Submission providers

	Contact Name	Organisation	Stakeholder	Submission subject	Considered by
1.	Keryn Eden	Occupational Health/Infection Control Nurse, Disability SA - Highgate Park	SA Govt	C1 Vaccinations	NHMRC
2.	Craig Boutlis	Director, IMACS, Infection Management and Control Service (IMACS), The Wollongong Hospital	NSW Govt	ICP bed ratios Gowns	Committee
3.	Michelle Bibby	Infection Prevention Australia	Infection control consultant	MROs	Committee
4.	David Andresen	Medical Microbiologist, Childrens Hospital at Westmead	Acute care	References for B4	Committee
5.	Kylie Fardell	Cooma GP	Primary care	MROs	Committee
6.	Sharon Stendt	Infection Control Coordinator, Flinders Private Hospital	Acute care	CJD	NHMRC – to refer to
7.	**Confidential**	**Confidential**	Acute care	Hand hygiene	Committee
8.	Angela Cooper	HIV, Hep C & Sexual Health Coordinator, North Qld	QLD govt	Gloves	Committee
9.	Marcus Handmer			PPE, uniforms, cleaning	Committee
10.	Sue Grieg	Sydney Hospital, Sydney eye Hospital	Acute care	IVDs Standard precautions	Committee
11.	Brian Clark	Janitech Australasia – Cleaning consultancy	Private consultancy	Cleaning	Committee
12.	Gary Bourke	National Uphostelry, Carpet Cleaners & Restorer's Association Inc (NUCCRA) - President	Private consultancy	Cleaning	Committee
13.	Stephen Kleid	Peter McCallum Cancer Centre – ENT surgeon	Private	Equipment processing Comments only.	NHMRC
14.	Rodney May	Boandik Lodge SA, Director of Nursing	Residential Aged Care	Hand hygiene	Committee
15.	Mary Newman-Martin	Hollywood Private Hospital – Infection Control Co-ordinator	Acute care – private hospital	Hand hygiene	Committee
16.	Angie Criddle	WACHS Midwest – Regional Clinical Nurse Specialist	WA govt	Hand hygiene, PPE, B4	Committee
17.	Brett Mitchell	Tasmanian Infection Prevention and Control Unit – Director	TAS govt	All sections	Tech writers for minor comments
18.	Darren Li	Australian Physiotherapy Association	Allied Health	Gloves Invasive procedures	Committee
19.	Mary Smith	Infection Control Co-ordinator - Victoria	VIC govt	Cleaning PPE	Committee

	Contact Name	Organisation	Stakeholder	Submission subject	Considered by
20.	Thea van der Mortel	Southern Cross University	University	Hand hygiene Cleaning Education (C3)	Committee
21.	John Penny	Viscon-systems	Private organisation Product manufacturer	C6 Facility design - ventilation	Committee
22.	Karen Heel	Public Health Nurse, Brisbane Southside Public Health Unit	Qld Govt	B2 Infectious disease ready reckoner	Committee
23.	Margaret Davidson	CNC Infection Control, Bentley Health Service	WA govt	PPE removal	Committee
24.	Marrianne McGhee	Nurse educator, St Vincents	Acute care	Instrument reprocessing	Committee
25.	CHICA	Canadian Hospital Infection Control Association	Acute care Professional association	All sections	Committee
26.	Liz Hume	Infection control co-ordinator, Mildura Base Hospital	Acute care – private hospital	Gloves	Committee
27.	Wendy Beckingham	CNC Infection Control Canberra Hospital	ACT govt	Section B Section C6: Facility	Committee and tech writers
28.	CRANA	Council of Remote area Nurses Australia	Remote area health Professional associations	Hand hygiene PPE Cleaning C – Mgmt and clinical governance	Committee
29.	Nick Demediuk	Dandenong Casey General Practice Association	Primary Care	Hand hygiene Gloves Cleaning Multi-dose vials	Committee
30.	RACS	Royal Australian College of Surgeons	Professional associations		
31.	Maggy Tomkins	South Eastern Sydney Illawarra Area Health Service	NSW govt	Sharps	Committee
32.	**Confidential**	**Confidential**	Private organisation; product manufacturer	Hand hygiene	Committee
33.	Ruth Barratt	New Zealand NO National Division of Infection Control Nurses	Professional association	General terminology Hand hygiene	NHMRC and Tech writers
34.	Tina Brady	Kimberley Clark	Private organisation; product manufacturer	Hand hygiene PPE Sterilisation Storage Ventilation Surgical procedures Education	Committee

	Contact Name	Organisation	Stakeholder	Submission subject	Considered by
				Surveillance	
35.	Gunther Kampf	Bode Chemie	Private organisation; product manufacturer	Hand Hygiene	Committee
36.	Michael Houghton	IC Net International	Private organisation; product manufacturer	Surveillance Antibiotic Stewardship	Committee
37.	Alasdair Godfrey	Hospira	Private organisation; Product manufacturer	Sharps; Needleless devices	Committee
38.	Beth Wardle	Gastroenterological Nurses College of Australia	Professional association	Addition of GESA/GENCA ref for endoscopy	NHMRC
39.	Anne Trimmer	Medical Technology Association of Australia	Professional association	Sharps; Needleless devices Equipment reprocessing	Committee
40.	Winnie Prendergast	Medtronic	Private organisation; Product manufacturer	Equipment reprocessing Sterilization and disinfection	Committee
41.	Matthias Maiwald	Matthias Maiwald	Consultant in Microbiology	Hand hygiene Surgical procedures	Committee
42.	Robyn Birch	Infection Control Redland Hospital	Qld govt	Cleaning Gowns 1 mtr rule Needless devices Staff health	Committee
43.	Helen Vertoudakis	ANZ Healthcare Manager		Cleaning	Committee
44.	Carolyn Jones	Health Care Infection Control Management Resources	Private organisation	All sections	Committee
45.	Kristin King	Baxter Healthcare	Private organisation; Product manufacturer	B4 Procedures	Committee
46.	Mary Rose Godsell	WA	WA govt	All sections	Committee
47.	Elizabeth Baker	Whitely Corporation	Private organisation; Product manufacturer	Environmental cleaning	Committee
48.	Graeme Shelley	Hartmann	Private organisation; Product manufacturer	Hand hygiene	
49.	Rebecca Conning	Australian and New Zealand College of Anaesthetists	Professional association	General supporting comments	NHMRC
50.	Susan Harper	Peter McCallum Cancer Centre	Specialist centre	MROs	Committee
51.	Patricia Coward		Qld govt	Hand hygiene PPE Cleaning Staff health	Committee

	Contact Name	Organisation	Stakeholder	Submission subject	Considered by
52.	Margaret Butler	St Vincents Hospital		PPE MRO Surgical procedures	Committee
53.	Amanda Brown	Infection control educator	Dentistry	PPE	Committee
54.	Fiona Morrisby	Australian Dental Association	Dentistry	PPE Sharps Instrument reprocessing Cleaning Applicability	
55.	Fiona Fullerton	CHRISP	Qld govt	Gloves Cleaning Transmission based precautions MROs B4 Staff health	
56.	Elinor Radke	Nurse Unit Manager, QEII Jubilee Hospital	Qld govt	Instrument reprocessing	Committee
57.	John Ferguson and Rosemary Aldrich	Hunter New England Health	NSW govt	All sections	Committee
58.	Sandy Berenger	Hunter New England Health	NSW govt	All sections	Committee
59.	Sue Atkins	Infection Control Consultant Royal District Nursing Service	Private organisation	ICP representation Clinical waste	NHMRC
60.	Fiona de Sousa	Sydney Adventist Hospital	Acute care – private hospital	Hand hygiene PPE Transmission based precautions B3 and B4 Section C	Committee
61.	Allan Firth	CarpetOz	Private organisation	Environmental cleaning	Committee
62.	Jeremy Rourke	Jeremy Rourke	Dentistry	PPE Staff health	Committee
63.	Rosalie Schultz	Central Australian Rural Practitioners Association	Professional association	PPE Hand hygiene Transmission based precautions Organisational support	Committee
64.	**Confidential**	**Confidential**	Private organisation; Product manufacturer		Committee
65.	Sue Templeton	Australian Wound Management	Professional	Surgical site infection	Committee

	Contact Name	Organisation	Stakeholder	Submission subject	Considered by
		Association	association	B4 C5 A'biotic stewardship	
66.	Karen Maskell	Department of Health and Human Services Tasmania	Tas govt	Cleaning Transmission based precautions MROs	Committee
67.	Mark Stevenson	Western District Health Service	Individual submission	Cleaning PPE Instrument reprocessing	NHMRC
68.	Dr Debra Graves	Royal College of Pathologists Australasia	Professional Association	Request one page summary	NHMRC
69.	Cyndee King	South Eastern Sydney Illawarra Area Health Service	NSW Govt	All sections	Committee
70.	Rod Givney	Hunter New England Health	NSW Govt	Immunisation Outbreak investigation and management	Committee
71.	Dusanka Sabic	ACCORD	Industry representative specialty products	Hand hygiene	Committee
72.	**Confidential**	**Confidential**	Infection control consultant	Sharps	Committee
73.	**Confidential**	**Confidential**	Private organisation; Product manufacturer	Sharps	Committee
74.	Yvonne Luxford	Royal Australian College of Physicians	Professional association	MROs PPE Transmission based precautions	Committee
75. ty	Paul Smollen	Australian Society for HIV Medicine and Australian Infection Control Association	Professional association	PPE Transmission based precautions Cleaning Equipment processing C2 staff health	Committee
76.	**Confidential**	**Confidential**	Professional association	Key recommendations Applicability to general practice	Committee
77.	Wendy Lorincz	Australian Medical Association	Professional association	Instrument processing Applicability to general practice	Committee
78.	Debra Gradie	Office of Health Protection	Aust govt	All sections	Committee
79.	Robyn Donnellan	North Coast CNC	NSW govt	All sections	Committee

	Contact Name	Organisation	Stakeholder	Submission subject	Considered by
80.	Jenny Martin	Council of Deans of Nursing and Midwifery	Professional association	All sections	Committee
81.	Dinah Morrison	Infection Prevention and Control Coordinator, ACT Health Community based services.	ACT govt	All sections	Committee Tech writers

Responses to comments

The following table provides a summary of the committees' considerations of the public consultation submissions and resultant changes to the draft Guideline. Comments were considered via teleconferences, email and a face to face meeting. Comments that

Responses to comments highlighted in the draft Infection Control Guidelines during the public consultation period.				
Overall				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
	#3	Overall well set out and easy to read and follow thankyou	Noted- Thank you.	
	#57	Commissions draft healthcare accreditation standards need to have a central place for the ICG and could be used to restructure the Chapter C1-Governace section.	The draft standards have been linked to the ICG and a number of the commission documents have been used in the development of Section C.	Implementation tools are being developed in partnership with the commission which will assist in the adoption of standards and reporting requirements related to HAI prevention
	#4	The document is generally excellent and the compilers and committee deserve congratulations	Noted. Thank you.	
	#58	The language in the guideline is cumbersome. Fundamentals need to be clearly expressed	The committee require greater detail to be able address the issue raised.	The Guideline has been redrafted to include an extensive glossary and remove the use of jargon

	#44	they appear to lack the perscriptiveness and detail of the current guidelines which is believe to be critical for a standardised national approach implementation and compliance. There is a great amount of detail in the introduction which would be invaluable through out the document Layout – inconsistent and confusing the order and frequency of recommendations varies between sections. It is not clear how to apply the considerations to these other settings. References to appropriate documents are not provided throughout the document in the absence of /to support recommendations CDNA guidelines were clear and prescriptive and referred to a broad range of practices and settings providing detailed minimum requirements to complementing existing standards Areas that have not been covered such as Infectious diseases, pandemic planning, reprocessing of medical devices, OH & S, Hospital Hotel service, engineering/health facility guidelines which are critical aspects to Infection control and prevention. And for the development of detailed policy and procedures eg,.The Australasian Society for Ultrasound in Medicine, (ASUM) B2: Guidelines For Disinfection Of Intracavity Transducers 2007, http://www.asum.com.au/site/files/P&S/B2_policy.pdf. It is stated that the guideline does not cover these areas but the important information required in these areas, it should direct the reader to the relevant resource pertaining. The document infrequently refers to relevant standards and there was the inclusion of state based standards which we had difficulty locating some of these references. We suggest it would be better to summarise the key aspects of these documents, and provide direct links.	This Guideline is based on the principle of infection prevention and management. A one size fits all approach is not feasible as HCF have varying context and populations so a risk management approach has been used to implement these principles. The Guideline encourages infection prevention to be an integral part of clinical care and not an additional process. Additional tools and resource had been provided in Section D to aid in access information not included in the guideline. Feedback from ICP indicated that a few key resources were better that an exhaustive list.	Section D has been removed and resources and tools will be placed at the end of each section to assist in accessing further information

	#54	• The document follows from the 2004 CDNA document but does not discuss specific differences between this and the earlier document; • Whilst references are used during the document (especially reviews), the documents primary failing is the use of evidence base is poor and often the document reflected uncertainty in the literature but often recited accepted wisdom even in the face of uncertainty from the literature. • The article Pratt RJ, Pellowea CM, Wilson JA et al (2007) epic2: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. Journal of Hospital Infection (2007) 65S, S1–S64 provides a far more balanced approach. • It seems again the opportunity is being missed for a peak body not to refer back to source documents to support its recommendations; • By not referring to source documentation as to why new terminology was introduced provides confusion e.g. transmission based or additional precautions are still used interchangeably on page 138; and • The 2004 document stated that successful infection control involves five elements including identifying infection control strategies in specialised health care settings (such as operating rooms, dentistry rooms and residential aged care facilities).	The scope and target audience have been specifically stated at the beginning of the chapter. The nature and the content of the guideline were determined from the outcomes of stakeholder forums which were conducted in March 2008. The process reports clearly outline what evidence has been used in the development of recommendations. Inconsistencies in terminology ie transmission and additional are pure oversights and have been corrected in the final draft.	More attention will be given to referencing in the final draft.
	#54	The document specifically mentioned that different health care settings provide their own risk assessment and method of implementation an infection control strategy. This document should specifically state that different health care settings may have different requirements and risk assessments can be made for the different health care requirements. For example specific settings page 8: • Sharps: Many dentists safely recap needles as per the ADA Inc guidelines. • Non surgical root canal treatment although an aseptic technique does not require sterile gloves. Non surgical root canal treatment does not require the clinician to touch with hands the sterile cavity. • Thus requiring changing sterile gloves from - sterile gloves must be used for procedures which require hand contact with sterile sites.	The risk management approach in the PPE section has been strengthened to enable great applicability to different health settings. Additional text has been added to assist in undertaking these risk assessments specifically in primary care.	Inserted: Different health care settings encounter differing levels of risk and so should conduct their own risk assessment in the development of local policies and procedures. Also reference to discipline specific guidance is recommended.

aim	#60	There needs to be clarification around the following. • In areas where a contradiction may occur are facilities expected to comply with this document or with state policy directives? • Is compliance with this document mandatory for private facilities, if so this should be stated in the introduction	Guideline is not a mandatory or legislative. It has been developed upon the principles of infection prevention and management so it can be adapted to guide the development of local policies and procedures irrespective of the facility being funded public or privately. Extensive consultation with jurisdictions has occurred so the guidelines can be integrated in to health department policy.	No change to Guideline
	#79	Infection control professional not practitioner	Accept	Term infection control professional is to be used throughout the Guideline
	#78	Need to refer to prevention and control through out the document	Accept	Will refer to prevention rather than control
	#33	The term 'infection prevention (&) control' would be more accurate to describe the direction that is now taken instead of the phrase 'infection control'. We would have liked to see more use of the word 'prevention'.	Accept	Will refer to prevention
	#33	We note the use of the title 'Infection Control Practitioner'. Again we would have thought that the move would be towards a title such as 'Infection Preventionist' to relate more to our role. On an aside, in New Zealand the use of the word 'practitioner' within a title is reserved for the specific Nursing Council 'Nurse Practitioner' role and so IC nurses are not allowed to use it. Overall this is a great document and resource for IP&C professionals in New Zealand and elsewhere.	Noted. Thank you.	Terminology in Australia has been determined as 'Infection control professional'
	#33	We note and approve the change in term from 'additional' to 'transmission-based'. This is in line with the CDC and other international guidelines.	Noted. Thank you.	
	#33	The patient-centred focus and patient tips are a very good addition.	Noted. Thank you.	

overall	#25	The “Putting it into Practice” sections at the end of each chapter are very well done • The outbreak management section is very well done • There are some terminology variations, this could be because of 'cultural language differences' but should be verified (e.g. 'correctly fitted' N95 rather than 'fit-tested')	Noted.	
overall	#25	• Overall, the document is comprehensive, but as a result seems to lack clear purpose for each section. It might be advantageous to make multiple smaller documents, or clearly delineate objectives for each section. • The document would be greatly improved if there could be 'quick access' links inserted (hyperlinks), so as to be able to take the reader directly to the desired detailed section by clicking on the TOC or the 'Finding Information' listings. • The document would be easier to read with a larger font size	This draft copy and has not been desk top published as yet. As it will be primarily based on the web the appropriate links will be added once the Guideline is finalised	Referencing and links to relevant sections to be included in final draft.
overall	#25	The summaries of recommendations do not completely capture the recommendations in the text, it would be better to either ensure their completeness, or remove them.	Accept	Some discrepancies between the text and recommendations have been identified and amended.
overall	#25	It was noted that the guidelines still use the one-metre rule for distance from respiratory patients (Canada and U.S. have changed to two-metres)	CDC Isolation Guidelines 2007 have been referenced in relation to the distancing requirement for patients on droplet precautions.	This is an area for further research and monitoring as a part of the review process.
overall	#25	Goggles are not required as part of Droplet precautions as they are in Canada	There is insufficient evidence to support the use of goggles as a routine part of droplet precautions.	This is an area for further research and monitoring as a part of the review process.
overall	#25	Airborne precautions require goggles, gloves and gown; in Canada, they do not (not transmitted via the contact route), but would be combined with other precautions as appropriate (e.g. contact)	Accept	Airborne precaution requirements have been amended.
overall	#25	CJD procedures are very different from Canada and do not seem practical (p. 55)	Specific guidance on the prevention and management of procedures	Section on CJD will be managed by the Australian Department of Health and Ageing
overall	#25	Pregnant workers are excluded from many tasks which is inconsistent with other guidelines	Accept	Recommendations consistent with the 9th Edition of the immunisation handbook

consultation	#69	no nursing representation on the Committee	ANF and numerous other nursing professional bodies were consulted prior t and during the development of the guidelines. ANF recommended that we consult with AICA in the development of this guideline	Steering Committee members, Brett Mitchell Sylvia Gandossi are registered nurses that also have post graduate qualifications in Infection control.
consultation	#69	NSW Operating Theatre Association, and Australian College of Operating Room Nurses. Did not received a copy of these Draft Guidelines	Noted.	ACORN were invited to the scoping phase of the guideline and also been consulted with on issues of reprocessing. In addition the consultation draft was provided to ACORN. There is limited guidance on the protocols for surgical procedures but ACORN standards have been referred to.
	#26	it would be best used and kept in infection control units as well as a useful document for health care managers	Noted. Thank you	
	#79	-Transmission Based Precautions should be replaced with Additional Precautions for consistency with Core Practice Principles for Infection Control Attachment A by the Australian Commission on Safety and Quality in Health Care's (ACSQHC) -Infection control should be changed to infection prevention throughout the document	Transmission based precautions is accept terminology by the majority of Australian States and the Commission. It depicts a more appropriate term for managing preventing and managing specific infections.	No Change to Guideline
7	#46	Does this include differentiating using soap and water for C .difficile and Norovirus, the latter being recommended by Rutala	Hand hygiene recommendation is for routine hand hygiene. In the presence of an infectious organism it will cross reference to hand hygiene for specific circumstances.	No change to guideline

11	#42	Table 1 useful? include links	Noted	It will be linked when it becomes a web based document
	#74	Table 1 – This is a poorly formatted table and is confusing. The premise is good, just the format to make it clear is lacking. Table 2 Specify the year for all of the reference material.	Noted.	Years will be included in the references.
	#59	This document talks about sharps management, but no other clinical and related waste streams. Clinical and related waste is mentioned in recommendations for policies and procedures as a suggested topic to address, but no guidance given in the main document.	It was not the original intention of the guideline to include guidance of housekeeping activities which are regulated by state and territory legislation	A section the principle for managing clinical waste has been added
Introduction				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
13	#29*	Recommendation: infection control practices should be developed by professional groups in each health care sector based on evidence as it is available and scientific principles. While the committee is composed of experts in infection control it is dominated by those from the acute and government public sectors. The guidelines acknowledge that they focus on acute care and state that the risk approach used to address the principles of infection control means are applicable to a wide range of healthcare settings. Unfortunately throughout the document there are prescriptive requirements which while applicable to the hospital care sector are not in others and the risk management approach is not adopted. What it does not acknowledge is that the rate and types but most importantly the risks vary greatly between the different healthcare facilities. This failure is critical in any discussion and feedback of this document. As stated in the introduction, that there is limited evidence available to support many routine practices intended to reduce infection risk and that practice is based on decisions made on scientific principles. Yet many of the recommendations are quite specific yet based on low levels of evidence especially in relation to primary care.	The guideline addresses infection prevention and control from a risk management and principle perspective. It is not within the scope of the guideline to provide detailed guidance on areas of clinical management.	Additional information has been included to guide HCW on how to incorporate a risk management approach in their specific care setting

13	#78 #17	200,000 infections" – this is an important statement and should be referenced	Accept	Reference "Reducing Harm to patients from Health care associated infection: The Role of Surveillance" Australian Commission for safety and Quality in Health care 2008
13	#25	Section on "Everybody's business" is good – includes risk management and human and systems factors.	Noted. Thank you	
13	#74	It is suggested that "GP Clinics" should be used instead of "GP surgeries". This is the more commonly accepted plural.	Accept.	Will be amended.
13	#74	Anyone working or entering a HF is at risk This is inaccurate. Although people working are very likely to be at risk, as are those 'admitted', it is questionable whether those simply entering a facility are It is suggested that it would be more accurate to say: "any person receiving care as an outpatient or inpatient of a healthcare facility is at risk of acquiring infection, and even staff are at some risk of acquiring infections"	The comment does not acknowledge the role the health care environment plays in the transmission of infection. Visitors and carers need to be aware of the measure they can take in limiting the spread of HAI.	No change to guideline

14	#71	This selective exclusion of evidence required by the existing national regulatory system is especially alarming given that a fifth NHMRC grade of evidence, “good practice points” (GPP) has been included to denote “Body of evidence is weak or non-existent. Recommendation of best practice based on clinical experience and expert opinion” [page 16]. However, the NHMRC is itself responsible for contributing to the weakness of evidence by ignoring product data legally required by the Australian regulatory framework. This juxtaposed disregard of the legal framework for TGA-regulated products and emphasis placed on expert opinion is of great concern to ACCORD; indeed it appears that “clinical experience and expert opinion” is being elevated above the evidence required by Australian law. ACCORD contends that the NHMRC is preferentially looking to peer-review literature and thus concluding incorrectly that there is a paucity of evidence. Had this Committee contained industry representation, the above omission would not have occurred. Every product category mentioned in the Draft Guidelines is manufactured by our industry, and all manufacturers are aware of compliance requirements with the TGA legislation. ACCORD recommends that evidence from Australian regulatory authorities be included in the Draft Guidelines e.g. amending Table 2 to reflect the current framework for all of the TGA regulated product categories mentioned within the document, as well as strongly referencing the TGA system in other relevant paragraphs.	The NHMRC’s considers the best available evidence in development of a recommendation. The parameters by which evidence is considered is outlined in the process report. The data-bases searched in gathering the evidence have been listed. The NHMRC has discussed the standards by which the TGA approval process is conducted and these considerations have been incorporated in the final document.	No change to guideline
14	#47	Introduction; page 14; table 2; United States (CDC) documents The following document should have been included: “Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008” [USA/CDC/HICPAC 2008].	Has been referred to but not formally reviewed using the AGREE process as recommendations were not drawn from the guideline for adaption.	Insert reference in list
14	#78	Is Aboriginal medical services meant specifically or the broader Indigenous health services	Noted.	Will specify as indigenous health services.
14	#57	Specify the year for all of the reference material	Accept.	Will include year of publication for guidelines. Full references are noted at the end of each chapter.

15	#25	Last 2 paragraphs: good information but does seem to suggest routine practices could be discontinued – perhaps it would be better to reinforce that standard precautions (routine practices) should always continue.	Accept.	Will review terminology and have adjusted text at B2 to reinforce that standard precautions must always apply.
15 Table 2	#47	"Systematic reviews of published scientific and …"; Alcohol products and other agents for hand hygiene The market for alcohol based hand rubs is a regulated market and all sponsors and manufacturers are subject to varying levels of controls. At the less regulated end of consumer and industrial products, the regulatory oversight is by the National Industrial Chemical Notification and Assessment Scheme (NICNAS). Whilst NICNAS has no review mechanism or skill, and the market is semi-self regulated, manufacturers must conform to an enforceable code of practice and truth in marketing guidelines from the Australian Consumer and Competition Commission (ACCC). At the medical end, antibacterial products are supervised strictly by the TGA and are regulated as fully regulated Over the Counter Medicines. Full pre-market submission is required for all data including efficacy, formula and manufacturing requirements (GMP licensing is separately and additionally enforced). Therefore, surely the search would have most easily been achieved by obtaining from the TGA a complete list of the products which have TGA approval in Australia for sale as Antibacterial handrubs and handwashes?	This falls outside of the scope of the guideline. For a full list of products refer to TGA. Guideline can only recommend factors to consider when choosing a product including that it must be a TGA approved product.	No change to guideline
15	#54	According to Table 2, the reference source of information for dental aspects was the 2003 US CDC dentistry guidelines – which are now seven years out of date. The document should instead refer to the ADA Inc 2008 Guidelines which are more current and reflect evidence and best practice. It actually does refer once to the ADA 2008 Guidelines on page 162 in the section which discusses separation between inlet air for dental compressors and air conditioning outlets. ADA Inc is cited on page 208 as giving "Organisational Support". Given this issue, it is useful that an additional grade of evidence has been included, namely "GPP-Body of evidence is weak or non- existent. Recommendation for best practice based on clinical experience and expert opinion", but in saying this, the ADA would like better cross referencing to professional guidelines.	Recommendations were drawn for the CDC dentistry guidelines prior to the release of the ADA guidelines.	Recommendations from ADA infection control Guideline 2008 has been included.

15	#47	"Limitations of the grading process…"; "The recommendations …were formulated by the Infection Control Steering Committee." It is noteworthy that Industry is not represented at all. Many of the matters raised in submissions could have been dealt with through a suitable Industry Representative having been present on the Steering Committee. Not having an Industry Representative has resulted in some recommendations within AGPCIH 2010 that run contrary to the law relating to the product ransmiss, indications and use.	Te Steering Committee is appointed by the NHMRC CEO under legislative requirements based on their relevant expertise to develop the Guideline. Consultation processes during the guidelines development have occurred in which industry representative were present. In addition the Guidelines undergo a public consultation period to inform specific areas of the guideline.	No change to guideline

16 Table 3	#47	NHMRC grades of evidence – "GPP = Body of evidence is weak or non-existent. Recommendations for best practice based on clinical experience and expert opinion" The evidence framework was developed for "clinical practice guidelines" but in fact all other guidelines primarily relate to the use and clinical practice with patients and medicines or treatments. The AGPCIH 2010 is not such a document. Many of the matters covered strike at the interface of practical care, but include products not normally intended for clinical trials, and not priced in our market size to allow for formally structured clinical trials. Carpet is one such example. The AGPCIH 2010 does not canvass such matters and instead notes no evidence is available (section B1.4 page 53, and section C6.2.3 page 164). The Steering Committee acknowledges that evidence is either weak or non-existent. However, the expert opinion is suggested as superior to the law, given that the reflections on the legal framework for medicines (Antibacterial handrubs and Antibacterial Handwashes) and medical devices (Sterilants, Disinfectants of all grades, and medical detergents) are completely omitted. RECOMMENDATION: 2.1 The AGPCIH 2010 revision should include a 5th category called "Lodged Statutory Evidence". This would be defined as evidence submitted to the TGA or any other appropriate regulator that is reflected in the regulatory scheme for that group of products. Such evidence is always represented on TGA approved product labels, such as specific biocidal kill claims for disinfectants. 2.2 The AGPCIH 2010 revision must be amended to reflect the current legal framework for all of the TGA regulated product categories mentioned within the document.	The NHMRC's considers the best available evidence in development of a recommendation. The parameters by which evidence is considered is outlined in the process report. The data-bases searched in gathering the evidence have been listed. The NHMRC has discussed the standards by which the TGA approval process is conducted and these considerations have been incorporated in the final document. .	No change to guideline
16	#44	Include key of what NHMRC grading for recommendations are in the relevant Tables throughout the document	This is specifically outlined in the process report. Does not need to be repeated throughout.	No change to guideline
16	#46	GPP= infection control principle ??	This has been defined in the introduction	No change to guideline
18	##42	Table 5 good reference guide	Noted. Thank you	No change to guideline
18	#79	Core strategies Addition of B3.4 Debriefing, Reporting, Policy Review	The inclusion of these additional subjects are beyond the scope of the guideline	No change to guideline

Section A				
Page	Who	Comment	Action	Response
General	#78	Patient centred care should be up front and not last front to reflect the importance of patient engagement	Patient centred care has been placed appropriately to how the guideline is structured with the Putting it in to Practice section last.	No change to guideline
General	#74	Greater consideration of susceptibility and scales of vulnerability The guidelines appear to have a high focus on transmission factors, and considerably less on susceptibility. It is noted that "immunocompromised" is mentioned a number of times, but it is not clearly defined. Patients have a spectrum of vulnerability and should therefore be managed based on where they fall on that scale	Accept	Will include terms immunosuppressed, immunocompromised, immunodeficient and immunocompetent into glossary.
General	#69	I like the risk assessments and scenarios and think this is an improvement	Noted. Thank you	No change to guideline
19	#58	3rd dot point to include asepsis 5th dot point include carers	Accept	Will amend
19	#79	4th dot point Infection control replaced with infection prevention	Accept	Will amend
19	#35	Last 2 bullets especially good as it includes the principle that IC is part of all care and involving patients is critical.	Noted. Thank you	No change to guideline
19	#17	Move last sentence in box upfront to beginning	The committee considers this more useful at the end.	No change to guideline
20	#46	Graphic for chain of infection and normal flora would be helpful	Accept	A graphic for chain of infection is to be included
20	#74	Visitors at risk: The use of the term 'visiting' is ambiguous. Does 'visiting' refer to actual visitors, those visiting friends or relatives, or to those visiting for admission? In Australia, the risk of infection for the former is very low and therefore further consideration should be given to this statement. If, however, this statement does refer to those visiting to be admitted as patients, it is suggested it might read better as "patients and staff" instead of "people visiting and working".	Terminology has been used to reflect that all people entering a health care facility should be mindful about minimising the risk of transmission of infection..	No change to guideline
20	#58	Summary: Inclusion of aseptic disciplines in modes of transmission A1.1: health status to include disease caused by diabetes, smoking and immune status of patient. Patents are colonised not groups	Accept	Inclusion of diabetes, smoking in health status

21	#46	Noroviruses are transmitted primarily through the fecal-oral route, either by consumption of fecally contaminated food or water or by direct person-to-person spread. Environmental and fomite contamination may also act as a source of infection. Good evidence exists for transmission due to aerosolization of vomitus that presumably results in droplets contaminating surfaces or entering the oral mucosa and being swallowed. No evidence suggests that infection occurs through the respiratory system	Agreed, Norovirus has not been associated with airborne transmission.	This oversight has been corrected throughout the guideline
21	#25	Norovirus is listed as being potentially transmitted by droplet/contact route in this section, but airborne transmission is mentioned later (see table B2.2). Suctioning mentioned here as aerosolizing* in contrast to previous parts of the document (see bullet #3)	Accept	Typo in Table B2.2 will be amended. Suctioning has been deleted from recommendation for airborne
21 direct transmission	#74	'Unprotected' in this context presumably refers to cuts in the skin which are not covered by a dressing. However, this is not the only scenario in which 'direct transmission' might occur. We also need to consider when there is either a breach in the skin, or any non-intact skin	This refers to an example of transmission. Other examples can also be considered.	No change to guideline
21	#42	droplet transmission- "one metre or less", consider that this distance may increase with forceful coughing and sneezing	Accept.	droplet distribution has been changed to at least 1 metre.

21	#57	The 1 metre rule represents a misreading of the CDC Guideline and should be changed throughout to 2-3 metres. Excerpt from HICSIG influenza statement – http://www.mja.com.au/public/issues/191_08_191009/fer10972_fm.pdf Droplet transmission Droplet transmission occurs via large droplets (> 5 □m diameter) generated from the respiratory tract. Droplet transmission involves direct deposition of large droplets onto the nasal mucosa, conjunctiva and, less frequently, the mouth of the new host. The maximum distance for droplet transmission is unresolved. Historically, the area of risk was defined as a distance less than 1metre around the patient, based on epidemiological and simulated studies of selected infections. Investigations during the 2003 outbreak of severe acute respiratory syndrome (SARS) suggest that droplets could reach individuals located 2metres from their source. The distance droplets can travel depends on the velocity and mechanism by which they are produced, the density of respiratory secretions, and factors such as temperature and humidity.8 From a sneeze or cough, large droplets may be propelled up to 6metres or 2metres, respectively, before settling or evaporating.8 The US Centers for Disease Control and Prevention (CDC) recommend donning a surgical mask within 2–3 metres (6–10 feet) of the patient, or on entry into the patient's room or bed space.9 Although evidence suggests that surgical masking of patients reduces the potential for transmission by filtering out virus,10 in practice these masks become saturated after 10–15 minutes of use and lose their efficacy.	The CDC Isolation Guidelines recommend a minimum1m though consideration need to be given to the severity of symptoms ie. violent, frequent coughing and sneezing. This is an areas where new evidence is emerging and will be monitored as a part of the ongoing review process	This has been included in Section B2 on transmission based precautions
21	#17	Please use consistent terminology throughout the document; also it would be helpful to have the definitions in the glossary for the terms 'rubella (German measles)' and 'rubeola (measles)' to point the difference	Accept	Will include in amended table for B2.3
21 A1.1.1	#69 #75	Contact transmission- applies really well to MRO's but not so well to other infectious agents e.g. Hepatitis A, EBV, VZV etc. This becomes confusing in terms of the PPE required in preventing transmission, because other controls are more relevant, e.g. hygiene, own toilet, food preparation control, immunisation.	Additional information has been added to transmission based precautions to highlight these issues	Managed in section B2
21 A1.1.1	#58	Include touch in contact transmision	Accept	Will include touch in the description.
21 A1.1.1	#58	Droplet transmission add: transmitted via droplets inclusive pertussis and menigococuus	This is not intended to be an exhaustive list but to illustrate the modes of transmission	More detail is provided in Table B2.3
21 A1.1.1	#78	Measles (rubeola) virus. Further on in the document the reference is to rubeola (measles) virus. The virus is also known as morbilli	Accept	Will amend.

21 Airborne	#79	Airborne transmission- include vomiting as an aerosol generating procedure Addition of the following to the end of that paragraph: These particles can also settles onto surfaces. Transmission can be a combination of routes. e.g Varicella transmission is via Airborne prior to the lesions eruption and contact with the skin lesions, Norovirus can be a combination via exposure to the aerosoloised vomitus, and or contact with contaminated surfaces.	This is an inaccurate statement as the mode of transmission from aerosolised vomit is via contact with infectious agents on formites and not via the respiratory system	More detail is provided on specific diseases in Table B2.3
21 Airborne	#58	If aerosolised procedures are undertaken the infectious agent will be transmitted by the airbourne route	Accept	Insert: Small-particle aerosols are created during breathing, talking, coughing or sneezing and secondarily by evaporation of larger droplets in conditions of low humidity. Certain procedures, particularly those that induce coughing, can promote airborne transmission
21 Airborne	#57	Second sentence- re-word and divide in to two sentences: Small-particle aerosols are created during breathing, talking, coughing or sneezing and secondarily by evaporation of larger droplets in conditions of low humidity. Certain procedures, particularly those that induce coughing, can promote airborne transmission	Accept	Insert: Small-particle aerosols are created during breathing, talking, coughing or sneezing and secondarily by evaporation of larger droplets in conditions of low humidity. Certain procedures, particularly those that induce coughing, can promote airborne transmission
22	#51	The summary box on page 29 includes four interventions for standard precautions, whereas table A1.1 on page 22 includes 6 interventions. The content of these two pages should be consistent	Page 29 lists the core strategies of standard precautions where as page 22 outline how they are implemented	No change to guideline

22 A 1.2.	#57	First dot point 'routinely applying standard infection control strategies to reduce risk of contact transmission to both patients and healthcare workers, such as …' [Standard IC Precautions is a base level Contact standard. Contact transmission-based precautions enables one to minimise contact transmission. Best to state that Standard IC precautions 'reduces risk of contact transmission' wherever this comes up subsequently	This dot point is introducing the concept of standard precautions and what they are	No change to guideline
22 A1.2.	#58	Include asepsis with transmission based precautions	Aseptic non touch technique is considered to be the application of standard precaution	No change to guideline
22 Table A1.1	#57	Re-word- 1st dot point 'Personal hygiene practices, particularly hand hygiene and cough etiquette, aim to reduce the risk of contact transmission of infectious agents.'[cross-transmission is a vague term	Accept	Replace with: Personal hygiene practices, particularly hand hygiene and cough etiquette, aim to reduce the risk of contact transmission of infectious agents.
22 Table A1.1	#58	How are aseptic and sterile techniques implemented? Need to explain the difference between medical and surgical asepsis	A section on aseptic non touch technique (ANTT) will added to the guideline to address medical and surgical asepsis	ANTT to be included as a section on implementation of Standard precautions
22 Table A1.1	#57	Re-word- 5th point and 6TH Appropriate reprocessing of reusable equipment and instruments, including effective cleaning, disinfection and sterilisation, aims to prevent patient-to-patient transmission of infectious agents (see Section B1.5). - Ensure all procedures that involve exposure or contact with sterile tissues or fluids are conducted in a sterile manner that avoids contamination (medical or surgical asepsis). Additional points • Screening of at risk patients or healthcare staff • Flagging of known colonised or infected patients • Cohorting healthcare staff so that staff do not care for infected and non-infected patients	This is a brief overview. More detail is provided in chapters.	No change to guideline
22	#79	Table A1.1 Reword last dot point- The appropriate use of aseptic non touch technique and sterile techniques prevents contamination of wounds and other susceptible key sites by infectious agents (see Glossary)	Consultation with ANTT™ has occurred to ensure the correct procedures for ANTT are provided	ANTT will be included as B1.7 in Standard precautions

22	#17	Inconsistencies with the use of the term in the guide- there is no use of the term 'aseptic non touch technique (ANTT). In Europe where some of these recommendations originated from, this term is used, for example EPIC guidance. Changing the term is confusing and we believe that the use of aseptic, sterile, and clean technique are inappropriately used in many cases throughout the guide.	Consultation with ANTT™ has occurred to ensure the correct procedures for ANTT are provided	Aseptic non touch technique will be included as B1.7 in Standard precautions
23	#47	Part A, A1, page 23, Table A1.2, 5th dot point "Using disinfectants effective against the specific infectious agent" Suggest that this be amended to read: "Use a TGA registered disinfectant with label claimed or published literature evidence against the specific infectious agent" Disinfectant should also have differential definitions included in the glossary after Appendix 3	Accept	Will be changed to: Use a TGA registered disinfectant with label claims specifying its effectiveness against specific infectious organisms. TGA terminology will be added to glossary.
23	#71	Table A1.2, 5th dot point [page 23] Amend – "using disinfectants effective against the specific infectious agent" To read – "using a TGA registered disinfectant with label claimed or published literature evidence against the specific infectious agent"	Accept.	Will be changed to: Use a TGA registered disinfectant with label claims specifying its effectiveness against specific infectious organisms.
23	#78	should be to be replaced with must in relation to infection control strategy	Should is acceptable. Infection control strategies will be different across different health care settings..	No change to guideline
23 table A1.2	#79	allocating a single room to a suspected or proven infected patient (isolation);	Accept	Will be amended.
23 table A1.2	#58	1st point: allocating a single room with door closure with ensuite, and may require special ventilation. 2nd: infected with the same infectious agent and antibiogram in a room 7yh –negative pressure	Accept	Will be amended.
23 table A1.2	#16	Dot point 6 – "providing a dedicated toilet", suggest change to: providing a dedicated ensuite Particularly for patients isolated with a pathogen whose reservoir is the gastrointestinal tract, use of single rooms with private bathrooms limits opportunities for transmission. This is of further importance when the patient has poor personal hygiene habits, faecal incontinence, or cannot be expected to assist in maintaining procedures that prevent transmission of microorganisms (Healthcare Infection Control Practices Advisory Committee [HICPAC], 2007)	Accept	Will be amended as suggested.

23 table A1.2	#78	"dedicated toilet" – is this referring to dedicated toilet and bathroom facilities, or dedicated toilet and hand washing facilities	Noted.	Will be amended to ensuite
23 table A1.2	#57	Re-word: Contact precautions are used when there is known or suspected risk of direct or indirect contact transmission of infectious agents (e.g. MRSA) that are not effectively contained by Standard Precautions alone (see Section B2.2). Again, it must be clear that SP is our base level Contact standard and that we add in Contact precautions in situations only where highly transmissible agents require additional levels of protection Droplet precautions '…. Transmitted over short distances by large droplets (> 5uM).	Accept	Will use suggested text
24	#58	Suggest transmission acquisition rather than colonisation in 1st sentence. Also include the follow up of outcomes in the 1st dot point	Terminology is consistent with Committee consensus. Will add to glossary.	No change to guideline
24	#44	This standard has been updated AS/NZS ISO 31000:2009,Risk management – Principles and guidelines	Accept	Will include in reference.
24	#79	Risk management end of 1st para to be have facility replaced with Health Service responsible for Health Service accountable to Commonwealth Health Service responsible for Commonwealth Health Service accountable to State health Service responsible for, State health Service accountable to Area Health Service responsible for Area Health Service accountable to Facility responsible for Facility accountable to Wards departments responsible for Wards departments accountable to	Level of detail is not necessary for the guideline. This guideline is also targeted to organisations outside state based health service facilities..	No change to Guideline
24	#46	There is a level of skill required to use a risk analysis matrix (how will that be addressed?)	Implementation tools and strategies are currently be developed on performing risk analysis in a health care setting.	Resource will be available on NHMRC website
25	#57	The two dot points under 'Evaluate risks' should be under 'Analyse risk' Under Evaluate risks, need to specify that the likelihood and consequences are assessed and the matrix Table A2.1 is consulted to arrive at a risk rating. E.g. example given on page 35.	Accept	Will include suggested changes.

25	#46	Figure A1.1-I think will be good to use an actual example that is infection prevention related as again this requires a level of experience or skill – the latter example on p 35 is in fact an outbreak situation p 46 is a cluster or potential outbreak	This is the diagram is to illustrate the methodology of how undertake a risk assessment . Multiple examples have been provided through out the guideline in addition to supporting material on decision making.	No change to guideline
26 A3.2	#79	Proposed Reword: Infection prevention is ultimately about people's expectation that their care will not result in infection.	The statement is to demonstrate that all people have a role in preventing infection. This includes management, staff, patients, and visitors of a health care facility..	No change to Guideline
26	#44	This Summary is very comprehensive and includes links to tools in Part D that assist in the delivery of patient centred care. However, the key messages are repetitive in the specific text boxes throughout the document, ie. 'Involving patients in their care', and not always consistently provided. While HCWs need to be aware of how to include the patient in their care, it may be more effective if we had a comprehensive individual section on involving patients in their care or providing a supportive document for patients as per the NHS UK Booklet National Institute for Clinical Excellence, NHS, 2003. Prevention of Healthcare Associated Infections in Primary and Community Care – Information for patients, their carer's and the public.	This has been considered as part of implementation of the guideline however is dependent on available resources to be able to conduct this work.	Addition of NICE guidance to the resource list
26	#25	Patient-centred approach is very good. Like mention of facility design and patient engagement	Noted. Thank you	
27	#60	• A3 – A Patient Centred Approach (page 27). The recommendation of 'posters in waiting rooms' is a contentious issue in private health care facilities. Talking posters / loop video are also suitable and may be preferred by private facilities. • Clarification around the following terms is required 'infection control' versus 'infection prevention and control'	Noted.	This is provided as an example only. Terminology should be infection prevention and control. This will be made consistent throughout the document.
27	#58	End of 1st sentence : minimise cross infection or transmission Delete: infection control breeches and use he term infection prevention Simplify 6th dot point	Accept	Will amend as per suggestions.
Section B1				
B1.1 Hand hygiene				

Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
general	#26	Hand hygiene should be spread to the broader community not just the acute care setting	Agreed	Hand hygiene chapter will include text of how 5 moments are applied in non acute care settings.
30	#79	Hand hygiene practices alone are not sufficient to prevent and control infection and need to be used as part of a multifactorial approach to clinical practices and health care.	Committee believe this statement is implied and stated in the guidelines, particularly when referenced to care bundle approaches	No change to Guideline
30	#54	In section B1.1 (Hand hygiene), no mention is made of any difference in hand hygiene for different procedures. In section B4 however hand preparation for surgical procedures is described, which differs from that outlined in page 30. This difference should be highlighted here and linked to section B4.	Agreed	Guideline will refer to B4 for specific hand hygiene practices for procedures.
	#54	The table in the 2004 document was most useful. Moreover, no details are included on how to dry ones hands after washing and there is no requirement to wash your hands before putting on gloves.	5 moments addresses all hand washing protocols.	A statement on drying after hand washing will be included
B1.1.2 When to perform hand hygiene				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
30	#25	it is not clear when HH should be performed: In this section the guidelines state that hands can become contaminated with infectious agents through contact with a patient, patient surroundings, the environment, or other HCWs. Then perhaps the HH opportunity or routine hand hygiene should include before patient environment contact?	5 moments model addresses when hand hygiene should be applied.	Text has been added to assist with the application of 5 moments in primary care.
30	#74	It is suggested that this list should also include: “after touching the patient’s surroundings, including their medical record”	Guideline is a principles based document, suggested additions considered too prescriptive for the guideline but could be considered by the local infection control policy	No change to Guideline
31	#29	Routine hand hygiene: despite largely endorsing the WHO five moments of hand hygiene guidelines there is issue in primary care as risk assessment has been excluded. There is no direct evidence that hand hygiene performed before and after low risk consultations in low-risk	It is noted that within primary care more invasive procedures and complex care are being undertaken	Guideline will also refer to discipline based guidelines including RACGP infection control

		patients (for example counseling sessions or simple blood pressure checks in low risk patient groups) requires handwashing before and after each consultation. The only benefit likely to be just performing it as a routine.	for which the 5 moments should be adhered to.	guidelines 2007
31	#33	We note that hand hygiene is not promoted prior to donning gloves, only after. Our thinking is that we should perform hand hygiene before donning gloves to protect the patients – we have demonstrated the effect of pinholes in gloves allowing organism transfer so should consider protecting the patient from the wearer as well as visa versa. This practice also forms part of the '5 Moments Approach to Hand Hygiene'	5 moments model is sufficient for HCW in the clinical context	Additional text will be provided on hand hygiene in relation to PPE
31	#17	Rec 1 – 5 moments: Hand hygiene is also performed after the removal of gloves. The sentence is not appropriate as it looks as part of the routine hand hygiene and people could think they should perform the hand hygiene with the gloves on.	Committee has reviewed and it is consistent with the 5 moments terminology being used.	No change to Guideline
	#69	Include also in the note HH performed also before fitting/placing and on removal of face protection. Routine hand hygiene should read hand hygiene before applying gloves	5 moments model is promoted in the Guideline. The reference to hand hygiene and PPE is documented in the PPE section	No change to Guideline
	#81	5 moments is limiting as HH required as a part of cough etiquette, before food handling and donning/removing PPE, toileting and during equipment reprocessing	Agreed	Committee will develop additional texts for non patient related hand hygiene requirements in situations eg food handling, waste disposal
Cough etiquette				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
31/32	#20 #80	Should cough etiquette be renamed respiratory etiquette given that it covers coughing and sneezing?	Agreed	Terminology was reviewed and has been changed to reflect respiratory hygiene and cough etiquette. Terms added to glossary
32 Table B1.1	#58	Add in last line……. and contaminated objects/materials – Cleaning of the environment with an alcohol wipe	Table is for cough etiquette only. Cleaning is covered in other sections of the guideline.	No change to guideline
32	#79	Remove Cough etiquette' from the HH section	Agreed	Respiratory

		If Cough etiquette remains, toilet etiquette should also be included in order to reduce HAI gastro infections		hygiene/cough etiquette will have a separate section
B1.1.3 What product should be used?				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
32	#51	This section should include a brief statement about the flammability properties of alcohol hand rub and the need to ensure appropriate use and storage of these products to minimise the risk to patients and staff	Agreed	terminology from the HHA safety statement and the WHO 2009 Guidelines will be incorporated
32	#14	Recommendation to use an alcohol based hand rub over washing the hands with plain or antiseptic soap and water. We question whether a clearer distinction needs to be made between health related, clinical activities (such as wound care, catheterization, administration of topical medication) and general care activities (such as assisting residents to dress or undress, assistance with mobility, before handing out meals). We emphasize frequently the need for our care staff (residential aged care) to wash their hands between all resident contacts because most of these contacts are non-clinical. As the recommendations stand now, they could be interpreted to mean that care giving staff will need to apply an alcohol based hand rub between each resident contact. We believe this could be excessive and lead to damaged skin. We accept that nurses who are performing clinical tasks would best apply an alcohol based rub to their hands before performing these sorts of tasks. I also cannot see a recommended time interval between applying alcohol based hand rubs. Should there be one, given that the rubs have a residual effect? Again, we could see care giving staff applying a rub scores of times a day, which would lead to skin damage.	The committee acknowledges the concerns of residential care, however from an infection prevention and control risk management perspective the HHA 5 moments are still be applicable in RCF. Generally, alcohol-based hand antiseptics cause significantly less skin damage than handwashing with plain or antiseptic soaps [77].	No change to guideline
32	#54	It is interesting that the document recommends alcohol-based hand rubs containing at least 70% v/v ethanol or equivalent for all routine hand hygiene practices in the healthcare environment, but only using soap and water when hands are visibly soiled – this is a significant change in practice. According to page 15, “routine practices should continue unless there is sufficient evidence to support alternative procedures” and the document	Recommendation for ABHR over soap is consistent with international guidelines and hand hygiene policies within Australia	No change to guideline

		makes the case on page 32-34 for this significant change.		
32	#44	70% v/v ethanol contrary to HHA production selection as outlined in HHA 4.2 1. The Product meets the EN1500 testing standard for bactericidal effect 2. The Product has Therapeutic Goods Administration (TGA) approval as a hand hygiene product However, product selection is ultimately the choice of each health care facility, and other factors should also be considered, such as: - Dermal tolerance. - Aesthetic preferences such as fragrance, colour, texture and ease of use - Practical considerations such as availability, convenience, functioning of dispenser, and ability to prevent contamination - Cost issues	Agreed	Choice of hand hygiene product has been moved from Section C to Section B1.1
32	#54	In the section regarding the choice of hand hygiene products, it is stated that alcohol-based hand rubs are highly effective against bacteria and viruses, but not against bacterial spores. The Guidelines should state that soap, water and disposable paper towels are recommended for use where bacterial spores are suspected to be present.	Section B2 includes recommendation about soap and water when bacterial spores are suspected to be present for Clostridium Difficile	No change to guideline
32 B1.1.3 and Rec 2	#72	"Alcohol-based hand rubs containing at least 70% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment." Cathy Murphy Confidential submission Australian healthcare workers will be limited in their use of such products as they would not strictly meet the stringent requirements as specified in the current wording of Recommendation 2 (70% cutoff). Detrimental because may impact on skin damage and non-compliance. Performance of an ABHR is not just dependant on the alcohol concentration – there are other formulations that can improve the micro activity. Also no elaboration is made on the different ways alcohol concentration can be measured (%v/v; %w/w; and %w/v) such as in the WHO guidelines. The systematic literature review is potentially biased based on the following factors: - it has excluded important papers from analysis (Rupp and Fitzgerald) - it is overreliant on European literature compared to US literature - it is overreliant on European standards eg. EN1500	NHMRC has reviewed information from TGA and the WHO Hand hygiene guidelines and adjusted the recommendation	Recommendation: Alcohol-based hand rubs that meet the requirements of EN 1500 AND contain between 60-80% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment.

		- this is not representative of expert opinion in this field - guidelines used by the reviewer are not sufficiently rigorous - Critical of the TGA process Adoption of this recommendation would cause disruption to supply, placement, storage and healthcare worker retraining and likely negatively impact compliance rates and hand hygiene activity. Recommendation: reconsider wording of Rec 2 to: Alcohol-based hand rubs that meet the requirements of either EN 1500 or ASTM E-1174 test AND contain between 60-80% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment providing that they do not cause adverse damage to healthcare worker's hands or negatively impact compliance rates.		
32 B1.1.3	#48	"Alcohol-based hand rubs containing at least 70% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment." Graeme Shelley, Hartmann PTY Ltd Based on scientific evidence it is difficult to understand the rationale for the cut-off point for sufficient efficacy of ethanol-based hand rubs being set at 70% (v/v). There is evidence that at least two formulations with 70% ethanol do not fulfill the EN 1500 efficacy requirements when applied with 3 ml for 30 seconds which is common practice in healthcare facilities (5). There is also evidence that a hand gel based on 62% ethanol supplied in Australia may be suitable to improve compliance in hand hygiene significantly but does not reduce healthcare-associated infections at the same time. Furthermore, the WHO guideline recommends ethanol at 80% or more as the standard (1). Many experts in the field such as Widmer, Rotter, Pittet, Boyce or Maiwald considered the low ethanol concentration as the probable key reason for the low levels of efficacy in a clinical setting (6, 7, 10). If in Australia ethanol with at least 70% v/v is recommended, it should be clear this concentration is equal to approximately 62.6% w/w. It is proposed that the WHO guideline is followed, and a recommendation for hand rubs containing at least 80% ethanol or equivalent is recommended.	NHMRC has reviewed information from TGA and the WHO Hand hygiene guidelines and adjusted the recommendation	recommendation Alcohol-based hand rubs that meet the requirements of EN 1500 AND contain between 60-80% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment.
32 B1.1.3	#71	"Alcohol-based hand rubs containing at least 70% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment."	NHMRC has reviewed information from TGA and the WHO Hand hygiene	recommendation : Alcohol-based hand rubs

		ACCORD The NHMRC recommendation is ambiguous, out of step with international recommendations, unsupported by the scientific literature, and unnecessarily restrictive given that all ABHRs on the Australian market are assessed by the TGA to ensure protection of public health and safety. Therefore, ACCORD recommends that the NHMRC should uphold the Australian regulatory system by recommending all products that have been entered on the Australian Register of Therapeutic Goods (ARTG); that is, approved as hand hygiene products by the TGA. Should the NHMRC persist with more specific recommendations regarding AHBR alcohol concentration, ACCORD suggests: • Reconsideration of the 70% lower ethanol limit, in step with international recommendations and in light of published literature results; • Inclusion of an upper alcohol limit, in step with long-standing knowledge regarding that alcohol diluted with water improves antimicrobial action, and as reflected by other guidelines' recommendations; • Rephrasing of the recommendation to remove ambiguity regarding "or equivalent" for the type of alcohol present; and, • Indication of the standard or performance criteria on which the recommendation is based. Evidence and rationale referred to in submission	guidelines and adjusted the recommendation	that meet the requirements of EN 1500 AND contain between 60-80% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment.
32 B1.1.3	#41	"Alcohol-based hand rubs containing at least 70% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment." Matthias Maiwald While these statements continue to be correct and are a correct quote of my systematic review, there are also other aspects pertaining to the choice of a good ABHR: - recognised international testing standards for antiseptics which is scientifically valid, objective, reproducible and relevant for clinical practice, does not fit the NHMRC criteria for evidence in the sense of Evidence-Based Medicine. The most stringent testing requirement internationally for ABHRs is the European standard EN 1500 which is supported by WHO HH guidelines. - different alcohol species (ethanol, isopropanol, n-propanol) have different antimicrobial activity. For example, an ethanol concentration of 80% v/v is approximately equivalent to isopropanol at 70% v/v and n-propanol at 60% v/v. Also,	NHMRC has reviewed information from TGA and the WHO Hand hygiene guidelines and adjusted the recommendation	recommendation Alcohol-based hand rubs that meet the requirements of EN 1500 AND contain between 60-80% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment.

		commercial alcohol preparations often contain blends of the different alcohol species. Thus, the most objective criterion would indeed be to pass stringent testing requirements rather than a concentration requirement. Thus, I realise that there are shortcomings with my own systematic review (as stated above), but if not in this edition of the NHMRC guidelines, I would encourage the Writing Committee to look at stringent antiseptic testing requirements at least for the next edition.		
32 B1.1.3	#15	Alcohol-based hand rubs containing at least 70% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment. ICP Hollywood Private Hospital A statement such as the above in relation to use of the preferred product seems to me to be bordering on endorsement of only a 70% product. Why does this statement not match the HHA website? “Alcohol-based hand rubs are more effective against most bacteria and many viruses than either medicated or non-medicated soaps” The reference documents used to back up the choice of product statement are not mentioned on the HHA website. Why is there no alignment between this two as HHA is based on recent research. I recommend that this statement wording is reconsidered as majority of HCW will think that they are not protected if the content is less than 70%. As you are aware and HHA explains that there is a difference from one alcohol type to another eg “Conversion tables are available for comparison between V/V and w/w for ethanol only (49). A sample of ethanol labelled with a concentration of 70% V/V is equivalent to an ethanol sample labelled as 62.39% w/w (49). Thus it becomes confusing for staff if this statement remains as is.	NHMRC has reviewed information from TGA and the WHO Hand hygiene guidelines and adjusted the recommendation	Recommendation : Alcohol-based hand rubs that meet the requirements of EN 1500 AND contain between 60-80% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment.
32 B1.1.3	#35	Alcohol-based hand rubs containing at least 70% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment. Gunther Kampf, Bode Chemie Recommendation: Follow the WHO guideline is followed, and recommend hand rubs containing at least 80% ethanol or equivalent. In our view the scientific literature on efficacy of alcohol-based hand rubs does not support the lower concentration limit of ethanol-based hand rubs being set at 70% (v/v). First, there is evidence that at least two formulations with 70% ethanol do not fulfill the EN 1500 efficacy requirements when applied with 3 ml for 30 seconds which is common practice in healthcare facilities (5). Second, the WHO guideline recommends ethanol at 80% or more (1). Third, there is also evidence	NHMRC has reviewed information from TGA and the WHO Hand hygiene guidelines and adjusted the recommendation	Recommendation Alcohol-based hand rubs that meet the requirements of EN 1500 AND contain between 60-80% v/v ethanol or equivalent should be used for all routine hand hygiene practices in the healthcare environment.

		that a hand gel based on 62% ethanol (Purell Gel) may be suitable to improve compliance in hand hygiene significantly but does not reduce healthcare-associated infections at the same time. Many experts in the field such as Widmer, Rotter, Pittet, Boyce or Maiwald considered the low ethanol concentration as the probable key reason for finding (6, 7, 10). If in Australia ethanol with at least 70% v/v is recommended, it should be clear this concentration is equal to approximately 62.6% w/w.		
32 B1.1.3	#41	"The addition of a low concentration of chlorhexidine to an alcohol-based hand rub enhances residual activity (Rotter 2004; Grayson et al 2009) but has been associated with skin sensitivity." Matthias Maiwald Of the articles included in my systematic review, only the New Zealand guideline (Larmer et al. 2008) made a statement to support the addition of chlorhexidine to ABHRs. However, the evidence cited was clearly insufficient to support such an addition, and this was criticised in my systematic review. None of the other major international systematic reviews and evidence-based guidelines contains a recommendation to add chlorhexidine, including the WHO guideline (World Health Organization, 2009a). The reference by Rotter (2004) in the NHMRC guideline may have been quoted out of context. While it is correct that the addition of chlorhexidine to ABHRs adds residual activity, this activity is small, according to Rotter, and likely to be overwhelmed by microorganisms in any subsequent touching act if hand hygiene is not performed again after each contact. Thus, the addition of chlorhexidine may even convey a false sense of security. In personal correspondence, Rotter made clear statements that he thinks that the addition of chlorhexidine to standard ABHRs is not necessary (M. L. Rotter, personal communication). Where Rotter supports the addition of chlorhexidine (or other substances with residual effect) is surgical hand antisepsis (scrubbing), to prevent regrowth under the surgical gloves, but this is a completely different application of hand hygiene than standard, wardbased hand hygiene. In conclusion, while the statement in the NHMRC guidelines on the addition of chlorhexidine to ABHRs is not incorrect per se, there is no evidence or microbiological rationale to support its addition to standard hand hygiene agents. Thus, the above sentence can be safely omitted.	Agreed	Sentence deleted.
32 B1.1.3	#48 #35	The addition of a low concentration of chlorhexidine to an alcohol-based hand rub enhances residual activity (Rotter 2004; Grayson et al 2009) but has been associated with skin sensitivity. Graeme Shelley, Hartmann Pty Ltd Gunther Kampf, Bode Chemie	Agreed	Sentence deleted.

		Given that the body of evidence for the role of CHG in hand hygiene is unclear, it is proposed that the sentence “The addition of a low concentration of chlorhexidine to an alcohol-based hand rub enhances residual activity” is deleted. Rationale: The “residual activity” is supported with a reference of Rotter which is his book chapter in Mayhall’s textbook, which is assumed to refer to the figure with the killing curves for surgical hand disinfection. Although the figure indicates that the addition of CHG at 0.5% to iso-propanol has some “residual activity”, this is not considered to be scientifically valid for the following reasons: • The figure referred to above in Mayhalls’ text describes data on the efficacy of surgical hand disinfection which does not appear to be the scope of this guideline in B1.1.3. • Rotter tried in 2007 to repeat his experiment in a prospective randomized double-blind trial and could not verify the data he presented in his book chapter (8). There was no additional activity of 0.5% CHG. Neutralization was validated so that the study design can be considered to scientifically sound in that detail (see below). • Many data on a “residual activity” of CHG in the literature are considered to be potentially false positives due to insufficient neutralization of ongoing biocidal activity of CHG after the exposure time. This effect has been shown to overestimate the efficacy according to EN 1500 by approximately 2 log10-steps (4), simply due an insufficient study protocol. The CDC guideline on hand hygiene also attributed “residual activity” to CHG (2) but the quality of the test methods in the original studies used to support “residual activity” were not designed to support the claim “residual activity” (3). • If healthcare workers expect a “residual activity” by CHG in hand hygiene which appears to not well supported by well-designed studies, they may be tempted to lower compliance which is against all global efforts to improve compliance in hand hygiene.		
32	#79 #46	Rewording The addition of a low concentration of chlorhexidine to an alcohol□based hand rub enhances residual activity (Rotter 2004; Grayson et al 2009) but has been associated with skin sensitivity in some persons Reference for skin sensitivity?	Agreed	Sentence deleted.
32 B1.1.3	#58	Recommend include details of SA review of ABHR	No reference or context provided	No change to guideline

32	#79	Reword: Antimicrobial soap may be remove is associated with skin care issues. Additional text • Hands should be washed with soap and water when caring for persons infected with CDAD, • hand should be washed with an antimicrobial solution when caring for persons suspected to be infected with Norovirus. • An antimicrobial solution should be used for a Procedural HH prior to an aseptic procedure and or aseptic non touch technique using either • 1. ABHR or • handwash with antimicrobial solution Both should be used for the recommended correct skin contact times and a thorough procedural HH technique should be completed.	Committee have reviewed comments but Supporting evidence is required to change from current practice	No change to guideline
32	#51	Rec 2 The ethanol concentration of commonly used alcohol hand rub formulations in healthcare settings are labelled by weight (w/w) rather than volume (v/v). To avoid confusion, it may be useful to include a statement in section B1.1.3 (What product should be used?) that explains that a sample of ethanol labelled with a concentration of 70% v/v is equivalent to a sample of ethanol labelled as 62.39% w/w . (Reference: Healthcare Infection Control Special Interest Group http://www.asid.net.au/hicsigwiki/index.php?title=Hand_hygiene_alcohol-based_agents).	Accept	Have elaborated on differences
32 Rec 2	#58	Add must comply with EN 1500 Standard	NHMRC has reviewed information from TGA	The standards TGA uses to assess products for use in Australian will be incorporated into the Guideline.
32	#17	Rec 3 should have liquid soap and water	Text is currently consistent with international guidelines	No change to guideline
32 B1.1.3	#28	Recommendations. 3. (Section B1.1.3) Choice of hand hygiene products when hands are visibly soiled – Soap and water may not be available in the bush so what is the acceptable standard? These recommendations will be difficult to achieve and maintain in the remote environment due poverty, isolation and its impact, without resourcing with regard to training, equipment and organizational support via policy/procedures.	Accept	An additional statement will be included on the use of alcohol detergent wipes, particularly for remote areas.
32 B1.1.3	#35	Note: Neutral hand wipe products may also be considered in instances where hygienic access to soap and water is not readily available such as	Accept	An additional statement will be included on the

		in community care settings. INFECTION CONTROL POLICY DOCUMENT: PD2007_036., 2.1.1.8 Promoting patient and visitor hand hygiene; Hand Hygiene in Western Australian Hospitals OD 0263/10 http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html		use of alcohol detergent wipes, particularly for remote areas.
33	#58	Disagree with vigorous rubbing the same goes corresponding point in table B1.2	Accept	The term 'vigorous' has been removed.
33 Table B1.2	#79	Suggested Reword: Apply the manufacturer's recommended amount of alcohol-based hand rub into a cupped hand. Dip the fingertips into the solution, rub hands vigorously so that the solution comes into contact of all surfaces of the hands, and wrists, follow the technique provided by the manufacturer. To achieve a bactericidal effect follow the minimum skin contact times	Guideline is a principles based document. Level of detail suggested should be administered by local infection control policy and protocols.	No change to guideline
33 Table B1,2	#17	Apply the amount of alcohol-based hand rub recommended by the manufacturer to dry hands. Please add the word 'on' in front of 'to dry hands'	Accept	Reference to manufacturers instructions has been included
33 Table B1.3	#79	1st dot point add antimicrobial soap 2nd and 3rd dot points hand and wrist to be covered and well as hand and wrists to be rinsed	Guideline is a principles based document. Level of detail suggested should be administered by local infection control policy and protocols.	No change to guideline
33 Table B1.3	#25	include the advice to use the paper towel to turn off taps so that hands are not re-contaminated.	Guideline is a principles based document. Level of detail suggested should be administered by local infection control policy and protocols.	No change to guideline
33 Table B1.3	#58	Describe by Action…., application of solution….,hands are dry and remove references to rubbing and vigorous. Note that hand driers should not be used	Guideline is a principles based document. Level of detail suggested should be administered by local infection control policy and protocols.	No change to guideline
33 B1.1.4	#78	We suggest that all references need to be carefully checked. Some are incorrect, and not all the references cited in the text are in the relevant bibliography. For example, the Larson (1996) citation is not in the bibliography, and the date for the Trick et al paper is inconsistent between citation and bibliography	Accept	Referencing will be reviewed for final document
33 B1.1.4	#60	There is a need to specify that nail polish as well as artificial nails are inappropriate in clinical care. A 'bare below the elbows' policy should also be recommended. Frequent changing of waterproof dressings should also be stressed	Accept	Studies have demonstrated that chipped nail polish may support the growth of

				organisms on the fingernails. Statement will be included for chipped nail polish and the risk of infection. Although level of detail suggested should be administered by local infection control policy and protocols.
33 B1.1.4 Hand Hygiene	#9	False nails and nail polish should be banned for all contact healthcare workers, not just surgical workers. Many hospital acquired infections are acquired in a ward situation (not just surgical) and if the evidence is solid enough to support a ban for surgical healthcare workers, it should be extended to all contact staff. Hand washing should be audited amongst senior staff as well as students and junior staff, and non compliance should be met with action.	Accept	WHO 2009 A growing body of evidence suggests that wearing artificial nails may contribute to the transmission of certain health care-associated pathogens. HCWs who wear artificial nails are more likely to harbour Gram-negative pathogens on their fingertips than those who have natural nails, both before and after handwashing154,534,974,975 or handrub with an alcohol-based gel.154
33	#58	Nails to the length of finger pad No nail varnish, artificial nails or adornments	Accept	Refer to above statement
33 B1.1.4	#79	- Artificial nails should not be worn if providing clinical care - Jewellery should be termed hand and wrist jewellery with the mention of watches. Also deletion of because of no scientific value limited to a plain band (e.g. wedding ring) and this should be moved about on the finger during hand hygiene practices has been suggested - Inclusion of whilst performing invasive procedures the wearing of any jewellery, even a plain band, is not recommended	Accept	Refer to above statement for artificial nails WHO 2009 Further studies are needed to establish if wearing rings results in a greater transmission of pathogens in health-care settings. The consensus recommendation is to strongly discourage the wearing of rings or other jewellery during health care.

33	#75	No mention of wrist jewellery, this needs to be added to distinguish between hand jewellery and wrist jewellery, to enforce no jewellery should be worn below the elbows.	Statement will be added. Guideline is a principles based document. Level of detail suggested should be determined and administered by local infection control policy and protocols, including a 'Bare below the elbows' policy	Statement on jewellery will be added.
	#9	Should recommend 'Bare below the elbows (no rings, bangles, watches, sleeves etc) should become common practice in Australian hospitals, as it has in the UK under the NHS review of infection control.	Guideline is a principles based document. Level of detail suggested should be determined and administered by local infection control policy and protocols, including a 'Bare below the elbows' policy.	Statement on jewellery will be added.
B1.1.5 Hand care				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
33 B1.15	#16	"Generally alcohol-based hand rubs cause significantly less damage than hand hygiene with plain or antiseptic soaps." Suggest the term irritation which is used in the WHO Guidelines on Hand Hygiene in Healthcare (2006), or skin reaction (Hand Hygiene Australia [HHA], 2009). My own experience is that HCW's do complain of the adverse affects of frequent hand hygiene (even mild dryness) and therefore use of the word "damage" may be interpreted negatively by some readers and discourage best practice in hand hygiene.	Accept	Will use the terms skin reaction or irritation instead of damage.
34 B1.15	#78	The importance of hand care is emphasised but the implication is that the procurement of hand care products within a health care facility should be done in consultation with the infection control practitioner. This could be usefully emphasised.	Section C outlines roles and responsibilities for staff within health care facilities. Guideline is a principles based document. Level of detail suggested should be determined and administered by local infection control policy and protocols..	No change to guideline
34 B1.15	#35	Hand care In addition to being chemically compatible with the alcohol-based hand rubs, soaps and moisturising lotions must be compatible with the materials and equipment with which the moisturised hands may come into contact	Guideline is a principles based document. Level of detail suggested should be determined and administered by local	No change to guideline

			infection control policy and protocols..	
34	#46	There could be a reference to the HHA hand auditing form for irritant contact dermatitis. Also a risk assessment form – for staff on employment e.g. do they have in exfoliating skin condition, eczema any other underlying medical condition. I believe there is a real gap in regards to staff treatment process as referring to infection control or occupational health advice is generally only reiterating current guidelines, wouldn't this advice be the same nationally and flowchart process could be used. This would support knowing when the staff member treatment should be sought from a specialist	Accept	Reference to form for staff responsible of occupational health and safety for irritant dermatitis. However risk assessment forms should be determined by local institutions.
34 B1.1.5	#47	Hand Care "Expert opinion concludes that:" (All 5 dot points) This is an area requiring urgent study. We are aware of reports of sensitivity to all of the various types of hand washes and handrubs. The products are all regulated by the TGA and the regulatory framework is too onerous and without sufficient flexibility. This matter is in discussion elsewhere with the regulator. Nonetheless, as a supplier of various products we have major concerns from a liability perspective as to the frequency of skin irritation under the current guidelines. Emollient usage within products is a critical issue not canvassed in the document. Many incidents of hand or skin irritation are simply not reported in the literature but rather turn up in statutory literature such as workers compensation records. This evidence does not appear to have been accessed but should definitely be canvassed prior to the revision.	Guideline is a principles based document based on the best available evidence. Level of detail suggested should be determined and administered by local infection control policy and protocols. The evidence is in compliance, and reduced nosocomial infections	No change to guideline
B1.1.1.6	#58a	6th: not conclusive to caring patient environment 8th be the patient advocate	Committee has reviewed and decided level of detail not required..	No change to guideline
B1.1.1.6	#75	there should be a statement in here describing when patients should undertake hand hygiene, not just stating they are to comply. Also in this section line 8 refers specifically to HCWs with fingernails, this should be moved out of this section and place into B1.1.4 and the statement expanded	Accept.	Statement on fingernails will be added. The Guideline supports the 5 moments model of when to apply hand hygiene.
35 involv pt in care	#35	Note: " It's okay to question healthcare workers about their hand hygiene practices" potentially challenges the patient and may jeopardise their care. Rather, healthcare workers should be encouraged to routinely advise the patient that hand hygiene has been performed prior to contact, thus reaffirming the responsibility of the HCW and reassuring the patient	Accept	Document will refer to Patient's Rights Charter and this is not consistent with consumer feedback.
35	#60	Putting it into Practice (page 35). Specify that nail polish should not be worn	Accept	Statement on nail polish will be included.

35	#58	Analysing the risk: hand solution checked? Evaluating the risk: clinical managers daily observations	Accept	Will include suggestions in text.
35 B1.1.1.6	#79	Change to 7th point –last sentence to read. When hand are washed with soap and water, or antimicrobial solution hands should be rinsed thoroughly and patted dry. 8th point add or hand and wrist jewellery for clinical cares.	Committee has reviewed and determined the current level of detail is suffice..	No change to guideline
B1.2 PPE				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
general	#63	Recommendations for use of personal protective equipment are developed for hospital and aged care settings, where there is a higher likelihood that clients carry pathogenic organisms, and/or are immune-compromised. Use of gloves, gowns, masks and eye protection in general medical examination, as recommended in these guidelines, would be very infrequently appropriate in primary health care. CARPA recommends these for certain procedures, rather than clinical examination, and this distinction may make implementation simpler as examination is unlikely to generate splash risk, while procedures may.	Disagree, PPE = personal protective equipment and is applicable to all settings.	No change to text
general	#58	Replace body fluids with body substances in this section	Noted, correct terminology as the concern is not only with fluids	Replace fluid with substances and add it the glossary as this is an area that has many local meanings and terminology. CDC / PIDAC examples simple. EPIC information practical application.
36 B1.2.2	#55	Congratulations on making a sensible comment in relation to the wearing of surgical scrubs outside the operating theatre environment	Noted.	
36 B1.2.2	#60	Recommend that the wording for not wearing operating theatre attire in public areas / outside the hospital be strengthened	Disagree, the statement is clear and indicates the intent of the heading where to wear PPE. Facilities need to “strengthen” the compliance through measures such as policy, procedures and governance for their individual facility.	No Change to text
36	#44	Suggest requires a specific reference to Operating Theatre Standards in	Disagree, Local policies	ACORN website provided

B1.2.2		relation to Uniform and foot wear, eg. as per/refer to ACORN Standards. This also applies to the wearing of jewellery and artificial nails. Standards for Perioperative Nursing including Nursing Roles, Guidelines and Position Statements, www.acorn.org.au	and procedures for the individual facility will strengthen compliance .	in Section D
36 B1.2.2	#79	Add the following to end of 1st para: and Professional Regulations. NSW Medical Practice Act, Infection Control Regulations, NSW Nurses Act 1991 Infection Control Regulations amendment	Disagree. location specific information is provided in Part D	No change to text
36 B1.2.2	#17	Factors to be considered are: • probability of exposure to blood and body fluids; • type of body fluid involved; and This point should be removed • probable type and probable route of transmission of infectious agents.	Disagree, from a risk management perspective the information on the type of body fluid/substance is necessary in making decisions about PPE. Not able to make adequate risk assessment and identification to enable risk prevention/control.	Replace fluid with substance throughout guidelines
36	#58	Delete the term high risk of contamination PPE in OTS are used to protect the patient from infection as well as the HCW from contamination	Disagree, the section will not make sense without high risk and the explanation given does not support the removal of the wording.	No change to text
36 B1.2.2	#52	This statement is not clear: It confuses the perioperative attire (unsterile pyjama/scrub suit) worn as a uniform by staff in the operating suite with the personal protective equipment (PPE) worn by staff on top of the perioperative attire. In the context of the operating suite, the term 'PPE' refers to cover gowns, gloves, mask and protective eyewear. It does not refer to the pyjama/scrub suit (ie unsterile perioperative attire) worn by staff. It is also unclear when it states the 'clothing that has been in contact with the patients should not be worn outside …" This would include the pajama/scrub suit as stated elsewhere in the draft document there is no evidence for not wearing the pajama/scrub suite operating suite attire outside the operating suite which is a common practice in many Australian HCF. This statement needs to be clearer re exactly what can and can't be worn outside the operating suite, within the HCF building (see attached submission to NSW Health).	Disagree, submission misses the point on risk assessment in the section and clearly stated intent of the first paragraph in B1.2.2. Local policies and procedures are required to assist with strengthening compliance	No change to text

		Areas of 'high risk contamination' would include areas such emergency department and mortuary, where pyjama/scrub suit is also worn, thus suggest these be added to examples given.		
37 B1.2.3	#58	Second dot point – not using it for swab is only for HIV and not for Hep C, Hep B	Committee does not understand the nature of the comment	No change to text
		Insert the risk assessment on choice of appropriate apron or gown at the start of Apron /Gown section(see bottom of table). Prior to commencing the task will indicate what type of apron or gown is required: o What is the nature of the exposure you require protection? Body substance or surfaces potentially contaminated by MRO		Added by Committee to assist with requests for clarification
37 Aprons	#17	Table B1.4 please remove 'or eat' Full body gown – include another point saying single use	Agree remove eat, Gown disposable vs single use dealt with	Additional table on gowns and their properties added to assist with appropriate selection
37	#74	It would be helpful if this section clarified that gowns and aprons must be changed between patients.	Agreed	Included in table on gowns
37	#58	2ND dot point faeces and diarrhoea is not sprayed	Disagree	Consider the use of the term splash
37	#69, #75	Separate this section into Aprons and Long Sleeved Gowns and give separate guidance: e.g. Impervious Aprons must be worn when there is a risk of splash or contamination during procedures or during contact precautions when contact with the patient or the patient environment is likely. Impervious long sleeve gowns must be worn if there is a risk of contact of the HCW's skin with a patients broken skin, extensive skin to skin contact, e.g. lifting a patient with scabies or non-intact skin, or there is a risk of contact with blood and body fluids which are not contained e.g. vomiting, uncontrolled faecal incontinence, or at the direction of the IP&C service for specific micro- organisms, outbreaks	Gowns know by various names in Australian State/ Territories. Current practices appear largely directed by local / health department protocols.	No change to text
37 B1.2.3	#35	Fluid resistant" performance criteria should be clearly defined and must be consistent with the criteria used by the Therapeutic Goods Administration or equivalent body in regulating the personal protective equipment (PPE) market. This criterion potentially prevents the use of poor quality PPE.	Disagree with prescriptive nature of the statement.	Link to ATRG will be provided in guideline http://www.tga.gov.au/docs/html/artg.htm
37 B1.2.3 Table 1.4	#2	Table 1.4 on aprons and gowns is a bit light on the indications for gowns. One hospital in my Area health service uses 95% aprons, 5% gowns and spends $400,000 less than a similar hospital that does the opposite (i.e., $46,000 vs. $446,000). Not only are aprons 0.08 cents compared to $1.20 for a gown, they are much smaller thus cheaper to dispose of and less harmful to the environment.	The purpose of apron and gown for prevention / control of infection is covered in the table	See table on aprons/gowns

		It should be clarified in the table that aprons are recommended for providing general care for patients with MROs in isolation rooms such that the only remaining indications for gowns are few.		
37 B1.2.3	#29	Aprons are often worn to protect clothing in very low risk situations in primary care and not treated as single use. Applying a risk assessment would see plastic gowns uses as single patient use items in risk situations such as dealing with MRSA infections or if actual contamination did occur.	Agree, dealt with in table on aprons/gowns.	No Change to text
37	#29	4. (Section B1.2.3) Wearing aprons/gowns	Disagree. The section heading is correct.	No change to text
37 Table 1.4	#39	Table B1.4: Characteristics of aprons/gowns MTAA recommends that single-use drapes and gowns in the operating theatre environment should be included. Both Australian College of Operating Room Nurses (ACORN) and the Royal Australasian College of Surgeons (RACS) (supported by the AAMI PB70 standard from the USA and EN13795 standard from the EU) make statements that single-use drapes (impervious) and gowns should be used to reduce the risk of an SSI. This is considered best practice and should be included in the draft Guidelines.	Disagree, this is not related to PPE may consider for inclusion in B4.3	No Change to text
37	#53	Does the current literature support 'subsequent use' and the option of 'short sleeve' gowns? Note that in the CDC - Guidelines for Infection Control in Dental Healthcare settings 2003: recommends disposable or reusable gowns, that cover clothing and skin. Changing is recommended if visibly soiled. This suggests that a gown is worn for extended periods of time and subsequent patients. Experience in the practice of dentistry (Victoria) indicates that long sleeve gowns are not routinely use, with the exception of 'oral surgery' where long sleeve sterile gowns are used. Short sleeve gowns are routinely used: • for multiple routine procedures on multiple patients • changed at the end of a session/day or when visibly soiled • laundered by office base practice staff – onsite and offsite • care is taken to prevent contact with the outer surfaces of the gown • they provide protection for underlying clothing –but may not be	The use of a short sleeve gown appears to be for the use of protection against soiling /clothing protection rather than infection control. 2008 ADA Guideline recommends protective clothing to be worn over clothes when treatment of patients generates aerosols. Gown type dependant on activity and extent of exposure as is when gown is to be disposed/changed	Additional table on gowns and their properties added to assist with appropriate selection

		fluid resistant or repellent • Hand hygiene is perceived to be easier and more effective with short sleeves • Potentially cuffs become moist when washing hands, and • contaminated surfaces of a long sleeve gown are potentially touched when fitting new gloves for subsequent patients.		
37 B1.2.3	#54	The section on wearing of aprons/gowns was not written with small office practice in mind – it is neither practical nor necessary for a dental clinic coat to be worn for a single patient procedure. It would not be practical to change gowns between every patient undergoing routine dental procedures, and even ignoring the enormous costs that would be involved, there is insufficient evidence to justify why this should be undertaken for dental practice. With regard to section B1.2.3 (Aprons and Gowns), many dental procedures generate aerosols which can lead to contamination of the external clothing of operator and assistant with blood and saliva, albeit in very small quantities. The usual situation in dental practice is for the operator and assistants to wear a clinical coat or gown, and to change these daily, or more frequently if they become visibly soiled. Changing to a situation where single use full body gowns are used for every patient as is recommended in B1.2.3 will add not only considerable financial cost to already extremely high overheads but also have environmental impacts through the volume of waste generated. Some types of dental practices have very high patient numbers each day (e.g. orthodontics, dental hygiene, periodontal maintenance). In general practice it would not be unusual for a dentist to perform procedures which generate aerosols on 20 different patients each day, which would mean forty disposable full body gowns per dentist and assistant each day. It may also not always be practicable or desirable for gowns to be removed in the clinic where the episode of care takes place.	Clinical and laboratory coats or jackets worn over personal clothing for comfort and/or purposes of identity are not considered PPE The decision to change a clinical coat needs to be based on a risk assessment. If the other garment has been potentially contaminated by blood or body substance the coat must be changed	
37	#79	Add at the end of the 1st sentence and or immediately upon disposal of body substances	Disagree	No Change to text
38	#79	Consider the addition of or immediately at disposal of body substance to the recommendation	Disagree	No Change to text
38 masks	#79	Replace Surgical mask with Splash Resistant Mask throughout this section	Noted but placed in glossary	Include ATGR terminology in glossary for surgical mask

38 B1.2.4	#54	In section B1.2.4 (Face and eye protection), Table B1.5 states that for procedures that generate splashes and sprays (which includes dental procedures) a mask and goggles is required. However on page 38 the draft advises that a face shield may be used as an alternative to mask and goggles. This appears contradictory. Moreover, in the dental setting it is not appropriate to use a face shield without a mask for procedures which generate aerosols.	Face shields do not replace the need for a mask	Table B1.5 to be reworked to reflect this
38	#54	The terminology “goggles” that must be worn during procedures that generate aerosol is unwieldy and should be a reference to “protective eyewear”. The draft recommends the use of goggles rather than safety glasses for eye protection. In the dental setting, many operators use magnifying loupes which are often fitted to safety glasses or prescription safety glasses. There are no goggles which provide an attachment for these through-the-lens loupes or which have lenses suitable for magnifying loupes to be inserted into. It would be very difficult and not in patients’ interest for dentists to implement the recommendation regarding goggles. Similarly, the use of goggles would not be compatible with operating microscopes, which are more commonly used in dentistry and widely used in some specialities. The 2008 ADA guidelines strongly recommend safety glasses with side-shield protection. Goggles may become scratched, fog up or distort the good vision so important for clinical dentistry. The correct terminology for an N95 mask for a health care setting is an N95 surgical respirator – to distinguish it from industrial N95 respirators which lack splash protection features.	Agree	The term protective eyewear is to be used instead of goggles . On page 39 “may” and “the most” has been removed from 1st sentence
38 B1.2.4	#79	Routine Care examples: general examination eg medical, physio, nursing. Procedures involving the respiratory tract (including the mouth)- Nasopharyngeal suctioning, Intubation	Agreed	Added to table B1.5
38 Table B1.5		Stick to standard precautions only. The table becomes confusing if other routes of transmission/protection are included. Mask and goggles, or full length face shield	Disagree	Table has been modified to highlight the combination of uses of face and eye protection
38 B1.5	#57	Table title indicates it is talking about SP and then you include requirements for Droplet and Airborne Prec in col 3 line 2. Face/ eye protection- routine care line, col3 line2 - as discussed above, routine care of patients under Droplet Precautions [capitalise] should include use of eye protection (safety glasses). This is a (very neglected) part of SP practice- see CDC Standard. Goggles- need to say goggles or safety glasses Mask- need to specific fluid-repellent surgical mask	Disagree	Table has been modified to highlight the combination of uses of face and eye protection
38	#69	Stick to standard precautions only, the table becomes confusing if other	Disagree	Table has been modified

table B1.5		routes of transmission/protection are included. Mask and goggles, or full length face shield.	Added	to highlight the combination of uses of face and eye protection
38 Table B1.5	#17	procedures that generate splashes or sprays – include face shield	included	Table has been modified to highlight the combination of uses of face and eye protection
38 Table B1.5	#51	Suggested change: Face and eye protection are not required for routine care unless caring for patients on droplet precautions (surgical mask and safety eyewear or airborne precautions (P2 {N95} respirator and safety eyewear. Reason: To ensure that the conjunctivae are protected. This is supported on page 75 of the draft Guidelines which states Indirectly vented goggles provide the most eye protection from respiratory droplets from multiple angles.	Disagree, eye protection is to be worn during procedures that generate splashes or sprays of blood or body substances	Section B2 has been modified to reflect these changes
38 Table B1.6	#25	Properties of different types of masks: there is no mention that an N95 respirator requires fit testing. This is captured in section 2.4.3, however when using the document will staff miss this important message	Noted	Additional information on fit testing and fit checking to be added to Governance section
38 Table B1.6	#75	“Intended use;” in the droplet precautions comment include “must be also worn with face shield/goggles”.	Disagree Table B1.6 outlines characteristics of masks	Covered in table B1.5
38 Table B1.6	#17	sealing – remove elasticised; intended use – remove HCW with resp infection and ‘when the patients infectious status is unknown.	Noted for first point but no change with out reason or appropriate reference for the second	Table B1.6 changed to provide greater clarity
38 Table B1.6	#79	Remove Routine and other care if the healthcare worker has a respiratory infection HCW should not be working with respiratory infections	Noted	Removed
38 Table B1.6	#35	This may be limiting thus should confirm that all masks made from polypropylene only or again establish a criteria based on TGA requirements as above and for the same reason.	Table provides guidance and AS criteria are stated in guideline.	No Change
38	#78	The reference to ‘N95’ as an alternative to ‘P2’ respirator could be deleted. The former is a US standard and is not used in the AS/NZS standard	Agree.	Use the term P2 respirator .
38/29	#52	Suggest adding anaesthetic procedures such as intubation and extubation to tables in the examples listed. Currently refers to ‘Respiratory Procedures’ however this needs to be more specific.	Noted.	Examples added in table B1.5
39	#79	Insert at end of 1st para: Children over two years of age should wear specifically designed child mask, and should not use masks with string ties as they are a choke hazard. In order to contain droplets in Children	Noted	Include comment in text

		under two use an Oxygen mask so that mucous membranes can be observed		
39	#75	masks and respirators can also be placed on patients…" While this is true, care must be taken when placing a respirator mask on a patient and must suit clinical need i.e. if patient is also COAD or in respiratory distress the mask will exacerbate symptoms. There is nothing in this section which mentions fit checking and fit testing of a mask. Both NSW Health IC policy and International Federation of Infection Control (IFIC) outline how both must be undertaken	Agree use only masks not respirators	Add to the text care must be taken when placing a respirator mask on a patient and must suit clinical need i.e. if patient is also COAD or in respiratory distress the mask will exacerbate symptoms.
39	#17	Under eye protection – Remove 'indirectly vented' or define it	Noted and agree	Removed
39	#78	We could not find reference to AS1719:2009 on the SAI web site.	Agree should be AS 1715:2009 in table B1.6	Table changed to include new standard
39	#51	Suggested change: Masks can also be placed on coughing patients to limit potential dissemination of infectious respiratory secretions from patients to others. Reason: The wording respirators should be deleted because these devices work under negative pressure and create a tight facial seal. These factors may create additional physiological and psychological stress in patients who have respiratory compromise or distress. In addition, respirators which feature valves for wearer comfort will not contain respiratory secretions because the secretions will escape through the valve on exhalation.	Agree usual practice for patient is mask.	Remove the term respirator from the sentence
39 B1.2.4	#75	"Face Shields"; face shields should not be an alternative to masks, they do not provide droplet or airborne protection, only that of body fluid splashes. Masks are worn underneath a face shield.	Agree	Face shields are used in addition to masks and an alternative to goggles
39 Table B1.6	#69	Intended use- in the droplet precautions comment include must be also worn with face shield/goggles. Not sure of the evidence for no mask- would feel more comfortable with mask and face shield- this is our protocol, but happy to be convinced	Agree	See above
39 B1.2.4	#47	Part B1.2.4; page 39, last item on page "Cleaning reusable face and eye protection" There are two product interface issues here. Firstly, detergents intended (labelled) for use in cleaning other medical devices are themselves registrable as Class I Medical Devices under the Medical Devices Regulation, 2002. Secondly, low level non-critical medical devices if they are to be disinfected should be disinfected to "low level Instrument Disinfectant" level by either a TGA registered Instrument Grade Disinfectant -Low Level or by heat as per AS/NZS 4187:2003.	Noted	Insertion of the following text: low level non-critical medical devices if they are to be disinfected should be disinfected to "low level Instrument Disinfectant" level by either a TGA registered

				Instrument Grade Disinfectant -Low Level or by heat as per AS/NZS 4187:2003.
40 Rec 5	#51	Suggested change: A surgical mask and goggles must be worn during procedures that generate large droplets, splashes or sprays of blood, body fluids, secretions or excretions into the face and eyes. Reason: A surgical mask is designed to protect against exposure to droplets but not aerosols. (Reference: Balazy, A. et al. 2006, 'Do N95 respirators provide 95% protection level against airborne viruses, and how adequate are surgical masks?', American Journal of Infection Control, 34(2):51-56.	Agreed	The term aerosols is to be removed from Rec 5 and the term eye protection instead of goggles
40 recommendation 5	#79	Suggested A splash resistant (remove surgical) mask or face shield and goggles must be worn during procedures that generate aerosols, splashes or sprays of blood, body fluids, secretions or excretions into the face and eyes	Disagree AS use the term surgical mask	No change to text
40 recommendation 5	#75	Change summary statement that only includes surgical mask and goggles to the phrase "facial protection". This way other items such as face shields and masks with visors are also covered, not just masks and goggles	Rec 5 has been altered	Discussed outside of Recommendation
40 Rec 5	#69	Include or face shield	Noted but managed elsewhere	Information provided separate to Recommendation
40 B 1.2.5 Gloves	#8	Is there any possibility of any additional commentary re double gloving (effectiveness or otherwise) Siegel et al is quoted in the document stating that 'evidence has not determined its effectiveness' however I understood there was research that showed it could be detrimental? It is an area that causes intense discussion at any BBV training sessions I have been involved in so would be useful if more research could be quoted if available/possible.	Information of double gloving is to be move to B4.4	Discussed in section B4.4
	#74	Suggestions on effective measures to prevent infection transfer through the gap between gloves and sleeves The gap often found between the top of gloves and bottom of gown sleeves provides a site with a high risk of contamination. Current advice is that gloves should be pulled up over the sleeve. However, this can be quite difficult, and often results in torn gloves, as well as the re-occurrence of the gap during use. A potential solution is the development of gown which extends to the knuckle and has a thumb hole to locate the sleeve securely. This can also be achieved in an ad hoc fashion by punching a hole in an existing gown. This is a small, but potentially very significant issue which these guidelines could benefit from making referencing	This needs to be managed at a local level with policies and procedures	No change to text
40	#55, #46	Clarification needed for utility gloves re: what type of glove is this	Definition of utility glove	Additional information on

			provided	the considerations required in the selection of gloves has been included
40		When gloves should be worn? Refer to WHO guidelines	Risk management approach developed	Text provided in below
40	#79	When should gloves be changed? ABHR should not be used to wipe gloves instead of HH or replacing gloves	Noted	Gloves section has been restructured to provide additional information
40	#60	Gloves can pose an infectious risk to patients when worn inappropriately. Clarify that hand hygiene should not be performed when wearing gloves	noted	Gloves section has been restructured to provide additional information
40	#79	In practice Sterile gloves are not always worn for aseptic procedures. For instance, Central venous Line packaging has fenestrations, and is not considered sterile. Most skin antiseptic solutions are not sterile No definition is found for aseptic procedure- provided in glossary A term that has gained widespread acceptance and is relative to clinical practice outside the controlled operating theatre environment. The term Aseptic Non Touch Technique. The technique ensures that key points are kept free from contamination during the clinical practice	This detail in included in B4.1 ANTT will be outlined in the guideline	Inclusion of information on ANTT to be provided in Standard precautions as a separate section
40 B1.2.5	#29	The evidence for the use of sterile gloves in the treatment of minor issues in primary care is lacking. There is evidence showing no difference to the rates of infection in primary care and emergency departments when clean gloves are used. A risk assessment is critical in this area. Long-standing usual practice in primary care has not been identified as a significant risk for healthcare associated infections. (The use of clean vs sterile gloves in primary care varies widely)	Noted but term “minor issues” is unclear.	Risk assessment for the type of gloves to be worn has been added to the guideline
40 B1.2.5	#54	Feedback from a number of dental clinicians is that when alcohol based products are applied to dry hands, powderless gloves do not always slide onto the hands easily, whereas use of a chlorhexidine handwash does not seem to create the same issue. It would be useful to have a clear statement that for dentistry gloves must be worn for all patient procedures. Section B1.2.5 states that gloves should be worn when contacting “non-intact skin or mucous membranes”, which could be read by some as “non-intact skin and non-intact mucous membranes”. It would be better to more clearly word this and the other sentences to refer to “mucous membranes and non-intact skin”.	Noted	Dental procedures added to gloves table
40, 41	#18	References to the usage of gloves in the draft guidelines are inconsistent and can cause confusion.	Disagree, risk assessment for the wearing of gloves needs to occur. Gloves for	No change to text

		Pages 7 and 41 of the Infection Control Guidelines recommend that "gloves must be worn as a single-use item." This is in contradiction to that which is stated in page 40, recommending that a risk assessment should be conducted before each procedure to determine the necessity for PPE including gloves. Current DoHA recommendation provides scope for the application of professional judgement in determining use of gloves for specific procedures. The APA supports these recommendations and believes that they can be extended to guidelines developed from a care-delivery perspective without any compromise to safety. For example, gloves should only be required during acupuncture and dry needling procedures where there is a risk or expectation that the healthcare worker will be in contact with blood, or when the needle shaft (as opposed to the hilt) is to be manipulated.	clinical care are not reusable. Acupuncture and dry needling needs to comply with the requirements of state and territory legislation	
40 B1.2.5	#54	Clarification is needed concerning the use of sterile gloves for aseptic procedures. The ADA recommends that it is not necessary that dentists should always use hand gels for routine dental procedures.	Comment noted	Risk assessment for the type of gloves to be worn has been added to the guideline
B1.2.5	#27	Gloves are not necessary for "contact precautions" as hand hygiene offers better protection (particularly now with the use of alcohol based hand rubs). Staff tend to don gloves and continue to multi-task – protecting themselves but not the patient or the environment. Alcohol based hand rubs must be easily accessed in order for this to work well and prevent transmission of MDROs and other significant pathogens. Hand hygiene policy: - Routine use of gloves is not recommended when caring for patients requiring 'contact precautions' unless as previously noted, when handling blood or body fluids. Good hand hygiene provides better protection. - Gloves must be changed between conducting clean and dirty procedures, even if performed on the same patient, - Gloves must not be washed or cleaned with hand washing agents or alcohol based hand rubs, - Gloves must not be worn when answering telephones, using computer keyboards, opening doors or writing patient notes. - Gloves must not be worn when taking linen off the linen trolley. Note that: gloves do not always provide a completely impermeable barrier to the user, therefore it is important that hand hygiene is performed before and after glove usage.	Noted, however CDC isolation G/L (2007) donning of both gown and gloves upon room entry is indicated to address unintentional contact with contaminated environmental surfaces. "Since the nature of the interaction with the patient cannot be predicted with certainty and contaminated environmental surfaces are important sources for transmission of pathogen"	No Change to text

		POLICY REFERENCES: Australian Government Department of Health and Aging, Infection Control Guidelines- January 2004. Centres for Disease Control (CDC)- Guideline for Hand Hygiene in Health-Care Settings- October 2002. World Health Organisation – Clean care is Safer Care http://www.who.int/gpsc/en/		
41	#59	Common practice in community and especially aged care to see vinyl gloves used during hands on care. Suggest recommendation to not use Vinyl gloves in clinical care.	Noted. Covered in reworked gloves tables	No Change to text
41	#58	Link the glove recommendations	Noted.	No Change to text
41	#51	Given the seriousness of latex allergy and its potential to cause dermatitis which may impact on infection control, this section should provide more detail about the selection of latex gloves. Specifically, it should recommend the use of low protein, powder-free latex gloves to prevent latex allergy. (Reference: National Institute of Occupational Safety and Health Latex allergy prevention guide http://www.cdc.gov/niosh/98-113.html)	Noted good point. Information on latex provided in table on gloves and additional resources	Provide additional information on latex allergy with links to National Institute of Occupational Safety and Health Latex allergy prevention guide http://www.cdc.gov/niosh/98-113.html) and Australasian Society of Clinical Immunology and Allergy (ASCIA) http://www.allergy.org.au/content/view/107/1/
41 Table B1.7	#35	HCW should wear gloves for any contact where there is a potential for contamination of the hands regardless of whether adequate hand hygiene facilities exist. The choice of glove such as latex, non-latex, powdered, powder-free, nitrile etc should be determined according to relevant local state/ territory guidance. The decision must be based on the nature of the task, glove efficiency and also issues relating to latex, powder or skin sensitivity. Use of gloves is an adjunct not a substitute for correct hand hygiene.	Noted.	No change to text
41	#69	Call the Nitrile gloves " synthetic" gloves e.g. Nitrile	Noted and agree, Nitrile commonest available type of synthetic glove used in healthcare.	Changed in table
42	#54	Later sections of the document about personal protective equipment (PPE) do however handle dental procedures better, and the section on coats on page 42 correctly points out that care no studies have demonstrated that uniforms transmit infectious agents.	Noted this is discussed earlier	
42	#51	Statement: Powdered gloves.	Noted	Information on latex

		Suggested change: High protein/allergen, powdered latex gloves. Reason: The risk of latex allergy is influenced by the amount of protein/allergen and powder in the latex glove; not by powder alone. (Reference: Hunt, A. et al. 2002, 'Management of occupational allergy to natural rubber latex in a medical centre: the importance of quantitative latex allergen measurement and objective follow-up', Allergy Clin. Immunol, 110:S94-106		allergy added
42 B1.2.6 Other Clothing	#9	2) Lanyards and Neckties should be banned as well. There is good evidence that neck ties harbor viable bacteria including MROs, as there is for lanyards. Australia is behind the international ballgame on this one, where neck ties and lanyards have been discouraged in parts of Europe.	Noted no evidence was provided to support this statement and committee had found low level evidence however it is recognised as a potential vehicle of transmission.	Addition of lanyards and neckties to B1.2.6. Studies have shown that is some evidence to suggest that lanyards and neck ties are potential vectors. However it is difficult to demonstrate their precise role that they may play in transmission of nosocomial infections1.
43	#79	Use the term donning not putting on for PPE	Noted but using plain English terms	No change to text
		Sequence on Applying PPE has been corrected and is consistent with the CDC Isolation Guidelines 2007		Sequence change to minor that of CDC
43	#20, #80	to complete a task on a patient using PPE, the HCW would have to perform HH 9 times. This is unworkable. If the PPE is being worn to protect the wearer from contact with blood or body fluids then it should be sufficient to perform HH, then put on the gown, mask and goggles, perform the task, remove the items of PPE in the correct order with care and perform HH afterwards	Agree and modified	Change sentence to: Hand Hygiene must be performed prior to putting PPE or after breaks and removing PPE" (or similar)
43	#60, #44	Enforcing hand hygiene between putting on each piece of PPE and removing it will be very hard to enforce. Hand hygiene has not been included in table 1.8. "prior to donning PPE – wash hands/perform hand hygiene and after removal of PPE." CDC guidelines state "perform hand hygiene prior to donning PPE or after breaks and re gloving etc." This is a more practical	Agree.	changed

[1] Despina Kotsanas, Carmel Scott, Elizabeth E Gillespie, Tony M Korman and Rhonda L Stuart What's hanging around your neck? Pathogenic bacteria on identity badges and lanyards. MJA 2008; 188: 5–8

		approach		
43	#17, #69	Steps 2 and 3 are not interchangeable. Steps 1 and 2 are.	Noted.	Text to be changed to reflect this
43	#51	The mask section of the table should include a statement that after donning a P2 respirator, the person should conduct a fit check to ensure that a proper facial seal has been achieved.	Agree	For p2 mask insert "conduct a fit check to ensure that a proper facial seal has been achieved"
43	#57	Hand hygiene only performed prior to donning (once) Sequence incorrect and illogical 1. Start with mask, if P2 mask, must fit-check after donning 2. Next protective eyewear (safety glasses/ goggles or face shield) 3. Next Long sleeved impervious gown, tied well 4. Gloves last, extend to cover wrist of gown. NB Keep hands away from face. Change gloves when torn or heavily contaminated	Noted but remaining consistent with CDC	No change
43	#52	It should be noted that when putting on PPE for surgical procedures, the eyewear and masks are put on first, prior to the surgical scrub, and the gown and gloves are put on next, after the surgical scrub. Suggest adding statement that in case of donning PPE for surgical procedures – the sequence will be different	Noted.	Sequence for surgical procedures/ dentistry need to be listed ie masks and protective eyewear applied first then surgical scrub in B4.3.Preprocedure putting on PPE for surgical procedures, the eyewear and masks are put on first, prior to the surgical scrub, and the gown and gloves are put on next, after the surgical scrub. For more detail Consult ACORN standard 26
43	#54	In Table B1.8, the rationale for putting on the gown before mask and gloves is not clear. In dentistry the usual sequence would be mask then eye protection then hand hygiene then gown and finally gloves.	Noted.	As above
43	#69	PPE removal Agree with sequence of gown removal followed by gloves, though the top diagram shows person undoing the back ties of gown with contaminated gloves which risks them contaminating their skin. Would recommend another person unties the back of gown. The diagram (2) showing removal of gloves also seems to show the gown still in place – a bit confusing, though the narrative is appropriate	Noted.	Sequence for removal 1.gloves,hand hygiene 2. goggles/face shield 3. gown 4. mask

43/44	#81	Hand hygiene needs to be incorporated into process in these diagrams	Disagree	No change
43/44	#55	mask should be first on and last off	Noted	using CDC sequence
43/44	#46	In addition, there should be a note above the mask removal – for airborne diseases – wash hands and then step outside the room to remove N95 articular respirator, disposed off in a closed reciprocal and wash hands again. The clarification between the removal of a surgical mask for droplet inside room and an N95 particulate respirator outside room or in anteroom would be helpful	Noted.	Include information on where to remove P2 mask
44	#53	Please review this sequence for removing PPE If the sequence for removing PPE is correct on page 44 could you please demonstrate untying the gown with dirty gloves, as glove removal is step 2 This should not be recommended • 2 Demonstrates accepted technique of glove removal but the illustration suggest the gown is still in place. • In surgical procedure: generally ties are undone by scout or other, then the gown is pulled off over the gloved hands and then the gloves are removed (as illustrated) dirty hand to outer surface of first glove and de-gloved hand (finger) to inner of opposing glove. • In general procedures where there is unlikely to be ready access to assistance to untie the gown, the gloves may be removed using illustrated technique hand hygiene performed, gown untied and removed and hand hygiene performed.	Noted	Sequence and images have been changed in line with CDC isolation guidelines 2007
44	#67	sequence for removing PPE This order is different from CDC and Vic guidelines. Why has it been changed from CDC when reference states adapted?	Noted unintentional error	Noted using CDC sequence
44	#17 #46	In sequence for removal – add hand hygiene at the end of each point of the table	Noted but not in line with conventional processes	Noted using CDC sequence
44	#25	• suggest that the gloves (usually the most heavily contaminated or “dirtiest”) be removed first; add “glove” to glove removal instructions, it should read “grasp outside of glove with opposite gloved hand,; peel glove off”; goggles and mask should always be removed down and away from the person. • With masks: the safest removal of N95 respirators that have straps	Noted	sequence and images have been changed in line with CDC isolation guidelines 2007

		that are separate, remove them “separately” beginning with the bottom strap (base of the neck), then the top strap (at the crown of the head). Otherwise, the “together” straps should be removed “together”.		
44	#57	Reverse the above sequence- 4,3,2,1 Disinfect hands with ABHR after each step (ie 4 times) as there is potential to contaminate self during subsequent steps if hands become contaminated 4. Gloves, Peel off one at a time without touching skin. Discard in waste container. 3. Gown, unfasten ties, pull away from neck and shoulders, hold inside of gown only, turn inside out and roll into bundle before discarding. 2. Eyewear, handle by ear-pieces or straps. Disinfect with large alcohol wipe or place in receptacle for re-processing. - Mask last, handle only by straps. [gloves are the most highly contaminated, remove them first and use ABHR removing gown has potential to create aerosol and eyes and mouth should be protected until last.]	Noted	sequence and images have been changed in line with CDC isolation guidelines 2007
44	#75	Step 2: the picture shows the gown is still on when removed in step 1. Step 3: the picture clearly shows the gown and gloves still on when they were removed in steps 1 and 2. In addition NSW, Canada and IFIC recommend removing gloves as per Step 1. Use the NSW Health posters for donning and removal. http://www.health.gov.on.ca/ ransmi/providers/program/emu/emerg_kit/pdf/kit_donning.pdf http://www.health.nsw.gov.au/resources/quality/hai/pdf/tool_protective.pdf	Noted	Sequence and images have been changed in line with CDC isolation guidelines 2007
44	#23	Sequence for removal should be: 1. gloves 2. hand hygiene 3. Eyewear 4. Gown 5. Mask 6. Hand hygiene	Noted	sequence and images have been changed in line with CDC isolation guidelines 2007
44	#19	Sequence of doffing GOWN;GLOVES; GOGGLES/FACE SHIED;MASK As well as step 2 and 3 of removing PPE are interchangeable. This is totally different from the CDC, DohA influenza and NSW health g/l Surely it is safer to remove the most contaminated article first, the gloves, then perform hand hygiene before proceeding to touch and	Noted	sequence and images have been changed in line with CDC isolation guidelines 2007

		remove the other items. Touching the		
44	#78	Removal of PPE. Pose 1 shows removal of the gown, while poses 2, 3 and 4 appear to show the gown still on. The diagrams are confusing as to the correct sequence. We believe that gloves should be removed after other contaminated PPE.	Noted	Sequence and images have been changed in line with CDC isolation guidelines 2007.
44	#16	2. Gloves Following dot point 6 “discard gloves in waste container” 4. Masks Following dot point 3 “discard in waste container” hand hygiene should be added after both of these points as gloves do not provide complete protection against hand contamination (HHA, 2009). Thus removal of face to remove eye/face protection may contaminate hands. Hand hygiene should always be performed after removing gloves (HHA, 2009). Although the ties used to secure the mask are considered clean, the front of the mask is considered contaminated (HICPAC, 2007) and may inadvertently be touched.	Noted	sequence and images have been changed in line with CDC isolation guidelines 2007
44	#20, #60	It would be helpful to cite a specific reference here for the actual section referred to rather than the home page address of the CDC	Noted.	Page 130 and 131 http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html
45	#75	“if you have an infection” comment would be better to leave this out what if they are on the prodrome for measles?	Noted	no change to text
46 B1.2.8	#47	Part B1.2.8; page 46; Risk Management case study; Treating risks Surely, with all of the evidence pointing towards environmental surface spread, and given the widespread availability of Hospital Grade Disinfectants, all of which must be independently proven through peer reviewed methods to kill large quantities of Staphylococcus aureus (even in hideously foul conditions). Surely then environmental surface hygiene should be conducted in the surgery with a Hospital Grade Disinfectant and wiped clean afterwards. Appropriate surface disinfection is inexpensive, works, and is simple to train staff, in what is acknowledged to be a “high risk situation requiring immediate response”.	Comments noted but content not correct. The routine use of chemical disinfectants is not necessary from an infection prevention and control risk management.	No Change to text
B1.3 Sharps				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
47 B1.3.1	#17	3rd para – butterfly needles have also been involved in sharps incidents – specify them as non-safety butterflies	Agree add non-safety butterfly needles. Hollow bore needles are the greater risk and this needs to be made clearer.	A table to identify hollow bore vs non hollow bore sharps. See below
47 B1.3.2	#54	Specific points: Sharps Page 47. In section B1.3.2 (Handling of sharps), the list of standard measures to avoid sharps injuries should include: use	Agree with these as additions to the current list.	Do add When and how do sharps

		ridged walled containers to transport contaminated non disposable sharps to the instrument reprocessing area, and dispose of disposable sharps as close to the area of use as practical.	Current dot points listed mainly refer to strategies in the OTR	injuries occur? - During use - After use and before disposal - After appropriate disposal and - After inappropriate disposal -
47	#46	the section on handling and disposing of sharps has a real occupational health focus which is the role of occupational health staff, whereas infection prevention and control focus should be on prevention strategies (which is included) and analysis of data to again look at prevention strategies	Disagree the items are/ should be everyone's focus. This is an issue for both OHS and Infection prevention and control	No change to text
47 B1.3.2	#79	Add: - point of use sharps disposal - Adequate assistance is required with unco-operative patients and children	Agree with first not second. Second point is too prescriptive relates to local procedures/ protocols as the basic premise is safety.	Additional information on disposal of sharps has been added
47 B1.3.2	#81, #44	Double gloving is not a strategy for avoiding a sharps injury as listed. It minimises blood exposure	agree	Double gloving will be raised a PPE measure in section B4
47 B1.3.2	#39	While the Guidelines are detailed regarding needlestick injuries, less emphasis is placed on scalpel safety. There are a number of guidelines outlining the safe use of scalpels, however there is a lack of knowledge about these guidelines. A recent review on scalpel safety in the operating room setting, states that it was limited by the quantity and quality of the available evidence19. The Australian Safety and Efficacy Register of New Interventional Procedures studied the literature and found no evidence that safety scalpels were in fact safer20. MTAA recommends that further detail and specific guidelines for scalpel safety be added. They should reference existing guidelines (e.g. Australian/New Zealand Standard 3825) and introduce new guidelines such the use of single-handed scalpel blade removers in combination with the hands-free passing technique. This would be in line with US practice. The US Joint Commission has stated that to ensure staff safety, a single-handed scalpel blade remover and a HFPT will become the norm in all operating suites in the next 5 years (the Joint Commission is responsible for inspecting hospital operating rooms for accreditation)28.	Partly agree for the purposes of the guideline.	Additional line to be added in B1.3.3 disposal of sharps. There are numerous safety devices available that assist with safe removal and disposal of sharps such as scalpel blade removers. Local protocol and procedures need to develop to outline their appropriate use.
47	#54	Recommendation 8 states that needles must not be recapped, bent, broken or disassembled after use. This does not reflect dental practice	Needles must not be disassembled but syringe	As above

		where multiple injections may be needed during a procedure on the one patient. In the dental setting it is usual to use re-sterilizeable syringe barrels with a cartridge of anesthetic and a screw in needle. It is also common to use more than one local anesthetic cartridge for a procedure. This injection system must be disassembled before disposable of the non-reusable components. It is safer to remove the needle from the syringe barrel once it has been recapped. Thus, in the section on "Safe handling of sharps" the comment that needles "must not be recapped" applies only to disposable syringes/needles, and this should be clarified to identify this point. A sentence should be included regarding the specific situation of dental practice which normally uses multiple dose cartridges and where recapping is commonplace to allow safe reloading of the syringe. This new text should also include that recapping of dental needles must use a one handed technique.	systems can be. Disagree, recapping is not required to load additional cartridges In the unlikely event that where recapping is unavoidable then a one handed technique be employed.	
48 B1.9	#81	In Para 1 and 2 Highlight NOT for compliance What if there is no soap and water? Emphasise site should not be squeezed, in some HCF there are multiple forms to complete	Can't be too prescriptive	Insert dot points: - ABHR can be used to clean the area if soap and water not available - Don't squeeze the affected area
48 B1.3.3	#54	In B1.3.3 (Disposal of sharps), Recommendation 9 states that sharps must be disposed of immediately. This implies that all sharps are single use, which is not the case. In the dental setting it is common to need to re-inject local anaesthetic during a procedure and dental syringes are designed to accommodate this. In these situations it would be acceptable to place the used syringe in a ridged walled container and dispose of the needle and cartridge at the end of the procedure. Sharps are a cause of injury in dental practice, an issue which reflects the large number of sharp non-disposable instruments that need to be handled during procedures and then reprocessed. The document says little regarding acceptable or best practice in this area.	Agree, not all clinical sharps can be disposable. Maybe we should qualify this with "where practicable single use sharps should be disposed off immediately after use and by the user or should be disposed of by the operator at the end of the procedure	Change to Rec 9 to Disposal of single use sharps. The person who has used the single use sharp must be responsible for its immediate safe disposal. Used disposable sharps must be discarded into an approved sharps container at the point-of-use. These must not be filled above the mark that indicates the bin is three-quarters full
47/48	#51	Given the evidence on pages 48-49 of the draft Guidelines that support an association between the use of safety devices and the reduction in needle stick injury in healthcare settings, the Guidelines should include a recommendation for consideration to be given to using safety devices where practicable.	This is implied and stated in the current text. There is insufficient Australian evidence for drafting of a recommendation.	No change to text Identified as an area for future research.
48 B1.3.4	#79	OH&S Legislation mandates the engineering risks out in the workplace, introducing safety devices, supervision and training of workers are obligations that are required by health care workplaces in order to comply with the OH&S Act	Compliance with state and national regulation covered in the governance section of the guideline.	No change to text

48-49	#37	Recommendations that the Guidelines should 1. provide greater clarity and direction for healthcare providers in distinguishing the many types of needleless devices available. 2. Advocate brand specific data rather than general design classification data as part of a selection process for needleless systems. 3. Ensure introduction of needleless systems is supported by adequate educational programs, bundled recommendations and epidemiological surveillance. 4. Inclusion of anti-reflux valves in the guidelines as an available technology and potential strategy to reduce catheter-related bloodstream infections. 5. Highlight the use of antiseptic barrier caps as a potential preventative strategy to reduce catheter-related bloodstream infections.	Disagree, this is beyond the current scope of the guidelines. Workplace protocols should encompass level of detail. Resources for additional information have been provide in section D	No change to text
49 B1.3.4	#39	1.3.4 Safety Devices. This section describes safety devices and their use; however no specific recommendation is made to actually use them. MTAA would like to see a guideline mandating the use of safety sharps. Recommendation 8 Safe handling of Sharps should state: Safety sharps should be used wherever possible.	This is beyond the scope of the Guideline in light of the available evidence in Australia. Further research on SED is required	No change to text
49 B1.3.4	#39	MTAA would like to see a national standard mandating the use of SEMDs in accordance with US, Canadian and European laws and recommends the following: • Prevention and management of occupational exposure to blood-borne viruses including the implementation and use of SEMDs. • Personal protective equipment (PPE), availability of SEMDs. • Evidence that system for use and management of invasive devices, incorporating infection prevention and mandatory use of SEMDs, is implemented and active. • Evidence that invasive device mandatory protocols (including the use of SEMDs) are active and complied with.	This is beyond the scope of the Guideline in light of the available evidence in Australia. As mention previously further research on SED is required in relation to patient safety and efficacy	No change to text
49 B1.3.4	#39	Section B1.3.4 Needleless devices states that the “adoption of needleless devices has contributed to a decrease in percutaneous injuries among healthcare workers. However, there may be implications for patient safety”. While it is difficult to assess the overall effect of needleless devices because of the wide variety of devices and systems that are in use, some studies have shown an increased risk of bloodstream infections (BSI) among patients16. MTAA recommends that this section be expanded to include: • Standards that address clarity and direction for healthcare providers in distinguishing the many types of needleless devices available. • Standards that ensure that the introduction of needleless	This is beyond the scope of the Guideline. Further research on SED is required and additional information on SED will be included as the guideline is revised	No change to text

		systems is supported by adequate educational programs, bundled recommendations and epidemiological surveillance. • Inclusion of anti-reflux valves in the guidelines as an available technology and potential strategy to reduce catheter-related bloodstream infections. • Guidelines that highlight the use of antiseptic barrier caps as a potential preventative strategy to reduce catheter-related bloodstream infections. Guidelines that advocate the use of brand specific data rather than general design classification data as part of a selection process for needleless systems. See consensus statement for position on SEMD by Australian Infection Control Association, Medical Technology Association of Australia, the Australian Nursing Federation, the Royal College of Nursing Australia, the Royal College of Pathologists Australasia and independent experts in relation to a national call to action for the prevention of needlestick injuries in the healthcare workplace.		
49	#79	Disinfection needleless connectors – 70% alcohol proven to be effective in swabbing before access	No supporting evidence provided for 70% guideline. This is against the recommendations by CDC (CDC 2002 prevention of catheter related BSI and draft 2009) and EPIC (EPIC 2 Pratt et al 2007) examination of evidence doesn't support this. See references below	No change to text
49 B1.3.5	#39	Section B1.3.5 Putting it into Practice –states that healthcare workers should "Avoid using needles where safe and effective alternatives are available". MTAA recommends that this read "Safe effective alternatives such as safety engineered medical devices including syringes with guards that shield the attached needle after use; needles that retract into a syringe after use and shielded or retracted needles used for intravenous cannulation should be used where possible".	Disagree to prescriptive	No change to text
49 B1.3.5	#79	Involv Pt in their care Patients will be educated prior to discharge about how to safely dispose of sharps used in the home so as not to injure community members	agree	Add to text
50 Risk Mx	#79	remove stick injury and classify as NSI	Preference to keep with sharps	No change to text

B1.4 Cleaning			Committee considerations	outcome
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
Overall	#35	The guidelines do not suggest a preference for TGA-registered/listed disinfectants be used in section B1.4. There is however acknowledgement in section B1.5 (PROCESSING OF INSTRUMENTS AND EQUIPMENT) that only compatible TGA-registered instrument-grade disinfectants be used during instrument cleaning and disinfection. Reference to TGA-registered chemical germicide is also mentioned in section B3.1 (MANAGEMENT OF MRO'S). Recommendation: when the guidelines refer to disinfectants in section B1.4 a preference for TGA-registered/listed disinfectants is recommended	Accept	TGA generic terminology will be used, linked to TGA and added to glossary
51	#58	Use the term re-usable instruments /equipment in this section	Not applicable as relates to the physical environment. Re-usable Instruments are referred elsewhere in guideline.	No change to Guideline
51	#54	Surface management Page 51. The section on surface barriers for protecting "clinical surfaces (including equipment)" would include items such as light handles that are touched frequently with gloved hands during the delivery of patient care – many dental units have removable handles that are cleaned mechanically and thermally disinfected, which is better for several reasons than using a barrier. Page 52 on the other hand correctly states that "Frequently touched surfaces can be cleaned with a detergent solution designed for general purpose cleaning. The exact choice of detergent will depend on the nature of the surface and the likely degree of contamination. Detergent impregnated wipes may be used to clean single pieces of equipment and small surface areas." The logic around surface management is not particularly well articulated. In section B 1.4.2 (Routine environmental cleaning), Table B1.12 recommends that the dental chair and its surrounds be cleaned daily and when visibly soiled. Many dental procedures generate aerosols which contaminate the dental chair and its immediate surrounds. It is also normal for the operator to touch parts of the dental unit with contaminated gloves. The recommendation should be for cleaning with a neutral detergent after each procedure. The description should be changed to read "Dental unit and contaminated surrounds". There should also be designated 'clean' and 'dirty' areas. In dentistry, most procedures create aerosols and thus contamination of working surfaces is assumed and thus these are routinely decontaminated. Likewise the statements regarding the frequency of cleaning (e.g. one wet mopping/wiping daily) may not be adequate. In the same vein, the	Additional text has been included on the need to refer to discipline based guidelines	No change to Guideline

		section on the implementation of droplet precautions makes a recommendation not to approach the patient within 1 metre – which is impractical in dentistry where working distances are typically one third of a metre and often less.		
51 B1.4	#47	Part B1.4; page 51; Routine management of the physical environment Figure B1.3 “Frequently touched/high risk surfaces” Suggest that the term High Touch Objects or HTOs should be used throughout the document. This is taken to include all of the high touch objects and surfaces. At the practical end, Carling (Carling 2008) clearly illustrates the advantage of a single, simple term to instruct cleaning staff on what items are high priority for cleaning processes.	Committee considers the term frequently touched to be more appropriate in the context of physical risk and the physical environment. It is also referred to in the research as frequently touched. The glossary elaborates on this term	No change to Guideline
B1.4 Cleaning	#9	4) The interval for cleaning surfaces commonly touched by patients should be reduced from one day, and some wards, eg. ICU should have continuous cleaning performed	Current text indicates frequency based on risk. Continuous is not realistic.	No change to Guideline
51 B1.4.1	#75	B 1.4.1 No mention in the cleaning section about new technologies such as microfiber cleaning clothes which negate the need for detergent and hydrogen peroxide disinfection sprays such as ‘nocospray,’ which eliminate a second room clean by hand with a disinfectant. Both these technologies have been established in European health care for 10 years.	Accept	Sentence will be included New technologies may replace the need for cleaning chemicals and disinfectants e.g. ultramicrofibre cloths (Rutala, 2007; Wren, 2008) and hydrogen peroxide mist (Shapey, 2008). More research is needed in these areas, particularly consideration to the scope of organisms removed or killed by new technologies and the practical application of these technologies.
51 B1.4.1	#81	Will reference to microfiber cloths be provided?	Additional information to be provided	Document will reference Wren 2008 and Rutala 2007

51 B1.4.1	#51	It would be useful if this section could include guidance on the role of microfiber cleaning products in healthcare settings, in particular microfiber cleaning products that are promoted as not requiring detergents or other cleaning chemicals. There is some literature available on the use of these products in healthcare settings but the expert opinion of the Working Committee would be valuable. (Reference: Rutala, W. et al. 2007, 'Microbiologic evaluation of microfiber mops for surface disinfection', American Journal of Infection Control, 35(9):569-573; Bergen, L.K. et al 2008, 'Spread of bacteria on surfaces when cleaning with icrofiber cloths', Journal of Hospital Infection 71:132-137; Moore, G. & Griffith, C. 2006, 'A laboratory evaluation of the decontamination properties of icrofiber cloths', Journal of Hospital Infection , 64:379-385).	Additional information to be provided	Sentence on new and emerging technologies will be included with reference to the articles submitted for more information.
B1.4	#55	Environmental cleaning – requirement to disinfect post detergent and water, hospitals are concerned with the workload of cleaning twice when some products can be used once with no pre-cleaning	Clarification on the cleaning process will be provided.	Text inserted about the concept of a two step cleaning process and rationale for cleaning.
51 Rec 10	#69	Specify neutral detergent/alcohol	Neutral does not need to be specified. Routine cleaning of surfaces consists of detergent as per manufacturers instructions.	No change to Guideline
51.	#78	It would be useful to include a reference that presents evidence for greater efficacy of detergent plus disinfectant over detergent alone for frequently touched surfaces	This is an area highlighted for future research. Currently not aware of research specifically that addresses this in practice.	No change to Guideline
51	#81	B1.4.2. Sentence ends with use of disinfectant solution-? Error	Clarification will be provided	Changed.
51	#17	B1.4.2 – is this a two step process or not? Contradicts page 91	Clarification will be provided	Additional information has been provided on the requirements of a two step cleaning process
51 B1.4.2	#29	Clean touched surfaces of shared clinical equipment between patient uses, with detergent solution. Exceptions to this should be justified by risk assessment. Agree but note that this is the first recommendation where the proviso 'exceptions to this should be justified by risk assessment' occurs. This recommendation needs to be rewritten for primary care to remove the implication that all touched surfaces should be cleaned between patients with detergent solutions. Long-standing usual practice of NOT cleaning	Clarification will be provided	Paragraph inserted about designated cleaning schedules within a facility. Text inserted about implementing recommendations in non acute care or primary care settings.

		items such the desk, door handles, blood pressure cuffs etc has not been identified as a significant risk for healthcare associated infections in primary care.		
51 B1.4.2	#29	Use surface barriers to protect clinical surfaces (including equipment) that are: • touched frequently with gloved hands during the delivery of patient care; • likely to become contaminated with blood or body substances; or • difficult to clean (e.g. computer keyboards). Exceptions to this should be justified by risk assessment. Agree but believe that this recommendation needs to be rewritten for primary care to remove the implication that computer keyboards require surface barriers. Long-standing usual practice of NOT using surface barriers has not been identified as a significant risk for healthcare associated infections in primary care.	Clarification will be provided however no change to recommendation	Paragraph inserted about implementing recommendations in non acute care or primary care settings.
51 B1.4.2	#15	12 (Section B1.4.2) Surface barriers These recommendations will be difficult to achieve and maintain in the remote environment due poverty, isolation and its impact, without resourcing with regard to training, equipment and organisational support via policy/procedures.	Clarification will be provided however no change to recommendation	Paragraph will be inserted about implementing recommendations in non acute care or primary care settings.
51	#69	Reconsider the double clean- use a combined detergent/disinfectant- has implications for cleaning staff requirement.	Clarification will be provided .	Text inserted about the two step cleaning process and rationale for cleaning.
51	#44	Current research suggests cleaning of the environment should routinely include the two step process for all cleaning, ie. Detergent and disinfectant, and not just where there is an endemic problem. In reality, this does not always occur, particularly where resources are inadequate. Therefore the document needs to place more emphasis on providing sufficient resources, including defining who is responsible for specific cleaning tasks and training required, to ensure cleaning is of a high standard, rather than relying on toxic chemicals alone.	Guideline is a principle based document based on the current available evidence. Individual organisations to still need to determine level of responsibility, consistent with governance processes.	Text inserted about the two step cleaning process and rationale for cleaning.
51	#69	A 2 step terminal clean is highly laborious and with phenol this neutral detergent clean prior to disinfection is not required (we don't do this- 1 step clean with phenols/ phenolic).	Will elaborate on 2 step cleaning process, and 2 in 1 products. Guideline will be based on the best available current evidence.	Text inserted about the two step cleaning process and rationale for cleaning.

			Changes to recommendations must be supported by strong evidence.	
51	#34	For routine environmental cleaning the guidelines recommend a detergent solution only unless MRO's are known or suspected to be present. There is an increasing body of literature demonstrating a correlation between improved environmental hygiene and decreased infection rates involving studies where disinfectants were used. Recommendation: Perhaps detergents could be recommended for minimal touch surfaces with disinfectants for high touch surfaces regardless MRO risk status.	Table B1.3 specifies this.	No change to guideline
51	#34	When a disinfectant is recommended the guidelines state that cleaning with a detergent should be done prior to disinfecting with another chemical. The guidelines do not acknowledge a one-step cleaning and disinfecting process can occur. There is currently TGA-registered disinfectant product available in Australia that performs a cleaning and disinfecting process in one-step. Recommendation: The guidelines may want to acknowledge use of a two/multiple-step cleaning and disinfecting process or a one-step cleaning and disinfecting process. (Reference to this single cleaning and disinfecting process is made in section B3.1 Management of MRO's) "the use of a detergent solution is followed by the use of a disinfectant so that surfaces are cleaned twice." – This quote from the guidelines in the paragraph above implies that the surface has only been cleaned (twice). Recommendation: Perhaps the sentence should read "…..so that surfaces are cleaned and disinfected." This is after all the process being described.	Clarification on the cleaning process will be provided	Will elaborate on the 2 step cleaning process and link to chapter.
51	#42	& 91, B1.4.2 – is the use of secondary clean with disinfectant evidence based as I did not think this was strictly necessary and the mechanical action of more importance not chemical, the point should also be made about allowing to dry	Clarification on the cleaning process will be provided	Will elaborate on 2 step cleaning process, and 2 in 1 products.
51 B1.4.2	#75	"Share equipment;" Include that the item must be cleaned between patients as well as the protective cover changed	Accept	Will include suggested text
52 B1.4.2	#47	Part B1.4.2; page 52; Routine management of the physical environment Use of disinfectants This section is the first reference to use of disinfectants and should inform the readers of the statutory framework and what it means in practice. Instead, it misuses terms, mixes product categories, and actually adds no value to practice or science. Suggest change to read as follows: "In acute patient care areas where the risk of patient vulnerability and risk of cross infection due to the presence of an MRO is high, then	Clarification on the cleaning process will be provided	Will include TGA terminology in glossary. Will include sentence on 2 step process and the applicability of cleaning with detergent and disinfectants in the routing cleaning section.

		contact precautions should be followed. This will require all patient surrounds and HTOs to be firstly cleaned with a suitable detergent and then subject to surface disinfection with a TGA registered Hospital Grade Disinfectant (preferably broad spectrum). In office based practices and other areas standard precautions should be routinely applied and patient contact surfaces, HTOs and patient surrounds should be subjected to thorough cleaning with a suitable detergent solution. Instrument Disinfectants should not be used for surface disinfection. There should be no use on larger surface areas of disinfectants which offer additional hazards, such as flammability or corrosivity.		MRO section will be cross referenced back to this section.
52 B1.4.2	#47	Part B1.4.2; page 52; Routine management of the physical environment Table B1.10 Characteristics of disinfectants - This table does not take account of the TGA registration status of the any of the recommendations. By using a citation from the GRAMPIANS Region Infection Control Group (2006) it suggests that recommendations from that group are superior to the Commonwealth legislative framework of law administered by the TGA. We are not sure if this is included to deliberately outrage industry and the TGA, or it is a genuinely well intended primer for any ignorant readers. We recommend that Table B1.10 be deleted. If instructive information in addition to, or to aid with the interpretation of TGA approved material is required, then this material should be included into the appendix at the rear of the document.	Grampians citation is adapted from 1996 NHMRC guidelines and offers practical guidance for health care workers.	Table B1.10 will be deleted and reference to TGA nomenclature and terminology will be used.
52 B1.4.2	#71	Section B1.4.2 “Routine environmental cleaning” – “Use of disinfectants” [page 52] Replace existing text with the following: “In acute patient care areas where the risk of patient vulnerability and risk of cross infection due to the presence of an MRO is high, then contact precautions should be followed. This will require all patient surrounds and HTOs to be firstly cleaned with a suitable detergent and then subject to surface disinfection with a TGA registered Hospital Grade Disinfectant (preferably broad spectrum). In office based practices and other areas standard precautions should be routinely applied and patient contact surfaces, HTOs and patient surrounds should be subjected to thorough cleaning with a suitable detergent solution. “Instrument Disinfectants should not be used for surface disinfection. There should be no use on larger surface areas of disinfectants which offer additional hazards, such as flammability or corrosivity.”	Text has been included on 2 step process and the applicability of cleaning with detergent and disinfectants in the routing cleaning section.	Will include TGA terminology in glossary. Suggested text will be included in Section B3.1 MROs.

52 B1.4.2	#29	Clean frequently touched surfaces with detergent solution at least daily, and when visibly soiled and after every known contamination. Clean general surfaces and fittings when visibly soiled and immediately after spillage. The evidence for a minimum of daily cleaning of frequently touched services in primary care is absent. Long-standing usual practice of regular cleaning (but not necessarily daily and of all frequently touched surfaces) has not been identified as a significant risk for healthcare associated infections in primary care..	The committee recommend that cleaning schedule s are developed by facilities where consideration has to be given to the risk of transmission in light of the nature of contact that occurs with that surface	Inserted statement on risk assessment when designing cleaning schedules for specific environment, including primary care.
52 B1.4.2	#62	10. Environmental surface risk assessment and cleaning frequency There is some considerable confusion in the dental community regarding appropriate guidelines for cleaning of environmental surfaces such as phone handsets and furniture within treatment rooms as opposed to phone handsets and furniture outside dental treatment rooms (e.g. administration areas and waiting room). Might I suggest that the detailed study of risk associated with similar item in different environments by the Victorian Dept of Health is worthy of reference or inclusion in the new NHMRC IC Guidelines. http://www.health.vic.gov.au/cleaningstandards/downloads/cleaning-standards-2009.pdf http://health.vic.gov.au/__data/assets/pdf_file/0017/20069/ballaratclean.pdf	The committee recommend that cleaning schedule s are developed by facilities where consideration has to be given to the risk of transmission in light of the nature of contact that occurs with that surface	Inserted statement on risk assessment when designing cleaning schedules for specific environment, including primary care. Will include references within guideline section.
52 FTS	#35	Frequently touched surfaces The guidelines seem to show a preference for clean cloths; water and detergent. In some instances detergent-impregnated wipes may also be used. This does not acknowledge the relatively high risk of cross-contamination using cloths and solution based detergents over single use pre-impregnated detergent or disinfectant based wipes. Recommendation: Perhaps the guidelines should refer to the cross-contamination risk associated with re-usable cloths VS pre-impregnated wipes. The guidelines may also consider acknowledging the use of pre-impregnated disinfectant wipes for frequently touched surfaces	Committee have reviewed comments but need to consider evidence to change practice from current Guideline content.	No change to guideline
52	#17	Minimal touch surfaces – tabletops are frequently touched surfaces, not minimal. Replace with ‘walls’.	Accept.	Change to frequently touched for tabletops
52	#42	bed screens (privacy screens) are not included or mentioned in this section	Accept	Privacy screens will be included
52	#78	The detail in the table of disinfectants is limited and could be expanded. See table 7.1 in the 2004 ICGs.	Agree	Table B1.10 has been deleted table and additional information

				inserted on the consideration required in the selection of cleaning products.
52	#51	This is a minor issue, but the term toxic should read hazardous to be consistent with the chemicals terminology that is used in workplace health and safety legislation in the various states and territories	Accept	Change terminology
52 disinfect	#35	The guidelines state in the paragraph above that "Alcohol should not be used to disinfect large environmental surfaces. " There is no reason given for why this is the case and yet alcohol is cited as a disinfectant in table B1.10. Recommendation: Please state why alcohol is not preferred for large surface areas	Accept Table B1.10 has been deleted.	Alcohol is not used because of flammability risk. Statement will be added.
52	#44	Characteristics of disenfectants: There are many new products currently being promoted in the market place for MRO/high level disinfectant cleaning, eg. detergent impregnated/other wipes, etc. Suggest there is a recommendation regarding the requirements and application of new products. This should include guidance regarding the specifications of the product, eg. Strength of ingredients required, kill rate, etc. as a guideline for healthcare facilities to choose appropriate products. For example: • Are combined detergent / disinfectant wipes acceptable for use in place of two-step cleaning for small areas / items? • Detergent solution is promoted for general cleaning, yet many facilities use alcohol wipes to clean equipment/surfaces between patient use. • Hydrogen peroxide, sodium hypochlorite and alcohol are the only listed products in this Table? Also Hydrogen Peroxide is noted as able to be utilised in a mist form – this is contrary to OH&S practices. • The Table would be more beneficial if an extra column was included for appropriate use	Table B1.10 has been deleted table and Elaboration on 2 step process has been addressed earlier	Additional information inserted on the consideration required in the selection of cleaning products.
52	#60	Alcohol is used in several specific situations to disinfect larger surfaces e.g. laminar flow cabinet of a Cytoguard room (ISOPP Standards of Practice 2007), Microbiology lab laminar flow cabinet (Facility Clinical Microbiologist recommendation). This is not allowed for in the current wording of the document. There is no recommendation on the role of combined detergent / disinfectant products.	Alcohol is not used because of flammability risk. Statement will be added. For special circumstances, should be considered at a local facility level.	Information on combined 2 in 1 products has been inserted.
52	#44	However, alcohol is included in the table B1.10 (p52). Need to clarify if and when alcohol may be used. Further evidence-based references need to be provided to support same.	Alcohol is not used because of flammability risk.	Table B1.10 will be deleted. Statement will be added about alcohol and cleaning.

52	#17	Table B1.10 – should be referenced appropriately. Isn't there better evidence to use than this book?	Noted.	Table B1.10 will be deleted.
52	#46	Source' references should be used for the table	Noted.	Table B1.10 will be deleted.
52 table B1.10	#19	The table in the booklet quoted above was adapted from the Guidelines for the Investigation of Gastrointestinal Illness, Published by the Victorian Government Department of Human Services Victoria 1998 http://www.health.vic.gov.au/ideas/diseases/gas_ill_index	Noted.	Table B1.10 has been deleted
52 Table B1.10		Page 52, Table B1.10 reference is from a small booklet production. It is not a published, reviewed document. Reference seems inappropriate for a National Guideline.	Noted.	Table B1.10 has been deleted. TGA generic terminology will be used, linked to TGA and added to glossary
53	#57	Shared clinical equipment Re-word 'While shared clinical equipment comes into contact with intact skin only and is therefore unlikely to directly cause infection, it can act as a vehicle (fomite) by which infectious agents are transferred to patients who subsequently may develop infection.	Committee has considered wording and state it refers to re-usable equipment and not just in contact with intact skin only.	No change to guideline
53 B1.4.2	#47	Part B1.4.2; page 53; Carpet No attempt has been made to describe the different types of soft floor coverings. It is not just "carpet". Several products are now available that offer different characteristics and can be easily and successfully cleaned and if necessary disinfected. Cleaning of soft floor coverings should be as per AS/NZS 3733:1995.	Consideration should be made at a local facility level of how it should be cleaned, what products, costs of cleaning. The cleaning of soft floorings should consider the need to remove/kill a range of microorganisms. This should also be determined by local policies.	Sentence has been inserted about considering cleaning products for different surfaces.
53	#69	Shared equip: Include that the item must be cleaned between patients as well as the protective cover changed. What is the efficacy of clear plastic wrap in protecting equipment? Include that the item must be cleaned as well as the protective cover changed Include other examples that may need wrapping, e.g. operating room camera, operating room light etc	Not aware of information on efficacy.	Add "and cleaned" after "should be changed' between patients"
53	#74	Clinical equipment requires definition, especially as to whether this might apply	This does not refer to re-usable medical equipment.	No change to guideline

		to surgical or endoscopic equipment. This is not clear in the relevant body of text for this recommendation.	Clinical equipment is defined using TGA criteria.	
53	#17	Cleaning implements and solutions – should remove 2nd point.	Accept.	Removed dot point
53	#66	Suggest more detail regarding the regular changing of water/mops cloths and between wards/rooms etc. In dealing with many gastro outbreaks many staff do not understand the concept of infection potentially being spread from room to room or ward to ward, using same mop, cloth, bucket of solution. Also importance of cleaning equipment between cleaning sessions could be raised. Various information on management of spills throughout with differences confusing could it all be in one condensed format in a table?	Guideline is a principles based document, suggested additions considered too prescriptive for the guideline but could be considered by the local infection control policy	No change to guideline
53	#79	Carpets should not be placed in clinical settings. The temperature required to kill pathogens such as Coronovirus (SARS) cannot be achieved by some equipment due to the metal handles on the machine. Bleach products which are recommended as disinfectants for terminally cleaning the rooms where patients with CDAD or Norovirus infections have been isolated are not recommended for some hospital shampoo machines. Resources should be provided for Health Services to replace carpets with surfaces that can be adequatlety cleaned and disinfected. Contaminated carpets have been associated with the transmission of Norovirus illness in carpet layers. Chessborough et al.	Consideration should be made at a local facility level of how it should be cleaned, what products, costs of cleaning. The cleaning of soft floorings should consider the need to remove/kill a range of microorganisms. This should also be determined by local policies.	Sentence has been inserted about considering cleaning products for different surfaces.
53	#69	Where is the evidence for steam cleaning carpet- should this be a chemical steam clean?	Noted.	Terminology will be adopted as per the AS/NZS:3733 1995 standard Additional statement inserted that reinforces that cleaning products and technologies be used according to manufacturers instructions.
53	#11	Comment Use of correct terminology when describing carpet cleaning processes. The term ‘Steam Cleaning’ is not consistent with the accepted industry terminology as per the Australian Standard AS/NZS:3733 1995 and may be confused with the use of steam generation machines which have recently been introduced into facility cleaning. The correct term as per	Accept Recommendations will be consistent with more recent evidence including the 2003 CDC environmental guidelines.	Terminology will be adopted as per the AS/NZS:3733 1995 standard. Additional statement inserted that reinforces

		the standard and industry literature is 'Hot Water Extraction' (HWE) or 'Hot Water Injection and Extraction' This is a real concern with all vacuum-equipped commercial cleaning equipment. Consideration should be given to the potential for aerosol contamination of surfaces and transmission for infection via water droplets and aerosols emitted from Scrubber Driers, Wet vacuums and Carpet Extraction equipment. Scrubber –driers scrub, clean and dry hard floors and are commonly utilised in all hard floor areas including operating theatres. Exhaust filters are available in very few models of vacuum equipped wet pickup devices. Please find attached an article on this subject, which I would like to include as part of this comment. The article has appeared in INCLEAN magazine and has been submitted for publication to Industry journals in the US and the UK.	Guideline will reinforce that cleaning products and technologies should be used according to manufacturers instructions, however specific detail should also be determined by local policies and environments.	that cleaning products and technologies be used according to manufacturers instructions.
53	#12	Use of correct terminology when describing carpet cleaning processes a) steam cleaning – The term 'Steam Cleaning' is generic and confusing as it could be interpreted as pertaining to using steam generation machines that are used in a number of cleaning processes and is not concurrent with the accepted industry description for corrective cleaning processes for carpeted surfaces. The correct terminology for this process is 'Hot Water Injection and Extraction' or 'Hot Water Extraction' (HWE) as defined in section 4.5.3 5.5.3 of AS/NZS 3733:1995. A reference to the relevant sections of AS/NZ 3733 in the infection control guidelines would be beneficial to all aspects of carpet maintenance including vacuuming, spotting and interim and corrective cleaning, as the standard sets out the precise methodologies to be followed with each cleaning method. b) using a method that minimises the production of aerosols and leaves little or no residue – This is very vague and prone to misinterpretation. The method of Hot Water Injection and Extraction (a.k.a. Steam Cleaning) involves high pressure water injection and vacuum extraction. The choice of equipment and comprehensive operator training in carpet cleaning techniques pertinent to the heathcare environment are the critical aspects in minimising aerosol production and minimising residue. Currently, the method of Hot Water Extraction, performed correctly, is the only corrective cleaning method that is recognised to minimise chemical and soil residue.2	Accept Recommendations will be consistent with more recent evidence including the 2003 CDC environmental guidelines.	Terminology will be adopted as per the AS/NZS:3733 1995 standard.
54	#57	Objective markers for cleaning: There is good evidence that using these	Accept	These examples will be

[2] *As/NZS 3722:1995 Standards Australia 1995. Preface page 2*

		objective measures improves cleaners' practices and demonstrated microbiological security of cleaning (ICHE references x 2). Suggest re-word: 'The use of more objective methods (e.g. 'black-spot auditing, detection of bacterial load with ATPase) of auditing surface cleanliness are recommended for high risk clinical zones.'		added to page 54
54	#44	Routine microbiological sampling of the environment to determine the effectiveness of cleaning has considerable limitations, including detection of specific classes of organisms (with exclusion of others), inconsistency and unpredictability of 'patient shedding' and other causes of environmental contamination, variation of effects of residual detergent/ disinfectants, and variations in sampling techniques and testing. Suggest include 'routine sampling is not recommended…' as a recommendation, and not just in the information, to make this clear to HCWs	Committee has prioritised recommendations for the guideline as part of the core concepts of infection control. Consider text is sufficient.	No change to guideline
54	#17	Process of spills management – replace 'kitty litter' with another example	Accept	Will be replaced with 'absorbent granules'
54	#69	Spills management; remove the line about using an absorbent clumping agent- creates a trip hazard; the goal should be to confine and contain then clean as soon as possible	Noted. No change. Spills that have excess liquid removed are easier to manage and clean up. Local protocols can use trip hazard signage or cordon off area until spill has been cleaned up and the area is safe to use.	
54	#46	management of blood and body substance bills – does not discuss the wearing of personal protective equipment in the table (which I believe should be included as it is written as a procedure	Noted. Specified above the table.	Inserted additional text into table.
55 B1.11	#43	Recommend stating the concentration and contact time required for Sodium Hypochlorite Request addition of disinfectant options. We refer to CDC guidelines for Environmental Infection Control in Healthcare facilities, June 6, 2003/52(RR10);1-42, Section Recommendations Environmental Services Part IIC. We therefore request in addition to Sodium Hypochlorite the provision to use 'TGA registered disinfectants with specific label claims for HIV or Hep B virus'.	Guideline will refer to TGA approved products and what should be considered when choosing a product. The research is not available on contact time required for Sodium hypochlorite but can be flagged for further research.	No change to guideline
55	#29	Site decontamination after spills of blood or other potentially infectious	Accept.	Will amend

B1.4.3		materials Spills of blood or other potentially infectious materials should be promptly cleaned as follows: wear utility gloves and other PPE appropriate to the task; confine and contain spill, clean visible matter with disposable absorbent material and discard the used cleaning materials in the appropriate waste container; clean the spill area with a cloth or paper towels using detergent solution. Use of chemical disinfectants such as sodium hypochlorite should be based on assessment of risk of transmission of infectious agents from that spill. Agree with the recommendation as written in the summary at the front of the document. Note that this is different than that in the text on page 55. Disagree that all spills need to be wiped with a partly diluted sodium hypochlorite solution. This practice has not been used in primary care and the use of detergent solutions alone with appropriate cleaning has not been associated with healthcare associated infection. Suggest correct the text in the document to that of the summary recommendation.		recommendation on page 55 to reflect recommendation in summary.
55	#17	Spillage of tissues with CJD Should refer to CJD chapter	Text taken directly from 2007 DoHA CJD chapter. All CJD related issues will be referred to DoHA 2007 CJD chapter	Insert reference to 2007 DoHA CJD chapter.
55	#25	Spillage of tissue from patients with CJD. Pg 55. This is not clear, e.g. does this mean CSF fluid in the lab?	Text taken directly from 2007 DoHA CJD chapter. All CJD related issues will be referred to DoHA 2007 CJD chapter	Insert reference to 2007 DoHA CJD chapter.
55 Table B1.11	#81	Clarity required around Sodium hypochlorite ie solution, dilute? And what happens is spill on upholstery or carpet?	Each organisation requires operational procedures to deal with spills on upholstered/ textile objects. Where a spill occurs on a carpet, shampoo as soon as possible. Do not use disinfectant.	We will reference CDC environmental guidelines for appropriate dilutions in additional resources. Sentence inserted about spills on carpet.
55 Table B1.11	#25	Management of blood or body substance spills including identification of the spill level, actions to be taken and the details of what should be included in a spill kit is very useful Great work with the “putting it into practice”	Accept.	Will reference resources that include general make up of spill kits.
55 Table B1.11	#75	Table B1.11 The cleaning of bodyfluid spills with bleach goes against NSW Health IC policy 2007_036 and the IFIC standards	There is evidence supporting the use of	Inserted sentence: There is evidence

			sodium hypochlorite to inactivate organisms.	supporting the use of sodium hypochlorite to inactivate various blood borne and gastrointestinal viruses, and bacteria such as C diff. The consideration to sodium hypochlorite should be based on risk assessment of the environment, the spill, risk of transmission of disease, and the surface area.
55 Table B1.11	#67	Page 55, Table B1.11 Management of Blood spills reintroduces the use of a disinfectant back into cleaning after a blood spill. I understand that adequate cleaning with soap and water is all that is required.	There is evidence supporting the use of sodium hypochlorite to inactivate organisms.	Inserted sentence: There is evidence supporting the use of sodium hypochlorite to inactivate various blood borne and gastrointestinal viruses, and bacteria such as C diff. The consideration to sodium hypochlorite should be based on risk assessment of the environment, the spill, risk of transmission of disease, and the surface area.
	#46	most people don't understand what 20,000 ppm (free chlorine) actually means and in my own consultation for cleaning procedure flipcharts I have still put 5000 ppm, but quantified this with (1 cup of Jasol to 7 cups of water) equals 5000 ppm	Guideline cannot refer to all products or brand names. As part of governance organisations need to make operational and work place level protocols for the chemicals and concentrations used and refer to manufacturers instructions.	Will reference CDC environmental guidelines in the resources about appropriate sodium hypochlorite formulations. Will refer to 'The blue book: Guidelines for the control of infectious diseases' VIC 2005
55	#78	We suggest specifying the concentration of NaOH solution	Noted.	Will refer to 'The blue book: Guidelines for the control of infectious

				diseases' VIC 2005
55 Rec 13	#69	Need for sodium hypochlorite?	There is evidence supporting the use of sodium hypochlorite to inactivate organisms.	Inserted sentence: There is evidence supporting the use of sodium hypochlorite to inactivate various blood borne and gastrointestinal viruses, and bacteria such as C diff. The consideration to sodium hypochlorite should be based on risk assessment of the environment, the spill, risk of transmission of disease, and the surface area.
55	#79	Sodium hypochlorite cannot be used on carpets for blood spills	Agreed	Sentence will be added that disinfectant should not be used on carpet.
55	#12	No outline of specific spot or spill control procedures and methodologies pertaining to carpeted surfaces. A spot control regime for carpet and fabric upholstery would assist cleaning management & staff in understanding the most effective methodologies control and proper removal of infectious or potentially infectious material from carpet and fabric. There are guidelines to spot and stain removal in AS/NZS:3733 and in AS/NZS:4849.1.2003 Upholstery Cleaning. The NUCCRA technical committee would be happy to assist in developing guidelines specific to healthcare environment.	Accept	Will reference Standards for specific guidance in the resources section.
55	#74	We would note that universal precautions should be applied to any spills –bleach cleaning should always occur	Guideline considers the use of a disinfectant based on risk assessment. The application of standard precautions when undertaking cleaning procedures has been stated	No change to guideline
55	#51	It would be useful if this section could provide guidance on the recommended concentration of sodium hypochlorite (parts per million (ppm) available chlorine) to use on blood and body substance spills. It would also be useful to include a brief statement on the need to ensure	There is evidence supporting the use of sodium hypochlorite to inactivate organisms.	There is evidence supporting the use of sodium hypochlorite to inactivate various blood borne and gastrointestinal

		workplace health and safety when using hazardous chemicals such as sodium hypochlorite. It would be of interest to include a brief statement on the reasons why sodium hypochlorite has been included for spills management when the 2004 edition of the Guidelines state that its use is generally unnecessary		viruses, and bacteria such as C diff. The consideration to sodium hypochlorite should be based on risk assessment of the environment, the spill, risk of transmission of disease, and the surface area. Will refer to 'The blue book: Guidelines for the control of infectious diseases' VIC 2005
56	#20, #80	where is the evidence to support the highly prescriptive nature of this table? The source quoted covers the idea of risk management based on level of risk of contracting infection, which is fine, but if staff are going to be asked to clean the alcohol handrub dispenser after each use then it would be good to supply supporting evidence for that requirement. This table is generally quite problematic. There are some poorly defined terms, and the frequencies of cleaning seem inconsistent across the risk groups and different items. The source it supposedly based on does not prescribe this level of cleaning (some examples below and in the following section of these gaps and inconsistencies Given there is not a lot of information out there on changes to infection rates in relation to minutely controlled environmental cleaning, the whole table seems unreasonably prescriptive	In the absence of other guidance, the cleaning frequency table has been developed to provide a benchmark guide to best practice cleaning schedules. Based on risk assessment of the environment. This can be used by facilities to implement a cleaning schedule and policy that suits their environment.	No change to guideline
56 B1.4.4	#47	Part B1.4.4; page 56; Table B1.12 "Recommended routine cleaning frequencies…" Low Risk 1 and 2 Firstly detergents recommended for use on medical devices should surely be those which are subject to regulatory supervision. These product which are required by law to have evidence as to performance and suitability for use in the label recommended application are subject to quality checking and may be subject to recall by the TGA for quality failure or other non-compliance. Recommend 1 be re-worded to say 1 Medical surface detergent or a detergent wipe, that is registered as a class I Medical Device with the TGA is recommended for cleaning of surfaces and HTOs in clinical, patient and resident areas. This detergent or detergent wipe should be recommended with clear instructions in regards to materials compatibility Secondly, the disinfectant recommendations should re-iterate the TGA	Accept	Information will be inserted on choice of product and document will refer to TGA terminology in the Therapeutic Goods Order No.54 for disinfectants and sterilants.

		licensing framework and confirm that the correct product will be used in the correct application. Recommend 2 be re-worded to say 2 Where transmission based precautions are required, a TGA registered Hospital Grade Disinfectant must be used if a disinfectant is required. The disinfectant chosen should have label claims against the organism of concern – refer to sections B2 and B3		
56 Table B1.12	#71	Table B1.12 "Recommended routine cleaning frequencies for clinical, patient and resident areas" [page 56] Amend - "1 Detergent or suitable cleaning product (for areas such as windows or items that have specific manufacturer's cleaning instructions))" To read -"1 Medical surface detergent or a detergent wipe that is registered as a class I Medical Device with the TGA (for cleaning of surfaces and HTOs in clinical, patient and resident areas). This detergent or detergent wipe should be recommended with clear instructions in regards to materials compatibility." Amend "2 -refers to multi-resistant organisms or infectious agents requiring transmission-based precautions…" To read – "2 Where transmission based precautions are required, a TGA registered Hospital Grade Disinfectant must be used if a disinfectant is required. The disinfectant chosen should have label claims against the organism of concern…"	Accept	Information will be inserted on choice of product and document will refer to TGA terminology in the Therapeutic Goods Order No.54 for disinfectants and sterilants.
56 Table B1.12	#80	The proposed 4□point scale could be improved by using terms that reflect a more consistent ordinal scale. There is a lack of clarity around these proposed terms. For example, the difference between 'significant' and 'high' is arbitrary. Using the following reference labels may provide greater clarity: • Outbreak • High Risk • Medium Risk • Low Risk In addition, the recommended cleaning schedule in an outbreak should reflect transmission□based precautions relative to the organism of concern.	Noted.	Will elaborate on the risk category terminology and provide reference to transmission based precautions.
56 Table B1.12	#80	Recommend moving Table B1.12 Recommended routine cleaning frequencies for clinical, patient and residential areas to after B1.5.4 Disinfection. These recommendations would be best placed after discussion of the Spaulding Classification, which is presented in B1.5.2	The table does not refer to reprocessing of instruments which is Section B1.5	No change to guideline
Table B1.12	#75	Aged Care facilities need to be placed as significant risk and not low	Based on risk assessment	No change to guideline

		risk. Aged care patients are actually at significant risk of infection. AICA does not support the placing of Aged Care facilities into low risk. Include cleaning between patients as a standard applies for most of the examples and maybe include a standard for outbreaks up the frequency of frequently touched areas bed rails, door knobs, keyboards, toilets etc Dental chairs, specify clean between pts, as well as daily	of the environment. This can be used by facilities to implement a cleaning schedule and policy that suits their environment. If there is a risk of transmission of specific infections then cleaning frequency should be adjusted accordingly.	
56 Table B1.12	#79	Renal units should be included as high risk due to invasive procedures and increased risk of BSI	Accept	Have included renal unit in high risk category.
56 Table B1.12	#25	Great job on table: B1.12 recommended routine cleaning frequencies for clinical, patient and resident areas The minimum cleaning frequency chart (B1.12) outlining patient risk area categories, cleaning schedules, numerous patient care items and the cleaning/disinfectant product to use, was very useful and included more categories of risk than the PIDAC document (http://www.health.gov.on.ca/english/providers/program/infectious/diseases/ic_enviro_clean.html • It is not clear what criteria are being used in table B1.12 to define low-high risk. E.g. why are rehabilitation and Residential care low risk areas? • Other documents (e.g. PIDAC) include a "how-to" schedule for items, discussion on cleaning practices and principles, checklists, staff education and new cleaning methodologies etc. similar sections would be useful, but might be a document in and of itself for non-critical equipment. • Terminal cleaning procedures (or cleaning after use) are inconsistently included in tables (e.g., p. 56)	Noted.	Will elaborate on definitions of risk areas.
56 Table B1.12	#55	Table B1.12 great to have a detailed table as a guide. Some terms are not clear - What does "one full clean" mean? - If a piece of equipment is cleaned and stored then why are we cleaning monthly and not just after use e.g. medical equipment not connected to a patient? - What is the difference between clipboard and notes folder?	Accept	Have made text consistent throughout table and defined cleaning terms in table.
56 Table B1.12	#78	There should be consistency in the frequency or otherwise of the cleaning of frequently handled/touched items e.g. light switches, door handles, bed rails.	Accept	Have made text consistent throughout table and defined

				cleaning terms in table.
56 Table B1.12	#69	Include cleaning between patients as a standard- applies for most of the examples and maybe include a standard for outbreaks- up the frequency of frequently touched areas- bed rails, door knobs, keyboards, toilets etc Dental CHAIRS: Specify clean between pts, as well as daily	The guideline is principle based document. Local cleaning schedule policies should outline responsibilities and specific protocols for their environment.	No change to guideline
56 Table B1.12	#17	Where does theatre/operating suite fit in this table?	Accept.	Have included operating suite in high risk category.
56	#66	Cleaning frequency table good inclusion however could key be at bottom of each page, where reference to disinfectant and detergent MRO potentially confusing reading as disinfectant only for MRO posing risk e.g. in Norovirus/Gastro outbreak cleaners may only use detergent. Could this be clarified by additional column in tables on p82 or 83 to denote additional disinfectant clean may be recommended for the specific infection/disease? - Curtains and blinds confusing as to what proximity to patient are they bed screens, what to do if soiled, regular inspection. What is cleaned or replaced annually, - Bed curtains often soiled and often touched need to be changed and or cleaned more than annually or biannually. - Fan section confusing is one fixed and one portable?? - Fridges ? is first section inside and other outside, should it be inspected and spot cleaned etc daily and full clean weekly. - Bath hoist equip etc should clean contact points after each use but also regular full detailed clean. - Manual handling equipment: there are many different configurations of this often shared equipment in smaller facilities and not ward specific? Consider recommending use of patient specific slings to be laundered /changed when soiled or on pt discharge etc (as concern re soiling and contamination of slings have heard of association with VRE outbreak) - Nebuliser is this in reference to the mask or the machine, please clarify and recommend cleaning for both	Accept. Table B1.1.2 is a guide for facilities to implement a cleaning schedule and policy that suits their environment. Depending on the risk of transmission of specific infections in that environment then cleaning frequency may be adjusted accordingly, and a documented cleaning schedule should be provided by the facility.	Will cross reference to transmission based precautions.
56 Table B1.12	#25	Inconsistencies : alcohol hand rub dispenser, bedside, the minimum cleaning frequency is listed as 'Clean daily & between patient use'. It is unclear if this means it must be cleaned between different patients (ie after one patient is discharged and another is admitted) or if it means after each time the dispenser if used for one particular patient. If the latter is meant it seems	Accept Table B1.1.2 is a guide for facilities to implement a cleaning schedule and policy that suits their environment. Depending	Have made text consistent throughout table and defined cleaning terms in table.

		like overkill given the dispenser is already being cleaned daily, and staff would be sanitising their hands with hand rub after touching the dispenser handle anyway. For other items the terms 'after use', or 'after discharge' are used. After use is clear, ie. Clean it following use. After discharge is clear, ie. A patient is discharged from a bed and the item is cleaned before the next patient is admitted, but 'between patient use' is unclear. Perhaps there needs to be a key that explains what some of these terms refer to, or perhaps there needs to be more consistent use of terms?	on the risk of transmission of specific infections in that environment then cleaning frequency may be adjusted accordingly.	
56 Table B1.12	#79	• Identify who should clean the ABHR dispenser at bedside, between patient use. • Clinical Handbasin taps have been identified in literature as high contamination areas. If ABHR is to be cleaned between each uses shouldn't the clinical handbasin also be included. • Resources for cleaning should be identified. • Carpet cleaning is not consistent with flooring frequency. Carpet should be removed. • Drip/Intravenous define clean contact points after each use. Identify who should do this? • Medical equipment should be changed to Patient care equipment of health care equipment. • Identify resources for cleaning the sharps bin trolley. • Toilet should be identified as a high risk area, and hand basin and tap handles, toilet button, door handle should be cleaned more regularly particularly during winter vomiting season. Staff should have swipe card access to Staff only bathroom facilities.	The guideline is principle based document. Local cleaning schedule policies should outline responsibilities and specific protocols for their environment.	No change to guideline
57-61 B1.4.2	#28	11. (Section B1.4.2) Cleaning of shared clinical equipment (Table on pages 57 – 61) These recommendations will be difficult to achieve and maintain in the remote environment due poverty, isolation and its impact, without resourcing with regard to training, equipment and organisational support via policy/procedures.	Guideline acknowledges issues and considers that a risk assessment should be undertaken under local conditions to inform local infection control policies.	No change to guideline
57	#20	It is unclear what is meant by 'one check clean' as opposed to a full clean. Does that mean that the object is cleaned again after its daily full clean only if there are signs of obvious soil, and if so would that mean that only the obviously soiled area is wiped as opposed to the whole object? Perhaps there needs to be a small key that explains some terms	Accept	Have made text consistent throughout table and defined cleaning terms in table.
57	#78 #25	Frequency of cleaning of the blood pressure cuff. This should be revised because high risk situations require more frequent cleaning than very high risk as it stands in the current draft. Why do BP cuffs used on very high risk, and significant and low risk patients get cleaned after use only, when BP cuffs used on patient who	Accept	Will correct discrepancy.

		are high risk get cleaned daily and after use? It seems illogical to clean the high risk ones more frequently than the very high risk ones		
57	#46	No recommendation on method of cleaning BP cuffs	Cleaning schedule s need to be developed by facilities where consideration has to be given to the risk of transmission in light of the nature of contact that occurs with that surface	No change to guideline
57 Table B1.12	#11	Correct terminology in relation to cleaning methods The table refers to “Steam Cleaning’ and ‘Shampooing’ of carpets. These are two distinct cleaning methods with different sets of equipment, chemical, methodology and residue. According to AS/NZS 3733 1995, HWE is a Corrective or Restorative Cleaning method whilst Shampooing is an interim maintenance procedure. It is important that the nomenclature and methodologies remain consistent within the final document and reflect current industry terminology. Recommended routine cleaning frequencies for clinical, patient and resident areas page 57 The term ‘Steam Cleaning’ is not consistent with the accepted industry terminology as per the Australian Standard AS/NZS:3733 1995 and may be confused with the use of steam generation machines which have recently been introduced into facility cleaning. The correct term as per the standard and industry literature is ‘Hot Water Extraction’ (HWE) or ‘Hot Water Injection and Extraction’.	Accept	Will refer to AS standard and correct it to state hot water extraction terminology.
57 Table B1.12	#12	Issues with terminology The terms ‘Shampoo’ or’ steam clean’ as described as the method under the minimum cleaning frequency requirements on the chart on page 57 are confusing and are not consistent with the cleaning process outlined in Section B1.4 of the draft document. According the AS/NZS:3733, ‘Shampooing’ and “steam” cleaning (Hot Water Extraction) are two distinct methods. ‘Shampooing’ is described in the standard as a ‘Surface Cleaning method’ 3, while Hot Water Extraction is defined as a Corrective or Restorative Cleaning Method.	Accept	Will refer to AS standard and correct it to state hot water extraction terminology.

[3] AS/NZS 3733:1995 Section 2, subsection 2.1.4 Guidelines in Carpet maintenance page 7.

		Both methods utilise a separate set of equipment, chemical and methodology. Choice of cleaning equipment for carpet in a healthcare situation and to ensure that the equipment is of sufficient quality to completely remove contaminants and leave the carpet as dry as possible. AS:NZS 3733 describes the suitable forms of equipment and broad specifications for the cleaning chemicals required to perform each method of carpet cleaning. Incorrect choice of chemical and equipment and lack of adequate operator training in the application of methodology increases the risk of inadequate removal of infectious material. Many healthcare facilities do not possess the correct equipment to extract or clean carpets adequately and we recommend that this be addressed by including a generic description of equipment and chemical required for HWE and spot removal. One of the issues in healthcare cleaning is the widespread promotion and use of twin cylindrical brush multipurpose scrubbers that are marketed for carpet cleaning in healthcare. These units do not adequately flush the carpet or remove residue as they do not utilise water pumps or vacuum extraction.		
57 Table B1.1.2	#20	Door knobs: Clean once daily is a tautology. Clean daily is sufficient clipboards, very high risk patients get a clean daily and between patient use, while high risk get one full clean daily and between patient use. Consistency? Curtains and blinds, some columns state patient bed curtains and others bed curtains. The very high risk column has curtains only being changed weekly after discharge (when there is no patient in the bed), whereas the high risk ones get cleaned monthly regardless of whether there is a patient in the bed or not. Presumably the former is meant to read weekly and on discharge. It is also unclear why there are three rows for this item. The first one is for non-MRO patients, and the second one refers to patients with MROs, however, what is the third row referring to, ie what is being cleaned yearly? It can't be the bed curtains because these are being done more frequently. If this last row refers to blinds then maybe the item blinds should be next to it rather than next the stuff on bed curtain changes and cleans why ceilings (which are never going to be handled or come into contact with anyone) need a yearly full wash, and spot cleaning as required, when walls, which one would imagine would be more likely to get touched/leant on and splashed etc, only require spot cleaning two rows for cleaning fridges? Does one refer to the outside and one to the inside? If so, it might be helpful to state that. P60The use of the prefix 'bi' as in 'bimonthly' and 'biannually' is used	Table B1.1.2 is a guide for facilities to implement a cleaning schedule and policy that suits their environment. Depending on the risk of transmission of specific infections in that environment then cleaning frequency may be adjusted accordingly.	Have made text consistent throughout table and defined cleaning terms in table.

		inconsistently in this table and prone to cause confusion. For example, bimonthly can be interpreted as twice per month or once every two months depending on which dictionary is referred to. In the table on p60 it is used to indicate twice per month as it goes weekly, bimonthly, monthly across the columns from left to right. On page 58, for the row Curtains and blinds, it goes weekly, monthly, biannually (in this instance meaning twice per year), annually in the first row, and yearly, yearly, yearly, biannually (in this instance meaning every two years) on the last row of that item. To prevent confusion it would be better to state specifically whether it was twice per month or twice per year or every two years Patient slide/board has no item heading. What is it that needs a full clean monthly? Sinks: why do the high risk patients get two full cleans and one check clean when the very high risk only get two full cleans? Surfaces (general) should have the word 'after' before the word discharge. The row Toilet: would be better worded 'one full clean & one check clean daily'. Windows for low risk patient are cleaned weekly, while bedside lockers, which would undoubtedly get more contact, are not required to be cleaned at all Why does manual handling equipment never need a full clean, whereas the undersides of beds must be cleaned regularly		
57 Table B1.1.2	#44	Excellent guide as gives clear instructions. However curtains & blinds need further defining, eg. specify if this is all curtains in the room windows and bed screens	For the purposes of this document it is not necessary. Recommended cleaning schedule s should be developed by facilities where consideration has to be given to the risk of transmission in light of the nature of contact that occurs with that surface.	No Change to guidelines
58	#67	Table B1.12 In this table it has Drip/Intravenous stands and on page 59 it has IV stand & poles. Are these not the same item? The cleaning is different. Perhaps the description is not clear as to the item intended.	Accept	Will make consistent.
59	#80	Computer and keyboard It is recommended that keyboard and computer be separated in the cleaning recommendations. During outbreaks, high and medium risk situations, the surfaces of keyboards (and other electronic equipment that requires frequent hand use in clinical settings, such as ICUs) should be cleaned daily or at discharge and in accordance with organism specific transmission based precautions	Table B1.1.2 is a guide for facilities to implement a cleaning schedule and policy that suits their environment. Depending on the risk of transmission of specific infections in that	

		Light switches During an outbreak or high risk situation, daily cleaning of light switches is recommended. Recommendations should be in accordance with organismspecific transmission based precautions, such as those described in Cleaning of Surfaces (General) on page 60	environment then cleaning frequency may be adjusted accordingly. This includes adjustment for outbreak situations.	
60 B1.12	#69, #75	Nebulizer: put in a comment that spacers are preferred and there are requirements to prevent aerosolising if using a nebulizer- room, HCW PPE etc. Remove fans altogether	Guideline is a principle based document. Preferences for particular instruments should be determined by local policies.	No change to guideline
Cleaning additional comment		No mention in this section that cleaners must be trained in cleaning and that a scope of practice and task list for cleaning is to be developed by each facility directing cleaners on what to clean and when	Accept.	Inserted text: Organisations should also facilitate job or task-specific education and training by accredited bodies for general and special cleaning of the physical environment.
Cleaning additional comment	#11	3)Training of Cleaning management & Staff Recommendations for proper training of cleaning staff in relevant certificate courses would reduce nosocomial infection rates, greatly improve cleaning outcomes and reduce costs.	Accept	Inserted text: Organisations should also facilitate job or task-specific education and training by accredited bodies for general and special cleaning of the physical environment.
Cleaning additional comment	#12	Comment 6: Proper training for cleaners employed to maintain carpets & hard floors Cleaning is a skilled profession and the outcomes are particularly relevant to healthcare. We would like to suggest a recommendation that cleaning staff undergo training appropriate to their professional role in the healthcare facility. Certificate traineeships are available in Asset maintenance: Carpet Cleaning, Aged Care Support Services, Cleaning support services, Laundry Support Services and Food Support services. Trained operators and managers in these areas would make a dramatic impact on infection control	Accept	Inserted text: Organisations should also facilitate job or task-specific education and training by accredited bodies for general and special cleaning of the physical environment.
62 case study	#79	Suggested for inclusion: Ideally, this risk can be eliminated, by the health service resourcing after hours cleaning squads through……. Add , with the nurse calling the cleaning squad. The potential for a ward outbreak as a result of prolonged fomitie exposure would be averted to	Specific protocols regarding facility operations should be determined at a local level.	No change to guideline

		evaluating the risk.		
63	#78	The correct term is 'reprocessing' not 'processing'. The term 'reprocessing' is used on P65 and many places elsewhere in the document P63 and P108. Reference is made to the Spaulding classification but there is no reference in the bibliography	Accept The term is reprocessing. Particular Spaulding classification has been adopted from CDC Isolation Guidelines. Will be referenced.	Error will be amended.
B1.5.3	#46	Cleaning – a good example would be blood glucometer machines as its evidenced that minute blood splashes can be passed from patient to patient because its not cleaned after use	Committee agrees with e.g. suggested but prefer to use current e.g.	No change to guideline
Table B1.12	#81	Keyboard then key board used	Tech writers	Will make consistent
B1.5 Reprocessing			**Considerations by the ICG committee**	**Outcome of discussion**
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
63	#58	Use the term re-usable instruments in this section	Accept	The term reusable instruments will be used
	#54	o Specific points: Instrument reprocessing Section B1.5. It is noted that the correct title for B1.5 should be "Reprocessing". o Overall, this important section is superficial and lacks detail. It is understood that the scope of the document is focused on core principles, and that detailed information on the reprocessing of instruments may have been omitted to avoid duplication of information. The view of the ADA is that too much emphasis has been placed here on Australian Standards AS/NZ 4187 and AS/NZS 4815, which are known to have significant deficiencies. o The ADA would seek to have B 1.5.5 Sterilisation in a more detailed format, so that it is as thoroughly documented material in previous chapters. In dental practice, protocols for sterilisation of instruments and the testing and record keeping for sterilisers has been an area of confusion. Inclusion of issues such as correct cycle types for different types of loads, cycle monitoring and steriliser maintenance would be useful. o More detail should have been included, especially steam sterilization, air removal mechanism, and the level and types of monitoring. The risk management case study on page 68, describing a dental surgery, is superficial and should have offered recommendations for more complex dental instruments	It is acknowledged that the current Australian Standards require review however it is beyond the scope of the current Guideline to include the level of detail required for reprocessing of reusable medical instruments. The principle considerations of reprocessing are provide and links to additional tools and resources are provided. The ADA Infection control Guidelines 2008 provide discipline specific information in regards to sterilisation that are harmonious to that of the principles of the Guideline	To this area is to be monitored as a part of the ongoing review process. Text to include - facilities need to consult discipline specific guidelines for further advice on reprocessing requirements.
	#54	The ADA would also disagree that sterilisation is preferable for routine	Agreed	Delete routine dental

		dental instruments - it is indeed necessary.		instruments from semi-critical column in Table B1.14
	#54	Section B1.5.3 should encourage the use of instrument cassettes to reduce sharps injuries.	This level of detail is beyond the scope of the guideline.	No change to Guideline content
B1.5	#40	Medtronic recommends: 1. A review of new clinical evidence relevant to non channelled nasopharyngoscopes currently classed as a Semi Critical device. 2. Input to the guidelines from end users eg ENT Surgeons, Head & Neck Surgeons, Speech Pathologists and Radiation Oncologists using nasopharyngoscopes in public hospitals and private rooms. 3. A cross functional reprocessing strategy that can be used in public and private practice that is designed to have a positive impact on productivity, decrease public hospital capital expenditure, decrease service repair costs and provide increased protection to the patient's environment. 4. A separate cleaning and disinfection policy for non channelled nasopharyngoscopes. 5. A study to review the capital costs for purchase of new nasopharyngoscopes to overcome the downtime in reprocessing and ongoing repair cost versus utilisation of sheaths and medium level disinfection. 6. A detailed timeline of implementation should be included.	The level of detail requested is beyond the scope of the Guideline which is a principles based document however submissions have been received from suggested stakeholder groups. These comments will be forward to the appropriate body that will be undertaking the revision of AS/NZ 4187 and AS/NZS 4815	No change to Guideline content
63 B1.5.1	#39	The Guidelines should outline the risks associated with the reprocessing of SUDs and ensure that healthcare settings continue to ban the practice of reprocessing.	Guideline refers to TGA definition of SUDs in section B4.1 which includes a specification that they should not be reprocessed.	Text to be added in the introduction of B1.5 All reusable medical devices and patient care equipment used in the clinical environment shall be reprocessed according to its intended use and manufactures advice Only TGA registered reusable medical devices shall be used. Prior to purchase, users shall ensure that manufacturer's reprocessing instructions are provided and are able to be followed by the health care facility Single use medical

				devices shall not be reprocessed. If a healthcare facility takes a decision to reprocess single use devices, the facility must be licensed by the TGA and will be considered a manufacturer. It will be subject to audit for conformance with the Essential Principles
63-66	#44	This section is very brief – as processing of medical devices constitutes one of the greatest infection control risks in healthcare facilities it should be more comprehensive, and refer the reader to the relevant references related to same. Also needs more reference to use of manufacturers' instructions. The future of AS/NZS4187 is unclear therefore national guidelines are important for this area. The whole section is not consistent with the Spaulding Classification of Medical Devices. There is confusion between Critical and Semi-critical Items, particularly related to the reprocessing of Flexible Endoscopes and Diagnostic Probes. For example in the current guidelines Cystoscopes are listed as critical devices, and similarly in NSW and WA State guidelines. However, they are listed as semi-critical in Table B1.14. This Table needs more detail regarding the equipment examples, and to reflect the Categories in B1.13, to minimise confusion, eg. "some endoscopes, ultrasound probes used in sterile body cavities" (these both need to be defined, and there is no reference to Probes used in semi-critical sites). Would be helpful to include examples of semi critical/non critical Probes eg. TOE Probe, TRUS and Transvaginal Probes vs non invasive Ultrasound Probes. Also need to define heat stable scopes, and give examples. There are conflicting guidelines available currently in Australia re Flexible Endoscopes and Diagnostic Probes, (eg. ASUM does not meet current requirements and is apparently under review by TGA; there are no national guidelines for processing of Flexible Cystoscopes), and the current CDNA guidelines assist in providing a standard national approach to these devices	The committee is aware of the issues regarding the reprocessing of medical however it is not able to give the level of detail required in the document to guide the broad scope of clinical practice in Australia	Text outlined above will be included in the Guideline. This is gap in evidence has been brought to the attention of the Australian Commission for Safety and Quality in Healthcare as well as jurisdictional health departments

	#75	In the whole section entitled “Processing of Instruments & Equipment” the words sterilisation and sterilising are spelt with an ‘s’ and not a ‘z’ which is the international way sterilizing and sterilization are spelt There is no mention is this section on the audit process that must occur with reprocessing, nor anything on parametric release of instruments nor anything on equipment testing and validation	Australian Government style guide requires spelling to comply with the English language and not the US	No change to Guideline content
	#25	The separate section for reusable medical devices requiring reprocessing was appreciated	Thanks	No change to Guideline content
63 Table B1.13	#344	Very confusing and contradictory. Refer Spaulding Classification of Medical Devices	Table B1.13 represents the Spalding’s principles and has been taken from the CDC (2008) Guidelines for disinfection and sterilisation in health care facilities.	No change to Guideline content
63	#81	Keyboard being disinfected rather than cleaned with detergent, not consistent with table B1.12	Noted	Change to text to clean
63	#56	Dried or baked materials on the instrument make the removal process more difficult and the disinfection or sterilisation process less effective or ineffective. To preserve the surfaces of the instruments, dissimilar metals should be cleaned separately.	It is beyond the scope of the Guideline to provide this level of detail on reprocessing of medical instruments	No change to Guideline content
64 B1.5.3	#47	Part B1.5.3; page 64; Cleaning Agents Again, this should be a clear statement on choice of an appropriate product that is subject to the Australian Government regulatory framework. The information currently included in this segment in terms of chemical content is in parallel with other written Australian documents. Suggest the following sentences be included at the commencement of this section: Medical instrument detergents for use in cleaning medical devices must be registered as a class I Medical Device with the TGA. The detergent should be used in accordance with the label instructions and the product should have clear instructions in regards to materials compatibility (on what or which devices the product is suitable for use). Some products are intended solely for use in Washer-Disinfector machines (these are also TGA registered medical devices), and so should only be used for the purposes intended on the label.	This information is too prescriptive in nature for the Guideline.	No change to Guideline content
64 B1.5.3	#75	There is no mention that the cleaning solution and style must be appropriate for each instrument and equipment, this is critical to the success of cleaning	It is beyond the scope of the Guideline to provide this level of detail on reprocessing of medical instruments.	Insert additional text on cleaning agents on page 64 – manufacturer’s instructions will guide the type of cleaning agent

				required. This is usually neutral ph or mildly alkaline……
64 B1.5.3	#53	Cleaning agents 'For instrument cleaning, a neutral or near□neutral pH detergent solution is commonly used as such solutions generally provide the best material compatibility profile and good soil removal and mildly acidic solutions may damage instruments.' Comment: whilst acknowledging the validity of the use of neutral detergents, AS/NZS4815:2006 AS/NZ4187:2003 clause 2.8 Notes: mild alkaline detergents in the pH range of 8.0 to 10.8 are preferred over neutral pH detergents in most applications. Industry experience suggests that 'mild alkaline detergents are routinely used. This may well be a simple issue of terminology choice, with near neutral being mild alkaline. But if change to practice is recommended (product constituent) based on current literature, it would be prudent to substantiate this by citing support as in other areas of the document. Anecdotal evidence suggests contradictions between recommendations or inconsistent terminology results in sceptical perception of guidelines and possible complacency and inconsistent practice.	Noted	The above text has been added
64	#44	Mildly Alkaline Detergent is recommended in AS/NZS 4187 – needs clarification. Reference to Manufacturer's instructions should also be emphasized	It is beyond the scope of the Guideline to provide this level of detail on reprocessing of medical instruments.	Text on referring to manufacturer instructions in the selection of cleaning agents has been added
64	#78	The statement 'Enzymatic cleaners are not disinfectants, and proteinaceous enzymes can be inactivated by germicides' needs to be modified to make it clear that enzymes should not be mixed with disinfectants due to possible incompatibility and inactivation of the enzyme	It is beyond the scope of the Guideline to provide this level of detail on reprocessing of medical instruments	No change to Guideline content
64	#75	"…instruments that can be disassembled must be for the cleaning, disinfection/sterilization process	Noted	Text to be added to on page 63, B1.5.3- instruments that can be disassembled must be for the cleaning, disinfection/ sterilization process
64	#44	Checking effectiveness of cleaning. Recommends using a magnified light only and claims other methods (soil testing, etc) are not routinely used. In our extensive review of healthcare facilities test methods are regularly used. Australian Standards outline specific test methods to check the effectiveness of cleaning to verify manual and automated processes, which we observe	It is beyond the scope of the Guideline to provide this level of detail on reprocessing of medical instruments	No change to Guideline content

		to be commonly practiced. It would be better to define recommended practices as per relevant standards, and refer to same. AS/NZ 2945 (Int), 2002. Batch type washer/disinfectors for health care facilities. www.standards.com.au International Organisation For Standardisation (ISO), 2006. ISO: 15883-3 Washer – Disinfectors. Soil tests.www.saiglobal.com.au		
64 B1.5.3 Cleaning	#56	Cleaning agents AS/NZ 4187 For manual instrument cleaning, a neutral ... Suggested text: For mechanical instrument cleaning alkaline detergents are recommended and also follow Instrument and Washer/Disinfector recommendations	This is covered further in the guideline text	No change to Guideline content
64 B1.5.3 Cleaning	#56	Checking effectiveness of cleaning ……. [CDC 2008]. These are available for use in health care facilities. At a minimum, all instruments…….. and be visibly clean. Suggested Text In addition, instrumentation should be free from detergent and rinse additive residue. AS/NZ 4187, Section11 Monitoring of Cleaning Process	This information is too prescriptive in nature for the Guideline.	No change to Guideline content
64 B1.5.3	#56	Include a mechanical cleaning section in methods of cleaning as per AS/NZ 4187. Details outlined in submission.	It is beyond the scope of the Guideline to provide this level of detail on reprocessing of medical instruments	No change to Guideline content
64 B1.5.3	#56	Manual Cleaning Cleaning is done manually for fragile, difficult-to-clean or heat sensitive instruments….. Friction - ...; insert careful not to generate aerosols Healthcare worker... task – impervious gown, plastic apron... AS/NZ 4187, Section 2.9.3 Manual Cleaning	This information is too prescriptive in nature for the Guideline. The paragraph below outlines that HCW should wear PPE appropriate for the task undertaken	No change to Guideline content
64 B1.5.4	#47	Part B1.5.4; page 64; Disinfection We remain somewhat confused as to why this section does not clarify for readers the structure and framework of the TGA classification structure for disinfectants sold in Australia for medical or healthcare applications. The framework for Sterilants and Instrument Disinfectants is particularly important in this segment and should be clearly noted in the text. We suggest that the following be included: The TGA supervises and regulates the market for products intended to be used to sterilise and disinfect instruments. The regulatory framework includes Sterilants at the highest level, followed by instrument	It is beyond the scope of the Guideline to provide this level of detail on reprocessing of medical instruments	A link to the Therapeutic Goods Order 54 (TGO 54) and its Guidelines http://www.tga.gov.au/devices/disinfectants.htm will be provided that outlines the standards for disinfectants and sterilants

		disinfectants of three subsidiary grades, being “Instrument Disinfectant - High Level”, “Instrument Disinfectant -Intermediate Level” or “Instrument Disinfectant – Low Level”. Instrument Disinfectants should only be used when sterilisation or thermal disinfection is not available. Chemical disinfection on instruments should only ever be conducted using an Instrument Disinfectant. Hospital Grade Disinfectants are not suitable for any form of instrument disinfection. There are various chemicals used in Instrument Disinfectants and all are hazardous. Thorough pre-cleaning should be finished prior to any Instrument Sterilisation or Disinfection and where a chemical Instrument Disinfectant is used, scrupulous attention should also be paid to rinsing away any disinfectant residues prior to instrument reuse (water quality for rinsing following Sterilisation or High Level Disinfection should be with sterile water only).		
64 B1.5.4	#71	Section B1.5.4 “Disinfection” [page 64] Include the following clarification regarding the TGA classification structure for clinical-use disinfectants sold in Australia: “The TGA supervises and regulates the market for products intended to be used to sterilise and disinfect instruments. The regulatory framework includes Sterilants at the highest level, followed by instrument disinfectants of three subsidiary grades, being ‘Instrument Disinfectant - High Level’, ‘Instrument Disinfectant - Intermediate Level’ or ‘Instrument Disinfectant – Low Level’. Instrument Disinfectants should only be used when sterilisation or thermal disinfection is not available. Chemical disinfection on instruments should only ever be conducted using an Instrument Disinfectant. “Hospital Grade Disinfectants are not suitable for any form of instrument disinfection. “There are various chemicals used in Instrument Disinfectants and all are hazardous. Thorough pre- cleaning should be finished prior to any Instrument Sterilisation or Disinfection and where a chemical Instrument Disinfectant is used, scrupulous attention should also be paid to rinsing away any disinfectant residues prior to instrument reuse (water quality for rinsing following Sterilisation or High Level Disinfection should be with sterile water only).”	It is beyond the scope of the Guideline to provide this level of detail.	A link to the TGA order 54 has been provided. Definitions in the glossary for disinfectants and sterilants will be consistent with that of the TGA
64 B1.5.4	#40	Section 1.5.4 Disinfection, last paragraph “Disinfection is not a sterilizing process. Where ever possible, sterilize items to be used in semi-critical sites, or employ single use items.” This statement conflicts with new evidence. High level disinfection could be replaced with the use of an endosheath combined with enzymatic detergent cleaning and disinfection with 70% ethanol which can provide	The purpose of this document is to outline the key principles reprocessing of reusable medical instruments. It is beyond the scope of the Guideline to provide this level of	No change to Guideline content

		a reliably decontaminated, patient ready instrument, when considering non channelled nasopharyngoscopes. A review of new technologies and clinical evidence could potentially identify current practices leading to 'over processing'. Such over processing can result in an increase in repair costs of scopes, and an increase in hospital capital expenditure when patients could be provided greater protection against Hospital Acquired Infections (HAIs) by the use of a sterile barrier. Clarity surrounding the words "Wherever possible" is also required. Who defines this and what parameters would it be based on?	detail.	
65 B1.5.5	#35	Sterilisation methods are designed to give a sterility assurance level (SAL) of at least 106, provided the sterilisation process is validated by the user. Records of sterilisation must also be kept; these enable items to be traced to an individual patient (e.g. in case of a recall or sterilisation breach identified after the case). Details of the documentation required can be found in Australian Standards AS/NZS 4187.5-2003 and AS/NZS 4815. Insert : The packaging method should be performed in a manner that facilitates aseptic presentation of the contents. Sequential wrapping using two barrier type wrappers provides a tortuous pathway that impedes microbial penetration and permits ease of presentation to the sterile field without compromising sterility. Correct use of a single, disposable, double-bonded, nonwoven rapper or equivalent may eliminate the need for sequential double wrapping. AORN Recommendation 111 Packaging Systems AORN Perioperative Standards and Recommended Practices 2008	It is beyond the scope of the Guideline to provide this level of detail	No change to Guideline content
65 B1.5.5 Sterilisation	#47	Part B1.5.5; page 65; Sterilisation; 2nd dot point Correction needs to be made as at least one Glutaraldehyde based Instrument Sterilant is available and should be included in the list of chemical instrument sterilants. Recommend include Glutaraldehyde in list of chemical sterilants after peracetic acid in 2nd dot point		include aldehyde in list of chemical sterilants after peracetic acid in 2nd dot point
	#54	The second last paragraph in this section is incorrect where it notes: "Records of sterilisation must also be kept; these enable items to be traced to an individual patient". The ADA believes that critical items that are sterilised need only be tracked back to a particular sterilisation cycle (batch identification).	The committee agrees with your comments. Under state and federal legislation records of records of sterilisation must also be kept to be verify that a appropriate reprocess is in placing.	Delete second sentence of 3rd paragraph in section B1.5.5. Sterilisation and insert Records of sterilisation must also be kept to be verify that a appropriates reprocess is in placing according to state and federal legislation.

65 B1.5.5 Sterilisation	#56	Sterilisation destroys all microorganisms (except prions) on the surface of an instrument or device, to prevent disease transmission. Delete rest of paragraph	The remainder of the sentence has been modified.	See above modification to Guideline.
65 B1.5.5 Sterilisation	#56	Remove Critical items and insert Reprocessing of heat resistant items is recommended by steam sterilisation due to the safety margin, reliability, validity and lethality.	Agreed	Insert additional text
65 B1.5.5 Sterilisation	#56	Details of the validation and documentation ...	It is beyond the scope of the Guideline to provide this level of detail AS/NZ 4187 has been referred to already	No change to guideline
65 B1.5.5 Sterilisation	#56	Processing standards should evolve to accommodate changes in equipment design and emerging technologies in sterilisation and Operating Theatre procedures. AS/NZ 4187, Section 2.9.3 Manual Cleaning	It is beyond the scope of the Guideline to provide this level of detail. AS/NZ 4187 has been referred to already	No change to guideline
65 B1.5.5	#40	Section 1.5.5 Sterilization paragraph 3 In this rapidly changing area, processing standards should evolve to accommodate changes in equipment design and emerging technologies in sterilisation. New technology has emerged since the current standards were written. Standards AS/NZS 4187:20033 and AS/NZS 4815:20064 have not issued addendums pertaining to new clinical evidence or technology. See submission with regards to nasopharyngoscopes.	The committee are aware of these issues and have considered the comments on nasopharyngoscopes.	No change to guideline
65 B1.5.6 Storage and Maintenance	#56	Dry, sterile, packaged instruments and equipment shall be stored in a clean, dry environment……. AS/NZ 4187, Section 9.2 Storage Areas for Sterile Items	It is beyond the scope of the Guideline to provide this level of detail. AS/NZ 4187 has been referred to already	No change to guideline
65 B1.5.6	#35	Insert: Correct storage and manual handling techniques must be employed to maintain the integrity of packaging Details of the documentation required can be found in Australian Standards AS/NZS 4187.5-2003 and EN ISO 11607-1:2003.	Accept	Australian Standards AS/NZS 4187.5-2003 and EN ISO 11607-1:2003
65 B1.5.6 Storage and Maintenance	#56	Table B1:14 General Criteria for Reprocessing……. Non-critical Contact with intact skin Cleaning [manual or mechanical],disinfect with compatible low level TGA-registered disinfectant after cleaning Spaulding's Classification, Qld Health Infection Control Guidelines, 2008	Accept	Cleaning [manual or mechanical],disinfect with compatible low level TGA-registered disinfectant after cleaning
65 B1.5.6	#75	This section must also state that sterile stock must be stored from direct sunlight, dust and vermin	This has been addressed previously	

66 Table B1.14	#40	General criteria for reprocessing and storage of equipment and instruments in healthcare setting. Critical and Semi Critical Reviewing table B1.14 raises concerns and questions regarding the classification examples – why are cystoscopes classed as a Semi Critical device and a Bronchoscope as Critical? Both have an operating channel and in principal are functionally the same. In the section under 'Notes' the document specifies "Critical items, particularly endoscopes, must be sterilized between patient uses". This begs the question 'which endoscopes specifically?' as the table is inconsistent in its classification of scopes. We were unable to locate this reference in the specified source document.	The purpose of this document is to outline the key principles reprocessing of reusable medical instruments. It is beyond the scope of the Guideline to provide this level of detail.	The examples in the tables will be to enhance clarity
66 Table B1.14	#35	Wraps should be low linting Note: correct manual handling techniques should be observed by all staff at all times	It is beyond the scope of the Guideline to provide this level of detail. AS/NZ 4187 has been referred to already	No change to Guideline
66 Table B1.14	#75	there is no mention that CJD items must also be reprocessed twice	The committee felt it was not appropriate to include CJD in table B1.14 due the additional considerations required with the potential risks associated with CJD transmission. The section on "Further considerations" addresses CJD.	No change to Guideline
66 Table 1.14	#39	Items such as endoscopes are 'critical' as "these items confer a high risk for infection if they are contaminated with any microorganisms and must be sterile at the time of use. This includes any objects that enter sterile tissue or the vascular system, because any microbial contamination could cause disease". MTAA would also include in this category any items that have been designed for single use, but reprocessed. The FDA has cautioned healthcare facilities about the risks to patients if flexible endoscopes and accessories are not properly processed. They provide a number of steps to reduce these risks. The sterilisation procedures for flexible endoscopes outlined by the FDA could be included under B1.5.5 Sterilisation.	IT has been stated in the Guideline that if a healthcare facility decides to reprocess single use devices, the facility must be licensed by the TGA and will be considered a manufacturer. It will be subject to audit for conformance with the Essential Principles However it is beyond the scope of the Guideline to provide specific detail on reprocessing of medical instruiments	No change to Guideline
66	#57	CJD: Internationally, enzymatic methods that destroy protease resistant prions are established. Is it not sensible to include reference to these as	The committee will refer comments on CJD to the	No change to guideline, linkages to the DoHA

		potentially we now have a standard method for reprocessing that does not require special considerations around prion contamination. All CSSDs should be switching to such validated enzyme cleaners for instruments that come in to contact with at risk tissues.	appropriate section of the DoHA who are maintaining the currency of the guidance relating to CJD	website have been provided for additional information regarding CJD
66	#60 #40	Further considerations (page 66). Previous CJD reprocessing advice for steam sterilisation time after cleaning should be 134o for 18min. Please clarify this change Further Consideration page 66 ”Steam sterilisation and the other methods listed above are not sufficient for reprocessing items potentially contaminated with certain types of infectious agents. This includes prions”.	The process listed in dot points has been taken from the 2007 revision of the DoHA infection control Guidelines on classical CJD. These points outline the reprocessing requirements for medical instruments that are quarantined ie kept for the exclusive use on a particular patient The DoHA will be maintaining the currency of the guidance on the protocols for procedures that are associated with the risk of CJD	Text to be added to the “further considerations” to clarify this additional information related to potential CJD transmission.
66	#40	The ASNZS 4815: 2006 1.5 REPROCESSING OF INSTRUMENTS AND EQUIPMENT Requires clarity for sterlization in office based practice. Standards are inconsistent and provide little guidance for end user.	The committee acknowledges that there are shortfall in the current ASNZ4815 however it is beyond the scope of the Guideline to provide specific information on the protocols for reprocessing of medical instruments	No change to guideline
66	#78	There is no mention of the nature, type and quality of sheaths, and the reprocessing thereof, used for ultrasound, tympanic, transvaginal, transrectal etc probes, as in the 2004 ICGs.	It is beyond the scope of the Guideline to provide specific information on the protocols for reprocessing of these medical instruments	No change to guideline
67 B1.5.7 Putting it into practice	#56	Involving patients in their care The process of cleaning, disinfecting and sterilising instruments and equipment It’s appropriate to ask about the cleaning and sterilising practices in the hospital.	Committee have provided guidance for consumer is a plain language format	No change to guideline
68	#54	Case studies Page 68. The theoretical case study with a dental mirror	The case studies purpose	No change to guideline

		with a loose mirror head is drawing a long bow since this is something which gets checked regularly in those practices which use mirrors with changeable ends.	is to illustrate the steps involved in undertaking a risk assessment	
69	#78	The reference to an N95 respirator could be removed, as it is a US standard. The correct term under the relevant Australian/New Zealand Standard is 'P2'	Agreed	The reference to N95 respirators has been removed from the guideline.
Section B2				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
General	#63	Transmission-based precautions are recommended where particular infections are known or suspected. The guideline does not describe how to implement this in primary health care. This is important because clients present to primary care with undifferentiated symptoms. While a high level of suspicion is appropriate in considering the diagnosis of unusual but important infections such as tuberculosis, implementation of infection control measures may not be appropriate because of the low absolute likelihood of disease. Thus in a low risk situation, tuberculosis infection control may be implemented on huge numbers of patients with no benefit to anyone, but costs in time, resources and possibly client comfort. Furthermore, as the risk of infection is related to duration of exposure, and the duration of exposure during a consultation is relatively brief in primary care, full implementation may have less benefit. Thus more detail is needed in this area. In particular it would be useful for CARPA to have clear clinical case definitions for situations where transmission based precautions are required, as primary care does not have the benefit of microbiological diagnosis.	It is thought that there maybe some confusion between possible and known or suspected infection. There is no evidence to support that the mode of transmission in primary care or office based practice differs to that of the acute care setting. However the risk of transmission differs due to the population groups and nature of care provided.	Additional text required to clearly define what known or suspected is and how that differs from a possible infection. Additional information will be added to demonstrate the aspects of a risk assessment required for transmission based precautions in primary care.
General	#66	1. Identify different categories and summary such as table on p81 at beginning of information on transmission based precautions as ward staff etc staff usually rush and only read small part of documents and don't go on to read rest if doesn't make sense early 2. There is room for confusion with how guidance on appropriate PPE is presented in some areas it appears that for conditions is primarily transmitted by the airborne and droplet route staff only need to consider the use of masks or eye protection. Risk that they wont recognise risk of some diseases being transmitted by a combination of routes. Elsewhere in the document mask, gown, gloves/HH and eye protection are all recommended. This may create friction between staff and also result in staff not wearing the appropriate range of PPE the method using the tick chart as on page 81 shows precautions in a clear succinct manner minimising options for argument and not taking	Noted Use of Standard precautions will be strengthened in this section and the use of transmission based precautions overlay this Noted	1.Diagram on the application of Transmission based precautions to be inserted. 2. Modification to table B2.1 3. this message will be strengthened.

		precautions. 3. Should stress the need for applying ppe before entering room as realistically unnecessary risks are taken ("just handing in drink, only in for moment or a quick chat").		
69	#57	Evidence supporting practice: Protecting healthcare workers from pandemic influenza: N95 or surgical masks? Gralton J, McLaws ML. Crit Care Med. 2010 Feb;38(2):657-67. Review. Conclusion " Evidence from laboratory studies of potential airborne spread of influenza from shedding patients indicate that guidelines related to the current 1-meter respiratory zone may need to be extended to a larger respiratory zone and include protection from ocular inoculation"This review also notes the requirement to go to a > 1 metre rule for precautions and also the requirement for eye protection. Physical interventions to interrupt or reduce the spread of respiratory viruses. Jefferson T, Del Mar C, Dooley L, Ferroni E, Al-Ansary LA, Bawazeer GA, van Driel ML, Nair S, Foxlee R, Rivetti A. Cochrane Database Syst Rev. 2010 Jan 20;(1):CD006207. Review.	Gralton , Mc Laws article used in the development of recommendations on masks. The conclusion states that there is a need for further evidence Similarly with the second article which has a public health focus found the methodology of the studies examined were of poor quality with high risk of bias	No change to guideline further discussion on distance of separation of patients discussed later
69	#79	Additional text to precede purple: Every point of care should assess the potential for cross infection risk and identify correct bed allocation opportunities and apply Additional Precautions when necessary	These comments were not deemed necessary by the committee.	No change to guideline
69-88	#79	All reference to transmission based precautions should be changed to additional	The term Additional precautions has been replaced with Transmission based precautions to reflect international terminology and guide clinician in what type of actions they need to take	No change to guideline
70	#57	Change as per evidence provided on droplets to include these additional points: • Screening of at risk patients or healthcare staff • Flagging of known colonised or infected patients • Cohorting healthcare staff so that staff do not care for infected and non-infected patients	Good points raised but predominantly relate to specific conditions and may cause confusion	No change to guideline but these concepts may be used in section B3
70	#78	It is unclear from the text whether the term 'airborne transmission' is the same as 'aerosol transmission'. This should be clarified to avoid ambiguity	Noted and agreed however reference to aerosol transmission not found	No change to guideline
70	#51	Suggested change: Use of personal protective equipment (including gloves, apron or gowns, and surgical masks or P2 (N95) respirators, visors or protective goggles). Reason: Surgical masks are not respiratory protective devices and	Oversight noted and agreed	Tech writers to change text

		cannot be referred to as respirators		
Contact precautions				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
71 Rec 14	#58	Use the term transmit rather than spread	Noted but terminology will be dependant upon how the document reads	No change to guideline
71 Rec 14	#44	MROs as a group of specific organisms are not listed in Table B2.2: Infections warranting transmission-based precautions before laboratory confirmation of infection. However as they are one of the most important organisms requiring contact precautions, they should be included.	Noted	Include MRO in table B2.1. as contact precautions
71 B2.2.2	#57	Re-word: Direct or indirect contact transmission of microorganisms during patient care is responsible for a majority of healthcare-associated infection in patients and healthcare staff. Suggested text Contact precautions are used when there is known or suspected risk of direct or indirect contact transmission of infectious agents (e.g. MRSA. C. difficile, or highly contagious skin infections/infestations) that are not effectively contained by Standard Precautions alone (see Section B2.2). Contact precautions are also applied when the presence of excessive wound drainage, faecal incontinence, or other bodily discharge suggests an increased potential for environmental contamination and risk of transmission. This sentence should be deleted. One is describing here situations in which correctly applied Standard Precautions will be sufficient (eg. Use of hand hygiene and PPE).	Noted and agree Noted and agree	Tech writers to change text Tech writers to remove this portion of text
B2.2.2 and B2.2.3	#20	These sections specifically describes a risk of transmission of organisms spread via the patient's environment or when there is 'an increased risk of environmental contamination and risk of transmission'. B2.2.2 states that the requirements for contact precautions are summarised on page 81, however there is no mention on page 81 regarding environmental cleaning. Also in B2.2.3 there is no mention of environmental cleaning in the section on 'key aspects of applying contact precautions'. The paragraph that starts 'The requirements for contact precautions are ….' Should be made to stand out against the other text on the page so the information leaps off the page at health care workers (HCWs) in a hurry, perhaps bold font? This comment applies to the same paragraph in other sections that cover transmission-based precautions. P72 Environmental cleaning?? P71, p74, p75, p77, p104 The document refers the reader to B1.1.7 on Hand Hygiene. There is no section B1.1.7, it finishes at B1.1.6. The five moments are covered in B1.1.2	Noted however details on cleaning will be referred to environmental cleaning section to avoid confusion	Tech writers to change reference to B1.1.7 on Hand Hygiene. To appropriate section Reference to Environmental cleaning section to be added in body of text and at the bottom of table B2.1
71 B2.2.3	#79	Key aspects of applying contact precautions relate to:	Comments noted the use	Hand Hygiene to be

		1) Correct patient placement 2) hand hygiene (see Section B1.1.7) 3) correct use and application of PPE; 4) Cleaning and handling of equipment; ; and 5) minimising patient transfer or transport	of standard precautions needs to be highlighted rather than hand hygiene	removed and replaced with Standard precautions
71	#81	Add MRSA to the list	Agreed	Tech writers to incorporate
71/72	#57	Issues to consider : - Rooms with ensuites (almost always preferred) - Rooms with anterooms (preferred) - What to do with the patient notes? Keep them outside - The patient bedside charts – keep them outside the room, disinfect hands upon leaving room and after writing in chart - What to do with the room doors – keep them closed - Signage required	AHFG and Handbook 260 consider anterooms a part of –ve pressure rooms. Other points raised are valid	Tech writers to integrate the other points raised in patient placement on page 72. The benefits of anterooms has been included in facility design in C6
71 B2.2.2	#29	In addition to standard precautions, implement contact precautions in the presence of known or suspected infectious agents that are spread by direct or indirect contact with the patient or the patient's environment. Agree but with the proviso that 'exceptions to this should be justified by risk assessment' be added. In primary care this recommendation would be excessive if implemented in the cases of all minor infections eg: colds	As previous, quantify the term "known and suspected". The principles of infection transmission are the same in all health care settings though the risks differ due to the population groups As primary health care continues to evolve in providing more complex and acute care it can not be exempt from adhering to these practice principles	Paragraph will be inserted on the considerations that need to occur when undertaking a risk assessment in primary care.
72 B2.2.3	#28	Rec 15 Hand hygiene and personal equipment to prevent contact transmission • perform hand hygiene; • put on gloves and gown upon entry to the patient care area; • ensure that clothing and skin do not contact potentially contaminated environmental surfaces; and • remove gown and gloves and perform hand hygiene before leaving the patient care area. These recommendations will be difficult to achieve and maintain in the remote environment due poverty, isolation and its impact, without resourcing with regard to training, equipment and organisational support	The above comments relate to this submission. Also the issues of resourcing and training should not compromise the provision of safe and quality care	No change to Guideline

		via policy/procedures.		
72	#27	Gloves are not necessary for “contact precautions” as hand hygiene offers better protection (particularly now with the use of alcohol based hand rubs). Staff tend to don gloves and continue to multi-task – protecting themselves but not the patient or the environment. Alcohol based hand rubs must be easily accessed in order for this to work well and prevent transmission of MDROs and other significant pathogens.	Currently there is no evidence to support a movement away from internationally recognised practice of using gloves to care for patients on contact precautions. The 2007 CDC Isolation guidelines state: Gloves are used to prevent contamination of healthcare personnel hands when 1) anticipating direct contact with blood or body fluids, mucous membranes, nonintact skin and other potentially infectious material; 2) having direct contact with patients who are colonized or infected with pathogens transmitted by the contact route e.g., VRE, MRSA, RSV 559, 727, 728; or 3) handling or touching visibly or potentially contaminated patient care equipment and environmental surfaces 72, 73, 559.	No change to guideline but this area will be tagged for monitoring of emerging research as a part of the ongoing review process.
72 Rec 15	#81	Last point on could this be interpreted as leaving the ward not just the room?	Committee disagrees	No change to guideline
72 Rec 15	#42	Recommendation 15 – not always a gown may be apron, need to be descriptive Needs to be specified as disposable long sleeve gown	Additional information has been included on gown selection in B1.2	Referral to section B1.2.on gown as new decision tool has been inserted and definition to be added to the glossary
72 Rec 15	#79	Recommendation 15 second dot point –apply gloves rather than put on. Addition to last point - perform hand hygiene before leaving the patient care area or immediately upon disposal of body substances	Noted suggestions how ever with to keep the recommendation in plain English.	No change to guideline
72 Rec 16	#79	Recommendation 16 terminology: donning rather than putting on and exiting rather that leaving as well as include immediately after disposing	Disposal of body substances related to	No change to guideline

		body substances.	standard precautions, we do not wish to complicate the recommendation	
B2.2.3	#29	Recommendation 17 Patient care equipment for patients on contact precautions Use patient dedicated equipment or single-use non-critical patient care equipment (e.g. blood pressure cuffs). If common use of equipment for multiple patients is unavoidable, clean the equipment and allow it to dry before use on another patient. Disagree in the primary care setting, see 11 above. Long-standing usual practice of NOT cleaning items such as blood pressure cuffs has not been identified as a significant risk for healthcare associated infections in primary care. This recommendation needs to be rewritten for primary care to remove the implication that all touched surfaces should be cleaned between patients with detergent solutions. Long-standing usual practice of NOT cleaning items such the desk, door handles, blood pressure cuffs etc has not been identified as a significant risk for healthcare associated infections in primary care.	The transmission of infection in primary care has not been demonstrated to differ to other settings and as such there is no evidence to support a change in practice	Para on risk management to has been added. Insert text on the development of cleaning schedules and that they need to consider the level of risk eg procedures rooms vs general consulting rooms that require a lower frequency of cleaning.
72 B2.2.3	#77	Patient care equipment for patients on contact precautions Use patient dedicated equipment or single-use non-critical patient care equipment (e.g. blood pressure cuffs). If common use of equipment for multiple patients is unavoidable, clean the equipment and allow it to dry before use on another patient. 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.	The guidelines encourages that a risk assessment be undertaken to assess the risk of transmission from the use of shared clinical equipment. Equipment that is in contact with intact skin in which there is a low risk of transmission the frequency of cleaning is reduced and need to comply with developed cleaning schedules.	No change to guideline as text on risk assessment has been added
72 B2.2.3	#28	Patient care equipment for patients on contact precautions These recommendations will be difficult to achieve and maintain in the remote environment due poverty, isolation and its impact, without resourcing with regard to training, equipment and organisational support via policy/procedures.	As above	No change to guideline as text on risk assessment has been added
72 Rec 17	#58	Add tourniquets and specify that equipment is to be cleaned and disinfected	We do not want an exhaustive list of equipment but encourage people to consider the level of risk associated with shared equipment. Also if	No change guidelines

			equipment is in contact with intact skin cleaning is sufficient.	
72	#79	Remove the text: Standard precautions concerning patient care equipment (see Section B1.5) are very important in the care of patients on contact precautions. Equipment should not be shared between patients	Noted but not practical particularly in primary care and ambulatory care settings	No change to guidelines
72	#79	Include CVL and skin conditions in examples for 1st dot point	Noted	No change to guidelines
73	#57	NICU example: This is a facile example that would probably not work given the range of interventions quoted. It misses out many important aspects to controlling such a situation. You should ask Dr James Branley to give you a proper example based on his effective control program for the Nepean Hospital NICU	Example taken from NSW published document	Insert reference where example was taken
Droplet precautions				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
74	#79	Splash resistant masks rather than surgical Suggested ordering for droplet precautions. The key aspects of applying droplet precautions relate to: 1. correct patient placement 2. hand hygiene 3. application and correct use of personal protective equipment; 4. cleaning of equipment; 5. minimising patient transfer or transport	The commonly accepted term is surgical masks and in accordance with Australian Standards they are required to be splash resistant. The use of standard precautions needs to be highlighted rather than hand hygiene	Replace hand hygiene with standard precautions in text and the remaining listed actions in the guideline can stay as they are.
74	#74	Application of Droplet P: This section would benefit from specifying that in terms of droplet precautions, surgical masks should be worn when within 1 metre of an infected patient	The CDC 2007 Isolation guidelines state that " a distance of <3 feet around the patient is best viewed as an example of what is meant by "a short distance from a patient" and should not be used as the sole criterion for deciding when a mask should be donned to protect from droplet exposure. Based on these considerations, it may be prudent to don a mask when within 6 to 10 feet of	This is an unresolved issue for the CDC and will be monitor as a part of the ongoing review process. Text from CDC isolation guidelines to be included on page 75. Consideration needs to be given to severity of symptoms ie. Violent, frequent coughing and sneezing.

			the patient or upon entry into the patient's room, especially when exposure to emerging or highly virulent pathogens is likely. More studies are needed to improve understanding of droplet transmission under various circumstances"	
74 B2.3.1	#57	1 metre rule – see above; should be 2 m Eye protection is an issue – see above RSV- check the CDC 2007 Isolation standard – page 109- Contact Precautions are specified for RSV		
74	#78	Droplet precautions should also include protection of the conjunctiva. The reference is only to the use of masks protecting the nasal or oral mucosa. Is this an oversight	The committee have discussed this issue and there is insufficient evidence to recommend the routine use of eyewear with individuals on droplet precautions. However, eye protection is a part of standard precautions and if the task has the risk of splashes or spray to mucosa- eye protection is to be worn	Reaffirm this in the text on pg 75 and link to PPE section. Monitoring the emerging evidence on the use of protective eyewear and droplet precautions will be monitored as a part of the ongoing review process.
74 B2.3.1	#81	Consistency between the term touch and contact required Bronchoscopy mentioned in main body of text but not in recommendations	noted	Bronchoscopy to be removed from text in droplet precautions. Ensure that touch is not used interchangeably with contact.
74 Rec 18	#51	Recommendation 18 Suggested change: In addition to standard precautions, implement droplet precautions for patients known or suspected to be infected with agents transmitted by respiratory droplets (ie large particle droplets >5μ in size) that are generated by a patient when coughing, sneezing or talking Reason: Or during suctioning should be deleted because it is generally considered to be an aerosol generating procedure and may require airborne precautions depending on the pathogen of concern.	Agree	Suctioning should be deleted from the recommendation

		Alternatively , the Guidelines should include a statement to the effect that some pathogens that are spread by droplet transmission in nature have the potential to spread by airborne transmission (particularly from close range exposure) when aerosol generating procedures are performed on infected patients, and that these procedures should be appropriately risk managed by using airborne precautions as indicated. For example, the World Health Organisation recommends airborne precautions using a P2 respirator when performing open suctioning of the respiratory tract involving pandemic (H1N1) 2009 virus. (Reference: WHO (2009) Infection prevention and infection control during suspected, probable or confirmed cases of pandemic (H1N1) 2009 virus infection and influenza like illness http://www.who.int/csr/resources/publications/cp150_2009_1612_ipc_interim_guidance_h1n1.pdf).		
74 Section B2.3.2	#29	In addition to standard precautions, implement droplet precautions for patients known or suspected to be infected with agents transmitted by respiratory droplets (ie large-particle droplets >5µ in size) that are generated by a patient when coughing, sneezing, talking, or during suctioning. Agree but with the proviso that 'exceptions to this should be justified by risk assessment' be added. In primary care this recommendation would be excessive if implemented in the cases of all minor infections	As discussed previously primary care cant be except from implementing the required infection control precautions if a person is known or suspected to have an infection that is spread by droplet route	Remove suctioning
74 B2.3.3	#29	When entering the patient care environment, put on a surgical mask. Agree but with the proviso that 'exceptions to this should be justified by risk assessment' be added. In primary care this recommendation would be excessive if implemented in the cases of all minor infections	As discussed previously primary care cant be exempt from implementing the required infection control precautions if a person is known or suspected to have an infection that is spread by droplet route	No change to text. Could use influenza season as an example: segregation in patient waiting rooms for persons with excessive cough. Availability of tissue, ABHR and a waste bin so pt can exercise respiratory etiquette.
74	#62	Mask wearing in Dentistry Considering the fact that droplet precautions with surgical masks are required within one metre of a droplet generating procedure it should not be necessary for dental staff to wear a surgical mask outside the one metre droplet zone (radius) unless precautions are indicated if the patient is suspected or confirmed for an airborne transmitted disease. In this case a triage and written risk assessment should be undertaken (see below) The wearing of a P2/N95 grade mask would be indicated	This aligns with the messages in the PPE section and the selection of masks	No change

		but as discussed below this would probably indicate a hospital based treatment scenario.		
	#62	Aerosols are an integral part of human life. They are caused by coughing, sneezing and even toothbrushing. There is no reason to believe that aerosols that have settled on surfaces are a source of Healthcare Associated infections (HAIs) J DENT RES 1969; 48; 49 Rudolph E. Micik, Robert L. Miller, Maurice A. Mazzarella and Gunnar Ryge Procedures Studies on Dental Aerobiology: I. Bacterial Aerosols Generated during Dental see http://pandemicflu.gov/professional/hospital/maskguidancehc.html#appA	The committee is unclear of what the issue being raised here is. The wearing of a P2 mask as a part of transmission based precautions need to be applied when a person is known or suspected to be infected and aerosol are generated.	No change to guideline
74/74	#60	The document acknowledges that organisms spread by droplet transmission may also be spread via contact transmission, therefore the gloves / gown used for contact precautions should also be recommended for use with droplet precautions (as outlined further on in Table B2.1)	Table B2.1 is to illustrate the different aspects of transmission based precautions. The link between droplet and contact will be strengthened elsewhere in the guideline	Insertion of the diagram outlining transmission based precautions will enhance HCW understanding of how contact and droplet precautions are linked.
75	#17	Need reference – there is insufficient evidence to support the use of P2 respirators for reducing the risk of infections transmitted by the droplet route See Gralton and McLaws 2009; Jefferson 2009	The committee agree with this statement	No change
75	#78	…. Surgical …… masks that meet Australian Standards are fluid resistant and protect the wearer from droplet contamination of the nasal or oral mucosa (DoHA 2006)'. What is the evidence for this claim? The DoHA document only makes the statement; it does not provide any evidence	DoHA statement being utilised in the document and therefore referenced, other evidence such as the McLaws 2009 article supports this	No change
75 Rec 19	#69 #52	Include in Rec 19 Surgical mask and face shield include hand hygiene before putting on mask, and after removing mask.	Agreed	this point is to be made stronger in the supporting text
75 Rec 19	#51	Suggested change: When entering the patient care environment, put on a surgical mask and safety eyewear. Reason: To ensure that the conjunctivae are protected. This is supported on page 75 of the draft Guidelines which states Indirectly vented goggles provide the most eye protection from respiratory droplets from multiple angles	The committee have discussed this issue and there is insufficient evidence to recommend the routine use of eyewear with individuals on droplet precautions. However, eye protection is a part of standard precautions and if the task has the risk of splashes or spray to	Monitoring the emerging evidence on the use of protective eyewear and droplet precautions will be monitored as a part of the ongoing review process.

			mucosa- eye protection is to be worn	
75 Rec 19	#57	add additional requirement Eye protection is indicated for close patient contact (within 2 metres) in accord with Standard Precautions. See discussion of this within the HICSIG Influenza IC Statement and below- http://www.mja.com.au/public/issues/191_08_191009/fer10972_fm.pdf		
75 Rec 19	#79	rewording –When entering the patient care environment, apply a splash resistant mask	As discussed prior surgical masks as splash resistant and we need to recognise what splash resistant face masks are known as.	No change to guideline
75	#79	Suggested examples (e.g. those who are immunocompromised, have or have anticipated prolonged lengths of stay, under 6 months of age, patients with Cystic Fibrosis, Cardiac conditions, patients with muscular dystrophy); and	Noted however we can't list every condition –	Maybe insert a few additional conditions.
75 Rec 20	#79	rewording Bed allocation for patients who require droplet precautions should be in a single-patient room when available, or co-horted with patient who have similar conditions (e.g RSV)	"Bed allocation" will not have meaning to settings other than acute care	No change to text
75 Rec 20	#58	When available 3m a part	There is insufficient evidence to support such a radical change in practice	This is an unresolved issue for the CDC and will be monitor as a part of the ongoing review process. Text from CDC isolation guidelines to be included on page 75. Consideration needs to be given to severity of symptoms ie. Violent, frequent coughing and sneezing.
75 Rec 20	#42	Recommendation 20 – droplet - Single room or cohorting or social distancing must be used not just 'when available'.	Agree with sentiment and is covered in the preceding text	Additional examples of separating patients in waiting room are to be added to assist with ways of implementing TBP. Note cough etiquette is now termed respiratory etiquette

75	#79	Patient transport: Children over two years of age should wear specifically designed child mask, and should not use masks with string ties as they are a choke hazard. In order to contain droplets in Children under two use an Oxygen mask so that mucous membranes can be observed.	The committee disagree with the use of oxygen masks as gas flow through the mask could potentially lead to the spread of droplets into the general environment. From a practical perspective, few children under the age of 2 years tolerate masks, nasal prongs are usually used for oxygen delivery. The choking risk is a theoretical risk, face masks with elastic ties as well as Hudson masks with elastic straps are used in all paediatric centres in this country	Added text concern about the droplet spread of respiratory pathogens then the appropriate mask should be worn when the child is outside of their isolation room or when being retrieved and the child's oxygen saturation is monitored at all times.
76	#26	under treating risks should it be considered to add immunisation of residents	The committee agrees with this points	Insert text: immunisation the 'treating risks' section
Airborne precautions				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
77 B2.4.1	#79	Certain infectious agents are disseminated through airborne droplet nuclei or small particles in the respirable size range that remain infective over time and distance. Airborne precautions are based on evidence that shows that: the use of P2 (N95) respirators prevents the inhalation by the wearer of small particles that may contain infectious agents transmitted via the airborne route (DoHA 2006); the use of negative pressure rooms may also reduce the transmission of infection; and wearing of correctly fitted masks by coughing adult patients prevents dispersal of respiratory secretions into the air (Siegel et al 2007) Identifying potential cross infection risk should be conducted at key entry and transfer points ED, Recommendation for admission, Ward and Hospital transfers, NETs, Ambulance	Comments noted. It is not clear to the committee what changes are required to the guideline	Need to reword this section to make it very clear that patients wear surgical masks, not P2 masks
	#62	Airborne Precautions in combination with Dental procedures (elective aerosol generating procedures generally) Measles, Chickenpox, SARS,	The committee agree the main sentiment of the	Insert a dot point on if a procedure needs to occur

		TB (? Influenza?) Many general practice out-patient (dental) procedures generate aerosols. When patients, for whom airborne precautions are indicated, need dental treatment they should be triaged: □ to delay treatment or □ to be listed on treatment lists as last patient of the day □ to minimize aerosol generating procedures or □ to be referred to a hospital for urgent treatment that will generate aerosols. Under no circumstances should airborne precaution patients be seen in office based practice without a written risk assessment. Considering the fact that most patients for whom airborne precautions are indicated should be quarantined, restricted to home or are too sick to be concerned about any dental treatments other than relief of severe dental pain then their treatment should be delayed wherever possible with analgesics until they are no longer infectious or quarantined. Urgent relief of pain treatment that will generate aerosol should be undertaken in a negative pressure room with HEPA filter air cleaning. Considering the accepted routine (CDC) for environmental surface cleaning after dental treatment of an airborne precautions patient is to clean twice with detergent and then wipe twice with disinfectant, then the use of P2/N95 respirators for office based dental treatment brings with it a plethora of risk management and environmental cleaning responsibilities.	submission. The Guidelines recommend that specialist procedural areas refer to their discipline specific guidelines for detailed guidance that is relevant to the field of practice. These aspects on aerosol procedures is covered in the 2009 ADA Guidelines	health professionals should consult their discipline infection control guidelines
	#74	Additional recommendation on nebuliser use The Guidelines should state that nebulisers should be banned from acute care, except where absolutely necessary. Nebulisers present considerable risk of cross-infection	The committee agrees with this statement but it may not be possible to ban their use though it may be necessary to ensure nebulisation occurs in a single room	The evidence to support this change of practice has not been identified by the committee. This is an area for consideration as a part of the ongoing review process.
77 B2.4.2	#29	In addition to standard precautions, implement airborne precautions for patients known or suspected to be infected with infectious agents transmitted person-to-person by the airborne route (ie airborne droplet nuclei or particles <5μ in size). Agree but with the proviso that 'exceptions to this should be justified by risk assessment' be added. In primary care this recommendation would be excessive if implemented in the cases of all minor infections	As discussed previously primary care cant be exempt from implementing the required infection control precautions if a person is known or suspected to have an infection that is spread by airbourne route	A case study for airborne precautions in primary care to be added
77 Rec 21	#69	Include, for viral diseases such as measles and chickenpox, HCW must be immune to provide patient care	Committee agree with statement	Add- Staff known to be immune to the infectious agent are not require to wear a P2 respirator
	#75	Include, for viral diseases such as measles and chickenpox, HCW must	As above	As above

		be immune to provide patient care		
77	#17	Will fit testing be included in the guideline?	Agreed	Inclusion of information on fit checking and fit testing to be added to guideline.
77 B2.4.3	#75	There is no mention that negative pressure rooms must be serviced and checked on a regular basis. Also there is no mention of a log book as record of room visitors which, during an outbreak or novel disease, is a way of tracking contacts	The committee agrees with these statements.	We should include 'correctly serviced/maintained' negative pressure room. With referral to the AHFG Re second point – visitors should be restricted and screened by nursing staff, and names recorded either in a log book or casenotes
77 B2.4.3	#29	Wear a correctly fitted P2 (N95) respirator when entering the patient care area when an airborne-transmissible infectious agent is known or suspected. Agree but with the proviso that 'exceptions to this should be justified by risk assessment' be added. In primary care this recommendation would be excessive if implemented in the cases of all minor infections	The committee acknowledges the issues for primary care. Additional information on assessment of risk will be included in the guideline to guide decision making	No change to recommendation but additional information to be included on conducting a risk assessment in primary care
77 B2.4.3	#29	Patients on airborne precautions should be placed in negative pressure rooms or in a room from which the air does not circulate to other areas. Exceptions to this should be justified by risk assessment. Agree but with the proviso that 'if available' as these are not available in primary care	There are not negative pressure rooms in primary care but there are single rooms, and we make recommendations about this in the national SONGs, e.g. for measles	No change to recommendation
77	#51	Suggested change: Use of appropriate personal protective equipment (particularly correctly-fitted respirators). Reason: The term masks has been used throughout the draft Guidelines to refer to surgical masks rather than P2 respirators, and its use in this section to refer to a respirator could cause confusion. Statement: N95 refers to the respirator being certified to exclude 95% of non-oil based sodium chloride particles sized at 0.3 microns in diameter. Suggested change: This statement should be deleted. Reason: The statement is referring to the NIOSH certification scheme for respirators in the U.S.A rather than the Australian certification scheme for respirators as per Australian Standard 1716:2003.	Agree agree Could refer to this	Ensure that the term P2 respirator has been used in the guideline and not P2 mask Insert text from Australian Standard Consider

		This section should include a statement that the minimum level of respiratory protection for airborne precautions is a P2 filter but that a higher level of respiratory protection may be required for high risk situations. Reference could be made to the content of table 4.1 (selection considerations – contaminant: micro-organisms) on page 33 of Australian Standard 1715:2009. This provides guidance on the selection of particulate filters in accordance with the micro-organism risk group. This section should also include information about conducting a fit check after donning a respirator to check the facial seal, and conducting respirator fit testing for workers who regularly wear respirators to ensure an adequate match between the brand and size of respirator and the wearer's face. (Reference AS 1715:2009 Selection, use and maintenance of respiratory protective devices).	Will be included	Insert fit checking in B2
77	#46	The need for personal protective equipment varies with the condition in question and the immune status of the healthcare worker. For example, if it is confirmed that a patient has measles and the healthcare worker is has known antibodies against measles then use of a P2 (N95) respirator is not required." I am concerned with the statement above – even though the measles vaccination does provide immunity and the mask is not required. This statement is fraught with potential misinterpretation e.g. midwives and whooping cough vaccination may believe they are immune and don't need to wear a mask looking after infants. Staff don't always have the in-depth knowledge of each disease process and level of immunity or efficacy vaccination provides and could put staff and patients at risk. How is the system monitored? In addition on p 81 Chickenpox/measles – reference to not wearing PPE, how is this system monitored, e.g visitors who are Immunocompromised? Again I think this is problematic regarding risk	The revised version of table B2.3 would provide the necessary guidance on whether immunity is sufficient for not wearing a P2 respirator.	No change
77-8	#66	term respirator confusion? In reference to mask or PAPR suit etc some staff consider this respirator .and N95 or P2 a high filtration mask as used in other literature previously could this be made clear and not interchange N95, P2 always type in same way as many staff don't understand this the same. Not sure if comments about respirator refer to PAPR hood or high filtration mask; I think it is meant to apply to mask…	The description of P2 respirator will be provided in the glossary	No change to the guidelines
77	#17	Will fit testing be included in the guideline?	We do need more in the governance section on	Information of fit testing will be inserted

			this, though not a manual on how to do it	
77	#79	Negative pressure rooms: replace may with do and effectiveness enhanced when applied with other safety measures	noted	No change
78 Rec 22	#69	Addition to Rec 22 Clean hands before fitting mask, and on removal of mask.	The 5 moments should drive our actions	No change
78 Rec 22	#74	There is very little in the document about infection-control measures for inpatients who have chronic respiratory infections (and also out-patients attending clinics) who may be a risk to other patients, e.g. those with multi-drug resistant Pseudomonas or MRSA. These are likely to be transmitted by airborne droplets. There also needs to be further consideration of Recommendation 22 (p78). This states that people should "wear a correctly fitted P2 (N95) respirator when entering the patient care area when an airborne-transmissible infectious agent is known or suspected." During winter months, it is arguable that airborne transmissible infections would be commonplace. It would be unfortunately unreasonable to expect every clinically exposed staff member would wear an approved respirator over the entire winter period. This could be clarified by adding some specifics – e.g. what is a 'patient care area' for this purpose? Is it an area where a patient with known flu is housed? Or is it where anyone with a cough / cold is present? There is also no mention of what precautions are needed to avoid airborne transmission for those who cannot wear a mask, e.g. those on CPAP, HFO, pilots involved in patient transportation, or indeed toddlers. This becomes particularly relevant when within a confined space with little or no ventilation, e.g. a H1N1 patient in a helicopter on CPAP moving from a smaller hospital to an Intensive Care.	The committee feel that this is beyond the scope of the guideline.	No change
78 Rec 23	#74	It may be beneficial to mention that if negative pressure rooms are used, that staff must ensure that the negative pressure is functional	This has been considered as a apart of a previous submission. The inclusion of text on 'correctly serviced/maintained' negative pressure room will be inserted with reference to the AHFG	No change
78	#79	Transfer of patients- additional information: Children over two years of age should wear specifically designed child mask, and should not use masks with string ties as they are a choke hazard. In order to contain droplets in Children under two use an Oxygen mask so that mucous membranes can be observed.	The committee agrees with this suggestion	Suggested text to be included.
78	#26	Page this would be good to place fit checking versus fit testing	The committee agrees with this suggestion	Addition of text on fit testing and fit checking

				here
79	#46	all the risk assessment case study's are about outbreak situations (good if intended audience is new infection control staff)– whereas staff working on wards(if intended audience) need day to day risk assessment examples	The committee agrees with this suggestion	Need a non outbreak example
80 B2.5	#79	Additional text: Identify patients requiring Airborne Precautions by questioning all patients about potential for cross infection risk at key entry points ED, Recommendation for admission, prior to bed allocation and ward admission, and transfers. Child specific masks should be available for children over two. Masks with strings should be avoided due to choke hazard	Should be done in initial assessment anyway	
81 Table B2.1	#75	replace gown with apron • Contact: stick to MRO's, keep the infectious diseases separate • Droplet: do not agree with wearing all the PPE as specified: as per standard precautions plus a visor or goggles and surgical mask • Airborne: as above - SP plus vaccine preventable diseases immunity plus P2 mask Do a separate category for norovirus as this is an issue Australia wide: Contact/Droplet	Modifications have been made to the table to provide greater clarity and consistency There are separate national norovirus guidelines, just as there are for CJD	Modifications have been made to the table to provide greater clarity and consistency
81 Table B2.1	#42	information below table stating if visitors /staff are immune or vaccinated the mask, gown, gloves are not required. I disagree with this statement as contact precautions to decrease the risk of transmission to others would still be required	The committee disagree with the suggested change and no evidence has been provided to support the submitters claims	No change
81 Table B2.1	#60	Recommend removal of the paragraph stating that staff who have had chicken pox / measles or vaccination do not require PPE when in the room of a positive patient. This message leads to confusion for staff and situations where unfamiliar staff incorrectly copy the behaviour of another person. In addition at our facility we have staff members who have had multiple episodes of chicken pox illness	Staff need to be vaccination in regards to chicken pox and measles	No change to table
81	#55	this table states that: 1. a mask is required for MROs, this is incorrect; 2. visitors are to wear PPE for MROs, at present we only require visitors to adhere to hand hygiene and not to visit multiple patients within the hospital at the same time; 3. SARS is listed as airborne on page 81 and then droplet on page 82	1.The table states that masks are required if the MROs if isolated in the sputum 2. Local policies will need to determine what visitors requirements are and this will be influenced by local epidemiology	Modification have been made to the table to provide greater clarity and consistency Table B2.2 has been deleted

			Oversight by the committee	
81 table B2.1	#44	Table B2.1 SARS is stated as requiring Airborne Precautions. Table B2.2 states Droplet/Contact Precautions Table B2.3 states Droplet/Contact/Airborne Conflicting advice.	Oversight by the committee	Table B2.2 has been deleted
125	#42	Table B2.1 information below table stating if visitors /staff are immune or vaccinated the mask, gown, gloves are not required. I disagree with this statement as contact precautions to decrease the risk of transmission to others would still be required.	This statement relates to individuals immune to pathogen transmitted via the airbourne route.	No change to guideline
81 & 82	#78	There appear to be anomalies in the norovirus entries. Transmission is stated to be by contact and droplet (page 81), but also by droplets, i.e. particles >5 micron in size, but the accompanying statement is (aerosolized vomitus) i.e. particles <5 micron in size on page 82, which would mandate the use of P2 respirators in patient management. See also page 86, where transmission of norovirus is stated to be 'contact; sometimes airborne'	Norovirus primarily route of transmission is via contact and droplet (as well as faecal/oral) but not airborne. Cleaning practices can generate aerosol however there is insufficient evidence to support that transmission occurs via the respiratory route	Norovirus transmission to be regarded as contact or droplet
81	#17	Should add: 'A person who is non-compliant with cough etiquette and has a productive cough and has an MRO isolated in sputum may need droplet precautions.'	More detailed information on specific disease is provided in the revised table B2.3	No change to table
81	#81	Referral to SARS why not pandemic influenza	The reference to influenza has been included	No change to table
81	#62	7. Influenza Precautions On page 81 and 82 it is clearly stated that influenza is transmitted by droplet (droplet precautions) However there appears to be uncertainty as to the route of transmission and appropriate precautions as there are at least three references that indicate that influenza is spread by aerosols Page 68; There is also a risk of exposure of staff to aerosol infectious agents (influenza in particular) Page 69; a lack of human clinical trials into the benefit of P2 (N95) respirators in reducing the risk of transmission of influenza; Page 162; aerosol droplets (e.g. TB, severe acute respiratory syndrome [SARS], influenza, chickenpox)	We are staying with predominantly droplet/contact	No change
		Table B2.2 has been deleted as its key messages were not clear to the target audience.		
		Table B2.3 Table has been replaced with a modified version of Appendix A from CDC Isolation guidelines (2007). Additional information has been provided on the special requirement for HCW (eg pregnant, non-immune, infected and immuno-compromised)		

Section B3				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
General	#69	Infectious diseases should not be included as part of MRO's. It would be better to keep infectious diseases separately as contact precautions get applied incorrectly e.g. with hepatitis A	Agree	There is a separate section for MROs.
General	#25	Terminology should be "Multidrug –Resistant Organisms"or "MDRO": to match with reference documents • PPE – statement regarding "glove use to be as effective a strategy as patient isolation when isolation not feasible" – is inconsistent with Canadian experience • Cohort – suggests not to cohort MDRO species patients if they have a different resistance mechanism or phenotype (example HAI MRSA and community MRSA), while this may be the correct direction to move, it is not practical as, since typing is not usually available. • Core Strategies • Screening is not included as a core strategy, as it is in other guidelines and general practice in Canada and the US.	Recommendations are consistent with practice and experience in Australia, particularly for cohorting different strains including community acquired and hospital acquired MRSA.	No change to Guideline
Infected pt transport	#74	The need for a clear statement to reduce risks arising from infected patient movement While it is understood that there are pragmatic barriers restricting patient movements, there remains a need for some kind of clear statement looking at attempting to minimise obvious risks posed by infected patients with free movement. Although there is some reference in the guidelines to the restriction of patient movement (e.g. Table A 1.2), as well as some discussion of what to do in the case of a mass outbreak, there remains considerable scope within these guidelines for unacceptable situations to occur. As an illustration of the potential issues, please consider the following possibility – a known carrier of Vancomycin Resistant Enterococcus (VRE), who also has psychiatric problems, leaving his scrupulously cleaned room, in which healthcare workers are assiduously gowned and gloved, and wandering at large in the hospital.	The committee agrees that infection control precautions need to be observed regardless of patient location. . Due to the vast difference in movement patterns and nature of facilities local policies are required to be drafted on patient movement in regards to receiving treatment as well as socialising.	Insert statement Due to varying nature of health care facilities, it is not feasible to suggest a generic policy on how to specifically manage movement of a patient with an MRO. Facilities should draft local policies regarding patient movement within and outside of the facility as a part of their treatment plan. These policies should not influence access to treatment, and should consider the social implications of managing a patient with an MRO, but also need to account for the risk of transmission of infection and outline strategies to

				mitigate that risk.
PPE and MROs	#5	As a rural GP who also works as a VMO in our local hospital, I have strong concerns regarding the precautions recommended for use with patients colonised with multi-resistant organisms. The draft document refers to 'perceived' stigmatisation. In my experience this perception by patients is quite accurate. I have no doubt that the requirements to isolate MRO positive patients, and gown and glove when in contact with them, detracts from the care they are offered. Manifestations of this varies from reluctance of clinicians to make contact because of the additional time and effort involved, to having such patients scheduled last on a list for the day when having investigations such as x-rays or surgical procedures. If there was clear evidence that such practices prevented transmission to other patients this discrimination might be tolerable, but to require and audit implementation of these in the absence of evidence is disturbing.	PPE is still regarded as an effective practice for certain situations. Additional text has been inserted regarding local policies and ensuring adequate patient care is provided..	No change to Guideline
	#55	The guideline talks of gowns only, can we assume this is gown or apron, as many of our facilities use aprons for contact precautions for MRSA etc	Additional information on the selection of gowns has been provided in B1.2.	A cross reference to addition information on the selection of PPE to be inserted
General	#69	Management of MROs Would have liked greater guidance regarding management of MROs within the operating theatre setting. There are currently a variety of procedures followed when caring for a patient with MRO undergoing surgery and in particular post procedure environmental cleaning of the operating theatre between patients. In the absence of any guidance within the draft document we need to extrapolate ward based guidelines which indicates a two step cleaning process of detergent followed by disinfectant. Some hospitals already follow this whilst others do not. Some clear guidance is required to provide a standard, practical approach	The Guideline recommends cleaning surfaces with detergent and a chemical disinfectant where MROs are present, however the frequency and procedures of cleaning should be established by local policies. Table B1.12 provides guidance for cleaning for which the operating theatre is considered as a high risk setting.	No change to guideline
	#55	Evidence supporting practice – due to the variety of alcohol based hand hygiene products it would be appropriate to have consistent terminology referring to "alcohol based hand products" rather than "alcohol based hand rubs". Rub implies a liquid rather than a gel or foam product	Terminology used is consistent with Hand Hygiene Australia.	No change to guideline
88 VRE	#44	Duration of precautions Recommends single room for faecally incontinent patients. This is inconsistent with advice on p. 90 and 92 which recommend all infected and colonised patents should be placed in single rooms	Agreed the inconsistency will be amended.	Table will be deleted and CDC appendix will be used which includes B2.3

89	#79	Note: Correct bed allocation, identification of patients with MROs, HH, environmental cleaning processes and good communication will minimise further transmission of MROs in the Health services Add to purple box: These communications should be addressed as required by the medical officer who ordered the test. Factsheets should be available for the patient and should be provided when the results are given to the patient	The guideline is a principle based document but suggestions would be suitable for inclusion within local policies..	No change to guideline
89	#46	It is evidence that preventable adverse events occur due to inadequate clinical care not being carried out rather than only reduced contact with clinical staff. Stelfox 2003 Safety for patients isolated for infection control. JAMA 290(14)1899-1905	Agreed. The Committee have reviewed and support current text in document.	Statement inserted about the need to ensure people in isolation continue to receive adequate medical care.
90 B3.1.2	#79	Core strategies: MRO control involves process to identify and contain the infectious patient by implementation of Additional Precautions when necessary ,adherence to correct hand hygiene practice , appropriate use of personal protective….	The term transmission based precautions is to be referred.	No change to guideline
90	#74	This section could also mention the importance of a “terminal” clean or bleach clean in the case of MROs.	The Guideline supports cleaning surfaces with detergent and a chemical disinfectant. Information on the cleaning of surfaces is provided in Table B1.12	Cross reference to Table B1.12 to be added
90	#44	Cleaning: This is contrary to some State Policies, eg. NSW	The Guideline supports cleaning surfaces with detergent and a chemical disinfectant. Information on the cleaning of surfaces is provided in Table B1.12	Cross reference to Table B1.12 to be added
91 MROs and visitors	#74	The need for clear guidance with regards to visitors to patients with a multiresistant organism (MRO) Although the guidelines advise that visitors should use the same precautions as staff when the patient has a MRO, in reality, often such practice is not observed. It is common to see a visitor leave a patient’s room and enter public areas, such as the kitchen facility which is often shared with staff.	The committee agrees that facilities should reinforce these policies at a local level. Patient information resources have been developed for visitors, carers and patientsto assist with the implementation of these policies.	Previously addressed
91	#42	Cleaning: is the use of secondary clean with disinfectant evidence based as I did not think this was strictly necessary and the mechanical action of more importance not chemical, the point should also be made about allowing to dry	The committee states that disinfectants have been shown to be effective against MROs, however the mechanical action is regarded as the most	Additional information on the two step cleaning process has been included and cross referenced to

			important step.	
91	#44	Suggest include this statement related to combined solutions and MROs into B1.4, as per above.	Accept	Will cross reference to Section B1.4
91	#52	Whilst chemical germicides/disinfectant solutions are currently used for VRE environmental cleaning, this is not current practice for other MRO (eg MRSA). Our current practice is to use neutral detergent for environmental cleaning for MRSA.	The committee states that disinfectants have been shown to be effective against MROs, however the mechanical action is regarded as the most important step.	Additional information on the two step cleaning process has been included and cross referenced to
91	#69	2 step cleaning not practical- use a detergent for routine cleaning and a combined detergent disinfectant on discharge. Clean frequently touched areas frequently with a detergent (otherwise the room will need to be evacuated)	Disinfectants have been shown to be effective against MROs, however the mechanical action of cleaning with detergent is regarded as the most important step. This can be combined with a chemical clean (e.g 2 in 1 process).	The 2 step process is elaborated on in B1.4 and cross referenced to,
91	#79	Isolation: Replace the term carriers with patients. Typing of strains and communication methods are necessary	Agreed	Will replace carriers with patients.
91 B3.1.2	#71	"Core strategies for MRO prevention and control" – "Environmental cleaning" Amend 2nd sentence – "Cleaning with detergent solution should then be followed by the use of a TGA-registered chemical germicide appropriate for the surface to be disinfected…" To read – "Cleaning with detergent solution should then be followed by the use of a TGA-registered Hospital Grade Disinfectant that is appropriate for the surface to be disinfected… Regarding antibacterial hand hygiene products, the NHMRC is advised to obtain a complete list of products which have TGA approval in Australia.	It has been stated that products are required to registered with the TGA. It is not appropriate for NHMRC to provide a complete listing of TGA approved HH products. The selection of these products has to be made at a local level	Reference to TGA registered products has been previously stated elsewhere in the guideline
91 B3.1.2	#43	Recommend TGA registered disinfectants. Listed Disinfectants and Commercial Grade Disinfectants are not registered. Refer to TG054.	Reference to TGA order 54 has been previously provided	No change to Guideline
91 B3.1.2	#47	Environmental cleaning; line 4 & 5 "…use of a TGA registered chemical germicide appropriate…" Recommend substitution with the following words: "…use of a TGA registered Hospital Grade Disinfectant which is appropriate…"	Accept	Change in text "In acute patient care areas where the risk of patient vulnerability and risk of cross infection due to the presence of an

				MRO is high, then contact precautions should be followed. This will require all patient surrounds and frequently touched objects to be firstly cleaned with a suitable detergent and then subject to surface disinfection with a TGA registered Hospital Grade Disinfectant. In office based practices and other areas standard precautions should be routinely applied and patient contact surfaces and patient surrounds should be subjected to thorough cleaning with a suitable detergent solution.
92 Rec 24	#79	Rec 24: A requirement for Health Services to resource implementation appropriately Identify • Implement Additional Precautions routinely for all patients processes or infected with a multi-resistant organism • Adherence with Standard Precautions • including: putting on gloves and gowns before entering the patient care area; etc	These comments support the current recommendation and are covered in key statements. Facilities need to implement this in their context.	No change to guideline
92 Rec 24	#75	Specify apron unless arms are expected to be contaminated	Level of detail can be included in local policies.	Reference to B1.2 on selection of gowns/aprons
92 Rec 24	#58	Patients colonised or infected with a known multi-resistant organism including if in the respiratory tract, then respiratory precautions must be maintained Plus add HH using an ABHR	The purpose of this section is to address core strategies for the management of MROs	A cross reference to respiratory precautions has been added
92 Rec 24	#57	MRO core strategies: Include • MRO screening of high risk patients • Flagging of MRO colonised/ infected patients in order to ensure proper placement	Local factors need to be considered to institute screening and must be organism specific. Committee has reviewed	No additional changes to the guideline

		Antibiotic stewardship measures	and agree it is covered in organism specific approaches. Electronic alert is mentioned in organism specific approaches.	
92 Rec 24	#79	Recommendation 24 rewording Implement Additional Precautions for all patients known to be infected with a multi-resistant organism, including: -applying gloves……	The terminology in the recommendation is consistent with the rest of the guideline	No change to guideline
92 Rec 24	#69	In Rec 24 Specify Apron, unless arms likely to be contaminated during patient care	Additional information has been providd on the selection of aprons/gowens in B1.2	No change to guideline
93/94 table B3.1 & B3.2	#25	Good summary of screening practices when required, although Australian practices may be different than Canadian. Canada has not adopted the routine use of MRSA throat swabs, newer data may support this practice, but it has not become routine thus this document is at variance with our guidelines	MRSA throat swabs have been shown to improve sensitivity for detection of carriers (Widmer 2008, Marshall 2007).	No change to guideline
92 B3.1.3	#79	Organism specific approach Inclusion of Renal Haemodialysis units in examples • Infectious Disease physicians should be resources for decolonisation consultations	This is to be determined in local policies and dependant upon available staff.	No change to guideline
93 TB3.1	#79	Renal units screened quarterly	This is to be determined at a local level with consideration to local epidemiology.	No change to guideline
B3.2 Decolonization and screening				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
94 screening	#69	Maybe could add in here that facilities could review their incidence of VRE and MRGN bacteraemia's or other sterile site isolates for ward of onset, patient demographics to inform decisions about routine screening	Noted this is an issue but considered outside the scope of guidelines	No change to guideline
94 B3.1.3	#75	Maybe could add in here that facilities could review their incidence of VRE and MRGN bacteraemias or other sterile site isolates for ward of onset, patient demographics to inform decisions about routine screening	Noted this is an issue but considered outside the scope of guidelines.	No change to guideline
94	#78	patients transferred from healthcare facilities known to have high rates of VRE and MRGN are not included for screening. The international transfer of patients from facilities is also increasing and perhaps all patients transferred internationally should also be screened	A recommendation has been added based on anecdotal evidence. Consider this as an area for future research.	Insert: Patients who are recent hospital admissions from international facilities into Australian facilities have increasingly been positive

				for gram resistant negative organisms. Consider screening these patients on admission for MROs (MRSA, VRE and MRGN). Consensus based recommendation
94	#44	VRE screening provides an optional directive only – needs to be more specific	Current management of long term positive VRE requires further research to optimise management. Screening is dependent on local factors and so only an example can be given, which may not be applicable to all settings. Local factors should be considered when developing a screening policy.	No change to guideline
94	#79	Comment: Expert direction and resources allocation is required for MRO screening	Agreed	This point will be highlighted in text include.
94 Table B3.2	#50	Suggested approach to screening for VRE and MRGN dependent on local acquisition rates (frequency of screening) Policy at Peter Mac haematology: • Active surveillance of all admitted haematology patients to identify colonised patients. This involves collection of admission and weekly perianal swabs for inpatients. The reason for frequent screening in this population is that the risk of VRE acquisition and risks associated with VRE infection are not constant for any single patient and vary considerably during the treatment period for haematological disorders - the presence of neutropenia, mucositis, and receipt of broad-spectrum antimicrobials all may vary greatly during a single hospitalisation. • VRE positive patients are isolated or cohorted, with separate segregation of van A and van B isolates. With the recent observation of other infections (MRGN, Clostridium difficile), and season respiratory infections, we strongly believe that single rooms are required as the standard of care for this population. • Appropriate infection control meaures remain in place continuously. These include gowning and gloving, enhanced	The inclusion of 3-6 month periodic screening has been provided as an example. Screening for MRGN and VRE should be considered as part of local facility measures and based on clinical judgement and local epidemiology. There is uncertainty about duration of carriage but long term carriage is common currently. Current management of long term positive VRE requires further research to optimise management. This will be an area closely	No change to guideline

		hand hygiene measures, and twice daily cleaning. The above measures have been put into place on the basis of a high rate of VRE colonisation and infection. Knowledge of VRE colonised patients greatly assists with clinical management - in many instances earlier targeted antimicrobial therapy can be commenced for presumed VRE infection when a VRE colonised patient becomes febrile and has only preliminary laboratory results available. Arguably, our own experience is now mirrored across many centres, as indicated by the VACIC VRE subcommittee report (2009) which showed considerable increases in number of VRE infections during a 3 year period. Furthermore, we wish to seek clarification on the proposed '3-6 monthly' screening, as this would not appear to be helpful from the perspective of infection control measures required to contain VRE. Point prevalence investigation has a different objective, and requires the support of different resources to active surveillance measures.	monitored for future direction as evidence emerges.	
	#3	Logistics for decolonization regime, how to go about this when patient has left facility, keeping track of time lines to meet criteria? If we are implementing transmission based precautions for MRSA whether the patient is colonised or infected, why go through the process of de colonisation and just treat them as colonised for life? They could turn up in another weeks time and have an infection and be re colonised, therefore the process is just a waste of time and resources This seems to just complicate the process! I think that it is worthwhile decolonizing staff if the need arises only (outbreak). I don't see the feasibility of decolonizing patients at all, we should just treat them as either colonised or infected, depending on symptoms for life, as we can then ensure that the appropriate contact precautions are put in place and remove any variability for carers, I think it may just confuse the issue, particularly if the patient is midway etc through the clearance process. To clear a patient is also difficult, and we do know that these bugs can re-present themselves, so could be a resource intense process for little return. Also we can then educate the patients about this and make sure they understand that they have got it for life and what to be aware of.	Suggested approach to decolonization have been considered by Committee. Current detail is deemed sufficient.	No change to guideline

		Likewise for VRE to screen every 3 – 6 months, again if they have got it they have got it for life. Surely we are just going to see resistance patterns to de colonisation techniques		
	#4	high quality evidence (RCT's) and contradict to some degree the draft document, it would be good to review these sections in light of the new data: Vol 362 PP9-17: Preventing Surgical-Site Infections in Nasal Carriers of Staphylococcus aureus Lonneke G.M. Bode, M.D., Jan A.J.W. Kluytmans, NEJM 2010	Accept	Sentence inserted: Consider screening for Staphylococcus aureus carriage and decolonisation with nasal mupirocin ointment and chlorhexidine body washes before high risk elective surgery such as cardiac and implant surgery.
94	#55	MRSA clearance guidelines – document states MRSA clearance following three swabs 10 weeks apart. How is it envisaged that this is achievable over along time frame? Current practice is over a much shorter time frame. It would be difficult to monitor all patients over a 10 week time frame, these patients would still need to be isolated under transmission based precautions until theirs creening is complete. This would increase the bed occupancy pressure of the HCF.	The clearance procedure demonstrates a successful strategy taken from a case study which tests for MRSA over 10 weeks, not that the last swab at 10 weeks.	No change to guideline
95	#57	The clearance criteria are wrong. See- http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/F22384CCE74A9F01CA257483000D845E/$File/mroscreenjun05.pdf This represents the last consensus agreement on MRO clearance criteria. It is uncertain why the current document specifies new criteria. On what basis was that done?	The clearance criteria is taken from WA example. The clearance is purely for known positives The clearance criteria will be considered for revision given the current status of MROs in Australia	The ACSQHC 2005 clearance policy will also be provided
95	#66	Clearance of MRO Should this be a heading and I wonder if there should be a comment about it being in accordance with local or state agreed approach as this appears to vary to that stated. ? What is the reference for this stated protocol for clearance?	The reference is taken from WA successful case example	The ACSQHC 2005 clearance policy will also be provided
95	#26	some beginning practitioners may not understand the definitions	Agreed	Additional terms will be included in the glossary.
96 Table B3.3 & B3.4	#25	Good summary pages, although strategies may be different than Canadian approaches. Have suggested that patients with community acquired MRSA in low risk wards may have less stringent precautions applied this is not a strategy recommended in Canada. It is unusual to have molecular results to differentiate between community and HA MRSA	In WA all MRSA isolates are typed. This is only conducted in WA	Reference to caMRSA will be removed from sentence..

97	#78	25%- 50% of antibiotic regimen. This is a very significant statement and should be referenced	Agree	Will reference ACSQHC antibiotic stewardship document.
99 B3.2	#70	this section is very thin on exactly what the "surveillance" data referred to actually consists of . It assumes it exists (on page 100 it says "examine surveillance data".) The reality is that data on cases of infection is not used systematically in healthcare practice in Australia to find outbreaks. Perhaps this should be acknowledged in the text & a way forward suggested (prompt collection & analysis to recognise anomalies in a time period quick enough to intervene for certain target infections?)	Section C also discusses surveillance. Detail in document is sufficient. Refer to surveillance data in resources.	No change to guideline
	#25	Well-written section. Good practical tools to be used are the Inclusion of "Risk Management Study" and "Putting in into Practice" sections	Noted. Thank you	No change to guideline
99	#79	edits to common outbreaks - remove (e.g. Salmonella, Campylobacter, norovirus); from respiratory pathogens - add influenza, RSV,. - also CDAD	Typos	Amended
99 B3.2	#68, #74	Salmonella, Campylobacter, Norovirus are incorrectly listed as respiratory pathogens	Typos	Amended
99 table B3.5	#78	The section on outbreak investigations is very much focused on an individual facility. It is important to document that there may be circumstances where public health agencies become involved in the investigation of outbreaks. These include notification of outbreaks associated with food or water, or involving notifiable pathogens. Some of these outbreaks may involve multiple healthcare facilities Tuberculosis may usefully be included as an example of an outbreak in a healthcare facility. Although fortunately not common the impacts are significant upon both patients and HCW Salmonella, Campylobacter and norovirus are not respiratory pathogens, and it appears that these should go on the line above for diarrhoeal pathogens	The purpose of this section is to highlight the steps for a facility to consider in the event of an outbreak. Additional information on notifiable diseases is included. The management of TB is complex and requires the involvement of the state/territory TB service.	No change to guideline
103	#79, #46	Patient Isolation: Instead of warning sign: Standardised Additional Precautions Signage should identify the isolation room and include the necessary precautions to be adopted	Typo.	Will change to transmission based precautions
103	#70	In cohorting, a discussion is needed on how to manage patients who have a clinical presentation consistent with the disease of interest but do not have a definitive diagnosis e.g. flu like symptoms but a negative flu lab test. Do they get cohorted with flu patients? Do they get cohorted with similar lab test negative patients? Where do you put them if you don't have enough single rooms? (You may want to use your chosen classification & determine where you will place your "probable" &	Recommendation includes suspected illness. If someone has a suspected transmissible illness need to manage using transmission based precautions.	No change to guideline

		"suspect" cases).	Guideline is principle based. This should be managed at a local level with available resources.	
103	#78	The reference is to cohorting and pandemic influenza is used as an example. We would suggest that SARS may be a more valuable example and likewise on pg 104 where there is a reference to excluding staff from work if unwell, SARS could be included here	Consider influenza as a more frequently occurring clinical problem.	No change to guideline
103	#46	restricting movement within the facility this raises the point about restricting staff movement from working in other healthcare facilities during an outbreak	This has been included in step 5 in the table.	No change to guideline
104	#70	Under "communication" : include management specifically, and through management raise consideration of media communication	This has been stated	No change to guideline
104	#79	Suggested interventions during an outbreak: 1. Correct bed allocation and the use of Standard Precautions 2. use of appropriate personal protective equipment (including gloves, apron or gowns, and surgical or P2 (N95) respirators 3. rigorous adherence to the 5 moments of hand hygiene (see Section B1.1.7); 4. implementing patient dedicated or single□use non□critical equipment (e.g. blood pressure cuff, stethoscope) and instruments and devices; 5. cleaning and decontamination of spills; and 6. increasing the frequency of environmental cleaning, using appropriate products. 7. timely contact follow-up processes remove remove following standard procedures for containment,	This has been reiterated in step 1 of Table B3.5.	No change to guideline
104	#75	"Environmental Cleaning" there needs to be a qualifying statement to say that "…increase frequency and efficiency of environmental cleaning must be from above the standard norm of that area to ensure…" if this is not incorporated then no one knows what the increase is from.	Agreed	Reinforcement of the need for increased cleaning frequency will occur
105	#46	- norovirus outbreaks – a rare example from my experience – results of specimens are not that readily available and ward clerks/orderlies/visitors are commonly sick as they don't take precautions walking past the patient room or while helping a sick neighbour	Agreed.	Reinforce the need for local guidance on managing specific infections.
105	#60	Norovirus is not easily destroyed by alcohol hand gel. Soap and Water should be encouraged for hand hygiene per NSW Public Health Advice. Clarify the transmission route of Norovirus e.g. droplet transmission or aerosolisation of droplets.	Table 2.3 will outline management of specific infections and a cross reference has been provided	No change to guideline
Section B4				

Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
B4	#39	The Guidelines should address the risk of infection associated with the maintenance, modification and repair of medical devices. Links to Accreditation of companies which maintain and repair surgical equipment as well as medical technology suppliers.	Committee considers this out of scope of the guideline. All equipment in use or maintenance, modification or repair needs to be cleaned. Local policies required to deal with these issues. Outside scope guidelines to address the matters raised.	No change to guideline
108 Table B4.1	#25	• Criteria for High risk should be changed by deletion of word “surgical” to state: • Any entry into sterile tissue, body cavities or organs, or repair of traumatic injury. • Add to the list of examples: Vascular access insertion procedures. Medium Risk: • Delete “minor skin surgery” and “minor dental surgery” as these are not defined and may include entry into sterile/vascular body sites. Low Risk: • Delete “injection through intact skin” as devices used for this purpose must be sterile for this critical application. Delete “dental examination” as this is not defined and such procedures may include contact with vascular system	Disagree with removal of ‘surgical’ – would result in manual vaginal, rectal examination becoming high risk. Can’t add sterile as mouth not sterile but procedures may be high risk. Don’t agree with minor skin surgery being deleted.	Low risk - will change dental examination to extra-oral dental examination
	#62	3. Entry into sterile tissue in dentistry I believe a statement needs to be made in the NHMRC guideline that acknowledges that in general dental practice that most procedures do not involve entry into sterile tissue. The exceptions would be □ Most dental implants □ Surgical removal or exposure of completely impacted teeth or tooth fragments □ Vital endodontics □ Surgical periodontics □ Maxillo-facial surgery (not a GP dentist procedure)	Comments noted.	Reference to discipline specific guidelines such as the ADA Infection control guidelines 2008 will be included.
108	#54	Earlier in the document on page 66, routine dental instruments are correctly classified as being for semi-critical use, but on page 108 dental examinations are placed into the low risk classification (non-critical) and	Accept	Low risk - will change dental examination to extra-oral dental

		all dental surgical procedures are placed into high risk (critical site). While some mention is made regarding storage of sterile materials, there appears to be no mention of autoclave testing or maintenance schedules associated with this.		examination Reference to ADA infection control guidelines (2008) will be inserted to provide specific guidance in this area.
108 B4.1.2	#45	At Section B4.1.2 at page 108, add a third sub-heading after the sub-headings “single dose vials” and “multi-dose vials” titled “Closed intravenous delivery devices” which would read as follows: “Closed intravenous delivery devices. Nosocomial infections occurring during infusion of medication, fluids, nutrition and/or blood in the hospital and ICU setting can be caused by the use of “open intravenous delivery devices” into which disease-causing micro-organisms can be introduced. (Maki D, et al., “The risk of bloodstream infection in adults with different intravascular devices: a systematic review of 200 published prospective studies”, Mayo Clin Proc 81 (2006) 1159- 1171). An “open intravenous delivery device” is vented to the outside air to allow it to properly drain, and includes glass containers, semi-rigid containers, burettes and any container which requires the use of a vented set or filter. Use of open intravenous delivery devices in Australian hospitals remains widespread in the case of burettes. Burettes are vertical glass cylinders used for the dispensing of intravenous fluid volumes in the range of 1ml to 150ml. Like other open delivery devices, burettes are vented to the outside air to allow proper draining. Many nosocomial infections can be avoided by using “closed intravenous delivery devices” (Rosenthal V et al, “International Nosocomial Infection Control Consortium (INICC) Report, Data Summary for 2006-2007”; American Journal of Infection Control 36 (2008) 627-637; 1 Australian Hospital Statistics 2005-06; AIHW, 2007. Sentinel events in Australian public hospitals 2004-05. AIHW, Jul 07; Analysis of First Year of IIMS data – Annual Report, 2005-06. NSW CEC, 2006.). See submission for more info	An open intravenous delivery device is obsolete practice. Burette vents are filtered. This section is not addressing intravenous delivery devices.	No change to guideline
108	#54	Pages 108 and 109 offer a clear explanation on the safe use of multi-dose vials for injectable materials, which is applauded.	Noted. Thank you.	No change to guideline
108 B4.1.2	#75	Incorrect statement “…items designed for single use must not be used for multiple patients.” This statement should read “items designed for single use must never be reused whether on the same patient or multiple patients	Current text is clear and supported by examples.	No change to guideline
108	#78	include a reference in the bibliography for the ADEC resolution that	Accept.	Reference will be

		injectable drugs should not be packaged in multi-dose vials		inserted: Australian Drug Evaluations Committee (ADEC) Resolution No.5578. 2005. http://www.tga.gov.au/docs/html/tganews/news19/inbrief.htm (Accessed September 2009).
109 B4.2	#44	Admin sets: Does not cover the routine practice in many facilities of disconnecting IV lines for showering pts/intermittent antibiotic therapy. While research is limited, direction is required	Accept	Will include GPP: 'Disconnection should be avoided if possible to minimise the potential of contamination of IV lines.' Insert resource: Will refer to IV nurses group as a resource.
109	#17	Move 'There may be some exceptional circumstances… to 2nd para of MDVs Replace 'clean' with 'sterile' needle and syringe to draw up required dose from vial…	Accept	Will replace clean with sterile.
109	#78	Bullet point 5. This is NOT recommended for any biological product as the stability of the biological cannot be assured. Neither is there any reference to the timeliness of the use of the product once drawn up in this manner	. This is currently addressed earlier in the Guideline (first dot point) which outlines need for compliance with manufacturers instructions.	No change to guideline
109	#78	P109. Contrary to the statement in the text, neither the Chant et al (1993) nor Katzenstein et al (1993) paper refers to vaccination programs. Also, the Chant et al (1993) paper provides no evidence of the use of multi-dose vials. In fact, the paper states that these were not used. Although we didn't check the full references, none of the titles of the papers cited against hepatitis B transmission suggest they refer to immunisation programs. We suggest that these papers be checked against the claims made in the guidelines. There is no reference given for the statement that the transmission of Pseudomonas aeruginosa has been associated with multi-dose vials in vaccination programs.	Accept	Will remove the reference to vaccination programs and Kerry Chant's paper.
109 B4.1.2	#29	Appropriate use of devices at the top of the page 109 the words 'if incorrectly used' should be inserted after '… injectable products' as there is no evidence that correctly used there is an issue. The education and training in this area	The Committee considered the text for MDVs carefully and majority of feedback has supported the text and	No change to guideline

		has increased markedly since the onset of HIV/AIDS. Pandemic influenza vaccine is delivered in multidose vials, as are other vaccines and treatments. While agreeing that ideally all medications should be provided in single use vials the reality is that primary care needs to safely be able to use these medications and without fear of retribution. The example given in the second paragraph after the dot points is excessive in its requirements and is likely to cause considerable concern amongst general practitioners and nurses in the general practice team. Table B4.2 Multidose Vials : the dot point should simply read 'single use vials should be used in preference to multidose vials'.	wording for MDVs. The procedures outlined in the guideline offer practical guidance if it is necessary to use a MDV.	
109 Table at Section B4.2	#45	At the Table at Section B4.2 (page 109), in the Fluid infusion and administration sets section, add two further dotpoints to the list presented: • The first further dotpoint would read: "Use of closed intravenous delivery devices should be standard practice and wherever possible replace the use of burettes for the dispensing of volumes in the range of 1ml to 150ml". • The second further dot point would read: "It is preferable to use premixed intravenous bags of medication wherever possible in order to reduce the risk of contamination or infection during mixing, dilution or preparation."	The key principles of the submission have been considered for inclusion	Suggestions considered text has been revised as follows: • "Use of closed intravenous delivery devices should be standard practice. • "It is preferable to use premixed intravenous bags of medication wherever possible in order to reduce the risk of contamination or infection during mixing, dilution or preparation."
109 Table 4.2	#39	The Guidelines include detailed infection control standards for the cleaning of equipment. They do not address the risks associated with the reuse of SUDs.	Accept	Will insert TGA description and include in the glossary: Single use medical devices (SUDs) are medical devices that are labelled by the original manufacturer as "single use" and are only intended to be used once. http://www.tga.gov.au/devices/fs-sudman.htm Single Use: Single - use

				means the medical device is intended to be used on an individual patient during a single procedure and then discarded. It is not intended to be reprocessed and used on another patient. Some single-use devices are marketed as non-sterile which require processing to make them sterile and ready for use. The manufacturer of the device will include appropriate processing instructions to make it ready for use.
110	#44	This is contrary to CDC Guidelines, which recommend 2% chlorhexidine	Systematic review was commissioned that found that at least 0.5% chlorhexidine was effective at skin antisepsis. Recognise that preparations with 0.5-4% chlorhexidine can be used for skin preparation.	No change to guideline
111	#26	Add the importance of securing IDC's	Accept	Sentence added from CDC: Properly secure indwelling catheters after insertion to prevent movement and urethral traction. (Category IB)
112 B4.2.1 112	#25	Insertion: 3rd bullet • Change wording in last sentence. The use of sterile, single-use lubricant or anaesthetic gel minimizes urethral trauma and discomfort. Maintaining the System: 3rd bullet • Reword sentence: Limit the use of indwelling urinary catheters to when deemed absolutely necessary (e.g. acute urinary retention,	Committee considers that the current level of detail is sufficient.	No change to guideline

		peri-operatively, or for urinary measurements in critically ill patients). The catheter should be removed without delay when it is no longer required.		
112 B4.2.1 112 TableB4.4	#25	There have been documented outbreaks of infection related to sharing of common urinary output measuring containers. ▪ Rutala WA, Kennedy VA, Loflin HB, Sarubbi FA. Serratia marcescens nosocomial infections of the urinary tract associated with urine measuring containers and urinometers. The American Journal of Medicine. 70: 659-663, 1981. Separate the 5th bullet under “Maintenance” into 2 separate practice statements: ▪ Empty the drainage bag frequently enough to maintain urine flow and prevent reflux. ▪ Use separate urine collection container for each patient for emptying or measuring urinary output. Avoid contact between the drainage bag and container. Following use on a patient, the container should be discarded if single use, or cleaned and sterilized if reusable. (re-word too long) ▪ Since the drafting of this document, new guidelines regarding UTIs have been published, please consider them in subsequent drafts: http://www.idsociety.org/content.aspx?id=4430#uti	Accept.	Will include suggested amendments: ▪ Empty the drainage bag frequently enough to maintain urine flow and prevent reflux. ▪ Use separate urine collection container for each patient for emptying or measuring urinary output. Avoid contact between the drainage bag and container. Following use on a patient, the container should be discarded if single use, or cleaned and sterilized if reusable. (re-word too long)
112 B4.2.2	#10	The guidelines include hand antisepsis as terminology but do not include description or detail on product use, concentration or selection info. With CVC insertion and access full sterile conditions (i.e. similar to surgical procedures) should be used and there is prescriptive information on sterile equipment and PPE but no mention of sterile antiseptics for skin preparation. Many antiseptics are not sterile when produced. There are manufacturers both here and overseas that do produce sterile single use antiseptics for use in clinical situations.	Accept	CDC 1. Prepare clean skin with 70% alcohol before peripheral venous catheter insertion [139]. Category IA 2. Prepare clean skin site with a 2% chlorhexidine-based preparation before central venous catheter insertion and during dressing changes. If there is a contraindication to chlorhexidine, tincture of iodine, an iodophor, or 70% alcohol can be used as alternatives [140, 141]. Category IA

112 B4.2.2	#69	Using a separate “sanitised” container and add remove gloves and cleanse hands Add in another dot point- as far as possible do not place patients with IDC’s in adjoining beds There is a HICPAC Guideline- I haven’t been able to download, but Guideline for prevention of Catheter Associated UTI, ICHE, 31 No 4, April 2010	Accept	Changes have been incorporated: ▪ Empty the drainage bag frequently enough to maintain urine flow and prevent reflux. ▪ Use separate urine collection container for each patient for emptying or measuring urinary output. Avoid contact between the drainage bag and container. Following use on a patient, the container should be discarded if single use, or cleaned and sterilized if reusable. (re-word too long) Will refer to the HICPAC guideline in the resources section.
B4.3	#55	surgical procedures – good to see a clear and concise comment in regards to artificial nails	Noted. Thank you	No change to guideline
112 Table B4.4	#75	Using a separate “sanitised” container and add remove gloves and cleanse hands. Add in another dot point as far as possible do not place patients with IDC’s in adjoining beds There is a HICPAC Guideline; Guideline for prevention of Catheter Associated UTI, ICHE, 31 No 4, April 2010	Accept	Changes have been incorporated: ▪ Empty the drainage bag frequently enough to maintain urine flow and prevent reflux. ▪ Use separate urine collection container for each patient for emptying or measuring urinary output. Avoid contact between the drainage bag and container. Following use on a patient, the container should be discarded if single use, or cleaned and

				sterilized if reusable. (re-word too long)
112 Table B4.4	#17	Could you please add as an appendix the reference and the level of grading for these recommendations. There are a number of systematic reviews that describe/make these recommendations as it is worth outlining their recommendations and referencing them. References include Lo et al 2008, Infection Control Hospital Epidemiology, S1, S41-50; Gould et al, and HICPAC 2008; Tenke et al, 2008, International Journal of Antimicrobial Agents 31S (2008) S68–S78	The process for grading recommendations is provided in the progress report and in the definitions of NHMRC grades in Section A.	No change to guideline
113	#17	Table B4.5 please clarify regularly empty urinary drainage bags as separate procedures each into a clean container Should eye protection be included?	Accept	Changes have been incorporated: ▪ Empty the drainage bag frequently enough to maintain urine flow and prevent reflux. ▪ Use separate urine collection container for each patient for emptying or measuring urinary output. Avoid contact between the drainage bag and container. Following use on a patient, the container should be discarded if single use, or cleaned and sterilized if reusable. (re-word too long) Eye protection is not standard procedure for emptying urinary drainage bags but could be considered if there is a risk of splashes to the eye. This should be determined at a local policy level.
113	#17	B4.2.2 CVCs are usually more than 15cm long… CVC's are actually from 5cm (5 FR) – 25cm (7FR) long (paeds/adults) and it depends on which side (L) or (R) as to intra luminal length. The shorter length must	Specific procedures on CVC management should be determined at the local	Sentence has been deleted specifying lengths.

		be noted as it highlights the need for catheter securement and checking of external catheter length to check for catheter migration.	level.	Resources such as the NSW CLAB resource will be provided
114	#17	Decision making – clarify why a peripheral venous access catheter is safer than a central venous access catheter.	Clinical decision making has been determined as outside the scope of the guideline.	Will delete sentence dot point
114	#74	Decision-making about IVDs It should be added that if CVC is required, a femoral site of insertion should be avoided.	Clinical decision making has been determined as outside the scope of the guideline.	Comment is accepted given there is evidence to support this (Hamilton, 2008 – Cochrane review).
115	#17	I am concerned this is an industry driven statement. Most evidence suggests minimum 2% (CDC, INS, O'Grady et al 2002; RNAO 2004)	Systematic review was commissioned that found that at least 0.5% chlorhexidine was effective at skin antisepsis (Rickard, 2009). It is recognised that preparations between 0.5-4% chlorhexidine can be used for skin preparation. Local facilities should determine which concentration is preferable within this range, dependent on local factors such as cost and availability.	No change to guideline
115	#17	Page 115 says best practice sterile gloves for IV insertion then on Page 125 says to use non-sterile gloves	Sterile gloves should be used as part of maximal barrier precautions. Non-sterile gloves can be used for insertion of peripheral venous catheters	The text has been refined on the identified pages to ensure consistency
115	#17	Chlorhexidine-impregnated sponges – there are other products on the market that have same effect & there is evidence to support this. There is only one brand of CHG sponges which makes this recommendation sound very industry based. The major downfall of CHG sponges is that it obscures the site and therefore makes assessment of site very difficult. Perhaps should read continuous release chlorhex product such as CHG or skin preps (min 2% Chlorhex: CDC recommendation) with same effect. (As a Vascular Access Nurse I am very willing to expand on this	Systematic review was commissioned by NHMRC that found strong evidence that CHG sponges reduced blood stream infection (Grade B). This review was a review of literature in Australia and internationally.	No change to guideline

		comment and discuss and provide evidence – my big concern is that Guidelines are recommending one product even though they haven't named the product!!)		
115 and P123	#78	states that chlorhexidine gluconate is a better skin treatment than other solutions, including povidone-iodine for skin preparation, but page 123, first dot point, says that they are equivalent	There is strong evidence that chlorhexidine gluconate is a superior solution for skin antisepsis.	Error on page 123. dot point on page 123 has been deleted.
115	#10	• On page 115 dot point 3 it is mentioned that there is some evidence that a two step application of alcohol based chlorhexidine followed by 10% aqueus povidone-iodine reduces colonisation rates. This does not make sence to me and if it is to remain included needs further clarification on why and when it should be considered. To use an alcohol based antiseptic followed by and aqueous is not obvious and may lead to poor practices. • On page 115 dot point 5 you mention there is some evidence that 5% alcohol based povidone-iodine is superior to 10% aqueus povidione. Iam unaware of the availavility of this product in Australia. The only 5% solution is aqueus that I know of is not labelled as sterile. There has been quite extensinve literature on use of 5% aqueue povidone-iodine for use in and near the eye as Chlorhexidine is contraindicated for eye tissue. However, the only manufacturer of sterile solution I can identify that makes this does not bring the product to Australia. As the eye is part of the mucous membrane system – sterility as a skin prop is important. Current practice amongst clinicians (so I understand) is to dilute 10% at the time of the procedure with water or saline and this does not give 5%.	Accept	Text has been revised to say: • Alcohols are the most effective and most rapid acting skin antiseptic. Alcohol based preparations that have 70% isopropyl alcohol v/v and at least 0.5% chlorhexidine are recommended for procedures penetrating skin. Typically available solutions range from 0.5% to 4% for which there is strong evidence (Grade A) that skin preparations with at least 0.5% chlorhexidine-gluconate solution reduces intravascular device colonisation. • If there are specific allergies in patients to chlorhexidine, use an alcohol-based solution supplemented with 5% povidone-iodine

				• If insertion is necessary through mucous membranes (or close to mucous membranes) alcohol based solutions should not be used. Use an aqueous solution supplemented with 2% chlorhexidine prior to surgery. If there are contraindications or allergies to chlorhexidine, use 10% aqueous povidone-iodine.
116	#25	Device replacement. In the Adult Population. CDC Guidelines for the Prevention of Intravascular Catheter-related Infections published in MMWR August 9, 2002 indicates: Replace peripheral venous catheter at least every 72-96 hours in adults to prevent phlebitis. This document indicates peripheral lines are to be changed every 2-3 days.	It is noted that the evidence around optimal replacement period of peripheral venous catheters has focussed on phlebitis as an endpoint. While phlebitis is important, there is little research available that assesses the optimal time of device replacement using blood stream infection as an endpoint. Although future research is warranted in this area, as a precautionary measure the committee advises that device replacement should be considered every 48-72 hours.	No change to guideline
116	#25	Replacement of administration sets: The document does not indicate frequency of changing administration sets for intermittent infusions.	Evidence is unclear. Clinical decision making is outside the scope of the	No change to guideline

			guideline.	
116	#17	To be clarified weather 'gauze dressing' should or should not be used.	Gauze dressings are already specified in guideline.	No change to guideline
116	#17	'Antibiotic or antimicrobial ointments (such as calcium mupirocin and polysporin) are strongly recommended for use in the management of tunnelled haemodialysis central venous catheters as they significantly reduce the number of IVD-related BSIs (Grade A).' Antibiotic or antimicrobial ointments – This is NOT recommended and there is strong evidence of complications and ointments will degrade materials used in catheters. It is also against manufacturers instructions for use. (CDC;Cancer Nursing Society of Australia;O'Grady et al;RNAO 2004 etc etc)	Statement on antibiotic or antimicrobial ointments refers to tunnelled haemodialysis CVCs. Noted that the use of antibiotic or antimicrobial ointments for other types of CVCs is not supported.	Sentence will be changed to: There is strong evidence that the use of an antimicrobial or antibiotic ointment (calcium mupirocin, Medihoney™ or Polysporin) on long-term tunnelled central venous devices used for haemodialysis access, significantly reduces IVD-associated bloodstream infections and exit site infections (Grade B). Use povidone iodine antiseptic ointment or bacitracin/neomycin/polymyxin B ointment at the hemodialysis catheter exit site after catheter insertion and at the end of each dialysis session only if this ointment does not interact with the material of the hemodialysis catheter per manufacturer's recommendation [139, 194-198]. Category IB
116	#17	Please clarify weather there is no minimum replacement time for dressing change.	Dressing change is indicated where the dressing is loose or soiled, or otherwise every 7-8 days depending on the type of device.	No change to guideline
116	#79	I question the validity of this statement. The literature describes Renal Units as having high rates of MRO's MRSA, VRE. Is the use of topical bung adding to the burdon. Why is this recommendation not following	There is Grade B evidence to use antimicrobial ointment for tunnelled	No change to guideline

		through to all CVLs. What do our expert microbiologists have to say about this recommendation or Evidence	haemodialysis central venous catheters only. The evidence only applies to renal dialysis patients which has a documented significant reduction in mortality using the ointment at the catheter insertion site (Lok, 2003). It's use is not supported for other patient groups given concerns about the association between widespread use of antibiotics developing antibiotic resistance bacteria (CDC, 2009, BSI infection g/l)	
117	#17	Replacement of administration sets – Could you consider the applicability of the skin site preparation to s/c infusions and their skin prep? We understand the review did not specifically look at this, but a reference or statement re this would be useful	It is considered that this procedure would require the same skin preparation as for peripheral IV lines.	No change to guideline
117	#17	Swap points 2 and 3 in table B4.8 for site preparation.	Committee considers is the correct order	No change to guideline
117	#17	There should be here another point for 'Disconnection of IV lines'. I.e. line should not be disconnected unless absolutely necessary.	Accept	Will include GPP: 'Disconnection should be avoided if possible to minimise the potential of contamination of IV lines.'
117	#17	Please define 'maximum barrier precautions' in the Glossary.	Accept	maximum barrier precautions' will be defined in glossary.
117 Table B4.8	#60	clarification around recommended strength of chlorhexidine ?should be 2% CHG in 70% isopropyl alcohol	Systematic review was commissioned that found that at least 0.5% chlorhexidine was effective at skin antisepsis (Rickard, 2009). It is recognised that alcoholic preparations with 0.5-4% chlorhexidine should be used for skin preparation. Local facilities should determine which concentration is preferable	No change to guideline

			within this range, dependent on local factors such as cost and availability.	
118 VAP	#35	B4.2.3- cite references Suctioning: Note: Consideration should be give to adding Closed suction to the “bundle” of reviewed practise in a unit to contribute to Best patient outcome, recognising the value of preventing contamination of staff with aerosols from a circuit with open suction. Insert: Ventilator-associated pneumonia is often due to Gram-negative bacteria. It is now recognized that bacteria causing ventilator-associated pneumonia often originate from the oropharynx or gastro-intestinal tract of the patient. Although it was once believed that frequent ventilator circuit changes were necessary to prevent VAP, it is now recognised that the ventilator is relatively unimportant in the geneses of pneumonia. Subglotic aspiration of secretions above the cuff of the ET Tube is useful.iii Adequate airway cuff pressure to minimize aspiration of secretions, yet minimize tracheal trauma, should be used. The head of the bed of the mechanically ventilated patient should be elevated to minimize gastric reflux. Ventilator circuits do not need to be changed on a scheduled basis. Hesse. Dearn R. and Kacmarek. Robert M, “Essentials of mechanical ventilation”, Second edition, McGraw-Hill Companies 2002. p10 pneumonia, pp77-78 Ventilator Circuits and Nosocomial Pneumonia Subglottic drainage: An adequate airway cuff pressure to minimize aspiration of secretions, yet minimize tracheal trauma, should be used.	Guideline is a principle based document. Local policies should specify specific practices related to VAP.	No change to guideline
119	#17	Table B4.9 – there should be a mention of filters on ventilators e.g. hydrophobic	Guideline is a principle based document. Local policies should specify specific practices related to VAP.	No change to guideline
120	#17	To help minimise the potential risk…Please clarify/ reword if this point is specific to immuno compromised patients so that it is consistent with table B4.11 (last point). The term ‘non-touch technique should be defined and should be in the Glossary. Insure consistency with the term aseptic and /clean technique. These terms need to be clear throughout the document.	Accept	Will reword sentence. ANTT will be added to glossary and referred to throughout the text. Terms have been added to glossary: Immuno-suppressed Immuno-competent Immuno-compromised
121		Viscus – please clarify use of this term	Accept	Typo will be changed to ‘viscous’

121	#54	Page 121. With regard to section B4.3 (Surgical procedures), in the 2004 guidelines it was necessary to use a sterile gown when performing dental surgical procedures however in Table B4.15 “Major dental procedures” do not require even the use of a gown. It is not clear here whether the gown referred to is a normal gown or a sterile gown, the former is recommended. Major dental surgical procedures such as dental implant placement carry a high risk of operator contamination with blood and/or saliva. Sterile gowns should be used for many procedures in this category. On the other hand, clarification is needed concerning the types of “dental surgery” being classed as critical procedures, i.e. tooth extraction or biopsy, etc. where the field is not sterile, versus implant placement and maxillary sinus lifts where entry is made into tissues.	Accept	Refer to specific ADA guidelines. Gowns will be included. Will change to major dental surgery which includes: • Most dental implants • Surgical removal or exposure of completely impacted teeth or tooth fragments • Vital endodontics • Surgical periodontics • Maxillo-facial surgery (not a GP dentist procedure) Eg. includes the surgical placement of dental implants given it is commonly done, penetrates sterile tissue, vascular tissue, nerves, bone etc so covers all bases
121-122	#44	As above, this is an example where the ‘Considerations’ are stated prior to the ‘Summary of processes’ and is contradictory, which could be confusing to the reader. In addition, reference to specialty bodies should be made, eg. ACORN	Accept	ACORN will be referred to in the resources.
121 B4.3.2	#4	With respect to the surgical infection prevention section, pp121-2, there have been a couple of papers in the recent New England Journal of Medicine which provide new relevant information regarding clorhexidine vs providone iodine as skin prep, and Preoperative “staph suppression” with chlorhexidine/mupirocin As these are both high quality evidence (RCT’s) and contradict to some degree the draft document, it would be good to review these sections in	The committee has reviewed the literature which supports the current recommendation for chlorhexidine-alcohol based skin preparation for skin antisepsis.	Will cite as reference.

		light of the new data: Vol 362: PP18-26 Chlorhexidine–Alcohol versus Povidone–Iodine for Surgical-Site Antisepsis Rabih O. Darouiche, M.D., Matthew J. Wall, Jr., NEJM 2010		
121 B4.3.3	#60	Nail polish should also be listed with the artificial nails / jewellery within this section	Accept	Will include artificial nails and nail polish
121 B4.3.2 B4.3.3	#35	removing or (insert) sealing in microorganisms that normally colonise the skin; preventing access of microorganisms into the incision postoperatively by use of a wound dressings or a microbial sealant Pre procedure considerations Insert : There is evidence that suggests the addition of a microbial sealant reduces the overall rate of surgical site infection. See clinical support references Wilkinson, Dohmen, Coyle, Towfigh Note: Evidence from surgery specific studies suggest the addition of a microbial sealant reduces the count of micro-organisms, reduces micro-organism migration into the wound and reduces the overall rate of surgical site infection. Note: A microbial sealant applied after prep prior to draping and surgery maintains the integrity of the operative site during and provides infection protection for between 5 – 7 days post operatively.. Table B4.13: Summary of processes during a surgical procedure – Insert: If a microbial sealant is being used, ensure dry before draping the patient	New technologies that are emerging will be considered for ongoing review. No recommendation can be made currently when the evidence has not been reviewed.	No change to guideline
121 B4.3.3	#75	While the statement on hair removal is correct, there needs to be inserted an additional statement that states "…if hair removal is warranted the hair is to be clipped and as close to the operative time as possible, hair must never be shaved." There is multiple evidence to document that hair must never be shaved and is supported by the Royal Australasian College of Surgeons. http://www.surgeons.org/Content/NavigationMenu/CollegeResources/Publications/Infection_Control.pdf	Accept	Sentence will be inserted. 'if hair must be removed, it should be clipped on the day of surgery or as close as possible to the time of operation. Hair must never be shaved."
122	#41	Recommend avoid removal of hair On page 122, it is stated: "There is no evidence that hair removal from patients influences the incidence of surgical site infection, but it might be appropriate in some clinical circumstances." There are a number of studies, starting in the 1970s, indicating that shaving is associated with a higher risk for surgical site infections (SSIs) than either clipping or depilatory creams or no hair removal, and that the risk for SSIs is decreasing from shaving to clipping to depilatories to no hair removal (Seropian and Reynolds 1971, Cruse and Foord 1973, Alexander et al. 1983). Thus, the above statement does not quite accurately reflect the situation. Interestingly, the statement beginning with "Avoid routine	Accept	Sentence will be inserted. 'if hair must be removed, it should be clipped on the day of surgery or as close as possible to the time of operation. Hair must never be shaved."

		removal of hair . . .” in the section on Patient preparation appears to be the appropriate conclusion, given the influence of hair removal on SSIs.		
122	#41	Preoperative decolonisation with nasal mupirocin ointment and chlorhexidine body washes are effective at reducing SSI On page 122, it is stated: “The evidence suggests that mupirocin or chlorhexidine nasal decontamination does not reduce the overall rate of surgical site infection.” Further down on the same page, under Patient preparation, it is stated: “Do not routinely use nasal decontamination with topical antimicrobial agents aimed at eliminating Staphylococcus aureus.” There is now clear evidence that nasal colonisation with Staphylococcus aureus is a risk factor for the development of SSIs, and that preoperative decolonisation with nasal mupirocin ointment and chlorhexidine body washes are effective (Kalmeijer et al. 2000, Perl et al. 2002, Perl 2003, Muñoz et al. 2008, Bode et al. 2010). The latest of these articles (Bode et al. 2010) was published in January 2010 in the New England Journal of Medicine, after the NHMRC guidelines were drafted. It appears unlikely that one should make a general recommendation to decolonise before surgery. However, given the devastating nature of such infections in certain types of operations, especially joint replacement surgery or major heart surgery, it appears appropriate to correct the above statements and add a statement like “Consider screening for Staphylococcus aureus carriage and decolonisation with nasal mupirocin ointment and chlorhexidine body washes before critical elective surgery.”	Accept	Sentence will be deleted on ‘The evidence suggests that mupirocin or chlorhexidine nasal decontamination does not reduce the overall rate of surgical site infection.” Sentence will be inserted: Consider screening for Staphylococcus aureus carriage and decolonisation with nasal mupirocin ointment and chlorhexidine body washes before elective surgery such as cardiac and implant surgery. (Bode 2010, Wenzl 2010,)
122 B 4.3.4	#78	Second dot point. Guidance should be given as to the clinical circumstances under which hair removal might be appropriate	Current detail is sufficient. Local protocols could elaborate.	No change to guideline
122 B 4.3.4	#35	Second dot point. Insert: Sterile surgical gowns and drapes are also critical as they provide a barrier between the surgical field, the surgical team and other potential sources of contamination. Insert : The addition of reference to (AJIC, “Guideline for the Prevention of SSI”, April 1999, Section I – E – 3 –b). Insert: sterile gowns and drapes should be lint resistant to reduce airborne particulates which have been demonstrated to contribute to poor surgical patient outcome and/or complications such as infection or granuloma. (AORN, “Airborne Particulates in the OR Environment”, June 1999, Vol 29 No. 6)	Current detail is sufficient. Local protocols could elaborate.	No change to guideline
122	#81	References to soap which implies a bar not liquid cleanser Touch to be replaced with contact	Accept	Will state liquid soap
122	#17	While there is evidence to support the efficacy of preoperative showering of patients in the hospital setting as a measure to reduce the rate of surgical site infection, there is no evidence of a difference on surgical site infection rate between chlorhexidine as a cleansing agent and plain	Accept	Statement will be referenced to NICE surgical site infection guideline where it was

		detergent or soap. In addition, chlorhexidine has been found not to be cost□effective for this application. – Can we check the evidence for this statement as it is common practice to use CHG preop wash. Please replace the work influences with the word 'decreases' to insure consistency with table B4.12 There is no evidence that hair removal from patients influences the incidence of surgical site infection, but it might be appropriate in some clinical circumstances. Please provide evidence for not using razors.		sourced from. Will amend terminology to make consistent. 'if hair must be removed, it should be clipped on the day of surgery or as close as possible to the time of operation. Hair must never be shaved."
122 Table 4.12	#74	Patient preparation There is also considerable evidence for tight blood sugar control as part of patient preparation (ref: Portland protocol) 1 http://www.providence.org/Oregon/programs_and_services/heart/portlandprotocol/default.htm	This information is stated in the bundle approach to infection prevention.	No change to guideline
122 Table B 4.12	#52	This table is a little confusing in relation to the hand preparation. The information appears to relate to those scrubbing however all people entering the operating room should be washing their hands and not only if visibly soiled. States that 'operating team' must wear sterile …attire however note also that anaesthetists wear sterile operating attire (gown and gloves) when doing invasive procedures. Not sure they would include themselves in 'operative team'. Operating suite/room or procedure attire – should include masks and eyewear.	Committee reviewed terminology and note the information provided is sufficient.	No change to guideline
122	#46	Does this affect the spread of MRSA?	Evidence is unclear about link between MRSA transmission and preparation for surgical site infection.	No change to guideline
122	#26	Use of sterile gown: good practice does not seem powerful	Accept	Will restate to say must use sterile gown. Already

				stated in bundled approach.
122 B4.3.4	#69	Considerations during a surgical procedure - Whilst all points are appropriate, greater guidance with regard to scrub times prior to surgical procedures would be helpful. In the previous Guidelines a 5 minute first scrub of the day and 3 minute subsequent scrub was stated. This was subsequently adopted and used by the Australian College of Operating Room Nurses(ACORN) to inform our standards and develop a clear step by step scrubbing process which has been taught to all nursing and medical staff across the country. - The current draft referring back to manufacturer's recommendations is unhelpful as this information is not clearly noted on the solution, though on investigation in the manufacturer's literature this is stated as a two minute continuous contact time for chlorhexidine and povidone-iodine solutions in common use. Alcohol as a scrub solution has not been widely adopted in NSW, but I would assume that the contact time would be less. Given these differences in contact time I can understand a reluctance to place a time frame on scrubbing procedures, but from a practical perspective when trying to teach the scrubbing procedure it would be helpful to have clearer guidance. It is hard enough to gain compliance from medical staff in particular re following correct scrubbing principles and greater guidance from the peak government body would have been helpful.	Noted. Guideline is a principles based document. Further detail should be sought in resources referred to in document.	Will refer to ACORN in suggested resources.
123	#55	Page 123 – first paragraph states "there is no evidence of difference between chlorhexidine and povidone-iodine for antiseptic skin preparation". CHRISP has a recommended practice for surgical skin antisepsis in the operating theatre that references studies to support chlorhexidine. http://www.health.qld.gov.au/chrisp/resources/rec_prac_skinprep.pdf There have been recent articles to support the use of chlorhexidine. Suggest change wording to there is limited evidence or reference articles to support claim	Accept	Error in statement. Has been fixed.
123	#17	Prepare the skin at the surgical site immediately before incision using an antiseptic (aqueous or alcohol-based) preparation: chlorhexidine or povidone-iodine are most suitable. This contradicts skin preparation recommendations for IV access where alcohol is recommended. Please check with the aqueous solutions suitable for surgical prep.	Accept	Have amended text.
123	#41	5. Comment on efficacy of different agents for preoperative skin antisepsis On page 123, it is stated: "There is no evidence of difference between chlorhexidine and povidone-iodine (either aqueous or alcohol-based preparation) for antiseptic skin preparation and the costs are similar."	Accept	Error in text. Have amended text and included suggested recommendations.

		Under Patient preparation, it is stated: “Prepare the skin at the surgical site immediately before incision using an antiseptic (aqueous or alcohol-based) preparation: chlorhexidine or povidone-iodine are most suitable.” And: “If diathermy is to be used, use aqueous-based preparations or ensure that antiseptic skin preparations are dried by evaporation and there is no pooling of alcohol-based preparations.” There is a vast body of evidence indicating that alcohol-based skin antiseptics are vastly superior to aqueous ones (chlorhexidine or povidone-iodine). This is well described in standard textbooks on antisepsis and infection control (Gröschel and Pruett 1991, Rotter 1997) and has been a topic of intensive research and evaluation since the 1970s. This has also been summarised in the US CDC guideline on prevention of surgical site infections (Mangram et al. 1999). In Table 6 about the property of antiseptics, the guideline lists alcohols as the type of antiseptic with the most rapid action and the most favourable spectrum of microorganisms effectively killed. The guideline concludes that alcohols remain the most effective and most rapidacting skin antiseptic. There are now several clinical studies indicating that alcoholic preparations are superior to aqueous ones for preoperative preparation of superficial skin. (Inaba et al. (1999); Segal and Anderson (2002), Seal and Paul-Cheadle (2004), (Darouiche et al. 2010. However, alcohols are unsuitable for antisepsis prior to surgery on mucous membranes (World Health Organization 2009b), so that aqueous antiseptics have to be used in these instances. Recommendation: alcoholic preparations (either supplemented with chlorhexidine or povidone-iodine) should be recommended for surgery through superficial skin, and aqueous preparations should be recommended for surgery through mucous membranes (or close to mucous membranes).		
123	#41	There have been discussions in Australian surgery that alcoholic preparations have a risk of causing fires in the operating theatre, especially when using diathermy. However, all such fires for which information is available have been caused by inadvertent misuse of antiseptics and diathermy (Tooher and Maddern 2004); this involved either use of too much alcohol (such as in pouring the alcohol over the patient) and resulting pooling and wetting of surgical drapes, or the connection and use of diathermy before the antiseptics have dried. It is therefore necessary to emphasise that it is important to avoid	Accept	Have included statement on flammability considerations with alcohol preparations. Have included suggested text: It is important to avoid pooling and wetting of drapes with an antiseptic

		pooling and wetting of drapes with an antiseptic and to let it dry before connecting the diathermy (drying time is necessary also for ensuring adequate antimicrobial action). Thus, when there is an emphasis on caution and appropriate usage, there is no need to recommend against using alcohols for surgical skin preparation, even when diathermy is used (Maiwald et al. 2006). See attached letter to the editor concerning the risk of surgical fires (Maiwald et al. 2006) for further information.		and to let it dry before connecting the diathermy.
123	#41	There are two other important issues concerning surgical skin antisepsis that should be included in the guideline, whether using alcoholic or aqueous preparations: 1. Repeated applications of the antiseptic: Concerning repeated applications, there appear to be insufficient published data concerning an exact procedure and an exact number of repetitions, but continuous application over a certain period of time or repeated applications of about three times are widely practised (A. Widmer, University of Basel, Switzerland, personal communication and unpublished data). 2. Sufficient contact time of the antiseptic on skin or mucous membranes to ensure sufficient killing of microorganisms. Concerning contact time, there appear to be again insufficient published data to recommend very specific time intervals. However, it is clear from the laws of physics underlying microbial time-kill-curves that the killing by antiseptics is always a time-dependent reaction and never happens instantly (Gardner and Peel 1998). The Royal Australasian College of Surgeons, in its guideline on infection control, recommends “at least two, but preferably five minutes [of overall contact time]” (Advisory Committee on Infection Control in Surgery 1998). There would obviously ethical problems in studying this in clinical trials, but there are anecdotal reports of catastrophic increases in SSI rates when the attention of surgical teams towards contact times lapsed (M. Borneff-Lipp, University of Halle, Germany, personal communication). Both, repeated applications and contact time are intimately linked, since repeated applications help to keep sufficient antiseptic on the surgical site during the contact time. I have attached two of my seminar talks (one on prevention of surgical site infections, another on skin antisepsis), one book chapter on the prevention of surgical site infections (Maiwald et al., in press).	Outside scope of document. But have included overarching statements	No change to guideline
123	#41	6. Comment on other important aspects of preventing infections in surgery There are a number of other important aspects concerning the prevention of SSIs that have not been mentioned in the draft NHMRC guideline. These aspects include, among others:	The level of detail suggested is beyond the scope of the guideline but a link to NICE surgical site	No change to guideline

		(a) more details on operating theatre attire, including the necessity to wearing face masks while operations are underway, (b) aspects of sterile supply of instruments, (c) surgical hand antisepsis (scrubbing) time and other details, (d) more details on antibiotic prophylaxis, including the timing of administration, (e) supplemental oxygen (this is still controversial from my reading of the literature), (f) perioperative glucose control, (g) treating remote infections before elective surgery, (h) control of patients' body temperature, (i) more details on postoperative wound care and wound drains, (j) operating theatre design and ventilation, including the need for theatre staff to limit excessive personnel movement, and (k) the usefulness of surgical site infection surveillance as a cornerstone (and requirement for infection control staffing requirement) in the prevention of SSIs.	infection guideline (2009) will be provided for further information.	
123 Table B4.13.	#75	Table B4.13 Insert a comment staying that skin prep must be dry before draping of patient. The Australian College of Operating Room Nurses, Standards S18 http://www.acorn.org.au/	Accept	Will insert: Skin preparation must be dry before draping of patient. It is important to avoid pooling and wetting of drapes with an antiseptic and to let it dry before connecting the diathermy (Maiwald et al. 2006).
124 B4.3.4	#52	In the hospital setting, it is good practice to use sterile gowns in the operating area, to prevent patients from being exposed to the risk of contamination. This statement is in contradiction to information above (Table B4.12) and below (Table B4.13) and current practice. Sterile gowns are always used for surgical procedures in the operating area	Accept	Will insert: Will also refer directly to table in B1.3 on gowns. In the hospital setting, sterile gowns should be used when entering the sterile field, to prevent patients from being exposed to the risk of contamination.
124. B4.3.5.	#78	We query the need to mention honey, silver etc if there is no evidence of efficacy	Accept	2nd dot point will be removed
124	#81	Replace de novo with an Australian word	Accept	Will delete 'either de novo or because of treatment failure'

124 B4.14	#20, #80	Cleansing: Does this apply to wounds healing by secondary intention?	This is beyond the scope of the guideline however resources for wound management will be provided in the resources list.	No change to guideline
124. Table B4.14.	#78	Seventh dot point. Specimen for culture should be taken before antibiotic treatment is started, to reduce the risk of a false-negative culture result	Accept	Will amend to say 'take a specimen for culture and then give the patient an antibiotic..'
125	#81	Intravascular devices does this include blood collection?	No. Phlebotomy will be excluded.	No change to guideline
125 B4.15	#20, #80	Inconsistent use of terms 'splash risk likely' and 'exposure risk likely'. Sequencing of content Would Table B4.15 be better placed in the section on standard precautions rather than after the section on transmission based precautions? Some of these key summary tables should probably be placed as foldouts at the start of the guidelines for easy access	These terms refer to different risks. It is noted that various terminologies are used throughout Australia. This table refers to procedures only – it will stay with the procedures section. Noted tables will be available to download from the internet separately.	No change to guideline
125 Table B4.15	#16	Procedure: Activities of daily living(washing, toilet etc) gloves and gowns also be checked in this section though dependant on the patients functional level due to the potential exposure of HCW to body fluids. Thus gloves should be worn in anticipation of contact with the patients blood or body fluids, mucous membranes, non-intact skin or where blood or body fluids have contaminated equipment or surfaces (Department of Health, 2006). Using gowns while showering or washing a patient will protect the HCW's clothing from contaminating microorganisms which could be transferred to another patient and also provide a barrier in the event of unplanned contact with blood or body fluids	The need for PPE should be based on risk assessment.	No change to guideline
125 Table B1.14		Clarification required regarding type of gloves (sterile / non-sterile) for suctioning.	It is the Committee's opinion that sufficient information has been provided .	No change to guideline

125 T B4.15	#25	Checklist of Standard Precautions for procedures. It is indicated that a gown is not required for Major dental procedures. In the line below, a gown is required for Routine dental procedures including dental examinations if exposure risk is likely. This seems inconsistent	Accept	Major dental procedures include a gown.
125 T B4.15	#46	could you consider including standard precautions for midwives during normal vaginal delivery	Accept	Will include in Standard precautions table the need for hand hygiene, sterile gloves, eye protection, gown.
Page 124: Table B4.14	#65	Management of Surgical Site Infection Guideline statement: "Avoid the use of eusol and gauze or dextranomer or enzymatic treatments for debridement in the management of surgical site infection." Whist the specific mention of avoiding the use of eusol for surgical site infection is applauded; this section does not cover all necessary topical agents that should be avoided. Agents such as Hydrogen Peroxide are still routinely used by some practitioners. Hydrogen Peroxide is avoided for irrigation or instillation into sinuses and cavities due to its weak antiseptic action and potential for air embolism (a very small risk but one with potentially catastrophic consequences). Inclusion of other potentially useless or harmful agents should be considered for inclusion in the guidelines. It is interesting that "enzymatic treatments" are specifically listed. Potent enzymatic debridement agents are not currently used in Australia, as to AWMA's knowledge there are no potent enzymatic agents licensed for use on wounds. However, there are newer, less potent agents such as glucose oxidase gel (Flaminal™) which have some enzymatic action and which are currently licensed in Australia for use on wounds. Clinicians report successful outcomes with these agents. Therefore, consideration should be given to reviewing the recommendation to avoid the use of enzymatic treatments. Additionally, consideration should be given to including a recommendation against the routine use of topical antibiotic preparations on surgical incisions and open wounds due to the potential risk for development of multi-resistant organisms and the often inappropriate carrier medium (i.e. chloromycetin eye or ear ointment is not in a delivery vehicle for wounds – it is for eyes or ears).	This level of detail exceeds the scope of the guideline. A reference to the AWMA on wound management has been provided.	No change to guideline
125 B4.4 Putting it into practice Table B4.15	#53	Checklist of standard precautions for procedures For major dental procedures - surgery -'gowns not recommended / required' For routine dental procedures – gowns recommended 'if exposure risk is likely'	Accept	Gowns will be included.

		Comment: Sterile field is required for all 'oral surgery', this includes the use of sterile gowns, gloves, drapes etc.		
125	#62	4. Glove wearing in dental practice On page 125, I believe there should be a tick in the Gloves column for Major Dental Procedures I believe the row header 'Routine dental procedures including dental examinations' Would better be 'Routine intra-oral dental procedures' As there are some extra oral dental procedures, such as extra-oral TMJ and cancer palpation, that do not require the wearing of gloves.	Sterile gloves have already been specified.	Change to: intra oral procedures
Page 125 Table B4.15	#65	Checklist of standard precautions for procedures The use of principles embodied in a risk management framework is welcomed. However, in this table those principles appear to have been overlooked in favour of a 'one size fits all' approach in relation to the 'Wound examination/dressing' section. Wounds include not only surgical wounds, but a variety of acute and chronic wounds managed in many different care settings by persons with varied training and resources. Aseptic technique is not the only technique used during a wound examination or dressing procedure. And, sterile gloves may not always be necessary for direct contact with the wound (as stated in Table B4.15) The current (2002) and draft (2010) AWMA Standards for Wound Management state (Available at www.awma.com.au): The interprofessional team comprehends the importance of, and is able to: 4.1 Determine when an aseptic wound management technique is required if the individual, their wound and their healing environment is compromised. Performance Criteria The clinician will: Use an aseptic wound technique using sterile equipment and sterile single use solutions • When the individual is immunosuppressed • When the wound enters a sterile body cavity (i.e. nephrostomy or central venous line • During the peri-operative period • When the wound healing environment is compromised • When the service provider protocols dictate . 4.2 Determine when a clean wound management technique is acceptable if the individual, their wound and their healing environment are not compromised. Performance Criteria The clinician will:	This level of detail exceeds the scope of the guideline. A reference to the AWMA on wound management has been provided	Will reference AWMA 2010 Standards for Wound Management for further information on wound management. www.awma.com.au

		• Use a clean wound management technique i.e. washing or showering of wounds when criteria for standard 4.2 are not demonstrated • When service provider protocols dictate The underlying principle of a wound examination or dressing procedure being an infection control procedure is absolutely supported. Therefore, the guidelines should consider discussing/presenting wound examination or dressing procedure in a manner that supports a patient-centred approach that focuses on the type of wound and risks involved.		
Section C				
C1 Management				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
C1	#29	In Section C – Management and Clinical Governance - overarching principles are sound but are resource intensive in a remote context with regard to risk management, training, implementation and organisational support. This might be an internal problem but the draft document is suggesting a huge commitment from each organisation to define its outcome measures for monitoring IC policies/processes The document has raised a question - What is in place to support effective risk management through training, monitoring and reporting by remote health staff as the document frequently reflects back on a flexible decision making framework to assess the risk and associated transmission/activity for the individual RAN or organisation via policy/procedures.	Comments noted but governance is an essential element to the provision of safe and quality care. Local policies and procedures for HCF need to give consideration to the infection prevention and management when conducting the activities they perform	No change to text
	#63	Organisational support in primary care is not well covered in the guideline, which focuses on hospital settings. As stated in the guidelines it is appropriate that each primary care service has a single person with appropriate authority, such as chief executive officer or principal practitioner, with responsibility for infection control. Adequate resourcing for infection is also necessary. However while dedicated infection control staff are required in hospitals, this may not be appropriate use of limited resources in primary care services. Countering this is the fact that without a person whose work is dedicated to infection control, there is a risk of infection control not receiving adequate attention. This is partly because of the difficulty in achieving surveillance for health care acquired infection in primary care. Surveillance is a key to determining the appropriate level of resources for infection control. The guideline and its reference describe hospital-based surveillance in detail, but do not consider surveillance within primary care.	The principal factors considered a part of governance have been highlighted. Mangers of health care facilitates need to give consideration to areas for effective infection prevention and management. The issue of surveillance is noted and this area will continue to progress given the work undertaken by the Australian Commission for Safety and Quality in	No change to text

		Costs of failure of infection control are challenging to document even in hospital settings. Reports and discussion papers by the Australian Commission on Safety and Quality in Health Care deal only with institution-based surveillance (2). CARPA believes that recommendations and mechanisms for surveillance in primary care are required. Alternative surveillance mechanisms could be consumption of infection control resources, such as volumes of hand cleaner, sterile gloves and other infection control consumables; and disease notifications through communicable disease control units.	healthcare	
	#78	The organisational support is a very useful and consistent part of the document and consistent with the all risk and systems approach to infection control.	Noted	No change to text
126	#46	Intro: "Infection control is an occupational health and safety issue, Disagree as Occupational health and safety and infection prevention and control may work collaboratively on some issues, however have distinctively different roles and the statement above is misleading. Infection prevention often provides consultancy to occupational health and safety and managers in regards to risk management, preventative strategies and analysis of data. Infection control in regards to say engineering airflows for patients, food preparation, patient education, systems analysis isn't occupational health and safety	Noted but disagree	Remove term occupational from 4th dot point from pg 127
127 ICPC	#44	Too general – needs to be more prescriptive, eg. a multidisciplinary committee (however named) should be established with Infection Control as a permanent item on the Agenda, etc. refer C1.2.3.	Disagree the document is a guideline and local policies are the appropriate place to provide greater detail governance structure will vary between facilities	No change to text
127 C1	#81	-Definition of clinical governance surely managers and clinicians must be accountable for minimizing risks to patients and staff. -'facility wide' be changed to 'organizational	Agreed but facility to remain to maintain relevance to smaller facilities/ practices	3rd para add minimizing risks to patients and staff
		Infection control practitioner	Noted and agree	change to infection control professional
129 C1	#57	Roles and responsibilities: in modern health service organisations, especially in the public sector, there may be a level of management above the health facility CEO, being the Chief Executive of the organisation of which that single facility may be a part. I suggest there is a strong governance role for that organisational Chief Executive, to ensure the functions and structures of infection prevention and control governance are in place across all	Noted and agree	No change to text

		settings in the organisation, to receive reports and recommendations for outcomes and quality improvement initiatives, and to ensure a safe and patient-centred organisation within which Infection Prevention and Control functions can become operational. This is especially the case where settings involving patient care, or training others in patient care, extend beyond a facility with four walls: such as with patient transport, training student clinicians and volunteers, Hospital in the Home, or the community and hospital facility interface		
129. C1.2.	#78	Fifth dot point. We believe the medical officer appointed to the hospital's Infection Prevention and Control program should have completed postgraduate training in a relevant field, such as microbiology, infectious diseases, epidemiology or industrial hygiene	Noted but this is not always possible in smaller facilities and office based practice.	No change to text
129	#46	literature discusses a clinical microbiologist or and infectious diseases physician is an essential part of an infection prevention program which I think should be specified rather than medical practitioner. CDC	Noted and agreed but this is not always possible in smaller facilities and office based practice.	Change the term medical practitioner to
130	#46	Infection Prevention Professional – To develop, manage and evaluate governance of Infection Prevention and Control systems, related programs and services. To provide expert infection prevention consultancy and strategic direction to the healthcare organisation and external agencies	Agreed	Integrate concepts into text on Infection control professionals
130	#59	There are many healthcare facilities that do not have access to an Infection Control Practitioner (ICP) or relevant committee. Suggest adding consultation with ICP or larger health service for program advice and support if ICP not available.	Agreed	integrate comment into text
130	#81	several references to 'facility or hospital' – can these be changed to read 'organization'?	Facility is the term that is applicable across a broad range of settings	ensure consistency in use of the term health care facility
130 C1.2.2	#58	ICP role: equipment and product evaluation	Agreed	add into C1.2.2
130 C1.2.3	#58	ICP C activity measured by: Operational plan with set priorities of key focus areas to target	Agreed	Add into C.1.2.3
127. C1.1	#78	patient ratio. Such guidance would be useful for managers	See below comment	No change
130 C1.2.3	#46	A multidisciplinary IPC Committee should review and guide the hospital's IPC program I think there should be room to include infection control into other committees when the setting is rural or remote which may include 10 to 20 healthcare facilities. The current process I use is to work through our executive committee. What the senior infection control professional mean? Until we have	Noted the IC programme and committee structure should meet and reflect the core business and risks of the facility or organisation and have the ability to respond and react appropriately whether site based, part of other	"Senior" to be deleted and leave as ICP.

		clear novice to expert guidelines I think this is the non-quantifiable statement. C1.2.4 – any infection-control professional should require qualifications whether the program is Office-based or laboratory-based don't think the program base matters.	committee structure or representing multiple facilities.	
130 C1.2.4	#58	INCLUDE the development of ICG. Support from executive required	Agreed	Need to add to C1.2.4 that local policies and procedures need to be developed addressing infection prevention and control as a part of their standard operating procedures
131 C1.3.1		Perhaps it would be better to put something along the lines of endorsed according to the government system of the healthcare organisation (we have a organisation wide process for endorsing policy not through an infection prevention committee) as we have seven regions and the process has been centralised	This is a principles based guideline and the key factors of governance have been discussed. Implementation is dependant on the local context	No change to text
131 C1.3.	#58	-Include CPG's in policies and procedures - of international evidence Surveillance oversight requires a microbiologist with laboratory support -need to include outbreak management , contact tracing for exposure to CDS C1.3.1 IPCC need a strategic operational plan which identifies key priorities and targets which are reviewed annually against key performance indicators and mandatory requirements for that facility. Include in policies: Immunisation stats for HCW - Mandatory ic education - Sterilisation and disinfection governance	This is mentioned later in the guideline	No change to text
131	#26	terminology of occupational health and safety. This means something different in most health care facilities. OH&S is an area that looks after manual handling where as occupational medicine unit looks after staff health and immunisations and such things as pre employment screen.	Noted could appear confusing	remove OH& S from 9th dot point and replace with sharps safety
132	#46	DELETE collaborate with Clinical Risk Departments and Executive Staff Adequately trained infection prevention professionals will be able to develop appropriate methods for critical incidents, sentinel events etc and report them through the appropriate organisational reporting systems. My opinion is that as professionals we need to take ownership of the service and to drive the program	Disagree a collaborative approach is more conducive to stakeholder buy in.	No change to text
133	#44	Resource allocation: This would be difficult to achieve in the private	Governance structures	No change to text

		sector as many of the services are independent/outsourced, eg. Laboratories, Pharmacies, etc Many outsourced agencies do not have the capacity to do trend analysis, etc. These recommendations are Public Hospital focused, and require further clarification if they are to be implemented in the private sector and non acute settings, eg. Aged Care	need to support resource allocation for the level of surveillance relevant to that facility	
132 C1.3.3	#46	Quality Improvement Thank you the terminology in the first sentence is very good of the paragraph below. I think it would be more true to say that - IPC programs include principles of quality management, through the use…..	Agreed	Accept proposed change
132 C1.3.3	#57	I think that specific cases require more than local research, but rather a robust system of investigation, identification of root causes, plans and actions to address those root causes, and a review within a set time frame of the effectiveness of those actions to prevent recurrence of the conditions which led to infection. Consider mandating a root cause analysis of deaths within 30 days of a documented healthcare acquired infection	This is beyond the scope of the Guideline	No change to text
133 C1.3.4	#79	The State Healthcare service, the Area Healthcare Service, The Network service, the health facility, the ward management should be resourced if these guidelines are to be adopted fully. Infection Prevention & Control Service resource allocation is not stated. Without dedicated funding to achieve the intent of the guidelines implementation compliance will fail. NSW ICP allocation in the rural health service is geographically challenged and not resourced for prevention activities	Noted and beyond the scope of the guideline to project resource funding	No change to text
133 C1.3.4	#46	health-care worker immunisation is a consultancy role only and that post exposure evaluation and care is the role of occupational health doctor and nurse or staff and the management of health-care workers with communicable infections – is a line management responsibility with consultation and support from infection control and occupational health. I am aware that often infection control wears the hat of occupational health and safety in small health care facilities in rural setting and I think this has created confusion about role delineation	Immunisation is a aspect of strategy for the preventing the transmission of preventable diseases which is an infection control strategy	No change to text
133 C1.3.4	#60	This section is not worded strongly enough. It needs to be made easier to interpret. Recommend a guide be attached to assist Leaders and Boards of Management in understanding how much time is required to undertake this role effectively in an organisation. Providing a ratio of FTE to bed numbers, patient separations etc would assist in this	The issue of ICP ratios is not as simple as identified in these comments and requires a significant amount of work to be undertaken before any ratio could be considered based on the literature available for the following reasons. It is not just about bed numbers or occupancy and staffing.	No change

			It is also affected by the following as an example: Activity – inpatient, outpatient/office practice, other services to be resourced e.g. community, dental, mental health Acuity – acute care, aged care, elective pts, emergency pts, demographics of patient population as customers. Experience – mentoring, support, scope of role. Therefore the ICG needs to be cautious about giving a number as is requested in the comnets as there is not sufficient evidence available to do that at this point based on Australian circumstances.	
ICP ratios	#44	The current CDNA Guidelines and the Australian Infection Control Association (AICA) recommend that the staffing level should be 1.5 ICPs to 200 acute care beds. In addition, AICA recommend 1 ICP to 250-300 long term beds. It is our understanding that the ACSQHC, in collaboration with AICA are currently reviewing core and essential elements of an Infection Prevention and Control Program according to organisation size. The Victorian Infection Control Practitioners Association have also reviewed the role of the ICP, and developed Competency Standards for ICPs, (Hobbs, L. 2008). None of this is referred to in the document. However we believe minimum levels need to be clearly defined and//referred to in other references, to ensure appropriate allocation of resources at a local		No change
ICP ratios	#2	the guidelines have squibbed the issue of an appropriate ratio of infection control practitioners (ICPs) to beds in favour of a number of lame motherhood statements about appropriate resourcing of infection control programs. There are a number of studies and publications that address the impact of understaffing infection control programs (starting with the Senic study…I will list references below that I think should be		No change

		included and discussed). There is nothing wrong with a desirable ratio of staff to beds being expressed as you did in the 2004 guidelines (the old sections 8.1 and 38.1). Given that every Australian hospital runs at 100% activity, the relationship between beds and activity is direct, so there's no need to express ratios in anything other than bed numbers. Given that every page of the guidelines revolves around support from infection control practitioners; to not specify what is expected of hospitals in their numerical staff profile of ICPs is a step backwards (especially in badly resourced states like NSW).		
134 C1.4.2	#60	This is now an old reference – should be updated to read ISO /ASNZS 31000	Correct	change to ISO /ASNZS 31000 throughout document
134	#46	It would good for infection prevention to take ownership of its systems and processes so my comment is about this title is it should say something along the lines of: TAKING AN ORGANISATIONAL SYSTEMS APPROACH TO INFECTION PREVENTION QUALITY AND SAFETY.	Agreed	Accept change
135	#46	Surveillance – remove follow up as this is occupational health role	Follow up refers to ongoing analysis and evaluation of prevention strategies	Change "follow up" to prevention strategy
C2 Staff health				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
C2	#51	The chapter on staff health and safety should include a brief statement that if staff members acquire a work-caused infectious disease, this event may require notification to the workplace health and safety and workers compensation authorities	Noted- Staff that contract an infectious disease in the course of their work, regardless of their immune status, are entitled to workers compensation. Notification to insure has to occur within 48hrs of notification	Include that staff that acquire a
C2 1.1:	#25	last line, 2nd paragraph: refers to disabilities, impairments and This does not seem to be relevant to IPAC. Unless it is with reference to requiring alternate means to complete those processes. Please clarify the intention of this paragraph • Under Five measures of protection: Suggest including staff orientation to this list although it is covered elsewhere. Also suggest that measures of protection should discuss three measures of protection : a) Engineering Controls b) Administrative Controls and C) PPE Controls and then put all measures of protection under these main headings for hazard prevention and control.	Agreed	remove disabilities and impairments

136 C2	#17	Consider rewording C2.1.2 responsibilities of HCWs and they don't all have the duty to disclose bloodborne virus.	Agreed	Change to duty to disclose infections status if it places others at risk
137	#66	Staff screening policies, assessment and immunisation this would be good expressed as a table. Also of note this process is often very difficult to implement in small institutions. So minimum requirement should be specified so at least some addressed even if organisation recommends referral to GP for review. Record keeping also very difficult without access to specific computer programs.	Agreed	Table on preemployment screening to be developed on the recommendations within of the NHMRC 9th Immunisation handbook
137 C2.2.1	#42	staff health screening policies: the paragraph suggests the facility should offer assessment, vaccination and /or screening but at pre employment this is the employee responsibility for Hepatitis B. Alternatively it should be at commencement of employment as there is no responsibility on a facility if they are not even employed	Issues should be addressed with insertion of table as mentioned above. Pre-employment screening – regardless of who is responsible need have what is necessary to document having being done.	as above
Page 137 C2.2.1	#25	Routine screening: It is confusing to include measures for screening staff during an outbreak in the "routine screening" section. It would be less confusing to exclude this, or have a separate section. If maintaining immunizations is considered a "duty of care" in the health care setting, it should be mentioned, e.g. Ontario guidelines state, "In the absence of contraindications, refusal of health care workers who have direct patient contact to be immunized against influenza implies failure in their duty of care to their patients	Agreed	Delete salmonella carriers from laboratory and other testing.
137 C2.2 screening	#70	screening for ……salmonella carriers…. May be instituted in an outbreak" The only value of this is for finding more cases even in this circumstance is for epidemiological analysis. I don't there's evidence that asymptomatic salmonella carriers are relevant to transmission. Symptomatic case are covered by the 2 day recommended restriction for diarrhoea on page 139. (There may be some value in screening for typhoidal salmonella carriage but this would be done on advice of public health		
2.2.1	#44	Routine tuberculin skin test only mentioned. Does not include QuantiFERON – TB Gold® testing, which is becoming more frequently used in healthcare settings Services Victoria, 2002. Management, Control and Prevention of Tuberculosis. Guidelines for health care providers, (2002 – 2005). www.dhs.vic.gov.au	Noted however tuberculin skin test is the current recommended standard for measuring prior exposure	No change to guideline
137 C2.2.1	#31	Second dot point: The first sentence is inaccurate. While infected healthcare workers (HCW) may (depending on their serology) be required not to practice exposure-prone procedures, this is usually a small part of direct patient care except for surgeons and dentists, even	Noted however duties may be modified if they have a confirmed BBV that may directly affect the risk of	Insert sentence: Duties may be modified if HCWs have a confirmed infection that may directly

		with the extremely broad definition of exposure-prone procedures used in this document.	transmission of infection during exposure-prone procedures. This results in the restrictions on their work practices restricted	affect the risk of transmission of infection during exposure-prone procedures. Work practices are likely to be restricted if they have a confirmed BBV. This may be determined at the local facility level.
137/8	#51	Suggested change: Though employers are not required to vaccinate staff, they must take all reasonable steps to protect the workplace health and safety of staff members who are exposed to vaccine-preventable disease risks. Reason: Employers of health care facilities have a statutory duty of care under their state/territory workplace health and safety legislation to ensure the workplace health and safety of workers, including for occupational vaccine-preventable disease risks.	Noted. Does not apply nationally	Suggest 'employers should take all reasonable steps
137	#17	C2.2.1 Does herpes simplex need to be included in pre-employment screening?	Agreed.	Remove Herpes from list
137 C2.2.2	#70	Distinguishing "smaller" & "larger" healthcare institutions is unwise in vaccination policy. It has no support in the Australian Immunisation Handbook. An unprotected receptionist in a GP practice who catches measles has an opportunity to expose hundreds of patients	Agreed	Demarcation between smaller and larger facilities to be deleted.
137	#51	Statement In larger facilities (where healthcare workers may be at significant occupational risk of acquiring a vaccine-preventable disease) a comprehensive occupational vaccination program should be implemented. Suggested change: In larger facilities (where healthcare workers may be at significant occupational risk of acquiring or transmitting a vaccine-preventable disease) a comprehensive occupational vaccination program should be implemented. Reason: Infected healthcare workers may transmit vaccine-preventable diseases to vulnerable persons in their care, for example transmission of pertussis to neonates and infants and the transmission of influenza to immunocompromised patients.	Agreed	Sentence added: Where healthcare workers may be at significant occupational risk of acquiring or transmitting a vaccine-preventable disease) a comprehensive occupational vaccination program should be implemented.
C2.	#62	Staff Immunisation I believe some reference should be made to staff immunisation requirements making it difficult if not impossible for work experience students to engage in work practices that would expose them to infectious agents. While the NHMRC IC Guidelines have guidance for immunisation on a disease basis it does not have the detail on an occupational basis as found in the Australian Immunisation	Noted and agreed work experience students that are going to be exposed to potential risks need undergo the same immunisation requirements	Change text to include work experience students but this is to be [placed in C2.2.1 staff screening policies.

		handbook. It would only add a few extra pages to include contemporary occupation based references from the handbook and provide a web-link for the Australian Immunisation Handbook. Perhaps occupational immunisation recommendation could be covered in Section C 2.4	to those on clinical placement .	
137	#51	Suggested change: A questionnaire (with recording of information gained) should check for details of medical and immunisation history history, particularly for rubella, measles, mumps, varicella (chickenpox), herpes simplex, Hepatitis B, immune disorders and skin conditions, and for prior exposure to tuberculosis (including working in high-risk settings and high-risk demographic background). It should also include latex allergy and risk factors for latex allergy (e.g. atopy), Reason: An immunisation history is needed to ascertain immunisation needs. A history of latex allergy or latex allergy risk factors history will influence decisions about the type of disposable gloves to be provided to the worker for infection control.	Noted this would be capture in the medical assessment	Latex allergy is referred to in the gloves section B1.2.
137 C2.2	#70	The only acceptable standards for evidence of immunisation are 1. documentary evidence that each dose of vaccine has been given or 2. serology. The only possible exceptions to this are 1. for measles (but not rubella or mumps) birth during or before 1966 & 2. a history of chicken pox for varicella immunity (Australian Immunisation Handbook page 315.) Except in these 2 situations, it is extremely unwise to substitute a "questionnaire (with…..details of medical history…..for rubella, measles, mumps, varicella……hepatitis B…..) or indeed to imply that information about these vaccine-preventable diseases can be gleaned in this way without documentation of actual vaccination. The national infection control guidelines should be consistent with the Australian Immunisation Handbook See p23 of the Australian Immunisation Handbook "if documentation cannot be produced, assume that the vaccine has not been given…." . Listed among the "False contraindications to vaccination" in table 1.3.4 on page 21 of the Handbook is "poorly documented vaccination history". The only deviation form this relates to pneumococcal (not specifically relevant for HCWs) & D-T vaccines given in the last 5 years, where this history should be elicited because of the risk of local reactions (see	Agreed. Each jurisdiction currently has policies as to the level of evidence required local policies will	Referred to Immunisation handbook Pre vaccination screening. http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/handbook-prevaccination-screening

		Australian Immunisation Handbook page 23 “Adults>= 18 years) . Even in this circumstance an effort should be made to check with the previous immuniser.		
C 2.2.2	#46	immunisation and P138 staff records should be removed from the guidelines	Disagree	Employers and health care facilities need to retain details of screening results and immunisations provided, including vaccine preventable disease history, date and results of serology, record of immunisations consented/ refused, date given and batch number, type and brand name of vaccine. Records need to be secure and accessible by authorised personnel when needed. Updated when relevant events occur. Maintained in accordance with the confidentiality and privacy laws
138 C2.2.3	#42	Staff records- facility should update records of vaccination given by them but should not be responsible for records at commencement of employment.	Noted Records need to be stored separate to staff applications and appointments	
138 C2.2.3	#25	C2.2.3 Staff Records – mention that immunisation records need to be readily accessible to address management of blood and body fluid exposures/outbreak management	Agreed	
138 C2.2.3	#75	This paragraph should include information about the need to maintain privacy in relation to record keeping	Noted and Agreed	Included in above
138	#51	Statement: Should such healthcare workers subsequently develop work-related infections, it is most likely that the healthcare establishment would not be found to be in breach of its duty of care. Suggested change: This statement should be deleted. Reason: It is potentially misleading. For example, if a worker refuses immunisation and the employer continues to expose the worker to risk without considering alternative ways to manage the worker’s exposure, then the employer may be found liable if the worker subsequently	Agreed	Delete and replace with below

		develops a work-caused illness		
138	#51	Statement: The management of vaccine refusal Suggested change: The management of vaccine refusal, contraindication to vaccination and vaccine non-response, for example by ensuring appropriate work placements, work adjustments and work restrictions. Reason: This will cover a wider range of scenarios where non-immune workers need to be appropriately risk managed, and provide examples of ways in which this may be achieved.	Agreed	Include text The management of vaccine refusal, contraindication to vaccination and vaccine non-response, for example by ensuring appropriate work placements, work adjustments and work restrictions
138	#55	Page 138 – staff refusal to comply with vaccination, "it is most likely that the healthcare establishment would not be found to be in breach of its duty of care", previous legal advice given to Qld is that the staff member is still entitled to workers compensation claims etc	Agreed	The management of vaccine refusal, contraindication to vaccination and vaccine non-response, for example by ensuring appropriate work placements, work adjustments and work restrictions.
		Table C1 will be replaced by table 2.3.6 from Immunization handbook http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-specialrisk238		
Table C1	#1	The Guidelines state that: Hepatitis A immunisation is recommended for healthcare workers in paediatric wards, ICUs and emergency departments that provide for substantial populations of Aboriginal and Torres Strait Islander children, and nursing and medical staff in rural and remote Indigenous communities	Agreed.	Immunisation handbook table will address this.
Table C1	#58	Hep A staff include endoscopy units, operating theatres and child care centres funded by health care facilities	Noted.	Table will refer to immunisation handbook
138 Table C1 and C2	#70	Table C1 from the Australian Immunisation Handbook has been (obviously) truncated. The "†" in the table in the MMR row refers to the footnote "†" : All adults born during or since 1966 should have evidence of either receiving 2 doses of MMR vaccine or immunity. Adults born before 1966 are considered to be immune due to extensive measles circulating widely in the community during this period of time" The real value of immunisation in protecting against infection is by achieving high levels of vaccination in a community. Not only should records of individual HCW vaccination be kept but a healthcare institution should be able to provide regular, institution wide data on levels of vaccination among its HCWs & this data should be regularly	Agreed.	Guideline will refer to immunisation handbook

		provided to the management		
138 Table C1	#51	An explanation should be provided for the symbol † which follows the wording MMR (if non-immune), i.e. † all adults born during or since 1966 should have evidence of either receiving 2 doses of MMR vaccine or immunity. Adults born before 1966 are considered to be immune due to extensive measles circulating widely in the community during this period of time. (Reference Australian Immunisation Handbook http://immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-specialrisk238 The statement Hepatitis A is recommended for healthcare workers in paediatric wards, ICUs and emergency departments that provide for substantial populations of Aboriginal and Torres Strait Islander children is taken from the superseded 8th edition of the Australian Immunisation Handbook. The current edition of the Handbook recommends hepatitis A vaccination for healthcare workers who work with remote Indigenous communities in NT, QLD, SA and WA, and medical, dental and nursing undergraduate students. The draft Guidelines only provide information on the immunisation recommendations for all healthcare workers and not for those working in specific situations. Without this, the immunisation information is incomplete and potentially misleading as healthcare workers may not be aware of additional vaccination needs. This information should include: • Healthcare workers who may be at high risk of exposure to drug resistant cases of tuberculosis: BCG • Carers of people with intellectual disabilities : hepatitis A and hepatitis B • Staff of nursing homes and long-term care facilities: influenza • Providers of home care to people at risk of high influenza morbidity: influenza • Laboratory personnel routinely working with other infectious agents: anthrax, vaccinia poxviruses, poliomyelitis, typhoid, yellow fever, meningococcal disease, Japanese encephalitis • Workers assigned to the outer Torres Strait Islands for a month or more during the wet season: Japanese encephalitis. (Reference: Australian Immunisation Handbook http://immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-specialrisk238. Information should be provided on serological confirmation of post-vaccination immunity for hepatitis B. Specifically, it should include the recommendations of the Australian Immunisation Handbook for post-	Agreed	Guideline will refer to immunisation handbook.

		vaccination serological testing 4 to 8 weeks after completion of the primary course of hepatitis B vaccination for those at significant occupational risk, for example healthcare workers whose work involves frequent exposure to blood and body fluids. (Reference Australian Immunisation Handbook http://immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-hepatitisb) Information should also be provided on managing non-responders to primary hepatitis B vaccination		
		Table C2 Exclusion periods for HCW modified from Staying Healthy in Child Care - Preventing infectious diseases in child care - Fourth Edition		
Page 138 C2.3	#25	Exclusion Periods for Healthcare Workers with Acute Infections – Last bullet states 'observe standard precautions….' which may be bit redundant as this is a daily practice and not something specific to disease specific restrictions….unless it's there for added emphasis	Agreed	Bullet point deleted.
139 Table c2	#55	Table C2 infectious diarrhoea – states staff must not come to work while symptomatic OR until 48 hours after symptoms have resolved. This should be AND.	Agreed	Typo will be amended.
139 Table c2	#25	Canadian guidelines differ in the number of days off required for Influenza (5 days from symptom onset) Other similar guidelines include the following organisms and information in documents similar to Table C2, including: (for specific information, please reference the OMA/OHA communicable disease surveillance protocols guidelines): • Influenza immunization, staff restrictions and chemoprophylaxis • Pertussis immunization, staff restrictions and chemoprophylaxis • Adenovirus conjunctivitis, staff restrictions • CMV work restriction for protection of staff and patients • MDRO screening in workers implicated in outbreaks • Group A strep screening, work restrictions and antibiotic prophylaxis • Measles, Mumps, Rubella and Varicella immunization, staff restrictions and post-exposure prophylaxis • Gastrointestinal illness including advice for specific pathogens including salmonella, shigella, norovirus and specific advice for outbreaks. • HSV staff restriction and management of open sores • Staph infection + strep infection states 'hospital food'…for inclusiveness, should be "healthcare facility food" or "patient/client food" • Page 140 Viral respiratory tract infections: states staff should be	Comments noted .	The table has been amended and the exclusion periods for HCW will be monitored as a part of the ongoing review process as additional evidence on viral shedding emerges. Additional text will be added to reinforce to HCW that if they are unwell they should not return to work Include separate section for noro.

		excluded until HCW are no longer symptomatic…. suggest adding or changing to a phrase that specifies that staff are no longer soiling their environment, i.e. coughing, sneezing, runny nose.		
139	#17	Table C2 Should dressings be occlusive for Staphylococcus and Streptococcus?	Yes	Amend to occlusive dressing
C2	#80	Herpes Zoster (Shingles) Infection While it might be technically possible for staff to provide direct patient care with active lesions that are covered, in the interests of both patient and staff safety that the individual be restricted from direct patient care duties until the lesions are no longer active. Influenza Recommend addition of "when medically cleared and/or no longer symptomatic	Shingles needs to be assessed on the basis of risk the HCW poses to the population group it interacts with.	Table has been modified to reflex comments. Evidence on viral shedding of Influenza will be monitored.
139	#58	Scabies and Lice: excluded until 1st treatment completed Staph infection: excluded from clinical duties until lesions are healing	Agreed	Amend text inline with comments
140	#51	Suggested change: This may involve appropriate work placements, adjustments or restrictions, or deployment to a role involving less risk. Reason: This provides a broader range of risk reduction strategies than just redeployment.	Agreed	Accepted text to be inserted
140 C2.3	#44	Exclusion periods: Suggest there is a reference to HCWs who are pregnant, and also HCWs working with pregnant women.	All exclusions still apply regardless of pregnant status	No change to Guideline
140	#51	The statement Those without immunity to … cytomegalovirus…, or who have not had cytomegalovirus infection should be deployed if they are at risk of contracting these diseases through their work should be amended so that all pregnant healthcare workers (both CMV seronegative and seroimmune) have the opportunity to avoid contact with patients who have CMV infection or who are in a known high risk group for CMV infection (e.g. immunosuppressed patients). This is because of the risk of intrauterine transmission of CMV caused by re-infection in pregnant women with preconceptual immunity to CMV, and subsequent congenital damage. (Reference: Boppana, S. et al. 2001, 'Interuterine transmission of cytomegalovirus to infants of women with preconceptual immunity', New England Journal of Medicine, 344(18):1366-1371; Ross, S.A. et al 2010, 'Cytomegalovirus reinfections in healthy seroimmune women', Journal of Infectious Diseases, 201:386-389). This section should also include a statement that pregnant health care workers should avoid exposure to patients with other infectious diseases that are associated with adverse reproductive outcomes, such as influenza (including pandemic strains of influenza	Noted. It is an emotive legal risk but can not exclude staff for being pregnant on the basis of CMV. There are studies that show that pregnant hcw are no more likely to acquire cmv or that it is more likely to employ it outside the health care setting through poor hygiene practices. The evidence provided is about reinfection. CMV can cause intrauterine damage in reinfected. We shouldn't be excluding seronegative. All pregnant women should be very strict about adhering to standard precautions.	We should delete the last sentence on page referring to CMV and reinforce the need for standard and transmission based precautions.

141 C2.4.2	#79	immunocompromised HCWs very brief. Referral to the Australian Immunisation Handbook and its recommendations for immunisation of immunocompromised HCWs, but it does not address the protection of patients from a HCW who has specific diseases, for example, cystic fibrosis where the HCW may have chronic infection with Pseudomonas aeruginosa	Agreed	Will refer to Immunisation Handbook
141 C2.4.2	#75	The addition of HIV to the immunocompromised healthcare workers is misleading. If someone has HIV, it does not necessarily mean they are immunocompromised. If someone with HIV is managed effectively on treatment, they may not be immunocompromised. This is a stereotype statement about persons infected with HIV	Committee disagrees with comment.	No change to Guideline
141	#79	C2.4.3 Health care workers who cannot perform HH due to damaged skin, must be furloughed, and forbidden to perform clinical care and assessed as fit for duty. C2.5 HCW who perform EPP must provide evidence of annual screening	Management of hand hygiene issues is outlined in section B1.1	No change to Guideline
141 C2.5	#80	The system of classification of procedures and associated risk of exposure (Table C3) is focussed on the surgical context, and on the transmission of infection from health professional to the patient. While there is no disputing that this context carries significant risk of harm to both patients and health professionals, a classification system hat adopts a more inclusive position may provide a much needed emphasis on nonsurgical exposures, such as needle stick injuries.	Noted.	No change to Guideline
141 C2.5	#75	There are SHEA recommendations now in ICHE March 2010, Vol 31, no 3, which categorises procedures by risk of transmission	Noted	No change to Guideline
141 C2.5	#67	Page 141, C2.5 The text has a reference to DoHA2004. If these guidelines are to replace the document noted should this be a reference?	Can still reference these guidelines	No change to Guideline
141	#3	Occupational exposure management – of the recipient; Why are we storing blood and not just doing a baseline for the recipient, logistics for storing in rural facilities, evidence to support this? If the recipient wants to have a baseline done is that permitted?	It has been recommended that baseline samples be stored to enable baseline testing. Testing of the exposed person must follow accepted guidelines, refer to Australian National Council on AIDS & Related Diseases (ANCARD) and Intergovernmental Committee on AIDS & Related Diseases (IGCARD) HIV Testing	Addition of ASHM website has http://www.ashm.org.au/default2.asp?active_page_id=251 Have jurisdictional guidelines on PEP. Additional text: It is important that each facility has its own specific policy on PEP.

			Policy, September 1998	
141	#69	There are SHEA recommendations now in ICHE March 2010, Vol 31, no 3 which categorizes procedures by risk of transmission	Noted.	No change to Guideline
141	#25	Categories of exposure: These risk categories seem to emphasize risk to patients, rather than risk to staff. The term "infection transmission prone procedures" may be more accurate as transmission could occur from the health care worker to patient or from patient to health care worker	This is how that have been defined in Australia	No change to Guideline
142	#78	Second dot point. Please specify what is regarded as a 'high titre'. Third dot point. Change the bracketed words to (by nucleic acid test). We suggest that a statement should be made as to what limitations on practice, if any, should be placed on a HCW who is HTLV-I positive. Second paragraph refers to current notification requirements for bloodborne viruses as being by name or code. We assume that this is for all persons and not just HCW. However, this is not clear.	He committee have approached ASHM for measure of a high titre level and are awaiting a response. However this level of detail is beyond the scope of the guideline	Change to nucleic acid test accepted and additional information can be obtained on occupational exposure on ASHM website for this section. http://www.ashm.org.au/default2.asp?active_page_id=251%20
Page 142	#25	Responsibilities: First line…suggest adding 'training' to appropriate information, testing etc., as receiving information and being trained are different Second paragraph: . . . poses a threat to public safety?..seems a little strong in light of the fact that there could be many registered/licensed practitioners who are just as much a risk but haven't been diagnosed or disclosed. Consider rewording	Accept first comment but not to second	Will amend first paragraph.
143	#81	2nd para is reference C2.5. correct	Cant find reference.	??
143	#31	4th para: There is a difference, which is confused here, between exposure to needlestick injuries and exposure to bloodborne virus infections. The USA mandated safety devices in response to the number of needlestick injuries occurring when accessing IV lines. However, this type of injury is extremely unlikely to result in a bloodborne virus infection. To prevent bloodborne infections, high risk needlestick injuries – such as after venipuncture or cannulation – need to be prevented. This is where resources to increase safety should be prioritised	Accept	Delete sentence that refers to Pratt in 4th para.
143 C2.6.2	#66	Should emphasise importance of timely evaluation of exposure by person with knowledge in the area of occupational exposures so source, recipient can be assessed, counselled and appropriate prophylaxis implemented in recommended time frames for best outcome dependant on exposure type, risk, immune status. ? benefit of inclusion of reference document link re Oc exposures QLD Health or MMWR CDC documents re assessment and prophylaxis etc would be helpful	For people that have an exposure to a known source, PEP should be offered for HIV as soon as possible after the incident. ASHM guidelines are for non occupational exposure. They reference the state	Additional information can be gained from ASHM website as it provides jurisdictional guidance. Also WHO/ILO PEP guidelines http://www.who.int/hiv/pub/prophylaxis/guidelines/en/

			guidelines for occupational exposure. CDC guidelines had to be referred to for occupational exposure. WHO can be used too	Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm
143 C2.6.2	#25	• Note that post exposure testing should be done within 1 hour, 2 at the very maximum and then at the designated time e.g. 3 month, 6 month intervals • There should be a requirement to regularly audit blood and body fluid incidents to review that the policy is workable, known by staff and readily accessible and responsive especially on weekends, after hours and on national holidays. Access to PEP should also be available in a timely fashion as part of the post-exposure protocols. Consider including a statement that all Blood and body fluid exposures need to have an investigation component to prevent recurrences	Accept there needs to be an organisation specific policy for PEP. This is covered in C2.6.3	No change to text
143 C2.6.2	#31	This section is confusingly worded. It sounds as if PEP refers to the entire process not just the PEP medications. It talks about continuing PEP but is not clear at which stage initial PEP medications should be given. Inexperienced people reading this may assume that you do not give PEP until baseline testing of the source and HCW have been done. Whereas, of course, that would be breaching the duty of care by delaying initial PEP far too long. The best advice is that PEP should be started as soon as possible if there is a significant risk of transmission (as described above) and then stopped if the HCW is already positive or the source definitively negative (with no possible risk factors in the window period). Post-exposure prophylaxis to prevent HIV infection. Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection. Geneva 2008 http://www.who.int/hiv/pub/guidelines/PEP/en/index.html would be good to include in the references as they developed an algorithm for giving PEP Need to state that standard guidelines for pre-test counselling or pre-test discussion for HIV, HBV and HCV must be followed when testing the	Accept Will refer to resources.	Initiation of HIV PEP depends on the type of exposure, the source's stage of HIV infection, the source's HIV viral load and the source's history of HIV antiretroviral therapy. Therefore, a thorough assessment of risk guides the actions to be taken Initiation of HBV PEP is dependent on the type of exposure, the source's HBsAg status and the exposed persons HBV immunisation history. Hep C At this time, there is no

		source and the HCW.		prophylaxis proven to be effective. The aim of follow up is to detect acute hepatitis C as soon as possible so that appropriate management can be instituted
P143 C2.6.1	#78	Third paragraph. The sense of the second sentence is unclear, perhaps due to punctuation or syntax	Noted.	Misplaced comma. Has been fixed.
144	#25	Add “no recapping of needles	Accept.	Add text
C3 Education and training				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
	#39	Accreditation to avoid infection risks associated with visitors to the perioperative environment The Guidelines include standards for healthcare workers in the perioperative environment. The standards cover attire, movement in and out of the theatre, removal of jewellery and artificial nails and nail polish. There is additional scope for the Guidelines to include mandatory safety training and education for all individuals in operating theatres	Noted reference to ACORN will be added to Appendix D.	Reference can be placed at end of section
	#39	The Guidelines should reference current standards and training, e.g. ACORN (Australian College of Operating Room Nurses) and MTAA: Introduction to Operating Theatre Protocols. MTAA has developed training in consultation with ACORN and NSW Quality and Safety Branch. It is designed to familiarise new medical company personnel with ACORN standards and protocols for visitors to the perioperative environment and includes aseptic techniques, principles of infection control, OH&S issues and patient and confidentiality requirements. The training has been approved by the ACORN Board and is reviewed every two years in line with the review of the standards.	as above	no change
	#39	The Guidelines should refer to the ACORN standards for Perioperative Nursing (2006), specifically Standard 24 (S24) which provides guidance to the perioperative team regarding access and presence of visitors within the operating suite. It should be noted that the current ACORN Standards are under review. The next edition of the Standards will be released in May 2010.	as above	no change
145	#17	Practitioners should be professionals	Agreed	Practitioners should be changed to professionals
145 summary	#25	• Last bullet – terminology is unclear: are carers a synonym for health	Noted	Use the term patients,

		care workers? • Records of ongoing training/professional development should be maintained	Record keeping covered in C3.2	their carers and their families
145	##20	This was a large study involving over 1400 students across four countries. The frequency of assessment on HH knowledge and skills influenced students' HH knowledge and practices (among other things). Students are often quite driven by assessment in terms of the importance they attach to learning particular content. Perceptions of importance given to HH in the curriculum, and by clinical supervisors and clinical facilities influenced HH beliefs, highlighting the important role of workplace socialisation in influencing students.	Comments noted	no change
145	#35	Engagement of healthcare companies to provide product in-service as well as relevant clinical product-related education, training and support is an important resource to assist clinicians and institutions in the application of a systemic approach to Infection Control.	Agree for the need for in-service but need to be avoid the issues of conflict of interest	no change
145	#46	in regards to infection control professionals' level of qualification literature supports training for an infection control professional and it has an impact on the outcome of an infection control programme in favour of a minimum qualification of graduate certificate and the development of a novice to expert framework which can be phased in over time	Noted and agree but not within the current scope of the guideline but related to the capacity building program of the Australian Commission for safety and quality in healthcare	no change
147	#25	o Specific information about education for cleaning/disinfecting for the appropriate staff would be beneficial e.g.: • Staff should be educated about special cleaning procedures needed for certain equipment. The manufacturer's recommendations should be followed • Contact time, temperature and concentration of cleaning/disinfection products must be adhered to according to manufacturer's instructions Staff training needs to occur when a new piece of equipment or process is instituted and records maintained of this training	Agreed and points have been addressed but not to such detail	need to include education and training on the use and management of new equipment
147	#17	Use another eg for caring for patients with hep B in a general medical ward	Agreed	Change example to caring for a patient of airborne precautions in –ve pressure room
P147	#78	. Sixth dot point. Only respirators are fit-checked, not masks.	Agreed	change to fit checking of respirators
149	#81	aren't medical staff health care workers	Agreed	Change to HCW
149	#25	• Hand hygiene placement needs to be part of educational sessions • Mention use of audits as an opportunity for education of staff	Comments are not specific enough for comment	Cross reference to C3.5.1 in regards to feedback

			however placement of hand hygiene products is outline in section B1.	from audits in other opportunities for education
149	#46	the example of hand hygiene programs as an education initiative is probably well supported financially in Victorian hospitals. Infection prevention and control programs are not well supported financially or with adequate FTE. If the hand hygiene initiative was given to infection prevention professionals with the financial supporting and FTE, this would be welcomed	Funding for hand hygiene programs was provided by jurisdictions and ACSQHC	no change
150	#46	I think mentoring is a very unrecognized area, and the fact that mentoring especially for novice infection prevention professionals is extremely time-consuming and not recognized as additional to your own workload.	Agreed	add comment- Mentoring requires support of administrators as can be a time consuming and be an additional workload
C4 Surveillance				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
C4	#36	Surveillance The papers currently referenced in your draft are perfectly accurate but are out of date in that electronic surveillance was not in use at the time of writing – and the world of Surveillance has moved on since then in particularly UK and USA – but sadly not in Australia for various political reasons.	The Surveillance section has been drafted to align with the planned national surveillance strategy for HAI proposed for the ACSQHC in order to provide a coordinated approach	No change to text
C4.2 152	#36	Without electronic surveillance it is not feasible to conduct facility-wide surveillance for all events; therefore surveillance is often targeted, with a focus on specific events, processes, organisms, medical devices or high-risk patient populations	Comment noted however electronic surveillance is not the only option for health care facilities	No change to text
C4 153	#36	Appropriate Case Management and Surveillance can substantially reduce healthcare-associated infections, morbidity and mortality. Both outcome and process measures are used for surveillance in large health facilities; process measures alone can provide a useful alternative, particularly in smaller facilities. Timely targeted feedback is critical for effective surveillance which can be most easily achieved with Electronic Surveillance	Comment noted however it is beyond the scope of the guideline to provide detailed information on this subject. Additional resources have been reference	No change to text
	#36	Suggest inserting a section (C4.6) on electronic surveillance – sample text provided C4.6 ELECTRONIC CASE MANAGEMENT & SURVEILLANCE SYSTEMS Systems which are now commercially available are designed to replace	Comment noted but beyond the scope of the guideline	No change to text

		practically all manual entry of data onto either a paper based system, An Excel Spreadsheet or similar. A full case management and surveillance system should save about 25% of an infection control nurses total working time and thus allow much more time for ward rounds and training.		
C4	#39	C4 Healthcare-Associated Infection Surveillance MTAA strongly recommends that the Guidelines address reporting standards and public disclosure of infection rates in hospitals. The Guidelines note that: "Australia currently has no system-wide approach to measurement of patient mortality caused by or associated with HAI". This differs from overseas approaches. The UK's National Health Service individually evaluates deaths caused by infection. Recent legislation in the US allows the Centers for Medicare and Medicaid to adjust reimbursement to hospitals in those cases where patient outcome has been impacted by infection (complications due to preventable infection are reimbursed at the same rate as a non-complicated treatment)33. The US Deficit Reduction Act provides that payment can be withheld if hospitals do not comply with preventative measures. This evidence-based approach has been shown to decrease adverse outcomes by individual care providers34.	Noted but beyond the scope of the guideline	No Change to text
154	#46	I think the addition of a sentinel events section would be important within the document. This process is more developed internationally e.g. through APIC – Association for Professionals in Infection Control in America, where publications presented at the National conference, outlines that infection prevention and control sentinel events causative factors are different to general health care sentinel events. Comment I may have missed this, however the laboratory systems for data look back is very limited. (I am unable to review a particular organism over a specified timeframe and look at the incidence). This is a significant risk issue. I have been able to do this in other healthcare facilities in other countries	Comment noted however it is beyond the scope of the guideline to provide detailed information on this subject.	No Change to text
155	#70	Outbreak Surveillance: this section doesn't describe any surveillance activity beyond the first two dot points. The rest seems to be just a précis of the previous section B3.2 & should be deleted	The purpose of this section is to provide an overview of HAI surveillance. Additional text has been provided to assist in the clarification of this point	Integrate added text below
156	#81	-Another reference to SARS – is that still considered an emerging disease? -What is the "correct abbreviation for Community acquired MRSA? CA – MRSA or cMRSA, or Non multi resistant MRSA (NMRMRSA	Committee agrees	Remove SARS ensure CA –MRSA consistent through out document

155	#35	In planning and preparation hospitals should give high priority to forecasting their potential range of equipment and supply needs in the event of an outbreak. These forecasts should be shared with medical device and equipment suppliers prior to any outbreak so as national supply contingencies can be implemented and their ability to maintain supplies continuously safeguarded where possible	This is not within the scope of the guidelines	No change to guideline
C4.6	#75	This section on “Notifiable Diseases” does not readily communicate the need for urgent notification and action when one is suspected or diagnosed. Nor is there a section on Quarantinable Diseases	All quarantinable diseases are also notifiable and CHO will be notified by Public Health Authorities in the jurisdictions.	No change to guidline
C5 Antibiotic stewardship			**Committee consideration**	**outcome**
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
C5.3.1	#36	Insert at end: Some automated surveillance systems offer the ability to incorporate pharmacy data to individual patients infections. These offer an automated solution to the efficient and timely response to the pharmacist’s decision of therapy pathway.	Noted but too prescriptive for guideline	No change to Guideline
	#65	Section C5 Antibiotic Stewardship The principles of antibiotic stewardship are supported. However, there appears to be a notable absence of reference to patient outcomes and review in evaluation of the efficacy of antibiotic therapy. Whilst it is absolutely supported that antibiotics must be used judiciously, wound infection must also be treated and monitored with clinical adequacy and effectiveness. Therefore, including a statement regarding clinical response to antibiotics is recommended for consideration.	The committee considers that the Clinical response, treating and monitoring infection and/or wound management is a component of AS not in addition to it and only one reason why infection outcomes may not be optimal.	No change to Guideline
158	#60	Antibiotic Stewardship Programs. Revise wording to encourage antibiotic stewardship to be introduced into Private Hospitals also (refer back to introduction section).	In the guideline there is no distinction between public and private in this section The term Australian hospitals is inclusive for both.	Note typo in paragraph 3 line 2 of example 'nit' should read 'unit'.
159	#44	These methods would be difficult to implement routinely in the private sector due to limited resources, and outsourcing of Laboratory and Pharmacy Services, with limited service agreements/computerised programs/expertise, etc. as per above. Consideration should be given to other methods, eg. auditing the appropriate use of prophylactic antibiotics for eg. defined procedures, eg. hip replacements, inc	Comments have been noted however the committee disagrees. Clinical governance should ensure that prudent use of antibiotics is an essential	No change to Guideline

		type, dose, frequency, etc.	component to prevention and management of HAI. In addition the other component suggested are listed in table C4	
C6 Facility design				
Page	**Who**	**Comment**	**Committee consideration**	**Outcome**
C6	#21	Lack of adequate standards in Australia with regards to quality airflow circulation and ventilation in health care. Propose NHMRC champion the development of a new Australian Standard specifically for ventilation of health care facilities. Revisions of international guidelines demonstrate an ever increasing need of directional airflow and pressurisation of spaces in health care and which Australian Standards have not yet kept pace with. In the US 1/3 of hospital acquired transmissions are claimed to be related to airborne transmission paths which is backed up with importance of AIR in CDC's 2003 publication - Guidelines for Environmental Infection Control in Health care facilities which is also referenced in your draft report. From my own observations about air 1. airborne spores attach to people, clothing and shoes 2. people bring airborne infections into areas . 3. pathogens transmitted by respiratory droplets via the air 4. bacteria on skin squamae and contaminates get into the air 5. air current paths carry particulate onto surfaces, into lungs. My international reference is ANSI/ASHRAE/ASHE Standard 170-2008 - an engineering standard for ventilation design of health care facilities in the US. The maintenance levels of ventilation systems should also be heightened and this cost should be related to infection control instead of just air conditioning.	Comments noted but currently not within the scope of the guideline however this information will be forwarded to the appropriate agencies and considered in the ongoing review of the guideline	No change to text
161 C 6 Summary	#81	Dot point 1 – please add 'practical' to this statement – there is no point putting carpet down if it is difficult to clean and prone to staining. Also – please clarify 'surfaces' to include floors, walls, benches, fixtures and fittings etc – consider the need for windows that open in non acute settings – aged care, mental health, rehab etc – not all work flow is done from clean to dirty – in equipment reprocessing it is done from dirty to clean – Adequate storage is required for all patient care equipment,	Noted	'Surface"needs to be defined and the additional points to be included in C6.4

		not just 'clean and sterile items'.		
161 C 6 Summary	#60	Include role of ante rooms outside negative pressure / purpose built isolation rooms	Noted but placed in C6.3	The role of anterooms to be included in C6.3 From AHFG Anterooms enable visitors and staff to change into and dispose of appropriate PPE when caring for an infectious patient. Anterooms increase the effectiveness of isolation rooms by reducing the potential escape of airbourne infectious particles into the corridor. Ideally the pressure in the anteroom is lower than that of ambient pressure in the adjacent corridor.
C6	#25	• Recommend adding a comment around the need to properly design for waste management. This can include the need for dedicated patient washrooms, dirty utility rooms accessible and with proper waste disposal mechanisms (washer disinfectors, macerators, hoppers etc.). • Spray wands have virtually been eliminated from use in Canadian design and if this is a current practice in Australia it should be discussed. • Personal protective equipment (PPE) access is also a frequently overlooked design element. All rooms should have access to PPE and it can be valuable to plan ahead for this by putting in alcoves or dedicated areas for this purpose.	Noted	Include additional points in C6.1 on storage such that PPE is accessible and available
162	#78	Filtration. See also the definition of HEPA on page 196. Is a HEPA filter the same as a P3 filter? This should be clarified. In simplified terms,	Filtration reference HICPAC guideline 4	Amend reference also add

[4] Sehulster LM, Chinn RYW, Arduino MJ, Carpenter J, Donlan R, Ashford D, Besser R, Fields B, McNeil MM, Whitney C, Wong S, Juranek D, Cleveland J. Guidelines for environmental infection control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago IL; American Society for Healthcare Engineering/American Hospital Association; 2004.

		under AS/NZS 1716:2003, a P3 filter should not allow penetration of more than 0.05% (i.e. retains >= 99.95%) of particles with a mass median diameter of 0.3 microns. The use of the words 'as small as' in the draft guidelines is misleading. 0.3 microns is the size for which such filters are least efficient. Particles larger and smaller than this are trapped more efficiently. The Sehulster (2004) reference cited does not refer to 99.97% efficiency in removing particles of 0.3 micron diameter. This situation is confused by the fact that there are two papers published in 2003 (not 2004 as cited in the NHMRC draft) with the same title, and with the same lead author. One is the full version of the guidelines, 249 pages long, and the second, which is cited in the NHMRC draft, is Part 2 only of the full version published in MMWR, and is about 42 pages long. The full version lists two authors and about 12 other 'contributors'. The MMWR publication, i.e. Part 2 only, lists only two authors. It is suggested that the paragraph in the NHMRC draft be reviewed and possibly modified, and a decision taken as to which of the Sehulster references should be cited	cited (3) Streifel AJ. Design and maintenance of hospital ventilation systems and prevention of airborne nosocomial infections. In: Mayhall CG, ed. Hospital epidemiology and infection control, 2nd ed. Philadelphia, PA: Lippincott Williams & Wilkins, 1999:1211–21	Heating, ventilation and air-conditioning systems shall control the concentration of airborne particulates in high risk areas to minimise the risk of infection by means of air pressure, flow control and air filtration. The level of control shall be proportional with the risk. Need to include compliance with AS 1324 - 'Air filters for use in general ventilation and air-conditioning' and AS 4260 - 'High efficiency particulate air (HEPA) filters - Classification, construction and performance'. Isolation room engineering requirementsTS 11 Engineering and Sustainable Services. available in the NSW Health Infection Control Policy (Circular 2002/45, NSW Health 2002
162	#25	• Using airborne, aerosol and isolation in the airborne section is confusing. It might be helpful to define each term in the context of design to help readers understand the precise manner in which the terms are being used. • Canadian guidelines distinguish between truly "airborne" pathogens (e.g. TB) and organisms that may incidentally be carried by air currents, but are not considered airborne (e.g. S. aureus on skin cells). Since this is a new use of the term, it might be worth dedicating a separate section to this issue	• Noted, will use consistent language in text. • the terms have been defined in the glossary • beyond the scope of the Guideline to provide too much detail on ventilation rates	ProvideCAS Z317.2-01Special Requirements for Heating, Ventilation, and Air Conditioning (HVAC) Systems in Health Care Facilities as a resource

		• Recommend consulting with CAS Z317.2-01Special Requirements for Heating, Ventilation, and Air Conditioning (HVAC) Systems in Health Care Facilities. This standard has a great deal of useful information for the ventilation system considerations. Of particular importance the need to design isolation rooms with monitoring systems for safety. These monitors should include visible and audible alarms for room failure. There are also references to minimum requirements for static pressure differentials between specially pressurized spaces, which are critical to ensure the areas are isolated from each other		
162	#54	In section C6.2.4 (Reducing water-borne transmission), some mention should be made of dental unit waterline biofilms, and the various ways of reducing this.		
163	#51	Aerosol droplets Suggested change: Aerosols. Reason: To avoid confusion between droplet and airborne transmission	Noted and accept	remove droplet from 2nd dot point
163	#17	Insert example of negative airflow pressure	Noted	Examples, varicella, measles Tb
163 C6.2.2	#25	• Hand Hygiene: in this section at a minimum it should be mentioned that all in-patient rooms require dedicated hand hygiene sinks separate from those located in the patient bathrooms. • It might be more useful to move the “staff preference” section about alcohol hand sanitizer selection to a different area of the document. Selection of the product isn’t as relevant in the design section, but is important information. • Adding point of care access to alcohol products is recommended.	Noted and accepted.	Staff preferences moved to section B1.3. Insert comment on availability of hand basins for HCW that are separate to patient bathrooms. In additional ABHR need to be suitably located out of the reach of children or in supervised locations. Careful consideration for placement of ABHR in mental health facilities, and alcohol withdrawal units Further guidance is available from HHA
164	#81	Floor coverings – OH&S issue relating to movement of wheel patient care equipment over carpeted floors	Noted and covered by TS7 floor coverings in healthcare facilities	no change
C6	#61	Main Point Summary - Carpet poses no adverse health effects when well maintained - There is no evidence that carpet contributes to the outbreak or spread of injections - Healthcare carpets are specifically designed for healthcare environments and are easy to keep clean when maintained	Noted and agreed the guideline does not recommend that carpet is not used in HCF rather that facilities consider what potential role flooring plays	see additional points below add reference link to Floor Coverings in Healthcare buildings

		appropriately - The perceived advantages of hard flooring over carpet are not substantiated by the evidence available - Other positive health effects of carpet should be included in the draft guidelines - noise abatement, better healthcare worker ergonomics, lower risk of falls and less injuries etc.	in the risk of transmission of infection within the facility This section will be broaden to all flooring	http://www.healthfacilityguidelines.com.au/hfg_content/guidelines/aushfg_TS7_FloorCoverings221009.pdf
C6	#61	Carpet It is relevant to note that US Centers for Disease Control and Prevention (CDC) Guidelines for Hand Washing and Hospital Environmental Control stated that 'recommendations against the use of carpet in patient care areas have been removed. Since there is no epidemiologic evidence to show that carpet influences the nosocomial infection rate in hospitals, whether to use carpet, therefore, is not considered an infection control issue'. The CDC guideline still applies. However, carpet is not advised for use in areas where there may be excessive or frequent spills, such as emergency and trauma areas, operating theatres, surgical recovery rooms, and laboratories. (CDC, 2003) Furthermore CDC guidelines do not recommend against using carpet in patient-care areas. (Ulrich S et al, 2008) CIAL agrees that it is not advisable to use carpet in areas exposed to excessive or frequent spills and would add to the list ensuites, wet areas and kitchens. The draft guidelines do not substantiate with evidence the recommendations on where and where not carpet should be used. No differentiation between a healthcare carpet and other carpets suitable for use in offices and general areas of healthcare facilities. Similarly there is no evidence to support the recommendation to use hard surface in a single patient room rather than a healthcare carpet.	Noted and agree. The guidelines advocates that a risk assessment be undertaken to determine the infection prevention aspects of choosing flooring. Other considerations are also required that are beyond the scope of this guideline. Further information provided in the AHFG and TS7	No change to text
164 C6.2.3	#61	Benefits of carpet outlined in submission. Response to text in guideline for floor coverings as follows 'Perceived Advantages of Hard Surfaces' The draft guidelines then discuss the perceived advantages of hard flooring in terms of infection control. CIAL disagrees for the reasons mentioned below. 'Easier to clean' Hard surfaces need to be mopped 2/3 times a day and vacuumed, requiring more manual labour than a carpeted floor. Hard surfaces also require periodic stripping and re-sealing, which can be disruptive for patients and staff. 'Easier to disinfect' Solution dyed nylon healthcare carpets are engineered to withstand	Noted the guideline does not recommend that carpet is not used in HCF rather that facilities consider what potential role flooring plays in the risk of transmission of infection within the facility Additional text on complying with manufacturer's instruction	Textile floor finishes should not be considered unless there is a comprehensive maintenance and replacement program in place complying with AS/NZS 3733 Textile floor coverings Cleaning maintenance of Residential and

		aggressive cleaning chemicals. 'Costing less, as disinfectant is less expensive than steam cleaning' The life cycle cost of maintaining carpet is less than vinyl, which is commonly used in healthcare facilities. (Bishop 2002) 'There is less surface area so hard floor coverings are less likely to act as a reservoir than carpet' Carpet is not a hand touch surface so the most important factor for the health of the staff and patients is the concentration of airborne contaminants. It has now been clearly established that there is significantly less inhalant particles in the air in carpeted rooms than non carpeted rooms. Carpet acts as a very effective filter by securely holding dust particles within the fibrous pile mass until safely removed by a properly functioning and well maintained vacuum cleaner and periodic deep cleaning. Additionally, carpet reduces the risk of slips and falls resulting from liquid spills. Unlike hard floors, healthcare care with a moisture barrier backing can withdraw and contain the liquid in a localised area until removed, thus reducing the risk. 6 'There may be occupational health and safety issues relating to staff vacuuming compared with mopping' Maintaining hard surface is more labour intensive than maintain carpet, hence there is a greater risk of occupational injuries. Hard floors require both vacuuming and damp mopping. Slippery floors are a significant cause of slip and fall injuries in healthcare facilities and particularly in aged care. 'When additional cleaning is required, hard floor surfaces are easier to clean than carpet' Hard surfaces require mopping, vacuuming, polishing and periodic stripping and resealing. US data show that vinyl flooring is more labour intensive and significantly more expensive to maintain than carpet. It is also more difficult to replace hard surface than carpet. (Berry M, 2003 and Bishop J, 2002) The report states that 'the use of carpet can be controversial as it is perceived to be difficult to clean compared with hard floor coverings'. On the contrary, carpet is easy to keep clean when maintained by a trained technician in accordance with manufacturers' instructions and following the guidance provided by Australasian standard AS/NZS 3733.	added.	Commercial Carpeting as a minimum standard. Also add that care and maintenance of floor covering needs to consider manufacturer's recommendations
164	#47	Part C6.2.3; page 164; Floor coverings This is a controversial area because these products are not subject to regulation and evidence is held by manufacturers and must conform with ACCC requirements for accuracy. The cost component in this area does not easily lend itself to any formalised clinical trials and the literature does not have a single study that conforms to the NHMRC evidence guidelines which compares outcomes for patients on floors with hard versus soft floor coverings. As commented by Ulrich (Ulrich	Comments noted however outside scope of the guidelines additional references have been added to decision making on selection of flooring	No change to text

		2008), "…the CDC/hicpac guidelines do not recommend against the use of carpeting in patient care areas…" and this is because of other advantages for patients offered by selective use of soft floor coverings. In this section on design, one would have hoped to at least see that the types of products which are suitable for use in healthcare would be distinguished from traditional "carpet". Ulrich comments that the "…ease of cleaning should be a key consideration" (Ulrich 2008) in the selection of what soft floor covering to select and where it can be located. We agree, but we disagree with the comments on AGPCIH 2010 in regards to the comparison with hard floors. In fact, work published by Dancer (Dancer 2009) and Goodman (Goodman 2008) are studies involving cross infection with MRSA, via environmental surfaces which in every case were hard surfaces and certainly not soft floor coverings. Evidence held by these manufacturers may be commercial in confidence and be reflected only in technical support literature and not reflected in any peer reviewed studies within the medical literature.		
!63/164	#60	Control of Surface Contamination through Material Selection (page 164, 165). Although the document recommends that carpeting should be avoided in areas where spills are likely to occur recommend that this should be worded more strongly to include all acute care patient care areas including general wards.	Noted but this is a risk based guideline and alerts to the facility wide considerations.	No change to text
165	#11	Carpets should undergo thorough steam cleaning on a regular basis as set by facility policy, using a method that minimises the production of aerosols Reducing water-borne transmission – page 165-166 This is a real concern with all vacuum-equipped commercial cleaning equipment. Consideration should be given to the potential for aerosol contamination of surfaces and transmission for infection via water droplets and aerosols emitted from Scrubber Driers, Wet vacuums and Carpet Extraction equipment. Scrubber –driers scrub, clean and dry hard floors and are commonly utilised in all hard floor areas including operating theatres. Exhaust filters are available in very few models of vacuum equipped wet pickup devices	Depends on the floor type and manufacturers recommendations	No change to text
165 C6.2.3	#11	Workplace Health and Safety Document reference: Section: C6.2.3 Control of surface contamination through material selection. – page 64 there may be occupational health and safety issues relating to staff vacuuming compared with mopping. This is a generic statement without substance. The committee should consult Workplace injury rates for commercial cleaners, which are available from the WHS authority in each state, to substantiate this statement or else consider withdrawing it.	Noted and agree	remove dot point on cleaning
165	#12	Comment 3: Furnishings page 165	Comments noted and in	Add reference to

C6.2.3		A reference to AS/NZS:4849.1.2003 Upholstery Cleaning would assist cleaning management in developing appropriate strategies for maintaining upholstered furnishings. Comment 4: Choice of cleaning equipment for carpet in a healthcare situation and to ensure that the equipment is of sufficient quality to completely remove contaminants and leave the carpet as dry as possible. AS:NZS 3733 describes the suitable forms of equipment and broad specifications for the cleaning chemicals required to perform each method of carpet cleaning. Incorrect choice of chemical and equipment and lack of adequate operator training in the application of methodology increases the risk of inadequate removal of infectious material. Many healthcare facilities do not possess the correct equipment to extract or clean carpets adequately and we recommend that this be addressed by including a generic description of equipment and chemical required for HWE and spot removal. One of the issues in healthcare cleaning is the widespread promotion and use of twin cylindrical brush multipurpose scrubbers that are marketed for carpet cleaning in healthcare. These units do not adequately flush the carpet or remove residue as they do not utilise water pumps or vacuum extraction. Comment 5: Choice of floorcoverings and surfaces that are appropriate to healthcare environments Reference: C6.2.3 Control of surface contamination through material selection p 164 The comments regarding carpet and hard floor suitability for healthcare settings are generalised and do not take in the many variations in texture, porosity, construction and material utilised in both hard floor and carpet construction. The term 'hard floor coverings' is generic and could be taken to include stone, concrete, timber, vinyl, terrazzo, unglazed and glazed tiles, vinyl, all of which have differing methods of construction and varying degrees of porosity which would affect their suitability for the health care environment. Comment 6: Workplace Health and Safety Reference: there may be occupational health and safety issues relating to staff vacuuming compared with mopping" p 164 This is a broad and potentially misleading statement with risk involved. Elimination of carpet for hard floor will lead to a rise in risk of injury when mopping and using polishers, scrubbers and cleaning equipment, and similar with increased use of carpet. There are detailed injury statistics for the cleaning injury from each state WH&S authority and it is suggested that they should be consulted before including or publishing statements relating to Workplace Health and Safety and Risk management. Safety concerns should also be included with hard floor as there is an	part have been addressed. It is beyond the scope of the guidelines to detail chemicals use for cleaning.	AS/NZS:4849.1.2003 Upholstery Cleaning to resource list

		increased risk of slip and fall injuries on hard floor surfaces.		
165 c6.2.4		“Ice machine;” should state that ice machines with scoops should be used for external use only. In addition they should be emptied and cleaned regularly and be made accessible only to staff, and not patients and visitors.	Noted additional information from HICPAC environmental guideliunes used. Also add reference to AS/NZS 3350.2.24 (1998).	Ice Machines and Ice Machines that dispense ice are preferred to those that require ice to be removed from bins or chests with a scoop. Ice for human consumption need to be differentiated from ice for first aid of storage of clinical specimens Do not handle ice directly by hand, and wash hands before obtaining ice. Use a smooth-surface ice scoop to dispense ice. Keep the ice scoop on a chain short enough the scoop cannot touch the floor, or keep the scoop on a clean, hard surface when not in use. Do not store the ice scoop in the ice bin. Do not store pharmaceuticals or medical solutions on ice intended for consumption; - sterile ice should be used for this purpose Clean, disinfect, and maintain ice-storage chests on a regular basis as per manufacturers instructions. Flush and clean the ice machines and dispensers if they have not been

				disconnected before anticipated lengthy water disruptions.
165 C6.2.4	#81	reducing water borne transmission – sources Dot point 2 add 'ice' (such as drinking water and ice) – ice machines are mentioned on next page	Noted additional text provided on ice machines	
165	#47	1. The AGPCIH 2010 does encourage the selection of products upon which a demonstrated method of cleaning and decontamination can be preformed; 2. The document notes that the cleaning of carpet is "perceived to be difficult to clean compared with hard floor coverings", but there is no attempt to distinguish between the various types of soft floor coverings; 3. Soft floor coverings that are suitable for use in healthcare settings, with construction and installation characteristics that enhance cleanability and hygiene standards whilst providing the feel and aesthetic response of 'carpet' are not considered separately; 4. There is no attempt to separate performance characteristics for varying types of soft floor coverings separating say woven fabric with jute backing from say 100% Nylon spray floc or even the 100% Nylon tufted textiles with 100% water resistance; 5. The only references provided relate to carpet, but in fact the most common source of transmission of HAI organisms are hard surfaces and HTOs. There is not a single reference to carpet acting as a source or fomite for the spread or outbreak of HAI; 6. The issues for use of appropriate soft floor coverings are not included on the basis of personal bias of the authors (GPP evidence only) and the other issues with soft floor covering benefits are not considered; 7. Recommendations on where 'carpet' should not be considered/avoided (page 165) do not include any evidence basis for the what is recommended; 8. There is no study to suggest that a single patient room with soft floor covering that is suitable for use in healthcare settings, is in any way inferior to a hard floor surface; 9. The issue for soft floor coverings is focused around cleanability for which there is almost no published literature or studies in peer reviewed journals;	Comments noted and we have broadened the text to healthcare flooring. TS7 provides guidance on the considerations that need to be given to the selection of floor coverings in a HCF	No change to text

		10. There is considerable scope to have Carpet Institute of Australia members, or their foreign principles, consider further research to validate the cleanability of the healthcare products currently offered for sale in Australia. This work would need to be conducted at a third party research institution (a university or CSIRO or equivalent) and the results would be published in a suitable peer review journal. Recommendation: 1. That specific feedback be sought from this industry segment for consideration in the next redraft of the document. 2. That the entire section on floor coverings and design issues be withdrawn and re-written to account for the information held by the industry segment.		
166	#17	Please consider a sentence where it would explain where more info regarding Ice machines could be found (e.g. CD/HICPAC Environmental Guideline 2003	Noted additional text has been added	
166	#42	The benefits of single rooms… The last dot point "private toilets…." Does not make sense and not sure what it is supposed to be	Noted and agree	remove the term private toilet and use the term dedicated (ie ensuite)
166 c^.3	#60	The benefits of single bed rooms clarify the wording for the last 'dot' point in relation to private toilets.	Noted and agree	as above
167 C6.4	#25	• C6. 4.1 It is important to add that the level of dust generated during the activity, the duration of the work and the type of work (demolition/plumbing etc.) needs to be considered when determining the types of barriers to use. CSA standard Z317.13-07 Infection control during construction, renovation, and maintenance of health care facilities is a good reference. • The involvement of infection control trained individuals in the process of design and for determining containment requirements should be added. • For materials and finishes other elements such as non-porous materials that are easily cleaned, seamless, and tolerate the healthcare facilities cleaning products would be important elements to consider. • Refer to CHICA position statement on construction and design for information related to this section [http://www.chica.org/pdf/HFDposition.pdf]	Noted but level of detail beyond the scope of the guideline. Additional reference have been provided	Consultation with the infection prevention and control unit (or equivalent) is advisable to ensure that building design and practices suitable address infection prevention and control principles. Infection Control Principles for the Management of Construction, Renovation, Repairs and Maintenance within Health Care Facilities. A Manual for Reducing the Risk of Health Care Associated Infection by Dust and Water Borne Micro-organisms

				2nd Edition Loddon Mallee Region Infection Control Resource Centre Infection Control Consultants

Note: Section D will be disbanded and placed at the end of each section

Section D				
169 D1	#47	Commonwealth legislation Recommend that the following also be included as additional dot points • Therapeutic Goods Order, Number 54, 1996 • Medical Devices Regulation, 2002	Accept	Will include in references.
169 D1	#54	Page 169. The bullet point on legislation/codes of practice refers to Dentists and Dental Technicians, but should refer to Dentists and Dental Prosthetists since the Dental Board of Australia will not register dental technicians, but will register dental prosthetists.	Accept	Will amend terminology to state dental prosthetists.
169 D1	#54	The sections regarding Infected Healthcare Workers should articulate clearly the legal duty to report status as a healthcare worker, to follow the requirements set by the relevant regulatory Board, and to accept that with some serological profiles the infected health care worker must not be placed in patient contact situations.	Noted. Already stated in guidelines: 'In some jurisdictions, healthcare workers who carry a bloodborne virus are legally obliged to declare their infectious status.'	
4187 and 4815 standards	#29	Again many of these standards and other resources have been developed by people outside the primary care arena. Many are heavily influenced by hospital practice, the regulatory sector and even industry. Evidence from primary care practice is notable by its absence. Particular criticisms of Australian Standards 4187 & 4815 dealing with instrument reprocessing and 4146 dealing with laundry practice deal largely with the bias in the Committees and lack of input from primary	Noted. Resources have been requested from primary care. Committee consensus was to refer to Australian Standards for reprocessing and note that this is a priority	

		care leading to inapplicability in many areas to primary care	area for review.	
	#46	Are the Australian Infection Control Association standards included	Yes. Some of the standards have been included as resources to refer to.	
	#51	This section could include a statement to the effect that the Workplace Health and Safety Acts for the various states and territories place a duty of care on employers to ensure workplace health and safety, including where occupational infectious disease hazards exist. Sharps: This section could include a statement to the effect that the Workplace Health and Safety Acts for the various states and territories place a duty of care on employers to ensure workplace health and safety, including where occupational infectious disease hazards exist	Accept.	Will be added to Section C2.1: Workplace Health and Safety Acts for the various states and territories place a duty of care on employers to ensure workplace health and safety, including where occupational infectious disease hazards exist.
	#25	Refer primarily to Australian, UK (especially Scottish), and US documents – there are several important differences in Canadian guidelines which might (or might not) better suit the Australian context, please see the following link for Canadian documents: http://www.chica.org/links_evidence_guidelines.html, specifically the PIDAC document would be relevant for this section. (http://www.health.gov.on.ca/english/providers/program/infectious/diseases/ic_enviro_clean.html)	Accept.	Guidelines will be included for further reference.
	#44 #67	As above, references should be noted throughout the body of the document where relevant. Nb. ACORN Standards are now 2008, and ? currently in the process of being updated (p174). ACORN 2008, Standards for Perioperative Nursing including Nursing Roles, Guidelines and Position Statements, www.acorn.org.au	Accept.	Resource will be included in the relevant section.
	#38	On behalf of the Gastroenterological Nurses College of Australia, I would like to ask that the guidelines include reference to the GESA/GENCA document: Infection Control in Endoscopy 2nd Edition. (2003) http://www.gesa.org.au/professional/guidelines/infectioncontrol.cfm As this is the definitive guideline for the reprocessing of endoscopic equipment.	Accept	Resource will be included in the relevant section.

Appendix				
178	#46	Check credentials of committee and detail	Noted. Committee have reviewed their details.	
Appendix 2.1	#25	(Table) from page 183 contains some good considerations and suggestions P. 187 good discussion of the rigorous process for guideline review.	Noted. Thank you.	
App3	Liz Coates	Exposure prone procedures appendix – dentistry deleted – insert comments from ADA guidelines.	Accept.	Comments on EPPs will be taken directly from the ADA Guidelines
190 App 3	#80	Biting - This sentence could be further clarified to improve meaning. Suggest: "Staff working in areas where there is a significant risk of being bitten should not be considered to be performing EPPs"	Accept.	Suggested change will replace current text: "Staff working in areas where there is a significant risk of being bitten should not be considered to be performing EPPs"
Appendix 3	#25	EPPs This is an interesting section and something that we will consider adding to our guidelines	Noted.	
192	#62	1. Glossary and definitions The glossary and definitions section of any document assists in preventing misunderstanding and ambiguity. Many of the terms in the previous NHMRC document definitions are not included in the new NHMRC draft. For clarity sake those definitions in AS 4187 or 4815 should be maintained unaltered in their defined meaning in the NHMRC Guidelines. A. On page 192 - We have **Orthodontics** See **Dentistry and orthodontics (including hygienists)** Apart from the word **orthodontics** appearing twice here there is no other reference to look up. B. The term "environmental contamination" is frequently used in the text of the draft but there is no definition. C. The term aerosol droplets is used on page 162 of the draft. Apart	Accept. Language will be reviewed to ensure it is consistent with other terminology in the guideline.	Comments on EPPs will be taken directly from the ADA Guidelines

		from confusing the issues of droplets (and droplet precautions) and aerosols (and airborne precautions) there is no definition in the glossary of „aerosol droplet‟		
192	Liz Coates	Exposure prone procedures appendix – dentistry deleted – insert comments from ADA guidelines	Accept.	Comments on EPPs will be taken directly from the ADA Guidelines
192	#53	Appendix 3: Exposure prone procedures Advice on EPPs in specific areas of clinical care 'Orthodontic – see Dentistry and Orthodontics (including Hygienists)' page 192 Comment: there appears to be no 'Dentistry' category or advice preceding this heading	Accept	Comments on EPPs will be taken directly from the ADA Guidelines
194	#47	Appendices; page 194; Glossary Suggest that the following definitions be included Antibacterial hand wash A TGA registered hand wash with antibacterial properties intended for washing hands with the aid of running water and which is included on the ARTG as a medicinal product Antibacterial Handrub A TGA registered Handrub with antibacterial properties intended for decontamination of hands without the use or aid of running water and which is included on the ARTG as a medicinal product Amend the following Alcohol based hand rub SHOULD READ A TGA registered alcohol containing preparation designed for reducing the number of viable microorganisms on the hands without the use or aid of running water and which is included on the ARTG as a medicinal product Clean An objective standard of suitable cleanliness that is defined for the surface, object or medical device Amend the following Detergent Solution SHOULD READ A medical grade detergent product that is registered as a Class I Medical Device with the TGA and which is intended to be used in the cleaning of surfaces or other medical devices Amend the following Disinfectant SHOULD READ A TGA registered disinfectant chemical product that is intended for use in disinfection of surfaces or medical devices Hospital Grade Disinfectant A TGA registered disinfectant for surfaces	Accept	Terminology from TGA order 54 will be inserted into guideline.

		for use in healthcare or healthcare related applications Instrument Disinfectant A TGA registered disinfectant for medical devices Medical Device A device which is intended for use with humans and used in therapeutic processes, being entered onto the Australian Register of Therapeutic Goods (ARTG)		
194	#47	ARTG The Australian Register of Therapeutic Goods is the official commonwealth register of all Therapeutic Goods, maintained by the TGA, and which therapeutic goods have been approved for use and sale in Australia and includes all medicines, medical devices, complementary medicines and other therapeutic goods	Accept	Link will be provided to TGA for all sections related to devices or products such as hand hygiene, cleaning and PPE.
P194 Glossary	#78	Glossary. We recommend that definitions should be modified in line with changes in the text, for example to bring them into line with recognised Australian standards and practice	Accept. Terminology will be reviewed and made consistent with the text.	
Glossary	#79	Aseptic technique Aseptic technique is analogous to clean technique but introduces extra practices to prevent infectious agents from entering a patient's bloodstream, particularly during invasive procedures performed outside a controlled sterile environment (e.g. intravenous therapy on the ward or in a community healthcare setting). This involves creating a sterile field around susceptible sites, and ensuring there is no direct or indirect contact between sterile products (e.g. syringe) and any non-sterile surface. Invasive procedure Entry into tissues, cavities or organs or repair of traumatic injuries	Noted. New section added for aseptic non touch technique.	
195 Glossary	#78	"hand hygiene" Hand hygiene also includes consistent and proper drying of the hands if water and soap have been used for cleansing. Drying should be included in this definition	Accept.	Text inserted about drying in definition.
195	Glossary	Clinical Waste Waste material that consists wholly or partly……. Swabs/dressings?…[delete, not clear enough]…….. EPA Regulations [7/2000] 'items saturated with or containing free-flowing blood or body fluids'	Accept. Definition for clinical waste will be clarified.	Clinical waste definition in guideline will be consistent with the European Standards
Pg 196	#18	The second concern relates to the draft guidelines' definition of an "invasive procedure" in page 196, which is described as the "entry into tissues, cavities, or organs or repair or traumatic injuries". The APA is of the view that this definition should use the term "surgical entry" instead of the generic "entry" to create a distinction between skin penetration by injection or acupuncture as compared to surgical incision.	Noted. Invasive procedures are not limited to surgical entry.	No change.

197 Glossary	#78	Reference to agents that are <5 micron in size. Where did the reference to the <5 micron dimension come from? It is not mentioned in the relevant Australian standard. Unless a reference can be quoted, we suggest that a more generic description should be given, as it is likely that this statement will be challenged	CDC 2007 Isolation Precautions.	No change.
198	#62	Sterile technique I believe the definition would make more sense if the word 'radius' was replaced with the word 'area', as generally operating room procedures have draped areas that are rectangular and not circular.	Noted. Area is a more commonly used and accepted term.	No change.
200	#80	number of abbreviations/acronyms missing, for eg. OMT, ZIG, nCJD, etc.	Noted.	Will spell out acronyms.
204 Reference	#78	CDC (2001) Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. MMWR 50(No. RR - 11)." This reference does not mention handling or disposal of sharps. There is also an updated version of this reference from 2005 (below): Panlilio AL et al. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post-exposure Prophylaxis. Morbidity and Mortality Weekly Report, 2005, 54 (No. RR-09):1–17 http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm	Accept. The reference should refer to *CDC Workbook for Designing, Implementing and Evaluating a Sharps Injury Prevention Program 2009*	Will amend.

Suggested additional topics

Topic	Who	Comment	Committee response
HAI prevention top 10	#57	Perhaps not here, but the Committee might consider inserting the following list of commandments for medical staff that is derived from a paper published in Internal Medicine Journal 2009, 39:574-581, composed by J Ferguson and C Boutlis: **10 infection prevention commandments for medicos** 1. Always disinfect your hands with alcohol-based hand rub BEFORE and AFTER touching a patient or performing a procedure. Set the example for your team and expect others to follow your lead.	The committee will consider the use of the 10 tips in implementation resources.

		2. Dress well for safer care – abandon ties and lanyards, bare your arms to the elbow- no wrist watches or jewellery. 3. Insist on the provision of alcohol-based hand rubs at the patient bedside and in your clinic / rooms. 4. Look beyond the obvious when seeking source(s) of infection. Healthcare-associated infection is characteristically multi-factorial. Surgical wound and device-related infection may be present even in the absence of visible local inflammation. 5. Take alcohol-impregnated wipes on your ward rounds and insist that equipment such as stethoscopes, sphygmomanometers and pulse oximeters is disinfected BETWEEN use on every patient. 6. Ensure your team follows a standard, methodical, sterile (aseptic) approach for all invasive procedures (especially intravascular line insertion). 7. Invasive devices are potent causes of serious infection with an escalating risk the longer they remain – remove them as soon as you can (within 3 days for peripheral cannulae) 8. Use antimicrobials with judicious restraint. Target antimicrobial therapy effectively- consult Therapeutic Guidelines: Antibiotic for the most appropriate agent(s), dose, route and duration. 9. Be the first on your team to have the influenza vaccine every year and make it known to others. Ensure that your high risk patients are vaccinated in accord with the National Immunisation Guidelines recommendations. 10. Insist upon receiving regular, relevant feedback about healthcare-associated infections like MRSA involving your patients	
Primary care	#77	AMA are concerned about the one size fits all approach and 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. 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	The does not provide a one size fits all approach. The Guideline focuses on the core principles of infection control and provides a risk management framework in which it can be applied. This allows for considerations of the level of risk to occur within the context in which the care is provided. Health care facilities need to develop local policies and procedure with this context and level of risk in mind. Guideline does refer to and utilises the information provided in discipline based guidelines such as RACGP 2007 Infection Control Guidelines.

		practices would currently be observing the RACGP Infection Control Standards for Office-based Practices (4th Edition) and the accompanying guidelines. 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.**	
	#74	**Consideration of breast milk in infection control** There are some quite unique issues associated with breast milk, including, for example, the development of breast milk banks. It is suggested some guidance on these issues be included in the guidelines.	This level of detail is considered to be outside the scope of the Guideline.
Dental	#54	Despite what is said in the Scope on page 180 about including office based practices involved in invasive procedures such as dental practice, overall the document has a strong hospital focus and appears not to have been written to address the needs of office-based practice. The current Communicable Diseases Network Australia (CDNA) guidelines have a dedicated dental chapter that addresses office-based practice which is useful, whilst this new document does not. This document is considerably shorter and less detailed than the 2004 document which one assumes it is designed to replace. While in some respects this is a good thing, in some areas the draft is too brief and the issues need more explanation (for example, the carebundle approach could be better described). Given that this document will be used not only in hospitals and large medical practices but also by doctors and dentists in small office practice as a definitive guideline for infection control, it lacks the required detail to inform practitioners on what is required to meet their obligations. The ADA is of the opinion that the average dental practitioner was to read this document it would raise more questions than it answers.	The Guideline focuses on a core principles approach and has been developed to be less prescriptive than previous guidelines, giving practical guidance on how to consider infection control risks and integrate it into work practices. The guideline provides a risk management framework in for its application. This allows for considerations of the level of risk to occur within the context in which the care is provided. Health care facilities need to develop local policies and procedure with this context and level of risk in mind. Guideline does refer to and utilises the information provided in discipline based guidelines such as ADA 2008 Infection Control Guidelines. .
Home care	#74	**More guidance required on Infection Control measures in the home setting** Palliative care staff will often see patients in their own homes or Aged Care facilities, and then provide care in an acute setting. Guideline B3.1.2 provides some general guidance on this area. However, the College would like guidance to be provided on this specific situation. In practice, infection control measures in the home setting are too often breached, and information about	The guideline focuses on the core principles of infection control. It is envisaged that the Guideline be integrated into local policies considering the risk of transmission of infection in that particular setting.

		patient risk factors is often minimal or absent. There is also the potential for staff to act as a conduit back to the acute setting for MRO's etc	
Residential aged care	#57	- For all the ICG thoroughness, there is a paucity of information for residential care, the one area where there needs to have much more guidance as generally they are so poorly resourced that relying on already set guidelines is much more likely (acute care generally has specific resources for IPC and trained and well resourced IPC staff and programmes and so can develop their own guidelines where necessary). - The cleaning recommendations under standard precautions (pp 56-62) are thorough and do set out guidelines for residential care under 'low risk' - For 'droplet' and 'airborne' precautions, there is no mention/recommendation about where to discard masks (e.g. in the room or outside). - Under Roles and Responsibilities (Section C1.2), there is documented roles and responsibilities for IPC staff in acute care and office-based care, but not in residential care – where once again, guidance may be considered more important due to the lack of national and international guidelines. - Ditto Section C1.3 – IPC Program. - Recommendation 17 (p. 9, line 4 of recommendation) should perhaps read '…unavoidable, clean *and disinfect *the equipment…'. - There is a lack of information on caring for patients with MRO in residential care facilities. Could there not be some guidance? - Health Status Screening and Immunisations (Section C2.2.1). How does this get done in practical terms for Residential care staff, particularly vaccinations, and who should maintain these records? Also, for Needle stick injuries (Section C2.6.2). - There does not appear to be much about dealing with Linen (which standard to use, education about how to deal with contaminated linen). - There could be more guidance on surveillance and outbreaks for residential care facilities.	The guideline focuses on the core principles of infection control. The guideline provides a risk management framework in for its application. This allows for considerations of the level of risk to occur within the context in which the care is provided. Health care facilities need to develop local policies and procedure with this context and level of risk in mind. Additional tools and resources will be provided to assist with implementation
Rural and remote area health services	#28	Throughout the document there is no correlation with remote practice to support the health practitioner in the governance of infection control in the remote setting. There is no overarching acknowledgement of remote and its challenges in the scope of the document despite reference to a "wide range of healthcare settings, including office based practice, residential care facilities, Aboriginal medical services, home and	The does not provide a one size fits all approach. The Guideline focuses on the core principles of infection control and provides a risk management framework in which it can be applied. This allows for considerations of the level of risk to occur within the context in which the care is provided.

		community nursing and emergency services" page13-14. The challenge in Infection Control standards and maintenance in remote health practice has many facets in regards to local culture, isolation and the remote environment. The document has not acknowledged this uniqueness and so, do we ask to get a cultural perspective, or at least challenge the status quo by asking for further more detail consultation?	Health care facilities need to develop local policies and procedure with this context and level of risk in mind.
Rural and remote area health services	#63	**Basics of infection control** As stated in the key recommendations, these guidelines were developed to apply to all health care facilities, and this should include remote primary care facilities. However the extent of implementation of infection control guidelines in all client consultations is not discussed. For example, primary care providers may provide consultations such as mental health consultations, medication administration and home-based follow up outside of clinics. Infection control guidelines for these consultations would be useful detail for CARPA. Greater emphasis on the needs and focuses of primary care providers is needed together with explicit consideration of the costs and benefits of infection control measures within primary health care. Particular issues which we feel require further detail are: • Infection control for consultations outside of clinical settings • Hand hygiene in primary care, whether washing with water and soap remains preferable in remote primary care • Clinical case definitions and settings for use of personal protective equipment in primary care • Appropriate infection control resource levels in primary care • Surveillance for Healthcare Associated Infections (HAI) in primary care • Alternative surveillance mechanisms	The does not provide a one size fits all approach. The Guideline focuses on the core principles of infection control and provides a risk management framework in which it can be applied. This allows for considerations of the level of risk to occur within the context in which the care is provided. Health care facilities need to develop local policies and procedure with this context and level of risk in mind. Guideline does refer to discipline based guidelines such as RACGP 2006 Infection Control Guidelines.
Rural and remote area health services	#67	I find the new format satisfactory and I understand the thinking behind it, but I am concerned about new rural infection control nurses. As I am relatively new to infection control (3 years), I remember how useful the original DoHA 2004 guidelines were to me, when I needed an answer. I wonder if this new format may not be as useful to independent rural nurses who often do not have local support, other than via phone or email to a regional centre.	Noted. There will be links and resources provided with the Guideline on the website.

Rural and remote area health services	#63	**For standard precautions** full implementation in primary health care presents additional challenges to implementation in hospitals. Standard precautions includes hand hygiene, personal protective equipment, handling and disposal of sharps, routine environmental cleaning. For example, recommendations for hand hygiene to be performed before and after every patient contact while supported by substantial hospital –base expert opinion, and are widely promoted in primary health care despite absence of evidence of effectiveness. CARPA's infection control guidelines, published through CRANA*plus* place strong emphasis on hand hygiene, consistent with the national guidelines. However CARPA emphasizes the benefits of soap and water over alcohol-based hand rubs, while these guidelines suggest that alcohol-based hand rubs are should be used for all routine hand hygiene. There may be reasons for this, such as higher likelihood of visible soiling in remote primary care. These should be made explicit to enable easier interpretation of the different guidelines.	There is good quality evidence that hand hygiene with ABHR is more effective at killing a range of micro organisms than washing with soap and water. The recommendation to use soap and water is only indicated when hands are visibly soiled (since ABHRs do not remove dirt or other organic material), or when Clostridium difficile or norovirus is suspected, given the mechanical removal of these organisms is more effective than microbicidal removal using an ABHR.
Annexes	#78	- The development of annexes in respect of specific known disease risks would be useful and reassuring to practitioners who deal with these known risks every day such as: - infection control issues relating to specific infectious diseases; - midwifery; - dental practice; - hospital ancillary services such as laundering of clothing and bedding; - engineering and health facility design; - the reprocessing of reusable instruments; - precautions relating to immunocompromised patients, e.g. aged persons, and health care workers (e.g. dietary modification for pregnant patients who are susceptible to listeriosis, or health care workers who have a chronic disease such as cystic fibrosis); - food preparation and handling procedures, and the need to comply with HACCP protocols; and - specific guidance for the safe disposal of clinical and related waste	Guidelines will be accompanied by downloadable resources and links to areas for further information within each chapter. Guideline does refer to discipline based guidelines such as RACGP 2007 Infection Control Guidelines and the 2008 ADA Infection Control Guidelines in specific areas.
Relevance to Mental health service	#69	Relevance to the Mental Health Services - Limited change to current SESIMHS operational practice. - Great relevance to general hospital setting compared to mental health settings. - Will require maintenance of current agreements, escalation pathways and interface with campus / network and site infection control teams. - The most significant impact for MH Services relates directly to Airborne Infections and operational access to negative pressure rooms. This could however be managed via routine existing infection	Comments noted.

		control interfaces. - There should also be a reinvigoration of hand wash campaigns within the MHS Inpatient units and this will be part of the ACHS preparation processes. -	
Laboratory issues	#78	- Suggest inclusion of references on infection control issues for laboratory staff covering the following: - -AS/NZS 2243.3:2002 Safety in laboratories Part 3: Microbiological aspects and containment facilities - - anthrax or plague, and microorganisms included on the COAG Tier 1 list of biosecurity-sensitive agents, such as Ebola virus and severe acute respiratory syndrome (SARS) coronavirus. - -cross-reference to AS/NZS 2243.3:2002 and DoHA guidelines on small pox and anthrax (links provided)	Accept. Links will be provided at the end of Section B2
Engineering controls	#78	Environmental Considerations' of the 2004 ICGs. This section contains guidance on air conditioning, cooling towers, respiratory isolation rooms and special purpose areas	Noted. Guidelines refers to the Australian Healthcare Facility Guidelines.
Regulatory issues	#71	ACCORD's primary and overarching concern is the seeming disregard and/or lack of recognition of the existing Australian regulatory system by the NHMRC, particularly standards set by TGA	TGA is referred and has been consulted in the development of the Guideline.
Waste Management	#29	A section on waste segregation and management is needed	Will be included as Section B1.9