Buckinghamshire Hospitals
NHS Trust

INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2008-2009

Date Produced:	
Approved by Infection Control Committee:	8th June 2009
Approved by Governance Committee:	14th July 2009
Presented to Trust Board:	29th July 2009

Executive Director: Dr Jean O'Driscoll
Director of Infection Prevention & Control

Written and Compiled by: Catherine Greaves
Matron, Infection Prevention & Control

July 2009

CONTENTS PAGE

	Page No.
Executive Summary	2
Introduction	3
Infection Control Arrangements and Budget Allocation	3
The Infection Control Programme	4
Surveillance	4
Outbreak Reports	6
Healthcare Commission Investigation	6
SHA IV Peripheral Cannulation Project	6
Standards for Better Health (Annual Health Check)	7
Care Quality Commission Registration	7
The Health Act 2006	7
Saving Lives/Infection Control Leads	7
Hand Hygiene	7
Link Practitioner Programme	8
Decontamination	8
Patient Environment Action Teams (PEAT) & Department of Health “Deep Cleaning” Initiative	9
Infection Control Manual	9
Educational Activities	9
Audit Activity	10
Antibiotic Review Group	10
Risk Management/Clinical Governance	10
Care Records System (CRS)	10
Building Projects	10
Service Level Agreements	10
Committee/Group Membership	11
Other Activities	11

Appendices

1.	Infection Control Governance Structure	13
2.	Infection Control Programme 2008/2009	14
3.	Infection Control Programme 2009/2010	27
4.	Surveillance Data	37
5.	Analysis of MRAS Bacteraemias	45
6.	Healthcare Commission Hygiene Code Inspection Report	48
7.	Building Works	49
8.	Audit Activity	50
9.	Education	67
10.	Antibiotic Review Group	70
11.	Summary of work Undertaken for Buckinghamshire Primary Care Trust	72
12.	Divisional Reports to Trust Board	73

EXECUTIVE SUMMARY

2008/9 was a highly successful year for Infection Control at BHT.

MRSA bacteraemia numbers fell to their lowest since mandatory reporting began; we had 11 cases, a fall of 77% from 2003/04 (47 cases) and well below our trajectory limit of 23 cases by year end. The rate per 1,000 bed days for 08/09 was 0.55. This was well below the average UK rate of 0.74 cases per 1,000 bed days, and was the lowest rate in the SHA for medium-sized Acute Trusts. Of these cases, 6 were considered to be acute-Trust-acquired, the other five were pre-48 hour cases ("community" cases). This underscores the importance of continuing to work across the Health Economy to reduce these numbers even further for all our local patients and residents.

A tremendous amount of work was thrown into achieving the national target of screening all elective admissions and day cases for MRSA. We achieved this (>100%) by the end of March 2009.

Regarding Clostridium difficile, we recorded 99 Trust-acquired cases for 2008/09, well below trajectory (130 cases by year end). Our rate for Clostridium difficile cases was 0.44 cases over 65 years per 10,000 bed days, again well below the UK average for this period of 0.79 cases/10,000 bed days. We had the second lowest Clostridium difficile rate in the SHA for medium-sized Acute Trusts. Our success in controlling Clostridium difficile infections was recognised by the Healthcare Commission when they visited in July 2008 to check on progress of actions identified following the 2006 Report. On 13th August it was formally documented that all remaining actions had been satisfactorily completed.

We were visited by the Healthcare Commission again on 30th and 31st December as part of their unannounced visits to all Trusts to examine compliance with The Health Act 2006. The report published on the HCC website on 13th March 2009 confirmed that the Trust was fully compliant (no breaches or improvement notices served). The Care Quality Commission has replaced the Healthcare Commission from 1st April 2009. BHT has been granted full registration due to its recognised compliance with the Hygiene Code and Standard C4a Standard for Better Health.

The Infection Control Link Practitioner programme continued with several study sessions being held throughout the year. The results of the Hand Hygiene audits demonstrated an ongoing improvement in compliance with the Policy, with an overall compliance rate of 90% (>10,000 observations). "Bare Below the Elbows" compliance was added as an observation field to the audit tool. As a WHO Complementary Site for Safe Clean Care, the Trust took part in campaigns to improve hand hygiene for patients, staff and visitors, including the Cleanyourhands Campaign.

Members of the team travelled to Leiden, in the Netherlands, in September 2008 to observe excellent MRSA control.

The Trust was also represented in Jerusalem in September at the launch of the MOSAR project, which aims to reduce the level of healthcare-acquired infection in rehabilitation facilities. BHT is the sole UK site chosen to participate in this EC-funded study.

January 2009 saw the publication of "*Clostridium difficile* – how to deal with the problem"; new national guidelines from the DH and HPA. Dr O'Driscoll is a member of the Working Party who produced these Guidelines and several examples of good practice come from BHT.

It is evident that good infection control practices are now embedded as part of everyday business at the Trust. Staff at all levels of the organisation need to continue to work hard to reduce the level of healthcare-acquired infections even further.

INTRODUCTION

This has been another challenging year for infection control both locally and nationally. The Healthcare Commission returned in July 2008 to review the Trust progress since the publication of the original Report into the outbreak of *C.difficile* published in July 2006 and the follow up report published in November 2007. Following this visit the Trust was considered to have made significant improvements such that they would not be continuing to monitor progress. The infection control team (ICT) and operational staff have worked hard to integrate the infection control service and embed infection control into the day to day workings of the organisation. As a result the Trust has achieved a huge reduction in it's MRSA bacteraemia and *C.difficile* rates.

In May 2008 Dr Ruby Devi, Consultant Microbiologist returned from maternity leave and we said goodbye to Dr Robert Sue-Ho, locum Consultant Microbiologist who had provided cover for the year. Three FY1 Doctors worked in Microbiology at Stoke Mandeville and undertook Infection Control audits. We also benefited from Senior Registrars on Oxford Rotations who worked alternately at each site. In November 2008, Rose Gallagher Senior Nurse, Infection Control, decided not to return to the Trust following her secondments to the Royal College of Nursing and North East Hertfordshire's NHS Trust. As a result Catherine Greaves Senior Nurse, Infection Control has continued as Lead Nurse for Infection Control across the whole Trust. In July 2008 we also said goodbye to Helen Bosley, ICN who left the Trust to join Oxford PCT as their Lead ICN. Niamh Whittome commenced maternity leave in July 2008 and cover was provided through secondment of Beverley Holt from ward 12B, WH until January 2009. In October we also welcomed Jackie Dalton who joined us as a trainee ICN.

The following report gives details of work involving the Department over the past 12 months and outlines some issues for the next 12 months. Commitment to preventing the spread of infection is essential from all staff in all departments and at all levels of management in order to maintain a high standard of infection control practice throughout the Trust.

INFECTION CONTROL ARRANGEMENTS AND BUDGET ALLOCATION

The Trust serves a population of approximately 500,000 people with inpatient beds at Stoke Mandeville, Wycombe and Amersham Hospitals. Dr O'Driscoll has continued in her role as Director of Infection Prevention and Control and the infection control governance arrangements for the Trust are described in Appendix 1.

The infection control team currently consists of the following staff:

Amanda Adkins - ICN	Karen McIntosh – Secretary (P/T)
Lisa Andrews - ICN	Karleen Mulder – Secretary
Dr Kathy Cann – Consultant Microbiologist	Dr Jean O'Driscoll – DIPC
Gill Case - ICN (P/T)	Lorraine Shaw - Secretary (P/T)
Gail Cregan - Secretary (P/T)	Fiona Simpson - ICN
Jackie Dalton - ICN	Dr David Waghorn – Consultant Microbiologist
Dr Ruby Devi – Consultant Microbiologist	Niamh Whittome - ICN (P/T)
Catherine Greaves - MIPC	

In March 2009 the budget allocation was as follows:

Microbiologists	Infection Control Nurses	Administrative support
4.0 WTE	7.66 WTE (1.0 vacant, 0.8 maternity leave and 0.4 protected PCT time)	2.77 WTE

Although there has been an increase in ICN and secretarial hours compared to last year there has been no increase in funding. The increase has been achieved by reviewing the skill mix following the departure of Rose Gallagher in November 2008. Along with all other SDU's within

the Trust the department was subject to a 4% efficiency saving which equated to £20,000. This was achieved as part of this review. The 1.0 WTE vacant post is currently being recruited to. Niamh Whittome is due to return from Maternity leave in June 2009.

The ICT has continued to provide a service to Buckinghamshire PCT, this involves 2 protected days by a band 7, ICN, a reactive service for the rest of the week plus 2 Consultant Microbiologist sessions (one to cover out of hours sessions).

THE INFECTION CONTROL PROGRAMME

Appendix 2 shows the Infection Control programme for the year 2008-2009. The following report details the progress of this programme. Appendix 3 describes the Infection Control Programme planned for the year 2009-2010 for the Trust.

SURVEILLANCE

Clear case definitions for in house surveillance have been developed and applied to data reported in this report. These can be found in Appendix 4.

Clostridium difficile

The Trust continues to participate in the mandatory reporting of *C.difficile* infection. From April 2008 – March 2009 the Trust reported:

	2-64 years		65 + years		
Acquisition	**W&A**	**SMH**	**W&A**	**SMH**	**Total cases**
BHT acquired	3	15	33	48	99
BHT associated	2	0	7	16	25
Community *(a)	5	6	12	18	41
(b)	0	0	3	5	8
(c)	0	0	0	3	3
(d)	1	0	2	3	6
Total cases	11	21	57	93	182

*Ref to Appendix 4 for definitions

The latest rates available for *C.difficile*, covering April 07 to March 08, show the Trust with 0.44 infections per 1000 bed days spent in our hospitals in all patients over the age of 2 years. This is less than half the national average of 0.91 cases per 1000 bed days over the same period.

The graph in Appendix 4 shows *C.difficile* by Division over the last three years. The annual C.difficile rates graphs show the rate for 1,000 admissions.

Meticillin Resistant Staphylococcus Aureus (MRSA)

The number of Buckinghamshire Hospitals NHS Trust (acquired and associated) non bacteraemia MRSA cases detected by the laboratories from April 2008 to March 2009 are displayed in the table below:

	SMH	**W&A**	**Total**
BHT acquired (category 1)	61	75	136
BHT associated (category 2)	56	20	76
Total MRSA	117	95	212

*Ref to Appendix 4 for definitions

The majority of MRSA isolates represent colonisation, however specific data on infection/colonisation rates due to MRSA are not available. The graphs in Appendix 4 show the new cases of hospital acquired MRSA (non bacteraemia cases). Because MRSA screening has increased there is increased identification and therefore it is difficult to see any impact of interventions undertaken.

The Trust continues to participate in the mandatory reporting of MRSA bacteraemias. The Trust reported 11 bacteraemias for the year 2008-9, of these 5 were attributed to the community, 3 were attributed to W&A and 3 to SMH. All MRSA bacteraemias have a Root Cause Analysis (RCA) undertaken. Learning points from RCA's are shared through the infection control leads and discussed at clinical governance meetings. Refer to Appendix 5 for further details on the 11 bacteraemias. Data published by the HPA has shown that the Trust 's MRSA bacteraemia rate is 1.0 per 10,000 bed days for the period April 2008 – March 2009 (last published national rate =1.16)

Glycopeptide Resistant Enterococci

The Trust reported 4 GREs (3 SMH, 1WH) under the mandatory surveillance scheme.

Extended Spectrum Beta Lactamase Producing Organisms (ESBLs)

ESBL producing organisms (including strains of E. coli and Klebsiella sp.) confer resistance to a wide range of beta lactam antibiotics. They may also be resistant to other classes of antibiotics. Treatment options are therefore limited and prompt infection control precautions are required when ESBL isolates are detected

The Trust laboratories have identified 276 isolates in urine specimens (128 W&A, 148 SMH) from April 2008 – March 2009. Of these 179 (88 W&A, 91 SMH) were specimens received from General Practitioners and 97 (40 W&A, 57 SMH) were from the acute Trust.

Delay in Isolation of Infected/Potentially Infected Patients

Delayed Isolation data has continued to be collected per patient bed day, and permits a prospective audit of the Trust's Isolation Policy. This information however relies on data obtained via a variety of means (e.g. bed management team, ICT, ward staff) and therefore reflects a trend, not necessarily accurate information. This information is now part of the Bed Management Governance Report which is reported monthly to the Risk Monitoring Group and Nursing and Midwifery Board to enable the Trust to identify risks associated with delayed isolation of patients.

Orthopaedic Surgical Site Surveillance

Since its formation in 2003, BHT has taken part in the national Surgical Site Infection Surveillance (SSIS) organised by the Health Protection Agency (HPA). The programme was established to encourage hospitals to use surveillance to improve the quality of patient care by enabling them to collect and analyse data on surgical site infections (SSI) using standardised methods. With Trusts feeding their data into a central agency i.e. the HPA, it has allowed individual hospitals to compare their rates of SSI with collective data from all hospitals participating in the service. There are 12 defined categories of surgical procedures within the national SSIS programme, but orthopaedic SSIS has been mandatory for all Trusts to perform since 2004/05.

The figures are presented separately for W&A and SMH because they are analysed and reported separately by the Centre for Infection in Colindale.

Total number of procedures April 08 – March 09 (W&A sites):

	Totals	Infections (W&A)	National Infection Rate
Hip replacements	413	16 (3.9%)	0.9%
Knee replacements	495	11 (2.2%)	1.2%

Total number of procedures April 08 – June 08 (SMH site):

	Totals	Infections (SMH)	National Infection Rate
Hip hemiarthroplasty	42	2(4.8%)	3.9%
Open reduction of long bone fractures	48	1(2.1%)	1.9%
Total number of procedures July 08-March 09			
Repair of neck of femur	236	3 (1.27%)	2.9%

In July 2008, the orthopaedic procedures were re-categorised by HPA. The category was changed to repair of Neck of Femur which now combines Hip Hemiarthroplasty and Dynamic Hip Screw procedures. The figures below are indicative of that change. The local infection rates for April – June 08 are above the national rate, however, these should be treated with caution as the numbers of procedures for this period are low.

OUTBREAK REPORTS

A total of 16 (15 W&A, 1 SMH) outbreaks of viral gastroenteritis associated illness occurred between April 2008-March 2009.

Availability of Isolation Facilities

Additional isolation through the use of cohort bays for MRSA have continued on both Wycombe and Stoke Mandeville sites (11 occasions on WH site and 1 at SMH). This has equated to 803 bed days for 2008-9. On the Wycombe site this has been made difficult with the majority of wards being specialty orientated and the need to try and keep same sex bays.

HEALTHCARE COMMISSION INVESTIGATION

Work continued on the actions identified following the publication of the report in July 2006 of the HealthCare Commission investigation into the outbreaks of *C.difficile* at SMH. In July 2008 the HCC returned to review the Trust's progress with these actions and on the August 13 signed off the actions as being satisfactorily completed. The Report acknowledged the substantial progress that had been made and pointed to the fact that Buckinghamshire Hospitals has the lowest *C.difficile* infection rate for acute hospitals in South Central (2007/08) Staff were commended for the improvement in systems and processes and the impact on infection rates and ultimately patient safety and quality of care.

SHA IV PERIPHERAL CANNULATION PROJECT

The trust was successful in applying to be a pilot site for the SHA IV cannulation project in 2007/8. Gladys Mhandu was appointed to undertake this role in April 2008. This involved the 'rolling out' of the IV model developed at Portsmouth Hospitals NHS Trust which has been found to greatly reduce the number of IV line associated infections. The project has been very successful and as a result there have been no peripheral line associated MRSA bacteraemias in 2008-9.

STANDARDS FOR BETTER HEALTH (ANNUAL HEALTH CHECK)

The main standard relating to infection control is standard C4a. The Trust declared compliance with this standard at year end 2007/08. The Trust will again be declaring compliance with this standard for year end 2008/09.

CARE QUALITY COMMISSION REGISTRATION

This is a new requirement for all Trusts commencing April 2009. The Trust gained unconditional registration for infection control with the Care Quality Commission.

THE HEALTH ACT 2006 – A CODE OF PRACTICE FOR THE PREVENTION AND CONTROL OF HEATHCARE ASSOCIATED INFECTIONS

This Act came into force in October 2006 with a view to trusts being monitored on compliance with the code by the Health Care Commission from April 2007. The HCC commenced unannounced visits to all acute Trusts to check compliance with duty 2, 4, 8 and 10j in 2008/09. They visited the Trust on 30th and 31st December 2008. The report published on the HCC website on 13th March 2009 reported that the Trust was compliant (no breaches or improvement notices served) Refer to Appendix 6.

SAVING LIVES/INFECTION CONTROL LEADS

The Infection Control Team have continued to work with the nominated Infection Control leads, Matrons and Link Practitioners from each SDU. Each SDU has been required to write its annual infection control work programme for the year. This included two mandatory items, hand hygiene and IV lines, as these were considered to be significant infection risks for the Trust. Each SDU also has an Infection Control Balanced Score Card to complete which includes the following items:

- Number or red and amber risks on the SDU risk register relating to infection control
- Hand Hygiene audit scores
- Number of MRSA bacteraemias
- RCAs returned within 5 working days
- Number of *C.difficile* infections.

Refer also to Appendix 8 for summary of audits undertaken as part of this work.

HAND HYGIENE

The Trust's Hand Hygiene campaign continued throughout 2008-2009. The Trust has continued to work with the National Patient Safety Agency (NPSA) as part of the national hand hygiene campaign and has utilised all resources made available by the NPSA to assist the local hand hygiene strategy. The hand hygiene strategy has continued to evolve as a result of local need and identified risks following incidents/audits. The Trust also signed up for the World Health Organisation (WHO) Global hand hygiene challenge. The following have been achieved during 2008-2009:

- Audit of hand hygiene continued as per the annual audit programme. A criteria to include 'Bare Below the Elbows' was include within the hand hygiene audit tool to monitor compliance. With Clinical Audit's involvement the results were analysed per hospital, staff group, and activity in order to help identify both areas of good practice and those that require improvement. Refer to Appendix 8 audit activity for details. Dissemination of the results to all staff groups and wards/departments was undertaken with Infection Control Leads and Modern Matrons taking responsibility within their areas for local improvement. The results were also discussed at divisional board meetings. These audits will continue as per the new audit programme for 2009-2010.
- Mandatory hand hygiene competency assessment is well established within the mandatory training programme, for both clinical and non clinical staff. It is also included within the Trust Induction training for all new starters. Training for other groups e.g. University of Bedford students has also continued.
- The hand hygiene competency assessment continues to be completed annually on all staff.
- A contract is now in place for the maintenance of floor signs.
- A section on hand hygiene was included in the Infection Control Knowledge Survey.
- The Trust was involved in the WHO Global Hand Hygiene Day (October 2008) which was aimed at children. Activities such as hand hygiene with the light boxes, hand printing, were taken up in various areas. Photographs were published in the local paper.
- During Infection Control week (20th-24th October 2008) notice boards were put up in the main entrances. Staff of all grades were encouraged to sign small hand pledging their commitment to reducing HCAI's. These small hands were then placed on larger hands on the notice boards for the public to see our commitment as a Trust to reduce HCAI's.

LINK PRACTITONER PROGRAMME

The link practitioner programme continued throughout 2008-09 on both the WH and SMH sites. Link practitioners continued to receive on-going education and support for their role and have been actively involved in undertaking both saving lives high impact interventional audits and hand hygiene observational audits. A programme of 4 study days took place during the year; in effect 8 study days were held as the days were repeated on both the SMH & WH sites. This ensured that all the ICLPs received the same information across the trust and allowed individual ICLPs to attend sessions on either site for their convenience. Refer to Appendix 9 for further details of the content of this programme.

DECONTAMINATION

The Trust is working toward the provision of a single site CSSD facility, which from the business case work will be, subject to Trust Board approval, a purpose built unit based on the Stoke Mandeville site. Designed to service all of BHT's activity and current contract provisions it has with health economy partners, it is expected that the new unit will come on line during the financial year

A JAG review of endoscopy services has been undertaken during the year. SMH site achieved JAG accreditation, WH site will undergo its accreditation process once the new endoscopy unit is built.

PATIENT ENVIRONMENT ACTION TEAMS (PEAT) AND DH 'DEEP CLEANING' INITIATIVE

The ICT were involved in the annual PEAT inspections. The following scores were achieved by all three sites.

Site	Environment	Food	Privacy & Dignity
Amersham	Good	Excellent	Good
Stoke Mandeville	Acceptable	Good	Good
Wycombe	Acceptable	Excellent	Acceptable

A programme of changes has been drawn up to address issues and improve future scores.

Following the success of the deep clean programme undertaken last year the Trust has extended this to an annual programme, which has been commenced this year. This is in addition to the 'deep cleaning' programmes already in place as part of outbreak management and refurbishment programmes.

INFECTION CONTROL MANUAL

The infection control manual continues to be updated and new sections added as required. The following sections were updated in 2008-9:

Introduction Feb 09
1.11 Meticillin Resistant Staphylococcus aureus (MRSA) Nov 08
1.15 Management of Patients with Tuberculosis Jan 09
2.1 Hand Hygiene Nov 08
3.2 Domestic Services May 08
3.3 Food Hygiene July 08
3.4 Needlestick & Other Inoculation Injuries Jan 09
3.5 Sharps Nov 08
3.6 Isolation Policy Nov 08
3.9 Pest Control Services Jul 08
4.3 Equipment – Recommended Disinfection Procedures Jul 2008

One new section was added to the manual:
1.20 Panton-Valentine Leukocidin (Pvl) Associated Staphylococcal Infections Jan 09

All sections of the manual were also uploaded onto the Trust intranet.

EDUCATIONAL ACTIVITIES

During the year 2008-2009 the Infection Control Team gave 318 hours of formal education sessions to both clinical and non-clinical staff. This included 144 hours of induction and mandatory training for Trust staff.

The figures included here do not include preparation time which can be considerable particularly for external presentations. Refer to Appendix 9 for further details of educational activities.

AUDIT ACTIVITY

This audit programme for the year can be found in the Infection Control Annual Programme, Appendix 2.

The following audits were undertaken:

- Ward/Department Environmental Audits
- Patient equipment audits
- Ward kitchen audits
- Sharps audit
- Saving Lives High Impact interventional audits.
- Hand hygiene observational audits
- Infection Control Knowledge Survey of Clinical staff.
- MRSA and Clostridium difficile policy audits
- Transfer Form audit
- Outbreak Policy Audit

Refer to Appendix 8 for further details of audit activities.

ANTIBIOTIC REVIEW GROUP

The group has continued to meet throughout the year. A report of activity can be found in Appendix 10.

RISK MANAGEMENT/CLINICAL GOVERNANCE

Dr O'Driscoll has represented Infection Control at the Risk Monitoring Group (formerly Clinical Risk Review Panel) and is responsible for producing the Infection Control Clinical Governance reports. Dr O'Driscoll is also a member of the Healthcare Governance Committee and attends Trust Board meetings. She provided Infection Control reports to each Board and has direct access to and monthly meetings with the Chief Executive.

CARE RECORDS SYSTEM (CRS)

An upgrade to the CRS System was implemented in early April 2008 in order to resolve the challenges experienced by the ICT with the CRS system outlined in last years report. This was largely successful. Further developments to the system have been put on hold due to Fujitsu ceasing to provide support. A new buyer has now been found and it is hoped that further development will be picked up in the coming year.

BUILDING PROJECTS

The ICT continue to provide support with both minor and major building projects including new builds and refurbishments. A list of schemes needing ICT input to a greater or lesser extent can be found in Appendix 7.

SERVICE LEVEL AGREEMENTS

The ICT has continued to provide a service to Buckinghamshire PCT this has continued to involve two days a week of protected ICN time in addition to the reactive clinical service. Refer to Appendix 11 for details of work undertaken.

COMMITTEE/GROUP MEMBERSHIP

Infection Control Committee
Trust wide Infection Control Group
Health and Safety at Work Committee
Quality Standards Committee
Risk Monitoring Group (formerly Clinical Risk Review Panel)
Medical Devices Committee
Medical Equipment Purchasing Committee
Nursing and Midwifery Board
Sisters Meetings
The Domestic Services Review Group (SMH & W&A)
County Environmental Health Committee
Sexual Health Steering Group
Regional Professional Development Group (microbiologists)
Decontamination Committee
Buckinghamshire PCT Infection Control Committee.
Healthcare Governance Committee
Critical Care Delivery Group
Orthopaedic Infection Group
SDU governance Meetings
Divisional Board Meetings

OTHER ACTIVITIES

Infection Control Times

The Infection Control Times newsletter has continued to be distributed monthly.

Study Day

The Infection Control Department held the sixth Trust wide Infection Control Study Day in May in the Post Graduate Centre, Wycombe Hospital. The day was well attended by 73 staff from all Trust sites and was well evaluated. Topics covered included:

- Legal issues
- Pandemic influenza
- Community MRSA
- Waste regulations
- ESBL infections.

Antibiotic and Infection Control Web Page

The antibiotic Web page went live in August 2008 in time for the new intake of junior doctors. Responsibility for the infection control web page has now been devolved to the infection control department this has given an opportunity to reorganised it. This is now much easier to navigate.

Research, Publications and Presentations

Dr J O'Driscoll

- Presentation to Plastic Surgeons on necrotising fasciitis, 6th May 2008.
- Presentation to NSIC staff on MOSAR Study, 7th May 2008.
- Presentation to Barts/Royal London Infection Journal Club on *C.difficile* Infection, 23rd May 2008.
- Presentation to West Middlesex Hospital on *C.difficile* Infection, 9th June 2008.
- Presentation at AHCP Conference, Harrogate, on new *C.difficile* Guidelines, 12th June 2008.

- "Food for Thought" Presentation at NSIC (MOSAR Study), 18th June 2008.
- Presentation at National *C.difficile* Conference, Manchester, 7th July 2008.
- Attendance at MOSAR Launch Meeting, Jerusalem, 9th-10th September 2008.
- Presentation to Infection Control Link Practitioners (SMH), 11th September 2008.
- Presentation to Infection Control Link Practitioners (WGH), 17th September 2008
- Visit to Leiden to assess MRSA control, 22nd-23rd September 2008 with Catherine Greaves, Matron for infection prevention and control and Anne Banks, Matron, Medicine.
- Presentation at SHA DIPC Meeting, Newbury, 24th October 2008.
- Presentation at Overview & Scrutiny Committee, 5th December 2008.
- Attendance at HCAI Seminar, House of Commons, London, 4th February 2009.
- European Steering Group on *C.difficle* meeting, Brussels, 24th February 2009.
- Presentation at HAI 2009 "Towards Zero", Westminster, London, 11th March 2009.

Publications/Posters

1. The epidemiology of the second phase of an outbreak of *Clostridium difficile*-associated diarrhoea at Stoke Mandeville Hospital. Haworth E, O'Driscoll J, Kirk A, Okoro C, Smith A.

2. Sputum cultures in spinal cord Injury patients with suspected pneumonia. Prasad A, O'Driscoll J.

3. A pilot study to evaluate the prevalence of malnutrition in patients with *Clostridium difficile* infection. Wong SS, O'Driscoll J, Weldon M, Yau CY.

4. Clostridium difficile infection: How to deal with the problem. HPA/DH.

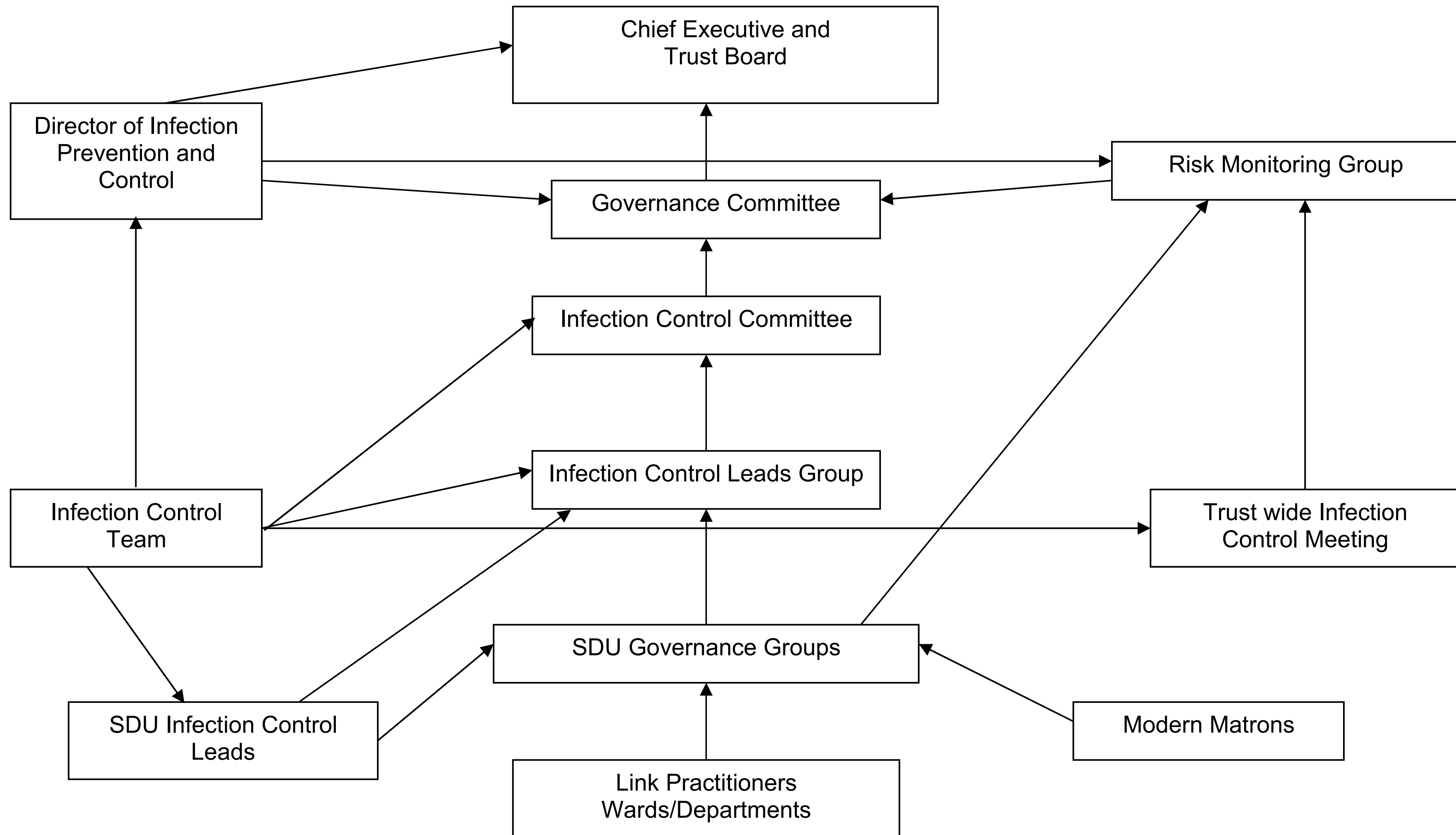
MSc Project Supervisor

ESBL: Prevalence among Enterobacteriaceae isolates from a National Spinal Injuries Centre. Tichewona Chinzowu.

Appendix 1

Buckinghamshire Hospitals NHS
NHS Trust

INFECTION CONTROL GOVERNANCE STRUCTURE



Dr J O'Driscoll
Director of Infection Prevention and Control
May 2008

Appendix 2 INFECTION PREVENTION AND CONTROL PROGRAMME 2008/2009

1. Summary:

The Infection Prevention and Control Annual Programme will clearly define the priorities for the Trust in relation to infection prevention and control activities as agreed by the Trust Infection Control Committee (ICC) which will also monitor the progress.

2. Aim of the Buckinghamshire Hospitals NHS Trust Infection Control Programme

To reduce preventable healthcare-associated infections within the activity of BH NHS Trust by a process of:

- Surveillance / Reporting
- Development, review and implementation of Infection Control Policies.
- Education / Training for clinical and support staff
- Audit of infection prevention and control practice
- Implementation of Saving Lives High Impact Interventions.
- Maintenance of the expertise of Infection Control specialist staff who will provide guidance on Infection Control measures
- Promotional Campaigns
- Response to local / regional / national initiatives
- Research
- Compliance with the Code of Practice for Prevention and Control of Infection.

The programme has been risk assessed using the Trusts risk matrix. The risk of not completing the actions identified is stated and then scored. The severity of the risk will always remain the same. The likelihood of the risk occurring is stated as it is at the current time (refer to date given). When the programme is reviewed at each ICC the likelihood of that risk occurring will also be reviewed and adjusted accordingly. It is expected that all stakeholders will work through the aspects of the programme that requires their input in order to keep the associated risk to a minimum. The aim of risk assessing the programme is to enable the Trust to easily identify priorities if the need arises.

3. Identified targets for the Trust

- Reduction of MRSA bacteraemias by 50% from 03/04 figures by 31 March 2009 (PCT LDP target). Trajectory illustrated in Appendix A.
- Reduction in rates of *Clostridium difficile* (SHA target). Appendix B.

4. Identified targets for Divisions and Service Delivery Units (SDUs)

- Annual Infection Control environmental audits by wards and departments: 100% of wards to achieve at least 85% compliance.
- Monthly reporting of:
  - Hospital acquired infections (MRSA and C. difficile)
  - Infection prevention and control training

- Annual reporting of:
    - Hand hygiene compliance
- Identification and management of Red Risks related to Infection Prevention and Control on risk registers
- Root Cause Analysis of MRSA Bacteraemias undertaken and forms returned within 5 working days of notification of Bacteraemia
- Implementation of the Saving Lives High Impact Interventions
- Appropriate use of antibiotics

5. The Infection Prevention and Control Programme 2008/09 has been developed using the following Department of Health guidance.

- Winning Ways: working together to reduce Healthcare Associated Infection in England December 2003
- Saving Lives: a delivery programme to reduce Healthcare Associated Infection including MRSA June 2005
- NHSLA Standards
- Standards for Better Health
- Code of Practice for Infection Prevention and Control (Health Act October 2006 and updated January 08)
- Clean, Safe Care – January 08

The purpose of this programme is to identify all key work streams required to ensure all appropriate actions are being taken by Buckinghamshire Hospitals NHS Trust to minimise the risk of hospital acquired infections.

Trust Board

Objectives	Actions	Lead	Timescales	Status April 09
Board takes an active part in ensuring that Trust-acquired infections are reduced to a minimum.	• The Board will receive Infection Control updates at each Public Meeting.	DIPC	Bimonthly	✓
	• The Board will receive the Annual Report.	DIPC	July 08	✓
	• The Board will receive regular Reports from Divisional Leads, Directors and Lead Nurses.	DIPC	To start May 08	✓
	• The Board's Communication Strategy will include the need to inform patients and the public on matters relating to IC.	JB/SK	July 08	Check
Risk April 08	Board does not take an active part in this issue	Likelihood = 1 Severity = 3	3	Green (low)

Divisions

Objectives	Actions	Lead	Timescales	Status April 09
To ensure that reduction of Trust-acquired infections are a priority for Divisions and SDUs.	• Each SDU will table an Infection Report update at Infection Control Lead Meetings.	SDU Infection Control Leads.	Bimonthly	Most SDUs provide a report
	• SDUs will partake in the Infection Prevention Performance Monitoring (Appendix C).	SDU Infection Control Leads	From May 08	Most SDUs partake
	• IC risks are fed into SDU/Divisional Risk Registers and reviewed monthly.	EH	Ongoing	✓
	• Lessons from IC SUIs reviewed regularly and acted upon.	Divisional Chairs and Lead Nurses	Ongoing	Ongoing
Risk April 08	Divisions and SDUs do not make this a priority and therefore infections are not reduced	Likelihood = 2 Severity = 2	4	Yellow (medium)

Infection Control Team in liaison with others

Objectives	Actions	Lead	Timescales	Status April 09
<u>Surveillance</u> Prompt action is taken when required following feedback of surveillance data.	Continue mandatory Surveillance of: • MRSA Bacteraemias • C. difficile • Glycopeptide resistant enterococci • Orthopaedic surgery wound infections. (formerly NINSS) Continue voluntary surveillance: • C. difficile (weekly reporting) • MRSA (non-Bacteraemias) • ESBL • Multi-resistant Acinetobacter baumannii Other ad-hoc surveillance.	KC/ICT	Ongoing	Ongoing
Risk April 08	Action is not taken resulting in continuing infection problems	Likelihood = 1	3	Green

Objectives	Actions	Lead	Timescales	Status April 09
		Severity = 3		(low)
<u>Education</u> Ensure that all Trust employees have a programme of education and training on the prevention and control of infection in order to understand their responsibility for infection control and the actions they must personally take.	• Ensure that all employees (including locum bank staff and contractors) receive infection control induction training at commencement of employment.	Divisional Managers	Ongoing	Ongoing
	• Ensure that all the above receive annual updates in infection control including hand hygiene competency assessment.	Divisional Managers	Ongoing	Ongoing
	• Embed e-learning as a modality for annual updates.	FS/JOD	July 08	Needs to start
	• Ensure all relevant staff receive training in aseptic techniques and are assessed as competent.	SW-F/GL	Ongoing	Ongoing
Risk April 08	Staff do not take up training and therefore do not understand their responsibilities resulting in greater infection risks	Likelihood = 2 Severity = 2	4	Yellow (medium)
<u>Decontamination</u> There are effective arrangements for the appropriate decontamination of instruments and other equipment	• Ensure Decontamination Programme is drawn up which quality assures Trust's decontamination process – achieved through Decontamination Committee. Specifically to: i) Audit Decontamination policy and practices – including training of staff. ii) Ensure compliance with HTM2030 and other relevant HTM documents. iii) Implement any relevant new guidance. • Make recommendations about purchase of new equipment and changes to operating environment.	NH	April 08 and ongoing.	Draft programme written
Risk April 08	Failure to provide adequate decontamination processes resulting in increased risk of infection and potential claims/litigation.	Likelihood = 1 Severity = 4	4	Yellow (medium)
<u>Policies</u> The Trust has appropriate policies in place in relation to	• Circulate updated policies to ICT • Policies ratified by ICC	CG	Ongoing	Ongoing

Objectives	Actions	Lead	Timescales	Status April 09
preventing and controlling the risks of HCAIs.	• New policies to be written ○ Microbiology Lab protocol for investigation of HCAI and surveillance. ○ PVL + Staph aureus • Policies to be revised ○ Isolation Policy ○ MRSA Policy	ICT ICT ICT ICT	July 08 Once national guidance is issued. July 08 July 08	Being written Policy has been written } Revised
Risk April 08	Staff will not be able to undertake correct practice if they do not have access to up to date/correct information	Likelihood = 1 Severity = 3	3	Green (low)
Audit of Policies Compliance with key policies is ensured through the implementation of high impact interventions and monitored through audit.	Policies to be audited • MRSA • C. Difficile • Outbreak • Isolation	ICT ICT	November 08 September 08 July 08 November 08	Completed
Assess standards of practice through audit of High Impact Interventions.	See separate Audit Programme (Appendix D)	GC	Ongoing	Ongoing
Risk April 08	Incorrect practice will not be identified and rectified resulting in increased infection risks	Likelihood = 1 Severity = 2	2	Green (low)
Antibiotic Prescribing Minimise antibiotic resistance by appropriate prescribing.	• Antibiotic Review Group to continue to update and merge relevant guidelines. • Audits of antibiotic prescribing to be undertaken regularly and results acted upon. • Monthly update of antibiotic usage graphs on intranet with feedback of unusual/inappropriate prescribing. • Develop Trust Antibiotic intranet web-site.	DW DW/BC BC/DIPC DW	Ongoing Ongoing From July 08 Ongoing	Ongoing Ongoing Ongoing launched 1/8/08
	• Ensure education on antibiotic prescribing to all doctors, updated annually.	DIPC	Ongoing	Ongoing
Risk April 08	Possible increase in antibiotic resistance resulting in difficulty	Likelihood = 2	6	Yellow

Objectives	Actions	Lead	Timescales	Status April 09
	in treating infections and an increasing reservoir of resistant organisms	Severity = 3		(medium)
Environmental audits Ensure environmental standards are maintained.	• Ensure environmental audits are carried out annually. • Matrons to monitor through rounds, Domestic Service review meetings.	ICT/Ward/Department Managers/Audit Dept SWF/Matrons	Ongoing	Ongoing
Risk April 08	Environmental issues are not identified and appropriate action taken	Likelihood = 2 Severity = 2	4	Yellow (medium)
Hand Hygiene audits Ensure that hand hygiene practice is maintained.	• Ensure hand hygiene audits are carried out according to audit programme and identified actions are implemented.	ICT/Ward/Department Managers	Ongoing	Ongoing
Risk April 08	Hand Hygiene practice is not maintained resulting in increased cross infection	Likelihood = 2 Severity =3	6	Yellow (medium)
MRSA Screening Compliance with Health Act requirements for MRSA screening.	• Ensure MRSA screening of all elective admissions starts.	ICT	From March 09	110% compliance
Risk April 08	Potential for sanctions if the Trust does not comply with the requirements of the health act.	Likelihood = 0 Severity = 4	0	Green (low)
MRSA Bacteraemias Improve MRSA bacteraemia rates though identification of root causes, corrective action and sharing of learning.	• Ensure timescales for RCA reporting are met and corrective actions/learning shared across Divisions. • Report root causes and action to Governance Committee and Trust Board.	Infection Control Leads. DIPC	Ongoing Ongoing	Ongoing Ongoing
Risk April 08	Bacteraemia rates will not improve resulting in adverse patient outcomes and scrutiny of the Trust by DH, SHA etc	Likelihood = 0 Severity = 4	0	Green (low)
Reduce IV line-associated infections.	• Formal training on peripheral line insertion and ongoing management as part of project funded by SHA.	DIPC	To start May-June 08	Completed
	• Central Line Packs to be issued.	BCh/ICT	July 08	Delay

Objectives	Actions	Lead	Timescales	Status April 09
	• Identify central lines placed in less than ideal situations.	ICT	July 08	✓
	• Baseline monitoring of line infections.	DIPC	April 08	✓
	• Monthly monitoring of peripheral line infections.	DIPC	Ongoing	Ongoing
Risk April 08	IV line associated infections will not reduce resulting in increase risk of litigation, scrutiny by DH, SHA etc.	Likelihood = 0 Severity = 3	0	Green (low)
Reduce needle stick injuries	Introduce safety cannulae across Trust.	OH/BCh/DIPC	Trialled from Feb 08	Preferred Product chosen
Risk April 08	Needle stick injuries will not reduce resulting in continuing risk of infection to staff and litigation for the Trust	Likelihood = 1 Severity = 2	2	Green (low)

Objectives	Actions	Lead	Timescales	Status April 09
Continue to make progress with:				
Development of Link Practitioner Programme	• Continue to develop this Trust-wide. • Continue to build on existing programme incorporating new initiatives as required.	HB/LA	Ongoing	Ongoing
Risk April 08	Link Practitioners will not be adequately supported/developed to undertake the role.	Likelihood = 1 Severity = 3	6	Green (low)
Hand Hygiene	• Monitor results of Patient Experience Tracker System • Continue with 'Clean your hands' campaign • Sign up to the WHO Global Campaign • Ensure clinical staff comply with 'Bare below the Elbows'.		Ongoing May 08	Ongoing Trust has signed up to this
Risk April 08	Risk of cross infection if staff do not comply with hand hygiene initiatives	Likelihood = 2 Severity = 3	6	Yellow (medium)
Emergency Planning	Participate in Trust's emergency planning Specifically for: • Pandemic Influenza (All relevant staff should undergo fit-testing of recommended masks) • Deliberate release – CBRN	KC	Ongoing	Ongoing
Risk April 08	Trust will not be adequately prepared	Likelihood = 2 Severity = 3	6	Yellow (medium)
Building development and Cleaning issues	• Continue input into building developments and refurbishments • Annual Joint Reviews with Contractors • Annual cleaning update	ICT IG IG	Ongoing Sept 08 Sept 08	Ongoing To be set-up Awaited
Risk April 08	Buildings will not be built, maintained and cleaned to facilitate good infection control practice	Likelihood = 2 Severity = 2	4	Yellow (medium)

Objectives	Actions	Lead	Timescales	Status April 09
Reactive, core clinical roles	Clinical advice/support to all areas: • Management of infectious patients • Investigation of outbreaks and clusters	ICT	Ongoing	Ongoing
Risk April 08	Advice and support not given to clinical areas resulting in inappropriate management and the spread of infection	Likelihood = 1 Severity = 3	3	Green (low)
Standards for better health	To ensure compliance with S4BH C4a is maintained. Evidence to support compliance with C4a and the Health Act is identifiable and readily available	CG/ICT	Ongoing	Ongoing
Risk April 08	Trust cannot provide adequate assurance of basic standards resulting in poor annual health check, adverse media attention and risk visits by the HCC	Likelihood = 1 Severity = 4	8	Yellow (medium)
Development of Trust's Web-site	This will be developed to include information on Infection Control	JB	From June 08	Trust's website is now live
Risk April 08	Inability to be able to provide patients and the public with information on infection control as required in the heath act	Likelihood = 1 Severity = 4	4	Yellow (medium)
Ensuring that all employees adhere to their responsibilities in relation to Infection Control	IC will be included in all appraisals and PDPs	SH	To be developed	To be developed
Risk April 08	Inability to demonstrate compliance with the requirements of the health act in respect of performance and development of staff	Likelihood = 3 Severity = 3	9	Amber (high)

Key to Leads:

JOD	Dr Jean O'Driscoll, DIPC	NH	Nick Hulme	BCh	Bob Chevin
JB	Juliet Brown	CG	Catherine Greaves	HB	Helen Bosley
SK	Sam Knollys	SW-F	Sarah Watson-Fisher	IG	Ian Garlington
EH	Liz Hollman	GL	Dr Graz Luzzi	SH	Sandra Hatton
KC	Dr Kathy Cann	DW	Dr David Waghorn	ICT	Infection Control Team
FS	Fiona Simpson	BC	Breda Cronnolly	OH	Occupational Health

APPENDIX A

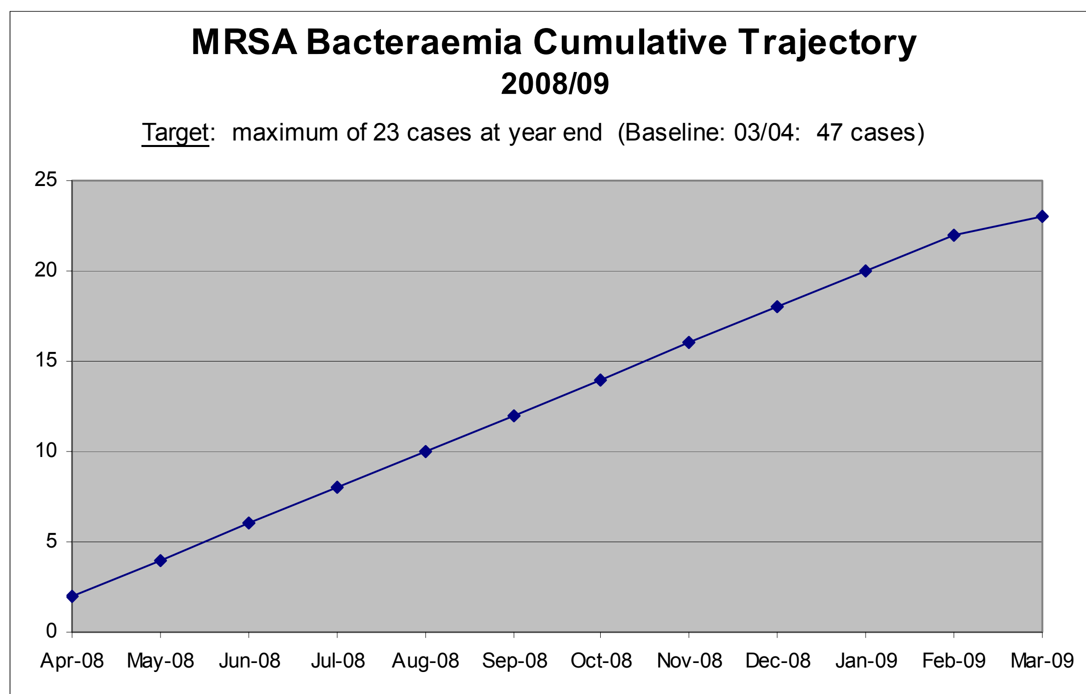
MRSA BACTERAEMIA TRAJECTORY
APRIL 2008 – MARCH 2009

Target for total number of cases by March 2009: 23

Monthly Target for Trust:

April 08	May 08	June 08	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan09	Feb 09	Mar 09	TOTAL 08/09
2	2	2	2	2	2	2	2	2	2	2	1	**23**

Cumulative Trajectory:



APPENDIX B

Cleanliness and Healthcare Associated Infections

Buckinghamshire Hospitals NHS Trust

	2008									**2009**			**2008/09 Total**
	Apr 08	May 08	June 08	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	
Number of *Clostridium difficile* infections for patients aged 2 or more	13	11	10	10	10	10	10	10	10	12	12	12	130

APPENDIX C

Service Delivery Unit Infection Prevention Performance Monitoring 2008 - 2009

SDU: Acute Medicine

	Measure	Target		Example	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
1	Red Risks to Infection Prevention and Control on risk register (Governance Lead)	0	Green 0 Amber 1 Red 2	1												
2	Hand Hygiene Audits (audit reports distriubted by ICT)	100%	Green ≥90% Amber 70-89% Red <70%	85%												
3	New Cases of MRSA Bacteraemia (Goverance Lead)	0	Green 0 Red ≥1	0												
4	Root Cause Analysis undertaken and form returned within 5 days MRSA RCA (Goverance Lead)	100%	Green 100% Amber 90-99% Red <90%	95%												
5	New Cases of Cat 1 and 2 Clostridium Difficile* (Goverance Lead)	0	Green 0 Amber >4 Red ≥6	0												

1 **Probable BHT acquired**: patients will have been inpatients >72 hours at a BHT site before onset of symptoms/ diagnosis OR have been in patients in a BHT site within 72 hours of onset/diagnosis

2 **BHT associated acquisition**: patients have been inpatients <72 hours or in a community setting AND have been BHT inpatient >72 hours ago and < 3 months ago.

Revised Audit Programme 2008/2009

Month	Audit Details	Undertaken by
March & April 2008	ICNA Management of Patient Equipment Audit	ICN
	Kitchen	Housekeeper/ICN
April 2008	HII – Reducing the Risk of Microbial Contamination Audit	ICLP
	MRSA Screening Criteria Audit	IC Project Nurse & ICNs
May 2008	Hand Hygiene Observational Audit including Phlebotomists **Medical Division**	Ward Managers/Modern matrons/ICLPs
	HII - Urinary Catheter Care Audit (insertion & ongoing management) **ITU, Spinal, Urology, Theatres**	Ward Managers/ICLPs
	HII – Care Bundle for Ventilated Patients **ITU & Spinal**	Ward Managers/ICLP
June 2008	HII Peripheral IV Lines Audit Outbreak Policy Audit	Ward Managers/ICLP DIPC/ICT
July 2008	Hand Hygiene Observational Audit including Phlebotomists **NSIC & Clinical Support Services**	Ward Managers/Modern matrons/ICLPs
August 2008		
September 2008	Sharps Audit	Frontier
	Hand Hygiene Observational Audit including Phlebotomists **Women & Children**	Ward Managers/Modern matrons/ICLPs
	Infection control Knowledge Survey	Clinical Audit/ICNs
	IC *Clostridium difficile* Policy Audit	F1/ICT
October 2008	Environmental Audits (over 2 months)	Ward Managers/ICLP
	HII – Surgical Site Infection	Theatres & ICN
	HII – Central Line Venous Catheter Care ongoing management **ITU**	Ward Managers/ICLP
November 2008	Environmental Audits continue	Ward Managers/ICLP
	Isolation Policy Audit	ICT
	IC MRSA Policy Audit	F1/ICT
December 2008/ January 2009		
February 2009	Hand Hygiene Observational Audit Including Phlebotomists **Surgical Division**	Ward Managers/MM/ICLP
March 2009	Transfer Form Audit	ICT
	Management of Patient Equipment & Kitchen Audit (over 2 months)	ICT

The aim is to provide a focus on elements of the care process and a method for measuring the implementation of policies and procedures. The Central Line Insertion Audit will be ongoing and included in the Central Line Insertion Packs when introduced.

NB Programme subject to change if new or re-audits are required

Appendix 3 INFECTION PREVENTION AND CONTROL PROGRAMME 2009/2010

1. Summary:

The Infection Prevention and Control Annual Programme will clearly define the priorities for the Trust in relation to infection prevention and control activities as agreed by the Trust Infection Control Committee (ICC) which will also monitor the progress.

2. Aim of the Buckinghamshire Hospitals NHS Trust Infection Control Programme

To reduce preventable healthcare-associated infections within the activity of BH NHS Trust by a process of:

- Surveillance / Reporting
- Development, review and implementation of Infection Control Policies.
- Education / Training for clinical and support staff
- Audit of infection prevention and control practice
- Implementation of Saving Lives High Impact Interventions.
- Maintenance of the expertise of Infection Control specialist staff who will provide guidance on Infection Control measures
- Promotional Campaigns
- Response to local / regional / national initiatives
- Research
- Compliance with the Code of Practice for Prevention and Control of Healthcare Associated Infections.

The programme has been risk assessed using the Trusts risk matrix. The risk of not completing the actions identified is stated and then scored. The severity of the risk will always remain the same. The likelihood of the risk occurring is stated as it is at the current time (refer to date given). When the programme is reviewed at each ICC the likelihood of that risk occurring will also be reviewed and adjusted accordingly. It is expected that all stakeholders will work through the aspects of the programme that requires their input in order to keep the associated risk to a minimum. The aim of risk assessing the programme is to enable the Trust to easily identify priorities if the need arises.

3. Identified targets for the Trust

- Reduction of MRSA bacteraemias to no more than 14 cases by 31 March 2009 (SHA target). Trajectory illustrated in Appendix A.
- Reduction in rates of *Clostridium difficile* (SHA target). Appendix B.

4. Identified targets for Divisions and Service Delivery Units (SDUs)

- Annual Infection Control environmental audits by wards and departments: 100% of wards to achieve at least 85% compliance.
- Monthly reporting of:
  - Hospital acquired infections (MRSA and C. difficile)
  - Infection prevention and control training

*Green = completed
Amber = in progress no obstacles to progress
Red = not started or obstacles to progress.

- Annual reporting of:
  - Hand hygiene compliance
- Identification and management of Red Risks related to Infection Prevention and Control on risk registers
- Root Cause Analysis of MRSA Bacteraemias undertaken and forms returned within 5 working days of notification of Bacteraemia
- Implementation of the Saving Lives High Impact Interventions
- Appropriate use of antibiotics

5. The Infection Prevention and Control Programme 2009/10 has been developed using the following Department of Health guidance.

- Winning Ways: working together to reduce Healthcare Associated Infection in England December 2003
- Saving Lives: a delivery programme to reduce Healthcare Associated Infection including MRSA June 2005
- NHSLA Standards
- Standards for Better Health
- Code of Practice for Infection Prevention and Control (Health Act October 2006 updated January 08 – replaced by Health and Social Care Act 2008)
- Clean, Safe Care – January 08

The purpose of this programme is to identify all key work streams required to ensure all appropriate actions are being taken by Buckinghamshire Hospitals NHS Trust to minimise the risk of hospital acquired infections.

Trust Board

Objectives	Actions	Lead	Timescales	Update
Board takes an active part in ensuring that Trust-acquired infections are reduced to a minimum.	• The Board will receive Infection Control updates at each Public Meeting.	DIPC	Bimonthly	
	• The Board will receive the Annual Report.	DIPC	July 09	
	• The Board will receive regular Reports from Divisions.	DIPC	Ongoing	
	• The Board's Communication Strategy will include the need to inform patients and the public on matters relating to IC.	JB/SK	July 09	
	• Ensure IPC is incorporated into all Executive Director job descriptions, with identified outcome measures.	SH	Ongoing	
RAG rating* April 09				Amber

*Green = completed
Amber = in progress no obstacles to progress
Red = not started or obstacles to progress.

Divisions

Objectives	Actions	Lead	Timescales	Update
To ensure that reduction of Trust-acquired infections are a priority for Divisions and SDUs.	• IC information will be publicly displayed on wards including C diff numbers, MRSA numbers and compliance with hand hygiene and Saving Lives audits.	ICLPs	Monthly from May 09	
	• Each SDU will table an Infection Report update at Infection Control Lead Meetings.	SDU Infection Control Leads	Bimonthly	
	• SDUs will partake in the Infection Prevention Performance Monitoring (Appendix C).	SDU Infection Control Leads	Ongoing	
	• IC risks are fed into SDU/Divisional Risk Registers and reviewed monthly.	EH	Ongoing	
	• Lessons from IC SUIs reviewed regularly and acted upon.	Divisional Chairs and Lead Nurses	Ongoing	
RAG rating* April 09				Amber

Infection Control Team in liaison with others

Objectives	Actions	Lead	Timescales	Update
Surveillance Prompt action is taken when required following feedback of surveillance data.	Continue mandatory surveillance of: • MRSA Bacteraemias • C. difficile • Glycopeptide resistant enterococci • Orthopaedic surgery wound infections. (formerly NINSS) Continue voluntary surveillance: • C. difficile (weekly reporting) • MRSA (non-Bacteraemias) • ESBL • Multi-resistant Acinetobacter baumannii • Commence voluntary surveillance of blood culture contamination Other ad-hoc surveillance	KC/ICT DIPC	Ongoing Monthly from April 09	
RAG rating* April 09				Green

Objectives	Actions	Lead	Timescales	Update
Education Ensure that all Trust employees have a programme of education and training on the prevention and control of infection in order to understand their responsibility for infection control and the actions they must personally take.	• Ensure that all employees (including locum bank staff and contractors) receive infection control induction training at commencement of employment.	Divisional Managers	Ongoing	
	• Ensure that all the above receive annual updates in infection control including hand hygiene competency assessment.	Divisional Managers	Ongoing	
	• Embed e-learning as a modality for annual updates.	FS/JOD	Oct 09	
	• Ensure all relevant staff receive training in aseptic techniques and are assessed as competent.	SW-F/GL	Ongoing	
RAG rating* April 09				Amber
Decontamination There are effective arrangements for the appropriate decontamination of instruments and other equipment	• Ensure Decontamination Programme is drawn up which quality assures Trust's decontamination process – achieved through Decontamination Committee. Specifically to: iv) Audit Decontamination policy and practices – including training of staff. v) Ensure compliance with HTM2030 and other relevant HTM documents. vi) Implement any relevant new guidance. • Make recommendations about purchase of new equipment and changes to operating environment.	IG	April 09 and ongoing	
RAG rating* April 09				Amber
Policies The Trust has appropriate policies in place in relation to preventing and controlling the	• Circulate updated policies to ICT • Policies ratified by ICC	CG	Ongoing	

*Green = completed
Amber = in progress no obstacles to progress
Red = not started or obstacles to progress.

Objectives	Actions	Lead	Timescales	Update

risks of HCAIs.	• New policies to be written
	  ○ Microbiology Lab protocol for investigation of HCAI and surveillance
	  ○ Blood Culture Guidance
	
	• Policies to be revised:
	As required per rolling programme
		ICT
		
		ICT
		ICT
			April 09
			
			As required	

RAG rating* April 09				Green
Audit of Policies Compliance with key policies is ensured through the implementation of high impact interventions and monitored through audit.	Policies to be audited • MRSA • C. difficile	ICT ICT	Nov 09 Sept 09	
Assess standards of practice through audit of High Impact Interventions.	See separate Audit Programme (Appendix D)	GC	Ongoing	
RAG rating* April 09				Green
Antibiotic Prescribing Minimise antibiotic resistance by appropriate prescribing.	• Antibiotic Review Group to continue to update and merge relevant guidelines. • Audits of antibiotic prescribing to be undertaken regularly and results acted upon. • Monthly update of antibiotic usage graphs with feedback of unusual/inappropriate prescribing to Division.	DW DW/BC BC/DIPC	Ongoing Ongoing Ongoing	
	• Ensure education on antibiotic prescribing to all doctors as required by national guidelines.	DIPC	Ongoing	
RAG rating* April 09				Amber
Environmental audits Ensure environmental	• Ensure environmental audits are carried out annually. • Matrons to monitor through rounds, Domestic Service	ICT/Ward/Department	Ongoing	

*Green = completed
Amber = in progress no obstacles to progress
Red = not started or obstacles to progress.

Objectives	Actions	Lead	Timescales	Update
standards are maintained.	review meetings.	Managers/Audit Dept SWF/Matrons		
RAG rating* April 09				Amber
Hand Hygiene audits Ensure that hand hygiene practice is maintained.	• Ensure hand hygiene audits are carried out according to audit programme and identified actions are implemented.	ICT/Ward/Department Managers	Ongoing	
RAG rating* April 09				Amber
MRSA Screening Compliance with Health Act requirements for MRSA screening.	• Ensure MRSA screening of all elective admissions. • Develop a programme of MRSA screening of all emergency admissions.	ICT	From April 09 From Oct 09	
RAG rating* April 09				Amber
MRSA Bacteraemias Improve MRSA bacteraemia rates though identification of root causes, corrective action and sharing of learning.	• Ensure timescales for RCA reporting are met and corrective actions/learning shared across Divisions. • Report root causes and action to Governance Committee and Trust Board.	Infection Control Leads. DIPC	Ongoing Ongoing	
RAG rating* April 09				Green
Reduce IV line-associated infections.	• Formal training on peripheral line insertion and ongoing management.	DIPC	Ongoing	
	• Central Line Packs to be issued.	BCh/ICT	April 09	
	• Monitoring of central line infections.	DIPC	Ongoing	
	• Monthly monitoring of peripheral line infections.	DIPC	Ongoing	
RAG rating* April 09				Amber
Reduce needle stick injuries	Audit NSIs, identify preventable causes and take appropriate action.		April 09	
RAG rating* April 09				Amber
Continue to make progress with:				

*Green = completed
Amber = in progress no obstacles to progress
Red = not started or obstacles to progress.

Objectives	Actions	Lead	Timescales	Update
Development of Link Practitioner Programme	• Continue to build on existing programme incorporating new initiatives as required.	LA	Ongoing	
RAG rating* April 09				Green
Hand Hygiene	• Monitor results of Patient Experience Tracker System • Continue with 'Clean your hands' campaign • Ensure clinical staff comply with 'Bare below the Elbows' • Focus on patient and visitor hand hygiene	ICT	Ongoing Ongoing	
RAG rating* April 09				Green
Emergency Planning	Participate in Trust's emergency planning Specifically for: • Pandemic Influenza (All relevant staff should undergo fit-testing of recommended masks) • Deliberate release – CBRN	KC	Ongoing	
RAG rating* April 09				Amber
Building development and Cleaning issues	• Ensure a cleaning strategy exists that is regularly monitored by the Board • Continue input into building developments and refurbishments • Check that Legionella Risk Assessments are carried out Trust-wide and any identified remedial actions required carried out • Annual Joint Reviews with Contractors • Annual cleaning update • Minutes of Domestic Review Group to go to ICC • Check there is an annual planned programme of operating theatre engineering checks	IG ICT IG/AM IG IG IG/AM	Ongoing Ongoing April 09 Sept 09 Sept 09 From April 09 April 09	
RAG rating* April 09				Amber

*Green = completed
Amber = in progress no obstacles to progress
Red = not started or obstacles to progress.

Objectives	Actions	Lead	Timescales	Update
Reactive, core clinical roles	Clinical advice/support to all areas: • Management of infectious patients • Investigation of outbreaks and clusters	ICT	Ongoing	
RAG rating* April 09				Green
Standards for better health	To ensure compliance with S4BH C4a is maintained. Evidence to support compliance with C4a and the Health Act is identifiable and readily available	CG/ICT	Ongoing	
RAG rating* April 09				Amber
Development of Trust's Web-site	This will be developed further	JB	Ongoing	
RAG rating* April 09				Green
Ensuring that all employees adhere to their responsibilities in relation to Infection Control	IC will be included in all appraisals and PDPs	SH	To be developed	
RAG rating* April 09				Amber

Key to Leads:

JOD	Dr Jean O'Driscoll, DIPC	NH	Nick Hulme	BCh	Bob Chevin
JB	Juliet Brown	CG	Catherine Greaves	AM	Anne Maguire
SK	Sam Knollys	SW-F	Sarah Watson-Fisher	IG	Ian Garlington
EH	Liz Hollman	GL	Dr Graz Luzzi	SH	Sandra Hatton
KC	Dr Kathy Cann	DW	Dr David Waghorn	ICT	Infection Control Team
FS	Fiona Simpson	BC	Breda Cronnolly	OH	Occupational Health

*Green = completed
Amber = in progress no obstacles to progress
Red = not started or obstacles to progress.

Appendix D

Audit Programme 2009/10		
Month	**Audit details**	**Undertaken by**
April	ICNA Management of Patient Equipment Audit (over 2 months)	ICN
	Kitchen	Housekeeper
	Hand Hygiene Observational Audit including Phlebotomists	Ward Managers/Modern matrons/ICLPs
May	ICNA Management of Patient Equipment Audit (cont'd)	ICN
	HII - Urinary Catheter Care Audit (insertion & ongoing management) **ITU, Spinal, Urology & Theatres**	Ward managers/ICLPs
	HII – Care Bundle for Ventilated Patients **ITU & Spinal**	Ward Managers/ICLPs
	Hand Hygiene Observational Audit including Phlebotomists	Ward Managers/Modern matrons/ICLPs
June	VIP Audit	Ward Managers/Modern matrons/ICLPs
	HII – Peripheral Line Audit	Ward manager/ICLP
	Hand Hygiene Observational Audit including Phlebotomists	Ward Managers/Modern Matrons/ICLPs
	Outbreak Policy Audit	DIPC/ICT
July	Hand Hygiene Observational Audit including Phlebotomists	Ward Managers/Modern matrons/ICLPs
August	Hand Hygiene Observational Audit including Phlebotomists	Ward Managers/Modern matrons/ICLPs
September	Infection Control Knowledge Survey	Clinical Audit/ICNs
	IC *Clostridium Difficile* Policy Audit	F1/ICT
	Hand Hygiene Observational Audit including Phlebotomists	Ward Managers/Modern matrons/ICLPs
October	Environmental Audits (over 2 months)	Ward Managers/ICLPs
	Hand Hygiene Observational Audit including Phlebotomists	Ward Managers/Modern matrons/ICLPs
	HII – Surgical Site Infection	Theatres & ICN
	HII – Central Line Venous Catheter Care ongoing management **ITU**	Ward Managers/ICLPs

November	Isolation Policy Audit	ICT
	Hand Hygiene Observational Audit including Phlebotomists	Ward Managers/Modern matrons/ICLPs
	IC MRSA Policy Audit	F1/ICT
	Environmental Audits (cont'd)	Ward Managers/ICLPs
December	Hand Hygiene Observational Audit including Phlebotomists	Ward Managers/Modern matrons/ICLPs
January 2010	Hand Hygiene Observational Audit Including Phlebotomists	Ward Managers/Modern matrons/ICLPs
February	Hand Hygiene Observational Audit Including Phlebotomists	Ward Managers/Modern matrons/ICLPs
March	Hand Hygiene Observational Audit Including Phlebotomists	Ward Managers/Modern matrons/ICLPs
	Transfer Form Audit	ICT

The aim is to provide a focus on elements of the care process and a method for measuring the implementation of policies and procedures.
NB Programme subject to change if new or re-audits are required.

Appendix 4 SURVEILLANCE DATA

DEFINITIONS OF HEALTH CARE ASSOCIATED INFECTIONS

MRSA Non Bacteraemias

Case definitions

1. **Probable BHT acquired**: BHT inpatients > 48hrs before diagnosis or inpatient at a BHT site within 48hrs of the diagnosis.

2. **BHT associated acquisition**: patients who have been inpatients <48hrs or in a community setting AND have been BHT inpatients or regularly attend BHT for therapeutic interventions >48hrs and <3 months ago.

3. **Non BHT acquired:**
   a) **home** : BHT inpatient < 48 hrs but resident in own home
   b) **nursing home /residential home** BHT inpatient <48 hrs but resident in nursing/residential home
   c) **community hospital**: BHT inpatients < 48hrs but resident in a community hospital and have not had an IP episode anywhere in the last 3 months.
   d) **other acute Trust**: BHT inpatients <48hrs and transferred from another acute Trust or had an IP episode in the other acute Trust in the last 3 months.
   e) **another country**: BHT inpatients < 48hrs and transferred form another country or have been an IP in another country in the last 3 months
   f) **private hospital**: BHT inpatients <72hours and transferred form a private hospital or been an inpatient in a private hospital in the last 3 months

MRSA Bacteraemias

Case definitions

1. **BHT -** Bacteraemia acquired during hospitalisation which was not present or incubating at the time of admission and was identified 48 hours or more after admission

2. **BHT- associated**:- Bacteraemia in outpatients
   OR Bacteraemia within 48hours of admission in patients who regularly attend BHT for therapeutic interventions e.g. haematology/renal.
   OR Bacteraemia occurring within 48hours of admission in patients admitted from the community who have been discharged from BHT within the past 90 days

3 **Community**
   a) **Home** Bacteraemia detected within 48 hours of admission in patients admitted from own home and no hospital stay in previous 90 days.
   b) **Nursing / residential home** Bacteraemia detected within 48 hours of admission in patients admitted from nursing/residential home and no hospital stay in previous 90 days.
   c) **Other hospital** Bacteraemia detected within 48 hours of admission in patients admitted from a hospital outside Bucks Hospitals Trust.

Clostridium Difficile

Case definitions:

1. **Probable BHT acquired**: patients will have been inpatients >72 hours at a BHT site before onset of symptoms/ diagnosis OR have been in patients in a BHT site within 72 hours of onset/diagnosis. (*If the diagnosis is confirmed on one BHT site but patient has been recently transferred (within 72hr) from another these cases must be allocated to the presumptive site of acquisition.)*

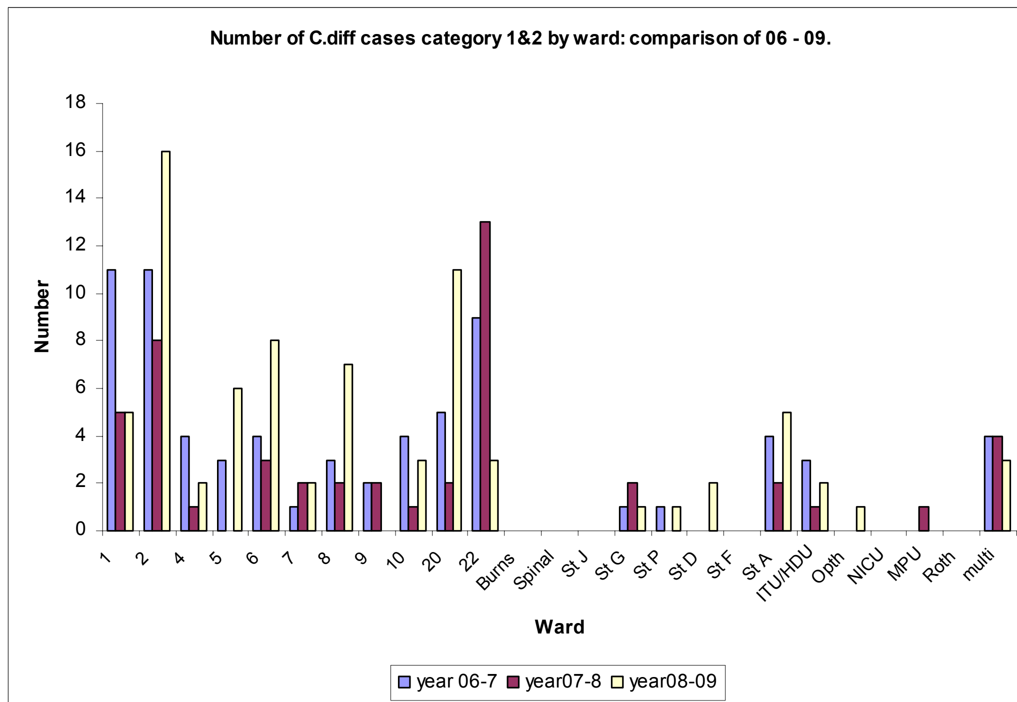
2. **BHT associated acquisition**: patients have been inpatients <72 hours or in a community setting AND have been BHT inpatient >72 hours ago and < 3 months ago.

3. **Non BHT acquired** -
   a) Home: BHT inpatients <72hours but resident in own home
   b) Nursing home/residential home: BHT inpatients <72hours but resident in a nursing home/residential home
   c) Community hospital: BHT inpatients <72hours but resident in one of the community settings listed.
   d) Other acute Trust: BHT inpatients <72hours and transferred from another acute Trust or been an inpatient at another acute Trust in the last 3 months
   e) another country: BHT inpatients <72hours and transferred form another country or been an inpatient in another country in the last 3 months
   f) private hospital: BHT inpatients <72hours and transferred form a private hospital or been an inpatient in a private hospital in the last 3 months

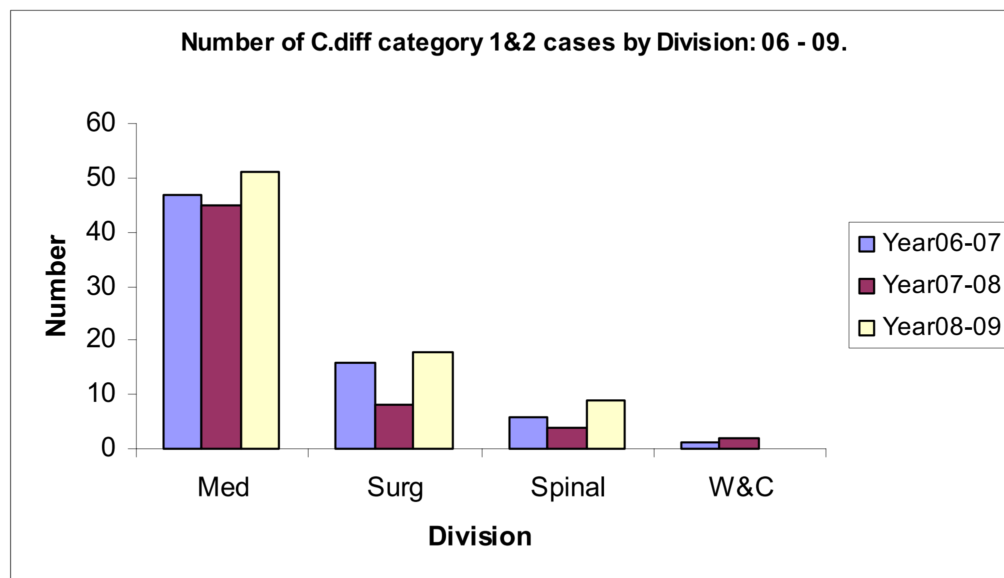
Annual MRSA /*C. difficile* surveillance data review

C.difficile SMH

Note ward 2,5,6,8,20 and ITU

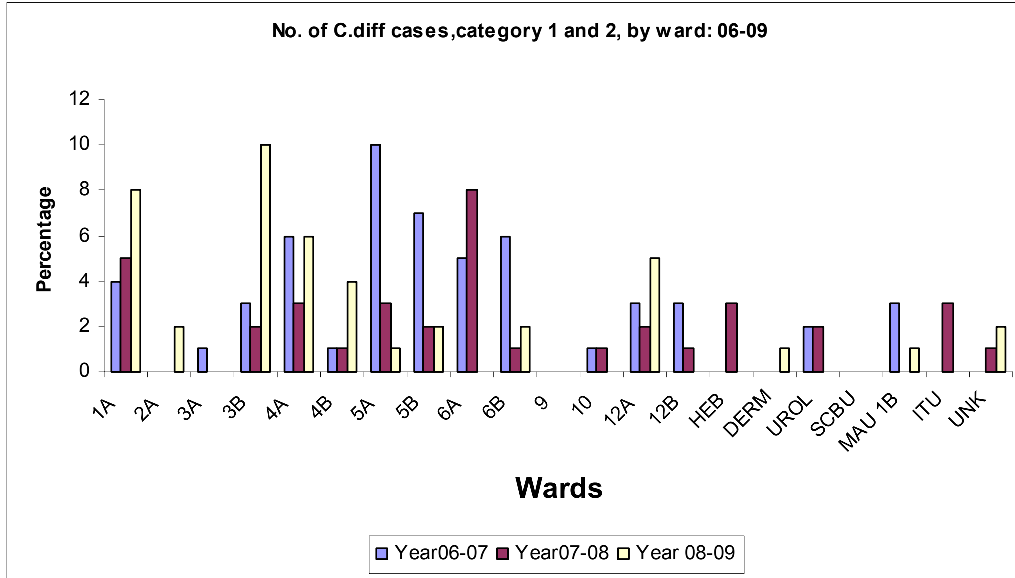


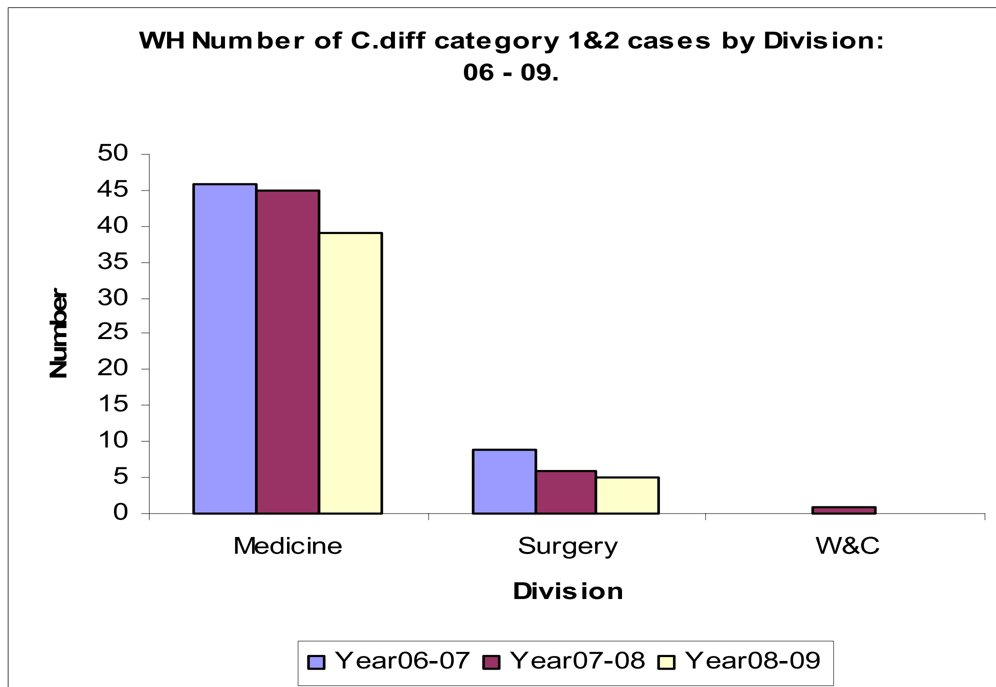
Note increase in Medicine, Surgery and Spinal



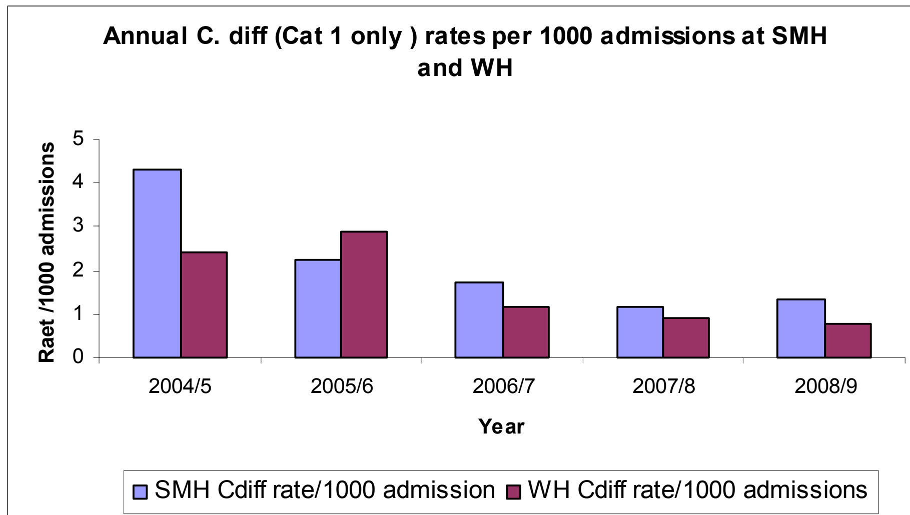
C.diff WH

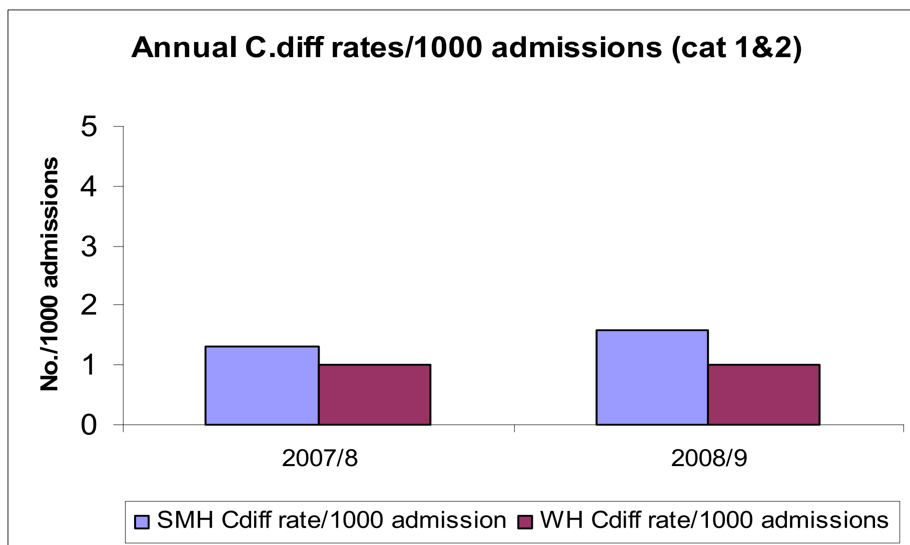
Note 1A, 3B, 12A





Annual rates *C.difficle*
Note slight increase in rate at SMH present when Cat1 and Cat1+2 are analysed



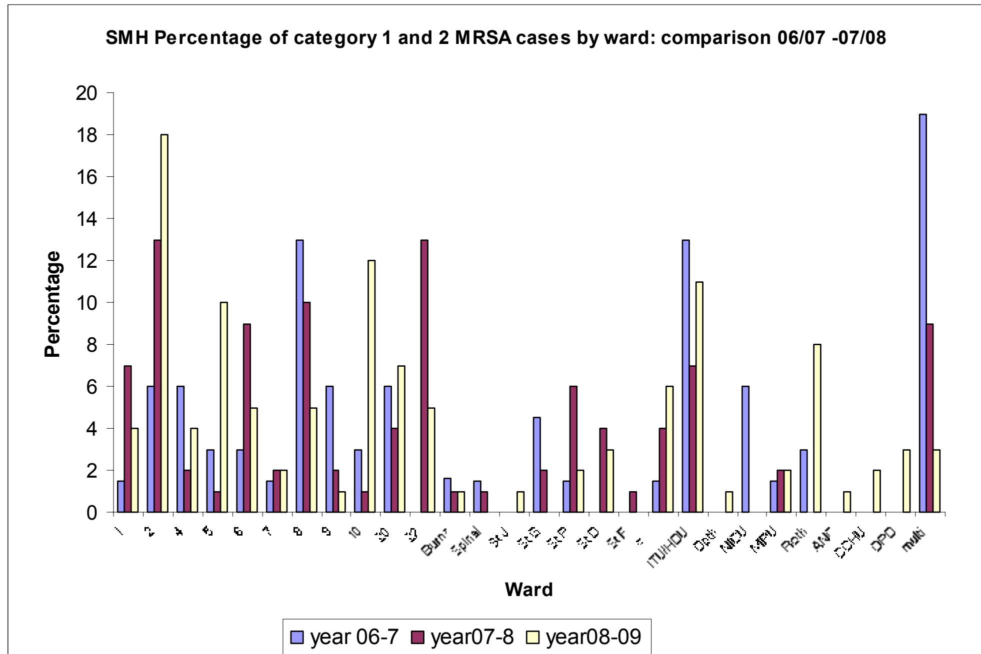


Year	SMH Admissions	WH Admissions
2006-7	41803	48246
2007-8	45121	50199
2008-9	47290	45618

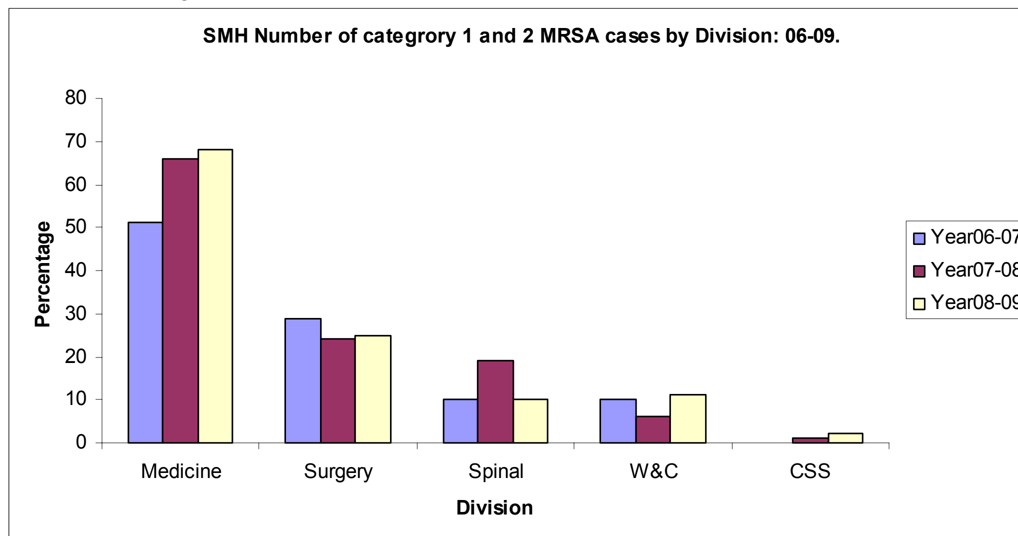
MRSA SMH

Note –

- Increase Ward 2, ITU and Rothschild
- decrease in “multiword”
- Increasing spread of locations where MRSA is identified



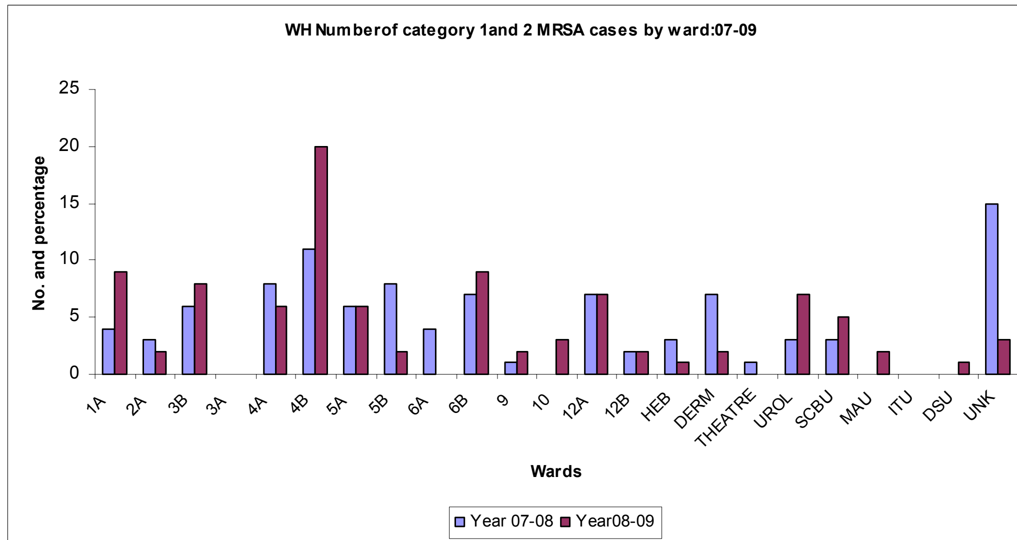
Note increasing numbers : Medicine and W&C



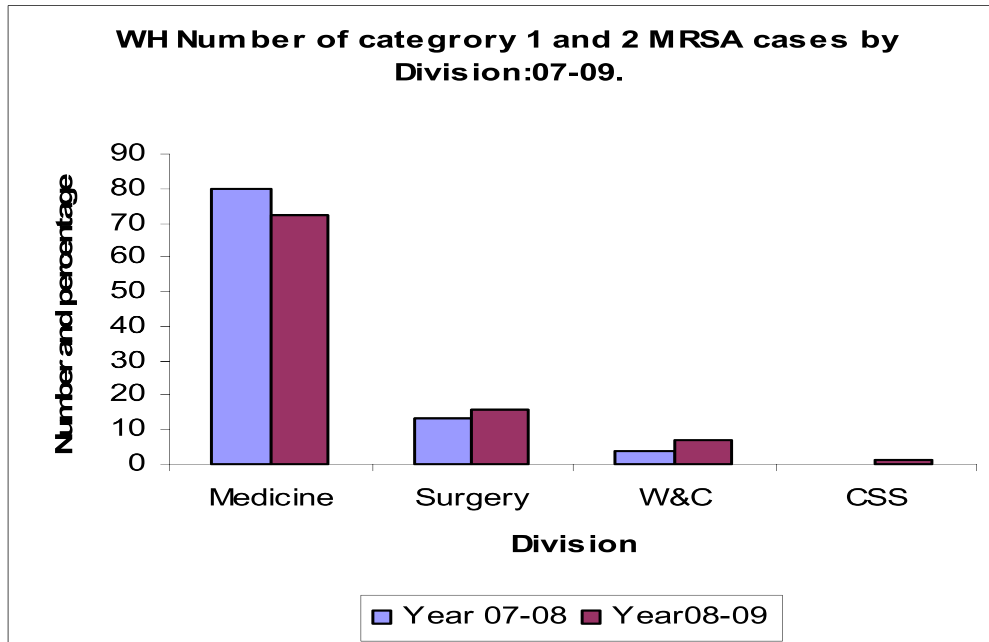
MRSA WH

Note –

- Increase in 1A, 3B, 4B, 6B, Urology and SCBU
- Decrease in unknowns
- Increasing spread of locations where MRSA is identified

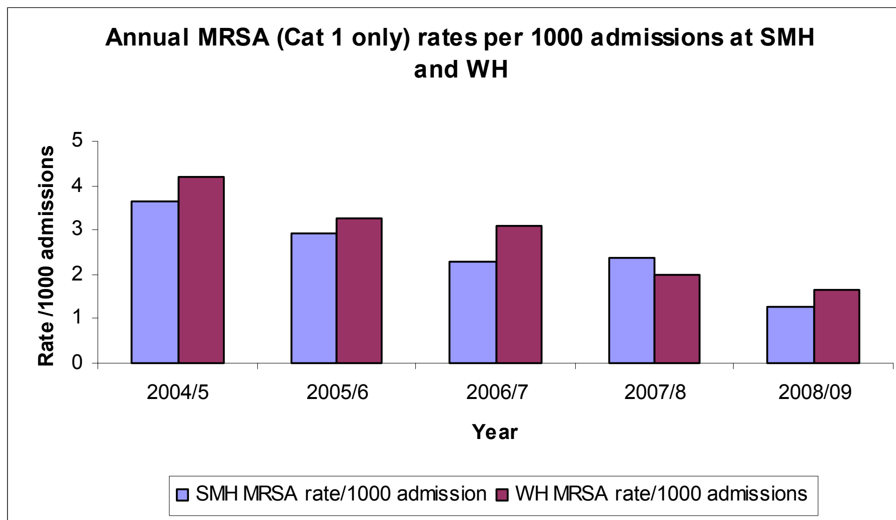


Note increase in Surgery and W&C

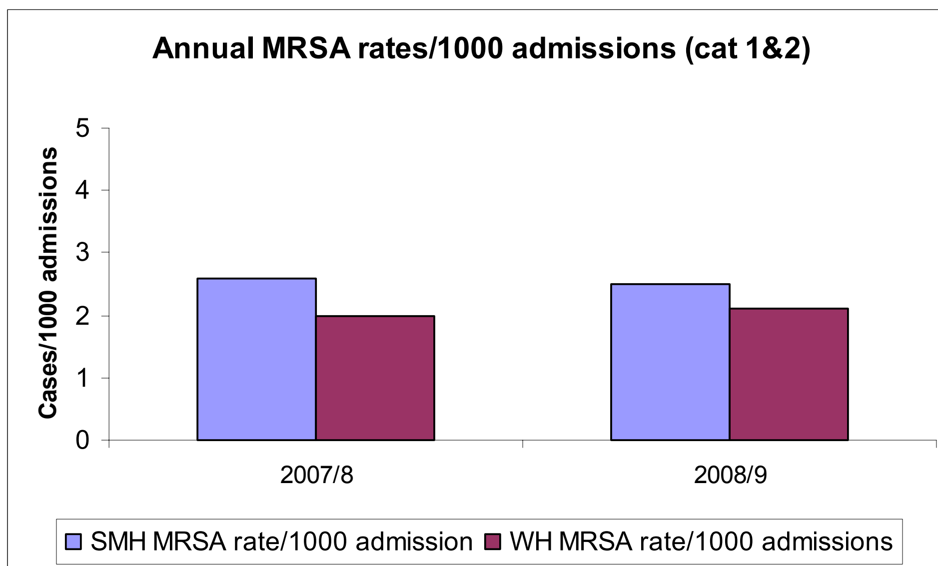


Annual rates MRSA

Rates are decreasing on both sites. The cat. 1 cases will include fewer positives from admission/preadmission screening.



No real change in MRSA rates on either site when cat. 2 cases are added.



Our decreasing / stable rates of MRSA cases implies good infection control measures in the face of increasing ascertainment (arising from more extensive screening).

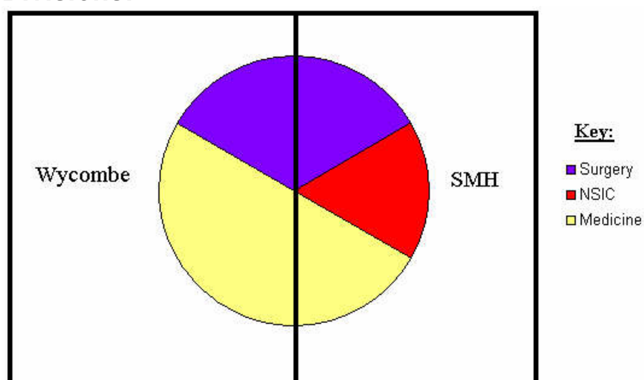
Appendix 5 – Analysis of MRSA Bacteraemias

April 2008 – March 2009: Total: 11 cases
(Same period 2007/08: 27 cases)

Pre 48-hour cases: 5

6 remaining cases;
3 SMH cases (2007: 11 cases)
3 WGH cases (2007: 6 cases)

Divisions:



3 SMH cases

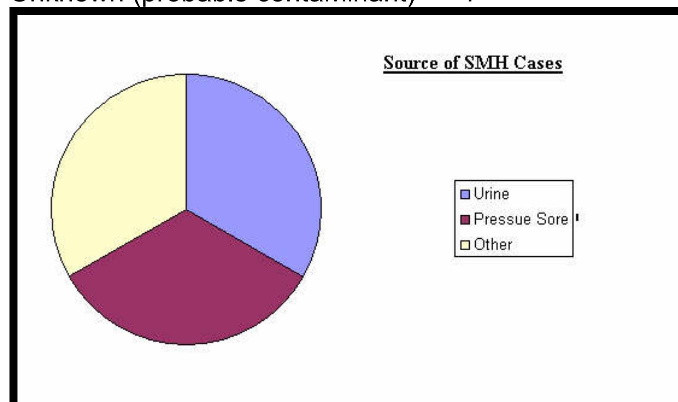
Division		SDU
Medicine	1	Medicine for Older People
Surgery	1	Orthopaedics
Spinal Injuries	1	Spinal Injuries

3 WH cases

Division		SDU
Medicine	2	Cardiology
		Medicine for Older People
Surgery	1	General Surgery

Root Causes of MRSA Bacteraemias

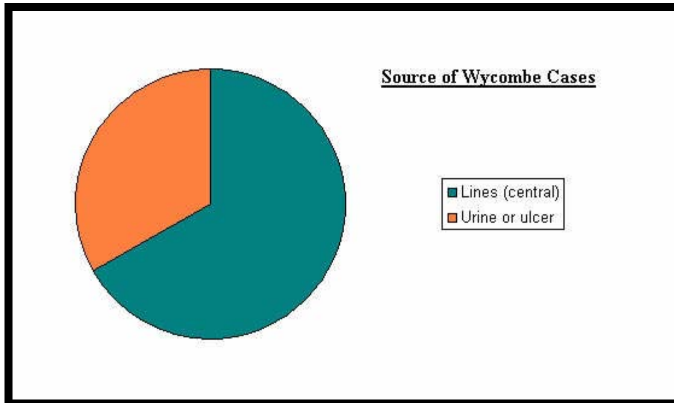
3 SMH cases
Source:
Urine (catheterised) 1
Pressure sore 1
Unknown (probable contaminant) 1



3 Wycombe cases

Source

Central intravascular line	2
Urine or leg ulcer	1



Action Plan: see over

Action Plan

Issue	What has been done since 1st April	What still needs to be done	Lead	Status March 09
Lines	Stickers have been issued to identify lines inserted in emergency situations.	• Medical and nursing staff to be reminded of the need to initiate VIP charts at insertion of all lines.	Sarah Watson-Fisher (SWF) and Graz Luzzi (GL)	✓
		• Lines to be checked at each handover of nursing staff.	SWF	✓
MRSA Suppression	Stickers have been issued to facilitate easy prescription.	Medical and nursing staff to be reminded of the need to initiate suppression as soon as the requirement is identified.	SWF/GL	✓
Blood Culture Technique	• Guidelines have been reiterated to medical staff. • Information on protocol included in Doctors' Induction Training.	• Importance of good technique to be highlighted to all relevant staff.	JOD/GL	✓
		• Documentation of blood cultures in clinical notes to be reiterated.	JOD/GL	✓
		• Poor performers to be retrained.	JOD/GL	Survey is underway
Peri-procedure MRSA cover	Appropriate cover to be given.	Highlight to all relevant staff.	JOD/GL	✓
VIP Chart for subcutaneous fluid	Protocol is being drawn up.	To be finished and issued.	Marilyn Park/SWF	Protocol completed March 09

Dr Jean O'Driscoll
Director of Infection Prevention & Control
Buckinghamshire Hospitals NHS Trust
12 May 2009

Appendix 6

Healthcare Commission

Hygiene code inspection report –
Buckinghamshire Hospitals NHS Trust

Inspections on cleanliness and infection control 2008/09

The Healthcare Commission is inspecting every hospital trust this year to check that they are following guidance on how to protect patients from infections, such as meticillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*.

Infections that develop while patients are receiving healthcare (known as healthcare associated infections or HCAI's) are one of the greatest safety issues facing the health service. To help tackle these infections, the Department of Health published a guide called The Code of Practice for the Prevention and Control of Healthcare Associated Infections in 2006. This is often called the 'hygiene code'.

The hygiene code lists the actions that NHS trusts in England must take to ensure a clean environment for the care of patients, in which the risk of infections is kept as low as possible. These actions, contained in the 11 duties of the code, cover all aspects of infection control, not only cleanliness.

For the inspection programme, we have chosen to assess a minimum of four duties of the hygiene code. Our assessors make unannounced visits, to ensure that they see the hospital as a patient or visitor would see it.

On 30 & 31 December, we visited Buckinghamshire Hospitals NHS Trust to check it was following our four duties from the hygiene code. The table below give a summary of the Healthcare Commission's findings.

Duty	Finding
Duty 2: The trust must have in place appropriate management systems for infection prevention and control	**No breach of hygiene code identified** (the trust is meeting this duty)
Duty 4: The trust must provide and maintain a clean and appropriate environment of healthcare.	**No breach of hygiene code identified** (the trust is meeting this duty)
Duty 8: The trust must provide adequate isolation facilities.	**No breach of hygiene code identified** (the trust is meeting this duty)
Sub-duty 10j: The trust must have in place an appropriate policy in relation to antimicrobial prescribing.	**No breach of hygiene code identified** (the trust is meeting this duty)

Good Practice

The Healthcare Commission has identified the following example of good practice for reducing the risks of HCAI's at Buckinghamshire Hospitals NHS Trust:

- The trust launched a project to track patients' experiences in ten clinical areas across all three sites. Patients are invited to answer five specific questions relating to key areas of practice, one of which is cleanliness. These reports are sent to the wards, where staff discuss the results and implement changes where needed.

Appendix 7

BUILDING PROJECTS

1. Endoscopy at WH – service moving within tower block – budget allocated - out to tender.
2. SMH Renal – due for completion soon.
3. Pathology/microbiology all sites – working with John Nelson in support of a Business Case looking at altering accommodation and re-providing services in a different way, rationalising across the sites.
4. Various wards at Wycombe undergoing upgrades.
5. Mandeville Wing SMH – handed over and occupied
6. SMH South Corridor emptied and all services relocated.
7. WH reception – redevelopment has started and coffee shop now open.
8. W&A – continuing to fit wall protection and advance on redecoration.
9. SMH – architect designing Burns and Plastics for tender shortly.
10. SMH - Claydon Wing – Phase 1 (Delivery Suite) handed over - phase 2 & 3 due Autumn 2009.
11. SMH A&E – creation of a Paediatrics area.
12. SMH NSIC adolescent unit – works have started to move staff around to free up an area which will then be converted to a new Adolescent Spinal unit.
13. Laparoscopic Theatre - WH – equipment being procured and final positioning to be agreed.
14. SMH – NSIC Bathrooms including ARJO Bathrooms – contract let and work starting to redevelop bathrooms on several wards.
15. WH – public toilets – design being developed to refurbish all public toilets over the whole site.
16. WH – Planning Permission being sought for an extension to the reception seating to extend the waiting area.
17. SMH – discharge lounge handed over – small finishes to be completed.
18. WH EMC – added an additional sluice room and patient toilet to allow patients in beds into the observation area.
19. WH – TWFM replacing carpet in WACU with vinyl flooring.
20. Phase 3 Theatres WH – tenders have been received to replace an existing air handling unit to increase the theatre air change rates.
21. Work has started on redeveloping the ITU/HDU's across both sites to comply with same sex requirements and work will then start in NSIC, SMH.
22. Work has started on upgrading X-Ray rooms at WH & at SMH.

Appendix 8 AUDITS ACTIVITY

Infection Control Knowledge Survey

The infection control mandatory training sessions commenced in November 2006 and were undertaken initially by an external agency – Infection Control Solutions. In July the Trust Infection Control Team took these sessions on and rewrote the programme to include local initiatives and data. At this time a non-clinical as well as a clinical session was introduced rather than a 'one size fits all' approach.

This survey was first undertaken in 2007, at that time the number of undelivered responses was high at 266, this problem was addressed and only 17 were undelivered in 2008.

Conclusions:
Although the return rate was only 39% the percentage of staff who stated that they had attended mandatory training appears greater than figures reported through the training dept. This may be a result of e-learning not being recorded in training department figures and sample bias i.e. those that responded were those that had attended training.

The following areas need to be given greater emphasis in mandatory training:

- The appropriate use of hand gel after administering an injection and when caring for MRSA positive patients.
- The wearing of nail varnish is not appropriate even if it is clear in clinical areas.
- The need to wear gloves and aprons when clearing up blood spillages.
- A copy of the infection control manual can be found in the Trust libraries and on the intranet.
- Awareness of who should be informed if an outbreak of D & V occurs, both in and out of hours, with particular emphasis on the rationale for informing Voluntary Services and Facilities and Estates.
- The need to stay off work for 48 hours after the last bout of D & V symptoms needs to be reinforced to doctors.
- Inclusion of the rationale for labelling 'high risk' blood specimens with a high risk sticker.

Following last years survey it came to light that high risk stickers were not available Trust wide. This issue needed to be dealt with as well as raising the profile of the use of the stickers.

In the 2007 report the junior doctors did not score well on attendance at infection control training this may have been because their induction was undertaken using a distance learning CD Rom. This was included as a question in the 2008 audit but not all seem to have recorded that they have completed it. Completion of the CD Rom is necessary for all junior doctors prior to commencement of employment so the figure should have been 44/44 rather than 6/44.

27% of staff (31% in 2007) did not feel that the session had changed their practice however from the comments made by staff many felt that they were already aware of what is required and that their awareness had been raised and their existing correct practice reinforced by the session.

The inclusion of 2 new questions asking whether infection control was included in appraisal and PDP (Personal Development Plan) in order to demonstrate compliance with this requirement of the Health Act 2006 showed that only 40% had it included at appraisal and 27% in their PDP. Free text comments received also highlighted more general problems with lack of appraisal and understanding of what a PDP is. These are currently being addressed by HR and Operational Management.

Following the audit in 2007 it was agreed to exclude Pathology staff for future audits with the exception of phlebotomists as they have direct patient contact, however 2 staff appear to have

been included and upon further investigation, there does not appear to have been any phlebotomists included in the original staff listing.

When reviewing many of the responses by staff group where groups did not score well it became apparent that this is because that particular practice does not form part of their daily work, thus reinforcing the need for refreshers/updates to be provided.

The infection control manual on the intranet was identified as difficult to navigate in the survey of 2007. This has been addressed as part of the Trust's review and improvement of the intranet and internet sites.

Recommendations:

- Use the results of this survey to focus the infection control mandatory training session for the coming year giving greater emphasis to the areas highlighted as having a poor understanding. These issues should also be worked into other sessions as appropriate (e.g. sessions for junior doctors and HCA induction).
- The uptake of appraisal and PDPs needs to be improved and infection control included within them.
- Review audit tool prior to reuse to incorporate any additional items.

Audit of *Clostridium difficile* Policy

The updated Trust-wide *Clostridium difficile* Policy was produced in July 2007. As required by the Health Act (2006), this was audited in November 2007 and repeated in September 2008. The audit was a retrospective study of medical notes and laboratory reports and included all inpatients (total 14 patients) where *Clostridium difficile* infection was diagnosed in July 2008.

Summary:

- There was a delay of 7 days between onset of symptoms and submission of a sample in 1 case.
- There was a delay of 2 days before a *C.difficile* positive patient was isolated in 1 case, and a delay of 1 day for another case.
- *C.difficile* Stickers were not fully completed in 7 cases (4 at SMH; 3 at WH), although these were in the notes.
- A GP discharge *C.difficile* proforma letter was not present in the notes in 1 case.
- A copy of GP *C.difficile* letter was not sent to ICT on discharge of the patient in 2 cases.
- *C.difficile* Treatment was started 1 day after diagnosis in 2 cases.
- Fluid balance charts were completed fully in 9 of 14 cases.

Good points noted included:

- 6 of the 14 patients were already in side rooms at the time of their diagnosis.
- *C.difficile* Stickers were found in the notes of 13/14 patients.
- Wards were asked to give the patients a *C.difficile* information Leaflet by the ICT in 11/14 cases.
- Stool chart was maintained in 13/14 cases.
- *C.difficile* antibiotic treatment was started on day of diagnosis in 11/14 cases.
- A GP *C.difficile* letter was sent to ICT on discharge of the patient in 2/14 cases. However 4 patients were in hospital when audit was done and 6 cases passed away while still inpatients but this was not due to C difficile infection.

Conclusions:

This audit showed an improvement in adherence to the *C.difficile* Policy across the Trust compared with the previous audit.

The introduction of *C.difficile* stickers is a definite step forward. These are placed in the notes by an Infection Control Nurse and are completed by ward staff. However, it is disappointing that 7 of 13 relevant stickers had not been filled out fully by the ward staff.

There appears to have been delays in instituting *C.difficile* treatment (however only by 1 day) in 2 patients.

Although it is encouraging that 9 of the 14 cases had fluid balance charts correctly completed, this needs to improve.

Recommendations

- All wards need to ensure that *C.difficile* stickers must be completed by ward staff as soon as possible.
- The Medical Team in charge of a newly-diagnosed patient must ensure that there are no delays in starting treatment.
- Ward staff to start a fluid balance chart for all patients with diarrhoea and complete this daily. Medical Teams need to review the charts daily and take any appropriate action to maintain fluid balance.

Audit of MRSA Policy

The updated Trust-wide MRSA Infection Control Policy was produced in July 2007. As required by the Health Act (2006), this was audited in November 2007 and repeated in January 2009 through a retrospective study of medical notes and included all new sporadic MRSA cases diagnosed in October 2008.

Conclusions:

- Of the 23 cases of MRSA diagnosed in October 2008, all 23 fulfilled admission screening criteria and were subsequently screened.
- The proportion of cases given suppression treatment was much improved (22/23) as compared to our previous audit (9/19) with minimal delay in starting therapy.
- There was poor documentation in the medical notes about the patient receiving an MRSA Leaflet.
- In only 10 cases was the giving of an Isolation Leaflet documented in the notes. Although this is not specified in the MRSA Policy, it is good practice for all isolated patients, including those in MRSA cohort bays.
- Although all cases were isolated, there were delays in isolation (>1 day from date of diagnosis) in 6 of the 18 cases at SMH; documentation of isolation in the medical notes was generally very poor.
- The screening of patients in the vicinity of an index case appeared haphazard. It is stated in the Policy that this should be done routinely.
- The labelling of patient notes with an “Alert” sticker appeared better at the 3 sites as compared to the previous audit.

Good points noted:

- The electronic patient record was flagged in all but 1 case.
- All patients were isolated.

Action Plan

Issue	Action	Who to do	Target date for completion
MRSA Sticker	1) Ensure one is affixed to the patient's notes as soon as possible.	ICN	March 09 and ongoing
	2) Ensure this is completed within 2 days of being affixed.	Ward Sister	March 09 and ongoing
Isolation	1) Isolation of patient to be documented in the patient's notes. This should include the time of notification of the need for isolation and the time the patient was isolated.	Ward Staff	March 09 and ongoing
	2) Isolation should be recorded in the ICN notes.	ICN	March 09 and ongoing
	3) Any delay in Isolation (>4 hrs) to be recorded as a Clinical Incident.	Ward Staff	March 09 and ongoing
Contact Screening	Ensure contact screening is undertaken and list of contacts documented in ICN records.	CG	March 09
Terminal cleaning of bed space	This needs to be logged by the Domestic Services Contractor and made available for inspection if required.	Brian Freeman	March 09

AUDIT OF MRSA ADMISSION SCREENING: Cycle 3 November 2008

Aim: to assess whether there has been an improvement in MRSA admission screening rates within the Trust since the previous evaluation in April 2008.

Results: The most common criterion for admission screens that were missed remains group patients hospitalised in the last 3 months. This category accounted for 58% of missed screens at SMH and 86% at WGH. Transfer from another hospital and previous history of MRSA infection/colonisation accounted for 17% of missed screens at SMH.

Conclusion: There has been a significant improvement in MRSA admission screening rates across the Trust since the 2nd cycle: 70% compared with 50% in April 2008. This improvement has occurred in parallel across the 2 sites. However, there is still room for improvement since almost a third of screens are still missed. 19% of screening swabs are received in the laboratory more than 48hours after admission - this is a combination of delays at ward level and transportation rather laboratory processing.

Recommendations

1. Move towards universal admission screening as per DH requirements[1]:
    a) all elective admissions by March 2009 - plans are in place for this – Trust wide we currently achieve 21% but wider implementation will start in Jan 2009.

b) screening of all emergency admissions as soon as possible and no later than 2011. Complex strategies aimed at multiple target groups make high uptake rates difficult to achieve. This is seen in other health policy e.g. vaccination. We are now facing a situation of diminishing returns where a large amount of effort will be required to get the screening uptake in these targeted groups over 70%. The Trust should move to universal emergency admission screening as soon as possible - other Trusts, including some of our neighbours, have already adopted this approach instead of delaying the inevitable and improving patient safety now.

2. Extend use of standardised admission documents and emphasise importance of MRSA screening section so that MRSA screening is mainstreamed into admissions process.
3. Awareness of screening criteria to be raised at Link Nurse Training and Senior Nurses meetings again.
4. ICT to continue to promote screening criteria during routine ward visits – refer to Clinical Guideline 14a and use of pocket guide for screening available from ICT.
5. SDUs and Divisions to consider audit results in their own governance meetings and devise action plans to improve uptake.
6. Improve transportation of swabs to the laboratory by regular checks at ward level that they have been collected by Porters
7. Review in 6 months or following implementation of universal emergency admission screening.

Audit of Outbreak of Infection Policy June 2008

It was decided to audit how the Trust manages Outbreaks by focusing on a Norovirus Outbreak on each site. The Stoke Mandeville Outbreak was on Ward 22 at the end of March/early April 08, and the Wycombe Outbreak was on Ward 6B in May 08.

A proforma was designed looking at compliance with each element of the Policy (Appendix 2). Both of these Norovirus Outbreaks were managed appropriately in line with the Outbreak Policy.

Recommendations:

- A notice needs to be designed to go on ward entrances at the time of bay or ward closures for suspected norovirus infection. Action: ICT
- A copy of the HPA report/Outbreak Report should be sent to the Leads in the relevant Division. Action: ICT.
- Any lessons learned should be discussed at Divisional Governance meetings. This should be documented. Action: Divisional Governance Leads

Results of Patient Equipment and Kitchen Audits March – April 2008

These audits are based on the Infection Prevention Society audit tools.

The standard for patient equipment is: There is a system in place that ensures that all reusable patient equipment decontaminated prior to re- use.

The standard for kitchens is: kitchens will be maintained to reduce the risk of cross infection in accordance with legislation.

Actions were taken to address short falls after these audits.

Division	Ward	Site	Results (%)	
			Pt Equip	Kitchen
SURGERY	6	SMH	78	65
	12A	WH	79	88
	Gynae Recovery	WH	92	N/A
	Gynae Theatres	WH	97	N/A
	Loakes Recovery	WH	100	N/A
	Main Recovery	WH	100	N/A
	Loakes Theatre	WH	93	
	New Wing Theatre	SMH	91	N/A
	Ophthalmic Theatres & Recovery	SMH	92	N/A
	Day Surgery	WH	-	86
	12B	WH	81	88
	4	SMH	85	88
	Urology	WH	89	86
	11	SMH	78	82
	7	WH	88	80
	ITU	WH		N/A
	ITU	SMH		N/A

Division	Ward	Site	Results (%)	
			Pt Equip	Kitchen
MEDICINE	A & E	SMH	69	70
	A & E	WH	97	88
	MAU	WH	98	100
	EAU	SMH	94	92
	3B	WH	85	88
	1A	WH	97	100
	SMW 20	SMH	84	92
	SMW 5	SMH	81	100
	CCU/2A	WH	97	96
	6B	WH	92	88
	4A	WH	84	85
	4B	WH	97	85
	SMW8	SMH	87	87
	SMW1	SMH	95	100
	SMW2	SMH	97	100
	5B (Stroke Unit)	WH	87	92
	Heberden	AH	83	92
	Wilkinson	AH	100	100
	Endoscopy	SMH	100	No kitchen
	Endoscopy	WH	100	No kitchen

Division	Ward	Site	Results (%)	
			Pt Equip	Kitchen
CLINICAL SUPPORT SERVICES	CCHU	SMH	100	83
	Sunrise Unit	WH	96	85
	5A	WH	98	95
	X-ray	WH	81	No kitchen

Division	Ward	Site	Results (%)	
			Pt Equip	Kitchen
ACCESS	OPD	AH	86	No kitchen
	OPD	WH	88	No kitchen
	OPD	SMH	92	No kitchen
	Dermatology OPD	AH		

Division	Ward	Site	Results (%)	
			Pt Equip	Kitchen
N S I C	St Patrick	SMH	70	64
	St David	SMH	73	53
	Spinal OPD	SMH	97	91
	St George	SMH	78	41
	St Andrews	SMH	67	33
	St Josephs	SMH	81	55
	St Francis	SMH	89	83

Division	Ward	Site	Results (%)	
			Pt Equip	Kitchen
W O M E N & C H I L D R E N	Rothschild	SMH	88	88
	Ward 10	WH	78	70
	Ward 9	WH	83	85
	SMW9	SMH	92	87
	Labour Ward	WH	89	75
	WACU	WH	90	N/A
	Delivery Suite	SMH	83	N/A
	ANC	SMH	95	N/A
	Ward 7	WH	73	N/A
	Ward 7 – Ward Kitchen	WH	N/A	79
	Ward 7 – Parents Kitchen	WH	N/A	65
	Ward 7 – Milk Kitchen	WH	N/A	61
	MacCarthy Ward (MPU)	SMH	98	92
	SCBU	WH	91	-

	SCBU – Milk kitchen	WH	N/A	86
	SCBU – Parents Kitchen	WH	N/A	65
	NICU	SMH	100	-
	NICU – Ward Kitchen	SMH	-	95
	NICU – Milk Kitchen	SMH	-	95

Results of Environmental Audit undertaken October-November 2008 by Ward Staff/Link Nurse Practitioners

Standard: The environment will be maintained appropriately to reduce the risk of cross infection.

For areas where the audit had not been undertaken these have been priorities for early this year (April 2009-March 2010).

Division	Ward	Site	Results (%)
MEDICINE	A & E	SMH	73%
	EMC (A&E)	WH	57%
	MAU	WH	92%
	EAU	SMH	88%
	3B	WH	Last ward audit undertaken 20/10/07
	1A	WH	Last ward audit undertaken 27/11/07
	SMW20	SMH	85%
	SMW22	SMH	Last ward audit undertaken 09/10/07
	CCU/2A	WH	Last ward audit undertaken 16/11/07
	6A	WH	*Ward Closed*
	6B	WH	Last ward audit undertaken 24/10/07
	4B	WH	85%
	SMW8	SMH	91% (4/1/09)
	SMW1	SMH	98%
	SMW2	SMH	88%
	5B (Stroke Unit)	WH	90%
	Drake Day Unit	WH	100%
	Heberden	AH	93%
	Wilkinson	AH	82%
	Endoscopy	SMH	98% (6/3/09)
	Endoscopy	WH	Last ward audit undertaken 15/10/07
	Day Hospital	SMH	78%
	SMW 5	SMH	95%
	4A	WH	90%

Division	Ward	Site	Results (%)
CLINICAL SUPPORT SERVICES	X-Ray-Ultrasound	SMH	88%
	X-Ray-General	SMH	86%
	X-Ray	WH	81%
	X-Ray	AH	89%
	CCHU	SMH	Last ward audit undertaken 7/2/08
	Sunrise Unit	WH	Last ward audit undertaken 3/10/07
	5A	WH	Last ward audit undertaken 13/10/07
Division	**Ward**	**Site**	**Results (%)**
ACCESS	Dermatology OPD	AH	91%
	OPD	WH	87%
	OPD	SMH	59% (1/2/09)
	OPD	AH	
Division	**Ward**	**Site**	**Results (%)**
NSIC	St Patrick	SMH	79%
	St David	SMH	92%
	Spinal OPD	SMH	79%
	St George	SMH	90%
	St Andrews	SMH	84%
	St Josephs	SMH	93%
	St Francis	SMH	93%
	Spinal Gym	SMH	70%
Division	**Ward**	**Site**	**Results (%)**
SURGERY	SMW6	SMH	98%
	12A	WH	87%
	Gynae Recovery	WH	Last ward audit undertaken 30/11/07
	Gynae Theatres	WH	62%
	Loakes Recovery	WH	72%
	Main Recovery	WH	0%
	Loakes Theatre	WH	100%
	Main Theatres	WH	96%
	New Wing Theatre	SMH	59%
	Ophthalmic OPD	SMH	52%
	Ophthalmic Theatres & Recovery	SMH	100%
	Ophthalmic Ward	SMH	94%
	DSU	SMH	86% 75% re-audit Apr 09
	Day Surgery Unit	WH	79%
	Plaster Room	WH	100%
	12B	WH	85%
	SMW4	SMH	93%

	Urology	WH	95%
	SMW11(Burns Unit)	SMH	90%
	7	WH	93%)
	ITU	WH	91%
	Pre-Op Assessment (POA)	AH	50%
	Pre-Op Assessment (POA)	SMH	89%
	Pre-Op Assessment (POA)	WH	85%
	ITU	SMH	75%
	ENT – Pre-op Assessment	WH	100%
	SAU (POD)	WH	100%
	Oral Surgery OPD	SMH	78%
	Oral Surgery	AH	93%
	SMW7(Plastics)	SMH	89%
Division	**Ward**	**Site**	**Results (%)**
WOMEN & CHILDREN	Rothschild	SMH	90%
	Ward 10	WH	Closed
	Ward 9	WH	92%
	SMW9	SMH	95%
	Labour Ward	WH	93%
	WACU (Ward 11)	WH	Last ward audit undertaken 6/11/07
	Delivery Suite	SMH	Department moved to new unit
	Antenatal/Gynae Clinic	WH	87%
	ANC	SMH	Last ward audit undertaken 28/11/07
	Ward 7	WH	93%
	Ward 3 (MPU)	SMH	100%
	SCBU	WH	55%
	NICU	SMH	89%

Hand Hygiene Observational Audit

Summary of Results:

Overall 10198 situations were observed where hand hygiene should have been performed.
1801 situations were observed where staff should have been "bare below elbows

	Hand Hygiene		Bare Below the Elbows	
Division	**Observations**	**%**	**Observations**	**%**
Medical	2564	90%	429	89%
National Spinal Injuries Centre	317 *	89%	90	92%
Women's & children's	2046	95%	344	94%
Clinical Support Services	1139	87%	213	92%
Access	169	94%	32	81%
Surgical	3773	90%	673	93%
Total 2008-2009	10198**	90%	1801	92%
Total 2007-2009	9162	90%	Not collected	

* This does not include Spinal Gym or Spinal OPD.
** This overall figure does include Spinal Gym and Spinal OPD.

Overall hand hygiene was carried out in 90% of opportunities observed during the year.

This compliance varied between doctors and nurses, with doctors performing hand hygiene in 84% cases and nurses and HCAs in 95% and 93% cases respectively. Phlebotomists recorded a compliance rate of 81% and other staff 74%.

Staff were "bare below elbows" on 92% occasions. This varied considerably between staff with doctors recording a compliance of 79%, nurses and HCAs 99%, phlebotomists 98% and other staff 91%.

Overall, hand hygiene was carried out in **90%** cases with the following staff groups demonstrating the following compliances:

- Doctors 84%
- Nurses 95%
- HCAs 93%
- Phlebotomists 81%
- Other staff 74%

"Bare below elbows" was carried out in **92%** cases with the following staff groups demonstrating the following compliances:

- Doctors 79%
- Nurses 99%
- HCAs 99%
- Phlebotomists 98%
- Other staff 91%

Results between different situations varied from 80% (After patient examination) to 99% (After handling a commode or bedpan).

Saving Lives High Impact Intervention Audits

High Impact Intervention Preventing Microbial Contamination

Observations were recorded for 770 clinical processes, compared with 1505 for the August 2007 audit and 774 for the 2006 audit.

Hand hygiene prior				Personal protective equipment				Correct aseptic technique			
No. obs	2008 %	2007 %	2006 %	No. obs	2008 %	2007 %	2006 %	No. obs	2008 %	2007 %	2006 %
759	**93%**	82%	82%	687	**96%**	87%	86%	556	**97%**	95%	91%

Safe disposal of sharps				Hand hygiene after				All applicable elements performed			
No. obs	2008 %	2007 %	2006 %	No. obs	2008 %	2007 %	2006 %	No. obs	2008 %	2007 %	2006 %
425	**99%**	97%	96%	712	**89%**	86%	83%	770	**83%**	69%	66%

Overall, the weakest element was ‘hand hygiene after’ at 89% compliance. The strongest element was ‘safe disposal of sharps’ which was carried out in 99% applicable observations. Overall, all applicable elements were performed in 83% processes.
There has been a substantial improvement in all areas since the last audit.

High Impact Intervention Care of the Ventilated patient – May 2007

Care of Ventilated Patients – Regular Observations

Audits were completed in ITU and NSIC. This audit consisted of the following 7 elements:

	Bed elevation		Sedation hold		Safe disposal		DVT prophylaxis	
	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes
TOTAL	**68**	**100 %**	**44**	**57%**	**48**	**98%**	**66**	**89%**

	GU prophylaxis		Tubing management		Humidification		All applicable elements performed	
	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes
TOTAL	**66**	**97%**	**66**	**89%**	**68**	**96%**	**68**	**62%**

Care of Ventilated Patients – Suction

Audits were completed in ITU. This audit consisted of the following 4 elements:

	Hand hygiene prior		Personal protective equipment		Safe disposal of equipment		Hand hygiene after		All applicable elements performed	
Ward	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes
TOTAL	**60**	**80%**	**43**	**100 %**	**26**	**100 %**	**60**	**85%**	**60**	**77%**

High Impact Intervention Care of the Urinary Catheterised patient May – October 2008

This audit was divided into two elements**:**

Urinary Catheter Care – Insertion

	Catheter needed?		Clean urethral meatus		Sterile drainage		Hand hygiene		Aseptic technique		All applicable elements performed	
	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes
TOTAL	**92**	**100 %**	**50**	**96%**	**91**	**100 %**	**89**	**96%**	**91**	**97%**	**92**	**95%**

Almost 100% compliance was achieved for all elements. Of the 92 cases the only exceptions were:

- The urethral meatus was not cleaned in 2 cases.
- Hand hygiene was not performed in four cases
- An aseptic technique was not used in 3 cases.

All applicable elements were performed in 95% of cases, an improvement on 2007 results of 90%.

Urinary Catheter Care – Continuing Care

	Hand hygiene		Catheter hygiene		Aseptic sampling		Drainage bag position	
Ward	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes
TOTAL	**97**	**99%**	**69**	**100 %**	**18**	**100 %**	**89**	**99%**

	Catheter manipulation		Catheter needed?		All applicable elements performed	
Ward	Appl Obs	% Yes	Appl Obs	% Yes	Appl Obs	% Yes
TOTAL	**80**	**96%**	**90**	**97%**	**97**	**92%**

Almost 100% compliance was achieved for all elements. Of the 97 cases the only exceptions were:

- Hand hygiene not performed in one case.
- The drainage bag was at floor level in one case.
- Catheter manipulation incorrect in 3 cases.
- Catheter was not needed in 3 cases.

High Impact Intervention preventing surgical site infection. October to December 2008

For this audit the following High Impact Interventions were assessed:

- Preventing Surgical Site Infection – Pre-operative Component
- Preventing Surgical Site Infection – Peri-operative Component

Pre-operative component – Data was collected from Ward 12B, Orthopaedics, at Wycombe Hospital only. An Infection Control nurse collected the information during the period of October – December 2008 resulting in 245 observations.

All patients were screened for MRSA. MRSA results were received prior to admission for all 245 patients. In this case they were not received because the patient was an emergency transfer. 3 (1%) of the 245 patients tested MRSA positive. All 3 of the MRSA positive patients received MRSA eradication therapy, which, in all cases, was successful. 3 full negative screens were obtained for all 3 patients.

There were also 4 patients with a history of MRSA, who should also have 3 negative screens. The table below shows how often this was carried out.

	3 full negative screens obtained	
	Testing positive for MRSA	**History of MRSA**
Yes	**3**	**3**
No		**1**
Total	**3**	**4**

One of the patients with a history of MRSA in 2000 did not have 3 full negative screens.

The **Peri-operative components** should have been conducted in both elective and trauma procedures, including hip hemi-arthroplasties. However, the theatres did not co-operate and no audit forms were returned for the peri-operative part of the audit.
The following recommendations have been made in light of the audit results:

HII No 3a, pre-operative component.
The pre-operative assessment should be congratulated on the positive results. These results should be disseminated to the relevant staff for discussion. The report should also be discussed at all of the relevant Clinical Governance directorate meetings.

HII No 3b, peri-operative component.
The reasons for non-compliance need to be discussed at the Clinical Governance directorate meetings and fed back to the Infection Control Nurse.

These results should be disseminated to the relevant staff for discussion.

All recommendations documented in the action plan should be actioned and signed off as completed by Divisional Nurse.

Theatres should participate fully when the audit is completed in October –December 2009.

High Impact Intervention care of peripheral IV lines. June 2008

Peripheral IV line insertion

In total 279 observations were made from 28 different wards/theatre areas, a reduction on the 670 observations recorded in the August 2007 audit. Many wards did not submit results.

Overall compliance for the different elements of the tool were as follows:

	Insertion using aseptic technique	Skin preparation performed	Dressing in situ	Insertion of device documented	All applicable elements performed
June 2008	**92%**	**96%**	**100%**	**85%**	**76%**
August 2007	95%	80%	91%	76%	61%

Specific focus needs to be made on the criteria 'insertion using aseptic technique' and 'skin preparation performed' as these aspects have a direct impact on the risk of infection following cannulation.

Peripheral IV line continuing care

In total 437 observations were made from 28 wards, compared with 364 observations from 30 wards in the last audit. Not all elements were applicable in all of the observations.

Overall compliance for the different elements of the tool were as follows:

Element of tool	**% compliance June 2008**	**% compliance Aug 2007**
Continuing clinical indication for device	**94%**	86%
Documented evidence of daily site inspection	**91%**	80%
IV dressing intact, clean and dry	**94%**	95%
IV device in situ < 72 hrs	**90%**	91%
Aseptic access	**99%**	96%
Admin sets replaced	**91%**	95%
All applicable elements performed	**73%**	66%

The audit has identified a positive trend in an improvement in standards of practice relating to on-going care of peripheral IV lines. The overall compliance with all applicable standards has increased from 66% in August 2007 to 73% in June 2008.

Following this audit the following actions were implemented:

- Development of a sticker to document insertion in areas such as haematology out-patients, radiology, day surgery etc. must continue as a priority to support documentation of IV insertion in high use non-inpatient areas.
- Sourcing of a label for IV giving sets to facilitate the changing of lines. The importance is reinforced in IV therapy teaching sessions.
- Development of a sticker to aid identification of emergency line insertions, e.g. in ambulances or A/E resus, to ensure lines that have been inserted under emergency and potentially non-aseptic conditions are replaced as soon as possible.

Transfer Form Audit

One of the requirements of the Health Act (2006) is to ensure that infection control information is given on transfer of every patient. A transfer form audit was undertaken in the month of March to establish the use of the Trust's Infection Control Transfer Form.

Two Medicine for older people wards (Ward 2, SMH & Ward 4B, WH) were audited as these wards always have their patient transferred in from other wards/healthcare settings.

At WH patients had had a total of 37 transfers. One patient had a completed infection control transfer form in their notes and one patient had one designed by MAU/EAU that did mention infection control issues.

At SMH patients had had 32 transfers and 14 forms were found in the notes. One of these was an infection control transfer form and the remaining 13 were the MAU/EAU designed form. Of these 13 forms only 8 were completed.

Points for Action:

- Wards need to be made aware of the audit and improvement with compliance of the form is required. (addressed by a memo to all wards/departments 7th April 2009)
- Awareness raised at Nursing and Midwifery Board/Sisters meetings
- Re-Audit.

Central Line Audit

Project Objective

The local Buckinghamshire Health Economy, in this case made up of The Buckinghamshire Hospitals Trust (BHT) and the Buckinghamshire Primary Care Trust (BPCT), recognised the possible benefits to both organisations and the associated populations, of setting up a joint investigation into the care of patients requiring treatments involving the placement and use of Central Venous Catheters (CVC's) and the incidence levels of associated Infections.

Aim of Project

- **To gain information on how Central Line related infections might be reduced**

This would also provide valuable information on the following

1. Consistency of procedures undertaken by both Medical and Nursing staff
2. Training and awareness of National Guidelines
3. Appropriateness of types of lines in use- single lumen and multi-lumen, tunnelled and Peripherally Inserted Central Catheters (PICC)
4. Root cause analysis – indication of patterns of infection
5. Care in the community and control of costs in the District Nurse field

Recommendations

- There should be a standard training for the inserting of central lines for all levels of staff.
- Training in the care and use of central lines should be available for all relevant qualified nursing staff. This should be competency based.
- Ultrasound equipment should be available in the units where central lines are placed and should be used on a routine basis. Training will be required to maximise use of the equipment.
- Central Line insertion packs should be used across the acute trust.
- There would be benefit in using a limited choice of Central lines e.g. limiting the number of manufacturers. This may reduce the cost of purchasing.

- There should be an assessment of the appropriate type of central line to be placed for each patient.
- The line type, purpose and care of patient should be tracked when moving across locations.
- At insertion, the use of a mandatory pro-forma should be kept in patients' notes to maintain standards.
- Ensure the VIP chart is maintained daily.
- A central line group should be developed across the acute and primary care trust to ensure good practice.
- A central line link nurse should be identified for each ward or unit.
- The overarching Central Line Policy which needs to be circulated.
- Central Line use across the Trust should be re-audited in October 2009.
- The Saving Lives High Impact Intervention in relation to Central Lines (Insertion and ongoing management) should be audited on a monthly basis on:
    - ITU/HDU (both sites)
    - St Andrew's Ward, SMH
    - SCBU/NICU
    - Wards 4 and 6, SMH
    - Wards 2a and 12a, WH.

Appendix 9 Education

Mandatory Infection Control Training

Training Attended by Staff Groups from 1st April 2008 to 31st March 2009

Division	Headcount	Number of staff to be trained	Overall % attendance	Total	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Surgery	1044	1044	107%	1119	46	53	82	152	109	72	102	121	42	99	52	189
Medicine	903	903	85%	766	41	61	40	139	53	49	81	80	36	61	28	97
Womens & Childrens	549	549	91%	501	26	50	42	64	8	25	42	59	52	33	32	68
NSIC	203	203	106%	216	11	2	11	12	8	21	31	22	11	39	17	31
CSS	780	780	125%	975	49	77	73	81	67	78	71	124	42	65	23	225
Corporate	601	601	102%	612	26	42	34	64	57	37	24	60	37	72	64	95
Total Attendance - 102%		4080		4189	199	285	282	512	302	282	351	466	220	369	216	705

Staff Group	Headcount	Number of staff to be trained	Overall % attendance	Total	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Admin & Clerical	765	765	93%	711	41	14	47	65	59	29	66	110	35	99	57	89
Allied Health Professionals	235	235	134%	315	15	16	18	27	32	32	9	4	32	24	15	91
Health Care Assistants	481	481	94%	452	19	47	21	23	24	21	79	39	27	73	20	59
Healthcare Scientists	155	155	111%	172	5	2	11	20	13	18	15	17	8	14	8	41
Managers	110	110	119%	131	12	4	15	22	19	12	3	4	3	4	11	22
Medical Staff	530	530	93%	492	11	4	11	216	40	21	18	77	10	45	12	27
Nurses	1387	1387	105%	1451	77	190	128	102	80	111	119	145	86	61	56	296
Scientific & Professional	125	125	95%	119	0	1	8	1	8	12	12	25	0	24	13	15
Support Staff	292	292	118%	346	19	7	23	36	27	26	30	45	19	25	24	65
				4189	199	285	282	512	302	282	351	466	220	369	216	705

Overall percentage of workforce attended Infection Control Training 2008/2009 = 102% This is due to staff turnover ie head count is based on number of posts and the overall attendance is based on number of individuals who have attended.

Student Nurses

45 hours of lectures were given during the year to pre-registration students. These included:
Semester 1 – Introduction to infection control
Semester 1 – Hand hygiene
Semester 3 – Health care associated infection
Semester 4 – Care of the immuno-compromised infection
Semester 6 – Care of the surgical patient
Semester 9 – Infection control management issues and IV lines

Post Basic Nurse Education

A variety of lectures were given for trained staff. These include:

- IV Therapy.
- Venepuncture & Cannulation.
- IV Therapy for District Nurses (Buckinghamshire PCT).
- Midwives Mandatory Training
- Staff Nurse Development Programme – Part 1
- Staff Nurse Development Programme – Part 2
- Return to Practice

Staff Induction Programme

The ICT has continued to support the monthly Trust Induction Day. This is now a two day event with infection control being part of day 2.

The junior doctors were required to undertake Web-based training covering all their health and safety training, including infection control. They had to score 100% in a quiz on Infection Control prior to commencement of employment in the Trust. They also received a talk from the Microbiologist that included infection control when they started in August and February and their hand hygiene competencies were formally assessed.

Input has also been provided on the HCA Induction programme organised by the Practice Development Team.

Consultant Teaching

The 6 monthly-Study half-days on mandatory training subjects have continued to ensure each Consultant receives an annual update on topics such as Infection Control. This includes a formal assessment of their hand hygiene techniques.

Infection Control Awareness Course for Link Practitioners

Each ICLP study day starts with an update about current issues regarding Infection Control including national concerns about increased trends e.g. measles rates. Updates include any current issues relating to planned building projects or changes within BHT.

Outbreaks or issues relating to a series of events that have occurred will be discussed in an open manner to facilitate learning through practice. Sharing of good practice is encouraged between the ICLPs. There is also an opportunity for ICLPs to bring their own concerns about any local issues that they may have regarding their individual areas of practice. These issues can be shared and the ICLPs support each other and try to find ways in which problems may be overcome.

Feedback from any recent audits is given to the ICLPs and is a good method of disseminating information to a wide population of staff.

Education and learning is encouraged and supported by expert members of the trust who are invited to make presentations to the ICLPs. These sessions are appreciated and well evaluated by the ICLPs

Topics undertaken during 2008 included

Regular slots	Infection Control Update
Individual sessions	Roles & responsibilities of ICLP
	Audit Programme 2008 & Action Plan Writing
	Evolving Role of the DIPC
	IV Lines -2% Chlorhexidine
	Hand Hygiene –Plating
	Waste Regulations
	Tuberculosis An emerging threat
	MRSA Screening Audit Results & Suppression + Eradication Therapy
	Loose Stool Checklist
	Audit – 'What's it all about ?
	Sepsis –Recognising Signs and Symptoms
	Patient Safety
	Clostridium difficile : Is 078 the new 027?
	Point of Care Testing
	The BHT Intranet – where to find infection control information
	Complaints and Infection Control
Formal Sessions	Microbiology
	Anatomy & Physiology of the Immune System
Snap Shot audits undertaken	Audit of commodes
	Use of alcohol gel at ward entrances
Representatives	B Braun New Safety Cannula

The proposed plan for the forthcoming year includes themed days as follows:

- Chesty Problems
- Wounds
- Rashes
- The NSIC patient

Appendix 10 ANTIBIOTIC REVIEW GROUP (ARG)

The Antimicrobial Review Group (ARG) is a subgroup of the Drugs and Therapeutics Committee (DTC) and reports to this Committee and the Infection Control Committee. Its purpose is to review and update old guidelines, to authorise any new guidelines with antimicrobial content, to ensure the appropriate introduction of new antimicrobials, to audit antimicrobial usage within Bucks NHS Trust and to work with Bucks PCT to improve antimicrobial prescribing in primary care. The ARG is chaired by Dr. David Waghorn, Consultant Microbiologist. Miss Breda Cronnolly is the Trust's Specialist Antimicrobial Pharmacist, having been appointed in May 2008.

1. Trustwide Guidelines

The following new guidelines were written, reviewed and then released within the 12 month period April 08 – March 09:

Teicoplanin use and monitoring
Panton-Valentine Leucocidin producing Staph aureus
Management of Pneumonia in Cervical Cord Spinal Injury Patients
Treatment of acute sigmoid diverticulitis
Antibiotic therapy for prosthetic joint infections
Use of Oseltamivir in Seasonal Influenza
Outpatient Parenteral Antimicrobial Therapy Service (OPAT) – early discharge policy

Many other already existing guidelines have been reviewed and updated over the same time period.

2. Antimicrobial Website

Bucks Trust Antimicrobial Website was introduced in August 2008 with great success, providing valuable information to all Trust healthcare workers on the use of antimicrobials together with results of audits and updates on important antimicrobial issues. The website will be a vital ongoing component of the Trust's commitment to improving and maintaining optimal antimicrobial usage.

3. Antibiotic Flash Card

The Trust's Antibiotic Flash Card, containing a summary of the most important and commonly encountered infections and their appropriate treatment, was updated again this year. It is distributed to all new medical staff as well as being published on the website.

4. Audit Programme

An annual audit programme, mainly performed by the Trust's pharmacy department was conducted. Audits performed included the following:

Orthopaedic antibiotic prophylaxis
Urological surgery prophylaxis
Tazocin use in elderly care
Gentamicin monitoring
Provision and use of MRSA suppression packs
Antibiotic prophylaxis in appendicectomy
IV to oral antibiotic switch

5. IV at Home Service

Progress has been made in developing the Trust's IV at Home Service with the release of the OPAT early discharge policy, the small expansion of the Community IV Specialist Nursing levels and the increasing numbers of patients able to be discharged for home IV therapy. A significant amount of work still needs to be done especially if both the Bucks PCT and acute Trust wish to develop such areas as hospital admission avoidance by way of home IV therapy.

6. Joint PCT/Acute Trust Project on Community-Acquired Infections requiring Hospital Admission

During the year Mr Umran Anwar, pharmacist, conducted a project looking at patients with infections initially treated in primary care who subsequently required hospital admission. The aim was to establish whether GPs are following PCT antibiotic guidelines and what percentage of subsequent hospital admissions of these patients could have been avoided. The report of this project will be available in the first couple of months of the next financial year.

7. New Trust Prescription Chart

The new Trust prescription chart was introduced this year which had received significant input from the ARG. A user review is being held and following comments made, a slightly revised version of the chart will be introduced next year.

8. Thames Valley Multidisciplinary Antimicrobial Workshop

Two regional meetings were held within the last 12 months. This is a gathering of pharmacists and infectious disease specialists to discuss current infection topics which are affecting healthcare provision across the region.

9. European Antibiotic Awareness Day – 18th November 2008

The Trust took part in this initiative promoted by the Department of Health by displaying posters and handing out leaflets throughout appropriate clinical areas of the Trust.

Appendix 11

PCT Annual Programme of Work 2008-09

Under the existing service level agreement between BHT and Buckinghamshire PCT the following work has been achieved:

- The development and implementation of an Infection Control Link Practitioner programme including a 3 day course and a further single day for new practitioners.
- The planning and implementation of the annual programme of audit, including the development of audit tools tailored to meet the need of PCT service, the support of ICLP's doing the audits, the production of audit reports with the assistance of The Clinical Audit Department and the production of action plans to address the issues identified by the audits.
- The provision of expert advice for the updating and review of policies.
- The provision of expert infection control advice and support for staff.
- Attendance and input into the PCT Peat inspections.
- Management of day to day queries and management of outbreaks.
- Expert advice and attendance at the PCT ICC.
- Expert advice and attendance at meetings as required by the PCT.
- Setting up and populating of the Infection Control intranet site for the PCT.
- Provision of training programmes for mandatory training, induction, home care workers.
- Delivery of induction sessions and the support of trainers providing mandatory training.
- Implementation of enhanced cleaning when required.
- The provision of expert advice on plans for the refurbishment of PCT services.
- The production of Infection Control Reports for PCT services.

Appendix 12

Buckinghamshire Hospitals NHS
NHS Trust

DIVISIONAL REPORT TO TRUST BOARD ON INFECTION CONTROL
For year 1st April 2007 to 31st March 2008

Date of Board Meeting: 2nd June 2008
Division: Medicine
Divisional Medical Lead: Dr P Clifford
Divisional Lead Nurse: Alison Brandon

Surveillance Data:
MRSA: Number of MRSA Bacteraemia cases in past 12 months: 6
Outcome of Root Cause Analysis: Issues identified: Poor VIP documentation, Delayed MRSA suppression, Multiple bed moves, Poor MRSA documentation, Staffing levels, Missed/delayed MRSA screening, poor PEG site documentation, Prolonged unnecessary venflon insertion
Actions being taken: Re-Launch of the matrons round to include checking of all charts, Pocket Guide to what and when to MRSA screen patients introduced for all clinical staff, Bedside handover in place on wards, Wards have had a review of skill mix and establishment, new emergency care documentation to be introduced formally which identifies staff to ask the question 'does this patient fit MRSA screening criteria', Nutritional nurse looking at documentation following PEG insertion, All patients who have an MRSA Alert and get admitted to hospital automatically get started on MRSA suppression
C difficile: Number of Divisional C diff cases in past 12 months: April 07-Mar 08 - 89 BHT Acquired & Associated cases within medicine (Further data available on Trust Intranet)
Any significant issues, eg clusters, outbreaks: March 07 4A cluster of C-Diff (3 patients), SMW 22 April 07 cluster of C-diff (2 patients), August 07 SMW 22 cluster of C-Diff (3 patients), March/April 08 Heberden cluster of C-Diff (2 patients) Potential risk factors identified, included cleanliness of the environment, staffing levels & poor hand hygiene by medical staff
Action being taken, where appropriate: Meetings were held on the wards to review the situation and practices on the wards at the time of the clusters • 4A - Enhanced cleaning was instigated and there were no further cases

- SMW 22 – Enhanced cleaning instigated
- SMW 22 - No link between the 3 case were identified
- Heberden - 2 specimens sent to reference lab for typing and both found to be the same type which could support evidence that ward spread could have occurred

Outbreaks:

March/April 2007 3B, 4B, 6B, ward 10 WH confirmed Norovirus outbreaks

August 07 6A confirmed Norovirus, October 07 5B Norovirus, December 07 5B, 3B, confirmed norovirus outbreaks

April 07 MRSA outbreak SMW8

Mar 08 SMW 22 confirmed norovirus outbreak

Mar 08 4B confirmed Influenza B outbreak

Mar/April 08 4B MRSA outbreak

Other Infection Control incidents, including ward closures:

Other suspected outbreaks of Viral gastroenteritis (norovirus) throughout the year on various wards but not confirmed. These did lead to some ward or bay closures.

Infection Control Risks on Risk Register:

Delayed isolation incidents:

48 potentially Infectious patients not isolated in side rooms or cohort area Trustwide (This information is not available just for the medical division at present- the figure given includes patients from all divisions (from April 07-March 08)

Results of most recent Hand Hygiene compliance audit:

Hand Hygiene Observational Audit carried out in September 2007, By speciality results are for General medicine 92%, MFOP 90% & Specialist medicine 85%, The way in which these audits are carried out has changed and will be done per division in the future.

The medical division is currently undertaking this audit for the month of May 08

Results of High Impact Intervention audits:

HII Peripheral Line care Review tool (insertion & Continuing care) Aug/Sept 07

HII 5B & ICNA Urethral Catheter management April 07

HII No 4 Care of ventilated pts May 07

HII 1 Reducing risk of microbial contamination

See Separate document for breakdown of results
Cleaning Audit Scores: At Amersham and Wycombe range between 82.6% and 100%. Average 97.46%. Jan-March 2008 at Stoke Mandeville ranges from 89% to 100%
Other issues or concerns: A&E SMH – a number of separate issues were raised following the patient equipment audit undertaken in April 2008, a report was compiled and sent to the relevant people for action. Action Plan currently being developed will include processes for cleaning medical equipment and replacement of some furniture plus surfaces, etc in the sluice

DIVISIONAL REPORT TO TRUST BOARD ON INFECTION CONTROL

Date of Board Meeting: 31st July 2008
Division: Surgery
Divisional Medical Lead: Giles Kidner
Divisional Lead Nurse: Anne Walker
Divisional ADO: Robert Peet

Surveillance Data:

MRSA: Number of MRSA Bacteraemia cases in past 12 months: (April 07- March 08)

- SMH 3 in total: 2 BHT acquired 1 from other hospital.
- WH 2 in total: 2 BHT acquired 1 other hospital.

Outcome of Root Cause Analysis: Identified areas to be addressed:

- Lack of documentation i.e. VIP form.
- Failure to comply with the Trust's MRSA screening policy and MRSA screening to include all sites and within 48hrs of admission.
- Failure/ delay in commencing MRSA suppression therapy.
- Lack of communication.
- Prophylactic Antibiotic cover not given in theatres.

Actions taken:

- Weekly audits.
- Regular Matron's round which includes checking charts and documentation.
- All staff reminded on the importance and relevance of documentation on the VIP form. Pocket guide to who requires screening and which sites to screen.
- MRSA suppression therapy held as stock item on surgical wards.
- MRSA suppression prescription stickers for the drug charts to prevent delay in prescribing.
- All MRSA +ve patients to have an MRSA alert on notes and on CRS and to have suppression therapy prescribed on admission following admission screen.
- Matrons to be involved in RCA to ensure timely actions.

C difficile: Number of Divisional C diff cases in past 12 months: (April 07- March 08)

- 14 in total: SMH 8, WH 6

Any significant issues, eg clusters, outbreaks:

None

Action being taken, where appropriate:

N/A

Outbreaks:

- Norovirus WD 12A 15 patients & 4 staff affected. Ward closed from 18/02/2008-25/02/2008.
- Norovirus on WD 12B 6 patients, no staff involved between 30/04/08-02/05/08. Only 1 positive result. Ward not closed.

Other Infection Control incidents, including ward closures:

3 patients identified with MRSA on 12a who had been admitted during April 08. Swabs sent for typing Action plan completed:

Actions:

- Discuss cases and practices at team meetings, Clinical Governance meeting etc.
- Hand hygiene teaching, decontamination of equipment.
- Liaise with Medirest in relation to environmental cleaning.
- Check mandatory training is up to date of all staff.
- Ward rota for cleaning of equipment, reiterated the importance of cleaning of equipment, especially beds on discharge.
- To involve all Multidisciplinary teams and challenge poor practice.

Infection Control Risks on Risk Register:

- Increase in post op orthopaedic infections.
- The infections are not included in the Mandatory Surgical Site Infection Surveillance Service reports as infections occurred following discharge, in comparison to previous quarters there is an increase. Meetings are on-going to address the issues raised and action plan in place.
- Extra-ordinary Orthopaedic MDT Infection committee established.
- Re-introduction of red line policy to reduce unnecessary traffic within theatre area August 08. Full launch planned with leaflets and visible management support.

Delayed isolation incidents:

- Prior to April 2008 divisional information is not available.
- Since April 2008 there has been 2 delayed isolation incidents Trust wide of potentially infections patients within the surgical division.
- Failure to isolate figures now collated and presented to Matrons to address.

Results of most recent Hand Hygiene compliance audit: Surgical division Completed February 2008.

- An overall Trust wide compliance level of 88% which was an improvement on Sept 07 which was 84%.
- Generally theatres were non compliant with percentages below the 85% compliance level ranging from 59%-83%. These areas are completing weekly audits. A meeting with theatre staff was carried out to discuss issues/ concerns

around hand hygiene and completing the audit. Now achieving average 93.63%.

- DSU (WH) were non compliant with 69% and are completing weekly audits. Now achieving average of 95.75%.

Results of High Impact Intervention audits:

- HII 5 Urinary catheters (April 07)
- HII 2b Peripheral IV lines (May 07)
- HII 4 Ventilated patients (May 07)
- HII 2a Central line management (July 07)
- HII 1 Reducing the risk of microbial contamination (August 07)
- HII 2b Peripheral lines (August 07)
- HII 3 Surgical site infection (Oct- Dec 07).

Cleaning Audit Scores:

SMH – Domestic Services Report (%)

Dom = Domestic Est = Estates

	Apr-08		May-08		Jun-08	
Area	Dom	Est	Dom	Est	Dom	Est
Day Surgery Unit	96	100			91	95
High Dependency Unit (HDU)	94	100	89	100	93	100
High Dependency Unit (HDU) recheck			88	100	85	100
Honeywell Theatre						
Intensive Care Unit (ICU)	88	100	95	100	96	95
Intensive Care Unit (ICU) (Recheck)	90	100			86	100
New Wing Theatres	88	100	91	80	96	95
New Wing Theatres recheck	89	100				
Opthamology Ward			94	100		
Opthamology Ward (recheck)						
Ophthalmic Outpatients						
Ophthalmic Theatre			95	100	92	100
Oral & Orthodontics					93	95
Orthodontic Department			95	100		
Orthopaedic & Plaster Room	86	100				
Ward 11 (Burns)	100	100	97	100		

SMH – Trust Report

Area	Mar-08	Apr-08	May-08	Jun-08
Burns Unit (Ward 11)	94			
Eye Ward	92	90	91	87
ITU	94	90	94	
Ophthalmic Unit				92
OPD 1&2		98		
Ward 4	97			

Ward 6			96	
Ward 7		96		
Ward 11		97		

WGH - Joint Scores

Functional Area		Weighting	Apr-08	May-08	Jun-08
Main Theatres		7		94	98
ITU		7	98		100
Ward 8 - DSU		4	92		
Gynae theatres		7	90	88	94
Urology Ward		4			
Urology Clinics		4			
Ward 12A		4		89	
Ward 12B		4			
Loakes Theatres		7		97	93

Overall cleaning standards are maintained at a good level. Local issues are addressed by Housekeepers, Sisters and Matrons.

Patient Equipment Audits

Theatres WGH: 96.5%

Theatres SMH: 92.5%

Surgical Wards: 84.33%

Specialist Surgery: 90.52%

Other issues or concerns:

- Infection Control Nurse undertaking rounds with Matrons.
- Divisional infection control link nurse has had enhanced communication and support to all departments.
- Urology Ward and Ward 4 to trial VIP nurse role with specific role of training and educating staff and auditing VIP chart completion.
- Pre op assessment infection control measures. Robust mechanism in place for assessing current infection status. Hip and knee MRSA +ve patients receive eradication therapy and require 3 negative screens. Other patients are given suppression therapy. Orthopaedic patients now being provided with liquid body soap to cleanse with day before surgery.

REPORTING TEMPLATE
DIVISIONAL REPORT TO TRUST BOARD ON INFECTION CONTROL

Date of Board Meeting: 24th September 2008
Division: Women & Children
Divisional Medical Lead: Mr Ian Currie
Divisional Lead Nurse: Mrs Celina Eves

Surveillance Data:
MRSA: Number of MRSA Bacteraemia cases in past 12 months: None
Outcome of Root Cause Analysis: N/A
Actions being taken: N/A
C difficile: Number of Divisional C diff cases in past 12 months: None
Any significant issues, eg clusters, outbreaks: N/A
Action being taken, where appropriate: N/A

Outbreaks: None

Other Infection Control incidents, including ward closures: MacCarthy Ward closed during Winter 07 due to a vomiting outbreak amongst the nursing and medical staff. The vomiting sickness did not spread to the patients.
Infection Control Risks on Risk Register: The implications for the Trust if the Division fails to screen all elective patients for MRSA.
Delayed isolation incidents: None
Results of most recent Hand Hygiene compliance audit: Obstetrics & Gynaecology 84% Paediatrics and Neonatology 95%
Results of High Impact Intervention audits: Obstetrics & Gynaecology 76% } for asepsis of peripheral line insertion, dressing and Paediatrics and Neonatology 75% } documentation

Obstetrics & Gynaecology 75% } for continuing care of peripheral cannulae
Paediatrics and Neonatology 72% }

W&C
Personal protective equipment 94% }
Correct aseptic technique 100% } overall 89% (2007 – 68%)
Safe disposal of sharps 100% }

Cleaning Audit Scores:

SMH:		**WH:**	
Paediatrics	93%	WACU	97%
Neonatology	96%	Paediatric ward	98%
Delivery Suite	92%	Neonatology	96%
Maternity	91%	Delivery Suite	89%
Gynaecology	94%	Maternity	94%
		Gynaecology	95%

Other issues or concerns:

Hard work is being maintained to ensure that compliance is improved in all aspects of infection Control throughout the Division. Infection Control is a standing agenda item on each O&G and Paediatric Business meeting.

Buckinghamshire Hospitals NHS
NHS Trust

DIVISIONAL REPORT TO TRUST BOARD ON INFECTION CONTROL

Date of Board Meeting: 26th November 2008
Division: National Spinal Injuries Centre, Stoke Mandeville Hospital
Divisional Medical Lead: Dr Ali Jamous
Divisional Lead Nurse: Debbie Green

Surveillance Data:
MRSA: Number of MRSA Bacteraemia cases in past 12 months: 2
Outcome of Root Cause Analysis: Consider use of antibiotic cover when probing deep pressure ulcers. VIP charts not always completed fully.
Actions being taken: Antibiotic cover being prescribed prior to probing deep pressure ulcers. 'No VIP, No Drip' initiative adopted.
C difficile: Number of Divisional C diff cases in past 12 months: 8 (Nov 07-Oct 08)
Any significant issues, e.g. clusters, outbreaks: No clusters or outbreaks identified.
Action being taken, where appropriate: N/A

Outbreaks: None.

Other Infection Control incidents, including ward closures: None
Infection Control Risks on Risk Register: NSIC 44. Increased infection risk when patients are inappropriately admitted to specialist areas e.g. St Patrick Ward.
Delayed isolation incidents: 2 incidents between October 07 and September 08
Results of most recent Hand Hygiene compliance audit: Hand Hygiene (July 08) 89% - Doctors 50%, Nurses 97%, HCAs 97%, other staff 97%. Bare Below The Elbows (July 08) 92% - Doctors 79%, Nurses 100%, HCAs 91%, other staff 95%.
Results of High Impact Intervention audits: Preventing risk of microbial contamination: all applicable elements performed in 82% (April

08) HII 2: Peripheral intravenous cannula care: all elements performed in 60% (June 08)(but few observations). 67% June 07. HII 6: Urinary catheter care: all elements performed in 90% (April 07). Being repeated currently.
Cleaning Audit Scores: See attached sheet for detail
Other issues or concerns:

DOMESTIC SERVICES REVIEW – REPORT FOR SEPTEMER 2008

WARD	SCORE	ISSUES
St David	95%	Debris, spillage on floor. Some beds bases dusty. Limescale around plug hole and taps in bath. Holder (aprons) marked inside.
St Patrick	92%	Marks, debris on floor. Dusty curtain rails. Beds frames dusty. Spillage on walls behind bins. Waste bin base dusty. Limescale around taps.
St Joseph	96%	Floor dusty behind bin. Dusty shelves. Holders (apron) marked inside. Commodes marked underneath.
St Andrew	88%	Dust behind door, appearance. Some beds bases dusty. Edges around sink. Spillage on walls behind bin.
St George	95%	Empty soap holder. Debris, marks on floor. Waste bin base dusty.
St Andrew	95%	Floor edges. Bed bases dusty. Limescale around plughole in sink.
St George	93%	Floor edges, marks. Dusty top of cupboard.

INFECTION CONTROL KITCHEN AUDIT – AUGUST 2008

WARD	SCORE	
St Andrew	93%	Compliant
St David	97%	Complaint
St Francis	93%	Compliant
St George	86%	Compliant
St Joseph	83%	Partial Compliance
St Patrick	89%	Compliant
Spinal Gym	92%	Compliant

Buckinghamshire Hospitals NHS
NHS Trust

DIVISIONAL REPORT TO TRUST BOARD ON INFECTION CONTROL

Date of Board Meeting: 29 January 2009
Division: Clinical Support Services
Divisional Medical Lead: Dr Ann Booth
Divisional Lead Nurse: Jeanette Tebbutt

Surveillance Data:
MRSA: Number of MRSA Bacteraemia cases in past 12 months: 0
Outcome of Root Cause Analysis: n/a
Actions being taken: Ongoing preventative measures: Good documentation noted on VIP charts Infection control nurse holds monthly meetings with managers of: Sunrise Unit (7th floor Wycombe) Ward 5a (Wycombe) CCHU (SMH) Matron round weekly Training for chemo/haematology nurses in: From the unit a Trustwide training audit was completed leading to a central line care training programme. Central line care training annually Development of a central line policy (in conjunction with Infection control team) which will now go Trustwide Mandatory infection control training Development of a day case VIP chart see attached (now implemented in all day case areas, ie theatre, gastro)
C difficile: Number of Divisional C diff cases in past 12 months: 0
Any significant issues, eg clusters, outbreaks: N/A
Action being taken, where appropriate:

Ongoing preventative measures:

Recruitment of housekeeper. Who does daily ward rounds/side room monitoring.

Positive feedback to staff from matrons ward round.

Outbreaks:

0

Other Infection Control incidents, including ward closures:

Ward 5a closed due to cluster of patients with diarrhoea from:

December 2008 (1 bay – 4 days)

January 2009 (1 bay – 3 days)

No reason identified. All advice from infection control completely followed.

Infection Control Risks on Risk Register:

Failure of SDU score card to be updated – now being updated, risk will be removed from register at end of month.

Training in infection control – new action plan in place see attached staff mandatory training sheet, and example of central data base.

Delayed isolation incidents:

9 incidents:

Failure to isolate figures now collated and presented to matron to address. Each incident now discussed with staff and awareness of correct policy and correct risk assessments implemented.

Ward 5a

Date	Hosp No	Division	Indication for Isolation	Initials	Code	No of Days
27/6/08	10845432	Medicine	MRSA	MK	2	1
11/7/08	10624737	Medicine	D&V	ZH	3	5
21/7/08	10628097	Medicine	D	GH	2	1
12/8/08	10832675	CSS	MRSA	SB	2	2
13/8/08	10174526	Medicine	D	RB	3	1
20/8/08	10933233	Medicine	MRSA	BR	2	3
10/9/08	20023314	CSS	MRSA	VS	2	6
4/11/08	10662388	Medicine	MRSA	RB	2	1
28/11/08	20074244	Medicine	MRSA	DH	2	5

Total: 9 patients – 25 days

Code:
2: Not enough side-rooms
3: Not following IC Policy/incorrect risk assessment

Results of most recent Hand Hygiene compliance audit:

Hand hygiene (July 2008) = 86%

Doctors = 94%

Nurses = 90%

HCA = 88%

Bare below the elbow (July 2008) = 93%

Doctors = 75%

Nurses = 98%

HCA = 100%

Action plan now in place see below.

Action	Whom	Comment	Date for review
Hand Hygiene-To ensure all clinical staff have attended the competency session.	Link nurses & managers	To work with the infection control team to incorporate into unit mandatory days and book onto Trust sessions	April 09
To ensure both clinical areas have mobile hand sanitisers to take to the patient.	Managers and clinical staff	To ensure hand hygiene compliance both prior to patient contact and after patient contact. To ensure hand hygiene is visible to the patient.	April 09
To ensure compliance with bare below elbows	All staff in clinical areas	For the nurse in charge to ensure all staff are complying with bare below elbows. To challenge any staff member who is not compliant. Disciplinary action to be taken if necessary.	April 09
Following the above: Within the Sunrise Unit to complete a weekly hand hygiene audit for a period of 4 weeks	Link Nurse & manager	To assess whether compliance has been achieved	May 09

Results of High Impact Intervention audits:

Preventing risk of microbial contamination : all applicable elements performed

April 2008 = 100%

Cleaning Audit Scores:

Infection control patient equipment and kitchen audit			
Ward 5a	Wycombe	Patient equipment	98%
		Kitchen	95%
CCHU	Stoke Mandeville	Patient equipment	98%
		Kitchen	95%
Sunrise Unit	Wycombe	Patient Equipment	96%
		Kitchen	85%
Radiology	Wycombe	Patient Equipment	74%
Radiology	Stoke Mandeville	Patient Equipment	81%

Cleaning audit scores			
Sunrise Unit	Wycombe	98.77%	December 2008
Ward 5a	Wycombe	89%	November 2008
X Ray	Wycombe	94.12%	November 2008
CCHU	Stoke Mandeville	94%	December 2008
X Ray	Stoke Mandeville	92%	November 2008

Other issues or concerns:

Targets

MRSA screening: elective admissions must achieve 100% by March 2009 (MRSA screening: emergency admissions 100% by March 2011).

Increased infection risk when patients are inappropriately admitted to specialist area ie gen med patients with certain conditions to a haematology ward.