

# SECTION 2

## CLINICAL GOVERNANCE

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*‘What is meant by a clinical governance framework is a set of initiatives designed to enhance care, and the promotion of a productive culture and climate within which care can thrive.’*

*Braithwaite & Travaglia 2008 (52)*

Clinical governance refers to a system through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, which includes the prevention of HAIs, by creating an environment in which excellence in clinical care will flourish (53, 54).

Clinical governance accountabilities for infection prevention and control include:

- Executive engagement and clearly defined leadership;
- Implementation, reporting and evaluation of a local HAI prevention program;
- Increasing consumer participation and education for infection prevention and control;
- HAI and antimicrobial stewardship surveillance; and
- Where relevant, inclusion and consultation with non-acute healthcare services in the HAI prevention program.

[NSQHS - VERSION 2  
NATIONAL STANDARDS](#)

[NSW Health](#)  
Incident Management Policy

The local HAI program is an integral component of each HO's clinical governance system and should be regularly evaluated. Evaluation findings should be used to update the HO's risk management plan. The NSW Health Incident Management System (IMS) should be used to record incidents.

## 2.1 National standards

The National Safety and Quality Health Service (NSQHS – Standard 3 Preventing and Controlling Healthcare-Associated Infection Standard) (Version 2) are a quality assurance mechanism aimed at protecting patients from harm and improving the quality of health service provision (12). The clinical governance and partnering with consumers Standards set the overarching system requirements for all other standards and are to be included in gap analysis, action plans and evidence requirements. . Specifically for the preventing and controlling healthcare associated infection Standard, the criteria are:

- Clinical governance and quality improvement to prevent and control HAIs and support antimicrobial stewardship
- Infection prevention and control systems
- Reprocessing of reusable medical devices
- Antimicrobial stewardship

Successful infection prevention and control requires a collaborative approach and several strategies across all levels of the healthcare system. These strategies include:

- Governance
- Risk identification and management
- Surveillance activities to identify areas for action and quality improvement activities (hand hygiene assessment, awareness and practice of aseptic technique)
- Safe and appropriate prescribing and use of antimicrobial agents through antimicrobial stewardship and consumer engagement.

Although all infection prevention and control programs have essential elements that must be considered, programs will need to be tailored to reflect local context and risk.

Resources within the National Standards provide detailed requirements and actions to comply with the preventing and controlling healthcare associated infection standard.

To understand the evidence requirements for accreditation [NSQHS - VERSION 2 NATIONAL STANDARDS Hospitals Accreditation Workbook](#) (55) provide further information on all the NSQHS.

## 2.2 Risk management framework

Infection prevention and control risks and being risk aware are an integral part of organisational IPC operations and must be identified and managed at the appropriate level for an IPC program to be effective (32).

Infection prevention and control threats should be addressed through a risk management process in order to maintain and improve patient and HW safety and provide safer care.

A successful approach to risk management occurs on many levels within a healthcare facility:

- **Facility wide**—for example, providing support for effective risk management through an organisational risk-management policy, staff training, follow-up of outcomes, monitoring and reporting.
- **Ward or department based**—for example, embedding risk management into all policies so that risks are considered in every situation.
- **Individual**—for example, considering the risks involved in carrying out a specific procedure and questioning the necessity of the procedure as part of clinical decision-making, attending education sessions (e.g. hand hygiene or respirator fit testing).

When implementing IPC measures all healthcare facilities need to consider the risk of transmission of infection and implement according to their specific setting and circumstances.

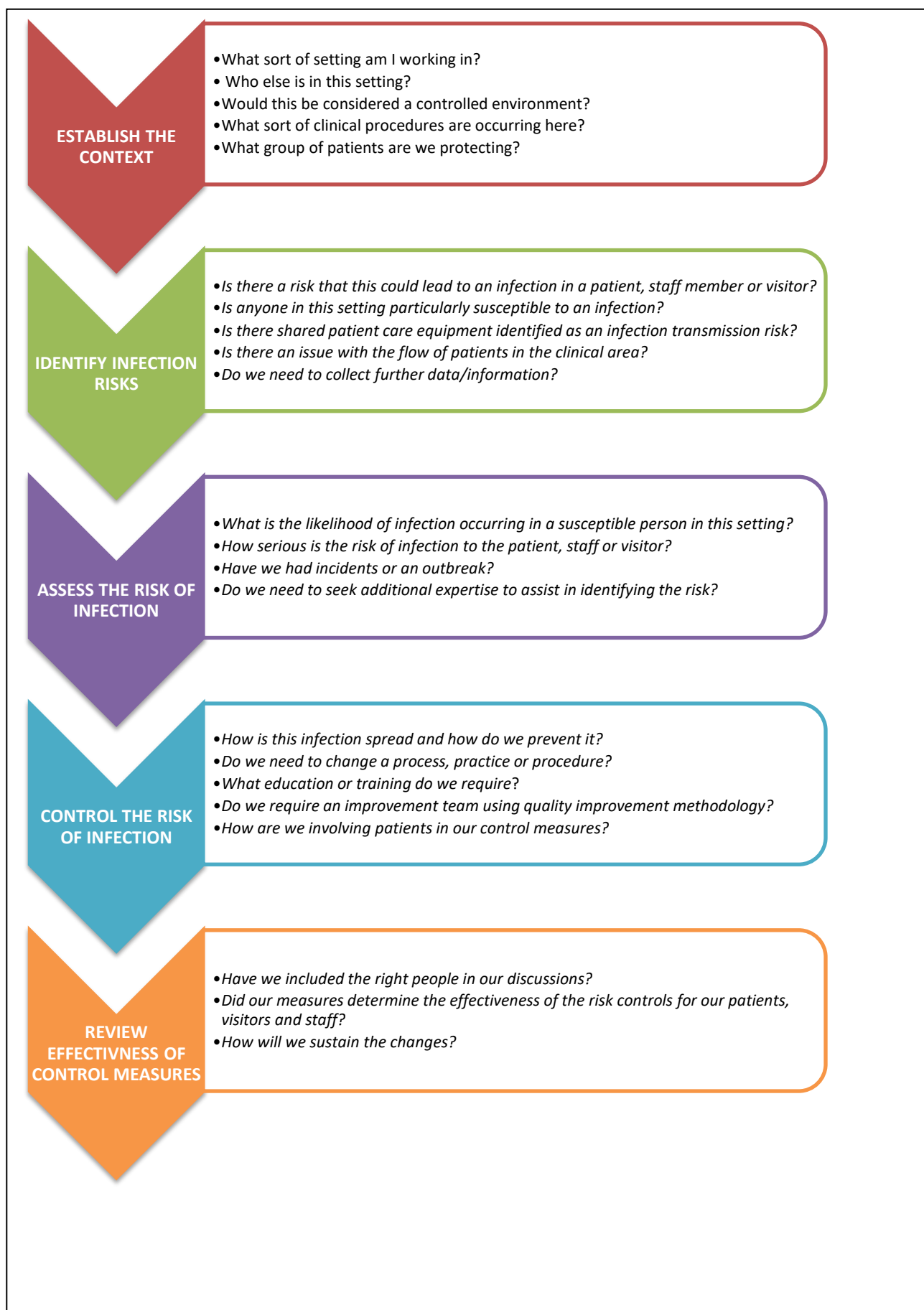
The local IPC program and plans should use a risk management framework consistent with NSW Health policy. For IPC, the risk framework for HOs should address five key actions of the NSW Health Risk Management Framework (56) described in Figure 1.

### [NSW Health PD](#)

Risk Management - Enterprise-Wide  
Risk Management Policy and  
Framework - NSW Health

### [Australian Guidelines for the Prevention and Control of Infection in Healthcare](#)

**Figure 1. Steps of risk management, based on the NSW Health Risk Management Framework**



### **Case study 3: Hospital with high *Staphylococcus aureus* Bacteraemia (SAB) rate**

*Regular performance monitoring at St Elsewhere Hospital revealed a higher than benchmark SAB rate over the preceding six months. The Infection Prevention and Control (IPC) Committee undertook a risk assessment to determine the appropriate management strategies.*

#### **1. Establish the context**

- A major metropolitan tertiary referral hospital with a regional cancer care service.
- Provide a significant trauma service.
- There has been a significant re-development of the cancer care services.
- A significant staff turnover within last year.
- Have operating theatres with over 90% utilisation
- Perform many intravascular insertion procedures on a daily basis

#### **2. Identify infection risks**

- Significant patient risk of infection associated with the trauma and cancer care service.
- A large number of patients have either short or long term central lines in place.
- Many patients are immunocompromised.
- IPC service regularly monitors SAB rates and vascular access device use.
- Adherence to aseptic technique and hand hygiene compliance.
- High turnover of staff may have impacted on staff education and training.

#### **3. Assess the risk of infection**

- Determine the type, source, location and significance of the infections.
- Determine the number of patients with intravascular access devices, their use and infections.
- Establish training and assessment of staff who insert intravascular devices.
- Review audits of intravascular access device insertion, access, care and compliance with policy and procedures.
- Identify if the risk is in a particular patient population by performing case reviews.
- Determine causal and infection risks posed by using trend data, type of patients and the location of the patients with infections.

#### **4. Control the risk of infection**

- Discuss the risk of infection with appropriate clinical groups to determine linkages and risks.
- Quality improvement program to improve compliance with intravascular access device procedures and infection control processes.
- Provide education and credentialing for the insertion, management and access of intravascular devices.
- Review aseptic technique and hand hygiene understanding and compliance.
- Development of a methodology for validation for each SAB case
- Development of a system to identify each suspected or known SAB infection to enable immediate investigation

#### **5. Review the effectiveness of control measures**

- Continue to monitor SAB rate.
- Ensure reporting to IPC and peak quality committees on a regular basis.
- Provide feedback to HWs.
- Develop a regular evaluation method that includes: monitoring of SAB rates, compliance with aseptic technique, SAB case validation, credentialed staff numbers, and audit processes for the insertion, management and removal of intravascular access devices.

## 2.3 Infection prevention and control program

Every HO is to have an infection prevention and control program in place. The success and effectiveness of such a program requires the development and involvement of suitably qualified personnel or the development of adequate systems to link in with such expertise. In line with the core components of an infection prevention and control program, the practical aspects include(1, 57):

[NSQHS - VERSION 2 NATIONAL STANDARDS Standard 3](#)

**Table 3. IPC core components**

Core components	Examples of practical application
<b>A governance structure that incorporates risk escalation, reporting and feedback</b>	<ul style="list-style-type: none"> <li>Documented organisational structure that includes committees that the program reports to with various aspects of the program</li> <li>An understanding with reporting manager on what is required to be reported urgently and how it is to be reported</li> <li>Knowledge of how to collect accurate and verified information, assess risk and document the information for reporting urgently (Brief)</li> <li>A simple documented reporting line for routine and urgent information</li> <li>A simple documented feedback plan for routine reports, incidents, audit results, quality improvement projects, outbreak reports etc.</li> </ul>
<b>Clearly defined objectives, functions and annual action plans</b>	<ul style="list-style-type: none"> <li>This is the overview of the program that is provided for accreditation surveys</li> <li>Certain information should be in a position description for infection prevention and control staff</li> <li>Can be included in a risk/operational plan for the infection prevention and control program</li> <li>Operational and business plans including actions and evaluations</li> </ul>
<b>Clear objectives that have scalability to manage any potential risks</b>	<ul style="list-style-type: none"> <li>Can be included in a risk/operational plan for the infection prevention and control program</li> <li>Identification and management strategies for organisms specific to local epidemiology</li> <li>Can also be included in response and escalation plan for outbreaks</li> </ul>
<b>Trained professional(s) to lead and manage the program</b>	<ul style="list-style-type: none"> <li>Relief or untrained staff should have an experienced mentor assigned</li> <li>Information on network of experienced staff who are able to answer questions or provide advice</li> </ul>
<b>Linkages between national, state, LHD and facility policies/guidelines</b>	<ul style="list-style-type: none"> <li>These will be reflected as references in local procedures, reports or plans</li> </ul>
<b>Microbiological/infectious diseases support</b>	<ul style="list-style-type: none"> <li>Establish linkages with local experts</li> <li>Develop systems and process to access clinical expertise</li> </ul>
<b>Education and training programs for all health workers that are evaluated</b>	<ul style="list-style-type: none"> <li>Evaluations may include competency/clinical assessments, aseptic technique audits, hand hygiene audits, environmental cleaning audits</li> </ul>

<b>for effectiveness and applicability to each of the health professional groups</b>	<ul style="list-style-type: none"> <li>• Review of incidents</li> <li>• HAI surveillance results</li> <li>• Reports of issues identified in clinical unit reviews</li> </ul>
<b>A HAI surveillance program that includes national, state and facility clinical and process indicators</b>	<ul style="list-style-type: none"> <li>• Documented program that includes clinical/process indicators, who collects the data, where the data is documented, how the data is analysed, how each case is validated, how it is reported and feedback to stakeholders</li> <li>• How trend data is monitored</li> </ul>
<b>Multimodal strategies to drive improvements in HAI rates, infection prevention practices, and patient infection risks</b>	<ul style="list-style-type: none"> <li>• Determine the strategies that are required to drive improvements e.g. hand hygiene, cleaning shared patient care equipment, patient education, standard and transmission based precautions, surgical antisepsis</li> <li>• What other programs are involved in contributing to the strategies e.g. antimicrobial stewardship, environmental cleaning, reprocessing of reusable medical devices, education programs, competency assessment programs</li> <li>• What committees contribute to these strategies e.g. product evaluation, new and emerging technologies (related to cleaning and reprocessing), operating theatre management (reduction of SSIs)</li> </ul>
<b>Monitoring/audit/evaluation of infection prevention and control practices and feedback mechanisms</b>	<ul style="list-style-type: none"> <li>• Development of an annual audit program for infection prevention and control with assigned responsibility</li> <li>• Ongoing risk assessments – use of a standard template and tracking of recommendations to ensure completion</li> <li>• Development of a standard templates for reporting that include communication and feedback.</li> <li>• Development of assessments for standard and transmission based precautions</li> <li>• Development of a monitoring program for critical shared patient care equipment</li> </ul>
<b>A program for the maintenance of standards and practices for reducing or eliminating contamination of environmental and equipment risks</b>	<ul style="list-style-type: none"> <li>• Inclusion in the reporting requirements for environmental cleaning audits to ensure benchmarks are met</li> <li>• Inclusion in assessment of reprocessing areas to ensure compliance with AS/NZS4187</li> <li>• Reporting of maintenance processes to peak committees</li> <li>• Maintain risk register of issues, interventions and outcomes</li> </ul>
<b>Built environment, materials and equipment at both the facility, clinical level and point of care to reduce the risk and transmission of HAIs</b>	<p>Inclusion of infection prevention and control staff in</p> <ul style="list-style-type: none"> <li>• designs, review and commissioning of building works</li> <li>• purchase of new equipment</li> <li>• compatibility of equipment and cleaning chemicals</li> </ul>

### 2.3.1 Roles and responsibilities of the health worker (HW)

Everyone who works in a HO has a responsibility to commit to the infection prevention and control principles to do no harm and, therefore, prevent and control infection in the healthcare setting.

[NSW Health PD](#)  
NSW Health Code of Conduct



Infection prevention and control is incorporated into the work practices of all clinical and non-clinical HWs. Each HW is accountable for the inclusion of infection prevention and control in the work they do. In addition, each HW is also ethically accountable for communicating or reporting breaches of infection prevention and control in any work they witness which is carried out by other HWs. Registered HWs have a legal obligation to comply with infection prevention and control as identified in the [Health Practitioner Regulation \(NSW\) 2016 – Reg 5 Infection Control Standards](#).

## 2.4 Preventative maintenance and asset management

Each HO is responsible for developing and carrying out its own maintenance and asset management strategy to meets the needs of the HO and the population it serves. This strategy must include consideration of the infection prevention and control implications of purchasing and maintaining plant and equipment and the construction and maintenance of buildings.

[NSW Health Strategic Asset Management Plan](#)

### 2.4.1 Purchasing new equipment

Infection prevention and control, and where relevant, reprocessing advice should be obtained before the purchase of any new consumables or equipment. Reprocessing staff should also be consulted for any reusable medical devices that require reprocessing. Advice should be based on an assessment of whether:

- the product is registered with Therapeutic Goods Administration (TGA) or an exemption from TGA is obtained
- the manufacturer is able to supply instructions for use (IFU) for individual items
- compliance with the IFU meets Australian standards policies and local guidelines
- the manufacturer has provided well designed studies that show a statistical significance for the safety of the product;
- the company has provided advertising material making bogus claims with no or little evidence to support the claims;
- there have been previous product recalls or shortages for the product;
- the product will increase or decrease the risk of infection to the patient or other individuals who may be present during the delivery of care;
- the product may be implicated in the transmission of infection over time (e.g. corroding materials);
- the use of the product will have infection prevention and control implications for other consumables, equipment or plant;
- the feasibility of the cleaning and reprocessing requirements for the product will impact on product functionality and safety;
- additional infection prevention and control and/or reprocessing training is required for individuals who will be handling new product;
- the product is compatible with existing equipment (if necessary);
- alternative products are available and whether these other products present a lower risk of infection; and

[NSW Health PD](#)  
NSW Health Goods and Service Procurement

[NSW Health PD](#)  
Process of Facility Planning

[NSW Health GL](#)  
NSW Framework for New Technologies and Specialised Services



- If new technology it meets the criteria for new technologies and will require referral to the LHD/SHN New Technologies and Specialised Services Committee for review

## 2.4.2 Review and maintenance of existing equipment

Each HO should undertake regular maintenance and routine review of all patient and non-patient care equipment, furnishings and fixtures according to manufactures instructions, mandatory requirement or a risk assessment. Results of the review that indicate an infection or transmission risk should always be reported back to infection prevention and control and, where necessary, involve the local infection prevention and control unit in any further investigations.

## 2.4.3 Demolition, refurbishment and construction

The local infection prevention and control unit should be involved in the planning and building stages of any demolition, refurbishment or construction activity.

During the planning stage, the local infection prevention and control staff should be allowed to identify opportunities to prevent the transmission of infectious organisms during construction activity and identify opportunities to implement engineering and environmental controls for better infection prevention and control in any facility that will be built, renovated or repaired.

[NSW Health GL](#)  
Health Facility Guidelines -  
Australasian Health Facility  
Guidelines in NSW

[Australasian Health  
Facility Guidelines](#)  
Part D Infection Control

The infection prevention and control implications of preserving any existing structures during a refurbishment should also be considered and assessed for infection risks as part of the planning process.

Prior to any demolition, refurbishment and construction activity, the HO should appoint IPC and clinical microbiology to the team that determines and evaluates:

- the risk of airborne dissemination of microorganisms during construction activity;
- whether any environmental or air sampling is required and, if required, how sampling will be undertaken;
- the infection prevention and control requirements of the new, renovated or repaired facility;
- whether additional infection prevention and control measures are required for patients, HWs and visitors during construction activity;
- what infection prevention and control measures are required by construction workers during construction activity; and
- the involvement of the local infection prevention and control unit in site inspections and commissioning of the new or refurbished facility.

[NSW Health PD](#)  
Water - Requirements for the  
Provision of Cold and Heated  
Water

[NSW Health GL](#)  
Engineering Services  
Guidelines

Building contractors, engineers and any other individuals involved in construction activity should comply with infection prevention and control requirements, as determined locally, when on site. A notification and remediation process should be implemented to address any breaches in infection prevention and control that have arisen during construction activity.

At the completion of construction, the infection prevention and control requirements for sign off will require a documented risk assessment. The risk assessment will be scalable depending on the extent of construction. The following table provides a minimum risk assessment checklist.

**Table 4. IPC Construction checklist example**

Infection Prevention and Control Commissioning Risk Assessment Element	Meets required standard? Yes/No or N/A	Recommendation if No	Risk level Low Moderate High
The area has been vacuumed with a HEPA filter vacuum			
The area has been thoroughly cleaned. This includes all horizontal and vertical surfaces to ensure all dust and debris has been removed.			
All installed medical/information technology equipment is clean			
The cleaning has been performed with the correct detergent / disinfectant (chemical or other)			
Air conditioning is working correctly and within recommended parameters as per engineering and building services and / or the Contractor			
The operating theatre or pharmacy clean room: air sampling and particle counts have been performed and results are within acceptable limits.			
> HEPA filters and clean flow systems (where installed) have been recertified			
If the water supply has been disrupted: maintenance/contractor has flushed water through all taps and water sampling has occurred (as per the Guidelines for the Control of Legionella (2013), as necessary, with results within acceptable levels (<10 cfu/ml)			
Sinks and plumbing fixtures are suitable for the task and properly located (as per relevant Standards)			
Air intake and exhaust outlets are located and working properly			
Single rooms meet requirements for patient isolation			
Hand hygiene basins correct set up e.g. water flow, sealed near wall, hand hygiene products			
Alcohol based hand rubs available, installed in correct positions and no risks identified e.g. near electrical outlets			

## 2.5 Staff health and HAI risk

HWs noncompliance with infection prevention and control can contribute to the potential transmission of microorganisms within healthcare settings (58-62). HWs carry their own commensal microflora and at times may become colonised or infected with other microorganisms that are in circulation within a healthcare facility (63).

HOs have a responsibility to take a proactive position on staff health matters that may put the health of patients, visitors or other HWs at risk of a HAI. A HW diagnosed with an infectious condition is obliged to practise in such a manner that does not put patients, visitors or other HWs at risk of infection.

[NSW Health PD](#)  
Code of Conduct

### 2.5.1 Risk assessing HWs

There are times when the HW may be the source of an infection and may promote the transfer of microorganisms to patients or to other HWs. Where a HW is unwell, ask the following questions prior to the delivery of any patient care to establish the presence and severity of this risk:

- Is the HW known or suspected of being colonised or actively infected and poses a direct risk to others with an MRO or other communicable disease such as a blood-borne virus?
- Is the HW displaying signs of an acute respiratory illness such as coughing or fever? e.g. Influenza, Pertussis, or Tuberculosis?
- Is the HW vomiting or has diarrhoea?
- Does the HW have any open wounds that are unable to cover with a waterproof or other dressing? This is particularly important if any wound inhibits compliance with hand hygiene.
- Is there a history of recent overseas travel or overseas hospitalisation?
- Is performance of an exposure prone procedure (EPP) likely?

At other times, the HW may be a susceptible host and may be at risk of acquiring an infection. To establish whether the HW is susceptible to infection, clinicians should consider the following risk factors prior to patient exposure:

- **Procedures that are being performed by the HW.** EPPs and aerosol generating procedures (AGPs) may increase the likelihood of microorganisms being transferred from patient to HW.
- **Presence of wound, ulcers, burns, contact dermatitis or exfoliative skin conditions.** Skin is a physical defence against infection. Breaches to the skin provide an access portal for infection.
- **Co-morbidities.** Certain conditions or behaviours, e.g. smoking, immune disorders that may increase the propensity for infection.
- **Pregnancy.** Acquisition of infections during pregnancy may have severe outcomes for the mother and/or fetus.
- **Contacts and exposure to particles carrying infectious material.** Consider whether the HW has had exposure to a patient with an infectious illness or exposure to symptoms of infectious disease (e.g. vomit, diarrhoea) without practicing transmission based precautions.
- **Vaccination or immunity status.** Prior vaccination or identified immune status to specified infectious diseases may protect the HW from the establishment of an infection. In some cases vaccination may also reduce the severity of illness.

The HO must have systems to ensure compliance with the Policy Directives that protect HWs. Where a HO identifies, or is made aware, that a HW is at risk or poses an infection risk to patients, visitors or other HWs, the level of infection risk should be assessed using the framework set out above. The duty of care required should then be reviewed against the level and consequences of the infection risk. If the level of the risk is deemed unacceptable the HW must be managed to ensure that the health and welfare of the HW or patients, visitors or other HWs are not compromised. This may result in exclusion of HW from the workplace or reassignment of duties in consultation with the relevant stakeholders.

#### [NSW Health PD](#)

Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases

### 2.5.2 Managing HWs

The best practice for mitigating the risk of transmission to and from HWs involves:

- The use of established lines of communication between HWs and their managers and local staff health or occupational vaccination/screening services; and
- A suitable escalation process to managers.

The implementation of these will require continual support and reinforcement at the HO Executive level.

Where a HW has notified their manager and/or staff health or occupational vaccination/screening services of a suspected or known infection risk posed by their own health, a timely assessment of the HW's condition should be undertaken and a suitable management response enacted. In some instances, a suitable management response may involve a change in duties, temporary leave or redeployment until such time as the infection risk has been deemed acceptable or eliminated.

#### [NSW Health PD](#)

Open Disclosure Policy

#### [NSW Health PD](#)

Work Health and Safety: Better Practice Procedures

#### [NSW Health PD](#)

Injury Management and Return to Work

#### [NSW Health PD](#)

Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases

At all times, staff health or occupational vaccination/screening services information must be treated in confidence by managers and staff health services. The HO must investigate and act further if it becomes aware that a HW has unknowingly posed an infection risk to patients and other HWs in the present and past.

#### [NSW Health PD](#)

Leave Matters for the NSW Health Service

#### [NSW Health PD](#)

HIV, Hepatitis B and Hepatitis C - Management of Health Care Workers Potentially Exposed

Managers and staff health or occupational vaccination/screening services also have a responsibility to minimise the risk of infection to HWs.

#### [NSW Health PD](#)

Management of health care workers with a blood borne virus and those doing exposure prone procedures

If a HW is immunocompromised or lacks sufficient protection against a vaccine preventable disease, a suitable management response may be to change the HW's duties or redeploy the HW in an area where there is a lower risk of infection. HWs should be made aware of infection risks prior to any anticipated exposure and be trained to use standard and transmission based precautions. If an exposure is known to have occurred, depending on the nature and extent of exposure (e.g. penetrating needle stick injury), the exposed HW may require immediate first aid, clinical care and/or treatment.

#### [NSW Health GL](#)

NSW Contingency Plan for Viral Haemorrhagic Fevers

If a HW is exposed to an infectious disease during the course of their work (e.g. caring for an infected patient without using standard or transmission based precautions), the management response should address:

- Notifying the HW of the exposure (if they are unaware);
- Whether they require clinical assessment;
- Incubation period, signs and symptoms of the infectious disease;
- Whether post exposure prophylaxis should be discussed, consented and administered;
- Precautions to be undertaken by the HW to prevent further spread of the disease (including time off work and return to work plan);
- Whether change of duties or home quarantine is required;
- Whether the Public Health Unit (PHU) and/or Safe Work NSW needs to be notified; and
- Referral to their General Practitioner or relevant specialist consultant.

In the event of a HW being exposed to or infected with an infectious disease during the course of their work and being required to take leave from work by the HO, a return to work program should be agreed to in consultation with the HW. Likewise, a consultative process, involving the HW, should be undertaken regarding any change in duties or temporary or longer term redeployment.

### 2.5.3 Exposure prone procedures (EPPs)

EPPs are a subset of invasive procedures in body cavities, or in poorly visualised or confined sites (e.g. mouth), where there is potential for contact between the skin of the HW and a sharp.

Key practice points:

- HWs who perform EPPs must know their human immunodeficiency virus (HIV), HBV and Hepatitis C virus (HCV) status and undertake annual testing in line with current NSW Health Policy and National Hepatitis B and C testing policies.
- HWs who are either HCV PCR positive or HBV DNA positive or HBeAg positive or HIV positive must not perform EPPs. Criteria for with HIV, HBV or HCV are under review and are expected to be updated in the near future. These HWs should seek expert advice. HWs who do not perform EPPs are not required to undergo routine blood borne virus testing.

[NSW Health PD](#)

HIV, Hepatitis B and Hepatitis C - Management of Health Care Workers Potentially Exposed

[NSW Health PD](#)

Management of health care workers with a blood borne virus and those doing exposure prone procedures

[National Hepatitis B Testing Policy v1.2](#)

[2017 National Hepatitis C Testing Policy v1.2](#)

### 2.5.4 HW screening and vaccination

Routine HW screening is not required for most infectious diseases. TB screening should be undertaken for new HWs who have been born or have lived (≥3 months cumulatively) in countries with a high incidence of TB or new and current HWs that have recently travelled (≥3 months in past three years) to countries with a high incidence of TB.

HWs with direct patient contact require immunological protection against the following vaccine preventable diseases:

diphtheria,  
tetanus,  
pertussis,  
hepatitis B Virus,  
measles,  
mumps,  
rubella,  
chickenpox

[NSW Health PD](#)

Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases

[The Australian Immunisation Handbook](#)

Annual influenza vaccination is either recommended or mandatory for HWs who work in high risk clinical settings.<sup>191</sup>

### 2.5.5 HWs with cystic fibrosis

HWs with cystic fibrosis (CF) should consult with their line manager and infection prevention and control staff on specific requirements for delivery of care. The patient management requirements described in [Section 9.3- Cystic Fibrosis](#) are not intended to be used to manage HWs with CF.

HWs with CF should always adhere to the requirements of standard precautions and where necessary, transmission based precautions.

### 2.5.6 HWs with herpes simplex virus

There is a risk that a HW with an oral/facial lesions (i.e. cold sores) associated with herpes simplex virus (HSV) may transmit infectious material to a patient when providing direct care. The appropriate management response should ensure that these HWs are not providing direct care to, or in close contact with, high risk patients, such as:

- Neonates
- Newborns
- Patients in delivery suites
- Severely immunocompromised
- Burns patients
- Patients with extensive eczema
- Ophthalmic patients (specified by local facility)
- Patients in an operating room if there is an exposed herpetic lesion.

The inclusion of other patient cohorts should be determined locally and be based on an established risk assessment.

## 2.6 Healthcare worker education

### 2.6.1 Mandatory requirements

Completion of mandatory training helps maintain a safe and healthy work environment and must be undertaken by all NSW Health staff to meet the 6 criteria specified in [NSW Health Policy Directive - Mandatory Training - Criteria for Approval](#) and [NSQHS - VERSION 2 NATIONAL STANDARDS](#).

Infection prevention and control training of HWs is an essential core component of an effective IPC program.

Currently there are core training modules that are mandatory for all clinical staff, including specific infection prevention and control issues; In addition, there are a number of additional training requirements targeted to HWs based on their roles and responsibilities within the organisation.

Further training may be directed locally by a Chief Executive (CE) in response to specific local training requirement and is deemed “CE Directive Training” rather than Mandatory Training.

### 2.6.2 Local education and training

Each HO should recognise that additional local education and training may need to be delivered to address specified local infection prevention and control issues. Such issues may be identified through an education gap analyses. Information for the gap analyses may be determined from:

- new or revised local procedures
- debrief recommendations made following an outbreak
- outcome from surveillance trends
- auditing results
- accreditation recommendations or requirements
- mandatory training requirements
- clinical competency/assessments required for the local facility.

The delivery of local education, training and competency/assessments can take many forms. Consideration of the content being delivered and the knowledge levels of the target audience should influence what modes are applied with adult learning principles.

Informal education should be considered as an essential part of the continuing development of all HWs. If practical, and without compromising patient dignity or safety, opportunities at the bedside are useful in providing informal one-on-one or small group infection prevention and control education to HWs.

## 2.7 Consumer/Patient/Carer education

The provision of education to patients and their family, carers and visitors is an effective way to reduce further carriage and spread of infection in the health care setting and in the community.

Patient education empowers patients, carers, their family and visitors to feel comfortable to ask questions about their care and participate in infection prevention and control activities. Starting conversations on education enables patients to express their concerns and further their knowledge on infection risks.

HOs should continually provide education to their consumers, patients and carers on general infection prevention and control topics, such as hand hygiene, vaccination programs, respiratory hygiene and cough etiquette.

[NSQHS -  
VERSION 2  
NATIONAL  
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Standard 2](#)

[Clinical  
Excellence  
Commission](#)  
Guide to  
Health  
Literacy



The time to give infection prevention and control information varies from patient to patient and not every patient will require specific infection prevention and control education. In general, individualised education should be provided to a patient:

- when an infection risk is identified and continued until the risk has subsided e.g. chemotherapy, organ or tissue transplant
- with a suspected or confirmed infectious disease
- undergoing surgery
- with a newly identified MRO
- in transmission based precautions
- who has an identified medical condition or immune disorder that increases their risk of acquiring an infection or MRO e.g. diabetes, hypogammaglobinaemia
- who has permanent indwelling devices such as a tracheostomy, supra-public catheter, intravascular device
- who has been recently hospitalised overseas in countries with known [high prevalence of MROs](#) or emerging novel infections.

Patients should also be provided with education at the time of discharge if ongoing infection prevention and control measures are required. In community health settings, infection prevention and control education should be provided when an infection risk is identified and then continually reviewed as part of the patient's care plan until the risk has abated.

When providing infection prevention and control education to patients, treating clinicians should provide personalised answers to the following questions:

- Why am I at risk?
- What is the level of risk that I have?
- Am I contagious?
- What symptoms will I experience if I get an infection?
- How does my condition affect me, my family and my visitors?
- What can I expect is going to happen to me?
- What can I expect from the HWs who are looking after me?
- What are my treatment options?
- What are the risks and benefits associated with the different treatment options?
- Are there any alternatives or other options that I should consider?
- What do I need to do if have signs or symptoms of an infection?
- When and how do I take my medication?
- How can I protect myself, my family and my friends?
- What do my family and visitors need to do to protect me and themselves?
- What should I do if I am concerned about the transmission and infection risks around me?
- How can I protect myself in my room?
- How can I protect myself and others if I leave the room?
- Who can I contact if I have any further questions or need to check something?

[ACSQHC Antimicrobial Stewardship Clinical Care Standard](#)

[ACSQHC information sheets](#)

Carbapenem Resistant Enterobacterales

[Clinical Excellence Commission information sheets](#)

*Clostridium difficile*  
Carbapenem-resistant Enterobacterales

[National Hand Hygiene Initiative Manual](#)

[NHMRC information sheets](#)

Healthcare associated infections  
*Clostridium difficile*  
Methicillin resistant *Staphylococcus aureus*  
Vancomycin resistant enterococci

[NSW Health Infectious Diseases Factsheets](#)

HW should first provide verbal education to the patient and then, if appropriate, provide the patient with written patient information sheets that have been approved by the HO. Any written material should be provided to patients as reference material rather than as a primary source of education.

Written material should always be explained and discussed with the patient. Any education and/or patient information provided to the patient is to be documented in the health record.

Every HW has a responsibility to provide infection prevention and control education to patients in their care and the patient's family, carer and visitors. HWs should provide infection prevention and control education to consumers/patients based on the scope and context of the patient/HW relationship, as illustrated by the following examples:

- A physiotherapist may educate a patient on why their wound must heal before the patient can use the hydrotherapy pool.
- A surgeon may educate a carer on how to help a patient take a shower prior to surgery.
- A diabetes educator may educate the spouse of a diabetic patient on how to check the patient's feet for signs of an infection.
- An infection prevention and control professional may educate a visitor with persistent cough not to visit a relative in NICU.
- An infectious diseases physician may educate a patient regarding their new diagnosis of CPE when discussing their treatment options.
- A nurse may educate their patient with a MRO on performing hand hygiene before leaving the room to go to medical imaging

There may be times when infection prevention and control education may include discussing sensitive patient information (e.g. sexual history, disease status, pregnancy). When providing education to a patient or their family, carer and visitors, clinicians should be aware of the physical environment and seek permission from the patient to disclose any sensitive information to family, carers or visitors.

[NSW Health Privacy Manual for Health Information](#)

Health literacy is the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action (64).

The health literacy of one person may vary markedly to the health literacy of the next person. The health literacy of most patients is usually very different to that of a HW. Therefore, clinicians should be mindful to use simple and clear language and avoid using medical jargon, such as medical abbreviations, terms and phrases, when providing information and education to consumers.

[NSW Health PD](#)  
Interpreters - Standard  
Procedures for Working with  
Health Care Interpreters

Depending on the individual consumer, it may be necessary to provide education and information in languages other than English. This can be done by engaging the services of a language interpreter or information sheets written in the patients preferred language.

Many support groups provide information on specific conditions, diseases, surgical procedures and treatments. These should be explored as an option when providing education and local information sheets are not available.

HOs need to ensure that the consumer infection prevention and control information is both accessible and understandable. The development of education and information sheets, pamphlets, videos for mass distribution and consumption should include consideration of the most effective

[NSQHS - VERSION 2 NATIONAL STANDARDS](#)  
Partnering with consumers

modes and mediums e.g. verbal, written, face to face, paper or online. The language of the information materials should be tested by a broad range of consumer advisors to ensure it is suitable for the target consumer group.

Clinicians also should seek consumer advice on whether to use signs and symbols, diagrams, images, colours and other visual tools to simplify and reinforce meaning.

Checking whether a consumer understands the infection prevention and control information provided is just as important as providing the information itself. One way to test if a consumer has clearly understood the information provided is to use the 'teach back' method. An example of 'teach back' is provided in Case Study 5. A follow up conversation a few days later is also a good way to reinforce education and check that information is clearly remembered and understood.

#### [NSW Health PD](#)

NSW Health Policy & Implementation Plan for Culturally Diverse Communities

#### [NSW Health GL](#)

Consumer Representatives - Working with Consumers in NSW Health

#### [NHMRC](#)

How to present the evidence for consumers: preparation of consumer publications

#### [NHMRC](#)

How to present the evidence for consumers: implementation and dissemination strategies

### 2.7.1 Evaluating the delivery of information to consumers

As part of a HO's commitment to quality and consumer focused care, all infection prevention and control consumer information should be evaluated to ensure that the information provided is clear, relevant, easily understood and meets the needs of the healthcare consumer. Examples of methods on how to evaluate information include:

- Review of information by HO consumer advisory groups
- Consumer surveys or focus groups
- Testing on a small number of patients

Additional information and resources on the development and evaluation of information for healthcare consumers is available from:

- [Clinical Excellence Commission](#) - Person Centred Care
- [Health Consumers NSW](#)

### 2.8 Communication between providers

Processes for communicating a patient's infectious status should be in place whenever responsibility for care is transferred between service providers or HOs. This includes communicating the status of the patient to the receiving facility and any health-related transport providers such as NSW Ambulance or Non-Emergency Patient Transport.

#### [NSQHS - VERSION 2 NATIONAL STANDARDS](#)

See [Section 7](#)

*Communicating with other hospitals* for information about communicating about patients with MROs

#### Case study 4: William's story - Using Teach back in the pre-admission clinic

*William is having knee replacement surgery next week. He has brought along his wife, Kate, to his pre-admission clinic visit. Simone is the nurse attending to William at the pre-admission clinic. This is a part of their conversation that shows how the Teach back method can be used when having a conversation with a patient.*

**Simone:** William, your surgery will take place at 11am next Thursday. You will need to be at the hospital at 7am so we have enough time to prepare you for theatre.

**William:** Okay.

**Simone:** Next Wednesday night, you need to take a shower before you go to bed. This is the special wash you need to use. It is different to the soap or body wash that you buy at the shops. Washing yourself with it will help reduce the risk of you getting an infection from the operation. Are you following me?

*\*Both William and Kate nod their heads in agreement\**

**Simone:** You also need to have a shower on Thursday morning before you come to hospital. So that means two showers with the special wash before you come in.

**William:** Okay.

**Simone:** So that I am sure that you know what needs to be done, can you tell me what you are going to do before the surgery next week William?

**William:** Sure. On Wednesday, I will have a shower at night and then on Thursday morning I will have two showers, using the special wash you have given me.

**Simone:** Let's go over that again. On Wednesday night you need to take one shower and use this special wash. Then on Thursday morning, you need take only one shower and use this special wash. How about I give you two packets of special wash and I'll write Wednesday night on this packet and Thursday morning on the other packet?

*\*Simone labels the special wash packets \**

**Kate:** That will make things easier to remember.

**Simone:** Okay William, so tell me in your own words what you are going to do next Wednesday night?

**William:** I'm going to have a shower after dinner and I will use this packet of special wash.

*\*William holds up the special wash packet labelled 'Wednesday Night'\**

**Simone:** Great. What else do you need to do?

**William:** On Thursday morning, I will have another shower and use this *special wash packet*. Then I'll come in at 7am. I better be clean after all of that!

**Simone:** Do either of you have any questions about using the *special wash packet*?

**Kate:** Should I use the *special wash packet* too? We share the same bed and I'll be driving him to the hospital.

**Simone:** No need for you to use it Kate. Just use the usual soap or body wash you have at home.

**Simone:** Do you have any further questions. It is important that you both know what needs to be done before William's operation.