Minutes of the 20th meeting of the Strategic Infection Prevention & Control Advisory Group on 3 August 2017
9.35am – 2.35pm

Health Quality & Safety Commission New Zealand

Present: Ashley Bloomfield (Chair), Lorraine Rees, Josh Freeman, Mo Neville, Sheldon Ngatai, Sue Wood, Trevor English, Sally Roberts, Jo Stodart, Gillian Bohm, Nick Kendall, Richard Everts, Bridget Goggin and Jane Pryer

In attendance: Gary Tonkin, Andrea Flynn and Nikki Grae

Guest presenter: Natasha Murray, Ministry of Health

Apologies: Arthur Morris and Lynette Drew

The meeting commenced at 9.35am.

1. Declaration of interest

Members were given an opportunity to update the declaration of interest register. One change was noted by Trevor English. The register had been revised and circulated prior to the meeting.

2. Minutes of the previous meeting held 11 May 2017

The minutes were accepted as a true and correct record.

3. Antimicrobial resistance (AMR)

Jane Pryer introduced Natasha Murray, a Public Health physician at the Ministry of Health (the Ministry) and member of the AMR Action Group. Jane explained there had been a delay in releasing the AMR action plan. The action plan is expected to be released at the end of the week[1].

Natasha discussed the action plan, which is based on the situational analysis undertaken by the AMR action group.

The five objectives have been developed for a wide group of people. Each objective has a series of priority areas to action.

Objective 1: Awareness and understanding
Objective 2: Surveillance and research
Objective 3: Infection prevention and control
Objective 4: Antimicrobial stewardship
Objective 5: Governance, collaboration and investment.

The action plan is split into year 1 activities and year 2-5 activities with specific actions for human health, animal health and agriculture with some applying to all. Year one commences once the plan is released.

[1] Released 6 August 2017, http://www.health.govt.nz/publication/new-zealand-antimicrobial-resistance-action-plan

A report evaluating progress and success of activities in the action plan will be published at the end of the first, third and fifth years.

The focus for year one will be developing business cases and establishing governance arrangements. Specific areas of focus for IPC include updating the current MRSA guideline, reviewing the health and disability services infection prevention and control standards, developing a response plan for carbapenemase-producing Enterobacteriaceae (CPE) – linking to objective 2 surveillance and review how IPC is implemented in hospital, primary care and schools and identifying training needs.

Jane Pryer talked about how Objective 3 supports the Commission's existing work to reduce HAIs for example the surgical site infection programme, which has a specific AMR process measure and the hand hygiene New Zealand programme. There are plans to strengthen linkages with international patient safety networks and be more active with activities for World Antibiotic Awareness week[2].

The work scoped in year one will be implemented over years 2-5.

The group suggested the IPCNC conference as a forum to highlight the action plan, particularly around IPC. The conference is in Auckland from 15-18 October.

There was discussion about the timeframe to complete the review of the IPC standards as this will need to involve Standards New Zealand. Jane will take this question back to the Ministry's team developing the year 1 activities.

Consideration should be given to how AMR and HAI fit together. This needs to be determined to avoid silos and support collaboration.

There was also discussion about moving from a focus on IPC to reducing HAI, which would support the work to not be seen as a purely nurse-led activity. The implications of this, particularly on communications and how it fits in a primary care context, will need to be considered further.

There was also support for a national response for multidrug-resistant organisms and Josh felt a national response plan to CPE could be achieved in year one. CPE has a very high consequence threat and IPC plays a pivotal role in breaking transmission. Josh to circulate additional information to members relating to CPE.

There was support for discussions related to stewardship being cross sector. The group suggested having human health expertise on any animal and agricultural health governance group in addition to the co-chairs.

ICNet could be utilised to support community surveillance.

Clarification was sought on resources particularly around the 2018/19 commitments as this would tie into other organisations' planning and funding. The Ministry understands significant investment is needed and will work with other groups and agencies. Some of the work is already in existing plans. The Chair summarised the discussion: the Ministry is working to determine resourcing to support its implementation; and the work needs a 'controlling mind' and project management to support it; and that SIPCAG is enthusiastic about contributing to this work and open-minded about the potential role that it can play.

[2] 13-19 November 2017, http://www.who.int/campaigns/world-antibiotic-awareness-week/2017/event/en/

A question was raised about linkages with the Cornerstone accreditation for general practices. Communication with the Royal College of General Practice would need to be part of the plan.

Action: Further discussion on the IPC section of the action plan at the next meeting 9 November.

Action: Ashley to raise CPE in relation to the AMR action plan at the next interim governance group meeting.

4. Healthcare Associated Infections Governance Group (HAIGG)

Once the AMR governance is established a decision will be made about the future of HAIGG. In the interim period a subset of HAIGG including MoH, ACC HQSC and chair of SIPCAG will meet to discuss key issues as required. Stewart Jessamine will be sending out an invite to bring this group together.

Further discussion still needed about SIPCAG's role and function as part of these national governance arrangements. Any suggested change for SIPCAG would need to be tested with the HQSC Board.

Action: Discuss SIPCAG's role in supporting/advising on HAIs at the next meeting.

5. HHNZ – update

Nikki provided an update on the work of the HHNZ programme to promote spread of auditing and the revised HH manual which was published last week.

Since the last SIPCAG meeting there has been communication with IPC champions, Infection Control Committee chairs, DHB CEs, IPC nurse's college and ASID via NZ bug about the revised hand hygiene auditing manual. Changes to the manual were communicated through a series of webinars, which were well attended. The programme has developed a reporting framework for spread which looks at the proportion of high risk and standard risk areas audited each period that meet the required minimum moments based on hospital size. Members provided feedback on the reporting template. It was suggested the table incorporate compliance in addition to spread of auditing. The programme was asked to consider showing progression and improvement over time.

Action: Consider the feedback provided on demonstrating spread and bring a revised version to the next SIPCAG meeting for consideration.

System for validating gold auditor trainers (GATs)

Andrea provided an update on the work to consider a system for validating gold auditor trainers. This was discussed at the last SIPCAG meeting following concerns that there could be inconsistent approaches being taken to training gold auditors at individual DHBs because of the lack of a national approach to training GATs.

Hand Hygiene Australia provide a 2-day training workshop for their trainers and trainers complete the same validation activities as auditors. HHA provide up-to-date resources for trainers on their website accessed with a username and password. Further questions could be asked about the support and training for those delivering 'train the trainer' training.

DHBs have been contacted to provide details of their GATs and a link to a survey has since been sent to GATs asking about training received/provided and any current validation.

Themes from the initial responses (thirteen) were around the need for:

- information about who the other GATs are
- a training day
- updated resources

The HHNZ programme will consider the feedback to the survey and identify and prioritise actions relating to the themes and where necessary engage the HH working group.

Feedback from members supports a standardised approach to training GATs.

Action: HHNZ programme to identify and prioritise actions relating to each theme from the survey feedback.

6. Healthcare associated *Staphylococcus aureus* bacteraemia (HA SAB)

Nikki summarised the changes to HA SAB surveillance published in the new HA SAB implementation guide. The implementation guide is based on the Australian Commission on Safety and Quality in Health Care (ACSQHC) *Implementation Guide for the Surveillance of* Staphylococcus aureus *Bacteraemia.*

From April 2017 the Commission's Health Quality Intelligence team will calculate bed days for the SAB denominator using national minimum data set (NMDS) data with the appropriate exclusions applied. This will ensure the denominator definition is applied consistently across NZ. It is intended that the September 2017 quality and safety marker report will be the first report using the new calculation for the denominator. Analysis of the denominator data showed there is variation across DHBs with many DHBs under reporting the denominator. The under reporting is generally consistent so wouldn't affect any trends. Nationally, the variation is slight but some DHBs have a larger difference between the NMDS calculated denominator and DHB reported denominator. Each DHB will receive their data using the NMDS calculation back to 2012 to compare with DHB reported data.

Surveillance of HA SAB following surgical procedures involving surgical implants is extended from 30 to 90 days.

A series of webinars have been held to discuss the implementation guide which includes a number of scenarios to assist teams in testing their application of the definition.

A draft letter to IPC champions and Infection Control Committee Chairs was included in the meeting papers and members had the opportunity to provide feedback. The group suggested being stronger on the usefulness of HA SAB as an overall marker for IPC and using the data for quality improvement. Mo suggested linking in the IPC quality improvement facilitators course. A framework for using the data to drill down explaining why it is important and what can be done with it was suggested as something that would be useful.

The initial focus of the programme has been on validating the data but there is further opportunity to look at how it is used and this links to other areas e.g. PIV.

7. Peripheral intravenous (PIV) line management

PIV line insertion and management was discussed at the last SIPCAG meeting. A report outlining existing quality improvement initiatives to reduce harm and education was included in the meeting papers. Nikki presented a summary of the information gathered, which is a preliminary overview of existing guidelines, education/training and quality improvement activities. She also presented a review of a sample of SAB source data. Feedback was sought from the Intravenous Nursing NZ (IVNNZ) executive, University medical schools, DHB quality and risk managers and a sample of IPC nurses. There are no specific guidelines for PIV lines in the national IPC standards.

The IVNNZ holds an annual conference each year in March. Dr Vineet Chopra MMBS is the keynote speaker for the 2018 meeting. A nurse specialist/educator forum will be held the day before conference on Thursday 15th March. This forum is independent from the conference and separate registration is required.

Some hospitals use the New Zealand instance of the Lippincott procedures.

Aseptic non-touch technique (ANTT) is promoted internationally. While some DHBs use this technique, it is not standardised across NZ.

The One Million Global (OMG) peripheral intravenous catheters (PIVC) study was the largest study of its kind aimed to identify and compare the prevalence of PIVCs in hospital populations worldwide. Thirteen hospitals in New Zealand participated. Recommendations for NZ from the OMG study include:

- continue periodic PIVC audits
- consider updating the NZ guidelines to clinically indicate replacement
- more education on signs of phlebitis
- move education on IV documentation
- consider IV teams.

Seven DHBs provided information about PIV related quality improvement activities. An overview was provided.

SAB source data from five large DHBs show 55% of SAB cases are linked to intravascular devices, and 34% of those are linked to PIV lines.

The group's discussion noted that New Zealand doesn't currently have standardised best practice/guidance to form a basis for a quality improvement programme. Sally commented on a bundle used in one of the hospitals she visited in the UK to demonstrate competency. They have to demonstrate competency initially and then every three years.

There are linkages to trigger tools and adverse events and also ICNet through integrating patient track.

The group discussed what SIPCAG could do and suggestions included facilitating sharing resources between hospitals and other organisations, promoting use of aseptic non-touch technique, using the information collected to highlight prevalence and tell a compelling story, engaging in discussions with the IC committee chairs asking what do they see, what do they do, and who do you share this information with. There were also discussions about a PIV bundle.

Any improvement activities should adopt a patient centred approach focusing on the patient experience and there is opportunity to educate patients so they know what to ask.

Reference was made to the Choosing Wisely campaign because of the relevance of PIVCs.

Workforce development in terms of PIVC insertion and maintenance is an opportunity.

Where there is evidence, standardised protocols and bundles should be used. Where there isn't sufficient evidence, quality improvement methodologies should be used with the goal of reducing harm.

Some elements of PIV management would be more relevant to particular HCW/teams e.g. insertion - ambulance teams and consideration should be given to the naming of interventions so not to accidently exclude procedures.

The programme could look at options around three areas and consider the target groups.

1. Insertion - includes unnecessary insertion and poor insertion practice
2. Maintenance
3. Removal.

Action: Further define the problem related to PIV infections including potential scope and what could be done with current resources.

8. International perspective on IPC from national IPC clinical lead and specialist

Sally gave a presentation on her overseas experience visiting a number of centres in the UK including the Public Health England Centre for Infectious Diseases Surveillance, Imperial College NHS Trust, Public Health Wales, ICNet International and Health Protection Scotland.

She was particularly interested in learning about how HAI and AMR strategies align, operational structures and SSI surveillance.

Observations on what makes a good IPC service include:

- MDT with the right skill mix
  - Clinical expertise provided by nurse specialists and clinical microbiologists
  - Good surveillance systems
  - Ready access to 'Intelligence' (data)
  - Quality improvement skills
- Leadership roles clearly defined (Director of IPC) in organisational structure
  - Report directly to CMO or CEO
  - Set strategic direction
- Translational research.

Action: review the final slide of Sally's presentation against the AMR action plan at the next meeting.

Nikki shared highlights from the International Consortium for Prevention & Infection Control conference she attended 20-23 June in Geneva. She felt this was one of the most relevant IPC conferences she has attended. There was a big focus on AMR although numerous other IPC topics were discussed such as hand hygiene, HAI surveillance, point prevalence studies, surgical site infection prevention, new WHO guidelines, and automated data collection. Although the slides aren't available, the presentations are available to attendees as a videos.

Action: Nikki to circulate the conference programme to SIPCAG members for review. If members would like to view a particular presentation they can contact Nikki.

9. SSIIP – update

A quarterly update report was included in the meeting papers. This was taken as read.

The SSIIP draft interim evaluation report was sent to members on 1 August. Members have until Tuesday to provide feedback. Feedback to inform the final stage of the evaluation will be accepted after 1 August.

Nikki provided a progress update on the anti-staphylococcal bundle to reduce SSIs. Seven DHBs and two private surgical hospitals have been confirmed as participating. Initial

teleconference meetings have occurred between each hospital team and HQSC IPC senior advisor and/or quality improvement advisor to review the current anti-staphylococcal interventions related to orthopaedic and cardiac surgical patients and to answer any questions related to the collaborative methodology. The first learning session is on 17 August in Auckland.

11 ACC update

Update on ICNet roll out

Nick and Trevor provided an update on the ICNet roll out. A workshop was held in Canterbury yesterday (2 August) to inform the work plan. The work plan will be finalised by end of August.

Trevor discussed where DHBs are at in terms of readiness. Interfacing labs is 'in scope' and all of the labs in NZ have indicated commitment. The work plan will cover governance, standard definitions, data control, support arrangements and national pricing.

There was some discussion about how this work can support those in DHBs developing business cases for ICNet. There will be a national business case that can be tailored to meet the individual DHB's budget prioritisation process. Individual support is available via Jim and Trevor to work with the DHB to further develop/refine the content.

There are opportunities for ICNet to support the national AMR action plan through an ICNet add-on module and interface with eMeds.

It was suggested ACC engage infectious diseases and public health specialists particularly around use of ICNet in the community. John Ferguson from Hunter Valley in NSW is an example of a hospital that has spread into aged care.

To get the most out of the ICNet system DHBs need to interface their systems. This should be considered during the business case development to maximise outcomes.

Action: Ashley and ACC to raise ICNet as an opportunity for AMR surveillance through interfacing e-meds at the interim governance meeting noted earlier.

Action: ACC to provide HQSC a quarterly update report on the ICNet rollout.

The next report *Supporting patient safety: Treatment injury information* is expected to be published in October 2017. This report is updated 6-monthly. A digital solution will be available from March 2018.

Bridget provided an update on the infections reference group that ACC has convened. The group includes representation from across the sector and is a reference group that provides advice on ACC's spending in relation to infections. The group first met on 1 June and is due to meet again early in November 2017.

12 Any other business

The meeting closed at 2.30 pm.

The next SIPCAG meeting will be on 9 November 2017.

Action list following SIPCAG meeting 4 August 2017

No	Meeting date	Topic	Action required	By whom	By when	Status
1.	3 August 2017	AMR	Further discussion on the IPC section of the AMR action plan at the next meeting 9 November.	Jane	9 November	Complete – tabled for discussion.
2.	3 August 2017	AMR	Ashley to raise CPE in relation to the AMR action plan at the next interim governance group meeting.	Ashley	At next meeting	
3.	3 August 2017	HAIGG	Discuss SIPCAG's role in supporting/advising on HAIs at the next meeting.	Jane	9 November	
4.	3 August 2017	HHNZ - spread	Consider the feedback provided on demonstrating spread and bring a revised version to the next SIPCAG meeting for consideration.	IPC team	9 November	Complete – tabled for discussion.
5.	3 August 2017	HHNZ - GAT	HHNZ programme to identify and prioritise actions relating to each theme from the survey feedback.	IPC team	9 November	In progress
6.	3 August 2017	PIV	Further define the problem related to PIV infections including potential scope and what could be done with current resources.	IPC team	9 November	Complete – tabled for discussion.
7.	3 August 2017	International perspective on IPC	Review the final slide of Sally's presentation against the AMR action plan at the next meeting.	Ashley	9 November	
8.	3 August 2017	International perspective on IPC	Circulate the International Consortium for Prevention & Infection Control conference programme to SIPCAG members for review. If members would like to view a particular presentation they can contact Nikki.	Nikki	18 September	Complete

No	Meeting date	Topic	Action required	By whom	By when	Status
9.	3 August 2017	ICNet roll out	Ashley and ACC to raise ICNet as an opportunity for AMR surveillance through interfacing e-meds at the interim governance meeting noted earlier.	Ashley	At next meeting	
10.	3 August 2017	ICNet roll out	Provide HQSC a quarterly update report on the ICNet rollout.	ACC	1 November	