Infection Prevention and Control
Annual Report 2014-15

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Director of Nursing, Director Infection Prevention and Control
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Appendix 1
Executive Summary

This has been the most successful year for preventing MRSA and Clostridium difficile cases. There were no MRSA bacteraemia to report and 15 cases of Clostridium difficile.

Outbreaks of Norovirus were well contained and occurred for a short period only.

The introduction of ICnet has provided the team with robust tools to review trends of infections and identify local patterns of antimicrobial resistance.

The Trust are actively reviewing isolation facilities in Critical Care Unit as capacity does not always meet demand. This is recorded on Trust Risk Register. Review and development is currently led by director of Operations.

The shift towards healthcare associated infections identified within a short time of admission demonstrates the need to work across the health economy to prevent avoidable healthcare associated infections.

Sterile Supplies Unit achieved accreditation with BS EN ISO 13485 standards.

The IPC team have worked closely with Estates to achieve compliance with national Water Safety standards, developing the Deep Cleaning Programme and refurbishment within the Trust.

Facilities led the deep clean programme for the year. During the year there were no linked cases of Clostridium difficile infections reported. PLACE assessment scores demonstrated 97.2% for cleaning.

The Friends of the Hospital and Education Department supported development of a bespoke training video used at induction to give an overview of infection prevention and control practices.

Training for Ebola preparedness has taken place with much support for the arrangements from the Emergency Planning Committee. The Trust has followed guidance from NHS England and Public Health England.

There is concern that the isolation facilities within Critical Care Unit do not meet capacity or national recommendations. A working party led by Director of Operations are developing plans for consideration to address these concerns.
1 INTRODUCTION

All care delivered at Dorset County Hospital is underpinned by the Trust vision to “Deliver Compassionate and Safe Healthcare”. As Director of Nursing and Director of Infection Prevention and Control (DIPC) I consider the safe and effective management of our patients integral to achieving this vision.

Prevention of Healthcare associated infections (HCAI) remains a key priority for the Trust. I report to the Trust Board on rates of Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Clostridium difficile infections (CDI) and outbreaks of infections. This year I am proud of the significant reductions of these serious infections that we have achieved. I acknowledge there is no room for complacency and am committed to supporting the multifaceted elements of care and services that contribute to the Infection Prevention and Control programme to prevent avoidable healthcare associated infections.

I report that our target of zero MRSA bacteraemia cases has been met. We have exceeded our target for CDI with 15 cases against a target of 22; of these cases, to date we have successfully appealed a total of 7 cases at the Post Infection Review group led by the Dorset Commissioning Care Group. These infections are taken seriously and rigorously investigated; a root cause analysis investigation of each case is led by Patricia Miller (CEO), the Clinician in charge of the case, Dr Cathy Jeppessen (Infection Control Doctor), Matron for the area, Ward Sister and Infection Control Nurse. Learning from these cases is taken to Divisional Governance meetings and action plans monitored at the Infection Prevention Committee.

The global threat associated with the outbreak of Ebola Virus Disease in West Africa has required all Trusts to develop and implement plans to manage potential cases. Primarily the IPC work programme focuses efforts to prevent healthcare associated infections (HCAI) for patients. The Ebola work stream has refocused efforts, acknowledging the importance of ensuring all our staff are provided with both the tools and training to protect themselves. Protecting staff is a fundamental principle of health and safety at work, as such this remains a key priority.

The Trust has invested in resources to improve the quality of Information and Communication Technology (ICT) across the Trust. The platform provided by investment in the IPC technology "ICNet" provides advanced toolkits to support the delivery of safer healthcare.

The threat of antimicrobial resistance within a wide range of infectious agents remains a Public Health global concern. The World Health Organisation\(^1\) describe the potential of “a post antibiotic era- in which common infections and minor injuries can kill- far from being an apocalyptic fantasy, is instead a very real possibility for the 21\(^{st}\) century”.

We have implemented Public Health England toolkit\(^2\) (2014) for the detection of Carbapenemase Producing Enterobacteriaceae: early detection management and control toolkit. These bacteria are multi-drug resistant and have very limited options for treatment. Detection and management is based upon identifying patients considered at risk of being carriers of these bacteria, isolating them at the point of entry to prevent potential transmission to other patients and screening them.
The Department of Health (2013) antimicrobial resistance strategy 2013-18 identified the following key areas for success:

- good infection prevention and control measures to help prevent infections occurring becoming the norm in all sectors of human and animal health;
- infections can be diagnosed quickly and the right treatment used;
- patients and animal keepers fully understand the importance of antibiotic regimens and adhere to them;
- surveillance is in place which quickly identifies new threats or changing patterns in resistance;
- there is a sustainable supply of new, effective antimicrobials.

Increasingly we are seeing the evolvement of bacteria to achieve viability against antibiotics. There is no room for complacency within an acute Trust; we have seen patients admitted to the Trust with multi drug-resistant urinary tract infections, whereby there are no oral antibiotics that are sensitive to the bacteria therefore requiring admission to hospital to receive intravenous antibiotics.

The Trust IPC strategy linked to antimicrobial resistance is:

- antimicrobial stewardship;
- identifying patients with multidrug organisms;
- isolating patients with multi-drug resistant organisms;
- application of good standard infection control measure e.g. hand hygiene, use of personal protective equipment, care of invasive devices;
- Maintaining a safe clean environment.

This has been a successful year for our programme to reduce healthcare associated infections. Many elements of the IPC programme have contributed to this success, these include the work of the IPC team, clinical and support staff employed by the Trust. In the forthcoming year the challenge to further reduce infections is represented in the national targets for MRSA and Clostridium difficile infections. Clearly achieving a safe environment remains a priority. I have reiterated my concerns to increase the capacity to isolate patients in Critical Care Unit. The shortfall of critical care isolation units has been added to the risk register, this is particularly important with the increase in multi-drug resistant bacteria and the requirement to reduce the risk of transmission within the unit. I recommend this is regarded as a high priority for the capital development programme.
2 INFECTION PREVENTION AND CONTROL ARRANGEMENTS

The Infection Prevention Committee (IPC) met on five occasions during 2014-15; the meeting in January 2015 was cancelled. The IPC has responsibility for overseeing corporate IPC issues and overseeing implementation and progress against the Annual IPC Work Plan.

**Chair of IPC**
Patricia Miller, Chief Executive Officer chairs the IPC.

**Director of Infection Prevention and Control**
Alison Tong, Director of Nursing is appointed Director of Infection Prevention and Control and is responsible for reporting to Trust Board on rates of Healthcare Associated Infections, Outbreaks of Infection, Serious Untoward Incidents and progress against the IPC Work Plan.

**Infection Control Doctor**
Dr Cathy Jeppesen, Consultant Microbiologist is appointed Infection Control Doctor (0.3 WTE). Cathy has responsibility for working with the IPC team to develop and implement the IPC work plan, developing Microbiology services; she also undertakes responsibility for Medical staff IPC education sessions.

**Infection Prevention and Control Team**
Anne Smith- Nurse Consultant IPC (1.0 WTE).
Emma Hoyle- Matron IPC (1.0 WTE)
Gloria Moss- Nurse Specialist IPC (1.0 WTE)
Cheryl Heard- Secretary IPC (1.0 WTE)

**Antimicrobial Pharmacist**
Andrew Harris is antimicrobial pharmacist. Key responsibilities of the role are:
Leading and reporting progress to the antimicrobial Committee;
Supporting antimicrobial stewardship by working closely with clinical teams;
Carrying out audits in line with national guidance;
Providing training with regard to antimicrobial stewardship to clinical staff;
Supporting the development and monitoring of antimicrobial policies with Clinical Consultant Microbiologists and Clinical Teams.

2.1 The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance\(^4\).

The code of practice is a legislative framework required for Care Quality Commission (CQC) registration.
Compliance criteria are:

<table>
<thead>
<tr>
<th>Criterion</th>
<th>What the registered provider will need to demonstrate</th>
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<tbody>
<tr>
<td>1</td>
<td>Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose</td>
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<tr>
<td>Criterion</td>
<td>What the registered provider will need to demonstrate</td>
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<tr>
<td>2</td>
<td>Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.</td>
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<td>3</td>
<td>Provide suitable accurate information on infections to service users and their visitors.</td>
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<td>4</td>
<td>Provide suitable and accurate information on infections to any person concerned with providing further support or nursing medical care in a timely fashion.</td>
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<tr>
<td>5</td>
<td>Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.</td>
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<tr>
<td>6</td>
<td>Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.</td>
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<td>7</td>
<td>Provide or secure adequate isolation facilities</td>
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<td>8</td>
<td>Secure adequate access to laboratory support as appropriate</td>
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<tr>
<td>9</td>
<td>Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.</td>
</tr>
<tr>
<td>10</td>
<td>Ensure, so far as is reasonably practicable, that care workers are free of and protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.</td>
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</tbody>
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Trust compliance with the Hygiene Code is assessed using the tools of Health Assure. The pie chart below demonstrates full compliance with 9 of the 10 elements. Criterion 7 “Provide or secure adequate isolation facilities” is currently rated as not fully compliant reflecting the limited isolation facilities in Critical Care Unit. Several options are currently being explored to improve facilities, acknowledging the limitations of the current footprint of the unit and the operational challenges of maintaining services during redevelopment.

The Hygiene Code

CQC Hygiene Code (HCAI) Overview

- Criterion Not Applicable: 0
- Red: 0
- Amber: 1
- Not Assessed: 0
- Yellow: 0
- Green: 9
- Guidance Not Applicable: 0
- Criterion Applicable: 0
- TOTAL: 10

Compliance with the Hygiene Code is regularly assessed using the Health Assure dashboard and reports.
2.2 EPIC 3: National Evidence Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England (2014)\textsuperscript{9}

These guidelines were commissioned by the Department of Health in 2001, reviewed in 2007 (epic2) and again in 2014. They provide comprehensive recommendations for preventing HCAI in acute care settings based on the best currently available evidence. A full GAP analysis was undertaken and presented at the IPC. The IPC has monitored the implementation of these guidelines and good progress is being made towards full compliance. A task group to review the insertion and management of Central Venous Catheters was established in response to this GAP analysis. A policy has now been developed. In 2015-16 a programme of surveillance of Catheter related blood stream infections will be implemented utilising the tools of ICNet to inform clinical practice.

3 HEALTHCARE ASSOCIATED INFECTIONS

3.1 HCAI Performance Targets

The annual performance from 2008/09 – 2014/15 is demonstrated in the chart 1 below.

![MRSA and CDI cases 2008/09- 2014/15](chart)

*In 2013 a process of appeal was established, this involved assessment before a panel to determine that no lapses of care have occurred. The adjusted rate for 2013/14 was 22 cases and for 2014/15 was 8 cases and one pending appeal at time of report. For purposes of direct comparison adjusted rates are not incorporated into the above chart.

3.2 Learning from healthcare associated infections

3.2.1 Clostridium difficile Infections

Clostridium difficile is a type of bacterium found in the gut that can cause diarrhoea in certain circumstances. There is a wide spectrum of symptoms associated with the bacterium ranging from mild diarrhoea to severe colitis. It can be found in healthy people and cause no symptoms (up to 3% adults and 66% of babies)\textsuperscript{8}. Clostridium difficile infection is associated with considerable morbidity and risk of mortality.
The following chart demonstrates the age range of patients whereby *Clostridium difficile* toxin was identified in stool samples processed in the microbiology laboratory. This clearly identifies patients over 60 are at significantly increased risk of CDI.

![Age range of patients with Clostridium difficile infection](image1)

One of the challenges of contemporary healthcare is the changing emphasis of care in community settings and the earlier discharge of patients from acute hospital settings. The chart below demonstrates both community and hospital acquired cases of *Clostridium difficile* toxin positive samples processed in the Trust. In 2006-07, 41% of cases were acquired in the Trust; in 2014-15, 20% of the total cases were acquired in the trust. This shift reflects the work to control antimicrobials and the progress with cleanliness in the Trust.

![Community/ Hospital acquired cases of Clostridium difficile infection (2014-15)](image2)

There were 3 deaths recorded on death certificates where this was identified in part 1 of the death certificate. These 3 patients were admitted to the Trust with the infection, although 1 of these patients had required frequent admissions with infections prior to her death. When reviewing these patients it is apparent that they had significant co-morbidities, highlighting the importance of prudent antimicrobial prescribing.

We have undertaken ribotype testing for all CDI patients at the Trust. Ribotyping is a laboratory method of reviewing the sequencing to detect specific characteristics of a sample and categorising them into genetically linked types. This provides evidence to suggest cross
infection may have occurred. We found no evidence to suggest cross infection during the year.

All cases of *Clostridium difficile* infection are reviewed by a team consisting of, Chief Executive or Director of Nursing, Infection Control Doctor, Antibiotic Pharmacist, Infection Control Nurse, Clinician in charge of care, Matron and Ward Sister for the relevant area.

At these meetings the Consultant in charge of the case presents the clinical case and their treatment (most importantly antibiotic treatment) for review by the group; the Ward Sister presents an overview of the nursing care the patient has received and includes most recent audit results of the environment and hand hygiene. The Antibiotic Pharmacist reports on recent antibiotics (including those administered within the community).

There were some common themes to improve upon, these may not necessarily contribute to achieving a reduction in HCAI’s but may help to identify infections earlier.

- Patient’s interactions with healthcare services are complex and involve both primary and secondary care services. Frequently patients admitted to the Trust will have received courses of antibiotics from primary care services; this can make it difficult assessing which course of antibiotics resulted in the *C. difficile* infection. The reality is antibiotics are necessary for patients who have infections; the risk of acquiring *C. difficile* infections does increase in elderly patients who have received courses of antibiotics and have underlying comorbidities.
- Collecting stool samples in a timely way facilitates early recognition of *C. difficile* infection. We found there was more likely to be a delay in collecting early stool samples when patients were independent with toileting leading to delay in reporting symptoms. It can also be difficult to determine patient’s normal bowel habits; these may be altered by administration of certain drugs, change in diet and underlying conditions.
- Delay in isolating patients with diarrhoea. Single rooms are rarely empty on wards as there are many reasons why patients benefit from being nursed in single rooms, these competing priorities combined with high bed occupancy across the trust can result in complex bed moves to accommodate patients who develop sudden onset diarrhoea.
- Accurate reporting of loose stools using VitalPac. This has proved challenging initially there were technical problems whereby staff reported they were unable to record bowel motions without recording a full set of observations. This technical problem has been resolved and we are working to encourage staff to maintain accurate records to facilitate early identification of any problems.

### 3.2.2 Challenges for *Clostridium difficile* reporting

The objectives for assigning cases of CDI have been reviewed and updated in 2014. The process for appealing cases as “not due to lapses in care” have increased the rigor for review. Lapses in care will need scrutiny and Divisions will need to focus on preventative actions to maintain compliance that support prevention of avoidable infections such as CDI. The objective for the Trust is no more than 14 cases for the year with penalties of £10,000 per case if this is exceeded (Rate 13.6 per 100,000 bed days).
3.3  *Eschericia coli* blood stream infections

The Department of Health requires Trusts to enter cases of E.coli positive blood cultures. E.coli bacteria are frequently found in the intestines of humans and animals. Some of these types of organisms live harmlessly in the gut whilst others can cause a variety of infections; these include most commonly urinary tract infections, intestinal infections and blood stream infections.

The chart below shows a total of 95 cases during the year, of these 82 were isolated from patients within 48 hours of admission.

![E. coli bacteremia 2014-15](image)

The chart demonstrates that patients are generally becoming unwell prior to their admission to hospital. One of the concerns with regard to E.coli infections is the increasing emergence of multi-drug resistant strains of these infections, making these infections difficult to treat due to limited selection of available effective antibiotics (Extended –spectrum beta-lactamases commonly abbreviated as ESBL).

3.4  MRSA Screening

In 2014 the Department of Health \(^7\) published revised guidance for implementation of modified screening for MRSA. This guidance is based on the cost effectiveness of screening all admissions to acute Trusts taking account of the national reduction of MRSA bacteraemia and Surgical Site Infections caused by MRSA. The guidance recommends reviewing local data and developing policy based on this and nationally recognised high risk groups of patients. Overall in 2014-15, 96.8% of patients were screened for MRSA.

Screening for MRSA and decolonisation of patients who screen positive for MRSA has been an important element to support the reduction of MRSA infections. However, it is not a “stand alone” element of the IPC programme; there are many elements that contribute to the reduction of healthcare associated infections e.g. clinical practice, environmental, patient engagement. The IPC has approved a policy that supports the reduction of MRSA screening; this will be closely monitored during 2015-16.
4 SURVEILLANCE

4.1 ICNet

The introduction of ICNet has provided the team with the tools to effectively monitor HCAI’s and support a robust programme of risk reduction since the introduction in 2013. The Information Communications and Technology (ICT) team have supported the IPC team as a pilot site to develop new elements into the ICNet system. It is due to the support and response of the ICT team to technical specifications that has resulted in the Trust being selected as a pilot site for new developments. This work has been led by Annette Guler, ICT Clinical Systems Project Manager.

The system provides a live feed from microbiology results supporting rapid review of patients with infections and appropriate timely interventions. The system also supports a live feed of patients admitted with infection alerts on PAS system facilitating early review and appropriate patient placement/ treatments. Most recently the IPC and ICT teams have worked with ICNet to develop a new component to identify patients in single rooms, risk rate the patient to support decision making by Clinical Site Managers and direct housekeeping managers to determine the level of cleaning required on vacation of the room.

The teams have also worked with Surgeons to develop live feed of surgical procedures they undertake, providing information to support review of patients who develop infections or are readmitted within specified time periods. This will promote effective retrospective review of patients having the same procedures and an early indication of when actions are required to identify increased rates of surgical site infections.

In the forthcoming year the IPC team will focus efforts for the management of Central Venous Catheters using the device management element of the programme.

During outbreaks of infection e.g. Norovirus the tools provided for review are efficient and frequently used at outbreak control meetings to demonstrate progression and ultimately control stages of the outbreak.

The system also provides support for monitoring “trends of infections”; this work will be of increasing importance to support the national programme of antimicrobial resistance. Essentially it is impossible to control elements without the tools to identify problems. Specific reports are easily set up on the system and identify local trends of resistant organisms.

The ICT investment in ICNet, Electronic prescribing and Vital Pac are important ICT systems that support patient safety and their value should not be underestimated.

5 SURGICAL SITE INFECTIONS

5.1 Breast Surgery

Three month surveillance of breast surgery was undertaken between January and March 2015. This was further to a three month surveillance of breast surgery completed October to December 2013. Data collection is ongoing for this audit. Initial review of returned questionnaires is encouraging and would indicate that the enhanced screening performed on
patients prior to admission has been of benefit in the reduction of post-operative surgical site infections.

5.2 Caesarean Section

Three month surveillance of Caesarean Section was undertaken between October and December 2014. This was led by Maria McMahon, DCH Midwife. 127 women were included in the audit having undergone either an elective or emergency Caesarean Section Delivery (CSD). Initial review of the data has highlighted some practices that need reviewing; most importantly there is the potential for inappropriate antibiotic prescribing in the community without clear supporting evidence of infection. This audit will be reviewed by the Division. Early results suggest a 2% reduction in Caesarean-Section surgical site infections since the previous surveillance undertaken in 2011.

5.3 Knees

The Infection Prevention and Control Nurses committed again to collecting Surgical Site Surveillance for patients who were undergoing prosthetic knee replacement. 89 questionnaires were distributed to the patients who were identified within the surveillance period. 80% of these were returned.

The final report from Public Health England for the quarter October to December 2014 will be reviewed with the Orthopaedic Team to review the results. Early indications suggest there has been an increase in the rate of infection.

6 OUTBREAKS OF INFECTIONS

6.1 Norovirus

The Trust experienced an outbreak of Norovirus between 17/01/2015 finishing on 06/02/2015. The outbreak affected 6 wards in total, all of which were either closed to admissions or had restricted admissions. A total of 48 patients were reported to have symptoms. Table 1 demonstrates the wards and numbers of patients affected. Lost bed days reflects empty beds on the ward during closure but does not take account of delayed patient discharges to Residential Care Homes/ community Hospitals.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Patients affected</th>
<th>Staff affected</th>
<th>Ward closed</th>
<th>Ward reopened</th>
<th>Lost bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnes (Elderly Care)</td>
<td>12</td>
<td>1</td>
<td>17/01/2015</td>
<td>28/01/2015</td>
<td>30</td>
</tr>
<tr>
<td>Hinton (Respiratory Medicine)</td>
<td>7</td>
<td>0</td>
<td>23/01/2015</td>
<td>31/01/2015</td>
<td>40</td>
</tr>
<tr>
<td>Maud Alex (Cardiac)</td>
<td>2</td>
<td>0</td>
<td>Not closed *symptomatic patient transferred to Barnes Ward.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Learning points from the Outbreak:

- Microbiology Laboratory staff were proactive by ensuring samples were processed early and the use of PCR technology provided increased confidence in the test results.
- Documentation by the Ward Staff has improved – this facilitates decision making for determining when it is safe to start cleaning the ward.
- Many of the patients on Barnes Ward had extended length of stay- this outbreak adds to the evidence that patients staying longer in hospital are at increased risk of health care associated infections that include norovirus.
- The housekeeping response was excellent. Housekeeping staff worked over weekends and out of hours to complete cleaning prior to wards reopening. This significantly aided the flow of patients in the hospital at some peak times.
- ICNet proved to have excellent outbreak functions that are used for outbreak meetings to support decision making processes.

### 6.2 Management of incident of Chicken Pox in Special Care Baby Unit (SCBU)

On 26/03/2015 Consultant Microbiologist was notified of a healthcare worker who had worked whilst asymptomatic in the infectious stage of chicken pox infection on SCBU. The infectious period for chicken pox is 1-2 days prior to the appearance of a rash. The risk of complicated infection with chicken pox is greatly increased in neonates.

An incident control meeting was held on the same day. The following actions were taken:

- Review of the babies to determine whether Varicella immunoglobulin was indicated in line with Department of Health recommendations (this was indicated for one baby).
- Review of the immunity of the mothers of the 10 babies considered exposed to chicken pox.
- Review of the immune status of SCBU and Maternity healthcare workers who potentially had contact with the healthcare worker.
- Notification to the parents of babies in the unit and those discharged.
- Isolation of babies exposed to the healthcare worker until the end of the incubation period.
- Surveillance of the babies exposed.
- Restriction of babies <28 weeks or 1000grams birth weight to the unit until 21 days following exposure.
- Notification to Public Health England and NHS England Local Area Team.
- Notification to SCBU network and communication with neonatologist at Portsmouth and Southampton Hospitals.
- Follow up of babies discharged from the unit to determine whether they contracted disease

There were no secondary cases reported from either babies or staff who had contact with the healthcare worker during the infectious period of the illness. The unit returned to normal activity on the 15th April 2015.

7 EBOLA VIRUS DISEASE

The outbreak of Ebola virus disease in West Africa generated significant international alarm requiring an international response, both in national and international support to control the outbreak. In the United Kingdom the threat of importing cases of Ebola has remained at a national low risk. However given the potential serious nature of the illness all Trusts have been directed to ensure effective arrangements are in place to manage any potential cases.

Arrangements at the Trust have been supported by the Emergency Planning Committee. These include securing one of the negative pressure rooms situated between Lulworth and Abbotsbury wards. Estates have worked with IPC to develop the facilities within the suite, involving installation of CCTV camera and intercom system, reviewing ventilation, redecoration and installation of storage facilities to contain the required personal protective equipment.

A training programme for key staff members has been established and implemented by Gloria Moss to ensure staff are able to effectively use the required level of Personal Protective Equipment (PPE) for their own personal safety.

8 EDUCATION

During the year IPC staff delivered 123 Mandatory IPC training sessions for both clinical and non-clinical staff. 76 % of staff employed at the Trust received mandatory training last year. There were also bespoke training sessions for different staff groups including, Portering,
Housekeeping, Estates, SSD, Medical Devices, Mortuary, Preceptorship, Volunteers and staff undertaking training in intravenous management.

In 2014, the Infection Control Team was able to source funding to support development of a training video for non-clinical/volunteer staff. An external media company was involved with filming the video and since October 2014. This short film has been used in mandatory training to introduce key elements of infection prevention and control practice.

Specialist training in the correct management of suspected Ebola patients was also undertaken, including Medical Staff, Nursing staff (in particular Clinical Site Managers), portering, ward and A&E staff was undertaken using the dedicated facilities of the Ebola room.

IPC staff also undertake education which is integrated informally into their daily ward rounds.

9 AUDIT

9.1 Peripheral Venous Cannula

In 2014 national guidance was published for the prevention of healthcare associated infections in NHS Hospitals. A full GAP analysis was undertaken and the insertion and management of Peripheral Venous Cannula (PVC) was one area that required improvement. PVC’s are commonly used devices in acute hospitals, used for the administration of intravenous fluids and drugs. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The new evidence presented in the national guidance suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident. Several audits were undertaken to monitor compliance with the management of PVC devices. The most recent audit (31/01/2015) demonstrated 96% compliance.

9.2 Urinary Catheter Audit

Urinary tract infections are the second largest single group of healthcare associated infections in the UK. Insertion of a urinary catheter is known to be a significant risk factor in the development of urinary tract infections and the risk increases with the duration of catheter insertion. It is therefore important to ensure there is a comprehensive process in place to
ensure that the risk of urinary tract infection is taken into account and considered prior to insertion of urinary catheter and there is a continuous process for review.

An audit was undertaken by the Infection Prevention and Control Nurses to establish compliance with the documentation standards within the Trust Urinary Catheter Care Policy. The audit took place across the adult inpatient clinical areas. A total of 51 patient records were included in the audit, this represented all the patients with a catheter in situ at the time of the audit.

The current system for documentation of insertion and management of urinary catheters has improved following previous audit February 2014 but ongoing documentation of urinary catheter care has decreased.

9.2.1 Catheter Record Booklet

During the year the IPC team has worked alongside Dorset Healthcare University NHS Trust to develop documentation to support best practice and to support reduction in catheter associated UTI's. Best practice recommendations have been considered and the IPC teams have collaborated and developed a Catheter Record Booklet which has been successfully trialed on several wards at DCHFT. This booklet is planned to remain with the patient who has a urinary catheter on discharge from acute care and remain with them in the community. The booklet covers patient and carer information as well as correspondence relating to the urinary catheter for the healthcare professional. The Dorset Clinical Commissioning Group is funding the printing of the booklet which will be officially launched in the summer of 2015.

9.3 Decontamination Audit

This audit was undertaken in November 2014 to gain insight into current practices with regard to cleaning/decontamination of invasive devices (probes). This was in response to a Medical Device Bulletin alert (MDA/2012/037).

Following the introduction of a validated system for decontamination and supported system for recording the process high level compliance has been achieved and results of this audit
over 3 areas was 100%. It has been agreed that ongoing compliance audits should be completed via Divisions and results feedback to the Decontamination Committee.

10 LINK GROUP

The IPC link group met on 5 occasions during the year. Over the course of the year various educational presentations from a variety of healthcare specialists were delivered to support their role in clinical practice. Various link staff have presented their improvements in practice to the group. One of the challenges of this group is attendance from the acute wards, where shift patterns and annual leave inevitably have an impact. This group worked hard to develop the theme for infection control week.

11 INFECTION CONTROL WEEK

This year's Infection Control Week focused on Personal Protective Equipment (PPE) to support the ongoing training for nursing a patient with suspected/confirmed Ebola and to highlight the correct use of gloves, aprons and masks on a daily basis. The theme this year was “television” for those more innovative staff.

The wards and departments once again rose to the challenge and there were some inspiring presentation's and displays.

They included Barnes Ward, the winner overall who produced a DVD film showing the “do's and don'ts" of entering an isolation room, the correct apron selection for each area of care and signage for rooms.

Lulworth Ward educated with a ward board around a waste and personal protection theme, “Paint the whole world with a Rainbow”.

“How clean is your Dialysis Unit” focused on cleaning of the environment to prevent the spread of infection.
Judging took place with the Chief Executive and Director of Nursing and prizes were awarded.

Weymouth College Students once again were on site to provide hand massage and visited the elderly care wards which the patients really enjoyed. Damers Pre School under-fives sang their way around the wards with their rendition of the “wisher washy” song to promote hand hygiene. This was well received especially with patients and visitors who sang along.

Sure wash attended the event travelling through the wards and departments reviewing staff hand decontamination technique with their interactive computer program. The team demonstrated a high standard of compliance throughout the Trust.
12.1 Sterile Services

12.1.1 Accreditation

The department implemented a full Quality Management System in 2013 / 2014.

External Audit by Notified Body Intertek in June 2014 resulted in the department being awarded certification to BS EN ISO 13485 with only one minor non-conformance issued at the time of the audit. This has subsequently been closed.

Accreditation not only gives quality assurance on the products produced but also allows the department to provide services for external customers.

A follow-up surveillance audit in November 2014 found no non-conformances and reported that the quality management system appeared to be functioning well.

The next surveillance audit is planned for May 2015.

12.1.2 Environmental Monitoring

The Clean room Validation is completed by an external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates
- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on five washed but unsterile items – Quarterly
- Water End toxin - Annual

Latest testing of all areas occurred on 18 February 2015 and all tests were below action level. The backroom was given a Class 8 clean room status, which is appropriate for the service.

There had been significant problems with Water TVC’s at previous testing. There has been re-configuration of water supply to key areas and fitting of bypass flush line to washroom jet gun which appears to have resolved the issues. This remains under quarterly review as part of the Quality Management meeting.

12.1.3 Tracking and Traceability

The TDOC tracking and traceability system has been upgraded as it was several versions behind. This occurred in December 2013 and since then all single packed items are now
individually bar-coded which improves traceability as well as tracking and stock levels. There have been further enhancements to the TDOC modules which include:

- Count on screen
- Repair module

These developments will improve the quality of the product dispatched and ensure traceability is maintained during repairs.

12.1.4 Shelf Life Testing

As part of the requirements of BSEN ISO 13485 a selection of items in the various types of packaging are sent for shelf life testing after the maximum 365 shelf life. These items are due to be sent for testing in May 2015.

12.1.5 Staff Training

A key quality objective of the sterile service department is to obtained funding / support for a nationally recognised training course for assistants. This forms part of the business development plan for 2015/2016 and is also within the training needs analysis.

12.2 Endoscopy

12.2.1 Quality Management System

The department is in the process of implementing a full quality management system in line with the system in place in sterile services. This will add further assurance to the quality of production in addition to the JAG accreditation.

The plan is to proceed with implementation of the quality system during 2015 with the aim to seek accreditation in November 2015 or May 2016. This will be dependent on assessment of floor plan and product release control. This will be undertaken in conjunction with our Quality Assurance consultant in April 2015. A preliminary report of the issues and recommendations has been presented at Decontamination Committee.

12.3 Trust Wide Audits

An Annual plan to audit all departments that receive and return instruments for processing through sterile services has been developed. The audit cycle started in September 2014 and audits have been completed in six departments. All audit results are registered with the audit department.

- The audit looks at:
  - How sterilised instruments are received, checked and stored
  - Stock rotation and management of expiry dates
  - Checks prior to use
  - Temporary storage and containers used to return contaminated items
The audit also looks at how departments control the use and disposal of single use items, preventing re-use. This includes ensuring there is a local protocol and posters are clearly displayed.

Any non-conformances from these audits are recorded on a log in Decontamination Portal on SharePoint. These are then monitored and required actions followed up through the decontamination committee

**12.3.1 Key Issues raised at audit**

There have been 3 key themes of areas that were addressed:

- Sterile items being stored in open storage within treatment areas and therefore at risk of advantageous contaminate.
- Poor stock rotation resulting in items going out of date or being used after expiry date.
- Lack of information displayed about disposal of single use items

The decontamination Lead has been working with the departments to support them in addressing issues raised.

**12.3.2 Future Plans for audit**

The transportation of processed and contaminated items needs assessment to understand the current situation and where clean and contaminated items may not be separated during transit. The decontamination Lead is planning to review the dispatch and arrival of items to and from Weymouth Day surgery to understand the current issues and make recommendations.
13.1 Water Quality

During 2014 the Water Quality Management Group (WQMG) has continued to make progress with the improvements to water management and quality.

The Trust Water Safety Plan has been updated and will be the vehicle which the Trust manage day to day issues associated with water. All documents are now available on the Estates SharePoint site.

The management of pseudomonas aeruginosa is an ongoing role and results are managed and reported to the WQMG on a quarterly basis. The Trust has a structured legionella sampling programme; to date results have been negative. The Estates Department continue to support and work with the Infection Control team on water issues.

The bi annual legionella risk assessment was undertaken during 2014, this was undertaken in the new British Standard format which identified priority areas. These are being managed with monitoring reports presented to the Water Quality Management Group on a quarterly basis.

13.2 Support for the Deep Clean Programme

The Trust embarked on a deep cleaning programme during the summer of 2014 utilising a vacant ward as a decant facility. Initially the programme was to undertake only a deep clean however it quickly became apparent that an empty ward offered the opportunity to undertake a programme of redecoration, reflooring / repairs as well as general maintenance. Estates supported the housekeeping team and achieved a deep clean/ refurbishment of six wards. This has allowed the physical condition of the building to be maintained to a high standard.

During the autumn the Trust remodelled its surgical and medical wards, this gave housekeeping and estates a further opportunity with empty wards to carry out additional refurbishment of three further wards.

13.3 Replacement of floor coverings

2014 has seen the replacement of floor coverings prioritised to support the deep clean programme.

Going forward through 2015/16 the allocation for major flooring repairs has been reduced but will be concentrated on replacements within patient areas.

13.4 Decoration and Environment

During 2012 a programme of upgrading and repairs to fire doors has commenced. This continued during 2014/15 and has seen the ward/department entrance doors being repaired and over clad with protection to reduce damage and improve the cleanliness of the surfaces.
The Estates Department has maintained its employed painting staff who have adopted a policy of responding to areas which have deteriorated, thus maintaining an overall acceptable decorative level, rather than trying to paint the whole of the ward in one operation. Opportunities where taken during the deep clean programme to redecorate complete wards. We also were able to commence redecoration of pathology and out-patient areas.

### 13.5 Ventilation

During 2014/15 the Estates Department have struggled to maintain 100% achievement level in its high level cleans within ward areas. However, the Estates Department do respond to areas identified through audits by Housekeeping and the weekly managerial audit. The Estates Department have struggled at times to maintain 100% level of regular high level theatre cleans, they are working with theatre staff to address this.

The Estates Department have also undertaken formal annual validations of theatre ventilation plant, to ensure compliance with HTM 03-01.

### 13.6 Ward Audits

The Estates Department contribute to the weekly ward audits in association with Infection Control and Housekeeping.

### 13.7 Capital Plans for 2014/15

The Estates Department has a small budget for environment improvement works, aimed at improving shower / bathroom facilities. The ward audits provide the evidence to allow these small funds to be targeted appropriately.

Capital schemes during 2014/15 saw the following developments completed:

- Improvements to Day Surgery Department.
- Urology out Patients Improvements
- Completion of a programme to replace Bed Pan Washers with Macerators.
- Completion of the decontamination facilities for Medical Equipment Library.
- Completion of replacing our hot water calorifiers to the east wing
- Dementia improvements to Barnes Ward
- Improvements to Ward Storage Areas
- Creation of two additional isolation rooms to Fortuneswell Ward
- Refurbishment of Ebola isolation room

Feasibility studies to improve clinical areas of HDU / ICU following emergence of CPE.

### 13.8 Ebola Isolation Room Facilities

Estates have supported the Infection Control Team with the remodelling and refurbishment works to provide improved isolation facilities for any potential Ebola presenting patients. This has included enhanced communication and security facilities.
14 INFECTION CONTROL ANNUAL REPORT - FACILITIES (TONY JAMES)

14.1 CLEANING SERVICES

14.1.1 Management Arrangements

The Head of Facilities is responsible for high standards of cleaning service delivery across all areas of the Trust. The Housekeeping and Portering Manager is responsible for the ‘day to day’ running of the service supported by an ‘in house’ team of Housekeeping Supervisors and Housekeeping staff.

14.1.2 Monitoring Arrangement

In order to ensure that cleanliness and environmental standards are maintained to the highest standards robust technical and managerial monitoring systems have been put in place.

Technical cleaning audits are carried out weekly and monthly by a team of appropriately trained personnel to provide and monitor data as required by the national cleaning standard. The minimum target score set by the Trust (using the NHS National Standards of Cleanliness Criteria) is 98% for very high risk areas and 95% for high risk areas. In areas where the target score is not reached there is a recertification timeframe set at 24 hours for very high risk and 48 hours for high risk areas. Additional focused monitoring also takes place in liaison with the IPC team.

On a day to day basis, the Ward Sisters/Charge Nurses and Matrons play a role in ensuring standards are being met with a number of inspections being taking place jointly.

In addition, weekly Managerial Audits are undertaken to verify the cleaning outcomes of technical audits and to identify areas for improvement. The managerial audit team consists of the Trust Board representative with responsibility for infection control, senior managers from Estates and Facilities, senior nurses with responsibility for Infection Control, pharmacy and public representatives. All patient and visitor areas are checked for cleanliness, standard of decoration and state of repair, condition of furniture, fabric fixtures and fittings. The opportunity to talk to patients and receive their feedback is also encouraged. An action plan is produced following the audit which is sent to the individual Ward Sister/Charge Nurse and Matron responsible for the ward/department. A follow up meeting ensures that all actions identified are completed.

The Head of Facilities meets with the Nurse Consultant Infection Prevention and Control monthly; focusing on both quality of service delivery and effective communication of the monitoring results.

A Patient Environment Action Team meeting takes place quarterly and oversee the cleanliness agenda. Reports are produced detailing cleaning results from Technical and Managerial audits. Cleaning reports are also presented to the Infection Prevention Committee and the Decontamination Committee meetings.

Feedback from ‘Friends and Family’ continued to rate the standard of cleaning across the Trust as very high.
14.2 The Role of the Infection Prevention and Control Team

The IPC Team worked in conjunction with the Trust Housekeeping Supervisory Team to ensure cleaning standards were met across the Trust. Daily reports are uploaded from IPC database giving direction on the recommendations for cleaning of single rooms following vacation of patients. This ensures resources are effectively and efficiently utilised.

14.3 Cleaning Schedules

Cleaning schedules are available in all in patient areas and updated where necessary to meet individual service needs. Processes are in place for cleaning staff to record completion of tasks and escalate cleaning problems. Amendments to the schedules are made in line with service developments.

14.4 Patient Led Assessment of the Care Environment (PLACE)

The Trust scored 98.5% for cleanliness in the 2014 Patient-Led Assessments of the Care Environment (PLACE) programme. The national average for cleanliness was 97.2%. Throughout the assessments the input of the patient assessors and the external validator was absolutely invaluable in ensuring a transparent, credible, impartial and robust process of evaluation.

14.5 IPC Training for Domestic Staff

The Trust in its assurance that cleanliness standards are consistent provides a comprehensive training package to domestic staff which includes the principles of Infection Protection and Control. 90 staff received training last year.

14.6 Deep Cleaning

The deep cleaning programme of ward areas was completed during 2014-15 and plans are in development to continue this in 2015-16. The Trust embraces the process of decontamination with hydrogen peroxide vapour (HPV) misting machines and uses this as normal practice where a ‘deep cleaning’ requirement has been identified by Nursing or the Infection Control Team and where upgrades or refurbishment has taken place.
Antimicrobials: Summary report for financial year 2014/15.

15.1 Overview

High quality antimicrobial prescribing is recognised as a key component in the slowing of the development of antimicrobial resistance in micro-organisms. In addition, some Healthcare Associated Infections (HCAIs) such as *Clostridium difficile* diarrhoea result from a complex interplay between antibiotic usage and other factors (e.g. hand hygiene, environmental cleaning, and patient factors). Prudent prescribing, with avoidance of unnecessary, or unnecessarily broad spectrum, high-risk antibiotics and attention to appropriate antibiotic course duration lessens the risk.

Antimicrobial stewardship is written into the Health and Social Care Act 2008 and in November 2011, the Department of Health published a guidance document entitled “Start Smart – Then Focus”, which outlines best evidence-based antimicrobial stewardship practice in the secondary healthcare setting which helps healthcare providers assess whether they meet Criterion 9 of The Act.

15.1.1 Overview of Work done in 2014/15

- Reformation of the Antimicrobial Management Committee into a focused Antimicrobial Stewardship Committee chaired by the Chief Pharmacist and reporting to the Infection Prevention Committee. The reformed committee will be holding its first meeting in April 2015.
- Continued work on increasing the range of antimicrobial guidance available on the Micro Guide smartphone app.
- Participation in *Clostridium difficile* post-infection RCA meetings and identifying themes related to antimicrobial prescribing and pharmaceutical review of patients.
- A training session on antimicrobial prescribing for FY1 doctors was led in conjunction with a Consultant Microbiologist.
- Numerous antimicrobial prescribing audits and ward rounds in conjunction with the Consultant Microbiologists to educate prescribers and identify trends in good and poor antimicrobial prescribing practice.
- Participation in the South West Region Annual Point Prevalence Audit.
- Increased antimicrobial surveillance of patients who have previously had possible or confirmed *Clostridium difficile* infection.
- Electronic Prescribing and Medicines Administration (EPMA) has been rolled out across the Trust during the financial year.

15.2 Annual Point Prevalence Audit

This audit has been undertaken at Trust level for 8 years. This study is an annual one-day “snapshot” audit of antibiotic prescribing and was undertaken at Dorset County Hospital Foundation Trust in March 2015 as part of a regional study that included over 9300 patients across 20 other Trusts from the South West of England.

The data collected can be used to;

i) Chart the Trust’s performance in previous years (8 years data collected) and/or
ii) Compare antibiotic prescribing data with other Trusts in the region

iii) Identify any trends highlighting areas requiring improvement or areas of best practice.

Results Summary 2014/15

100% of inpatients on all inpatient wards (excluding SCBU and maternity) at DCHFT were seen as part of the audit.

40% of patients at DCHFT were on antibiotics, which compares to regional average of 35%. Looking at historical data, there is an apparent increasing trend of antibiotic usage at both Trust and Regional level; although at DCHFT this has dropped slightly over the last two years.

97% of antibiotic doses were appropriate at DCHFT and the route was deemed appropriate in 100% of cases.

49% of inpatient prescriptions at DCHFT had a course length or review date stated on the chart or in the notes, compared to the regional average of 81%. This is an area that has shown significant deterioration in the last 12 months. Primarily down to the switch to EPMA and the inability to record review dates on prescriptions within the current EPMA set-up. A duration or stop date can be prescribed, but these do not warn that the last dose is being/has been given. Once the last dose has been given, the prescription silently disappears from the list of active orders.

To further break this down, 33 prescriptions has stop dates entered on EPMA (mostly STAT doses), whilst 43 prescriptions only had review dates documented in the notes as currently advised to avoid the risks discussed above.

This issue is being raised with JAC as an enhancement request. The Department of Health guidelines on Antimicrobial Stewardship (Start Smart Then Focus, 2011) state that “all antibiotic prescriptions should have a duration or review date on the drug chart and in the medical notes”.

Graph showing prevalence of antibiotic use (% of inpatients on antibiotics)
96% of inpatient prescriptions had an indication documented either in the notes or on the drug chart, compared to a regional average of 96%. This is short of the required standard, which is 100%. The audit demonstrates that some prescribers at DCHFT are failing in the very basics of documenting in medical notes and this represents a medico-legal risk to both the prescriber and the Trust. However, despite losing the prompt on the paper drug chart to document the indication, recording in the medical notes has been sustained.

86% of antibiotic prescriptions at DCHFT were in line with current antibiotic guidelines (v 87% regional average), 4% no guideline available (v 4% regional average) and 10% not in line with guidelines (v 5% regional average).

A comparison of the most commonly prescribed antibiotics at DCHFT v Region (as % of total number of antibiotic prescriptions) showed that use of a broad spectrum antibiotic (co-amoxiclav) has decreased to 12% in line with the regional average following last year’s changes to antibiotic guidelines.
A comparison of the route of antibiotics at DCHFT v Region shows that 53% of prescriptions were for IV antibiotics at DCHFT, compared with 50% across the region.

15.3 Conclusion and Action

There is a trend of increasing prevalence of antibiotic use at DCHFT which is mirrored regionally.
Antibiotic usage on certain DCHFT wards is very high and indicates that targeted audit may be appropriate.
There is a higher proportion of antibiotics prescribed by the intravenous route at DCHFT than across the region and more promotion of IV to oral switches needs to be considered.

15.4 Financial summary for year 2013/14.

The table below shows the cost of anti-infective drugs prescribed at DCHFT over the last 5 financial years. Figures include issues to inpatients and outpatients and cover all clinical directorates as reported from JAC via DSUM.

<table>
<thead>
<tr>
<th>Year</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics</td>
<td>£ 447,600</td>
<td>£354,493</td>
<td>£ 402,540</td>
<td>£ 424,415</td>
<td>£ 372,273</td>
</tr>
<tr>
<td>Antifungals</td>
<td>£166,833</td>
<td>£131,231</td>
<td>£ 128,338</td>
<td>£ 118,739</td>
<td>£ 168,391</td>
</tr>
<tr>
<td>Antivirals</td>
<td>£511,916</td>
<td>£495,366</td>
<td>£ 501,053</td>
<td>£ 503,467</td>
<td>£ 504,693</td>
</tr>
<tr>
<td>Totals</td>
<td>£1,126,349</td>
<td>£981,090</td>
<td>£1,031,931</td>
<td>£1,046,621</td>
<td>£1,045,357</td>
</tr>
</tbody>
</table>

It can be seen spending on antimicrobials is largely static over the last couple of years.

15.5 Future plans for 2015/16

Continue the work of the Antimicrobial Stewardship Committee.
Continue to develop the F1 education programme, enhancing delivery following feedback from the 2014/15 session and ensuring a second session for those unable to attend on the first date.
Continue to build on the regular and structured audit programme.
Identify means of utilising EPMA as a useful resource in antimicrobial stewardship.
16. CONCLUSION

2014-15 has been a most successful year for Infection Prevention and Control across the Trust. Targets for reducing the incidence of MRSA and *Clostridium difficile* infections have both been met and exceeded. Preventing healthcare associated infections remains a high priority in the Trust.

The IPC team now have surveillance tools that are fit for purpose and provide the opportunity to review trends in susceptibility of different micro-organisms and develop strategies to raise awareness to the required control measures. We are confident that the forthcoming year will provide opportunities to review different HCAI work streams; these include reviewing insertion and management of central venous catheters.

The IPC team works collaboratively with acute, non-acute healthcare trusts, and private sector across Dorset to develop best prevention and control practices for patients. We recognise the changing arena of healthcare services and acknowledge the requirement to adapt services to support delivery of high quality safe care for patients.
References


<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Operational Lead</th>
<th>Date of completion</th>
<th>Measure of success</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve target for <em>Clostridium difficile</em> infection (CDI) of ≤ 14 cases (does not include cases whereby no lapses of care were identified.)</td>
<td>Undertake Root Cause analysis of all hospital acquired cases of CDI.</td>
<td>Matron where the case of CDI occurs.</td>
<td>Ongoing</td>
<td>All cases of CDI will have RCA investigation and relevant action plan if deficits identified. RCA’s will be discussed by IPC team and any trends reported to IPC.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Standardise the recording of stools within Division.</td>
<td>Matron to lead</td>
<td>June 2015</td>
<td>All divisions will have clear standardised process for recording stools. Feedback strategy to IPC.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Matrons to feedback completion of action plans to Infection Prevention Committee</td>
<td>Matron where the case of CDI occurs.</td>
<td>At IPC meetings</td>
<td>Learning from RCA’s will be shared across the Trust.</td>
<td></td>
</tr>
<tr>
<td>Divisions to develop IPC HCAI improvement plans for 2015-16</td>
<td>Matrons work with Clinical staff to develop IPC programme relevant to Division. IPC performance matrix standards to be met. Learning from performance data to be disseminated.</td>
<td>Miles Tompkins Diane Smith Simeon Edwards Michelle Smith Abigail Orchard Jo Hartley Alison Bryan</td>
<td>May 31 2015</td>
<td>Matrons to report progress against divisional IPC plan at IPC on rotational basis.</td>
<td>Evidence that IPC performance matrix is discussed and actioned at Divisional Governance meetings.</td>
</tr>
<tr>
<td>High standards of hand hygiene practice throughout the Trust.</td>
<td>Hand hygiene audits to be undertaken by all clinical wards/departments. Wards/departments that achieve&lt;90% to present action plan to Infection Prevention Committee.</td>
<td>Ward Sisters/ Departmental Managers</td>
<td>Monthly</td>
<td>Hand hygiene results &gt;95% and sustained at this level for all wards/departments.</td>
<td></td>
</tr>
<tr>
<td>Monitor compliance with standards for insertion and management of Central</td>
<td>Develop and roll out collection of CVC data using ICNet.</td>
<td>Anne Smith Emma Hoyle Gloria Moss</td>
<td>Quarterly</td>
<td>Data for CVC’s will be accurately captured.</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Operational Lead</td>
<td>Date of completion</td>
<td>Measure of success</td>
<td>Evidence</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
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<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Venous Catheters. Collate data on Catheter related blood stream infections to feed back to Divisions for action.</td>
<td>Interpret data and feedback to Divisional Matrons</td>
<td>Anne Smith/ Emma Hoyle/ Gloria Moss</td>
<td>Quarterly</td>
<td>Data analysed and reported to Divisional Matrons</td>
<td></td>
</tr>
<tr>
<td>Divisional Matrons feedback data to Divisional Governance meetings and where required develop plan to improve performance.</td>
<td>Divisional Matrons feedback data to Divisional Governance meetings and where required develop plan to improve performance.</td>
<td>Divisional Matrons</td>
<td>Quarterly</td>
<td>Rate of Catheter related bloodstream infections is identified and reduced.</td>
<td></td>
</tr>
<tr>
<td>Surveillance of Surgical Site Infections</td>
<td>SSI – Review results with clinicians. If required, action plan to be developed and implemented</td>
<td>Anne Smith/ Emma Hoyle/ Gloria Moss</td>
<td>Quarterly</td>
<td>Surgical site surveillance meets national mandatory requirement</td>
<td></td>
</tr>
<tr>
<td>Audit programme- to audit compliance with Key IPC policies</td>
<td>PVC</td>
<td>Anne Smith</td>
<td>Quarterly</td>
<td>PVC observations will be observed daily and recorded on Vital Pac. Policy will be changed to remove routine cannula replacement.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CVC</td>
<td>Anne Smith/ Emma Hoyle</td>
<td>Ongoing</td>
<td>CVC data will be captured using ICNet. Data on Catheter related blood stream infections will be collated and disseminated to Divisions for review and action if required.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TSE</td>
<td>Clinical Audit Kim Dennick</td>
<td>?</td>
<td>Audit demonstrates compliance of assessment of patient’s pre operatively.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MRSA decolonisation</td>
<td>Gloria Moss</td>
<td>September 2015</td>
<td>Audit demonstrates compliance with MRSA policy recommendations for decolonisation.</td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Action</td>
<td>Operational Lead</td>
<td>Date of completion</td>
<td>Measure of success</td>
<td>Evidence</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Urinary catheter documentation</td>
<td>Audit demonstrates improvement in documentation of the care of patients with urinary catheters.</td>
<td>Emma Hoyle</td>
<td>May November 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deep clean programme</td>
<td>Develop deep clean programme with Facilities/Matrons/Estates. Execute agreed deep cleaning programme.</td>
<td>Tony James</td>
<td>May-September 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Update Education programme.</td>
<td>Emma Hoyle, Gloria Moss</td>
<td>June 2015</td>
<td>Education reflects national and local requirements for mandatory IPC training.</td>
<td></td>
</tr>
<tr>
<td>Ebola</td>
<td>Maintain compliance with PHE Ebola guidance. Implement staff training to reflect this.</td>
<td>Anne Smith</td>
<td>Ongoing</td>
<td>Trust compliant with national guidance for management of patients with suspected Ebola.</td>
<td></td>
</tr>
<tr>
<td>Infection Control Week</td>
<td>Develop plan for IPC week. Organise and implement plan.</td>
<td>Gloria Moss</td>
<td>Oct 2015</td>
<td>Staff engaged with IPC programme.</td>
<td></td>
</tr>
</tbody>
</table>

Anne Smith
April 2015