

 **HotDoc** | CPD WEBINAR

What's New in the Infection Control Guidelines




PRESENTED BY

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Wed 28 June
12:30pm AEST



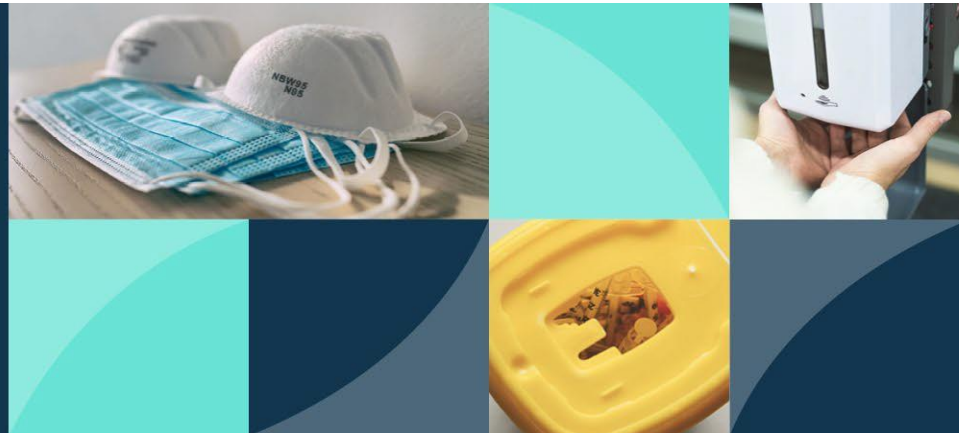
In the spirit of reconciliation, HotDoc acknowledges the Traditional Custodians of country throughout Australia and their connections to land, sea and community.

We pay our respect to their elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

Infection prevention and control guidelines

for general practices and other office-based and community-based practices

Presented by Sara Drew RN | Grad Cert IPC



Acknowledgement of Country

I would like to recognise the traditional custodians of land and sea, on whose lands we work, live and play. I wish to pay my respects to all traditional owners and elders past, present and future.

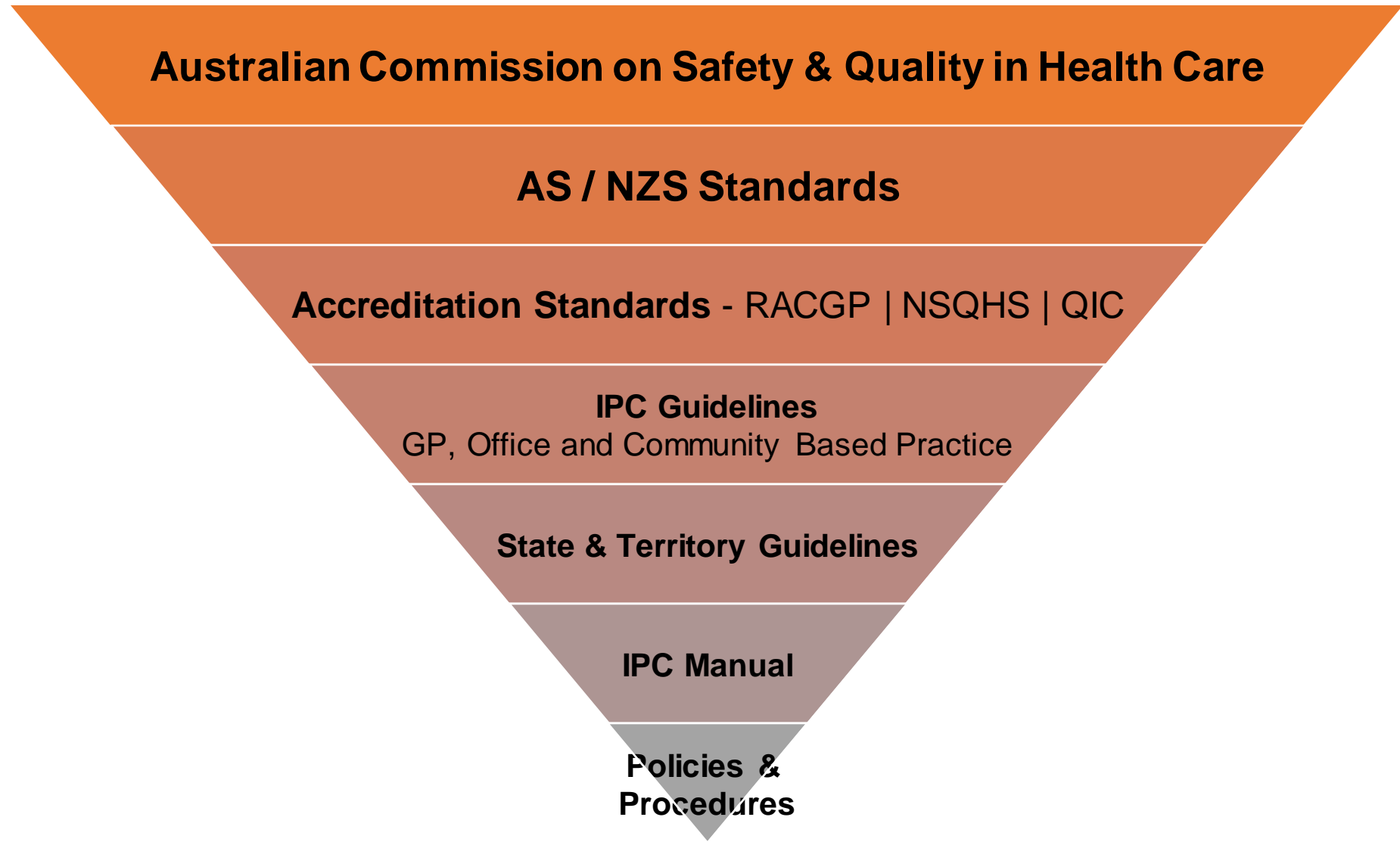




Aim

- the intention of the IPC Guidelines and its development process
- discuss infection prevention and control requirements for accreditation, as per the *Standards for general practices*, and the role of the IPC Guidelines in supporting practices to meet those requirements
- review training in infection prevention and control and the role of an IPC coordinator
- briefly review each section of the IPC Guidelines, outlining newly added information and key supporting aspects from each.

IPC Standards, Guidelines and Professional Obligations



Infection prevention and control in the Standards



Indicator

GP4.1 A ▶ Our practice has at least one clinical team member who has primary responsibility for:

- coordinating prevention and control of infection
- coordinating the provision of an adequate range of sterile equipment (reprocessed or disposable)
- where relevant, having procedures for reprocessing (sterilising) instruments onsite or offsite, and ensuring there is documented evidence that this reprocessing is monitored and has been validated
- safe storage and stock rotation of sterile products
- waste management.

GP4.1 B ▶ Our practice has a written, practice-specific policy that outlines our infection control processes.

GP4.1 C ▶ Our practice has a clinical team member who has primary responsibility for educating the practice team about infection prevention and control.

GP4.1 D ▶ All members of our practice team manage risks of potential cross-infection in our practice by methods that include:

- good hand hygiene practices
- the use of PPE
- triage of patients with potential communicable diseases
- safe storage and disposal of clinical waste including sharps
- safe management of blood and body fluid spills.

GP4.1 E ▶ Our patients are informed about respiratory etiquette, hand hygiene, and precautionary techniques to prevent the transmission of communicable diseases.

GP4.1 F ▶ Our practice records the sterilisation load number from the sterile barrier system in the patient's health record when sterile items have been used, and records the patient's name against those load numbers in a sterilisation log or list.

Infection prevention and control in the Standards

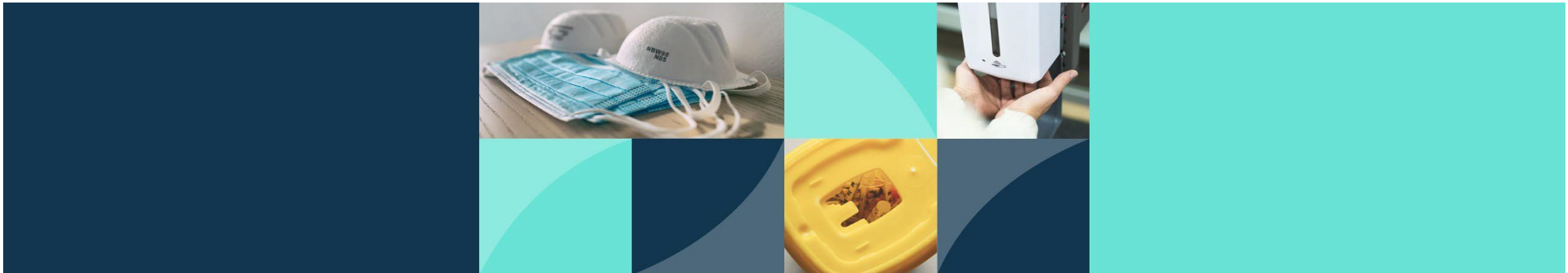


Infection prevention and control may also form a part of a practice's:

- emergency response plan
- training requirements for non-clinical staff
- systems and processes to identify, implement, and test solutions to prevent near misses and adverse events
- effective triage and consultation types that meet patient needs
- safe provision of home and other visits
- setup and maintenance of practice facilities
- equipment onsite and in the doctor's bag.

The IPC Guidelines

for general practices and other office-based and community-based practices



Development of the IPC Guidelines



Australian
Immunisation
Handbook

STANDARDS
Australia



NHHI
National Hand Hygiene Initiative

Purpose of the IPC Guidelines

The updated IPC Guidelines do not implement new requirements that are not already in place via:

- The RACGP *Standards for general practices*
- Australian Standards and Australian/New Zealand Standards
- National guidelines (including the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*)
- other national or jurisdictional legislation.

The update has consolidated and contextualised advice from these sources for general practices and other office-based practices.

Content of the IPC Guidelines



The IPC Guidelines address:

- the basics of infection prevention and control
- managing risks to staff
- managing the practice environment
- managing equipment
- managing outbreaks
- practice set-up

Transmission of infection in health care

- Droplet and airborne transmission are not distinctly separate modes
- Transmission through the air is now understood to apply to a continuum of particle sizes, from large droplets to smaller particles that dry and remain airborne for hours.
- Transmission via aerosols (suspensions of liquid or solid in air) spans droplet and airborne modes.



Coordinating infection prevention and control

Role of the infection prevention and control coordinator

The infection prevention and control coordinator's roles include:



- assessing the risks of infection transmission throughout the practice
- drafting and finalising infection prevention and control policies and protocols for the practice
- regularly reviewing protocols and implementing changes in response to identified risks
- organising training and education for the entire staff about protocols and assessing competence
- educating patients on infection prevention and control activities
- ensuring that any contractors who may access premises comply with the practice protocols
- staying up to date with emerging risks by monitoring state and national infection surveillance reports.

Coordinating infection prevention and control

Qualifications and training

- There is currently no minimum or standardised educational requirement to practice as an infection control professional, or to coordinate an organisational infection prevention and control program.
- The Australasian College for Infection Prevention and Control recommends that healthcare workers apply for credentialing in infection prevention and control.
- Practices must ensure that staff involved in reprocessing have received adequate education, training and regular competency assessment, and that these are documented.
- While there are recommended qualifications for reprocessing, there is no minimum requirement.



Hand hygiene

Practices must:

- have hand-hygiene facilities readily accessible to patients and staff and installed in or near all patient management areas including treatment areas and consulting areas
- correctly select hand-hygiene products to achieve adequate cleaning and disinfection
- educate staff on effective hand hygiene and hand care.



Hand hygiene



Facilities for hand hygiene

- Hand hygiene facilities must be provided in all examination and treatment areas and in or close to toilets.
- Alcohol-based handrub should be provided in disposable cartridges with disposable nozzles, designed for hands-free dispensing.
- Refillable dispensers must not be used.
- Alcohol-based handrub should not be placed near a sink, but at point of care and other work areas such as workstations in a reprocessing room.
- Consider installing hands-free or elbow-operated taps for handwashing, where required.

Hand hygiene


The IPC Guidelines detail:

- when hands must be cleansed
- methods and products
- technique, duration and drying
- hand hygiene for patients.

Table 2.2. The 5 moments of hand hygiene

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

Source: National Hand Hygiene Initiative¹

 **Key messages for patients about hand hygiene include the following:**³

- Hand hygiene is the most important way to reduce our risk of infection – this applies to everyone, including healthcare workers and patients.
- Alcohol-based handrub does not work properly on dirty hands – wash visibly soiled hands in liquid soap and water.
- When you wash your hands (with liquid soap and water or with an alcohol-based handrub), the cleansing product must reach all parts of the surface of your hands.
- You must dry your hands properly after washing soap and water – pat them dry with a clean paper towel.
- If you use an alcohol-based handrub, keep rubbing your hands until they are dry – there is no need for a towel.
- Your health professionals should have short, smooth, clean fingernails.
- It is OK to ask your health professional about whether their hands are clean.

Personal protective equipment

The appropriate PPE in any clinical situation depends on the risk assessment and the type of clinical procedure or activity.

PPE must be applied and removed in the correct order to prevent transmission of infection.

PPE is designed for single use, then disposed of or appropriately laundered. However, some items of PPE are sometimes worn for a longer period in special circumstances, such as during a pandemic.

Method for putting on and removing gloves

Putting on gloves

1. Perform hand hygiene and ensure your hands are completely dry.



2. Handle the glove at the top edge of its cuff and create an opening using your thumb and four fingers.



3. Ease your hand into the glove and gently pull the cuff over your wrist until it comfortably fits.



4. With your bare hand, take the second glove at the top edge of its cuff.



5. Repeat step 3 with the second glove on your other hand.



Removing gloves

1. Pinch the outside of one glove near the wrist.



2. Peel the glove off so it ends up inside out.



3. Keep hold of the peeled-off glove in your gloved hand while you take off the other glove.



4. Use one or two fingers of your non-gloved hand inside the wrist of the other glove to peel off the second glove from the inside, and over the first glove, so you end up with the two gloves inside out, one inside the other.



5. Dispose of the gloves safely and perform hand hygiene.

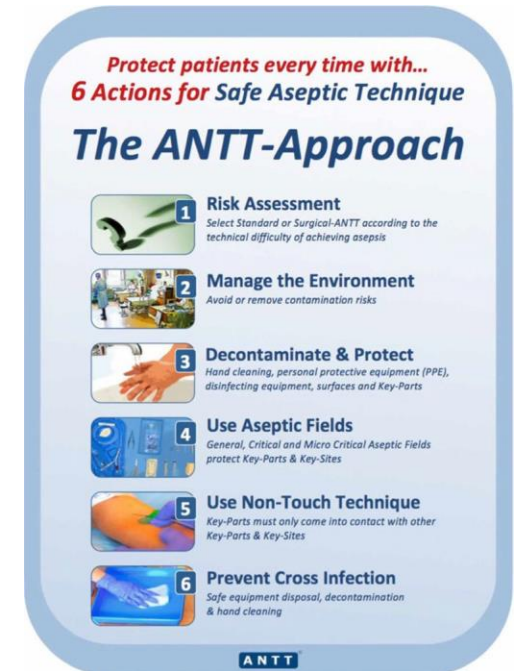


Aseptic technique

All staff involved in procedures must be familiar with standard aseptic technique and know when to apply it.

The IPC Guidelines:

- detail the principles and terminology surrounding aseptic technique, as well as the steps for both standard and surgical aseptic technique.
- detail the application and agents used for skin asepsis.

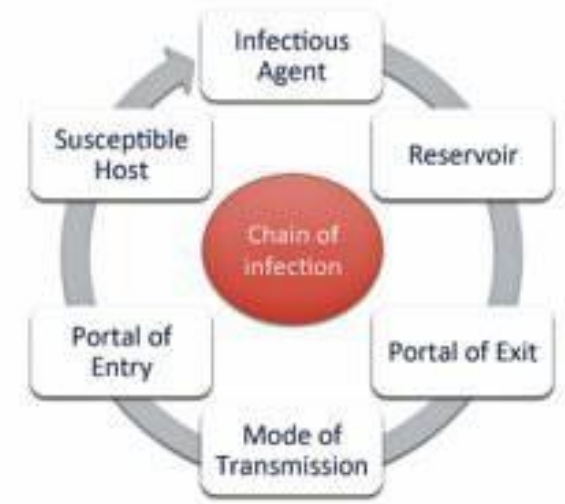


Levels of precaution

It is essential that standard precautions are always applied because staff or patients may be:

- at risk of infection from others who carry infectious agents
- infectious while asymptomatic, undiagnosed, or before laboratory tests are confirmed
- at risk from infectious agents present in the surrounding environment, including surfaces, objects or equipment
- performing specific procedures or tasks that are associated with an increased risk of microorganism transmission

Chain of Transmission



Levels of precaution

Respiratory hygiene and cough/sneeze etiquette

- Respiratory hygiene and cough/sneeze etiquette must be always applied as part of standard precautions.
- Hand hygiene must be performed after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions.



- Patients requesting a consultation with respiratory symptoms should be triaged by a health professional via phone or videoconference to determine whether the consultation should be via telehealth or in person.
- All patients with symptoms of respiratory infection must be encouraged to wear a mask inside the clinic, if able, or seen outdoors to reduce risk to other patients and staff.

Levels of precaution

Transmission-based precautions



- The IPC Guidelines detail and provide strategies for aerosol-generating procedures and for managing contact, droplet and airborne precautions.
- The guidelines suggest practices develop and implement a protocol to elicit self-reporting by staff and patients of any symptoms that could be due to an infectious disease before they enter the practice.
- Strategies include routine questioning by reception staff when booking appointments by telephone, a telephone 'on hold' recorded message, questions or instructions added to the online booking system, and notices on the practice website and main door.

Levels of precaution

Aerosol-generating procedures



- Practices must identify and follow the latest advice on infection prevention and control when performing aerosol-generating procedures (eg nebulisation, spirometry, peak expiratory flow, oxygen supplementation via nasal cannulas or mask) from national and state/territory health departments.
- Guidance is also published by the Australian and New Zealand Society of Respiratory Science and the Thoracic Society of Australia and New Zealand.

Staff screening, immunisation and management

Practices must ensure that all staff are aware that:

- they must inform the infection prevention and control coordinator, practice manager or employer if they have a known or suspected infectious disease that could be transmitted in the workplace, and that they are not to come to work until they are considered no longer infectious
- if they have a notifiable disease, they must not come to work until they have completed the required isolation period or met testing requirements, following health department advice.



Staff screening, immunisation and management

Exclusion periods

Practices should implement recommended exclusion periods for those with known or suspected infectious diseases.

The infection prevention and control coordinator must stay up to date with health department requirements for notifiable diseases.

Table 6.3. Staff exclusion periods for infectious illness

Acute infection	Exclusion
Conjunctivitis	Must not provide patient care while eye discharge present.
Gastroenteritis – norovirus infection suspected	Must not come to work for at least 48 hours after resolution of symptoms (eg diarrhoea and/or vomiting).
Gastroenteritis – infection with other pathogen suspected (eg giardiasis, <i>Shigella</i> infections, <i>Salmonella</i> infections, <i>Campylobacter</i> infections)	Must not come to work while symptomatic (eg diarrhoea and/or vomiting) and until 24 hours after symptoms have resolved.
Glandular fever	Not required (even for those with direct patient contact) if well enough to return to work and follow standard precautions.
Hand, foot and mouth disease	Must not come to work until all blisters have dried. Exclusion not necessary for contacts of someone who has hand, foot and mouth disease.
Herpes Simplex infections (cold sores)	If exposed herpetic lesion, must not provide direct care to neonates, newborns, patients with severe immunocompromise, patients with burns or extensive eczema, or patients undergoing minor surgical procedures. May provide direct patient care to other patients. Mask is unnecessary, but lesions should be covered with a dressing, if possible. Hand hygiene practices to minimise the risk of transmission need to be maintained.
Herpes Zoster infections (Shingles)	Must remain at home while unwell. Must not provide ANY direct patient care if lesions cannot be covered (eg ophthalmic zoster). If active lesions can be covered, can provide care to all patients except for pregnant women, neonates, severely immunocompromised patients.

Sharps

Clear protocols for safe handling, use and disposal of sharps are necessary to prevent injury that could lead to infection.

All staff who may encounter sharps need education about the safe use and disposal of sharps.

The Standards require that members of our practice team manage risks of potential cross-infection via methods that include safe storage and disposal of clinical waste including sharps (GP4.1 ► D).



GP4.1 ► D All members of our practice team manage risks of potential cross-infection in our practice by methods that include:

- good hand hygiene practices
- the use of PPE
- triage of patients with potential communicable diseases
- safe storage and disposal of clinical waste, including sharps
- safe management of blood and body-fluid spills.

You must:

- be able to demonstrate that practice team members manage risks of cross-infection
- ensure the practice team has access to PPE
- safely store and dispose of sharps and clinical waste.

Sharps

The IPC Guidelines recommend the use of safety-engineered medical devices in general practice wherever possible.

Practices may reduce the risk of sharps injuries through the use safety-engineered medical devices and other technologies that significantly reduce the risk of sharps injury, such as:

- self-retracting single-use lancets for blood glucose testing
- self-retracting cannula insertion devices
- round-tipped scalpel blades instead of pointed sharp-tipped blades
- vacuum blood collection tubes
- properly installed scalpel blade removal devices
- plastic ampoules in place of glass
- sharps containers meeting Australian Standards and appropriately mounted.



Exposure to blood and other body substances

All staff must be aware of how to prevent exposure to blood or body substances.

Any blood or other body substances to which a staff member is exposed must be managed as potential sources of blood-borne viral infections, regardless of the individual's diagnosis or perceived risk.

All staff need to know what to do if they are (or someone else is) exposed to blood or body substances, including who to report the incident to and what immediate actions are needed.

Exposure to blood and other body substances

Management of an occupational exposure involves:

- first aid
- immediate decontamination of the exposed area
- risk assessment
- rapid testing of the exposed person and the source person for blood-borne viruses
- prompt post-exposure prophylaxis (if indicated),
- full documentation of the incident
- analysis of the cause of the exposure incident
- modification of procedures as required to reduce the risk of recurrence
- staff education.

Section 8 of the IPC Guidelines explores these steps in more detail and gives practices practical detail for the management of each.

Exposure to blood and other body substances

Responsibilities for managing exposure to blood and body substances

The practice must have written policies and procedures to manage accidental exposure to blood or body substances, whether by penetrative injury or splash to eyes, mucous membranes or broken skin. These policies should be relevant to the daily routines of the practice and must be reviewed and updated regularly .

In the event of an exposure incident, all staff must know:

- what to do immediately after an exposure
- who is responsible for ensuring that necessary activities are carried out
- who to report to.

Exposure to blood and other body substances

Responsibilities for managing exposure to blood and body substances

Employers must ensure that staff receive regular training and education appropriate for the tasks they are expected to perform.

Staff involved in exposure-prone procedures must have access to appropriate information, training, counselling and vaccination programs.

Table 8.1. Policies and procedures to prevent blood-borne infections

Each practice must have clear policies and procedures for all of the following:

Safe handling and disposal of sharps

Safe handling and transport of specimens

Safe handling and disposal of waste

Environmental cleaning

Appropriate management of blood and body substance spills

Safe handling and cleaning of reusable medical devices

Exposure to blood and body substance

Hand hygiene

Where patients and staff can access personal protective equipment

How and when staff members are educated on the appropriate application, removal, and disposal of personal protective equipment.

Cleaning, laundry and waste management

- Practices must have a current cleaning policy that identifies staff members' responsibilities, work health and safety issues, and procedures for routine scheduled cleaning, unscheduled cleaning, and monitoring of effectiveness.
- The practice must perform a risk analysis to determine the methods, frequency and thoroughness of cleaning and the products used.
- Avoid reusable linen where possible.
- All staff, including those without primary responsibility for cleaning, laundry or waste management, must understand and follow policies for cleaning and hygiene throughout the practice.



Cleaning, laundry and waste management

The IPC Guidelines include:

- details on what to include in a practice cleaning policy
- examples of items in a practice cleaning schedule and accompanying template
- details on the selection and use of disinfectants and detergents
- details on cleaning spills, including contents of a spills kit
- details on cleaning after contamination by blood or other body substances (spills), including a sample spills cleaning protocol and accompanying template.

Cleaning, laundry and waste management

The practice must have an up-to-date policy for waste management that conforms to state or territory regulations and meets the current national standard for management of clinical and related wastes.

Waste must be safely and appropriately segregated into clinical (and related) waste and general waste as it is generated. Staff responsible for handling waste must receive regularly updated education and training on safe handling and disposal.

The IPC Guidelines include detail on:

- Work health and safety considerations
- Waste segregation
- Clinical waste containers
- General waste containers
- Storage of waste
- Collection and disposal of waste.

Reprocessing reusable medical devices

Requirements and recommendations related to reprocessing reusable medical devices are primarily based on requirements as set out in:

- *AS/NZS 4815 – Office-based health care facilities not involved in complex patient procedures and processes—Cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of the associated environment*
- *AS/NZS 4187 – Reprocessing of reusable medical devices in health service organisations.*

As Section 10 is based on these existing standards, there are no changes to practice requirements for reprocessing. Guidance will be updated after the new standard comes into effect.

Reprocessing reusable medical devices



- You can choose to reduce the volume of medical devices that require reprocessing by replacing some or most categories with disposable alternatives.
- Practices that reuse medical devices that require sterilization can choose either to do all reprocessing on site or outsource to an off-site provider.

- Reprocessing of items that require sterilisation should only occur within the practice if the current relevant standard can be met.
- Practices should have a designated area for processing reusable medical devices and must establish a workflow pattern that prevents the packaging, sterilisation and storage areas becoming contaminated. This involves systematically moving from 'dirty' to 'clean' within the designated area. The reprocessing area must be separate from treatment and administration areas.

Reprocessing reusable medical devices

The IPC Guidelines further details about:

- correct sterile barrier systems
- preparing, loading, running and unloading a steriliser and documenting cycles
- storing sterilised reusable medical equipment
- record keeping
- maintenance
- tracking reusable medical devices for patient tracing
- using offsite sterilisation services and reusable medical devices on loan.

Example of sterilisation flow in a small office facility

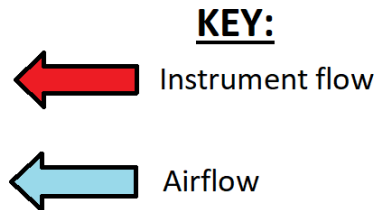
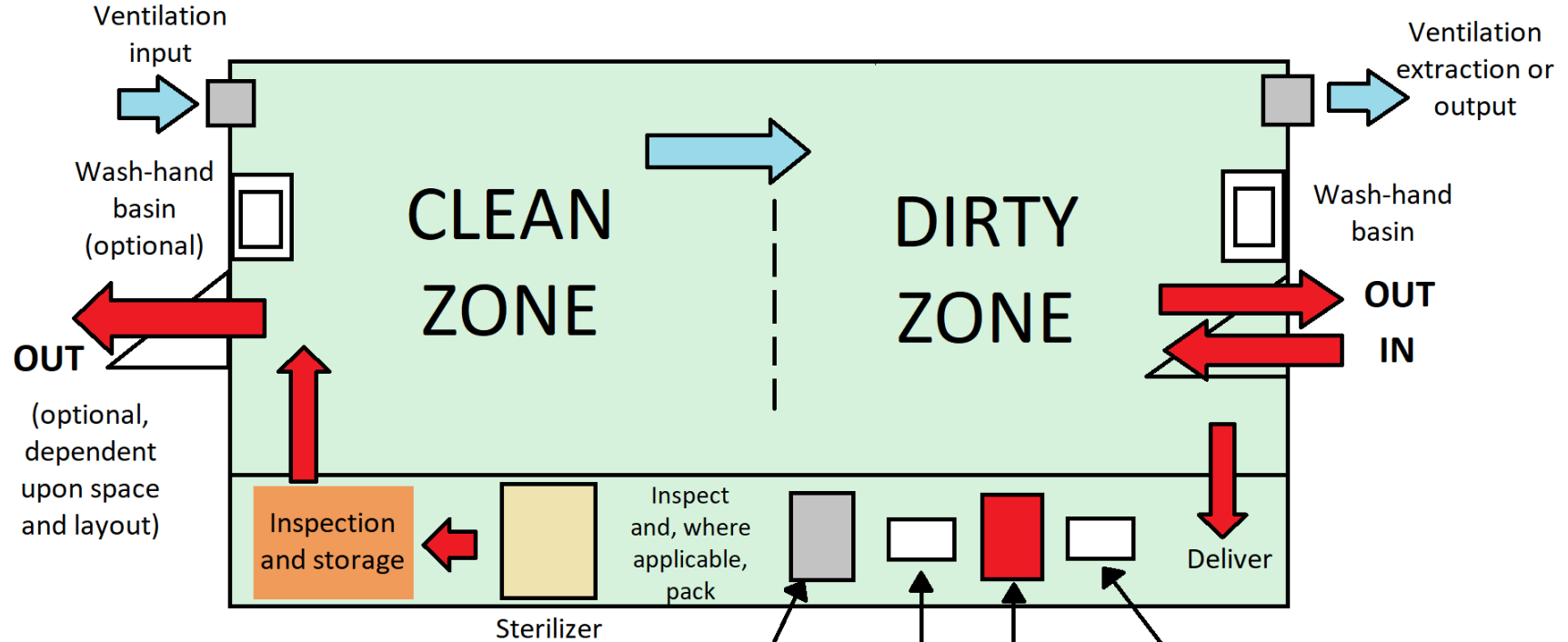


Image adapted from:

QLD Health (2019, March). *Infection Control Management Plans for Non-Hospital Healthcare*.

Available from: <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/infection-prevention/management-plans-guidance/icmp>

Disease surveillance and outbreak response

- Staff should be familiar with their statutory responsibilities for monitoring and reporting disease outbreaks or other infection prevention and control incidents to the relevant state/territory authorities.
- The practice must develop procedures to ensure that notifiable diseases are promptly reported.
- Educate all staff on disease surveillance and outbreak response
- Your practice can use an infection prevention and control kit at reception for when a patient presents with a suspected or confirmed infectious disease.

Disease surveillance and outbreak response

Monitoring for threats

- General practices and other office- and community-based practices must have systems in place that allow for monitoring threats of outbreaks, bioterrorism and emerging diseases.
- You could nominate a member of the clinical team to take responsibility for receiving and acting on notifications from federal and state/territory health departments about emerging infectious diseases.
- General practices and other office- and community-based practices need to have systems in place to ensure prompt reporting of notifiable diseases to the relevant state/territory health department.

Planning a practice



Aspects of building design and organisation that affect infection prevention and control include:

- choice of surface materials for walls, floors, desks and examination/treatment tables
- material and design of fixtures and fittings
- provision of areas that can be used for isolation
- adequate ventilation
- design of reprocessing area and storage
- waste storage areas
- placement and design of hand hygiene equipment.

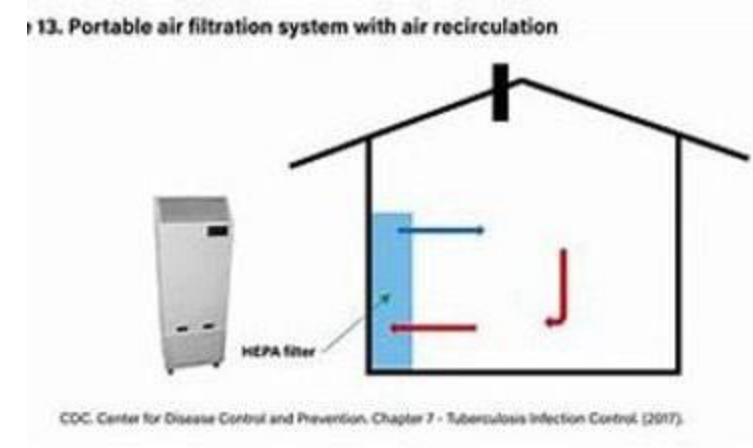
Your infection prevention and control coordinator should be involved in purchasing decisions about:

- consumables
- equipment
- personal protective equipment
- hand hygiene agents
- manual or automated cleaning, disinfecting and sterilising systems
- furnishings
- reusable medical devices
- single-use and single-patient use devices
- chemicals used for environmental cleaning and disinfection
- waste management systems
- other relevant clinical purchases.

Planning a practice

Ventilation

- Ventilation must be designed to achieve 6–8 air changes per hour (ie the number of times per hour that the whole volume of air in each room is replaced by fresh air) in general areas.
- Fresh air is preferable to recirculated air.
- Flows less than 6 air changes per hour are inadequate to help prevent airborne microbial transmission.
- In rooms where aerosol-generating procedures (eg spirometry) occur, a ventilation rate of 12 air changes per hour is recommended.



Planning a practice

Ventilation

- The direction of airflow must be from 'clean' to less clean areas, to avoid dispersing contaminated air.
- Standard heating, ventilation, and air conditioning systems are not specifically designed to prevent transmission of airborne infections, but can be used to optimise ventilation to assist in reduction of risk of transmission.
- Heating, ventilation, and air conditioning systems must be well maintained and regularly serviced. Unless the practice has adequate natural ventilation that consistently achieves adequate cross-flow of air, air conditioning must be run to ventilate the area to achieve 6–8 air changes per hour, even when heating or cooling are not needed.

Planning a practice

Ventilation

- Windows and doors can be opened for additional ventilation when there is a high risk of airborne transmission, although this does not guarantee adequate airflow. Fans can be used to improve air flow.
- If necessary, portable air-cleaning devices with HEPA filtration can be used in addition to other ventilation in areas with inadequate fresh air and circulation. The clean air delivery rate must be sufficient for the room volume.
- Toilets must be fitted with exhaust fans.

Air Changes/hour (ACH) and time required for airborne – contaminant removal by efficiency*

ACH § ¶	Time (mins.) required for removal 99% efficiency	Time (mins.) required for removal 99.9% efficiency
2	138	207
4	69	104
6+	46	69
8	35	52
10+	28	41
12+	23	35
15+	18	28
20	14	21
50	6	8

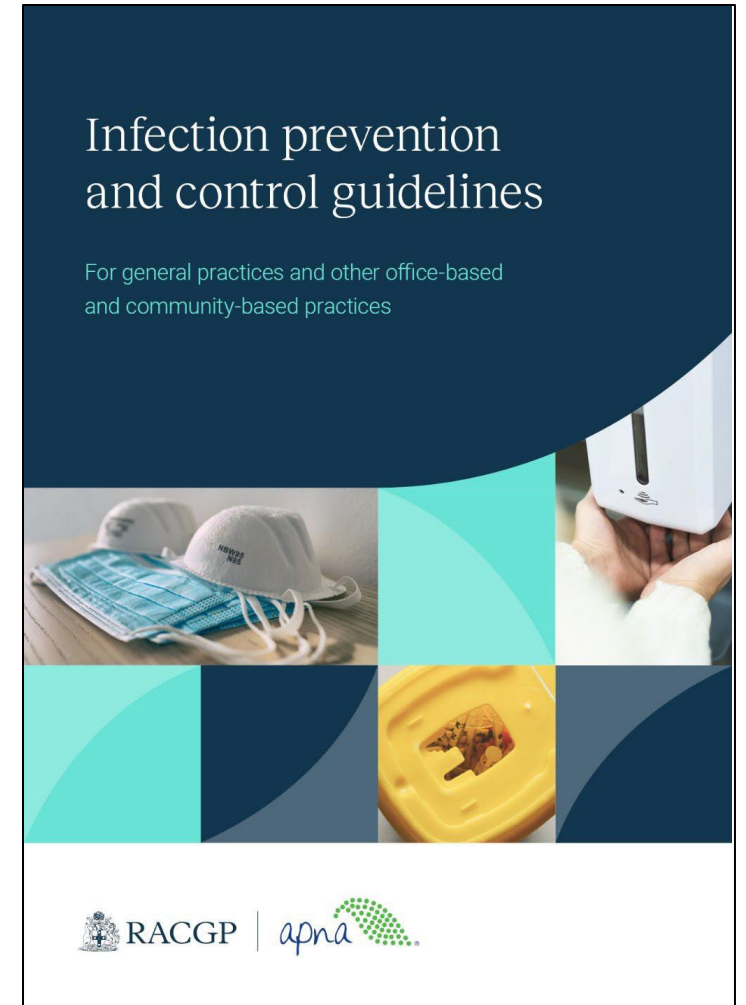
* This table is revised from Table S3-1 in reference 4 and has been adapted from the formula for the rate of purging airborne contaminants presented in reference 1435.

+ Denotes frequently cited ACH for patient-care areas.

§ Values were derived from the formula:

IPC Guidelines on the RACGP website

<https://www.racgp.org.au/>



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