Surrey and Sussex NHS
Healthcare NHS Trust

Trust Board in Public
27 September 2012
Agenda item: 2.6.2

IPCAS Annual Report

For:	Information
Summary:	**This Paper provides the IPCAS Annual Report 2011-2012** The IPCAS Annual Report summarises the achievements, developments, performance and standards by the Trust and its staff in key areas and against key objectives relating to infection prevention and control and prudent antibiotic prescribing throughout 2011-2012.

Action:	The Board is asked to receive this report for information
Presented by:	Dr Des Holden, DIPC
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Notes:

Trust objective:	Please list number and statement this paper relates to. Reduce Healthcare Associated Infections (HCAI)
Legal:	What are the legal considerations and implications linked to this item? Please name relevant act Health & Social Care Act (2008)
Regulation:	What aspect of regulation applies and what are the outcome implications? This applies to <u>any</u> regulatory body – key regulators include: Care Quality Commission, MHRA, NPSA & Audit Commission CQC

INFECTION PREVENTION-CONTROL & ANTIBIOTIC STEWARDSHIP (IPCAS)

ANNUAL REPORT FOR 2011/12

&

ANNUAL PROGRAMME FOR 2012/13

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June 2012

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SECTION A:
ANNUAL IPCAS REPORT FOR 2011/12

1. OVERVIEW

1.1 Introduction

This Infection Prevention-Control & Antibiotic Stewardship Annual Report and Programme for Surrey & Sussex Healthcare (SASH) NHS Trust has been prepared for and is submitted to the Trust Board by the Infection Prevention- Control and Antimicrobial Stewardship (IPCAS) Team on behalf of the Trust's IPCAS Group. It summarises the 'state of play' in terms of achievements, developments, performance and standards by the Trust and its staff in key areas and against key objectives relating to infection prevention and control and prudent antibiotic prescribing.

There is a sustained national focus on the central importance of Heathcare Associated Infections (HCAIs) to the safe delivery of healthcare, so the activity in this area within acute NHS Trusts and between organisations within local health economies continues to intensify. Against this background, there has been strengthening of engagement of all levels of SASH staff, facilitated by the formal appointment of the Medical Director who is also the Director of Infection Prevention and Control (DIPC) and the identification of HCAI clinical leads for each clinical directorate. In the last quarter of 2011/12 there was considerable focus on antimicrobial stewardship with the formation of the Antimicrobial Stewardship Group (ASG), implementation of a rigorous ward based clinical round and audit programme, and pilot of newly designed drug prescription chart, the benefits of which were apparent towards end of year but will be fully realised in the coming financial year and thereafter.

Also in the last quarter of 2011/12, a standard set of infection control KPIs for clinical directorates was agreed upon and will be embedded in 2012/13. Divisional directors will be responsible for achieving targets set for their clinical departments, and performance against Trust and divisional targets will be monitored at Management Board for Quality & Risk (MBQR), Infection Control Taskforce (ICTF), Infection Prevention, Control and Antibiotic Stewardship Group (IPCAS) and divisional meetings.

HCAIs remain a significant challenge and, despite low numbers of Trust apportioned MRSA bloodstream infections (BSIs) and a sustained reduction in number of cases of *Clostridium difficile* infections (CDIs), the Trust did not achieve the nationally and locally agreed targets set for these two HCAIs by end of year 2011/12. For 2012/13, even more stringent targets have been set for these two outcome indicators, no more than 3 cases of MRSA BSI and 43 cases of *Clostridium difficile* Infection (CDI). Tackling these infections is a key priority and our goal must be that not a single preventable infection is allowed to develop in our Trust.

The IPCAS Team continues to work closely with the Trust's operational team in order to optimise patient flow, use of isolation facilities and in the management of outbreak situations. The provision of 2 additional modular wards, with associated proportional increase in single room facilities has contributed towards improvements in all these aspects.

In delivering this report and in setting the Annual Programme for the forthcoming year, the members of the IPCAS Team look forward to continuing to work with the executive, operational, clinical and support teams of the Trust in improving practices in infection prevention and control and antibiotic prescribing for the benefit of our patients. It is clear that there is a better appreciation of the vital importance of high standards in these aspects of clinical care and that, through training and education, surveillance and reporting, policy and audit, with clinical liaison and support, the IPCAS Team can continue to encourage improvements in practice.

The Team also continues to emphasise the fundamental requirement that individual departments must continue to embed, through the guidance and leadership of their designated senior clinical leads, the principles and practices of IPCAS into the daily activity of every member of staff.

The Department of Health's (DH) Code of Practice for Infection Prevention & Control (Health & Social Care Act, 2008), remains the basis for the development of the Trust's IPCAS programme and activity for the Trust, with additional guidance and advice drawn from NICE Guidance and other key national publications.

1.2 Effective management systems for prevention and control of HCAI

The Chief Executive has overall responsibility for the control of infection within SASH NHS Trust. The Medical Director, Dr Des Holden, is the Trust designated Director of Infection Prevention and Control (DIPC) and reports directly to the Chief Executive. The Lead Infection Prevention and Control Nurse (IPCN), Ashley Flores, acts as deputy DIPC. There is now a nominated clinical lead for each directorate who act as advocates for the IPCAS agenda. The Trust Board has a Non-Executive Director, Yvette Robbins, with lead responsibilities for overseeing infection prevention and control and antibiotic stewardship.

The **Trust IPCAS Group** (formerly Infection Control Committee) is chaired by the DIPC. The IPCAS Group meets and reports quarterly to the Management Board for Quality and Risk (MBQR). The IPCAS Group is responsible for developing IPCAS strategy, overseeing and scrutinising function to ensure delivery of the IPCAS annual programme, and keeping the Trust Board appraised of progress against the annual programme and of significant IPCAS risks. This Group has representation from throughout the Trust and met regularly throughout 2011/12, minutes of which are available as separate documents.

The **Infection Control Task Force (ICTF)** was set up in April 2008, under the chairmanship of the DIPC. The ICTF is composed of the IPCAS Team, Divisional Senior Nurses, Matrons, Medical HCAI Leads, representatives from Estates and Facilities, and other key departments and its main function is to monitor key infection control performance indicators and hold to account those with primary responsibility as required. The ICTF is a forum for presentation and discussion of, and dissemination of learning from, Root Cause Analysis (RCA) investigations for cases of CDI, MRSA Blood Stream Infections (BSI) and outbreaks. The ICTF met fortnightly throughout 2011/12.

The **IPCAS Team** has responsibility for the day-to-day running and monitoring of IPCAS principles and practices throughout the Trust. The team comprises 3 IPCNs (x 2.91WTE), a 1 WTE IV nurse specialist, 0.5 WTE antimicrobial pharmacist, 0.8 WTE IPCAS administrator and a 1 WTE IPCAS programme manager (on secondment). Consultant Medical Microbiology support is provided by Dr Karen Knox (infection control lead), Dr Bruce Stewart (laboratory lead)

and Dr Donald Lyon (antimicrobial stewardship lead). Laboratory support is provided by the Operational Manager for Microbiology. The IPCAS Team reports directly to the DIPC (Medical Director) and to the Chief Nurse.

The IPCAS Team has a wide remit which includes:

- Provision of specialist clinical advice on any issue relating to infection prevention-control and antibiotic stewardship to clinical staff within the Trust and outside, patients and the public, operational and executive managers of the Trust, the Committees on IPCAS and Management Board for Quality and Risk, and to the Trust Board
- Continual infection surveillance
- Co-ordination of the Outbreak Control Group through a laboratory-based ward liaison service
- Production and review of Trust policy on all areas relating to infection prevention control and antibiotic stewardship
- Audit of practices and standards of clinical staff and clinical areas
- Provision of Education, Training and Practice Development to all clinical and support staff
- Management of information systems to monitor and feed back to Directorate clinical and operational leads performance on HCAIs, *Saving Lives* interventions, root cause analysis, antibiotic prescribing practices, etc.
- Production of the Annual Report and Annual Programme
- Maintenance and management of the IPCAS Risk Register

Each division within the Trust has IPCAS as a standing item on the agenda for governance meetings in order to regularly review infection control performance and to facilitate the implementation of infection control initiatives. IPCAS is included in staff induction, annual mandatory training and appraisal.

In the last quarter of 2011/12, a standard set of infection control KPIs for clinical directorates was agreed upon and will be embedded in 2012/13. Divisional directors will be responsible for achieving targets set for their clinical departments, and performance against Trust and divisional targets will be monitored at MBQR, ICTF, IPCAS group and divisional meetings.

2: Mandatory surveillance

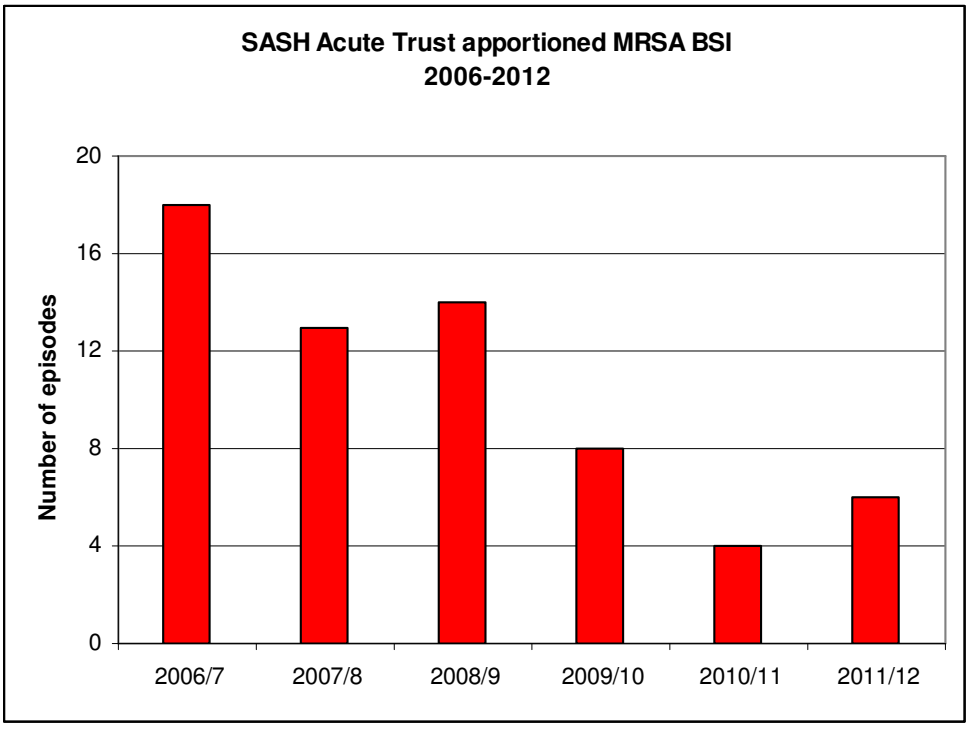
Some infections and micro-organisms are reported by the Trust to the DH as part of the national mandatory surveillance programme. At present, the only annual targets that are set, as agreed with West Sussex Primary Care Trust acting as the primary local healthcare commissioner, are for MRSA BSIs and CDI.

From January 2011 and July 2011 respectively, BSIs due to methicillin-sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* (*E.coli*) have been added to the national reporting database. As yet there are no targets set for these infections but the IPCAS team is monitoring local trends and actions is taken on individual cases as indicated.

2.1 Methicillin-resistant *Staphylococcus aureus* bloodstream infection (MRSA BSI)

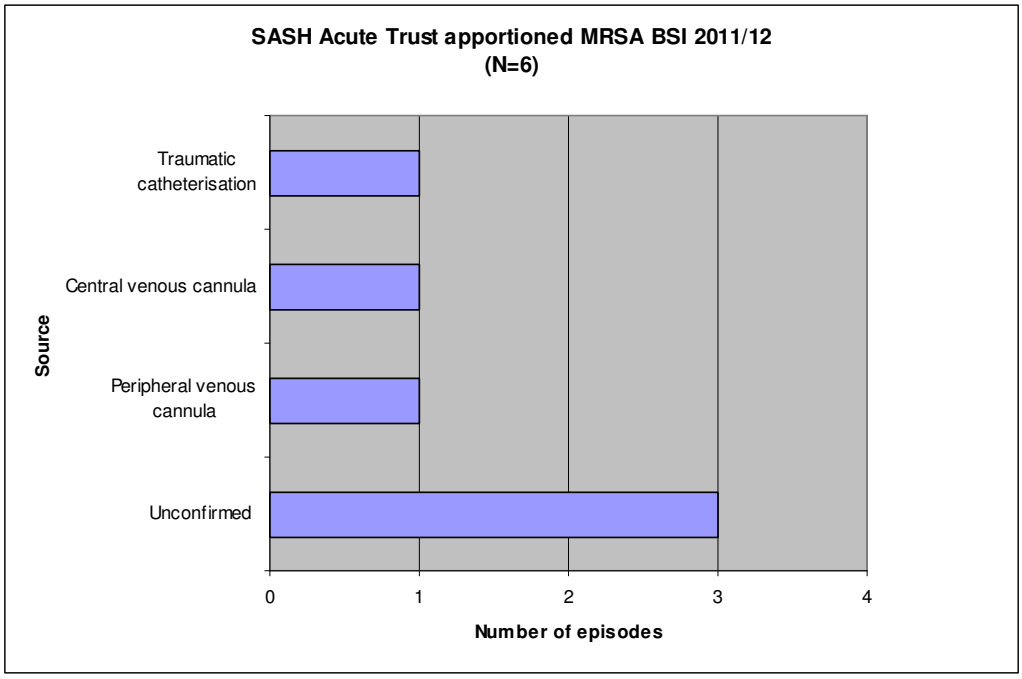
In 2011/12 the Trust reported 6 Trust apportioned MRSA BSIs. Although a small number of cases when compared with historical data, this was above the locally set target of 4.

Figure 1: Annual numbers of MRSA BSIs between the years 2006/07 and 2011/12:



Each case was subject to a detailed investigation undertaken by the IPCAS Team in conjunction with the clinical team(s) (figure 2). Two of the cases were potentially preventable being in associated with indwelling intravascular cannula infection.

Figure 2: Trust apportioned MRSA – underlying source of infection 2011/12:



Throughout the year there has been a sustained focus on hand hygiene, care of intravenous cannulae, urethral catheters and surgical wounds, improved blood culture taking technique and tissue viability care (e.g. prevention and management of pressure ulcers), along with monitoring of admission and inpatient MRSA screening protocols. There is a continued challenge to maintain this focus in order to further reduce risk in these areas.

2.2 *Clostridium difficile* infection (CDI)

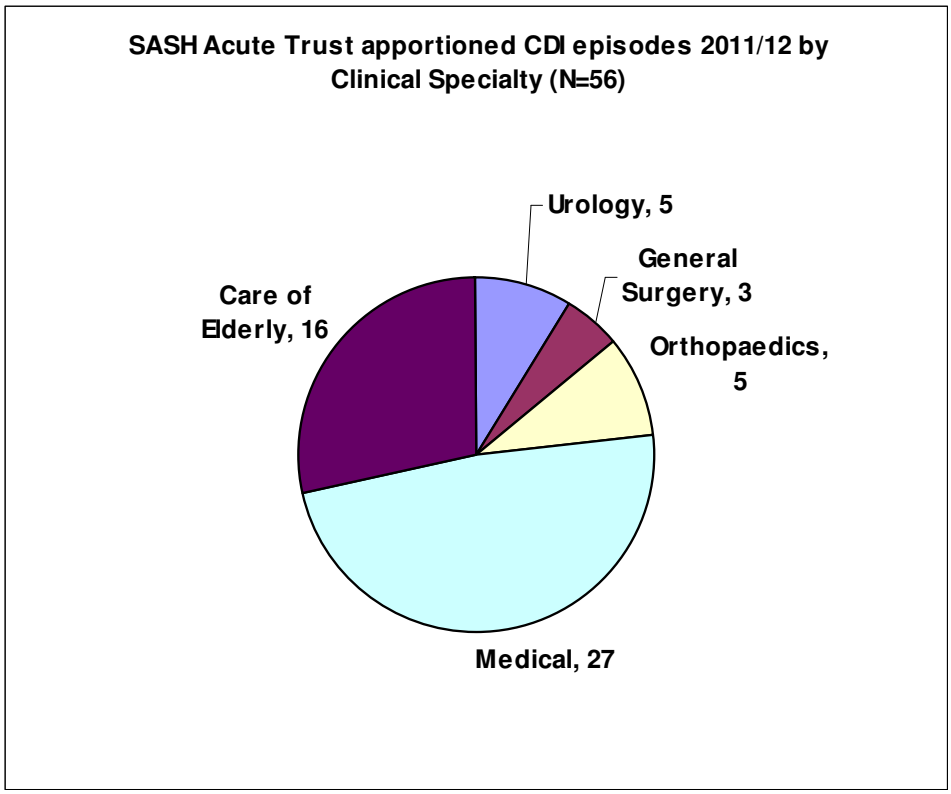
The annual numbers of Trust apportioned cases of CDI are shown in Table 1.

Table 1: Annual numbers of Acute Trust apportioned CDI per 1,000 bed days:

Year	Trust apportioned CDI (number)	Trust apportioned CDI rate (cases per 1,000 bed days)
2007/08	187	1.072
2008/09	99	0.552
2009/10	91	0.512
2010/11	70	0.398
2011/12	56	0.318

In 2011-12 the Trust reported 56 Trust apportioned CDIs in 53 patients. Although this was a continuation of a downward trend from previous years, the locally agreed target of 50 cases for the year was not achieved. Review of all cases, in the form of RCA, undertaken by the IPCAS team in conjunction with clinical teams, showed a spread of infection across clinical specialties (figure 3) with 86% of cases having had prior antibiotic exposure. A proportion of antibiotic prescribing was not in line with Trust Antibiotic Policy.

Figure 3: Allocation of Acute Trust apportioned CDIs by clinical specialty



The ICTF has provided the forum for case presentation by clinical teams and dissemination of learning. Clinical engagement in this process improved throughout the year. It is envisaged that this will be strengthened further in the coming year, with vital support from the Chief Executive, Medical Director/DIPC, Chief Nurse and HCAI leads.

Assuring appropriate antibiotic use is a major priority for the Trust. During the year there has been enhanced focus on antibiotic stewardship, formation of the Antimicrobial Stewardship Group and implementation of a regular antibiotic clinical ward round. This focus will be continued into the coming financial year and sustained thereafter. (See Chapter 10.)

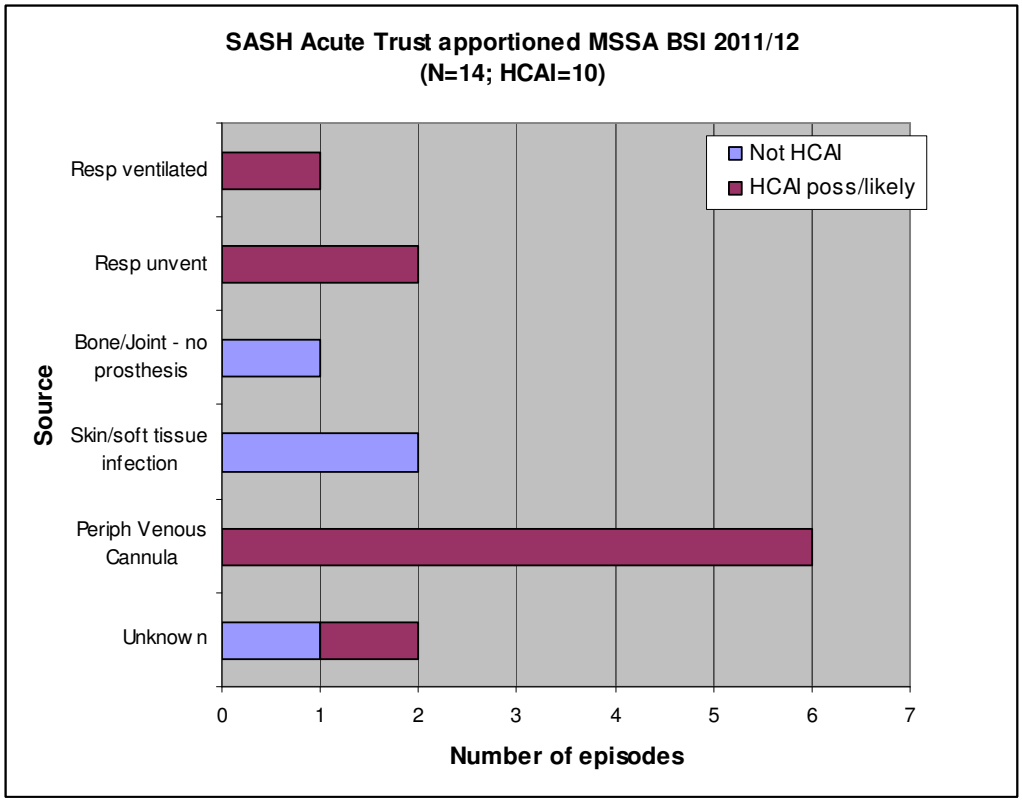
Environmental decontamination regimen includes the use of vaporised hydrogen peroxide as part of the 'terminal' clean process and the annual deep clean programme. The annual programme has been a challenge to implement. Environmental decontamination continues to be a high priority for the Trust and will be the focus for new initiatives in 2012/13.

The continued focus on improvements in antibiotic prescribing, environmental cleanliness and hand hygiene has contributed to a risk reduction for both MRSA BSI and CDI. In addition, rigorous application of 'period of increased incidence' (PII) control measures for CDI has consistently prevented escalation of small clusters of cases into significant outbreaks.

2.3 Methicillin-sensitive *Staphylococcus aureus* bloodstream infection (MSSA BSI)

As of 1st January 2011, the Trust has reported all cases of MSSA BSI onto the national HCAI capture database. Cases are apportioned as for MRSA BSIs. Analysis of the data for 2011/12 shows MSSA BSI to be an infection predominantly arising in the community. Of the 56 BSI reported episodes, 14 were apportioned to the Acute Trust. Figure 4 shows the breakdown of focus of infection, where a focus was confidently identified, and whether associated with healthcare intervention. Six episodes were in association with peripheral intravascular cannulae, the management of which presents a clear target for intervention and improvement, which continues to be reflected in focused infection control activity.

Figure 4: Acute Trust apportioned MSSA BSI with likely source of infection 2011/12



2.4 *Escherichia coli* (*E. coli*) BSI

From 1st July 2011 the Trust has reported all cases of *E. coli* BSI onto the National HCAI capture database. This initiative was commenced largely in response to a steady rise in Gram-negative infections nationally in order to identify potential areas for intervention to reduce risk. Figure 5 illustrates this trend for SASH cases since 2009. Of concern is the steady increase in proportion of multi-resistant extended-spectrum beta-lactamase (ESBL) producing strains. Infections with these organisms present a significant management challenge both from antibiotic treatment and infection control perspectives. It is expected that the focus on these organisms will be intensified.

Figure 5: All episodes of Trust reported *E.coli* BSI between 2009 and 2012 with proportion of ESBL-producing isolates

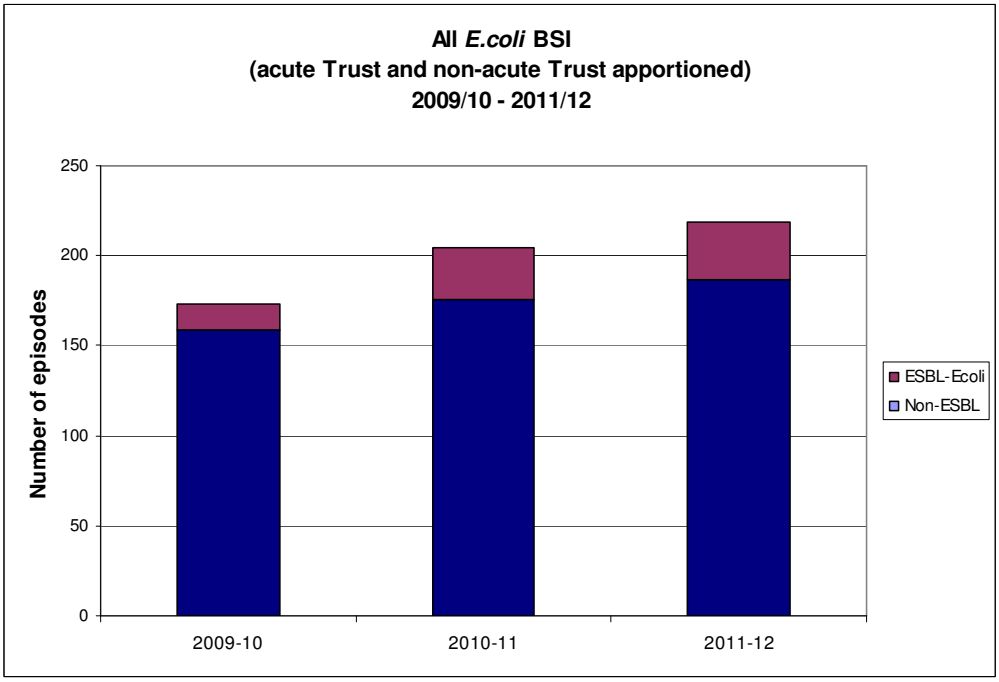
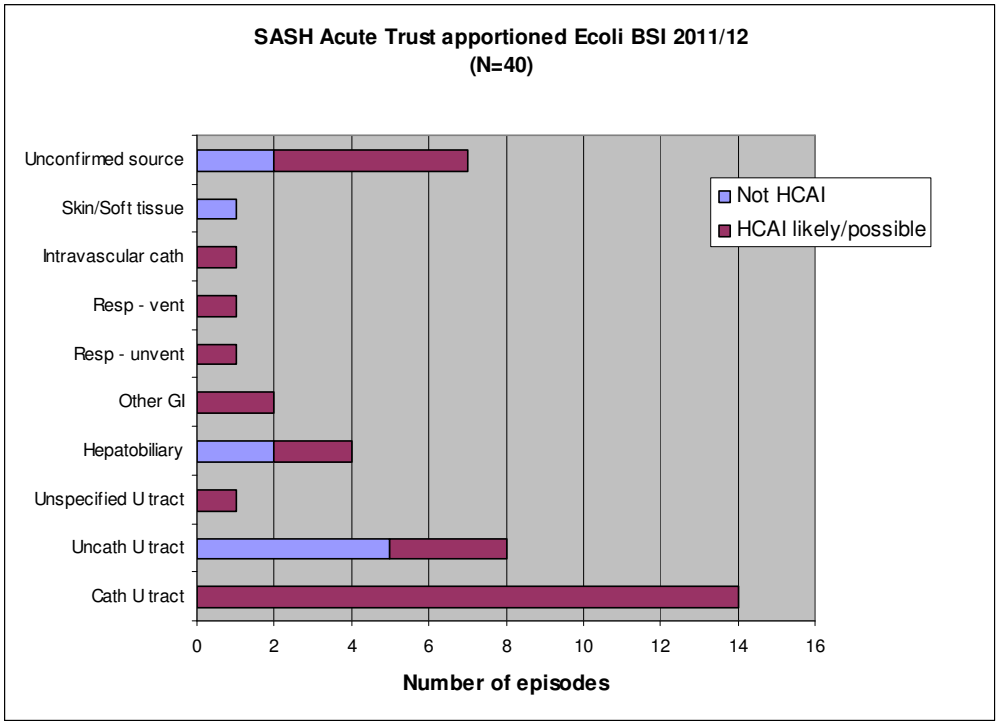


Figure 6: Acute Trust apportioned *E.coli* BSI with detailing likely HCAI and source of infection



Analysis of the data reported by SASH for 2011-12 illustrates that, as with MSSA BSI, this is largely an infection arising in the community. Of the 178 reported BSI episodes from July 2011 – March 2012, 40 were Trust apportioned. Figure 6 shows the breakdown of focus of infection, where a focus was confidently identified, and whether the infection was associated with a heathcare intervention.

The predominance of *E.coli* BSIs associated with indwelling urinary catheters and urological interventions provides the main area for intervention and improvement, which continues to be reflected in focused infection control activity.

2.5 Glycopeptide-resistant Enterococcal (GRE) BSI

GRE BSIs are reported via the National HCAI capture database. Five cases were identified in 2011-12, arising in patients with complex clinical diagnoses who had required broad spectrum antibiotic administration. Antibiotic selection pressure is probably the single most important factor for development of GRE BSI. It is expected that the Trust will continue to report occasional cases but there is no evidence that cases thus far have been associated with cross infection. The focus on antibiotic stewardship and appropriate infection control precautions will ensure minimisation of risk.

2.6 Influenza

All laboratory diagnosed cases of influenza were reported onto the National Influenza database for the period October 2011 to March 2012. No hospitalised in patients required admission to the intensive care unit. There was no requirement for a cohort ward.

The last flu vaccine campaign showed a marked increase in the number of staff vaccinated; 1200 in 11/12 compared to 700 in 10/11.

3: MRSA screening and suppression

3.1 Methicillin-resistant *Staphylococcus aureus* screening

MRSA admission/pre-admission screening for all patients undergoing elective surgical and investigative procedures was introduced in April 2009. Patient group exceptions have been identified in accordance with DoH guidance and are detailed in Trust policy. Screening for all emergency admissions has been fully in place since December 2010. The Trust has consistently achieved scores of above 95% for both screening sets each quarter but RCAs of MRSA BSI and local audits have shown there is room for improvement which is being actioned.

3.2 MRSA Suppression protocol

The Infection Prevention and Control team will continue quarterly checks of MRSA suppression protocol and ensure results are fed back to the HCAI Taskforce and Divisional Governance committees. The IPC team will continue to raise any identified issues on ward rounds and through training.

4: Laboratory Infection reporting

4.1 Voluntary Laboratory reporting

The Microbiology Laboratory provides voluntary reports to the Health Protection Agency (HPA) on a range of organisms/infections. These data are reported via the HPA's electronic reporting system, Co-Surv. Reporting practices are governed by CPA-accredited laboratory standard operating procedures.

4.2 Statutory Laboratory reporting

In October 2010, all laboratories were required to comply with new statutory requirements for reporting of certain notifiable infectious diseases to the HPA. This is fulfilled largely by electronic reporting via Co-Surv, but supplemented by postal and telephonic communication.

5: National HCAI Point Prevalence Study 2011

The Trust took part in the fourth HCAI Point Prevalence Survey (PPS) and the first National Survey on Antibiotic use in England in 2011. This provided a snapshot of the levels of healthcare-associated infections (HCAI) and levels of antibiotic use in hospital Trusts in England in the autumn of 2011.

Nationally, there was an overall drop in HCAI prevalence from 8.2% in 2006 to 6.4% in 2011. The SASH rate was lower than the national average at 5.2% (N=29).

6: Catheter-associated urinary tract infection (CAUTI)

Catheter associated urinary tract infections (CAUTI) are the second most common healthcare associated infection (HCAI). These infections are the cause of significant morbidity and mortality and are the cause of 9% of all bloodstream infections (BSI), increasing the cost of treatment and length of stay. Catheter associated urinary tract infections lead to increased antimicrobial use and subsequent development of antimicrobial resistance. The longer a urinary catheter remains in situ the greater the risk of CAUTI occurring.

Four catheter associated urinary tract infections were found during the PPS study. CAUTIs caused 13.3% of the total infections at SASH, compared to 17.2% nationally.

In 2011/2012 the strategy at SASH to reduce the potential harm to patients relating to urinary catheters and UTIs includes:

- **Reduce the number of indwelling catheters.**
  Numbers of urinary catheters and clinical indication is included in the matron's ward rounds. Numbers of urinary catheters and UTIs are also measured as part of the Patient Safety Thermometer.

- **Improve Education and Training**
  Insertion and care of urinary catheters is now included in the 'Train the Trainers' programme for aseptic technique in clinical areas, included in Urology Study days and is part of Statutory/mandatory training.

- '**HOUDINI study**
  The 'HOUDINI' study is an evidence based protocol for the removal of indwelling urethral catheters, with the aim of reducing the duration of catheterisation and the incidence of CAUTI. There is evidence that nurse initiated catheter removal protocols significantly reduce the length of time catheters are in situ with a corresponding reduction in CAUTI. The protocol is based on a series of clinical indications (HOUDINI) for the insertion and continued use of an indwelling urinary catheter. This collaborative project aims to identify baseline prevalence of indwelling urinary catheter use and implement a protocol for nurse initiated urinary catheter removal to reduce CAUTI.

7: Outbreaks

7.1 *Clostridium difficile*

Clusters of *Clostridium difficile* infection are identified at an early stage using the Department of Health guidance '*Clostridium difficile*: how to deal with the problem (2008), which provides the following definition:

A 'Period of Increased Incidence' (PII) of *Clostridium difficile* is two or more cases (occurring >48 hours post admission, not relapses) in a 28 day period.

Once a PII is identified the ward is placed under enhanced infection prevention and control precautions, including:

- Daily review by IPCAS team and enhanced surveillance of new cases
- Enhanced cleaning
- Weekly environmental audits
- Weekly Good Antimicrobial Prescribing audits

Table 2: SASH PIIs of *Clostridium difficile* 2011/12:

Ward	**Number of cases**	**Date**	Typing results
Buckland	4	July 2011	Different ribotypes, thus no evidence of outbreak
Chaldon	2	December 2011	Different ribotypes, thus no evidence of outbreak
Abinger	2	January 2012	One of the cases not isolated during further testing thus no evidence of outbreak
Newdigate	2	March 2012	Same ribotype. Consistent with cross infection and outbreak– SI declared.

7.2 Norovirus

Noroviruses are a group of viruses that are a common cause of gastroenteritis (diarrhoea and vomiting), particularly during the winter season. Norovirus often causes outbreaks because it is easily spread from one person to another, and the virus is able to survive in the environment for many days.
Between October 2011 and March 2012, there were 9 confirmed and 14 unconfirmed (microbiologically) outbreaks of norovirus. This resulted in a total of 219 says where wards were either fully or partially closed.

8: The Code of Practice for Infection Prevention and Control

The Code of Practice for Infection Prevention and Control lays out guidance for NHS organisations on the measures that should be in place, and the assurances that should exist, to ensure proper standards in the principles and practices of prevention and control of HCAIs throughout an organisation. The compliance criteria are listed below:

Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Provide suitable accurate information on infections to service users and their visitors.
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

On 16th December 2011 the Care Quality Commission (CQC) carried out an unannounced inspection at SaSH relating to 3 outcomes, of which Outcome 8 was one - Cleanliness and Infection Control. The inspectors found that the hospital maintains an appropriate standard of cleanliness and is taking reasonable steps to protect people from infection. However, the inspectors had moderate concerns in the prevention and monitoring of MRSA infections and a compliance action was set to address this. A number of actions were immediately taken:

- All handover sheets amended to have MRSA status on every patient every day
- Monitoring of handover sheets integrated into daily Matrons round checks.
- Review of Infection Control Key Performance Indicators – MRSA screening included in monthly KPIs and monitored by the Infection Control Taskforce.
- Infection Control nurses carrying out 'cross audits' for key aspects of care.
- Introduction of a new Peripheral cannula care plan

Since the inspection, intravenous line care and MRSA screening has been closely monitored by the senior nursing team.

9: IPCAS Audit

A programme of audit is in place to ensure that key policies and practices are being implemented appropriately. The following is a summary of the key IPCAS policies which have been audited in 2011/12.

9.1 Saving Lives High Impact Interventions

The ICTF monitors the programme of weekly *Saving Lives High Impact Interventions* audits in every clinical area. This has been in place since 2008, with the aim of clinical areas taking local ownership over monitoring compliance, and taking action where reduced compliance is evident. Audits are carried out weekly with a cross-audit occurring the first week of every month. Audit results form part of key discussion at ICTF meetings so progress with compliance is monitored, and ongoing high standards of infection prevention and control are promoted with key clinical procedures and practice. The High Impact Interventions are:

- Hand hygiene
- Intravenous cannula
- Urethral catheters
- Central venous catheters
- Ventilated patient/tracheostomy
- Renal dialysis ongoing care
- Surgical site infection care bundle

The results are monitored and reported via a "RAG-rated" balanced scorecard system so that areas of poor performance could be identified and given support for improvement.

The table below shows percentage compliance with Saving Lives Care Bundles throughout 2011/12.

Table 3: Saving lives and hand hygiene 2011/2012:

Hand Hygiene	99%
IVC insertion (central/peripheral)	94%
IVC Care	98%
UC Care	98%
Urinary catheter insertion	100%
Surgical site infection care bundle	99%
CVC Ongoing care	99%
Ventilated patient / Tracheostomy - Regular obs	89%
Ventilated patient / Tracheostomy - Ongoing care	98%
Renal dialysis (Haemofiltration) - Ongoing care	96%

9.2 Aseptic non-touch technique (ANTT)

A system of 'Train the trainers' is in place to monitor aseptic technique throughout in-patient areas. A qualified nurse in every area has been trained to monitor and audit aseptic technique in relation to the administration of intravenous drugs. Thus, the technique is standardised throughout the Trust. ANTT audit results are examined on a monthly basis and any issues identified are taken forward by the Divisions.

687 audits were carried out in 2011/2012, with an average pass mark of 85%. Further information on compliance figures pertaining to specific areas can be obtained via the IPCAS Team.

9.3 Orthopaedic surgical site infections (SSI)

The Trust participates in the Health Protection Agency's Surgical Site Infection Surveillance Service (SSISS). The undertaking of prospective surveillance in at least one category of orthopaedic procedures for one surveillance period during a financial year is mandatory. The Trust conducts surveillance for orthopaedic surgery within the following categories; Hip replacement, knee replacement and repair of neck of femur.

Results (where available) for SSI surveillance periods for 2011/12 are shown in the table below. (Note Jan – March 2012 data validation and reconciliation in progress at the time of writing).

Table 4: Number of operations and rates of SSI by category

Quarter	Operation	Knee replacement	Repair neck of femur	Hip replacement
SASH Apr-Jun 2010	Total No. No. Infected (%)	51 0 (0)	131 3 (2.3%)	61 6 (9.8%)
SASH Jan-Mar 2011	Total No. No. Infected (%)	28 0 (0)	89 4 (4.5%)	43 1 (2.3%)
SASH Jul-Sep 2011	Total No. No. Infected (%)	49 1 (2.0%)	106 1 (0.9%)	42 1 (2.4%)
SASH Oct-Dec	Total No. No, infected (%)	39 1 (2.6%)	107 1 (0.9%)	53 1 (1.9%)
SASH Cumulative 4 quarters	Total No. No. infected (%)	167 2 (1.2%)	433 9 (2.1%)	199 9 (4.5%)
All Hospitals Previous 5 years	Total No. % infected	203950 1.4%	52307 1.8%	193193 1.1%

The aim of SSISS is to enhance the quality of patient care by encouraging hospitals to use data obtained from surveillance to compare their rates of surgical site infection (SSI) over time and against a benchmark rate, and to use this information to review and guide clinical practice. SASH was identified by the Health Protection Agency as being above the 90th percentile for hip replacement. This percentile accounts for the last 4 periods of data collection however, numbers of SSI from the hip replacement category are on a downward trend as are SSIs within the repair of NOF category.

The surgical division is accountable for the provision of a SSISS data collector with the IPCAS team validating, reconciling and supporting administration for data submission, producing and feeding back summary reports. The Trust has met the required mandatory data collection however participation in continuous surveillance provides more meaningful data. Compliance with continuous surveillance has improved and the IPCAS Team continue to work with the surgical division promoting awareness of and engagement in SSISS, reviewing strategies and practice for reducing SSI rates.

10: Antimicrobial Stewardship

10.1 Antimicrobial Stewardship Team

- There have been no major changes in the composition of the Antimicrobial Stewardship Team in the past year
- The Trust Antimicrobial Pharmacist continues to undertake both antimicrobial pharmacy and general pharmacy roles, and this limits the time available for antimicrobial pharmacy activity
- The Antimicrobial Pharmacist has started a postgraduate training course in infection management for pharmacists. Bursary funding has been granted for the first year.

Continuing funding will be required for completion of the course in order to facilitate the development of the Trust Antimicrobial Stewardship Programme.

- Data support is required for antibiotic consumption reporting – a business case is to be written for the pharmacy JAC programme (ReportPlus). This has been delayed by issues with the Cerner system which needs to be upgraded to support ReportPlus.
- The Trust Antimicrobial Stewardship Group was established in Feb 2012 to oversee the revision and development of antibiotic guidelines and policies and to promote good antimicrobial prescribing practice. The group meets monthly meeting chaired by the Lead Consultant Microbiologist, with Consultant representatives from clinical divisions.

10.2 Trust antibiotic strategy and progress review

- The current Trust strategy for prudent antimicrobial use, including ongoing initiatives in education & training, data support and restriction system for antibiotics has been incorporated into the new Trust Antimicrobial Prescribing Policy currently under preparation.
- The Trust Antibiotic Stewardship Programme was assessed using the ASAT tool by the SHA antimicrobial pharmacy lead during the year. The score for 2011/12 was 84%, 6% higher then the previous year. The area of greatest weakness was training and education – this will be targeted in the coming year.

Acute Hospital Antimicrobial Self Assessment Tool (ASAT)
SASH 2009/10, 2010/11 & 2011/12

Section number	Contents	Max score	Score for the Year		
			2009/10	2010/11	2011/12
1	AM management in the Trust	9	8	9	9
2	Operation delivery of AM strategy	40	37	38	38
3	Risk assessment of AM chemotherapy	6	4	5	4
4	Clinical governance assurance	12	9	11	11
5	Education and Training	31	15	18	18
6	AM pharmacist	12	8	9	11
7	Patient, carers and the public	19	10	11	17
Overall		**129**	**91 (70%)**	**101 (78%)**	**108 (84%)**

A twice-weekly Consultant Microbiologist-led antibiotic ward round with the Antimicrobial Pharmacist/Ward Pharmacist was started in February 2012. Issues identified on the ward round are fed back directly to the ward doctors (if present) followed by a summary report which is sent by the Consultant Microbiologist to all consultants whose patients were audited.

The Good Antimicrobial Prescribing (GAP) audits have highlighted issues related to documentation of clinical indication and stop date / duration on the drug chart. The Antimicrobial Stewardship Team is leading the new adult drug chart project as a way of ensuring improved compliance with this aspect of Trust policy.

10.3 Policies and guidance

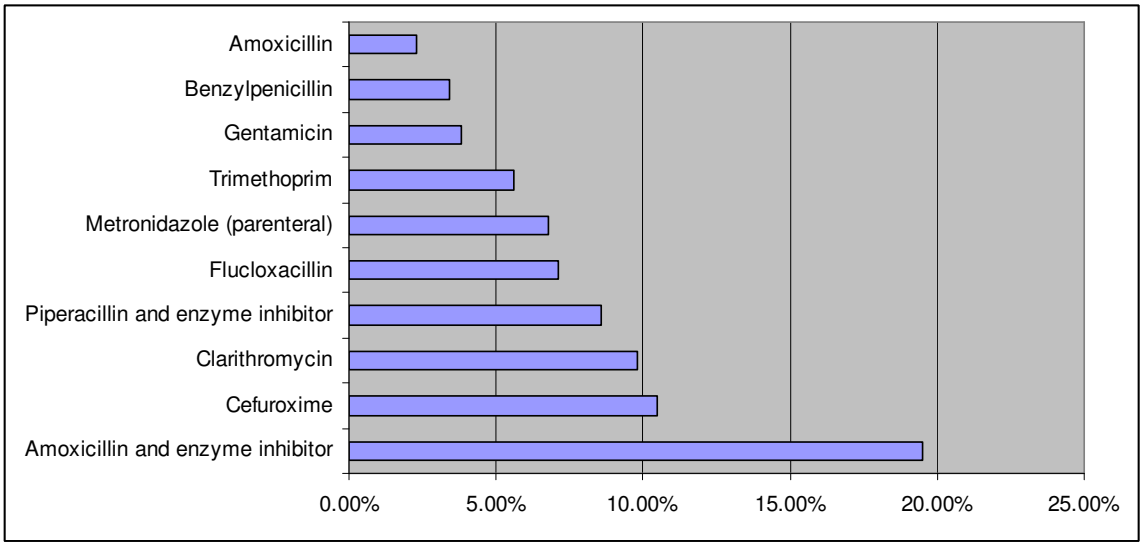
- The Trust Antibiotic Policy and adult antimicrobial guidelines are undergoing major revision to promote narrow spectrum antibiotic use and reduced selective pressure for *C.difficile*. A launch campaign for the new policies and guidelines is planned.
- Guidance on antibiotic use in children has been revised by the Paediatric Department and published on the intranet in Dec 2011

10.4 Surveillance and monitoring

A series of antibiotic audits was carried out during the year:

Good Antibiotic Prescribing (GAP) ward audits:
GAP audits were conducted on a rolling basis throughout the year and monthly per ward since August 2011. A summary of the GAP audit results by division is shown in the table. Improvements in audit scores have been seen since the start of the GAP audit programme, but significant room for improvement remains. The lowest GAP scores have been seen consistently in documentation of clinical indication and stop date / duration (elements 1&2) and this is one of the major drivers for the development of the new drug chart.

Antibiotic point prevalence study – HCAI/Antimicrobial PPS England:
The Trust participated in the HPA led Europe-wide Healthcare Associated Infection and Antimicrobial Point Prevalence Study (Nov 2011). 561 patients were included in the audit. 186 (33%) of the patients were on antibiotics (n= 266) of which 5% were associated with healthcare associated infections. A majority of prescribed antibiotics were given parentally for treatment of lower respiratory/pneumonia (45%) infections followed by surgical site infections (21%) and urinary tract infections (14%). 84% of prescribed antibiotics had reasons documented in the patient notes. The figure below showed the top ten antibiotics prescribed in the study:



It is noted that the most frequently used antibiotics are amoxicillin with enzyme inhibitor (mostly co-amoxiclav), and cefuroxime. Since these are broad spectrum antibiotics with risk of inducing *C.difficile*, the new antibiotic guidelines are being developed to significantly reduce use of these agents, and to make greater use of narrower spectrum antibiotics such as benzylpenicillin, amoxicillin and gentamicin.

Targeted audit – Orthopaedic prophylaxis audit:
The audit was carried out over a period of 3 weeks from 30th January 2012-17th February 2012. Three wards including one elective and two trauma orthopaedic wards were piloted. Drug charts and anaesthetic notes were the sources used for data collection.

Thirty nine patients were audited of whom 18 were trauma and 21 elective patients. 95% and 65% of elective and trauma patients received the correct stat doses of cefuroxime and flucloxacillin respectively. Only 10% of elective surgical and 18% of trauma surgery patients received the correct antibiotic regimen. One patient with penicillin allergy did not receive teicoplanin as advised in the SASH guidelines. A majority of the elective cases were prescribed with the correct antibiotic agents, compared to trauma cases. However antibiotics were not always used at the correct time intervals, in terms of the postoperative dosing. This audit was fed back to the surgical & orthopaedic department.

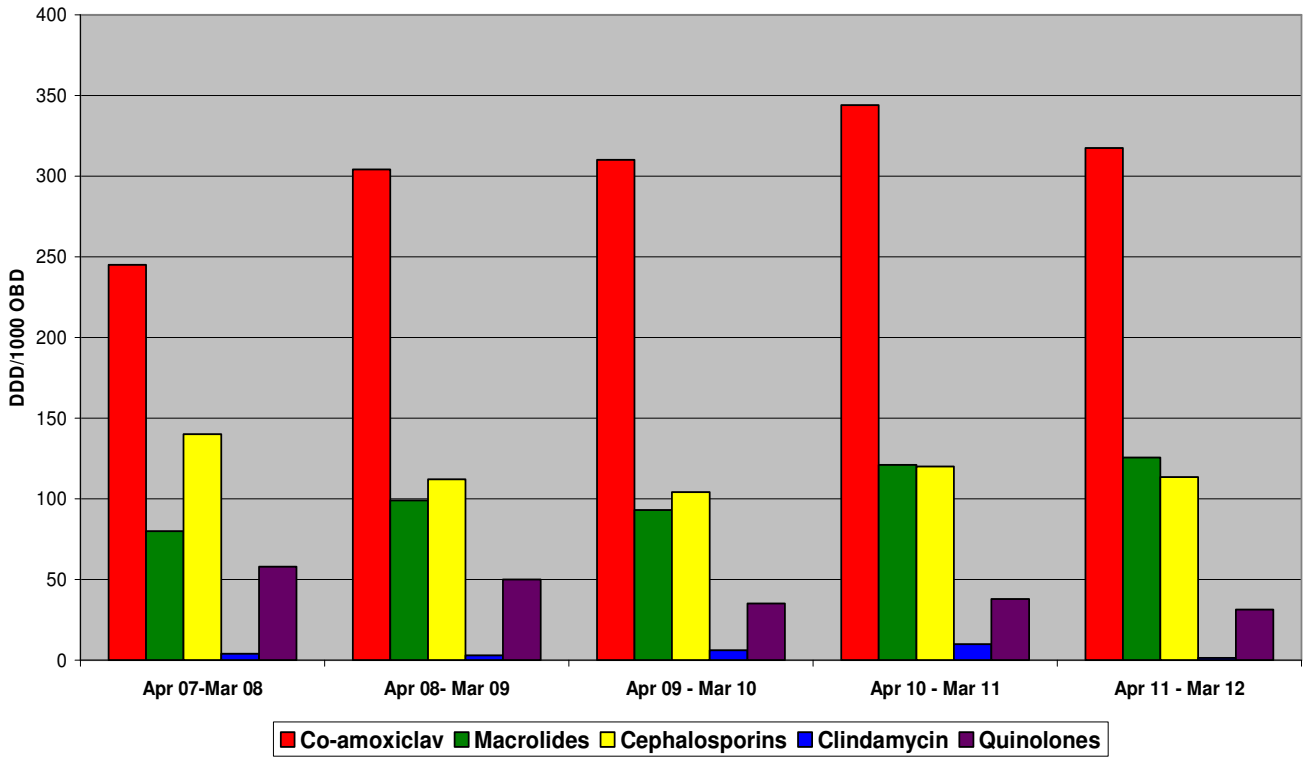
10.5 Consumption data report

The Antimicrobial Stewardship Team maintains surveillance of "*C.difficile* associated antimicrobials" and restricted antimicrobials. Antibiotic usage/consumption expressed as WHO defined daily doses (DDDs) and DDDs per 1000 occupied bed days (OBD) in 2010/201 is shown in the following figures:

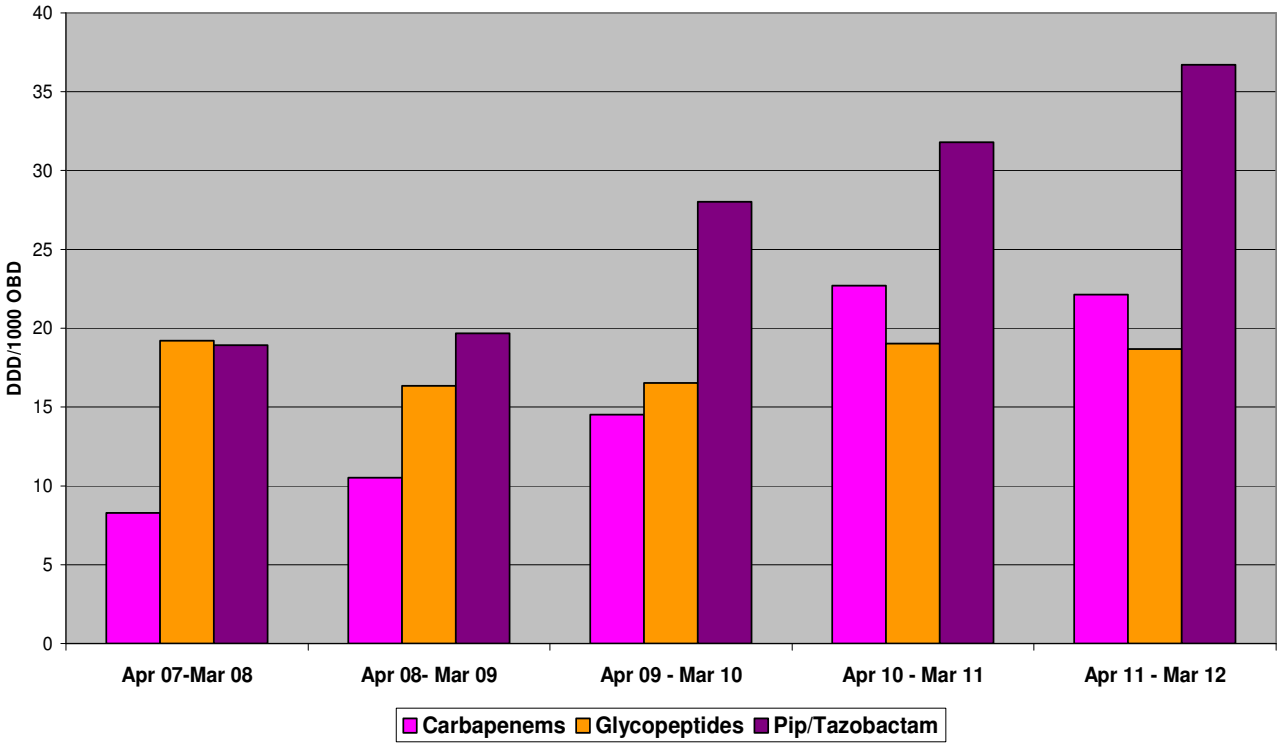
Of the five main groups of *C.difficile* associated antimicrobials, the greatest consumption was of co-amoxiclav. There was a modest reduction in consumption in year 2011/12 as compared to year 2010/11, but a greater reduction will be sought after introduction of the new Trust antibiotic guidelines.

Consumption of restricted antimicrobials was at a lower level as compared to the *C.difficile* associated antimicrobials. An upward trend in usage was seen, in particular for piperacillin/tazobactam – this trend will be monitored as the new antimicrobial policy to introduced in the coming year.

SASH Antimicrobial Consumption for C.difficile associated antimicrobials (DDD/1000 OBD)



SASH Restricted Antimicrobials (DDD/1000 OBD)



10.6 Education and Training

The Antibiotic Stewardship Team promoted the annual European Antibiotic Awareness Day 2011 which coincided with the launch of Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Antimicrobial Stewardship initiative "Start Smart – Then Focus".

An active campaign was held at the post graduate medical centre and laminated credit card size empirical antimicrobial guides and posters for promoting "Start Smart – Then Focus" were handed out to prescribers during the lunch time period. Information on antibiotic prescribing and resistance was displayed on boards to raise healthcare professionals and public awareness on prudent use of antibiotics. All staff were invited to the presentation given by a Consultant Microbiologist highlighting the issues of resistance and importance of prudent antimicrobial prescribing.

Formal training sessions were delivered by Antibiotic Stewardship Team:

- Annual in-house training for pharmacists and pharmacy staff (Mar 2012)
- Infection control champions training: using antibiotics prudently (Mar 2012)
- Antibiotic stewardship: rolling half day (Feb 2012)
- Annual antibiotic awareness day (Nov 11)
- MRSA PGD training for occupational health (Nov 11)
- SPR and staff grade induction (Oct 2011)
- Infection control awareness week: Masterclass –use of appropriate antibiotics (Sep 2011)
- To Junior doctors FY1,FY2 (August 2011)
- Antibiotic therapeutic drug monitoring drop in sessions for nurses and doctors (July 2011)

11: Decontamination

The Trust Decontamination Group was established in July 2011, is chaired by an Executive Decontamination Lead, and reports to the IPCAS Group. The purpose of the group is to: ensure the delivery of the Trust-wide strategy for decontamination of the environment, medical devices and related items; oversee and scrutinise the delivery of Trust Decontamination policies and procedures; be responsible for reporting to the IPCAS Group any concerns or exemptions; monitor objectives and standards set out in best practice, national guidance etc; monitor training and competence for decontamination of devices and the environment across the Trust

11.1 Decontamination of Nasoendoscopes in OPD clinics

ENT clinics take place at East Surrey and Crawley Hospitals and community ENT clinics. The current procedure for decontamination of nasoendoscopes is manual, using the Tristel (Chlorine dioxide) wipe system. Audits of nasoendoscope decontamination were carried out in 2011.

In order to move towards best practice as detailed within the DH 'Choice Framework for local policy and Procedures 01-06 – Decontamination of flexible endoscopes (2012) (CFPP 01-06), a risk assessment of current practice with options appraisal for central decontamination or local reprocessing in community clinics is being undertaken.

11.2 Environmental cleanliness

Environmental cleanliness is audited against the National Cleaning Standards 2007 by the Facilities team, and scores are monitored at the Taskforce, Decontamination Group and IPCAS Group meetings. Scores have remained complaint for very high, high and significant risk areas. The IPCAS Team continues to collaborate with the Estates and Facilities managers to prevent and control HCAI through high environmental standards.

The Matron's are also responsible for carrying out monthly audits of each clinical area using a tool which looks at environmental cleaning and other aspects of infection control. This tool was revised in February 2012.

11.3 Decontamination of patient equipment in wards/departments

A total of 13 audits were carried out by Infection Prevention & Control Nurses during the period September 2011 to April 2012, using the Quality Improvement Tools published by the Infection Prevention Society in 2011. These are tools designed for detailed measurement of all aspects of practice/environment, and measure baseline compliance with standards and identify areas for improvement work. The audit tools used questions from the following question sets:

- Patient Equipment- Management of equipment (including single use policy)
- Monitoring & Physiological equipment
- Resuscitation equipment
- Respiratory Equipment
- Manual Handling equipment
- Miscellaneous equipment

Results of audit scores ranged from 65% to 100%. Results are fed back to clinical areas, the Decontamination Group and HCAI Taskforce, and actions agreed.

12: Infection Prevention & Control Champions

The aim of Infection prevention & Control Champions is to support the Trust's drive to deliver safe high quality care by their involvement in the process of the prevention & control of infections. Within their clinical areas they are responsible for; being a role model for and raising awareness of infection prevention and control practice and policy, acting as a resource and liaison, and monitoring compliance with key practices through audits (e.g. ANTT, hand hygiene, Saving Lives).

Champion meetings have convened quarterly with the agenda incorporating an educational focus in addition to updates on IPC issues e.g. HCAI rates, lessons learnt from RCA, audits, policies and protocols. Agendas are available from the IPCAS team.

Attendance at meetings has been from a variety of clinical areas. Representatives from Central Surrey Health, St Catherine's Hospice and the National Young Peoples Centre for Epilepsy are invited as part of Service Level Agreements.

In 2012/13 the aim is to drive improvements with attendance at champion meetings and continue to support the champions in modelling the way and raising the profile of the IPC agenda within their clinical areas through ongoing liaison & education of key infection prevention & control issues.

13: Intravenous Nurse Specialist Service

The Trust is supported by 1 WTE Intravenous Nurse Specialist, who is part of the IPCAS team. This Nurse Specialist runs a Peripherally Inserted Central Catheters (PICC) and midline insertion service, the advantages of which are include long term access, nurse-led bedside placement, low complication rates, increased patient comfort, reduced tunnelled and CVP line insertions saving theatre and anaesthetic time. There was a continued increase in the number of PICCs and Midline insertions in 2011. This nurse is also competent to interpret PICC tip position on chest X-ray.

The introduction of an ultrasound guided upper arm insertion technique using a micro-introducer has allowed the intravenous nurse specialist to expand the service to include PICC insertion for long-term reliable intravascular access, chemotherapy, TPN and for patients identified as difficult to cannulate and bleed.

A nurse led vascular access service aims to reduce insertion delays, especially for patients waiting to be discharged home for continued intravenous antibiotic therapy. In 2011 108 Peripherally Inserted Central Catheters (PICC)/Midlines were inserted for antibiotic therapy and 1241 bed days were saved. 82% of PICC/Midlines were inserted by the vascular access nurse. The average time for nurse PICC/Midline insertion was 20 hours from the time of the initial referral.

14: Training

Training continues to be a high focus for the IPCAS team. The team are involved the following training programmes:

- Statutory/mandatory training
- Trust Welcome Day
- Aseptic technique
- IV cannulation
- Urinary catheterisation study days
- Estates and Facilities (lead by Facilities Manager)
- SLASH training for Junior Doctors (Saving Lives – Aseptic Skills for Healthcare)
- Ad-Hoc training following incident investigation.

Figures on attendance at Statutory and Mandatory training are provided by the Training Department and monitored by the IPCAS Group.

SLASH training for Junior Doctors (Saving Lives – Aseptic Skills for Healthcare):
The concept of SLASH evolved from the Department of Health *Saving Lives* initiative and the principles of aseptic non-touch technique. The objective is to ensure that all staff are trained in evidence-based practice when undertaking key clinical procedures, implementation of which contributes to a reduction in the risk of HCAI. SLASH is a skills station-based workshop focusing on the following subjects:

- Insertion and care of IV devices
- Insertion and care of urinary catheters
- Taking blood cultures
- Hand hygiene

Medical staff (FY1 and FY2) attended the SLASH training sessions as part of their induction into the Trust.

SECTION B:
IPCAS ANNUAL PROGRAMME 2012/13

Surrey and Sussex NHS Healthcare NHS Trust

1: Summary of progress against IPCAS Programme objectives for 2011/12

The Infection Control Annual Programme for 2011/12 laid out 28 specific objectives under the 10 standing duties of the Code of Practice. Of these 21 were fully completed in-year, 2 were closed following review, 3 were commenced and 2 were carried forward to 2012/13.
These partially-completed objectives are:

- Review environmental decontamination policies and assurance framework
- Audit system for recording competence for decontaminating reusable devices at frontline level
- Further expansion of the Antibiotic Stewardship training programme.

Programme Objectives for 2012/13 are detailed in pages 30-42.

I: Gaps and concerns with compliance with Code of Practice on the prevention and control of infections and related guidance

ID	Outcome/GAP	Action	Owner	Target date	Code of Practice
1.1	A system for sharing relevant infection control information during internal movement of patients needs to be embedded	Develop a system to ensure relevant IPC information is shared during internal movement of patients Under review SBAR stickers	Divisional Chief Nurses	**31/12/11 Current system continues. No new system agreed**	4
1.2	The Trust needs to develop a system for monitoring Medical attendance at update or new starter IPCAS related training	Develop a base line with available data and review possible methods for annual review of training	IPCAS Programme Manager	**30/09/11 Complete**	6
1.3	The Trust should be able to evidence local training of decontamination of medical devices and fixtures and fittings	Embed a system for local monitoring and recording of competence to decontaminate medical equipment and environment. (Non HSDU)	Divisional Chief Nurses / Lead Nurse Infection Control	**31/08/11 Audit required 31/03/12**	2
1.4	Low uptake and late commencement of flu vaccination during 2010/11 flu season	Prepare plans for 2011/12 flu vaccinations and ensure stocks are ordered in advance.	Head of Occupational Health	**31/08/11 Complete**	10
1.5	Suggested overarching decontamination lead responsible for monitoring decontamination of reusable devices, nursing equipment and the environment.	Review assurance framework processes for decontamination to include one Executive Lead and reporting of committees	Executive with lead for Decontamination	**31/03/12**	2
1.6	Increased surveillance requirements, both local and national, are having an increasing impact on IPC Nursing Team workload.	Prepare and present a business case for an IPC Surveillance Nurse. To reduce need for qualified IPC Nurses to act as data collectors	Lead Nurse Infection Control	**30/09/11 Following review Closed**	1

II: Audit and surveillance of compliance with Code of Practice on the prevention and control of infections and related guidance

ID	Outcome/GAP	Action	Owner	Target date	Code of Practice
2.1	To ensure regular monitoring of attendance at IPCAS related training (excluding Medical and Dental staff)	Ensure training performance data is embed into Taskforce Meetings	IPCAS Programme Manager	**30/06/11 Complete**	6
2.2	To ensure regular monitoring of compliance with code of practice	Embed evidence into Governance departments "CIRIS" software and review reporting system	IPCAS Programme Manager	**Following review Closed**	1
2.3	All providers should have made suitable and sufficient assessment of the risks to patient of receiving healthcare with respect to HCAI	Review IPCAS related risk assessments	IPCAS Programme Manager	**31/12/12**	1
2.4	Provide suitable accurate information on infections to service users and their visitors	Review IPCAS public leaflets	Lead Nurse Infection Control	**31/08/11 Complete**	3
2.5	Ensure relevant information is provided during external transfer of patients	Audit use of transfer form during external transfers and report findings to the HCAI Taskforce	Lead Nurse Infection Control	**31/05/11 Complete action required**	3
2.6	Ensure patients who are MRSA positive when identified are managed appropriately.	Audit use of MRSA decolonisation and report findings to the HCAI Taskforce	Lead Nurse Infection Control	**31/05/11 Complete**	5
2.7	Ensure waste management policies and procedures are embed and being monitored appropriately	Report on compliance with waste management policies and procedures to be presented to IPCAS Group	Head of Logistics	**31/03/12 Reported to IPCAS group**	9
2.8	Ensure that single use devices are being used appropriately	Carry out an audit of use of single use devices	Lead Nurse Infection Control / Matrons	**31/12/11 Incorporated into Decontamination audits**	9
2.9	Ensure that Divisional reports to board continue to include the information required	Review Divisional reports to Board	IPCAS Programme Manager	**30/09/11 Complete**	1
2.10	To monitor compliance with Antibiotic guidelines	To develop a system of Antibiotic audit base on department of health high impact intervention using a care bundle approach	IPCAS team	**30/07/11 Complete**	9
2.11	To ensure antibiotic audit results are feedback to appropriate clinical teams and governance meetings	To incorporate audit results relevant to division in regular divisional IPCAS reports	IPCAS team	**30/07/11 Complete**	9

III: Service improvement and IPCAS strategy objectives

ID	Outcome/GAP	Action	Owner	Target date	Code of Practice
3.1	No assurance framework that documents that equipment and the environment is suitable for the purpose, kept clean and maintained in good physical	Develop an assurance framework or policy that documents how the Trust monitors compliance with Criteria 2 and current level of compliance	Executive with lead for Decontamination / Trust Infection Control Doctor	**31/03/12**	2
3.2	In order to further reduce the risk of urinary tract and blood stream infections. The Trust needs accurate information on the numbers of urinary catheters used. Once established this number should be reduced where possible	Implement the actions and monitoring detailed in the CAUTI Strategy discussed at taskforce	Lead Nurse Infection Control	**31/03/12**	9
3.3	Medical attendance and engagement at IPCAS Group meetings needs to be increased	Review terms of reference of IPCAS Group and HCAI Taskforce	DIPC	**31/08/11 Complete**	1
3.4	The Trust should endeavour to implement new actions each year to try and reduce the numbers of Clostridium *difficile* linked to inpatient stays	Implement the actions and monitoring detailed in the Clostridium *difficile* pilot study developed during 2010/11	Lead Nurse Infection Control / Trust Infection Control Doctor	31/03/12 **Complete**	9
3.5	IPC strategy aims to achieve the ability to demonstrate level 3 compliance with current NHSLA standards	Review the Trust "Structure and Function of Infection Prevention-Control and Antibiotic Stewardship policy to ensure its still fit for purpose"	IPCAS Programme Manager	30/09/11 **Complete**	1
3.6	Increase provision for source isolation by establishing a extra side rooms at the East Surrey Hospital site	9 further side rooms allocated as part of Charlwood/ Copthorne and Hazelwood.	DIPC / Lead Nurse Infection Control	31/03/12	7
3.7	In line with changes Trust incident investigation there is a need to devolve RCA investigation to clinical teams	Review the process for carrying out and feeding back investigations post 72 hour cases of Clostridium *difficile*	DIPC/ Trust Infection Control Doctor	**30/07/12 Complete**	6
3.8	Ensure the long term infection prevention and control strategy meets the needs of the Trust	Review the IPC strategy to detail what actions have been met, are outstanding a and are still relevant	Lead Nurse Infection Control	31/12/12	1
3.9	Increase engagement of medical staff in Antibiotic Stewardship programme	Review medical attendance at IPCAS group HCAI taskforce.	DIPC	**31/08/11 Complete**	1

Surrey and Sussex NHS Healthcare NHS Trust

Infection Prevention-Control and Antibiotic Stewardship (IPCAS):

Annual Programme for 2012/13

April 2012

Trust IPCAS Leads: Dr Des Holden, Medical Director and DIPC*
Dr Karen Knox, Consultant Medical Microbiologist and Trust Infection Control Doctor
Ashley Flores, Lead Nurse in IPC and Deputy DIPC
Dr Donald Lyon, Consultant Medical Microbiologist and Lead for Antibiotics

* Director for Infection Prevention and Control

Summary

Each year the IPCAS team prepares an annual programme of work which is included in the Annual Report and monitored by the IPCAS Group. The main purpose of this programme of work is to ensure that a culture of continual improvement is maintained and to try and reduce infection risks that patients, staff and visitors are exposed to a minimum. The programme is based on:

- HCAI Objectives
- CQC and NICE compliance
- SHA site visit recommendations.

To maintain links to compliance with the Code of Practice each action will be linked to the most relevant criterion of the Code of Practice.

Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Provide suitable accurate information on infections to service users and their visitors.
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections.
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

Reduce the number of HCAI, in order to meet the Objectives for 2012-2013: **CDI**

Surrey and Sussex NHS Healthcare NHS Trust

Area	No.	Current level	Issue identified	Suggested action	Progress and assurance	Timeline	Executive Lead / Responsible Person	Outcome	Monitoring Process	Criterion*
	1		**Increase engagement of clinical teams in RCA process**	Presentation of RCAs by clinical teams at HCAI Taskforce meetings with feedback of lessons learned at Clinical Governance meetings	RCAs are being presented at the HCAI Taskforce meetings	**01/04/12**	Des Holden	Partially achieved	Monitor at IC Taskforce	9
	2		**Drive improvement through the publication of KPI data**	Publish KPIs for Infection control on every ward, to include e.g. antimicrobial choice, documentation of antibiotic duration and indication, MRSA screening compliance	KPI data published on a monthly basis outside all wards	**01/04/12**	Ashley Flores	Achieved	Monitor at IC Taskforce	9
	3		**Improve risk assessment of diarrhoea at ward level**	Launch diarrhoea risk assessment tool	Tool disseminated for comment at Nursing Documentation Group	**30/06/12**	Ashley Flores		Monitor at IC Taskforce.	1
	4		**Increase presence of IPCAS team in clinical areas**	Implement Quality Ward rounds	In progress. 3 wards per month	**01/04/12**	Ashley Flores	Achieved	Monitor at IC Taskforce .	9

* Criterion of the Health & Social Care Act 2008

Reduce the number of HCAI, in order to meet the Objectives for 2012-2013: **CDI**

Surrey and Sussex NHS Healthcare NHS Trust

Area	No.	Current level	Issue identified	Suggested action	Progress and assurance	Timeline	Executive Lead / Responsible Person	Outcome	Monitoring Process	Criterion*
	5		**Ensure standards of environmental cleanliness are maintained and improved beyond current national guidance**	1. Develop risk based cleaning system 2. Develop exemption sheet for cleaning 3. Introduce use of Tristel	Tristel discussed at Taskforce – for discussion at Management Board	**31/10/12**	Ruth Bradburn Ruth Bradburn Ashley Flores		Monitor at IC Taskforce Group.	2
	6		**Inclusion of *Clostridium difficile* Trust infection control teaching programmes**	Continue to include in statutory and mandatory training programme	Management of *Clostridium difficile* included in Trust statutory and mandatory training	**01/04/12**	Ashley Flores	Achieved. In progress	Monitor at IC Taskforce	9
	7		**The Trust DIPC and IPC Team should liaise with other Trusts to establish best practice, standards, policies and guidelines against which to compare SaSH.**	Best practice with Frimley and Ashford and St Peters Trusts has been discussed. Three actions identified: 1. Disposal of patient wash water in sluice 2. GP admissions with diarrhoea to be admitted to side rooms 3. Use of Tristel for cleaning	1. Memo sent to nursing staff (01/06/12) 2. DH discussed with BE 3. Meeting with rep 18/05/12 to arrange trial	**30/06/12** **30/06/12** **30/06/12**	Executive Lead: Sally Brittain Responsible Person: Ashley Flores	In progress	To be discussed at Nursing Forum (NEG), NMPC, IC Taskforce add date ad actions	

* Criterion of the Health & Social Care Act 2008

Reduce the number of HCAI, in order to meet the Objectives for 2012-2013: **Antimicrobial Stewardship**

Surrey and Sussex NHS Healthcare NHS Trust

Area	No.	Current level	Issue identified	Suggested action	Progress and assurance	Timeline	Executive Lead / Responsible Person	Outcome	Monitoring Process	Criterion*
	8		**Antimicrobial Prescribing: 0.5wte Antimicrobial Pharmacist time is dedicated to this focus**	Increase resource allocation for Antimicrobial Stewardship work programme to 1.0 WTE	Not yet actioned.	**14/06/12**	Executive Lead: Des Holden		Antimicrobial Stewardship Group (ASG) reports to IPCAS Group.	9
	9		**Increase Medical engagement in Antibiotic Stewardship programme**	Develop antibiotic stewardship steering group (ASG) to address issues identified from audit	ASG has met twice, and will meet on monthly basis	**01/04/12**	Donald Lyon	Achieved	ASG reports to IPCAS Group	6
	10		**Increase awareness of medical staff re antimicrobial stewardship**	Extend training in antimicrobial stewardship for appropriate staff - Deliver Stat/Mandatory to medical staff, FY1 training in Antimicrobial stewardship	Sessions have commenced	**30/09/12**	Consultant Medical Microbiologists	Achieved – in progress	Monitor at IPCAS Group	6
	11		**Antibiotic audit tool should support and promote revised antibiotic prescribing policy**	Revise antibiotic audit tool (GAP) to align with Department of Health "Start Smart then Focus"	In progress 20/06/12	**30/09/12**	Amy Lee		Monitor at ASG	9

* Criterion of the Health & Social Care Act 2008

Reduce the number of HCAI, in order to meet the Objectives for 2012-2013: **Antimicrobial Stewardship**

Surrey and Sussex NHS Healthcare NHS Trust

Area	No.	Current level	Issue identified	Suggested action	Progress and assurance	Timeline	Executive Lead / Responsible Person	Outcome	Monitoring Process	Criterion*
	12		**Review use of broad spectrum restricted antibiotics**	Targeted audit of Meropenem use	Not yet commenced 20/06/12	**30/09/12**	Amy Lee		Monitor at ASG	9
	13		**Increase awareness and availability of Trust antibiotic policy**	Produce pocket sized, concertina format mini antibiotic prescribing guidance and give to all doctors (consultants included)	In progress	**31/07/12**	Amy Lee		ASG	9
	14		**Provision of antimicrobial policy reflects current requirements/national guidance**	Revision of Trust Antimicrobial Policy	Agreed by Chiefs For submission to MBQR	**30/06/12**	Lead CMM for antibiotics/Lead Antibiotic Pharmacist		ASG and IPCAS Group	9
	15		**Improved documentation of antibiotic prescribing decisions**	Implementation of revised drug chart to support antimicrobial stewardship programme	Revised version circulated for comment	**30/06/12**	Chief Pharmacist		ASG	9
	16		**Develop systems to monitor antimicrobial prescribing practice**	Regular Antibiotic ward rounds to review antimicrobial use	Ward rounds commenced March 2012	**31/10/12**	Lead CMM for antibiotics	Actioned	ASG	9

* Criterion of the Health & Social Care Act 2008

Reduce the number of HCAI, in order to meet the Objectives for 2012-2013: **MRSA BSI**

Surrey and Sussex NHS Healthcare NHS Trust

Area	No.	Current level	Issue identified	Suggested action	Progress and assurance	Timeline	Executive Lead / Responsible Person	Outcome	Monitoring Process	Criterion*
	18		**MRSA screening documentation:** Variation in practice was noted in the way in which MRSA screening is recorded	Ensure ward staff complete 'MRSA screening' documentation in Nursing Assessments	Already included on ward handover sheets	**31/05/12**	Executive Lead: Jo Thomas Responsible Persons: Jamie Moore & Lisa Cheek	Actioned	Divisional Governance & Clinical Effectiveness Group.	9
	19		**Review Trust audit calendar to include key issues identified** **Include in Safety thermometer**	Review Trust audit calendar to include key issues identified Include in Safety thermometer	Clinical indication for Urinary catheters and UTIs included in Trust Safety Thermometer	**31/05/12**	Executive Lead: Jo Thomas	Actioned	NMPC	9
	20		**MRSA screening - recommended frequency:** It is recommended that the Trust reviews the recommended frequency of re-screening	Review MRSA policy re frequency of MRSA re-screening.	Has been discussed at IPCAS team meeting. Agreed to carry out weekly screening on high risk wards - to be defined	**30/06/12**	Executive Lead: Des Holden		IC Taskforce and IPCAS Group	9

* Criterion of the Health & Social Care Act 2008

Reduce the number of HCAI, in order to meet the Objectives for 2012-2013: **MRSA BSI**

Surrey and Sussex NHS Healthcare NHS Trust

Area	No.	Current level	Issue identified	Suggested action	Progress and assurance	Timeline	Executive Lead / Responsible Person	Outcome	Monitoring Process	Criterion*
	21		**Implement Best Practice: Training of medical staff:** Offer OSCE-based competency training for doctors on hand washing (as done at the Royal Surrey County Hospital)	Consultants to lead on OSCE-based competency training for doctors on hand washing and insertion of invasive devices	Not yet actioned	**30/06/12**	Executive Lead: Des Holden		IC Taskforce	6, 9 10
	22		**Improve documentation**	Embed the following care plans through education, audit and feedback: ○ Peripheral Cannula Care Plan ○ Urinary Catheter Care Plan	○ Rolled out in clinical areas ○ Included in statutory and mandatory training ○ Peripheral care plan Included in 'Quality Ward Rounds'	**30/06/12**	Ashley Flores		IC Taskforce and NMPC	9
	23		**Revise policy for 'Management of urinary catheters' through inclusion in statutory and mandatory training**	Launch new policy for Management of urinary catheters	Policy agreed at MBQR – for EIA and minor amendment	**30/06/12**	Ashley Flores		IC Taskforce and NMPC	9
	24		**Facilitate a reduction in CAUTIs and bloodstream infections where urinary catheters are a source**	- Repeat CAUTI prevalence study - Roll out HOUDINI project	Lead Nurse Infection Control	**30/06/12**	Ashley Flores		IC Taskforce and IPCAS Group	9

* Criterion of the Health & Social Care Act 2008

Reduce the number of HCAI, in order to meet the Objectives for 2012-2013: **Compliance with the Code of Practice for Infection Prevention and Control & NICE Guidance**

Surrey and Sussex NHS Healthcare NHS Trust

Area	No.	Current level	Issue identified	Suggested action	Progress and assurance	Timeline	Executive Lead / Responsible Person	Outcome	Monitoring Process	Criterion*
	25		**All providers should have made suitable and sufficient assessment of the risks to patient of receiving healthcare with respect to HCAI**	1. Review IPCAS related risk assessments 2. Review stool chart, to include assessment of diarrhoea	In progress	**31/10/12** **30/06/12**	Ashley Flores		IPCAS Group	1, 4
	26		**Ensure relevant information is provided during external transfer of patients**	Audit use of transfer form during external transfers and report findings to the IC Taskforce	Revised Transfer policy in progress.	**31/12/12**	Ashley Flores		IPCAS Group	4
	27		**Ensure waste management policies and procedures are embed and being monitored appropriately**	Report on compliance with waste management policies and procedures to be presented to IPCAS Group	Report coming to IPCAS Group 18/06/12	**18/06/12**	Dave Axten		IPCAS Group	9
	28		**Ensure that single use devices are being used appropriately**	Carry out an audit of use of single use devices	Included in rolling programme of decontamination audits	**31/05/12**	Ashley Flores		IPCAS Group	9

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Surrey and Sussex NHS Healthcare NHS Trust

Area	No.	Current level	Issue identified	Suggested action	Progress and assurance	Timeline	Executive Lead / Responsible Person	Outcome	Monitoring Process	Criterion*
	29		**Trusts use input from local patient and public experience for continuous quality improvement to minimize harm for HCAI**	1. Continued attendance at Patient's Council meetings. 2. REAL TIME monitoring of patient feedback. – Review of results	1. Infection Control attend Patient Experience Group 2. Real Time monitoring in progress	**30/11/12**	Ashley Flores	Actioned	NMPC	NICE Guidance
	30		**Trusts regularly review evidence based assessments of new technology and other innovations to minimize harm from HCAIs and antimicrobial resistance**	1. Attend IPS conference and assess new technologist innovations 2. Evaluate port-less cannulae	1. ICN attends every year 2. In progress	**31/12/12**	1. Ashley Flores 2. Jill Clarke		IPCAS team and IC Taskforce	NICE Guidance
	31		**Norovirus outbreak**	- Norovirus Action Plan. Include ED clinicians in norovirus planning meetings. - Consider Decant Ward - Consider use of colour-coded aprons for norovirus outbreaks	Norovirus planning meetings to be scheduled for September and October 2012	**31/10/12**	Ashley Flores		IPCAS Group and IC Taskforce	9

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Reduce the number of HCAI, in order to meet the Objectives for 2012-2013: **Compliance with the Code of Practice for Infection Prevention and Control & NICE Guidance**

Surrey and Sussex NHS Healthcare NHS Trust

Area	No.	Current level	Issue identified	Suggested action	Progress and assurance	Timeline	Executive Lead / Responsible Person	Outcome	Monitoring Process	Criterion*
	32		**No assurance framework that documents that equipment and the environment is suitable for the purpose, kept clean and maintained in good physical condition**	Develop an assurance framework or policy that documents how the Trust monitors compliance with Criterion 2 and current level of compliance		**30/08/12**	Ian Mackenzie/ Karen Knox/ Ashley Flores		Decontamination Group	2

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Reduce the number of HCAI, in order to meet the Objectives for 2012-2013: **Further SHA site visit recommendations**

Surrey and Sussex NHS Healthcare NHS Trust

Area	No.	Current level	Issue identified	Suggested action	Progress and assurance	Timeline	Executive Lead / Responsible Person	Outcome	Monitoring Process	Criterion*
	33		**Priority space and storage review**	1. Carry out Trust wide space review 2. Review ward top-up service – consider move to centralized stores	Trust wide space review has been carried out	**30/06/12**	Executive Lead: Ian Mackenzie		Monitored at IPCAS Group	6
	34		**Waste storage:** A number of waste points were over laden with bags awaiting collection, presenting infection control and Health & Safety risks	Review frequency of waste collection, especially in the mornings	Review scheduled for 22/06/12	**30/06/12**	Executive Lead: Ian Mackenzie Responsible Person: Philip Stone		Monitored at IC Taskforce	9
	35		**Sharps waste management:** A sharps box was observed to be overfull, with a syringe visibly projecting out of the container	1. Audit sharps use and disposal 2. Include sharps in statutory training	- Mock CQC audit and spot checks - Daniels sharps audit arranged twice per year - Feedback to all divisions via IC Taskforce meeting	**Monthly from May 2012**	Responsible Person: Jo Thomas Responsible Person: Ashley Flores		IC Taskforce	10
	36		**Commode Storage:**	Review practice of storing clean commodes immediately adjacent to waste collection bins	Walk round has taken place with Carol Dixon, Ashley Flores and Ian Mackenzie to review practice	**30/06/12**	Responsible Person: Ian Mackenzie		IC Taskforce	11
	37		**Obstructed Fire and Emergency Exits:**	There is a need to remove all emergency exit signage from de-designated fire and emergency exit doors	Dave Axten has visited area with fire officer. Assurance required	**30/06/12**	Executive Lead: Ian Mackenzie			13

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