

DIRECTOR OF INFECTION PREVENTION AND CONTROL

ANNUAL REPORT 2009-10

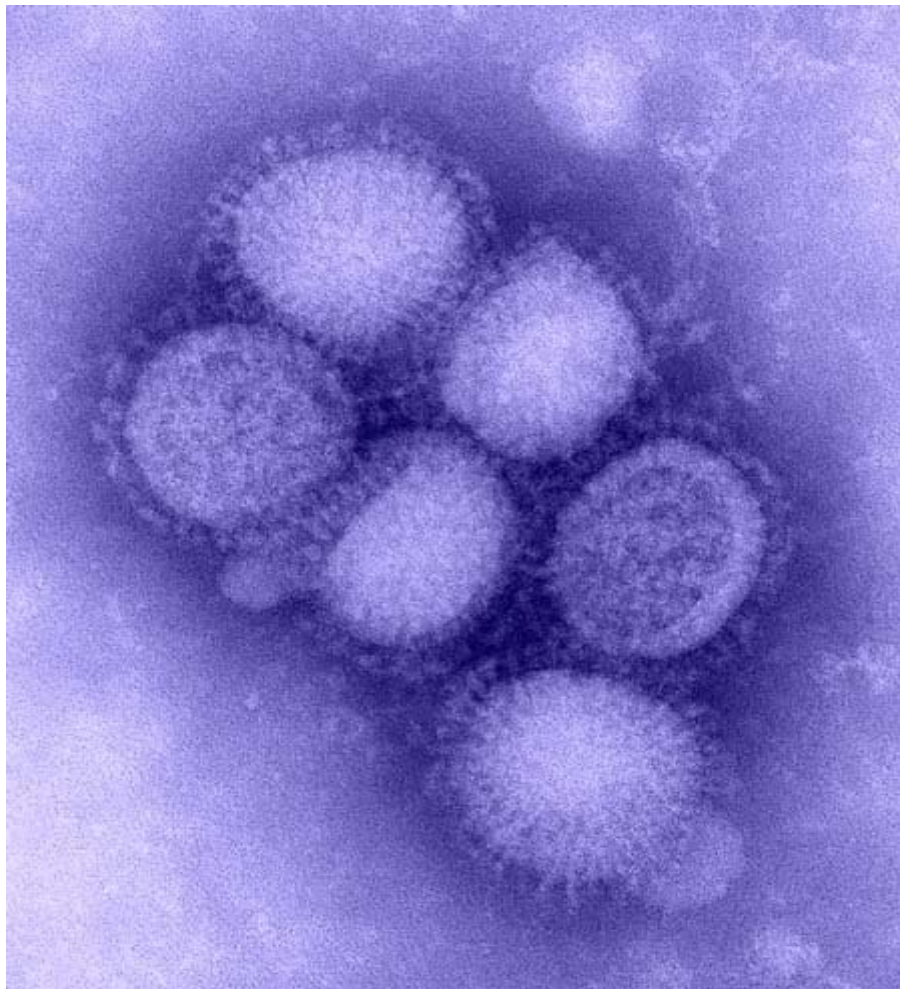


Image of H1N1 Influenza (Courtesy CDC Atlanta)

Executive Summary

- Preventing healthcare associated infections remains a priority Patient Safety and Quality indicator.
- Monitoring compliance with High Impact Interventions is key to the programme to reduce healthcare associated infections.
- Provision of a safe clean environment is a fundamental expectation for patients receiving care at the Trust.
- Rates of infections have reduced significantly. Staff must remain focused to achieve the goal of no preventable infections.
- Focusing on the actions identified in Root Cause Analysis across the Trust and feeding back the lessons via directorate governance frameworks needs to be embedded in the forthcoming year.
- Maintaining the focus on cleaning and environmental standards is important both in terms of preventing infections and public perception.
- Surveillance is a fundamental requirement for Infection Prevention and Control service development.

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1. INTRODUCTION

- 1.1 Preventing avoidable healthcare associated infections remains a key priority for the Trust. To maintain the momentum to improve practice and the clinical environment within the financial constraints of the Trust will inevitably present challenges in the forthcoming year, however provision of high quality care within a clean safe environment must underpin service reconfiguration.
- 1.2 Preventing healthcare associated infections (HCAI) requires a range of complex interdependent factors involving commitment from all members of clinical teams, support services and most importantly the patient. Factors that influence the prevention of HCAI include, good laboratory facilities, screening patients to identify risk factors, provision and availability of isolation facilities, prudent antimicrobial prescribing, surveillance, consistent clinical practice e.g. hand hygiene, care of invasive devices, cleaning and decontamination of medical equipment. Essentially focusing upon patient safety initiatives and maintaining this focus is critical to preventing avoidable HCAI's.
- 1.3 The emergence of new infectious diseases remains challenging locally, nationally and internationally. The pandemic of Swine Flu demonstrated that nationally a response could be mobilised, and the communication channels of the internet provide a readily available resource for practice. The trust coped with the relatively low numbers of patients admitted with suspected swine flu, but as DIPC I am conscious that this pandemic did not stretch resources significantly. It is therefore important that the Trust participates in Emergency Planning exercises to develop capabilities and achieve confidence that plans can be operationalised if required. The future of novel evolving micro-organisms remains uncertain.
- 1.4 2009-2010 has proven to be challenging in terms of delivering sustainable reductions in healthcare associated infections. The target for MRSA bacteraemia acquired in the Trust was 4, this target was met. The target for *Clostridium difficile* was 54; this was exceeded by 4 cases. Reducing preventable infections remains a most important target for the Trust, and it is the effort of all healthcare workers in the Trust that is improving outcomes for patients. I am clear that the focus for the Trust is on reducing *preventable* infections, and will endeavour to develop best practice and embed lessons learned from investigations of avoidable infections. As the Director of Infection Prevention and Control I cannot, and will not accept compromises in clinical practice that result in preventable healthcare associated infections. Directorates must maintain the reduction of preventable infections as a key goal in directorate governance frameworks in the forthcoming year.

2 Care Quality Commission

2.1 The Care Quality Commission required all acute Hospital Trusts to register compliance against the Health and Social Care Act 2008 in April 2009. The Trust achieved unconditional registration. There are a range of measures that may follow if a Trust is found to be in breach of the Act, ranging from warnings, prosecution and fines to suspension or cancellation of registration. The outcome of the inspection on 8th September 2009 identified the following measures where the CQC had no concerns:

- *Having appropriate mechanisms for the trust's board to ensure that sufficient resources are available to effectively prevent and control HCAI's;*
- *Ensuring that workers involved in patients' care receive appropriate information, training and supervision on how to prevent and control infections;*
- *Performing a programme of audit to ensure that policies and practices are being followed;*
- *Having managers (or a single manager) who lead the trust's cleaning and decontamination of equipment used in treatment;*
- *Matrons having personal responsibility for, and can be held to account for, providing a safe and clean care environment, and the nurse in charge of a patient area having direct responsibility for ensuring cleanliness standards are maintained on their shift;*
- *Ensuring that the environment for providing healthcare is suitable, clean and well maintained;*
- *Having cleaning arrangements that detail the standards of cleanliness required and making cleaning schedules available to the public;*
- *Having adequate provision of suitable hand-wash facilities and antibacterial hand rub;*
- *Having a policy for uniforms and work wear to ensure that staff wear clothing that is clean and fit for purpose;*
- *Providing patients and the public with general information on how the Trust is preventing and controlling infections, and providing other service providers involved in the transfer of patients with key policy information;*
- *Explaining to visitors of patients their roles and responsibilities in the prevention and control of HCAI's;*
- *Helping patients to be aware of how to reduce the risks of HCAI's so that they can be vigilant (for example, by telling staff when they think there could be an issue)*

- *Providing or securing adequate isolation facilities; Following appropriate policies and protocols on the prescription of antimicrobial drugs*
- 2.2 However, the CQC found one breach in the standard “*Using effective arrangements for the appropriate decontamination of instruments and other equipment, which are detailed in appropriate policies.*”
A further inspection on 18th September 2009 identified that the Trust had taken action to address these failings and no further action was required.
- 2.3 This inspection has resulted in significant improvements to ensure that standards of cleanliness are maintained and monitored. Most importantly the findings of this inspection has resulted in Matrons refocusing their responsibilities for cleanliness, engaging with Ward Sisters to develop robust systems of assurance to monitor standards of cleanliness. Audits of commode cleanliness, mattress inspection are ongoing and there is an online training package that is used in clinical practice to ensure that staff are familiar with the processes required for cleaning. There is no room for complacency against standards of cleanliness, I am confident that staff are fully aware of their roles for delivering safe clean care and the Trust will not accept failure to deliver the highest standards of cleanliness. This is integral to the Trust plans to prevent avoidable healthcare associated infections.

3. The Infection Prevention Committee

- 3.1 The Infection Prevention Committee (IPC) is chaired by the Chief Executive and meets six times yearly. All clinical directorates are required to nominate senior representation to attend meetings. Each directorate is required to submit a Healthcare Associated Infection Improvement plan, outlining the directorate priorities to create a safe clean environment for patients, a target of no preventable infections staff and visitors. Progress against these plans is reported at the IPC and Directorate Governance meetings. Within these plans there are clear roles and responsibilities for staff to ensure that theses plans are aligned to the Trust vision to reduce healthcare associated infections to a minimum.
- 3.2 The Health and Social Care Act 2008 provides an assurance framework for healthcare organizations to achieve compliance. A key function of the IPC is to monitor compliance against this framework. The criteria for compliance are outlined in Table 1.

Table 1 Compliance against which healthcare organisations will be judged:

Compliance Criteria	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible services users are and any risks their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection.
3	Provide suitable accurate information on infections to service users and their visitors.
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisation's, that will help to prevent and control infections.
10	Ensure, so far as is reasonable practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitable educated in the prevention and control of infection associated with the provision of health and social care.

[Appendix 1](#) provides an assurance framework and proposed actions to maintain compliance with the Health Act 2008.

The IPC also receives progress reports against the proposed annual work programme of the Infection Control Team ([Appendix 2](#)).

Membership of the Committee includes, Director of Nursing/Operations, Infection Control Doctor, Medical Director, Dorset and Somerset Health Protection Unit, NHS Dorset, Estates Manager, Head of Nursing, Head of Housekeeping and Directorate representatives.

4. The Decontamination Committee

4.1 The Decontamination Committee is chaired by the Director of Operations and meets six times yearly. A member of the Infection Control Team attends to provide expert advice on decontamination practice. Following the collapse of the Dorset and Somerset collaboration for centralized decontamination services the Trust has invested significant resources to upgrade existing Sterile Services Department (SSD) and Endoscopy decontamination to achieve compliance with national decontamination standards. During the forthcoming year the Trust will seek full accreditation of SSD services with the registered body.

5. Partnership Working

5.1 NHS Dorset Primary Care Trust

During 2009-2010 there is evidence of joint working between NHS Dorset and the Trust. Regular monthly meetings to review cases of MRSA bacteraemia or *Clostridium difficile* are held to ensure that joint learning occurs. Joint working will be of key importance in the forthcoming year whereby the emphasis for reductions in cases of *Clostridium difficile* across the health community.

One of the key challenges for the Trust has been to introduce MRSA screening for elective and emergency patients during the year. The effectiveness of this strategy will be the development of a seamless approach to decolonising patients, both for inpatients in the Trust and those identified in the community. Perhaps one frustrating element of MRSA screening is the failure to secure the support from community services to decolonise patients found to be MRSA positive prior to admission. Other acute hospital trusts in Dorset have successfully implemented a patient focused approach, whereby patients identified as MRSA positive receive screening/decolonisation treatment from their General Practitioners, when the patient journey does not naturally require re-attendance at hospital. The politics of commissioning should not and must not influence a patient-centered flexible approach to service delivery. As healthcare professionals it is important that we do not lose sight of working in the patient's best interests.

5.2 Dorset Infection Control Network

The Dorset Infection Control Network is hosted by Bournemouth and Poole Primary Care Trust. The network works across all health economies and has been influential in working with independent health providers to standardize infection control practices. Perhaps, one of the challenges is the introduction of new sterilisation standards for dentistry and General Practices, whereby the rigor of European Standards will be monitored in the forthcoming year. Another key role emerging is responsibility to support development of Infection Control practices with Residential Care Homes to meet the standards of the Care Quality Commission.

5.3 Dorset Infection Control Forum

The Dorset Infection Control Forum is an established network of Infection Control Nurses. The forum meet monthly to develop cross organisational policies, with the goal of achieving consistent practice and education across all provider services. During the course of the year a Norovirus Outbreak toolkit for acute trusts and community settings has been

developed to facilitate best practice in line with national recommendations. Anne Smith, Nurse Consultant IPC currently joint chairs the forum.

6. Patient involvement

- 6.1 The IPC considers patient and public involvement an important component when developing services. During the year IPC staff have been invited to meet with the patient renal forum to discuss infection control and have received positive feedback following these sessions. During the course of work the IPC are involved in related patient complaints, these are taken seriously and service development takes account of relevant findings.



Gloria Moss Infection Control Nurse meeting with Renal Patient's Forum.

- 6.2 The introduction of increased screening for MRSA brings the team into much closer communication with patients. The team contact patients found to be positive for MRSA prior to admission and organise decolonisation treatment. Patient feedback from these interactions has been positive, patients stating they appreciate the opportunity to discuss their MRSA with nurse specialists.
- 6.3 In March 2009, Anne Smith, Nurse Consultant was invited to an event at the House of Lords "*What we have achieved and what is around the corner*". The conference outlined the significance of emerging pathogens, underpinned by the efforts to reduce MRSA and *Clostridium difficile*. Key themes of education of staff, cleanliness, future vaccines, the importance of isolation facilities and patient engagement emerged from the day. One of the most important learning points was the importance of patients understanding how infections are acquired, and understanding the difference between infections that patients are admitted to hospital with and those acquired as a result of their treatments.



Representing the Trust at the House of Lords HCAI event

- 6.4 A new patient information leaflet was developed in 2009, outlining the Trust strategy to prevent healthcare associated infections, and the role that patients can play to prevent infections.

7 Healthcare Associated Infections

- 7.1 Healthcare associated infections remain a major concern to patients admitted to hospital. The Trust has developed a strategy to ensure staff are engaged in the fight to prevent avoidable infections. Key elements for preventing these infections are:

- Trust Board support for the IPC programme;
- Embedding Directorate HCAI improvement plans into governance structures;
- Prudent antimicrobial prescribing;
- Provision of adequate isolation facilities
- Consistent compliance with IPC guidelines to prevent infections;
- Maintaining a clean environment;
- Effective communication with patients and visitors;
- Learning lessons from Root Cause Analysis.

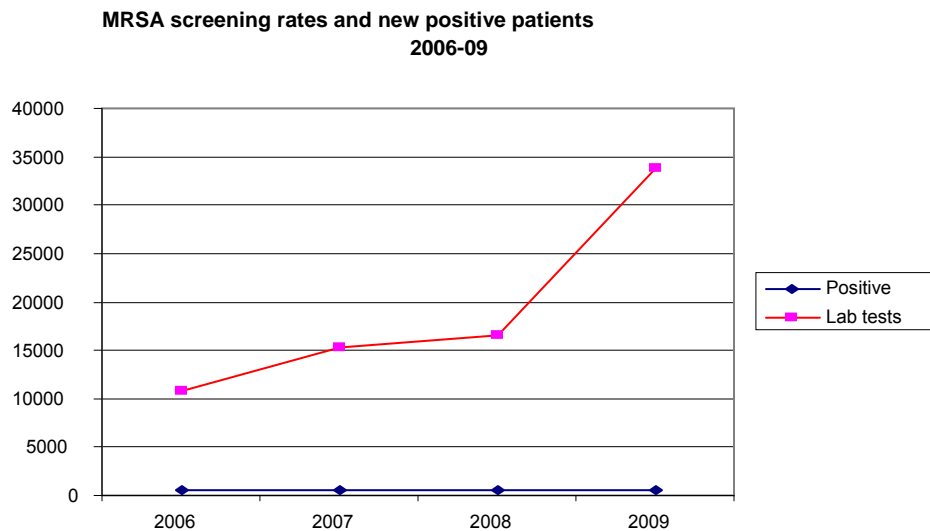
- 7.2 The Trust has supported all of the elements to improve the outcomes for patients; however the goal is to strive for “no preventable infections”. One of the key challenges for this forthcoming year is to review the availability of isolation facilities, particularly in Elderly Care, whereby the number of patients colonised with organisms like MRSA and ESBL is high, and the requirement for isolation facilities often exceeds demand. Frequently patients are transferred from Elderly Care wards to achieve isolation for an infectious condition; this has the potential to cause further confusion, interruption in care planning and could be avoided with the increase in isolation facilities within the unit. The IPC team will monitor this situation and report findings to the Infection Prevention Committee for consideration in service development.

7.3 Meticillin Resistant *Staphylococcus Aureus* bacteraemia

7.3.1 MRSA bacteraemia is a life threatening infection in the bloodstream. Frequently patients are colonised with MRSA on their skin prior to the bacterium entering their bloodstream. Colonisation of the skin is not a state of infection, but by actively screening for the bacterium, the opportunity to suppress the skin carriage can prevent patient's getting infections. The treatment for skin colonisation is relatively cheap and easy to apply, consisting of a 5 day course of skin disinfectant applied daily and a nasal ointment applied 3 times. Patients are rescreened to determine whether the treatment has been effective. An alert is placed onto the Patient Administration System to serve as an alert for staff when admitting patients found to be colonized during previous admissions. The Department of Health issued an operational guidance for screening elective admissions for MRSA by 2010 and plans to introduce screening for emergency admissions by December 2010. The introduction of screening for emergency admissions was brought forward to reduce MRSA bacteraemia in emergency admissions and to rationalise the business case for laboratory services.

7.3.2 The following chart 1 demonstrates the rates of laboratory tests (DCHFT and community samples) for MRSA screens against the number of newly identified patients colonized with MRSA.

Chart 1 MRSA screening rates and numbers of new MRSA positive patients.

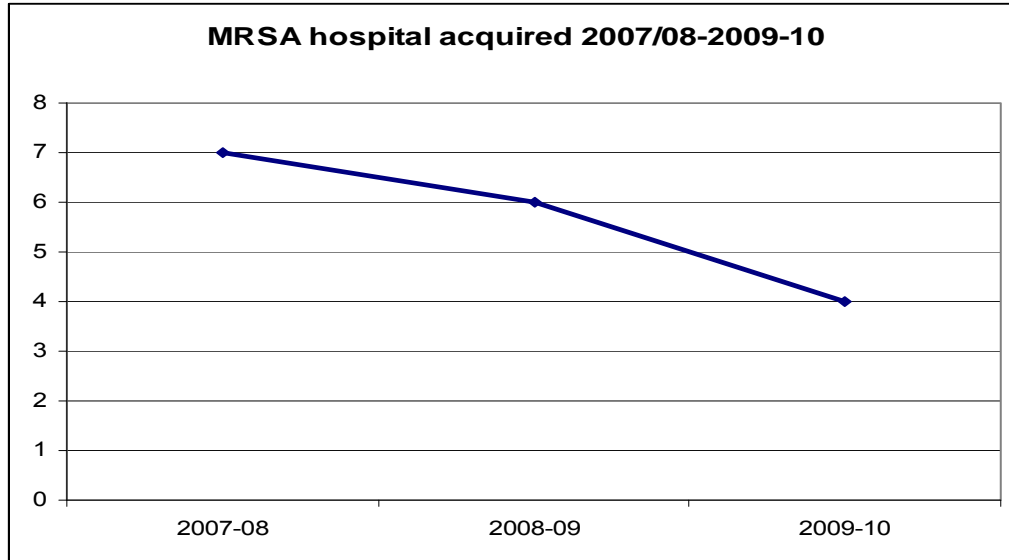


Clearly the numbers of new patients identified as colonized with MRSA has changed very little since 2006. The rate of detection in 2006 was 5.57% (603 new patients) in 2006, and 1.7% (580 new patients) in 2009-10. Nationally, there has been significant debate regarding the cost effectiveness of universal MRSA screening programs. There may well be benefits for large Trusts with high rates of MRSA bacteraemia. However,

for small Trusts it is difficult to capture cost benefits of universal screening against the previous targeted approach as the evidence suggests the previous targeted approach captured patients in risk groups for MRSA colonisation. The National Audit Office undertook an assessment of new national initiatives on healthcare associated infection since 2004. The cost nationally is estimated to be approximately £130 million per annum, and as yet the NAO is unable to form a judgement on the relative cost and benefit of the MRSA screening initiative (NAO 2009). I would recommend that an analysis of MRSA screening costs is undertaken in the forthcoming year, the cost benefits are being challenged nationally.

- 7.3.3 There were a total of 9 cases of MRSA bacteraemia identified in the microbiology laboratory during 2009-10 (14 cases reported in 2008-09). The allocation of MRSA bacteraemia against Trust targets is complex and not always captured within the confines of “days since admission”.

The Trust reported 4 cases of MRSA bacteraemia acquired by patients within the Trust for 2009-00 against a target of 4. Of these cases 2 were considered to be associated with peripheral vascular catheters, essentially preventable infections. These are the infections that clinical staff need to focus upon to prevent serious preventable, essentially ensuring we do the right thing for patients every time. The National Audit Office report (2009) identified that the Primary Care trust role in tackling HCAI’s in community settings is evolving, but not as clear as it needs to be. Enhanced surveillance identified that around a third of MRSA bloodstream infections and 45% of *Clostridium difficile* infections appeared to be acquired outside of hospital, or as a result of a previous hospital stay. Clearly this information is relevant to local circumstances and working with NHS Dorset to prevent infections with joint initiatives is fundamental to reducing HCAI’s across the health community. A recent joint review of the RCA process has been undertaken, led by Sonia Norris, Department of Health HCAI improvement team, and representatives from the Strategic Health Authority, NHS Dorset, Dorset Primary Care Trust and Dorset County Hospital. One of the key areas for improvement is the process of following up action plans, ensuring an Executive Lead. This work will be taken forward in the forthcoming year. The chart below demonstrates the reduction in cases of MRSA bacteraemia acquired in the Trust during the period 2007-2010.



7.3.4 MRSA bacteraemia is one indicator of rates of infections used to measure performance. There are other pathogenic microorganisms associated with venous catheters that also cause considerable morbidity and mortality for patients.

A review of *Staphylococcus aureus* bacteraemias for 2009 undertaken by Dr Clements identified that 30% of bacteraemia at the Trust were associated with cannula infections. There were 53 episodes of *staphylococcus aureus* bacteraemias, 17 of which were acquired 48 hours post admission. These infections require an increased length of stay for the patient incurring significant avoidable excess costs. *Staphylococcus aureus* bacteraemia requires a minimum of 14 days of intravenous antibiotic treatment and carries a 40% risk of serious complications such as endocarditis, osteomyelitis, septic arthritis, meningitis and brain abscess.

Mortality associated with *Staphylococcus aureus* bacteraemia is 25% (40% with MRSA bacteraemia)

All cases of *Staphylococcus aureus* bacteraemias are reviewed and followed up by Consultant Microbiologists.

7.3.5 A review was undertaken in 2009 jointly with the Renal Team and Infection Control Team regarding line insertion and ongoing management. The outcome of this was the development of a robust policy for line management, and further guidance for the treatment of line associated infections for renal patients. This is absolutely critical as line infections in renal patients is associated with significant morbidity and mortality.

7.3.6 The Clinical Support Worker Team undertook an audit of Peripheral Venous Catheters (PVC) in January 2010 to determine whether the documentation for patients with PVC's was in place.

The documentation introduced the guidance from the Department of Health to prevent catheter associated infections, by ensuring there is an adequate system to review how long catheters have been insitu, and the condition of the insertion site requiring daily inspection/appropriate replacement/removal of cannula.

The audit results outlined in the table2 below demonstrate that the Trust need to address care of cannula's as a priority in the forthcoming year.

Table 2 Audit of Peripheral Venous catheters to identify correct review process is in place (January 2009).

Ward	Total Patients on ward	Patients with PVC	PVC dated	VIP sheet in place	VIP sheet completed
Hinton	20	6	4	1	0
Ilchester	32	16	8	9	1
Lulworth	29	6	4	1	0
SSU	27	13	8	4	1
POW	19	6	6	4	1
Ridgeway	26	8	4	5	4
Hardy	21	7	4	3	0
Abbotsbury	25	10	5	7	0
Purbeck	19	15	4	11	1
Total	218	87 (40%)	47 (54%)	45 (52%)	8 (9%)

7.3.7 Line associated infections are generally considered to be preventable infections. It is therefore critical that the evidence based care bundle becomes firmly embedded in clinical practice and that all clinical staff understand and implement effective practice for insertion and management of peripheral venous cannula. The Infection Prevention and Control Team are committed to educating staff and have incorporated relevant PVC training into mandatory education sessions, and provide support for ward teams to achieve compliance.

The Director of Infection Prevention and Control seeks assurance from Clinical Directors that the Saving Lives High Impact Intervention for the insertion and ongoing care of Peripheral Venous Cannula is firmly embedded within all inpatient areas.

It is recommended that a root cause analysis investigation is undertaken for all Staphylococcus aureus line associated infections.

Matrons to report compliance against monthly audits with this care bundle at the Infection Prevention Committee.

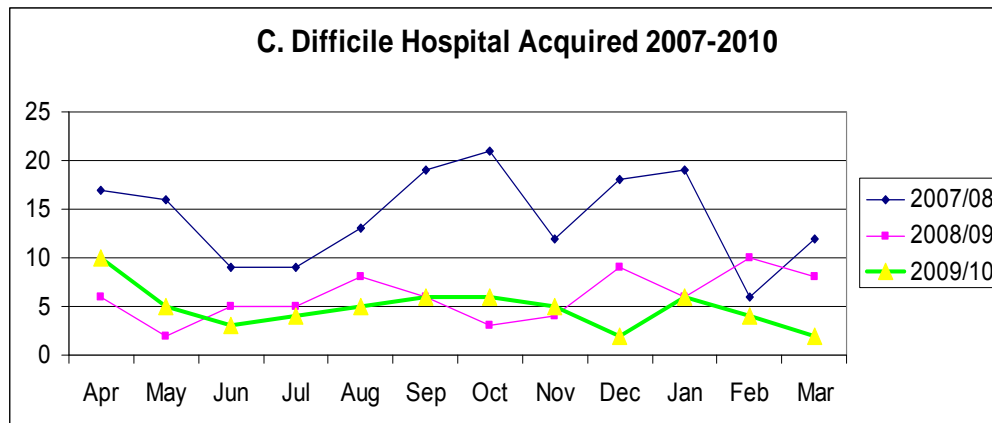
7.4 Clostridium difficile

7.4.1 The target for cases of *Clostridium difficile* was 54 cases for 2009-10. The number of cases identified post 72 hours of admission was 58 cases. Whilst the target was not met this is a significant improvement from 2008-09 whereby there were 72 cases acquired in the hospital (19.4% reduction).

The main control mechanisms for *Clostridium difficile* are prudent antimicrobial prescribing, rapid isolation of symptomatic patients, environmental cleanliness and hand washing.

7.4.2 A root cause analysis (RCA) is undertaken for all cases of *Clostridium difficile* acquired in the Trust. The review involves the consultant in charge of the patient to comment on antimicrobial prescribing, review of hand hygiene audit results, environmental cleaning results and potential for cross infection. Key findings from these RCA's are that reduced cleaning on wards is associated with increased cases of *Clostridium difficile*, and maintaining the Trust commitment to the role of the antibiotic pharmacist is a key control mechanism for preventing these infections.

The following chart demonstrates the year on year reductions of hospital acquired cases of *Clostridium difficile* since 2007.



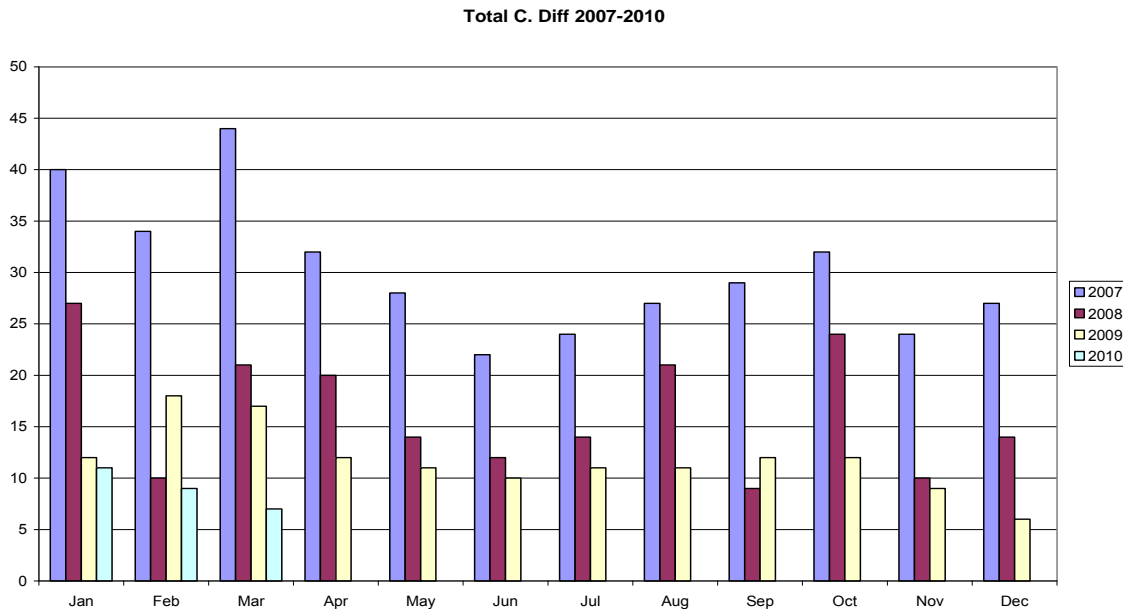
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2007/08	17	16	9	9	13	19	21	12	18	19	6	12	171
2008/09	6	2	5	5	8	6	3	4	9	6	10	8	72
2009/10	10	5	3	4	5	6	6	5	2	6	4	2	58

Nationally excess costs for hospital cases of *Clostridium difficile* are estimated to be in excess of £4,000. The estimated excess costs over this period for the Trust therefore equate to:

2007/08	£684,000
2008/09	£288,000
2009/10	£232,000.

7.4.3 Reducing hospital cases of *Clostridium difficile* impacts on the community wide cases. Chart 2 below demonstrates the total number of cases of *Clostridium difficile* since 2007, demonstrating reductions across of health economy.

Chart 2 total number of Clostridium difficile isolates (2007-2010)



7.4.4 It is critical that the Infection Prevention and Control Team maintain close links with Primary Care staff to facilitate a community wide approach to the control of *Clostridium difficile*.

The Director of Infection Prevention and Control seeks assurance for ongoing commitment to protected time for the antimicrobial pharmacist as this is a pivotal role in prevention and control of *Clostridium difficile*. *Clostridium difficile* is associated with significant morbidity and mortality, excess costs of £4,300 have been identified per case.

7.5 Surveillance of Surgical Site Infections

7.5.1 During 2009-10 two modules of surveillance for patients undergoing hip replacements were undertaken in the Trust. The surveillance identified one patient with a post operative wound infection, equating to a rate of 0.3% of surgical site infection for hip replacement, compared with a national rate of 1.2% for all Trusts participating in the scheme over the previous 5 years. However, the national rate includes proactive follow up

of patients post discharge. The following table3 outlines the results and comparative data.

Table 3 trends in Surgical Site Infection for Hip Replacements.

	No. of operations	Inpatient and readmission infections No.	%age infected	Trust overall rate of SSI for last 4 periods	All participating Trusts rate SSI last 5 years
2008 Q3	79	1	1.3%		
2008 Q4	90	0	0%		
2009 Q3	64	0	0%		
2009 Q4	101	0	0%		
				0.3%	1.2%

These results whilst reassuring need further validation. Inpatient stays are increasingly shorter; this means that infections acquired during admission may not be evident during the patient's admission. In this surveillance scheme patients who are readmitted within 30 days of surgery with an infection are included in the surveillance returns, but there is no post discharge follow up.

7.5.2 Nationally there is a move towards actively following up patients following discharge for 30 days, acknowledging that post operative infections are more frequently treated in the community. Nationally the rate of infection for patients followed up for 30 days post discharge increases to 1.8% for hip replacements and is perhaps a more accurate representation of infection rates. One of the important considerations for patients undergoing elective surgery relates to the risk of infection. It is therefore important in the forthcoming year to review the arrangements for surveillance, to ensure the Trust is able to benchmark with other Trusts and to demonstrate low rates of infection, or alternatively to identify areas of practice that need improvement. This review must incorporate developing post discharge surveillance.

7.6 Caesarean Section Surveillance

7.6.1 Shirley Pike, Midwife Maternity completed a pilot Caesarean Section surveillance period during July – September 2009 organised by the Health Protection Agency. A total of 143 C. section operations were performed

during this period, a total of follow up reviews of 131 of these patients took place (representing 91.61%- compared with national average of 76.4%). This high rate of follow up is above the recommendation of 70% to achieve a realistic estimate of rates of infection, demonstrating the commitment of Shirley to the pilot project. Table 4 demonstrates rates of post discharge questionnaires completed (PDQ) follow up locally and nationally.

Table 4: Number of operations and post-discharge follow-up

Operations and PD follow-up	Your Hospital		All hospitals	
	Apr-June 09	Jul-Sept 09	Apr-Sept 09	Range
Total operations		143	4107	
Number reviewed by Midwife		121	2564	
% reviewed by Midwife		84.6%	62.4%	8.8-97.8%
Number of PDQ completed		105	1789	
% all operations with PDQ completed		73.4%	43.6%	5.6-73.4%
Number of ops with any PD follow-up		131	3137	
% all operations with some follow up		91.61%	76.4%	11.9-97.8%

Table 5 demonstrates the rate of infections reported during this surveillance period. All of the reported infections were superficial incisional infections, none of the patients required readmission for treatment.

Whilst the rate of infection appears higher than the overall rate for other hospitals participating in the pilot, a comment from the project manager must be taken into account:

“There appears to be a relationship between the percentage follow-up and the rate of infection for those hospitals who took part in the c-section pilot. The completeness of follow-up should be taken into account when interpreting rates of SSI based on post-discharge data and in comparing these rates with other hospitals or over time.”

Table 5: Rates of SSI at your hospital.

Surgical site infections	Your hospital		All hospitals
	Apr-June 09	Jul-Sept 09	
No. inpatient/readmission		0	45
% infected		0%	1.1%
No. midwife confirmed		12	221
% infected		8.39%	5.38%
All HCP		12	266
% infected		8.39%	6.48%
No. patient reported		6	139
% infected		4.2%	3.38%
All SSI		18	405
% infected		12.59%	9.86%

A meeting to discuss future participation in the C. Section Surgical Site Infection audit is currently being arranged to discuss both the results and practice that might reduced the rate of infection and future audits.

8. Surveillance

8.1 The Infection Prevention and Control Team report to the Board that the work on the Surveillance Database remains incomplete. Surveillance is the cornerstone of IPC practice, facilitating recognition of outbreaks/clusters of infections that require review, and facilitating good record keeping for reference.

8.2 The National Audit Office report (2009) in its recommendations states *“The department should require individual trusts to develop mandatory surveillance system for other significant bloodstream infections; and a rolling programme of surveillance for other local infection risks such as device related infections, ventilator associated pneumonia and surgical site infections”*.

Failure to secure a fully functioning surveillance system is a major concern and remains a key development for effective practice. This is the 4th year that the development of an effective surveillance database has been raised with the Board. The current manual systems employed are labour intensive, do not have the capacity to capture relevant data and do not make effective use of clinical time. Most importantly the current systems employed do not facilitate effective review of trends of infection. This presents a significant clinical risk as reliance upon staff identifying trends for infections early risks delay in recognising outbreaks of infections.

The IPCT in keeping with the recommendations of the NAO recommendations propose to collect data on venous line associated infections. The accuracy of this data collection is dependent upon provision of a robust surveillance database. These infections are a cause of significant morbidity and mortality for patients.

The Director of Infection Prevention and Control maintains that every effort is made to develop the Surveillance Database as a key ICT priority. If this cannot be achieved in house alternative commercial systems must be considered.

9. Outbreaks of Infections

9.1 Norovirus

Nationally there has been an increase in the number of Norovirus laboratory reports, this trend has been reflected across the South West region, particularly large outbreaks reported in local Trusts during December and January.

Outbreaks of Norovirus are hard to prevent as Norovirus is essentially widespread within community settings. Whilst the illness itself is not pleasant for patients and staff, outbreaks cause wide-scale disruption to hospital services.

The following table 5 outlines ward closures during 2009-10.

Ward	Patients	Staff	Ward closed	Ward reopened
Barnes	12	10	27/04/2009	08/05/2009
Prince Of Wales	3	3	06/05/2009	13/05/2009
CCU	3	3	12/05/2009	15/05/2009
Ilchester	12	7	10/06/2009	17/06/2009
Barnes	11	4	10/06/2009	25/06/2009
Ilchester	22	13	13/12/2009	29/12/2009
Barnes	17	0	18/12/2009	29/12/2009
Prince of Wales	5	2	24/12/2009	03/01/2010
Purbeck	13	24	04/01/2010	14/01/2010
Abbotsbury	12	16	14/01/2010	21/01/2010
Total	69	55		

During 2009-10 the contents of the Ward Outbreak Packs have been reviewed by the IPC team. Larger posters advising that the ward is closed have been developed and an outbreak checklist has been introduced. These packs are available from the Clinical Site Managers to ensure access is available as required.

9.2 MRSA outbreak of surgical wounds

In July 2009 there was a serious outbreak of MRSA wound infections. A total of 8 patients were infected with MRSA during the course of surgery. One of these infections resulted in the patient acquiring a MRSA bacteraemia. A look-back exercise was undertaken to identify patients with post operative wound infections. Staff were screened and a healthcare worker was found to be colonised with an outbreak strain of MRSA; samples were typed and found to be identical to the patients. Expert advice was sought from the Health Protection Agency, the outbreak was described as very rare. The General Practitioner of patient's

identified in the look-back exercise and considered to be at risk of developing MRSA wound infections were notified and advised to contact the surgical team should the patient develop wound infections. No further notifications were received.

Key lessons learned from this outbreak were the importance of robust systems of surveillance to identify clusters of infection as early as possible.

9.3 Tuberculosis

In March 2009 a patient was admitted to EMU and subsequently found to have pulmonary tuberculosis. A look-back exercise was undertaken to identify patients and staff who may have been exposed during the patient's care. A total of 17 patients were identified who were considered to have been exposed to tuberculosis during the course of their admission. Of these 17 patients, 3 had died before screening could take place, 4 patients declined screening and 11 patients were screened by the respiratory Nurse Specialist. None of the patients screened were identified as screening positive for Tuberculosis.

Key lessons learned following this look-back exercise is the importance of achieving isolation as soon as pulmonary tuberculosis is suspected or forms part of the differential diagnosis.

9.4 Pacemaker and complex device insertion

A joint review of policy by Cardiology Team and IPCT was undertaken in 2009 in response to a cluster of patients who developed infections post operatively. The review included environmental elements, antimicrobial prophylaxis, skin decontamination and pre operative screening.

The recommendations of this meeting that have been implemented are:

- Change of air filters supplying the Catheter Laboratory;
- Cleaning schedules revised with clear accountabilities;
- New guidance for antimicrobial prophylaxis;
- Introduction of pre-operative screening for *Staphylococcus aureus* carriage.
- Introduction of chlorhexidine 2% as pre-operative skin disinfectant.

Since these measures has been implemented there have been no new cases of significant post operative infections resulting in removal of pacemaker devices.

9.5 Swine Influenza

During 2009-10 a pandemic was declared. This resulted in rapid escalation of flu plans to facilitate admission to hospital of symptomatic patients.

National directives were received via the HPA and DoH. Emergency supplies of antiviral treatment courses and a large stock of Personal Protective Equipment was received into the Trust and secure storage facilities and stock control was established. Distribution was organised by NHS Dorset.

The arrangements for managing suspected/confirmed cases of swine flu were established throughout the Trust, the main isolation facilities located on Abbotsbury ward in the negative pressure rooms, and the negative pressure room in Critical Care for ventilated patients.

Plans were updated according to the recommendations in national and international guidance.

The virulence of Swine flu in relation to the numbers of patients requiring hospitalisation did not meet the predicted numbers in the national pandemic flu plans.

The Strategic Health Authority held a review meeting recently with the Directors of Infection Prevention and Control, key lessons from the experience of local health services have been fed back and will be used to inform future change in policy.

10 Policy Review

10.1 Review of antibiotic prophylaxis in Orthopaedic Surgery

It became apparent when reviewing the Root Cause Analysis of the cases of *Clostridium difficile* associated diarrhoea that a significant number were associated with the antibiotic prophylaxis in orthopaedic patients during 2008 (this trend was not previously apparent). Cephalosporin antibiotics were used as prophylaxis for these patients; in view of the strong association between the use of cephalosporins and *Clostridium difficile* a review of antibiotic prophylaxis took place with the Orthopaedic team and a revised antibiotic schedule was agreed using lower risk antibiotics. There have been no cases of c. diff as a result of prophylaxis in orthopaedic surgery (prior to this 7 cases in 14 month period).

Core policies reviewed during 2009-10:

- Hand Hygiene
- A-Z of Isolation requirements by organism
- Safe Handling and disposal of Sharps (Occupational Health)
- Decontamination Policy
- Management of MRSA
- Swine Influenza
- Guidelines for Management of Scabies

- Insertion, Manipulation and Management of Intravenous devices (Education department).
- Pest Control Policy (Housekeeping)
- Cleaning Policy (Housekeeping).

11. Education

In 2009-10 there were a total of 161 formal Infection control training sessions and numerous ward based ad-hoc training. All training material has been updated to incorporate the legislative requirements and a focus on management of Peripheral Venous Cannula. The breakdown of staff

- 1,590 clinical staff received Infection Control Training;
- 524 non-clinical staff received Infection Control Training.

A ward based cleaning programme was introduced in response to the CQC inspection visit, whereby clinical leads were responsible for ensuring that clinical staff had completed the on line power point training package. This training is not captured in the OLM system.

The challenges for the Trust must focus on implementation of best practice that is promoted at training sessions. Consistent evidence based practice is key to achieving the reduction in HCAI's.

12 Audit

The following audits were undertaken in 2009-10:

12.1 Isolation Audit-

This audit was a Trust wide audit of the use of single rooms during November 2009. The audit identified that 45% of single rooms were used for patients with a known infection on the day of the audit. There were no patients on the day of the audit with known infections that were awaiting placement in a single room. However, one of the challenges for Clinical Site Managers is to secure appropriate isolation facilities for patients at any given time. Frequently single rooms are not available on the ward that the patient is resident at the time of the audit (most commonly there are not sufficient isolation rooms on Elderly Care). This results in transfer of patients to other wards, with inevitable interruption of planned care. During the forthcoming year the IPCT will develop a tool to review isolation facilities and patient transfers in more detail.

12.2 Audit of isolation room signage-

This audit was undertaken following the CQC visit whereby staff when questioned were not familiar with the correct signage for isolating patients.

The audit identified that some of the Perspex holders had become dislodged and that staff were not familiar with the correct signage in line with Trust policy for individual infections. As a result of this audit Perspex holders for signage have been replaced where broken and Mandatory training incorporates an update on the use of appropriate signage for use on isolation facilities.

12.3 Sharps Awareness Audit

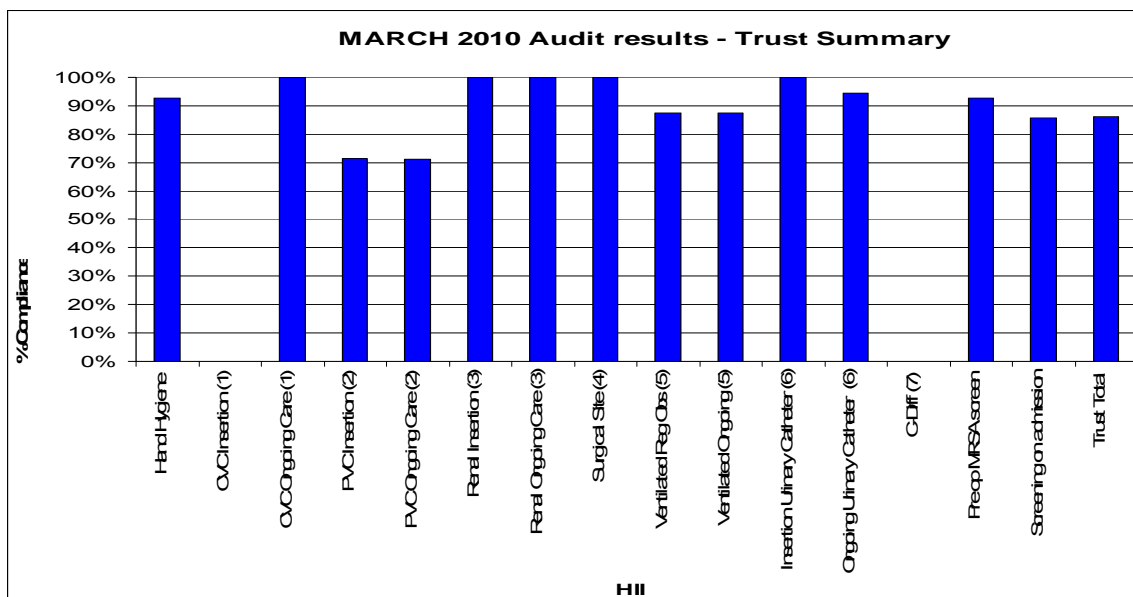
This audit was undertaken by a representative of Daniels, the supplier of sharps bins to the Trust. The audit identified some clinical areas where sharps bins had not been assembled correctly (1.2%) and the same amount that were overfilled. 105 of bins were not labelled which is a breach of the statutory waste management regulations. To address the identified failings the results of this audit have been incorporated into Mandatory training sessions for clinical staff.

12.4 MRSA screening audit

This audit was undertaken on Emergency Medical Admissions unit to test compliance with Trust policy to screen all emergency patients on admission to the Trust. The initial results of this audit were that 87% of patients were screened for MRSA. Follow up audits demonstrate increased compliance across the Trust with screening recommendations.

12.5 Saving Lives High Impact Interventions

These audits are undertaken in clinical wards. The audit tools have been developed by the Department of Health and consist of Care Bundles, the aim being to achieve consistent safe practice that will reduce HCAI's. All wards are required to undertake monthly Hand Hygiene Audits and ongoing care of Peripheral Vascular Catheters. The chart below demonstrates aggregated scorecard for March 2009.



13 Trust Environment

The Trust financial pressures during 2009-10 has inevitably resulted in a review of the agreed refurbishment programme from the previous year. However, the Trust has completed a major refurbishment of the Emergency Admissions Unit, developed 3 en-suite isolation rooms on Purbeck Ward and re-floored the bays on Ridgeway Ward, refurbished 2 bathrooms on Abbotsbury and is in the process of re-flooding the main streets.

SSD department and Endoscopy has also benefited from a refurbishment programme to achieve compliance against national standards.

There is still a requirement for an urgent review of the environment within the surgical, orthopaedic and paediatric wards as these wards remain in need of major refurbishment.

During the year the Anne Smith sat on the review panel formed by the British Safety Institute to review cleaning standards for NHS organisations. This group was established at the request of the Department of Health HCAI improvement team. The project group established a draft BSI publically available specification for cleaning standards. The draft specification has been reviewed by Sally Pinnock, Head of Nursing and an action plan developed to meet the proposed standards. The Trust position is stronger than previously due to the investment to meet the existing national cleaning standards. There is no room for complacency, the Trust needs to remain aligned to national developments for cleaning standards as these are an important component for infection prevention and control and public perception.

14 Antibiotics: Usage and Cost summary for financial year 2009/2010. (Robin Parsons, Antibiotic Pharmacist)

14.1 Financial breakdown

Table 1 details the annual costs incurred for the last FIVE financial years due to anti-infective prescribing for “All Clinical Directorates” at DCHFT;

Table 1.

	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010
Antibiotics	£484,401	£437,353	£502,165	£533,879	£484,838
Antivirals	£204,742	£271,664	£288,469	£413,768	£454,254
Antifungals	£59,170	£58,965	£67,237	£40,457	£110,918
TOTAL	£748,313	£767,982	£857,871	£988,104	£1,050,010

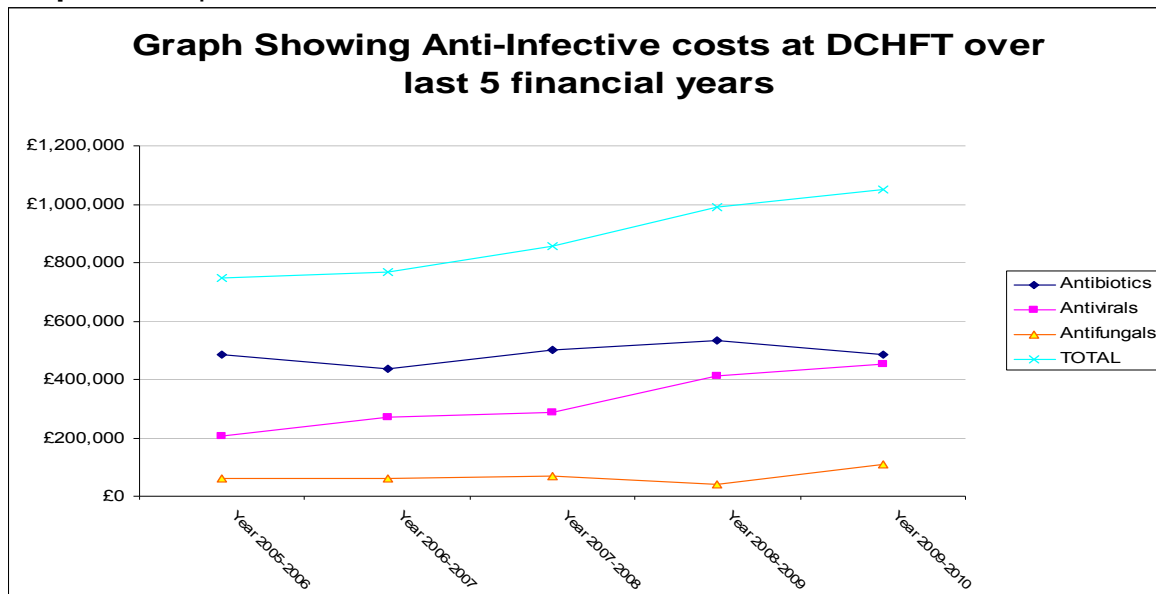
Changes from financial year **2008/09** are as follows;

Antibiotics	- 9.2% (- £49000)
Antivirals (includes HIV drugs)	+ 9.8% (+ £40500)
Antifungals	+ 174% (+ £ 70500)
GRAND TOTAL	+ 6.3% (+ £ 62000)

HIV drugs	£399,242
Non-HIV Antivirals	£55,012

HIV drugs	+12.8%
Non-HIV Antivirals	-7.9%

Graph 1; A representation of data from Table 1;



14.2 Antibiotics

- The antibiotic spend was approximately 9% (£49000) less than financial year 2008/09.

- The decrease in cost does not necessarily correlate to a decrease in overall usage of antibiotics but it may be partly explained by the fact that in the last year, some antibiotics have come off patent and cheaper generics have become available (i.e. piperacillin/tazobactam, teicoplanin).
- Usage figures (i.e. measures of prescribing volume) can be determined by evaluating Daily Defined Dosages (DDDs) for each individual antibiotic, but the process is very labour intensive and due to resource limitations have not been calculated.

14.3 Antivirals

- Approximate 10% increase in the total antiviral (AV) spend when compared to 2008/9.
- A large proportion (88% this year) of the AV spend is due to HIV drugs which are prescribed via the GUM clinic and dispensed via Healthcare at Home.
- The increase in spend is due to a combination of an increasing HIV patient population requiring treatment (increased from 35 patients in 2003 to 72 in 2008) and increasingly expensive HIV drug regimens (i.e. increase in quad therapy, increased resistance requiring 3rd line drugs and salvage therapy).
- Prescribing of HIV- antivirals is by specialist only.
- Non-HIV anti-viral spend **decreased** by about 8% (~£5000) from 2008/09.
- Graph 1 indicates that over the last five years the AV spend is increasing and may soon surpass antibiotics.

14.4 Antifungals

- There has been a substantial increase in the anti-fungal spend. Compared to financial year 2008/09 the increase is 174%. 2008/09 however, was not a typical/average year for antifungal prescribing (costs were very low) and a comparison with 2007/08 which shows a 65% increase is more constructive.
- Regardless, this represents a substantial percentage increase in costs although the absolute costs of antifungals remain about 10% of the total anti-infective spend.
- One of the possible reasons for the higher spend is a likely increase in the number of cases of neutropenic sepsis and or sepsis not-responding to antibiotics which require anti-fungal treatment. It is difficult to easily predict the number of neutropenic cases each year but it is likely to increase with an ageing demographic and with more patients being treated with chemotherapy.
- £16000 of the total antifungal increase of £70500 is due to a single treatment course
– the funding for which was approved by the PCT.
- Prescribing of antifungal treatment, especially the more specialist and expensive drugs (caspofungin, Ambisome, voriconazole) are well

14.5 Antibiotic Usage

The Antibiotic Point Prevalence Study is an annual one-day “snapshot” audit of antibiotic use and was undertaken at Dorset County Hospital in February 2010 as part of a regional study that also included 18 other Trusts from the South West of England.

- The standard of antibiotic prescribing at Dorset County Hospital NHS Foundation Trust was comparable to that of the average in the South West Region.
- 36.7% of patients at DCHFT on the day of audit were on antibiotics, which compares to regional average of 31.5%. This is higher than both the regional average and DCH average over the last few years.
- The ward pharmacists considered doses were appropriate in 100% of cases and that the route was appropriate in 97.5% of cases.
- The indication of treatment was documented in 86% (+4% 2009) of prescriptions compared to a regional mean of 90%. This is short of the standard (which should be 100%) *but* represents an improvement on recent years. An “indication” box has been added to the new Adult Medicine Prescription and Administration Record (due for launch June 2010) to assist DCH achieve the required standard.
- 69% (+5% 2009) of antibiotic prescriptions at DCHFT were in line with current DCH antibiotic guidelines (regional average 78%). This is an improvement, but more work is required – in 2010, education, re-launching of guidelines and a new “antibiotic website” should improve the situation further.
- DCHFT usage of the cephalosporins (high risk *C. diff.*) is marginally higher than the regional average, but the gap between the two is continuing to fall. Reducing DCHFT’s usage further *may* help to reduce *C. diff.* rates. New Surgical Antibiotic Treatment guidelines have been published with alternatives to cephalosporins being recommended, once these guidelines are established DCHFT usage should fall further.
- DCHFT is maintaining a low usage of quinolones (high risk *C. diff.*) and is currently using less than the regional average.

14.6 Conclusion and Actions

- The audit did not highlight any major problems with antibiotic prescribing at this time. On the day of the audit however, DCH had a higher percentage of patients on antibiotics than would normally be expected and further auditing needs to be undertaken to ensure that over-prescribing of antibiotics is not commonly occurring at DCH. A formal audit program is being developed and is due to be rolled out in May/June 2010.
- There has been a notable shift in drug use patterns as Trusts look to restrict certain antibiotic groups such as the quinolones and cephalosporins. DCHFT is making good progress in this area – and further work, such as the development of an antibiotic website, modelled on Nottingham University Hospitals Trust should help to raise the awareness of all antibiotic related guidelines and reduce inappropriate usage further.
- **Guidelines developed and approved by the Antibiotic Working Group 2009/10;**
 - 1 Guidelines for the Prevention of Infection in Adult Asplenic and Dysfunctional Spleen Patients.
 - 2 Guidelines for the use of intravenous immunoglobulins in adults with severe Group A Streptococcal disease or severe Staphylococcal toxic shock syndrome.
 - 3 Guidelines for the immediate management of neutropenic fever
 - 4 Adult Surgical Antibiotic Treatment Guidelines
 - 5 Antibiotic Treatment of Diabetic Foot Ulcers
 - 6 Recommended Methods of Administering Intravenous Antibiotics in Adults
 - 7 Orthopaedic Perioperative Antibiotic Prophylaxis Guidelines for Adults.
 - 8 IV to Oral Antibiotic Switch Guidelines
 - 9 Guidelines for the management of *Clostridium difficile* Associated Disease (CDAD).
 - 10 Management of Acute Upper Gastro-Intestinal Bleed
 - 11 Penicillin Allergy Poster

Robin Parsons
Antibiotic Pharmacist
April 2010

15 Conclusion

2009-10 has been a challenging year for the Trust with significant financial challenges. There have been a number of areas as outlined in the report where progress has not reached the achievements that were planned. That said, there has been significant effort and improvement across the clinical teams in the ownership of infection prevention and control management. The Healthcare Associated Infection improvement plans being developed by the directorates are showing a level of understanding and commitment to the work required, that is to be commended. The drive and enthusiasm of the central infection prevention and control team and the directorate teams I have no doubt will continue to improve the safety of the services we provide.

As the Director for Infection Prevention and Control I am determined that the Trust will focus in 2010-11 on patient safety initiatives.

Appendix 1

ASSURANCE FRAMEWORK FOR HEALTH AND SOCIAL CARE ACT 2008

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
1. Have in place and operative effective management systems for the prevention and control of HCAI which are informed by risk assessments and analysis of infection incidents.						
1a Board Level agreement outlining the board's collective responsibility for minimizing the risk of infection and the general means by which it prevents and controls such risks.	Infection Control Policy ratified by Trust Board 2009. Policy outlines collective responsibilities for minimizing risks of infection and the infrastructures in place to control risks.	Maintain compliance with this policy and amend in light of emerging evidence.	Maintain awareness of any national developments that may influence requirement to adjust the policy.	Director for Infection Prevention and Control (DIPC).	Ongoing	Registration with Care Quality Commission is maintained. National Health Litigation Standards Authority assurance maintained against this criteria.
1b The designation of an individual as Director of Infection Prevention and Control (DIPC), to be accountable directly to the chief executive and the board.	DIPC is the Director of Nursing and reports to Chief Executive and the Board quarterly.	Maintain compliance.	Quarterly reports from DIPC to Trust Board.	DIPC	Ongoing	Board minutes demonstrate quarterly reporting on Healthcare associated infections.
1c Mechanisms by which the Board intends to ensure sufficient resources are available to secure the effective prevention and control of HCAI. These should include implementing an appropriate assurance framework, infection control programme, infection control infrastructure and information systems.	Assurance framework in place 2009-10. Risk Manager reports any clinical concerns relating to HCAI to IGC.	This assurance framework to be monitored. Maintain compliance.	Quarterly reports to board identify any deficits against this framework. Concerns regarding HCAI are escalated when necessary to IGC.	DIPC Risk Manager	Ongoing Ongoing	Board reports identify any areas of concern via quarterly reports or exception reporting. IGC minutes identify any areas associated with HCAI for escalation.

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
	<p>Infection Control programme monitored by Infection Prevention Committee.</p> <p>Infection Control information systems do not meet the service requirements.</p>	<p>Maintain compliance.</p> <p>Infection Control Surveillance database will meet service requirements.</p>	<p>Continue monitoring progress at IPC against annual IPC team work programme.</p> <p>Infection Control Surveillance database development will be completed and meet the requirements for effective surveillance.</p>	<p>DIPC</p> <p>ICT Manager</p>	<p>Ongoing</p> <p>May 2010</p>	<p>Evidence that the IPC work programme is progressing against established targets.</p> <p>Surveillance database is operational and facilitates effective system for monitoring patients with infections and a system to communicate requirements for early detection of patients with infections.</p>
<p>1.c Ensuring that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient information on, and training and supervision in, the measures required to prevent and control risks of infection.</p>	<p>All staff/volunteers receive infection control training at induction and thereafter annually.</p> <p>Contracts incorporate advice on infection prevention and control.</p>	<p>Maintain compliance</p> <p>Maintain compliance.</p>	<p>Continue to provide infection control education for staff/volunteers.</p> <p>Managers to continue to provide IPC information in contracts.</p>	<p>Infection Control Nurse Consultant</p> <p>Managers with responsibility for setting contracts for outside contractors working within the Trust.</p>	<p>Ongoing</p> <p>Ongoing</p>	<p>OLM training records identify that staff have received IC education.</p> <p>Evidenced by contracts that incorporate IPC advice.</p>
<p>1.d A programme of audit to ensure that key policies and practices are being implemented</p>	<p>IPC work programme incorporates</p>	<p>Maintain compliance.</p>	<p>Develop audit programme for 2011-2012.</p>	<p>Infection Control Team Matrons</p>	<p>May 2010</p>	<p>Audits will be recorded on Clinical Audit intranet with</p>

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
appropriately.	planned audits against compliance with key policies.					appropriate action plans. HCAI performance framework will report progress against key audits.
1f A policy addressing, where relevant the admission, transfer, discharge and movement between departments, and within healthcare facilities.	Admissions policy takes account of risks of HCAI. July 2008 Transfer of care policy and checklist take account of risks of HCAI. February 2010. Discharge policy takes account of infection control risks. February 2010	Maintain compliance with policy. Maintain compliance with policy. Maintain compliance with this policy.	Integrate IPC daily worksheets to feed into information for Clinical Site Managers. Audit compliance with policy.	Infection Control Nurse Consultant Director of Operations Matrons.	June 2010 September 2010	Isolation audits identify that patients are appropriately isolated to prevent cross infection. Audit report recorded on clinical audit intranet site with appropriate action plan if required.
1g Designation of a decontamination lead.	Decontamination lead is Director of Operations.	Maintain compliance.	Quarterly reports to IGC identifying outstanding compliance with decontamination standards.	Director of Operations	Quarterly	IGC minutes demonstrate quarterly reports. Risk register identifies any decontamination risks identified.
2 Provide and maintain a clean and appropriate environment which facilitates the prevention and control of HCAI.						

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
2a Policies for the environment that make provisions for liaison between the members of the Infection Control Team and the persons with overall responsibilities for facilities management.	Estates Manager and Housekeeping Managers are members of the IPC. Environmental policies are approved via the IPC e.g. legionella (Feb 2009), pest control (2009), cleaning.	Maintain compliance.	Cleaning policy in draft. Policy to be ratified by IPC.	Head of Nursing/ Housekeeping Manager.	June 2010	Policies available on the intranet.
2b Lead Managers are designated for cleaning and decontamination of equipment used in treatment.	Decontamination Manager is lead for SSD and equipment library. Endoscopy Manager is lead for endoscopy decontamination Ward Sisters/Department Managers are leads for equipment cleaned within the clinical area.	Maintain compliance. Maintain compliance Maintain compliance.		Directorate Manager Critical Care and Theatres. Endoscopy Manager Ward Sisters/ Departmental Managers.	Ongoing	Decontamination services are compliant throughout the Trust. Audits demonstrate compliance. Decontamination risks are appropriately recorded on the Trust Risks register and where necessary escalated to Integrated Governance committee..
2c Lead Managers for cleaning involve Directors of Nursing, Matrons and the ICT in all aspects of cleaning services from	PEAT committee includes attendance from all required to meet	Current review of cleaning services in line with draft BSI specification.	Action plan developed to be discussed at PEAT meetings.	Director of Nursing Head of Nursing Infection Control	January 2011	Cleaning Action Plan will be in implemented in line with revised national

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
contract negotiations and service planning to delivery at ward level.	criteria.			Nurse Consultant.		specification.
2d Matrons have personal responsibility and accountability for delivering a safe clean care environment and that the nurse in charge of any patient area has direct responsibility for ensuring that cleanliness standards are maintained throughout that shift.	<p>Job descriptions outline responsibilities for cleanliness.</p> <p>IPC education emphasises the roles and responsibilities for cleanliness.</p> <p>Ward Sisters responsible for joint monthly environmental audits to monitor cleanliness.</p>	Maintain compliance.	<p>Ward Sisters/Departmental Managers to ensure that all clinical staff with responsibilities for cleaning have undertaken online education training in cleaning processes.</p> <p>Audit by questioning clinical staff.</p>	<p>Ward Sisters.</p> <p>Matrons</p>	<p>Ongoing</p> <p>July 2010 January 2011</p>	<p>All clinical staff with responsibility for cleaning will when questioned identify they have received training in cleaning.</p> <p>Audit results demonstrate compliance.</p>
2e All parts of the premises are suitable for the purpose, kept clean and maintained in good physical repair and conditions.	A refurbishment programme was in place but due to financial constraints is currently on hold.	Trust premises will be maintained clean and in good state of repair.	Trust Board to consider priorities for refurbishment.	Director of Finance.	??	Wards that require refurbishment will present in good physical repair and condition.
2f The cleaning arrangements detail the standards of cleanliness required in each part of the premises and the schedule for cleaning frequencies is publically available.	All premises in the Trust have detailed cleaning schedules. Cleaning schedules are available on all Ward / Departments for public scrutiny.	Maintain compliance	Maintain awareness of any changes in national cleaning specifications and adopt best practice accordingly.	Head of Housekeeping.	Ongoing	Cleaning schedules are maintained in line with national specifications and are publically available,
2g There is adequate provision of suitable hand-washing facilities and antibacterial hand-rubs.	Alcohol hand gel is available at the point of care throughout the	Maintain compliance.		Head of Housekeeping.	Ongoing	PEAT audits demonstrate compliance.

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
	Trust. Hand wash facilities are available in all clinical areas.	Maintain compliance.				
2h There are effective arrangements for the appropriate decontamination of instruments and other equipment. These should be incorporated into decontamination policies.	SSD currently undergoing extensive refurbishment.	SSD will achieve full accreditation.	SSD Manager to achieve relevant qualification. Accreditation process to be undertaken.	Theatre and Critical Care Manager.	July 2010	Accreditation of SSD services will be achieved.
	Endoscopy decontamination currently undergoing refurbishment to increase capacity.	Endoscopy will maintain compliance against national decontamination standards.				Endoscopy will maintain compliance and accreditation.
	REI department undertake decontamination of some equipment used during investigation procedures. Compliance with manufacturers guidance in place.	Maintain standards of decontamination of equipment.	Undertake audit to demonstrate compliance with decontamination standards.	REI Sister/ IPCT/SSD	Oct 2010	Audit results presented to Decontamination Committee
	Oral Facial/ Max undertake decontamination of equipment used during investigation.	Decontamination standards will be met.	Undertake audit to demonstrate compliance with decontamination standards.	OPD Sister/ IPCT/SSD	Oct 2010	Audit results presented to Decontamination Committee

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
	Medical equipment library in place to decontaminate reusable equipment. Decontamination policy in place (September 2009).	Medical equipment will be decontaminated according to manufacturers guidance in suitable premises. Maintain compliance.	Review current services and processes for decontamination of medical equipment.	Theatre and Critical Care Manager.	September 2010	Medical equipment decontaminated against national standards in suitable premises.
2i The supply and provision of linen and laundry supplies reflect HSG (95)	Linen supply is contracted out to Sunlight laundry. Services compliant with HSG- quality visit during 2009.	Maintain compliance.	Monitor quality of laundry services.	Housekeeping Manager.	Ongoing	Any issues with supply of linen will be reported via decontamination committee.
2j Uniform and work wear policies ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose.	Uniform policy in place(March 2008) Incorporates bare below the elbow.	Maintain compliance	Policy due for review.	Director of Nursing	August 2010	Staff familiar with uniform policy.
3. Provide suitable and sufficient information on HCAI to the patient, the public and other service providers when patients move to the care of another healthcare or social care provider.						
3a General principles pertaining to the prevention and control of HCAI and key aspects of the providers policy on IPC.	Patient information leaflet developed February 2009.	Maintain compliance.	Review information leaflet	Infection Control Nurse Consultant.	February 2011	Information leaflet is available on the internet/ intranet and on clinical wards.
3b The roles and responsibilities of individuals in the prevention and control of HCAI to support	Roles and responsibilities outlined in patient	Maintain compliance.				As above

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
them when visiting.	information leaflet.					
3c Supporting vigilance in patients.	Vigilance encouraged in information leaflet.	Maintain compliance				As above
3d The importance of compliance by visitors with hand hygiene and visiting restrictions.	Outlined in above information leaflet.	Maintain compliance.				As above
3e Reporting breaches of hygiene and cleanliness.	Incorporated into patient information leaflet.	Maintain compliance.				As above
3f Explanation of incident outbreak management	Patient/visitor information leaflets produced for Norovirus. Reviewed December 2009.	Maintain compliance.	New outbreak packs available via the Clinical Site Managers when outbreak is declared.	Clinical Site Managers		Information leaflets will be <input type="checkbox"/> available during outbreaks of infection.
3g Feedback that is focused on the patient pathway.	Patient pathways reviewed at Dorset Infection Control Forum/ Network meetings.	Maintain compliance.	Review MRSA patient pathway for patients discharged prior to MRSA positive results being available.	Nurse Consultant Infection Control	August 2010	Pathway will ensure follow up of patients identified as colonized with MRSA during admission process and is consistent across Dorset..
3h Provision across organisational boundaries, such as preadmission screening and post operative care.	Pre admission screening is undertaken for elective patients. Full compliance not yet achieved.	Full compliance will be achieved.	Directorate Managers to take appropriate remedial action to ensure that all elective patients within the DOH operational framework are screened for MRSA and appropriately decolonized prior to elective surgery.	Directorate Managers.	Ongoing reporting via Trust performance framework.	Performance framework demonstrates high level compliance with this standard in line with Commissioning requirements.

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
4. Provide suitable accurate information on infections to service users and their visitors.						
	<p>Patient/ visitor information leaflet outlining arrangements for Infection control is available in clinical areas/ entrances to hospital.</p> <p>Information regarding MRSA screening is currently shared with General Practitioners, currently no action for patients found to be colonized who have been discharged from hospital.</p>	<p>Maintain status</p> <p>Patients identified with MRSA should be offered decolonisation if their results are available after discharge from hospital. Results of MRSA screening should be communicated to the patient directly.</p>	<p>Review information leaflet</p> <p>Pan Dorset approach to agree pathway for managing MRSA positive patients on discharge from acute Trusts.</p>	<p>Nurse Consultant IPC</p> <p>Infection control doctor Nurse consultant IPC.</p>	<p>September 2010</p> <p>November 2010</p>	<p>Information leaflet is available for visitors /patients.</p>
5. Ensure that patients presenting with an infection or who acquire an infection during care are identified promptly and receive appropriate management and treatment to reduce the risk of transmission.						
Arrangements to prevent HCAI should be as such to demonstrate that responsibility for IPC is effectively devolved to all professional groups in a provider	All directorates are required to produce an annual HCAI improvement plan. These are	Maintain compliance.		Matrons/ Clinical Directors	Ongoing	HACI improvements plans are evidenced in minutes of directorate governance

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
and clinical specialties and directorates.	<p>monitored at the IPC and Directorate Governance meetings.</p> <p>A Root Cause analysis is undertaken for patients who acquire MRSA Bacteraemia or <i>Clostridium difficile</i> during their hospital stay.</p>		A review of RCA's should be undertaken to identify key themes for organizational learning.	Infection control Doctor/ Nurse Consultant IPC.	September 2010	<p>meetings.</p> <p>Report forwarded to Risk Management Committee for dissemination.</p>
6. Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections.						
A provider should, so far as is reasonably practicable, ensure that staff, contractors and others involved in the provision of healthcare co-operate with it, and with each other, so far as is necessary to enable the body to meet its obligations under this Code.	<p>All staff are required under the terms of employment to comply with Trust IPC policies.</p> <p>Contractors are made aware of their obligations via the contracts established.</p>	Maintain compliance.	Take appropriate action for breach of Trust policy/ established contracts.	DIPC	Ongoing	
7. Provide or secure adequate						

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
isolation facilities.						
Provide adequate isolation facilities, as appropriate for patients sufficient to prevent or minimize the spread of HCAI. Policies should be in place concerning the allocation of patients to isolation facilities based on local risk assessment. This should include special ventilated isolation facilities.	Isolation audits undertaken in 2009-10 indicate sufficient resources. Isolation policy in place (June 2007. Negative and Positive pressure isolation facilities in place.	Maintain compliance. Maintain compliance Maintain compliance.	Repeat audit . Review policy.	Matrons Infection Control Doctor and Nurse Consultant IPC.	October 2010 June 2010	Audit results available on Clinical audit intranet site. Compliant approved policy
8. Secure adequate access to laboratory support.	Laboratory fully accredited.	Maintain compliance.		Laboratory Manager		Accreditation achieved and maintained.
9. Have and adhere to appropriate policies and protocols for the prevention and control of HCAI.						
9a Standard infection control precautions.	Policy in place June 2007	Maintain compliance	Review and update	Nurse Consultant IPC	June 2010	Policy is in place.
9b Aseptic technique	Policy in place June 2009	Maintain compliance				Policy in place
9c Outbreaks of communicable disease	Policy in place April 2008	Maintain compliance	Review and update	Nurse Consultant IPC	February 2011	Policy in place
9d Isolation of patients.	Policy in place June 2007	Maintain compliance	Review and update	Nurse Consultant IPC	June 2010	Policy in place
9e Safe handling and disposal of sharps.	Incorporated into Standard precautions.	Maintain compliance	Review and update	Nurse Consultant IPC	June 2010	Policy in place
9f Prevention of occupational exposure to blood borne viruses including prevention of sharps injuries.	Policy in place December 2009	Maintain Compliance		Occupation Health Manager		Policy in place
9g Management of occupational	Policy in place	Maintain		Occupational		Policy in place

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
exposure to blood borne viruses	December 2009	compliance		Health Manager		
9h closure of Wards, departments to new admissions	Policy in place July 2007	Maintain compliance	Review and update	Nurse Consultant IPC	July 2010	Policy in place
9i Environmental disinfection policy.	Currently under review incorporated into decontamination	Develop separate policy	Develop policy for disinfection	Nurse Consultant IPC	August 2010	Policy in place
9j Decontamination of reusable medical devices	Policy in place September 2009	Maintain compliance.				Policy in place
8k Antimicrobial prescribing	Different relevant policies in place	Maintain compliance	Currently under review to further develop intranet site.	Infection Control Doctor Antimicrobial prescribing pharmacist		Maintain compliance
9l Reporting HCAI to HPA as directed by the DOH.	Policy in place October 2009	Maintain compliance		Nurse Consultant IPC		Maintain compliance
9m Control of outbreaks and infections with specific alert organisms.	Policies in place for: Norovirus- May 2007 Clostridium difficile December 2007 MRSA- February 2009	Maintain compliance	Review policy Review policy	Nurse Consultant IPC	May 2010 December 2010	Maintain compliance
10 Ensure, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitable educated in the prevention and control of infection.						
10a all staff can access relevant	Policies available	Maintain		Human		Policies available on

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
occupational health policies.	on intranet	compliance		Resources Manager		intranet
10b Occupational health policies on prevention and management of communicable diseases in healthcare workers, including immunization are in place.	<p>Policies in place. Staff Immunisation Inoculation risk Pre-employment policy Exposure Prone policy. Occupational Health representative attends Trust Induction programme.</p> <p>All staff attend appointments at Occupational Health for immunisation risk assessments as requested.</p>	<p>Maintain compliance.</p> <p>Set up needle stick injury forum in collaboration with DPCT, DCHFT and other agencies where relevant.</p>	Contact relevant persons for meetings and establish terms of reference.	Occupational Health Lead	December 2010	Minutes of meeting available. Information on needle stick injuries incorporated into IPC annual training.
10c Prevention and control of infection is included in induction programmes for new staff and in training programmes for all staff.	Induction and Mandatory training programmes incorporate Infection Prevention and control Training.	Maintain compliance.	Annual review of training programme.	Infection Prevention and Control Team.	January 2011	OLM demonstrates staff members who have received IPC training. Annual appraisal identifies staff training.
10d There is a programme of ongoing education for existing staff (including agency/locum staff and staff employed by contractors)	Contracts for agency staff stipulate required elements of training for staff employed.	Maintain compliance.		Human Resources Manager.		Evidenced by contracts with agencies.

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
10e There is a record of relevant immunizations.	Occupational Health records record immunizations on appointment in health screening records.	Maintain compliance		Occupational Health Manager		Staff records
10f There is a record of training an updates for all staff.	OLM records all staff training.	Maintain compliance.	Introduce staff ESR.	ICT Manager		Staff records reflect training received.
10g The responsibilities of each member of staff for the prevention and control of infection is reflected in their job description and in any personal development plan or appraisal.	All staff job descriptions reflect generic infection control responsibilities to comply with trust policy. Those with additional responsibilities e.g. Matrons/ Ward Sisters are reflected accordingly.	Maintain compliance. Record of training in annual appraisal.		Managers		Staff job descriptions.

APPENDIX 2

INFECTION PREVENTION AND CONTROL WORK PROGRAMME 2010-2011

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance	
1. Have in place and operate effective management systems for the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks their environment and other users may pose to them.	IPC to meet 6 times annually.	Maintain compliance		DIPC	Ongoing	Minutes of IPC	
	Attendance at IPC monitored by Chair of Committee.	Maintain compliance		DIPC	Ongoing	Minutes of IPC	
	Trust Board receives and approves IPC Annual Report.	Maintain compliance	Infection Control Doctor/ Nurse Consultant to present to TB.	ICD/ Nurse Consultant IPC	TBA	Trust Board minutes	
	Trust Board receives quarterly update from DIPC on HCAI	Maintain compliance.					
	Directorate HCAI improvement plans presented to IPC following approval at Directorate Governance meetings.	Monitor progress against plans at IPC on rotational basis		Elderly Care Critical Care Maternity Medicine Renal Services Paediatrics Surgery Theatres Orthopaedics		May 2010 July 2010 July 2010 Sep 2010 Sep2010 Nov 2010 Jan 2011 An 2011 Mar 2011	IPC minutes
	Root Cause Analysis is undertaken for cases of MRSA bacteraemia and <i>Clostridium difficile</i> involving all relevant members of the MDT.	Maintain compliance	Undertake review of all RCA's to develop strategic report of key issues.	Infection Control Doctor and Nurse Consultant IPC	September 2010	IPC Minutes	
						Risk Register	

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
	<p>Serious untoward incidents reported to SHA as appropriate e.g. HCAI deaths, Major Outbreaks</p> <p>Support and advice for clinical teams is available and developments are planned with Matrons.</p>	<p>Maintain compliance</p> <p>Planned supporting framework to develop best practice involving weekly planned visits to ward to facilitate practice development.</p>	<p>Report when necessary.</p> <p>Establish framework for Achieving Control Together.</p>	<p>Risk Manager/ IPCT</p> <p>IPCN's Ward Sisters</p>	<p>Ongoing</p> <p>June 2010</p>	<p>ACT ward rounds in place and outcome reports available.</p>
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection.	<p>PEAT group receives reports on state of cleanliness.</p> <p>Joint audit of environmental cleanliness between housekeeping and Ward sisters</p> <p>Managerial audits undertaken every fortnight.</p>	<p>Review terms of reference of PEAT in light of British Safety Institute Publically Available cleaning Specification.</p> <p>Maintain status</p> <p>Maintain status</p>	<p>Develop action plan to reflect PAS.</p> <p>Implement action plan</p> <p>ICT to facilitate information via Productive Ward programme Environmental audits to be displayed publically</p> <p>Develop mechanism for monitoring actions from these audits</p>	<p>Head of Housekeeping</p> <p>Director with responsibility for cleanliness</p> <p>Matrons</p> <p>Head of Housekeeping</p>	<p>April 2010</p> <p>Action identified within action plan.</p> <p>Ongoing</p> <p>Ongoing</p>	<p>Environmental audit results to be displayed on Ward LCD screens.</p> <p>Audit results reported to PEAT</p>

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
	PEAT inspection to take place annually.	Maintain status	Schedule audits in line with national programme with appropriate membership.	Director with responsibility for cleanliness	Feb/Mar 2011	PEAT results will be submitted to national programme.
	Legionella policy in place.	Maintain status	Ongoing monitoring of water quality.	Estates Manager	As necessary	IPC informed on any adverse results from water sampling and assurance of appropriate remedial action.
3. Provide suitable accurate information on infections to service users and their visitors	<p>Patient/visitor information leaflet available.</p> <p>Patient's GP's are notified if patient is colonized with MRSA.</p>	<p>Maintain status</p> <p>Develop effective community model for informing patients in the community if they are colonized with MRSA and systematic approach to decolonizing patients.</p>	<p>Review patient information leaflet on infection control.</p> <p>Establish joint working party with NHS Dorset and Dorset PCT to review current practice and develop effective model to inform patients and facilitate decolonisation if found to be positive .</p>	<p>Nurse Consultant IPC</p> <p>Nurse Consultant Infection control Doctor</p>	<p>September 2010</p> <p>December 2010</p>	<p>Information leaflet available on all wards and key information points in the Trust and Trust internet site.</p> <p>Progress to be reported via IPC-evidenced by minutes of Committee.</p>

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
	<p>Patients colonized with MRSA receive information leaflets.</p> <p>Patients with <i>Clostridium difficile</i> associated diarrhoea receive information leaflets.</p> <p>Patient Intravenous Cannula Information developed</p>	<p>Maintain status</p> <p>Information leaflets will be approved by patient forums.</p> <p>Maintain status.</p>	<p>Review existing MRSA information leaflets and update accordingly in line with work of MRSA working party.</p> <p>Review existing information leaflets and submit via PAL's forum for critique.</p> <p>Review information leaflet via patient forum</p>	<p>Infection Prevention and control Nurses</p> <p>Infection Prevention and Control Nurses PALS</p> <p>Infection Prevention and Control Nurses PALS</p>	<p>February 2011</p> <p>March 2011</p> <p>October 2010</p>	<p>Information leaflets are approved at IPC.</p>
4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion.	<p>Medical discharge summaries have provision for information regarding infections.</p> <p>Nursing discharge summaries have provision regarding infectious</p>	<p>Maintain status</p> <p>Maintain status</p>	<p>Audit compliance</p> <p>Audit compliance</p>	<p>Infection Prevention and Control Team</p> <p>Infection Prevention and control Team</p>	<p>July 2010</p> <p>September 2010</p>	<p>Audit results demonstrate compliance</p> <p>Audit results demonstrate compliance.</p>

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
	status.					
5. Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.	Ineffective surveillance database	Effective surveillance database with adequate reports facility.	ICT to complete Surveillance database.	Head of ICT.	??	Functioning surveillance database with output reports.
	Informal system to identify patients requiring isolation.	Develop robust daily worksheets on shared drive for use by Clinical Site Managers.	IPCT to develop daily worksheets and save on shared drive.	IPCN	June 2010	Daily worksheets utilized for effective use of isolation facilities.
6. Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections.	Unscheduled antimicrobial audit programme	Planned antimicrobial audit programme	Develop audit schedule	Antimicrobial pharmacist/ Consultant Microbiologists.	May 2010	Audit programme in place Directorate feedback Feedback at antibiotic Working Group and IPC
	Monitoring antimicrobial prescribing by Consultant Microbiologists	Maintain status	Consultant Microbiologists to attend: Intensive Care Ward rounds Diabetic foot ward rounds Cardiology ward rounds Ongoing review of patients with significant results	Consultant Microbiologists	Ongoing	
	Review of patients with	Ensure data is	Undertake	Matrons	Commence	Datex system

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
	line infection	captured on Surveillance database. Initiate RCA for all line associated infections.	RCA for all line associated infections.		June 2011	records all RCA's undertaken for line associated infections. Output report available.
	Poor compliance with PVC Saving Lives High Impact Interventions.	100% compliance with PVC High Impact Interventions	All adult inpatients areas to participate in PVC Care Bundle.	Matrons to monitor performance. Ward Sisters to implement.	April 2010	100% compliance across the Trust with PVC High Impact interventions.
			Mandatory updates to continue to educate staff regarding safe insertion/ management of PVC	IPCT	Ongoing	Mandatory IPC training programme incorporates PVC training.
	Contaminated blood culture samples overall 7.5% (13% for A&E	Blood culture contamination rate less3%.	Monitor contamination.	Infection control Doctor.	Ongoing	Directorate HCAI plans reflect this measure.
			Directorate Managers to ensure all staff are trained when involved in this process. Directorates to develop action plan when	Directorate Managers		

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
	<p>Aseptic technique undertaken staff report variance in practice.</p> <p>Cleaning schedules for clinical equipment used in wards and departments are in place.</p> <p>Hand Hygiene audits undertaken monthly</p>	<p>Review of aseptic procedures undertaken in clinical areas.</p> <p>Medical Equipment Library will have protocols in place that reflect manufacturers guidance and have an audit system in place.</p> <p>Hand hygiene audits frequency to increase when</p>	<p>rates exceed 3%.</p> <p>Develop appropriate ward based training for clinical staff undertaking aseptic techniques in line with Trust policy.</p> <p>Facilitate review of cleaning methods and develop protocols with SSD manager with responsibility for Medical Equipment Library. Staff will receive training in the identified methodology for cleaning medical equipment.</p> <p>Review current hand hygiene audit tool and</p>	<p>IPCT/ Nicola Tutton</p> <p>Infection Control Matron/ SSD Manager</p>	<p>September-March 2011</p> <p>August 2010</p>	<p>OLM training records reflect staff trained in aseptic technique.</p> <p>Equipment library cleaning manual available. OLM records reflect that staff have received training in decontamination methods.</p>

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
		standards below 70% to weekly.	consider introducing IHI tool across the trust in			
7. Provide or secure adequate isolation facilities	Bi annual audit of isolation facilities. Annual audit of air pressure in isolation facilities	Establish system for exception reporting when patients with infections are not isolated in timely manner. Maintain status	IPCT to develop exception reporting for isolation. Ventilation audit to be undertaken annually.	IPCN Estates Manager to facilitate	July 2010	Report to IPC quarterly evidenced Report submitted to IPC on completion.
8. Secure adequate access to laboratory support as appropriate	Microbiology laboratory is accredited.	Maintain status	No action required at present.	Laboratory Manager		
9. Have and adhere to policies, designed for the individual's care and provider organisation's, that will help to prevent and control infections.	a) Standard precautions b) Outbreaks of Communicable disease c) Isolation of Patients d) Ward Closure policy e) Disinfection policy	Compliant policy Compliant policy Compliant policy with audit programme Compliant policy Develop policy	Review policy Review policy Review policy Review policy Develop compliant policy and	Nurse Consultant IPC Nurse Consultant IPC Nurse Consultant IPC Nurse Consultant IPC Matron IPC	June 2010 February 2011 June 2010 July 2010 September 2010	

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
	f) Clostridium difficile policy	Clostridium difficile policy updated to reflect national guidance.	implement Develop and implement policy.	Infection Control Doctor	May 2010	
	g) MRSA policy in place	Policy updated to incorporate latest DOH guidance and working party recommendations.	Develop and implement policy	Nurse Consultant IPC	November 2010	
	h) Surveillance and Mandatory reporting policy in place.	Policy reflects Health Protection Legislation England 2010.	Develop and implement policy	Nurse Consultant IPC	January 2011	
	Hand Hygiene audits undertaken monthly	Review supporting audit tool	Roll out IHI audit tool across the Trust	Matron IPC IPCN	December 2011	Audits reviewed at IPC/ Ward sisters meetings evidenced in minutes
	MRSA screening is monitored for compliance by information team.	Maintain status and support clinical teams to achieve compliance.	Monitor screening for elective and emergency patients.	IPCT	Ongoing monthly	Audit reviewed at IPC and evidenced on clinical audit website
	Decolonisation treatment can be delayed in some clinical areas.	Monitor compliance with MRSA decolonisation.	Audit compliance and where relevant work with clinical teams to improve compliance with policy standards.	IPCT	March 2011	Audit reviewed at IPC and evidenced on clinical audit website

Objective	Current state	Future state	Action	Responsibility	Date of completion	Evaluation of measures of success/ assurance
	Currently Matrons monitor performance against Saving Lives HII for all wards and record on performance framework.	Develop effective performance management of results of Saving Lives HII.	Matrons to feed back via Directorate Plans to IPC and Directorate Governance frameworks.	Matrons	Ongoing	Evidenced by minutes of IPC and Directorate governance meetings.
10. Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.	All staff are required to receive mandatory IPC updates at induction and annually thereafter. IPC training incorporates prevention of needle stick injuries.	All staff receive mandatory training. This will be monitored at appraisal and via Directorate HCAI plans.	Work with Education Manager to develop reporting framework.	Nurse consultant IPC IPS secretary.	September 2010	