



Infection Prevention & Control News

Issue No 5

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Welcome to the Fifth issue of the Infection Prevention and Control Team (IPCT) news bulletin!

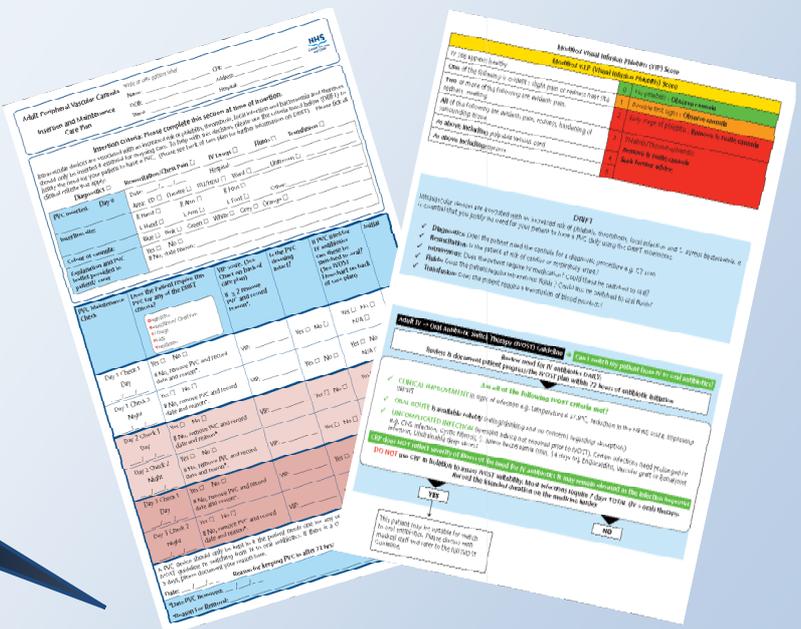
We have returned this time with even more infection prevention and control news and developments as well as informative specialist articles provided by members of the team.

We hope you enjoy!!

Please send any submissions or feedback to Pamela Joannidis/Angela Robertson and look out for the next issue later in the year!!

Things happening in IPC...

Launch of new PVC Care Plan!!





PVC Care Plan

PVC ? Think Twice!

We all know that having a Peripheral Venous Catheter (PVC) puts your patient at risk of infection. To help you make decisions about PVCs, we have revised and refreshed the NHS GGC Peripheral Venous Catheter (PVC) care plan with staff in wards 9D and 5C at the QEUH, to make you

“Think Twice about every PVC in every patient.”

We want you to think twice about putting a PVC in your patient using a mnemonic called DRIFT.

Ask yourself – Does your patient need a PVC for any of the following?

Diagnostics

Does the patient need the cannula for a diagnostic procedure e.g. CT scan

Resuscitation

Is the patient at risk of cardiac or respiratory arrest?

Intravenous

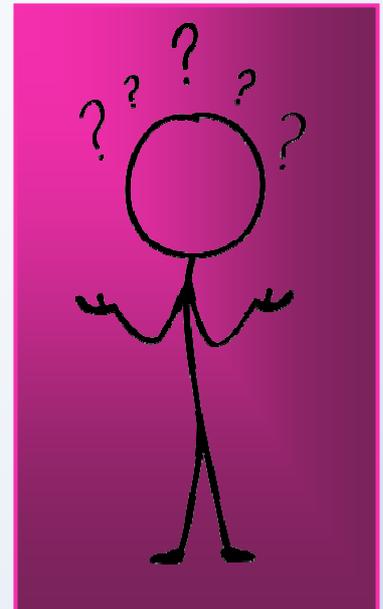
Does the patient require IV medication? Could these be switched to oral?

Fluids

Does the patient require intravenous fluids? Could this be switched to oral fluids?

Transfusion

Does the patient require a transfusion of blood products?



Once you have inserted a PVC, complete the insertion criteria details at the top of the PVC care plan.

Every day that your patient has a PVC increases their risk of infection. We want you to “Think Twice” each day that the PVC is in your patient, using the DRIFT mnemonic above to help you decide when to remove it. We are also asking you to think twice each day about switching from IV to oral medication using the NHS GGC IVOST guidelines.

Record twice per day the reason for keeping the PVC in. Also document that you have considered switching to oral medication.

We want you to take the PVC out as soon as possible and definitely within 3 days of insertion. To help keep track, the new care plan only has space for 3 days of records. In the rare event that the patient needs it for longer, then there is a continuation sheet to document care and decisions. In this situation, we urge you to consider alternative line options that carry less risk of infection.



PVC Care Plan

Following staff feedback, a change in format and layout has been made to make the care plan easier to use

Add Patient details at the top of the page or affix a label

Complete this section upon insertion, detailing the insertion criteria. Use the DRIFT information on the reverse of the care plan for further guidance.

The new care plan features areas for three day, twice daily checks. A continuation sheet is available of needed.

Adult Peripheral Vascular Cannula Write or affix patient label

Insertion and Maintenance Care Plan

Name: _____ CHI: _____
 DOB: _____ Address: _____
 Ward: _____ Hospital: _____

Insertion criteria: Please complete this section at time of insertion.
 Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics Resuscitation/Chest Pain IV Drugs Fluids Transfusion

PVC Inserted: Day 0 Date: ___/___/___ Hospital: _____
 Area: ED Theatre ITU/HDU Ward Unknown

Insertion site: R Hand R Arm R Foot
 L Hand L Arm L Foot Other: _____

Colour of cannula: Blue Pink Green White Grey Orange

Explanation and PVC leaflet provided to patient/carer: Yes No
 If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria?	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST flowchart on back of care plan)	Initial
Day 1 Check 1 Day ___/___/___	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, remove PVC and record date and reason*.	VIP: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
Day 1 Check 2 Night ___/___/___	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, remove PVC and record date and reason*.	VIP: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
Day 2 Check 1 Day ___/___/___	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, remove PVC and record date and reason*.	VIP: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
Day 2 Check 2 Night ___/___/___	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, remove PVC and record date and reason*.	VIP: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
Day 3 Check 1 Day ___/___/___	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, remove PVC and record date and reason*.	VIP: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
Day 3 Check 2 Night ___/___/___	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, remove PVC and record date and reason*.	VIP: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Intusion Phlebitis (VIP) Score

Modified V.I.P. (Visual Intusion Phlebitis) Score

IV site appears healthy	0	No phlebitis - Observe cannula
One of the following is evident: slight pain or redness near site	1	Possible first signs - Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis - Remove & re-site cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis - Remove & re-site cannula
As above including: palpable venous cord	4	Seek further advice
As above including: pyrexia	5	

DRIFT
 Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic: Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT:** In signs of infection e.g. temperature > 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably:** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION:** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves
DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine cards.

YES NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the IVOST Guideline.

The reverse of the care plan features more information on:

- VIP Scoring
- DRIFT
- IVOST

IPC Website: new 'Updates' page

We have now added a 'News and Updates' page to our website. This new page will list any updates the department has made to its existing documents, as well as any new launches and any other pieces of work which may be of interest.

We hope this page will prove useful for staff, particularly those not in the Infection Control Team or colleagues working in the community, who may be trying to find the latest versions of our SOPs and other related documents, as well as helping to keep everyone informed of any new documents we have put together.

We are always looking for feedback so if anyone has any suggestions for other information they would like to see added here, get in touch to let us know!

IPC News and Updates

Welcome to the Infection Control Team News and Updates page.

Here you will find the information on any new or updated department news bulletin.

Whats New?.....

Please see the lists below for information on any new

IPC Updated Documents:

- [Loose Stool SOP](#) (approved)
- [Norovirus SOP](#) (approved)
- [Measles SOP](#) (approved)
- [Rubella SOP](#) (approved)
- [Mumps SOP](#) (approved)
- [Interim Tuberculosis SOP and Care Checklist](#) (pending)

IPC News bulletin

You can also keep up to date with the team via the IPC News bulletin.

[IPC News Bulletin - Latest Issue](#)

Infection Prevention And Control

- [About Us](#)
- [IPC News and Updates](#)
- [Care Checklists](#)
- [Decontamination](#)
- [Education & Training](#)
- [Guidelines & Documents](#)
- [Hand Hygiene](#)
- [Urethral Urinary Catheter Care Hub](#)
- [Healthcare Improvement Scotland \(HIS\) HAI Standards / HEI Reports](#)
- [Prevention and Control of Infection Manual \(Policies / SOPs / Guidelines\)](#)
- [Water Safety Information Hub](#)
- [MERB-CoV Information Hub](#)

South Glasgow IPC Fun Day!



The Queen Elizabeth University Hospital Adult Infection Prevention & Control Team (IPCT) ran a Fun Day on 13th September 2018 held in the atrium of the main hospital. It was attended by approximately 150 staff from both the adult and the paediatric hospital. The day was used to raise awareness of Infection Prevention & Control and focussed specifically on Standard Infection Control Precautions (SICP). The IPCT displayed information and chatted with staff answering any queries that they had in relation to IPCT as well as setting challenges for staff with prizes for completing correctly. The IPCT are always looking for innovative ways of promoting Infection Prevention & Control and look forward to another successful session next year.

Bug Byte:

Staphylococcus aureus Bacteraemia (SAB)

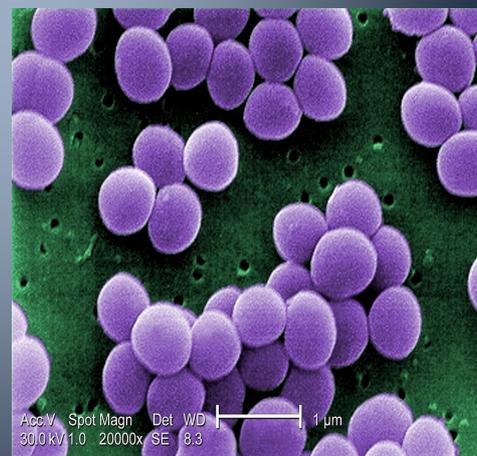
What is *Staphylococcus aureus* Bacteraemia?

Staphylococcus aureus is a bacterium which is commonly found on the skin and mucous membranes. Usually this colonisation causes no problems however if the bacteria enters the body through broken skin or via a medical procedure such as venous cannulation it can lead to a blood stream infection or bacteraemia.

Why does it matter?

Your blood is normally a sterile environment, so to have the presence of bacteria in a blood culture specimen is abnormal. This is serious because the bacteria and toxins they produce can travel through the bloodstream to your whole body causing widespread illness.

If you have a SAB you will receive at least 14 days worth of intravenous antibiotics and in some cases, for example if you have had a hip or knee joint replacement, antibiotic treatment can last up to 6 weeks.



A strain of SAB as seen under a very high magnification (x20 000) Scanning Electron Micrograph (SEM).

See the [SAB Treatment Algorithm \(HIS\)](#) which can be found linked on the IPC Team Documents page of the NHSGGC Website, for further guidance.

How can we prevent bloodstream infections such as SAB?

On average in NHS Greater Glasgow and Clyde 38 patients per month are diagnosed with a SAB. Of the healthcare associated cases 30% are caused by an intravenous (IV) access device e.g. Peripheral Venous Catheter (PVC), Peripherally Inserted Central Catheter (PICC) or Central Venous Catheter (CVC).

IV access devices should be used to deliver the appropriate treatment e.g.

Diagnostics, **R**esuscitation/ Chest Pain ' **I**V Drugs ' **F**luids or **T**ransfusion (DRIFT) and not be left in place for any longer than is necessary as this can provide an easy access point for bacteria and other microorganisms to enter the bloodstream and cause illness.

Ensure that a care plan is in place for all devices and follow the advice surrounding care and maintenance, and most importantly remove the IV access device when no longer clinically required.

Of course bloodstream infections can also arise because of other conditions e.g. skin or soft tissue infections or following surgical procedures so it is important that any ongoing infective conditions receive timely expert advice from the local microbiology team on the most appropriate treatment course.

SAB Ward Rounds

Staphylococcus aureus bacteraemia (SAB) rates remain a challenge for NHSGGC and we are currently above the national rate.

The Infection Control Doctors and Consultant Microbiologists are now conducting SAB ward rounds in QEUH, GRI and RAH. This is a real time review of the patient which includes an assessment of antimicrobial therapy and the identification of the source of the SAB where possible. Identification of source is important as it enables us to target future interventions. There is also a review of PVC and CVC documentation where appropriate. We are also providing feedback regarding any learning to clinical staff and we are happy to answer any queries.

A SAB group has been established with clinical representation to discuss this important issue. If anyone has any ideas regarding intervention to reduce SABs please get in touch with me; Teresa.Inkster@nhs.net

Dr Teresa Inkster, Lead ICD

Meet the Team!! - Royal Hospital for Children IPC Team

The team is lead by Lead Infection Prevention and Control Nurse (IPCN), Susie Dodd. Senior IPCN Angela Johnson, IPCNs Katie Anderson and Lynne Kennea and Administrator Sharon Carlton complete the small but perfectly formed team. Together, the team hold a wealth of IPC knowledge and experience and take great pride in driving best practice in Infection prevention and control within the Royal Hospital for Children. Children and their parents have a unique set of needs and challenges and we are passionate about preventing healthcare acquired infections amongst our patients working in partnership with staff in the children's hospital to ensure we do that in the safest way possible.

Think you know what we do? Think again! Our day varies from start to end and typically includes;

- ✓ Delivering education sessions to small groups and groups of over 100 staff
- ✓ Responding to incidents and carrying out complex and detailed investigations
- ✓ Daily surveillance and monitoring of lab results
- ✓ Daily ward visits to speak to staff and parents
- ✓ Auditing practice throughout the RHC site
- ✓ Formulating reports detailing healthcare acquired infections across the site
- ✓ Reviewing and updating policies
- ✓ Liaising with facilities staff to keep the environment safe
- ✓ The list goes on.....



The challenges are daily and we work as a team to overcome these. We were all ward nurses once upon a time (some still are!) and primarily we consider ourselves part of the bigger RHC team. So if you see us coming, don't run and hide! Say hi and ask how we can help! We are here to support staff, patients and parents. Contact the RHC IPC Team on 0141 4516382!

IPC Puzzle Page

.....OK, time for a bit of fun!!

Puzzle 1:

Use the picture clues to work out the Infection Control term!!

EASY:

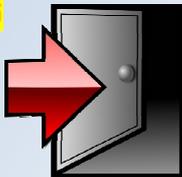


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GETTING HARDER



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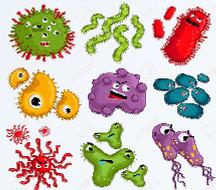


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THE TOUGH ONE



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Puzzle 2:

Winter is coming.....Rearrange the letters to reveal the winter condition, use the clues to help!

GETTING HARDER

A respiratory illness characterised by coryzal symptoms including fever, cough, headache, sore throat and aching muscles and joints

SROVINORU ←

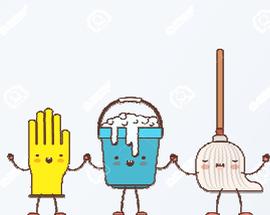
→ ZLUEINFNA

YORITREPRAS LYCINTSYLA URSIV ←

EASY: Causes outbreaks of gastroenteritis and normally occurs during winter and early spring

THE TOUGH ONE: This is a highly contagious virus that affects the respiratory system. Persons most at risk include young children, the elderly and immunocompromised adults.

Puzzle 3:



1. What would you use to clean up wet blood?
2. What would you use to clean up dried blood?
3. What does this symbol mean?



Puzzle Answers

Puzzle 1: Easy: Hand Washing

Getting Harder: Outbreak

The Tough One: Alert Organism

Puzzle 2: Easy: Norovirus,

Getting Harder: Influenza

The Tough One: Respiratory Syncytial Virus (that was a hard one, well done if you got it! !)

Puzzle 3: Wet blood: Chlorine granules or 10 000ppm available chlorine solution

Dried blood: 10 000ppm available chlorine solution

Symbol: single use

Useful Links



- ✓ [Infection Prevention and Control Manual \(link is available on all desktops\)](#)
- ✓ [Infection Prevention and Control Team Contact Details](#)
- ✓ [National Infection Prevention and Control Manual](#)