Infection Prevention and Control Annual Report 2017-18

Nicola Lucey, Director of Nursing and Quality of Infection Prevention and Control
Emma Hoyle, Associate Director Infection Prevention and Control

INDEX

EXECUTIVE SUMMARY

- The Trust met the trajectories set for MRSA bacteraemia and *Clostridium difficile* infections for 2017-18.
- Hand hygiene compliance has remained high and sustained at 97%
- Outbreaks of Norovirus were well contained and occurred for short periods only
- Successful reduction in infections reported via Surgical Site Surveillance
- 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
- Divisions are responsible for developing and delivering plans to prevent healthcare associated infection
- Successful renegotiation of ICNet contract for a further 5 years. Infection control surveillance and data system has been instrumental in sustaining infection control compliance.

1. INTRODUCTION

This is my second year as Director of Nursing and Quality with the responsibility of Director for Infection Prevention & Control (DIPC) and this report summarises the work undertaken in the Trust for the period 1st April 2017 – 31st March 2018.
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 if MRSA bacteraemia and reported 10 cases of *Clostridium Difficile* against a target of 14 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.

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 & Quality & Infection Prevention & Control

2. INFECTION PREVENTION AND CONTROL ARRANGEMENTS

2.1 INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 6 times during 2017- 2018. 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 Director of Nursing & Quality, Nicola Lucey who also acts as the Director of Infection Prevention and Control (DIPC) with responsibility for reporting to Quality Committee.

2.2 DIPC REPORTS TO QUALITY COMMITTEE

The DIPC has presented to the following items during 2017-2018:

- 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 & CONTROL TEAM

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

- Nicola Lucey, Director of Nursing and Quality, and Infection Prevention and Control;
- Professor Craig Williams, Consultant Microbiologist and Infection Control Doctor;
- Emma Hoyle, Associate Director Infection Prevention & Control
- Abigail Warne, Specialist Nurse (Trainee)
- Julie Park, IPC Nurse
- Cheryl Heard, Administrator
- Rhian Pearce, Antimicrobial Pharmacist.

Anne Smith, Nurse Consultant IPC (2007-2017) retired in June 2017 leaving a legacy of strong leadership and a wealth of knowledge.

In June 2017 the IPCT received the GEM (Going the Extra Mile) Award for Patient Safety.

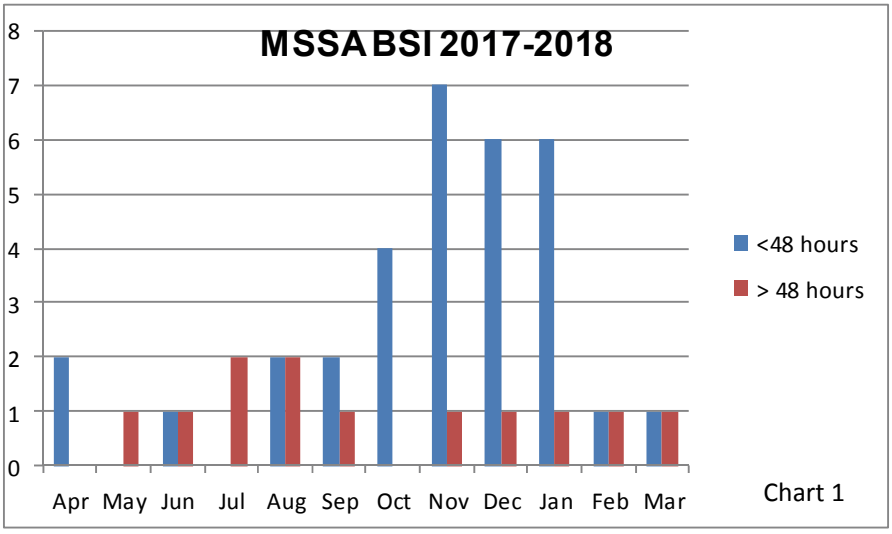
3. HEALTHCARE ASSOCIATED INFECTIONS

3.1 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

There were no cases of MRSA bacteraemia in 2017-2018. 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 2017-2018 there were a total of 45 cases of MSSA bacteraemia, of these 33 cases were identified <48 hours of admission and 12 identified >48 hours after admission (Chart 1).



These are significant infections; we have implemented control measures that include, screening for certain high-risk patient groups, and decolonisation of high-risk patients prior to procedures. However, analysis of cases in the >48 hour group has shown that only a minority are truly trust-acquired, with many 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 is an NHS ambition to halve the numbers of healthcare associated Gram –negative BSIs by 2021 (PHE 2017). 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 *P. aeruginosa.*

3.3.3 In 2017-2018 there were a total of 137 positive BSI samples for E.coli. 21 of these cases were attributed to the Trust (Chart 2). This was an increase in 4 cases from 2016-2017. All of these cases were reviewed and though no trends were identified it has been agreed to move forward with a more formal approach 2018-2019 with a full Root Cause Analysis (RCA) process for each HAI. 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 2017-2018.

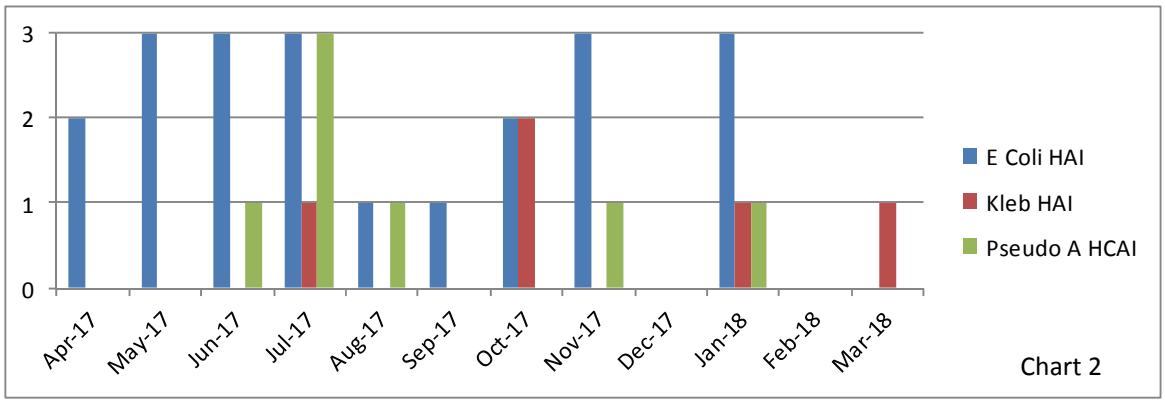


Chart 2

3.3.4 2017-2018 was the first year for mandatory data collection for Klebsiella spp.and *P. aeruginosa.*

3.3.5 The IPCT has been involved in the nationally organised events and training via NHS Improvement (NHSI). Through these events it has been highlighted that the majority of Trusts have reported action surrounding urinary catheter care. At DCHFT the IPCT have been addressing the following to check current processes:

- Review of urinary catheter care including documentation and discharge
- Participation in nation Surgical Site Surveillance audit for Bowel Surgery to benchmark Trust.

- Audit and subsequent actions into monitoring of indwelling devices e.g. Peripheral vascular cannula
- Individual review of *E.coli* BSI cases

3.4 *CLOSTRIDIUM DIFFICILE* INFECTION (CDI)

This has been the most successful year for reducing cases of CDI. The Trust trajectory for the year was 14 cases. In total the Trust reported 10 cases detected >3 days after admission; of these cases 2 were appealed as non-preventable with no lapses in care; this resulted in 8 cases reported as hospital acquired (Chart 2).

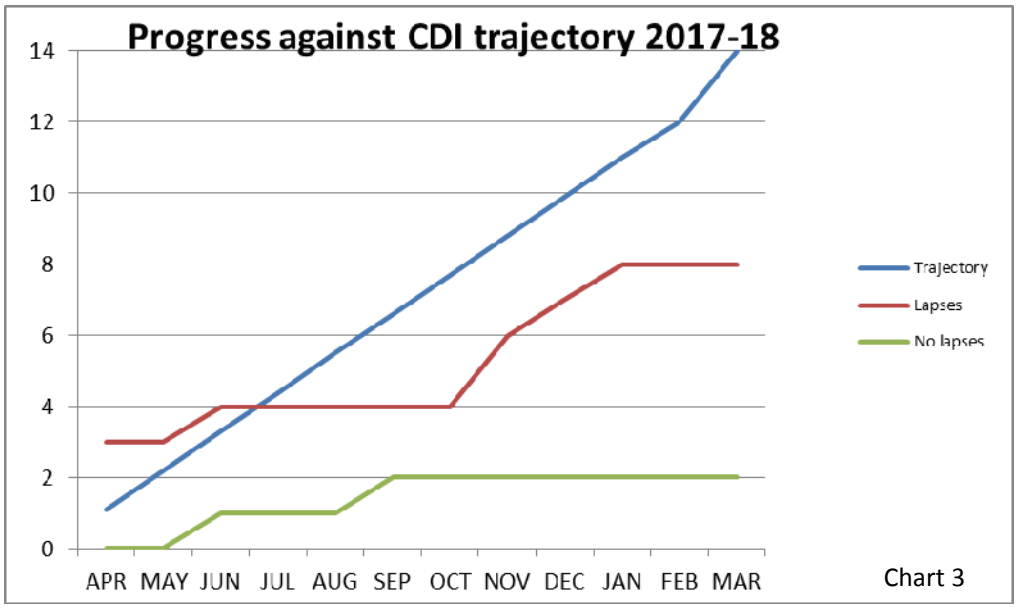


Chart 3

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 8 different phage types. We can confidently say that we have not had any outbreaks or linked cases of CDI in the Trust 2017-2018.

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 fed back and signed off by the relevant Matron at the IPCG.

4. 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 5 outbreaks of Norovirus 2017-18. All of these were 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 increase in cases of Influenza A & B during the Winter 2017/2018. This did cause some pressure at operational level at DCHFT but this was managed by strict screening, isolating and treatment.

In preparation for 'Flu Season' all Trust staff were offered the annual flu vaccine. 70.1% of front line staff were immunised and 63.23% of all staff. An increase from 53% 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.

Chart 4 (below) identifies the number of cases tested by the Virology Laboratory at DCHFT and the number of positive results. Not all of these cases identified were inpatients at DCHFT.

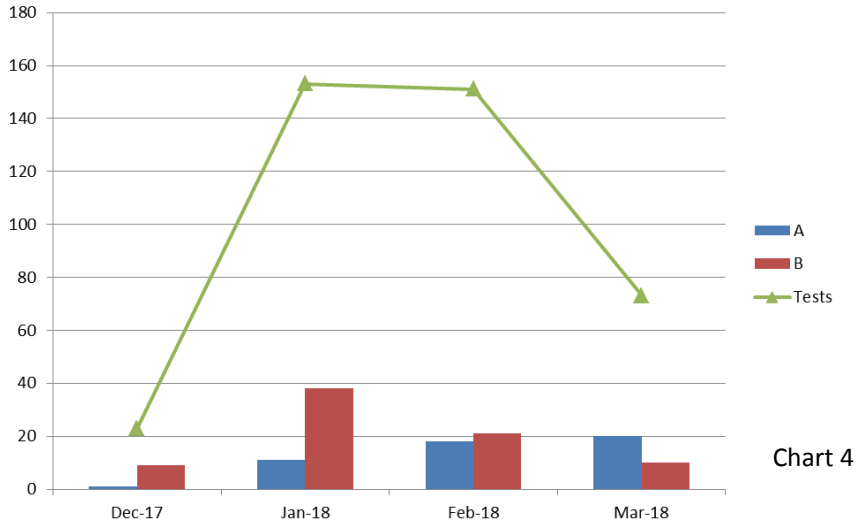


Chart 4

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 2017-2018 the IPC team have supported 9 modules for surveillance. Surveillance is more robust following the introduction of 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.

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 2016 (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.
There were no infections reported for this period.

Table 1 April – June 2016 Hip Replacement Surveillance

Operations & Surgical Site Infections		Dorset County Hospital NHS Foundation Trust	
		Apr-Jun 2017	Last 4 periods
Operations	Total number No. with PQ given % with PQ completed	82 82 79.3%	239 239 79.1%
Surgical Site Infection	No. of inpatient/readmission % infected	0 0.0%	0 0.0%
	No of post discharge confirmed % infected	0 0%	3 1.3%
	No of patient reported % infected	0 0.0%	0 0.0%
	All SSI % infected	0 0%	3 1.3%

Surgical Site Surveillance of Knee Replacement

Further to a request from the orthopaedic team surveillance was completed between July-September 2017 for knee replacement surgery. Only one infection was identified post discharge which in comparison to previous data is a significant improvement (Table 2).

Table 2 July – September 2017 Knee Replacement Surveillance

Operations & Surgical Site Infections		Dorset County Hospital NHS Foundation Trust	
		July- Sept 2017	Last 4 periods
Operations	Total number No. with PQ given % with PQ completed	72 72 87.5%	298 298 84.9%
Surgical Site Infection	No. of inpatient/readmission % infected	0 0.0%	2 0.7%
	No of post discharge confirmed % infected	1 1.4%	8 2.7%
	No of patient reported % infected	0 0.0%	0 0.0%
	All SSI % infected	1 1.4%	10 3.4%

Surgical Site Surveillance of Repair of Neck of Femur

Further to a request from the orthopaedic team surveillance was completed between July-September 2017 for repair of neck of femur surgery. This is the first time that this audit was performed and no infections were identified. The national average currently is 1.3%.

Surgical Site Surveillance of Large Bowel Surgery, Gastric Surgery, Cholecystectomy, Bile duct, liver, pancreatic surgery & Small Bowel

In discussion with the General Surgeons it was agreed to carry out a module of surveillance. This surveillance formed part of the benchmarking project being carried out relating to the national ambition to reduce gram negative blood stream infections (BSI) by 50% by 2021. Nationally it has been reported that biliary surgery/procedures are part of the speciality trend associated with these BSIs.
This is the first time this surveillance has been carried out and as defined in Table 3 the infection rate is low in comparison with the national average.

Table 3 October – December 2017 - Surgery

Operations & Surgical Site Infections	DCHFT	National Date (All hospitals in the surgical category)
Large Bowel	4% (1 case)	11.3%
Gastric Surgery	0%	3.4%
Cholecystectomy	2% (1 case)	6.1%
Bile duct, liver, pancreatic surgery	0%	8.7%
Small Bowel	0%	8.4%

Surgical Site Surveillance of Breast Surgery (Jan – March 2018 - data not available for 2017-2018 Annual report)

Following the data collected October - December 2016 and ongoing review of Breast Surgery it was agreed with the Breast Surgeons to complete the SSI January – March 2017. This data is not yet available formally via PHE.

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, now on a quarterly basis.

Initial results in January 2016 showed a lapse in compliance from the previous year but since then improvement has been noted and IPCT support and input to the clinical areas has reinforced documentation policy. Since January 2017 weekly audits demonstrated compliance of 95% and above and it was then decided audits would move to being quarterly in 2017. It is evident that teams across the trust are working hard to achieve the desired 100% compliance and are committed to optimising patient safety. The last quarters overall audit result was 94%. Previous quarters were 95% and 97%.

5.3 Carbapenamase 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. Unless we act now, learning from experiences elsewhere across the globe, rapid spread of carbapenem-resistant bacteria has great potential to pose an increasing threat to public health and modern medicine as we know it in the UK.

In the UK, over the last five 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 now advise 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 between 84% and 93% during this year. Some areas had no documentation in their admission packs for this and these have all now been resolved to either have these assessments in the admission packs or by the use of stickers placed into notes which have been implemented well in maternity. The IPCT continue to work with ward teams to ensure these assessments are completed on admission and the last two patients that have been confirmed to have CPE were both correctly identified on admission and correct actions were taken so no other patients or staff were put at risk**.**

5.4 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: 71%. Audit to be repeated 6 monthly.

- Indwelling Urinary Catheter Recording on Vital Pac

Trust wide compliance in recording patients with urinary catheters on VitalPac was reported as 79% compliance in November 2017. Monthly audits are now in place and compliance in March 2018 was 84%. Monthly audits continue.

6. EDUCATION

A total of 37 formal education sessions for both clinical and non-clinical staff were hosted by the IPCT during the year.

From April 2017 the Mandatory Training for clinical and non-clinical staff is via an online workbook. Overall compliance with mandatory IPC training over the year was 88% for clinical staff and 78% for non-clinical staff.

7. POLICY DEVELOPMENT/REVIEW

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

- Infection Prevention and Control Policy
- Standard Precautions Policy
- Collection of Microbiological Specimens Guideline
- MRSA Policy
- Screening Protocol for Candida auris
- Management of Norovirus and infectious diarrhoea policy
- Policy for the Management of patients with multi-drug resistant Gram-negative bacteria including Extended Spectrum Beta-lactamases (ESBL)
- Urinary Catheter Care Policy

8. INFECTION CONTROL WEEK

This year's Infection Control Week focused on E-coli infections and the link to catheter care. The theme for the week was Magic with a strapline of 'Making Infections Disappear' as the idea was to promote the removal of catheters when they are no longer needed. The wards and departments put up some wonderful educational display boards and worked hard to highlight the importance of catheter care and the HOUDINI project for catheter assessments and their removal. On the Wednesday the annual judging of the displays led by Nicola Lucey, Neal Cleaver and Dr Cathy Jeppesen took place.

The winners included:
Overall Winner – Ridgeway Ward
Best Educational Display – Lulworth Ward
Best Creativity – Critical Care Unit
Best Interactive Display – Purbeck and Ridgeway Ward
Best Link Nurse – Lisa Cosh
Best Magic Theme – Day Lewis Ward
Best Patient Involvement – Kingfisher Ward
Best Flu display- Maternity Unit
Other participating wards – Abbotsbury, Emergency Department, Hinton, IIAU, Moreton and Stroke Unit.

We were also supported with Reps from Schülke, 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 magic themed cake for another competition. Dorset Cereals also provided a lovely hamper as a competition prize and the Poet laureate pub in Poundbury gave a voucher for a meal for 2.

9. FACILITIES REPORT - CLEANING SERVICES (PAUL ANDREWS)

9.1 MANAGEMENT ARRANGEMENTS

The Head of Facilities is responsible for high standards of cleaning service delivery across all areas of the Trust. The Assistant Facilities Manager – Housekeeping, is responsible for the operational 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.

The Trust understands the importance of a clean, appropriate environment and focuses on providing excellent outcomes. The Housekeeping team is supported by external window cleaners and pest control operatives.

Housekeeping staff are allocated to their own area, giving them ownership of the standard; the number of hours for each area is determined by the Credits for Cleaning information system, with further input from local stakeholders, on a risk adjusted basis.

Outcomes for cleaning are monitored through several sources including internal monitoring, internal patient satisfaction surveys, the PLACE assessment and the CQC inpatient survey.

9.2 MONITORING ARRANGEMENTS

In order to ensure that cleanliness and environmental standards are maintained to the highest standards a robust technical and environmental monitoring system has been put in place.

Technical cleaning audits are carried out weekly and monthly by a team of appropriately trained personnel to provide and monitor data as required by the NHS National Standards of Cleanliness Criteria (98% for very high risk areas and 95% for high risk areas). The audits are managed by ServicTrac, and in areas where the target score is not reached, there is a rectification timeframe set at 24 hours for very high risk and high risk areas. Additional focused monitoring and validation of the audit scores also takes place in liaison with the IPC team. All audit scores are feedback through the IPC bi monthly meeting, and recommendations on cleaning can be made through this group.

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

Dorset County Hospital have introduced in 2018 weekly Environmental Audits and these verify the cleaning scores using a Patient Led Assessment of the Care Environment (PLACE) style of assessment to identify areas for improvement or refurbishment. All patient and visitor areas are checked for cleanliness, standard of decoration, state of repair, and condition of furniture, fabric fixtures and fittings. The opportunity to talk to patients and receive their feedback is also encouraged. An

action plan is produced following the audit which is sent to the individual Ward Sister/Charge Nurse and Matron responsible for the ward/department. A follow up meeting ensures that all actions identified are completed.

Feedback from 'Friends and Family' continued to rate the standard of cleaning across the Trust as very high, and the housekeeping department consistently receive positive feedback in the high standard of cleaning undertaken in wards and departments.

9.3 PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT (PLACE)

In May 2017 the Patient Led Assessment of the Care Environment (PLACE) was undertaken at Dorset County Hospital. This included assessment of the cleanliness, condition, appearance and maintenance of the environment. The Hospital's score for cleanliness this year was 99.02% and the condition, appearance and maintenance was scored at 93.80%, both higher than the national average.

We are currently preparing for our 2018 PLACE Assessment.

DCH PLACE Score comparisons by Region and Upper Quartile

	DCH Scores for 2017	Average Comparison by Region 2017	Upper Quartile by Acute Small
Cleanliness	99.02%	98.4%	99.49%
Food	88.07%	89.7%	94.06%
Organisational Food	90.67%	88.2%	91.3%
Ward Food	87.24%	90.4%	97.11%
Privacy, Dignity and Wellbeing	85.02%	83.3%	85.55%
Condition, Appearance and Maintenance	93.80%	93.5%	96.36%
Dementia	77.60%	77.9%	92.48%
Disability	85.66%	83.2%	90.16%

9.4 PREMISES DEVELOPMENT AND REFURBISHMENT

The IPC and Housekeeping Teams have had extensive input into plans, before and during works, on various sites this year where redevelopment or refurbishment have been, or are due to be, undertaken to ensure that IPC standards were met.

9.5 IPC TRAINING FOR DOMESTIC STAFF

The Trust ensures that cleanliness standards are consistent and provides a comprehensive training package to domestic staff which includes the principles of infection prevention and control. 97% of housekeeping staff received training in the principles of infection control last year (2017/18).

9.6 DEEP CLEANING PROGRAMME

The Deep Cleaning programme of ward areas was started during 2017 and this has continued throughout 2018, with refurbishment works identified by our Estates teams being carried out prior to the housekeeping deep clean using the hydrogen peroxide vapour (HPV fogging) machine.

A deep clean of specified clinical areas including the use of hydrogen peroxide vapour (fogging) has been completed following outbreaks of viral gastroenteritis. This has also been carried out on all inpatient areas with confirmed or suspected Norovirus outbreaks

The Trust embraces the process of decontamination with hydrogen peroxide vapour (HPV fogging) machines, and uses this as normal practice where a ‘deep cleaning’ requirement has been identified by Nursing or the Infection Control Team. We continue to use the HPV machines in sluices during outbreaks, and when a ward is placed on heightened cleans, as this seems to shorten the time the ward is closed to admissions.

10. ESTATES REPORT (ANDREW MORRIS)

10.1 WATER QUALITY

Throughout 2017, the Water Quality Management Group (WQMG) maintained responsibility for the Trust's water services. The WQMG is supported by the Estates Team, which are audited by external water specialists. The incumbent Compliance Officer left the Trust in August 2017. A new Compliance Officer was appointed in October 2017.

In late 2017, the Community Protection Division of the Dorset Councils Partnership was requested to carry out a Risk Assessment of the water system, an outstanding requirement of the applicable Act and Regulation. They commented in part that the Trust has, "An extremely well monitored and maintained system… maintained to the highest possible standard to prevent any contamination issues."

Check and Audit analysis of the Private Water Supply is outstanding due to LINAC works but expected to be finalised at the earliest opportunity.

Issues identified in the 2016 L8 Risk Assessment continue to be rectified on an ongoing basis, including developments in system monitoring and inspection, and improvements in the ability to isolate supplies which is expected to facilitate an accelerated delivery of outstanding items in the existing Risk Management Plan.

Investigations regarding untimely pipework corrosion are well underway with external consultants. This matter presents risks primarily to continuity of supply rather than direct infection. However, secondary matters arising from this issue which might increase infection risks, albeit substantially less likely, have been recognised and taken into account.

There is some ongoing concern regarding the potential consequences of the regular blockage of foul drains due to misuse of the system, most commonly by the disposal of paper towels in toilets at Trust HQ.

The West Annex has now been brought into service with all supplies included in routine safety schedules. The Risk Assessment is due to take place in the very near future with dates to be confirmed. Good practice also requires reassessment of the Trust as a whole in 2018.

Bacteriological surveillance, principally for Legionella and Pseudomonas, has continued according to previous schedules across the Trust. As a matter of good practice it is the intention to carry out a review to ensure coverage continues to be suitable and sufficient.

Over the period covered by this report there were THREE instances of raised Pseudomonas counts discovered during regular testing. It is the authors understanding that prophylactic procedures defined in HTM and/or WSP were followed in each case with no contamination identified in subsequent samples. There were no instances of Legionella detected.

On the TWO occasions known to the author where precautionary samples were taken due to identified risks there were no bacteriological concerns identified.

The Estates Department continue to support and work with the Infection Control team on water issues.

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 2017/18, replacement flooring has been provided in medical and surgical outpatients, women's health waiting area, children's centre, discharge lounge, ENT waiting area and Rehabilitation / Physiotherapy, which involved the replacement of heavily worn or damaged vinyl or carpeted surfaces.

The Estates team have completed many minor vinyl flooring repairs and replacement of carpet tiles across the hospital in corridors, shower rooms & ward or non-clinical areas.

10.4 DECORATION AND ENVIRONMENT

The estates team continue to respond to defective areas, identified through the environmental auditing process, thus ensuring a decorative standard which is of an acceptable standard.

An extensive programme of decorations to the internal streets, including refurbishment of front reception area and entrance to Damers Restaurant is underway.

10.5 VENTILATION

The position with regard to achieving a programme of Ward Area high level deep cleans continues to be challenging. Estates through the Weekly Managerial Audit process remain responsive to any deficiencies reported.

During 2017/18, Estates and the Housekeeping team have again facilitated a high level deep cleaning to Critical Services (Theatres / Invasive procedure). Any deficiencies are reported through to the Decontamination Committee.

The Estates Department have continued to undertake formal annual validations of critical ventilation plant, in compliance with HTM 03-01 and are currently carrying out any recommendations that have been identified in the report. This work is being completed under a permit to work system. Two members of staff have been trained

to be Appointed Person (Ventilation) and are expecting to be appointed by the Authorising Engineer (Ventilation) on his next visit in March/April 2018.

10.6 WARD AUDITS

The managerial audits were renamed 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 PROJECTS IN 2017/18

Capital schemes during 2017/18 saw the following infection prevention improvements completed:

- Full refurbishment of Cardiac Catheter Lab - This included significant improvements to ventilation to meet Department of Health requirements and non-touch access between the lab and control room.
- Replacement of air conditioning system in the Coronary Care Unit and High Dependency Unit - This added resilience to the system and mitigated infection risk from condensate.
- Refurbishment of the utility room in the minors area of the Emergency Department - This included enclosed storage, wipe able wall coverings and the removal of unnecessary sanitary-ware
- Installation of additional sink and repositioned sanitary ware in the utility room in Lulworth Ward.
- Replacement of the DEXA scanner in the Rehabilitation Department - including additional containment for services to assist with cleaning
- Refurbishment of X-Ray room 2 - including a new wash hand basin to conform to Trust standards.

Work has been ongoing on the construction of new Radiotherapy bunkers and a cancer outpatient's centre. This has involved infection prevention measures to mitigate the risk of infection to the adjacent oncology ward including additional filtration to the ventilation system and limitations on opening windows.

Robust project management ensures IPC are included in pre-construction discussions on larger and higher risk projects. This allows contractors more time to plan measures to reduce dust and debris contamination before they are approved and begin work on the hospital site.

11 DECONTAMINATION REPORT (JULIE KNIGHT, DECONTAMINATION LEAD)

11.1 TRUST WIDE AUDITS

Management, Decontamination and disposal of Reusable and single use surgical instruments

The annual audit was carried out of departments that use reusable and single use surgical instruments.

The audit looked at:

- How sterilised instruments are received, checked and stored
- Stock rotation and management of expiry dates
- Checks prior to use
- Temporary storage and containers used to return contaminated items

The audit also looked at how departments control the use and disposal of single use items, preventing re-use. This includes ensuring there is a local protocol and posters are clearly displayed.

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

KEY FINDINGS

The two key themes from previous year continue:

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

The incidences have significantly reduced again this year and ALL have seen a marked improvement. The decontamination Lead has been working with the departments to support them in addressing issues raised.

The Full audit report is not currently available as the final results are still awaited. The full report will be presented at the Decontamination Committee.

11.2 AUDIT OF INVASIVE DEVICES

This audit reviews the use of invasive devices and their local decontamination between patients. The audit covers the following areas:

The audit objectives are to:

- Ensure patient safety and reduce risk of cross infection.
- Ensure that invasive equipment is cleaned in accordance with manufacturer's recommendations.
- Ensure traceability of equipment cleaning

To date audit results have been received from:

- Urology Prostate Clinics
- Women's Health Ultrasound
- Main Theatres – Difficult Airway
- Day Surgery – Difficult Airway

Results for fertility Clinic and Renal Access have been chased and will be followed up with Senior Nurses for these areas.

KEY FINDINGS

No.	Standard	Number of records compliant	Compliance	Trend
	Details of cleaning process identified in healthcare records (Y/N)	77	*78.57%*	↑
↓	*Patient Identification in Place (Y/N)*	77	*100%*	↑
	Tri-Wipe System details completed (Y/N)	77	*79.76%*	↓
	Destination of Device Identified (Y/N/NA)	77	*100%*	↑
	Member of Staff Signature in Place (Y/N)	77	*100%*	↑

There has been improvement in all but one factor in the audit. Compliance with completion of the tri-wipe / tristel has decreased and the compliance with recording of details in health care records remains low.

The compliance by area for these factors is as follows:

Details of cleaning process identified in healthcare records (Y/N)

Area	Compliance percentage
Urology Prostate Clinics	100%
Women's Health Ultrasound	100%
Main Theatres – Difficult Airway	43.7%
Day Surgery – Difficult Airway	40%

Tri-Wipe System details completed (Y/N)

Area	Compliance percentage
Urology Prostate Clinics	100%
Women's Health Ultrasound	100%
Main Theatres – Difficult Airway	68%
Day Surgery – Difficult Airway	100%

In summary there are two areas where improvement in documentation of process is required. Effective decontamination and application of process has been observed, assurance is not possible in all cases due to gaps in documentation.

The decontamination lead will be working with these areas to understand the issues and support development of an improvement plan.

12. STERILE SERVICES (KATE STILL, DECONTAMINATION SERVICES MANAGER)

12.1 QUALITY MANAGEMENT SYSTEM - ACCREDITATION

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

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

An unannounced Audit was undertaken in the department in January 2018 and certification was maintained.

The next surveillance Audit by the Notified Body Intertek is scheduled for July 2018 and will be a Transition Audit to meet the updated version of BS EN 13485:2016.

12.2 ENVIRONMENTAL MONITORING

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

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

The laboratory also tests:

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

Latest testing of all areas occurred on 14 February 2017 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.

12.3 TRACKING AND TRACEABILITY

Patient registration by clinical users against sterile items at the point of operation is now being undertaken in Theatre 3 and Orthodontics.

A roll out programme has been recommended for all treatment areas which require funding. The case has previously been presented in 2017 at Decontamination Committee, Divisional Meeting and Health Informatics but funding has not been available to purchase the scanners and software licences required to roll this out to all treatment areas.

It should be noted that there have been incidents where items have been used on a patient and it has been subsequently found that the items have expired their sterility period or have already been used on another patient and not returned for re-processing. Patient registration at point of use would significantly reduce this risk.

12.4 SHELF LIFE TESTING

Products that had been packed and sterilised for greater than 365 days (our maximum shelf life) are sent for sterility testing when a new wrap is introduced.
This testing will now be undertaken on an annual basis, regardless of whether a new wrap has been introduced, in order to give ongoing assurance that our shelf life period continues to be appropriate.

12.5 STAFF TRAINING

Four members of staff are working towards obtaining the IDSc Technical Certificate in conjunction with Ruskin University which will be equivalent to the NVQ 4 in the New Healthcare Science NVQ scheme. It is hoped that all four candidates will undertake the final examination in May 2018 but no later than October 2018.

12.6 ENDOSCOPY DECONTAMINATION UNIT

12.6.1 QUALITY MANAGEMENT SYSTEM - ACCREDITATION

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

In order to be able to register processing of endoscopes with the MHRA, and serve external customers, works need to be completed to provide a controlled environment and product release area. Plans have been put in place to undertake minor building works in the department to create the necessary space in a room adjacent to the Decontamination Unit. If these works are completed and a suitable dispatch created we would seek to re-audit. Currently discussions are taking place around whether there is sufficient external work available to warrant full registration as there is currently a need for additional clinic space to undertake an Endoscopy 'Hot Clinic' which may take clinical priority over the need for full registration of the Decontamination service in Endoscopy.

12.6.2 ENVIRONMENTAL MONITORING

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

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

The laboratory also tests:

- Product bio burden on cleaned endoscopes at point of release from the washer and at plus 3 hours 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 plus 3 hours - Annually

Latest testing of all areas occurred on 14 February 2017.

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.

12.6.2 TRACKING AND TRACEABILITY

Patient registration by clinical users at point of use is now being undertaken in all 3 treatment rooms in Endoscopy and provides accurate traceability of all endoscopes used.

13. ANTIMICROBIAL REPORT - Andrew Harris, Acting Antimicrobial Pharmacist
Antimicrobials: Summary report for financial year 2017/18.

13.1. Overview

Antibiotic misuse is widespread and has potentially profound adverse consequences, most notably the development of antimicrobial resistance. Judicious antimicrobial prescribing is recognised as a key component in slowing the development of resistance. In addition, some Healthcare Associated Infections (HCAI's) such as *Clostridium difficile* diarrhoea result from a complex interplay between antibiotic usage and other factors (e.g. hand hygiene, environmental cleaning, and patient factors). Prudent prescribing, with avoidance of unnecessary, or unnecessarily broad spectrum, high-risk antibiotics and attention to appropriate antibiotic course duration lessens the risk.

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

13.2. Summary 2017/18

- The Antimicrobial Stewardship Committee (ASC) has met sporadically throughout the year. Attempts have been made to increase clinician engagement. However, maternity leave has reduced the pharmacy capacity for antimicrobial stewardship.

- 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.

- Audits have been performed on an ad-hoc basis. A formal programme of sustained auditing has been hampered by limited resource and IT support. Existing paper based audit tools are being transferred to an electronic system (audit R) to improve data capture and automate reporting. Timely reporting with feedback to clinicians is recognised as a major driver for changing behaviour and improving prescribing.

- DCHFT are expected to meet the AMR CQUIN (Commissioning for Quality and Innovation) for 2017/18 (see 3.1 for further detail).

- DCHFT performs well/satisfactorily against the national benchmark for antimicrobial consumption and 72hr empiric review of antibiotic prescriptions (see 3.2 for further detail).

- A formal work plan has been developed outlining key objectives and corresponding time frames. Broadly, objectives reflect key national recommendations relating to stewardship.
- Mandatory training sessions in Antimicrobial Stewardship have been provided for all Foundation level doctors.
- Continued work on increasing the range of antimicrobial guidance available on the Micro Guide smartphone app.
- Participation in *Clostridium difficile* RCA meetings and identifying themes related to antimicrobial prescribing and pharmaceutical review of patients.

13.3. AMR and 72hr empiric review CQUIN targets for the financial year 2017/18

Antibiotic prescribing in English hospitals has been increasing steadily, adjusted for admissions; rising by 6% between 2010 and 2014. Piperacillin-tazobactam and carbapenem prescribing has risen more sharply; by 62% and 42% respectively in 5 years. These increases in prescribing have coincided with increased antimicrobial resistance. This ongoing rise in antibiotic prescribing and resistance prompted NHS England to instate two mandatory national CQUINs relating to antibiotic usage for the financial year 2016-17:

1) Reduction in antibiotic consumption as measured by Defined Daily Dose (DDD) per 1,000 admissions against the baseline year (Jan 2016-Dec 2016) as follows:

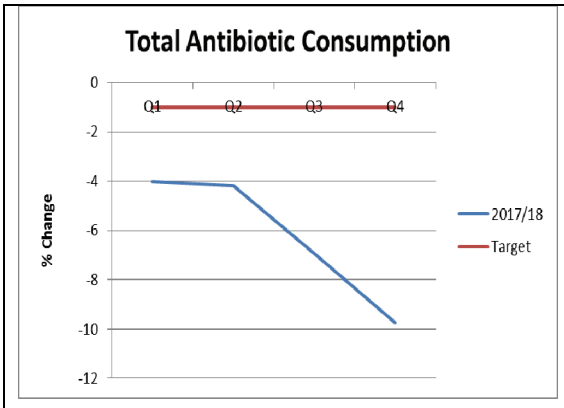
i. Reduction by ≥1% of total antibiotic consumption

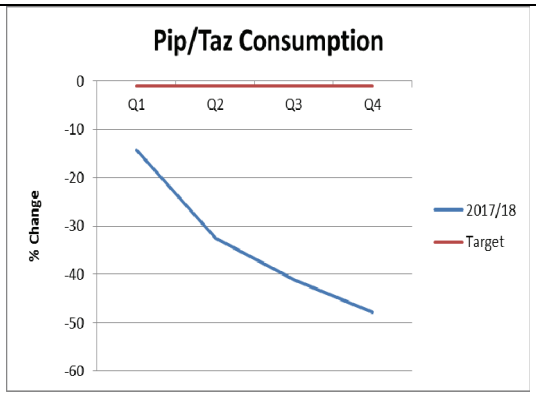
ii. Reduction by ≥1% of consumption of carbapenems

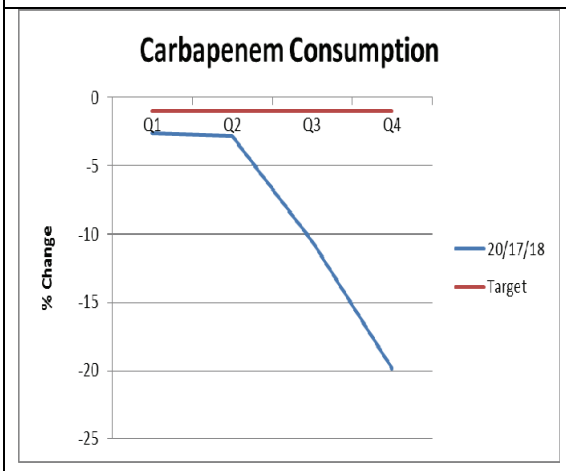
iii. Reduction by ≥1% of consumption of piperacillin-tazobactam

2) To provide documented evidence of senior clinician (consultant and/or microbiologist and/or antimicrobial pharmacist) review of antibiotics within 72hrs of commencement for sepsis, for 90% of antibiotics by the final quarter.

13.4 DCHFT's performance against the CQUIN targets



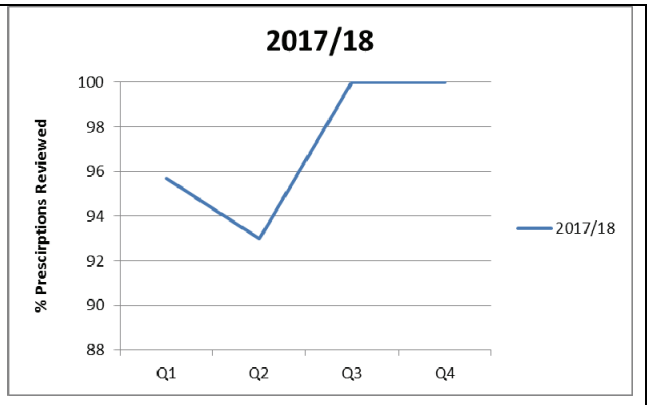




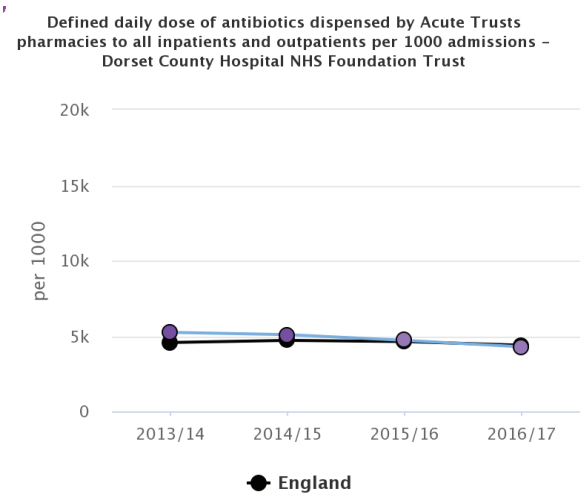
DCHFT are comfortably achieving the AMR CQUIN targets across all three indicators. By year end, total antibiotic consumption was down 9.7% against the reference year, carbapenem consumption was down by 19.8% and piperacillin/tazobactam consumption was down by 47.9%. Piperacillin/tazobactam reduction was contributed to by worldwide shortages, but has prompted changed to guidelines to encourage use of narrower spectrum agents.

*% change in consumption for the rolling year ending each quarter compared to baseline year (Jan 2016 – Dec 2016).

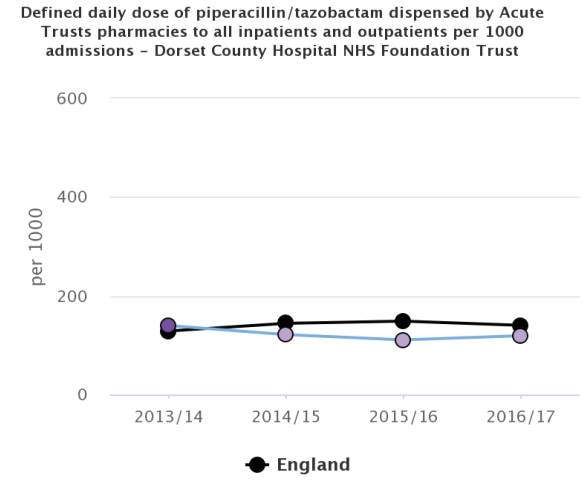
Last year's success with the 72 hour review has continued thoughout the year, and the last two quarters reached 100%.

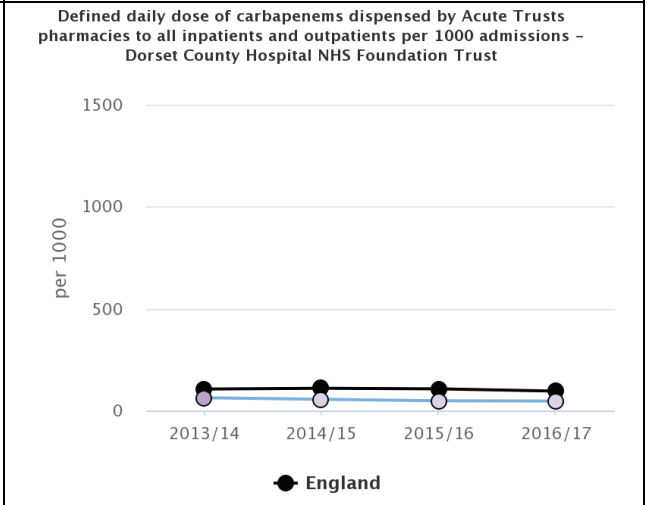


13.5. DCHFT CQUIN indicators against the national picture



In 2013/14 antibiotic consumption was higher than the national average. A progressive reduction in consumption coupled with an increase in admissions over the last 4 years has brought all three AMR CQUIN indicators below the national average; 4% (total antibiotics), 17% (piperacillin-tazobactam) and 52% (meropenem) less than the corresponding national value. In addition, the percentage of antibiotics with documented evidence of review is higher than the national average (see chart overleaf). It should be noted that these data are unadjusted for the confounding effects of case mix, age and sex. As such, direct comparison between DCHFT and the national average is limited. Note that 2017/18 data has not yet been published by Public Health England.





Compared with benchmark: Better / Similar / Worse — Lower / Similar / Higher / Not Compared — Low … High

Benchmark Value: Lowest | 25th Percentile | 75th Percentile

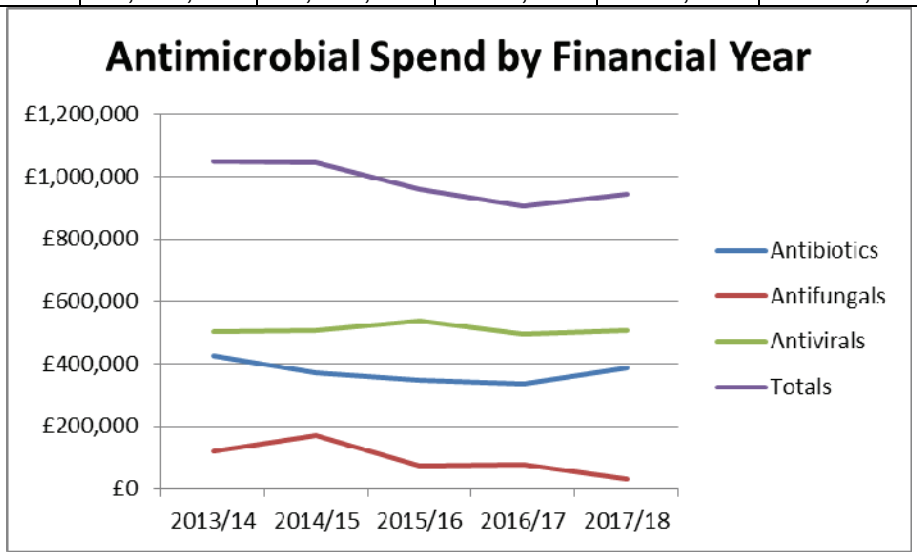
Indicator	Period	Dorset County Hospital		England		
		Count	Value	Value	Lowest	Range
Defined daily dose of antibiotics dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 admissions	2016/17	116,582	4,279.0	4382.1	1,759.8	
Defined daily dose of piperacillin/tazobactam dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 admissions	2016/17	3,242	119.0	140.0	3.3	
Defined daily dose of carbapenems dispensed by Acute Trusts pharmacies to all inpatients and outpatients per 1000 admissions	2016/17	1,250	45.9	97.1	2.9	
Percentage of antibiotic prescriptions with evidence of review within 72 hours; by quarter	2016/17 Q2	133	88.0%	86.6%*	38.0%	

a. DDDs are from Acute Trust submissions for the 2016/17 AMR CQUIN made to PHE Admissions are from hospital episodes statistics, available at HSCIC.
b. Results are based on Q1 and Q2.

13.6. Anti-infectives spend for year 2016/17

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

Year	2013/14	2014/15	2015/16	2016/17	2017/18
Antibiotics	£424,415	£372,273	£349,149	£334,500	£388,009
Antifungals	£118,739	£168,391	£74,239	£76,525	£31,372
Antivirals	£503,467	£504,693	£536,935	£493,356	£505,354
Totals	£1,046,621	£1,045,357	£960,323	£904,381	£942,735



Overall spend has increased slightly, despite reduced consumption. Of note, is the limited availability of piperacillin/tazobactam, which has resulted in a switch to alternative antibiotics with a higher acquisition cost for some indications.

13.7. Summary of future work

- To delineate channels within the organisation to effectively disseminate audit results and garner support for AMS. As an example, we intend to regularly attend governance meetings with the view of making AMS a standing item on the agenda.
- Updating and streamlining the existing audit programme to incorporate CQUIN specific indicators for 2018/19
- To develop a strategy to improve antimicrobial review and de-escalation. This is will be of particular importance as this forms part of the AMR CQUIN for the 2018/19 financial year. In addition, continuation of the SEPSIS CQUIN in 2018/19 may result in overprescribing of broad spectrum antimicrobial regimens and inappropriate continuation of these agents. A Small scale study is in progress to explore existing deficits in the review process of antimicrobials and identify potential barriers to de-escalation.
- To develop a systematic approach for reviewing local susceptibility patterns as part of the antibiotic guideline development process.
- To establish an AMR CQUIN group to specifically monitor progress against the 2018/19 AMR CQUIN and steer intervention. This group will report to the AMS committee and sepsis committee.
- 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.
- Participate in the South West Point-Prevalence after an absence in 2017/18.

14. CONCLUSION

2017-2018 has been a most successful year with trajectories for both MRSA and Clostridium difficile being met. 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 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.

The annual work plan for 2018-2019 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.

Emma Hoyle

Associate Director Infection Prevention & Control

Appendix 1

Infection Prevention & Control Work Plan 2018-2019

	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	2nd May 2018 – Exception/Assurance report delivered
		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 – business case completed January 2018 in preparedness	Contract renewal	Associate Director Infection Prevention & Control	31st May 2018 **Completed**	31st May 2018 – Contract renewed
		The Trust will maintain a high standard of Infection Prevention & Control	Divisional Matrons to develop HCAI improvement plans for 2018-2019 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 2018	

	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 2019	
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	May 2018	11th May 2018 – PLACE assessment completed – await results
			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 2019	

	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 to be implemented Trust wide	All clinical equipment will be identified as clean or requiring cleaning	IPCT to implement process Divisional Heads of Nursing / Matrons to monitor	June 2018	
		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	September 2018	June 2018 – Policy ratified and ready for distribution
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 2019	
		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 2019	
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 2019	

	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 ≤ 13 cases (does not include cases whereby no lapses of care were identified	Undertake Root Cause analysis of all hospital acquired cases of CDI	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 2019	April 2018 – 0 cases May 2018 – 0 cases
		Reduce rates of Gram-negative blood stream infections (BSI) by 50 % by 2021	Undertake Root Cause analysis of all hospital acquired cases of gram negative BSI	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	Associate Director Infection Prevention & Control	March 2019	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
				Infection Prevention Group (IPG)			
		Ensure the Trust is robustly prepared for Winter	Develop Influenza Plan 2018-2019 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	IPCT	Bi-Monthly	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
				care hand hygiene standards.			
			Participate in World Health Organisations Hand Hygiene Day & Infection Control Week	Staff engage with IPCT promote best practice.	IPCT	5th May 2018 October 2018	May 2018 – 'Gloves are off' campaign launched
		Education	Support DCHFT e-learning mandatory training programme	Education reflects national and local requirements for mandatory IPC training.	IPCT	March 2019	
7	Provide or secure adequate isolation facilities	Ensure the risk of cross infection is reduced Trust wide	Undertake annual audit of isolation precautions to ensure appropriate signage, PPE precautions are in place. Ensure that audit incorporates patients who should be in isolation.	Audit identifies appropriate precautions to effectively manage patients with infections.	IPCT	March 2019	June 2018 – Daily ward rounds by IPCT reinforce practice
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 2019	
			IPCT at DCHFT to take	One ICNet system	Associate Director	March 2019	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			nursing lead on development of ICNet 'single instance' across Dorset	across Dorset	Infection Prevention & Control		
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections	Audit programme- to audit compliance with Key IPC policies	PVC audits undertaken to ensure compliance with observation standard	PVC observations will be observed every shift and recorded on Vital Pac	IPCT	Quarterly	
			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	Quarterly	
			Participation in mandatory Surveillance of Surgical Site Infections	Surgical site surveillance meets national	IPCT Divisional Consultant	March 2019	June 2018 – Mandatory Surveillance of Hip surgery in

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			for Orthopaedics and Breast. Review results with clinicians. *Orthopaedic surveillance SSI cases to be discussed at Orthopaedic Governance meetings.* If required, action plan to be developed and implemented Results to be presented at Divisional Governance Meetings and IPC	mandatory requirement Rates of SSI are within acceptable parameters	Leads		progress Apr-Jul 2018
			Support the DCHFT Sepsis Screening and treatment Policy	CQUIN Sepsis Screening target will be met	Associate Director Infection Prevention & Control	March 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	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 2018 (IPCT) July 2018 (Provider)	
		Prepare all clinical staff to provide direct patient care for those requiring airborne precautions	Divisional fit mask train the trainer sessions planned June/July 2018	All clinical staff will have access to FFP3 training and able to care for patients using airborne	Divisional Matrons	November 2018	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	control of infection associated with the provision of health and social care			precautions			
		Staff at DCHFT are equipped with the knowledge, skills and equipment to care for 'high risk' infectious patients	Ensure all 'IPC Emergency Boxes' are maintained and in date Ensure all relevant policies are up to date and staff are aware of roles and responsibilities in relation to 'high risk' patients.	All clinical staff are aware and able to support the emergency preparedness of the trust for IPC issues	Associate Director Infection Prevention & Control / Lead Emergency Planner	September 2018	

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 2018