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Exploring barriers, enablers and opportunities to best practice infection prevention and control in residential aged care homes

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Acknowledgements



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IMMERSE 

This project is funded by the MRFF Dementia, Ageing and Aged Care Mission

Background



IMpleMenting Effective infection prevention and control in ReSidential aged carE (IMMERSE)

To identify and address barriers to best practice infection prevention and control (IPC) in residential aged care – implementation research

Inappropriate care is a pressing problem in health care – evidence to practice gaps

In Australia 10%–87% of care received was inappropriate (Runciman WB, MJA 2012)

Improving and sustaining good IPC practice in residential aged care can be challenging
Several stakeholders – aged care workers, residents, families, visiting health care workers



Bottom-up Approach – Behavioural perspective



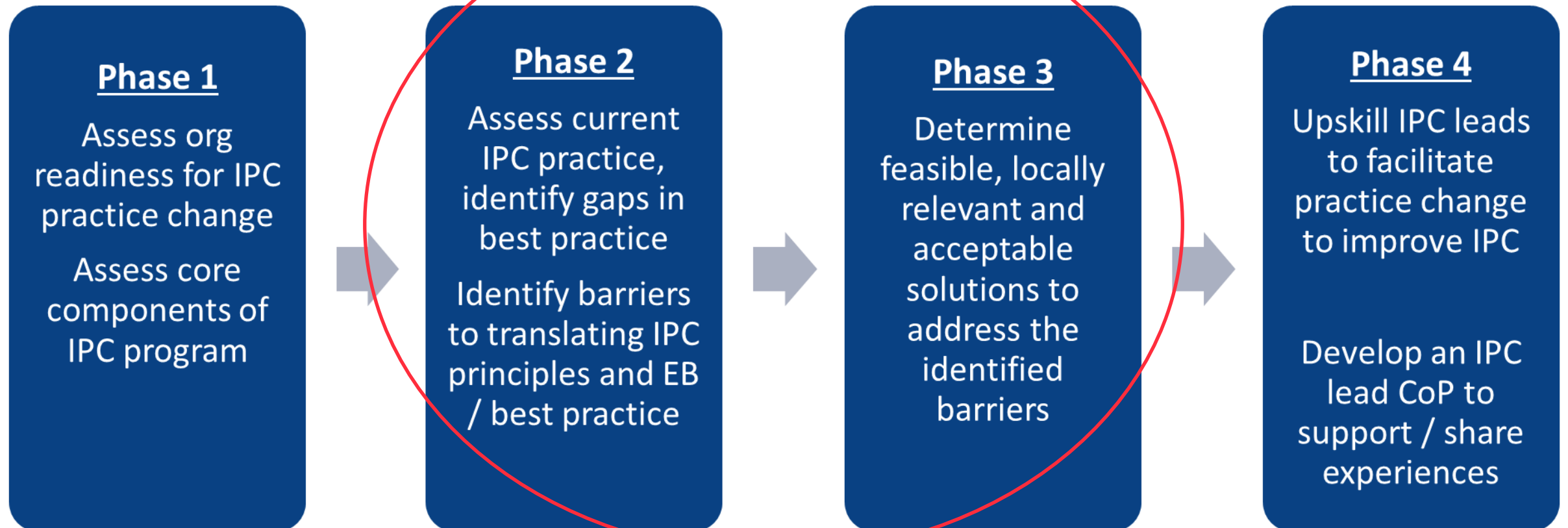
Understand the problem before jumping to the solutions

1. Who needs to do what, differently?
2. What factors influence whether or not they do it?
Barriers and enablers to performing these behaviours
3. Which strategies can be effectively used to target those factors?
4. How best to evaluate success of the implementation intervention?

The IMMERSE project



Objectives: To identify and address barriers to best practice infection prevention and control (IPC) in residential aged care



Identify the evidence to practice gap



Ways to achieve this – use existing resources/information (staff feedback, complaints and complements), observe, data from audits, ask staff

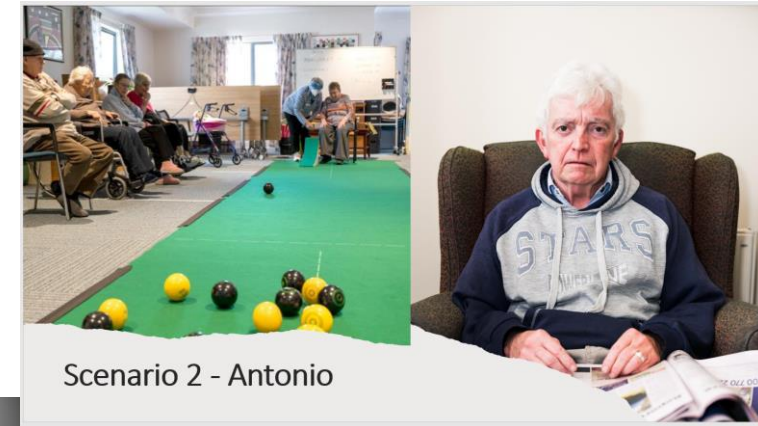
What we did in IMMERSE – scenarios similar to vignettes

Identified areas of good practice

For example, *Assist resident to wash hands with soap and water when the resident's hands are potentially soiled*

And 10 evidence-practice gaps

For example, *Perform hand hygiene after cleaning and disinfecting shared equipment and touched surfaces*



Scenario 2 - Antonio



Scenario 1 - Mary



Explore factors that influence whether or not they do it



Interviewed staff about their knowledge, skills, beliefs, attitudes (and other topics known to affect behaviour) related to the selected IPC priority area

Barriers

- **Environmental context and resources** – access to sinks for hand washing, or ABHR in communal areas (removed because resident with cognitive impairment was drinking it)
- **Emotion** – feeling they are wasting “clean” gloves

Enablers or facilitators

- Staff had good **knowledge** of IPC. For example, why they perform hand hygiene, where to find information on IPC at their facility
- **Memory** - Visual cues or prompts for performing hand hygiene or donning/doffing PPE
- **Role & identity** - Staff felt it was their responsibility to ensure enough IPC products on the floor



NAME OF FACILITY
SUMMARY OF PHASE 2 IMMENSE FINDINGS



Priority infection prevention and control (IPC) areas

The two priority IPC areas selected by (NAME OF PERSON AND ROLE) were:

1. Performing hand hygiene before and after helping a resident transfer
2. Changing gloves (removing and disposing) and performing hand hygiene between procedures or tasks involving residents



What we did

We interviewed three staff (ENs, RN) with varying levels of residential aged care experience and asked them about their knowledge, skills, beliefs, and attitudes related to the above IPC areas



Enablers that facilitate good IPC practice

Staff interviewed

- had good knowledge of hand hygiene and IPC
- felt IPC was a high priority for them, their colleagues, and managers
- had high self-confidence in performing IPC
- reported hand hygiene was routine
- felt being prompted/reminded by colleagues or visual cues (when they see ABHR dispensers) helped them perform hand hygiene



Barriers that hinder good IPC practice

Barriers to performing best practice IPC were identified:

- Access to alcohol-based hand rub (ABHR) in some communal areas is limited where a resident was consuming it
- Suboptimal access to gloves and wipes in residents' rooms
- Some staff felt gloves are still "clean" after donning, and that it's a waste to throw these gloves away if they have not yet touched a resident or performed a task
- Staff interviewed had not had hand hygiene competency assessed

Recommended strategies to overcome these barriers:

- Adopt a risk assessment approach for placement of ABHR. Refer to [safety and quality guideline](#) on ABHR produce and placement options
- Staff suggested carrying their own small bottle of ABHR could help – they recalled doing this in the past
- Work with staff and consumers to look at ways to make it easier to access IPC products in residents' rooms – develop a facility-wide approach
- Senior staff & IPC champions reinforce correct glove use and how prolonged glove use can transmit infection
- Run regular hand hygiene competency assessment



Building on your good practice

To keep up best practice IPC, we suggest you continue to:

- hold regular staff training on IPC principles and hand hygiene
- conduct spot checks or audit with feedback of hand hygiene and appropriate use of PPE
- encourage staff to plan ahead at start of shift – nurses check for where PPE and hand hygiene products are, check supply of IPC on floor
- prompt/remind each other to perform hand hygiene



Sharing what we've learnt from other facilities involved in IMMENSE

We explored barriers to encouraging and assisting residents to perform hand hygiene when entering or leaving a communal area (for example, before and after meals or lifestyle activities) and found the following:

- Some staff reported they assist the resident with hand hygiene before or after a meal only if hands were visibly soiled
- It was not always priority area or part of their routine practice (however it is recommended that it should be routine practice where possible)

To overcome the above barriers, we suggested:

- Providing written (for example as part of protocols or procedures) and verbal information about health consequences and benefits of supporting residents with hand hygiene
- Work with staff and consumers to come up with ways to support residents with recommended hand hygiene before and after meals and during communal activities
- Encourage staff to plan ahead at start of shift, and check IPC supplies on floor
- Management to ensure adequate supply of multiple sizes of gloves and disinfectant wipes



Theoretical Domains Framework – 14 Constructs

KNOWLEDGE

SKILLS

ROLE AND IDENTITY

BELIEFS ABOUT CAPABILITIES

BELIEFS ABOUT CONSEQUENCES

OPTIMISM

REINFORCEMENT

INTENTION

GOALS

MEMORY, ATTENTION & DECISION PROCESSES

ENVIRONMENTAL CONTEXT & RESOURCES

SOCIAL INFLUENCES

EMOTION

BEHAVIOURAL REGULATION

Intervention functions – behaviour change techniques

Education/Instruction

Training

Enablement

Persuasion

Incentivisation

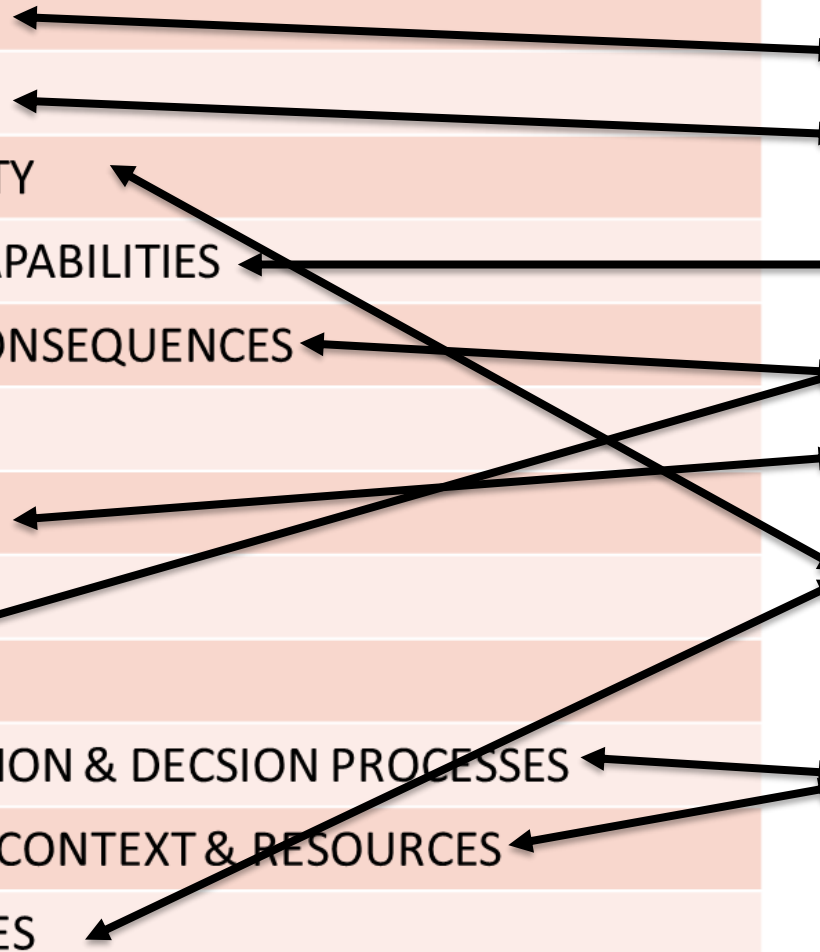
Modelling

Restrictions

Environmental restructuring (prompts, cues)

Coercion

*****MATCHING THE SOLUTION TO THE IDENTIFIED BARRIERS*****



What we've learnt from IMMERSE



Good news

- We identified many enablers and most of the barriers we did identify were not major barriers

Practice change takes time – start small

Importance of **engaging with stakeholders** - range of staff, involve residents and their families

- From start – for example to help identify areas that need improvement
- In the design – how to measure and explore the problem and how to improve
- Provide updates, feedback

Practice change takes resources

- IPC leads need support from leaders and their peers – best to work in a team, not in isolation
- Tap into available resources – new aged care IPC guidelines, other IPC leads within organisation, staff interested in IPC who are not IPC leads



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Thank you!

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