

Summit proceedings

EACH PRESENTATION is included in the Appendices to this document. A summary of key points made in each presentation and issues raised during the discussion which followed it is set out below.

3.1 Opening address

Dr Jeremy McAnulty
A\Deputy Chief Health Officer, NSW Health

Key points

- An overview of the data on the prevalence of MROs in NSW collected via NSW Health's standardized mandatory system for monitoring MROs and other healthcare associated infections which commenced in January 2003. Only state aggregate data are made available to the NSW Department of Health. The Australian Council on Healthcare Standards (ACHS) receives the data from the hospitals, prepares reports for them and aggregates data for the Department.
- Health service providers and the Department can make a difference by:
 - developing evidence based policy and supporting its implementation
 - educating health care workers and patients
 - encouraging appropriate antibiotic use
 - identifying and monitoring organisms more accurately
 - improving infection control
 - evaluating what we do and improving what we can.
- NSW Health is keen to work toward development of a nationally consistent approach to MRO surveillance, control and prevention.

Issues raised during discussion

- The adequacy of the scope of the recommendations.
- The extent to which there is a commitment from Government and the Department to act on the

recommendations – particularly with regard to allocating additional resources to enable the system to respond effectively.

- The need for reporting on implementation of the recommendations to be incorporated in key performance indicator (KPI) reporting by Area Chief Executives to the Director-General.

3.2 Process for development of MRO prevention and control recommendations

Professor Lyn Gilbert
Chair, NSW MRO Expert Group

Key points

- The history of MRSA in Australian healthcare settings, dating back to its identification in Melbourne in 1965 and its subsequent establishment as an endemic organism in eastern Australian hospitals; and summary of data regarding emergence of other MROs, including community acquired (ca) MRSA, and the need to investigate their complex epidemiology.
- Overview of the reasons for development of resistance.
- Acknowledgement of existing control and prevention efforts nationally; and the lack of a standardized national approach.
- Overview of the role and recommendations of the Expert Group and resource issues and limitations.

Issues raised during discussion

- MRSA-focused policies will also contribute to control and prevention of other MROs; and benefits will ensue from better control of antibiotic use including reduction of the potential for further resistance development, reduced healthcare costs, longer life for existing antibiotics.
- The need for appropriate surveillance and control strategies for CaMRSA as well as healthcare associated MROs.

- The challenge of getting HCW compliance with guidelines and the importance of ensuring that behavioural issues are addressed in program design; and change management strategies.
- Consumer delegates highlighted the need for education of consumers and the general community; and the importance of engaging consumers to act as community educators.
- The importance of categorising preventable MRO infections as adverse events.
- Consumer accounts of MRO colonisation and infection; infection control practices and staff attitudes to them and to infection control practices.
- The need for additional resources for Areas to enable them to respond effectively to MROs.

3.3 Launch of NSW Hand Hygiene Program

Professor Clifford Hughes
NSW Clinical Excellence Commission

Key points

- In 2006 the Clinical Excellence Commission (CEC) will run a Hand Hygiene Campaign across NSW with the slogan, 'Clean hands saves lives'.
- An overview of the evidence base – including cost-benefit and cost-effectiveness data – for hand hygiene as an infection control strategy; mortality and morbidity resulting from breaches of infection control procedures; the effectiveness of hand hygiene campaigns; the role, performance and benefits of alcohol-based rubs versus hand washing.
- An overview of the process for development and implementation of the NSW CEC Hand Hygiene Campaign which includes development of a toolkit; securing senior management and key stake holder commitment; identifying lead members of staff in each ward and department, including clinical champions; assessing the costs of implementing the recommendation for near-patient placement of alcohol rub.
- An intensive marketing and media campaign with a Hand Hygiene Day will occur at the commencement of the Campaign.
- An overview of the proposed evaluation methodology for the Campaign.

Issues raised during discussion

- Strategies to overcome the power differential between patients and staff, and junior and senior staff, so that it is accepted that others in the workplace will 'speak up' if they observe someone who has not cleaned their hands before or after contact with patients.
- The important role that Area Community Councils have in supporting patients to request that HCWs clean/wash their hands; the role that Area and facility infection control committees can play; and the importance of multi-disciplinary membership of those committees – nursing, medical, consumer, infection control, laboratory etc.
- Sustainability strategies.

3.4 MRO Surveillance recommendations

Professor Lyn Gilbert
Chair, NSW MRO Expert Group

Key points

- The role of surveillance in case detection, based on agreed case definitions and identification of outbreaks and trends; and producing data for service planning, informing cost effectiveness studies, benchmarking and quality assurance.
- The rationale for reporting of all MRO BSIs – particularly *Staphylococcus aureus* BSIs which are the most common, and in many cases, preventable.
- The role and benefits of electronic notification; and an overview of data required.
- The role proposed for Area Infection Control Committees in standardised review of all MRO BSIs and the importance of feedback to the treating clinician while patients are still in hospital.
- A Key Performance Indicator (KPI) approach is recommended because it is important that Area Health Services are able to see how the Area and individual facilities perform compared with other Area Health Services with comparable hospitals. KPIs are also a way of making administrators accountable to the public and bringing healthcare associated infections to the attention of executives.

Issues raised during discussion

- Resource implications and expertise required for standardised review of all MRO BSIs.
- The need for policy to be implemented in community healthcare settings as well as hospitals.
- The complexities of monitoring trends and recognizing problems when they begin to occur due to relatively small numbers of infections; and the tools available to assist real time monitoring of changes in such situations.
- The need for uniform national minimum surveillance of BSIs, MROs and other HAIs – particularly those associated with surgery.
- There was strong support for standardising systems for data collection throughout the state – ie while consistent data definitions are used at present, there is not a standardised system for compiling those data or for harvesting them from existing IT systems in NSW Health facilities.
- The value of using bodies which are independent of health departments for data aggregation and analysis – as occurs in NSW and Victoria at present; and the benefits or otherwise of mandatory versus voluntary surveillance and monitoring. ACHS was identified as an appropriate organization for aggregation of national data.
- The importance of timely feedback systems. Six monthly reporting, as currently occurs in NSW was not regarded as sufficiently timely for clinical improvement activities.
- It was agreed that transparency is important and that HAI data should be made publicly available, however there was limited support for hospital league tables similar to those which have been implemented in the UK. The argument against such tables was the need for complex explanations regarding differences in case mix; statistical methods and chance variations; and the incentive created for hospitals to select less complex patients to ensure that their infection rates are low.
- The importance of Area Infection Control Committees, and the need for strong links between them and clinical governance units to establish local mechanisms for reviewing and responding to HAI data.
- The inadequacy of the current level of investment in infection control practitioners across the state; and in infectious disease physicians and microbiologists outside metropolitan areas is an impediment to effective infection control programs.

It was agreed that every hospital should have access to infectious diseases physician expert advice and infection control practitioners.

3.5 Screening recommendations and options

Dr John Ferguson
Hunter and New England Area Health Service

Key points

- A review of the evidence for various approaches to MRSA control and prevention confirms that standard infection control precautions are insufficient for that purpose; additional contact precautions are required to effectively control MRSA transmission in healthcare facilities. There is a demonstrated 38 fold higher frequency of transmission from patients not suspected of carrying MRSA (not in contact isolation) compared with MRSA patients held in isolation. The corollary of this is that MRSA screening of patients at high risk for colonisation is an important mechanism for reducing spread from non-isolated colonised patients.
- MRSA colonised patients are at significantly higher risk of developing infection; early identification may enable decolonisation treatment prior to developing infection/prior to elective surgery.
- Examination of three different guidelines – Dutch; New Zealand; and the Society of Hospital Epidemiologists of America (SHEA) – highlights an emerging consensus that the northern European approach to control of MRSA should be supported.
- The key elements of the guidelines cited are active screening to identify reservoirs (patients and health care workers); improved compliance with hand hygiene by healthcare workers; contact additional infection control precautions for all patients known to be colonised with important MROs including MRSA; antibiotic stewardship; and active decolonisation programs for certain colonised patients and staff.
- Prevalence of MRSA on admission to NSW hospitals is still relatively low. An approach based on risk factors and local epidemiology is most cost-effective.
- The literature shows that even in endemic situations, such as the UK, MRSA prevalence can be reduced through ring fencing of particular units – or a ‘search and destroy’ policy. This has significant resource and staffing implications. It also requires targeting the staff reservoir, through staff screening and management of colonised staff.

3.6 Search and destroy approach to screening

Professor Richard West
Royal Australasian College of Surgeons

Key points

- Overview of MRSA morbidity and mortality data and associated costs; the endemic situation in NSW and other Australian hospitals; and the importance of creating an environment where patients can be assured they will not get MRSA when they are admitted to hospital.
- Additional resources are required to support effective MRSA control and prevention; and a standardised national approach is required.
- The risk factors for MRSA are well documented and the 'Search and destroy' approach is well documented to be an effective control strategy in Scandinavia while providing MRSA patients with equitable rights and access to care.
- A dedicated laboratory service to conduct MRSA typing is required to support control and prevention efforts.
- KPIs must be introduced so that Area executives take the issue seriously and Area infection control committees must be established.
- Detailed policy is required regarding infection control measures, discontinuing isolation measures and for notifying community nurses and GPs when the patient is discharged.
- The editorial in the journal, *Infection Control and Hospital Epidemiology*, by Margreet Vos, titled, 'MRSA: We Can Overcome, But Who Will Lead the Battle?' (Vol. 26 No. 2 February 2005) was commended to the Summit.

Issues raised during discussion following Dr Ferguson's and Professor West's presentations:

- The extent to which effective control measures from the low MRSA prevalence setting can be generalised to an endemic setting was discussed. It was noted that the literature shows that low prevalence countries are often dealing with limited numbers of patients from a single source; and that some of the key elements of the 'search and destroy' approach work in epidemics such as ambushing with alcohol gel; and feedback to clinicians and selective screening of high risk patients.

- Strategies proposed for addressing current MRSA problems in NSW included encouraging hospitals to identify the wards with high MRSA prevalence and consideration of screening of patients when they are readmitted to hospital; and targeting those wards for implementation of control strategies.
- Active screening has resource implications for laboratories – particularly with regard to turn around times for testing and microbiology service capacity. Both funding and expertise need to be addressed and dedicated funding, separate from clinical unit budgets, will be required to be allocated to each Area rather than relying on the discretion of clinical units for funds.
- The cessation of the SWAPS typing project was identified as a potential impediment to MRSA management – both in community and hospital settings. There was not a consensus regarding the number of laboratories which should have molecular typing expertise – ie a single reference laboratory or a number of larger laboratories. The role of typing in identifying the source of MRSA and understanding its epidemiology was acknowledged as a key element of effective control programs.
- The variation in MRSA prevalence between rural and metropolitan facilities; and between facilities of different sizes in metropolitan areas was discussed in terms of implications for screening. It was agreed that screening of high risk patients is important regardless of MRSA prevalence.
- Admission screening of patients previously identified with MRSA was agreed to be essential, as was a mechanism for identifying such patients and obtaining agreement on criteria for determining that a previously infected or colonised patient had cleared MRSA.
- It was agreed that elective joint replacement units should be established separately from traumatic orthopaedic units; and screening used to ensure that elective units remain free of MRSA.
- The potential impact of community MRSA was acknowledged. Recent outbreaks in the rural areas were noted.
- Vascular surgery wards must be ring fenced.
- Renal dialysis and transplant units should also be categorised as high risk units where patients should be screened on admission and regularly thereafter.
- It was reported that there is pressure in public hospitals to provide single rooms for private patients, rather than use them for infection control purposes.

- Effective nursing care of patients with MRSA requires a higher staffing ratio than is currently provided.
- Screening of staff in ring-fenced units was identified as an important component of control strategies. It was acknowledged that staff screening has not been considered for a range of reasons to date – logistics; resources; industrial issues; turn around time for and interpretation of results; lack of consensus on case definitions, treatment protocols and clearance criteria.
- It was noted that the HISS project, the pilot which preceded the implementation of mandatory monitoring of healthcare associated infections in NSW, found MRSA rates were five times higher in major metropolitan hospitals, than at other facilities. It was hypothesized that the reason for this is that major metropolitan hospitals have more patients who are at high risk of MRSA. Introducing notification of MRSA will therefore assist with making appropriate decisions regarding resources allocation and targeting areas of need.
- There was unanimous agreement that the reporting against implementation of the Expert Group's recommendations for controlling MRSA should be made KPIs for Area Chief Executives – in particular, screening of ICU patients on admission and discharge; and ring-fencing elective joint replacement, vascular surgery and cardiac surgery wards.
- It was noted that the Expert Group would also be overseeing the development of detailed policy, including screening guidelines for implementation by Area Health Services. It was proposed that Areas be required to report to the Department on their screening plans for various types of patients and specialty units.
- It was agreed that a communication strategy for consumers is required to ensure they are aware of screening requirements; the reasons for screening requirements; isolation requirements if they are found to be colonised or infected and require admission; and the potential need to delay surgery if they are found to be colonised.
- It was agreed that patients transferred between hospitals should be screened for MRSA and isolated (either physically or via contact precautions) until their MRSA status is known.
- The need to ensure seamless communication between healthcare settings regarding a patients MRSA status and infection control precautions required (eg hospital, rehabilitation, nursing homes,

community care) and education of consumers and healthcare workers was stressed.

- It was suggested that there is a significant existing volunteer pool members of which could play an important role in community education.
- Empowerment of patients to request that healthcare workers adopt appropriate infection control practices was identified as a priority, along with the need to ensure healthcare workers are accepting of such requests.
- There was an additional recommendation made for development of community information and consumer involvement in implementing strategies.

3.7 Antibiotic prescribing software packages in Australian Hospitals

Ms Paula Doherty
NSW Therapeutic Advisory Group

Key points

- An overview was provided of existing strategies to decrease antibiotic prescribing including treatment guidelines; restricted access; audit and feedback (drug usage evaluation or DUE); education (academic detailing, prescribing cards, bulletin, JMO orientation); and benchmarking usage data.
- There is a range of antibiotic prescribing software products available. These products can assist with the management of antibiotic prescribing. An overview was provided of three systems currently in use in Australian hospital settings – the John Hunter Hospital *Anti-Infective Registration System (AIR)*, the Royal Melbourne Hospital *Guidance* system and the Austin Hospital *Infectious Diseases Electronic Antibiotic Advice and Approval System (IDEA3S)*.

Issues raised during discussion

- The criteria for choosing a system were discussed including resource implications in terms of pharmacists and infectious diseases physician support; technical issues; and determination of the balance between restriction and registration.
- Development of an electronic prescribing system for NSW Health facilities is only in the very early stages. However a system wide approach is required regardless of the availability of an IT solution.
- Manual systems for auditing antibiotic prescribing are time consuming, resource intensive and have limited

capacity for timely interventions where there is inappropriate prescribing. Telephone approval systems are neither effective nor an appropriate use of infectious diseases staff time.

- The complexity of care in ICU, morbidity profile of patients and urgency of treatment needs presents some barriers to implementation of IT supported antibiotic prescribing control. Nevertheless, it is appropriate to challenge free ranging antibiotic rights for ICU clinicians.
- Clinical pharmacists are an essential component of the workforce needed to improve antibiotic use.
- The intention of moving to electronic support systems for antibiotic control should be compatible with IT systems for electronic medical records, prescribing, pathology and pharmacy.
- Antibiotic prescribing is complex and decision support tools can only be used as a guideline. Clinicians also need electronic access to other information to guide prescribing.
- The special needs of paediatric settings were noted.

3.8 Environmental recommendations

Ms Joe-anne Bendall NSW Health

Key points

- An overview was provided of the UK experience, where cleanliness has become a major patient concern and patients have statutory power to inspect and report on cleanliness in hospitals. The UK document *A matron's charter: an action plan for cleaner hospitals* is the key policy guidance for cleanliness in UK healthcare facilities.
- An overview was provided of the evidence regarding the role of the environment in MRSA and other MRO transmission; and as a reservoir for MROs.
- Current NSW guidelines require revision to accommodate a risk-based framework. The Victorian framework incorporates a risk management framework, an auditing process and reporting requirements.
- To be effective, environmental cleaning must be used concurrently with other infection control strategies.

3.9 The Victorian experience with Environmental Cleaning Standards

Mr Clinton Dunkley Victorian Department of Human Services

Key points

- History of the development of the Victorian Standards. The Standards may be used for clarification for cleaners and contractors; to aid contract management; to ensure consistent infection control standards and requirements; and for benchmarking.
- Cleaning staff play an important role in the health team and should be recognised and supported by hospital management for their potential to reduce infection related risks, as well as their contribution to amenity.
- Victorian Cleaning Standards have been adopted by the UK NHS. A further update is planned for 2006 along with development of an auditors' course and a training program for cleaning staff. The frequency of auditing and reporting is also being considered for review.

Issues raised during discussion following Ms Bendall's and Mr Dunkley's presentations:

- The extent to which there is evidence that cleaning contributes to MRO control.
- The costs of cleaning in accordance with the Victorian Standard have not been well quantified. The focus on cleaning arose out of complaints regarding amenity as well as infection control concerns.
- The Expert Group's recommendations regarding evaluation should include examining the impact of cleaning on responding to outbreaks.
- The role of Environmental Service managers in collaborating to make cleaning standards uniform was acknowledged. It was also noted that cleaning departments are frequently targeted in budget cuts; and that adoption of the recommended standards will have resource implications for Areas.
- The Summit was advised that some environmental cleaning staff have recently been involved in work to update the NSW cleaning guidelines – and that those guidelines have not been finalised. The state of play with these guidelines needs to be examined.
- Traditional cleaning services have been based on floor space rather than risk. The Victorian Standard, which applies only to hospital settings, involves a risk management approach and raises the profile of environmental cleaning services.

- There was a suggestion that standards be developed for a range of healthcare settings – not just hospitals.

3.10 Evaluation of implementation of recommended strategies

Professor Lyn Gilbert
and Professor John Kaldor

Key points

- The rationale for the evaluation is the importance of demonstrating savings and achievement of goals.
- The recommendations will need to be reviewed and changed in response to evaluation findings.
- MRO eradication is the long term goal, while at the same time acknowledging the difficulty of achieving such a goal.

Issues raised during discussion

- Various approaches to evaluation were discussed, including randomised control studies. It was agreed that the approach would depend on the availability of resources and that the existing HAI monitoring system would be a useful source of data on changes in MRO rates.

- It was noted that systematic evaluation provides the basis to compare returns on investment of resources in different strategies, and to discontinue approaches which do not demonstrate a return.
- It was suggested that some things would have to be accepted at face value – eg that having a certain standard of cleanliness in hospitals is a good thing. Research on other aspects of MRO control – such as behavioural change and hand hygiene were identified as more amenable to evaluation re their effect on the incidence of MROs.
- It was also agreed that if continual surveillance of MRSA identified decreasing bacteraemia rates, then it is a reasonable indicator of improvement – despite methodological limitations. It was agreed that there were significant difficulties to establishing an empirical research project to measure improvement and effect.
- It was acknowledged that multiple factors contribute to effective MRO control and that historical data from hospitals will contribute to identifying improvements.
- It was agreed that patient outcomes measures are important indicators of successful MRO control – eg length of stay following elective joint replacement.

APPENDIX 1

Participants

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