Understanding the implications of NICE guidance on infection control

Following the publication of Getting Ahead of the Curve (Department of Health, 2001), greater emphasis has been placed on infection control in primary and community care (called community care throughout this article). For years, guidance on reducing the incidence of preventable health care-associated infections in community care has been based on standards developed for acute care settings. But in many cases, practices common in acute care are not directly transferable to the community. Also, shorter hospital stays mean care previously provided in hospital is increasingly carried out in the community.

In 1998, the Department of Health commissioned national evidence-based guidelines on the prevention of health care-associated infections (Pratt et al, 2001), which focused on hospitals. In 2003, a follow-on set of guidelines was commissioned and part-funded by the National Institute for Clinical Excellence (NICE) for use in community care (Pellowe et al, 2003).

Development of the guidance has involved extensive research of the evidence base, and assessment of the economic implications of implementing changes to practice. This has ensured that the recommended changes are both clinically and financially sound.


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Nicola Pratelli discusses the implications for practice

KEY WORDS
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REFERENCES
Department of Health (2001)
Getting Ahead of the Curve.
London: DoH.

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DEADLINES
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In the past, guidelines for infection control in the community have been based on guidance developed for acute care situations. In 2003, with funding from the Department of Health and the National Institute for Clinical Excellence, evidence-based guidelines have been developed specifically for use in primary care and the community.

Nicola Pratelli discusses the implications for practice

In the community regular handwashing can be a challenge, with low staffing levels, inaccessible sinks and a lack of basic resources such as soap and towels. This issue is being addressed through the recommended use of alcohol hand rubs, which are an easily accessible and realistic alternative to washing when hands are not heavily soiled. Although alcohol does not remove dirt and organic matter, it is effective in substantially reducing transient micro-organisms.

Expert opinion is clear about when gloves must be worn. In situations where gloves should be used, the practitioner must choose between sterile or non-sterile gloves. The guidance found that although natural rubber latex and other synthetic materials were the most commonly used, vinyl gloves made to European Community standards offer the same level of protection.

Polythene gloves are not suitable for clinical use due to their permeability.

Plastic aprons are recommended for general use, although they need to be stored away from potential contamination. Specialised respiratory protective equipment should be worn when caring for patients with tuberculosis or patients who are severely immunocompromised and at increased risk of infection.

All sharps injuries are considered preventable and expert opinion encourages health care providers and their employees to pursue safer methods of working by using safety devices and appropriate sharps procedures.

Conclusions To improve patient outcomes and reduce health care costs, it is essential that all those providing care in the community are fully informed about hand decontamination, the appropriate use of gloves and protective clothing, and the safe disposal of sharps. In order to comply with the guidance, health care providers have a duty to provide sufficient supplies of soap, hand rub, towels and sharps containers. They are also required to ensure that everyone involved in providing care in the community is trained in hand decontamination, the use of protective clothing and the safe disposal of sharps.

HAND HYGIENE

■ Hands must be decontaminated immediately before direct patient contact/care and after any activity or contact that potentially results in hands becoming contaminated

■ Hands must be decontaminated, preferably with an alcohol-based hand rub unless visibly soiled, between caring for patients and between different care activities for the same patient (Pellowe et al, 2003).

The guidance

This makes three recommendations on standard principles for infection control.

The guidance states that ‘patients are put at potential risk of developing an infection when health care personnel caring for them have contaminated hands’. Unfortunately, many health care workers appear to have a poor understanding of the impact that handwashing can have on those in their care.

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Conclusion

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