AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

A national approach *C difficile*

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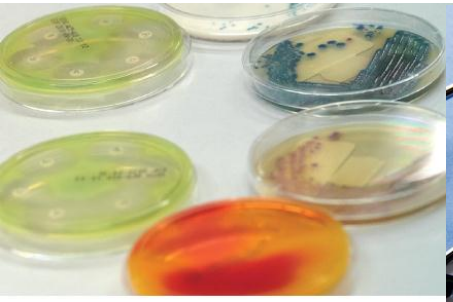



- Background
- Why CDI?
- Progress (or not) to date in national data collection and analysis
- Future ….

Performance and Accountability Framework

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Australian health organisation

- Large country; small population along seaboard
- Federation of 8 states & territories
- Health funded by commonwealth but managed by states & territories
  - No real national HAI surveillance
  - Diversity of definitions
  - Data ‘owned’ by 8 jurisdictions

- 50% surgery undertaken in private hospitals

Health Reform 2011

National Health and Hospitals Network Act 2011

ACSQHC

National Health Performance Authority

Independent Pricing Authority

Performance and Accountability Framework

Performance and Accountability Framework

The Commonwealth, states and territories will develop a new Performance and Accountability Framework, which will incorporate national performance indicators agreed by the Council of Australian Governments (COAG), and national clinical quality and safety standards to be developed by the Australian Commission for Safety and Quality in Health Care.

This framework will provide the basis for national reporting for Medicare Locals and Local Hospital Networks.

Role of ACSQHC

- established by the Council of Australian Governments
- to lead and coordinate national improvements in safety and quality in health care.
- providing strategic advice to Health Ministers on best practice thinking to drive safety and quality improvements.
- develop and support national safety and quality standards
- formulate national accreditation schemes
- develop national datasets
- monitor, report and publish on safety and quality matters
- provide leadership
- promulgate knowledge on safety and quality.

Role of National Health Performance Authority

- to monitor, and prepare reports on, matters relating to the performance of the following:

  (i) local hospital networks;

  (ii) public hospitals;

  (iii) private hospitals;

  (iv) primary health care organisations;

  (v) other bodies or organisations that provide health care services;

Independent Hospital Pricing Authority

- determines the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis

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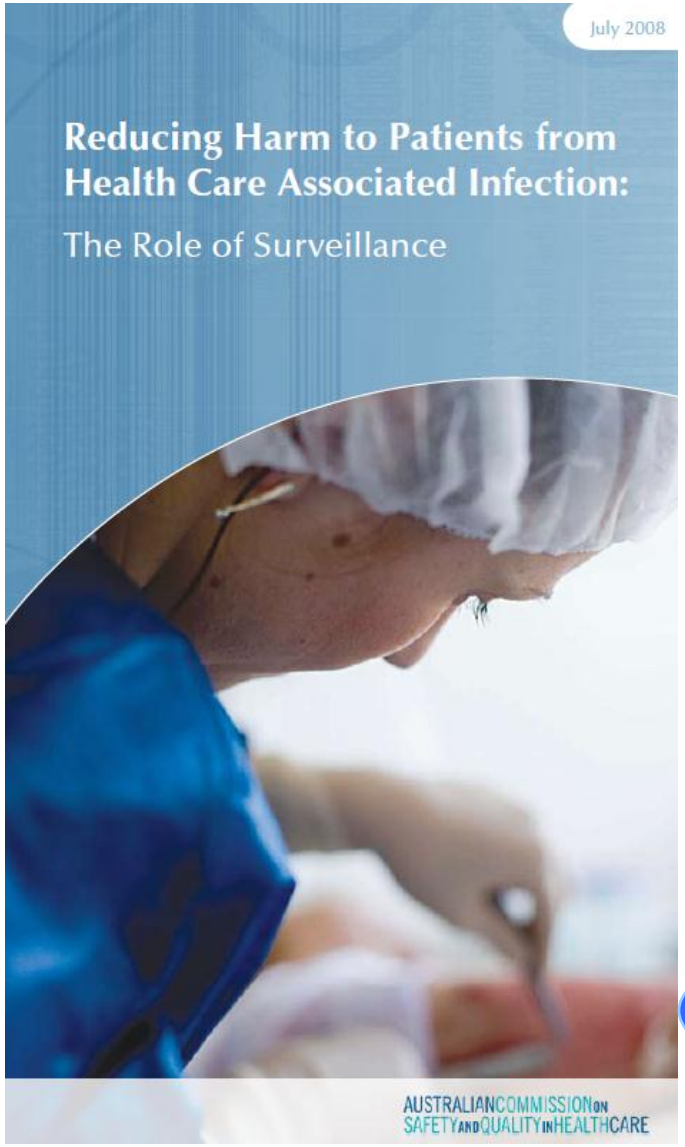
National HAI surveillance: mid 2007

No systematic Australia-wide approach to HAI surveillance

- Considerable variation
- Work undertaken by many disparate specialist groups
  - Despite widespread activity in most jurisdictions
  - Many individual initiatives (some endorsed by AHMC)
  - Publication of a number of national reports
    - 1999 - Joint Expert Technical Advisory Committee on Antibiotic Resistance (JETACAR)
    - 2001 - National surveillance of HAI in Australia
    - 2003 - National Strategy to Address Health Care Associated Infections
    - 2004 - Health Care Associated Infections Advisory Committee
    - 2006 - Expert Advisory Group on Antimicrobial Resistance (EAGAR)

HAI Surveillance



- Addressing areas of national importance in surveillance

In December 2008, Health Ministers approved the following actions for implementation of a national approach to the surveillance

1. All hospitals establish HAI surveillance

2. All hospitals monitor and report into a national data collection

- ***Staphylococcus aureus*** **blood stream infections**
- ***Clostridium difficile*** **infections**
- **Hand hygiene rates**

Reason for monitoring *Clostridium difficile*

- Causes significant patient morbidity and mortality in hospitals and long term care facilities.
- Few data available on the incidence of *C.difficile* in Australia
- Inconsistent approach to the identification and management in Australia.
  - Local ability to detect and respond to occurrence is limited.
  - Limited ability to detect any increases in cases or trends due to absence of surveillance.
- Highly virulent strains of *C.difficile* emerging overseas must be detected early to prevent major harm to Australian patients.

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Progress 2009 -2010

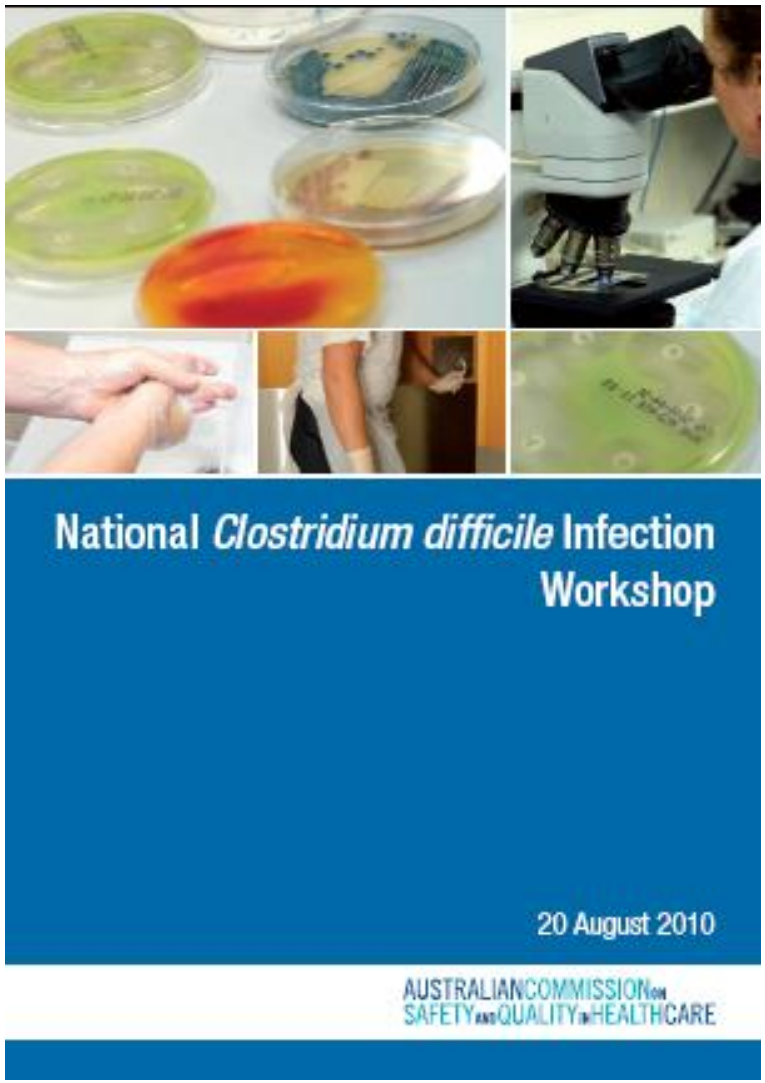
2009

- First case of hypervirulent *C.difficile* identified in Western Australia
- Consensus definition endorsed by all jurisdictions in January
  - Based on international recommendations – adapted for ease of use
- Development of *C.difficile* Data Set Specifications (DSS) endorsed by all Health Ministers

2010

- Hypervirulent cases *of C.difficile* identified in Victoria & NSW
- Discussion at CDNA re possibility of making CDI 'notifiable'
- National survey of *C.difficile*
- ACSQHC coordinated a national workshop with representation from all jurisdictions to assist in the management of *C.difficile* infection

Survey



- Proposed survey caused anxiety among jurisdictions especially in regard to patient identification
- No agreement for clinical data to be included
- ACSQHC convened a workshop of experts to assist policy makers with information and agreement on future options

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Agreed priority action areas from the workshops

- Implementation of antibiotic stewardship programs in all health care facilities
- Cleaning protocols (policy, education, compliance and auditing)
- Early risk identification/ assessment of patients
- Investigation of *C.difficile* infections (RCA, sentinel events and feedback for hospitals)
- Provision of education and information to frontline staff on the prevention of *C.difficile*, including cleaners
- Consistent national definition for *C.difficile* and criteria for classification of severe disease for surveillance purposes.

National Survey 2010

- National laboratory based snapshot of *C.difficile* isolates for a 1 month period.
- Included isolates from patients presenting with or developing diarrhoea during hospitalisation
- All jurisdictions excluding Victoria were included. (Victoria had recently undertaken a statewide survey)
- 330 isolates were collected
- No clinical information on severity of disease was collected.

Recommendations

- Further surveillance including epidemiological and clinical information to define epidemiology and clinical correlates of strain information
- Guidelines for the control of *C.difficile*, antibiotic stewardship in hospitals, aged care facilities and the community
- Standard laboratory procedures
- Formation of reference facilities to undertake strain typing for *C.difficile.*

Progress 2011 - 2012

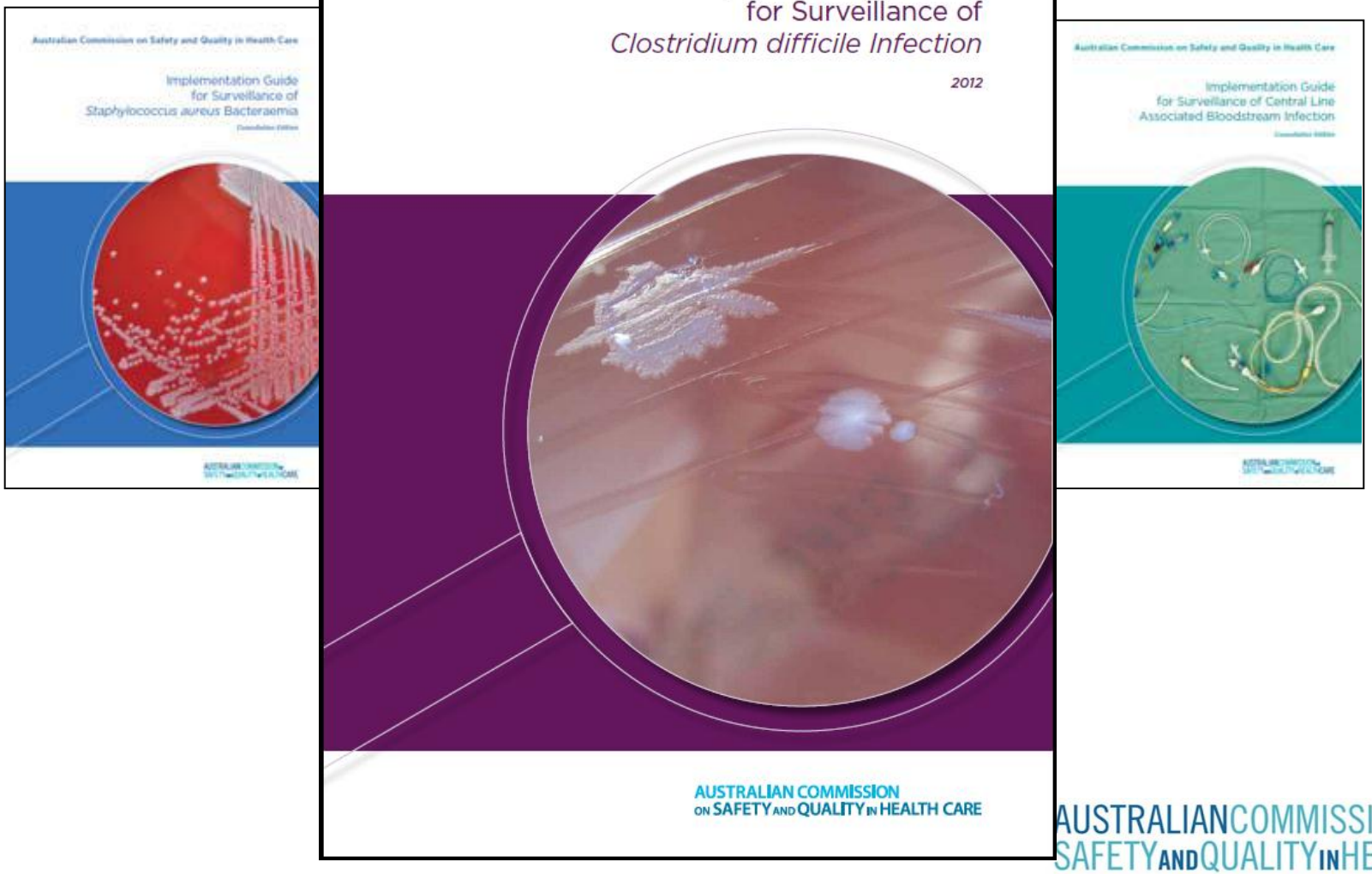
2011

- Guidelines for diagnosis and treatment (MJA 2011:194;7)
- Element in the national core indicators for safety and quality (Performance and Accountability Framework)

2012

- Developed Implementation guide for surveillance of *C.difficile*
- Repeat national survey of *C.difficile*
- The DSS submitted to National Health Infection Standards Statistics Committee (NHISSC) and national meta data registry MeTeOR
- Awaiting approval by all jurisdictions (7/8)

Surveillance implementation guides



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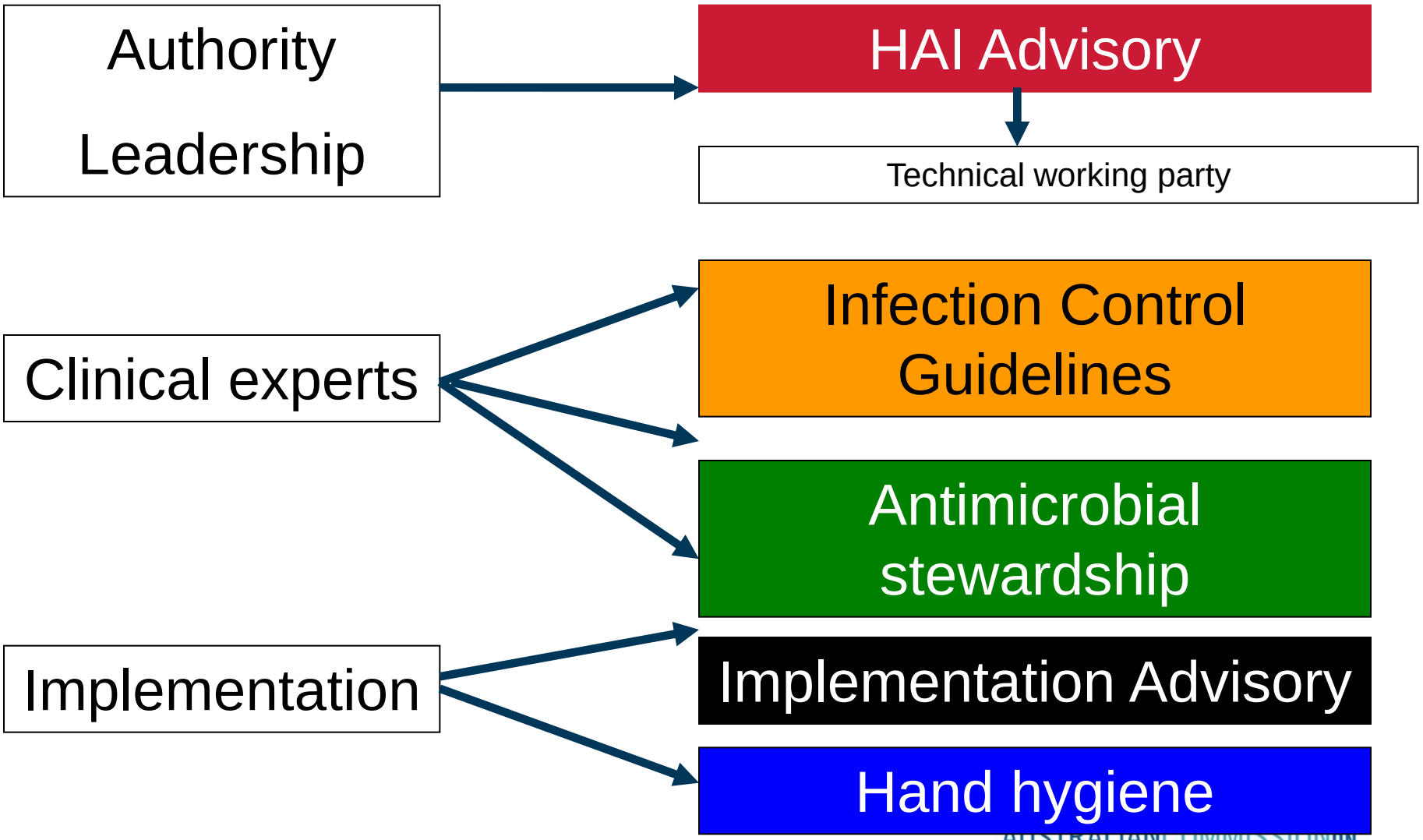
Surveillance Implementation Guide

- Developed by the ACSQHC Health Care Associated Infection Technical Working Group, made up of jurisdictional representatives.
- Provides consistent national *C.difficile* surveillance definition.
- Current definition includes
  - hospital identified *C.difficile*.
  - additional information for optional surveillance to determine healthcare associated or community onset *C.difficile*.

Putting policy into practice



Technical working group

- Meet monthly with ACSQHC
- Representatives:
  - Queensland: Centre Healthcare Related Infection Surveillance Program (CHRISP)
  - Victoria: VICNISS and Dept Human Services
  - South Australia: Communicable Diseases Branch
  - Western Australia: HISWA
  - Tasmania: Tasmanian Infection Control Unit
  - 2012 onwards NSW: Clinical Excellence Commission

2012 Hospital reporting PAF

My Hospitals website national reporting of SAB and hand hygiene rates

Australian Government
Australian Institute of Health and Welfare

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Safety and quality

Staphylococcus aureus bacteraemia

This page currently presents data on healthcare-associated *Staphylococcus aureus* bacteraemia (SAB) associated with care provided by each hospital.

The SAB data are provided to the AIHW by state and territory health authorities for public hospitals and by individual private hospitals. Data are only reported for hospitals where available—generally, this is for hospitals covered by a healthcare-associated infection surveillance program. Day hospitals are not usually covered by a healthcare associated infection surveillance program as healthcare associated infections are not generally diagnosed during a day hospital stay.

Three pieces of information are reported for hospitals that have information on SAB:

1. the number of cases of SAB associated with care provided by the hospital (both admitted and non-admitted care) during the reported time period
2. the number of days of patient care under surveillance during the reported time period for the hospital
3. the SAB rate for the reported time period expressed as the number of cases of SAB per 10,000 days of patient care.

There is a national benchmark of no more than 2.0 cases per 10,000 days of patient care for acute care public hospitals in each state and territory. This benchmark was agreed by the Council of Australian Governments in the National Healthcare Agreement.

The NSQHS Standards 2013

Standard 1
Governance for Safety and Quality in Health Service Organisations

Standard 2
Partnering with Consumers

Standard 3
Healthcare Associated Infections

Standard 10
Preventing Falls and Harm from Falls

Standard 9
Recognising and Responding to Clinical Deterioration in Acute Health Care

Standard 4
Medication Safety

Standard 8
Preventing and Managing Pressure Injuries

Standard 5
Patient Identification and Procedure Matching

Standard 7
Blood and Blood Products

Standard 6
Clinical Handover

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Criteria for Standard 3

- **Governance and systems for IPC and surveillance**

3.2.1 Surveillance systems for HAI are in place
3.2.2 HAI surveillance data are regularly monitored…

Where are we now?

- monitoring of hospital-identified CDI rates endorsed by Health Ministers in 2008 (HAI surveillance) and 2009 (core, hospital-based outcome indicators)
- specified for reporting by NHPA in the *Performance and Accountability Framework* (PAF)
- CDI surveillance Data Set Specification (DSS) has been published
- *Implementation Guide* describes the preferred method for capturing data.
- routine surveillance of CDI occurs in all jurisdictions
- no single system used nationally for hospital-level surveillance
- monitors the number of hospital-identified cases, per 10000 occupied bed days (hospital-acquired or non-admitted may also be recorded)

- CDI strain is optional for capture where local typing is available.
- no formalised process for generating national CDI reports. Jurisdictional practice varies.
- Survey currently underway……
  - Includes the collection of clinical patient information

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Reporting Capabilities for 2013

Enterprise Data Warehouse 2013

- The purpose of this report will be to show rates of CDI, by strain, over time. The report will be able to report this data by
  - Hospital
  - Local Health Network
  - Jurisdiction
  - National trends

Repository for CDI data

- Recommendations from HAI Advisory Committee
  - Periodic snapshot typing (1-2 times per year) with clinical data
  - Typing of all specimens where patients has “severe disease” eg admission to ICU
  - Explore collaboration on analysis and reporting
- Credentialed users will access reports on CDI via the COGNOS Reporting Layer of the NHR-EDW. Initially, the reports will be generated by Commission staff