Practice Nurse IPC Forum

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Agenda

- Feedback from IPC forum survey & plans forward
- Clostridium Difficile and MRSA Bloodstream Infections - Post infection reviews: why they are important and how Primary Care fits into the bigger picture
- Measles – what you need to know from an IPC perspective
- Leg Ulcer infection – antimicrobial prescribing – NICE guidance

Primary Care IPC Forum Survey Results & Plans

- Display Survey (send copy out with p point)

You said….we listened

Advance notice of Forum dates
Practical advice of dissemination of information to all staff- to continue

All IPC Forum dates published via Surrey Training hub for this year

Small local face to face forums to allow discussion and practical solutions – F2F session

Erika will come out to your Practice / PCN & do short CQC ICP prep teaching sessions with any staff on request

Help with standardising IPC across practices especially in light of the standards of cleanliness

Standard PC cleaning standards toolkit has been drafted – chasing National team for launch

Bookings for all IPC Forum dates for this year

- These have now been added to Eventbrite and also added to the Surrey Training Hub website. It is on a page that is linked under the “Training Courses” page - link below
- Please use access code **SHL0019**
- Infection Prevention Control Forum : Surrey Training Hub

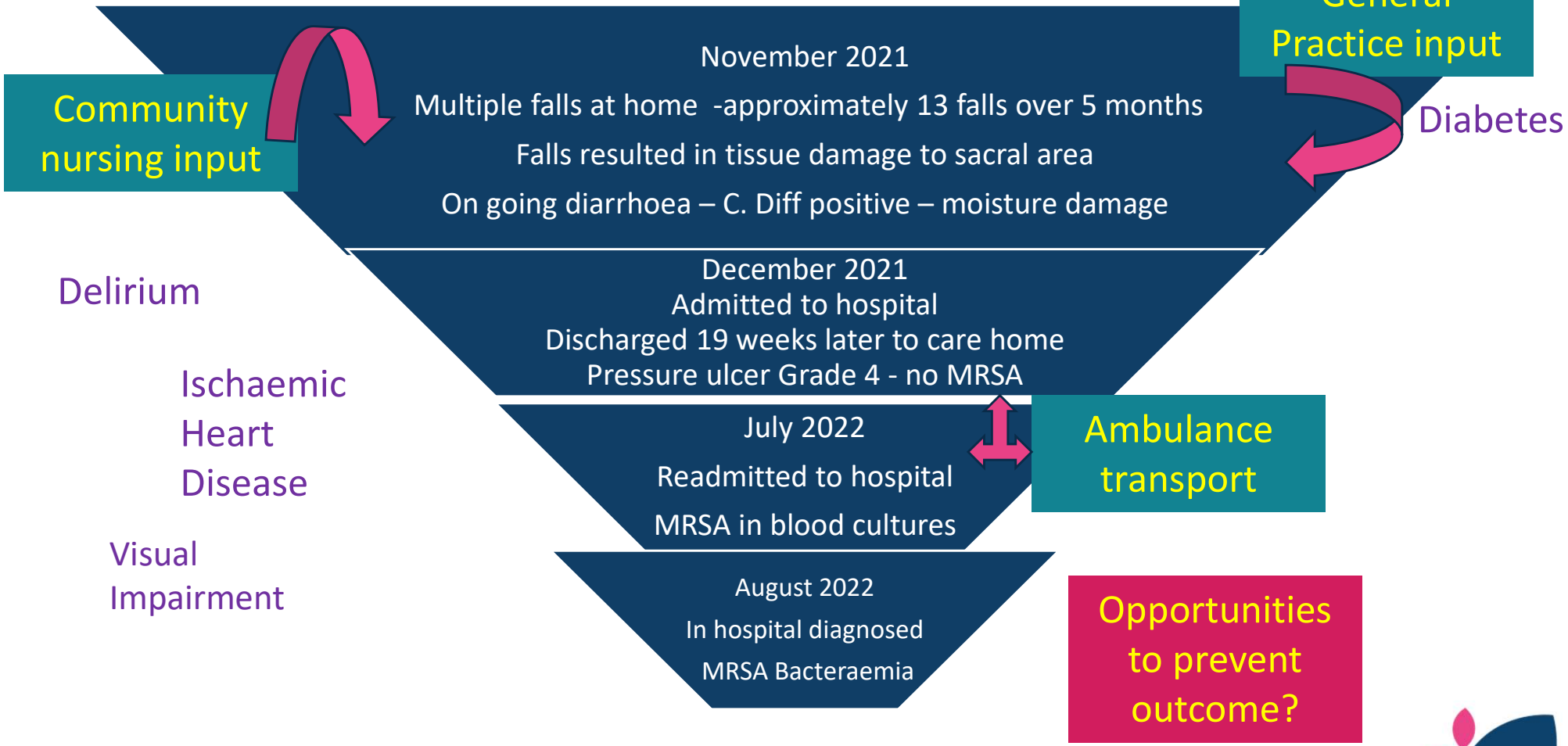
- NG152 Leg ulcer infection: antimicrobial prescribing visual summary (nice.org.uk)

MRSA Bacteraemia Post Infection Reviews

What are they?

- MRSA Bloodstream Infections - Bacteraemia is an invasion of the bloodstream by bacteria. Bacteraemia occurs when bacteria enter the bloodstream. This may occur through a wound or infection, or through a surgical procedure or injection. Bacteraemia may cause no symptoms and resolve without treatment, or it may produce fever and other symptoms of infection
- They infections can be prevented and nationally there is a zero-tolerance threshold.
- This is because MRSA BSIs are associated with increased risk of mortality and are therefore deemed as avoidable harm in all Health and Care settings. The ICB has a responsibility to hold post infection reviews for community acquired MRSA BSI.
- This year we have 9 community associated MRSA Bacteraemia's in Surrey already
- Post Infection Reviews aim to applying test of effectiveness learning into clinical practice, to reduce the risk of MRSA BSIs occurring & improve patient outcomes.
- This learning opportunity relies on strong partnership working by all organisations involved in the patient's care pathway, to jointly identify and agree the possible causes of, or factors that contributed to, the patient's MRSA BSI.

A Surrey Patient journey – Mr M



Learning themes from MRSAb so far

- Importance of good diabetes management
- Frail elderly male with multiple co-morbidities risk factor
- Poor mobility/history of falls
- The importance of wound management
- VAC therapy in the community
- Lack of communication between all services including referral processes, discharge summaries, documentation, telephone assessments instead of face to face

Clostridium Difficle Post Infection Reviews

- Clostridum Difficile (C. difficile) infection is associated with an increased risk of mortality . Nationally there are targets to reduce these infections.

C.difficile can cause disease when the normal bacteria in the gut are compromised, usually by someone taking antibiotics, allowing the C.difficile to grow to high levels.

The toxin that some strains of C.difficile produce can reach levels where it affects the intestines and causes mild to severe diarrhoea. C.difficile can lead to serious infections of the intestines with severe inflammation of the bowel (pseudomembranous colitis)

- Same process as MRSA BSI reviews

- We need you – to support with EMIS information and contribute to our post infection reviews – great learning and CPD opportunity!

Clostridium Difficle Post Infection Reviews

- 1st October 2022 – 3rd March 2023 35 reported cases community acquired / associated

- Findings from reviews so far:
- 17 of the 30 reviewed were patients over 70 years of age
- 18 of the 30 reviewed were female
- 12 of the 30 reviewed were male
- 5 of the 30 reviewed have leg ulcers/leg wounds/cellulitis
- 6 of the 30 reviewed have UTIs
- 11 of the 30 reviewed have UTIS or Leg wounds/cellulitis/ulcers
- 2 of the 30 reviewed have both UTI and leg wound/cellulitis/ulcers

MRSA Bacteraemia / Clostridium Difficle Post Infection Reviews continued

How might you be involved?

- Before the meeting the PM / GP will be contacted by Kate Gorman from the ICS Patient Safety Team, and she will require some background details from the GP Practice to be submitted via the Post Infection Review form This will aid the completion of the timeline and to see what other partners we need to involved in the review – you might be asked to provide some input from a nursing perspective – e.g. wound / diabetes care
- Once all of the information is gathered from all of the organisations involved in the patient's care then a meeting with everyone is arranged (via MS teams) by the ICS Patient Safety team.
- System partners meet to discuss the patients care pathway in the 3 months leading up to the MRSA BSI / C. diff occurring.
- All aspects of care, comorbidities and risk factors are discussed to establish, (where possible), the cause or contributing factors and identify learning across the health & social care system
- Action points are then agreed and ways in which these can be collaboratively achieved
- Contact Kategorman@nhs.net for more information

Measles – what you need to know in Primary Care

- Measles is now circulating in England and the World Health Organisation (WHO) has warned that Europe is likely to see an increase of infections and is urging action to increase vaccination rates

- Coverage for the MMR vaccination programme in the UK has fallen to the lowest level in a decade.

- Uptake for the first dose of the MMR vaccine in 2-year-olds in England is currently 89%, and uptake of two MMR doses at age 5 years is 85.5%, well below the 95% target set by the World Health Organization (WHO) which is necessary to achieve and maintain elimination.

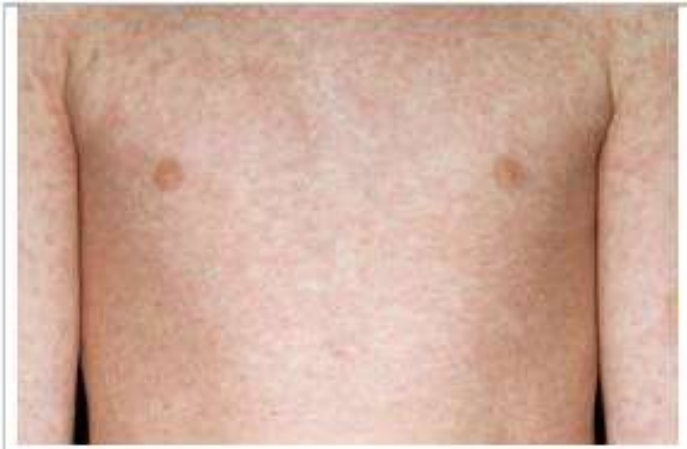
What can you do as a Practice?

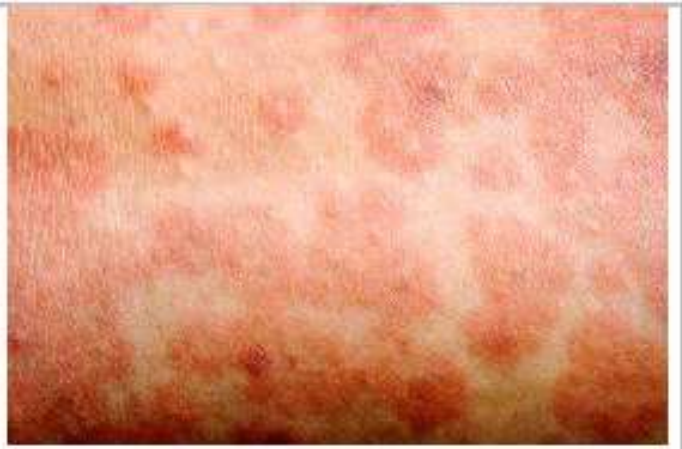
- Ensure all of the Practice staff are immunised https://www.gov.uk/government/publications/immunisation-of-healthcare-and-laboratory-staff-the-green-book-chapter-12
- Promote MMR to your patients – GRT Lead to support this community
- Ensure patients with a fever and rash illness are isolated on arrival
- Notify the Health Protection Team of suspected measles cases and include their MMR vaccination history – do you know how to contact?
- https://www.gov.uk/guidance/contacts-phe-health-protection-teams#surrey-and-sussex-hpt-south-east
- You may need to undertake contact tracing for measles exposures in your setting, this can include excluding unvaccinated health care workers

- **Managing suspected cases: ISOLATE patients presenting with a rash and fever.**
- Signs should be placed in waiting areas advising patients with a rash to report to reception so that they can be isolated and reduce the spread of infection.
- Measles outbreak resources - GOV.UK (www.gov.uk)

- Measles period of infectiousness generally starts from about 4 days before the rash and lasts up to 4 days after the onset of the rash. Patients with suspected measles should be advised to stay off nursery, school or work for at least 4 days from when the rash first appears.
- Receptionists should be made aware that any patients with fever and a rash, or who are unwell and have an epidemiological link to a confirmed case of measles, are potentially infectious and should attend at the end of surgery to minimise the risk of transmission.
- When a GP refers a suspected measles case to A&E/hospital they should inform the hospital staff ahead of time, so that the case can be appropriately isolated on arrival.

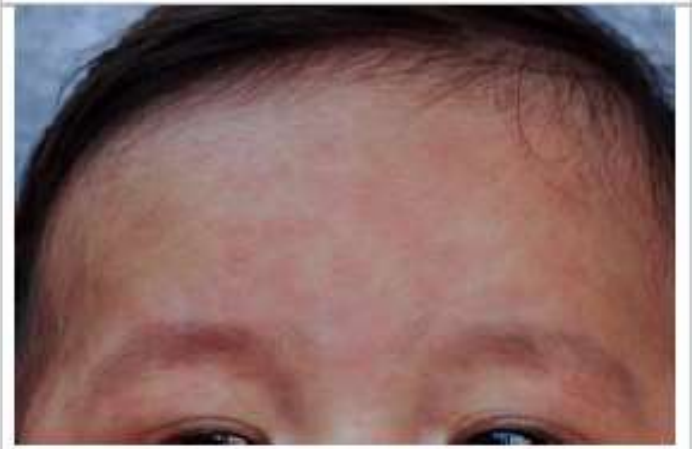
- **Be alert for cases:** Measles - NHS (www.nhs.uk) – do you know what the signs are? Have your staff had a refresher?

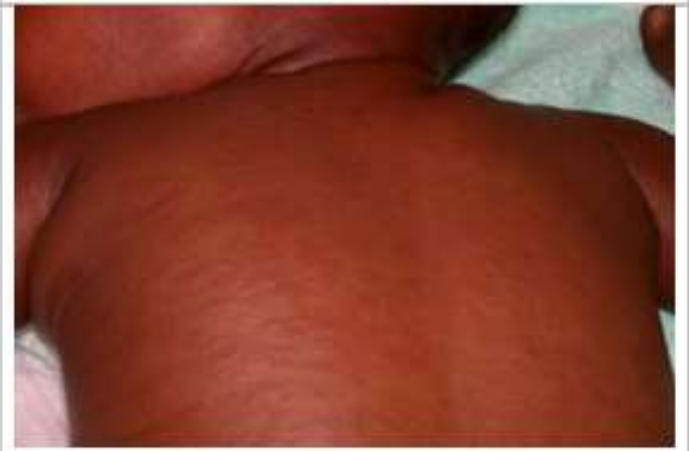




The rash starts on the face and behind the ears before spreading to the rest of the body.

The spots of the measles rash are sometimes raised and join to form blotchy patches. They are not usually itchy.

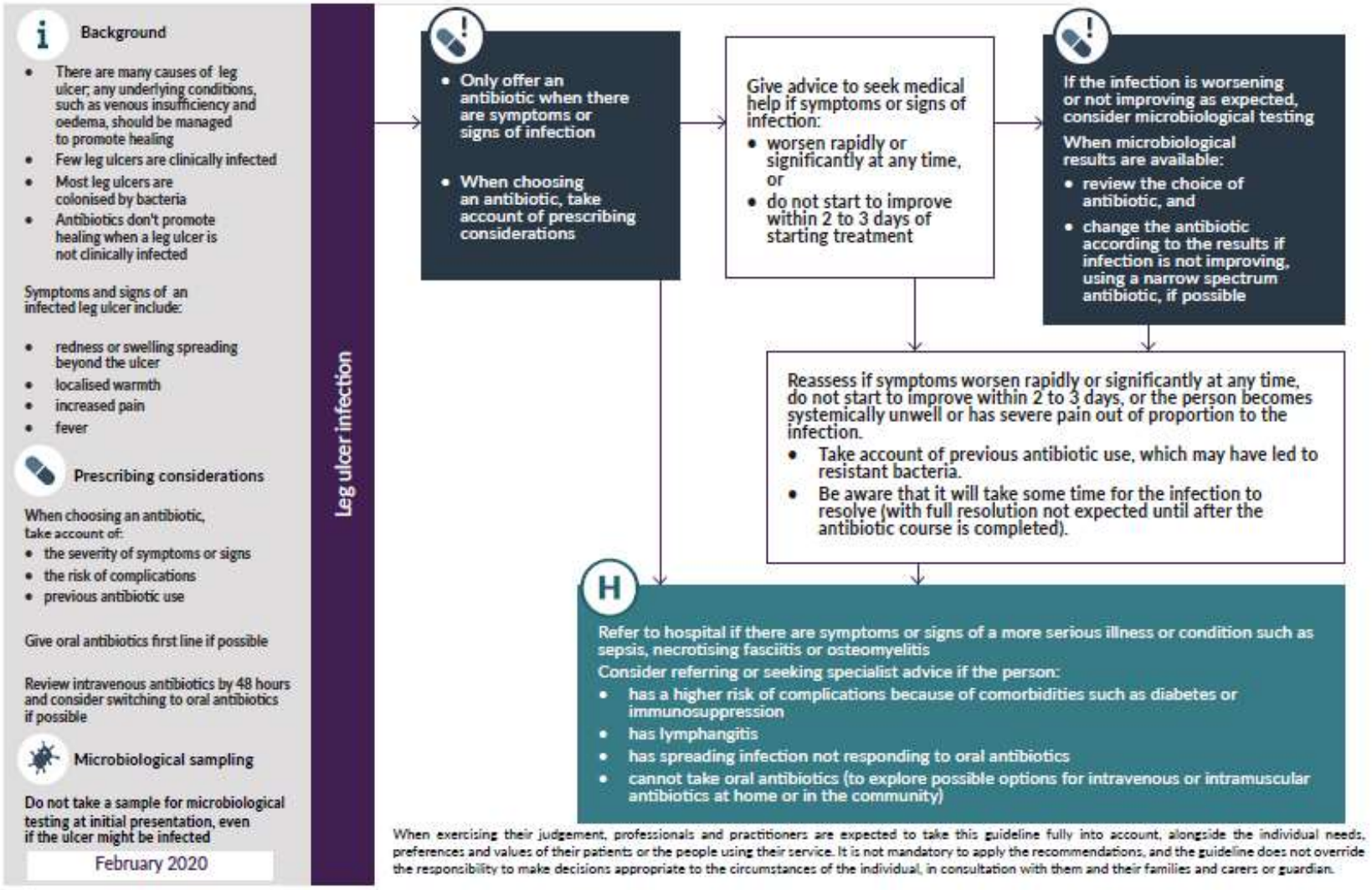




The rash looks brown or red on white skin. It may be harder to see on brown and black skin.
Images: https://dftbskindeep.com/all-diagnoses/measles/ https://www.nhs.uk/conditions/measles/

Leg ulcer infection: antimicrobial prescribing

NICE National Institute for Health and Care Excellence



When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Leg ulcer infection: antimicrobial prescribing

Choice of antibiotic: adults aged 18 years and over

NICE National Institute for Health and Care Excellence

Antibiotic[1]	Dosage and course length
First-choice oral antibiotic	
Flucloxacillin	500 mg to 1 g[2,3] four times a day for 7 days
Alternative first-choice oral antibiotics for penicillin allergy or if flucloxacillin unsuitable	
Doxycycline	200 mg on first day, then 100 mg once a day (can be increased to 200 mg daily) for 7 days in total
Clarithromycin	500 mg twice a day for 7 days
Erythromycin (in pregnancy)[4]	500 mg four times a day for 7 days
Second-choice oral antibiotics (guided by microbiological results when available)	
Co-amoxiclav	500/125 mg three times a day for 7 days
Co-trimoxazole[3,5,6] (in penicillin allergy)	960 mg twice a day for 7 days
First-choice antibiotics if severely unwell (guided by microbiological results if available)[7]	
Flucloxacillin ***with or without***	1 g to 2 g four times a day IV
Gentamicin[6,8] ***and/or***	Initially 5 mg/kg to 7 mg/kg once daily IV, subsequent doses if required adjusted according to serum gentamicin concentration
Metronidazole	400 mg three times a day orally or 500 mg three times a day IV
Co-amoxiclav ***with or without***	1.2 g three times a day IV
Gentamicin[6,8]	Initially 5 mg/kg to 7 mg/kg once daily IV, subsequent doses if required adjusted according to serum gentamicin concentration
Co-trimoxazole[3,5,6] (in penicillin allergy) ***with or without***	960 mg twice a day IV (increased to 1.44 g twice a day in severe infection)
Gentamicin[6,8] ***and/or***	Initially 5 mg/kg to 7 mg/kg once daily IV, subsequent doses if required adjusted according to serum gentamicin concentration
Metronidazole	400 mg three times a day orally or 500 mg three times a day IV
Second-choice antibiotics if severely unwell (guided by microbiological results when available or following specialist advice)[7]	
Piperacillin with tazobactam	4.5 g three times a day IV (increased to 4.5 g four times a day if severe infection)
Ceftriaxone ***with or without***	2 g once a day IV
Metronidazole	400 mg three times a day orally or 500 mg three times a day IV
Antibiotics to be added if MRSA infection is suspected or confirmed (combination therapy with antibiotics listed above)[7]	
Vancomycin[6,8]	15 mg/kg to 20 mg/kg two or three times a day IV (maximum 2 g per dose), adjusted according to serum vancomycin concentration
Teicoplanin[6,8]	Initially 6 mg/kg every 12 hours for three doses, then 6 mg/kg once a day IV
Linezolid (if vancomycin or teicoplanin cannot be used; specialist advice only)[8]	600 mg twice a day orally or IV

[1]See BNF for appropriate use and dosing in hepatic impairment, renal impairment, pregnancy and breastfeeding, and administering intravenous (or, where appropriate, intramuscular) antibiotics.
[2]The upper dose of 1 g four times a day would be off-label.
[3]The prescriber should follow relevant professional guidance, taking full responsibility for the decision, and obtaining and documenting informed consent. See the GMC's Good practice in prescribing and managing medicines and devices for more information.
[4]Erythromycin is preferred if a macrolide is needed in pregnancy, for example, if there is true penicillin allergy and the benefits of antibiotic treatment outweigh the harms. See the Medicines and Healthcare products Regulatory Agency (MHRA) Public Assessment Report on the safety of macrolide antibiotics in pregnancy.
[5]Not licensed for leg ulcer infection so use would be off-label. [6]See BNF for information on monitoring of patient parameters.
[7]Review intravenous antibiotics by 48 hours and consider switching to oral antibiotics if possible. [8]See BNF for information on therapeutic drug monitoring.

Topics for next Forum?

- Please send suggestions to:

syheartlandsicb.shipc@nhs.net

Thankyou for your continued support to achieve continuous IPC improvements within the Primary Care setting

Patient Promotion

- Prioritise vaccines: Ensure you have a clinical and admin immunisation lead who work together to support the team to improve uptake. Make sure practice staff feel confident about vaccines to be able to support your patients in making informed choices (see below for resources).
- Make every contact count (MECC): Admin and clinical staff can opportunistically check when patients are visiting for other reasons if they are up to date. Details about the routine schedule are here:
- https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule and details about catching up those with incomplete or uncertain vaccination status are here: https://www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status
- Invites and reminders: Ensure that everyone is invited in good time for their vaccines and follow up those that do not attend. Remember that Child Health Information Services (CHIS) send out monthly invite letters and there is good evidence to support call/recall interventions.
- Appointments: Ensuring vaccination appointments are available, timely and flexible makes them more accessible for patients.
- Speaking with patients: Consider a call back system where a trusted professional could call parents/carers/patients who are unsure.
- New registrations: Ensure robust processes are in place to obtain immunisation histories, review and offer catchup immunisations.

- Evidence suggests that NHS leaflets are among the most trusted sources of information. Consider the need for translated leaflets as well which are available from UKHSA and WHO. Update your practice website, PPG, Patient TV & waiting room with leaflets and links to vaccine information.

- **Resources**
- • Flyer for use in primary and secondary care which addresses common questions about MMR, with an English version available to order https://www.gov.uk/government/publications/measles-dont-let-your-child-catch-it-flyer-for-schools
- Download versions in Arabic, Afrikaans, Bengali, Chinese, Cantonese, French, Hindi, Hebrew, German, Italian, Lithuanian, Polish, Portuguese, Romani, Romanian, Swahili, Tagalog, Tamil, Turkish, Urdu, Ukrainian and Yiddish.
- • MMR leaflet with more detail on the infections covered by MMR available to order in English, Bengali, Polish, Romanian, Somali, Ukrainian and Yoruba
- Measles leaflet for young people

https://www.gov.uk/government/publications/think-measles-poster-about-measles-in-young-people

- Measles outbreak poster for primary and secondary care including outbreak poster and leaflet and poster for GP reception areas
- Immunisation - GOV.UK (www.gov.uk)
- Routine childhood immunisation resources are available here: https://www.gov.uk/government/collections/immunisation#immunisation-leaflets-and-guidance-for-parents and supporting videos here: https://www.healthpublications.gov.uk/ArticleSearch.html?sp=Sreset&keyword=IMMS
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- Search Publications - Health Publications

Notification of suspected measles cases

- Registered medical practitioners should notify all suspected measles cases ideally by phone as soon as possible to the local Health Protection Team (HPT), so that timely public health management can be undertaken. Currently other viral rash illnesses are much more common than measles particularly in children but when measles is suspected you do not need to wait for laboratory confirmation before notification, and please include MMR vaccination history on the notification, as this will assist with prioritising case and contact management (i.e., unvaccinated individuals would be more likely to be a case compared to those with a history of 2x MMR).
- Clinicians should telephone the **South East HPT**; In hours (9am-5pm) 0344 225 3861 or Out of Hours
- • Surrey Sussex 0844 967 0069

Laboratory testing

- Appropriate testing can be discussed with HPT on notification. In some cases where rapid confirmation of the clinical diagnosis is required (e.g. suspected cases where vulnerable contacts have been exposed), the HPT will assist in the assessment and help to arrange testing.
- The HPT routinely sends out oral fluid kits to all suspected cases of measles, these are for the surveillance of measles in England and take up to two weeks to process.

IF A MEASLES CASE PRESENTS AT ANY HEALTHCARE SETTING, THEN THE FOLLOWING CONTACT TRACING ACTIONS ARE THE RESPONSIBILITY OF THAT ORGANISATION:

Contact tracing and warning & informing

- Where suspected cases of measles have not been appropriately isolated then the healthcare establishment is responsible for doing a look back and following up patients who have been exposed in the waiting area. The HPT can provide guidance on assessing the exposure of patients, with particular attention to identifying and managing immunosuppressed and vulnerable contacts (e.g., pregnant women, infants) to determine if they should be offered Post-Exposure Prophylaxis with immunoglobulin or MMR. The HPT can also provide a warn and inform letter template which can be used by the healthcare setting to send to exposed patients and staff.
- **Healthcare worker exclusion from work** Of note health care workers who are exposed to a confirmed or likely case and do not have satisfactory evidence of protection (2 documented doses of MMR or a positive measles IgG blood test) may be excluded from work from the 5th day after the first exposure to 21 days after the final exposure.