EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS – 29 AUGUST 2014**
SUBJECT:	**EKHUFT INFECTION PREVENTION AND CONTROL ANNUAL PROGRAMME 2014-15**
REPORT FROM:	**DIRECTOR INFECTION PREVENTION AND CONTROL (INTERIM)**
PURPOSE:	**Information**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The production of an Infection Prevention and Control Annual Programme is a requirement under The Health and Social Care Act 2008**:** *Code of Practice on the prevention and control of infections and related guidance.* Produced for the Chief Executive and Trust Board, it describes the programme of work planned by the Infection Prevention and Control Team (IPCT).

SUMMARY:

The IC Annual Programme for 2014-15 is based on utilising performance management systems to ensure compliance with all of the elements of the Code of Practice and in particular to drive forward policies aimed at reducing the spread of MRSA, C. difficile, including the attainment of NHS England targets, and other healthcare associated infections within the hospital environment.

Key areas of focus for 2014/15 include:

- Root cause analysis (RCA) during 2014/15 for cases of E.coli bacteraemia occurring within 30 days of surgery
- RCA will also be undertaken for all cases of Meticillin-resistant Staphylococcus aureus occurring within 30 days of surgery, or associated with a vascular access device.
- Implementation of the HOUDINI protocol trust wide in order to improve the management of urinary catheters, and in particular, indications for insertion.
- The launch of the new "*Policy for the Detection, Management and Control of Carbapenemase-Producing Organisms (CPOs), including Carbapenemase-Producing Enterobacteriacea (CPEs)*".
- A complete review of the Infection Prevention and Control Manual
- Implementation of Phase 2 of the Sharps "Safety Needles" project with regard to drawing-up needles, insulin syringes and sub-cutaneous and intra-muscular needles
- Implementation of hydrogen peroxide vapour for the high-level decontamination of isolation side rooms (plus bays and wards where appropriate) following a six month pilot, commencing in July/August 2014. Whilst the pilot is being implemented and evaluated, the Business Case for full implementation will be completed and submitted
- Development of a business case for additional Infection Prevention and Control specialist nursing resource, including additional administration/clerical support.

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IMPACT ON TRUST'S STRATEGIC OBJECTIVES

Assurance against regulatory compliance.

FINANCIAL IMPLICATIONS:

Funding for additional Infection Prevention and Control Specialist Nursing resource, plus additional administration / clerical support.

LEGAL IMPLICATIONS:

Compliance with the Health and Social Care Act 2008, *Code of Practice on the prevention of healthcare associated infections and related guidance*

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

N/A

BOARD ACTION REQUIRED:

(a) to note the report
(b) to discuss and determine actions as appropriate

CONSEQUENCES OF NOT TAKING ACTION:

N/A

East Kent Hospitals University NHS
NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL PROGRAMME

APRIL 2014 – MARCH 2015

Version:	1
Ratified by:	
Date ratified:	
Name of originator/author:	Sue Roberts, Director Infection Prevention and Control (Interim) / Debbie Weston, Deputy Lead Nurse
Director responsible for implementation:	
Date issued:	

Putting patients first

CONTENTS

1. INTRODUCTION

The production of an Infection Prevention and Control Annual Programme is a requirement under The Health and Social Care Act 2008**:** *Code of Practice on the prevention and control of infections and related guidance.* Produced for the Chief Executive and Trust Board, it describes the programme of work planned by the Infection Prevention and Control Team (IPCT). Divisional Infection Prevention and Control Key Performance Indicator Targets have been developed for 2014/15.

According to the Code of Practice, the Infection Control Annual Programme should:

- set objectives that meet the needs of the organisation and ensure the safety of service users;
- identify priorities for action;
- provide evidence that relevant policies have been implemented to reduce infections; and
- report progress against the objectives of the programme in the Director Infection Prevention and Control's (DIPC's) Annual Report.

This year's programme is designed to specifically focus on attaining compliance with the standards identified in the Code of Practice and maintaining compliance with NHS Litigation Authority Risk Management Standards level 3, appropriate to Infection Prevention and Control. It also describes the actions required to support the achievement of NHS England, and Clinical Commissioning Group (CCG) MRSA bacteraemia and Clostridium difficile targets, along with new initiatives such as the implementation of the HOUDINI protocol (see Section 13) and a six-month trial of Deprox (hydrogen peroxide vapour) (see Section 6).

1.1 MRSA bacteraemia target 2014-15

The NHS England target of "no avoidable bacteraemias" continues, with cases provisionally assigned for investigation to either East Kent Hospitals University Foundation Trust (EKHUFT) or one of the four Clinical Commissioning Groups (CCGs) by Public Health England, based on information reported via the PHE HCAI PIR data capture system (DCS) regarding the timing of blood culture collection in relation to the date of admission. Final assignment is determined at the PIR, which has to be undertaken within 14 working days of notification from the HCAI PIR Team of the provisional assignment, and this is recorded with PHE via completion of the patient survey on the DCS. Under new NHS England guidance for 2014/15, the bacteraemia can be assigned to a "third party" through the arbitration process lead by the Regional Director of Nursing or the Regional Medical Director (or their designated nominees). Third party assignment provides an acknowledgement of the complex nature of MRSA bloodstream infections being reported which previously may have been allocated by default to providers or CCGs who were not involved in the patients care, or who can provide a strong case following the PIR that there were no possible failings in patient care.

1.2 Clostridium difficile infection target 2014-15

The EKHUFT C. difficile target for 2014-15 is 47 cases (2013/14 target of 29 cases; outturn of 49 cases). New Guidance from NHS England for 2014/15 requires organisations to determine at RCA whether there has been a "lapse in the quality of care". A lapse in care would be indicated by evidence that policies and procedures consistent with national guidance and standards were not followed. Each case of C. difficile infection occurring post-72 hours will be assessed by the relevant CCG in order to determine whether or not it is associated with a lapse in care, according to agreed Kent-wide definitions. The CCG will exercise discretion in deciding whether any individual case of C. difficile infection affecting a patient under its Contract should count towards the aggregate number of cases on the basis of which contractual sanctions are calculated. For 2014/15, the contractual sanction that can be applied to each C. difficile case in excess of an acute organisation's objective will be reduced by 80%, from £50,000 to £10,000. Where cases are not linked to with identifiable lapses in care, it is proposed that those cases are not considered when contractual sanctions are being calculated. This decision is for the CCG to make at its entire discretion, and is not subject to challenge through contract resolution procedures.

Note: MRSA bacteraemia and C. difficile cases falling under NHS Thanet and South Kent CCGs will be discussed at the NHS Thanet/South Kent Coast HCAI Assurance Panel.

1.3 Aim of the Annual Programme

The IC Annual Programme for 2014-15 is based on utilising performance management systems to ensure compliance with all of the elements of the Code of Practice and in particular to drive forward policies aimed at reducing the spread of MRSA, C. difficile and other healthcare associated infections within the hospital environment.

1.4 Care Quality Commission

According to the Code of Practice good infection prevention and control practice is essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. Good management and organisational processes are crucial to ensure that high standards of infection prevention and control are developed and maintained.

The Health and Social Care Act 2008 established the Care Quality Commission (CQC) and sets out the overall framework for the regulation of health and social care activities. Regulations made under this Act describe the health and social care activities that may only be carried out by providers that are registered with the CQC and set out the registration requirements that those providers must meet to become and remain registered. The CQC has enforcement powers that it may use if registered providers do not comply with the law.

The main purposes of the Code of Practice on the prevention and control of infections (The Code) are to:

- make the registration requirement for cleanliness and infection control clear to all registered providers so that they understand what they need to do to comply;
- provide guidance for the CQC's staff to make judgement about compliance with the requirement for cleanliness and infection control;
- provide information for people who use the services of a registered provider;
- provide information for the general public.

The law states that the Code must be taken into account by the CQC when it makes decisions about registration against the cleanliness and infection control requirement. The regulations also say that providers must have regard to the Code when deciding how they will comply with registration requirements. So, by following the Code, registered providers will be able to show that they meet the requirement set out in the regulations. However, the Code is not mandatory so registered providers do not by law have to comply with the Code. A registered provider may be able to demonstrate that it meets the regulations in a different way (equivalent or better) from that described in this document. The Code aims to exemplify what providers need to do in order to comply with the regulations.

The table below is the Code of Practice and sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirement for cleanliness and infection control.

Compliance 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 post 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.

2. THE INFECTION PREVENTION AND CONTROL TEAM (IPCT)

The IPCT are the medical and nursing infection control experts responsible for carrying out the work described in the Infection Control Annual Programme.

EKHUFT IPCT currently consists of 5.0 Consultant Microbiologists (of whom 3 hold the following roles respectively: Clinical Director (Laboratory Medicine); Head of Service/Chair of the Antimicrobial Stewardship Committee, and interim Infection Control Doctor); seven Infection Prevention and Control Clinical Nurse Specialists (one of whom is the Interim Director, Infection Prevention and Control); and two Infection Control Sisters (of whom one is in a designated training post). Secretarial/administration support is provided by 1 x full time band 3 Secretary at the QEQM, and 1 x part time (24 hours/week) band 2 Data Administration Clerk at WHH, with an additional 7 hours support provided by the Pathology Secretary at K&C.

The IPCT is further supported by 3 wte Antimicrobial Pharmacists.

2.1. Infection Prevention and Control Manager (IPCM)/VitalPAC

The Infection Prevention and Control Clinical Nurse Specialists will continue to use the IPC Manager component of VitalPAC for the day to day tracking and management of colonised/infected patients. Use of the "Checklist" function by the Specialist Nurses as part of the documentation process, along with recording the patient isolation and MRSA suppression protocol, will be embedded during 2014.

Patients with diarrhoea will be reviewed and assessed daily via the "D&V List". Where patients with diarrhoea have been assessed either by the Nursing staff, or by the IP&C Clinical Nurse Specialist as "Pathway B" (Diarrhoea Assessment Tool), the patient must be reviewed again on the next working day to ensure that s/he is isolated, that the green "Record of Stool Specimen Collection" is present in the notes and completed, indicating that the specimen has been obtained, and a "case" opened on IPC Manager. The case will be closed if the stool specimen is negative for C. difficile/Norovirus.

From the 1st October 2014 – 31st May 2015, patients with "vomiting" (on its own) will be assessed for Norovirus (outside of this period, there is no requirement to assess patients with "vomiting" unless it is known that there is Norovirus activity within the Trust/community).

3. THE INFECTION CONTROL COMMITTEE

The EKHUFT Infection Control Committee (ICC) is a multidisciplinary Trust committee which includes Divisional Infection Control Leads and external representation from the Kent, Surrey and Sussex Public Health Team (Public Health England) and Quality Leads from Canterbury, Ashford, South Kent Coast and Thanet Clinical Commissioning Groups. The ICC oversees the activity of the IPCT and supervises the implementation of the Infection Control Annual Programme. The membership and Terms of Reference of the ICC were revised in 2011 to accommodate the Divisional management arrangements. The ICC will continue to meet bi-monthly during 2014/15. Trust wide Ward Managers and Matrons will be invited to attend the meetings, which will be held via video-conferencing.

4. BACKGROUND TO THE DEVELOPMENT OF THE ANNUAL PROGRAMME FOR 2014/15

Divisional ownership and accountability

Performance management in promoting Divisional ownership and accountability for infection prevention and control will continue to be a key focus during 2014-15. Divisional Infection Prevention and Control Key Performance Indicator (KPI) Targets have been further developed for 2014/15 and the primary focus of the KPI Targets continues to be on the full implementation of key infection prevention and control policies related to the management of C. difficile, MRSA and invasive devices, as well as achieving full compliance with the requirements of the Code of Practice.

5. MRSA BACTERAEMIA

There were eight cases of MRSA bacteraemia attributed to EKHUFT in 2013-14 (two cases belonged to the t008 "Lyon" clone).

For 2014/15:

- All cases of MRSA bacteraemia will continue to be reported internally via Datix.

The IPCT will continue to lead on all Post Infection Reviews (PIRs) (to be held within 14 working days of receipt of confirmation of the provisional assignment from PHE) regardless of whether or not the case has been provisionally assigned to the Trust.

NB: Following the PIR, the organisation to whom the bacteraemia is *provisionally* assigned is responsible for completing the PIR survey on the Data Capture System, *regardless of the final assignment*. If the *final* assignment is different to the *provisiona*l assignment, the person completing the Survey on behalf of that organisation will be required to "disagree" with the final assignment. This will prompt a new Survey being sent to the other organisation (i.e. – where a case is provisionally assigned to the CCG and finally assigned at PIR to EKHUFT, the CCG Quality Lead/Infection Control Specialist Nurse Advisor will complete the Survey, and disagree with the case being finally assigned to the CCG. PHE will then issue a new Survey to the IPCT).

- Greater engagement will be required from the Divisions during 2014/15 with regard to completion of the preliminary investigation as part of the PIR process; the IP&C Clinical Nurse Specialists will undertake this in conjunction with the Ward Manager/Divisional Matron.

- The Ward Manager will be required to present the case at the PIR meeting, which will be chaired by the site-based IP&C Clinical Nurse Specialist.

- The PIR Meeting will be held within 14 working days of confirmation of the bacteraemia and provisional assignment from PHE.

  Attendance will be mandatory for the Ward Manager or Ward Sister/Charge Nurse, Divisional Matron(s), Consultant Medical Microbiologist, the patient's Medical Consultant/Registrar and CQC Head of Quality/Infection Control Specialist Nurse Advisor. If the Antimicrobial Pharmacist cannot attend the meeting, antibiotics that were prescribed for the patient will be reviewed by the Consultant Medical Microbiologist prior to the PIR.

- The IP&C Clinical Nurse Specialists, in conjunction with the Senior Divisional Matron and the Head of Nursing, will monitor compliance with completion of the PIR action plan, ensuring that all actions are signed off as "complete" within a specified time-frame. At the end of each Quarter, the IPCT will review all PIRs undertaken for completion of actions overall.

- The Ward Manager and Divisional Matron will be required to present the PIR at the ICC. The Divisional Head of Nursing will be required to ensure that learning from PIRs is shared across the Division and that the PIR is reported via the Divisional governance framework.

Key actions arising from the MRSA bacteraemia Recovery Plan 2013/14 remain continued areas of focus for 2014/15:

- Review of individual MRSA colonised inpatients by the IP&C Clinical Nurse Specialists in conjunction with ward nursing and medical staff, with documentation recorded on IPC Manager.

- Declaration of an "MRSA Period of Increased Incidence" (PII) where there are 2 or more cases of MRSA acquisition on a ward with a calendar month (patients with no previous history of MRSA) - review meeting to be held in conjunction with the Ward Manager and the Divisional Matron. These Meetings will be reported in the Infection Prevention and Control Monthly Report to the Divisions and at the ICC.

A review of the eight bacteraemias that occurred during 2013/14 has highlighted the following non-compliances as common themes, and the IPCT will work with the Divisions to ensure that these non-compliances are addressed:

- Medical/nursing staff not checking the Patient Administration System for the presence of the MRSA "tag", or looking in the wrong place (i.e. checking the "Special Register" rather than the banner bar);

- MRSA Patient Management Plan not commenced promptly/not completed daily;

- Delays in commencing decolonisation protocol;

- Sites missed on screening;

- Peripheral cannula and urinary catheter management not recorded on VitalPAC;

- Obtaining catheter-specimens of urine in order to diagnose urinary tract infection.

Implementation of the VitalPAC MRSA module during 2014 will enable "real-time" monitoring of compliance with screening and commencing decolonisation protocol. Compliance with the management of invasive devices will be formally reported via the VitalPAC Indwelling Devices Report.

The existing programme of actions for individual cases of MRSA colonisations/bacteraemias that are carried out by the IPCT and described in the current Trust Policy for the Management and Control of Meticillin-resistant Staphylococcus aureus (MRSA) will continue. The Policy will be revised in 2014.

5.1 Surveillance during 2014-15

Mandatory surveillance of *Staphylococcus aureus* including *Meticillin Resistant Staphylococcus aureus* (MRSA) bacteraemia will continue. MRSA bacteraemia epidemiological data will be reported on a monthly basis to all wards/departments as well as to the Executive Team, CCGs, Divisional Infection Control Leads, Matrons, Ward/Department Managers, Clinical Service Managers, Consultants and Junior Doctors.

MRSA isolates that are considered to be hospital acquired will continue to be reported on a monthly basis using a similar reporting system, which will identify any wards requiring additional support and/or intervention. This includes surveillance of Mupirocin (MupR) MRSA (t008 "Lyon" clone),

Root Cause Analysis for cases of Meticillin-sensitive Staphylococcus aureus (MSSA) bacteraemia will be undertaken by the IPCT, in conjunction with the Divisions for MSSA bacteraemia occurring within 30 days of surgery, or associated with a vascular access device.

Action plans will be developed and compliance monitored by the IPCT.

The number of cases requiring RCA, and the root causes of the bacteraemia will be reported in the Infection Prevention and Control Monthly Report and also at the ICC. The Divisions will be required to report RCA outcomes via their Governance frameworks, ensuring that learning is shared across the Division, and implement any actions arising from the RCA within a specified timeframe.

6. CLOSTRIDIUM DIFFICILE

6.1 Background

The EKHUFT C. difficile target for 2014/15 is 47 cases. Root Cause Analysis for all cases of hospital acquired C. difficile infection will continue. Cases will continue to be deemed as avoidable/unavoidable and compliant/non-compliant; the justification for these decisions will be clearly recorded. In addition to this, new guidance on the C. difficile objectives from NHS England states that a key focus of Root Cause Analysis (RCA) will be determining whether there have been any "lapses in the quality of care". At the time of writing, there has been Kent-wide agreement regarding "lapses of care" definitions in order to ensure a standardised approach. The IPCT will make an interim decision at the RCA as to whether or not there is likely to have been a "lapse of care". The final decision will be made by the CCG.

Key non-compliances arising from RCA's undertaken during 2013/14 were identified as follows, and the IPCT will work with the Divisions in order to address them:

- Specimen collection delayed/missed opportunities/specimen not obtained as mixed with urine/ "Record of Stool Specimen Collection" label not used: there will be a continued emphasis by the IPCT on the early submission of stool specimens on patients admitted with diarrhoea, who develop diarrhoea within 72 hours of admission, or who have been assessed as fitting the criteria for Pathway B of the Diarrhoea Assessment Tool, as well as the use of the "Record of Stool Specimen Collection" label.

- Staff not aware of, or do not fully understand, the Diarrhoea Assessment Tool/patients not assessed appropriately: education for staff regarding the Diarrhoea Assessment Tool will be ongoing.

- Delays in isolating patients who have been assessed as Pathway B or who have a positive GDH antigen/toxin result: the IPCT will work with the nursing staff and Bed Managers to ensure that patients are isolated appropriately and delays in isolation escalated appropriately.

In addition to the above, the IPCT will ensure the following actions are undertaken for each patient who is GDH antigen or toxin positive:

- The IP&C Specialist Nurses will meet with each Ward Manager and Infection Control Link Practitioner in order to ensure that key messages regarding the use of the Diarrhoea Assessment Tool, appropriate stool specimen collection, isolation and other aspects of C. difficile prevention

and management are understood, and that there is a strategy for ensuring that these are known by all staff and embedded in practice.

- Full implementation of the C. difficile patient management plan for patients who are diagnosed with C. difficile (and those suspected of relapsing, awaiting laboratory confirmation). **NB:** The "Discharge Summary" on the back of the Management Plan must be completed by the ward/staff/ Medical Team and sent to the patients GP on discharge.

- "Stamping" of the Antibiotic Prescription Drug and the continuation pages in the patients notes with the C. difficile ink stamp.

- Placement of the C. difficile "Alert" label in the medical notes of patients.

- In-patients will be provided with a "Clostridium difficile Important Information Card".

  NB: "Community" patients whose C. difficile infection is confirmed via a specimen sent from the GP surgery and who are not in-patients, will be sent a "Clostridium difficile Important Information Card" and an accompanying letter. A copy of the letter to the patient will also be sent to the GP, along with a covering letter.

- Promote the use of Flexiseal Bowel Management Systems for patients who are bed bound and who have liquid stools.

- Use of Hydrex for hand washing (staff and visitors).

- Completion of a Datix Incident Report for all > 72 hour C. difficile toxin positive cases. The Divisional Matron will be the nominated Investigator, supported by the IP&C Clinical Nurse Specialist.

- Once a month, the IPCT will identify whether any patients with known C. difficile infection (pre and post 72 hour cases) have died, and review the death certificate. For post-72 hour cases, in the event that C. difficile is recorded on part 1a of the Death Certificate, the IPCT will report it is a Serious Untoward Incident via STEIS. For pre-72 hour cases, the IPCT will inform the appropriate CCG Chief Nurse and Quality Lead, who will report the death as an SUI within their organisation. A Root Cause Analysis meeting may be held, attended by the IPCT, if the patient was an inpatient within EKHUFT.

- A Period of Increased Incidence will be declared in the following circumstances:

  - 2 or more cases of C. difficile infection occurring > 72 hours post admission on a ward within 28 days. Where initial ribotyping identifies the same strain, a Serious Untoward Incident (SUI) will be reported pending enhanced "finger printing". Should this then identify that the isolates are indistinguishable, the IPCT will conclude that cross-infection has occurred, and the incident will be reported as an Outbreak as per DH guidelines (DH, 2008).
  - 2 or more cases of C. difficile infection in patients with the same Consultant;
  - where there are 2 or more cases of GDH antigen acquisition occurring > 72 hours post admission within 28 days;
  - where there is a "burden" of C. difficile infection and GDH carriage at any time (these may be pre or post 72 hour cases), which in itself increases the risk of a C. difficile cluster/ outbreak.

  Where a PII has been declared for 2 or more cases of C. difficile infection occurring > 72 hours post admission within 28 days, the Ward Manager and the Divisional Medical Lead, will be required to present the PII at the next Infection Control Committee meeting.

- Ribotyping of C. difficile toxin positive isolates will continue to be undertaken for >72 hour cases to distinguish between sporadic cases and outbreaks.

- Audit of antibiotic prescribing in wards where there has been a PII.
- Infection control environmental audits revisited by wards experiencing 2 or more cases in a 28 day period plus enhanced support from the IPCT.
- Regular review of antibiotic policy as well as prescribing compliance according to Trust policy.
- The implementation of hydrogen peroxide vapour for the high-level decontamination of isolation side rooms (plus bays and wards where appropriate) following a six month pilot, commencing in July/August 2014. Whilst the pilot is being implemented and evaluated, the Business Case for full implementation will be completed and submitted.

The completion of actions arising from the RCA will be monitored and signed off by the site-based IC Specialist Nurses, who will maintain a site-based rolling action plan.

Divisions will be required to ensure that the RCA is reported to their Divisional Governance Meeting and that lessons for learning are taken forwards and acted upon. The Divisions will need to feedback on this at the bi-monthly ICC meetings.

The programme of actions for individual cases of C. difficile and carried out by the IPCT as described in the revised Trust Policy for Prevention, Control and Management of C. difficile Infection will continue.

7. E. COLI BLOOD STREAM SURVEILLANCE

Mandatory surveillance of E. coli blood stream infections has been a Department of Health requirement from June 2011 and continues to be undertaken within EKHUFT by the IPCT. As of April 2014, RCAs will be undertaken for all cases of E. coli bacteria associated with surgery within the last 30 days. This will be led by the IP&C Clinical Nurse Specialists with support from the Ward Manager and Divisional Matron, and action plans implemented as appropriate. Information relating to these RCAs will be reported within the Infection Prevention and Control Monthly Report issued to the Divisions and at the ICC. The Divisions will be required to report RCA outcomes via their Governance frameworks.

8. SURVEILLANCE INTERNAL REPORTING

Mandatory surveillance of C. difficile will continue and C. difficile epidemiological data will continue to be reported on a monthly basis to the Executive Team, all wards/departments, Matrons, Ward/Department Managers, Consultants and Junior Doctors.

Individual Divisions in conjunction with the IPCT will be responsible for undertaking a Root Cause Analysis on cases of C. difficile positive >72hrs post admission. Meetings will also be held where a period of increased incidence is identified (PII) according to DH guidance (two or more new cases occurring >72hrs post admission, not due to a relapse in a 28 day period on a ward DH, 2008) (KPI target). A period of enhanced support from the IPCT/action planning will be implemented for wards experiencing PIIs.

The number of patients who are GDH antigen positive (confirmed > 72 hours post admission) will continue to be collated per ward each month and feedback to the Divisions. Two or more cases on a ward within a 28 day period will be investigated using the “GDH Checklist”, a meeting held with the Ward Manager and Divisional Matron, and “GDH antigen PII” declared.

An outbreak of C. difficile infection will be called if 2 or more cases are caused by the same strain, related in time and place, over a defined period that is based on the date of onset of the first case (DH, 2008).

Outbreaks of C. difficile will be reported as Serious Untoward Incidents (SUI).

The DIPC will compile a register of all deaths occurring within 30 days of a C. difficile diagnosis and report the mortality rate to the Patient Safety Board. Any rise in mortality in comparison with the baseline will

require investigation to rule out acquisition of a hypervirulent strain (e.g. O27) and ensure that appropriate multi-disciplinary management has taken place.

8.1 Antibiotic management

The following actions with regard to Antimicrobial Stewardship will be undertaken during 2014 following appointment of a new Lead Antimicrobial Pharmacist:

- The Trust Antimicrobial Guidelines and Pocket Guide are to be reviewed and updated
- Infection Control Doctor / Antimicrobial Pharmacist led education sessions for medical staff
- Daily antimicrobial stewardship ward rounds (review of all patients on restricted antibiotics)
- A Trust wide point prevalence audit of antibiotic usage by the antimicrobial pharmacist team and the ward pharmacists in September 2014. Audit results will be sent to the specialty leads for actions
- Monthly audit reports of antibiotic usage by each division will be extracted from the Pharmacy databases each month and sent to the monthly Divisonal Governance Board meeting. The Lead Antimicrobial Pharmacist will attend these meetings.
- The DH "START SMART and THEN FOCUS" initiative will be launched in September 2014, along with changes to the drug chart, to encourage review of antibiotics at 48 hours.
- Participation in European Antibiotic Awareness Day (18th November)
- Development of an Antibiotic Guidelines Smartphone App in conjunction with IT.

9. SURVEILLANCE OF ALERT ORGANISMS

Surveillance of alert organisms will continue and include the following:

Meticillin Resistant *Staphylococcus aureus*
Sensitive *Staphylococcus aureus*
E. coli
Streptococcus pyogenes
Mycobacterium tuberculosis
Resistant Acinetobacter
Glycopeptide Resistant Enterococcus (GRE)
Extended spectrum beta lactamase producing Klebsiellae (ESBL'S)
*Carbapenem-producing organisms

*** NB**: Work will be undertaken during autumn 2014 with the launch of the new "Policy for the Detection, Management and Control of Carbapenemase-Producing Organisms (CPOs), including Carbapenemase-Producing Enterobacteriacea (CPEs)". All elective and emergency admissions will need to be risk-assessed on admission for CPO carriage / infection, and rectal screens taken if they are deemed to be at risk. CPO / CPE positive patients will need to be isolated in a single room with strict standard precautions for the duration of their hospital admission (including on any future re-admissions), and may require 1:1 nursing.

10. NATIONAL SURGICAL SITE SURVEILLANCE SCHEME

Surveillance of surgical site infection following orthopaedic surgery has been included in the mandatory healthcare-associated infection surveillance system in England since April 2004; although EKHUFT has been participating in this scheme since 1998. The National Surveillance Scheme enables hospitals in England to undertake surveillance of healthcare associated infection, compare their results and national aggregated data, and use the information to improve patient outcomes.

All NHS Trusts where orthopaedic surgical procedures are performed are expected to carry out a minimum of three months surveillance in at least one of the four orthopaedic categories.

- Total hip replacements

- Knee replacements
- Hip hemiarthroplasties

EKHUFT complete surveillance in the 3 categories.

Post discharge surveillance is also undertaken for these categories at 30 days post–op.

Systems will continue to be strengthened between the Trauma and Orthopaedic Division, particularly at WHH, and the IPCT to ensure that the surveillance results are used to maximum benefit with regard to service improvement as appropriate. The Bone and Joint Group, established during 2013, will continue to meet during 214/15, which will be chaired by one of the Consultant Microbiologists. The IPCT will receive quarterly reports and meet regularly with the Division to discuss outcomes and actions.

11. POLICIES AND PROCEDURES FOR DEVELOPMENT/REVIEW

Review of the Infection Control Manual (Policies to be reviewed during 2014)	
Section 1	Introduction to the Infection Prevention and Control Manual
Section 1A	Assurance Framework Policy for the Management of Risks associated with Healthcare Associated Infections
Section 2	Hand Hygiene Policy
Section 2A	Isolation Policy for Patients with Infectious Diseases
Section 2B	Policy for the Management and Control of Meticillin-Resistant Staphylococcus Aureus (MRSA)
Section 2C	Policy for the Prevention, Management and Control of Suspected or Confirmed Respiratory Tuberculosis, including Multi-Drug Resistant Tuberculosis and Non-Respiratory Tuberculosis
Section 2D	Policy for the Management and Control of Viral Haemorrhagic Fever (VHF)
Section 2E	Policy for the Control of Glycopeptide Resistant Enterococci (GRE)
Section 2F	Policy for the Prevention / Management of Varicella Zoster Virus (VZV) – Chickenpox and Shingles
Section 2H	Policy for the Infection Control / Antibiotic Management of Meningococcal Meningitis / Septicaemia
Section 2I	Policy for the Control of Infestations – Scabies, Head Lice, Pubic Lice and Body Lice
Section 3	Policy for the Management of Outbreaks of Viral Gastroenteritis due to Norovirus
Section 4B	Policy for the Management of Potential Blood Borne Virus Exposures in the Community
Section 5	Disinfection Policy
Section 5A	Policy for the Decontamination of Reusable Medical Devices Outside of the Sterile Services Department
Section 6	Policy for the Control of Outbreaks of Infection within East Kent Hospitals University NHS Foundation Trust
Section 7	Ward Kitchens and Patient Food Handling Policy
Section 8	Policy for the Management of Mattresses (including Dynamic Mattress Systems), Pillows and Zipped Seat Cushions
Section 9	Policy for the Care of Asplenic Patients
Section 11	Guidelines for the Investigation, Control and Prevention of the Spread of Group A Streptococcal Infection in Acute Settings
Section 13	Policy for the Admission, Movement / Transfer and Discharge of Patients with an Infection/ Infectious Disease
Section 14	Policy for Aseptic Non-touch Technique (ANTT)
Section 15	Guideline for the Prevention and Management of Surgical Site Infection Prevention and Control Team
Section 17	Policy for the Management of Ultra Clean Vent

Section 18	Environmental Policies and Infection Prevention and Control
Section 19	Guidelines for the Management and Control of PVL-Associated Staphylococcus Aureus Infection (PVL-SA)
Section 20	Surgical Hand Antisepsis, Gowning and Gloving

Support with implementation of revised/new policies will be provided by the IPCT where indicated**.**

11.1 NHS Litigation Authority Risk Management Standards – Level 3

In order to maintain compliance with the infection control related NHSLA risk management standards for Level 3, monitoring reports will be presented to the ICC annually by the Director, Infection Prevention and Control. Reports will be included in the Annual Infection Prevention and Control Report.

12. SHARPS "SAFETY NEEDLES"

Phase 2 of the Sharps "Safety Needles" project will be implemented during August with regard to drawing-up needles, insulin syringes and sub-cutaneous and intra-muscular needles, in order to comply with ***Sharps Instruments in Healthcare Regulations****, Guidance for employers and employees (Health and Safety Executive, May 2013)*. Phase 1 covered the implementation of safety peripheral cannulae and blood collection systems.

13. AUDIT

The Code of Practice (2008) requires that there is a programme of audit to ensure that key policies are being implemented appropriately.

The IPCT will undertake or commission the following audit projects (with appropriate support from the Trust Clinical Audit Department and external agencies):

TITLE AND FREQUENCY	LEAD	AREA AUDIT APPLIES TO
Management of sharps (annual). Wards/departments will be required to submit an action plan to the IPCT addressing areas of non-compliance with best practice	IPCT	Trust wide (January/February 2015)
Ward/Department Infection Control Audits of Environmental and Clinical Practice Standards (Wards will be audited annually; departments will be audited every 18 months). Wards/ Departments that achieve > 5 non-compliances in one or both standards are entered onto an Infection Control Risk Register. A letter is sent to the Divisional Head of Nursing. Audits will be reported at the ICC. Ward/ Department Managers will be required to submit an action plan addressing non-compliance – this must be monitored by the Division	IP&C Clinical Nurse Specialists/Sisters in conjunction with Ward/ Department Managers or Link Practitioner	Trust wide in all clinical departments
Commode audit (condition, cleanliness) (6 monthly)	IP&C Clinical Nurse Specialists in conjunction with Gama Healthcare	Trust wide every six months (February and August)
Mattress/zipped item check (Monthly)	Initiated by the IP&C Clinical Nurse Specialists and undertaken by the	Trust wide

	Ward Managers/Divisional Matrons and their nursing teams	
Environmental audits (assessment of compliance with the Code of Practice) Monthly	Divisional Heads of Nursing/Matrons	All Wards and Clinical Departments
Continuous real time compliance monitoring will be carried out on the following:		
Monthly – MRSA screening compliance within 24hrs of admission/pre-assessment, as per Trust policy	Divisional Infection Control Lead	Trust wide – as appropriate. This will be commenced following the implementation of the MRSA Module on VitalPAC during 2014
Monthly – rescreening compliance following MRSA decolonisation as per Trust policy	Divisional Infection Control Lead	Trust wide – as appropriate. This will be commenced following the implementation of the MRSA Module on VitalPAC during 2014
Monthly – compliance with MRSA isolation/cohorting as per trust policy	Divisional Infection Control Lead	Trust wide – as appropriate. This will be commenced following the implementation of the MRSA Module on VitalPAC during 2014
Monthly – compliance with cannulae being removed at 96hrs	Divisional Infection Control Lead	Trust wide via VitalPAC
Weekly – hand hygiene compliance	Divisional Infection Control Lead	Trust wide via the Meridian system
Weekly commode cleanliness audits (relevant wards/departments)	Divisional Infection Control Lead	Trust wide via the Meridian system
Trust wide implementation of the High Impact Interventions (DH 2005) appropriate to specialty* (included in KPIs) • Peripheral intravenous cannula (insertion and continuing care) • Central Venous Catheter insertion and continuing care • Temporary dialysis catheter Insertion and continuing care • Urinary catheter insertion and continuing care. The insertion and management/ ongoing care of these devices will be recorded and monitored through VitalPAC	Divisional Infection Control Lead	Trust wide – as appropriate (VitalPAC Indwelling Device Report)
Compliance with antimicrobial prophylaxis prescribing in surgery	Divisional Infection Control Lead	Surgical Divisions – Trust wide
Compliance with antimicrobial prescribing for acute infections in	Divisional Infection Control Lead	All Divisions – Trust wide 1. Quarterly point prevalence

medicine		study ULTC 2. CAP time to 1st dose 3. In addition to formal audit of prescribing, antibiotic stewardship rounds will be conducted at least twice weekly by microbiologists and antimicrobial pharmacists on each main hospital site. 4. Pharmacy will prepare daily lists of restricted antibiotic scripts for review on stewardship rounds.

14. IMPLEMENTATION OF THE HOUDINI PROTOCOL

Work will be undertaken during 2014 to reduce the incidence of urinary catheters within EKHUFT, and this will involve the implementation of the HOUDINI Protocol, an acronym to help staff remember the appropriate indications for catheterisation and to remind them to make the catheter "disappear" where the indications for catheter insertion have not been met.

- A trust wide baseline audit of urinary catheter use will be undertaken on a given day across the three sites to identify reasons for insertion, compliance with policy and delay in removal when no longer clinically indicated, including recording on VitalPAC.

- A pilot study will be undertaken on a medical ward (St Margarets ward QEQMH) to enable the development and refinement of appropriate tools to ensure they are 'fit for purpose' e.g. Urinary catheter pathway including HOUDINI protocol, protocol and competency assessment tool for the use of a bladder scanner and standardised protocol for trial without catheter (TWOC).

- The IP&C Clinical Nurse Specialists will work in collaboration with the Community IPCT (Kent Community Health Trust) to introduce the robust use within EKHUFT of the "Catheter Passport" used in the Community.

- Following the completion of the pilot on St Margarets ward the HOUDINI protocol will be implemented Trust wide in the UCLTCs Division and Specialist Services Division. Once completed, the same approach will be repeated in the Surgical Services Division.

- During quarter three, following full implementation of HOUDINI, a repeat audit will be completed to compare practice pre and post HOUDINI implementation and quantify improvements. Urinary catheter care bundle data will continue to be captured using VitalPAC and will be used to inform outcomes by exploring data recorded on catheter days.

It is hoped that the successful outcome of this project will influence practice nationally, as few Trusts have fully implemented HOUDINI, to date.

15. EDUCATION

Introduction

The Code of Practice requires:

> 'that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with providing care, receive suitable and sufficient information on, and training and supervision in, the measures required to prevent and control the risks of infection'.

This need is met through provision of a mandatory e-learning package based on Department of Health evidence based infection control guidelines, completed biennially.

Soft Facilities Management contract staff and Estates staff are also required to undertake induction and annual mandatory training including a competency assessment (Divisional KPI). This is currently provided by the IP&C Clinical Nurse Specialists on each main hospital site but will be delivered by DVD during the latter part of 2014.

Training sessions planned for 2014-2015 by the IPCT include:

- Participation in the "Clinical Awareness" Programme as part of Corporate Induction for new staff.
- All junior doctors receive a short induction session provided by the IPCT. This includes a presentation and handouts on infection prevention and control practices including the insertion of peripheral cannulae and other invasive devices as well as education on hand hygiene and blood culture collection (completion of Blood Culture Collection e-learning and competency assessment).
- As part of induction, all junior doctors also undergo mandatory training and assessment of competence on the insertion of peripheral venous cannulae and phlebotomy skills including the taking of blood cultures (provided by the Vascular Access Team in conjunction with the IP&C Clinical Nurse Specialists) and hand hygiene training (emphasis on use and application of alcohol hand rub).
- Participation in the F1 Junior Doctors programme includes antibiotic prescribing and the role of the microbiology laboratory in the diagnosis of infection.
- IC Induction for medical students.
- Ad hoc sessions for Divisions/departments
- Infection Control education for newly qualified nurses – attendance at the Preceptorship Conference run by the Practice Development Nurses; presentation/quiz (approximately 1 - 2 hours).
- IC Management of the Acutely Ill Patient (as part of the in house training course).
- Education on the management of urinary catheters as part of the induction programme for Healthcare Assistants.
- Hand hygiene training for IC Link Practitioners, Trust wide.
- Infection Control annual mandatory training for all Serco/Portering/Estates staff. **NB:** This will be delivered by DVD during the latter part of 2014 and will be taken over by Serco. The IP&C Clinical Nurse Specialists will undertake 3 (1 for each site) half-day updates annually for the Domestic Supervisors, and will review the competency assessment.

The Deputy Lead Nurse Infection Prevention and Control will continue to maintain links and contacts with Canterbury Christ Church University regarding the infection prevention and control components of Student Nurse training.

16. INFECTION CONTROL LINK PRACTITIONER PROGRAMME

- Continue to develop the Link Practitioner Programme through education and support of the Link Practitioners. The Programme established at the QEQM during 2011/12 will continue; the Programme at K&C was revised during 2013/14 and will continue.
- Provide site-based quarterly education sessions/IC Link Practitioner (ICLP) meetings.

- Continue to involve Link Practitioners in the annual Infection Control audits of Environmental and Clinical Practice Standards.

- Promote/monitor hand hygiene assessments of clinical healthcare workers by Link Practitioners to ensure that all clinical health care workers have their hand hygiene competency assessed annually.

17. HAND HYGIENE CAMPAIGN

The IPCT will continue to promote effective hand hygiene:

- Include hand hygiene in all teaching sessions (induction etc).

- The IPCT will provide support, as required, to Divisions who are underperforming with regard to hand hygiene audit results.

- Provide training sessions on undertaking hand hygiene audits appropriately to relevant staff.

- Undertake annual practical hand hygiene assessments for ICLPs and issue them with a "Certificate of Competency", in order that they can undertake practical hand hygiene training for staff working within their clinical areas. Work is being undertaken in collaboration with the Information Department in order to facilitate the reporting and recording of completion of individual competency assessments.

18. LEGIONELLA MANAGEMENT/MONITORING (Controlling the risk associated with water supply and air conditioning systems)

The ICC will monitor compliance with best practice for control of Legionella as outlined in the HSE Approved Code of Practice for control of Legionella in healthcare premises (L8) and HTM 04. The ICC overview of compliance will include:

- Quarterly report on compliance with the Trust Legionella Control Policy

- Annual Review of the Legionella Risk assessments for each Hospital Site

- Review of all Estates actions in response to positive Legionella Cultures.

- Monitoring hot and cold water systems supplying high risk patients for Legionella colonisation in accordance with L8.

The Water Quality and Safety Committee was established in 2013 to improve oversight of the Legionella control programme and new DH guidelines on the control of Pseudomonas in augmented care units, and will continue to meet throughout 2014/15. This Committee includes Infection Control representation and reports to the ICC.

19. HOSPITAL HYGIENE

The IPCT will provide support/advice to hotel services/contractors as required as well as advising on day-to-day issues.

20. NEW BUILDS AND SITE DEVELOPMENT/RE-CONFIGURATION OF CLINICAL SERVICES/DECANT AND DEEP-CLEAN PROGRAMMES

The IPCT will advise on all new developments/reconfiguration projects relating to service and buildings within the Trust based on national guidelines and best practice. The IP&C Clinical Nurse Specialists will work with the Hospital and Facilities Managers on the development/implementation of site-based decant programmes to facilitate refurbishment works and deep-cleans of wards.

21. PLANNED BUSINESS CASES

- Develop a business case to fully implement a hydrogen peroxide system for the high level decontamination of ward environments following occupation of infected cases e.g. C. difficile, and other resistant organisms.
- Develop a business case for an additional specialist nursing resource, including additional administration/clerical support.

22. DAY-TO-DAY INFECTION CONTROL MANAGEMENT

A key role of the IPCT is the support of Clinical Divisions in achieving compliance with national infection prevention and control standards as well as the continued reduction of healthcare associated infection. The use of VitalPAC IPC Manager will continue to be embedded and refined during 2014/15. The day to day management of the service includes:

- Surveillance of infection and the initiation of action as appropriate according to trust policies.
- Ad hoc advice on the infection control management of patients, as appropriate.
- Day-to-day management of issues relating to Infection Control.
- 24/7 on call IP&C Clinical Nurse Specialist service.
- 24/7 on call Consultant Microbiologist service.

23. MANAGEMENT OF OUTBREAKS OF INFECTION

The IPCT will lead on the management of outbreaks of infection/contact tracing exercises where indicated (i.e. clusters/outbreaks of ESBL coliform colonisation/infection; carbapenemase-producing organisms; mupirocin-resistant MRSA; respiratory tuberculosis requiring contact tracing of staff and patient contacts). This will involve close working with the Divisional Matrons, Heads of Nursing and Medical Directors, as well as the local Public Health Team (Public Health England) and the Clinical Commissioning Groups. Such incidents will be reported as a clinical incident via Datix and will be reported at the ICC and in the Infection Prevention and Control Annual Report to the Trust Board of Directors.

24. RESPONSE TO DISEASE THREATS

The IPCT will respond to local, national and international guidance in relation to emerging disease threats such as pandemic influenza, viral haemorrhagic fever and MERS-CoV over the coming year, and work with the Emergency Departments to ensure that they are prepared.

25. NOROVIRUS OUTBREAKS

The IPCT will continue to pay particular attention to reducing the impact of Norovirus outbreaks on the service by reviewing the policy and supporting staff in the management of cases.

26. SPENCER WING (QEQMH and WHH)

The IPCT will continue to provide the infection control service to the Spencer wing, including an annual audit of compliance with Infection Control Environmental and Clinical Practice Standards (to be undertaken before the end of December 2015), and attendance at the Spencer Wing Infection Control Committee. The Spencer Wing ICLPs will attend the QEQMH and WHH ICLP Meetings.

27. BENENDEN HOSPITAL

The IPCT will continue to provide the infection control service to Benenden Hospital (SLA established in February 2012), including annual audits of compliance with Infection Control Environmental and Clinical Practice Standards (to be undertaken in June 2015) and attendance at the Benenden Infection Control Committee. The Infection Prevention and Control Link Practitioners will attend the WHH ICLP Meetings.

Sue Roberts (Interim DIPC) and Debbie Weston (Deputy Lead Nurse)

On behalf of the Infection Prevention and Control Team
August 2014