Royal Devon and Exeter NHS Foundation Trust

Policy for Surveillance and Reporting of Infectious Disease, Healthcare Associated Infection and Antibiotic Resistant Organisms

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Controlled document

This document has been created following the Royal Devon and Exeter NHS Foundation Trust Policies, Procedures, Protocols, Guidelines and Standards Policy.
It should not be altered in any way without the express permission of the author or their representative.

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

The Strategic Directions 2007-2012 were agreed by the Board of Directors in October 2007 to support the Trust's vision "Respond, Deliver, Enable". The Key Milestones below will ensure there is a shared understanding about what needs to be delivered.

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience		Waiting	
Assurance Framework		Privacy and Dignity	
Monitor/Finance/Performance		Efficiency and Effectiveness	
Care Quality Commission Outcomes:	8	Delivery of Care Closer to Home	
		Infection Control	✓
NHSLA Risk Management Standards for Acute Trusts			
NHSLA CNST Maternity Clinical Risk Management Standards:			
Other *(please specify)*:			
Note: This policy has been assessed for any equality, diversity or human rights implications			

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1. Introduction

Surveillance is an essential component of infection prevention and control (DH/PHLS, 1995). High quality information on infectious diseases, healthcare associated infection and antimicrobial resistant organisms is essential for monitoring progress, investigating underlying causes and applying prevention and control measures (DH, 2003a).

Surveillance will be undertaken as part of a national surveillance scheme or may involve the use of a locally defined protocol. Some national surveillance schemes are mandatory, others are voluntary.

All surveillance systems have four key components (DH/PHLS, 1995):

- Data collection using standard case definitions
- Collation of data
- Analysis and interpretation
- Timely dissemination of information

2. Alert Organism and Condition Surveillance

Alert organisms and alert conditions are those that may give rise to outbreaks.

2.1 Alert Organisms

Alert organisms are identified in the microbiology laboratory and include organisms such as MRSA and other antibiotic resistant organisms e.g. Vancomycin Resistant Enterococci and Extended Spectrum Betalactamases (ESBLs), *Clostridium difficile, Streptococcus pyogenes,* Norovirus and Respiratory Syncytial Virus (RSV). The Medical Microbiologist is responsible for informing clinical teams when a new clinical isolate (i.e. not screening specimens) of an alert organism has been identified.

Advice on the control measures, if needed, will usually be provided by the Infection Control Team (ICT), who will also investigate clusters of cases.

2.2 Using Alert Organism Surveillance to Monitor Performance

MRSA and *C.difficile* pose particular challenges in acute hospital settings. Therefore, acute wards/units at the RD&E will receive feedback from the ICT on the number of new cases per month as part of the Ward to Board Report. This will enable wards and units to determine the impact, or not, of prevention and control strategies.
Where appropriate, trends in MRSA and *C.difficile* acquisition will be reviewed at Directorate Governance Group meetings. In addition, the Director of Infection Prevention and Control makes quarterly reports of trustwide data to the Infection Control Committee which in turn reports to the Safety and Risk Committee.

In lower risk settings i.e. primary care and mental health, these data will be reported via the relevant infection control committee.

2.3 Infection Control Flag

Some patients will become long term carriers of alert organisms e.g. MRSA and other antibiotic resistant organisms. These patients will have an infection control (IC) alert put onto PAS by the infection control team. In addition, for in-patients at the RD&E the alert will be displayed automatically on the electronic white board. It is the responsibility of the clinical staff to contact the ICT for details about the type of alert organism a 'flagged' patient may be carrying.

2.4 Alert Conditions

Alert conditions are identified through clinical diagnosis, not laboratory tests, and therefore staff in clinical areas must inform the Infection Control Team (ICT) of any suspected occurrence of these conditions at the earliest opportunity. Alert conditions include:

- Chicken pox/shingles (Herpes zoster)
- Diphtheria
- Food poisoning
- Influenza
- Measles
- Meningitis
- Meningococcal septicaemia
- Mumps
- Ophthalmia neonatorum
- Other childhood exanthemata
- Plague
- Poliomyelitis
- Pyrexia of unknown origin with history of foreign travel
-
- Rubella
- Scabies
- Scarlet fever
- Severe soft tissue infections
- Suspected infective diarrhoea and/or vomiting
- Suspected legionellosis
- Tuberculosis
- Typhoid/Paratyphoid
- Viral haemorrhagic fevers
- Viral hepatitis
- Whooping cough

2.5 Notifiable Diseases

Some 'alert' conditions are 'Notifiable diseases' (see list below). This a legal term denoting diseases that must, by law, be reported to the 'proper officer' i.e. the Consultant for Communicable Disease Control (CCDC), who is based in the Devon Health Protection Unit. Notification books are kept in EMU, ED, Bramble Unit, Culm and Torridge wards at the RD&E. Elsewhere notification books can be obtained from the Infection Control Team.
It is the responsibility of the physician in charge of each case to make the notification.

Diseases that are notifible are:

- Acute encephalitis
- Anthrax
- Leprosy
- Leptospirosis
- Malaria
- Rabies
- Relapsing fever
- Smallpox
- Tetanus
- Typhus
- Yellow Fever
- Food poisoning
- Dysentery (amoebic or bacillary)
- Measles
- Rubella
- Meningococcal septicaemia
- Viral hepatitis
- Ophthalmia neonatorum
- Paratyphoid fever
- Scarlet fever
- Meningitis
- Typhoid fever
- Diphtheria
- Poliomyelitis
- Viral haemorrhagic fevers
- Cholera
- Plague
- Tuberculosis
- Mumps
- Whooping cough

2.6 RIDDOR Reporting

Any infection reliably attributable to the performance of the work of an employee within the Trust is reportable to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). Reporting is normally undertaken by Risk Management on the advice of the Occupational Health Service.

In addition, certain exposures to micro-organisms may also be reportable as dangerous occurrences e.g. exposure to HIV or Hepatitis B/C as a result of an inoculation injury. Once again reporting is undertake by Risk Management.

3. Voluntary Targeted Surveillance

3.1 Venous Access Device Associated Bacteraemia Surveillance

The infection control team will undertake continuous laboratory based ward liaison surveillance of all positive blood culture isolates at the RD&E. The protocol used is based on the bacteraemia surveillance protocol developed by the Public Health Labotatory Service (PHLS) Nosocomial Infection National Surveillance Service (PHLS, 2001). Results, in the form of a written report, are provided to Executive Directors, Clinical Directors, Lead Nurses, Senior Matrons and Senior Managers who are expected to work with the ICT to target appropriate prevention and control strategies if indicated.

3.2 Other Voluntary Targeted Surveillance

The need for intermittent targeted surveillance of other types of infection or sub groups of patients will be determined in response to local need and will be detailed in the annual infection control programme.

4. Mandatory Surveillance

The Trust complies with all requests for mandatory surveillance of healthcare-associated Infection in accordance with the requests made by the Department of Health.

4.1 Laboratory Based Surveillance

Under current requirements, the RD&E reports all of the following, *regardless of the source of the specimen,* to the Communicable Disease Surveillance Centre of the Health Protection Agency:

- Staphylococcal bacteraemia (all),
- Toxigenic *Clostridium difficile* positive results from patients over the age of 2,
- Bacteraemia caused by Glycopeptide-resistant Enterococci

4.2 Mandatory Enhanced Surveillance Scheme (MESS) – MRSA, MSSA, *E.coli* Bacteraemia and *Clostridium difficile* infection

All are reported via the MESS. MRSA bacteraemia and toxigenic *Clostridium difficile* positive data are used by the DH and Monitor as infection control performance indicators.. An enhanced data set for *Staph. aureus* bacteraemia was introduced in 2005 (SH, 2003b) and for *Clostridium difficile* infection in 2008 (DH 2008). The ICT are responsible for collecting and reporting the additional data via a dedicated secure website. The Chief Exective must ensure that the data is entered on the site 'signed off' by the 15th of each month.

4.3 Root Cause Analysis (RCA)

Each Trust is required to undertake an investigation based on the principles of root cause analysis of each MRSA bacteraemia and toxigenic *Clostridium* difficile where it is cited as cause of death on Part 1 of the death certificate . The IPCT will determine the extent of investigation into other infections or infection control incidents but this will usually include all Trust attributable C.difficile infections.

<u>These invetsigations will be undertaken as soon as possible after idenification of the incident preferably within 7 days and will involve, as a minimum, medical and nursing representatives from the team/ward responsible for the care of the patient, a microbiologist and an ICN.</u>

4.4 Orthopaedic Surgical Site Infection Surveillance

Targeted surveillance of orthopaedic implant surgery is also a mandatory requirement. Data collection must be undertaken in the clinical setting for a minimum of three months every year and reported vua the HPA surgical site infection surveillance service. At the RD&E, this is undertaken continuously for hip and knee replacements. In addition, continous surveillance of spinal surgery is undertaken.

5. Serious Incidents Requiring Investigation

Serious incidents requiring investigation associated with infection must be reported via the normal reporting system for serious untoward events (Refer generic Trust Policy). In addition the Infection Control team will inform the Regional Epidemiologist and the CCDC.

The DH (2003) define serious incident associated with infection as those that "produce, or have the potential to produce, unwanted effects involving the safety of patients, staff or others". Reportable incidents are those that:

- result in signifance morbidity or mortality, and/or
- involve highly virulent organisms; and/or
- are readily transmissible; and/or
- require control measures that have an impact on the care of other patients, including limitation of access to healthcare services

A serious incident includes:

- Outbreaks
- Deaths associated with Clostridium difficile infection where CDI features on Part 1 of the death certificate
- Infected healthcare worker or patient incidents requiring a lookback exercise e.g. TB, vCJD, blood borne viral infections
- Significant breakdown of infection control procedures, such as the use of invasive instruments released from a failed sterilisation cycle or the use of contaminated blood products.

6. PATIENT AND PUBLIC INFORMATION

6.1 This policy will be made available to the public on the Trust website

6.2 The website also provides a link to the DIPC annual report which included results of surveillance activities.

7.0 MONITORING

7.1 Compliance with this policy will be monitored by the Board through the Infection Control Committee and Governance Committee.

8. References

Dept of Health (2003a) *Winning ways*. *Working together to reduce Healthcare Associated Infection in England*. Report from the Chief Medical officer. London. DH. Available at < http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4064682> Accessed 2/10/11.

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