Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
24th November 2011

TITLE	**Director of Infection Prevention and Control 6 month update April to September 2011.**
EXECUTIVE SUMMARY	There were 2 MRSA bacteraemias in one patient which means the Trust is just within its target of 4 for the year. C difficile levels continue to be within target with 12 cases (annual target 33).
BOARD ASSURANCE (RISK)/ IMPLICATIONS	Assurances are provided by the infection control audits reported on. There is a risk that the MRSA and C difficile targets may not be reached as they are so demanding this year.
STAKEHOLDER/ PATIENT IMPACT AND VIEWS	There is a patient representative on the Control of Infection Committee
EQUALITY AND DIVERSITY ISSUES	N/A
LEGAL ISSUES	N/A
The Trust Board is asked to:	Note information
Submitted by:	Dr Angela Shaw Director of Infection Prevention and Control
Date:	31st October 2011
Decision:	For Noting

Trust Board
24th November 2011
Director of Infection Control
6 monthly update

Infection Control Statement

Infection Control is the responsibility of all healthcare workers. The Trust has a zero tolerance approach to healthcare associated infections.

Infection Control Arrangements

The nurses in the Infection Control Team now consist of a Consultant Nurse in Infection Prevention and Control, a senior Specialist in Infection Prevention and Control and a Specialist Nurse in Infection Prevention and Control (development role).

The senior Specialist in Infection Prevention and Control is due to leave the Trust in December 2011.

The Control of Infection Committee has met in June and September 2011 and the Infection Control Team has met fortnightly.

Mandatory Reporting

There is mandatory reporting to the Health Protection Agency of the following: MRSA bacteraemias (blood stream infections), Clostridium difficile infections in patients over 2 years of age, glycopeptide resistant enterococcus bacteraemias, MSSA bacteraemias (since January 2011) and Escherichia coli bacteraemias (since June 2011). There are targets for the first two of these.

MRSA bacteraemias

The Trust went over a year without a hospital-acquired MRSA bacteraemia between July 2010 and August 2011.

Unfortunately we then had 2 episodes within a month from the same patient, though neither were thought to be avoidable. The first episode was thought to be secondary to a skin condition that he was admitted with (bruises and blisters) and the second to a chest infection. He responded to treatment on both occasions but died following another chest infection while still on treatment.

At present there is no system in place to appeal against repeat cases.

Three patients have had MRSA in blood cultures taken on admission. A root cause analysis was performed on one of these who had an infected line site soon after discharge from the Trust.

There have been no MRSAs in blood cultures which were thought to be contaminants.

The percentage of contaminants in blood cultures as measured by coagulase negative Staphylococci remains low with an average of 2.1% between April and September 2011. 54% of these were in Paediatrics which are not included in the phlebotomy-led service and which may include significant cultures.

Root cause analysis of MRSA in blood cultures since April 2010.

	2010-11		2011-12 (April-Sept)	
Likely source	**HA**	**CA**	**HA**	**CA**
IV line	**0**	**0**	**0**	**1**
Surgical site	**1**	**0**	**0**	**0**
Chest	**0**	**1**	**1**	**1**
Urine	**0**	**1**	**0**	**0**
Skin/soft tissue	**1**	**1**	**1**	**1**
Contaminants	**3**	**0**	**0**	**0**
Total	**8**		**5**	

MSSA (Methicillin-sensitive Staphylococcus aureus) bacteraemias

There is a mandatory requirement to report MSSA bacteraemias since January 2011. In April to September there were a total of 19 cases, 4 hospital-acquired (taken >48 hours after admission). All the post-48 hour ones were babies on NICU.

Glycopeptide-resistant enterococcus bacteraemias

There were 2 cases in April to September

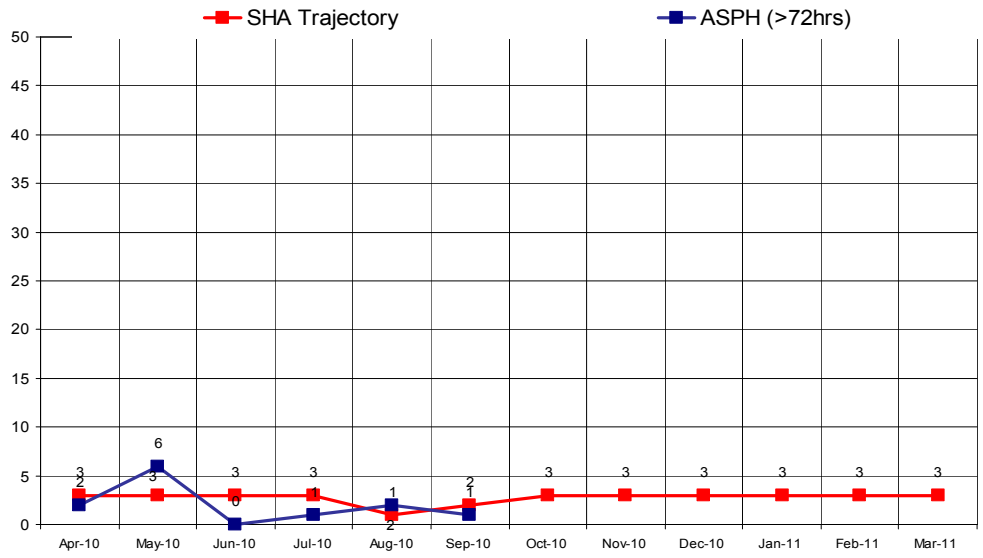
Clostridium difficile

There were 12 hospital-acquired cases in April to September 2011 (total 35). This is the same as the previous 6 months but half the number in the same period last year (24). Our target for this year is no more than 33, with a target of no more than 15 for the first 6 months so we are within target.

One patient has died with C difficile on part 1a of his death certificate and 3 with it on part 1b (one admitted with it).

The commonest possible causative factor is antibiotic use, particularly the use of Tazocin. Means of reducing the use of Tazocin for respiratory tract infections have been put in place but are hampered by supplies of alternatives like aztreonam.

ASPH Monthly Performance of Clostridium difficile acquired in ASPH - April 11 - March 12



E coli bacteraemias

These have been reportable since June 2011.
There have been 86 cases between April and September 2011. 20 of these were taken at least 48 hours after admission.

9 cases were ESBL (extended spectrum beta-lactamase) producers, which are highly resistant strains. 2 of these were hospital-acquired.

44% of all cases between June and September were thought to be secondary to urine infections.

Antibiotic prescribing

Antibiotic audits compliance rates						
	July 09 %	**Nov 09 %**	**May 10 %**	**Sept 10 %**	**Feb 11 %**	**June 11 %**
Allergy box filled in	90	98	90	90	95	93
Antibiotics prescribed in line with guidelines	91	92	93	95	97	94
Addition instruction box filled with indication	73	75	77	90	90	94
Start date filled in	99	99	99	99	99	99
Stop/review date filled in or number of days	62	67	69	75	77	83
Surgical & orthopaedic patients: 1 pre-dose	100	100	100	93	100	100
Surgical & orthopaedic patients: Nil post dose	71	80	69	80	92	79

As can be seen from the above table the compliance rates with indication and stop/review dates had continued to improve at the last audit in June 2011. Another audit will take place in November 2011. However the impression from the antibiotic ward rounds is that compliance fell after the intake of new doctors in August, despite training at induction.

Other Audits

High Impact Interventions:

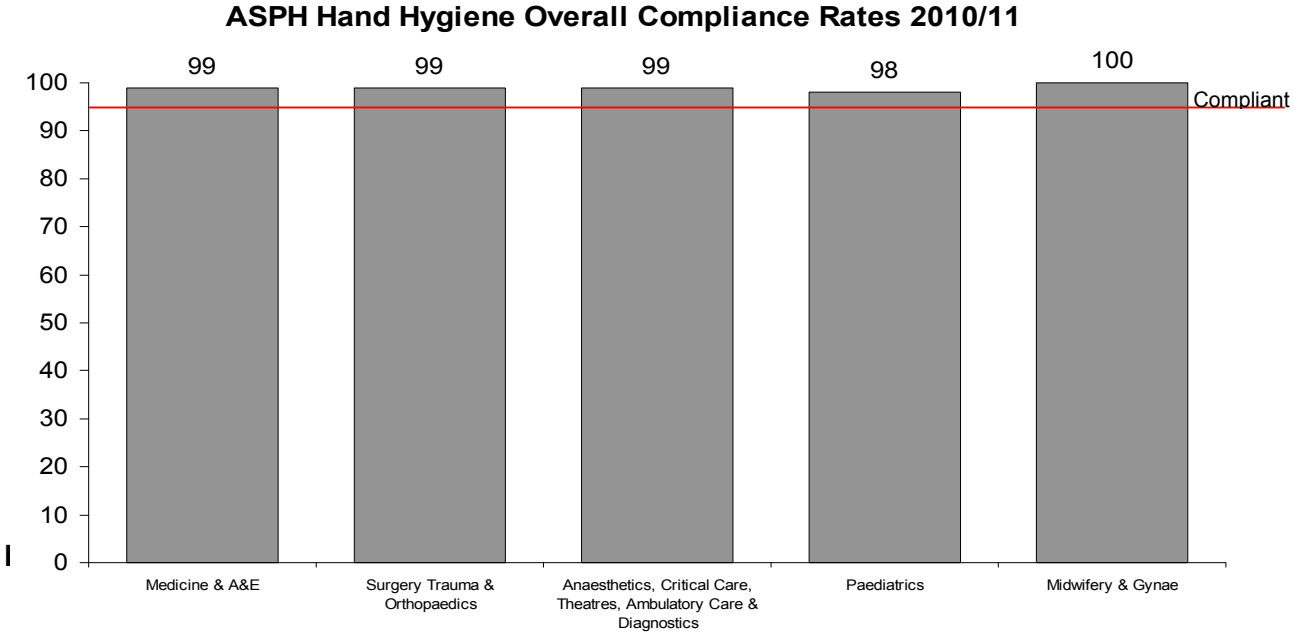
There continues to be improvements in most care bundles. The reliability of the scores has been questioned by some matrons as wards self-audit and are criticised if scores are low. Cross audit of other wards (peer review) may be better, although this is part of the instructions for completing the audits.

High Impact Intervention Scores (average % per month of all providing data)

	HII 1 insertion CVC	HII 1 continuing care CVC	HII 2 insertion Peri	HII 2 continuing care Peri	HII 5 Vent	HII 6 insertion Catheter	HII 6 continuing care Catheter	HII 7 C. diff
Apr-11	100%	99%	96%	96%	100%	95%	95%	100%
May-11	100%	100%	94%	95%	100%	96%	95%	100%
Jun-11	100%	99%	97%	98%	100%	99%	100%	100%
Jul-11	100%	100%	99%	99%	100%	100%	100%	100%
Aug-11	100%	100%	94%	96%	100%	95%	96%	100%
Sep-11	100%	99%	99%	98%	100%	100%	100%	100%

Hand Hygiene

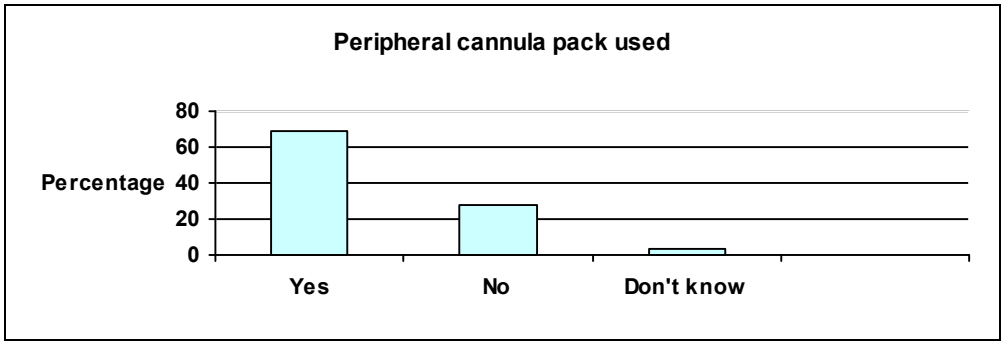
The results of the hand hygiene audits in April to September 2011 are shown below:
They have shown improvement since the same period last year. The same concern about self-audit applies to this.

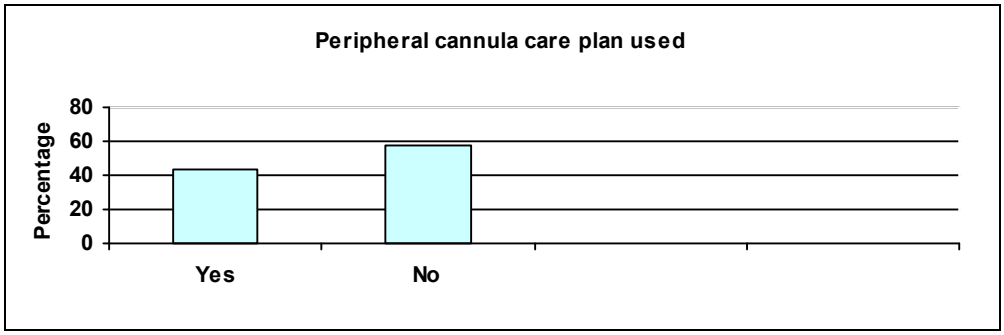


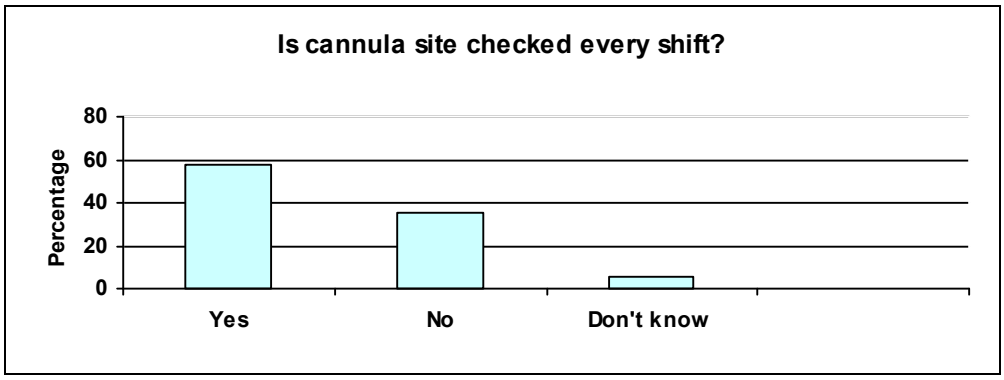
All patients in the Trust with peripheral cannulas in situ were audited between 19th and 22nd August 2011.

Results are for 129 patients unless otherwise stated.

There was improvement in most items measured. For example the cannula pack was only used in 20% in March 2009, and site checked every shift in 44% in 2009. However there is still room for improvement.







Surgical site infections:

The Orthopaedic hips and knees survey performed in January to March 2011 showed that there were no infections at Ashford Hospital (58 hip and 56 knee operations). There was one infection in knees at St Peter's 8.3% (of 12 patients).

The latest colo-rectal surgical site infection survey started on October 1st 2011.

Other issues

MRSA Outbreak in Obstetrics: Five women developed infections with PVL (Panton Valentine Leukocidin) positive MRSA who had all had caesarean sections between 26th June and 31st July 2011. All five Staphylococci have been typed and shown to be the same strain (Bengal Bay strain). There has been an extensive screening exercise to try and find a staff source for the organism, although to date no source has been found. An Outbreak meeting was held in October 2011 and an Action Plan produced.

Submitted by: Dr Angela Shaw

Date: 31.10.2011