



HCAI Technology Innovation Programme
Showcase Hospitals Combating Infection
24th June 2010

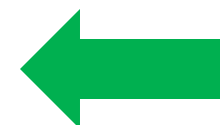
Working together – how hard can it be?

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will be determined by the type of services provided by a hospital rather than whether it is in the NHS or private sector. The guidance is, therefore, intended for both.

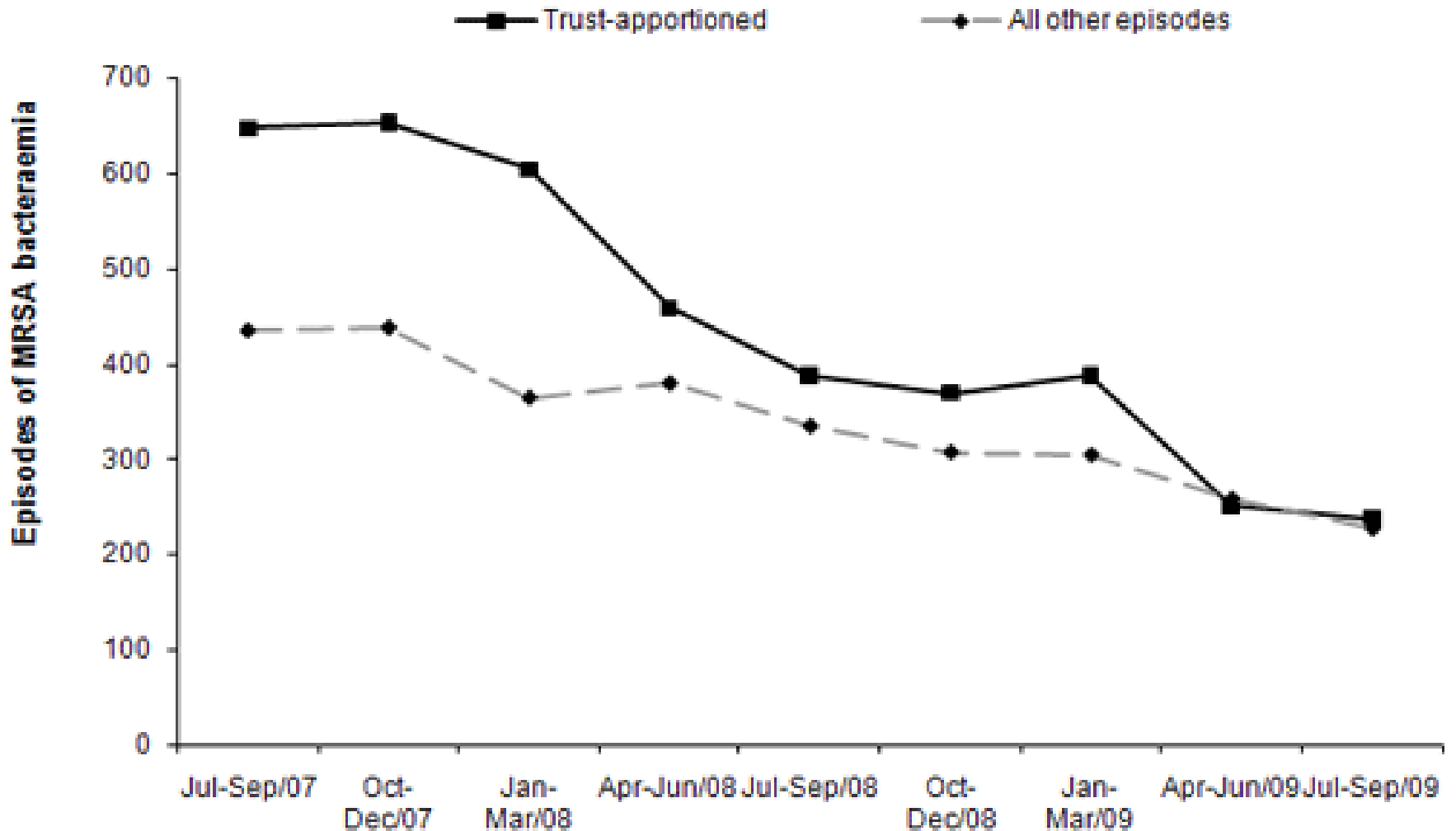
Overall it should have no financial or manpower implications.



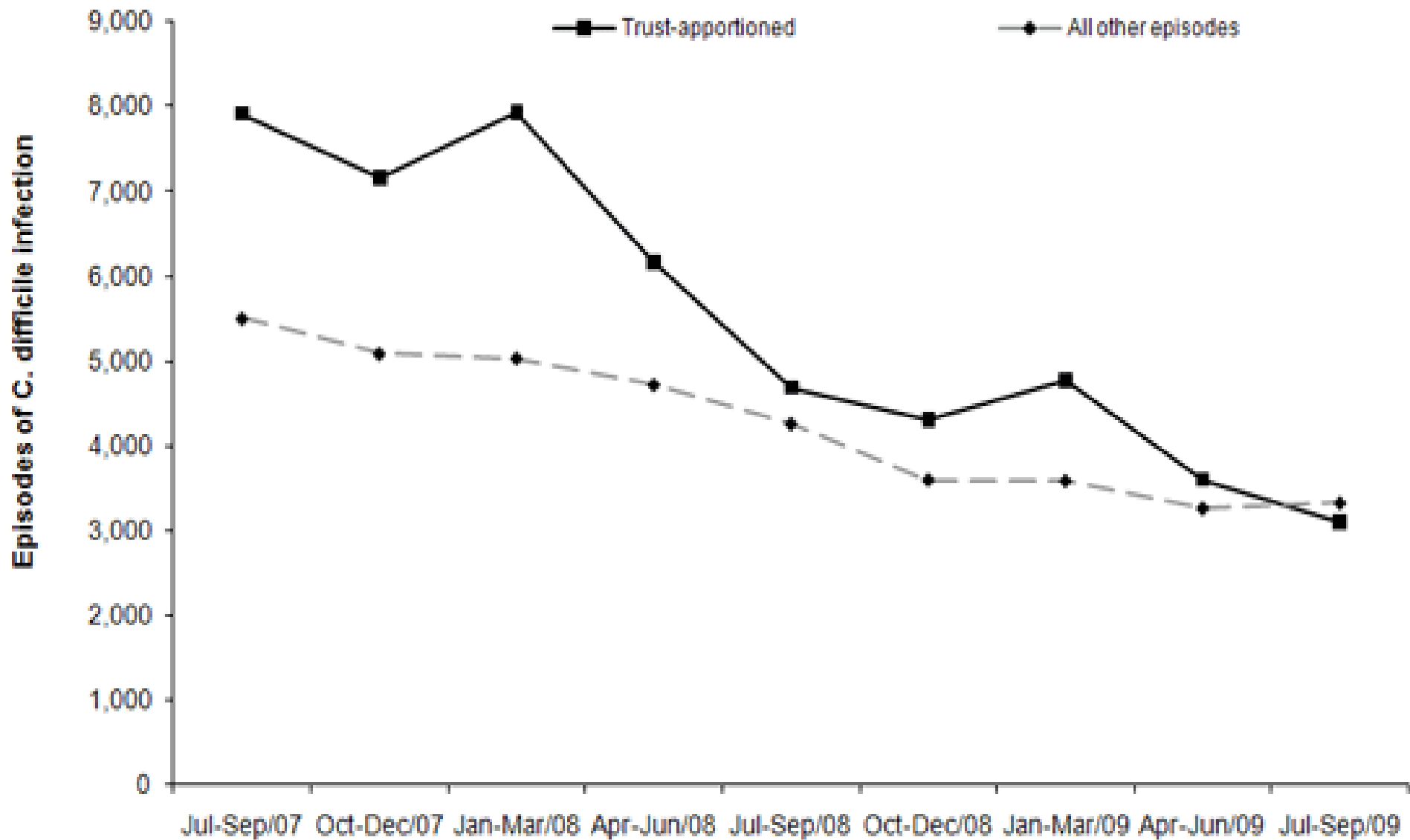
This guidance:

- recommends that purchasers of health care include enhanced surveillance, prevention and control in their contractual requirements.
- recommends routine surveillance of hospital acquired infection, including non outbreak associated infection.
- recommends arrangements for the control of outbreaks of infection in hospitals.
- recommends the action which should be taken by the hospital in response to major outbreaks of infection in the community.

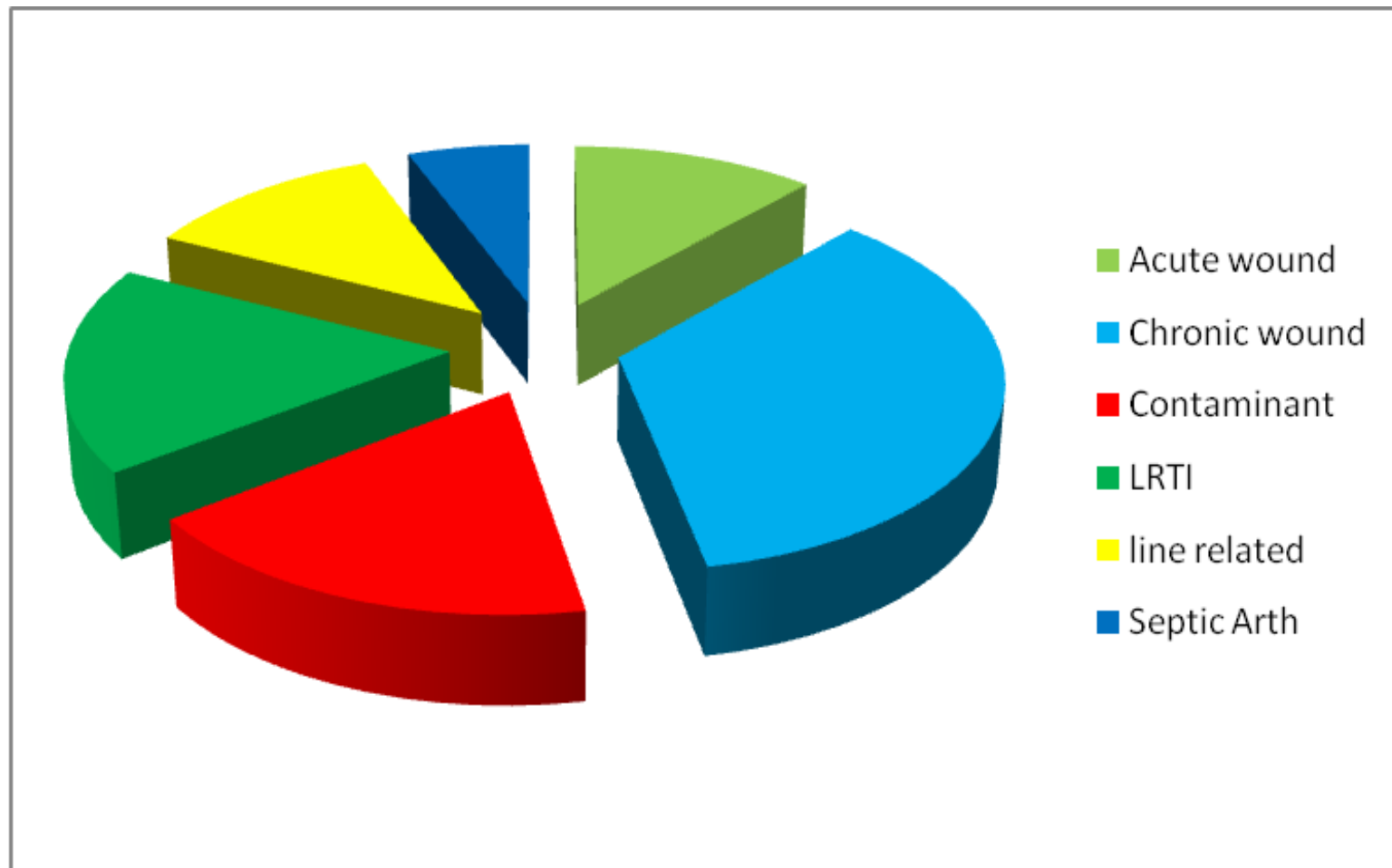
MRSA rates 07-09



C.Difficile infection 07-09







When it goes wrong

- Stoke Mandeville – 2004/05
- Maidstone and TW- 2005/06
- Godstone Park – 2009

The report opens - An awful tragedy occurred at Stoke Mandeville in 2004 and 2005. Over 30 people died as a consequence of two outbreaks of infection caused by the bacterium *Clostridium difficile*.

What happened at Stoke Mandeville reflects many of the organisational failings identified in the Bristol report. There appears to have been what in the Bristol report was called a “club culture”; senior staff were unresponsive to and feared by other staff; senior managers concentrated too much on one responsibility (achieving financial balance in the case of Bristol, and meeting targets for waiting times in the case of Stoke Mandeville) and neglected others; trust’s board not actively engaged in the safety of patients; and, there was confusion as to which of a number of organisations, was responsible for what, in dealing with the outbreaks of infection.

- During 2003 – a number of small outbreaks
- First hospital wide outbreak Oct 2003-June 2004
 - 174 new cases and 19 deaths
 - New strain
 - Request from IPC for cohort ward – not available
 - IPC advice not fully supported by managers

- Second hospital wide outbreak Oct 2004-June 2005.
 - 160 new cases and 19 deaths
 - Same new strain

- record of fluid balance was poor
- consistently low blood pressure for a number of days but no apparent action
- Multiple ward moves
- Documentation better in the younger cases than those over 80 years

Conclusions of the investigation

Contributory factors for the first outbreak

- a poor environment for caring for patients
- poor practice in the control of infection
- lack of facilities to isolate patients
- and insufficient priority being given to the control of infection by senior managers.

Conclusions of the investigation

Contributory factors for the second outbreak

- The failure of the trust to implement the lessons from the first outbreak
- a dysfunctional system for governance

Conclusions of the investigation

Confusion over roles

- HPU saw its role as advisory and supportive
- Delay in reporting concerns to SHA – April 05
- Delay in reporting concerns to DH – May 05
- SHA focused effort on delivery of the top national priorities and did not intervene until asked to do so by the HPU

Lessons learned

- rapid isolation of patients with diarrhoea
- restricting the movement of infected patients between wards
- rapid identification and notification of outbreaks
- establishment of a multidisciplinary outbreak committee which meets regularly
- rapid institution of recommended changes
- close monitoring of all components of the management of outbreaks including cleanliness, decontamination, the environment for patients, antibiotic regimes
- communication with patients, staff and outside agencies

Maidstone and Tunbridge Wells

- Overall there were over 500 cases and approx 60 deaths between October 2005 to September 2006
- Outbreak in 2005 –
 - Unrecognised as an outbreak – 150 cases
- Outbreak in 2006
 - Trust recognised it had a major outbreak and reported – 258 cases

Maidstone and Tunbridge Wells

Conclusions of the investigation

Contributory factors for the outbreak

- poor environment for caring for patients
- poor practice in the control of infection
- lack of facilities to isolate patients
- Lack of staff
- and insufficient priority being given to the control of infection by senior managers.

Maidstone and Tunbridge Wells

- Patient safety was the Boards top priority
 - Inconsistent
 - High bed occupancy
 - Patient movement
 - Failure to isolate

The system to bring clinical risk to the attention of the board did not function effectively

The board appeared insulated from the realities and problems on the general wards

Maidstone and Tunbridge Wells

- Other agencies
 - The Primary Care Trust
 - Health Protection Unit
 - Strategic health Authority

Maidstone and Tunbridge Wells

Lessons learned

- appropriate antibiotic prescribing,
- need for effective isolation,
- importance of scrupulous cleanliness and hygiene,
- the need to provide a high standard of care of patients infected with *C. difficile*, including having adequate staff.

Godstone Park

Review of the major outbreak of
E. coli O157 in Surrey, 2009

Report of the Independent Investigation Committee
June 2010



- *E. coli* O157 infection is relatively uncommon but, because the illness it causes (bloody diarrhoea which can be complicated by haemolytic uraemic syndrome [HUS]) can be severe or fatal, it remains a serious public health issue.
- The report was issued this week



Godstone Park

So what happened?

Between August & September 2009
several people were infected following a
visit to Godstone farm.....



Godstone Park

Management of the outbreak – key concerns

- Delay in recognising the outbreak
- Unacceptable delay in initiating control measures at the farm.
- Unacceptable delay in carrying out surveillance
- Failure to communicate the incident to community and hospital clinicians including paediatrics

Thursday 20 August

HPU - 1 informs HPU -2 of a child with presumptive *E. coli* O157 who had visited Godstone Farm on 8 August. On the same day, Croydon EHD informs Tandridge EHD of two cases: the same case and a sibling.

Wednesday 26 August

South East London HPU informs HPU-2 of a case of *E. coli* O157 who had visited Godstone Farm on 15 August and had also recently returned from holiday in Spain. HPU-2 informs Tandridge EHD of this case on the same day.

Thursday 27 August

The microbiology laboratory at St Richard's Hospital, Chichester, informs the Chichester office of HPU-2 Chichester of a presumptive case of *E. coli* O157 who had become unwell on 24 August.

Friday 28 August

HPU-2 Chichester office passes on details of this case to the Leatherhead office which relays them to Tandridge EHD. Later that day, the EHD find out that this case visited Godstone Farm on 21 August and had no other apparent risk factors. Tandridge EHD telephones Godstone Farm to advise on extra signage and make arrangements to visit as soon as possible after the Bank Holiday. One of the HPU-2 staff also rang Tandridge DC to emphasise the importance of dealing with this case before the Bank Holiday Weekend.

Bank Holiday Weekend 29 to 31 August

Tuesday 1 September

Following the Bank Holiday weekend, Tandridge EHD informs HPU-2 of a fourth case of *E. coli* O157, the sister of the case reported on 20 August, who became ill on 18 August and suggests there may be an outbreak associated with Godstone Farm.

Wednesday 2 September

HPU-2 and Tandridge EHD make arrangements to visit Godstone Farm the following day.

Thursday 3 September

A joint team from HPU-2 and Tandridge EHD visit Godstone Farm and discuss various options with the Farm owners to reduce the risk of infection. The visit focuses particularly on adequacies in handwashing facilities and on the risk associated with feeding animals. **By the evening of Thursday 3 September, the total of confirmed and presumptive cases known to have visited Godstone Farm rises to eight.**

Friday 4 September

Following the site visit an email is sent by HPU-2 to Godstone Farm. This suggests extra signage and extra staff to emphasise the importance of handwashing, measures to prevent waste spilling on to paths, and closure of sandpits. It also suggests that the Farm 'may want to consider voluntary closure for a time'.

The Farm owners decide to restrict direct contact with animals by closing the two animal petting barns and goat bridge to the public, and by prohibiting the feeding of animals by visitors. They also close some of the sandpits .

Monday 7 September

A staff member from the Veterinary Laboratory Agencies (VLA) Winchester office visits Godstone Farm at the request of the HPU to take samples. A multi-agency outbreak control team (OCT) teleconference is convened by HPU-2 after further new cases are reported over the weekend. The OCT agrees that there does not appear to be any ongoing risk and that 'no further measures (are) needed and the Farm did not need to be closed'. This is because the animal petting barns have already been closed and none of the cases reported so far visited the Farm after 31 August. Next meeting 18th Sept

Tuesday 8 September

The outbreak is declared an HPA level 2 incident. The local Nephrology Unit calls HPU-2 to express serious concern about **cases of HUS associated with Godstone Farm** which they have admitted. Told by the HPU that the matter 'is in hand'.

Thursday 10 September

VLA informs HPU-2 of the preliminary farm sample results. Information about the outbreak is sent to neighbouring HPUs; all hospitals, walk-in centres and GPs in Surrey; and to the Local Education Authority. The Nephrology Unit requests to speak to a senior member of staff at the HPU-2 because **three new patients are admitted** with HUS, and they are concerned that the Farm was still open. They are reassured once again and informed that the person leading on negotiations with the Farm will call back. Nobody from HPU-2 returns the call.

Friday 11 September

VLA confirms that the majority of samples taken from ruminant animals (**25 of 30 [83%] tested**) are positive for ***E. coli* O157**. Two further patients are admitted and one of the paediatric nephrologists in the Nephrology Unit has a conversation with the HPU-2 , expressing frustration at the lack of information regarding why the Farm is still open. The HPU assures that the person in charge of negotiations will call before the end of the day but there are no calls. The Nephrology Unit calls the HPU again at 5pm, but there is no response and it appeared the office is closed until Monday. South East and South West London HPUs report a further seven presumptive cases of *E. coli* O157, two of whom had visited Godstone Farm, on 1 and 4 September respectively. This raises the possibility that the Farm is still a public health risk and causes concern that the true size of the outbreak has been underestimated. **Decision to request the farm to close**

Saturday 12 September

Tandridge EHD visits Godstone Farm before it is due to open at 10.00am and the Farm agrees to immediate voluntary closure for an indefinite period.



Godstone Park - overview

- There were 93 cases of *E. coli* O157 infection associated with the outbreak,
- This included 65 primary cases (people infected at the Farm), 13 secondary cases (people infected from contact with a primary case) and 15 asymptomatic carriers (people who tested positive to the organism but had no symptoms)
- Most cases were children under 10 years of age
- All cases were from Surrey, Sussex, Kent, or the South London boroughs
- Primary cases had visited the Farm between 8 August and 4 September
- Primary cases became ill between 13 August and 18 September.



Godstone Park

- Regulatory agencies should explore ways of working together in regulating Open Farms clarifying roles, responsibilities and relationships

Collaboration

- Collaborative working requires everyone to know their role
- Not to assume others know theirs
- When we get it wrong the consequences can be severe.



- The Corps
- The Corps
- The Corps



- The Patient
- The Patient
- The Patient



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