Better Infection Prevention and Control in Aged Care

For more than 30 years, I have worked as an infection control expert. As a nurse, I am relentless in my commitment to safer healthcare. I never expected that my family or I would encounter widespread infection control breaches. During my mother's last nine months of life in residential aged care, *I witnessed first-hand a system that was unfortunately broken and high-risk*. I observed numerous deficiencies in basic methods of infection control. For these reasons, I welcomed the Royal Commission into Aged Care Quality and Safety and The Aged Care Quality and Safety Commission (the Commission) reforms that followed.

Recent research and Royal Commission (RC) results demonstrate the overwhelming lack of well-structured, organised, managed and effective infection prevention and control (IPC) programs resulting in substandard care, deplorable conditions, suffering, increased risk and poor outcomes for many aged care residents.

In 2020 the Commission initiated a series of infection control monitoring visits or spot-checks of residential aged care settings that highlighted the following concerns:

- incorrect wearing of masks and frequent touching of either the face or the mask
- lack of cleaning of shared equipment between patient uses
- unnecessary wearing of personal protective equipment (PPE)
- lack of physical distance between staff
- insufficient preparation of and training in outbreak management plans.

Residential aged care is one of the most challenging settings to reduce the spread of infection between staff, residents and visitors. There are well-documented cases of spread between each. Prevention is complex due to residents' vulnerability because of their age and comorbidities, the emphasis on non-restrictive care environments and routine intermingling between residents, staff and visitors. The absence of staff with infection control specialist knowledge, basic IPC training and insufficient supply of essential protective items, including PPE, compound the problem.

The RC's recommendations address these deficiencies. For the aged care sector, they likely require significant change and investment in staff as well as the appointment of an IPC lead who will oversee the organisation's formal IPC program. Providers must now ensure that sufficient supplies of necessary IPC equipment and devices are available for staff and that staff are trained and competent in basic measures such as hand hygiene, PPE selection, use, removal and disposal. Staff must also understand and comply with standard and transmission-based precautions. Non-compliant providers may be subject to regulatory action by the Commission. The Commission also maintains and publishes a public register of non-compliant providers for at least one month before being placed on an archival public non-compliance register. Placement on either public register brings a degree of disruption to a provider's reputation.

The RC noted that *"Infection control should be a central feature of care for aged care providers."* Commonwealth data show that from January 2020 to date at least 2051 residents in aged care have contracted COVID-19.10 One-third of them died.

Such poor performance horrifies the families of loved ones in care and more than ever before the public is closely monitoring the quality of care at sector-wide and individual facility levels. Savvy providers should take advantage of this exposure and do everything to capitalise on the chance to be a shining example of safe aged care. To achieve this, providers must start by ensuring that their staff and residents can work and live in an environment where risks of infection are mitigated. This is not just a regulatory requirement it is also a fundamental right for residents and staff and a moral obligation for providers.

Providers can begin their organisation's commitment to IPC by making sure they have an IPC Lead. This is a condition of accreditation or reaccreditation. Providers must also ensure they are compliant with the updated Aged Care Quality Standards.

The new IPC Lead role is an exciting one. It's one I would have jumped at in my early infection control career and it's one I wish had existed when my Mum was in care. As an IPC Lead you are expected to:

- assist with developing and implementing outbreak management plans,
- provide assistance on day one of any outbreak as part of an outbreak management team, and
- provide training to staff on IPC and use of PPE.

As an infection control expert, I have learnt that implementing change, especially when it requires additional costs for organisations or significant changes to how staff work, is difficult but not impossible. If staff or a staff representative is engaged in the plans for IPC change, staff generally feel that they are valued, and their views are important. I have found this to be the case with both clinical and ancillary staff. Get those members who have views on IPC involved early and you will be amazed at the insights they can bring and the obstacles they can help you avoid in implementation and acceptance. Staff also respond well to posters and clear, accurate visuals.

There are good examples available via the Commission's website, from the national Health Department's websites and PPE manufacturers who offer educational tools and resources. It's also often useful to have a basic info sheet for families and visitors that shows the steps your organisation is taking to keep their family member safe.

Despite your best efforts some staff may be serial non-compliers in terms of IPC. My experience is that a safe, non-judgemental approach and an opportunity for discussion about their objections can often lead to the non-complier becoming your organisation's biggest IPC fan. Fears and misunderstandings have to be identified and addressed with compassion and respect. For the odd cases of ongoing non-compliance each provider should have a policy outlining how to manage the staff member and what alternative actions may need to be taken and in which order.

However you look at it, IPC is everybody's business. My hope is that all Australians receive safe care especially as they age. A comprehensive, detailed overview of basic and specific residential aged care, IPC strategies and measures is available in the Australian Government's 2021 *Guidance on infection prevention and control for residential care facilities in the context of COVID-19*. In my view there are a few key elements that underpin good, safe IPC. I have outlined some of them in the following table and I hope they help you and your staff to care for our aged safely and with dignity.

This article was written by Dr Cathryn Murphy, Adjunct Honorary Associate Professor at Bond University and supported by O&M Halyard Australia.

Cath Murphy PhD is a registered nurse whose career over several decades has covered senior infection prevention positions within the clinical, government, non-government and professional associations in her home country Australia and internationally. She is currently a member of two Standards Australia committees. Cath is an Honorary Adjunct Assoc. Professor at Bond University on the Gold Coast, Australia. For more than 20 years Cath has provided independent consulting services to a range of clinical, public policy, professional associations and commercial clients throughout the world.

Career highlights include working in the USA at the CDC, consulting for the World Health Organization and serving as the elected APIC President in 2010. Cath's passion for improving patient safety through better and smarter infection control and prevention is unrelenting. Cath's ideas are innovative and practical. She looks forward to learning from and giving reliable, high-quality service to her professional peers and colleagues particularly those involved in infection control and prevention and perioperative care and nursing.

CATEGORY AREA	EVIDENCE THAT IT IS IN PLACE
Standard and transmission-based precautions (TBPs)	• Signage is available distinguishing between standard and TBPs • Staff routinely and correctly undertake IPC risk assessments before delivering care • Proper practice is observed, routinely monitored and reported • IPC policies exist • Staff receive IPC education at orientation and regularly thereafter • Management has policies for reporting and responding to non-compliance • Management and senior staff champion and role model IPC • TBPs are applied to patients suspected or confirmed to be infected with agents transmitted by the contact, droplet or airborne routes.
Hand hygiene (HH)	• Sufficient supply of alcohol-based handrub (ABHR) • Staff perform HH as per the five moments of HH • Precedes and follows all PPE use
Personal protective equipment (PPE)	Sufficient supply of masks, gloves, gowns and eye protection are always available and accessible: • education and training on correct PPE • signage promotes correct order for PPE donning, doffing and disposal.
Masks (surgical) Levels 1-3	• Provide education around mask ratings and guidelines, right mask for right task • Level 1 mask is worn if there is a low risk of exposure to blood or body fluid (BBF) • Level 2 or 3 worn if there is risk of BBF exposure
Masks or respirators (particulate filter respiratorsP2/N95)	• P2/N95 respirator is worn if there is significant COVID risk All staff: • are trained in use • fit tested before using a P2/N95 for the first time • fit check each time a P2/N95 is used
Gloves	For direct contact with patients: • vinyl gloves are not recommended for the clinical care of patients • latex free nitrile gloves are superior and safer for use for latex sensitive staff and residents
Gowns	• Where risk of blood and bodily fluid (BBF) splash is high an impervious gown should used
Eye protection	• Protective eyewear or face shields are worn if there is the potential BBF splashes or sprays into the face and eyes • Single-use or reusable face shields may be used in addition to surgical masks, as an alternative
Cleaning and disinfection	• Shared equipment is cleaned and disinfected between patient use • Shared furniture and environments are cleaned and disinfected regularly according to the risk of contamination, mode of transmission and risk to others • Spills of BBF are cleaned and disinfected immediately according to an approved local policy
Vaccination	• Residents and staff are vaccinated against influenza and COVID-19
Separation	The organisation: • has policies and plans for segregation of residents with a transmissible infection • staff are familiar with and can follow the policies and plans • has adequate signage and supplies for segregation
Outbreak Management Plan	• An Outbreak Management Plan must be in place and it must conform with the Commission's requirements