Department of
Health, Social Services and Public Safety
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WRITTEN STATEMENT TO THE ASSEMBLY BY HEALTH MINISTER EDWIN POOTS – WEDNESDAY 4 APRIL 2012 – INTERIM REPORT ON PSEUDOMONAS INCIDENTS IN NEONATAL UNITS

I wish to make a statement to the Assembly about the publication of the Interim Report of the Independent Review of Incidents of *Pseudomonas aeruginosa* Infection in Neonatal Units in Northern Ireland.

I will begin by expressing again my condolences to the families who suffered the loss of their baby.

I also want to thank the families who have contributed to this review so far. The death of a baby is devastating for their parents and the wider family circle. The suffering of a baby who has contracted a potentially life-threatening infection is heart-rending and the anguish of their families is unspeakable. To relive these events so others may never have to suffer the same must have been incredibly difficult but it was selfless and hugely courageous.

I want to acknowledge also that this has been a difficult time for the staff who have been involved.

On 31 January, I made a statement to the Assembly to update Members on the pseudomonas incidents in neonatal units. I said then that I had asked the Regulation and Quality Improvement Authority (RQIA) to facilitate an independent review of these incidents, and that I had asked for an interim report by end of March so that urgent actions could be taken.

Professor Pat Troop has led the review. On 30 March she presented the interim report to my Department.

The interim report focuses on the first two Terms of Reference of the review. These were: (1) to investigate the circumstances contributing to the occurrences of pseudomonas infection in neonatal units from 1 November 2011, and (2) to review the effectiveness of the Trusts' management of the occurrences of pseudomonas infection and colonisation within neonatal units.

The Interim Report is being published today, 4 April, on the RQIA's website: www.rqia.org.uk. The report is also being placed in the Assembly Library.

The report is concise and is written with the lay reader in mind. I would encourage Members to read the report fully and closely.

The Interim Report contains 15 recommendations (Annex A). A number of these can be implemented immediately, and will be. I have asked my Department to develop an action plan with a timetable for taking forward those recommendations that require a significant lead-in time or investment.

I want to thank Professor Troop and the review team for completing this phase of the review within the timeframe that I set, and for the clarity of their report.

The Review will now focus on the third and fourth Terms of Reference. These are: (3) to review the effectiveness of the governance arrangements across all five Health and Social Care Trusts with regard to the arrangements for the prevention and control of infection and all other relevant issues in the respective neonatal units, and (4) to review the effectiveness of the communication between the DHSSPS, the HSCB, the PHA and the five Health and Social Care Trusts in respect of all relevant information and communications on the pseudomonas bacterium. I have asked to receive the final report by 31 May 2012.

The Review team has made it clear that it is keen to hear from the families who have not yet accepted their invitation to engage with them.

I am grateful to the Health, Social Services and Public Safety Committee for agreeing to meet during the Easter recess to hear directly from Professor Troop and the Review Team. They will be able to explain more fully the significance of their findings through response to the questions that Members will want to ask.

I want to underline that I am determined to ensure that the lessons from this Interim Report and the forthcoming Final Report are applied diligently and effectively across all relevant parts of the HSC which is clearly the only appropriate response to the tragic events that led to this Review. I will report further to the Assembly at that stage.

We must not forget that at the centre of this matter are families who have been bereaved through these tragic events, as well as many more families who have been through great anxiety. We owe it to these families to do everything we can to prevent such tragedies and incidents from happening again.

Annex A

Recommendations

1. The current interim guidance that sterile water should be used when washing all babies in neonatal care (Levels 1, 2 and 3) should be continued pending early consideration of the Department of Health (England) guidance issued on 30 March 2012.2

2. Tap water should not be used in maternity and neonatal units during the process of defrosting frozen breast milk.

3. The current arrangements for testing water in neonatal units in Northern Ireland for pseudomonas should be continued pending early consideration of the Department of Health (England) guidance issued on 30 March 2012. This guidance sets out recommendations for water testing for all augmented care units including neonatal care.

4. The presentation of test results of water samples should be standardised across the laboratories which undertake this for HSC organisations.

5. The review team recommends that guidance on cleaning sinks should be reviewed so that practice is standardised across all clinical areas.

6. Regional guidance on the cleaning of incubators and other specialist equipment for neonatal care should be produced.

7. Independent validation of hand hygiene audits should be carried out on a regular basis, supported by robust action plans where issues of non-compliance are identified.

8. The intensive care accommodation in the neonatal unit at Antrim Area Hospital should be expanded to allow more circulation space around cots.

9. Pseudomonas aeruginosa should be identified as an alert organism for neonatal intensive and high dependency care. When identified from a sample from a baby, taps and sinks should be tested in rooms which had been occupied by that baby since birth.

10. Surveillance arrangements should be established for Pseudomonas aeruginosa for augmented care settings including neonatal care.

11. All relevant organisations should work to an agreed regional protocol for the declaration of outbreaks.

12. Arrangements for the typing of strains of Pseudomonas aeruginosa should be established in Northern Ireland.

13. A regional neonatal network should be formally established in Northern Ireland.

14. The hours of availability for the regional transfer service for neonates should be expanded with plans put in place to move to a 24 hour service.

15. The development of the new Regional Neonatal Intensive Care Unit at Royal Jubilee Maternity Service should be expedited as soon as possible. In the interim period, improved accommodation for the purposes of isolation and for the cleaning of equipment should be made available for the current unit. Steps to improve the space around each cot should be considered.