What Makes an Effective IPC Program?

Lyn Gilbert

Mare Bashir Institute for Emerging Infections & Biosecurity

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SHE

THE UNIVERSITY OF SYDNEY

Marie Bashir Institute

"tackling infections, locally and globally"

lyn.gilbert@sydney.edu.au

What would I want if I (or my parent/partner/child) were a patient?

- NOT to get a preventable HAI!
  - Information about risks; how I can help to protect myself?
  - Truthful explanation if things go wrong
- NOT to be a source of infection or MRO transmission
  - How can I help to prevent spread, if I have an infection/MRO?
  - Explanation of isolation & transmission-based precautions
- Seeing HCWs doing HH (because I don't want to have to ask)
- A clean and tidy ward……

What makes an effective IPC program?

- We have all known the answer for years……..
  - Hand hygiene; aseptic technique; no unnecessary devices;
  - HAI surveillance & feedback; environmental cleaning;
  - correct standard & transmission-based precautions;
  - appropriate antimicrobial use; HCW immunisation;
  - patient involvement etc, etc……

IPC unit staffing in Australia

American Journal of Infection Control 43 (2015) 612-6

2015

Contents lists available at ScienceDirect

American Journal of Infection Control

journal homepage: www.ajicjournal.org

Major article

Hospital infection control units: Staffing, costs, and priorities

Brett G. Mitchell PhD, MAdvPrac[a,b,*], Lisa Hall PhD[c], Deborough MacBeth PhD[d], Anne Gardner PhD[b], Kate Halton PhD[c]

Survey of 152 Australian hospitals
2/3 public; >19,436 beds (=22%)

- **ICPs:** mean no. 0.66/100 overnight beds
  - Public (0.79) > private (0.43) hospitals
  - Mean: age - 50; experience -10 yr IPC/27 yr hospital
- Extra resources wanted?
  - IT support for surveillance; IPC training DVDs/online courses
  - Access to ID physician/clinical microbiologist

Adequate IPC resources?

- Q: how can 1-2 ICPs per 250 beds achieve all this?
- A: On their own, they can't
- What else is needed?
  - State/national policies; accreditation requirements; public reporting of HAI process/outcomes
    - e.g. NHHI – improved HH compliance; SAB reporting – reduced rates; NSQHS 3 – aseptic technique/AMS
  - Administration/clinical leaders who support/prioritise IPC
    - Hospital culture – good IPC practice not optional
    - Provide adequate resources - "*staff, stuff, space, systems*"
    - Accountability & transparency when things go wrong

IPC workforce

- One way to enhance it……
- Ward link nurse program for IPC
  - ideally also medical, allied health, support service IPC leads
  - supported & co-ordinated by IPC unit
- Rationale: theory-practice gap
  - every ward/unit has different patient & staff mix/culture
  - IPC links as local champions/opinion leaders/role models
  - Support network
  - Frontline ownership of IPC

Infection control champions (ICC)

American Journal of Infection Control 42 (2014) 1303-7

Contents lists available at ScienceDirect

American Journal of Infection Control

journal homepage: www.ajicjournal.org

Major article

Qualitative evaluation and economic estimates of an infection control champions program

Elisa Lloyd-Smith PhD [a], Jim Curtin RN [a], Wayne Gilbart RN [a], Marc G. Romney MD, FRCPC [a,b,*]

[a] Infection Prevention and Control, St. Paul's Hospital, Providence Health Care, Vancouver, BC, Canada
[b] Department of Pathology and Laboratory Medicine, Faculty of Medicine, University of British Columbia, Vancouver, BC, Canada

- Research funded ICC project
- 16 units in 3 hospitals in Canada; one ICC & back-up appointed
- 12 month program; 2 hours/week dedicated time - funded
- Education program; develop ICC program; ICP mentors
- Evaluation: focus groups of various HCWs

Infection control champions (ICC)

- Results of focus groups:
  - Program feasible/valuable:
    - ICCs: +ve role models; proactive educators; useful resource
    - Provide liaison with IPC unit for staff, patients & families
  - Barriers:
    - inadequate time, staff awareness of IPC, support for after-hours staff, support from senior staff
    - staff turnover

Lloyd-Smith et al AJIC 2014;43:1303-7

Successful IPC link program needs……

Factors for sustainability

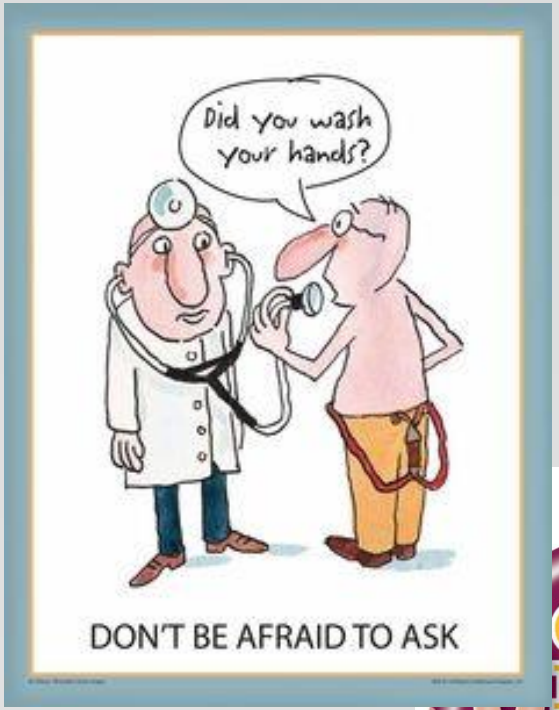
- Defined roles/goals – program evaluation
- Dedicated resources; continuing education; infrastructure
- Establishment of a network
- Engagement at all levels incl. senior leadership support
- Easy identification of ICC on unit; >1 ICC per unit
- Continuity, long-term commitment
- Expanded membership beyond nurses

Conclusion:

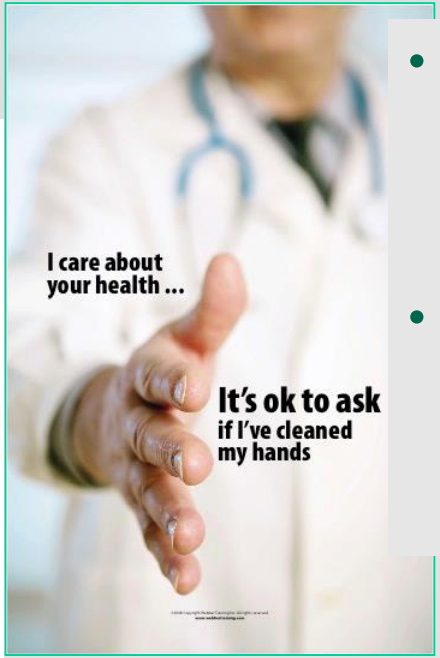
- Pilot successful; permanent unit-based funding
- Name changed from ICC → link nurse → IPC link (expanded)

Lloyd-Smith et al AJIC 2014;43:1303-7

Patient participation



- It's OK to ask & some patients are willing
- But, even with specific training, only some will ask nurses, but rarely doctors



- When they do ask, they may get short shrift
- And there's more to patient participation in IPC than HH

PXJ

Patient Experience Journal

Volume 2 | Issue 2 Article 9

2015

Should I stay or should I go? Patient understandings of and responses to source-isolation practices

Authors
Mary Wyer, Rick Iedema, Christine Jorm, Gary Armstrong, Su-Yin Hor, Claire Hooker, Debra Jackson, Clarissa Hughes, Matthew V.N. O'Sullivan, and Gwendolyn L. Gilbert

JCN *Journal of* Clinical Nursing

Journal of Clinical Nursing

ORIGINAL ARTICLE

Involving patients in understanding hospital infection control using visual methods

Mary Wyer, Debra Jackson, Rick Iedema, Su-Yin Hor, Gwendolyn L Gilbert, Christine Jorm, Claire Hooker, Matthew Vincent Neil O'Sullivan and Katherine Carroll

HCWs don't talk to patients about IPC and they are often confused & anxious

- I just didn't know what was going on. How did I contract it? Where did I get it from? And no one ever really explained.
  - Miller, after 2 weeks of isolation for HA-MRSA

- *Q: Have you had any conversations with people about [infection control]?*
- A: No, just through listening to the nurses and looking at what they are doing.
  - Michael, after 7 months of isolation for HA-MRSA

- I noticed that when the nurses do the change of dressing…they use sterile gloves. And when the doctor came in to check the wound, she used the blue gloves …. And then she actually put her finger in my open wound. And now I'm worried…
  - June, prolonged re-admission with wound infection

***Quotes from patient video interview; PhD research by Mary Wyer**

Why involve patients in IPC?*

- They have the most at stake

  I'm fighting for my foot ….and see what happens?

  Eden, MRSA osteomyelitis, after team enters her room, examines her foot, exits without hand hygiene or PPE.

- They want to protect others from harm……..

  I do feel funny when I go make a cup of tea… … it's like, "Oh, careful not to touch two [cups]." You know? Someone else has to use that other one.

  Norris, MRSA infection in finger

- But may unwittingly contribute to MRO spread

  …in the [communal patient kitchen] ..there's paper towels and I always take a paper towel and I try and touch everything, like doors and everything like that, with a paper towel.

  James, MRSA infection of his finger

- They are present 24/7 & develop insight & expertise

***Quotes from patient video interview; PhD research by Mary Wyer**

Talking with patients about IPC

- Pamphlets & information sheets not enough
- Conversations about IPC should start on admission & be repeated
  - What are the risks? how can I protect myself?
  - Why are you wearing gloves, mask, gown? (and why is someone else not wearing them?)

Talking with patients about IPC

- Ward nurses (& doctors) often don't know how to, or don't think about, explaining to patients:
  - HH; SP or T-BP; MRO colonisation; how an HAI occurred
- A potential role for IPC LN/ML
  - Training ward staff to talk to patients
- Informing patients will encourage them:
  - to clean their hands & ask HCWs and so…….
    - improve HCW HH compliance
    - reduce MRO transmission & HAIs

Conclusions: an effective IPC program?

- Administrative and clinical leadership & support
- Adequate ICP FTE
- IT & specialist support (IDP, Microbiology, Epidemiology)
- Distributed leadership – IPC link program
  - in every ward & unit: all professional & support service groups
  - ?potential requirement for the next NHQHS std. 3 – c.f. AMS?
- Patient participation, education, respect
- Charter of Healthcare Rights - more than a cliché?

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

For further information please visit www.safetyandquality.gov.au

AUSTRALIAN COMMISSION on SAFETY and QUALITY in HEALTHCARE

What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
Access	
I have a right to health care.	I can access services to address my healthcare needs.
Safety	
I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect	
I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication	
I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation	
I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy	
I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment	
I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

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- & many others