Infection Control Management Plan – Development Guide

Department of Health Guideline – V1.1 August 2025

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An electronic version of this document is available at: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/infection-prevention/management-plans-guidance/icmp

Disclaimer

Contents

Document Scope

This document provides guidance for owners and operators of healthcare facilities as defined by chapter 4 of the *Public Health Act 2005* (Qld) (the Act) on infection risk and management issues that are likely to be encountered in healthcare facilities. Healthcare services are rapidly expanding in the range of services they offer in response to technological advancements and patient demand.

Therefore, this document refers to infectious risks in general and does not include specific information relating to every healthcare activity and/or type of healthcare facility. The owner or operator of a healthcare facility must critically assess and identify all risks associated with any activity undertaken within that healthcare facility.

Infection control management plan (ICMP)

The purpose of developing an ICMP is to prevent or minimise the risk of infection in relation to the provision of declared health services at a healthcare facility, for:

- persons receiving services at the facility
- persons employed or engaged at the facility
- other persons at risk of infection at the facility.

Chapter 4 of the Act requires a person involved in the provision of declared health services, as defined under the Act, to take reasonable precautions and care to minimise the risk of infection to other persons. A declared health service is defined in the Act as a service that is intended to maintain, improve or restore a person's health AND involves an invasive procedure or activity that exposes the person, or another person, to blood or another bodily fluid.

All healthcare facilities that provide declared health services as defined under the Act must have an existing ICMP and the onus for its development and implementation rests with the operator of the healthcare facility. If the operator of the facility intends to provide a declared health service not identified in an existing ICMP, the operator must review and amend the ICMP to address the infection risks associated with the service prior to its provision. New healthcare facilities must have an ICMP prior to providing declared health services.

Chapter 4 (s155)[1] of the Act states that an ICMP must include the following:

- identify the infection risks associated with the provision of declared health services undertaken at the facility
- detail the measures to be taken to prevent or minimise the infection risks
- state how the operator is to monitor and review the implementation and effectiveness of measures undertaken to reduce infection risks
- include details about the provision of training in relation to the ICMP for persons employed or otherwise engaged at the facility
- be reviewed and updated before offering new declared health services
- state how often it is to be reviewed (not more than one year)
- additional person, other than the owner/operator must be listed if they also hold responsibility for the provision of advice and/or monitoring the effectiveness of the ICMP.

The importance of an ICMP in delivery of high-quality patient care

A facility infection control program should be structured, implemented and managed to:

1. Reduce the incidence and risk of preventable healthcare associated infection.
2. Prevent infection transmission within healthcare facilities and to the community at large.
3. Create an organisational framework that promotes the use of resources for the delivery of safe and cost-effective healthcare services.

The facility Infection Control Management Plan details infection risks and strategies to minimise risks for services that the healthcare facility provides.

Ensuring compliance

The object of the *Public Health Act 2005* is to protect and promote the health of the Queensland public. One aspect of the Act (Chapter 4) imposes obligations on persons and some healthcare facilities that provide declared health services to minimise infection risks. Administration of the Act falls to Queensland Health.

Section 390 of the Act provides authority for a Public Health Unit authorised person to enter a healthcare facility to investigate a complaint or monitor compliance with the Act. When deemed necessary the authorised person may undertake appropriate action to address an infection risk or an identified non-compliance with the requirements of the Act.

In this instance, an authorised person may ask to see the facility ICMP. They may take a copy of the ICMP and other supporting documentation for review. The ICMP should include detailed information about infection risk management strategies relevant to the declared health services being delivered within the facility.

An authorised person may ask questions of the operator and staff about infection control practices and take photographs of the premises. An authorised person is not permitted to enter any part of the facility where a patient is being interviewed, assessed or receiving treatment by a health practitioner.

On entering the premises, the authorised person must:

- produce or display the authorised person's identity card for the occupier's
- inspection; and
- inform the occupier about the reason for entry.

Non-compliance with Chapter 4 of the Public Health Act

Queensland Health can appoint appropriate staff as 'authorised persons' under the *Public Health Act 2005* (the Act). These authorised persons have the authority to enter a healthcare facility to determine whether reasonable precautions and care are being undertaken at the facility to minimise infection risks for patients, staff or other persons at risk of infection at the facility (e.g. a parent who is present while their child undergoes a procedure). An authorised person may enter the healthcare facility to investigate a complaint regarding infection control risks or as a part of a regulatory compliance program to determine the level of compliance with the requirements of the Act.

Where infection control risks are not being appropriately managed, the authorised person may undertake appropriate action to address the infection risk or identified non-compliance with the requirements of the Act. The regulatory action undertaken will depend upon the scope and seriousness of the non-compliances identified. This could include:

- requiring the infection control management plan to be amended
- issuing an 'improvement notice' to address identified non-compliances
- where there is a serious risk of harm to a person, issuing a 'directions notice' to
- require the healthcare facility to stop providing declared health services at the facility
- a prosecution for breaches of the Act.

The ten core elements in an ICMP

ICMP No.	Core Element
ICMP1	Handwashing and hand hygiene
ICMP2	Personal protective equipment
ICMP3	Management of blood/body fluid exposures
ICMP4	Infection control and employee health
ICMP5	Immunisation
ICMP6	Environmental hygiene
ICMP7	Pre-treatment assessment of infection control risk
ICMP8	Appropriate use of single-use medical devices and reprocessing of reusable medical devices
ICMP9	Delegation of responsibility for infection control
IMCP10	Process for the investigation of infection control incidents

Steps in developing an ICMP

An ICMP requires the owner or the operator of a healthcare facility to identify each infection control risk and outline a plan of action to minimise these risks. Risks may include, but are not limited to:

- transmission of infection from contaminated hands or objects
- direct exposure to blood or bodily fluids
- exposure to a vaccine preventable disease
- cross-infection and direct exposure to infectious droplets or aerosols from
- patients/clients with symptoms of communicable diseases, e.g. influenza and measles
- transmission of infection due to incorrect or inappropriate cleaning, disinfection or sterilization of re-useable medical devices or incorrect use of single-use medical items.

Resources and information to support development of an ICMP

The requirements for a declared health service providers in relation to ICMPs is explained on the Queensland Health website at: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/infection-prevention/management-plans-guidance/icmp

This webpage also provides two ICMP templates:

- Hospital Infection Control Management Plan Template
- Non-hospital Infection Control Management Plan Template

To support the development of an ICMP Appendix 1 contains infection prevention and control fundamentals. The source for these fundamentals is the Australian Guideline for the Prevention and Control of Infection in Healthcare (2024), available online on the Australian Commission on Safety and Quality in Healthcare website at: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-guidelines-prevention-and-control-infection-healthcare

Developing the ICMP – 7 steps

How to develop the ICMP

The aim of this section is to step through what needs to be included in the ICMP (7 steps).
The activities in this section will help the person responsible to think through what infection control strategies need to be in place to ensure safe practice and minimise the risk of transmission of infection between persons in the facility. The activities will also help the person responsible to complete the documentation necessary to meet the minimum requirements of an ICMP as specified in the legislation.

Step 1: Who is the owner/operator of the healthcare facility?

There are certain obligations on owners and operators of healthcare facilities. Establish who the owner of the healthcare facility is, whether there is a separate operator, or whether the owner and operator are the same person.

The owner of the healthcare facility must:

- Ensure that the ICMP meets the legislative requirements of the Act.
- Ensure that declared health services are provided in compliance with the ICMP;
- Ensure the operator of the facility reviews the effectiveness and implementation of the ICMP at least yearly.

Operators, including those owners who are also the operator, of healthcare facilities must:

- Develop and implement an ICMP before declared health services are provided.
- Keep a copy of the ICMP in a readily accessible place to people engaged in the facility,
- Sign and date the ICMP, and
- Sign and date the ICMP each time it is reviewed
- Review the effectiveness and implementation of the ICMP at least yearly.
- If the operator of the facility intends to provide a declared health service not identified in an existing ICMP, the operator must review and amend the ICMP to address the infection risks associated with the service prior to its provision.

The owner is responsible for the work practices of all people delivering declared health services to clients. The owner may be a company entity.

The operator of a healthcare facility is the person who has the day-to-day operation and control of the facility. If the owner and operator are separate people, or there are multiple operators within a larger organisation (such as where a single facility may have multiple sites), then both the owner and the operator/s are responsible for ensuring the safety of the public from an infection control perspective and to minimise risk in the workplace.

Activity 1

Who is the owner of the healthcare facility? There may be more than one owner or it may be a company entity.

Who is the operator of the healthcare facility? The owner may also be the operator or there may be multiple operators.

Owner/s	Operators

Step 2: Services offered by the healthcare facility or service.

A healthcare facility or service provider may offer a range of services, some of which may be defined as ‘a declared health service’ according to the Act and some may not.

A declared health service is one that is intended to maintain, improve or restore a person’s health AND involves an invasive procedure or activity that exposes the person, or another person, to blood or another bodily fluid. An invasive procedure is one involving the insertion of an instrument, appliance or other object into human tissue, organs, body cavities or body orifices that exposes the person or another person to blood or another bodily fluid.

For example, noting these examples are not exhaustive lists for these types of healthcare providers:

- A dental surgeon may list the following procedures with an infection risk (invasive and exposure to blood and body fluids) that need to be managed in the ICMP including dental extractions, dental restorations, dental implants, and gum surgery.
- A podiatrist may list foot surgery, toenail excision and injections.
- A homebirth midwifery service may list normal delivery, episiotomy, injections, venepuncture, IV insertion, heel puncture, blood glucose monitoring, suturing, bladder catheterisation.
- A home nursing service would include some of the same procedures as the homebirth midwifery service (refer to previous point) and may also include other procedures such as wound debridement, surgical drain removal etc.
- An acupuncturist may list needle insertion as an invasive procedure.
- A medical radiation service may list injections, intra-cavity ultrasound, biopsy, endoscopy.

Remember, the above are only examples and not a definitive list. If you are unsure as to whether a procedure is invasive or not or if a procedure is a declared health service seek expert guidance.

Services and level of risk

Some professional peak bodies have developed resources that may assist health practitioners with developing an ICMP. The Australian Dental Association and the Royal Australian College of General Practitioners, have guidelines that cover aspects of infection management for the types of invasive procedures likely to be delivered in their settings.

It is essential that the ICMP identify the infection risks associated with the provision of declared health services at their facility. Listing the individual or types of declared health services will assist in identifying the infection risks associated with their provision.

The ICMP must be reviewed and updated if a new type of service is to be provided, even if the infection risk and management strategies are likely to be the same as for services already being offered. If a new procedure involves an increased level of infection risk, then appropriate management strategies will need to be added.

Activity 2

What invasive procedures or activities that may expose an individual to blood or bodily fluids are offered as part of the healthcare service?

No.	Invasive procedures or activities undertaken by the healthcare service
1.	
2.	
3.	
4.	

Step 3: Assess the level of risk

The majority of procedures undertaken in both hospital and non-hospital settings are considered low risk in terms of transmission of infection. However, any invasive procedure that interrupts the integrity of the skin or mucous membrane puts the patient at risk of infection and exposes others to potentially infectious blood and bodily fluids. Healthcare workers (and others) are at risk of contracting blood borne viruses such as hepatitis B, hepatitis C and HIV from patient interaction if standard precautions for infection prevention are not adhered to.

Each procedure has a level of risk associated with it. Healthcare facility personnel need to be aware of the risks associated with each of the procedures that they undertake, in the context in which the healthcare is delivered, and have strategies that address and manage the risks adequately.

A decision about level of risk and ways to manage risks will be made by the clinician at the time of each encounter. Many of the risks that are identified will apply across all the procedures: e.g. risk of infection transmission from contaminated hands. Other risks may be procedure specific.

Standard precautions are best practice. Implementing standard precautions in all invasive interactions with patients is the recommended infection management approach. **Standard precautions protect everyone.**

Patients and visitors to the healthcare facility share a responsibility to minimise transmission of infections between themselves and other people. They may need to be reminded to follow hand hygiene, respiratory hygiene (including correct disposal of tissues) and cough etiquette. They should be encouraged to inform staff if they have an illness that may put others at risk.

Resources

Please read this section in conjunction with the following resources:

- National Health and Medical Research Council, Australian Guidelines for the Prevention and Control of Infection in Healthcare 2024: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-guidelines-prevention-and-control-infection-healthcare

Australian/New Zealand Standard on Risk Management AS/NZS ISO 31000:2009

Workplace Health and Safety Queensland: How to manage work health and safety risks Code of Practice 2011: https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0022/72634/how-to-manage-work-health-and-safety-risks-cop-2021.pdf

Activity 3

List the infection control risks associated with any invasive procedures that are undertaken in the facility or during service provision.

No.	Infection control risks identified
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	*[add more lines if necessary]*

Analyse the level of risk

Infection risk has two components:

1. the likelihood of an injury (or exposure)
2. the seriousness of the consequences (or impact).

The likelihood of risk can range from rare to almost certain and the impact or consequences can range from insignificant to catastrophic. There is a matrix commonly in use to help you to assess the level of risk. Think about the source of the risk, the consequences, the likelihood of the consequences occurring and any other factors affecting the risk, such as any management strategies that are already in place.

Figure 1: Risk analysis matrix

Likelihood	Consequences				
	Negligible	Minor	Moderate	Major	Catastrophic
Almost Certain	Medium	High	High	Extreme	Extreme
Likely	Medium	Medium	High	High	Extreme
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Low	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Risk rating	Response to risk
Low risk	Manage by routine procedures
Medium risk	Manage by specific monitoring or audit procedures
High risk	This is serious and must be addressed immediately
Extreme risk	The magnitude of the consequences of an event, should it occur, and the likelihood of that event occurring, are assessed in the context of the effectiveness of existing strategies and controls

Source - Australian Guidelines for the Prevention and Control of Infection in Healthcare (2024) - National Health and Medical Research Council (NHMRC)

Assessing the level of risk

To illustrate how to assess the level of risk needlestick injury (NSI) will be used as an example.

Occupational exposure to blood borne viruses is a risk in any clinical practice that involves an invasive procedure. Large scale studies in the United States have shown that the transmission rate of HIV through NSI from a known HIV infected person to a healthcare worker is less than 0.2% - that is 2/1000 injuries (Wicker et al. 2008). The risk would be zero from a non-HIV infected patient. The transmission rate of HCV (hepatitis C virus) through NSI from a known HCV infected person is 1.8% but HBV (hepatitis B virus) ranges from 1–30% depending on the actual HBV status of the patient (Zingman 2013).

Even though the risk of transmission of a blood borne virus through an NSI is **rare**, the consequence (or impact) of this transmission may be considered **major**. Therefore, the overall risk is rated as **medium** (pink circle in Figure 2). The management strategy for assessed level of risk for NSI would need to be adequate i.e. specific monitoring or auditing and be evident in the ICMP.

Figure 2: NSI Risk analysis using matrix

Likelihood	Consequences				
	Negligible	Minor	Moderate	Major	Catastrophic
Almost Certain	Medium	High	High	Extreme	Extreme
Likely	Medium	Medium	High	High	Extreme
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Low	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

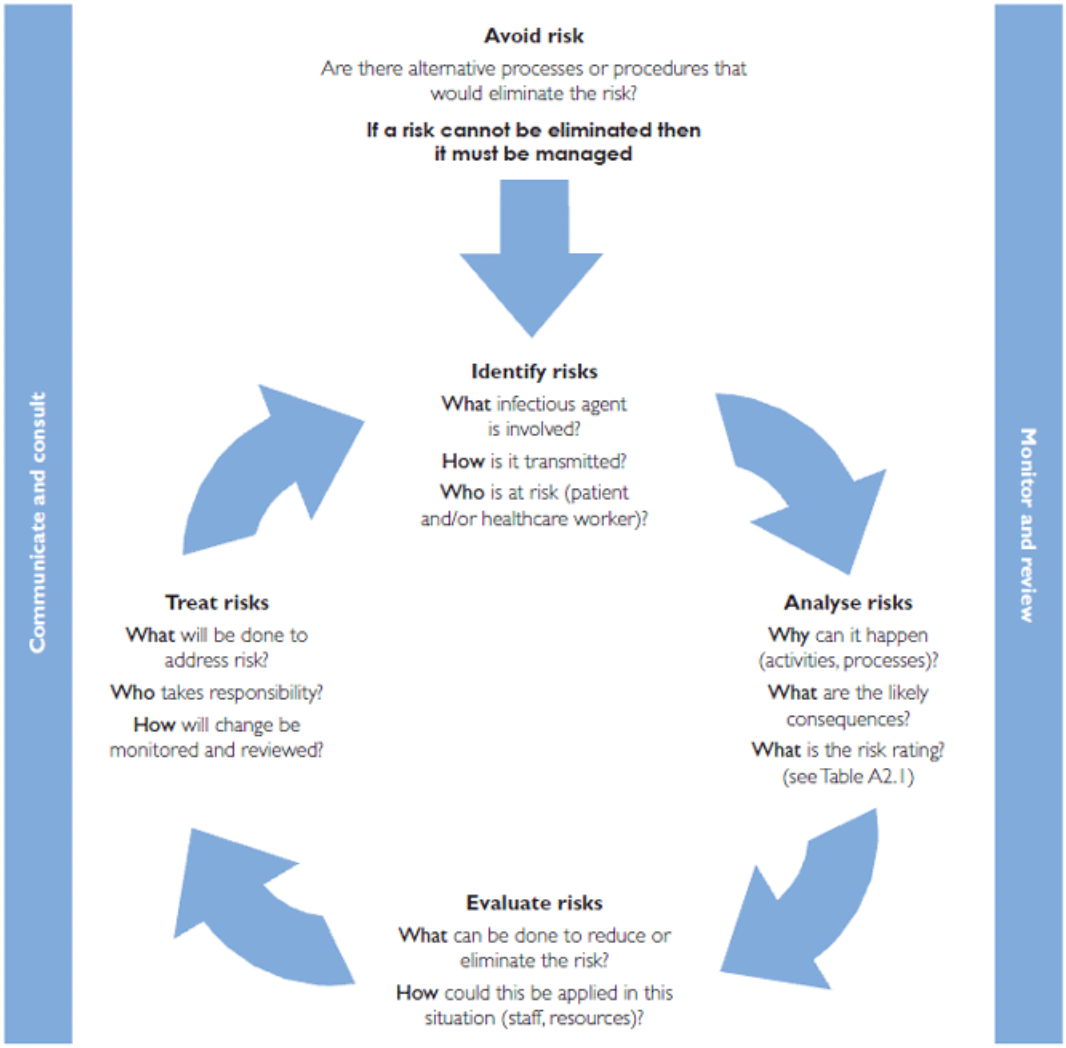
Risk rating	Response to risk
Low risk	Manage by routine procedures
Medium risk	Manage by specific monitoring or audit procedures
High risk	This is serious and must be addressed immediately
Extreme risk	The magnitude of the consequences of an event, should it occur, and the likelihood of that event occurring, are assessed in the context of the effectiveness of existing strategies and controls

The basis of good infection control practice is to assume that everyone is potentially infectious. Pre-procedure screening of patients for blood borne viruses is not routine so **standard precautions are essential during every clinical encounter.**

Step 4: Manage the risk

The following flowchart outlines the thinking process about how best to manage infection control risks in the healthcare facility.

Figure 3: Risk management flowchart



Risk management follows an established hierarchy of controls. See Table 1 that lists the hierarchy of control and gives examples of how effective risk management may be demonstrated in relation to the risk of infection transmission through needlestick injury and other general hazards.

Table 1: Risk management hierarchy of controls and examples in relation to needlestick injury and other general hazards

No.	Hierarchy of controls	Management strategy
1.	Eliminate the hazard or threat	Do not use sharps
2.	Minimise or replace the hazard or threat	Vaccination of staff (for example: vaccination against hepatitis B)
3.	Control the risk using engineered devices that do not require human actuation	Use of Safety engineered devices
4.	Control the risk of using devices that require human actuation	Use of Safety engineered devices
5.	Control the risk with procedures	Aseptic non-touch technique for the disposal of sharps
6.	Control the risk with personal protective equipment	Appropriate use of gloves, apron/gown, eye protection
7.	Control the risk through administrative means	• Staff managing sterilization processes are adequately trained • Cleaning schedules documented and followed
8.	Control the risk with warnings and by raising awareness	• Hand hygiene posters displayed • Alcohol based hand rub available at point of care • Cough etiquette displayed

Activity 4

Using the list of identified infection transmission risks that are listed in Activity 3, what measures could be put in place to eliminate or minimise the risk? Use information supplied in Section 2 of this booklet—where Standard Precautions are explained in more detail—to determine appropriate management strategies.

No.	Identified risk	Risk management strategy
1.		
2.		
3.		
4.		
5.	*[add more lines if necessary]*	

Step 5: Monitor risk management measures

The ICMP should include evidence that infection management strategies are working. Measures may include observation, surveys and inspections, outcomes and critical incident reviews, and audits. How and when monitoring will take place should be included in the ICMP.

A healthcare facility or service could utilise one of the many self-audit tools that are available online to guide monitoring and evaluation of infection management practice (such as, the Dental Board of Australia's self-audit tool). Self-audit tools help owner/operators to recognise what is working well and to identify areas where infection control practice can be improved. Monitoring can be carried out on a specific practice, procedure, or in a discrete clinical area. If a problem is identified additional risk management strategies may be considered, such as new equipment, new procedures, or education and training of staff followed by additional surveillance. If the same audit tool is used pre-and post-training, then changes in outcomes can be measured.

Some professional peak bodies provide infection management guidelines for practitioners/members and audit tools to monitor practice against minimum infection control standards.

Table 2: Risk management strategies and types of evidence

Practice	Risk management strategy	Examples of evidence
Hand hygiene	• Alcohol based hand rub available at point of care • Handwashing facilities available • Posters • Staff training • Peer review of practice	• Hand-rub invoices • Audit records
Use of PPE	• Policy • Peer review of practice (3 monthly)	• Documentation • Staff training records • Audit records
Environmental cleaning	• Policy • Procedures • Environment cleaning schedules • Quality cleaning products and equipment	• Documentation • Staff training records • Daily/weekly schedules and sign-off
Handling of sharps	• Policy • Sharps containers at point of care • Peer review of practice (6 monthly)	• Audit records
Reprocessing of medical equipment	• Trained staff • Functional equipment • Policies and procedures	• Sterilization equipment records • Staff training records
Respiratory hygiene and cough etiquette	• Posters • Placement of tissues, hand rub and waste bins • Regular audits • Cleaning procedures	• Audit records
Aseptic technique	• Peer review – Observed practice • Staff training	• Audit records
Waste management	• Policies • Procedures • Trained staff • Review of waste segregation practices	• Minutes of meetings • Audit records
Employee health	• Orientation • Safe work culture • HR policies	• Staff vaccination records • Sick leave records
Management of incidents/exposures	• Orientation • Safe work culture • HR policies • Response plan	• Meeting minutes • Needlestick injury records
Patient pre-treatment assessment	• Trained staff • Triage • No show policies for ill patients	• Patient appointments and ‘no-shows’ records

Linen management	• Policies/procedures • Industry standards	• Laundry invoices • Contractor credentials
Hand hygiene	• Alcohol based hand rub available at point of care • Handwashing facilities available • Posters • Staff training • Peer review of practice	• Hand-rub invoices • Audit records
Use of PPE	• Policy • Peer review of practice (3 monthly)	• Documentation • Staff training records • Audit records
Environmental cleaning	• Policy/procedures • Environmental cleaning schedules • Quality cleaning products and equipment	• Documentation • Staff training records • Daily/weekly schedules and sign-off

Activity 5

List all the **risk management strategies** you have in place and the types of evidence you collect in the facility to manage the following infection risks.

Practice	Risk management strategy	Evidence
Transmission of infectious illness between people by direct contact		
Transmission of droplet spread infection between people		
Exposure to infection from blood and body fluids		
Exposure to infection from contaminated environment or equipment		

Step 6. Staff training

Effective infection control practice in a healthcare setting requires ensuring that people have both the knowledge, and the skills required to minimise risk. Healthcare facilities should provide specific education and training for all persons employed or otherwise engaged at the facility including healthcare workers, non-clinical staff, students, etc. about infection prevention and control principles, any policies and procedures that are relevant to the facility.

This information should be provided in the context of staff roles in the organisation or practice, and with a focus on respecting and maintaining patient confidentiality always.

The aim of staff training is two-fold:

1. Inform healthcare workers and other staff about the infectious hazards they will face during their employment
2. educate them about their role and responsibilities in minimising the spread of infection to others. legislation (*Public Health Act 2005)* the obligation to minimise risk applies as follows:

"(1) persons involved in the provision of a declared health service must take reasonable precautions and care to minimise the risk of infection (the infection risk) to other persons."

At a minimum, all staff (clinical and non-clinical) should be educated about:

- modes of transmission of infectious agents
- risk identification, assessment and management strategies including standard and transmission-based precautions
- the importance of staff vaccination and the process for recording vaccination histories
- orientation to the physical work environment with a focus on its risks for infection
- safe work procedures
- correct use of standard precautions
- correct choice and use of PPE, including procedures for putting on and removing PPE
- appropriate attire (shoes/hair/nails/jewellery)
- hand hygiene practices
- levels of cleaning required for clinical areas and equipment
- how to deal with spills
- safe handling and disposal of sharps
- reporting requirements of incidents such as sharps injuries and exposures
- waste management
- antimicrobial stewardship (AMS) policy and practice.

Healthcare workers may also require job or task-specific education/training in:

- instrument cleaning and sterilization competency testing
- risks and prevention of multi-resistant organism transmission
- insertion and management of peripheral lines.

Training should be provided as part of orientation, with periodic updates and refresher courses as required for their specific jobs with refresher training and assessment of key skills annually. Additional training may be required when a different procedure or new equipment is introduced into practice. Records of training should be kept as evidence of ongoing infection control education.

Education strategies could include:

- educational meetings, presentations, workshops or and case discussions,
- printed or audio-visual resources
- presentations from visiting infection prevention and control expert
- continuing professional education available from peak bodies and professional associations
- on-line learning modules from government agencies, e.g. Australian Commission on Safety and Quality in Healthcare https://www.safetyandquality.gov.au/our- work/healthcare-associated-infection/infection-prevention-and-control-online- modules/

Activity 6

The practice manager of a busy dental surgery has developed the annual infection control training plan for the facility. The training plan includes hand hygiene training and assessment as part of the orientation for all new staff. The practice employs 3 full-time dentists (one of which is the practice owner), a part-time dentist, a dental hygienist, 5 dental assistants, 3 reception staff, 1 part-time accounts clerk, and the practice manager.

Note: This activity has been structured around a dental practice as an example. Positions itemised in the following table should be adjusted to reflect the staff actually employed in the healthcare facility.

Who should attend the annual refresher training for hand hygiene? Why or why not? (Tick all that apply)

Who?	Tick if applies	Why or why not?
Practice owner	☐	
Full-time dentist	☐	
Part-time dentist	☐	
Dental hygienist	☐	
Dental assistant	☐	
Reception staff	☐	
Accounts clerk	☐	
Practice manager	☐	

Activity 7

Suggest a reasonable strategy to effectively train and assess staff hand hygiene practice.

Training:
Assessment:

Activity 8

Who should attend the training relating to the purchase of a new sterilising unit? (tick all that apply)

Note: This activity has been structured around a dental practice as an example. Please adjust the positions in the table to reflect the staff employed in the healthcare facility.

Who?	Tick if applies	Why or why not?
Practice owner	☐	
Full-time dentist	☐	
Part-time dentist	☐	
Dental hygienist	☐	
Dental assistant	☐	
Reception staff	☐	
Accounts clerk	☐	
Practice manager	☐	

Activity 9

Suggest a reasonable strategy to effectively train and assess sterilising operation and practice.

Training:
Assessment:

Activity 10

Here is a list of other people who are not regular staff of the healthcare facility who might need to be included in the infection control training plan. Provide a rationale as to why infection control training for them is necessary.

Who?	Why?
Students	Will be developing essential clinical skills
Contractors	
Cleaners	
Work Experience	
Locum staff (relieving staff)	

Step 7. Responsibility for Infection Risk Management

Chapter 4 of the *Public Health Act 2005* is clear. The responsibility for infection risk management in healthcare facilities sits with the owner, owner/operator and the operator of the facility.

The owner:

The owner of the facility may or may not be the operator. Section 153 of the *Public Health Act 2005* states that:

"…if the owner and the operator of a healthcare facility are different persons: The owner must ensure—

(a) there is an ICMP for the healthcare facility that complies with section 155 [1] and includes matters prescribed under section 155 [2]

(a) declared health services provided at the healthcare facility are provided in compliance with the ICMP; and

(c) the operator reviews the effectiveness and implementation of the ICMP at intervals of not more than 1 year".

For example: a large national healthcare and insurance company owns at least 15 dental practices in Queensland. As the owners of the business the senior management have overall responsibility for the quality of care that is provided by all sections of the company.

The operator:

In relation to each healthcare delivery site, the person who operates the practice is directly responsible for ensuring staff and patient safety in that practice. That person will most likely be either the senior clinician or the practice manager. In addition, all APHRA registered health professionals (doctors, midwives, dentists, podiatrists, acupuncturists, chiropractors, physiotherapists, occupational therapists, optometrists, osteopaths, paramedics, pharmacists, radiographers and Aboriginal and Torres Strait Islander Health Practitioners) have a professional responsibility (duty of care) to patients that includes protecting patients from harm.

The operator of the facility is defined as: "the person who has the day-to-day operation and control of the facility".

Section 155 of the *Public Health Act 2005* states that:

(3) The ICMP must be written in a way likely to be easily understood by persons employed or otherwise engaged at the facility.

(4) The operator of the facility must—

   a. sign and date the ICMP; and

   b. sign and date the ICMP each time it is reviewed.

(5) The operator must keep a copy of the ICMP at a place at the facility that is readily accessible to persons employed or otherwise engaged at the facility.

(6) If, after developing an ICMP for a healthcare facility, the operator of the facility intends to provide a declared health service not identified in the ICMP, the operator must, before providing the service, review and amend the ICMP to address the infection risks associated with the service.

(7) Workplace and work practices under Workplace Health & Safety legislation and to comply with safety policies and procedures of the facility.

Remember that the owner/s and operator/s of the health facility were identified in **Step 1 (Activity 1)** in this workbook. Consider who is accountable for what activities in terms of infection control management and who is responsible for the ICMP and its regular review.

Activity 11

Whose signature must appear (as the responsible person) on the ICMP document if the facility is owned by a:

Owned by:	Signed by:
Large national company?	
Business partnership between 4 people?	
Sole owner/operator (health professional)?	
(Non-clinical) practice manager?	
Family trust?	

Activity 12

Last two instances when the ICMP should be reviewed and by whom?

Instances to review ICMP:	By Whom?

Further information

For further information refer to the following:

1. National Health and Medical Research Council (2019) Australian Guidelines for the Prevention and Control of Infection in Healthcare. Canberra: Commonwealth of Australia. Access at: www.nhmrc.gov.au/health-advice/public-health/preventing-infection
2. Chinese Medicine Board of Australia, 2023, Infection prevention and control guidelines for acupuncture practice. Access at: https://www.chinesemedicineboard.gov.au/Codes-Guidelines/Infection-prevention.aspx
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Appendix 1 – Infection prevention and control fundamentals

Healthcare-associated infections (HAIs) can occur in any healthcare setting and during any type of clinical service delivery. Preventing and controlling infections is a fundamental component of safe and high-quality care. It should be integrated into everyday clinical practice and not viewed as a set of procedures reserved for specific situations or activities.

This document provides an overview of the core principles of infection prevention and control. Whilst it outlines foundational concepts, it is not intended to serve as a comprehensive guide to all aspects of infection control practice. Instead, it supports the consistent application of essential strategies across diverse healthcare environments.

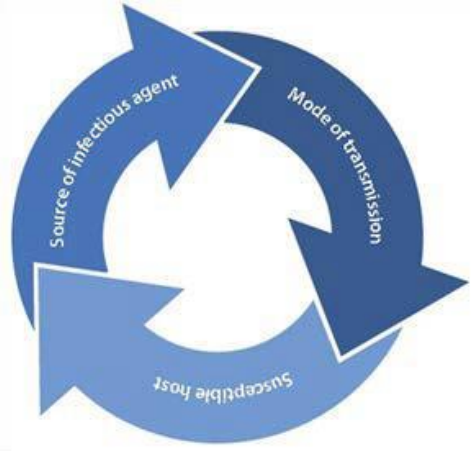
The Infection prevention and control fundamentals included are:

- Chain of infection & hierarchy of control
- Standard precautions
- Transmission-based precautions
- Reprocessing of reusable medical devices
- Respiratory hygiene and cough etiquette
- Aseptic technique
- Waste management
- Exposure to blood/body fluids

Chain of Infection

For infectious agents to be transmitted three main elements are required to be present.

Figure 4: Chain of infection (NHMRC 2010)



Three Essential Elements
Source of infectious agent
Mode of transmission
Susceptible host

Patients, healthcare workers and visitors are most likely sources of infectious agents. These individuals may be:

- displaying symptoms of the infectious agent
- in the incubation period of the infection and show no symptoms
- chronic carriers of an infectious agent with or without symptoms.

Other sources of infection may include but are not limited to, air, water, or medical equipment and devices that have been contaminated.

Mode of transmission

Contact: may be direct; transferred from one person to another or indirect transfer occurring from an environmental surface.

For example, direct contact may involve the blood from one person having contact with another person's bloodstream via, a penetrating injury or a mucosa splash.

Indirect contact occurs, for example, when a person coughs or sneezes into their hand and then touches a door handle to open the door. The door handle is now contaminated.

Indirect contact occurs when the next person touches the door handle and then their face.

Droplet: Can occur when an infected person coughs, sneezes or talks or when certain procedures are performed (e.g. respiratory function test or sputum sample collection). Transmission may follow when the droplets are expelled from the infected person travel through the air and contact the mucosa of another person. The distribution of infection via droplets is limited by the force of the explosion and gravity.

Airborne: Small-particle aerosols are created through breathing, talking, coughing or sneezing. Due to the small particle size these infective agents may be dispersed over long distances and remain airborne for an extended period (compared to droplets). Transmission occurs when the susceptible host inhales the particles. Examples of infectious agents that may be transmitted via inhalation include: measles virus, chicken pox virus, and tuberculosis (TB).

Vehicle: Infection may also be transmitted via other common sources such as contaminated food, water, devices or equipment. These are termed 'vehicles'.

Susceptible host

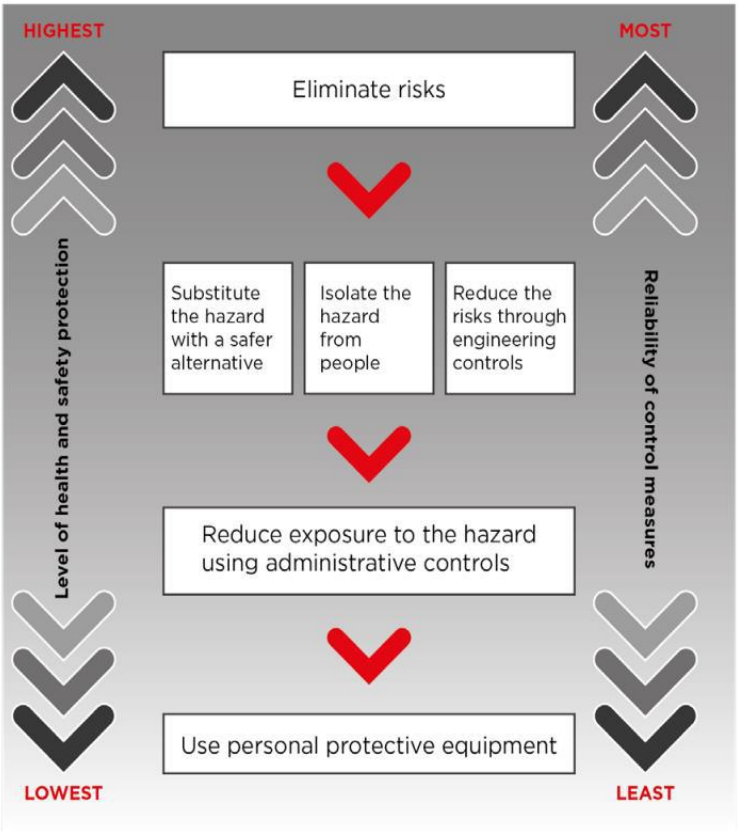
A number of factors can impact on susceptibility to infectious organisms. These include: specific immunity, age, health status, and genetics. Specific immunity can render a patient or healthcare worker non-susceptible to a particular disease. Immunity may be generated by prior infection or vaccination. Advancing age and co-morbidity can increase susceptibility to infection. Very young patients may also be at particular risk.

The chain of infection may be broken by implementing standard and transmission-based precautions.

Hierarchy of Control

The hierarchy of controls is a model used in work health and safety management (Figure 5) to control hazards that ranks controls from most to least reliable. If it is not reasonably practical to eliminate risks, then risks must be minimised, as far as is reasonably practicable, by using one or a combination of substitution, isolation, or engineering controls, followed by administrative controls and personal protective equipment (PPE).

Figure 5. Hierarchy of Control



Standard Precautions

Standard precautions refer to the work practices that are applied to all patient interactions regardless of their perceived or confirmed infectious status. This ensures a basic standardised level of infection prevention and control. Standard precautions are used by healthcare workers to prevent or reduce the risk of transmission of infectious agent from:

- a person to another person
- a person to the environment
- the environment to a person.

Standard precaution strategies include, but are not limited to: hand hygiene, personal protective equipment, environmental cleaning, sharps-handling and disposal, reprocessing of reusable medical devices.

Hand hygiene

Hand hygiene is one of the principal strategies to limiting the transmission of infection. Hand hygiene is required to be performed before and after every occurrence of patient contact or contact with the patient's environment. **This includes immediately prior to glove placement and upon removing of gloves.**

A range of hand hygiene products are available for use in a healthcare services environment, these include:

- Alcohol based hand rub – for use when hands are visibly clean.
- Surgical Alcohol based hand rub - for use prior to performing invasive surgical procedures.
- Plain soaps - for general routine/social contact and cleaning visibly soiled hands.
- Antimicrobial soaps - for use prior to performing invasive surgical procedures.
- Hand lotion – to protect the integrity of the skin, the use of a compatible hand lotion is suggested.

The correct hand hygiene product to be used is dependent upon the situation that has occurred or is about to occur. Hand hygiene products for clinical use are required to be registered with the Therapeutic Goods Administration (TGA).

Further information regarding hand hygiene is available from the National Hand Hygiene Initiative: https://www.safetyandquality.gov.au/our-work/infection-prevention-and-control/national-hand-hygiene-initiative

Personal protective equipment

Personal protective equipment (PPE) refers to an assortment of equipment that can be used individually or in combination to protect the mucous membranes, airways, skin and clothing from contact with infectious agents.

Personal protective equipment includes: surgical masks, protective eyewear and face shields, gloves, gowns, aprons.

Factors to be considered when choosing appropriate PPE are:

- probability of exposure to blood and body substances
- type of body substance involved
- probable type and probable route of transmission of infectious agents.

PPE is to be put on in a sequence that maintains sterile and clean fields. Remove PPE in a manner that reduces the risk of any contamination to the person and/or the surrounding environment.

The use of PPE alone is not enough, hand hygiene is required as part of the sequence when putting on and/or removing PPE.

PPE must conform to legislative, Australian Standard and/or industry standards or guidelines.

Environmental cleaning

Infectious agents may contaminate surfaces in any healthcare facility. As a risk management strategy, environmental surfaces should be decontaminated using the cleaning method aligned with the level of contamination and the item to be cleaned. To ensure that cleaning occurs on a regular basis, **a cleaning schedule** detailing the method of cleaning and the timeframe for completion should be implemented.

For routine environmental cleaning general surfaces may be divided into two types:

Minimal touch surfaces: Surfaces that have limited contact with hands. This includes areas like ceiling, floors, and non-clinical areas such as administration offices. These surfaces can be cleaned with a pH neutral detergent and water solution. It is recommended that dusting with a damp cloth is used over dry dusting or mopping. A damp cloth will limit the amount of dust and other possible microbes being inhaled.

Frequent touch surfaces: These are surfaces near the patient as well as frequently touched areas. The examples include but not limited to: doorknobs, light switches, and some wall areas. These areas of contamination are required to be risk assessed to decide the correct cleaning solution. If the risk has been identified as low a detergent and water solution is recommended. However, if the infection risk has been assessed as high the surfaces will require to be cleaned with detergent and water, followed by a disinfectant solution. Please ensure that the manufacturer's instructions are followed.

Environmental cleaning includes the cleaning of patient equipment that does not require sterilization. For cleaning of clinical equipment always follow the manufacturer's instructions.

Sharps-handling and disposal risk

The risks associated with the use of sharp devices in a healthcare facility relate to the possible injury and potential exposure to blood borne infectious agents. These include the blood borne viruses (BBV)—hepatitis B virus, hepatitis C virus and human immunodeficiency virus (HIV). **Injuries from needles and other sharp instruments carry the highest risk of potential BBV transmission in any healthcare facility.** Most sharps injuries can be prevented through effective handling and disposal of sharps.

Examples of devices that may be associated with a sharps injury:

- hollow bore sharps: disposable needles/syringes, injector pens
- non-hollow bore (solid) sharps: glass vials, dental probes, scalpel blades, suture needles, acupuncture needles, other sharp solid instruments.

Handling sharps

Precautions to prevent sharps injuries should be embedded in daily practice. These may include, but are not limited to:

- use of personal protective equipment
- establishing a neutral drop zone
- using instruments to retract tissues, to grasp needles, to load and unload scalpels
- avoid hand to hand passing of sharp instruments
- avoid re-capping needles
- availability of point of use sharps containers for immediate disposal of sharps
- care during the reprocessing of reusable medical devices.

Disposal of single-use sharps

The person who has used a disposable (single use) sharp instrument must be responsible for the safe management and disposal after use.

Single use disposable sharps are to be placed into a container that is compliant with Australian Standard 4031 or AS/NZS 4261. These containers are to be clearly labelled, puncture and leak proof.

The location of the sharps containers should be as close as practical to the patient treatment area, out of reach of children in a secure position, preferably wall mounted to prevent tipping.

Staff training

- Single-use sharp devices

All clinical staff should be trained in the healthcare facility's policies and procedures on the safe disposal of single use sharps. This includes the compliant sharps container being placed as close as practical to the point of use, and that the person that uses the sharp is disposing it into the sharps container.

- Reusable medical devices

All clinical staff should be trained in the procedure for safe handling of reusable medical devices. This includes the safe transfer of devices from the clinical environment to the reprocessing/sterilization area and correct PPE to handle devices throughout the reprocessing cycle.

Transmission based precautions

Transmission based precautions are applied in addition to standard precautions. These work practices are implemented where standard precautions alone may be insufficient to contain and prevent further infection.

Transmission based precautions should be tailored to the mode of transmission of the infectious agent.

A combination of approaches is necessary and may include the following:

- allocating a single room/space with a closing door to the patient
- wearing specific personal protective equipment
- providing patient dedicated equipment
- using TGA registered disinfectant- following manufacturer's instructions
- restricting movement of patient and healthcare worker.

In addition to these general requirements, the below are specific to the three (3) types of transmission-based precautions.

Transmission based precautions may include the following:

Contact precautions: include continued use of standard precautions, patient isolation, placement of PPE prior to entering the patient room (with attention to the placement of gowns and gloves), removal of PPE without causing environmental contamination, adherence to hand hygiene procedures, limited patient movement within the healthcare facility, special handling of patient equipment, environmental cleaning of the patient setting.

Droplet precautions: include continued use of standard precautions, patient isolation, placement of PPE prior to entering the patient room (with attention to the placement of surgical mask and contact with the patient environment), removal of PPE without causing environmental contamination, adherence to hand hygiene procedures, limited patient movement within the healthcare facility, special handling of patient equipment, environmental cleaning of the patient setting.

Airborne precautions: include continued use of standard precautions, patient isolation, placement of PPE prior to entering the patient room (with attention to the placement of a P2/N95 respirator), removal of PPE without causing environmental contamination, adherence to hand hygiene procedures, limited patient movement within the healthcare facility, special handling of patient equipment, environmental cleaning of the patient setting. In some clinical settings the use of a negative pressure room may reduce the transmission of infection.

Further information may be obtained from sections A1.2.2, B2, B3 and B5 of the Australian Guidelines for the Prevention and Control of Infection in Healthcare (NHMRC).

Reprocessing of reusable medical devices

Single-use items are never to be reprocessed. The packaging of single-use items will display the following symbol:


Single-use device symbol

However, equipment and devices designed for ‘single patient use’ can be used multiple times on the one patient. Single patient use devices may be reprocessed and reused on the same patient in accordance with the manufacturer’s instructions. Single patient use device packaging will not display the symbol shown above. Healthcare facilities should develop and implement local procedures relevant to their facility.

Any instrument or equipment that is intended to be used on multiple patients is required to be reprocessed. The level of reprocessing will depend on the procedure the item was used for; and the intended use of the item on future patients.

To identify the correct level of reprocessing required for an individual item, engagement with all relevant documents is necessary. These may include but are not limited to; manufacturer’s instructions and industry guidelines.

The NHMRC Guidelines (reference) identify three core elements to reprocessing:

Cleaning: is the removal of all foreign matter from the device; this includes non-organic and organic material. This is normally accomplished using detergent solution. Thorough removal of all matter from the device is essential, any organic or non-organic material that is left on the device will impede the disinfection and or sterilization processes that may follow.

Disinfection: is a process that uses thermal or chemical procedures to disinfect medical devices. Disinfection is not a sterilization process.

- **Thermal disinfection:** is a process that uses heat and water, at temperatures high enough to destroy infectious agents. An automated washer disinfector is the most common device used to achieve thermal disinfection.
- **Chemical Disinfection:** can be achieved with a compatible TGA registered clinical grade disinfectant. This may be used alone or in a thermal disinfector. However, whenever possible medical devices if possible are to be sterilized.

Sterilization: this process is intended to prevent disease transmission associated with the use of reusable medical devices. The most common method used in healthcare facilities is steam sterilization. Appropriate reprocessing systems are to be aligned with state and federal legislation. **Acceptable methods of sterilization Australia is either steam or dry heat sterilization.**

Details of acceptable sterilization practices, testing and supporting documentation can be found in AS 5369:2023, Reprocessing of reusable medical devices and other devices in health and non-health related facilities. AS 5369:2023 is designed for a wide range of facilities involved in the reprocessing of reusable medical devices and other devices.

These include:

- **Hospitals and healthcare facilities:** The standard is crucial for hospitals and clinics that rely on reusable medical devices for various procedures.
- **Dental practices**: Dental clinics benefit from the guidelines to help ensure that their instruments are properly sterilised.
- **Veterinary clinics**: Veterinary practices also use reusable medical devices that require stringent reprocessing to help ensure animal safety.
- **Non-medical facilities**: Facilities such as beauty salons and tattoo parlors that use reusable instruments can also adhere to the standard to maintain high hygiene standards.

AS 5369:2023 provides important guidelines for the reprocessing of reusable medical devices. The standard outlines the important steps and procedures to help ensure that devices are effectively cleaned, disinfected, and sterilised. It covers a wide range of devices used in medical and non-medical settings.

Key elements in AS 5369:2023 include:

- **Product families**: The new standard introduces a preliminary step for grouping devices into Product Families based on steam penetration resistance (SPR). This step involves determining the device's SPR, identifying the most challenging device to sterilise, and grouping devices accordingly.
- **Spaulding classification**: Devices are classified based on their intended use (Critical, Semi-critical, or Non-critical) before being assigned to a Product Family.
    - Critical devices must be sterilised.
    - Semi-critical devices, which come into contact with mucous membranes or non-intact skin, should be sterilised or high-level disinfected depending on the risk of infection and the nature of the device.
    - Non-critical devices require cleaning and low-level disinfection.
- **Validation and monitoring**: The standard emphasises the importance of conducting test loads to evaluate steam penetration and identify the master product for each Product Family. Performance qualification (PQ) tests should be conducted on groups of devices to help ensure effective sterilisation.

Respiratory hygiene and cough etiquette

To stop the spread of infection through coughing and sneezing, each facility should implement policies to limit droplet and airborne transmission. This is achieved by ensuring staff are trained in the following:

- Covering mouth and nose with a disposable single use tissue when coughing or sneezing.
- Coughing or sneezing into the inner elbow rather than using their hand.
- Using disposable tissue to contain secretions, blowing nose etc.
- Ensuring that the tissue is placed in the waste and hand hygiene is performed immediately.
- Hand hygiene performed after contact with respiratory secretions (contact with a tissue), this can be using soap and water or alcohol-based hand rub.

Supporting patients and visitors by:

- Offering to re-book an appointment for when they feel symptoms have passed (except where the appointment was originally booked to obtain treatment for the symptoms).
- Placing posters in waiting areas to raise awareness of respiratory hygiene and cough etiquette.
- Providing tissues, waste bin and hand hygiene products for patients and visitors.

Aseptic technique

Aseptic technique protects patients during invasive clinical procedures by employing infection control measures that minimise, as far as practicably possible, the presence of pathogenic microorganisms (NHRMC Guidelines).

The five essential principles of aseptic technique are:

1. Sequencing: Performing a risk assessment
    a. Pre-procedure preparation
    b. Performing the procedure
    c. Post procedure, handover and documentation
2. Environmental control:
    a. Prior to aseptic procedures, healthcare workers must ensure there are no avoidable nearby environmental risk factors, such as bed making or patients using commodes
3. Hand hygiene:
    a. Perform hand hygiene before a procedure and after a procedure or body fluid exposure.
4. Maintenance of aseptic fields:
    a. Cleaning and/or disinfection of equipment and patient prior to procedure(s)
    b. Establishing an aseptic field
    c. Use of sterile equipment - Maintenance of the aseptic field, including protecting the key sites and key parts
    d. Use of a non-touch technique
5. PPE:
    a. Correct selection and use of sterile and non-sterile PPE

Waste management

Healthcare facilities are to follow state legislation and local council requirements for clinical and related waste.

When handling waste there are several recommendations to follow:

- Apply PPE when handling waste. PPE is to be appropriate for the type of waste being handled.
- Waste should be contained in appropriate receptacles that are clearly identifiable by colour and label:
    - yellow bag to indicate clinical waste
    - sharps container that conforms with AS 23907:2023
    - black or white bag/container to indicate general waste
    - purple bag/container to indicate toxic waste.
- All waste should be disposed of according to the facility waste management plan.
- Healthcare workers should be trained in correct handling procedures for waste disposal for their facility.

Exposure to blood/body fluids

Blood and/or body fluids is defined as any fluid that originates from within a person. For example: blood, vomitus, faecal matter, urine, tears, saliva. All organic bodily substances are to be treated as potentially contaminated.

Occupational exposures may include, but are not limited to:

Exposure to blood

This may occur through direct contact via an injury sustained with a sharp device i.e. needle or sharp instrument. This may arise during a procedure, while disposing of a sharp device or during the reprocessing of the reusable medical device. Other exposures may occur via direct blood to blood contact, blood contact with the mucosa i.e. blood contacting; eyes, nose, mouth.

Exposure to body fluids

Body fluids include, saliva, mucus, vomitus, faecal matter, semen and tears. Contact with these bodily fluids with non-intact skin, or the mucosa of another person is considered an occupational exposure.

Managing Occupational exposure incidences
Healthcare workers face the risk of injury from needles and other sharp instruments during many routine procedures. Each healthcare facility is required to have policies and procedures aligned to their facility. This includes an Incident Exposure Procedure and a complete record of the incident.

Guidance is available in the Management of occupational exposure to blood and body fluids – Infection prevention and control 2024 access at:
https://www.health.qld.gov.au/__data/assets/pdf_file/0032/1398191/occ-exposure-blood-body-fluids.pdf?t=1672531200

Immediately following exposure to blood or body fluids, the exposed person should undertake the following as soon as possible:

For eye exposures:

- irrigate well with clean water or normal saline – remove contact lenses
- irrigate eyes while they are open for at least 30 seconds.

For other mucous membrane exposures:

- if blood or body fluids are in the mouth spit out first
- irrigate well with water.

For intact skin exposures:

- wash with soap and water to remove any blood or body fluid.

For skin wounds/non-intact skin exposures:

- do not squeeze wounds to express blood
- wash with soap and water to remove any blood or body fluid
- undertake appropriate clinical care of wounds
- If clothing is contaminated, remove clothing and shower if necessary.

When water is not available, use of non-water cleanser or antiseptic should replace the use of soap and water for washing intact skin or cuts or punctures of the skin. Application of topical antiseptics such as chlorhexidine to the wound site has not been shown to reduce the risk of transmission, however, their use is not contraindicated.

Recording an occupational exposure

All occupational exposures are to be recorded in a facility register. This register is to be used as a tool to investigate why the incident occurred and how it may be prevented or minimised in the future.

This approach to risk management requires identification, analysis, and evaluation of the event and review of risk management strategies. Action may include modifying facility procedures, policies or enhancing staff training.

The following should be assessed and documented by an appropriately trained person as soon as possible after every incident of occupational exposure:

- information about the exposure
- date and time of the exposure
- type of exposure including site, blood, or body fluid involved first aid
- employed (Not considered infectious for blood borne virus unless visible blood – faeces. nasal secretions, saliva, sputum, sweat, tears, urine, vomitus)
- the nature and extent of the injury
- the nature of the item that caused the injury e.g. the gauge of the needle
- the nature of the body fluids involved
- the volume of blood and body substances to which the healthcare worker was exposed
- information about the source person
- the BBV status of the source individual
- demographic factors associated with an increased risk of infection with a BBV^^
- information about the exposed person
- the status of the exposed person concerning BBVs, including vaccination
- current pregnancy status, pregnancy risk, and current lactation
- medical history

Healthcare facilities should take reasonable steps to ensure that employees are protected against vaccine-preventable diseases. This may be achieved through routine screening at the start of employment. This often occurs by, personal assessment (a questionnaire), immunisation records or laboratory testing.

All personal information must be stored in accordance with confidentiality and privacy laws.

When developing an ICMP, the risk posed by vaccine preventable diseases needs to be considered and how they may be managed through the implementation of a vaccine preventable immunisation program. The program should include:

- a facility immunisation policy
- a current immunisation register
- information about relevant vaccine-preventable diseases
- the management of vaccine refusal (including the reduced risk of healthcare worker transmitting disease to a vulnerable patient).

For further information please refer to the Australian Immunisation Handbook:
https://immunisationhandbook.health.gov.au

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Version control

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