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<thead>
<tr>
<th><strong>Title</strong></th>
<th>The Control and Prevention of Healthcare Associated Infection</th>
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<td>October 2013</td>
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<tr>
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<td>5 minutes</td>
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<tr>
<td><strong>Please classify the paper as:</strong></td>
<td>To note the progress with the control and prevention of healthcare associated infection</td>
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<tr>
<td><strong>Executive Summary</strong></td>
<td>Summarises progress on achieving annual objectives for MRSA bacteraemias and <em>Clostridium difficile</em> infection, other reportable infections including periods of increased incidence of <em>Clostridium difficile</em> infection</td>
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<td>To ensure our organisation is stable and viable with the resources to deliver its vision</td>
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<td><strong>Please describe how this affects patients/staff/carers etc.</strong></td>
<td>To improve year on year the safety of our organisation for patients, visitors and staff and the outcomes for our patients.</td>
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<td><strong>Please describe what stakeholders think about this.</strong></td>
<td>Of interest to external audience as a measure of patient safety and quality care given that reduces risk of HCAI</td>
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<td><strong>Please identify the risks associated with this issue and describe how they will be dealt with. Please set out in the report in risk register format the risks associated with the issue.</strong></td>
<td>Non achievement of C difficile target for 2013/2014</td>
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<td>Non achievement of MRSA bacteraemia target for 2013/2014</td>
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<td><strong>Please describe the aspects of this paper that might require wider stakeholder engagement or public consultation, and early engagement with Governors.</strong></td>
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<td><strong>Recommendation</strong></td>
<td>The Board is asked to receive this report.</td>
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<tr>
<td><strong>Author/Presenting Director</strong></td>
<td>Maggie Arnold</td>
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1. **Aim**

The following paper aims to update the Board on progress with the control and prevention of healthcare associated infection (HCAI).

2. **Healthcare Associated Infection Surveillance Report for September 2013**

2.1 *Clostridium difficile* episodes in September

There was 9 post-48 hour episodes reported in September which was an increase compared to August. So far in 2013/14 in GHNHSFT there have been a cumulative total of 35 episodes of *Clostridium difficile* infection (post 48 hour episodes) against a cumulative target of 26. The total year target is 52.

2.2 *Meticillin Resistant Staphylococcus aureus* (MRSA) Bacteraemia

The last case of post 48 hour MRSA bacteraemia occurred on 26.6.13.

2.3 *Meticillin Sensitive Staphylococcus aureus* (MSSA) Bacteraemias

There were 6 episodes reported in September.

2.4 *Escherichia coli* Bacteraemias

There were 16 episodes reported in September.

3. **Hand Hygiene**

3.1 Trust-wide hand hygiene compliance for September was 96%. The return rate for the hand hygiene audits was 98%. Six areas failed to make two hand hygiene audit returns but all areas did make one return. It is the divisions’ responsibility to follow up all non returns and poor compliance.

3.2 Hand hygiene awareness stands for the public and staff will take place in November. All divisions are requested to support the stands by attending a session throughout the day. Staff and members of the public will be educated on hand hygiene technique.


4.1 The Infection Control Nurses will undertake targeted training in the Emergency Departments, Acute Care Units and Guiting ward. The training will focus on early identification of diarrhoea and vomiting, communication on handover and early isolation.

4.2 Our Trust’s *Norovirus Escalation Plan* has been reviewed and updated as part of the winter plan and will be approved at the Infection Control Committee in October.

4.3 GHNHSFT *Norovirus Toolkit* has been reviewed and an update for all Saving Lives leads will be given at the Annual Saving Lives Study Day. Enhanced cleaning in public toilets including the Emergency Departments will commence Monday 30th September.

4.4 As part of the countywide communication strategy posters, leaflets and banners have been approved by all organisations in the county and will be launched in October.

4.5 New isolation posters have been approved by the infection Control Committee and will be distributed.
5. **Updated Guidance on the Management and Treatment of Clostridium difficile Infection**

The guidance for the management and treatment of *Clostridium difficile* infection has been updated and approved by the Antimicrobial Stewardship Group in September (Annex A).

6. **Clostridium difficile Infection Diagnostics**

The Microbiology Department has undertaken a review of diagnostic test methods currently used for CDI diagnosis following publication of DH guidance on testing algorithms. An assessment of current testing methodology has been performed against a recommended new testing algorithm that complies more closely with DH recommendations. The assessment shows that the new recommended test method (using GDH as the initial screening method along with a sensitive toxin detection EIA) is highly sensitive and specific, with more timely production of comprehensive test results to aid infection control and clinical decision making. The new recommended test algorithm is also more cost-effective and also retains use of PCR testing on selected samples, where necessary. A paper supporting the recommendation to change to this new testing algorithm has been written by the Microbiology Departmental Head, Dr Alan Lees (Annex B).

7. **The Annual Saving Lives/Infection Control Study Day**

The Annual Saving Lives/Infection Control Study Day will be held on October 23rd; all clinical areas are expected to be represented. The theme of the day will be “shared learning”. The day will include:

- Learning from infection control incidents
- A carers feedback
- The launch of the updated Peripheral Venous Cannula and MRSA policy
- The launch of the new hand hygiene tool and isolation posters
- An update on Tuberculosis, Legionella, Norovirus, Influenza and Decontamination of the environment

8. **Influenza**

Planning for seasonal influenza has commenced and a plan is in place to increase the vaccine uptake amongst our Trust staff. Flu champions have been identified who will assist in promoting and administering the flu vaccine. A series of emails reminding staff of the importance and benefits of yearly influenza vaccination have been disseminated and it is hoped that accurate levels of vaccination for staff groups can be recorded by *Working Well*, with any staff receiving vaccination from their GP being encouraged to report this to *Working Well*.

9. **The Peripheral Venous Cannulation Policy**

The Peripheral Venous Cannulation Policy has been reviewed by a working group and approved at the Infection Control Committee. The policy is underpinned by the principles of aseptic not touch technique (ANTT) and *Safety Cafes* and train the trainers updates will be used to launch the changes (Annex C).
10. **Pseudomonas aeruginosa management**

The results of the hard work put in to adhering to the DoH HTM04-01 addendum on Pseudomonas Aeruginosa Management in Augmented Care, specifically in the Neonatal Unit, has been accepted as a poster presentation at the Federation of Infection Societies annual conference in Birmingham in November 2013. Many thanks should go to all those involved in the on-going work surrounding this new DoH guidance.

11. **Key Actions for October**

- An electronic hand hygiene audit tool will be launched at the Saving Lives/Infection control study day
- The divisions will follow up non returns with Saving Lives and hand hygiene audits
- A business case will be developed and submitted to take forward a multidisciplinary review of *C difficile* infection cases and referral for faecal transplantation
- The revised Peripheral Venous Cannulation policy will be launched to clinical staff and implemented November 4th.
- Influenza vaccinations will be publicised and made available to staff
- The Trust Board will be asked to approve a paper recommending a change to CDI diagnostics (CDI testing algorithm)

**Authors:** Maggie Arnold Director of Infection Prevention and Control  
Cheryl Haswell, Matron, Infection Prevention and Control

**Presenting Director:** Maggie Arnold Director of Infection Prevention and Control
**Clostridium difficile infection (CDI) in adults**

Healthcare workers should use the “SIGHT” mnemonic when managing suspected potentially infectious diarrhoea. Use the [Bristol Stool Chart](#) to monitor frequency and severity of diarrhoea.

| S | Suspect that the diarrhoea may have an infective cause where there is no clear alternative cause for diarrhoea (drugs eg laxatives, underlying bowel disease) – if you suspect CDI on clinical grounds, start treatment for CDI empirically pending test results and then review that treatment when the results become available |
| I | Isolate the patient immediately - consult the bed managers or infection control team (ICT), if necessary, particularly if no isolation facilities available |
| G | Gloves and aprons must be used for all contacts with the patient and their environment (in the patient “zone”) |
| H | Hand washing with soap and water should be carried out before and after each contact with the patient and the patient’s environment |
| T | Test the stool for evidence of toxigenic Clostridium difficile, by sending a specimen immediately |

### The Bristol Stool Form Scale (Bristol Stool Chart)

| Type 1 | Separate hard lumps, like nuts (hard to pass) |
| Type 2 | Sausage-shaped but lumpy |
| Type 3 | Like a sausage but with cracks on its surface |
| Type 4 | Like a sausage or snake, smooth and soft |
| Type 5 | Soft blobs with clear-cut edges (passed easily) |
| Type 6 | Fluffy pieces, a mushy stool |
| Type 7 | Watery, no solid pieces ENTIRELY LIQUID |

Reproduced by kind permission of Dr K. W. Hutton, Reader in Medicine at the University of Bristol
Table 1. Initial assessment and management

If CDI is suspected, send a stool (faeces) specimen to the microbiology lab and start antibiotic treatment immediately (see table 2). Review CDI therapy if initial test result is negative. If symptoms continue despite a negative result, and clinical suspicion of CDI remains, send a further stool specimen for testing after 5 days. Repeat CDI testing during therapy or as “test of cure” is not required

Assess clinical severity of CDI at diagnosis and then daily

**Mild CDI**: not associated with a raised WCC; typically associated with <3 stools of types 5–7 per day

**Moderate CDI**: associated with a raised WCC <15 x 10⁹/L; typically with 3–5 stools per day

**Severe CDI if any** of the following:

<table>
<thead>
<tr>
<th>1. White Blood Cell count &gt;15x10⁹/L</th>
<th>2. Temp &gt;38.5°C</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Albumin &lt; 20g/L</td>
<td>4. CRP &gt;200</td>
</tr>
<tr>
<td>5. Acutely rising serum creatinine (e.g. &gt;50% increase above baseline)</td>
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<tr>
<td>6. Evidence of severe colitis (abdominal signs, radiology, endoscopy)</td>
<td></td>
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</table>

**Life-threatening CDI if any** of: hypotension, ileus, toxic megacolon, CT evidence of severe disease

**Notes for severe / life threatening CDI:**
1. Request early gastroenterology and/or surgical and/or critical care review
2. the number of stools may be a less reliable indicator of severity

**Isolate** patient in a single room

**Fluid & electrolyte replacement and nutrition review as necessary**

**Review current therapy:**
1. Stop antibiotics and other drugs that might cause diarrhoea if possible
2. Stop PPIs/H₂ antagonists unless required acutely

**Avoid anti-motility drugs** (e.g. loperamide)

---

Table 2. Specific antibiotic therapy for CDI

**First episode of Mild/Moderate severity**

**METRONIDAZOLE 400mg po tds for 10-14 days**
If Nil by mouth use: **METRONIDAZOLE 500mg iv tds for 10-14 days**

If increasing severity of CDI OR no response to therapy within 7 days, change to:

**VANCOMYCIN 125mg po or via NG tube qds for 10-14 days**

**Note**: Patients with mild disease may not require specific *C. difficile* antibiotic treatment

**First episode of Severe disease**

**VANCOMYCIN 125mg po or via NG tube qds for 10-14 days**
If evidence of severe CDI continues or worsens:
- **ADD in Metronidazole 500mg iv tds** + increase vancomycin dose to 250mg po/NG qds
- Discuss potential additional / alternative therapy with consultant medical microbiologist*
- Obtain surgical / gastroenterology / critical care review as appropriate
*options may include vancomycin po/NG up to 500mg qds, fidaxomicin\(^\#\) 200mg po bd, intracolonic vancomycin (500 mg in 100–500 ml saline 4–12-hourly, given as retention enema: 18 gauge Foley catheter with 30 ml balloon inserted per rectum; vancomycin instilled; catheter clamped for 60 minutes; deflate and remove), intravenous immunoglobulin 0.4g/kg as 1 dose (consider repeat)

<table>
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<tr>
<th>Second episode of CDI</th>
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</table>

**Assess severity as above**, if assessed as severe CDI then manage as severe disease (see above)

Review medication; stop any predisposing antibiotics, PPIs/H2 antagonist if possible

In non-severe disease commence **VANCOMYCIN 125mg po or via NG tube qds for 10-14 days**

- If poor response discuss potential alternative therapy with consultant medical microbiologist

<table>
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<tr>
<th>Subsequent episode of CDI i.e. ≥ third episode</th>
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</table>

**Assess severity as above**, if assessed as severe CDI then manage as severe disease (see above)

Review medication; stop any predisposing antibiotics, PPIs/H2 antagonist if possible.

In non-severe disease commence **VANCOMYCIN 125mg po or via NG tube qds** pending discussion with consultant medical microbiologist regarding potential additional / alternative therapy*.

Obtain gastroenterology review

*options may include a 6 week tapering po vancomycin regime (125 mg qds for one week, 125 mg tds for one week, 125 mg bd for one week, 125 mg od for one week, 125 mg on alternate days for one week, 125 mg every third day for one week) or fidaxomicin\(^\#\) 200mg po bd 10-14 days, intravenous immunoglobulin 0.4g/kg as 1 dose (consider repeat), donor stool transplant.

\(^{*}\) Fidaxomicin use is **restricted** and requires approval by consultant medical microbiologist
CLOSTRIDIUM DIFFICILE TESTING

1. **Aim**

To ask the board to consider approving a change in local testing for *Clostridium difficile* infection (CDI) consistent with updated national guidance.

2. **Background**

*Clostridium difficile* is a bacterium which can produce toxins capable of damaging the human large bowel. This most commonly manifests as a diarrhoeal illness in relation to antibiotic use; on occasion severe and/or recurrent disease occurs.

*C. difficile* can form spores which are capable of surviving in the environment and acting as a source of cross infection. Stringent infection control precautions including cleaning are required in order to minimise this risk of spread within our hospitals.

Success in reducing the numbers of patients with CDI is felt to have been linked to the introduction of national mandatory surveillance and local target setting with performance management. The 2013/14 target for our trust is 52 cases of CDI for inpatients present in the hospital more than 48 hours.

Laboratory diagnosis of CDI is performed in the trust microbiology laboratory and involves testing stool (faeces) samples from patients with diarrhoeal illness. However, a number of different testing methods exist and establishing the best way to diagnose CDI is not straightforward. Recently published data from a large UK multicentre study and updated national guidance on CDI testing attempt to clarify this situation and are considered further below.

3. **Laboratory diagnosis of CDI**

Merely identifying the presence of *C. difficile* bacteria in a patient stool sample is not sufficient to confirm CDI, it is the detection of the toxins (or potential to produce toxins) that is important. This is because a proportion of people will carry *C. difficile* strains without the ability to produce toxin harmlessly in their bowel. Misidentifying these patients as CDI cases could result in unnecessary treatment for CDI and run the risk of failing to identify the true cause of their diarrhoea.

Although some of the older tests for CDI were very reliable, they tended to be too slow for optimum patient and infection control management. In 2008 this was recognised in updated national guidance and around that time we, like many other laboratories, decided to use a quicker test for *C. difficile* called toxin EIA (enzyme immunoassay). However, as experience with these EIA tests grew it became apparent that their accuracy was inadequate. This led to the local change to PCR (polymerase chain reaction) testing for the presence of the *C. difficile* toxin gene in April 2011. The PCR test is very sensitive and it should be noted that it detects the potential to produce toxin rather than the toxin itself. This allows identification of patients who are potentially excreting *C. difficile* which can aid infection control precautions. However, an unintended consequence of the local introduction of the PCR test was that an increased number of CDI “cases” were reported compared to EIA and this resulted in performance management concerns regarding our target. This issue was previously considered by the board in December 2011 and a decision was made to continue with PCR, add toxin EIA testing of PCR positives for mandatory reporting purposes and await further data and guidance on this subject.
Updated guidance on the diagnosis and reporting of *Clostridium difficile*\(^1\) was produced in 2012 and a detailed analysis of the large multicentre study which supported these recommendations was published in September 2013\(^2\). The guidelines conclude that, “The Department and ARHAI advise that organisations adhere to a two stage testing approach which consists of a GDH EIA (or a NAAT or PCR) test to screen samples, followed by a sensitive toxin EIA test (or a cytotoxin assay)\(^1\).”

GDH (glutamate dehydrogenase) EIA is a test not previously used by us, it detects the presence of the *C. difficile* bacterium with further testing required to detect toxin or potential to produce toxin. The guidance also suggests that laboratories may wish to add a third test, for example PCR, for those samples with unclear initial results as this would identify potential *C. difficile* excretors. Data from over 12 000 test results in the UK study\(^2\) suggested that about 8% of samples would require a third test ie PCR if this method was adopted. It is important to note that this study also concludes that use of PCR alone leads to over-diagnosis of CDI and that “this assay should not be used alone to diagnose C difficile infection.” The authors recognise however that this UK study data contradicts recent guidance from the USA which does recommend use of a PCR test alone.\(^5\) It is clear therefore that there is not yet international consensus on the best testing approach for CDI. The UK guidance does recognise this and states that “It must be remembered that no test or combination of tests is infallible and the clinical condition of the patient should always be taken into consideration when making management and treatment choices.” Our current practice is to retrospectively test PCR positive results with sensitive toxin EIA in order to clarify each month which samples require mandatory reporting. PCR results alone are therefore currently used for initial patient management and infection control decisions, the lack of timely toxin results can make clinical interpretation of the PCR result difficult.

### 4. Proposed change to laboratory diagnosis of CDI

In light of the updated guidance and recently published data, it is proposed that we change our current laboratory testing for CDI.

Note that in 2013 we have already stopped confirming PCR positive results with a second PCR test. This change will save an estimated £20 000 per annum and was undertaken because this additional test was no longer adding value to our results. The second PCR test had allowed early detection of the hyper-virulent strain of *C. difficile*, designated ribotype 027, which is no longer prevalent in our population.

The proposal is to switch from initial PCR to GDH and sensitive toxin EIA testing, with PCR only performed on GDH positive, toxin EIA negative results, or in other selected cases.

**Benefits:**

- Clear alignment with current national guidance, GDH and toxin EIA is the commonest testing algorithm in England.
- Result turnaround time maintained at less than 24 hours, earlier availability of toxin result assists clinical interpretation and patient management.
- Retaining PCR as an optional third test ensures that potential *C. difficile* excretors will continue to be identified for infection control purposes.
- A more cost-effective testing algorithm which will not adversely impact on patient or infection control management. Estimated cost saving by switching to this testing method is £32 000 per annum.

**Risks:**

- Given our previous experience with changes in CDI testing impacting on mandatory reporting data, we must be confident that this proposal does not pose a similar risk. Although the recently published data\(^2\) does not suggest that this would be the case, the microbiology laboratory has undertaken a parallel testing
exercise on 208 local samples. The results are summarised in the table below. Note that in this study any samples testing GDH positive, sensitive toxin EIA positive and PCR negative would have the effect of increasing our mandatory reporting numbers. In this study no samples with this combination of results were identified.

Table: Local parallel testing exercise for CDI, data for 181 samples

<table>
<thead>
<tr>
<th>GDH EIA</th>
<th>TOXIN EIA</th>
<th>PCR</th>
<th>Report to clinicians</th>
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<td>Positive</td>
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</tr>
</tbody>
</table>

181

*Result needs to be considered in clinical context. Potential C. difficile excretor, infection control precautions may be required

Note: The remaining 27 samples tested were from preselected known PCR positive specimens. 25 of these were GDH positive. 12 were sensitive toxin EIA positive, of these all were both PCR and GDH positive. This supports the national recommendation that GDH is a good screening test for CDI.

- A risk of not implementing this change is that we will have to consider alternative CDI testing strategies in order to fully comply with the national guidance, specifically to move away from our current practice of retrospective toxin EIA testing. Initial investigations suggest that alternative strategies may create logistical problems in terms of achieving an equivalent result turnaround time whilst maintaining the sensitivity of toxin EIA results.

Conclusion:

- In conclusion, the proposed change in testing method will ensure appropriate patient and infection control management, will fully comply with national guidance and should not result in a significant change in mandatory reporting numbers.

5. Recommendation

The board is asked to approve the proposed change in local testing for CDI.
References


   http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1232006607827

4. NHS centre for Evidence Based Purchasing, Evaluation report Clostridium difficile toxin detection assays CEP08054, February 2009. 

THE UPDATED PERIPHERAL VENOUS CANNULATION POLICY

1. Aim

The aim of this proposal is to consider the changes required to update the Trusts peripheral venous cannulation policy which will contribute to the reduction in infections associated with an invasive device by:

- Reducing variations in practice
- Improve compliance with trust policy
- Promote the use of aseptic non touch technique (ANTT®) during cannulation
- Improve the experience of patients who require a peripheral venous cannula

2. Introduction

The peripheral cannulation policy has been reviewed and updated and this paper outlines the key changes and associated costs with implementing the new policy. In the last year our trust used 255,736 peripheral cannulae.

3. Recommended changes to policy

3.1 Effective prevention and control of infection needs to be embedded in everyday practice and this can be achieved by the promotion of aseptic non touch technique (ANTT®). Developed in University College Hospital, London, ANTT® is a framework to both standardise and raise clinical standards whilst undertaking aseptic clinical procedures. The main focus of ANTT® is to minimise the introduction of microorganisms, which may occur during preparation, administration and delivery of IV therapy. In order to further reduce the potential for contamination, the technique follows some fundamental rules pertaining to infection control and staff/patient protection such as effective hand washing, maintaining an aseptic environment and the wearing of non-sterile gloves. The EPIC 2: National evidence-based guidelines for preventing guidelines for preventing healthcare-associated infections in National Health Service (NHS) hospitals in England recommend that ANTT® must be used for accessing the venous system.

ANTT® should be undertaken when performing cannulation. The step by step clinical guidelines are designed to allow the practitioner to: identify and protect the key parts during a procedure, institute a non-touch technique, ensure effective hand decontamination is undertaken and personal protective equipment is used at the appropriate time.

As part of the updated policy, ANTT® will be promoted as part of the education and launch of the policy changes and will include a poster detailing the cannulation procedure using ANTT®, a video and development of a phone app.

3.2 Plastic trays

A clean working environment and an aseptic field are essential precautions for all invasive clinical procedures. This can be achieved effectively by a non-touch-method and a basic aseptic field such as a well cleaned plastic tray or trolley.

Audit has shown that there is variation in practice with the clean working environment for ANTT cannulation; this includes using an oval sharps tray (the preferred receptacle used by medical staff) which cannot be adequately cleaned, a dressing trolley, Gratnell trolley, or blue procedure tray. This variation in practice is confusing and makes compliance with policy difficult to monitor with the variety of choice available.
The ANTT organisation recommends the use of a procedure tray or trolley for cannulation. Currently plastic trays are not in use throughout the Trust but some clinical areas have these in use. To introduce ANTT for cannulation using a plastic tray would be a cost pressure for some clinical areas. However, our current suppliers of sharps containers, Daniels Healthcare, are willing to supply 200 procedure trays free of charge which allows the option of a sharps container to also be used with the tray.

3.3. Disposable tourniquets

Best practice according to Epic 2 guidance recommends that disposable tourniquets should be used for peripheral venous cannulation. Although the introduction of disposable tourniquets was unfunded within our trust 72 clinical areas are using a variety of disposable tourniquets (6 types) the cost of which ranges from £0.09 to £4.53 and currently costs our trust £10,464.25 per annum.

As part of the policy review it is recommended that a standard disposable tourniquet is implemented following the trial of Tournistrip in several clinical areas at a cost of 0.22p per tourniquet. This outcome of this would standardise practice and result in a cost pressure of £977.51 trustwide. However, it should be noted that company that supplies the preferred disposable tourniquet are very willing to negotiate a commitment rebate to reduce the price and win the business.

4. Dressing packs

The current trust policy recommends the use of sterile field to undertake cannulation. Due to the cost pressure of this recommendation in the previous policy review it was established that the cheapest sterile filed that could be obtained from procurement was in a sterile dressing pack that included a sterile field costing £0.45. This recommendation was poorly adhered to as staff felt using a dressing pack resulted in excess waste as most of the pack was not used. Staff were also confused regarding the use of non sterile gloves as the pack contained sterile gloves. Best practice guidance from the ANTT organisation suggests that a sterile field is not necessary if the principles of ANTT are used during the procedure. Therefore it is recommended that sterile field should not be used for cannulation. The actual cost saving is difficult to confirm due to the non compliance with use for cannulation and dressing packs are supplied to clinical areas for other uses other than cannulation. 84 areas in our trust use wound care packs the areas that do not use the packs are non clinical areas.

As part of the outcome of this policy review it has been identified that the current dressing packs used in our trust should be reviewed to identify if the trust can procure dressing packs at a lower price, this work has been commenced by the Matron for Infection Control in consultation with the Tissue Viability Nurses.

5. Policy launch

The new revised policy will be launched trustwide to all staff that cannulate. A Safety café approach will educate staff on the policy changes, the principles of ANTT and cannulation procedure. It will be also be officially launched at the annual infection control /Saving Lives study day on October 23rd

6. Conclusion

The revised insertion of peripheral venous cannulae policy will be implemented in October 2013 if the changes outlined above are agreed.

Cheryl Haswell. Trust Lead for Saving Lives/ Matron Infection Prevention and Control
Deborah Painter. Clinical Skills Practitioner

Presenting Director: Maggie Arnold. Nursing Director