Resources, both human and material, are increasingly being allocated towards the practice of infection control to meet health care obligations. Whether this attention has resulted from careful strategic planning or from unwanted media attention following critical incidents is irrelevant. What is important is that with the increased public presence comes greater responsibility. In response, a sustainable framework for infection control practice is required. This entails a strategy that embraces the principles of both corporate and clinical governance to address ‘top down’ and ‘bottom up’ management approaches.

Defining infection control

The paradigm of infection control has evolved in response to the changing nature of health care delivery, statutory obligations, economic reforms, research, technological changes and governance. Infection control can be described as a worldwide culture that promotes the minimisation of preventable infection. Ideally, the craft of infection control should be moulded within a framework of total quality management which integrates strategies such as strategic/business planning, quality improvement, risk management and cost-benefit analysis. The generic tools are standard infection control principles, fashioned to suit the practice setting within the constraints imposed by limited resources. The aim is to minimise preventable infection and improve health outcomes.

The United Kingdom approach

The National Health Service (NHS) in the United Kingdom set the charter for change in health care through their adoption of the principles of corporate and clinical governance. The Executive of the NHS demonstrate their accountability (corporate governance) through their annual review of the organisation’s system of internal controls including financial, operational and compliance controls and risk management strategies. A report is provided to shareholders.

Management tools such as a mission statement and a strategic/business plan support the concept of corporate governance. These tools map out boundaries by informing staff of the organisation’s health care priorities, aims, goals and objectives. They ensure that the direction and the accountability of the organisation are clearly articulated.

Once established, employees are empowered to plan and execute health care programmes that are aligned with the overall organisational philosophy. This process of empowering clinicians encapsulates the concept of clinical governance.

Australian infection control culture

Within Australia, the call to minimise preventable infections is consistently being made by politicians, the Commonwealth and state health departments, hospital executives, infection control personnel and members of the public. And yet leadership in this area remains unclear. Interpretation of various impacting statutes, regulations, standards and guidelines varies between stakeholders such as hospitals, public health, governments and professional associations. This uncertainty in governance has created ambivalence in the management of health care associated infection, as ownership and accountability shifts between people, departments, professions and organisations.

Rather than contribute to this confusion, the membership of the Australian Infection Control Association (AICA), the professional association representing this speciality field, should champion and advocate for the mission of AICA, that is ‘to speak with one voice’, for the purposes of establishing national standards of practice and developing a framework for governance.
In an effort to address this responsibility, the AICA Strategic Plan (2001-2003) articulates the commitment to total quality management and clearly establishes the national agenda for the specialist practice of infection control. Two key national activities initiated as a result of the strategic plan include the following:

- The development of minimum standard definitions for the surveillance of surgical site and blood stream infection as benchmarking prerequisites. These standards facilitate the participation of all facilities that undertake health care associated infection surveillance activities.
- The formulation of the Commonwealth report on national surveillance of health care associated infection provides governments and health care workers with an overview of current Australian and overseas surveillance activities, the financial and human costs of nosocomial infection, and gaps in surveillance activities.

Whilst the AICA methodology for the surveillance of surgical site and blood stream infection has been defined, the process of influencing patient outcomes requires further exploration. The humanisation of infection statistics is an important step in recognising the impact that health care associated infection has on individuals, organisations and society. It is essential to focus attention on the desired outcomes and to design strategies to support the achievement of these outcomes. Infection control practitioners (ICPs) are ideally positioned to successfully lead this campaign.

However, the responsibility for preventing and controlling infection can be overwhelming for the ICP who is becoming increasingly distanced from the patient’s bedside. In many instances, ICPs are not part of the direct patient care team and may have little direct influence on health practices. Additionally, the risk of infection acquisition is compounded by factors that are beyond the ICPs’ control such as changing patient demographics, drug therapy, increasing invasiveness of procedures and duration of hospitalisation. A further impacting factor is society’s unachievable expectation that health care should equate to zero risk.

Whilst it is true that ICPs are faced with many factors hampering their ability to effect change, they must find a way to influence health outcomes. It is my belief that, firstly, ICPs must embrace the underlying concepts of the NHS charter for change and adopt the principles of corporate and clinical governance. Secondly, infection control programmes must be targeted and outcome focused. To assist in achieving this, the aims, goals and objectives of the programme must be clearly articulated in the infection control management plans. Finally, we must educate the public regarding surveillance methodology, the risks of acquiring an infection and promote aspects of infection prevention.

### Emerging governance within Australia

Corporate governance, as outlined by the NHS Executive, involves the establishment of national standards for service and treatment through national service frameworks. This is supported by the local delivery of high quality health care driven by clinicians and underpinned by professional self-regulation.

Within Australia, the adoption of governance structures are in their infancy. However, a number of organisations, associations and industries have adopted this management strategy. Various health departments, individual hospitals and other bodies, such as AICA, have contributed to national standards of practice. Some of these are the AICA minimum standard definitions for surgical site and blood stream infection (mentioned above), the CDNANZ document *Infection control in the health care setting: guidelines for the prevention of transmission of infectious diseases*, the review of Australian Standards (AS) such as AS 4187, and the development of the Australian Council on Healthcare Standards *Fundamentals for infection control services*. Such initiatives provide evidence of our commitment to national standardisation and to the establishment of a framework for effective governance in Australia.

Clinical governance promotes clinician driven change. In the context of infection control, the charter for clinical governance requires programme directors and ICPs to define the scope of their infection control programmes. Defining the extent and depth of service delivery is important for a number of reasons. Primarily, the priorities and targets of the programme will be dependent on the core business of the participating facilities and the demographics of the population served. Defining the parameters of practice is necessary to determine stakeholders, the sphere of practice and how the programme interrelates with staffing and patient outcomes so that infection control responsibilities are addressed throughout the continuum of care.

### Conclusion

Delineating and documenting the infection control programme demystifies the role of the ICP and enables staff to conceptualise the programme and consider how they can contribute to outcomes. It is important that ICPs recognise the valuable contribution of the bedside clinician and collaborate with them in developing benchmarks or targets within a risk management framework. A collaborative framework for monitoring and evaluating interventions will result in shared responsibility for outcomes. Sustainability of such a framework based on clinical governance will only be possible with consumer focused corporate support.