Appendix B

NHSI Infection Control Review – Questions and Suggestions for SUFT

QUESTIONS:	
Annual Report	
Criterion 7:	
How many side rooms do you have? Do you have any rooms for TB patients etc?	Hospital has 525 beds 120 side rooms (including paeds)
You are outside the average for small bowel, #NOF. However there isn't any discussion on what the RCAs found, lessons learned etc?	Discussed with consultants No RCA's undertaken. Will add narrative to Annual Report High risk and frail elderly patients
What training has the IP undertaken? What posters, publications etc?	Ad hoc face to face training I learn mandatory training Tool box talk for contractors HCA induction training Overseas nurses Posters regarding screening
Isolation signs: would you advise gelling hands after you have left the side room as you would have touched internal door handle?	New isolation does states gel hands
Policies	
Outbreak: in date. Would your team include PHE? Reference is EPIC 2 from 2007... why not EPIC 3? Page 8 states to isolate when CDI has been isolated. Surely it is when the patient has had diarrhoea and CDI is suspected and specimen sent?	Yes To be amended To be amended and Stool sample poster to be produced and used as a training tool Will be added to C diff policy
Compliance Audits	
Audit Programme: what audit tool do you use?	Policies audited using tool based on IPCS questions We audit knowledge and practice
How is the trust assured that 100% scores are an accurate reflection?	To undertake peer audits to ensure an accurate reflection (MEMS trainer will be undertaking hand hygiene policy audit August)
Is peer review undertaken?	Not at time of visit – plans in place to undertake peer review

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What is the trigger for escalation?	Very High risk areas 98% High risk areas 95% Significant risk 85% Low risk 75%
What action is undertaken on areas where score is below that which is acceptable?	QA team escalate to ward manager and matron- Discussed at HoN and action plan sent to ward manager and matron with details of failings
Sepsis 6: completed actions seem to be fall in June. **Q:** What action has been taken?	Karen Kinnear has requested Sherrie Bradshaw Sepsis Lead identify areas that require improvement and target them for extra training for the ward managers- Sherrie Bradshaw is keeping a log of this data
CDI/MRSA themes from RCA	
MRSA summary: same themes identified in both cases. How has the trust actioned these to endure sustained good practice? Who attends the RCA? Is this led by clinical teams to ensure lessons learned?	Action plans and shared learning- John Day (ICD) to advise. Lessons from RCA to be added to Clinical Governance Report CCG, Consultant, Matron Ward Manager, ICN, Microbiologist, Anti Biotic Pharmacist, DDIPC if required
IPCC	
Are written reports received from sterile services, estates etc. If not I would advise that this is commenced for governance?	To be introduced – September IPCC
Hygiene Code by exception: not discussed. How is assurance escalated?	To be included in September IPCC
Risk register: not discussed. How is assurance escalated?	Projected at IPCC – assurance not escalated currently-DDIP to add to Clinical Governance report
Sharp's: what lessons learned, what actions taken?	Findings taken to Heads of Nursing and added to Clinical Governance report Also agenda item at Health and Safety Committee
Is the trust compliant with safer sharps?	Yes However need to introduce safer sharps for insulin pens –Diabetic CNS leading on this in conjunction with pharmacy
CDI 30/7 all cause mortality	
Is this reviewed? Is the trust assured as per National guidelines?	Formal reporting to be implemented and incepted on monthly DDIPC

	report
Blood Culture Contamination Rates	
How has the trust been assured that they do not have an issue with compliance?	Consultant Microbiologist is in the process of collecting this data and will have a report for September IPCC
Estates:	
Is the information available? Is the trust assured?	John Henry to provide any requested evidence in the absence of Sam Wallace
SUGGESTIONS:	
IPC Team	
ICD does not currently review blood culture contamination rates as not a requirement to do so. Advised that this should be undertaken to assess if there is a problem with practices in the clinical area.	Consultant Microbiologist is in the process of collecting this data – this will identify areas that may require training – education
Domestic Managers	
Advised to report back to IPC committee with a written report for assurance.	To provide report for next IPCC September 2017
Estates managers:	
Advised to provide written reports back to IPC committee for assurance. In addition, I would advise that outstanding estates issues are reported back to IPC committee as this is a concern.	These have been requested and will be ready for next IPCC September
Annual Report	
Ensure abbreviations are used appropriately e.g. IPC.	Corrected as identified
No statement to say you are compliant or not with the Hygiene Code only that you endeavour to be.	Corrected and amended as required
Criterion 1: I would add the governance structure.	To be included in next year's report as advised by NHSI
Criterion 4: add in about web page, leaflets, discharge summaries etc.	To be included in next year's report as advised by NHSI
Criterion 5: MRSA screening uptake; link to later section on MRSA. At present it leaves the question of ....RCA, lessons learned, how disseminated etc.	To be included in next year's report as advised by NHSI

Criterion 6: what's your training compliance?	Added as advised by NHSI
Criterion 7: how many side rooms do you have? Do you have any rooms for TB patients etc.	120 rooms including paeds Policy in place for TB patients to be transferred if required IC001
CDI: put lapse in care data into your table.	To be added as advised by NHSI
Hygiene Code Compliance:	
To state which section is being developed and how assurance is provided.	To be added
IP workplan:	
I would review this.	
You may wish to plan against Hygiene Code, this would then support your Annual report next year.	To be amended as advised by NHSI
I would not use "business as usual" as this won't provide assurance and issues can slip until an end of year review.	Noted and will amend
RCA: add e-coli. The actions are not measurable; you may wish to strengthen them so they are focussed and SMART. The word "continue" is used a lot: suggest this is reviewed as it infers that there isn't any innovation and there is.	Noted and corrected
MRSA/CDI Recovery Plans	
Advise to develop assurance response.	MRSA plan in progress awaiting discussion with CCG ICN on her return from leave
Policies	
Currently not following National Guidelines.	Noted C diff policy is the policy in question – this relates to sampling – policy amended to state sample after first episode
Definition p6 is incorrect. It is not x3 episodes in 24hrs but X1 episode of type 5-7.	(Amended and to be re published as above)
Section 5.9: use definitions in DH guidance which defines PII and outbreak. This does not match what you have in your policy.	Noted and to be amended and sent to IPCC for ratification

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Compliance Audits	
Advise to use the national benchmark tool produced by the IPS for assurance.	IPS is incorporated in our audits –