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Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**27th October 2016**
Board Sponsor:	**Helen O'Dell, Interim Chief Nurse** **Director of Infection Prevention and Control**
Paper Author:	**Suzanne Morris, Deputy Director of Infection Prevention and Control**
Subject:	**Infection Prevention and Control Annual Report**

Executive summary

This interim 6 month report updates the Board on progress and actions taken following CQC visit.

The focus of infection, prevention and control has been;

- Infection, prevention and control committees and meetings reviewed with Director of Clinical Governance and NHSI new meeting format commenced September 2016

- Clear line of reporting for Infection, prevention and control, meetings and committee to Quality and Performance committee

- Standing Operating Procedure (SOP) for hand hygiene implemented, hand hygiene auditors trained

- Process for non-compliance with hand hygiene established

- Senior Nurse Infection Prevention and Control Ward Review – template agreed and implemented

- Close working with NHSI Infection ,Prevention and Control Lead – visits to clinical areas

- Review of clinical areas to ensure good utilisation of space and compliance with waste management is on-going

- Raising awareness of reporting of estates issues and housekeeping concerns – one number for reporting to helpdesk, estates report via helpdesk or online

- Completed Infection, prevention and control code of practice self-assessment tool

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Action required by the Board
The Board is asked to discuss and note the report, the actions undertaken and planned, and the position at 30th September 2016.

Links to corporate objectives	The infection, prevention and control annual report concerns the objectives of: ***excellent outcomes; great experience****;*
Identified risks and risk management actions	Key risks in relation to infection prevention and control and their mitigation are detailed in the CQC Quality and Safety Improvement Plan
Resource implications	None relevant to this report
Appendices	Infection prevention and control annual report

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Brighton and Sussex University Hospitals NHS Trust

Director of Infection Prevention and Control

6 month interim report

October 2016

Suzanne Morris
Deputy Director of Infection Prevention and Control

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Section 1

Executive Summary

This 6 month interim report provides a brief description as to the current activities for the prevention, control and management of infection.

The control of healthcare associated infections is of a major public concern and has been identified as a key issue for Brighton and Sussex University Hospital NHS Trust. A high standard of infection prevention is fundamental to the care of patients at the Trust.

The Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 (2015). A requirement of this Act is for the Board of Directors to receive an annual report, to reflect the activities that have been undertaken within the Trust to prevention, control and manage infections; a 6 month interim report will be submitted to the Board of Directors.

It has been a busy 6 month for the Infection Prevention Team, who continued to maintain high visibility and engagement I the clinical areas. The team still faces a challenge due to lack of resources within the team and dedicated electronic infection control surveillance software, using paper system which is time consuming.

This six month interim report provides a further update to the Board following the annual report 2015-16 and provides a brief description as to the current activities of the Infection Prevention Team and others in the prevention, control and management of infections. I

Key points:

- There has been zero Trust apportioned MRSA bacteraemias reported against a ceiling target of zero (last case reported 15th July 2015)
- There has been one case of MRSA bacteraemia, which was Community apportioned following a review by NHS England
- There are 27 Trust apportioned *Clostridium difficile* toxin positive cases against a ceiling target of 46
- There has been three period of increased incidents related to *Clostridium difficile,* one has been escalated to an outbreak. Appropriate individuals were informed, control measures implemented
- The Trust has reported 13 Trust apportioned MSSA bacteraemias
- The Trust has reported 139 *Escherichia coli (E. coli)* bacteraemia, this is a whole economy
- Hand hygiene Standard Operating Procedure for hand hygiene was implemented for hand hygiene

compliance, which involves a range of frequencies of auditing

In addition to our on-going activities we have also:

- Change the structure of infection prevention meetings
- Improve the formatting of information presented at these meetings
- Implemented a Standard Operational Procedure for hand hygiene auditing
- Give advice and support to 3Ts in relation to the new build at the Royal County Hospital site
- Give advice and support to Estates in relation to air handling units and ventilation

Our continued goal is to deliver 'harm free care', and not a single preventable infection should be allowed to develop in our Trust. I would like to thank staff for their efforts and hard work to deliver our goal. I would also like to thank the following individuals who have contributed to this report:

- Suzanne Morris; Deputy Director of Infection Prevention and Control
- Martin Still, Infection Prevention Nurse
- Andrew Davies, Infection Prevention Nurse
- Mildred Ruwona, Infection Prevention Nurse Trainee
- Vikesh Gudka, Lead Pharmacist Infectious Diseases
- Sarah Zahoppoulos, Occupational Health Advisor
- Peter Brown, Decontamination Operational Lead
- William Haynes, Deputy Director of Facilities and Estates
- Terece Walters; Influenza Vaccination Co-ordinator

Who have helped in compiling this six month interim report.

Helen O'Dell

Interim Chief Nurse

Director of Infection Prevention and Control

Section 2

Surveillance

Surveillance of infections is one of the most important components of infection prevention practices. It is defined as the on-going, systematic collection, analysis, interpretation and dissemination of data regarding an infectious event. This information forms the bases of the infection prevention service provided to the Trust

Mandatory Healthcare Associated Infection Surveillance

The control of healthcare associated infections (HCAI's) is of a major public concern and has been identified as a key issue for Brighton and Sussex University Hospital NHS Trust (Trust).

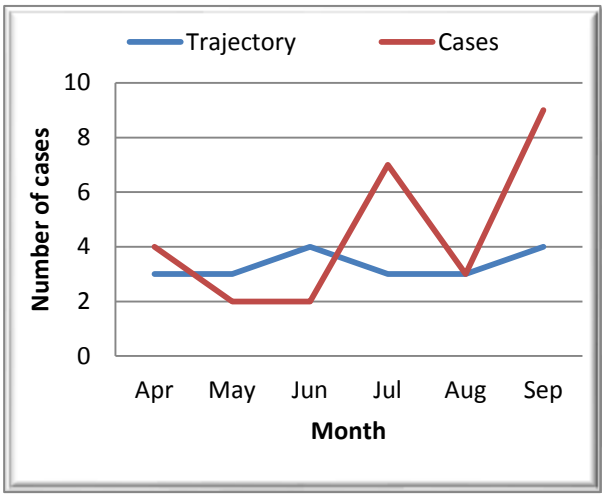
***Clostridium difficile* infection**

The incidence of *Clostridium difficile* infection (CDI) is monitored by the Trust and the Department of Health. It is important that we reduce the number of CDI cases; the annual trajectory set by the Department of Health is for <46 cases, hence we have produced our own internal monthly trajectory. At the time of writing this report we have had 27 cases against an internal trajectory of 20 cases. Please note for April – September 2015 the Trust had also reported a total of 27 cases of Trust acquired *Clostridium difficile* infection.

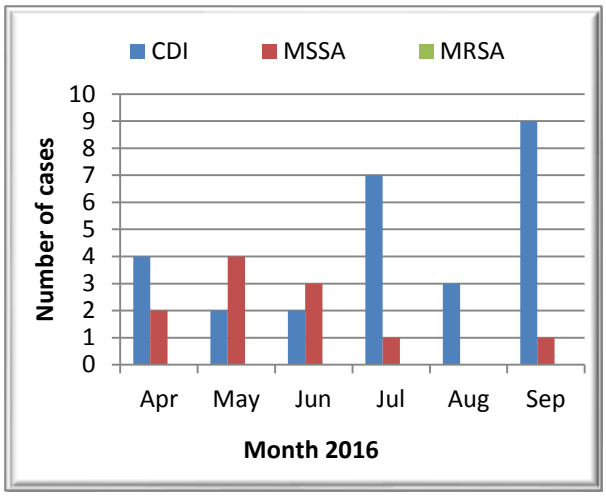
A *Clostridium difficile* infection action plan is in the process of being complied, which will be implemented during October 2016. However several aspect of the plan has already been action, including:

- Trust wide training for the use of sporcidial wipes
- Trust wide commode audit
- Implementation of a RCA review panel
- Hand hygiene awareness training/audits

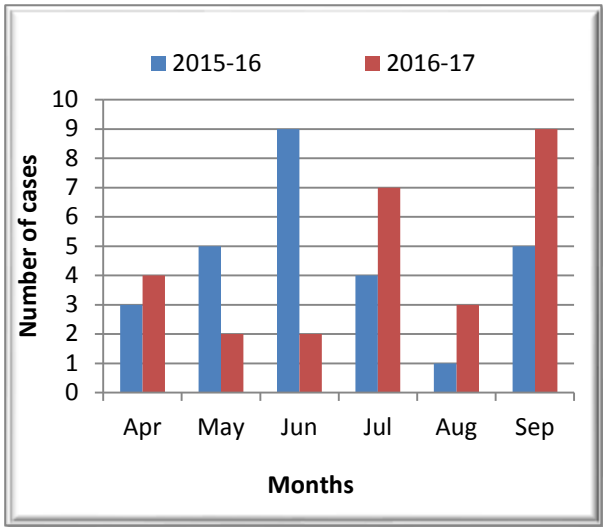
Graph 1: Demonstrates the number of monthly cases of hospital acquired *Clostridium difficile* infection against the Trust internal monthly trajectory



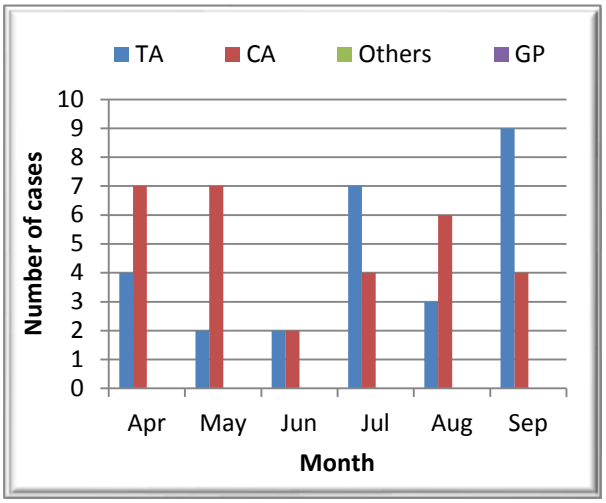
Graph 2: Demonstrates the numbers of monthly cases of hospital acquired *Clostridium difficile* infections from April 2016 till September 2016



Graph 3: Demonstrates the number of monthly cases hospital acquired *Clostridium difficile* infections cases for the first 6 months of 2016-17, compared to the same time frame for 2015-16



Graph 4: Demonstrates the number of monthly cases of hospital acquired, community acquired, GP and other *Clostridium difficile* infection for the first 6 months of 2016-17 (Key: TA – Trust acquired, CA – Community acquired)



Meticillin Resistance *Staphylococcus aureus* Bacteraemia

In accordance with the Department of Health targets for reducing the incidence of Meticillin Resistance *Staphylococcus aureus* (MRSA) bacteraemia the Trust has to report less than zero cases for 2016-17. The last hospital acquired MRSA bacteraemia case was reported on the 15th July 2015.

There has been one case of community acquired MRSA bacteraemia reported, a Post Infection Review (PIR) was undertaken by the Infection Prevention Lead for the Clinical Commissioning Group (CCG), the case was attributed by Public Health England (PHE) to the community.

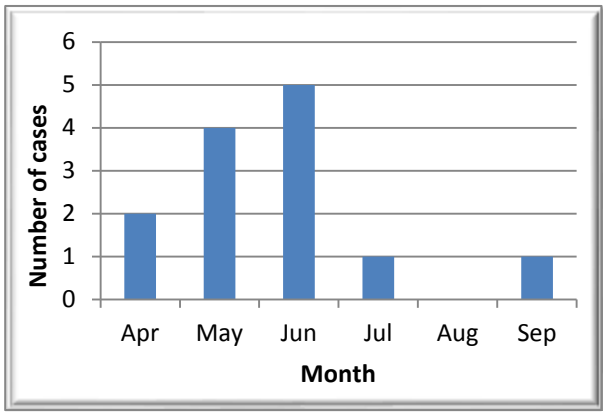
Meticillin Sensitive *Staphylococcus aureus* Bacteraemia

There were 13 Trust-apportioned Meticillin sensitive *staphylococcus aureus* (MSSA) bacteraemias. There is no national benchmark or annual threshold set for MSSA bacteraemia rates; however the Trust aims to have 3 cases per month. The Trust carries out a Root Cause Analysis (RCA) on these cases where required in order to aid learning. From these 2 cases were identified as being venous- line related, in

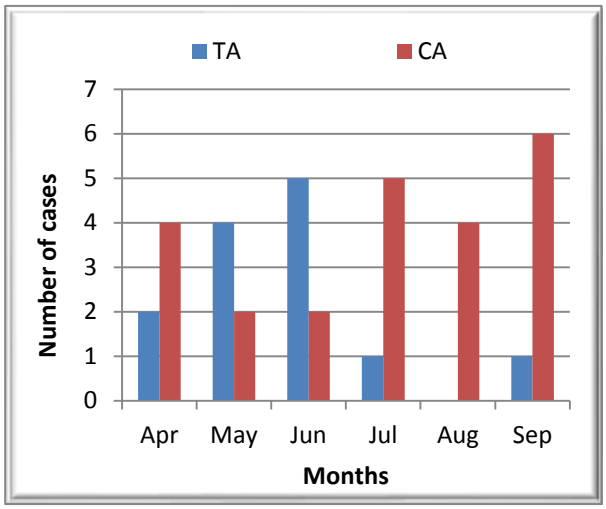
particular to documentation. Individual actions plans have been implemented as part of the RCA process; in addition the following are in progress:

- VIP audit
- Review of ANTT practices
- Development of appropriate ANTT poster
- Development of appropriate ANTT competencies

Graph 5: Demonstrates the numbers of monthly cases of hospital acquired MSSA bacteraemia from April 2016 till September 2016



Graph 6: Demonstrates the number of monthly cases of hospital acquired, community acquired, MSSA bacteraemia for the first 6 months of 2016-17 (Key: TA – Trust acquired, CA – Community acquired)



***Escherichia coli* Bacteraemia**

The Trust has reported 139 cases of *Escherichia coli (E. coli)* bacteraemia, a steady increase over the past few years, which has also been experienced and recognised nationally. There is no national benchmark or annual threshold for *E. coli* bacteraemia or a standard for attribution of acquisition.

Surgical Site Infection Surveillance

To date in this financial year Surgical Site Infection Surveillance (SSIS) has been undertaken for cranial surgery for the period April – June 2016. Orthopaedic SSIS is mandatory by Public Health England (PHE) for 1 quarter per year. In order to meet this mandatory requirement the IPT will undertake Total knee replacement (TKR) surgery SSIS October – December 2016.

Cranial surgery SSIS was undertaken April-June by the IPT. 104 patients matched the criteria for inclusion in the surveillance. 1 patient acquired SSI infection, which was classified as deep incisional. The cranial surgery infection rate was 0.96%, compared to the national cranial surgery SSIS average rate of 1.9%.

Serious Incidents

The Trust reports any incident which meets the definition of a Serious Incident (SI) as requested by NHS England. The reports are submitted via STEIS. The Trust is required to report to the CCG those incidents that fulfil the SI criteria; the following summarise the first 6 months for 2016-17:

- One SI has been raised related to a Period of Increased Incident of *Clostridium difficile* infection, where the majority of the cases were identified to have the same ribotyping

- There were no cases of MRSA bacteraemia reported
- There were zero *C. difficile* cases classified as 1a on the death certificate where *C difficile* had a significant contribution to the cause of death
- There were no reports of infected healthcare worker or patient incident necessitating a look back exercise

Period of Increased Incidents

There were three suspected or confirmed Periods of Increased Incident (PII) during the first 6 months of 2016-17. The majority of these cases were clinically mild, although they frequently occurred in patients who were seriously ill from other causes. During a PII the team will conduct several audits, including CDI snap shot audit, hand hygiene audit, environmental audits.

These incidents were reported internally via the Trust Datix system, and as required to the PHE, CCG as part of the internal mandatory surveillance of HCAI i.e. PII related to *C difficile*. Reports on these incidents are available from the IPT. A summary of the reports is available below.

Table 1: Highlights which wards which were reported as having a PII.

Ward	Date	Number of cases	Ribotype
Egremont	**July**	**2**	**Unknown 002**
Ardingly	**May**	**3**	
Level 8 Tower	**July**	**3**	**Sporadic**

* PII – Period of Increased Incident, two (2) or more cases occurring >48hrs post admission (not relapses) in a 28 days period on one clinical area

When a ward has PII, the following actions are implemented by the IPT:

- Isolating appropriately according to the Trust Isolation Policy
- Implement control measures i.e. correct use of PPE, cleaning of the environment and equipment, in the case of *C. difficile* the removal of the alcohol based hand rub from the point of care
- Complete DATIX
- Communication email is circulated to Clinical Staff, Senior Management Team, DIPC, IPT, Consultant Microbiologist, Operational Team, Bed Managers on a daily basis following patients review
- Patients, and where necessary carers/relatives, are informed and kept up to date with the situation
- Sample is forwarded to the Reference Laboratory for ribotyping
- RCA investigation is commenced
- Hot spot / CDI audits are undertaken by the IPT
- Communication with external stakeholders i.e. CCG, PHE

Ardingly Ward: 4 cases of *Clostridium difficile* infection was reported, 3 cases were reported as Trust Acquired, the 4th Community Acquired, however since the patient was discharged and developed symptoms 3 days post discharge, the case has been included in this PII.

The first case was identified on the 21st May 2016, the last case on 8th August 2016.

Ribotyping of specimens from 4 patients on the ward has indicated that the infections could be linked, therefore this PII has been escalated to an 'Outbreak' and a Serious Incident investigation is in progress.

Egremont Ward: 2 cases of *Clostridium difficile* infection were reported. The first case was reported on the 7th July, due to the acuity of the patient and inadequate staff skill mix, the patient was not sourced isolated immediately when they became symptomatic. Unfortunately, ribotyping was not undertaken; an investigation by the microbiology laboratory is in progress. The 2nd case was transferred to the ward on the 14th July, during the RCA again due to the acuity of the patient and inadequate staff skill mix, the patient was not sourced isolated immediately when they became symptomatic. Ribotying indicated 002 strain. The *Clostridium difficile* infection spot check audits score were 95%, the deficits were action upon immediately. Although both patients were on the same ward at the same time, they were not next to one another; however it is not possible to say with certainty that the PII on Egremont Ward was not an outbreak situation, as it was not possible to identify the ribotyping of the first case.

Level 8 Tower: 3 cases of *Clostridium difficile* infection were reported. The first case was reported on the 29th July, 2nd case on the 2nd August, and the 3rd case on the 5th August. All three patients were source isolated immediately the patient became symptomatic.

The *Clostridium difficile* infection spot check audits score were below 95%, 1st case 55%, 2nd case 55% and the 3rd case 81%. The non-compliance identified included; incorrect isolation door signage displayed, documentation not completed (Bristol stool chart), issues with antibiotic prescribing, storage of linen, and incorrect waste stream implemented. Feedback was provided to the clinical staff. Action plan was implemented with support from the IPT, subsequent *Clostridium difficile* snap short audits, the ward obtained 100%.

Although these patients were on the same ward at the same time, they were not in direct proximity to one another during their admission, and they had not used the same bed space. Ribotyping of specimens from 2 patients were identified as sporadic, though classed as sporadic they were different ribotypes, the 3rd case was recorded as colonisation. This incident is reported as a PII.

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Section 3

IV Therapy Service

The aim of the IV Therapy Service is to provide high quality; evidence based intravenous therapy nursing to patients within the Trust. The service aims to be comprehensive, flexible and easily accessible. The service also incorporates Outpatient Parenteral Antibiotic Therapy.

Training

Cannulation and venepuncture training for Registered Nurses has been completed via a workbook with an assessment, which is signed off by a mentor. For HCA's training is offered via a face to face training session, which is followed by a practical assessment, which is signed off by a mentor.

A two day IV study day course is provided for all staff, required to be competent in the administration of IV drugs/therapy. Between April and September 2016 the IV team have provided five courses, a total of 131 attendees.

A one day IV Update course for all staff who administer IV therapy, which is required every three years. Between April and September 2016 the IV Team have provided six courses, a total of 185 attendees.

Cannulation and venepuncture training sessions, for the HCA's, required to be competent in this skill. Between April and September 2016 the IV Team have provided two sessions, unfortunately due to reduce resources two sessions were cancelled, a total of 40 attendees.

The IV Team have also provided 18 individual departmental IV update, including Renal, ITU and Midwifery,

An ad-hoc IV Update was arranged for the Imaging Department; which was undertaken in May, a total of 15 attendees.

Two ad-hoc IV study day and four administrations of IV drugs/therapy days were arranged for the International Nurses, a total of 25 attendees.

Peripherally inserted central catheter line insertion

Between April and September 2016 the IV Team have:

- inserted 500 peripherally inserted central catheter (PICC) line insertion
- conducted 1000 patient assessment for PICC line insertion, line maintenance, USS cannulas and USS venepuncture
- 526 difficult cannulas and 66 USS guided cannulas were sited
- Out Patient Parenteral Antibiotic Therapy (OPAT) have reviewed and provided specialists support to 105 patients

HSJ Awards

The IV Team have been short listed for the Patient Safety category in the HSJ awards. The short list was based on evidence they submitted to the change of practice the Trust has implemented in relation to the remove of PVC's. A member of the team and the previous team leader are attending a further presentation to the HAJ award panel on the 17th October, if they are successful the award will be presented later in the year.

Cannula Audit

The IV Team conducted a peripheral venous catheterisation management audit during July 2016, across the Trust. The audit score margin is from 0-100% compliance. Peripheral venous catheterisation (PVC) is the most common procedure in t hospitalised patients, notwithstanding substantial clinical experience with PVC care there is considerable morbidity associated with the use of these devices.

Feedback was given immediately to the clinical staffs, which was confirmed with a follow up email to the Ward Leader and Matron.

Table 2: A summary of the audits results per ward and the common themes for non-compliance are provided in the tables below.

Clinical area	**Score**
Level 7A	35%
Level 8 Tower	69%
Level 8A East	57%
Level 8A West	42%
Level 9A East, West and South	75%
Level 11	44%
Renal	59%
ED/CDU PRH	48%
Albourne	54%
Ansty	66%
Clayton	85%
Hosted Keynes	37.50%
Hurstpierpoint	71%
Lindfield	82%
Newtimber	10%
Balcombe	53%
RAMU	88%
Pycombe	66%
ED Majors 2, 2B and Resus	75%
ACU	75%
AMU	50%
SAU	87%
Ardingly	50%
Baily	37%
Bristol	43%
Catherine James	46%
Chichester	51%
Donald Hall	100%
Egremont	23%
Grant	54%
Haemotology	52%
Howard 1	43%
Howard 2	86%
Jowers	53%
Level 5 HDU	77%
Level 6A	47%
Vallance	57%
Twineham	74%
Solomon	76%
Trust average:	**59%**

The complications associated with PVC's can have potentially damaging or even fatal consequences for the patient. Infection and phlebitis are avoidable if simple hygiene and safety principles are adhere to for each patient at the point of contact.

Documentation was inconsistence in the documentation of the date and time of insertion, name of who inserted the device not recorded, VIP scores not recorded, dressing was not clean or intact, insertion documentation not completed if device inserted off the ward i.e. Emergency Department (ED), Theatres, and if the PVC was in situ for >72hrs, the rational was not documented.

The results demonstrates a significant non-compliant to the Trust IV management policies, which is very disappointing. This can significantly influence the quality of care provided and the outcome for the patient, therefore it is imperative that staff adopt the principles associated with the management and care of patient who have these devices in situ.

Individual Ward Leaders have been requested to produce and implement an individual local action plan, the IV Team has formulated a Trust wide action plan which includes the following points:

- Facilitation and support from the IV Team at local level

1. IV Team conduct weekly audits for areas where their compliance score is low
2. Reinforce training in the management of IV access devises using internal and external resources
3. Drive the use of cannulation packs and blood culture pack through the Trust
4. Change in the IV Team working hours, thereby increasing the frequencies they are working on the clinical floor
5. Repeat the IV access devise and management audit in December 2016 Trust wide
6. Order code to be issued to Ward Leaders and placed on the IV *info-net* page to enable easy ordering

Section 4

Infection Prevention Team

Surveillance of infections is one of the most important components of infection prevention practices. It is defined as the ongoing, systematic collection, analysis, interpretation and dissemination of data regarding an infectious event. This information forms the bases of the infection prevention service provided to the Trust.

The Infection Prevention Team provides a comprehensive infection prevention service Trust wide. They provide a liaison and telephone consultation service for all inpatient and outpatient services, with arrangements for service cover during declared outbreak via the 'on-call' Consultant Microbiologist.

In April 2016 an Infection Prevention Nurse (Band 7) retired, and an Infection Prevention Trainee (Band 6) left the service. This gave the opportunity to review the structure of the team and the job descriptions for the roles within the team.

In April 2016, Andrew Davies was appointed as the substantive the Infection Prevention Nurse (Band 7).

From October 2015 till June 2016, Suzanne Morris; provided the Trust with a senior management. In June 2016 she was appointed as the substantive Deputy Director of Infection Prevention and Control.

In August 2016; interviews were held for the Infection Prevention Practitioner (Band 6) and the Infection Prevention Analysis (Band 5). The positions were offered to two individuals, and the appointed process is in process with a potentials start day 1st January 2017.

Job description for an Infection Prevention Surveillance Nurse, Infection Prevention Data in-putter, and a Clinical Educational role which world cover both infection prevention and venous access education is in progress.

Infection Prevention meetings

The infection prevention meetings use to comprise of the Infection Prevention Action Group (IPAG), which was held on three Fridays per month, and the Hospital Infection Prevention Committee (HIPC), which was held once a month on a Friday.

The meeting structure was reviewed with the Director of Infection Prevention and Control, Deputy Director of Infection Prevention and Control, Director of Clinical Governance and the

NHS Improvement Lead for Infection Prevention, the new meeting structure was implemented in September 2016, and comprises of the following:

- Infection Prevention Review Group; meets on the 1st Friday of the month, purpose of the meeting is to review and sign off the RCA/PIR investigations pertaining to HCAI's for approval and sharing, to determine if the investigation report meets the requirements for quality and effectiveness, Duty of Candour. For Terms of Reference (TOR) refer to Appendix 1

- Infection Prevention Operational Group; meets on the 3rd Friday of the month. Purpose of the meeting is to promote and protect the health and wellbeing of patients, visitors and staff. To provide a collective specialist and operational resource that supports and drives improvement in the prevention and management of infection. For TOR refer to Appendix 2

- Infection Prevention Committee; meets on the last Friday of the month. Purpose of the meeting is to advise the Chief Executive and the Board of all aspects of infection prevention, to provide assurance that the environment within the Trust is clean and safe. For TOR refer to Appendix 3

- A meeting with the Clinical Commissioning Group (CCG) will be held on the 2nd Friday on alternative months. Purpose of the meeting is to review the RCA in relation to CDI for lapses in care. The first meeting will be held in November, where the TOR will be ratified

Infection Prevention Governance

Governance related to infection prevention as been reviewed. All Trust apportioned CDI cases (post day 3 cases) are investigated using the Root Cause Analysis (RCA) process. The expectation is that the RCAs are completed within 30 days of the notification. Currently this is not always being achieved in the divisions due to various clinical commitments.

The RCAs are robust; they involve the IPT, Consultant Microbiologist and Antimicrobial Pharmacist, the Clinical Team looking after the patient, Ward Leader/Matron, and the patient Consultant. The responsibility for completion of the RCA rests with the relevant division and must be completed collectively by the relevant teams. The RCA is discussed and an action plan created.

Each RCA, including the associated action plan will be presented and monitored at the Infection Prevention Review Group, and at the Divisional Governance meetings, facilitating the sharing and learning across the Trust. Infection prevention is a standing item on the agenda of these meetings, this is where the progress of the action plan from the RCA will be monitored and progressed

NHS Improvement visits

Following the Trust recent CQC visit, the NHS Improvement Lead for Infection Prevention is closely working with the IPT and Trust, to enable the Trust to be fully compliant with the Health and Social Care Act 2008, to deliver improvements in targeted infection prevention risk areas, to bring about rapid improvement in the delivery of infection prevention practices. This support has enable the team to bring together the values and

ambitions of the Trust, review the teams capacity and capability to improve the way the infection prevention service is delivered.

NHS Improvement Lead for Infection Prevention has made several visits to the Trust focusing on environmental and equipment cleanliness.

Brighton Marathon

Brighton Marathon took place on the 17th April 2016, although there are enormous health benefits in participating in a marathon, it also places a huge physical challenge on the body.

On the day a large team of doctors, paramedics and nurses (including the IPT) working in conjunction with the St John Ambulance Team, along with physiotherapists and podiatrists, provided first aid and medical treatment as required.

Picture 1: Runners on route through Brighton

The medical provision went extremely well, the strong relationship and understanding, which had developed between the different organisations was key to how well the event went.

There were 433 individuals who required medical treatment, 2,137 social contacts (provision of plasters Vaseline etc), this was a rise of 85% compared to 2015. 6 individuals were transfer to the Trust (1 individual was not related to marathon).

The main objective of the IPT was to assess current practices and opportunities for improvement in relation to infection prevention practices in a 'field' situation. Infection prevention strategies are designed to protect patients, public and staff. Routine practices that are critical to the prevention of infection included hand hygiene using of alcohol based hand rub, use of personal protective equipment, cleaning and disinfection and management of waste. An observation report and recommendations was submitted, and was discussed at the debrief meeting, which will be incorporated into next year event.

Picture 2: Clinical staff making up electrolyte oral fluids

Health Organization 'Clean Hands Saves Lives'

The Trust took part in the World Health Organization (WHO) 'Clean Hands Saves Lives Campaign on the 5th May 2016. The campaign focussed on raising awareness in practising effective hand hygiene to reduce risk of infections in surgical patients. The IPT led the campaign with Mildred Ruwona Infection Prevention Nurse Trainee; coordinating the campaign.

- The campaign was launched on by sending emails to the Infection Prevention Link Practitioners and Surgeons and Surgical Directorates informing them about the campaign
- Information about the campaign was also communicated through Trust intranet and at Practitioners Improvement Meetings (PIMs)
- A Clean Hands Saves Lives Newsletter was sent out on during March 2016
- Hand hygiene leaflets and booklets were distributed within the Trust
- A Twitter campaign gave healthcare workers the opportunity to show their commitment by sharing photos with hashtag ***#safesurgical hands*** on the social media site.

Picture 3: Clinical staff twittering!

Picture 4: Clinical staff and patients twittering!

Seven departments participated in the competition, and the standards were high, there were two joint winners;

Poster Winner 1: Cardiac Level 7A

Poster Winner 2: Main Theatres

On 20th June 2016, Suzanne Morris Deputy Director of Infection Prevention and Control, Caroline Davies Deputy Chief Nurse and Mildred Ruwona Infection Prevention Nurse Trainee presented the prizes to the winners.

This was a very positive day, with many clinical areas across the Trust participating. The posters have been presented to the Trust Communication Team, requesting them to be reviewed as potential Trust wide hand hygiene posters.

Semelweiss Hand Scanner Trial

The Semelweiss scanner is an innovative device for providing immediate quality assured feedback regarding hand hygiene technique. It is designed to help learn the technique for proper hand hygiene and can be used by staff, patients and the public.

The Trust is trialling the Semelweiss Scanner; it is objective, and instantly highlights any defects, and raises the awareness of potential hand hygiene issues.

A special alcohol based hand rub is applied to the hands, and then they are placed into the scanner, which demonstrates the flaws in the hand hygiene technique.

The Semelweiss Scanner has been used to raise hand hygiene awareness, as it provides real-time feedback on hand hygiene technique to individuals in the clinical setting, public awareness sessions, training sessions for nursing staff, medical staff and hotel service staff as well as the Contractors working on the 3T's project.

The information the trial is providing is helping the company to make alterations to enable the scanner to be fit for purpose in an acute healthcare setting, as well has having a unique database of hand images, which could be used as part of the Trust mandatory hand hygiene training.

Fit mask testing

To ensure compliance regarding fit testing (face mask FFP 3) across the Trust, a programme is in the process of being developed. This program will ensure appropriate training is provided to the nominated members of staff from each clinic staff (2-3 members of staff). The first training for 'train the tester' has been arranged for December 2016, further sessions will be provided in early 2017, with the aim to training 50 fit testers. All records of fit testing completed will be stored at local level as well as a copy being held within the Infection Prevention Department and Health and Safety.

Surveillance

The IPT currently has an inadequate solution in place for surveillance of HCAI's. This results in the following:

- Delays to identification and treatment of infections
- Unknown and missed infection episodes
- Risks to patient safety
- Risks of avoidable mortality to patients not mitigated
- High band Infection Prevention Nurses spending 40% of their time on clerical work is inefficient
- No ability to widen surveillance

The current system has now failed on several occasions, and as a result patients are at risk of delays in affective management, and the exposure of infections to other patients. The Infection Prevention Nurses (IPN's) are spending a large amount of their time in the office searching databases, approximately 40% of their time, rather than being out on the wards helping to prevent and reduce the impact of HCAI's, which is particularly significant under the Trust current building plans, which will have an impact on the Trust for the following 10 years.

This issue has been raised via reports to the Infection Prevention Committee, Quality and Performance Committee and the Board of Directors.

Section 5

Antimicrobial Stewardship

Antimicrobial stewardship optimises the treatment of infection and minimises the associated collateral damage such as the emergence of resistant organisms and *Clostridium difficile* infection.

Antimicrobial Stewardship is an overarching system of strategies to improve the use of antibiotics to benefit patient outcomes from infection, and it remains an integral part in the Trust achieving its *Clostridium difficile* infections. Continued reduction in overall antimicrobial consumption and particularly penicillin and carbapenem prescribing is a priority in slowing the emergence of antimicrobial resistance.

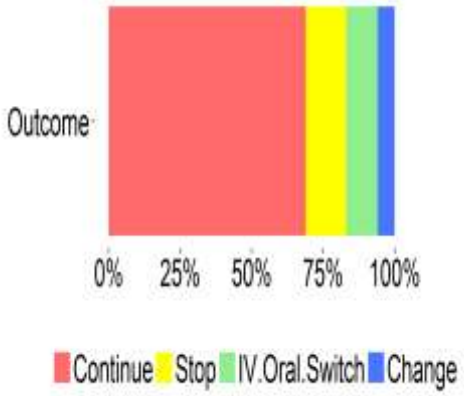
The approach within in the Trust is proactive i.e. antimicrobial policy, formulary and restriction, guidelines or pathways for treatment and prophylaxis, and reactive i.e. antimicrobial prescription review, audit and feedback. The National Antimicrobial Resistance CQUIN for 2016-17 is an opportunity to further the Antimicrobial Stewardship agenda.

Provisional analysis from July – August 2016 of the Trust antimicrobial prescribing; the sample size was 202 antimicrobial prescriptions, 19 from PRH; 177 from RSCH; 6 were not documented

- Administration route: 115 (57%) were IV; 85 (42%) were PO; 2 (1%) were topical
- Indication was documented in 182/202 (90.1%, 95% Binomial Confidence Interval (CI) 85.1% – 93.8%) prescriptions (no missing data)
- Indication was consistent with trust guidelines in 165/184 (89.7%, 95%CI 84.3% – 93.7%) prescriptions (data missing in 18/202 (9%))
- Duration was documented in 171/200 (85.5%, 95%CI 79.8% – 90.1%) prescriptions (data missing in 2/202 (1%))
- Duration was consistent with trust guidelines in 144/176 (81.8%, 95%CI 75.3% – 87.2%) prescriptions (data missing in 15/202 (7%))
- 72-hour review was documented in 126/151 (83.4%, 95%CI 76.5% – 89.0%) prescriptions (data missing in 51/202 (25%))

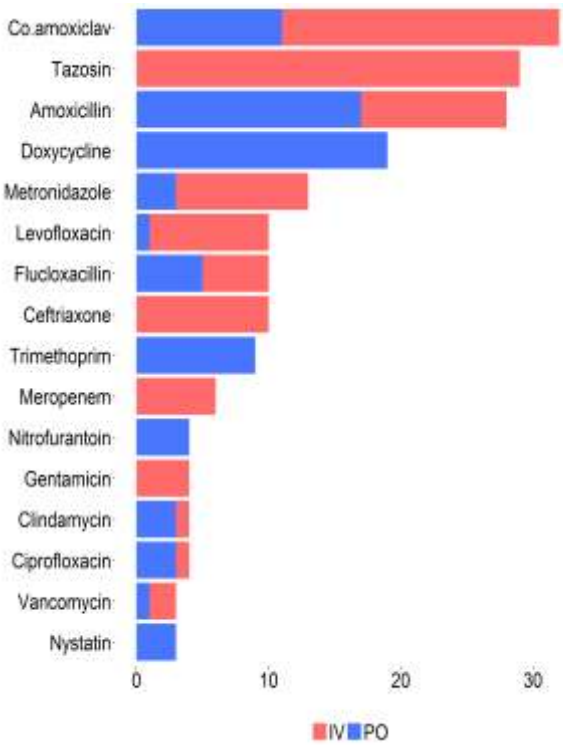
Table 3: Outcome of antimicrobial reviews (data missing in 67/202 (33%)):

Continue	93	69%
Change	8	6%
IV to oral switch	15	11%
Stop	19	14%
Total	135	100%



Choice of antimicrobial

Chart 7: The following shows all antimicrobials with ≥3 prescriptions ranked by frequency:



Co-amoxiclav, Tazosin, Amoxicillin and Doxycycline cover half of all antimicrobial prescriptions (total n = 108).

Table 4: Adherence to indication guidelines for these antibiotics is shown below:

Antibiotic	**N**	**Indication complies with guidelines**	**Indication complies with guidelines (%)**	***P*-value***
Co-amoxiclav	32	22/29	76%	-
Tazosin	29	26/26	100%	0.01093
Amoxicillin	28	25/26	96%	0.0538
Doxycycline	19	16/19	84%	0.7185

* *P*-values from Fisher exact test in 2x2 contingency tables comparing Co-amoxiclav with Tazosin, Amoxicillin and Doxycycline. The Co-amoxiclav vs Tazosin comparison was statistically significant i.e. Co-amoxiclav prescriptions were less likely to comply with trust guidelines than Tazosin prescriptions.

Focusing on the co-amoxiclav prescriptions, 14/20 (70%) IV prescriptions complied with trust guidelines compared with 8/9 (89%) oral prescriptions. Sample size was too small to reach statistical significance (*P*=0.3816, Fisher exact test), though the trend is suggestive.

Overall, 95/105 (90%) IV prescriptions complied with trust guidelines for indication, compared with 68/77 (88%) for oral prescriptions. This difference was not significant (*P*=0.8208, Pearson's χ^2 test).

Conclusions

- Indication is documented in 90% (85% - 94%) of antimicrobial prescriptions

(binomial 95% confidence intervals in parenthesis)

- Indication is consistent with trust guidelines in 90% (84% - 94%) of prescriptions
- Duration is documented in 86% (80% - 90%) of antimicrobial prescriptions
- Duration is consistent with trust guidelines in 82% (75% - 87%) of prescriptions
- There is ~10% data missingness for both indication and duration consistency with trust guidelines. This could bias the results (maybe pharmacists are more likely to leave this question blank if they aren't sure, and are more likely to be uncertain if the prescription differs from guideline).
- 72-hour reviews are documented in 83% (77% - 89%) prescriptions, though there is 25% data missingness
- Outcome of antimicrobial review has 33% data missingness. Of those documented, the most common outcome (two-thirds) is to continue with the present treatment.
- The most common antimicrobials used are co-amoxiclav, tazosin, amoxicillin and doxycycline, which together represent half of all prescriptions.
- Of the most commonly used antimicrobials, the indication for co-amoxiclav was the least consistent with trust guidelines. IV prescriptions of co-amoxiclav were less consistent than oral, though the difference did not reach statistical significance due to small sample size.
- Overall for all antibiotics, there was little difference in indication consistency with trust guidelines for oral vs IV prescriptions.

Recommendations and discussion points

- Add "antimicrobial indication" to the form
- Modify "72-hour review" question to include prescriptions <72 hours duration, as this is causing confusion
- Consider including "discussed with micro" along with adherent to trust guidelines. Presumably if micro have agreed then it's not a "bad" prescription from an antimicrobial stewardship perspective
- Encourage complete data entry!

Section 6

Decontamination

The purpose of decontamination is to prevent the spread of microorganisms and other noxious contaminants that may threaten the health of human or animals, or damage the environment.

Internal local audits completed:

- ENT OPD – This service provision was centralised on Monday 25th July 2016 into the Endoscope Decontamination Unit (SSD)
- RACH Level 7 Theatres – a JAG audit has been undertaken and an action plan developed, re-audit will commence in March 2017.
- Clinical Media Centre – This service provision will be centralised into SSD by the end of November 2015.
- TMBU – the audit in September 2015 found that the decontamination of linen was noncompliant with the requirements of HTM 01-04; there is an action to transfer the reprocessing of linen to the Trust's external linen provider.

Forthcoming audits:

- Research Lab – It has recently been bought to the Head of Decontamination attention that the lab are reprocessing equipment using a bench-top steriliser, arrangements are being made to conduct an audit.
- Mortuary – There doesn't seem to of been an audit for several years, arrangements are being made to conduct an audit.

Capital Projects:

- Hot R.O. Loop – The replacement of the contaminated loop will be going out to tender soon, there has been severe delays to this project due to staffing in Procurement. This project will not be complete until next financial year due to the delays.

  The contamination is being managed at source and is regularly sampled, analysed and audited by the Decontamination, Water and Infection Prevention committees.
- Replacement Washer Disinfectors (PRH) – Enabling works are due to commence in November with project completion currently May 2017, work is underway to bring this date forward.

- Third Steriliser (PRH) – specification is currently with NHS Supply Chain, project completion should be end of March 2017.

On-going Projects:

- Cardiac Theatre – Centralisation of the decontamination of the Sorin Heater/Cooler units is underway, this will be achieved by removing the decontamination of dynamic mattresses off-site for ITU/HDU. This should be complete by November.
- SSD – implementation of the new HTM's for decontamination this has already commenced but additional testing is required for the storage cabinets of flexible Endoscopes

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Section 7

Education

Our vision is to provide consistently excellent and safe patient-centred care, through staff having the required knowledge to reduce the risk of infections.

Educating healthcare workers about infection prevention and control is required by the Trust as part of its registration (Department of Health, 2015). All staff in the Trust, including volunteers, are required to receive a Trust induction and update that reflects national competencies as outlined by Skills for Health (2011). The General Medical Council (2009) has also published outcomes and standards that include infection prevention for undergraduate medical doctors. Likewise, the Nursing and Midwifery Council mandate that infection prevention and control is covered on pre-registration nursing courses (Nursing and Midwifery Council, 2010).

During the first six months of the 2016-17 fiscal year, the PT has delivered around 162 hours of education/ training via 161 sessions. Approximately 849 staff, students (medical/ nursing) and other groups e.g. volunteers, undertook education related activities in relation to infection prevention and control.

This figure currently excludes the number that attended Trust induction and clinical/ non-clinical updates. As of September 2016, 70% of Trust staff is compliant with their infection prevention update. In order to ensure consistency for the Trust induction, the learning outcomes as specified by Skills for Health (2011) were covered for all staff.

For the update the expectation is that staff are familiar with the content of the IP workbook (clinical or non-clinical). The session is an opportunity to update on the position of the organisation in relation to infection prevention and negotiate learning outcomes so as to suite those in attendance. For example, when delivering an update specifically to phlebotomy teams then the focus can be on blood borne virus protection and sharps management.

The IPT has delivered more teaching hours and sessions in the first half of 2016/17 than it did in the whole of 2015/16 (162 verses 109 hours and 161 verses 59 sessions). There has been focus on hand hygiene and auditor training and trialling a new hand hygiene training tool, the Semmelweis hand hygiene scanner. There has been improvement in mandatory training compliance, from 44% to 70%.

Other options are being explored with Leading and Development, to increase the Trust compliance rate. Including the development of a specific practice educator role covering both

infection prevention and venous access, this will enable greater focus on education at the point of care as well as other initiatives.

Table 5: Infection prevention is an integral part of induction and Core Module (mandatory) update training, as well as several bespoke training sessions. The table below demonstrates infection prevention training undertaken in the first 6 months of 2016-2017.

Session	Participants	Number of participants	Method of delivery	Learning outcomes	Frequency/ dates	Number of sessions	Estimated Hours
Trust Induction	All new starters to the Trust. Excludes volunteers		Face to face	Satisfy skills (2011) for health competency framework and passport schemes	Twice monthly. Once in Brighton, Once in Haywards Heath	12	9
Annual update - clinical staff	All clinical staff (6000)		Face to face (lecture style), IRIS e-learning, and workbook	Staffs are already expected to know skills for health competencies and these are summarised in a workbook. This is an update in relation to how BSUH is performing and to clarify any specific outcomes	Several times a month	33	16.5
Three yearly update	Non-clinical staff (1382)		Face to face (lecture style), IRIS e-learning, and workbook	Staff are already expected to know skills for health competencies and these are summarised in a workbook. This is an update in relation to the BSUH is performing and to clarify any specific outcomes	Monthly	12	6
Hand Hygiene auditor sessions	Healthcare staff that undertake audits	65	Face to face	By the end of the session an attendee will be able to describe each of the 5 moments for hand hygiene in relation to their area, explain/demonstrate how to undertake a hand hygiene audit, explain/demonstrate how to give staff feedback in relation to hand hygiene	27. 06. 2016 - 26. 09. 2016; 16 days were set aside	66	66

				practices, both positive and negative and record this feedback, describe the SOP rating in relation to compliance scores and appropriate actions including escalation, demonstrate how to upload the data to the dashboard			
Training and evaluation of the Semmelweis hand scanner	Staff across the organisation including; Cath Labs, ED, Hotel Services, Maternity, L8A West, Medical Students	278	Face to face and some self-administered	The scanner assesses application of an alcohol rub which contains UV particulars, against a 7 stage hand hygiene technique. Staff are given a % compliance and a pass/fail status	April – September 2016	17	9.5
HCA induction	Healthcare assistants	150	Fac-to-face	What is infection prevention; how do organisms spread; examples of vectors/fomites; common infections in hospitals; importance of hand washing; alcohol hand rubs; environmental cleaning and the importance of; commode cleaning	Monthly	6	4.5
Volunteers		15		Skills for health competencies: responsibilities; hand hygiene; personal protective equipment; dealing with blood spillage; management of injury; cleaning of equipment/ environment and personal fitness for work	RSCH 24th May 2016	1	0.5
		11			PRH 12th April	1	0.5

		18			19th July 2016	1	0,.5
University Students	BSc Year 3 Nursing	80	Face to face	Revision and application of standard principles for infection prevention according to NICE (2012) clinical guideline and epic3 (2015)	12th September 2016	2	6
Medical Students	BSMS Module 301: Clinical Foundation Course Year 3	146	Face to face lecture theatre	Satisfy skills (2011) for health competency framework and outcomes for General Medical Council (2009)	21st September 2016	1	2
Sporicidal wipe training	Ward staff; 86 areas	86	Face to face by a company representative from Clinell®	A company representative visited clinical areas. Training included; reiteration of correct usage of wipe demonstrated and issues identified discussed with contact staff when and as appropriate, 5 principles of effective decontamination demonstrated where appropriate, small group training session/discussions also undertaken during audit as necessary ranging from 1:1 staff sessions or small groups up to 4 staff	Between April – September – 9 days	9	41
Total		**849**				**161**	**162**

Section 8

Occupational Health

Our staff health is important to us. Occupational Health Team works closely with the Infection Prevention Team to ensure that staffs are protected against infection.

Sharp injuries

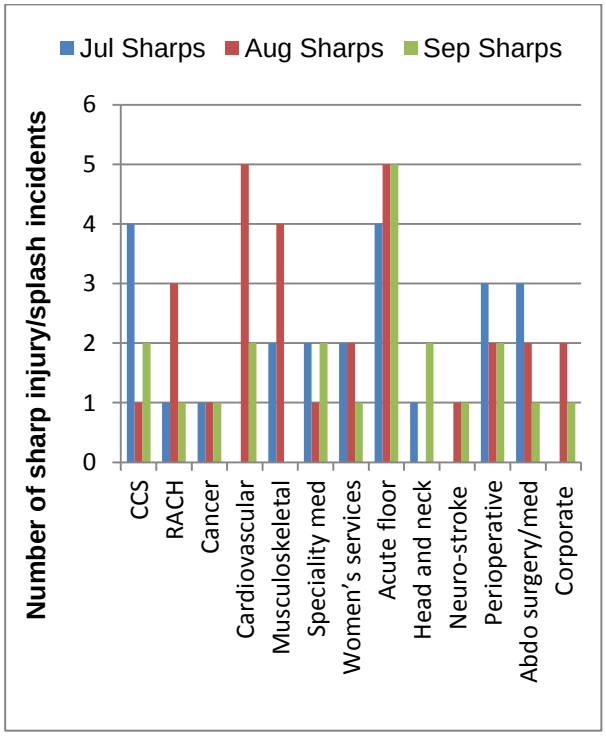
There were a total of 73 splashes sharps injuries reported to Occupational Health since July 2016.

Occupational Health continues to provide information for new staff to the Trust via the Trust induction on the prevention and management of sharps and splash injuries. This information is reinforced with mandatory training, which is available through IRIS.

Table 6: Demonstrates the type of sharp injury involved.

Causative sharp	Total
Occurred during procedure (various)	10
Splash	19
Patient moved	2
Re-sheathed needle	3
Delayed disposal	10
Upon removal of sharp	4
Caused by 2nd party (colleague)	5
Incorrectly disposed of needle	8
Overfilled sharps bin	1
Bitten by patient	1

Chart 8: Demonstrates the number of incidents reported by division, which sustained a sharp or splash incident.



Influenza immunisation program

Criterion 10 of the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance (2015), states '*arrangements for provision of influenza vaccination for healthcare workers where*

appropriate'. Under the Health and Safety at Work Act (1974), the Trust has specific duties to protect, so far as reasonably practicable those at work and others who may be affected by their work activity. The Control of Substances Hazardous to Health (COSHH) Regulations (2002) requires the Trust to assess the risk from exposure to hazardous substances including pathogens, and to bring into effect the measures necessary to protect staff and others from those risks as far as is reasonably practicable.

Any vaccine preventable disease that is transmissible i.e. person to person, will pose a risk to healthcare workers, patients, and others. Healthcare works have a duty of care towards their patients, which include taking reasonable precautions to protect themselves from communicable diseases (Green Book, Chapter 12).

Department of Health (May 2016) stated that more people than ever received the vaccination against influenza; this was not reflected in the Trust uptake, which was 46.5% (PHE 2016).

Influenza immunisation helps to prevent influenza in healthcare workers, and may also reduce the transmission of influenza to vulnerable patients (Green Book Chapter 12). Healthcare workers are more likely to be exposed to the influenza virus, every year a number of healthcare workers will acquire influenza, particularly where there are influenza outbreaks.

The Trust is committed to providing a robust influenza immunisation program; this has been based on a local risk assessment as described in '*Immunisation against Infectious Disease'* (Green Book). The vaccine will be available to all staff free of charge (COSHH Regulations 2002). The first batch of vaccination was delivered to the Trust on Monday 10th October and the immunisation program commenced. The Trust aim is to offer the influenza vaccine to all staff, if any member of staff declines the vaccine, they will be requested to complete a form stating that they have been offer the vaccine and have chosen to decline the opportunity to be vaccinated.

As well as the vaccination being offered by the Occupational Health Service, there is a team of Nominated Nurse Vaccinator, who are offering vaccination to staff on the clinical wards and at drop in clinics. The dates of these will be advertised on the Trust infonet. There is a link on the staff infonet for staff to make contact with a nominated vaccinator.

The aim of the progamm, is that the majority of vaccination will have been administered by the end of December 2016. A judgement will be made at this time, to whether it is appropriate to continue to offer the influenza vaccination from January to March 2017.

Influenza immunisation is one of the most effective interventions the Trust can provide to protect staff, patients and the services the Trust provides.

Section 9

Infection Prevention Audits

Healthcare workers compliance with infection prevention practices and principles is vital in preventing the spread of infection. One tool to assess infection prevention practice in clinical areas is audits. This section provides a summary of the audits undertaken between April – September 2016

Ice Machines – February 2016

The purpose of this audit was to protect patients, visitors and staff from the risk of infection and the environment is managed effectively to minimise reservoirs for micro-organisms.

The Health and Social Care Act 2008 (2015)] state that good infection prevention (including cleanliness) is essential to ensure that people who use health and social care service receive safe and effective care.

During February 2016 visited all clinical areas to locate ice machines, as there was no assist list available. At the time of the audit 35 ice machines were identified. The general findings were:

- 35 ice machines drew water from the mains water supply
- 2 ice machines are on a planned maintenance program
- 33 ice machines are not on a planned maintenance program
- 2 ice machines dispense ice from a nozzle directly into a receptacle on demand
- 33 ice machine produced ice that was not fit for human consumption (Food Act)
- 14 ice machines were broken
- Evidence of contamination with microorganisms; black mould, green/pink substance inside the ice machines, lime-scale
- There is no cleaning process for the ice machines

Feedback was given at Infection Prevention Action Group on 19th February, 2016. The CEO made the decision that the ice machines were not fit for purpose and should be removed immediately. An internal patient safety alert was issued; broken machines and those not fit for purpose were removed.

The requirement for ice; for therapeutic reasons have been identified, which has indicated flake ice would be more appropriate. It has been agreed

that these should be sited at strategic placements across the Trust, which are being identified by senior nursing staff. IPT has been working with procurement to identify appropriate machines, and the Water Safety Group.

***Clostridium difficile* infection snap shot audits**

The NHS Outcomes Framework 2015-16 (DH 2014) stipulates within Domain 6 that NHS organisations reduce the incidence of HCAI's including *Clostridium difficile* infections. The Trust trajectory for 2016-17 is ≤46 Trust acquired cases. Part of the strategy for this reduction includes auditing the High Impact Interventions for *Clostridium difficile* infection reductions that reflect national guidance (DH 2008).

Since April 2016; *Clostridium difficile* infection snap shot audits have been undertaken by the IPT; these have been conducted for all positive inpatient cases, irrespective of their acquisition (hospital and community) of *Clostridium difficile* infection. The IPT has conducted 69 audits, which has provided a compliance percentage rate of 89%. The expectation is that all clinical areas audited are 100% compliant.

Feedback was given immediately to the clinical staffs, which is confirmed with a follow up email to the Ward Leader and Matron. The audit process is on-going and is part of the IPT annual programme of work.

A summary of the audits results per ward and the common themes for non-compliance are provided in the tables below.

Table 7: April 2016, the IPT undertook 9 audits, compliance ranged between 70-100%, with an average compliance of 91%. Current themes for non-compliance; isolation door signage not displayed, source isolation not implemented under the sample result was known.

Clinical Area	Audit Score
Ardingly	100%
AMU	94%
HDU RACH	94%
Vallance	87%
Bailey	70%
Howard 2	100%
AMU	100%
RACH L9	84%
Grant	93%

Table 8: May 2016, the IPT undertook 10 audits, compliance ranged between 88-100%, with an average compliance of 95%. Current themes for non-compliance; incorrect waste stream used, isolation door signage not displayed, source isolation not implemented under the sample result was known.

Clinical Area	Audit Score
Howard 2	100%
Level 8AW	100%
Albion	93%
Ardingly	94%
Ardingly	88%
Jowers	88%
Bristol	100%
L8A East	100%
Vallance	100%

ITU	88%

Table 9: June 2016, the IPT undertook 8 audits, compliance ranged between 54-88%, with an average compliance of 82%. Current themes for non-compliance; no sporicidal wipes available, isolation door signage not displayed, source isolation not implemented under the sample result was known.

Clinical Area	Audit Score
Balcombe	88%
Haem-Oncology	54%
AMU	88%
Overton	87%
Baily	88%
Ardingly	88%
L9A	88%
L8	77%

Table 10: **J**uly 2016, the IPT undertook 11 audits, compliance ranged between 58-100%, with an average compliance of 86%. Current themes for non-compliance; isolation door signage not displayed.

Clinical Area	Audit Score
AMU	78%
Egremont	88%
Ardingly	93%
Pyecombe	58%
AMU	100%
Egremont	87%
Catherine James	94%
Trafford	100%
Jowers	75%
L9A West	88%
L9A East	80%

Table 11: August 2016, the IPT undertook 21 audits, compliance ranged between 55-100%, with an average compliance of 90%. Current themes for non-compliance; isolation door signage not displayed.

Clinical Area	Audit Score
Newick	94%
Ardingly	94%
L8Tower	55%
L8Tower	81%
Howard 2	82%
L8Tower	100%
L8Tower	100%
L8Tower	100%
Pyecombe	57%
AMU	94%
Pyecombe	94%
Pyecombe	94%
Pyecombe	100%
Level 8	93%
Level 8	93%
Balcombe	100%
Ansty	94%
L8 Tower	100%

AMU	87%
L5 ITU	88%
AMU	94%

Table 12: September 2016, the IPT undertook 18 audits, compliance ranged between 69-100%, with an average compliance of 90%. Current themes for non-compliance; isolation door signage not displayed.

Clinical Area	Audit Score
Bailey	82%
L9A East	90%
NEWICK	88%
Grant	100%
ITU RSCH	94%
Howard 2	94%
Chichester	75%
Catherine James	75%
Newick	94%
Horsted Keynes	75%
Horsted Keynes	69%
Howard 1	94%
Grant	94%
Horsted Keynes	100%
RSCH-ITU	100%
L8 Tower	92%
Howard 2	100%
Howard 1	100%

MRSA suppression therapy – May 2016

Although the prevalence of Meticillin Resistant *Staphylococcus aureus* (MRSA) has diminished, MRSA transmission continues to occur.

The purpose of this audit was to check compliance to IC 007 MRSA policy. All MRSA positive patients, and/or patients' known to be MRSA positive and/or with less than three negative consecutive screens since a positive MRSA screen receive MRSA suppression therapy.

The IPT undertook an audit of MRSA suppression is April and May 2016. The IP team visited all the wards with MRSA positive patients.

Health and Social Care Act 2008

Criterion 5 states that healthcare providers will need to demonstrate "*prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.*

Criterion 9 states; healthcare providers "*Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.'*

Audits were undertaken by Infection Prevention Team over three days in April / May 2016 using the audit tool in Appendix 1.

Case finding involved extracting from OASIS, all inpatients with a previous history of MRSA and checking WinPath® for MRSA screen results. The MRSA databases were also reviewed and an audit form completed for each patient that fulfilled inclusion criterion.

The wards were visited. Each MRSA positive patient's nurse was asked if they were aware of their patients' MRSA status. Drug cards were reviewed for MRSA suppression prescriptions and administration. Patients were asked if they are aware of their MRSA status.

Results

60% of the clinical staff providing direct care for MRSA positive patients was aware of the patients MRSA status. MRSA suppression therapy was prescribed for 45% of cases, 15% did not have it prescribed but clinical staff had administered the MRSA suppression therapy. However there was no evidence that the patient's hair had been washed as per policy. 15% of patients were not aware of their MRSA status.

Key issues identified include:

- Audit results have indicated that clinical staffs are not acting upon the results communicated to them from the IPT. The MRSA status is always documented on the hand over sheet or verbalised to colleagues and medical staff so the message is lost

- Ward clerks no longer check OASIS for patient alerts, and clinical staff do not routinely check OASIS

- Full suppression therapy not given to all patients

- Patients were generally aware of their MRSA colonisation status, 2 patients cited that they had acquired their colonization from the Trust

The IPT has made several recommendations to enable the clinical areas to be compliant with IC 007 MRSA Policy:

- Results of the audit to be shared with all relevant staff at ward meetings, hand overs. Raising the profile of identifying MRSA position patients and acting accordingly on their results

- Ward Clerk checks all inpatient admissions on OASIS for the 'red diamond' MRSA alert, and check the inside cover of the patients health records for a MRSA positive sticker

- If OSASIS indicate the patient is MRSA position, but there is no MRSA positive sticker in the health records, to insert a MRSA positive sticker

- OSASIS PAS should be reviewed daily to identify all patients in their clinical are who are MRSA positive, and inform the Ward Leader or Nurse-in-Charge

- Ensure hand-over sheets are updated with patients MRSA status according to local ward policy

- Not all MRSA positive patients receive MRSA suppression therapy (in accordance to the IC 007 MRSA policy). This increases the risk of MRSA infection / transmission to other patients.

Commodes – September 2016

14th-16th September 2016, the IPT conducted a commode audit across the whole Trust, a total of 44 areas were visited, and a total of 121 commodes audited for structural integrity,

cleanliness and presence of the 'I am clean' sticker.

To comply with the Health and Safety at work Act 1974 and the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, the commode must be in a good state of repair and be clean. This is to ensure no harm could come to the patient physically or by risk of cross infection.

It is Trust policy that all commodes are disinfected after use with a sporicidal wipe and an 'I am clean' label placed on the commode to indicate it has been disinfected.

Up to 3% of commodes had visual soiling on either the wheels, frame or hard seat compared to 9% when last audited in December 2015. 3% of the frames had some coating missing, 2% of hard seats had some cracks and 4% soft seats had some damage.

This was an improvement since December 2015 when 10% had frame damage and 21% soft seat damage.

50% of commodes had the 'I am clean' sticker present compared to the last audit when it was 36%.

An action plan will be sent to the directorates and monitored at the monthly infection prevention operating meeting. The next audit is planned for December 2016.

Cleaning wipe dispenser – September 2016

Audit was undertaken of the GAMA cleaning wipe dispensers across the Trust. A total of 86 areas were visited (the audit is still ongoing). In each ward/department the bays, side rooms, toilets, clean and dirty utility, treatment room etc were reviewed. Initial findings; many of the red dispensers are broken and require replacement, many areas do not have the green dispensers due to refurbishment, and some are damaged and require replacement, others require relocation.

Hand hygiene audit

Effective hand hygiene plays an important role in reducing HCAIs, and for this reason it must be practised by everyone; to protect our patients, staff and the public.

A Standard Operational Procedure (SOP) was ratified at the Hospital Infection Prevention Committee (HIPC) on the 3rd June 2016. It was issued on the 10th June and was operational from the 13th June 2016. Data from the May monthly hand hygiene audits was used as a baseline; this dictated where wards started on the SOP audit criteria implemented; which were:

- Daily audits clinical areas scored <85%
    - Daily monitoring until scores are >86% for 7 consecutive days, then move to weekly audits
- Weekly audits clinical areas scored 86-95%
    - Weekly monitoring until scores reach >95% for at least 4 consecutive weeks, then monthly, if at any time one of the weekly scores falls below 96%, move to daily
- Monthly audits clinical area scored 96-100%
    - Monthly audit score 96-100%, continue with monthly monitoring
- Non-return in the monthly monitoring, weekly audits were required

Initially there were 46 clinical areas on monthly, 30 clinical areas on weekly and 25 clinical areas

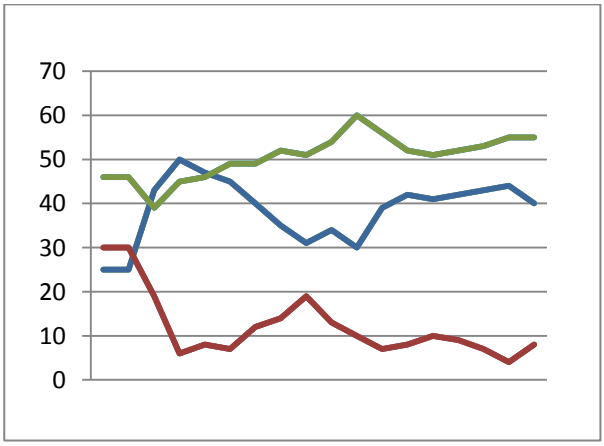
on daily audits. It was anticipated, that the weekly audits would probably stay static, with an increase in daily and a decrease in monthly audits.

Daily audits: there was a significant increase in the daily audits from 25 clinical areas to 50 clinical areas, this trend decreased, with a second wave of increased activity seen and there is at present 40 clinical areas on daily audits

Weekly audits: the weekly audits remained static for a short while following the introduction of the SOP. This was followed with a steady decrease in the number of clinical areas on weekly audit. A second wave was seen, which peaked with 19 clinical areas on weekly audits, since then there has been a stead downward trend, with 8 clinical areas at present on weekly audits

Monthly audits: the monthly audits remained static for a short while following the introduction of the SOP. This was followed with a steady decrease which bottom out at 39 clinical areas. A steady increase was then seen, peaking at 60 clinical areas on monthly. A second shallow decrease wave was seen, this has turned upwards and there are at present 55 clinical areas on monthly audits.

Graph 9: Hand hygiene audit movement across the Trust from 17th June 2016 (Green line monthly audit, red weekly audit and blue daily audits)



IPT spot check hand hygiene audits

During the Trust recent Clinical Quality Commission (CQC) visit it was identified that hand hygiene compliance within the Emergency Department was below an acceptable level.

The IPT visited the department in May and conducted a spot check hand hygiene audit, the score was 7%. This audit identified that there was a lack of suitable hand decontamination facilities within the department. Additional hand hygiene based alcohol rub dispensers were installed at the point of care, including additional hand washing sinks. Hand hygiene awareness sessions were provided by the IPT, which included medical teams, nursing teams, paramedic team and Hotel Services teams.

Six ad-hoc training session were delivered by the IPT team for ED staff. Training included the use of the 'glow box', WHO '5 Moments', hand hygiene technique, and how to apply the hand hygiene products.

There was a significant lack of staff awareness of WHO '5Moments', despite it being implemented in 2007, hence this was a key part of the training, as the audit is focus around the '5 Moment'. Posters were issued and displayed within the department, to reinforce the message in relation to the WHO '5 Moments'. Subsequent audit were undertaken by the IPT, which showed a slow by steady improvement with compliance to hand hygiene

Table13: Hand hygiene audit carried out by the IPT, results

DATE	AREA	Audit Score
17th May	ED, Majors and Resus	7%

9th June	ED, Majors 2B	18%
9th June	ED, Majors A and Resus	55%
14th June	ED, Majors 2B	80%
15th June	ED, Majors 2A	70%
21st June	ED, Resus	60%
30th June	ED	80%

Issues raised by some of the ED staff:

- Hand washing soap made hands dry
- Staff in Majors 2A informed that often hand wash soap dispenser was empty
- Paper towels sometimes unavailable in changing rooms

Staff engagement was very good, and work every hard to address these issues and improve the department hand hygiene score. The audit score on the 5th October for the department was 94%.

Maternity L12 and L13

The SOP was implemented in June 2016, and this identified Maternity L12 and L13 compliance score was well below an acceptable level. The IPT undertook an initial audit on 21st June for L12, their score was 40%, and an audit on the 22nd June for L13 was their score was 25%. The auditing on L13 was challenging as it was not possible for the team to enter the room when mothers were in labour. During the audit an assessment was also conducted for the availability of hand hygiene alcohol based rubs and hand washing sinks within the departments, there was a lack of available alcohol based hand rub at the point of care i.e. patients rooms.

The clinical leads took ownership at a local level; they developed an action plan and implemented it to improve clinical practice. As part of this action plan; each morning staff reminded each other about their latest hand hygiene scores during handover period, this had a significant impact and within a short period of time their hand hygiene score was 94%. Staff also discussed the issues identified during the audits. Subsequent hand hygiene audits were done by the IPT, results were fed back to the Ward Leader. Two ad-hoc training session were delivered by the IPT team for Maternity. Training included the use of the 'glow box', WHO '5 Moments', hand hygiene technique, and how to apply the hand hygiene products.

Table 14: Hand hygiene audit carried out by the IPT, results

Date	Area	Audit score
21st June	L12	40%
22nd June	L13	25%
1st July	L12	94%

There were significant improvements in hand hygiene practices in the department resulting in increased hand hygiene scores within a short period, the department is currently on monthly hand hygiene audits.

Section 10

Estates and Hotel Services

Continuous measurement and management of performance of Estates and Facility Management Service is also vital in the prevention and control of hospital acquired infection.

During 2016 the Patient Led Assessments of the Care Environment (PLACE) is a self-assessment of non-clinical services which contribute to healthcare delivered in the NHS and was introduced in 2013 to replace the form Patient Environment Action Team (PEAT). The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing the Trust. This is done in equal partnership with NHS staff to both identify how they are currently performing and to identify which services can be improved for the future.

PLACE took place across the Trust from March through to June. Due to the difference in size of all of our sites, some of these assessments took only one day and others a whole week.

We had huge support from Healthwatch organisations from Brighton and Hove and Mid Sussex who joined clinical teams, ex patients and visitors in looking at the way in which our environment supports patient care.

Ahead of each annual assessment we organised a training session to introduce the programme to external volunteers who have not experienced this work before, and to update others to changes to the programme.

This year the assessments were extended to include criteria on how well healthcare premises are equipped to meet the needs of caring for patients with dementia and disability. This however focused on a limited range of aspects with strong environmental or building associated components opposed to a comprehensive assessment relating to dementia and disability. Organisations are encouraged to separately undertake a comprehensive dementia-related assessment using a recognised environmental assessment toolkit.

Below are the assessment summary's in relation to the four sites within the Trust that were audited for 2016, the Sussex Eye Hospital (S.E.H) was not included this year due to an extensive refurbishment programme. These summaries were written by external assessors only and not Trust staff.

Royal Alex Children's Hospital

- The Alex is a fairly modern children's hospital that is friendly, welcoming and bright
- The mainly glass structure around the lifts and waiting areas can prove to be challenging for visitors with issues regarding fear of heights. Seating should be available away from glass walls
- There are no large permanent signs for floor levels and directions to wards
- The Day Surgery adolescent room needs an upgrade as soon as possible as does the children's waiting area - broken toys and drawing materials. Bad selection of books, which all give a bad impression
- General tidying up and hiding of equipment is required in reception areas
- The staff are dedicated, professional, caring and forward thinking in terms of treating children with disabilities and special functional needs
- This building needs to maintain its cutting edge position by ensuring there is consistency throughout the wards, waiting and reception areas, i.e. in terms of signage, cleanliness, tidiness, facilities and information available to parents, children and young people
- A deep thorough clean of floors and windows needs to be done as wear and tear and general use has begun to set in
- The same information should be available on all ward notice boards, stickers, notices should be laminated and left neater and tidier and removed if torn or broken
- Curtains around beds should be replaced with more cheerful, child friendly ones
- The "Sensory Garden" play area was partly signposted and the garden was closed due to wind damage but no signs to say when it would re-open again
- Ensure visitors and parents are made aware that they can use staff lifts as may not like using the glass passenger ones
- Staff should be made aware that mobile phone use is an issue and that intricate conversations should be kept to a minimum on the ward/bay areas and peace and quiet held in high regard for children recovering from surgery
- Ensure there are separate dinner plates for children with sensory issues

Royal Sussex County

- Level 12 Post Natal ward; heating overbearingly hot and could not be turned down. Some windows were secured closed and could not be opened. This was picked up last year during the PLACE audit and has not been rectified
- A hospital with buildings of very different ages. The older building does not offer the same level of privacy as the newer one, but there was a high level of cleanliness throughout. A major weakness is signage
- In the old building the cleanliness is a high standard, décor depends on what has recently been refurbished. In general, in good order but does not yet cater adequately for dementia patients
- ITU- modern, very clean appearance, calm and well ordered, lots of staff. First impressions were very positive. More information required regarding who is in charge and the different uniforms/roles would be helpful for the public/patients

- In Overton Ward there was good evidence of patient feedback and staff ratios was also on display
- There has been piped oxygen installed, which needs to be boxed in, the floor needs the old polish stripping off as appears messy
- In main OPD there is no access for wheelchair users for WC facilities, the building looks tired and signage is very confusing

Princess Royal

- A building that is showing its signs of age looking a bit tired. More storage on the wards needed
- Better facilities for private conversations between staff and patients
- A/E reception desk needs disability access (this was also highlighted last year 2015)
- Plumpton Ward needs a thorough bathroom refurbishment
- The external and internal décor of the building needs refreshing, majority of wards have inadequate storage
- Because of lack of storage, wards are cluttered and creating a fire hazard
- Signage is dated and needs improvement
- There are no large permanent signs for floor levels and directions to wards. When the lift doors open you do not know which floor you are on

Sussex Orthopaedic Treatment Centre

- A very spacious unit with good standards of cleanliness and well maintained. The unit was let down by the food service
- Patients had trouble opening packets for cheese and biscuits, one patient said getting a sandwich wrapper opened was difficult and had received no assistance

Table 14: The scores for the Trust 2016 site assessments are shown below with comparison to the national average scores:

	RSCH	RACH	PRH	SOTC	Nat Av
Cleanliness – housekeeping nursing	98.65	98.10	95.7	98.45	98.1
Ward food/hydration	83.8	73.46	92.4	75.8	88.2
Privacy, Dignity	76.04	87.32	91.98	75.47	84.2
Condition, appearance, maintenance	83.8	88.67	86.47	94.68	93.4
Dementia	55.25	N/A	57.85	59.22	75.2
Disability	66.8	74.3	65.52	71.37	78.8

Since the formal assessments earlier on this year, the Trust has met with Healthwatch assessors from both Mid Sussex and Brighton and Hove to discuss progress and action from the visit.

A number of issues highlighted have already been actioned or are in the process. It has been agreed that both Healthwatch teams will visit both sites on a regular monthly basis joining clinical teams to undertake environmental walks. This will enable us to jointly identify how we can improve the environment for our patients.

Table 15: the following table highlights the areas commented on during the PLACE visit and the action the Trust are taking to improve the patient experience:

Area	You Said	We Will
RACH	Signage in general and consistency with information	This is currently being looked at by the clinical teams

	displayed on notice boards	
RACH	Signage on the Sensory Garden gate	This will be displayed on the gate with opening times
RACH	Children's Menu and crockery	Catering contract about to go out to tender, all menus will be looked at for content as will crockery etc
RACH	Day Surgery Waiting area and adolescent room	These areas are currently being looked at by the clinical teams for improving facilities
RACH	Improve information given to parents with regard staying overnight	Information leaflet currently being designed
RSCH	Some of the windows on Level 12 of the Tower Block will not open properly and some are locked shut	Estates are currently in the process of repairing the faulty windows. It is a very labour intensive job taking 3-4 hours per window
RSCH	Heating on level 12 Tower Block extremely hot and could not be controlled	Estates are currently dealing with the fault
RSCH	Signage in general is poor	A huge project is currently underway to change the style and improve the signage across site, a number of areas have already been changed, project should be finished by the end of 2016
RSCH	Overton ward needs the new piped oxygen boxed in and old polish on floor stripping off	The piped oxygen is currently being boxed in and the polish has been removed
RSCH	Main OPD has no facility for a Disabled access WC	Plans have been drawn up to reconfigure these facilities, building work should start very shortly
RSCH	The site does not cater enough for Dementia patients	This is a huge project. As and when we re-decorate an area the facilities will be changed

		accordingly
PRH	Building showing signs of age looking tired	There is an on-going decoration programme for the site
PRH	A/E reception has no access for disabled patients/visitors	Plans have been drawn up for the refurbishment of this area
PRH	Signage in general needs updating	Currently the signage at RSCH is being updated, once this project has finished the signage at PRH will be looked at
PRH	Plumpton Ward needs bathroom refurbishment	The plan is to refurbishment and change flooring in these bathrooms
SOTC	Bad Food service on the day of assessment	The food service is being looked at with the integration of nursing staff assisting with handing out the food trays to patients and will include the opening of packaged food items

Appendix 1: Infection Prevention Review Group Terms of Reference

Infection Prevention Review Group Terms of Reference

Purpose

- To review and sign off the RCA/PIR investigations pertaining to a Healthcare Associated Infection for approval and sharing
- Determine if the investigation report meets the requirements; for quality and effectiveness, Duty of Candour
- Take an accurate record of the group membership and its conclusions
- Communicate the outcome of the group to the Infection Prevention Committee and Commissioner

Membership

Chief Nurse/Director of Infection Prevention and Control (Chair)
Deputy Director of Infection Prevention and Control (Deputy Chair)
Consultant Microbiologist/Infection Prevention Doctor
Medical Director
Director of Governance
Antimicrobial Pharmacist
Directorate Lead Nurse (as per rota)

(7 members)

In Attendance

Individuals presenting investigation report:
Consultant/Medical representation
Ward/Department Manger
Matron
Directorate Lead Nurse

Quorum

One third of membership (7) with a minimum of:

- Chair or Deputy Chair.
- Medical Director/Consultant Microbiologist
- Antimicrobial Pharmacist

Deputies

Deputies required for all members.

Key Outputs

- Annual infection prevention control
- Annual infection prevention work and audit plan
- Assurance with regards to adherence against CQC Requirements

Time, Frequency & Duration

Monthly – 1st Friday, 08.00-09.30hrs

Support Arrangements

Venue:	Board Room, St Mary's
Secretary:	Infection Prevention Administrator
Agenda:	Standard agenda
Papers:	Circulated by 6 days prior to meeting
Minutes:	Draft within 1 week agreed by Chairman / Deputy Chair within 2 weeks

Linkages to other meetings & groups

- Infection Prevention Committee

Governance, rules and behaviours (STANDARD)

- Decision maker – meeting Chairman
- Compliance with Standing Orders
- All members are expected to attend – absenteeism is an exception other than during authorised leave
- Meetings will start and end on time
- Papers to conform to Trust guidance on Board and Committee papers.
- All blackberries and mobiles must be switched off unless expressly agreed by the Chair
- Authority to cancel meeting: Chair
- Access to any information, senior management and other employees necessary to discharge its duties

Standing agenda

1. Introduction and Apologies for Absence
2. Declarations of Interest
3. Minutes of Previous Meeting
4. Presentation of investigations (RCA/PIR)
5. Review completed action plans

Appendix A – Key Outputs:

- Responsible for ensuring a robust quality assurance process is in place for the closure of RCA/PIR on behalf of the Trust
- Responsible for reviewing and scrutinising the RCA/PIR and action plans
- Authorised to seek any information they require from any employee and all employees as directed to co-operate with any request made by the Chair
- Authorised by the Infection Prevention Committee to take action in respect of any activity within their terms of reference
- Supporting timeliness of responses to investigation providing clininical terams if delays are occurring
- Monitoring the quality of investigations received
- Seeking assurance that agreed actions have been completed withn the appropriate time scales
- Seeking assurance that regular audit is in place to monitor actions from action plans
- Linking themes and trends to performance within the Trust and any on-going quality concerns
- Authorising the closure of the RCA/PIR if satisfied that the investigation report and action plan meets the required standard
- Ensure that Duty of Candour has been completed to the expected standard and arrangements are made to share the report apporpatiel
- Consultant and Ward/Department Leaders will be expected to present at the meeting a summary from their investigation of; their findings, trends or themes, learning from the incident and how this will be shared, support given to the patient/family/carers/staff and an action plan to support the investigation findings

- The definition of 45 days is, within 45 working days (Monday-Friday) of the incident occurring or the Infection Prevention Team being made aware that it had occurred
- The definition of between 45 and 60 days is – within 45-60 working days (Monday to Friday) of the incident occurring or the Infection Prevention Team beingmade aware that it had occurred

Sub-groups

Not applicable

Appendix 2: Infection Prevention Operational Group Terms of Reference

Infection Prevention Operational Terms of Reference

Purpose

- To promote and protect the health and wellbeing of patients, staff and visitors
- Provide a collective specialist and operational resource that supports and drives improvement in the prevention and management of infection
- To provide the Infection Prevention Committee with assurance that appropriate systems are in place to reduce infection risk to patients, staff and visitors

Membership

Chief Nurse/Director of Infection Prevention and Control
Deputy Director of Infection Prevention and Control (Chair)
Consultant Microbiologist/Infection Prevention Doctor
Directorate Lead Nurse (12 DLN's)
Hotel Service Manager
Clinical Director for Facilities and Estates
3T's representative
Infection Prevention Nurse
Infection Prevention Administrator

(20 members)

In Attendance

Clinical (Medical) Leads
Deputy Chief Nurse
Chief Operating Officer
IV Therapy Team Representative

Quorum

One third of membership (20) with a minimum of:

- Chair or Deputy Chair.
- 2 Directorate Lead Nurses

Deputies

Deputies required for all members.

Key Outputs

- Annual infection prevention control
- Annual infection prevention work and audit plan
- Assurance with regards to adherence against CQC Requirements

Time, Frequency & Duration

Monthly – 3rd Friday, 08.00-09.30hrs

Support Arrangements

Venue:	Board Room, St Mary's
Secretary:	Infection Prevention Administrator
Agenda:	Standard agenda
Papers:	Circulated by 6 days prior to meeting
Minutes:	Draft within 1 week agreed by Chairman / Deputy Chair within 2 weeks

Linkages to other meetings & groups

- Infection Prevention Committee

Governance, rules and behaviours (STANDARD)

- Papers should not be used where a verbal update/slides will suffice
- Papers to be presented are to have a maximum length of 4 sides of A4; a long document may be circulated for more detailed information where appropriate
- Papers to conform to Trust guidance on Board and Committee papers
- All members are expected to attend – absenteeism is an exception other than during authorised leave
- Meetings will start and end on time
- All blackberries and mobiles must be switched off unless expressly agreed by the Chair
- Authority to cancel meeting: Chair

Standing agenda

1. Introduction and Apologies for Absence
2. Declarations of Interest
3. Minutes of Previous Meeting
4. Review action plan
5. Infection Prevention Surveillance
6. QC scores
7. Current IP issues
8. AOB
9. Next meeting

Appendix A – Key Outputs:

- To lead the implementation across the Trust of infection prevention measures, which incorporates best practice and evidence based research
- Support the Infection Prevention Team in working towards the implementation of standards and strategies, developing action plans for implementation with the Trust when necessary
- Facilitate and assist each division to include infection prevention in all work plans, ensuring clear objectives and detailed action plans with appropriate measures in place to monitor progress and performance
- Promote communication and engagement with all Trust staff
- Provide a forum for the divisions to share difficulties, successes, ideas and new ways of working
- Facilitate ownership and responsibility across te Trust, particularly at the patient inferface, so that all staff members and departments recognize that infection prevention is their business
- Ensure that infection prevention is integral to all core Trust activity
- Ensure that infection prevention issues are communicated effectively via the divisional representatives to all relevant staff

Sub-groups

Not applicable

Appendix 3: Infection Prevention Committee Terms of Reference

Infection Prevention Committee Terms of Reference

Purpose

- The Committee is accountable to the Board of Directors
- To advise the Chief Executive and the Board on all aspects of infection prevention
- To provide assurance that the environment within the Trust is clean and safe

Membership

Chief Nurse/Director of Infection Prevention and Control (Chair)
Deputy Director of Infection Prevention and Control
Medical Director (Deputy Chair)
Director of Clinical Governance
Consultant Microbiologist/Infection Prevention Doctor

(5 members)

In Attendance

Deputy Chief Nurse
Infection Disease Doctor
Infection Prevention Team
Antimicrobial Pharmacist
Directorate Lead Nurse (from each Directorate)
Director of Estates
Head of Nursing and Midwifery Education
Head of Risk Management
Specialist Clinical Leads for Infection Prevention
Clinical Commissioning Group representative
Public Health England representative

Quorum

One third of membership (5) with a minimum of:

- 1 Board member, one of whom must either be the Medical Director or the Chief Nurse.
- One Clinical Directorate representative
- One representative from Infection Prevention Team

Deputies

Deputies required for all members.

Key Outputs

- Annual infection prevention control
- Annual infection prevention work and audit plan
- Assurance with regards to adherence against CQC Requirements

Time, Frequency & Duration

Monthly – Last Friday of each month, 08.00-10.00hrs

Support Arrangements

Venue:	Board Room, St Mary's
Secretary:	Infection Prevention Administrator
Agenda	Set through
Papers:	Circulated by 6 days prior to meeting
Minutes:	Draft within 1 week agreed by Chairman / Deputy Chair within 2 weeks

Links to other meetings & groups

- Health and Safety Committee
- Decontamination Committee
- Water Safety Group
- Waste Management
- Infection Prevention Operational Group
- Infection Prevention Review Group (RCA/PIR)
- Infection Prevention Team Operational
- IV Therapy Team Operational
- Antimicrobial Stewardship Committee

Governance, rules and behaviours (STANDARD)

- Decision maker – meeting Chairman
- Compliance with Standing Orders
- All members are expected to attend – absenteeism is an exception other than during authorised leave
- Meetings will start and end on time
- Papers to conform to Trust guidance on Board and Committee papers.
- All blackberries and mobiles must be switched off unless expressly agreed by the Chair
- Authority to cancel meeting: Chair
- Access to any information, senior management and other employees necessary to discharge its duties

Standing agenda

1. Introduction and Apologies for Absence
2. Declarations of Interest
3. Minutes of Previous Meeting
4. Matters Arising from previous meeting
5. Chairman's remarks
6. Facilities and Estates monthly scorecard
7. Report from Deputy Director of Infection Prevention and Control (including external performance monitoring)
8. Quarterly reports from four Directorate Lead Nurses, based on scorecards and associated action plans (to cover all Directorates over the course of one quarter)
9. Referrals to Board Assurance Framework / Risk Register
10. External Reports
11. Policies
12. Quarterly Updates of Infection Prevention Program Plan
13. Risk and issues reports from Sub Committee Chairs / Papers for Information and Acceptance
14. Date of Next Meeting

Appendix A – Key Outputs:

- Annual Director of Infection Prevention and Control (DIPC) report to the Board of Directors
- Monthly risks and issues report from Director of Infection Prevention and Control (DIPC) report to the Board of Directors via Quality & Performance Committee
- Scrutiny and assurance activity on behalf of the Board of Directors in relation to infection prevention
- Identification and remediation (where required) of exceptions to timely delivery of the infection prevention work plan
- Plans for the operationalization of national strategy
- Assurance that infection prevention strategy and performance is being delivered
- Reviews of risks related to infection prevention, and assurance that such risks are addressed and monitored
- Identification of operational and strategic infection prevention and control risks, and referral to the Risk Committee
- Monitoring (by exception) of Trust delivery plans to deliver targeted and/or trajectory reduction and sustainable improvement in cleanliness
- Identification of priorities for education and training of all grades and disciplines of staff to ensure reduction of HCAI's
- Through Directorate reports, review and monitoring of
    - Trust HCAI's key performance indicators (KIP's) and compliance data
    - Trust performance against national and local targets and/or trajectory
    - standards via the KPI's including MRSA blood stream infections and *Clostridium difficile* infections reductions

Sub-groups

The Committee will be responsible for reviewing and authorising both standing and time limited sub-groups and their agenda. The following groups will support and report into the Committee:

- Decontamination Committee
- Water Safety Group
- Waste Management
- Infection Prevention Operational Group
- Infection Prevention Review Group (RCA/PIR)

Appendix

Senior Nurse Infection Prevention and Control Ward Review

Ward name	Senior Nurse	Date

Take five steps into ward and document your first impression

Key: Y = YES / N = NO

Infection Prevention / Hand Hygiene

To check	Circle	Circle	Number of observations	Number of non-compliances
Are all staff Bare Below the Elbow	Y	N		
Are all staff undertaking HH as per the 5 moments	Y	N		
Is alcohol hand rub visible on every bed	Y	N		
Has the ward completed the weekly HH audit	Y	N		
Are the wash hand basins accessible	Y	N		
Are the wash hand basins used solely for this purpose	Y	N		

Personal Protective Equipment

To check	Circle	Circle	Number of observations	Number of non-compliances
Is PPE worn appropriately	Y	N		
Is PPE removed at the right time	Y	N		
Are hands decontaminated prior to donning and removing	Y	N		

Patient Environment

To check	Circle	Circle	Number of observations	Number of non-compliances
Check 10 items (e.g. bed frames, lockers bed tables)	Y	N		
Are raised toilet seats clean	Y	N		
Has last planned periodic curtain change been undertaken and recorded on shared drive	Y	N		

MRSA Pathway

To check	Circle	Circle	Number of observations	Number of non-compliances
Have all patients been MRSA screened on admission	Y	N		
Have all patients been MRSA screened weekly	Y	N		
Do known MRSA patients have correct pathway	Y	N		
Has the patient been informed of MRSA status	Y	N		

Isolation

To check	Circle	Circle	Number of observations/reviews	Number/type of non-compliances
Are all patients requiring isolation isolated	Y	N		
Are isolation room doors closed	Y	N		
Have patients with type 5-7 stool been risk assessed	Y	N		
Do patients in isolation know why they are isolated	Y	N		

Equipment Cleaning

To check	Circle	Circle	Number of observations/items if applicable	Number/type of non-compliances
Are daily cleaning records up to date	Y	N		
Are weekly cleaning records up to date	Y	N		
Are individual wash bowls stored in patients locker (or disposable)	Y	N		
Check 10 items of near patient equipment	Y	N		

Linen

To check	Circle	Circle	Number of observations if applicable	Number/type of non-compliances
Is clean linen stored in a designated area	Y	N		
Is clean linen not adjacent to used/dirty linen	Y	N		
Are linen skips managed correctly	Y	N		

Waste

To check	Circle	Circle	Number of observations if applicable	Number/type of non-compliances
Is the waste cupboard secure	Y	N		
Is the waste stored correctly – off the floor	Y	N		
Is the waste segregated	Y	N		
Are the waste bins within the clinical area appropriate	Y	N		
Are the bins clean	Y	N		
Are the bins fit for purpose silent closing within the clinical area	Y	N		

Mattresses

To check	Circle	Circle	Number of observations if applicable	Number/type of non-compliances
Do mattresses not in use have a decontamination certificate	Y	N		
Mattresses are not stored on the floor	Y	N		
Has a monthly mattress audit been undertaken	Y	N		
Does every mattress on a bed have a SKI sheet	Y	N		

Sluice

To check	Circle	Circle	Number of observations if applicable	Number/type of non-compliances
Is the sluice clean and tidy	Y	N		
Is the sluice free from clean items	Y	N		
Are commodes , bedpan shells raised toilet seats clean	Y	N		
Are chemicals stored as per COSSH recommendations	Y	N		

Communication

To check	Circle	Circle	Number of observations if applicable	Number/type of non-compliances
Are the Cleaning schedules displayed	Y	N		
Is the last months Quality Check Score displayed	Y	N		
Is the welcome board up to date – correct staff members	Y	N		
Is the patient to staff ratio for today displayed	Y	N		
Is the information in relation to PALS and complaints clearly displayed	Y	N		
Is information in relation to Fire Alarm	Y	N		

testing clearly displayed				

Comments
Feed back

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