Standard 3: Preventing and controlling healthcare associated infections

Background

The purpose of this document is to provide additional information relating to frequently asked questions in regard to the criteria included in Standard 3: Preventing and Controlling Healthcare Associated Infection.

Questions

Q: What is the first thing we need to do to meet the Standards?

As every health service organisation will differ in its state of preparedness for the National Standards, it is important that the key personnel in the organisation including those responsible for governance, read the following documents for each Standard as a starting point to assist the organisation in determining what the next steps for their organisation will be.

- the Standards,
- the Safety and Quality Improvement Guides (SQIG) and
- the Safety and Quality Workbooks.

The Safety and Quality Implementation Guide (SQIG) and the Workbooks provide a significant resource on how best to address each criterion and what actions and evidence should be considered. It is suggested that the organisation has an understanding of all the Standards and supporting documents and has reviewed all the content in the SQIG to prevent duplication and prioritise action.

Q: When you talk about Standards, what do you mean?

Many organisations prepare organisational documents that are titled as standards. For the purposes of these FAQ’s any reference to Standards relates to the National Safety and Quality Healthcare Standards (NSQHS) developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC) unless otherwise specifically identified.

This includes documents developed by professional colleges or organisations, Standards Australia, or any other group.
Q: How does the Performance and Accountability Framework (2012) relate to Standard 3?

The Framework has been designed to facilitate the achievement of key national health policy objectives, such as:

- ongoing improvement of the safety and quality of the health system;
- ensuring efficiency and sustainability through a rigorous data collection, monitoring and reporting system;
- improving integration between the primary health care and hospital sectors; and
- enabling comparisons between all sectors of the Australian health system including comparisons across the public and private sectors to assist them to improve performance.

Q: What is a gap analysis?

A gap analysis is the comparison of actual performance with potential performance. The gap analysis or baseline review is good starting point to assist the health service organisation to develop an action plan and prioritise how to best utilise resources.

A gap analysis or baseline review is a tool that can assist a health service organisation to identify areas that do not require any additional interventions and also identify areas where the health service organisation that may need to be improved or changed.

Q: What is risk management?

Risk Management is a process of responding to risks once identified.

Risk management follows a logical sequence involving establishing context in the health service organisation, identifying what the risk is, analyzing how and who the risk will affect, avoiding the risk if possible, evaluating what can be done about the risk, determining who will be responsible for implementing the appropriate management or treating the risk.

For Standard 3, risk relates to the acquisition or transmission of an infection or infectious agent by patients, workforce and/or visitors whilst in a health service organisation.

How this risk is managed will be determined by the type of services and activities undertaken in and by the health service organisation. Determining how the risk is managed will require local application of the principles of risk management.

Q: What is a risk assessment?

The identification and assessment of risk is an integral part of a successful infection prevention and control program. When assessing risk, the likelihood and consequences need to be assessed for a specific clinical setting within the health service organisation. This is important as risk may vary from one area to another and therefore require different management strategies as part of the risk management process.

Risk assessment is a process that is, in turn, made up of three processes: risk identification, risk analysis, and risk evaluation.

Risk identification is a process that is used to find, recognise, and describe the risks that could affect the achievement of objectives.

Risk analysis is a process that is used to understand the nature, sources, and causes of the risks that have been identified and to estimate the level of risk. Risk analysis is also used to study impacts and consequences and to examine the controls that are currently in place.

Risk evaluation is a process that is used to compare risk analysis results with risk criteria in order to determine whether or not a specified level of risk is acceptable or tolerable.

Reference - ISO 31000; section A2 Australian Guidelines for the Prevention and Control of Infections in Healthcare NHMRC 2010

For further information on the risk management approach and an example of how it can be applied to aseptic technique refer to the following link


Q: How does risk assessment or baseline review help infection prevention and control?

A health service organisation will need to consider the scope of its infection prevention and control program and identify the areas that are working well and will provide sufficient evidence to demonstrate that the intent of the criterion and items contained within each criterion is met. Undertaking a gap analysis of current governance arrangements, systems, processes and practices, and their effectiveness, could be a strategy to assist the health service organisation to identify those areas that do not require any additional interventions and to identify areas that may need to be improved or changed.

The gap analysis or baseline review is good starting point to assist the health service organisation to develop an action plan and prioritise how to best utilise resources. A risk assessment can strengthen a gap analysis. The results of both will assist the determination of priorities for improvement and action throughout the Standard.

Section A2 in the Australian Guidelines for the Prevention and Control of Infections in Health Care (NHMRC, 2010) provide detailed information about risk assessment processes for infection prevention and control.

A template for undertaking a baseline assessment/gap analysis is provided in section 1.6.4 of OSSIE Toolkit for the Implementation of Australian Guidelines for the Prevention and Control of Infections in Health Care. Both of these documents are available on the Commission website www.safetyandquality.gov.au/
**Q: How does risk management influence infection prevention and control for Standard 3?**

For Standard 3, risk management will be related to the risk of acquisition or transmission of an infection or infectious agent for patients, workforce and visitors whilst in a health service organisation. Using a risk management approach will allow the organisation to identify areas where there is high or low risk and prioritise how they will respond accordingly.

For further information on the risk management approach refer to the following link


**Q: How do I incorporate risk management into policies, protocols and procedures relating to IPC?**

There must be organisational support for adopting a risk management approach at all levels of the facility, from health service organisational management to all members of the workforce.

When developing or reviewing policies, protocols and procedures, the inclusion of effective risk management can be achieved by utilising the principles of the risk management process i.e. the possibility of avoiding the risk and how this will be achieved, if the risk cannot be avoided or eliminated, how it will be managed?

Inclusion of how the workforce will be trained in the principles of risk management, how the organisation will undertake follow-up of outcomes and compete monitoring and reporting of outcomes and interventions are examples of how risk management can be included in policies, protocols and procedures.

For further information on the risk management process refer to section A2 Australian Guidelines for the Prevention and control of Infections in Healthcare NHMRC 2010.

**Q: How often do I need to undertake a risk assessment?**

The frequency of review of risk will be determined by changes occurring in the clinical setting or the health service organisation. This includes changes to equipment used; clinical knowledge base; the type of patients treated or by changes to activities occurring in the health service organisation.

**Q: What is surveillance?**

With reference to Standard 3 - Surveillance is the ongoing, systematic collection, analysis, interpretation and dissemination of data relating to a healthcare related event for use to reduce morbidity and mortality and improve health. These key components are closely integrated with the timely dissemination of these data to those who need to know.

The principles of surveillance is divided into 4 objectives

- Detect and monitor adverse events
- Assess risk and protective factors
- Evaluate preventive interventions
- Provide information to event reporters and stakeholders and partner with them to implement effective prevention strategies.

Reference - Adapted from Reducing Harm to Patients from Health Care Associated Infections: The role of surveillance, ACSQHC 2009

**Q: How can I provide evidence that our facility is performing well?**

The results of audits and surveillance will provide evidence to demonstrate how your organisation is performing. These results should ideally be collated over time to show trends and where possible, report raw data and avoid reporting averages. Averages will hide the best and worst results from the data collected and these data may be significant in demonstrating improvements.

**Q: How can I demonstrate our data compares to other departments or health service organisations?**

Results of quality activities and surveillance activities will provide data. These data provide the basis for evaluation of performance and identify areas that have improved or require further improvement. A way of evaluating performance is to compare data that has been collected using the same criteria and definitions with other departments or other organisations. Benchmarking can be undertaken internally, externally or both. In addition, health group surveillance (e.g. between private organisations) can also provide a method of comparison of data.

**Q: Is the ACSQHC currently developing any audit tools for Standard 3?**

The supporting resources that have been developed to support Standard 3 are the Safety and Quality Implementation Guide (SQIG), the Guide for Small Hospitals and the supporting workbooks for Day Procedures and Hospitals. These documents provide health service organisations with strategies and examples of outputs (evidence) that they should consider for their organisation to demonstrate how the intent of Standard 3 has been addressed.

The guides provide suggestions where appropriate on tools that currently exist that should be considered by health service organisations to demonstrate compliance.

We will try to add additional appropriate resources to our website as they are identified or made available.

**Q: Does a small organisation need to undertake hand hygiene compliance auditing?**

The intent of item 3.5 in Standard 3 relating to hand hygiene states that - the organisation needs to demonstrate how they have implemented and support a hand hygiene program consistent with the national hand hygiene program co-ordinated by Hand Hygiene Australia (HHA).

The Standard 3 Safety and Quality Improvement Guide (SQIG) clearly identifies that some very small organisations may not be required to undertake hand hygiene auditing by direct observation, this should be checked with the jurisdiction, parent organisation and/or licensing requirements.
Regardless of local requirements:

- the organisation does need to demonstrate how compliance with the national program has been addressed,
- that compliance is being reported to the highest levels of governance in the organisation, and
- that action is being taken to address non-compliance.

Refer to the following resources for additional information and alternate methods for an organisation to demonstrate they have addressed the intent of auditing the hand hygiene program.

Safety and Quality Implementation Guide (SQIG)

or to the NSQHS Standards Guide for Small Hospitals

Q: Does a small organisation need gold standard hand hygiene assessors to do hand hygiene auditing?

Having a gold standard assessor (GSA) is not a requirement of Standard 3. All hand hygiene assessors need to undertake an annual competency assessment and a minimum number of hand hygiene audits to retain their auditor status. GSA status may be difficult to maintain in a small organisation.

If hand hygiene auditing is undertaken as part of the National Hand Hygiene Initiative (NHHI), an appropriately trained auditor who has completed training at a workshop using the HHA model needs to complete the audits to support consistency with the NHHI.

Gold standard assessors can undertake hand hygiene audits and train additional hand hygiene auditors. An auditor trained by a GSA can only undertake hand hygiene audits and cannot train other auditors.

For further information on training and auditing hand hygiene, refer to the Hand Hygiene Australia website: www.hha.org.au/

Q: Do we have to use Aseptic Non-Touch Technique (ANTT) for aseptic technique?

No, aseptic technique protects the patient during a procedure that is invasive or dealing with tissue or equipment that under normal circumstances would be considered sterile. Aseptic technique is designed to minimise the transmission of infectious agents occurring during a procedure.

ANTT is a registered proprietary name for aseptic non-touch technique by the ANTT project and is an example of aseptic technique. ANTT provides a framework for aseptic practice that was developed in the UK. There is no requirement for a health service organisation to use ANTT but if ANTT is chosen the health service organisation needs to ensure that it meets the identified risks and is consistent with other required activities including hand hygiene in the Australian context.
For further information on the risk management approach and an example of how it can be applied to aseptic technique refer to the following link


Q: Does aseptic technique need to be applied organisation wide, or can it focus on a specific procedure or clinical area?

As a starting point the baseline assessment/gap analysis may be used to review the whole organisation to determine and prioritise areas of risk, gaps in policy, training and/or education and assessment. For example, if there is an area where many high risk procedures are undertaken, look at systems in place for assessment and monitoring competency and compliance with protocols currently in place, or take action to address gaps (also includes assessing risks in departments and specific procedures).

For further information on the risk management approach and an example of how it can be applied to aseptic technique refer to the following link


Q: Is there a recommended sample size for auditing aseptic technique?

The sample size is not easily defined as it will depend on the risk associated with the activity being audited. For example, if you audit 5 people and none of them are performing aseptic technique correctly that may be sufficient to alert you to a problem. The results you have obtained from this small sample have highlighted an increased risk in that particular activity or procedure and the organisation needs to respond with action.

Alternatively, you may audit another activity requiring aseptic technique where a larger sample is required to gather sufficient evidence. It is difficult to identify the minimum number of audits required as it will vary from facility to facility and with the activity being audited based on risks.

One option to review risk may be to look at hand hygiene compliance before and after moments 2 and 3 in your facility. This may assist you target areas where aseptic technique needs to be targeted as aseptic technique and compliance with hand hygiene in Moments 2 and 3 are linked.

It is also important that you use your evidence and data to demonstrate improvements over time.
Q: What is the expectation for training of the workforce who reprocess reusable medical devices?

The knowledge and skill required to effectively reprocess reusable medical devices is specialised and cannot be assumed knowledge. Therefore each health service organisation will need to consider:

- the scope of training and assessment required based on activities undertaken and being performed
- specialised training in the reprocessing and sterilisation technologies used in the organisation
- if there is a requirement for mandatory training in this area in your jurisdiction or organisation
- accessing nationally recognised competency based courses that currently exist
- how competency based training for the relevant workforce in the organisation could be increased
- the need for training may include staff outside the sterilising services department (SSD). Reusable devices may require decontamination for transport from outside the theatres or procedure rooms to SSD for reprocessing e.g. nasoendoscopes in an ENT clinic
- in addition to training in standard and transmission based precautions, local assessment is required to determine the necessary training to maintain safety of the workforce, patients and equipment. This may include proprietary training by suppliers, network/district training or online training resources that are competency based
- if processing is outsourced, it is important that any cleaning or decontamination that is undertaken prior to transfer of the items for processing is covered by training on how to perform this task safely
- Any contract for the outsourcing of processing reusable medical devices must identify the responsibilities of the external contractor and the health service organisation; and equipment processing is in accordance with Australian Guidelines for the Prevention and Control of infections in Health Care (NHMRC 2010) and meets current national and international standards.

Q: Does an invasive devices policy require information on removal of invasive devices?

A policy should include the organisation’s requirements for removal of devices if the device is required to be removed as part of its use e.g. urinary catheters, peripheral IV devices. The removal of devices does not need to be a separate policy but included in the procedure/policy for insertion or maintenance. Health service organisations may include in the procedure an assessment checklist to assess competence, this can be used when training workforce.

This policy should cover all the members of the workforce who could insert and remove the devices, different groups will frequently be responsible for different aspects of insertion, maintenance and removal of invasive devices e.g. a doctor may insert the device but a nurse may remove it.
**Q: Do all reusable devices require monitoring, training and traceability systems to be in place?**

The Safety and Quality Improvement Guide (SQIG) provides additional information relating to the scope in the application of the Standards for reusable devices included in the following items of Standard 3.

In 3.16 - reusable equipment, instruments and devices includes any of those items that are reused in patient care areas. However, the prioritising of how you monitor or the level of processing required will be determined by the primary use of the item. A risk assessment should assist the organisation in prioritising those items required to be disinfected or sterile between uses. Equipment and instruments that are required to be sterile have greater risk associated with their use and would require good systems for regular monitoring. This is outlined in the Australian Guidelines for the Prevention and Control of Infections in Health Care (NHMRC 2010) refer to section B 1.5; and in more detail in relevant national and international standards on the requirements for levels of reprocessing required for semi-critical and critical items.

In 3.17 – the type of traceability systems required for reusable items and equipment that are sterile or required to be sterile based on how they are used and the extent of the systems required for this will be determined depending on the scope of services provided.

In 3.18 - Training and competency of the relevant workforce will be determined by the scope of services offered by the organisation and may extend beyond the procedural environment. This will be identified during your risk assessment for the organisation but you should consider clinics and clinical areas where reusable medical devices are used and decontaminated prior to being reprocessed further, the workforce in these areas may require training and competence assessment.

**Q: Does the private sector need to refer to jurisdictional recommendations for workforce immunisation or to the Australian Immunisation Guidelines?**

Item 3.6.1 requires a workforce program to be in accordance with the NHMRC Australian Immunisation Handbook (NHMRC current edition). To support how this is achieved by an organisation, the Safety and Quality Improvement Guide (SQIG) provides suggested strategies on how an organisation might achieve this. To further assist organisations reference to relevant jurisdictional Departments of Health resources should be considered as well to respond to the identified risks by the organisation.

The reason for referring to a number of resources is the NHMRC Australian Immunisation Handbook (NHMRC current edition) provides information and recommendations on many vaccines that health care workers are not necessarily required to have as part of their work. Jurisdictional requirements give context to identified areas of risk that need to be addressed to ensure safe provision of health care in Australia. The Australian Guidelines for the Prevention and Control of Infections in Healthcare (NHMRC 2010) should also be considered for workforce immunisation. It is understood that there is variation in the requirements for each jurisdiction and within jurisdictions depending on activities and risks with populations.

For further assistance with assessing risk for workforce immunisation refer to:
Q: What resources are available for Standard 3?

Links to additional resources, sites or organisations that can provide additional information are listed below. These resources are also listed in the back of the Safety and Quality Improvement Guide for Standard 3.

**International organisations**
Centres for Disease Control and Prevention
http://www.cdc.gov/
Agency for Healthcare Research and Quality
www.ahrq.gov
Canadian Patient Safety Institute
www.patientsafetyinstitute.ca
Institute for Healthcare Improvement
www.ihi.org
National Patient Safety Agency
www.npsa.nhs.uk
National Institute for Health and Clinical Excellence
www.nice.org.uk
Patient Safety First
www.patientsafetyfirst.nhs.uk

**National organisations**
Australian Commission on Safety and Quality in Healthcare
www.safetyandquality.gov.au
Department of Health and Ageing
www.health.gov.au
Hand Hygiene Australia (HHA) - National Hand Hygiene Initiative
www.hha.org.au/
MyHospitals
www.myhospitals.gov.au/
Therapeutic Goods Administration
www.tga.gov.au/
Australian and New Zealand Intensive Care Society (ANZICS) - Central Line Associated Blood Stream Infections (CLABSI)
National Prescriber Service (NPS)
www.nps.org.au/
National Health and Medical Research Council (NHMRC)

State and territory organisations
ACT Health
www.health.act.gov.au
NSW Department of Health
www.health.nsw.gov.au
NSW Clinical Excellence Commission - NSW
www.cec.health.nsw.gov.au
Northern Territory Department of Health and Families
www.health.nt.gov.au
Queensland Health
www.health.qld.gov.au
Centre for Healthcare related Infection Surveillance and Prevention (CHRISP) - QLD
Patient Safety and Quality Improvement Service – QLD – provides examples of audit tools
SA Health
www.sahealth.sa.gov.au
Department of Health and Human Services - Tasmania
www.dhhs.tas.gov.au
Department of Health - Victoria
www.health.vic.gov.au
VICNISS Healthcare Associated Infection Surveillance System - Victoria
Victorian Quality Council
Western Australian Department of Health
www.health.wa.gov.au
Office of Quality and Safety - WA

www.safetyandquality.health.wa.gov.au

Change improvement

Australian Resource Centre for Healthcare Innovations

http://www.archi.net.au/resources/moc/making-change

Institute of Healthcare Improvement:
Register at www.ihi.org (free), then log in so that you can access resources on the IHI website

- Change improvement white paper
- Engaging physicians in quality improvement

National Health and Medical Research Council, barriers to using evidence


National Health and Medical Research Council, implementing guidelines