

Australian Infection Control Guidelines

Preventing and managing infection in health care

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Australian Infection Control Guidelines

How helpful will these guidelines be in assisting the primary care team in managing infection control issues relevant to their health care setting?

Plain English

- My practice is in an area of significant social disadvantage and at last count 159 languages are spoken
- I draw many of my practice staff from the local area
- Will the guidelines be easily readable, informative and relevant/practical for my staff to implement??

Language

- Doff your PPE
 - Old English
 - Well understood in Infection Control Circles
 - Virtually no penetration in the primary care arena

Language

- Additional precautions vs. Transmission based precautions
 - Clear, informative change

Steering Committee Composition

- Heavily weighed by State and Federally employed experts with extensive hospital experience
- Poorly funded primary care representation

Issues for Primary care

- Pervasive belief that hospital based healthcare translates directly to primary care
- Extremely risk adverse approach
- “primary care should follow the same principals as hospitals do” followed by proscriptive list of requirements

- Belief that the risk profile in Primary Care is the same as in hospitals even when a risk hasn't been established
- Lack of research

Multi-dose Vials

- ‘must never be used’
- Ignorance
 - There is expertise in primary care
 - The realities of primary care including insurance issues
 - About actual causes of such things as Hep C outbreaks
 - How does banning them fix the poor education in IC if it is to blame?



Public Consultation

- Lack of capacity in primary care to respond
 - Time
 - Funding
 - Priority

The Hospital - Primary Care Divide

- Interestingly, many of the major problems of recent past have stemmed from the hospital sector and especially the public sector.
 - For example hand hygiene audits indicate low compliance levels even during studies
 - This indicates that human factors may be more compelling than the content of the standard i.e. we do not need to account for and provide a nanny state approach to what is a management issue in public healthcare
 - But rather we need to focus on the functional requirements needed for the standard so as to provide management with the tools to manage themselves
 - This all will allow a more principled approach rather than the prescriptive approach to the detail contained in the standard.

The Hospital - Primary Care Divide

- General agreement on principles (so references to Health Care Facilities)
- Major issues in some areas in their application
 - prescriptive elements suitable for infection control practitioners to improve their departmental budgets, achieve improvements in facilities

Issues

- Government: risk adverse (only no risk ok)
- I.C. Professionals: influence hospital administrators
- Primary care: lack of funding to be represented on Australian Standards, ICG Steering Committee
- Lack of evidence based research but especially in primary care

Discipline Specific Guidelines

vis. The RACGP Infection Control Standards and ADA Guidelines

- To explain implementation
 - E.g. Hand hygiene, spills management, environmental cleaning
- Cover areas not addressed by the Australian Guidelines
 - E.g. Waste, linen, sterilisation

5 Moments of Hand Hygiene

- Education and Training
- Availability and product location
- 5 moments but the critical 3 are
 - ~~–~~ Before and after procedures
 - After each consultation (which effectively covers the ‘before’ in general practice)
- Deficiencies are
 - Posters with an image of a sick patient in a hospital bed with a drip and one of hospital surrounds
 - WHO web site alternates b/w hospital and health care facility and refers to wards for their world hand hygiene day project

Spills Management

- Hypochloride
 - OHS issues
 - Strength
 - Bleaching and rusting
- Norovirus
 - No clear cut management guidelines
 - Hysteria about residual virus in the carpet

Environmental Cleaning

- Cleaning all areas patients have contact with between patients?
 - Door knobs
 - Desks
- Cleaning all items with patient contact between uses
 - BP cuffs?
- Cleaning the keyboard and pens used during each consultation?

Environmental cleaning

- Cleaning Methods
 - Extraordinary measures do not need to be taken in an office practice environment.
 - Routine cleaning involving damp wiping mopping with detergent and water is sufficient for almost all surfaces.
 - Avoid dry dusting and sweeping as this will cause airborne bacteria levels to rise.

Environmental Cleaning

- More research into identifying and quantifying any risk identified is required before primary care should alter practice

Sterilisation

- Australian Standards
 - Hospital sector dominated
 - Audience different
 - Administrators
 - I.C. Professionals
 - CSSD managers
 - Little primary care input
 - Costly e.g. AS4187 @ \$139.50
 - Refers to a myriad of other costly standards
 - AS4187 refers to 43 other standards

Laundry

- Australian Standards
 - No primary care input
 - Usual 1 size fits all
 - Ignores available evidence from primary care
 - Extensive Canadian studies showing v. Low risk
 - Ignores advances in technology
 - Oxygenating washing products

Waste management

- Environmental Sustainability
- Global Warming
- Climate Change

- Vic & WA State EPA Authorities still adopt the waste industry guidelines
 - Everything is clinical waste and needs high temp. incineration

Risk Management

- Burden of risk reduction
- Professional Conduct
- Standard Precautions

Calculation of Risk

		Insignif	Minor	Moderate	Major	Extreme
5	Almost Certain	L	M	H	E	E
4	Likely	L	M	H	E	E
3	Occasionally	L	M	H	E	E
2	Unlikely	L	L	M	H	H
1	Rare	L	L	M	M	H

E = Extreme risk; immediate action required

M = Moderate risk, who is responsible?

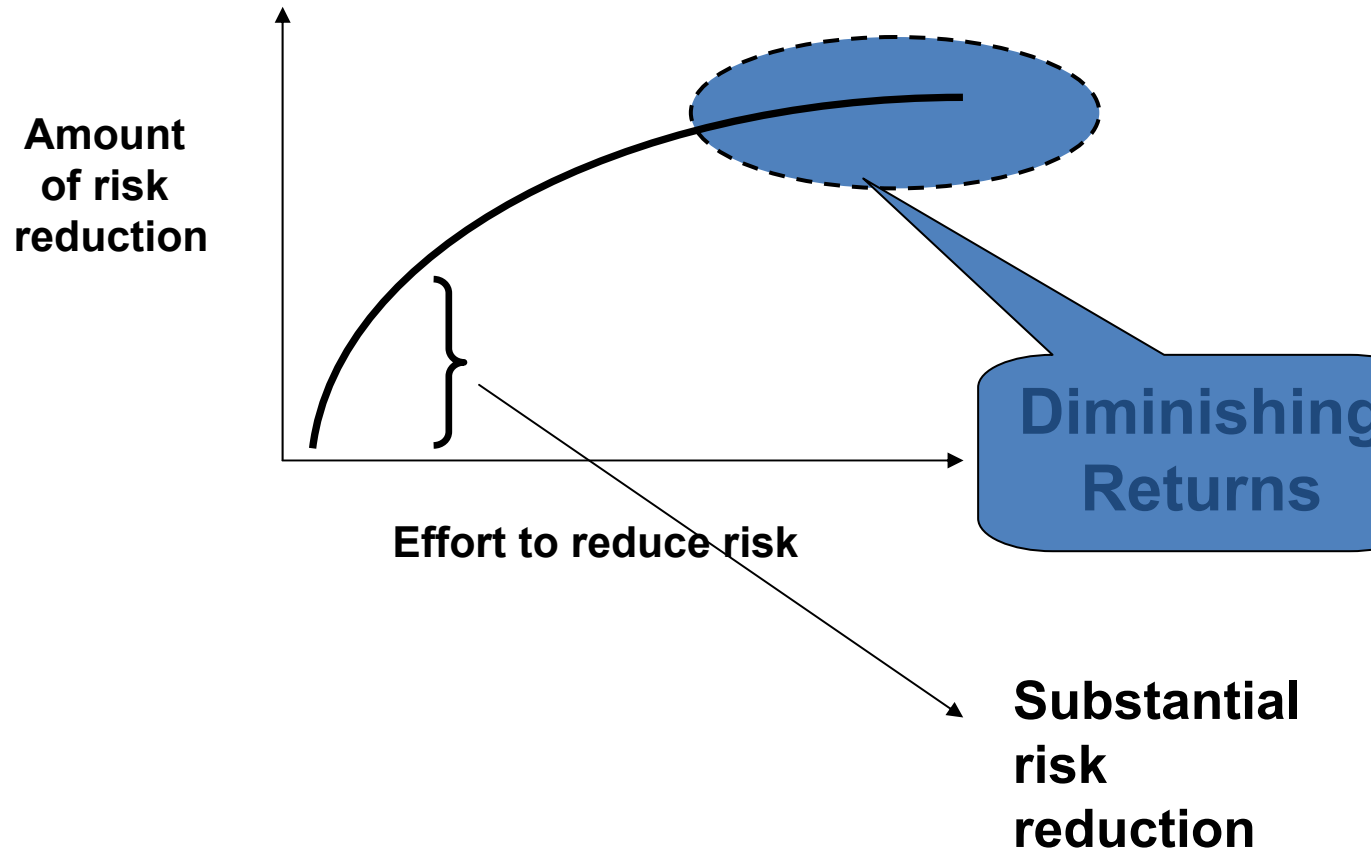
H = High risk; regular monitoring

L = Manage by routine procedures

Calculating risk reduction

- How do you decide whether to act?

Burden (must be less than) Probability x Severity



RISK THEORY
The “Calculus”
of Risk

A person has a duty to take steps to prevent a loss when

$$B < P \times L$$

B = the Burden imposed in preventing the loss

P = the Probability that the Loss will occur

L = the Severity of the Loss

***Judge Learned Hand (1872-1961),
U. S. Court of Appeals***

The “Calculus” of Risk

Doctors Context

A DOCTOR has a duty to take steps to prevent an adverse event when

$$\mathbf{B < P \times S}$$

B = the Burden (cost/time/resources) of taking precautions to prevent an adverse event occurring.

P = the incidence of that complication

S = the severity of the complication

When Should I act?

- Should I act?
- The burden to manage the risk must be in proportion to the potential saving.



ole

- The cost/burden of protecting the office supply of paper clips.



- Sheets, recording etc.



- Is not justified by the savings made.



Improvements

- Increased focus on evidence
- Increased readability and useability in primary care
- Improved wording less 'in the ward'
- Inclusion of some primary care examples
- Reference to discipline specific guidelines
- Less reference hopefully to Australian standards

- Our practice can demonstrate the principles and procedures necessary to prevent the transmission of infectious diseases through immunisation and infection control.

Indicators

- **A. Our practice team can identify the person/s in the practice with the responsibility for the coordination of infection control processes (defined in the job description of the appointed staff member/s).**

- **B. The person/s responsible for coordinating the infection control processes within our practice (and other relevant practice staff) can describe in detail how sterile procedures are undertaken, including where relevant:
provision of an adequate range of sterile reprocessed or disposable equipment**
- **procedures for having instruments sterilised off-site, including documentary evidence of assurance of a validated process**
- **procedures for on-site sterilisation of equipment, including monitoring the integrity of the whole sterilisation process, validation and steriliser maintenance**
- **safe storage and stock rotation of sterile products.**

- **▶ C. Our practice team members can demonstrate how risks of potential cross infection within our practice are managed including procedures for:**
 - **hand hygiene**
 - **the use of personal protective equipment**
 - **utilisation of triage policy**
 - **safe storage and disposal of clinical waste including sharps**
 - **managing blood and body fluid spills.**

- **▶ D. Our practice is visibly clean and our practice team can demonstrate the process for the routine environmental cleaning of all areas of the practice and provide documentation outlining the process for those responsible for cleaning.**

- **E. Our practice has a written practice specific policy that outlines our practice's infection control plan, procedures and staff education and assessment of competency.**

- **Useful resources**
- www.racgp.org.au/infectioncontrol
- www.racgp.org.au/pandemicresources.
- To order a copy of the *Infection control standards for office based practices* contact RACGP Publications on 03 8699 0414, or order from the website at www.racgp.org.au/publications.

- Use of P2 masks
- Clean vs. Sterile gloves in minor skin surgery
- Water for wound irrigation
- Norovirus management