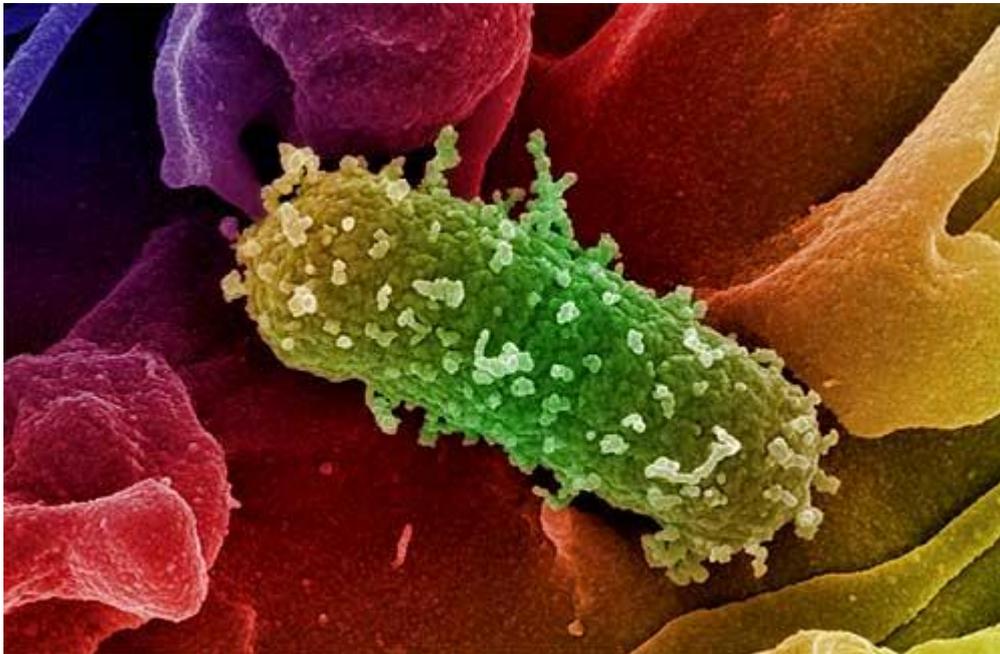# INFECTION PREVENTION AND CONTROL DEPARTMENT

ANNUAL REPORT 2010/2011

Dr Stephen Barrett
Director of Infection Prevention & Control

Emma Dowling
Matron Infection Prevention & Control

CONTENTS

GLOSSARY	
CNS	Clinical Nurse Specialist
DIPC	Director of Infection, Prevention & Control
HCAI	Healthcare Associated Infection
IPC	Infection Prevention & Control
ICU	Intensive Care Unit
IPCN	Infection Prevention & Control Nurse
IPCT	Infection Prevention & Control Team
KPI	Key Performance Indicator
MRSA	Meticillin Resistant *Staphylococcus aureus*
OPD	Out patients Department
PCT	Primary Care Trust
RCA	Root cause analysis
SEPT	South Essex Partnership NHS Trust
SHA	Strategic Health Authority
SSI	Surgical Site Infection
SUHFT	Southend University Hospital Foundation Trust

INFECTION PREVENTION & CONTROL

1.0 EXECUTIVE SUMMARY

This report outlines activity and events related to infection prevention and control for the period from 1 April 2010 to 31 March 2011. Health care associated infection (HCAI) continues to be an important issue for the Trust. Although the trust target is zero avoidable infections, the year 2010/2011 showed continued improvement in the trust's performance regarding MRSA bacteraemia again surpassing the DoH target and improving on C difficile cases.

- The Trust achieved the MRSA bacteraemia and Clostridium *difficile* improvement objectives. There were 2 MRSA bacteraemias against a trajectory of 3 (33% under target), whilst there were 27 Clostridium *difficile* cases against a trajectory of 65 (58% under target).

- The Trust implementation of 'Saving Lives' continued and included the application of evidence based improvements in intravenous line care, isolation utilisation, antibiotic usage and the surgical site infection bundle.

- Increased engagement and ownership of infection prevention and control continued and was enhanced by performance monitoring with feed back including the surveillance of infections, hand hygiene compliance and the Trust wide emphasis of quality and safety.

- The Trust achieved the target of 95% hand hygiene compliance during this period and many areas achieved more. Training in hand hygiene for all staff and improvements to hand hygiene facilities continued.

- Training in infection prevention and control included the flu pandemic, and was delivered through staff induction, mandatory updates and link nurse sessions and update sessions.

- There were 15 outbreaks during this period which were associated with norovirus. In total 738 bed days were lost due to the norovirus outbreaks. In addition there was one *C. difficile* outbreak involving 6 patients and an outbreak of multidrug resistant *Acinetobacter baumannii* (MRAB), predominantly involving the Intensive Care Unit.

- The key risks during this period were predominantly associated with maintaining standards of cleaning and maintenance.

- In line with Department of Health recommendations the Trust extended the MRSA screening programme to include all emergency admissions .This commenced on the 31st December 2010.

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- Patients with Pandemic flu were admitted and managed without major long term disruption.

2.0 BACKGROUND INCLUDING INFECTION PREVENTION AND CONTROL ARRANGEMENTS

The Infection Prevention & Control Department provides the infection prevention and control service for Southend Hospital NHS Trust. The work of the Infection Prevention and Control Department supports the Trust in minimising the risk of healthcare acquired infection to patients in accordance with and taking into account:

- Department of Health (2009). The Health Act 2008 Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance

- Winning ways (Department of Health 2003)

- Towards Cleaner Hospitals and lower rates of infection (Department of Health 2004)

- A matron's charter: an action plan for cleaner hospitals (Department of Health 2004)

- Revised guidance on contracting for cleaning (Department of Health 2004)

- Saving Lives: A delivery program to reduce healthcare associated infection (HCAI) including MRSA (Department of Health 2005)

- Going further faster: implementing the Saving Lives delivery program (Department of Health 2006)

- The national specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes. (National Patient Safety Association 2007)

- Essential steps to safe clean care (Department of Health 2007)

- Clean, safe care: reducing infections and saving lives (Department of Health 2008)

- Board to ward how to embed a culture of HCAI prevention in acute trusts (Department of Health 2008)

- Clostridium *difficile* infection: How to deal with the problem (Health Protection Agency & Department of Health 2009)

- NHSLA (National Health Service Litigation Authority)   Risk management standards

2.1 The infection prevention and control service is delivered and facilitated by an infection control team which includes 1 WTE Infection Prevention and Control Matron, 2 WTE Infection Prevention and Control Nurse Specialists and 0.8 Personal Assistant.

2.2 The Director of Infection Prevention and Control (DIPC) is a Consultant Microbiologist. The DIPC is directly accountable to the Chief Executive and has direct reporting lines to the Director of Nursing and medical directors. The DIPC is responsible for the strategy, policies, implementation and performance relating to infection control and development of the annual report. The DIPC attends the Trust board and other meetings as planned or required.

2.3 The core infection prevention service includes an infection control advisory service, proactive infection prevention work and education and training throughout the organisation. It also undertakes audit, policy formulation and advice, surveillance and epidemiology, outbreak and control management.

2.4 The IPC team (IPCT) meets weekly formally to review infection control issues and performance. A co-ordinated plan of work is agreed and disseminated. Minutes of this meeting are available from the IPCT.

2.5 Infection control link-staff meet quarterly. The programme is facilitated by a member of the IPCT

2.6 The Trust infection prevention and control committee (IPCC) is chaired by the DIPC and met bi-monthly during 2010/11 with representatives from boards and key service areas. The minutes are available on the Trust intranet. This committee reports to the Corporate Team Meeting.

2.7 The Infection Control Team 2010/11:

- Dr Stephen Barrett - Consultant Microbiologist and Director of Infection Prevention & Control
- Dr Marilyn Meyers - Consultant Microbiologist
- Sarah Ballard Smith - Director of Nursing and Executive Lead for Infection Prevention & Control
- Cheryl Schwarz - Associate Director of Nursing
- Emma Dowling - Infection Prevention and Control Matron
- Judith Holdsworth - CNS
- Claire Whittington - CNS
- Elaine Bibby - Secretary to Consultant Microbiologists
- Laura Search – Personal Assistant to the Infection Control Team

3.0   REPORTING AND COMMUNICATION

The IPCN's and Medical Microbiologists are in daily contact in relation to operational issues and there is a planned and minuted weekly meeting. The Director of Infection Prevention and Control may attend the Executive Team Meeting once a month to provide assurance against trajectories and compliance against the Hygiene Code and an update of any other relevant matters. In addition they meet regularly with the Executive Lead for Infection Prevention and Control.

3.1   Internal Reporting Arrangements

The Infection Control Committee meet bi-monthly. The IPCC is responsible for monitoring implementation of the annual programme and the Care Quality Commissions core standards 4a and 4c, and the Hygiene Code (2008). It formally reports to the Corporate Team Meeting.

3.2   Out of hours service

The IPCN team provide 24 hours availability on call rota. The Consultant Microbiologists are also available on a rota out of hours.

4.0 REPORTS TO THE EXECUTIVE TEAM AND TRUST BOARD

Monthly assurance is provided to the Executive Team on MRSA, MSSA, *Escherichia coli* bacteraemia and *Clostridium difficile* cases. The Executive team also receives information on the current position concerning MRSA hospital colonisation, MRSA screening compliance and High Impact Interventions compliance. Monthly reports were provided to the PCT electronically for reporting to the SHA and via the Clinical Quality Group as direct reporting as KPI's. The Trust Board were kept informed on a monthly basis of all the mandatory surveillance reports, the extended range having taken effect from the beginning of 2010.

4.1   MRSA Bacteraemia

For 2010/11 the Trust was set a trajectory of not more than 3 MRSA bacteraemias. This was achieved with a total of 2 during the year. Monthly figures for MRSA bacteraemias from April 2007 onwards are shown in Fig 1, which demonstrates an improvement from 2008/09 where during this period the reported total was 16.

Fig: 1
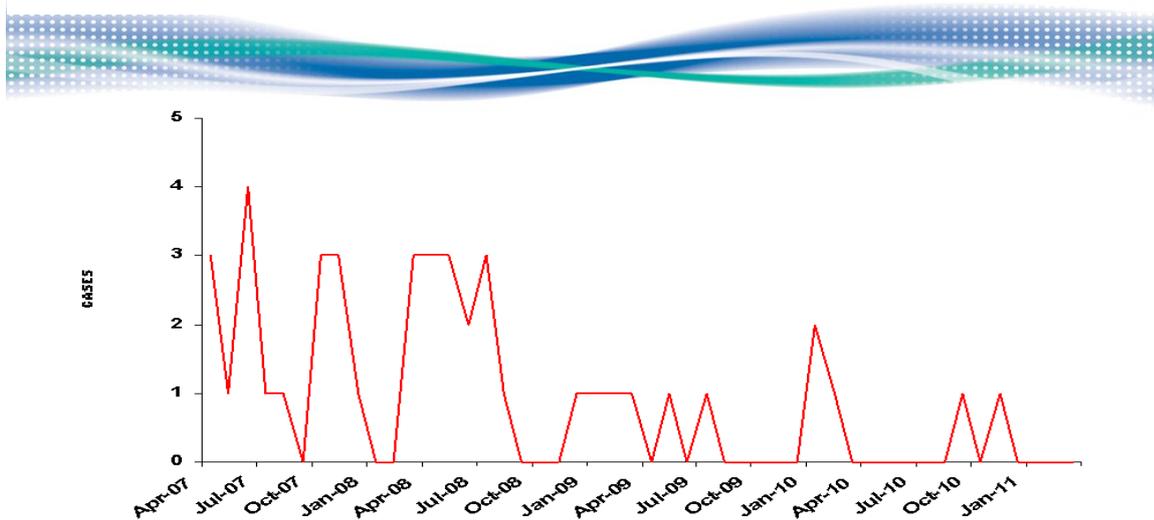
4.2   MRSA bacteraemia summary Root Cause Analysis (RCA)

RCAs are undertaken for each MRSA bacteraemia by the IPCN and Consultant managing the patient. The RCAS are amalgamated and discussed at a meeting chaired by the Chief Executive Officer with a remedial action plan developed with immediate effect.

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RCA's for 2010/11

Date received	> 48 hours after admission	Age	Known MRSA carrier
12/09/2010	Yes	66yrs (male)	Yes
11/11/2010	Yes	56 yrs (male)	No (missed admission screen)

4.3   MRSA screening

The Department of Health required all Trusts to screen all elective patients for MRSA from April 1st 2009 and all other admissions as soon as possible thereafter, but no later than 2011. Patients at Southend Hospital NHS Foundation Trust are screened for MRSA at point of referral at their OPD appointment. The IPCT receives confirmation of these results from the microbiology department. All patients with a positive screen result are contacted informing them of their result and a letter sent to the patient. Their GP receives a letter/fax advising on the correct topical decontamination protocol to be prescribed for the patient and advice on follow up screening.

The Trust has procedures in place to comply with requirements to screen all admissions other than the exceptions defined by the Department of Health.

Monthly data	YTD
Total elective admissions	14683
Elective admissions screened	13588
% of elective Admissions screened	92.5%
Total emergency admissions	23345
Emergency admissions screened	20317
% of emergency admissions screened	87.0%

The large numbers of patients selected for pre-admission screening has been reflected in very little transmission of MRSA within the hospital since most patients are detected and decolonised before admission.

Fig 2

New MRSA acquisitions
All directorates April 09– March 11

Southend University Hospital NHS
NHS Foundation Trust

MRSA Hospital Acquisition - April 2009 - to date
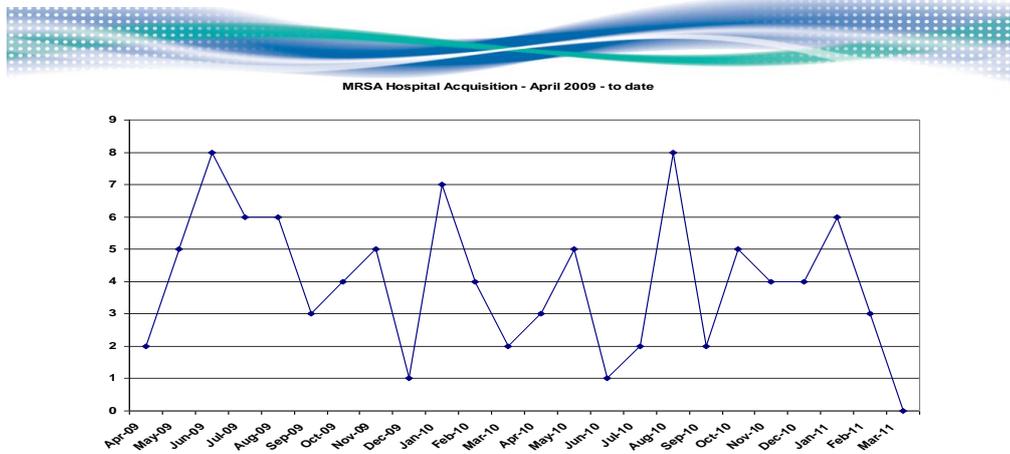
Fig 3

MRSA activity
(New hospital and community acquisition cases)
April 2009– March 2011

Southend University Hospital NHS
NHS Foundation Trust

MRSA acquisition - April 2009 - to date

Hospital acquired pt   community acquired pt
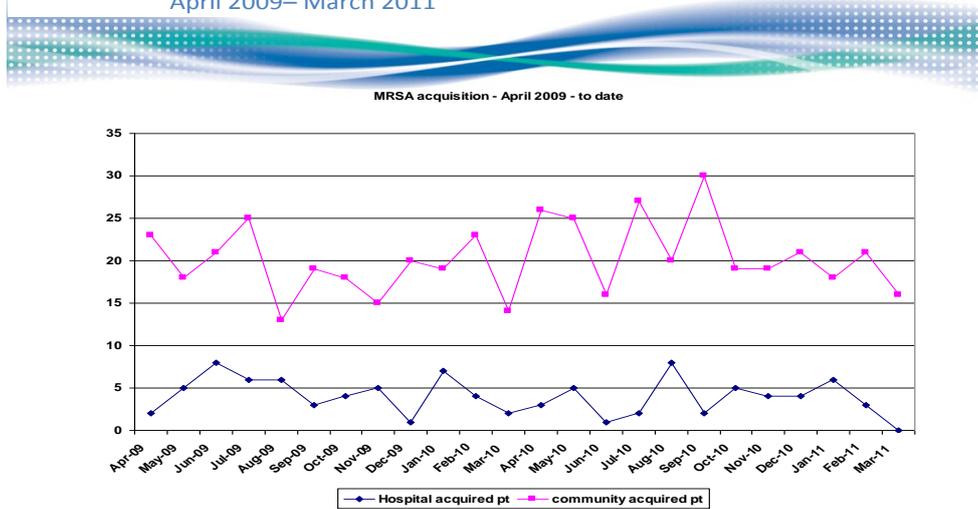
4.4   MRSA pre-printed sticker

In line with the Trust MRSA bacteraemia reduction programme a pre printed sticker continues to be used by the IPCT. This improves prescription accuracy of decolonisation therapy and reduces the delay in starting therapy .The Trust moved to Octenisan anti bacterial body wash in Feb 2011 from Stellisept body wash. This change was cost-neutral and now allows patients to receive the same product for their decontamination therapy in primary and secondary care settings.

4.5   Meticillin Sensitive *Staphylococcus aureus* bacteraemia

The Dept of Health extended mandatory surveillance to include MSSA bacteraemia from January 2011 in Gateway Reference 15353; the Trust had already been reporting MSSA bacteraemias voluntarily since the beginning of 2010.

Total Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias by month April 09 – to date

Southend University Hospital **NHS**
NHS Foundation Trust

MSSA - APRIL 09 - TO DATE
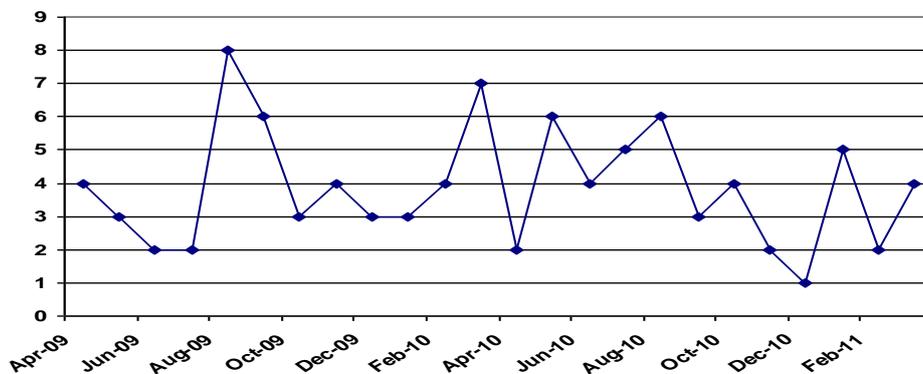
4.6   Escherichia coli bacteraemia

The Department of Health will be extending mandatory surveillance reporting to include bacteraemias due to this organism from June 2011, the Trust has been collating this information since April 2010 but at present there is no reporting mechanism.

4.7   Clostridium difficile associated diarrhoea

In common with most healthcare organisations in the UK, the Trust continues to see a downward trend in its annual rate of *Clostridium difficile* infection. The external trajectory set for the year 2010/11 was 65 and the Trust achieved this with a total for the year of 27 this compares with the 2009/10 total of 65. This marks a significant achievement for the Trust.

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Fig: 4   Total *Clostridium difficile* cases by month
                          April 2009 – March 2011

Hospital Acquired *Clostridium difficile* 2009- 2011
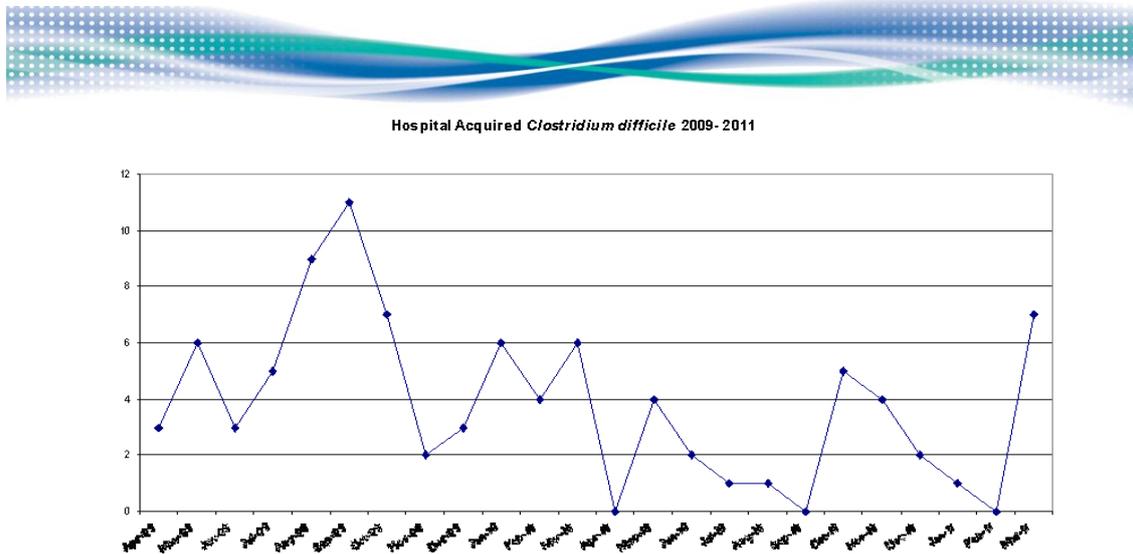
4.8   Other Resistant Bacteria

In keeping with national and international trends, there is a steady increase in the number of gram negative bacilli found resistant to multiple antibiotics. Principal amongst these are the extended spectrum beta-lactamase (ESBL) – producing bacilli. These bacteria produce enzymes which inactivate most penicillin and cephalosporin antibiotics, which are the mainstay of antibiotic therapy. Such ESBL producers often show individual resistance to other groups of antibiotics as well which in some cases leave few antibiotic choices for treatment and which generally necessitate intra-venous therapy. Two patients were found with the widely publicised NDM metallo beta-lactamase enzymes which caused concern internationally in 2010. These patients were treated successfully and there was no evidence of spread.

5.0   OUTBREAKS AND WARD CLOSURES

5.1 Multidrug resistant *Acinetobacter baumannii*

Between August 2010 and February 2011, 23 patients in the Trust were found to have multidrug resistant *Acinetobacter baumannii* (MRAB).

MRAB is a gram negative bacillus for which man is an incidental host and the main reservoir is thought to be in the environment, similar to *Pseudomonas* species.   In contrast to pseudomonas however, MRAB is more resilient and can persist inert in the environment for longer periods. It is characteristically of low pathogenicity, and strains found in hospitals are generally resistant to almost all antimicrobials. The OXA-23 strains found in Southend, which is that generally, found in other hospitals in South East England, is sensitive to a single antibiotic, namely Colistin, which has to be given by the intravenous or inhalational routes. The typical patient that becomes colonised with MRAB, as with MRSA and other multiresistant hospital-acquired bacteria, has multiple underlying morbidities, repeated hospital admissions and repeated exposure to antibiotics. The first cases in the recent outbreak were noted in vascular surgical patients, and later cases occurred on the Intensive Care Unit. A few were detected on other wards including medical and surgical, with some patients also in respiratory care. A study of the times and locations of new patient-isolates sometimes revealed potential incidents of patient-to-patient transmission, though in others no obvious connection with other patients was apparent. The connection of many patients with the Intensive Care Unit reflects the experience of other hospitals and that Intensive Care Units deal with the most compromised patients, make much use of antibiotics, and microbiologically investigate patients intensively.

Enhanced surveillance of certain of the other clinical areas where MRAB patients had been detected was responsible for the finding of the small number of the other cases in the outbreak, indicating the potential for wide spread of MRAB.

Affected patients were mainly subject to respiratory tract colonisation with MRAB, and where treatment was indicated nebulised, or intra-venous, Colistin was administered. No patient was thought to have died as a result of MRAB and there was no apparent excess mortality in MRAB patients.

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Advice was sought from the Health Protection Agency, and on 11th March Peter Hoffman, who is an environmental scientist with the HPA, visited the Trust and inspected the affected areas. He produced a report making a number of recommendations covering environmental and instrument decontamination and the use of disposable items. With Estates and Facilities, the Infection Prevention & Control Team is working through these recommendations.

By way of controlling the outbreak, each MRAB patient was isolated and their immediate environment was terminally cleaned with enhanced use of disinfectants during their stay. The outbreak was considered terminated, however it is noteworthy that the same organism had caused an outbreak of MRAB on one of the surgical wards in the Trust five years previously.

5.2 *Clostridium difficile*

A single outbreak of infection occurred in October on Eleanor Hobbs ward. Five patients were detected within a short period of time and all subsequently found to have the same strain of *Clostridium difficile*. Enhanced environmental hygiene and training of staff was undertaken and no further cases were detected.

5.3 Norovirus outbreak April 2010- March 2011

It was necessary to close wards on a total of 15 occasions during the period April 2010 – March 2011, in all cases due to suspected Norovirus. According to the Health Protection Agency (HPA), the economic impact of operational difficulties resulting from Norovirus outbreaks is estimated to be more than £100 million each year to NHS inpatient services.

Summary of Ward Closures due to Norovirus

Date	Ward	Norovirus confirmed	Days closed	Bed days lost
20.04.10	Castlepoint	Yes	7	68
25.04.10	Blenheim	Yes	6	38
26.04.10	Princess Anne	Yes	6	24
27.04.10	Bedwell	Yes	9	38
29.04.10	Eleanor Hobbs	Yes	8	96
18.06.10	Rochford	Yes	7	22
03.11.10	Eleanor Hobbs	No	2	22
21.12.10	Bedwell	Yes	6	26
28.12.10	Stambridge	Yes	8	8
12.01.11	Princess Anne	Yes	5	0
22.02.11	Eleanor Hobbs	Yes	10	88
26.02.11	Elizabeth Loury	Yes	15	139
07.03.11	Blenheim	Yes	8	53
25.03.11	Benfleet	Yes	10	93
27.03.11	Paglesham	Yes	9	23
			Total	738

Key lessons learnt during this period include:-

- The importance of a robust communication plan for patients, visitors and staff about the prevention and management of viral gastroenteritis (*Norovirus*) which commences implementation in September each year.

6.0 SURGICAL SITE INFECTION SURVEILLANCE

- Orthopaedic Surgery

  The Department of Health requires all hospitals performing orthopaedic surgical operations (joint replacements and implants for fracture surgery) to monitor surgical site infections (SSI) for a three month period each year. This was extended to continuous surveillance from April 2010.

- Other surgical specialities

  As from April 2010 4 additional separate patient cohorts were included in the surveillance programme

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Trust Surgical Site Surveillance programme 2010/2011:

Period	Category	Closing date for data submission
July – September 2010	Repair of neck of femur	31st December 2010
	Knee replacements	
October – December 2010	Repair of neck of femur	31st March 2010
	Knee replacement	
	Abdominal hysterectomy	
January – March 2011	Repair neck of femur	30th June 2011
	Knee replacements	
	Large & small bowel	
April – June 2011	Repair of neck of femur	30th September 2011
	Hip replacements	
	Amputations	

Results obtained from the Health Protection Agency's Surveillance of Surgical Site Infections.

April – June 2010

Category	Total number of SUHFT operations	Number of SSI's	SUHFT (%infected)	Total no. of operations for all hospitals	Total no. of SSI's for all hospitals	All hospitals (% infected)
Repair neck of femur	77	0	0.0	27255	516	1.9
Knee replacement	41	0	0.0	171331	2050	1.2

July – September 2010

Category	Total number of SUHFT operations	Number of SSI's	SUHFT (%infected)	Total no. of operations for all hospitals	Total no. of SSI's for all hospitals	All hospitals (% infected)
Repair neck of femur	72	2	4.2	30981	580	1.9
Knee replacement	84	2	2.4	177688	2204	1.2

*Although figures indicate our infection rate for Knee replacements is above that of all other hospitals average % this did only involve 2 patients with infections at **SUHFT**.
Both infections were unlinked cases, isolated different organisms and were under different consultants. There were no practice issues raised.

October – December 2010

Category	Total number of SUHFT operations	Number of SSI's	SUHFT (%infected)	Total no. of operations for all hospitals	Total no. of SSI's for all hospitals	All hospitals (% infected)
Repair neck of femur	72	1	1.4	35941	683	1.9
Knee replacement	62	0	0.0	182116	2295	1.3
Abdominal hysterectomy	43	0	0.0	6086	173	2.8

INFECTION PREVENTION & CONTROL

7.0 SAVING LIVES: HIGH IMPACT INTERVENTIONS

Saving Lives was introduced by the Department of Health in June 2005.The High Impact Intervention tools are based upon a 'care bundle' concept , integrating the latest evidence based guidelines and providing a means for staff to measure compliance to key clinical procedures. High impact interventions assist clinical governance by ensuring that all patients receive a consistently high quality care.

During 2010/2011 audits were undertaken on the following care bundles.

Hill No. 1	Central venous catheter care bundle – Insertion
Hill No. 1	Central venous catheter care bundle – Ongoing care
Hill No. 2	Peripheral venous catheter care bundle – Insertion
Hill No. 2	Peripheral venous catheter care bundle – Ongoing care
Hill No. 3	Renal dialysis catheter care bundle – Insertion
Hill No. 3	Renal dialysis catheter care bundle – Ongoing care
Hill No. 4	Care bundle to prevent surgical site infection – Pre operative
Hill No. 4	Care bundle to prevent surgical site infection – Peri operative
Hill No. 5	Care bundle for ventilated patients – Ongoing care
Hill No. 5	Care bundle for ventilated patients – Regular observations
Hill No. 6	Urinary catheter care bundle – Insertion
Hill No. 6	Urinary catheter care bundle – Ongoing care
Hill No. 7	Prevention of spread of *C difficile*

The results are presented monthly in graph format. Any compliance issues are addresses through the Matrons and reported at the Infection Prevention and Control Committee.

8.0   TRAINING AND EDUCATION

Main teaching programme	Frequency	Providers
IPC induction for all staff (including medical)	Fortnightly	IPCN/DIPC
Facilities staff	as required	IPCN
Renal Unit	X 6 a year	IPCN
NHS Professionals	as required	IPCN
Trained Nurse Development course	monthly	IPCN
1 day IC workshop (all grades)	quarterly	IPCN/DIPC
IC awareness days	quarterly	IPCN/DIPC
Link Nurse Session	quarterly	IPCN
Paediatric Staff Development	quarterly	IPCN
Day stay theatre / Post-op	annually	IPCN
Mandatory Infection Control	daily	IPCN
Junior doctors	biannually	DIPC
(ARU) IC for student nurses		
Sharps Awareness day	x3 a year	IPCN

New education programmes are added as required.

8.1 Infection Prevention Mandatory training

3,727 (70%) of staff trained between 01/04/10 – 31/03/11.

8.2 Infection Prevention and Control Link Nurses

The IPCT recruits Link nurses for every clinical area through out the Trust. To date we have recruited 76 link nurses. The agreed standard is to have a registered nurse and a Healthcare Assistant for each area, and to date the sessions have been well attended.

Link Nurse Sessions are run quarterly and provide education and information provision for approximately two hours, and sessions are frequently provided by guest speakers.
The aim of these sessions is to update on any new guidance / policies and to increase the flow of Infection Prevention and Control communications.

Infection Prevention and Control Link Nurse Programme 2011 / 2011		
Date	**Guest Speaker**	**Discussion / Programme**
11.03.10	Judy Holdsworth IPCN	Swine Flu Discussion/feedback of RCA's undertaken & new or updated policies Q & A session
22.07.11	Clinell Rep Dan Dallas – Waste Manager Judy Holdsworth - IPCN	Update on Clinell products Waste Management Discussion/feedback of RCA's undertaken & new or updated policies Q & A session
11.10.10	Dr Steve Barrett – Consultant Microbiologist & Director of Infection Prevention & Control Judy Holdsworth – IPCN	Norovirus Update Discussion/feedback of RCA's undertaken & new or updated policies Q & A session
25.02.11	Steve Taylor – Facilities Roger Western – Microbiology Ruth Nicholls – Octenisan Rep Judy Holdsworth - IPCN	Process for reporting maintenance issues on the wards Microbiology, pathology, A & P & laboratory processes Introduction of Octenisan in the Trust Discussion/feedback of RCA's undertaken & new or updated policies Q & A session
17.06.11	Julie Coleman – Practice Development Nurse Ruth Nicholls – Octenisan Rep Judy Holdsworth – IPCN	CQC in relation to infection control Feedback & discussion of Octenisan Quiz regarding assessment for isolation

		Discussion/feedback of RCA's undertaken & new or updated policies Q & A session
23.09.11	Claire Whittington – IPCN	Infection Control on line E learning programme
	Judy Holdsworth - IPCN	Preparation for oncoming Norovirus season Discussion/feedback of RCA's undertaken & new or updated policies Q & A session
16.12.11	Judy Holdsworth – IPCN	Compliance with Hand Hygiene code MRSA screening Light box training. Discussion/feedback of RCA's undertaken & new or updated policies Q & A session

9.0   COMPLIANCE AGAINST HYGIENE CODE

The Health and Social Care Act 2008 Code of Practice for the prevention and control of Healthcare Associated Infections (HCAI's) became operational in April 2009 and revised April 2011.Known as the Hygiene Code it now includes primary dental care and independent sector ambulance providers. From April 2012 it will include primary medical providers. The Code of Practice outlines compliance criteria the Trust is required to meet and supporting guidance for implementation. The Annual Work Plan and GAP Analysis details the Trust's compliance.

The GAP Analysis (i.e. analysis of areas where requirements are not completely met) shows an increased compliance with the Hygiene Code. The 10 criteria and supporting evidence are RAG (Red-Amber-Green) scored.

RED-Non –compliance based upon insufficient evidence

AMBER-Processes in place but requires development

GREEN-Evidence available to support compliance

This Trust has no red scores, which would indicate non-compliance. At the time of this report there are now only 3-amber scores

Criterion	Compliance criteria point	Compliant	Comments
1	Systems to manage and monitor the prevention and control of infection. Those systems use risk assessments and consider how susceptible service users are and any risks their environment and other users may pose to them		
2	Provide and maintains a clean and appropriate environment which facilitates the prevention and control of HCAI.		Labelling of decontaminated equipment needs improvement
3	Provide suitable accurate information on infections to service users and their visitors. Patient information leaflets reviewed and updated		
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing / medical care in a timely fashion.		Interhealth Care Transfer Form.1st Quartley Audit due July 2011
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment are care to reduce the risk of passing on the infection to other people.		
7	Provide or secure adequate isolation facilities		Out of service Negative pressure rooms added to Risk Register
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 reasonably practicable, that care workers are free of and are protected from exposure to infections during the course of their work, and that all staff are suitably educated in the prevention and control of infection with the provision of health and social care.		European Union directive. The implementation of sharp safety devices by May 2013 .IPCT in conjunction with procurement to develop a roll out plan.

10.0 INFECTION PREVENTION AND CONTROL POLICIES

During 2010/11 the IPCT reviewed and updated many of the existing policies in line with national guidelines and advice to ensure that the requirements of the Hygiene Code 2008 were being met. All Infection Prevention and Control policies are on the Infection Control section of the Trust Intranet site.

No.	Policy	ICN	Published Date	Review Date
IC007	MRSA Policy	ED	12/2011	12/2011
IC010	Transmissible Spongiform Encephalopatheis Policy CjD vCJD	ED	01/08/10	01/08/12
IC011	Policy for the Collection of Infection Surveillance Data within Southend Hospital	ED	Awaiting publication 2011	2013
IC012	Glycopeptide resistant Enterococci (GRE) Policy	ED	01/11/11	01/11/12
IC013	Care of the deceased patient identified as infectious or potentially infectious	ED	01/11/10	01/11/12
IC016	Infection Control Strategy	ED	01/01/11	01/01/2013
IC017	C Difficile Policy	ED	01/11/2010	01/11/2012
IC018	Policy for Management of Spillage of Biological Fluids	ED	01/09/10	01/09/2012
IC025	Diarrhoea & Vomiting Policy	ED	01/08/2010	01/08/2012
IC027	Standard Precautions	ED	01/10/2010	01/10/2012
IC028	Control of multi resistant gram negative bacillus including ESBL's	ED	01/2011	01/2013
IC029	Policy for the Prevention & Control of multi resistant gram negative bacilli	ED	01/2011	01/2013
HS06	Prevention of Sharps Injury	ED	01/02/2011	01/02/2013
CM60	Decontamination	ED	01/01/2010	01/12/2011

10.1 Patient Environmental Action Team (PEAT) inspection

The PEAT programme was established to assess NHS hospitals in 2000 and has been managed by the NPSA since 2006 and was passed back to NHS Estates to manage in 2008. Under the programme, every inpatient healthcare facility in England with more than ten beds is assessed annually and given a rating of excellent, good, acceptable, poor or unacceptable.

10.2 Environmental audit

Environmental audits are carried out on a monthly basis. The audit team consist of,

- Matron
- Domestic supervisor
- Member of the Quality Assurance Team
- On a rota basis a member of the Infection Prevention and Control Team

INFECTION PREVENTION & CONTROL

This audit tool records the cleanliness, according to a visual check against the NHS National Standards of Cleanliness 49 Elements. Elements include floors, walls, beds, sinks, baths and medical equipment. The area being assessed is defined as a functional area according to the designated risk factor. Each element is scored using the PEAT Assessment Standards - The following definitions are used as a guide:

Excellent (Score 5) - Consistently high, exceed expectations across all aspects of the element being measured. An occasional, obviously temporary incident i.e. sweet wrapping can be overlooked if it is an isolated occurrence. Good (Score 4) - Almost always meet expectations and often exceed them. Acceptable (Score 3) - Usually meet expectations though there is room for improvement in some areas. Poor (Score 2) - Regularly fail to meet expectations and there is significant room for improvement. Unacceptable (Score 1) - Fail to meet expectations in most areas and improvements required urgently.

An Audit is required to score 95% or above to pass. Audits below this score will require an action plan and re-audit to be carried out within a specified period.

10.3   Results

The table below details the PEAT assessments carried out over the past three years for infection prevention. Of the seven categories assessed infection prevention scores are as detailed below.

Year	Excellent	Good	Acceptable	Poor	Unacceptable
2009	√				
2010	√				
2011	√				

11.0 AUDIT

Code of practice for the prevention and control of Healthcare associated infections under the Health and Social Care Act 2008 requires that all NHS organisations have in place an audit programme to ensure key policies and practice are being implemented appropriately

Month	Audit	Score
April 2010	C diff IC 0017	100%
May 2010	Aseptic policy	Nil audit as policy is in draft form and awaiting ratification

June 2010	MRSA IC 007	100%
July 2010	TB IC 002	Nil in patient cases
	C diff IC 0017	Only 1 in patient
August 2010	Hand Decontamination IC 009	94%
September 2010	Infected patients in theatre IC 005	Policy being updated
	MRSA IC 007	96.5%
October 2010	C diff IC 017	100%
November 2010	Isolation IC 019	96.5%
December 2010	MRSA IC 007	98%
January 2011	C diff IC 0017 on going audit HINI 'Swine Flu' IC 023	On going 97%
February 2011	Standard Precautions IC 022	98%
March 2011	MRSA IC 007	97%

12.0 KEY ACTIONS / ACHIEVEMENTS IN INFECTION PREVENTION FOR 2010/11

- The IPCT has successfully extended surgical site infection surveillance programme to include the areas recommended by the SHA in compliance with the HCAI task group policy.   Namely, continuous surveillance of repair of neck of femur, total knee replacement for April 2010 – March 2011 then changed surveillance to collecting data for total hip replacement.   October – December 2010 – abdominal hysterectomy and from January – March 2011 large and small & bowel surveillance. April 2011-June 2011-Amputations surveillance.

- Improvement with compliance MRSA pre admission screening with accordance with The Department of Health requirements.

- Achieved and exceed MRSA bacteraemia reduction trajectory

- Achieved and exceed *Clostridium difficile* reduction trajectory

- Developed and escalated a clinical contingency plan which defines restrictions in service when the full complement of the IPCT is not available.

- Infection Prevention Control Policies updated and reviewed

- Infection Prevention and Control Patient information leaflets updated

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13.0 OBJECTIVES AND WORK PLAN FOR 2011/12

The attached work programme underpins the detail of the work to be undertaken by the infection prevention and control service to:
- Implement effective systems to prevent and control Health Care Acquired Infections.
- Challenge and change culture, and educate all staff, patients, relatives and visitors of the importance of all infection prevention and control procedures (including hand decontamination).
- Identify risks in infection control and work with colleagues to provide solutions to reduce, control or eliminate those risks.
- Undertake audits of Infection Prevention Policies and the environment
- Promote, improve the reliability of and monitor the clinical infection control practices
- Provide clear, concise and evidence based policies and guidelines, which are accessible to all staff groups.

Appendix 1 **Infection Prevention and Control Programme for 2011/2012**

Compliance criteria point	Programme of work 2011/12	By whom (lead)	Evidence	Date to be achieved
1. Systems for 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 pose to them.	Increase the Infection Control Committee (IPCC) meetings from bi monthly to monthly	Director of Infection Prevention and Control (DIPC)	Minutes & papers	August 2011
	Review IPCC Terms of Reference annually	Director of Infection Prevention Control (DIPC) and IPCC members	Minutes & papers	June 2011
	Review resources allocated to the Infection Prevention and Control service/infrastructure	DON / ADN /Matron IPC		
	Present annual programme 2011/12 (including annual audit programme) and Annual Report 2010/11 to Board of Directors through the Quality Assurance Committee. Ensure report available to the public. Additional briefing to Board of Directors at least yearly.	DIPC / IPCC / Matrons	Minutes / Risk register/ Web Site	August 2011
	Review Healthcare associated infection risks identified on the Trust Assurance Framework/Risk Register regularly (quarterly and when required) and report to Board of Directors	IPC Matron	Minutes / Risk register	Monthly / Quarterly
	Provide HCAI statistics for performance reporting at Board of Directors and at the IPCC, including details of trends	DIPC IPC Matron	Minutes	
	Continue to undertake root cause analysis for HCAI (MRSA/MSSA bacteraemia, Clostridium difficile). Evidence of lessons learnt through the RCA process are shared and agreed .Evidence of actions implemented produced.	DIPC, IPCT, Ward Managers, Matrons.	Completed RCA Tools. Minutes	Quarterly
	Review all outbreaks of HCAI at the Infection Control Committee.	DIPC,IPCT	Minutes. Annual report	On going
	Assess new and existing policies with regard to infection prevention and control and make recommendations for change	IPCT	Update programme with review dates	On going
	Plan and deliver a full education programme for all staff.	IPCT	Programme / emails /	On going

Compliance criteria point	Programme of work 2011/12	By whom (lead)	Evidence	Date to be achieved
			attendance records	
	Launch new e-learning module for clinical/non clinical Commence and evaluate new style education for ongoing essential training • E-learning module	IPCT	E learning Programme / presentation material / records of undertaking	Sept 2011
	Plan and deliver an ongoing programme of training and support for infection prevention link practitioners.	IPCT	Programme / presentation material / records of attendance	Quarterly sessions during 2011/2012
	Review and up date Hand Hygiene audit tool- Continue education and support for ward staff to undertake hand hygiene compliance. Hand hygiene compliance to be monitored in all in-patient areas monthly. Areas of non compliance to be discussed at IPCC	IPCT	Minutes	Aug 2011
	High Impact Interventions Audits undertaken monthly. Provide feedback at IPCC regarding progress and recommended actions.	Matrons	Graphs	On going
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Infection prevention input to environmental audits and report poor compliance	IPCT Matrons	Audit reports minutes	Commenced May 2011
	Introduction of Clinell 'I am clean' labels following the decontamination of equipment	ED	Audit	June 2011
	Continued Infection Prevention and Control input /participation with **PEAT** assessments.	IPCT	**PEAT** reports and minutes	As required
	Provide expert advice to all service developments to ensure infection risks are considered and good infection prevention facilities/practices built into the development. In particular, ensure that infection prevention is considered in the built environment through provision of infection prevention expertise to capital projects from concept stages to commissioning, as well as more minor refurbishment projects.	IPCT	Evidence of sign off of projects	As required

Compliance criteria point	Programme of work 2011/12	By whom (lead)	Evidence	Date to be achieved
3. Provide suitable accurate information on infections to service users and their visitors.	Continue to produce and publish Public Information leaflets	IPCT	Update programme with review dates	On going
	Update and review the contents and design of the Infection Prevention and Control Web site	ICPT	Web Site	Aug 2011
	Review and update 'Tummy Upset' poster	IPCT	New Noro Virus Poster	Aug 2011
4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion	Review and update letters GP D/N in conjunction with PCT and local GP's	IPCT + PCT ICN	Letters	Achieved June 2011
	Audit of inter care transfer form to monitor compliance	Discharge team	Audit Reports	Quarterly
	Ensure evidence required by commissioners is presented to IPCC	IPCT	Minutes	On going
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.	Continue to participate in the Surgical site Surveillance Schemes	IPCT	Programme of categories with collection dates. Reports	On going
	MRSA Policy (IC007) amend screens now valid for a 12 week period	IPCT	Ratified policy	July 2011
	Monitor screening emergency and elective patients data and report to IPCC and PCT- Develop the Infection Prevention and Control DASHBOARD	IPCT		Aug/Sept 2011
6. Ensure that all staff and those	See criterion 1 (programme of education, audit and monitoring of practice)			

Compliance criteria point	Programme of work 2011/12	By whom (lead)	Evidence	Date to be achieved
employed to provide care in all settings are fully involved in the process of preventing and controlling infection.				
7.Provide or (secures) adequate isolation facilities	Provide specialist infection control advice to new build or refurbishment projects such as bathroom facilities and isolation facilities Produce a formal record of side room availability.	IPCT		As required
	Risk assessment for the Negative Pressure Rooms (Westcliif Ward) added to Risk Register	IPCT		June 2011
8. Secure adequate access to laboratory support as appropriate.				
9. Have and adhere to policies, designed for the individual's care and provider organisations, which will help to prevent and control infections.	Revise policies as per schedule or following publication of new evidence/guidelines.	IPCT		As required
	Continue with audit programme of IPC policies compliance with Policies	IPCT		

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Compliance criteria point	Programme of work 2011/12	By whom (lead)	Evidence	Date to be achieved
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.	Provide specialist infection prevention input to Occupational Health policies as required.	IPCT		
	Support the Occupation Health Service Department in the importance of staff having influenza vaccination. Work is required regarding the European Union Directive on the prevention of sharps injuries in the healthcare sector. These provisions must be implemented by May 2013.The purpose of the Directive is: • To achieve a safe working environment • To prevent injuries with all medical sharps including needle sticks • To protect workers at risk • To set up an integrated approach establishing policies in risk assessment, risk prevention, training, information, awareness raising and monitoring • To put in place response and follow-up procedures Not all devices currently procured are safety devices	IPCT IPCT / Procurement	Audit to be produced identifying safer needle devices currently in use throughout Trust with an implementation plan of safety devices to be produced. Procurement to have discussions with selected company to plan 'roll out' of safety needle devices	May 2013