

ITEM: 11/067

Doc: 12

Meeting: Trust Board
Date: 27th April 2011

Title: Infection prevention and control report: 1st January – 31st March 2011 Haringey & Islington Community Health Services.

Executive Summary

Enhancing patient safety and best practice in preventing and controlling infection is a high priority in all NHS Trusts and other healthcare providers. Infection prevention and control practitioners are central to every effort to reduce the risk to patients from infection. The attached report outlines the position in relation to Infection Prevention and Control Performance and activity for 1st January 2011 – 31st March 2011 for Haringey & Islington Community Health Services.

MRSA Bacteraemia

There have been no cases of MRSA Bacteraemia diagnosed or associated within the Alliance during this reporting period, with the last case being May 2009.

MRSA Screening

Surveillance data shows there is 100% compliance to this within this reporting period

C-Difficile

There have been no cases of c. difficile during this reporting period and previous quarter.

Surgical Site Surveillance (SSI)

This is not applicable to community services within the Alliance and therefore is not monitored.

Urinary tract Infections (UTI's)

During this quarter there have been a total of 8 results from urine samples sent for laboratory analysis that have returned positive for pathogens known to cause UTI's. When this is compared with the data gathered and kept on the patients with indwelling urinary catheters there is no correlation with those that had catheters and those that were reported E. Coli / other causative pathogen. This is positive to note as the UTI's were not catheter related but it does indicate that a proportion of patients require better hydration and assistance in meeting good hydration levels than is currently happening. This has been shared with clinical staff, including dieticians, who ordinarily manage hydration in order to prevent UTI's.

Action: For information

Report from: Kris Khambhaita - Lead Nurse Infection Prevention & Control

Sponsor: Susan Tokley - AD Quality Assurance & DIPC

Compliance with Care Quality Commission Regulations / Outcomes

Lead: Director of Nursing & Clinical Development

Reference:

Regulation 12 / Outcome 8: Cleanliness and infection control

Infection Prevention and Control Surveillance Report

January – March 2011



Kris Khambhaita – Lead Nurse Infection Prevention & Control

7th April 2011

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Introduction and Background:

A Healthcare associated infection (HCAI) can seriously impact on a patient's quality of life. Along with the complexity of care already being received by patients in the community, a HCAI will mean healthcare professionals require increased resources to provide care and treatment, including time and prescription costs. It is almost impossible to pick up a newspaper today or watch the news broadcast without reading or hearing about infections; "killer bugs" such as *C. difficile* (*C.diff*) and Multidrug Resistant Staphylococcus Aureus (MRSA). Surveillance of HCAI's is key to their control and necessary to estimate rates of infection; which allows planning, monitoring of trends; enabling prevention of outbreaks. It also provides data for analysis towards planning infection prevention and control intervention strategies as well as to evaluate the impact of infection control intervention programmes in place.

In the last quarter the stroke rehabilitation in-patient area of Chestnut Ward; Greentrees Rehabilitation Unit based at St. Ann's Hospital has continued to implement the productive community hospital modules (Institute of Innovation). NHS Haringey has continued to participate fully with implementing the Cleanyourhands campaign until it formally closes next month. Edwards Drive is a residential respite home for residents of Haringey with learning difficulties. These patients are cared for by the GP and therefore mandatory surveillance and national targets are not applicable to this service however all current best practice and evidence based research initiatives are fully implemented to ensure clients and staff alike have a safe, quality experience, and infection prevented is given due consideration. There are no other healthcare in-patient areas within Haringey.

Within Islington Community Health Services there are no adult in-patient areas; Simmons House is a residential child and adolescents mental health service (CAMH's) with 22 residential beds; the clients are under the care of their registering GP. Similarly the inmates at Pentonville Prison that require healthcare input are under the care of their GP; both these areas therefore fall outside of the national mandatory surveillance reporting and national targets around HCAI's.

The Lead Nurse for Infection Prevention and Control provides infection prevention and control advice, support, staff education and conducts surveillance on Chestnut ward consisting of 32 beds, visiting the ward minimum twice a week. The below Surveillance data relates to the patient population who were in-patients on Chestnut ward and for this quarter covers the period 1st January 2011 – 31st March 2011.

The surveillance data collected focused on the following areas:

- *Clostridium difficile* (*c. difficile*)
- Multidrug Resistant Staphylococcus Aureus (MRSA) colonisation
- MRSA bacteraemia
- Micro-organisms that contribute to a urinary tract infection

Clostridium difficile

Other than prudent use of antibiotics the most important preventative measure in the fight against *C. difficile* is the use of standard precautions. These include hand hygiene, personal protective equipment (PPE), cleaning and decontamination of the clinical environment.

Samples were sent for each patient who had loose stools and / or diarrhoea after 48 hours of admission to Chestnut Ward. No samples returned with a *C. difficile* toxin positive result during this reporting period. There have been no cases of *C. difficile* infection being acquired by any in-patients in the past 16 months. It is encouraging to note this progress and it is a clear indicator of infection prevention and control strategies and the trust *C. diff* action plan making a positive difference within the clinical setting. It is hoped that the good practices that are in place in the current quarter continue whilst services undergo reforms.

MRSA

MRSA remains an important nosocomial pathogen which causes healthcare – associated infection in hospitals and in the community. Ayliff et al (1998) state that staphylococcus aureus is a versatile pathogen with the ability to develop or acquire resistance to many of the antibiotics and some of the antiseptics used in treating and preventing infection. All new referrals are screened on admission in line with the Department of Health (DH) screening guidelines.

MRSA colonisation

MRSA colonisation reflects the carriage of MRSA on the body, without clinical signs of infection. The numbers of patients' colonised within the in-patients area during this reporting period are outlined below.

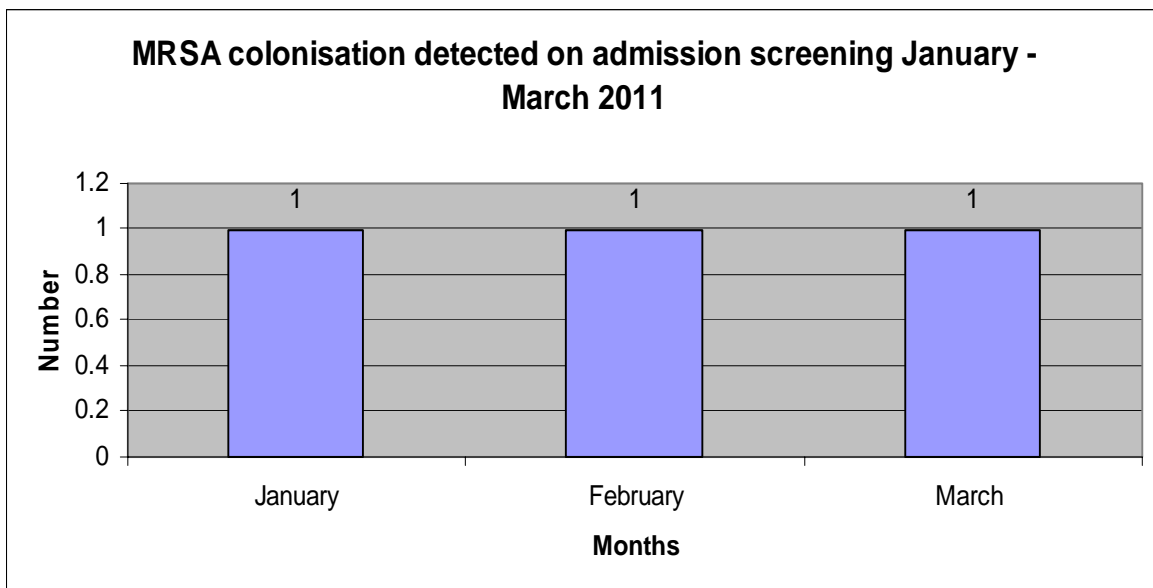


Figure 1: graph showing MRSA colonisation positive results for this reporting period

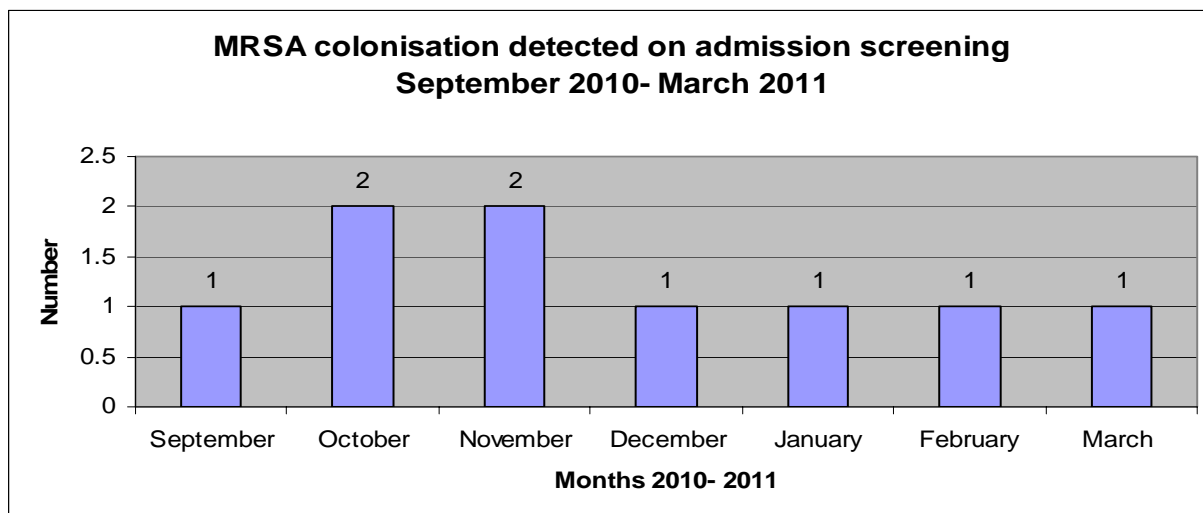


Figure 2: graph showing MRSA colonisation positive results last 6 months comparison.

Figure 1 above shows the colonisation rates for this quarter, while figure 2 provides a 6 month comparison. Figure 1 data represents admission screening specimens taken in 100% of admissions within 48 hours of arrival onto the ward which subsequently tested positive for MRSA colonisation (this was not known and not stated at time of referral). There are a total of 3 positive results, the same as the previous quarter. Close monitoring of this will continue and any significant increase will be notified to the ward ahead of the next quarterly report.

MRSA Bacteraemia

There have been zero MRSA bacteraemia infections in the last quarter. Since the IPC service was established 4 years ago; there has been only 1 recorded bacteraemia. A RCA was conducted and it concluded that this patient had previously had a bacteraemia at the acute sector shortly before being transferred into Greentrees, there were also actions for the nursing team to implement around communication and documentation.

Urinary Tract Infections (UTI's)

UTI's are the largest single group of HCAI and the presence of a urinary catheter and the duration of its insertion are contributory factors to the development of a urinary tract infection (Emmerson 1996). Catheterisation increases the risk of acquiring a urinary tract infection. The longer a catheter is in place, the greater the danger. The highest incidence of healthcare-associated infection is associated with indwelling urethral catheterisation. Many of these infections are serious and lead to significant morbidity. In acute care facilities, 20-30% of catheterised patients develop bacteriuria, of which 2-6% develop symptoms of UTI. The risk of acquiring bacteriuria is approximately 5% for each day of catheterisation, and therefore most patients with a long term catheter have bacteriuria after 30 days of catheterisation (Pratt et al 2007).

During this reporting period there have been a total of 3 results from urine samples sent for laboratory analysis that have returned positive for pathogens known to cause and contribute to UTI's as shown in figure 3. When this is compared with the data gathered and kept on the

patients with indwelling urinary catheters there is no correlation with those that had catheters and those that were reported E. coli / other causative pathogen positive. This is encouraging to note as the UTI's were therefore not catheter related but it does indicate that a proportion of patients require better hydration and assistance in meeting good hydration levels than is currently happening. This has been shared with clinical staff, including dieticians, who ordinarily manage hydration in order to prevent UTI's not associated with catheters. Figure 4 provides a 6 month comparison.

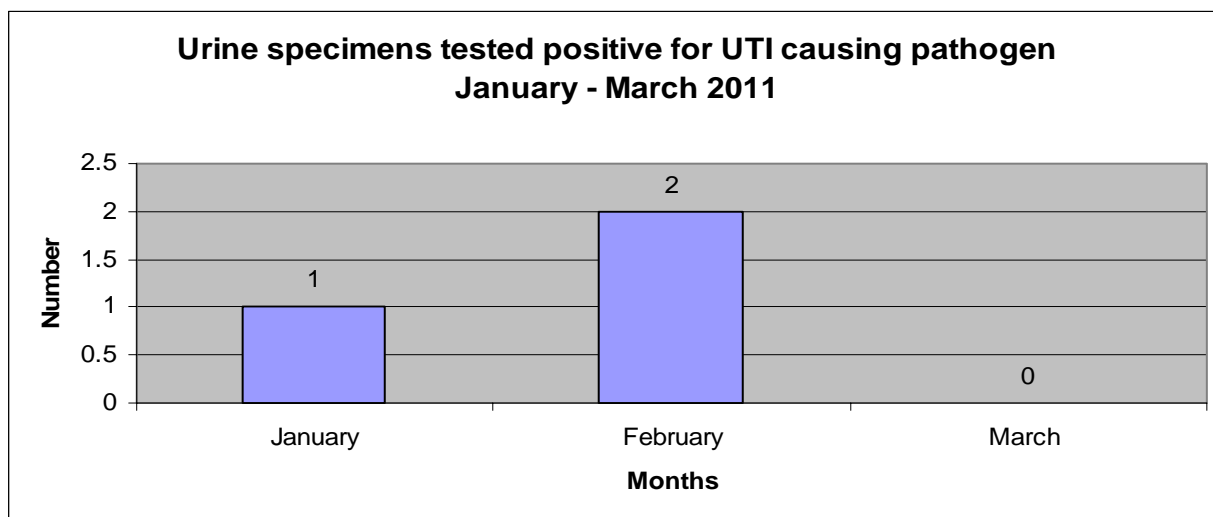


Figure 3: Urine samples positive for UTI causative pathogens January 2011 – March 2011

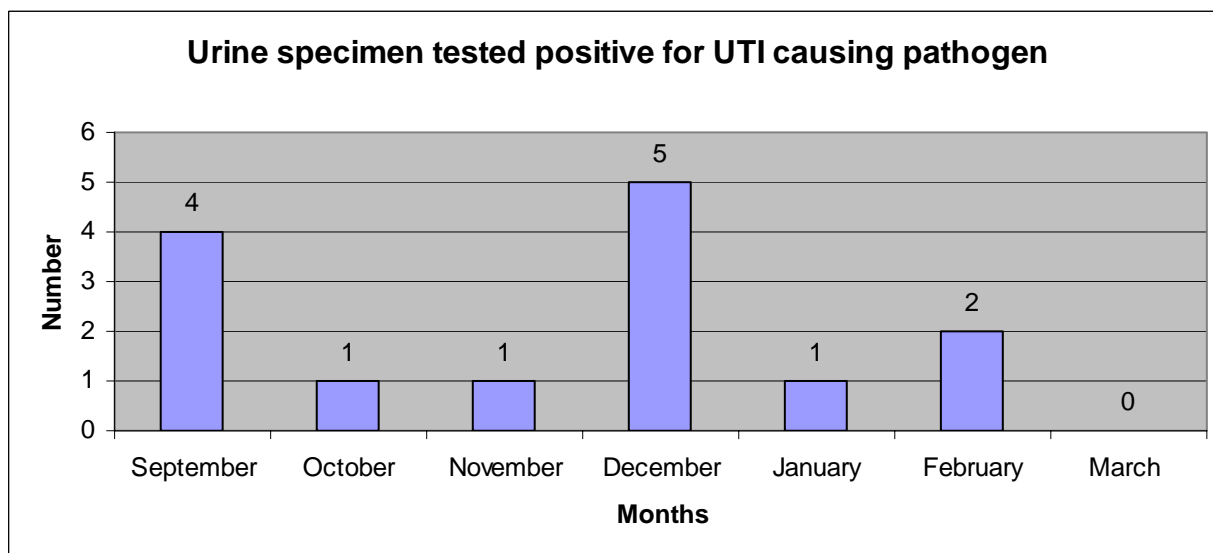


Figure 4: Urine samples positive for UTI causative pathogens September 2010 – December 2010

Outbreaks

The Infection Control Team continues to react to outbreaks and incidents of infections and develop appropriate control strategies in collaboration with clinical staff and management across the trust, not just in the inpatient areas. There are no outbreaks to report for this reporting period either in the inpatient areas or within the community.

Conclusion:

There has been a significant amount of continued effort invested in using and maintaining the surveillance systems set in 2007 for monitoring HCAI's during this reporting period. These systems assist in the identification of outbreaks/ and infection trends at an early stage so that immediate action can be taken to identify and control the source, identify problem areas, set priorities for infection control activity and meet national standards with an aim to reducing rates of HCAI's in the PCT. It also enables us to report thoroughly and accurately on the state of healthcare associated infections within the in-patient rehabilitation unit.

The Infection Control Team continue to support and advise healthcare professionals involved in the care of patients/clients with communicable diseases and/or colonised/infected with resistant organisms.

Reduction of HCAI's requires commitment from all clinical teams, infection control team and managers. It is everyone's responsibility. The link practitioner's for infection control have been involved in assisting with capturing and collating data on the ward on request. With a collaborative approach HCAI remains a very low incidence within Community Health Services.

References:

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