INFECTION PREVENTION AND CONTROL – KNOWING A LOT ABOUT A LOT OF THINGS AND THE ART OF CAPACITY BUILDING AND NURTURING NEW PRACTITIONERS

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SHEA/CDC Cert Infection Control, Cert Med Micro, DipLdrshp&Mgt.CICP-E; Future Leaders of Healthcare DrPH Candidate

NSW Chief ICP & HAI Advisor | IPAC COVID-19 Response Clinical Lead | Clinical Excellence Commission
Infection Prevention and Control Practitioner (CICPE).

NSW GOVERNMENT

CLINICAL EXCELLENCE COMMISSION

Acknowledgement of Country and Elders

Before we begin,

I would like to acknowledge the traditional owners of the land where we meet today.

I pay my respects to their Elders past and present.

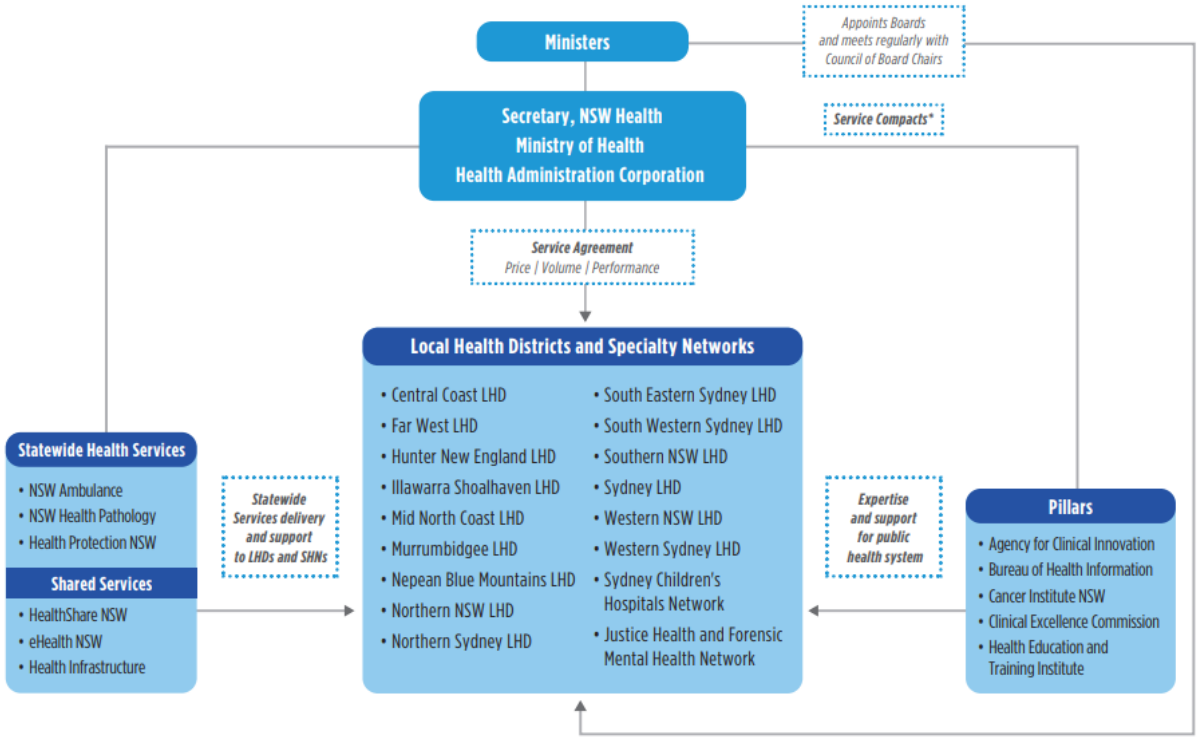
It is upon their lands that we meet.

About the CEC

- Established in 2004, the board-governed Clinical Excellence Commission (CEC) is one of five pillars of the NSW health system.
- Pillar agencies provide specialist services and support to frontline health teams in hospitals and care settings.

•setting standards for safety, and monitoring clinical safety and quality processes and
•improving performance of individuals, teams and systems in prioritising safety.

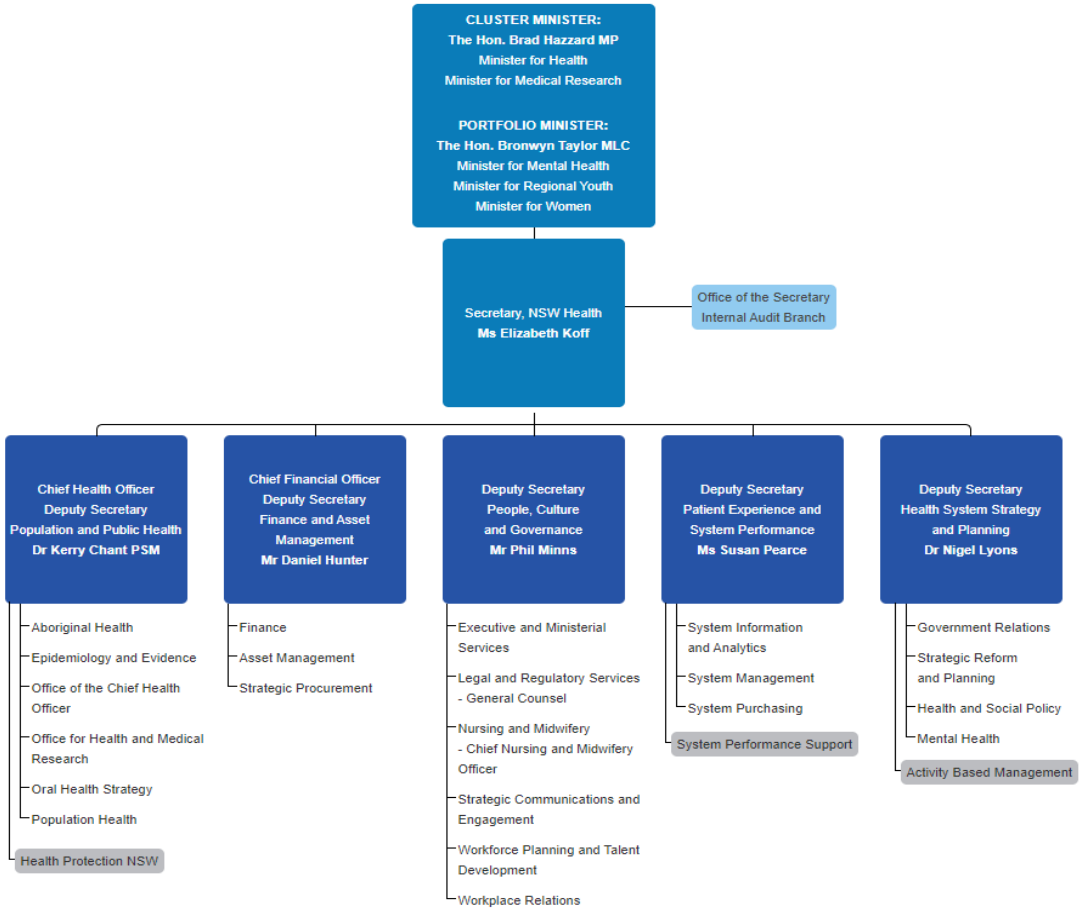
NSW GOVERNMENT | CLINICAL EXCELLENCE COMMISSION



St Vincent's Health Network is an affiliated health organisation.
*Service Compact – Instrument of engagement detailing service responsibilities and accountabilities.

GOVERNANCE

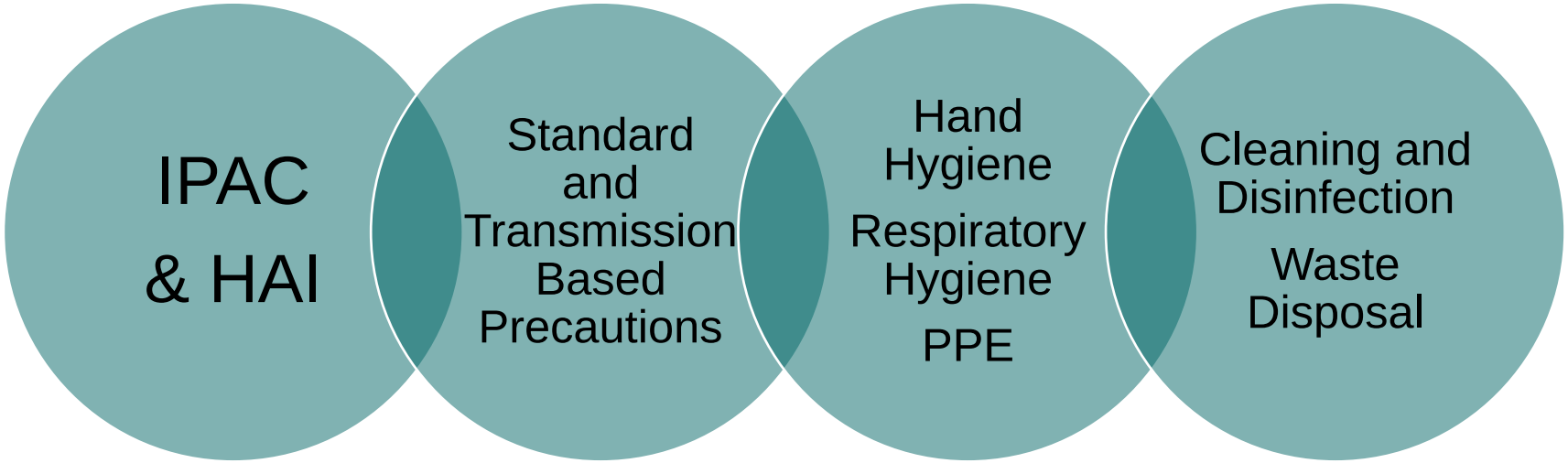
Ministry of Health organisation chart



IPAC LEAD COVID

Infection Prevention and Control

Infection Prevention and Control (IP&C) refers to evidence-based practices and procedures that, when applied consistently in healthcare settings, can prevent or reduce the risk of transmission of microorganisms to healthcare providers, clients, patients, residents, visitors and general community.



The Healthcare Associated Infections (HAI) Program provides expertise in Infection Prevention and Control and assists local health districts and specialty networks in NSW to manage and monitor the prevention and control of HAIs.

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HAI & IPAC ACROSS AUSTRALIA

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Queensland Government
Queensland Health

Australian Government
Department of Health

Infection Prevention and Control Expert Group (ICEG)

VICTORIA State Government health.vic
Victoria's hub for health services & business

Government of South Australia
SA Health

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Government of Western Australia
Department of Health

Tasmanian Government | Department of Health

HAI STEERING COMMITTEE

NORTHERN TERRITORY GOVERNMENT | Department of Health

ACT Government | Health

Australasian College for Infection Prevention and Control

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History

1980 - NSW Health Circular released on the role of the Infection Control Sister in the health care setting

1984 - Federal grant to conduct a national survey on nosocomial infections

1995 - Regulation of Infection Control practice in NSW

- **First NSW Policy (Circular) Blood and body fluid precautions – AIDS and related illnesses – 1980s**
- **Policy revised 1992 – Universal Precautions – 1996 – Standard Precautions**
- Glutaraldehyde in NSW Public Health Care Facilities (Policy and Guidelines for Safe Use of) – 1997
- Colour coding of Cleaning Equipment – 1996
- Waste Management Guidelines - 1998
- Information Bulletin 2000/6 Infection Control Audit Tool
- **Circular 2002/45 Infection Control Policy**
- **Management of Reportable Infection Control Incidents eg EPP, infected HWs, reprocessing breaches - 2001**
- **Infection Control Guidelines – Oral Health – 2002**
- Occupational Screening and vaccination - 2003
- Circular 2004/26 Workcover NSW Reporting Requirements: Occupational Exposures to Bloodborne Pathogens
- Circular 2003/39 Management of Health Care Workers Potentially Exposed to HIV, Hepatitis B, and Hepatitis C
- Infection Control – Animals as patients in health facilities - 2007

- HAI Program – AIDS/ID Branch in mid 1990s – 2 staff
- Transferred to Q&S Branch 2007 – 1 person
- Occupational exposures removed from program
- Environmental cleaning not transferred
- Transferred to CEC in 2011
    - team of staff with a Manager

- Established late 1990s
    - HAI Steering Committee
    - HAI Expert Advisory Group
    - Sterilisation group
    - IPAC group
- Revised over the years
- Biggest change to Steering Committee in 2007 – reduced IPAC/ID membership – more LHD executive and CGU

- HIS Program – 1998 – UNSW – 11 hospitals – defined indicators
- Infection Control – Quality Monitoring Program (2004)
- Data managed by ACHS – reported released every 6 months (more like 9 months)
- EpiNet – 2006 – data managed by ACHS
- Moved to NSW Health in approx. 2009
- 2010 – review of surveillance for NSW – independent consultancy company – report never released – cost for surveillance program too expensive
- Revised Quality Monitoring Program – reduced the number of CIs
- 2011 – CEC – publicly available until 2015
- Version 3 – Clinical Indicator Manual. No electronic surveillance system

NSW GOVERNMENT

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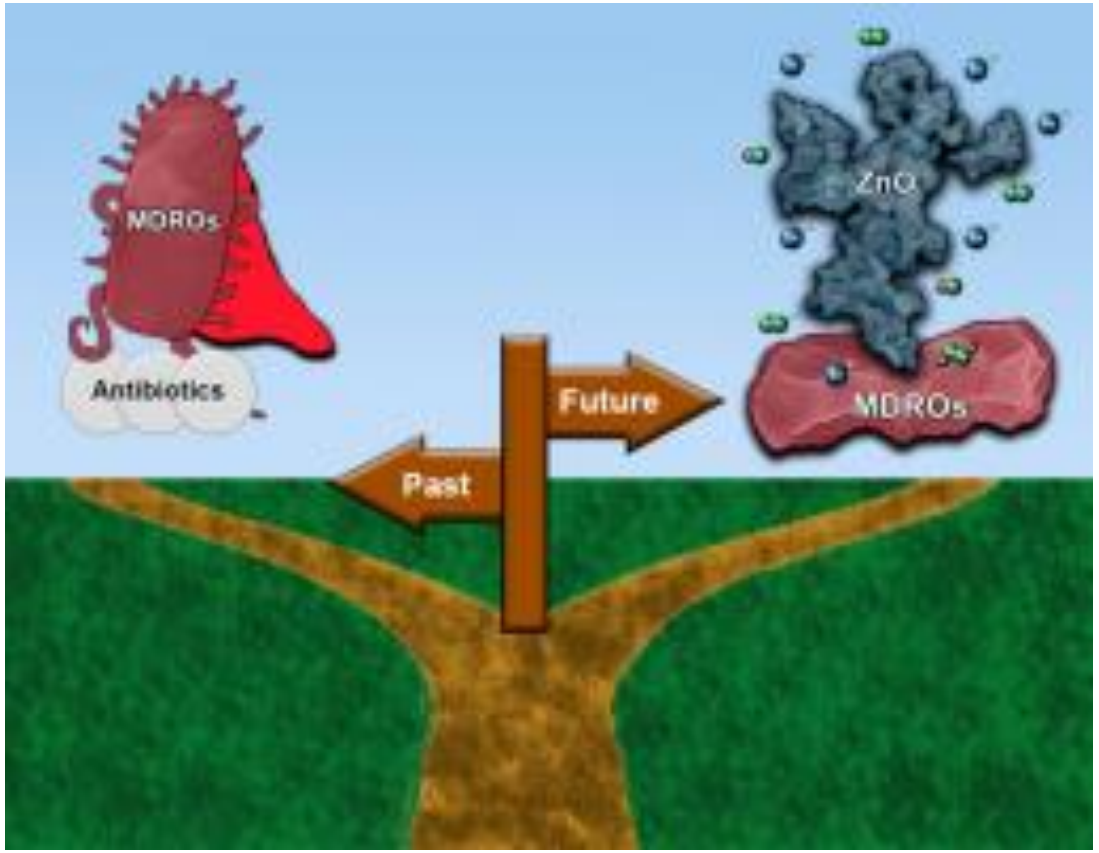
MROs



MRO Summit June 2005 – report released July 2006

Major Recommendations

1. HH program – CEC funded
2. MRO policy
3. ICU MRSA – mandatory indicator
4. Every MRO BSI to be investigated
5. Every AHS – IPAC Committee
6. MRO screening programs
7. Environmental cleaning standards – NSW Policy
    1. Education for cleaning staff
8. MRO funding for AHSs (over $900,000 to be allocated for projects)
    - epidemiologist

Investigations – changed how we do things

1. Multi-dose vials and HIV – late 1980s
2. Anaesthetics – Hep C
3. Multiple breaches of IPAC - investigated
4. Bloodborne Virus Panel established
5. Contaminated joint replacements – loan equipment
6. EBOLA
7. Heater Cooler equipment
8. COVID-19
9. Monkey Pox

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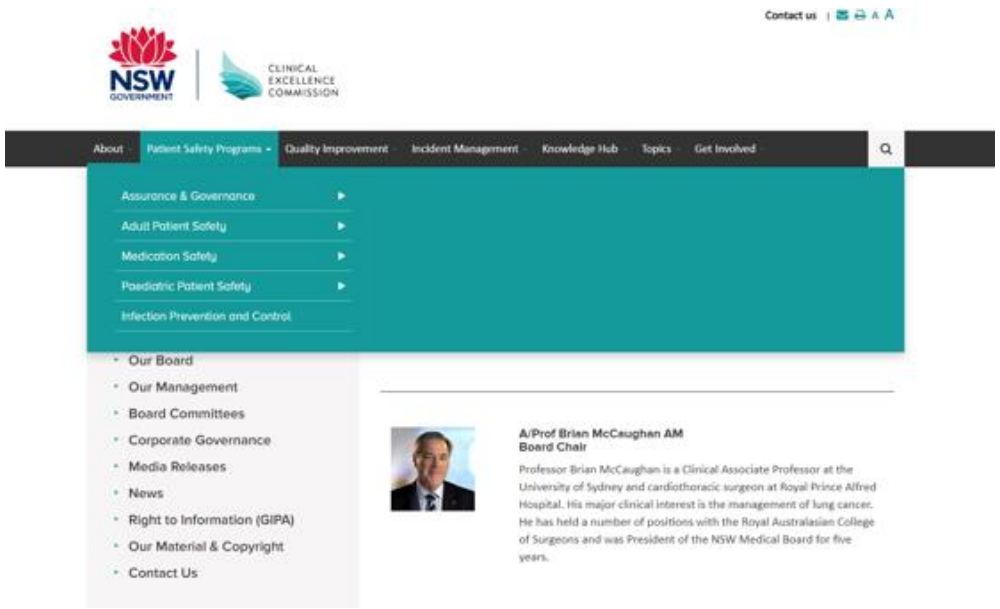
HAI GOVERNANCE

HAI STEERING

HAI EAC

HAI RAC



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HAI PRIORITIES

Management of Critical MROs (Multi drug resistant Organisms)
- CPE made notifiable 28/2/2019
- CPE Guideline
- VRE Guideline
- MRO Guideline
- C.Auris Guideline
- NICU MRO Management Guideline

Health protection Collaboration
- Supporting and guidance to PH

Mandatory Clinical Indicator Manual
- NSW health surveillance system

Mycobacterium chimaera management
- Reconvene working party
- Cleaning Guideline Develop

Oral Health Fact Sheet For Repro

IPC Clinical Handbook Revision

Reprocessing of re-usable medical equipme
- General Rules for Reprocessing diffic
- Endoscope reprocessing Guidelin
- Management of Loan Sets Guid
- Reprocessing Competencies

Environmental Cleaning Policy Revision

Revision Safety Alerts

OUTBREAK MANAGEMENT / PANDEMIC/ EMERGING DISEASES

HAI W e Revision

NE ational Benchmark – Resource Development

ces

of resources for Ebola Management

cal Leade Community of Practice Forum

s
- Masters f Public Health UNSW, Uni Syd
- Conferences

HAI Data Reporting and review

Research Partnerships
- Gloves off Trial
- HNELHD SSI bundle

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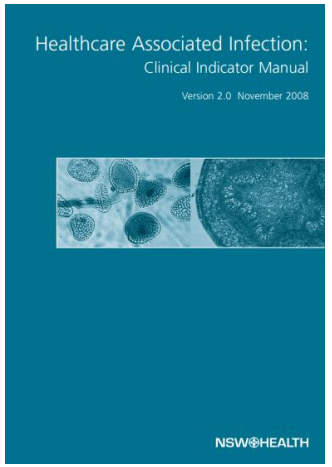
The Mandatory Indicators for Routine Surveillance of HAIs in NSW

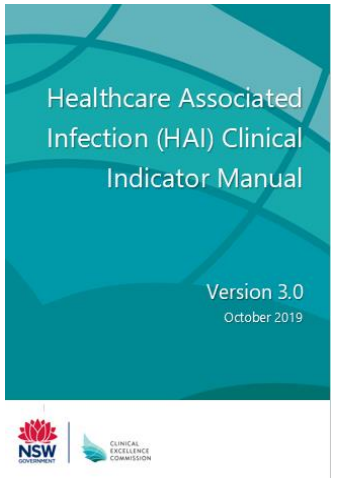
1. Centrally-inserted central line-associated blood stream infections in adult and paediatric intensive care units
2. Peripherally-inserted central venous line-associated blood stream infection in intensive care units
3. *Staphylococcus aureus* bloodstream (SAB) infection
4. Acquisition of methicillin-resistant *S. aureus* in adult and paediatric intensive care units
5. Vancomycin-resistant enterococcal blood stream infection (*Enterococcus faecium* or *Enterococcus faecalis* only) New
6. Carbapenemase-producing *Enterobacterales* blood stream infection New
7. Carbapenemase-producing *Enterobacterales* healthcare acquired screening and/or clinical isolates New
8. *Clostridium(Clostridioides) difficile* infection
9. Surgical site infections following cardiac bypass surgery
10. Surgical site infections following knee arthroplasty
11. Surgical site infections following hip arthroplasty.

MONTHLY REPORTING

&

Within 45 days of the end of the reporting month

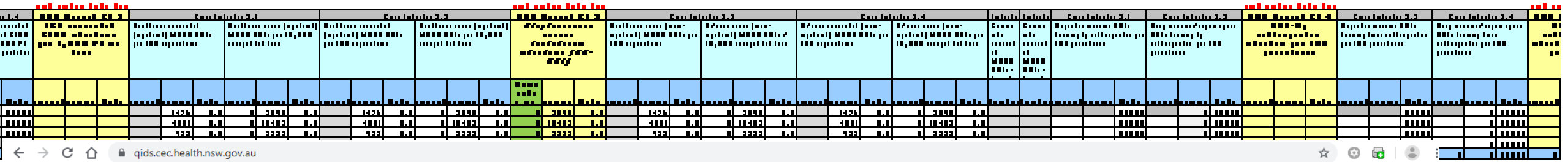




Deleted indicator

Acquisition of meropenem-resistant *Acinetobacter baumannii* (MRAB) in intensive care units

NSW SURVEILLANCE



qids.cec.health.nsw.gov.au

Apps Intranet - SLHD

QIDS

Andie Lee

Home

Report List

Improvement Projects

My Dashboards

Filters Search for Dashboards

Hand Hygiene
3 reports

BTF Reports
3 reports

HAI Dashboard
3 reports

Pressure Inju
6 reports

Falls Dashboard
9 reports

HAC Dashbo
Hospital Acquire
7 reports

HAI Dashboard

95 - NSW MoH HAI Surveillance Data By Location

Build Report | Edit Chart | Data Table | About

Cancel | Generate Report

Location

Location: Western Sydney LHD

Date Range

Year Month: 2019-01 To 2019-08

HAI

Indicator: CI - Clostridium Difficile Infections in Acute Care Services per 10,000 Occupied Bed Days

Cancel | Generate Report

Condition Report
1 report

Mortal
Death Ra
3 reports

Paediatric ICU CICLAB

Adult ICU CICLAB

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PDs & Guidelines

TITLE
• SURVEILLANCE & RESPONSE FOR CARBAPENEMASE-PRODUCING ENTEROBACTERALES (CPE) IN NSW HEALTH FACILITIES
• INTRAVASCULAR ACCESS DEVICES (IVAD) - INFECTION PREVENTION & CONTROL
• TRIGGERS FOR ESCALATION FOLLOWING DETECTION OF INFECTION OUTBREAKS OR CLUSTERS
• ENVIRONMENTAL CLEANING
• ENDOSCOPY
• INFECTION PREVENTION AND CONTROL PRACTICE HANDBOOK REVISION
• SAFET ALERT AND INFORMATION BULLETINS

- PREVENTION AND MANAGEMENT OF CARBAPENEMRESISTANT ENTERBACTERIACEAE IN NSW HOSPITALS INFORMATION FOR CLINICIANS
- CPE Patient information translated in to 10 languages
- Update of Ebola education PowerPoint
- Revision and publish updated Donning and Doffing PPE for Ebola
- Development of HETI Transmission based Precautions Online Modules
  - ❑ Contact Precautions
  - ❑ Droplet Precautions
  - ❑ Airborne Precautions
  - ❑ Enhanced Precautions Pandemic Flu
  - ❑ Enhanced Precautions VHF
- REPROCESSING AND SUPPORT FOR COMPLIANCE WITH AS/NZ 4187
  - ❑ General Rules for Reprocessing complex and difficult to clean devices – Video laryngoscopes
  - ❑ QARS – Register of Reusable Ultrasound Probes

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RESOURCES/FACTSHEETS 2019

NSW Infection Prevention and Control and HAI Reduction Safety Program

Infection Prevention and Control

Healthcare Associated Infections

- Program Overview and Update
- Policies, Guidelines and Handbook
- Surveillance
- Hand Hygiene
- Hand Hygiene Governance
- Hospital Acquired Complications
- NSQHS Standard 3
- Resources

Infection Prevention and Control Precautions

Transmission-Based Precautions

Environmental Cleaning

Reprocessing of Reusable Medical Devices

Multi-drug Resistant Organisms and Emerging Pathogens

High Consequence Infectious Diseases

Catheter associated urinary tract infections (CAUTI) prevention

Home ▸ Keep patients safe ▸ Infection Prevention and Control ▸ Healthcare Associated Infections

Infection Prevention and Control

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Archive

Healthcare Associated Infections

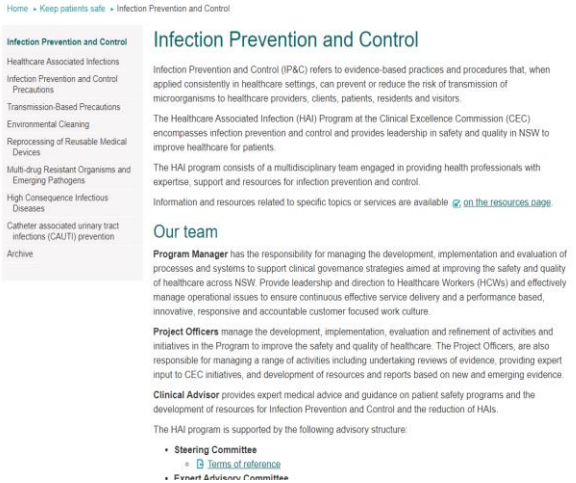
There are around 165,000[1] healthcare associated infections (HAIs) in Australian health facilities each year, making them the most common complication affecting patients in hospital. A HAI can cause great suffering to patients. They can also impact on healthcare resources. It is estimated that HAIs account for two million hospital bed days in Australia each year.[2] Most HAIs are potentially preventable adverse events, rather than an unpredictable complication in health.

Healthcare associated infections can occur in any healthcare setting, but it is possible to significantly reduce the rate with effective infection prevention and control. Patients, visitors and staff - regardless of location or position - all play a role in the reduction of HAIs. Good Infection Prevention and Control practices are important to promote patient safety and reduce HAIs.

Refer to Australian Commission on Safety and Quality in Healthcare – The NSQHS standards for more information.

References

1. Mitchell BG, Shaban RZ, MacBeth D, Wood CJ, Russo PL. The burden of healthcare-associated infection in Australian hospitals: a systematic review of the literature. Infection, Disease & Health. 2017 Sep 1;22(3):117-28.



Home ▸ Keep patients safe ▸ Infection Prevention and Control

Infection Prevention and Control

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Archive

Infection Prevention and Control

Infection Prevention and Control (IP&C) refers to evidence-based practices and procedures that, when applied consistently in healthcare settings, can prevent or reduce the risk of transmission of microorganisms to healthcare providers, clients, patients, residents and visitors.

The Healthcare Associated Infection (HAI) Program at the Clinical Excellence Commission (CEC) encompasses infection prevention and control and provides leadership in safety and quality in NSW to improve healthcare for patients.

The HAI program consists of a multidisciplinary team engaged in providing health professionals with expertise, support and resources for infection prevention and control.

Information and resources related to specific topics or services are available on the resources page.

Our team

Program Manager has the responsibility for managing the development, implementation and evaluation of processes and systems to support clinical governance strategies aimed at improving the safety and quality of healthcare across NSW. Provide leadership and direction to Healthcare Workers (HCWs) and effectively manage operational issues to ensure continuous effective service delivery and a performance based, innovative, responsive and accountable customer focused work culture.

Project Officers manage the development, implementation, evaluation and refinement of activities and initiatives in the Program to improve the safety and quality of healthcare. The Project Officers, are also responsible for managing a range of activities including undertaking reviews of evidence, providing expert input to CEC initiatives, and development of resources and reports based on new and emerging evidence.

Clinical Advisor provides expert medical advice and guidance on patient safety programs and the development of resources for Infection Prevention and Control and the reduction of HAIs.

The HAI program is supported by the following advisory structure:

- **Steering Committee**
  - Terms of reference
- **Expert Advisory Committee**

Key areas of focus for the HAI program are:

- Development and review of HAI related policy directives, guidelines, practice handbook and resources
- State-wide support for the identification, prevention and management of emerging and critical organisms
- State-wide support for the National Hand Hygiene Initiative (NHHI)
- Development and review of HAI clinical indicators
- State-wide support for the implementation of National Standard 3
- State-wide support for the implementation of AS/NZS 4187: 2014 Reprocessing of reusable medical devices in health service organizations
- State-wide support for Environmental cleaning programs.

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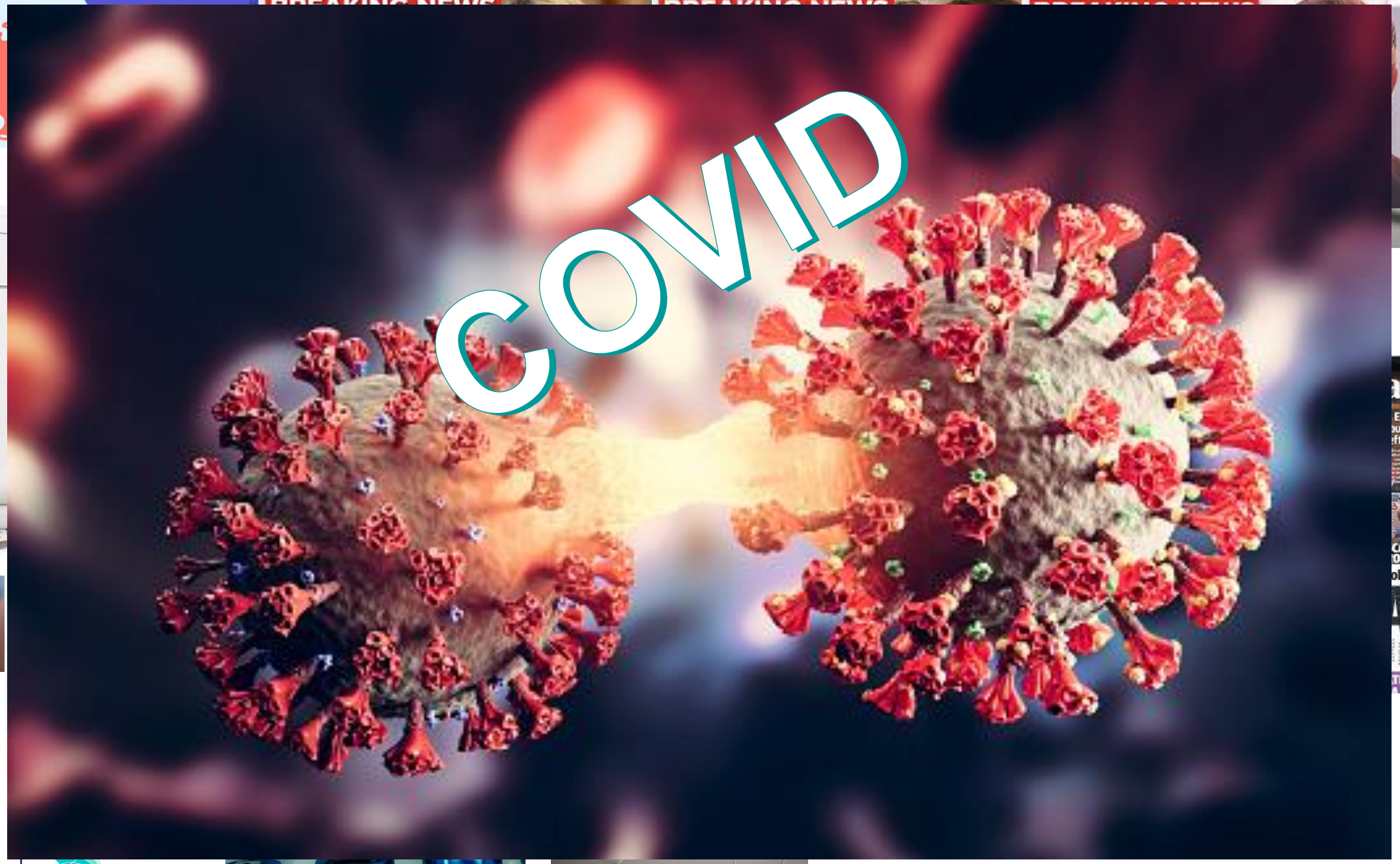
http://www.cec.health.nsw.gov.au/keep-patients-safe/infection-prevention-and-control


COVID

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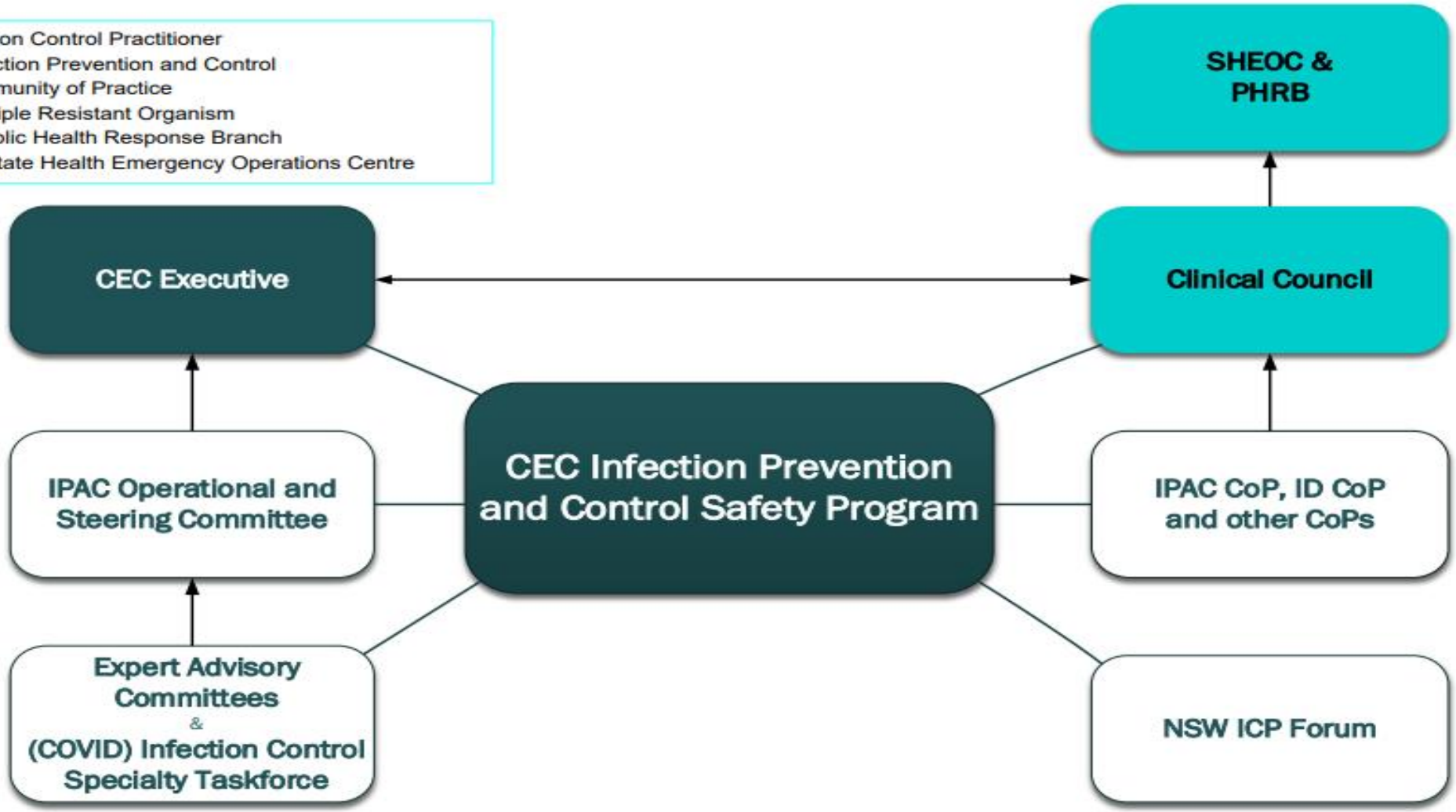
- 290,456 emails 1/1/2021-23/5/2022
- 152,077 emails 24/01/2020 – 23/5/2022

FIGURE 1: CEC INFECTION PREVENTION AND CONTROL SAFETY PROGRAM GOVERNANCE STRUCTURE

ICP – Infection Control Practitioner
IPAC – Infection Prevention and Control
CoP – Community of Practice
MRO – Multiple Resistant Organism
PHRB – Public Health Response Branch
SHEOC – State Health Emergency Operations Centre



NSW Chief IPC & HAI Advisor

Project Management Officer

Clinical Advisor/ Medical Infectious Diseases (0.2)

Clinical Advisor/ Medical Infectious Diseases (1FTE)

Principle ICP Advisor

Clinical Advisor ICP

Program Lead HealthShare IPC

Program Lead Quarantine/Airport IPC

Nurse Educator Quarantine/IPC

Project Officer RPP

Project Officer HH, Reprocessing

IPAC Connects x7

Project Admin Support

Health Worker Transmission group

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IPAC Quarantine Program Building IPC Capacity

Program Lead IPAC Quarantine program 26/4

IPAC/HAI Program Management Sept 2021

Nurse Educator 12/4

24 FTE

CNC-Infection Prevention and control Nurse

RN-Infection Prevention and control Nurse (7)

Admin Support

HR Support

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Committee Structure

HAI Steering Committee

Hai Expert Advisory Committee

HAI Operational Steering Committee

Advisory Committees

HAI/IPAC Specialty Taskforce

Expert Advisory Committees

- Environmental Cleaning
- MRO
- Reprocessing

IPAC EXPERTISE

ALIGNED WITH ID

Health Infrastructure

- Facility Guidelines, issues, risks, preventative maintenance

Bureau of Health Information

- HH report

HealthShare

- Environmental cleaning / PTS

Agency for Clinical Innovation

- Environmental cleaning, surgical services, CVAD, ICU

Ministry of Health

- Response to risks eg HCDs, communicable diseases, emerging MROs, Ministerials and Briefings

MULTIDISCIPLINARY CLINICIAN ENGAGEMENT – SPECIALTY TASKFORCE

HETI

- Advice on modules
- Developing new modules

NSW Ambulance

- Cleaning and other IP&C matters

LHDs/SHNs - numerous

eHealth

- HAI surveillance program

ACSQHC

- Consultation on draft documents

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IPAC EXPERTISE

ALIGNED WITH ID

Aus. HFG

NSQS - Standard 3

Australian HAI Steering

MRO REFERENCE

AMS – NATIONAL

ICEG

NATIONAL EVIDENCE TASKFORCE

PUBLIC HEALTH – LHDS/SHN

POLICY AND GUIDELINES

COVID RESOURCES FOR HEALTH

MULTIDISCIPLINARY CLINICIAN ENGAGEMENT – SPECIALTY TASKFORCE

RACF

WOG – ABF, ADF, DAWES

QUARANTINE

INTERNATIONAL STUDENTS

AIRPORT

MARITIME

CORRECTIONS

VENTILATION COMMITTEE

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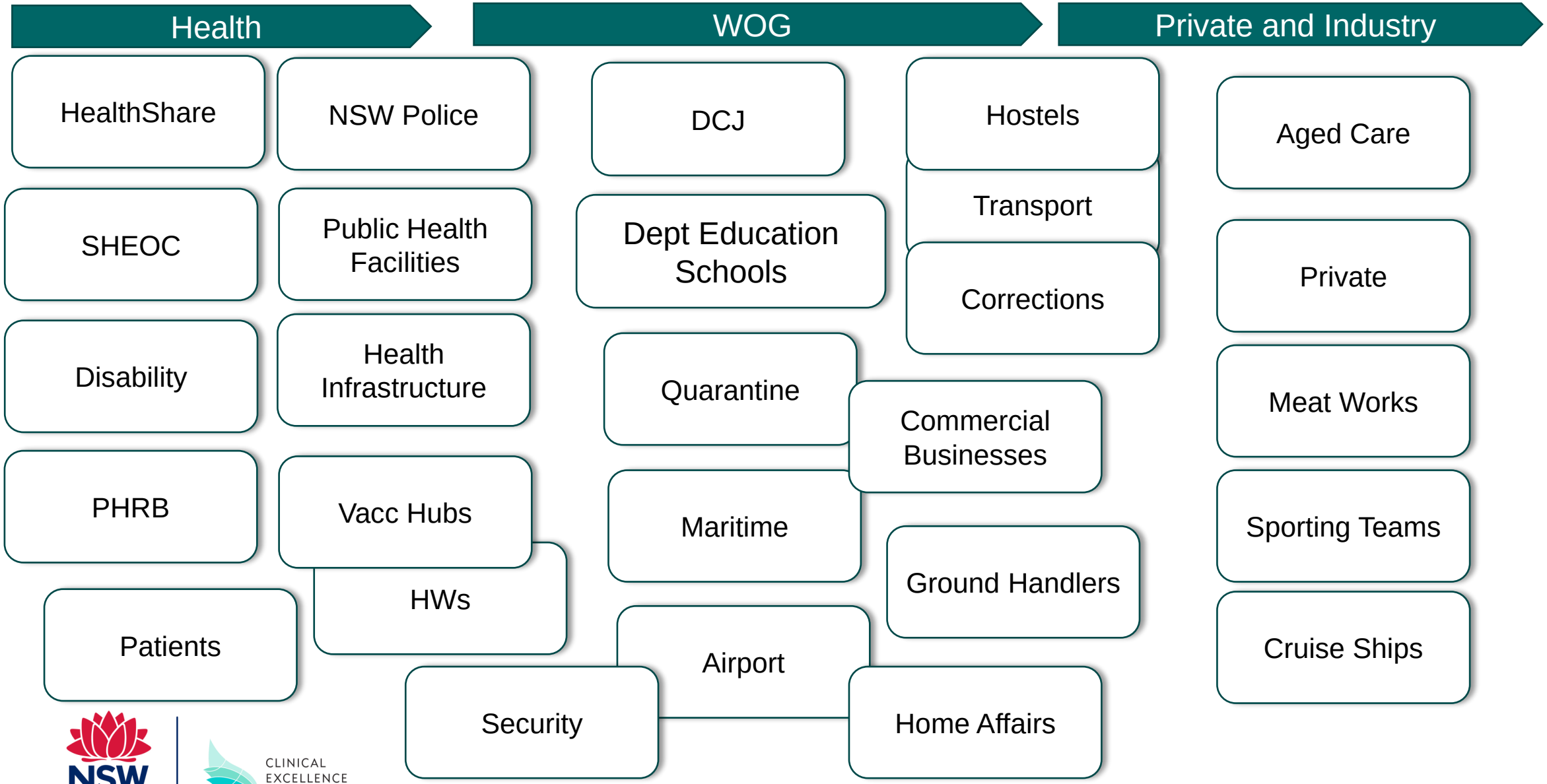
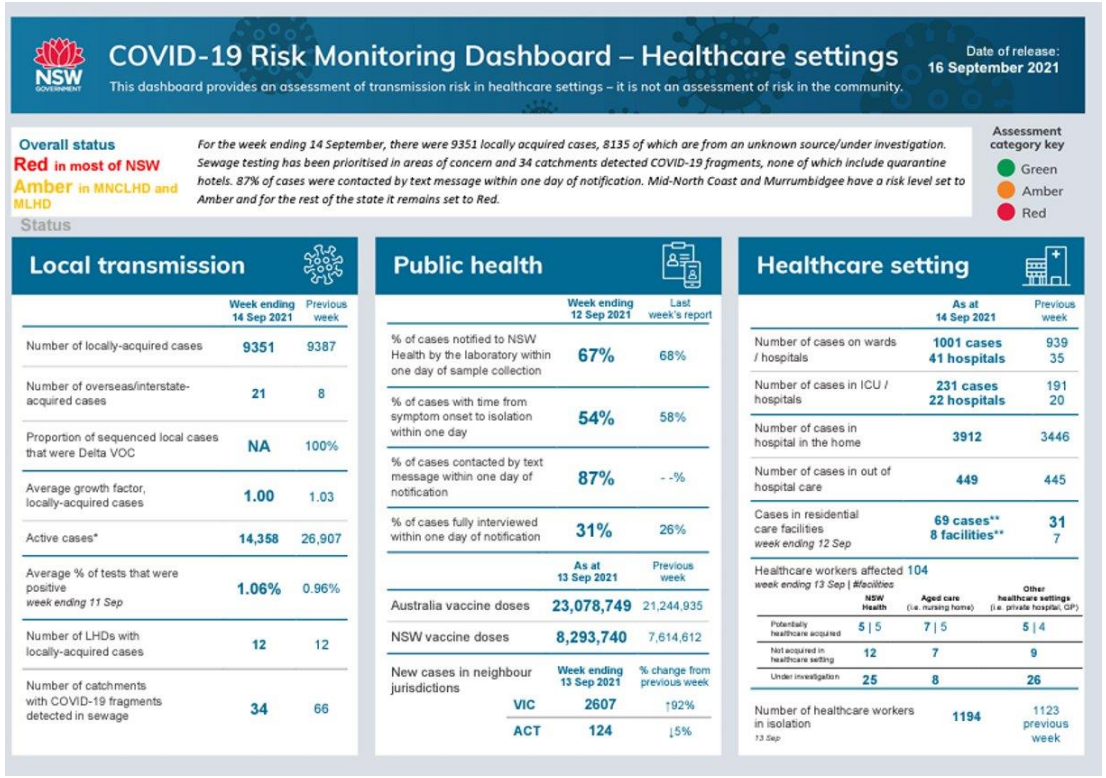
COVID-19 IPAC Support



IPAC – Primary Framework



COVID-19 Risk Monitoring Dashboard – Healthcare settings

This dashboard provides an assessment of transmission risk in healthcare settings – it is not an assessment of risk in the community.

Date of release: 16 September 2021

Overall status
Red in most of NSW
Amber in MNCLHD and MLHD

For the week ending 14 September, there were 9351 locally acquired cases, 8135 of which are from an unknown source/under investigation. Sewage testing has been prioritised in areas of concern and 34 catchments detected COVID-19 fragments, none of which include quarantine hotels. 87% of cases were contacted by text message within one day of notification. Mid-North Coast and Murrumbidgee have a risk level set to Amber and for the rest of the state it remains set to Red.

Assessment category key: Green, Amber, Red

Status

Local transmission

	Week ending 14 Sep 2021	Previous week
Number of locally-acquired cases	9351	9387
Number of overseas/interstate-acquired cases	21	8
Proportion of sequenced local cases that were Delta VOC	NA	100%
Average growth factor, locally-acquired cases	1.00	1.03
Active cases*	14,358	26,907
Average % of tests that were positive *week ending 11 Sep*	1.06%	0.96%
Number of LHDs with locally-acquired cases	12	12
Number of catchments with COVID-19 fragments detected in sewage	34	66

Public health

	Week ending 12 Sep 2021	Last week's report
% of cases notified to NSW Health by the laboratory within one day of sample collection	67%	68%
% of cases with time from symptom onset to isolation within one day	54%	58%
% of cases contacted by text message within one day of notification	87%	- -%
% of cases fully interviewed within one day of notification	31%	26%

	As at 13 Sep 2021	Previous week
Australia vaccine doses	23,078,749	21,244,935
NSW vaccine doses	8,293,740	7,614,612

New cases in neighbour jurisdictions	Week ending 13 Sep 2021	% change from previous week
VIC	2607	↑92%
ACT	124	↓5%

Healthcare setting

	As at 14 Sep 2021	Previous week
Number of cases on wards / hospitals	1001 cases 41 hospitals	939 35
Number of cases in ICU / hospitals	231 cases 22 hospitals	191 20
Number of cases in hospital in the home	3912	3446
Number of cases in out of hospital care	449	445
Cases in residential care facilities *week ending 12 Sep*	69 cases** 8 facilities**	31 7

Healthcare workers affected 104
week ending 13 Sep | #facilities

	NSW Health	Aged care (i.e. nursing home)	Other healthcare settings (i.e. private hospital, GP)
Potentially healthcare acquired	5 | 5	7 | 5	5 | 4
Not acquired in healthcare setting	12	7	9
Under investigation	25	8	26

Number of healthcare workers in isolation *13 Sep*	1194	1123 previous week

3.4 NSW Risk Matrix

Green Alert Low transmission risk	Yellow Alert Low to moderate transmission risk	Amber Alert Moderate to high transmission risk	Red Alert High transmission risk
Risk assessment of cases and community transmission will be determined by the Risk Escalation Review Panel **Standard precautions** apply at all times – **transmission-based precautions** apply as required **Hand hygiene and physical distancing always apply**			
• All patients with an acute respiratory infection (ARI) to wear a mask on presentation and transit if able • HWs managing suspected or confirmed COVID-19 patients to wear P2/N95 respirator and eye protection • Testing of symptomatic patients and health workers' (HWs) • HW to wear a surgical mask and eye protection when providing care for patients with an ARI • HWs in ED to wear surgical masks in clinical areas during patient care. Eye protection to be used when providing clinical care for patients with an ARI (within 1.5m) • Routine Cleaning	• All patients with an acute ARI to wear a mask on presentation and transit if able • HWs managing suspected or confirmed COVID-19 patients to wear P2/N95 respirator and eye protection • Testing of symptomatic patients and HWs • HW to wear a surgical mask and eye protection when providing care for patients with an ARI • HWs in ED to wear surgical masks in clinical areas during patient care. Eye protection to be used when providing clinical care for patients with an ARI (within 1.5m) • Enhanced cleaning of high touch points, shared toilet, and shower facilities	• All patients on admission and during transit to wear a mask if able • HWs managing suspected or confirmed COVID-19 patients to wear P2/N95 respirator and eye protection • Risk screening of all patients for symptoms, increased testing • Symptomatic and selected surveillance testing of patients and HWs • Surgical masks and eye protection to be worn in ED and other clinical areas for all patients when providing clinical care • Surgical mask for HWs in non-clinical area and shared spaces (e.g., on entry, corridors, office spaces) • Enhanced cleaning of high touch points, shared toilet, and shower facilities	• All patients on admission and during transit to wear a surgical mask if able • HWs managing suspected or confirmed COVID-19 patients to wear P2/N95 respirator and eye protection • Screening of all patients for symptoms, consider testing all admissions including ED presentations • Consider selected surveillance testing of some HWs • All ED HWs to wear P2/N95 respirators and eye protection in clinical areas when providing direct care • Surgical masks and eye protection to be worn in all clinical areas for all patients when with 1.5m • Universal surgical mask use by all HW within health facilities • Enhanced cleaning of high touch points, shared toilet, and shower facilities

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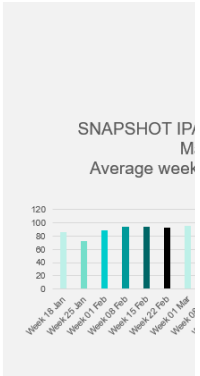
COVID-19
Guidance to support risk assessment of workers, residents and visitors in Residential Aged Care

The CEC plays a lead role in all components illustrated in this figure. This document details the auditing process as an essential element of quality assurance for the NSW Hotel Quarantine and Airport Program.

COVID-19 Infection Prevention and Control Quality Audit Framework



PPE GUIDANCE FOR COMMUNITY PHARMACIES

Pharmacy Activity During Red Alert – High Community Transmission		Precautions Required: Frequent hand hygiene	Surgical mask[2]	P2/N95 Respirator	Eye Protection[3]
PATIENT/CUSTOMER MUST WEAR A MASK Everyone entering the pharmacy should undergo COVID-19 risk screening. Individuals with COVID-19 symptoms should not enter the pharmacy					
Direct patient/customer facing clinical services including vaccination (e.g. OTP dosing, disease screening, COVID-19 risk screening, over the counter advice, wound care, inhaler technique). Keep physical distancing (1.5m) if the patient/customer needs to remove their mask for a short period.	STANDARD PRECAUTIONS[1]	✓	✓	✗	✓ Face shield preferred
Direct patient/customer facing activities (e.g. prescription handling)	STANDARD PRECAUTIONS[1]	✓	✓	✗	✗
All other staff in pharmacy (not involved in patient/customer facing roles)	STANDARD PRECAUTIONS[1]	✓	✓	✗	✗
GLOVES[4] AND APRONS/GOWNS[5] ARE NOT REQUIRED IN ANY OF THESE SITUATIONS					

Staff Contact

Depending on risk assessment
Depending on risk assessment for AGB/AGP

PPE worn by health worker contact and case	Contact type: Transient contact – Low Risk Scenarios (Transient, limited contact that does not meet the definition of face-to-face contact. Note: always subject to local documented risk assessment, including assessments of occupational exposures and of the closed space)	Medium Risk Scenarios (Face-to-face contact within 1.5 metres for less than 4 hours OR Based on agreed documented risk assessment including assessments of occupational exposures and of the physical environment)	High Risk Scenarios (Face-to-face contact within 1.5 metres hours or greater OR Case with AGBs / undergoing AGI)
Staff Contact: No PPE **Case**: No PPE	Moderate#	Moderate OR High	High
Staff Contact: Surgical mask **Case**: No PPE (or vice versa)	Low	Moderate#	High
Staff Contact: Surgical mask **Case**: Surgical mask	Low	Low#	Moderate## OR High
Staff Contact: Surgical mask and eye protection **Case**: No PPE	Low	Low#	Moderate## OR High
Staff Contact: Surgical mask and eye protection **Case**: Surgical mask	Low	Low	Low (if no AGB/AGP) OR Moder
Staff Contact: P2/N95 mask and eye protection **Case**: With or without PPE	Low	Low	Low

LOW RISK — Continue to work HW alert to mild symptoms. Test (rapid antigen test [RAT] or PCR) if symptomatic

MODERATE RISK — Continue to attend work with risk management plan. RAT at day 2 and 6 post exposure. For 14 days after exposure:
- Consider redeploying to lower patient risk area if possible
- Mask wearing at all times – surgical or P2/N95 as per CEC guidance
- Do not enter shared spaces such as tearooms & do not participate in any staff gatherings
- Careful monitoring for symptoms

HIGH RISK — Immediately isolate for 7 days.
- Day 1-2 and 6 RAT
- Return to work (RTW) when day 6 test result returns negative asymptomatic
- After RTW, RAT at least every second day until day 14
- Routine PCR testing is not required
- Continue to monitor for symptoms until day 14 and immediate test if symptomatic. PCR testing is recommended if symptoma negative
- Apply additional requirements on RTW as per Table 1

COVID-19 exposures in Residential Aged Care S
Version 1.1 – Marc
Page

Resident or Visitor Contact

* Depending on risk assessment
** Depending on risk assessment for AGB/AGP
* Individual risk assessment to ensure fit check seal

PPE worn by resident/visitor contact and case	Contact type: Transient contact – Low Risk Scenarios (Transient, limited contact that does not meet the definition of face-to-face contact)	Medium Risk Scenarios (Face-to-face contact within 1.5 metres for less than 4 hours)	High Risk Scenarios (Face-to-face contact within 1.5 metres for 4 hours or greater OR Case with AGBs / undergoing AGP)
Contact: No Mask **Case**: No Mask	Moderate*	Moderate* OR High	High
Contact: No PPE **Case**: Surgical mask	Low	Moderate*	High
Contact: Surgical mask **Case**: No PPE	Low	Moderate*	High
Contact: Surgical mask **Case**: Surgical mask	Low	Low	Moderate**
Contact: Surgical mask **Case (HW)**: P2/N95 respirator	Low	Low	Low
Contact: No PPE **Case**: P2/N95 respirator	Low	Low	Low^

Note: For actions based on risk classification in the matrix above are in the table on page 9. In the context of widespread exposure or an outbreak please consult with the public health unit.

PPE not worn correctly should be considered as no PPE

Actions based on risk classification

lassification	Low Risk	Moderate Risk	High Risk
	For all categories below, monitor for symptoms, and test[1] and isolate if symptomatic		
rements for nts	Isolation not required	Isolate for 7 days **OR** If after risk assessment[1,2,3] Consideration for residents to leave their room and RAT at least every second day for 7 days and day 12 post exposure	Isolate for 7 days Consideration for residents to leav risk assessment[1,2,3] and RAT daily least every second day for 7 days Test every 48-72hrs from day 8-14 isolation and able)
rements for rs	Isolation not required	Do not attend the Residential Aged Care Facility until negative day 6 swab Isolation in the community not required Test at day 2 and 6 post exposure	Isolate in community until day 7 if r Test at day 2 and 6 post exposure Do not attend the Residential Aged next 7 days after leaving isolation

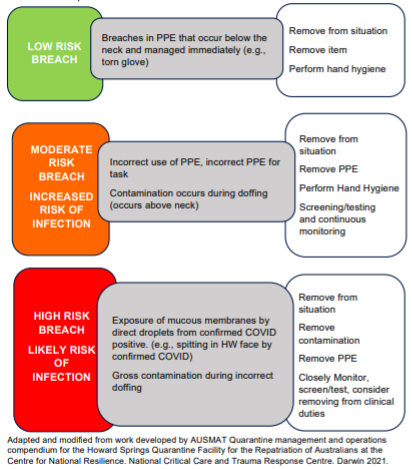
se note: Testing in this document refers to rapid antigen test (RAT) unless otherwise specified

ssessment should be made regarding the ability of residents to be isolated within the Aged Care Facility. Cohorting of residents based on level of risk may b nding on the layout of the premises and resident factors

d to detect cases early, identify ongoing transmission and guide implementation of additional

every second day

COVID-19 exposures in Residential Aged Care Settings
Version 1.1 – March 2022
Page 9 of 9



Adapted and modified from work developed by AUSMAT Quarantine management and operations compendium for the Howard Springs Quarantine Facility for the Repatriation of Australians at the Centre for National Resilience. National Critical Care and Trauma Response Centre. Darwin 2021.

COVID-19 exposures in Residential Aged Care Settings
Version 1.1 – March 2022
Page 8 of 9

er (HW) by minimising
ysical contact with
: care equipment or from

contaminated environmental surfaces

Droplet Precautions protect the HW's nose, mouth and eyes from droplets produced by the patient coughing and sneezing

Airborne Precautions protect the HW's respiratory tract from very small and unseen airborne particles that become suspended in the air

For more information refer to COVID-19 IPAC manual

COVID-19 exposures in Residential Aged Care Settings
Version 1.1 - March 2022
Page 6 of 9

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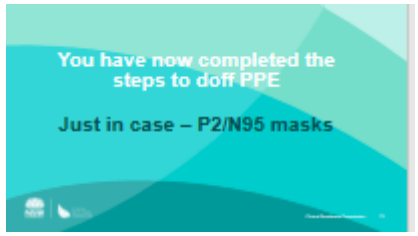
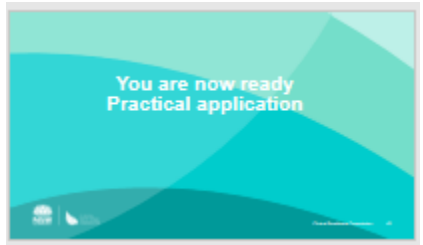
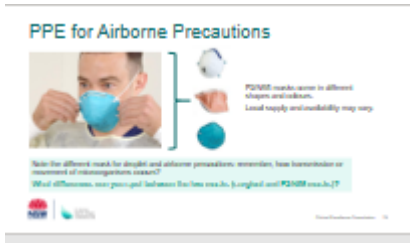
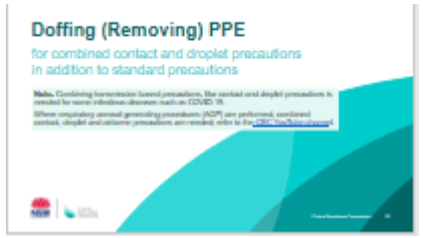
COVID-19 exposures in Residential Aged Care Settings
Version 1.1 – March 2022
Page 9 of 9









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Education - videos

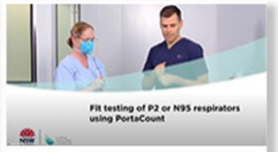
Fit testing

Overview fit testing of P2 or N95 respirators. Fit test preparation and setup - Video 1

Platform: YouTube

Length: 8m 51s

Open video in new window

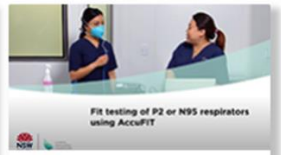


PortaCount fit testing of P2 or N95 disposable respirator - Video 2A

Platform: YouTube

Length: 9m 55s

Open video in new window



AccuFIT fit testing of P2 or N95 respirators - Video 2B

Platform: YouTube

Length: 10m 46s

Open video in new window

PPE

NSW Health staff should view these videos via My Health Learning for the recognition of the completion of their training.

PPE for Combined Contact and Droplet Precautions

Platform: YouTube

Length: 5m 50s

Open video in new window

PPE for Combined Contact, Droplet and Airborne Precautions

Platform: YouTube

Length: 6m 53s

Open video in new window

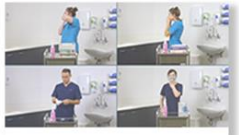
Donning and doffing CleanSpace HALO PAPR with half mask

Platform: YouTube

Length: 15m 22s

Open video in new window

Airborne Precautions - Donning and Fit Checking of Respirators



Overview

Duration: 8m 13s

Platform: YouTube

Open video in new window

KN95 Cupped Respirator

Duration: 3m 24s

Platform: YouTube

Open video in new window

Duckbill style P2 or N95 respirator

Duration: 3m 28s

Platform: YouTube

Open video in new window

Table 3: IPAC guidance for assessment and management of acute respiratory infection

INFECTION PREVENTION & CONTROL GUIDELINES FOR ASSESSMENT & MANAGEMENT OF ACUTE RESPIRATORY INFECTION

Any patient presenting with or undergoing investigation for an acute respiratory virus/illness during PEAK INFLUENZA SEASONAL PERIODS and COVID-19 pandemic should be Managed u…
APPLY droplet precautions for all ARIs[1]; add airborne precautions for AGPs[2]. NOTIFY Infection Prevention and Control (IPAC) or relevant team (as per local process…
HAND HYGIENE COMPLIANCE REMAINS ESSENTIAL TO PREVENT HEALTHCARE TRANSMISSION
Category A High Risk workers MUST be vaccinated – Unvaccinated workers (due to medical conditions) in Category A High Risk roles must always wear a surgical mask while…

MANAGEMENT GUIDE ED/CLINIC	MANAGEMENT GUIDE WARD AREAS	PRECAUTIONS & ISOLATION PERIOD	INFECTION PR… SERVICE MONIT…
• Risk screening of all patients for symptoms and epidemiological factors • All patients with an Acute respiratory infection (ARI) to wear a mask on presentation and transit if able or tolerated • Rapid clinical assessment and testing (consider COVID-19*) with decision to admit or discharge after clinical assessment • Use rapid testing strategies for early diagnosis and treatment • Implement Droplet precautions, surgical mask, and eye protection to be worn by HW for patients with an ARI • Patients with ARI should be isolated in a single room if available OR in bed space with curtains drawn OR cohorted • Spacers are the preferred method for the safe delivery of inhaled medications • Communicate acute respiratory virus** risk with relevant department for admitted patients. **Non-admitted Patients:** • Influenza testing not recommended unless patient from residential aged care facility (RACF). For COVID-19 testing requirements follow the CDNA National Guidelines.	• Patients with suspected or confirmed COVID-19 prioritised for a single room/ensuite • Implement **Droplet** precautions (surgical mask and eye protection) for all ARI and **Airborne** precautions for suspected or confirmed COVID-19 • Spacers are the preferred method for the safe delivery of inhaled medications • Patients with ARI- if nebulisers are used, use in a designated room or location where patients & visitors have limited access or draw curtain during nebulisation – HWs are to wear P2/N95 respirator during nebulisation if in patient zone • Patient to wear surgical mask when outside their designated patient zone if able or tolerated • Cohorting should only occur based on known results (same respiratory pathogen), risk assessment and as directed by IPAC or Infectious Diseases (ID) team • Encourage patients to perform hand hygiene, respiratory hygiene and cough etiquette • Implement enhanced cleaning of the environment and patient equipment • Communicate acute respiratory virus** risk with relevant department during intra and inter hospital transfer	**ENDING CONTACT & DROPLET PRECAUTIONS** **Influenza** 3 days after commencement of anti-influenza medication AND resolution of ARI symptoms for ≥24 hours **OR** 5 days after commencement of respiratory symptoms if patient not treated with anti-influenza medication AND afebrile /asymptomatic for ≥24 hours CDNA National Guidelines. IF PREGNANT WOMAN DELIVERS WITHIN THE ABOVE TIME FRAMES: ➢ Baby to be isolated with mum ➢ Mum to be instructed on contact & droplet precautions • Clean and disinfect shared equipment & room with a TGA approved disinfectant ***COVID-19** De-isolate according to current CEC IPAC manual **Acute respiratory viruses** Check with your IPAC service for precautions and isolation period	• Where possibl… be directly not… ED/Patient Flo… • Admitting tean… (Monday - Frid… to after-hours … • Team may con… per current pr… ❒ Clinical rounds … by IPAC liaising wi… via patient notes … ❒ Attendance at … ❒ Patient reports … ❒ Influenza and C… patient flow & exe… ❒ Escalate risks/c… for escalation ❒ Site IPAC Cont… ❒ District IPAC co…

Notes:

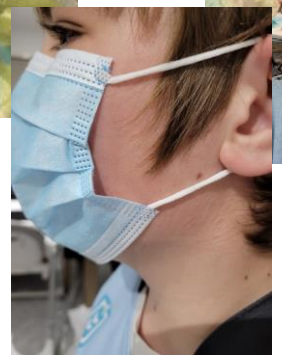
- Influenza and COVID-19 Vaccination Compliance: Mandatory annual influenza vaccination of workers employed in Category A High Risk positions and COVID-19 recommended doses
- All unvaccinated workers (due to medical condition) in Category A High Risk roles must always wear a surgical mask while providing care

(Vaccination takes approx. 2 weeks for antibodies to develop and provide protection so if the 2-week period is not reached by the 1 June staff are required to wear a mask until this period is reached).

[1] ARI – Acute Respiratory Infection [2] AGP- Aerosol generating procedure

* Risk assessment of cases and community transmission will be determined by the Risk Escalation Review Panel

**Acute respiratory viruses include respiratory syncytial virus, parainfluenza, rhinovirus, metapneumovirus, adenoviruses etc.



NSW Health

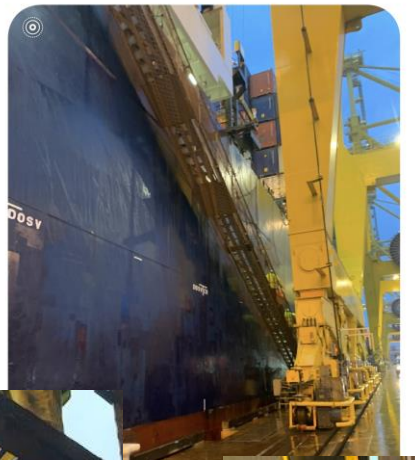
Keeping safe in the tearoom

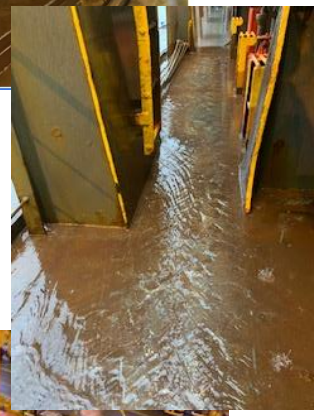
Think before you drink

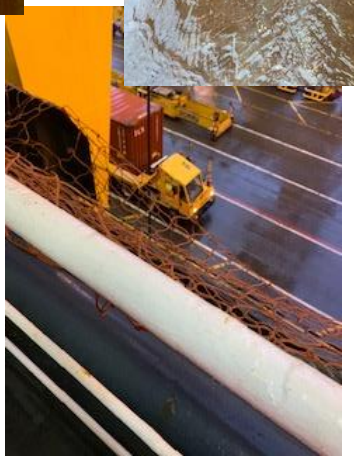
› Think can I remove my mask safely?
› Think can I drink and not expose a colleague?

Keep before you eat

› Keep your mask on unless eating
› Keep your distance from colleagues
› Keep numbers in this area to a minimum
› Keep your mask on if in a break out area







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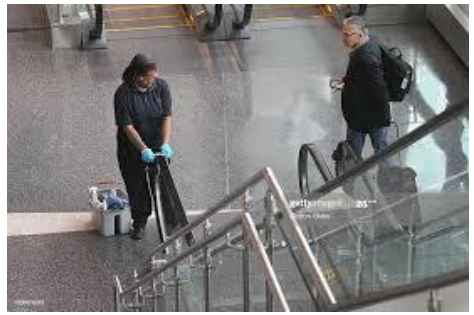
What surfaces are high touch points?



What other surfaces has the airport decided are high touch points?

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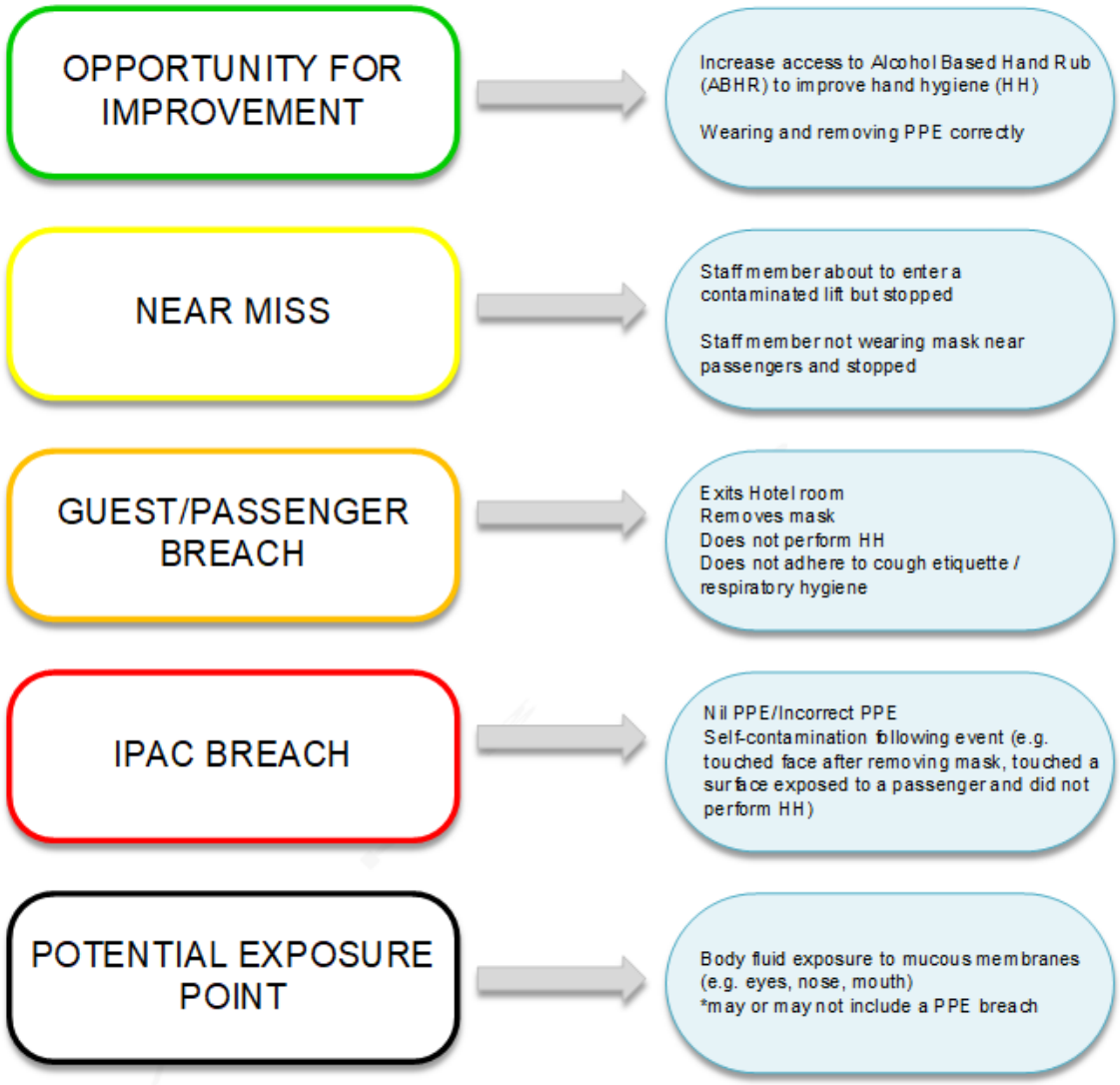
https://www.cec.health.nsw.gov.au/keep-patients-safe/COVID-19/infection-prevention-and-control

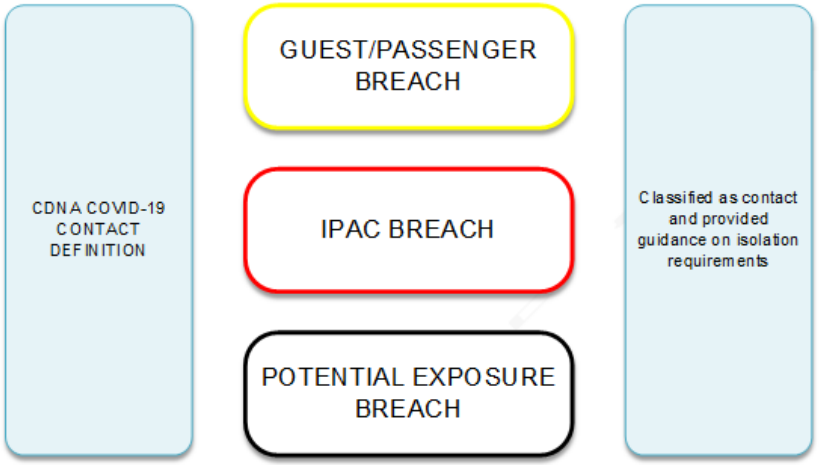
IPAC Auditing Risk and Incident Management Categories – COVID-19

The following diagram outlines the categories of IPAC risks and incidents and some examples of what they might include.



Infection Prevention and Control – Breach Investigation

The below outlines how the IPAC Auditing Risk and Incident Management Categories – COVID-19 supports and contributes to the Public Health Contact Tracing, CCTV Risk Assessment and Identification of Contacts



Staff wearing PPE as per the recommendations may be classified as a close or casual contact if one or more of the above occurs that would change the risk assessment.

	Opportunity for Improvement	Near Miss	Guest Passenger Breach	Hotel/Agency IPAC Breach	Potential exposure point
Observation (IPAC Audit)	Report in audit	Report in audit and escalate to supervisor	Report in audit and escalate to police onsite and SHEOC	Report in audit and escalate to SHEOC	Report in audit and escalate to SHEOC
Risk Assessment required from an IPAC audit or specific requested review	Report in risk assessment report	Report in risk assessment report and escalate to supervisor	Document in risk assessment report and escalate to police onsite and SHEOC	Document in risk assessment report and escalate to SHEOC	Document in risk assessment report and escalate to SHEOC
Investigation of observed or reported breach and observe other risks while onsite	Document in report and escalate to supervisor	Document in report and escalate to police onsite and SHEOC	Document in report and escalate to SHEOC	Document in report and escalate to SHEOC	Document in report and escalate to SHEOC

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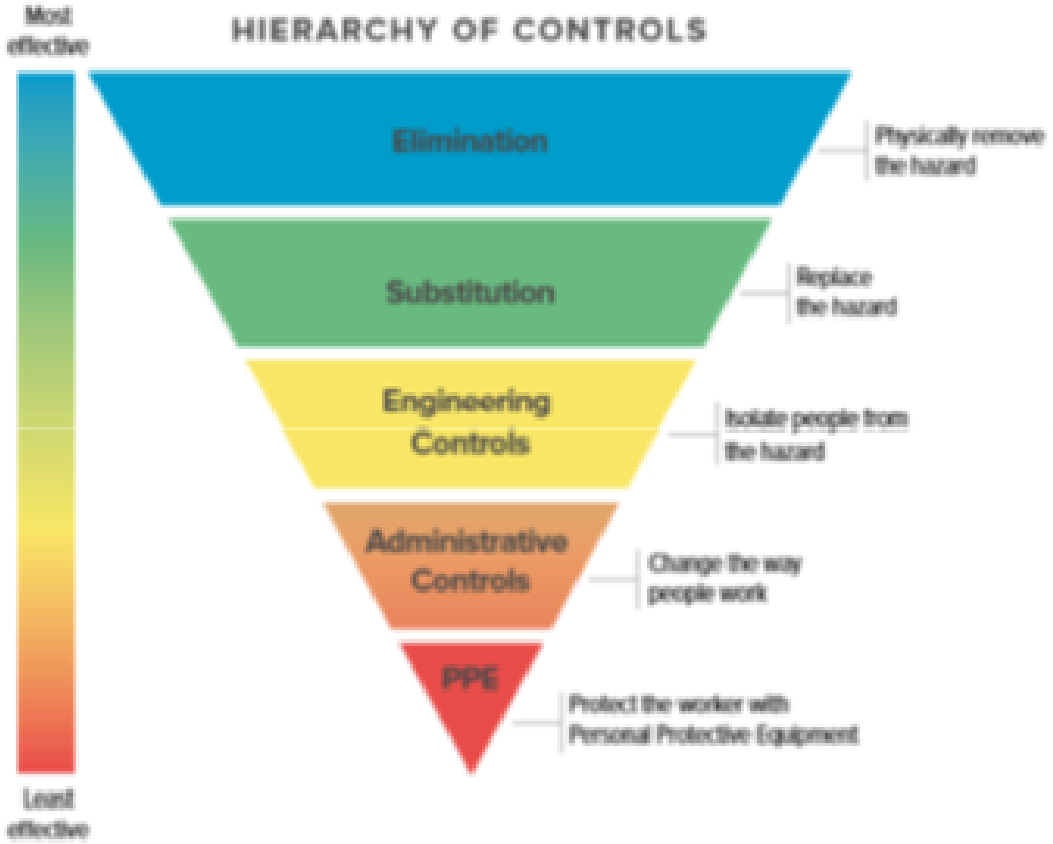
Hierarchy of Controls and Infection and Prevention and Control Principles



IPAC

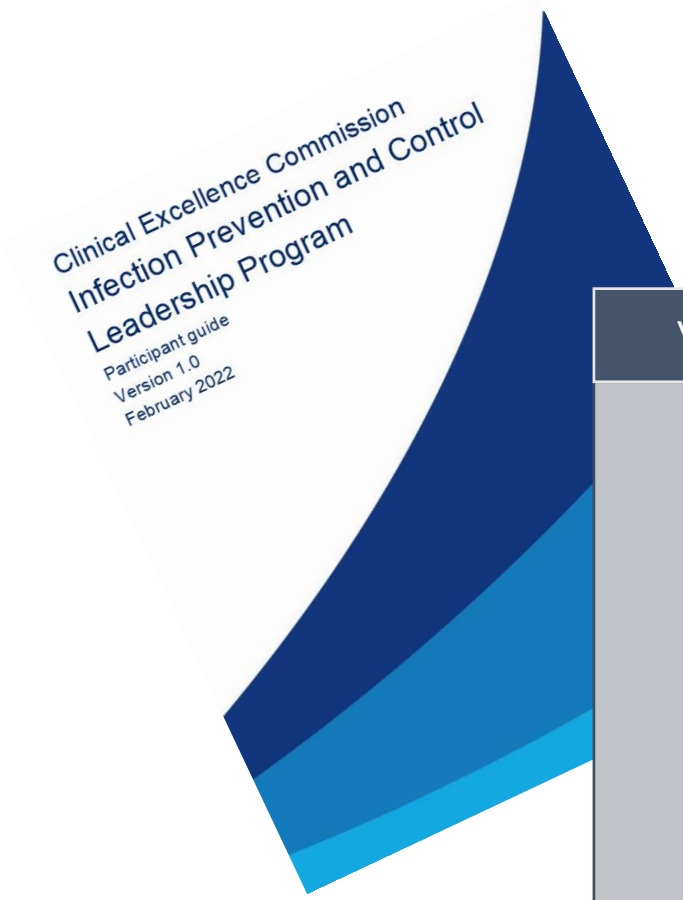
- **STANDARD PRECAUTIONS**
  - Hand Hygiene, Physical distancing
- **TRANSMISSION BASED PRECAUTIONS**
  - PPE
- **ENVIRONMENTAL CLEANING**
- **CLEANING SHARED EQUIPMENT**
- **COVID-19 SURVEILLANCE**
  - Screening
- **RISK REVIEW & ONGOING IMPROVEMENT**
  - Education

Pathway to IPAC – Transformational Leadership

ACSQHC – Learning modules

ACIPC - Foundations

University/ Colleges – Grad Cert, Masters, PhD



COHORT 1 – IPAC Connects

7 Clinicians

VISION	MENTORSHIP	PARTNERSHIP
strong networking community	develop a career pathway and overall growth in the field of Infection Prevention Roadmap for the Novice Infection Preventionist	Enhance critical thinking and problem-solving skills Teach IPAC connects both scientific skills, e.g., leadership, management ski lls, such as effective presentations

- **QUARANTINE**
- **LHD – Clinical**
- **Public Health**
- **Hand Hygiene - GSA**

COHORT 2

- **20 Foundation Courses**
- **Additional 10 leadership**
- **Pre-requisites**
- **Mentorship**

Leadership in the health and care services is about delivering high quality services to patients by:

- demonstrating personal qualities
- working with others
- managing services
- improving services
- setting direction
- creating the vision, and
- delivering the strategy.

ICP JOB ADVERTS

	NSW	QLD	Vic	SA	TAS
Registered Nurse/Specialist	2	1	4		
Clinical Nurse - IPAC		5			
CNC 1					
CNC 2	2				
CNC 3	1				
Senior CNC/CNC			3		
Manager/Other		1	1	1	1
Aged Care	4		1		
Royal Flying Drs	1 (IC Specialist)				

The Clinical Nurse Consultant (CNC) is an expert practitioner who, through leadership facilitates evidence based practice.

1.Minimum five years full time equivalent post qualification experience, with at least three years full time equivalent experience working in infection control; a relevant field or such other qualifications or experience deemed appropriate.

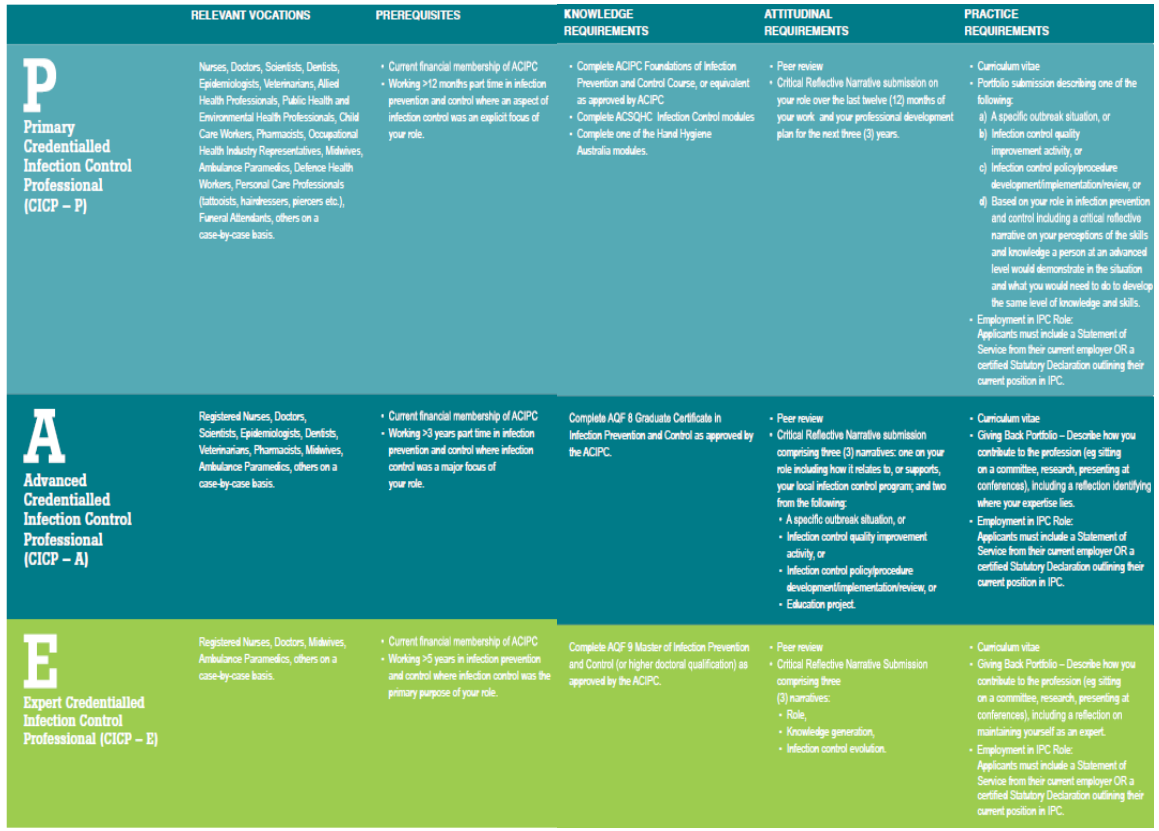
What You Need

We anticipate you will have:

- Post Graduate qualifications in Infection Control or Equivalent
- Minimum 3 years previous experience in Infection Control
- Sound knowledge of NSQHS and other national standards relating to Infection Control
- Gold standard hand hygiene auditor

•The CNC3 provides expert clinical consultancy advice to patients, carers and other health care professionals within the specialty field of infection Control.
The role incorporates the components of resource/liaison, education, surveillance, clinical practice, quality improvement and education by: Providing an expert patient-centred consultancy practice.
•Providing education on complex clinical issues to clients.
•Collaborate with the multidisciplinary Infection prevention team to provide clinical leadership, support and advice to facilities and services within the LHD.
•Identifying and adopting innovative clinical practice models eg. Implementation and evaluation of new treatments, technologies, and therapeutic techniques relating to Infection Control
•Participates and collaborates in the design and conduct of quality improvement initiatives.
•Develops in consultation with others specialised infection control education resources for clients to be utilised by other health care professionals.
•Represent the Hospital infection control practitioners and LHD on local and state wide groups or committees as required.

Credentialing



	RELEVANT VOCATIONS	PREREQUISITES	KNOWLEDGE REQUIREMENTS	ATTITUDINAL REQUIREMENTS	PRACTICE REQUIREMENTS
P Primary Credentialled Infection Control Professional (CICP – P)	Nurses, Doctors, Scientists, Dentists, Epidemiologists, Veterinarians, Allied Health Professionals, Public Health and Environmental Health Professionals, Child Care Workers, Pharmacists, Occupational Health Industry Representatives, Midwives, Ambulance Paramedics, Defence Health Workers, Personal Care Professionals (tattooists, hairdressers, piercers etc.), Funeral Attendants, others on a case-by-case basis.	• Current financial membership of ACIPC • Working >12 months part time in infection prevention and control where an aspect of infection control was an explicit focus of your role.	• Complete ACIPC Foundations of Infection Prevention and Control Course, or equivalent as approved by ACIPC • Complete ACSQHC Infection Control modules • Complete one of the Hand Hygiene Australia modules.	• Peer review • Critical Reflective Narrative submission on your role over the last twelve (12) months of your work and your professional development plan for the next three (3) years.	• Curriculum vitae • Portfolio submission describing one of the following: a) A specific outbreak situation, or b) Infection control quality improvement activity, or c) Infection control policy/procedure development/implementation/review, or d) Based on your role in infection prevention and control including a critical reflective narrative on your perceptions of the skills and knowledge a person at an advanced level would demonstrate in the situation and what you would need to do to develop the same level of knowledge and skills. • Employment in IPC Role: Applicants must include a Statement of Service from their current employer OR a certified Statutory Declaration outlining their current position in IPC.
A Advanced Credentialled Infection Control Professional (CICP – A)	Registered Nurses, Doctors, Scientists, Epidemiologists, Dentists, Veterinarians, Pharmacists, Midwives, Ambulance Paramedics, others on a case-by-case basis.	• Current financial membership of ACIPC • Working >3 years part time in infection prevention and control where infection control was a major focus of your role.	Complete AQF 8 Graduate Certificate in Infection Prevention and Control as approved by the ACIPC.	• Peer review • Critical Reflective Narrative submission comprising three (3) narratives: one on your role including how it relates to, or supports, your local infection control program; and two from the following: • A specific outbreak situation, or • Infection control quality improvement activity, or • Infection control policy/procedure development/implementation/review, or • Education project.	• Curriculum vitae • Giving Back Portfolio – Describe how you contribute to the profession (eg sitting on a committee, research, presenting at conferences), including a reflection identifying where your expertise lies. • Employment in IPC Role: Applicants must include a Statement of Service from their current employer OR a certified Statutory Declaration outlining their current position in IPC.
E Expert Credentialled Infection Control Professional (CICP – E)	Registered Nurses, Doctors, Midwives, Ambulance Paramedics, others on a case-by-case basis.	• Current financial membership of ACIPC • Working >5 years in infection prevention and control where infection control was the primary purpose of your role.	Complete AQF 9 Master of Infection Prevention and Control (or higher doctoral qualification) as approved by the ACIPC.	• Peer review • Critical Reflective Narrative Submission comprising three (3) narratives: • Role, • Knowledge generation, • Infection control evolution.	• Curriculum vitae • Giving Back Portfolio – Describe how you contribute to the profession (eg sitting on a committee, research, presenting at conferences), including a reflection on maintaining yourself as an expert. • Employment in IPC Role: Applicants must include a Statement of Service from their current employer OR a certified Statutory Declaration outlining their current position in IPC.

- Commenced in 1997 (Version 1_)
- Voluntary process
- 3 year award
- Independent Credentialing Board
- 3 significant evolutionary phases:
  - 1997, 1999 – Tertiary Quals, 2006
  - 2011, 2015
- Awarded based on the assessment of a portfolio of evidence

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ACIPC
Australasian College
for Infection Prevention and Control

Evidence base

- Growing evidence based demonstrating the value of credentialing
- Certified individuals in the technology industry, regardless of their educational background, outperform their noncertified counterparts.
- The relationship between certified nurses and patient care quality is well established. High performing organizations with Magnet status or other specialty certifications recognize that credentialed staff is an important indicator to patients and employers that their professionals are qualified and competent.
- Studies indicating a correlation between success (eg, reduced infection rates, improved outcomes) and IP certification are starting to emerge. Most recently, a team from Columbia University, Porgorzelska et al, published study results linking lower methicillinr esistant Staphylococcus aureus infection rates in California hospitals to program directors certified in infection prevention and control.
- Another study published several years ago by Krein et al indicated that certified IPs may be better prepared to interpret the evidence and promote key infection prevention practices within their organization.
- Additionally, employers are starting to indicate that CIC is preferred or required for new hires.

- American Association of Critical-Care Nurses. AACN Certification Corporation.
- Safeguarding the patient and the profession: the value of critical care nurse
- certification. Am J Crit Care 2003;12:154-64.
- Porgorzelska M, Stone PW, Larson EL. Certification in infection control matters: impact of infection control characteristics and policies on rates of multidrugresistant
- infections. Am J Infect Control 2012;40:96-101.
- Krein SL, Hofer TP, Kowalski CP, Olmsted RN, Kauffman CA, Forman JH, et al. Use of central venous catheter-related bloodstream infection prevention practices by US hospitals. Mayo Clin Proc 2007;82:672-8.

IPAC – Clinical Practice

E
Expert Credentialled Infection Control Professional (CICP – E)

P
Primary Credentialled Infection Control Professional (CICP – P)

A
Advanced Credentialled Infection Control Professional (CICP – A)

Patricia Benner
The American Journal of Nursing
Vol. 82, No. 3 (Mar., 1982), pp. 402-407

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NSW Chief ICP & HAI Advisor | IPAC COVID-19 Response Clinical Lead | Clinical Excellence Commission

Infection Prevention and Control Practitioner (CICPE).

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