
Low flush volume after medication or solution administration. 10 ml flush required if the connector has been exposed to blood.*	Facilitates thorough flushing of device Appropriate for fluid restricted patients, including neonates and pediatric patients
Neutral fluid displacement	Eliminates the need for a specified clamping sequence; for patient safety, clamping is required only when the device is not in use Compatible with a variety of valved and non-valved catheters
Low priming volume (0.08 ml)	May allow for more medication to be delivered and less to be retained in the device
Lipid compatible	Can be used with a wide range of IV fluids
No clamping sequence required. (Clamp when not in use for patient safety)	Simplifies training

1 Replace if a pressure over 325 psi is applied to the connector.

* Flush per organization protocol. Flush with a volume of 10 ml after exposure to blood. Replace if a 10 ml flush cannot be performed.

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One·Link
Needle-free IV Connector

Safer Together

Enhancing patient care. Simply. Neutrally.

One-Link, Needle-free IV Connector

- ✓ Power injector compatible (up to 325 psi)*
- ✓ Straight fluid path
- ✓ Non-PVC and Non-DEHP
- ✓ Easy to clean surface
- ✓ Low priming volume of .08 mL

The neutral displacement ONE-LINK connector is designed to help reduce the risk of thrombotic catheter occlusions compared to devices with higher reflux volumes.[1] Less chance of reflux means simplified training and usage — and more time to focus on your patients.

Plus, ONE-LINK is a needle-free connector that can be used throughout your facility. From OR to ER. Neonatal to Oncology.

Preventing infections and improving medication safety is our business. Let's raise the standards and help make healthcare **Safer Together.**

*Prior to power injection, ensure all parts of the IV System are compatible. Replace if a pressure over 325 psi is applied to the connector. The ONE-LINK IV Connector is intended for single patient use with a vascular access device for administration of drugs and solutions without needles and can be used to aspirate blood.

For safe and proper use of this device please refer to the Instructions for Use.

1 Data on file, Baxter Healthcare Corporation.

Preventing and Controlling Healthcare Associated Infections

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31 Progress Street, Mornington,
VIC 3931 Australia

T: (03) 5976 1555
F: (03) 5977 0044
E: sales@amcla.com.au
W: www.amcla.com.au

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