We... involve others ...are all leaders ... are proud ..work in partnership ... are transparent ... add value

West Hertfordshire Hospitals NHS
NHS Trust

Trust Board Meeting
12 February 2015

Title of Paper:	**Infection prevention and control annual report**
Agenda Item:	**16/24**
Lead Executive:	**Tracey Carter, Chief Nurse & Director of Infection Prevention and Control**
Author:	**Nyarayi Mukombe, Assistant Director of Infection Prevention and Control**
Trust Objective:	Tick as appropriate: ☒Achieving continuous improvement in the quality of patient care that we provide and the delivery of service performance across all areas; ☐Setting out our future clinical strategy through clinical leadership in partnership and with whole system working; ☐Creating a clear and credible long term financial strategy.
Purpose:	The purpose of this report is to inform patients, public, staff, the Trust Board, and Commissioners of the infection prevention and control work undertaken in April 2013 to March 2014 and progress against performance targets and programme of work for 2014/2015

Previously discussed and date for further review:

Committee	Date
Trust Leadership Executive Committee	29 January 2015
PSQR	3 February 2015

Benefits to patients and patient safety implications
Assurance that Infection Prevention & Control Team is working efficiently to achieve clean and safe services to them.

Risk implications for the Trust	**Mitigations actions (controls)**
Failure to achieve compliance with agreed infection targets will affect the rating for the Trust and CQC Outcome 8: Cleanliness and Infection Control.	A framework exists within the Trust to manage the infection prevention and control agenda via the monthly Infection Prevention and Control Panel and the Bi-weekly Local Health Care Associated Infection (LHCAI) Meeting

Links to Board Assurance Framework, CQC outcomes, statutory requirements

Legal implications (if applicable)
The Trust must so far as reasonably practicable ensure that it meets the Care Quality Commission requirements of Outcome 8 (regulation 12) Cleanliness and Infection Control, the requirement of this outcome is that the Trust complies with The Health and Social Care Act 2008 (updated 2010): Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

Financial implications (if applicable)

Recommendations (delete as appropriate)

The Trust Board is asked to note the contents of the report.

West Hertfordshire Hospitals NHS
NHS Trust

INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2013-2014

Contents

Executive Summary

In 2013/2014, the Trust experienced a mixed level of attainment with regard to the healthcare associated infection (HCAI) objectives. The incidents of *Clostridium difficile* infection (CDI) and that of Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia were both breached. CDI trajectory was 24, the trust reported 28 cases of CDI. MRSA bacteraemia the trajectory was 0 avoidable cases; the trust reported 3 cases of MRSA bacteraemia.

Other items of note were:

- The Infection prevention and control (IPC) team had reduced staffing capacity which had an impact on the IPC work plan.
- Period of Increased Incidences of *Clostridium difficile* on Aldenham ward both had 027 strain.
- *Clostridium difficile* outbreak in Intensive Care Unit (ITU) in March 2014
- A programme of antimicrobial stewardship has been implemented as this helps reduce *Clostridium difficile* infection and reduce the risk of antimicrobial resistance.
- Series of Visits from the NHS Trust Development Authority (TDA)
- CQC inspection in December 2013
- Trust wide continuous total hip and knee replacement surveillance (mandatory requirement fulfilled)
- Extension of Breast Surgery SSI surveillance at SACH April to June 2013 following outlier notice from Public Health England. Development and publication of prophylactic antibiotic policy (ratified March 2014)
- Benchmark of Spinal Surgery rate of infection July to September 2013
- Theatre refurbishment/maintenance programme at SACH & WGH (commencement November 2013)
- Maintained continuous educational practice, mandatory induction and managed to undertake the session on demand, despite resources.
- Renew/production of policies and guidelines

1. Introduction

The purpose of this report is to inform patients, public, staff, the Trust Board, and Commissioners of the infection prevention and control work undertaken in April 2013 to March 2014, the infection prevention and control (IPC) arrangements within the trust, the incidents of Health Care Associated Infections (HCAI) within the Trust & IPC activities in 2013/2014 and progress against performance targets the state of infection prevention and progress against performance targets and programme of work for 2014/2015

The Trust Board recognises and agrees their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is designated to the Director of Infection Prevention & Control (DIPC). In this trust this individual is also the Chief Nurse.

Publications have highlighted the importance of infection prevention and control as an integral part of quality health care. Unfortunately, not all health care associated infection is preventable; therefore swift reaction to problems such as cross-infection and infection outbreaks is always a necessary element of the work of the Organisation and the Infection Prevention & Control Team (IPCT).

However, a proactive approach is vital to help avoid hospital-acquired infection. Within the Trust, provision of a comprehensive education programme, the development, implementation and review of policies and guidelines and infection surveillance are all components of the IPCT's proactive approach to infection prevention and control

2. Infection Prevention and Control Arrangements:

The Chief Executive accepts on behalf of the Trust Board responsibility for all aspects of infection Prevention and control (IPC) within the Trust. This responsibility is delegated to the Chief Nurse (as Director of Infection Prevention and Control).

- The Chief Nurse (CN) is the designated executive lead and Director of Infection Prevention and Control (DIPC). She reports directly to the Chief Executive and the Board, and is chair of the Trust Infection Prevention and Control Panel (IPCP). As the Executive Director with responsibility for IPC the CN delegates operational responsibility at Divisional level to the Heads of Nursing/Midwifery.
- The CN/DIPC leads, and is accountable for the review and communication of the strategy, assessment of milestones and ensures that appropriate planning takes place in order to deliver the objectives.
- The CN/DIPC works in close collaboration with the Consultant Microbiologist/ Infection Control Doctor (ICD) and Assistant Director Infection Prevention and Control(ADIPC) (who is an infection prevention and control nurse specialist) incorporating national guidance into local policy, monitoring key performance indicators(KPIs) and compliance with the Infection Prevention and Control Annual Plan. The CN is the ADIPC line manager.
- The ICD provides a source of expert microbiological, and IPC advice and supports the DIPC. The ICD takes the lead in all medical matters relating to infection prevention and control as well as professional and operational lead for the IPC Medical Team.
- The ADIPC has responsibility for the operational management of the IPC Team and for ensuring Infection Prevention and Control is embedded within the Trust. The ADIPC also provides a source of expert IPC advice and is responsible for ongoing development and evaluation of communication strategies at Trust and Divisional levels aimed at facilitating infection prevention policies, guidance and practice. This role works closely with the DIPC and ICD.

3. Infection Prevention and Control Team Nurse and administrative staff (IPCT) establishment

The Trust serves a population of approximately 550000 people in Hertfordshire and North London, with inpatient beds at Watford General Hospital, St Albans Hospital, with minor injuries and outpatient services is also provided at Hemel Hempstead general hospital.

The IPCT establishment whole time equivalent (WTE) is;

- 1.0 WTE Assistant DIPC retired in August 2013 (Band 8), A 1.0 WTE Interim Assistant DIPC came into post on the 20th August 2013, ADIPC post was recruited into and commenced on the 8th January 2014
- 1.0 WTE Lead Nurse Infection Prevention and Control (band 8) from February 2014
- 1.0 WTE Senior Nurse Infection Prevention and Control (band 7) resigned 20th of August 2013.
- 1.0 WTE Infection Prevention and Control Nurse (Band 6) x 1
- 1.0 WTE Infection Prevention & Control Support Worker band 3 x1
- 1.8 WTE Team Administrative Assistants (Band 4).
- The IPCT was also supported by the Deputy Director of Nursing

4. Infection Prevention & Control Doctor/ Consultant Microbiologist

Infection Control Doctor/Consultant Microbiologist x1 and two other Consultant Microbiologists, The 3 consultant microbiologists, all play a key role in infection prevention and control.
An antimicrobial pharmacist is also part of the IPCT.

5. The Trust Infection Prevention and Control Committee (ICC)

The name has now changed to Infection Prevention and Control Panel
The Committee met monthly and was chaired by the CN in her capacity as the DIPC. The Infection Control Committee is the main forum for monitoring and delivery of the IPC strategy as well as the development and implementation of a Trust wide annual HCAI action plan. The Committee had the following groups which each provided regular reports to the committee meetings:
Bi weekly Healthcare Associated Infection (HCAI) group

- Antibiotics Group
- Trust Water Safety Group

The Terms of Reference for the ICC can be found in Appendix 1. These are reviewed yearly.

6. Mandatory Surveillance Reporting of Healthcare Associated infections (HCAI)

The Department of Health requires mandatory surveillance of specific categories of healthcare associated infections (HCAI). This allows national trends to be identified and can be used as a measure of progress within a Trust and an indicator of standards.
The Trust is required to report on the alert organisms indicated below:

- MRSA (methicillin resistant staphylococcus aureus) bacteraemia
- Clostridium *difficile* infection (CDI).
- *Escherichia coli* (E.coli) bacteraemias
- MSSA (methicilin sensitive staphylococcus aureus) bacteraemia

National mandatory reporting for these organisms is co-ordinated by the Public Health England (PHE) using a Data Capture System (DCS).

The IPC nursing team perform a daily review of all alert organisms and report any alert organisms that are identified. The system allows prompt recognition of any organisms / infections that could be spread to others and also the recognition of outbreaks of infection.

In line with Department of Health (DH) guidelines, patients admitted to the hospital are screened for MRSA. This enables early isolation and treatment if the patient is identified as being colonised with MRSA, hence reducing the risk of colonisation and infection for all patients. Patients identified as MRSA positive in the pre-operative assessment clinic are treated prior to surgery where possible.

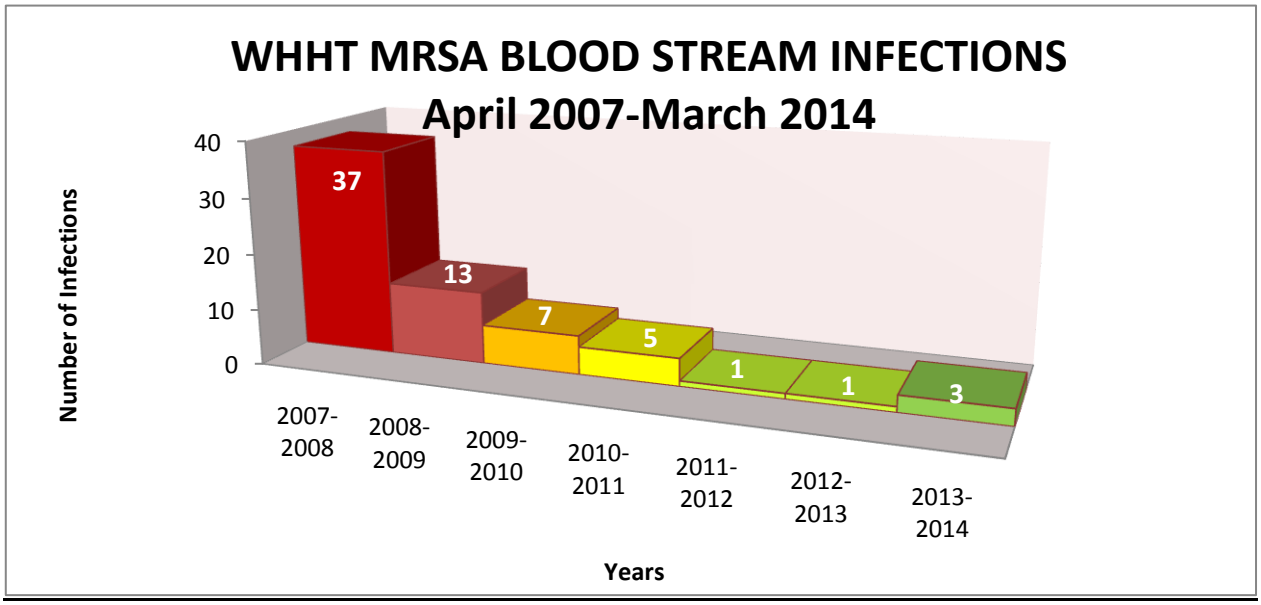
7. MRSA bacteraemia:

The DH began mandatory surveillance of MRSA bacteraemia in 2001 by all NHS Trusts in England. In 2003 the DH set a target of a 50% reduction in MRSA bacteraemia to be achieved by 2007/8. The trajectory set for the 2013/14 financial year was zero avoidable MRSA bacteraemias. The government has set organisations to deliver zero tolerance on MRSA bloodstream infections.
For all cases of MRSA bacteraemia a Post Infection Review (PIR) is carried out. The purpose of the PIR is to identify how a case of MRSA bloodstream infection occurred and to identify actions that will prevent it reoccurring.

Three bacteraemia were reported in 2013/2014. Following PIR meetings, Learning points from these were shared through the Infection Prevention & Control Panel meeting and discussed at Divisional governance meetings. IPC Team maintains a MRSA Action/Tracker log to track the actions identified from PIR meetings.

7.1 Post 48hrs MRSA bacteraemias:

The graph below shows the MRSA bacteraemias from 2007 to March 2014.



8. Methicillin Sensitive *Staphylococcus aureus* (MSSA) Bacteraemias

Like MRSA, meticillin-susceptible *S. aureus* (MSSA) bacteraemias are subject to mandatory reporting. There were 7 reported cases of MSSA bacteraemia identified as Trust attributable during the period of April 2013 - March 2014. Currently there are no targets set for the MSSA bacteraemias.

Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
1	1	1	0	0	2	0	0	1	1	0	0

9. Escherichia *coli* bacteraemia

The reporting of Esherichia *coli* bacteraemia became mandatory in June 2011. Currently there are no targets set for this condition. Over the year 34 Trust attributed Escherichia *coli* bacteraemia have been identified as Trust attributable during the period of April 2013 - March 2014.

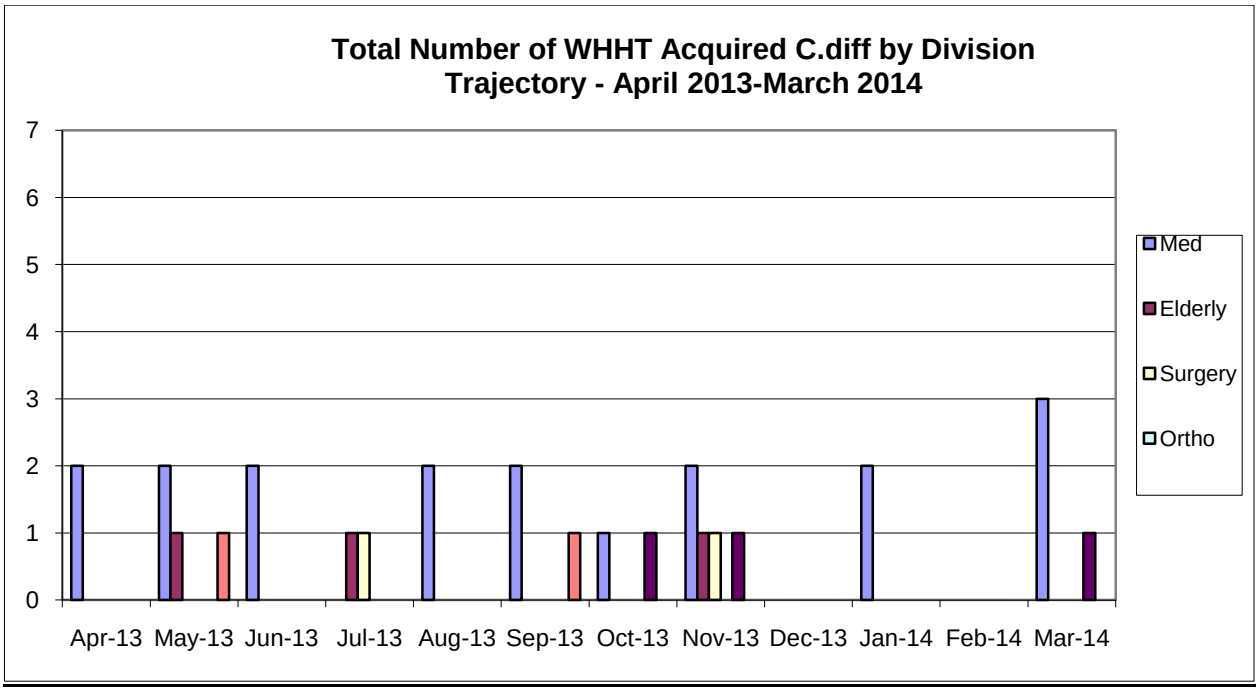
Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
0	1	2	5	4	7	2	1	2	2	6	2

10. *Clostridium difficile* (Mandatory Surveillance)

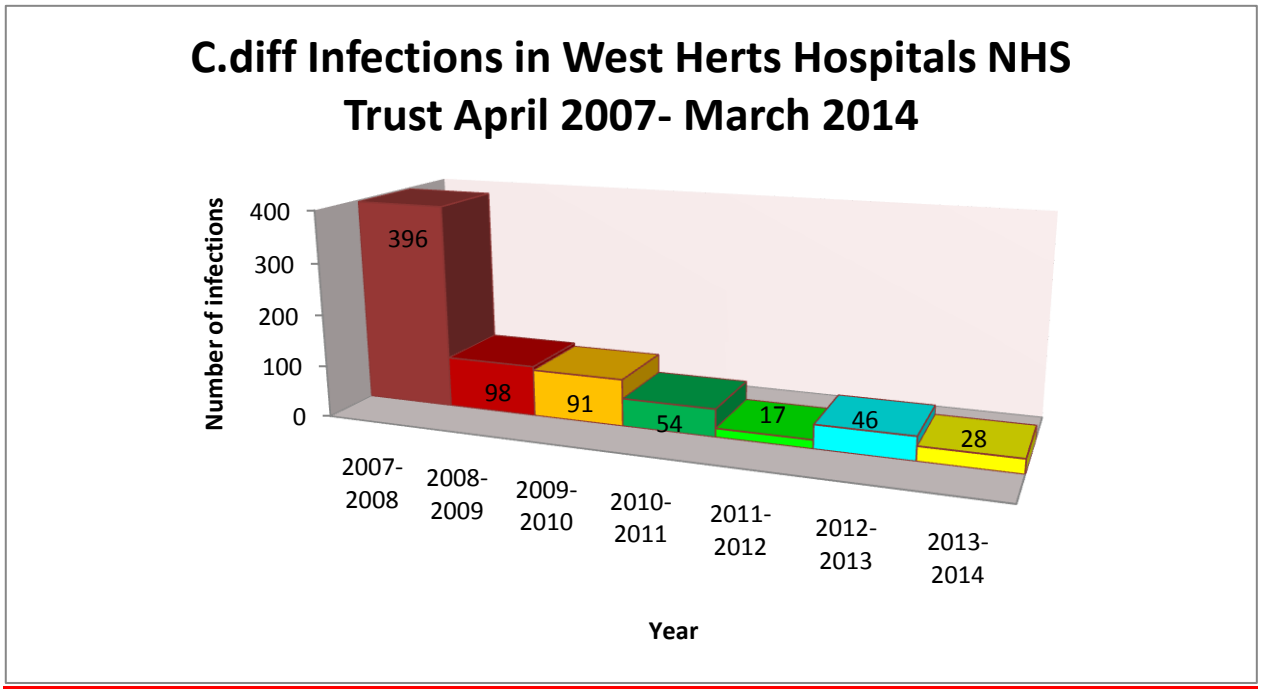
The *C.diff* trajectory for WHHT during the year 2013-2014 was 24. There were 28 West Herts acquired *C.diff* isolates from April '13 –March '14 (in comparison with 46 in the previous year) therefore significant reduction in hospital acquired C.*diff* cases even though the Trust exceeded the trajectory. No obvious cause for this increase has been identified; however there has been an increase in patient numbers over the last year. Audits and education remain on-going.

Figure 2 below identifies the total number of *C.diff* isolates – inpatients by division, hospital & community acquired for the year 2013-2014.

Figure 2 . WHHT *Clostridium difficile* cases



The graph below shows the CDI cases from 2007 to March 2014.



11. MRSA screening compliance:

It is the DH requirement that all patients being admitted for planned and emergency admissions should be routinely screened for MRSA to identify their MRSA status and prompt isolation and commencement of decolonisation protocol.
Mandatory MRSA screening continues for both elective and emergency admissions with the exception of some low risk areas.

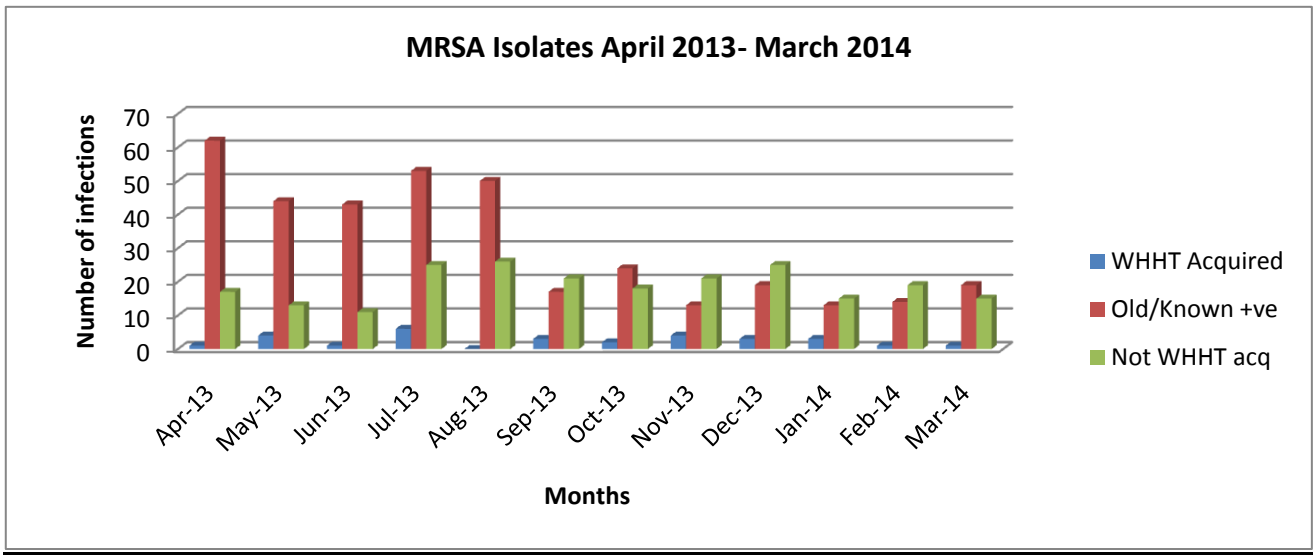
Table 1. % Compliance for elective admission screening April '13 – March '14

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
% Compliance	97.6	99.2	99.3	99.1	99.5	99	99.5	98.9	99.1	98.8	98.9	98.7

Table 2. % Compliance for emergency admission screening April '13 – March '14

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
% Compliance	92.9	93.1	95.2	95.7	95.7	95.5	95.8	95.3	94.3	95.9	95.8	93.8

Figure 1. MRSA Isolates reported in WHHT



12. Orthopaedic Surgical Site Surveillance (Mandatory Surveillance)

It is a mandatory requirement to conduct surveillance of orthopaedic surgical site infections. The PHE healthcare associated infection and antimicrobial resistance department (HCAI & AMR) run the surgical site infection surveillance service (SSISS). The data collected is forwarded to the PHE for analysis and reporting. The system is controlled and validated to allow comparisons between hospitals. There are 12 defined categories of surgical procedures within the national SSIS programme, but orthopaedic SSIS has been mandatory for all Trusts to perform since 2004/05.

- Trust wide continuous total hip and knee replacement surveillance (mandatory requirement fulfilled)
- Regular Surgical site infection committee (SSIC) meetings in division of surgery chaired by the SI lead Ortho surgeon

- Extension of Breast Surgery SSI surveillance at SACH April to June 2013 following outlier notice from PHE. Development and publication of prophylactic antibiotic policy (ratified March 2014)
- Benchmark of Spinal Surgery rate of infection July to September 2013
- Surgical site infection prevention nurse (SSIPN) involvement in Theatre refurbishment/maintenance programme at SACH & WGH (commencement November 2013)
- March 2014. SSI surveillance and prevention notice boards visible in Theatres and Clinical areas at SACH
- Orthopaedic Extraordinary review October 2013 in response to increased number of THR SSIs at WGH
- SSIPN key role in Orthopaedic Microbiology MDT from October 2013 following Orthopaedic Extraordinary review
- Remodelling of SSI Prevention Infoflex database January 2014
- Peer support – visit from St George's hospital February 2014

13. Incidents and Outbreaks of Infection

One of the main roles of the IPC Team is the prevention and management of outbreaks of infection.

Outbreaks of infection continue to be the major cause of infection related incidents in any hospital in the United Kingdom. An outbreak is defined as two or more patients presenting with the same symptoms of a communicable disorder connected by place and time. Outbreaks were identified on 5 wards within the Trust during the period of April 2013 – March 2014.

8.5 **April 2013** – there was *Serrata* outbreak in the Special Care Baby Unit.This has been reported as a Serious Incident. Typing results came back as four samples were indistinguishable**.** None of the environmental screening swabs identified *Serratia.*

13.2 June 2013 – Diarrhoea and vomiting.Samples for all patients have been sent to Cambridge for enhanced Norovirus testing and they came back as negative.

13.3 September 2013- There was MRSA transmission involving three patients on ITU. Typing results for the 3 WHHT acquired patients were all the same. There was staff screening for MRSA. Aldenham ward including two patients and both supporting evidence of some transmission.

13.4 November 2013- Period of increased incidence (PII) of CDI on Aldenham ward with 027 strain. There was evidence of some transmission. Full investigation, isolation, deep cleans was undertaken and further transmission identified.

13.5 March 2014 – Clostridium *11ifficile* outbreak which was related to time, place and ribotypying. There was evidence of some transmission. In ITU with two patients both confirmed with ribotype 258, again full investigation isolation training education by IPCT and no further transmission was identified.

14. Carbapenem-resistant bacteria:

Carbapenems (such as Meropenem) are a powerful group of broad-spectrum antibiotics which are often the last effective defense against multi-resistant bacteria. Infections with Carbapenem-resistant enterobacteria are an emerging threat. It is seen mainly in the Indian subcontinent but has also been reported in the Mid-East, North Africa, Europe and the USA. In this country, less than 100 cases have been identified by the Health Protection Agency (now PHE) with bacteria that are Carbapenem-resistant. Many have been associated with patients who have received prior treatment abroad, in India or Pakistan, but there are reports of a few incidents of cross infection in the UK. In December 2013, PHE issued the "Acute trust toolkit for the early detection, management and control of Carbapenemase-Producing Enterobacteriaceae (CPE)**.** The toolkit requires that the Trust should have a dedicated pre prepared plan to prevent the spread of CPE. The toolkit required that certain measures relating to screening, identifying, isolating and managing suspected or confirmed cases are in place by the end of June 2014. The Trust is fully compliant with the toolkit.

15. Water safety Group

The DH issued an Addendum to the current HTM 04-01 – Pseudomonas aeruginosa – advice for augmented care units, in March 2013. Following this the trust formed the Water Safety Group (WSG). During the year the group has met. Water sampling undertaken in the* locally agreed protocol, and routine water flushing in clinical areas training and education provided by external authorised engineer for matron/ward managers, estates staff and other key personnel. The Water Safety group is chaired by the DIPC.

16. External Visits:

16.1 CQC visits

There was 1 unannounced CQC visits to the Trust specifically in relation to infection prevention in December 2013.

16.2 NHS Trust Development Authority (TDA) and Clinical Commission Group (CCG) visits.

The NHS Trust Development Authority (TDA) was formed in 2013 and is responsible for providing leadership and support to the non-Foundation Trust sector of NHS providers. The key functions of the TDA include monitoring performance and providing support, this includes clinical quality, governance and risk.

Between April 2013 to November 2013 there were several visits by the TDA and CCG in the year, Due to the rise in hospital acquired *C.diff* infections, the Trust Development Authority and Clinical Commissioning Group visited the Trust to review practice and procedures. Actions identified by TDA and CCG and have been addressed and continuously addressing through a Trust C. *diff* Action Plan which later developed into Trust Infection Prevention & Control Action Plan for the full report of the visits, see Appendix 2.

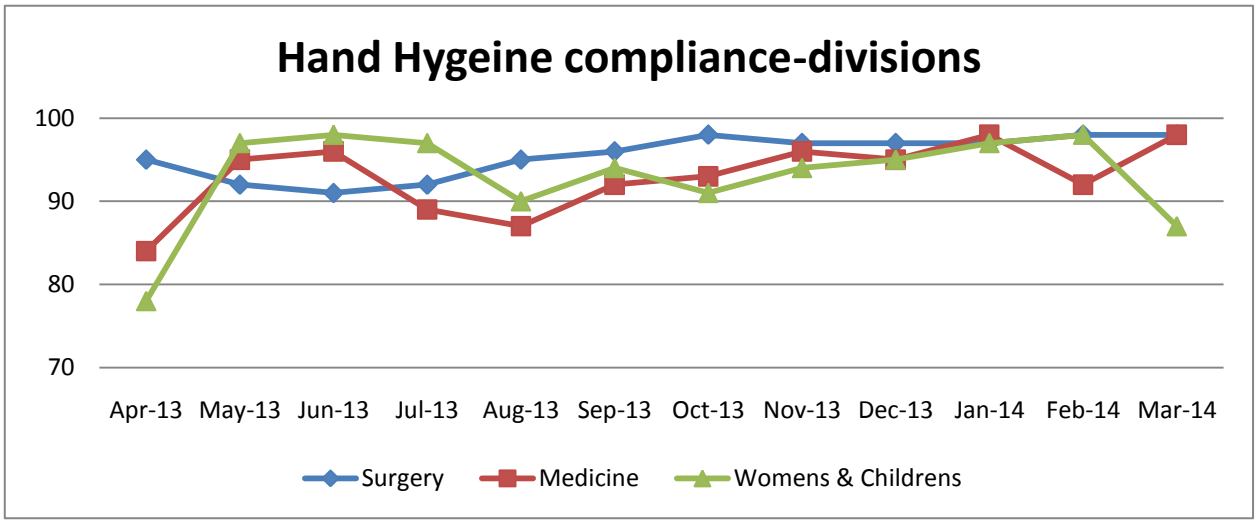
17. Antimicrobial stewardship

It is important that antimicrobials are used appropriately. Inappropriate use can increase the risks of acquiring healthcare-associated infections, such as MRSA and *C. difficile*. It can also promote antimicrobial resistance which can reduce the efficacy of antibiotics.
An annual point prevalence audit was carried out in November 2013. There was the implementation of the of the care bundle across the trust.

18. Hand Hygiene

Effective hand hygiene remains the single most important intervention in the reduction of HCAI.
Hand hygiene continues to be monitored on a weekly basis and results are displayed on departmental notice boards. Areas of concern are visited by a member of the infection prevention and control nursing team. Repeated non-compliance is fed back to the relevant senior staff, the heads of nursing/midwifery include the work compliance in the divisional exception reports with action to complete

Figure 3. Hand Hygiene Audits - Overall Compliance April '13 – March 14



19. Policies and Procedures

The IPC team continued to review and revise the Trust's IPC policies during 2013-2014 in line with the review date and as part of the strengthening of clinical governance arrangements to convert them to clinical guidelines.
Policies and procedures are up-dated as required and are available on the Trust Intranet site. Compliance with these policies is monitored through audits, root cause analysis and surveillance. This enables timely provision of infection control data and feedback to individual divisions. All related guidelines have been renewed and on the IPC intranet site

20. Environment

The 12-week rolling programme for environmental deep cleaning of in-patient areas continues, including the acute assessment unit. Progress is presented at each ICC, and ongoing challenges due to capacity and lack/absence if decontamination facility has impacted on the success of this progressive in

21. Audits

A number of audits have been undertaken during the year which include:

Table 3. Audits undertaken April '13 - March 2014

Audit	Date	Frequency	Undertaken by:
Sharps audit	April 2013	Annual	Daniels Healthcare
Commode audit	On-going	Weekly	IPCT
Environmental audits	On-going	6 monthly	Ward mangers/matrons
Hand Hygiene audits	On-going	Weekly	Wards/Departments
Hand Hygiene audits	As required	As required	IPCT
Hand Hygiene audits	On-going	Ad-hoc	Gojo

Audit results are disseminated to departmental heads and matrons for cascading within their clinical area. Where appropriate, results are also sent to infection control link persons.
Actions to address area of non compliance are taken by the division and actions include in the trust action plan 2013-2014.

22. Training

Staff training has continued throughout the year, both formally and informally. Much of the education is ad-hoc on a daily basis when IPCN's visit wards/departments and e-learning is also available for bi-annual mandatory infection control training. This training data is not all included in the figures below.

A total of 1648 members of staff received training by the infection control nurses throughout the course of the year. This includes induction, three yearly mandatory training, study days, courses and infection control training sessions. Unfortunately due to lack of delegates, the February, *C.diff* study session was cancelled and only one member of staff attended one of the four pre-planned ward based education sessions. The reason for poor attendance was due to the inability to release staff from the clinical areas. The mandatory sessions were provided upon direct request of the director of HR for October 2013 –March 2014.

Infection prevention and control awareness days were undertaken in conjunction with 'Think clean' week from the 29th April to 3rd May 2013. Various topics were covered. This is directed at raising awareness of infection prevention and control and is directed towards staff and visiting public. Competitions and other events were included in the days to encourage participation with an element of fun.

23. Infection Prevention and Control Link Practitioners

There were 6 link practitioner meetings in the year, various topics discussed.

24. Future Priorities & Direction - 2014/15

- Provide infection control training for both induction and mandatory for all disciplines of staff. This will be available formally and via e-learning.
- Maintain a high visibility in the clinical areas.
- Introduction of the new hand hygiene audit tool and train all auditors on the use of the new tool.

- Continue to raise awareness amongst staff regarding the importance of hand decontamination in the prevention and control of infection in all educational sessions and on routine visits to clinical areas

- Continue to deliver the infection control single study days, six day infection control awareness course and *C.diff* study programme.

- Maintain a programme of audits to determine Trust compliance with key infection control policies and procedure

- Maintain current surveillance systems and review as appropriate.

25. Recommendation

The Trust Board is asked to note the contents of the annual report.

Appendix 1 INFECTION CONTROL COMMITTEE -TERMS OF REFERENCE

Status: Sub Group of the Business Integrated Standards Executive

Chair: Director of Infection, Prevention & Control

Membership:
Infection Control Doctor (Deputy Chair)
Director of Nursing
Assistant Director Infection Prevention & Control
Infection Control Nurses
Consultant Microbiologists
Consultant in Communicable Disease Control
Occupational Health Manager
Clinical Champions (Doctors)
Heads of Nursing/Midwifery
Matron Representatives
Director of Estates & Facilities/Trust Decontamination Lead
Antimicrobial Pharmacist
Chief Pharmacist/Deputy
Patient & Public Panel Representative
Lead Nurse, Infection Control – CCG
Capacity Manager
Surgical Site Infection Surveillance Nurse
Head of Information

This core membership should be supplemented by appropriate staff with managerial responsibilities or experience pertinent to particular agenda items for such time as the particular item is under discussion.

Frequency of Meetings: Monthly

Quorum: 6 (Must consist of DIPC or Infection Control Doctor, Infection Control Nurse, Microbiologist & Divisional Representatives)

Compliance with The Health & Social Care Act, Code of Practice for the Prevention and Control of Health Care Associated Infections 2008 (2010) **which outlines 10 compulsory duties to prevent and manage healthcare-associated infections by:**

- Agreeing a Programme of work for ICT
- Undertaking regular self assessments of compliance with the Hygiene Code
- Reviewing the HCAI Action Plan and health economy strategy for HCAI's
- Reviewing the HCAI programme of work and audit schedules

1. Remit

The remit of the Trust Infection Control Committee is to:

- Strengthen the prevention and control of infection in the Trust
- Improve surveillance of hospital infection
- Monitor and optimise antimicrobial prescribing

The Trust Infection Control Committee will:

- Endorse all Infection Control Policies, Procedures, and Guidance

- Provide advice and support on the implementation of policies, and monitor the progress of the Annual Infection Control Programme

- Provide assurance to the Trust Board that the MRSA & *C.diff* Action Plans are being driven throughout the organisation

- To communicate through the Divisional Infection Control Leads, the actions being taken forward and further actions that need to be embraced to achieve compliance/progress

- To support the use of best practice to prevent and manage the spread of infections and ultimately improve patient and service user safety

- To ensure that the Trust provides a safe environment, in terms of infection risk and within the sphere of current knowledge, for patients, staff and visitors

- To ensure that specific and appropriate attention is given to serious incidents to manage them effectively

- To assist in the review of any Service Level Agreements for contracted, commissioned or provided services relating to infection control

- To ensure that robust plans for the management of outbreaks of infection are in place and to monitor their effectiveness

- To monitor and review compliance with CQC Outcome 8 Cleanliness and Infection Control; escalating any areas of non compliance

- Ensure that the national and local Infection Prevention Control Policies are implemented in line with the Heath and Social Care Act (2008), CQC Regulations(Outcome 8) and Saving Lives, in partnership with other healthcare providers.

- Ensure the group links with existing Government / Department of Health, Local and Trust initiatives and directives which includes:

    - MRSA, MSSA, *E.coli* and C. *diff* reporting
    - Hygiene Code Duties

2. Accountability

The Trust Infection Control Committee will report directly to the Business Integrated Standards Executive.

3. Organisational Responsibilities

The Chair of the Trust Infection Control Committee will be a member of the Business Integrated Standards Executive and will maintain a direct link thereby providing assurance of the progress of the infection control agenda within the Trust.

The following groups will report directly to the Trust Infection Control Committee:

Local HCAI Meeting
Trust Water Management Committee
Antibiotic Committee
SSI Steering Group

4. Responsibilities

4.1 Secure appropriate arrangements for the control of hospital infection:

- Ensure senior management and board level commitment
- Review service agreements on hospital infection control
- Secure appropriate composition and functioning of hospital Infection Control Team, including support staffing and resourcing
- To seek assurance of governance arrangements in relation to decontamination, including hospital cleaning programmes and performance (PEAT) and assurance that the Trust is meeting statutory regulations in this respect
- Ensure that programmes for the control of infection are in place and working effectively
- Ensure that appropriate infection control policies and procedures are in place, implemented and monitored
- Ensure that education on infection control is included in induction and orientation programmes for all Trust staff
- Through relevant staff, oversee and monitor infection control policies, procedures and processes by ensuring compliance with the Health and Social care Act 2008.

4.2 Improve quality of service provision through clinical audit and continuing professional development (CPD)

- Review the infection control content of clinical audit and CPD programmes for Trust staff, including the Infection Control Team

4.3 Secure a safe clinical environment through:

- High standards of hygiene and general cleanliness of the hospital environment
- Consideration of infection control issues in service developments, by:
    - Ensuring appropriate contracts are in place and monitored and
    - Involving Infection Control Teams in service specification, including building works and purchase of equipment

4.4 Ensure that microbiology services meet the infection control and public health Surveillance needs by:

- Ensuring that appropriate and timely information is provided to the Infection Control Team
- Ensuring that laboratories report regularly to the Health Protection agency Communicable Disease Surveillance Centre
- Ensuring appropriate staffing and IT support to undertake surveillance

4.5 Ensure that appropriate surveillance is being undertaken by:

- Implementing a programme of surveillance based on a risk assessment and contemporary epidemiological evidence of prevalence and incidence

4.6 Utilise surveillance data to guide the control of infection by:

- Review information outputs on infection rates and delivery of control measures at local, hospital and Trust level (including benchmarking comparisons with other providers) and ensure that clinicians, managers and CCDCs are provided with appropriate and timely information

4. Monitor and 19ptimize antimicrobial prescribing by:

- Promoting optimal prescribing to contain and control antimicrobial resistance

5. References

Department of Health Operating Framework for NHS England 2009/10 – Operating Framework for 2012/13
https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13

Department of Health (2008). *Clostridium Difficile Infection: How to Deal with the Problem*. London: Department of Health

Department of Health (2010) The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. London: Department of Health https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Department of Health (2008). *Clean, Safe Care: Reducing Infections and Saving Lives*. London: Department of Health

Department of Health (2010). *Saving Lives: Reducing Infections, Delivering Clean and Safe Care – Isolating Patients with Healthcare Associated Infections 2008.* London: Department of Health

These Terms of Reference will be reviewed annually

Review of Terms of Reference to take place in April 2014

Appendix 2 TDA Healthcare Associated Infections (HCAI) Feedback Report

Healthcare Associated Infections (HCAI) Feedback Report.	
Trust:	West Hertfordshire Hospital Trust (WHHT)
Visit Dates:	4th&15th April 2013. 1st May 2013 17th June 2013 alongside the CCG 29th July 2013 alongside the CCG 11th December 2013 alongside CCG
	Trust Development Authority: Dr. Debra Adams, Head of Infection Prevention and Control (Midlands and East) **WHHT:** Sam Jones; Chief Executive Office

	04/04/13	15/04/13	01/05/13	17/06/13	29/07/13	11/11/13
Jackie Ardley; Interim Director of Nursing/Director of Infection Prevention and Control (DIPC)	Not in post	Not in post	Not in post	Not in post	yes	yes
Maxine McVey; Interim Director of Nursing/Director of Infection Prevention and Control (DIPC)	yes	yes	yes	yes	yes	yes
Francis Stratford; Assistant DIPC/Infection Prevention Nurse	yes	yes	yes	Post advertised	Post advertised	
Jiovanna Foley; interim Assistant DIPC/Infection Prevention Nurse						yes
Dr Robin Wiggins; Consultant Microbiologist	yes	yes	yes	yes	yes	yes
Sabita Parida; Consultant Microbiologist	yes		yes	yes		
Prema Singh; Consultant Microbiologist			yes	yes	yes	yes
Tejal Vaghela; Antibiotic pharmacist	yes		yes	yes	yes	
Manwar Hussein; Head of Cleaning, Medirest	yes					

Louise Gaffney				yes	yes	
John Facer, Interim Head of Facilities						yes
Lisa Loveridge Occupational Health Lead						yes

Ward staff/Matrons

Jan Norman; Exec Nurse HVCCG visited in collaboration in June and July 2013.
Fiona Simpson; Head of IPC HVCCC December 2013

Criteria 1:Executive leadership.

EXECUTIVE LEADERSHIP

April 2013: The CEO is fully supporting and driving the agenda for HCAI to ensure the Trust identifies and implements robust infection prevention and control (IPC) strategy that will reduce and sustain improvement across the organisation for 2013/4. This approach from the CEO is welcome and appreciated in all staff members across the Trust and is part of the "Operation Onion strategy-peeling back the layers.....and in summary, it is listening to our clinical and non-clinical staff and looking at immediate changes we can make to ensure our patients are treated quickly, efficiently and correctly, first time".
Every staff member approached was proud to work in the organisation.
The pace of the changes and the need to provide sufficient and appropriate resources that are requiredare fully endorsed by the CEO.
It was noted that some of the Senior Trust staff were wearing stoned rings, nail polish, wrist watches etc. This should be reviewed, and a culture of these staff of being role models developed.

THE DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) :

April 2013: This role has recently passed to, Maxine McVey; Interim Director of Nursing/ DIPC.
She is aware of the concerns surrounding the provision of high quality, sustained IPC for patients within WHHT.
The need for robust: IPC Action Plan; Annual Programme of Work; Roles and Responsibility awareness of staff; Detailed policies, Prompt, appropriate identification of incidences and outbreaks, and an Audit Plan are priorities for the organisation.
Furthermore, she is aware that Trust Board papers will need to be reviewed to ensure appropriate information is reported.

July 2013;This role has recently passed to, Jackie Ardley; Interim Director of Nursing/ DIPC.
Following the visit assurance was provided that the new interim DIPC is aware of the issues as identified above.
Feedback had been provided prior to the meeting regarding Outcome 8 self assessment- assurance was obtained that this had been reviewed.
We requested information as to whether non-exec Directors (NEDs) undertook clinical visits. Jackie Ardley informed us at present they had not visited the clinical areas. However, she was introducing a system where visits would be undertaken. We advised that these visits should be productive and that the NEDs could be appropriately trained so that they were aware of what to look for on the visits. Verbal assurance was provided that the NEDs would be trained and that each visit would map a CQC outcome in order that the Board would receive compliance assurance or escalation of non-compliance

The delivery of these objectives requires the continued support of the Executive to ensure that a board to ward and ward to board approach drives the motivation for change.

August 2013; telephone call with Jackie Ardley. Jackie confirmed that the Maxine McVey is taking the lead on progressing HCAI in the trust. 50% of her time will be allocated to this. This will enable the Trust to develop sustainable HCAI strategies. In addition, Jenny Wilson will continue with the trust in expert advisory capacity. Furthermore, a Lead Nurse with previous IPC experience has been seconded into the post for a 3/12 period, to provide interim cover until the post is filled.

May 2013; IPC Executive support has been organised by the Trust. Jenny Wilson (Reader at University of West London)will be working with the Trust to review IPC, governance and assurance. Eight days support over eight weeks has been arranged to commence this week.

Nail polish and rings were not visible on this visit
Action Plan- this is currently being worked upon.

June 2013; The Action Plan is now up and running. However, both the TDA and CCG would advise that this is made more detailed with evidence of what actions are being undertaken. Furthermore, names in addition to roles should be included under the responsibility section.
Environment; a large piece of work utilising the IPSaudit tool has been undertaken by Head of Nursing for Medicine- this provides the Trust with a baseline of key risks from which to identify future plans for; estates, training, equipment etc.

July 2013;The action plan was reviewed with Robin Wiggins, Maxine McVey, IPC nurse andTejalVeghela . We recognise that work is on-going and the plan and that the Trust is looking at a new process to ensure this a “live “document. As discussed by the TDA and the CCG areas still require more detailed evidence of the actions which are on-going in the Trust. Concern was raised at the meeting regarding the rag rating of

some items as they were appearing as amber but had breached the agreed dates completion dates. It was agreed at the meeting that this would be rectified and MaxineMcVey and Katrina (IPCN) would re-assess and ensure up-to-date accuracy of this report.

LEGISLATION;

May 2013; confirmation requested that the Trust will be compliant with the new Sharps directive which comes into law on 11 May 2013 as it was not evident that the DIPC/Lead Nurses were aware of the requirements.

June 2013; A group has been set upand the Trust is demonstrating action on this.

July 2013;at the Action Plan reviewdiscussion was held regarding assurance that the aseptic suite pharmacy department had been included in the assessment as these areas are often re-capping sharps as part of their standard procedures. Tejal, Katrina and Maxine McVey agreed to follow this up and provide assurance.

INFECTION PREVENTION AND CONTROL NURSE TEAM:

April 2013;The team consists of:

- 8Bassistant DIPC/Infection Prevention Nurse.This role appears to be required to provide both Strategic and Operational delivery. A review of the role with clear requirements may provide more clarity. The post holder was observed appropriately challenging poor practice and escalating concerns.
- Band 7 x 1 RN WTE.
- Band 6 x 1 RN WTE.
- Band 4 x 1 PA admin. WTE.
- Band 4 x 0.6 hrs Data administrator (3 days per week) .
- Band3 x 1 Health Care Support Worker WTE

The team has had the opportunity to attend conferences and study days. However, they have worked in the Trust along time and would benefit from opportunities to learn from other organisations outside their region.

The team describe a traditional approach to IPC management by attempting to undertake the vast amount of IPC work that I would expect to see owned at ward manager, Matron and Directorate level.

May 2013; this is still to be identified.

June 2013; The Lead nurse is retiring and the Band 7 has handed in her notice. Until these posts are advertised and appointed to a Band 8 with IPC experience who currently works in the Trust will be seconded in to support the team. However, this will still leave the Trust at risk and it was advised that this is included on the Trust risk register until all appointments are made

July 2013;Candidates for Band 7 and 8B have been shortlisted. Interviews are being held in August 2013.
August 2013 e-mail update; these posts have been re-advertised. The post is advertised as an *B/C depending upon experience.

IPC COMMITTEE
April 2013;The IPC committee is currently under review to ensure that the correct people are identified to report into this structure and ensure assurance. The recent visit identified that there is a discrepancy between the information provided and the level of quality provided in the clinical areas.
May 2013; this is under review and will be supported from advice from Jenny Wilson to ensure appropriate Governance.
The last two meetings minutes and attendance has been reviewed. It is understood that this meeting is now being urgently reviewed in terms of attendance, reports and escalation, to ensure appropriate assurance and governance is in place.

June 2013; Sam Jones (CEO) will review the structure and the IPC papers which are currently being sent to the Board.

July 2013;The 1st meeting with the new structure was held on the 29th July 2013. Whilst the TDA did not attend for more than 15 minutes, the meeting was very well attended (professions of those attending will be reviewed at a later date). There was clear feedback and ownership at Matron level with individual verbal reports being received in response to the newly developed dashboard.

HEALTH ECONOMY WORKING
There is a Health economy Group which the Trust attends. However, it is felt to be more confrontational than supportive. This issue has been discussed with the Exec Nurse at the CCG who supports this to some extent. Therefore, we are aiming to change the format of this meeting, set up a short life working group to look at C. difficile across the HE based around successful approaches introduced in other areas.
May 2013; meeting attended by the TDA and the format was developing a strong HE approach to IPC

DECONTAMINATION LEAD.
This was not investigated at this visit. However, there are named leads in endoscopy.
July 2013;Both the CCG and the TDA have requested a visit to theatres and the decontamination area in the future. The CCG has recently appointed a HCAI lead who will commence in post in October 2013 and it is proposed and agreed by Jackie Ardley that this will be facilitated after this date.

RISK ASSESSMENT
Patients are identified as having diarrhoea using the Bristol Stool Chart which was introduced in December 2012. This should be included in the C. difficile policy.

May 2013; advised that the C. diff policy has been re-written and that advice is being sought from the health economy for advice on other policies. It was advised that Jenny Wilson will also be reviewing these to ensure all policies were appropriate
June 2013; Policies are still being reviewed- this needs to be prioritised. However, due to staff changes this may be difficult. The CCG has supported this by providing a collection of policies for the Trust to adapt.
July 2013;assurance was received at the meeting from Maxine McVey that all the IPC policies were in date and that in specific relation to the C. difficile policy that this was being approved by the Trust. The Trust acknowledged at the action plan review meeting that the remainder of the policies would be reviewed over the next 12 months to ensure they are compliant with the latest guidance. At present the priority was being focussed in other areas. The CCG have offered a set of policies to the Trust to use and have also suggested that their HCAI advisor may be able to offer assistance to the Trust

DATA MANAGEMENT
The Trust has recently introduced a new Root Cause Analysis review. This appeared to be well attended and lessons identified. The process still requires tweaking in order to cover all aspects e.g. staffing levels on the ward. Furthermore, trending of findings is required to identify themes.
C. difficile associated mortality was still being reviewed; issues which had been identified by the Trust included education of Junior doctors when completing death certificates and completing the years mortality data. This was currently reported as; Seven death certificates recorded *C. difficile* infection in part 1 (direct cause of death) and 13 in part 2 (Contributing to the death).
May 2013; 30/7 all cause C. diff mortality. C. diff mortality has been reviewed by the Trust. It is advised that 30/7 all cause C. diff mortality is reviewed both by the Trust and the Health Economy.
It was identified that the Trust is now reporting all C.diff associated mortality on part one of the death certificate as a Serious Incident as per requirements.
June 2013; The CCG and the Trust has confirmed that mortality has been reviewed and is now a standing item for review.
July 2013;Maxine McVey and Robin Wiggins confirmed that a business case had been developed to look at the implementation of ICNet in the Trust to facilitate with the data management required by all IPC teams now. A discussion was held that this is something the Health Economy may wish to look at. This will be discussed at the next Health Economy meeting.

Criteria 2: Clean and appropriate environment.

April 2013; Visits were undertaken to; Stroke Unit, Stroke Ward, Croxley,Sharratt wards and the isolation suite.
This is an old hospital- work is needed on the estate as paint was peeling, ends were missing of fascia boards etc.
The wards wereextremely cluttered which would seriously impede cleaning and therefore did not support the assurance that wards were

regularly deep cleaned.
There is insufficient storage on the wards.
The Trust did utilize Hydrogen Peroxide- but due to the high bed capacity it was difficult to empty the ward and this had to be undertaken by closing bays and moving patients into corridors on some occasions.
Evidence was observed that some of the Matrons/Ward Sisters were not aware of their responsibilities for cleanliness/ decontamination.
Staff did not display a basic knowledge of infection prevention and control
There is a lack of hand hygiene facility on the isolation unit to provide assurance staff are not carry C. difficile spores out of the unit.
The Equipment was extremely old and not fit for purpose.
Foot operated opening mechanism of clinical waste bins were broken with staff manually opening the bins. In addition the bins were also rusted and therefore could not be well cleaned. This is a serious impediment to hand hygiene in areas which have seen outbreaks of *C. difficile*
Many chairs which were ripped but still in use.
Drip stands were observed covered in tape and with gloves tied around them.
Fans were observed which were thick with dust
No processes were apparent for decontamination of physiotherapy equipment.
Nurses interviewed were not able to differentiate between cleaning and disinfection processes.
Bleach solution was observed decanted into vomit bowls and left on shelves for ease of use in clinical areas.
There appeared to be no assurance that equipment was decontaminated between patients.
May 2013; visits to the elderly care ward, SCBU and a very brief visit to AAU were undertaken. These wards had undergone a major de-clutter and were visibly tidier. The staff when questioned identified a clear shift in the Trust towards IPC. The Directors/CEO were visible and challenging on the wards. New equipment was being trialled and orders had been approved by the Finance Director and equipment was being purchased across the Trust which included; new chairs, waste bins, drip stands etc.

July 2013; At the Action Plan Review meeting we were assured that all equipment had now been purchased for all areas. The Exec Nurse for the CCG requested further assurance from Maxine McVey that this was the case as she had received information earlier that the remainder of the waste bin order had just been processed. Maxine McVey would follow this up and reflect this in the Action Plan.
On the clinical visit it was identified that there is still not sustained practice in documentation of cleaning commodes and making up bleach solutions. The process identified by the staff was that these systems were undertaken daily- however there was gaps in the evidence on the wards. Immediate action was undertaken by the Matron.
Of the three areas visited the resuscitation trolleys had been checked but they were visibly dusty. This was actionedimmediately.

Policies; environmental policies were not reviewed. However, there are concerns relating to the C. diff policy (see notes below).
May 2013; policies were being reviewed and support from the CCG was being provided. It was advised that all IPC policies were reviewed within the next 12 months with priority being given to those identified as essential e.g C. difficile, decontamination etc.

June 2013; Policy review is still required- see text above.
July 2013; Assurance was provided by Maxine McVey that ALL the IPC policies were in date. The proposed review of contents was currently on hold in order to prioritise other areas. However, assurance was provided that these would be reviewed with the next 12 months

CLEANING SERVICES;
April 2013;Cleaning is provided by an external contract; Medirest. The clinical staff are pleased with the level service and staff and managers have no concerns. The cleaners and Medirest managers are embedded within the organisation and feel part of the team

Cleaning includes at least a once daily application 1: 1000 ppm free chlorine in neutral detergent to hard services at least once every 24 hours. Enhanced cleaning is undertaken in the environments of known *C. difficile* cases. Decontamination of side rooms is undertaken by addition of Hydrogen peroxide fogging. A programme of decanting bays for fogging has been increasingly difficult as bed occupancy has run to 100% occupancy on many occasions and the areas are very cluttered.
May 2013; nil to note
June 2013; two issues of concern have been noted. On visiting the isolation suite the housekeeper "cleaned"the whole room with one cloth finishing with the hand wash basin. On another area where microfiber clothes were being used the incorrect method of use was utilized- this meant the same surface was used to "clean" the whole area.
The Cleaning Schedules are from 2009 and the supervisor was unable to tell us whether these were still appropriate.
July 2013;A meeting was held with Louise Gaffney, Robin Wiggins and Jackie Ardley to discuss the concerns relating to the incorrect cleaning methods utilised by the MEDIREST team observed and noted at the previous meeting. This was concerning because whilst the clinical areas appeared visibly clean, incorrect methods utilized meant that in fact assurance could not be confirmed, especially with regards to hand-wash basin cleaning process and the use of micro-fibre process required for use. Assurance from the Trust was received that staff would receive refresher training – however it was not clear how many had received this so far. The Trust would provide information regarding this. Cleaning schedules had been reviewed by the Trust and Medirest. Maxine McVey assured us that these had not required updating since 2009 and were therefore still appropriate.
Louise Gaffney reported that the Trust were moving towards the introduction of the 2007 cleaning standards.
Assurance was given that training of MEDIREST staff included microfiber and the latest pseudomonas guidelines.
Medirest and the Trust had agreed changes to the new contract would be undertaken within 3 months to ensure appropriate training.
Clinical visit findings; high level dust still visible in the three clinical areas visited. This was identified to the Head of Nursing, Matron and Sister on each area. Action was taken at the time.

At the Cleaning review meeting the Trust assured the CCG and TDA that a Water Group was in place and it was good to see that tap flushing compliance was part of the dashboard.

On visiting the wards, which included the HDU area, lime-scale was identified on the taps. This was pointed out at the time of the visit to staff.Hertfordshire may be an area with “hard” water which may cause a build-up of lime-scale relatively quickly. The Trust may wish to look at the frequency of the de-scaling as this, along with the issues identified at the previous visit regarding hand-wash basin cleaning may increase the risk of pseudomonas related infections in the future.
Toilet brushes were examined in each clinical areas. Each brush was extremely well worn and one was nearly bald on one side. The Trust needs to review the frequency for changing these brushes to facilitate staff being able to clean the toilets after patients use.
The wards are sustaining their “clutter free” environment.
Decontamination wipes were available in all areas.
In a public toilet also used by staff outside the ward it was observed that the hand wash basin had mould growing on the back sealant area, a ceiling tile was missing and the panel below the sink was also missing. This was the 2nd panel behind a handwash sink that had been identified (the other was in an isolation anti-room). We were informed by the Head of Medicine that all of this was on the estates plan for 25uctioning.
On HDU the staff were aware of the correct decontamination of nebulizer acorns to prevent the risk of legionella.

July 2013; Waste storage.
On visiting the clinical areas waste is stored outside the ward areas in yellow trucks. The majority of the boxes were unlocked and were easy access to anyone. It is recommended that the Trust discuss this with the portering staff to ensure compliance.

Criteria 3: Information to service users and visitors.

The web site is informative for patients but the data on C. difficile and MRSA only goes up to 2012.
May 2013; no further action had been undertaken on this and remains outstanding for action by the ICT
There are regular IPC patient initiatives and leaflets are available.
June 2013; The web site page has been updated.
July 2013;The web site had been up-dated . This need to go green on the Action Plan

A nurse ward dashboard was observed last updated in May 2011- ward staff were not concerned. We had been assured by the Matron earlier that she undertook a quality ward round each day- this was not evident in practice. Reinforcement of Trust staff roles, responsibilities and accountability is imperative.

May 2013; Ward Matrons had met several times with the DoN/DIPC. Roles and responsibilities had been discussed. Matrons Quality rounds are under development.
IPC dashboard is in development
June 2013; One or two dashboards on the wards were out of date. It was explained that these were no longer used, It was advised that these were removed or updated to stay no longer audited.
July 2013;Again out of date patient facing dashboards (completed March 2013) were identified on the ward. This was immediately removed when pointed out to staff. We would recommend that this is reviewed as part of the quality round .

Criteria 4: Suitable accurate information on infections.

The Trust provided detailed epidemiological analyses including, ribo-typing, bed moves, time line plots of the *C. difficile* cases from April 2012 to March 2013. This clearly identified the patient movement within the Trust is high in order to deal with bed capacity issues and that there is on-going 027 "house strain" which has not been eradicated.

The Trust has an antibiotic formulary and a nominated antibiotic pharmacist who is empowered to question antimicrobial prescribing and to terminate unnecessary prolongation of courses of antibiotics. Improvements were required to reducing use of broader spectrum antibiotics and duration of antibiotic treatment, including improving review and stop dates.

PPI prescribing remains high and could be reduced further.

Antibiotic treatment. The Trust has used oral Vancomycin for treatment of *C. difficile* routinely for at least the last two years. Some cases have also been treated with Fidaxomicin since UK licensure in 2012.

A self-assessment was undertaken in 2011 using the Manchester tool- it is recommended that this is repeated.
May 2013; the Trust will undertake the Manchester re-audit within next 6/52.
Anti-microbial pharmacist is instigating the SMART process initially focusing on high risk areas e.g. elderly care.
June 2013; The Pharmacist and Microbiologist Clinical Lead for antimicrobial reported back some excellent work that had been undertaken regarding antimicrobial audits. The Manchester audit had been undertaken- it was requested that this was forwarded onto Richard Seal (NHS TDA).
Antimicrobial audits are being rolled out across the Trust.
The pharmacy chart has been updated to reflect antimicrobial advice.
July 2013; Robin Wiggins and Tejal identified the audits that had been undertaken specifically in relation to elderly care and respiratory care and how these had been fed back via the rand round. They identified the conflicting requirements of both teams in the management of pneumonia but felt that they had the engagement of the physicians working forward.

The team were working on developing an antimicrobial app for laptops etc. Funding had been sourced. This is good investment by the Trust in antimicrobial stewardship.

July 2013;It was advised at the Action Plan review meeting that App development is included in the Trust Action plan and that a realistic date is identified an a caveat why this will be quite long due to the issue of developing the system, legal processes etc.

On the clinical visit it was identified when visiting one clinical room that the doors to the storage cupboards for medicines had become detached a while back and this had been escalated as a concern. Following discussions with my colleague Richard seal- Chief Pharmacist TDA it was identified that the Trust needed to action the replacement of any doors on pharmacy cupboards to ensure compliance. Furthermore, on one ward Clexane was stored under the U-bend of the sink. This is concerning for two reasons- potential contamination of the outer package areas and secondly because it should be locked up. This was actioned by the ward manager immediately- however a lockable cupboard was not available as identified previously. On another ward the IV fluids door was open- this was actioned immediately by the ward staff. However, as this has been identified on two wards this visit it would be advisable that a message went out across the Trust identifying actions required by staff to ensure compliance with the storage of medicines.

June 2013; The Trust is developing a HCAI quality dashboard which will provide both local and high level detail- this is still under construction.
July 2013; the dashboard had been populated by the majority of the Divisions this month and was being used to discuss HCAI at Divisional meetings throughout the Trust.

Criteria 5: Prompt identification/appropriate treatment and care of patients with infection

April 2013;There is a prompt laboratory access and reporting to the ward area for Inpatients.
The developing RCA process is robust. Previous emphasis was on the IPCT to provide details, however this is now being delivered by the Consultant and Nursing team.
The information on ward staffing levels should be incorporated into the RCA and fed back to the IPCC- it is acknowledged that a staffing review is being undertaken by the Director of nursing as currently it is reported that they are running at about 30% below target for full time staff (amended 1st May) on some wards. The shortfall being made up intermittently by bank and agency staff. Retention of staff has proved difficult because of the attraction of working in London. The mix of qualified to unqualified nursing to care staff is approximately 55% qualified to 45 % unqualified. In addition they are running at 100% occupancy.

It was noted that there had been an issue with *Serratia*on the neonatal unit; this had not been identified as a Serious Incident, an

outbreak/incident control team had not been established and external support from the health protection agency had not been sought. Furthermore from identifying this as an issue on the Monday it took until Weds afternoon to call a meeting at which time an SI had still to be reported to the CCG.

June 2013; The CCG reported that the Trust is now reporting outbreaks appropriately.
RCAs are now being led by the Lead Clinician which is embedding learning across the organisation. However, an RCA was not reviewed at this visit- the Trust needs to ensure that the process clearly identifies any risk and these are actioned, disseminated and trends identified.

July 2013; On visiting the clinical areas documentation of devices was observed. Each patient (x4) had the correct documentation available in their folders. However, not every patient was having their VIP scores reviewed every shift as recommended. It is advised that this is reviewed as part of the quality rounds.

Criteria 6: Staff engagement in the process of preventing infection.

The DIPC is going to confirm that IPC is in everyone's Job description from the Chief Exec down.
May 2013; this was confirmed that it is in Nurses JDs but still awaiting confirmation with regards to all other disciplines.
June 2013; the Trust is rolling out Roles and Responsibility cards for all staff.
July 2013;at the Action Plan review meeting we were informed by Maxine McVey that the Roles and Responsibility cards will be rolled out soon.
Maxine McVey informed the group that IPC is not in everyone's job description. The TDA and CCG requested that the Trust reviews this as identified previously and that it is included in the Action Plan.
Furthermore, the CCG and TDA requested information as to whether a Trust e-mail had been disseminated recently so that staff were aware of their responsibility to be bare below the elbows and comply with hand hygiene. Todays visit to the clinical areas identified this as a continuing area of concern with both bare below elbows and hand hygiene (on entering the ward, removing gloves and following patient car) were still not being complied with. These issues were identified to the ward staff at the time of the visit and appropriately addressed.

April 2013;It was disappointing to observe poor compliance to policy from ward based staff e.g. inappropriate wearing of personal protective clothing.
Ward staff, while concerned about the level of nursing capacity and staffing levels understanding of their responsibility to infection prevention management was lacking e.g. staff were not aware of the differences between cleaning and disinfection and the equipment required. Storage of bleach solutions. Failure to decontaminate equipment between patients. Inappropriate cleaning of bed pan bases with dirty toilet brush stored on the floor.
May 2013; The IPC nurses had developed training packages, information leaflets and held awareness days. Decontamination wipes were

now available in the Trust and equipment was visibly clean when evaluated on ward visit.
N.B; the majority of sharps boxes had not had the temporary closure mechanism used. Furthermore the sharps trays were contaminated and had old tape attached. The Infection Control Team/DIPSC were not aware of the Sharps Safety Regulations which come into UK law on 11th May 2013- confirmation that the Trust has undertaken appropriate actions with regards to this is still awaited on 3rd May 2013.
June 2013; Hospital staff were compliant with bare below the elbows on the all the wards visited at Watford.All sharps boxes were compliant. The Trust was implementing the EU Sharps Directive.
July 2013; On the clinical visit it was identified that several sharps boxes had not been signed for on assembly. All boxes were correctly assembled- this was actioned immediately by the TDA/ Matron.

AUDITS;
April 2013;Hand hygiene audits were reviewed and it was noted that that that were not at the time of the visits cross audited, although it was reported that this is being introduced.
A review of the other audit results e.g. Infection Prevention Society Quality Improvement Tool http://www.ips.uk.net/template1.aspx?PageID=84&cid=91&category=Quality , Saving Lives, Mandatory Surveillance, environmental audits, Surgical Site audits etc will be reviewed at my next visit.
May 2013; it is advised that cross audits are undertaken to ensure accuracy, as the majority of reports are stating 100% compliance which is not felt to be an accurate reflection.
June 2013; the Trust is commencing cross auditing of Hand Hygiene.
July 2013;At the Action Plan review meeting Maxine McVey and Katrina confirmed that peer reviewed hand hygiene audits had commenced and the 1st months data had been reported by the ward areas.
However, Maxine McVey identified that the peer review process associated with providing assurance of the "saving lives " audits was still under discussion from April 2013. The TDA and CCG requested assurance that this would be developed and provided a several suggestions on how this could be delivered. Maxine McVey provided assurance that they would introduce x1 peer review audit in August in order to be able to provide assurance to the Board. At the IPC Committee Jackie Ardley identified that this would be introduced immediately and devices were chosen as the HII topic for August.

July 2013;Robin Wiggins provided assurance to the group that blood culture contamination rates were being undertaken and were approximately 2%. On the clinical visit it was identified that medical staff prepared the IV cannula trays and put a hand paper towel over it in advance. The nurses identified that they tried to discourage this process not only because trays should be prepared at point of use but that the amount of expensive waste from packages that had been opened in advance and then not used was high. The Trust may wish to investigate this from both asepsis and cost perspective. The white trays on the ward were appeared old, and werenot able to be cleaned effectively. Staff were aware that they were free from Daniels and would be contacting them to arrange new supplies. A doctor was

observed cleaning the tray post use.

May 2013; It had been requested previously that audits undertaken during the PII/outbreak of C. difficile were forwarded. It was reported that audits were undertaken by Medirest/trust auditors but specific audits not undertaken by IPC nurse. The Trust had not followed the "C. diff- How to Deal with the Problem" guidance of undertaken p.p. 14 section 2.5.ii. it is strongly urged that this is adopted. Audit tool provided for the Trust as a guide.

The Infection Prevention Control link nurse system did not seem to be effective on the wards visited. This system needs to be reviewed,contacts have been provided to the Trust of other effective systems already introduced in other Trusts.
May 2013; The Lead Nurse has still to approach other Trusts to identify best practice. The deadline for this is 28th May 2013 on the action plan. This needs to be developed promptly to ensure the IPC message is cascaded to the areas.
June 2013; The Trust has contacted other Trusts to identify how they will develop their link programme. Furthermore the new Lead Nurses when appointed may have innovative ideas

Criteria 7: Secure adequate isolation facilities.

The trust operates a policy of time to isolation less than 2 hours. Breaches are noted and escalated appropriately.
The Trust has an isolation suite. However, there is no hand wash facility on exit/entrance to the unit. Therefore, staff may inadvertently transfer C. diff spores out of theunit. It is essential that this is addressed as a priority.
May 2013; assurance provided that this is being addressed by facilities.
June 2013; This was being addressed and should be in-place by end of July 2013. It is essential that there is no delay in this process as it was identified in April and three months is a significant amount of time to rectify this issue. With this in mind is the Trust assured that other estates issues identified are being addressed in a timely manner?
July 2013; the hand wash basin had now been fitted in the isolation suite

April 2013; It was noted that the Trust had an issue with *Serratia.* However, no outbreak committee had been convened and no serious incident (SI) had been submitted. No outside support had been requested from the Health Protection Agency or the Clinical Commissioning Group. This issue was being dealt with in-house. At the time of noting this, 12 babies had been identified as being colonized.The DIPC dealt with this immediately. However, it raises concerns as to the early identification, reporting, appropriate action and transparency within the organisation.

Out of hours curtain change and deep clean are undertaken and assurance was given by the Trust thatthis was timely and appropriate. However, due to the amount of clutter the cleaning staff would come into contact with it is difficult to be assured that this was able to be undertaken fully.

June 2013; the wards have undergone a major deep clean.

See area of concern noted on "cleaning" the isolation room above.

July 2013; see "cleaning" concerns above

Criteria 8: Secure adequate access to laboratory support.

This is reported to be in place with out of hours service through the microbiologists.

July 2013; At the Action Plan review Robin Wiggins updated the group that the transformation of laboratory services was still under review in this geographical area.

Criteria 9: Have appropriate policies and assurance

This is of concern. The policy relating to *C. difficile* lacks robustness and advice has been provided on issues to include;

- Bristol Stool Chart.
- SIGHT protocol is not included/referred to
- It does not state enteric precaution required.
- It does not state alcohol gel is not effective and soap and water essential (in light of lack of HH facilities in isolation suite this is needed)
- Decontamination of equipment not using alcohol
- There is no mention of identifying periods of increased incidence/outbreaks.
- No links to/or patient information leaflets
- Death certificate requirements

Whilst I appreciate it guides staff to other policies due to time constraints they will rarely go past this 1st search, for info.

May 2013; advised that this policy has now been reviewed.

I have not had a chance to review the other policies but I would advise that the Trust looks at these.

June 2013; Policy review is still being undertaken and I would advise that this is a priority area for action.

July 2013; At the Action Plan review Maxine McVey assured that the C.diff policy would be ratified this month. A review of the other policies was on hold as priority was being given to other areas. Assurance was verbally provided that ALL other IPC policies were in date. Assistance has been offered from the CCG to support this.

Criteria 10: Assurance (as far as possible) that healthcare workers are free from and protected from infection and are suitably educated.

The IPC nursing team currently provide training and education for staff. There is an annual IPC study day aimed at link workers and front line nursing staff- this was planned for June but is now being brought forward.

IPCNs provide Ward training. Mandatory training for all staff is undertaken.
A 2hr C. difficile training session is provided throughout the year but this is poorly attended by the medical staff- The DIPC is addressing this with the Medical Director.
Poor use of personal protective equipment, inappropriate storage of equipment were observed, decontamination of equipment between patients was observed and staff knowledge of decontamination was extremely poor.
May 2013; on the arranged ward visits compliance was noted
June 2013; compliance with PPE was noted.
July 2013;a variety of staff including; nurse, doctors, physio, housekeeping were identified wearing stoned rings and were not compliant with bare below the elbows. This was addressed immediately.

April 2013;I have not reviewed the issues pertaining to occupational health, however during the subsequent visit to the IPCC I will raise this item.
May 2013; it was confirmed that occupational health were on the IPC committee but did not regularly attend or provide a written report. Whilst duplication of information is not advantageous, cross communication with regards to needle-stick injuries, vaccination (e.g. measles which is a current issue) would provide assurance.
June 2013; Occupational Health have been requested to now provide a written report to the IPC Committee
July 2013;At the Action Plan review meeting, concern was raised by the CCG and TDA regarding staff IPC training. Maxine McVey informed the CCG and TDA that IPC was part of the mandatory training process every 3yrs. Maxine McVey identified that the Trust was currently identifying only 80% compliance with mandatory training. Discussions were held and both the TDA and CCG identified this as a concern and it was advised that this should go on the risk register as there may be staff who after their induction had never attended an update. In addition, it was advised that all training including attendance at Grand rounds, link practitioner etc was captured to ensure evidence was available.
July 2013; e-mail assurance; In a later e-mail from Jackie Ardley it was identified that the Trust had that week reviewed this and was nowimmediately implementing a 1yr Mandatory training process of which HCAI would be included.

Staff vaccination for all members was still under review and Occupational Health reported into the Trust IPC Committee

West Hertfordshire Hospitals NHS
NHS Trust

Appendix 3

Infection Prevention & Control Annual Plan 2014-2015

To comply with the Health and Social Care Act 2008 (updated 2010)

The purpose of the Infection Prevention & Control (IPC) annual plan is to set out the activities the organisation needs to do to ensure that safe quality care is provided. It will also provide assurance to the board that the programme of work if delivered will minimise any risks. The proposed activities of the IPC team, which will ensure that the service meets the statutory requirements.
This programme is based around compliance with:

- The Health and Social Care Act 2008 (updated 2010) – Code of Practice on the prevention and control of infections and related guidance also known as the Hygiene Code.

The Hygiene Code is underpinned by ten compliance criteria, the programme of work is mapped to the compliance criteria, which will ensure that the Trust continues to maintain and strengthen its compliance. The annual plan is signed off by the Quality and Safety Group.

Monitoring delivery of the program

Progress against the programme will be monitored by the Infection Prevention and Control Panel (IPCP).

Key:

	Action has slipped/ compliance <80%
	Action is not yet complete but is on track/ compliance between 80 % and 89%
	Action has been completed/ Compliances ≥ 90%

Issue / Problem	Actions	Lead	Timeline	Progress/ Assurance			
Trust Board Objectives				**Q1**	**Q2**	**Q3**	**Q4**
The Board will monitor the Trust compliance with the Health and Social Care Act 2008.	• The TLEC, Quality and Safety Group (QSG) and Infection Prevention and Control Panel (IPCP) will receive the Annual IPC Report.	DIPC	July 2014				
	• The Board will receive Infection Prevention & Control (IPC) updates and key indicators at each Board Meeting • MRSA BSI annual trajectory is 0 • Clostridium difficile infection (CDI) annual trajectory is 31	DIPC	Monthly				
	• The Board will receive information relating to assurance on compliance with the Code of Practice, CQC outcome 8 and key indicator targets via the Quality and safety group and challenge concerns in relation to compliance	DIPC	Monthly				
	Divisional Objectives:						
All divisions to ensure that the reduction of healthcare associated infections is a priority.	• Each Division will table clinical issues and exception reports for the Quality and Safety group actions to the IPCP	IPC leads/ HoN/ HoM	Monthly				
	• Each division will present their divisional action plan as per rolling programme to the IPCP	HoN/HoM	Quarterly				
	• All staff attend Trust induction and mandatory update sessions • Trust target for mandatory training is 90%	IPC/ HoN/HoM	Monthly				
	• Lessons from IC SIs/outbreaks are reviewed monthly, reported to the IPCP and Quality and safety group and acted upon.	HoN/HoM	Monthly				

	• All High Impact interventions inc hand hygiene scoring less than 95% with formulate an action plan with evidence of actions taken and returned to IP&C Team, this which will be discussed at the local HCAI	Ward/Dept Manager/ Hon/HoM	Monthly				
	• Any member of staff persistently not complying to hand hygiene policy or high impact intervention will be named on audits for review and escalation as required	Ward/Dept Manager/ HoN/HoM	Monthly				
	• Participate in the Test Your Care audits	HoN/HoM	Monthly				
	• Isolate patient with an infection e.g diarrhoea within two hours (DH) to reduce the risk of cross infection	Matron/ward manager	Ongoing /monthly				
	• There should be evidence of a rolling programme for equipment replacement, to ensure all the equipment is fit for purpose	Ward/Dept Manager/ Hon/HoM	May 2014 Ongoing				
	• For all new equipment to be purchased cleaning instruction for the equipment should be obtained from the manufacturer and these submitted to IPCT for approval before a purchase is agreed. •	Hon/HoM Matron	As required				
	• Patient equipment e.g Commodes, BP cuffs must be cleaned in between each patient use	Ward/Dept Manager/ Matron	As required				
	• Patient isolated in side room for infection control reasons should have dedicated equipment for use e.g disposable BP cuffs, hoist slings.	Ward/Dept Manager/ Matron	As required				
	• Equipment decontamination /cleaning schedules that specifies cleaning standards for equipment such as commodes, BP cuffs are in place	Ward/Dept Manager/ Matron	Monthly /Ongoing				
	• 6 monthly environmental audits to ensure that all ward areas are well maintained and appropriately managed to reduce the risk of infection (April/May and Oct/Nov)	Ward/Dept Manager/ Matron	6 monthly			**Q3**	
	• Refurbishment program to be developed by each ward and in conjunction with estates	HoN/Head of estates	As required				
	• Divisions take ownership of RCA and are completed in a timely manner (within 14 days).	HoN	As required				
	• Surgical division to fulfil the Mandatory SSISS	HoN (surgery)	Quarterly				
	• Women and Children division to look into C- section SSIS	HoM	Q3				

	Estates and Facilities; Operational						
	• Assure quality of environmental cleanliness/ audit of the clinical areas	Head of Facility	Monthly On going				
	• Ensure deep cleans are carried out as per schedule (every quarter and any estates work is carried out prior to the deep clean	Heads of Facilities & Estates	As per Deep clean programme				
	• Annual PLACE inspection interfaced with 15 “Steps”	Head of Facilities	Yearly				
	• Involve Infection Prevention and Control in all building works (from planning to finish of the building works)	Director of Facilities and Estates	As required				
	• Availability of a decant ward so as Deep clean can be carried out	Director of operations	As required				
	• Minutes and papers from the Water Safety Group meetings to be tabled at the IPCP	Head of Estates	Monthly				

Infection Prevention & Control Team Plan

Core Duty	Actions	Lead	Timeline	Progress and Assurances			
				Q1	Q2	Q3	Q4
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	The IPCP will receive monthly information on: • Mandatory surveillance (MSSA, MRSA & E coli bacteraemias and CDI) • Audits • IPC Training • Progress on action plans • Outbreaks & Incidents • New publication relating to IPC/Microbiology		Monthly/ on going				
	• Provide reactive service to meet needs of incidents/enquiries/outbreaks	ADIPC	As required				
	• Work proactively with multi-disciplinary staff and departments to reduce risk of HCAI	ADIPC/Lead Nurse	On-going				
	• Identify and inform IPCP of any risks associated with IC resources and ability to provide service; • Recruit 3 more CNS to the team to ensure there is enough recourses to support the delivery of the IPC annual plan	ADIPC	May 2014				
	• Work collaboratively with Clinical Commission Group, Trust Development Authority & the Hertfordshire HCAI reduction group	ADIPC	As required				
	• Submit a business case for an Infection Surveillance software	ADIPC	July 14				
	• Collate and submit alert organisms as directed by the Public Health England onto the data capture system.	ADIPC					
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of	• Ensure audits are carried out 6 monthly and provide Trust wide compliance results to IPCP. Any clinical areas achieving less than 95% compliance to produce a remedial action plan. The completion of action plans managed through Local HCAI	HoN/HoM	April/May 2014				
			Oct/Nov				

Core Duty	Actions	Lead	Timeline	Progress and Assurances			
				Q1	Q2	Q3	Q4
infections.	meetings.		2014				
	Audits by the Infection Prevention and Control nurses: ❖ Decontamination of patient equipment (HII8) ❖ Personal Protective Equipment ❖ Management of Linen ❖ Isolation Precautions ❖ Management of sharps	Lead Nurse	As per audit schedule				
	• Re launch of the HII8 audits for decontamination of medical equipment, monthly for each clinical area	ADIPC/Lead Nurse	Monthly October 2014				
	• Support all clinical areas at times of outbreaks in managing Terminal/Deep clean at end of outbreak	ADIPC/ Lead Nurse IP&C	As required				
	• Audit availability of hand hygiene facilities in the trust	ADIPC	November 2014				
3. Provide suitable accurate information on infections to service users and their visitors	• **Maintain information leaflets for patients and visitors** • Ensure all patient and public information leaflets are current and available on the Trust website	Lead Nurse IPC	As required				
	• Maintain information leaflets for contractors/volunteers/bank & locum staff	Lead Nurse	September 2014				
	• Attend Trust AGM with supporting display for the public	Lead Nurse	September 2014				
	• Review all Hand hygiene posters and leaflets visible encouraging visitors and patients to use facilities and challenge staff	ADIPC/ Lead Nurse IPC	December 2014				
	• Review hand gel and soap supplier, public signage	ADIPC	November 2014				
	• Participate in National Hand Hygiene Awareness Day.	IPC Team	May 2014				
	• Participate in international Infection Prevention and Control Week	IPC Team	October 2014				

Core Duty	Actions	Lead	Timeline	Progress and Assurances			
				Q1	Q2	Q3	Q4
4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.	• Maintain up to date polices and guidelines for Infection Prevention on the Trust intranet.	ADIPC	As required				
	• Staff information leaflets to be available	ADIPC/ Lead IP&C Nurse	January 2014				
	• Inform G.P. if patients are discharged before MRSA results are known and new MRSA	Lead IP&C Nurse	As required /daily				
	• Inform G.P of admitted patients indentified to have *Clostridium difficile*	Lead IP&C Nurse	As required /daily				
	• Flagging on Patient Administration System/ICE information system for appropriate management.	IPCT	As required/ daily				
	• Continue inserting information stickers for alert organisms in the health records of patients.	IPCT					
	• Raise awareness on current IPC issues within the Trust; "Top Tips" IPCN news letter	IPCT	Monthly				
5. Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.	• All patient `s microbiological results are managed as a priority within the IP&C team. Patients are visited on the wards and ward staff liaised with ensuring that staff understand and are aware of the correct infection prevention & control measures required for that particular organism	Lead Nurse IPC	As required/ daily				
	• Ensure timescales for RCA/PIRs reporting are met and corrective actions/learning shared across Divisions through Clinical governance meetings	IPCT/HoN	As required/ monthly				

Core Duty	Actions	Lead	Timeline	Progress and Assurances			
				Q1	Q2	Q3	Q4
	• Appropriate use of detection, management and isolation of diarrhoea flow chart for timely isolation of affected patients.	IPCT/HoN	As required /daily				
	• Audit MRSA and *Clostridium difficile* care pathways and feedback results to clinical areas, HoN/HoM and IPCP	Lead Nurse/ ADIPC	December 2014				
	• Mandatory update to includes outbreak management and isolation	ADIPC/ Lead Nurse	As required /daily				
	• Inform bed management /ED staff of any outbreaks (e.g of Norovirus or any other infection) in local care home and NHS Trusts	ADIPC/ Lead Nurse	As required /daily				
6. Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.	• Review and update IPC Training schedule for all Trust employees including contractors and volunteers : Mandatory, Induction; Ad hoc related to DH & local initiatives	Lead Nurse IP&C	April 2014 Annually				
	• A requirement to comply with infection prevention and control is included in all job descriptions:	HR/ADIPC	Immediate				
	• Review formal training on peripheral line insertion, CV/aseptic technique, ongoing management to be included in Education /training review; (Peripheral IV study day, Central IV study day, Venepuncture and Cannulation)	PDN	As required when new updates are published				
	• Link Practitioner Educational meetings – maintaining records of attendance and feedback at local HCAI meetings	ADIPC/ Lead Nurse	Bi- monthly				
7. Provide or secure adequate isolation facilities	**Ensure adequate isolation precautions and facilities as appropriate to prevent or minimise the spread of infections** • Ongoing review of capacity within isolation ward to meet clinical need.	IPCNs	As required /daily				
	• Isolation Policy is audited by the IPCT annually	ADIPC/ Lead Nurse IP&C	November 2014				

Core Duty	Actions	Lead	Timeline	Progress and Assurances			
				Q1	Q2	Q3	Q4
	• Audit side room availability including rooms with both negative & positive ventilation	ADIPC/ Lead Nurse IP&C	As required				
	• The IPCT will provide advice and support on the management of infectious patients during an increased incidence of infection or outbreak to contribute in the management of appropriate usage of the side rooms.	ADIPC	As required/ daily				
8. Secure adequate access to laboratory support as appropriate	• Ensure the microbiology laboratory has appropriate protocols and standard operating procedures as required for accreditation by Clinical Pathology Accreditation (UK) Ltd.	ICD/ Consultant Microbiologist	As required				
9. Have and adhere to policies, designed for the individual's care and provider organisations, which will help to prevent and control infections. Compliance with key policies is ensured through the implementation of high impact interventions and monitored through audit.	Policies are updated with review dates and clearly marked up where they link to other policies both on the actual policy. Policies/guidelines to be revised – **Priority to** o The implementation of carbapenemase-producing Enterobacteriaceae (CPE) tool kit	ADIPC/ Infection Control Doctor	April 2014				
	o Blood Culture collection	ADIPC	July 2014				
	o Prevention of Intravascular devices related infections	ADIPC/	July 2014				
	o Bed/mattress management	IPC/TVN	November 2014				
	o Outbreak Policy	ADIPC	January 2015				
	o Management of linen (replaces Guideline for the management of patient soiled personal clothing)	Lead Nurse	January 2015				
	o MRSA (combine all MRSA polices into one document)	ADIPC	December 2014				
	o Urinary catheter & suprapubic catheter management	Continence nurse/ ADIPC	January 2015				
	o Decontamination – Management of blood other body fluid spillage	ADIPC	January 2015				
	o Building and Renovation in hospital (NEW)	ADIPC	Jan 2015				
	o Purchase, trial and loan equipment (NEW)	ADIPC	February				

Core Duty	Actions	Lead	Timeline	Progress and Assurances			
				Q1	Q2	Q3	Q4
			2015				
	• VHF (was in date, reversed due to the West Africa Outbreak)	Lead Nurse	September 2014				
10.Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.	• Annual Gap analysis of training needs;	Lead Nurse IPC	April 2014 Annually				
	• Review Annual training programme for all staff including contractors, locums, volunteers, bank & agency.	ADIPC/ Lead Nurse IPC	April 2014				
	Related Occupational Health policies are in date: • Review, update and amendment of OH Clearance document.	Occupational Health Manager	As required				
	• Incorporating changes to exposure prone procedure restrictions for HIV infected healthcare workers	Occupational Health Manager	Annually				
	• Development of a Patient group directive which would form a working schedule and guideline for immunisation	Occupational Health Manager	September 2014				
	• Flu campaign	Occupational Health Manager	September 2014				
	• Mask fit testing for staff in the required clinical areas	Health & safety manager	June 2014; 2yrly fit testing				
	• Compliance with EU Sharps Directive	H&S Manager	April 2014				

Report prepared by Nyarayi Mukombe, Assistant DIPC
Report Presented by Tracey Carter, Chief Nurse & DIPC
Date: December 2014