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10 MAY 2010

Any Issues re: Patient Flow and Systems at Outset of Outbreak

I was asked in January 2008 to cover Patient Flow for the Northern Health and Social Care Trust; this was a new post with no predecessor. My substantive post at this time was Lead Nurse, Acute and Emergency Care. The team consisted of 21 staff, 20 of which have a nursing background, covering Antrim, Causeway Mid-Ulster and Whiteabbey Hospitals. Upon my move to this temporary acting up appointment in Patient Flow, work within Antrim Hospital had already commenced to move to condition specific medical wards, a further creation of 24 medical beds in C4 and the implementation of a medical assessment model into Ward B1, this was coincidental with the outbreak. At this time the outbreak had also been declared and this was coincidental with my move to Patient Flow, Ward A1 was identified as the isolation ward for Cdiff Positive patients. This meant that all patients within Antrim Hospital and the outlying hospitals who were identified as CDiff positive would transfer to this ward for isolation and treatment, (if deemed clinically stable to transfer from other hospitals). An operational policy for A1 and the reorganisation of the medical wards was written by the General Manager, Lead Nurses, which was widely consulted upon with Clinicians, Physicians, Infection Control and other line managers including Patient Flow. This policy enhanced the safe transfer of these patients and ensured the proper procedure for admission to the ward was carried out. It was my responsibility to ensure my staff implemented this policy. Their biggest daily challenge was to ensure bed and sideroom capacity was available for direct admissions. The policy for A1 along with the Policy for the condition specific wards enhanced and supported the patient flows.

Causeway Hospital has a similar set up with a Medical Assessment Unit (MAU), although they do not have condition specific medical wards they did however have the Physician of the Week model which allowed for continuity of care and control over the movement of patients for MAU to medical beds. Causeway mainly managed their own Cdiff positive patients in side rooms within the Medical and Surgical Wards. Whiteabbey and Mid-Ulster are smaller sites with fewer medical beds and had few patient flow issues as some new cases of Cdiff positive patients were transferred to A1 for isolation.

If not clinically suitable to move these patients were isolated in side rooms within Whiteabbey and Mid-Ulster Medical Wards. The Policy allowed for the seamless transfer of newly diagnosed patients from the smaller sites if clinically stable to these beds.

Other challenges around Patient Flow were down to the length of time required for the rapid response teams to complete Level III terminal cleans at ward level. This was a cleaning and disinfectant regime and was categorised into different levels, ie Level I, II and III depending on the infection risk of the patient. Cdiff positive patients were categorised as a Level III clean. This sometimes delayed the movement of patients and at times caused a backlog in A&E and at ward level. Patients discharging or transferring from the hospital back to nursing homes, residential care or within the Trust could also be delayed as these areas were cautious regarding the outbreak.
Weekly outbreak operational site meetings were held, and chaired by an Assistant Director. I attended Antrim Hospitals site meetings and minutes were taken with dedicated actions to be carried out. Information regarding new cases was emailed daily from microbiology so that we could monitor progress, numbers and new cases. Within the hospital new cases were identified through Infection Control, Ward Managers, Patient Flow and Lead Nurses, verbal communication was very important and this was very clearly channelled through line management down to Ward/Department staff and actioned.

The Patient Flow Staff all met this challenge with enthusiasm and willingness to improve Patient Flows and to ensure the right patient in the right place. Although it was challenging at times, there was no absence by my staff due to stress related problems from the outbreak.

Re-Organising within Budget

The Operational Policy within A1 was implemented and work with Infection Control was increased. However there was no increase in my staffing levels but a reorganisation of how they worked. This was within my current budget for Patient Flow. If sick leave or vacancies occurred, for other reasons bank staff were available to cover but only as a temporary measure and not as a result of the Cdiff outbreak.

Use of Side Rooms plus any Laundry Issues

A1 cohort ward had 8 side rooms and 16 beds (consisting of 4 x 4-bedded bays), within the Operational Policy. Two side rooms were to remain free for any new Cdiff patients within Antrim Hospital or transfers from within the Trust. This was mainly managed by Patient Flow through networking with the Physicians and Ward Staff. It was the Patient Flow Co-ordinators role and responsibility to keep the flows going in the ward and hospital, and if challenges occurred this was escalated to Lead Nurses and myself for actioning.

Side room availability within the Medical and Surgical Wards (apart from A1 for the purpose of Cdiff) was always a challenge. Side wards within Antrim and the outlying hospitals continued to be used for patients with Cdiff. These patients could also remain at ward level if their clinical status did not allow them to be moved, ie cardiac patient requiring monitoring. Patients with general high infection risks, ie MRSA etc, or on the care of the dying pathway took precedence; therefore it was imperative that the information and risk assessment for these patients was clear, allowing staff to make decisions to move patients out if necessary. On my move to patient flow, information was not always clear around side room availability and the patient flow staff relied heavily on the infection control team to advise if a patient still required a side room. This was very time consuming for patient flow and infection control, as phonecalls were being made out of hours to ascertain information. Each Friday the Patient Flow and Infection Control team would meet to identify patients who were low risk and could move out if required, over the coming weekend. This information could change on an hourly basis. I met with the Infection Control team and Patient Flow Co-ordinators and from that an Infection Control Risk Assessment tool (IRAT) was devised for Ward Managers / Staff to complete daily and bring to the daily bed meetings. This tool identified low and high risk patients at ward level that could be cohorted or moved out of siderooms to ward bays to accommodate the placement of new cases. This process is still in place today. Patients can now be moved without consultation with Infection Control. Relationships between Infection

Control and Patient Flow are good and the wards now have accountability and responsibility for moving their patients without fault.

Laundry supply issues were not apparent, although the storage of laundry was raised by the Task Force and steps were taken by Senior Managers and Ward Staff to implement an approved measure to protect the laundry at ward level, ie zipped trolleys and laundry is delivered in plastic bags and remained covered. Ward stocks were increased and A1 had a designated laundry room and this was discussed weekly at site operational meetings chaired by the Assistant Directors.

Resource Issues

The Chief Executive made it very clear to all teams from the start of the outbreak that she did not want to compromise patient care in any way; therefore resources were not an issue. However, we did have a responsibility to monitor this at weekly outbreak meetings. All line managers had access to and received copies of minutes of these meetings and also communications regarding actions from the Senior Team Meetings would be discussed and implemented by the responsible officer for that area.

I or my team did not feel hampered by lack of resources.

Whether targets were realistic or unrealistic

Priorities For Action (PFA) Targets remained the same; however A&E Waiting Time, Elective or Discharge Targets were not considered if a patient was diagnosed with Cdiff and required isolation. As I previously stated the length of time it took to complete a Level III terminal clean in a bay or side room was a challenge and patients, if in A&E, remained in an isolated area designated for them until the clean had been completed, then the cleaning process took place in A&E for that area also. If a patient was diagnosed at ward level they were moved immediately to a side room in A1. All other business continued as usual.

My team continued to meet A&E, Elective and Discharge Targets as necessary within the constraints of the situation as previously described. I cannot comment on whether these targets were realistic or unrealistic.

Whether established networks were in place

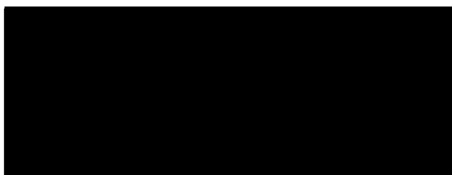
At the time of my acting up appointment the Trust had just amalgamated and work was ongoing to establish Trust-wide communication within Patient Flow between the four sites. To establish good communication and networking I introduced a four-way conference call between the four sites three times during the day and once during the night. All admissions into the hospital came through Patient Flow; each site was required to submit their bed state and any information around potential transfers into the Isolation Ward. The Operational Policy for A1 had been introduced and this established networks between the transferring hospitals, medical and nursing staff with Patient Flow staff. As I stated earlier the closer networking with the Infection Control Team and Patient Flow was productive, as we had to work together in partnership on a daily basis.

Inter-Intra Hospital Transfer of Patients

At the time of my acting up appointment, internal transfers between wards in Antrim happened on a daily basis, and there were high numbers of medical patients boarded to surgical wards due to capacity issues. This reduced when the Medical Assessment Unit model was introduced. Condition specific wards were identified and medicine acquired a further 25 beds in Antrim. To monitor the amount of internal transfers I implemented a monthly audit on each site, which highlighted the reasons why a patient was internally transferred and allowed us to monitor that this was for clinical reasons. This also identified the gaps in some of the services, ie availability of telemetry facilities outside of the cardiology wards and also any movement of patients for infection control purposes other than Cdiff.

All patients for admission or transfer into the hospitals were screened by nursing and medical staff using a risk assessment tool. The receiving ward would request specific information around the patients infection status and then complete the risk assessment proforma which was then held in the patients notes. If the patient had been previously infected they had to meet certain criteria setdown by Infection Prevention and Control team and task force before they could transfer. The risk assessment tool is still ongoing today and patients are isolated if necessary. Visiting times within the Trust were reduced from open visiting to set times of the day; this helped at ward level and also from an operational perspective allowed the domestic staff to clean appropriately.

I confirm that the contents of this statement are true.



Helen McClurg

General Manager – Patient Flow

27 April 2010

Any changes implemented by the Trust in your Area of work as a result of the outbreak.

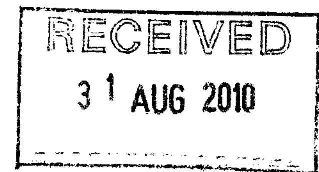
I, Helen McClurg, hereby make this further witness statement as requested.

1. Infection Prevention and Control Admission Risk Assessment Form. The risk assessment tool is completed by Nursing and Medical Staff in the Accident &Emergency Department for all adult and paediatric patients who are awaiting admission. This tool identifies if the patents are high risk and it allows the Patient Flow Staff to identify side rooms for isolation. This tool is used for all infection risk patients.

2. A list, from Microbiology, of patients who have been diagnosed with Clostridium Difficile is available for reference in the Accident &Emergency Department, the list also identifies the date of diagnosis. If a patient arrives in A&E, is displaying symptoms i.e. diarrhoea, Nursing and Medical Staff can make reference to this list and if the patient has been diagnosed within the last 3 months make an informed decision that the patient needs to be isolated.

3. The NHSCT Antrim Ward A1 Operational Policy – This identifies the patient pathway and process for isolation with Clostridium Difficile Infection.

4. The infection prevention risk assessment tool (IRAT). This tool has been implemented throughout the Acute Trust and is completed by Nursing staff at ward level. It is forwarded to the Patient Flow staff daily to identify side room availability.



I the undersigned confirm that the above content is true and accurate

Witness Signature ____________________

Name (Print)

Date 27 August 2010

WITNESS STATEMENT TO THE *C DIFFICILE* PUBLIC INQUIRY

PROVISION OF SUPPORTING DOCUMENTS

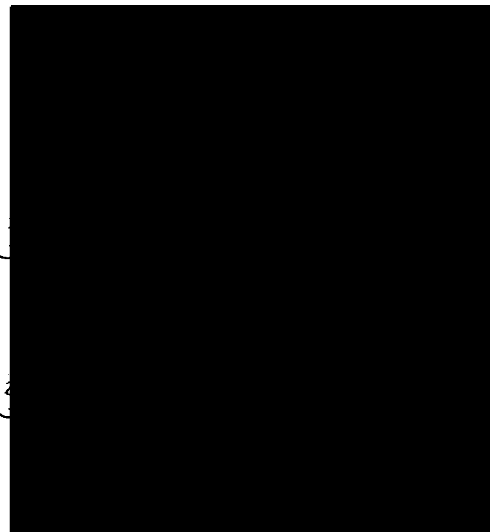
WITNESS NAME: Helen McClurg

1 I, Helen McClurg, hereby make this further statement in order to exhibit the supporting documents to which I refer in my statement of 27 April 2010.

2. On page 1 in paragraph 1 I refer to an Operational Policy for A1. This document is currently held by the inquiry and the associated reference number is NHSCT-16-56 (as per Jennifer Holmes).

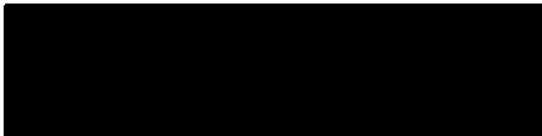
3. On page 2 paragraph 2 I refer to a cleaning and disinfectant regime. This is contained within Section 3 of Northern Trust Domestic Services Manual, the document currently held by the Inquiry and the associated reference number is NHSCT-16-142 (as per Jennifer Holmes).

4. On page 4 paragraph 2 I refer to an Infection Control Risk Assessment Tool (IRAT). This document is currently held by the Inquiry and the associated reference number is NHSCT-16-72 (as per Jennifer Holmes).



I declare this statement is true to the best (

Dated this 27/08/10 day of August 2

Signed: 

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INQUIRY REFERENCE DOCUMENTS

Document 1 - Page 1 Para 1 - INQ REF: NHSCT-16-56

Document 2 - Page 2 Para 2 – INQ REF: NHSCT-16-142

Document 3 – Page 4 Para 2 INQ REF: NHSCT-16-72