PUBLIC INQUIRY INTO THE OUTBREAK OF CLOSTRIDIUM DIFFICILE IN NORTHERN TRUST HOSPITALS

WITNESS STATEMENT OF OLIVIA DORNAN

Full Name:	**Dr Olivia Dornan**
Name of Employing Organisation	**Northern Health and Social Care Trust**
Headquarter Address:	**The Cottage, 5 Greenmount Avenue, Ballymena, BT43 6DA**
Position or Role within Organisation:	**Consultant in Accident & Emergency Medicine**

PERSONAL EXPERIENCE

1. I qualified from Queen's University Belfast in 1982, with the qualification MBBCHBAO. I subsequently trained in various hospitals in Northern Ireland (Royal Victoria Hospital, Ulster Hospital, Mater Hospital and South Tyrone Hospital). I accepted a Consultancy post in Accident & Emergency at the Mater Hospital in 1993 and worked in that role until June 1999. I then commenced work as a Consultant in Accident & Emergency at Antrim Area Hospital. I remain employed in this capacity.

2. In addition to retaining the above full time clinical role, I became Clinical Director of Acute and Emergency Medicine on 1st September 2007.

3. I am on the GMC Specialist Register and hold a current licence to practice medicine.

4. I am providing this statement in relation to the Public Inquiry into the Outbreak of Clostridium Difficile (*'the Outbreak'*) in Northern Trust Hospitals between 16th June 2007 and 31st August 2008 and pursuant to a request that I received, in correspondence dated 25th March 2010, from Ms Ellen McAleavey, Solicitor to the Inquiry.

5. In particular, I am providing this statement in relation to Term of Reference (2) 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."* Further, I propose to address the points listed on page (2) and in Annex A of the above correspondence, as requested.

6. I do not have a list of patients who were diagnosed with Clostridium Difficile in Antrim Area Hospital during the Outbreak. I cannot, therefore, say whether I was directly responsible for the care of any such patient/s. It is, however, possible that I may have cared for such patient/s during the Outbreak.

ORGANISATION AND MANAGEMENT

- Workload and resources

7. Prior to the Outbreak in Northern Trust Hospitals, in June 2007, emergency patient attendances and admissions at/in A&E departments had been steadily increasing in Antrim Area Hospital and, as far as I am aware, across the United Kingdom, on an annual basis. The increase continued throughout the Outbreak period. The consequential strain on workloads and existing resources was inevitable.

8. A rapidly growing demand for admissions gave rise to the issue of *'trolley-waiting,'* a term used for patients waiting in A&E, often for long periods of time, until an appropriate hospital bed could be found.

9. At Antrim A&E, great efforts were made to ensure that systems were in place for looking after *'trolley-waiting'* patients, both in terms of nursing and medical care. It was our departmental policy to ensure that patients, experiencing admission delays, were moved from a trolley onto a hospital bed as soon as possible.

10. Another effect of the rising numbers of emergency medical admissions over the years leading up to and during the Outbreak was the pressure on the medical admissions system at Antrim Hospital.

11. As with A&E service pressures, these medical inpatient pressures were part of a nationally recognised problem. At Antrim Hospital, Consultant Physicians and their teams of junior doctors took turns to assume responsibility for new emergency admissions on a daily basis. This was referred to as the *'Physician of the Day'* model, which was widely in use throughout the UK at the time. Patients were initially admitted to a Medical Admissions Unit at B1, under the care of the Physician of the Day, and his/her medical team. They were subsequently moved out to another of the medical wards under the care of the same team. If a medical bed could not be found, patients were moved to be a *'medical outlier'* in one of the surgical wards. As the medical teams became busier, this system became less effective, with patients frequently being moved around from ward to ward and doctors travelling between wards to reassess patients who were distributed widely across the hospital. In response to this problem, the Trust set up a *'Medical Outliers'* Project Team in 2007, of which I was a member (please see paragraphs 17-21 below).

- Systems

(i) Isolation facilities

12. During the Outbreak, patients requiring hospital admission, who were suspected of having Clostridium Difficile, usually bypassed the A&E department altogether and were admitted straight to the purpose-built isolation facility at Ward A1. Failing this, such patients were admitted to an isolation facility such as a single room or cohort bay in another ward. On a number of occasions, however, due to the very high demand on Antrim's isolation beds, patients were diverted to A&E for immediate assessment and care to await a suitable isolation area elsewhere in the hospital. Some of these patients were delayed in the A&E department for long periods.

13. Within our A&E department we were, of course, concerned about dealing with patients, suspected of having Clostridium Difficile Associated Diarrhoea (CDAD), as we were working within a relatively crowded area from which patients dispersed to a wide range of care facilities, both within the hospital and in the community.

14. As far as I am aware, none of the A&E departments in Northern Ireland had purpose-built isolation facilities in 2007. In order to prevent or minimise the spread of Clostridium Difficile within the A&E department, every effort was, however, made by A&E staff, to isolate such patients in line with the Trust's Infection Control policies/guidance (please see below) and by our patient flow staff (middle tier managers responsible for bed allocation).

15. Prior to a partial A&E reconfiguration at United Trust in 2006, the Day Surgery Unit, adjacent to Antrim's A&E department, was relocated to allow the resultant vacated space to be converted into an A&E expansion. As an incidental result of this change, a room that had previously been a Day Surgery operating theatre was incorporated into

our department. This room had been identified as a contingency A&E isolation facility as part of planning for a Severe Acute Respiratory Syndrome (SARS) pandemic in 2003, as it had a number of features such as negative pressure ventilation. It also had its own sink and, being originally an operating theatre, it was relatively easy to keep clean. Use of this room for patient care, within the A&E department, remained a contingency for isolation emergencies only.

16. We used the above vacant theatre room as our emergency isolation facility during the Outbreak.

(ii) Medical Outliers

17. The Medical Outliers Project Team (as referred to at paragraph 11 above) was tasked with reducing the number of outlying medical patients to zero with a view to greatly reducing the movement of doctors from ward to ward.

18. This Team was set up by the Trust in 2007 and was operational during the Outbreak. Successful implementation of the Project was expected to reduce the spread of infection in Antrim Hospital.

19. Essentially, as a result of work undertaken by this Project Team, the number of medical beds in Antrim Area hospital was increased, by changing the balance between medical and surgical beds, to reflect current demand. A new specialty ward-based system to provide medical care was also introduced which resulted in trainee doctors and consultant teams being allocated to work within a single medical ward and to look after all of the patients on that ward.

20. The Medical Admissions Unit was then staffed by a separate team of doctors, who worked there each weekday, under the leadership of a dedicated Acute Physician.

21. The above measures, which were completed by around February 2008, dramatically reduced the number of Medical Outliers and patient movement within the hospital. Doctors worked in a base ward, almost exclusively, except when on call. Their movement around the hospital was, therefore, substantially reduced.

- Priorities

22. During the Outbreak, patient care and wellbeing remained my first priority. Ensuring compliance with, and awareness of, all required infection control measures was also matter of extreme priority for me, at this time, both as Clinical Director and a Consultant working in the A&E Department.

- Responsibility and Accountability

23. I had clinical managerial responsibility for unscheduled medical and emergency medical care throughout the Northern Trust during the Outbreak.

24. I reported to the Medical Director and the Director of Emergency, Primary Care and Older Peoples' Services.

25. Prior to the Outbreak, the Trust Infection Control Committee was responsible for overseeing the implementation of infection control policies. When the Outbreak was declared, an Outbreak Control Team was formed. Key members of the Infection Control Committee/Team included senior members of Trust staff.

COMMUNICATION

- To staff from management

26. During the Outbreak, all Trust staff were working in a situation that was constantly changing. As more patients suffering from Clostridium Difficile were identified, more information was collated/analysed regarding their symptoms and more guidance was issued regarding infection control (please see below).

27. One challenge, at ward and department level was, therefore, to ensure that the most up to date version of each guidance document, produced by the Trust, was communicated to clinicians.

28. The Trust's Guidelines on empiric antimicrobial prescribing and on the best-practice management of Clostridium Difficile were frequently updated and re-circulated during the early stages of the Outbreak. Obviously, it took time for all clinical areas to catch up with the latest editions of these documents. I do, however, consider that experienced clinicians (including myself) learned that the most effective way of communicating was via the Trust's intranet site, backed up by regular *'walkabouts'* to wards to standardise and raise awareness of key information.

29. Simplification of key messages was also crucial during the Outbreak. For example, an Antibiotic Prescribing *'Aide Memoire'* was introduced. This effectively ensured good routine practice in busy ward environments.

30. Active participation in clinical audits was an additional and important way of communicating effectively with frontline clinicians. As Clinical Director, I (in conjunction with the microbiology department) involved individual ward staff and trainee doctors in rolling weekly audits of their own antibiotic prescribing practice. This was another way of improving clinical standards/awareness of infection control issues and ensuring that good performance was sustained on all wards, with the co-operation of doctors with various levels of experience.

31. Our most junior trainee doctors (those in the first Foundation Year) carried out a Trust wide audit cycle to improve doctors' hand hygiene practice. This was another way of ensuring that all doctors assumed responsibility for this important element of infection control.

32. During the outbreak, Consultant staff received regular e-mail updates, containing information about the incidence of new cases of Clostridium Difficile within the Trust. This ensured that staff, at Consultant level, could access information relating to the daily status of the Outbreak and promoted constant clinical vigilance/surveillance at ward level.

- To management from staff

33. I regularly received information from Consultant staff in relation to Clostridium Difficile at Clinical Directorate meetings. Information of this nature was also frequently discussed/considered, as required, in person, by telephone and via intranet/e-mail facilities. In addition, I worked very closely with microbiology staff during the Outbreak.

- To patients/relatives

34. I was not directly involved in communicating with patients/relatives during the Outbreak.

- Guidance/protocols from Control of Infection Team

35. During the Outbreak, A&E staff were guided, to a significant degree, by the Control of Infection Team at Antrim Area Hospital, and by our patient flow staff, who were responsible for bed management.

36. One of the challenges, in infection control, is to ensure that all staff are aware of up to date guidance and protocols on topics such as antimicrobial prescribing, hand hygiene and use of personal protective

equipment. Modern medical practice places increasing emphasis on guidelines and protocols, many of them complex, for a wide range of conditions and situations. Trainee doctors and hospital Consultants have a highly pressurised working day with many competing demands and, in this context, it is difficult to ensure that they will be able to access complex data in real time. As previously stated, however, during the Outbreak, guidelines and protocols could be and were usefully accessed by clinical staff, at all levels via the Trust's Intranet facility.

- From microbiology

37. The medical microbiology department, within the Northern Trust, had an exceptionally high profile, particularly in relation to infection control by comparison with equivalent departments within other Trusts in which I have worked. The department widely published regular and clear guidance on antimicrobial prescribing and infection control which, effectively, prevented the widespread misuse of broad spectrum antibiotics, such as the third generation cephalosporins.

38. Before and during the Outbreak, the microbiology department employed a wide range of measures to disseminate knowledge regarding infection control, from in-person briefings by the microbiologists, use of e-mail cascades, the intranet, *'paper'* copies of protocols in wards and departments and widespread signs/posters. In my opinion, staff within this department did everything possible to promote best practice from an infection control perspective. As a result of these interventions, primarily directed by the microbiology department, the Trust saw steady measurable improvement in clinical practice and when the information had fully infiltrated within the Trust, at ward level, excellent practice, from an infection control perspective, became normality.

- Access to relevant meetings

39. I was a member of the Outbreak Control Team and attended almost all of the meetings held by that Team during the Outbreak, notwithstanding my high clinical workload.

- Media Handling by Trust

40. I do not have any comments to make in relation to how the Outbreak was handled by the Trust from a media perspective. I had no personal involvement in this regard.

SUPPORT

- Management (both top and line)

41. As an A& E Consultant and Clinical Director, I felt that I received excellent support from all of my colleagues during the Outbreak and from the Medical Director and Chief Executive, in particular.

- Public/visitors

42. I did not have any direct involvement in support issues pertaining to the public/visitors during the Outbreak.

- Morale of staff

43. All Trust staff were working in difficult circumstances during the Outbreak. We were in a new situation that was constantly changing. I do, however, consider that every effort was made to ensure that very high standards of clinical care were maintained and that the needs of patients remained paramount.

- Stress

44. The Outbreak period was, of course, a stressful time for Trust staff. I do, however, consider clinical staff remained focused on providing the best possible standard of care in a demanding situation.

45. Finally, I wish to express my condolences to those who lost relatives in the course of the Outbreak.

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

SIGNED

Dr Olivia Dornan

DATED 21.5.10

The College of Emergency Medicine

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14th October 2010

Dr O Dornan, Consultant
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Dear Dr Dornan,

RE: ISOLATION FACILITIES FOR PATIENTS IN EMERGENCY DEPARTMENTS

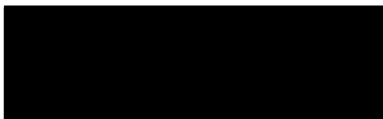
Further to our recent telephone conversation, I am writing to confirm that the current level of provision of isolation facilities within the UK's Emergency Departments is of major concern to the College. The College considers that every Emergency Department should have adequate purpose-built isolation facilities to permit the assessment and treatment of patients who may present with a suspected infectious disease. Such facilities should have an adequate specification to prevent the spread of air-borne infections.

We also recognise the importance of securing facilities that offer privacy and dignity to patients. We believe that Emergency Departments should have an adequate number of single rooms as well as the multifunctional resuscitation and treatment areas that are often divided by curtains or screens.

The College is soon to participate in a consultation exercise with the Department of Health regarding the next edition of the Health Building Note and we will be expressing this view.

Please let me know if I can be of any further assistance.

Yours sincerely,



John Heyworth
President