

**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST  
COUNCIL OF GOVERNORS  
THURSDAY 13 NOVEMBER 2014**

<b>Title:</b>	<b>REPORT ON INFECTION PREVENTION AND CONTROL UP TO 30 SEPTEMBER 2014</b>
<b>Responsible Director:</b>	Philip Norman, Executive Chief Nurse and Executive Director for Infection Prevention and Control
<b>Contact:</b>	Dr Beryl Oppenheim, Director of Infection Prevention and Control. Ext 16523

<b>Purpose:</b>	To provide the Council of Governors with information relating to infection prevention and control issues (including the reportable cases of MRSA bacteraemia, MSSA bacteraemia and episodes of <i>Clostridium difficile</i> infection) up to 30 September 2014.
<b>Confidentiality Level &amp; Reason:</b>	None
<b>Annual Plan Ref:</b>	Strategic Aim 4 : Quality of Services
<b>Key Issues Summary:</b>	This paper sets out the position for the 2014/15 MRSA bacteraemia and <i>Clostridium difficile</i> infection trajectories and provides incidence of MSSA and <i>E. coli</i> bacteraemia within the Trust and supporting actions to ensure continued improved performance.
<b>Recommendations:</b>	The Council of Governors is asked to accept this report on infection prevention and control progress.

<b>Approved by:</b>	Philip Norman	<b>Date:</b>	31 October 2014
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# UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

## COUNCIL OF GOVERNORS THURSDAY 13 NOVEMBER 2014

### REPORT ON INFECTION PREVENTION AND CONTROL UP TO 30 SEPTEMBER 2014

#### PRESENTED BY THE EXECUTIVE CHIEF NURSE

#### 1. Introduction

This paper provides a report on performance against the 2014/15 objectives for meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium difficile* infection (CDI) up to 30 September 2014. It also provides updates on meticillin-sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* (*E. coli*) bacteraemias, new multi-drug resistant gram negative isolates, facilities initiatives, and relevant infection prevention incidents.

#### 2. Executive Summary

The annual objective for MRSA bacteraemia is 0 avoidable cases. There were no MRSA bacteraemias reported during September 2014; in total we have had 1 bacteraemia for this financial year to date.

The annual objective for CDI for 2014/15 is 67 cases, with cases judged as avoidable counting towards this objective for local penalties. Performance for September 2014 was 7 Trust apportioned post 48 hour cases, all of which were reportable to Public Health England (PHE) in accordance with Department of Health guidance, and 6 of which were assessed as unavoidable on local review.

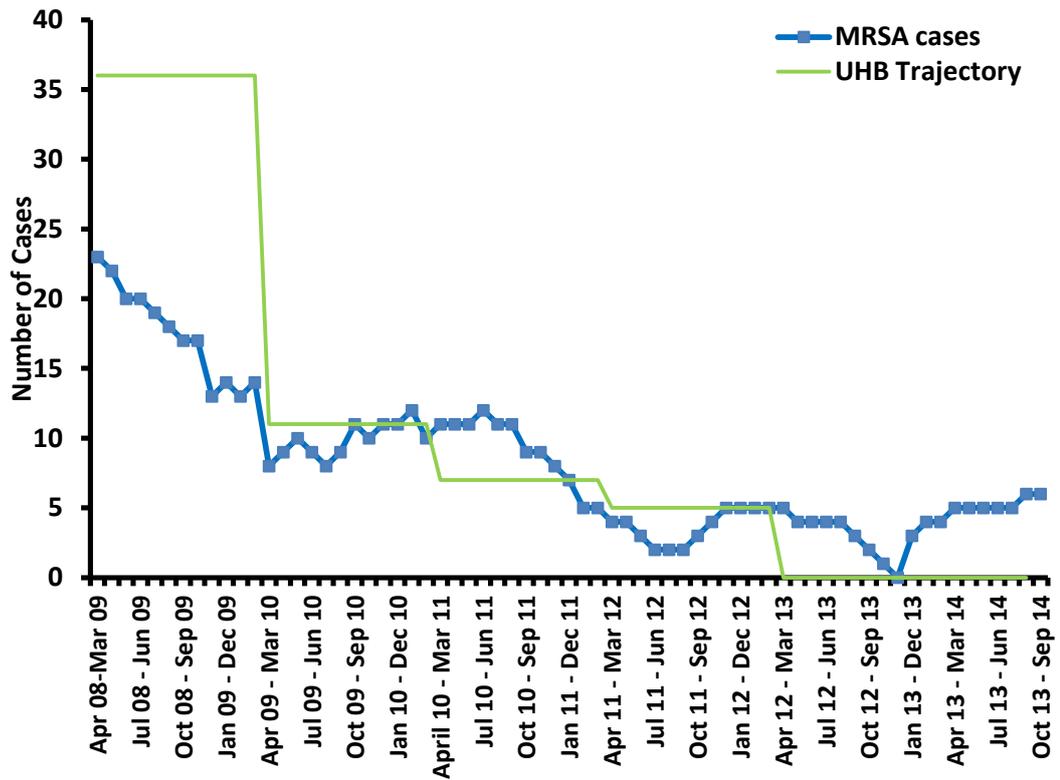
All incidences of MSSA and *E. coli* bacteraemia continue to be reported in line with PHE mandatory reporting requirements.

#### 3. Incidents of MRSA Bacteraemia

##### 3.1 MRSA bacteraemias 2014/15

There were no cases of MRSA bacteraemia identified during September. Figure 1 shows the number of Trust apportioned cases of MRSA against the rolling annual trajectory (April 2008 – current). Monthly incidence of MRSA bacteraemias is shown in Table 1.

**Figure 1:** Number of Trust apportioned MRSA cases at UHBFT against a rolling annual trajectory (April 2008-current).



**Table 1:** Monthly number of MRSA bacteraemias at UHBFT up to 31 September 2014.

Month	Total bacteraemia	Time of bacteraemia acquisition?	
		Non Trust apportioned	Trust apportioned
April 2014	0	0	0
May 2014	1	1	0
June 2014	0	0	0
July 2014	0	0	0
August 2014	1	0	1
September 2014	0	0	0
<b>Total</b>	<b>2</b>	<b>1</b>	<b>1</b>

**Note:** Objective for the financial year 2014/15 is zero avoidable cases.

### 3.2 Continuing actions to improve performance for MRSA bacteraemia

The process for review of MRSA bacteraemias in 2014/15 is the same as in 2013/14. Issues to be addressed as part of the learning from previous cases include:

- Improving the clinical management and documentation of all invasive devices including central and peripheral cannulae, urinary catheters,

nephrostomies and stents in accordance with Trust policies and procedures.

- Ensuring that all relevant staff are aware of patients' MRSA status and what the implications are.
- Ensuring the optimal management of all patients with MRSA colonisation and infection, including decolonisation treatment, prophylaxis during procedures, and treatment of infections.

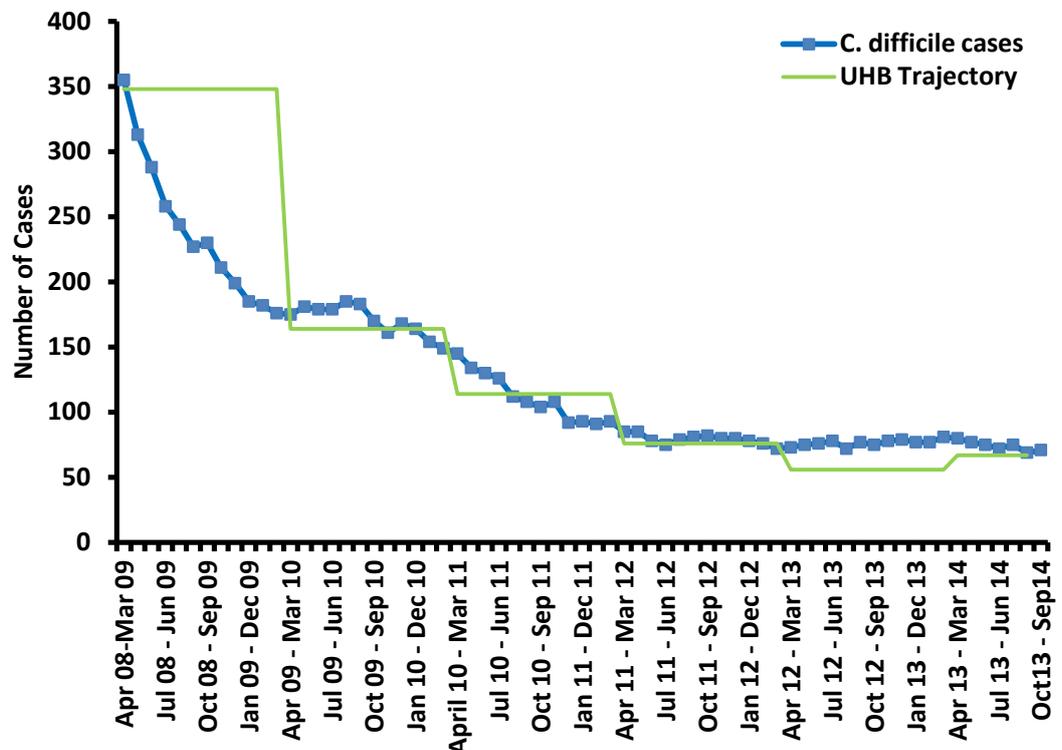
#### 4. Episodes of *C. difficile* Infection (CDI)

##### 4.1 Current Figures

The annual CDI objective for 2014/15 is 67 cases. Performance for September 2014 was 7 reportable cases all of which were post 48 hours and attributable to the Trust. As for 2013/14 all cases are being reviewed jointly with commissioners against avoidability criteria, those deemed unavoidable being excluded from consideration of penalties.

For September 1 case was avoidable and 6 deemed unavoidable. Figure 2 shows the number of Trust apportioned cases of CDI against the rolling annual trajectory (April 2008 – current). Monthly incidence of CDI to date is shown in Table 2.

**Figure 2:** Number of Trust apportioned cases of CDI at UHBFT against a rolling annual trajectory (April 2008-current).



**Table 2:** Monthly number of CDI cases at UHBFT up to 30 September 2014.

Month	Total number of CDI	Objective (Trust apportioned) Monthly/ (annual)	Time of CDI acquisition		Commissioners reviewed unavoidable cases	Commissioners reviewed avoidable cases
			Pre	Post 48 hours (Trust apportioned)		
April 2014	8	5.8	2	6	6	0
May 2014	11	5.8	5	6	4	2
June 2014	9	5.8	5	4	3	1
July 2014	12	5.8	4	8	7	1
August 2014	8	5.8	3	5	2	3
September 2014	7	5.8	0	7	6	1
<b>Total</b>	<b>55</b>	<b>35 (67)</b>	<b>19</b>	<b>36</b>	<b>28</b>	<b>8</b>

#### 4.2 Actions to improve performance for CDI 2014/15

We now need to carefully review lessons learnt from our review process to improve performance in this financial year. Particular actions for focus include:

- Reinvigorating the antimicrobial stewardship programme which includes: ensuring that antibiotic prescribing is in line with Trust guidelines; mandating the requirement for a written indication for every antibiotic prescription; and ensuring and documenting an early review of the continuing appropriateness of each prescription.
- Ensuring that systems are in place to minimise any chances of transmission of infection either from cases or carriers of *C difficile*.
- Continuation of the rapid reviews by the Infection Prevention & Control team of any area reporting two or more cases of CDI.

#### 4.3 Facilities Update

The environmental monitoring of clinical areas continues to exceed the 95% compliance requirement.

### 5. **Other Alert Organisms**

#### 5.1 Multiply resistant gram negative bacteria

During September no carbapenemase producing Enterobacteriaceae (CPE) or multiply resistant *Pseudomonas aeruginosa* (carbapenemase producers) were isolated.

#### 5.2 Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia

Reporting of MSSA bacteraemia has been mandatory since 1 September 2011. Performance for September 2014 was 12 cases, 5 of which were Trust apportioned.

### 5.3 E. coli bacteraemia

From 1 September 2011, reporting of *E. coli* bacteraemia has been mandatory. *E. coli* is part of the normal bacterial flora carried by all individuals. It is the commonest cause of clinically significant bloodstream infection. *E. coli* bacteraemia represents a heterogeneous group of infections. Performance for September 2014 was 10 Trust apportioned and 17 non-Trust apportioned cases.

## 6. **Outbreaks of Diarrhoea and Vomiting**

There were no outbreaks of diarrhoea and/or vomiting in September 2014.

## 7. **Serious Incidents Requiring Investigation (SIRI) related to Infection Prevention & Control**

All MRSA bacteraemia, and CDI cases that result in death (Part 1 of the death certificate) or surgery, are reported as Serious Incidents Requiring Investigation (SIRIs). Those deaths on Part 2 of the certificate are of patients considered to have died *with* MRSA or CDI rather than *of* it. There have been no MRSA or CDI deaths reported on Part 1 or 2 of the death certificate for September 2014.

## 8. **Recommendations**

The Council of Governors is asked to accept this report on infection prevention and control progress.

Mr Philip Norman  
Executive Chief Nurse and Executive Director for  
Infection Prevention and Control

31 October 2014

## **Infection Prevention and Control Report**

### **Explanation of the terms used in the report**

#### **Meticillin Resistant *Staphylococcus Aureus* (MRSA) – sometimes referred to as a ‘superbug’**

*Staphylococcus aureus* (also known as staph) is a common type of bacterium (bacteria or germ). It is often carried on the skin and inside the nostrils and throat, and can cause mild infections of the skin such as boils as well as much more serious infections.

MRSA is a form of *Staph aureus* which is resistant to many of the commonly used antibiotics. It is extremely rare for healthy people to carry this bug but it is found in around 1-2% of the population in the United Kingdom. Individuals who have MRSA on their skin and in their nose are described as being ‘colonised’, which does not usually cause harm to people who are healthy.

MRSA can cause infections such as blood stream infections and wound infections, particularly if there is an opportunity for the bacteria to enter the body such as a result of surgery (operation) or catheters (tubes or lines) going into veins. The transmission and risk of MRSA infection, including MRSA blood stream infection, can be addressed effectively if measures are taken to identify MRSA carriers as potential sources, then they are treated (with antibiotic body wash) to reduce the risk of transmission (referred to as decolonisation).

This requires screening of patient populations for MRSA carriage, either before or on admission to hospital, to identify carriers and implement a decolonisation regimen.

#### ***Clostridium Difficile* Infection (CDI)**

*Clostridium difficile* is a bacterium present in the large bowel of approximately 10% of healthy individuals. It usually causes no problems. However, antibiotics given to treat other infections can suppress the "normal" bacteria in the bowel, leaving the *Clostridium difficile* bacteria to overgrow.

This overgrowth can lead to the production of toxins (poisons), which have an irritant effect on the gut (bowel), causing inflammation of the bowel. Patients can exhibit no symptoms at all, but commonly they have watery diarrhoea, abdominal (tummy) pain and sometimes fever, especially in the elderly and in people who are immunosuppressed (where the immune system is less effective in fighting diseases, for example in individuals who have cancer).

There is also the possibility of person-to-person spread. To prevent such spread, hand washing with soap and water is key, along with isolating the patient to prevent further spread (individual is cared for in single room which is referred to as ‘source isolation’), appropriate antibiotic prescribing (used only when necessary) and for the shortest period that is appropriate and cleaning of the environment to remove *Clostridium difficile* spores (an especially tough form of the bacteria) which may persist in the environment.

### **Meticillin Sensitive *Staphylococcus Aureus* (MSSA)**

MSSA is the term used for the more antibiotic sensitive form of *Staph aureus* and is a common type of bacterium that can live harmlessly on the skin. Around 30 % of people carry *Staph aureus* in their nose or on their skin, causing them no harm. MSSA is not normally a risk to healthy people and the majority of people who carry it do not have symptoms and are not aware they are carrying it. People who have MSSA in their nose or on their skin are said to be 'colonised'.

Sometimes MSSA can cause wound infections including after surgery, abscesses or boils, which may take a long time to heal and can sometimes lead to blood poisoning.

### **Escherichia coli or *E. coli* infection**

*E. coli* is the name of a germ, or bacterium that is present in the bowel of humans and animals.

There are many types of *E. coli*, and most of them are harmless. But similar to Clostridium Difficile Infection, some can cause problems and symptoms can include bloody diarrhoea. *E. coli* can also be a common cause of urinary and abdominal (tummy) infections including in patients in hospital and some of these cases can also lead to blood stream infections.

### **Carbapenemase producing Enterobacteriaceae (CPE)**

Enterobacteriaceae are a family of bacteria that live in the gastro-intestinal tract (bowel and stomach) of humans and animals. They include bacteria such as *E coli* and Klebsiella. These bacteria are a common cause of infections such as urinary infections, abdominal (tummy) infections and blood stream infections.

A major threat to our being able to treat these infections has been the development in these bacteria of mechanisms to evade the action of antibiotics (bacteria becomes resistant to antibiotics).

Carbapenems are a very important class of antibiotics used to treat the most serious of infections, so bacteria with the ability to evade these groups are a particular threat to all aspects of modern medicine such as surgery, intensive care and organ transplantation.