



National Safety & Quality Health Service
Standards 2nd ed.

Standard 3 –
preventing and
controlling healthcare
associated infection
Audit Tools

Version 2.3
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Government
of South Australia

SA Health

Table of Contents

Introduction	3
Criterion: Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship.....	5
1. Audit: Healthcare worker knowledge of infection prevention and control. (Relates to Action items: 1.20, 1.21 & 3.1)	5
2. Audit: LHN compliance with the <i>SA Health Healthcare-Associated Infection Surveillance Policy Directive</i> (Relates to Action item 3.4) (NEW AUDIT).....	7
3. Audit: Ward compliance with <i>SA Health Healthcare Associated Infection Surveillance Policy Directive</i> (Relates to Action item 3.4) (NEW AUDIT).....	9
4. Audit: Ward compliance with <i>SA Health Hygiene Policy Directive</i> (Relates to Action item 3.8)	10
Criterion: Infection prevention and control systems	11
5. Audit: Healthcare worker compliance with <i>SA Health Hand Hygiene Policy Directive</i> (Relates to Action item 3.8).....	11
6. Audit: Healthcare worker competency in donning & doffing personal protective equipment (Relates to Action item 3.11)	13
7. Audit: LHN compliance with the <i>SA Health Aseptic Technique Policy Directive</i> (Relates to Action item 3.9) (NEW audit)	17
8. Audit: Compliance with the use and management of invasive devices: intravascular devices (Relates to Action item 3.10)	19
9. Audit: Compliance with the use and management of invasive devices: indwelling urinary catheter (Relates to Action item 3.10).....	20
10. Audit: Ward compliance with implementation of standard precautions (Relates to Action items 3.5).....	21
11. Audit: Ward compliance with implementation of standard precautions: safe management of sharps (Relates to Action items 3.5, 3.6 & 3.7)	25
12. Audit: Ward compliance with implementation of transmission-based precautions (TBP) (Relates to Action item 3.5, 3.11)	27
13. Audit: Laundry practices (Relates to Action item 3.12)	29
14. Audit: Cleaning practices (Relates to Action item 3.12).....	30
15. Audit: Neonatal Ward compliance with implementation of standard precautions (Relates to Action item 3.5).....	31
Criterion: Reprocessing of reusable medical devices	37
16. Audit: Storage of sterile stock (Relates to Action item 3.14) (REPLACEMENT AUDIT).....	37
17. Audit: Sterilisation and reprocessing practices (Relates to Action item 3.14).....	41
Criterion: Antimicrobial stewardship	42
18. Audit: AMS self-evaluation tool (Relates to Action items 3.1, 3.2, 3.3, 3.4 3.15 & 3.16)	42
19. Audit: National Antimicrobial Prescribing Surveys (NAPS) (Relates to Action items 3.1, 3.2, 3.3, 3.4 3.15 & 3.16)	43

Introduction

This SA Health suite of audit tools has been designed to assist health facilities in meeting the requirements for compliance with the National Safety and Quality Health Service Standards (2nd ed), Standard 3 - Preventing and Controlling Healthcare Associated Infection.

The Standard requires that policies, procedures and/or protocols should be regularly monitored and reports generated that show the results of any process audits conducted. The review of audit results will aid in the development of an action plan to improve processes, if required. Audit results should be reported to staff and appropriate governance committees.

Each audit tool aims to assist with demonstration of evaluation of the requirements for accreditation as described in Standard 3. These audit tools are examples of audits only and can be modified for your facility.

Instructions for use are described for each individual audit. There are seventeen different audit tools provided which align with selected criteria and action items within Standard 3.

These results can be recorded in an MS Excel workbook, which is available from the SA Health Infection Control Service; HealthICS@sa.gov.au.

SA Health resources relating to accreditation to the Australian Commission on Safety and Quality in Health Care (ACSQHC) – National Safety and Quality Health Service Standards (NSQHS) – 2nd edition are available via the SA Health Accreditation Resources web page:

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/safety+and+quality/standards+and+accreditation+on+safety+and+quality/sa+health+accreditation+resources>

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Criterion: Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

1. Audit: Healthcare worker knowledge of infection prevention and control. (Relates to Action items: 1.20, 1.21 & 3.1)

Objective: to identify the level of knowledge of infection prevention and control principles amongst clinical staff

Ward or unit area: **Total number of staff observed:**

Assessor: Date:

Instructions for use: It is recommended that a sample of between 5 and 10 subjects are audited using the tool. The audit tool is designed to audit **clinical staff** only. Expected answers are in red. (Fill in the point score for each question in the appropriate box).

Professional group - allied health (AH), doctor (Dr), nurse/midwife (NM), student allied health (SAH), student doctor (SDr), student nurse/midwife (SNM)	HCW 1	HCW 2	HCW 3	HCW 4	HCW 5	HCW 6	HCW 7	HCW 8	HCW 9	HCW 10	Result per topic
Type of HCW professional:											
1. HCW can articulate knowledge of standard & transmission-based precautions. Ask the following questions:											
1.1 When are standard precautions used? <i>When there is a risk of exposure to blood or body fluids and to minimise the risk of transmission of healthcare associated infection , – 1 point</i>											
1.2 What practices do standard precautions include? <i>HH; aseptic technique; equipment cleaning & reprocessing; environmental cleaning; appropriate use of PPE; safe handling of sharps; waste & soiled linen – 1 point each (up to 8 points total)</i>											
1.3 What PPE are required for: a) Contact precautions <i>Gloves, gown and/or apron – 1 point each (Up to 3 points total)</i>											
b) Droplet precautions <i>Surgical mask – 1 point</i>											
c) Airborne precautions <i>N95/P2 respirator – 1 point</i>											
1. Sub-total (out of 14)											

Professional group - allied health (AH), doctor (Dr), nurse/midwife (NM), student allied health (SAH), student doctor (SDr), student nurse/midwife (SNM)	HCW 1	HCW 2	HCW 3	HCW 4	HCW 5	HCW 6	HCW 7	HCW 8	HCW 9	HCW 10	Result per topic
Type of HCW professional:											
2. HCW can articulate knowledge regarding the management of multi-resistant organisms <i>Single room; contact precautions; hand hygiene; cleaning of environment & patient equipment – 1 point each (Up to 5 points total)</i>											
3. HCW can articulate knowledge regarding the importance of immunisation <i>HCW have an increased exposure risk to vaccine preventable diseases; may transmit infections to susceptible patients – 1 point each (Up to 2 points total)</i>											
4. HCW knows where to locate local infection prevention & control policies, procedures and general information on infectious diseases. - 1 point											
5. HCW knows how to contact their Infection Prevention & Control Unit or representative. - 1 point											
Q 2-5. Sub-total (out of 9)											
Total Score per HCW	/ 23	/ 23	/ 23	/ 23	/ 23	/ 23	/ 23	/ 23	/ 23	/ 23	
Action items: 1.9, 1.20, 1.21 & 3.1 - Healthcare worker knowledge of infection prevention & control principles				Overall level of knowledge = % $\frac{\text{total number of points}}{\text{maximum number of points possible (i.e. number of HCW tested x 23)}} \times 100 = \text{xx\%}$							
Feedback / Comments											

Criterion: Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

2. Audit: LHN compliance with the SA Health Healthcare-Associated Infection Surveillance Policy Directive (Relates to Action item 3.4) (NEW AUDIT)

Objective: to identify LHN compliance with the *SA Health Healthcare Associated Infection (HAI) Surveillance Policy Directive*

Ward or unit area:

Assessor: Date:

Instructions for use: It is recommended that a sample of 5 to 10 ward areas are audited using this audit tool.

Y = compliant with criteria; N = not compliant with criteria (Fill in Y or N as appropriate).

Policy Statement:
 Reliable surveillance data underpin all quality improvement processes, and regular monitoring and feedback is associated with improved patient outcomes. An effective surveillance system is one that delivers timely information to drive change and to evaluate the effectiveness of interventions.
 The Healthcare Associated Infection Surveillance Policy Directive formalises hospital surveillance monitoring and feedback for improved patient outcomes.

Questions	Compliance	Links to evidence if available electronically
1. The LHN has a process in place for identification of laboratory results relevant to collecting information for the healthcare-associated infection (HAI) program.		
2. The LHN has a documented HAI surveillance procedure or manual (including data collection forms and tools).		
3. The LHN undertakes data quality checks and validation prior to reporting to local and statewide data collections.		
4. The LHN uses state and national standardised surveillance definitions.		
5. The LHN can demonstrate evaluation and use of surveillance data prior to and post practice change/s designed to reduce the risks associated with HAI.		
6. The LHN can demonstrate action/s taken when an increase in HAI is identified.		
7. The LHN has documentation from relevant committees/meetings indicating that HAIs are reported within the organisation.		

Questions	Compliance	Links to evidence if available electronically
8. Regular reports are generated for executive, departments and staff (including trends over time & outbreak or intervention specific data).		
9. HAI surveillance reports are available to consumers and other relevant groups.		
10. HAI surveillance data are provided to the state Infection Control Service in accordance with the SA Health HAI Surveillance Policy Directive		
Total score	/ 10	
Action item 3.4: - LHN compliance with surveillance strategy for healthcare associated infections	Score for compliance = % $\frac{\text{total number of Yes answers}}{\text{maximum number of points possible}} \times 100 = \text{xx}\%$	
Feedback / Comments		

Criterion: Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

3. Audit: Ward compliance with SA Health Healthcare Associated Infection Surveillance Policy Directive (Relates to Action item 3.4) (NEW AUDIT)

Objective: to identify ward compliance with the SA Health Healthcare Associated Infection Surveillance Policy Directive

Ward or unit area:

Assessor: Date:

Instructions for use: It is recommended that a sample of 5 to 10 ward areas are audited using this audit tool; **one sheet per ward**. The audit tool is designed to audit **clinical staff only**.

Y = compliant with criteria; N = not compliant with criteria (Fill in Y or N as appropriate).

Policy Statement:										
Reliable surveillance data underpin all quality improvement processes, and regular monitoring and feedback is associated with improved patient outcomes. An effective surveillance system is one that delivers timely information to drive change and to evaluate the effectiveness of interventions.										
Questions								Compliance		
Circle Y or N as appropriate										
1. Have you seen any HAI surveillance data/reports specific to your ward in the last 3 months? Ask 5 HCWs. (circle Y or N)										
HCW 1		HCW 2		HCW 3		HCW 4		HCW 5		
Y	N	Y	N	Y	N	Y	N	Y	N	
2. Are you aware of your ward's HAIs rate/s? For example SAB, MRO and / or surgical site infection? Ask 5 HCWs. (circle Y or N)										
HCW 1		HCW 2		HCW 3		HCW 4		HCW 5		
Y	N	Y	N	Y	N	Y	N	Y	N	
3. Do you know where to find local HAI surveillance results? Ask 5 HCWs. (circle Y or N)										
HCW 1		HCW 2		HCW 3		HCW 4		HCW 5		
Y	N	Y	N	Y	N	Y	N	Y	N	
Total score								/ 15		
Action item 3.4: - Ward & HCW compliance with HAI surveillance data/report knowledge						Score for compliance =% $\frac{\text{total number of yes answers}}{\text{total number of yes and no responses}} \times 100 = \text{xx}\%$				
Feedback/comment:										

Criterion: Infection prevention and control systems

4. Audit: Ward compliance with SA Health Hygiene Policy Directive

(Relates to Action item 3.8)

Objective: to assess ward compliance with the SA Health Hand Hygiene Policy: alcohol-based hand rub (ABHR) is available at point of care and product has not expired

Ward or unit area:

Assessor: Date:

Instructions for use: Audit key areas & each bed to identify whether ABHR is available & that it is fit for purpose.

Y = available & has not expired, N = not available or has expired. (Fill in Y or N as appropriate)

Bed Number	ABHR available at point of care	ABHR has not expired	Bed Number	ABHR available at point of care	ABHR has not expired
1			20		
2			21		
3			22		
4			23		
5			24		
6			25		
7			26		
8			27		
9			28		
10			29		
11			30		
12			31		
13			32		
14			33		
15			34		
16			Treatment room		
17			Medication room		
18			Nurses Station		
19					
Action item 3.8: – Ward Compliance with ABHR at point of care and product has not expired			Score for compliance = % $\frac{\text{total number of Yes answers}}{\text{total number of beds \& areas audited}} \times 100 = \text{xx\%}$		
Feedback / Comments					

Criterion: Infection prevention and control systems

5. Audit: Healthcare worker compliance with SA Health Hand Hygiene Policy Directive (Relates to Action item 3.8)

Objective: to identify the percentage of clinical staff / health care workers (HCW) who comply with the SA Health Hand Hygiene Policy

Ward or unit area: **Total number of staff observed:**

Assessor: Date:

Instructions for use: It is recommended that a sample of between 5 and 10 subjects are audited using the tool. The audit tool is designed to audit **clinical staff only**.

Y = HCW complies, N = HCW does not comply. (Fill in Y or N as appropriate in each box).

Professional group - allied health (AH), doctor (Dr), nurse/midwife (NM), student allied health (SAH), student doctor (SDr), student nurse/midwife (SNM)	HCW 1	HCW 2	HCW 3	HCW 4	HCW 5	HCW 6	HCW 7	HCW 8	HCW 9	HCW 10	Result per topic
Type of HCW professional:											
1. HCW has short, clean fingernail?											
2. HCW does not wear acrylic (false) nails											
3. HCW does not wear nail polish											
4. HCW is not wearing a wrist watch											
5. HCW is not wearing a bracelet (medical alert may need to be worn elsewhere other than wrist)											
6. HCW is not wearing rings (1 plain band acceptable)											
7. Hand hygiene competency has been assessed using ABHR											
8. Hand washing competency has been assessed using soap and water											
9. HCW can state the HHA auditing program implemented in their area/organisation (^ see next page additional info)											
Total Score per HCW	/ 9	/ 9	/ 9	/ 9	/ 9	/ 9	/ 9	/ 9	/ 9	/ 9	

<p>Action item 3.8: - HCW compliance with SA Health Hand Hygiene Policy Directive</p>	<p>Overall compliance score =% $\frac{\text{total number of yes answers}}{\text{total number of yes \& no answers} \times \text{no. of staff audited}} \times 100 = \text{xx}\%$</p>	<p>Percentage of staff that fully comply =% $\frac{\text{total number with perfect scores}}{\text{total number of staff audited}} \times 100 = \text{xx}\%$</p>
<p>Feedback / Comments</p>		

^ Hand hygiene compliance tools recommended by SA Health, [National Hand Hygiene Initiative \(NHHI\) 5 moments](#) or [SA Health Hand Hygiene Observational Tool](#)

Criterion: Infection prevention and control systems

6. Audit: Healthcare worker competency in donning (putting on) & doffing (taking off) personal protective equipment

(Relates to Action item 3.11)

Objective: to identify the percentage of health care workers (HCW) who are competent in donning & doffing personal protective equipment (PPE)

Ward or unit area: **Total number of staff observed:**

Assessor: Date:

Instructions for use: It is recommended that a sample of between 5 and 10 audits are completed using the audit tool. The audit tool is designed to audit **any HCW**.

Y = HCW complies, N = HCW does not comply. (Fill in Y or N as appropriate in each box).

Also refer to the SA Health Training Tool for the Use of PPE and Respirator Fit Testing Tool.

Professional group - allied health (AH), doctor (Dr), nurse/midwife (NM), student allied health (SAH), student doctor (SDr), student nurse/midwife (SNM)	HCW 1	HCW 2	HCW 3	HCW 4	HCW 5	HCW 6	HCW 7	HCW 8	HCW 9	HCW 10	Result per topic
Type of HCW professional:											
Donning											
1. Perform hand hygiene	Either alcohol-based hand rub or hand wash										
2. Put on disposable gown	Both ties at the back of the gown have been secured										
3. Correctly put on surgical mask or particulate filtration respirator (PFR)	Surgical or PFR (i.e. P2/N95 or equivalent) – fitted correctly, fit check performed										
4. Put on eye protection - (goggles, safety glasses or face shield)	Eye protection put on correctly (Note: must be applied in addition to prescription glasses)										

Professional group - allied health (AH), doctor (Dr), nurse/midwife (NM), student allied health (SAH), student doctor (SDr), student nurse/midwife (SNM)

		HCW 1	HCW 2	HCW 3	HCW 4	HCW 5	HCW 6	HCW 7	HCW 8	HCW 9	HCW 10	Result per topic	
Type of HCW professional:													
5.1 Remove eye protection	Remove using the arms of the goggles, safety glasses or face shield												
5.2 Dispose of eye protection	Place in designated container for reprocessing or in a waste container												
6. Perform hand hygiene	Either alcohol-based hand rub or hand wash												
7. Remove mask / respirator (if applicable)	Mask is removed by the straps and carefully placed in general waste bin												
8. Perform hand hygiene	Either alcohol-based hand rub or hand wash												
Doffing sub-total per HCW		/ 11	/ 11	/ 11	/ 11	/ 11	/ 11	/ 11	/ 11	/ 11	/ 11		
Total score per HCW (putting on & taking off)		/ 17	/ 17	/ 17	/ 17	/ 17	/ 17	/ 17	/ 17	/ 17	/ 17		
Action item 3.11: - HCW Compliance in donning & doffing personal protective equipment (PPE)		Overall compliance score =% $\frac{\text{total number of correct steps}}{\text{total number of steps assessed}} \times 100 = \text{xx\%}$ <i>(i.e. number of HCW assessed x 14)</i>						Percentage of staff that fully comply =% $\frac{\text{total number of perfect scores}}{\text{total number of staff audited}} \times 100 = \text{xx\%}$					
Feedback / Comments													

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Criterion: Infection prevention and control systems

7. Audit: LHN compliance with the SA Health Aseptic Technique Policy Directive (Relates to Action item 3.9) (NEW audit)

Objective: to identify LHN compliance with *SA Health Aseptic Technique (AT) Policy Directive*

Assessor: Date:

Instructions for use: It is recommended that the Local Health Network assess the questions / compliance statements outlined in this audit tool and report the audit results to staff and appropriate governance committee /s.

Y = compliant with criteria; N = not compliant with criteria (Fill in Y or N as appropriate).

Policy Statement:

The Aseptic Technique Policy Directive ensures that all hospitals maintain a sustainable, high quality care environment in which all clinical staff are aware of the importance of using the principles of aseptic technique when performing medical procedures on patients.

Questions / Compliance statements	Compliance	Links to evidence and resources if available electronically
1. The LHN has a documented aseptic technique clinical procedure / work instruction.		SA Health Aseptic Technique Policy Directive
2. The LHN has identified the procedures that require aseptic technique.		SA Health aseptic technique resources
3. The LHN has a documented record that includes the number and names of staff who have completed aseptic technique training.eg SA Health Aseptic Technique e-learning module, Staff training and self-assessment workbook: aseptic technique		SA Health aseptic technique e-learning module SA Health aseptic technique staff training &self-assessment workbook
4. The LHN has a documented record of the number of clinical staff who have completed relevant aseptic technique competencies.		
5. Aseptic technique process and competency audits are undertaken as per the facilities audits schedule and results are reported to staff and at appropriate governance committees.		
6. Actions are taken by the LHN to reduce identified risks associated with aseptic technique. eg An action plan identifies risks from training reports, competency reports and audit results and documents progress and improvements.		
Total Score	/6	

Action item 3.9. Aseptic Technique	Score for compliance = % $\frac{\text{total number of Yes answers}}{\text{maximum number of points possible}} \times 100 = \text{xx\%}$
Feedback / Comments	



Criterion: Infection prevention and control systems

8. Audit: Compliance with the use and management of invasive devices: intravascular devices (Relates to Action item 3.10)

Objective: to identify staff compliance with maintenance of intravascular devices

Instructions for use: It is recommended that a sample of 5 to 10 audits (1 patient per audit sheet) are completed using the audit tool. The audit tool is designed to audit **patients with an IVD**.

Y = complies, N = does not comply.

Patient UR:

Ward or unit area:

Assessor: Date:

Type of devices Circle applicable device type						Site of device Circle applicable site							No. of insertion attempts		
PIVD	CVC	PICC	Vas-cath	Arterial line	Swan Ganz	Hand	Cubital fossa	Forearm	Wrist	Intra-jugular	Subclavian	Femoral Cubital fossa	Other: _____	(Record number if information available)	
Circle Y or N as appropriate for each question															
1. Is there documentation in the case notes, i.e. insertion date, site, and type?													Y	N	
2. Is there documentation in all other relevant files, i.e. case notes, nursing care plan, electronic notes?													Y	N	
3. Is there a record of observation/ maintenance of the device at a minimum, each shift?													Y	N	
4. Is a recommended cannulation site chosen?													Y	N	
5. Is a recommended dressing used?													Y	N	
6. Is there a date & time on dressing?													Y	N	
7. Is the dressing dry and intact?													Y	N	
8. The insertion site is clean and dry with no sign of phlebitis or infection													Y	N	
9. Has the patient been provided with information e.g. Consumer Information Sheet?													Y	N	
Total score													/ 9	/ 9	
10. Has the PIVD been <i>in situ</i> for the recommended amount of time? (i.e. Adults - no longer than 72 hours. Children and neonates – refer to LHN Policy)													Y	N	
*if question 10 answered adjust total score													/ 10	/ 10	
Action item, 3.10: - Compliance with the use and management of invasive devices - Intra vascular devices (IVD)										Score for compliance =% $\frac{\text{total number of yes answers}}{\text{total number of questions}} \times 100 = \text{xx}\%$					
Feedback/comment:															

Criterion: Infection prevention and control systems

9. Audit: Compliance with the use and management of invasive devices: indwelling urinary catheter (Relates to Action item 3.10)

Objective: to identify staff compliance with maintenance of indwelling urinary catheters

Instructions for use: It is recommended that a sample of 5 to 10 audits (1 patient per audit sheet) are completed using the audit tool. The audit tool is designed to audit **patients with an indwelling urinary catheter**.

Y = complies, N = does not comply.

Patient UR

Ward or unit area:

Assessor: Date:

Indwelling urinary device site (tick applicable)	Urethral	Supra-pubic
Circle Y or N as appropriate for each question		
1. Documentation - reason for Insertion and continued use is recorded	Y	N
2. Documentation - ease of insertion (i.e. no. of attempts) is recorded	Y	N
3. Catheter support in place e.g. tape, leg bag straps	Y	N
4. Drainage bag is no more than 3/4 full	Y	N
5. Drainage bag is not touching the floor	Y	N
6. Bag is below patient bladder	Y	N
7. Catheter & bag connections are secure	Y	N
8. Catheter & tubing are not kinked	Y	N
9. Has the patient been provided with information on the care of the catheter?	Y	N
Total score	/ 9	/ 9
Action item 3.10 - Compliance with the use and management of invasive devices: indwelling urinary catheter	Score for compliance =% $\frac{\text{total number of yes answers}}{\text{total number of questions}} \times 100 = \text{xx\%}$	
Feedback/comment:		

Criterion: Infection prevention and control systems

10. Audit: Ward compliance with implementation of standard precautions

(Relates to Action items 3.5)

Objective: to identify ward compliance with implementation of standard precautions

Links to SA Health resources:

Prevention and management of infection in healthcare

settings. <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/healthcare+associated+infections/prevention+and+management+of+infections+in+healthcare+settings>

EPA Waste and Recycling

https://www.epa.sa.gov.au/community/waste_and_recycling

Instructions for use: It is recommended that a sample of 5 to 10 ward areas are audited using this audit tool. **Y = ward is compliant with criteria; N = ward is not compliant with criteria** (Fill in Y or N as appropriate).

Ward or unit area:

Assessor: Date:

Topic	Questions	Compliance	Comments
1. Hand Hygiene	1.1. There is a soap dispenser at every sink (these are not empty)		
	1.2. There are paper towels available at every sink		
	1.3. There are waste bins at every sink		
	1.4. Alcohol-based hand rub is available throughout the ward/unit		
1. Sub-total		/ 4	
2. PPE	2.1. Non-sterile gloves available & readily accessible		
	2.2. Long sleeve gowns/aprons available & readily accessible		
	2.3. Protective eyewear available & readily accessible		
	2.4. Surgical masks available & readily accessible		
2. Sub-total		/ 4	
3. Shared patient equipment	3.1. Detergent / detergent-disinfectant (wipes or solution) are available for cleaning of patient care equipment		
3. Sub-total		/ 1	

Topic	Questions	Compliance	Comments
4. Linen (Also see Audit No.13)	4.1. Linen bags are not over filled e.g. bags are less than ¾ full		
	4.2. Wet / leaking linen bags are placed in a plastic bag		
	4.3. Staff in the onsite laundry service have attended annual infection control education (view attendance records)		
	4.4. Clean linen trolleys are regularly cleaned and serviced (view cleaning schedule)		
	4.5. Soiled linen is stored in areas separate from the clean linen storage area		
	4.6. Laundered linen is stored on clean shelves and if necessary wrapped in a protective covering for transport		
4. Sub-total		/ 6	
5. Clinical waste (previously known as medical waste)	5.1. Containers of medical waste are stored in a secure location		
	5.2. All necessary equipment required to clean & disinfect the area in case of accidental spillage is available & easily accessible		
	5.3. Medical waste is separated from general waste		
	5.4. There are adequate clinical waste bins in the ward/unit		
	5.5. Suitable containers are used as recommended by SA EPA Guidelines (Sep 2003)		
	5.6. Containers of medical waste are not overfull		
	5.7. There are signs at clinical waste bins to identify what items are suitable to discard		
5. Sub-total		/ 7	

Topic	Questions	Compliance	Comments
6. General waste	6.1. There are adequate general waste bins in the ward/unit		
	6.2. General waste bins no more than 3/4 full		
6. Sub-total		/ 2	
7. Consumer information	7.1. The ward/unit has consumer information displayed regarding infection prevention and control		
7. Sub-total		/ 1	
Combined total score		/ 25	
Action items 3.5: - Ward compliance with implementation of Standard Precautions		Score for overall compliance =% $\frac{\text{total number of yes answers}}{\text{total number of questions}} \times 100 = \text{xx}\%$	
Feedback/comment:			

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Criterion: Infection prevention and control systems

11. Audit: Ward compliance with implementation of standard precautions: safe management of sharps (Relates to Action items 3.5, 3.6 & 3.7)

Objective: to identify ward compliance with implementation of sharps safety practices

Instructions for use: It is recommended that a sample of 5 clinical staff (HCW) per area is assessed using the audit tool.

Y = ward is compliant with criteria; N = ward is not compliant with criteria
(Fill in Y or N as appropriate).

Ward or unit area:

Assessor: Date:

General ward questions										Compliance	
Circle Y or N as appropriate											
1. Sharps disposal containers are not overflowing or overfilled i.e. must not be filled above the mark that indicates the maximum fill level.										Y	N
2. Sharps disposal containers are stored safely away from the public and out of reach of children i.e. not on floor										Y	N
3. Sharps are disposed of directly into a sharps disposal container at point of use										Y	N
4. Inappropriate re-sheathing of needles does not occur. Observe 5 HCW. (circle Y or N)											
HCW 1		HCW 2		HCW 3		HCW 4		HCW 5			
Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
5. HCW is aware of the action required following a needlestick exposure. Ask 5 HCWs. (circle Y or N)											
HCW 1		HCW 2		HCW 3		HCW 4		HCW 5			
Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
6. HCW can identify where to find information regarding the safe use of sharps. Ask 5 HCW. (circle Y or N)											
HCW 1		HCW 2		HCW 3		HCW 4		HCW 5			
Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Total score										/ 18	
Action items 3.5, 3.6 & 3.7: - Ward & HCW compliance with implementation of standard precautions: safe management of sharps										Score for compliance =% $\frac{\text{total number of yes answers}}{\text{total number of yes and no responses}} \times 100 = \text{xx}\%$ (e.g. if 5 HCW audited per questions 5, 6, 7 then total = 18)	
Feedback/comment:											

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Criterion: Infection prevention and control systems

12. Audit: Ward compliance with implementation of transmission-based precautions (TBP) (Relates to Action item 3.5, 3.11)

Objective: to identify ward compliance with implementation of transmission-based precautions

Ward or unit area:

Assessor: Date:

Instructions for use: It is recommended that a sample of between 1 and 5 patients on transmission-based precautions per ward area are assessed using the audit tool.

Randomly select 1 to 5 patients, one sheet per ward (Fill in Y or N as appropriate).

Question	Pt. 1	Pt. 2	Pt. 3	Pt. 4	Pt. 5	Comments
Compliance (Y or N)						
1. HCW caring for the patient is aware of why their patient is in TBP and can state the infection / organism (ask patient care clinician)						
2. Is TBP necessary i.e. does the patient remain infectious?						
3. Patient is placed in a single room (as appropriate)						
4. For airborne precautions ONLY – patient is in a negative pressure room with door shut						
5. Are bathroom facilities appropriate? (i.e. ensuite, dedicated commode or bathroom)						
6. Is the correct transmission-based precaution signage displayed?						
7. Is the required PPE available –						
7.1 non-sterile gloves						
7.2 disposable long sleeve gowns/plastic aprons						

Question	Pt. 1	Pt. 2	Pt. 3	Pt. 4	Pt. 5	Comments
Compliance (Y or N)						
7.3 masks (surgical for droplet or P2/N95 for airborne)						
8. Is PPE properly discarded upon leaving the room?						
9. Has a relevant alert been documented implemented (electronic, case-note, other local procedure or system?)						
10. Appropriate daily cleaning is conducted (detergent + disinfectant)						
11. Has the patient/consumer been provided with information regarding their care management e.g. VRE, MRSA, influenza						
Total Score	/13	/13	/13	/13	/13	
Action item 3.5 - Ward compliance with implementation of Transmission-based Precautions		Score for compliance =% $\frac{\text{total number of yes answers}}{\text{total number of questions}} \times 100 = \text{xx\%}$				
Feedback/comment:						

Criterion: Infection prevention and control systems

13. Audit: Laundry practices (Relates to Action item 3.12)

Objective: Laundry practices meet Australian Standard AS /NZS 4146: 2000

To monitor the processes and practices of the laundry to ensure relevant Australian Standards are met.

(Applicable to those SA Health facilities with in-house laundry services)

Ward or unit area:

Assessor: Date:

Instructions for use: Use one audit sheet per audit.

Y = staff member or laundry service complies, N = staff member or laundry service does not comply.

Questions	Compliance	
Circle Y or N as appropriate		
1. Appropriate protective clothing is worn, i.e. gloves and gowns when handling soiled linen.	Y	N
2. Staff in the laundry service have attended annual infection control education (view attendance records)	Y	N
3. Linen trolleys are regularly cleaned and serviced. (view cleaning schedule)	Y	N
4. Soiled linen is stored in areas separate from the clean linen storage area	Y	N
5. Laundered linen is stored on clean shelves and if necessary wrapped in a protective covering	Y	N
6. Operating theatre linen is inspected for staining and damage. (view records)	Y	N
7. Records are kept of each wash parameters (type of linen washed, maximum wash load, wash program or process, duration of each operation, water level, water temperature, chemicals and their dosage, machine type and other relevant information)	Y	N
8. Records are kept for all relevant tests as specified in Sections 2.2 to 3.6.4 including requirements as per 3.5.2 (Thermal) and 3.5.3 (Chemical disinfection) of AS/NZS 4146:2000.	Y	N
Total Score		/ 8
Action item 3.11 - Laundry practices meet Australian Standard AS/NZS 4146:2000	Score for compliance = % $\frac{\text{total number of yes answers}}{\text{total number of questions}} \times 100 = \text{xx}\%$	
Feedback/comment:		

Criterion: Infection prevention and control systems

14. Audit: Cleaning practices (Relates to Action item 3.12)

Objective: to identify LHN compliance with the *SA Health Cleaning Standard for Healthcare Facilities Policy Directive*:

To monitor the processes and practices detailed in the SA Health Cleaning Standard for Healthcare Facilities Policy Directive are met.

Refer to the SA Health Cleaning Standard Toolkit available

at: <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/healthcare+associated+infections/prevention+and+management+of+infections+in+healthcare+settings/environmental+hygiene+in+healthcare>

Cleaning standard toolkit

- [Appendix 5 - Risk matrix and classification of functional areas \(PDF 465KB\)](#)
- [Appendix 6 - Risk classification of functional areas within hospitals \(PDF 21KB\)](#)
- [Appendix 7 - Cleaning schedule \(PDF 60KB\)](#)
- [Appendix 8 - Audit tool \(internal\) \(XLS 283KB\)](#)
- [Appendix 9 - Audit tool \(external\) \(PDF 112KB\)](#)

Criterion: Infection prevention and control systems

15. Audit: Neonatal Ward compliance with implementation of standard precautions (Relates to Action item 3.5)

Objective: to identify ward compliance with implementation of standard precautions

Ward or unit area:

Assessor: Date:

Instructions for use: It is recommended that a sample of 5 to 10 ward areas are audited using this audit tool.

Y = ward is compliant with criteria; N = ward is not compliant with criteria; N/A = not applicable
(Fill in Y or N or N/A as appropriate).

Topic	Questions	Compliance	Comments
1. Hand Hygiene	1.1. There is a soap dispenser at every sink (these are not empty)		
	1.2. There are paper towels available at every sink		
	1.3. There are waste bins at every sink		
	1.4. Alcohol-based hand rub is available in the patient zone (see also Audit No. 4) Note - at the end of each bed or immediately near if unable to be placed on the end of the bed		
	1.5. Staff with skin concerns have been assessed by WHS		
	1.6. Staff who are exempt from soap use have individual wash		
	1. Sub-total		/ 6
2. Bare below the elbows (See also Audit No.5)	2.1. Staff are not wearing long sleeves		
	2.2. Staff are not wearing jewellery / watch Note - plain ring & Medic Alert bracelets exempt		
	2.3. Staff nails are clean and short, and no nail polish or artificial nails		
	2 Sub-total		/ 3
3. PPE	3.1. Non-sterile gloves available & readily accessible		
	3.2. Disposable aprons available & readily accessible		

Topic	Questions	Compliance	Comments
	3.3. Long sleeve gowns/aprons available & readily accessible		
	3.4. Protective eyewear available & readily accessible		
	3.5. Surgical masks available & readily accessible		
	3. Sub-total	/ 5	
4. Linen	4.1. Linen bags are not over filled e.g. bags are less than ¾ full		
	4.2. Wet / leaking linen bags are placed in a plastic bag (may be marked N/A if not seen when auditing)		
	4.3. Soiled linen is stored in areas separate from the clean linen storage area		
	4.4. Laundered linen is stored on clean shelves with a protective covering		
	4. Sub-total	/ 4	
5. General waste	5.1. There are adequate general waste bins in the ward/unit (each patient room and treatment area)		
	5.2. General waste bins are no more than ¾ full		
	5. Sub-total	/ 2	
6. Clinical waste (previously known as medical waste)	6.1. Containers of clinical waste are stored in a secure location (away from public access)		
	6.2. Spill kits available and accessible		
	6.3. Clinical waste bins are no more than ¾ full		
	6.4. Signage displayed to identify appropriate items to discard in clinical waste		
	6. Sub-total	/ 4	

Topic	Questions	Compliance	Comments
7. Shared patient equipment	7.1. Detergent / detergent-disinfectant (wipes or solution) are available for cleaning of patient care equipment		
	7.2. Baths are cleaned between use		
	7.3. Breast pumps are cleaned between use		
	7.4. Breast pump accessories are not cleaned in hand hygiene sinks		
	7.5. Pacifiers are reprocessed as per local procedures		
	7.6. Pacifiers are reprocessed as per the AS/NZS 4187:2014 Australian Sterilisation Standards		
	7.7. Baby wash solution is single patient use		
	7.8. Stethoscopes are designated or cleaned and disinfected between use		
	7.9. Thermometers are designated or cleaned and disinfected between use		
	7.10. Cots/cribs cleaned and disinfected between use		
	7.11. Crib filters are changed as per manufacturer's instructions		
	7.12. Sterile water is used for humidified cribs		
	7.13. Cot mattresses are in good repair		
	7.14. Ultrasound gel is single use		
	7.15. Audiology assessment equipment is cleaned between use		
	7.16. Eye assessment equipment is single use or reprocessed accordingly to manufacturer's instructions		
	7.17. Portable computers have a regular cleaning schedule		
	7.18. Are washing machines used in the area		

Topic	Questions	Compliance	Comments
	7.19. If used, does the washing machine meet the AS/NZS 4146:2000 Laundry Practice		
	7. Sub-total	/ 19	
8. Transmission-based precautions (TBP)	8.1. Is the correct TBP signage displayed		
	8. Sub-total	/ 1	
9. Environment	9.1. Patient rooms are free from clutter and in good repair		
	9.2. Corridors are free from clutter and in good repair		
	9.3. Dirty utility room free from clutter and in good repair		
	9.4. Dirty utility room has a clean / dirty flow		
	9.5. Daily clean completed using detergent & disinfectant e.g. sodium hypochlorite 1,000 ppm solution		
	9.6. Discharge clean completed using detergent & disinfectant e.g. sodium hypochlorite 1,000 ppm solution		
	9.7. Is the clean performed by PSA / cleaning staff		
	9.8. Gloves changed between individual patient pods / areas		
	9.9. Cleaning cloth changed between individual patient pods / area		
	9.10. PSA/Cleaning staff have received training		
	9.11. Mop changed between patient rooms		
	9.12. Sterile stock is stored as per AS/NZS 4187:2014 Australian Sterilisation Standards		
	9. Sub-total	/ 12	

Topic	Questions	Compliance	Comments
10. Hand hygiene sinks	10.1. No aerators in taps		
	10.2. Annual thermostatic mixing valve (TMV) maintenance is performed		
	10.3. No waste products are discarded in sink, i.e. wash water, breast milk		
	10.4. No washing of reusable equipment in sink (i.e. bowls, breast pump equipment)		
	10. Sub-total	/ 4	
11. Clinical Practices	11.1. Shared medications are not used		
	11.2. Eye toilets are performed using sterile water		
	11.3. Mouth toilets are performed using sterile water		
	11. Sub-total	/ 3	
12. Communal room	12.1. Communal room has cleaning schedule in place		
	12.2. Hand hygiene facilities are available		
	12.3. Surfaces / chairs can be wiped		
	12. Sub-total	/ 3	
13. Milk room	13.1. Are operating procedures in place		
	13. Sub-total	/ 1	
14. Policy and procedures	14.1. Are specific policies and procedures are up-to-date and include relevant infection control requirements		
	14. Sub-total	/ 1	
15. Infection control liaison (ICLN)	15.1. There is a nominated ICLN representation		
	15. Sub-total	/ 1	

Topic	Questions	Compliance	Comments
16. Consumer information	16.1. Visitors / parents are educated on hand hygiene requirements		
	16.2. Parents are educated on the use of hand hygiene sinks		
	16.3. Parents are educated on the use of shared equipment		
	16. Sub-total	/ 3	
Total score			/ 72
Action items 3.5: - NICU/NNU compliance with implementation of Standard Precautions		Score for compliance =% $\frac{\text{total number of yes answers}}{\text{total number of yes and no responses}} \times 100 = \text{xx}\%$	
Feedback/comment:			

Links to SA Health resources:

Prevention and management of infection in healthcare settings:

[.https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/healthcare+associated+infections/prevention+and+management+of+infections+in+healthcare+settings](https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/healthcare+associated+infections/prevention+and+management+of+infections+in+healthcare+settings)

Criterion: Reprocessing of reusable medical devices

16. Audit: Storage of sterile stock (Relates to Action item 3.14) (REPLACEMENT AUDIT)

Objective: Ward/clinical areas practices meet Australian Standard AS/NZS 4187:2014
(outside the Sterilisation Department and theatre sterile store)

Instructions for use: It is recommended that a sample of between 5 and 10 storage areas are audited using the audit tool, (one area per audit sheet).

Ward or unit area:

Assessor: Date:

Questions	Compliance	
Circle Y or N as appropriate		
1. Is the sterile stock storage area dedicated to that purpose only? "sterile reusable medical devices should be stored on or in designated shelving, cupboards, drawers or containers ¹ ". Non sterile stock may be stored in the same area but segregated from sterile stock by a barrier, dividers or partition ² .	Y	N
2. Access to sterile store area is restricted to those who have an adequate understanding in handling sterilised items e.g. in-service training	Y	N
3. Is clear signage present to identify sterile stock storage area?	Y	N
4. Are hand washing facilities / Alcohol Based Hand Rub (ABHR) available at or near the sterile storage entrance?	Y	N
5. The storage area is visibly clean and enables the floor area to be cleaned without environmental contamination of sterile stock (Stock is at least 250mm from the floor).	Y	N
6. The sterile stock is stored 440mm below the ceiling fixtures ((potential for temperature increase close to lighting / ceiling	Y	N
7. Are Items protected from direct sunlight and dust?	Y	N
8. Walls, floors and work surfaces are constructed so that difficult-to-clean corners are minimized and surfaces are non-porous, smooth and easily cleaned	Y	N
9. Is there a cleaning program in place for the storage area?	Y	N
10. Are storage containers kept clean, dry and in good condition?	Y	N
11. Is there a cleaning program in place for the storage containers?	Y	N

Questions	Compliance	
Circle Y or N as appropriate		
12. Cardboard boxes are NOT used as storage containers for items sterilised in the healthcare facility. (porous, cannot be adequately cleaned and may harbour organisms)	Y	N
13. Commercial dispenser boxes are disposed of when empty and not topped up or reused	Y	N
14. Is sterile stock that is delivered after hours stored correctly?	Y	N
15. Sterile stock is packed in a manner that does not compromise the integrity of the items eg. stock is not tightly packed into storage containers or shelving, or wrapped with elastic bands, sticky tape etc.	Y	N
16. Staff can describe the general requirements for identifying the safe use of a conforming sterile pack:		
a) Within expiry date (if applicable)	Y	N
b) Indicator on the pack has changed to the correct colour	Y	N
c) Pack is intact and visibly clean, i.e. no holes or tears, no water marks, no dust present	Y	N
d) No additional writing is on the pack (excludes CSSD labelling)	Y	N
e) Batch label identifying sterilisation details is present	Y	N
17. There is a system for stock rotation based on sterilisation date. (Auditor to spot check dates are in order and evaluate staff understanding) For example Ask a staff member where to take stock from when required i.e. take from right hand side, front, top	Y	N
18. There is a procedure for identification and management of items that are identified as non-conforming to sterile pack requirements to ensure they are not used e.g. a torn pack in the sterile stock storage area Note: see question 16 for conforming stock.	Y	N
19. Ask staff to explain the correct procedure for removing non-conforming stock from the area	Y	N
20. Was any non-conforming stock identified during the audit? If so, follow correct procedure for removal and advise area manager	Y	N

Total score		/ 24
Action item 3.14 - Compliance with AS/NZS 4187:2014: storage of sterile supplies	Score for compliance = % $\frac{\text{total number of yes answers}}{\text{total number of questions}} \times 100 = \text{xx}\%$	
Feedback/comment:		

1. Australian / New Zealand Standard, AS/NZS 4187: 2014 *Reprocessing reusable medical devices in health service organisations*, Standards Australia
2. Queensland Government, Department of Health, *Storage design for sterile and non-sterile stock for new and refurbished healthcare facilities* , version 1, June 2013

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Criteria: Reprocessing of reusable medical devices

17. Audit: Sterilisation and reprocessing practices (Relates to Action item 3.14)

Objective: LHN practices meet Australian Standard AS/NZS 4187:2014

Refer to the SALHN AS/NZS 4187 Audit Tool **available**

at: <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/healthcare+associated+infections/prevention+and+management+of+infections+i+n+healthcare+settings/reprocessing+of+medical+devices>

Criterion: Antimicrobial stewardship

18. Audit: AMS self-evaluation tool

(Relates to Action items 3.1, 3.2, 3.3, 3.4 3.15 & 3.16)

Objective: to monitor improvements in effectiveness of antimicrobial stewardship programs and adherence to the SA Health Antimicrobial Stewardship Policy Directive

Refer to the SA Health Antimicrobial Stewardship Program: Self-evaluation toolkit available at: <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+programs/antimicrobial+stewardship> (see Related resources section)

Related resources

- Antimicrobial Stewardship Policy Directive (PDF 290KB)
- SA Health Antimicrobial Stewardship Program: Self evaluation toolkit (XLSX 49KB)

Criterion: Antimicrobial stewardship

19. Audit: National Antimicrobial Prescribing Surveys (NAPS)

(Relates to Action items 3.1, 3.2, 3.3, 3.4 3.15 & 3.16)

Objective: to monitor improvements in effectiveness of antimicrobial stewardship programs

Refer to the [National Centre for Antimicrobial Stewardship](#), and is delivered by the [Guidance Group](#).



Version control and change history

Version	Date from	Date to	Amendment
2.3	28/10/2020	Current	Add new audit (NICU related)
2.2	12/4/2019	7/10/2020	Minor alteration
2.1	30/1/2019	12/4/2019	Minor alteration
2.0	18/12/2018	30/1/2019	Update references to the NSQHS Standards 2 nd edition and addition additional audits
1.1	11/05/2016	18/12/2018	Minor alteration
1.0	June 2015	11/05/2016	Original version

For more information

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Adelaide SA 5000
Telephone: 1300 232 272
www.sahealth.sa.gov.au/infectionprevention

Official –I1-A2



www.ausgoal.gov.au/creative-commons

Version 2.1 (Jan 2019)

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