DIRECTOR OF INFECTION PREVENTION AND CONTROL

ANNUAL REPORT
APRIL 2014 - MARCH 2015
## Annual Report

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1. Executive summary – Overview of Infection Control activities in the Trust

This has been a very challenging year for Colchester Hospital University Foundation NHS Trust as it continued to come under intense regulatory scrutiny. This was compounded by increasing staffing difficulties in clinical areas and problems in maintain the flow of emergency patients through the hospital in the last quarter of the financial year. Overall I can to report that the control of Health Care acquired infections (HCAI) remained at high levels but there were unexplained increases in numbers of patients with hospital attributed *Clostridium difficile* disease in January and March.

The main focus of infection control activity was to continue the good work already established in maintaining the low levels of *Clostridium difficile* and MRSA bacteraemia acquired within the hospitals of CHUFT in the face of staffing issues throughout the hospital and within the Infection Control team.

We continued to use the Saving Lives High Impact Interventions and Hand Hygiene rates to monitor good infection prevention practice. These results were reported monthly to the board through a board sub-committee. The results are also discussed at local divisional governance groups and the Hospital Infection Control Committee. The area that caused most concern initially was a perceived decline in hand hygiene standards and a gradual decline in environmental standards in the latter part of the year.

The Antibiotic Management Team continued to review antibiotic guidelines and audit their use. On European Antibiotic Awareness Day (November 18th) the team ran a travelling educational stall through the main hospital site visiting most of the wards.

The Isolation ward continued to be a vital part of our approach to reducing *C difficile* and MRSA cases in the hospital.

There were 32 cases of hospital attributed *Clostridium difficile* disease; 16 of these occurred in January and March. Typing of these strains showed that they were all different from one another, evidence against a hospital outbreak. As in previous years all cases were followed up with an internal investigation and discussion at the North Essex HCAI Scrutiny Panel. Part of this process included a judgement as to whether any of the cases could have been managed better and thus possibly prevented; of the 32 cases 7 were associated with what is nationally termed “no lapses in care”.

There were no cases of MRSA bacteraemia attributable to the hospital during the year.

Key achievements

- **Performance** – generally low levels of Cdiff and no MRSA bacteraemia.
- ‘Governance’ – evidence that Saving Lives and Hand Hygiene data is discussed and acted upon at divisional and departmental level.
- **Infection Control policies and guidelines** - Maintenance and updating of “on-line” infection prevention and control manual
- **Integrated computerised surveillance system** – continues to generate clinical reports and supports case management
• **Annual Mandatory updates for all staff** – the uptake continues to increase year on year

**On-going work**

• To continue the trend of minimal number of patients with MRSA and *Clostridium difficile*.
• To introduce improved management of peripheral IV devices.
• To reduce the number of urinary catheterisations in the trust
• To continue to participate in the development of the catheter passport
• To collect data on bacteraemia caused by “ordinary” *Staph aureus* (MSSA) and *Escherichia coli* Governance – to continue to embed throughout the organisation
• Mandatory bi-annual updates for all Trust Staff

Dr Tony Elston Director of Infection Prevention and Control /Consultant Microbiologist & Infection Control Doctor
2. **Description of Infection Control Team arrangements**

Dr Tony Elston  
Consultant Microbiologist/Director of Infection Prevention & Control  
☎ 01206 747316

Dr Sima Jalili  
Consultant Microbiologist  
☎ 01206 747326

Heather Dakin  
Senior Infection Control Nurse/Team Leader  
☎ 01206 742706

Marcia Hirst  
Infection Control Nurse  
☎ 01206 744267

Allison Munson  
Infection Control Audit/Surveillance Nurse  
☎ 01206 742708

Vicky Bywater  
Infection Control Nurse  
☎ 01206 744265

Paul Raven  
Quality Hub Data Manager  
☎ 01206 744266

Laura Mooney  
Antibiotic Secretary  
☎ 01206 744268

Janine Sawyer  
Infection Control Team Secretary  
☎ 01206 744268
**Infection Control Team Activities**

Members of Infection Control Team visit clinical areas on a daily basis maintaining a high profile and are easily accessible. Each Clinical area has an Infection Control Nurse designated to them.

**Members of the team are involved in the following committees/meetings:**
- Infection Control Team Meeting
- Hospital Infection Control Committee
- Medicine Management Committee
- Clinical Product Review Group
- Matron and Senior Nurse meeting
- Ward Sisters Meetings
- Procedures Development Advisory Committee
- Risk Management Committee
- Senior Management Advisory Group
- Service review meetings for facilities management
- Clinical Executive Board
- Intravenous Management Group
- Trust Clinical Governance Committee
- Patient Safety Committee
- PEAT inspection team/annual and monthly
- PEAT Operational Steering Group Meeting
- Facilities Service Level Agreement Meeting
- Patient Safety and Quality meeting
- Capital Planning Update Monthly Meeting
- High Impact Action Group – Urinary Catheter Management Group

**The Director of Infection Prevention and Control attends and reports to the following:**
- Trust Clinical Governance Committee, Clinical Executive Board, Risk Management Committee and Medicines Management Committee.

**There is an active North East Essex HCAI Operational Group.** The group includes representatives from ACE, CHUFT, the HPA and Essex County Council Social Services. The remit is to review progress in HCAI prevention in each of the organisations and to monitor progress against a joint action plan.
**Hospital Infection Control Committee**

The Terms of Reference for the Hospital Infection Control Committee were reviewed in 2014 in light of the restructuring of the Divisions in the Trust.

There was a restructuring of the Sterile Services and EBME management which led the creation of a new post which also included the role of the Trust Decontamination Lead role.

Out of 5 meetings held, attendance is given as follows:

<table>
<thead>
<tr>
<th>Role</th>
<th>27/06/2014</th>
<th>24/09/2014</th>
<th>02/12/2014</th>
<th>21/01/2015</th>
<th>18/03/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Infection Prevention &amp; Control (Chair)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Consultant Medical Microbiologist</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Senior Infection Control Nurse</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Chief Executive Officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Director of Nursing and Patient Experience</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Head of Facilities Manager</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Health &amp; Wellbeing Manager</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Pharmacist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic Pharmacy technician/pharmacist</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Representatives from each of the four Clinical Divisions to include 1 medical, 1 nursing and 1 managerial / professional</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
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<tr>
<td>Sterile Services / Trust Decontamination Lead</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Patient representative</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant in Communicable Disease Control Essex Health Protection Unit</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

X indicates attendance.
Organisational structure and reporting line to the Trust Board

Trust Board

Executive Team

QPS

Hospital Infection Control Committee

Dr Tony Elston, Consultant Microbiologist/DIPC

Heather Dakin, Senior Infection Control

Barbara Stuttle, Director of Nursing

Dr Sima Jalili, Consultant Microbiologist

Vicky Bywater, Infection Control Nurse

Marcia Hirst, Infection Control Nurse

Allison Munson, Infection Control Nurse

Paul Raven, Data Manager

Laura Mooney, Antibiotic Secretary

Janine Sawyer, Team Secretary

Organisational structure and reporting line to the Trust Board
3. DIPC reports to the Trust Board – summary

The DIPC reported monthly to the Quality and Patient Safety Assurance Committee, which itself reports monthly to the board.

Outbreaks

Viral Gastro-enteritis

<table>
<thead>
<tr>
<th>Date</th>
<th>Ward</th>
<th>Number of bays, Ward closed</th>
<th>Number of days ward affected</th>
<th>Cases confirmed by PCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/01–13/01/2015</td>
<td>Layer Marney</td>
<td>A and B bay</td>
<td>8 days</td>
<td>Yes</td>
</tr>
<tr>
<td>05/01–08/01/2015</td>
<td>Wivenhoe</td>
<td>A bay</td>
<td>4 days</td>
<td>Yes</td>
</tr>
<tr>
<td>07/01–12/01/2015</td>
<td>Aldham</td>
<td>A bay</td>
<td>6 days</td>
<td></td>
</tr>
<tr>
<td>09/01–12/01/2015</td>
<td>Langham</td>
<td>Whole ward</td>
<td>3 days</td>
<td>Yes</td>
</tr>
<tr>
<td>19/01–23/01/2015</td>
<td>Dedham</td>
<td>A bay</td>
<td>4 days</td>
<td>Yes</td>
</tr>
<tr>
<td>25/02–03/03/2015</td>
<td>Langham</td>
<td>Ward closed 26/02</td>
<td>6 days</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Actions taken
- Wards visited daily by Infection Control Nurse and daily management plan agreed with local and Trust site team
- Decision to close bay or Ward agreed by Infection Control team
- Increased and enhanced cleaning in place
- Cohort nursing/care managed

Increased incidence of C difficile cases led to the decision to close Langham Ward on 2 occasions in 2014.

<table>
<thead>
<tr>
<th>Date</th>
<th>Ward</th>
<th>Number of days closed</th>
<th>Number of patients affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>30/09 – 05/10/2015</td>
<td>Langham</td>
<td>6 days</td>
<td>2</td>
</tr>
<tr>
<td>28/11 – 02/12/2015</td>
<td>Langham</td>
<td>4 days</td>
<td>2</td>
</tr>
</tbody>
</table>

Action Taken:
There were a number of meetings to review and agree action plan which included our Care Commissioning Group (CCG) partners from Infection Control.
- Ward closed
- Close monitoring and support of clinical teams from IC team
- All antibiotic prescriptions reviewed and all clinical teams reminded to do this regularly
- PPI prescriptions also reviewed
- Enhanced and increased cleaning with Chlorine based products HPV fogging
- Infection Control environmental audit completed immediately
- All staff completed infection control e-learning
- Several adhoc IC update sessions on the Ward re PPE and Isolation practices in particular
- Carpet removed from sisters and Doctors office and replaced with vinyl flooring
Plan in place to undertake a complete ward refurbishment planned for April 2015 in order to pick up fabric of bathroom issues and other minor fabric issues which will support the ability to complete effective cleaning and storage of equipment.

Management of Water Safety

The Trust Water Safety Management group met monthly and reported to the Hospital Infection Control Committee.

The Head of Maintenance is the Responsible Person (Trust) in line with HTM 04-01. The group is chaired by the Director of Infection Prevention and Control, a Consultant microbiologist and Senior Nurse Infection Control are also members of the group.

Management of risk of Water safety including Legionella and pseudomonas policy

The Legionellosis in Building Water Systems Operational Arrangements policy was updated in February 2015 and changed to the Water Safety policy to include the latest pseudomonas national guidance. The policy is based upon the current legislation in HTM 04-01 and includes the managerial responsibilities for water quality on all Trust sites.

Work has been undertaken in the past year to educate and seek assurance relating to guidance for ‘Flushing of little or under used water outlets’. This work ties in the Risk of Pseudomonas/Legionella from water outlets in high risk clinical areas.

The Trust continues to monitor through the Water Safety Group the compliance with 'Best Practice Guidance on Water Sources and Potential Pseudomonas aeruginosa contamination of water Systems.'

The Health and Safety Executive visited the Trust in November 2014 and one of the areas reviewed related to compliance with national Legionella policy; there were no areas of concern noted.

Viral Haemorrhagic Fever and Ebola Outbreak

Following the outbreak of Ebola in West Africa and the potential for cases to be imported to the UK an Ebola Group was set up to update and re-affirm our existing Viral Haemorrhagic Fever Policy. This group confirmed that appropriate mechanisms were in place for dealing with potential cases and raised staff awareness accordingly. One case of possible infection was admitted to the hospital and this subsequently proved to be a false alarm.
4. **Budget allocation to infection control activities**

Infection Control budget sits within the Corporate Division with the Executive Lead being the Director of Nursing and Quality.

It has been a challenging time over the past 18 months in terms of nursing staffing in particular within the Team. The team lost a 0.64 wte Surgical Site Infection Surveillance Nurse post to support the Trust in risk management for another 8 months of the year there was band 6 Nurse wte post vacancy.

**Staff**

<table>
<thead>
<tr>
<th></th>
<th>Month 1 Budgeted</th>
<th>Month 1 Actual</th>
<th>Month 12 Budgeted</th>
<th>Month 12 Actual</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>0.40</td>
<td>0.40</td>
<td>0.40</td>
<td>0.40</td>
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<tr>
<td>Nursing Band</td>
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<td>8a</td>
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<td>1.00</td>
</tr>
<tr>
<td>A&amp;C Band</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1.50</td>
<td>1.10</td>
<td>1.50</td>
<td>1.10</td>
</tr>
<tr>
<td>5</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

* staffing allocation shown as whole time equivalents (wte)

**Annual Budget**

The yearend budget completed with £21 000 underspend relating to staffing costs. This past 18 months has seen some staff movement into and out of the team in both nursing and administration staff. Band 7 Nurse who was in the team for 6 months left for promotion opportunity, some challenges recruiting to the Surgical Site Surveillance Nurse Post.

Project monies had been reduced to £4 000 approximately spent as below:

- Updated version of Urinary Catheter Passport 2000 copies
- Penicillin allergy/ hand hygiene awareness cards 5000 cards
- Urinary catheter pack stickers

**Training/education for IC Team 2014/15**

1 member of Team to undertake 2 modules on BSc pathway Essex University (MH)
2 members of Team commence final module MSc Biomedical Sciences Distance learning (VB)

**Training requirements for the Team in the coming year 2015/2016**

1 member of staff to commence final module of MSc (HD)
1 member of staff to commence final module of MSc (VB)
1 member of staff to attend Annual Infection Prevention Society annual conference
1 member of Team to undertake 2 modules on BSc pathway (MH)
5. HCAI statistics

Results of mandatory MRSA bacteraemia reporting

<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>CHUFT March 2015</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

It is over 2 years since there had been an MRSA bacteraemia case attributed to the Trust.

Colchester Hospital University NHS Foundation Trust: Clostridium difficile reports by specimen date month

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Actual (&gt; day1)</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
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<td>3</td>
<td>9</td>
<td>0</td>
<td>7</td>
<td></td>
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<tr>
<td>Trust Envelope</td>
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<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
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<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>C.Diff Panel Reviews Decision Pending</td>
<td>1</td>
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<td>0</td>
<td>1</td>
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<td>0</td>
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<td>2</td>
<td>3</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C.Diff with no lapses in Care</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- Panel reviews with clinical teams for each case to look at root causes for each case
- Close working with community colleagues relating to all cases including pre 48 hours to look at issues in the community care settings
- There has been a continual programme of reviewing antibiotic prescribing with changes to policy and regular feedback and education to clinical staff
- No strong themes emerged though there was a trend for patients to have received antibiotics for longer than 7 days
- There was an increased incidence of cases of c difficile cases in September – November 2014 totalling 4 cases on Langham Ward
- Planned refurbishment, decant and deep clean of Langham Ward planned to commence April 2015
- Plan for decant Ward to support deep clean programme for 2015/16
Carbapenemase Producing Coliforms (CPC’s)

In the UK, over the last five years, we have seen a rapid increase in the incidence of infection and colonisation by multi-drug resistant carbapenemase-producing organisms.

Carbapenemase Producing Coliforms (CPC’s) produce an enzyme which renders them resistant to all betalactam antibiotics. They are often resistant to other classes of antibiotics, which may limit treatment options. A Trust policy for the management of CPCs has been produced which includes the regional toolkit guidance.

Whilst the Trust currently has only seen a handful of patients colonised with these organism the risk factors for transfer in from other hospitals must be recognised and they should be isolated and screened as per the policy guidelines. Those patients found to be positive have the records alerted on the Portal system to isolate and screen for further admissions.

Surgical Site Infection Surveillance

<table>
<thead>
<tr>
<th>CHUFT SURGICAL SITE INFECTION RATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large Bowel</td>
</tr>
<tr>
<td>April-June</td>
</tr>
<tr>
<td>July-Sept</td>
</tr>
<tr>
<td>Oct-Dec</td>
</tr>
<tr>
<td>Jan-March</td>
</tr>
</tbody>
</table>

| 2014/2015 |
| April-June | 1/121 | 0.8% | 1/87 | 1.1% | 0/108 | 0.0% |
| July-Sept | 1/118 | 0.8% | 0/94 | 0.0% | 1/120 | 0.8% |
| Oct-Dec | 1/98 | 1.0% | 0/93 | 0.0% | 3/124 | 2.4% |
| Jan-March | 1/71 | 1.4% | 0/42 | 0.0% | 0/99 | 0.0% |

NB: The national programme for surgical site surveillance suggests that at least 50 cases need to be surveyed in a three month period in order to obtain good quality figures which are statistically significant.

Surgical Site Surveillance encourages hospitals (both NHS and private) 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.

The mandatory requirement is for each Trust to complete surveillance in 1 module of orthopedic surgery for 1 quarter per financial year. The Trust has always been keen to be able to benchmark in more areas of surgery and plans to continue this in the coming year.

It provides national data that can be used as a benchmark allowing individual hospitals to compare their rates of SSI with collective data from all hospitals participating in the service. The Orthopaedic SSI data reported for 2014/15 compared very favourably with the National benchmarking.

The Surgical Division have given an extra 7.5 hours allocation to the Surgical Site Infection Nurse post with the purpose that the Vascular module can be completed and infections monitored continuously in this area.

The Surgical Site Infection/Infection Control nurse post was recruited into after an absence of over a year in the post as of February 2015. There is a plan to have a rolling programme of SSI surveillance
once again to include Bowel surgery and other modules not previously available e.g. Caesarian Section in this coming year.

6. Hand hygiene and Aseptic protocols

Hand Hygiene
The Hand Hygiene policy was updated in February 2015. The Trust overall hand hygiene observation scores are achieving over 95% on a monthly basis, with between 2,500-4,500 observations per month.

Aseptic Protocols
This year the ANTT policy and guidelines were reviewed and extended. The roll out programme continues and should be completed and embedded with the appointment and support therein of 5 clinical skills nurses posts.

7. Cleaning Services

Management arrangements
The facilities management of Housekeeping, portering, security and Estates is an in house service, with linen and waste management services sub contracted.

Monitoring arrangements
The Infection control team continues work with the Trust facilities team to support high standards of cleaning are met across the Trust and are members of the PLACE team. The IPC sit on the monthly Patient Environment Action Group through which the monthly NPSA audits are monitored.

The Matrons work with their Ward Sisters in the monitoring process by the completion of daily and monthly audits utilizing the NPSA standards for cleanliness tools. Daily audits assist in ensuring prompt identification and rectification of any issues.

Monthly ‘Mock’ PLACE inspections took part throughout the year which includes Patient governors on the team.

PLACE Scores
Place has a higher proportion of Governors and Patient representatives than in the PEAT process. The annual PLACE assessment took place over 3 days in and the results will not be available until July 2015.

Decontamination of the Environment with Hydrogen Peroxide Vapour (HPV)
Environmental decontamination with (HPV) gas is used regularly:
- as part of the terminal clean process of bed spaces occupied by patients with certain conditions such as *C difficile*;
- Monthly cleaning of ad hoc equipment in Ward/departments which
- Deep clean of clinical areas after increased cases of norovirus
- As part of the general deep clean process or following ward refurbishment

The benefit to using HPV is that it has a high level kill rate of micro-organisms and can reach areas which conventional cleaning methods cannot without damaging equipment or the environment.
8. Decontamination

A new Decontamination Manager was appointed in the summer of 2014. He performed an audit of decontamination and made a number of recommendations. Following the Executive meeting in November 2014 it was agreed that an update should be provided to the Quality and Patient Safety Assurance Committee (QPS) for discussion, approval of the plan and to provide assurance that Decontamination issues will be addressed and patient safety increased. The QPS meeting was held and agreed the actions required.

The following actions were advised:

- Funding to be arranged for training of key staff in their duties as “Users”. (as documented in Choice Framework for Policies and Procedures 01-01) to provide assurance of competence
- Funding required for additional estates technician and training of additional 3 technicians to allow weekly testing and validation of Endoscope washer disinfectors. Action – Estates manager and finance.
- Update existing guidance on CJD - currently going through PDAC process.
- Create 5-year Decontamination Strategy – DIPSC and Decontamination Lead.

Continued audits six monthly will take place until action plans and risks are eliminated or reduced as far as possible.
9. Audit

Extent of audit programme

Saving Lives High Impact Interventions
The audit focus has been driven by the generic annual infection control audits and monthly 'Saving Lives' audits, the latter giving the ability to drill down into more detail within specific clinical practices.

The plan is to move to the Infection Prevention Society Quality Improvement Tools for the audit of Clinical practices for the Infection control team use initially. This will support the saving lives auditing to focus on clinical practices.

<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
<th>CVC - Insertion Actions</th>
<th>CVC - Continuing Care</th>
<th>PVC - Insertion Actions</th>
<th>PVC - Continuing Care</th>
<th>Renal Dialysis - Insertion Actions</th>
<th>Renal Dialysis - Continuing Care</th>
<th>Surgical Site Infection - PeriOperative</th>
<th>Ventilated Patients - Continuing Care</th>
<th>Urinary Catheter Care - Insertion Actions</th>
<th>Urinary Catheter Care - Continuing Care</th>
<th>Cdiff - Prevention</th>
<th>Cdiff - Prevention of Spread</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 14/15</td>
<td></td>
<td>95.92%</td>
<td>94.35%</td>
<td>95.06%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>97.44%</td>
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<td>100.00%</td>
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<td>May 14/15</td>
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<td>96.23%</td>
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<tr>
<td>June 14/15</td>
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<td>July 14/15</td>
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<tr>
<td>August 14/15</td>
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<td>95.38%</td>
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<td>97.96%</td>
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<td>98.04%</td>
<td>96.72%</td>
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<td>97.78%</td>
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<td>January 14/15</td>
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<td>93.75%</td>
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<td>98.06%</td>
<td>88.89%</td>
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<td>97.62%</td>
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<tr>
<td>February 14/15</td>
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<td>84.62%</td>
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<tr>
<td>March 14/15</td>
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<td>93.75%</td>
<td>99.05%</td>
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</tbody>
</table>

Generally compliance with clinical practice procedures as above are to a high standard. The main issues relate to documentation of invasive devices, this is being supported through enhanced education and introduction of invasive device insertion packs with labels, in particular for urinary catheter insertion and intravenous cannulation packs revised.

These reports are reported by exception through local governance meetings and through the HICC.

Audit of Blood Culture Contamination Rates
An audit undertaken with a focus in A&E indicated that the contamination rate was 8%. Whilst there is no national UK ‘standard’ for blood culture contamination rates, it is recognised that the rate should be below 3%. Wider data collection/audit will be undertaken in the coming year and reported through the appropriate governance routes.

New kits and education events for blood culture taking are planned for 2015/16.
The NPSA cleaning scores from the housekeeping perspective in particular saw a downward trend during the months of November to January. This was raised by the DIPC through the monthly reports to the Quality and Patient Safety committee and upwards to the Trust Board.

The Ward sisters and Matrons undertake daily environmental inspections to ensure issues are resolved promptly. The Matrons and Ward Sisters complete the monthly National Patient Safety Association (NPSA) environmental audits.

These audit results are collated within the Infection Control department and reports are discussed and actions reviewed at the monthly divisional governance and performance meetings.

The audit data is displayed in all ward/department areas to increase public awareness and for all clinical team members to see. The monthly reports are widely distributed and results reviewed.

A number of initiatives to improve and maintain cleanliness in the environment have included:

- Trial of new technologies such as microfiber and Ultraviolet
- HPV fogging of equipment – to fog clean equipment or ward/department areas
- Making detergent wipes readily available for staff to use to keep equipment clean in between each use

Ward/department cleaning schedules are displayed in public areas to together with contact details should there be any concerns.
10. Targets and Outcomes

1) Key issues relating to Infection control are now on the agenda of all directorate and divisional clinical governance group meetings. Working closely with speciality matrons to improve performance around and awareness of Infection control related incidents.

2) Evaluation of Saving Lives data and Hand Hygiene audits throughout the division, strengthening the robustness and timeliness of data. This has been achieved by increasing understanding of the elements of the care bundle elements and increasing the numbers of observations of care within all areas. Working with Infection Control to ensure the data is presented in a clear and comprehensive way.

3) A key role of Matrons is devoted to environmental monitoring, with matrons undertaking the NPSA environmental audit with the housekeepers. This enables issues to be addressed in a timely way in the vast majority of cases.

4) Policies Updated in 2014/15

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy</th>
<th>Next review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>246</td>
<td>Management of Chickenpox and Shingles Procedure, Including Immunization for Healthcare Workers</td>
<td>31/01/2016</td>
</tr>
<tr>
<td>124</td>
<td>Visiting Pets Procedure</td>
<td>31/01/2016</td>
</tr>
<tr>
<td>360</td>
<td>Procedure for the Management of Extended Spectrum Beta Lactamase (ESBL) Producing Organisms and Other Multi-Resistant Gram Negative Bacteria (including Carbapenemase Producing Organisms), and Prevention of Spread</td>
<td>30/04/2016</td>
</tr>
<tr>
<td>361</td>
<td>Isolation Procedure</td>
<td>30/04/2016</td>
</tr>
<tr>
<td>080</td>
<td>Tuberculosis (TB) Management Procedure</td>
<td>31/05/2016</td>
</tr>
<tr>
<td>322</td>
<td>Isolation Unit Operational Procedure</td>
<td>30/06/2016</td>
</tr>
<tr>
<td>371</td>
<td>Viral Haemorrhagic Fever (VHF) Procedure</td>
<td>30/06/2016</td>
</tr>
<tr>
<td>343</td>
<td>Hydrogen Peroxide Vapour (HPV) Decontamination Procedure</td>
<td>31/12/2016</td>
</tr>
<tr>
<td>090</td>
<td>Hand Hygiene Procedure</td>
<td>28/02/2017</td>
</tr>
<tr>
<td>210</td>
<td>Infection Control Procedure</td>
<td>28/02/2017</td>
</tr>
</tbody>
</table>
5) The on-going engagement of the clinical teams caring for the patients in undertaking RCA but supported by the Infection Control team continues to be a positive process in broadening knowledge and understanding of the root causes of the infection.

6) Infection control audit programme 44/51 areas audited in 2014/15 due to staffing shortages the auditing did not commence until October 2014. There were many aspects of good practice with some reduction standards of environmental cleanliness and patient equipment this was particularly noticed when staffing levels were consistently below template.
11. Antibiotic Management Team Report


The Antibiotic Management Team (AMT) meets every 6 weeks to plan and monitor the strategy for Antimicrobial Stewardship within the Trust. The work of the team continues to follow the good practice principles set out in the Department of Health’s 2011 document Antimicrobial Stewardship: Start Smart – Then Focus (revised April 2015). Individual staff from multidisciplinary teams are encouraged to be involved in the AMT work when the focus is on a particular area or infection within the speciality and to help implement initiatives for improving the quality of prescribing moving forward.

Monthly trends on Datix (Trust electronic incident reporting system) are monitored as a regular agenda item by AMT. From identifying trends in incidents or near misses education can be enhanced and systems can be implemented to minimise the risks in the future, for example as a result of the monitoring small laminated cards have been made available for all clinical staff detailing the antibiotics to be avoided or used with caution in patients with a confirmed penicillin allergy. Results of these actions are fed into the Medication Safety Committee for further monitoring.

Existing guidelines continue to be reviewed and new guidance produced working with the relevant lead clinicians. Enhancements to the team’s intranet pages have resulted in improved access to the guidance and the ability to access the most frequently used guidance in a timely manner. The team are liaising and building close links with other Trusts within the East of England to ensure that guidance is in line with other Hospitals within the region and follows best practice. An antimicrobial “app” was introduced Summer 2014 which allows Trust staff to download guidance for access via their mobile phones. Recent download figures have shown that:

- the Adult guidance has now been downloaded 577 times and the Paediatric 42 (but this has only recently been published. The guidance has been accessed 1463 times in total.
- The data shows the actual time of the day the guidance was opened - With the exception of a slight drop-off between 2am and 6am, the guidance is used 24/7, every day.

Work within the team has expanded to include Antifungal Stewardship. A change in recommended products and new guidance has been implemented to help implement this & patients receiving systemic antifungal agents are also monitored during AMT ward rounds.

Regular monitoring through audit continues. A rolling programme of audit looking at antibiotic prophylaxis during surgery has been expanded and now the following surgical specialities are monitored:

- Vascular
- Gastrointestinal
- Urology
- Orthopaedics
- Breast
- Obstetrics and gynaecology
- Pacemaker
- Interventional Radiology
Quarterly audits are conducted by Pharmacy & Infection Control staff to ensure adherence to guidance: course length, documentation and compliance with guidelines are all areas that are monitored. Results are feedback to ward managers, matrons, associate directors of nursing & division clinical directors. Ad-hoc audits are planned for specific indications or areas identified as having an increased antibiotic consumption following discussions at the AMT meetings.

The team continues the work initiated by the 2012 local CQUIN which was designed to reduce the number of omitted doses during an inpatient treatment course of antibiotics.

Involvement in the training and education of all staff that supply, prescribe or administer antibiotics continues to be a priority for the team. Monthly corporate induction is attended to provide a brief session to all new prescribers to the Trust. Junior doctors receive a session from the Consultant Microbiologist at the start of their training and have an opportunity to visit an information stand as part of the induction fayre. Pharmacy staff attend sessions during the year and these focus on supporting doctors and ensuring quality prescribing for all inpatients being treated with antibiotics. E-learning packages for both nursing staff and doctors are available and continue to be promoted. The packages are reviewed regularly to ensure that the contents reflect current recommended practice & themes identified from incidents/near misses. Currently new packages focusing on nursing staff working in both paediatrics and neonatal areas are being written. The antimicrobial e-learning package will be amalgamated with the Infection Control e-learning package. This will be mandatory for staff to complete. The team also provide training on both speciality away days and at ward level for nursing staff when requested.

Ward rounds continue at least weekly and provide an opportunity to monitor current practice and for education and discussion with the patients team. Complex patients are followed up and monitored during their inpatient stay and advice is given at discharge. Figures for the number of patients seen and the outcome of discussions for 2014 are displayed below:

Prepared by Claire Allen, Clinical Pharmacy Technician and Vicky Bywater, Infection Control Nurse on behalf of the Antibiotic Management Team
May 2015
12. Training Activities

Induction and Mandatory update for all staff

<table>
<thead>
<tr>
<th>Course</th>
<th>Number of sessions</th>
<th>Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>31</td>
<td>507</td>
</tr>
<tr>
<td>Infection Control e-learning Clinical</td>
<td>N/A</td>
<td>246</td>
</tr>
<tr>
<td>Clinical</td>
<td>N/A</td>
<td>876</td>
</tr>
<tr>
<td>Non-clinical</td>
<td>N/A</td>
<td>876</td>
</tr>
<tr>
<td>Infection Control Awareness/adhoc</td>
<td>53</td>
<td>822</td>
</tr>
<tr>
<td>Doctors Induction &amp; Foundation Programme</td>
<td>2</td>
<td>119</td>
</tr>
<tr>
<td>Maternity stat days</td>
<td>8</td>
<td>202</td>
</tr>
</tbody>
</table>

*Training & Development include Nursing / Clinical staff within Non-Med. Med refers to Doctors and Consultants only there may be some duplication with e-learning and face to face sessions.

E-Learning

Infection Control E-Learning is part of the mandatory requirement at induction for all staff to complete it. This continues to be updated at least annually or in light of new evidence or initiatives.

Renal Care

The Infection Control Team works closely with the renal team both in the Dialysis Unit (managed by Fresenius) and the 3 beds (which includes a side room for isolation purposes) for acute renal case management on Langham Ward. The Renal Unit continues with its programme of screening patients for MRSA on a monthly basis. The Unit also participates and reports its NPSA cleanliness audits which are conducted with the Specialist Medicine Matron for the Trust. Hand Hygiene and Saving Lives care bundle data are monitored through the Specialist Medicine Governance committee and the monthly contract review meeting with Fresenius for the Renal Unit.

General

The Infection Control Team continues to expand the provision of Infection Control training to as many staff groups as possible within the Trust. Ongoing regular sessions are delivered to the following groups:

- Induction for Trained Nurses / Health Care Workers – Monthly
- General induction for all staff – Monthly at least
- Induction Fayre for incoming medical staff – twice a year
- Teaching for senior and junior medical staff – 3 sessions
- Women’s Services Statutory Update - Monthly
- MSc Physiotherapy (Pre-Registration) at Essex University once a year

A total of 94 sessions were delivered by the ICT to a total of 2772 members of Trust staff with a further staff completing an infection control update via e-learning. This a reduction of the number of staff reached in the previous years which may be indicative of the reduction of teaching opportunities due to the Trust being extremely busy in the latter end of the year together with Trust departments being short of nursing staff.
The divisions have their attendance with training, including mandatory update and induction training data provided to them and are required to feedback on their compliance levels, this includes Infection Control training.

**Link Nurses**

The attendance at the meetings has remained high at a level of 15 – 20 of Infection Control Link staff per meeting.

The topics covered this year have included:

- Role of the Health protection Agency
- Antibiotic updates
- Surgical site infection update
- Sterile services
- Microbiology updates on various organisms

The Infection control link role continues to extend to representatives from all staff groups.

**World Hand Hygiene Day**

This event occurs around May 5th each year and the Infection Control Team spread the word with a hand hygiene road show which includes visits to as many areas as possible to promote good hand hygiene practices.

**Annual Trust Infection Control Conference**

The conference was postponed this year due to poor staffing levels within the team and in the clinical areas.
### 13. IC Programme for 2015/2016

<table>
<thead>
<tr>
<th>Key points</th>
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<tbody>
<tr>
<td>Compliance with Hygiene Code (2008 updated 2010)</td>
</tr>
<tr>
<td>To review action plan against the code on a regular basis</td>
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<tr>
<td>Saving Lives audits</td>
</tr>
<tr>
<td>Continue to support clinical teams in the education and use of the tools</td>
</tr>
<tr>
<td>ICT data manager continues to work with local teams to tailor reports to department</td>
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<tr>
<td>To target three ‘High Impact Interventions’:</td>
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<tr>
<td>Appropriate use of urinary catheters</td>
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<tr>
<td>Appropriate use of Isolation Facilities for HCAI</td>
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<tr>
<td>Effective use of risk assessments for HCAI</td>
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<tr>
<td>To promote Peer review of audits to promote learning across the divisions</td>
</tr>
<tr>
<td>Annual IC audits</td>
</tr>
<tr>
<td>Continue with annual rolling programme of Infection control audits with timely feedback to clinical teams</td>
</tr>
<tr>
<td>Facilitate the MRSA screening project</td>
</tr>
<tr>
<td>To continue to assist divisions in achieving compliance with MRSA emergency admission screening procedure</td>
</tr>
<tr>
<td>To support a robust system is in place to assure compliance with the target</td>
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<tr>
<td>To support the feedback of data to support this work</td>
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<tr>
<td>Facilities Contract review</td>
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<tr>
<td>To work with Trust Facilities management team to look at aspects of the contract which require Infection Control advice</td>
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<tr>
<td>Promote e-learning programmed and audit uptake</td>
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<tr>
<td>Continue updating programmed annually</td>
</tr>
<tr>
<td>To audit uptake and report to HICC bi monthly</td>
</tr>
<tr>
<td>Mandatory annual updates for Infection Control for all staff groups</td>
</tr>
<tr>
<td>To continue to support the Trust programme at induction and Mandatory update sessions – update annually</td>
</tr>
<tr>
<td>Programme available in e-learning format for induction</td>
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<tr>
<td>Update IC policies</td>
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<tr>
<td>Update Hand Hygiene procedure</td>
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<tr>
<td>Isolation Unit procedure</td>
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<tr>
<td>IC manual update</td>
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<tr>
<td>Ongoing updating on web based Manual</td>
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<tr>
<td>ICNet surveillance system</td>
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<tr>
<td>To continually evaluate effectiveness of the system</td>
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<tr>
<td>Continue with Surgical site surveillance</td>
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<tr>
<td>Continue with agreed rolling programme of modules in addition to the mandatory modules</td>
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<tr>
<td>Promote the adoption within the Trust of Surveillance in areas such as caesarian sections as the new modules become available</td>
</tr>
<tr>
<td>Infection Control Link System</td>
</tr>
<tr>
<td>To continue to develop the link role into other healthcare disciplines</td>
</tr>
<tr>
<td>To further develop the role of the Link role to enhance local infection control Induction</td>
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<tr>
<td>Surveillance</td>
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<tr>
<td>E coli bacteraemia RCA and reporting</td>
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<tr>
<td>MSSA bacteraemia RCA and reporting</td>
</tr>
<tr>
<td>MRSA bacteraemia RCA and reporting</td>
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<tr>
<td>C diff RCA and reporting</td>
</tr>
<tr>
<td>CPC reporting and RCA</td>
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</tbody>
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