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[Organisation Name]

Infection Prevention and Control Policy and Procedure Manual

Document Control

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1. PURPOSE

The purpose of this document is to provide a structured, evidence-based framework for the prevention, management, and control of infection risks at [Organisation Name].

This document establishes clear systems and responsibilities to minimise the risk of healthcare-associated infections, protect patients, staff, visitors, and the community, and support the delivery of safe, high-quality, and culturally appropriate healthcare.

It ensures alignment with legislative requirements, infection prevention and control guidelines, and accreditation standards, and supports continuous quality improvement across all service areas.

This document is designed to support consistent, high-quality infection prevention and control practices across Aboriginal Community Controlled Health Services. It provides a scalable framework that supports a range of service models, including fixed-site, outreach, and community-based service delivery.

2. SCOPE

This document applies to all people engaged with [Organisation Name], including employees, visiting clinicians, contractors, service providers, students, volunteers, patients, and visitors.

It applies across all service delivery environments, including clinical, non-clinical, administrative, outreach, and community-based settings, and covers all activities where there is a risk of exposure to infectious agents.

This document always applies during the delivery of care, handling of clinical materials, environmental cleaning, and any activity that may impact infection prevention and control within the organisation.

3. RESPONSIBILITIES

3.1. Chief Executive Officer

The Chief Executive Officer (CEO) is responsible for:

- Ensuring an effective infection prevention and control (IPC) system is implemented and maintained
- Providing appropriate resources to support IPC activities
- Ensuring IPC risks are managed through organisational governance and risk frameworks
- Supporting compliance with legislation and accreditation standards

3.2. Practice Manager

The Practice Manager is responsible for:

- Operational oversight of infection prevention and control systems
- Monitoring infection-related incidents, injuries, and near misses
- Ensuring audits, monitoring, and review activities are undertaken
- Supporting staff training, competency, and compliance
- Escalating infection risks and incidents through appropriate governance pathways

3.3. All Employees

All employees are responsible for:

- Complying with infection prevention and control policies and procedures
- Maintaining a clean, safe working environment
- Reporting hazards, incidents, exposures, and near misses
- Participating in required training and competency assessment
- Maintaining required immunisations relevant to their role

3.4. Infection Prevention and Control (IPC) Lead(s)

Infection Prevention and Control (IPC) Leads are formally designated roles within [Organisation Name] with responsibility for the coordination, implementation, and continuous improvement of infection prevention and control systems.

The IPC Lead(s) report to the Practice Manager and operate within the organisation's clinical governance and risk management frameworks.

IPC Lead(s) responsibilities include:

- Coordinating and maintaining infection prevention and control systems and procedures
- Ensuring policies and procedures are current, evidence-based, and aligned with relevant guidelines and standards
- Monitoring compliance with infection prevention and control practices through audits and review activities
- Supporting staff education, training, and competency assessment in infection prevention and control
- Ensuring timely dissemination of information relating to infection risks, outbreaks, and changes to guidelines
- Monitoring and escalating infection risks, incidents, and trends through appropriate governance pathways
- Supporting incident investigation and implementation of corrective actions
- Contributing to Continuous Quality Improvement (CQI) activities relating to infection prevention and control

The IPC Lead(s) are authorised to provide guidance, implement corrective actions, and escalate risks where infection prevention and control practices do not meet organisational or regulatory requirements.

3.5. Clinical Governance Oversight

The Clinical Governance Committee (or equivalent governance body) is responsible for oversight of infection prevention and control systems within [Organisation Name].

This includes the review of infection prevention and control audit outcomes, incident trends, exposure events, and identified risks. The Committee is responsible for ensuring that infection prevention and control systems are effective, compliant with legislative and accreditation requirements, and continuously improved through the organisation's clinical governance and risk management framework.

The Committee must ensure that identified risks, non-compliance, and improvement actions are appropriately escalated, monitored, and addressed.

4. DEFINITIONS

Term	Definition
Aseptic Technique (ANTT)	A set of practices used to prevent contamination of sterile sites and equipment during clinical procedures.
Clinical Governance	A framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.
Continuous Quality Improvement (CQI)	An ongoing process of identifying, analysing, and improving systems and practices to enhance quality, safety, and service delivery.
Cultural Safety	An environment that is spiritually, socially, and emotionally safe for Aboriginal and Torres Strait Islander peoples, where there is no assault, challenge, or denial of identity, and where cultural rights, values, and expectations are respected.
Disinfection	A process that eliminates many or all pathogenic microorganisms on inanimate objects, except bacterial spores.
Hand Hygiene	Any action of hand cleansing, including washing with soap and water or the use of alcohol-based hand rub, to reduce or inhibit the growth of microorganisms.
Incident Management System	A structured process for reporting, investigating, and managing incidents, including exposure events and infection risks.
Infection Prevention and Control (IPC)	A set of evidence-based practices and procedures designed to prevent or minimise the risk of transmission of infectious agents to patients, staff, and the community.
Pandemic	An epidemic occurring worldwide or over a wide geographic area, crossing international boundaries and affecting a large proportion of the population.
Personal Protective Equipment (PPE)	Specialised clothing or equipment worn by staff to minimise exposure to hazards that may cause injury or illness, including infection risks.
Practice Team:	Includes all employees, clinicians, contractors, and other persons engaged by [Organisation Name] who are involved in clinical care, service delivery, or operational support, regardless of service setting. The terms ‘practice team’ and ‘workforce’ are used interchangeably within this document
Risk Register	A formal system used to record, assess, monitor, and manage risks within the organisation, including infection prevention and control risks.
Sharps	Objects or devices capable of causing cuts or puncture wounds, including needles, blades, and other sharp instruments, which may be contaminated with blood or body substances.
Standard Precautions	The minimum infection prevention and control practices that must be applied to all patient care, regardless of suspected or confirmed infection

Term	Definition
	status, to reduce the risk of transmission of microorganisms.
Sterilisation	A validated process used to render a product free from all viable microorganisms.
Transmission-Based Precautions	Additional infection prevention and control measures implemented for patients known or suspected to be infected with pathogens that require specific control measures (e.g. contact, droplet, airborne precautions).

5. REFERENCES AND ASSOCIATED DOCUMENTS

References
Work Health and Safety Act 2011 (Cth)
Work Health and Safety Regulation 2017 (NSW)
Australian Guidelines for the Prevention and Control of Infection in Healthcare
[Organisation Name] Policy and Procedure Manual
[Organisation Name] WHS and Employment Handbook
RACGP Standards for General Practices 5th Edition
RACGP Infection Prevention and Control Guidelines for General Practices and Other Office-Based and Community-Based Practices
[Organisation Name] Pandemic and Influenza Response Plan

5.1. Legislative Compliance

[Organisation Name] will comply with all relevant legislative and regulatory requirements relating to infection prevention and control.

[Organisation Name] acknowledges its obligations as a Person Conducting a Business or Undertaking (PCBU) under the Work Health and Safety Act 2011 (NSW) and Work Health and Safety Regulation 2017 (NSW). Infection prevention and control is recognised as a workplace health and safety risk, requiring the organisation to eliminate or minimise, so far as is reasonably practicable, the risk of exposure to infectious diseases for workers and others.

This includes implementing safe systems of work, providing appropriate training and equipment, and ensuring that infection risks are identified, assessed, controlled, and monitored through the organisation's risk management framework.

6. POLICY

This document provides a flexible framework that may be adapted to reflect local service context, workforce, infrastructure, and community needs.

6.1. Principles of Infection Prevention Control

6.1.1. Policy

[Organisation Name] recognises that healthcare settings present inherent infection risks to patients, staff, and the broader community. Effective infection prevention and control require a systems-based, risk-managed approach supported by leadership, training, monitoring, and continuous improvement. [Organisation Name] has implemented systems that minimise the risk of healthcare associated infections.

[Organisation Name] has designated responsible roles for the coordination and implementation of infection prevention and control systems. Specific areas of responsibility may be delegated to other members of the practice team (e.g. infection prevention and control processes, sterilisation process, environmental cleaning, immunisation, education) and these particular responsibilities are documented in the relevant position descriptions.

[Organisation Name] has written policies relating to key infection prevention and control processes which are reviewed and updated regularly.

All members of the practice team have an individual responsibility to identify any potential infection risks within the practice and to be familiar with and implement the relevant infection prevention and control procedures of [Organisation Name].

New members of the practice team, including contracted or casual staff, are educated on the infection prevention and control policies that are appropriate to their duties as part of their induction to [Organisation Name] workplace and their competency is assessed and recorded. Mechanisms are in place to ensure ongoing education and competency on a regular basis and when changes occur to [Organisation Name] procedures.

Subject to informed consent, the immunisation status of [Organisation Name] practice team is known and recorded. Any refusal of recommended immunisation is also documented. Clinical team members are provided with access to the current Australian Immunisation Handbook and [Organisation Name] team members are offered the recommended immunisations in accordance with this handbook as appropriate to their duties.

[Organisation Name] remains alert to changes to guidelines for infection prevention and control and can implement them accordingly in a timely manner. We have a system for monitoring and obtaining information about national and local infection outbreaks, as well as about emerging new risks of cross infection. We have an effective mechanism for timely receiving and dissemination of any important communication or updates about emerging diseases or infection prevention and control measures to all relevant team members.

6.1.2. Procedure

The Infection Prevention and Control (IPC) Lead(s), in conjunction with the Practice Manager have primary responsibility for coordinating and sustaining infection prevention and control processes.

This includes:

- Continually modifying and improving [Organisation Name] procedures and written policies in accordance with the most recent evidence and guidelines, and adopting a risk management approach when implementing infection prevention and control measures
- Ensuring the timely dissemination of information concerning changes to infection prevention and control procedures or information about national and local infection control outbreaks
- Maintaining practice team knowledge, education and competency in infection prevention and control activities and ensuring the consistent implementation of infection prevention and control policies and procedures
- Ensuring the organisation remains visibly clean and the environmental cleaning processes are documented
- Appropriate delegation of infection prevention and control responsibilities and documentation of such delegation
- Educating patients on infection prevention and control activities

To ensure consistency of workplace practices [Organisation Name] policy and procedure manual contains the following infection prevention and control protocols:

- Prevention of disease in the workplace by serology and immunisation
- Blood and body substance spills management
- Blood and body substance exposure and sharps injury management
- Hand hygiene
- Standard and aseptic procedures
- Environmental cleaning of clinical and non-clinical areas
- Provision of sterile instruments
- Safe storage and stock rotation of sterile products
- Procedures for waste management including the safe storage and disposal of clinical waste and general waste
- The appropriate use and application of standard and transmission-based precautions, including the management of patients with potential communicable diseases
- Access for patients and practice team members to personal protective equipment including education on appropriate application, removal, and disposal
- Safe handling of pathology specimens
- Ongoing education and training
- Mechanisms for assessing staff competency in infection prevention and control procedures

6.2. Blood and Body Substance Spills

6.2.1. Policy

[Organisation Name] maintains documented systems for the safe and effective management of blood and body substance spills to minimise the risk of infection transmission to patients, staff, visitors, and contractors.

For the purposes of this policy, blood and body substances include (but are not limited to): blood, vomit, urine, faeces, sputum, wound exudate, and body tissue. All blood and body substances are treated as potentially infectious, regardless of the known or perceived infection status of the source.

[Organisation Name] applies standard precautions at all times, including during the management of blood and body substance spills. Where indicated, transmission-based precautions are implemented in accordance with current infection prevention and control guidelines.

[Organisation Name] will ensure that:

- Blood and body substance spills are managed promptly to reduce the risk of exposure and transmission
- Only trained and authorised staff manage spills
- Appropriate personal protective equipment (PPE) is available and used
- Spill management processes are supported through training, competency assessment, and monitoring
- Exposure incidents are reported and managed in accordance with post-exposure protocols

The Infection Prevention and Control (IPC) Lead(s) or designated staff member (e.g. Practice Nurse, Clinical Lead, or Practice Manager) are responsible for:

- Coordinating and maintaining spill management systems

- Ensuring staff and relevant contractors are familiar with this policy and procedure
- Ensuring staff receive appropriate training and competency assessment
- Ensuring staff are aware of actions to take following exposure to blood or body substances
- Monitoring compliance and escalating risks or incidents as required
- Monitoring and maintaining spill kits (including expiry dates and stock replacement

Spill Kits

[Organisation Name] maintains readily accessible blood and body substance spill kits in identified locations throughout the service.

Each spill kit consists of a rigid, lidded container and includes:

- Laminated spill management procedure and inventory checklist
- Small bucket with marked water level
- Pre-measured detergent in a labelled container
- Non-sterile utility gloves
- Eye protection (goggles and/or face shield)
- Surgical masks
- Disposable aprons
- Paper towels
- Scrapers (e.g. firm cardboard)
- Hazard signage to restrict access to the area
- Clinical and general waste bags
- Polymerising beads or other approved absorbent material

The detergent used for routine cleaning is appropriate for managing most spills. Where transmission-based precautions apply, an approved disinfectant with label claims against the relevant microorganism is used in accordance with manufacturer instructions.

The spill kit locations are:

{Insert Locations}

6.2.2. Procedure

As part of [Organisation Name] induction process, all members of the practice team are provided with information about practice protocol for managing spills of blood and body substances including what to do in the event of a needle-stick injury or exposure to blood or body substance.

Only staff with documented spill management training and immunisation status are authorised to clean blood and body substance spills.

In [Organisation Name], the spills kit is located {Insert Location}

[Organisation Name] management of spills is flexible enough to cope with different types of spills, considering the following factors:

- Nature of the spill: for example, sputum, vomit, faeces, urine or blood
- Pathogens most likely to be involved: for example, stool samples may contain viruses or bacteria, whereas sputum may contain Mycobacterium tuberculosis

- Size of the spill: for example, a spot, small or large spill
- Type of surface: for example, carpet or vinyl flooring
- Area involved: for example, in a contained area such as a consultation room or in a public area such as the waiting area, and
- Possibility of some material remaining on a surface where cleaning is difficult (e.g. between tiles) and the possibility of bare skin contact with that surface.
- The affected area must be left clean and dry. Disposable items in the spills kit must be replaced after each use and reusable items cleaned according to protocol

Only those practice team members with their immunisation status and spills management training recorded are permitted to clean spills of blood or body substances.

The method for cleaning spills at [Organisation Name] is as follows:

1. Apply standard precautions
2. Restrict access to the area using hazard signage
3. Don personal protective equipment
4. Prepare detergent solution as per instructions
5. Tear off enough paper towel to manage the spill
6. Prepare the appropriate waste bags
7. Clean the spill as outlined below

Hard Surfaces

- Remove any solid material using disposable paper towel or scraper
- Clean the area with detergent and water, using fresh paper towel for each wipe
- Rinse if required and dry the surface
- Apply disinfectant if indicated by risk assessment
- Dispose of contaminated materials appropriately

Soft Surfaces and Carpets

- Apply polymerising beads or absorbent material to contain the spill
- Remove residue using scraper or disposable material
- Clean with detergent and water using fresh paper towel for each wipe
- Quarantine the area until completely dry
- Arrange professional steam cleaning where required
- Apply disinfectant if indicated
- Dispose of contaminated materials appropriately

Exposure Management

Any exposure to blood or body substances (including needle-stick injuries or splashes) must be:

- Reported immediately
- Managed according to [Organisation Name] post-exposure procedures
- Documented through incident reporting systems

6.3. Hand Washing and Hand Hygiene

6.3.1. Policy

[Organisation Name] recognises effective hand hygiene as the single most important measure to prevent the transmission of infection in healthcare settings.

Hand hygiene reduces the risk of cross-contamination through direct contact with patients, contact with body substances, and contact with contaminated surfaces and equipment.

[Organisation Name] adopts a risk-based, evidence-informed approach to hand hygiene consistent with:

- Australian Guidelines for the Prevention and Control of Infection in Healthcare
- RACGP Infection Prevention and Control Guidelines
- World Health Organization (WHO) 5 Moments for Hand Hygiene

Hand hygiene must be performed in accordance with the WHO 5 Moments:

1. Before touching a patient
2. Before a procedure
3. After a procedure or body fluid exposure risk
4. After touching a patient
5. After touching a patient's surroundings

Gloves do not replace hand hygiene. Hand hygiene must be performed before donning gloves and after removing gloves.

To support effective hand hygiene:

- Fingernails must be kept short, clean, and free of artificial nails or nail enhancements
- Jewellery on hands and wrists should be minimised
- Cuts or abrasions must be covered with waterproof dressings
- Nail brushes are not used, as they may damage skin and increase infection risk

[Organisation Name] ensures that:

- All staff receive education and ongoing training in hand hygiene
- Hand hygiene facilities and products are readily accessible
- Products selected are appropriate to the level of hand hygiene required and staff skin health
- Compliance is monitored through observation, audit, or quality improvement activities

Facilities and Products

[Organisation Name] provides dedicated hand hygiene facilities in all clinical areas, including:

- Hot and cold running water
- Liquid soap via disposable cartridges or pump packs
- Single-use paper towels
- Alcohol-based hand rub (ABHR)

Soap bars are not used under any circumstances.

Liquid soap containers are not topped up. If refilling is required, containers must be cleaned and dried thoroughly prior to refilling.

Hot air dryers are not used in clinical areas. Single-use paper towels are used for hand drying and prior to aseptic procedures.

Alcohol-based hand rub is available:

- In all clinical areas
- In treatment and examination rooms
- In common areas
- In doctors' bags and during outreach or home visits where hand washing facilities are unavailable

Hand moisturiser compatible with hand hygiene products is made available to reduce skin irritation and support compliance.

6.3.2. Procedure

Hand hygiene methods at [Organisation Name] are implemented in accordance with clinical risk and procedure requirements as outlined below:

Routine hand cleaning for soiled hands	Wet hands → wash with neutral liquid soap → rinse thoroughly → turn off taps using paper towel if not hands-free	20-30 seconds	Single use Paper towel	When hands are visibly dirty, after toilet use, after body fluid exposure
Alcohol based hand rub (ABHR)	Apply sufficient product → rub all hand surfaces until dry	20-30 seconds OR Until dry	Rub hands until dry, without wiping	When hands are not visibly soiled, when needed. At each of the 5 moments of hand hygiene; Before touching a patient, Before a procedure, After a procedure or body fluid exposure risk, After touching a patient, After touching a patient's surroundings

Hand washing for standard aseptic (clinical) procedures	Wash with liquid soap or antimicrobial cleanser → rinse → dry → ABHR if indicated	1 minute	Single use Paper towel	Before any procedures requiring a clean or 'no touch' technique
Hand washing for surgical aseptic procedures	Remove jewellery →Wet hands and forearms →Wash with antimicrobial → cleaner (4% chlorhexidine or 0.75% detergent-based povidone or 1% aqueous povidone) → Clean under nails only if needed (do not scrub hands with nail brush as they can break the skin and be a source of infection) →Rinse carefully, keeping hands above elbows →Taps must be turned off using hands-free controls, a sterile towel, or assistance from another staff member where required.	First wash of the day: 5 minutes Subsequent washes: 3 minutes	Sterile towels	Before significant invasive surgical procedures

Hand hygiene facilities and configurations may vary depending on service model, infrastructure, and setting.

Location	Hand washing facilities	Equipped for routine hand washing	Equipped for aseptic hand washing	Equipped for Surgical hand washing
Patient toilets	Liquid soap Paper towel / air dryer	Yes	No	No
Consulting rooms	Liquid Soap Antimicrobial cleaner (2% Chlorhexidine) Paper towel	Yes	Yes	No
Treatment room	Liquid Soap	Yes	Yes	Yes

	Antimicrobial cleaner (4% Chlorhexidine) Paper towel Sterile towel			

Monitoring and Compliance

- Hand hygiene compliance is monitored through audits and quality improvement activities
- Non-compliance is managed through education, feedback, and performance management where required
- Hand hygiene practices are reviewed regularly and updated in line with emerging evidence or guideline changes

6.4. Standard and Aseptic Procedures

6.4.1. Policy

[Organisation Name] applies a risk-based approach to aseptic practice to minimise the risk of infection during all clinical procedures.

[Organisation Name] adopts the principles of Aseptic Non-Touch Technique (ANTT) as the nationally and internationally recognised framework for aseptic practice in healthcare.

Aseptic procedures are categorised as:

- Standard ANTT – used for routine clinical procedures where key parts can be protected using a non-touch technique
- Surgical (or Invasive) ANTT – used for more invasive procedures requiring a sterile field and sterile equipment

The level of aseptic technique applied is determined by:

- The invasiveness of the procedure
- The level of risk of introducing microorganisms into sterile tissue or body sites
- The patient's vulnerability (e.g. immunocompromised, neonates, chronic wounds)

All clinical staff are responsible for applying the appropriate level of aseptic technique in accordance with this policy and relevant clinical guidelines.

6.4.2. Procedure

General Principles (Applicable to All Aseptic Procedures)

All aseptic procedures at [Organisation Name] must include:

- Performance of hand hygiene in accordance with the Hand Hygiene Policy
- Use of standard precautions at all times
- Selection and use of appropriate personal protective equipment (PPE)
- Preparation of a clean and safe working environment
- Use of sterile or appropriately disinfected instruments and equipment
- Reprocessing of reusable instruments in accordance with approved reprocessing procedures

- Safe disposal of clinical waste and sharps

Standard ANTT® (Routine Aseptic Procedures)

Standard ANTT® is used for procedures such as:

- Wound dressing changes
- Venepuncture and cannulation
- Injections
- Minor skin procedures (e.g. simple biopsies, mole removal)
- Management of ulcers and lacerations

Standard ANTT® is achieved by:

- Performing hand hygiene immediately before the procedure
- Using clean, single-use gloves
- Identifying and protecting key parts (e.g. needle tips, wound contact surfaces)
- Using a non-touch technique wherever possible
- Cleaning wounds with sterile saline or potable water as clinically appropriate
- Preparing skin using an approved skin antiseptic
- Using clean or sterile dressing materials as indicated
- Maintaining clean environmental surfaces
- Using drapes to establish a clean working field where required
- Ensuring instruments and equipment are sterile or appropriately disinfected

Surgical (Invasive) ANTT®

Surgical ANTT® is required for procedures that:

- Involve entry into sterile body sites
- Present a high risk of infection if contamination occurs

Surgical ANTT® involves:

- Establishing a sterile field
- Performing surgical hand preparation
- Using sterile gloves, gowns, drapes, and instruments
- Preparing the patient's skin using an appropriate antiseptic agent
- Ensuring all items entering the sterile field are sterile
- Maintaining strict separation between sterile and non-sterile areas
- Ensuring that non-sterile items or personnel do not breach the sterile field

If sterility is compromised at any point, the procedure must be paused, and corrective action taken before continuing.

Environmental and Equipment Controls

- Clinical procedures must be performed in areas that are visibly clean and fit for purpose
- Reusable equipment must be cleaned, disinfected, or sterilised between patients in accordance with approved procedures
- Single-use items must not be re-used

Training, Competency, and Review

- All clinical staff receive education and training in aseptic technique, including ANTT® principles
- Competency is assessed at induction and reviewed periodically
- Aseptic practices are monitored through clinical audits and quality improvement activities
- This policy is reviewed in line with changes to evidence, guidelines, or accreditation requirements

6.5. Handling and Use of Chemicals

6.5.1. Policy

[Organisation Name] ensures that all chemicals, cleaning agents, and disinfectants used within the service are selected, handled, stored, used, and disposed of safely to protect patients, staff, visitors, and the environment.

Chemical management at [Organisation Name] complies with:

- Work Health and Safety Act 2011 and Regulations
- Australian Guidelines for the Prevention and Control of Infection in Healthcare
- Manufacturer instructions and Safety Data Sheets (SDS)
- [Organisation Name] Waste Management and WHS procedures

[Organisation Name] uses approved cleaning agents and disinfectants appropriate to the level of risk and intended purpose. This may include detergent-based products and disinfectants (including chlorine-based products where clinically indicated), provided they are used strictly in accordance with manufacturer instructions and risk assessment.

[Organisation Name] ensures that:

- Chemicals are not substituted or mixed unless approved by manufacturer guidance
- Appropriate disinfectants are available for situations requiring enhanced cleaning (e.g. outbreaks, blood or body substance spills, transmission-based precautions)
- All chemicals are used only for their intended purpose

Chemical Preparation and Labelling

Where cleaning solutions or disinfectants are diluted or prepared on site:

- Solutions are prepared in accordance with manufacturer instructions
- Solutions are prepared as required and discarded within the timeframe specified by the manufacturer

- Containers are cleaned, rinsed, and allowed to dry between uses
- Over-preparation and “topping up” of solutions is not permitted

All chemical containers, including decanted or diluted solutions, must be clearly labelled with:

- Product name and active ingredient
- Intended use
- Dilution ratio (where applicable)
- Date of preparation and expiry (if applicable)
- Hazard warnings and required PPE

Safety Data Sheets (SDS)

- A current SDS is available for all hazardous chemicals used at [Organisation Name]
- SDS are readily accessible to staff (hard copy and/or electronic)
- Staff are trained to locate and interpret SDS information
- SDS are reviewed and updated when products change

Storage and Security

[Organisation Name] stores chemicals:

- In designated, secure storage areas
- Away from food preparation or clinical supply areas
- In a manner that prevents unauthorised access, including access by children
- In cupboards fitted with child-proof locks where chemicals are stored below waist height

Chemical storage areas are clearly labelled and maintained in a clean, orderly condition.

Training and Personal Protective Equipment

[Organisation Name] ensures that:

- Only staff trained in the safe handling and use of chemicals are permitted to use them
- Training includes correct dilution, application, storage, disposal, and emergency response
- Appropriate PPE is provided and used as specified by the SDS (e.g. gloves, eye protection)

Disposal

- Chemicals are disposed of in accordance with manufacturer instructions and [Organisation Name] Waste Management procedures

- Unused or expired chemicals are not disposed of via sinks or general waste unless explicitly permitted
- Spill management procedures are followed for chemical spills

6.5.2. Procedure

Product selection may vary based on service context, procurement arrangements, and local risk assessment. Examples of commonly used products may include:

Product	*Intended use*	*Storage location*	*SDS available*	*PPE*
VIRACLEAN	General environmental cleaning	Storage Room	*Yes*	*Gloves*
BACTOL	Disinfectant for clinical surfaces	Storage Room	*Yes*	*Gloves, eye protection*
ISOWIPES	Equipment and small surface disinfection	Storage Room	*Yes*	*Gloves*

6.6. Single Use Items

6.6.1. Policy

[Organisation Name] ensures that single-use items and medical devices are used once only and are not reprocessed, cleaned, disinfected, or reused under any circumstances, unless they are specifically designated by the manufacturer as single-patient use and reused strictly in accordance with manufacturer instructions.

This policy is designed to:

- Prevent the transmission of infection
- Maintain patient and staff safety
- Ensure compliance with national infection prevention and control standards
- Meet legislative, accreditation, and professional obligations

6.6.2. Procedure

Single-use items are medical devices or equipment intended by the manufacturer to be used on one patient for one procedure and then discarded. These items must not be reused, even if they appear clean or intact.

Examples of single-use items include, but are not limited to:

- Oxygen masks and oxygen tubing
- Nebuliser sets and spacers
- Razors and spatulas
- Auriscope/otoscope tips
- Liquid nitrogen applicators
- Pins or monofilaments for sensory testing
- Single-use medications including eye drops, ointments, and topical preparations
- Lancets for blood glucose testing
- Spirometer and peak flow mouthpieces

- Disposable instruments and procedural consumables

Mandatory Single-Use Clinical Items

The following items are single-use only in this practice and must never be reused:

- Dressings and wound care products
- Suture materials and suture needles
- Hypodermic needles and syringes
- Scalpel blades and handles designed for single use
- Blood collection devices
- Injection equipment and sharps

These items must be disposed of immediately after use into approved waste streams.

Single-Patient Use Items

Some items may be labelled by the manufacturer as single-patient use rather than single-use. These items:

- May be reused only for the same patient
- Must never be shared between patients
- Must be cleaned, stored, and reused strictly in accordance with manufacturer instructions
- Must be clearly labelled with the patient's name
- Must be disposed of once the manufacturer's reuse limit is reached or the item becomes damaged or contaminated

Examples may include selected monitoring devices or aids where permitted by the manufacturer.

Use of Medications and Vials

- Single-dose vials are used in preference to multi-dose vials wherever possible
- Single-dose vials are used once and discarded immediately after use
- Multi-dose vials are only used where clinically necessary and must be managed in accordance with:
  - Manufacturer instructions
  - Cold chain and storage requirements
  - Clearly documented protocols

When multi-dose vials are used:

- Aseptic technique must be used at all times
- Vials must be labelled with the date of opening and discard date
- Vials must be discarded immediately if contamination is suspected
- Staff must be trained and monitored in correct handling to minimise infection risk and medication errors

Single-Use Fluids and Solutions

- Wherever possible, saline solutions, skin preparation agents, and topical solutions are purchased in single-use sachets or containers
- Where larger containers are used:
  - They are dated when opened
  - They are stored in accordance with manufacturer instructions
  - They are discarded within the recommended timeframe
  - Decanting into smaller containers is not permitted unless explicitly allowed by manufacturer instructions

Disposal of Single-Use Items

- Single-use items contaminated with blood or body substances are disposed of in accordance with the [Organisation Name] Waste Management Procedure
- Sharps are disposed of immediately into approved sharps containers
- Clinical waste is segregated, handled, and removed in line with WHS and environmental requirements

6.7. Instrument and Equipment Processing Area

6.7.1. Policy

[Organisation Name] applies a risk-based approach to the management of instruments and equipment to minimise the risk of infection transmission and ensure patient and staff safety.

Instrument management models are determined by clinical risk, service capability, infrastructure, and workforce capacity. Services may utilise single-use instruments, onsite reprocessing and sterilisation, or external sterilisation services where appropriate.

All instruments and equipment are classified according to their intended use (critical, semi-critical, and non-critical), and are managed in accordance with national infection prevention and control guidelines, manufacturer instructions, and relevant accreditation standards.

[Organisation Name] ensures that:

- Critical instruments used in sterile body sites are sterile at the point of use
- Semi-critical instruments are appropriately cleaned and disinfected or sterilised based on risk
- Non-critical equipment is cleaned and disinfected between patients
- Reprocessing of reusable instruments, where undertaken, complies with validated cleaning, disinfection, and sterilisation processes
- Staff responsible for instrument handling and reprocessing are trained and assessed as competent

Where instrument reprocessing is undertaken, it must occur in a designated area that supports appropriate workflow, separation of clean and contaminated processes, and compliance with infection prevention and control standards.

This policy ensures infection risks are minimised while maintaining compliance with legislative, regulatory, and accreditation requirements across all service areas.

6.7.2. Procedure

Instrument Management Models

[Organisation Name] may implement one or more of the following instrument management models, based on service context:

- Use of single-use, sterile instruments for clinical procedures
- Onsite cleaning, disinfection, and sterilisation of reusable instruments
- Use of external sterilisation services where appropriate

The selected model must be supported by documented procedures, staff training, and quality assurance processes.

Single-Use Instrument Model

Where single-use instruments are utilised:

- Only manufacturer-supplied sterile instruments are used for invasive procedures
- Instruments are checked for packaging integrity and expiry prior to use
- All instruments are disposed of immediately after use in accordance with waste management procedures
- Single-use items must not be reused under any circumstances

Reusable Instrument Reprocessing

Where reusable instruments are used:

- Instruments are cleaned, disinfected, and/or sterilised in accordance with manufacturer instructions and national infection prevention and control guidelines
- Reprocessing must occur in a designated area that supports separation of contaminated and clean workflows
- Validated sterilisation processes must be used where required
- Sterility assurance processes (e.g. indicators, logs, tracking) must be implemented and documented
- Staff performing reprocessing must be trained and assessed as competent

Where external sterilisation services are used, processes for transport, tracking, and verification of sterility must be clearly documented.

Non-Critical Equipment (All Areas)

Non-critical reusable equipment (e.g. blood pressure cuffs, examination couches, diagnostic devices) must be:

- Cleaned between patients using appropriate detergent and/or disinfectant
- Cleaned in designated areas (not hand hygiene sinks)
- Maintained in a clean and serviceable condition
- Inspected regularly and removed from service if damaged or unable to be effectively cleaned

Monitoring and Compliance

Compliance with instrument and equipment management requirements is monitored through:

- Infection prevention and control audits
- Incident and exposure reporting
- Review through clinical governance processes
- Accreditation and regulatory review activities

Identified risks, non-compliance, or system gaps must be addressed through corrective actions and integrated into Continuous Quality Improvement (CQI) processes.

6.8. Sterility Assurance

6.8.1. Policy

[Organisation Name] ensures that all items used for procedures involving normally sterile tissue, sterile body cavities, or the bloodstream are sterile at the point of use.

Sterility assurance is achieved through a risk-based approach that may include the use of single-use sterile instruments, validated onsite reprocessing and sterilisation, or external sterilisation services, depending on service capability and clinical requirements.

All sterile instruments and consumables must be:

- Sourced, processed, and maintained in accordance with manufacturer instructions and national infection prevention and control guidelines
- Stored, handled, and transported in a manner that maintains sterility until point of use
- Traceable where required to support patient safety and incident management

[Organisation Name] ensures that staff involved in the handling, storage, and use of sterile items are appropriately trained and competent, and that sterility assurance systems are monitored through governance and Continuous Quality Improvement processes.

6.8.2. Procedure

Sterile Instruments and Consumables

Sterile instruments and consumables may be obtained through:

- Manufacturer-supplied single-use sterile items

- Onsite cleaning, disinfection, and sterilisation processes
- External sterilisation services where appropriate

All sterile items must be:

- Stored in clean, dry, and designated areas that protect packaging integrity
- Checked prior to use for:
  - Packaging integrity
  - Sterility indicators (where applicable)
  - Expiry dates
- Managed to ensure traceability where required, including recording batch or lot numbers for high-risk items or procedures

Single-use sterile items must be disposed of immediately after use and must not be reused.

Reusable Instrument Sterilisation (Where Applicable)

Where reusable instruments are utilised:

- Cleaning, disinfection, and sterilisation must be undertaken in accordance with manufacturer instructions and national infection prevention and control guidelines
- Validated sterilisation processes must be used
- Sterility assurance systems (e.g. indicators, logs, tracking) must be implemented and documented
- Instruments must be stored in a manner that maintains sterility until use

Where external sterilisation services are used, transport, handling, and verification processes must be clearly documented.

Stock Management and Storage

- Stock must be rotated using a first-in, first-out system
- Expired, damaged, or compromised sterile items must be removed from use immediately
- Storage conditions must protect sterility, including protection from moisture, dust, and damage
- Disposal must occur in accordance with the [Organisation Name] Waste Management Procedure

Monitoring and Continuous Quality Improvement

Sterility assurance processes must be monitored and reviewed through:

- Infection prevention and control audits
- Incident and near-miss reporting
- Review of sterilisation records and traceability systems (where applicable)

- Updates to standards, guidelines, or manufacturer instructions

Identified risks or non-compliance must be addressed through corrective actions and integrated into Continuous Quality Improvement (CQI) processes and the organisation's risk management framework.

6.9. Waste Management

6.9.1. Policy

[Organisation Name] is committed to ensuring that all waste generated by the service is managed safely and responsibly to minimise the risk of injury or infection to patients, staff, contractors, and visitors, and to prevent environmental harm. Waste is handled, stored, transported, and disposed of in a manner that meets legislative, regulatory, and accreditation requirements.

Waste management practices are informed by the RACGP Infection Prevention and Control Guidelines (5th edition), the Australian Guidelines for the Prevention and Control of Infection in Healthcare, relevant NSW public health and environmental protection requirements, and applicable regulated waste standards.

All members of the practice team receive education and training appropriate to their role in relation to waste handling and disposal. This includes training in the safe disposal of sharps, management of blood and body substance contamination, spill response, and the actions to take in the event of occupational exposure.

[Organisation Name] applies standard precautions when handling all waste and ensures that waste is segregated at the point of generation. Waste is managed according to risk and disposed of using approved systems and licensed contractors.

Waste Classification

Clinical and related waste is defined as waste that has the potential to cause infection, sharps injury, public offence, or environmental harm. This includes discarded sharps; human blood and blood products; human tissue (excluding hair, teeth, nails, urine, and faeces); items containing free-flowing or expressible blood; waste generated from patients with known or suspected epidemiologically significant communicable diseases where required; and pharmaceutical, chemical, or cytotoxic waste as defined under regulation.

General waste refers to waste that does not meet the criteria for clinical and related waste. This includes office and administrative waste, kitchen waste, urine and faeces, hair, teeth and nails, disposable nappies, used tongue depressors, non-hazardous pharmaceutical waste such as expired saline, and items lightly contaminated with blood or body substances where there is no expressible blood.

6.9.2. Procedure

All practice team members handling waste use appropriate personal protective equipment, with gloves worn as a minimum. Waste is never compressed by hand. Waste is segregated at the point of use into clinical and related waste, cytotoxic waste, sharps, and general waste, including recyclable and confidential waste streams.

Sharps are disposed of immediately after use into approved puncture-resistant sharps containers located in all clinical areas where sharps are generated. Sharps containers are clearly labelled, not overfilled, and sealed and replaced once the designated fill line is reached. Sharps containers are removed and disposed of by a licensed regulated waste contractor.

Clinical waste is disposed of into yellow, rigid-walled containers lined with yellow clinical waste bags and clearly labelled with the biohazard symbol. These containers have secure lids and hands-free operation where practicable and are positioned away from public access and out of reach of children. While awaiting collection, clinical waste is stored in a locked, clearly identified area that is separate from clean supply storage and accessible only to authorised staff.

[Organisation Name] engages licensed regulated waste contractors for the collection and disposal of clinical and related waste in accordance with regulatory requirements. Collection frequency is determined based on service needs, waste volume, and regulatory requirements. Final disposal is undertaken using approved methods such as high-temperature incineration or other regulated treatment processes appropriate to the waste classification.

Cytotoxic waste is segregated at the point of use and disposed of into purple containers lined with purple cytotoxic waste bags and clearly marked with the cytotoxic symbol. These containers are rigid, sealable, and stored securely in locked areas away from public access. Cytotoxic waste is collected by a licensed contractor. [Organisation Name] engages a licensed regulated waste contractor for cytotoxic waste disposal, with collection occurring as regularly as required and final disposal by high-temperature incineration.

Hazardous chemical waste is managed in accordance with manufacturer instructions and Safety Data Sheets. Chemicals requiring specialised disposal are not disposed of via general waste or sewerage systems. Approved licensed contractors are engaged for the treatment and disposal of hazardous chemical waste as required.

General waste is segregated into recyclable, non-recyclable, and confidential waste streams in accordance with local council requirements, privacy obligations, and confidentiality protocols. Waste lightly contaminated with blood or body substances that does not meet clinical waste criteria is disposed of in lined general waste bins positioned away from public access. Confidential waste is shredded prior to disposal.

Responsibility for oversight of waste management systems, including monitoring stock levels of waste containers and coordinating collection schedules, is delegated to the IPC Lead(s) or designated staff member. Compliance with waste management procedures is monitored through routine audits, incident reporting, and accreditation review processes.

6.10. Sharps Management

6.10.1. Policy

[Organisation Name] is committed to minimising the risk of sharps injury to patients, practice team members, contractors, and visitors, and to preventing the transmission of blood-borne infections associated with sharps use and disposal.

Sharps injuries represent a significant occupational health and safety risk in healthcare settings. All sharps contaminated with blood or body substances are considered potentially infectious. Safe handling, use, and disposal of sharps are essential components of infection prevention and workplace safety.

Sharps include, but are not limited to, needles, syringes, lancets, scalpels, suture needles, and any other object capable of causing a penetrating injury.

[Organisation Name] applies a hierarchy of control approach to sharps safety and gives preference, where clinically appropriate, to devices designed to reduce the risk of sharps injury, such as safety-engineered or needle-free systems.

The practice team member who generates or uses a sharp is responsible for its safe handling and immediate disposal. This responsibility cannot be delegated.

[Organisation Name] ensures all practice team members receive training appropriate to their role in:

- Safe use and disposal of sharps
- Location and correct use of sharps containers
- Actions to take in the event of a sharps injury or exposure incident

Sharps containers are available in all areas where sharps are used and are positioned to support safe disposal while preventing unauthorised access, particularly by children.

6.10.2. Procedure

Sharps Containers

Sharps containers used within [Organisation Name]:

- Comply with current Australian regulatory requirements for sharps containers
- Are rigid, puncture-resistant, and clearly labelled
- Are positioned approximately 900–1300 mm from the floor, based on ergonomic and safety considerations.
- Are secured to prevent tipping or removal
- Are placed so the container opening is clearly visible at the point of disposal
- Are not located on the floor or over other waste or linen receptacles
- Are replaced when the designated fill line is reached and are never overfilled

Filled sharps containers are sealed and stored securely with clinical waste and are not reopened. Collection and disposal are undertaken by a licensed regulated waste contractor. [Organisation Name] engages a licensed regulated waste contractor for sharps waste disposal.

Safe Use and Disposal of Sharps

The following practices apply to all sharps use within [Organisation Name]:

- The person using the sharp is responsible for its safe disposal
- Sharps are disposed of immediately after use or at the conclusion of the procedure
- Used sharps are not carried unnecessarily within the practice
- Needles and syringes are disposed of together as a single unit
- Needles are not recapped, bent, broken, or removed by hand
- Injection trays are used where required to transport sharps safely
- Assistance is sought when performing procedures on uncooperative patients or children to reduce the risk of injury
- Sharps containers are sealed and replaced promptly once the fill line is reached

Sharps Injury and Exposure Management

In the event of a sharps injury or exposure to blood or body substances:

- Immediate first aid is provided in accordance with exposure management procedures
- The incident is reported as soon as practicable
- Appropriate medical assessment and follow-up is arranged
- The incident is documented and reviewed to identify contributing factors and prevention strategies

Safer Sharps and Equipment

[Organisation Name] actively reduces the risk of sharps injury through procurement practices and uses safer sharps devices where clinically appropriate. These may include:

- Self-retracting single-use lancets
- Safety-engineered cannulas and needleless systems
- Vacuum blood collection systems
- Scalpel blade removal devices
- Plastic ampoules where available

6.11. Standard Precautions

6.11.1. Policy

Standard precautions are to be followed by all members of the practice team who provide patient care or who may come into contact with blood or body substances (including secretions and excretions, but excluding sweat), regardless of the patient's known or perceived infection status. All blood and body substances must always be considered potentially infectious.

Standard precautions are a set of work practices consistently applied to achieve a baseline level of infection prevention and control across all healthcare settings and situations. They are designed to protect both patients and practice team members, and encompass the following measures:

- Hand hygiene – performed in accordance with the practice's hand hygiene policy
- Use of appropriate personal protective equipment (PPE), such as gloves, gowns, plastic aprons, masks, and eye protection, selected according to the task and level of exposure risk
- Respiratory hygiene and cough etiquette
- Aseptic technique – using standard or surgical aseptic procedures as appropriate to reduce patient exposure to microorganisms
- Safe handling and disposal of sharps and waste
- Immunisation – all clinical and healthcare staff, including administrative personnel with patient contact, should be appropriately immunised according to national guidelines
- Effective reprocessing of reusable equipment and instruments, where applicable

- Environmental controls, including design, maintenance, cleaning, and management of spills
- Support services such as waste disposal, laundry, and cleaning services

The RACGP Infection Prevention and Control Standards (5th Edition) recommend that heavy-duty gloves, gowns, aprons, masks, eye protection, or other protective barriers are used whenever staff are performing procedures, handling blood or body substances, managing spills, or dealing with waste. PPE selection should be guided by a risk assessment for each procedure or task.

6.11.2. Procedure

All staff involved in patient care or who may have contact with blood or body substances are required to understand and use standard precautions when they are likely to be in contact with:

- Blood
- Body substances including secretions and excretions (but excluding sweat)
- Non-intact skin, and
- Mucous membranes

Staff should:

- Perform hand hygiene before and after patient contact and after removal of gloves
- Select PPE appropriate to the task, ensuring it covers potential exposure areas
- Follow safe practices for handling sharps, waste, and contaminated materials
- Follow cleaning, environmental, and spill management procedures as outlined in the practice's infection prevention and control manual
- Participate in regular training and updates on standard precautions and infection prevention measures

6.12. Transmission Based Precautions

6.12.1. Policy

Transmission-based precautions are additional measures used on top of standard precautions to prevent the spread of infectious diseases that are highly transmissible or epidemiologically significant. They are applied to patients who are known or suspected to be infected with pathogens such as influenza, measles, tuberculosis, or other communicable diseases.

All practice team members are trained to triage, identify, and apply transmission-based precautions and are aware of the appropriate personal protective equipment (PPE), isolation, and patient management measures.

Transmission-based precautions include:

- Contact precautions – to prevent direct or indirect transmission via touch
- Droplet precautions – to prevent transmission via respiratory droplets
- Airborne precautions – to prevent transmission via small particles that remain suspended in the air

These precautions may include isolation of the patient, appropriate signage to alert staff and visitors, and using barriers and PPE to prevent disease spread.

6.12.2. Procedure

Transmission-based precautions are applied for patients known or suspected to be infected with highly transmissible pathogens. The main goal is to minimise exposure to others through a combination of environmental, administrative, and personal measures.

Key practice measures include:

- Patient management and triage:
  - Patients with suspected infectious diseases should be identified at reception or by telephone triage before entering the practice
  - Where possible, patients are isolated in a single consultation room or advised to wait in their car until seen
  - Appointment scheduling may prioritise infectious patients to minimise contact with others
- Environmental and administrative controls:
- Maintain 1.5 metre distancing in waiting areas
- Display educational posters on hand hygiene, respiratory etiquette, and cough etiquette
- Clean surfaces and high-touch areas between patients

Personal protective equipment (PPE):PPE selection is determined by the type of transmission risk (airborne, droplet, contact) and is consistent with RACGP 5th Edition recommendations.

Requirement	Airborne transmission	Droplet transmission	Contact transmission
Gloves	*Use if direct contact with patient or environment*	*Use if direct contact with patient or environment*	*For all manual contact with patient, associated devices and environmental surfaces*
Impermeable gown, apron	*Use if clothing likely to be contaminated*	*Use if clothing likely to be contaminated*	*Use when health professional's clothes are in substantial contact with the patient (including items in contact with the patient and their immediate environment)*
Mask	*P2/N95 respirator*	*Surgical mask*	*Protect face if splash is likely*
Goggles/face shield	*If splash or aerosol likely*	*Protect face if splash is likely*	*Protect face if splash is likely*
Special handling of equipment	*Single use equipment or reprocess after patient use (includes all equipment in contact with patient)*	*No special requirements*	*Single use equipment or reprocess after patient use (includes all equipment in contact with patient)*
Other	*Encourage respiratory etiquette; isolate or segregate patient if possible; provide a mask if isolation is not possible; communicate infectious status to other healthcare*	*Encourage respiratory etiquette; isolate or segregate patient if possible; provide a mask if isolation is not possible; communicate infectious status to*	*Encourage respiratory etiquette; isolate or segregate patient if possible; provide a mask if isolation is not possible; wash hands after removing gloves and gowns; communicate infectious*

	providers (e.g., ambulance, ED)	*other healthcare providers*	*status to other healthcare providers*

Source: RACGP Infection prevention and control standards for general practices and other office-based and community-based practices (5th edition)

6.13. Personal Protective Equipment

6.13.1. Policy

[Organisation Name] ensures that appropriate personal protective equipment (PPE) is available, accessible, and used by all practice team members to minimise the risk of exposure to infectious agents, blood, body substances, and hazardous chemicals. PPE includes gloves, gowns, aprons, masks, goggles, and face shields.

All members of the practice team receive education and training in the correct selection, application, removal, and disposal of PPE. This ensures a consistent understanding of the purpose of PPE, compliance with standard and transmission-based precautions, and alignment with accreditation, regulatory, and workplace health and safety requirements.

The practice is committed to:

- Ensuring PPE is readily accessible in all relevant areas
- Providing ongoing education and competency assessment on PPE use
- Maintaining PPE stock and equipment in good condition and within expiry dates
- Selecting PPE appropriate to the task, risk of exposure, and patient factors
- Integrating PPE use with broader infection prevention and control measures, including hand hygiene, safe handling of sharps, and waste management

6.13.2. Procedure

All members of [Organisation Name] workforce have easy access to appropriate personal protective equipment (PPE). In all areas where PPE is used, educational posters demonstrate correct application, removal, and disposal. PPE is available in all areas where clinical care or procedures are undertaken, and the IPC Lead(s) or designated staff member is responsible for stock control, maintenance, and reordering of supplies.

PPE is used whenever there is potential contact with blood, body substances, or hazardous chemicals (e.g., liquid nitrogen). This includes, but is not limited to:

- Examinations involving mucous membranes
- Cleaning, dressing, or removing bandages from wounds
- Cleaning up after procedures
- Preparing instruments and equipment for sterilisation
- Assisting with or performing procedures
- Cleaning contaminated surfaces or spills of blood and body substances
- Collecting blood or handling pathology specimens
- Controlling bleeding

All team members receive education and competency training in PPE during induction and on an ongoing basis. Training covers the correct selection, application, removal, and

disposal of PPE for the presenting situation, ensuring the safety of both staff and patients.

The PPE used at [Organisation Name] includes:

- Gloves: sterile, non-sterile, general-purpose utility, and heavy-duty puncture-resistant
- Face masks: surgical masks and P2/N95 respirators
- Eye protection: goggles or face shields
- Gowns: long- and short-sleeved, cuffed, disposable or reusable
- Plastic aprons

All team members are competent in:

- Selecting appropriate PPE for the clinical situation
- Explaining the purpose of different PPE types
- Correctly applying, removing, and disposing of PPE safely

Guidance on PPE use:

- Disposable gloves should be worn when handling blood or body substances, contact with non-intact skin, contaminated equipment or surfaces, and during venepuncture
- Sterile gloves should be used for any procedure penetrating skin or mucous membranes, during venepuncture for blood cultures, and whenever a sterile field is required
- Heavy-duty gloves are worn for instrument processing, general cleaning, and handling spills of blood or body substances
- Surgical masks should be used during procedures where splashes or droplet generation are likely, to protect staff and patients, and when patients are suspected or known to have infectious diseases
- P2/N95 respirators are worn when there is a risk of airborne transmission of diseases, including tuberculosis or pandemic influenza
- Eye protection is used to prevent splashes of blood or body substances and during procedures or cleaning where there is a risk of droplet or airborne transmission
- Gowns and plastic aprons are worn when there is a risk of contamination of clothing or skin with blood, body substances, or airborne/droplet-transmissible pathogens

All PPE is disposed of according to the practice's infection prevention and control procedures, and used PPE is never reused.

6.14. Laundry

6.14.1. Policy

[Organisation Name] implements a risk-based approach to linen and surface management to minimise the risk of infection transmission.

Where disposable coverings are used, including paper bed rolls or disposable fitted sheets, these must be replaced between each patient and disposed of in accordance with the organisation's waste management procedures.

Where reusable linen is used, it must be handled, transported, and laundered in a manner that minimises the risk of cross-contamination. This includes the safe handling of contaminated linen, use of appropriate personal protective equipment, and laundering in accordance with infection prevention and control guidelines.

All linen and surface management practices must align with risk assessment, infection prevention and control procedures, and relevant legislative and accreditation requirements.

6.14.2. Procedure

All patient examination couches and treatment surfaces must be covered with disposable paper bed rolls or appropriate protective coverings for each patient.

After each patient, used disposable coverings must be removed and disposed of in accordance with the organisation's waste management procedures. Surfaces beneath the covering must be cleaned and disinfected between patients in line with standard precautions and manufacturer's recommendations for environmental cleaning products.

Where disposable coverings are used as the primary method of infection control, no laundering of textiles is required. The Practice Manager or designated staff member must ensure adequate stock levels are maintained and monitored.

Where reusable linen is used, it must be handled, transported, and laundered in a manner that minimises the risk of infection transmission. This includes the safe handling of contaminated linen, use of appropriate personal protective equipment, and laundering in accordance with infection prevention and control guidelines.

All linen and surface management practices must align with risk assessment and organisational infection prevention and control procedures to ensure a hygienic environment and minimise the risk of infection transmission.

6.15. Safe Handling of Pathology Specimens

6.15.1. Policy

Laboratory investigation of specimens is integral to clinical care, enabling detection and identification of microorganisms and, where appropriate, assessment of antibiotic sensitivity. The accuracy of laboratory results depends on specimens being collected correctly, of adequate quantity, labelled properly, and transported under appropriate conditions.

Specimens may contain microorganisms capable of causing disease; therefore, care must be taken during collection, handling, and transport to protect both patients and healthcare workers. Suboptimal practices can lead to false results, including overgrowth of some organisms, loss of delicate organisms, or degradation due to incorrect storage temperature.

Where external pathology collection services are used, local arrangements for specimen collection, handling, and transport must be documented in accordance with service-specific workflows

6.15.2. Procedure

[Organisation Name] ensures safe handling of pathology specimens through the following measures:

- All specimen containers are pre-labelled with the patient's details prior to collection to minimise handling post-collection
- Collected blood and body substance specimens are placed into the appropriate container as specified by the testing laboratory
- Each container is wiped clean to remove any visible soiling, checked for correct identification, and securely sealed to prevent leakage
- Specimens are placed upright in waterproof bags or containers during handling or transport
- Pathology request forms are kept separate from specimens to prevent contamination, but linked correctly to the corresponding sample
- For transport outside the facility, specimens are packed according to relevant regulations, using an absorbent inner container and a sealable, robust, waterproof outer container, labelled in accordance with postal or transport guidelines
- Specimens are stored or transported at temperatures appropriate to the test requirements, ensuring that laboratory results are not compromised
- Staff are trained to use standard precautions, including hand hygiene and personal protective equipment, during specimen collection and handling to reduce the risk of exposure to infectious material
- Where external pathology collection services are used, local arrangements for specimen collection, handling, and transport must be clearly documented to ensure specimen integrity and minimise infection risk
- This procedure ensures that all specimens are handled safely, maintains their integrity for accurate laboratory analysis, and protects both patients and practice team members from potential infection hazards

6.16. Pandemic and Influenza Outbreaks

6.16.1. Policy

A pandemic or outbreak is a communicable disease event that may occur locally, regionally, nationally, or globally and has the potential to significantly affect patients, staff, service delivery, and the broader community. Pandemic or outbreak events may include influenza, COVID-19, measles, tuberculosis, gastroenteritis, or other emerging or re-emerging infectious diseases.

[Organisation Name] is committed to protecting the health, safety, and wellbeing of staff, patients, visitors, and community members during pandemic and outbreak conditions. The organisation will maintain systems to support the early identification, assessment, escalation, and management of communicable disease risks, while ensuring continuity of essential health services where safe and reasonably practicable to do so.

Pandemic and outbreak management will be guided by current public health legislation, Work Health and Safety obligations, RACGP Standards, NSQHS Standards, and relevant public health authority advice. The organisation acknowledges that pandemic and outbreak risks must be managed through a

coordinated, risk-based approach that integrates infection prevention and control, workforce planning, business continuity, communication, and staff wellbeing.

[Organisation Name] will designate responsible officers to coordinate pandemic and outbreak preparedness and response. These roles will be documented within the organisation's governance structure and supported by clear escalation pathways, staff training, and access to current information. Pandemic and outbreak management systems must be reviewed regularly and updated in response to changes in evidence, legislation, public health advice, service needs, or lessons learned from previous events.

6.16.2. Procedure

Leadership and Responsibility

The Chief Executive Officer must ensure that [Organisation Name] maintains a current Pandemic and Outbreak Response Plan and associated Business Continuity arrangements.

The Practice Manager and Infection Prevention and Control Lead(s) must:

1. Coordinate pandemic and outbreak preparedness, response, and recovery activities.
2. Ensure staff receive training and timely updates relevant to the outbreak or pandemic event
3. Maintain communication with NSW Health, the local Public Health Unit, and other relevant stakeholders
4. Escalate risks, incidents, and operational impacts through the organisation's governance framework
5. Ensure the Pandemic and Outbreak Response Plan and Emergency Response and Business Continuity Plan are accessible, current, and reviewed at least annually or earlier if required

The Pandemic and Outbreak Response Plan is stored at: [Insert Location].

Identification and Screening

During pandemic or outbreak conditions, the organisation must implement screening, triage, and risk assessment processes appropriate to the identified infectious risk and current public health advice.

Staff must:

1. Apply pre-screening processes where required, including telephone screening prior to attendance where appropriate
2. Identify patients, visitors, or staff with signs, symptoms, or exposure risks relevant to the outbreak condition
3. Escalate identified risks in accordance with organisational procedures
4. Provide clear instructions to symptomatic persons regarding attendance, waiting arrangements, masking, and isolation requirements

Where indicated by risk assessment or public health advice, the organisation may implement measures such as symptom screening on arrival, physical distancing strategies, visitor restrictions, or modified waiting arrangements.

Infection Prevention and Control Measures

The Practice Manager and Infection Prevention and Control Lead(s) must ensure that infection prevention and control measures are strengthened in response to the level of risk presented by the pandemic or outbreak.

This may include:

1. Increased use of standard and transmission-based precautions
2. Enhanced access to appropriate PPE
3. Reinforcement of hand hygiene and respiratory hygiene using soap and water or alcohol-based hand rub
4. Enhanced environmental cleaning and disinfection of clinical and high-touch surfaces
5. Review of ventilation and airflow management where relevant
6. Removal, restriction, or increased cleaning of shared items where required by risk assessment
7. Use of signage and communication materials to support infection prevention and control requirements

All measures implemented must align with current public health advice and organisational risk assessment.

Patient Flow and Service Delivery

The organisation must adjust service delivery arrangements as required to minimise infection transmission and maintain safe access to care.

The Practice Manager and relevant clinical staff must:

1. Review appointment scheduling to reduce overcrowding and support safe patient flow
2. Use isolation or segregation strategies for patients with known or suspected infectious conditions where appropriate
3. Promote telehealth or remote consultations where clinically appropriate and operationally feasible
4. Modify service delivery arrangements, including home visits or outreach, based on risk assessment and service need
5. Communicate any changes to service delivery, access arrangements, opening hours, or safety requirements to patients and community in a timely manner

Where external pathology collection services are used, local arrangements must be documented.

Management of Unwell Staff

Any staff member who is unwell, symptomatic, or identified as a relevant exposure risk must be managed promptly and safely.

Managers must:

1. Ensure symptomatic staff are separated from others as soon as practicable

2. Arrange clinical assessment, testing, or referral in accordance with current public health advice
3. Ensure affected work areas are cleaned and disinfected as required
4. Record relevant exposures, incidents, and actions taken in accordance with organisational procedures
5. Support safe transport arrangements where required

Return to work must occur in accordance with current public health requirements, clinical advice, organisational policy, and role-specific risk assessment.

Workforce Planning and Operational Continuity

The organisation must maintain workforce and business continuity planning to support safe continuation of essential services during pandemic or outbreak conditions.

The Chief Executive Officer and Practice Manager must:

1. Determine minimum safe staffing levels based on service context, workforce availability, clinical risk, and operational priorities
2. Identify staff who may be at increased risk due to health conditions, pregnancy, caring responsibilities, or other vulnerabilities
3. Consider modified duties, remote work, or alternative work arrangements where appropriate
4. Maintain contingency arrangements for staff replacement, surge capacity, and cross-training where feasible
5. Monitor essential clinical and operational supplies, including PPE, hand hygiene products, medications, cleaning products, and critical equipment
6. Identify alternative suppliers or contingency procurement pathways where required

Communication Strategy

Effective communication must be maintained throughout pandemic or outbreak response activities.

The Practice Manager and Infection Prevention and Control Lead(s) must:

1. Provide staff with regular updates regarding risks, PPE requirements, screening processes, leave requirements, and other relevant changes
2. Ensure communication materials are clear, timely, and accessible
3. Keep patients and community informed of any changes to service delivery, access requirements, or public health instructions through appropriate communication channels
4. Maintain communication with local health authorities and relevant external stakeholders where notification, consultation, or coordination is required
5. Ensure key communications are documented where required to support governance, traceability, and accreditation expectations

Supporting Staff Wellbeing

Pandemic and outbreak response planning must include measures to support the physical and psychological wellbeing of staff.

The organisation must:

1. Promote access to relevant immunisation programs in accordance with current recommendations
2. Support access to wellbeing resources, counselling, or Employee Assistance Programs where available
3. Encourage regular team check-ins, supervision, and debriefing
4. Consider flexible or modified work arrangements where appropriate
5. Ensure staff are provided with clear expectations, role clarity, and current information to reduce uncertainty and distress

Recovery and Post-Event Review

Following a pandemic or outbreak event, the organisation must undertake a structured recovery and review process.

The Chief Executive Officer, Practice Manager, Infection Prevention and Control Lead(s), and other relevant delegates must:

1. Coordinate the transition back to routine operations in line with current public health advice and organisational readiness
2. Review the effectiveness of response measures, communication systems, workforce planning, and service continuity arrangements
3. Identify strengths, gaps, and lessons learned
4. Document findings and incorporate them into updated pandemic, business continuity, risk, and infection prevention and control systems
5. Ensure corrective actions are monitored through Continuous Quality Improvement processes

7. RECORDS MANAGEMENT

All records collected in relation to this policy and its procedures must be retained, stored, accessed, and disposed of in accordance with the Privacy Act 1988 (Cth), the Fair Work Act 2009 (Cth), applicable health records legislation, and relevant RACGP and NSQHS requirements.

Records may include, but are not limited to, staff training records, competency assessments, screening and triage records, outbreak communications, incident reports, exposure notifications, stock and PPE monitoring records, risk assessments, and business continuity documentation.

Pandemic and outbreak-related incidents, exposures, and identified operational risks must be recorded through the organisation's incident management system and risk management framework where applicable. Records must be maintained in a secure format, with access restricted to authorised personnel only, and retained in accordance with legislative, regulatory, and organisational requirements.

8. CULTURAL SAFETY IN INFECTION PREVENTION AND CONTROL

[Organisation Name] is committed to ensuring that all infection prevention and control practices are delivered in a culturally safe, respectful, and trauma-informed manner, consistent with the principles of Aboriginal Community Controlled Health Services.

The organisation recognises that infection control measures, including the use of personal protective equipment, isolation, screening processes, and restrictions on movement or

visitors, may cause distress, fear, or discomfort for Aboriginal and Torres Strait Islander patients, families, and communities.

Staff must ensure that all infection prevention and control measures are communicated clearly and respectfully, with consideration given to cultural, social, and community contexts. Where possible, patients and families should be supported to remain connected, and care must be delivered in a way that maintains dignity and minimises distress.

Cultural safety must be embedded within all infection prevention and control systems, including staff training, risk assessment, incident management, and Continuous Quality Improvement processes.

9. MONITORING AND REVIEW

Infection prevention and control systems are monitored through a structured audit and review program to ensure effectiveness, compliance, and continuous quality improvement.

Infection prevention and control performance and risks must be reported to the Clinical Governance Committee and, where applicable, escalated to the Board or governing body.

The Practice Manager and Infection Prevention and Control Lead(s) are responsible for ensuring the following monitoring activities are undertaken:

- Monthly hand hygiene audits
- Quarterly infection prevention and control audits, including environmental cleaning, PPE use, and waste management
- Annual review of infection prevention and control systems, policies, and procedures
- Ongoing monitoring of incident reports, exposure events, and identified infection risks

Infection prevention and control risks must be recorded, monitored, and reviewed within the organisation’s Risk Register and linked to clinical governance, incident management, and Continuous Quality Improvement (CQI) systems.

All infection-related incidents and exposures must be recorded in the organisation’s incident management system and reviewed in accordance with organisational procedures. Findings from audits, incident investigations, and risk assessments must be escalated through clinical governance structures and used to inform corrective actions and system improvements.

Audit outcomes must be documented and reported through clinical governance and management structures. Identified risks or non-compliance must be addressed through corrective actions and integrated into Continuous Quality Improvement (CQI) processes.

10. DOCUMENT CONTROL

This policy and associated procedures will be reviewed at least every two years or sooner if:

- Legislative or regulatory requirements change.
- New evidence, guidelines, or best practice information becomes available.
- Improvements or learnings from audits, incidents, or pandemic responses indicate a need for revision.
- Organisational policies, procedures, or structures change.

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Note: All staff must ensure they are referencing the current version of this policy and procedure. Outdated versions must be replaced and archived according to document control procedures.

APPENDIX 1 -

Referenced Documents and Resources

The following external and internal resources have informed the development of this policy and procedure:

Document Title	Type	Location / Access
Work Health and Safety Act 2011 (NSW)	Legislation	https://legislation.nsw.gov.au
Work Health and Safety Regulation 2017 (NSW)	Legislation	https://legislation.nsw.gov.au
SafeWork NSW Codes of Practice (Managing the Work Environment and Facilities, Managing Psychosocial Hazards)	Regulatory Guidance	https://www.safework.nsw.gov.au
Public Health Act 2010 (NSW)	Legislation	https://legislation.nsw.gov.au
Privacy Act 1988 (Cth)	Legislation	https://www.legislation.gov.au
Health Records and Information Privacy Act 2002 (NSW)	Legislation	https://legislation.nsw.gov.au
Australian Guidelines for the Prevention and Control of Infection in Healthcare	Clinical Standard	https://www.nhmrc.gov.au
NSQHS Standards	External Standard	https://www.safetyandquality.gov.au
RACGP Standards	External Standard	https://www.racgp.org.au
Infection Prevention and Control Policy & Procedure	Internal Document	Organisation Intranet / SharePoint
Work Health and Safety Policy	Internal Document	Organisation Intranet / SharePoint
Incident Management Policy	Internal Document	Organisation Intranet / SharePoint
Risk Assessment and Management Policy	Internal Document	Organisation Intranet / SharePoint
Pandemic and Outbreak Response Plan	Internal Document	Organisation Intranet / SharePoint
Business Continuity Plan	Internal Document	Organisation Intranet / SharePoint
Hand Hygiene Audit Tool	Internal Tool / Template	Organisation Intranet / SharePoint

Document Title	Type	Location / Access
Infection Prevention and Control Audit Tool	Internal Tool / Template	Organisation Intranet / SharePoint
Blood and Body Substance Spill Management Flowchart	Internal Tool / Guide	Organisation Intranet / SharePoint
Sharps Injury and Exposure Management Flowchart	Internal Tool / Guide	Organisation Intranet / SharePoint
Personal Protective Equipment (PPE) Quick Guide	Internal Tool / Guide	Organisation Intranet / SharePoint
Waste Segregation and Disposal Guide	Internal Tool / Guide	Organisation Intranet / SharePoint
Cleaning and Disinfection Schedule Template	Internal Tool / Template	Organisation Intranet / SharePoint
Infection Risk Assessment Template	Internal Tool / Template	Organisation Intranet / SharePoint
Infection Control Incident Report Template	Internal Tool / Template	Organisation Intranet / SharePoint
Transmission-Based Precautions Guide	Internal Tool / Guide	Organisation Intranet / SharePoint
Pandemic and Outbreak Response Checklist	Internal Tool / Template	Organisation Intranet / SharePoint
Staff Immunisation Record Template	Internal Tool / Template	Organisation Intranet / SharePoint
Infection Prevention and Control Training Register	Internal Tool / Template	Organisation Intranet / SharePoint
Equipment Cleaning and Sterilisation Log	Internal Tool / Template	Organisation Intranet / SharePoint
PPE Stock Monitoring Template	Internal Tool / Template	Organisation Intranet / SharePoint
Risk Register	Internal Register	Organisation Intranet / SharePoint
Incident Register	Internal Register	Organisation Intranet / SharePoint