Stockport NHS
NHS Foundation Trust

STOCKPORT NHS FOUNDATION TRUST

Health Care Infection Prevention Update

HEALTH SCRUTINY COMMITTEE

APRIL 2010

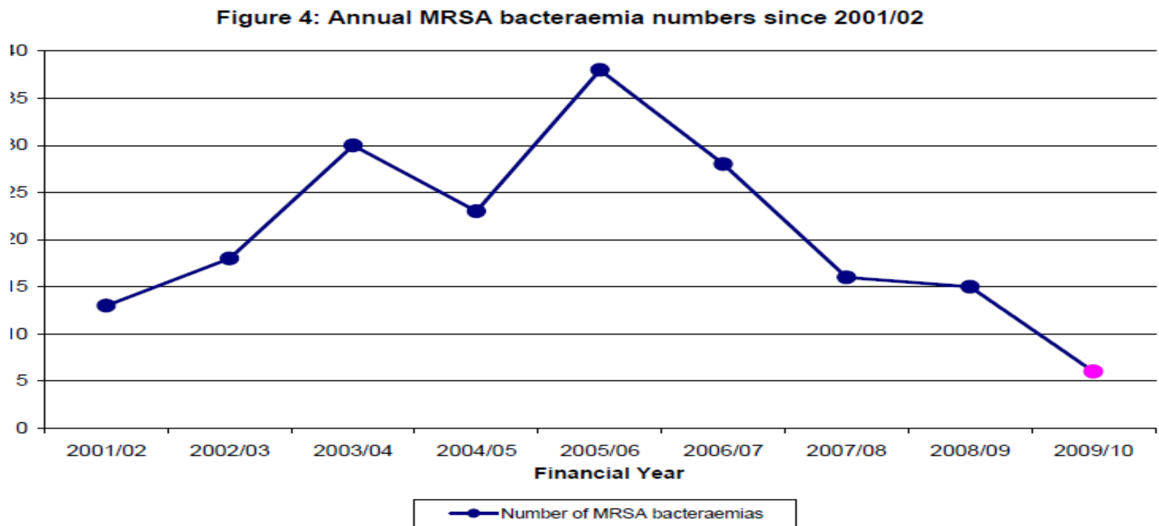
AGENDA ITEM 4

Health Care Infection Prevention Update for Stockport NHS Foundation Trust over Winter 2009/10

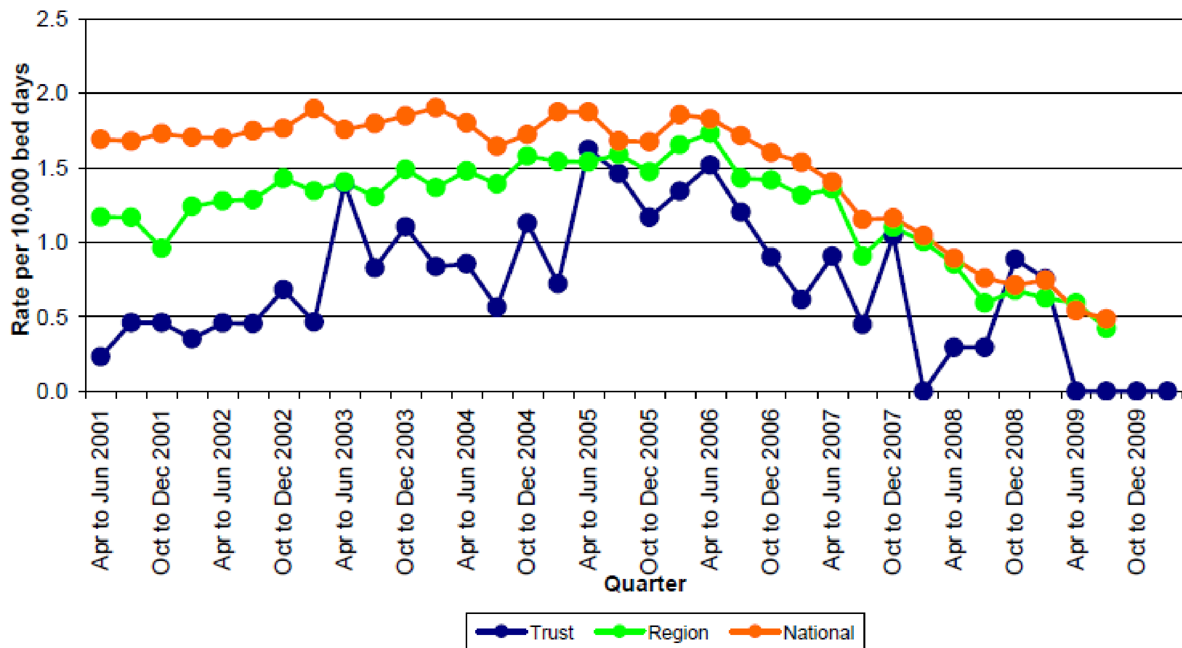
Aim

Maintain zero tolerance for avoidable hospital acquired infection as evidenced by following graphs

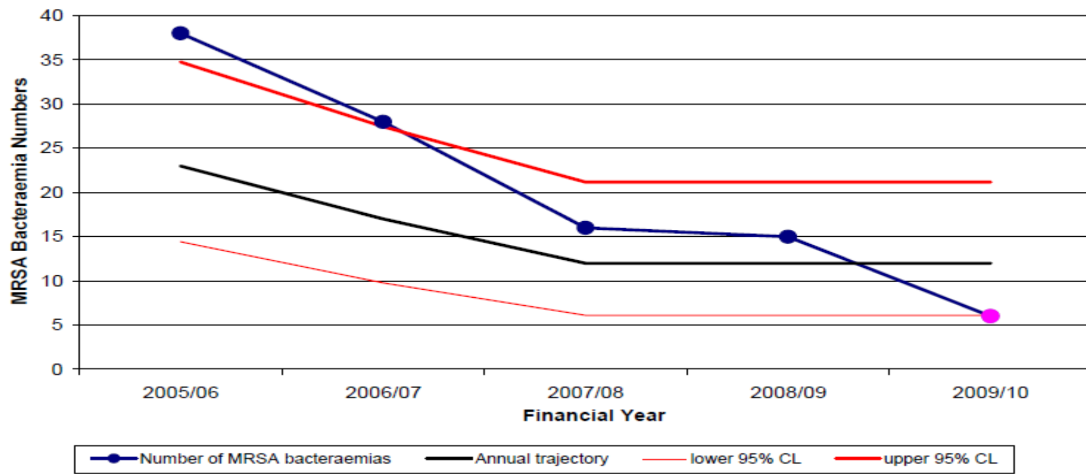
Graph 1: Year on year reduction of MRSA bacteraemia rates for Stockport NHSFT [1]



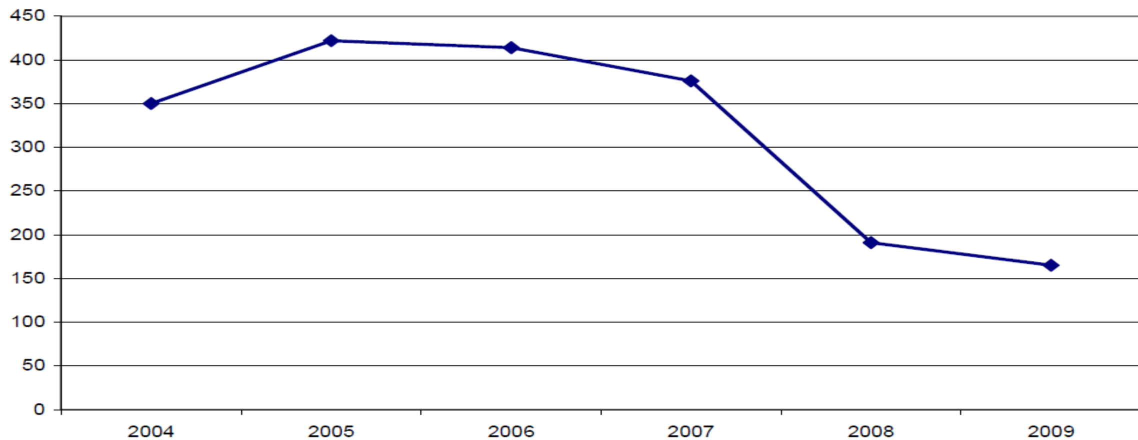
Graph 2: Comparison of national and North West regional trends for quarterly MRSA bacteraemia rates [1]



Graph 3: Guidance chart for annual MRSA bacteraemia data to ensure trust is well below the trajectory



Graph 4: Year on year reduction of Clostridium difficile rates for Stockport NHSFT since 2004[1]



From April 2009 to end of February 2010 there have been 6 MRSA bacteraemias of which 4 were pre-48 hours after admission and 2 were post-48 hours after admission. (From April 2008 to end of March 2009 there were 15 MRSA bacteraemias of which 6 were pre-48 hours after admission and 9 were post-48 hours after admission).

From April 2009 to end of February 2010 there have been 75 Clostridium difficile infections assigned to Stockport NHS Foundation Trust compared with 86 infections for the year Arpil 2008 to the end of March 2009.

Over winter 2009/10 one of the main Infection Prevention challenges was managing and containing swine influenza. This was successfully done by having a dedicated area in one particular ward for such patients. To our knowledge there has been no cross-infection of swine influenza between patients during the epidemic.

More recently norovirus has been prevalent. Again Infection Prevention measures within Stockport NHS Foundation Trust have meant that there has been minimal disruption of services due to norovirus.

The Infection Prevention Measures that have been enhanced or put in place to address Health care Associated Infections (HCAI) over the winter of 2009/10 have included:-

Maintaining involvement of Board level members in Infection Control walk-abouts with the IPC Team

Reviewing and streamlining Root Cause Analysis

- for every MRSA bacteraemia within 3 days of the positive laboratory results
- all Clostridium difficile deaths , where mentioned in the death certificate
- all Device related bacteraemia

Device related infections have been targeted recently including the Urinary catheter group working hard to minimise unnecessary urinary catheterisation and ensure where it is needed optimal care is ensured. Device related infections are being addressed on the Intensive Care Unit by their participation in the Matching Michigan initiative.

Extending Monthly Saving Lives audits carried out by matrons and ward managers to all departments in the hospital and actions fed back to the department and the IPC Team

New appointments

- In January 2010 a replacement Infection Prevention Doctor was in post.
- In October 2009 a replacement Senior Infection Prevention Nurse was in post.
- In October 2009 an IT data analyst was appointed to analyse and feedback infection prevention and control data. This has resulted in a more user friendly database of Infection Prevention information so that everyone can produce data and graphs relevant to themselves and their individual departments
- In October 2009 an MRSA tracker nurse was seconded for a year to assist with the implementation of the DoH requirements for MRSA screening. Since the appointment the number of MRSA screens from elective admissions and high risk emergency admissions have been increasing.
- Band 4 IPC nurse to start in April 2010

Strengthening the appropriate usage of isolation rooms throughout the trust, prioritising mainly for patients with diarrhoea.

Cleaning – continuing review and improvements in this area including - Updated version of cleaning standards being formatted by Facilities

Improved accessibility of training on Infection Prevention and Control (IPC) issues with the introduction of evening training sessions to improve attendance by Senior Medical Staff

Since May 2009 the microbiology scientific staffs have been working an extended working day so that now many more specimens including all Clostridium difficile specimens and MRSA screens are processed over the weekend as well as during weekends too now.

In February 2009 Stockport NHSFT microbiology department invested in an automated antibiotic sensitivity testing machine which ensures greater accuracy and a quicker turnaround time for antibiotic sensitivities which allows earlier targeted treatment of infections rather than using broad spectrum antibiotics (which are a risk factor for both MRSA colonisation and Clostridium difficile infection). The usage of this has gradually been extended.

Stockport NHSFT laboratory medicine is working with the whole of the Stockport Healthcare economy to promote appropriate specimen collection and laboratory test requesting (e.g.

urine cultures) to prevent inappropriate antibiotics treatment of patients with contaminated specimens

Data collection of patients with Clostridium difficile is being enhanced to gain a greater understanding of factors involved in this infection.

Regular updating of Stockport NHSFT antibiotic prescribing guidelines to keep in line with national up-to-date guidelines and promote best antibiotic prescribing practises.e..g. surgical antibiotic prophylaxis guidelines changed in December 2009 to help prevent Clostridium difficile infections.

Working with the advancing quality initiative team to promote best practice in antibiotic prescribing for pneumonia and for prophylaxis for hip arthroplasties.

Working with Stockport NHSFT gastroenterologists to reduce unnecessary prescribing of Proton Pump Inhibitors which are a risk factor for Clostridium difficile infections

Review of feedback of point prevalence antibiotic usage audits done quarterly to ensure they are relevant to the individual departments and to ensure better stakeholder involvement.
" 5 day antibiotic stop labels" introduced in March 2010 to prevent overuse of antibiotics

Working even more closely with the Stockport Community Infection Prevention Team and other key stakeholders to prevent Clostridium difficile, MRSA and other HCAI across the whole Stockport Health Economy. This has been assisted by Stockport Community Infection Prevention Team creating a new post for a Senior Infection Prevention Nurse Manager to assist with this in October 2009

The Stockport NHSFT Infection Prevention Team network with other healthcare providers across the Northwest eg NORWIC, Greater Manchester Pathology Network to address issues related to the prevention of HCAI . An example of working together is the setting up of a ribotyping service at Manchester HPA, funded by the Greater Manchester Pathology Network to type Clostridium difficile isolates to see if isolates are similar, and possibly acquired by patient to patient transfer, or different, where cross-infection is less likely. Writing of a minimum standards document to address MRSA screening across the whole of Greater Manchester has also been addressed – August 2009

Stockport NHSFT is proactive in taking part in National Research Initiatives regarding Clostridium difficile – currently involved in a Clostridium difficile toxoid trial.