



The effect of changing the function and clinical specialty of Ward A1

After the declaration of Clostridium Difficile Outbreak in January 2008, my Ward, A1 was identified as the isolation facility to be used to treat and care for patients with a diagnosis of Clostridium Difficile. Ward .

The main responsibility for me as Ward Manager was to make this change of facility as seamless as possible, however realised that I had no time to prepare myself, or my staff for this major change. The two clinical specialties ie; Stroke and Oncology were to be transferred to other wards and all patients with Clostridium Difficile within The Trust were to be transferred directly to Ward A1. Nurses with specialist knowledge and expertise in stroke and oncology transferred with their patients, leaving those staff left behind feeling desolate and worthless. Redeployment of staff had to take place from other wards and these staff joined the team feeling unhappy and discontent about having to transfer from their wards. As a manager all skills had to be used to lead staff through this change, manage resources, ensure adequate staffing levels and skill mix to manage this increased work load, keep morale up and meet regularly with staff to ensure they were being updated in the ever changing policies and procedures.

It was evident that if our ward was to change to an isolation facility that we would require collaborative working with our cleaning teams. Cleaning teams were identified for Ward A1, by The Domestic Services Manager, cleaning rotas investigated, cleaning regimes introduced and cleaning "Sign off" documentation shared between nursing and domestic services.

On a positive note, a medical consultant and staff grade doctor were identified to work on the ward which ensured continuity of practices and procedures, increased knowledge and expertise and enabled more cohesive working. This working arrangement encouraged morale, as strong working relationships between medical and nursing soon became apparent. Finally because the change of function in Ward A1 happened so quickly, training / teaching sessions had to be organised very promptly. The Infection Prevention Control

Team facilitated these sessions, bringing the teaching / training to ward level where staff could more easily avail of them .

Preparation of staff for changes in Ward A1

Unfortunately I felt I had no time to prepare staff for this change, however staff did have some knowledge of nursing patients with Clostridium Difficile as we had 8 single rooms for isolation purposes in our bed compliment. Policies and Procedures to direct staff followed soon after the change of facility was made along with teaching / training as above

Issues surrounding sense of personal responsibility.

I felt personally responsible for leading staff through this change of working. I felt a real need to maintain morale and secure staffing levels to an acceptable level to meet the increasing demands of isolation nursing. The staffing levels I required were provided by The Trust. Morale was difficult to measure, however I monitored sick leave and ensured re- deployment of staff from other areas to maintain staffing levels. We met as a team daily initially so as we could discuss concerns and issues and address these openly before they could escalate.

As Ward Manager, I personally felt responsible for ensuring staff were aware of all policies and procedures which at the early stage were changing frequently. I also had to ensure Policies and Procedures were being complied with. As we were meeting daily these changes in policy were discussed. We also used ward meetings, communication book, Ward Diary and safety briefings to disseminate this information.

I had to ensure staff received the appropriate training and knowledge to manage patients with Clostridium Difficile. As knowledge and skills increased, nursing staff felt more empowered and were keen to share this expertise with other wards and even other hospitals and Trusts.

The information that I received from attending the weekly Clostridium Difficile Outbreak Meetings held with Dr Kearney, Consultant Microbiologist, Ward Consultant and Infection Control Nurse Lead also needed to be disseminated to staff. These minutes were made available, however urgent issues which needed to be promptly addressed were communicated at our daily meetings, safety briefings and communication book.

I would estimate that by the end of February 2008, I and my nursing team in Ward A1 had overcome the initial problems in establishing an isolation facility and felt confident in managing the nursing and Infection Control issues within the ward.

Sustainability of Improvements

During the Outbreak, the frequency of audits such as hand hygiene, commode and mattress audits had to be increased. This was to provide assurance that standards of hygiene remained consistently high.

Bowel charts were introduced so as an accurate record could be kept of each patient who had a diagnosis of Clostridium Difficile. This documentation allowed staff to monitor progress and recovery and continued to be used after the Outbreak was over for all patients who had symptoms of diarrhoea. Cleaning assurance labels were introduced so as the public and staff could be assured that all equipment taken to a patient had been decontaminated before being used. This initiative is consistently used throughout The Trust. High Impact Interventions Number 7 and Hand Hygiene Audits were introduced during the outbreak. These continue to be audited weekly and evidence of compliance is evident from the scores.

The ward environment is audited monthly by domestic supervisor and the ward manager. An action plan is devised following on from the audit and subsequently evaluated and the audit loop closed. To ensure I, as Manager was satisfied with the level of cleaning carried out each day, I countersigned in the presence of Domestic Supervisor, that cleaning had been completed to an acceptable standard. This Procedure has been introduced Trust Wide.

It is mandatory that nursing staff attend yearly Infection Control Updates ie: on going training. Records of training are maintained at ward level and also fed up to Governance Department on a monthly basis.

To ensure improvements are sustained, Infection Prevention Control Nurses visit the wards regularly to ensure compliance with all infection control issues. If there are any issues causing concern, targeted support will be initiated, action plans put in place, followed through and evaluated until improvement is sustained.

Finally as a Manager, when I observe nursing staff advising medical staff or other professionals on hand hygiene compliance, antibiotic use or practices and procedures relevant to Ward A1, I feel improvements made as a result of the Outbreak have now been embedded and more importantly sustained.

Relationships between ICN and Task Force

In May 2008 I was asked by Director of Nursing to join The task Force as I had experience in managing Clostridium Difficile. We were tasked with providing assurance to Senior Management that practices and procedures in relation to Clostridium Difficile were being adhered to, hand hygiene audits introduced, mandatory infection control training targets achieved, environmental issues addressed and every new case of Clostridium Difficile investigated in relation to ward practices and procedures, environmental cleanliness and antibiotic compliance.

On initiation of The Task Force, I felt there was a perception by Infection Prevention Control Team (IPCT) that we were being asked to take over their roles and responsibilities. It was made clear at the initial meeting that the role of the task force was to be supportive and facilitative to the team and they were invited to our weekly Task Force Meetings. These meetings assisted with role clarification and helped to improve relationships. The Task Force was very visual at ward level, very interactive and accessible. Audits were carried out, action plans put in place, time scales set and signed off by our Task Force when complete. These audit results were shared with IPCT. The Task Force introduced targeted support to wards where there had been

issues or concerns. Again we, The task Force shared our findings with our IPCT. The task Force gained a great deal of knowledge and expertise during the outbreak and were used frequently as an educational resource. This recognition did, I feel cause some resentment from IPCT. As a Task Force we also met frequently with Senior Management Team to provide assurance that we were making every effort to reduce and sustain the number of HCAI within NHSCT. The recognition we received from senior staff again did not always assist with bridging the gap between the Task Force and IPCT. I believe that relationships did improve as our roles and responsibilities became more established and this was evident when we joined together in October 2008 to put The High Impact Intervention Education Programme in place. I believe that the sharing of audit results, targeted support reports and action plans did ultimately assist in building and improving relationships between these two teams.

Perception of “stigma” attached to Nurses dealing with Clostridium Difficile Symptoms.

Nurses in Ward A1 did initially feel undervalued and worthless as their colleagues commented on their change of ward facility to Clostridium Difficile Nursing. Staff wearing scrub suits were easily identified in public areas and peers again would openly comment to staff about the type of ward they were now working in.

Initially staff believed that they required little skills to nurse patients with Clostridium Difficile. They were concerned that they would lose their nursing knowledge and expertise as a result of specialising on the one condition. Staff also perceived the work load to be very repetitive. However as education and knowledge increased, they soon became used as an educational resource outside of the ward area and felt much more empowered and valued.

Senior Management did visit the ward regularly which encouraged staff, however media coverage often encouraged patients and family members to take their frustrations out on nursing staff, often blaming them for having contracted Clostridium Difficile within the hospital. This did add to the

“stigma”, however I cannot over emphasise the support we received from Senior Management which was a real morale booster to both myself and to nursing staff. Senior Management, at all times recognised the contribution of nursing staff to the management and control of Clostridium Difficile during the outbreak.

I can confirm the content of this statement is true to the best of my recollection.

Signed: Mrs Diane Russell
[REDACTED]
Antrim Area Hospital 23/04/10