Takeaways from workshop 2: IPC

Guests attending workshop:

- Jane Barnett, National IPC lead at Southern Cross Hospitals
- Frances Hughes, Aged Care Association
- Tim Blackmore, Capital & Coast DHB
- Susan Jack, Southern DHB

Note Joshua Freeman, Canterbury DHB, provided input following the workshop.

Goal for IPC in Aotearoa New Zealand: a culture that supports and facilitates IPC seamlessly from houses to hospitals.

IPC governance and leadership required

- COVID-19 highlighted issues with IPC
- Need to establish national governance and leadership for IPC
    - Consider 'Director of IPC' role that reports to the exec level of a DHB e.g. UK example, Canterbury DHB
- Need for a united and integrated approach at all levels across the different professional groups and agencies that offer IPC advice
- Need the responsibility and accountability for IPC to sit with people who report in at a high enough level (exec) to give IPC the prominence and importance it requires (the UK have done this previously)
- IPC governance requirements have been strengthen in the Health and Disability Standards review but need to ensure these are enacted from a national to regional level
- Health Practitioners Competence Act could be a lever for action

Coordinated national approach to IPC

- Health reforms provide a good opportunity to embed IPC at all levels
- ARC should be included and treated as a mainstream provider
- Should also consider IPC in prisons
- Ongoing dialogue and data sharing across country needed
- A national standardised infection control alert system would be good – there is a current alert system but it is not used in a uniform way across the country.
- The national approach should factor in equity issues
- It should also plug gaps – e.g. recognised Seasonal Employer (RSE) workers fall through gap – they are not eligible for funded vaccines but can only get a vaccine once an outbreak has occurred

IPC guidelines and standards

- All providers covered by Health and Disability Service Standard (including ARC)
- Need national guidelines and standards (including for cleaning) for a range of settings including GP clinics
- Educational materials need to be reputable with an accreditation system (not marketing material from companies e.g. those who sell cleaning products)
- People working in multiple settings and staff sharing are an IPC risk

Building IPC expertise

- IPC is lacking a strong community and independence – it needs resource
- IPC expertise should be evidence-backed and engaged with regardless of professional status or background – IPC nurses often hold IPC expertise that is overlooked due to traditional hierarchies within the medical field
- IPC expert nurses should be resourced to do community work

- ARC struggle to access IPC educational info + cannot always access DHB training – patchy across the country

Facility design

- Design limitations in hospitals and ARC cause issues for IPC
- Standards/design requirements are important for every care environment where there is crowding. The health standards include design requirements.
    - Updated health and disability sector standards are coming next year and are more explicit regarding IPC input being needed at the design phase.
- Need experts to draw on for facility design
- Standards or stringent requirements without resource allocation risk places closing and regions will not have access to e.g. ARC
- Future design could ensure flexible areas that can be repurposed or areas that can be cut off from others
- ARC don't have all the facilities that hospitals have. While facilities need to meet building design certifications these are not necessarily at the standard required for good IPC. For example, buildings now mix independent living and care rooms, there is no space for donning and doffing.
- Current built environments are inadequate when it comes to managing airborne infectious diseases. In an ideal world, we would have negative pressure rooms to isolate patients but this is not practically feasible – instead we should rethink our approach to ventilation and air cleaning more generally across facilities.
- It is most likely too impractical to design and build specific quarantine facilities and have surge staffing available for outbreaks but there should still be planning about how this will be managed. What level of infectious disease can you manage there and at what point would you need to move? Any isolation facilities would need to be age friendly.

ARC specific challenges

- ARCs deal with outbreaks all the time
- ARC are people's homes and this needs to be factored in
- There is a strong disconnect and lack of integration for IPC across all contexts in NZ and the ~40,000 beds range in settings
- Staffing ratios of trained to untrained staff are inadequate
- AMR screening important but difficult to implement – union rules
- High levels of migrant workers (up to 70% in Auckland)
- Could improve pre-employment practices, info, vaccinations
- Comms needs different languages
- Residents should have better screening

This workshop was focused on human health but there should be two-way sharing of expertise and lessons between human and animal health sectors.