

Structures of Hospital Hygiene and Infection Control – an overview

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Rationale

EUNETIPS exists to

- enhance cooperation among nations
- share experiences and learning
- promote and support initiatives in infection prevention for patient safety particularly at the European level, recognising and making the most of all single member societies experience and skills .

Network ethos

- It respects and assumes the values of histories, traditions, activities and specificities of the existing scientific and professional societies
- It leaves each country to evolve at its own pace and to respect local characteristics
- Retains informal contact, shares initiatives, experiences, promotes joint products etc
- Guarantees mutual support for both critical situations and specific needs



Comparison of recommendations in national/ regional Guidelines for prevention and control of MRSA in thirteen European countries

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A. Eastaway⁹, P. Elstrom¹⁰, M. Girod Schreinerova¹¹, P. Hartemann¹², R. B.G. Iversen¹⁰, B. Jans¹³,
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Survey development

- Network meeting Stockholm 2009
- Presentations from participants on national structures and issues led to development of the survey
- Adoption of the Recommendation for Patient Safety and infection control June 2009 prompted further thinking on the impact of structures and resources for EU countries, organisations and patients

Survey

- Simple document completed electronically with manual evaluation
- Distributed to 26 member societies (18 countries) for completion with one response per country
- Analysis and discussion on the results and implications – still!

Results

- 16 responses out of possible 18 countries
- Questions directed at the hospital level (not community or mental health)
- Reporting on 7 of the survey responses

*Note term Infection control/hospital hygiene
Used synonymously throughout



Participants



Responses



Legislation

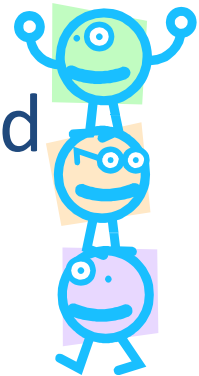
- 14 /16 reported the presence of national legislation for IPC. Additionally, 7 of the 14 countries also reported legislation at the state level.

Guidelines/recommendations

- Availability of IC/HH guidelines/recommendations to support practice
- From Government institutions 15/16
- From national professional or scientific institutions 12/16

IC/HH teams

- IC/HH doctors and nurses available in all 16 countries
- Link doctors used in 7/16 countries
- Link nurses/practitioners used in 12/16
- Use of non-specialist staff to undertake IC/HH staff roles reported
- Emerging roles e.g. DIPC role in England



Ratio of full time-specialist staff to patients

- Variation – ratios v minimum staff numbers
- 12/16 identified ratios of ICN's including some with additional patient risk factors and local need
- Emerging new roles (anti-microbial pharmacist, data analysts, in IC/HH teams – no baseline to work from
- More variation with ICD role
- Integration between acute and community settings requires consideration
- Possible differences between public and private facilities



Fulltime dedicated IPC staff (2009) – per acute hospital

Country	IC/HH Doctors per beds	IC/HH Nurses per bed
Austria	1:450	1:300
Bulgaria	1:500	1:200
England	1:1000	1:250 (informal)
France	1:800	1:400
Croatia	¼ FTE	1:250
Greece	1-2 FTE	1:300
Germany	1:>400	1:150-250*
Spain	1:300	1:250

Employment of staff

- Numerous potential models exist
- Hospital – 16/16
- Working with or pooling of staff – 12/16
- Private company – 4/16

- Models for employment undoubtedly impacts on numbers of staff employed

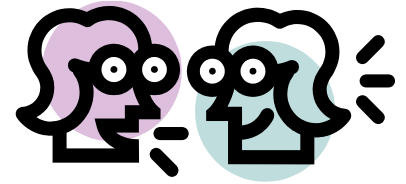
Media/public interest



Keyword MRSA

Country	Outcome
UK	800 (Daily Mail-118 – The Sun)
Netherlands	117 Volksgrant
Netherlands	182 Telegraaf
Bulgaria, Greece, Malta, Romania, Spain	< 10
Belgium, Germany, France	10-100

Notification



- Infectious diseases notifiable in all 16 countries
- Notification of MRSA varies according to sample and legislative requirements
- Outbreak notification to state institutions in 11/16 countries
- Public reporting of in-house statistics for resistant organisms 8/16

What does it mean?

- Small survey, EU and non-EU countries
- Not intended to assess compliance with (2009/C 151/01)
- Significant differences exist between IPC resources, political and clinical priorities and health issues in the participating countries
- It is not possible to currently identify specific approaches that produce demonstrable reductions in HCAI's

Considerations

- Many limitations to the survey but it highlights the diversity of structures and resources across Europe (EU and non-EU members) for IPC
- Patient and staff movement across borders is unlikely to reduce in the short term and may increase
- *Staff and patients will cross borders with very different perceptions of risks, quality and safety if variation is present, impacting in IC/HH at organisational and possibly national levels.*

Considerations -2

- Media profile of IC/HH varies widely
- Media is influential at the local, regional and political level - friend or foe?
- Differences in resources and available data (notification and surveillance) on IPC will make choice on health decisions difficult based on quality (but possibly not price!)
- Money is in short supply

Future considerations

- Looking forward to future healthcare needs and public contact with healthcare – how will IPC structures cope with changes to length of stay, increase in long term conditions and public health threats e.g. Liver disease, obesity, anti-microbial resistance?
- Ratio of specialist staff/teams to patients – need to consider community needs, in-patients v admissions, risk factors and the use of link and other staff

Recommendations

- Are difficult!
- Await the outcomes of TRICE
- Consider more widely the needs and roles of IC/HH team competence as influencers and facilitators as opposed to 'doers' or educational achievement
- Consider a more in-depth study to investigate structures, resources, systems and processes as well as 'softer issues' to complement TRICE and EU recommendation

