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Dear Ms Goodrick

### **Draft Australian Guidelines for the Prevention and Control of Infection in Healthcare**

Thank you for providing the AMA with an opportunity to comment on the consultation draft of the infection control guidelines. The AMA is very supportive of evidence-based guidelines for the prevention and control of infection that are appropriate for the level of risk applicable to the various healthcare settings.

The AMA acknowledges that the intention of the guidelines is to enable all healthcare settings, including office-based medical practices, to develop their own protocols and processes for infection control. However, we read the guidelines as being pitched at the acute care setting. We are aware that the Australian Commission on Safety and Quality in Health Care is seeking to develop a national approach to safety and quality in all healthcare settings, but the AMA is concerned that the 'one size fits all' approach is not appropriate.

Firstly, good medical practice requires good infection prevention and control. But it must be recognised that this is a costly undertaking for medical practices, in terms of administrative and financial resources. We do not support an approach where health care providers are required to implement infection control guidelines that are:

- beyond the level of risk that occurs in the particular healthcare setting;
- are not practical to implement; and/or
- for which there is no evidence to justify adherence to the guideline.

For example, it seems excessive to expect that general practices would wash and dry blood pressure cuffs between patients (recommendation 17). We are not aware of evidence that demonstrates that there is a high rate of cross infection occurring in the general practice setting because blood pressure cuffs are not washed and dried between patients. This particular recommendation would be costly to implement. It would require each consulting room to have at hand at least 20 BP cuffs, and there would be additional staff costs to wash and dry the cuffs after every use.

A national approach must be sufficiently flexible to accommodate the relative risks. Further, if the guidelines become too onerous and disconnected from practice in the real and diversified world of medical practice then there is a risk that practices may

push to be allowed to be accredited under alternative standards frameworks or walk away from accreditation altogether.

Accordingly, the AMA recommends that the guidelines be clear about which recommendations apply to what level of risk. There may be particular recommendations that apply to certain classes of procedures for example, applying dressings, treating lacerations or ulcers or performing minor surgery. This would help people to identify the level of risk in their particular healthcare setting, and to adhere to the guidelines as appropriate.

From an implementation perspective, all general practices would currently be observing the RACGP Infection Control Standards for Office-based Practices (4th Edition) and the accompanying guidelines. There has been significant investment in the development of these standards. They have been reviewed by experts in infectious diseases, pathology and infection control. General practitioners, practice nurses, steriliser technicians and accreditation agencies participated in the review process.

If the intention is that all medical practices adopt new infection control guidelines it must be clear to them why existing practices are no longer appropriate and that the evidence demonstrates that any new practices will enhance patient safety. The AMA recommends that when the final guidelines are released that they are accompanied by information that explains the rationale for the new recommendations.

Yours sincerely

A handwritten signature in black ink, appearing to read 'A. Pesce', written in a cursive style.

Andrew Pesce  
President

12 March 2010

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