

Infection prevention and control report

Quality and patient safety Sub committee of Trust Board 20th January 2011

Covering Quarter 3 2011/12 1st October 2011-31st December 2011

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1. MRSA related issues

There has been 1 Trust attributable MRSA bacteraemia episode so far in 2011/12. This was in a surgical patient on Coyle ward in July 2011. The agreed objective for 2011/12 is 2 trust attributable cases.

There have been 2 PCT attributable MRSA bacteraemia episodes so far in 2011/12, diagnosed in May and October. These have been fully investigated by the IPC team of NCL in collaboration with Whittington Health and presented at ICC. Outstanding actions for improvement from these RCA's are held on a HCAI RCA plan monitored through ICC.

The agreed objective for 2012/13 is 1 trust attributable MRSA bacteraemia.

MRSA screening audits demonstrated **94%** compliance in November 2011 (up from 91%) for our emergency patients. Rapid MRSA screening using Polymerase Chain reaction (PCR) technology has been introduced for augmented care patients (Critical care and neonatal unit) and emergency surgical patients.

MRSA screening audits demonstrated **88%** compliance in November 2011 (down from 90%) with elective patients. These results have been feedback to relevant outpatient staff. There was 100% compliance in MRSA screening prior to Caesarean section surgery.

There were no MRSA bacteraemia episodes diagnosed in patients covered by the Community Infection control services in Islington and Haringey.

2. Clostridium difficile diarrhoea issues

Trust attributable (post 48 hour) *C.difficile* cases at end of December 2011 were below trajectory with 11 cases against target to date of 26.

The target for trust attributable *C. difficile* cases for 2011/12 is 34. All post 48-hour cases are followed up with a focused questionnaire and staff feedback. Antimicrobial prescribing in these patients was fully compliant with trust policy. 10 out of 11 patients were immediately isolated when their symptoms commenced.

There were no cases of *C.difficile* diarrhoea diagnosed in patients covered by our community Infection control services in Quarter 3 2011/12.

2 medical patients admitted with diarrhoea had *C.difficile* diarrhoea recorded on part 1a of their death certificates in December 2011 and STEIS SUI reports are underway. These cases were not linked in time place or person. The focus of both STEIS investigations is on non-compliant antimicrobial prescribing and management of diarrhoea in primary care. The management of both patients within the ICO has not raised any critical issues so far. Widespread communication and collaboration between ward staff, bed management team, Microbiology, IPCT and patients relatives was clearly documented.

3. MSSA/E.coli bacteraemia episodes

There have been nine Trust attributable MSSA bacteraemia episodes and ten Trust attributable *E.coli* bacteraemia episodes since 1st April 2011. There are as yet no set objectives for these organisms.

4. Other relevant Healthcare associated Infection (HCAI) issues

Whittington Health (acute inpatient beds only) recently took part in a European point prevalence study focusing on HCAI and antimicrobial prescribing. Our HCAI prevalence rate was calculated at 5.3%. In 2006 when we participated in a similar HCAI prevalence study our rate was 11.9%. This significant improvement in HCAI prevalence over 5 years is due to shared responsibility for Infection prevention and control and results have been shared with staff through Nursing and Medical directorate leads and via our link staff.

Many of the acute Trusts within NCL had severe norovirus outbreaks, leading to ward closures in the time period leading up to Christmas 2011. A few sporadic cases (in staff and patients) were diagnosed in Whittington Health but due to the close collaboration between IPCT, ED staff, bed management team and facilities we were able to prevent an outbreak and associated service disruption. No norovirus outbreaks were diagnosed by our Community Infection control team.

5. Audit

All ward and outpatient based IP and C audits are presented as an IPC dashboard, see Appendix A. Overall most areas have improved with 85% of audits in ward areas being fully compliant.

Audits showing concerning results include:

6 wards non-compliant in hand hygiene audit. These wards are completing follow up audits and feedback of results.

6 wards non-compliant in environment audit. These wards have had appropriate interventions by their ward managers and input from the facilities team.

8 wards non-compliant with MRSA suppression protocol starting and completing. Further guidance on the correct prescribing of MRSA suppression therapy has been given by IPCT.

The dashboard results have been shared with ward managers, matrons, facilities staff and divisional leads.

The Whittington Health IPC dashboard will continue in 2012/13 but will be further expanded to include community clinical services such as Sexual health, dental services and Childrens' services.

More emphasis will be placed on ward staff (monitored through Heads of nursing) completing IP and C based audits rather than the Visible leadership team. IPCT will continue to collate and disseminate information supported by clinical governance administration support.

Annual audits aimed at assessing the clinical environment from an infection prevention and control perspective will continue to be conducted within all provider services via a detailed report incorporating recommendations to reach current best practice.

6. IP and C training

The majority of FY1 and 2 doctors and core medical trainees have received ICP training including review of aseptic technique, use of personal protective equipment and correct hand decontamination.

Infection control mandatory training is now provided via the new E-learning package and other face to face training continues as per set education programme. Mandatory clinical and non-clinical face to face IPC training is delivered at least fortnightly at various sites throughout the ICO.

7. Antimicrobial prescribing

Antimicrobial targets of <10% unjustified IV antimicrobial prescribing longer than 72 hours, <10% restricted antimicrobials used but not discussed and <10% antimicrobials continuing for more than 7 days (unjustified) were all achieved in Q3 2011/12. Documentation of duration

and indication of antimicrobials has improved to 69% but not reached the agreed target of over 90%. Antimicrobial sessions have been delivered to FY1/2, CMT, orthopaedic staff and Anaesthetic trainees in 2011/2. Weekly ward based antimicrobial audits performed by Dr Andrews and Ai-nee Lim will continue in 2012/3. It is predicted that £44,500 savings (7.6% fall) will be achieved on expenditure on antimicrobials in 2011/12.

Antimicrobial steering group at Whittington Health has been expanded to include junior medical representatives and community based staff. All three divisions have Consultant representatives. There are plans to include input from local GP's.

8. Surgical site surveillance

Orthopaedic surgical site infection surveillance data in Q2 2011/12 has shown infection rates in hip implants of 0% (national benchmark 1.2%), knee implants 0% (benchmark 1.1%) and repair of fractured neck of femur NOF 5.7% (benchmark 2.4%) respectively.

Surgical site infection working group and a fractured NOF workstream have been set up with representation from IPCT. The focus of these groups is to reduce length of stay and increase compliance with pre, intra and post-operative factors known to reduce the risk of complications.

Presentation of audit data of patients undergoing NOF surgery to anaesthetic and orthopaedic staff demonstrated non-compliance issues around antimicrobial prophylaxis and documented operation times. Mr Haddo, Consultant Orthopaedic surgeon is carrying out further analysis of operation times and education sessions have been set up for anaesthetic trainees.

14% of patients in a 6 month period (who were MRSA negative and had surgery for fractured neck of femur) acquired MRSA colonisation. There should be no MRSA transmission so increased vigilance is required with focus on correct bed spacing and 100% hand hygiene compliance.

9. Integration of acute and community teams

Sue Tokley is leading work on the integration of the community and acute side Infection prevention and control teams by 31st March 2012. The teams are currently working very closely together and covering leave, combining policies and teaching etc;

Work to combine the acute and community IPC annual plans is underway and will be available for the start of 2012/13. One band 7 post is out to advert. Dr Julie Andrews has agreed to be the DIPC for the ICO without an increase in programmed activities but will require appropriate administration support.

10. Decontamination issues

Dr Micheal Kelsey and both IPC lead nurses attend the decontamination committee. There are ongoing issues with endoscopy rinse water test results, validation of bedpan washers and surgical equipment failing decontamination procedures but these problems have active and timely action plans that are monitored through the decontamination committee.

A full review of dental services is underway and the IPCT have participated in review and relocation of 2 dental service delivery areas that did not meet national guidance.

11. New Whittington Health Infection prevention and control committee

See appendix B for the terms of reference of the newly formed IPCC for Whittington health. This combines the previous acute Trust ICC and the Islington and Haringey IC subcommittee.

There is representation from all three divisional heads of nursing plus Consultant representation from Surgery and Women/Childrens' health divisions. Additional specialist support is provided from higher risk areas such as dental services, podiatry, maternity and Critical care.