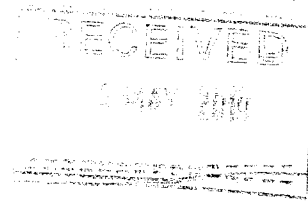


Witness statement Clostridium Difficile Inquiry

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At the time of the C.Diff outbreak I was a band 6 Assistant Clinical Sister, and did not have overall responsibility for the Accident and Emergency Department in Antrim Hospital.

During the Clostridium Difficile outbreak one problem, which emerged, was that staff found difficulty isolating patients, who were potentially C.Diff positive in the Accident and Emergency Department. Isolation patients are usually placed in room 11/12 within the department.

This room does not have an en suite and is therefore in my opinion not ideal for isolation patients. In my experience Accident and Emergency Departments do not have en suite facilities.

The room does not have adequate storage for laundry, incontinence pads etc and that leads to more movement in and out of the room than would have been ideal. Due to the location of the isolation room it makes it more difficult for staff to monitor the patients.

There is no call bell in cubicle 11/12. A request has been submitted for fitting of a call system but it is a minor capital works project.

If cubicle 11/12 was in use the Procedure Room, the Paediatric and Gynae cubicles had to be used in order to isolate patients. This would mean that all equipment in these rooms would have to be moved out before the patient could be placed in the room. Single use equipment or equipment that could be thoroughly washed was used instead. If potentially infected patients require resuscitation they have to be nursed in the same area as other patients being treated. If space permitted, staff would not nurse other patients on trolleys beside potentially infected patients. Resuscitation equipment and stock in that area had to be disposed of and the full area needed to be terminally cleaned following the transfer of the patient. This caused delays in treatment for other patients.

Once the outbreak was declared, Management and Infection Control set up a number of initiatives and protocols in order to advise staff. Initiatives such as the C.Diff folder, which was updated every 3 months of patients who had C.Diff and were clear or were still known carriers. This enables staff to fast track patients who are re admitted. Protocols for isolation precautions on the transfer of patients to wards were also implemented.

Community Infection Control staff began to contact the Accident and Emergency Department with details of outbreaks declared in the community. Unfortunately information from Nursing/Residential Homes was and still remains a problem. Elderly patients are often sent to the department unaccompanied and with a less than full medical history; therefore it is difficult to assess the patient's infection risk. The Accident and Emergency Department has now developed a more pro-active approach. We now would routinely contact the Nursing/Residential Home or next of kin to

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complete the Infection Control forms. Staff in the Emergency Department also will try to take a sample of any loose motion for C.Diff testing at the earliest opportunity. As a department we will isolate any patient from a Nursing/Residential Home where an outbreak has been declared, but yet the patient is not displaying any symptoms. Regular outbreaks in the community and lack of communication still remains a problem and as recently as Friday 23 rd April 2010 I personally contacted Public Health as there were five Nursing Homes on the out break list for Diarrhoea for more than 3 weeks. This is a logistical nightmare for Accident and Emergency staff when the dept is busy and it was found that all the out breaks had been declared over, but Accident and Emergency had not been notified.

This is a true and accurate statement



Sister Mary Catherine Mc Coy
4 May 2010