THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

REPORT OF THE INFECTION CONTROL EDUCATION SESSION FOR GOVERNORS HELD ON 30TH MAY 2008

SHEILA MORGAN gave an overview of Healthcare Acquired Infection (HCAI). She cited three case scenarios to highlight potential problems on different patient journeys.

THE HEALTH ACT 2006 introduced the Code of Practice for Prevention and Control of Healthcare Associated Infections. Failure to comply may result in either an improvement notice being served by the Healthcare Commission or being placed on “special measures”.

The three main headings are:

1: Management, Organisation, Environment (9 duties listed).
2: Clinical Care (1 duty).
3: Healthcare workers (1 duty). Lists available from Sheila.

MANDATORY SURVEILLANCE.
Staph. aureus. MRSA bacteraemia, (individual Trust targets to be reduced 20% year on year 2005 - 2008), GRE bacteraemia, Clostridium difficile (2007/08 local targets set 5% reduction aged 65 plus) and specific elective Orthopaedic surgical site infections.

STRATEGIES: Hand Hygiene, Decontamination of Equipment, Management of Alert Organisms, Asepsis and documentation of IV access.
The ‘Clean Your Hands” Campaign is now in its third year. Great emphasis is placed on hand wash procedure, also alcohol based hand rub available at ward entrances, bottom of beds and portable bottles to ensure everyone cleans their hand at the point of care.
Notices to prompt staff, involvement of patients and visitors.
Campaign coordinators to engage staff at **all** levels.
However most important is hand washing/hand cleaning before and after patient contact as outlined by the NPSA (National Patient Safety Agency) re. “5 Moments of Care” (leaflets distributed)
Wash hands 40-50 seconds, rinse and dry thoroughly with disposable (paper) towel, Alcohol rub, 20-30 seconds, bare from the elbow down (no jewellery, or wristwatches), short natural nails, keep skin in good condition,(emollients are provided).
Decontaminate all equipment after patient contact, e.g. commodes, bedpans, toilet seats, including underside, Stethoscopes, also Telephones, keyboards (keyboards flash when cleaning needed), all done by routine cleaning, disinfection, or sterilisation as appropriate.

CLEANLINESS AUDITS are undertaken by Ward/Departments, via Ward Accreditation**,** Hotel Services (credits for cleaning), the Patient Environment Action Team (PEAG) and weekly Hand Hygiene Audits.

ISOLATION: used for 2 groups of patients - Protective for vulnerable patients (immunocompromised); and source known to have and may spread pathogenic micro organisms.
Strict protocols are observed. Terminal cleaning is undertaken when patient vacates the room – curtains, walls, entire cubicle including all equipment, appropriate methods used for each, any unused disposable material is discarded.

ASEPSIS: To avoid contamination, achieved by ensuring only sterile equipment and fluids used in invasive medical/nursing procedures .To achieve this there are: a Practice Improvement Team Steering Group, a Practice Improvement Facilitator, an On-line Teaching Programme and Assessments of Competence. There is a protocol for the Care and Documentation of IV Access and Continued Care, together with Staff education.
There is an Education programme re: infection control for all staff employed together with a poster and cartoon campaign for visitors. Patients are encouraged to be vigilant.

Dr. S. Pedler gave a presentation on MRSA and C difficile – the microbiological view.
He gave an extremely knowledgeable and excellent presentation of the history of antibiotics. He started by saying the UK is a world leader in Infection Control and it hits the headlines here mainly because we are so well documented making our reporting system world class. Penicillin was first used in the 1940s and in the 1950s the first penicillin resistant infections occurred. Meticillin was then developed and used and was still effective in the 1980s. MRSA gradually moved up the country and was first diagnosed in the RVI in 1995 and is now common. C difficile is more recent. Why do we seem to have such a poor record? (a) Until recent years infection control was given a low priority, (b) high bed occupancy as decreed by the government. We have in excess of 90% occupancy and in some instances as high as 98%. The ideal would be 80-85% to ensure time for really thorough cleaning between each patient.
How are the infections acquired? By contact patient to patient, via unclean hands, in the environment.
The MRSA bacteria themselves have a short life in the environment.
MRSA can be killed by washing, disinfecting or boiling, not so C difficile. It has hard resistant spores and needs autoclaving to be destroyed. It is known to be in the gut of young infants but it then disappears in most cases
C. difficile causes antibiotic associated diarrhoea and pseudo membranous colitis, this causes the destruction of the lining of the colon and can be fatal. Dr Pedler dismissed the myth of ‘flesh eating bugs’ - they can be treated and cured, there is no nightmare scenario. However he is concerned that other resistant infections already known in the world will migrate here. As yet there is no proven treatment although there soon should be.

Matthew Lowery, Senior Clinical Pharmacist presented The Role of Antibiotic Prescribing.
Problems: Inappropriate use of broad spectrum antibiotics, the use of inappropriate antibiotics in patients with resistant organisms, the use of IV

antibiotics for non severe infections and not switching to oral antibiotics when patient starts to improve. There is a laminated card that has a summary of the guidelines on them that fits into the ID badge holder.

The antibiotic stop and review policy is in place and should, indeed must be observed.

The role of the pharmacist: Ensure guidelines are followed, Education of Junior Medical Staff. Antibiotic Stop/Review and Indication Policy. There are 2 antibiotic/infection control pharmacists based on the main admissions ward of the Trust.

He finished off by showing that total antibiotic usage in the Trust had decreased since the introduction of the Stop / Review and Indication policy and that there had been a decrease in C difficile over the same period.

Diane Palmer: Spoke on Learning from Experience, both ours and other people's.
Procedure when Bacteraemia is discovered.
Matron informed, completes an RCA within 24 hours, this record is sent to the Clinical Risk Department. Directorate Team hold review meeting, Actions given to Directorate, Actions identified for whole organisation.
Analysis of sample Risk Factors:
32.2% had Urinary Catheter in situ.
40.6% had in addition 1 or more peripheral cannulae
27.1% had had a peripheral cannula inserted.
66.4% complex medical conditions or significant co-morbidity including immuno-compromise.

Melanie Hornett: Spoke on organisational arrangements. We recapped on the progress of the fight against infection over the past few years. The primary duties of the DIPC are: Responsibility to the CEO for infection Control, working relations with all Directors, Directorates, Professional Groups, Ancillary workers, the Public and Public Bodies.
MH presented: **Current plans and Priorities,** Hand Hygiene, Saving Lives campaign, including the focus on peripheral lines, central lines and urinary catheter care, and the role of Sisters and Charge Nurses in implementing the Infection Control Policies in practice and ensuring standards of essential patient care. Control of antibiotic prescribing.

Sharon Gordon: Spoke on the Savings Lives Campaign. She heads one of the largest Infection Control Team in the country - there are 15 nurses in her team.

Diane Palmer: Expanded on the Ward Accreditation Scheme. Each ward is assessed on their anti infection procedures in each area. There are Traffic Lights Indicators, GREEN is 100% compliance, Amber is 80-99%, and red is less than 80%. It is well received by the Staff, the COG will be kept up to date on this and I hope Melanie or Diane will give a presentation on this to the Governor's meeting. A truly great initiative.

The morning concluded with Melanie speaking on working in the community and reiterated the MRSA and C Difficile Targets.

May I apologise for the length of the report, much has been missed out however. Thank you, Melanie and all of the team for a truly informative morning, all the speakers were interesting, enthusiastic and concise. Everyone present appreciates the time and effort you put into these events.

Heather S. Abrahams
Public Governor
30th June 2008