East Kent Hospitals University NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL PROGRAMME

APRIL 2017 – MARCH 2018

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Ratified by:	Infection Prevention and Control Committee
Date ratified:	
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Date issued:	

We care

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1. Introduction

This Programme has been developed on behalf of East Kent Hospitals University NHS Foundation Trust (EKHUFT) Infection Prevention and Control Committee.

The Infection Prevention and Control Programme exists to co-ordinate and monitor the work of the Infection Prevention and Control Committees and Teams in preventing and controlling infection through effective communication, education, audit, surveillance, risk assessment, quality improvement and development of policies and procedures.

The Programme addresses the national and local priorities for infection prevention and control and extends throughout healthcare, health protection and health promotion.

Operational delivery of the programme is regularly monitored and reviewed and reported through the detailed implementation plan.

The programme and associated implementation plan require all disciplines to work together to promote good infection prevention and control practice. Central to these efforts are the detailed work plans, governance systems, scrutiny and monitoring and reporting arrangements for the effective prevention and control of infection across EKHUFT.

Infection prevention and control clearly does not rest solely within the domains of our Infection Prevention and Control Committees and Teams. Everyone has infection prevention and control responsibilities. Service users who depend on EKHUFT require all of us to follow best practice as described in the EKHUFT Infection Prevention and Control Manual.

The Infection Prevention and Control Committee and the Infection Prevention and Control Team (IPCT) with support of the link practitioners will co-ordinate delivery of this extensive body of work. All those involved in delivery of healthcare are participants in this programme by actively assisting through each individual's infection prevention and control actions whether delivering or receiving care.

1.1 Aim of the Annual Programme

The IPC Annual Programme for 2017-18 is based on utilising performance management systems to improve patient safety, enhance quality of care and ensure compliance with the *Code of Practice* with particular emphasis to provide evidence based policies to reducing the risks of acquisition and spread of MRSA, *C. difficile*, antibiotic resistant organisms (i.e. CPO/GRE) and other healthcare associated infections within the healthcare environments.

1.2 Care Quality Commission

The Health and Social Care Act 2008 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.

The *Code of Practice* for the prevention and control of infections (The Code) states 10 criteria against which a registered provider's compliance is monitored and judged.

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 pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Ensure prompt identification of people who have or at risk of developing an infection, so that they receive timely and appropriate treatment and care to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities 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	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

2. The Infection Prevention and Control Team (IPCT)

The IPCT consists of medical and nursing infection prevention and control specialists responsible for monitoring and ensuring compliance with the standards and activities described within the Infection Prevention and Control Annual Programme.

EKHUFT IPCT currently consists of:

- 3.5 Consultant Microbiologists (of whom 3 hold the following roles respectively: Clinical Director (Laboratory Medicine); Head of Service/Chair of the Antimicrobial Stewardship Committee, and Infection Prevention and Control Doctor)

- The current status of the team is: ten Infection Prevention and Control personnel - one of whom is the Deputy Director of Infection Prevention and Control, two Infection Prevention and Control staff members and a Decontamination Lead.

- The proposed team structure is under review and described in the following table:

Role	**Working time**	
DIPC		
DDIPC	Monday to Friday	
IPCD	Monday to Friday – on call duties as per micro rotas	
3 x IPC Clinical Nurse Specialists	37.5 hours – working every 3rd Saturday	
3 x IPC Sisters	37.5 hours – working every 3rd Saturday	
3 x IPC assistants	37.5 hours – working every 3rd Saturday	
1 x IPCAA	Monday to Friday	
1 x IPCDA	Tuesday to Friday	
IPCLPs (infection prevention and control link practitioners)	Designated time	Ring fenced hours to allow relevant activity in their areas of employment

- Secretarial/administration support is provided by 1 x full time secretary at the QEQM, and 1 x part time (24 hours/week) Data Administration Clerk at WHH.

2.1. Infection Prevention and Control Team Activity

- The IPCT meet regularly with attendance from Microbiology, IPCD, Pharmacy, Decontamination Lead and members of the nursing teams (as deemed relevant and appropriate) attend when possible to discuss clinical issues.

The regular agenda items for meetings are:

- Clinical items:
    - MRSA
    - *C. difficile*
    - Incidents and outbreaks
    - Policy review programme
    - Audit programme
    - Central line infections
    - Hospital acquired pneumonia's
    - Surgical site infection surveillance
    - Implementation of infection prevention and control initiatives
    - AOB
- Issues discussed at the IPCT meetings may be included on the Infection Prevention and Control Committee agenda as necessary.
- The DIPC provides an update to the Board quarterly.
- The IPCT:
    - Provides specialist advice, formulates, monitors and evaluates the implementation of policies, including the Major Outbreak Policy.
    - Ensures the use and incorporation of evidence-based practice in the writing and reviewing of policies.
    - Are responsible for the daily management and advice on Infection prevention and control clinical cases and incidents.
    - They advise EKHUFT at a strategic level on service and building developments which will impact on infection prevention and control.
    - Provide education to all staff on infection prevention and control.
    - Develop and complete a programme of audit relating to infection prevention and control.
- An Infection Prevention and Control Team Annual Plan is produced by the DDIPC which includes educational, audit and surveillance activities.
- The DIPC Annual Report is circulated to all the members of the Infection Prevention and Control Committee (IPCC).
- The IPCT will identify requirements for additional resources to support and promote infection prevention and control practices.
- The IPCT Terms of Reference will be reviewed annually by the Infection Prevention and Control Team.

3. Development Process

This Annual Programme has been developed by the DDIPC, and then distributed to all Members of the Infection Prevention and Control Committee (Appendix 1).

4. Roles and Responsibilities

The Chief Executive Officer, the DIPC and the Board have the ultimate and collective responsibility for ensuring that the importance of the prevention and control of infection is engendered in all staff. They must ensure that the processes and necessary resources are available to allow for effective prevention and control of Infection.

The DIPC advises on the measures necessary for the prevention and control of Healthcare Associated Infections.

Clinical Directors and professional leads ensure that monitoring of clinical practice is relevant to the control of all HCAIs and is undertaken routinely, that results are monitored and action taken as appropriate. They must also ensure that all staff within their teams attend training, comply with infection prevention and control policies and practices, and clinical areas participate in appropriate audits as recommended by the Infection Prevention and Control Team/Committee.

Clinical staff:

- to attend annual infection prevention and control continuing education sessions;
- to comply with practice recommendations at all times.

Non clinical staff:

- to comply with standard infection prevention and control practice recommendations at all times.

Infection Prevention and Control Team:

The Infection Prevention and Control Team are responsible for producing and updating all IPC policies. They are also responsible for providing expert support and advice on infection prevention and control issues. The IPCT will ensure appropriate training and support on infection prevention and control issues are available for staff. They will also provide training to enable clinical staff to carry out relevant infection prevention and control audits in their clinical areas. Periodically the IPCT will also perform audits and/or surveys on the wards and other clinical areas. If audits, surveys or routine surveillance data identify any areas of concern, the IPCT will feed these back to the local Infection Prevention and Control Lead and other relevant staff. In the event of an outbreak, IPCT will set up an Outbreak Committee and will advise on any additional procedures which are required.

5. The Infection Prevention and Control Committee (IPCC)

The EKHUFT Infection Prevention and Control Committee (IPCC) is a multidisciplinary Trust committee which includes Divisional Infection Prevention and Control Leads and external representation from the Kent, Surrey and Sussex Public Health Team (Public Health England) and the Infection Prevention and Control Leads from Canterbury, Ashford, South Kent Coast and Thanet Clinical Commissioning Groups. The IPCC oversees the activity of the IPCT, supervises the implementation of the Infection prevention and control Annual Programme, reviews Divisional compliance with the Key Performance Indicator Targets, and holds the Divisions to account as required. Arrangements are currently being discussed to promote greater medical engagement from the Divisions. The IPCC will continue to meet bi-monthly during 2017-18, and will be chaired by the Chief Nurse.

6. Key Areas of Infection Prevention and Control Activity

The restructuring of the IPCT focus is to assist, support and advise on measures that support the Trust compliance with the *Code of Practice* (Health and Social Care Act 2008) and to enhance the quality of care offered to patients and demonstrate the reduction in the risks of acquiring HCAIs.

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 2017/18. Divisional Infection Prevention and Control Key Performance Indicator (KPI) primary focus continues to be the management of *C. difficile*, MRSA and invasive devices, and CPOs as well as achieving full compliance with the requirements of the *Code of Practice*. More Divisional engagement will be required during 2017/18, particularly with regard to the RCA/PIR process for cases of MRSA and *C. difficile* infection.

The IPCT have a high profile in the clinical areas with regular visits to these areas to monitor the compliance with effective isolation of patients, current practices and policy implementation.

Daily - The IPCT react to notifications of infections from the laboratory system through VitalPAC. These are checked for new and existing cases. On identification of new cases the IPCT collect the demographic data on the patient and complete the appropriate case information on the system. The clinical sites will be visited and/or phoned (if a visit is not possible), communication and advice given will be added to the patient electronic record relating to providing care pathways, patient information leaflets, isolation precautions and appropriate treatment.

Once per week – The IPCT visit every inpatient area to review patients known to the service, provide advice or information to staff on any existing patients not known to the service.

Once per month - the IPCT will liaise and work with the ICLPs incorporating educational sessions and review of audits which address localised Infection prevention and control issues.

Once per year – the IPCT will carry out an environmental audit, write up the report, discuss real time concerns and feedback timeline for revisit where necessary; this is in addition to the environmental audits that are undertaken by the Senior Matrons.

As required – Telephone advice or visits to wards to deal with any clinical queries. This also includes the management of infection prevention and control incidents, periods of increased incidence (PII) and outbreaks.

When required - the IPCT will discuss and advise on the appropriate isolation of cases, support for staff, contact tracing, investigation of sources/reasons for outbreaks and planning of appropriate actions.

7. Policy/Guideline Development

The policies for infection prevention and control undergo regular review. The policies are evaluated and up-dated following risk assessment, and as new guidelines or evidence become available, or alternatively every 2 years as stated in the Organisations Policy on Policies, Standards, Protocols and Guidelines. There is a planned programme for the review of infection prevention and control policies. Every clinical area has electronic access to a copy of the Infection Prevention and Control Manual containing the policies. The IPCT are also involved in advising departments on their individual policies.

8. Audit Activities

There is an annual audit programme of Infection Prevention and Control/Environmental audits in conjunction with the Housekeeping services, nursing and Allied staff. Every area is audited annually with a follow up meeting arranged 6 weeks later to check on action points.

There is an audit of compliance with key policies/practice areas. The planned audit programme is part of the IPCT action plan. An audit report and action plan is prepared by the IPCT, presented to the IPCC on a quarterly basis and agreed with the committee members - once agreed this is then distributed to the key people involved.

9. Surveillance Activities

For 2017/18

Surveillance of alert organisms will continue and include the following:

- Methicillin Resistant Staphylococcus aureus (MRSA)
- Methicillin Sensitive Staphylococcus aureus (MSSA)
- E. coli (E. coli)
- Streptococcus pyogenes
- Mycobacterium tuberculosis
- Resistant Acinetobacter
- Glycopeptide Resistant Enterococcus (GRE)
- Extended spectrum beta lactamase producing Klebsiellae (ESBL's)
- Carbapenemase-producing organisms (CPO)

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

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 Prevention and Control Leads, Matrons, Ward/Department Managers, Clinical Service Managers, Consultants and Junior Doctors.

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 the case has been provisionally assigned to the Trust or one of the CCGs.

Greater engagement will be required from the Divisions during 2017/18 with regard to completion of the preliminary investigation as part of the RCA and PIR process; this will be undertaken by the Ward Manager/Divisional Matron in conjunction with the IPCT.

The Ward Manager/Divisional Matron must assist with arranging the PIR Meeting and will be required to present the case at the PIR meeting, which will be chaired by the site-based IPC Clinical Nurse Specialist.

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

- the Ward Manager or Ward Sister/Charge Nurse
- Divisional Matron(s)
- Divisional Head of Nursing
- the patient's Medical Consultant/Registrar
- Site based Consultant Microbiologist
- CCG Head of Infection Prevention and Control
- Antimicrobial Pharmacist.

Completion of the PIR action plan, ensuring that all actions are signed off as "complete" within a specified time-frame, will be monitored by the IPCT in conjunction with the Senior Divisional Matron and the Head of Nursing.

The IPCT will review all PIRs undertaken for completion of actions overall; where these have not been completed, this will be escalated to the Divisional Head of Nursing and Divisional Medical Director by the DIPC.

The Ward Manager and Divisional Matron will be required to present the PIR at the IPCC. The Divisional Head of Nursing and Divisional Medical Director 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.

Reviews of individual MRSA colonised inpatients and review meetings for any 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) - will 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 IPCC.

Compliance with the management of invasive devices will continue to be reported via the VitalPAC Indwelling Devices Report, which is submitted to the IPCC.

The *Clostridium difficile* target for 2017/18 is 46 cases.

Root Cause Analysis for all cases of hospital acquired *Clostridium difficile* infection will continue. Cases will continue to be deemed as avoidable/unavoidable and compliant/non-compliant, and the justification for these decisions will be clearly recorded. A *provisional* decision as to whether or not there has been a "lapse of care" will be made at the RCA, and *formally* agreed at the CCG Task and Finish Group, which meets bi-monthly.

Failure to appropriately assess patients using the existing Diarrhoea Assessment Tool has led to the IPCT developing and implementing a revised assessment Tool, and will support the Ward Managers and Matrons in ensuring that staff understand and are competent with this procedure.

In addition to the above, the IPCT will ensure that staff fully implement the *C. difficile* Patient Management Plan for patients who are diagnosed with GDH antigen or toxin positive *C. difficile* infection. The IPCT will liaise with the CCGs and the IPCT for Kent Community Health NHS Foundation Trust regarding pre-72 hour cases of *C. difficile* as appropriate if there are links to EKHUFT.

The ward manager will carry out 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 IPCT.

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 liaise with the Clinical Risk Department regarding whether or not this meets the criteria for reporting on STEIS. For pre-72 hour cases, the IPCT will inform the appropriate CCG Chief Nurse and Quality Lead, who will report the patient's death as appropriate 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;

- 2 or more cases of GDH antigen acquisition occurring > 72 hours post admission within 28 days;
- 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 Prevention and 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 to be requested by the DIPC;
- cleaning will be reviewed by the site-based IPCT as part of the RCA preliminary investigation;
- environmental and clinical practice standards audits revisited by wards experiencing 2 or more cases in a 28 day period plus enhanced support from the IPCT;
- the programme of actions for individual cases of *C. difficile* will be carried out by the IPCT as described in the revised Trust Policy for Prevention, Control and Management of *C. difficile*.

E. coli blood stream surveillance

Mandatory surveillance of E. coli blood stream infections continues to be undertaken within EKHUFT by the IPCT.

MSSA bloodstream surveillance

RCAs will be undertaken in conjunction with the Divisions for all cases of MSSA bacteraemia occurring within 30 days of surgery, or where they are associated with an intravascular access device.

Internal surveillance 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.

An outbreak of *C. difficile* infection will be called if there are "2 or more cases 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), and reported as Serious Untoward Incidents via the Clinical Risk Department.

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.

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.

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.

10. Antibiotic Management

The Antimicrobial Stewardship and Management are undertaken by the Lead Antimicrobial Pharmacist in conjunction with Microbiology, the Infection Prevention and Control Doctor and IPCT.

Monthly audit reports of antibiotic usage by each Division will be extracted from the Pharmacy databases each month and sent to the monthly Divisional Governance Board meeting. The Lead Antimicrobial Pharmacist will attend these meetings. Implementation of the antimicrobial stewardship programme will incorporate and report on activity relating to:

- Education sessions for medical staff
- Daily antimicrobial stewardship ward rounds (review of all patients on restricted antibiotics)
- Audit "3 day review" of antibiotics as per DH "START SMART THEN FOCUS" initiative
- Participation in European Antibiotic Awareness Day
- Submission of Antibiotic Stewardship CQUIN data to PHE.

11. 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	Frequency	LEAD	Audit Areas
Sharps management audit Follow-up audit in order	Annual Undertaken within 6 months of the initial audit	IPCT	Trust wide To review areas where there were non-compliances
Environmental and Clinical Practice Standards audits	Wards will be audited annually; departments will be audited every 18 months	IPCT in conjunction with Ward/ Department Managers or IC Link Practitioners	Trust wide Results of > 5 non-compliances in one or both standards are entered onto an Infection Prevention and Control Risk Register. A letter is sent to the Divisional Head of Nursing. Audits will be reported at the IPCC. Ward/ Department Managers will be required to submit an action plan addressing non-compliance – this must

			be monitored by the Division
Commode audit Commode cleanliness audits (relevant wards/departments) Repeat audits	Annual Weekly As appropriate if concerns raised in annual audit	IPCT with Gama Healthcare	Trust wide Concerns will determine reaudit i.e. condition, cleanliness and monitoring of the replacement programme
Mattress/zipped item check (Monthly)	Monthly As appropriate if concerns raised in annual audit	IPC & Nursing Teams	Trust wide Concerns will determine reaudit i.e. condition, cleanliness and monitoring of the replacement program
Continuous real time compliance monitoring will be carried out on the following:			
MRSA screening compliance within 24hrs of admission/pre-assessment	Monthly	Ward managers	Trust wide – as appropriate
Re-screening compliance following MRSA decolonisation as per Trust policy	Monthly	Ward managers	Trust wide – as appropriate
MRSA isolation/cohorting as per Trust policy	Monthly	Ward managers	Trust wide – as appropriate
Bare below the elbow and hand hygiene compliance	Weekly	Ward managers	Trust wide
Implementation of High Impact Interventions (DH 2005) (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	On insertion and whilst in situ	Ward managers	Trust wide – as appropriate (VitalPAC Indwelling Device Report) The insertion and management/ongoing care of these devices will be recorded and monitored through VitalPAC
Compliance with antimicrobial prophylaxis prescribing in surgery formal audit of prescribing	On prescribing	Pharmacy/ Microbiology	Surgical Divisions – Trust wide
Compliance with antimicrobial prescribing for acute infections in medicine	On prescribing	Pharmacy/ Microbiology	All Divisions – Trust wide
Antibiotic stewardship rounds	Daily	Microbiologists and antimicrobial pharmacists	Trust wide Pharmacy will prepare daily lists of restricted antibiotic scripts for review on stewardship rounds

12. The HOUDINI Protocol

The HOUDINI Protocol, to reduce the incidence of urinary catheters within EKHUFT and the associated risk to patients of developing a catheter-associated urinary tract infection (CAUTI), will be monitored to ensure embedded across the Trust 2017/18 and includes:

- Use of the HOUDINI Protocol for the insertion and removal of urinary catheters, including all associated documentation (i.e. Urinary Catheter Guidelines; Bladder Scanning Protocol; Trial without Catheter Protocol).
- Use of the Urinary Catheter Passport for all patients with a urinary catheter within EKHUFT.
- Urinary catheter care information will continue to be captured via VitalPAC

13. Educational Activity

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'.

All staff receive infection prevention and control education in the format of a mandatory e-learning package which incorporates evidence based infection prevention and control guidelines.

Soft Facilities Management contract staff and Estates staff are also required to undertake induction and annual mandatory training including a competency assessment, currently delivered by DVD. Trust wide compliance on mandatory training is reported to the Trust Board as part of the Quality and Patient Safety Report.

All junior doctors receive a short induction session provided by the IPCT.

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 IPCT) and hand hygiene training.

Participation in the F1 Junior Doctors programme includes antibiotic prescribing and the role of the microbiology laboratory in the diagnosis of infection.

IPC Induction for medical students.

Ad hoc sessions for the Divisions and departments.

Infection Prevention and Control education for newly qualified nurses – attendance at the Preceptorship Conference run by the Practice Development Nurses Management of the Acutely Ill Patient (as part of the in house training course).

14. Infection Prevention and Control Link Practitioners

Continue to develop the Link Practitioner Programme through education and support of the Link Practitioners.

- Provide site-based education sessions/IPC Link Practitioner (IPCLP)
- Continue to involve Link Practitioners in the annual IPC audits of Environmental and Clinical Practice Standards.

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

15. 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 IPCLPs and issue them with an electronic "Certificate of Competency", in order that they can undertake practical hand hygiene training for staff working within their clinical areas. Compliance is electronically recorded.

16. Legionella Management and Monitoring

The IPCC 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 IPCC overview of compliance will include:

- Quarterly report on compliance with the Trust Legionella Control Policy.
- Annual Review of the Legionella Risk assessments in collaboration with Estates, for each Hospital Site.
- Review of all Estates actions in response to positive Legionella Cultures.
- Estates reporting of the monitoring hot and cold water systems supplying high risk patients for Legionella colonisation in accordance with L8.

17. Hospital Hygiene

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

18. New Builds, 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 IPCT 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.

19. The Duty of Candour

The Duty of Candour Regulations (CQC Regulation 20) as they apply to IPCT for *C. difficile* and MRSA bacteraemia cases, all other incidents whereby a Datix would be raised are continuing.

20. Working with the CCGs – Supporting the Wider Healthcare Economy

The IPCT works closely with the CCGs to support the prevention and control of healthcare associated infections across the wider healthcare economy as appropriate. This includes active membership of the Kent-wide HCAI Assurance Panel and the HCAI Improvement Forum.

EKHUFT performance with regard to HCAI prevention and control will be monitored by the Commissioners via compliance with IPC Quality Metrics (see Appendix 1).

21. Promotional Campaign Work

The IPCT aim to raise staff awareness on infection prevention and control issues. This will be done in various ways:

- Hand hygiene awareness weeks (at least annually)
- Articles in the staff magazine
- Production of a web page and blog
- Continuous campaigns relating to the concerns/issues and infection/disease themes
- Presentations to various members of staff and public on infection prevention and control
- Flu vaccination month.

Promotional and campaign work will be constantly under review by the IPCT in line with current clinical issues.

The IPCT works with public and service users and expansion of this work is planned. Information available to the public in pre-assessment clinics and on admission will be continually reviewed. One of the IPCLPs will be a member of the Patient Experience Group and will work closely with some volunteers from the Patients Panel on patient information.

22. Service Cover and Business Continuity

The DIPC and DDIPC plan leave, to ensure that one staff member is always available for service cover. The DIPC co-ordinates leave with the Microbiologists to ensure that there is infection prevention and control doctor cover available at all times.

The IPC Clinical Nurse Specialists leave is arranged to ensure that, there is no more than one of the team on annual leave at any one time.

A Business Continuity Plan has been developed to provide a clear management programme in the event of any major incident/pandemic situation occurring.

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 IPCC 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 and viral haemorrhagic fever 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, embedding the process of aiding identification of Norovirus and supporting staff in the management of cases.

Appendix 1: EKHUFT Acute Trust Quality Metrics

Ref.	Local Requirement Reported	Reporting Period	Format	Timing and Method	Governance	Reporting Type
	Health Care Associated Infections / Infection Protection and Control	**2017-2018**				
1.0	Infection Prevention and Control Annual Programme and Annual Report	April 17- March 18	Annual IPCT Programme	To be sent to the CCG for review at the end of Q1. Quarterly update or exception reports. Annual report to go to Board June/July, Annual programme to be reviewed at each IPCC meeting as agenda item.	Presenting at the CQRG	Written report
2.0	Trust wide HCAI improvement plans (i.e. MRSA bacteraemia Action Plan; *C. difficile* Action Plan; PIR and RCA action plans)	April 17 - March 18	Improvement/ Action plans	To be sent to the CCG for review at the end of Q1. Quarterly update or exception reports. HCAI improvement plan, C. diff action plan, currently no formal sign off when complete. CCG to have sight off the reviewed action plans @ IPCC. Also detailed action logs from PIR/RCAs to go to HCAI assurance panel / Task & Finish group.	Presenting at the CQRG	Written report
3	MRSA screening of eligible patients in line with locally agreed policy (10 patients selected at random from 1 ward per hospital site per month)	Monthly	Monthly audit of compliance with MRSA Screening policy (screening within 24 hours of admission / every 7 days)	Monthly audit to be included in IPC Report	Presenting at the CQRG	Written report
4.0	Pre 48 hr cases of MRSA bacteraemia to be reported to the CCG the next working day the positive result	April 17 - March 18	CCG to receive notification of all incidence of MRSA (including HCAI DCS unique ID code) the next working day via secure email.	As they occur	Presenting at the CQRG	E-mail

5.0	Post 48 hr cases of MRSA bacteraemia to be reported to the CCG within 2 working days of the positive result	April 17 - March 18	CCG to receive notification of all incidence of MRSA (including HCAI DCS unique ID code) within 2 working days via secure email.	As they occur	Presenting at the CQRG	E-mail
6.0	CCG to be invited to all post 48 hour MRSA PIR meetings.	April 17 - March 18	Cross reference against HCAI national database.	As they occur	Presenting at the CQRG	E-mail
7.0	To report cases of MRSA bacteraemia on STEIS following completion of the Post Infection Review	Monthly/as they occur	STEIS reporting to demonstrate openness and Trust wide learning	Monthly within SI report to CCG	Presenting at the CQRG	Report
8.0	C-diff reporting of all cases (pre 72 hour and post 72 hour) within 2 working days of identification	April 17 - March 18	CCG to receive notification of all incidence of C-diff (including HCAI DCS unique ID code) within 2 working days via secure email.	As they occur	Presenting at the CQRG	E-mail
9.0	Post 72 hour C-Diff Root Cause Analysis (RCA)	April 17 - March 18	RCA to be shared with the CCG within 28 working days of specimen date.	As they occur	Presenting at the CQRG	E-mail
10.0	In conjunction with the CCG, undertake an assessment of every confirmed post 72 hour case of C. diff to determine if lapses in care contributed to infection.	April 17 - March 18	Assurance process to be defined to review the evidence demonstrating the assessment process, lessons learnt and actions implemented (Assurance Panel, meeting between CCG and Acute Trust)	As they occur	Presenting at the CQRG	Meeting

11.0	Periods of increased incidence (PIIs) of C. diff are reported to the CCG as they occur	April 17 - March 18	Monthly submission identifying any PIIs.	Monthly Report	Presenting at the CQRG	E-mail
12.0	Confirmed outbreaks of HCAIs where there is evidence of transmission to be reported as an SI (with the exception of Norovirus outbreaks, which will be reported in the Monthly Report)	Quarterly	Monthly submission of HCAIs where there is transmission, to demonstrate openness, Trust wide learning.	Monthly Report	Presenting at the CQRG	Report
13	All cases of E. coli bacteraemia associated with surgery within the last 30 days, and all cases of MSSA bacteraemia occurring within 30 days of surgery or associated with a vascular access device, which require Root Cause Analysis, and therefore requiring RCA to be reported to the CCG	Monthly	Completed dataset submission in required timescale.	Monthly report	Presenting at the CQRG	Report
14	Outcomes of RCA for all cases of E-coli and MSSA bacteraemia occurring within 30 days of surgery and/or associated with a vascular access device, to be reported to the CCG	Monthly	Monthly report on all E. coli and MSSA RCAs, to include details of the investigations and what actions the Organisation is taking to reduce incidence and identify specific learning	Monthly report	Presenting at the CQRG	Report
15	Outbreaks (excluding Norovirus) and incidents of other infectious diseases (i.e. TB contact tracing exercise), and to complete investigation reports and action plans.	Monthly	Quarterly exception report on outbreaks (excluding Norovirus) incidents of infectious diseases, to include details of the investigations and what actions the Organisation is taking to reduce incidence.	Monthly report	Presenting at the CQRG	Report

16	Compliance with local antibiotic policies	Quarterly	Audit of compliance with the antibiotic prescribing policy and action plans for improvement	Quarterly	Presenting at the CQRG	Report
17	The organisation participates in awareness-raising programmes to support best practice in antimicrobial prescribing including European antibiotic awareness day (EAAD)	Annually	Evidence and detail of participation in annual report.	Annually	Presenting at the CQRG	Report
18	100% compliance with providers' internal hand hygiene policy.	Monthly	Total number of staff audited Total number of staff in each of the above areas observed as complying with hand hygiene compliance. Report to be broken down to staff category per ward	Monthly report- Embedded in monthly report	Presenting at the CQRG	Report
19	Hand Hygiene training	Monthly	To provide data in relation to % of all relevant staff who have undertaken relevant hand hygiene training. Actions to improve compliance and follow-up non-compliance to be incorporated into HCAI Organisation Wide Action Plan	Monthly report Reported at IPCC meeting	Presenting at the CQRG	Report

20	Local mandatory IPC training programme is delivered as per locally agreed plan for each staff group	Monthly	To provide a quarterly report broken down by % compliance by staff group Directorate To provide in relation to % of relevant staff who have undertaken relevant training in hand hygiene.	Monthly report	Presenting at the CQRG	Report
21.0	Evidence of preparedness in the event of any infection prevention threat (e.g. Ebola, Pandemic Influenza etc.)	April 17 - March 18	To provide evidence of the policies and processes that have been implemented in response to any CAS alerts	Annually or if there are any changes to national guidance Annual Report	Presenting at the CQRG	Policy