Royal Devon and Exeter NHS
NHS Foundation Trust

# Infection Control Annual Report 2008/09

Board Date: 24th June 2009

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## Key Issues/Executive Summary

1. The Trust is compliant with the Health Act 2006 - Code of Practice for the Prevention and Control of Health Care Associated Infection (the 'Hygiene Code').

2. An unannounced Healthcare Commission inspection against Duties 2, 4, 8 and 10j identified that the Trust is fully compliant with these duties and commended the Trust on the development and implementation of the Nursing Quality Assessment Tool, which incorporates key standards related to infection prevention and control.

3. The Trust has made a self assessment of full compliance against the Health and Social Care Act 2008 - Code of Practice for the Prevention and Control of Health Care Associated Infection and, as a result, registered with the Care Quality Commission in February 2009. Registration was been accepted without conditions.

4. The Trust is also compliant with C4a of the Healthcare Standards. Compliance was confirmed by Internal Audit.

5. Following the success of achieving a 65% reduction in MRSA bacteraemias between 2004/5 and 2007/8, a further 17% reduction has been achieved in 2008/9 with only 15 cases identified. 8 of these bacteraemias were community acquired.

6. There has been a 31.9% reduction in *Clostridium difficile* infection. The deep cleaning programme, incorporating hydrogen peroxide vapour decontamination, is believed to have been the most significant strategy in achieving this reduction (Appendix 12).

7. MRSA screening of elective patients was implemented on 9th February 2009, ahead of 31st March deadline.

8. The Trust has completed the majority of the planned infection control activities outlined in the annual programme 2008/9 (Appendix 1).

9. Despite control measures described in previous annual reports, multiple ward outbreaks of Norovirus infection outbreaks continue to place considerable pressure on the organisation. Spread of Norovirus, across multiple wards, is exacerbated by high bed occupancy and movement of patients and staff within the hospital setting.

10. The rate of surgical site infection for hip arthroplasty (identified prior to discharge and on re-admission) is 0.6% This compares favourably with the aggregated rate of 1.0% for all hospitals participating in the mandatory orthopaedic surveillance programme.

11. The rate of surgical site infection for knee arthroplasty (identified prior to discharge and on re-admission) is 0.55%  This compares favourably with the aggregated rate of 0.7% for all hospitals participating in the mandatory orthopaedic surveillance programme

12. The rate of surgical site infection for abdominal hysterectomy (identified prior to discharge and on re-admission) is 1.3%  Again, this compares favourably with the aggregated rate of 2.1% for all hospitals participating in the national voluntary surveillance programme.

13. Hand hygiene compliance has continued to improve and stands at 85% compliance at the end of year.

14. A comprehensive programme of education and training has been provided to all relevant disciplines of staff and high attendance rates have been achieved.

## 1. INTRODUCTION

1.1 This is the fifth annual report produced by the Joint 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 remains 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 2008/9, 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 2008/9 (Appendix 1). This is designed to 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 Eastern area of the Devon Primary Care Trust (DPCT).

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 nursing 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:

| | |
|---|---|
| 2.8 WTE Band 7 | Clinical Specialist Leads |
| 2.0 WTE Band 6 | Nurse Specialists |
| 1.0 WTE Band 6 | Audit and Surveillance Nurse |
| 1.0 WTE Band 3 | Health care assistant |

One of the band 7 nurses (1.0 WTE) commenced 12 months of maternity leave in June 2008 and 1.0 WTE is a new post which we have been unable to fill despite national advertising.

2.1.4 The DPT nursing team consists of:

| | |
|---|---|
| 1.0 WTE Band 7 | Clinical Specialist Lead |
| 2.0 WTE Band 6 | Nurse Specialists |

2.1.5 The DPCT nursing team consists of:

| | |
|---|---|
| 1.0 WTE Band 7 | Clinical Specialist Lead |
| 0.8 WTE Band 6 | Nurse Specialist |

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 All four Consultant Medical Microbiologists play an active role in infection control. However, one Microbiologist fulfils the role of Infection Control Doctor with 4 sessions of clinical time allocated for

this purpose. The same microbiologist is also the infection control doctor for the DPCT and DPT.

2.1.9 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 specialist post graduate programme of study and are experienced in the field of infection control.

## 2.1 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.

## 2.2 Directors of Infection Prevention and Control (DsIPC)

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.

## 2.3 Infection Control Committee (ICC)

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

## 2.4 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.

## 2.5 Links to the Antimicrobial Subcommittee

The purpose of the Antimicrobial Subcommittee of the Drug and Therapeutics Committee is to ensure that antimicrobial drugs are used prudently and responsibly within the Trust. The Antimicrobial Subcommittee is chaired by the Infection Control Doctor/DIPC and reports to the Governance Committee through the Drug and Therapeutics Committee, which also has a medical

microbiologist as a member. The Subcommittee provides reports to the Infection Control Committee and also liaises with the joint formulary committee.

### 2.6 Links to Clinical Governance/Risk Management/Patient Safety

The DIPCs are members of the Governance Committee, the Nursing and Midwifery Governance Committee, Patient Safety Steering Group 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. 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.

3.1.1 The Directors of Infection Control have a formal minuted meeting at least bi-monthly with the Chief Executive and other members of the Executive Team, including the Medical Directors, Chief Operating Officer and the Director of Nursing And Patient Care. In addition, information regarding outbreaks, significant incidents and performance against HCAI target is communicated daily to all Executive Directors.

### 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 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). Antimicrobial control is addressed in the annual programme of the Antimicrobial Subcommittee which is attached to the appended infection control annual programme.

### 3.3 Board Decisions

The Board approves the annual report and annual programme. Policies and guidelines developed by the infection control team, both new policies and significant revisions of existing policies and guidelines are generally

considered by other relevant committees before receiving formal approval from the Governance Committee. The Governance Committee is a sub committee of the Board and decision briefings are reported to the Board.

## 4. OUTBREAK AND INCIDENT REPORTS

4.1 Incidents and outbreaks are usually 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 on request.

### 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.

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 Research shows that outbreaks are only controlled effectively by closing affected areas to new admissions until free of infection. Closure must then followed by through environmental cleaning and disinfection. This is the approach taken within the RD&E.

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 new admissions.

- Use of a rapid test for norovirus detection (Norovirus PCR).

- Designating isolation rooms on Torridge ward for medical admissions with symptoms suggestive of, or confirmed as, Norovirus infection.

4.3.5 Despite the rigorous measures outlined above, some patients, usually those with mild symptoms, can be overlooked with their symptoms attributed to another underlying non infectious condition. Therefore, some patients with Norovirus infection can unwittingly transmit the infection to other patients in multiple occupancy wards. Likewise patients admitted to the hospital during the incubation period of the infection show no signs of Norovirus infection on admission but become symptomatic once admitted to a multi-bedded area with transmission to other patients resulting in an outbreak. The bar chart at Appendix 5 shows the number of wards closed to admissions following recognition of confirmed cases of Norovirus over the last six years.

4.3.6 Movement of patients from the Emergency Medical Unit to specialty wards or from medical specialty wards to surgical wards to vacate acute beds for new medical admissions makes a significant contribution to the spread of Norovirus from ward to ward *prior* to recognition of an index case.

As a result of such movement, two large outbreaks of Norovirus, affecting multiple wards were experienced over the course of the winter months (refer Appendix 6).

### 4.4 *Clostridium difficile*

4.4.1 *Clostridium difficile* is a bacterium 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 If 3 or more potentially linked cases of C. difficile infection are linked to a particular ward, or area of the hospital, this is investigated and reported to the PCT and the Regional Epidemiologist in the Health Protection Agency as a potential outbreak. The area involved is thoroughly cleaned, and is now decontaminated using hydrogen peroxide vapour. Other potential factors including antibiotic use are investigated and corrective action taken where appropriate.

4.4.4 During 2008/9 an outbreak of linked cases was detected on surgical wards Abbey and Otter. An outbreak meeting control team was formed. Environmental cleaning was undertaken and an investigation of possible causes was undertaken. Outcomes included training of clinicians to improve early detection of possible cases and also prudent antimicrobial prescribing training. Environment inspections of the area were satisfactory, but deficiencies in cleaning frequency were identified, never the less. Work was undertaken to ensure cleaning was achieved at the appropriate frequency.

4.4.5 Further small outbreaks of 3 patients have been detected on separate medical wards, Clyst in August 2008 and Creedy. These were managed following outbreak meetings and investigations. In all cases wards are closed to admissions while a deep clean is undertaken, and patients are isolated and nursed on Torridge ward, where the staff have a special interest in management of *C. difficile* infection. Minutes of outbreak meetings are available on request.

### 4.5 Endoscopy unit

4.5.1 In 2008 a project to redesign and refurbish a central endoscopy decontamination unit was completed. Automated endoscopy washer disinfectors have been installed which are fully compliant with HTM 2030, and are equipped with comprehensive traceability and assurance systems. In addition state of the art storage cabinets have been installed which extend the period that clean endoscopes can be safely stored before they require reprocessing.

4.5.2 A near miss incident occurred because one of the washer disinfectors was not fully configured for one endoscope. This resulted in one endoscope channel not being recognised by the washer disinfector, and could have resulted in a failure to decontaminate.

4.5.3 The error was noted and corrected. As a result all the endoscopes were checked and no further errors in configuration were found.

## 4.6 Cold Water Supply in the Centre for Women's Health

4.6.1 During commissioning of the Centre for Women's Health it was found that cold water temperatures could not be maintained reliably below 20°C. This failed to comply with legionella control standards, and potentially increased the risk of Legionnaires Disease in those who used the building.

4.6.2 Consequently additional control measures, using copper and silver ions, were installed, and the supply closely monitored for legionella. The results of monitoring have remained satisfactory, and within safe limits. There have been no cases of Legionnaires Disease.

## 4.7 Measles Cases

4.7.1 Measles cases have increased during 2008, and although there has not been a particularly high incidence in Exeter, and no outbreaks have occurred in the hospital, several cases and suspect cases have been admitted.

4.7.2 In co-operation with Occupational Health and the Human Resources Department a programme has been implemented to ensure that front line staff are immunised with MMR, or have evidence of past infection with measles, mumps and rubella. This is to ensure that staff are not at risk of infection, and cannot pass it on to vulnerable patients.

## 4.8 MRSA colonisation of babies on the Neonatal Unit

4.8.1 A baby transferred to Plymouth from Exeter NNU was found on arrival to be colonised with meticillin resistant *Stapylococcus aureus* Subsequently, a second baby was found to be colonised, also after transfer to Plymouth. Babies did not develop clinical infection.

4.8.2 A full investigation was conducted into how these babies became colonised with MRSA. Investigation included screening of all staff in the neonatal unit, and delivery unit staff who were connected with the babies.

4.8.3 Although 2 members of staff were detected with MRSA carriage, these staff did not have clinical contact with the babies, and molecular typing showed that the strains were different from those carried by the babies. The identified staff were never the less successfully treated for MRSA colonisation.

4.8.4 No source for the babies colonisation was identified. However, no further babies became colonised. In addition, the staff screening exercise showed that carriage rate in staff with significant clinical contact in the neonatal unit was undetectably low.

## 4.9 Mould growth in the Haematology Unit

4.9.1 Yarty ward, which accommodates the Haematology Unit, has 10 *en suite* isolation rooms for accommodating high risk immunosupressed patients. It was noted that one of the en-suite bathrooms had visible black mould growing at the base of a door frame that was damp.

4.9.2 No clear link of fungal infection in patients was established, though such visible fungal growth is an unacceptable risk. Air quality monitoring in several rooms did not show significant contamination of air with fungal spores.

4.9.3 The affected room was closed until it was refurbished, and the defect leading to a wet doorframe was rectified. In addition, a programme of refurbishment of all the bathrooms in isolation rooms was undertaken.

## 4.10 Atypical Scabies on a Medical Ward

4.10.1 An outbreak of scabies occurred following the admission of a patient with atypical (Norwegian) scabies. This is a highly infectious variant of scabies associated with a skin rash which can resemble infected eczema.

4.10.2 The patient was treated and isolated following a delay, and subsequently died of unrelated causes. The outbreak report is available from the infection control team.

4.10.3 After a delay members of staff complained of itchy rashes and scabies was identified. An outbreak team was convened.

4.10.4 Eleven symptomatic staff were identified and treated by GPs or Occupational Health, and 34 asymptomatic staff contacts treated. The GPs of patients identified as being at risk of infection were contacted by letter. No patients with linked scabies infection have been identified.

# 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. When *Staphylococcus aureus* is found in the bloodstream it is referred to as a *Staphylococcus aureus* bacteraemia.

5.1.2 *Staphylococcus aureus* bactreaemias have been reported since April 2001, so at the end of the year 2008/9 eight full years of reports had been submitted. Data has been submitted monthly since October 2005.

5.1.3 Reports from this Trust consist of all *Staph. aureus* isolated from blood cultures processed by the Trust 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 patients admitted to 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. This Trust was 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. During 2008-9 the new target was to maintain these low levels. However, a further 17% reduction has been achieved, with only 15 cases during the last year (refer also Section 11).

5.1.8 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. Of these 15 cases reported during 2008-9, 8 cases were identified in the first 48 hours indicating community, rather than hospital, acquisition. (Appendix 7).

5.1.9 Despite the enhanced data set, the HPA report continues to attribute *all* MRSA bacteraemia, regardless of source, to the RD&E.

## 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 one of the causes 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. *C. difficile* infection is a devastating infection for patients. It also prolongs, hospital stay and prevents other patients having access to healthcare opportunities. Control and prevention is the highest priority.

5.3.2 Mandatory surveillance for infection in over 65 year olds has been undertaken since 2004. For the first time in 2007 episodes of *C. difficile* in patients between the ages of 2 and 65 were also reported.

5.3.3 For mandatory reporting purposes, all diarrhoeal stools submitted to the microbiology laboratory 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.

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

5.3.5 During 2008/9 the Trust has managed to reduce the rate of *C. difficile* infection (Appendix 8). Rates declined particularly following the deep clean programme during 2008. Each case is examined and precipitating factors investigated. If there appear to be linked cases in an area of the hospital strains are sent to reference facilities for typing, and a deep clean is immediately undertaken, which includes hydrogen peroxide (H2O2) misting.

## 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 Continuous surveillance of all knee and hip arthroplasty was started in July 2007.

5.4.4 Quarterly reports are received from the Health Protection Agency. The most recent report received is for Oct - Dec 2008.

5.4.5 The aggregated rate of infection (identified prior to discharge and on re-admission) for all hospitals participating in the surveillance programme is 1.0% for hip arthroplasty and 0.7% for knee arthroplasty. For the same time period the Royal Devon and Exeter rate is 0.6% for hip arthroplasty and 0.55% knee arthroplasty.

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

## 5.5 MRSA screening of elective admissions

5.5.1 The rationale for screening of non emergency patients is to identify MRSA carriers, enabling to application of the decolonisation or suppression treatment either immediately prior to admission or on admission and the use of appropriate systemic antimicrobial prophylaxis at time of procedure, if this is appropriate.

5.5.2 The assumption is that this will reduce the risk of MRSA infection for the carrier and reduce the risk of transmission to other patients, although there is little evidence to support this strategy. Under the Operating Framework for the NHS in England (2007) all NHS Trusts were required to implement procedures to screen *all* elective admissions by 31st March 2009.

5.5.3 More recent guidance from the DH identified that all elective admissions should be routinely screened, with the exclusion of:

- Day case ophthalmology
- Day case dental
- Day case endoscopy
- Minor dermatology procedures,
- Children
- Maternity/obstetrics except for elective caesareans
- Termination of pregnancy

With the above exclusions, the implication of this strategy is that approximately 42,000 patients per year require screening prior to treatment at the RD&E. This has major implications for clinical and laboratory resources. With each MRSA screen consisting of at least two swabs taken from the patients nostrils and throat, the microbiology laboratory expected to process and report on an additional 84,000 specimens per year. A new screening

room in the laboratory was established and staffing increased to process the specimens. The laboratory became operational in February 2009.

Based on data from March 2009, the first full month of screening, MRSA was detected in less than 1% of those patients screened.

## 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 central vascular devices remain the commonest risk factor associated with hospital acquired bacteraemia, and are a focus for prevention.

6.1.3 Feedback of central vascular devices associated bacteraemia rates to high risk specialties has enabled targeted work to be undertaken to reduce infection rates.

6.1.4 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 or increased prevalence and the impact of control interventions.

6.2.3 An extensive dataset from *C. difficile* patients including antibiotic use and response to treatment is also collected. Information obtained has helped to improve both control and patient management.

6.2.4 A monthly surveillance meeting is held by the team caring for inpatients with C. difficile. This monitors cases, precipitating causes, treatment and outcomes. Lessons learned are disseminated to clinicians and

others involved. Minutes of the meetings are available from the infection control team.

### 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 9).

6.3.4 The number of new cases across the whole local health community also continues to reduce (Appendix 10). 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 A voluntary module of surveillance was undertaken, using the Surgical Site Infection Surveillance Service of the HPA, between July and September 2008 for abdominal hysterectomy.

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 Abdominal hysterectomy has a relatively high risk of infection, because the nature of the surgery means that the procedure is classified as clean contaminated.

6.5.4 The aggregated rate of infection (identified prior to discharge and on re-admission) for all hospitals participating in the surveillance programme was 2.1%. For the same time period the Royal Devon and Exeter rate is 1.3%.

## 7. HAND HYGIENE

7.1. Previous annual reports have described our participation in the NPSA 'cleanyourhands' campaign continues which involves four main components:

- Point of care alcohol hand rub
- Awareness and role model posters
- Patient involvement
- Audit of practice using an adapted Lewisham audit tool with feedback to wards/dept using run charts.

7.2 Further progress has been made in raising the level of compliance within the Trust which is now at 85% (Appendix 11).

## 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 staff education, with assessment of competency made in relation to intravascular drug administration, intravascular cannulation and venepuncture.

### 8.1 A review of Intravenous Venous Drug Administration practice

8.1.1 The purpose of the review was to :

- Evaluate the quality and safety of IV practice among ward nursing staff on a one to one basis with respect to principles of asepsis and, in particular, the use of aseptic non touch technique.
- Offer immediate verbal feedback to staff on their performance followed by written assessment including recommendations for further action
- Identify exemplary practitioners who will champion IV practice at ward level and act as an assessor for new practitioners.
- Identify areas of education provision that need to be improved.

8.1.2 As a pilot study, two wards were selected for review and 19 nurses were observed in practice. Compliance with correct practice was measured using criteria set out in the Saving Lives High Impact Intervention.

8.1.3 Recommendations were made that included carrying out similar reviews on each ward in the Trust. This work has commenced and will be reported on in 2009/10.

### 8.2 Care of Peripherally Inserted Central Venous Catheters (PICC)

8.2.1 The use of PICC has greatly increased since the appointment of the Vascular Access Team. Patients who previously would have had multiple of peripheral vascular devices for lengthy IV treatments are now more appropriately managed, reducing pain and discomfort.

8.2.2 PICC insertion by the VAT is always undertaken to a high standard using an aseptic technique.

8.2.3 Ongoing care of the line is managed by the ward staff and the need for additional training has been highlighted. Workshops and ward based training sessions have been implemented in the latter part of the year to meet this need.

## 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 (Facilities Manager). Both the Infection Control Lead Nurse and Infection Control Doctor are members of the Decontamination Committee.

9.1.3 All surgical instruments are reprocessed centrally in the Hospital Sterilisation & Decontamination Unit (HSDU) which continues to be fully compliant to the standard ISO9001/2000 ENISO 13485 and is working to the 93/42/EEC + 2007/47/EC Directive.

9.1.4 A surgical instrument tracking system was installed and commissioned in the HSDU March 2008. A tracking module has been installed within all the 22 Theatres on site and will be able to track instruments through the HSDU processes and link into Theatres. To be completed by end of May 2009

9.1.5 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 the Directive 93/42/EEC + 2007/47/EC 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 In August 2008 a cystoscope was returned from the supplier with incomplete documentation, which failed to indicate that it had not been repaired. Subsequently a leak test failure was detected during cleaning, but after it had been used on a patient.

The clinician involved was informed, but no complications were experienced by the patient.

A single person in the endoscopy decontamination department has now been given charge of return and receipt of scopes following repair or servicing. Instruments cannot be put into use without full documentation being present. A complaint was made to the suppliers over documentation, and was investigated by them.

9.3.3 An incident occurred on 21st March 2009 when an unsterilised load of surgical instruments was released to central theatres, however routine checks prior to use identified the error and all items were returned to HSDU. Technicians were retrained do ensure that standard operating procedures are followed.

## 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, 2007. 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 housekeeping 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, matrons and senior matrons are sent a printed list of the cleaning results at the time of audit, this includes Patient equipment cleaning failures. When rectified the ward sisters /charge nurses email a response back to the monitoring team so as to close the audit loop.

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. Action plans are implemented for wards or departments failing to reach the required standards as laid down by the NPSA.

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.

10.2.7 An annual external audit of cleaning standards is undertaken by South Devon Healthcare NHS Foundation Trust.

### 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 are complete revisions of all ward work schedules for projects such as cook-freeze patient meal service (2007), transfer of Maternity and Gynaecology services from Heavitree (2007), transfer of clinical services from Wonford site to the Heavitree site (2009/10). This is 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 financial parameters

10.3.3 The impact of cook freeze service on cleaning activities has been monitored closely since 2007. This identified that additional resources were required at ward level to ensure full compliance with work schedule requirements throughout the day and evening. This funding was secured on a non-recurring basis for 2008/09 and has been secured for a non-recurring basis for the first 6-months in 2009/10 whilst a project exploring the feasibility of a separate Ward Support Worker role for ward based food service requirements and other non-clinical support duties e.g. cleaning of patient equipment is undertaken

10.3.4 Call-off funding for a dedicated infection outbreak cleaning team was first allocated in 2006/07 and has since made a significant difference to the response times for organising outbreak and specialist cleaning and the turnaround time for re-opening a closed ward. It has been confirmed that this funding will be recurring annually.

10.3.6 Additional monies were also secured to increase the cleaning resources available for public area cleaning and specialist cleaning requirements through a 24-hour period. Since the introduction of this funding the cleaning of WC's in public areas and outpatient departments has been increased during the day and there has been a significant reduction in the number of complaints (written and verbal) received from patients and visitors regarding the cleanliness of these facilities. The specialist cleaning team now operate until 10pm on a Sunday – Thursday night and overnight on a Friday and Saturday night. This has led to a significant improvement in terms of 'turn-around' time for the specialist cleaning of side rooms, bed spaces or even bays that have been vacated by infected patients. On average there are 325 ad-hoc specialist cleans undertaken each month.

10.3.7 Additional non-recurring money was also allocated in 2008/09 to enable a second deep cleaning programme to be implemented in July 2009. This was the second consecutive year that a deep cleaning programme had been implemented, however, this time, in addition to traditional methods of deep cleaning such as use of steam cleaners and chlorine releasing disinfectants, hydrogen peroxide vapour was used to achieve a higher level of disinfection. Hydrogen peroxide vapour is effective against *Clostridium difficile* spores and its use in this programme is believed to have been the most significant strategy to achieve a substantial reduction in new cases of *C.difficile* infection in

the hospital. A further £100k has been allocated for 2009/10 for the deep cleaning programme to continue within in-patient areas. It is hoped that this will commence in June 2009.

### 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. The ICNA Environment audit tool is used by the Ward matrons to further assess environmental cleanliness.

### 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. However a review of night cleaning services is being undertaken in 2009 as it is envisaged that some of this work can be undertaken during the late afternoon / evening and will provide a more robust infrastructure to support ad-hoc specialist / outbreak cleaning requirements during late afternoon / evenings, particularly when we have outbreak situations e.g. Norovirus.

10.5.2 Following patient consultation, restricted visiting hours were introduced and this continues to provide improved access for cleaning.

### 10.6 User Satisfaction Measures

10.6.1 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. It is hoped that in 2009, ward housekeeping staff will also become involved in this process

10.6.2 In 2008 we employed a new post of Ward Catering Monitoring Officer. This post holder is primarily involved with the auditing of the patient meal service both within the catering department and at ward level. She also issues in-patient satisfaction surveys for both food and cleaning services. These are returned to GSU for collation and results will be reported to the board on a 6-monthly basis.

### 10.7 Patient Equipment Cleaning

10.7.1 Following work undertaken by one of the Divisional Lead Nurses a definitive list of Patient Equipment was established in order to identify responsibility, frequency and method of cleaning. There is 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 and this is also be included in the Ward Support Worker project as referred to in 10.3.3.

### 10.8 Training

10.8.1 In 2008/09 funding has been secured through Widening Participation Strategy and a subsequent Training Needs Analysis (TNA) bid to fund British Institute of Cleaning Science (BICSc) training for Housekeeping Services staff. This is a national qualification – Certificate of Professional Competency in Healthcare Cleaning. Four Housekeeping Supervisors have completed the certificate and are currently being trained as BICSc assessors. Eighty Five Housekeeping Services staff have voluntarily signed up to take the certificate and we are liaising with LDS and Exeter College (who will be our external training provider / assessor) to work with the Trust to roll out this training.

10.8.2 A new Cleaning Manual has been written for all Housekeeping staff based on the national NHS Cleaning Manual. This incorporates a self-assessment training needs analysis tool which is then evaluated by Housekeeping Supervisors to identify initial and refresher training needs for Housekeeping staff. This links into core competencies for staff and KSF.

## 11. TARGETS AND OUTCOMES

### 11.1 MRSA Bacteraemia

Having achieved a 65% reduction in MRSA bacteraemias in 2004 to 2008 the target for 2008/09 was to maintain low levels ie no more than 18 cases. We are pleased to report a further reduction has been achieved during the last year with only 15 cases of MRSA bacteraemia being identified.

Root cause analysis of these cases helps identify the source of the bacteraemia and actions required to reduce risk in the future. Progress against action plans are monitored by the Infection Control Committee.

Particular themes that have emerged include:

- Eight cases were identified from blood cultures taken within 48 hours of admission which suggests community acquisition.
- None of the patients were elective admissions
- All patients had multiple co-morbidities
- Six of the patients who became bacteraemic in hospital were probably chronic carriers of MRSA but did not fall into risk groups for emergency admission screening.

- Two patients who became bacteraemic in hospital were known to have had MRSA carriage in the past but this was not identified on admission.

- Two of the patients with community acquisition resided in care homes. The others lived in their own homes.

- Two of the community acquired bacteraemias may have been prevented if infected chronic wounds had been swabbed in the community and antibiotic sensitivities used by General Practitioners to inform appropriate antimicrobial therapy prescription.

### 11.2 *C.difficile* infection

11.2.1 Improvement targets have been set for all NHS Trusts, with the RD&E expected to achieve a 30% reduction over the next three years based on the number of cases identified more than two days after admission. Any identified in the first two days of an admission are community acquired and cannot be attributed to the acute hospital setting.

11.2.2 The actual number of cases recorded for 2007-8 was 213. The number of cases in 2008-9 was 145. This is a **31.9%** reduction in one year.

11.2.3 Whilst swift isolation of patients with symptoms, management of confirmed cases on a designated isolation ward, prudent antimicrobial prescribing, hand washing and routine environmental cleaning are all important prevention and control strategies, the deep cleaning programme with hydrogen peroxide vapourisation is believed to have been the most significant strategy in achieving this reduction.

11.2.4 The run chart at Appendix 13 demonstrates the progressive impact of the programme on the number of cases identified.

### 11.3 Cleaner hospitals (PEAT scores)

PEAT (Patient Environment Action Team) inspections are undertaken annually by self assessment. The team undertaking the inspection includes a member of the public. Overall, standards continue to improve with a score of 'Good' awarded for the environment demonstrating that high standards have been maintained.

### 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). In February 2009, the Trust was inspected by the Health Care Commission against Duties 2, 4, 8 and 10j of the Hygiene Code and was found to be fully compliant.

### 11.6 Health and Social Care Act 2008.

11.6.1 From April 2009, the Care Quality Commission (CQC) will be the new independent regulator of health and adult social care services across England. They will be responsible for registering, reviewing and inspecting these services. The CQC is an amalgamation of the Healthcare Commission, the Commission for Social Care and Inspection and the Mental Health Act Commission.

11.6.2 The Trust have had to register with the CQC and self assess compliance with the new requirements and regulations under the 2008 Act that require us to protect patients, staff and others from identifiable risks of acquiring a healthcare-associated infection (HCAI). The Trust has assessed itself as meeting the new requirements.

### 11.7 Local Targets

11.7.1 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).

11.7.2 An ambitious Trust wide hand hygiene aspiration of 85% was agreed at the start of the year, having achieved compliance of 70% by the end of 2006/7. This aspiration has become a reality in the average Trustwide compliance rates, However, a small number of areas still strive to reach this challenging level of compliance.

## 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/unit specific hand hygiene compliance charts are available from the Infection Control team on request.

### 12.3 Audit of Patient Placement, Isolation and Infection Risk Assessment

This is an annual observation audit undertaken on all wards to measure compliance with infection control policies and guidelines that impact on patient placement, isolation and infection risk assessment. Key results show that:

12.3.1 One hundred and sixty four single occupancy rooms are available for in-patient use within the Trust.

12.3.2 *En suite* facilities were available in 53% of the single occupancy rooms

12.3.3 Whilst 51% of single room occupants were in the room for infection control reasons, the remainder were occupied by patients who were not infectious. The majority of these were in a single room because this was the only bed available on admission or the only bed appropriate to the gender of the patient.

12.3.4 This meant that a small number (19) of patients with infectious conditions were placed in multiple occupancy rooms, although risk assessment had indicated that risk of transmission to other patients was low. This number of patients is lower than in previous audits but still suggests that availability of single rooms for infection control purposes is sub optimal.

### 12.4 MRSA Screening and decolonisation of MRSA positive in-patients

Screening and decolonisation of the MRSA positive patients was audited and most patients were managed appropriately. However, delays in appropriate topical treatment of five MRSA positive patients were observed. This prolongs the period of isolation and limits single room availability.

### 12.5 Audit of blood culture techniques

12.5.1 An audit of blood culture collection techniques was undertaken following a route cause analysis (RCA) for an MRSA bacteraemia. The RCA indicated that a contaminated blood culture may have resulted in a pseudo-bacteraemia, i.e. the organisms were on the patients skin, but not in the blood.

12.5.2 The audit showed that most blood culture technique was satisfactory, but that the use of special collection systems, rather than a syringe and

needle could be improved. Training for junior doctors will now incorporate update sessions on blood culture technique from 2009.

## 12.6 Antibiotic Prescribing

12.6.1 Audit and surveillance of antibiotic use and prescribing is undertaken and monitored through the Antimicrobial Subcommittee and co-ordinated by the Antimicrobial Pharmacist

12.6.2 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 was planned to introduce regular audits to most clinical areas. This was delayed by our Antimicrobial Pharmacist leaving and a gap before a replacement could take up the post. These audits will start in April 2009

12.6.3 An audit of antimicrobial prescribing in patients who developed *C. difficile* was undertaken and has been reported at a Trust meeting and to a national meeting of the British Infection Society. Following this audit ciprofloxacin became a restricted antibiotic in the Trust, and its use is subject to approval by a microbiologist. Use is subject to surveillance monitored by the Antimicrobial Subcommittee

## 12.7 Peripheral cannula care

12.7.1 The most common complication of PVC use is phlebitis, which may be caused by infection and or physical-chemical irritants[1]. Infection can either be localised or more worryingly can result in systemic sepsis. This study was considered to be of particular relevance for the following reasons:

- PVC are the most commonly used intra vascular (IV) device. PVC complications contribute to morbidity, prolonged hospital stay and increased cost.
- Reducing the incidence of peripheral line related infections has been identified as a high impact intervention in the Department of Health publication “Saving Lives” 2005[2].
- Surveillance undertaken within the Trust has identified that some of the hospital acquired bacteraemias are directly related to PVC. In 2006 there were seven, in 2007 five and within the first three quarters of 2008.

12.7.2 Good compliance with many of the Trust standards was evident in relation to cannula size, dressing type, condition and PVC entry site and dwell time.

12.7.3 Equally the number of PVC where the insertion date was documented had vastly improved from the 2008 audit. This facilitates the prompt removal of devices after 72 – 96 hours.

12.7.4 Although an improvement on the previous audits, no clinical need could be found for 27% of the PVCs in situ. An unnecessary invasive device is a potential source of infection and this was flagged as an area for improvement.

12.7.5 The most reassuring aspect of this audit was the reduced prevalence of phlebitis. Only 3% of patients had a VIP score of 2 and no patients had a higher score. This, in conjunction with the improved number of days in place vastly reduces the risk of infection.

### 12.8 Sharps Safety Audit

12.8.1 The annual sharps safety audit focuses on safe disposal of sharps, including the type of bins used, the position of sharps bins and whether this reduces risk of accidental harm to patients, visitors(in particular children) and staff, and the use of trays to facilitate point of use disposal.

12.8.2 The findings of the audit show that sharps safety standards are high across the Trust but a small number of recommendations were made for further improvement and these recommendations are being implemented.

12.8.3 The report was presented to the Trust Health and Safety Committee.

## 13. TRAINING ACTIVITIES

### 13.1 Induction and update training for Trust Staff

The training needs analysis at Appendix 13 identifies the induction, annual update training and continuing education provided within the Trust. High attendance rates for all disciplines of staff have been achieved in 2008/9 and reported to the Infection Control Committee by each Directorate Lead.

### 13.2 Information for Contractors

Information for contractors has been developed and is provided to contractors in the Estates Department prior to accessing clinical areas.

### 13.3 For Infection Control Specialists

13.3.1 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.

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

13.3.3 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.

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

13.3.5 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.

### 13.4 For the Joint DIPCs

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

13.4.2 In addition to training undertaken as part of their personal development as Lead Nurse and Infection Control Doctor, the DIPCs have attended South West 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.

**APPENDIX 1**

# Progress against Infection Control Annual Programme 2008-9

## Infection Prevention and Control (IPC) Annual Programme 2008/9

(Updated to reflect progress March 2009)

## 1. Introduction

This year's annual programme is once again mapped to the structure of the Code of Practice for the Prevention and Control of Health Care Associated Infections (also known as the Hygiene Code) which was revised in January 2008. Compliance with the Code is enforceable by the Healthcare Commission under the Health Act 2006 and a declaration of compliance with the Code is part of the Annual Health Check for the Trust. The Code comprises eleven duties grouped into three areas pertinent to healthcare associated infection:

- Management organization and the environment (Duties 1-9)
- Clinical care protocols (Duty 10)
- Health care workers. (Duty 11)

The programme continues to address all high priority areas including specifically those associated with national performance targets:

- the further reduction of MRSA bacteraemia following on from the successful reduction over the last three years, and
- reduction in *Clostridium difficile* infection following an increase in 2007/8

Antibiotic regulation and control is an important part of infection control. Recently, this has been enhanced by the formation of the Antimicrobial Sub-committee of the Drugs and Therapeutic Committee to over see the antibiotic control team. The annual programme for the Sub committee is appended for information.

## 2. Programme

| Code of Practice Point | 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 | Hold four Infection Control Committee (ICC) meetings with decisions briefings to the Governance Committee. | Directors of IPC (DsIPC) | Quarterly | Held as planned |
| | The ICC will review its TOR | DsIPC | Nov 2008 | Completed |
| | Regular attendance by a DIPC at Trust Governance Committee | DsIPC | 6 weekly | Regular attendance |
| | Present annual programme 2008/9 and annual report 2007/8 to Trust Board | DsIPC | June 2008 | Annual report presented June 2008. |
| | Continue to strengthen Directorate level responsibility for infection control by developing a Directorate report template for Directorate infection control leads to use to report to the Infection Control Committee on:<br>• Infection control training, including training in antibiotic use<br>• Progress on action plans following root cause analysis of healthcare associated infection<br>• Actions to improve compliance with hand hygiene/bare below the elbow strategy<br>• Compliance with Saving Lives audits<br>• Outbreaks and Incidents | Judy Potter (JP)/Directorate Lead Nurses | June 2008 | Template designed and used for first time in May 2008 |
| | Develop business case for additional infection control practitioners in light of continually increasing workload in the acute Trust namely:<br>Surveillance<br>Audit<br>24/7 clinical advice<br>Outbreak management<br>Root cause analysis | JP | June 2008 | Business case submitted and approved. Additional staff commenced employment in January 2009 |

| Code of Practice Point | Programme of work 2007/8 | By whom (lead) | By when | Progress/Outcome |
|---|---|---|---|---|
| …..*Duty 2 continued* | Policy development<br>Training<br>Clinical facilitation | | | |
| | Develop patient placement and movement policy | JP | May 2008 | Policy approved in May 20008 |
| | Work with Devon PCT interim infection control lead, to agree levels of service to be provided for 2009/10 | JP/AC | Dec 2009 | SLA rolls over again for 2009/10 |
| 3. Duty to assess risk of acquiring healthcare associated infection and to take action to reduce or control risks | Regular review HCAI risks identified on Trust Risk Register and report to Governance Committee | JP | Quarterly | Completed as required |
| | Complete research project to determine whether MRSA carriage is higher in pregnant health and care workers than other pregnant women | Penny Criddle (PC) | Sept 2008 | Project closed to recruitment. Analysis for report underway. |
| | Review arrangements for minimising risk of *C.difficile* acquisition in Trust including: | | | |
| | • Agree reduction targets for Trust and Directorates | ICT/ICC<br>ICC | June 2008 | Trust targets agreed with PCT |
| | • Use of Torridge ward by all directorates | | April 2008 | Agreed |
| | • Minimising exposure of recovered patients to further *C.difficile* spores | CD - Surgery | April 2008 | Process agreed |
| | • Use of $H_2O_2$ environmental disinfection | DIPC/Exec Team | May 2008 | Commenced with deep cleans in July 2008 |
| | • Restricting access to quinolone antibiotics | Hazel Hedicker/JP | May 2008 | Restrictions commenced July 2008 |
| | • Feedback to Directorates of cases identified in 3 months post discharge. | AC/Medical Directors | Quarterly | |

| Code of Practice Point | Programme of work 2007/8 | By whom (lead) | By when | Progress/Outcome |
|---|---|---|---|---|
| | Use of NPSA action through learning tool for all *C.difficile* infection resulting in death (Part 1) or colectomy. | ICT | As required | |
| | Audit patients with *C.difficile* infection for selected *C.difficile* risk factors and 30 day outcome. Report findings to Infection Control Committee ( ICC) 6 monthly. | AC/Ray Sheridan | Starting April 2008. | Commenced on time. Reports provided to ICC |
| | Further reduce risk of MRSA and other bacteraemias through focused work on:<br>• Peripheral cannula care, including: | | | |
| | i. Establishing cost for introduction of 2% chlorhexidine in alcohol for skin prep | JP | May 2008 | Cost established BC1 submitted and approved. Product change implemented. |
| | ii. Improved documentation of insertion, removal and monitoring - pilot on Otter and Culm. | JP/Vicki Shawyer | June 2008 | Pilot successful. Awaiting publication of new prescription chart before roll out |
| | • Long term central lines, in oncology and haematology including: | | | |
| | i. Use of Saving Lives High Impact intervention No1 - central venous catheter care bundle to assess standards. | Tina Grose/ICT | July 2008 | First round of data collection complete |
| | ii. Plan action for improvement based on results | ICT | Sept 2008 | Inadequate data at present |
| | Undertake continuous alert organism surveillance with SPC feedback on MRSA and C.difficile to: | ICT | | |
| | - Wards and directorates | | 2 Monthly | Completed |

| Code of Practice Point | Programme of work 2007/8 | By whom (lead) | By when | Progress/Outcome |
|---|---|---|---|---|
| …..*Duty 3 continued* | - Infection Control and Governance Committees | | Quarterly | Completed |
| | Undertake mandatory, continuous surveillance of : | | | |
| | • *Staph. aureus* and VRE/GRE bacteraemia | ICT | Monthly reporting | Completed |
| | • | | | |
| | • *C. difficile* in the over 2 year olds | | Monthly reporting | Completed and under trajectory |
| | ▪ Orthopaedic surgical site infection | CP | Quarterly reports | Completed |
| | Continue continuous all organism bacteraemia surveillance | CP | Quarterly reports | Completed |
| | Approach Welsh Public Health Service for permission to use caesarean section surgical site infection surveillance protocol with a view to undertaking at least 3 month period of surveillance by year end | CP | March 2009 | Will become available via the English surveillance centre later this year. Therefore postponing this. Abdominal Hysterectomy surveillance undertaken instead. |
| | Continue to improve data collection of continuous orthopaedic surgical site infection surveillance within the T&O directorate | PM/JP | June 2008 | Named nurse identified in Orthopaedic to liaise with all wards |
| | Develop effective procedure/s for screening and decolonisation of all surgical elective patients by end of 2008/9. | JP/Angela Edmunds | September 2008 | Approved process implemented February 2009 |

| Code of Practice Point | Programme of work 2007/8 | By whom (lead) | By when | Progress/Outcome |
|---|---|---|---|---|
| …..*Duty 3 continued* | Produce report of the prevalence study of catheter associated urinary tract infection following removal of silver coated catheters as the Trust standard catheter undertaken in March 2008. | CP/JP | May 2008 | Report finalised - presented to Nov 08 ICC. |
| | Continue to work with the pharmacy department to develop surveillance of antimicrobial consumption when enhanced IT systems are available - refer to Antimicrobial Sub Committee programme Appendix A. | AC/JM | Ongoing | |
| 4. Duty to provide and maintain a clean and appropriate environment for healthcare | Ensure that there is infection control input to environmental monitoring systems | | | |
| | a)Cleanliness Standards validation audits | JP | Quarterly | Completed |
| | b)PEAT assessments | Diane Ody/JP | March 2008 | Completed. Awaiting results |
| | Provide specialist input to Cleaning Standards Group, PEAG and Matrons Charter group. | | | |
| | Continue with Year ¾ of '*Cleanyourhands*' campaign which includes:<br>a) Patient involvement<br>b) Poster campaign<br>c) Near pt alcohol hand rub<br>d) Hand hygiene training<br>e) Observational audits with feedback charts | JP<br><br><br><br><br>Link Nurses | Continuous<br><br><br><br><br>Monthly | Response to NPSA Alert completed.<br><br><br><br><br>Trustwide.85% compliance achieved |
| | Ensure infection control and microbiology input to Decontamination Committee through attendance at meetings | JP/AC | Quarterly | Meeting attended in May &November. |
| | Establish system for assessing patients for TSE risk prior to invasive procedures which will allow approval | Medical Directors/AC | June 2008 | Policy/ assessment form approved |

| Code of Practice Point | Programme of work 2007/8 | By whom (lead) | By when | Progress/Outcome |
|---|---|---|---|---|
| ……..*Duty 4 continued* | of revised TSE policy.<br><br>Provide infection control/microbiology input to review of Legionella control measures through attendance at Legionella Control Team meetings<br><br>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, in particular<br>a) Acute Model of Care/Emergency Hub<br>a) Heavitree development projects including dialysis unit, day surgery, dermatology<br>b) Honiton dialysis unit | <br><br>JP/AC<br><br>Infection Control Team (ICT) | <br><br>6 monthly<br><br>According to Project Plans | <br><br>Meeting held May 2008<br><br>Involvement continues. |
| 5. Duty to provide information on healthcare associated infections to patients and public | Ensure that DIPC Annual Report is posted on RD&E website following presentation to the Board.<br><br>Review and update range of patient information leaflets<br><br>Present on progress with infection control and performance targets at Trust constituency meetings<br><br>Work with PALs, Complaints, Legal Dept, Comms Dept and FOI officer to provide timely, accurate and comprehensible information to press enquiries, FOI requests and patient concerns/complaints and report common themes to ICC. | Janet Oatley<br><br>PC<br><br>JP<br><br>JP/AC | July 2008<br><br>Sept 2008<br><br>As required<br><br>As required | Posted July 2008<br><br>Completed<br><br>Not required<br><br>Timely responses provided |
| 6. Duty to provide information when a patient moves from the care of one healthcare body to another | Audit use of IC alert on E-whiteboard as outlined in section 10<br><br>Investigate possibility of improving communication re IC risks with ED IT system. | KL<br><br>JP/Fred Cock | Aug 2008<br><br>Dec 2008 | Completed<br><br>This feature will be incorporated into new IT system |

| Code of Practice Point | Programme of work 2007/8 | By whom (lead) | By when | Progress/Outcome |
|---|---|---|---|---|
| 7. Duty to ensure cooperation<br><br>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 | Ensure that all approved policies and guidelines are available to all staff on Comex and the RD&E Trust web site.<br><br>Participate in joint 'Action through Learning' opportunities and other investigations with PCT and/or Devon Partnership Trust | Janet Oatley<br><br>JP | Within two weeks of approval<br><br>As required | All policies have been put on Comex and RDE website in a timely manner<br>Attendance provided as required. |
| 8. Duty to provide isolation facilities, adequate to need | Also - refer duty 4 re. built environment<br><br>Support the directorates to make plans for increasing provision of additional isolation rooms in:<br>• Torridge ward<br>• Orthopaedic trauma<br>• Vascular surgery | <br><br>Cathy Webb<br>Peter Vickery<br>Matthew Bryan | <br><br>End of 2009 | |
| 9. Duty to ensure adequate lab support | Business plans for additional resources to support MRSA screening strategy in laboratory | Julie King/AC | June 2008 | Funding approved. Screening programme implemented |
| 10. Duty to adhere to all clinical policies and protocols applicable to infection prevention and control | Develop PVL *Staph aureus* guidance<br><br>Review and update the following IC policies/guidance<br>• Animals and Pets in healthcare premises<br>• CVC guidelines<br>• Decontamination Policy<br>• ESBL Guidance<br>• Infection Control Policy<br>• Legionella Policy | CK/JT<br><br>JP<br>PC/Vascular Access Team ( VAT)<br>JP<br>CK<br>JP<br>AC | August 2008<br><br>Dec 2008<br>June 2008<br>May 2008<br>Dec 2008<br>May 2008<br>Aug 2008 | Completed<br><br>Completed<br>Completed<br>Completed<br>Completed<br>Completed<br>Completed |

| Code of Practice Point | Programme of work 2007/8 | By whom (lead) | By when | Progress/Outcome |
|---|---|---|---|---|
| | • MRSA (section on MRSA screening and decolonisation) | JP | Aug 2008 | Completed |
| | Undertake the following audits to monitor compliance with selected infection control policies/guidelines: | | | |
| | • Patient placement, isolation and infection risk assessment | CP/Jeanette Thomas (JT) | June 2008 | Completed |
| | • Observation audit of hand hygiene | Link Nurses | Monthly | Compliance chart reports distributed regularly |
| | • Renal dialysis catheter care using 'Saving Lives' High impact intervention No 3 Care bundle | Renal Vascular Access Nurse | Quarterly reports | New tool being developed reflecting local needs |
| | • Use of nasal mupirocin prophylaxis in dialysis pts | Renal Vascular Access Nurse | To be agreed | Completed |
| | • MRSA decolonisation of patients known to be MRSA positive on admission | Kath Leader (KL) | August 2008 | Completed |
| | • Use of IC alert on admission and prior to movement of patient and, if present, appropriateness of action. | KL | August 2008 | Completed |
| | • Sharps disposal procedures | ICT | July 2008 | Completed |
| | • Peripheral cannula care | VAT | May 2008 | Completed and re-audit completed in Jan 2009.. |
| | • Antimicrobial prescribing - refer to Antimicrobial Sub Committee programme Appendix A. | AC / Gemma Morla | | |

| | | | | |
|---|---|---|---|---|
| 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 | Deliver mandatory training as per training needs analysis | ICT | Ongoing | Completed |
| | Update presentations Corporate induction | JP | April 2008 | Completed |
| | Deliver infection control and invasive procedures training for medical staff as part of DOPs | ICT | Each new intake of junior doctors | Completed |
| | Revise and update e-training package for medical staff | ICT | Ongoing | Completed Oct. 2008 |
| | Deliver at least one link nurse training course | ICT | Dec 2008 | Provided April, July and Oct and Jan Completed |
| | Provide quarterly link nurse updates | ICT | Quarterly | |
| | Produce 'table topper' HCAI information for staff in restaurant to compliment that provided for visitors. | Wendy Shaw | As required | |

## 3. Monitoring Delivery

Progress against the programme will be monitored by the infection Control Committee. Significant lapses in progress will be reported to the Board via the Governance Committee.

## 4. References

Department of Health (2008) *The Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections*

**Appendix A**

# Antimicrobial Subcommittee Annual Programme 2008/9

## 1. Introduction

The Antibiotic Policy was adopted by the RD&E Trust in 2007, and as a result the Antimicrobial Subcommittee of the Drug and Therapeutic Committee was formed. It is constituted under section 3.7 of the terms of reference of the Drug and Therapeutic Committee. It reports through the Chair and members of the Drug and Therapeutic Committee to the Trust Governance Committee.

The Antibiotic Subcommittee liaises with the Directors of Infection Prevention and Control (DIPC) and the Infection Control Committee.

The purpose of the Antimicrobial Subcommittee is to ensure that antimicrobial drugs are utilised throughout the Trust in a way which results in optimal treatment of infections while minimising the risk of adverse effects including healthcare associated infections. To support this purpose, the committee has adopted its first annual programme.

**ANTIMICROBIAL MANAGEMENT TEAM (AMT) ACTION PLAN: DRAFT (January 2008)**

| Issue Identified | Activity | Lead | Timescale | Progress |
|---|---|---|---|---|
| **1. Audit and surveillance.** | | | | |
| Trust audit programme | Devise an annual programme of audit and surveillance. | GM | March 2008 | Completed |
| Antimicrobial Prescribing audit. | Conduct a pilot audit to evaluate recording of information on antibiotic treatment in the medical notes and on the drug chart. Evaluate initial appropriateness of antibiotic prescription against Trust guidelines and timing of iv to oral switch | HP | January 2008 to May 2008 | - Hazel Parker collected data on two wards: Abbey and Harbourne and produced a final report |
| | Role out above audit selection of wards | GM & NH | Annual | Starting April 2009 |
| Antibiotic point prevalence audit | Participate at the antibiotic point prevalence study of all patients prescribed antimicrobials on a single day. Collect data on choice of agents, indication and signs/symptoms of infection. Benchmarking information available by the end of April. | GM & ward pharmacists | Annually | Data collected on February 2008. Results presented on the Regional antibiotic meeting on May 2008. Comparison graphs of 2006 and 2008 figures done for the AMT meeting by 10th of June. |
| Antimicrobial surveillance | Establish and implement a system to provide regular reports of antimicrobial consumption using DDD which can be used for surveillance purposes. | DD & GM | December 2008 | Project presented on the Regional antibiotic meeting on May 2008. Cannot be achieved with available IT in pharmacy |
| | Prospective surveillance of antimicrobial prescribing in patients with *C.Difficile* infections. Programme of routine prescribing data collection on Torridge ward to establish data-base and regular reports. | Micro F2 & JM & GM | Ongoing | Torridge doctors are collecting data for each patient. Form developed and in place. Data for Jan to July presented various meetings including ICC Nov.2008 |

| | | | | |
|---|---|---|---|---|
| Restricted antibiotics | Surveillance and monitoring of restricted antibiotic use.<br>Update and improve the restricted antibiotic form<br>Develop a database. | GM<br><br><br>JM | March 2009 | Spreadsheet is being created to control the expenditure and audit the data easily. |

| **2. Clinical activity** | | | | |
|---|---|---|---|---|
| Microbiology ward rounds | Develop a referral system from ward pharmacists to AMT and perform weekly ward round. | Microbiology Consultants | October 2008 | Rounds Started March 2008<br>Referral system or whole ward format piloted |

| **3. Policies and Guidelines** | | | | |
|---|---|---|---|---|
| Formulary of antimicrobials. | Produce a list of antimicrobials which are approved for use within the Trust. The formulary will indicate that certain antimicrobials will be subject to restrictions. The formulary will be reviewed annually or as appropriate by the AMT. | GM | Draft March 2008 | Deferred due to change of antimicrobial pharmacist, no one in post August 2008 to January 2009 |
| Antimicrobial prescribing policy | Develop a policy for antimicrobial IV to oral switch and guidelines for good antimicrobial prescribing. | AC& GM | Draft March 2008 | Guideline approved on D&T Committee on 29th of July. |
| Improving access to antibiotic guidelines on Comex. | Establish an antibiotics prescribing area on Comex.<br>Investigate the possibility of developing an interactive website. | JM<br>& GM | March 2009 | Antimicrobial guidelines are a new section under Pharmacy on Comex. |

| | | | | |
|---|---|---|---|---|
| Quick antibiotic reference card | Routine annual update the antibiotic quick reference card | GM | Ready for distribution to coincide with intake of new doctors in August each year. | Update of the antibiotic quick reference card done by May 2008. Approved on the AMT meeting, 10th of June. Distributed on time |
| New guidelines | Gentamicin dosing guideline | GM | May 2008 | Done by May 2008 |
| | Vancomycin dosing guideline | GM | May 2008 | Done by May 2008 |
| | Endocarditis prophylaxis. | TR | When NICE guideline approved | Decided to use NICE guidance |
| | Children antibiotic guidelines develop in corporation with Department of Paediatrics. | AC & GM | October 2008 | Guidelines in place Dec 2008 |
| Update/review guidelines | Update HAP and CAP | AC& GM | September 2008 | Work in progress CAP and Aspiration pneumonia March 2009 |
| | Update the therapeutic monitoring of antibiotic levels in adults and children. | Medical Microbiologists | May 2008 | Updated Vancomycin and Gentamicin guidelines in place Children's in paediatric guidelines |

| **4. Education.** A programme of education on the appropriate use of antimicrobials. | | | | |
|---|---|---|---|---|
| Medical students | Provide training on prudent prescribing for final year medical students in 'Preparing for practice' sessions. | AC | To Discuss | |
| Doctors | Provide PowerPoint slideshow on the principles of good antimicrobial prescribing for RD&E induction website. | AC | August 2008 | PowerPoint presentations for prudent antimicrobial prescribing produced and implemented on Comex, Oct 2008. Training sessions also implemented for F1, F2 and StR Juniors |
| | Develop an on-line power-point training for junior doctors. | AC | To Discuss | |

| | | | | |
|---|---|---|---|---|
| Pharmacists | Training on prudent prescribing | GM | To Discuss | Partly achieved: Power point developed and emailed to all pharmacists. Waiting to restart Wednesdays meetings to do a session. |
| | Training on dosing and monitoring levels of toxic antimicrobials | GM | To Discuss | |

| **5. Research and training for the Antibiotic Pharmacist.** | | | | |
|---|---|---|---|---|
| | Complete the diploma on pharmaceutical practice and therapeutics for the University of Bath. | GM | April 2008 | Last unit done by April 2008. Waiting for the final results. |
| | Attend relevant meetings. | GM | Annual 2008 | |
| | Master on antibiotics | GM | April 2009 | Started a master on antibiotics with the University of Barcelona and Hospital del Mar. |

**ANTIMICROBIAL MANAGEMENT TEAM (AMT) ACTION PLAN:**

## References


DH (2003) *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/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4095070&chk=J9Gyqw> Accessed 21/01/07.

DH (2005). *Saving lives: a delivery programme for reducing healthcare associated infection (HCAI) including MRSA*. London: DH. Available at: <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthcareAcquiredInfection/HealthcareAcquiredGeneralInformation/SavingLivesDeliveryProgramme/fs/en> Accessed on 21/01/07.

Department of Health (2006) *The Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections* http://www.dh.gov.uk/prod-_consum_dh/groups/dh_digitalassets/@en/documents/digitalasset/dh_4139337.pdf

Optimising the clinical use of antimicrobials: Report from the Clinical Prescribing Subgroup of the Interdepartmental Steering Group on Antimicrobial Resistance. http://www.dh.gov.uk/assetRoot/04/08/43/95/04084395.pdf

Specialist Advisory Committee on Antimicrobial Resistance (SACAR) UK Template for hospital antimicrobial guidelines. http://www.advisorybodies.doh.gov.uk/sacar/hospitail-antimicrobial-guidelines-template-may05.rtf.

Royal Devon and Exeter NHS
NHS Foundation Trust

# INFECTION CONTROL COMMITTEE

## Terms of Reference

| **These Terms of Reference are used as evidence for:** | |
|---|---|
| Healthcare Commission Core Standard numbers: | C4a |
| NHSLA Risk Management Standards for Acute Trusts: | ✓ |
| NHSLA CNST Maternity Clinical Risk Management Standards: | ✓ |
| Other (*please specify)*: | Hygiene Code |

**1. Accountability**

1.1 The committee 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 Annual Programme, which it also supports and monitors.

**3. Membership**

3.1
- Joint Directors of Infection Prevention and Control (Chair)
- Infection Control Nurse Specialists
- Audit and Surveillance Nurse Specialist
- A Consultant Microbiologist representing the Medical Microbiologists
- Chief Executive or a representative with delegated authority
- Chief Operating Officer
- Medical Director
- Director of Nursing & Patient Care or representative
- Consultant in Communicable Disease Control
- Occupational Health Physician or Nurse
- Divisional Manager Facilities/Decontamination Lead
- Divisional Infection Control Leads
  - Lead Nurse - Medicine
  - Lead Nurse - Surgery

- Lead Nurse - Child Health
- Lead Nurse - Women's Services
- Lead Nurse - Trauma & Orthopaedics/Critical Care
- Superintendent Physiotherapist - Professional Services

- Divisional/Directorate medical staff infection control champions
  - Medicine
  - Surgery
  - Child and Women's Health
  - Cancer Services
  - Trauma & Orthopaedics
  - Critical Care
- Hotel Services Manager
- Deputy Director of Planning & Estates
- Antimicrobial Pharmacist

3.2 The Committee/Group/Forum will review the membership of the Committee annually to ensure that it reflects the requirements of the Hygiene Code.

3.3 The Chairman will serve for three years.

3.4 Individuals may be co-opted for specific projects.

**4. A Quorum**

4.1 A quorum will consist of not less than 5 members of the Committee with at least the following members present:

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

**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.

5.2 Any member of staff may raise an issue with the Chairman, normally by written submission. The Chairman will decide whether or not the issue shall be included in the Committee's business. The individual raising the matter may be invited to attend.

5.3 The Chairman will prepare a ***'decision briefing'*** report after each Committee meeting to be sent to the Governance Manager within one month of a meeting for inclusion at the subsequent Governance Committee meeting.

**6. Frequency of Meetings**

6.1 Meetings will be held no less than 4 times in each accounting year.

6.2 Extraordinary meetings may be called at the request of the Director of Infection Prevention & Control or 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.

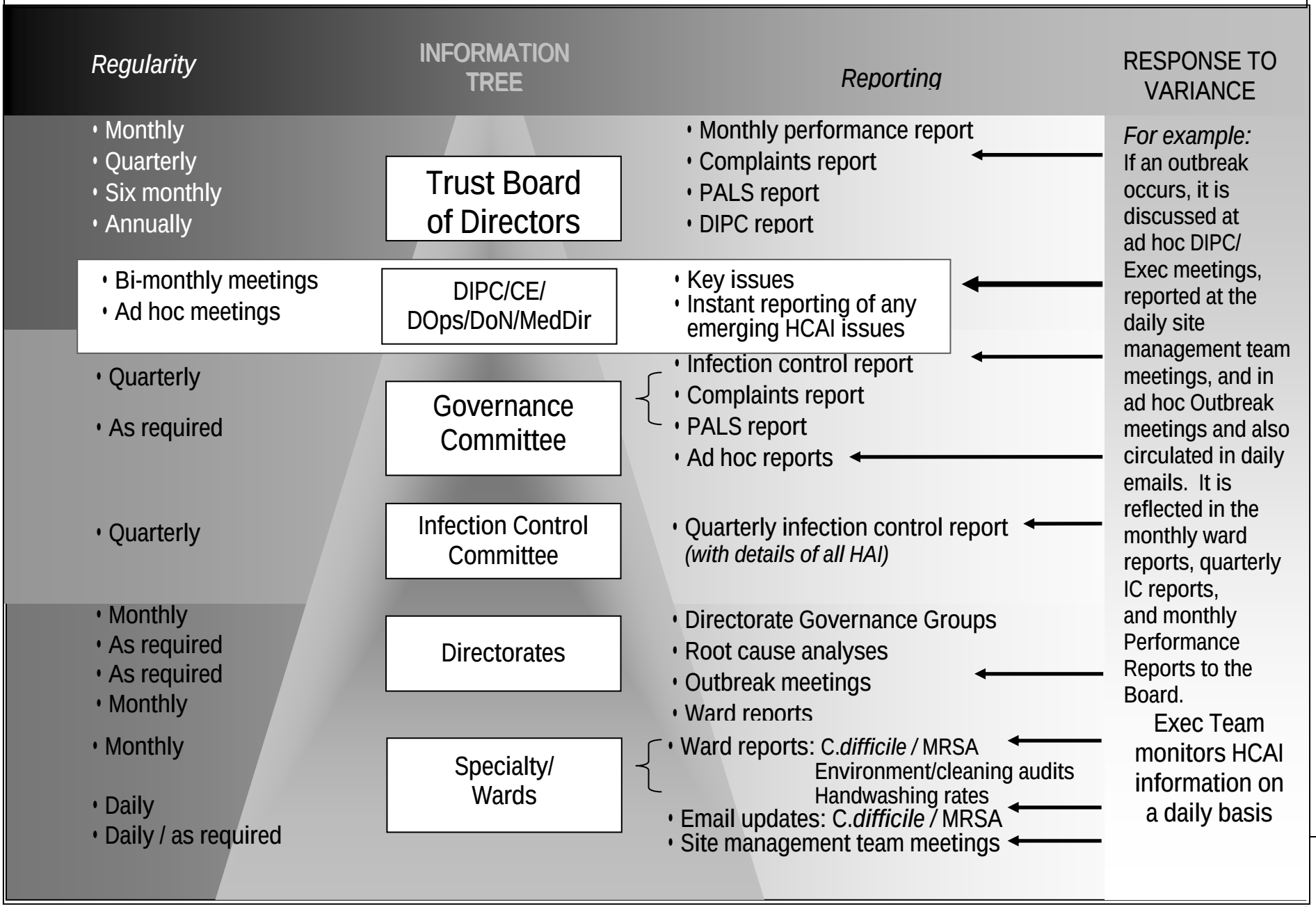
7.9 Receive the DIPC Annual Report

## 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.

## Healthcare Associated Infection Reporting Mechanisms

**Appendix 3**



**APPENDIX 4**

## Infection Control Committee – Decision Briefings

**Date of Meeting: 22/05/2008**

| Number | Description of Decision |
|---|---|
| 1. | The following revised / updated policies were approved<br>Decontamination<br>Patient Placement<br>Respiratory Syncitial Virus<br>Torridge Operational Policy<br>Infection Control Policy |
| 2 | The Annual Programme 2008/9 was approved |

**Date of Meeting: 21/08/2008**

| Number | Description of Decision |
|---|---|
| 1. | The revised Consent Form with CJD screening questionnaire has been approved by Information Governance. It should be implemented and replace the current Consent Form as soon as it can be printed. All divisions will need to ensure that appropriate advance information is disseminated about the change. |

**Date of Meeting: 13/11/2008**

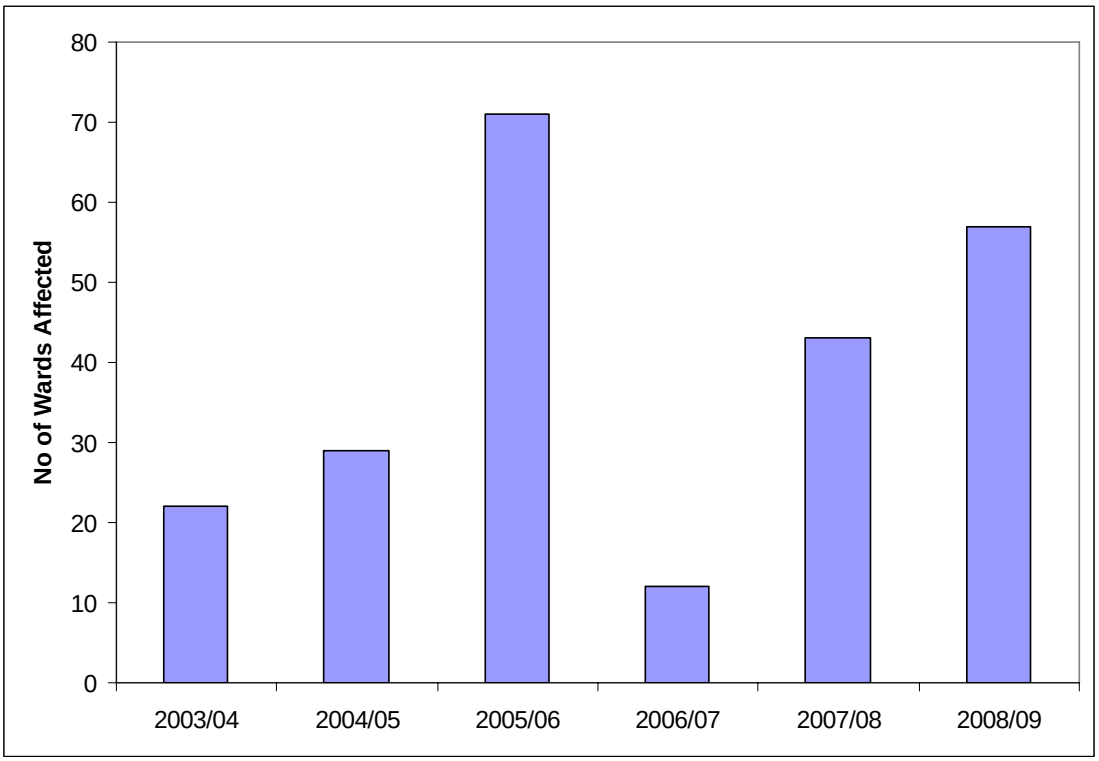
| Number | Description of Decision |
|---|---|
| 1. | Legionella risk assessment for the Centre for Woman's Health should be reduced to the same level as the rest of the Wonford site, following implementation of a copper/silver system and monitoring of legionella in the water systems. |
| 2 | The following new policies were approved, subject to minor corrections.<br>1. PVL Policy<br>2. Infection Control Guidelines for Non RD&E Employees<br>3. Cleaning Policy<br>4. Pest Control Policy |
| 3 | The following existing policies were approved following routine review and revision<br>1. ESBL Policy<br>2. Guidance on Animal & Pets in Healthcare Facilities<br>3. Guidelines for the Management of Central Venous Catheters<br>4. Food Safety Management Policy<br>5. Legionella Policy |
| 4 | Results of a Trust of *C. difficile* cases were presented. A high rate of community acquired cases were noted. This will be taken to the Devon PCT Infection Control Committee. |

**Date of Meeting: 05/02/09**

| Number | Description of Decision |
|---|---|
| 1. | **1) Policies approved**<br>- Guidelines for the Management and Control of MRSA.<br>This is a major revision including screening of elective patients<br>**2) Policies Reviewed**<br>- Major Outbreak Policy<br>- Aseptic Technique Policy<br>- Tuberculosis Management in a Hospital Setting<br>These were approved for 2 years without need of revision |
| 2 | **Annual Programme**<br>Progress against 2008/9 program was monitored and found to be on target in most areas<br>Provisional Programme for 2009/10 was approved with minor amendments |
| 3 | **MMR vaccination of staff**<br>Action to improve compliance with Trust Immunisation Policy agreed.<br>Non-compliance to be put on Trust Risk Register<br>Medical Director to take to Executive Group<br>Ongoing work Occupational Health, HR and IC in progress |
| 4 | **Surveillance and Learning through Action**<br>Reports for MRSA and *C. difficile* reviewed. Improvement in C. difficile rates following ward deep cleans noted. |

**APPENDIX 5**

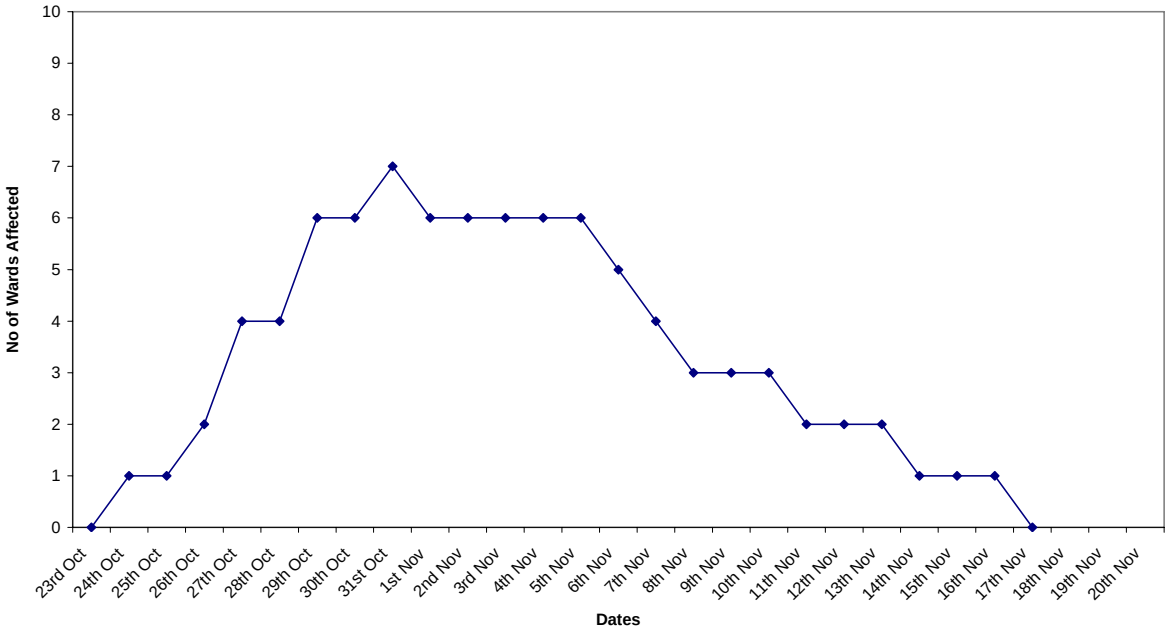
## Outbreaks of suspected or confirmed Norovirus



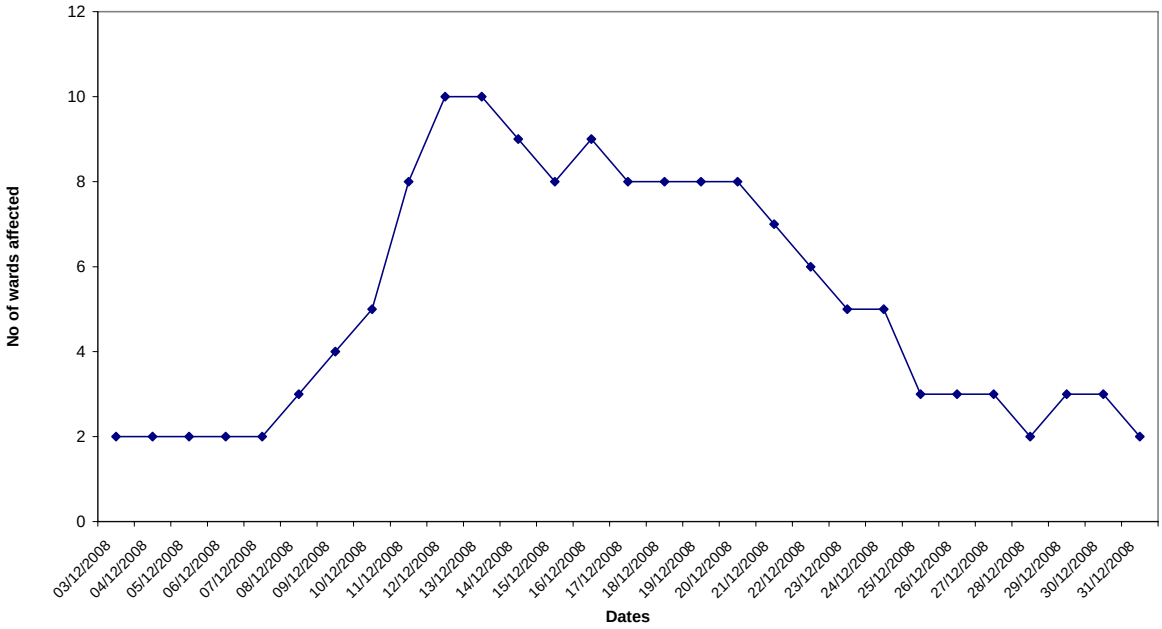
**APPENDIX 6**

# Norovirus Outbreaks

**Norovirus Outbreak Oct/Nov 2008**

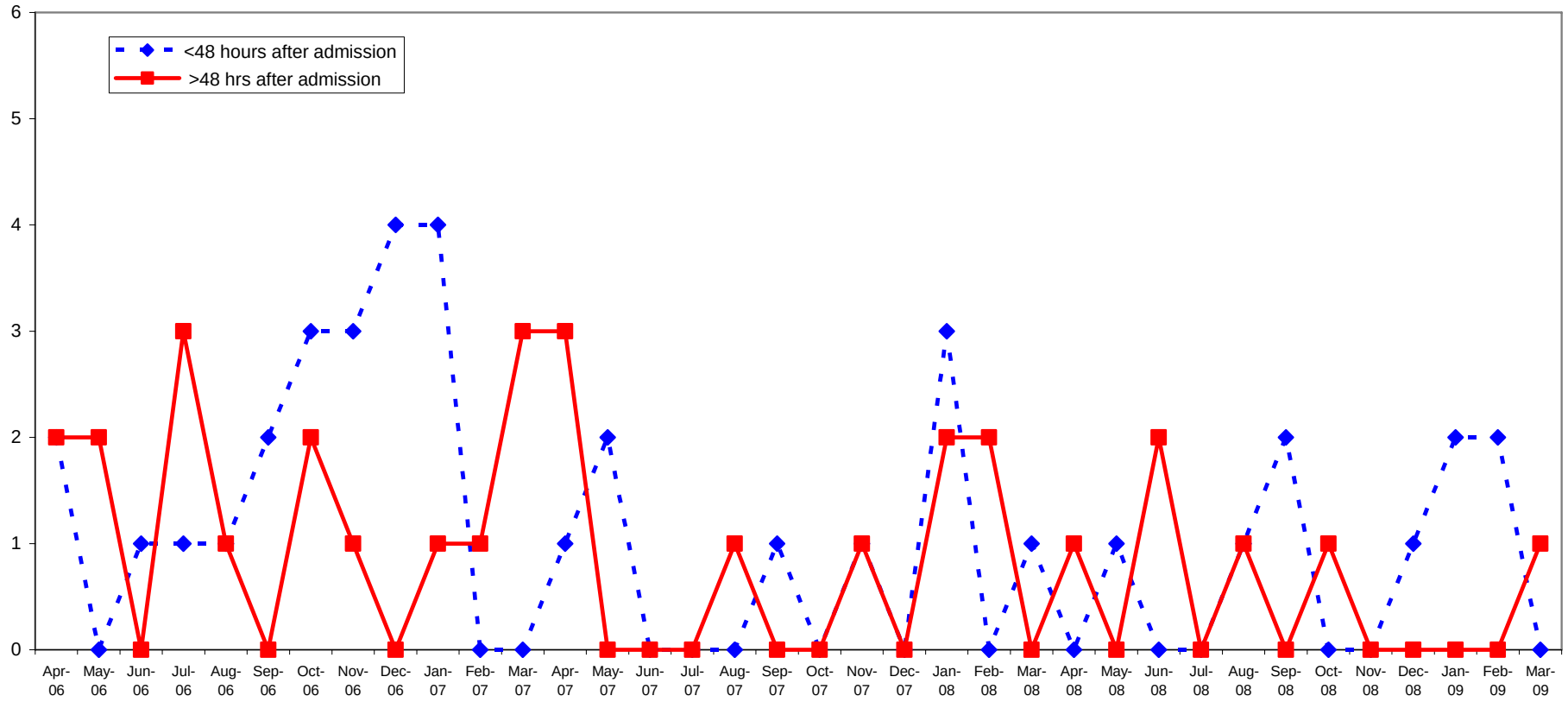



**Norovirus Outbreak Dec 2008**



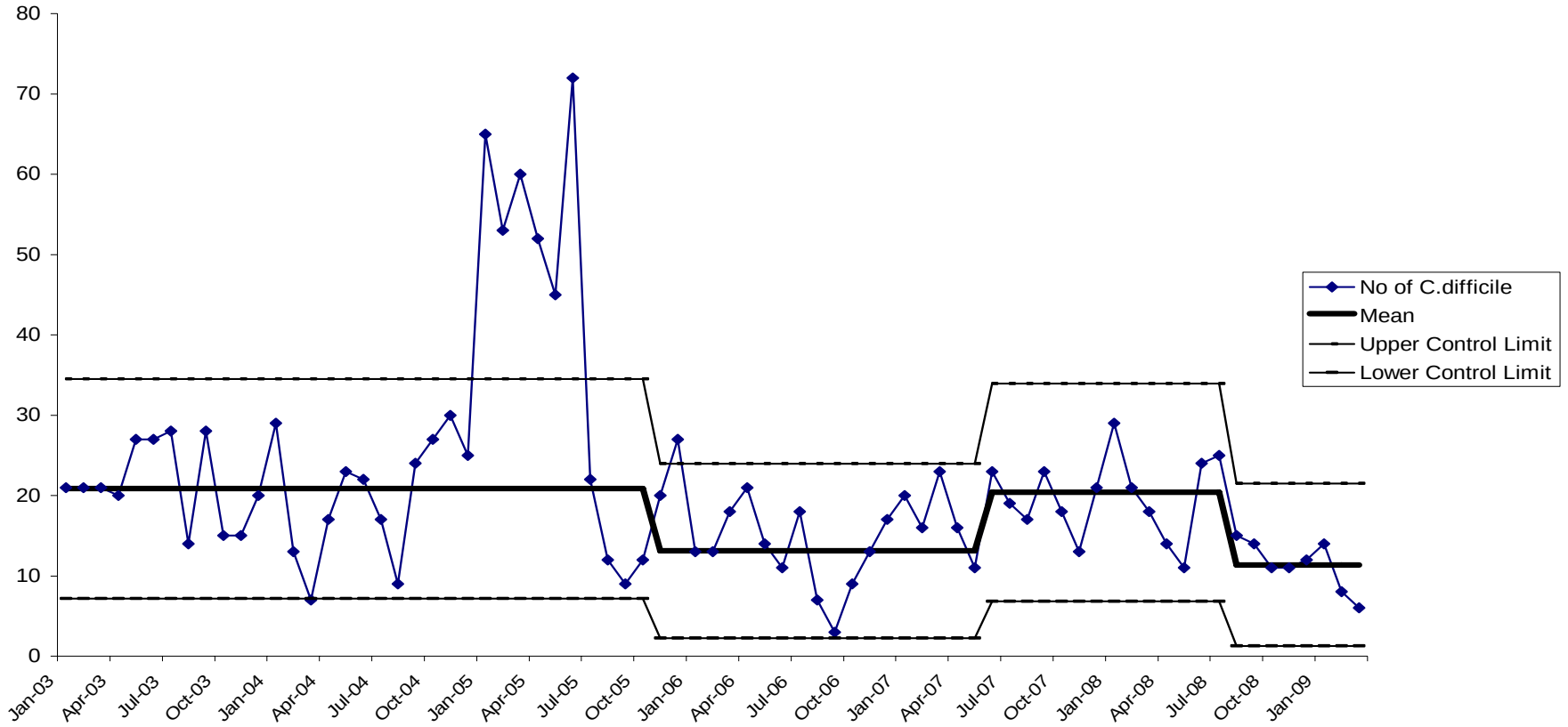
**APPENDIX 7**

## MRSA Bacteraemias - Pre and Post 48 hours of admission



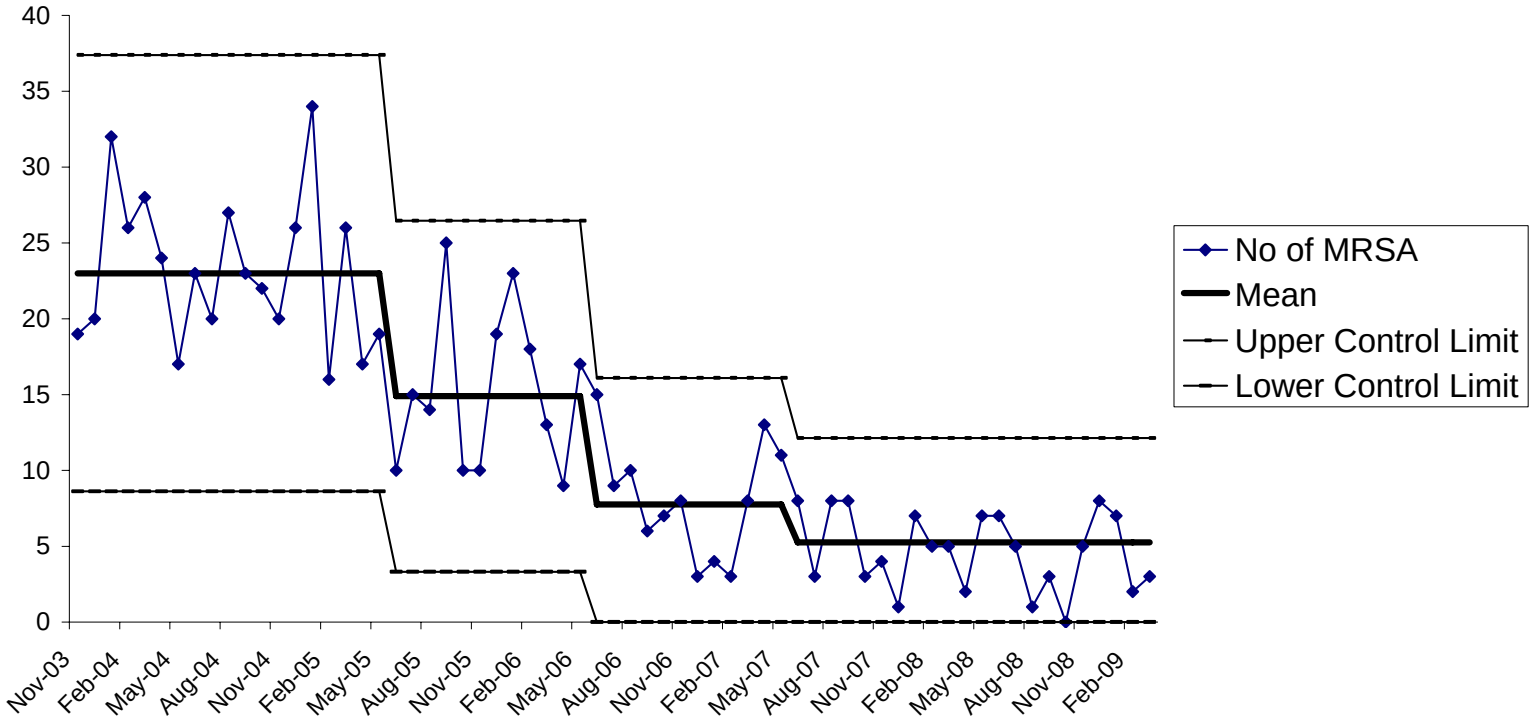
**APPENDIX 8**

**New cases of *Clostridium difficile* infection**
(All cases identified following admission to the RD&E)



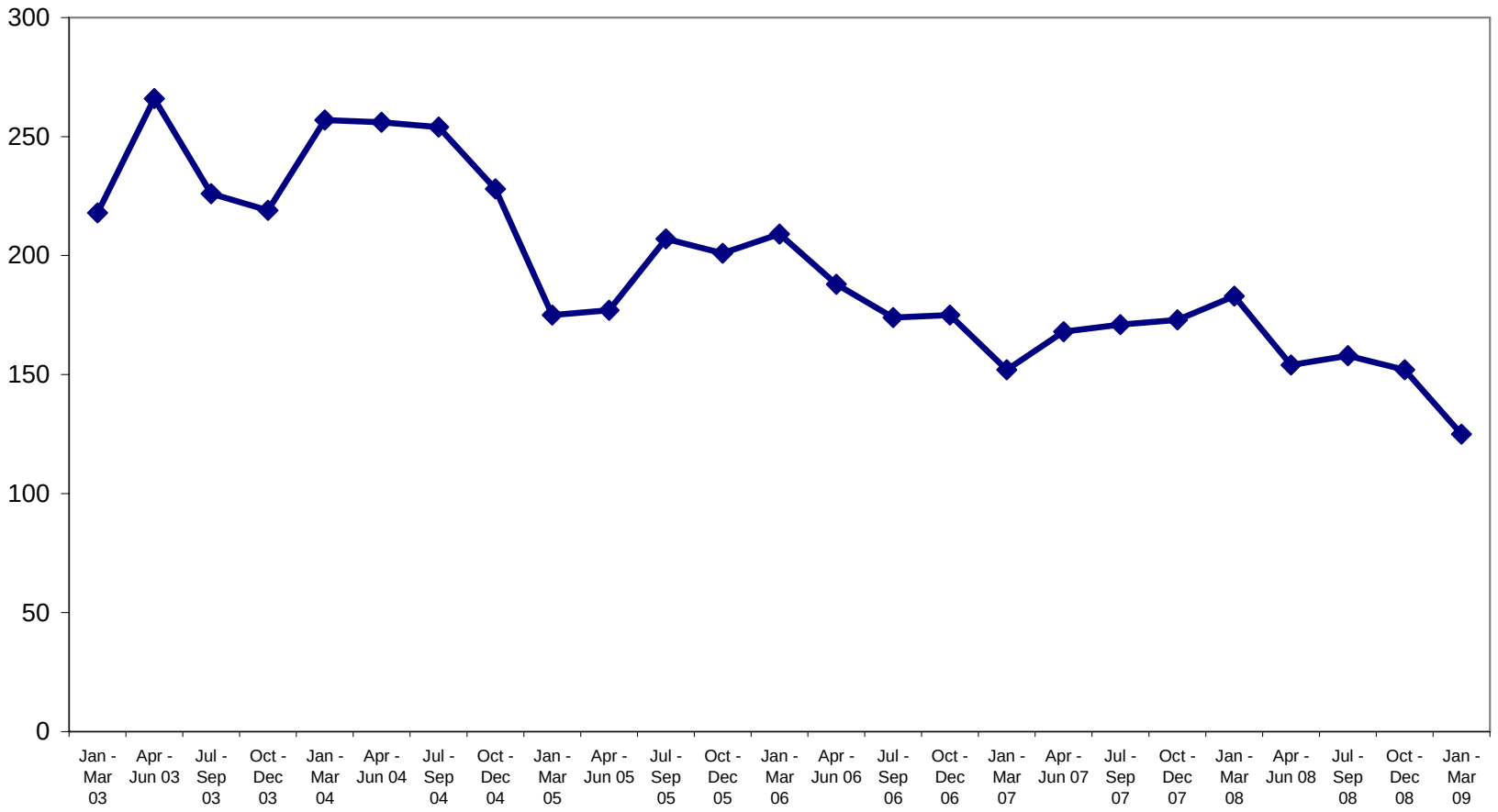
**APPENDIX 9**

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

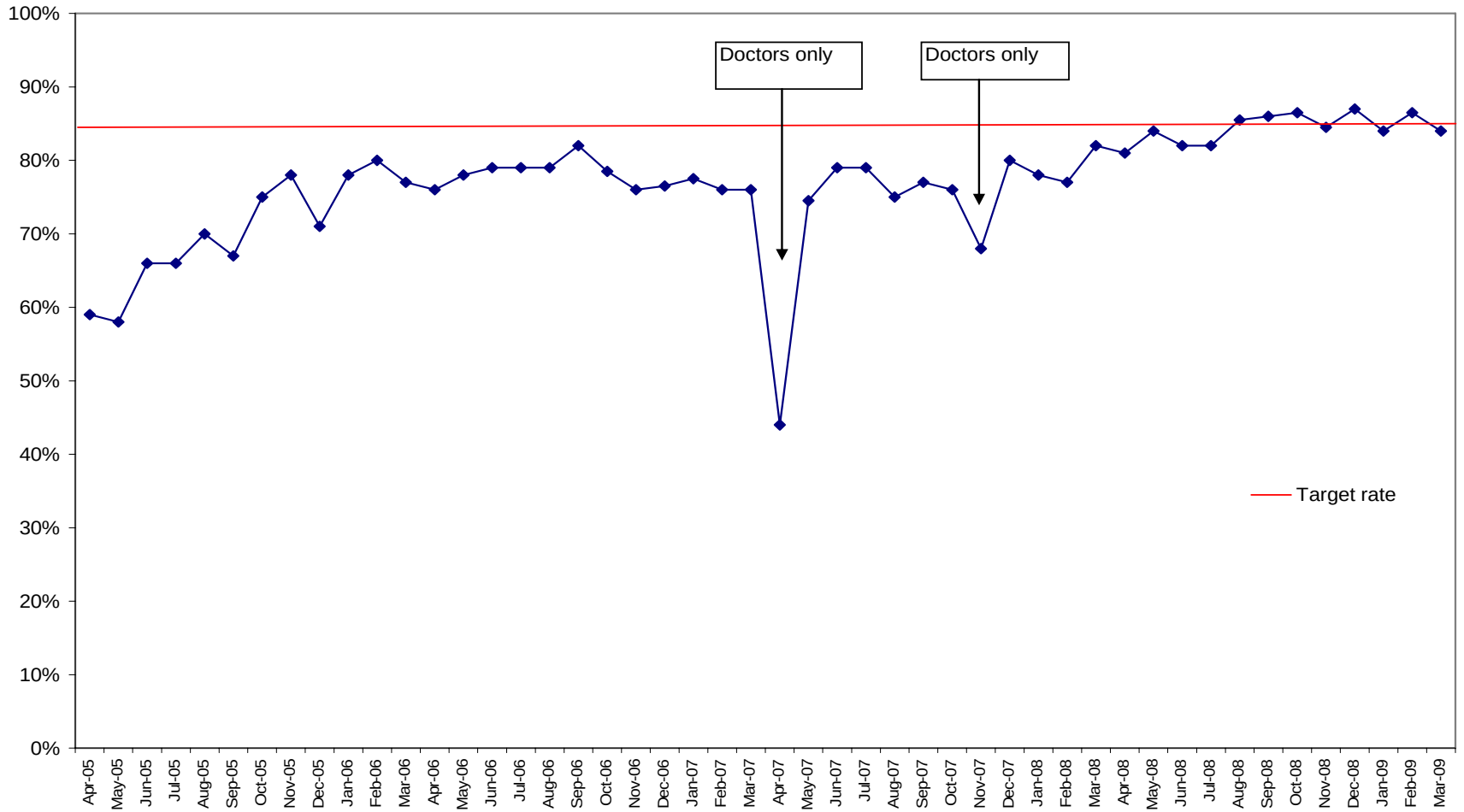


**APPENDIX 10**

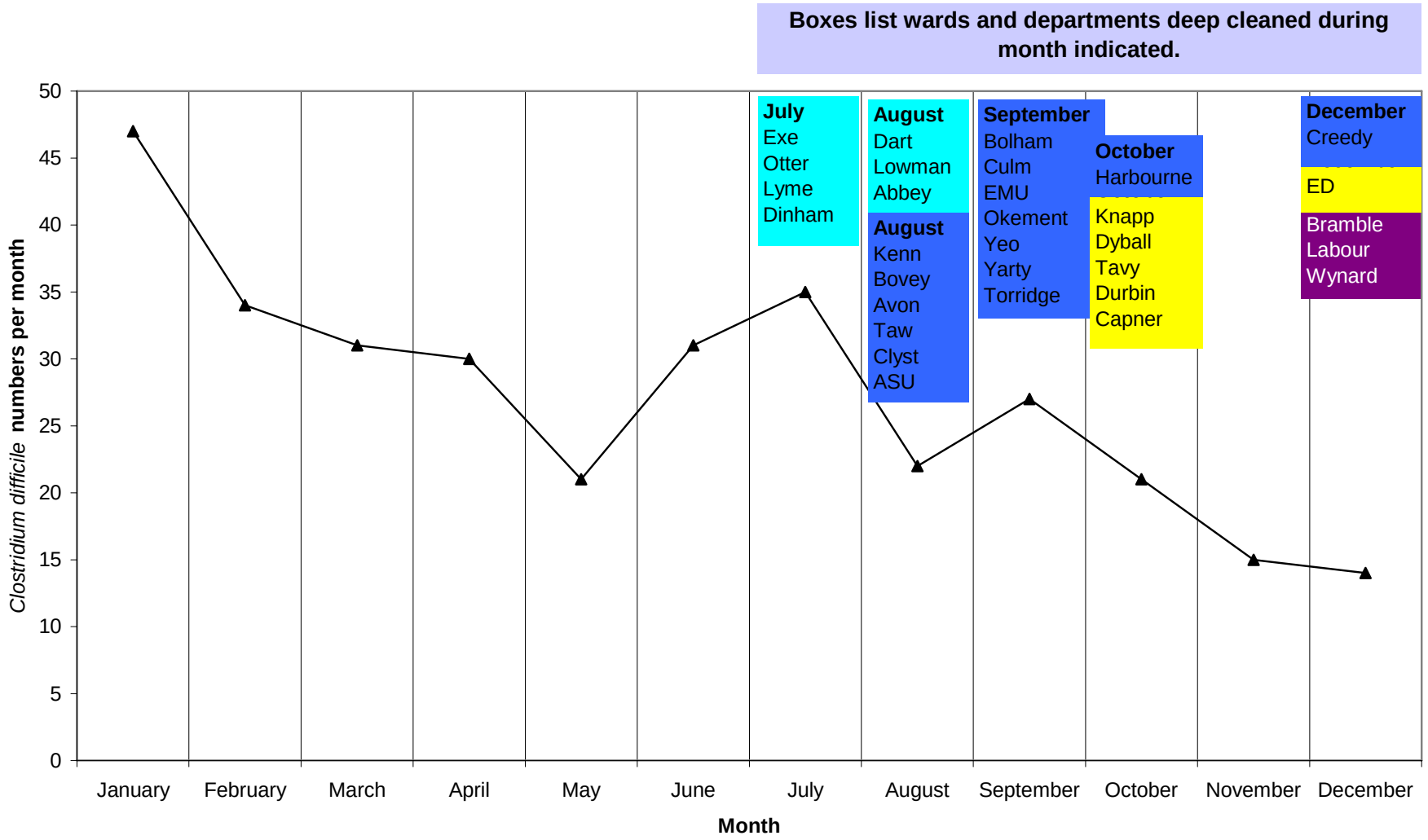
**Total Number of New MRSA Incidences per Quarter across the Whole Healthcare Community**



## Overall Trust Hand Hygiene Compliance



## Deep Cleans & *Clostridium difficile* Numbers in 2008



**APPENDIX 13**

## 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<br><br>Or attendance at Directorate/dept arranged infection control update | Emailed Power-point presentation<br><br>Specialist led session | Annual<br><br>Annual |
| SpRs and Specialty training doctors | Doctors induction or Corporate induction<br><br>Completion of Infection Control Update for Medical Staff within a week of induction | Specialist led session<br><br>Access power point presentation on Comex | Completion of Infection Control Update for Medical Staff | Access point presentation on Comex or via Directorate Infection Control Lead | Annual |
| Foundation doctors | Doctors induction<br>Completion of Infection Control Update for Medical Staff within a week of induction | Specialist led session<br><br>Access power point presentation on Comex | Completion of Infection Control Update for Medical Staff | Access point presentation on Comex or via Directorate Infection Control Lead | Annual |
| **Nursing and Operating Dept staff** | | | | | |
| Registered Nurses | Attendance at corporate induction | Specialist led session | Attendance at Directorate/dept arranged essential training day/session<br><br>Or attendance on 'Infection Control for Registered Nurses' study day<br>Or attendance on other infection control study days. | Specialist led session | Annual |
| Non Registered | Attendance at corporate | Provided by RN in | Attendance at Directorate/dept | 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** |
| Nurses | induction.<br><br>Demonstration of practical hand hygiene technique as part of local induction | the workplace | arranged essential training<br><br>Or attendance at 'It's a bugs life' study day | | |
| Operating department practitioners (ODPs and ODAs) | Attendance at corporate induction.<br><br>Demonstration of practical hand hygiene technique as part of local induction | Specialist led session<br><br>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<br><br>Attendance at ½ study day – infection control for physios and OTs | Emailed Powerpoint presentation | Annual |
| Clinical support workers to AHPs | Attendance at corporate induction<br><br>Demonstration of practical hand hygiene technique as part of local induction | Specialist led session<br><br>Provided by registered AHP in workplace | Completion of Infection Control Update for Allied Health professionals | Emailed Power-point presentation<br><br>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 |