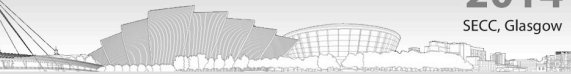


The times they are a changing ...
Dr. Evonne Curran, Health Protection Scotland
Broadcast live from the 2014 Infection Prevention Society conference

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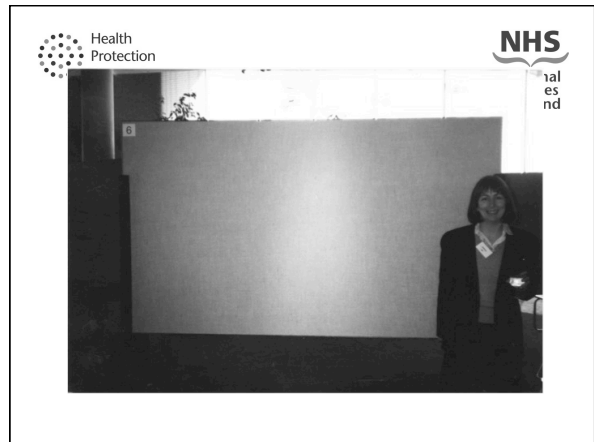
Infection Prevention
2014
SECC, Glasgow



The times they are a changing...

Dr Evonne Curran (Nurs D)
Nurse Consultant Infection Control
Health Protection Scotland

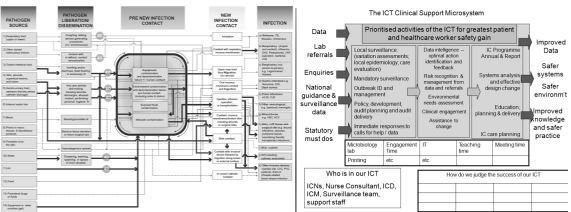
www.webbertraining.com September 29, 2014



Health Protection Scotland

NHS
National Services Scotland

I am have been a brain-dumpaholic.



CONFESION 1

Health Protection Scotland

NHS
National Services Scotland

We have not always made it as easy for our clinical colleagues

CONFESION 2

Health Protection Scotland

NHS
National Services Scotland

In the presentation...

- How every part of the system has changed and is changing
- Reflections on our current approach for a safer going forward

Health Protection Scotland

NHS
National Services Scotland

The key messages

- The goal does not change – but the **how, what, where** and the **why** does
- Be mindful of **changes** and their **consequences**
- **Stop, reflect** and change your **MO**

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Health Protection Scotland

NHS National Services Scotland

When you are finished changing
– you are finished

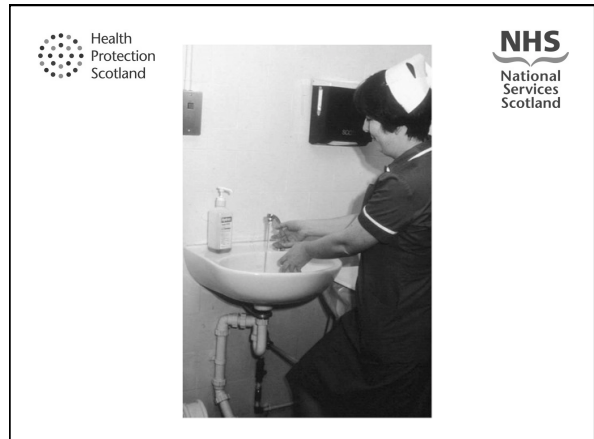
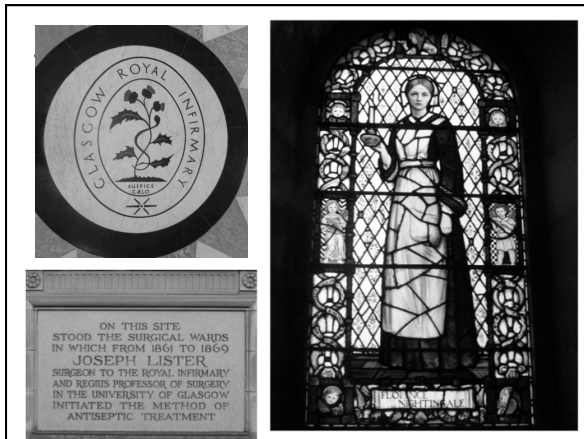
Benjamin Franklin

Health Protection Scotland

NHS National Services Scotland

The times they are a changing ...

- But it has *aye* been
 - Pathogens, patients, healthcare, environments, media, politicians, guidance, science, care facilities, IPCTs (and budgets)
- We don't recognise
 - the changes in real-time
 - how change has made us resilient / weak



The times they are a changing ...
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Source: JIP Obk Col 14

Table 1: <i>Staphylococcus aureus</i> outbreak details (by location, duration, people infected and staff)						
Outbreaks	Median duration (range) (mths = months)	Patients infected	Family members infected	Staff infected	Staff colonized or infected	
NICU (inc. 1 SCBU)	4 mths (0.5-12 mths)	38	2	1	18	
Outpatient settings	1 week (1 week-1 mth)	31	0	0	3	
Surgical wards	12 mths (4-14 mths)	68	0	0	24	
(Cardiothoracic 3; liver transplant; neuro (including ICU))						
ICU (1 included general wards)	3 mths (3-5 mths)	26	0	0	0	
Maternity/newborn nursery	2 mths (2-9 mths)	48	2	0	12	
Burns	16 mths (2-32mths)	27	2	2	13	
General wards	4 mths	4	0	4	6	
Dermatology wards	1 mth	1	0	3	3	
		243	6	12	79	

Where we deliver care

The evolving pathogen story

THE LANCET, FEBRUARY 14, 1981

Hospital Practice

IS PSEUDOMEMBRANOUS COLITIS INFECTIOUS?

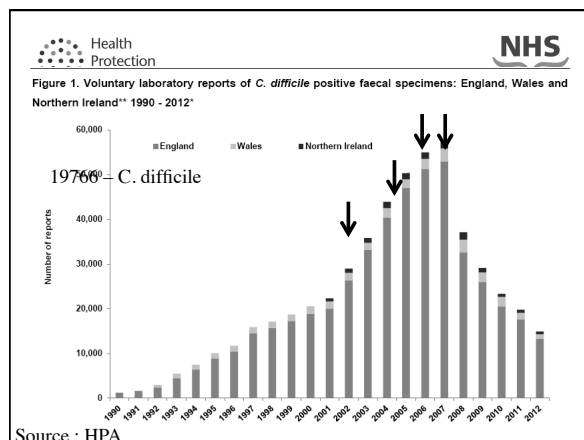
CHARLES GREENFIELD ANDREW BURROUGHS
MELVYN SZAWATHOWSKI NATHAN BASS
PAUL NOONE ROY POUNDER

Academic Department of Medicine and Department of Microbiology, Royal Free Hospital, Hampstead, London NW3 2QG

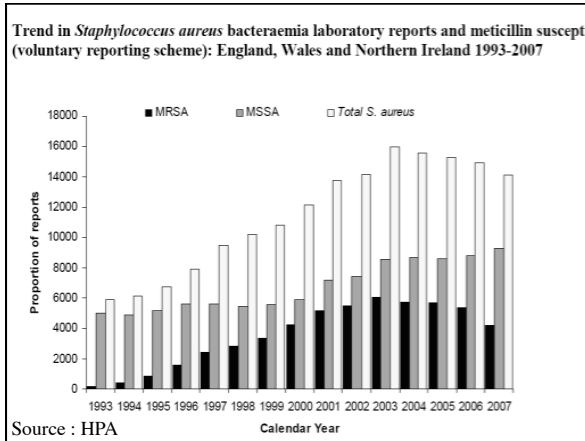
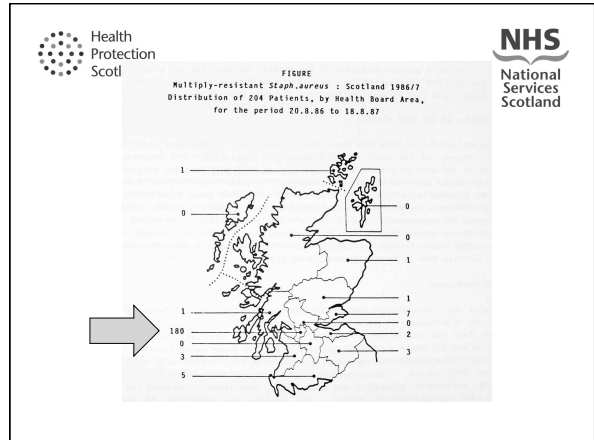
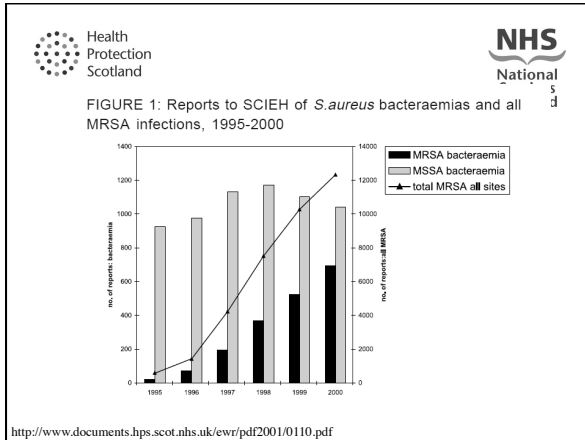
Summary A cluster of eight patients in two adjacent hospital wards acquired acute diarrhoea within a period of 11 days. All their stool samples contained *Clostridium difficile* toxin and *C. difficile* was isolated in every case. Three patients had rectal biopsy findings compatible with pseudomembranous colitis (PMC). All the patients responded to treatment with oral vancomycin. Until the possibility of PMC being acquired by cross-infection is clarified such patients should be nursed in isolation with strict enteric precautions.

We were very good at measuring things that went up

ICM colleague on IPaC in the 1990s



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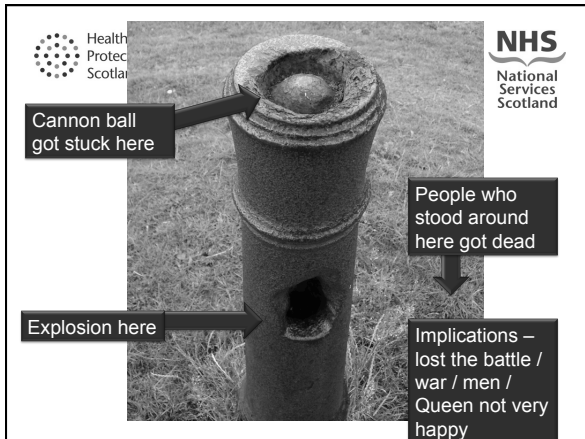


CPE

If we are not having GNOs outbreaks now....

Why not use our knowledge on outbreak epidemiology

- Endoscopes
- Infusates (MDVs)
- Transplant units
- NICUs





WHY?

- Scotland
- Active failure
- Defences
- Operating conditions on the day
- Organisation and culture?



Prevention

The times they are a changing ...
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What changed

- Investigation for **individual blame**
 - Descriptive data who did what / what happened
- Investigation of **system malfunction**
 - What provoked this / how do we make sure this never happens again here or anywhere else






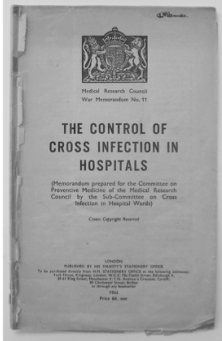
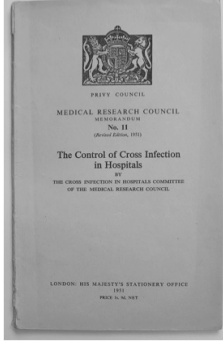
Journal of Hospital Infection 86(5) (2014) 51-570
 Available online at www.sciencedirect.com
 Journal of Hospital Infection
 Journal homepage: www.elsevierhealth.com/journals/jhin



epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England

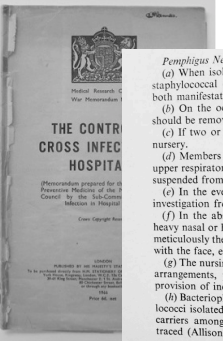
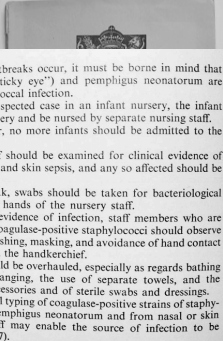
H.P. Loveday^{a*}, J.A. Wilson^a, R.J. Pratt^a, A. Golsorkhi^a, A. Tingle^a, A. Bak^a, J. Brown^a, I. Prieto^a, M. Wilson^a

^a Richard Wells Research Centre, College of Nursing, Midwifery and Healthcare, University of West London (London).
^b Faculty of Health Sciences, University of Southampton (Southampton).
^c Microbiology and Infection Control, Leeds Teaching Hospitals and University of Leeds (Leeds).

Penicillus Neonatorum

(a) When isolated cases or outbreaks occur, it must be borne in mind that staphylococcal conjunctivitis ("sticky eye") and pemphigus neonatorum are both manifestations of staphylococcal infection.

(b) On the occurrence of a suspected case in an infant nursery, the infant should be removed from the nursery and be nursed by separate nursing staff.

(c) If two or more cases occur, no more infants should be admitted to the nursery.

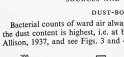

(d) Members of the ward staff should be examined for clinical evidence of upper respiratory tract infection, and skin sepsis, and any so affected should be suspended from duty.

(e) In the event of an outbreak, swabs should be taken for bacteriological investigation from the nose and hands of the nursery staff.

(f) In the absence of clinical evidence of infection, staff members who are heavy nasal or hand carriers of coagulase-positive staphylococci should observe meticulously the rules of hand-washing, masking, and avoidance of hand contact with the face, either direct or via the handkerchief.

(g) The nursing technique should be overhauled, especially as regards bathing arrangements, procedure for changing, the use of separate towels, and the provision of individual toilet accessories and of sterile swabs and dressings.

(h) Bacteriophage or serological typing of coagulase-positive strains of staphylococci isolated from cases of pemphigus neonatorum and from nasal or skin carriers among the nursery staff may enable the source of infection to be traced (Allison and Hobbs, 1947).

SOURCES AND MODES OF INFECTION 13

DUST-BORNE INFECTION

Bacterial counts of ward air always show considerable rises at the time when the dust content is highest, i.e. at bedmaking and sweeping times (Brown and Allison, 1937, and see Figs. 3 and 4).

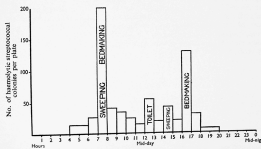


Fig. 3. Variations in the numbers of haemolytic streptococci in ward air during 24 hours.

PREVENTION AND CONTROL OF CROSS INFECTION 25

not undertake nursing duties. Ward maids should wear gowns while cleaning, and should remove them and wash their hands and forearms thoroughly before performing other duties.

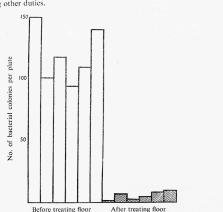




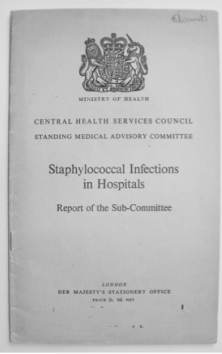
Fig. 6. Bacterial counts of ward air during sweeping.

A cupboard or small room should be reserved for dusters, cleaning articles, brooms, etc. They should not be kept about the ward or kitchen. Dusters and floor-cloths should not be washed out in kitchen sinks, ward hand-basins, or baths.


Don't wash dusters in wash-hand basins or baths!

Published the same year as EM Cottrell appointed, 1959



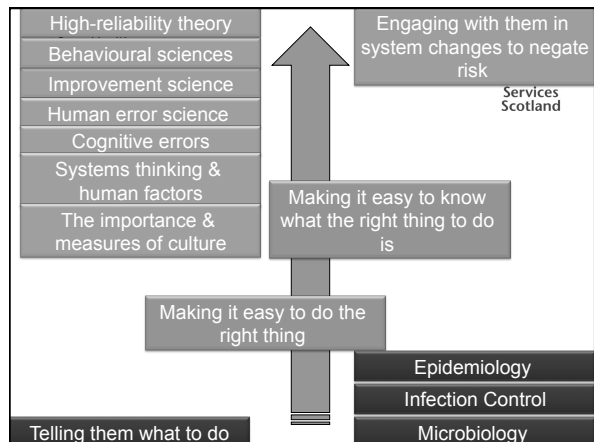
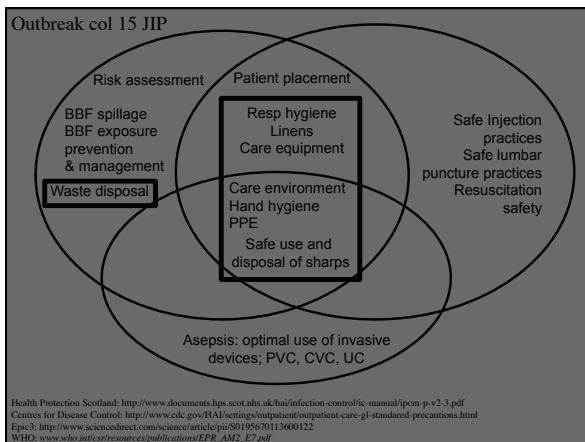
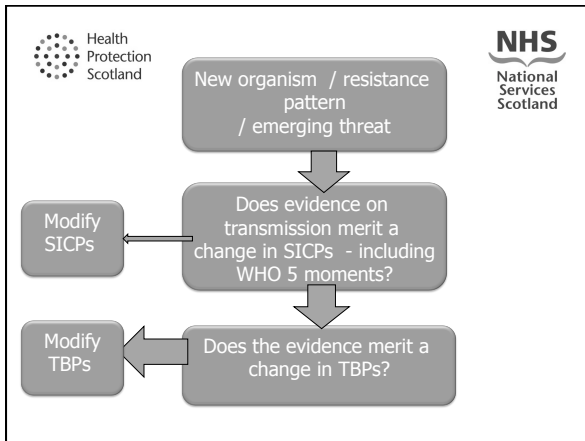
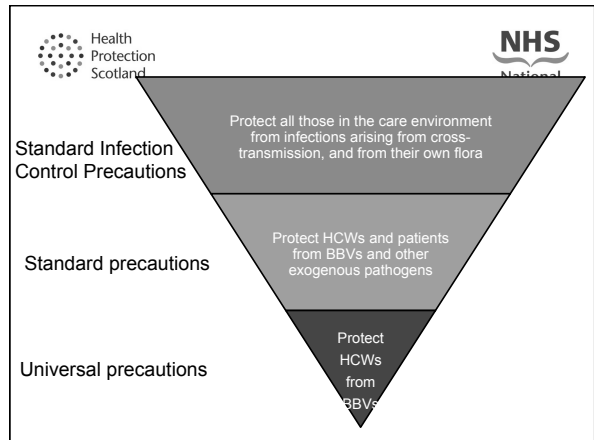
The times they are a changing ...
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Health Protection Scotland 



Guidance – 1 case of MRSA 1986

"All other patients and staff must be screened and isolated and treated if any samples are positive. Medical, nursing, paramedical (particularly physiotherapists and phlebotomists) and domestic staff should be screened. It may be necessary to close wards to new admissions, particularly to surgical or intensive care patients."
 (Anon, 1986)

Outbreak column12 JIP





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plus ça change, plus c'est la même chose?



Or

The only constant is change
(Wigglesworth)

Current threats to our patients NOW

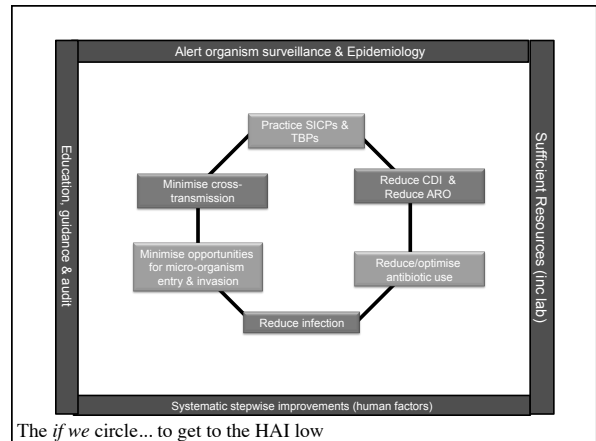
- Standard Precautions – not standard
- Outbreak threat - ever present
- Alert organisms - considered job done
- Invasive devices – risk recognition
- CPE – Screen, find, isolate – not enough
- Vulnerability of the people we care for

Regret, Reason, Remedy

- **Regret:** Apologies about being a brain-dumpaholic
- **Reason:** Seemed like the right thing to do at the time
- **Remedy:**
 - Keep it simple
 - Make it doable
 - Make sure it needs doing

McFarlane – Drop the pink elephant







Five moments for hands
For infection prevention
Essential for all

A HAND HYGIENE HAIKU




The times they are a changing ...
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The times they are a changin'
 (what, where, why and how)

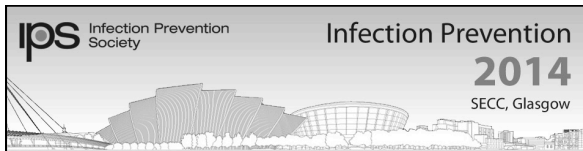
What stays the same is the goal:

To prevent, prepare for and
 manage outbreaks wherever care
 is delivered



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Our vision is that no person is
 harmed by a preventable
 infection




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Infection Prevention 2014
 SECC, Glasgow


Infection Preven


+ ips <http://www.ips.uk.net/>


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Coming Soon

October 1 (Free Teleclass ... Broadcast Live from IPS Conference)
INFECTION CONTROL IN THE 21ST CENTURY
Dr. Stephanie Dancer, NHS Lankashire

October 2 INFECTION PREVENTION & CONTROL IN CYSTIC FIBROSIS
Prof. Lisa Saiman, Columbia University Medical Center, New York

October 8 (Free WHO Teleclass – North America)
PUBLIC REPORTING AND DISCLOSURE OF HAI RATES: POSITIVE IMPACT OR CONFUSION?
Dr. Marianne McGuckin and John Govednik, McGuckin Methods International
Sponsored by the World Health Organization Patient Safety Agency

October 9 ENHANCED ENVIRONMENTAL CLEANING IN CONTROLLING CLOSTRIDIUM DIFFICILE INFECTIONS IN THE HOSPITAL SETTING: DOES IT MATTER?
Prof. Farrin A. Manian, Harvard Medical School

www.webbertraining.com/schedule1.php