Standard 3: Preventing and Controlling Health Care Associated Infections - Are you ready?

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Why have a Standard about preventing infection?

- About half healthcare associated infections are thought to be preventable
- HAI is the most common complication affecting patients in hospital
- Infections increase morbidity, mortality, pain & suffering
- Cost to patients, hospital staff and the health system
- Mechanisms exist to reduce the rate of infections caused by healthcare.
- No single cause of infection, there is no single solution to preventing infections
- Successful infection prevention and control requires a range of strategies across the healthcare system
National Safety and Quality Standards

- Approved by health ministers September 2011
- Address areas where:
  - Large numbers of patients effected
  - Known gap between current situation and best practice outcomes
  - Evidence based, achievable improvement strategies exist
Standard 3: Preventing and Controlling Healthcare Associated Infections

The intention of this Standard is to:

• Prevent patients from acquiring preventable healthcare associated infections and effectively manage infections when they occur by using evidence-based strategies.

• Applied in conjunction with
  – Standard 1, ‘Governance for Safety and Quality in Health Service Organisations’ and
  – Standard 2, ‘Partnering with Consumers’
Criterion included in this Standard

- Governance and systems for infection prevention, control and surveillance
- Infection prevention and control strategies
- Managing patients with infections or colonisation
- Antimicrobial stewardship
- Cleaning, disinfection and sterilisation
- Communicating with patients and carers
Priorities for Standard 3

- Having an effective governance framework
- Identifying what is working well
- Knowing your risks and/or gaps
- Having systems to gather, review and report evidence
- Having a plan to address risks and respond
- Aiming for the best (either 0 or 100%)
- Demonstrating progress/improvement
- Engaging with others in the organisation
Where is the evidence for Standard 3?

• Infection control guidelines
  – best available evidence
  – endorsed by Health Ministers
  – risk-management framework
Getting started – Assess the current situation

- Risk assessment
- Gap analysis
  - Current governance arrangements, policies, processes
  - Resources already in use
  - Data currently collected, results of audits
  - Current resistance patterns, infections
- Raise awareness
  - Share results of the risk assessment
  - Invite interested staff to become involved
Resources and Support
Australian Guidelines for the Prevention and Control of Infection in Healthcare

Implementation guide

The OSSIE Toolkit for the implementation of The Australian Guidelines for the Prevention of Infection in Health Care

Guidebook for Primary Care Settings (companion to the OSSIE toolkit)

Provides a template for undertaking a baseline assessment to assess progress against the Guidelines – use as a starting point for the gap analysis.

## Risk Management

### Risk Matrix

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Negligible</td>
</tr>
<tr>
<td>Rare</td>
<td>Low</td>
</tr>
<tr>
<td>Unlikely</td>
<td>Low</td>
</tr>
<tr>
<td>Possible</td>
<td>Low</td>
</tr>
<tr>
<td>Likely</td>
<td>Medium</td>
</tr>
<tr>
<td>Almost certain</td>
<td>Medium</td>
</tr>
</tbody>
</table>

- **Low risk**: Manage by routine procedures.
- **Medium risk**: Manage by specific monitoring or audit procedures.
- **High risk**: This is serious and must be addressed immediately.
- **Very high risk**: The magnitude of the consequences of an event, should it occur, and the likelihood of that event occurring, are assessed in the context of the effectiveness of existing strategies and controls.

HAI Surveillance resource

Addressing areas of national importance in surveillance

- In December 2008, Health Ministers approved the following actions for implementation of a national approach to the surveillance of *Staphylococcus aureus* (including MRSA) and other virulent micro-organisms:
  - 1. All hospitals establish HAI surveillance; and
  - 2. All hospitals monitor and report into a national data collection;
  - *Staphylococcus aureus* (including MRSA) bloodstream infections; and
  - *Clostridium difficile* infections.

Surveillance guides
National Hand Hygiene Initiative

HHA model

- Standardises practice across Australia
- Work with infection control community
- Adapted WHO guidelines for Australian context
- Majority of amendments have been incorporated into new standard WHO policy
- Validated audit tool
- Credentialing of auditors
- Educational module with on-line questions (300,000+ participants)

http://www.hha.org.au/
Antimicrobial stewardship

Summarises current evidence about AMS programs and their implementation in hospitals

Resources on webpage


Antibiotic Awareness Week
18-24 November 2013
Antimicrobial stewardship

Therapeutic Guidelines: Antibiotic
Criterion 3.14.2 Evidence based guidelines for antibiotic prescribing and management
Available at
Antimicrobial Prescribing Modules

aimed at prescribers in their first 2 years out of medical school, as well as nurse practitioners, hospital pharmacists and university students.

can be accessed at

www.nps.org.au/health_professionals/online_learning
## AMS in Different Settings

Table 2 provides suggestions for ways in which strategies to support antimicrobial stewardship (AMS) might be implemented in different settings.

**Table 2: Options for implementation of antimicrobial stewardship in different settings**

<table>
<thead>
<tr>
<th>Program elements</th>
<th>Health service organisation (e.g. Local Hospital Network/district or private hospital organisation)</th>
<th>Large urban hospital or tertiary facility (includes large private hospitals)</th>
<th>Other or rural/district hospital</th>
<th>Service or less than 50 beds in Day surgery/procedure unit or services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive leadership</td>
<td>Network/district/management group executive sponsorship and support for AMS program</td>
<td>Local executive sponsorship and support for AMS program</td>
<td>Local executive sponsorship and support for AMS program</td>
<td>Owner/management support for AMS program</td>
</tr>
</tbody>
</table>
| Governance arrangements, structure and lines of communication | Director of AMS program and multidisciplinary AMS committee, comprising core representation of:  
  a member of executive  
  a pharmacist  
  an infectious diseases physician and/or medical microbiologist  
  AMS part of safety and quality plan  
  Links to committees responsible for drugs and therapeutics | Director of AMS program – pharmacist, infectious diseases physician or medical microbiologist with Multidisciplinary AMS team (see below)  
  Links to committees responsible for drugs and therapeutics | Pharmacist (where possible)  
  When no pharmacist available a clinician/nurse with dedicated time for AMS coordinates with input from local or network/distinct infectious diseases physician and medical microbiologist  
  Links to committees responsible for drugs and therapeutics | Facility manager coordinates with input from local or network/distinct infectious diseases physician and medical microbiologist  
  Facility manager coordinates, with support from specialist visiting clinicians and/or pharmacist where available  
  Links to committees responsible for drugs and therapeutics |
| AMS team | No | Yes  
  AMS director (appointed from multidisciplinary AMS team) pharmacist, infectious diseases physician or medical microbiologist and pharmacist with dedicated time for AMS  
  With inclusion of infection control practitioner, practising clinicians from key departments including intensive care | Yes  
  Onsite or network/distinct  
  Pharmacist recommended with dedicated time for AMS  
  Prescribing clinician and/or nurse  
  Coordinates with input from infectious diseases physician and medical microbiologist  
  (These services may be available onsite or as an agreed external consultancy) | Yes  
  May be onsite or local network/distinct  
  Facility manager, prescribing clinician and pharmacist where available (onsite or as an agreed external consultancy) or nurse or external support from an infectious diseases physician and medical microbiologist (as an agreed external consultancy) |
| Antimicrobial policy with defined components | Yes  
  Outlines scope of program, is endorsed by network/district/management group executive and roles and responsibilities defined | Yes  
  Outlines scope of program; endorsed by senior executive and management group; roles and responsibilities defined  
  May be developed and implemented locally or as part of higher level process | Yes  
  Probabilistically determined by a district-wide approach to outline scope of program | Yes  
  Probabilistically determined by a network/distinct-wide approach to outline scope of program  
  Policy specifics agreed local approach to surgical prophylaxis |

(Table continued on next page)
AMS - Flexible arrangements for 2013 for health service organisations (less than 50 beds)


### Standard 3: Preventing and Controlling Healthcare Associated Infections

#### 3.14 Antimicrobial stewardship

**Flexible arrangements for 2013 for health service organisations (less than 50 beds)**

<table>
<thead>
<tr>
<th>Action</th>
<th>Requirements</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.14.1 An antimicrobial stewardship program is in place.</td>
<td>Can the facility show:</td>
<td>A summary or &quot;map&quot; of current governance arrangements, policies, processes and resources that can be used to support AMS. A baseline assessment can be used to understand the local context for implementation and identify actions required for implementing a program.</td>
</tr>
<tr>
<td>a baseline assessment to provide a snapshot of current resources and activity to support an Antimicrobial Stewardship (AMS) program</td>
<td></td>
<td>The team may be established within a facility (onsite) or as part of a Local Hospital Network/ District committee, depending on the local circumstances.</td>
</tr>
<tr>
<td>a team or committee relevant to facility size and structure, with terms of reference</td>
<td></td>
<td>The AMS team should work with relevant individuals, such as the person responsible for infection prevention and control or quality and safety, to encourage coordination and reduce duplication of effort.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The AMS team should also have links with any relevant existing committees or groups, such as committees responsible for drug and therapeutics and infection prevention and control.</td>
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<tr>
<td></td>
<td></td>
<td>The AMS team will reflect the size of the facility and complexity of services offered. Examples of team composition include:</td>
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<tr>
<td></td>
<td></td>
<td>o a medical practitioner, the facility manager and a pharmacist (if available) or nurse</td>
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<td>o a group of interested clinical staff and a member of the facility management</td>
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<td></td>
<td></td>
<td>o visiting clinicians and or pharmacists that have expressed an interest in supporting AMS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o an existing committee such as one responsible for drug and therapeutics, or infection prevention and control.</td>
</tr>
</tbody>
</table>
AMS Website

- “Antimicrobial Stewardship in Australian Hospitals’
- Downloadable tools and resources (example policies, guidelines, templates, pocket cards etc)
- Link to antimicrobial prescribing e-learning modules
- Links to international websites
- Presentations

Commission Resources
Antibiotic Awareness Week 2012

• pocket card “MindMe”
• presentation outlining the problem of antimicrobial resistance and overview AMS programs
• can be downloaded, organisations can include own data and resources.

Available at
Flexible Transition

There will be a flexible transition during 2013 consisting of:

• 120 days remediation period, instead of 90 day
• 15 core actions declared developmental
• Safety and Quality Improvement Guides and Accreditation Workbooks
• requirements for 7 actions prescribed by the Commission
• establishment of health service support networks
• negotiations with accrediting agencies to:
  - continuation of existing accreditation cycle
  - extend existing accreditation certificates when there is a change over to programs including the NSQHS Standards

Information available at:
Advice Line  1800 304 056

• Dedicated telephone line operated during business hours
• Dedicated email address for queries
• Website with frequently asked questions generated from phone and email queries
• Opportunity for onsite visits where required
• Mediation and advice for health services during survey visits
Accreditation Workbooks

Day Procedure Services Accreditation Workbook
September 2012

Hospital Accreditation Workbook
September 2012
Key points

• Standards are about safety and quality of patient care
• Health care associated infections are a major patient safety and quality issue
• Infection prevention and control can reduce the rates of infection and improve patient safety and quality of care
• Safety and quality is an organisational responsibility (governance)
• Communication and collaboration are key to improvement
• Know your risks and gaps
• Have systems to gather, review and report evidence and demonstrate improvement
• Use an action plan
• Engage staff by keeping them informed about progress and lessons learned, seek their advice and involvement
Advice Centre
1800 304 056

www.safetyandquality.gov.au