Minutes of the 17th meeting of the
Strategic Infection Prevention & Control
Advisory Group on 25 October 2016
3.30pm – 5.00pm

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Present:	Ashley Bloomfield (Chair), Arthur Morris, Lorraine Rees, Richard Everts, Sheldon Ngatai, Bridget Goggin, Jenny Parr, and Sue Wood.
In attendance:	Gary Tonkin, Andrea Flynn, Nikki Grae, Olivia Jones (minutes), Debbie Jowitt, and Lynette Drew.
Apologies:	Karen Orsborn, Trevor English, Sally Roberts, Jo Stodart, Gillian Bohm, Josh Freeman, Theresa Dyer, Nick Kendall, Mo Neville, and Jane Pryer.

The meeting commenced at 3.35pm via teleconference.

Sheldon Ngatai and Jenny Parr joined the meeting at 3.40pm.

1.1 Minutes of the previous meeting held 4 May 2016

A correction was noted on Page 5, para 1, 'Private surgical providers have their own systems and SSI rates are understood to be comparable with public providers'.

The minutes will be corrected to reflect this change.

The minutes were confirmed as a true and correct record with changes noted above.

1.2 Actions update

Action 8 - *Share ESR CDI report once finalised*
The report is still not finalised by ESR so not released.

Action 9 - *seek further information about review of NZ Standards Health and Disability Standard for IPC 8134.3:2008 within Ministry and feedback*
The standards were deemed suitable back in 2012 and therefore will not be changed anytime soon.

Action 10 - *highlight in the audit report DHBs that are auditing more areas*
This has been superseded by the work to consider development of an organisational measure.

Action 11 – *Share IPC programme plan on website*
To ensure consistency across the Health Quality & Safety Commission (the Commission), all quality improvement programmes will develop a project charter and programme plan. The project charter will be a public document published on the Commission's website.

2.1 Meta-analysis on interventions to reduce Gram-positive SSIs

Nikki Grae provided a summary of the results of the decolonisation and pre-operative screening survey that was sent to all DHBs in September 2016. The purpose of the survey was to gather a baseline about current decolonisation and screening practices across New Zealand. All 20 DHBs responded.

For orthopaedic surgery, six out of 20 DHBs pre-screen for MRSA and three for MSSA. Four DHBs have a nasal decolonisation protocol, and seven DHBs decolonise patients' skin prior to an orthopaedic procedure.

Of the five DHBs that perform cardiac surgery, one pre-screens for MRSA and two for MSSA. Three DHBs have a nasal decolonisation protocol and four DHBs decolonise patients' skin prior to a cardiac procedure.

All DHBs that screen use a culture method rather than polymerase chain reaction to screen for MSSA. The majority of DHBs that decolonise patients or have patients decolonise themselves do this twice per day for five days. Chlorhexidine is the only agent used for skin decolonisation and the use of chlorhexidine shower, wash or wipes is equally distributed among DHBs.

Arthur Morris led the discussion on the anti-staph bundle discussion paper. Members of the group were asked for their comments on each of the following questions contained in the discussion paper.

1. *Do you think there would be benefit in adding an anti-staphylococcal bundle to the existing interventions associated with the SSII programme?*

   Members agreed that there is strong evidence to support the bundle.

2. *Based on logistics and simplicity, we recommend universal decolonisation (decolonise all orthopaedic and cardiac surgical patients with topical nasal and skin agents). Do you agree?*

   The group agreed that the bundle is more likely to be adhered to if there is a consistent process to follow for all surgical patients. There is also a cost associated with screening and a chance that it won't be followed up. Universal decolonisation ensures that all surgical patients are treated.

3. *Based on potential resistance with mupirocin use, we recommend povidone-iodine for nasal decolonisation as our first choice. Do you agree?*

   The group noted that there is already one DHB using povidone-iodine for nasal decolonisation which is applied on the morning of operation.

4. *Based on logistics and simplicity, we recommend the chosen nasal preparation is administered twice the day before and once morning of surgery. Do you agree?*

   There was a question about whether a single dose is sufficient. The discussion paper proposes the use of a single dose however the frequency of application will be decided based on feedback from the consultation process.

5. *Based on logistics and simplicity, our first choice for skin decolonisation is chlorhexidine (wash or wipes) administered twice the day before and once the morning of surgery. Do you agree?*

There was discussion about a recent paper on chlorhexidine resistant staph aureus overseas. It is known to exist in New Zealand but this is based on unpublished research. The skin decolonisation would be applied at the same time as the nasal application.

6. *Based on the meta-analysis we recommend that any bundle should consist of <u>BOTH</u> nasal and skin components. Do you agree?*

   The group agreed that there should be two components to the bundle.

There was a question about whether the bundle should include antiseptic sutures. It was noted that the focus for the bundle is to be a pre-operative process that patients can undertake themselves. Antiseptic sutures were not covered in the meta-analysis report.

The group noted the importance of providing patients with clear instructions on how to apply the bundle and agreed that evaluating compliance would be sensible. Most DHBs do not currently collect compliance data. The challenge for the programme will be identifying a method of measuring compliance that provides useful reliable data that isn't time consuming to collect.

The discussion paper will be distributed in November to enable feedback to be received before end of the year. The group reviewed the stakeholder list for distributing the consultation paper and made some recommendations.

3.1 HHNZ update

Development of an organisational measure

Lynette Drew led the discussion on the hand hygiene organisational (structure) measure. The working group met on 14 October via teleconference and discussed options for a measure for the spread of hand hygiene improvement across each hospital.

The group has proposed a measure based on the percentage of all acute clinical areas covered through a year's auditing divided by the total acute clinical areas. The target would be 100 percent of the areas are audited during the period.

The following considerations have been taken into account and will be investigated to ensure that the measure is a viable option:

- Acute clinical areas and wards are clearly defined to ensure all DHBs use a consistent definition.
- A proposal to reduce the number of audit periods from three to two, but extend each period audit to six months. There will be guidance on how to ensure auditing is performed consistently throughout the audit period as opposed to an increase of auditing at the end of the period to meet the minimum number of moments required. This could include a requirement to submit a minimum number of moments every month.
- The proposed measure will be discussed with the regional IPC teams.
- The Commission's measurement and evaluation team will be consulted on the proposed organisational measure and change to the existing process measure.

The objective is that by increasing the number of areas audited, hand hygiene will become embedded into organisational culture and will be led by the wards rather than IPC staff.

The group discussed the proposed measure and queried the assumption that the responsibility of ensuring good hand hygiene practice across DHBs sits with the IPC team. It was noted that this is an opportunity to emphasise that ensuring good hand hygiene practice is the responsibility of senior leaders as opposed to an IPC burden.
There was a concern about the proposed six month audit periods and how this might affect commitment to hand hygiene practice. The group agreed in principal with the measure proposed.

An update and draft board paper will be provided at the SIPCAG meeting on 2 February 2017.

Validation of *Staphylococcus aureus* bacteraemia (SAB)

Nikki Grae provided an update on the SAB data validation process. A spreadsheet was developed to consider other parameters that could be collected and was successfully tested with one DHB. The parameters included date of first culture, MRSA or MSSA, and the source of SAB. The extra parameters would allow the programme to gather more information on the causal factors of SAB. A decision was made to put this process on hold as it was considered that validating the current data is more of a priority than collecting additional parameters at this time.

There is limited resource for an intensive validation process therefore it was decided that it would be preferable to focus on improving the consistency of SAB data by capability building in surveillance methods and the use of clinical scenarios to assess and build on current practice. The scenarios will be used to look at how SAB cases are being determined and to ensure a consistent approach nationally. Regular webinar meetings will be held with DHBs to discuss if particular SAB cases meet the definition. The group commented that the scenario training is a really good tool as long as it is well supported with a quality improvement approach.

Validation of the SAB denominator has been investigated with several DHBs that reported significant variation in bed days. The HH team concluded that along with regular checks by DHBs when they report SAB data, periodic reviews by the team will ensure there is no unwarranted variation.

Updates

HAIGG

Ashley Bloomfield provided an update on HAIGG. The group noted that the AMR strategy is likely to require a broader multi-sectoral governance group.

The next HAIGG meeting is scheduled for 30 November.

ACC investment in national roll out of ICNet

Bridget Goggin provided an update on ACC's investment into the national roll out of ICNET across all 20 DHBs. There was discussion around the timing of the rollout which is yet to be confirmed.

AMR Action group

Debbie Jowitt provided an update on the draft of the AMR plan, and is collecting feedback for a collated response to the Ministry of Health which is preparing a business case for the AMR implementation plan. The national AMR action plan will be completed by May 2017.

IPC Programme Plan 2017/18

Andrea Flynn provided an update on programme planning for 2017/18 financial year. This will be presented at the next SIPCAG meeting in February 2017. A programme charter will be developed that will be accessible from the Commission's website.

The Hand Hygiene programme will be running a pilot with a few selected private surgical hospitals that meet the programme's criteria in 2017.

A focus for the Surgical Site Infection Improvement programme in 2017 is to spread the programme and continue building capability.

Any other business

There was no general business.

The meeting closed at 5.05pm.

The next meeting will be held on 2 February 2017.

Action list following SIPCAG meeting 25 October 2016

No	Meeting date	Topic	Action required	By whom	By when	Status
1.	4 May 2016	HAIGG Update	Jane to share ESR CDI report once finalised.	Jane Pryer	August 2016	The report is still not finalised by ESR so not released.
2.	4 May 2016	IPC Programme Planning and Reporting	Jane to seek further information about review of NZ Standards Health and Disability Standard for IPC 8134.3:2008 within Ministry and feedback to the group Update from Jane: No new progress on the standards as yet other than myself and Carolyn Clissold will be meeting with HealthCert in September to look at current auditing against the NZS 8134.3.1 2008 NZ Standards and whether the audits are the tool to ask for better evidence against each standard (the standards themselves were deemed suitable back in 2012 and therefore will not be changed anytime soon).	Jane Pryer	August 2016	In progress.
3.	10 February 2016	IPC Programme Plan	Seek permission to share an edited version of the final IPC Programme Plan on the website.	Gabrielle	August 2016	In progress: A project charter will be available on the Commission website early 2017.