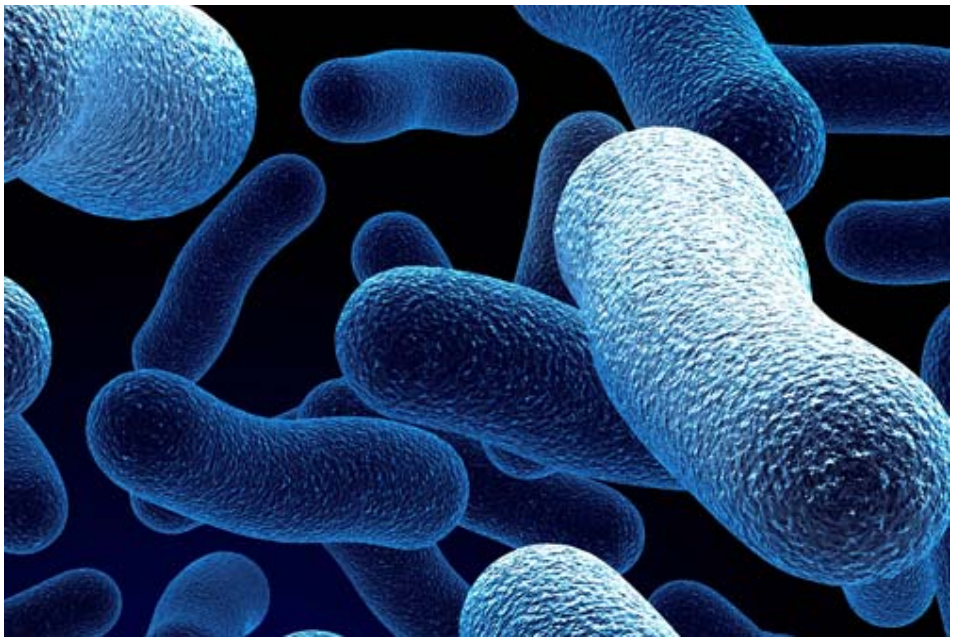
INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Infection Prevention and Control Annual Report 2018-19



Nicola Lucey - Director of Nursing and Quality/ Director of Infection Prevention and Control
Emma Hoyle - Associate Director Infection Prevention and Control
Dr Paul Flanagan – Infection Control Doctor

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EXECUTIVE SUMMARY

The annual report provides a summary of the Infection prevention and control activity over the last year and status of the healthcare associated infections (HCAIs) for Dorset County Hospital NHS Foundation Trust.

The Director of Nursing and Quality is the accountable board member responsible for infection prevention and control and undertakes the role of the Director of Infection Prevention and Control.

The Infection Prevention and Control Group function in order to fulfil the requirements of the statutory Infection Prevention and Control committee. It formally reports to the sub-board Quality Committee, providing assurance and progress exception reports. All Trusts have a legal obligation to comply with the Health and Social Care Act (2008) – part 3 Code of Practice for the Prevention and Control of HCAIs), which was reviewed and updated in 2015.

The workplan, led and supported by the Infection Prevention and Control team (IPCT), sets clear objectives for the organisation to achieve with clear strategies in place to meet the overall Trust strategy of Outstanding.

Overall 2018/19 was a successful year, meeting key standards and regulatory requirements for infection prevention and control. Below is the highlight of those:-

- The Trust met the trajectories set for MRSA bacteraemia and *Clostridium difficile* infections for 2018-2019
- The Trust has successfully reduced healthcare acquired infections year on year
- Hand hygiene compliance has remained high and sustained at 97%
- Only one outbreak of Norovirus which was well contained and occurred for a short period only
- The Trust achieved above the national average for several elements of the PLACE assessments for the year.
- The Sterile Supplies department continues to maintain a full Quality Management System in line with BSO standards.
- Mitigation and enhanced monitoring continued to control pseudomonas and legionella in tap water in high risk areas
- Trust remains key national benchmark for use of data management system in infection prevention & control (ICNet).

INTRODUCTION

This is my third year as Director of Nursing and Quality with the responsibility of Director for Infection Prevention and Control (DIPC) and this report summarises the work undertaken in the Trust for the period 1st April 2018 – 31st March 2019.

The Annual Report provides information on the Trust's progress of the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAI's).

I am pleased to report good progress against the trajectory for HCAIs. The Trust met the target for zero cases of MRSA bacteraemia and reported 10 cases of *Clostridium difficile* against a target of 13 cases. In addition, the Trust has been very proactive in reviewing trends and improvements in Gram-negative blood stream infections (BSIs) with sharing across system partners as part of the Dorset STP. The Infection Prevention and Control Team has seen their system and partnership working as key to supporting the health and safety of the population, sharing good practice, offering support where able and championing the benefits of digital support in the management of infection and prevention.

These low rates of infection have been achieved by the continuous engagement of the Trust Board and most importantly the efforts of all levels of staff employed by the trust. The commitment to deliver safe, clean, quality care for patients remains pivotal in the goal to reduce healthcare associated infections to an absolute minimum of non-preventable cases.

I am proud of the efforts, innovation and leadership in practice of the Infection Prevention and Control team as without their support the quality improvements towards our strategic mission "Outstanding care for people in ways which matter to them" would not be possible. Their support for training and engaging with the clinical teams has been at the highest standard, reflective of the care provided and experience by our visiting public.

Of course I am never complacent with our ambitions remaining high as I look forward to another year ahead of delivering outstanding services every day through effective, efficient and joined up infection prevention and control.

Nicola Lucey
Director of Nursing and Quality
Director of Infection Prevention and Control

1. INFECTION PREVENTION AND CONTROL ARRANGEMENTS

2.1 INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 6 times during 2018- 2019. It is a requirement of *The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections,* that all registered providers: *"have in place an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks".*

The IPCG is chaired by the Chief Executive Officer, Patricia Miller. Director of Nursing & Quality, Nicola Lucey, who also is the Director of Infection Prevention and Control (DIPC), is in attendance and acts as deputy Chair, with the responsibility for reporting to the sub-board Quality Committee for assurance.

2.2 DIPC REPORTS TO QUALITY COMMITTEE

The DIPC has presented to the following items during 2018-2019:

- Monthly MRSA Bacteraemia surveillance;
- Monthly *Clostridium difficile* surveillance;
- Monthly hand hygiene rates;
- Outbreak and incident reports;
- Antibiotic Stewardship Report;
- Progress with national ambition to reduce Gram Negative Blood Stream Infections by 50% by 2021

2.3 INFECTION PREVENTION and CONTROL TEAM

The IPCT has welcomed new members in the year and consists of:

- Nicola Lucey, Director of Nursing and Quality/ Director of Infection Prevention and Control
- Dr Paul Flanagan, Consultant Microbiologist and Infection Control Doctor – Joined October 2018
- Emma Hoyle, Associate Director Infection Prevention and Control
- Abigail Warne, Specialist Nurse – Ongoing Maternity Leave since June 2018
- Julie Park, IPC Nurse – Ongoing Maternity Leave since September 2018
- Christopher Gover, Specialist Nurse – Seconded to team to cover Maternity Leave
- Debs Scott-Denness - Seconded to team to cover Maternity Leave
- Helen Belmont – Bank Specialist Nurse
- Cheryl Heard, Administrator
- Rhian Pearce, Antimicrobial Pharmacist – Returned from Maternity Leave November 2018

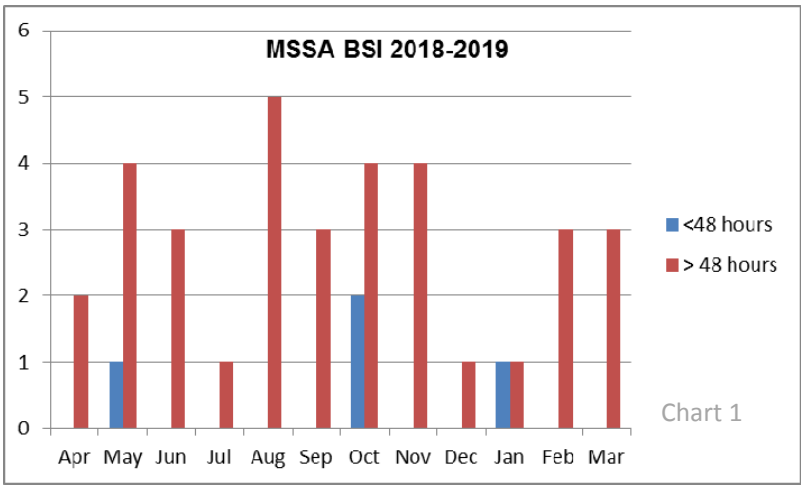
2. HEALTHCARE ASSOCIATED INFECTIONS

3.1 Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia

There were no cases of MRSA bacteraemia in 2018-2019. The last case of MRSA bacteraemia assigned to the Trust was July 2013. This provides confidence that the IPC practices in place have been sustained. Our performance is in keeping with national data whereby Trust apportioned cases of MRSA (blood samples taken ≥48hours post admission) have significantly reduced.

3.2 *Staphylococcus aureus* bacteraemia (MSSA)

In 2018-2019 there were a total of 38 cases of MSSA bacteraemia, of these 34 cases were identified <48 hours of admission and 4 identified >48 hours after admission (Chart 1). This is a significant reduction compared to last years MSSA bacteraemia cases >48 hours which was 12 cases.



To achieve this reduction we have implemented control measures that include, screening for certain high-risk patient groups, decolonisation of high-risk patients prior to procedures and close monitoring of indwelling devices. Analysis of cases in the >48 hour group has shown that only one was trust-acquired, with the other three relating to a source present prior to admission.

3.3 Gram Negative Blood Stream Infections

3.3.1 Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram –negative BSIs by 2021 (PHE 2017). February 2019 it was announced that the date for achieving this reduction has been changed to 2023. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.)*

3.3.2 Mandatory data collection has been in place for several years for E.coli. In addition, from April 2017 additional mandatory data collection and surveillance has been in place for Klebsiella spp.and Pseudomonas *aeruginosa.*

3.3.3 In 2018-2019 there were a total of 143 positive BSI samples for E.coli. 20 of these cases were attributed to the Trust (Chart 2). This was a decrease by 1 case from 2017-2018. All of these cases were reviewed via Root Cause Analysis (RCA) by the IPCT no trends or issues were identified to progress to Divisional involvement. All cases of E.coli that occur >48hrs after admission are reviewed by the Consultant Microbiologist and Infection Prevention & Control Team. A full data collection process is carried out in accordance with Public Health England guidance; this includes all mandatory and optional data. Full antibiotic review is carried out taking into account the preceding 28 days. No lapses in care have been identified in the cases 2018-2019.

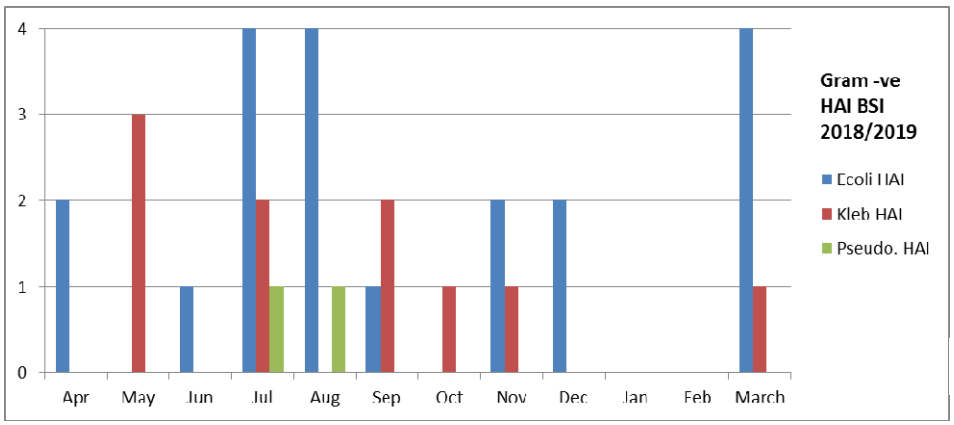


Chart 2

3.3.4 In 2018-2019 there were a total of 42 positive BSI samples for Klebsiella sps, 10 of these cases were attributed to the Trust (Chart 2). This was an increase by 5 cases from 2017-2018.

3.3.5 In 2018-2019 there were a total of 7 positive BSI samples for Pseudomonas *aeruginosa*, 2 of these cases were attributed to the Trust (Chart 2). This was a decrease by 5 cases from 2017-2018.

It has been noted that there has been a rise in taking blood cultures for investigation over the past 3 years (Chart 3). This is in response to the action by the Trust to diagnosis and management of sepsis.

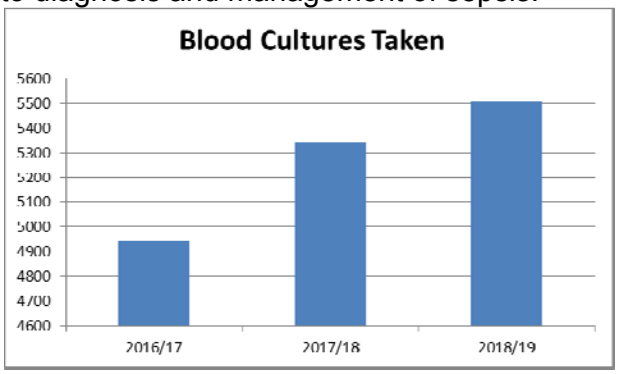


Chart 3

3.3.6 The IPCT continues to be involved in the nationally organised events and training via NHS Improvement (NHSI). Through these events it has been recognised and agreed that the reduction of gram negative BSIs is proving difficult to achieve and the target date for completion has been extended to 2023. At DCHFT the IPCT have been addressing the following to check current processes:

- Review of urinary catheter care including documentation and discharge
- Participation in national Surgical Site Surveillance audit for Bowel Surgery to benchmark Trust 2017/2018.
- Audit and subsequent actions into monitoring of indwelling devices e.g. Peripheral vascular cannula
- Individual review of *E.coli* BSI cases

Within Dorset the four healthcare Trusts are working together on joint projects to seek solutions to this target as the majority of cases are community acquired and support is required to achieve resilience county wide. Nationally, the decrease in gram negative BSI has not been recognised and NHSE/i have agreed to stretch the target to 20203. This will enable further engagement with primary care.

3.4 *CLOSTRIDIUM DIFFICILE* INFECTION (CDI)

This has been the most successful year to date for reducing cases of CDI. The Trust trajectory for the year was 13 cases. In total the Trust reported 10 cases detected >3 days after admission; of these cases 7 were appealed as non-preventable with no lapses in care; this resulted in 3 cases reported as hospital acquired (Chart 4).

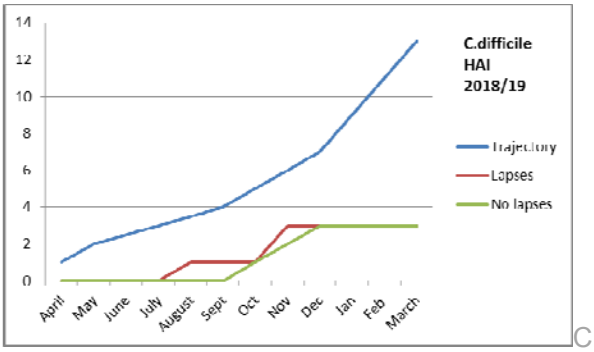


Chart 4

All samples are forwarded to the PHE reference laboratory for ribotyping. This provides an overview of the different strains of *Clostridium difficile* toxins and an opportunity to ensure that any potential linked cases are reviewed and outbreaks detected early. Over the course of the year we identified 6 different phage types. We can confidently say that we have not had any outbreaks or linked cases of CDI in the Trust 2018-2019.

All cases of hospital acquired CDI require a Root Cause Analysis investigation. The results are presented to Patricia Miller, Chief Executive Officer and scrutinised to identify any relevant learning from the cases. The learning actions when completed are then presented and signed off by the Divisional Matron at the IPCG.

3. OUTBREAKS OF INFECTION

4.1 Norovirus

Outbreaks of this viral illness have been identified at the Trust during this year in line with seasonal reporting. Individual cases have also been reported in very small numbers. There has been 1 outbreak of Norovirus 2018-19. This was identified quickly, patients sampled and isolated in line with Trust policy. In comparison with the national average the number of bed days lost due to outbreaks remains low.

4.2 Influenza

There has been a national reduction in cases of Influenza A & B during the Winter 2018/2019 in comparison to the previous year. The Trust was able to demonstrate learning from the previous year and the impact at operational level for the Trust was minimal.
In preparation for 'Flu Season' all Trust staff were offered the annual flu vaccine. 82.6% of front line staff were immunised and 79.17% of all staff, an increase from 63.23% the previous year.
The Trust did not have any outbreaks of influenza and all cases identified in the Trust were isolated and treated in a timely manner.

5 CLINICAL AUDIT

5.1 SURGICAL SITE SURVEILLANCE

Surgical site infections (SSIs) are defined to a standard set of clinical criteria for infections that affect the superficial tissues (skin and subcutaneous layer) of the incision and those that affected the deeper tissues (deep incisional or organ space).

Preventing surgical site infections is an important component of Infection Prevention and Control programmes. There is a Mandatory requirement by the Department of Health for all Trusts' undertaking orthopaedic surgical procedures to undertake a minimum of three months' surveillance in each financial year.

SSI for orthopaedic surgery involves 3 stages of surveillance:
Stage 1- collection of data relating to the surgical procedure and inpatient stay
Stage 2 (not mandatory) collection of post discharge surveillance at 30 days post procedure
Stage 3- review of patients readmitted within 365 with SSI

During 2018-2019 the IPC team have supported 2 modules for surveillance. Surveillance. The IPCT are able to facilitate a less time consuming model of data collection utilising the IPC data tool ICNet. The system facilitates readmission alerts, and data upload from PAS, theatre and microbiology systems and the ability to directly upload the data to PHE SSI site.

Over the last year the accessibility of ICNet has been increased for the surgeons to monitor and keep a live active list of their potential and actual infections. Aligned

with the national 'Getting it right first time' (GIRFT) audit this will continue over the Summer of 2019.

Surgical Site Surveillance of Hip Replacement

The following tables demonstrate the number of operations completed, and number of completed post discharge questionnaires for April- June 2018 (Table 1) and last 4 periods for which data was available.

The percentage of post discharge questionnaires returned by patients is significantly higher than the national data for all hospitals.

During this quarter the increased incidence of post-operative infections in orthopaedic cases were monitored and actions taken to investigate and seek the root cause.

Further to intensive investigation no source was found and no further infections identified.

Table 1 April – June 2018 Hip Replacement Surveillance

Operations & Surgical Site Infections		Dorset County Hospital NHS Foundation Trust	
		Apr-Jun 2018	Last 4 periods
Operations	Total number No. with PQ given % with PQ completed	98 98 81.6%	337 337 79.8%
Surgical Site Infection	No. of inpatient/readmission % infected	3 3.1%	3 0.9%
	No of post discharge confirmed % infected	2 2.1%	5 1.5%
	No of patient reported % infected	0 0.0%	0 0.0%
	All SSI % infected	5 5.1%	8 2.4%

Surgical Site Surveillance of Breast Surgery (Jan – March 2019 - data not available for 2019-2020 Annual report)

Data collection for this audit was completed at the end of April 2019 the final report is not yet available from Public Health England.

5.2 Peripheral Venous Cannula (PVC)

In 2014 national guidance was published for the prevention of healthcare associated infections in NHS Hospitals. A full GAP analysis was undertaken and the insertion and management of Peripheral Venous Cannula (PVC) was one area that required improvement. PVC's are commonly used devices in acute hospitals, used for the administration of intravenous fluids and drugs. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The evidence presented in the national guidance

suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident or when the PVC is no longer required.

Regular auditing commenced in January 2016 and remains ongoing. Should compliance fall below 90% additional weekly/monthly audits are carried out. Divisional leads are invited to IPCG on a bi-monthly basis to discuss their areas results. The annual average for compliance is 90%.

5.3 Compliance with Urinary Catheter Policy

Over the past year the following audits have been completed in relation to Urinary Catheter Care

- Discharge from DCHFT with Urinary Catheter Pathway

Trust wide compliance in issuing patients with catheter care record on discharge from hospital: Urgent and Integrated Care 32% Family Services and Surgical 80%. Divisional Matrons are reporting findings via their Quality Groups and working with staff to improve results.

- Indwelling Urinary Catheter Recording on Vital Pac

Trust wide compliance in recording patients with urinary catheters on VitalPac has improved by 10% over the last year. Monthly audits are now in place and compliance at year end: Urgent and Integrated Care 86% Family Services and Surgical 89%

5.4 Carbapenemase producing enterobacteriaceae audit

Carbapenem antibiotics are a powerful group of β-lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been the antibiotics that doctors could always rely upon (when other antibiotics failed) to treat infections caused by Gram-negative bacteria.

In the UK, over the last 8 years, we have seen a rapid increase in the incidence of infection and colonisation by multi-drug resistant carbapenemase-producing organisms. A number of clusters and outbreaks have been reported in England, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

Public Health England recommend that as part of the routine admission procedure, all patients should be assessed on admission for Carbapenemase-producing Enterobacteriaceae status.

This audit aims to determine the level of compliance across the trust with the screening assessment being conducted on admission and the correct actions taken if screening is required.

Regular audits have shown overall trust compliance rates to be at 89%. IPCT continue to work with ward teams to ensure these assessments are completed on admission.

6. EDUCATION

The Infection Prevention & Control Team provided formal education sessions training for both clinical and non-clinical staff. IPCT also was incorporated into the following programmes and the team were involved in delivering formal sessions:

- Care Certificate for Health Care Support Workers
- Preceptorship Training
- Overseas Recruitment Training
- Intravenous Training
- Tissue Viability
- Volunteers Training

Mandatory Training for clinical and non-clinical staff has been offered via an online workbook. Overall compliance with mandatory IPC training over the year was 84% for clinical staff and 92% for non-clinical staff. IPCT recognised that additional support and training was required and so now provides monthly face to face formal mandatory training sessions for staff in addition to the online package. This has been in place from early 2019.

7. POLICY DEVELOPMENT/REVIEW

The following policies have been developed / reviewed during the year:

- Infection Prevention and Control Operational Policy for Haematology/Cancer Ward
- Hand Hygiene Policy
- Guidelines for patients discharged with an Urinary Catheter (urethral & suprapubic)
- Aseptic and Aseptic Non-Touch Technique (Clean) Protocol
- Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Policy
- Scabies, Treatment of - Suspected or Confirmed Guidelines
- Isolation Policy
- Seasonal Influenza Policy
- Guidelines for the use of portable fans in the healthcare setting
- Clostridium difficile policy

8. INFECTION CONTROL WEEK

This year's Infection Control Week focused on 'the gloves are off' – reducing inappropriate glove use and promoting good hand hygiene risk assessments. The wards and departments did not disappoint and created some wonderful educational display boards and worked hard to highlight the importance the topic. During the

week the annual judging of the displays led by Patricia Miller and Nicola Lucey, took place.

Overall winner – Kingfisher Ward

The winners included:
Award for Most Imaginative – Ilchester Ward
Award for Most Educational – Maternity
Award for Most Entertaining – Renal Dialysis
Overall Winner – Kingfisher Ward for demonstrating strategic awareness, most aligned to Trust values and link to evidence based practice

Other participating wards – Abbotsbury, Ridgeway, Purbeck, Moreton, Prince of Wales Wards, Theatres and the Stroke Unit.

We were also supported with Reps from Schülke, Clinell, Vernacare, Daniels and GoJo who kindly donated prizes for the winners and some came in to promote IPC with stands in Damers restaurant. Damers restaurant also made a brilliant themed cake for another competition. Poundbury Garden Centre and the Plaza Cinema also provided some prizes.

9. FACILITIES REPORT - CLEANING SERVICES (PAUL ANDREWS)

TO PROVIDE AND MAINTAIN A CLEAN AND APPROPRIATE ENVIRONMENT THAT FACILITATES THE PREVENTION AND CONTROL OF INFECTIONS.
CLEANING SERVICES

9.1 CLEANING SERVICES

9.1.1 Management Arrangements

The Head of Estates and Facilities is responsible for high standards of cleaning service delivery across all areas of the Trust. The Deputy Facilities Manager is responsible for the 'day to day' running of the service supported by an 'in house' team which is made up of a Housekeeping Team Leader supported by Housekeeping Supervisors and Housekeeping staff.

Mandatory training for all housekeeping staff is currently recorded as 94 %

9.1.2 Monitoring and Auditing

Dorset County Hospital has robust systems in place to ensure that all healthcare premises provided are suitable and fit for purpose. The environments are monitored to ensure they are clean, maintained and in good physical repair and condition. Various audits are carried out by IPC and Housekeeping Services, which include the '49 elements', and inspections all monitor standards of cleanliness and ensure that environmental policies and procedures are adhered to. In addition the Trust participates in the annual Patient-Led Assessments of the Care Environment (PLACE).

PLACE assessments are a system for assessing the quality of the patient environment. They are conducted via self-assessments with external patient and Healthwatch validation, and assessments are undertaken every year. The results are reported publicly to help drive improvements in the care environment.

The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care. The non-clinical activities of concern are cleanliness; food and hydration; privacy and dignity and wellbeing and condition, appearance and maintenance of healthcare premises and a disability and dementia domain which measures whether the premises are equipped to meet the needs of a disabled person and dementia sufferers against a specified range of criteria. Additionally for 2018 there was more focus on disability and dementia awareness categories. These categories focus on the issues of access and mobility provided for disabled patients during their stay, aspects relating to food and food service, and the provision of dementia friendly environments.

DCH comparison by Upper Quartile of South of England and Acute Small Trusts

	DCH Scores for 2018	National Average for 2018	Upper Quartile of South of England	Upper Quartile of Acute Small-country wide
Cleanliness	99.48%	98.59%	99.42%	99.48%
Food	96.81%	90.71%	93.32%	91.75%
Organisational Food	92.10%	89.60%	93.1%	92.16%
Ward Food	97.66%	91.88%	94.25%	92.85%
Privacy, Dignity and Wellbeing	86.67%	85.81%	87.97%	84.85%
Condition, Appearance and Maintenance	94.46%	94.72%	95.97%	96.06%
Dementia	78.84%	81.34%	87.72%	84.58%
Disability	84.24%	85.47%	90.54%	88.03%

In summary the 2018 PLACE results for Dorset County Hospital demonstrated a high level of compliance across the Trust with the majority of categories scoring above the national average and noting improved or sustained practice in many areas.

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

Technical cleaning audits are carried out weekly and monthly by a team of appropriately trained personnel, and patient leads, to provide and monitor data as required by the national cleaning standards. The minimum target score set by the Trust (using the 2007 NHS National Standards of Cleanliness Criteria) is as follows:

- Very high risk areas 98%
- High risk areas 95%
- Significant risk areas 85%
- Low risk areas 75%

In areas where the target score is not reached there is a rectification timeframe set at 24 hours for very high risk and 48 hours for high risk areas. Additional focused monitoring and validation of the audit scores also takes place in liaison with the IPC team and an action plan is agreed and implemented. As a Housekeeping team we have maintained 100% auditing in all very high and high risk areas for 2018.

9.1.3 Deep Cleaning Programme

The deep cleaning programme of ward areas was started during 2017 and plans are in development to continue this in 2019-20, with areas identified and working alongside our Estates colleagues to address works that are required prior to the housekeeping deep clean using the HPV machine.

The Trust embraces the process of decontamination with hydrogen peroxide vapour (HPV) misting machines and uses this as normal practice where a 'deep cleaning' requirement has been identified by Nursing or the Infection Control Team and where upgrades or refurbishment has taken place.

9.1.4 Patient Feedback

Feedback from 'Friends and Family' shows housekeeping receive consistently positive feedback for the delivery of very high cleaning standards across Dorset County Hospital.

10 ESTATES REPORT (ANDREW MORRIS – Head of Facilities and Estates)

10.1 WATER QUALITY

Throughout 2018, the Estates Team have maintained responsibility for the Trust's water services, reporting to the Water Quality Management Group (WQMG). Activities to maintain water quality continue to be supported and audited by independent experts in water hygiene management from Water Hygiene Centre with the WQMG sitting FOUR times per annum.

The 'Water Safety Policy' and accompanying 'Operational and Maintenance Procedures' documents were both formally adopted this year by WQMG.

Regulatory requirements to ensure the wholesomeness and sufficiency of the DCH borehole supply have been amended following changes to the *Private Water Supplies (England) Regulations 2016*. As a consequence both check and audit analysis of the supply has been delegated to the authority, the Community Protection Division of the Dorset Councils Partnership to enhance communication and reduce costs.

There has been considerable success in the closure of items identified in the 2016 L8 Risk Assessment and other water safety related issues that have emerged during the year including;

- Replacement of North Wing Cold Water Storage Tanks (CWST),
- Deactivation of Children's Centre CWST and dead-leg removal,
- Installation of pilot system for Hot Water System temperature monitoring,
- Upgrade of borehole dosing system.

Other outstanding items, primarily issues around dead-legs, back-flow prevention and intrusive inspection, have had to be deferred to FY19/20.

In 2019 several Risk Assessments, such as Legionella, are due to be carried out. These will form an integral part of the full internal review of DCH outlets, currently underway, to improve compliance and assurance regarding water safety at point of use including flushing, hot water boiler servicing and such like.

Pipework corrosion issues continue to occur resulting in leaks. These primarily present risks to continuity of supply rather than direct infection issues. Investigations supported by BSRIA laboratories (Building Services Research and Information Association) have determined the likely root cause to be a latent defect from original construction. As a consequence leaks are handled on an ad hoc basis with a concurrent project underway to mitigate the consequences of isolation when effecting repairs by means of additional isolation valves.

The Robert White Centre has now been brought into service with all utilities and equipment currently under warranty. Full handover of the facility to Estates Dept. is due in May 2019 and will be included in all surveillance and routine safety schedules.

Bacteriological surveillance, principally for Legionella and Pseudomonas, has continued according to previous schedules across the Trust. It is the Estates Dept. intention to bring this work in-house to improve costs and control. A review of sampled outlets and scheduling will take place as part of this development.

Over the period covered by this report, MAR18 – MAR19, there were TWELVE instances of raised Pseudomonas counts discovered during regular surveillance testing;

- POW – FOUR separate instances.
- Fortuneswell Ward – FIVE separate instances.
- SCBU – ONE instance.

WSP procedures were followed in all instances and, based on subsequent investigation, are believed to have extrinsic causes. There were no instances of Legionella detected.

10.2 SUPPORT FOR THE DEEP CLEAN PROGRAMME

The Deep Cleaning programme of ward areas commenced in 2017 and this has continued throughout 2018. It is supported by the Estates Team who undertake any necessary refurbishment work prior to the housekeeping team using the hydrogen peroxide vapour process (HPV fogging) to clean the agreed areas.

10.3 REPLACEMENT FLOOR COVERINGS

During 2018/19 the Estates delivery team and contractors have completed more than 120 various flooring repairs and a number of necessary replacements in corridors, shower rooms & ward or non-clinical areas.

10.4 DECORATION AND ENVIRONMENT

The Estates team continue to respond to reactive requests for decoration identified by staff and through the environmental auditing process. We are also carrying out proactive, scheduled inspections of high use and public facing areas to maintain an acceptable standard.

10.5 VENTILATION

During 2018/19 Estates and Housekeeping have continued to carry out high level deep cleaning in critical areas. Any deficiencies are reported through the Decontamination Group.

The Estates team have continued to carry out annual validations on all Theatres and Critical Areas in compliance with HTM 03-01 Part B. They carry out any remedial works that are recommended. We have TWO Appointed Person's and work is carried out under a Permit to Work system. All validation reports are checked by our Authorising Engineer whose next visit is due in April 2019.

10.6 WARD AUDITS

Environmental audits and the Estates Department have continued to support the weekly audits in association with Infection Control, Pharmacy Housekeeping and Patient Representatives.

10.7 CAPITAL WORKS

10.7.1 Robert White Centre - The construction took over 18 months and was handed over in June 2018. The construction site was adjacent to the main cancer inpatient ward so careful measures were used to minimise the risk of infection from construction dust. This worked successfully and there were no recorded cases of infection attributed to the construction work.

The end result is the trust now has an HTM compliant space with measures including fully lagged pipes throughout with no dead legs, the addition of 24 wash hand basins to the Trust estate, correct air flow rates in all rooms, regular cleaning that takes in to consideration the higher frequency of immunocompromised patients, appropriate signage to encourage the correct use of basins and sinks.

10.7.2 MRI Scanner - The replacement of the MRI scanner included enhancements to ventilation flow rates in the scanner room to conform to guideline level and the

creation of a trolley wait area with ventilation and water services in the space operating to a compliant level for cannulation.

10.7.3 Emergency Department - The refurbishment of cubicles in the major injuries area of ED was carried out in a live clinical environment, Measures to mitigate infection of adjacent live areas included solid demarcation lines, access adopted through an alternative area of the hospital, liberal use of tack mats and regular site meetings with the IPC team to review practices. The completed project has added an additional wash hand basin, improved flooring and ventilation in the area.

10.7.4 Mortuary - The mortuary was fully refurbished to bring it to a compliant HTM level that also satisfies the Human Tissue Authority requirements. This work took approximately 5 months to complete and included weekly meetings on site with representatives from IPC. IPC-related improvements include:

- Addition of a boot wash and shower/changing room immediately adjacent to the post mortem suite
- Removal of all porous material from the post mortem suite and addition of hygienic cladding to the walls and stainless steel surface covers
- New flooring throughout including colour changes to clearly show clean, transitional and dirty areas
- New fridges with compliant separation
- Ventilation improvements to all areas to comfortably meet HTM flow rates
- Dedicate post mortem benches with integrated water services
- New sluice unit
- Removal of dead leg pipework

10.7.5 Other Capital Works

Three heavy use toilets in North Wing 1 Entrance were refurbished. Work included new floors, modifications to the ventilation to improve airflow and coating the walls in hygienic cladding to make cleaning easier and more effective.

Compliant wash hand basins were added to rooms in the rehabilitation department and in the surgical assessment unit.

A new toilet was formed in the service corridor in response to demand for toilets in that area. This has helped balance the use of toilets in the area and improves cleanliness.

11 DECONTAMINATION SERVICES REPORT (Kate Still, Decontamination Services Manager)

11.1 STERILE SERVICES

11.1.1 Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN 13485.

The Notified Body Intertek attended in July 2018 to complete a Transition Audit to certify that the QMS meets the latest version of BS EN 13485:2016.

This Accreditation continues to give quality assurance on the products produced and also allows the department to provide services for external customers.

The next surveillance Audit by the Notified Body Intertek is scheduled for May 2019.

11.1.2 Environmental Monitoring

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

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

The laboratory also tests:

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

Latest testing of all areas occurred on 14 February 2019 and the pack room was given a Class 8 clean room status, which is appropriate for the service.

All results are trended and corrective actions are undertaken for any areas or items found to be outside of acceptable limits. There are no areas of particular concern at this time.

ProReveal testing was introduced in May 2018 following an update to HTM 01-01; this involves 50 instruments per washer (200 in total) being tested on a quarterly basis to detect any residual protein on the instrument surface, after being released from the washer-disinfector but prior to sterilisation. Results have been in excess of 99% for each test; this gives assurance that the detergent used in each validated washer-disinfector is effective.

11.1.3 Tracking and Traceability

Patient registration by clinical users against sterile items at the point of operation is undertaken in one Theatre and one Outpatient Department at the moment.

Best practice would see this system being used in all patient treatment areas and this has been recommended through the Decontamination Group Meeting; currently there is insufficient funding for the purchase of the necessary scanners and software licences. Patient tracking at the time of use significantly reduces the risk of expired items or used instruments being inadvertently being used on a patient.

11.1.4 Shelf Life Testing

Products that had been packed and sterilised for greater than 365 days (our maximum shelf life) are sent for sterility testing on an annual basis and when a new wrap is introduced. All expired samples that were sent for testing still showed 100% sterility in the last round of testing which gives assurance that the decontamination process is effective.

11.1.5 Staff Training

All Supervisors have now attended the SSD Managers/Supervisors course at Eastwood Park. This City & Guild qualification gives assurance that they have a full understanding of the Decontamination process.

All members of staff receive training appropriate to the area of production they are working in and are observation assessed following initial training. Refresher training is repeated for all staff after 3 years of service followed by further observation assessment by a Supervisor. No member of staff will work independently without having been assessed as being competent to undertake the role.

11.2 ENDOSCOPY DECONTAMINATION UNIT

11.2.1 Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN 13485:2016 as an extension to scope of the existing certification in the Sterile Services Department.

This service is not registered with the MHRA, as the unit does not have a controlled environment product release area, therefore full registration cannot be achieved; this means that an endoscope reprocessing service cannot be offered to external customer.

11.2.2 Environmental Monitoring

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

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

The laboratory also tests:

- Product bio burden on cleaned endoscopes at point of release from the washer and at 3 hours following release which is the maximum usage period following release – Quarterly
- Product bio burden on surrogate scopes stored in a drying cabinet for 7 days and at 3 hours following release - Annually

Latest testing of all areas occurred on 14 February 2019.

All results are trended and corrective actions are undertaken for any areas or items found to be outside of acceptable limits. There are no areas of particular concern at this time.

Weekly rinse water samples are taken from each washer chamber on a weekly basis to be tested for TVC and pseudomonas aeruginosa. There have been occasional raised results but no confirmed root cause has been established. Protocol has been followed on each occasion with the relevant chamber being placed on restricted use for low-risk scopes only with an internal Field Safety Notice being issued for any high-risk scopes processed in the affected chamber. Various corrective actions have been undertaken on the advice of the Authorised Engineer (Decontamination) and further advice has been sought from Public Health England. As the results have returned to within specified limits on the week following the raised result and pseudomonas results have been negative on each occasion it is deemed that there is no immediate concern. Evidence from the Decontamination network indicates this is similar to other units.

11.2.3 Tracking and Traceability

Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and provides accurate traceability of all endoscopes used and significantly reduces the risk of an endoscope that has expired the 3 hour window being used on a patient.

11.3 TRUST WIDE AUDITS

11.3.1 Audit #4430 Compliance with Decontamination Procedure for Invasive Devices (Guideline 1341)

It is a required standard of HTM (Health Technical Memorandum) 01-01:2016 that full traceability of reusable items can be evidenced. In relation to invasive probes,

used in the Outpatient or Theatre setting, this requires the completion of the Tristel Wipe audit book and the insertion of the Tristel Wipe decontamination sticker being placed in the patient's health care record.

The only exception was in Ultrasound; the Radiology Patient System is audited for the same information as patient's health care records are not accessed during this diagnostic process.

This annual audit is carried out by the audit team member for each area with results then reviewed by the Audit Lead and any non-conformances discussed at the Decontamination Group meeting.

The 2018 audit showed that compliance with the use of the appropriate system is overall very good and has been sustained in those areas familiar with its use.

The only non-conformance related to appropriate record keeping in the patient's health care records and additional training will be arranged; that particular area will now be under increased surveillance to ensure future compliance.

11.3.2 Audit #4423 Decontamination and Single Use Instruments

This annual audit is used to measure compliance with requirements for the management of sterile instruments and single use instruments as per HTM 01-01:2016 and the sample involved each department that is supplied by Decontamination Services and/or uses single use surgical instruments.

This observation audit is carried out by the audit team member for each area with results then reviewed by the Audit Lead and any non-conformances discussed at the Decontamination Group meeting.

The outcome of the 2018/19 audit showed excellent and sustained compliance with the appropriate storage of sterile items and the transportation of contaminated items.

The only non-conformances related to the failure to display a 'single use' poster in some storage areas. These were rectified on the day the results were reviewed.

It was agreed at the Decontamination Group meeting that the Decontamination Lead would undertake spot checks to ensure compliance is maintained.

12 ANTIMICROBIAL REPORT - Rhian Pearce, Antimicrobial Pharmacist Antimicrobials: Summary report for financial year 2018/19.

1. Overview

Antibiotic misuse is widespread and has profound adverse consequences, most notably the development of antimicrobial resistance. Judicious antimicrobial prescribing is recognised as a critical component in slowing the development of resistance.

A growing body of evidence demonstrates that Antimicrobial Stewardship (AMS) can both optimise the treatment of infections and reduce adverse events. AMS now features heavily on the government's healthcare agenda, with numerous publications and directives issued to promote stewardship across all healthcare settings.

2. Summary 2018/19

It has been a challenging year for stewardship at DCHFT, without an antimicrobial pharmacist in post for 15 months. This coincided with the departure of two microbiologists and a general lack of pharmacy resource. We are, therefore, pleased to welcome Dr Lucy Cottle to the team, who has brought a renewed sense of enthusiasm and focus to stewardship at DCHFT. Under her clinical leadership, we are confident that the stewardship programme will be a success

- The Antimicrobial Stewardship Committee (ASC) has met sporadically throughout the year and in recent years has suffered from dwindling clinician engagement. Since clinical leadership is critical to the success of any antibiotic stewardship programme, we are pleased to welcome Alastair Hutchison (Medical director) as the new chair.

- EPMA reporting capacity has continued to improve. Several reports have been developed to allow targeted intervention and improve data capture to support a wide range of stewardship activities. We have also introduced a powerful reporting database (REFINE), which allows active surveillance of antibiotic prescribing across the Trust. It also allows comparison of prescribing trends against other hospitals.

  Effective antimicrobial oversight is the foundation of any stewardship program. Regional and national benchmarking of antimicrobial prescribing is a significant stimulus for driving improvement, but sustained progress can only be delivered through continued investment in informatics and IT solutions. This continues to be an area of focus for the Antimicrobial Stewardship team.

- We are updating our exiting guidelines to incorporate robust diagnostic criteria as well as streamlining information into an easy-to-use format. We also aim to reconfigure our webpage to make our guidelines easier to access.

- Audits have been performed on an ad-hoc basis. Limited resource has hampered a formal programme of sustained audit activity. Existing paper-based audit tools are being transferred to an electronic system to improve data capture and automate reporting. Timely reporting with feedback to clinicians is recognised as a significant driver for changing behaviour and improving prescribing.

- Our formal work plan has been updated to reflect key national recommendations relating to stewardship.

- DCHFT has achieved part of the AMR CQUIN (Commissioning for Quality and Innovation) for 2018/19. Of note, a progressive reduction in antimicrobial consumption over to the last 5 years has allowed DCHFT to meet this particular CQUIN target for the third year running. Our performance compares favourably to the regional and national benchmark.

- DCHFT did not meet the 90% CQUIN target in Q4 for the 72hr empiric review of antibiotic prescriptions. Our overall performance for this particular CQUIN is consistent with the national picture, see 3.1 for further detail).

- Continued work on increasing the range of antimicrobial guidance available.

- Participation in *Clostridium difficile* RCA meetings and identifying themes related to antimicrobial prescribing and pharmaceutical review of patients.

3. AMR and 72hr empiric review CQUIN targets for the financial year 2018/19

Antibiotic prescribing in UK hospitals has been increasing steadily, adjusted for admissions; rising by 6% between 2010 and 2014. Piperacillin-tazobactam and carbapenem prescribing have risen more sharply; by 62% and 42% respectively in 5 years. Additionally, prescribing rates across UK hospitals appear to be variable, and although some variability is expected due to differences in case mix, it does not fully explain the picture. These increases in prescribing and unexplained variability have coincided with increased antimicrobial resistance. This ongoing rise in antibiotic prescribing and resistance prompted NHS England to instate mandatory national CQUINs. 2019 is the third cycle of AMR CQUINs;

1 Reduction in antibiotic consumption as measured by Defined Daily Dose (DDD) per 1,000 admissions against the baseline (2016/17 calendar year, minus 2%) as follows:

i. Reduction by ≥2% of total antibiotic consumption
ii. Reduction by ≥2% of consumption of carbapenems

Unlike previous years, the CQUIN for 2018/19 does not include a target for reducing piperacillin/tazobactam consumption. This follows a global shortage in 2017, which resulted in a dramatic reduction in piperacillin/tazobactam use.

2 Increase the proportion of antibiotic usage within the Access group of the AWaRe* category:

- Access group ≥55% of total antibiotic consumption (as DDD/1000adm)
  OR
- Increase by 3 percentage points from baseline 2016 calendar year.

*WHO created the Access, Watch and Reserve antibiotic categories to assist antimicrobial stewardship. Antibiotics are categorised as follows:

Reserve – antibiotics that need to be reserved due to antimicrobial resistance
Watch – second-line agents
Access – antibiotics which are narrow spectrum and used as first-line treatment options.

3 To provide documented evidence of antibiotic review within 24 -72hrs of initiation in patients diagnosed with sepsis. Compared to previous years, the outcome of the review needed to comply with more stringent criteria, based on 'START SMART, THEN FOCUS' objectives. This was a scaled target, with the expectation of 90% compliance by the final quarter.

3.1 DCHFT's performance against the CQUIN target.

DCHFT has successfully reduced total and carbapenem antibiotic usage for the financial year 2018/19, comfortably achieving the CQUIN goal. This represents a total reduction of 25% for total antibiotic usage and 35% for carbapenems, compared with the 2016 baseline calendar year (Fig.1,2). A reduction in carbapenem consumption has coincided with an 81% increase in the use of carbapenem sparing agents (Fig. 3).

DCHFT'S performance compares favourably with other Trusts in the region (Fig 1), achieving the greatest reduction in antibiotic consumption overall. In 2013/14, antibiotic consumption was higher than the national and regional average (Fig 1). A progressive reduction in consumption coupled with an increase in admissions over the last 5 years has brought total antimicrobial and carbapenem consumption well below the regional and national mean (Fig 1,2). This is a noteworthy achievement, especially following the introduction of the sepsis CQUIN goals in 2017/18 -2019/20, where we might expect overprescribing of broad-spectrum antimicrobials and inappropriate continuation of these agents.

Fig 1

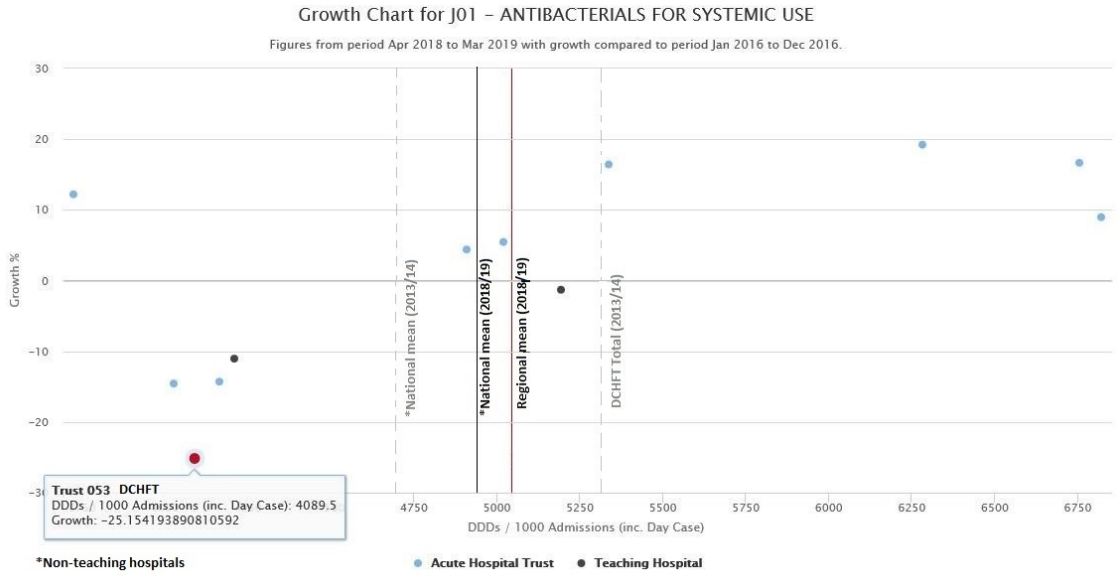


Fig 2

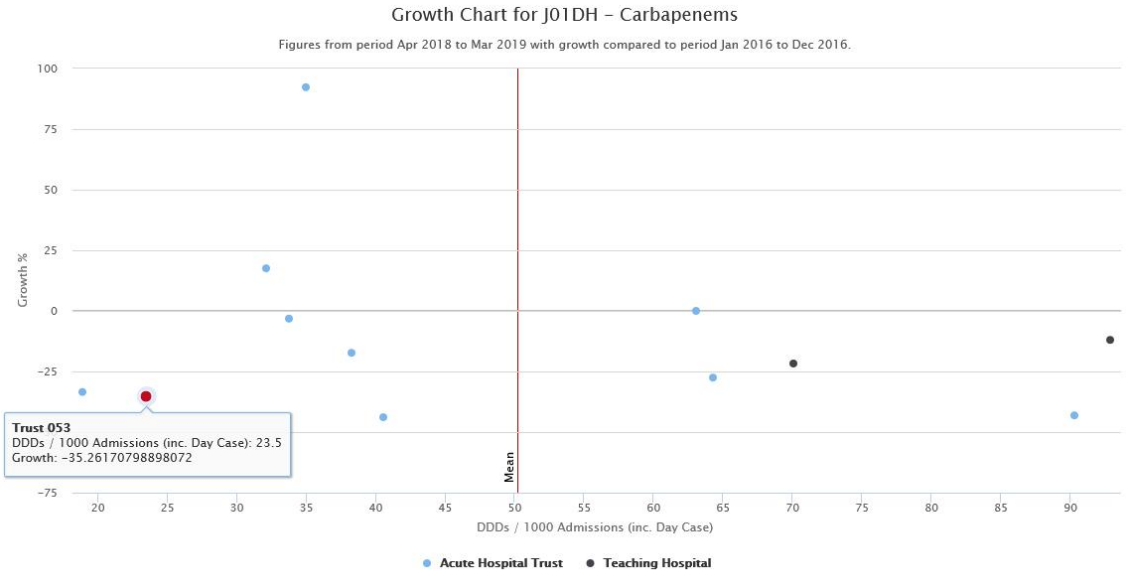
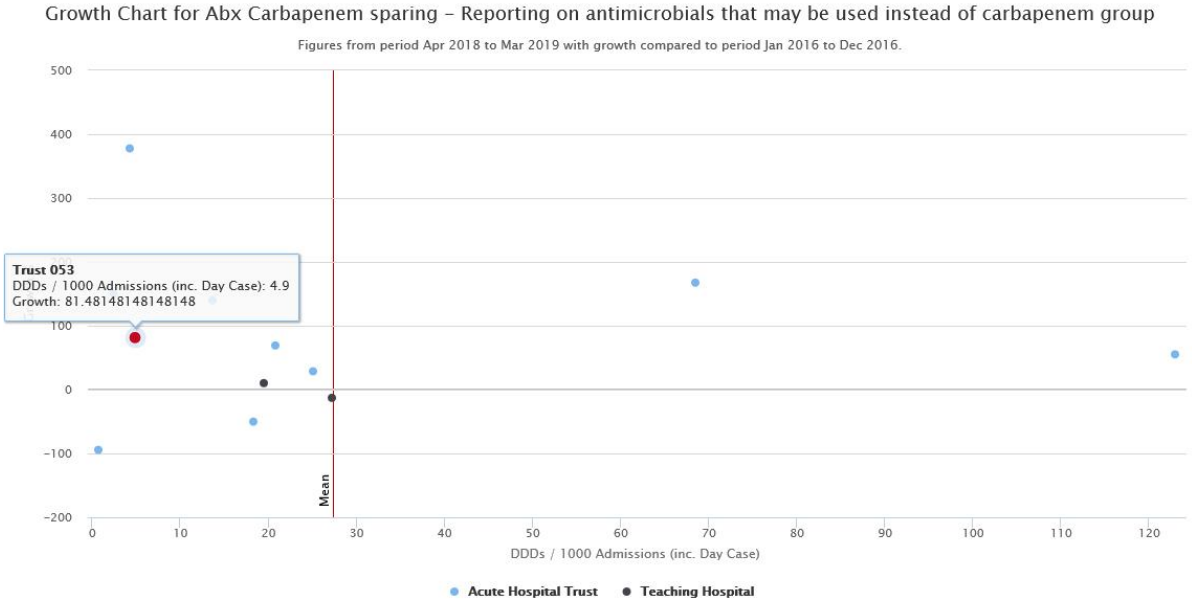
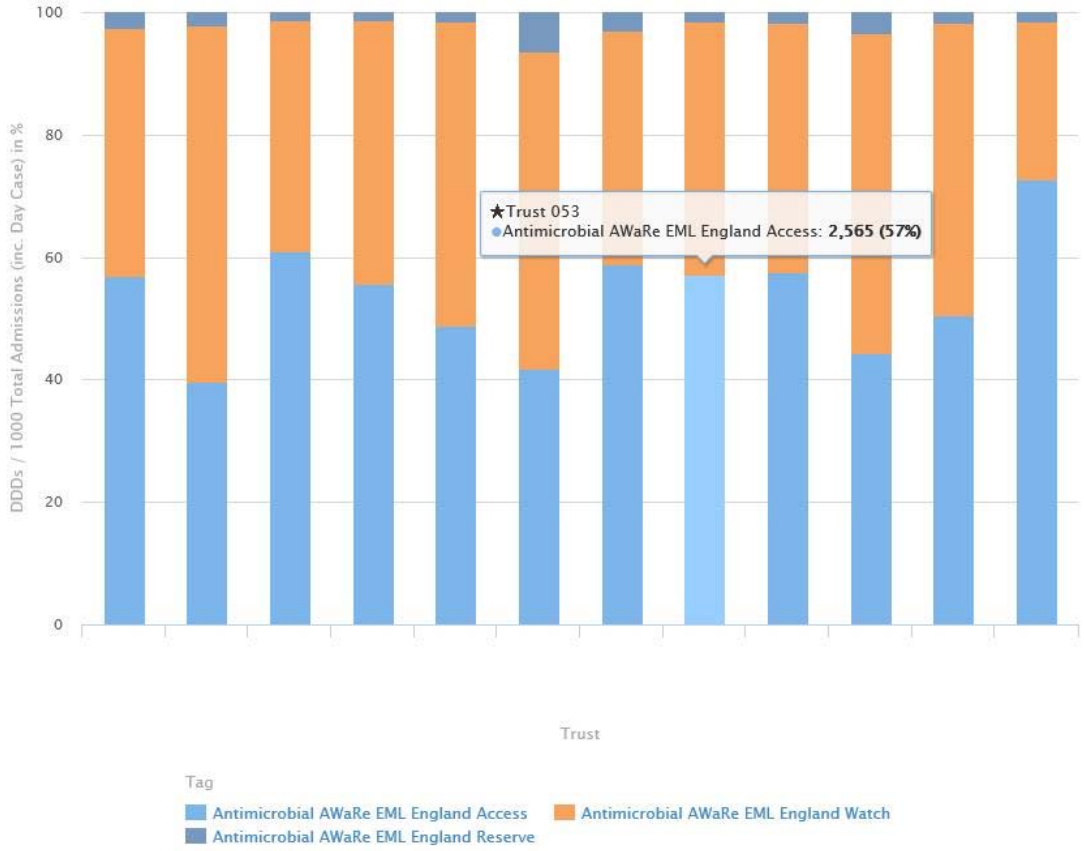

Growth Chart for J01DH – Carbapenems
Figures from period Apr 2018 to Mar 2019 with growth compared to period Jan 2016 to Dec 2016.
Growth %
DDDs / 1000 Admissions (inc. Day Case)
Mean
Trust 053
DDDs / 1000 Admissions (inc. Day Case): 23.5
Growth: -35.26170798898072
Acute Hospital Trust
Teaching Hospital

Fig 3


Growth Chart for Abx Carbapenem sparing – Reporting on antimicrobials that may be used instead of carbapenem group
Figures from period Apr 2018 to Mar 2019 with growth compared to period Jan 2016 to Dec 2016.
DDDs / 1000 Admissions (inc. Day Case)
Mean
Trust 053
DDDs / 1000 Admissions (inc. Day Case): 4.9
Growth: 81.48148148148148
Acute Hospital Trust
Teaching Hospital

57% of DCHFT's total antibiotic consumption for 2018/19 comprises antibiotics from the AWARE access category (Fig. 4), exceeding the CQUIN threshold of 55%. This target has been introduced to monitor the proportion of narrow-spectrum antibiotics used. This is a sensible measure, as using consumption data alone, measured by DDDs, is a poor surrogate for overall antibiotic stewardship performance. In reality, a Trust would meet the consumption targets by using a larger proportion of broad-spectrum antibiotics instead of narrow-spectrum agents. This is a known limitation of how antibiotic consumption figures are currently calculated, and using AWARE categorisation alongside consumption helps mitigate this limitation.

Fig 4 Proportion of total antibiotics by AWARE category



DCHFT failed to meet the 90% target for 72 hr review of antimicrobials in Q4, achieving 74% instead. However, a sustained improvement earlier in the year meant DCHFT met the targets for the previous quarters (Q1, Q2, Q3). The overall trend and attainment figures are broadly in line with the national picture (Fig. 5)

In a further breakdown of results, it can be seen that DCHFT performed particularly poorly for intravenous to oral antimicrobial switch (IV/PO switch) and de-escalation indicators (Fig 6), falling well below the national mean. Our existing EPMA system, lacks the functionality to support de-escalation and review of antimicrobials, e.g. the use of 'soft stop dates' that prompt a review of antimicrobials, previously possible on paper-based drug charts.

Fig 5

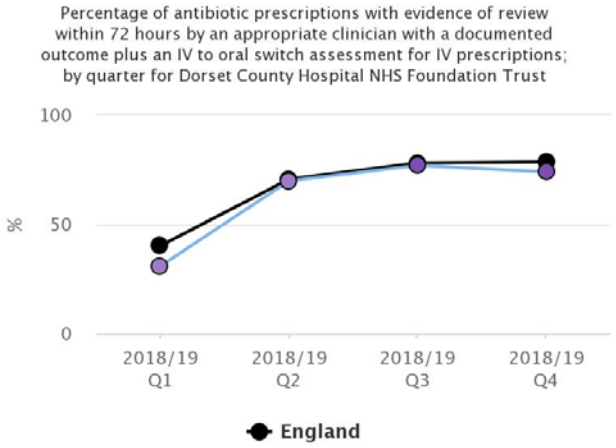


Fig 6

Compared with benchmark: Better Similar Worse Not compared

Quintiles: Best Worst Not applicable

Benchmark Value

Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Dorset County Hospital		Trust type	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Percentage of antibiotic prescriptions with evidence of review within 72 hours by an appropriate clinician with a documented outcome plus an IV to oral switch assessment for IV prescriptions; by quarter New data	2018/19 Q4	34	74.0%	76.4%*	78.6%*	0.0%		100%
Percentage of antibiotic prescriptions with evidence of review within 72 hours; by quarter New data	2018/19 Q4	46	100%	90.3%*	92.4%*	35.6%		100%
Percentage of antibiotic prescriptions reviewed within 72 hours with a stop, switch or IV to oral switch decision documented; by quarter New data	2018/19 Q4	16	34.8%	58.0%*	58.8%*	11.1%		94.9%
Percentage of antibiotic prescriptions reviewed within 72 hours with a stop decision documented; by quarter New data	2018/19 Q4	6	13.0%	16.4%*	19.1%*	0.0%		50.7%

These data are unadjusted for the confounding effects of case mix, age and sex. As such, direct comparison between DCHFT and the national or regional average is limited. In addition, the audit indicators used by the CQUIN are prone to inter-rater variability, which may in part explain the variability seen across England (Fig. 6).

Outcome data were not collected or published as part of the CQUIN, and as such there is concern over the unintended consequences of the CQUIN goals, including its potential impact on patient outcomes.

5. Summary of future work

- A thorough analysis of our performance against the CQUIN targets for 2018/19 has highlighted areas of weakness. Improving our guidelines and their accessibility is a crucial measure in remedying these deficits. The current Trust site for antibiotic guidelines is challenging to navigate. To date, we have been unable to improve this webpage and are now exploring a web-based version of Microguide to replace the existing trust site. Microguide has an excellent track record in improving antibiotic prescribing in other Trusts and has been specifically developed as a platform for antimicrobial guidelines.

- To establish an AMR CQUIN group to monitor progress against the 2019/20 AMR CQUIN and steer intervention. This group will report to the AMS committee.

- Updating and streamlining the existing audit programme to incorporate CQUIN specific indicators for 2019/20. The CQUINs for 2019/20 focus on diagnosis and treatment of lower UTI in patients over 65, antibiotic prophylaxis in colorectal surgery and antifungal stewardship. Antimicrobial consumption trends will be monitored centrally and do not form part of the CQUIN for 2019/20.

  Next year's CQUIN has a demanding data collection element. NHS England has stipulated that stewardship teams should not collect data; instead, their time is better spent steering intervention and focussing on quality improvement measures. We would echo this recommendation and urge the Trust to recognise that the current data collection demands cannot be absorbed by the stewardship team, without displacing other core stewardship activities. This is likely to have a detrimental, and potentially irrevocable, impact on future stewardship outcomes.

- To develop a systematic approach for reviewing local susceptibility patterns as part of the antibiotic guideline development process.

- To delineate channels within the organisation to disseminate audit results and garner support for AMS. As an example, we intend to regularly present audit findings at divisional meetings.

- To better integrate the laboratory and stewardship programme to ensure rapid provision of test results and that clinicians understand their implications.

- We plan to introduce a comprehensive package of antimicrobial prescribing and stewardship training for doctors, nurse prescribers and pharmacists. This will be delivered via e-learning.

- We intend to introduce a new set of metrics for monitoring stewardship activity; focusing on process and outcome measures to better illustrate the value and sustainability of our programmes. We also hope that this will provide us with evidence for future investment and better resource allocation.

- As pharmacist recruitment and retention improves, we are keen to implement a framework for pharmacy-led interventions to optimise antimicrobial therapy, including dose optimisation and systematic conversion of intravenous to oral antimicrobial therapy.

It is essential that we continue to make progress, and as a team, we are pushing ourselves with a new set of challenging ambitions for next year. However, we are unlikely to meet these goals without increased engagement from the organisation, recognising that AMR is a threat to patient outcomes across all clinical divisions and is a shared responsibility. There is also a potential financial loss for the Trust if insufficient resources are allocated to meet the CQUIN targets for next year.

2018-2019 has been a very successful year with significant reductions in healthcare acquired infections reported i.e. Clostridium difficile and MSSA blood stream infections. Trajectories for both MRSA and Clostridium difficile were achieved demonstrating excellent practice and engagement with infection prevention and control by Trust staff.

This report demonstrates the continued commitment of the Trust and evidences successes and service improvement through the leadership of a dedicated and proactive IPC team. It is also testimony to the commitment of all DCHFT staff dedicated in keeping IPC high on everyone's agenda.

The annual work plan for 2019-2020 reflects a continuation of support and promotion of infection prevention & control. Looking forward to the year ahead the staff at DCHFT will continue to work hard to embed a robust governance approach to IPC across the whole organisation and the IPC team and all staff will continue to work hard to improve and focus on the prevention of all healthcare associated infections.

2019-2020 will be an exciting year as the Trust develops its role within the Infection Prevention and Control Integrated Care System (IPC ICS) working closely with the other Dorset Health Trusts to share and provide quality infection control Dorset wide.

The Trust remains committed to preventing and reducing the incidence and risks associated with HCAIs and recognises that we can do even more by continually working with colleagues across the wider health system, patients, service users and carers to develop and implement a wide range of IPC strategies and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Emma Hoyle

Associate Director Infection Prevention & Control

Appendix 1

Infection Prevention & Control Work Plan 2019-2020

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
1	Systems to manage and monitor the prevention and control of infection	Assurance to Trust Board that Infection Prevention & Control standards are maintained throughout the Trust	Bi- monthly Infection Prevention Group to meet and ensure provision of exception and assurance report to the Quality Committee	Further reduction in Healthcare Acquired Infections (HCAIs)	Associate Director Infection Prevention & Control	Bi-Monthly	
		Business continuity and provision of 'live' data for quality of IPC care to remain at a high standard	IPCT to maintain current contract with ICNet	Contract renewal	Associate Director Infection Prevention & Control	Nov 2019	
		The Trust will maintain a high standard of Infection Prevention & Control	Divisional Matrons to develop HCAI improvement plans for 2019-2020 Divisional Heads of Nursing work with Clinical staff to review IPC programme relevant to Division	Heads of Nursing to report progress against divisional IPC plan at IPG on rotational basis	Divisional Matrons Heads of Nursing / Quality	Sept 2019	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Heads of Nursing to report on a monthly basis to Divisional Quality & Governance meetings IPC performance standard dashboard to be met Learning from performance data to be disseminated	Evidence that IPC performance dashboard is discussed and actioned at Divisional Governance meetings	Heads of Nursing / Quality	March 2020	
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	DCHFT will maintain a clean and safe environment for patient care	Dorset County Hospital to support PLACE assessment	The environment is safe and clean	Infection Prevention & Control Team	Sept 2019	
			Maintain current annual deep clean programme with Facilities/Heads of Nursing/ Estates. Execute agreed deep cleaning programme	Deep clean programme is undertaken.	Facilities Manager	Facilities Manager	
			Participation in weekly environmental technical audits	Review of weekly audits identifies deficits and monitors remedial actions have been taken	IPC Team Facilities Manager Estates Manager Patient representatives Pharmacy	March 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		All clinical equipment is clean and ready for use at point of care	Use of Clean/Dirty indication stickers implemented Trust wide 2018/19	All clinical equipment will be identified as clean or requiring cleaning	IPCT to implement audit process Divisional Heads of Nursing / Matrons to monitor	August 2019	
		DCHFT will maintain a clean and safe water system	Policy to be updated and communicated and implemented Trust wide. Regular audits will be carried out to confirm the effectiveness of the policy.	DCHFT will deliver the Water Safety Policy	Head of Estates	March 2020	
3	Provide suitable accurate information on infections to service users and their visitors	Patients will be fully informed about their presenting infections. All new cases of *CDifficile,* MRSA and ESBL will be counselled by an IPCN	IPCT to visit newly identified infectious patients and their carers. Provide verbal and written information and contact details	Positive patient feedback	IPCT	March 2020	
		The Trust will have up to date patient information relating to infection control	Review of all IPC patient information. Check meets standards and revise accordingly	Positive patient feedback	IPCT	March 2020	
4	Provide suitable accurate information on infections to any person concerned with providing	The Trust will have a reliable and available Infection Prevention & Control Team. Providing support to all	IPCT to continue to carry out a daily ward round to all acute areas including Kingfisher & Emergency Department, providing clinical support	Minimum cross infection, reduced prolonged outbreaks of infection, reduced	IPCT	March 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	further information support nursing/ medical care in a timely information	patients and staff	to staff and patients	HCAIs			
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	Achieve trajectory for *Clostridium difficile* infection (CDI) of ≤ 16 cases (does not include cases whereby no lapses of care were identified	Undertake Root Cause analysis of all hospital acquired cases of CDI under the revised definitions – Hospital Onset- Healthcare Acquired and Community Onset Healthcare Acquired	All cases of CDI will have RCA investigation and relevant action plan if deficits identified. RCA's will be discussed by IPCT and any trends reported to Infection Prevention Group (IPG)	Divisional Head of Nursing / Matrons	March 2020	
		Reduce rates of Gram-negative blood stream infections (BSI) by 50 % by 2023	Undertake IPC led Root Cause analysis of all hospital acquired cases of gram negative BSI – escalate to full RCA if lapses in care	All cases of Gram negative BSI will have RCA investigation and relevant action plan if deficits identified. RCA's will be discussed by IPCT and any trends reported to Infection Prevention Group (IPG)	Associate Director Infection Prevention & Control	March 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		Ensure the Trust is robustly prepared for Winter	Review Influenza Policy Summer 2019 Ensure staff are familiarised with the Outbreak/Noro policy	The Trust will be able to function effectively during the Winter months and Infection Control standards are maintained	Associate Director Infection Prevention & Control	November 2018	
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection	High standards of hand hygiene practice throughout the Trust.	Hand hygiene audits to be undertaken by all clinical wards/departments. Wards/departments that achieve<90% to present action plan to IPG.	Hand hygiene results >95% and sustained at this level for all wards/departments Departmental Managers to report to IPG with action plan when hand hygiene results <90%.	Divisional Head of Nursing / Matrons	Monthly	
			Validation of hand hygiene audits	High level compliance with WHO 5 moments of care hand hygiene standards.	IPCT	Bi-Monthly	
			Participate in national infection control promotion events	Staff engage with IPCT promote best practice.	IPCT	October 2019	
		Education	Support DCHFT mandatory training programme Via e-learning and face to face training	Education reflects national and local requirements for mandatory IPC training.	IPCT	March 2020	
7	Provide or secure adequate isolation	Ensure the risk of cross infection is reduced	Undertake annual audit of isolation precautions	Audit identifies appropriate	IPCT	March 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	facilities	Trust wide	to ensure appropriate signage, PPE precautions are in place. Ensure that audit incorporates patients who should be in isolation.	precautions to effectively manage patients with infections.			
8	Secure adequate access to laboratory support as appropriate	IPCT to support and be involved in the county wide pathology project ensuring delivery of safe patient care is not affected	IPCT to be involved in county wide meetings where appropriate and provide expert support for the project	Safe transition of service	Associate Director Infection Prevention & Control	March 2020	
			IPCT at DCHFT to take nursing lead on development of ICNet 'single instance' across Dorset - Dorset-Wide ICNet project to be implemented once funding released	One ICNet system across Dorset	Associate Director Infection Prevention & Control	Nov 2019	
9	Have and adhere to policies, designed	Audit programme- to audit compliance with	PVC audits undertaken to ensure compliance	PVC observations will be observed every shift and	IPCT	Quarterly	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	for the individual's care and provider organisations that will help to prevent and control infections	Key IPC policies	with observation standard	recorded on Vital Pac			
			Urinary catheter documentation audits undertaken to ensure compliance with observation standard	Urinary catheters will be reviewed on a daily basis and care documented on Vitalpac	IPCT	Monthly	
			Audit compliance with CPE screening recommendations.	Audit identifies that documentation supports appropriate risk assessment is undertaken for patients admitted to Trust.	IPCT	Biannually	
			Participation in mandatory Surveillance of Surgical Site Infections for Orthopaedics and Breast. Review results with clinicians. *Orthopaedic surveillance SSI cases to be discussed at Orthopaedic Governance meetings.* If required, action plan	Surgical site surveillance meets national mandatory requirement Rates of SSI are within acceptable parameters	IPCT Divisional Consultant Leads	March 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			to be developed and implemented Results to be presented at Divisional Governance Meetings and IPC				
			Participation in the national GIRFT Audit 2019 for Surgery	Completion of 6 month audit. Audit identifies low infection rates post operatively.	Associate Director Infection Prevention & Control/Medical Director	October 2019	
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	Reduce the number of sharps injuries caused by sharps disposal	Undertake annual Sharps Audit to ensure Trust wide adherence to recommended practice. Action plan with Divisions to reduce risks identified on audit.	Audit identifies compliance with safe management of storage and disposal of sharps	IPCT	June 2019 (IPCT) July 2019 (Provider)	
		Prepare all clinical staff to provide direct patient care for those requiring airborne precautions	Divisional fit mask train the trainer sessions planned July 2019	All clinical staff will have access to FFP3 training and able to care for patients using airborne precautions	Divisional Matrons	July 2019	
		Staff at DCHFT are equipped with the knowledge, skills and equipment to care for	Ensure all 'IPC Emergency Boxes' are maintained and in date	All clinical staff are aware and able to support the emergency	Associate Director Infection Prevention & Control / Lead		

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		'high risk' infectious patients	Ensure all relevant policies are up to date and staff are aware of roles and responsibilities in relation to 'high risk' patients.	preparedness of the trust for IPC issues	Emergency Planner		

There are 10 criteria set out by the *Health and Social Care Act 2012* which are used to judge how we comply with its requirements for cleanliness and infection control. This is reflected in the *Care Quality Commission Fundamental Standards Outcome 8* and detailed above in the annual work plan which is monitored by the Trust's Infection Prevention and Control Group.

Emma Hoyle – Associate Director Infection Prevention & Control May 2019