INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Infection Prevention and Control Annual Report 2021-22

Nicola Lucey – Chief Nursing Officer/Director of Infection Prevention and Control

Emma Hoyle - Deputy Chief Nursing Officer**/**Associate Director Infection Prevention and Control

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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 Chief Nursing Officer 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 work plan, 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 2021- 2022 was a challenging but 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, Gram Negative Organisms and *Clostridium difficile* infections for 2021-2022
- The Trust continued to develop and adjust in the global pandemic of COVID-19 in response to the local and national requirements
- Hand hygiene compliance has remained high and sustained at 97%
- No outbreaks of Norovirus
- The Sterile Supplies department continues to maintain a full Quality Management System in line with BSO standards.
- Mitigation and enhanced monitoring continued to mitigate risk of 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).

1. INTRODUCTION

This is my sixth year as Chief Nursing Officer, 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 2021– 31st March 2022. The Annual Report provides information on the Trust's progress on the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAI's).

The pandemic has continued to remain challenging for the Trust and Infection Prevention and Control over the reporting year as the world-wide pandemic of COVID-19 maintained its dominance particularly in healthcare. The Infection Prevention and Control team have been vital in developing and supporting the Trust. They have continued to provide expert counsel to others across the system and southwest region, sharing best practice and challenge to ensure COVID-19 secure environments for patients and staff.

The Trust met the target for zero cases of preventable MRSA bacteraemia. The Trust reported 20 trajectory cases of *Clostridium difficile* against a target of 22 cases and was under trajectory for gram negative organisms. 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 prevention and control.

These lower rates of infection have been achieved by the continuous engagement of the Trust Board and most importantly the efforts of all levels of staff. The commitment to deliver safe, quality care for patients remains pivotal in the goal to reduce HCAI's to an absolute minimum of non-preventable cases. I am incredibly proud of the teamwork that has enabled this positive track record of patient safety.

Quality improvement requires constant effort to seek, innovate and lead practice. The Infection Prevention and Control team epitomizes this quality improvement ethos, and they significantly contribute to achieving our strategic mission: "Outstanding care for people in ways which matter to them". 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.

I am never complacent and have ongoing high ambitions for patient safety. 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
Chief Nursing Officer
Director of Infection Prevention and Control

2 INFECTION PREVENTION & CONTROL ARRANGEMENTS

2.1 INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 5 times during 2021- 2022. 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 was chaired by the Chief Executive Officer, Patricia Miller, Chief Nursing Officer, 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 2021-2022:

- Monthly MRSA Bacteraemia surveillance.
- Monthly *Clostridium difficile* surveillance.
- Monthly hand hygiene rates.
- Outbreak and incident reports.
- IPC risk assessments relating to COVID-19

2.3 INFECTION PREVENTION and CONTROL TEAM

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

- Nicola Lucey, Chief Nursing Officer / Director of Infection Prevention and Control
- Emma Hoyle, Associate Director Infection Prevention and Control/Deputy Chief Nursing Officer
- Dr Cathy Jeppesen, Infection Control Doctor and Consultant Microbiologist
- Dr Lucy Cottle and Dr Amy Bond, Consultant Microbiologists
- Abigail Warne, Specialist Nurse- secondment to Matron IPC role from March 2021- Maternity Leave until September 2022
- Julie Park, IPC Nurse
- Christopher Gover, IPC Nurse
- Emma Karamadoukis, IPC Specialist Nurse
- Helen Hindley, IPC Nurse
- Sophie Lloyd, IPC Nurse (Secondment - Joined October 2021)
- Tina Arnold, As and When IPC Nurse (Joined September 2021)
- Cheryl Heard, Senior Administrator & Fit Mask Co-ordinator
- Rhian Pearce, Antimicrobial Pharmacist

3. HEALTHCARE ASSOCIATED INFECTIONS

This year NHS England updated the trajectories for C*lostridium Difficile* and Gram-negative blood stream infections. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.).* This was from one definition of a case – sample taken over 72 hours after admission was deemed a HCAI requiring review. This year the definition is as follows:

- HOHA – Hospital onset healthcare associated – cases detected within 48 hours after admission
- COHA – Community onset healthcare associated – cases that occur in the community or within 48 hours of admission when the patients has been an inpatient in the Trust reporting the case in the previous 4 weeks
- COIA – Community onset indeterminate association - cases that occur in the community with admission to the reporting Trust in the previous 12 weeks but not in the previous 4 weeks
- COCA – Community onset community associated – cases that occur in the community with no admission to the reporting Trust ion the previous 12 weeks

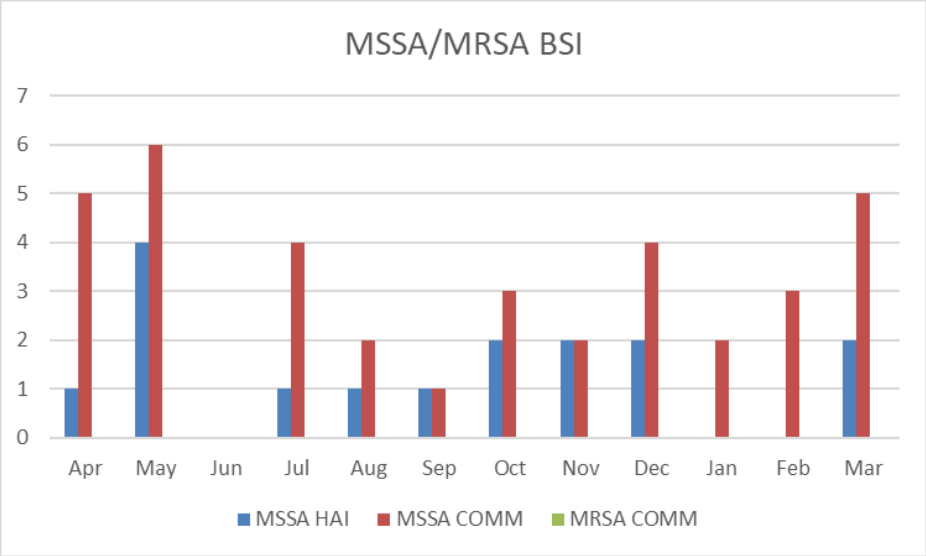
For the purposes of agreed trajectories HOHA and COHA are now combined in reporting.

3.1 METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) BACTERAEMIA

There were no preventable cases of MRSA bacteraemia in 2021-2022 assigned to the Trust. The last case of preventable 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 2020-2021 there were a total of 54 cases of MSSA bacteraemia, of these 38 cases were identified <48 hours of admission and 16 identified >48 hours after admission. No national trajectories have been set for these organisms. At DCHFT this is a reduction in cases to the previous year.



To manage MSSA blood stream infections 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 via audit.

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 25% March 2021 (PHE 2017) and 50% March 2024 (PHE 2019). 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.).* National update awaited in reference to the change in reporting 2021-2022.

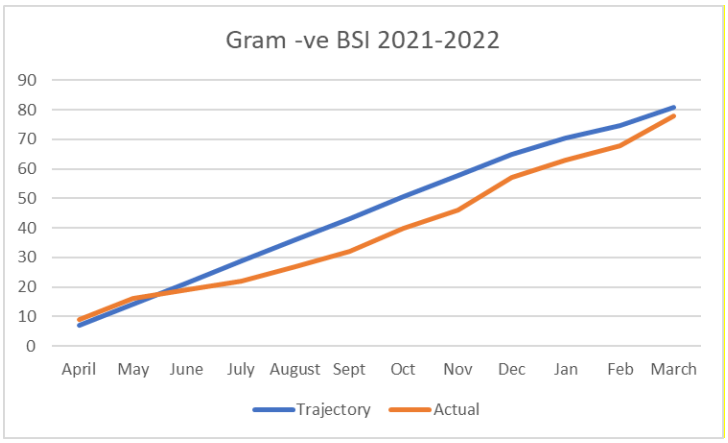
3.3.2 Mandatory data collection has been in place for several years for E. coli. In addition, from April 2017 additional mandatory data collection and surveillance has been in place for Klebsiella app. and Pseudomonas *aeruginosa.* 2021-2022 formal trajectories for gram-negative blood stream infections were set by NHSE/I at 81 cases (55 *Escherichia coli* 3 Pseudomonas *aeruginosa* and 23 Klebsiella sps). Noted this trajectory was HOHA and COHA combined for the first time.

3.3.3 In 2021-2022 there were a total of 148 positive BSI samples for E. coli. 49 of these cases were attributed to the Trust – HOHA & COHA. All cases of E. coli that occur >48hrs after admission are reviewed by the 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.

3.3.4 In 2021-2022 there were a total of 50 positive BSI samples for Klebsiella sps. 20 of these cases were attributed to the Trust – HOHA & COHA. All cases of Klebsiella sps. that occur >48hrs after admission are reviewed by the Infection Prevention & Control Team. A full data collection process is carried out in

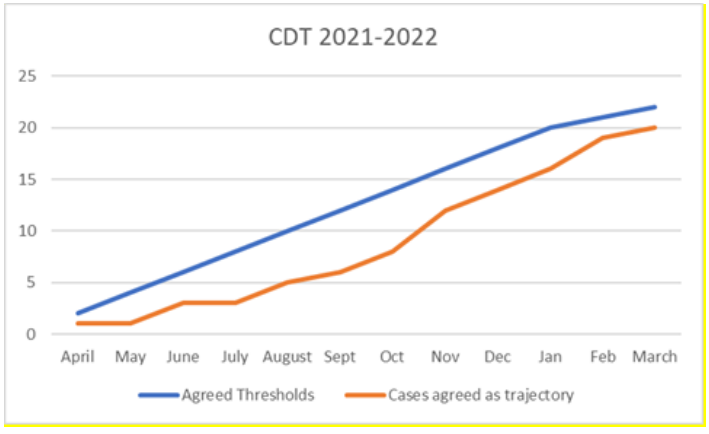
accordance with Public Health England guidance; this includes all mandatory and optional data.

3.3.5 In 2020-2021 there were a total of 24 positive BSI samples for Pseudomonas *aeruginosa*, 9 of these cases were attributed to the Trust – HOHA & COHA. All cases of Klebsiella sps. that occur >48hrs after admission are reviewed by the 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.



3.4 *CLOSTRIDIUM DIFFICILE* INFECTION (CDI)

In 2020-2021 COVID-19 pandemic trajectories were not nationally set. However, formal trajectories set for 2021-2022 by NHSE/I at 22 cases. In total the Trust reported 55 cases detected HOHA/COHA; of these cases 35 were appealed as non-preventable with no lapses in care; this resulted in 20 cases reported as hospital acquired. The Trust identified 55 cases in total (2 less than last year).



All cases of hospital acquired CDI require a Root Cause Analysis investigation. The results are presented to Patricia Miller, Chief Executive Officer, or Nicola Lucey (Chief Nursing Officer/Director of Infection and Control) 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.

4. OUTBREAKS OF INFECTION

4.1 NOROVIRUS

There have been no outbreaks or cases of Norovirus in the reporting year 2021-2022. This could be attributed to the national and local lockdowns implemented because of the COVID pandemic and measures put in place to manage social contact, plus the enhanced personal protection equipment for staff and visitors. However, it is noted that norovirus outbreaks occurred throughout the South West region in the 2021-2022 period.

4.2 INFLUENZA

There has been a national reduction in cases of Influenza A & B during the Winter 2021-2022 in comparison to the previous years. The impact of social distancing, mask wearing in the community and local lockdowns reduced the infectivity to zero at DCHFT and we had no inpatients with influenza.

In preparation for 'seasonal flu' all Trust staff were offered the annual flu vaccine. 59.9% of front line staff were immunised and 50.3% of all staff, a decrease from 91% the previous year. Additional vaccination sessions were arranged to support.

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 all 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 2021-2022 the IPC team have supported 2 modules for surveillance. The IPCT can 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.

The two audits completed were Oct-Dec 2021 (Knees) and Jan- March 2022 (Breast). Only one infection was identified in Oct-Dec Post Op Knee surgery 2021 data collection and the surgical and microbiology team reviewed and managed the

case. This is reflected in the UKHSA report. There were no breast infections recorded for the final surveillance quarter Jan-Mar 2022.

5.2 PERIPHERAL VENOUS CANNULA (PVC) AUDIT

PVCs are devices commonly used in acute hospitals, for the administration of intravenous fluids and medication. 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 monthly auditing to check that all PVC's are having visual infusion phlebitis (VIP) score checks completed has continued this year and remains ongoing. The annual average compliance for this year's audits has been 92% up from 79% last year.

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.

5.5 ISOLATION AUDIT

This year's side room isolation audit took place in February and looked at all inpatient areas (excluding Kingfisher Ward and ITU) with results as follows; Out of 43 rooms in use for infection control purposes 56% had correct signage, 44% incorrect signage and a total of 100% overall side rooms in use across the trust. At the time of audit being carried out staff were educated on the importance of using correct signage to protect not only the patient but also themselves and visitors and thus reducing the transmission of infection.

5.6 COMPLIANCE WITH URINARY CATHETER POLICY

Over the past year the following audit has been carried out monthly in relation to Urinary Catheter Care.

- Indwelling Urinary Catheter Recording on Vital Pac

Compliance with the requirement to accurately document indwelling urinary catheter insertion on VitalPac has been good with an overall trust compliance of 94% of all catheters being recorded. When split between the Divisions, Family and Surgery returned 91% compliance and Urgent and Integrated Care 95% compliance. These percentages are an average. Urinary tract infections are the second largest single group of healthcare associated infections in the UK. Insertion of a urinary catheter is known to be a significant risk factor in the development of urinary tract infections and the risk increases with the duration of catheter insertion. It is therefore important to ensure there is a comprehensive process in place to ensure that the risk of urinary tract infection is considered and considered prior to insertion of urinary catheter and there is a continuous process for review.

5.7 Carbapenemase producing enterobacteriaceae audit (CPE)

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 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.

UK Health Security Agency (UKHSA) recommends that as part of the routine admission procedure, all patients should be assessed on admission for Carbapenemase-producing Enterobacteriaceae status. Although UKHSA advice on this changed in December 2019 we now have a dedicated policy for CPE and it remains that all patients admitted to the Trust must have a screening risk assessment carried out on admission.

This audit, which was carried out between April 2021 and March 2022, 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.

Results show that the overall compliance with undertaking the admission screening risk assessment was 76.3%. This has increased by 2.3% on the previous year's 74% result. This audit will be repeated next year and, it is anticipated that compliance will improve. To demonstrate continued adherence to CPE guidance and Trust policy this audit will be repeated for 2022-23. In conjunction with the role out of a new CPE policy ward and unit leads have also had the opportunity to discuss changes in guidance with the IPC Team and it is hoped that this will have a positive impact upon future audit results.

6 EDUCATION

Despite the COVID pandemic the Infection Prevention & Control Team continued to provide formal face to face education sessions training for both clinical and non-clinical staff. IPCT also was incorporated into the following programmes and all of the nursing team were involved in delivering the sessions:

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

Mandatory Training for clinical and non-clinical staff has been also offered via an online workbook.

Overall compliance with mandatory IPC training over the year was 84% for clinical staff and 79% for non-clinical staff. The Divisions are responsible to release staff to access their training. During the pandemic some release of staff for mandatory training was reduced due to the safety pressures, as pressure reduced staff were able to move forward with the mandatory training.

IPCT recognised that additional support and training was required and now provides face to face mandatory training in addition to the online package.

Throughout the pandemic the infection control team also promoted the use of PPE, revisited hand hygiene and supported good IPC clinical practice trust wide, this included educating and demonstrating to staff how to effectively apply the fundamentals of donning and doffing to further protect themselves in their working environment.

7 POLICY DEVELOPMENT/REVIEW

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

Clostridioides difficile Diarrhoea Policy	295
Microbiological Specimens - Collection of	323
Hand Hygiene Policy	386
Pandemic Influenza Plan	802
Viral Haemorrhagic Fever - Patients with Suspected - Policy for the Management of	856
Haematology/ Cancer Ward - Infection Prevention and Control Operational Policy for	1,174
Patient Discharge with a Urinary Catheter (Urethral and Supra-Pubic)	1,446
Avian Influenza - Infection Prevention and Control Advice for Management of Patients with Suspected	2,042
Good Infection Prevention Practice: using ultrasound gel	2,058
Carbapenemase Producing Enterobacteriaceae (CPE) - Policy for the Assessment and Management of Patients with	2,075

8. COVID-19

The global pandemic of Covid-19 remains ongoing and at the forefront of providing healthcare services that are safe for both patients and staff. The trust response continues to be led by the Incident Management Team.

The hospital environment has been adapted to suit the needs for this new virus and the complexities that it creates. Over the past 2 years the IPCT have continued to support the trust throughout the pandemic with updates to guidance in line with Public Health England and expert response to emerging situations. The IPCT have also worked closely with the Dorset wide ICS to share best practice and learn from other trusts in the Southwest region and beyond.

At DCHFT the IPCT have continued to manage the routine swabbing of inpatients to ensure patients are swabbed for Covid-19 on admission, day 3 and day 5-7 as per national guidance. This has helped to ensure any potential cases or outbreaks are identified in a timely manner and have ultimately helped to achieve a low rate of nosocomial transmission.

However, due to the extremely transmissible nature of Covid-19 and increased prevalence in the community we did have 6 wards with identified outbreaks between September 2021 and March 2022. Comparatively this was a low number of outbreaks for an inpatient setting in the South West region. No outbreaks were reported between January 2021 and September 2021.

No reported staff outbreaks of COVID-19 but due to the reduction in national COVID-19 preventative measures, the community rise in infections rose steadily between January and March 2022 leading to multiple staff absences due to requirement to self-isolate as infected with COVID-19 or a close contact of COVID-19 outside of work.

The Trust followed national IPC guidance throughout the pandemic, and this is supported by the board assurance framework. On investigation due to the nature of the virus and its transmissibility it was hard to identify the root cause of outbreaks. However, the outbreaks were during a period when visiting was not completely restricted and community rates were rising.

The response from the ward teams, matrons, CSM, microbiologists and IPCT was prompt enabling actions required following positive results to be taken quickly. Personal Protective Equipment (PPE) supplies have remained good and there have been no shortages.

9 Infection Prevention and Control Surveillance System (ICNet)

Last year we updated on the joint procurement and implementation of a County Wide instance of ICNet, an infection prevention and control surveillance system supplied by Baxter Healthcare Ltd.

a. The status of the Dorset partners varied at the inception of this Programme:

- Dorset County Hospital (DCHFT)
- Poole Hospital (UHD)
- Dorset Health Care (DHC)
- Royal Bournemouth and Christchurch Foundation Trusts (UHD)

b. The IPC Programme is divided into three phases:

Phase 1 – DCH migration to hosting by DHC – completed July 2020

Phase 2 – UHD (both sites) implementation – completed 2021

Phase 3 – DHC implementation – scheduled September 2022

There have been several delays due to the pandemic which consisted of staff availability in testing, pathology lab issues and new pathology systems due to be installed. It is hoped that by the end of this current year the system will be running smoothly across the trusts.

10 Infection Prevention & Control Week - October 2021

To celebrate 'International Infection Prevention week' on the 18th – 22nd October 2021. The IPCT requested wards produce a poster presentation with an open IPC theme (in View of the current workloads, Covid-19 pandemic and ongoing staffing issues). '*Every action counts - Supporting excellence in infection prevention and control behaviours'.*

The poster presentation could encompass any area of IPC that as a ward, they felt improvements in practice could be made, whether this be hand hygiene, PPE, Glove use etc. The overall aim is to persuade everyone – staff, patients, and visitors to follow good practice in infection prevention and control keeping healthcare settings as safe as possible. Many wards within the trust produced beautiful poster displays encompassing many different IPC topics and the judging was carried out by the IPCT and N Lucey and N Johnson (Interim Chief Executive). Prizes were awarded to **Barnes and Day Lewis combined display (first), Evershot (second) and Lulworth ward (third).**

11 FACILITIES REPORT - CLEANING SERVICES Sarah Jenkins
HOTEL SERVICES REPORT- CLEANING SERVICES Sarah Jenkins

INFECTION PREVENTION CONTROL & CLEANLINESS ANNUAL REPORT 2020/21

Throughout the past year the Housekeeping Team have continued to work hard to maintain the cleanliness of the hospital, coping, as all services, with the fast-changing nature of the service due to the continuing challenges of the covid 19 pandemic and the restarting of services following their cessation in the last two years.

We have continued to work in collaboration with the teams throughout the hospital and our outside contractors, particularly with our colleagues in infection prevention control and the wider nursing teams, to ensure our continued focus on providing and maintaining a hygienically clean and appropriate environment for our patients, visitors and colleagues. With the introduction of the Standards of Healthcare Cleanliness 2021, the emphasis on cleanliness being everyone's responsibility will hopefully further enhance these relationships.

Cleanliness

Cleaning services throughout the buildings occupied by the Trust, both on and off the main hospital site, in both clinical and non-clinical areas, are provided by an in-house team of staff supervised through a 24/7 rota by a team of supervisors. This team is augmented by external contractors, managed by the Hotel management team, who undertake the window cleaning and pest control aspects of cleanliness.

The expansion of the number of off-site buildings has led to changes in the service provision, with the expansion of the clinical offering provided by the acquisition of the lease on a floor of South Walks House being of particular note. The extension of this lease, both in terms of time and the area being utilised, will lead us to further review the offering to all external areas, with the appointment of a new supervisor responsible for the staff on these areas supporting this.

As far as is practicable staff are allocated to a particular area, giving them a sense of ownership, and belonging to the area as well as continuity in the cleaning regime. The amount of time allocated daily is determined by the frequency of cleans as outlined in the Standards of Healthcare Cleanliness and by input from the clinical and housekeeping teams. We continue to review these considering changes to IPC guidance, presence of infection outbreaks and the differing pressures caused by reduced numbers of staff at times of increased sickness.

We continually review the cleaning needs of the hospital and in particular this year we have had to look at the provision in the emergency department due to ongoing

building works. The new Standards of Healthcare cleanliness have necessitated changes in the frequency of cleans and consequently changes in the cleaning schedules. We are about to become a pilot site for a new software system which will enable us ensure compliance with the new standards and ensure that the cleaning schedules remain fit for purpose.

Standards of cleaning are monitored through the audit process, the frequency of which is determined through the functional risk category assigned in accordance with the new national standards. These standards also set a timetable for the rectification of failures based on the risk category. Standards are further monitored through reports received from PALS, the environmental audit process and through PLACE and PLACE lite. Feedback is given to staff on the areas from these audits.

Despite the difficulties of the past 12 months, cleaning standards have been maintained with highlighted issues being remedied in reasonable timescales.

Deep Cleaning

The pressures of the pandemic and the number of patients visiting the hospital have severely limited our ability to carry out our deep clean programme in the way that we would have wished. We have taken every opportunity to carry out such cleans as and when we have been able.

Many cubicles continue to be deep cleaned on a regular basis following the discharge of patients and bays have been cleaned following infection outbreaks. As alluded to above, the pressures on flow have limited our ability to carry out the bay cleans as we would have liked but we continue to work with the clinical teams to ensure that these are carried out where possible.

The deep clean process is supported by fogging with a hydrogen peroxide vapour. We have replaced the HPV machines in the course of the past few months and the staff are currently receiving training on their use for the roll out across the Trust. These machines provide far greater assurance in terms of reporting and are safer for the operatives in that the machines are turned on remotely once the operator has sealed the room, the vents and fire alarm sensors are covered without the operator having to use a ladder and reports are generated to confirm successful operation.

Internal Monitoring

The housekeeping team monitor the cleaning standards through audits. The frequency of these audits is dependent on the new functional risk categories to which the area is assigned, and these vary between weekly and annually. The timescale for rectification of failures is also dictated by this categorisation.

Star ratings are being assigned for display instead of the percentage of cleanliness achieved, rated from 5 to 1 star. The percentage needed to achieve the five-star status is also linked to the functional risk category. Should an area receive 3 stars or less than a list of remedial actions is followed to ensure that the area is brought back up to and remains at standard.

In spite of all the difficulties, audit scoring has remained consistently high which is a credit to the dedication and hard work of the housekeeping team.

We have recently purchased new auditing software which is currently being rolled out across the Trust. The reporting that this will offer will lead to greater accountability of the cleaning and the audit process. This will also assist with the new aspect of auditing required which looks at the process of cleaning, efficacy audits, which are required annually in each area.

Whilst we have carried out weekly environmental audits from time to time during the last twelve months, we have not been able to hold them as frequently as we have liked, nor have the patient assessors been able to accompany us. This program has recently restarted and so in the fullness of time it is hoped that these will once again see our patient assessors accompany us to the wards.

The pandemic also mean that we have not been able to carry out full PLACE assessments, Patient Led Assessment of the Care Environment, in the last year. However, we have carried out two sessions of PLACE lite, with a smaller team carrying out a limited number of PLACE assessments and we were pleased to welcome our patient assessors to these. In these the cleanliness and condition of the areas are looked at from a patient’s perspective and the results were very pleasing, showing the hard work done by all teams to maintain the cleanliness and condition of the hospital.

12 ESTATES REPORT (DON TAYLOR – Head of Estates and Facilities)

12.1 WATER QUALITY

The Estates Team are responsible for maintaining the majority of the Trust's potable water systems, reporting to the Water Quality Management Group (WQMG) and Infection Prevention and Control Group. Provisions for water safety are independently audited by experts from the Water Hygiene Centre.

The Estate
Changes and additions to the property portfolio, through reorganisation, capital works and acquisition, have presented technical challenges requiring significant change in terms of capability and resource.

Several major unit repairs and replacements have been carried out including the main water softening plant, borehole pump and supply pipe, and hydrotherapy pool chlorine dosing system.

Policy & Governance
Some appointments required by the Water Safety Policy have been made and funding now supports the engagement of an Authorising Engineer (Water). The policy itself and its accompanying Operational and Maintenance Procedure require review and update to be brought in line with changes to regulation and DCHFT practice.

Risks
HCWS (Hot and Cold-Water Systems) are managed within capability and availability and, in general, the main site systems need investment to mitigate age related and maintenance issues. Over the period the MECH team attended approximately 500 leaks and, of the systems monitored, roughly half have displayed temperature or biological control issues. Some legacy issues with non-compliant installations have been resolved. The acquisition of additional properties and capital projects have presented some challenges. Measures to mitigate the various problems have been identified.

The table below shows the routine samples and raised counts.

	Outlets	**Samples Taken**	**Raised Counts**
Legionella	21	161	1
Pseudo. A	209	630	89

The table below shows the samples and raised counts following concerns for water safety. Measures to ensure immediate user safety are communicated as required.

	Outlets	**Samples Taken**	**Raised Counts**
Legionella	43	429	135
Pseudo. A	83	463	3
Coliforms	42	463	162
E. coli	42	463	3

12.2 SUPPORT FOR THE DEEP CLEAN PROGRAMME

A Deep Cleaning programme has been produced.

12.3 REPLACEMENT FLOOR COVERINGS

Approximately 200 separate flooring jobs of various types, from minor repairs to complete replacement, have been carried out by directly employed labour.

12.4 DECORATION AND ENVIRONMENT

The Estates team continue to deliver high quality decoration on request, through the environmental auditing process and routine inspections of high and public use areas. The pandemic has affected access in some high-risk areas.

12.5 VENTILATION

The Estates team continue to carry out routine inspection and maintenance on all ventilation systems and formal validations on all Theatres and Critical Areas in compliance with HTM 03-01 Part B carrying out remedial works as required. During Covid the Estates team worked tirelessly with Consultants and Heads of Department in making changes to our ventilation systems both to aid Covid treatment and to respond to the multiple reorganisations. An AP(V) under the auspices of an AE(V) maintain the Permit to Work system and ensure all statutory and regulatory records are validated. Following changes to the HTM 03-01 all ventilation issues are discussed at the newly formed Ventilation Safety Group which meets every 3 months

12.6 WARD AUDITS

The Estates Dept. continue to support weekly environmental audits in association with Infection Control, and Housekeeping although these have been limited due to the pandemic.

12.7 CAPITAL WORKS

Renal POD unit – modular unit quickly procured and installed outside pharmacy and the Renal unit. This was in response to the pandemic and allowed Renal to treat Patients with or without Covid-19 symptoms outside of the normal Renal department. The unit had increased ventilation installed to meet the trusts hybrid VSG requirements which exceed HTM requirements, the unit also has appropriate water services and wash hand basin provision, all parts deigned to meet HTM standards.

ded Lift car linings on 3 & 4 in the north wing, and south wing lifts C & D, apart from the technical upgrades the shortly prior to the lift cars were refurbished and relined with easier to clean with new surfaces.

h Walks House temporary arrangement for clinic use with the installation of vinyl flooring, internal sub room division and air scrubbers to reduce risk of airborne infections. The E&F team have supported the maintenance of temporary hand wash units and deliver mitigation of the HCWS.

Installation of new Oxygen storage tank for greater capacity along with enhanced pipework arrangements for an improved resilience of clinical services.

Changes to pathology labs with enabling works for new equipment digital services to increase capacity and deliverable support of clinical teams. This incorporated additional wash hand basins, changes to machinery layouts to aid staff space and help improve process flow. The works were necessary to support infrastructure changes to incorporate combined service changes and improvements including support to the digital service team.

Water systems remedials have been covered under water quality above.

Roof and Gutter works have been carried out across the estate, reducing locations of known water ingress by around 80%, as well as preventative treatment on trial locations to mitigate the root causes and potential infection hazards.

AHAH- Refurbished admin space in Damer`s house for clinic use, this included wash hand basins, flooring, benching, and storage space for Pharmaceuticals including waste to current standards.

Therapies off-site which led to the purchase of Redwood house at Charlton down. Due to the previous standard of the property which was being used as a charities office there was a need to refurbishment the property including the management of a substantial asbestos hazard. The extent of the refurb included enhancements of the admin/clinic spaces, to ensure we met current standards the team upgraded the water system to facilitate the supply for new wash hand basins. Toilets refurbished for staff and patients in addition to increasing the size of the reception waiting area.

Scanning bureau works to include an additional office space born from space saved by reducing paper storage.

Fortuneswell bay that was previously used as an admin space returned to clinic use with new floors, lighting, and the addition of a wash hand basin.

Maternity Bereavement room was created from space previously used as a kitchenette, this to improve patients' facilities with the need for a forget me not suite.

Critical care relative's room – this involved the conversion of a vacated office space to create a new relative's room to provide patient privacy.

Neurophysiology department changes which mainly involved the division of an existing large room, then converting it into two clinical spaces. This required new independent ventilations systems within both spaces to meet current compliance requirements, in addition to wash hand basins, new flooring and an upgraded nurse call system.

Ilchester ward nurse base, alterations to the nurse station to include greater visibility of patients and ward in general.

Abbotsbury ward sisters' office was converted into a staff rest area and a small quiet room reconfiguration for staff carried out.

Site wide replacement of the fire alarm system is still ongoing, much of the works are now completed as we approach the final change over stages. The works had

been particularly difficult to manage as these started at the beginning of the pandemic and continued throughout. This requires the management of access for contractors into all areas of the site including clinical and potentially high-risk areas. The need for Drewlec to maintain and adopting to meet ever changing DCH IPC procedures and processes has been paramount, thus ensuring the safety of patients, staff, visitors, and the contractors themselves carrying out the works.

Orthopaedic outpatients' refurbishment – This area has been extensively refurbished with the enhancement of consulting, clinic, staff, and treatment spaces. These works required upgrades to ventilation, nurse call, water systems and facilities in general to meet current HBN and HTM standards.

13 DECONTAMINATION SERVICES REPORT
(Phillip Barton-Young – Service Manager: Theatres, Anaesthetics, CRCU and Decontamination)

STERILE SERVICES DEPARTMENT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN ISO 13485:2016. The department is also registered with the Medicines and Healthcare products Regulatory Agency (MHRA).

As a result of Brexit there are some ongoing changes in regulatory requirements. The Medical Device Directive has transferred to the Medical Device Regulation UK MDR 2002 (as amended) our Notified Body that was based in Sweden as an EU Representative has been transferred successfully after a transitional audit to a UK based competent authority.

The Notified Body will be undertaking a two-day surveillance audit in July 2022. The Accreditation held by the service continues to give quality assurance on the products produced and also allows the department to provide services for external customers.

External Customers

The department provides a service to various external customers including dental practices in East and West Dorset, a local GP practice and the Dorset & Somerset Air Ambulance. Undertaking work for external customers is only possible due to the accreditation achieved by the service.

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 in February 2022 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 currently.

For compliance with HTM 01-01 ProReveal testing is undertaken on a quarterly basis; this involves 50 instruments per washer (200 in total) being tested 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.

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 used on a patient.

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 or when a new wrap is introduced. Previous testing still showed 100% sterility which gives assurance that the decontamination process is effective.

A new double-bonded wrap was introduced in 2020 and sets wrapped in this will be sent for testing once they have expired their 365-day shelf life.

Staff Training

All Managers and Supervisors have achieved qualifications relevant to their role. This gives assurance that they have a full understanding of the Decontamination process and can effectively manage SSD on a day-to-day basis.

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.

ENDOSCOPY DECONTAMINATION UNIT

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 customers.

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 in May 2022.

The department is awaiting formal results from the testing for reporting and trending.

Tracking and Traceability

Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and more recently in the outpatient Urology Suite. This provides accurate traceability of all endoscopes used and significantly reduces the risk of endoscopes that have expired the 3 hour window being used on a patient.

TRUST WIDE AUDITS

Audit #4936 Compliance with Decontamination Procedure for Invasive Devices (Guideline 1341)

It is a required standard of HTM (Hospital 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 2021 audit results have yet been reviewed.

Audit #5010 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 involves each department that is supplied by Decontamination Services and also 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 2021/22 audit has not yet been reviewed due to awaiting one final submission. This will be followed up and submitted once return is received.

14 ANTIMICROBIAL REPORT - RHIAN PEARCE (Antimicrobial pharmacist)

Antimicrobials: Summary report for financial year 2021/22

1. Overview – national context

Antibiotic misuse has profound adverse consequences, most notably the development of antimicrobial resistance. Judicious antimicrobial prescribing is a critical component in slowing the development of antimicrobial resistance (AMR).

Antimicrobial stewardship (AMS) refers to an organisational or healthcare system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. Addressing AMR through improving stewardship is a national medicines optimisation priority, led by NHS England and supported by PHE.

2. Summary of AMS activity at DCHFT (2021/22)

<table>
<tr><th colspan="2">2.1 Achievements 2021/22</th></tr>
<tr><td>1. Antimicrobial Stewardship Committee</td><td>• The Antimicrobial Stewardship Committee (ASC) has struggled to convene over the last year. Re-invigorating the ASC will be a priority for the coming year.</td></tr>
<tr><td rowspan="2">2. Surveillance

• Effective surveillance of antibiotic prescribing, resistance patterns, HCAIs and infection related outcomes is the foundation of any stewardship program, but sustained progress in this area 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.</td><td>Antibiotics Consumption:

❖ 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/DEFINE), which has greatly improved our ability to monitor antibiotic prescribing trends across the Trust. It also allows us to compare our prescribing trends against other hospitals.</td></tr>
<tr><td>Local antimicrobial resistance monitoring:

• We looked at resistance data for Enterobacteriaceae in urines Q1 2019-2021 and changed our empirical antibiotic regimens for UTI in response to this piece of work.</td></tr>
<tr><td></td><td>Patient outcomes for infection syndromes:

Draft data spec. produced for business intelligence.

National AMR dashboard in development – plan to include infection related outcomes.</td></tr>
<tr><td>3. Trust Policies (includes guidelines, PGDs, PSDs, clinical pathways)</td><td>Antimicrobial prescribing guidelines:

Continued work on updating guidelines to include robust diagnostic criteria as well as streamlining information into an easy-to-use format. In total, eight new/rewritten guideline were published, thirteen updated</td></tr>
</table>

	and six new guidelines are near completion
	Patient Group directions and clinical pathways: We developed a clinical pathway for neutropenic sepsis patients admitted to the emergency department, along with two supporting PGDs to allow nursing staff to initiate antibiotics without a prescription. We also updated a further ten PGDs.
4. Formulary additions:	**Ceftazidime/avibactam** Ceftazidime/avibactam was a welcome addition to the local formulary, improving the range of antibiotics available locally to treat increasingly complex cases involving resistant bacteria.
	Fidaxomicin The formulary status of fidaxomicin was updated to reflect its new position in the management of C.difficile, allowing GPs to prescribe it in accordance with NICE criteria.
5. RCAs	• Continued participation in *Clostridium difficile (c-diff)* RCA meetings where we provide a formal review of antibiotic prescribing, feeding back to clinical teams directly. This also gives us the opportunity to capture any emergent themes related to antimicrobial prescribing and c-diff trends. • Continued contributions to RCAs and datix involving antimicrobials.
6. laboratory-based diagnostic testing Improving the range of laboratory-based diagnostic testing for infection is recognised as an essential tool for tackling resistance and optimising patient outcomes	• Procalcitonin was introduced to steward early discontinuation of antimicrobials in COVID patients admitted to ICU. We are currently exploring the utility of procalcitonin outside of ICU.
7. Education	**Mandatory training** Implemented a 3 yearly mandatory training programme, delivered via e-learning, for all prescribers on AMS, using the ARK toolkit. Anticipated roll-out in September, to coincide with our EPMA upgrade which has new functionality to support the ARK tool.
	Face-face teaching sessions: o Gentamicin/Teicoplanin/Vancomycin prescribing (F1s) o Introduction to the Antibiotic review toolkit with case studies. (F1s) o Management and treatment of cellulitis (Clinical Pharmacists)

	○ Antifungal stewardship (Band 7 Clinical Pharmacists**)** ○ Training day for regional foundation pharmacists on AMS
8. Audits/QI projects:	• Review of antimicrobial prescribing in surgical patients (Lulworth C-diff PII) • Review of antimicrobial prescribing in stroke patients (Stroke C-diff PII • Prevalence of missed doxycycline –polyvalent cation interactions at DCH • Review of inpatient carbapenem prescribing (PPS performed weekly over a 3-month period) • Review of inpatient antifungal prescribing in IFI (PPS performed weekly over a 3-month period) • Introduced a 30-45 min daily short intervention project to stop or de-escalate antibiotics in 2-3 patients per day (started Apr 2022).
9. AMS ward rounds:	Full ward rounds looking at prescribing in detail (AB & RP): – Ilchester, Apr 2021 – Barnes May 2021 – Day-Lewis, Jun 2021 – Fortuneswell, Aug 2021 – Purbeck, Nov 2021 – Lulworth, Dec/Jan 2022 (c-diff PII) – Stroke, March/Apr 2022 (c-diff PII) Summary: General improvement across prescribing standards compared to historical baseline. Findings were minor and not indicative of major or systemic problems with prescribing.

2.2 National targets/regional benchmarking.

- **CQUINs:** Suspended due to COVID for 2021/22. However, we anticipate their re-introduction for 2022/23
- **Antibiotic consumption trends - NHS standard contract:** Typically, antibiotic consumption targets form part of the standard NHS contract. However, the COVID pandemic has had a significant impact on antimicrobial consumption both regionally and nationally; for this reason, no specific targets were agreed for the financial year 2021-22.

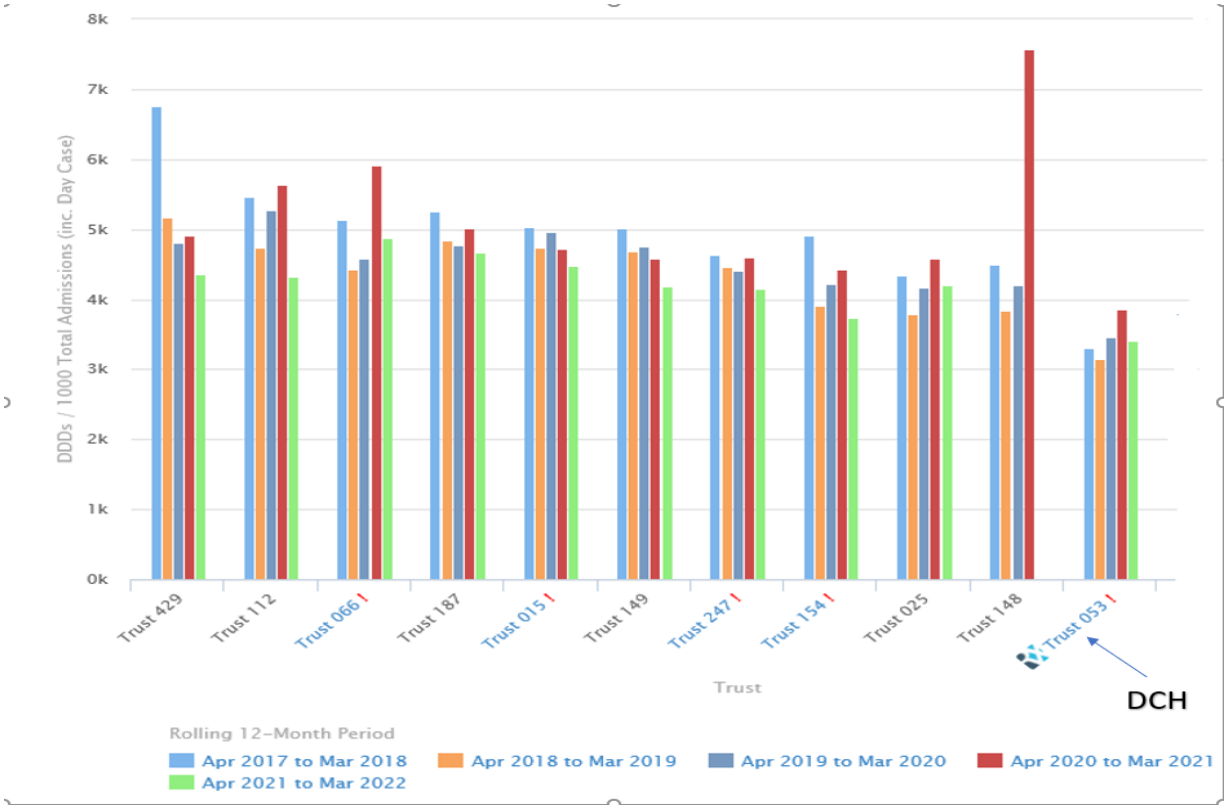
2.3 Antimicrobial consumption for DCH 2021/22

Total antibiotic consumption, adjusted for admission is down 11% from the previous financial year (see fig 1), comparable to pre-pandemic levels. Like other trusts, we observed an upswing in antimicrobial use during the first and second wave of the pandemic, increasing the total consumption, adjusted for admissions, for the financial year 2020-21.

DCHFT continues to have the lowest total antibiotic prescribing rates regionally, measured as total antibiotic use adjusted for activity (total DDDS/1000 total admission inc day case).

Fig. 1

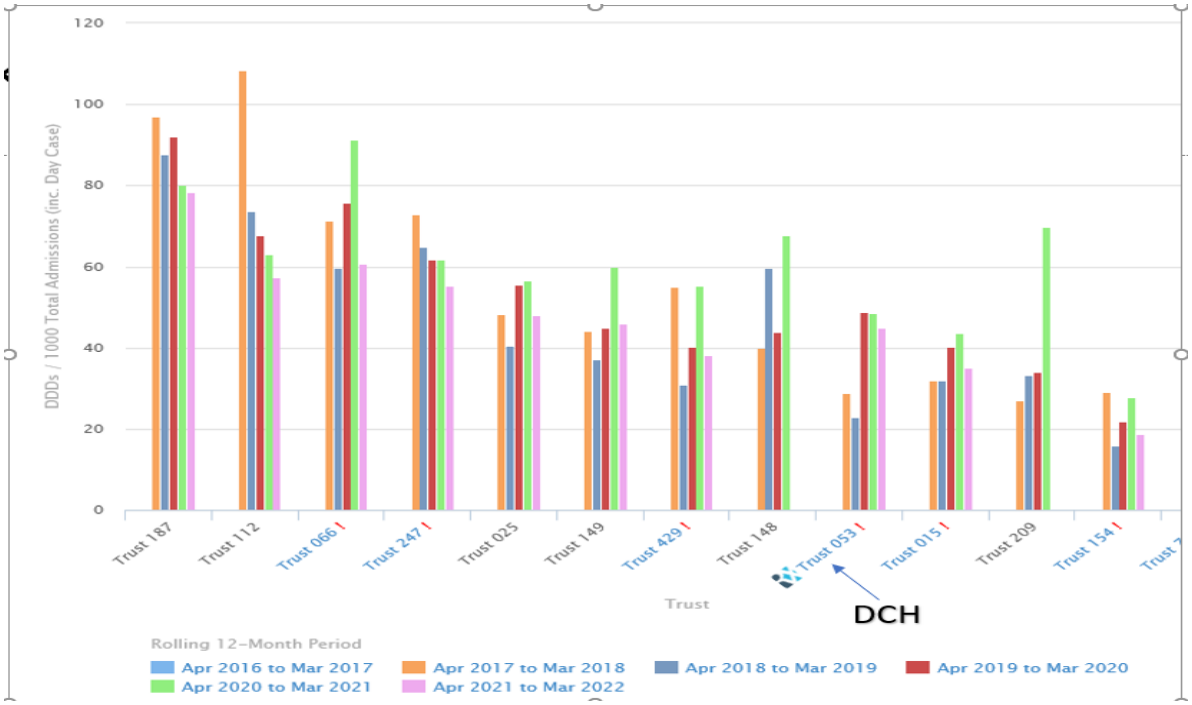
Total antibiotic consumption (DDDs/ 1000 admissions) by financial year – in region comparison.



2.2.2. Carbapenems

Carbapenem prescribing is down 8% on the previous financial year (Fig. 2). However, this still represents a significant increase compared with the 2018/19 financial year, equating to an approxamate doubling (96%) in consumption (Fig. 2). We perform regular audits of inpatient carbapenem use, which indicate that carbapenem use is generally appropriate, with the vast majority being recommended by the microbiology team. Resource permitting, we also plan to implement a regular review of local resistance data, to include monitoring of ESBLs, which may be driving carbapenem use locally.

Carbapenem consumption (DDDs/ 1000 admissions) by financial year – in region comparison.

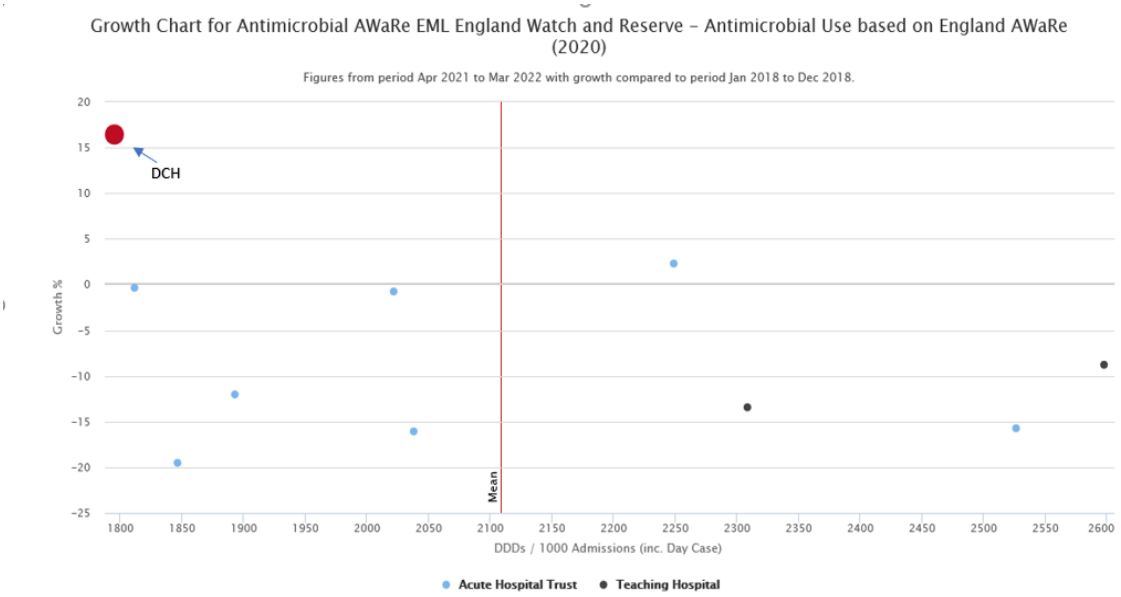


2.2.3. Proportion of total antibiotics by AWaRe category

The AWaRe Classification of antibiotics was developed in 2017 by the WHO Expert Committee. It was recently adapted by NHSE as a tool to support antibiotic stewardship efforts nationally. Antibiotics are classified into three groups, Access, Watch and Reserve. Access antibiotics tend to be narrower spectrum and should be used first line, whereas watch and reserve antibiotics are generally broader spectrum with activity against more resistant organisms and their use should be limited.

Using consumption data alone, measured by DDDs, is a poor surrogate for overall antibiotic stewardship performance; a trust would meet the consumption targets by using a larger proportion of broad-spectrum antibiotics instead of narrow-spectrum agents. Using AWaRe categorisation alongside total consumption, is a more balanced approach to measuring performance when using top-line consumption trends.

Fig 3.



As part of the NHS standard contract for the coming financial year (2022/23), NHS trusts are required to reduce 'watch-reserve' antibiotics by 4.5% compared to their 2018 baseline. Compared to other trusts in the South-Central region, DCH are outliers for growth in watch-reserve antibiotics from their 2018 baseline, seeing the largest growth regionally over this period (equating to a 16% increase), see FIG 3. However, despite this growth, DCHFT are the lowest prescribers of antibiotics from the watch and reserve category, measured as DDDs per 1000 admissions, compared with regional peer hospitals (See Fig 3).

At present, the exact drivers/reasons for this sustained increase in watch and reserve antibiotic use are undetermined.

2.3. Limitations

Data are unadjusted for the confounding effects of case mix, age, and sex. As such, direct comparison between DCHFT and the national or regional picture is limited. In addition, patient outcome data and resistance trends are not routinely collected or published alongside consumption data, raising concerns over the potential unintended consequences of targeting consumption targets in isolation.

3. Summary of future work

- Continued work on developing a set of metrics for monitoring stewardship activity, focusing on process and outcome measures to better illustrate the value of our programme. We also intend to develop a clear work-plan for AMS, to better illustrate the need for future investment and improve resource allocation.

We must 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 CQUIN targets when they are re-introduced.

15 Conclusion

The last year continued to be dominated by COVID-19 and the IPCT workload remained high as a result. Keeping the Trust staff and patients safe is priority during this time and the working day of the IPCN remains unpredictable. I personally would like to thank my team for their dedication and maintenance of their positive spirit particularly as the pandemic has continued with new challenges.

2021-2022 has been a very successful year with significant reductions in healthcare acquired infections reported i.e., gram negative blood stream infections. Trajectories for both MRSA and *CLOSTRIDIUM DIFFICILE (CDI)* were achieved demonstrating excellent practice and engagement with infection prevention and control by Trust staff.

The higher numbers of *CDI* over the pandemic time have been reviewed via a deep dive. A root cause has not been agreed but the Trust is confident that the national guidance is met in relation to management of CDI and continues to work within the southwest IPC team to explore possible reasons.

This report demonstrates the continued commitment of the Trust and shows evidence of success 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 2021-2022 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.

2022-2023 will be a progressive year as DCHFT the final stages of the Dorset-Wide implementation of ICNET as a single instance is achieved.

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

Deputy Chief Nursing Officer

Associate Director Infection Prevention and Control

Infection Prevention & Control Work Plan 2

Infection Prevention & Control Work Plan 2022-2023 V1

	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)	Director of Infection Prevention & Control (DIPC)	Bi-Monthly	Bi-monthly IPCG meetings in place.
		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. Support of the Dorset wide project to be clinically lead by DCHFT	Contract renewal	Associate Director Infection Prevention & Control (ADIPC)	October 2022	May 2022 Dorset wide ICNet roll-out in progress-
		The Trust will maintain a high standard of Infection Prevention & Control	Heads of Nursing to report on a monthly basis to Divisional Quality & Governance meetings IPC performance standard dashboard to be achieved Learning from performance data to be disseminated and evidenced via Divisional performance	Evidence that IPC performance dashboard is discussed and actioned at Divisional Governance meetings	Divisional Heads of Nursing / Quality	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			reports				
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. Cross infection rates low	Facilities Manager	Sept 2023	
			Maintain current annual deep clean programme with Facilities/Heads of Nursing/ Estates. Execute agreed deep cleaning programme	Deep clean programme is undertaken.	Facilities Manager	March 2023	
			Participation in weekly environmental technical audits	Review of weekly audits identifies deficits and monitors remedial actions have been taken	Facilities Manager (Lead) Estates Manager Patient representatives Pharmacy IPC Team	March 2023	
		All clinical equipment is clean and ready for use at point of care	Daily/Weekly Nursing Cleaning regimes in place in all clinical areas	Evidence via weekly audits – report compliance to IPCG	Divisional Heads of Nursing / Quality	Bi-Monthly	
		DCHFT will maintain a clean and safe water system	Policy in place and implemented Trust wide. Regular audits will be carried out to confirm the effectiveness of the policy.	DCHFT will deliver the Water Safety Policy. Water Safety is a standing item at IPCG. Additional	Head of Estates	March 2023	May 2023 – Post COVID recovery meetings in place

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
				meetings to be arranged and reported on for individual locations.			
		DCHFT will maintain a clean, safe and effective ventilation system	Establish ventilation safety group the reports to IPCG on a bi-monthly basis. Develop Ventilation Policy to measure compliance with HTM-03 and reduce risk of airborne infections in the healthcare settings	Compliance with refurbishment with HTM – 03 a/b	Head of Estates	March 2023	
		DCHFT will adhere to NHS Cleaning Standards 2021	Facilities and Housekeeping to enure standards are maintiand and auditted vi monthly audit process	DCHFT will maintain high standards for cleaning within new framework – Bi monthly feedback to IPCG	Head of Facilities	March 2023	
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 2023	May 2022 – IPCT continue to visit patients with newly acquired infections and established infections to provide information and reassurance.
		The Trust will have up to date patient	Review of all IPC patient information.	Positive patient	IPCT	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		information relating to infection control	Check meets standards and revise accordingly. Apply Equality and Diversity policy to all IPC information leaflets	feedback			
4	Provide suitable accurate information on infections to any person concerned with providing further information support nursing/ medical care in a timely information	The Trust will have a reliable and available Infection Prevention & Control Team. Providing support to all patients and staff	IPCT to continue to carry out a daily ward round to all acute areas including Kingfisher, Maternity & Emergency Department, providing clinical support to staff and patients. Off site support available e.g. South Walks House, Redwood House, Weymouth OPD	Minimum cross infection, reduced prolonged outbreaks of infection, reduced HCAIs	IPCT	March 2023	May 2022 - Daily IPCT ward rounds in place.
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate	Achieve trajectory for *Clostridium difficile* infection (CDI) TBC cases 2022-2023 (does not include cases whereby no lapses of care were	Divisions to undertake Root Cause Analysis of all hospital acquired cases of CDI under the revised definitions – Hospital Onset-Healthcare Acquired and Community Onset	All cases of CDI will have RCA investigation and relevant action plan if deficits identified. RCA's will be	Divisional Heads of Nursing / Quality / Matrons	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	treatment and care to reduce the risk of passing on the infection to other people	identified)	Healthcare Acquired. IPCT to support. Antimicobial Pharmacist and IPC Doctor to support pharmacy and medical element. This must be completed within 14 days of infection.	discussed by IPCT and any trends reported to Infection Prevention Group (IPG). Delays in RCA progress will be reported at IPCG on the Divisional Dashboards. Face to Face RCA meetings to be re-established with Executive Lead.			
		Achieve trajectory for Gram-negative blood stream infections (BSI) TBC cases 2022-2023	Undertake IPC led data analysis of all hospital acquired cases of gram negative BSI – escalate to full RCA if lapses in care identified	All cases of Gram negative BSI will have investigation and relevant action plan if deficits identified.	ADIPC	March 2023	
		Ensure the Trust is robustly prepared for Seasonal variations in IPC.	Support staff vaccination programme for seasonal influenza/COVID-19 Reinforce Respiratory Guidance/Seasonal	The Trust will be able to function effectively during the variance in season IPC activity and Infection Control	ADIPC	October 2022	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Influenza Policy and Pandemic Influenza Policy Ensure staff are familiarised with the Outbreak/Noro/COVID -19 policy	standards are maintained			
		Ensure Trust remains aligned to United Kingdom HSAgency (UKSHA) COVID-19 Infection Control Guidance.	Maintain COVID-19 Board Assurance Framework and report bi-monthly to IPCG , Quality Committee and Trust Board	The Trust will be able to support the demands of the COVID-19 pandemic	ADIPC	Ongoing	
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 Heads of Nursing / Quality / Matrons	Monthly	
			Validation of hand hygiene audits	High level compliance with WHO 5 moments of care hand	IPCT/ External auditors	Bi-Monthly	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
				hygiene standards.			
			Participate in national infection control promotion events	Staff engage with IPCT promote best practice.	IPCT	October 2022	
		Education	Support DCHFT mandatory training programme and other IPC training within educational packages Via e-learning and face to face training	Education reflects national and local requirements for mandatory IPC training.	IPCT	March 2023	
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. Undertake quarterly PPE audit to confirm compliance with policy	Audit identifies appropriate precautions to effectively manage patients with infections.	IPCT	March 2022	
		Ensure adequate isolation facilities in new build and any	IPCT to be involved in: • ED15	New build is fit for purpose for isolation	ADIPC	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		new build has the pandemic planning as part of process	• New build Critical Care • New build ED • Southwalks	requirements and pandemic preparedness			
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 at DCHFT to continue to support development of ICNet 'single instance' across Dorset - Dorset-Wide ICNet project. IPCT to continue to monitor efficacy of data since transfer to single instance laboratory system Dorset Healthcare to go live Summer 2022	One ICNet system across Dorset	ADIPC	October 2022	
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and	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	Urinary catheters will be reviewed on a	IPCT	Monthly	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	control infections		compliance with observation standard	daily basis and care documented on Vitalpac			
			Audit compliance with CPE screening recommendations. Divisional Matrons to review results with wards and develop action plans dependant on results of audits	Audit identifies that documentation supports appropriate risk assessment is undertaken for patients admitted to Trust	IPCT Divisional Matrons	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 to be developed and implemented Results to be presented at Divisional	Surgical site surveillance meets national mandatory requirement Rates of SSI are within acceptable parameters	IPCT Divisional Consultant Leads Divisional Matrons	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Governance Meetings and IPCG				
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	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	Sept 2022 (IPCT) Oct 2022 (Provider)	
		Prepare all clinical staff to provide direct patient care for those requiring airborne precautions	Divisional fit mask testers in place to support evolving needs created continuous change of suppliers of masks influenced by COVID-	All clinical staff will have access to FFP3 training and able to care for patients using airborne	Lead Fit Mask Tester	Bi-monthly feedback via IPCG/H&SG	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	the provision of health and social care		19 pandemic	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	IPCT/ Lead Emergency Planner	October 2022	
		Environmental controls are in place to ensure ventilation meets standard for respiratory pandemic precautions	Estates to ensure clinical and non-clinical areas have documented assessment and controls in place to support pandemic guidance	DCHFT can demonstrate compliance	Estates Lead	September 2022	

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 Deputy Chief Nursing Officer /Associate Director Infection Prevention & Control May 2022 V1