Agenda item 10

South Tees Hospitals NHS

NHS Foundation Trust

Meeting / Committee:	Board of Directors	**Meeting Date:**	July 2014

This paper is for: (Only 1 column to be marked with x as appropriate)	Action/Decision	Assurance X	Information

Title:	Healthcare-associated infection report for June 2014

Purpose:	The purpose of this report is to provide performance information on healthcare-associated infections.

Summary:	The paper provides information on: Surveillance information on MRSA and MSSA bacteraemia, *Clostridium difficile*-associated diarrhoea, bacteraemia due to glycopeptide-resistant enterococci, ESBL-producing coliform infections and other important healthcare-associated infections for the month of May 2014. • There is no official MRSA bacteraemia target for 2014/15. There has been one trust-assigned case in June 2014, one overall case for 204/15. • There is no official MSSA bacteraemia target for 2014/15. There have been three trust-apportioned cases in June 2014 with a total of eight the first three months of 2014/15. • The *C. difficile*-associated diarrhoea target for 2014/15 is to have no more than 49 Trust-apportioned cases of *C. difficile* among patients aged over 2 years. There has been four trust attributed cases in June, with a total of 15 cases in the first three months of 2014/2015.

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Recommendation:	All the centres must continue to support and engage completely with all measures to reduce healthcare-associated infections.

HEALTHCARE ASSOCIATED INFECTION REPORT (DATA TO END OF JUNE 2014)

1. SURVEILLANCE DATA

1.1 MRSA bacteraemia

MRSA	*Annual total 13/14*	*Jul 13*	*Aug 13*	*Sep 13*	*Oct 13*	*Nov 13*	*Dec 13*	*Jan 14*	*Feb 14*	*Mar 14*	Apr 14	May 14	Jun 14	Total 2014/15 to date	Target for 2014/15
Total cases	*8*	*0*	*0*	*0*	*1*	*0*	*1*	*0*	*1*	*3*	0	0	1	1	NA
Not trust assigned	*4*	*0*	*0*	*0*	*1*	*0*	*1*	*0*	*1*	*1*	0	0	0	0	NA
Trust assigned	*4*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*2*	0	0	1	1	**NA**

There has been 1 case of MRSA bacteraemia in June 2014. This case was trust-assigned and was a patient in a community hospital. The most important lesson learnt for this case was that the system for dealing with a patient with a post-operative wound infection in a community hospital needs to be improved. An external MRSA review is taking place on 11th July 2014.

1.2 MSSA bacteraemia

MSSA	*Annual total 13/14*	*Jul 13*	*Aug 13*	*Sep 13*	*Oct 13*	*Nov 13*	*Dec 13*	*Jan 14*	*Feb 14*	*Mar 14*	*Apr 14*	May 14	Jun 14	Total 2014/15 to date	Target for 2014/15
Total cases	*92*	*7*	*8*	*8*	*7*	*6*	*3*	*9*	*16*	*8*	*6*	16	11	33	NA
Not trust apportioned	*64*	*4*	*5*	*8*	*2*	*5*	*1*	*7*	*13*	*5*	*5*	12	8	25	NA
Trust apportioned	*28*	*3*	*3*	*0*	*5*	*1*	*2*	*2*	*3*	*3*	*1*	4	3	8	NA

There have been 11 cases of MSSA bacteraemia in June 2014; three of which are classed as trust-apportioned. Root cause analyses have been requested from the clinical teams concerned.

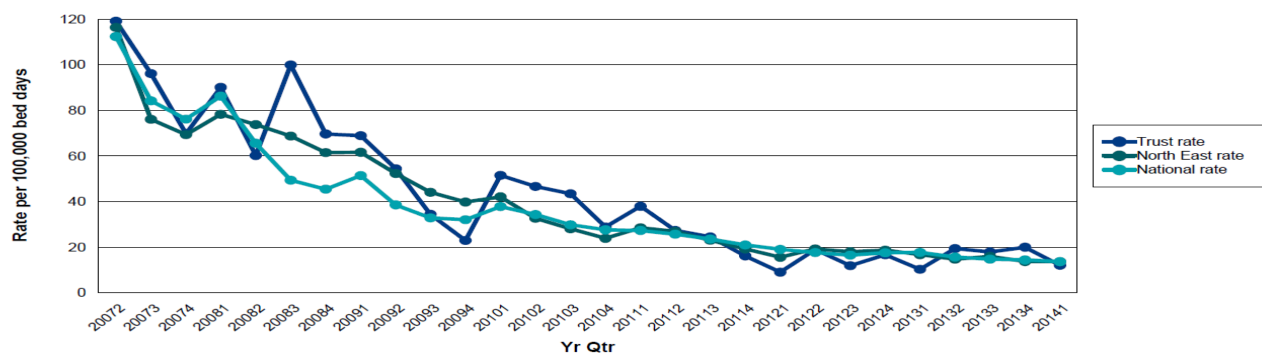
1.3 *Clostridium difficile*

C.difficile	*Annual total 13/14*	*Jul 13*	*Aug 13*	*Sep 13*	*Oct 13*	*Nov 13*	*Dec 13*	*Jan 14*	*Feb 14*	*Mar 14*	Apr 14	May 14	Jun 14	Total 2014/15 to date	Target for 2014/15
Total cases	*114*	*9*	*9*	*11*	*7*	*6*	*16*	*9*	*7*	*10*	11	15	11	37	NA
Not trust apportioned	*57*	*5*	*7*	*3*	*4*	*2*	*6*	*7*	*2*	*7*	7	8	7	22	NA
Trust apportioned	*57*	*4*	*2*	*8*	*3*	*4*	*10*	*2*	*5*	*3*	4	7	4	15	**49**
-JCUH	*46*	*3*	*2*	*6*	*3*	*4*	*10*	*2*	*4*	*2*	2	5	4	11	
-FHN	*3*	*1*	*0*	*2*	*0*	*0*	*0*	*0*	*0*	*0*	2	1	0	3	
-CBH	*2*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	0	1	0	1	
-RPCH	*2*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	0	0	0	0	
-ECH	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0	0	0	0	
-GGH	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0	0	0	0	
-The Rutson	*3*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0	0	0	0	
-The Friary	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0	0	0	0	
-The Lambert	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0	0	0	0	

There have been 11 cases of *C.difficile* infection in June 2014, four of which are classed as trust-apportioned. The annual target is to have no more than 49 trust-apportioned cases. Deaths within 30 days after *C.difficile* diagnosis: for May 2014, 3/15 patients died during this period. Since April 2009, 199/964 (21%) have died during the 30 day follow-up period.

The graph below provides the most up-to-date data from Public Health England comparing the incidence of trust-apportioned *C difficile* cases with the regional and national average incidence to the end of March 2014.

Rate of Trust apportioned CDI per 100,000 bed days - National, Regional and Trust Comparison



Rate based on trust apportioned cases only.

C.difficile action plan

The following actions were completed in June 2014:

<u>Cleaning</u>

- A trust-wide patient bed area checklist has been implemented to provide assurance on the cleanliness and safety of the bed area prior to the patient admission.
- A business case on the use of hydrogen peroxide vapour decontamination after terminal cleans and for use of sporicidal wipes to clean the environment of patients with *C. difficile* was presented at formal management group on the 1st July 2014. A further review of the costs has been requested to be resubmitted on the 15th July 2014.
- Implementation of daily commode cleaning checks by senior sisters/charge nurse.
- IPC team attended Carillion's annual domestic update training – robust and thorough programme was observed.
- Trial of an alternative pocket mop head has commenced.
- Endeavour have commenced ad-hoc mop head audits.
- Carillion have commenced weekly mop head stock counts and single-use duster usage.
- Carillion have completed a review of neutral detergent and finalising a proposal to change product.
- Audit North are completing a cleaning service review.
- Second nurse cleaning workshop has been completed, third is planned for 10th September 14.

<u>Antimicrobial prescribing</u>

- Implemented an antibiotic awareness campaigns for prescribers and nurses, respectively entitled 'SPARED' and 'ERA' from 2nd June 2014. The twice weekly antibiotic ward round has been modified to collect additional antibiotic audit data including information on whether the indication and stop date has been included on the patients' drug charts.

Communication

- Continuation of the weekly HCAI collaborative.
- Implemented a weekly *C. difficile* newsletter, titled 'focus on five' from the 6th June 2014. This highlights the key issues of antibiotic prescribing, communication, cleaning, hand hygiene and isolation. It is to be shared at staff handovers and meetings and to be displayed on staff notice boards. Each week has a different focus; in June 2104 the antibiotic prescribing, cleaning and isolation was highlighted.
- Deputy DIPC has attended three centre / directorate governance meetings to share information on HCAI performance, key actions.

Performance monitoring

- Development of a weekly clinical matron HCAI monitoring checklist has been completed.
- Each trust-apportioned case has a root cause analysis and critical incident review completed. Three clinical incident reviews have been completed since last month. Lessons learnt / themes have included non-submission of clean**your**hands and saving lives data, isolated patient using a communal ward shower due to lack of en-suite shower facilities and omission of green C.difficile sticker in the patient medical notes.

The following actions are planned for July 2014

Cleaning

- Interactive IPC workshop, including cleaning responsibilities at the Trusts Patient Safety Conference on 9th July 2014.
- Patient transport chairs are receiving a deep clean at JCUH site on 5th/6th July 2104.

Communication

- Survey of frontline staff regarding the use of HCAI collaborative newsletter.
- Development of HCAI communications plan.
- Deputy DIPC and then IPCN's to continue to attend centre/directorate governance meetings.
- Implementation of C.difficile media campaign.

Performance Monitoring

- Monthly *C.difficile* performance reporting to Monitor.
- Review of *C.difficile* clinical incident panel action plans.
- Implementation of the clinical matron weekly HCAI monitoring checklist.
- Professor Mark Wilcox is completing a second review on 21st July 2014.
- IPCN and clinical matron to visit Coventry Hospital to review *C.difficile* management and cleaning.
- Further Trust visits / communication to be planned for August / September 2014.

1.4 Surveillance for other healthcare-associated infections

	Total for 13/14	June 2014	Total 14/15
Bacteraemia due to glycopeptide-resistant enterococci	6	2	2
Bacteraemia due to *E. coli*	334	20	97
ESBL producing coliform infections	960	107	269
• sample taken in community	591	75	172
• sample taken in our trust	369	32	97
• bacteraemias	17	2	7
Other alert organisms	1	0	0

2. OUTBREAKS

Diarrhoea & vomiting outbreaks	Annual total 13/14	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Total 13/14 to date
Total number	2	0	0	0	0	0	1	1	0	0	0	0	0	0
Total number of patients affected	43	0	0	0	0	0	29	14	0	0	0	0	0	0
Total number of staff affected	8	0	0	0	0	0	3	5	0	0	0	0	0	0

3. RECOMMENDATIONS

All centres to continue to support and engage completely with all measures to reduce healthcare-associated infections.

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July 2014