Infection Prevention and Control Framework

Purpose

- The aim of the Infection Prevention and Control Framework is to reduce the spread of infection amongst clients, staff and the people who come in contact with them
- To outline a programme that complies with the requirements of NZS 8134.3:2008 Health and Disability Services (Infection Prevention and Control) Standards.
- To monitor and control the spread of infection in the community where the Total Care Health and Access Community Health provides services
- To ensure the organisation meets all legislative and accreditation obligations

Scope

a. Applies to all staff and contractors

b. Is the governing framework for supporting all Infection Control Policies and Procedures.

Definitions (Relevant definitions extracted from NZS 8134.0:2008 Health and Disability Services (General Standard)

c. Airborne Precautions

i. Are used for known or suspected infections spread by airborne particles 5 microns or smaller in size. Clients with these issues are most likely to be in hospital. The room should be a negative pressure room, personnel should wear respiratory protection while in the room and the ventilation should exhaust away from people and not be recirculated.

d. Cough Etiquette/Respiratory Hygiene

i. The use of tissues to cover the mouth and nose when coughing or sneezing, prompt disposal of the tissue after use, followed by regular hand hygiene (a general term that applies to hand washing or the use of alcohol gels or rubs to decontaminate) and if possible:

ii. Wear a surgical mask if caring for someone coughing or sneezing or if tolerated get the person to wear one.

iii. Spatial separation greater than 1 metre from person sneezing or coughing

iv. If tissues are not available, an alternative may be to contain droplets with the upper sleeve/arm.

e. Contact Precautions

i. Are intended to reduce the risk of transmission of organisms by direct or indirect contact with the consumer environment.

f. Droplet Precautions

i. Are used for known or suspected infections spread by large droplets greater than 5 microns. Service providers are required to wear a surgical mask.

g. Epidemic

i. A disease affecting or tending to affect an atypically large number of individuals within a population, region or community at the same time.

h. Outbreak

i. An increase in occurrence of a complication or disease (infection) above the background rate. Thus, an outbreak may be one episode of a rare occurrence or many episodes of a common occurrence.

i. Pandemic

i. An epidemic (sudden outbreak) that becomes very widespread and affects a whole region, a continent or the world.

j. Personal Protective Equipment (PPE)

i. Equipment designed to reduce the risk of disease transmission between consumers and service providers. Such equipment typically involves gloves, eye protection, apron/gown and masks, and may include ventilation device modifications/types.

k. Hand Hygiene

i. A general term that applies to handwashing, antiseptic hand wash, antiseptic hand rub, or surgical antisepsis. Refer to "Guideline for hand hygiene in healthcare settings" (Centres for Disease Control and Prevention).

l. Standard Precautions (Pre 1996 referred to as universal precautions)

i. Precautions taken by all service providers and applied to all consumers regardless of their presumed infection status. Standard precautions recognise that blood, all body fluids, secretions and excretions (except sweat) regardless of whether or not they contain visible blood, non intact skin, and mucous membranes, may be potentially infectious, and that precautions are required to reduce risk of transmission of disease from both recognised and unrecognised sources of infection. Standard precautions include, but are not limited to, hand hygiene and the use of PPE.

m. Surveillance

i. The systematic process of data collection, collation and analysis for the purpose of characterising risk groups and identifying control strategies and the timely dissemination and feedback of these data to those who need to know.

n. Transmission Based Precautions

i. Are used to prevent transmission of highly transmissible or epidemiologically important infectious agents when rate of transmission is not completely interrupted using standard precautions. When used singly or in combination, they are always used in addition to standard precautions. The three categories of transmission based precautions are:

- Contact precautions
- Droplet precautions
- Airborne precautions.

Responsibilities

a. National Clinical Leaders

i. Takes responsibility for planning and oversight of the infection control programme, including but not limited to:

- Delegating day to day management within the regions
- Developing and approving the annual infection control plan
- Develop and approve the infection control education programme

- Making recommendations for staff immunisation strategies
- Product review – related to IC, e.g. hand-rubs, wound management products.

ii. Planning and managing infection control audit and surveillance activities
iii. Development/delegation and approval of infection control policies and procedures
iv. Recommending IC resource allocation within the regions.

b. Clinical Advisors/Clinical Managers/Clinical Nurse Leaders/Clinical Team Leaders

i. Planning and implementing the agreed infection control plan at regional level
ii. Providing statistical reports to the National Clinical Leaders group
iii. Providing clinical supervision to clinical staff and support workers (SW)
iv. Providing advice to RHP on infection control issues after seeking advice from relevant professionals
v. Providing IC education and resources at RHP orientation and ongoing
vi. Maintaining the education database for RHP.

c. Community Nurses

i. Attending IC education programmes
ii. Using current IC practices and complying with the IC programme
iii. Overseeing SW personal care practice to confirm appropriate IC practice
iv. Confirming any identified or suspected infection is documented in the electronic incident reporting system, followed up and referred on as appropriate
v. Providing advice to Support Workers on infection control issues after seeking advice from relevant professionals, e.g. clinical advisor, community nurses, or the SUs own GP, if the SU has been diagnosed with a transmissible infection
vi. Reporting any transmissible infections occurring with the client or others at the client's location to the CNL/CM/CTL so advice can be sought re infection control including requirement for immunisation or containment strategies.

d. Care Coordinators

i. Ensure the nurse is made aware of the infection control concerns raised by the SW.

e. Support Workers

i. Washing hands and using hand rub as per the hand hygiene protocol
ii. Using cough etiquette when sneezing or coughing
iii. Reporting to the Care Coordinator if you have a transmissible infection
iv. Providing a doctor's certificate when contracting transmissible infections and staying away from work until a clearance has been provided
v. Never preparing food or meals if you have vomiting or diarrhoea. You must report to your Care coordinator, and stay away from work until you have been free of symptoms for 24 or 48 hours
vi. Reporting SU infections to the Community Nurse, for advice on prophylactic treatment or other infection containment strategies
vii. Reporting when an infection is suspected or identified.

Framework Process

a. Annually each October the National Clinical Leaders Group (NCLG) will plan the IC programme for the following year.

b. The IC education plan for the following year will be approved/authorised by the NCG by 30 November of each year.
c. The IC audit programme will be decided for the coming year and will include at least two hand hygiene audits.
d. Note: Surveillance activities are not considered appropriate at the present time as the ability to collect robust and reliable data is not at the level required to produce accurate, useful and meaningful data. The potential for surveillance will be reviewed annually at each January NCLG, and planning decisions made at that time.
e. The staff immunisation programme will be agreed and ratified for the following year; this may be a targeted programme such as annual staff influenza vaccine or a targeted programme for high risk communicable diseases such as pertussis.
f. Data on staff illness during epidemics/pandemics including seasonal 'flu' will be monitored through annual analysis of sick leave data and will inform content of staff education and immunisation programmes for the following year.
g. Resource needs for the programme require CEO consent, which must be obtained prior to implementation.
h. The approved programme will circulate to Regional Managers and Clinical Advisors/Clinical Nurse Leaders/Clinical Managers/Clinical Team Leaders for implementation in their areas.
i. Clinical Advisors/Clinical Nurse Leaders/Clinical Managers/Clinical Team Leaders will provide reports of progress and statistical reports to the NCLG at quarterly meetings.

Associated Documents

Infection Prevention and Control Policy
Sharps Management
Blood or Body Fluid Exposure Management
Infection Control Management of Multi-Drug Resistant Organisms in the Community
Standard Precautions
Communicable Diseases
Infectious Diseases and Staff Exclusion Table
Hand Hygiene
Difference between Influenza and the Common Cold
Reporting and responding to Contagious Infections

References

a. NZS 8134 3.5:2008 Health and Disability Services (Infection Prevention and Control Standards)
b. NZS 8134. 0:2008 Health and Disability Services (General) Standard.
c. World Health Organisation Hand Hygiene Self-Assessment Framework 2010.
d. Australian Commission on Safety and Quality in Health Care: National Core Standards for Safety and Quality in Health Care: *Standard 3 Preventing and Controlling Health Care Associated Infections*.
e. Centres for Disease Control & Prevention - respiratory hygiene/cough Etiquette in Healthcare Settings. (Atlanta USA).