Using a clinical governance framework to identify barriers to infection control practice

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Clinical Governance

"the system by which the governing body, managers, clinicians & staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers"

Widely used in Australia & internationally as part of quality & safety reforms

Scally & Donaldson

Relevance of clinical governance for ICPs

Clinical governance frameworks are strongly aligned with IP competency models

However, competency models tend to focus on the role of the ICP as a skilled individual, able to identify, negotiate and overcome barriers to successful implementation of practices.

In contrast clinical governance also considers broader cultural and system issues at a higher level, aiming to improve the organisational context in which clinicians and patients interact.

Clinical governance framework

- well trained staff
- safe environment

- early recognition & intervention
- feedback on performance

- alignment of goals
- excellent communications

- good practice spread
- clinical policies evidence based

- access to evidence
- time allowed to plan
- IT support

- open & participative leadership
- education & research valued

Rationale for study

AIM: to explore ICPs perceptions about the current context for evidence based practice and clinical governance in Australian and New Zealand hospitals

WHY? A clear understanding of how contextual factors in all dimensions mediate IP ability to engage with EBP and enact good clinical governance is necessary to drive practice improvements in this area and sustain current successes

Data Collection

Web-based survey of hospital based ICPs across Australia & New Zealand (Nov 2013 – April 2014)

Snowball sampling approach

Survey based on existing instruments:

* demographics
* IP role & responsibilities
* professional development & EBP
* context, culture & leadership for IC

Responses mapped against clinical governance framework

Demographics

Characteristic	N=300
Over 50 years of age	53%
Female	94%
Worked in IP more than 10 years	44%
Employed in public hospital	75%
Work as a sole practitioner (<= 1 FTE)	53%
Work in team of 1.1-3.0 FTE	28%
Work in team of >3.0 FTE	15%

Engagement with evidence based practice

Evidence based practice activity	
Involved in policy development	86%
Involved in strategic planning	78%
Participated in research	42%
Attended an IC conference	69%
ACIPC member	80%
ACIPC credentialed	15%
Completed IC specific degree	58%
Attended professional development in last year	60%

Sources of evidence utilised:

* Most common: evidence based guidelines, peer reviewed literature and colleagues
* Non-peer reviewed literature only used by 26%

Access to resources (receptivity of context)

Level of access to….	Always / Often n (%)	Sometimes / Rarely n (%)	Never n (%)
Risk avoidance dimension			
Key decision makers if there is a problem	127 (83%)	41 (15%)	6 (2%)
Authority to close beds in event of an outbreak	109 (41%)	74 (28%)	81 (31%)
Coherence dimension			
Key decision makers for planning	180 (66%)	87 (32%)	6 (2%)
Peer support from external IC colleagues	177 (65%)	91 (33%)	6 (2%)

**Private hospitals
better access**

Access to resources (receptivity of context)

Level of access to….	Always / Often n (%)	Sometimes / Rarely n (%)	Never n (%)
Infrastructure dimension			
Infectious disease physician/microbiologist	159 (58%)	79 (29%)	34 (13%)
Statistician/epidemiologist	61 (23%)	114 (42%)	96 (35%)
Peer support from internal IC colleagues	146 (53%)	82 (30%)	46 (17%)
Culture dimension			
Financial support for continuing professional development	84 (30%)	147 (54%)	43 (16%)
Time provided for continuing professional development	93 (34%)	146 (54%)	34 (12%)
Time provided for research activities	35 (13%)	127 (47%)	107 (40%)

Large teams better access

Sole practitioners less access

Private hospitals better access

Challenges to IC (culture & leadership)

Not challenges

* Lack of internal IC leadership (66%)
* Lack of IT skills in IC team (50%)
* Lack of literacy skills in IC team (46%)
* Lack of access to EB guidelines (46%)

Serious challenges

* Workforce/leader resistance to IC (19%)
* Lack of interest or leadership within organisation (17%)
* Lack of IT solutions (19%)
* Inability to provide adequate IC education (16%)

Private hospitals/bigger teams/tertiary qualifications perceived fewer challenges

Summary of findings & implications for practice

Highly skilled, strong capacity for EBP
* IPs highly trained, access range of resources
* Strong engagement in professional development

Strengths for clinical governance (risk avoidance)
* High levels access to decision makers
* Strong leadership & literacy skills within IC team
* Good access to EB guidelines

Challenges for clinical governance (culture, coherence & infrastructure)
* Organisational leadership lacking
* Lack of interest or active resistance
* Poor access to specialist expertise, financial resources, IT solutions

For more info, paper is in press with AJIC

Questions

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