Minutes of the 26th meeting of the Strategic Infection Prevention & Control Advisory Group on 20 August 2019 9.30am-3pm

Present:	Karen Orsborn (Acting chair), Sally Roberts, Mo Neville, Linda Shepherd, Sheldon Ngatai, Richard Everts, Tanya Jackways, Jo Stodart, Sue Wood (via zoom for parts of the meeting)
In attendance:	Gary Tonkin, Nikki Grae, Carol Ratman, Marie Talbot
Guests:	Item 4: Natasha White, Wendy Goble Ministry of Health (via zoom);
	Item 13: Item 13 Jade Cincotta, Ministry of Health (via zoom).
Apologies:	Arthur Morris, Gillian Bohm, Josh Freeman

The meeting began at 9.30am.

1. Declaration of interest
There were no updates to the declaration of interest register.

2. Minutes of the previous meeting held 4 April 2019
The minutes were accepted as a true and correct record. The action log was reviewed.

Matters arising:
Circulate a copy of the CDHB Infection Control Committee executive group Terms of Reference, that had previously been supplied by Josh Freeman, to SIPCAG members.

3. ACC update
Rosemary Jarmey, ACC joined the meeting and provided an update on the ICNet expansion programme and standardising HAI surveillance definitions work as it relates to ICNet.

Three quarters of DHBs are either using ICNet or have a business case underway. ICNet is a modular system, with functionality spanning public health and hospital services. Currently only the infection prevention, registry and antibiotic stewardship (in one DHB) functions are being used in New Zealand. The aim is to have one platform that has all modules at a nationally consistent price.

Areas of current focus for the ACC ICNet team include working on Labsift rules /tags to improve consistency; seeking to establish a minimum data set that has clear definitions, and supporting the Operational Group's oversight over change control and definitions etc.

Next steps –

- Support the National Service Hub at CDHB to set up a national operating governance group – inaugural meeting is being held on 6 September. As part of their work the group will develop the minimum set of infections that will be monitored by ICNet. This will inform the minimum dataset that needs to be passed to ICNet to enable

infections to be identified. Healthscope has mapped their current microbiology codes to SNOMED-CT to produce a reference set of codes. This code set will be added to ICNet and form part of a data standard together with the minimum dataset.

- Baxter will run a user-group workday (early March 2020) and regular webinars to ensure ICNet is used consistently
- Enable ICNet infection control data is available 24/7 via systems such as Patient trak / eVitals
- Celebrate either nationally or internationally what ICNet has achieved to date e.g. publish papers.

Linda Shepherd, ACC updated the group about the ACC national forum being planned for early October, focussing on the roll out of the Peripheral Intravenous Catheters (PIVC) Know your IV Lines and Aseptic technique (AT).

The "Know your IV lines" PIVC package is being offered to DHBs and private surgical hospitals at this forum. The package was developed and tested by HVDHB. The package will be offered as a one-year funding agreement with DHBs and private surgical hospitals who have completed an initial Point Prevalence audit and submitted the results to ACC. Rollout to as many DHBs and Private Surgical Hospitals (PSHs) as possible in three cohorts is planned over the next three years. Invites will be sent out soon for a national forum.

The group questioned what audit support would be given to support the Know your IV Lines roll out. ACC will be recruiting a small pool of clinical auditors. this resource will assist with auditor training. The group discussed that IV nurses could be auditors, not just IPC nurses as they are already stretched. Not all DHB's have IV nurses so senior nurses, quality team members or RMO's could also be an option. There is an opportunity to spread the auditing work away from specialist teams, who should function as advisors. This would make quality and patient safety part of the mainstream responsibility.

The group also questioned how success and the impact of the package will be measured. ACC is working on finalising these measures.

The ACC Aseptic Technique (AT) pilot project started two months ago. The HVDHB is leading this project with input from three co-pilot sites. These include CCDH, CMDHB and Mercy Ascot.

ACC will be emailing updates about their programme of work via a newsletter, the first of which will be in the next few weeks. Linda also provided copies to the group of the reviewed and revised ACC publication 'How to treat - wound infection prevention and treatment' and the most recent treatment injury publication "Supporting Treatment Injury".

4. Antimicrobial Resistance (AMR) update

Natasha White and Wendy Goble, Ministry of Health (MOH) joined the meeting via telephone and provided an update on progress in relation to the national Antimicrobial Resistance (AMR) action plan. The Health AMR Coordination Group (HARC) has confirmed three key priorities: coordinating how AMR surveillance is reported; carbapenemase-producing Enterobacteriaceae (CPE); and regional and national guidance.

The work will involve ensuring alignment with the work of other agencies and within the Ministry. e.g. the Health and Disability Standards Review, Choosing Wisely, and the Commission community prescribing atlas of variation.

Updated AMR information will be published on the Ministry website in the next two weeks. Messages will be sent to stakeholder groups re a simple call to action.

Action

1. SIPCAG members to let Natasha know if there are any other AMR initiatives.

5. Hand Hygiene New Zealand (HHNZ) update

Nikki Grae provided an update on HHNZ. The latest compliance report data shows that national compliance with best practice hand hygiene remains high at about 85 percent. The rate of healthcare associated *Staphylococcus aureus* bacteraemia (HA-SAB) has increased but there is less variation due to the Commission's work to clarify definitions. Work to better understand HA-SAB source data will identify further opportunities for improvement. A review of all auditors, re compliance with annual validation requirements (training and recording the minimum number of moments), has been completed by the team and individualised messages sent to DHB hand hygiene coordinators with the data for their DHB.

The results of a survey sent to DHBs and private hospitals regarding hand hygiene audit periods shows a preference to change from auditing periods of varying lengths to three 4-month periods a year. Hand Hygiene Australia has confirmed that this is possible in the hand hygiene database.

Decision

1. SIPCAG **agreed** to moving to three 4-month auditing periods (Jul-Oct, Nov-Feb, Mar-Jun). As there are no financial implications this change doesn't need to go to the HQSC Board.

Actions

1. Send audit review results to Quality & Risk Managers as well as HH Coordinators
2. Communicate the adjusted audit periods to all necessary stakeholders involved in the HHNZ programme.
3. Update any manuals or reference materials to reflect the updated audit periods.
4. Look at difference between DHBs, the number of HH moments collected and if there are differences in infection rates.

6. Orthopaedic Surgical Site Infection Improvement Programme (SSIIP) – light surveillance and what's next

Nikki Grae presented feedback from the sector on the SSIIP discussion paper about a potential move to light surveillance for orthopaedic surgery. A total of 46 surveys were completed on behalf of individuals, teams, or organisations with all twenty DHBs responding. In addition, three letters from independent organisations/colleges (NZ Private Hospital Surgical Association, Southern Cross Hospital Network, and Royal Australian and NZ College of Obstetricians and Gynaecologists) were received with the following results:

- the majority (65.22% of survey respondents) agreed with the option of having light surveillance protocol for orthopaedic SSI data collection and reporting

- alternative procedures preferred were spinal surgery (56.52%), caesarean sections (54.35%) and colorectal surgery (34.78%)
- alternative procedures some DHBs currently collect surveillance data on are caesarean sections (40%), colorectal surgery (15%), spinal surgery (12.5%) and vascular surgery (5%). 52.5% of respondents indicated that their DHB doesn't collect surveillance data on any alternative procedures
- the top three alternative process measures preferred to report on nationally were preoperative interventions for obese patients (41.3%), anti-staph bundle for orthopaedic & cardiac surgery (41.3%) and glycaemic control (36.96%)
- the main process measures some DHB's currently collect surveillance data are anti-staph bundle for all orthopaedic & cardiac surgery (45%) and antibiotic prophylaxis & skin prep QSMs across all clean procedures (20%). 35% of respondants indicated that their DHB doesn't collect surveillance data on any alternative process measures.
- re having a suite of measures (procedures or process) to choose from for SSI surveillance - 57.7% said No and 42.22% said Yes. The comments from those who choose No to this question indicated that they interpreted this as having to do a suite of measures not choosing between measures
- the highest scoring options to focus HAI surveillance on, other than SSIs, was peripheral intravenous infections (65.85%) and *Clostridiodes (Clostridium) difficile* infections
- re support for having a point prevalence survey across New Zealand to identify which HAI holds the greatest opportunity for improvment – 60% said Yes, 37.5% said Maybe and 2.5% said No.
- re interest in participating in a collaborative project to implement a bundle to reduce SSI risk for a specific procedure with opportunity for local customisation – 52.27% said Yes, 38.64% said Maybe and 9.09% said No.

Feedback was sought on the different options and on the next steps –

- **SIPCAG agreed** in principle to the move to the option of light surveillance noting the Commission is coming back to SIPCAG in November 2019 with detailed options on how light surveillance would work, and to the following considerations:
    - What should be the trigger and follow-up requirements for a DHB with a high SSI rate if they move to light surveillance. The full details of SSI infections would still be available. Options discussed included: targeting the issue through case note reviews and developing a checklist tool for a detailed review of an SSI case, working closely with the DHB on the methodology used (linked to the Serious Adverse Event reviews), identify KPI's (though this would be local and not a good long-term measure), linking to the IPC Standards, and expecting infection control committees to be involved in having oversight of surveillance and governance.
    - There was discussion regarding whether a suite of outcome and/or process measures should be collected nationally.
    - How to future proof patient records and systems to enable the development of process measures in the future is important to consider. This will involve detailed mapping of programmes and governance structures to better understand the current systems.

Actions:

1. HQSC to prepare a paper for SIPCAG's consideration in November with further detail on implementing light surveillance, including: the support, guidance and expectations for DHBs, and other measures, that should be associated with this change
2. A paper will be considered by the Commission Board at its November meeting for approval to add light surveillance as an option for orthopaedic SSI surveillance.
3. Over the longer term, Commission team seek to improve our understanding of the IPC governance structure of each DHB, differences in infection rates, and a map of all IT programmes currently used.

7. SSIIP – anti-staph bundle update

Nikki Grae provided an update on the anti-staph bundle. The collaborative has now finished with eight hospitals teams implementing the anti-staph bundle. The results of the outcome data tracking through December 2018 (for the eight hospitals) are as follows:

- Impact on *S.aureus* SSI rates – cardiac aggregate down from 1.55 to 0.96 (38% decrease), orthopaedic aggregate down from 0.58 to 0.15 (74% decrease), all cardiac & orthopaedic down from 0.96 to 0.49 (49% decrease)
- Impact on total Staph SSI rates (per 100 procedures) - cardiac aggregate down from 2.11 to 1.37 (35% decrease), orthopaedic aggregate down from 0.72 to 0.33 (54% decrease), all cardiac & orthopaedic down from 1.27 to 0.62 (51% decrease)
- Impact on total SSI rates (per 100 procedures) - cardiac aggregate down from 4.83 to 3.95 (18% decrease), orthopaedic aggregate down from 1.38 to 0.95 (31% decrease), all cardiac & orthopaedic down from 2.75 to 2.02 (20% decrease)
- While there was a decrease in non-Staph SSI's they were not statistically significant – cardiac 2.71 to 2.58 and orthopaedic 0.67 to 0.62.
- The change in rates (per 100 hip & knee procedures) of superficial SSI's, pre and post anti-staph bundle, in orthopaedic surgery - *S.aureus* 0.18 down to 0.04, total Staph 0.21 down to 0.04, total SSI 0.46 down to 0.41
- The change in rates (per 100 hip & knee procedures) of deep/organ space SSI's, pre and post anti-staph bundle, in orthopaedic surgery - *S.aureus* 0.28 down to 0.11, total Staph 0.32 down to 0.30, total SSI 0.85 down to 0.56
- The change in rates (per 100 cardiac procedures) of superficial SSI's, pre and post anti-staph bundle, in cardiac surgery - *S.aureus* 0.63 down to 0.54, total Staph 0.73 up to 0.74, total SSI 2.37 down to 2.71
- The change in rates (per 100 cardiac procedures) of deep/organ space SSI's, pre and post anti-staph bundle, in cardiac surgery - *S.aureus* 0.80 down to 0.39, total Staph 1.22 down to 0.54, total SSI 1.98 down to 1.28

Questions related to anti-staph bundle compliance have been added to the SSI data collection form in National Monitor (ICNet) and a patient education video is available for use - Stay safe from infection.

The next step, if there is interest, will be a second tranche collaborative with the intention to extend to further surgeries. The outcome data collected will be used to promote the anti-staph bundle sector wide and encourage take up of the bundle. Southern Cross Hospital Network is already rolling the bundle out across their hospitals.

Actions:

1. Letters to be distributed widely across the sector in the next couple of months, to determine interest in implementing the anti-staph bundle.
2. The SSI page of the Commission website to be updated with information and data from the first collaborative and links sent to consumer councils.

8. Clinical lead update – Sally Roberts and Arthur Morris

Sally Roberts provided an update on:

IPC portfolio and SSI programme clinical leads which included participation in the:

- Atlas of healthcare variation and behavioural insights team 'nudge' project (Sally)
- MOH Antimicrobial Resistance coordinating group (HARC) on 6 Aug 2019 (Sally)
- preparation of the options paper for SSIIP (Sally & Arthur)
- HQSC Clinical Leads meeting on 20 June 2019, (Sally & Arthur)
- ACC Leadership Group Meeting on 2 July 2019 (Sally)
- SSIIP Orthopaedic and Cardiac Expert Faculty Groups (Arthur)

Publications:

- Morris AJ, Roberts SA, Grae N, Jowitt D. Getting surgical antibiotic prophylaxis right, lessons from the National Orthopaedic Surgical Site Infection Improvement Programme: a call for action! NZ Med J 2019; 132 (1490): 55-58.
- Morris AJ, Roberts SA, Grae N, Frampton CM. Surgical site infection rate is higher following hip and knee arthroplasty when cefazolin is under-dosed. Accepted for publication in the American Journal of Health-System Pharmacy.
- Roberts SA, Grae N, Muttaiyah S, Morris AJ. Healthcare-associated *Staphylococcus aureus* bacteraemia: time to reduce the harm caused by a largely preventable event. (Viewpoint) Submitted to the NZ Medical Journal.

Conference abstracts –
International Congress on Infection Prevention and Control, 10-13th September, Geneva, Switzerland. Sally Roberts and Nikki Grae will present and talk to three abstracts:

- Reducing *Staphylococcus aureus* SSI using the anti-staphylococcal bundle in NZ (oral presentation)
- NZ Hand Hygiene programme: requirements to sustain improvement in a changing environment (poster)
- Reduction in the SSI rate following sustained improvement in process measures (poster).

9. Healthcare associated infection (HAI) Improvement programme 2019 work programme

Gary Tonkin and Nikki Grae spoke to an A3 which set out the main themes of the 2019/20 HAI work programme: Governance and leadership, Surgical Site Infection Improvement Programme, Hand Hygiene, Data for Improvement, HAI engagement and collaboration.

- Under the data for improvement workstream there is a plan to create a national HAI platform that will contain access to relevant data and dashboards, guidelines, case

studies, tools, information for consumers and links to the work of agencies and groups working in the sector.

- Engagement and collaboration will include engagement with DHB Infection Control Committee (ICC) chairs, initially on an individual basis then regionally/nationally. The aim is to form a network with ICC chairs, to build capability in quality improvement and to inform future activities.

Actions

1. Develop a template list of questions to ask ICC chairs, including the 'what level of data, in their opinion, is needed to ensure healthcare associated infections are under control?'
2. Clinical lead and IPC specialist to hold teleconference meetings to review questions and obtain feedback from ICC chairs.

The data for improvement workstream includes undertaking Point Prevalence Survey (PPS) to understand the burden of infection and identify areas of focus for quality improvement. The Commission is working on a PPS plan including what the PPS should include, how the survey should be run, system design and testing, and developing user training which is a key factor.

The group discussion regarding this included:

- Private hospitals are keen to participate in a PPS but their patients who develop infections often get moved to DHB hospitals
- If the infections recorded are restricted to a set list, then unknown infections can be missed so a full PPS should be planned
- The ECDC PPS form is available through ICNet / Baxter but there may be additional cost and delays in time if modification is required.
- The PPS will be a big exercise. If rolled out over time will need to avoid seasonal variations. Possible options include:
    - Training local auditors
    - Having a trained group of auditors to go around all DHB's and run the PPS. This would take 6-8 weeks and would also need a local DHB resource to help with local forms etc.
    - Initially run a pilot, then roll out to all DHB's over time.

Decisions:

1. SIPCAG **agreed** to a full Point Prevalence Survey (rather than a smaller scope PPS). Initial test sites could include some private surgical hospitals and some small, medium and large DHBs.

Actions:

1. Develop a PPS plan including checking the appropriate methodology and electronic system to be used.
2. Talk to National Health Service Wales and the people who recently ran a PPS in Australia about what worked and didn't work for them.

10. SIPCAG – Terms of reference (TOR) and membership

Gary Tonkin briefed SIPCAG on the proposed changes to the ToR and membership of SIPCAG. The meeting **noted** that:

- SIPCAG needs to be able to review its function annually to flexibly respond to changing requirements in HAI
- The existing ToR allows SIPCAG the power to co-opt members for specific projects. The ability to co-opt members should be exercised more.
- The membership of SIPCAG could be strengthened by having:
    - Another senior DHB member
    - A DHB Director of Nursing (DON) and or an Infection Control Committee (ICC) Chair
    - representatives from other agencies (Ministry of Health, ACC and ESR) who can make decisions on behalf of their agencies
    - A general surgeon (rather than a specialist cardiac or orthopaedic surgeon) nominated by the Royal Australasian College of Surgeons
    - An additional Consumer Representative
    - Stronger Maori representation throughout the membership.

The discussion of the proposals **noted:**

- The proposals outlined in the paper
- The current focus of SIPCAG is on healthcare associated infections (HAIs), noting that ACC follow HAIs at the primary care level via their treatment injury claims. At some stage SIPCAG could look at HAIs in primary care, and in aged residential care. It was suggested that an Aged Residential Care (ARC) representative would be useful.
- From an equity perspective it was important to have more Maori and Pacific representation on SIPCAG.

Decision:

1. SIPCAG **endorsed** the proposals contained in the paper and **agreed** that the ToR and membership be revised to reflect the meeting discussion
2. The updated version of the ToR and memberships will be circulated to SIPCAG for agreement out of session.

11. IPC Standards Review update

Jade Cincotta and Donna Gordon (MoH) joined the meeting via zoom and provided an update on the IPC Standards Review –

- The Ministry is mandated to review the Health and Disability Standards every four years, if required. Scoping workshops are being held to see the breadth of change required. Seven scoping workshops have just been completed.
- The next phase (mid Sept 2019 to end Jan 2020) will be to form working groups – Peoples rights, Staff & Structure, Pathways and Infection (IPC and environment - some standards mirror Safe Environment standards). The first draft resulted in 144 expressions of interest and a selection process will now take place. The role of the working groups will be to give feedback on the scoping workshops, test thinking, and to give clinical / specialist input.
- from March 2020 MoH will work in partnership with Standards NZ to complete the Review by the end of 2020.

SIPCAG asked Jade and Donna–

- if the group will be kept informed and engaged in the IPC Standards review process. The Ministry responded that it will keep SIPCAG in the loop.
- if the current New Zealand IPC Standards will be used as a template along with IPC Standards from the UK, Australia and Canada. The Ministry responded that they will let SIPCAG know. The intention is to have standards that are strengths based and person centred.

12. Any other business

The next SIPCAG meeting is planned for November 2019, comms to go out re selection of a suitable date.

Action list following SIPCAG meeting 20 Aug 2019

No	Meeting date	Topic	Action required	By whom	By when	Status
11.	4 April 2019	SSIIP – reducing the burden of orthopaedic data collection	Review evidence for preventing inadvertent hypothermia as a contributing factor to SSI	Arthur		On hold
22.	30 January 2019	SSIIP options paper	Follow up with the Wales HAI programme to see how they are progressing with their SSI programme and ICNet.	IPC team	April 2019	Complete
	20 August 2019	ICC executive group ToR	Circulate a copy of the CDHB ICC executive group ToR, supplied by Josh Freeman to SIPCAG members	IPC team		
	20 August 2019	Antimicrobial Resistance (AMR)	Let Natasha White, MoH know of other AMR initiatives	SIPCAG		
	20 August 2019	Hand Hygiene (HH) Audit Review Results	Send audit review results to Quality & Risk Managers as well as HH Coordinators Look at the difference between DHB's, the number of HH moments collected, and if there are differences in infection rates.	IPC team		
	20 August 2019	Hand Hygiene (HH) change to audit periods	Communicate the adjusted audit periods to all necessary stakeholders involved in the HHNZ programme.	IPC team		

No	Meeting date	Topic	Action required	By whom	By when	Status
	20 August 2019	Light Surveillance	Prepare a paper for SIPCAG's consideration at its November meeting, on the options for implementing light surveillance. Subject to SIPCAG's agreement the paper will go to the next HQSC Board meeting for sign-off. Look at IPC governance structure of each DHB, differences in infection rates, and a map of all IT programmes used now	IPC team		
	20 August	Anti-staph bundle	Letters to be distributed widely across the sector in the next couple of months, to determine interest in implementing the anti-staph bundle. The SSI page of the HQSC website to be updated with information and data from the first collaborative and links sent to consumer councils	IPC team		
	20 August	Engagement with ICC chairs	Develop a template list of questions to ask ICC chairs, including the 'what level of data, in their opinion, is needed to ensure infection is under control?' Clinical lead and IPC specialist to hold teleconference meetings to review questions and obtain feedback from ICC chairs	IPC team		
	20 August	Point Prevalence Survey (PPS) Plan	Develop a PPS plan including checking the appropriate methodology and electronic system to be used. Talk to National Health Service Wales, and the people who ran the PPS in Australia and NZ about what worked and didn't work for them.	IPC team		