AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 9th November, 2007, at 10.00 am
Council Chamber, Sessions House
County Hall, Maidstone

Ask for: **Paul Wickenden**
Telephone **01622 694486**

Tea/Coffee will be available from 9:45 am

Membership (17)

Conservative (12): Lord Bruce-Lockhart (Chairman), Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mr J A Davies, Mr D A Hirst, Mrs S V Hohler, Mr G A Horne MBE, Dr T R Robinson, Mr R Tolputt and Mrs E M Tweed

Labour (4): Mr M J Fittock (Vice-Chairman), Mrs C Angell, Ms A Harrison and Mrs E D Rowbotham

Liberal Democrat (1): Mr D S Daley

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item		Timings
1.	Substitutes	
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes - 12 October 2007	
Infection Control		
4.	Role of the Director of Public Health *Meradin Peachey Director of Public Health for Kent will give evidence to the Committee.*	10:10-10:30 am
5.	Dartford & Gravesham NHS Trust *Mark Devlin, Chief Executive and Iris Smith, Director of Infection Control will be in attendance for this item.*	10:30-11:15 am
	Break 11:15-11:30 am	
6.	Maidstone & Tunbridge Wells NHS Trust *Glenn Douglas, Interim Chief Executive and Amy Page, Chief Nurse will be in attendance for this item.*	11:30 am-12:30 pm
	Lunch break 12:30-1:15 pm	

7.	East Kent Hospitals Trust *Matthew Kershaw, Chief Operating Officer, Julie Pearce, Director of Nursing and Sue Roberts, Deputy Director of Infection Prevention & Control will be in attendance for this item.*	1:15-2:00 pm
8.	Medway NHS Trust *Jacqueline McKenna, Director of Nursing and Strategic Planning and Linda Dempster, Head of Infection Control will be in attendance for this item.*	2:00-2:45 pm
	Break 2:45-3:00 pm	
9.	Health Overview & Scrutiny Committees The opportunity to contribute to the Healthcare Commission Annual Health Check on Infection Control *Sheona Browne, Area Manager for Kent of the Healthcare Commission will be in attendance for this item.*	3:00-3:45 pm
10.	Conclusion and Outcomes from Evidence	3:45-4:15 pm
11.	Date of next programmed meeting – Tuesday 27 November 2007 commencing at 10:00 am	

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Stuart Ballard
Head of Democratic Services
(01622) 694002

1 November 2007

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held at Sessions House, County Hall, Maidstone on 9 November 2007.

PRESENT: Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Ms A Harrison, Mrs S V Hohler, Mr G A Horne, MBE, Mr J F London (substituting for Mr J A Davies), Dr T R Robinson, Mrs E D Rowbotham, Mrs P V A Stockell (substituting for Lord Bruce-Lockhart), Mr R Tolputt and Mrs E M Tweed.

OTHER MEMBERS PRESENT: Mr G K Gibbens (Cabinet Member for Public Health) and Mr K Lynes (Cabinet Member for Adult Social Services).

OBSERVERS: Councillor Mrs D Phillips, East Sussex County Council, Councillor Mrs J Etheridge and Councillor Mrs J Shaw, Medway Council together with a number of representatives of the Patient and Public Involvement Fora across Kent and Medway, parish councils and members of the public.

IN ATTENDANCE: Mr P D Wickenden, Overview and Scrutiny Manager and Dr D Turner, Research Officer to the NHS Overview & Scrutiny Committee.

UNRESTRICTED ITEMS

(Mr M J Fittock, Vice-Chairman, presiding)

60. Lord Bruce-Lockhart

The Overview and Scrutiny Manager informed the Committee that Lord Bruce-Lockhart was continuing to make good progress following his recent operation and hoped to be back chairing the Committee soon.

RESOLVED:- that a further letter be sent to Lord Bruce-Lockhart on behalf of the Committee expressing their best wishes for a speedy recovery.

61. Urgent Business

The Vice-Chairman sought and gained the approval of the Committee to discuss the agenda and papers for the meeting as urgent business. This was because the requisite statutory notice had not been given for the meeting, as a result of the short notice in trying to assemble a great deal of written evidence following the Committee's last meeting on 12 October 2007.

62. Minutes – 12 October 2007

RESOLVED that:- the Minutes of the meeting held on 12 October 2007 were correctly recorded and that they be signed by the Vice-Chairman, subject to the deletion of Mrs E M Tweed from those shown as present.

63. Infection Prevention and Control

(Mr A D Crowther declared an interest as a member of Medway NHS Trust)

(1) The substantive item of business before the Committee was as indicated at the last meeting (Minute 54 of 2007 refers). The Vice-Chairman stated that the Committee would be asking a series of questions of a range of people today, and at the next meeting of the Committee, following the recent Healthcare Commission report relating to the investigation into the outbreaks of Clostridium difficile within Maidstone & Tunbridge Wells NHS Trust. The recent ratings awarded by the Healthcare Commission to each Health organisation against a set of 24 Core Standards were also relevant.

(2) The Vice-Chairman reminded the Committee, those watching the webcast and those present at the meeting that the purpose of the meeting was to look at lessons to be learned from the publication of these two reports. He hoped that the question-and-answer process would help in restoring public confidence in the safety of the public using the services of the acute hospitals across Kent and Medway.

(3) Since the last meeting a number of Members of the Committee had visited the three hospitals within the Maidstone & Tunbridge Wells NHS Trust – namely the Kent and Sussex Hospital, Tunbridge Wells; Pembury Hospital; and Maidstone Hospital – to see at first hand those wards and areas which were mentioned in the report.

(4) The Vice-Chairman invited the Overview and Scrutiny Manager to hold up for those present a file containing written evidence that had been sought from a range of stakeholders across the Kent and Medway Health economy which had not been published as part of the papers for the meeting.

(5) Finally the Vice-Chairman informed the representatives of the Patient and Public Involvement Fora, parish councils and members of the public present that, if time permitted, after all Members of the Committee had asked their questions he would invite questions from anyone else present.

(6) In addition to the agenda and papers, Members had received a series of briefing materials from the Committee's Research Officer which included:-

(a) a chronology of events;
(b) a briefing note on the NHS Scrutiny, Patient and Public Involvement, and Complaints mechanisms;
(c) a briefing note on NHS targets on healthcare associated infections (HAI);
(d) a briefing note on statistical data on Clostridium difficile in the NHS;
(e) statistics relating to the number of death certificates mentioning Methicillin Resistant Staphylococcus Aureus (MRSA) in England as well as the annual counts of glycopeptide-resistant enterococcal (GRE) bacteraemia (bloodstream infection) for NHS acute trusts in Kent and Medway;
(f) a briefing note on the NHS star rating system for 2000 to 2005;
(g) a briefing note on the Healthcare Commission Annual Health Check ratings;
(h) statistical information on the performance of NHS trusts in Kent and Medway on Core Standards relating to Infection Control;
(i) a briefing note on Patient Environment Action Team (PEAT) cleanliness scores; and
(j) the auditors' local evaluation scores for NHS trusts in Kent and Medway for 2006/2007.

(7) Additional evidence was tabled at the meeting, received from the Healthcare Commission, the Chief Executive of the South East Coast Strategic Health Authority, West Kent Primary Care Trust, Eastern & Coastal Kent Primary Care Trust, and the Health Protection Agency. During the meeting a facsimile letter was received from Roger Gale, MP which was summarised for the Committee by the Overview and Scrutiny Manager.

64. Role of the Director of Public Health

(Item 4)

(In attendance for this item were Dr Mathi Chandrakumar, Director of the Kent Health Protection Unit; Meradin Peachey, Director of Public Health; Mark Devlin Chief Executive and Iris Smith, Director of Infection Control, Dartford & Gravesham NHS Trust; Glenn Douglas, Interim Chief Executive, Amy Page, Chief Nurse and Gail Locock, Lead Nurse for Infection Control, Maidstone & Tunbridge Wells NHS Trust; Matthew Kershaw, Chief Operating Officer, Julie Pearce, Director of Nursing and Sue Roberts, Deputy Director of Infection Prevention and Control, East Kent Hospitals Trust and Jacqueline McKenna, Director of Nursing and Strategic Planning and Linda Dempster, Head of Infection Control, Medway NHS Trust)

The Committee asked both Meradin Peachey and Dr Chandrakumar a range of questions and supplementary questions, as set out in Appendix 1 to these Minutes.

(1) Each Trust had been invited in advance of the meeting to provide written evidence in the form of answers to a series of questions. The responses of each Trust were published in the Committee's papers. The questions were:-

(a) A request to see the management structure for Infection Control within the Trust;
(b) What was the process within the Trust for dealing with MRSA and Clostridium difficile?;
(c) What was the management structure for the nursing profession within the Trust?;
(d) What was the process for training nurses in the importance of Infection Control within the Trust?;
(e) How were the patients and visiting public kept informed of the importance of Infection Control?; and
(f) Was the cleaning in the hospital(s) undertaken by an in-house contractor or an external contractor and what were the standards of cleanliness required?

(2) In addition to the written evidence the Committee then raised a series of questions with each individual Trust's representatives, as set out in Appendix 2 of these Minutes.

65. NHS Overview and Scrutiny Committee's opportunity to contribute to the Healthcare Commission Annual Health Check on Infection Control

(Sheona Browne, Healthcare Commission Area Team Leader for Kent, Medway and East Sussex and Sandra Tracey, Assessor, Healthcare Commission were in attendance for this item)

(1) The Committee had before it a presentation regarding third-party commentaries on Trusts' self declarations in respect of Healthcare Commission Core Standards – and the way that Overview and Scrutiny Committees, Patient and Public Involvement Forums, Foundation Trust Boards of Governors and Strategic Health Authorities could contribute to the Annual Health Check by this means.

(2) Also before the Committee were details relating to the weighting of the information which the Healthcare Commission received from third party commentaries, as well as some examples of intelligence that had been extracted from 2006/2007 commentaries and "top tips" for those submitting commentaries, derived from previous Annual Health Checks.

(3) The Committee noted that the most useful commentaries:-

a) were written in a clear and concise way;
b) contained information relevant to the current Annual Health Check;
c) clearly related to one or more Core Standard;
d) stated whether the third party thought that the Trust was compliant with the relevant Standard;
e) contained supporting evidence from a range of sources;
f) included detailed information, for example dates and outcomes;
g) clearly demonstrated how the third party had been involved;
h) used full names and avoided the use of acronyms; and
i) focused on commenting on the Standards rather than the criticism of the content of Standards and the system of assessment.

(4) The Committee were also informed that it helped if third parties contributing to the dialogue:-

a) had regular interaction with the Trust;
b) had access to Trust reports that highlighted patient concerns, e.g. patient survey reports, Patient Advisory Liaison Services reports, complaints reports, etc.;
c) had attended Board and other Trust meetings where these issues were discussed;
d) were familiar with current legislation and Trust policies on relevant issues, such as safety and equality;
e) carried out their own surveys and reviews;
f) witnessed at first hand where the policies and initiatives were being implemented;
g) had been involved in the development of new initiatives; and
h) felt able to challenge Trusts and influence change.

(5) The Committee then proceeded to ask a range of questions of the Healthcare Commission representatives, as set out in Appendix 3 of these Minutes.

Conclusions and outcomes from evidence

(1) The Committee concluded the session by agreeing that it would need to meet again to discuss this topic further on 27 November 2007.

(2) The Overview and Scrutiny Manager reminded the Committee of some of the issues which had arisen during the day. These items were only indicative of some of the discussion and were by no means exhaustive. The Committee would return to the conclusions and recommendations arising from thorough examinations of Infection Control across Kent and Medway following the next meeting, on 27 November.

(3) Some of the issues raised included:-

a) the Director of Public Health's statement that part of her role was proactive monitoring of infection prevention and control across the Kent and Medway Health economy;
b) the role of the Strategic Health Authority;
c) how best practice in individual Trusts was shared so that there was a consistent approach across the Kent and Medway Health economy;
d) how the Primary Care Trusts were dealing with the issue of antibiotic prescribing;
e) what methods were being used to engage patients and the public, and inform them how they could help prevent healthcare-associated infections;
f) the welcome opportunity to receive an action plan from the Maidstone & Tunbridge Wells NHS Trust on how they were responding to the Healthcare Commission report;
g) how adult social care and other stakeholders were responding to the issue of step-down facilities and delayed discharge, given that bed occupancy within the Maidstone & Tunbridge Wells NHS Trust was currently at 95%, instead of the recommended level of 85%;
h) understanding from the Strategic Health Authority how the money earmarked by the government recently for deep cleaning was to be allocated to Trusts across Kent and Medway;
i) the welcome offer by the Healthcare Commission to undertake some training for Members of the Committee on what makes a good third party dialogue contribution to the Annual Health Check; and
j) the Healthcare Commission's welcome offer for Members to accompany them on some visits to Health organisations so that Members could see at first hand how the Committee might contribute to the Healthcare Commission's Annual Health Check.

This page is intentionally left blank

Investigation

Investigation into outbreaks of *Clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust

October 2007

Healthcare Commission

Executive summary

Executive summary

The Healthcare Commission carried out this investigation to look into outbreaks of *Clostridium difficile* (*C. difficile*) at Maidstone and Tunbridge Wells NHS Trust and to assess the care provided to patients with this infection. It also considered whether the trust's systems and processes for the identification, prevention and control of infection were adequate.

Our particular focus was on the care of patients infected with *C. difficile*. We looked at measures taken to control the spread of the bacterium and the state of systems to control this infection. More broadly, we sought to disseminate wider lessons for the NHS on how best to prevent, control and treat infection with *C. difficile*.

This investigation was carried out between October 2006 and April 2007. Staff from the Healthcare Commission worked with a team of external expert advisers (for membership see Appendix B). We reviewed in detail the case notes of a sample of 50 patients who had contracted *C. difficile* during an admission to the trust, and had died. We interviewed nearly 200 people including patients who had been infected with *C. difficile*, and their relatives, and past and present staff at the trust and other organisations. We examined over 1,000 documents including policies, reports, audits and records of meetings. We carried out scheduled and unannounced visits to wards.

The executive summary outlines our findings. The evidence on which the findings are based is in the body of the report.

Synopsis of events

The trust had a relatively high rate of infection with *C. difficile* over several years but no one in the trust or local health community was aware of this. In the autumn of 2005 the number of patients with the infection doubled but this was not identified. In this unrecognised outbreak 150 patients were affected, and a number died where *C. difficile* was definitely or probably the main cause of death. The number of newly infected patients declined slightly at the beginning of 2006 and then rose again. This time the trust recognised it had a major outbreak and reported this to the strategic health authority and health protection unit on 12 April 2006. From April to September 2006, 258 patients were affected. Overall, from October 2005 to September 2006 more than 500 patients developed the infection, and we estimate that there were approximately 60 deaths where *C. difficile* was definitely or probably the main cause.

Our key findings are summarised below and set out in full in the body of this report.

Management of patients infected with *C. difficile*

The trust's guidelines for the management of patients infected with *C. difficile* were not sufficiently clear about the importance of isolation of patients with the infection. The trust's policy for responding to outbreaks was not fit for its intended purpose. The infection control team was keen to isolate patients with *C. difficile* but the scarcity of side rooms made this difficult. Many patients with the infection were grouped together in bays on wards, but before and during the outbreak some patients infected with *C. difficile* were not isolated; they were nursed on open wards. The other patients on these wards, and those on wards with infected patients in

bays, were at risk of catching the infection and some of them did. It took four months to establish an isolation ward exclusively for patients with *C. difficile*. In our view this was partly because of the pressure on beds and the trust's desire to meet targets.

The Healthcare Commission reviewed the case notes of a sample of 50 patients who had died having had *C. difficile*. We found that in 80% of the cases, at least one element of the clinical management or monitoring of *C. difficile* infection was unsatisfactory. Areas of concern included infrequent reviews of patients by doctors, the lack of systematic monitoring of whether the patients were recovering from *C. difficile*, and the failure, in many cases, to change antibiotic treatment for *C. difficile* when a patient had failed to respond to the initially prescribed therapy. There was inadequate monitoring for common complications of *C. difficile*, especially dehydration and poor nutrition, and of serious complications, especially colitis. The review found several examples of antibiotic prescribing that predisposed vulnerable patients to developing *C. difficile* infection.

During the investigation, 26 patients and their families contacted the Healthcare Commission. They were unhappy about the care received. They told us that when patients rang the call bell because they were in pain or needed to go to the toilet, it was not always answered, or not in time. A particularly distressing practice reported to us was of nurses telling patients on some occasions to "go in the bed," presumably because this was less time-consuming than helping a patient to the bathroom. Some patients were left, sometimes for hours, in wet or soiled sheets, putting them at increased risk of pressure sores. Families claimed that tablets or nutritional supplements were not given on time, if at all, or doses of medication were missed. Wards, bathrooms and commodes were not clean and patients had to share equipment such as zimmer frames which were not cleaned between use.

The number of deaths from *C. difficile*

One of the aims of the investigation was to clarify how the trust had estimated the number of deaths from *C. difficile* since April 2004.

The trust assured us that its review of case notes involved patients who had died in hospital, had tested positive for *C. difficile* and had *C. difficile* mentioned on their death certificate. Our scrutiny of their information, however, found that the review had considered less than half of these patients. This review could not, therefore, have accurately ascertained the number of deaths since April 2004. Nonetheless the trust relied on this review to obtain a figure.

The trust told us that there had been no deaths that were definitely caused by *C. difficile* between April 2004 and March 2006. In the Healthcare Commission's sample of 50 patients who died and had contracted *C. difficile* between April 2004 and September 2006, our experts found that in 26% of the cases (13) it was definitely or probably the main cause of death and in 78% (39), *C. difficile* had definitely or probably contributed to the patients' deaths.

The 50 patients whose notes we reviewed were slightly older than the total number of patients who died and had contracted *C. difficile* infection, which may suggest they were more likely to die by reason of their age. However, at the same time, we excluded those patients with life threatening illnesses. On balance, we feel that our estimate of the proportion of deaths attributable to *C. difficile* is reasonable.

Based on this proportion identified in our review, we estimate that of the total 345 patients who died in the relevant periods who had been infected with *C. difficile,* there were approximately 90 deaths where *C. difficile* was definitely or probably the main cause of death, and about 60 of these happened in the outbreaks between October 2005 and September 2006. It is not, however, correct to conclude that these patients died because of the care they received.

Many of the 90 people may well have died of other causes if they had not acquired *C. difficile* infection. Some would have died of *C. difficile* infection even if they had had the best care.

Table 1: Estimated number of deaths were *C. difficile* was definitely or probably the main cause

April 2004 September 2005	October 2005 March 2006	April 2006 September 2006	TOTAL
30	35	25	90

The Commission is unable to say exactly how many of the deaths attributable to *C. difficile* infection were 'excess' deaths, that is, people who would not have died had they not developed *C. difficile*. However there is evidence from other studies that patients infected with *C. difficile* are considerably more likely to die than comparable patients who do not have it. The trust's own data showed that from 2003/2004 to 2006/2007, between 32.4 and 46.3% of all patients over 75 died if they had *C. difficile*, compared to between 6.1 and 6.7% of patients in the same age group if they did not.

In a press statement on 30 June 2006, the trust reported that six people had definitely died from *C. difficile* since the start of the outbreak in April. The trust quite properly used an existing classification to try to identify the number of deaths from *C. difficile*, but was mistaken in not reviewing all death certificates where *C. difficile* was mentioned. It would have been better to include probable deaths with definite deaths in press releases, particularly following the publication of the Healthcare Commission's report into outbreaks of *C. difficile* at Stoke Mandeville Hospital, which used this approach.

Our analysis also suggests that relying on death certificates leads to an underestimate of the contribution of *C. difficile* infection to the death of patients, since 20% of the patients in our sample where *C. difficile* was not mentioned on the death certificate had an infection with *C. difficile* that our experts considered was probably or definitely the main cause of death.

Arrangements for the control of infection

The individual appointed by the chief executive to be the director of infection prevention and control (DIPC) had no real understanding of the role at the outset. The DIPC failed to avail himself of sufficient knowledge about procedures and processes in other trusts such as surveillance and feedback. Management of the infection control team was inadequate. There was no strategic direction and there

was confusion over who actually managed the team. There were differences of opinion between the microbiologists which meant a lack of consistency of approach.

Policies for the control of infection were on the trust's intranet, but they were nearly all out of date and not all staff could gain access to the intranet. The trust did not have several key policies that we would have expected to see. Updated training in infection control was mandatory in the trust, but between September 2005 and October 2006 only 51% of clinical staff attended this.

In the 2005 national survey of staff carried out by the Healthcare Commission, 30% of staff at the trust agreed that "the trust does enough to promote the importance of hand washing to staff." The typical score for an acute trust was 77%. For promoting the importance of hand washing to patients and visitors, the trust's score was 33% compared to a typical score of 59% for an acute trust. Of the trust's staff, only 38% agreed with the statement "infection control applies to me in my role." The typical acute trust score was 79%.

Rates of *C. difficile* infections had fallen by September 2006 and were generally maintained at or below the level seen before the outbreaks, with some small clusters of cases. The senior infection control nurse became the acting director of infection prevention and control in April 2007. The trust has informed us that a new consultant microbiologist is also being recruited, and will be appointed as the director of infection prevention and control.

Factors contributing to the outbreaks

Many of the buildings, especially at the Kent and Sussex Hospital, were old and in a poor state of repair. Many of the wards did not have sufficient storage, space in utility rooms, or hand basins, making the control of infection difficult. The beds on several wards were much too close together, making it difficult to clean between them and seriously compromising the privacy of patients. Although there had been improvements generally in cleanliness and hygiene since the outbreak was declared, there were still some serious concerns. When we visited, we observed levels of contamination that were unacceptable, such as bedpans that had been washed but were still visibly contaminated with faeces.

Information from nurses, other clinical staff, patients and families, and from reported incidents and complaints, indicated that shortages of nurses contributed to the spread of infection because they were too rushed to undertake hand hygiene, empty and clean commodes, clean mattresses and equipment properly, and wear aprons and gloves appropriately and consistently.

The trust's bed occupancy rates were consistently over 90% in the medical wards at both Maidstone Hospital and Kent and Sussex Hospital. Higher bed occupancy led to less time for thorough cleaning of beds and the areas around them, between one patient's moving and another occupying the same bed.

'Escalation' areas were often opened up these were areas in the hospital that did not usually function as general wards but which were used as such when there were no suitable beds available elsewhere in the hospital. They were often in unsuitable areas such as a previous children's ward or the area for day surgery. The bathroom facilities were inadequate, as were the 'dirty utility' rooms, since they were not

designed for ill or adult patients. When these areas were first opened, cleaning and laundry services were not in place. By definition for these areas there were no funds for dedicated staff, and at least initially they were staffed almost entirely by bank or agency nurses, bringing little continuity of care. Many of these factors increased the risk of transmission of infection.

Arrangements for governance

There had been considerable change over the relevant period in the structure and responsibilities relating to governance and the management of risk. This had led to confusion over accountability. The trust's system for handling serious untoward incidents was poor, with little evidence of adequate investigation and very few reports being produced. Other incidents that were reported by staff consistently highlighted problems relating to the levels of staff, poor care for patients, 'escalation' wards and poor processes for handover when patients moved from one ward to another. Many of these matters required consideration and resolution at a strategic level but were rarely considered by the board, whether as a whole board or at its governance and risk sub-committees. There was no systematic mechanism to follow up any actions required or to share lessons.

Overall, the system that was intended to bring clinical risk to the attention of the board did not function effectively, and the board appeared to be insulated from the realities and problems on the general wards.

A new structure of governance was introduced in January 2007. It aimed to increase the involvement of senior clinical staff in making decisions and taking responsibility.

The trust's board and infection control

The board stated that infection control had always been a priority. Before the outbreak it only monitored the MRSA rate, as there was a national performance target in relation to MRSA, though not as regards *C. difficile*. Until recently, the board considered the annual report on control of infection solely as a retrospective document rather than a prospective plan for the coming year where the board could influence and agree priorities.
The information presented to the board was often incomplete or inaccurate, leaving non-executives at a disadvantage in being able to perform their role to scrutinise and challenge on matters relating to the care of patients or concerning infection control.

An outbreak occurred in the autumn of 2005, and in early 2006 the trust recognised that it had a second outbreak. Despite this and the gaps in controls that they revealed, the trust in May 2006 declared itself in the Healthcare Commission's annual health check as being in compliance with the standard for control of infection in the core national standards.

Informing the public

The second outbreak was declared on 12 April 2006. The trust did not issue a press statement until an enquiry was received from the local press over two months later. Information in the press release suggested that the outbreak was due to patients with the infection being admitted to the hospital from the community. The outbreak was not discussed by the trust's board in public until 25 July 2006. On several occasions

the board, and relatives of patients who attended the board's meetings, were given information that was not accurate. For example, in July 2006 it was reported that the antibiotic policy had been reviewed in line with the correspondence from the Chief Medical Officer in England, in December 2005. In fact, no action had been taken until the outbreak was declared in April 2006.

The statements from the trust concerning the outbreak under-reported the number of deaths, since they included only those in which *C. difficile* was considered to have definitely contributed and not those where *C. difficile* probably contributed. Moreover, even those figures were not accurate, since not all the cases in which *C. difficile* was mentioned on the death certificate had been reviewed.

The response of managers and the trust's board

The trust has had a challenging agenda since it was established by a merger in April 2000.

The board unambiguously stated that its top priority was the safety of patients. However, the fact that the organisation did not recognise the first outbreak of *C. difficile* is not consistent with the trust doing its best to reduce the risk of infection to patients, staff and visitors. Progress had been made in many areas but there were serious problems with high bed occupancy, the movement of patients, and with some patients with diarrhoea being cared for on open wards. The board paid insufficient attention to its responsibilities to protect patients against infection.

The lack of organisational stability, with numerous structural changes over the last three to four years, and a high turnover of senior managers, meant that managers could not settle into roles and focus on the key issues. Many felt there was little delegation. The style of management was described as reactive, with frequent changes of direction.

Developments since the investigation was announced

To increase the space between beds, a number of beds have been removed from wards at Kent and Sussex and some wards have had new sinks and macerators installed.

The trust carried out a review of the number of nurses in April 2007 and approved an increase in the number of nurses on the wards to match those of comparable trusts.

The trust has also developed an integrated approach to the clinical management of *C. difficile*, known as a 'care pathway'.

Overall conclusion

The trust had no effective system for surveillance of *C. difficile.* As a consequence, it failed to identify an outbreak in 2005 that involved 150 patients. This was a serious failing. When the second outbreak was declared in April 2006, patients were cared for on a number of wards until an isolation ward was established in the August.
The clinical management of *C. difficile* infection in the majority of the patients fell short of an acceptable standard in at least one aspect of basic care. Some patients, who might have been expected to make a full recovery from the condition for which

they were admitted, were prescribed broad-spectrum antibiotics during their stay in hospital, contracted *C. difficile* and some died.

The infection control team was not managed properly and standards of cleanliness and infection control were not good. Since the outbreaks, the number of cases has fallen to below the levels previously experienced by the trust. However, as late as April 2007, we found unacceptable examples of the use of contaminated equipment.

The trust delayed announcing the outbreak and then produced figures that almost certainly underestimated the number of deaths. We estimate that approximately 90 patients definitely or probably died from *C. difficile* in two and a half years, about 60 of these during the outbreaks from October 2005 to September 2006. It is not correct to conclude that 60 patients died because of the care they received. Some may well have died of other illnesses and some would have died from *C. difficile*, even if they had had the best care.

The trust struggled with a number of objectives which they regarded as imperative. These occupied senior managers' time and compromised the control of infection, and hence the safety of patients.

The roles of external organisations

The creation of the Health Protection Agency has led to some confusion about the role of various bodies in respect of the control of infection in acute trusts.

Although the primary care trusts commissioned services from the trust, they were preoccupied with the numbers of patients treated and the cost, and had given little attention to the quality of care or the control of infection. They saw the latter as the responsibility of the health protection unit (HPU), which is part of the Health Protection Agency.

The HPU did not have close routine involvement with the trust, and generally worked in a reactive way, responding to concerns. The HPU staff saw their role as being to support organisations in their management of infections, rather than to supervise or monitor infection control. Once the outbreak was reported, the HPU endeavoured to support the trust. The HPU was concerned about aspects of the handling of the outbreak and raised these matters with the trust and the strategic health authority (SHA).

It was clear that, until recently, the focus of the SHA with regard to healthcare associated infection had been more on MRSA, since it was one of the top national priorities to which a target for performance was attached. The SHA, however, responded to the concerns of the HPU and was instrumental in initiating our investigation.

The national picture and lessons for other organisations

The Healthcare Commission was concerned about the standard of medical and nursing care of patients who developed *C. difficile* infection. The diagnosis of *C. difficile* infection needs to be respected as a diagnosis in its own right. The infection needs to be taken seriously as a potentially life threatening condition. Patients should be regularly reviewed and given appropriate medical and nursing care.

The investigation into the outbreaks at Maidstone and Tunbridge Wells NHS Trust has thrown up a number of similarities with the findings of our previous investigation into outbreaks of *C. difficile* at Stoke Mandeville Hospital, part of Buckinghamshire Hospitals NHS Trust. Both trusts had undergone difficult mergers, were preoccupied with finances, and had a demanding agenda for reconfiguration and private finance initiative (PFI), all of which consumed much management time and effort. They also had poor environments, with many dormitory style wards and few single rooms which could be used for isolating patients with infections. In both we observed unacceptable examples of contamination and unhygienic practice.

Additionally, the impact of financial pressures was to reduce further already low numbers of nurses and to put a cap on the use of nurses from agencies and nursing banks. There was unrelenting pressure to reduce the number of beds. Thus, both trusts had very high occupancy levels, could not manage with fewer beds, and so had to open 'escalation' beds, often at short notice and in unsuitable environments, without proper support services and equipment in place and, by definition, without permanent staff. The effect of all this was to compromise seriously the control of infection and the quality of clinical care.

In both trusts there were many complaints from patients and relatives about the quality of nursing care. These primarily related to patients not being fed, call bells not being answered, patients left in soiled bedding, medication not administered, charts not completed, poor hygiene practices, and general disregard for privacy and dignity. Not only were these distressing, but in the case of seriously ill patients, poor care related to hygiene, medication, nutrition and hydration may have adversely affected the outcome for the patients.

While it should be noted that improvements have subsequently been made at Stoke Mandeville, it seems unlikely that these similarities are coincidental. We are concerned that where trusts are struggling with a number of problems that consume senior managers' time, and are under severe pressure to meet targets relating to finance and access, concern for infection control may be undermined.

Lessons need to be reinforced about appropriate antibiotic prescribing, the need for effective isolation, the importance of scrupulous cleanliness and hygiene, and the need to provide a high standard of care of patients infected with *C. difficile*, including having adequate staff. More attention also needs to be paid to the accuracy of death certification.

Dartford and Gravesham NHS
NHS Trust

Health Overview & Scrutiny Committee

Friday 9 November 2007

Hospital Acquired Infection & Infection Control in Dartford & Gravesham NHS Trust

In attendance for East Kent Hospitals NHS Trust:
Mark Devlin, Chief Executive
Iris Smith, Director of Infection Control

This page is intentionally left blank

Dartford & Gravesham NHS Trust – NHS Overview and Scrutiny Committee 9 November 2007

1) The management structure for Infection Control within the Trust?

The Director of Infection Prevention & Control reports directly to the Chief Executive.

Trust Infection Prevention & Control Structure & Reporting

Trust Board

↑

Clinical Governance Committee

↑

Infection Control Committee (Quarterly Meetings)

Director of Infection Prevention & Control

Consultant Microbiologist | Senior Nurse Infection Control | Medical Director

Consultant Physician | Consultant Surgeon | Director of Nursing

Assistant Director of Governance | Sterile Services Manager | Carillion Services

Occupational Health Manager | Health Protection Unit Representative

↑

Infection Control Team (Meets daily)

Director of Infection Prevention & Control (Iris Smith)
Consultant Microbiologists (Dr A Gonzalez & Dr. L Cotter)
Senior Nurse Infection Control (Peter Orsman)
Senior Sister Infection Control (Sr C Hannay)

Senior Leads in Infection Control (Meets quarterly)

Matron Surgical Specialities	Matron Medicine
Matron Elderly Medicine	Matron Emergency Medicine
Matron Day Care Unit	Matron Critical Care
Matron Critical Care Outreach Team	Manager Paediatric Services
Manager Theatre Services	Manager Physiotherapy Services
Manager Radiology Services	Manager Midwifery Services
Bed Bureau Manager	Night Team Manager

↑

Infection Control Link Staff (Quarterly meeting with ICT)
All wards & departments have a nominated member of staff with specific responsibility for infection control in their area

2) What is the process for dealing with both MRSA and C Difficile?

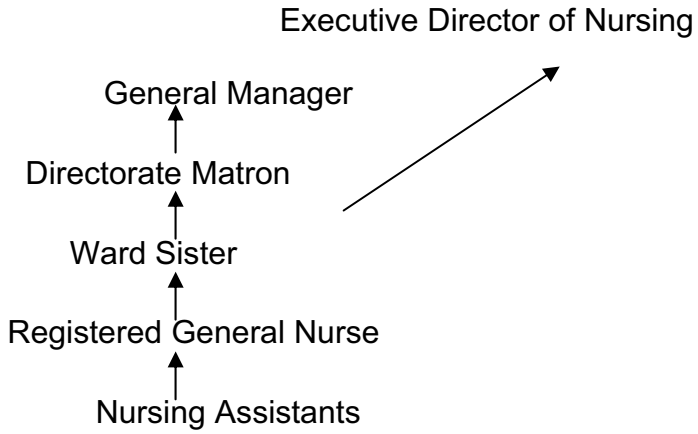
Both conditions have Pathways of Care outlining procedures to be followed by Doctors, nurses and other clinical staff to ensure effective treatment of the patient and reduction of risk for others. This will include treatment, isolation, cleaning etc

3) What is the management structure for the nursing profession within the Trust?

The hospital is divided into clinical directorates representing clinical specialties:

General Emergency Medicine
Surgical Specialties
Obstetrics, Gynaecology and Paediatics

Each area is run by a Clinical Director, who is a senior Consultant and a General Manager, with a professional background. The nursing staff have direct operational accountability through to the General Manager and professional accountability to the Director of Nursing. The Director of Nursing carries overall strategic and professional responsibility for nursing and the standards of nursing within the Trust.



4) What is the process for training nurses of the importance of infection control?

Infection Control is part of the Trust induction programme and is mandatory for all clinical staff including Doctors, Nurses, medical and nursing students. The programme covers such aspects as hand hygiene, principles of infection prevention and controls, risk assessment, existing staff are required to attend regular update sessions.

5) How are the patients and visiting public kept informed of the importance of infection control?

'Bug Board' – Notice board in main corridor shows Trust infection rates (MRSA bacteraemia, Clostridium difficile, post operative hip & knee replacements). Information on MRSA, C diff is provided together with an overview of activities

undertaken across the Trust to minimise the risk of infection and of the importance of hand hygiene

'Best by the Bedside' – Notice at entrance to all wards inviting the public to participate in hand hygiene.

Information leaflets – for patients and relatives explaining condition MRSA, C. diff, TB etc

Others PPI meetings, press releases

6) Is the cleaning in the hospital(s) undertaken by an in-house contractor or an external contractor? What are the standards of cleanliness required?

Cleaning is provided by our PFI Partners Carillion. Standards are based on National Standards for cleaning and are monitored formally each month by the Matrons and Ward Sisters. The Trust's Contract Performance Manager regularly meets with the Matrons to address contract performance and other issues.

The Trust has a redecoration and deep cleaning programme (commenced July 2005) which allows each ward to be closed, redecorated and deep cleaned. To date 14 wards have been completed. This programme is due for completion by Spring 2008.

This page is intentionally left blank

Maidstone & Tunbridge Wells NHS

NHS Trust

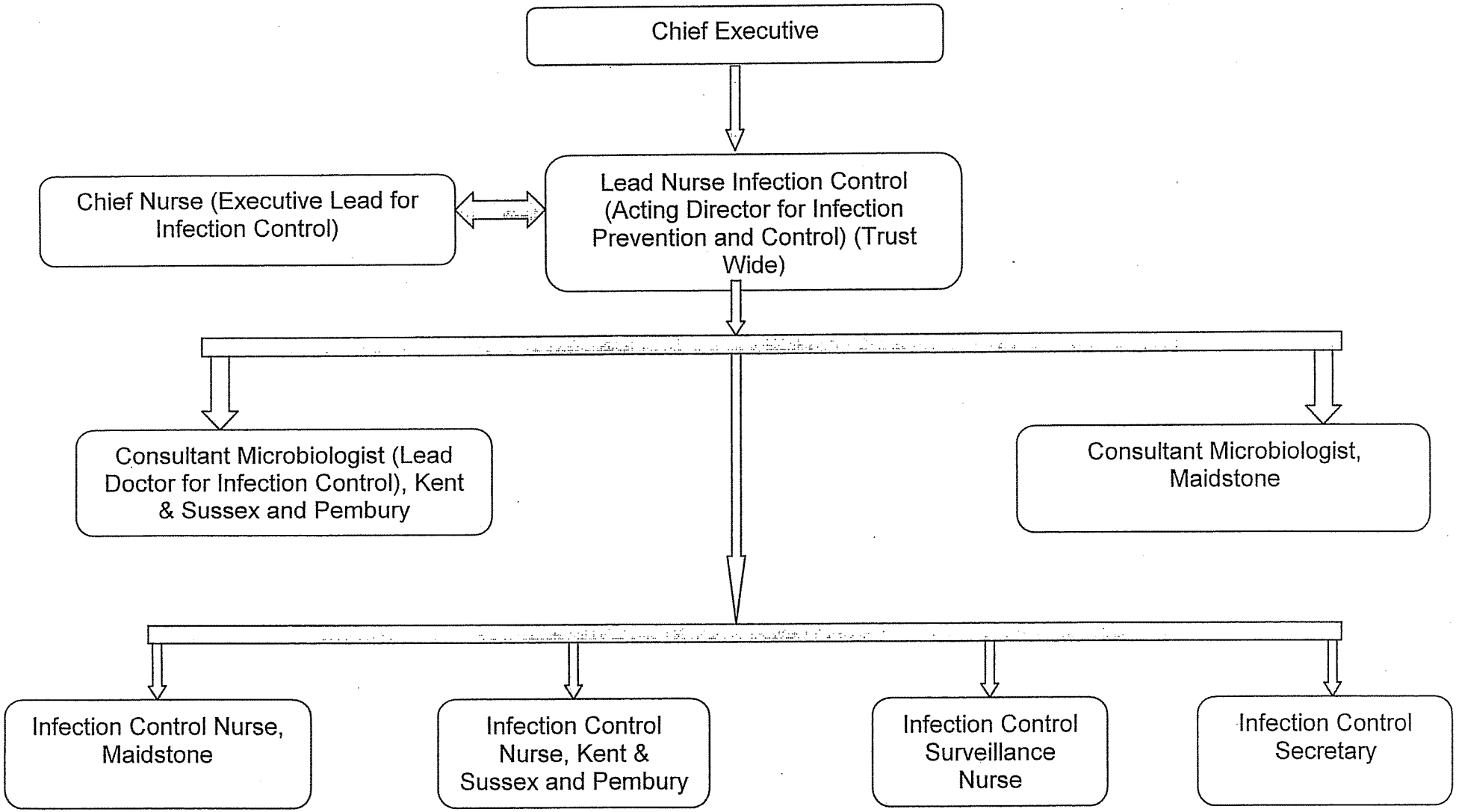
Health Overview & Scrutiny Committee

Friday 9 November 2007

Hospital Acquired Infection & Infection Control in Maidstone NHS Trust

In attendance for East Kent Hospitals NHS Trust:
Glenn Douglas, Interim Chief Executive
Amy Page, Chief Nurse

Infection Control Management Structure



October 2007

Maidstone and Tunbridge Wells NHS Trust

Policy Title: # GUIDELINES FOR THE CARE OF PATIENTS WITH *CLOSTRIDIUM DIFFICILE* ASSOCIATED DIARRHOEA

Originated by: Infection Control Committee

Policy lead: Gail Locock, Lead Nurse Infection Control

Other contributors: Members of Infection Control Team and Infection Control Committee

Supersedes: Guidelines for the Care of Patients with *Clostridium difficile* – November 2004

Approval date: February 2007

Review date: February 2008

Evidence:

1. CMO/CNO Letter – Infection caused by Clostridium difficile. 21st December 2005.
2. National Clostridium difficile Standards Group: Report to the Department of Health (2004)
3. High Impact Intervention Number 6: Reducing the risk of infection from and the presence of Clostridium difficile. Department of Health. May 2006.
4. Department of Health (1994) Clostridium Difficile Infection: Prevention and Management

Why this guidance is necessary:

To ensure all staff are aware of how to care for patients with *Clostridium difficile* associated diarrhoea and to reduce the risk of cross infection.

How it will be launched:
Through poster campaign via cascade through Senior Nurses and Clinical Directors, Induction and Mandatory Training

How it will be audited:
Annually using audit tool included from the Saving Lives High Impact Intervention No 6 audit tool

CONTENTS **PAGE**

SUMMARY

1. *Clostridium Difficile (C. difficile)* is a cause of antibiotic-associated diarrhoea and pseudomembranous colitis (PMC).

2. *C. difficile* is a spore forming Gram positive anaerobic bacillus. The spores are highly resistant to heat, chemicals, desiccation and exposure to air

3. Age - over 65 years and gastro-intestinal surgery are independent risk factors

4. The clinical signs are; offensive, explosive diarrhoea, which can contain blood and mucous, abdominal pain, pyrexia and leukocytosis. The patient can go on to develop dehydration and electrolyte imbalance.

5. **The treatment should be discussed with the Consultant Microbiologist**
   Stop unnecessary antibiotics; treat dehydration, Oral metronidazole 400mgs three times daily for 7-10 days.

6. Where possible isolate the patient and keep dedicated toilet/commode facilities until 3 days after formed stools

7. Standard Infection Control precautions must be used at all times

8. Ensure patient has access to adequate hand washing facilities

9. Cleaning must be vigilant and the domestic supervisor must be informed of the need to thoroughly clean and disinfect all patient touch points and horizontal surfaces around the patient each day

1.0 Introduction

1.1 *C. difficile* is a cause of antibiotic-associated diarrhoea and pseudomembranous colitis (PMC). It occurs sporadically in the community and can be endemic or epidemic in hospitals or nursing homes.

1.2 The organism is a spore forming Gram positive anaerobic bacillus. The spores are highly resistant to heat, chemicals, desiccation and exposure to air. They are found widely throughout the environment, and can survive for long periods of time in dry, dusty places.

1.3 Transmission is by the faecal-oral route via spores. About 3% of the normal population and approximately 36% of hospitalised patients carry the organism..

2 Risk Factors of Acquiring the Disease

2.1 Antibiotics most commonly implicated are quinolones, clindamycin, ampicillins and cephalosporins.

2.2 Age - over 65 years of age is an independent risk factor

2.3 Gastro-intestinal surgery

3 Pathogenesis

3.1 Spores ingested orally are not affected by acid in stomach and germinate in small intestine. They adhere to wall of colon and secrete toxins A and B. Systemic antibodies are found to both toxins.

3.2 Toxin A is an enterotoxin, which causes extensive tissue damage resulting in inflammation, necrosis and fluid loss. Diarrhoea is due to increased gut wall permeability and decreased absorptive capacity leading to a fluid accumulation.

4 Clinical Features

4.1 The clinical signs are; offensive, explosive diarrhoea, which can contain blood and mucous, abdominal pain, pyrexia and leukocytosis. The patient can go on to develop dehydration and electrolyte imbalance.

4.2 Complications include toxic megacolon, paralytic ileus and PMC.

5 Diagnosis

5.1 Diagnosis is by either clinical features or detection of toxin in the stool.

6 Treatment

6.1 Stop all unnecessary antibiotics – taking advice from the Consultant Microbiologist. Treat dehydration.

6.2 Codeine and loperamide are contra-indicated in antibiotic associated diarrhoea.

6.3 Oral metronidazole 400mgs three times daily for 7-10 days.

6.4 If there is no improvement discuss alternative treatment with the Consultant Microbiologist.

7. Control of Infection

7.1 The number and presentation of *C. difficile* cases will influence the management of *C. difficile* infection. Daily monitoring of *C. difficile* cases by the Infection Control Team (ICT) together with epidemiological investigation will result in initiation of 3 categories of management:

1. Sporadic cases (hospital or non-hospital acquired)
2. Localised cluster of cases (2 cases of suspected hospital acquired *C. difficile* in a defined area per week)

3. Outbreak – potential localised outbreak, as a result of suspected cross transmission of *C. difficile* (2 or more related cases of *C. difficile* or 2 or more cases of hospital acquired *C. difficile* per week above an agreed background level for one week)

7.2 **Sporadic Cases**

Following identification of *C. difficile* infection the following infection control measures must be implemented:

a. Isolation and patient care procedures

- Immediate isolation of the patient in a single room. An en-suite bathroom is preferable. Patients who do not have access to en-suite facilities must have a commode dedicated for their use. Instigation of cohorting affected patients together in one area when numbers exceed side room capacity.
- Patients who require being moved from a bay or main ward area to a side room for isolation following confirmation of *C. difficile* infection must have the bed space thoroughly cleaned with a solution of hypochlorite detergent disinfection (1,000 ppm available chlorine) e.g. Actichlor plus, this is to include the bed head equipment, any fixed equipment at the bed space (monitors etc.), the curtain rail and the curtains changed prior to occupation by the next patient.
- Patients should be provided with an information leaflet on *C. difficile* for their information (available from each ward, PALS or the ICT).
- All staff entering the patients' room must wash their hands with soap and water prior to leaving. This includes following removal of protective clothing. **The use of alcohol hand disinfectant is not advised, as this is not effective in killing the spores of *C. difficile*.**
- ALL staff **must** wear aprons and gloves (refer to Universal Precautions Policy) for any direct contact with the patient/patient environment or when exposure to faeces is anticipated.
- All patient linen is to be treated as foul/infected and disposed of using the red laundry bag and alginate inner bag system.
- Patient transfers to other wards must be kept to a minimum in order to prevent spread of infection. Should a patient require a transfer to another ward due to clinical need the receiving ward must be informed of the patients' infection status to enable suitable accommodation (e.g. side room) to be identified.
- The patient may be removed from isolation for C. difficile infection when a 'symptom free status' has been achieved. This is defined as two consecutive type 1 - 4 stools and no type 5, 6 or 7 stools in the preceding 72 hours. Toxin negative stool results are NOT required.
- A *C. difficile* GP letter must be completed by the patients medical team and sent to the patients GP following discharge (see appendix 1) provided to the ward by the ICT
- No special precautions are required for deceased patients.

b. Clinical patient management

- The patient should be prescribed appropriate antibiotic therapy to treat *C. difficile* infection
- Antibiotic prescriptions should be critically reviewed within all unnecessary antibiotics avoided. A Consultant Microbiologist should be consulted for advice if required.

- A stool chart must be implemented (see appendix 2) and updated following every bowel action. Absence of bowel motions must be documented on a daily basis.
- Patients who experience prolonged *C. difficile* diarrhoea (>4 weeks) should be managed in close conjunction with the Consultant Microbiologists. Note: repeat faeces specimens for C. difficile toxin testing are unnecessary.
- Patients who develop diarrhoea following a period of being symptom free may have been re-infected or relapsed. These patients must be isolated immediately and a faeces specimen sent for *C. difficile* toxin testing.

c. Cleaning

- The room must be cleaned thoroughly on a daily basis using a solution of hypochlorite detergent disinfection (1,000 ppm available chlorine) e.g. Actichlor plus. Any concerns in relation to the standard of environmental cleanliness must be reported to the Domestic Supervisor immediately to allow prompt rectification of the problem.
- Any equipment required for patient management/care must be dedicated for that patient only or disposable, and should be thoroughly cleaned after use or when no longer required with a chlorine-detergent based disinfectant as above. This includes equipment such as BP cuffs, moving and handling equipment, physiotherapy equipment etc.
- Therapy mattresses/beds must be returned to the manufacturers for centralised decontamination in a red bag.
- Should the patient require transfer to other dept's (e.g. X-ray, theatres etc.) then the patient's C. difficile status must be declared in advance to enable dept's to make appropriate arrangements to prevent the spread of infection.
- Once a patient no longer requires a side room, a terminal clean of the room is required using a solution of hypochlorite detergent disinfection (1,000 ppm available chlorine) e.g. Actichlor plus. A curtain change (window/privacy curtain) is also required.

7.3 Localised Cluster of Cases

The affected area will be informed of the identification of a potential cluster of hospital acquired *C. difficile* by the ICT (see also Outbreak Policy)

In addition to guidance provided above in 7.2, the following additional measures will be implemented:

- ICT to inform Director of Infection Prevention and Control (DIPC) or Deputy, in addition to Ward Manager and Bed Manager. Other staff to be informed according to the Trust Outbreak of Communicable Disease Policy.
- ICT to investigate situation to determine if cross transmission of *C. difficile* may have occurred.
- Instigation of enhanced patient monitoring within the affected area by the ICT to identify potential secondary cases, with daily reporting of situation to DIPC.
- Control of staff deployment to other areas to ensure adequate staffing levels are present.
- Promotion of hand hygiene to raise awareness locally, with particular emphasis on the use of soap and water.
- All visitors to the ward (including visiting staff) must be directed to wash their hands on entering and exiting the ward and isolation rooms. Hand washing basins should be signposted.

- Covering of food items at all times to avoid contamination with *C. difficile* spores.
- Restriction of patient admissions to affected area (ward/bay) for 48 hours to prevent 'seeding' of infection to other areas.
- Restriction of patient admissions from affected area (ward/bay)
- Patients in the affected area who develop diarrhoea/loose stools must have faeces specimen sent for *C. difficile* toxin testing. All patients in the affected area must have stool charts present and completed.
- Instigation of enhanced cleaning measures using a solution of hypochlorite detergent disinfection (1,000 ppm available chlorine) e.g. Actichlor plus
- Staff working on the ward must change their uniforms on a daily basis. Sufficient supplies of uniforms must be available.

7.4 **Potential outbreak of *C. difficile***

The identification of more than 2 or more related cases of *C. difficile* or 2 or more cases of hospital acquired *C. difficile* per week above an agreed background level for one week will initiate specific actions by the ICT and the DIPC in order to manage a potential outbreak of *C. difficile* (see also Outbreak Policy)

In addition to guidance provided in 7.2 above, the following additional measures will be implemented:

- ICT and DIPC consider need to form outbreak committee (see Outbreak of Communicable Diseases Policy). Chief Executive to be informed of decision.
- Potential outbreak to be reported to Kent Health Protection Unit as a hospital acquired infection Serious Untoward Incident (SUI) by the ICT.
- Potential outbreak to be reported to the SHA by the DIPC by completion of Trust SUI form
- Typing of C. difficile isolates by the Health Protection Agency to be requested.
- Restriction of admissions to and transfers from affected area.
- Resolution of the cluster/outbreak will be confirmed by the ICT. Following confirmation, the affected area will undergo a thorough clean of the whole ward environment, including all patient equipment with a solution of hypochlorite detergent disinfection (1,000 ppm available chlorine) e.g. Actichlor plus. A full curtain change is required.
- Patients may not be admitted to the ward until clean is completed and the nurse in charge is happy with the standard of cleanliness.
- Enhanced cleaning measures should be implemented and continue for a period of four weeks following resolution of the cluster/outbreak.

8.0 Auditing Compliance to this Policy

8.1 In order to ascertain compliance with this policy the following audit tool needs to be completed.

8.2 This is to be carried out be the Infection Control Nursing Team.

Elements / Observation	Antibiotic policy applied?		Correct hand hygiene?		Effective environmental cleaning completed?		Gloves and apron worn?		Single room / cohorting used?		All elements performed?	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
Total												
% Compliance												

Indicate 'YES' when the element was performed or considered not applicable and 'NO' to show that it was not performed.

- The tool is designed to facilitate rapid feedback for improvement and should be repeated at regular intervals to gauge progress
- The objective is to ensure that all elements of the clinical process are performed all of the time
- The percentage compliance gives an indication of which particular element needs attention

9.0 References:

CMO/CNO Letter – Infection caused by Clostridium difficile. 21st December 2005.

National Clostridium difficile Standards Group: Report to the Department of Health (2004)

High Impact Intervention Number 6: Reducing the risk of infection from and the presence of Clostridium difficile. Department of Health. May 2006.

Department of Health (1994) Clostridium Difficile Infection: Prevention and Management

APPENDIX 1

DISCHARGE LETTER FOR GP'S RE CLOSTRIDIUM DIFFICILE

Infection Control Department

Direct dial: 01622 224037 / 4038

Department of Microbiology
Preston Hall Hospital
London Road
Aylesford
Kent
ME20 7NJ

Date:

Dear Doctor

Re: _____ **DOB:** _____

The above was recently an inpatient on _____ Ward

During their hospital stay your patient was diagnosed as having Clostridium difficile infection and was treated with

_____

_____

_____

Clostridium difficile infection is almost exclusively associated with the use of antibiotics. Infection may become manifest whilst on antibiotics, but a significant number of cases occur following cessation of therapy, the incubation period extending to several weeks. Symptoms may include fever, abdominal pain, diarrhoea (with/without blood or mucus).

We are therefore writing to inform you that there is a small chance following discharge that:

1 Your patient could relapse with the infection. If this happens, please treat with oral Vancomycin, 125mg qds x 10 days or Metronidazole 800mg followed by 400mg tds x 10 days. If concerned about the severity of infection, hospital admission should be considered.

2 Future administration of broad-spectrum antibiotics could precipitate infection. (If antibiotics are required, a short course of a narrow-spectrum agent is preferable).

The discharge criteria for patients with *C difficile* is 72 hours symptom free and/or when clinically well enough for discharge (as for all patients).

For further advice either contact the Medical Registrar on call or the Medical Microbiologist on 01892 632356 or 01622 224048 or via switchboard outside working hours.

Yours sincerely

Discharging Consultant

Copies to: GP
Patient File
Infection Control Dept

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 2

STOOL CHART

Please affix patient label

Name:

Date of Birth:

Hospital Number:

Ward:

Date	Time	Stool Type	Amount	Colour/ Consistency	Blood Present ?	Sample sent?		Comments (please refer to chart overleaf)
						Date	Signature	

For all patients with diarrhoea of uncertain cause:

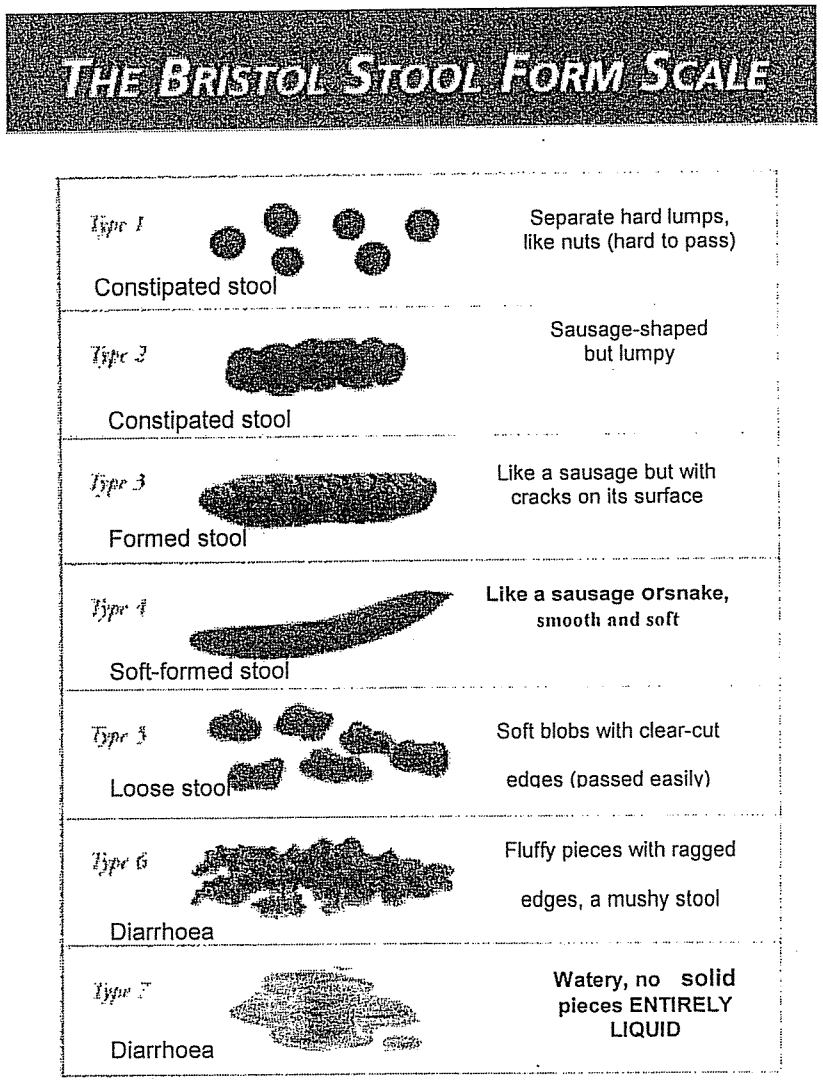
- Send a specimen for microscopy, culture and sensitivity (M, C & S).
- If the patient has had antibiotics recently, or is over 65 years of age, please request *Clostridium difficile* investigation (a single specimen may be sent for M, C & S and *Clostridium difficile*).
- Please state on request form if diarrhoea could be related to food, foreign travel or bowel disease.
- If possible send a specimen of stool that is not contaminated by urine.

  However, if this is not possible, a specimen of stool can be processed if urine is present but please state that this is the case on the request form.

NB: If patient has been in hospital for >48 hours, specimen will only be tested for *Clostridium difficile* investigation.

Definition of Diarrhoea:

An increased number (2 or more) of watery/liquid stools (i.e. type 6 & 7) that is greater than normal for the patient, within a duration of 24 hours.



With thanks to the Infection Control Dept Buckinghamshire Hospitals NHS

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Guidelines Title: **Guidelines for the control of Methicillin Resistant Staphylococcus Aureus (MRSA) in the hospital setting**

Originated by: *Infection Control Committee*

Main author: *Kate Chandler*

Other contributors: *The Infection Control Team*

Policy lead: *Gail Locock*

Supersedes: *List all existing policies superseded by this policy???*

Review date:

Approval date:

Evidence: **1. Guidelines for the control and prevention of methicillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities by the joint BSAC/HIS/ICNA working party on MRSA.** Journal of Hospital Infection (May 2006).

Why this policy is necessary:

How it will be launched:

How it will be audited:

CONTENTS

0 SUMMARY

1. **Meticillin Resistant Staphylococcus Aureus** (MRSA) is resistant to a wide range of antibiotics, therefore rendering treatment difficult with limited, potentially toxic, drugs.
2. MRSA appears to have the propensity to rapidly colonise wounds.
3. **Colonisation**: Occurs when a micro-organism establishes itself in a particular environment such as a body surface or mucous membrane without producing disease.
4. **Infection:** Entry of a pathogen into the body and its multiplication in the tissues leading to symptoms such as pyrexia, inflammation and septicaemia.
5. High-risk categories of patients must be screened either before or on admission.
6. All Patients for planned orthopaedic surgery (including day surgery) must be screened for MRSA before admission at pre-assessment. Results must be known before admission to treat accordingly any MRSA positive patients identified.
7. Follow section 2 for screening procedure.
8. Isolate all positive patients, whether colonised or infected.
9. Start topical decontamination treatment as outlined in section 4 and appendix 2.
10. Take extra Infection Control advice for patients with signs of clinical infection.
11. Every effort should be made to continue with the patients' normal sequence of treatment for other medical conditions.
12. The nature of MRSA infection/colonisation and the relevance of practices and procedures should be explained to the patient and relative.
13. Explanatory leaflets are available on all wards, stocks from the Patient Advice and Liaison (PALS) and from the Infection Control Nurses.

0.1 References

This policy is based on the **Guidelines for the control and prevention of methicillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities by the joint BSAC/HIS/ICNA working party on MRSA.** Journal of Hospital Infection (May 2006).

1 AIM

The aim is to control MRSA in the acute setting, thus preventing potential infections and the use of a limited number of toxic drugs.

2 INTRODUCTION

The British approved name of '**Methicillin'** has changed to '**Meticillin'**

Meticillin Resistant Staphylococcus Aureus: Normal antibiotic sensitive *Staphylococcus Aureus* is carried as part of the body flora by approximately 30% of the population at any one time. However, sometimes Meticillin Resistance occurs as the result of mutation. Some strains of MRSA are pathogenic and some show epidemic potential. However, it is not possible to detect which strain is present at the outset. Two characteristics of epidemic MRSA are of vital importance to clinical staff:

- MRSA appears to have the propensity to rapidly colonize wounds.
- MRSA is resistant to a wide range of antibiotics, therefore rendering treatment difficult with limited, potentially toxic, drugs.

For the Trust, significant extra work and expense is required to contain the spread of MRSA and ward closure may be considered in outbreak situations. However, it is possible to prevent MRSA transmission by all health care workers by using good Infection Control practices. These include handwashing, the appropriate use of gloves and aprons and the isolation or cohorting of positive patients when possible. As new cases of MRSA are identified it is important to maintain good Infection Control practice at all times.

3 ADMISSION SCREENING CRITERIA: (WHO TO SCREEN)

- All patients that have been admitted to this hospital or any other hospital in the last year.
- All patients previously known to be MRSA positive.
- Patients admitted from nursing homes, residential homes or other long term care facilities.
- Patients with long term wounds e.g. Leg ulcers, pressure sores, long term surgical wounds.
- Patients with long term indwelling devices e.g. urinary catheters, pegs, tracheostomy etc.

NB. It is the responsibility of the admitting nurse to review the patient's notes and patient centre for evidence of a patient's history of MRSA. i.e. look for red tick in MRSA box on patient centre, check past microbiology reports or look for evidence of note tagging with MRSA sticker.

See appendices two and three

3.1 High risk patients.

ICU:

- Screen all patients on admission at the Kent and Sussex / Maidstone hospital.
- Routinely screen patients once a week for MRSA, culture and sensitivity for those whose stay is prolonged.

3.2 Orthopaedic Joint replacement:

Aim: To prevent the patient becoming infected by their own MRSA and reduce the risk of cross infection.

NB. The incidence of infection is low in these patients, but the effect of MRSA infection when it occurs can be devastating.

- All Patients for planned orthopaedic surgery (including day surgery) must be screened for MRSA before admission at pre-assessment.
- Results must be viewed before planned admission to treat any positive patients accordingly.

Treatment recommended for pre-assessed orthopaedic patients identified MRSA positive.

See appendix one

NB. All swab results must return to the pre-assessment clinic for review. Staff should also liaise with the infection control team.

3.3 Emergency orthopaedic and trauma admissions:

Many patients in this group are elderly and may be resident in nursing or care homes and/or be in regular contact with hospital or other healthcare services.

Please refer to admission screening criteria

3.4 Renal medicine:

All patients on dialysis should be screened for MRSA on admission to the programme.

NB:

- Maidstone Hospital dialysis unit, refer to East Kent MRSA policy
- Pembury Hospital dialysis unit, refer to Guys Hospital MRSA policy

3.5 Oncology/chemotherapy inpatients:

These patients are at particular risk of MRSA bacteraemia because of their immunosuppression and the procedures for vascular access that are an essential part of their treatment.

- Patients must be screened on admission,
- Treated if positive with topical decolonisation
- Isolated with isolation precautions.
- Monitored closely for the duration of their admission
- Re-screened only if they develop signs or symptoms of infection.

4 SCREENING

Take swabs from:

- Nose – anterior nares – one swab for both sides
- Axilla
- Groin or perineum
- Any wounds or lesions
- Any long term indwelling device sites
- Take CSU specimen for patients with indwelling catheters and obtain a urethral swab from the insertion site.
- Collect sputum from patients who present with productive coughs
- Swab umbilical site of neonates

See appendix four

5 CRITERIA FOR PATIENTS WITH A KNOWN HISTORY OF MRSA

- Staff must check the patient centre for a red tick in MRSA box. This indicates whether or not the patient has a past history of MRSA
- Advise infection control team of patients admission
- Treat as a positive case
- Instigate source isolation precautions on admission-ideally in a single room.
- Collect a full MRSA screen
- Continue isolation precautions throughout admission period despite a negative screen.

NB The Infection control team will assess the need for decolonisation on receipt of results.

6 PLACEMENT OF PATIENTS FOUND NEWLY OR KNOWN TO BE MRSA POSITIVE:

Ideally the patient should be isolated in a single room with dedicated toilet facilities. Placement however will depend on the facilities available and the associated level of risk that is posed to them and others.

The infection control team will advise on placement if the patient can not be accommodated in a single room or cohorted.

A poster /information sheet detailing isolation precautions should be displayed prominently, to alert visitors, allied health professionals and healthcare staff to the cross infection risk.

7 PATIENT INFORMATION

7.1 Patients

Patients identified with MRSA infection or colonisation should be informed of their condition.

The psychological wellbeing of each patient must be considered. The nature of MRSA infection/colonisation and the relevance of practices and procedures should be explained to the patient and relative. Explanatory leaflets are available on all wards; stocks can be obtained from Patient Advice and Liaison (PALS) and from the Infection Control Nurses.

It is the responsibility of the clinical team / ward staff to inform the patient of their MRSA status and issue a patient information leaflet to the patient and any visitors as required.

NB. The Infection control team can be contacted to discuss any issues or concerns that the patient or family may have as a result of this.

7.2 Visitors

Visitors must be fully informed of the need for hand washing and isolation techniques (children and babies should be discouraged from visiting).

- Relatives and Visitors concerned with the direct care of the patient will be expected to wear gloves and aprons.
- Gloves and aprons do not need to be worn for social visiting. Visitors can still have close contact with the patient, including hand holding and kissing.
- Visitors visiting non- infected patients on the same day should visit them first and then visit with the infected patient last.

NB. Visitors should be advised not to visit other patients in the hospital after visiting a cross infective patient. i.e. MRSA/CDT

All visitors should decontaminate their hands using soap and water or alcohol hand rub after leaving the room / bed space of the patient.

8 TREATMENT

8.1 Colonisation (i.e. with no clinical signs of infection).

Instigate isolation precautions ASAP (see '***Isolation Nursing'*** Intranet; MTW policies/guidelines/information.

NB: For further advice on isolation techniques contact an Infection Control Nurse

8.2 Infection

Where there are clinical signs of infection, systemic therapy may be advised by the Consultant Microbiologist (Maidstone ext 24048 or Kent & Sussex ext 32356), in addition decolonize, following the procedure as listed above.

8.3 Signs of infection:

Pyrexia, local heat, swelling, tenderness or erythema, wound dehiscence, purulent

8.4 Decolonisation regime:

- 4% Chlorhexidine body wash/shampoo for five days (Apply following Manufacturers instructions) see appendix nine

- Mupirocin nasal ointment (bactroban) TDS for five days (Apply following manufacturers instructions)

- Naseptin nasal cream is to be used as an alternative for staphylococci eradication QDS for ten days if MRSA organism is Mupiricin resistant. (Apply following manufacturers instructions)

NB: The use of **mupirocin wound ointment (bactroban**) must be discussed with the Consultant Microbiologist before use.

- The decolonisation course should last for five consecutive days. (Unless otherwise advised by the infection control nurse)
- Re-screen patient following two days rest from treatment
- Continue with isolation precautions throughout admission period
- If there are signs of infection take individual advice from the Infection Control Team

NB: No more than two courses of mupirocin decolonisation are advised because prolonged or repeated use (i.e. for more than two courses for five days) may encourage resistance.

8.5 Neonate decolonisation

- Will depend on individual cases.

Careful consideration should be given regarding the appropriate use of agents used for decolonisation.

This must be discussed with the infection control team, paediatrician/ neonatologist.

9 MRSA IDENTIFIED DURING OTHER MICROBIOLOGICAL INVESTIGATIONS

9.1 Blood Culture

- Isolate patient and take full MRSA screen as above.
- Decolonisation will be advised by Infection Control Team.
- IR1 form will be generated by the infection control team and sent to the ward manager to complete a 'Root Cause Analysis' investigation to find what factors or events led to the infection.
- A photo copy of the IR1 and accompanying letter will be sent to the patient's Consultant for them to participate in the investigation from a medical perspective.
- Pink IR1 copies will be sent to the clinical risk team.

9.2 Wounds

- Isolate patient and take full MRSA screen as above.
- Decolonisation will be advised by the infection control team on receipt of results

9.3 Urine

9.3.1 MSU

- Isolate patient and take full MRSA screen.
- Decolonisation will be advised by Infection Control Team
- Dedicate toilet facilities
- Encourage patient hand hygiene
- Clinical team should liaise with consultant microbiologist to discuss systemic treatment if patient displays signs and symptoms of infection.

9.3.2 CSU

- Isolate patient and take full MRSA screen.
- Decolonisation will be advised by Infection Control Team
- Encourage patient hand hygiene
- Practice aseptic catheter care
- Consider changing catheter under systemic treatment if patient displaying signs or symptoms of infection
- Clinical team should liaise with consultant microbiologist to discuss the necessary systemic treatment.

NB. Some cases may require decolonisation to start immediately

10 PATIENTS REQUIRING SURGERY

See appendix seven and eight

Prior to any planned or invasive procedure, efforts should be made to minimise the level of risk of infection through topical and systemic decolonization, and prophylactic antimicrobial therapy as appropriate.

When positive MRSA patients require surgery, the following action is recommended:

- Inform the infection control team
- Operating surgeon / ward staff must liaise with the operating department to ensure the theatre manager is aware of the patient's MRSA status.
- Decolonisation is recommended two days prior to surgery and continued post operatively to complete the five day course
- Clinical teams are advised to liaise with the consultant microbiologist to discuss systemic prophylaxis
- Obtain MRSA screen if patient develops signs and symptoms of infection post operatively.

Where patients are transported to theatre on a bed, the ward staff must ensure the bed is clean and linen is changed at the preparation stage.

Infected or colonised patients should be treated using the full dirty case procedure, and operated on at the end of the list. Patient confidentiality must be respected.

11 SOURCE ISOLATION

Whether in a side ward or open ward, good clinical techniques will be effective in preventing the spread of MRSA between patients. Full isolation nursing guidance can be found on the intranet linked to MTW policies/guidelines/information.

Good hand hygiene remains one of the most important means to prevent transmission of infection.

Hand hygiene with soap and water or alcohol gel is recommended for use by all ward personnel and visitors after direct patient contact and prior to contact with other patients. An alcohol-based handrub should be readily available for use between procedures involving the same patient or after very transient, low risk patient contact. (This does not replace the need for proper hand washing).

All visitors including visiting staff must be encouraged to decontaminate their hands on entry and when leaving each ward.

12 PATIENT MOVEMENT:

12.1 Transportation:

The risk of cross-infection from an MRSA-colonised or infected patient to other patients in an ambulance is minimal. Good infection control practices and routine cleaning should suffice to prevent cross infection.

NB. High risk categories of susceptible patients should not be transported in the same ambulance as a known MRSA-positive patient.

Lesions should be covered.

12.2 Visits to Other Departments:

Transfer of the patient with MRSA between wards should be strictly limited and carefully supervised. Notification of the patient's MRSA status must be given in advance.

It may be necessary for a patient with MRSA to attend other departments within the trust for essential procedures or investigations. The receiving area should be notified of the patients MRSA status in advance of the transfer, so that appropriate arrangements can be made. Normally this is straightforward but if necessary advice can be obtained from the Infection Control Team with regard to individual patient circumstances. Situations will vary depending on patient need, positive site and underlying risks to others. For outpatients a risk assessment, on the need for contact precautions, must be carried out.

Any known MRSA patient scheduled to visit any department for essential procedures or investigations must be placed last on the clinic list

- All attendants who may be in contact with the patient should wear disposable plastic aprons to protect their clothing whilst in contact with the patient.
- Aprons should be removed when contact with the patient has finished and disposed of as clinical waste.
- Gloves need only be worn if staff transporting the patient has skin abrasions. i.e. cuts, burns eczema and dry or cracked skin
- Clinical staff within the department should wear gloves appropriately. i.e. whenever contact with body fluids is anticipated.
- Trolleys and chairs used to transport the patient to the department should be cleaned with Actichlor Plus before being used for another patient. This is the responsibility of the user. i.e. Nurse or porter
- All linen should be dealt with as infected and placed in the dissolvable plastic bag within the soiled linen red canvas bag.
- Staff should decontaminate their hands thoroughly after dealing with the patient and on cleaning the trolley or chair.
- Cleaning and decontamination of occupied spaces and medical equipment with in the department should be undertaken using Actichlor Plus once the patient has left the department.

12.3 Mobilisation and Rehabilitation of Patients

Every effort should be made to continue with the patient's normal mobilisation and rehabilitation treatment. Advice should be sought from the Infection Control Team as to the suitability of mixing with other patients. The positive body-site and nature of underlying disease will be considered.

13 STAFF SCREENING

13.1 Screening of staff

Staff screening for MRSA may be necessary if transmission continues on a unit despite active control measures, if epidemiological aspects of an outbreak are unusual, or if they suggest persistent MRSA carriage by staff. The Infection Control Team will decide if screening is needed and will arrange for it to be done in conjunction with the Occupational Health Department.

- Staff found by chance to have MRSA in specimens taken for clinical reasons should be screened to determine if MRSA is present in the common sites for MRSA carriage.
- Staff should **NOT** send screening swabs from themselves unless asked to by the Infection Control Team.
- The sites to be screened are nose, throat and any areas of abnormal or broken skin.

NB. Swabs should, if possible, be taken as staff come on duty at the beginning of their shift rather than during or at the end of a shift. Staff found to be MRSA positive should then also be screened in the groin or perineum.

13.2 Treatement

- Staff found to MRSA positive will be referred to the Occupational Health Department for treatment.
- The same combination of agents used for decolonization of patients will be used for decolonization of staff. Usually, only staff members with colonized or infected hand lesions should be off work while receiving courses of clearance therapy.
- One five day course of clearance therapy should be given and then two days later a repeat set of screening swabs taken.

- Three negative screens at weekly intervals (taken when the staff member is not receiving clearance therapy or any antimicrobial treatment) are needed before a previously positive staff member can be considered to be clear of MRSA.
- The Consultant Microbiologists will advise if further courses of clearance therapy or other treatment will need to be given to those staff who remain positive for MRSA on re-screening.

14 CLEANING

MRSA has the ability to survive in dust, thus the need for dust minimization and the removal of fomites from contact surfaces is essential.

- All surfaces within the Bed space of an MRSA positive patient must be cleaned with actichlor plus twice daily i.e. locker tops, windowsills, medical rail, tables, floor etc. throughout their admission period

- The bed space and all equipment used by the patient must be terminally cleaned with actichlor plus following the patients discharge. Curtains must also be changed

- Pillows and mattress must be checked for damage.

- Alcohol gel must be available at the end of the patient's bed.

- Instruments and equipment should preferably be single patient use i.e. disposable blood pressure cuffs etc.

- Multiple-patient-use items should be decontaminated with actichlor plus before use on another patient.

- All healthcare personnel should be aware of local policies for environmental cleaning, equipment decontamination, waste and linen management. **These protocols must be applied rigorously.**

15 OUT PATIENT CLINICS/CLINCAL INVESTIGATION UNITS/A&E DEPARTMENTS

Any known MRSA patient scheduled to visit any department for essential procedures or investigations must be placed last on the clinic list

It is the responsibility of the nurse in charge of the department or clinic to request a terminal clean.

- Any clinical room or space occupied by a known MRSA patient must be decontaminated with Actichlor plus i.e. all surfaces
- Curtains need only be decontaminated if the procedure carried out on the patient presents a high risk of contamination into the environment. i.e. dermatological procedures
- As a rule all reusable curtains in clinical areas must show evidence of a rolling laundering programme every Six months.
- All reusable patient equipment must be decontaminated in line with manufacturers guidance and trust decontamination guidelines i.e. blood pressure cuffs, oxygen saturation probe etc
- All disposable items must be disposed of as clinical waste.
- All linen must be treated as infected linen. i.e. disposed of in alginate bag within the red canvas bag.

NB. All protocols can be found under infection control on the intranet linked to MTW policies/guidelines/information.

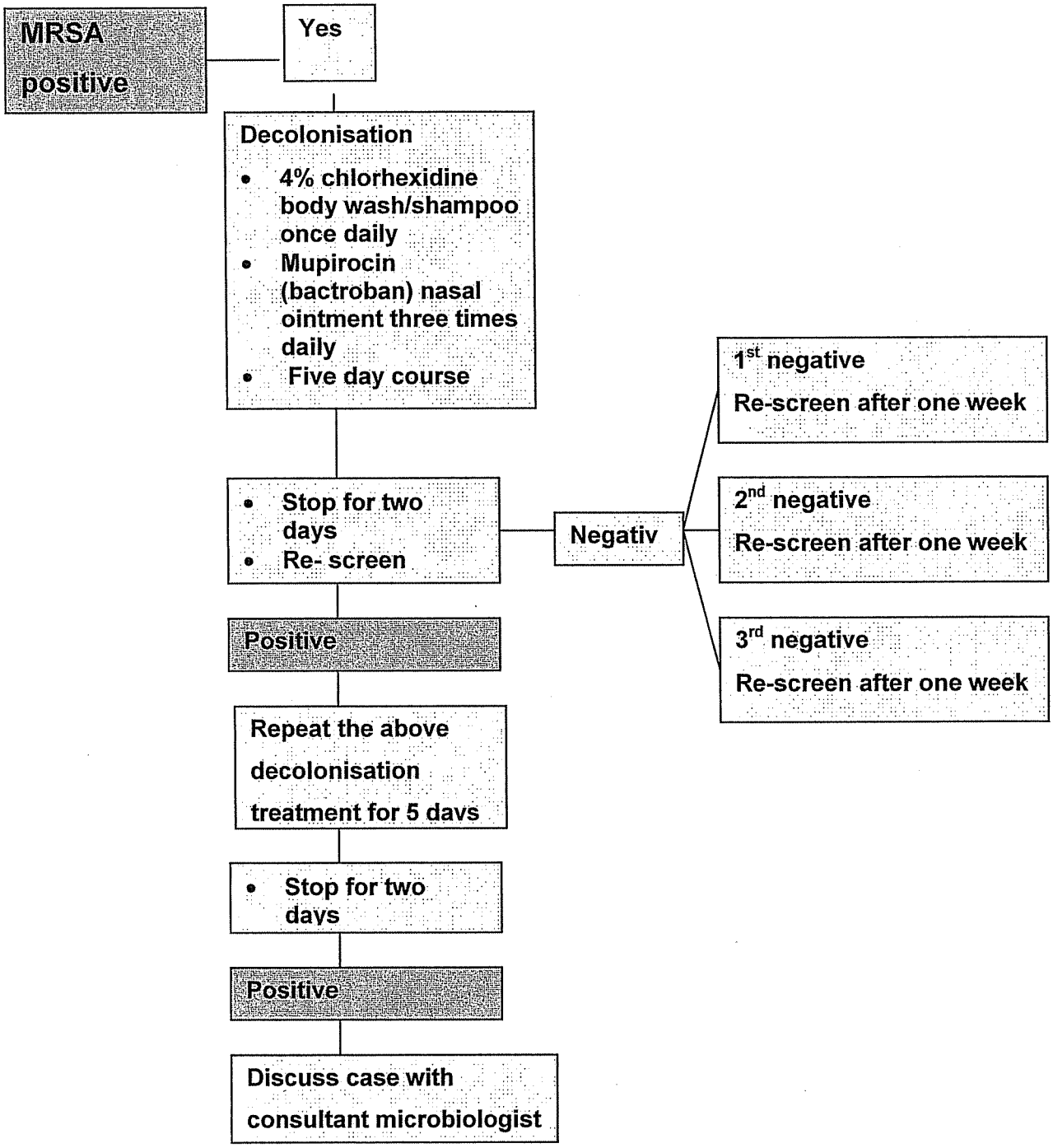
16 REFERENCES

1. Guidelines for the control and prevention of methicillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities by the joint BSAC/HIS/ICNA working party on MRSA. Journal of Hospital Infection (May 2006).

2. Screening for methicillin-resistant staphylococcus aureus (MRSA) colonisation: A strategy for NHS trusts: a summary of best practice DOH (October 2006)

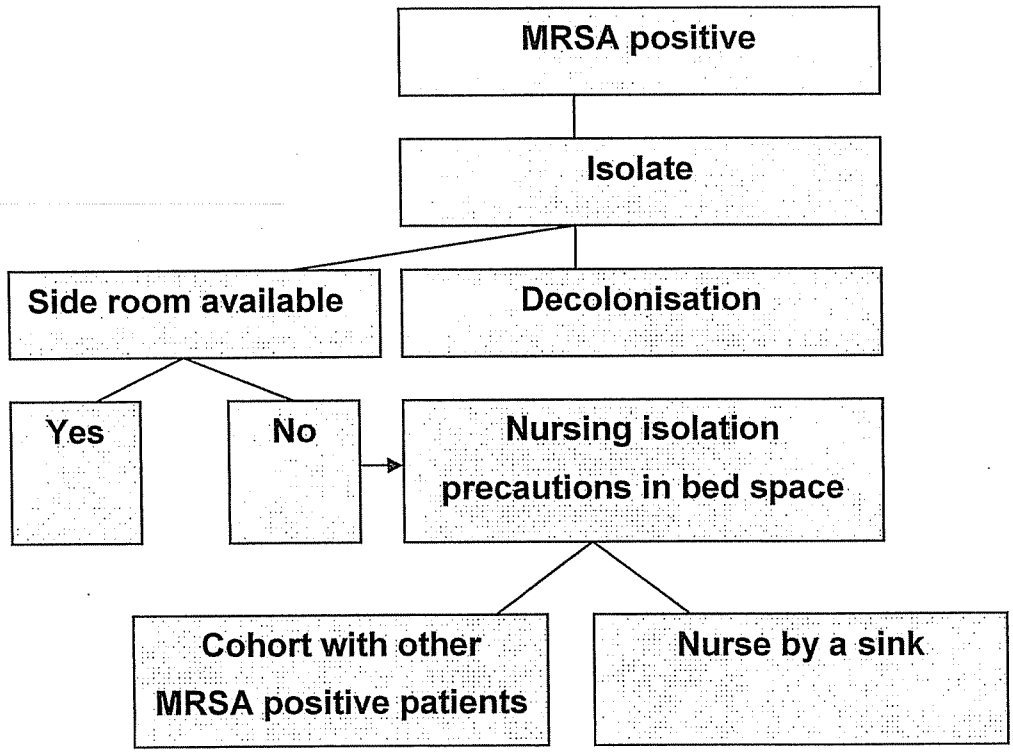
17 APPENDIX ONE

Recommended protocol for treatment of pre-assessed orthopaedic elective patients MRSA positive



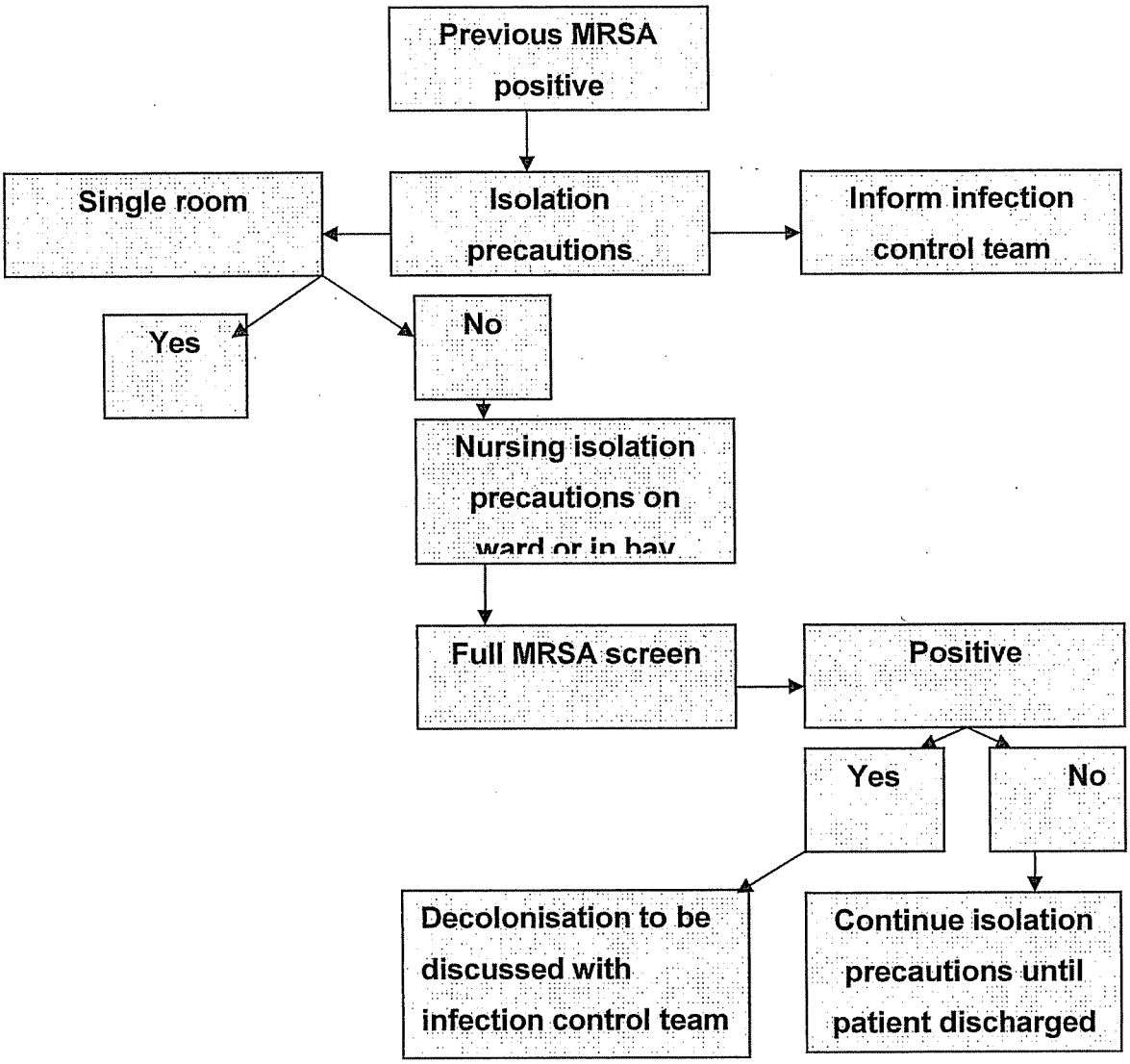
18 APPENDIX TWO

Flow chart for MRSA positive patients



19 APPENDIX THREE

Flow chart for previous MRSA positive patient.

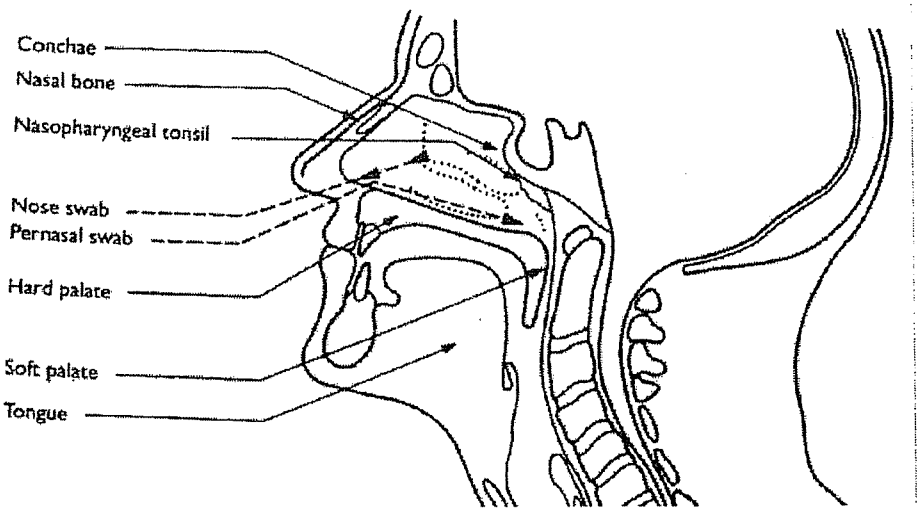


20 APPENDIX FOUR

PROCEDURE FOR TAKING MRSA SCREEN SWABS

Nose: One swab, moisten first, rotated in each anterior nostril in turn. Anterior nares (just inside the nose). It is not necessary to use one swab for each nostril.

Area to be swabbed when sampling the nose.



Chronic Wound: Clean or irrigate as normal
Take swab

Acute Wound: Take swab prior to cleaning.

Groin and Axilla.

Pre-moisten swab. Use one swab for both groins. One swab for both axillae. **It is not necessary to use one swab for each side for either groin or axillae.**

NB. MRSA screening should ideally be taken before a patient washes however screens can be taken at any time of the day or night if required.

21 APPENDIX FIVE

Department of infection control.

Patient prescription for Decolonisation of Meticillin Resistant Staphylococcus aureus

THIS FORM TO BE ATTACHED TO TREATMENT CARD

PATIENT:	HOSPITAL NO:
WARD:	CONSULTANT:

	Date of course							
Pharmacy use		Time	1	2	3	4	5	
	Mupirocin Nasal Ointment	8						
		14						
		22						STOP
	Mupirocin Nasal Ointment to indwelling device sites							Wait 2 days then take 1st set of clearance swabs
	Mupirocin 2% Ointment for Wounds							
	4% Chlorhexidine Body wash/shampoo	With wash						
	4% chlorhexidine as Shampoo. Apply once on commencement of protocol.							
	Chlorhexidine Antiseptic Dusting Powder	After wash						
Doctor's Signature:		Date:						

Mupirocin Nasal Ointment	Apply a match sized amount to each nostril on a disposable cotton bud 3 times a day.
Mupirocin Nasal Ointment	Apply to all indwelling device sites daily (eg, IVIs, catheters).
Mupirocin 2% Ointment	Apply to wounds/lesions once daily (Pharmacy will dispense appropriate number of tubes.
4% Chlorhexidine	Use instead of soap for the duration of the protocol.
4 % Chlorhexidine for Shampoo	Wash hair once on commencement of protocol.
Chlorhexidine Dusting Powder	Apply to axilla and perineum once daily after bath (obese patients)

Enter No. of Treatment Sites

IV (Number) Catheter

Wounds

Stoma (Number)

N.B. PLEASE ENSURE PRESCRIPTION IS SIGNED BY DOCTOR AND EACH DOSE IS SIGNED FOR BY THE NURSE ADMINISTERING TREATMENT.

FAILURE TO DO THIS CONSTITUTES A DRUG ERROR.

22 APPENDIX SIX

WARD MRSA CHECKLIST

Patients Name	Hospital Number	Date and signature
The nature of MRSA has been explained to the patient and their relatives where appropriate (with patient's consent). Information leaflet provided. Yes / No Questions answered Yes / No Contact infection control team if required.		
Visitors are asked to wash/gel hands when leaving the area		
Patient isolated in single room: Trolley or wall mounted equipment wrack containing essential equipment outside room. Patients notes outside room Isolation poster on door Yellow bin inside room Alcohol gel available outside room and at the end of patient's bed.		
Patient isolated on ward Preferably by a sink Cohorted with other known positive MRSA patient's Equipment trolley at the end of bed Yellow bin at the end of bed Isolation poster Alcohol gel at the end of bed		
Isolation nursing is being carried out in accordance with Trust Isolation Procedure (Infection Control policy on intranet). Equipment is provided: • Disposable gloves • Disposable aprons • Hand decontamination equipment • Clinical waste bin at the end of the bed or inside isolation room • Single patient use non-disposables e.g. Blood pressure cuff, hoist slings etc.		
Domestic Supervisor informed of need for isolation/terminal cleans Bed spaces and all surfaces must be cleaned twice daily		
Decontamination procedure followed according to trust MRSA procedure, yellow chart in use.		
Inform other departments of patient's MRSA status before transfer and/or prior to investigation/treatments. Please indicate which departments visited and informed.		

23 APPENDIX SEVEN

MRSA POLICY FOR THEATRES

All known MRSA patients having planned surgery ***must*** be placed on the end of the list.

- Porters and nurses involved in the transfer of patients must wear gloves and aprons as necessary depending on likely contact with the patient or contaminated beds etc.
- Hands must be decontaminated when aprons and then gloves are removed.
- There is no need to wear gloves and aprons through the hospital unless direct clinical contact with the patient is likely en route.
- On arrival to theatre the patient should be taken directly to the operating theatre.

Theatre Personnel

- Universal precautions must be strictly adhered to (Infection Control Manual, intranet, linked to MTW policies/guidelines/information).
- Additional protective clothing is not necessary although there should be masks and goggles available for the scrub team should splashes be likely.
- Unnecessary equipment should be removed from theatre before the patient's arrival.
- Excess staff members should be asked to leave.
- The patient should be anaesthetised and recovered in theatre. If this is not possible, the patient should be segregated as far as possible within the recovery area and nursed by staff dedicated to their care, employing standard isolation precautions.
- Theatre should be cleaned immediately after the patient has vacated. Actichlor Plus one tablet to one litre of water must be used for environmental disinfection. Any metal surfaces must be rinsed with clean water once the hypochlorite has dried. Doors must then be closed and theatre left for 20 minutes to allow for a complete air exchange.
- All rubbish to be disposed of as clinical waste.
- Linen must be handled as infected.
- All theatre personnel involved in the care of the patient must change theatre clothing at the end of the case.

ENSURE HANDS ARE WASHED WITH HIBISOL AFTER EVERY PATIENT INTERVENTION AND AFTER REMOVING GLOVES.

24 APPENDIX EIGHT

RISK ASSESSMENT FOR MRSA IN THEATRE

To be completed by person in charge of operating list

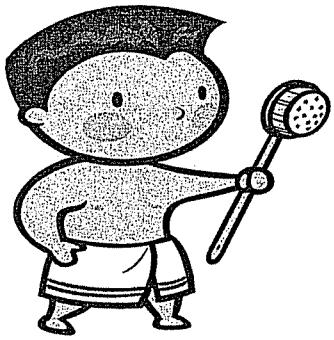
Patient Name: Hospital Number Site of MRSA

	Yes	No	
Has the patient a heavily exudating wound?			If yes, gloves and aprons to be worn when clinical contact anticipated en route to theatre.
Is the patient very confused or agitated?			If yes, anaesthetise in theatres due to disturbance of linen – skin shred.
Does the patient's bed have a head down and raise facility?			If no, trolley must be used for transfer to ensure safety.
Does the patient's bed have clean linen prior to transfer to theatre?			If no, trolley to be used. Linen must not be changed in anaesthetic room due to skin shred
Are there any medical indications for the patient not being anaesthetised on a bed, requiring transfer to trolley?			If yes, use trolley for transfer to ensure safe airway.

25 APPENDIX NINE

Patient information

Skin decolonisation using 4% chlorhexidine body wash / shampoo



Patients should bathe daily for Five days.

- **The skin should be moistened and the antiseptic detergent should be applied thoroughly to all areas before rinsing in the bath or shower**

- **Special attention should be paid to known carriage sites such as the axilla, groin and perineal area**
- **The antiseptic solution should also be used for all other washing procedures and for bed bathing**
- **Clean clothing, bedding and towels should be provided for each bath and hair wash**

Maidstone and Tunbridge Wells NHS Trust

26 APPENDIX TEN

OCCUPATIONAL HEALTH DEPARTMENT PROCEDURE FOR TREATMENT OF STAFF

MAIDSTONE & TUNBRIDGE WELLS NHS TRUST
MRSA NOTIFICATION

SURNAME _____ FIRST NAME _____

JOB TITLE _____ WARD/DEPT _____

MEMBER OF STAFF NOTIFIED (DATE) _____

SEEN BY OCCUPATIONAL HEALTH (DATE) _____

The recent swab results show that MRSA is present in the following sites:

NOSE ☐ THROAT ☐ SION ☐

Therefore you will need to commence the following treatment:

1. **Bactroban (Mupirocin 2%)**
   Three times per day. Apply a small amount to the tip of your little finger and apply to one nostril ensuring even cover to the entire surface of the nostril, wash hands, repeat with other nostril. The ointment may also be applied to skin lesions on the advice of the Consultant Microbiologist/Infection Control Nurse.

2. **4% chlohexidine Body-wash/shampoo**
   - Used daily added to your bath water (20mls) or simply use as a shower gel substitute. **(NB always refer to manufacturers guidelines before use).**
   - Use as a hair shampoo three times per week or ensure hair and scalp is thoroughly immersed in bath water daily. You may use a conditioner following shampooing.

3. **Chlorhexidine gluconate mouthwash**
   Gargle three times a day.

Protocol

The following decontamination procedure is recommended for those staff who are colonised with MRSA.

	Frequency	Product	Duration
Hair wash	Daily if possible	4% Chlorhexidine	5 days

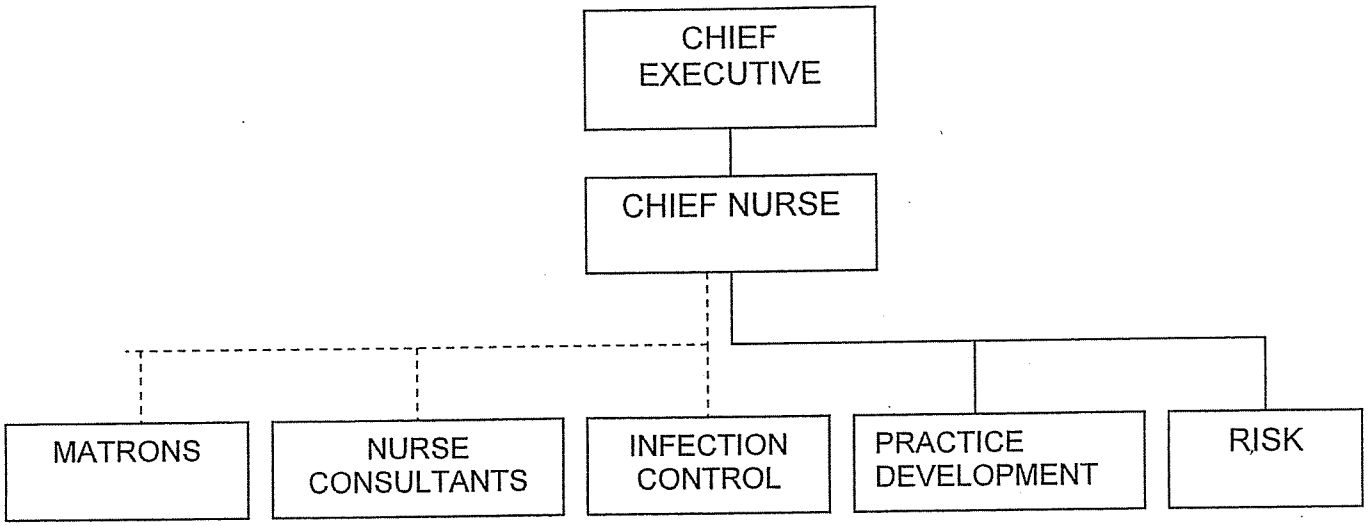
Skin wash	Daily bath or Shower if possible	4% Chlorhexidine	5 days
Nose	Morning Afternoon Evening	Bactroban	5 days
Throat	Morning Afternoon Evening	Chlorhexidine	5 days

27 APPENDIX ELEVEN

Staff MRSA Investigation Flow Chart	
Identification of MRSA outbreak (two or more cases believed related within same area- or unexplained case within high risk area e.g. SCBU /. ITU that warrants concern	
Liaise with Consultant Microbiolog8st provide details: - patient name / clinical information / ward / consultant	
Consultant Microbiologist to advise on whether staff screening warranted	
ICN to obtain staff number and list of names for screening based on criteria outlined by Consultant Microbiologist. (time frame for screening outlined by Consultant Microbiologist	No further action to be taken
Principal Microbiologist to be informed if staff screening to be undertaken and number of staff concerned. Agreement to be obtained prior to proceeding subject to departmental resources and screening guidelines	If **NO** Inform Consultant Microbiologist if resources limited. To discuss with Director for Infection Prevention and Control
Occupational Health Department to be notified that MRSA investigation has been recommended and agreement to proceed obtained. List of staff names to be screened to be provided.	
Staff for screening identified by Consultant Microbiologist. ICN to forward list of staff to Principal Microbiologist for coding prior to commencement of screening.	
Coded list forwarded by Principal Microbiologist to: Consultant Microbiologist / Reception Staff / Laboratory personnel / Infection Control Nurses to forward list to Occupational Health	
Infection Control Nurses to issue out staff screening guidance to ward / department / staff grouping concerning procedure once agreed / authorized by Consultant Microbiologist.	
Staff screening to commence with limitation on number of swabs per day / time of week as outlined by Principal Microbiologist	
Consultant Microbiologist notified of any positive staff. Occupational Health to be notified by Infection Control Nurses.	Occupational Health to notify staff member concerned. Treatment to be issued where necessary. Any staff found to be colonized **to continue working** whilst on treatment unless otherwise advised by Consultant Microbiologist or Occupational Health Physician.

Maidstone and Tunbridge Wells NHS
NHS Trust

NURSE LEADERSHIP STRUCTURE



4. **What is the process for training nurses/clinicians etc on the importance of infection control?**

Infection control training is included in both the annual mandatory update and the Trust welcome day.

Trust Welcome Day
The Trust welcome day incorporates all new members of staff, both clinical and non-clinical, with the exception of new doctors. The welcome days are run every 2 weeks on alternating sites across the Trust and the infection control nurses have a 1 ½ hour slot covering general infection control issues and hand hygiene technique training and a knowledge test quiz. This has been the process since January 2007. (The infection control training presentation is attached).

Annual Mandatory Updates
The Mandatory updates are for all clinical members of staff, with the exception of doctors, and are run twice weekly on alternating sites across the Trust and the infection control nurses have a 45 minute slot covering general infection control issues and hand hygiene technique training. This has been the process since January 2007. (The infection control training presentation is attached).

Doctors Induction
Doctors induction takes place twice per year in February and August with the new intake of doctors. The infection control nurses have a slot on both occasions at both ends of the Trust.

Clinical Governance Half Days
The infection control nurses also have a regular presentation on the clinical governance half days to each directorate throughout the year where there is a large audience, made up mostly of doctors, including consultants, and the presentation is updated throughout the year to give the most up to date infection control rates. (Training presentation attached – titled infection control especially hand hygiene)

Ad-Hoc Training
In addition to these pre-planned structured sessions, the infection control nurses will also carry out what is termed ad-hoc training in the clinical environment in response to an incident in order to have quick instillation of knowledge and awareness which are open to all staff members in the specific area, both clinical and non-clinical, including doctors.

5. How are the patients and visiting public kept informed of the importance of infection control?

It is vital that the general public, both in the shape of patients and visitors are kept informed of any issues relating to infection and made aware of the important role they have to play in helping to prevent and control any outbreaks of infection.

Information Leaflets

There is a small selection of patient and visitor information leaflets currently available within the Trust covering MRSA, C. difficile, Norovirus and hand hygiene. There are to be 3 further leaflets available by the end of the year covering discharge advice for MRSA and C. difficile and a new leaflet about ESBLs. These are available in wards and departments in the lealfet racks which are stocked up by a volunteer who works with the PALS service. These leaflets are also available in the pre-assessment clinics and PALs offices, on the intranet and directly via the infection control team.

Press Releases

The Trust take a very proactive stance on informing the general public in the event of an outbreak of infection and a press release will be issued via the trust communications team.

Information at Entrance to Hospital Sites

There is hand hygiene facilities at the entrance to the hospital sites as well as general infection control information. In the event of an outbreak this information will be altered to give the most up to date picture.

Patient and Public Involvement (PPI)

The Lead Infection Control Nurse meets every two months with a representative of the PPI forum and presents approximately twice per year to the forum meetings.

This page is intentionally left blank

East Kent Hospitals NHS
NHS Trust

Health Overview & Scrutiny Committee

Friday 9 November 2007

Hospital Acquired Infection & Infection Control in East Kent Hospitals NHS Trust

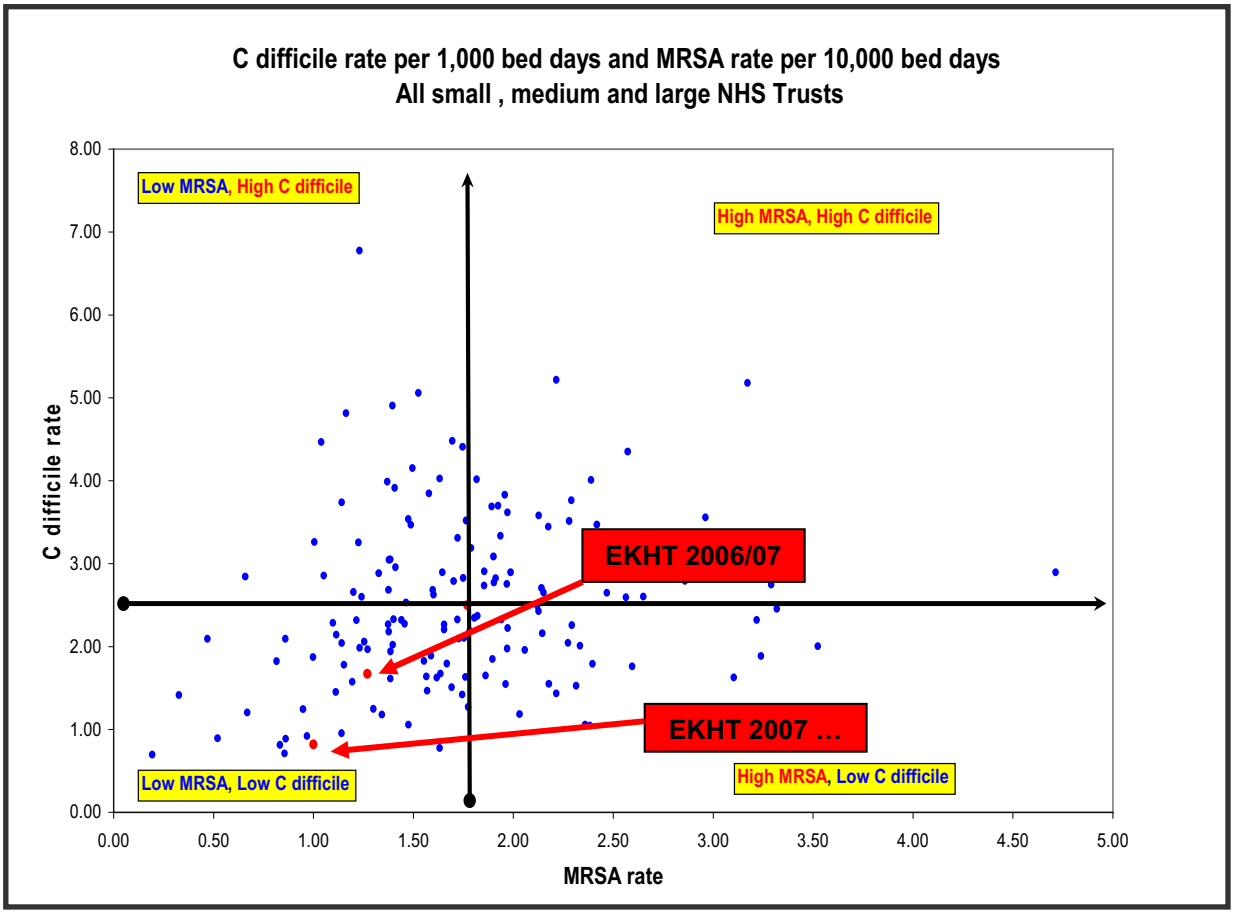
In attendance for East Kent Hospitals NHS Trust:
Matthew Kershaw, Chief Operating Officer
Julie Pearce, Director of Nursing, Midwifery & Quality
Sue Roberts, Deputy Director of Infection Prevention & Control

This page is intentionally left blank

Introduction

The Trust continues to maintain a high profile around infection prevention and control in the delivery of safe quality care. Since 1 April 2007 East Kent Hospitals has demonstrated significant progress in the reduction of MRSA bacteraemias and Clostridium Difficile. Figure 1 shows the Trust's performance for both MRSA bacteraemias and C.difficile and benchmarked against similar sized NHS Trusts. East Kent Hospitals is currently in the bottom left hand quadrant showing low rates in both infections and strong infection prevention and control performance when compared with other Trusts. MRSA rates are 0.79 compared to a national average of 1.59 per 10,000 bed days and C.diff rates are 0.8 per 1,000 bed days compared to a national average of 2.5.

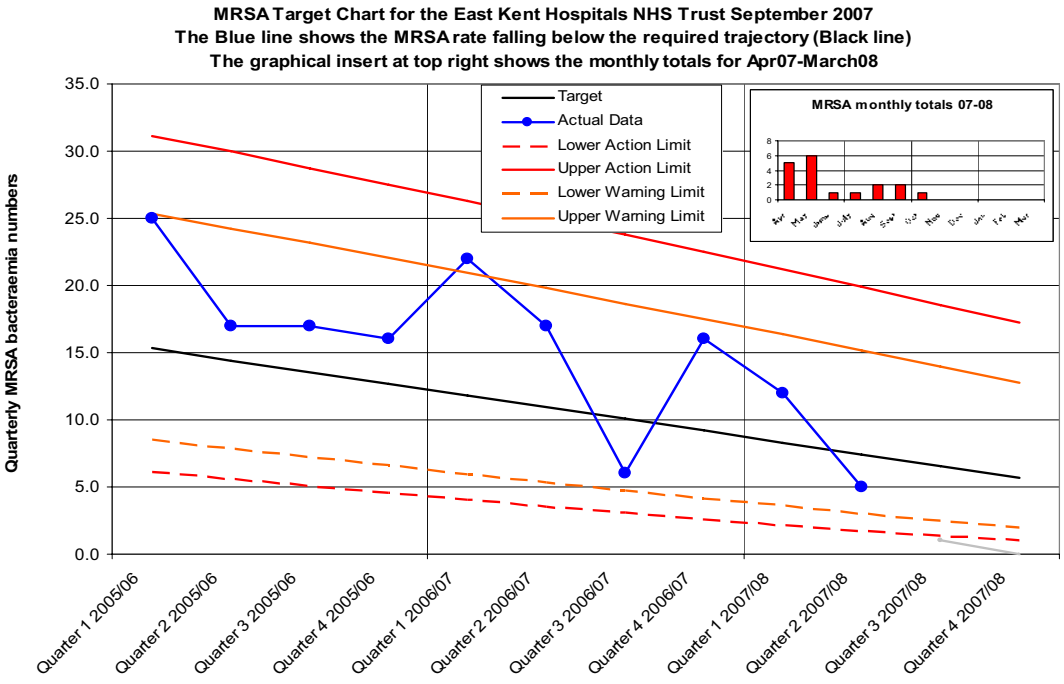
Figure 1: National comparison of C difficile and MRSA rates.



At a local level current performance figures indicate the lowest rates in MRSA bacteraemias for several years. Improvements in the Trust's infection rates are shown in figures 2 and 3.

The Department of Health's target for 2007/08 is 28. Figures for the period April to September show 17 cases compared to 39 cases in the same period last year. Out of the 17 reported cases, 10 are pre 48 hour cases which means that the patient was already positive for MRSA bacteraemia on admission. Improvements in practice have had a positive impact on infection rates and hence progress towards the year end target requires the continued focus on MRSA control measures.

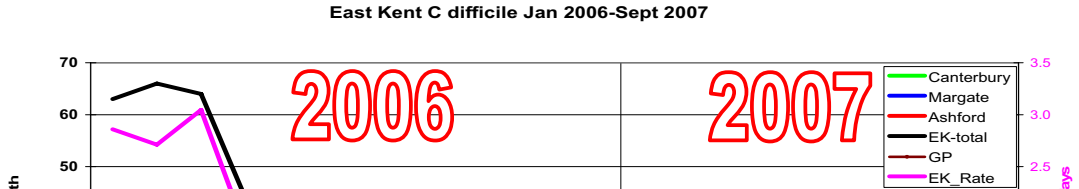
Figure 2: MRSA Bacteraemia



The total number of cases has decreased during September from 17 to 13, the lowest monthly total since surveillance began in January 2002 and in excess of a 50% decrease on the January to September period for the previous year. The rate per 1,000 bed days [aged >65 & including PCT cases] in the Apr-Sept period is 0.8 /1,000 bed days (NHS average 2.5 for acute Trusts excluding single specialty and paediatrics).

In order to maintain this low level it will be essential for ward staff to react quickly to each case of C difficile and promptly implement all infection control measures including a check on the antibiotic prescribing. In support of the work the Trust has already implemented an antibiotic prescribing practice and there is also dedicated microbiology support at the Queen Elizabeth the Queen Mother Hospital to intervene and amend treatment accordingly.

Figure 3: Clostridium difficile



	Jan			Apr			Jul			Oct			Jan			Apr			Jul		
Canterbury	24	12	16	13	16	6	5	8	4	7	12	7	5	4	2	6	4	2	0	5	6
Margate	24	26	24	15	11	13	11	11	12	6	13	7	4	9	9	6	8	8	10	6	2
Ashford	15	28	24	16	5	5	18	11	6	12	8	11	11	4	7	5	4	4	8	6	5
EK-total	63	66	64	44	32	24	34	30	22	25	33	25	20	17	18	17	16	14	18	17	13
GP	8	5	16	9	3	9	5	11	4	14	8	8	12	3	16	8	6	7	6	6	9
EK_Rate	2.9	2.7	3.0	1.9	1.3	1.4	1.4	1.5	1.2	1.4	1.4	1.2	1.3	0.7	1.3	0.9	0.7	0.78	0.9	0.8	0.8

Since April, East Kent Hospitals has received considerable scrutiny from external agencies in relation to its performance in infection prevention and control against the national trajectory. This scrutiny has involved inspections from the Department of Health HCAI / MRSA Improvement team and the Healthcare Commission. Where recommendations have been made these have been incorporated into the current programme and have been subjected to regular performance reporting by the Trust's Clinical Management Board and Trust Board and also be the Department of Health. A follow- up visit by the review team on 19 October noted the considerable progress that had been achieved in ensuring that healthcare associated infections continued to feature in board level discussions and that outcomes were reflected in operational practices, embracing the "Board to Ward" philosophy.

1. The Management Structure for Infection Control in the Trust

The management structure for infection control encompasses reporting, governance and monitoring arrangements. There are a number of roles and committees that are key to this process (appendix 1). The Trust Board executive and non executive members play an important role in ensuring that adequate controls are in place and are assured on the effectiveness of the actions taken in relation to performance, patient safety and outcomes. Whilst all executive directors have a statement detailing their responsibilities in supporting the delivery of safe, quality care, the Medical Director and the Director of Nursing, Midwifery and Quality have specific responsibilities defined in relation to infection prevention and control. Similarly there is the expectation that the non executive directors will also contribute to the Trust's infection control programme. A recent amendment to their handbook has resulted in the following expectation from Non Executive Directors:

"Non Executive Directors will hold Executives to account for the "quality" of service delivered and the patient experience, including, <u>but not exclusively</u> assurance on:

Clinical governance standards; safe equitable and consistent clinical practice; and the safety of the patient through systems that ensure staff are appropriately trained and skilled; the environment is clean and safe; and the opportunities for harm (e.g. through infection) are minimized"

Non Executive Directors Manual (August 2007)

The infection prevention and control programme is delivered through a robust strategy led by the Director of Infection Prevention and Control and the Infection Control Team. Their roles are outlined below.

Director for Infection Prevention & Control (DIPC)

The DIPC is responsible for leading the Trust Infection Control Team (ICT) is directly accountable to the Chief Executive and reports directly to the Trust Board on a regular basis.

The DIPC is a consultant Medical Microbiologist and is supported by a deputy who is the lead Infection Control Nurse/Advisor.

DIPC responsibilities include:

- Leading the Infection Control Team
- Overseeing the maintenance, development and implementation of Infection Control Policy
- Reporting directly to the Chief Executive and Trust Board on Infection Control matters
- Identifying and challenging poor infection control practice in the Trust
- With support from Microbiology and Pharmacy colleagues, identifying and challenging poor antimicrobial prescribing
- Monitoring Healthcare Associated Infection (HCAI) and making appropriate changes in policy in response to identified threats.
- Representing the ICT on the EKHT Clinical Governance Steering Group
- Liaison with other governance structures including patient safety and risk management

The Infection Control Team (ICT)

The ICT meets monthly and is chaired by the DIPC or Deputy DIPC.

The ICT is comprised of medical and nursing Infection Control professionals who are responsible for the day to day operation of the infection control service including maintenance of up-to-date policies, provision of advice to clinical and management colleagues, monitoring of infection risks in clinical areas, monitoring of compliance with infection control policies and response to outbreaks of hospital infection. The main business of the ICT is to produce and implement the Infection Control Annual Programme and to resolve current infection control problems in the Trust by appropriate action or issue of advice. Members of the ICT provide a 24/7 on call service for provision of infection control advice to clinical and management colleagues.

The ICT reports to the Infection Control Committee.

The Infection Control Committee (ICC)

The ICC meets quarterly and is chaired by the DIPC or deputy.

The ICC is comprised of the ICT, the Chief Executive (or CE representative), nominated infection control leads from all Clinical Directorates and representatives from other relevant groups within the Trust including:

- Hotel Services
- Estates
- Pharmacy
- Occupational Health
- Risk Management

The ICC reports to the Clinical Governance Steering Group and is responsible for supervising the delivery of the Annual Infection Control Programme and the Infection Control Annual Report.

Infection Control in Clinical groups

Infection Control leads have been nominated for each Clinical Directorate and have responsibility for implementing specific Infection Control Key performance targets for their directorate. The IC leads are essentially responsible for implementing and monitoring infection control policies in their clinical areas.

As part of the performance monitoring arrangements, key indicators have been agreed with all directorates from which a monthly report is compiled on local performance and reported to the Clinical Management Board of which the Clinical Directors are all members.

Infection Control leads report to their Clinical Director within the Directorate Clinical Governance framework and represent their Directorate on the Infection Control Committee.

In addition, these specific infection control arrangements feed into the Trust's existing governance and assurance arrangements. The minutes of the Infection Control Committee are reported to the Clinical Governance Committee chaired by the Medical Director. The steering group in turn reports to the Governance Committee (Board sub-committee) and to the Trust Board. In terms of direct reporting to the Board, the Director for Infection Prevention & Control has a reporting line to the Chief Executive and provides regular reports to the Board on MRSA bacteraemia and Clostridium Difficile performance.

2. Process for Dealing with MRSA bacteraemias and Clostridium Difficile

The Trust has separate policies for the management of MRSA (September 2005) and Clostridium Difficile (March 2007). In addition the management of HCAIs also forms part of the Operational Escalation Plans for each hospital, this ensures that infection control is a key factor in the internal movement of patients during times of extreme bed pressures.

The management principles adopted are:

- Identification of the patient
- Safeguarding other patients through the isolation of individuals and cohorting in bays or on wards known cases.
- Decolonisation of affected patients as appropriate
- Use of isolation precautions in patient care
- Use of equipment dedicated to the patient to reduce the spread of infection through contamination

Hand hygiene practices are consistently a key control principle. The isolation of patients is also a key control measure. The Trust has recently committed over £150,000 of the HCAI funding from the Strategic Health Authority to purchase equipment for use in isolation rooms and cohorted bays.

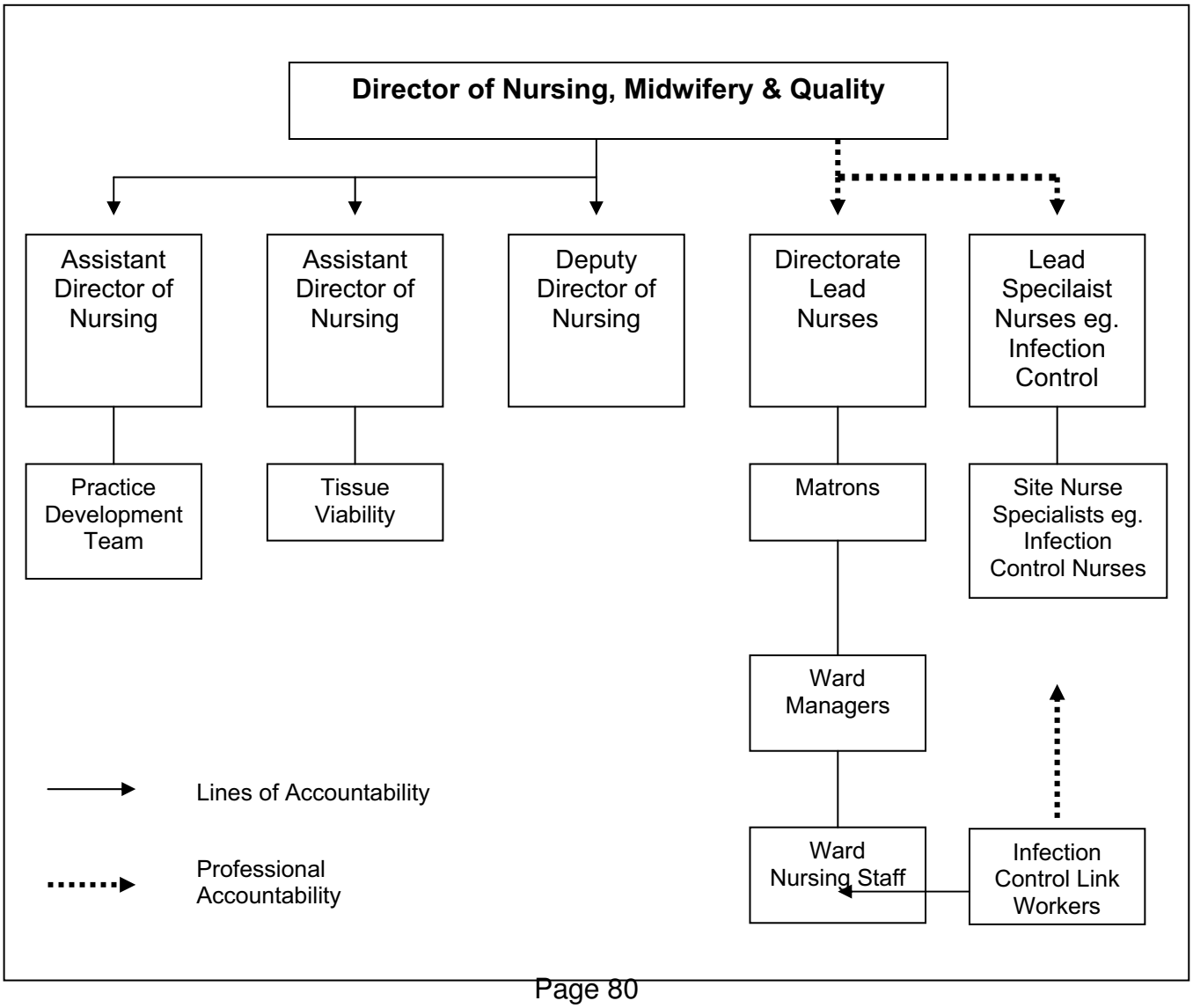
The treatment of patients with HCAIs follow distinct care plans, again there is a separate care plan for patients with positive results for either MRSA bacteraemia and clostridium difficile.

In addition to managing the outcomes the Trust ultimately wants to minimise the risks of acquiring infection. In support of this the Trust has also implemented a number of proactive measures including:

- MRSA screening for all admissions (including emergency admissions)
- Commencement of decolonisation treatment for all high risk and vulnerable groups whilst awaiting screening results
- Prospective audit of antibiotic prescribing and the associated risk of clostridium difficile with interventions and amendments to prescriptions as appropriate.

In spite of the improvements to date incorporating changes in clinical practice and greater staff awareness, each case of MRSA bacteraemia and Clostridium difficile is formally reported on a Trust Adverse Incident Report Form and is subject to a full Root Cause Analysis investigation. This process which involves all nursing, medical staff and the infection control team ensures that the reasons behind why and how the infection has occurred are understood and actions can be identified to address any gaps in the system, facilitate changes in practice or provide further understanding of infection prevention and control. The outcomes of the investigations are discussed with the clinical teams and also shared across Directorates through feedback at the infection control leads meeting.

3. Management Structure for the Nursing Profession



In addition to the management structure for the nursing profession, the adherence and awareness of infection prevention and control practices is promoted through local link workers. The role of the Infection Control Link Worker is to act as a resource in the clinical area and to liaise with the Infection Control Advisor with regard to all infection control issues. This includes helping to create and maintain an environment which will ensure the safety of the patient/client, his or her relatives, visitors and healthcare workers, using infection control knowledge, expert knowledge of the clinical area/department, communication and teaching skills.

In order to influence practice and raise awareness, each Infection Control Link Worker must have the support of his/her Ward/Department Manager. The Link Worker role can be undertaken by any healthcare worker or employee from any department within the Trust, and as well as registered Nurses, should include Healthcare Assistants and staff members from other departments such as Physiotherapy and Occupational Therapy for example.

The role of the Infection Control Link Worker has been formalised in East Kent Hospitals through the Link Worker contract. This sets out the responsibilities of the role which are then agreed with the individual and the ward manager. These responsibilities include:

- To act as a "role model" for colleagues by promoting best practice in relation to Infection Control
- To take every opportunity to update and extend knowledge of Infection Control
- To inform the Infection Control Advisor of any compromised and/or infected patients within their clinical area and to ensure appropriate patient placement and infection control precautions.
- To act as a resource, in conjunction with the Infection Control Advisor, for staff concerning infection control related problems within their clinical area
- To liaise with the Ward Manager / Departmental Manager with regard to the implementation of infection control policies and procedures
- To assist in the education of staff/patients in their clinical area as appropriate, in relation to Infection Control, with particular emphasis on the principles of Infection Control.
- To undertake assessment of hand decontamination technique of staff members in their own ward/department, including technique for hand washing and the application of alcohol hand rub.
- To assist in the education of patients with infection/colonisation (i.e. MRSA/*Clostridium difficile*) and their visitors, as appropriate, under the guidance of the Infection Control Advisor
- To assist the Ward Manager in ensuring that staff are aware of, and comply with, the Trusts MRSA policy in relation to the management of MRSA in High Risk/Low Risk areas
- To ensure that all new staff (including students on placement) receive a local Infection Control induction, appropriate to the clinical area, which covers where applicable the following:

    - Guidelines for the Prevention of Infections associated with Central Venous Catheters (incorporating the 10 Important Points)
    - Guidelines on the Management of Urinary Catheters and Drainage Systems (incorporating the 10 Important Points)

- Guidelines for the Prevention of Infections associated with Peripheral Venous Catheters (incorporating the 10 Important Points)
- 10 Important Points for the Safe Use/Disposal of Sharps
- 10 Important Points for the Use of Alcohol Hand Rub
- The Infection Control Manual, with particular reference to the following policies: Guidelines for the Management of MRSA, Guidelines for the Management of *Clostridium difficile* (including the flow chart), Isolation Policy for Patients with Infectious Diseases, Disinfection Policy and Guidelines for the Prevention of the Transmission of Blood-Borne Viruses

Infection Control Link Workers are provided with dedicated time to fulfil the responsibilities of the role.

4. Process for Training Nurses of the Importance of Infection Control

The completion of infection control training is an annual mandatory training requirement for all clinical staff. The training is delivered through an e-learning package and is accompanied at the end by an assessment. The training programme covers:

- A general introduction to the Department of Health EPIC guidelines which focus on evidence based recommendations for the prevention of HAI in general care settings, providing guidance on infection control precautions that can be applied as standard principles by all staff all of the time.
- How infection spreads
- Hand hygiene
- Personal protective equipment
- Use and disposal of Sharps
- Assessment

The pass mark for infection control is set at 85% and in order for the training to be recorded this must be achieved. Compliance with all mandatory training including infection control is monitored centrally via the Workforce Planning Department. Monthly reports are produced for all directorates providing a summary of performance and the opportunity to follow up with staff that have not completed the training. Compliance with mandatory training is further enhanced through the Study Leave policy which requires all required training to have been completed prior to study leave being granted.

In addition to the mandatory e-learning package, a comprehensive training programme is delivered by the Infection Control Team for all senior nurses. This programme includes training on:

- MRSA bacteraemias – meeting the trajectory
- Learning Lessons – Clostridium Difficile and the Stoke Mandeville Report
- The Risks of Urinary Catheters
- Lines & Slime – the management of invasive devices

Training is also provided on infection control guidelines and new practices. Maintaining awareness to policies and procedures and ensuring that staff understand the infection control practices are key actions for the Infection Control Link Workers.

Recent training has included the introduction of chloroprep frepp for skin disinfection and the implementation of revised vascular guidelines.

Further training is provided at induction and on specialist study days.

Awareness to infection control procedures is also raised through the weekly infection control audits completed by all clinical areas. Departments are required to report to their Directorate Infection Control Leads against a range of agreed indicators. These include; hand hygiene compliance, MRSA screening compliance, completion of mandatory infection control training, MRSA bacteraemia and C diff rates and the outcomes of root cause analysis. The results of these audits are reviewed locally and actions agreed to improve practice. These results are also scrutinised by the Clinical Management Board to which a monthly summary report is submitted. This process helps to promote compliance with infection control practice locally, improve practice at the point of care and encourage ownership throughout the directorate.

5. Patient & Public Information on the importance of infection control

Patients and members of the public have an important role to play in the prevention and control of healthcare associated infections. For the past 4 years the Trust has produced patient information leaflets on MRSA and Clostrodium difficile. These leaflets have explained what the infection is, how it is caused and what can be done to prevent it.

Information on infection control performance is also shared with the public through regular reports to the Trust Board. The information contained in these reports is also available on the Trust's web site.

The Trust recognises that the information to patients needs to convey confidence in addition to performance. In recent years, our focus has been on maintaining progress against the year on year reduction target for MRSA and hence communications have reflected this. However since April 2007 the Trust has actively sought the assistance of the public in reducing hospital associated infections. In recent months this has been and continues to be supported with actions targeted at involving the patient in their care through a message of "It's ok to ask" – this assists patients to have the confidence to ask the healthcare professional if they have cleaned their hands or about any other aspect of their care.

The recent HCAI funding award has also been used to enhance communication on infection prevention and control. The Trust is currently in the process of standardising and improving existing signage at the entrances to the hospitals and wards. The signage aims to provide clear message to staff, patients and members of the public on appropriate hand hygiene.

The Trust has been fortunate to have the support of the local Public and Patient's Involvement Forum to offer further insight into how patients and the general public may perceive our services including access, the cleanliness and condition of the hospitals and clinical outcomes. In recent months the PPIF members have assisted in site walkrounds, PEAT assessments and the completion of audits on hand hygiene compliance. The Trust has also involved representatives from the PPIF in developing information leaflets and improving signage at the entry to wards in relation to healthcare associated infections.

Reassurance of patients prior to their admission to hospital is important to the Trust. The development of a communications strategy has identified a number of different routes through which confidence in our infection control systems, clinical practices and patient care can be offered. Using the HCAI funding, an information leaflet has been developed to accompany appointment letters. A similar information leaflet is also given to all emergency admissions. In addition we are also reviewing how information is presented in other areas such as the intranet, there are a number of proposals to improve the resources available to patients and the general public such as presentation of data in a user friendly format and a section on frequently asked questions.

Improving communication with patients and the public is a key objective in the Trust's current focus on reducing hospital acquired infection.

6. Hospital Cleaning and the Required Standards of Cleanliness

Since July 2004, cleaning services in East Kent Hospitals have been provided by Medirest Healthcare. The contract which was awarded for seven years is primarily an 'output' specification which means that the standard is for all the cleaning elements to be clean at all times. The expected standards of these elements which include the cleaning of walls, ceilings, patients lockers and floors have been taken from the "National Specifications for Cleanliness in the NHS". These standards are subject to ongoing review and were last updated in May 2007

The Medirest contract utilises dedicated and rapid response teams to ensure that all wards and departments have access to a cleaning services 24 hours a day, 365 days a year. This means that at any point during the day or night wards have the opportunity to request and do request cleaning.

The service provided by Medirest is comprehensive in providing the day to day cleaning of a ward area in addition to an all inclusive cleaning contingency which includes both vacation cleans as well as infection control cleans. At ward and department level every senior member of staff has been issued with a Service Level Agreement (SLA) which details the cleaning service to be provided. The SLA has to be signed off by the end user, Medirest and Soft FM services. This agreement can be customised to meet the needs of differing areas and their specific requirements.

Monitoring of cleaning standards as part of the contract and also at an operational level is essential. The monitoring takes a number of different forms including visual inspections, requests for additional cleaning and also monitoring against indicators such as response times for the rapid response team. Performance is reported on a monthly and quarterly basis to the Head of Hotel Services who is the Trust representative responsible for the management of the contract. In addition to reporting performance these reports also provide assurance through evidenced practice. Local scrutiny of the cleaning standards is co-ordinated through the annual monitoring programme which involves 'joint monitoring' by both Nursing (ward manager/matron) and the Medirest monitoring team. This involves the scoring of all rooms within the area/ward on a pass/fail basis. A copy of the monitoring report has to be received within one hour by the participant(s) and any other senior manager requesting a copy. If there are any indications that there are issues with the cleaning standards in any area then the frequency of monitoring can and is increased until the end user is reassured that the cleaning service is reaching the required

standard. It is the expectation of the Trust that all areas should achieve a minimum score of 95% for cleaning any areas not achieving this score are identified in the Medirest monthly report and the specific reasons for failure are identified. Helplines are in use across the Trust and all end users (Staff, visitors and patients) are encouraged to report any concerns with the cleaning service.

In addition to the technical cleaning audits, there are also managerial audits due to be introduced at quarterly intervals. These will focus on specific areas and seek to verify that the technical audits are accurate in their representation of cleaning standards.

The Trust is proactive in its management of the Patient Environment Action Team (PEAT) criteria with a year round programme involving Project groups (includes Nursing, Infection Control, Estates, Patient representatives, Soft FM and Medirest), and also PEAT financial allocations for PEAT projects as identified either from the PEAT self assessment or in the follow- up site assessments involving input from Infection Control, Estates, Soft FM, Hospital Managers and the Medirest. The Trust results for 2007 were:

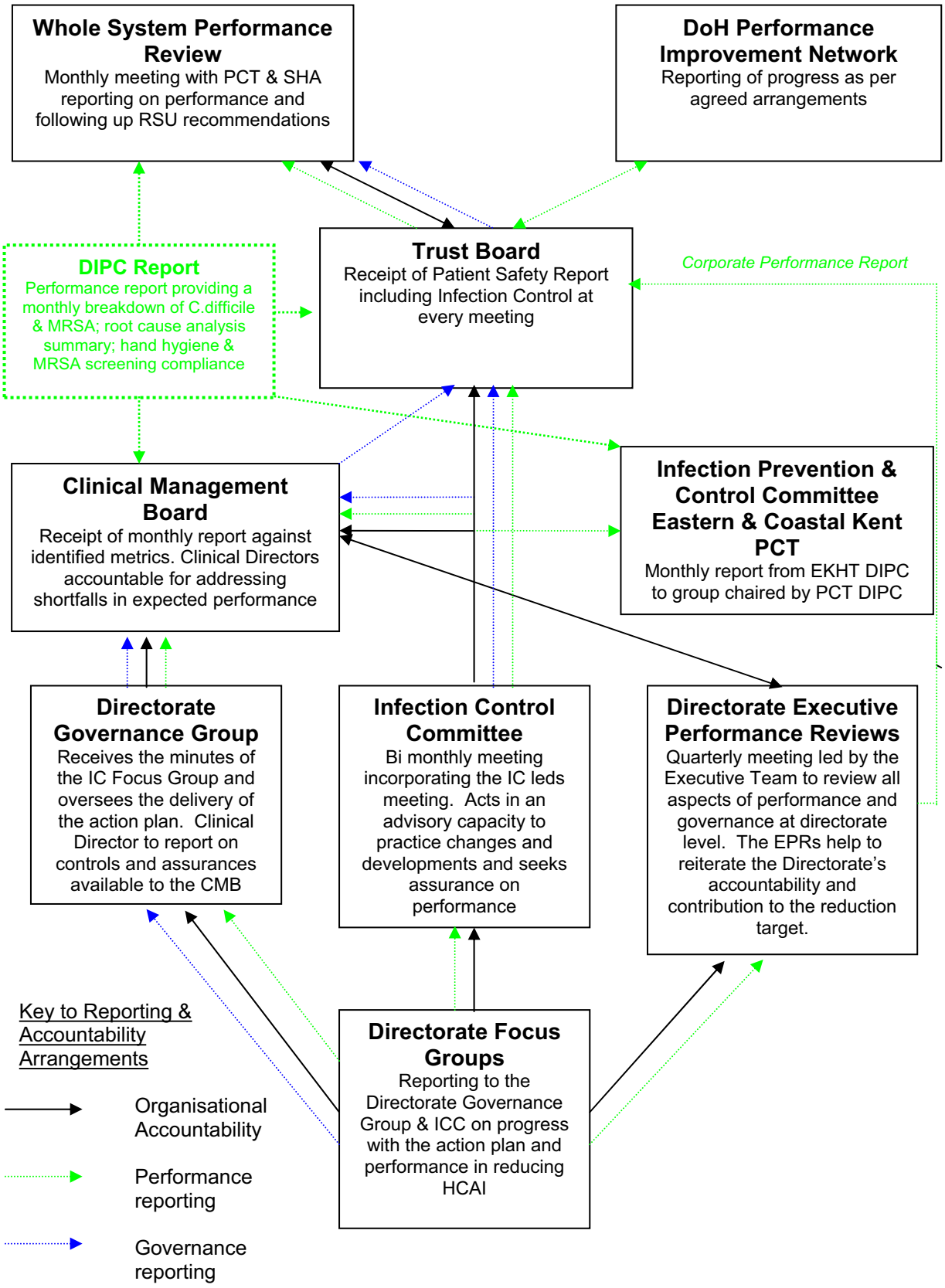
SITE	**ENVIRONMENT**	**FOOD**	**PRIVACY & DIGNITY**
BUCKLAND	GOOD	EXCELLENT	GOOD
WILLIAM HARVEY	EXCELLENT	EXCELLENT	EXCELLENT
KENT&CANTERBURY	EXCELLENT	EXCELLENT	EXCELLENT
QEQM	EXCELLENT	GOOD	GOOD

Although primarily an ‘output’ spec there are areas that are described as ‘in puts’. Examples are ‘Deep cleaning’, bed mattress and frame following every patient occupation, remaking of the bed with clean linen following every patient discharge/transfer, internal and external glass surfaces etc. In addition there is also the opportunity to provide additional deep cleans on request.

The Trust does not distinguish between Trust and Medirest employees in the contribution that individuals can make to infection prevention and control. All the Medirest cleaning staff receive training in both cleaning techniques and use of cleaning equipment as well as training directly from the Infection Control Nurse relevant to infection control procedures and practices. The Soft FM contract specifies that all staff requiring specialist task(s) training must receive it within the first week of employment for example cleaning techniques in specialist areas, equipment use. A summary of all Medirest training is contained within the Medirest monthly performance report.

This page is intentionally left blank

Appendix 1: Performance Reporting Structure



This page is intentionally left blank

The Medway NHS
NHS Trust

Health Overview & Scrutiny Committee

Friday 9 November 2007

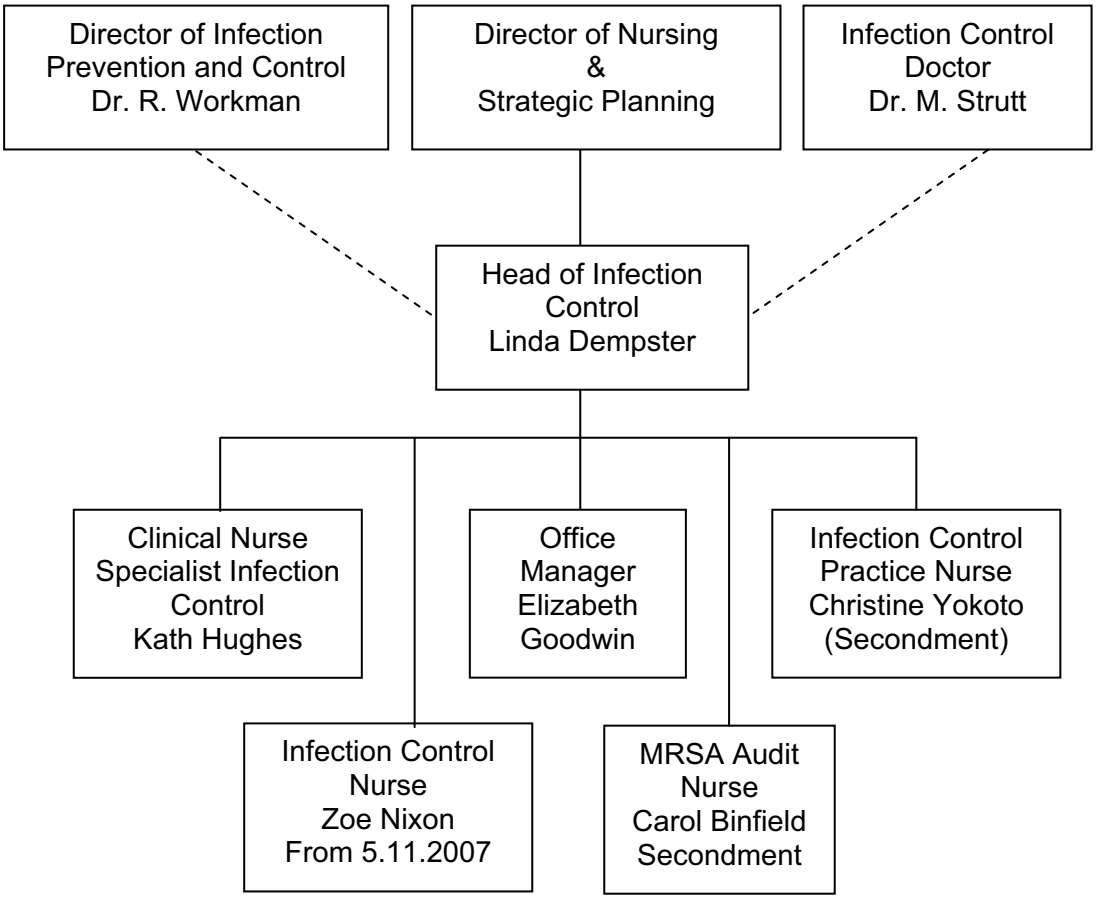
Hospital Acquired Infection & Infection Control in Medway NHS Trust

In attendance for Medway NHS Trust:
Jacqueline McKenna, Director of Nursing & Strategic Planning
Linda Dempster, Head of Infection Control

This page is intentionally left blank

The Medway NHS
NHS Trust

Question 1 - Infection Control Structure



Infection Prevention and Control is everybody's responsibility at Medway NHS Trust. Teams are supported by the Infection Control Team.

Question 2a - Meticillin Resistant Staphylococcus aureus (MRSA) Management

- Policy in operation based upon National recommendations.
- MRSA screening:
    - All surgical specialities admissions screened: elective patients at pre-admission clinic, emergency admissions on admission.
    - MRSA patients across Surgical Directorate nursed on an MRSA cohort ward.
    - All patients to high risk areas are screened on admission e.g.:

        ICU
        NICU
        Haematology

    - Screening of high risk patients in other areas e.g. known MRSA:
        Previous admission in past year

Transfers from other Trusts
Admissions from Nursing/Residential Homes
Prior to invasive procedures

- Screening results take 24 hours. All patients with MRSA are 'tagged' on Patient Administration System. Results phoned to wards by Microbiology.
- Patients are treated for MRSA carriage with topical hygiene protocol (nasal Mupirocin) and washed with Stellisept) for five days then re-screened. Two treatments per admission.
- Wounds treated with silver/iodine dressings.
- MRSA infections treated with appropriate antibiotics (Vancomycin).
- Patients are either nursed on Victory Ward or in isolation rooms in other areas.
- All MRSA bacteraemias are investigated by the Clinical Directorate undertaking Root Cause Analysis.
- Monthly data is distributed widely giving MRSA and *Clostridium difficile* data per ward, with hospital acquisitions. Weekly reporting via the Nursing and Midwifery (NMAS) Accountability System. MRSA acquisitions are part of Performance Management.
- MRSA bacteraemia zero tolerance, all bacteraemias are treated as a breach.
- Fully adopted the Saving Lives Care Bundles for:

    - Central Venous Devices
    - Peripheral Lines
    - Urinary Catheters
    - *Clostridium difficile*
    - Surgical Site Infections
    - Ventilator Associated Pneumonia

- Monthly Hand Hygiene Audits undertaken, areas not reaching 95% re-audited weekly.
- Daily checking of alcohol hand rub on each bed space.
- Patient information leaflets widely available.
- Patients with infections are highlighted on the Medway Trust Bed Occupancy System.
- The Trust participates in the mandatory surveillance of Surgical Site Infections for hip and knee replacements, long bone fractures and internal fixations plus vascular grafts and amputations.
- Medway has appointed two nurses on secondment to the Infection Control Team to assist in the monitoring of compliance with both practice and MRSA patient management.
- Enhanced cleaning using micro-fibre technology.
- Investment in the 24/7 Rapid Response Cleaning Team.

Question 2b - *Clostridium difficile* Toxin Diarrhoea

- Policy in operation based on national recommendations.
- All patients with diarrhoea are isolated in single rooms.
- Stool samples tested 6 days a week (2 hour test).
- Confirmed cases:
    - Review of antibiotic therapy.
    - Saving Lives High Impact Interventions

- Hand washing with soap and water
- Chlorclean for cleaning of patient room/equipment
- Designated commode or toilet
- Stool chart/Bristol Stool Chart
- Fluid balance sheet
- All cases raised as clinical incidents
- Daily medical review
- Commence appropriate treatment on suspicion/confirmation of case

- Two or more cases are treated as an outbreak and raised as a Serious Untoward incident (as per CMO recommendations).
- Key actions for reducing rates:

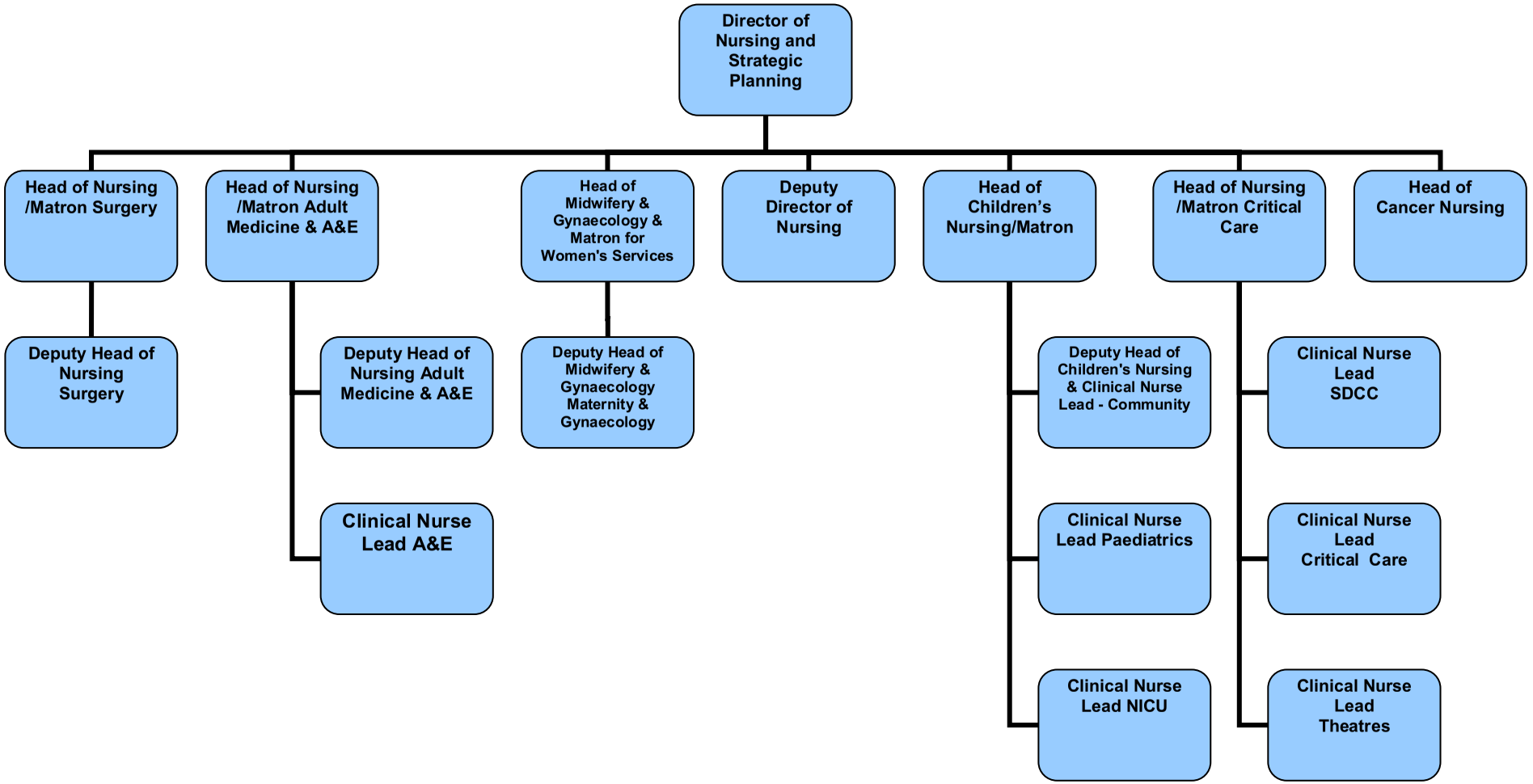
    - Cleaning standards to national recommendations. Use of chlorine based cleaning products.
    - Restricted antibiotic policy
    - Antimicrobial Pharmacists (2)
    - Probiotic yoghurts

- Close collaboration with PCTs/Kent HPU to investigate cases acquired in Primary Care settings.
- Upgrading of environments and purchase of equipment with close patient contact has been enhanced by the Department of Health funding.

This page is intentionally left blank

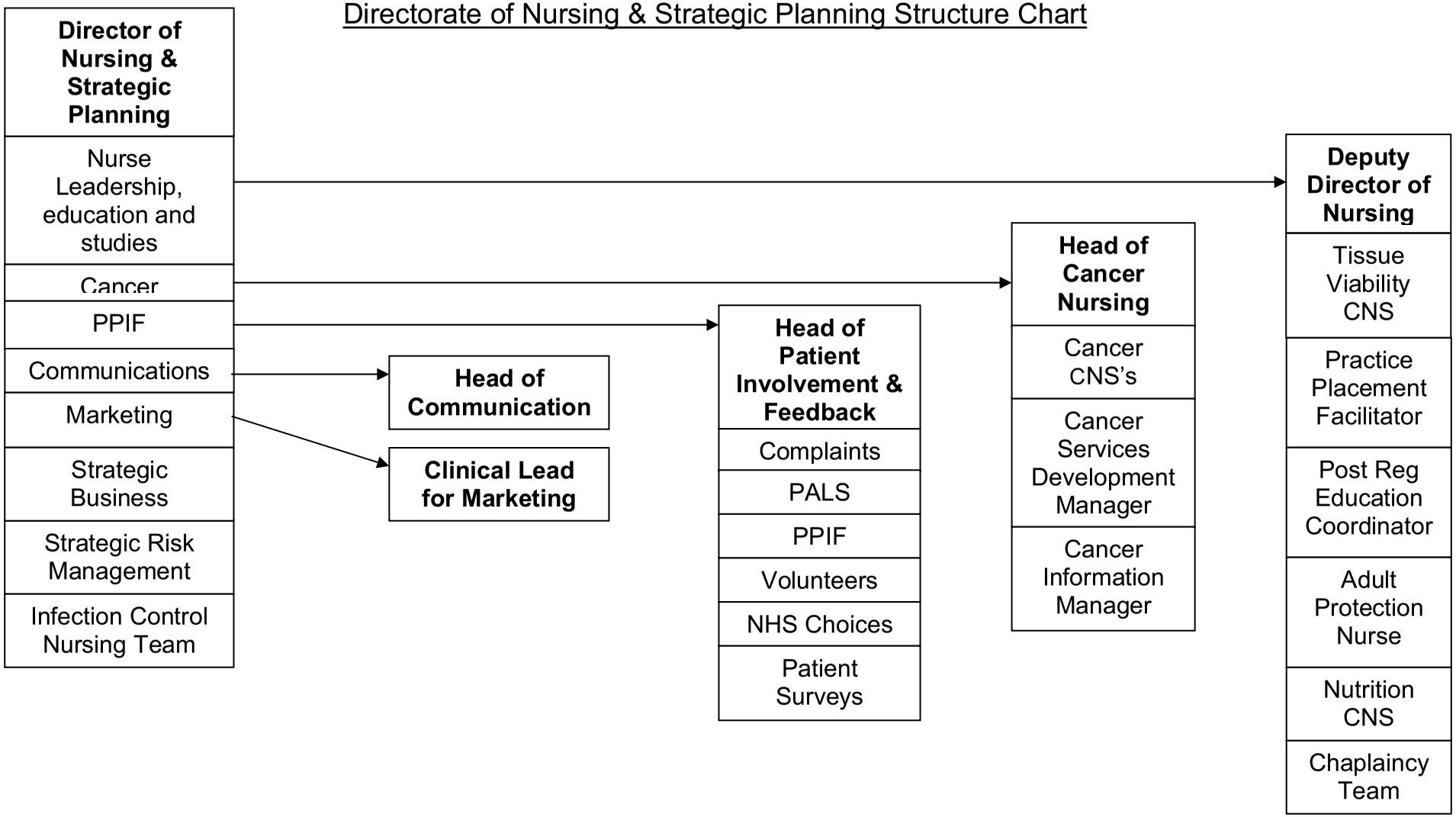
Question 3

Professional Nursing & Midwifery Structure Chart



The Medway NHS
NHS Trust

Directorate of Nursing & Strategic Planning Structure Chart



Question 4 - Infection Control Training for <u>All</u> Staff

- **<u>All</u>** staff including flexi-staff, medical staff, students (medical and nursing) Allied Health Professionals receive Infection Prevention and Control on Induction, including hand hygiene.
- **<u>All</u>** staff should attend mandatory annual updates, a variety of options are available:
  - E-learning
  - Monthly sessions
  - Team specific sessions
  - Consultant updates

Attendance recorded on PROMPT, this is a performance indicator for Directorates. Infection Prevention and Control training is part of KSF outlines, monitored at IPR. Consultants have Infection Prevention and Control in job plans.

Medway NHS Trust has a well established Link Practitioner Network, staff have four days study leave to attend and keep updated. These staff are then able to provide support to the clinical teams while they work.

All wards have 'glo tanks' and train teams in hand hygiene in the clinical setting.

Question 5

Medway NHS Trust has a range of leaflets available including:

- Reducing the Risk of Infection in Hospitals – Caring for your Drip – A Guide for Patients and Carers
- MRSA – Meticillin resistant Staphylococcus aureus
- Norovirus
- *Clostridium difficile*
- Hand Washing
- Reducing the Risk of Infection in Hospitals – What you can do to help – Guide for Patients
- Reducing the Risk of Infection in Hospitals – What you can do to help – Guide for Visitors

Information boards are displayed in wards and departments together with the main entrance to the hospital.

When the Trust are experiencing problems with outbreaks, we do readily release press/ media announcements and ask that the public support to assist us in our campaigns.

Medway Trust has a large number of volunteers who assist in many ways, including receptions on wards asking every visitor to decontaminate their hands.

Publicity is spread widely about the 'clean**your**hands' campaign which the Trust participates in.

Members of the Patient and Public Forum attend the Infection Control Committee and accompany us on PEAT and ward environmental audits. The Trust has a

comprehensive audit programme. Audit scores are performance indicators for the Directorates.

Question 6

Cleaning at Medway NHS Trust is provided totally in-house.

Cleaning standards are to the National Cleaning Standards.

Health Overview & Scrutiny Committee

Friday 9 November 2007

Other written evidence received

This page is intentionally left blank

Kent County Council HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Scrutiny of Infection Control – C. difficile and MRSA

Written evidence from

Professor Richard James
Director, Centre for Healthcare Associated Infections
University of Nottingham
CBS Building
University Park
Nottingham NG7 2RD

Background

Hospital-acquired infections, now usually called healthcare-associated infections (HAI), are responsible for 1.4 million infections per day worldwide. In the USA the figures for 2002 were **1.7 million infections** with **98,987 deaths**, which is far more than from AIDS. Hospital patients in the USA with Staphylococcus aureus (S. aureus) infections had, on average, **3 times** the length of hospital stay (14.3 days vs 4.5 days); **3 times** the total hospital charges ($48,924 vs $14,141) and **5 times** the risk of in hospital death (11.2% vs 2.3 %) than patients without this infections [Noskin et al. Archives Internal Medicine 165:1756-1761 (2005)].

We do not have such accurate estimates in the UK as the widely quoted figure of HAI being responsible for **5,000 deaths** per year and additional costs to the NHS of **£1 billion** is an extrapolation of some old USA data. It is not disputed however that there is likely to be considerable under-reporting on death certificates of HAI related deaths and that many of these deaths are preventable. The scale of HAI infections in the UK was however revealed in a prevalence survey taken during February to May 2006 by the Hospital Infection Society and the Infection Control Nurses Association and are summarised in the Table.

Country	Number of hospitals	Number of patients	Infection prevalence rate
UK and Ireland (exc. Scotland)	273	75,763	7.6%
England	190	58,795	8.2%
Wales	23	5,325	6.3%
Northern Ireland	15	3,625	5.5%
Republic of Ireland	45	7,518	4.9%

MRSA

The MRSA **infection** rate in English hospitals in 2006 was **1.28%**. The MRSA **carriage** rate in patients admitted to hospital (MRSA located in the nose or on the skin but not causing an infection) is higher at **7-8%**. A recent study found that a person infected with MRSA has a **44.2%** chance of becoming readmitted to hospital whilst still infected [Rowbotham et al. J. Hospitals Infection 65:93-99 (2007)]. These are important figures when considering the chances of transmission of MRSA from one patient to another patient which occurs principally by contact.

C. Difficile

The C. difficile infection rate in English hospitals in 2006 was **1.98%**. C. difficile is present in the intestines of about 3% of the population. Faecal contamination of the hospital environment by C. difficile cells or spores is the source of infection of other patients. Frequent hand washing using soap and water is the best way to prevent transmission as alcohol gels are not active against C. difficile spores. Clostridium difficile associated disease (CDAD) occurs mostly in patients infected with C. difficile when their normal gut flora is disturbed, for example during antibiotic treatment. The clinical manifestation of CDAD can range from diarrhoea to severe pseudomembranous colitis, with a mortality rate of up to 30%. CDAD is most common in elderly hospitalised patients and residents of care homes, but it is increasingly becoming recognised as a community-associated disease.

CDAD is a serious problem because there are very few antibiotics that are effective and relapses are common after antibiotic treatment. Old age, the presence of other serious illnesses and poor overall health may increase the risk of severe disease. It is very difficult to eliminate the environmental contamination of hospitals by C. difficile spores without using very extensive "deep cleaning" methods. Recent outbreaks of CDAD with increased severity, a high relapse rate and significant mortality have been related to the emergence of a new, hypervirulent C. difficile 027 strain in Europe. C. difficile is now responsible for twice as many deaths in the UK as MRSA. In England, the mandatory surveillance programme for CDAD in hospitals has reported 55,681 cases in 2006. This represents an 8% increase in CDAD cases from 2005 to 1006, after a 17% increase from 2004 to 2005.

Strategy to reduce the number of healthcare-associated infections

HAI is a complex, multilayered problem that ultimately depends on exposure to patients to sources of infections, and the interactions of patients with pathogenic bacteria such as C. difficile and MRSA. An understanding of HAI involves the following elements;

- **Pathogens** – Antibiotic resistance, virulence, epidemiology
- **Patients** – risk factors, contacts with staff/other patients
- **Place** – hospital environment, isolation capacity, estate quality and design
- **Practice** – leadership, systems, strategy, staff training, local and national policies

To achieve a significant reduction in HAIs requires an integrated HAI strategy that reflects the scale and complexity of the problem and the resources needed to impact on it. There are no simple solutions. The integrated HAI strategy should consist of the following elements, the first group are national whilst the second group are Trust specific.

National elements

- There is a need for multidisciplinary research programmes on pathogens, especially C. difficile, extended to spectrum beta-lactamase producers (ESBLs) and MRSE
- There is an urgent need for clinical studies of the cost vs benefit of intervention strategies designed to reduce HAIs (i.e. a new hand hygiene product may be effective in killing C. difficile bacterial cells in laboratory studies but will it lead to a reduction in CDAD in a hospital environment)
- Screening of all hospitals admissions for MRSA (this is now government policy)

Trust specific elements

- Strong leadership to all staff from the Trust Chief Executive on the importance of reducing hospital infections.
- Involve patient groups such as National Concern for Healthcare Infections and possibly experts from outside the Trust (in a role equivalent to non-executive Directors of a company) to oversee Trust policies relevant to HAI.
- Design new Hospitals with the aim to help reduce infections.
- Increase isolation capacity to >10% of beds and/or utilise cohort nursing of infected patients. Consider adopting the Lewisham Isolation Priority System (LIPS) if not already in use in the Trust. Provide information about isolation policies to patients, as required by the Health Act 2006, and put systems in place to monitor and report on observance of these policies.
- Investment in Trust Microbiology laboratories will be required to deliver universal MRSA screening in the next year for all non-emergency hospital admissions, and in the next three years for all hospital admissions. There is a shift from traditional slow, culture based microbiology methods to rapid molecular diagnostic tests that raises issues of capital investment, the choice of rival commercial MRSA assay systems, staff training etc.
- The data on MRSA carriage rates provided by universal screening on admission will open a can of worms concerning where all this MRSA is coming from that will require more attention to community facilities such as care homes. It will also highlight the need for more isolation capacity and may be in conflict with the need to isolate patients infected with C. difficile.
- Develop procedures for counselling MRSA carriers to avoid their stigmatisation and to assist their time spent in isolation.
- Develop protocols for decolonisation of MRSA carriers being aware that a large increase in the use of Mupirocin as a nasal cream may select for resistance to this agent.
- Be aware of the increasing problem of community-associated MRSA (CA-MRSA) that causes skin and soft tissue infections in the young and healthy of the community. Rapid molecular diagnostic tests for detection of the PVL toxin hat is present in most CA-MRSA isolates should be considered. Methicillin-sensitive S. aureus (MSSA) producing PVL toxin are potentially serious pathogens in their own right that have already been identified in UK hospital patients.
- Develop protocols for advising patients carrying PVL encoding MRSA or MSSA to avoid sharing towels etc with family members as these strains are more transmissible that the hospital-associated strains.

- Plan for the potential health disaster of an influenza outbreak, in combination with a high carriage rate of CA-MRSA, triggering a rapid increase in life threatening invasive infections such as necrotizing pneumonia that has a mortality rate >50% in <72 hours.
- Enhance the influence of Infection control teams over important matters such as patient movement with the hospital.
- Monitor bed occupancy rates and be concerned if they exceed 85% as this conflicts with good infection control.
- Monitor infection rates in individual wards and feedback this information to clinical teams.
- Can information on post-discharge infection rates be obtained from PCTs to feedback to clinical teams.
- Introduce effective measures to increase hand hygiene compliance (screen savers on hospital computers carrying HAI messages; staff badges with a message that patients can ask them to wash their hands). Encourage staff to buy in for any policy initiatives and appoint staff champions.
- Resolve the issue of the effectiveness of different hand hygiene products against MRSA and C. difficile.
- Improve staff training and involvement in improving infection control – there are some interesting initiatives being developed by the NHS Education Scotland (www.nes.scot.nhs.uk/hai/resources/)
- Cleaning regimens need to consider the patient hand-touch sites such as door handles, switches, bed controls. Hydrogen peroxide vapour eliminates MRSA and C. difficile on surfaces but for how long does this effect last? What are the best methods to eliminate C. difficile spores from the hospital environment?
- Look at the effectiveness of policies on antibiotic prescribing on C. difficile infection rates. Consideration of the use of probiotics in elderly hospital patients to reduce CDAD.
- Be aware of new technology including (1) new diagnostic tests to rapidly identify hypervirulent strains of C. difficile that are associated with more severe CDAD; (2) new hand hygiene agents whose antimicrobial effect persists on the skin; (3) ward curtains and theatre/ICU staff uniforms etc containing antimicrobial silver, etc but cost benefits studies are required before their widespread adoption. Does the Trust have a policy for horizon scanning to facilitate the rapid introduction of effective HAI related technologies?
- Consider the possible benefits and issues that would arise from a policy to screen selected staff for MRSA carriage.
- Improved communication with patients and visitors concerning infections – many of which only become apparent after patient discharge from hospital. There is a balance to be struck between providing more specific information and the risk of frightening patients, however it is obvious that many patients are already seriously concerned about admission to hospital for elective surgery.

Infection Control and Hospital Acquired Infections

Clostridium difficile and MRSA

By Hugh Pennington, Emeritus Professor of Bacteriology, University of Aberdeen

1. Many thanks for asking me to submit evidence about the control of hospital acquired infections in Kent. I share the wish of the Health Overview and Scrutiny Committee that the practices and processes for managing this issue are as robust as possible. The Healthcare Commission Report of its investigation into the *C. difficile* outbreaks at the Maidstone and Tunbridge Wells NHS Trust revealed scandalous deficiencies there. Patient safety had lost out in a desire to meet financial and other targets. Robust infection control procedures were the last things on the minds of the senior managers. They should have been paramount.

2. It is correct to describe Britain as the 'sick man of Europe' when considering the incidence of hospital acquired infections. For MRSA I believe that we made a big mistake in the early 1990s when epidemic strains (EMRSA) evolved in England – we did not take them seriously enough, and by lack of resolute action allowed them to spread nationwide. They are now so firmly established that achieving the level of infection seen at present in countries like Norway and the Netherlands (about 10 times less than in the UK) – even with very robust policies applied with enthusiasm by all – will in my opinion take about a decade.

3. The big problem with MRSA is that there are many patients with chronic infections (e.g. discharging surgical wounds) and significant numbers of patients who have acquired the organism in hospital to become carriers (the organism lives silently in their noses or on their perineums). Through no fault of their own, they act as an MRSA reservoir; they have conditions which take them (and their microbes) into hospital repeatedly.

4. Breaking the cycle of transmission of MRSA requires the placement of a barrier between the infected (and the carrier) and the uninfected. The Dutch and the Norwegians do this by physical isolation in single rooms with strict barrier nursing. Patients coming from a high incidence country like the UK are automatically isolated until the results of screening tests are available. (Carriage can be eliminated in some but not all). MRSA is looked for aggressively. This is the 'search and destroy' policy. I do not think we will get a sustained grip on MRSA in the UK without it. Any proposed MRSA control policy should be tested for robustness by using it as the benchmark. I note that the East Kent Hospitals NHS Trust is moving in the right direction with its screening policy.

The biggest problem is the provision of properly staffed single rooms dedicated to infection control use. It must have the highest priority.

5. It beggars belief that *C. difficile* was taken so lightly at Maidstone (and, of course, at Stoke Mandeville and many other hospitals). The best figures on the proportion of infected (and treated) patients who die from it come from Canada. The mortality rate is about 7%. For any infectious disease this is a very high figure. At its worst peak in 1918 the influenza pandemic (considered to be the biggest acute killer in the 20th century) had a mortality rate that ranged from 6 to 10%. Maybe *C. difficile* was taken so lightly because one of the three big risk factors for suffering from the

colitis that it causes (the other two are being treated with antibiotics and being admitted to hospital) is being over 65 and ageism was at work. The majority of cases of *C. difficile* colitis contract their infection in hospital. Prevention requires the same policy as for MRSA - the physical isolation of the infected (those with diarrhoea) from the uninfected with rigorous barrier nursing.

6. None of these policies are new. They were worked out with supporting science more than a century ago. But persuading hospital managers to implement them has been difficult. It usually takes a scandal to move them. There has been one in Kent. Strike while memory is still fresh and before it fades. Public pressure from bodies like yourself will be needed to direct more funding into infection control. And just as important is the need to engender support within the NHS locally for the experts in the infection control teams.

Hugh Pennington
Emeritus Professor of Bacteriology
University of Aberdeen

31 October 2007

The Medway NHS
NHS Trust

Patient Advice & Liaison Service (PALS) Medway NHS Trust

Report to the County Council's NHS Overview and Scrutiny Committee regarding complaints relating to infection control.

I regret that it is not possible to provide accurate figures for this at present. PALS receives more requests for information about issues, rather than complaints and our former method of reporting did not identify a separate heading for infection. The contacts would have been logged as either complaints about patient treatment or requests for information about the hospital. From the beginning of October 2007, however, we have started a new database which includes a separate heading for infection.

I cannot remember any contacts relating specifically to winter vomiting. We have had a few over the past year or two relating to Clostridium difficile, but the majority have related to MRSA. Even so, the figures have been small, perhaps averaging one or two a month, and often only asking for information about it.

Complaints about cleanliness have been logged if that is the main subject, but some complainants will add it in as an afterthought and until now we have had no way of picking this up separately. Again, however, the numbers are very small. Unfortunately I have been unable to access the figures for October 2001, when PALS first started, to March 2002 but the totals since then are as follows:

2002-2003 = 1	(Total contacts on all issues 978)
2003-2004 = 6	(" " " " " 1317)
2004-2005 = 7	(" " " " " 1490)
2005-2006 = 15	(" " " " " 2109)
2006-2007 = 8	(" " " " " 2386)

As soon as a complaint is received we take action. We will go to the relevant ward or department and speak to the manager and/or the lead nurse. We will contact the housekeeping manager to ask her to address the situation and if infection issues are involved we contact the Infection Control team, often asking them to contact the complainant to provide explanations and information. If the complaint relates to an incident in the past, however, it may be more appropriate for the complainant to submit a formal complaint in order to have the matter investigated. In these cases we will provide the necessary information on how to complain and will also write the complaint letter if necessary. We would also offer the option of a formal complaint if we are unable to resolve the issue and/or refer the complainant to the Independent Complaints Advisory Service.

Any contacts falling within the remit of clinical governance and risk are reported quarterly to the Trust Board and monthly to the directorates, but we will, of course, inform whoever needs to know as quickly as possible.

Vivien Bouttell
PALS Manager. 26/10/07

This page is intentionally left blank

Maidstone & Tunbridge Wells NHS Trust PALS Report

Following a request by the NHS Overview and Scrutiny Committee, the Patient Advice and Liaison Service (PALS) Officer looked at all concerns raised in relation to infection control. This was, as requested, by calendar years from the commencement of the PALS service in 2002 until the present day. It is noted that there are still cases to be added to the 2007 database.

The complaints raised to PALS around infection control are broken down into concerns raised about MRSA, Clostridium Difficile, Winter Vomiting (Norovirus), issues around cleanliness and issues around hygiene. In addition to concerns raised, PALS also noted the requests for advice or information relating to infection control.

	Kent & Sussex	Pembury	Maidstone	Total
2002 - concerns MRSA	1			1
2002 - concerns C Difficile				0
2002 - concerns Winter Vomiting				0
2002 - concerns cleanliness	4			4
2002 - concerns hygiene	1		2	3
2002 - information/advice	2		2	4
	8	0	4	12
2003 - concerns MRSA	1		3	4
2003 - concerns C Difficile				0
2003 - concerns Winter Vomiting				0
2003 - concerns cleanliness	8		4	12
2003 - concerns hygiene	3		5	8
2003 - information/advice	1		3	4
	13	0	15	28
2004 - concerns MRSA		1	7	8
2004 - concerns C Difficile				0
2004 - concerns Winter Vomiting				0
2004 - concerns cleanliness	5	1	11	17
2004 - concerns hygiene	1	4	8	13
2004 - information/advice	4		10	14
	10	6	36	52
2005 - concerns MRSA	2		5	7
2005 - concerns C Difficile			1	1
2005 - concerns Winter Vomiting	2			2
2005 - concerns cleanliness	4		7	11
2005 - concerns hygiene	2	2	8	12
2005 - information/advice	2		15	17
	12	2	36	50
2006 - concerns MRSA	8		6	14
2006 - concerns C Difficile		1	6	7
2006 - concerns Winter Vomiting				0
2006 - concerns cleanliness	7	1	13	21
2006 - concerns hygiene	12		17	29
2006 - information/advice	4		17	21
	31	2	59	92

2007 - concerns MRSA	1		1	2
2007 - concerns C Difficile			4	4
2007 - concerns Winter Vomiting				0
2007 - concerns hygiene	8		17	25
2007 - concerns cleanliness	4		7	11
2007 - information/advice	9	3	23	35
	22	3	52	77

PALS deals with advice, help, information, comments and concerns.

In 2002, PALS had 1393 enquiries, of which, the issues listed above totalled 0.86% of all cases.
In 2003, PALS had 1627 enquiries, of which, the issues listed above totalled 1.72% of all cases.
In 2004, PALS had 2474 enquiries, of which, the issues listed above totalled 2.1% of all cases.
In 2005, PALS had 3095 enquiries, of which, the issues listed above totalled 1.62% of all cases.
In 2006, PALS had 2847 enquiries, of which, the issues listed above totalled 3.23% of all cases.

In 2007, of those data-based, to date (1860), the issues listed above totalled 4.14% of cases. It is noted that there is a backlog of cases due to long-term sick leave and shortage of staff in PALS in 2007. All infection cases have been logged, therefore, the overall percentage will decrease.

An increase in the numbers of cases would have been expected each year, due to increased national press issues relating to MRSA and C. Difficile, in particular, as well as more patient / relative awareness, though it is noted that this still only totalled a maximum of 4% of callers to PALS. Many of the enquiries for information and advice related to people who did not have the infections, but wanted to know more information.

For concerns raised, PALS deals with these in a number of ways:

- Raising the issue at an appropriate level, for example ward manager, matron, director level
- For serious concerns, PALS advises patients to put the complaint in writing (as a formal complaint)
- For serious concerns, that the patient declines to put in writing, PALS raises by completing an incident form as well as raising at the appropriate level (i.e. senior management / Board level)
- PALS reports all 'high' risk cases to the Board in CLIP (Complaints, Litigation, Incidents and PALS) reports
- PALS discusses matters of serious concern at CLIP meetings

All complaints are investigated by the team involved and the response is usually fed back to the complainant, by that team.

Annie Oakley, MTW PALS Nov 2007

Maidstone & Tunbridge Wells Hospitals
Patient Public Involvement Forum

Shaping Health
Better decisions
Better health

Press Release

Issued: 12 noon 22 October 2007

David Herbert, Chairman of Maidstone and Tunbridge Wells Acute Hospital Trust (MTW) Patient & Public Involvement Forum (PPIF), comments on the Healthcare Commission's report on the outbreaks of C. difficile at the Trust's hospitals

"Since its inception, the Forum has been monitoring hygiene and cleanliness at the Trust's hospitals. During 2004 the Forum carried out a number of inspections and (as noted in the report) in December 2004 published a report with recommended actions. These included increasing the number of cleaning staff and cleaning time; supervision by ward sisters of the clinical aspects of the cleaners' work; ward sisters or housekeepers to become responsible for the organisation; training and management of cleaners; comprehensive and consistent schedules for cleaning each ward; a systematic approach to cleaning and maintenance; more storage facilities; informing patients and visitors of infection control policy and segregation of elective surgical patients from emergency admissions.

"The Forum made further inspections between April and October 2005 and during November and December 2005 conducted a Hygiene and Cleanliness survey of patients. Our findings suggested that improvements were being made but our earlier recommendations had not been fully implemented. Our inspection reports and the results of the survey were presented to the Trust and made public.

"Subsequently, we have participated in PEAT inspections. We have also held numerous meetings with staff and management, including: the infection control nurse; managers in estates department responsible for domestic cleaning; the quality monitoring officer; the director of nursing and the chief executive. We have questioned them and sought assurances from them, on hygiene, cleanliness and infection control. In addition we have challenged the Trust Board on these issues at public meetings. Earlier this year, in a press release, we commented on a slow but gradual improvement in cleanliness at the Trust's hospitals but warned that further improvements were needed to achieve consistently acceptable standards. In particular, we commented on the standard of hand hygiene by staff, patients and visitors.

"In our comments on the 2006-2007 Annual Health Check in April 2007, we questioned the adequacy of the Trust's systems for patient safety, noted that we had

pressed repeatedly for improved hand hygiene with disciplinary measures against staff who were not compliant, and questioned the underspend on nursing budget in the context of the need for more nurses to relieve pressure on existing staff. We also commented that we did not believe the Trust was compliant with National Specifications on Cleanliness.

“We believe that standards have improved at the Trust's hospitals since the C. diff outbreaks occurred. We are surprised that the results of an unannounced inspection by the Healthcare Commission in June/July of this year have not been made public since we understand the findings from this inspection confirm standards have improved, in which case publication of the results would help reassure the public and rebuild confidence.

“We also feel that the focus of criticism almost exclusively on management failings deflects attention from other fundamental questions that need to be asked. The extreme financial pressures faced by the Trust and Government targets certainly impacted on patient care at MTW. This is a national issue that needs to be seriously debated. Do these pressures distort priorities? Can this be avoided? (The problem is not unique to MTW since the same problem was identified in the Stoke Mandeville report and must exist elsewhere).

“Trust management at MTW has had to operate with facilities and estate at 2 of its 3 hospitals; Kent and Sussex and Pembury, arguably not fit for purpose in the 21st century. Consequently, and understandably, management has focussed heavily on progressing the PFI project for a new hospital at Pembury to the detriment, seemingly, of other priorities. But why has this situation arisen? Does the allocation of funding in the NHS accurately reflect the health needs of local communities? Also, since the incidence of C. diff is rising at hospitals throughout the country it is not unreasonable to assume that failings at MTW are not confined to MTW. The Commission acknowledges that 30 of the estimated 90 deaths at MTW were not related to the outbreaks. There are ‘background’ levels of C. diff at virtually all hospitals. Recent figures show that 20 NHS Trust's have higher levels of C. diff than MTW. With the possible exception of Stoke Mandeville, no other Trust will have been subjected to the same level of scrutiny as MTW. How many deaths at these hospitals are attributable to C. diff? (This is not to excuse or underplay the failings at MTW but simply to put into context what has happened).

“The question should also be asked: what responsibility lies with those clinicians and nurses at MTW who treated patients with C. diff? Management cannot ensure a safe environment for patients without their support in maintaining standards. Could they have done more? MTW has many excellent clinicians and nurses who are dedicated to their work but it is apparent from anecdotal evidence from patients and families that this does not apply to all. Are there wider issues around attitudes of clinicians and their willingness to take ownership of problems and around nursing standards and training, which need to be debated?

“Finally, coverage of the Commission's report has been selective. The level of implicit or direct personal criticism of the Chief Executive and the Chairman of the Trust, in my view, is unjust. Ultimately, the Chief Executive is accountable for standards in the Trust and it is right that she should be held to account. Some of the things that happened are inexcusable but the underlying causes go deeper. It is simplistic to attribute blame to those one or two individuals who are easy targets. It might have

been informative to have heard Rose Gibb's response to the report. It would be surprising if she had nothing to say, or is she bound under her severance terms from public comment? It offends natural justice if she has no right of reply and it is in the public interest that her views should be heard."

All correspondence should be addressed via our Forum Support Organisation:

Kent & Medway Networks Ltd
Office Hours: Monday - Friday 8:30 am – 4:30 pm
Unit 24, Folkestone Enterprise Centre, Shearway Road, Folkestone, Kent, CT19 4RH
Tel: No: 01303 297050 Fax No: 01303 297069 Email: janine@kmn-ltd.co.uk

This page is intentionally left blank

Eastern and Coastal Kent NHS
Primary Care Trust

Health Overview & Scrutiny Committee

Friday 9 November 2007

Eastern & Coastal Kent Primary Care Trust

This page is intentionally left blank

1) As commissioners how do you quality assure the care the Primary Care Trust are purchasing on behalf of the patient?

As commissioners the PCT adopts a zero tolerance to all avoidable infections.

Eastern and Coastal Kent PCT appointed a Director of Nursing who is responsible for infection control across the PCT area and who works with the PCT and other providers to minimise the risk of health care acquired infections. All providers must adhere to and comply with the 2006 Hygiene Code. The code sets out eleven duties and sub duties all of which are monitored using a performance monitoring tool. An assessment is currently being undertaken by all providers and this will provide assurance of performance and actions taken to address how shortfalls or deficits will be managed with timescales.

A Provider Assessment Document is used to assess willing Providers against a series of quality metrics.

Key Performance Indicator benchmarking documents have been devised to set standards across the local health economy. Provider performance and development is reported into and discussed at the monthly Infection Prevention and Control Committee (IPCC). Provider's performance is measured against Standards for Better Health, which is reported to the SHA and in turn to the PCT Board.

Issues raised within the Infection Prevention and Control Committee are discussed and actions formulated with defined timescales.

Breaches in targets for MRSA and Clostridium Difficile achievement are scrutinised within the IPCC. Providers are asked to submit a detailed action plan and decisions are then made within the commissioning team to address this.

2) As a provider of services how are you as a PCT ensuring that you are good practice in infection control?

All providers work to achieve both the Standards for Better Health and the Hygiene Code requirements. Performance is measured against the PCT local health economy performance tool.

The PCT (provider arm) has appointed an Infection Prevention and Control development coordinator to lead on the delivery of the PCT Health Care Associated Infection Plan and monitor progress and development within the PCT provider arm.

Infection prevention and control is included in induction programmes for all staff within the PCT. Best practice is shared across the local health economy and disseminated through the IPCC.

Root cause analysis are undertaken for all MRSA bacteraemias to ascertain causative factors. Such cases are reported to and discussed within the local health economy Infection Prevention and Control Committee. Learning is then shared across the health economy.

Local community hospitals, Primary Care, and the home visiting services including intermediate care are taking the hand hygiene campaign very seriously.

3) How are the PCT dealing with healthcare associated infections as a public health issue?

There is now statutory reporting of MRSA and Clostridium Difficile to the Health Protection Agency and public health reports this to the local health economy wide Infection prevention and Control Committee.

There are specific targets for both MRSA and C. Difficile for all acute trusts. Any rise in infections the Health Protection Agency visit to advise. If changes are not made then the health commission are asked to investigate.

Any outbreaks are reported to the public through press releases.

The PCT support all providers of services across the local health economy to meet their trajectories for both MRSA and Clostridium difficile.

Acute Trusts must demonstrate a reduction in the numbers of Clostridium difficile by 25% for 2007 and by 30% for 2008 and an overall 50% reduction for MRSA.

South East Coast Strategic Health Authority injected extra funding for developments in infection prevention and control, part of which is being used to develop projects that address public health issues.

The PCT is to undertake a hand hygiene campaign for the community and community hospitals. We are currently looking to developing communication systems to increase public understanding and confidence within local health care systems. The PCT is leading on the making of a hand hygiene video to reinforce our commitment to promoting safe practice and indeed for empowering the public to challenge practices within healthcare organisation. The PCT will work in close collaboration with Trusts, Kent County Council and the National Patient Safety Agency to achieve this.

4) What work are you doing as a PCT with the GPs to reassure the public that the acute hospitals and community hospitals are safe?

GP services are currently being assessed using Standards for Better Health and the Quality and Outcomes Framework.

A key priority is to work with General Practice, PCT teams and the acute Trusts to develop an antibiotic benchmarking policy, together with a performance monitoring tool to ensure treatment is both appropriate and safe.

The PCT is sending out a letter to all GP Practices to remind them about appropriate prescribing of antibiotics and their role in the prevention of infection that could be acquired in both community and district hospitals.

There is GP representation at the local health economy Infection Prevention and Control Committee to support some of the work across patient care pathways.

West Kent NHS
Primary Care Trust

Health Overview & Scrutiny Committee

Friday 9 November 2007

West Kent Primary Care Trust

This page is intentionally left blank

West Kent NHS
Primary Care Trust

5th November 2007

SENT VIA EMAIL

Paul Wickenden
Overview and Scrutiny Manager
Kent County Council
Sessions House
County Hall
Maidstone ME14 1XQ

Dear Paul

Health Overview and Scrutiny Committee – 9 November 2007 – EVIDENCE

Thank you for the opportunity to submit written evidence for the above meeting. You asked for evidence covering four topics. I have not included all of the papers to support these statements, which would be a considerable amount and some of which are not available electronically. They are available if Members would like them, and confirm the statements made below:

(1) As commissioners how do you quality assure the care the Primary Care Trust are purchasing on behalf of the patient?

We have a contract, which is based on a national NHS contract for Acute Trusts. This contract has a section that relates to Clinical Key Performance Indicators (KPI)

We monitor performance at a number of levels:-

(a) formal meetings between our contracting team and the Trusts at Director and senior manager level – monthly;

(b) formal monitoring meetings between the PCT, Trusts and the Strategic Health Authority (SHA) - monthly at CEO and Director level;

(c) where we get patient and representative complaints/concerns, we fully investigate and seek improvement from the organisations involved;

(d) ad hoc visits from PCT Directors as well as the CEO. For example the Director of Infection Prevention and Control (DIPC) is the PCT Director of Nursing and he visits the wards in our local hospitals regularly to observe care delivery and talk to the Directors of Nursing, Matrons, and ward staff;

(e) review of regulatory reports such as the Patient Environment Action Team, the Healthcare Commission Annual Health Check;

(f) regular meetings between the PCT and Acute Trust Directors of Nursing;

(g) regular meetings between the PCT and Acute Trust Infection Control nursing teams;

(h) Monthly meeting of the West Kent Infection Prevention and Control Committee, chaired by the PCT DIPC. This has DIPC representation from all the NHS providers in West Kent;

(i) Ad hoc reports such as the recent one on *clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust;

(j) Untoward Incidents are reported to the SHA and PCT, with subsequent root cause analysis and action plans as necessary;

(k) The Board receives a report at every public meeting on performance against KPI;

(l) The Executive Team are considering proposals to provide additional evidence of the quality of clinical services in all healthcare providers commissioned by West Kent PCT. More details of this will be released when further work is done.

(2) As a provider of services how are you as a PCT ensuring that you are observing good practice in Infection Control?

The Assistant Director for Adult Services with the Director and Deputy Director for Community Services have been working closely with community staff across all services to ensure that managing the risk of infection is high on everyone's agenda.

Meetings have been held with a representative from West Kent Shared Services Environment team, to ensure that our internal performance systems are independently audited and scrutinised regularly. The community hospitals have regular PEAT (Patient Environment Action Team) assessments carried out.

Copies of last years overall PEAT scores for each community hospital and the quarterly audit results as covered in the SLA with WKSS* (see below) are shown.

PEAT visits 2007

PEAT assessments were carried out during February and March this year. These are led by the Head of Environment Services for WKSS and supported by the Modern Matron of the site and a senior manager.

The results are available in detail, however below is a summary of the findings:

Hospital	Date	Overall score	Action plan comments
Tonbridge	March	Good	Attention to detail e.g. walls, doors, electrical equipment.
Sevenoaks	Feb	Good	Some areas requiring attention e.g. electrical equipment, flooring
Livingstone	Feb	Good	Attention to detail e.g. small equipment

Gravesham	Feb	Very Good	
Edenbridge	Feb	Very Good	
Hawkhurst	March	Very Good	

Quarterly cleaning audit report

The last quarterly cleaning audit was carried out in September 2007. Again this is carried out by the Head of Environment Services for WKSS to provide external scrutiny of our service standards.

The audit is set against the National Specification for Cleanliness in Hospitals. The pass rate being 85%.

Audit results

Livingstone: 83%*
Gravesham: 91%
Hawkhurst: 91%

*The Modern Matron and the Locality Manager responsible for the Livingstone Hospital have implemented a programme of work with WKSS to ensure that the next audit result is brought up to the standard required to reach at least 85%.

The current SLA with WKSS means that the following Hospitals are excluded from the external audit process.

Tonbridge Cottage

Edenbridge

Sevenoaks

Internal audits are carried out but these are not benchmarked in the same way as the WKSS audit. The current situation with these 3 community hospitals is being reviewed and discussion is ongoing with WKSS to evaluate the additional cost to the PCT to include quarterly audits for these sites in the SLA for 2008/09.

This page is intentionally left blank

The chart below shows all the community hospitals and the appropriateness of the bed spacing and hand washing facilities to manage the control of infection.

Hospital	Open beds	Bed spacing	Closed beds	Bed spacing	Single rooms	Bathrooms/hand washing facilities	Other actions
Gravesham Community (Sapphire Wing)	12	All single rooms	10	All single rooms	All single rooms	One ensuite in each room plus 2 additional bathrooms	Hand gel at entrance to ward area. Hand gel at the foot of each bed All staff carry small hand gel containers
Livingstone	30	Meets requirement	0 (8 beds decommissioned due to bed spacing issues)	Meets requirement	0	1 full wash basin within each of the 8 bays. 1 ensuite within the 2 bedded bay. 2 bathrooms. 2 shower rooms 5 toilets with full wash basin facilities.	Hand gel at entrance to ward area Hand gel at the foot of each bed All staff carry small hand gel containers
**Hawkhurst	19	Meets Requirement except one ward area see below	4	Meets requirement	See below	See below	Hand gel at some entrances but not all See below
Edenbridge	10	Meets requirement	7	Meets requirement	7	1 en suite in each single room. 2 additional bathrooms	Hand gel at all entrances. All staff carry small hand gel containers.

						4 shower rooms 6 toilets with full wash basin facilities.	
***Sevenoaks	24	18 beds do meet requirement. ***6 beds do not meet requirement	23	Meets requirement	4	5 bathrooms 4 shower rooms 4 Toilets with full wash basin facilities. 28 wash basins.	Hand gel at all entrances. Hand gel at the foot of every bed. On trolleys, nursing station and sluice.
***Tonbridge Cottage	15	***Does not meet requirement	15	Ward area not set up therefore no data available at this time.	3	4 bathrooms 4 shower rooms 16 toilets with full wash basin facilities 36 wash basins across the site (including those in closed ward areas)	Hand gel at all ward entrances. All staff carry small hand gel containers.

** Hawkhurst: a Clinical Governance audit was carried out in September by 2 locality managers and the locality facilities coordinator. The action plan from that audit was reviewed October 30th. The written report following that review will be available in mid November. The action plan included hand gel to be provided at every entrance and at the foot of each bed, bed spacing in one area of the ward to be reviewed as well as privacy and dignity issues.

*** The bed spacing is under review at Tonbridge Cottage Hospital and at Sevenoaks Hospital, as it appears that some of the bed spacing does not currently meet the recommended 3200mm. The AD for Adult Services is aware of this and is being supported to resolve the issue. (See below)

Bed Spacing

During the Community Hospital review, work was done, with WKSS to prepare CAD plans of each community hospital inpatient area and to demonstrate optimal bed spacing within each ward (3200 mm) whilst maintaining bed numbers.

The plans are available for viewing.

This highlighted areas where the bed spacing would be compliant with the recommendations and where it would not. Actual bed spacing is being reviewed as a matter of urgency within each community hospital by the senior nursing staff and is shown in the chart above. Any non compliance is being addressed to ensure optimal spacing is in place throughout. If this leads to the need to reduce bed numbers in the interim, this will be highlighted as a matter of urgency. (See ***Tonbridge Cottage Hospital and Sevenoaks Hospital above). The compliance with optimal bed spacing is now in place.

In addition the issues around nightingale wards have been addressed and there are bays identified in each ward area allowing for no more than 6 beds in any one bay. The Assistant Director for Adult Services is working closely with the Community Hospital Modern Matrons and the Locality Managers to ensure all recommendations relating to cleaner hospitals is being implemented, reviewed and audited.

All cases of MRSA and C. Diff. are reported as required.

Current Action Plans

Current plans in place include:

- A review of the square footage of each community hospital and benchmarking against national cleaner hospitals data to ensure the appropriate number of cleaning hours are in place for each hospital site.
  Completion: end November 2007.

- Review of the job specification for the housekeeper role prior to developing this role across each community hospital site.
  Completion: end of November 2007.

- Unannounced PEAT visits have been set up for November and December 2007, carried out by the Head of Environment services for WKSS, accompanied by the AD for Adult Services. These are as follows:

  1. Hawkhurst Hospital 21st November
  2. Edenbridge Hospital 22nd November
  3. Tonbridge Cottage Hospital 28th November
  4. Sevenoaks Hospital 3rd December
  5. Livingstone Hospital and Sapphire unit 4th December.

  Results available end December 2007.

- Application for deep clean money for each community hospital. This includes confirmation of square footage for each area and total costs to undertake deep clean.

    1. Livingstone Hospital-WKSS
    2. Gravesham Sapphire Wing-GFM
    3. Hawkhurst Hospital-internal
    4. Edenbridge-internal
    5. Sevenoaks Hospital-internal
    6. Tonbridge Cottage Hospital-internal

- *Review of the SLA with WKSS as not all sites within the PCT are included in the SLA and are therefore not included in the external auditing and bench marking process. This requires discussion with the Finance Director as the SLA currently sits with him.

In the community, where staff work in people's homes, they have well-established systems to ensure that standards of clinical practice are maintained, and all nurses carry alcohol gel with them and ensure appropriate levels of cleanliness whilst providing care for patients. Dressings are disposed of appropriately, and equipment is either disposable or is returned for sterilisation and decontamination via systems that are compliant with statutory requirements.

(3) How are the PCT dealing with healthcare associated infections as a public health issue?

Monitoring and surveillance is the way we identify changes in patterns of infection rates. It is now a statutory requirement to monitor MRSA and C Difficile. All cases are reported to the Health Protection Agency (HPA). The Primary Care Trusts get a copy. All trusts have a responsibility to notify the HPA of any outbreaks or infections. This is a way of identifying emerging diseases.

The West Kent Infection Prevention and Control Committee discusses and analyses surveillance data, in part via an expert subcommittee as relevant, on a monthly basis. The Board receives the surveillance information, including trends, at each public Board meeting.

Implementing the national standards is the responsibility of individual providers. The west kent infection patient safety committee monitor audits of practice and share good practice to ensure compliance with standards.

New guidelines and protocols for Kent and Medway are developed by the Kent and Medway Directors of Infection Control Committee which is led by the clinical director of the Health protection agency.

I understand that the committee already has a copy of the memorandum of understanding with the HPA and the terms of reference for the infection control committee.

(4) What work are you doing as a PCT working with GPs to reassure the public that the acute hospitals and community hospitals are safe?

The Medical Director (also a local GP) has written to MTW offering to meet senior clinical and managerial staff, in conjunction with the Local Medical Committee if appropriate, to discuss how General Practitioners might best advise their patients about the current situation at the Trust with regard to clinical safety.

Whilst there have been frequent anecdotal reports of patients expressing concern to their GP about potential treatment at MTW, the commissioning team reports that there appears to be no current evidence of patients cancelling previously booked procedures to a greater extent than before the crisis broke, nor is there any convincing current evidence of a decrease in fresh referrals to MTW for elective care. It nevertheless remains our view that it is possible that a trend towards patients being referred further afield for treatment will ultimately emerge.

I hope that this information is helpful. If you require anything further please don't hesitate to contact me.

Yours sincerely,

Barrie Collins
Director of Nursing/Director of Infection Prevention and Control

This page is intentionally left blank