

INFECTION CONTROL ANNUAL REPORT

APRIL 2007- MARCH 2008

Dr. Alaric Colville and Mrs. Judy Potter

Directors of Infection Prevention and Control

CONTENTS

Section		Page
	Key Issues/Executive Summary	1
1	Introduction	2
2	Infection Control Arrangements	3
3	DIPC Reports to the Board	5
4	Outbreaks and Incident Reports	6
5	Mandatory Surveillance of Healthcare Associated Infection	10
6	Voluntary Surveillance of Healthcare Associated Infection	12
7	Hand Hygiene	15
8	Aseptic Clinical Protocols	15
9	Decontamination	16
10	Cleaning Services	17
11	Targets and Outcomes	19
12	Audit	20
13	Training Activities	23
14	Policies and Guidelines	23
Appendices		
Appendix 1	Progress against Infection Control Annual Programme 2007/8	
Appendix 2	Infection Control Committee Terms of Reference	

Appendix 3	Healthcare Associated Infection Reporting Mechanisms	
Appendix 4	Infection Control Committee – Decision Briefings	
Appendix 5	Outbreaks of suspected or confirmed Norovirus	
Appendix 6	New cases of <i>Clostridium difficile</i> infection	
Appendix 7	MRSA Bacteraemias - Pre and Post 48 hours of admission	
Appendix 8	All new cases of MRSA identified more than 3 days after admission	
Appendix 9	Total Number of New MRSA Incidences per Quarter across the whole Healthcare Community	
Appendix 10	Overall Trust Hand Hygiene Compliance	
Appendix 11	Decontamination Committee - Annual Report	
Appendix 12	Infection Control Training Needs Analysis	

Key Issues/Executive Summary

1. The Trust is compliant with the Health Act 2006 - Code for the Prevention and Control of Health Care Associated Infection (the 'Hygiene Code')
2. The Trust was able to declare compliance with C4a of the Healthcare standards
3. The Trust has achieved the majority of the planned infection control activities outlined in the annual programme 2007/8.
4. There has been a reduction in new cases of MRSA and the MRSA bacteraemia target was achieved with a 65% reduction.
5. *Clostridium difficile* infection remains a key issue within the Trust and whilst numbers remain low in comparison with many other organisations, an increase has been seen in 2007/8.
6. Norovirus infection outbreaks continue to place considerable pressure on the organisation but the availability of a rapid test for Norovirus detection aids rapid detection and timely control measures prevent further spread.
7. Hand hygiene compliance has continued to improve and stands at 81% compliance at the end of year.
8. Up to the point of discharge, no surgical site infections were observed in patients who underwent hip and knee arthroplasty between July and December 2007. This compares to national rates of 1.4% for hip arthroplasty and 0.7% for knee arthroplasty.
9. Voluntary surgical site surveillance of large bowel surgery has shown a reduction of infection from 12.8% in 2005 and 5.8% in 2008. This compares favourably with the national aggregated rate of 9.1%.
10. Standards of environmental cleanliness remain a priority and the deep cleaning of all wards was achieved by March 2007. However, some challenges in man power availability have been identified in areas with increased *C.difficile* infection and measures have been taken to rectify this.

1. INTRODUCTION

- 1.1 This is the fourth annual report produced by the Directors of Infection Prevention and Control at the Royal Devon and Exeter NHS Foundation Trust (RD&E). The annual report is a public document and was first introduced following the publication of the Chief Medical Officer's report entitled 'Winning Ways' in 2004.
- 1.2 Healthcare associated infection has become a top priority for the public, patients and staff. Avoidable infections are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources. Investment in infection prevention and control is therefore both necessary and cost effective. The resources committed by the RD&E to infection prevention and control can be appreciated in the contents of this report.
- 1.3 The purpose of this report is to inform patients, public, staff, Trust Board and Commissioners of the infection control work undertaken in 2007/8, the management arrangements, the state of infection control within the RD&E and progress against performance targets.
- 1.4 The report describes infection control activities that were planned and detailed in the annual programme for 2007/8 (Appendix 1). This is designed to produce continuity and address national and local priorities. This report also details the responses required for those unpredictable incidents, detected through surveillance and alert observation, that must also be controlled to reduce the risk of preventable infection in patients.

2. INFECTION CONTROL ARRANGEMENTS

2.1 Infection Control Team (ICT)

2.1.1 The infection control team employed by the RD&E also provides a service to the entire Devon Partnership Trust (DPT) and the localities of the Devon Primary Care Trust (DPCT) formerly known as Exeter, East Devon and Mid Devon PCTs.

2.1.2 The lead nurse (1.0 WTE) is responsible for leading the infection control nursing service across the three organisations and managing the associated service level agreements. For each organisation, there is a distinct clinical infection control team functioning within the combined service. All members of the nursing service are capable of working in each of the three organisations, with regular rotation amongst the Band 6 posts helping to develop specialist practitioners who recognise and respond to differing levels of risk, differing needs and can apply their clinical knowledge and skills in a variety of settings.

2.1.3 The RD&E nursing team consists of:

1.8 WTE Band 7	Specialist Clinical leads for defined clinical areas
2.0 WTE Band 6	Infection Control Nurse Specialists
0.8 WTE Band 6	Audit and Surveillance Nurse

In addition, a successful bid to the Strategic Health Authority for healthcare associated infection funding resulted in the short term (6 month) appointment of an additional 1.0 WTE Band 6. This funding was used for enhanced ward based education known as clinical facilitation.

2.1.4 The DPT nursing team consists of:

1.0 WTE Band 7	Specialist Clinical Lead
2.0 WTE Band 6	Infection Control Nurse Specialists

2.1.5 The DPCT nursing team consists of:

0.6 WTE Band 7	Specialist Clinical Lead
0.8 WTE Band 6	Infection Control Nurse Specialists

2.1.6 The department is supported by admin and clerical staff:

1.0 WTE Band 4	Office Manager.
1.0 WTE Band 3	Team Secretary

2.1.7 The DPT funds 50% of the band 3 secretarial post and also 0.1 WTE of the Lead Nurse salary.

- 2.1.8 There remains an element of the original 'shared service' funding between the PCT and the RD&E with monies equivalent to a 0.75 WTE Band 7.
- 2.1.9 All three Consultant Medical Microbiologists play an active role in infection control. However, one Microbiologist fulfils the role of Infection Control Doctor with 4 sessions allocated for this purpose. The same microbiologist is also the infection control doctor for the DPCT and DPT.
- 2.1.10 An on call service ensures that infection control advice is available 24 hours a day, 7 days a week. All nurses providing this service have completed a recognised specialist programme of study and are experienced in the field of infection control.

2.2 Budget allocation

2.2.1 Staff

Budget allocation for staffing is in accordance with the grades of staff indicated in Section 1.

2.2.2 Support (IT etc)

The cost of licences for infection control surveillance software, IC net, were met from within the infection control budget.

2.2.3 Training

The infection control team has a small budget for training and also a charitable fund which can be used for educational purposes.

2.3 Director of Infection Prevention and Control

The Infection Control Doctor and the Lead Nurse continue to share the role of Director of Infection Prevention and Control (DIPC), reporting directly to the Chief Executive.

2.4 Infection Control Committee (ICC)

The Committee is chaired by the DIPC and meets quarterly. The terms of reference and membership have been reviewed this year and are attached at Appendix 2.

2.5 Reporting line to Trust Board

The DsIPC report to the Board through the Chief Executive. The ICC reports to the Trust Board via the Governance Committee. The assurance framework for infection prevention and control can be viewed at Appendix 3

2.6 Links to Drug and Therapeutics Committee

A Medical Microbiologist is a member of the Drug and Therapeutics Committee and provides the link between the Committees. In addition an Antimicrobial Subcommittee has been established during the last year as a sub group to the Drug and Therapeutics Committee and is chaired by the Infection Control Doctor/DIPC.

2.7 Links to Clinical Governance/Risk Management/Patient Safety

The DIPCs are members of the Governance Committee, the Nursing and Midwifery Governance Committee and the Health and Safety Committee.

3. DIPC REPORTS TO THE BOARD

The DIPC is accountable directly to the Trust Chief Executive and reports to the Chief Executive and Board. Both the Infection Control Doctor and the Infection Control Lead Nurse who share the DIPC appointment are members of the Governance Committee. Reporting arrangements are outlined at Appendix 3.

3.1 Number and Frequency

The Infection Control Committee (ICC) meets 4 times a year. The committee reports to the Trust Board, through the Governance Committee, which meets 8 times a year. A "Decision Briefing" is prepared after each ICC meeting, and is included as a standing item in the following Governance Committee meeting (Refer Appendix 4). This ensures that the most important items from the ICC are formally noted by the Governance Committee and thus, brought to the attention of the Board.

3.2 Annual Action Plan/Annual Programme

An annual programme is prepared by the ICT, agreed each year by the ICC and approved by the Board. The annual programme for 2007/8 runs from April to March and is prepared for the ICC meeting each year. The programme of work is mapped to the duties of the Hygiene Code. Progress against the annual programme is monitored by the ICC. The programme and progress against the annual programme can be found at (Appendix 1)

3.3 Board Decisions

The Board approves annual plans, policies and guidelines developed by the infection control team, both new policies and significant revisions of existing policies and guidelines. These and other issues are generally considered by the Governance Committee and other relevant committees first.

4. OUTBREAK AND INCIDENT REPORTS

4.1 Incidents and outbreaks are unpredictable events. Every year the Infection Control Team recognises and responds to significant episodes. Some incidents are potential risks that have to be controlled; others turn out to be chance clusters not caused by cross infection. It is not unusual to see variation in surveillance data, and the ICT has to be alert to all potential outbreaks, and investigate them accordingly.

4.2 Incidents and outbreaks may be recorded in several different ways. Many are recorded in the minutes of the weekly Infection Control Team Meeting. Some are included in Infection Control Committee minutes. Where an outbreak is considered significant because of its size or the lessons learnt in its management, a specific outbreak report is prepared and disseminated through the Governance system.

Some noteworthy events are listed below. The ICT and ICC minutes are also available for examination.

4.3 Norovirus outbreaks

4.3.1 Norovirus causes an unpleasant, usually short lived, illness with diarrhoea and vomiting (previously called winter vomiting disease). Every year there are outbreaks thorough-out the community, usually during the winter months.

4.3.2 It is a very infectious condition that can spread easily and rapidly if introduced into any institution such as a school or hospital. If Norovirus spreads in a hospital it can be extremely disruptive, affecting patients and staff. Research shows that control by closing affected areas until free of infection is the most effective solution.

4.3.3 Norovirus will always remain a threat to the hospital. A significant effort and commitment will always be required to minimise the impact.

4.3.4 The RD&E has developed a system to minimise the risks and the impact of what is the inevitable introduction of Norovirus into the hospital when there is activity in the local community. This system includes:

- Identifying patients with symptoms suggestive of norovirus infection on or prior to admission. A questionnaire about symptoms is used to assess emergency admissions both in the Emergency Medical Unit and in the Emergency Department.
- Designating isolation rooms on Torridge ward for medical admissions with symptoms suggestive of, or confirmed as, Norovirus infection.
- Use of a rapid test for norovirus detection (Norovirus PCR).

- 4.3.5 As shown in appendix 5, 2007/8 was a difficult year for Norovirus in the RD&E, with more ward closures than in the previous year. This reflected activity in the community and neighbouring Trusts in the South West.
- 4.3.6 A major outbreak meeting was held in January to examine and review the response to Norovirus. Additional resource was committed to providing more frequent, twice daily, and out of hours Norovirus PCR tests. This allowed management of suspected infections to be improved, for example areas can be rapidly opened when suspected cases prove not to be due to norovirus.

4.4 *Clostridium difficile*

- 4.4.1 *Clostridium difficile* is a germ that can cause colitis (inflammation of the colon), and symptoms range from mild diarrhoea to life threatening disease. Infection is associated with healthcare, particularly the use of antibiotics which can upset the bacterial balance in the bowel that normally protects against *C. difficile* infection. Infection may be acquired in the community or hospital, but symptomatic patients in hospital may be a source of infection for others.
- 4.4.2 *C. difficile* infection rates are closely monitored in the RD&E, and are also reported to the Health Protection Agency through its mandatory national surveillance programme (see HPA website www.hpa.org.uk). Control of *C. difficile* is taken very seriously in the RD&E. Continuous surveillance is in place using statistical process control methods to detect possible outbreaks. Any incident is investigated to ensure guidelines are being followed and to implement special measures if necessary. Laboratory testing for *C. difficile* is available 7 days a week.
- 4.4.3 In 2007/8 the RD&E experienced an increase in its rate of *C. difficile* cases (Appendix 6), particularly in the winter months, although the organisation continues to perform well compared with many other Trusts. Several clusters of infection were investigated.
- 4.4.4 Typing of strains showed that about half of the cases were due to the 027 strain that is recognised as causing a particular problem in hospitals.
- 4.4.5 Control included isolation of patients on Torridge ward, an intensive terminal clean of wards with clusters or cases, investigation of antibiotic use, and reinforcement of routine environmental hygiene and staff hygiene including hand decontamination.
- 4.4.6 Studies and experience suggest that to control *C. difficile* a range of measures must be effectively in place, and inadequacies in any one can increase the risk of outbreaks. These measures include early

recognition of cases, effective isolation, antibiotic control, good hand hygiene and effective regular environmental cleaning.

- 4.4.7 Increased *C. difficile* occurred particularly when the hospital was extremely busy and during co-incidental Norovirus activity. Outbreak investigations suggested that pressure on staff, especially domestic cleaning and nursing staff may have been contributory. Although ward hygiene audit scores were high, cleaning frequency may not always have been sufficient for the purposes of *C. difficile* control. Action to improve possible areas of weakness in environmental hygiene has been undertaken.
- 4.4.8 Investigation of hand hygiene and antibiotic use suggested that practice was generally good.

4.5 Endoscopy unit

- 4.5.1 In June 2007, isolates of *Mycobacterium lentiflavum* were made from 3 specimens obtained by bronchoscopy from patients' lungs (broncho-alveolar lavages). This is an environmental mycobacterium, an organism not usually associated with human infection. The likely source was contamination of bronchoscope channels used to take samples during the investigations.
- 4.5.2 Flexible endoscopes are instruments such as bronchoscopes, gastroscopes and colonoscopes, used to visualise the gut and respiratory pathways. They are delicate instruments, and have to be decontaminated using chemical methods, as heat decontamination would destroy them.
- 4.5.3 Rinse water used in the decontamination process may occasionally become contaminated with organisms, including environmental bacteria. The resulting contamination of endoscope channels can lead to false results from culture, and occasionally infection in patients. It was felt that contaminated rinse water was the most likely cause, although routine testing had revealed no problem.
- 4.5.4 An outbreak meeting was held and likely causes considered.
- 4.5.5 Investigations included taking water samples and filters from the endoscope washer disinfectors to culture for mycobacteria.
- 4.5.6 Samples from the washer disinfectors were investigated at the RD&E Food and Environmental Microbiology Laboratory and also sent to the Regional Mycobacterium Unit in Cardiff.
- 4.5.7 Immediate control measures included changing all external and internal filters in the washer disinfectors and using ethanol to flush all endoscope channels after the final rinse.

- 4.5.8 A review of isolations from bronchoscopically obtained specimens was conducted to determine if there were additional possible cases.
- 4.5.9 Investigations confirmed that the rinse water and internal filters were contaminated with slow growing mycobacteria, types normally found in low numbers in domestic water supplies.
- 4.5.10 Cultures were negative following control actions.
- 4.5.11 In addition the old endoscope washer disinfectors were replaced as part of the programme to provide a central endoscope decontamination unit in the new endoscopy suite. The replacement machines are state of the art and water used is supplied through a reverse osmosis unit. In addition rinse water can be easily sampled as part of a routine quality assurance process implemented with the new machines.
- 4.5.12 Investigations showed that no patients were infected, and none inappropriately treated as a result of the incident.

4.6 Cold Water - legionella risk reduction in the Centre for Women's Health

- 4.6.1 The water system in large buildings can support the growth of legionella bacteria, which in certain circumstances can lead to cases of Legionnaires' disease. Normally the risk is controlled by keeping hot and cold water systems within defined temperature limits, although other methods of control are recognised.
- 4.6.2 Monitoring of water temperatures during and after commissioning of the Centre for Women's Health showed that, in some areas of the new building, the cold water temperatures failed to achieve the required temperature for legionella control. At times the cold water monitoring showed it exceeded the requirement to be less than 20°C.
- 4.6.3 In response the Trust continued an enhanced monitoring of water temperatures within the building and began weekly cultures of the cold water system for legionella at selected points at the end of the cold water distribution systems.
- 4.6.4 To control and reduce the risk of Legionnaires' disease, cleaning staff started daily flushing of outlets in at risk areas. In addition a business case for and the purchase and installation of a silver/copper ion system was fast tracked.
- 4.6.5 Silver/copper ion systems are recognised methods of controlling legionella in water supplies, and they release copper and silver ions into the water system at levels safe for humans that inhibit the growth of bacteria. The system was installed in January and commissioned on 4th February 2008.

4.6.6 Culture for legionella showed limited isolation of *Legionella pneumophila* and other legionella species prior to commissioning the copper/silver ion system. Levels of legionella isolation have subsequently dropped. Monitoring by culture continues but the risk to patients and staff is considered to be very low.

5. MANDATORY SURVEILLANCE OF HEALTHCARE ASSOCIATED INFECTION

Mandatory reports are made to the Health Protection Agency (HPA). Some reports are made on line monthly and others are quarterly.

5.1 *Staphylococcus aureus* bacteraemia

5.1.1 *Staphylococcus aureus* is a bacterium commonly found colonising humans. Although most people carry this organism harmlessly, it is capable of causing a wide range of infections from minor boils to serious wound infections and from food poisoning to toxic shock syndrome. In hospitals it can cause surgical wound infections and bloodstream infections.

5.1.2 This has been reported since April 2001, so at the end of the year 2007/8 seven full years of reports had been submitted. Data has been submitted monthly since October 2005.

5.1.3 Reports from the RD&E consist of all *Staph. aureus* isolated from blood cultures processed by the RD&E Microbiology Department.

5.1.4 These include all isolates, whether true infections or contaminated blood cultures; hospital acquired or community acquired infections.

5.1.5 Although most blood cultures originate from the RD&E, specimens submitted from community hospitals and General Practitioners are also included in the returns.

5.1.6 Results are expressed by the HPA as total episodes of *Staph. aureus* bacteraemia, and meticillin resistant *Staph. aureus* (MRSA) bacteraemia. Rates of bacteraemia episodes per 1000 bed days, are also calculated.

5.1.7 Targets for reduction of MRSA bacteraemia were set by the DH using 2003/4 data as the baseline. The RD&E were required to make a 60% reduction by 2008 i.e. no more than 20 cases in 2007/8. A 65% reduction was achieved with 18 cases reported. This is a major achievement for the Trust.

5.1.8 The HPA report continues to attribute all MRSA bacteraemia, regardless of source, to the RD&E.

5.1.9 In October 2005, an enhanced data set was introduced which allows the distinction to be made between MRSA bacteraemia occurring before admission or within 48 hours of admission and those that occur more than 48 hours after admission.

5.1.10 In 2007/8 50% of the bacteraemias occurred within the first 48 hours of admission (Appendix 7).

5.2 Glycopeptide resistant enterococcal (GRE) bacteraemia

5.2.1 Enterococci are normally found in the gut, and are part of the normal human gut flora.

5.2.2 Although a common cause of urinary tract infections, enterococci can occasionally cause serious infections such as endocarditis. In immunocompromised patients, for example, haemodialysis patients and haematology patients, especially those with intravascular lines, enterococci may cause bacteraemia.

5.2.3 Glycopeptide resistant enterococci are resistant to glycopeptide antibiotics such as vancomycin and teicoplanin. These have been reported to the HPA since July 2003. The same criteria for selection and denominators as *Staph. aureus* applies.

5.2.4 The number of cases reported are low and cases are usually sporadic. Further information can be obtained from the Infection Control Team.

5.3 *Clostridium difficile*

5.3.1 *Clostridium difficile* is a bacterium that may grow in the bowel and cause diarrhoea and colitis which can be life threatening. It is mainly a complication of antibiotic therapy and particularly affects the frail and elderly who have been prescribed broad spectrum antibiotics.

5.3.2 *C. difficile* is a healthcare associated infection (first recognised in 1977), and has been linked to serious outbreaks in hospitals. Mandatory surveillance for infection in over 65 year olds has been undertaken since 2004.

5.3.3 For mandatory reporting purposes, all diarrhoeal stools submitted to the microbiology laboratory from people aged 65 or more are examined for *C. difficile* toxins. Episodes are reported. An episode consists of one or more *C. difficile* toxin positive stools during a 28 day period. For the first time in 2007 episodes of *C. difficile* in patients between the ages of 2 and 65 were also reported.

5.3.4 Total number of stools examined for routine culture and *C. difficile* are also reported as denominators.

5.3.5 Although the number of cases remains below the national average, an increase in cases has been experienced during 2007/8 and considerable effort continues to reduce levels further (Appendix 6).

5.4 Orthopaedic Surgical Site Infection

5.4.1 In 2004 it became a mandatory requirement to conduct surveillance of orthopaedic surgical site infections, using the Surgical Site Infection Surveillance Service of the HPA. The data set collected is forwarded to the HPA for analysis and reporting. This system is controlled and validated to allow comparison between centres.

5.4.2 The requirement is for a 3 month module of surveillance of *one* of the orthopaedic options, namely

- Open reduction of long bone fracture
- Hip arthroplasty
- Knee arthroplasty

5.4.3 However, this year *continuous* surveillance of all knee and hip arthroplasty was started in July 2007.

5.4.4 We have received reports on the first two quarters i.e. July to September and October- December.

5.4.5 The aggregated rate of infection (identified prior to discharge) for all hospitals participating in the surveillance programme is 1.3% for hip arthroplasty and 0.7% for knee arthroplasty. At the Royal Devon and Exeter, 0% infections were identified.

5.4.6 Surveillance reports are available on request from the Infection Control Team.

6. VOLUNTARY SURVEILLANCE OF HEALTHCARE ASSOCIATED INFECTION

In addition to mandatory surveillance, the infection control team conducts voluntary surveillance to monitor hospital infection in several areas. Some of the surveillance is ward based, such as surgical site infection, some is laboratory based. These include the following:

6.1 Bacteraemia surveillance

6.1.1 Hospital acquired bacteraemia for **all** organisms (not just *Staph. aureus* or MRSA) is undertaken routinely. This surveillance includes recording the major risk factors for hospital acquired bacteraemia, defined as bacteraemia occurring after 48 hours in hospital.

- 6.1.2 Invasive devices, mainly peripheral and central cannulae remain the commonest risk factor associated with hospital acquired bacteraemia, and are a focus for prevention.
- 6.1.3 Measures to reduce the length of time dialysis patients use central lines before permanent dialysis access is established have contributed to a significant reduction of staphylococcal bacteraemias in this group of patients.
- 6.1.4 The Trust has established a Vascular Access Team to improve intravenous practice and educate relevant staff groups. One early result is an increased use of peripherally introduced central catheters (PICC), which are safer and more comfortable for patients who require intravenous therapy over several days.
- 6.1.5 Reports are issued quarterly to all departments. Copies can be obtained from the Infection Control Department.

6.2. *Clostridium difficile* toxin positive diarrhoea

- 6.2.1 In addition to mandatory reporting, and Trust wide monitoring of *Clostridium difficile* infection which is reported to the Infection Control and Governance Committees, ward specific cases are monitored and feedback provided to individual wards in the form of statistical process control charts.
- 6.2.2 This assists with the early identification of clusters of cases and the impact of control interventions.
- 6.2.3 An extensive dataset from *C. difficile* patients including antibiotic use and response to treatment is now collected. Information obtained will help to improve both control and patient management.

6.3. MRSA Newly Identified

- 6.3.1 The numbers of patients diagnosed as MRSA positive for the first time are collected from laboratory data.
- 6.3.2 This includes people who are colonised (i.e. carrying the organism without any sign of infection) and those who have an infection of any type, not just blood stream infections.
- 6.3.3 The number of new cases identified more than three days after admission continues to decrease. (Refer Appendix 8).
- 6.3.4 The number of new cases across the whole local health community appears to have plateaued (Appendix 9). However, this demonstrates the number of new people who become colonised or infected not the cumulative total. Consequently, the total number of people in the community with MRSA colonisation or infection continues to rise.

6.4 Antimicrobial Resistance

- 6.4.1 Antimicrobial resistance is detected in the microbiology laboratory when bacterial isolates are routinely tested for antimicrobial sensitivities.
- 6.4.2 However studies have shown that because of the bias present in the selection of samples sent for laboratory testing, rates of resistance measured in the laboratory do not reflect that truly present in the community. Resistance tends to be overestimated.
- 6.4.3 Since 2005, the laboratory has tested all significant isolates of coliform organisms for the presence of extended spectrum beta-lactamase (ESBL) and AmpC enzymes.
- 6.4.4 These enzymes when present in bacteria cause resistance to a wide range of penicillin and cephalosporin antibiotics, and are often linked to other resistance factors.
- 6.4.5 ESBL positive organisms are widely spread in the Country and have caused outbreaks in some communities.
- 6.4.6 Infections tend to occur in elderly people, especially those with urinary tract infections, and urinary catheters.
- 6.4.7 Current monitoring shows ESBL rates in the RD&E catchment area are stable.
- 6.4.8 *Staph. aureus* rates of resistance to meticillin (MRSA) is also routinely monitored.

6.5 Surgical Site Surveillance

- 6.5.1 In 2007 voluntary surveillance of surgical site infection following large bowel surgery, using the Surgical Site Infection Surveillance Service of the HPA, took place between October and December.
- 6.5.2 As with mandatory monitoring for orthopaedic infections, the data set collected is forwarded to the HPA for analysis and reporting. This system is controlled and validated to allow comparison between centres.
- 6.5.3 Operations on the large bowel have a relatively high risk of infection, because the large bowel is heavily contaminated with bacteria.
- 6.5.4 Results showed that the rate of infection was lower than that observed during a previous period of large bowel surgical site infection monitoring in 2005.

6.5.5 The overall rate was 12.8% in 2005 and 5.8% in 2008. 5.8% compares favourably with the 9.1% aggregated rate for all hospitals that have participated in the surveillance programme since 1997.

6.5.6 The full report can be obtained from the Infection Control Team.

7. HAND HYGIENE

7.1. The NPSA 'cleanyourhands' campaign continues and involves four main components:

- ◆ Point of care alcohol hand rub
- ◆ Awareness and role model posters
- ◆ Patient involvement
- ◆ Audit of practice and feedback to wards/dept using run charts.

7.2 Audits are usually multidisciplinary. However, particular concern about compliance amongst some medical staff led to an audit of medical staff only in April 2007. This confirmed that compliance was unacceptably poor.

7.3 A range of *additional* interventions were made, focusing particularly on medical staff, including the availability of electronic training updates, introduction of the bare below the elbow policy and positive role modelling from some senior medical staff.

7.4 Another audit of medical staff was undertaken in November and a 35% increase in compliance was recorded. Trustwide compliance is now at approximately 80% (Appendix 10).

8. ASEPTIC CLINICAL PROTOCOLS

The principles of asepsis are included on the Trust induction programme for new staff. Clean and aseptic technique principles are also provided as part of nursing and medical student education.

8.1 Saving Lives High Impact Interventions

A dramatic reduction in line associated bacteraemias has been achieved in the dialysis patients following a series of improvements in practice over the last two years. The renal dialysis catheter care high impact intervention is now used on a monthly basis to monitor practice in all the dialysis units. This work is coordinated by the renal vascular access nurse to whom requests for further details should be directed.

9. DECONTAMINATION

9.1 Arrangements

- 9.1.1 The Decontamination Committee is responsible for monitoring decontamination arrangements and compliance overall and reports directly to the Governance Committee.
- 9.1.2 This is chaired by the Trust Decontamination Lead. Both the Infection Control Lead Nurse and Infection Control Doctor are members of the Decontamination Committee.
- 9.1.3 The achievements made in decontamination over the last year are recorded in the Committee's annual report (Appendix 11).
- 9.1.4 The Hospital Sterilisation & Decontamination Unit (HSDU) continues to be fully compliant to the standard ISO9001/2000 ENISO 13485 and is working to the 93/42 EEC Directive.
- 9.1.5 All surgical instruments are centrally re-processed following the removal of the final bench top sterilisers during 2007.
- 9.1.6 A surgical instrument tracking system was purchased during the year and implementation will be complete in the summer of 2008.
- 9.1.7 During the course of the year major expansion of the Endoscopy unit has been completed and now includes a central endoscopy decontamination unit which is HTM 2030 compliant.

9.2 Audit

- 9.2.1 HSDU conduct internal audits to ensure their compliance with ISO9001/2000, ISO13485 and 94/32 EEC Directive and are externally audited twice a year by a notified body.
- 9.2.2 An audit of the Endoscopy Unit by the Joint Advisory Group, included criteria relating to decontamination. The findings of the audit were positive. Report available on request.
- 9.2.3 Audit against Healthcare standard C4c by the Internal Audit Department demonstrated full compliance with the standard.

9.3 Incidents/Failures Investigated

- 9.3.1 All incidents are reported to the Trust Risk Manager and are graded as minor, moderate or major.
- 9.3.2 All incidents graded moderate or above are fully investigated. If any learning outcomes are identified system changes are implemented.

9.3.3 A problem with contamination of endoscope rinse water with environmental mycobacteria was encountered. This is more fully described in Section 3.4.3 of this report.

9.3.4 No patients were harmed and the commissioning of a new endoscopy unit with centralised decontamination and replacement washer disinfectors, has eradicated problems associated with the older models of washer disinfectors.

10. CLEANING SERVICES

10.1 Management Arrangements

All cleaning services are managed in-house.

10.2 Monitoring Arrangements

10.2.1 Monitoring is undertaken in accordance with the National Specification for Cleanliness in the NHS. Housekeeping Services use the NHS approved Credits for Cleaning (C4C) monitoring system which was successfully introduced during 2006.

10.2.2 Dedicated monitoring officers (2.0 WTE) record technical monitoring on a weekly basis as required by the National Specification.

10.2.3 Areas of cleaning failure are recorded on a rectification sheet which is given to the duty supervisor to action and follow up.

10.2.4 All ward sisters /charge nurses are sent a printed list of the cleaning results at the time of audit so that if there are any nursing issues these can be noted and rectified. Matrons are now also sent a copy of any nursing issues identified

10.2.5 Collated results of monitoring are e-mailed to the Lead Nurses, Senior Matrons and Matrons on a monthly basis and show 3-month rolling results for wards and departments.

10.2.6 In addition to this a Quarterly Management audit is undertaken by a multi-disciplinary team and the results of this are used to monitor the technical audits undertaken on a weekly basis.

10.3 Budget Allocation

It is a rolling budget. Any additional requirements or new areas are funded by the division to which they relate. Preparation of BC1 Forms and costings are supplied by the Hotel Services Manager.

10.3.1 The Credits for Cleaning (C4C) programme has now been successfully in use for over 2 years and a significant amount of data relating to

current resources and the recommended minimum frequency of clean requirements has been recorded.

- 10.3.2 The output data is used in the re-design of Housekeeping Services and their delivery in order to meet the ever changing needs of the Trust. Examples of this were the complete revision of all ward work schedules introduced in preparation for the introduction a cook-freeze patient meal service which requires ward level plating of meals as opposed to the previous system that was plated in the main kitchens.
- 10.3.3 The impact of cook freeze service on cleaning activities has been monitored closely in 2007/8 and this has identified that additional resources are required at ward level to ensure full compliance with work schedule requirements throughout the day and evening.
- 10.3.4 C4C was also used to re-design the work schedules and manpower required for the Centre for Women's Health that opened in June 2007. This was effective in allowing the Lead Nurses more freedom to negotiate the delivery of cleaning services within their areas of responsibility whilst remaining within the set parameters.
- 10.3.5 Call-off funding for a dedicated infection outbreak cleaning team was allocated in 2006/07 and has made a significant difference to the response times for organising terminal cleaning and re-opening a ward. It has been confirmed that this funding will be allocated annually.
- 10.3.6 Additional monies were also secured from the Strategic Health Authority to increase the cleaning resources available for public area cleaning and specialist cleaning requirements through a 24-hour period.

10.4 Clinical Responsibility

The Matrons and Senior Matrons have responsibility for ensuring that clinical care is provided in a clinically hygienic environment. They work closely with the Housekeeping Supervisors, the Housekeeping Services Manager and the Hotel Services Manager to ensure that standards are maintained.

10.5 Clinical Access

- 10.5.1 Access to the clinical areas is made during the day time in in-patient areas and in the evening or at night in outpatient or day case departments. This minimises disruption to patients and clinical staff.
- 10.5.2 Following patient consultation, restricted visiting hours have been introduced and this has continued to provide improved access for cleaning.

10.6 User Satisfaction Measures

10.6.1 A satisfaction survey of Matrons is undertaken quarterly

10.6.2 The Housekeeping supervisors hold monthly meetings with Ward Sisters/Charge Nurses and Matrons and in 2007 the ICNA Environmental audit tool was introduced to provide structure to the visual inspections and monthly meetings.

10.6.3 In 2008 we are employing a further new post of Quality Monitoring Officer (ward catering). Although this post holder will primarily be involved with audited the food services at ward level, they will also be undertaking pain-patient satisfaction surveys for both food and cleaning services.

10.7 Patient Equipment Cleaning

10.7.1 Following work undertaken by one of the Divisional Lead Nurses a definitive list of Patient Equipment has been established in order to identify responsibility, frequency and method of cleaning and there is now a Patient Equipment Cleaning Policy.

10.7.2 A further review of this document is currently in progress in order to ensure compliance with the Minimum Frequencies of Cleaning requirements for patient equipment.

11. TARGETS AND OUTCOMES

11.1 MRSA Bacteraemia

The target of a 60% reduction over three years, based on the baseline in 2003/4, has been achieved. In fact, a 65% reduction was achieved, a reduction from 52 cases in 2003/4 to 18 cases in 2007/8.

11.2 Cleaner hospitals (PEAT scores)

PEAT inspections are undertaken annually by self assessment. The team undertaking the inspection includes a member of the public. Overall, standards have improved since 2006/7 and the PEAT report has been submitted to the National Patient Safety Agency. The final score will be available in July 2008.

11.3 Deep cleaning programme of all wards

All in-patient areas were deep cleaned by the end of March 2008.

11.4 Healthcare Standards – C4a

Although several of the standards are related to infection control, core standard C4a is specifically relevant. Following assessment by the internal audit department the Trust continues to declare compliance with this standard.

11.5 Compliance against the Hygiene Code

Compliance with the Hygiene Code continues to be strengthened through achievements identified in the annual programme of work (Appendix 1).

11.6 Local Targets

11.6.1 Progress with the Infection Control Annual Programme has been monitored by the Infection Control Committee and, in general, planned activities have been completed (Appendix 1).

11.6.2 An ambitious Trust wide hand hygiene target of 85% was agreed at the start of the year, having achieved 70% by the end of 2006/7. Further improvement has been made with compliance at 81% in March 2008 (Appendix 10).

12. AUDIT

12.1 Environmental Audit

As reported in Section 7, cleanliness standards audits are undertaken monthly by the Trust monitoring officers and are validated quarterly by a team which includes infection control nurses and Matrons. The audit assesses both environmental and patient equipment hygiene. Reports are available on request from the Hotel Services Manager.

12.2 Hand Hygiene Audit

12.2.1 Observational audit of hand hygiene practice has continued, using an adapted Lewisham Observational Audit tool.

12.2.2 Observations are undertaken by link nurses who submit the data to the Infection Control Team. Feedback on compliance is provided in the form of a run chart.

12.2.3 Ward specific hand hygiene compliance charts are available from the Infection Control team on request.

12.3 Audit of Mupirocin Use in Renal Medicine

12.3.1 Patients receiving dialysis via a haemodialysis line should receive nasal mupirocin on insertion of a central venous catheter for dialysis and thereafter a 5 day course once a month.

- 12.3.2 This intervention was agreed in 2006 to reduce the risk of *Staph. aureus* bacteraemia in these high risk patients. Application of the mupirocin is preceded by a nasal swab to monitor *Staph. aureus* carriage and mupirocin sensitivity.
- 12.3.3 Previous audit in 2006 had shown poor compliance due to national supply problems of mupirocin. The audit in 2006 also showed that a documentation system needed to be established to support the process.
- 12.3.4 Following introduction of a new documentation system and resolution of the supply problems another audit was undertaken in September 2007.
- 12.3.5 This audit showed that an increased number of outpatients were receiving mupirocin and an increased number had nasal swabs taken (76%).
- 12.3.6 The audit also revealed that nasal carriage of *Staphylococcus aureus* remains low. No mupirocin resistance has been detected.
- 12.3.7 A full report can be obtained from the Infection Control Department on request

12.4 Audit of Patient Placement, Isolation and Infection Risk Assessment

- 12.4.1 This is an annual audit undertaken to formally assess the appropriateness of patient placement and use of isolation facilities and risk assessment of patients who cannot be isolated.
- 12.4.2 The audit identified that the introduction of an infection control alert (IC alert) onto the electronic white board has allowed patients with an IC Alert to be identified more readily by ward staff. As a result, nursing staff were able to identify patients on wards with an IC alert who would have been unknown previously.
- 12.4.3 Twenty eight patients were nursed in bays, who would have been better placed in single rooms if these had been available. However investigation of these patients showed that the majority had been risk assessed and that they were being managed appropriately to minimise risk to others.
- 12.4.4 A full report can be obtained from the Infection Control Department on request.

12.5 MRSA Screening Audit on Hip / Knee Replacement / Revision Patients

12.5.1 Orthopaedic patients undergoing Hip or Knee replacements should be screened in the preadmission assessment clinic. An audit was taken to check the percentage of patients who were being screened and percentage of those who were identified as carriers of MRSA.

12.5.2 One hundred and twenty eight patients were included in the audit. 91% had been screened prior to admission. No carriers were identified.

12.6 Audit of the number of contaminated blood cultures

12.6.1 Contaminated specimens can result in wasted microbiology time and the potential for inappropriate antibiotic therapy.

12.6.2 Risk of contamination with skin flora can be reduced through adherence to good clinical hygiene during the phlebotomy process.

12.6.3 The results of this audit showed that 48.5% of positive blood culture specimens contained probable contaminants.

12.6.4 As most of the cultures were obtained in either the Emergency Department or Emergency Medical Unit, efforts to reduce contamination have been focused in these areas.

12.7 Antibiotic Prescribing

12.7.1 A new antimicrobial pharmacist was appointed in 2007, and additional pharmacist support for antimicrobial control was achieved as part of a successful bid for infection control monies from the SHA.

12.7.2 A programme of audits was started in early 2008 to monitor compliance with antimicrobial prescribing guidelines, including the use of stop dates and iv to oral switches. After a successful pilot it is planned to introduce regular audits to most clinical areas.

12.7.3 Audits were also conducted to look at antimicrobial prescribing in community acquired pneumonia cases and antibiotics prescribed to patients with *C. difficile*.

12.7.4 During 2007 an Antimicrobial Subcommittee of the Drug and Therapeutics Committee was formed to take responsibility for antimicrobials in the Trust. This first met in March 2008, and approved an annual programme which included audit activity

13. TRAINING ACTIVITIES

13.1 Induction for all Staff

The training needs analysis at Appendix 12 identifies the induction, annual update training and continuing education provided within the Trust.

13.2 For Infection Control Specialists

13.2.1 All members of the Infection Control Team are members of the Infection Prevention Society (IPS) and attend SW branch meetings which provide the opportunity for update and networking. All receive specialist journals as a benefit of membership which also aids development.

13.2.2 Three members of the team attended the IPS Annual Conference in Brighton. The Lead Nurse attended in her role as President of the IPS.

13.2.3 Three of the infection control nurse specialists are undertaking a Post Graduate Diploma in Infection Control, one in the first year and two in the second year. The programme of study is provided by Inverness College and is available on-line.

13.2.4 The Infection Control Doctor is a member of the Royal College of Pathologists and participates in the College's continuing professional development scheme. His annual CPD plan includes infection control.

13.2.5 He is also a member of the IPS. This year among other meetings with infection control educational content he attended the International Federation of Infection Control conference.

13.3 For the Joint DIPCs

13.3 The DsIPC both already hold specialist qualifications and have considerable experience within the field of infection control.

13.3.1 In addition to training undertaken as part of their personal development as Lead Nurse and Infection Control Doctor, the DIPC's have attended South West and national DIPC events.

14. Policies and Guidelines

A schedule for policies and guideline revision/development is included in the annual programme (Appendix 1). All policies are available on the Trust website and intranet.

Progress against Infection Control Annual Programme 2007/8

	Code of Practice Duty	Programme of work 2007/8	By whom (lead)	By when	Progress/Outcome
1.	General duty to protect patients, staff and others from HCAI	No specific work is mapped to this section as this duty overarches all the other duties outlined below.			
2.	Duty to have in place appropriate management systems for Infection Prevention and Control	<p>Hold four Infection Control Committee (ICC) meetings with decisions briefings to the Governance Committee.</p> <p>The ICC will review its TOR</p> <p>Regular attendance by a DIPC at Trust Governance Committee (GC)</p>	<p>Director of Infection Prevention & Control (DIPC)</p> <p>DIPC</p> <p>DIPC</p>	<p>Quarterly</p> <p>Nov 2007</p> <p>6 weekly</p>	<p>ICC meetings held according to schedule</p> <p>Complete</p> <p>DIPC has attended each GC meeting. Reports made quarterly. Infection Control Committee decisions briefings made after each Infection Control Committee. Outbreak and incident reports made as necessary.</p>

		<p>Present annual programme 2007/8 and annual report 2006/7 to Trust Board.</p> <p>Continue to strengthen Directorate level responsibility for infection control by ensuring that clinical Directorate leads include infection control issues at every Directorate Governance Group meeting</p> <p>Ensure that ICT has appropriate membership ensuring that provision is made to fill gap left by ICN embarking on 12 months maternity leave</p> <p>Work with Devon PCT interim infection control lead, to agree levels of service to be provided including Infection Control Doctor provision</p> <p>Agree triggers for ICT seasonal on call availability</p>	<p>DIPC</p> <p>Directorate infection control leads</p> <p>Judy Potter (JP)</p> <p>JP/Alaric Colville (AC)</p> <p>JP/MN Orzel</p>	<p>June 2007</p> <p>Each DGG</p> <p>June 2007</p> <p>June 2007</p> <p>July 2007</p>	<p>Completed</p> <p>Further strengthening required in Trauma and Orthopaedics, Child and Womens Health and Critical Care.</p> <p>Complete.</p> <p>Complete.</p> <p>Complete.</p>
3.	Duty to assess risk of acquiring healthcare associated infection and to take action to reduce or control risks	<p>Regular review HCAI risks identified on Trust Risk Register and report to Governance Committee</p> <p>Complete research project to determine whether MRSA carriage is</p>	<p>JP</p> <p>Penny Criddle (PC)</p>	<p>As required</p> <p>Sept 2008</p>	<p>Updated January 2007</p> <p>Completion delayed due to need to seek ethics</p>

	<p>higher in pregnant health and care workers than other pregnant women.</p> <p>Undertake continuous alert organism surveillance with SPC feedback on MRSA and C.difficile to :</p> <ul style="list-style-type: none"> - Wards and directorates - Infection Control and Governance Committees <p>Undertake mandatory, continuous surveillance of :</p> <ul style="list-style-type: none"> - Staph aureus and VRE bacteraemia - C. difficile in the over 2 year olds - Orthopaedic surgical site infection <p>Continue all organism bacteraemia surveillance</p> <p>Introduce surveillance of ESBL/AmpC coliforms in blood cultures and urine with feedback to Infection Control Committee</p>	<p>JP</p> <p>JP</p> <p>AC</p> <p>ICT</p> <p>C Pym (CP)</p> <p>CP</p> <p>ICT</p>	<p>Two Monthly</p> <p>Quarterly</p> <p>Continuous</p> <p>Continuous</p> <p>Continuous</p> <p>Quarterly</p> <p>May 2007</p>	<p>approval for changes to protocol.</p> <p>Completed.</p> <p>Completed.</p> <p>Completed.</p> <p>Completed</p> <p>Completed</p> <p>Completed.</p>
--	--	---	--	--

	Agree another focus for voluntary surgical site infection surveillance e.g. vascular	Infection Control Committee	May 2007	Completed
	Establish method for undertaking continuous orthopaedic surgical site infection surveillance that results in data collection within directorate	Pam Matten/JP	May 2007	System established but needing <u>considerable</u> supervision from Infection Control team to ensure that all patients and all information included.
	Undertake the following audits of practice :			
	Side room availability and utilisation	CP/Jeanette Thomas (JT)	June 2007	Completed
	Observation audit of hand hygiene	Link Nurses	Monthly	Audits undertaken in all areas although some not completed monthly.
	Nasal Mupirocin prophylaxis in dialysis pts	CP	May 2007	Completed x 2
	MRSA screening in preop. orthopaedic patients	CP	July 2007	Completed

		<p>Complete a prevalence study of catheter associated urinary tract infection following removal of silver coated catheters as the Trust standard catheter.</p> <p>Use Saving Lives High Impact Intervention tools to audit invasive procedures</p> <p>Continue to work with the pharmacy department to develop surveillance of antimicrobial consumption when enhanced IT systems are available</p>	<p>JP</p> <p>Ward Matrons</p> <p>AC</p>	<p>March 2008</p> <p>1st audit by Sept 2007</p> <p>Ongoing</p>	<p>Completed.</p> <p>Vascular access team have repeated audit of PVC. Bundle and renal team using dialysis line bundle regularly.</p> <p>Enhanced systems not yet unavailable.</p>
4.	Duty to provide and maintain a clean and appropriate environment for healthcare (including environmental hygiene, medical device decontamination and clinical hygiene)	<p>Ensure that there is infection control input to environmental monitoring systems</p> <p>a) Cleanliness Standards validation audits</p>	<p>JP</p>	<p>Quarterly</p>	<p>Completed</p>

		b)PEAT assessments	Linda Hall	March 2008	
		Provide specialist input to Cleaning Standards Group, PEAG and Matrons Charter group.	JP	As required	Specialist input provided to all
		Continue with 'Cleanyourhands' campaign which includes:	JP	Ongoing	Year 3 commenced. Posters distributed. Other awareness raising activities dovetailed with HCAI monies publicity campaign
		a) Patient involvement			
		b) Poster campaign			
		c) Near pt alcohol hand rub			
		d) Hand hygiene training			
		e) Observational audits with feedback charts	Link Nurses	Monthly	Trustwide compliance at approximately 80%
		Facilitate the introduction of new soap dispensers and higher quality soap	Hazel Hedicker	September 2007	Installed throughout Trust
		Undertake site survey to ensure that new soap dispensers are sited appropriately for ease of use.	Carlton Kneil (CK)	June 2007	Completed
		Work with Decontamination Lead, HSDU Manager and Critical care DM	AC/Peter Vickery	September 2007	Installation of cabling started.

	<p>to introduce electronic patient/surgical Instrument traceability system</p> <p>Ensure infection control and microbiology input to Decontamination Task Group through attendance at task group meetings</p> <p>Provide infection control/microbiology input to review of Legionella control measures through attendance at Legionella Control Team meetings</p> <p>Provide expert advice to all service developments to ensure infection risks are considered and good infection control facilities/practices built into the development. In particular, ensure that infection control is considered in the built environment through involvement of infection control expertise to capital projects from concept stages to commissioning</p> <p>a) Phase 4 b) Acute Model of Care/Emergency Hub c) Cardiology</p>	<p>JP/AC</p> <p>JP/AC</p> <p>Infection Control Team (ICT)</p>	<p>Quarterly</p> <p>6 monthly</p> <p>According to Project Plans</p>	<p>Should go live April 2008</p> <p>Completed</p> <p>Two meetings held plus extraordinary meetings regarding CWH.</p> <p>Complete Ongoing Complete</p>
--	--	---	---	--

		<p>d) Ophthalmology room in ED</p> <p>e) Endoscopy expansion</p> <p>f) Day surgery</p>			<p>Ongoing</p> <p>Ongoing</p> <p>Complete</p>
5. *	Duty to provide information on healthcare associated infections to patients and public	<p>Ensure that DIPC Annual Report is posted on RD&E website following presentation to the Board.</p> <p>Review range of pt information leaflets and explore possibility of audio advice on MRSA, C.difficile and Norwalk.</p> <p>Participate in members' focus group on Healthcare associated infection (HCAI) following membership survey results which highlighted HCAI as a top issue for members</p> <p>Present on progress with infection control and performance targets at Trust constituency meetings</p>	<p>Janet Oatley</p> <p>PC</p> <p>JP</p> <p>JP</p>	<p>July 2007</p> <p>Sept 2007</p> <p>July 2007</p> <p>Oct 2007</p>	<p>Complete</p> <p>Review completed.</p> <p>Completed</p> <p>Completed</p>
6. *	Duty to provide information when a patient moves from the care of one healthcare body to another	<p>Develop further the use of IC Alert on PAS and the e-whiteboard for infection control issues</p> <p>Investigate possibility of improving communication re IC risks with ED IT system.</p>	<p>JP</p> <p>JP/Fred Cock</p>	<p>Dec. 2007</p> <p>Dec 2007</p>	<p>Completed</p> <p>No progress. Business case required from ED for interface.</p>

7.	<p>Duty to ensure cooperation</p> <p>Each NHS body, so far that is reasonably practical, ensures its staff, contractors and others included in provision of healthcare co-operate with each other to meet obligations of code</p>	<p>Continue to provide training for contractors as required e.g. window cleaners, patient line</p> <p>Clarify infection control measures required for building contractors in terms of their protection but also in relation to dust minimisation, environmental cleaning.</p>	<p>JR</p> <p>ICT</p>	<p>As required</p> <p>As required</p>	<p>Has not been required</p> <p>Clarification provided as required.</p>
8.	<p>Duty to provide isolation facilities, adequate to need</p>	<p>ICT to work with paediatrics to ensure arrangements are in place to manage MDRTB should the need arise.</p> <p>Also - refer duty 4 re. built environment</p>	<p>JR</p>	<p>July 2007</p>	<p>Completed</p>
9.	<p>Duty to ensure adequate lab support</p>	<p>Enhance MRSA screening provision as per DH MRSA screening strategy</p> <p>a) position paper re implications of strategy for RD&E Infection Control Committee</p> <p>b) Business plans for additional resources if increase in screening agreed necessary</p>	<p>JP/AC</p> <p>Directorate leads</p>	<p>August 2007</p> <p>Depend on above</p>	<p>Superseded by HCAI monies project</p>

10.	Duty to adhere to all clinical policies and protocols applicable to infection prevention and control	Agree and implement antibiotic policy and committee	AC	August 2007	Completed
		Review and update the following IC policies/guidance			
		Standard Precautions	JP	July 2007	Completed
		C.difficile	JR	June 2007	Completed
		CJD	AC	June 2007	Approved in principle. Introduction of effective system for establishing risk factors for each patient to developed before policy goes live.
		Hepatitis B & C	JR	June 2007	Infection Control Committee agreed that this guidance was no longer required.
		Herpes simplex	Heather Pellow	Nov 2007	Completed
		Measles	Janet De' Witt	June 2007	Completed
Scabies	Sandra Marshall	June 2007	Completed		

10continued	VRE	PC	Oct 2007	Completed
		Viral gastroenteritis	JR	May 2007	Completed
		Viral haemorrhagic fever	JP	April 2007	Completed.
		Protective isolation	JR	Sept 2007	Completed
		MRSA	JP	ASAP	Completed
		Staff Health and Illness	PC	June 2007	Completed
		Decontamination Policy	JP	Nov 2007	Completed - approval at May ICC meeting
		Ward closure Policy	CK	June 2007	Completed
		Terminal Clean Guidelines	JP	May 2007	Completed
		Cystic Fibrosis	PC	Aug 2007	Completed
		IV policy/CVC guidelines	PC	Sept 2007	Update underway now that Vascular access nurse in post.
		Avian/Pandemic 'flu plans (infection control aspects)	AC	December 2007	Completed
		Develop guidance for PVL producing Staph. aureus infections	JT	Sept 2007	Awaiting publication of national guidance

11.	Duty to ensure that healthcare workers are free and are protected from exposure to communicable disease during the course of their work and are educated in infection prevention and control	Work with Occupational Health and Medical Director to improve uptake of MMR by Clinical staff in high risk areas	AC/VP/Anne Rossiter (AR)	July 2007	Completed
		Facilitate fit testing of FFP3 respirators in areas of high risk	JR	March 2008	Completed
		Develop infection control and invasive procedures training for medical staff as part of DOPs	AC/PC	September 2007	One training session completed.
		Revise and update e-training package for medical staff	JP	Dec 2007	Completed
		Continue to provide mandatory induction and update training for all other groups of staff	ICT	Ongoing	Completed. E-training developed for Allied Health professionals and other peripatetic staff.
		Deliver at least one link nurse training course	ICT	Dec 2007	Completed
		Provide quarterly link nurse updates	ICT	Quarterly	Completed
		Periodic publication of the 'Bug Issue' for staff	ICT	As required	Superseded by Trust infection control newsletter.

		Repeat infection control symposium for senior staff	ICT	Dec 2007	IC included in senior nurse away day. Masterclass with primary care focus completed.
		Revise pre-employment screening procedures in light of new national guidance on HIV and Hep C.	AR	Mar 2008	Completed - updated policy.

Infection Control Committee Terms of Reference

Healthcare Standards (CORE – C4a)	✓	Complaints	
Healthcare Standards (DEVT - please specify which standard)		Monitor	
Service Development Strategy		Finance	
Local Delivery Plan		Performance Management	
Assurance Framework	✓	Business Planning	
Other (Please specify)			
Code of Practice	✓		

1. Accountability

- 1.1 The Committee is a subcommittee of the Board of the Royal Devon and Exeter NHS Foundation Trust. It normally reports to the Chief Executive and the Board through the Governance Committee of which the Director of Infection Prevention and Control is a member.

2. Purpose

- 2.1 The Infection Control Committee is the forum for consultation between the Trust's Infection Control Team and all other Directorates and Departments of the Trust.
- 2.2 The Committee agrees and endorses the Infection Control Teams Annual Programme, which it also supports and monitors.

3. Membership

- 3.1 The Members of the Committee shall be appointed by the Board of Directors.
- 3.2 The Director of Infection Prevention and Control is chairman of the Committee
- 3.3 The membership shall be:
- Infection Control Team
 - Director/s of Infection Prevention and Control

- Chief Executive or a representative with delegated authority
- Medical Director
- Director of Nursing & Service Improvement or representative
- Consultant in Communicable Disease Control
- Occupational Health Physician or Nurse
- Director of Facilities/Decontamination Lead
- Directorate Infection Control Leads
- Medical staff - clinical champions for infection control issues
- Hotel Services Manager

3.2.1 This membership ensure that all disciplines and groups of staff are represented on the committee

3.2.2 If necessary additional members may be co-opted or invited at the discretion of the committee, for example if their skills are required to cover particular topics.

4. A Quorum

4.1 A quorum will consist of not less than five members of the Committee, and shall include:

- A Director of Infection Prevention and Control
- One of the following:
 - Chief Executive (or representative),
 - Medical Director or Director of Nursing & Service Improvement

5. Procedures

5.1 The Infection Control Committee shall appoint a secretary to prepare and distribute agendas, keep minutes and deal with any other matters concerning the administration of the Committee. The Secretary shall distribute unapproved minutes of the Committee's meetings to all members of the committee and the Governance Committee Manager within one month of a meeting.

5.3 The Chairman will prepare a '**decision briefings**' sheet after each Committee meeting to be sent to the Governance Committee Manager within one month of a meeting.

5.4 Any member of staff may raise an issue with a member of the Committee. The Chairman will decide whether or not the issue shall be included in the Committees business. The individual raising the matter may be invited to attend.

6. Frequency of Meetings

- 6.1 There will be four meetings a year. The Committee' annual cycle is the accounting year.
- 6.2 An extra-ordinary meeting may be called by the Director of Infection Prevention Control or at the request of the Chief Executive.

7. Duties and Responsibilities

- 7.1 Agree and monitor an annual programme of activity including surveillance, audit and education programmes.
- 7.2 Advise and support the Infection Control Team on the most effective use of available resources in delivering an annual programme to include audit surveillance and education.
- 7.3 Draw the attention of the Chief Executive and the Board to any serious problems or hazards relating to infection control.
- 7.4 Review reports on hospital acquired infection and infection control problems.
- 7.5 Commission, approve and review policies for all aspects of infection control and monitor their implementation.
- 7.6 Draw up plans for management of outbreaks both in the hospital and the hospital's response to major outbreaks in the community.
- 7.7 Ensure that all relevant legislation, Health Service Guidelines etc is reviewed and that appropriate amendments/additions are made to local policies and procedures.
- 7.8 Review the funding and resource implications of other infection control issues such as provision of adequate hospital facilities and accommodation and make appropriate recommendations to the Trust Board.
- 7.9 Receives the DIPC Annual Report.

8. Review

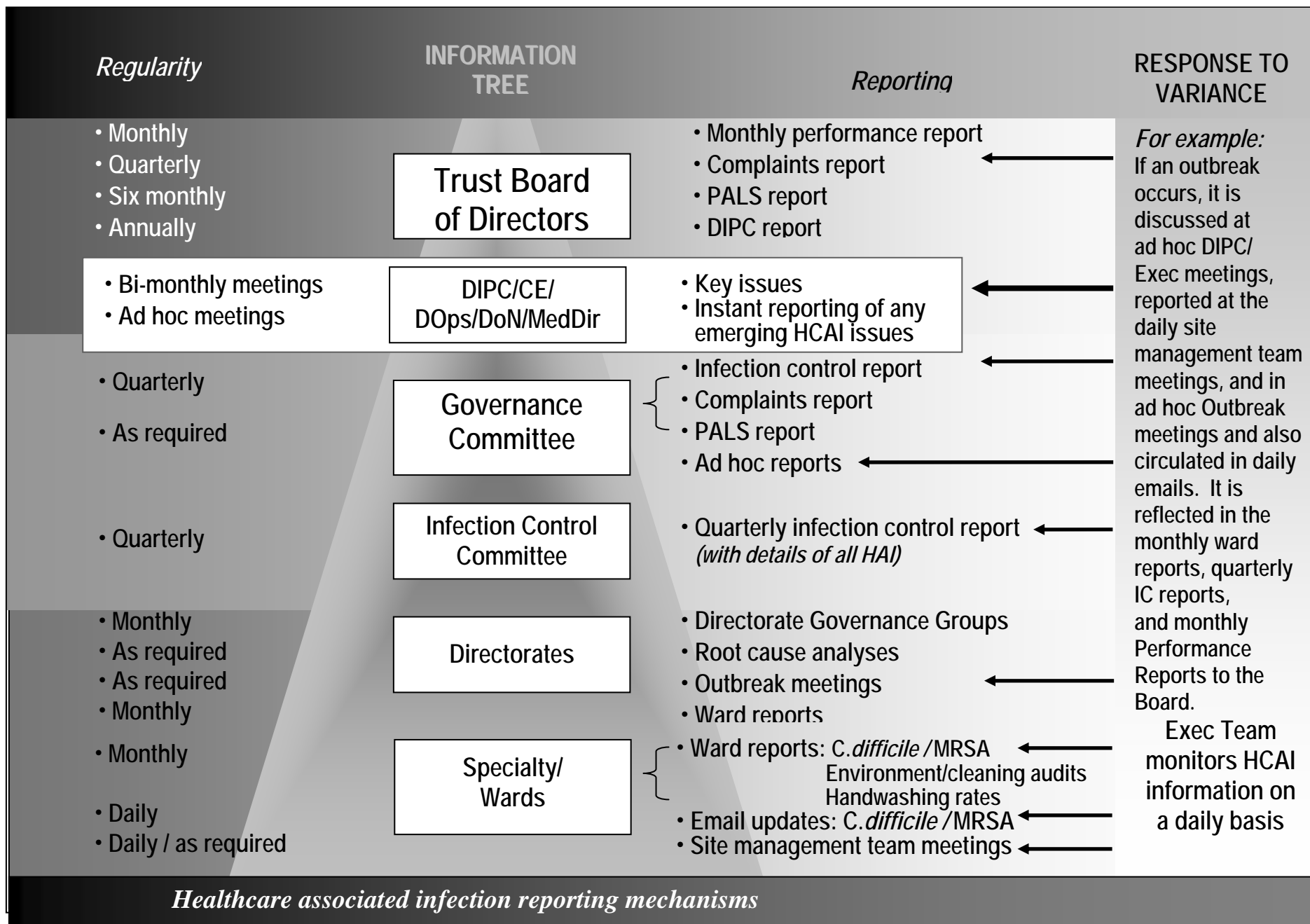
- 8.1 The Infection Control Committee will review its Terms of Reference annually and make recommendations to the Governance Committee for any changes required to ensure that the Committee remains fit for purpose.

9. References

9.1 Guidance on the functioning of the Infection Control Committee is produced by the Department of Health, the Health Protection Agency and Professional Bodies and Societies such as the Infection Control Nurses Association, the Association of Medical Microbiologists and the Hospital Infection Society.

9.2 Relevant Documents include:

- Health Act. Code of Practice for the Prevention and Control of Health Care Associated Infections. DH 2006
- Standards in Infection Control in Hospitals AMM, HIS, ICNA, PHLS:1993
- Hospital Infection Control: Guidance on the Control of Infection in Hospitals (The Cooke Report) DH: 1995
- Guidance for Clinical Healthcare Workers Protection against blood borne viruses DH:1998
- Winning Ways DH: 2003



Healthcare associated infection reporting mechanisms

Infection Control Committee – Decision Briefings**Date of Meeting: 23rd May 2007**

Number	Description of Decision
1.	Training in use of cannulas and central lines will be implemented in F1 and F2 training programme
2.	The annual programme and DIPC annual report was approved for presentation to Board. The DIPC annual report also forms the Committee's annual report

Date of Meeting: 23rd August 2007

Number	Description of Decision
1.	Infection Control 53% of Consultants have not completed the PowerPoint training on Comex. Non completers will be emailed again
2.	MRSA outbreak in NNU April 2007. Typing shows identical strain carried by SHO – likely source. Another SHO also positive for MRSA another strain, carriage now cleared for both. Screening for new neonatal staff is being considered.
3.	The Measles and Scabies policies updates were both approved by the committee.
4.	Audits Target for hand hygiene ward audits raised to 85% compliance Antibiotic prescribing on EMU for community acquired pneumonia, 50% compliance rising to 80% after ward round. Will organise audit meeting for EMU medicine.

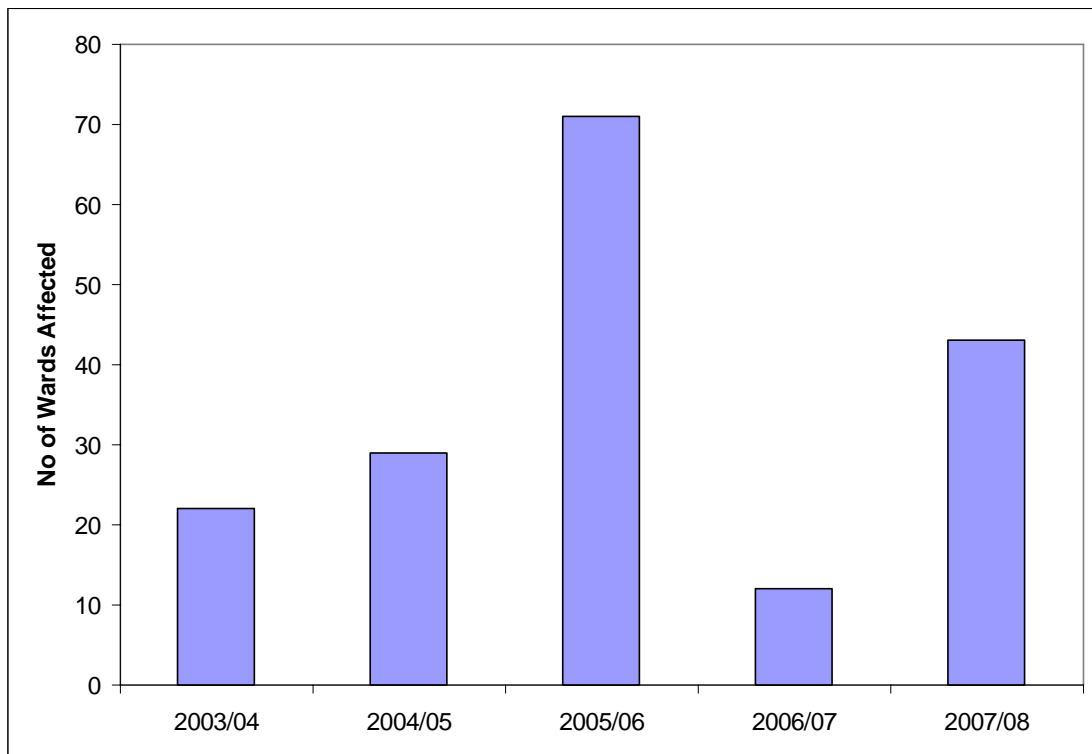
Date of Meeting: 22nd November 2007

Number	Description of Decision
1.	A pilot project for pre-employment screening of paediatric staff has been agreed and will be reviewed in March 2008.
2.	Following the report on Maidstone / Tunbridge Wells Trust, the DIPC's will make an additional presentation to the Board each year, to ensure effective infection control reporting.
3.	Following Additional Funding, provision for Clinical Facilitation by an Infection Control Nurse will be possible in areas with identified problems. An IV access Team is being formed, this will contribute to reducing bacteraemias.

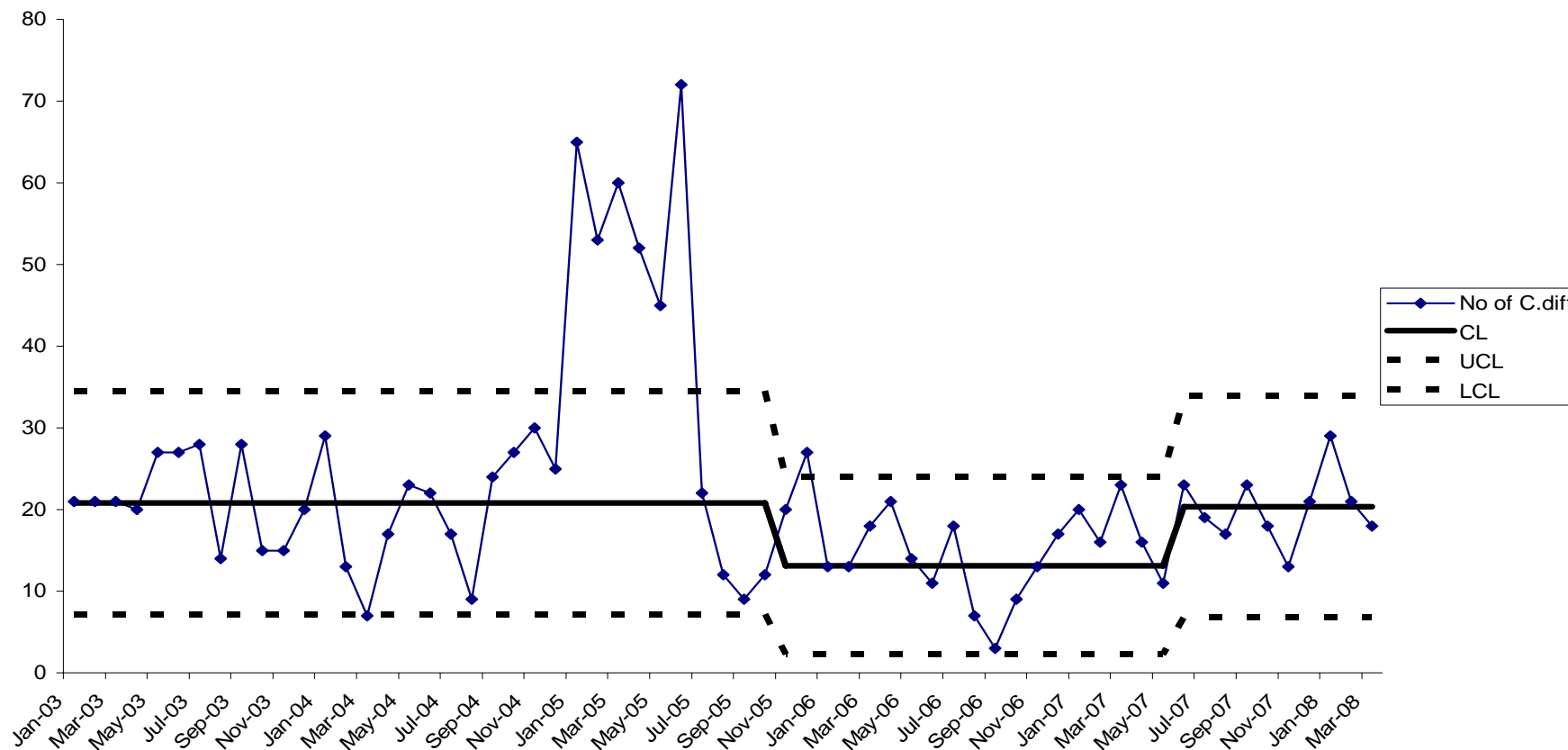
Date of Meeting: 14th February 2008

Number	Description of Decision
1.	The following policies were approved TSE Policy Avian Influenza Mumps Policy Staff Screening & Immunisation Policy The Mumps and Screening & Immunisation are occupational health lead and are on both Comex sites
2.	<i>Clostridium difficile</i> Increased activity including several ward clusters (based on typing) were noted. Measures including environmental hygiene discussed.
3.	HCAI Funding Spending on new commodes and patient slides. MRSA screening pilot underway, IV access team and new pharmacist in post.
4.	Legionella control – Centre for Women's Health The copper/silver ionisation system has been installed and commissioned.

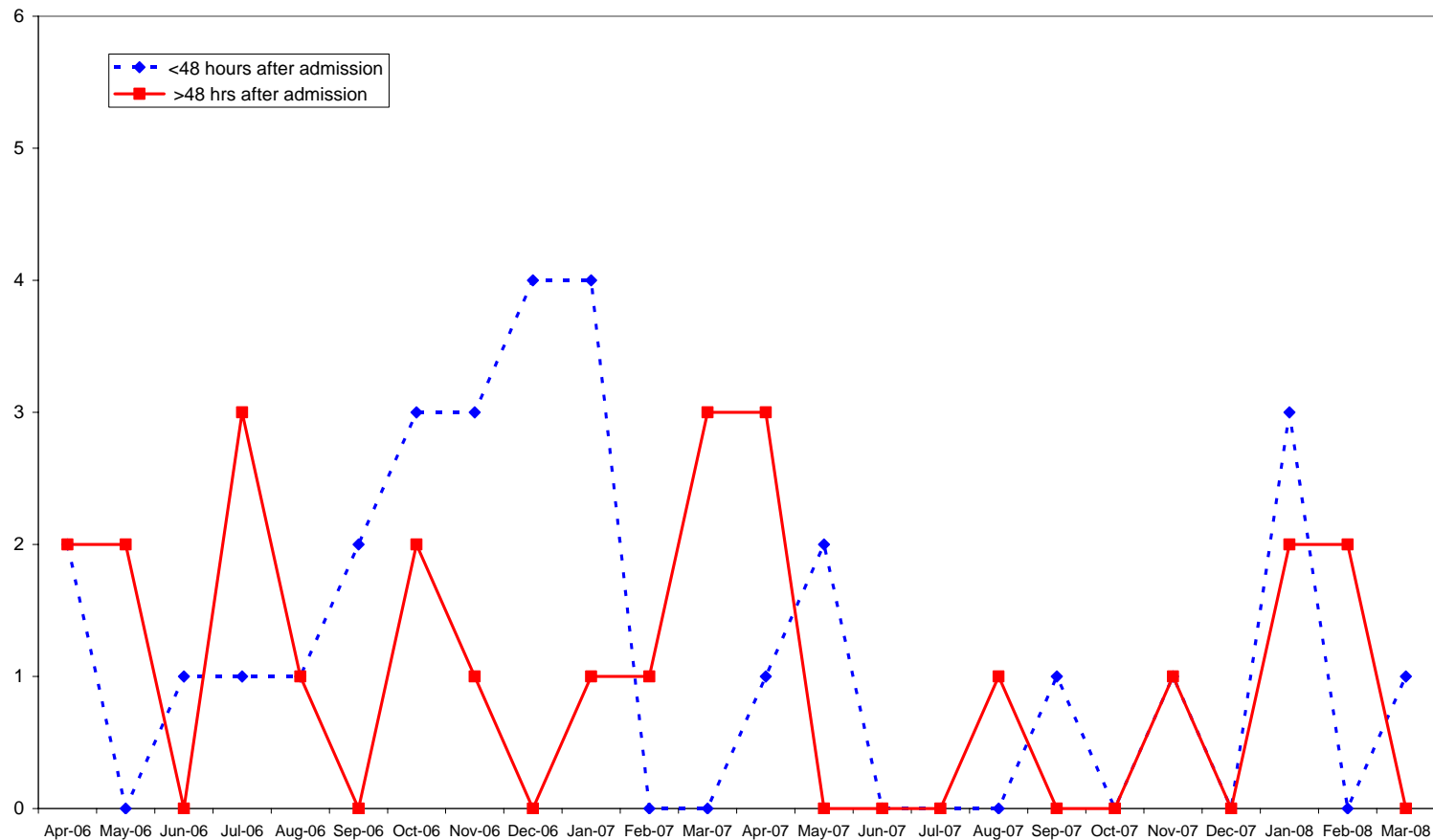
Outbreaks of suspected or confirmed Norovirus



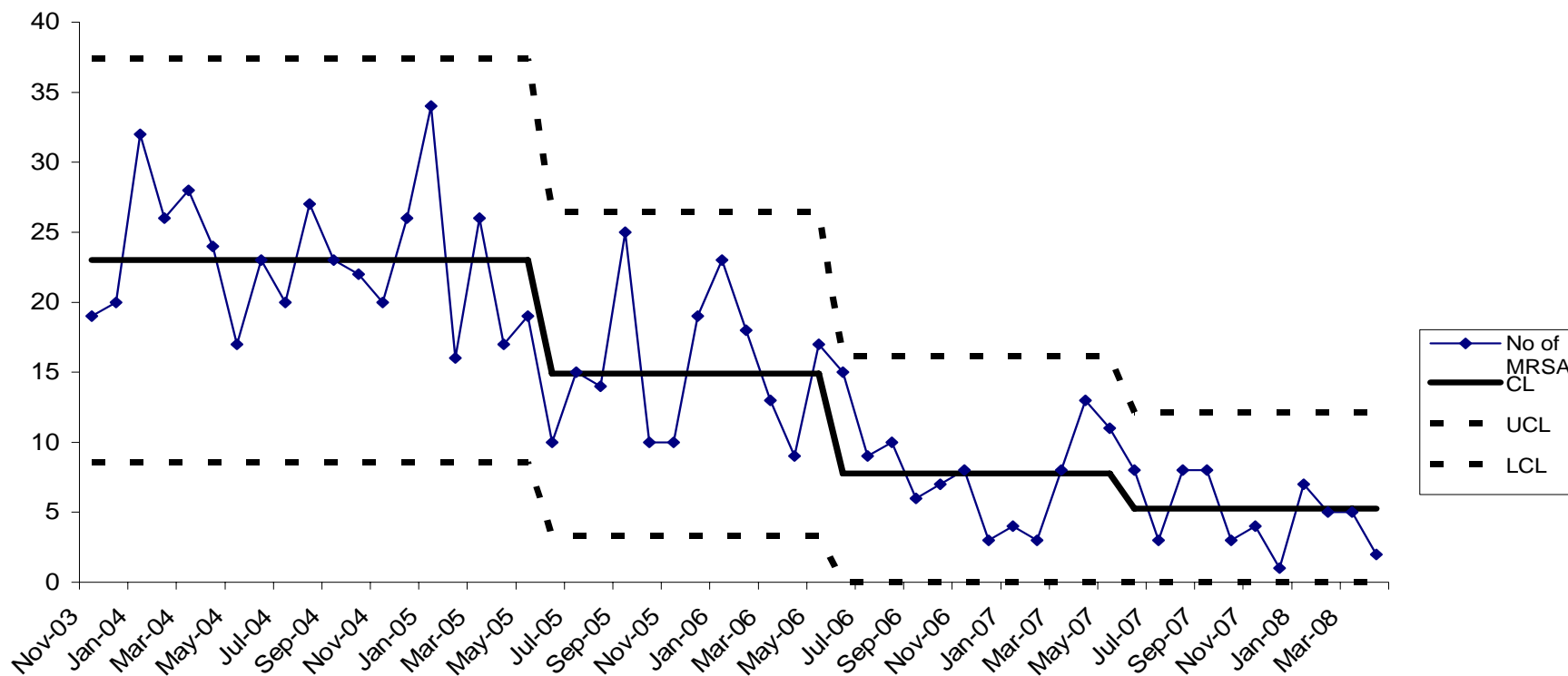
New cases of Clostridium difficile infection



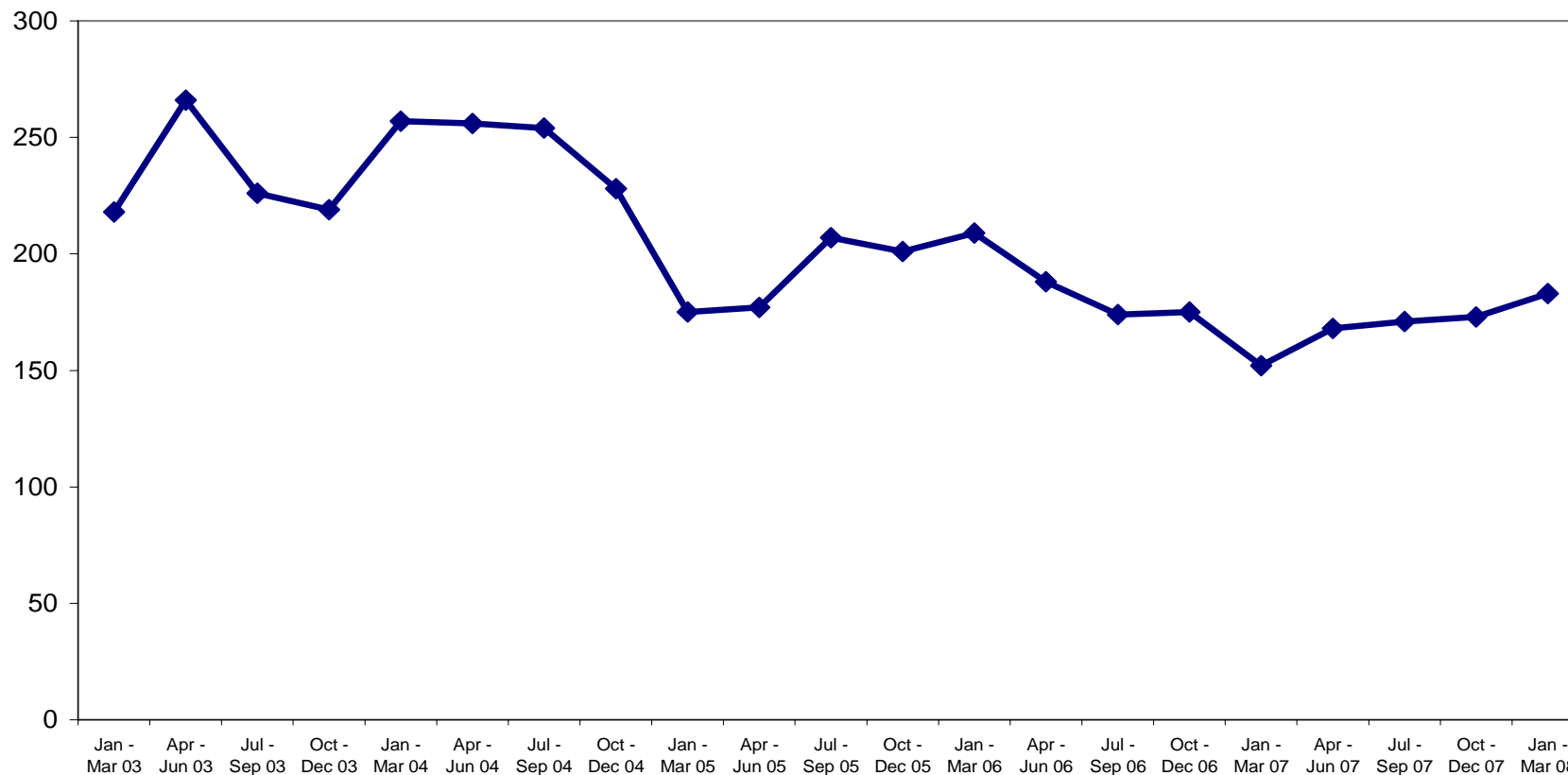
MRSA Bacteraemias - Pre and Post 48 hours of admission



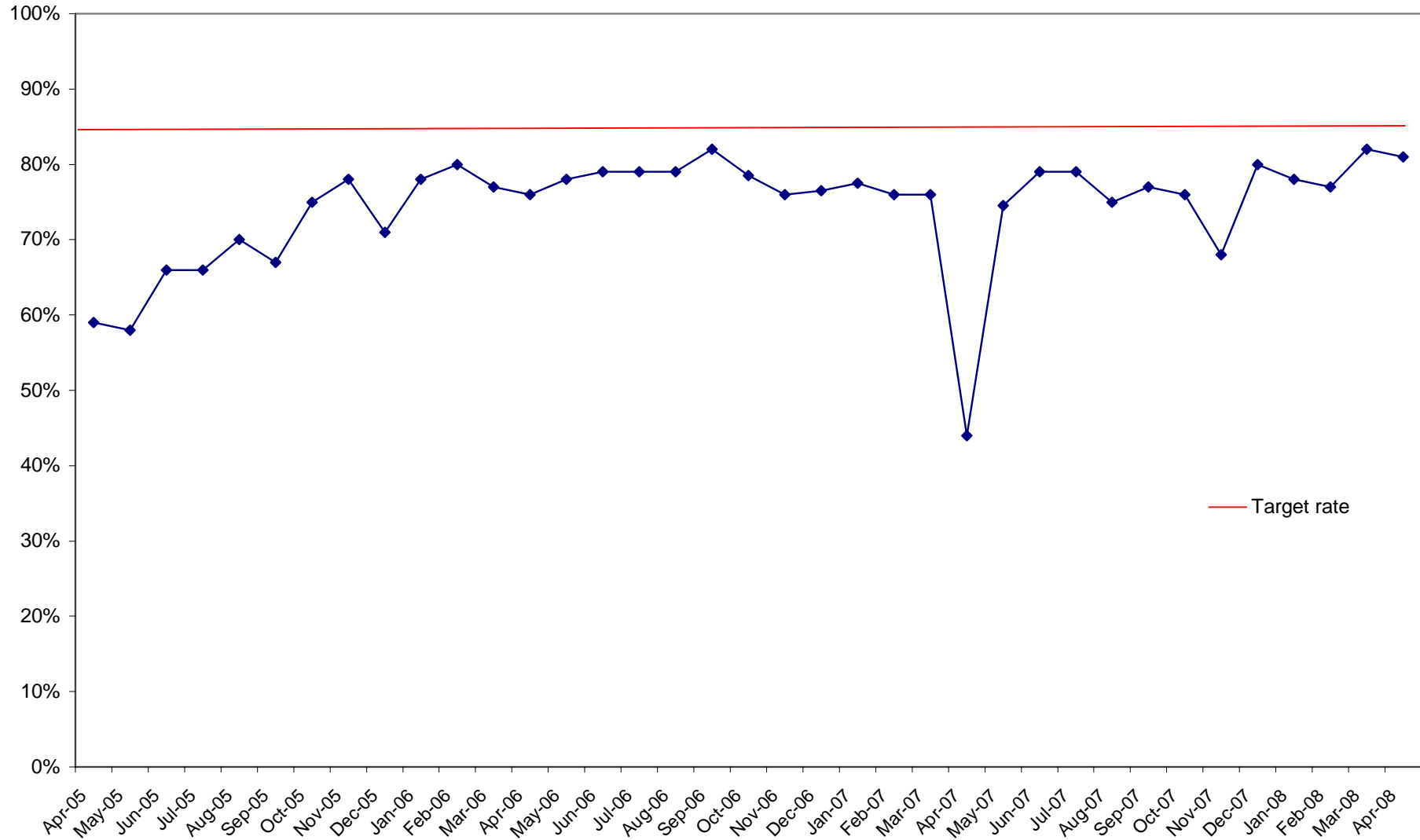
All new cases of MRSA identified more than 3 days after admission



Total Number of New MRSA Incidences per Quarter across the Whole Healthcare Community



Overall Trust Hand Hygiene Compliance



Decontamination Committee - Annual Report

<p>What we've achieved</p> <ul style="list-style-type: none"> ◆ Compliance with Healthcare standard C4c. ◆ Reduction in list of difficult to clean instruments. ◆ External review of current systems and process between all theatres and HSDU to improve flow and meet increasing demands. ◆ Significant investment in new surgical instruments to support additional surgical activity ◆ Refurbishment of the Endoscopy unit including new sterilisers. ◆ Removal of the 4 remaining benchtop sterilizers in PEOC. ◆ Additional staffing within HSDU ◆ Healthedge Tracking & Traceability System implemented in HSDU 	<p>What is planned</p> <ul style="list-style-type: none"> ◆ Change outstanding theatres to standardised disposable suckers. ◆ Improved and co-ordinated system to ensure instrument traceability through HSDU and theatres ◆ Continue to reduce the instruments on the difficult to clean list
<p>Difficulties</p> <ul style="list-style-type: none"> ◆ Ensuring that theatre lists are not compromised as a consequence of sterile instrument shortfall. This has put high pressure on the HSDU for certain periods but is being addressed as a priority. 	<p>What we need help on ...</p> <ul style="list-style-type: none"> ◆ Ensuring that all directorates record and monitor decontamination issues and risks on their risk registers and to feed this information to the Trust Decontamination Lead for review by the Decontamination Task Group and for possible addition to the Trust Risk register ◆ All staff involved in any aspect of decontamination participating in the on-line National Decontamination programme.

Infection Control Training Needs Analysis

Staff group	Induction		Update/Ongoing		
	Mandatory learning events/opportunities/evidence	Method of delivery	Mandatory/Essential learning events/opportunities/evidence	Method of delivery	Frequency
Medical staff					
Consultants	Attendance at corporate Induction	Specialist led session	Completion of Infection Control Update for Medical Staff	Emailed Power-point presentation	Annual
			Or attendance at Directorate/dept arranged infection control update	Specialist led session	Annual
SpRs and Specialty training doctors	Doctors induction or Corporate induction	Specialist led session	Completion of Infection Control Update for Medical Staff	Access point presentation on Comex or via Directorate Infection Control Lead	Annual
	Completion of Infection Control Update for Medical Staff within a week of induction	Access power point presentation on Comex			
Foundation doctors	Doctors induction Completion of Infection Control Update for Medical Staff within a week of induction	Specialist led session	Completion of Infection Control Update for Medical Staff	Access point presentation on Comex or via Directorate Infection Control Lead	Annual
		Access power point presentation on Comex			
Nursing and Operating Dept staff					
Registered Nurses	Attendance at corporate induction	Specialist led session	Attendance at Directorate/dept arranged essential training day/session	Specialist led session	Annual
			Or attendance on 'Infection Control for Registered Nurses' study day Or attendance on other infection control study days.		
Non Registered Nurses	Attendance at corporate induction.	Provided by RN in the workplace	Attendance at Directorate/dept arranged essential training	Specialist led session	Annual

Staff group	Induction		Update/Ongoing		
	Mandatory learning events/opportunities/evidence	Method of delivery	Mandatory/Essential learning events/opportunities/evidence	Method of delivery	Frequency
	Demonstration of practical hand hygiene technique as part of local induction		Or attendance at 'It's a bugs life' study day		
Operating department practitioners (ODPs and ODAs)	Attendance at corporate induction. Demonstration of practical hand hygiene technique as part of local induction	Specialist led session Provided by qualified ODP or RN	Attendance at Directorate/dept arranged essential training	Specialist led session	Annual
Bank Staff - Nursing	Attendance at corporate induction	Specialist led session	Completion of Infection Control Update for Bank Staff	Emailed Power-point presentation	Annual
Infection Control Link Nurses	Attendance at 'link the chain' link nurse course	Specialist led session	Attendance of link nurse updates	Specialist led session	Quarterly
Professional Services					
Allied Health Professionals (AHPs)	Attendance at corporate induction	Specialist led session	Completion of Infection Control Update for Allied Health professionals Attendance at ½ study day – infection control for physios and OTs	Emailed Powerpoint presentation	Annual
Clinical support workers to AHPs	Attendance at corporate induction Demonstration of practical hand hygiene technique as part of local induction	Specialist led session Provided by registered AHP in workplace	Completion of Infection Control Update for Allied Health professionals	Emailed Power-point presentation Specialist led session	Annual

Staff group	Induction		Update/Ongoing		
	Mandatory learning events/opportunities/evidence	Method of delivery	Mandatory/Essential learning events/opportunities/evidence	Method of delivery	Frequency
Diagnostics, Medical Physics and Radiotherapy					
Clinical staff in Radiology, Medical physics, radiotherapy and similar.	Attendance at corporate induction	Specialist led session	Completion of Infection Control Update for Allied Health professionals	Emailed Power-point presentation	Annual
Biomedical scientists (BMS)	Attendance at corporate induction	Specialist led session	Completion of Infection Control Update for Biomedical Scientists	Emailed Power-point presentation	Annual
Point of care testing BMS	Attendance at corporate induction	Specialist led session	Attendance at POC Testing infection control session	Specialist led session	Annual
Facilities					
Porters and Housekeepers and Linen Services staff	Attendance at corporate induction	Specialist led session	Attendance at department infection control training	Specialist led session	Annual
Estates	Attendance at corporate induction	Specialist led session	Attendance at department infection control training	Specialist led session	Annual
Others					
Ward clerks/ ward administrators	Attendance at corporate induction	Specialist led session	Attendance at infection control update for ward clerks	Specialist led session	Annual
Trust Board	Attendance at corporate induction	Specialist led session	Receive DIPC Annual Report and presentation to the Board	DIPC led session	Annual
Directorate and Service Managers	Attendance at corporate induction	Specialist led session	Updates from Directorate Infection Control Leads at Directorate Governance Groups	Directorate IC Lead or Specialist led session	Annual
Volunteers	Attendance at corporate induction	Specialist led session	Completion of Infection Control Update for Volunteers	Emailed Powerpoint presentation	Annual