



C DIFFICILE INQUIRY WITNESS STATEMENT

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A. PERSONAL EXPERIENCE

I have worked as a Consultant Physician with special responsibility for the Elderly in Whiteabbey Hospital, Northern Health and Social Care Trust (NHSCT), for more than twenty years. During that period I have encountered and cared for sporadic cases of C Difficile Associated Diarrhoea (CDAD), usually in frail, elderly, immunocompromised (ie. lowered resistance to infection) patients who had received multiple courses of broad spectrum antibiotics for recurrent infections.

Prior to the outbreak of CDAD in the NHSCT in January 2008, I believed that our ability to diagnose, treat and prevent spread of this infection within our hospital was at a high standard and in keeping with what was considered best practice.

I will attempt to comment on my subsequent experience of caring for patients with this condition on the Whiteabbey Hospital site in the period leading up to and following the declaration of 'outbreak' status in January 2008 using the recommended headings below .

B. ORGANISATION AND MANAGEMENT

WORKLOAD AND RESOURCES

During the period in question I was not aware of any particular shortages of key staff members ie medical, nursing or allied health professions, in the medical or Care of the Elderly wards. It is my perception that there may have been a higher than normal rate of staff turnover because of uncertainty regarding the future of medical provision at Whiteabbey Hospital following service reconfiguration outlined in 'Developing Better Services', but I have no factual evidence of this.

Regarding medical staff, the introduction of new rotas to meet the requirements of the European Working Time Directives resulted in shorter rotations of junior trainees in most wards and necessitated more frequent induction training which always included educational input from one of our Infection Prevention and Control Nurses.

Specifically regarding cleaning and domestic services, while I did not perceive, nor was I made aware of, understaffing or shortages of equipment or materials prior to the increase in CDAD cases or the declaration of outbreak status, there was undoubtedly a noticeable increase in observed cleaning activity, not only in the wards and clinical areas but throughout the hospital, including the corridors, stairs etc. following declaration of the outbreak.

While both Microbiology and Infection Control staff were always available and helpful prior to the outbreak, they were contacted much more frequently and proved immensely supportive with both practical advice and regular, sometimes daily visits, during those periods when several cases and several wards were involved. This advice was given freely both within and outside normal working hours.

SYSTEMS

When a case of diarrhoeal illness in hospital was suspected as being due to CDAD, faecal samples were obtained immediately and sent to the Microbiology Laboratory in Antrim Area Hospital for analysis. Notification of a confirmed case of toxin positive CDAD was automatically sent on the day of detection by the Microbiology Department to the medical and nursing staff of the ward involved and also to the Infection Control Lead Nurse responsible for that hospital who visited the ward, advised staff and organised a Root Cause Analysis (RCA) meeting, involving senior medical, nursing and pharmacy staff, to take place on the ward at the earliest opportunity. A summary of the relevant findings of that meeting were forwarded to the Microbiology Department and the Outbreak Control Team.

Protocols and Guidelines for managing the infection were available both in print and online access on the Northern Trust Intranet site containing detailed advice on all aspects of care for such cases, and these were updated regularly. In practice however advice was invariably sought over the phone from Microbiology medical staff by ward medical staff and face to face advice was usually available on the same day from the responsible Infection Control Nurse on duty. In depth cleaning regimes were rapidly commenced in all confirmed cases and all cases were isolated in single side rooms or an isolation bay.

PRIORITIES

Where a patient was confirmed as having CDAD the priorities for medical management were the cessation of all broad spectrum antibiotics, commencement of appropriate anti C Difficile antibiotics (initially Metronidazole but later in the outbreak Vancomycin as first choice), discontinuation of aggravating medications including laxatives and PPIs, close monitoring of the patient including a regular bowel chart, commencement of intravenous fluids if clinically indicated, routine bloods, use of personal protective equipment and

scrupulous hand cleansing. Nursing staff effected isolation and instigated environmental cleaning. Other groups of staff working with these patients were informed and took appropriate precautions. Patients and families were informed of the diagnosis and provided with advice and written information.

Within the wider hospital setting a range of measures were adopted to minimise the risk of spread of the C Difficile organism eg. placing antiseptic hand gel dispensers at the entrance to each ward for use when entering or exiting the ward, and implementing a 'bare below the elbow' dress code for all staff members. Regular audits were carried out to ensure that these measures were being adhered to eg. hand cleansing and antibiotic prescribing audits, with all wards and staff receiving feedback of the results.

RESPONSIBILITY AND ACCOUNTABILITY

Having being invited to join the Outbreak Control Team which was set up and chaired by the then Chief Executive in January 2008, I recall being impressed by not only the seniority and range of representatives from virtually every Directorate including Finance, Public Health, Community Services, Pharmacy and a GP representative, but also by the genuine enthusiasm and determination to resolve the problem almost regardless of cost. Staff at ward level, in particular ward managers, implemented the guidance and protocols emerging from these executive meetings and took responsibility for collecting the detailed information and audit data required to feed back to the Infection Prevention and Control team in order to monitor progress toward eradication of the problem.

Along with other senior colleagues I endeavoured to lead by example eg. regular use of gel on entering and leaving the ward and full hand cleansing and use of gloves and aprons between each patient contact. I ensured that all new staff working in the wards were provided with information about preventing and managing CDAD infection in their induction packs and that any changes in policy were updated and accessible via the Trust Intranet site on every ward.

B. COMMUNICATION

STAFF

Communication between the key staff members responsible for managing individual cases on a ward during that period was extremely good and despite the undoubted stress and additional work involved for the Laboratory, Infection Control, Ward and Cleaning staff, everyone involved seemed to make an extra effort to ensure that patient care issues were addressed in keeping with the latest recommendations. I was not made aware of any disputes or concerns

regarding professional boundaries which one might reasonably have expected under these circumstances.

Regular bulletins and newsletters were circulated both in print and on the Intranet updating staff on the current situation re the outbreak and for senior staff in all disciplines daily figures were circulated giving the numbers and distribution of cases within the Trust.

Factual information regarding the nature of the outbreak, including the presence of a new strain of C Diff was made widely available to staff which I feel helped to offset some of the morale issues relating to adverse media coverage which was at its height around that time. Staff were encouraged to take an online infection control module which was later included as part of their appraisal process.

PATIENTS/RELATIVES

In Whiteabbey we were perhaps fortunate in not only encountering lower numbers of C Diff patients than in Antrim Area Hospital but also virtually all of our patients were frail and elderly with significant co-morbidity which made it easier to explain to both patients and relatives why they were vulnerable to such opportunistic infections. Full and open explanations of the condition and its management were always given at the earliest opportunity by experienced staff and written information was provided. We rarely encountered hostile reactions or criticism from relatives.

Many of the affected patients had been transferred to the medical and Care of the Elderly wards from other wards and hospitals and a decision was taken early in the outbreak not to transfer those patients back to Ward A1 in Antrim Area Hospital unless a clear benefit in terms of care or management of the patient could be justified, which was rarely the case. This decision was supported by Infection Control and Senior medical management and helped to remove some additional stress and concern from patients and relatives who were often reluctant for further moves of frail, ill and occasionally terminal patients, many of whom suffered from dementia and end-of-life and quality of life issues dominated their clinical management.

GUIDANCE/PROTOCOLS

Detailed and regularly updated guidance on all aspects of managing the patients and the environment was forthcoming from the Outbreak Control Team and widely disseminated through lines of management to all staff as well as published regularly on the Trust Intranet site which was available to all professional staff.

Specific guidance for completion of death certification for patients who died having suffered from CDAD was issued by the Chief Medical Officer and circulated to all medical staff. An external medical expert, Dr Jim McLaughlin, audited the death certification of patients with CDAD who died during the outbreak period and reported satisfaction with adherence to the recommended guidelines.

MICROBIOLOGY

Microbiology services in general, and Dr Kearney in particular, were at the forefront in both identifying and leading the measures which needed to be taken to control this outbreak and which proved ultimately successful. Dr Kearney and her colleagues, despite being under immense pressure during the outbreak period, visited Whiteabbey on several occasions to update all medical staff on the latest version of the C Difficile management guidelines, in addition to providing expert advice on numerous occasions on individual cases. Data on incidence, prevalence, ribotypes and surveillance were produced and widely distributed by the Microbiology Dept.

RELEVANT MEETINGS

Monthly Outbreak Control Team meetings were held in Trust Headquarters at The Cottage, Ballymena, where senior management in all directorates attended and the Chief Executive chaired. From these meetings numerous recommendations were made and disseminated throughout the Trust facilities for implementation. Local ward meetings took place with Microbiology staff, Infection Control staff, ward medical and nursing staff, pharmacy and environmental control staff, if a ward had several cases. RCA meetings were held at the earliest opportunity regarding individual cases of CDAD.

MEDIA HANDLING

The Trust PR officer handled interaction with the media during the period of the outbreak and there was undoubtedly a perception that the Trust was being unfairly labelled as culpable because of poor hygiene without acknowledging other key contributory factors such as the newly introduced, more toxic ribotype 027 strain of C Difficile. Little attention appeared to be paid to the roles of excessive antibiotic use or the age, frailty and significant co-morbidities present in most of the patients affected.

C. SUPPORT

MANAGEMENT

As previously stated I believe senior management led from the front in this situation as soon as the nature and extent of the problem was realised. Time, information and resources were made available to give clinical staff the best opportunity of rapidly bringing the outbreak under control while dealing with intense media scrutiny.

PUBLIC/VISITORS

The patients and relatives we dealt with in Whiteabbey were generally understanding and supportive of our efforts to treat and control further spread of the disease and were receptive to the adoption of a range of additional infection control measures such as hand cleaning on entering the ward and restricted visiting.

MORALE OF STAFF

Morale in staff working in Whiteabbey could reasonably be said to be at a reduced level around the time of the outbreak because of the impending changes associated with acute service reconfiguration within the Trust. That notwithstanding I believe the response of all levels of staff to this new threat with significant increase in workload was excellent and reflected the high degree of professionalism and loyalty of the remaining staff to continuing to care for patients on the Whiteabbey site.

STRESS

The combination of increased physical workload, learning and employing new techniques, carrying out frequent audits, attending many more meetings, feeling under constant scrutiny and dealing with the real concerns of worried patients and relatives must have added to the already high levels of stress particularly among nursing and domestic services staff, but at no stage did I become aware of this affecting their standard of performance or their ability to achieve the required targets.

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


James Gilmore MD

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