Statement to Public Inquiry into the Outbreak of Clostridium Difficile in Northern Trust Hospitals

Statement of Dr Murtagh, Consultant Physician, Antrim Area Hospital

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Position or Role within Organisation: Consultant Physician

This Statement has been provided in response to a request from the Public Inquiry into the Outbreak of Clostridium Difficile in Northern Trust Hospitals. I have been asked to provide a Statement to assist with the second Term of Reference of the Inquiry, namely, "*to examine and report on the experiences of patients and others who were affected directly by the outbreak, and to make recommendations accordingly.*"

PERSONAL EXPERIENCE

1. I was appointed as a Consultant Physician in General Medicine with a special interest in Respiratory Medicine at Antrim Area Hospital in January 2006 and I was in the post throughout the period of the Clostridium difficile Outbreak ('the Outbreak').

2. My duties involved looking after patients admitted acutely under general medical take-in as per the on- call rota, as well as continued care of ward patients with general medical and respiratory disorders. I do not have a list of the patients who were diagnosed with Clostridium difficile at Antrim Area Hospital and cannot recollect whether I was involved in the care of any patients with Clostridium difficile during the Outbreak. It is, however, possible that I might have had some involvement in the care of such a patient. It is also possible that a

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patient or patients whom I was involved in treating may have required treatment for Clostridium difficile at some time after the date of my involvement in their care.

3. I recall a personal feeling of deep empathy for patients and their families and carers, which I believe was widely shared among Antrim Area Hospital staff. My perception is that the Outbreak increased the feeling of pressure on medical and nursing staff and added to the intensity of the existing workload. My impression was that the Outbreak had an adverse effect on morale that was widespread amongst staff.

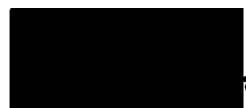
ORGANISATION & MANAGEMENT

- **Workload and Resources**

4. My perception is that the workload in acute general medicine had been steadily increasing prior to the Outbreak and that it continued to increase during the Outbreak, with both an increased number of patients being admitted to hospital, and a trend towards increased numbers of more elderly patients with complex disease and multiple co morbidities being admitted. There was a perception amongst medical staff that there was insufficient bed capacity on the Antrim site for medical patients and that the site had insufficient numbers of junior doctors and nursing staff per patient when compared to other hospitals in the region.

- **Systems**

5. It was evident from the patient medical records that I was seeing that many patients had had multiple admissions to hospital. Also due to the geography of the region some patients had experienced previous admissions to hospitals in Belfast as well as to other hospital sites within the Northern Health & Social Care Trust. Within the Northern

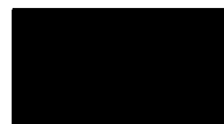


Health & Social Care Trust patients could be transferred to Antrim Hospital from other sites in the Trust in order to access specialist services, and patients could also be transferred from Antrim out to other sites when specialist medical services were no longer required. The system for acute medical admissions at Antrim was such that during the relevant period many patients I cared for experienced prolonged waits in A&E pending availability of medical beds. Patients admitted under my care were regularly managed as outliers on surgical wards due to lack of availability of beds on designated medical wards. Patients were also transferred from medical wards to non-medical wards as their acute condition improved and when discharge was expected within 24 -48 hours, or if they no longer required acute medical care but needed to remain in hospital awaiting a residential placement or social care package.

6. The Trust had an Infection Control Committee which I understood to have responsibilities for implementing regional guidance on infection control and developing local trust procedures and protocols. Nurse members of the Infection Control Team visited the wards to monitor standards and facilitate the training of staff.

7. When I took up my post in 2006 I was made aware of the Trust's existing protocol for antibiotic prescribing which discouraged the use of cephalosporin antibiotics in most situations with the exception of the treatment of meningitis. The ward-based pharmacists performed an important role in scrutinising patient prescription kardexes and would request that medical teams review prescriptions that did not follow protocol.

8. Prior to taking up my post at Antrim Area Hospital I had last worked in the NHS in 2001 at Belfast City Hospital as a research registrar. Although I was aware of the established link between cephalosporin antibiotics and increased risk of Clostridium difficile infection, it was my experience, from where I had worked previously, that these antibiotics



were still frequently used, particularly for the treatment of hospital-acquired pneumonias and exacerbations of bronchiectasis and cystic fibrosis. When I joined Antrim in 2006 I noted that members of the Infection Control Team appeared to have a higher visibility on the wards than I had noted elsewhere before. In previous posts I had not been accustomed to ward-based pharmacists playing such an active role in monitoring antibiotic prescriptions and in encouraging adherence to protocols. Although I initially felt that the Trust's antibiotic protocol was an erosion of my clinical autonomy I did recognise that there was a need for change to prescribing practice in order to reduce healthcare-associated infection and I came to acknowledge the potential benefits of a more restrictive prescription protocol. In specific cases it was still possible to prescribe cephalosporins following discussion of the case with a member of the medical microbiology team, whom I always found to be approachable.

9. With respect to cleanliness, I do not recall forming any impression as to whether Antrim Hospital was in any way more or less clean than sites where I had worked previously.

- **Priorities**

10. In the period prior to the Outbreak my perception was that management structures were focused on addressing Department of Health targets for elective and emergency care. My perception was that management was prioritising measures to address A&E trolley waits and delayed discharges. My perception is based on informal discussions with colleagues at the time as well as my recollection that management ideas and proposals relating to these areas were discussed at the Antrim Physicians' meetings.

11. My perception is that after the Outbreak was declared, management was prioritising the acute care of infected patients as well as measures to limit the spread of infection.

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- **Responsibility and accountability**

12. In April 2007 the United Hospitals Trust merged with Homefirst Trust to form the Northern Health & Social Care Trust. Although trust wide many individuals were appointed to new roles my perception is that there was no significant change in the management roles for medical staff. On the Antrim site medical staff remained under the immediate responsibility of the Clinical Director for Medicine through the Medical Directorate, with the Medical Director having responsibility for all the clinical directorates in the Trust and sharing management responsibility with a Senior Management Team under the ultimate responsibility of the Trust Chief Executive.

13. Prior to the declaration of the Outbreak the Trust Infection Control Committee had responsibility for overseeing the implementation of infection control protocols. Once the Outbreak had been declared a specific Outbreak Control Team was formed which I understood to have included key members of the Infection Control Committee as well as members of the Trust senior management team including the Chief Executive.

COMMUNICATION

- **To staff from management**

14. Once the Outbreak was declared there was a large increase in the volume of communications from management. Management communicated with consultant medical staff in relation to the Outbreak verbally via routine Physicians' Meetings as well as at ad hoc meetings, specifically convened to address relevant issues. However, the bulk of the communication was via emailed reports. As the situation was changing on an almost daily basis, my impression was that email was

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an effective means of communication. At times the rate of change in protocols and procedures and the volume of communications was so large that it was difficult to keep up to date.

- **To management from staff**

15. Medical staff communicated with management structures mainly via the Medical Directorate Office and the Clinical Director following discussions at formal Physicians' Meetings.

- **To patients / relatives**

16. I do not recall any specific communication with a patient infected with Clostridium difficile or such a patient's relatives, though I do recall regularly needing to reassure uninfected patients and their carers that hospital staff were doing everything possible to prevent further patients being affected.

- **Guidance /protocols from Control of Infection team**

17. My recollection is that the Infection Control Team had already issued guidance on healthcare-associated diarrhoea at some time before the Outbreak was declared. After the declaration of the Outbreak the Team issued specific guidance on management of Clostridium difficile infections. The guidance was regularly updated and disseminated to medical staff via e-mail. I generally found the guidance to be clearly written and informative. At times it was, however, difficult to keep pace with the frequency of updates.

- **From microbiology**

18. Most of the communication from microbiology consisted of the updates to the protocol for managing Clostridium difficile and antibiotic

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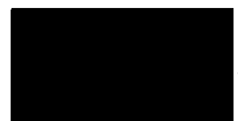
prescribing. The microbiology team did ask medical staff to engage with them regarding opinions on revisions of the Trust's antibiotic prescribing protocol. I recall myself and my fellow respiratory consultants having a meeting with Dr Kearney, Consultant Microbiologist, and her colleagues regarding revisions to the protocol for the use of antibiotics to treat community-acquired pneumonia and other respiratory tract infections. The group discussed how the proposed protocols related to best practice guidance available at that time from international learned societies including the British Thoracic Society. I found that members of the medical microbiology team were always contactable and ready to provide advice in appropriate cases.

- **Access to relevant meetings**

19. Medical staff held discussions through the routine scheduled Physicians' Meeting which was organised through the Medical Directorate. All physicians were invited to attend. Management was represented at these meetings by the Clinical Director for Medicine, and other members of the management team also attended on an ad hoc basis to address relevant issues. I am not aware of any other meetings that I felt I should have had access to.

- **Media handling by the Trust**

20. My perception is that there was inadequate handling of the media by the Trust. At the time it appeared that the broadcast media were carrying the story of the outbreak on an almost daily basis, yet I seldom witnessed any Trust representative appearing on a broadcast to give the trust perspective on the story.



SUPPORT

- **Management (both top and line management)**

21. I felt there was excellent support for medical staff from the Clinical Director for Medicine and the Medical Directorate office, and good support from management in general.

- **Public/visitors**

22. Frequently, the views expressed by the public and visitors reflected the reporting of the situation in the media and were usually of a negative nature. Some patients cancelled outpatient appointments or appointments for day procedures and I recall individual patients reporting to me that a fear of catching Clostridium difficile was the reason.

- **Morale of staff**

23. The morale of staff was adversely affected during the outbreak. I believe that this was due to the increased pressure from an increased intensity of workload, concern for the safety of affected patients, and the perceived negativity towards the Trust in media reports and in opinions expressed by the public.

- **Stress**

24. As well as feeling under increased stress myself I perceived that many of my colleagues appeared to be feeling the same way. The reasons for low morale stated above were also the main sources for increased stress.

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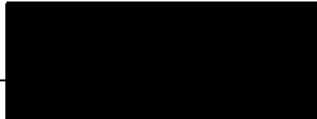
25. I wish to express my condolences to those who lost relatives during the Outbreak.

I confirm that the content of this statement is true to the best of my knowledge, information and belief.

Signature 

Date 21/5/2010