Audit of the public health management of meningococcal disease in the South West

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INTRODUCTION

Invasive meningococcal disease is caused by a gram-negative bacteria called Neisseria meningitidis. It is a serious life-threatening condition that disproportionately affects young children and teenagers. It is a notifiable disease.

The Health Protection (Notification) Regulations 2010 state the duty of medical practitioners and laboratories:

“to notify the proper officer where there is reasonable grounds for suspecting a patient has a notifiable disease... (and) if the case is considered to be urgent, notification must be provided orally as soon as reasonably practicable (within 24 hours)”

The role of public health in protecting the wider population centres around:

- Areas for improvement within the Health Protection Team (HPT)
- Teaching opportunities e.g. around notification responsibilities
- Engagement with acute trusts
- Ward rounds
- Direct discussions with clinicians

AIM

To assess the public health management of meningococcal disease in the South West over a period of 12 months to identify areas for improvement across the wider healthcare system.

RESULTS

Notification

Early notification, i.e. within 24 hours, occurred in 61% of cases. 10% of cases were notified more than 3 days late, up to 10 days in a few cases. The audit identified specific hospitals where delayed notification was a concern.

Documentation

Incomplete documentation of HPZone records was also identified as a concern, particularly with regards to pre-admission antibiotics and vaccination status.

Investigation

Actions relating to laboratory investigation of cases were well completed. However challenges were noted in terms of understanding to what extent they are completed. For example, an action to “advise throat swab for culture” may have been completed but there was limited evidence of nasopharyngeal swab results on HPZone records.

CONCLUSIONS

The audit highlighted delays in notification and highlighted specific trusts to work with to improve early notification. It also identified areas for improvement within the Health Protection Team (HPT) processes to ensure accurate and consistent recording of information.

A total of 10 recommendations were made to ensure better collaborative working across the health system and improve quality of care for patients and the public.

Areas for action:

- Dissemination of results to stakeholders
- Engagement with acute trusts
- Teaching opportunities e.g. around notification responsibilities
- Raising awareness e.g. regarding unusual presentations
- Health Protection Team internal processes e.g. use of the case record form, to establish a minimum dataset and how to record, updates to the SOP and provision of a diagnostic template
- Re-audit

The recommended changes have been fed back to the SOP and a training session is being planned.

ACKNOWLEDGEMENTS

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REFERENCES