# Implementing an Infection Prevention & Control Program for Primary Care

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## Background

In the realm of patient safety, Primary Care practices have not traditionally been as vigilant as hospitals in instituting Infection Prevention and Control (IPAC) policies and procedures. This is, in part, due to a lack of legislative requirements and oversight in primary care, and in part because focus on IPAC in non-hospital settings has typically been in areas of higher risk procedures, such a endoscopy and surgery.

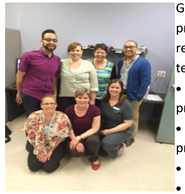
In the summer of 2014, in preparation for the upcoming influenza season and in engaging in preparedness training for Ebola, the South East Toronto Family Health Team (SETFHT) conducted an audit of our IPAC practices. The audit was conducted by members of SETFHT's Joint Health and Safety Committee (JHSC) and a member of the IPAC team at Toronto East General Hospital. At the time of the audit, there did exist several individual IPAC policies and procedures, and many of the staff have worked in hospitals and have integrated IPAC procedures that had not specifically been put into policy at SETFHT; however, we had no overarching IPAC program.

The audit tool was adapted from the Community IPAC Audit Tool. 54% of the items were graded as "red" (i.e., not in compliance) and 20% were "yellow" (i.e., in compliance with minor improvements of additional staff education). It became very clear that we needed to develop a comprehensive IPAC program, with evaluation/audit tools.

The SETFHT Board supported our application to IDEAS for advanced training to assist us in this important patient safety work. Our overall project aim is to increase full compliance with PIDAC (Provincial Infectious Diseases Advisory Council, Public Health Ontario) requirements/standards for infection control for clinical office practice from 25% to 80% by December 31, 2015. For the purposes of our IDEAS training, our aim was to increase full compliance with PIDAC requirements/standards for the reprocessing of instruments from 25% to 80% or more by June 15, 2015, as measured by the percentage of required policies approved by SETFHT's JHSC and the percentage of standards met on audit. In addition to developing policies and procedures, our key change ideas included:

- Developing a standardized process for instrument reprocessing across our two clinic sites;
- Eliminating the use of re-usable specula;
- Staff and MD education.

## Our Project Team



Getting the right people to the table to consider all our issues was a challenge. At the time we put the project team together, we were short staffed on our clinical support team and as the individuals responsible for instrument reprocessing, they were absolutely vital to the success of the project. Each team member brought unique skills and experiences:

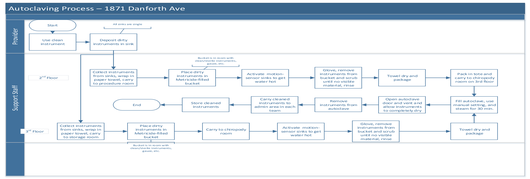
- Maureen Gans (co-chair), Director, Interprofessional Practice & QI: experience reviewing IPAC procedures in non-hospital facilities.
- Jason Santos (co-chair), RN: a certified member of our Joint Health & Safety Committee with previous hospital experience.
- Lauren Cripps, RN: previous experience in instrument reprocessing.
- Noreen McMullen and Jennifer Neumann, clinical support staff: responsible for reprocessing and exam room prep.
- Dr. Sam Tirkos, family physician: the co-chair of our Quality Committee.
- Stephanie Houghton, HR Manager: a last-minute but vital addition to the team, as she chairs our Joint Health and Safety Committee and manages the clinical support staff.

## Instrument Reprocessing

We chose to start our project with instrument reprocessing. While there is a greater likelihood of spreading airborne infections in a primary care setting, the impact of a blood-borne pathogen transmission as a result of poor instrument reprocessing would be greater in terms of impact to the patient, impact to our reputation, and legal liability.

Chiropody instruments, vaginal specula, and IUD insertion instruments form the bulk of our reprocessed instruments. Our two chiropodists clean their own equipment, and have special ultrasound machines to shake debris from files and other chiropody tools prior to autoclaving. Our clinical support staff gather, scrub and autoclave other instruments used by the MDs and residents. Our RNs and NPs use disposable specula, although the NPs who offer IUD insertion do require those instruments to be reprocessed.

The process at our 840 Coxwell Avenue site was reasonably straightforward; our 1871 Danforth site was more complicated, as there are two floors from which staff had to gather equipment.

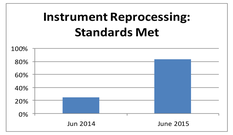


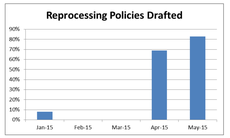

The process map quickly identified a number of issues for the team to tackle:

- The vast majority of MDs were disposing of dirty instruments into the hand-washing sinks in the exam rooms.
- We do not have "dirty" rooms for storing and scrubbing instruments: the clinical support staff gathered dirty instruments from the exam rooms and placed them in buckets in a hall closet that is filled with clean supplies.
- The autoclave at our Danforth site is housed in the Chiropody room; sometimes the Chiropodist runs the machine at lunch, which means the autoclave door is open to allow the instruments to dry when patients are in the room.
- The process map outlined the procedure as performed by two very competent staff; we were unsure about the adequacy of the training giving to other staff, or their ability to perform these procedures on an ad hoc basis.

Next Steps:

- The team created policies/procedures for all aspects of the reprocessing process. In early June, we audited that part of our IPAC program and we did meet our target of achieving 80% of the PIDAC standards.
- What was missing: training manual for staff; storage of dirty instruments; clean/dirty clinic spaces.




## Challenges

**Disposable vs. Reusable Specula**

The project team recommended moving to disposable specula in order to:

- Improve patient flow and clinic efficiency;
- Reduce the risk of cross-infection;
- Decrease costs:
  - The cost of disposables at one clinic site per week is $33 (plus the environmental cost of landfill)
  - The cost of reusables per week is $480 in staff time and about $50 in bags, tape, biologic and chemical indicators (plus the environmental cost of disposal of chemicals into the water system).

The MD group chose to continue to work with reusable specula.

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**Storing Dirty Instruments**

The project team considered options for depositing dirty instruments. Appreciating that most providers would not re-wrap their instruments and walk them down the hall to a central storage area, we sourced a small metal bucket with insert that can be safety housed between the exam table and wall and filled with soapy water. The clinical support staff will remove the buckets at the end of each day, scrub and package the instruments in the "dirty area", and store them for autoclaving when they have a full load.

**Creating Clean/Dirty Spaces**

The clinical support staff use whatever sink is available to scrub dirty instruments prior to packaging them for the autoclave. All sinks in the clinic are fitted with an automatic on-off faucet, which is great for hand hygiene but makes filling the sinks difficult. We have identified options and costs involved to create "dirty rooms" for instrument prep, and then a "clean room" to house the autoclaves.

## Future Directions

We have almost completed or updated the other IPAC policies/procedures required for the program. All policies will be reviewed by the JHSC and then forwarded to the Board for approval by the end of this year. The JHSC will take over the program and begin regular audits, and annual policy reviews/updates. We intend to post our policies/procedures on our website.

With influenza season approaching, we plan on using our Patient Advisory Council to assist us in developing education materials and posters to encourage staff and patients to be vigilant about hand hygiene, masking when they have coughs, and identifying patients who should be isolated from the rest of the waiting room.

The IPAC program will form part of a broader incident management program that will also include incident reporting and vaccine management.