Minutes of the 27th meeting of the Strategic Infection Prevention & Control Advisory Group on 28 July 2020
1pm-3pm, via Zoom

Present:	Arthur Morris (Late), Claire Doyle, Claire Underwood, Gillian Bohm, Greg Simmons (Chair), Jocelyn Peach, Jo Stodart, John Robson, Josh Freeman (Late), Max Bloomfield, Sally Roberts, Sheldon Ngatai, Sue Wood, Tanya Jackways
In attendance:	Gary Tonkin, Nikki Grae, Andrea Flynn, Ashvindev Singh, Marie Talbot (minute taker)
Apologies:	Andi Shirtcliffe

The meeting began at 1pm. Greg Simmons opened the meeting with a Karakia.

1. Minutes of the previous meeting held 20 August 2019

The minutes were accepted as a true and correct record. The action log was reviewed.

Matters arising:
Review hand hygiene (HH) compliance data to look for differences between District Health Boards (DHBs), the number of HH moments collected and infection rates – update to be given at the next SIPCAG meeting– IPC Team

2. SIPCAG members and attendees - introductions

Each person at the meeting gave a brief description about their work and their interest in SIPCAG.

3. Overview of the 2020/21 Healthcare Associated Infection (HAI) programme – background and future focus

Gary Tonkin talked to this paper and gave some background regarding:

- the progression of the HAI programme at HQSC
- an increase in DHB funding from July 2019 which has meant that the team has been able to increase capability with the addition of a quality improvement advisor and a data analyst
- priorities over the coming year

Key projects:

- **Learning from COVID-19** – encompassing a cross sector approach, including community and tertiary care, the IPC team is working to explore the scope to further support the sector and plan future work based on learnings from the past several months. The aim is to understand what has worked well and what the gaps have been in relation to knowledge learning and resources. Surveys of key IPC groups in hospitals and aged residential care (ARC) sectors, and a stocktake of assessments and reviews gathered by the sector, are underway. A multi-agency collaboration to ensure coordination of this work is essential.

- **Healthcare associated infections (HAI) platform** – planning to build a platform that will be one stop shop for IPC resources, guidelines, tools, templates and data. New Zealand does not have a Centre for Disease Control and prevention (CDC) or similar available for the IPC sector and other interested stakeholders.

  Discussions are underway to form a national multi-disciplinary governance group to assist with the multi-agency approach to all IPC programmes.

  Sally Roberts shared that the MOH is planning to create a central agency or resource centre for IPC guidance in response to the lack of central IPC leadership in NZ to date. Also, work is underway to initiate an IPC reset for primary care and support the sector to run their own IPC risk assessments.

- **National point prevalence survey (PPS)** - Currently we don't know the overall burden of healthcare associated infections in NZ. A previous PPS was completed in the 1990's at Auckland DHB and since then health has changed significantly. Overseas, where PPS's have been completed, valuable information has been gained on the rate of infection (10% in Australian and Singapore studies) and where interventions should be targeted.

  The IPC team has embarked on a PPS across all DHBs and voluntary private surgical hospitals (PSHs) to estimate the burden of infection in NZ to better inform our ongoing work. Currently this project is between the planning and pilot implementation phases. The software system being used for this is REDCap. The survey questions are taken from ECDC PPS and we have been able to utilise and modify the electronic survey built in REDCap for use in Australia and Singapore.

  Information will be collected in an identifiable form and then deidentified before data analysis occurs. The methodology to be used has been adapted from those used in Australian and Singapore. A Privacy Impact Assessment (PIA) is being reviewed internally and will then go to the northern regional Privacy Impact Assessment Committee for approval. A Health and Disability Ethics Committee, out of scope, application will be submitted requesting a letter stating that the PPS is out of scope for requiring ethical approval. This will reduce the risk of roadblocks occurring in each DHB and PSH.

  Research assistants/nurses to conduct the PPS throughout NZ will be engaged to assist with data collection. Training resources on data collection and application of infection definitions have been developed.

  Guidance was sought, from SIPCAG members, on
  - the option of either hiring research assistants to complete the PPS nationwide or to use inhouse Research Nurses with HQSC team support. Comment was made that sending in a HQSC team member to support inhouse Research Nurses would be a good approach.
  - potential buy-in to the PPS from DHBs. It was suggested that buy-in should be high and it was recommended that HQSC present to the Chief Medical Officers (COMs), Chief Operating Officers (COOs) and Directors of Nursing (DONs) national groups to assist with full buy-in.

  Next steps are to complete the pre pilot at Auckland DHB to test the data collection process followed by a full pilot (small, medium and large DHB and one PSH) to validate the data collection tool (REDCap), methodology, hardware requirements, establish how

data is recorded in different DHBs and estimate timing to collect data for each patient. A steering group will be established to oversee the PPS.

- **Surgical site infection (SSI) improvement** – This programme started in 2013 with a focus on orthopaedic hip and knee replacements and was extended to cardiac surgery two years later. The programme has driven changes in practice in giving an appropriate antibiotic prophylaxis dose on time and the use of an alcohol skin prep prior to the skin being incised. Compliance with these measures has increased significantly from 40% initially to between 90-95 percent. Correlated with this there has been a drop in SSI rates of approx. 20–25 percent. Further work was undertaken to look at the types of organisms that were causing infections with 40% being caused by Staphylococcus. An anti-staph intervention bundle has now been implemented by one cohort group including DHBs and PSHs and is underway with a second cohort group (5 DHBs and 5 PSHs) with the potential that SSIs will be reduced by another 20%. Four of the DHBs are paired with a PSH in the same town which makes sure we have collaboration and increased standardisation of the products and number of applications for the products.

  Currently DHBs collect a full suite of information on every orthopaedic and cardiac procedure. Data collection can be reduced by moving to 'light surveillance' for orthopaedic surgery which involves recording minimal information for the denominator (number of procedures) and undertaking full data collection for the numerator (procedures for which there is an SSI). This will free up time spent on manual data collection to complete recommended root cause analysis, or deep dive analysis, on all deep and organ-space SSIs to identify potential factors contributing to the SSIs. DHBs have been offered the option of moving to light surveillance for orthopaedic surgery with 11 DHBs transitioning to this and 6 DHBs choosing to remain with full surveillance. Three DHBs have yet to indicate their decision on this. Over the next few months, a working group will be convened to work on a root cause analysis / deep dive tool to ensure it is a standardised, relevant and useful tool for the sector.

  An article has been published in the American Journal of Health-System Pharmacy in relation to the dosing of antibiotics showing that people that weigh more than a certain weight should have 2 or 3 grams of antibiotic, applicable to all surgical procedures. A manuscript has been submitted in relation to the timing of surgical prophylaxis which, once published, will indicate that we can recommend that prophylaxis is given some time before incision as opposed to just before incision. This will reduce the SSI rate and is applicable to all clean surgery.

  The output of the IPC programme has been recognised internationally, one of a few programmes with a quality improvement component. Commentary on a published paper regarding the length of surgical antimicrobial prophylaxis has been written. This commentary was requested and published by Lancet Infectious Disease Journal. Comment was made that it would be good to communicate this through to national stakeholders via a range of pathways.

- **Hand Hygiene programme** – This is a long-standing programme and the IPC team will continue to work with DHBs as well as focusing on the implementation of the programme across PSHs and providing them with ongoing support. A voluntary DHB and PSH working group will be formed to identify quality improvement activities eg focusing on hand hygiene methodology for operating theatres and to look at patient / whānau engagement in hand hygiene.

Ongoing work will continue to strengthen auditing and the annual validation of auditors. Also, an electronic hand hygiene dashboard will be created and published, which will replace the current reports. This will allow users of the dashboard to fully analyse and filter the data. Long term the programme would like to dive deeper into our *Staphylococcus aureus* bacteraemia source in terms of linkages to types of lines or other devices / procedures or medical care related to those infections. Healthcare associated *Staphylococcus aureus* bacteraemia is the hand hygiene outcome measure.

Comment was made in relation to consumer engagement, that it would be good to highlight creating an environment where consumers can act as the eyes and ears in relation to auditing, using consumers' experiences to identify where protocols have not been followed correctly. Presently it is very difficult for consumers to speak up when these situations occur. There should be an environment where it is possible for the patient to halt proceedings and question what the correct protocols are, that should be being followed. This might cross over with the 'speaking up for safety' or 'Kōrero mai' programmes but it would be good to tighten the controls around this as part of the audits. Further comment was made in relation to the lack of facilities in hospitals for patients to maintain good hand hygiene, which needs to be addressed.

4. New areas of work - aged residential care -

The IPC senior advisor is working with the Aged Residential Care (ARC) Programme team to reduce the inappropriate use of antibiotics and incidents of urinary tract infections within the aged residential care setting. This aligns with the revised Health and Disability Services IPC Standards which will be published in 2021, ties in with antimicrobial resistance work, supports stronger relationships with DHB and ARC networks and will identify any Māori health equity issues and opportunities for improvement. There is also a health literacy component and the project will be one of the main ARC programme focus areas for the next year.

5. Any other business

The next SIPCAG meeting is planned for late September 2020, comms to go out re selection of a suitable date.

Action list following SIPCAG meeting 28 July 2020

Item No. Action No.	Meeting date	Topic	Action required	By whom	By when	Status
1	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
2	20 August 2019	Hand Hygiene (HH) change to audit periods	Look at the difference between DHB's, the number of HH moments collected, and if there are differences in infection rates.	IPC team	June 2020	Completed and on SIPCAG agenda
3	28 July 2020	PPS	Present to the Chief Medical Officers (CMOs), Chief Operating Officers (COOs) and Directors of Nursing (DONs) national groups to assist with full buy-in.	IPC team	December 2020	