



**WITNESS STATEMENT FOR PUBLIC ENQUIRY INTO CLOSTRIDIUM DIFFICILE OUTBREAK IN THE NORTHERN TRUST.**

4th may 2010

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Consultant Geriatrician

Qualifying in 1995, I achieved my CCST in Geriatric and General Internal Medicine in 2005. I was employed from April 2006 until June 2009 as a Consultant Geriatrician (with responsibility for the community) and General Physician in the legacy United Trust which subsequently became part of the Northern Trust.

At this time I had responsibility for developing Community geriatric Services within the trust, patients receiving rehabilitation on the Larne site and general medical and acute stroke patients on the Antrim site.

From June 2009 I have been working as a Consultant Geriatrician in the Belfast Trust.

*Issues around assumption of responsibility for isolation ward and changes necessitated by the designation of A1 as the isolation ward*

At the time A1 was identified as the most appropriate area as an isolation ward, Dr. Flannagan (medical director) had asked Dr. Vahidassr to discuss with myself and Dr. Howard, as the Elderly Care team in Antrim Area Hospital, whether we would take on responsibility of caring for patients in A1.

Dr. Vahidassr, Dr. Howard and I felt that we were able to provide a coordinated, multisystem approach to the medical care of patients with clostridium difficile infection, who were often frail and elderly. We agreed to take on the care of patients in the isolation ward if the trust could provide us with assistance with the care of the general medical patient work load. This was agreed but unfortunately it took a period of time to find locum medical staff to fill the positions. I can't remember how long.

This would mean extra work load for the team, as we would not only be taking on a ward of patients with clostridium difficile, who required daily senior medical input, from throughout the trust, but also we would be losing our 'stroke unit' which had been located in A1 with trained nursing staff. The stroke patients along with our general medical take in patients, were to be cared for on one of the surgical wards(C5). This raised concerns among the Elderly care team as the skill mix of the nursing staff in C5 was not ideal for managing patients who had an acute stroke.

Throughout this difficult time, we were aware that A1 was the most appropriate isolation area and that the patients with clostridium difficile infection were very frail, sick and required a coordinated approach to their care. However, we felt that our patients with acute stroke missed out on coordinated care provided in a stroke unit with nursing staff who had an interest in stroke.

Dr. Vahidssar, Dr. Howard and I also felt that we should support our nursing staff. They were changing from nursing patients with oncological problems and stroke to often frail sick patients with multiple daily episodes of diarrhoea. This was another reason we agreed to take on responsibility for the isolation ward. Moral was often low amongst the nursing staff, especially when there were no signs of the isolation ward returning to it's original function as a stroke unit. I feel it would have been worse if Dr. Vahidssar, Dr, Howard and I were not providing the medical care as we did.

*Advice and support received from the microbiology consultant and Infection Control Team.*

*Opportunity for involvement in senior Management Team Meetings*

Once the Elderly Care Team assumed responsibility for the care of patients with clostridium difficile infection in A1, we worked closely with the microbiology department. This involved, working with Dr. Kearney on the treatment protocol and attendance at weekly meetings with the consultant microbiologists, pharmacy, infection control and ward sister.

Some time into the outbreak we set up weekly antibiotic rounds with the consultant geriatrician and consultant microbiologist of the week and were able to get fairly prompt ribotyping results aiding us in identification of patients with O27 and subsequent management.

These meetings were also useful in getting information from the Senior Management meetings , although we ourselves were only asked to attend one senior management outbreak control meeting.

*Perception of media attitude*

My perception of the media was that while it raised awareness of hygiene issues in general, it also raised anxiety levels among the general public and made interactions with patients and relatives, increasingly fraught at times. From chatting to colleagues in other trusts in Northern Ireland , they were affected by outbreaks of Clostridium Difficile infection, but my perception was that the Northern Trust got the brunt of the media coverage. I felt the Northern trust were open and honest in all dealings with the media.

### *Views on changes to policies and Issues on moving patients around the hospital*

Working in the Isolation ward and attending weekly meetings with microbiology, pharmacy and infection control, I was aware of a constant pressure and drive to improve policies around hygiene, cleanliness and antibiotic prescription. Everyone I was working with was doing their utmost to improve the situation. The isolation ward was running well, antibiotic prescribing had changed yet it was extremely disappointing when initial monthly figures did not demonstrate the reduction in numbers of new cases expected. I remember some discussion over how to enforce change to policies at this time and a renewed focus on monitoring of adherence to policy change and providing information to the community.

Prior to the outbreak being confirmed, I believe there had been an increase in the number of acute admissions to Antrim Hospital, increasing bed pressures and bed occupancy. This may have been in part due to reduced opening hours of the Whiteabbey and Mid Ulster A&E departments. It seemed that there were a lot of medical outliers and patients were often moving wards several times during admission due to constant pressures.

Plans were put forward by the medical consultants to change their ownership of patients to ward based, to improve continuity of care, reduce transfers and reduce the number of consultant teams caring for patients on each ward. The advent of the Clostridium Difficile outbreak coincided with this model being taken on board. While there will always be the need to move some patients to different wards during their admission, I noticed that this was significantly reduced from when I joined the trust in 2006 to the time I left in 2009. Another policy introduced by the trust around this time was the Slips, Trips and Falls policy, which highlighted that moving elderly patients often added to confusion and could result in falls.

I attended the RQIA review of the Clostridium Difficile Outbreak in the Northern Health and Social Care Trust and was sitting at the Information table. I was disappointed to learn that feedback from the few patients and carers that were interviewed by RQIA was that they were given no information. While working on the isolation ward, the medical team were accessible at all times to discuss the diagnosis with patients or relatives, and this was a large part of our increased workload. We also had information leaflets situated at the entrance of the ward for anyone to take. In addition the nursing staff would have explained to patients and family why they were being cared for in A1 on moving there.

After finding this out we reviewed how we gave information to patients and relatives.

### Severity of Ribotype 027

It was noticed by all 3 Elderly Care consultants that patients who had more severe/relapsing Clostridium Difficile infection often turned out to be the 027 ribotype. The severity and number of relapses was unlike our previous experience of managing patients with Clostridium Difficile infection. Our learning curve for managing these patients was steep and often they proved to be very challenging. These patients often had multiple co-morbidities and were frail to start with.

This was a stressful time for all involved, patients, their families and trust staff.

I confirm to the best of my knowledge that the contents of this statement are true.

Signed:



Dated:

6th May 2010.