ELEMENTS OF AUSTRALIAN INFECTION CONTROL AND PREVENTION PROGRAMS

SUMMARY

In 2007 the Australian Commission for Safety and Quality in Healthcare initiated a series of interventions designed to improve patient safety in terms of the prevention and control of healthcare associated infections.

The Commission’s work involved substantial collaboration with stakeholders and experts. In the early stages of this work the Commission recognized an urgent and important need to improve the capacity of hospitals to survey, prevent and control healthcare associated infections. This need has been validated by subsequent comprehensive work including a review of literature and a review of associated local, jurisdictional and national programs.

The Commission designed the model based on the following:

1. advice from its HAI Implementation Advisory Group;
2. international IC Program models considered in the Literature Review of The Infection Control Practitioners’ Scope of Practice; and
3. comments provided by stakeholders contributing to the National Stakeholder Review Of Australian Infection Control Programs: The Scope Of Practice Of The Infection Control Professional/Practitioner/Consultant.

Stakeholders and the authors of both reviews recommended that the Commission develop a generic model outlining essential and recommended elements for Infection Control and Prevention (IC) activity in Australian acute hospitals. In October 2008 the Commission sought comment from the Australian infection control community on such a proposed model. Those comments have been considered and incorporated in the final proposed model included in this paper.

Table 1 details recommended essential elements for all acute care hospital programs irrespective of hospital size. In contrast, Table 2 details specific recommended and optional elements in a step-wise format according to hospital size. The classifications of hospital are based on the mean number of beds associated with the classifications stipulated by the Australian Institute of Health and Welfare in their annual publication “Australia’s Health” (www.aihw.org).

Executive endorsement and commitment by hospital executives including provision of resources as stipulated in this model are fundamental to the success of an ICP program. In addition, hospital executives must actively promote and be accountable for the outcomes of the IC Program.

INTRODUCTION

Despite their formalization in the early 1960s the structure, function and impact of Australian IC Programs remain inconsistent throughout the nation. These inconsistencies limits the effectiveness of these programs in terms of local, and subsequently, national HAI prevention. The limited effectiveness perpetuates the annual experience of several thousand Australians...
who suffer serious morbidity and even mortality from HAIs acquired in acute hospitals and other care settings.

This is a sobering fact which should alone, motivate every Australian healthcare organisation to develop and continue to invest in an organisation wide IC Program. Patients receiving care from those organisations who continue to operate without an organisation wide IC Program will most likely continue to suffer increasingly complex and perhaps more frequently acquired HAIs. It is inevitable that these organisations will be burdened with even greater direct and indirect HAI-related costs. The costs, scrutiny and negative consequences to hospitals with increased HAI related litigation and other remediation and retribution will negatively impact the hospital's ability to operate as normal. Reduced operation causes less throughput and greater attention from hospital funders, politicians, the media and consumers.

Conversely, an international experience suggests that hospitals with Executive support and investment in IC Program are able to substantially reduce HAI burden and maintain profitable levels of output. Additionally they are able to better manage HAI risk and avoid much of the negative ramifications of HAIs.

Underpinning the success of the Australian Commission on Safety and Quality in Healthcare initiatives is the need for frontline infection control staff to have the necessary skills, authority and support of organizational leaders to spearhead local activities consistent with those suggested by the Commission. Recent Commission work indicates a sizeable gap between the current and needed infection prevention and control professionals (ICP) role, scope and function.

The Commission has designed this model as a tool to assist ICP working in acute care hospitals to and designed the model to assist ICP working in acute care hospitals to:

- engage clinicians at a local level;
- develop communication processes to engage senior managers about the role of the ICP in prevention and reduction of healthcare associated infections (HAI);
- foster consensus regarding realistic organisational HAI prevention goals and resource allocation based on the use of data for reporting, planning and action including a risk management approach to infection control issues.

BACKGROUND

The overarching goal of the Commission’s HAI program is to identify and address systemic problems and gaps that are limiting the extent to which HAIs can be either reduced or eliminated. The Commission’s approach is to work collaboratively with recognized experts and relevant authorities to identify these problems and develop feasible, affordable and implementable solutions that are attractive to the Australian infection prevention and control community, the jurisdictions and key stakeholders.

Early in their process of problem identification the Commission identified the need to increase the ability of ICP to engage and educate clinicians, managers and healthcare consumers to adopt a collective HAI prevention mindset. Based on expert and stakeholder advice the Commission recognizes that providing ICP with suitable skills and resources is critical to building IC Program capacity.

This approach was validated in two of the Commission’s most recent important pieces of HAI work; a Literature Review of The Infection Control Practitioners’ Scope of Practice and a National Stakeholder Review Of Australian Infection Control Programs: The Scope Of Practice Of The Infection Control Professional/Practitioner/Consultant. Reports from both initiatives were tabled at the 13 November 2008 Inter-Jurisdictional Committee meeting and can be downloaded from the Commission’s website by following links published at http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-03
In summary the Literature Review found that no single, ideal and valid program model for reducing HAIs currently exists in Australia. It also found that multi-level buy-in and well articulated systems of governance are required for IC Program success. The Literature Review’s key recommendations were that the Commission recommends a minimum and uniform model of IC Program activities which should be engineered into every Australian inpatient setting. The Review also cautioned that governance, control assurance procedures, administrative and clinical buy-in would be prudent to the success of such a model.

Similarly the National Stakeholder Review found substantial inconsistency between strategic governance of IC Program within the jurisdictions, and variation according to hospital size. The Review also reported that hospital executive support is a key component of a successful IC Program. Importantly, the Review’s recommendations addressed governance, IC Program components, ICP scope of practice and ICP education and training. The recommendations included a call for clinical governance to “reside at all levels of a hospital” and “hospital commitment to IC through active executive participation and sponsorship.”

The Review recommended that the IC Program model:

- should be informed by the size and complexity of the healthcare organisation and its community partners, and assessed needs and priorities; and
- requires sufficient funding to support the specified program activity domains and adequate resources to implement and sustain these activities.

Where possible the proposed model incorporates the principal findings and recommendations of the Commission’s Literature and Stakeholder Reviews. Its design, focus and recommendations are entirely consistent with the Commission’s overarching HAI goal and its key intentions to build ICP capacity.

A draft version of the model circulated for comment to the Australian Infection Control Association (AICA) membership provoked extensive and detailed critique, comment and suggested additions. The Commission considers AICA members to be appropriate representatives of the Australian infection prevention and control community. Where practical, the Commission incorporated AICA member comments into this final version of the model. This final version is offered as a general reflection of the preferred “typical” core and essential elements of an Australian acute care hospital’s IC program (IC Program) regardless of size. It also includes additional recommendations categorised according to hospital size and type.

Acute hospitals are either public or private sector and provide services primarily to admitted patients with acute or temporary ailments. This model does not apply to non-inpatient settings including sub-acute, mental health, community-based settings, general practice, diagnostic radiology, clinical laboratories, specialist rooms, long term or residential care or emergency response settings.

To determine a reasonable ratio of ICPs to bed numbers the Commission reviewed recommended international models from eleven published reports. There was no standard methodology or formula for ICP staffing. Accordingly the Commission offered recommendations similar to those promulgated by Health Canada (2004). During the consultation process and based on AICA membership feedback the ratio was downwardly adjusted to those in the current document.

THE PROPOSED MODEL OF AUSTRALIAN INFECTION CONTROL PROGRAMS

Patients admitted to Australian acute hospitals are provided with care across an often expansive continuum. The specific composition of that continuum will likely vary between hospitals and for individual patients. However, a core principle implicit in this proposed model is

---

that each hospital’s standard of infection prevention and control will be consistently excellent across each component of the continuum. That consistency and inclusion of various components ensure a seamless approach to infection prevention and control.
The model includes two key content areas which are:

1. essential IC Program minimum elements regardless of acute hospital size, acuity or patient mix (Table 1); and
2. recommended and optional IC Program elements according to acute hospital size and complexity (Table 2).

It is important to note that the model assumes that non-outbreak conditions apply as it recognizes the sometimes substantial and sustained need for additional resources in outbreak response and management situations.

Content area elements are classified under three Section headings:

1. Program Management and Governance (Section 1);
2. Infection Prevention and Control (Section 2); and
3. Performance Improvement and Research (Section 3).

Figure 1 details the Model’s structure including content areas and section headings.

The approach is based on recommendations in each Section that provide the following:

- practice(s) based on sound principles of epidemiology;
- awareness of all health care workers and others regarding their role in HAI prevention and control;
- partnerships that facilitate and support implementation of generic and specific infection prevention and control interventions;
- mechanisms and processes to ensure implementation of and compliance with infection prevention and control interventions; and
an appropriately staffed and resourced IC Service Program.

Processes and resources

At a local level implementation of the model must include sufficient Executive and hospital level support for IC Program activities. These include necessary resources and education for the IC Program staff and for other staff to comply with IC Program recommendations. The extent of needed resources will vary according to hospital size and complexity as well as by IC Program priorities and goals.

Internally hospitals must ensure they employ appoint a person with dedicated responsibility for IC Program oversight and that that person has access to persons skilled and trained in infectious diseases, pathology, pharmacy, microbiology and epidemiology.

Hospitals must establish and maintain formal structures to facilitate and support internal and external reporting of IC Program outcomes. Internal reporting should include the provision of data to the hospital’s IC Committee and where applicable to Risk Management Department, Quality or Patient Safety Committee, individual clinicians and the Board of Directors. External reporting may include the contribution of data to jurisdictional and nationally agreed datasets.

Vested authority

All Executive staff should champion IC Program initiatives and lead by embedding infection control principles into the culture of the organisation. The Executive should actively participate in the IC Program through IC Committee membership, periodic review of IC Program outcomes and importantly in assisting IC Program staff to gain access to medical staff leaders.

The Chief Executive (CE) must continue to hold the position of extreme authority within a hospital. However it is a critical requirement that the CE empowers the ICP and IC Program team members with sufficient well defined authority to intervene and take appropriate immediate and remedial actions and make recommendations regarding disciplinary corrective action in the event of infection prevention or control breaches or unexpected and unreasonable HAI or occupational infectious disease risk.

Governance issues

There are multiple layers within a hospital where clinical governance is a critical issue. The recommendations included in the Commission’s recent National Stakeholder Review Of Australian Infection Control Programs: The Scope Of Practice Of The Infection Control Professional/Practitioner/Consultant form the basis of the proposed model and in summary include:

- active executive involvement and support for the IC Program at every level;
- responsibility and accountability ranging from the level of individuals providing direct patient care, to leadership and Executive including the Board where applicable and subsequently to appropriate bodies at individual state and territory and/or national level;
- governance that addresses the respective roles and contributions of specialist, consumer and community groups in relation to the IC Program;
- clarity of the specific role, function and activities of the IC Committee; and
- adoption of various measures to maximize, monitor and evaluate clinician adherence to IC best practices and to take appropriate remedial action in the event of breaches.

CONCLUSION

In Australia the widespread adoption of this model will immediately and in the longer term increase the ability of ICP to engage and educate clinicians, managers and healthcare consumers to adopt a collective HAI prevention mindset. It will also provide ICP with suitable
skills and resources needed to build national ICP and IC Program capacity, and to provide a suitable framework that enables hospitals to appoint appropriately qualified ICP. This increased capacity will decrease HAI incidence. Importantly, the remaining work of the Commission’s HAI Program is entirely dependent on that increased capacity.
Table 1: Model of Essential Minimum Elements For IC Programs in all Australian acute care hospitals.

SECTION 1:
Programme Management and Governance

An Infection Control Practitioner/Professional (ICP) or multiple ICPs, depending on the hospital’s size, case mix complexity and infection risk of populations serviced, are designated time, authority, physical and financial resources to coordinate the hospital’s IC Program.

The ICP:
- has skills, experience and qualifications relevant to their specific clinical setting and is able to develop, implement, coordinate and evaluate a hospital-wide IC Program;

is supported annually by the hospital with resources and time to maintain clinical and professional currency. This should include support for credentialing and/or further relevant post-graduate qualifications.

The hospital’s Chief Executive Officer (CEO) or designated equivalent administrator:
- has a performance agreement which includes infection prevention and control outcomes as a key performance indicator;
- endorses the inclusion of specific articulated infection prevention and control roles, responsibilities and accountabilities for relevant personnel within the Hospital’s Management Plan;
- attends and participates in each IC Committee (IC Committee) meeting;
- ensures the ICP is resourced:
  - in terms of co-workers, information technology, access to up-to-date information, designated office/ work space and tools to meet relevant infection prevention-related legislative, regulatory and accreditation requirements;
  - to achieve negotiated healthcare associated infection (HAI) reduction targets and to perform the essential tasks outlined below.
- ensures that the hospital’s IC Program includes involvement of a medical practitioner to support and play a leadership role in the IC Program.
- commits to the IC Program vision, mission, priorities, targets and annual infection prevention plan with specific, measurable goals for HAI risk mitigation and reduction. These are outlined in an annual infection prevention and control business plan which the CEO or their designate and the ICP jointly develop.
- supports an organisational culture that promotes individual responsibility for infection prevention and control among all staff and values the IC Program contribution to the safety of patients, healthcare workers and others. This support includes ensuring IC Program staffing levels consistent with the recommendations included in this document AND including responsibility for infection prevention and control as a component of every staff member’s job description.
- authorises the ICP to:
  - implement IC Program recommendations;
  - intervene when clinical or other practices pose infection risks (e.g. halt building and construction activities, close units during outbreaks and guide patient placement for isolation or cohorting); and
  - recommend remedial action when infection prevention and control measures are compromised or breached.

Management appraises the ICP’s performance at least annually and individual professional development goals are negotiated, supported and opportunities provided.

A multi-disciplinary IC Committee reviews and guides the hospital’s ICPP, strategies and plans. Membership must include but not be limited to the CE/CEO or his/ her Executive designate as well as a medical practitioner. Meeting frequency depends on the hospital’s size, case mix complexity and infection risk of populations serviced. The IC Committee activity is measured against negotiated annual performance goals as stipulated in the business plan.

The IC Committee has an organisational communication strategy to facilitate its day to day activities.
required reporting activities and has the capability of being escalated in response to an incident. National and/or state infection prevention and control policies relevant to the hospital are endorsed by the ICPC, implemented and compliance monitored. At a minimum these policies should form the basis of the hospital’s ICPP directives which could be in either hard copy, electronic or other formats. Suggested topics to be addressed depending on hospital need include:

- Hand Hygiene;
- Standard and Transmission Based (previously Additional) Precautions (including Isolation) and Personal Protective Equipment;
- Aseptic technique and Prevention of Device-Related Infections and other HAIs (e.g. surgical site infections, catheter-related bloodstream infections, ventilator associated pneumonia and urinary tract infection);
- HAI Surveillance;
- Communicable Disease Post Exposure Management and Follow-up;
- Environmental cleaning and disinfection (in collaboration with Environmental Services);
- Reprocessing of re-usable equipment and supplies (in collaboration with Sterilising Services);
- Outbreak Management;
- Critical Incident Management and Investigation;
- Epidemiologically Significant Organisms (including MROs);
- Safe management of waste and sharps;
- Prevention and management of bloodborne pathogen exposure (in collaboration with Occupational Health & Safety);
- Surge capacity for novel respiratory and other communicable disease emergencies (in collaboration with Emergency Response Committees and Outbreak management Teams); and
- Construction/ refurbishment/ engineering.

Regular and ad-hoc communication processes exist between the IC team and relevant public health authorities.

The hospital supports ICP attendance at relevant state or national professional organisation meetings by providing conference leave and funding workshop, conference or other professional development-related registration fees in accordance with Award conditions.

SECTION 2: Infection Prevention

The hospital has access to an accredited (e.g. NATA) laboratory and pharmacy staff systems, protocols and resources exist to:

- perform surveillance and auditing;
- implement the recommendations included in national and state guidelines;
- implement and participate in periodic intensive local, state, national or global HAI reduction campaigns including application of recommendations for HAI surveillance and reporting;
- provide education regarding infection prevention core principles to all new staff and to existing staff at least annually;
- ensure collaboration between ICPP and other stakeholders such as Infectious Disease and Pharmacy Departments to support antimicrobial stewardship;
- collaborate with product and device committees to assess the infection prevention implications of new devices, procedures and technologies;
- provide regular, meaningful feedback of HAI data to individual clinicians, specific specialty departments/units, quality improvement, senior management and others as stipulated in the annual IC Program business plan; and
- provide advice and information to staff regarding new and emerging infectious disease threats and trends.

Education related to specific and general HAI prevention is routinely provided to patients and families e.g. Brochures, pamphlets, face-to-face, information sheets.
SECTION 3:  
Performance Improvement and Research

The hospital supports:

- local research regarding specific cases of infection, outbreaks or preventative strategies; and
- adoption of relevant research findings that reduce or prevent HAIs.

Comprehensive and epidemiologically sound systems, protocols and resources exist to:

- actively manage all infection prevention components of accreditation;
- design, undertake and respond to results of periodic audits and formal reviews of relevant clinical practice and performance eg. Antibiotic utilisation, hand hygiene compliance;
- collaborate with Clinical Risk Departments and Executive staff to develop appropriate methods for rapid response, remediation, investigation and evaluation of infection prevention critical incidents (e.g. sterilisation failures); and
- provide basic, minimum infection control education to staff, healthcare workers and volunteers appropriate to their roles, risks and the services provided by the hospital.

Surveillance and HAI monitoring strategies are designed and driven accordingly to local activity, performance and epidemiologically significant organism trends.
Table 2: Model of Specific Recommended And Optional Elements For Infection Prevention And Control Programs In Australian Acute Care Hospitals According To Size And Assuming Non-Outbreak Conditions.

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>LEVEL 4</th>
<th>LEVEL 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E.g. Principal referral and specialist women’s and children’s hospitals</td>
<td>E.g. Large Hospital</td>
<td>E.g. Medium Hospital</td>
<td>E.g. Small Hospital</td>
<td>E.g. Day Only Procedure Centre</td>
</tr>
<tr>
<td>Mean No. Beds</td>
<td>400</td>
<td>150</td>
<td>60</td>
<td>20</td>
<td>NA</td>
</tr>
</tbody>
</table>

**SECTION 1: Programme Management/Governance (Excludes Outreach Hospital in The Home Or Community Based Program)**

- **LEVEL 1**
  - Minimum 4 FTE ICPs
  - IC team meets at least monthly with Senior Administration, Directors of ICU, Surgery and IC Committee to review performance against IC Program goals.
  - Infection Control Link/Liaison Programme is supported where it adds value.
  - Consumer representation on the IC Committee is encouraged.

- **LEVEL 2**
  - Minimum 1.5 FTE ICPs
  - IC team preferably meets monthly and definitely meets at least second monthly with Senior Administration, Directors of ICU, Surgery and IC Committee to review performance against IC Program goals.
  - Infection Control Link/Liaison Programme is supported if it adds value.

- **LEVEL 3**
  - Minimum 0.6 FTE ICP
  - IC team meets at least quarterly with Senior Administration, Directors of ICU, Surgery and IC Committee or their equivalents to review performance against IC Program goals.
  - Infection Control Link/Liaison Programme should be supported if it adds value.

- **LEVEL 4**
  - Minimum 0.5 FTE ICP
  - IC team meets at least quarterly with Administration, Medical Administration and IC Committee or their equivalents to review performance against IC Program goals.

- **LEVEL 5**
  - Minimum 0.5 FTE ICP
  - IC team meets at least twice a year with Senior Administration, Practice Manager or their equivalents to review performance against IC Program goals.
<table>
<thead>
<tr>
<th>LEVEL</th>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>LEVEL 4</th>
<th>LEVEL 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E.g. Principal referral and specialist women’s and children’s hospitals</td>
<td>E.g. Large Hospital</td>
<td>E.g. Medium Hospital</td>
<td>E.g. Small Hospital</td>
<td>E.g. Day Only Procedure Centre</td>
</tr>
<tr>
<td></td>
<td>- National or state policies for HAI prevention in ICU, NICU, OR, Dialysis, Paediatric, Oncology, Dialysis, Day Surgery, Endoscopy and other Units are adopted as applicable.</td>
<td>- National or state policies for HAI prevention in ICU, NICU, OR, Dialysis, Paediatric, Oncology, Dialysis, Day Surgery, Endoscopy, and other Units are adopted as applicable.</td>
<td>- National or state policies for HAI prevention in Oncology, Dialysis, Day Surgery, Endoscopy, and other Units are adopted as applicable.</td>
<td>- May exercise option to substitute prospective outcome indicator measurement for signal surveillance, process indicator measurement, or point prevalence surveillance.</td>
<td>- May exercise option to use external experts for ad-hoc consultation including with Catering, Occupational Health, Environmental Services and Facilities Design, and Engineering Departments (including input into all building and engineering projects).</td>
</tr>
<tr>
<td></td>
<td>- Routinely undertakes prospective outcome indicator measurement and may undertake additional process indicator measurement, signal surveillance or point prevalence surveillance.</td>
<td>- Routinely undertakes prospective outcome indicator measurement and may undertake process indicator measurement, signal surveillance or point prevalence surveillance.</td>
<td>- May exercise option to substitute prospective outcome indicator measurement for signal surveillance, process indicator measurement, or point prevalence surveillance.</td>
<td>- May exercise option to use external experts for ad-hoc consultation including with Catering, Occupational Health, Environmental Services and Facilities Design, and Engineering Departments (including input into all building and engineering projects).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Contributes to large aggregate data collection systems as required.</td>
<td>- Contribute to large aggregate data collection systems.</td>
<td>- Has formal links with and receives reports from Catering, Occupational Health, Environmental Services and Facilities Design, and Engineering Departments (including input into all building and engineering projects).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Has formal links with and receives regular reports from Catering, Occupational Health, Environmental Services and Facilities Design, and Engineering Departments (including input into all building and engineering projects).</td>
<td>- Has formal links with and receives regular reports from Catering, Occupational Health, Environmental Services and Facilities Design, and Engineering Departments (including input into all building and engineering projects).</td>
<td>- May exercise option to use external experts for ad-hoc consultation including with Catering, Occupational Health, Environmental Services and Facilities Design, and Engineering Departments (including input into all building and engineering projects).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEVEL</td>
<td>LEVEL 1 E.g. Principal referral and specialist women’s and children’s hospitals</td>
<td>LEVEL 2 E.g. Large Hospital</td>
<td>LEVEL 3 E.g. Medium Hospital</td>
<td>LEVEL 4 E.g. Small Hospital</td>
<td>LEVEL 5 E.g. Day Only Procedure Centre</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>SECTION 3: Performance Improvement/ Research</td>
<td>• Serves as quality improvement (QI) team member and collaborates with Quality Improvement Unit or equivalent to initiate QI special projects as needed • Advanced QI processes (e.g. PDSA, SPC charts, Six Sigma and Lean Methodologies) are used where they add value. • Outcomes of IC education are evaluated (e.g. through either pre/post tests, compliance monitoring or observation of behaviour change). • Proven targeted HAI prevention interventions are routinely implemented to reduce specific endemic and epidemic HAI rates.</td>
<td>• Consults to QI team and initiates QI special projects as needed • May use advanced QI processes, where they add value. • Proven targeted interventions are implemented as needed to decrease specific endemic and epidemic HAI rates.</td>
<td>• Initiates QI special projects as needed. • Proven targeted interventions are implemented as possible to decrease the risk of specific HAIs.</td>
<td>• Initiates QI special projects as needed • May implement proven targeted interventions to decrease the risk of specific HAIs.</td>
<td>• Initiates QI special projects as needed. • May implement proven targeted interventions to decrease the risk of specific HAIs.</td>
</tr>
<tr>
<td>LEVEL</td>
<td>LEVEL 1</td>
<td>LEVEL 2</td>
<td>LEVEL 3</td>
<td>LEVEL 4</td>
<td>LEVEL 5</td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td>E.g. Principal referral and specialist women’s and children’s hospitals</td>
<td>E.g. Large Hospital</td>
<td>E.g. Medium Hospital</td>
<td>E.g. Small Hospital</td>
<td>E.g. Day Only Procedure Centre</td>
</tr>
<tr>
<td>SECTION 4: Other</td>
<td>• At least one FTE ICP has at least 5 years FTE IC Program experience.</td>
<td>• Preferable that at least one ICP has at least 3 years IC Program experience</td>
<td>• Preferable that at least one ICP has at least 18 months IC Program experience</td>
<td>• ICP has option to seek AICA credential or formal, post-graduate infection prevention qualification or equivalent</td>
<td>• ICP has option to seek AICA credential or formal, post-graduate infection prevention qualification or equivalent</td>
</tr>
<tr>
<td></td>
<td>• Formal, structured mentoring (from either an internal or external experienced peer who hold AICA Credential or from peer with formal, post-graduate infection prevention qualification or equivalent) is available for all ICP with less than 2 years IC Program experience.</td>
<td>• Is provided with formal, structured mentoring (from either an internal or external experienced peer who holds AICA Credential or formal, post-graduate infection prevention qualification or equivalent) if ICP has less than 18 months IC Program experience.</td>
<td>• Can opt to receive formal, structured mentoring (from either an internal or external experienced peer who holds AICA Credential or formal, post-graduate infection prevention qualification or equivalent) if ICP has less than 1 years IC Program experience.</td>
<td>• Relationship is established between hospital and state/national professional body to seek advice when required.</td>
<td>• Relationship is established between hospital and state/national professional body to seek advice when required.</td>
</tr>
<tr>
<td></td>
<td>• All ICP with more than 2 years experience hold or are working towards an AICA credential or formal, post-graduate infection prevention qualification or equivalent.</td>
<td>• All ICP hold, intend to or are working towards AICA credential or formal, post-graduate infection prevention qualification or equivalent.</td>
<td>• ICP is strongly encouraged to seek AICA credential or formal, post-graduate infection prevention qualification or equivalent.</td>
<td>• Access to a credentialed ICP provider/consultant is available if needed.</td>
<td>• Access to a credentialed ICP provider/consultant is available if needed.</td>
</tr>
</tbody>
</table>

**GLOSSARY/ LIST OF ABBREVIATIONS**

- **AICA**: Australian Infection Control Association Inc
- **HAI**: Healthcare associated Infection Control
- **ICP**: Infection Control Professional/Practitioner/Consultant
- **IC**: Infection Control and Prevention