Buckinghamshire Healthcare NHS
NHS Trust

INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2010-2011

Date Produced: June 2011
Approved by Infection Prevention & Control Committee: June 10th 2011
Approved by Healthcare Governance Committee: July 12th 2011
Approved by Trust Board: 3rd August 2011

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

Written and Compiled by: **Niamh Whittome**
Matron, Infection Prevention & Control & The Infection Prevention & Control Team

CONTENTS PAGE	Page No.
Executive Summary	2
Introduction	3
Infection Prevention & Control Arrangements	3
The Infection Prevention & Control Programme	3
Surveillance	3
Outbreak Reports	7
Saving Lives/Infection Prevention & Control Leads	8
Hand Hygiene	8
Link Practitioner Programme	9
Decontamination	9
Patient Environment Action Teams (PEAT)	10
Infection Control Manual	10
Educational Activities	11
Audit Activity	11
Antibiotic Review Group	11
Risk Management/Clinical Governance	11
Building Projects	12
Committee/Group Membership	12
Other Activities	13
Appendices	
1. Infection Prevention & Control Governance Structure	14
2. Infection Control Programme 2010/2011	15
3. Draft Infection Control Programme 2011/2012	30
4. Surveillance Data	40
7. Hand Hygiene Observation Audit Results	43
8. Link Practitioner Programme	49
9. Education	50
10. Audit Reports	52
11. Occupational Health Annual Audit of Needlestick Incidents 2010/11	63
11. Antibiotic Review Group	68

EXECUTIVE SUMMARY

This was another busy year for the Infection Prevention and Control Team.

Once again the Trust achieved excellent results for C. difficile and MRSA Bacteraemia performance. Fifty-eight cases of C difficile (aged 2 years and above) were BHT-attributable against a limit of 65 cases for the year.

Two cases of MRSA Bacteraemia were detected that were BHT-attributable (limit = 5 cases).

Our strong performance means even more challenging limits for 2011/12 for both infections. All members of staff will need to work hard to ensure that these are achieved. For the first time cases in our new Community areas of the Trust will need to be included with "Acute" Trust cases. No leeway has been given by the Department of Health to allow any relaxation of the Bacteraemia and C difficile "objectives" as a result of our becoming a larger organisation.

Two new elements of mandatory surveillance have been added recently; MSSA (Meticillin Sensitive Staphylococcus aureus) and E.coli Bacteraemia. Reporting of MSSA Bacteraemias began in January 2011 and E.coli will start in June 2011. The first year of surveillance will be for baseline purposes only.

I am especially pleased by our improvement in the field of orthopaedics as this had been a problematic area in recent years. Our rate of post-operative infections following hip and knee replacement procedures is now below the national average (0.7% vs 1.1%) and (0.8% vs 1.2%) respectively. This is due to a concerted effort by all relevant parties to ensure that at every step in the patient pathway from pre-op assessment to discharge, every care is taken to minimise the risk of infection.

The Trust was hit by influenza in December and January. Most cases were due to Influenza A H1N1 ("Swine" flu) (42), but there were also several cases of Influenza B (15) and one case of Influenza A H3N2. Severe cases were nursed on ITU and unfortunately a few patients died due to the infection. The uptake of influenza vaccination by staff was disappointing and there is a focussed effort to improve this during the 2011/12 flu season.

Once again hand hygiene was given prominence across the Trust in 2010/11 and monthly audits of hand hygiene compliance continued with mostly excellent results. Other key areas of infection control were also audited to check that standards remained high and any deficiencies could be rectified.

The adoption of a zero tolerance approach to breaches in good practice in relation to infection prevention and control ensures that this key element of patient safety remains a priority for the Trust from Board to Ward.

Dr Jean O'Driscoll

INTRODUCTION

The following report outlines the department's activities over the past 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 prevention & control practice throughout the Trust.

Staff Changes

In May we said goodbye to Gail Cregan who left the team after 5 years. October we welcomed Aileen Jack who unfortunately had to leave the team in March due to location problems. We welcomed back Sharon Nyadzo from maternity leave in March. FY1 & FY2 Doctors worked within Microbiology at Stoke Mandeville and undertook some Infection Prevention & Control audits. We also benefited from Registrars (ST3) on Oxford Rotations who worked on the Wycombe hospital site.

INFECTION PREVENTION & CONTROL ARRANGEMENTS

The Trust serves a population of approximately 725,000 people with inpatient beds at Stoke Mandeville, Wycombe, Amersham, Marlow, Thame and Buckingham hospitals. Dr O'Driscoll has continued in her role as Director of Infection Prevention & Control and the infection prevention & control governance arrangements for the Trust are described in Appendix 1.

The IPCT currently consists of the following staff:

Dr Jean O'Driscoll – DIPC	Lisa Andrews – ICN
Dr Kathy Cann – Consultant Microbiologist	Jackie Dalton – ICN
Dr Ruby Devi – Consultant Microbiologist	Sharon Nyadzo – ICN
Dr David Waghorn – Consultant Microbiologist	Karen McIntosh – Secretary
Niamh Whittome- Matron IPC	Karleen Mulder – Secretary
Amanda Adkins - ICN	Lorraine Shaw - Secretary

THE INFECTION PREVENTION & CONTROL PROGRAMME

Appendix 2 shows the Infection Prevention & Control programme for the year 2010-2011. The Programme clearly defines the priorities for the Trust in relation to infection prevention & control activities as agreed by the Trust Infection Prevention & Control Committee which monitors the progress of this programme. Appendix 3 outlines the programme for 2011-2012.

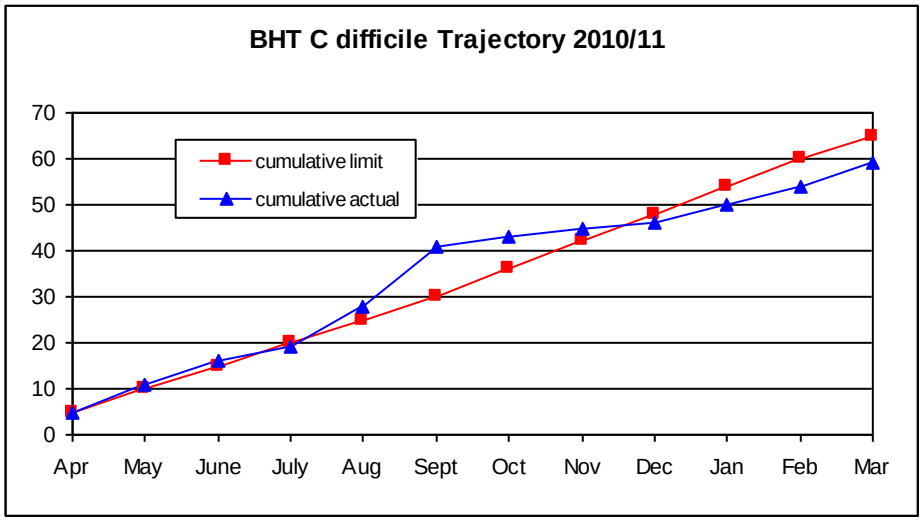
SURVEILLANCE (Mandatory & Voluntary)

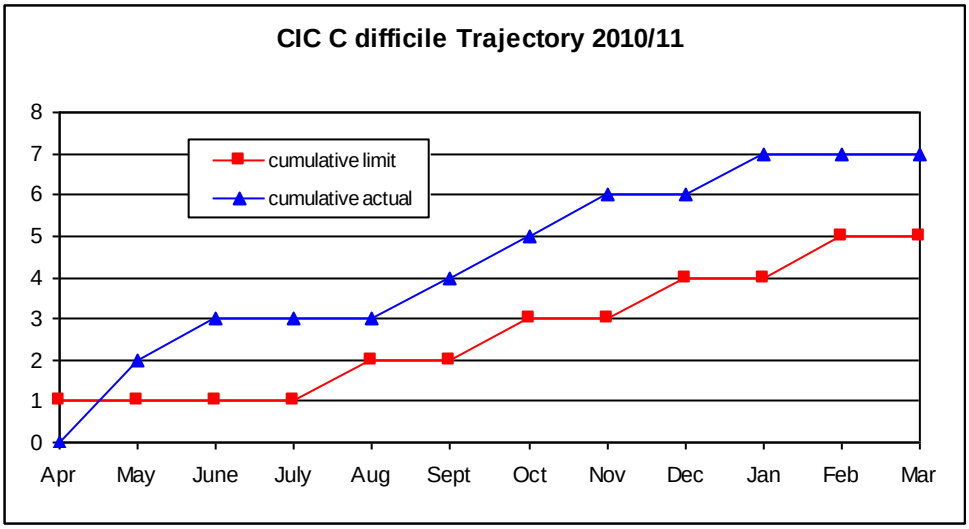
Clear case definitions for in- house surveillance have been developed and applied to data reported in this report. These can be found in Appendix 4.

Clostridium difficile

We continue to participate in the mandatory reporting of C.difficile infection. Table below shows our C.difficile figures for the year. Our limit for the year was 65. Our year end numbers were 58.

The CIC (Community and Integrated Care) Division limit was an arbitrary limit applied for the year based on previous years' outturns. These cases were attributed to NHSB (the PCT) for 2010/11, but from 2011/12 cases attributable to CIC will be included in numbers reported by BHT.





Tabled below are our reported cases from April 2010- March 2011 using the in house definitions in appendix 4:

Acquisition	2-64 years			65 + years			Total cases
	W&A	SMH	CIC	W&A	SMH	CIC	
BHT acquired	4	5	0	22	20	4	55
BHT associated	1	1	0	6	9	0	15
Community *(a)	4	1	0	10	13	2	30
(b)	0	0	0	2	0	0	2
(c)	0	0	0	0	1	1	2
(d)	0	0	0	0	0	0	0
N/A cases i.e relapses	2	1	0	4	6	1	
Total cases	7	7	0	40	43	7	104

Meticillin Resistant Staphylococcus Aureus (MRSA) Non-bacteraemias

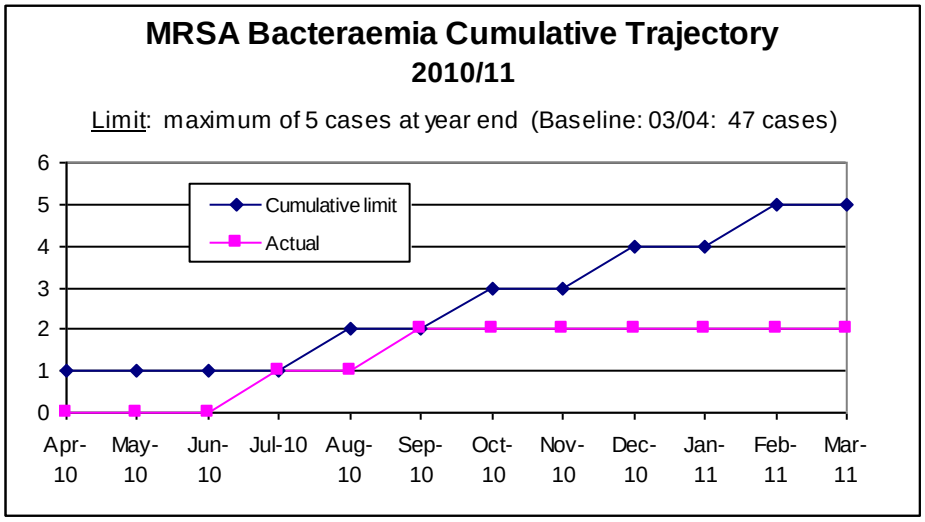
The number of Buckinghamshire Healthcare NHS Trust (acquired and associated) **non bacteraemia** MRSA cases detected by the laboratories from April 2010 to March 2011 are displayed in the table below:

	SMH	W&A	CIC	Total
BHT acquired (category 1)	29	27	0	56
BHT associated (category 2)	21	29	3	53
Total MRSA non-bacteraemia	50	56	3	109

*Ref to Appendix 4 for definitions

Meticillin Resistant Staphylococcus Aureus (MRSA) Bacteraemias

Mandatory reporting of MRSA bacteraemias continues. Two cases were allocated to the Trust which was below the limit of 5 cases. All MRSA bacteraemias have a Root Cause Analysis (RCA) undertaken. Learning points from these are shared through the Infection Prevention & Control Leads and discussed at clinical governance meetings.



Summary of MRSA Bacteraemia Cases Detected at BHT April 10 – March 11

Total no of cases: 4
Post-48 hour cases ("BHT-allocated"): 2

(In 2009-10, 12 cases were detected; 3 of these were post-48 hour cases).

BHT-allocated cases:

Site:
Both cases were detected at WGH

WGH cases:
Case 1: probably related to pressure sores present on admission.
Learning points from the Root Cause analysis included the fact that a full MRSA screen was not done on admission.
The patient's VIP chart was not maintained fully during admission.

Case 2: probably related to a PEG tube.
MRSA screening was not done prior to PEG insertion which is in the PEG Policy.
The PEG tube should have been removed when no longer required.

MSSA Bacteraemias

MSSA Bacteraemias detected April 2010 to March 2011.

	SMH	WGH	CIC	Total
Total Numbers	45	15	0	60
BHT/CIC Associated	8			8

It became mandatory to report MSSA Bacteraemias to the HPA in January 2011.
Between Jan and March 2011, 16 cases were detected. Only 2 of these were detected 48 hours or more after the patient's admission.

Glycopeptide Resistant Enterococci Bacteraemia

No cases were reported in 2010/11.

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 275 new isolates in urine specimens (143 W&A, 130SMH) from April 2010 – March 2011. Of these 195 (107 W&A, 88 SMH) were specimens received from General Practitioners (153 in 2009/10). 78 (36 W&A, 42 SMH) were from the acute Trust (90 in 2009/10).

Multi Resistant Acinetobacter Baumannii (MRAB)

MRAB is a bacterium that is found commonly in the environment. Approximately 25% of people may carry Acinetobacter on their skin or in their bowels asymptomatically. The trust laboratories identified 23 new isolates of MRAB for 2010/11. It is likely that seventeen of these 23 patients acquired the MRAB at BHT.

Influenza:

December & January 2010/11
Influenza A H1N1 (swine flu),
42 cases confirmed, SMH 33 and WH 9

Influenza B
15 cases confirmed, SMH 9 and WH 6

Influenza A H3N2
One case at WH

Delay in Isolation of Infected/Potentially Infected Patients

Delayed Isolation data has continued to be collected per patient bed day, and permits an ongoing audit of the Trust's Isolation Policy. This information however relies on data obtained via a variety of means (e.g. bed management team, IPCT, 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 Wycombe & Amersham (W&A) and SMH because they are analysed and reported separately by the Centre for Infection in Colindale. The figures below include or infections (in-patients, readmissions and post discharge)

Total number of procedures April 10 – March 11 (W&A sites):			
	Totals	**Infections (W&A)**	**National Infection Rate**
Hip replacements	426	3 (0.7%)	1.1%
Knee replacements	478	4 (0.8%)	1.2%
Total number of procedures July 10 – Sept 10			
	Totals	**Infections (SMH)**	**National Infection Rate**
Repair of neck of femur	85	2(2.4%)	1.9%

OUTBREAK REPORTS

A total of 14 outbreaks of confirmed viral gastroenteritis associated illness occurred between April 2010 - March 2011. A further 24 were unconfirmed but resulted in ward closures.

(For April 2009 – March 2010 the Trust had reported 13 confirmed outbreaks of norovirus)

SAVING LIVES/INFECTION PREVENTION & CONTROL LEADS

The IPCT have continued to work with the nominated Infection Prevention & Control Leads, Matrons and Link Practitioners from each SDU. Each SDU has been required to write its annual infection prevention & 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 Prevention & Control Balanced Score Card (BSC) to complete which includes the following items:

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

This information is held on the Trust Scorecard drive.

The Future of this meeting was discussed in March as infection control issues will be incorporated/reported in the Divisional Governance meetings. IC Divisional leads will continue to maintain the BSC and work programmes. Any concerns must be escalated onto the risk register. Divisions and SDUs should monitor IC issues and these will be reported to the IPCC. All divisions to have representation at the IPCC meetings and be able to report SDU IPC concerns

HAND HYGIENE

The Trust's Hand Hygiene campaign continued throughout 2010-2011. 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 has been achieved during 2010-2011:

- Audit of hand hygiene continued as per the annual audit programme. Assessment of 'Bare Below the Elbows' compliance was included within the hand hygiene audit tool. The focus of the audit tool was around the WHO 5 moments as part of the national 'clean your hands Campaign'. A central hand hygiene drive continues to be the central drive for inputting the monthly hand hygiene observational audit results. Dissemination of the results to all staff groups and wards/departments was undertaken with Infection Prevention & Control Leads and Modern Matrons taking responsibility within their areas for local improvement. Areas with results below the compliance level of 90% must complete weekly audits until the compliance level is achieved (see appendix 7). Areas must produce an action plan to the address areas of low compliance or non participation. The results are also discussed at divisional board meetings. These audits will continue as per the new audit programme for 2011-2012.
- The academic component of mandatory hand hygiene is now provided by an e learning module. Hand hygiene practical sessions are organised monthly via the training department. The sessions are face to face and run by the IPCT and the hand hygiene practical and competency assessment is completed. These are now well established within the mandatory training programme, annually for clinical and bi-annually for 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.
- A contract continues to be in place for the maintenance of hand hygiene 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 05/05/2010 which was aimed at children. Activities such as assessing hand hygiene compliance with the light boxes, hand printing and a poster for the children to colour in was taken up in various areas.
- Infection Prevention & Control week (18/10/2010) was aimed at visitors hand hygiene when entering the Trust. Mobile hand hygiene dispensers were manned at various entrances to the Trust by the IPCT and a patient representative. Photographs were taken of visitors and displayed on IPC notice boards and in the IC Times. Also visitors were asked to complete a small questionnaire around their understanding and experience of hand hygiene practices.
- IPCT and communications produce a video highlighting the process of hand hygiene and which products are appropriate during outbreaks. This was placed on the Trusts Internet site which linked to u tube, also was shown at the main entrances to Trust.
- An Interview was carried out with local papers discussing hand hygiene within the Trust.

LINK PRACTITONER PROGRAMME

The Infection Prevention & Control Link Practitioner (ICLP) programme comprised three study days throughout the year as planned on both Wycombe Hospital and Stoke Mandeville Hospital sites. For the first time the fourth study day was held as a combined study day in the Floyd Auditorium. Once again the well attended study days were repeated across the sites to ensure all the ICLPs received the same information across the Trust and allowed individuals to attend the days on either site. ICLPs received an ongoing education building on the previous years' work. The role of the ICLP includes taking part in the High Impact Intervention (HII) audits across the Trusts for their wards and departments. The Hand hygiene audit underwent changes so that the audit is now completed on a monthly basis.

A particular highlight this year was the award received by the ICLPs in the Trust Staff Awards scheme, in which they were awarded second place in recognition for their continued work to ensure our patients are cared for in Clean & Safe Environment.

Please refer to Appendix 8 for further details of the content of the programme.

DECONTAMINATION

The Trust continues to work towards the provision of a single site CSSD facility. It will be designed to service all of BHT's activity and current contract provisions and is expected that the new unit will come on line during the next financial year.
Members of the IPCT attend the Trust's Decontamination Committee meetings which are Chaired by the Director of Property Services.

PATIENT ENVIRONMENT ACTION TEAMS (PEAT)

The IPCT were involved in the annual PEAT inspections in February 2010 and January 2011. The final report for 2011 has not yet been received. The following results were taken from https://report.npsa.nhs.uk/PEAT/Results/Trust/?id=10304 the National Patient Safety Agency website.

Year	Sites	Results		
		Environment	Food	Privacy & Dignity
2010	Amersham	Good	Excellent	Good
	Stoke Mandeville	Acceptable	Excellent	Excellent
	Wycombe	Good	Excellent	Excellent
	Waterside Unit	Good	Good	Good
2009	Amersham	Good	Excellent	Good
	Stoke Mandeville	Acceptable	Good	Good
	Wycombe	Acceptable	Excellent	Acceptable

INFECTION CONTROL MANUAL

The infection control manual continues to be updated and new sections added as required. Manual was updated to include community information during the year in order that everyone has the same advice.

The following sections were updated in 2010-11.

Updated Infection Control Manual Sections
1.3 Chickenpox/Shingles
1.8 VRE
1.10 Meningitis
1.18 Legionella & Legionnaire's Disease
1.11 MRSA
1.12 Notifiable Infectious Disease
1.15 Tuberculosis
1.19 MRAB
1.17 Pandemic Influenza
2.2 Peripheral Lines
2.1 Hand Hygiene
2.11 Aseptic Technique
3.3 Food Hygiene
3.4 Needlestick & Other Inoculation Injuries
3.8 Laundry
3.7.2 Protective Isolation
3.15 Animals on Trust Premises
4 Decontamination
5.2 Employee Health
5.3 Operating Theatres

All sections of the manual were also uploaded onto the Trust intranet in addition to being distributed to be included in hard copies of the manual located in clinical areas.

EDUCATIONAL ACTIVITIES

In April the IPCT and training department launched an IPC e-learning module for staff. A non-clinical & clinical module is available. Hand Hygiene practical face to face sessions are delivered monthly set dates organised by the training department. These are one hour long sessions. We continue to deliver face to face Induction training for all new Trust staff. See appendix 9 for more detailed information regarding further education sessions

AUDIT ACTIVITY

The audit programme for the year can be found in the Infection Prevention & Control Annual Programme see Appendix 2.

The following audits were undertaken:

- Ward/Department Environmental Audits
- Patient equipment audits
- Ward kitchen audits
- HII Urinary Catheter Care audit
- HII Care Bundle for ventilated patients.
- HII Peripheral Line audit
- HII Surgical Site Infection audit
- HII Central Line Venous Catheter Care Ongoing Management
- Hand hygiene observational audits
- Hand Hygiene Practice & Facilities audit
- Sharps Management
- Infection Control Knowledge Survey
- Isolation Policy Audit
- MRSA and Clostridium difficile policy audits
- MRSA Sticker Audit
- Outbreak Policy Audit
- Patient Passport Audit
- Personal Protective Equipment
- Transfer Form audit

Formal reports provided by Clinical Audit & Effectiveness Department

All formal reports are disseminated to relevant wards, departments, committees to highlight key findings and recommendations for their action. See appendix 10.

ANTIBIOTIC REVIEW GROUP

The group has continued to meet throughout the year. A report of activity can be found in Appendix 12.

RISK MANAGEMENT/CLINICAL GOVERNANCE

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

BUILDING PROJECTS

The ICT continued to provide support with both minor and major building projects including new builds and refurbishments. This included:

- Amersham Health Centre
- Wycombe Birthing Centre
- Rayners Hedge
- Marlow Hospital
- Thame Hospital
- Buckingham Hospital
- Burns & Plastics OPD, SMH
- St Francis Ward, SMH
- Florence Nightingale House
- Upgrade of SMH laboratory
- Ward 9 WH upgrade
- 6A upgrade for WPH
- Installation of Laparoscopic Theatre, WH

COMMITTEE/GROUP MEMBERSHIP

Infection Prevention & Control Committee
Trust wide Infection Prevention & 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 Midwifery & Therapy Board
Ward Team Leader Meetings
Senior Practitioner Forum
The Domestic Services Review Group (SMH & W&A)
County Environmental Health Committee
Regional Professional Development Group (microbiologists)
Decontamination Committee
Buckinghamshire PCT Infection Prevention & Control Committee.
Healthcare Governance Committee
Critical Care Delivery Group
Orthopaedic Infection Group
SDU governance Meetings
Divisional Board Meetings
Tissue Viability

OTHER ACTIVITIES

Infection Control Times

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

Infection Prevention & Control Notice Boards

Updated as necessary in response to global and national events i.e. H1N1 and WHO Global Hand Washing.

Research, Publications and Presentations

Dr J O'Driscoll

Research:

Environmental air sampling in a ward containing a ceiling-mounted novel air disinfection unit (ADU).
(£38,000 Grant from NHS Innovations).
The results showed a significant reduction ($p<0.0001$) in airborne micro-organisms when the ADU was operating compared to it being switched off.

Do probiotics prevent antibiotic-associated diarrhoea including Clostridium difficile-associated diarrhoea in patients with spinal cord injury: a randomised controlled trial.

Publications:

Wong SS, O'Driscoll J, Weldon M & Yau CY(2010): Nutritional status predicts hospital length of stay and mortality in patients with Clostridium difficile infection. Proc Nutr Soc 69 (OCE2), E175

Wong SS, O'Driscoll J, Weldon M &Yau CY (2010); Do regular oral nutritional supplements improve clinical outcomes in patients with Clostridium difficile infection; a pilot study. Proc Nutr Soc 69 (OCE2) E174

Presentations:

European Congress of Clinical Microbiology and Infectious Diseases, April 2010, Vienna:

- Infection Control measures during a C. difficile outbreak (Educational Workshop)
- Joint Chair with Prof F. Barbut (Pasteur Institute) of Official Symposium on New aspects of emerging C. difficile infections.

Royal College of Physicians update at Stoke Mandeville Hospital June 21st 2010:
C. difficile update.

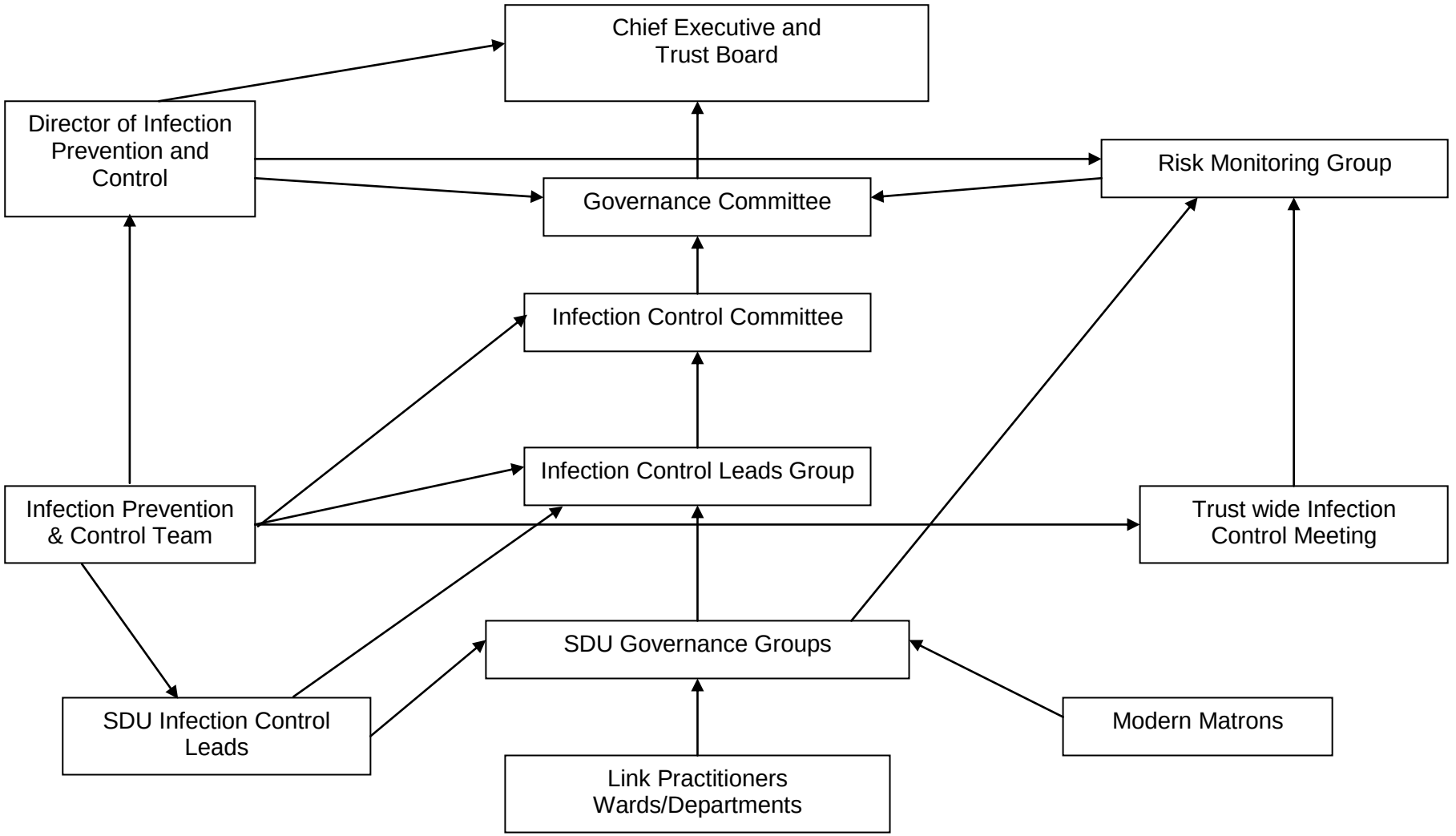
Welsh Microbiology Association Summer Meeting, Cardiff June 25th 2010:

Recent developments in C. difficile infection.

Appendix 1

Buckinghamshire Healthcare 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 2010/2011

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 Trust's 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

- MRSA objective: No more than 5 cases of BHT-attributed (ie detected more than 48 hours after admission) MRSA Bacteraemias. Trajectory illustrated in Appendix A.
- Reduction in numbers of cases 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 and Amber Risks related to Infection Prevention and Control on Balanced Scorecards.
- 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 2010/11 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
- NAO Audit 2009

6. The incorporation of Community Health Buckinghamshire (CHB) into BHT from 1st April 2010 will provide challenges and opportunities for strengthening infection prevention and control for the local population.

Priorities for 2010/11 include:

- Streamlining Policies and Guidelines
- Streamlining induction and annual training updates
- Improving the care of in-dwelling urinary catheters across the healthcare boundaries
- Improving the transfer of information about specific infection risks across the healthcare boundaries

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 10	✓
	• The Healthcare Governance Committee will receive regular Reports from Divisions. Issues of concern will be highlighted to the Board.	KG	Ongoing	
	• Ensure IPC is incorporated into all Executive Director job descriptions, with identified outcome measures.	SH	Ongoing	
RAG rating* for June 2010				Green

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	Ongoing	June 10: Productive Ward expand-ing. Single board per area required.
	• 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 * June 2010				Amber

Infection Control Team in liaison with others

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.	NW/JOD	August 10	June 10: Programme has been developed successfully. Over 1000 participants to date.
	• Ensure all relevant staff receive training in aseptic techniques and are assessed as competent.	Lead Nurse/GL	Ongoing	June 10: Ensure nurses can pass calculation test.
RAG rating * June 10				Amber
Surveillance Prompt action is taken when required following feedback of surveillance data.	Continue mandatory surveillance of: • MRSA Bacteraemias	KC/ICT	Ongoing	
	• C difficile	KC/ICT	Ongoing	
	• Glycopeptide resistant enterococci	KC/ICT	Ongoing	
	• Orthopaedic surgery wound infections (formerly NINSS)	KC/ICT	Ongoing	
	Continue voluntary surveillance: • C difficile (weekly reporting)			
	• MRSA (non-Bacteraemias)			
	• ESBL			
	• Multi-resistant Acinetobacter baumanii			
	Commence voluntary surveillance: • MSSA Bacteraemias	DIPC	Monthly from	

Objectives	Actions	Lead	Timescales	Update
			April 10	
	• Line-associated infections	DIPC	Monthly from April 10	
	• Ventilator-associated pneumonia	DIPC	Monthly from April 10	
	Continue to participate in the "Matching Michigan" Project (commenced Dec 09)	DIPC	-	
RAG rating * June 10				Green
<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.	IG	Ongoing	
	• Make recommendations about purchase of new equipment and changes to operating environment.			
	• Joint Policy with CHB required.	NW/FS	July 10	
RAG rating * June 2010				Green
<u>Policies</u> The Trust has appropriate policies in place in relation to preventing and controlling the risks of HCAIs.	• Circulate updated policies to ICC	NW	Ongoing	
	• Policies ratified by ICC	NW	Ongoing	
	• New policies to be written: Joint BHT/CHB Policies	NW/FS	Ongoing	
	• Policies to be revised: As required per rolling programme	ICT	As required	
RAG rating *June 10				Green
<u>Audit of Policies</u> Compliance with key policies is	<u>Policies to be audited</u> • MRSA	ICT	Nov 10	

Objectives	Actions	Lead	Timescales	Update
ensured through the implementation of high impact interventions and monitored through audit.	• C. difficile	ICT	Sept 10	
Assess standards of practice through audit of High Impact Interventions.	See separate Audit Programme (Appendix D)	AA	Ongoing	
RAG rating * June 10				Amber Some slippage from Programme
<u>Antibiotic Prescribing</u> Minimise antibiotic resistance by appropriate prescribing.	• Antibiotic Review Group to continue to update and merge relevant guidelines.	DW	Ongoing	
	• Audits of antibiotic prescribing to be undertaken regularly and results acted upon.	DW/BC	Ongoing	
	• Monthly update of antibiotic usage graphs with feedback of unusual/inappropriate prescribing to Division.	BC/DIPC	Ongoing	
	• Ensure education on antibiotic prescribing to all doctors as required by national guidelines.	DIPC	Ongoing	June 10: New doctors get training as part of induc-tion.FY1 & FY2 doctors receive annual updates.
RAG rating * June 10				Amber
<u>Environmental audits</u> Ensure environmental standards are maintained.	• Ensure environmental audits are carried out annually.	ICT/Ward/Depart ment	Ongoing	
	• Matrons to monitor through rounds, Domestic Service review meetings.	Managers/Audit Dept/Chief Nurse/ Matrons	Ongoing	
	• Review PEAT scores		When available	
RAG rating * June 10				Green

Objectives	Actions	Lead	Timescales	Update
MRSA Screening Compliance with Health Act requirements for MRSA screening.	Continue to ensure that all eligible elective and emergency admissions are screened.	Director of Operations	Ongoing	
RAG rating * June 10				Green
MRSA and MSSA Bacteraemias Improve MRSA and MSSA 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.	Infection Control Leads.	Ongoing	
	• Report root causes and action to Governance Committee and Trust Board.	DIPC	Ongoing	
RAG rating * June 10				Green
Reduce IV line-associated infections.	• Formal training on peripheral and central line insertion and ongoing management.	DIPC	Ongoing	
	• Monitoring of central line infections.	DIPC	Ongoing	
	• Monthly monitoring of peripheral line infections.	DIPC	Ongoing	
RAG rating * June 10				Green
Reduce needle stick injuries & preventable occupational infections.	Audit NSIs, identify preventable causes and take appropriate action (BHT and CHB).	WPH	From April 10	June 10: 09/10 audit circulated. Prospective audits in place.
	Monitor and encourage uptake of staff vaccination, eg influenza, varicella and MMR.	WPH	From April 10	June 10: In place
RAG rating * June 10				Amber
Link Practitioner Programme	Continue to build on existing programme incorporating new initiatives as required.	LA	Ongoing	
RAG rating * June 10				Green
Hand Hygiene	• Monitor results of Patient Experience Tracker System	ICT	Ongoing	
	• Complete the audit of provision of hand hygiene	FS	July 10	

Objectives	Actions	Lead	Timescales	Update
	facilities at CHB			
	• Continue with 'Clean your hands' campaign	ICT	Ongoing	
	• Ensure all staff groups in all clinical SDUs achieve 90% or more compliance on monthly audits.	DC/DLNs	Ongoing	
	• Ensure clinical staff comply with 'Bare below the Elbows'	ICT	Ongoing	
	• Focus on patient and visitor hand hygiene	ICT	Ongoing	
	• Review the hand hygiene component of the Annual Staff Survey and take action to correct any deficiency highlighted.	IPCT	July 10	
RAG rating * June 10				Green
Emergency Planning	Participate in Trust's emergency planning Specifically for: • Pandemic Influenza (All relevant staff should undergo fit-testing of recommended masks)	KC	Ongoing	
	• Deliberate release – CBRN	KC	Ongoing	
RAG rating * June 10				Green
Building development and Cleaning issues	• Ensure a cleaning strategy exists that is regularly monitored by the Board	IG	Ongoing	
	• Continue input into building developments and refurbishments	ICT	Ongoing	
	• Check that Legionella Risk Assessments are carried out Trust-wide and any identified remedial actions required carried out	IG/AM	April 10	
	• Joint BHT/CHB Legionella Policy to be produced	IG/AM	Sept 10	
	• Annual Joint Reviews with Contractors	IG	Sept 10	
	• Annual cleaning update	IG	Sept 10	
	• Minutes of Domestic Review Group to go to ICC		From April 09	
	• Check there is an annual planned programme of operating theatre engineering checks	IG/AM	July 10	June 10: Problem with access to theatres.
RAG rating * June 10				Amber

Objectives	Actions	Lead	Timescales	Update
Reactive, core clinical roles	Clinical advice/support to all areas: • Management of infectious patients	ICT	Ongoing	
	• Investigation of outbreaks and clusters	ICT	Ongoing	
RAG rating * June 10				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	NW/ICT	Ongoing	
RAG rating * June 10				Green
Provision of information for patients, relatives and staff:	• Development of Trust's website	NW/FS	Ongoing	
	• Provision of relevant leaflets. New leaflets to be produced as required.	NW/FS	Ongoing	
RAG rating * June 10				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	June 10: NW to check. ?E-learning cert to be used as evidence.
RAG rating * June 10				Amber

Key to Leads:

JOD	Dr Jean O'Driscoll, DIPC	AM	Anne Maguire	NW	Niamh Whittome
JB	Juliet Brown	IG	Ian Garlington	KG	Keith Gilchrist
SK	Sam Knollys	SH	Sandra Hatton	IPCT	Infection Prevention & Control Team
EH	Liz Hollman	GL	Dr Graz Luzzi	WPH	Workplace Health
KC	Dr Kathy Cann	DW	Dr David Waghorn	AA	Amanda Adkins
FS	Fiona Simpson	BC	Breda Cronnolly		

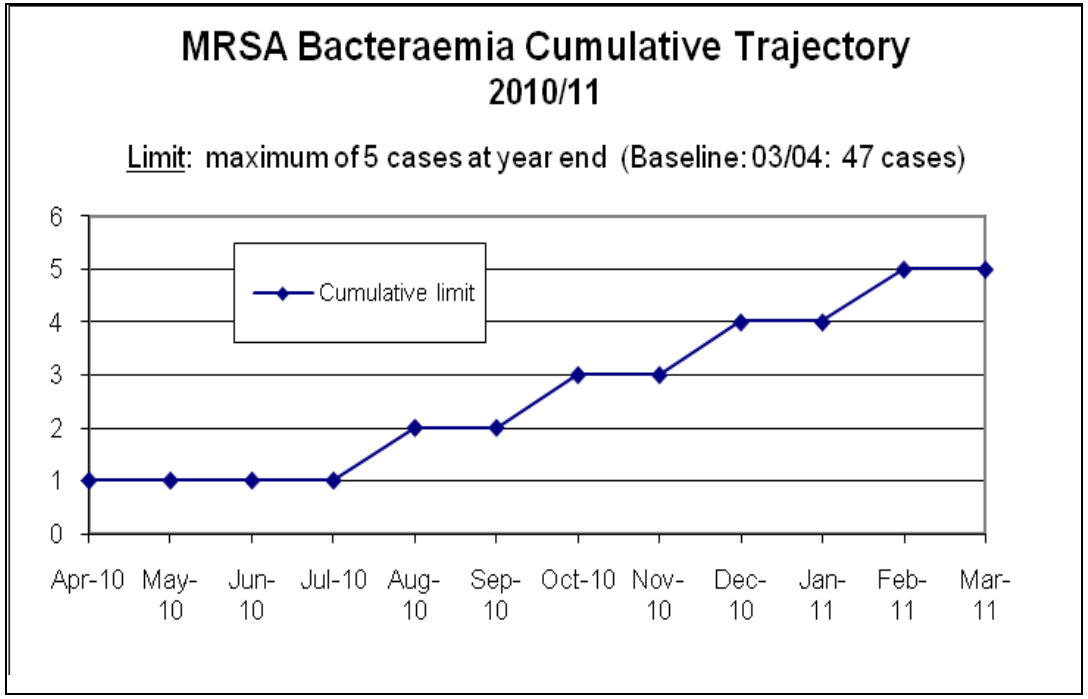
APPENDIX A

MRSA BACTERAEMIA TRAJECTORY
APRIL 2010 – MARCH 2011

Target for total number of cases by March 2011: 5

Monthly Target for Trust:

	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Limit	1	0	0	0	1	0	1	0	1	0	1	0



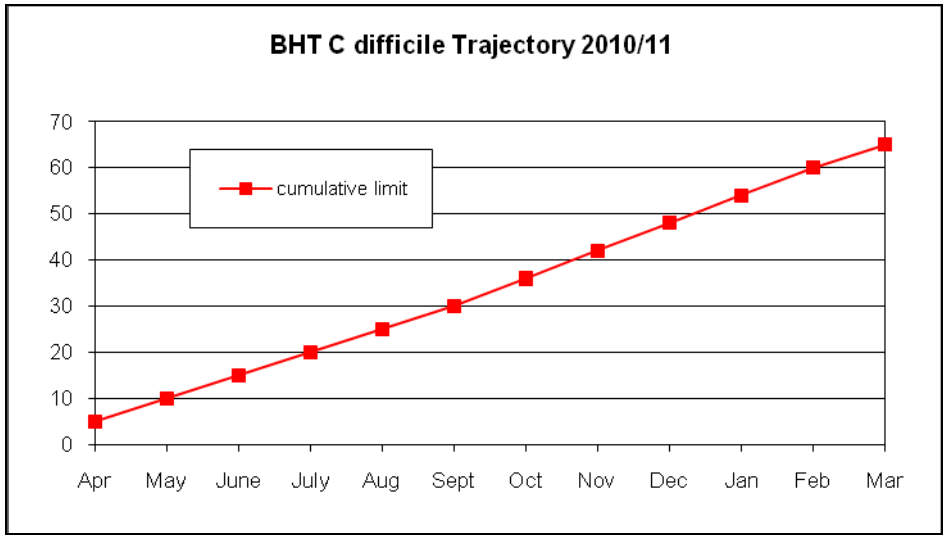
Appendix B

Clostridium difficile TRAJECTORY for BHT
APRIL 2010 – MARCH 2011

Target for total number of cases by March 2011: 65

Monthly Target for Trust:

BHT C difficile Trajectory 2010/11												
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Limit	5	5	5	5	5	5	6	6	6	6	6	5
cumulative limit	5	10	15	20	25	30	36	42	48	54	60	65

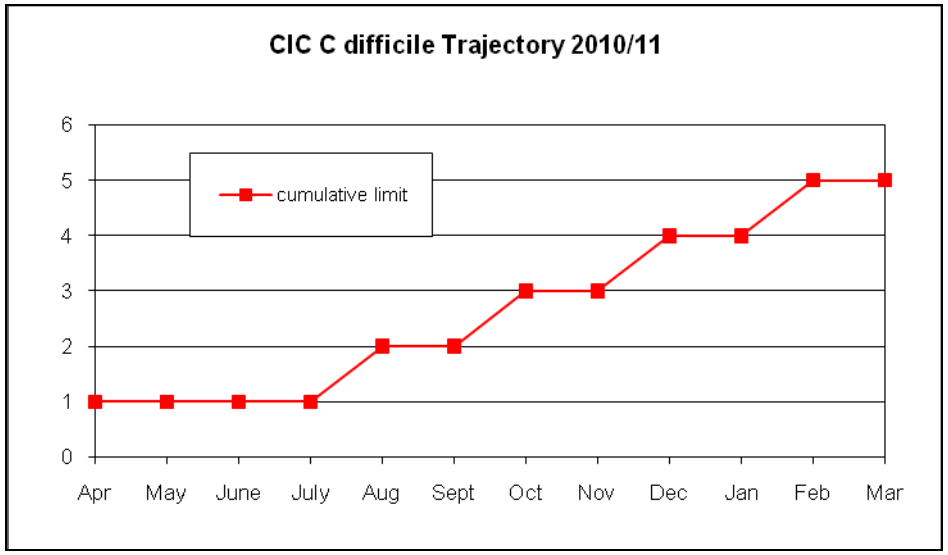


Clostridium difficile TRAJECTORY for Community Integrated Care
APRIL 2010 – MARCH 2011

Target for total number of cases by March 2011: 5

Monthly Target for CIC:

BHT C difficile Trajectory 2010/11												
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Limit	1	0	0	0	1	0	1	0	1	0	1	0
cumulative limit	1	1	1	1	2	2	3	3	4	4	5	5



Draft Audit Programme 2010/11				
Month	**Audit details**	**Areas to complete Audit**	**Undertaken by**	**Return to**
April	ICNA Management of Patient Equipment Audit (over 2 months)	All wards/departments	Infection Prevention Nurse (IPN)	N/A
	Kitchen	All wards/departments – not Theatres	Housekeeper	IC Department
	Hand Hygiene Observational Audit including Phlebotomists	All areas/departments	Ward Managers/Modern matrons/ICLPs	Entered onto Hand Hygiene drive
May	ICNA Management of Patient Equipment Audit (cont'd)	All wards/departments	IPN	N/A
	HII - Urinary Catheter Care Audit (insertion & ongoing management	ITU, Spinal, Theatres, Urology, Rothschild	Ward managers/ICLPs	Clinical Audit Department
	HII – Care Bundle for Ventilated Patients	Spinal – St Andrews, ITU	Ward Managers/ICLPs	Clinical Audit Department
	Hand Hygiene Observational Audit including Phlebotomists	All areas/departments	Ward Managers/Modern matrons/ICLPs	Entered onto Hand Hygiene drive
June	VIP Audit	All wards/departments including DSU, endoscopy, X-ray, Day stickers	Ward Managers/Modern matrons/ICLPs	Clinical Audit Department
	HII – Peripheral Line Audit	All clinical areas/departments	Ward manager/ICLP	Clinical Audit Dept.
	Hand Hygiene Observational Audit including Phlebotomists	All areas/departments	Ward Managers/Modern Matrons/ICLPs	Entered onto Hand Hygiene drive
	Transfer Form Audit		ICT	ICT
	HII Surgical site Infection Pre op section	One speciality Trustwide	F1/ICPT	F1/ICPT
July	Hand Hygiene Observational Audit including Phlebotomists	All areas/departments	Ward Managers/Modern matrons/ICLPs	Entered onto Hand Hygiene drive

	HII – Surgical Site Infection	All pre-op departments, All theatres	Theatres & ICN	Clinical Audit Department
	HII Surgical Site Infection Peri operative section	All Theatres	Divisional Leads, Theatre Managers, ICLP's	Clinical Audit
August	Hand Hygiene Observational Audit including Phlebotomists	All areas/departments	Ward Managers/Modern matrons/ICLPs	Entered onto Hand Hygiene drive
September	Infection Control Knowledge Survey		Clinical Audit/IPNs	Clinical Audit Department
	IC *Clostridium Difficile* Policy Audit		F1/ICT	ICT
	Hand Hygiene Observational Audit including Phlebotomists	All areas/departments	Ward Managers/Modern matrons/ICLPs	Entered onto Hand Hygiene drive
	Hand Hygiene Observational Audit including Phlebotomists	All areas/departments	Ward Managers/Modern matrons/ICLPs	Entered onto Hand Hygiene drive
	HII – Central Line Venous Catheter Care ongoing management **ITU**	All areas	Ward Managers/ICLPs	Clinical Audit Department
	HII Surgical Site Infection Pre op section	One Speciality	F1/IPCT	F1/ICPT
October	Hand Hygiene Observational Audit including Phlebotomists	All areas/departments	Ward Managers/Modern matrons/ICLPs	Entered onto Hand Hygiene drive
	HII Surgical Site Infection Elective Hip & Knee replacements only	Loakes Theatres & IPCN	Loakes Theatres & IPCN	Clinical Audit
	HII Central Line Venous Catheter Care ongoing management	ITU, St Andrews.		
November	Isolation Policy Audit		ICT	
	Hand Hygiene Observational Audit including Phlebotomists	All areas/departments	Ward Managers/Modern matrons/ICLPs	Entered onto Hand Hygiene drive
	IC MRSA Policy Audit		F1/ICT	ICT

	Environmental Audits	All wards/departments	Ward Managers/ICLPs	IC Department
	HII Surgical Site Infection Elective Hip & Knee replacements only	Loakes Theatres & IPCN	Loakes Theatres & IPCN	Clinical Audit
December	Hand Hygiene Observational Audit including Phlebotomists	All areas/departments	Ward Managers/Modern matrons/ICLPs	Entered onto Hand Hygiene drive
	HII Surgical Site Infection Elective Hip & Knee replacements only	Loakes Theatres & IPCN	Loakes Theatres & IPCN	Clinical Audit
January 2010	Hand Hygiene Observational Audit Including Phlebotomists	All areas/departments	Ward Managers/Modern matrons/ICLPs	Entered onto Hand Hygiene drive
	HII Surgical site Infection Pre op section	One Speciality	F1/ICPT	F1/ICPT
February	Hand Hygiene Observational Audit Including Phlebotomists	All areas/departments	Ward Managers/Modern matrons/ICLPs	Entered onto Hand Hygiene drive
March	Hand Hygiene Observational Audit Including Phlebotomists		Ward Managers/Modern matrons/ICLPs	TBC
	Outbreak Policy Audit		DIPC/ICT	N/A

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 3

INFECTION PREVENTION AND CONTROL PROGRAMME 2011/2012

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 Prevention and Control Committee (IPCC) which will also monitor the progress.

2. Aim of the Buckinghamshire Hospitals NHS Trust Infection Prevention and 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 Trust's 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

- MRSA objective: No more than 3 cases of BHT-attributed (ie detected more than 48 hours after admission) MRSA Bacteraemias. Trajectory illustrated in Appendix A.
- C difficile objective: No more than 45 cases of BHT-attributed (ie detected more than 72 hours after admission) C difficile cases. Appendix B.

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

- Annual Infection Control environmental audits by the Infection Prevention and Control Team (IPCT): 100% of wards to achieve at least 85% compliance.

Monthly reporting of:
  - Hospital acquired infections (MRSA and C. difficile)
  - MRSA, MSSA and E.coli Bacteraemias
  - Hand hygiene compliance
- Identification and management of Red and Amber Risks related to Infection Prevention and Control on Balanced Scorecards.
- Root Cause Analysis of BHT-attributed MRSA and MSSA 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 2011/12 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
- NAO Audit 2009

6. The incorporation of Community Health Buckinghamshire (CHB) into BHT as the Community and Integrated Care (CIC) Division from 1st April 2010 has provided challenges and opportunities for strengthening infection prevention and control for the local population which needs to be further developed.

Priorities for 2011/12 include:

- Improving the care of in-dwelling urinary catheters across the healthcare boundaries
- Improving the transfer of information about specific infection risks across the healthcare boundaries
- Improving uptake of Infection Prevention and Control training by healthcare staff
- Improving the uptake of influenza vaccination by healthcare staff

The purpose of this programme is to identify all key work streams required to ensure all appropriate actions are being taken by Buckinghamshire Healthcare NHS Trust to minimise the risk of healthcare 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	August 11	
	• The Infection Prevention and Control Committee will receive regular Reports from Divisions including a summary of any Infection Control concerns. An exception report will go to the Healthcare Governance Committee.	KG	Ongoing	
	• Ensure IPC is incorporated into all Executive Director job descriptions, with identified outcome measures.	SH	Ongoing	
RAG rating* March 2011				Green

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	Ongoing	
	• Each SDU will include an Infection Report update at Divisional Governance Meetings.	SDU Infection Control Leads	Bimonthly	
	• SDUs will partake in the Infection Prevention Performance Monitoring.	SDU Infection Control Leads	Ongoing	
	• The use of transfer forms to highlight HCAI information needs to be strengthened. The Trust's Discharge Policy needs to be ratified, released and audited.	Matrons	July 11	
	• 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* March 2011				Green

Infection Control Team in liaison with others

Objectives	Actions	Lead	Timescales	Update
<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.	ADOs	Ongoing	
	• Ensure that all the above receive annual updates in infection control including hand hygiene competency assessment.	ADOs	Ongoing	
	• Ensure all relevant staff receive training in aseptic techniques and are assessed as competent.	Lead Nurse/GL	Ongoing	

	• All staff who:
	  ○ Carry out urinary catheterisation
	  ○ Provide ongoing care for individuals with urinary catheters
	  ○ Insert peripheral and central venous catheters
	  ○ Provide ongoing care to patients with peripheral or central venous catheters
	will receive training which includes the management of associated infection control risks related to these devices.
		Lead Nurse/GL	Ongoing	

RAG rating* March 2011				Amber
<u>Surveillance</u> Prompt action is taken when required following feedback of surveillance data.	Continue **mandatory** surveillance of: • MRSA Bacteraemias	IPCT	Ongoing	
	• C difficile	IPCT	Ongoing	
	• Glycopeptide resistant enterococci	IPCT	Ongoing	
	• Orthopaedic surgery wound infections	IPCT	Ongoing	
	• MSSA Bacteraemias	IPCT	From Jan 2011	
	• E.coli Bacteraemias	IPCT	From June 2011	
	Continue **voluntary** surveillance: • C difficile (weekly reporting)	IPCT	Ongoing	

Objectives	Actions	Lead	Timescales	Update
	• MRSA (non-Bacteraemias)	IPCT	Ongoing	
	• ESBL	IPCT	Ongoing	
	• Multi-resistant Acinetobacter baumanii	IPCT	Ongoing	
	• Line-associated infections	DIPC	Ongoing	
	• Ventilator-associated pneumonia (ITU/HDU)	DIPC	Ongoing	
	• Catheter-associated UTIs (CAUTIs)	DIPC	Monthly from April 11	
	• Continue to participate in the "Matching Michigan" Project (commenced Dec 09)	DIPC	-	
	• Blood culture contaminants	DIPC	Ongoing	
RAG rating* March 2011				Green
<u>Decontamination</u> There are effective arrangements for the appropriate decontamination of instruments and other equipment	• Ensure that the Decontamination Programme 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.	IG	Ongoing	
	• Make recommendations about purchase of new equipment and changes to operating environment.	IPCT		
RAG rating* March 2011				Green
<u>Policies</u> The Trust has appropriate policies in place in relation to preventing and controlling the risks of HCAIs.	• Circulate updated policies to IPCC	NW	Ongoing	
	• Policies ratified by IPCC	NW	Ongoing	
	• Policies to be revised: As required per rolling programme	IPCT	As required	
RAG rating* March 2011				Green
<u>Audit of Policies</u> Compliance with key policies is	<u>Policies to be audited</u> • MRSA	IPCT	Nov 11	

Objectives	Actions	Lead	Timescales	Update
ensured through the implementation of high impact interventions and monitored through audit.	• C. difficile	IPCT	June 11	
Assess standards of practice through audit of High Impact Interventions.	See separate Audit Programme (Appendix C)	AA	Ongoing	
RAG rating* March 2011				Amber
<u>Antibiotic Prescribing</u> Minimise antibiotic resistance by appropriate prescribing.	• Antibiotic Review Group to continue to update and merge relevant guidelines.	DW	Ongoing	
	• Audits of antibiotic prescribing to be undertaken regularly and results acted upon.	DW/AC	Ongoing	
	• Monthly update of antibiotic usage graphs with feedback of unusual/inappropriate prescribing to Division.	AC/DIPC	Ongoing	
	• Ensure education on antibiotic prescribing to all doctors as required by national guidelines.	DIPC	Ongoing	
RAG rating* March 2011				Amber
<u>Environmental audits</u> Ensure environmental standards are maintained.	• Ensure environmental audits are carried out annually.	IPCT	Ongoing	
	• Matrons to monitor through rounds, Domestic Service review meetings.	Managers/Audit Dept/Chief Nurse/ Matrons	Ongoing	
	• Review PEAT scores	NW	When available	
RAG rating* March 2011				Green
<u>MRSA Screening</u> Compliance with Health Act requirements for MRSA screening.	Continue to ensure that all eligible elective and emergency admissions are screened.	Director of Operations	Ongoing	
RAG rating* March 2011				Green
<u>MRSA and MSSA Bacteraemias</u> Improve MRSA and MSSA	• Ensure timescales for RCA reporting are met and corrective actions/learning shared across Divisions.	Infection Control Leads.	Ongoing	
	• Report root causes and action to Governance	DIPC	Ongoing	

Objectives	Actions	Lead	Timescales	Update
bacteraemia rates though identification of root causes, corrective action and sharing of learning.	Committee and Trust Board.			
RAG rating* March 2011				Green
Reduce IV line-associated infections.	• Monitoring of central line infections.	DIPC	Ongoing	
	• Monthly monitoring of peripheral line infections.	DIPC	Ongoing	
RAG rating* March 2011				Green
Reduce needle stick injuries & preventable occupational infections.	Audit NSIs, identify preventable causes and take appropriate action.	WPH	Ongoing	
	Monitor and encourage uptake of staff vaccination, eg influenza, varicella and MMR.	WPH	Ongoing	
RAG rating* March 2011				Green
<u>Link Practitioner Programme</u>	Continue to build on existing programme incorporating new initiatives as required.	LA	Ongoing	
RAG rating* March 2011				Green
<u>Hand Hygiene</u>	• Monitor results of Patient Experience Tracker System	IPCT	Ongoing	
	• Continue with 'Clean your hands' campaign	IPCT	Ongoing	
	• Ensure all staff groups in all clinical SDUs achieve 90% or more compliance on monthly audits.	ADNs	Ongoing	
	• Ensure clinical staff comply with 'Bare below the Elbows'	IPCT	Ongoing	
	• Focus on patient and visitor hand hygiene	IPCT	Ongoing	
	• Review the hand hygiene component of the Annual Staff Survey and take action to correct any deficiency highlighted.	IPCT	When results available	
RAG rating* March 2011				Green
<u>Emergency Planning</u>	Participate in Trust's emergency planning Specifically for: • Pandemic Influenza (All relevant staff should undergo fit-testing of recommended masks)	KC	Ongoing	

Objectives	Actions	Lead	Timescales	Update
	• Deliberate release – CBRN	KC	Ongoing	
RAG rating* March 2011				Green
Building development and Cleaning issues	• Ensure a cleaning strategy exists that is regularly monitored by the Board	IG	Ongoing	
	• Continue input into building developments and refurbishments	IPCT	Ongoing	
	• Check that Legionella Risk Assessments are carried out Trust-wide and any identified remedial actions required carried out	IG	Ongoing	
	• Annual Joint Reviews with Contractors	IG	Sept 11	
	• Annual cleaning update	IG	Sept 11	
RAG rating* March 2011				Green
Reactive, core clinical roles	Clinical advice/support to all areas: • Management of infectious patients	IPCT	Ongoing	
	• Investigation of outbreaks and clusters	IPCT	Ongoing	
RAG rating* March 2011				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	NW/IPCT	Ongoing	
RAG rating* March 2011				Green
Provision of information for patients, relatives and staff:	• Development of Trust's website	NW	Ongoing	
	• Provision of relevant leaflets. New leaflets to be produced as required.	NW	Ongoing	
RAG rating* March 2011				Green
Ensuring that all employees adhere to their responsibilities in relation to Infection Control	IC will be included in all appraisals and PDPs	SH	Ongoing	
RAG rating* March 2011				Amber

Key to Leads:

JOD	Dr Jean O'Driscoll, DIPC	AC	Anna Colthorpe	NW	Niamh Whittome
JB	Juliet Brown	IG	Ian Garlington	KG	Keith Gilchrist
SK	Sam Knollys	SH	Sandra Hatton	IPCT	Infection Prevention & Control Team
EH	Liz Hollman	GL	Dr Graz Luzzi	WPH	Workplace Health
KC	Dr Kathy Cann	DW	Dr David Waghorn	AA	Amanda Adkins

Infection Prevention & Control Audit Programme 2011/12

Buckinghamshire Healthcare NHS Trust

Month	Audit Details	Areas to Complete Audit	Undertaken by	Return to
April	Hand Hygiene Observational Audit	All Wards/ Departments/ Areas	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed
May	Infection Prevention & Control Audit (including Environment, Kitchen and Patient Equipment	All Wards/ Departments/ Areas	IPCT	
	HII – Urinary Catheter Care Audit (Insertion & ongoing management)	All Wards/ Departments/ Areas	Designated person(s) from ward/ department/ area	IPCT
	HII – Care Bundle for Ventilated Patients	NSIC & ITU	Designated person(s) from ward/ department/ area	IPCT
	Hand Hygiene Observational Audit	All Wards/ Departments/ Areas	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed
June	Infection Prevention & Control Audit (including Environment, Kitchen and Patient Equipment	All Wards/ Departments/ Areas	IPCT	
	HII – Peripheral Line Audit – Insertion & continuing care including VIP Form including DSU, Endoscopy, X-ray, Day Stickers	All Wards/ Departments/ Areas	Designated person(s) from ward/ department/ area	IPCT
	HII – Surgical Site Infection Pre-op	Burns & Plastics	IPCT	
	HII – Surgical Site Infection Peri-op	Theatres - Burns & Plastics	Designated person(s) from ward/ department/ area	IPCT
	Hand Hygiene Observational Audit	All Wards/ Departments/ Areas	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed
July	Dekomed Bedpan Washer Audit	All Bedpan Washers	Dekomed	
	Infection Prevention & Control Audit (including Environment, Kitchen and Patient Equipment	All Wards/ Departments/ Areas	IPCT	
	Personal Protective Equipment	All Wards/ Departments/ Areas	Designated person(s) from ward/ department/ area	IPCT
	Hand Hygiene Observational Audit	All Wards/ Departments/ Areas	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed
August	Hand Hygiene Observational Audit	All Wards/ Departments/ Areas	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed
September	IC *Clostridium difficile* Policy Audit	All Wards/ Departments/ Areas	Microbiology	
	HII – Surgical Site Infection Pre-op	General Surgery & Vascular	IPCT	
	HII – Surgical Site Infection Peri-op	Theatres General Surgery & Vascular	Designated person(s) from ward/ department/ area	IPCT
	Hand Hygiene Observational Audit	All Wards/ Departments/ Areas	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed
October	HII – Long Line Venous Catheter Care ongoing Management	All Wards/ Departments/ Areas	Designated person(s) from ward/ department/ area	IPCT
	HII – Surgical Site Infection Pre-op	T&O Elective & Emergency	IPCT	
	HII – Surgical Site Infection Peri-op	Theatres T&O Elective & Emergency	Designated person(s) from ward/ department/ area	IPCT
	Hand Hygiene Observational Audit	All Wards/ Departments/ Areas	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed

Month	Audit Details	Areas to Complete Audit	Undertaken by	Return to
November	**IC Isolation Policy Audit**	**All Wards/ Departments/ Areas**	Microbiology	
	IC MRSA Policy Audit	**All Wards/ Departments/ Areas**	Microbiology	
	HII – Surgical Site Infection Pre-op	**Ophthalmology, ENT & Oral**	IPCT	
	HII – Surgical Site Infection Peri-op	**Theatres Ophthalmology, ENT & Oral**	Designated person(s) from ward/ department/ area	IPCT
	Hand Hygiene Observational Audit	**All Wards/ Departments/ Areas**	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed
December	**Infection Control Manual Audit**	**All Manual Holders**	All manual holders	IPCT
	HII – Surgical Site Infection Pre-op	**Theatres Urology**	IPCT	
	HII – Surgical Site Infection Peri-op	**Theatres Urology**	Designated person(s) from ward/ department/ area	IPCT
	Hand Hygiene Observational Audit	**All Wards/ Departments/ Areas**	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed
January	**IC Knowledge Survey**	**All Wards/ Departments/ Areas**	All clinical staff	Electronic Survey
	Hand Hygiene Facilities	**All Wards/ Departments/ Areas**	Designated person(s) from ward/ department/ area	IPCT
	Hand Hygiene Observational Audit	**All Wards/ Departments/ Areas**	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed
February	**Safe Handling & Managements of Sharps**	**All Wards/ Departments/ Areas**	Designated person(s) from ward/ department/ area	IPCT
	Transfer Form	**All Wards/ Departments/ Areas**	Designated person(s) from ward/ department/ area	IPCT
	HII – Surgical Site Infection Pre-op	**Gynae**	IPCT	
	HII – Surgical Site Infection Peri-op	**Theatres -Gynae**	Designated person(s) from ward/ department/ area	IPCT
	Hand Hygiene Observational Audit	**All Wards/ Departments/ Areas**	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed
March	**Outbreak Policy**	**All Wards/ Departments/ Areas**	DIPC/IPCT	DIPC
	HII – Surgical Site Infection Pre-op	**Spinal**	IPCT	
	HII – Surgical Site Infection Peri-op	**Theatres - Spinal**	Designated person(s) from ward/ department/ area	IPCT
	Hand Hygiene Observational Audit	**All Wards/ Departments/ Areas**	Designated person(s) from ward/ department/ area	Enter results onto Hand Hygiene Drive Community Staff as previously instructed

One element of the Trusts 5 patient promise is to provide a clean and safe hospital for our patients. By completing various audits we can show we are monitoring and addressing any issues to improve our patients stay.

The aim is to provide a focus on elements of the care process and a method for measuring implementation of policies and procedures.

NB **This programme is subject to change**

Key: IPCT = Infection Prevention & Control Team
DIPC = Director of Infection Prevention & Control

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 (add up attendances to see if total greater than 48 hours) and within the previous 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 < 48 hrs 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 in-patient episode in the other acute Trust in the last 3 months.
   e) **another country**: BHT inpatients < 48 hrs and transferred form another country or have been an IP in another country in the last 3 months
   f) **private hospital**: BHT inpatients <48 hours 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.

Case definitions:

1. **Probable BHT acquired**: Patients are inpatients >72hrs at a BHT site before onset of symptoms and diagnosis

   OR

   Have been discharged and develop symptoms within 72hrs of discharge and positive result confirmed (i.e via GP, patient does not have to be an inpatient to be categorised as Cat1)

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

1st December 2009

Appendix 7

Buckinghamshire Hospitals NHS Trust

INFECTION PREVENTION & CONTROL DEPARTMENT

Ward/Departmental Hand Hygiene Audit Results April 10 - March 11

Red = Non Participation

Amber = Below 90% - Non compliant

	Divisional %		100%	100%	99%	100%	99%	99%	100%	98%	100%	99%	99%	100%
Division	Ward/ Department	Site	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
ACCESS	OPD	SMH			99%	99%	98%	98%	100%	96%	100%	99%	98%	99%
	OPD	WH	100%		100%	100%	100%	98%	100%	97%	100%	97%	100%	100%
	POA	SMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Moved to Surgery	
	POA	WH/AH	100%		100%	100%	100%	100%	100%	100%	100%	100%		

	Divisional %		100%	100%	100%	100%	97%	100%	99%	99%	99%	99%	98%	100%
Division	Ward/ Department	Site	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
CLINICAL SUPPORT SERVICES	Breast Screening	SMH	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%
	Breast Screening	WH	100%	100%	100%	100%	100%	99%	99%	100%	100%	100%	100%	100%
	CCHU Cancer/ Haematology Care	SMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	SMW5	SMH	99%	99%	99%	100%	85%	98%	92%	99%	100%	88%	84%	99%
	Clinical Photography	SMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Clinical Photography	WH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Clinical Photography	AH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Dietetic Clinic	SMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Dietetic Clinic	WH/ AH		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	Orthotist	SMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Orthotist	WH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Orthotist	AH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Radiology	SMH	100%	98%	96%	96%	100%	100%	100%	98%	100%	100%	100%	100%
	Radiology	WH	98%	98%	98%	99%	99%	100%	100%	100%	99%	100%	98%	100%
	Radiology	AH	99%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	SLT Clinic	SMH		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	SLT Clinic	WH		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	SLT Clinic	AH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Sunrise Unit	WH	100%	100%	100%	100%	100%	94%	100%	100%	92%	100%	91%	100%
	MSK	SMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	MSK	WH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	MSK	AH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Divisional %	**96%**	**94%**	**95%**	**98%**	**96%**	**95%**	**94%**	**94%**	**95%**	**96%**	**95%**	**97%**
Division	**Ward/ Department**	**Site**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
NSIC	St Andrews	SMH	94%	97%	98%	99%	99%			89%	96%	95%	92%	98%
	St David	SMH	99%	97%	93%	96%	100%	90%	96%	100%	99%	98%	99%	98%
	St Francis	SMH	91%	80%	91%	97%	92%	99%	95%	92%	94%	94%	92%	100%
	St George	SMH	93%	92%	98%	98%	95%	90%	91%	94%	97%	96%	96%	96%
	St Josephs	SMH	97%	97%	92%	97%	97%	99%	98%	91%	98%	97%	100%	
	St Patrick	SMH	100%	92%		100%	77%	100%	87%			100%	100%	100%
	Spinal Gym	SMH		85%	83%			87%	94%	91%	94%	91%	94%	
	Spinal OPD	SMH	95%	100%	97%	100%	100%	99%	100%	100%	100%	98%	100%	98%
	Occupational Therapy	SMH	83%		83%	93%					46%	87%	78%	88%
	Cystoscopy	SMH	97%	96%	100%	97%	97%	97%	95%	97%	96%	99%	99%	97%

	Divisional %		**95%**	**96%**	**94%**	**96%**	**96%**	**97%**	**98%**	**98%**	**96%**	**95%**	**98%**	**98%**
Division	**Ward/ Department**	**Site**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
MEDICINE	3B	WH	**98%**	**90%**	**94%**	**83%**		**98%**	**99%**	**99%**	**97%**		**98%**	**100%**
	4A	WH	**94%**	**94%**	**92%**	**94%**	**From Aug 10 Ward 4A results amalgamated with Ward 4B results**							
	4B (escalation from Dec)	WH	**99%**	**100%**	**98%**	**100%**	**96%**	**97%**	**96%**	**99%**	**95%**	**100%**		
	5B (Stroke Unit)	WH	**96%**	**97%**	**94%**	**98%**	**98%**	**96%**	**96%**	**96%**	**100%**	**96%**	**97%**	**97%**
	6A (escalation ward)	WH	**Unit closed**											
	6B	WH	**91%**	**94%**	**91%**	**93%**	**99%**	**98%**	**99%**	**96%**	**100%**	**100%**	**100%**	**96%**
	9	WH	**Ward 4A & 4B moved to ward 9 Dec 10**								**98%**	**99%**		
	A & E	SMH	**98%**	**100%**	**98%**	**100%**	**98%**	**98%**	**99%**	**100%**	**97%**	**100%**		**100%**
	CCU (2A)	WH	**94%**	**94%**	**98%**	**97%**	**93%**	**96%**	**97%**	**97%**	**81%**	**99%**	**96%**	
	Cardiac Day Unit & Lab	WH	**91%**	**96%**	**78%**	**82%**	**96%**			**88%**	**88%**	**76%**	**89%**	**98%**
	Day Hospital	SMH	**92%**	**100%**	**97%**	**99%**	**100%**	**100%**	**99%**	**100%**	**100%**	**93%**	**99%**	**94%**
	Dermatology OPD	AH	**81%**	**100%**	**94%**	**93%**	**96%**	**90%**	**100%**	**96%**	**89%**	**90%**	**100%**	
	Drake Day Unit	AH	**100%**	**100%**	**100%**	**100%**	**100%**		**100%**	**100%**			**100%**	
	EAU (SMW10)	SMH		**91%**	**83%**	**93%**		**94%**	**91%**	**90%**	**98%**		**91%**	**98%**
	EMC	WH	**100%**	**100%**	**95%**	**93%**	**100%**	**100%**		**100%**	**90%**	**91%**	**92%**	**84%**
	Endoscopy	SMH	**100%**	**100%**	**98%**	**99%**	**100%**	**99%**	**100%**	**100%**	**94%**	**100%**	**96%**	**100%**
	Endoscopy	WH	**99%**	**99%**	**94%**	**99%**	**100%**	**100%**	**99%**	**100%**	**100%**	**99%**	**100%**	**100%**
	GUM Clinic (SHAW)	WH	**100%**	**100%**	**100%**	**100%**	**97%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	
	Hayward Unit	WH		**100%**	**100%**	**98%**	**100%**		**100%**	**100%**			**100%**	
	Heberden	AH	**92%**	**95%**	**96%**	**98%**	**100%**		**Reconfigured to Bucks Neuro Rehab Unit**					
	MAU	WH	**97%**	**99%**	**99%**	**99%**	**91%**	**99%**	**97%**	**97%**	**95%**	**92%**	**90%**	
	SMW1	SMH	**98%**	**93%**	**98%**	**97%**	**96%**		**97%**	**99%**	**Wards 1 & 2 Merged and Moved to Surgery**			
	SMW2	SMH	**90%**	**99%**	**94%**	**94%**	**95%**	**95%**	**99%**	**93%**				
	SMW9	SMH	**Ward Moved to Medicine Dec 10**									**95%**	**97%**	**96%**
	SMW20	SMH		**95%**	**92%**	**99%**	**98%**	**99%**	**99%**	**99%**	**100%**	**100%**	**100%**	**100%**

	SMW22 (escalation)	SMH			96%	Ward Closed				98%				
	SMW8	SMH	83%	100%	94%	97%	100%		100%	100%	100%	96%	97%	100%
	Wilkinson Ward	AH	96%	97%	98%	94%	99%	100%	100%	100%	97%	98%	98%	100%
	Rayners Hedge		87%	80%	78%	96%		72%	Reconfigured to Bucks Neuro Rehab Unit					
	Bucks Neuro Rehab Unit	AH	Opened in October 2010						100%	99%		78%		
	Divisional %		94%	96%	94%	97%	96%	98%	97%	97%	99%	99%	98%	98%
Division	**Ward/ Department**	**Site**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
Womens & Childrens	Ward 4 was 9	SMH		95%	68%	93%	97%	99%	96%	98%	100%			
	Labour Ward	SMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Aylesbury Birth Centre	SMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
	Wycombe Birth Centre	WH	90%	99%	93%	94%	UNIT CLOSED			88%	93%	95%	93%	98%
	Gynae OPD & Antenatal Clinic	SMH	92%	95%	99%	100%	98%	100%	97%	97%	100%	100%	98%	98%
	Gynae OPD & Antenatal Clinic	WH	93%	99%	92%	100%	99%	97%	92%	99%	100%		98%	
	Rothschild Ward	SMH	97%	98%	93%	97%	83%	98%	97%	99%	96%	97%	97%	99%
	NNU	SMH		92%	100%	95%	100%	97%	100%	100%	100%	100%	100%	100%
	Ward 3 Paediatrics	SMH	96%	100%	97%	94%	91%	96%	96%	96%	100%	100%	100%	100%
	Childrens Day Unit	WH	90%	96%	98%	98%	98%	95%	94%	93%	94%	93%		93%
	Paediatric OP Clinic	SMH	100%	87%	90%	87%	92%	97%	95%					
	Paediatric OP Clinic	WH	92%	91%	95%	96%	98%	94%	92%	97%	96%	91%		97%

	Divisional %		**99%**	**100%**	**98%**	**94%**	**96%**	**98%**	**98%**	**99%**	**97%**	**97%**	**95%**	**99%**
Division	**Ward/ Department**	**Site**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
CIC	Buckingham Community Hospital OPD		**100%**	**96%**	**81%**	**88%**	**84%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	Buckingham Community Hospital Ward		**98%**	**100%**	**100%**	**92%**	**99%**	**99%**		**98%**	**100%**	**98%**	**92%**	**100%**
	Florence Nightingale House	SMH	**100%**	**100%**	**99%**	**98%**	**98%**	**100%**		**100%**	**98%**		**81%**	**97%**
	Thame Community Hospital		**98%**			**83%**	**82%**	**80%**	**96%**	**96%**	**92%**	**UNIT CLOSED**	**UNIT CLOSED**	
	Chartridge	AH	**UNIT CLOSED**					**100%**	**98%**		**99%**	**100%**	**100%**	**99%**
	Marlow Community Hospital		**UNIT CLOSED**							**94%**	**90%**	**94%**	**100%**	**100%**
	Waterside & Chalfonts Community Hospital	AH				**100%**	**100%**	**98%**	**100%**	**100%**	**99%**	**100%**	**100%**	

Hand Hygiene Observational Audit Report – April 2010- March 2011

CONCLUSIONS & DISCUSSION

- This report shows as Trust how committed we are to continually improve on hand hygiene practices to provide a safe environment for our patient's.
- Even though the report shows the areas are compliant it does not highlight areas which have not participated throughout the year.
- The overall compliance level hand hygiene/ bare below the elbows has improved from 94% (2009/10) to 97%.
- There has been a great increase in the number of observations recorded from 110,213 in 2009/10 to 152,602.
- The hand hygiene compliance per division ranged from 96% to 99%.
- Compliance levels for staff groups ranged from 92% to 99%

RECOMMENDATIONS

- Staff should be congratulated on achieving these excellent results.
- This report must be discussed at local meetings, Infection Prevention & Control Committee meetings, and Divisional Clinical Governance meetings.
- This report must be disseminated Trust wide via the Infection Prevention & Control Directorate Leads, Associate Divisional Nurse's and Modern Matrons and fed back to all grades/groups of staff.
- There must be a system is place to show that ward staff have seen the audit report.
- Even though the overall months result may be at the compliance level staff who are responsible for the hand hygiene data must look at the month's data. If the data shows certain areas are below the compliance level a mini action plan must be complete too show how these issues are being addressed.
- If the month's compliance level is below the recommended level then weekly audits must be completed along with an action plan. This must show how low compliance is being addressed.
- Areas of non participation throughout the year (not highlighted in this audit) should be addressed on a monthly basis.
- All hand hygiene results must be displayed at ward level for public information.

Appendix 8

Infection Prevention & Control Link Practitioners Programme 2010-11

Study Day 1 – February & March

IC Update - Lisa Andrews, Infection Prevention & Control Nurse
Challenges Ahead for the DIPC – Dr Jean O'Driscoll, Director of Infection Prevention & Control (DIPC)
Which Infection Control Forms? – Jackie Dalton, Infection Prevention & Control Nurse
Feedback from Mattress Audit – Carol Bounden, Huntleigh Healthcare Rep
The Year Ahead for Infection Prevention & Control Link Practitioner Nurses – Lisa Andrews, Infection Prevention & Control Nurse
Audit Exercise (carried out by the Link Practitioners)
Decontamination Update – Lisa Andrews, Infection prevention & Control Nurse

Study Day 2 – May & June

IC Update - Lisa Andrews, Infection Prevention & Control Nurse
Infections in Diabetes – Louise Meakes, Lead Nurse, Diabetes
Legionellosis Risk Management Awareness Training – Daniel Pitcher, Projects Director, Water Hygiene Centre
Audit Exercise around Blood Glucose Monitors on the wards
Surgery and the Problems of Infection - Presentation & Group Discussion

Study Day 3 – November

IC Update - *Lisa Andrews* – Infection Prevention & Control Nurse
ATP Trials & results – Niamh Whittome, Matron, Infection Prevention & Control
Probiotics Study – Food for Thought – Samford Wong, Specialist Dietitian
Urinary Tract Infection (UTI) Case Studies - *Zac Etheridge,* Microbiology SHO
Change Management – *Rachael Corser,* Divisional Lead Nurse, Community Integrated
Emergency Planning & Business Continuity – Lesley Whitesmith, Operations Manager & Karyn Finch, Whole Systems Resilience & Escalation Lead

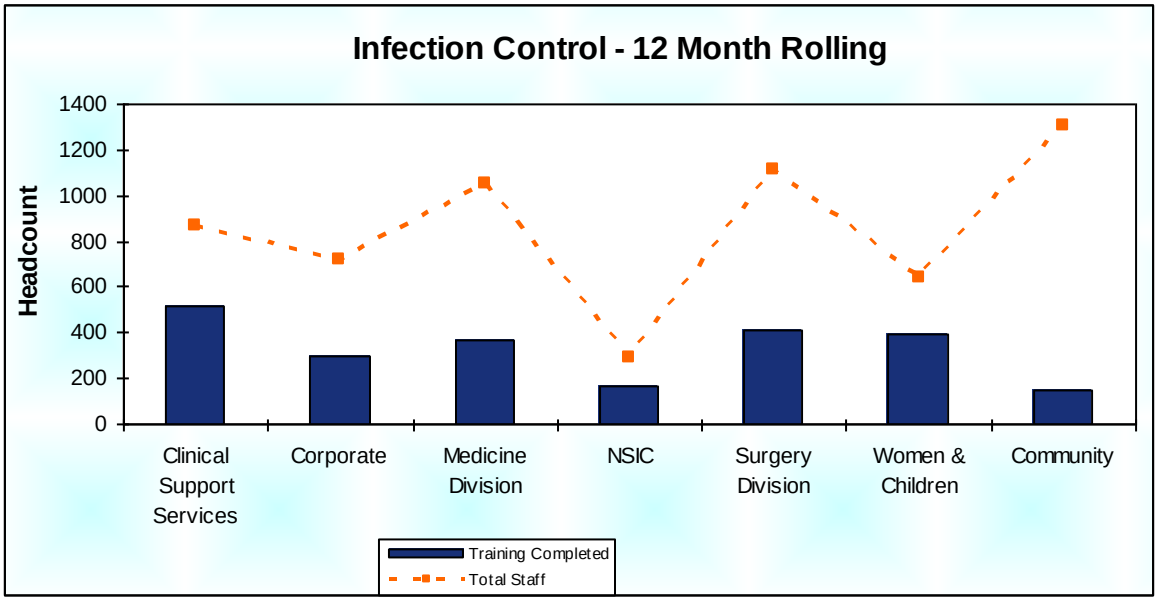
Appendix 9 Education

Mandatory Infection Control Training

Training Attended by Staff Groups from 1st April 2009 to 31st March 2010

12 month rolling data - Infection Control

	Infection Control 01.04.2010 to 31.03.2011		
Division	Training Completed	**Total Staff**	**Infection Control training**
Clinical Support Services	917	867	105.77%
Corporate	396	719	55.08%
Medicine Division	558	1046	53.35%
NSIC	211	287	73.52%
Surgery Division	588	1107	53.12%
Women & Children	517	640	80.78%
Community	219	1304	16.79%
Grand Total	3187	5970	53.38%



68% of acute staff have completed Infection Control Training within the last 12 months (01.04.2010 to 31.03.2011)
17% of Community staff have completed Infection Control Training within the last 12 months (01.04.2010 to 31.03.2011)

The total number that have attended 'classroom' sessions is 1220 which includes Corporate Induction.

The breakdown for e-learning is as follows:

	Total	**Total Passed**
Non Clinical	729	710
Clinical	1529	1476

Student Nurses

A number 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.
- Staff Nurse Development Programme – Part 1
- Staff Nurse Development Programme – Part 2
- Return to Practice

Appendix 10 – Summary of Audit Results

A list of all audits undertaken can be found on page 11.

Management of Patient Equipment Audit – April 2010

CONCLUSIONS & DISCUSSION

- The overall compliance score for this audit was 97%.

RECOMMENDATIONS

- 'I am clean' stickers were introduced following the CQC visit as it was very difficult to ascertain if or when equipment had been cleaned. These should be used on equipment to show when the equipment was cleaned as it is the responsibility of the person using the equipment to ensure it has been cleaned appropriately and left ready for use. If these are not being used at present it is recommended they are introduced.
- There have already been discussions within theatres regarding the 'I am clean' stickers. This involved an inventory of equipment being listed for each theatre which can be signed off at the end of each clean between each procedure. This must be put in place.
- To liaise with the Infection Prevention and Control Nurse for any support or queries in relation to this audit.
- A system is required at ward/dept level which ensures staff are aware of how equipment should be cleaned (e.g. A-Z cleaning inventory must be signed off by all staff members, this is available in all wards and relevant departments).
- Local policies must be clearly documented for staff information

Kitchen Audit – April 10

CONCLUSIONS & DISCUSSION

- The overall compliance score for this audit was 90%.

RECOMMENDATIONS

- High standards of cleaning of fixtures and the environment must be maintained in all kitchens to maintain patient safety. There needs to be improvements in the cleaning done to ensure this. In order to achieve this, managers need to monitor the cleaning and management of kitchens on a regular basis and address any issues as they arise. Regular monitoring by facilities needs to continue to include the monitoring of the cleanliness of kitchens.
- To liaise with the Infection Prevention and Control Nurse for any support or queries in relation to this audit.
- Staff should be aware of and adhere to Trust Policies as per the Infection Control Manual.

Urinary Catheter Care Audit (Insertion & Ongoing Management – May 10

CONCLUSIONS & DISCUSSION

- The 2010 urinary catheter management observational audit was disseminated to all wards/departments for completion. This is in contrast to the 2009 audit where only a small number of specific areas were audited. This has led to an increase in both the total number of participating areas and total observations and provides a more comprehensive assessment of the management of urinary catheters across the Trust.
- All wards/departments were asked to participate, although it was recognised that for some areas the audit would not be applicable.
- The urinary catheter care audit comprises of two high impact interventions; insertion and ongoing care. The audit results for both interventions identify areas of participation and non-participation, although not all areas returned the audit stating this.

- Compliance levels for individual elements in the insertion part of the audit was of a consistently high standard.
- Compliance levels for the individual elements in the continuing care part of the audit ranged from 94% to 100%. The compliance level for the hand hygiene element was 100%.
- As both the presence and duration of insertion of a urinary catheter are factors in the development of a urinary tract infection, a review of the continuing need for a catheter should be an integral part of catheter management. The "catheter needed" element identified a number of catheters that were in place and not required. The compliance level for this element was 94%. As with all elements, wards/departments should identify individual elements where the focus for improvement should be made. To ensure the maximum protection from infection for patients, all areas should work to achieve 100% compliance with all individual elements.
- As there is a significant increase in the number of observations from the 2008/2009 audits, direct comparisons can not be made. However the overall compliance level for all applicable elements for the on going care of catheters has dropped from 100% in 2009 to 88%.

RECOMMENDATIONS

- Areas with low compliance or who didn't participate must produce an action plan to show how they are addressing these issues and how they are monitoring compliance.
- It is not possible to tell from the audit whether the individuals being audited are Doctors or Nurses. Future audits should record the staff group of the individual carrying out the urinary catheter insertion.
- To improve the management of urinary catheters within the Trust, the Infection Prevention and Control Team are currently developing a tool for use in clinical areas. Following the piloting of the tool in specific areas, it will then be introduced across the Trust.

Care Bundle for Ventilated Patients – May 2010

CONCLUSIONS & DISCUSSION

- The Intensive Therapy Units across the Trust were not required to undertake this audit as they have a daily audit process already in place which incorporates all the relevant components of this audit and are able to produce data to show excellent standards of compliance
- For future audits we need to incorporate all areas where patients are ventilated, e.g. Neonatal Intensive Care Unit, although this may require a slightly different audit tool.
- St Andrew's Ward and St George's Ward scored below the minimum standard of 85% compliance for 'All applicable elements performed'.
- Hand hygiene prior to intervention for ventilated patients on St George Ward was the area that let them down the most; this only achieved a score of 56%.

Transfer Form Re- Audit – May 2010

CONCLUSIONS AND DISCUSSION

- As identified in the previous Transfer Form Audit (2009), Infection Control information is communicated to other areas using a variety of methods and forms. The type and amount of information also continues to differ widely and the information is often difficult to find. This is due to the numerous forms used as they are not easily recognisable as the standard form would be. This serves to impede staff in locating accurate and succinct information efficiently to ensure safe patient management.
- Verbal handovers were often documented as a method of communication and it is possible that infection control information was transferred in this way but there was no written verification of this.
- The Inter-Healthcare Transfer Form remains largely under utilised as a standard form for communicating the infection status of patients who are transferred to a new environment across the trust including inpatient community areas. As is evident from the re-audit results, for a number of patients transferred with known or potential infections, this information was

absent. Safe and prompt management of these patients may have been delayed resulting in the unnecessary risk of potential cross infection to other patients.
- The recommendations following the 2009 audit identified key leads for action, including the implementation of the Inter-Health Transfer Forms within areas and the measurement of compliance. The re-audit unfortunately demonstrates a lack of improvement in compliance in the Inter-Healthcare Transfer Form usage.

RECOMMENDATIONS
- Although infection control information is communicated in various ways using a variety of forms, the Inter-Healthcare Transfer Form should be used as a standard for all patients on transfers/discharge for conveying information about any infection risk.
- Compliance levels continue to be low and need to be improved. Wards should be made aware of the audit results and education needs met. This can be done by raising awareness at Head Nurses/Sisters meetings and cascading down.
- Matrons/Sisters are responsible for implementing the use of the Inter-Healthcare Transfer Form within their areas and monitoring compliance.
- If discharge/ transfers packs are available then the Inter-Healthcare Transfer Form must be included within the pack.
- The Transfer Policy is currently being drafted and includes the Inter-Health Transfer Form. Once this policy has been finalised it should be disseminated to all staff to ensure they are aware of its content.
- Further development of the Care Records System (CRS) must include the Inter-Health Transfer Form which will have to be completed on each transfer.
- IPCT to redevelop the audit tool to include other methods of handover of infection etc e.g. referral forms, verbal handover and to include a column asking if it has been clearly documented in the notes.

Peripheral Line Audit Insertion & Continuing Care Including VIP Form – June 2010

CONCLUSIONS & DISCUSSION

Peripheral IV line insertion
- 946 observations were made from 40 wards/areas, the majority of which were from theatres.
- Compliance levels appear to have improved this year overall. However, within divisions, compliance for all elements performed has actually fallen, except for Surgery, whose results are improved significantly due to the large number of observations from theatres.
- Key acute areas within the Divisions did not participate.

Peripheral IV line continuing care
- 560 observations were made from 37 wards/ areas.
- For each element the compliance ranges from 66%; name of person inserting documented, to 99%; aseptic access.
- The compliance level for all applicable elements performed was only 44%. Within division this ranged from 27% (Surgery) to 100% (Clinical Support Services).
- It is good to note that the elements concerning the care of the cannulae, e.g. ‘aseptic access’, ‘appropriate action taken if VIP score >1’ and ‘dressing clean and intact’ all achieved high levels of compliance, although there is still room for improvement.
- Much of the reason for the low overall compliance is in relation to the documented evidence of the insertion of the cannulae, e.g. type and position of cannula inserted, name of person inserting, date of insertion. In fact the lowest compliances for individual actions were 66% for ‘name of person inserting documented’ and 69% for ‘date and time of insertion documented’. **ALL these elements can be improved upon if staff members comply with correctly completing the documentation at the time of insertion.**

RECOMMENDATIONS

As a result of this audit and analysis of the results the following recommendations have been made:

- **Medical staff should be informed** of the results of this audit as they **play a significant role** in the element for **insertion of the cannulae; 81% of peripheral IV cannulae are inserted by doctors** (although the majority of these are recorded as inserted in theatres). The importance of completing the documentation should be emphasised at education sessions, which should improve the levels of compliance.
- When completing the audit more emphasis must be put on increasing the number of observations undertaken in some areas. A **MINIMUM** of **20** observations of practice must be undertaken for the audit to assist with data analysis. This may mean that the audit will need to be performed on more than one occasion throughout the month.
- Head Nurses and IC Divisional leads must ascertain the reasons why areas have not participated in order to ensure that all areas participate in future audits where applicable. This will provide data that is more meaningful, reliable and comparable. Some areas may need to participate in insertion and/or on-going management.
- If the audit is not appropriate for a particular ward or area then we request that the audit tool is returned with 'not applicable' scored across it, clearly indicating the ward or department.
- In future if an area is unable to participate in an audit, a formal response stating the reason for non participation must be sent to the Clinical Audit Department. This should only be done once every effort has been made to address the problem by the Modern Matron and Divisional Lead.
- The IPCT should review the suitability of this audit to all departments and determine whether specific areas should be targeted where the number of peripheral lines is highest.
- Results of the audit should be included in the divisional IC performance template by IC divisional leads.
- Use of the VIP chart must continue to be promoted and its initiation on insertion and management of devices improved. This to be addressed through education sessions, i.e. IV therapy, venepuncture and cannulation and ward handover between staff.
- The Daycase Stickers are available to be used in areas such as haematology out-patients, radiology, day surgery etc. These areas should then participate in the Peripheral IV line Insertion elements.
- Information on the type of staff inserting lines must be included to assist analysis of data to identify where educational input may be required.
- All IV administration sets should be labelled using the recommended labels and changed in line with the IC policy section 2.2.
- Red emergency line stickers should be used on all lines inserted in emergency situations and potentially non-aseptic conditions and are then replaced as soon as possible.
- All aspects of Peripheral IV line insertion and ongoing management of IV lines must be included in education sessions such as IV therapy teaching sessions.
- It is not the responsibility of just the Link nurses to complete the observations. Many staff should be involved in completing the audits. They should be supported by the ward to ensure that observations are undertaken on as many occasions as possible (including night duty) and to share the workload and increase participation at ward level.

Surgical Site Infection Pre & Peri Op Audit – Plastics – June 2010

CONCLUSIONS AND RECOMMENDATIONS

Pre-Operative component.

- All patient must be screened for MRSA on admission. 18 (43%) of patients were not screened for MRSA prior to surgery. This may have been due to an emergency situation but this should be clearly documented on the audit form. This will help when compiling the report.
- There weren't any positive MRSA results identified from the 24 patients screened.

Peri–Operative Component.

- In the section regarding antibiotic prophylaxis within 60 minutes, 11"No"s,15 "Not applicable" and 3 "Not recorded" were submitted. If there is a reason why antibiotics were not given, e.g. due to samples are being taken, this must be clearly documented on the audit form. All prophylactic antibiotics must be given as the Trust policy/guidelines.
- In some instances a "No" response was given when maybe "Not applicable" was more appropriate, e.g. Hair removal, 30 "No"s were documented,
- Normothermia was recorded in 33 out of 42 patients. 7 were documented as "Not recorded" and 2 as "No". All patients undergoing surgery must have normothermia monitored and maintained. Maintaining a body temperature above 36c in the peri-operative period has been shown to reduce infections.
- All elements were performed correctly for only 18 (55%) patients.

Personal Protective Equipment – July 2010

CONCLUSIONS & DISCUSSION

- This is the first year this audit has been completed Trustwide to include the Acute and the Community areas/wards. A total of 63 areas/ wards participated.
- This audit has highlighted gaps in practice which must be addressed in order to reduce the risks for both patients and staff and to ensure practice is in line with guidance.
- Scores by question varied from 90% to 100%.

RECOMMENDATIONS

- Correct practice in line with Trust guidelines for the use of personal protective clothing needs to be maintained.

IC Clostridium difficile Policy Audit – September 2010

CONCLUSIONS

The major deviations from the desired care in 2010 were failure to maintain a daily stool chart and daily fluid balance chart. The stool chart is of particular importance as it indicates whether the patient is responding to therapy and informs the decision to de-isolate the patient. The practice of maintaining a daily stool chart has decreased from previous years. Furthermore, CDAD was often not mentioned in discharge summaries or a letter not sent to the GP. This was in line with previous audits. Antibiotic treatment was initiated on the day of diagnosis in all patients, and this was an improvement on previous years. Stool samples were sent promptly in general, and this was also an improvement on previous years. In general, patients were quickly isolated following symptom onset. One patient was not isolated until 5 days following symptom onset, although initial stool samples were negative for C. Difficile, and the patient was isolated the day following diagnosis. Apart from this patient, there was a general improvement from 2009 in isolation of patients.

Standard	Compared to 2009
Daily stool chart entry	Worse
Stool specimen sent immediately	Improved
Patient isolated immediately	Improved
Appropriate antibiotics started promptly	Improved
Information sent to GP and IPCT on discharge	Similar
Sticker complete in the notes	Worse

Action plan

1. Infection control nurses to ensure C. Difficile stickers placed in notes and to prompt ward staff to complete them.
2. Stool charts to be filled in daily when the diagnosis is made.

3. Fluid balance charts should be completed daily and appropriate action taken to normalise fluid balance where necessary
4. Doctors should mention CDAD on the discharge summary.

Surgical Site Infection Pre & Peri-Op – General Surgery – September 2010

CONCLUSIONS AND RECOMMENDATIONS

Pre-operative component

- All staff involved in the screening of these patients must be congratulated. 92.5 % of patient's were screened and 1 patient was found to be positive. This patient was treated appropriately.

Peri-operative component

- Data was only collected from Main Theatres at Wycombe. In future audits all theatres must participate or return the tool stating 'not applicable'.
- Theatre areas must clearly document from which theatre the data as been collected e.g. Loakes.
- All answers must be documented clearly e.g. 9 patients had hair removed but 14 had hair removed with clippers.
- All staff completing the audit must know the correct process.

The tool to be adjusted to include definitions of 'yes' 'no' 'N/A'.

Long Line Venous Catheter Care Ongoing Management – October 2010

CONCLUSIONS & DISCUSSION

- Only 15 wards completed an audit form and 19 other wards/areas documented no long lines present during the audit period. This suggests that there would be a significant number of other wards/areas that we cannot say for sure did not have any long lines present at the time of the audit and would be documented as non-participating.
- The few areas of non-compliance can be improved upon with only a small amount of attention to the issues detailed above.

RECOMMENDATIONS

As a result of this audit the following recommendations have been made:

- Use of the VIP chart should continue on insertion and management of devices.
- The results of this audit should be displayed to promote the very high quality of care provided by staff for their patients.

Surgical Site Infection Pre & Peri-Op Trauma & Orthopaedic Elective & Emergency - October 2010

CONCLUSIONS & RECOMMENDATIONS

Pre-operative component

- All staff involved in the screening of these patients must be congratulated. 96% of patients were screened and 1 patient was found to be positive. Unfortunately we were unable to ascertain whether the patient was given MRSA suppression or eradication treatment treated prior to surgery. Pre-op assessment clinical staff had sent out the relevant paperwork but there was no documentation on admission stating if treatment completed or not. Please document clearly in patient's notes when treatment is given and completed.
- A question should be added to the admission paperwork which should be asked when a patient known to be colonised with MRSA is being admitted e.g. did you completed 5 days of

suppression therapy prior to admission? This should be clearly documented in the patient's notes.
- 5 patient details were illegible. These details were taken from the peri-operative component. Please make sure all documentation is legible.
- MRSA screens were missed for 2 (4%) patients. All patients who fit the pre operative MRSA screening criteria must have a pre operative screen completed prior to admission.

Peri-operative component
- There was 100% compliance with hair removal and maintenance of Normothermia.
- Regarding prophylactic antibiotics 2 patients were not given them. Please make sure all relevant patients are given the appropriate antibiotic or clearly state 'not applicable'.
- This report, results and issues highlighted must be disseminated to the appropriate staff and discussed at the relevant meetings e.g. Clinical Governance.

Infection Prevention And Control Knowledge Survey (Clinical Staff)-November 2010

The aim of the survey was to evaluate the knowledge acquired and retained by clinical staff at training sessions. This year the survey was conducted on-line.

RESULTS AND RECOMMENDATIONS:

376 staff members completed the survey.

74% had completed both components of the IPC mandatory training (e-learning and hand hygiene practical) in the past year.
- It is of concern that 47% answered that alcohol hand sanitiser can be used when decontaminating hands before contact with a patient with norovirus. (Alcohol has no activity against norovirus or C. difficile spores)
- This needs to be highlighted at future training sessions.
- 48% of respondents said that IPC hadn't been included in annual appraisals when it should be.
- It was encouraging that training sessions had led to a change in practice in a significant proportion of respondents.

MRSA Policy Audit – December 2010

RESULTS AND CONCLUSIONS
- Of the 22 cases of MRSA diagnosed in December 2010 who could be evaluated, 21 were screened on admission.
- 19/22 cases received suppression therapy. 2 further cases were discharged on the day of admission and thus were not given suppression. Thus, only 1 patient does not appear to have received suppression therapy when he or she should have done.
- MRSA stickers outlining the necessary communication of information with patients were present in the notes of 17/22 patients. However only 3/22 were fully completed; 7/22 were partially completed and the remainder were blank.
- All cases were isolated (17% being cohort-nursed rather than in side-rooms). 9/15 patients were isolated within 2 days of MRSA detection; another 5 patients were already isolated at the time of detection.
- The labelling of patient notes with an "Alert" sticker was done in 20/22 cases and 100% of electronic records were flagged.
- Although not in the current MRSA Policy, the inclusion of mention of MRSA in discharge communication was assessed. This was done in 11/16 eligible patients.

RECOMMENDATIONS

- Improvement in completion of the MRSA stickers is required.
- One of the Infection Prevention and Control nurses should write in the notes if a patient transferred from another hospital is known to have MRSA.
- More prompt isolation of patients is required.
- Mention of MRSA in the discharge summary should be routine.

Environmental Audit – November 2011

CONCLUSIONS & DISCUSSION

- This is the first year this audit has been completed Trustwide to include the Acute and the Community areas/wards. A total of 75 areas/wards participated.
- This audit has highlighted gaps in practice which must be addressed in order to reduce the risks for both patients and staff and to ensure practice is in line with guidance.
- To achieve the target compliance level the score must be 85% or above as set by the Infection Prevention Society. The overall compliance for all areas of this audit was 91%. Only 5 areas achieved a compliance level of 100%.
- 27 of the 136 audit questions (20%) achieved compliances of less than 85%.
- For the questions with the lowest compliance please see table on page 8.
- 18 of the 75 wards/areas (24%) achieved compliances of less than 85%.
- Where 'no' answers are documented wards/areas must complete and return an action plan. The action plan must highlight how wards/areas are going to address the issues highlighted. 27 areas did not return a completed action plan.
- 40 wards/areas did not participate in the audit.

Surgical Site Infection – Pre & Peri-Op Audit – Urology – December 2011

CONCLUSIONS & RECOMMENDATIONS

Pre-operative component

- 25 (96)% of patients were screened as per the screening criteria and none were found to be positive. 1(4%) was not screened.

Peri-operative component

- Data was only collected from Urology Theatres at Wycombe. In future audits all theatres must participate or return the toll stating 'not applicable'.
- In 12(46%) of cases hair removal was not carried out – when completing the observations staff must make it clear whether the answer is No or N/A. See note at top of tool.
- N/A column to be added to the Normothermia criteria of the peri-operative tool, this was found to be necessary on analysis of this audit.

Hand Hygiene Practice and Facilities Audit – January 2011

CONCLUSIONS & DISCUSSION

- This is the first year this audit has been completed Trustwide to include the Acute and the Community areas/wards. A total of 59 areas/wards participated.
- This audit has highlighted gaps in practice which must be addressed in order to reduce the risks for both patients and staff and to ensure practice is in line with guidance.
- To achieve the target compliance level the score must be 85% or above as set by the Infection Prevention Society. The overall compliance for all areas of this audit was 95%. Only 16 areas achieved a compliance level of 100%.
- Only 6 of the 45 audit questions achieved compliances of less than 85%.
- 5 of the 59 wards/areas who completed the audit achieved compliances of less than 85%.

RECOMMENDATIONS

- At present hand hygiene observational audits are completed on monthly basis by all wards/ areas/ departments. Therefore all hand hygiene observational questions must be removed from the audit tool.

Transfer Form Audit – February 2011

CONCLUSIONS & DISCUSSION

- This is the first year the audit was to be completed by all areas where applicable. This information is required for compliance with the Health and Social Care Act (2008) section 12 criterion 8.
- The audit tool should have only been completed by the receiving ward and not by the transferring ward.
- In total 230 transfers were audited compared to 130 in the previous audit.
- Unfortunately these results demonstrate the continued lack of compliance with the Inter-Healthcare form usage. In previous audits it was shown that the Inter-Healthcare form was not being used (22%). In this audit only 13% of transfer the Inter-Healthcare form was used but other ways of handing over the information e.g. verbally or another form was used in 60% of transfers.
- 37% of patients had infection prevention and control issues documented in the notes when they were added over.

RECOMMENDATIONS

- Areas of good practice should be recognised and commended. The two best-performing Divisions regarding the handover of information were Women and Children and Community and Integrated Care.
- Clear instructions should be issued with the Transfer Form Audit proforma detailing how it should be completed.
- Transfer of information on communicable infection risks should be part of good practice when transferring any patient. Ideally, it should be part of the standard transfer documentation to reduce the need for additional paperwork. If the patient is being transferred to **another** healthcare provider, the Inter-Healthcare Transfer form should be used. (The **discharge summary** should also mention any relevant Infection risk.) Some form of written record should be used when transferring a patient **within** the Trust, preferably the Form, but another means can be used if necessary.

Safe Handling & Disposal of Sharps Audit - March 2011

CONCLUSIONS & DISCUSSION

This is the first sharps audit undertaken by Buckinghamshire Healthcare NHS Trust (BHT), which includes the newly formed Community Integrated Care Division.

A total of 52 areas across the trust did not participate in this audit. It is recognised by the ICT that this audit may not apply to all areas; however, if that is the case, an audit tool still needs to be returned to the IC department clearly marked not applicable.

A number of areas have indicated a ‘no’ response on the audit tool. For each no response there should be a corresponding entry/action made on the action plan which should be returned with the audit.

RECOMMENDATIONS

- The draft audit report was discussed at the Health and Safety Committee meeting and the recommendation made for the audit to be repeated in six months. This is in response to the Health and Safety Executive focus on the safe management of sharps.
- When the audit is being completed staff must know the correct process. Training must be put in place, if relevant, so staff are aware of the need for clear and correct documentation.
- Increased input is required to educate staff. Further advice is available from the Workplace Health Department.
- In addition to the current input at Trust induction sessions, the sharps management policy needs to be included in staff induction at department level.
- Education on sharps management should continue to be re-enforced in the mandatory annual update for all clinical staff by the infection control team.
- Department Managers need to monitor compliance to policy within their area and promote correct practice at all times.
- Adequate supplies of sharps trays must be available for staff to use.
- To further reduce the incidence of sharps injury and promote safer management of sharps throughout the Trust, a collaborative approach between the Infection Prevention and Control Team and Workplace Health should continue. The ongoing identification of the site, location, staff group and mode of injury through Workplace Health reports should continue to inform departments and staff groups where further education and training is required.

HII Preventing Surgical Site Infection – Surgery on patients with Spinal Injuries – March 2011

Conclusions & Recommendations
Pre-operative component:

- According to guidelines 14.A.6 MRSA screening, all patients having a cystoscopy should have a pre op screen completed if already an inpatient. A system must be put in place to address this issue and clearly document in the notes if screens are completed out of area.

Peri-operative component

- The WHO surgical checklist was undertaken in 100% of cases.
- Within New Wing Theatres prophylactic antimicrobials were administered in line with Trust antibiotic guidelines.
- 1 (10%) patient had hair removed by shaving. All hair must be removed using clippers not shaving to comply with national guidelines. Please have clippers available.
- It is unclear if the glucose monitoring and normothermia should have been maintained or if it was 'not applicable'. Staff should be reminded to complete the form correctly by ticking the appropriate column.

Audit Report of Checklist for CVC Insertion 2009/2010 & 2010/2011 – March 2011

Conclusions & Recommendations
There has been an increase in use of the packs from 807 in 2009-2010 to 1007 10 2010-2011 but unfortunately the return rate of the audit and checklist form doesn't reflect this.

The main areas for usage is as expected are ITU and theatres for both years.

Due to the poor return rate staff that use the CVC packs must be reminded of the importance of using forms as part of an audit trail and how this is used to monitor compliance and change practice. All staff must complete and return the Audit and Checklist to Infection Prevention & Control which must completed at the time of insertion.

In relation to the questions around what aseptic technique and PPE only gloves reached 100% for 2010-2011 with dressing sterile gauze being the least compliant for that year and dry after insertion for 2009-2010.

There has been an improved year on year relating to documentation in notes and VIP chart commenced.

Staff are to be encouraged to use the CVC pack for insertion of other long lines e.g. PICC

Appendix 11

BHT OH needle stick injuries audit (April 2010– March 2011)

INTRODUCTION

The Occupational Health Department collates information from self-reported needle stick injuries (NSI) and splash incidents.

178 needlestick, sharps or splash injuries were reported to Occupational Health from April 2010 – March 2011. 144 were reported April 2009 – March 2010, but BHT staffing has increased from approx 4,500 to 6,500 in this time.

There was insufficient data to analyse 25 cases, but of the 153 remaining cases:

- 65 (42.4%) occurred at Stoke Mandeville Hospital (SMH)
- 42 (27.5% at Wycombe Hospital (WH)
- 21 (13.7%) in community locations
- 19 (12.4%) in dental practices
- 5 (3.2%) at Amersham Hospital.

DISTRIBUTION OF INCIDENTS ACROSS THE THREE MAIN HOSPITAL SITES

Stoke Mandeville Hospital (see Appendix 1)

	Procedure	Disposal	Other	Total
Theatres	9	4	1	**14**
Unknown	5		5	**10**
NSIC	1	2	3	**6**
Labour W	4	1	1	**6**
Obs T	2	1	2	**5**
A&E	2		2	**4**
Gynae T	1	1		**2**
SSD	2			**2**
Xray	2			**2**
DSU	2			**2**
1		1	1	**2**
8	2			**2**
10	1		1	**2**
4	1			**1**
ITU	1			**1**
5b	1			**1**
7			1	**1**
6		1		**1**
20	1			**1**
Total	**37**	**11**	**17**	**65**

The data suggests that the departments and wards with the most reported incidents (4 or more) are Theatres, NSIC, Labour Ward, Obstetric theatres and A&E at SMH

Wycombe Hospital (see Appendix 2)

	Procedure	Disposal	Other	Total
12	1	2	2	**5**
2a	2	1	1	**4**
Theatres	3		1	**4**
EMC	2	2	0	**4**
ITU			3	**3**
6b	1	1		**2**
5b			2	**2**
Gynae T	2			**2**
Card Cath	1	1		**2**
MAU	1		1	**2**
Waterside	1			**1**
3b	1			**1**
3a	1			**1**
Labour W	1			**1**
Labs	1			**1**
Xray	1			**1**
A&E	1			**1**
OPD	1			**1**
18			1	**1**
6a			1	**1**
4a			1	**1**
Unknown			1	**1**
Total	**20**	**7**	**15**	**42**

The data suggests that the departments and wards with the most reported incidents (4 or more) are Ward 12, Emergency Medical Centre (EMC), Theatres and Ward 2a.

Amersham Hospital

	Procedure	Disposal	Other	Total
Dermatology	1	1	1	**3**
Oral Surgery Theatre		1		**1**
Other			1	**1**
Total	**1**	**2**	**2**	**5**

Community

	Procedure	Disposal	Other	Total
	13	**3**	**6**	**21**

Example comments - “patient moved”; “while disposing”.

Dental

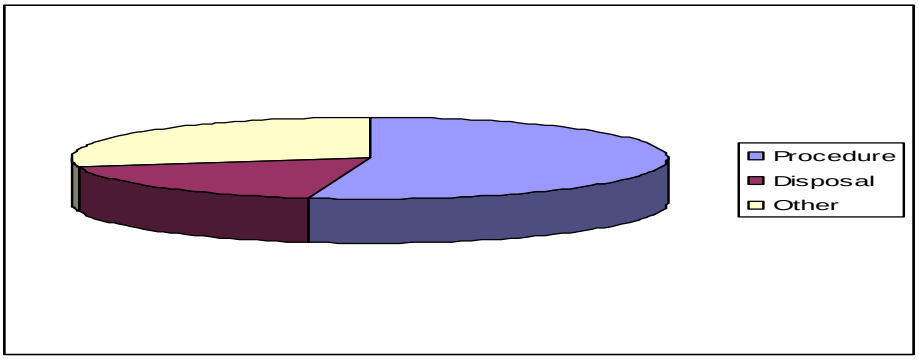
	Procedure	Disposal	Other	Total
	8	**5**	**6**	**19**

Example comments – “removing scaling tip”; “removing needle syringe”
.

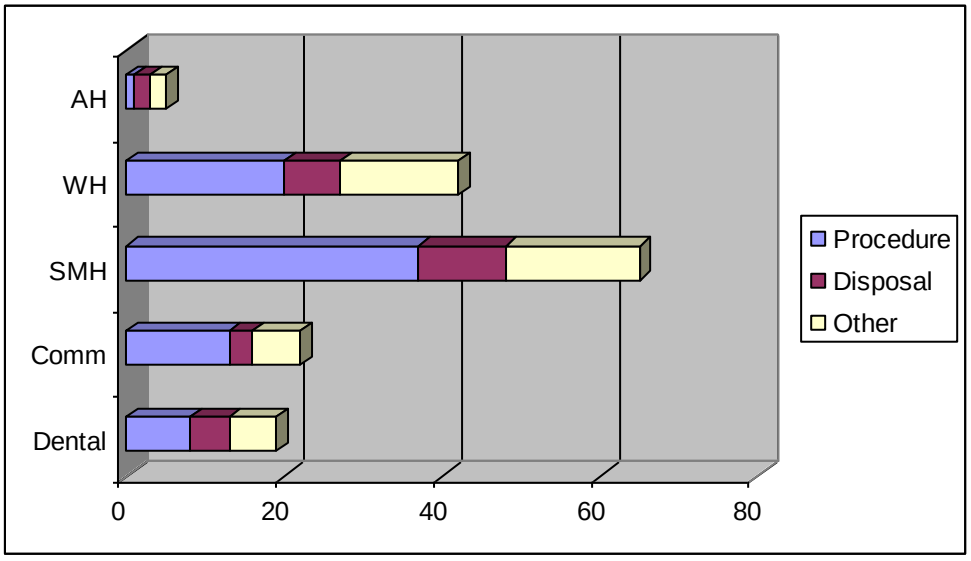
TYPE OF INJURY

The data was analysed to try and identify the main reported mechanism for the NSIs, eg during a 'procedure' (venesection, operation, etc) or on 'disposal' (discarded sharp on instrument tray, bins, etc). The data for the combined hospital sites was as follows:

- In 80/153 (53%) cases it was described as being the result of a 'procedure'
- In 28/153 (18%) cases it was described as being 'on disposal'.
- In 45/153 (29%) cases it was not possible to determine the cause of the NSI.



A summary of the data breakdown across the various hospitals and other sites is as below.



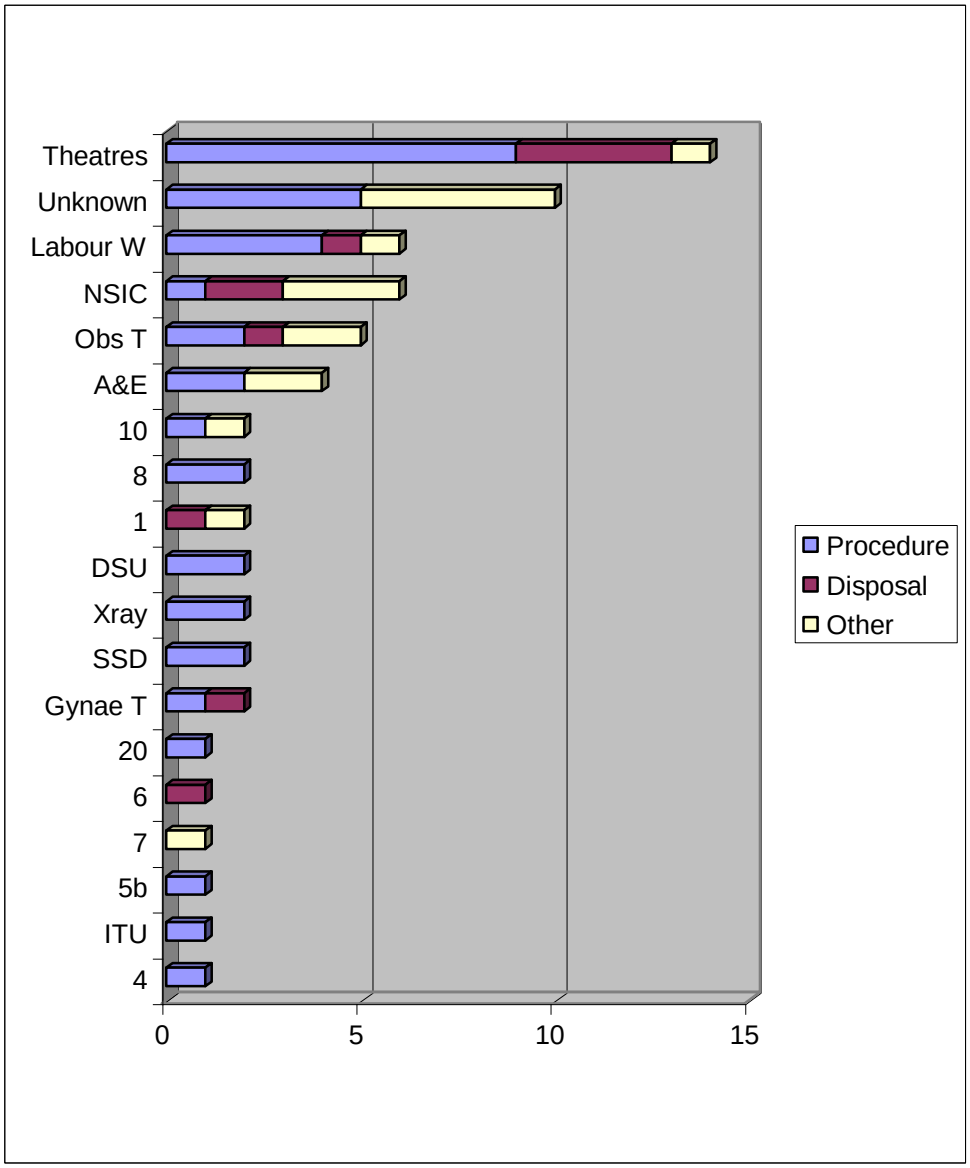
COMMENTS AND CONCLUSIONS

- SMH (all) theatres had most reported incidents see **appendix 1** (? reflects level and type of activity).
- 18% needle stick injuries reported as occurring 'on disposal' but 53% occurred during procedures.
- OH staff need to ensure that robust details are taken of the type of incident and the location (especially at SMH).
- Continued vigilance is requiring to try and reduce the number of incidents on disposal.
- Should consideration be given to more detailed analysis of SMH theatres to see if incidents can be reduced here?

Appendix 1

Stoke Mandeville Hospital – distribution of NSI and splash incidents

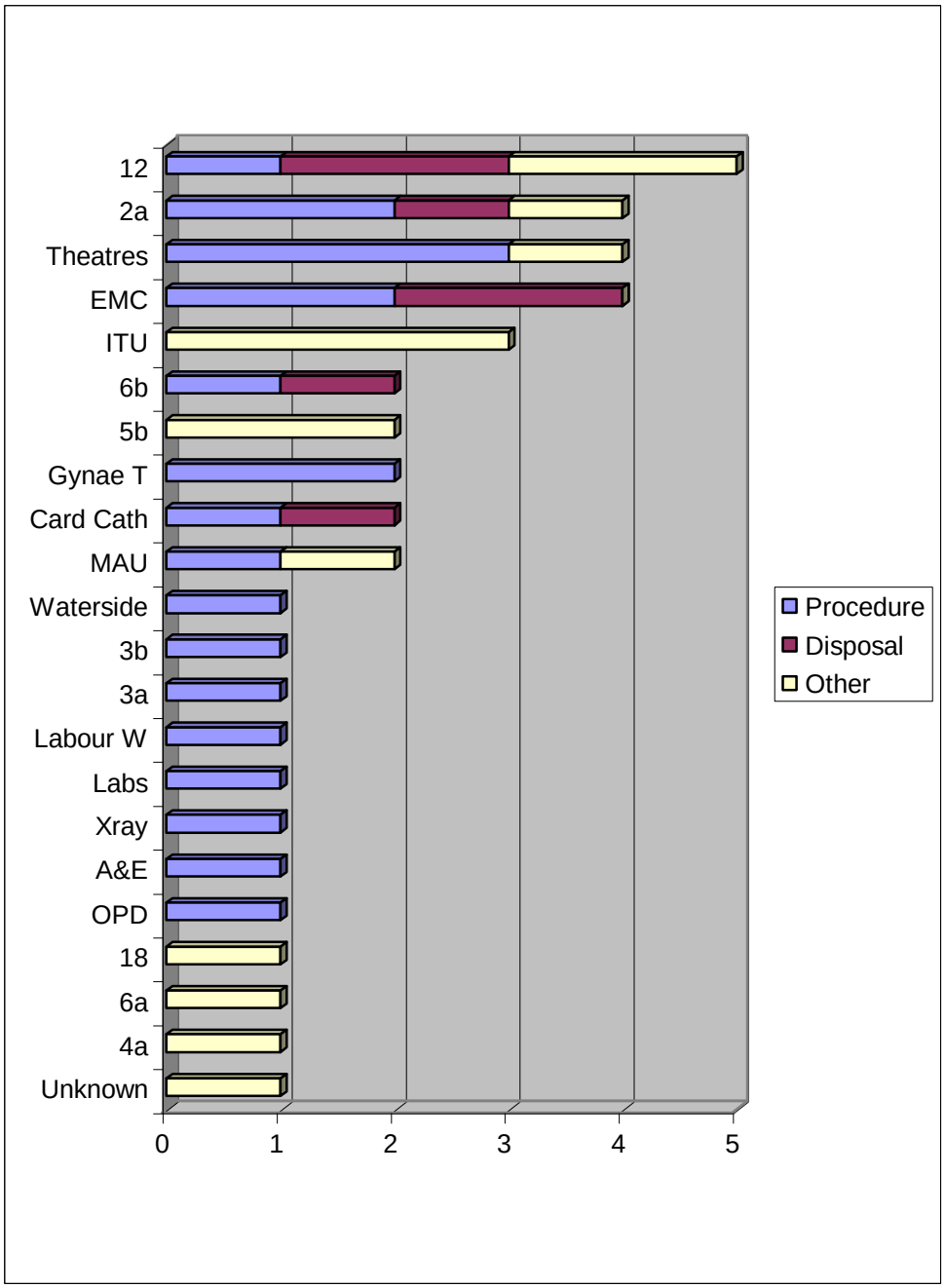
In Stoke Mandeville Hospital the highest number of reported injuries occurred in Theatres, NSIC, Labour Ward, Obstetric theatres and A&E.



Appendix 2

Wycombe Hospital – distribution of NSI and splash incidents

In Wycombe Hospital the highest number of reported injuries occurred in wards 12 (combined), 2A, Theatres and EMC.



Appendix 12

ANTIBIOTIC REVIEW GROUP (ARG)
ANNUAL REPORT APR 10 – MAR 11

The Antimicrobial Review Group (ARG) is a subgroup of the Drugs and Therapeutics Committee (DTC) and reports to the DTC 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 in Buckinghamshire healthcare NHS Trust and to work with community pharmacists to improve antimicrobial prescribing in primary care. The ARG is chaired by Dr. David Waghorn, Consultant Microbiologist. Anna Colthorpe is the Trust's Specialist Antimicrobial Pharmacist, having been appointed in October 2010.

1. Trustwide Guidelines

The following new guidelines were written, reviewed and then released within the 12 month period April 10 – March 11:

103.1 Empirical Short Course Home Antibiotics
409.1 BCG Vaccination of Neonates
549.1 National Chlamydia Programme and its Application for Pregnant Women
669.1 Nebulised Drugs in Adults
675.1 Displacement Values for Commonly Used IV Antibiotic Preparations
697.1 Protocol for the Administration of Cyclophosphamide
721AA.1 Admission Avoidance Guideline: Acute Diarrhoea in Adults
723AA.1 Admission Avoidance Guideline: Community Acquired Pneumonia
731.1 Recommended Empirical Antibiotic Regimens for Paediatric and Neonatal Infectious Conditions
743.1 Appropriate Use of Anidulafungin
746AA.1 Admission Avoidance Guideline: Cellulitis Algorithm

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. The website has been continually updated in the last year. Current issues regarding antimicrobials are highlighted on the home page then archived.
A new and improved website is currently being developed. The new website will be easier for the user to navigate around, with improved layout and consolidation of information. New features will include an educational section with self-assessment questions based on individual Trust guidelines. It is hoped that the new website will be up and running by mid July 2011.

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. A large poster version of the antibiotic flashcard was developed and is on display in all clinical areas around the three hospitals.

4. Audit Programme

An annual audit programme, performed by the Trust's Microbiology department and the Trust's pharmacy department was continued. However the programme has been severely limited during this year due to low staffing levels within the pharmacy department leading to a more stringent prioritisation of work.
Audits which were performed included the following:

Diagnosis and treatment of urinary tract infection in older adults: audit of practice at Stoke Mandeville hospital
Antibiotic Prophylaxis & Post-operative Infection following Spinal Surgery
Treatment of sepsis at Stoke Mandeville hospital: audit of practice
Antibiotic Prophylaxis for Elective Hip and Knee Replacement Surgery

For the coming year, a formal surgical prophylaxis audit programme is to be introduced. This will be accompanied by other ad-hoc audits, for example the audit of flashcard guidance for patients admitted to the Trust, Neonatal gentamicin monitoring and omission of IV antibiotic doses.

5. New Trust Prescription Chart

A new Trust prescription chart had been introduced in 2008-09 which had received significant input from the ARG. A user review of the chart was carried out after 6-8 months and suggestions were made for improvement. A revised version of the chart was produced early in 2011 and is currently being piloted on 2 wards at SMH and WH. Comments from this pilot will be fed back to the relevant committees and any final changes will be made prior to a new revised prescription chart being distributed trustwide.

6. Antibiotic ward rounds

Antibiotic ward rounds have continued this year after the success of the first year. A joint consultant microbiologist / pharmacist ward round is carried out weekly, to look at antimicrobial prescribing.
During the year there were some disruptions to the service due to the Microbiology Laboratory merging onto one site at Stoke Mandeville but the service is planned to continue on into 2011 – 2012.

In 2010 – 2011, a total of 41 ward visits were made. The prescriptions of all patients on antimicrobials on the day of the ward visit were reviewed to assess clinical appropriateness and whether the regimens prescribed were in line with Trust guidelines. Interventions were made in 39% of patients' therapy. The rounds were also used to educate junior pharmacy and medical staff who were encouraged to join the ward round when possible.

7. IV at Home Service

The OPAT service was re-established during this year and has proved to be a great success in supporting early hospital discharges. Currently there are three nurses in post and a fourth is in the process of being recruited.

It is hoped that in 2011-2012 the admission avoidance protocol will be established in both EMC (Wycombe) and A&E (Stoke Mandeville), enabling patients to receive appropriate antimicrobial therapy without the need for hospital stay.

8. Antimicrobial Expenditure

As a result of constant review of antibiotic usage within the Trust by the ARG, cost savings have been made during this financial year. This is achieved through monthly divisional reports on antibiotic usage.

A total of £20,000 was saved by promoting the use of oral clarithromycin over intravenous use, and £25,000 was saved by changing to generic versions of imipenem and piperacillin/ tazobactam.

9. National guidance, publications and alerts

The ARG keeps up to date with all national publications and issues associated with antimicrobials including drug alert information. This year a Trust working group with ARG representation ensured that all recommendations made to improve the safe prescribing of gentamicin to neonates were followed through.