



ENGINEERS
AUSTRALIA

CLINICAL ENGINEERING DEVELOPMENT

15th - 17 November 2019, MELBOURNE

WORKSHOP DETAILS

The Biomedical Engineering College within Engineers Australia is committed to maximising opportunities for development of practitioners within the discipline. To that end, a Development Workshop will be held in Melbourne from 15 - 17 November 2019, on the weekend prior to the *ABEC 2019 Conference*. This Workshop continues an annual series, focusing on Clinical Engineering under the auspices of the College's National Committee on Clinical Engineering (NCCE).

The workshop is intended for emerging or developing Biomedical Engineering practitioners at all levels of academic qualification. It aims to provide the forum and opportunity for these individuals to extend both themselves and their Clinical Engineering knowledge, to mentor with experienced individuals, and to establish or enhance networking opportunities amongst their peers.

Workshop Location & Times:

Venue: To be determined (but close to Melbourne University)
MELBOURNE VIC

Friday 15th November - 7.30PM – Welcome Dinner and introductions

Saturday 16th – 9.00am – 5.00pm, followed by Dinner from 6.30pm

Sunday 17th – 9.00am – 3.00pm

Sunday afternoon – Conference Registration

Note: Times are approximate at this stage and may change. A detailed program will be provided to participants closer to the workshop dates.

Participants should plan on arriving in Melbourne by late afternoon on the Friday, in time for the welcome dinner and introductions, planned for 7.30pm.

Accommodation & Meals:

Accommodation will be provided for interstate and non-Melbourne residents, for the Friday and Saturday nights only, at a nearby hotel.

Catering will be provided for the duration of the Workshop. A dinner will also be held on the Saturday night at a location TBD.

Costs:

The NPCE will cover the cost of accommodation on Friday 15th and Saturday 16th November and all meals for the duration of the Workshop.

Travel, any extra accommodation costs, and attendance at *ABEC 2019 Conference* are the responsibility of the participant or their sponsoring organisation.

Participants

Criteria:

It is expected that individuals attending will currently be practicing within the field of Clinical Engineering. They should be committed to it as a career but at the same time may be at a relatively early stage in their professional development within it. Participants are expected to provide significant input in terms of preparation and presentation and hence must be sufficiently motivated to participate successfully.

It is not an instructional forum. A maximum of twelve participants will be involved, along with four practitioners of standing within the discipline. The role of the latter will be to provide appropriate moderating input, and stimulate discussion on the presentations by the participants.

Selection:

Each Divisional Branch of the College shall seek nominations for participation in the broadest possible manner. Nominations are to be addressed to the Workshop Convenor for consideration.

A registration form accompanied by a brief resume of each nominee is to be submitted along with a statement of support from their employing organisation and any other supporting information that is deemed appropriate. The nominee must also list their first three preferences of topics to address from the attached Topic Listing, or suggest a topic of their own with relevance to clinical engineering.

Presentations:

Participants will be advised of their acceptance into the program, and which of their topic preferences has been assigned to them. This topic is to be researched as appropriate and a 20-minute presentation prepared for delivery to the group. This topic, on the basis of the material presented, will then become the subject of an open forum discussion, during which time other attendees will be encouraged to share their thoughts, knowledge and experience for the benefit of all in an informal, open and non-judgmental manner. The final result, depending on the topic, may be a consensus conclusion or even a recommendation but at the very least both a broader and deeper understanding of the topic in hand.

A copy of the presentation must be forwarded to the Workshop Convenor at least fourteen (14) business days prior to the commencement of the workshop to enable printing of presentation notes for distribution to delegates and mentors at the workshop.

Prizes:

A number of prizes will be available. Attendees will be judged on depth of research and understanding of their chosen topic, value and content of their presentations, adherence to timing, and their abilities to lead a subsequent discussion on their topic.

Enquiries & Applications:

Nominations and any enquiries should be made to the Workshop Convenor, Michael Flood (02) 6112 8325 or 040 1147 605 or by email to mike@locusconsulting.net.au

Further details of the Biomedical College and the National Committee on Clinical Engineering can be found on the Engineers Australia website (www.engineersaustralia.org.au)

Nomination can be made by completing the nomination form [here](#) and emailing it to Michael Flood at mike@locusconsulting.net.au

To assist in planning, Nominations forms are to be completed as soon as possible.

Clinical Engineering Development Workshop

POTENTIAL TOPIC LISTING

1. *EMI/EMC Understanding the unpredictable*

We have seen many new technologies introduced in the clinical environment that have a potential impact on the safe delivery of patient - and that impact is often unpredictable or unidentifiable. We are seeing wireless networking in common use, and RFID labelling for everything from stock control, equipment location and patient tracking is being touted as the next great cost saving in the hospital. Introduction of mobile communications in a responsible manner can improve patient safety.

Biomedical engineers have a responsibility to ensure the introduction of these technologies does not compromise patient safety. Give an overview of the subject, the technologies and their impact on patient safety, and the role of the biomedical engineer in developing sensible policies - recommendations to the vendor, the clinical user and the institution. What is happening overseas - it is relevant or applicable here?

2. *Pulse Oximetry*

What is it? Why do we do it? How do we do it? Who do we do it on? What are we actually measuring? Research the rationale for measuring oxygen saturation and under what circumstances it is a meaningful measure of oxygenation. Detail other allied measurements of oxygen in the body. Describe the principles of the measurement of oxygen saturation and possible causes of error in the measurement and errors in relating the measured values to pathology. Comment on the way it is used in the hospital setting.

3. *Delivering Anaesthesia*

What types of anaesthesia are available to clinicians today? Discuss the various agents, method of delivery to the patient and the technology involved in doing so. What role do medical gases, reticulated throughout the hospital, play in this? What are the risks to the patient and how are they managed and minimised. What are the cases for and against intravenous vs gaseous delivery?

4. *To test or not to test - how much or how little?*

Determine current practices for decisions related to safety and performance testing in Clinical Engineering departments. Discuss possible risk management strategies that may be employed as aids to determination. How can we find out about other examples of changes that may make testing more beneficial? Part played by Biomedical Engineering personnel with regard to development of standards. Are we testing too much or too little - how do we know? What is the role of OHS&W legislation and how should it affect approaches taken?

5. *Introduction of new technologies*

What part do CE departments play in the planning and acquisition of new technologies? What can be done to improve this process - how can we show that we can make a difference? Discuss the processes of technology assessment and product evaluation - is there a difference?

6. *Do CEs and BMETs need to know Anatomy/Physiology etc ?*

Discussion of how we can interface with and make better decision for clinicians if we know what the body does and why the clinician is so hot under the collar about one piece of equipment vs another. Do we need to know more than just A & P? Should we know about disease states, pharmacological effects, etc? What impact will A&P knowledge have on capacity to assess new technologies, estimate life of equipment, select replacement equipment?

7. *Critical Event Response*

What are the considerations to take into account when dealing with medical equipment which is thought to have resulted in a patient death - dealing with the process? What are the requirements for reporting – Hospital Executive, TGA, Coroner? Does the equipment need to be quarantined?

8. Impact of the changing focus of healthcare – the hospital in the home concept

Day only admissions are changing bed utilisation and the medical equipment associated with minimally invasive surgery etc. What is the influence of these changes on hospital utilisation, BME services, and healthcare in general? What is the relation between these changes and the concept of a “Continuum of care”? Address the differing specifications of home and hospital equipment, the maintenance and test routines to which they are/should be subjected, and the allocation of responsibility arising for the use of home equipment. How do you ensure this equipment is safe to use, and being used safely?

9. Who are we trying to impress?

Accreditation - ACHS EQUIP, ACQ, ISO

Possibly all of the above, plus our administrators and DOH. Show an understanding of the need for the accreditation process and the differences between the different systems. Discuss the certification vs accreditation issues. How do we demonstrate that staff within departments are appropriate or competent to fulfil their role? An assessment of how your healthcare establishment rates on these considerations would be interesting

10. Benchmarking

How do we do it? Who do we do it with? What is it anyway? What benefits could we expect from benchmarking? What has benchmarking in Clinical Engineering or related areas achieved, or is it a feel-good buzz phrase which produces little but keeps the quality managers off our back?

11. Renal Dialysis - do we care about it? Do we know about it?

Clinical Engineering departments often have little knowledge of the dialysis units or the devices used therein. Should we be doing more to help our dialysis staff? Would you attempt to perform in-house or outsource? Why?

12. Safety when using the Electrosurgery Unit

Significant testing of electrosurgical instruments and accessories in recent years has moved the focus from the generator to the things attached to it. Give an overview of the subject, with a balanced set of recommendations. What needs testing, how often, by whom, how? What about the new modalities available – things like high voltage bipolar and low voltage monopolar modes? What are the implications for safety?

13. Patient Monitoring

The monitoring of patients is now beyond the bedside. Patient information is available through local networks, intranet and internet services. What are the developments, benefits and limitations of this “remote” patient monitoring.

14. Earth leakage in systems

“Systems” of equipment may exhibit earth leakages in excess of the allowance for individual medical devices. Are there standards that provide guidance in this situation? What is the real nature of the hazards, if any, and what approaches are appropriate?

15. Specifications for ICU

Consider the prospect of a hospital moving to a new site and requiring a 12 bed ICU. Address the considerations of space, data management, equipment specifications, reticulated supplies etc. We have all seen under equipped ICUs, yet over specification is wasteful. Address the balancing required, and the means of determining the optimal balance. Who would you involve in this design process? Why? What input/contributions would you expect from the representatives of various work groups/individuals?

16. Blood pressure measurement

Stories of discrepancy between automated and manual blood pressure measurement are legend, while invasive blood pressure measurement is susceptible to artefact associated with lines and damping devices. Explain the lot! Explain the discrepancies. Demystify it all!

17. Sterilisation/Disinfection

Discuss the pros and cons of the various types of sterilisation and disinfection in common use in hospitals – steam, glutaraldehyde, paracetic acid, ethylene oxide etc. Discuss time to process, validation, cost, OH&S, detrimental effects of technique on equipment being sterilised/disinfected, and explain why different techniques are used for different equipment

18. Allergic reactions to medical materials

Many medically used materials are credited with allergic reactions ranging from trivial to profound – latex, silicone, adhesives, skin preparations, glutaraldehyde etc. Tell us about them.

19. Trialling medical equipment

Great disasters or successes in medical equipment acquisitions are often attributable to the trial process undertaken. How do you undertake a trial, manage the sales staff, get around the inducements and staff biases to optimise the technical, financial and clinical considerations. What weighting should be given to the technical, financial and clinical aspects?

20. Closed loop control systems

For many years, it has been possible to monitor a number of clinical parameters in the ICU environment, and to feed these to computerised systems that would manage infusion rates and ventilation regimens to optimise patient treatment, with the option of raising the alarm in the event of patient deterioration. Where is the technology? Why?

21. Temperature control

“Temperature control of patients by medical equipment is more likely to compromise patient care than any of the electrical hazards for which we test extensively” – anon. True or False? Discuss the techniques and technologies used for temperature control and their function in terms of the equipment used and human physiology. Discuss the effectiveness and risks presented. How should we manage these risks?

22. Surgical equipment

The management of surgical equipment and instruments is seen by some as the last frontier of neglect by clinical engineering services. Surgical equipment is often not tracked, documented or individually identifiable. Questions of warranty, equipment performance, and equipment servicing and tracking arise. Is this small enough to be absorbed in the grand scheme of things, or worthy of attention? What means are available for tracking down to the individual instrument?

23. Cardiac Protected Electrical Areas

What are they and why do we have them? Do they save lives? Should the concept be questioned, the justification revisited or should they simply be scrapped as an expensive waste of resource

24. Standards critique

There are many standards out there that we have need to use of in a range of ways, from influencing our decisions daily though to very occasional referral. Some are up-to-date whilst others no longer reflect current practice. Few are "stand-alone", they often interact and rely heavily on reference to others. Choose a standard, series of standards or issue that is addressed in a number of standards - describe and discuss it.

25. Quality systems and the BME

Quality systems, quality management, ISO 9001 - they are all the buzz. We require it of our suppliers, but do we apply the same standards to our own activities? Should we?! What are quality systems? Do we need them, and should we implement them in our own departments? Many institutions already have, many are working towards them, but what are they, and are they an effective tool in managing the activities of our own departments, or just another certificate on the wall?

26. Risk management and the Biomedical Engineering Department

Risk analysis and risk management is where it's all happening these days. Claimed to be a tool to direct resources to where most effective and appropriate, it would seem to be a natural for application to the activities of any BME Department. AS3551:2004 recommends it. How should it be applied across a range of activities including setting of device test intervals? Could it realistically be used in a service's defence should it not capture a failure that resulted in a patient injury?

27. Ethics and practice?

Engineers Australia has a Code of Ethics. It is one of the tools to maintain professional standards. Give an overview of the Engineers Australia Code of Ethics, and how the code would relate to your role as a clinical engineer.

28. Imaging modalities, how and why?

There are a range of different imaging modalities that are available to clinicians as an aid to diagnosis. These include a variety of x-ray based systems as well as Nuclear Medicine, Ultrasound and MRI. How do they differ in principle.....and application? Which ones are increasing in popularity, are any declining, why may this be so?

29. Use of non-original parts for repairs

There are often a range of options available to those of us involved in the repair of medical devices. From third party pulsox probes and batteries to exchange boards from non-OEM sources. What issues should be considered when going down this path, is price the main determinant? What questions may the coroner ask should this strategy be revealed during his enquiries? What are the answers to those questions?

30. How can Clinical Engineering practitioners keep in touch?

In this global era the problems and issues that you face day to day, are also being faced by countless others around the world. How should we keep in touch, share our problems and establish and maintain our networks? The Internet is an obvious facilitator, is it used to best advantage and how may it be used better? What resources are out there now for us to use, what should be out there in an ideal world?

31. Electrosurgery - What are our choices?

Manufacturers of ESUs claim many things that supposedly set their units apart from all others. These include waveform, power and closed loop control that may all result in superior clinical outcomes, however the technicalities are often lost on the surgeons. Are these claims true? What are the real differences between brands X, Y and Z and is there hard evidence that supports any claims made?

32. Clinical Engineering and Information Technology – A Happy Marriage?

It is no surprise that today's clinical devices and systems employ substantial amounts of IT infrastructure, from PCs to servers and networks. How should these be supported and managed? Do CE departments have the skills and expertise? If not should they acquire them? Do IT departments understand clinical issues surrounding medical devices? Should the two departments work in a collaborative manner, how may this occur and would it result in any boundaries or grey areas? How could we clarify these and define areas of responsibility?

33. Career Paths for Young Engineers?

The future can be somewhat daunting for young engineers. What are the possibilities? How can individual goals be achieved within the context of the profession? Consider what changes could be made to assist young engineers to achieve their dream jobs.

34. Are you asleep?

Depth of anaesthesia has been a problem since the first anaesthetic was delivered. Various monitoring methods are employed to indicate patient awareness. Describe the problem, methods the solutions used to determine that the patient is "asleep".

35. *Your own topic*

If you have a potential topic of clinical Engineering relevance which you would like to research, write up and present, then propose it to the workshop convenor asap. We cannot guarantee that your topic will be accepted, so get your proposal in early. Generally a topic should address engineering or technology issues associated with clinical practice, and relevant to the practice of clinical engineering in health care establishments.