Royal Devon and Exeter NHS
NHS Foundation Trust

Infection Prevention & Control

Annual Report 2009 - 2010

Respond, **D**eliver & **E**nable

CONTENTS

Key Issues/Executive Summary

1. The Trust received an unannounced inspection by the Care Quality Commission and provided assurance that it is compliant with the Health and Social Care Act 2008 - Code of Practice for the Prevention and Control of Health Care Associated Infection (the 'Hygiene Code').

2. The Trust has achieved an 86% reduction in MRSA bacteraemias since reduction targets were set in 2004-5. During 2009-10 there were seven cases of which only three were hospital acquired.

3. There has been a further 27% reduction in cases *Clostridium difficile* infection identified more than 72 hours after admission. The number of cases is considerably lower than the national target set for 2009-10.

4. The rate of surgical site infection for hip arthroplasty (identified prior to discharge and on re-admission) is 0.8%. This compares favourably with the aggregated rate of 0.9% for all participating hospitals.

5. The rate of surgical site infection for knee arthroplasty (identified prior to discharge and on re-admission) is 0.3%. This compares favourably with the aggregated rate of 0.6% for all participating hospitals.

6. Significant reductions have been made in relation to central venous catheter related bacteraemias as a result of focused training and competency assessment.

7. MRSA screening of elective patients has continued with very low rates of MRSA carriage identified in most specialties (less than 1%).

8. Hand hygiene compliance has been maintained at a high standard. However, in general, medical staff compliance continues to be lower than other disciplines and will be the focus for improvement work in 2010-11.

9. A comprehensive programme of education and training has been provided to all relevant disciplines of staff on general infection prevention and control, antimicrobial prescribing and aseptic technique.

10. Despite control measures described in previous annual reports, multiple ward outbreaks of norovirus infection outbreaks continue to place considerable burden on the organisation. As reported last year, spread of norovirus infection, across multiple wards, is exacerbated by high bed occupancy and movement of patients and staff within the hospital setting. It is hoped that the work in 2010-11 to reduce movement within the medical directorate wards and to reduce outlying to surgical wards will have a positive impact on Norovirus transmission. However the potential for unrecognised transmission within admission wards will remain.

1. INTRODUCTION

1.1 The purpose of this report is to inform patients, public, staff, Trust Board and Commissioners of the infection control work undertaken in 2009/10, the management arrangements, the state of infection prevention and control within the RD&E and progress against performance targets. .

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 authors would like to acknowledge the contribution of other colleagues to this report, in particular, the sections on decontamination and cleaning.

2. INFECTION PREVENTION AND CONTROL ARRANGEMENTS

2.1 Infection Prevention and Control Team (ICT)

2.1.1 The infection prevention and control team employed by the RD&E also provides a service to the entire Devon Partnership Trust (DPT) and the Eastern area of Devon Provider Services (DPS).

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, specialist practitioners are developed who recognise and respond to differing levels of risk, differing needs and can apply their clinical knowledge and skills in a variety of settings.

2.1.3 The RD&E nursing team consists of:

1.0 WTE Band 7	Clinical Lead
4.0 WTE Band 6*	Nurse Specialists
1.0 WTE Band 6	Audit and Surveillance Nurse
1.0 WTE Band 3	Health care assistant

*One of these posts is funded as a band 7 but following two unsuccessful attempts to appoint following external advertisement, a band 6 nurse was appointed with a view to developing someone into the band 7 role from within the team.

2.1.4 The DPT nursing team consists of:

0.8 WTE Band 8A	Senior Nurse Specialist/Clinical Lead*
1.0 WTE band 7	Nurse Specialist
1.0 WTE Band 6	Nurse Specialist

*this post holder is also deputy to the Lead Nurse for the whole team.

2.1.5 The DPS 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 5 Administration 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 DPT and DPS.

2.1.9 An on call nursing 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 infection prevention and control specialists.

2.2 Budget allocation

2.2.1 Staff

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

2.2.2 Support (IT etc)

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

2.2.3 Training

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

2.3 Directors of Infection Prevention and Control (DsIPC)

The Infection Control Doctor and the Lead Nurse continue as Joint Directors of Infection Prevention and Control (DIPC), reporting directly to the Chief Executive.

2.4 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 1.

2.5 Reporting line to Trust Board

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

2.6 Links to 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 regular reports to the Infection Control Committee and also liaises with the joint formulary committee.

2.7 Links to Clinical Governance/Risk Management/Patient Safety

The DIPCs are members of the Governance Committee, the Non Medical Professionals Governance Committee, Patient Safety Steering Group and the Health and Safety Committee.

3. DIPC REPORTS TO THE BOARD

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.

The Directors of Infection Prevention and 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 targets is communicated daily to all Executive Directors.

3.2 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 Code of Practice. Progress against the annual programme is monitored by the ICC. The programme for 2009 -10 and progress made can be found at Appendix 2.

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. 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.

4.1 *Staphylococcus aureus* bacteraemia

4.1.1 *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.

4.1.2 *Staphylococcus aureus* bacteraemias 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.

4.1.3 Reports from this Trust consist of all *Staph. aureus* isolated from blood cultures processed by the Trust Microbiology Department. These are expressed by the HPA as total episodes of *Staphylococcus aureus* bacteraemia and methicillin resistant *Staphylococcus aureus* (MRSA) bacteraemia.

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

4.1.5 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.

4.1.6 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.

4.1.7 Despite the enhanced data set, the HPA report continued to attribute *all* MRSA bacteraemia, regardless of source, to the RD&E during 2009-

10. However, this has been changed for 2010 -11 when only those identified more than 48 hours after admission will be attributed to the acute trust.

4.1.8 National reduction targets and outcomes are described at section 14.

4.2 Glycopeptide Resistant Enterococcal (GRE) Bacteraemia

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

4.2.2 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.

4.2.3 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.

4.2.4 The number of cases reported are usually low and cases are usually sporadic, however, an increase was noted in haematology patients as outlined in section 6.11.

4.3 *Clostridium difficile* Infection (CDI)

4.3.1 *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.

4.3.2 Mandatory surveillance for CDI in over 65 year olds has been undertaken since 2004. Since 2007 episodes of CDI in patients between the ages of 2 and 65 have also been reported.

4.3.3 For mandatory reporting purposes, all diarrhoeal stools submitted to the microbiology laboratory are examined for *C. difficile* toxins. Episodes are reported via the HPA mandatory enhanced surveillance system. An episode consists of one or more *C. difficile* toxin positive stools during a 28 day period. Cases that occur more than 72 hours after admission are attributed to the acute Trust with those identified within the first 72 hours likely to have been community acquired.

4.3.4 CDI may develop some time, days or weeks, after exposure to antibiotics. Patients with symptoms contaminate the environment around them and can infect other patients at risk.

4.3.5 Control of CDI is taken extremely seriously in the RD&E and designated isolation facilities are provided for patients with CDI on Torridge ward and these patients are managed by a team who have developed the expertise in management of CDI..

4.3.6 Each case identified in hospital 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.

4.3.7 Strain typing is a specialised service provided by a network of reference laboratories. This is an indispensable service which helps us to manage and minimise CDI. In 2009-10 selected strains were typed where possible clusters of CDI were noted. In fact very few incidences of cross infection were shown. In addition there were no predominant strains present in the trust. The 027 strain which is associated with severe outbreaks was not seen.

4.3.8 Deaths associated with CDI (i.e. where CDI is recorded on Part 1 of the death certificate) are reported to the PCT as Serious Untoward Incidents and a root cause analysis (RCA) undertaken for each case. Any learning identified from the investigation is shared internally and with commissioners and other providers through the NHS Devon RCA group.

4.3.9 As for MRSA bacteraemias national targets are set and our performance against these targets is shown at Section 14.

4.4 Orthopaedic Surgical Site Infection

4.4.1 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.

4.4.2 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

4.4.3 However, a more accurate rate can be ascertained by continuous surveillance and therefore, continuous surveillance of all knee and hip arthroplasty started in this Trust in July 2007.

4.4.4 The aggregated rate of infection (identified prior to discharge and on re-admission) for the calendar year of 2009 for hip arthroplasty at the RD&E is 0.8%. This is below the national average aggregated rate of infection of 0.9%.

4.4.5 The aggregated rate of infection (identified prior to discharge and on re-admission) for the calendar year of 2009 for knee arthroplasty at the RD&E is 0.3%. This is below the national average aggregated rate of infection of 0.6%.

4.5 MRSA Screening of Elective Admissions

4.5.1 The rationale for screening of non emergency patients is to identify MRSA carriers, enabling 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.

4.5.2 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 elective admissions by 31st March 2009.

4.5.3 The 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

This has had 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 April 2009 - March 2010, MRSA carriage was detected in less than 1% of those patients screened.

5. 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:

5.1 Bacteraemia Surveillance

5.1.1 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.

5.1.2 Although there have been improvements, invasive devices, mainly central vascular devices, remain the commonest risk factor associated with hospital acquired bacteraemia, and continue to be focus for prevention activities

5.1.3 Feedback of central vascular devices associated bacteraemia rates to high risk specialties has enabled targeted work to be undertaken to reduce infection rates with rewarding improvements seen this year (refer Appendix 8)

5.1.4 Reports are issued quarterly to all departments. Copies can be obtained from the Infection Control Department.

5.2 *Clostridium difficile* infection

5.2.1 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 annoated run charts.

5.2.2 This assists with the early identification of clusters of cases or increased prevalence and the impact of control interventions.

5.2.3 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.

5.2.4 A weekly review meeting is held by the team caring for inpatients with CDI. This monitors cases, precipitating causes, treatment and outcomes. Lessons learned are disseminated to clinicians and others involved.

5.3 MRSA - Newly Identified

5.3.1 The numbers of patients diagnosed as MRSA positive for the first time are collected from laboratory data.

5.3.2 This includes people who are colonised (i.e. carrying the organism without any sign of infection) and those who have an MRSA infection of *any* type, not just blood stream infections.

5.3.3 The Infection Prevention and Control team advise on appropriate management of in-patients to reduce risk of transmission to other patients.

5.3.4 The number of new cases identified more than three days after admission continues to remain low following several years of reduction. (Refer Appendix 9).

5.5 Abdominal Hysterectomy - Surgical Site Infection Surveillance

5.5.1 A voluntary module of surveillance was undertaken, using the Surgical Site Infection Surveillance Service of the HPA, between April- June 2009 for abdominal hysterectomy as a follow up to the previous period of surveillance in 2008.

5.5.2 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.

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

5.5.4 The aggregated rate of infection (identified prior to discharge and on re-admission) for all hospitals participating in the surveillance programme was 1.5%. For the same time period the Royal Devon and Exeter rate was 1.1%.

5.5.5 However, unlike the previous period of surveillance, data collection also included post discharge surveillance using outpatient clinic feedback and patient feedback via patient questionnaire. This has revealed a much higher rate of infection and, as a result, an improvement programme has been implemented using the Saving Lives care bundle for reducing surgical site infection, which included changes to antimicrobial prophylaxis, skin disinfection methods and dressing protocols.

5.5.6 Surveillance will be repeated in 2010 -11 to measure the impact of these changes.

5.6 Caesarean Section - Surgical Site Infection Surveillance

5.6.1 The Surgical Site Infection Surveillance Service of the HPA recruited hospitals to participate in a pilot of a new voluntary module of surveillance for patients who had undergone C. section.

5.6.2 Data collection was complex and included infections in in-patients and readmissions, infections reported by community midwife and patient reported infections via a patient questionnaire. Patients who did not return a questionnaire were followed up by phone call by the infection control team.

5.6.3 Although the in-patient and readmission rate of infection was lower than the aggregated rate for all participating hospitals, a higher than anticipated rate of infection after discharge was identified and again an improvement programme has been implemented with a repeat period of surveillance planned for 2010-11.

5.7 Spinal surgery - Surgical Site Infection Surveillance

5.7.1 Surveillance of spinal surgery was undertaken voluntarily again through the HPA Surgical Site Infection Surveillance Service between January - June 2009.

5.7.2 Since September 2009 spinal surgery has been under continuous surveillance and the latest report received from the HPA (for the October to December 2009 period) shows that the aggregated rate of infection for all hospitals participating is 0.9% whilst the rate at the RD&E is lower at 0.7%.

6. OUTBREAK AND INCIDENT REPORTS

6.1 Background

An incident is a near miss, or a failure of infection control without significant consequence, but where lessons may be learnt with the potential to prevent more serious events. Outbreaks occur when there are two or more linked infections which may or may not be preventable. These events are recognised through surveillance, reporting or routine ICT activities and are by definition unpredictable.

6.2 Response to Incidents and Outbreaks

Every year the Infection Control Team recognises and responds to many incidents and potential outbreaks. Some are real but 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.

6.3 Recording and Reporting Incidents and Outbreaks

Incidents and outbreaks may be recorded in several different ways. Many are recorded in the minutes of the weekly Infection Control Team Meeting and important occurrences are included in Infection Control Committee minutes. Where an outbreak is considered particularly significant because of its size or the lessons learnt in its management, an outbreak report is prepared. All important infection control incidents and outbreaks are disseminated through the Governance system and Ward to Board communication and awareness is maintained.

6.4 Noteworthy Incidents and Outbreaks

Some noteworthy incidents and outbreaks are listed below. The ICT and ICC minutes are also available for examination on request.

6.5 CDI Outbreak on a Surgical Ward

6.5.1 Surveillance showed a possible increase of CDI associated with admissions to a surgical ward. Eight cases were recognised between March and May, of which half presented after leaving the ward. An outbreak meeting was called, and the HPA Regional Epidemiologist and Microbiologist informed.

6.5.2 A bundle of control measures was implemented, including a deep clean of the ward using hydrogen peroxide vapour.

6.5.3 Investigations showed that antibiotic use was not excessive, and was within guidelines. Nevertheless, additional teaching on antimicrobial use was given to medical staff.

6.5.4 Hand hygiene audits on the ward did not indicate bad practice.

6.5.5 Some problems were identified with cleaning standards on the ward, especially at weekends. These were addressed. After deep cleaning and disinfection with hydrogen peroxide vapour, the outbreak ceased.

6.5.6 Stored specimens were sent to a reference laboratory for typing the *C. difficile* strains of possible outbreak cases. All were the same ribotype – 012. This confirmed that there was an outbreak associated with the ward. One patient died shortly after *C.difficile* was identified in stool, but CDI was not identified as the principal cause of death. No other patients died as a result of this outbreak.

6.5.7 This outbreak was not immediately obvious because patients developed infection after discharge home from the ward or following transfer to other wards. Surveillance was effective because the outbreak was recognised even at a low level over 3 months in patients, half of whom developed infection after discharge from the implicated ward.

6.6 A Cluster of CDI Cases on a Medical Ward.

6.6.1 In this case surveillance suggested that there was a possible outbreak among a ward where patients were receiving treatment for kidney diseases. Again an outbreak meeting was convened. In this case complex arrangements had to be made to transfer patients safely to other areas of the hospital to allow the ward in question to be deep cleaned.

6.6.2 In this case typing of the *C.difficile* stains involved did not show that a single common type was involved. There was little evidence to support significant cross infection. The patients involved were frail, subject to infection and more prone to CDI. It is possible that this was a chance occurrence. However with so many cases a deep clean of the ward was justified to reduce the risk of an outbreak developing, as each symptomatic patient heavily contaminates the environment around them.

6.7 Norovirus Outbreaks

6.7.1 Norovirus infections cause outbreaks of diarrhoea and/or vomiting. In 2009 – 10 there have been numerous incidents in the hospital requiring wards and bays to be closed to admissions.

6.7.2 At times there have been several wards closed simultaneously, causing considerable disruption to normal working of the Trust. These infections not only affect patients but also staff and visitors.

6.7.3 Norovirus outbreaks in 2009-10 have been widespread in the community. All hospitals in the region have been affected on several occasions, as have other organisations such as nursing homes, schools, hotels etc.

6.7.4 It is likely that norovirus is introduced into hospitals by patients, staff and visitors, in a pattern of many separate incidents on a background of widespread community infection. Because this is such an infectious condition it spreads very easily in hospital.

6.7.5 The last year has seen the highest number of wards affected with Norovirus infection since 2005-6 (Appendix 5 Figure 1)

6.7.6 The most challenging period for the hospital was between January and March 2010 when two large outbreaks occurred affecting multiple wards. (Appendix 5 Figure 2)

6.7.7 There are many measures designed to identify and isolate patients potentially infected with norovirus on admission to hospital. Information for visitors discourages visits from people likely to carry the virus into

hospital. However it is clear that these measures are not effective enough.

6.7.8 To contain and prevent serious norovirus outbreaks in hospitals will probably require a complete change of current management arrangements common to British hospitals. The use of admission wards and triage areas where patients newly admitted to hospital are first seen may be efficient, but also provides an opportunity for cross infection in patients who then are moved to many wards throughout the hospital. Ideally, patients would not be moved from the ward they are admitted to, and would also be accommodated in single rooms. Currently neither of these measures are possible in any UK NHS hospital.

6.7.9 Lack of capacity for acute emergency medical admissions also results in outlying of patients from medical wards to other specialties. This further aids the spread of infection. However, there is increasing awareness within the RD&E that such movement exacerbates the risk of multiple ward outbreaks and it is hoped that work underway to minimise movement will help reduce the impact of norovirus next winter.

6.8 Pandemic Influenza - Overview

6.8.1 The influenza pandemic that occurred in 2009 has fortunately proved to be much less severe than was either predicted or feared.

6.8.2 Early in the pandemic an outbreak occurred among Exeter University students. Some of these were admitted to the RD&E. Initially staff involved in their care were offered prophylactic oseltamivir (Tamiflu), though after the pandemic became established in the UK prophylaxis was discontinued. Staff were also offered influenza vaccine when it became available, as were inpatients considered at risk from influenza infection.

6.8.3 During the pandemic two patients with the pandemic influenza H1N1 strain were admitted to the ITU, and unfortunately one died. However these people were infected within the community and there was no evidence of cross infection within hospital.

6.9 Influenza H1N1 in the Neonatal Unit.

6.9.1 A premature baby born in Exeter and nursed on the RD&E neonatal unit (NNU) was tested for respiratory virus infection when complications developed. A test was positive for both respiratory syncytial virus (RSV) and Influenza H1N1.

6.9.2 Precautions were taken to isolate this baby, and determine how she could have been infected. Screening of staff an parents revealed no

cases, and in addition further tests of the baby failed to confirm infection with either virus.

6.9.3 In the end it could not be established how the initial positive result occurred. Samples are tested by PCR for these viruses in the regional HPA laboratory, which was under considerable pressure at this time because of the demand created by the influenza pandemic.

6.9.4 There was no evidence of cross infection, and the staff of the NNU responded effectively and took appropriate precautions to ensure the safety of both the affected baby and the other babies on the NNU.

6.10 Legionnaires' Disease Incident

6.10.1 Legionnaires' disease is a type of pneumonia caused by a bacterium, *Legionella pneumophila,* that lives in water, including piped water supplies. Outbreaks have been identified in hospitals, hotels and other large buildings.

6.10.2 A patient was diagnosed with Legionnaires' disease after readmission to the RD&E, a circumstance that alerts us to possible infection in hospital. However the initial admission was for a near drowning event, a risk for Legionnaires' disease, and still within the likely incubation period.

6.10.3 It was felt that the patient was probably not infected in the hospital. Nevertheless to be sure, checks were made on all the Legionnaires' disease prevention measures in the areas where the patient had been nursed, and the water supply was cultured for *Legionella pneumophila.* No legionella was isolated.

6.10.4 Records were checked and showed that all appropriate preventative measures were in place and parameters such as hot and cold water temperatures were correct.

6.10.5 This was a useful exercise to assure us not only that the patient was not infected in hospital, but also that controls were in place and monitoring records were complete and accessible. The patient recovered.

6.11 Vancomycin Resistant Enterococci

6.11.1 Enterococci are species of bacteria, normally present in the gut which occasionally cause urinary tract infections but are not usually troublesome in normal people.

6.11.2 However, those who are immunosuppressed are more at risk of infection, especially patients being treated for cancers, such as leukaemia and lymphoma.

6.11.3 In this vulnerable group of patients, we screen for Vancomycin resistant enterococci (VRE), as such organisms are potentially difficult to treat. So stool specimens are routinely examined for the presence of VRE in the absence of infection – known as colonisation. Isolates of VRE from blood cultures are reported to the HPA as part of mandatory surveillance.

6.11.4 In May 2009 it was noted that there had been more isolates of VRE in the first quarter of the year than the whole of 2008. It was not clear whether this was chance or a significant observation. It was not immediately possible to collect strains for typing to demonstrate whether there was a true outbreak.

6.11.5 However, a programme of increasing awareness was introduced. Measures were discussed including ensuring that individual infection control practice was enhanced in these high risk patients.

6.11.6 The rate of VRE isolation returned to baseline.

6.12 MRSA infection in Surgical Patients

6.12.1 All patients admitted for elective surgery should now be screened for MRSA (meticillin resistant *Staphylococcus aureus*) carriage prior to admission, with certain exceptions. Surveillance shows that less than 1% of elective admissions are colonised with MRSA, and many of these patients are already known to be infected or colonised.

6.12.2 In addition surveillance shows that the rate of acquisition of MRSA in in-patients has dramatically fallen in recent years, as has MRSA bacteraemia. Therefore MRSA infections which may have been acquired through surgery are treated very seriously.

6.12.3 A patient was identified with a deep wound infection due to MRSA which developed shortly after surgery. The patient was screened as MRSA negative prior to surgery. This raised the possibility that the infection had been caused by contamination at surgery.

6.12.4 It was decided to screen operating theatre staff and others involved in the patients immediate post operative care for potential carriage to exclude a staff carrier as the source. Several members of staff were screened but no carrier was identified.

6.12.5 It was clear that staff were extremely uncomfortable about being screened, and were unsure of the consequences of being screened should they be found positive. Clinical staff have a professional duty of care, agreed by professional medical and nursing organisations, not to be a source of infection to their patients and therefore should agree to be screened. However the Trust also has a duty of care to staff, and must reassure them that they will be cared for should they be found positive for MRSA carriage. Carriage can usually be cleared by the use

of decolonisation regimens allowing people to return to work safely for their patients.

6.12.6 The Trust will introduce a guideline to reassure staff that their rights and needs will be protected if they need to be screened for any infectious agent during the course of an outbreak investigation.

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 Previous success in raising the level of compliance within the Trust has been maintained (Appendix 10).

8. ASEPTIC CLINICAL PROTOCOLS

The principles of asepsis are included on the Trust induction programme for new staff. Clean and aseptic technique principles are also provided as part of nursing and medical staff education, with assessment of competency made in relation to intravascular drug administration, intravascular cannulation and venepuncture. Particular emphasis has been placed on aseptic procedures when inserting and managing the ongoing care of central venous catheters.

8.1 Care of Peripherally Inserted Central Venous Catheters (PICC)

8.1.1 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.

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

8.1.3 Ongoing care of the line is managed by the ward staff and the need for additional training was highlighted to reduce risk of infection. Workshops and ward based training sessions were implemented in 2008-9 and have continued during 2009-10 with excellent results (refer Appendix 8).

8.2 Care of Central Venous Catheters for Administration of Parenteral Nutrition (PN)

8.2.1 Central venous catheters used for the administration of parenteral nutrition are associated with a high risk of infection. Surveillance undertaken by the Nutritional Support Team and the Infection Control Team identified that this was the case at the RD&E (Appendix 8).

8.2.2 Several improvements to practice have been made in the last year and work continues to reduce the risk of infection further.

8.2.3 Improvements include identifying two wards in the hospital where patients requiring PN will be managed to ensure that the staff involved in managing the catheter are trained and assessed as competence, but will also maintain that competence by managing the lines on a frequent basis.

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, who is one of the Joint DsIPC. The Infection Control Doctor is also a member of the Decontamination Committee.

9.1.3 The work of the members of the Decontamination Committee over the last year is summarised in their annual report at Appendix 11.

9.2 Audit of Decontamination

9.2.1 Hospital Sterilisation and Decontamination Unit, which reprocess all surgical and other invasive reusable instruments, 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 Audits of the decontamination of lower risk patient equipment (i.e. non invasive equipment such as commodes, monitors, infusion pumps) is audited in two ways: Firstly, it is included as part of the Nursing Quality Audit and as part of the Credits for Cleaning audits (refer section 10.2).

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 (1.4 WTE) undertake & 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 any wards or departments failing to reach the required standards as laid down by the NPSA.

10.2.6 A greater focus is being given to 'closing the loop' in terms of rectification of outstanding faults. Also a greater emphasis is being placed on root cause analysis of recurring faults and identifying robust actions required to resolve these issues

10.2.7 A quarterly management audit is undertaken by a multi-disciplinary team, which includes a matron and an infection control nurse specialist and the results of this are used to monitor the technical audits undertaken on a weekly basis.

10.2.8 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 4 years and significant amounts of data relating to current resources and the recommended minimum frequency of clean requirements have 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.

10.3.3 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 continues to be closely monitored. The implementation of cook-freeze required additional resources at ward level to ensure full compliance with work schedule requirements throughout the day and evening. Funding was secured on a non-recurring annual basis and it is envisaged that in 2010 a project will be actioned to explore the feasibility of two separate roles for ward based food service requirements and all cleaning services

10.3.4 Call-off funding for a dedicated infection outbreak cleaning team continues to be allocated on an annual basis. The positive impact of this funding is well recorded e.g. improved response times for organising outbreak and specialist cleaning and the turnaround time for re-opening a closed ward.

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. This continues to ensure that these facilities are maintained to a satisfactory standard of cleanliness throughout each day thus significantly reducing the number of complaints (written and verbal) received from patients and visitors regarding the cleanliness of these facilities.

10.3.7 The specialist cleaning team continue to operate until 10pm on a Sunday – Thursday night and overnight on a Friday and Saturday night. The site practitioner team liaise with these staff on a Friday and Saturday night and this continues to be a positive example of collaborative working.

10.3.8 There continues to ensure swift ‘turn-around’ times for the terminal cleaning of side rooms, bed spaces or even bays that have been vacated by infected patients. The number of cleans required has increased in the last year with an average of 425 per month. These are reported to the Infection Control Committee and Trust Exec on a quarterly basis.

10.3.9 Additional non-recurring money continues to be allocated each year and a third deep cleaning programme took place from July – October 2009. Deep cleaning took place overnight meaning that wards remained out of use for a shorter period of time. Also housekeeping services staff undertook the deep cleaning of all patient equipment therefore releasing nursing staff time to care for patients. We continue to use steam cleaners, chlorine releasing disinfectants and hydrogen

peroxide vapour to achieve a high level of disinfection. A further £100k has been allocated for 2010/11 for the deep cleaning programme to continue within all in-patient and some outpatient areas. Nursing, operations and housekeeping colleagues have worked together to produce a programme of cleaning due to commence in June 2010.

10.4 Clinical Responsibility

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

10.5 Clinical Access

10.5.1 Access to the clinical areas is made during the day time in in-patient areas and in the evening or at night in outpatient or day case departments. This minimises disruption to patients and clinical staff. 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 2009 the National Specifications of Cleanliness in the NHS 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 The Ward Catering Monitoring Officer continues to audit the meal service both within the catering department and at ward level. The post holder 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 was 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. Three Housekeeping Supervisors completed the Assessors certificate and are currently training Housekeeping staff in the COPC. Eighty Five Housekeeping Services staff have voluntarily signed up to take the certificate and to date 41 have completed this qualification. We work in partnership with Exeter College - external training provider / assessor and the BICSc national assessor.

10.8.2 Monitoring evidence has shown that housekeeping staff who have completed the COPC are demonstrating a more methodical approach to their work leading to a greater work output, greater attention to detail and higher cleaning scores

It is hoped to apply for further funding in 2010/11

10.8.2 A Cleaning Manual has been issued to all Housekeeping staff based on the national NHS Cleaning Manual. This incorporated a self-assessment training needs analysis tool which was 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. AUDIT

Audits are undertaken to identify areas for improvement in practice or cleanliness.

11.1 Environmental Audit

As reported in Section 10, 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.

11.2 Hand Hygiene Audit

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

11.2.2 Observations are undertaken by link nurses who submit the data to the Infection Control Team. Feedback on compliance is provided to each ward in the form of a run chart and poster with recommended measures for improvement sent to matrons and Divisional IPC Leads.

11.3 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:

11.3.1 172 single occupancy rooms are available for in-patient use within the Trust. This is slight increase since 2008-9 when 164 single rooms were available for in-patient use.

11.3.2 *En suite* facilities were available in 48% of the single occupancy rooms which is a small reduction since last year.

11.3.3 Whilst 50% 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. This is similar to the findings in 2008-9.

11.3.4 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 the same as last year and still suggests that availability of single rooms for infection control purposes is sub optimal.

11.4 Pre admission MRSA Screening and Decolonisation

11.4.1 Nineteen patients who had been identified as MRSA carriers prior to admission for elective procedures were included in the audit.

11.4.2 The GPs of 17 of these patients had been informed of the results prior to admission and asked to prescribe topical decolonisation treatment. Of the two that were not contacted, one was already an in-patient at the time and thus decolonisation was managed as an inpatient and the other patient had been screened but the incorrect form had been used and therefore a GP letter was not triggered. This highlighted the need to use the correct forms.

11.4.3 Only 79% of the 17 patients started the treatment prior to admission. This is an issue for general practice and will be fed back through the PCT.

11.4.4 Only 74% brought the treatment into hospital with them as requested.

11.4.5 A number of recommendations were made mainly related to the information provided to GPs and patients to provide greater clarity.

11.5 Use of Personal Protective Equipment

11.5.1 This audit was undertaken by the Infection Control Team during February & March 2010. It reviewed the use and availability of personal protective equipment (PPE).

11.5.2 Compliance was high across the Directorates with one exception. In one directorate, gloves were inappropriately over-used and this adversely affected hand hygiene compliance.

11.5.3 Feedback has been provided at Directorate level regarding areas for improvement.

11.6 Antibiotic Prescribing

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

11.6.2 The annual report for the Antimicrobial Sub-Committee is at Appendix 12 and highlights the audits undertaken in 2009-10.

11.7 Peripheral Venous Cannulae (PVC) Insertion and Aseptic Technique

11.7.1 PVC are the most commonly used intra vascular (IV) device. PVC complications contribute to morbidity, prolonged hospital stay and increased cost.

11.7.2 Previous audits have focused on the ongoing care of cannula. This audit focused solely on insertion technique using the DH Saving Lives care bundle.

11.7.3 15 patients were observed being cannulated in admission areas/wards. All the staff observed were doctors.

11.7.4 Elements of the audit were performed well, in particular appropriate skin disinfectants and dressings were used on 100% of occasions. Appropriate protective clothing was used on all but one occasion.

11.7.5 There is room for improvement around documentation of the procedure and timing of hand hygiene.

11.8 Emergency Admission – Infection Risk Assessment

11.8.1 Three emergency admission wards were included in the audit.

11.8.2 All three areas use documentation that includes an infection control assessment.

11.8.3 The two main criteria for assessment relate to previous history already held on record and recent history obtained from the patient.

11.8.4 The compliance with completion of required documentation was poor overall. The best area of compliance relates to recent diarrhoea and vomiting history.

11.8.5 IC Alert checking seems to be less well documented now than it was in the 2008 audit.

11.8.6 Recommendations are made to address areas of poor compliance and improvement work will be taken forward by clinical leads in the areas concerned.

12. TRAINING ACTIVITIES

12.1 Induction and Annual Update Training for Trust Staff

Acceptable attendance rates for all disciplines of staff have been achieved in 2009/10 and were reported to the Infection Control Committee by each Directorate Lead who maintain their own databases. It is anticipated that in 2010-11 that the electronic staff record will be capable of providing the data on training rates.

12.2 Information for Contractors

Information for contractors is available in the Estates Department prior to accessing clinical areas.

12.3 For Infection Prevention & Control Specialists

12.3.1 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.

12.3.2 Three members of the team attended the IPS Annual Conference in Harrogate.

12.3.3 Four infection control nurse specialists continued studying toward a Post Graduate Diploma in Infection Control, The programme of study is provided by Inverness College and is available on-line. Two of the four graduated in June with the other two due to graduate in 2010 - 11.

12.3.4 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. He is also a member of the IPS

12.4 For the Joint DIPCs

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

12.4.2 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.

13. POLICIES AND GUIDELINES

A schedule for policies and guideline revision/development is included in the annual programme (Appendix 2). All policies are available on the Trust website and intranet.

14. TARGETS AND OUTCOMES

14.1 MRSA Bacteraemia

Having achieved all targets set between 2004-5 and 2008- 9, the subsequent targets have related to maintaining low numbers of MRSA bacteraemia i.e. less than 18 cases per year. In 2009-10 a further significant reduction has been made with only 7 cases identified, 4 of which were identified within 48 hours of admission and therefore were not hospital acquired. Of the remaining three cases which were hospital acquired, one was identified to be a contaminant rather than a true infection.

Root cause analysis of MRSA bacteraemias 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 risk factors for MRSA bacteraemia that have emerged include:

- Unknown MRSA carriage status on emergency admission
- Multiple co-morbidities
- Multiple admissions/interventions
- Presence of chronic wounds
- Presence of indwelling devices

The introduction of MRSA screening of emergency admissions should be helpful in maintaining low numbers. This will be introduced during 2010-11.

14.2 *C.difficile* Infection

14.2.1 Improvement targets have continued to be been set for all NHS Trusts, both a national target and a local stretch target. The target for acute

Trusts is based on the number of cases identified more than 72 hours after admission to exclude those that are community acquired.

14.2.2 A reduction of 27% was achieved in 2009-10 which means that we have achieved both the national and more demanding local stretch target.

14.2.3 Swift isolation of patients with symptoms, management of confirmed cases on a designated isolation ward, prudent antimicrobial prescribing, hand washing and high standards of routine environmental cleaning are all important prevention and control strategies. The annual deep cleaning programme is also invaluable in reducing the burden of spores in the environment.

14.3 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.

14.4 The Health and Social Care Act 2008. Code of Practice for the Prevention and Control of Healthcare Associated Infections

14.4.1 Compliance with the 'Hygiene Code' continues to be strengthened through achievements identified in the annual programme of work (Appendix 2).

14.4.2 In November 2009, the Trust was inspected by the Care Quality Commission against 15 measures of the Hygiene Code.

14.4.3 The inspectors found no evidence that the RD&E was breaching the regulation but made one recommendation relating to the cleaning of commodes. A follow up inspection was made in February 2010 allowing the CQC to gain assurance that the recommendation had been implemented. Reports of the two inspections can be found at http://healthdirectory.cqc.org.uk/findcareservices/informationabouthealthcareservices/summaryinformation/searchfororganisation.cfm?FaArea1=customWidgets.trustsafteyquestions_show_1&cit_id=RH8&question=HCAI

14.5 Local Targets

14.5.1 Progress with the Infection Control Annual Programme has been monitored by the Infection Control Committee and, in general, planned activities have been completed (Appendix 2).

14.5.2 An ambitious Trust wide hand hygiene aspiration of 85% was agreed at the start of 2008-9 and achieved. This level of compliance has been

maintained Trustwide although work continues to improve compliance amongst some professional groups and in particular amongst medical staff who will be the main focus of improvement work in 2010-11.

14.5.3 For the first time the Trust agreed local health care associated infection targets with commissioners as part of the quality programme. These targets related to central venous catheter associated bacteraemias.

14.5.4 Targets were agreed in relation to bacteraemia rates associated with peripherally inserted central catheters which are used across the Trust and central venous catheters (CVC) used in high risk specialties i.e. Haematology, Oncology, Dialysis and Paediatric oncology.

14.5.5 The Trust has performed well against these agreed targets which demonstrates the positive impact of our improvement strategies. Appendix 8 shows targets and performance against the targets.

15. CONCLUSION

Healthcare associated infection remains a top priority for the public, patients and staff. In response, a robust annual programme of work has, yet again, been implemented over the last year which has been led by an experienced and highly motivated Infection Prevention and Control Team. Particularly notable successes include maintaining compliance with the Code of Practice for the Prevention and Control of Health Care Associated Infection, surpassing national targets for MRSA bacteraemia and *C.difficile* infection, low levels of surgical site infection in orthopaedic surgery, improvements in central line associated infection and high standards of cleanliness.

Challenges remain and, in particular, efforts to minimise the impact of outbreaks of Norovirus infection on the organisation must continue.

The Infection Prevention and Control Team do not work in isolation and the considerable successes over the last year have only been possible due to the commitment for infection prevention and control that is demonstrated at all levels within the organisation. Such commitment will be crucial to maintain high standards into the future.

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

- Directorate Infection Control Leads
  - Lead Nurse - Medicine
  - Lead Cancer Nurse
  - Lead Nurse - Surgery
  - Lead Nurse - Child Health
  - Lead Nurse/Head of Midwifery - 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 Capital & 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.

9. Monitoring the effectiveness of the committee

9.1 Minutes of the Infection Control Committee will be reviewed by the DIPC to determine whether the committee is effective as defined by the duties and responsibilities in these terms of reference. The outcome of this review will be included in the published DIPC annual report which is presented to the Trust Board

9.2 Decisions made by the Infection Control Committee will be reported quarterly to the Trust Governance Committee in a decisions briefing paper.

Royal Devon and Exeter NHS
NHS Foundation Trust

.

Infection Prevention and Control (IPC) Annual Programme 2009/10

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 has been revised under the new legal requirements of the Health and Social Care Act 2008.

The new Hygiene Code consists of one overarching regulation which requires that patients, healthcare workers and others are protected against identifiable risks of acquiring a healthcare associated infection. The regulation is underpinned by nine compliance criteria which are broadly similar to the11 duties of the previous 2006 Hygiene Code. This year's programme of work will ensure that the Trust continues to maintain and strengthen its position in terms of compliance with the requirement of the Hygiene Code.

Antibiotic regulation and control is an important part of infection control. However, as it is such a significant area the programme of work for this aspect of infection prevention and control is determined and monitored separately by the Antimicrobial Committee which is a sub committee of the Drug and Therapeutics Committee

2. Programme

Code of Practice Criteria	Programme of work 2008/9	By whom (lead)	By when	Progress/Outcome
1. The Trust has in place and operates effective management systems for the prevention and control of HCAI that are informed by risk assessments and analysis of infection incidents	Hold four Infection Control Committee (ICC) meetings with decisions briefings to the Governance Committee.	Directors of IPC (DsIPC)	Quarterly	Completed
	The ICC will review its TOR	DsIPC	Nov 2009	Completed
	The ICC will receive quarterly Divisional IPC reports on behalf of the Board, which will identify progress with: o Infection control training, including training in antibiotic use o Progress on action plans following root cause analysis of healthcare associated infection o Actions to improve compliance with hand hygiene/bare below the elbow strategy o Compliance with Saving Lives audits o Outbreaks and Incidents	Divisional Leads	Quarterly	Reports received quarterly from most divisions.
	Present annual programme (2009-10) and the DsIPC annual report 2008-9 to the Trust Board.	DsIPC	June 2009	Completed
	Make other presentations to the Board as required and provide monthly data for monitoring progress against national targets for MRSA bacteraemia and C.difficile	DsIPC	As required	None required
	Regular attendance at, and provision of quarterly reports to the Governance Committee	DsIPC	Quarterly	Completed

Code of Practice Criteria	Programme of work 2008/9	By whom (lead)	By when	Progress/Outcome
…….monitoring and analysis continued	Review the HCAI risks and identified risk reduction measures identified on the Trust risk register ensuring that any additional risks identified through surveillance and audit are added, if required.	Judy Potter (JP)	Quarterly	Completed
	Continuous mandatory surveillance for MRSA/MSSA	Infection Prevention and Control Team (IPCT)	Reported Monthly	Completed
	Continuous mandatory surveillance for VRE bacteraemias	IPCT	Reported Monthly	Completed
	Continuous mandatory surveillance of *C.difficile in the over 2yr olds*	IPCT	Reported Monthly	Completed
	Continuous mandatory surgical site infection in orthopaedics - Hip and Knee replacements with feedback to relevant clinical teams	IPCT	Reported Quarterly	Completed
	In house, continuous all organism bacteraemia surveillance identifying risk factors, sources and line associated bacteraemia rates.	IPCT	Monthly/Quarterly	Completed
	Complete 6 months voluntary participation in spinal surgical site infection surveillance with feedback to relevant clinical teams	IPCT	June 2009	Completed. Continuous surveillance in place since October 2009
	Repeat a 3 month voluntary surgical site surveillance for abdominal hysterectomy with feedback to relevant clinical teams	IPCT	June 2009	Completed. Results fed back to clinicians. Improvement plan implemented.

Code of Practice Criteria	Programme of work 2009/10	By whom (lead)	By when	Progress/Outcome
…….monitoring and analysis continued	Undertake continuous alert organism surveillance with SPC feedback on MRSA and *C.difficile* to:			
	- Wards and directorates	IPCT	2 Monthly	Completed
	- Infection Control and Governance Committees		Quarterly	Completed.
	Participate in the HPA national pilot for C-section surgical site infection surveillance	Catharine Pym and Liz Trevelyan	July - Sept 2009	Completed. Results fed back to clinicians. Improvement plan implemented.
	Monitor implementation of MRSA screening for elective patients (number of patients screened as a proportion of the number of patients who should be screened)	Steve Roffe/Judy Potter (JP)	Monthly	Ongoing. More than 100%.
	Repeat audit of blood culture contamination rates	AC	Nov 2009	Awaiting report
	Analyse and report back on the research project to determine whether MRSA carriage is higher in pregnant health and care workers than other pregnant women	Penny Criddle	Sept 09	Data analysed. Report being written.
	Undertake root cause analysis of: • All MRSA bacteraemias, • All deaths due to *C.difficile* infection (recorded on Part 1 of death certificates), • *C.difficile* infection that results in colectomy • Staph aureus bacteraemias in Renal Patient.	IPCT/Divisional Leads	Report summary of key issues to ICC quarterly	Completed
	Ensure that action plans are completed.			
	Undertake monthly review of *C.difficile* cases in the RD&E, highlighting common themes with feedback to clinical teams	Ray Sheridan/Alaric Colville (AC)	Monthly	Completed. Now weekly review
	Audit patients with *C.difficile* infection for selected *C.difficile* risk factors and 30 day outcome.	AC	Report quarterly ICC	Completed

Code of Practice Criteria	Programme of work 2009/10	By whom (lead)	By when	Progress/Outcome
…….monitoring and analysis continued	Undertake further clinical facilitation in relation to IV drug administration in selected wards. Feedback to individuals and matrons on standards of practice identified through **audit** of practice and retrain staff where appropriate.	Kath Leader/Julie Roberts	July 2009	Julie Roberts has resigned her post and Kath Leader on extended sick leave. Therefore this work on hold.
	Implement infection reduction care bundles, and monitoring of same with reports to relevant Divisional Governance Group:			
	o Dialysis CVCs - reports to Divisional Governance group	Louise Oakaby	Quarterly	Reported via Medical Division GG
	o Ventilator Associated Pneumonia	Chris Day/Sue Hudson	Quarterly	Underway as part of pt safety programme
	o Hickman lines in Cancer Patients	Tina Grose	Quarterly	Incorporated into routine audit
	o Reducing surgical site infection			IHI/SHA work has superseded this.
	o Urinary catheterisation in Stroke Patients - reports to Divisional Governance group	Berni George	Quarterly	To be carried forward to 2010-11.
	Other audits - Criteria 2 and 8			
2. Provide and maintain a clean and appropriate environment which facilitates the prevention and control of HCAI. *Liaison between members of the ICT and Facilities/Estate**s***	Monthly meetings between Hotel Services and Infection Control Team to review cleaning issues	JP/Hazel Hedicker	Monthly	Completed

Code of Practice Criteria	Programme of work 2009/10	By whom (lead)	By when	Progress/Outcome
	Ensure that there is infection control input to environmental monitoring systems			
	a) Cleanliness Standards management audits b) PEAT assessments	IPCT	Quarterly Annually	Completed. PEAT assessment completed Jan.
	Provide specialist input to Cleaning Standards Group, PEAG, Environment and Waste Management Committee, Deep cleaning programme meetings.	IPCT	Quarterly	'Good' achieved for environment
	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: a) Acute Model of Care/Emergency Hub b) Heavitree development projects including dialysis unit, day surgery and theatres, c) Heavitree dialysis unit d) Community theatre transfer e) Single room development on Durbin	IPCT	According to project plans	Dialysis unit, day surgery and theatres completed Single rooms on Durbin completed
	Provide infection control/microbiology input to review of Legionella control measures through attendance at Legionella Control Team meetings	JP/AC	Quarterly	Legionella Control Operational Plan reviewed and updated.
Designated Decontamination Lead	Establish hand over of Decontamination Lead role from facilities manager to DIPC	Diane Ody (DO) & JP	April 2009	Completed
Patient equipment cleaning	Audit compliance with patient equipment cleaning policy.	IPCT	Sept 2009	Included at part of cleanliness audits and NQAT.
	Provide specialist infection control input to Matrons Charter Group.	CK	Quarterly	Matrons Charter group disbanded

Code of Practice Criteria	Programme of work 2009/10	By whom (lead)	By when	Progress/Outcome
Frequency of cleaning	Establish frequency with which areas at higher risk of *C.difficile* infection should be deep cleaned using H_2O_2 environmental disinfection	AC/JP and DO	April 2009	Completed
Sluice refurbishment	Following on from successful bid for funding to refurbish sluices and installation of macerators, establish implementation group to plan, implement, monitor and revise planned programme taking into account operational issues, bed capacity and deep cleaning programme	DO	April 2009	Completed
Hand hygiene	Continue with Year 4 of '*Cleanyourhands*' campaign which including:			Year 4 activities completed.
	a) Observational audits of compliance	Link Nurses	Monthly	
	b) Feedback to clinical areas on compliance	JP	2 monthly	
	c) **Audit** provision of hand wash facilities	IPCT	Sept 2009	
Decontamination	Ensure infection control and microbiology input to Decontamination Committee through attendance at task group meetings	JP/AC	Quarterly	Completed.
Linen and laundry	Further review of linen storage at ward level for areas of high usage.	Lead Nurses/JP	June 2009	Completed.
3.Provide suitable an sufficient information on HCAI to the patient, the public and other service providers when Patients move to care of another healthcare or social care provider.	Ensure that DIPC Annual Report is posted on RD&E website following presentation to the Board.	Janet Oatley	June 2008	Completed
	Make new and revised policies available on the Trust website	Janet Oatley	Within month of approval	Completed

Code of Practice Criteria	Programme of work 2009/10	By whom (lead)	By when	Progress/Outcome
	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.	JP	As required	
4. Ensure that patients presenting with an infection or who acquire an infection are identified promptly and receive appropriate management and treatment to reduce risk of transmission	Pursue and implement use of IC alert with ED IT system.	Melanie	July 2009	Completed
5.Gain co-operation of staff, contractors and others involved in the provision of care in preventing and controlling infection	Audit provision of infection control guidance to contractors	IPCT/Estates	December 2009	Carried forward to 2010/11 programme
6. Provide or secure adequate isolation facilities	Determine feasibility of installation of an additional magnehelic gauge to monitor negative pressure ventilation in a second room on Torridge.	AC/TM	Dec2009	Carried forward to 2010/11 programme
7. Secure adequate access to laboratory support	Following implementation of MRSA screening of elective patients, plan for implementation of admission screening for emergency patients	Julie King/AC/JP	March 2010	BC for emergency admission screening completed and approved.
8. Have and adhere to appropriate policies for the prevention and control of HCAI to infection prevention and control	Develop new policy for MRSA decolonisation of babies Review and update where necessary the following policies/guidance	AC	May 2009	Completed
	o Antimicrobial Policy	AC	July 09	Completed
	o C.difficile and antibiotic associated colitis	JP	Aug 09	Completed
	o Cystic Fibrosis - Infection control guidelines	Carlton Kneil (CK)	Nov 09	Completed
	o Herpes Simplex	Kath Leader(KL)	Nov 09	Completed

Code of Practice Criteria	Programme of work 2009/10	By whom (lead)	By when	Progress/Outcome
	o Infection Control and Torridge Operational Policy	JP	May 09	Completed
	o Measles	CK	Aug 09	Completed
	o Protective Isolation Policy	JP	Aug 09	Completed
	o Scabies	KL	Aug 09	Completed
	o Source isolation Policy	JP	Aug 09	Completed
	o Staff Health and Illness	CK	Aug 09	Completed
	o Standard Infection Control Precautions	JP	Aug 09	Completed
	o Surveillance Policy	JP	June 09	Completed
	o Terminal Cleaning Coordination	CK	Nov 09	Completed
	o Varicella Zoster	JT	Nov 09	Completed
	o VRE	CK	Aug 09	Completed
	o Viral Gastroenteritis	JT	Aug 09	Completed
	o VHF	AC	Nov 09	Completed
	o Ward Closure	CK	Aug 09	Completed
	Undertake the following audits to monitor compliance with selected infection control policies/guidelines:			
	• Patient placement, isolation and infection risk assessment	ICT	June 2009	Complete
	• Use of personal protective equipment	ICT	Oct 2009	Completed

Code of Practice Criteria	Programme of work 2009/10	By whom (lead)	By when	Progress/Outcome
	• Provision of hand washing facilities	ICT	July 2009	**Audited as part of PEAT Jan 2010**
	• Observation audit of hand hygiene	Link Nurses	Monthly	
	• Use of nasal monthly mupirocin prophylaxis in dialysis pts	Renal Vascular Access Nurse	April 2009	Completed
	• MRSA decolonisation of patients known to be MRSA positive prior to elective admission	IPCT	August 2009	Completed
	• Sharps disposal procedures	IPCT	July 2009	Completed
	o Peripheral cannula insertion in ED, EMU and Anaesthetics	IPCT	Sept 2009	Completed
	Establish Trust wide group to review compliance with NICE surgical site infection guideline with the aim of identifying any gaps in current practice, developing relevant policy and implementing a surgical site infection care bundle.	JP	May 2009	Superseded by Patient safety first IHI/SHA work. Work on antimicrobial surgical prophylaxis protocols continues.
9. Ensure that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work and that staff are suitably educated in the prevention and control of HCAI	Deliver mandatory training as per training needs analysis	IPCT	Ongoing	
	Update presentations corporate induction	CK	April 2009	Completed
	Deliver infection control and invasive procedures training for medical staff	Penny Criddle	Each new intake of junior doctors	Completed
	Revise and update e-training package for medical staff	IPCT	July 2009	Completed
	Deliver at least one link nurse training course	IPCT	Dec 2009	Completed

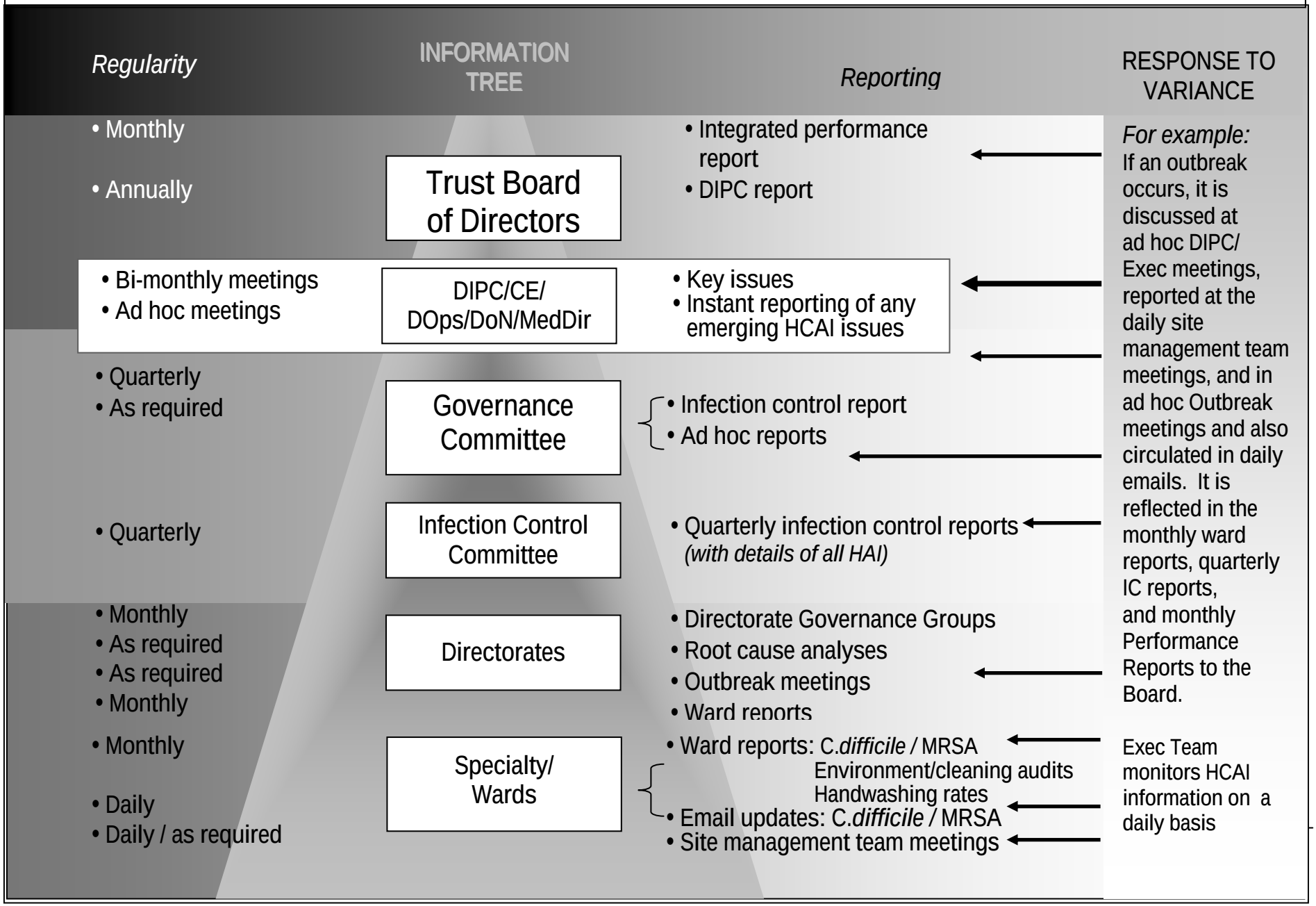
	Provide quarterly link nurse updates	IPCT	Quarterly	Completed
	Work with Vascular Access Team and Learning and Development Service to deliver workshops and updates on CVC management.	IPCT	As required	Workshop programme in place
	Provide other adhoc training as required/need identified.	IPCT	As required	Swine flu training provided in May 2009 to various groups
	Finalise Immunisation and Vaccination Policy including management of non compliant staff	HR Director	Sept 2009	Completed.

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.

Healthcare Associated Infection Reporting Mechanisms

APPENDIX 3



APPENDIX 4

Infection Control Committee – Decision Briefings

Date of Meeting: 07/05/09

Number	Description of Decision
1.	**Immunisation & Vaccination policy** It is still difficult to achieve a high compliance with this policy, and there is inadequate provision in the policy to ensure that staff understand how important the Trust regards protection against Vaccine Preventable Disease. ICC Chair will write to Director HR to seek resolution of these issues as soon as possible.
2	**Policies for Approved** 1. Guidance on Group A Streptococcal Infections 2. Interim Guidance on the Management of Swine Influenza
3	**Audit** 1. **Hand Hygiene Compliance** Overall compliance good. The results of hand hygiene compliance for medical staff collected in April will be discussed with Medical Directors, as soon as they are collated. 2. **Peripheral Venous Cannula** Latest audit showed significant overall improvement
4	**Annual Programme and Annual Report** 1. The annual programme has been completed except for one point which is in progress 2. The annual DIPC report is complete and will be presented to the Board at the first opportunity
5	**Centre for Women's Health** Low levels legionella non-pneumophila still sporadically isolated. Not considered risk to patients or staff.
6	**Torridge Ward** The committee will produce a report on the benefits of maintaining a ward were *C. difficile* patients can be cohorted.
7	**Norovirus Outbreaks** A review meeting will be held 21st May 2009 following recent hospital outbreaks affecting multiple wards. Determine ways of reducing risk of future outbreaks

Date of Meeting: 05/08/09

Number	Description of Decision
1	**Policies Approved** 1. Inoculation Injury Policy 2. Neutropenic/Clean Diet Guideline (produced by Dietetics team
2	**Policies updated and amended** 1. Measles 2. Scabies 3. Staff Health & Illness 4. Vancomycin Resistant Enterococcus 5. Viral Gastroenteritis 6. Ward Closure 7. Protective Isolation Guidance 8. Standard Infection Control Precautions 9. Surveillance Policy
3	**Audit** **Hand Hygiene Compliance** Compliance is usually about 85% overall but decreases when audits are undertaken amongst medical staff only. There has never the less been a huge improvement in Medical staff compliance in the last 2 years. This has been discussed with Medical Directors and issues are being addressed within areas of low compliance by Directorate Governance systems.
4	**Central Venous Catheter training** The committee recommend that this should be mandatory for nurses and F1 and F2 doctors. This is being taken forward with learning and development and F1/2 training teams
5	**Terms of Reference** These have been updated

Date of Meeting: 19/11/09

Number	Description of Decision
1	**Policies Approved** 1. C.difficile Infection Policy 2. Infection Control Guidelines for Patients with Cystic Fibrosis 3. Herpes Simplex Information and Guidance 4. Guidelines for Terminal Cleaning Co-ordination 5. Varicella Zoster Virus, Chickenpox and Shingles 6. Infection Control Guidelines for Preventing and Controlling BBVs in Haemodialysis Units 7. Viral Haemorrhagic Fever 8. Protocol for the management of Mumps Contact for Healthcare Workers 2009 9. Inoculation Injury Policy
4	**Surveillance** Surgical site infection data to be presented graphically in future meetings
5	**Review of Annual programme** Some work behind schedule/on hold due to staff vacancies. The Committee accepted that this work should be suspended at present.

Date of Meeting: 04/02/10

Number	Description of Decision
1	**Policies updated and amended** Hand Hygiene Policy ESBL has become Extended spectrum beta lactamases (ESBLs) and resistant Amp C type beta lactamases (AMPCs) Legionella Control Policy
2	**A report on the benefits of a cohort ward for C. difficile infected patients (Torridge) was presented by Dr Ray Sheridan.** This strongly supported the use of a cohort ward, and detailed additional benefits for the Trust. The report is can be downloaded from IAN from Infection Control>Committee Meetings http://ian.exe.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61011&type=full&servicetype=Attachment
3	**Review of Terms of Reference** A section on monitoring the effectiveness of the committee has been added and the lead cancer nurse included in the membership. Approved for a further 12 months with these additions
4	**Legionnaires' Disease** Systems were tested following a case in a hospitalised patient. Patient found to be infected in the community, but all monitoring and water testing showed that the Trust performed well with control measures.
5	**Norovirus** An assessment of the RD&E policy compliance against a South West SHA Norovirus Checklist has been completed. The RD&E is compliant is all areas with the exception of the allocation of staff to designated areas if norovirus is limited to a bay. Judy Potter has marked the Trust as compliant with the escalation procedures although we use alternative methods of circulating messages.
6	**Care Quality commission** Following the Hygiene code inspection in November, a successful repeat visit was made in February and the recommendations on commode cleaning have been lifted.

APPENDIX 5

Outbreaks of suspected or confirmed Norovirus

Figure 1

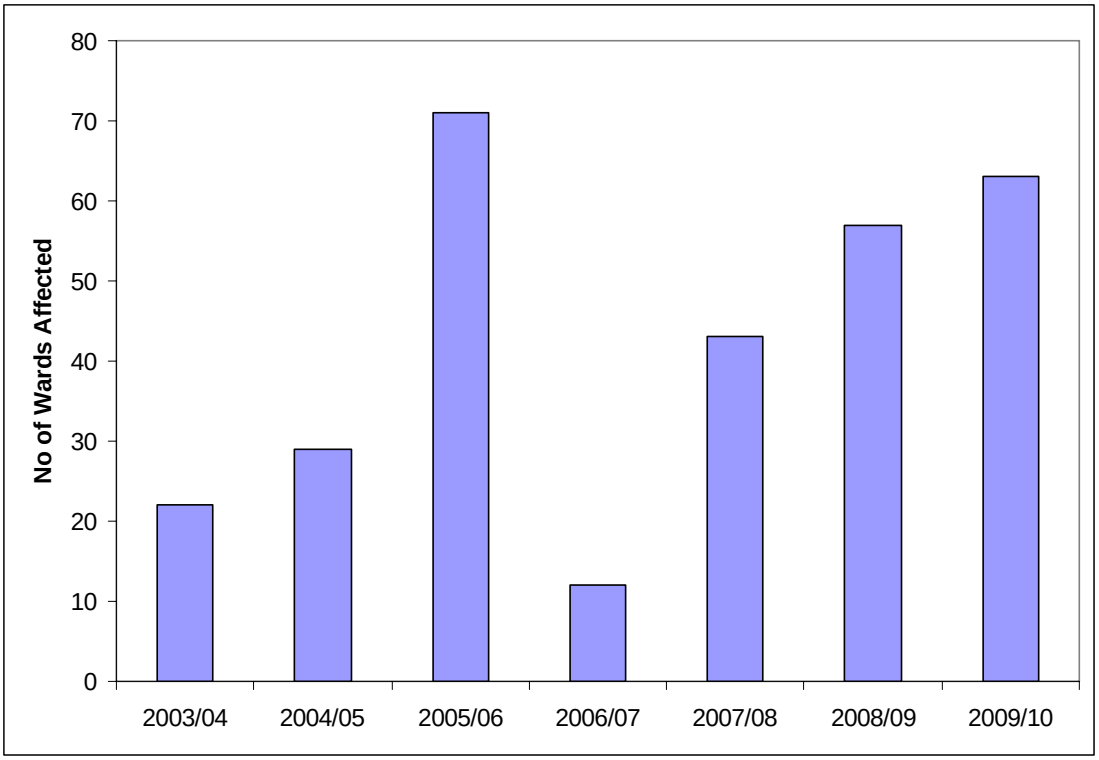
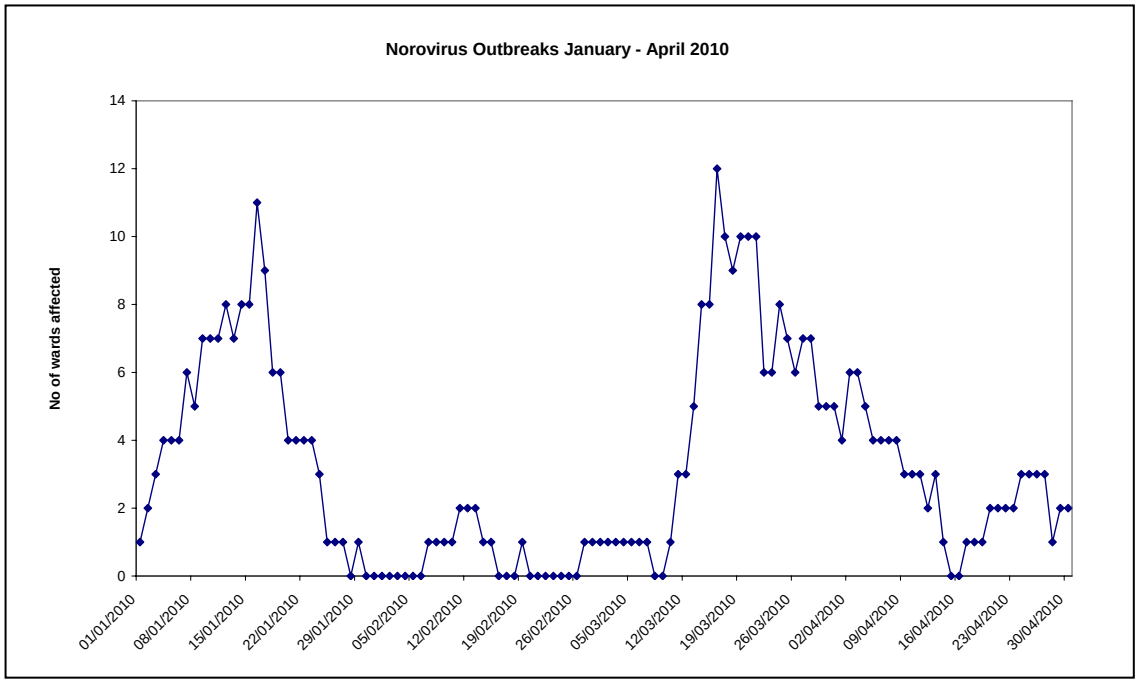
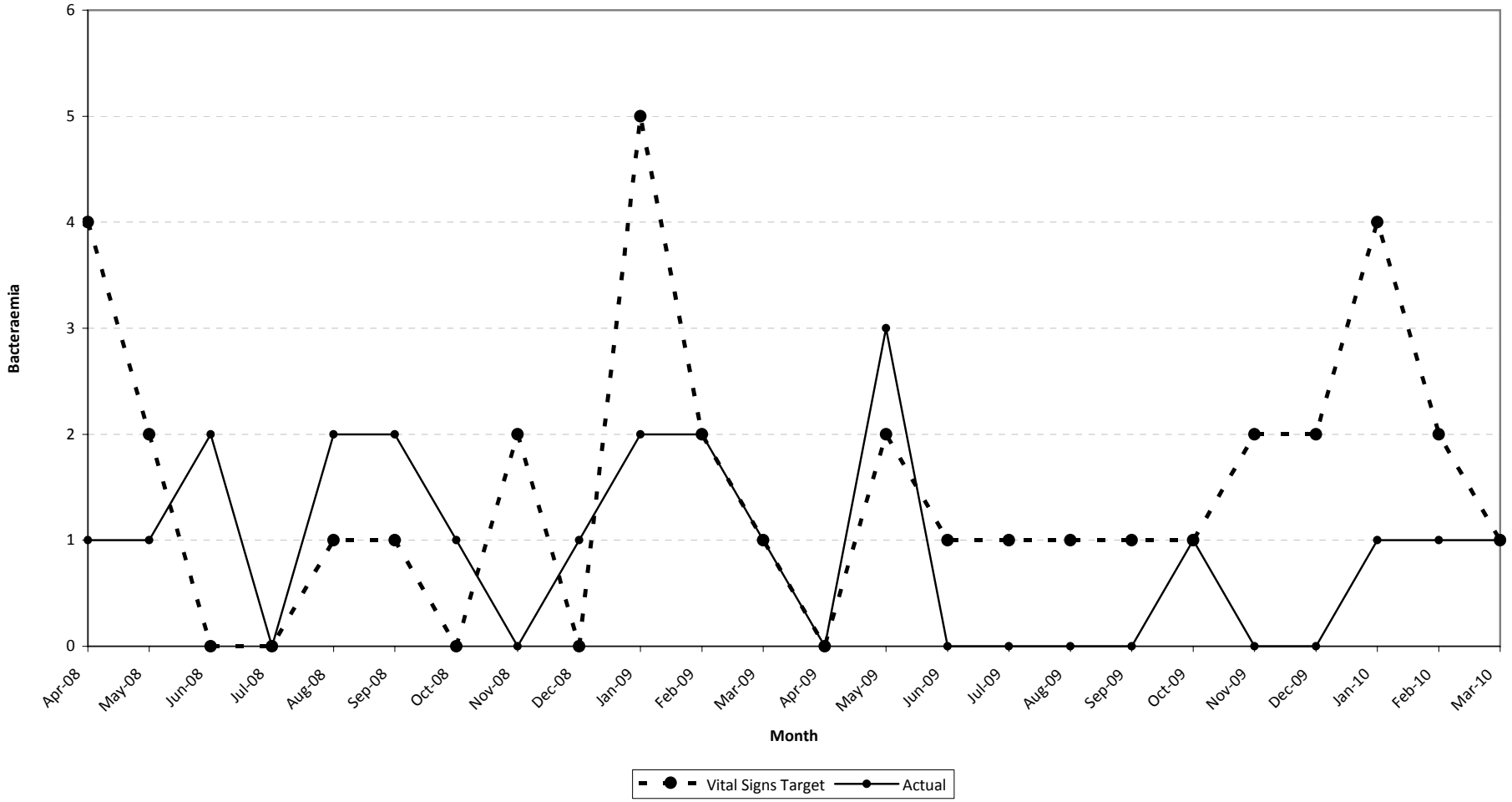


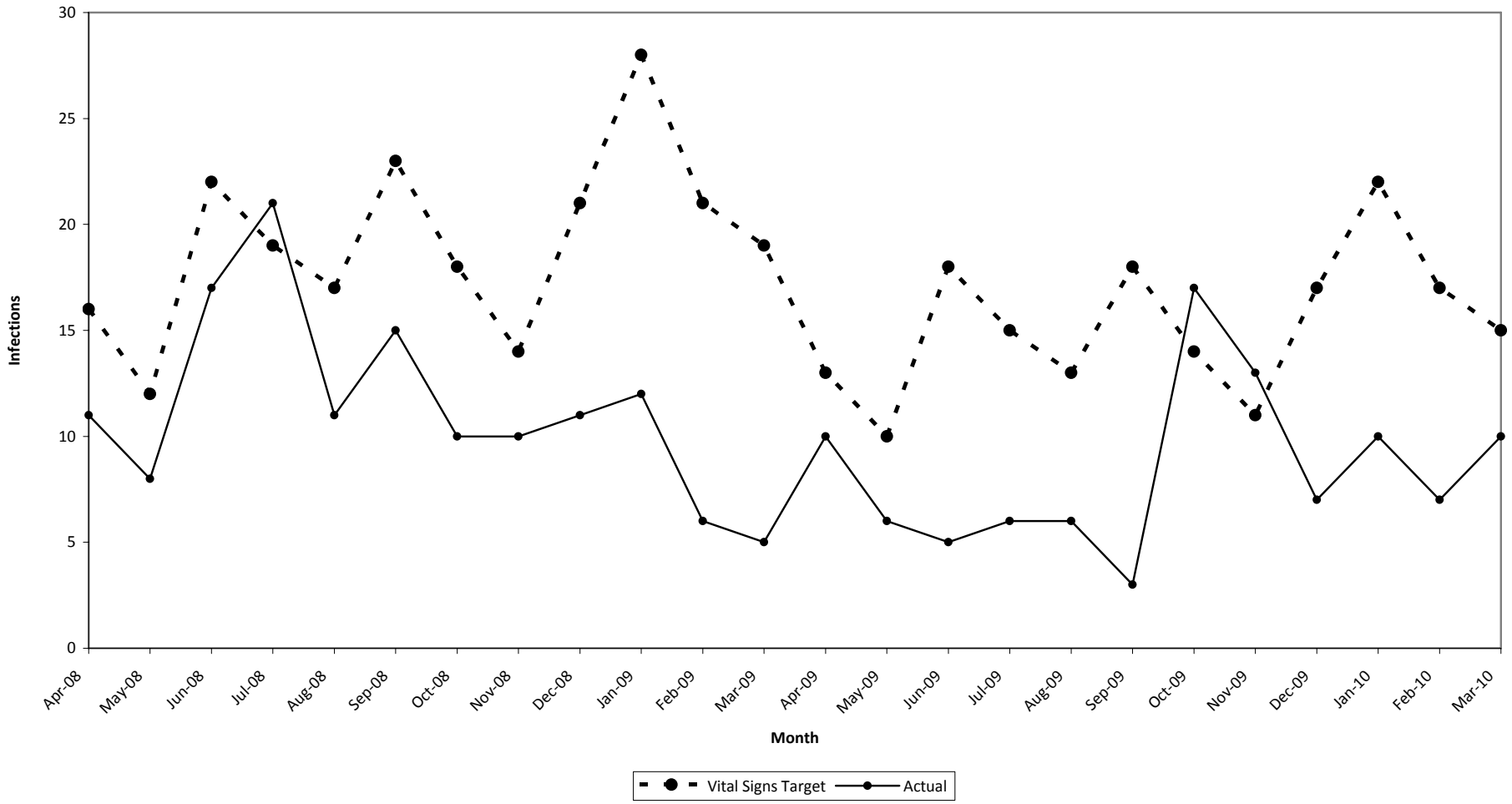
Figure 2



Number of MRSA Bacteraemia and Trajectory

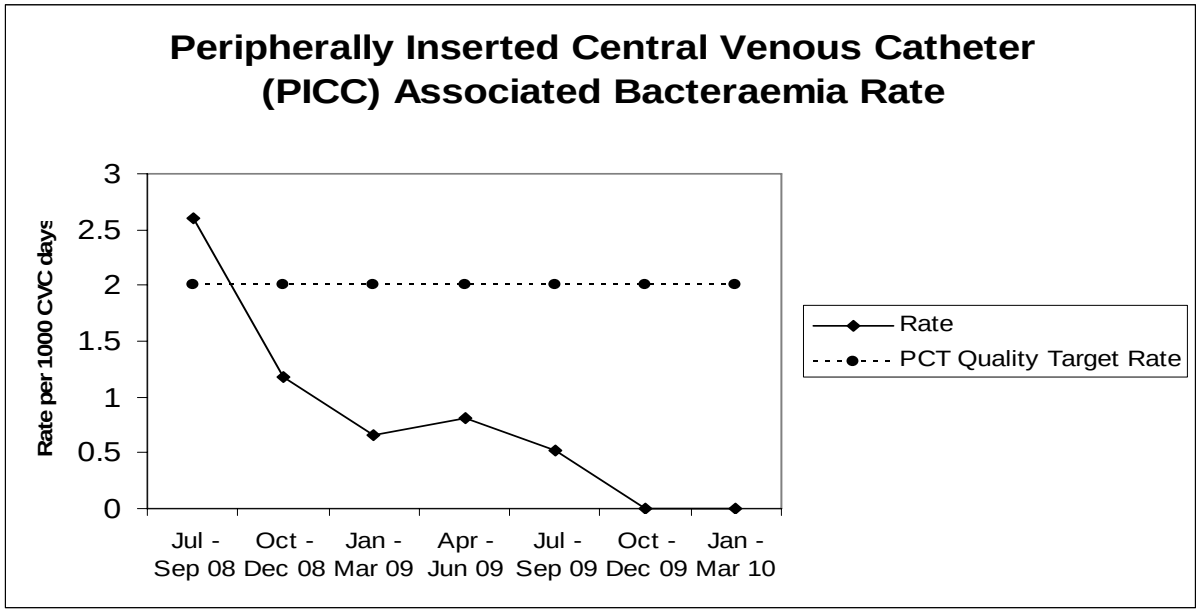


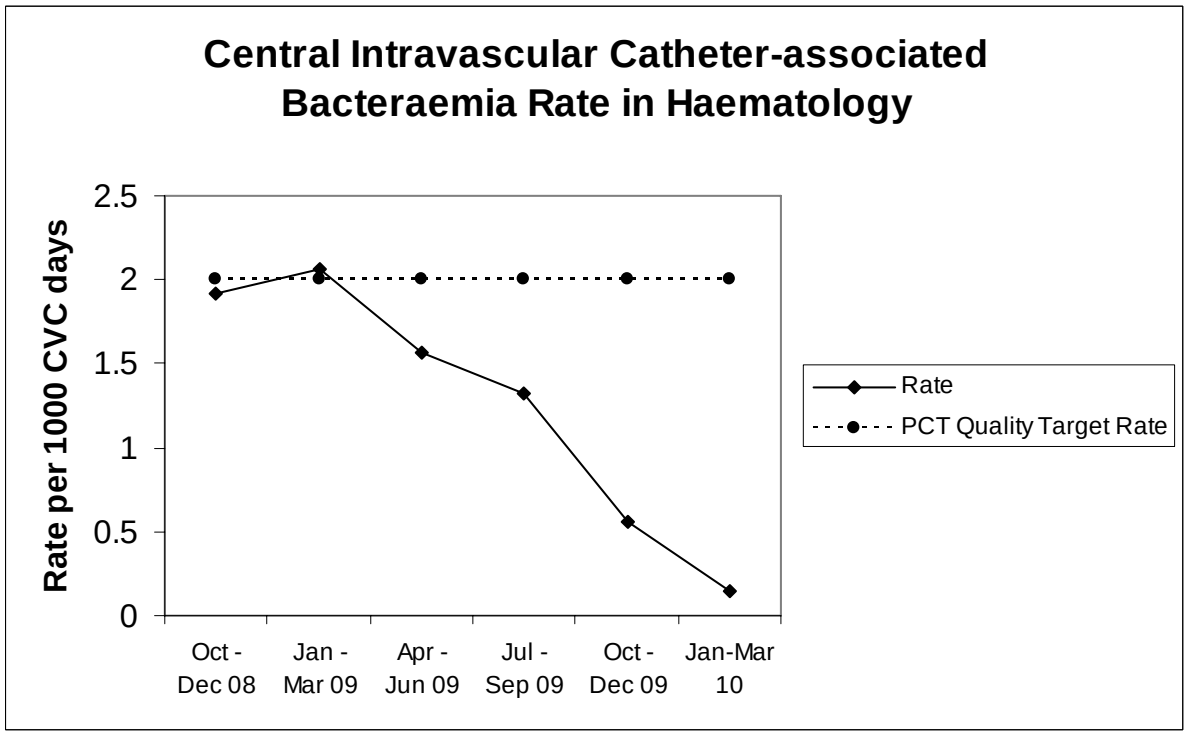
Clostridium Difficile Infections and Trajectory

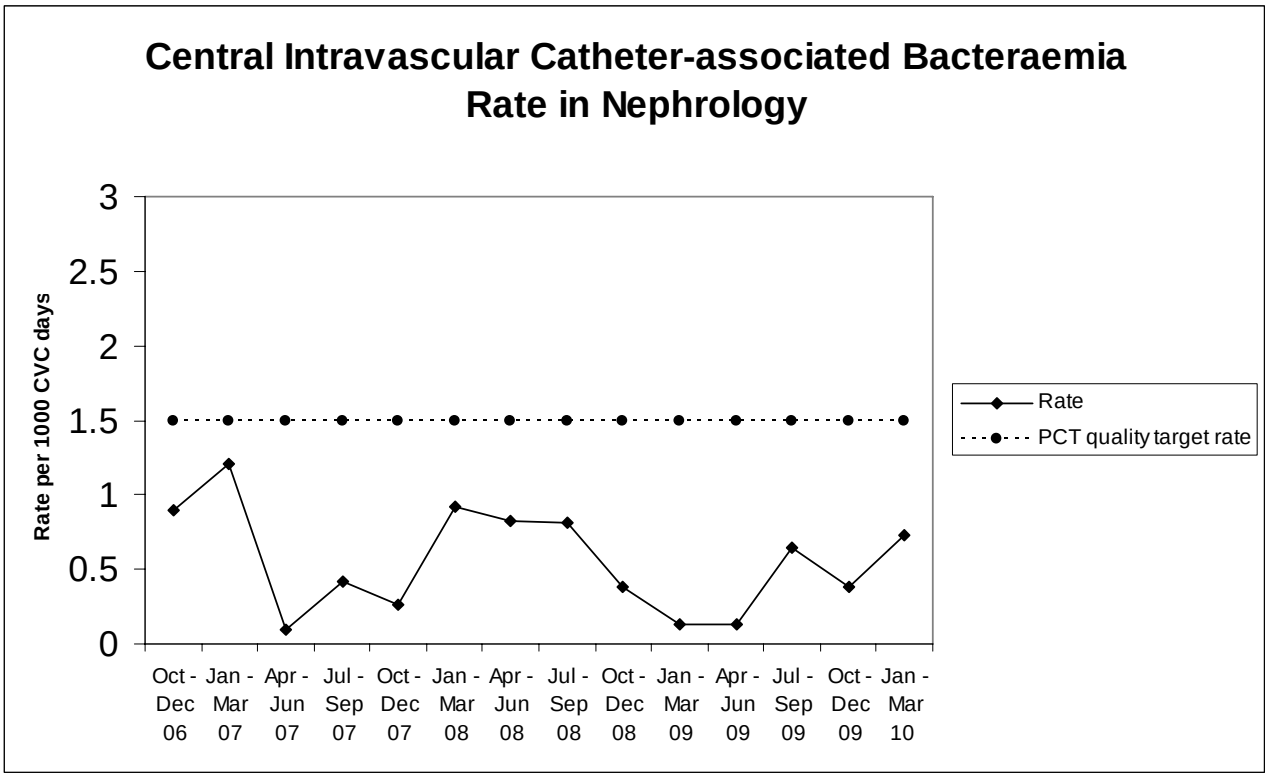


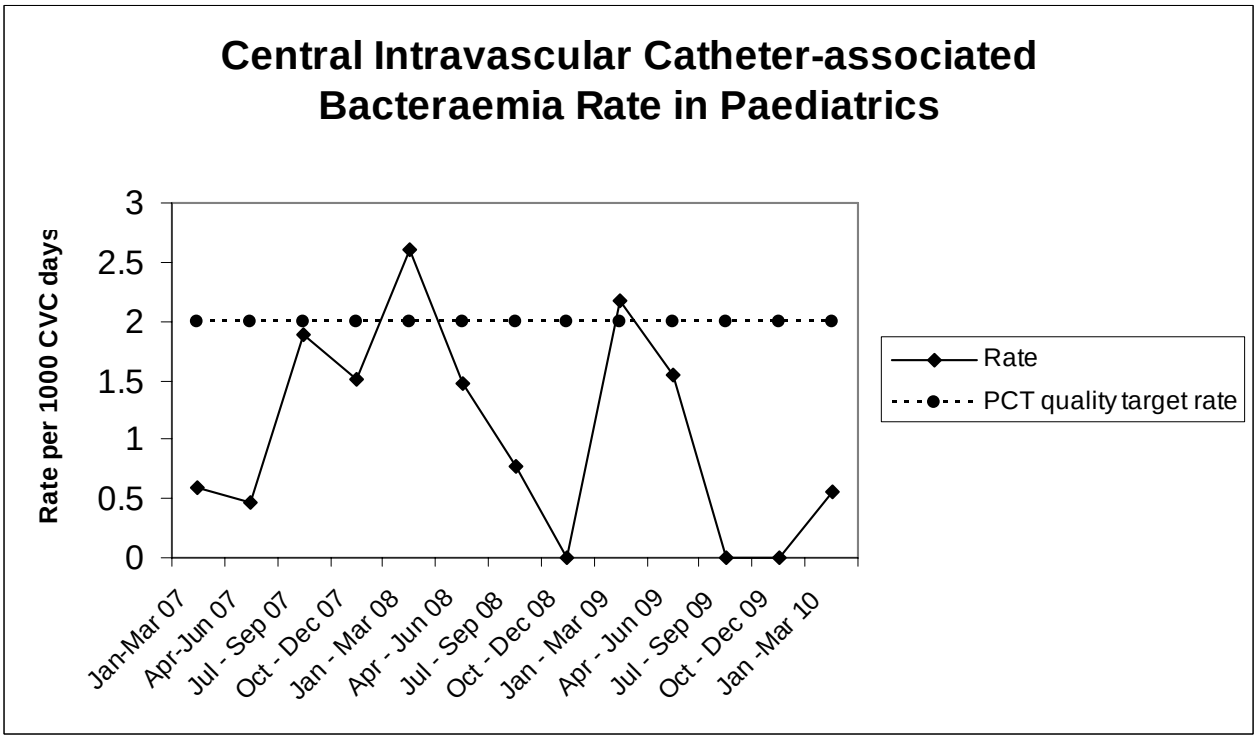
APPENDIX 8

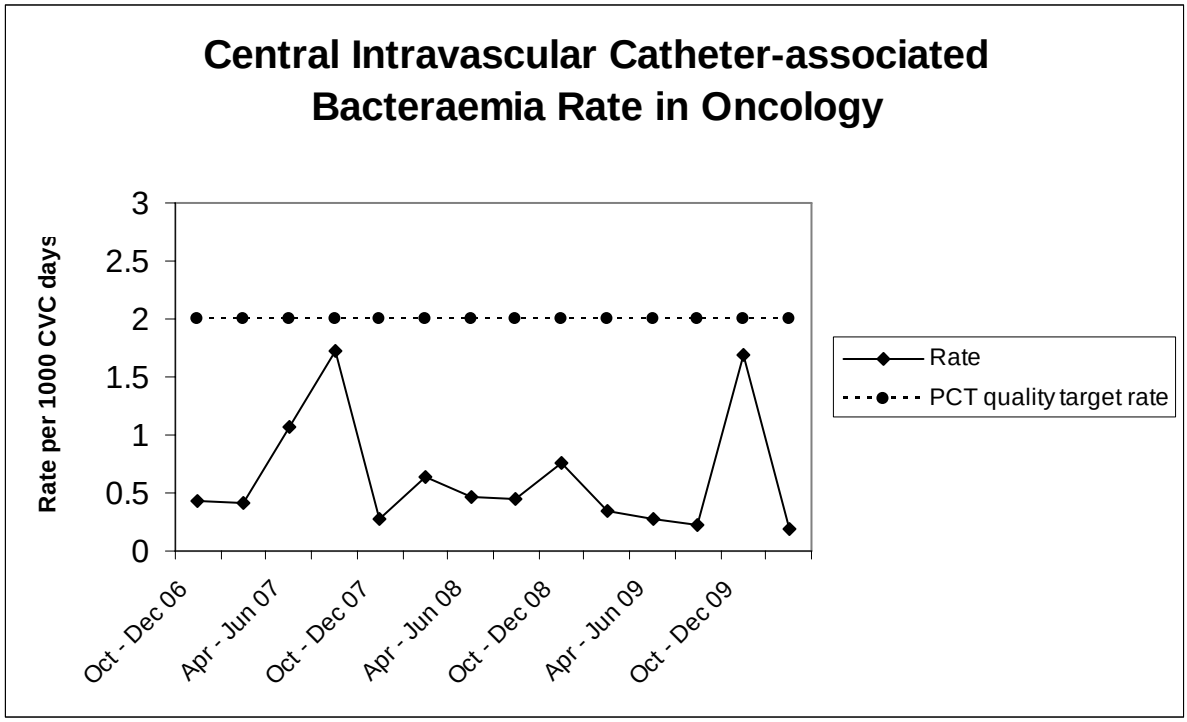
Central Venous Catheter Associated Bacteraemia Rates

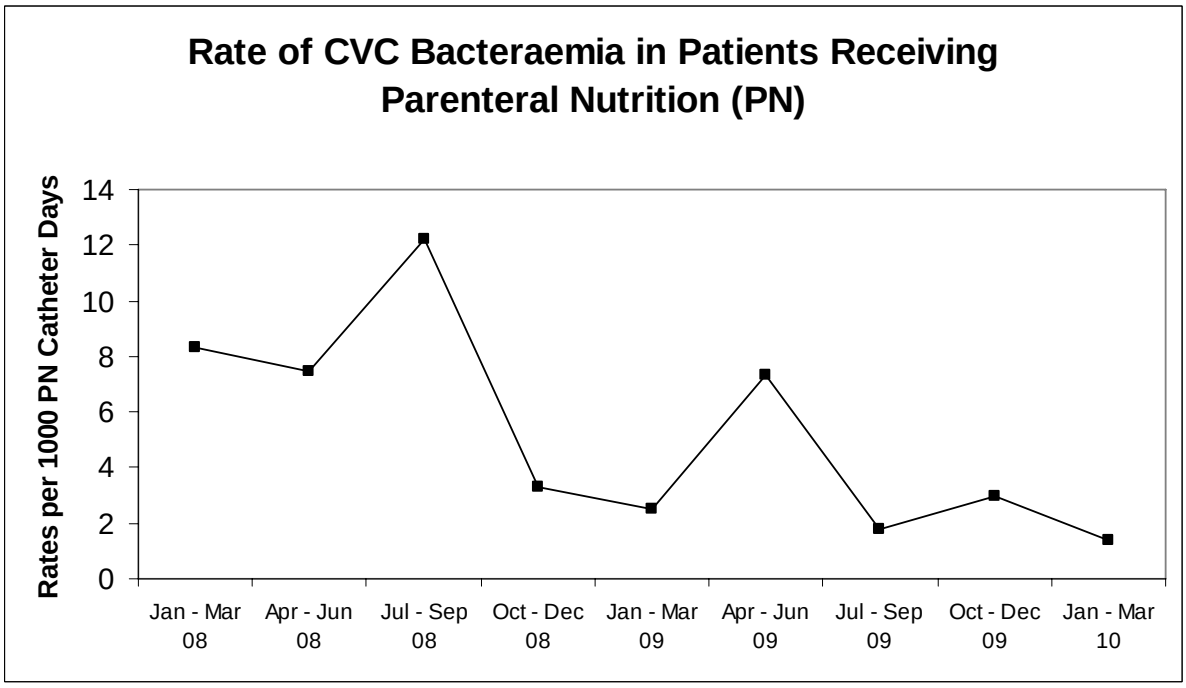





Central Intravascular Catheter-associated Bacteraemia Rate in Nephrology
Rate per 1000 CVC days
3
2.5
2
1.5
1
0.5
0
Oct - Dec 06
Jan - Mar 07
Apr - Jun 07
Jul - Sep 07
Oct - Dec 07
Jan - Mar 08
Apr - Jun 08
Jul - Sep 08
Oct - Dec 08
Jan - Mar 09
Apr - Jun 09
Jul - Sep 09
Oct - Dec 09
Jan - Mar 10
Rate
PCT quality target rate


Central Intravascular Catheter-associated Bacteraemia Rate in Paediatrics
Rate per 1000 CVC days
3
2.5
2
1.5
1
0.5
0
Jan-Mar 07
Apr-Jun 07
Jul - Sep 07
Oct - Dec 07
Jan - Mar 08
Apr - Jun 08
Jul - Sep 08
Oct - Dec 08
Jan - Mar 09
Apr - Jun 09
Jul - Sep 09
Oct - Dec 09
Jan -Mar 10
Rate
PCT quality target rate

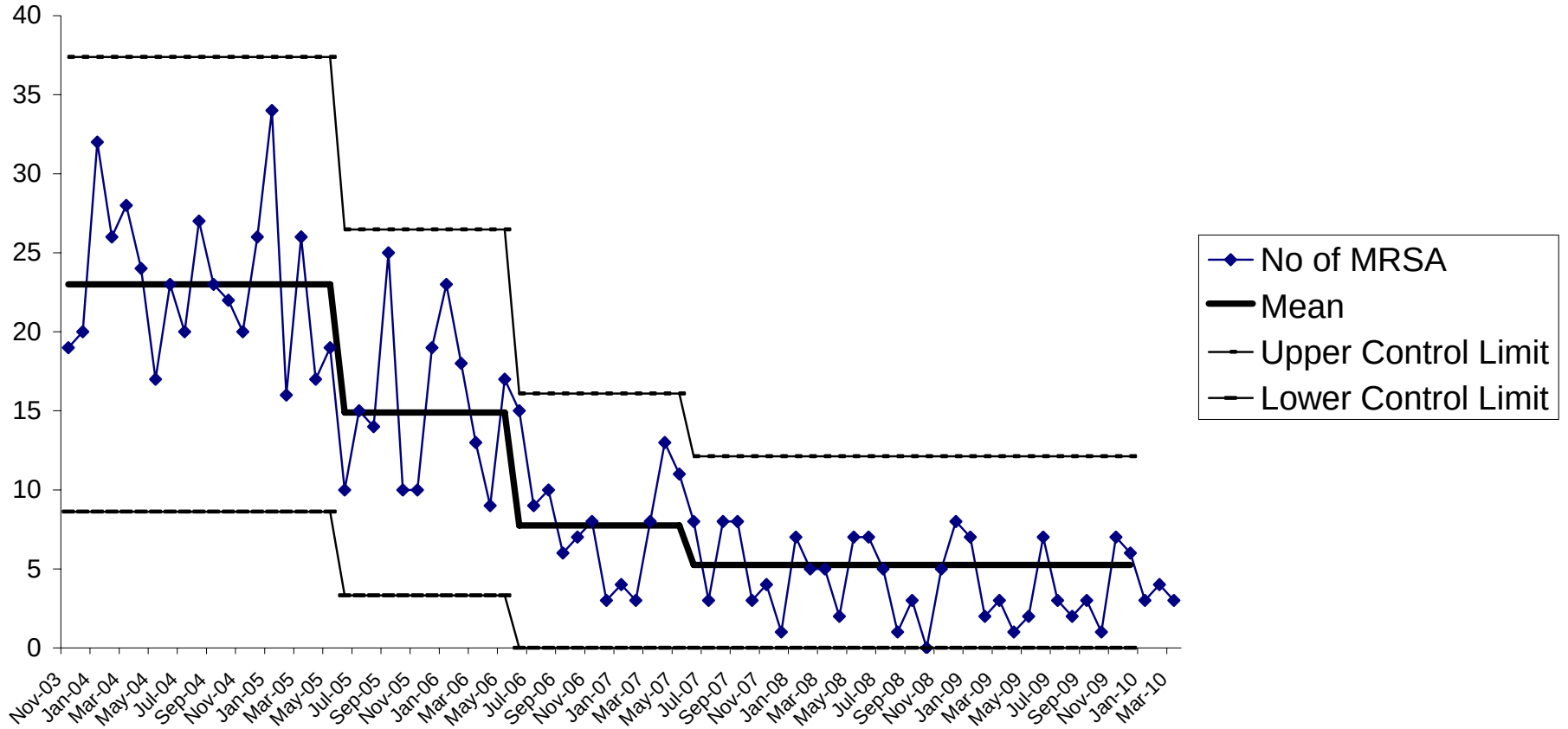




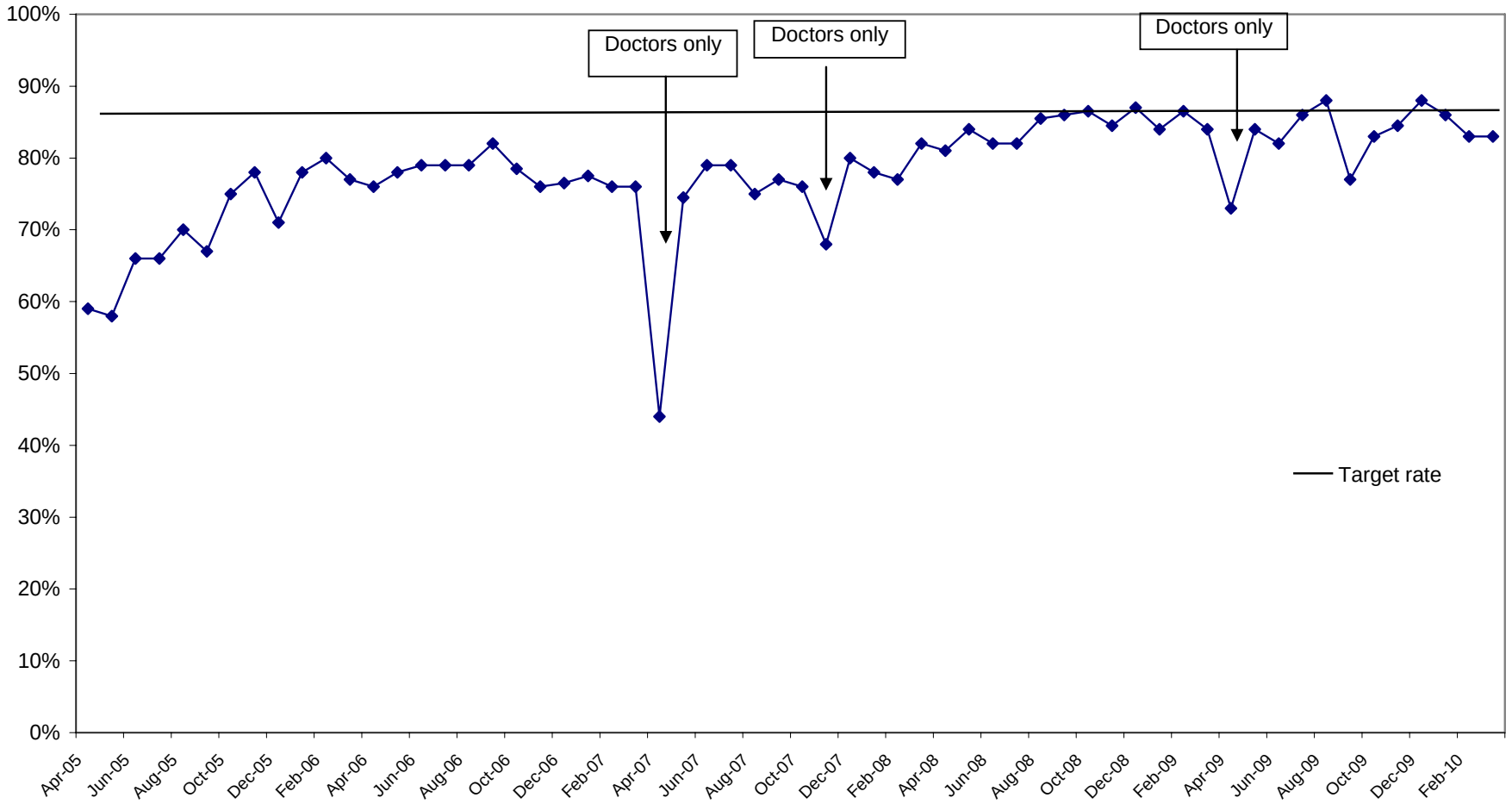
NB - No PCT target agreed.

APPENDIX 9

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



Overall Trust Hand Hygiene Compliance



APPENDIX 11

Royal Devon and Exeter NHS
NHS Foundation Trust

DECONTAMINATION COMMITTEE

ANNUAL REPORT TO THE GOVERNANCE COMMITTEE 2009/10

What we've achieved	**What is planned**
• ISO accreditation achieved in HSDU • Compliance with CQC standards • Full implementation of Healthedge instrument tracking system in all theatres • Elimination of all difficult to clean instruments where an alternative exists including sigmoidoscopes, proctocopes, diathermy, suction catheters. • Implementation of equipment and process for high level disinfection of ENT clinic endoscopes in Endosocpy Unit decontamination Unit. • Identification of further improvements necessary in for endoscopy decontamination particularly out with the Endoscopy Unit i.e. ITU, theatres, cardiology and ENT and support for proposals for improvement from Medical Directorate • Changed to single use ENT instrument sets on Otter ward • Reviewed and updated Loan Surgical Instruments Policy • Reviewed and updated Terms of reference	◆ Further work to enhance endoscope decontamination at the RD&E and at Tiverton and Axminster endoscopy units to ensure the same standards in all settings ◆ Establish robust system for water quality monitoring at Axminster and Tiverton and escalation plan in event of water quality failure. ◆ Identify areas that would benefit from the use of Healthedge instrument tracking system outwith theatres ◆ Pursue trial of single patient trays of instruments in ENT outpatients ◆ Update Trust Decontamination Policy
Difficulties	**What we need help on …**
◆ Improvements in endoscopy decontamination in PFI hospital at Tiverton ◆ Eliminating use of Labcaire washer disinfector in central theatres for out of hours disinfection of endoscopes from ITU, theatres and ENT.	• Support for business case to improve endoscopy decontamination in areas outwith the central endoscopy unit and eliminate use of Labcaire washer disinfector. • Way forward for improvements at Tiverton Hospital.

Risks managed through activities of the committee and statement of how well these risks have been managed
Instruments traceability - healthedge tracking system implemented in all theatres
Nasoendocope decontamination - equipment and process for high level disinfection of nasoendoscopes established

APPENDIX 12

Royal Devon and Exeter NHS
NHS Foundation Trust

Antimicrobial Subcommittee of the Drug and Therapeutics Committee
ANNUAL REPORT TO THE GOVERNANCE COMMITTEE 2009 – 2010

What we've achieved	**What is planned**
• The Committee met four times between March 2009 – March 2010 • The Healthcare commission were satisfied with antimicrobial stewardship on their annual visit • Antimicrobial prudent prescribing champions have been identified for directorates / high risk areas within the Trust **Policies and Guidelines** • Community acquired pneumonia guideline updated • Surgical prophylaxis (draft version currently being circulated for consultation) • Adult vancomycin dosing and monitoring guideline updated • Paediatric Antibiotic Monitoring Guidelines updated • Adult quick antibiotic reference Card updated and distributed • Paediatric antibiotic quick reference card designed and distributed. • Stroke unit aspiration pneumonia guideline • New drug chart with antimicrobial section designed and currently being trialled **Audit and Surveillance** • Monthly quality of antimicrobial prescribing audit • Annual regional point prevalence study (February 2010) • Vancomycin in Haematology audit (report currently being written) • Quinolone prescribing • Weekly Antimicrobial Review Rounds • *C. difficile* infection ward rounds **Education** • Produced induction Training Tracker presentation on prudent prescribing for new doctors • Contributed to teaching for several professional groups • Antimicrobial Pharmacist nearing completion of an Independent Prescribing Course (Bath University)	• Ongoing quality of antimicrobial prescribing audit and / or antimicrobial prescribing care bundle (introduction expected 2010) • Annual E-learning package on prudent antimicrobial prescribing for all prescribers within the Trust • On-going review of surgical prophylaxis guidelines – posters will be produced for anaesthetic rooms • Restricted antimicrobial list to allow tighter control of antimicrobial use with in the Trust • Training and education to support the implementation of the new adult vancomycin guideline • Increased Antibiotic Review Round activity / presence A new antimicrobial stewardship programme has been set out for 2009 - 2010, including audit and surveillance, clinical activity, policies & guidelines, education and several new developments. This was agreed at the March 2010 Antimicrobial Subcommittee quarterly meeting and can be found in the Antimicrobial Subcommittee section in IaN.
Difficulties	**What we need help on …**
• Limited IT resources makes recommended surveillance impossible to achieve • No web-based access to an antimicrobial formulary within the Trust • Joint formulary current format is inflexible	• IT provision to achieve effective surveillance of antimicrobial use within the Trust, in defined daily dose format, traced to clinical directorates and areas / wards • On-line formulary