

NZS 8134.3:2008

New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards

Superseding NZS 8142:2000



NZS 8134.3:2008



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New Zealand Standard

**HEALTH AND DISABILITY SERVICES
(INFECTION PREVENTION AND
CONTROL) STANDARDS**

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NOTES

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CONTENTS

Foreword	5
Referenced documents	6
Related documents and guidelines	7
Infection control management	NZS 8134.3.1
Implementing the infection control programme	NZS 8134.3.2
Policies and procedures	NZS 8134.3.3
Education	NZS 8134.3.4
Surveillance	NZS 8134.3.5
Antimicrobial usage	NZS 8134.3.6

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NOTES

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FOREWORD

The aim of NZS 8134.3 is to facilitate quality and consistently safe health and disability services by identifying practices designed to reduce the rate of infections in the health and disability sector.

NZS 8134.3 is applicable to all health and disability services. The Standards are mandatory for those services that are subject to the Health and Disability Services (Safety) Act 2001. Other health and disability services, should consider adopting them as they promote current accepted good practice.

The benefits and desired outcome of implementing NZS 8134.3 are:

- (a) Improved safety for consumers, staff, and visitors;
- (b) Increased attention to the basic principles of infection control;
- (c) Identifying a consistent and applicable infection control baseline for services.

This document is intended to be generic and address the basic principles and systems that are the foundation for effective infection control. It is not intended to be an infection control manual or educational tool.

NZS 8134.3 is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

WHAT CAN YOU BUY

NZS 8134.3 *Health and disability services (infection prevention and control) Standards* consists of this document plus:

- (a) NZS 8134.3.1 – Infection control management
- (b) NZS 8134.3.2 – Implementing the infection control programme
- (c) NZS 8134.3.3 – Policies and procedures
- (d) NZS 8134.3.4 – Education
- (e) NZS 8134.3.5 – Surveillance, and
- (f) NZS 8134.3.6 – Antimicrobial usage.

NZS 8134.3 comprises part of NZS 8134:2008 and may be purchased as a set, that is loose-leaf, four-hole punched, and shrink wrapped for insertion in a binder with room for NZS 8134.0 *Health and disability services (general) Standard*, NZS 8134.1 *Health and disability services (core) Standards*, and NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards*.

REFERENCED DOCUMENTS

Reference is made in this document to the following:

NEW ZEALAND STANDARDS

NZS 8134.0:2008	Health and disability services (general) Standard
NZS 8134.1:2008	Health and disability services (core) Standards

JOINT AUSTRALIAN/NEW ZEALAND STANDARDS AND HANDBOOK

AS/NZS 4146:2000	Laundry practice
AS/NZS 4187:2003	Cleaning, disinfecting and sterilising reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities
AS/NZS 4360:2004	Risk management
AS/NZS 4815:2006	Office-based health care facilities – Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment
SAA HB 436:2004	Risk management guidelines – Companion to AS/NZS 4360:2004

OTHER PUBLICATIONS

Ministry of Health. *He korowai oranga: Māori health strategy*. Wellington: Ministry of Health, 2002.

Office for Disability Issues. *New Zealand disability strategy*, 2001.

NEW ZEALAND LEGISLATION

Code of Health and Disability Services Consumers' Rights 1996

Health and Disability Commissioner Act 1994

Health and Disability Services (Safety) Act 2001

Health Information Privacy Code 1994

Privacy Act 1993

LATEST REVISIONS

The users of this Standard should ensure that their copies of the above-mentioned New Zealand Standards are the latest revisions. Amendments to referenced New Zealand and Joint Australian/New Zealand Standards can be found on <http://www.standards.co.nz>.

WEBSITES

Ministry of Health	http://www.moh.govt.nz
New Zealand Legislation	http://www.legislation.govt.nz
Office for Disability Issues	http://www.odi.govt.nz

RELATED DOCUMENTS AND GUIDELINES

ASSOCIATED STANDARDS AND HANDBOOKS

When interpreting this Standard it may be helpful to refer to other documents, including but not limited to:

NEW ZEALAND STANDARDS

NZS 4304:2002 Management of healthcare waste

NZS 4121:2001 Design for access and mobility: Buildings and associated facilities

NZS 8134.2:2008 Health and disability services (restraint minimisation and safe practice) standard

NEW ZEALAND HANDBOOK

SNZ HB 8149:2001 Microbiological surveillance of flexible hollow endoscopes

JOINT AUSTRALIAN/NEW ZEALAND STANDARDS

AS/NZS ISO 11137.1:2006 Sterilization of health care products – Radiation – Requirements for development, validation and routine control of a sterilization process for medical devices

AS/NZS ISO 11137.2:2006 Sterilization of health care products – Radiation – Establishing the sterilization dose

AS/NZS ISO 11137.3:2006 Sterilization of health care products – Radiation – Guidance on dosimetric aspects

AUSTRALIAN STANDARDS

AS 1668.2-2002 The use of ventilation and airconditioning in buildings – Ventilation design for indoor air contaminant control

AS 2828:1999 Paper-based health care records

RELATED LEGISLATION

Fire Safety and Evacuation of Buildings Regulations 2006

Food Act 1981

Hazardous Substances and New Organisms Act 1996

Health Act 1956

Health and Disability Commissioner Act 1994

Health and Safety in Employment Act 1992

Health Practitioners Competence Assurance Act 2003

Health (Retention of Health Information) Regulations 1996

Medicine Regulations 1984

Misuse of Drugs Regulations 1977

Human Rights Act 1993

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Local Government Act 2002

Medicines (Standing Order) Regulations 2002



Misuse of Drugs Act 1975
 New Zealand Building Code
 New Zealand Bill of Rights Act 1990
 New Zealand Public Health and Disability Act 2000
 Official Information Act 1982
 Public Records Act 2005
 Resource Management Act 1991
 Smoke-free Environments Act 1990

INFECTION CONTROL REFERENCES AND RECOMMENDED TEXTS

- Association for Professionals in Infection Control and Epidemiology. *The APIC text of infection control and epidemiology*. 2nd ed. Washington: APIC, 2005.
- Ayliffe, G A J, Fraise AP, Geddes AM and Mitchell K. *Control of hospital infection: A practical handbook*. 4th ed. London: Arnold, 2000.
- Bennett, J V and Brachman, P S (eds). *Hospital infections*. 4th ed. Philadelphia: Lippincott Raven, 1998.
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- Mayhall C G (ed). *Hospital epidemiology and infection control*, 3rd ed. Philadelphia: Lippincott Williams and Wilkins, 2004.
- Nicolle, L E. 'Preventing infections in non-hospital settings: Long-term care.' *Emerging Infectious Diseases*, Vol 7 No. 2 (Mar–Apr 2001): 205 – 207.
- Scheckler, W E, Brimhall, D J, Buck, A S et al. 'Requirements of Infrastructure and Essential Activities of Infection Control and Epidemiology in Hospitals: A Consensus Panel Report.' *American Journal of Infection Control* 26 (1998): 47 – 60.
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- Wenzel, R P (ed). *Prevention and Control of Nosocomial Infections*, 4th ed. Baltimore: Williams & Wilkins, 2003.
- 2006 Red Book Report of the Committee on Infectious Diseases. Illinois: American Academy of Paediatrics, 2006. Also available online at <http://aapredbook.aappublications.org/>

MINISTRY OF HEALTH GUIDELINES

Ministry of Health. *Communicable disease control manual*. Wellington: Ministry of Health, 1998.

Ministry of Health. *Guidelines for the control of methicillin-resistant Staphylococcus aureus in New Zealand*. Wellington: Ministry of Health, 2002.

Ministry of Health. *Guidelines for the control of multidrug-resistant organisms in New Zealand*. Wellington: Ministry of Health, 2007.

Ministry of Health. *Guidelines for the management of norovirus outbreaks in hospitals and elderly care institutions*. Wellington: Ministry of Health, 2007.

Ministry of Health. *Guidelines for tuberculosis control in New Zealand 2003*. Wellington: Ministry of Health, 2002.

Ministry of Health. *Immunisation handbook 2006*. Wellington: Ministry of Health, 2006.

Public Health Commission. *Guidelines for the control of legionellosis: Guidelines for public health services*. Wellington: Public Health Commission, 1995.

Te Puni Kokiri. *Hauora o te Tinana me ōna Tikanga: A guide for the removal, retention, return and disposal of Māori body parts, organ donation and post-mortem: Māori and their whānau*. Wellington: Te Puni Kokiri, 1999.

Te Puni Kokiri. *Hauora o te tinana me ōna tikanga: A guide for the removal, retention, return and disposal of Māori body parts, organ donation and post-mortem : Māori and their whānau*. Wellington: Te Puni Kokiri, 1999.

CENTER FOR DISEASE CONTROL AND PREVENTION (CDC) GUIDELINES

<http://www.cdc.gov>

CDC. *Guideline for isolation precautions: Preventing transmission of infectious agents in healthcare settings*. Atlanta: CDC, 2007.

CDC. *Guideline for preventing healthcare-associated pneumonia*. Atlanta: CDC, 2003.

CDC. 'Guidelines for infection control in dental healthcare settings.' *Morbidity and Mortality Weekly Report* RR-17 (2003).

CDC. *Guidelines for the prevention of surgical site infection*. Atlanta: CDC, 1999.

CDC. *Guidelines for the prevention of intravascular device-related infections*. Atlanta: CDC, 2002.

CDC. *Guidelines for environmental infection control in health-care facilities*. Atlanta: CDC, 2003.

CDC. 'Guidelines for infection control in healthcare personnel.' *American Journal of Infection Control* 26 (1998) 289 – 354.

CDC. 'Guidelines for preventing the transmission of mycobacterium tuberculosis in health-care facilities.' *Morbidity and Mortality Weekly Report* vol. 55 RR-17 (1994) 1 – 142.

CDC. 'Guidelines for the management of occupational exposures to hepatitis B, hepatitis C, and HIV, and recommendations for postexposure prophylaxis.' *Morbidity and Mortality Weekly Report* Vol. 50 RR-11 (2001) 1 – 52.

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CDC. *NIOSH guide to the selection and use of particulate respirators*. Atlanta: CDC, 1996.

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CDC. 'Recommendations for preventing transmission of infections among chronic hemodialysis patients.' *Morbidity and Mortality Weekly Report* vol. 50 RR-5 (2001).

CDC. *12 steps to prevent antimicrobial resistance among hospitalized adults*. Atlanta: CDC, 2003.

ASSOCIATION FOR PROFESSIONALS IN INFECTION CONTROL AND EPIDEMIOLOGY (APIC) GUIDELINES AND STATE OF THE ART REPORTS

Alvarado, C J, and Reichelderfer, M. 'APIC Guideline for infection prevention and control in flexible endoscopy.' *American Journal of Infection Control* 28 (2000): 138 – 155.

Bartley, J M. 'APIC State-of-the-art report: The role of infection control during construction in health care facilities.' *American Journal of Infection Control* 28 (2000) 156 – 69.

Duncan, S L. 'APIC State-of-the-art report: The implications of service animals in health care settings.' *American Journal of Infection Control* 28 (2000) 170 – 180.

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Rutala, W A. 'APIC Guideline for selection and use of disinfectants.' *American Journal of Infection Control* 24 (1996): 313 – 42.

GENERAL

American Institute of Architects. *Guidelines for design and construction of healthcare facilities*. Washington: AIA, 2006.

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Drinka, T J K and Clark, P G. *Health care teamwork: Interdisciplinary practice & teaching*. Westport, CT: Greenwood Publishing Group, 2000.

Neal, L J editor. *Rehabilitation nursing in the home health setting*. Glenview: Association of Rehabilitation Nurses, 2002.

Queensland Health. *Capital works guidelines – Building and refurbishment: Infection control guidelines*. Brisbane: Queensland Government, 2002.

Ward, V, Wilson, J, Taylor, L et al. *Preventing hospital-acquired infection: Clinical guidelines*. London: Public Health Laboratory Service, 1997.

RECOMMENDED JOURNALS

American Journal of Infection Control (AJIC). Available at <http://www.ajicjournal.org/>

Infection Control and Hospital Epidemiology. Available at <http://www.journals.uchicago.edu/loi/iche>

Infection Control. New Zealand Nurses Organisation National Division of Infection Control. Available at <http://www.infectioncontrol.co.nz>

International Journal of Infection Control. Available at <http://www.theifc.org/journal.asp>

Journal of Hospital Infection. Available on <http://intl.elsevierhealth.com/journals/jhin>

Morbidity and Mortality Weekly Report (MMWR). Available on <http://www.cdc.gov/mmwr>

New Zealand Public Health Report (NZPHR). Available on <http://www.surv.esr.cri.nz/surveillance/NZPHSR.php>

WEBSITES

Australian and New Zealand College of Anaesthetists <http://www.anzca.edu.au>

Australian College of Operating Room Nurses (ACORN) <http://www.acorn.org.au>

Australian Council of Healthcare Standards <http://www.achs.org.au>

American Academy of Pediatrics <http://aapredbook.aappublications.org/>

Association of Perioperative Registered Nurses (AORN) <http://www.aorn.org/>

Association for Professionals in Infection Control and Epidemiology (APIC) <http://www.apic.org/>

Center for Disease Control and Prevention (CDC) <http://www.cdc.gov/>

European Society of Clinical Microbiology and Infectious Diseases <http://www.escmid.org>

Evidence Based Practice in Infection Control (EPIC) <http://www.epic.tvu.ac.uk/>

Hand Hygiene Resource Center (HHRC) <http://www.handhygiene.org/>

HepNet – the Hepatitis Information Network <http://hepnet.com/news.html>

Hospitals Infection Program <http://www.cdc.gov/ncidod/dhqp/index.html>

Infection Control in Healthcare Settings <http://infectionctrl-online.com/>

Johns Hopkins POC – IT Center <http://hopkins-abxguide.org/>

Medicines and Healthcare GET_ Products Regulatory Agency http://www.mhra.gov.uk/home/idcplg?IdcService=SS_PAGE&nodeId=5

Medscape <http://www.medscape.com/>

National Nosocomial Infections Surveillance System (NNIS) http://www.cdc.gov/ncidod/dhqp/nnis_pubs.html



National Patient Safety Agency (NPSA) – Clean your hands campaign	http://www.npsa.nhs.uk/cleanyourhands
National Resource for Infection Control (NRIC)	UK http://www.nric.org.uk
New Zealand Ministry of Health	http://www.moh.govt.nz/
Standards New Zealand	http://www.standards.co.nz/
The Cochrane Collaboration	http://cochrane.org
The Royal Institute of Public Health	http://www.riphh.org.uk
US Food and Drug Administration	http://www.fda.gov
World Health Organization	http://www.who.org

PROFESSIONAL ASSOCIATIONS

Australian Infection Control Association	http://www.aica.org.au
Community and Hospital Infection Control Association of Canada (CHICA-Canada)	http://www.chica.org/
Infection Control Association NSW Inc (ICA)	http://www.icansw.org.au
Infection Control Association (Singapore)	http://www.icas.org.sg/
Infection Control Association of Southern Africa	http://www.infection.co.za/
Infection Control Nurses Association (Europe)	http://www.icna.co.uk
International Federation of Infection Control	http://www.theifc.org
NZNO National Division Infection Control Nurses	http://www.infectioncontrol.co.nz
Society for Healthcare Epidemiology of America (SHEA)	http://www.shea-online.org
The Association for Professionals in Infection Control and Epidemiology (APIC)	http://www.apic.org/Infection

MICROBIOLOGY

American Society for Microbiology	http://www.asm.org
Association of Medical Microbiologists	http://www.amm.co.uk
Bugs & Drugs on the Web	http://www.antibioticresistance.org.uk/ARFAQs.nsf/About?OpenPage
Cells Alive	http://www.cellsalive.com
Fleming Forum	http://www.flemingforum.org.uk
Gallery Electron Microscope Work. Dennis Kunkel	http://www.denniskunkel.com/
Microbe World	http://www.microbeworld.org/
National Centre for infectious diseases	http://www.cdc.gov/ncidod/id_links.htm

NOTES

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New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards – Infection control management

Superseding NZS 8142:2000

NZS 8134.3.1:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.1: INFECTION CONTROL MANAGEMENT WHAKAHAERENGA WHAKATINA WHAKAPOKENGĀ

NOTES

Copyright Standards New Zealand

CONTENTS

Foreword.....5

Standard 1 Infection control management.....7

Copyright Standards New Zealand

NOTES

Copyright Standards New Zealand

FOREWORD

The aim of NZS 8134.3 is to facilitate quality and consistently safe health and disability services by identifying practices designed to reduce the rate of infections in the health and disability sector.

NZS 8134.3 is applicable to all health and disability services. The Standards are mandatory for those services that are subject to the Health and Disability Services (Safety) Act 2001. Other health and disability services, should consider adopting them as they promote current accepted good practice.

The benefits and desired outcome of implementing NZS 8134.3 are:

- (a) Improved safety for consumers, staff, and visitors;
- (b) Increased attention to the basic principles of infection control;
- (c) Identifying a consistent and applicable infection control baseline for services.

This document is intended to be generic and address the basic principles and systems that are the foundation for effective infection control. It is not intended to be an infection control manual or educational tool.

NZS 8134.3 *Health and disability services (infection prevention and control) Standards* includes referenced and related documents and guidelines along with the following Standards:

- (a) NZS 8134.3.1 – Infection control management;
- (b) NZS 8134.3.2 – Implementing the infection control programme;
- (c) NZS 8134.3.3 – Policies and procedures;
- (d) NZS 8134.3.4 – Education;
- (e) NZS 8134.3.5 – Surveillance;
- (f) NZS 8134.3.6 – Antimicrobial usage.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

- G 1** Infection control management is a set of systems and structures which organisations should have in place to safeguard and improve the quality of care.
- G 1.1** The lines of accountability define the relationships between management/governing body, quality/risk management, clinical governance body, infection control committee, and infection control team/personnel.
- There is evidence of an assessment of the organisation's needs for infection control that specifies requirements such as resources, job descriptions, and terms of reference.
- G 1.3** Each organisation is unique. The content and detail of the programme should be appropriate to the size, complexity, and degree of risk associated with the services provided.
- Priority is to be given to managing risk in relation to infection control and there is a process that clearly demonstrates this.
- G 1.4** Relevant key stakeholders may include but are not limited to:
- (a) Infection control specialists, physicians, and nurses;
 - (b) Clinical microbiologists;
 - (c) Service providers including clinical staff;
 - (d) Public Health Units of District Health Boards (DHBs);
 - (e) Quality Improvement Teams;
 - (f) Medical Officers of Health;
 - (g) Consumers.
- G 1.6** The committee is a group that provides representation from relevant disciplines within the organisation and has overview of the infection control programme. For smaller organisations this committee could be part of an already established committee involved in quality or other activities.
- G 1.7** This may include but is not limited to:
- (a) Endorsing the infection control programme, associated policies, and procedures;
 - (b) Assisting in the implementation of the programme;
 - (c) Monitoring the progress of the infection control programme;
 - (d) Documenting the frequency of the review of the programme;
 - (e) Ensuring a process exists for timely reporting of notifiable diseases and notifiable outbreaks to the local Medical Officer of Health; and
 - (f) Any reporting requirements to other key stakeholders/interested parties.
- G 1.8** There is a clear process for consultation and planning including infection control expertise for facility changes, including renovation and design of buildings and staffing changes, when a change in staff ratio, skill mix, or additional services will impact on infection control risk.
- G 1.9** In rare situations (for example measles, avian influenza) exposed susceptible contacts will be absented from work on the advice of the service provider's general practitioner, the occupational health service and/or public health services.
- Visitors may be restricted from entering healthcare facilities.
- Consumers may require a transfer to an appropriate specialist service to meet their needs.

INFECTION CONTROL MANAGEMENT

WHAKAHAERENGA WHAKATINA WHAKAPOKENG

Standard 1 **There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

- 1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.
- 1.2 Reporting lines and frequency are clearly defined within the organisation including processes for prompt notification of serious infection control related issues.
- 1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.
- 1.4 The infection control programme is developed in consultation with relevant key stakeholders, taking into account the risk assessment process, monitoring and surveillance data, trends, and relevant strategies. The governing body/senior management shall approve the programme.
- 1.5 There is a defined process for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation.
- 1.6 There is an infection control team/personnel and/or committee that is appropriate for the size and the complexity of the organisation which is accountable to the governing body/senior management and monitors the progress of the infection control programme.
- 1.7 The role of the infection control team/personnel and/or committee shall be clearly identified.
- 1.8 There is a clear process for early consultation and feedback with the infection control person/team, when significant changes are proposed to staffing, practices, products, equipment, the facility, or the development of new services.
- 1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

NZS 8134.3.2:2008

New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards – Implementing the infection control programme

Superseding NZS 8142:2000



NZS 8134.3.2:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.2: IMPLEMENTING THE INFECTION CONTROL PROGRAMME WHAKATINANA I TE HŌTAKA WHAKATINA WHAKAPOKENGĀ

NOTES

Copyright Standards New Zealand

CONTENTS

Foreword.....	5
Standard 2 Implementing the infection control programme	7

Copyright Standards New Zealand

NOTES

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FOREWORD

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- (f) NZS 8134.3.6 – Antimicrobial usage.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

- G 2** Staffing and other resources required to implement the infection control programme should take into account the size and complexity of the organisation and its served population, and should meet the expectations of accepted infection control practices.
- G 2.1** These skills and expertise may be externally contracted.
- The number of staff required is not based solely on inpatient bed numbers. For example, in large complex facilities, provision should be made for the needs of outpatient services, special care units (such as intensive care units and neonatal units), community-based health services, mental health and addiction services, and exceptionally vulnerable consumers such as those with compromised immunity.
- Depending on the size and complexity of the service, infection control personnel should have access to adequate resources to enable them to achieve their responsibilities. This may include but is not limited to:
- (a) Office space;
 - (b) Secure storage for records;
 - (c) Access to relevant information and resources such as at least one current infection control text, relevant journals, bibliographic databases, library, the internet, and infection control personnel;
 - (d) Dedicated time allocated to meet the needs of the programme;
 - (e) Sufficient administrative, information technology (IT), and audit staff.
- G 2.2** This may include but is not limited to;
- (a) Implementation of infection control policies and procedures;
 - (b) Education;
 - (c) Ensuring advice and information is available on infection control and prevention;
 - (d) Surveillance;
 - (e) Ensuring links to the organisation's quality and risk management programmes are established and maintained;
 - (f) Reporting and making recommendations to the infection control committee/governing body/senior management on infection control and prevention.
- G 2.4** Successful case finding, surveillance, and investigation of outbreaks are dependent on access to the consumer information management system. Infection control personnel should be able to access electronic data systems directly where these exist. Consumer confidentiality is maintained in line with current legislation, including the Privacy Act and Health Information Privacy Code.

IMPLEMENTING THE INFECTION CONTROL PROGRAMME

WHAKATINANA I TE HŌTAKA WHAKATINA WHAKAPOKENGĀ

Standard 2 **There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

- 2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.
- 2.2 The infection control team/personnel and/or committee shall facilitate implementation of the infection control programme.
- 2.3 The infection control team/personnel members shall receive continuing education in infection control and prevention.
- 2.4 The infection control team/personnel shall have access to records and diagnostic results of consumers.

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New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards – Policies and procedures

Superseding NZS 8142:2000

NZS 8134.3.3:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.3: POLICIES AND PROCEDURES

NGĀ KAUPAPAHERE ME NGĀ WHAKARITENGA

NOTES

Copyright Standards New Zealand

CONTENTS

Foreword.....	5
Standard 3 Policies and procedures.....	7

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NOTES

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FOREWORD

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- (d) NZS 8134.3.4 – Education;
- (e) NZS 8134.3.5 – Surveillance;
- (f) NZS 8134.3.6 – Antimicrobial usage.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

- G 3.1** It is recommended that all policies and procedures should:
- (a) Include written material relevant to the organisation;
 - (b) Reflect current accepted good practice and relevant legislative requirements;
 - (c) Have sufficient flexibility to respond to individual consumer/service needs;
 - (d) Be in a user-friendly format;
 - (e) Contain the appropriate level of technical information;
 - (f) Be readily accessible to all personnel;
 - (g) Be developed and reviewed regularly in consultation with relevant service providers; and
 - (h) Identify the links to other documentation within the organisation.
- G 3.2 (a)** Hand hygiene is a critical measure for reducing the transmission of infection. The timeliness of hand hygiene, technique, and appropriate products for the setting should be included in any hand hygiene policy or procedure;
- G 3.2 (b)** Standard precautions are designed to reduce the risk of acquiring and spreading infective organisms. Standard precautions should be used at all times. Standard precautions:
- (a) Apply to all;
 - (b) Are designed to protect staff and consumers;
 - (c) Ensure that personal protective equipment is provided and used when in contact with blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin;
 - (d) Are used at all times when transmission-based precautions may be required; and
 - (e) Include cough etiquette, which is important in the prevention of respiratory transmissible illnesses;
- G 3.2 (c)** Transmission-based precautions cover:
- (a) The isolation precautions required to manage those people who are diagnosed with or suspected of having infectious diseases;
 - (b) The management of those pathogens with clinical significance, such as multi-resistant organisms; and
 - (c) Providing a protective environment for severely immunocompromised persons.
- G 3.2 (d)** The prevention of infection and management of personnel with infectious, communicable diseases and potential pathogens of clinical and public health significance, such as chickenpox, tuberculosis, multi-resistant organisms. The policies and procedures should include:
- (a) Assessment;
 - (b) Placement;
 - (c) Immunisation; and
 - (d) Exposure management issues.
- G 3.2 (e)** See NZS 8134.3.6;
- G 3.2 (f)** Outbreak management/pandemic planning procedures should include information on the investigation and management of suspected or actual outbreaks;
- G 3.2 (g)** The method of cleaning, disinfection and sterilisation should meet AS/NZS 4815 and AS/NZS 4187;
- G 3.2 (h)** Single use items are manufactured for a single patient or a single episode. Reprocessing is at the organisations risk, as it may pose a risk to the consumer;
- G 3.2 (i)** The risk of airborne infection created by environmental disturbances to consumers during renovation and construction. Services should ensure design and function is consistent with infection control principles.
- G 3.3** This consultation and input may include but is not limited to:
- (a) Cleaning, disinfection, and sterilisation of reusable medical devices;
 - (b) Kitchen or catering;
 - (c) Environmental services, for example cleaning;
 - (d) Laundry;
 - (e) Waste;
 - (f) Clinical procedures;
 - (g) Pandemic planning;
 - (h) Occupational health (needlestick injuries and other blood and body fluid exposures, pre-employment, and ongoing screening as appropriate);
 - (i) Ventilation and air quality systems.

POLICIES AND PROCEDURES

NGĀ KAUPAPAHERE ME NGĀ WHAKARITENGA

Standard 3 Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

- 3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.
- 3.2 Policies and procedures shall include but are not limited to:
 - (a) Hand hygiene;
 - (b) Standard precautions;
 - (c) Transmission-based precautions;
 - (d) Prevention and management of infection in service providers;
 - (e) Antimicrobial usage;
 - (f) Outbreak management;
 - (g) Cleaning, disinfection, sterilisation, and reprocessing of reusable medical devices (if applicable) and equipment;
 - (h) Single use items; and
 - (i) Renovations and construction.
- 3.3 Policies and procedures (whether or not developed by contracted services or in-house services) that may affect the transmission of infection shall clearly identify who is responsible for the policy development and implementation, and shall be consistent with infection control policies and principles. Processes shall be in place to ensure ongoing infection control team/personnel involvement.

NZS 8134.3.4:2008

New Zealand Standard



Health and Disability Services (Infection Prevention and Control) Standards – Education

Superseding NZS 8142:2000

NZS 8134.3.4:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.4: EDUCATION MĀTAURANGA

NOTES

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CONTENTS

Foreword.....	5
Standard 4 Education.....	7

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NOTES

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FOREWORD

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G 4.2

This may include but is not limited to:

- (a) Policies/guidelines and key infection control issues relevant to the service;
- (b) How staff can access current infection control information;
- (c) Hand hygiene;
- (d) Standard and transmission-based precautions;
- (e) Blood and body fluid exposure management;
- (f) Outbreak identification and management;
- (g) Prudent antimicrobial prescribing;
- (h) Cleaning, disinfection, and sterilisation practices of medical devices and equipment;
- (i) Practice in relation to single-use items; and
- (j) Surveillance.

G 4.5

This may include information and/or education for relatives and visitors, for example, pamphlets on infectious diseases such as Methicillin-resistant *Staphylococcus aureus* (MRSA).

EDUCATION MĀTAURANGA

Standard 4 **The organisation provides relevant education on infection control to all service providers, support staff, and consumers.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

- 4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.
- 4.2 All service providers and support staff receive orientation and ongoing education on infection control that is relevant to their practice within the service or organisation.
- 4.3 Infection control education is evaluated to ensure the content is pertinent to the scope of service and reflects current accepted good practice.
- 4.4 The content of infection control education sessions is documented and a record of attendance maintained.
- 4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

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NZS 8134.3.5:2008



New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards – Surveillance

Superseding NZS 8142:2000

NZS 8134.3.5:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.5: SURVEILLANCE ĀROHI

NOTES

Copyright Standards New Zealand

CONTENTS

Foreword.....	5
Standard 5 Surveillance.....	7
Appendix	
A Surveillance – Additional information (Informative)	8
Table	
A1 Surveillance guide	9

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NOTES

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FOREWORD

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- (d) NZS 8134.3.4 – Education;
- (e) NZS 8134.3.5 – Surveillance;
- (f) NZS 8134.3.6 – Antimicrobial usage.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

- G 5.1** Reference should be made to:
- (a) Appendix A;
 - (b) The Ministry of Health mandatory hospital acquired blood stream infection surveillance programme; and
 - (c) The Institute of Environmental Science and Research Ltd (ESR) multi-drug resistant organism (MDRO) surveillance programme.
- G 5.2** These should include but are not limited to:
- (a) Multi-drug resistant organisms including:
 - (i) Methicillin resistant *Staphylococcus aureus* (MRSA);
 - (ii) Extended spectrum beta-lactamase producing enterobacteriaceae (ESBLs), and
 - (iii) Vancomycin resistant *enterococci* (VRE);
 - (b) *Clostridium difficile*.
- G 5.3** Effective surveillance requires the support and cooperation of clinicians, service providers, and management who provide clinical services in which there is a risk of acquiring infection.
- G 5.4** Accurate information can only be obtained if all persons involved in surveillance have the same understanding of what is meant by certain terms. Therefore standardised definitions of infection events, indicators, and outcomes are used and these increase the likelihood that any observed changes or trends are real and not due to differences in interpretation of terms.
- The definitions of infection events, indicators, and outcomes used should reflect the organisation's needs and outcomes/goals. These definitions will be different for different types of facilities (see table A1 in Appendix A). In general, facilities should use or adapt definitions developed and published by national, international, or other surveillance organisations.
- G 5.6** The type(s) of surveillance chosen will vary according to the objectives of the surveillance programme (see table A1 in Appendix A). In general, the larger the facility or the greater the number of events detected, the more frequent should be the surveillance and the reporting of surveillance activities.
- G 5.7** The findings, outcomes, and recommendations which follow surveillance activities should be recorded and tabled at the nearest timely meeting of the infection control committee. A summary should be lodged with senior management and recommended follow up should be acted upon and supported with documentation.

SURVEILLANCE

ĀROHI

Standard 5 **Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

- 5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.
- 5.2 Surveillance shall be conducted on multi-resistant organisms and organisms associated with antimicrobial use.
- 5.3 Senior management and all service providers shall take responsibility for surveillance activities and promote surveillance monitoring as one of the premier quality assurance programmes impacting on consumer safety.
- 5.4 Standardised definitions are used for the identification and classification of infection events, indicators, or outcomes.
- 5.5 The type of surveillance to be undertaken should be appropriate for the organisation, including:
 - (a) Size;
 - (b) Type of services provided;
 - (c) Acuity, risk factors, and needs of the consumer;
 - (d) Risk factors to service providers.
- 5.6 The surveillance methods, analyses, and assignment of responsibilities are described and documented.
- 5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.
- 5.8 There is evidence of communication between services on consumers who develop infection.

APPENDIX A

SURVEILLANCE – ADDITIONAL INFORMATION

(Informative)

- A1 Events under surveillance may be detected in a variety of ways. These may include but are not limited to, chart review, walk rounds, review of laboratory reports, medication or pharmacy records, or notification by medical staff. A surveillance programme should incorporate at least two different detection or case finding methods. If possible, one of these should entail active surveillance, where infection control personnel actively look for the events under surveillance such as on walk rounds, as opposed to passive surveillance where infection control personnel rely on others to report the events.
- A2 For each type of infection event, indicator or outcome identified, the data collected should include basic consumer demographics and infection or outcome information as well as information on known consumer risk factors such as invasive devices or procedures. The frequency of data collection will depend on the type of surveillance, the event being monitored, and the size and type of the service or facility (see table A1).
- A3 Data analysis may include but is not limited to a review of the quantity, frequency, source, site, and type of event. When identifying variations and trends in event occurrence, numbers of Infection events, indicators, and outcomes are not generally as useful as infection rates. Rates compensate for fluctuations in the size of the population under surveillance and are a more accurate reflection of what is occurring. The denominator used to calculate rates will be different for different kinds of surveillance and for different types of services or facilities (see table A1).
- A4 Systematic surveillance refers to the regular collection, collation, and analysis of information on infection events and rates, either continuously or at regular intervals, and the timely dissemination and feedback of data. The projected use of the data shows how the data will be used to evaluate or assess infection control activities.
- Surgical facilities should, as a basic minimum activity, undertake continuous surveillance of *Staphylococcus aureus* blood stream infections and conduct regular surveillance of wound infection rates following clean surgical procedures in joint replacement surgery and Caesarean sections.

TABLE A1 – SURVEILLANCE GUIDE

	Hospitals and acute care facilities	Rest home facilities	Office-based and home care	Community residential
Standardised definitions	<ul style="list-style-type: none"> Usually requires laboratory confirmation or clinician diagnosis 	<ul style="list-style-type: none"> Usually place greater reliance on signs and symptoms and less reliance on clinician, laboratory, or radiological confirmation 	<ul style="list-style-type: none"> Variable, depending on type of event under surveillance 	<ul style="list-style-type: none"> Variable, depending on type of event under surveillance
Types of surveillance	<ul style="list-style-type: none"> Larger facilities usually target specific types of events or specific high risk areas Smaller facilities usually target specific types of events or all events facility-wide Post-discharge surveillance for specific events such as surgical site infections (SSIs) 	<ul style="list-style-type: none"> Usually target specific events or all events facility-wide 	<ul style="list-style-type: none"> Usually target specific types of events or all events 	<ul style="list-style-type: none"> Usually target specific types of events or all events
Types of events typically monitored	<ul style="list-style-type: none"> Surgical site infections (SSIs) <i>Staphylococcus aureus</i> septicaemia Pneumonias Device-related infections Multi resistant micro-organisms 	<ul style="list-style-type: none"> Lower respiratory tract infections (LRTIs) Skin and soft tissue infections (SSTIs) (such as cellulitis, infected pressure sores) Influenza Urinary tract infections (UTIs) Eye infections 	<ul style="list-style-type: none"> Device-associated infections Procedure associated infections 	<ul style="list-style-type: none"> Gastroenteritis Skin infections Infestations
Data collection	<ul style="list-style-type: none"> Continuous or intermittent For acute events or in high risk areas such as ICUs, data collection may be daily 	<ul style="list-style-type: none"> Regular at least monthly 	<ul style="list-style-type: none"> Regular at least monthly 	<ul style="list-style-type: none"> Regular at least monthly
Data analysis: rate calculations	<ul style="list-style-type: none"> As per ACHS (Australian Council of Healthcare Standards) 	<ul style="list-style-type: none"> Number and type of infections occurring in a defined time period 	<ul style="list-style-type: none"> Number and type of infections occurring in a defined time period 	<ul style="list-style-type: none"> Number and type of infections occurring in a defined time period
Frequency of report to governing body	<ul style="list-style-type: none"> Twice a year or more frequently 	<ul style="list-style-type: none"> Minimum once a year 	<ul style="list-style-type: none"> Minimum once a year 	<ul style="list-style-type: none"> Minimum once a year
Frequency of programme review	<ul style="list-style-type: none"> For larger facilities, usually twice a year For smaller facilities, usually once a year 	<ul style="list-style-type: none"> Once a year 	<ul style="list-style-type: none"> Once a year 	<ul style="list-style-type: none"> Once a year
NOTE – This table is provided as a guide.				



New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards – Antimicrobial usage

Superseding NZS 8142:2000

NZS 8134.3.6:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.6: ANTIMICROBIAL USAGE WHAKAMAHINGA ANTIMICROBIAL

NOTES

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CONTENTS

Foreword.....	5
Standard 6 Antimicrobial usage.....	7

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NOTES

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G 6.5

Antibiotic guidelines should:

- (a) Be consistent with local resistance data;*
- (b) Discourage indiscriminate use of third and fourth generation Cephalosporins and older broad spectrum antibiotics;*
- (c) Have clear recommendations for dose, timing, and duration of surgical prophylaxis.*

ANTIMICROBIAL USAGE

WHAKAMAHINGA ANTIMICROBIAL

Standard 6 Acute care and surgical hospitals will have established and implemented policies and procedures for the use of antibiotics to promote the appropriate prudent prescribing in line with accepted guidelines. The service can seek guidance from clinical microbiologists or infectious disease physicians.

For a residential home/unit or aged care service, it is the consumer's individual GP who is responsible for guidance on the management of antibiotic use.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

- 6.1 *The organisation, medical practitioner or other prescriber has an antimicrobial policy which is consistent with the current accepted practice of prudent use in the treatment of infections.*
- 6.2 *Where prophylactic antibiotics are prescribed, a policy/guideline exists for their appropriate use.*
- 6.3 *Evidence of good practice guideline use, or specialist advice on antimicrobial therapy and prophylaxis can be demonstrated.*
- 6.4 *Regular auditing and monitoring of compliance with prophylactic and therapeutic antimicrobial policies shall be a component of the facility's infection control programme.*
- 6.5 *Information on the antimicrobial susceptibility patterns of significant clinical isolates should be fed back to the infection control team/personnel and prescriber by the local diagnostic laboratory.*

S*

* applies to acute, secondary or tertiary services only

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