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## Major Article

## Credentialing of Australian and New Zealand infection control professionals: An exploratory study

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**Background:** Despite evidence from overseas that certification and credentialing of infection control professionals (ICPs) is important to patient outcomes, there are no standardized requirements for the education and preparation of ICPs in Australia. A credentialing process (now managed by the Australasian College of Infection Prevention and Control) has been in existence since 2000; however, no evaluation has occurred.

**Methods:** A cross-sectional study design was used to identify the perceived barriers to credentialing and the characteristics of credentialed ICPs.

**Results:** There were 300 responses received; 45 (15%) of participants were credentialed. Noncredentialed ICPs identified barriers to credentialing as no employer requirement and no associated remuneration. Generally credentialed ICPs were more likely to hold higher degrees and have more infection control experience than their noncredentialed colleagues.

**Conclusions:** The credentialing process itself may assist in supporting ICP development by providing an opportunity for reflection and feedback from peer review. Further, the process may assist ICPs in being flexible and adaptable to the challenging and ever-changing environment that is infection control.

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The evolution of nursing services and the subsequent move toward specialization has resulted in a number of challenges for the profession. The literature is rich with discussion about global issues associated with the advanced practice nurse, including definitions, preparation and competency requirements, and evaluation of the role.<sup>1-6</sup> There is ongoing effort to differentiate between various advanced nursing practice roles, including nurse practitioner, nurse specialist, and nurse consultant.<sup>7-9</sup> The infection control professional (ICP) is one such advanced practice role in the nursing profession. Although most ICPs are nurses, it is also important to note that ICPs have a diverse professional background, including medical doctors, microbiologists, and epidemiologists.<sup>10</sup>

Originally established in the United Kingdom in 1960, the first ICP in the United States was appointed at Stanford University Hospital in 1963.<sup>11</sup> After the results of the Study on the Efficacy of Nosocomial Infection Control conducted by the Centers for Disease Control and Prevention in the United States in the 1970s,<sup>12</sup> most health care facilities in high-income countries established an ICP position.<sup>10,13,14</sup> Although the focus of the role differs slightly from country to country,<sup>13</sup> there are strong similarities in the elements of the role.<sup>15,16</sup> There is commonality in the international recognition of the need for the ICP role and the various elements of the infection control program, and there is significant variance between countries in the way nurses are prepared for this specialized practice area.<sup>13</sup> In many countries, including Australia, there is no mandatory requirement for the education or training of ICPs; however, most positions in Australia are nursing roles, and there are no additional preparation requirements for this specialized role.

The lack of requirements for minimum or standardized education to practice as an ICP has been acknowledged by the Australian Commission on Safety and Quality in Health Care.<sup>17</sup> The Australian Commission on Safety and Quality in Health Care also recognizes

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the evolution and expansion of the scope of practice for the Australian ICP with varying skills and resources. In combination, these factors have implications for patients and health care providers in terms of safe practice because of potential variations in the knowledge, skills, and experience of Australian ICPs.<sup>17</sup> Therefore, the credibility of those responsible for infection control advice and the development and coordination of infection control programs in Australian and New Zealand health facilities warrants further exploration.

The Australasian College of Infection Prevention and Control (ACIPC), formerly known as the Australian Infection Control Association, sought to address the issue by developing a credentialing process for ICP.<sup>7,18,19</sup> This decision was made in the context of early discussions among national nursing organizations around the credentialing of nursing specialties and recognition that self-regulation is one of the hallmarks of professionalism.<sup>20</sup>

Established in 2000, the ICP credentialing process remains a peer-review process; however, the specific elements have been refined over the last 15 years. Peer review is a common method of performance review widely used within the health professions and therefore deemed suitable for the assessment for ICP.<sup>21</sup> The credentialing process for ICPs in Australia broadly involves an assessment of the experience, qualifications, and practice of the applicant. Depending on the applicant's background and experience, the supporting documentation may include a combination of a peer review from a colleague, curriculum vitae, reflective narrative, portfolio, and details of an implemented education program.<sup>21</sup>

In the United States, some work has been done to evaluate the outcomes associated with certification. In a study into the use of central venous catheter-related bacteremia infection prevention practices in U.S. hospitals, Krein et al<sup>22</sup> found there was an association between the infection control program being led by a certified ICP and the adoption of evidence-based practices designed to prevent these infections. The authors postulated that this positive association may be caused by the certified ICP being better prepared to interpret evidence and promote prevention practices within the organization.

Pogorzelska et al<sup>14</sup> studied the relationship between infection control policies aimed at multidrug resistant organisms in Californian hospitals, structural issues (hospital and infection control unit characteristics), and rates of infection. They found that having an infection control director certified in infection control was a significant independent predictor of lower methicillin-resistant *Staphylococcus aureus* bacteremia rates. The likely reasons proposed for this association were that the ICP may directly influence the bacteremia rates through adoption of evidence-based practices implemented by a potentially more experienced and knowledgeable ICP or that certification itself may be an indicator of the overall quality of the organization and a more supportive organizational climate. In recent work, a practice analysis of certification in the United States demonstrated significant changes in tasks and associated knowledge required for competent practice.<sup>23</sup> In turn, this has resulted in changes to the certification process.

Despite the longstanding nature of the ICP credentialing process, only a small number of ACIPC members have been credentialed.<sup>24</sup> The reasons for this low uptake by members have not previously been formally identified. Similarly, there has not been any attempt to determine the characteristics of those members who have been credentialed and whether, and if so how, they differ from noncredentialed ICPs.

The aims of this article are to identify the perceived barriers to credentialing for the Australian and New Zealand ICP and to describe the characteristics of the credentialed ICP in comparison with their noncredentialed colleagues. The specific research questions designed to achieve these aims are as follows:

1. What proportion of Australian and New Zealand ICPs are credentialed?
2. What are the characteristics of the credentialed ICP?
3. How do credentialed ICPs differ from their noncredentialed colleagues?
4. What are the stated reasons for not being a credentialed ICP?

## METHODS

A cross-sectional study design was used where participants completed an online Web-based survey. The survey conducted was anonymous and was developed using validated questions from international and state-based surveys.<sup>25-27</sup> Demographic data on the person completing the survey, in addition to their employer (organization), were collected. From a list, participants were asked to identify infection prevention and control tasks they undertook and how they spent their time. Using Likert scales, participants were also asked their priorities and how frequently they accessed a range of resources—infectious disease or microbiology support, ICP support (within or external to their organization), epidemiologic or statistical support, and a professional association for advice, peer-reviewed and non-peer-reviewed literature.

### Sample and participants

The participants in this study were ICPs working in Australia or New Zealand. Participants were recruited in a number of ways. First, ACIPC members were contacted via e-mail via an online list-server forum. New Zealand ICPs were also e-mailed an invitation to participate by the Infection Prevention and Control Nurses College of New Zealand Nursing Organisation. Brochures promoting the study and calling for participants were distributed at a national infection control conference organized by the ACIPC in October 2013.

### Data collection

Each ICP was limited to submitting 1 survey, and this was monitored using data on the Internet Protocol address of the computer used to complete the survey and cross-checked with the demographic data provided. No duplicate samples were identified.

### Ethical considerations

Ethics approval was obtained from the Human Research Ethics Committee at (Avondale College of Higher Education) in addition to multisite human research ethics approval from 3 Australian health departments.

### Data analysis

Data were extracted from the online survey tool and entered into SPSS Statistics v21 (IBM, Chicago, IL) for data analysis. Comparisons of demographic data between credentialed and noncredentialed ICPs were undertaken using Fisher exact test and analysis of variance for the comparison of means. Nonparametric data was compared using the Mann-Whitney *U* test. Logistic regression was performed to explore the characteristics associated with being credentialed. Variables found to be significant at the 0.1 level in univariate analysis were included in the logistic regression model.

Likert scales were used to collect data on responses to questions related to how frequently specific activities were undertaken; how often they accessed specific resources; to rank priorities for additional resources; and to determine the level of agreement with proposed reasons for noncredentialing. Responses from questions that used Likert scales were subsequently scaled. Means and SDs

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