



Infection Control Management Plan Template for Queensland Acupuncture Practices 18 April 2011



ACN 010 020 390

Australian Acupuncture and
Chinese Medicine Association Ltd
ACN 010 020 390

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EXPLANATORY NOTES

This document is intended as a template Infection Control Management Plan (ICMP) for acupuncture practices in Queensland.

This document was prepared by Ian Murray on behalf of the Australian Acupuncture and Chinese Medicine Association Ltd and reviewed by AACMA CEO, Judy James.

Preliminary feedback was sought on a preliminary draft from key stakeholders and this feedback was used to develop a further draft for broader consultation.

An open forum for Queensland acupuncture practitioners to discuss the draft Template ICMP was held in Brisbane on 28 November 2010. Notice of the open forum was sent to all AACMA members, local acupuncture teaching institutions (Endeavour College of Natural Health and Australian Institute of Applied Sciences) and other associations with acupuncture members in Queensland (Australian Natural Therapists Association Ltd and Australian Traditional-Medicine Society Ltd).

Feedback on the consultation draft was sought on the following areas, but did not need to be limited to these areas:

- Relevance
- Usefulness
- Ease of understanding
- Ease of use and application in the acupuncture practice.

Timelines for the consultation process

22 October 2010	Feedback on preliminary draft
12 November 2010	Consultation draft released
28 November 2010	Information session on the ICMP template
3 December 2010	Feedback on the revised consultation draft
10 December 2010	Final draft completed
18 April 2011	Publication date

Acknowledgements

AACMA collaborated with Queensland Health, Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP) in the development of this template. Many thanks are extended to Mr David Gunderson from Queensland Health for his valuable advice and feedback on this document. Tim Chandler and Jazz Tyrril-Smart are also acknowledged for in-house editing and layout.

Publication

Published by
Australian Acupuncture and Chinese Medicine Association Ltd (AACMA)
PO Box 1635
COORPAROO DC QLD 4151

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INTRODUCTION

As of 15 December 2006 all health facilities in Queensland providing a declared health service must have an Infection Control Management Plan (ICMP).

Chapter 4 of the Public Health Act (Queensland) 2005 imposes a statutory duty on persons involved with the provision of declared health services. 'Persons involved in the provision of a declared health service must take reasonable precautions and care to minimise the risk of infection (the **infection risk**) to other persons.' This duty is reinforced by the requirement that a healthcare facility must have an ICMP.¹

Who is required to have an ICMP?

The following declared health services are required to have an ICMP:

- Public hospitals
- Private hospitals
- Queensland Health Oral Health Services
- Dentists
- Acupuncturists
- Podiatrists
- Independent practice midwives
- Family Planning Queensland
- Queensland Ambulance Service
- St John Ambulance Service
- Royal Flying Doctor Service
- 'Non-accredited' General Practitioners.²

It is clear that Acupuncture is a declared health service when you consider Chapter Four of the Public Health Act (Queensland) 2005 which states:

declared health service means a service provided to a person that involves the performance of an invasive procedure or an activity that exposes the person or another person to blood or another bodily fluid

invasive procedure means a procedure involving the insertion of an instrument, appliance or other object into human tissue, organs, body cavities or body orifices including subcutaneous and intramuscular injections.

Healthcare facilities providing a declared health service must have an ICMP in place now whilst new healthcare facilities must have an ICMP prior to providing any declared health services. This applies to healthcare facilities regardless of whether they are operating from an office or residential address and includes home visits and mobile premises.

1 Public Health Act (Qld) 2005, s. 151.

2 http://www.health.qld.gov.au/chrisp/ic_guidelines/sect1_icprogram.pdf, p. 3.

Infection Control Management Plan (ICMP)

An ICMP is a documented plan that demonstrates how you will minimise the risk of infection for your patients, staff, contractors and anyone else who may come in contact with your facility. The ICMP must show that you have identified the infection risks at your facility and detail the measures taken to prevent or minimise these risks including the training of staff in applying your plan.

There are ten core elements set out by the Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP). You must be able to demonstrate that you meet the minimum standard of compliance for each element. You should also develop your ICMP to suit the scope of practice within your facility.

The ten core elements in an ICMP are:

- ICMP 1 Hand washing and hand hygiene
- ICMP 2 Personal protective equipment
- ICMP 3 Management of blood/body fluid exposures
- ICMP 4 Infection control and employee health
- ICMP 5 Immunisation
- ICMP 6 Environmental hygiene
- ICMP 7 Pre-treatment assessment of infection control risk
- ICMP 8 Non-reuse of single-use medical devices and reprocessing of reusable medical devices
- ICMP 9 Delegation of responsibility for infection control
- ICMP 10 Process for the investigation of infection control incidents

How to develop an ICMP

To make the process simpler, the AACMA has gathered the appropriate data and expanded each of the core elements into individual components to form an ICMP document more specific to acupuncturists. We have also developed an Assessment Template (Appendix A) and Compliance Plan (Appendix B) to help you put your ICMP in place.

Using the ICMP document, conduct an audit on your practice one core element at a time to determine whether or not you meet the minimum standard required. Record your compliance or otherwise on the Assessment Template (Appendix A) as you go through each core element. Work your way through the ICMP document, one core element at a time, expanding points as appropriate to suit your scope of practice.

Once you have completed your audit, use the ICMP Compliance Plan (Appendix B) to list those core elements where you have failed to meet the minimum standard. The ICMP Compliance Plan will allow you to document the actions you will take in order to meet the minimum standard. Your documentation must include details on when training sessions are scheduled and who is responsible for implementation. Core elements that do not meet the standard required must be reviewed again in three months.



Figure 1. ICMP Compliance Flowchart

Upon completion of this process you will have created your own ICMP. Keep your ICMP in a place which is easily accessible by all staff at your facility and review it annually using the same process as when you completed your first audit.

Whilst this document has attempted to be thorough in covering many aspects of clinical practice it is impossible to account for all conceivable risks in a facility given the unique differences found from one facility to the next. Where a possible risk has been identified which is not covered by this document use a risk matrix template to conduct a risk assessment and put measures in place to minimise that risk where appropriate.

Information on the types of risk matrices available and how to use them is available from: http://toolboxes.flexiblelearning.net.au/demosites/series11/11_08/events_alive/shared/documents/using_matrix_approach.doc.

Standard and additional precautions

In order to understand how to implement an ICMP you first must understand the concept of standard precautions and additional precautions.

Standard precautions are a set of work practices used to achieve a basic level of infection control in a clinical setting.

Standard precautions are:

- Personal hygiene practices, including hand hygiene and cough etiquette
- The use of personal protective equipment (PPE)
- Aseptic technique
- Safe handling and disposal of sharps and other waste
- Environmental controls such as design and maintenance of the clinical environment, spills management, cleaning, laundry, and waste management
- Correct reprocessing of reusable equipment and appropriate use of cleaning products.³

³ National Health and Medical Research Council (NHMRC), Australian Guidelines for the Prevention and Control of Infection in Healthcare, 2010, p. 33.

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Standard precautions must be used if it is likely you will come into contact with:

- Blood, wet or dried
- All other body fluids, except sweat, regardless of whether blood can be seen or not
- Mucous membranes
- Non-intact skin
- Items or surfaces that have come into contact with blood or body fluids.⁴

Whilst standard precautions assist in establishing a basic level for infection control, additional precautions are used to prevent the spread of infection where standard precautions alone are not adequate. Additional precautions are used in situations where known or suspected infection could be spread, such as in outbreaks of the flu or gastroenteritis.

Often referred to as transmission-based precautions, additional precautions are categorised according to the three routes of infection transmission in healthcare settings:

- contact precautions
- droplet precautions and
- airborne precautions.

Transmission-based precautions should be tailored according to the infection threat and may involve any of the following:

- Segregate the patient from others by moving them into a separate room and ask the patient not to touch communal objects such as toys and magazines.
- Provide dedicated toilet facilities.
- Use appropriate personal protective equipment such as gloves and masks.
- Provide the patient with a mask and instruct them on its use.
- Provide the patient with tissues to cover their mouth and nose when coughing or sneezing and provide a bin for their disposal.
- Restrict the movement of both the patient and staff.⁵

⁴ Ibid., p. 33.

⁵ Royal Australian College of General Practitioners (RACGP), *Infection Control Standards for Office Based Practices*, 4th ed, 2006, p. 21.

ICMP 1 – HAND WASHING AND HAND HYGIENE

1.1 Risk

Cross-infection from contaminated hands due to poor compliance with hand hygiene

1.2 Minimum standard to demonstrate compliance

- Staff and visitors have access to hand-washing sinks, hand-washing solutions, paper hand towels and alcohol-based hand product (ABHP) when appropriate.
- Alternative hand disinfection products such as ABHP are available when appropriate.
- Wounds or abrasions on exposed skin are covered by impervious dressings.
- Staff understand hand hygiene relevant to staff roles and responsibilities.

1.3 Possible actions to improve compliance with ICMP 1

- Increase the number of hand-washing sinks.
- Introduce the use of an ABHP and where practical make ABHP available in treatment rooms and reception.
- Install 'How to Hand Rub' and 'How to Hand Wash' signage over sinks and in staff rooms as a reminder of correct hand hygiene. Posters are available for download from <http://www.hha.org.au/AboutHandHygiene.aspx>.
- Hold formal training for all staff. Resources are available from Queensland Health: http://www.health.qld.gov.au/chrisp/hand_hygiene/e_learning.asp.
- Ensure all staff complete the Hand Hygiene Australia online self-administered learning package at: <http://www.hha.org.au/LearningPackage.aspx>.⁶

1.4 Hand hygiene

Hand hygiene is considered to be the foundation of all infection prevention and control programs.⁷

Hand hygiene compliance has been shown to reduce the number of infection outbreaks in healthcare facilities, reduce transmission of antimicrobial resistant organisms and reduce overall infection rates.

The Queensland Health hand hygiene protocol has been developed by adopting the standard set by the Australian Commission on Safety and Quality in Healthcare for the Prevention of Healthcare Associated Infection. The healthcare-associated infection standard mandates the requirement for:

Developing, implementing and auditing a hand hygiene program consistent with the current national hand hygiene initiative (i.e. the 5 Moments for Hand Hygiene).

1.4.1 When hand hygiene must be performed

Hand hygiene must be performed before and after any patient contact or after handling blood or body fluids regardless of whether gloves are worn or not.⁸

6 http://www.health.qld.gov.au/chrisp/icmp_pha/docs/risk_mgmt_mitigation.pdf.

7 http://www.health.qld.gov.au/chrisp/policy_framework/protocol_1.pdf, p. 1.

8 http://www.health.qld.gov.au/chrisp/ic_guidelines/sect2_elements.pdf, p. 2.

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To assist in the education of when hand hygiene is required the World Health Organization (WHO) has developed the '5 Moments for Hand Hygiene':

Moment 1: Before touching a patient

Moment 2: Before a procedure

Moment 3: After a procedure or body fluid exposure risk

Moment 4: After touching a patient

Moment 5: After touching a patient's surroundings^{9,10}

1.4.2 Indications for hand hygiene

When hands are visibly clean use an alcohol-based hand product (ABHP).¹¹

When hands are visibly dirty soiled with creams, oils, blood or other body fluids wash hands with soap and running water. Hand washing with soap and water should also be performed after using the toilet or if there is contact with potential spore-forming contaminants including *Clostridium difficile*.¹²

There are a number of different hand-wash techniques, depending of level of exposure. For routine acupuncture treatment where there is no contact with mucous membranes or non-intact skin, a routine/social hand hygiene technique is sufficient. For higher risk procedures where contact with mucous membranes or non-intact skin is possible, then an aseptic/clinical hand hygiene technique is recommended.

When performing acupuncture where there is no perceived risk of contact with mucous membranes or non-intact skin, perform routine/social hand hygiene.

1.4.3 Routine/social hand hygiene – ABHP

The following steps for hand product technique are recommended by Queensland Health:

- Remove jewellery
- Apply quantity of alcohol-based hand hygiene product as per manufacturer's recommendations into cupped hand
- Rub hands palm to palm
- Right palm over left dorsum with interlaced fingers and vice versa
- Palm to palm with fingers interlaced
- Backs of fingers to opposing palms with fingers interlaced
- Rotational rubbing of left thumb clasped in right palm and vice versa
- Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa
- Rubbing hands together until hands are dry before continuing with patient care, do not rub off excess product.

9 <http://www.hha.org.au/UserFiles/file/Manual/ManualJuly2009v2%28Nov09%29.pdf>, p. 6.1.

10 http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf, p. 101.

11 http://www.health.qld.gov.au/chrisp/ic_guidelines/sect2_elements.pdf, p. 3.

12 http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf, p. 152.

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If hands feel dry after being rubbed together for less than 10–15 seconds, it is likely that an insufficient volume of product was applied.¹³

Detailed instructions and posters on 'How to Handrub' are available from Queensland Health: http://www.health.qld.gov.au/chrisp/hand_hygiene/How_To_HandRub_web.pdf.

1.4.4 Routine/social hand hygiene – plain soap and water

The following steps for routine/social hand wash technique are recommended by Queensland Health:

- Remove jewellery
- Wet hands thoroughly and lather vigorously using a neutral pH liquid soap for 15–30 seconds
- Rub hands palm to palm
- Right palm over left dorsum with interlaced fingers and vice versa
- Palm to palm with fingers interlaced
- Backs of fingers to opposing palms with fingers interlocked
- Rotational rubbing of left thumb clasped in right palm and vice versa
- Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa
- Rinse under running water
- Do not touch taps with clean hands – if elbow or foot controls are not available, use paper towel to turn off taps
- Pat hands dry using paper towel.

Avoid using hot water, as repeated exposure may increase the risk of dermatitis.¹⁴

Detailed instructions and posters on 'How to Handwash' are available from Queensland Health: http://www.health.qld.gov.au/chrisp/hand_hygiene/How_To_HandWash_web.pdf.

1.4.5 Aseptic/clinical hand hygiene – antimicrobial soap and water

The following steps for aseptic/clinical hand wash are recommended by Queensland Health:

- Remove jewellery
- Wash hands thoroughly using an antimicrobial soap (e.g. chlorhexidine gluconate 2% soap) for one minute using the technique outlined in 1.4.4 Routine/social hand hygiene
- Rinse carefully
- Do not touch taps with clean hands if elbow or foot controls are not available, use paper towel to turn off taps
- Pat dry hands using clean paper towels.

Where there is a likelihood of contact with mucous membranes, such as needling BL1 Jingming, GV28 Yinjiao or EX-HN12 Jinjin, perform aseptic/clinical hand hygiene.

¹³ Ibid., p. 152.

¹⁴ Ibid., p. 152.

1.5 Hand hygiene facilities

The adequate supply of hand hygiene products and facilities is essential to increase hand hygiene compliance:

- Hand-washing sinks with running water should be within easy access of the patient treatment rooms.
- Disposable paper towels should be available to dry hands completely.
- Hand basins should be fitted with non-hand operated taps.
- Hand-washing sinks must be used for hand washing only and not for any other purpose.
- Supply liquid hand wash or alcohol-based hand product, preferably in disposable containers.
- ABHP should be placed inside the treatment room to increase hand hygiene compliance by the practitioner.
- Do not place ABHP dispensers next to sinks as this can cause confusion for some practitioners by implying they need to rinse their hands with water after using ABHP.¹⁵

1.6 Considerations for alcohol-based hand products

Alcohol-based products should contain either ethanol (ethyl alcohol), isopropanol (isopropyl alcohol) or n-propanol (n-propyl alcohol) or a combination. Some products may also contain other antiseptics such as 0.5–1.0% chlorhexidine gluconate. There is a clear positive association between the bacterial reduction and the concentration of alcohol contained in ABHP products, with higher concentrations being more effective.¹⁶ Hand Hygiene Australia suggests the ideal ABHP is one that has an ethanol content of >70%.¹⁷

When comparing alcohol concentrations it is essential you identify the unit of measure and not just the numerical value of the concentration. Alcohol concentrations for ABHP can be reported in a number of ways:

- volume/volume (v/v)
- weight/weight (w/w)
- weight/volume (w/v)

For example a sample of ethanol labelled with a concentration of 70% v/v is equivalent to an ethanol sample labelled as 62.39% w/w.¹⁸

ABHP's should be used on dry hands because their antimicrobial efficacy is sensitive to dilution with water. For similar reasons ABHP should not be used at the same time as soap.¹⁹ ABHP should never be applied to gloves.²⁰

Recent studies have demonstrated minimal rates of cutaneous alcohol absorption; however some practitioners may be concerned about absorption of alcohol due to religious reasons. In this case an alcohol-based hand product that contains isopropanol (isopropyl alcohol) is the preferred option as it may be less likely to be absorbed than ethanol.²¹

15 <http://www.hha.org.au/UserFiles/file/Manual/HHAManualJuly2009v2%28%Nov09%29.pdf>, p. 4.4.

16 *Ibid.*, p. 4.3.

17 <http://www.hha.org.au/About/ABHRS/product-selection/product-selection.aspx#Concentration>.

18 *Ibid.*, p., p. 4.3.

19 *Ibid.*, p. 4.4.

20 *Ibid.*, p. 4.4.

21 *Ibid.*, p. 4.10.

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The ABHP product selected should have Therapeutic Goods Administration (TGA) approval as a hand hygiene product.²²

Hand Hygiene Australia suggests that there is no maximum number of times that ABHP can be used before hands need to be washed with soap and water, however some manufactures do specify a maximum number of times their product should be used before hand washing is required.^{23,24} Depending on the product selected, a build-up of emollient may occur after repeated use and may be washed off with soap and water.

Select an ABHP that has an alcohol content of 70% v/v or greater and is labelled with an AUST R number to indicate it is approved by the TGA for use as a hand hygiene product in Australia.

1.6.1 ABHP and Fire Safety

ABHP has a good fire safety record when used correctly in a healthcare setting. There have been no documented fires directly related to the presence of ABHP in hospital wards in Australia, and only one documented in the USA.²⁵

To reduce the risk of fire do not store or use hand products near open flames or ignition sources and ensure all staff are using ABHP correctly by rubbing hands together until hands are dry before moving onto another activity.²⁶

Clinics using ABHP products should have material safety data sheets for the product they are using and undertake a risk assessment, such as the one available from Hand Hygiene Australia.²⁷

1.7 Alcohol wipes for hand hygiene

Alcohol impregnated wipes contain a relatively small amount of alcohol and are not considered more effective than washing hands with soap and water. The use of alcohol wipes should be limited to cleaning visibly clean shared patient equipment only.²⁸

1.8 General hand care

Intact skin is a first-line defence mechanism against micro-organisms and so any damaged or broken skin may not only lead to infection in the host, but can also harbour micro-organisms, increasing the risk of transmission to others. Cuts, abrasions or rashes should be covered with an impermeable film dressing. Common porous Band-aid style dressings are not recommended for clinical use because they can become the ideal environment to harbour micro-organisms.²⁹

22 Ibid., p. 4.1.

23 Ibid., p. 4.7.

24 http://www.health.qld.gov.au/chrisp/hand_hygiene/product_select.pdf.

25 <http://www.hha.org.au/UserFiles/file/Manual/HHAManualJuly2009v2%28%Nov09%29.pdf>, p. 4.10.

26 Ibid., p. 4.10.

27 http://www.hha.org.au/UserFiles/file/Generic_Alcohol_Based_Hand_Rub_Risk_Assessmentv2.pdf.

28 <http://www.hha.org.au/UserFiles/file/Manual/HHAManualJuly2009v2%28%Nov09%29.pdf>, p. 4.5.

29 Ibid., p. 4.8.

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There are many factors that can lead to irritation of the skin on the hands, compromising hand hygiene.

- Choose products without fragrances or preservatives.
- Washing hands with soap and water immediately before or after using an ABHP is unnecessary and may lead to dermatitis.
- Using hot water for hand washing increases the risk of skin irritation and cracking.
- The use of hand moisturiser at work is recommended to prevent healthy hands drying and cracking.³⁰

How gloves are used should also be taken into consideration. Choose gloves that are powder free and latex free and do not don gloves when hands are wet from hand washing or ABHP. Also change gloves frequently to prevent moisture build up.³¹

See ICMP 2 – Personal protective equipment (PPE) for further information on glove use.

1.9 Fingernails and jewellery

Wearing jewellery and artificial fingernails can interfere with hand hygiene and as such should not be worn. Fingernails should be kept short at less than 5 mm long. Bracelets, watches and rings with stones or ridges should not be worn when providing clinical care.³²

1.10 Training and education

To achieve a satisfactory level of hand hygiene all staff must undertake training upon employment and then annually.

Training packages covering all aspects of hand hygiene including the five moments of hand hygiene are available from Queensland Health at: http://www.health.qld.gov.au/chrisp/hand_hygiene/e_learning.asp and from Hand Hygiene Australia at: <http://www.hha.org.au/LearningPackage.aspx>.

³⁰ Ibid., p. 4.8.

³¹ http://www.health.qld.gov.au/chrisp/ic_guidelines/sect2_elements.pdf, p. 17.

³² <http://www.hha.org.au/UserFiles/file/Manual/HHAManualJuly2009v2%28%Nov09%29.pdf>, p. 5.3.

ICMP 2 – PERSONAL PROTECTIVE EQUIPMENT (PPE)

2.1 Risk

Exposure to blood/body fluids.

2.2 Minimum standard to demonstrate compliance

- Staff wear protective gloves when performing 'at risk' procedures or tasks.
- Appropriate PPE is applied in situations requiring standard or additional precautions.

2.3 Possible actions to improve compliance to ICMP 2

- Purchase or provide additional protective Australian Standards approved eyewear.
- Identify the high splash-risk procedures and determine alternative practices where possible.
- Provide free or subsidised Hepatitis B vaccinations for staff.³³

2.4 Personal protective equipment

In a healthcare setting all body fluids must be considered infectious regardless of the patient's real or perceived infection status. PPE in healthcare settings can include gloves, goggles or face shield, masks and impermeable aprons or gowns. Whilst it may seem unlikely that during the practice of acupuncture you will require the use of protective eyewear, masks or aprons, situations may arise where some of these items are required. Masks are required during the application of additional precautions for a patient with flu-like symptoms, whilst gloves and aprons are essential components required of a spills kit (See also ICMP 6 – Environmental hygiene). Ultimately, the scope of practice within your facility will determine their use.

The decision to wear PPE should be based upon the likelihood of exposure, quantity and type of fluids which might be encountered and the likely route of transmission for a suspected infectious agent.

2.5 Gloves

Gloves protect skin from direct contamination with blood and body fluids either directly from the patient or from items or surfaces that have been contaminated by blood or body fluids. Wearing gloves is not a replacement for hand hygiene. Using an ABHP or washing with soap and water is required before and after glove use.³⁴

2.5.1 When to wear gloves

Gloves are a component of standard precautions and as such must be worn if it is likely you will come into contact with:

- Blood, wet or dried
- All other body fluids except sweat, regardless of whether blood can be seen or not
- Mucous membranes

33 http://www.health.qld.gov.au/chrsp/icmp_pha/docs/risk_mgmt_mitigation.pdf.

34 http://www.health.qld.gov.au/chrsp/ic_guidelines/sect2_elements.pdf, p. 5.

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- Non-intact skin
- Items or surfaces that have come into contact with blood or body fluids.³⁵

Under normal circumstances there is minimal chance of exposure to blood or body fluids during the insertion of acupuncture needles. Therefore, the use of gloves is not considered necessary under these circumstances.

There are times, however, when the practitioner may be exposed to blood or body fluids and the use of non-sterile examination gloves is recommended. The use of non-sterile examination gloves is recommended in the following circumstances:

- When removing acupuncture needles where there is a chance of blood exposure (as unintended bleeding may occur); the hand that removes the needles need not be gloved; the other that would be used to swab or apply pressure to the site following needle withdrawal should be protected by gloving
- During acupuncture point injection therapy, gloves should be worn on both hands
- Treatments that intentionally cause bleeding (such as use of a lancet or dermal hammer) then gloves should be worn on both hands
- Where any direct contact with blood or body fluids is likely, other than sweat (such as unintended bleeding from cupping or where non-intact blisters have resulted).

Gloving on both hands is strongly recommended for needle insertion and removal to/from mucous membranes or adjacent areas. Examples are CV 1 Huiyin, GV 1 Changqiang, GV 28 Yinjiao, Ex-HN 12 Jinjin.

2.5.2 Glove selection

Non-sterile examination gloves are used for contact with non-sterile body areas and performing procedures that do not require sterile PPE, such as when performing acupuncture point injection. Non-sterile examination gloves for clinical use must comply with AS/NZS 4011.³⁶

Heavy-duty reusable utility gloves are appropriate for cleaning equipment and general cleaning duties. Utility gloves must be cleaned and stored dry between uses, and replaced when showing signs of deterioration.³⁷

See also ICMP 6 – Environmental hygiene.

2.5.3 Supply of gloves

For procedures that involve contact with non-sterile body areas and performing procedures that do not require sterile technique, healthcare facilities must supply non sterile examination gloves that comply with Australian Standards AS/NZS 4011.³⁸

The cost of using non-sterile examination gloves in practice can be as low as 10 cents per patient. Ensure your non-sterile examination gloves comply with Australian Standards AS/NZS 4011.

35 NHMRC, op. cit., pp. 9, 10.

36 http://www.health.qld.gov.au/chrisp/ic_guidelines/sect2_elements.pdf, p. 5.

37 Ibid., p. 5.

38 Ibid., p. 5.

2.5.4 Guidelines for use of examination gloves

- Glove use does not replace hand hygiene. Hand hygiene must be performed before and after glove use.
- Examination gloves must not be removed and reused at a later time for the same patient.
- Examination gloves must not to be washed or disinfected between patients as the cleaning products may damage the integrity of the gloves.
- When gloves are removed they must be immediately discarded in the waste and must not be reused for another patient.
- Gloves must not be used to perform different procedures on the same patient.
- Gloves must be changed or removed if moving from a contaminated body site to another body part on the same patient.
- Gloves must also be changed or removed after touching a contaminated body site before touching the patient's surroundings.
- Gloves must be changed between patients.
- Gloves must be changed when punctured, torn or otherwise damaged.^{39,40}

2.5.5 Application and removal of gloves

Instructions on how to correctly don and remove non-sterile gloves can be found on page four of the World Health Organization Glove Use Information Leaflet available at: <http://www.ascquality.org/Library/Glove%20Use%20Information%20Leaflet%20%28WHO%29.pdf>.

2.6 Masks

Masks are used by both healthcare workers and their patients to prevent the transmission of infection by airborne or droplet spread.

There are two types of masks relevant to office-based practice, regular surgical and P2 (N95) masks. All masks should be fluid repellent and disposable.⁴¹ The level of protection required should determine the type of mask used.

2.6.1 Surgical masks

Surgical masks do not give an air tight seal but are adequate for use by patients who are suspected or known to have an infectious disease spread by droplet transmission.⁴² Surgical masks for use in an office-based practice should comply with AS 4381.

2.6.2 P2 (N95) masks

When airborne transmitted diseases such as active tuberculosis or pandemic influenza are suspected or confirmed, a disposable P2 (N95) particulate filter respirator should be worn by non-immune people to prevent inhalation of contaminated air. P2 masks are capable of filtering 95% of particles 0.3 µm in size and are equivalent to US standard N95.⁴³

39 Ibid., p. 5.

40 http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf, p. 153.

41 RACGP, op. cit., p. 13.

42 Ibid., p. 13.

43 http://www.health.qld.gov.au/chrisp/ic_guidelines/sect2_elements.pdf, p. 11.

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P2 masks must be fitted snugly around the mouth and nose with no gaps in order work effectively.⁴⁴ P2 masks are less effective with beards or unshaven faces because of the loss of seal caused by facial hair.

2.6.3 Considerations when wearing a surgical or P2 mask

- Do not touch the mask when it is being worn.
- Do not wear the mask around the neck.
- Always remove the mask by grasping the strings or elastic and discard it in waste receptacle immediately.
- Replace the mask if it becomes wet or soiled.

2.7 Eyewear

Protective eyewear is essential for procedures where there is the possibility of splash or spraying fluids such as washing equipment soiled with blood or body fluids.

Protective eyewear needs to be clear, antifogging and close fitting and should comply with AS/NZS 1337.^{46,47}

2.8 Plastic aprons

Non-sterile plastic aprons should be worn when there is the risk of contact contamination or splash of blood or body fluids such as when cleaning up spills or manually cleaning contaminated cupping or *guasha* equipment prior to high-level disinfection or sterilisation.⁴⁸ Touching the front of the apron should be avoided. When the apron is contaminated it should be removed and disposed of if disposable or cleaned if reusable.⁴⁹

See also ICMP 8 – Non-reuse of single-use medical devices and reprocessing of reusable medical devices.

2.9 Clothing

Clothes worn by healthcare workers should be clean and appropriate for the type of duties performed. Fully enclosed shoes capable of resisting penetration from dropped sharps must also be worn.

A dropped syringe can easily penetrate the upper of a running shoe resulting in a needle-stick injury. Always consider clothing as a form of PPE.

2.10 Immunisation

Refer to ICMP 5 for specific information regarding immunisation.

44 RACGP, op. cit., p. 14.

45 Ibid., p. 13.

46 Ibid., p. 14.

47 http://www.health.qld.gov.au/chrisp/ic_guidelines/sect2_elements.pdf, p. 6.

48 RACGP, op. cit., p. 63.

49 Ibid., p. 15.

ICMP 3 – MANAGEMENT OF BLOOD/BODY FLUID EXPOSURES

3.1 Risk

Exposure to blood/body fluids as a result of a needle-stick injury.

3.2 Minimum standard to demonstrate compliance

- Sharps containers that comply with AS4031/92 are available at the point of use.
- No needles are recapped after use or modified before disposal.
- No needles are re-inserted into guide tubes after use.
- Staff are informed of the importance of Hepatitis B vaccination in the healthcare setting.

3.3 Possible actions to improve compliance to ICMP 3

- Increase the number of sharps containers located at the point of use.
- Provide free or subsidised Hepatitis B vaccinations for staff.
- Ensure that practice policy dictates no recapping of hypodermic needles and no reinserting acupuncture needles into guide tubes.⁵⁰

3.4 Sharps

Incorrect handling of contaminated sharps is the greatest risk of occupational exposure to infectious blood-borne pathogens for the healthcare worker. The risk of needle stick injury begins at the first moment a sharp is first exposed and only ends when the sharp is removed from the workplace.

The risk of needle stick injury is very real and the consequences may be severe. A survey of Australian nurses found that in the previous 12 months, 11.2% of nurses had at least one needle stick or other sharps injury.⁵¹

In the healthcare setting, the estimated risk of infection after needle stick injury is:

- HIV – 0.3%.
- Hepatitis C between 2% and 8%.
- Hepatitis B, in the absence of vaccination 30%.⁵²

3.4.1 Training in sharps handling

In any practice where acupuncture is performed all staff must undertake a sharps handling education program upon employment.

The Centre for Disease Control has developed a comprehensive sharps handling document, Safe Work Practices for Preventing Sharps Injuries which is a suitable training resource. It can be found as Appendix C of the Workbook for Designing, Implementing and Evaluating a Sharp Injury Prevention Program, available from: http://www.cdc.gov/sharpsafety/pdf/sharpsworkbook_2008.pdf.

50 http://www.health.qld.gov.au/chrisp/icmp_pha/docs/risk_mgmt_mitigation.pdf.

51 <http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-hepc-manual-toc~phd-hepc-manual-ch3~phd-hepc-manual-ch3-14>.

52 <http://immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-home>.

3.5 Dealing with blood or body fluid exposure

As soon as possible after needle stick injury:

- Gently encourage bleeding if the exposure involves a cut or puncture, then wash the area with soap and water.
- When there is no water available, use of a non-water cleanser or antiseptic; the use of caustic agents such as bleach is not recommended.
- If clothing is contaminated, remove clothing and shower if necessary.
- Inform an appropriate person to ensure that necessary further action is undertaken.
- Immediate medical attention is suggested as prophylaxis for some conditions is ideally commenced 1–2 hours after exposure and is most effective if administered within 24–72 hours of exposure.
- Treatment may involve testing for HIV and Hepatitis as well as tetanus inoculation and counselling.⁵³

Immediate medical attention is suggested after a needle-stick injury as prophylaxis for some conditions is ideally commenced 1–2 hours after exposure and is most effective if administered within 24–72 hours of exposure.

As soon as possible after other types of exposure:

- Wash the exposed area with soap and water.
- When there is no water available, use of a non-water cleanser or antiseptic; the use of caustic agents such as bleach is not recommended.
- If eyes are contaminated then rinse open eyes with water or normal saline while they are open, for at least 30 seconds.
- If blood or other body fluids get in the mouth, spit fluid out and then rinse the mouth with water several times.
- If clothing is contaminated, remove clothing and shower if necessary.
- Immediate medical attention is suggested.
- Confidentially document the circumstances of the incident for further investigation.

All workplace incidents and the circumstances under which they occur should be confidentially documented. A sample document for recording workplace incidents can be downloaded from: http://www.deir.qld.gov.au/workplace/resources/pdfs/firstaidrecord_form2004.pdf. This documentation should be used to review procedures and processes to minimise the risk of reoccurrence.⁵⁴

If there is a risk the patient has been exposed to potentially infectious blood or body fluids they must be advised of the situation. The patient should be encouraged to seek medical advice in relation to screening and possible treatment. The incident must be confidentially documented and the circumstances reviewed.

If the event involved a clean needle stick injury or body fluid exposure onto intact skin the exposed person should be reassured that there is no risk of transmission of any blood-borne viruses and does not require any further follow up. It is still a requirement to record and analyse the event in order to enable review procedures and processes to minimise the risk of reoccurrence.⁵⁵

See also ICMP 10 – Process for the investigation of infection control incidents.

⁵³ http://www.health.qld.gov.au/chrisp/ic_guidelines/P3_Revision_April09.pdf.

⁵⁴ Ibid.

⁵⁵ http://www.health.qld.gov.au/chrisp/signal_infection/sism_section8.pdf, p. 1.

ICMP 4 – INFECTION CONTROL AND EMPLOYEE HEALTH

4.1 Risk

Patient exposure to blood and body fluids from a healthcare worker infected with Hepatitis B, Hepatitis C or HIV.

4.2 Minimum standard to demonstrate compliance

- Standard precautions are used by all staff.

4.3 Possible actions to improve compliance to ICMP 4

- Ensure that all staff understand their responsibilities in regard to standard precautions.⁵⁶

4.4 Exposure-prone procedure

An exposure-prone procedure is one in which there is potential for direct contact between the skin of the HCW and sharp surgical instruments, needles or sharp tissues in body cavities or in poorly visualised or confined body sites. During an exposure-prone procedure there is potentially a high risk of transmitting a blood borne disease between an HCW and a patient.

Acupuncture is generally not considered to be an exposure-prone practice and as such there is a very low risk of transmission of blood-borne viruses such as Hepatitis B, Hepatitis C or HIV from an infected practitioner to a patient when standard precautions are applied. Because there is no increased risk of patients acquiring a blood-borne virus during a routine acupuncture consultation it is not necessary for practitioners to disclose their HIV/HBV/HCV status to patients.⁵⁷

*Practitioners with a blood-borne virus such as Hepatitis B, Hepatitis C or HIV are not required to disclose their health status to their patient.
Practitioners with a blood-borne virus such as Hepatitis B, Hepatitis C or HIV must not perform exposure-prone procedures.*

Refer to ICMP 3 – Dealing with needle stick injury, for any needle stick injury.

⁵⁶ http://www.health.qld.gov.au/chrisp/icmp_pha/docs/risk_mgmt_mitigation.pdf.

⁵⁷ NHMRC, op. cit., p. 179.

ICMP 5 – IMMUNISATION

5.1 Risk

Exposure to, and or acquisition of a vaccine-preventable communicable disease.

5.2 Minimum standard to demonstrate compliance

- All staff are informed of their risks to communicable diseases at orientation or commencement of employment.
- Pregnant staff, or those women who may be planning pregnancy, understand the risks of exposure to communicable diseases.
- All staff are informed of vaccinations recommended for healthcare professionals as listed in the Australian Immunisation Handbook.
- All staff are required to complete a pre-employment staff health questionnaire to assess their immune status.

5.3 Possible actions to improve compliance to ICMP 5

- Advise all staff at interview and before commencement of the known and potential risks of exposure to any communicable diseases in the context of the health services you provide.
- Implement a staff health assessment form to assess the current immunity of your staff to the known communicable diseases. A sample Staff Health and Immunisation Assessment Form is available for download from: http://www.health.qld.gov.au/chrisp/icmp_pha/docs/sample_stfhthform.doc. Educate staff about vaccine-preventable disease using the online training resources provided by Queensland Health: http://www.health.qld.gov.au/chrisp/elearn_VPD/index.html.
- Provide free or subsidised Hepatitis B vaccinations for staff.⁵⁸

5.4 Immunisation

Despite using standard and additional precautions and a high level of general hygiene, healthcare workers are at increased risk of contracting and transmitting some vaccine-preventable diseases. Contact with vaccine-preventable infections such as influenza, rubella, measles, mumps, varicella and pertussis can carry serious health risks for those in the community who are susceptible. Many vaccine-preventable diseases are infectious several days before symptoms become apparent increasing their ability to spread prior to detection.⁵⁹

5.4.1 Employer responsibilities

Employers in Australia are not responsible for the provision of vaccinations for staff; however, the employer must advise staff which vaccine preventable diseases they may be exposed to in the work environment by referencing the latest edition of The Australian Immunisation Handbook (currently 9th edition, 2008).^{60,61}

58 http://www.health.qld.gov.au/chrisp/icmp_pha/docs/risk_mgmt_mitigation.pdf.

59 <http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-specialrisk238>.

60 <http://www.health.gov.au/internet/main/publishing.nsf/Content/icg-guidelines-index.htm>.

61 RACGP, op. cit., p. 26.

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Healthcare students must also be afforded the same consideration as employees.⁶²

Vaccination is not compulsory. However, it is an employer's responsibility to inform staff of the vaccine-preventable diseases that their employees may be exposed to in their work environment. Vaccination for Hepatitis B is compulsory to work in direct patient contact in Queensland government facilities.

5.4.2 Recommended vaccinations

The Australian Immunisation Handbook recommends employers encourage all non-immune workers to be vaccinated against:

- Hepatitis B
- Influenza
- Pertussis (dTpa, provided dTpa has not been given previously)
- MMR (if non-immune)
- Varicella (if seronegative)

Healthcare professionals working in remote Aboriginal communities should also include vaccination for Hepatitis A.⁶³

5.4.3 Pregnancy and vaccination

Both the employer and the pregnant staff member have a responsibility to reduce the risk of injury to the foetus, including exposure to vaccine preventable disease. The employer should inform the pregnant employee of the risk to her pregnancy from vaccine preventable disease such as measles, mumps, rubella, varicella, parvovirus, diphtheria, tetanus, pertussis and influenza and enable her to avoid patients who pose the risk of such infections.⁶⁴ It is the responsibility of the pregnant employee to advise the employer of her pregnancy.⁶⁵

5.4.4 Immunisation Records

All healthcare facilities should develop and maintain confidential and up-to-date immunisation records for all staff. Records will assist in reducing the exposure of non-immune staff to vaccine-preventable disease during outbreaks. Employees should maintain their own records by updating their immunisation status regularly and have access to their personal records on request.^{66,67}

Records should include:

- Past immunisation history
- Advice given to employee regarding immunisations recommended based on duties performed
- The response from the employee after immunisation advice
- Training given by the employer in relation to vaccine-preventable disease and the facility's ICMP
- Immunisations received during employment.⁶⁸

⁶² NHMRC, op. cit., p. 205.

⁶³ <http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-specialrisk238>

⁶⁴ Ibid.

⁶⁵ NHMRC, op. cit., p. 211.

⁶⁶ Ibid., p. 205.

⁶⁷ RACGP, op. cit., p. 28.

⁶⁸ Ibid., p. 28.

ICMP 6 – ENVIRONMENTAL HYGIENE

6.1 Risk

Cross-infection due to poor compliance with cleaning of patient care equipment and environment.

6.2 Minimum standard to demonstrate compliance

- All staff demonstrate an understanding of the correct disposal methods for clinical waste.
- Cleaning audits are conducted on a regular basis.
- All clinical surfaces are decontaminated with detergent and water on a regular basis.
- All reusable patient care equipment is decontaminated and reprocessed according to AS4187 or AS4185.

6.3 Possible actions to improve compliance to ICMP 6

- Ensure that appropriately labelled waste receptacles are available for clinical and general waste streams.
- Introduce single-use, disposable devices for those items that are labour intensive in regard to cleaning and disinfection.
- Develop a cleaning and disinfection audit tool to assess compliance with AS/NZS 4185:2006 (Office-based healthcare facilities – Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment).
- Introduce regular cleaning audits.⁶⁹

6.4 Waste disposal

The overriding consideration for the disposal of waste from an office-based practice is to reduce the risk of infection. Safe and effective waste disposal will not only reduce the risk of infection but also save money and reduce impact on the environment. All staff must be trained in safe waste management.

6.4.1 Non-sharps waste

Clinical waste refers to waste that has the potential to cause disease, such as sharps or human tissue and any free-flowing liquid body substance.⁷⁰ As the non-sharps waste generated by acupuncture practice does not involve any free-flowing liquid body substance it is considered to be general waste.

Non-sharps waste contaminated by blood or body fluids that is not clinical waste, e.g. swabs, should be placed directly into a rigid walled waste bin with a non-hand operated lid that is lined with a plastic waste bin liner. The use of plastic shopping bags as a bin liner is not acceptable. Waste bins should not be overfilled or compacted by hand. Waste bins should be positioned in such a way as to reduce the chance of access by small children.

⁶⁹ http://www.health.qld.gov.au/chrisp/icmp_pha/docs/risk_mgmt_mitigation.pdf.

⁷⁰ <http://www.derm.qld.gov.au/register/p00785aa.pdf>, p. 2.

Bins containing non-sharps waste contaminated by blood or body fluids that is not clinical waste, e.g. swabs, should be emptied regularly using standard precautions. Upon removal, the plastic bin liner should be tied off and double bagged; that is, placed in a second waste bin liner and tied off. Waste bins must be cleaned regularly at a frequency determined by the clinic operator.

It is important to note that in an office-base practice small amounts of urine, blood or faeces may be disposed of in the sewerage system.⁷¹

Waste such as soiled cotton wool balls, tissues and bandaids without free flowing blood or body fluids is considered general waste.

6.4.2 Sharps waste

See ICMP 3 – Management of blood/body fluid exposures.

6.5 Cleaning

Regular cleaning throughout all areas of an office-based practice is an important infection control measure. Every practice should have documentation outlining what requires cleaning, the cleaning products used and frequency of cleaning performed.⁷²

6.5.1 Frequency of cleaning

Whilst section 18 of the Infection Control Guidelines for the Prevention of Transmission of Infectious Diseases in the Healthcare Setting provides recommendations, the frequency of cleaning should be determined by the activity of the practice. Items that must be cleaned regularly include floor coverings, desks, phones, treatment tables, clinic toys, sinks and refrigerators.

For an example of a cleaning schedule suitable for office-based practice see Appendix C.

6.5.2 Cleaning methods

There are some general guidelines regarding cleaning methods which should be considered.

- Hard floors should be cleaned with a wet mop and not a broom. Brooms spread dust and bacteria in the air, aiding the spread of infection.
- Hard surfaces should also be cleaned using a damp or dust-retaining cloth for the same reason. For general or routine cleaning the use of detergent and warm water is acceptable.
- Surfaces that come in contact with the patient should be cleaned with a suitable disinfectant, ensuring the surface is clean and dry before each use.
- Surfaces contaminated with oils and grime should be cleaned with detergent and water before using a disinfectant.
- Reusable cleaning cloths and mops should be cleaned or washed after use and allowed to dry when stored. Sponges are not recommended because they do not easily dry once wet.

⁷¹ Ibid., p. 2.

⁷² RACGP, op. cit., p. 37.

- Carpets and other soft furnishings should be cleaned with a vacuum cleaner fitted with a particulate-retaining filter.
- Blinds and curtains should be cleaned regularly or when visibly soiled.
- Waiting room toys must be cleaned regularly with detergent and water using either a spray or wipes. Careful consideration should be given to the type of toys purchased to ensure ease of cleaning and other child safety considerations such as choking hazards.⁷³

It is important to note that, if a disinfectant is to be used, items or surfaces should be first cleaned.

6.5.3 Cleaning products

Whilst there are many products which can be used, it may improve safety and compliance for a practice to minimise the number of products available. Products must only be used according to the manufacturer's directions with attention given to use-by dates and PPE.

Material safety data sheets (MSDS) for all cleaning products must be kept in a central location that is easily accessible by staff.

6.6 Linen

Whilst there is little evidence of disease transmission between patients via soiled linen in an office-based practice, good laundry practice prevents cross infection between patients and ensures clean linen is not contaminated before use. Practitioners must always ensure they have adequate linen supplies to change linen between patients when required.⁷⁴

6.6.1 When to change linen

Health professionals should consider the risk of cross infection between patients to determine when linen must be changed. The presence of blood or body fluids on linen is not always obvious primarily because the amount of blood leakage from an acupuncture site is often only very small. Leakage of saline from an injection site is often colourless and may also be easily missed. If an injection site comes in contact with linen, that linen must be considered soiled and therefore changed before the next client.

Linen must be changed when:

- It is recognised that a patient requires contact precautions to prevent spread of infection, such as the presence of scabies or lice.
- The linen is visibly soiled.
- There is blood or body fluid spill on the linen.⁷⁶

6.6.2 Changing linen

- Always check for misplaced sharps on treatment tables before changing linen.
- Soiled linen should be stored in a container with a lid, lined with a plastic bag. When possible this should be done at the point of generation.

⁷³ Ibid., pp. 37–41.

⁷⁴ Ibid., p. 44.

⁷⁵ Ibid., p. 44.

⁷⁶ Ibid., p. 44.

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- Any linen contaminated with blood or body fluids must be placed in a plastic bag identifiable to laundry staff before being placed with other soiled linen.
- Standard precautions should be used when changing linen contaminated with blood or body fluids.
- If the treatment table is contaminated with blood or body fluids it must be cleaned with detergent and water then cleaned with disinfectant and allowed to dry.⁷⁷

6.6.3 Washing, drying and storing linen

When processing laundry many consider the temperature of the wash cycle to be the most important factor but this is not the case. Factors which must be considered when processing linen:

- Storage
- Transportation
- Chemicals used and their concentration
- Duration and temperature of the wash
- The amount of agitation during the wash cycle
- Method of drying.

Linen with blood or other stains should be processed as soon as possible by rinsing contaminants off with cold water and applying an oxygenated stain remover before washing.⁷⁸

Washing linen using a hot or cold wash cycle is acceptable provided a suitable laundry detergent is used to the manufacturer's specifications. Chlorine bleach or activated oxygen based laundry detergent such as Napisan can be added to the wash to provide an enhanced germicidal effect. Care should be taken to avoid overloading laundry machines as this decreases the agitation and hence cleaning effectiveness. A hot tumble dryer is the preferred method of drying because the higher temperature provides significant antimicrobial action.⁷⁹

Use of an off-site commercial laundry service meeting AS/NZS4146:2000 to process linen for a healthcare service is acceptable.

Clean and dirty linen must not be transported together unless there is a suitable barrier preventing direct contact to reduce the risk of cross contamination.

All clean linen storage areas must be clean, dry, dust free and distinctly separate from the soiled linen area to prevent cross contamination.

Soiled and clean linen must be stored in distinctly different areas and transported in separate receptacles to prevent contamination of clean linen.

6.7 Managing blood and body fluid spills

It is important to remember that risks from blood or body fluid spills can include penetrating injury from blood-contaminated sharp objects in the spill area, such as broken glass, and splash or aerosol exposure during cleaning.

⁷⁷ Ibid., p. 44.

⁷⁸ Ibid., p. 44.

⁷⁹ Ibid., p. 45.

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In an office-based practice you are unlikely to encounter spills in the form of large quantities of blood. Although you are more likely to encounter vomit as a body fluid spill, the term also includes urine and faeces.

To effectively deal with body fluid spills in a timely manner, healthcare facilities should have a procedure in place to manage spills which includes the prior assembly of a spills kit. This kit may stand alone or be added to the infection control kit (ICMP 7 – Pre-treatment assessment of infection control risk).

6.7.1 Spill kit

The contents of a spills kit may vary from one practice to another but all should include:

- A rigid container such as a bucket to carry the contents of the spills kit. A lid is preferred but not essential.
- Non-sterile examination gloves or waterproof utility gloves.
- Absorbent material such as kitty litter.
- Paper hand towel sheets or roll.
- Something to scrape up solids such as vomit. A number of pieces of stiff cardboard or plastic may be suitable.
- Liquid detergent for general cleaning is suitable for most spills.
- Disposable vomit bags.
- Plastic waste bags; plastic shopping bags are not suitable.⁸⁰

6.7.2 Cleaning up blood and body fluid spills

- Stop traffic through the area until it is clean and dry.
- Use standard precautions and appropriate personal protective equipment, including suitable gloves, plastic apron, and eye protection.
- When cleaning spill take care to not create an aerosol.
- Contain and absorb the spill using disposable towels or absorbent material such as kitty litter.
- Use the card from the spill kit to scrape up any solid material.
- On hard surfaces clean the area with detergent and water then dry the area thoroughly.
- Do not use liquids to clean the carpet as it will spread the spill. Clean the area with a damp cloth containing detergent and water or use carpet cleaner.^{81,82}

A spill kit is an essential part of any ICMP and may be combined with an infection control kit (see ICMP 7).

6.8 Decontaminating and reprocessing reusable patient care equipment

See ICMP 8 – Non-reuse of single use medical devices and reprocessing of reusable medical devices.

⁸⁰ Ibid., p. 42.

⁸¹ Ibid., pp. 42-43.

⁸² http://www.health.qld.gov.au/chrisp/ic_guidelines/sect2_elements.pdf, p. 32.

ICMP 7 – PRE-TREATMENT ASSESSMENT OF INFECTION CONTROL RISK

7.1 Risk

Cross-infection due to inappropriate accommodation of clients with symptoms of communicable diseases, e.g. influenza, measles and chickenpox.

7.2 Minimum standard to demonstrate compliance

- All patients receive a pre-treatment questionnaire at first visit or booking.
- All patients are triaged when calling for appointments to prevent transmission of known communicable diseases in waiting rooms.
- All patients with known or suspected highly transmissible communicable diseases are segregated from other patients upon arrival.
- Non-urgent procedures or treatment is delayed until patient has recovered from highly transmissible communicable diseases.

7.3 Possible actions to improve compliance

- Introduce a booking-in form that identifies patients with known or potential communicable diseases.
- Identify a room in the facility that may be utilised to segregate infectious patients from the waiting room area.⁸³

7.4 Triage by reception staff

In order to reduce the spread of infection from potentially infectious patients all reception staff should be trained to recognise signs and symptoms of common infectious diseases and how to respond.

The process of triaging starts when the appointment is first made. When taking a booking reception staff should ask the patient for an indication as to the reason for the visit. When a patient indicates they have a fever, rash, cough, diarrhoea or infectious disease this information should be passed on to the practitioner before the patient arrives for treatment. When a localised outbreak or pandemic has been identified the questions asked by reception staff may need to be more specific.⁸⁴

Signage in reception asking patients with symptoms of infectious disease to make themselves known to reception may also be appropriate.⁸⁵

All patients suspected to have highly transmissible infectious diseases should have non-urgent treatment postponed until they are no longer infectious. If treatment cannot be postponed their appointment should be booked when the practice will have the fewest number of patients waiting for treatment.⁸⁶

83 http://www.health.qld.gov.au/chrisp/icmp_pha/docs/risk_mgmt_mitigation.pdf.

84 RACGP, op. cit., 101.

85 Ibid., p. 101.

86 Ibid., p. 101.

7.5 New patient intake questionnaire

Many clinics already use a patient intake form to gather personal and health details about their patients. Patient intake forms should also contain questions to establish the possible presence of infectious disease.

7.6 Dealing with infectious patients

All patients with known or suspected highly transmissible infectious diseases should be instructed to use transmission-based precautions. The transmission-based precautions used should be tailored to the type of infection threat and may involve any of the following:

- Segregate the patient from others by moving them into a separate room and ask the patient not to touch communal objects such as toys and magazines.
- Provide dedicated toilet facilities.
- Use appropriate personal protective equipment.
- Provide the patient with a mask and instruct them on its use.
- Provide the patient with tissues to cover their mouth and nose when coughing or sneezing and provide a bin for their disposal.
- Restrict the movement of both the patient and staff.
- Provide the patient with access to hand washing facilities or ABHP.⁸⁷

7.7 Infection control kit

An infection control kit is used to manage patients with a confirmed or suspected infectious disease. This kit may stand alone or be added to the practice spills kit (see ICMP 6 – Environmental hygiene). It should be kept in a rigid walled container such as a bucket; a lid is preferred but not essential.

The kit should contain:

- Non-sterile examination gloves
- Regular surgical masks for patients and N2/P95 masks for staff
- Tissues; plastic rubbish bags for used tissues
- Disposable vomit bags
- Alcohol-based hand product
- Alcohol wipes or disinfectant spray for cleaning surfaces
- Yellow biohazard bags
- Disposable gown or plastic apron.⁸⁸

A infection control kit is an essential part of any ICMP and may be combined with an spill kit (see ICMP 6).

⁸⁷ Ibid., p. 102.

⁸⁸ Ibid., p. 156.

ICMP 8 – NON-REUSE OF SINGLE USE MEDICAL DEVICES AND REPROCESSING OF REUSABLE MEDICAL DEVICES

8.1 Risk

Cross-infection due to the re-use of medical devices marked as single-use only.

8.2 Minimum standard to demonstrate compliance

- No medical device labelled as 'single use only' is reprocessed for reuse.
- Senior member of staff is responsible for pre-purchase evaluation of new products.⁸⁹

8.3 Possible actions to improve compliance to ICMP 8

Appoint a senior staff member to perform a risk assessment on any new products being considered for trial or purchase.

Conduct an audit on all items used for patient care to ensure that any items marked as 'single use only' are not reprocessed for reuse.⁹⁰

8.4 Single-use medical devices

Single use medical devices have several advantages over devices that need to be reprocessed. They reduce the risk of cross infection, they save staff time that would otherwise be used in reprocessing and they reduce the risk of occupational injury by removing the risk to staff caused by reprocessing.

Good practice dictates that all critical items used in the provision of acupuncture should be single use. Such critical items include acupuncture needles, dermal hammers and blood lancets. Semi-critical items such as needle guide tubes should also be single use only disposable items.

All items labelled 'single-use device' must be disposed of in the appropriate manner immediately after use. Each facility should have an inventory management process to ensure adequate supplies of single-use devices such as acupuncture needles, dermal hammers and blood lancets are in stock at all times.

Good practice dictates all acupuncture needles, dermal hammers, blood lancets and guide tubes should be single use only disposable items.

8.5 Reprocessing reusable medical equipment

For details on reprocessing reusable medical equipment refer to the AACMA Infection Control Guidelines for Acupuncture.⁹¹

⁸⁹ http://www.health.qld.gov.au/chrisp/icmp_pha/docs/risk_mgmt_mitigation.pdf.

⁹⁰ http://www.health.qld.gov.au/chrisp/icmp_pha/docs/risk_mgmt_mitigation.pdf.

⁹¹ Australian Acupuncture Association Ltd, Infection Control Guidelines for Acupuncture, 2007, www.acupuncture.org.au/infection_control.

ICMP 9 – DELEGATION OF RESPONSIBILITY FOR INFECTION CONTROL

9.1 Risk

Preventable patient or staff harm due to the absence of an infection prevention program.

9.2 Minimum standard to demonstrate compliance

- Senior staff member/members are allocated responsibility for the practice/facility infection control program.
- Relevant infection control guidelines are accessible by all staff members.⁹²

9.3 Possible actions to improve compliance to ICMP 9

- Appoint a senior staff member to take responsibility for the infection control portfolio.
- Ensure that the infection control officer is provided with sufficient education and/or resources to perform in this role.
- Ensure that any relevant guidelines, policies and standards are accessible to all staff.⁹³

9.4 Responsibility for ICMP

According to the Public Health Act 2005, sec. 154, the owner/operator of the facility must:

- (a) develop and implement an ICMP
- (b) provide adequate resources to ensure the effectiveness and implementation of the ICMP
- (c) review the effectiveness and implementation of the ICMP at appropriate intervals
- (d) provide appropriate training in relation to the ICMP to employees and other persons engaged at the facility.

In some facilities it may be appropriate to nominate a senior staff member to take responsibility for the annual audit of the ICMP and maintenance of any day-to-day operational issues. It is however important to remember final responsibility lies with the owner/operator of the facility.

In circumstances where an acupuncturist rents a room in a multi-modality facility, the question can arise as to who is responsible for the ICMP. In these circumstances it is often best to foster a collaborative relationship in order to get an ICMP in place rather than argue about whose responsibility it is.

9.5 ICMP document

The ICMP must be kept in a place which is freely accessible by all staff.

⁹² http://www.health.qld.gov.au/chrisp/icmp_pha/raq9.asp?R8Q3=3&R8Q4=3.

⁹³ http://www.health.qld.gov.au/chrisp/icmp_pha/docs/risk_mgmt_mitigation.pdf

ICMP 10 – PROCESS FOR THE INVESTIGATION OF INFECTION CONTROL INCIDENTS

10.1 Risk

Non-compliance with established policies/procedures resulting in a preventable infection.

10.2 Minimum standard to demonstrate compliance

All breaches of infection control or near misses are reported to practice/facility management. There is a procedure in place for the management of patients involved in an infection control breach.⁹⁴

10.3 Possible actions to improve compliance to ICMP 10

Develop a policy for the facility that outlines the procedure for investigating an infection control breach or near miss.⁹⁵

10.4 Incident investigation

All breaches of infection control, including occupational exposures to blood and body fluids, such as needle stick/sharps injury or body fluid exposure, or near misses, should be confidentially documented to include the circumstances under which they occurred. This documentation should be used in an analysis of the event to enable review procedures and processes to minimise the risk of reoccurrence.⁹⁶

Incident reporting documents are intended for use by staff and employees only and should not be completed in front of or given out to patients.

See also ICMP 3 – Exposure to body fluids as a result of needle-stick injury.

⁹⁴ http://www.health.qld.gov.au/chrisp/icmp_pha/raq10.asp?R9Q3=3&R9Q4=3.

⁹⁵ http://www.health.qld.gov.au/chrisp/icmp_pha/docs/risk_mgmt_mitigation.pdf.

⁹⁶ http://www.health.qld.gov.au/chrisp/ic_guidelines/P3_Revision_April09.pdf, p. 4.

GLOSSARY OF TERMS

AACMA	Australian Acupuncture and Chinese Medicine Association Ltd
ABHP	Alcohol-based hand product
AS	Australian Standard
CHRISP	Centre for Healthcare Related Infection Surveillance and Prevention
HH	Hand hygiene
HQCC	Health Quality and Complaints Commission
HSP	Health service provider
ICMP	Infection Control Management Plan
NHMRC	National Health and Medical Research Council
NZS	New Zealand Standard
PPE	Personal protective equipment
RACGP	The Royal Australian College of General Practitioners
SA	Standards Australia
TGA	Therapeutic Goods Administration
WHO	World Health Organization

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APPENDIX A – ICMP SELF ASSESSMENT FORM

Name of Health Care Facility:		
Type of Health Services Provided:		
Date of ICMP Assessment:		
Name of Facility Owner/Operator:		
Person Responsible for Monitoring ICMP:		
Date of Last ICMP Review	Name of Reviewer and Signature	Date of Next ICMP Review
Staff Training		

ICMP	Minimum Standards for Compliance	YES	NO
1.	Staff & visitors have access to hand washing sinks, hand washing solutions, paper hand towels and alcohol based hand rub (ABHR) when appropriate.		
1.	Alternative hand disinfection products such as alcohol hand rubs are available when appropriate.		
1.	Staff understand hand hygiene relevant to roles and responsibilities.		
1.	Wounds or abrasions on exposed skin are covered by impervious dressings.		
2.	Staff wear protective gloves when performing "at risk" procedures or tasks.		
2.	Appropriate PPE is applied in situations requiring standard or additional precautions.		
3.	Sharps containers that comply with AS4031/92 are available at the point of use.		
3.	No needles are recapped or after use or modified before disposal.		
3.	Staff are informed of the importance of Hepatitis B vaccination in the health care setting.		
5.	All staff are informed of their risks to communicable diseases at orientation or commencement of employment.		
5.	Pregnant staff, or those women who may be planning pregnancy, understand the risks of exposure to communicable diseases.		
5.	All staff are informed of vaccinations recommended for health care professionals as listed in the Australian Immunisation Handbook.		
5.	All staff are required to complete a pre-employment staff health questionnaire to assess their immune status.		
6.	All staff demonstrate understanding of the correct disposal methods for clinical waste.		
6.	Cleaning audits are conducted on a regular basis.		
6.	All clinical surfaces are decontaminated with detergent and water on a regular basis.		
6.	All reusable patient care equipment is decontaminated and reprocessed according to AS4187 or AS4185.		
7.	All patients receive a pre-treatment questionnaire at first visit or booking.		
7.	All patients are triaged when calling for appointments to prevent transmission of known communicable diseases in waiting rooms.		
7.	All patients with known or suspected highly transmissible communicable diseases are segregated from other patients upon arrival.		
7.	Non-urgent procedures or treatment is delayed until patient has recovered from highly transmissible communicable diseases.		
8.	No medical device labelled as "single use" only is reprocessed for reuse.		
8.	Senior member of staff is responsible for pre-purchase evaluation of new products.		
9.	Senior staff member/members are allocated responsibility for the practice/facility infection control program.		
9.	Relevant infection control guidelines are accessible by all staff members.		
10.	All breaches of infection control or near misses are reported to practice/facility management.		
10.	There is a procedure in place for the management of patients involved in an infection control breach.		

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APPENDIX C – CLEANING PROCEDURE SCHEDULE

Area to be Cleaned	Items Cleaned	Product Used	Method used	Frequency of cleaning
Reception	Furniture			
	Toys the waiting area			
	Bench tops			
	Floors/carpets			
	Telephones			
	Desks			
	Door handles			
Treatment Rooms	Treatment tables			
	Sinks			
	Waste Bins			
	Bench tops			
	Desks			
	Stethoscopes			
	BP Cuffs			
Common Areas	Refrigerators			
	Toilets			

Appendices A, B and C are available on the members' section of the AACMA website as downloadable Word documents.



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