

Healthcare Associated Infections Governance Group (HAIGG)

Date: Wednesday 17 December 2014

Venue: Wellington Airport Conference Centre, (De Havilland Room) Wellington

Time: 09.00 – 15.00

Present: Sally Roberts, Arthur Morris, Deborah Williamson, Bob Buckham, Ruth Barratt, Sheldon Ngatai, Geoffrey Roche, Jane Pryer, Don Mackie & Jane O'Malley (Co-chairs), Gabrielle Nicholson Grant Pidgeon.

Invited: Catherine Gerard (HQSC) Grant Storey (MoH), Murray Tilyard (BPAC)

Apologies: Hasan Bhally, Chris McKenna, Noeline Whitehead

1. Welcome and introductions

Don welcomed and introduced Grant Pidgeon to the group as the new Medical Officers of Health representative.

2. Confirmation of Teleconference minutes (22 September 2014)

Minutes confirmed and accepted as true and accurate, with the following amendments:

- Gabrielle Nicholson's surname to be corrected
- Deborah Williamson's surname to be corrected
- *Staphylococcus aureus: aureus* to be lower case, the name to be in italics

3. Action plan update

13.30 Vaccination for healthcare workers

A discussion within the group around vaccination requirements of clinical staff was held. Whilst mandatory vaccination cannot be included in the Health & Disability Services (Infection Prevention And Control) Standards (NZS8134.31:2008), it was noted that there was no specific legal reason why vaccination could not be incorporated into the National Standards in some way, such as a statement that to the effect that "institutions can encourage staff to get vaccinated," or "each DHB should encourage vaccinations amongst staff." It was also noted that such a policy was consistent with the principles of ensuring workplace safety, and that vulnerable patient groups, such as the immunocompromised, or children with cancer, were to be considered. Other points were raised:

- Policies in Australian jurisdictions and institutions were discussed, such as the policy that non- vaccinated healthcare workers are to wear masks.
- Haematology and oncology units were identified as points where staff immunisation was particularly needed.
- Informing staff of the need for staff vaccination at the commencement of training, and at recruitment stage, was a suggested measure.
- At Auckland District Health Board, a policy of voluntary vaccinations was replaced with an 'opt-out' approach to staff vaccinations. This new approach was supported by the senior leadership team and consultation with healthcare workers unions was undertaken early in the process. For those who did not take up the offer, chose to

'opt-out', was sent to them via their manager to determine the reason for the decision not to be vaccinated. Seventeen percent gave personal choice as the reason; 23% expressed a preference for relying on natural immunity.

- The need to include cleaning staff, ward clerks and other non- medical staff in vaccination programmes was noted.
- It was noted that the healthcare worker union is supportive of healthcare worker vaccinations

In general the process of reviewing the NZ Standards was identified as the key issue:

- evidence base approach needs to be established for a vaccination requirement to be incorporated into the NZ standards.

Action:

Jane Pryer to draft a "statement of intent" to the Director General which raises the "awareness and consciousness" of staff expectation around vaccination to protect vulnerable patients. The co-chairs are to speak with clinical leaders in early 2015 on the need of a vaccination policy for healthcare workers

Sally Roberts and Ruth Barratt to share successful approaches used to increase staff vaccination uptake.

Jane O'Malley to engage with a variety professional groups, including the New Zealand Nurses Organisation, on this matter.

4.1 Community Antimicrobial Resistance

Murray Tilyard, Best Practice Advocacy Centre (BPAC), gave a presentation on the use of antibiotics in the community setting in New Zealand. He also demonstrated MedTech 32, an online platform (referral tool) that can be used by general practices to calculate the risk of a condition based on ethnicity, age, social status and other critical factors, and can generate referrals. The BPAC guidelines and other resources were introduced. Key points of the presentation are as follows:

- A recent paper by Associated Professor Mark Thomas, Alesha J Smith and Professor Murray Tilyard, "Rising antimicrobial resistance: a strong reason to reduce excessive antimicrobial consumption in New Zealand"¹, provides supporting evidence for the need to reduce antibiotics consumption.
- New Zealand's antibiotics use does not compare favourably with that in other countries.
- There is some regional variation which has not fully been explained. Differing patient demographics may account for regional antibiotics use.
- Greater longevity has led to an increase in multi-morbidity and polypharmacy, which raises the need for improved prescribing.

¹Mark Thomas, Alesha J Smith and Murray Tilyard, "Rising antimicrobial resistance: a strong reason to reduce excessive antimicrobial consumption in New Zealand". *The New Zealand Medical Journal* 23 May 2014, Volume 127 Number 1394, pp 72- 84. <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-127-no.-1394/6136>

- A need was identified for better communications amongst the secondary sector, for the purposes of reducing prescribing errors.
- The need for new technology together with strong clinical leadership and national consistency was noted
- British National Formulary (BNF) advice has not been used by BPAC as it is not based on New Zealand infection profiles and resistance patterns. Currently it has not been possible to develop new guidance due to a lack of national agreement. BPAC's Antibiotics Guide is recommended by Dr Tilyard as an interim solution.

Discussion

It was asked whether there was a process for reviewing responsible prescribing. In response it was noted that there is currently limited means for performing reconciliation between primary and secondary care. It was suggested reconciliation may be possible through electronic systems, but this does not happen currently. The need for appropriate clinical safeguards was noted.

It was noted that 2013 rates for antibiotics consumption showed a decrease. It was suggested that BPAC's antibiotics booklet, *Antibiotics: Choices for Common Infections*,² be endorsed by the Ministry of Health. In response it was noted that the Ministry is discussing this matter with PHARMAC. It was also noted that the Antibiotics text could be circulated and updated.

It was noted that there are no independent guidelines for antibiotic use available in New Zealand for veterinarians. It was noted that veterinary users are concerned and want MPI to address the need for guidance.

4.2 Health Quality & Safety Commission (HQSC) Atlas AMR Steering Group

Catherine Gerrard (HQSC) presented the Atlas of Healthcare Variation, a system for the collation of medical data sets.³ An example of the outputs of this system is the HQSC report, published in the *New Zealand Medical Journal*, "Variation in benzodiazepine and antipsychotic use in people aged 65 years and over in New Zealand."⁴ The utility of the Atlas approach is as much to do with the questions its results pose as with the results themselves. The pioneer of the Atlas approach is John Wennberg, a leading researcher of unwarranted geographic variation in healthcare.

- Where the data presented calls for explanation, the Atlas system has a text book for the insertion of an explanatory note
- Data is encrypted at the NHI level
- Data inputs include hospital data, and antibiotic resistance data from ESR. Pharmaceutical data is sourced from community dispensing.

² Available at: http://www.bpac.org.nz/Supplement/2013/July/docs/Antibioitcs_guide_2013.pdf

³ <http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/>

⁴ G Jackson, C Gerard, N Minko, N Parsotam. "Variation in benzodiazepine and antipsychotic use in people aged 65 years and over in New Zealand." *New Zealand Medical Journal* (2014) June 20; 127 (1396):67-78. Available at: <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-127-no.-1396/6169>

Discussion

It was noted that clinical pharmacologists can influence prescribing practices in a particular healthcare setting. Also noted was the need for healthcare strategies to be communicated to the lower organisational levels for implementation.

4.3 Best Practice Guidelines update

Sally Roberts outlined the newly released Australian Therapeutics Guidelines v15. A best practice guidelines for antibiotics, and invited discussion on the suitability of this guideline for the secondary care sector in New Zealand. The need for such guidelines was explained:

- Some DHBs have no on-site antibiotics expertise; advice is sought at the initiative of individual staff about individual patients from larger neighbouring DHB's
- Considerable variation in prescribing within an individual DHB has been observed
- American guidelines are currently being used in some areas in New Zealand; these guidelines recommend twice the dosages recommended in New Zealand in some cases
- The recommended guidelines would need to be suitable for use by both infectious disease services and non- experts.

A recommended basis for such a guidelines text was the Australian resource, *Antibiotic version 15, 2014*, published by the Therapeutics Guidelines group.⁵

Discussion

The following points were discussed:

- the need to establish a straightforward access path for the resource was noted
- it was noted that the proposed guidelines alone will not improve stewardship
- the need to measure performance and feed-back this information was noted, i.e. the need to measure improvements made by the establishment of the new guidelines
- it was noted that optimal use of antibiotics was a government strategic goal (source: Medicines New Zealand strategy)
- It was noted that the guidelines ought to be applicable to residential and primary care, as well as the work of DHBs.
- Consideration to be given to local needs and variation

Agreed

- Australia is more aligned to New Zealand – large number of Infectious Diseases physicians have had input into the development of the Australian therapeutic guidelines
- Acknowledgement that there is antibiotic availability differences between the two countries
- Consider adopting the online edition of the Australian therapeutic guidelines (ATG) for use in secondary care. Further discussion required to assess the use of the ATG for primary care

⁵ <http://www.tg.org.au/?sectionid=41>

Action:

- Establishment of a working group of New Zealand clinicians to review the Australian therapeutic guidelines (ATG)
- Engagement with PHARMAC and the Therapeutics Guidelines Group on producing and endorsing a New Zealand edition of the ATG
- Members of HAIGG to work collaboratively on some of the discussion points around AMR with agreed time frames

4.4 Update from ESR

Debbie Williamson provided an update on current ESR surveillance activities:

- ESBL- producing *Enterobacteriaceae*
- *Staphylococcus aureus*
- *Neisseria gonorrhoeae*.

The purpose of this surveillance is to provide contemporary information on antimicrobial susceptibility against antimicrobial agents, and to provide information on the strain types in circulation, e.g. information on local and regional transmission, emergence of new strains, and comparison with overseas strains.

Recent findings:

- MRSA strain CC398 has recently emerged in pigs
- Hospital- onset *C. difficile* infection: data is captured from pilot sites
- The New Zealand Microbiology Network is now operational

Discussion on skin sepsis and topical antibiotics.

High levels of prescribing of fusidic acid prescribing were described, and it was noted that there are discussions on changing the rules around prescribing. The following points were made:

- pressure is placed on prescribers by patients, especially when cellulitis is developing
- the problem appears to be a New Zealand- specific one
- there are regional variances in DHB prescribing of cephalosporin consumption
- there has been an increase in antimicrobial consumption of antibiotics
- the increase in fusidic acid consumption has led to an increase in fusidic acid resistance in New Zealand.

Agreed:

It was agreed that the HAIGG should progress the issue of topical use of antibiotics for skin infections. The baseline would need to be established and definitions to be used in infection prevention and control would need to be specified.

Action:

- national data to be presented to and considered by the HAIGG mid- 2015

5. IT and Surveillance

Gabrielle Nicholson and Debbie Williamson provided an update on IT and surveillance.

Background

ESR and HQSC have been concurrently but independently working toward the development of systems to support better health outcomes associated with healthcare associated infections (HAI) and antimicrobial resistance (AMR). The Commission wants to progress work for its Infection Prevention and Control (IPC) programme, in particular regarding its Surgical Site Infection Improvement Programme and the delivery of a national system to support IPC point of care activities. ESR has been contracted by the Ministry to progress work for an enhanced national surveillance system to support AMR and hospital-onset *Clostridium difficile* infection surveillance.

Both the Commission and ESR have identified a need for an investment in IT to support quality improvements in IPC point of care activities, along with surveillance of AMR and HAIS.

Summary

- the National IT Board has provided specifications for the envisioned system.
- a steering group comprising of ESR, the Ministry of Health, and HQSC will lead the process.
- A proposal will be provided from HQSC and ESR to the National IT Board during the next financial year;

Discussion

The following points were raised:

- Clinical leadership will require input of DHBs Chief Financial Officers and Chief Executives
- The input of a health economist was required; it was recommended that the Ministry of Health's Chief Economist be consulted with.
- The proposal would be stronger if the IT system was capable of being linked via the web to other systems, such as primary care
- If the proposed IT system is placed on the critical List it must be implemented by DHB IT boards within five years.

Agreed

- agreement from HAIGG with the proposed approach of procuring a joint business case between HQSC, MoH and ESR
- A steering group will be established early in the New Year; it is intended that it will have representation from the National Health IT Board.

Pharmacy update

Bob Buckham provided the following updates and discussion points:

- New Zealand Hospital Pharmaceutical Society of New Zealand role in vaccinating during the influenza season.
- The New Zealand Medical Association and the New Zealand Hospital Pharmacy Association have prepared a joint vision statement, regarding community- based treatment of infections and how they are managed.
- A UK “gateway to treatment” was described, whereby if a patient at a GP surgery does not currently meet the treatment threshold, they can still be given a prescription for use if needed within a limited time frame along with information about the infection and self- management
- The need for health literacy and support people for patients were discussed.

6. Ebola to date.

Don Mackie presented an update on the Ebola situation and the Ministry preparedness activities.

Key points:

- Around one person per month arrives in New Zealand from Ebola- affected countries; the New Zealand Customs Service has good systems in place for the tracking of passenger movements
- The risk to New Zealand of a case remains very low
- The mechanisms for moving a sample to the Victorian Infectious Diseases Reference Laboratory (VIDRL) was tested recently and found to work well when a hoax package was delivered to the offices of the New Zealand Herald on 11 November 2014.
- A high level of interest was noted amongst Primary Care, as indicated by attendance numbers at a recent primary care Ebola information session in held in Auckland – Similar seminars have also been held in Wellington
- The MoH roadshows were well received by the four designated receiving hospitals around the country
- New Zealand have a joint agreement with Australia in contracting Aspen Medical as the medical service provider for deployment of New Zealanders wishing to work in Ebola Treatment Centres

Discussion

- The Ebola situation has provided an opportunity for all PPE- related responsibilities to be reviewed and with a particular resource review on primary care facilities
- It was noted that the resources required for Ebola readiness, has stretched resources for many healthcare facilities around New Zealand
- Consultation with Infection Prevention and Control services is variable across DHB's

7. IPC Post graduate study

Ruth Barratt proposed that Waiariki Institute of Technology be assisted in obtaining Health Workforce New Zealand, for their Infection Prevention and Control Masters- level course. It was noted that Waiariki Institute of Technology has been teaching IPC around twenty years.

The following points were made:

- it was suggested that the first stage was to decide on the content and type (Master's degree, diploma course, or otherwise) of a suitable course on IPC, based on the health sector's needs, and then determine who best to provide the course
- it was suggested that it was preferable to have a single provider for such a course
- it was suggested that a larger university with greater resourcing and breadth and scope of research activity, with a science background and laboratory, and an atmosphere of critical analysis, was a preferred site for such a course
- on the other hand, it was noted that Waiariki Institute of Technology has an established record of teaching IPC

Agreed

It was agreed that HAIGG would note the course content, identify the need, and find a strategic partner for the IPC course.

Action:

- Jane O'Malley to discuss with several key people and organisations on the process of accreditation of tertiary level courses and with the Nursing Council processes, course content, and where the envisioned course is best placed institutionally.

8. Round the room

Ruth Barratt discussed a survey report on the role of IPC teams in New Zealand, Australia and America and the impact this has on Healthcare Acquired Infection rates. Results not yet published. For discussion at a later date within the group.

Discussion on recruiting new HAIGG members

It was suggested that representatives from primary care, the Public Health Group, and the College of GPs be sought for membership with the HAIGG. It was also suggested that specifications be drafted for new membership, such as seeking members:

- with national oversight
- with strategic thinking ability
- seen by their peers as knowledgeable.

Debbie Williamson – ESR, publication of the antimicrobial consumption report due out in February 2015

9. Close of Meeting.