Setting up a community and mental health infection control service

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Abstract

In February 1996, a large public hospital network in New Zealand decided to expand its infection control service to include coverage for both community health and mental health within its geographical area, a task undertaken by the hospital-based infection control practitioner (ICP). This paper describes the establishment of the service, the problems encountered by the ICP, and the initiatives and strategies implemented to address identified problems. Plans to improve the service in the future are also outlined.

Background

Auckland is the largest city in New Zealand. Spread over a wide geographical area it is also the fastest growing region of the country, with a population of around 1.1 million. Auckland Healthcare developed out of the restructuring of New Zealand's public health system in 1992, when the old hospitals and area health boards were grouped into corporations. These business units – there are 23 of them throughout New Zealand – are called Crown Health Enterprises or CHEs and are charged with providing quality health care while operating as successful businesses.

Auckland Healthcare, the largest CHE, comprises four hospitals and two community-based services, plus clinical support services. The four hospitals are:

- Auckland Hospital, New Zealand's largest tertiary and trauma hospital and a major teaching and research centre;

- Green Lane Hospital, New Zealand's premier centre for the treatment of heart and respiratory conditions;

- the National Women's Hospital, largest provider of maternity services in New Zealand and Australia, and

- Starship Children's Hospital, the country's only paediatric facility.

The two community-based services are divided into Community Health (CHS) and Mental Health (MHS). Overall, Auckland Healthcare provides local hospital and outpatient services for over 300,000 residents of central Auckland, plus regional services for 30 per cent of the national population, and employs approximately 8000 people, of whom five are infection control nurse practitioners (ICPs).

The trend in both the United States and Australasia is for health care to shift from the inpatient hospital to the outpatient and home care setting. As with other health-care services, Auckland Healthcare has recorded increases in the numbers of acute patients and occupancy rates of all intensive care facilities and decreases in the average length of stay within hospitals. Thus, more care is moving out into the community and community-related services are expanding.

Traditionally, infection control has been hospital-based and infection control policies and roles were generally designed to this end. However, infection control and its associated practices must not stop at the hospital gate. It is important that non-hospital-based health-care workers carry out the correct infection control practices, to ensure that their patients progress along the health continuum; this may help prevent hospital readmissions. In order to achieve that, infection control support must be accessible to all staff, regardless of the setting in which they work.

Establishment of community infection control

In February 1996, following the restructure of the Auckland Healthcare Infection Control Service, a half-time infection control role was allocated to both CHS and MHS, to reflect the health-care shift from hospital-based services into the community and in recognition of the need for community services to have access to infection control.

Problems encountered by the newly appointed ICP included the following.

- There was a perception that infection control was only for hospitals and not relevant in the community setting. Comments such as, "You isolate people with infectious diseases," and "You're supposed to wash your hands all the time" were made to the ICP.

- Hostile attitudes toward the ICP and the practice of infection control generally reflected a lack of understanding of the role. Comments such as, "What would you know? You're not a mental health [or community] nurse" were made.

- Staff lacked knowledge of inappropriate infection control practices, such as the common one of double-bagging rubbish and equipment from identified 'infectious' patients such as hepatitis B carriers.

- Dirty dressings and rubbish were discarded in people's homes, normally an acceptable practice; however, if the client was deemed 'infectious' (had, for example, methicillin-resistant *Staphylococcus aureus* (MRSA)), his or her rubbish was transported back to base in the nurse's car.

- Non-evidence-based disinfection practices were employed; for instance, the soaking of instruments in unlabelled, unidentifiable pink 'disinfecting' solutions prior to their being washed in detergent and autoclaved.

- A fear of human immunodeficiency virus (HIV) prevailed among many of the staff.

These issues were compounded by a lack of resources; even basics like handbasins with soap and paper towels were lacking. Gloves, a rare commodity, were brought out only when a known 'infectious' case was to be treated. Another difficulty faced initially was the location of the various sites. The official listing contained about 25 sites but, more than a year later, the ICP had identified approximately 50, the diversity of which necessitated the use of different approaches by that ICP. Services provided ranged from inpatient areas, community nurses and therapists to a refugee centre and a sexual health clinic for sex industry workers.

Strategies

On commencing in the role, the ICP identified an initial plan. Since there were no other community-based infection control positions in the country it was first necessary to establish a definition of the role. The definition of 'nosocomial infection'

in the mission statement of the overall infection control service was thus informally expanded to refer to cross-infection rather than just hospital-acquired infection. Following this, the ICP decided to focus primarily on education and the provision of advice and a consultancy service for staff. Once the service was established, other areas, such as policy development, could be worked on. In the community there is less focus on surveillance than in a hospital, and it is limited to inpatient exposure episode management, outbreak control and contact tracing. The community public health surveillance program is well-established and run by the Public Health Communicable Diseases team, with whom a relationship has been forged.

A visitation schedule for the various sites was set up, in order to establish a rapport with staff and inspire confidence, since those staff had not had access to an ICP previously. Some needs could be assessed at the initial visit but it was often during subsequent visits, when more staff interaction and/or audits occurred, that the issues to be addressed were identified. Regular reports to the quality committees for both the CHS and MHS were instigated, to ensure that people at all levels of the organisation knew what initiatives the ICP was instigating and what the outcomes of those were. ICP involvement with the orientation of new staff helped promote infection control practices early on in these people's employment and were a good public relations exercise for the ICP.

As time went on an educational plan was developed; however, since much of the education is based on whatever is needed at a certain point in time, this plan is always evolving and changing.

The New Zealand Council on Healthcare Standards requires regular infection control environmental audits within hospital settings. To implement this type of monitoring in the community, an audit tool was designed specifically for that setting and enabled the ICP to continually assess needs and identify problems. Further, an audit schedule was devised to facilitate regular auditing of each area. Community-based sites are audited annually, whereas inpatient areas such as psychiatric institutions and the rehabilitation facility are assessed on a 6-monthly basis.

About 6 months after the ICP's appointment a multidisciplinary infection control committee was set up. Prior to this, community-based matters supposedly went to one of the hospital infection control committees, but in practice this did not happen. The new committee meets on a 3-monthly basis, with minutes sent to all areas within both the CHS and MHS.

This committee comprises representatives from both services, plus occupational health and nursing, as well as a quality coordinator and a public health physician.

A collaborative relationship formed with the community and mental health occupational health nurse led to several initiatives, among them a combined orientation program for new staff, a hepatitis B education program and better communication between infection control and occupational health.

Several infection control liaison nurses were also appointed. These representatives attend biannual infection control study days and assist their colleagues by answering basic queries. They are also encouraged to attend meetings of the infection control committee.

Conclusion

These initiatives have resulted in increased infection control awareness among staff and identification and correction of major infection control problems in the community setting. Future plans include increased collaboration with the occupational health nurse, more joint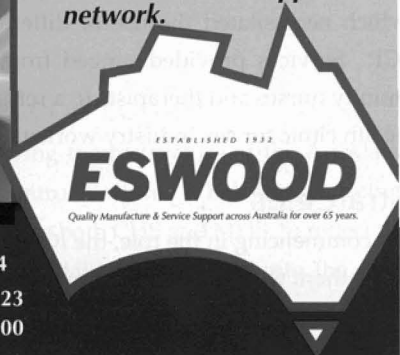 audits and the development of a sharps awareness program. Further development of the role of the liaison nurses is also planned. That role should be more formalised and extra liaison nurses need to be appointed. Also, community-specific infection control policies must be developed, since the current, generic inter-service infection control manual is still very hospital-specific. Initial priorities include policies for community MRSA management and isolation of infectious diseases within the mental health setting. Surveillance of home intravenous-related infections is also a possibility and this may be done in conjunction with other home-care providers in different parts of the country.

In conclusion, the role of the ICP within the community mental health setting is quite different to that which exists in the hospital setting, although the principles are essentially the same. There are many challenges involved in breaking down barriers and a number of historical and preconceived ideas to overcome. Nevertheless, the author finds the role more than merely challenging – it is also most rewarding.

[This article adapted from the author's presentation at the Australian Infection Control Conference in Melbourne in May 1997.]