THE EMERGING ROLE OF THE INFECTION CONTROL NURSE

Report of a symposium held on

Tuesday 24 July 1979

at the King's Fund Centre

Reported by Mr J Barrie Sheard

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King Edward's Hospital Fund for London

King's Fund Centre
126 Albert Street London NW1 7NF

THE EMERGING ROLE OF THE INFECTION CONTROL NURSE

Programme for the Symposium held on 24 July 1979

Chairman: Miss D M Cutcliffe SRN SCM DN, Regional Nursing Officer North East Thames RHA

10.00 a.m.	Registration and coffee
10.30	Welcome to the King's Fund Centre Miss Hazel O Allen, Assistant Director
10.35	Chairman's Introduction
10.40	Infection Control - Retrospect and Prospect Dr Brendan Moore, Consultant Bacteriologist (retired)
10.55	The Role of the Infection Control Nurse Miss M Webster, Infection Control Nursing Officer, St Thomas' Health District
11.10	The Control of Infection Officer Dr G A J Ayliffe, Consultant Microbiologist, Hospital Infection Research Laboratory, Dudley Road Hospital, Birmingham
11.25	The Infection Control Team and Infection Control Committee Dr D J H Payne, Director, Public Health Laboratory, St Mary's General Hospital, Portsmouth
11.40	Education of Personnel Miss E A Jenner, Infection Control Nursing Officer, Islington Health District
11.55	The relationship of the Infection Control Team with colleagues in hospital and community - Dr S E J Young, Epidemiologist, Communicable Disease Centre, London
12.10 p.m.	Law and related matters connected with infectious diseases Mr K K Ibrahim, Senior Legal Adviser, DHSS
12.25	Reflections on the morning session Dr Brendan Moore, Consultant Bacteriologist (retired)
12.40	Chairman's remarks
12.45	Lunch
13.30	Assemble for group work
15.00	Tea
15.10	Reporting back
15.50	Panel Discussion
16.20	Chairman's Closing remarks

Objectives of the seminar

1. To describe the present organisation of infection control within the hospital and its links with the community.

2. To focus on the role and responsibilities of the infection control nurse, the infection control officer and other members of the infection control team. What are the responsibilities of the team and what relationships are necessary for these to be fulfilled?

3. To make recommendations for the education and development of infection control personnel with the aim of enhancing the service they provide.

Infection Control - Retrospect and Prospect

Dr Brendan Moore, Consultant Bacteriologist

This particular duty has developed since 1959 in the United Kindom and also over in the United States of America where there are now over 4,000 posts and in the Netherlands there has been a remarkable increase. It is preventive medicine and should be fitted into each comprehensive hospital organisation.

The job of the Infection Control Officer (ICO) and the Infection Control Nurse (ICN) is to focus on the environment and its hazards. It can be divided into two main Headings:

Environmental Monitoring

Here the non medical pollutionist examines and monitors the permissable levels of pollution (already EEC levels for certain matters have been set) and, in fact, helps to improve the highly emotive but very difficult to define 'quality of life.'

Epidemiological approach

Dealing here with the diseases of man and not from the environment and here the nurse epidemiologist comes about.

Four different studies can be undertaken but it must be understood by all that we have come a long way from the Nurse who spends 10-15 minutes per day per hospital on Infection Disease Control.

1. The Descriptive Study

2. Hypothesis testing

3. Intervention Study

4. Method Study - needing deep thought and evaluation

Here the speaker issued a challenge for a group of nurses who are ICN's to present a report on the results of an intervention study in a ward setting backed by microbiological results and statistics confirming the facts.

The Role of the Infection Control Nurse.

Mrs. M. Webster - Nursing Officer, Infection Control, St. Thomas' Health District.

The Infection Control Nurse is a Clinical Nurse Specialist whose aim is to achieve and maintain throughout her area of responsibility the highest possible standards of practice of prevention and control of infection with regard to the safety of patients and staff. The post is an advisory staff post with daily contact with the Consultant Microbiologist but as a nurse within the Infection Control Team.

Using this nursing knowledge and expertise the welfare of the patients and staff is assisted, and is a truly clinical and practical approach. Informal relationships have to be developed with all grades and categories of hospital staff to enable investigations to be undertaken, and a sense of humour and immense tact has to be developed.

The following matters are necessary:

1. Identify promptly infected patients and staff who present specific infection risks;
2. Arrange for prompt isolation with co-operation with ward sister and consultant, in accordance with the District Policy;
3. Compile records, including case notes and laboratory reports;
4. Retain information as to staff records of infection and liaise as necessary with G.P's;
5. Checking by visits that infection control and septic procedures are being carried out in accordance with agreed policy;
6. Identify outbreaks of infection and carry out investigations to find their source and mode of spread, and implement control measures.

This identification is assisted by the computerised Infection Control print-outs.

Other aspects of day to day work include:

A. Hospital Hygiene - disposal of infected linen, refuse, domestic cleaning, as examples;

B. Liaising with the CSSD department and using proper sterilisation and disinfection procedures;

C. Advising about new and old medical equipment;

D. Dealing with high risk areas - theatres and special care baby units.

Associated with this is the role of teaching both formally and informally during the daily visits.

There are difficulties often a limit in time available which means priorities have to be set.

However, what is needed is a commitment of the profession of nursing as a whole that ICN's are required in todays nursing structure. Also it is essential that support from the other members of the team, particularly the Microbiologist, without support of both senior nursing staff or the microbiologist or both the role of ICN is extremely difficult. Often ICN's have dual roles of Occupational Health and Infection Control, or Clinical Teaching and Infection Control and sometimes all three roles and this means that precedence of one of the roles has to be taken.

Education Now there is a Foundation Course in Infection Control brought about by the determination of the Infection Control Nurses Association. However, most of the ICN's now in post have acquired their training on the job and through experience.

From small beginnings in 1959 with the first post there are now 160 posts after twenty years have elapsed.

The Control of Infection Officer.

Dr. G.A.J. Aycliffe, Consultant Microbiologist, Hospital Infection Research Laboratory, Dudley Road Hospital, Birmingham.

Early in the 1950's Colebrook suggested that an Infection Control Officer should be employed but hospitals seemed unlikely to afford a full-time post. The Cohen Committee report of 1959 recommended that hospitals should appoint a senior member of the existing medical staff. This has been done in a variety of ways from medical registrars to consultant surgeons with a variety of enthusiasm and success.

There is in fact very little documentation on the subject and hence the importance today of this Symposium.

This section of the paper was illustrated with slides and went through various questions:

WHO? should the ICO be?

A senior member of the medical staff with a special interest and training in the subject and be aware of recent developments.

The choice could be an Infection Disease Consultant, a surgeon, a physician, a medical officer of Environmental Health, a scientific staff member, but it was RECOMMENDED that he should be a Consultant Microbiologist who is really the only suitably trained person and also he has ready access to microbiological records.

Appointed by?

This could be Administration at either District or Area level, also the appointments committee, but it was recommended that it should be the Medical Staff Committee.

Responsible to?

Four groups were mentioned, the Medical Staff Committee, Administration at District or Area level, The Management Team or the Control of Infection Committee.

Area of responsibility?

The hospital departments including catering, laundry, C.S.S.D., pharmacy, domestic, engineering as well as clinical areas. The ICO must liaise with the MOEH and microbiologist (if not the same person) the ICN and the Community staff if infection is out in the Community.

This particular function can cause cross currents with the different professionals as it cuts across normal channels.

The legal responsibilities of the ICO are at present uncertain, particularly in areas of catering and pharmacy and these need defining.

Training.

It was suggested that there should be a basic and updating course and even suggested that everyone should do the same examination.

The Infection Control Team and Infection Control Committee.

Dr. D.J.H. Payne, Director Public Health Laboratory, St. Marys General Hospital, Portsmouth.

There is nothing laid down on who should be the members of the Infection Control Team, these are the facts for Portsmouth. Membership consists of ICO (Microbiologist), Deputy (who acts as CSSD liaison) and sees all new doctors whether a Consultant or Houseman, deals with CSSD procedures, setting up drips, laying trays etc. The next member of their team is a Microbiological Technician usually referred to these days as a Scientific Officer he examines autoclaves and also does investigations. The final member of their team is the ICN who collects information by spending 15-20 minutes each day in the laboratory getting the facts on what infections there are.

They have a standard enquiry form detailing date and name of patient, operation date and or diagnosis, site of swab, organism with comments on phage type. Usually the ICN is on the nursing procedures committee and/or any training duties.

Their team have adopted a Disinfection Policy and arranged quick liaison with both District Nurses and Health Visitors in the community.

In his opinion the Committee for Infection Control only meets once a year but can meet as necessary. The IC Committee is open to the Senior Nursing Staff. One of the great points of the IC Committee is that its minutes can be sent for their educational value to Doctors, Pharmacists and Ward Sisters to name but three. An important matter stressed is that the ICN must be someone who is capable of talking to a Ward Sister as an equal and so get their confidence - it must be established early on that they are not snoopers.

In his opinion if there is cross infection in a hospital it is a measure of failure. The important thing to sell about Infection Control is that its preventive measures can save beds and that the job is not a sinecure.

Education of Personnel.

Miss E.A. Jenner, Infection Control Nursing Officer, Islington Health District.

Without any doubt the IC Team is the ICO, the ICN and the MOEH all of whom have interrelated duties. Unfortunately there is still confusion and there is still cross infection in Hospitals. The basic role of the ICN is one who is trained to anticipate problems, has communication skills, can solve problems, can implement policies and also has skills in teaching staff. There are still too many gaps in ICN posts in the country and the job needs defining. Sometimes they hold a Sisters post, sometimes a Nursing Officer 1 or 2. Because of the diversity of the jobs no formal education is yet given but now with the formation of the Infection Control Association certain steps have been taken. These are:

1. There is need for a formal foundation course;
2. The RCN in June 1978 started the first course for ICN's with already 12 months experience;
3. A course for ICN's with 4/5 years experience.

It must be remembered that Education is a continuing process.

In conclusion, she wanted -

1. To see the job defined,
2. a graded system of education, and
3. to see that employers recognised the clinical specialists of tomorrow.

The relationship of the Infection Control Team with colleagues in hospital and community

De S E Young, Epidemiologist, Communicable Disease Surveillance Centre, London.

The ICN must be a senior nursing officer because of the importance of professional relationships with staff including outside staff.

Examples of problems with the community are Influenza, gastro-enteritis, food poisoning. The community can and does affect the hospital and also vice-versa. It is, therefore, important to prepare links with General Practitioners, District Nurses, Environmental Health Officers and have planned action already prepared. This is done through formal procedures of liaison but once established, these links are best if left to be as informal as practical. Meetings are held for special problem areas such as:

1. Paediatrics
2. Obstetrics
3. Intensive care

Without doubt, Control of Infection must have teeth to act as necessary.

The Infection Control Committee can form a forum of communication which, for example, with Lassa Fever procedures can be useful.

Law and related matters with infectious diseases.

Mr. K.K. Ibrahim, Senior Legal Advisor, DHSS.

A difficult area to speak upon but he divided it into two basic areas:

1. The particular law as contained in the Public Health Act, 1936 amended by the Public Health Act, 1961 and by the Health Service and Public Health Act, 1968 as amended again by the National Health Services Act, 1972 and also the Local Government Act, 1972. The term 'proper officer' was referred to but for most parts as far as Infectious Diseases it is to be MOEH we look to for action.

   There are also other specific problems that deal with food poisoning as they relate to food borne and ice cream borne infections.

2. The Control of matters within hospitals to stop infection. Certain matters are difficult in that there exists crown exemption but he stressed that hospitals adopt good neighbours policy and do what other organisations have to do by law. The new Health and Safety at Work Act has many implications within the hospital service.

   Another law problem deals with confidentiality of laboratory findings and the law of defamation.

   There is law enabling persons to be compensated for stopping them off work, Section 41 Public Health Act, 1961 and certain diseases are recognised e.g. Anthrax whereby there is compensation for contracting the disease (industrial diseases).

   The need to obtain consent to treat says that in law you must have permission, with certain exemptions in Mental health premises.

   The law has Local Authorities on the one hand and the DHSS on

the other and the need to keep it a dual exercise for both within the hospital and in community is important.

Sometimes it is necessary to extend the list of Infectious Diseases from time to time, recently this occurred with both Lassa Fever and Marlberg Disease.

Problems have arisen with Section 41 action when the proper officer (usually the MOEH) requests the person to stop work, this is all very well with a person actually suffering from the disease but what happens when the person is only a carrier? Another problem quoted is the person who lives in one Local Authority area and works in another area, who serves the notice to stop work? Usually a compromise has to be reached. The time has arrived when Central Government should have a special fund for when Compensation and when stopping people off work is necessary.

Reflections of the morning session.

Dr. Brendan Moore.

His main comment was that very similar ideas had been produced from the different presenters of the papers. There was definately a need for the complex interrelationships to be prepared into a full study report.

DISCUSSION GROUPS.

After the formal papers were presented in the morning session, the Seminar divided into four Discussion Groups as detailed below and these had either one or two Resource Experts assigned to them along with a Group Leader.

All four Groups met for a period of 1½ hours and having elected a Reporter he/she reported back to the full Seminar. Details of the reporting back session are given starting on Page 15.

GROUP	TITLE OF GROUP DISCUSSION	Resource Expert(s)	Group Leader
A	Infection Control Officer and Infection Control Committee	Dr.G.A.J. Ayliffe Dr.D.J.H. Payne	Mrs.B.Fletcher
B	Relationships	Dr.Susan Young Dr.Brendan Moore	Miss.E.Johns
C	Education	Miss.E.A. Jenner	Dr.P.A.Meers
D	Infection Control Nurse	Mrs. Margaret Webster	Miss.M.Worsley

REPORTING BACK SESSION OF GROUP WORK.

GROUP A - INFECTION CONTROL OFFICER AND INFECTION CONTROL COMMITTEE.

This Group were given a prepared set of questions as follows:

Infection Control Officer
1. Who?
2. Experience and training
3. Appointed by?
4. Responsible to?
5. Area of responsibility and functions
6. Relationship to others.

Important decisions
1. Is Infection Control Officer head of team?
2. Is he responsible for infection problems in the whole hospital, including kitchens and pharmacy?
3. Is the MOEH concerned with infection in hospital?
4. What are the legal responsibilities of the ICO?

In reporting back it was recognised that there were many different answers.

There should be a structure recognised officially and Management Teams should appoint an Infection Control Committee to each District.

The group agreed that the ICO should preferably be a Microbiologist and when he is on leave there should be developed a proper Deputy system for proper and adequate cover for a District.

On the question of experience it was agreed that personality was very important and that the ICO should get on with people; there is certainly need for formal courses but in the interim practical experience was important assisted with half day courses or Seminars.

Often a type of apprenticeship to an experienced Microbiologist is essential in getting experience.

There should be a formal appointment and often today it was found that the Job Description included giving advice to the Infection Control Committee. The Group thought that the ICO should be responsible to the District Management Team as against responsible to the Medical Advisory Committee. He should act as an advisor to the whole of the hospital Departments, including kitchens, pharmacy, CSSD's and Laundries. It was mentioned that sometimes the advice of the DHSS was against the ICO or even the Infection Control Committee advice.

For example the latest suggestion that water in hospitals should be lowered in temperature to save fuel, this could be against Infection Control ideas.

It was agreed that the MOEH was concerned particularly with dealing with outside contractors and problems of infection in the Community that come into the hospital.

The Control of Infection Committee (CIC) is an advisory body to prevent infection but this Committee functions need clarifying, particularly with the HASAWA making it the more difficult.

A small Committee basically is necessary with power to co-opt other interested parties (for example - Pharmacist, Occupational Health, CSSD, Engineer, MOEH, EHO, Senior Nurse, Anethetist).

On the question put about legal responsibility it was thought that there was no legal right as the ICO and also the CIC acted in an advisory capacity.

One of the most important functions was to disseminate information in the form of Minutes and Policy statements such as a Disinfection Policy, Antibiotic Policy.

A useful sub Committee structure was mentioned in conclusion to the reporting stage of Group A in that three separate Sub Committees had been started in one District firstly one on Food Hygiene, the

second on Barrier Nursing and techniques, and the third on Education. The one message that came through time and time again with this session was that Close team work was the prime importance.

GROUP B - RELATIONSHIPS.

This Group was given three questions to consider in their session and these were as follows:

The relationship of the Infection Control Team with colleagues in hospital and community.

1. Are formal links with colleagues useful or necessary for enforcement of policies? If so, with whom?
2. Should there be a systematic accountability? If so, to whom?
3. Is more than a nominal link possible with personnel outside the hospital?

Reporting back was said to be difficult as all three questions merged into each other. The overall impression of members of the Group was that no two Districts in the United Kingdom were the same, so that no strict approach is possible. The important matter is that the best for that particular District should be aimed for. This means that there should be a flexible approach but a formal link for communication established for the Team members was essential.

The District Management Team should have policy, but the CIC should have procedures and not use enforcement. For example, a Disinfection Policy is good but it was felt that an Anti-biotic Policy was difficult due to the need to have freedom of clinical choice.

It was felt that the CIC should be accountable to the DMT who in its turn carries the main responsibility.

Good communication with outside community nursing care team, and a good working relationship should be fostered. Dealing with the Community the need to foster close relationships with the PHLS/EHO/ICN is relatively easy, but the Hospital Laboratory/ICN and the EHO is difficult.

In concluding this report it was stressed again that there should be no hard and fast rules, but each District CIC doing the best for each District.

GROUP C - EDUCATION.

This group were given a comprehensive questionaire asking them to define the minimal educational requirements, the immediate educational needs, constant and eventual educational needs, who should determine courses, who should organise them, whether the courses should be multidisciplinary and if they should develop into a formal examination.

In reporting back the Group consisted of 13 Nurses, 3 Doctors and 1 other. They agreed that the skills needed by the ICN was practical nursing experience as an SRN plus experience of at least 2 years plus the right personality. With regard to the ICO the person should be a Consultant/microbiologist but if another Consultant he should obtain advise from a microbiologist.

Educational needs.

1. First appointed - should have 1 month in the laboratory plus the opportunity of meeting other Senior Nursing Officers.
2. Foundation Course - a joint course of Clinical Studies started 6 months after appointment. This should be an obligatory course, and be full time of at least 3 weeks and 3 days duration.
3. Advanced Course - an optional course after 2 years experience with a Diploma or Degree level. Based on the Module system including home study. This would be to provide Clinical Nurse Specialists.

4. Refresher Courses should also be available but optional.
5. Special Studies - on the use of computers or epidemiological studies were suggested.

On the question of the courses it was suggested that the Infection Control Association should be asked to help prepare these courses.

Group D - Role of the Infection Control Nurse

Four areas were looked into by the panel:

1. The possibility of establishment patterns officially recommended.
2. Reviews of gradings and remunerations.
3. Possible factors influcencing number of nurses in each district and use of dual roles.
4. Ways that the nursing profession can assist.

It was agreed by the group that each district should have an ICO and also a full-time ICN and that this should have the support of the DHSS.

On the second part the post should be of Nursing Officer, paid according to experience and responsibility.

On the third part a minimum of two full-time ICN's to cover and relieve during holidays and sickness. The total number is, however, influenced by the specialities of the district, population of district and also the geographical spread of the district.

There is difficulty with a dual role as at times priorities have to be set and this can be a problem.

On the fourth and last point - the Nursing profession can greatly help by firstly welcoming the need of the ICN, secondly, by recognising that education and training in this special field is very necessary, thirdly, for making a career structure and fourthly, for the General Nursing Council recognising the ICN as a Clinical Nurse Specialist.

The group concluded their reporting session by stating that the Medical profession can greatly assist by all recognising that preventive medicine is a number one priority.

PANEL DISCUSSION.

All the presenters of the morning papers formed a panel and a useful session developed ranging from questions on the number of beds each ICN can properly look after; confirming that although the law is relatively easy on isolating a patient the treatment can be difficult; on a question of accountability it was suggested that the ICO was responsible to the District Management Team and they in their turn were the responible group to the Health Authority; an education query stated that what was really needed for the ICN was a truly practical nurse with perhaps 5 weeks training at the laboratory bench and not a PhD degree and solely an academic nurse.

CHAIRMANS CONCLUDING REMARKS.

The Chairman, Miss D.M.Cutliffe, in thanking members of the panel for both presenting their papers in the morning and also assisting the Group Work and Panel Discussion also thanked all the delegates for helping to make the Seminar so worth while. Hopefully when the report is circulated in the near future it will help to make the job of Infection Control all that much easier and pave the way for better preventive health care.