Infection Prevention & Control & Cleanliness Annual Report 2018/19

✓0. Reference Information

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1. Purpose of Paper

1.1. Why is this paper going to Trust Board and what input is required?

For approval from Executive Committee.

2. Executive Summary

2.1. Context

The Annual Report provides assurance in terms of compliance with the Code of Practice on the prevention and control of infections and related guidance (The Health and Social Care Act 2008).

2.2. Summary

In the year 2018/19 was another year of improvements and new challenges in the continuing campaign to reduce avoidable Health Care Associated Infection (HCAI) at RJAH Orthopaedic NHS Foundation Trust.

Successes include meeting our MRSA bacteraemia target of zero for the thirteenth year running and seeing a reduction in E coli bacteraemia associated with health care. However our numbers of C.difficile cases rose and at 3 cases we were over our target of 2 cases.

We are struggling with the increased requirement for side rooms as national guidance has changed to include more antibiotic resistant organisms in the list of those needing isolation and the increase in incidence of patients with ESBL carriage on the Spinal Injuries Unit has doubled from previous years. The unit currently has one bay with doors which limits the ability to effectively cohort single sex requirements, therefore a capital bid request for 3 additional sets of doors has been submitted to secure funding.

The increased flu vaccination uptake of 60.8% against a target of 75%, demonstrates the hard work of our lead Practice Nurse facilitator to raise awareness of the benefits of the flu vaccination and included a staff story to raise awareness of the seriousness of the flu virus. Working alongside TeamPrevent and additional nurse vaccinators, improved the accessibility and availability of the flu vaccine.

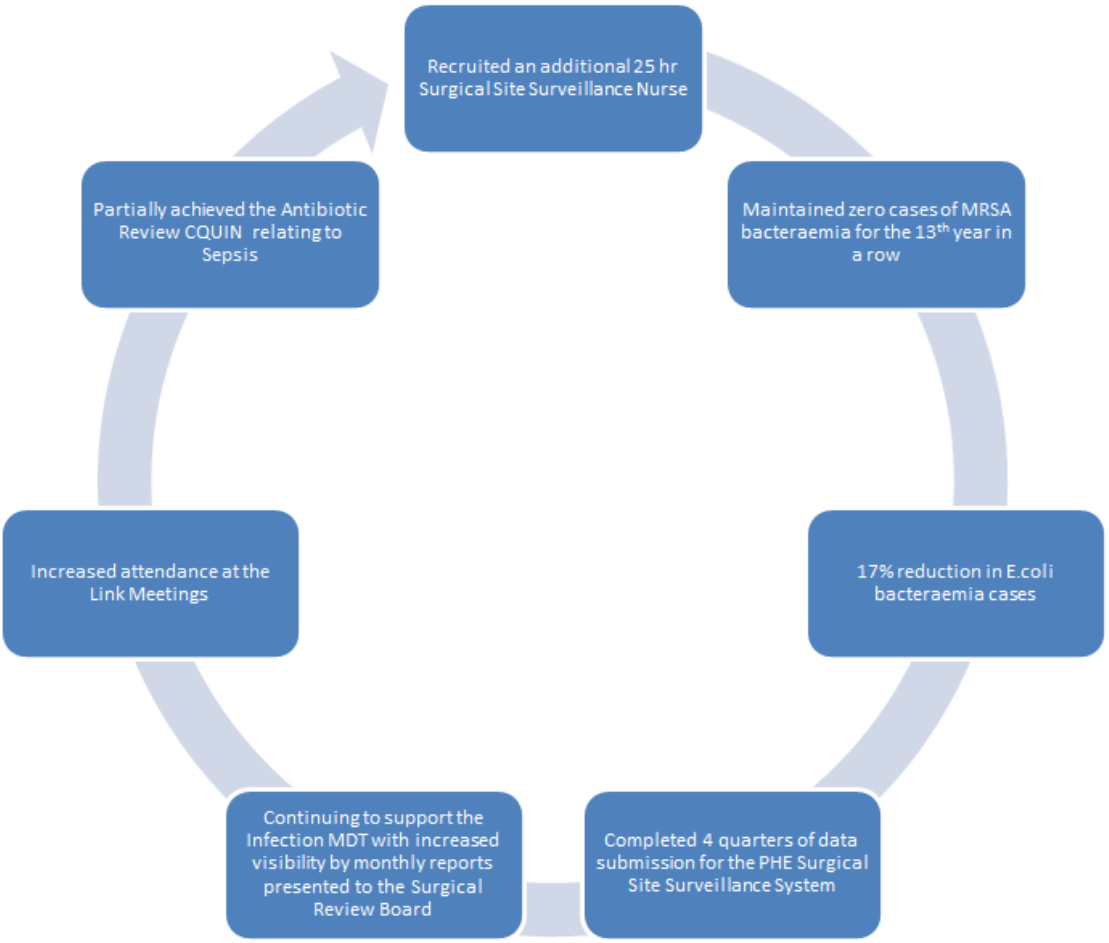
2.3. Conclusion

The Board is asked to:

(a) To note the report

(b) To discuss and determine actions as appropriate

Infection Prevention & Control Team Achievements – 2018/19



3. The Main Report

3.1. Introduction

The Director of Infection Prevention and Control (DIPC) is required to produce an Annual Report on the state of Healthcare Associated Infection (HCAI) in the organisation for which she is responsible and release it publicly according to the Code of Practice on the prevention and control of infections and related guidance (The Health and Social Care Act 2008). The Annual Report is produced for the Chief Executive and Trust Board of Directors and describes the activity of the Infection Prevention and Control Team (IPCT) during the year, including progress made against the work plan and targets identified in the Infection Prevention and Control Annual Programme. It also includes Divisional performance against key areas in Infection Prevention & Control. Ward specific audits are reported on a monthly basis through Trust wide key performance indicators (KPI's) and are displayed on public STAR boards.

3.2. Health & Social Care Act Code of Practice

The Robert Jones & Agnes Hunt Orthopaedic Hospital has registered with the Care Quality Commission and have acknowledged full compliance with the Health and Social Care Act (2008) Code of Practice (commonly known as the Hygiene Code).

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 the susceptibility of service users 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 are at risk of developing an infection so that they receive timely and appropriate treatment 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.

3.2.1. Criterion 1 a): Systems to manage and monitor the prevention and control of infection.

IPC Structure

The **Chief Executive Officer** has overall accountability for the control of infection at RJAH.

The **Director of Infection Prevention & Control** is the Executive Lead for the IPC service, and oversees the implementation of the IPC programme of work through her role as Chair of the Trust Infection Prevention and Control and Cleanliness Committee (IPCC). The DIPC approves the Annual IPC report and releases it publicly. She reports directly to the Chief Executive and the board on IPC matters. The DIPC has the authority to challenge inappropriate practice.

The **Infection Control Doctor (ICD)** is the Clinical Lead for the IPC service and is contracted for 3 sessions a week to include the microbiology ward round and microbiological reporting. The role includes:

- Advising and supporting the DIPC
- Oversees local IPC policies and their implementation by ensuring that adequate laboratory support is in place
- Attends the Water Safety Group and Decontamination Group
- Chairs the Trust Antimicrobial Stewardship Committee
- Provides expert clinical advice on infection management
- Attends the Infection multidisciplinary team meetings providing expert advice on complex/infected cases
- Has the authority to challenge inappropriate practice including inappropriate antibiotic prescribing decisions

The ICD reports to the DIPC on IPC matters.

The **Infection Prevention and Control Team** (IPCT)

The Infection Prevention and Control Team (IPCT) are the medical and nursing infection prevention and control specialists responsible for carrying out the work described in the infection control programme of work.

RJAH Orthopaedic Hospital NHS Foundation Trust (RJAH) IPCT currently consists of:

- Consultant Microbiologist: 24h infection control advice is available from the on-call consultant microbiologist
- Infection Prevention and Control (IP&C) Clinical Nurse: (1 WTE) Band 7
- Surgical Site Surveillance Nurses: (1 WTE) Band 5
- Infection Control Analyst (0.8 WTE): Band 4

The **Antimicrobial Pharmacist**: The Trust employs 0.5 WTE Antimicrobial Pharmacist who works closely with the ICD and other members of the IPC team. There is robust management of antimicrobial stewardship throughout the Trust. The role of the antimicrobial pharmacist includes:

- Attending and contributing to the Trust Infection Prevention & Control Committee meetings and the Antimicrobial Stewardship Committee meetings
- Supporting antimicrobial stewardship initiatives
- Participating in and contributing to the ward rounds with the ICD
- Carrying out audits in line with national guidance
- Providing training regarding antimicrobial stewardship to clinical staff within the Trust

Infection Prevention Control Committee

The RJAH Infection Prevention & Control Committee (IPCC) is a multidisciplinary Trust committee with outside representation from Public Health England and the CCG. The IPCC oversees the activity of the IPCT and supervises the implementation of the infection control programme of work. The IPCC met every 3 months during 2018/2019.

Attendance at IPCC

	Apr 2018	*Aug 2018*	*Nov 2018*	*Jan 2019*
DIPC	*apol*	*apol*	*apol*	*apol*
ICD	✓	✓	✓	✓
IPCN	✓	✓	✓	✓
Ass. DON	✓	✓	✓	✓
SSSN	✓	*apol*	*apol*	✓
CCDC (PHE Rep)	*apol*	*apol*	*apol*	*apol*
Antimicrobial Pharmacist	*apol*	*apol*	*apol*	*apol*
Facilities Manager (Estates & Facilities Representation)	✓	✓	✓	✓
Matron (Medicine)	✓	*apol*	*apol*	✓
Matron (Surgery)	✓	✓	✓	✓
Matron (Theatre & OPD)	✓	✓	✓	✓
Theatre Manager	*apol*	✓	*apol*	*apol*
Head of IPC SCCG & TWCCG	✓	✓	✓	✓
Clinician Rep	✓	*apol*	*apol*	*apol*
TSSU Rep	✓	*apol*	✓	*apol*

The IPC Programme of Work

The IPC programme of work 2015-2018 was specifically designed to focus on achieving full compliance with the standards identified in the Code of Practice, and the achievement of National and local infection related targets, using a template set by the Shropshire & Telford & Wrekin IPC Lead – the Trust has achieved full compliance on all the standards with the exception of having a fit-for-purpose IT system to support surveillance activity; therefore the identification of a most cost-effective solution utilising internal systems and exploring local solutions continues to be required. This has been highlighted and reported on the Risk Register.

IPC Link Practitioner System

The Infection Control Link Practitioner group meets bi-monthly.

Topics of discussion for 2018/2019 have included:

- Saving Lives toolkit revised version & feedback on current audits
- Health Care Associated Infections/PIR Documentation
- Theatres Inspection Updates
- Clinimatic/Macerator Cleaning Checklist
- Catheter Associated Urinary Tract Infections (CAUTI) Datix Reporting
- Glove Awareness Week – w/c 1st May 2018
- Urinary Catheter Card
- Daniels Sharps Training
- Waste segregation update from Facilities
- CDI cases, appeals process and shared learning
- Decontamination of a side room following discharge of patients with alert organisms
- Flu vaccine updtaes
- Increased incidence of ESBL carriage
- FIT testing for FFP3 masks
- Commode cleaning station implementation

Link Nurse Attendance

Ward	*April*	*June*	*Aug*	*Oct*	*Dec*	*Feb*
Ludlow			✓	✓		✓
OPD	✓	✓	✓			✓
POAU	✓	✓	✓		✓	
Powys			✓	✓		
Clwyd	✓	✓		✓	✓	✓
HDU		✓				
Theatres	✓	✓	✓			
Anaesthetics	✓					
Recovery	✓		✓	✓	✓	
Oswald			✓		✓	✓
Radiology						
TSSU		✓				
Gladstone					✓	✓
Wrekin	✓				✓	✓
SIU OPD	✓		✓	✓	✓	✓
Kenyon						

Alice	✓					✓
Sheldon	✓					✓
Therapies		✓		✓	✓	✓
Baschurch	✓	✓	✓	✓		✓
ORLAU	✓	✓	✓	✓	✓	✓
Library personal	✓	✓	✓	✓		✓
Orthotics		✓	✓			
Porters		✓	✓	✓		
Facilites					*Education Session*	

The wards/departments are assessed on their attendance to Infection Control link meetings and feedback is given through the STAR assessment programme.

3.2.2. Criterion 1 b): Monitoring the prevention and control of infection

Mandatory Surveillance

Blood Stream Infection

- MRSA
  There were 0 cases of MRSA bacteraemia at RJAH in 2018/19. The target remains at 0 MRSA bacteraemia, any case attributed to RJAH would be considered a never event for the Trust.

- MSSA
  There were only 2 cases of MSSA bacteraemia attributed to RJAH in 2018/19. Post Infection Reviews were carried out on both occasions and lessons learnt identified and shared via Link Nurse meetings and SNAHP.

  In the first case, other skin commensals were identified which were probably skin contaminants obtained during blood culture procedure.

  The second case was a deep tissue infection was the source of the blood stream infection, root cause analysis was undertaken and lessons learnt were shared with the multi- disciplinary team.

- E. coli (gram negative bacteraemia)
  In light of the Department of Health's new ambition to reduce healthcare associated blood stream Infections by 50% by the year 2021, the Local Health Economy felt that it would be prudent to convene a group to look at more joined up ways of working locally to try to prevent blood stream infections in our patients. Infections can occur across the wider health economy (hospital and community settings); therefore, reductions can only be achieved by working together across the whole health and social care sector.

During 2018/19 the health economy continues to focus on *E.coli* as one of the largest infection groups and this is supported by the Quality Premium for CCG's. The local health economy Infection prevention and Control (IPC) group has worked together and agreed a reduction plan with a focus to reduce E.coli by 10% or greater.

- There were 5 cases of *E.coli* bacteraemia in 2018/19 which was a 17% reduction since 17/18. All cases were reviewed individually to determine whether there were common themes to help identify priority areas for action, 1 case was related to the billary tract and the other 4 cases were linked to urinary catheters and were unavoidable.

- C. *difficile*
  There were 3 individual cases of C difficile at RJAH in 2018/19 against target of 1. The Trust appealed all 3 cases which were considered by the Commissioners in which 2 cases were upheld and agreed for removal from the Trust's actual number of cases for the purpose of calculations of financial sanctions. The 3rd case that was not upheld was declined due to not adhering to the antibiotic policy.

  The learning outcomes from the 3 cases concentrates on antibiotic prescribing and antibiotic prophylaxis. Lessons learnt include involving the surgeons in the case and tabling the surgeons responses of the rationale for further post operative antibiotic doses.

  Post Infection Reviews were carried out on all 3 occasions and lessons learnt identified and shared via Link Nurse meetings and SNAHP, an example of which is shown below:

Robert Jones and Agnes Hunt 2018/19 CDI Post Infection review Outcomes							
Quarter	**CCG**	**Date of Specimen**	**Ward**	**Appeals panel decision**	**Rationale for decision**	**Appeals Panel Additional Comments/Actions**	**Provider assurance**
1	SCCG	04/09/18	Powys	Upheld	1. Appropriate antibiotics prescribed 2. No indication to suspect transmission	The panel noted the response by staff to the onset of diarrhoeal symptoms were immediate with timely stool specimen collection and prompt isolation.	Share the outcome of the investigation with all staff directly involved in the incident and staff from the area where the incident occurred Face to face 'Keeping the Skills Alive' training dates arranged
2	TWCCG	17/01/19	Clwyd	Upheld	1. No evidence to suggest cross infection	1. The panel request further information, as it is unclear to the reason for extra doses of cefuroxime being administered post surgery. 2.The panel noted the immediate response of staff to diarrhoeal symptoms; obtaining a timely stool specimen and prompt isolation.	Antibiotic guidelines- MRSA negative: Cefuroxime 1.5g Repeat dose every 6hours in prolonged surgery. Maximum of 3 doses. History of MRSA: Vancomycin 1g. Surgeons response "The reason for 2 antibiotic shots post surgery is due to metal implanted into the patient. It is standard protocol in RJAH in spines to give 2 post op antibiotic doses for patients having surgery with implants"

Face to face 'Keeping the Skills Alive' training delivered during October 2018, proved beneficial and provided Clwyd Ward with the knowledge and skills in the exemplary management of their first C. *difficile* infection.

Surgical Site Surveillance (SSI)

Since July 2008, hospitals are required to have systems in place to identify patients who are included in the surveillance and later develop a surgical site infection.

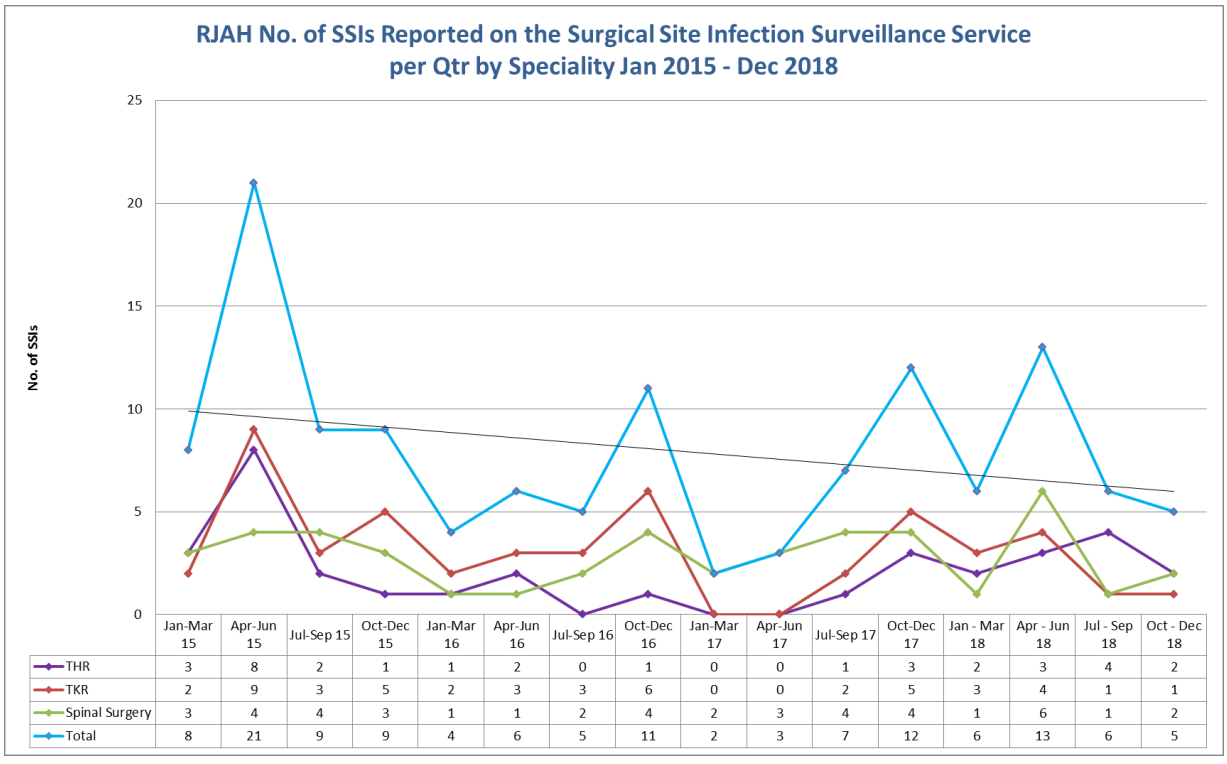
From January 2018 – December 2018, data on 4425 operations – total hip replacements, total knee replacements and spinal surgery was collected by the RJAH surgical site surveillance team. During this period, there have been a total of 30 SSIs reported, 11 Hips, 9 Knees, 10 Spinal, compared to a total of 24 SSIs reported Jan 17 – Dec 17 (4 Hips, 7 Knees, 13 Spines).

PHE analyses the submitted data at quarterly intervals to identify hospitals whose SSI incidence falls above the 90th or below the 10th percentiles nationally for a given surgical category, enabling the Trust to benchmark itself against the national rate of infection.

Surgeon specific data allows the surgical site surveillance team to provide analysis of infection rates to individual surgeons as part of their validation and appraisal process.

The graph below shows a downward trend of the total number of SSIs that have been reported to PHE between Jan 2015 and Dec 2018. The graph also shows the breakdown by Hips, Knees and Spinal specialities.

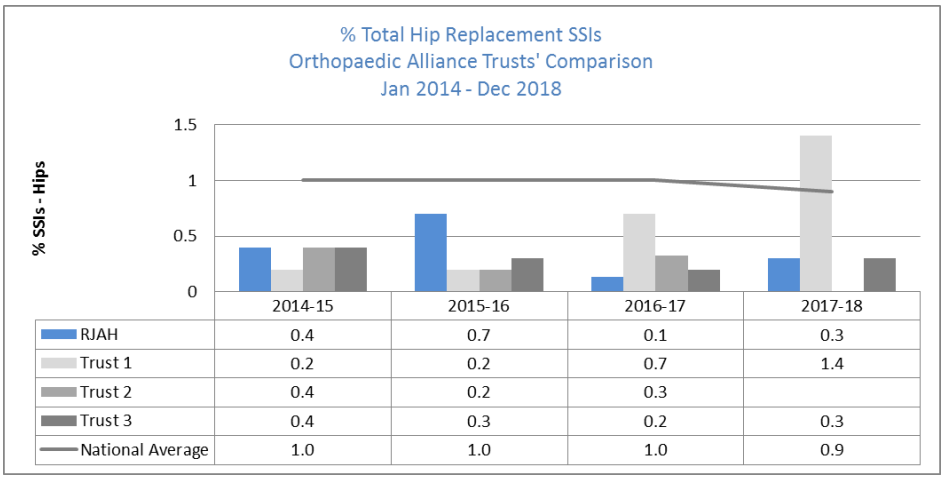
The Trust submits surgical site infection data to the PHE database on a quarterly basis; these reports are always one quarter in arrears to allow a window of time for any infections to present, Jan 19 – Mar 19 will be reported at the end of June 2019.



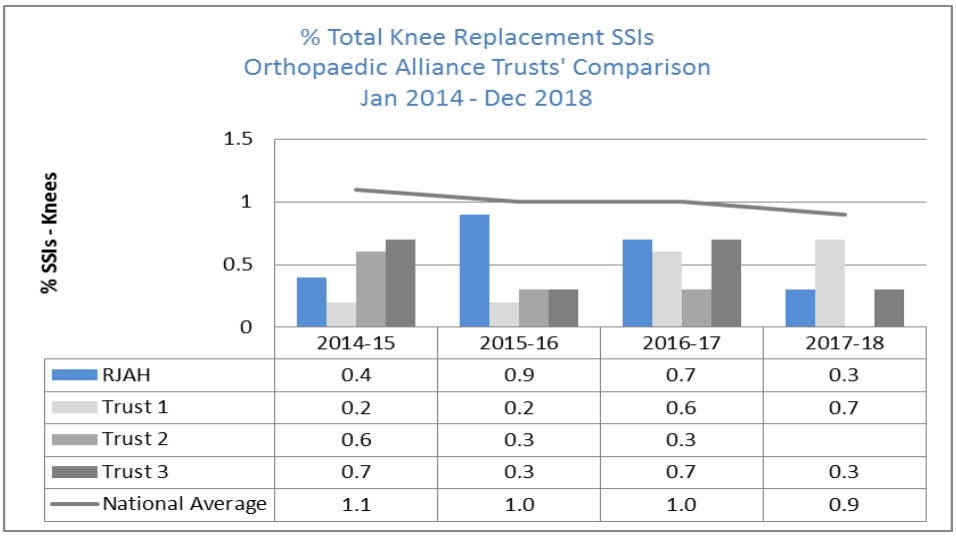
	Jan-Mar 15	Apr-Jun 15	Jul-Sep 15	Oct-Dec 15	Jan-Mar 16	Apr-Jun 16	Jul-Sep 16	Oct-Dec 16	Jan-Mar 17	Apr-Jun 17	Jul-Sep 17	Oct-Dec 17	Jan - Mar 18	Apr - Jun 18	Jul - Sep 18	Oct - Dec 18
THR	3	8	2	1	1	2	0	1	0	0	1	3	2	3	4	2
TKR	2	9	3	5	2	3	3	6	0	0	2	5	3	4	1	1
Spinal Surgery	3	4	4	3	1	1	2	4	2	3	4	4	1	6	1	2
Total	8	21	9	9	4	6	5	11	2	3	7	12	6	13	6	5

How does RJAH compare to other Trusts within the Orthopaedic Alliance who have completed 4 quarters data each year?

The following graphs show the comparison of SSI rates for Hips and Knees. RJAH consistently perform below the national average. 'Trust 2' show no data for 2017-18 as their submission for this period was 3 quarters only.

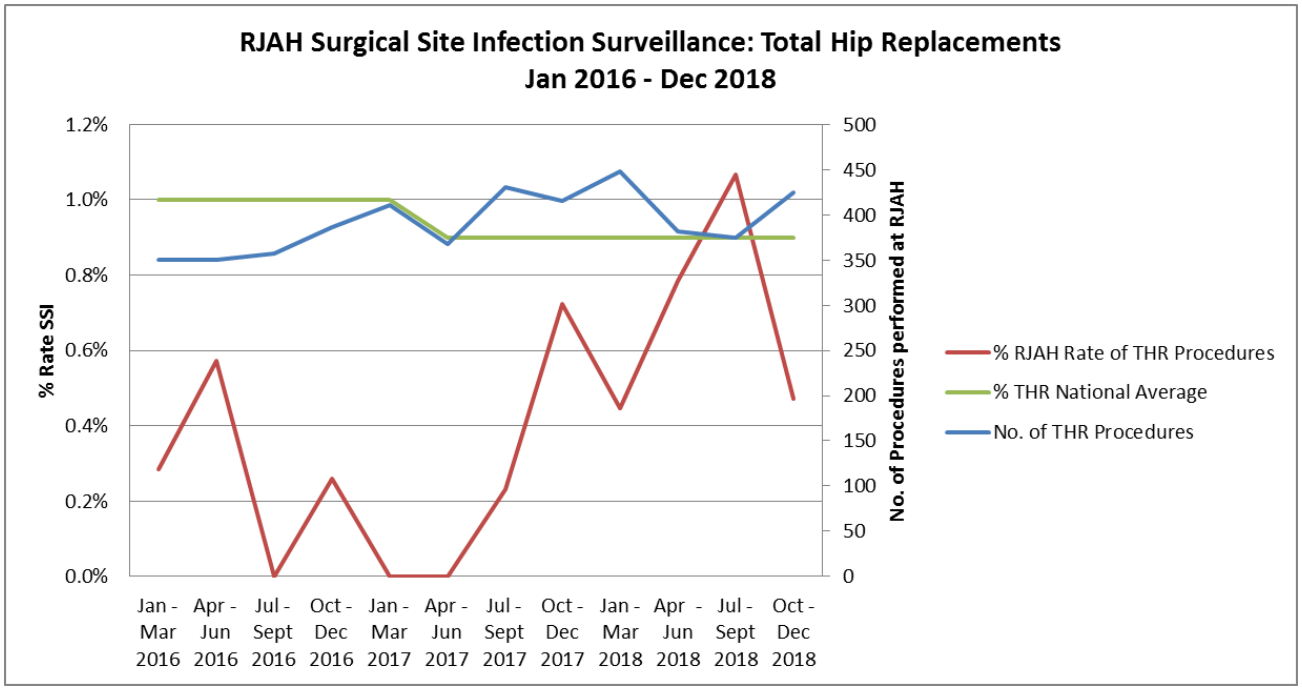


	2014-15	2015-16	2016-17	2017-18
RJAH	0.4	0.7	0.1	0.3
Trust 1	0.2	0.2	0.7	1.4
Trust 2	0.4	0.2	0.3	
Trust 3	0.4	0.3	0.2	0.3
National Average	1.0	1.0	1.0	0.9

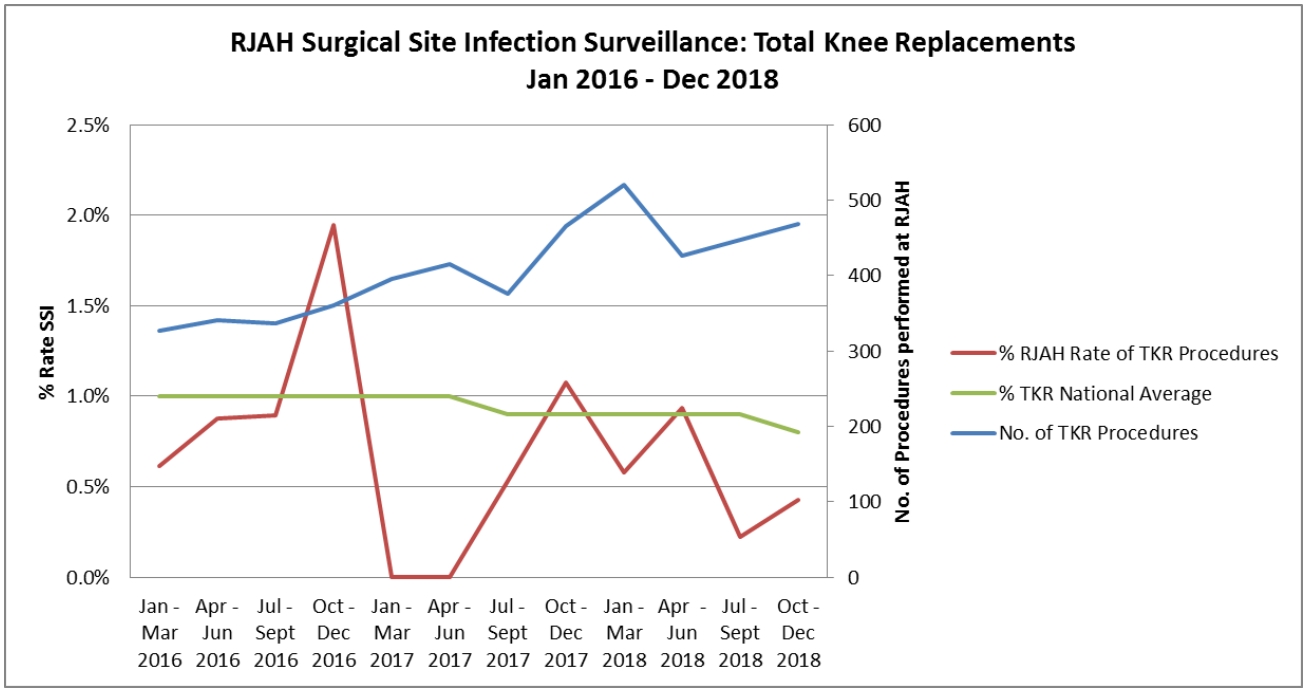


	2014-15	2015-16	2016-17	2017-18
RJAH	0.4	0.9	0.7	0.3
Trust 1	0.2	0.2	0.6	0.7
Trust 2	0.6	0.3	0.3	
Trust 3	0.7	0.3	0.7	0.3
National Average	1.1	1.0	1.0	0.9

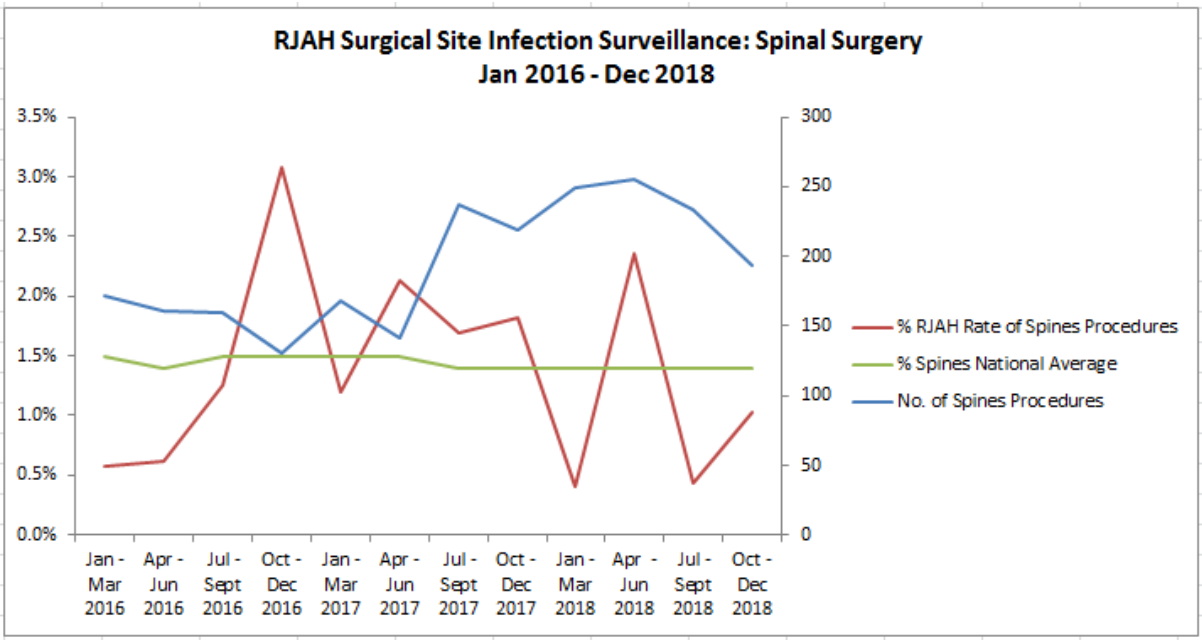
The graph below shows the RJAH % rate of SSI for total hip replacements has been consistently below the national average through 2016 and 2018 with the exception of Jul-Sept 18.



The RJAH rate of SSI for total knee replacements has been consistently below the national average through 2016 and 2018, with the exceptions being Oct-Dec 2016, Oct – Dec 2017 and Apr – Jun 2018.



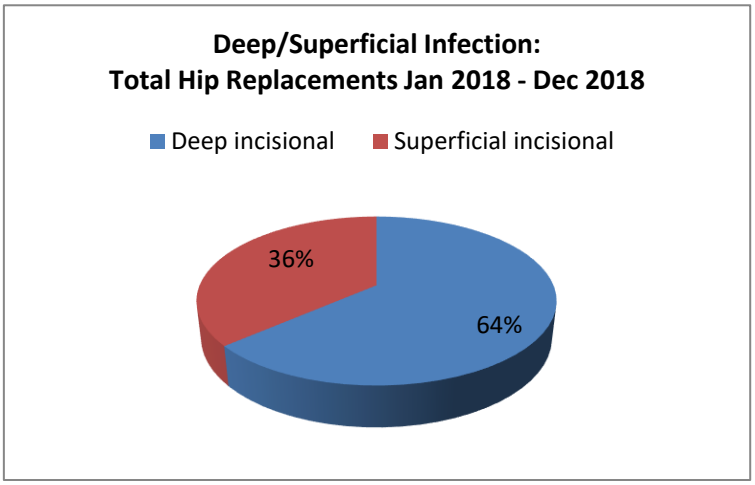
The RJAH rate of SSI for spinal surgery has been below the national average 7 quarters out of the 12 during the period Jan 2016 and Dec 2018, with peaks showing in Oct-Dec 2016 and Apr – Jun 2018.

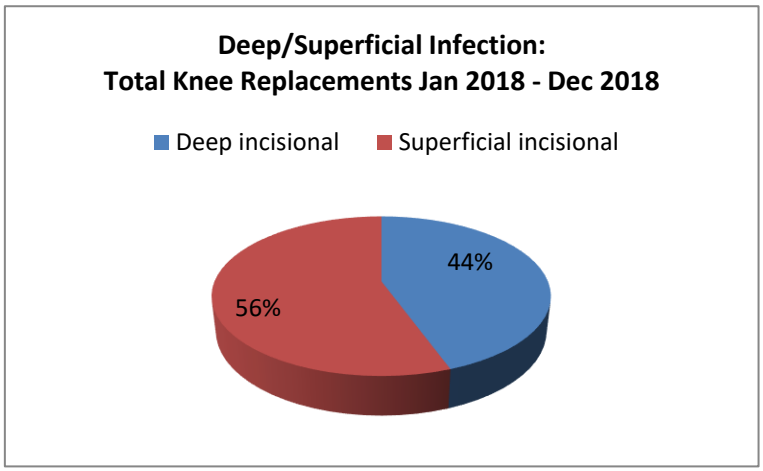


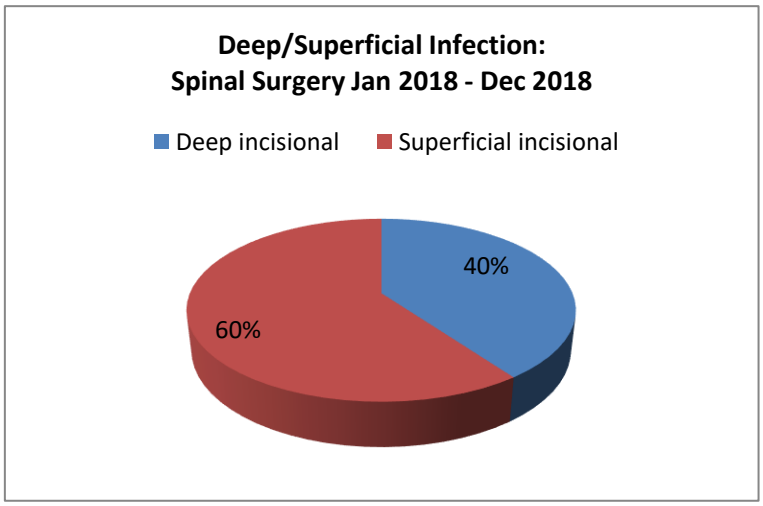
The pie charts below show the infections reported split by Deep/Superficial:

Description of Deep Incisional Infection: SSI involving the deep tissues (i.e. fascial & muscle layers and the infection appears to be related to the surgical procedure.

Description of Superficial Infection: SSI involves only the skin or subcutabeous tissue of the incision.


Deep/Superficial Infection:
Total Hip Replacements Jan 2018 - Dec 2018
Deep incisional
Superficial incisional
36%
64%


Deep/Superficial Infection:
Total Knee Replacements Jan 2018 - Dec 2018
Deep incisional
Superficial incisional
44%
56%

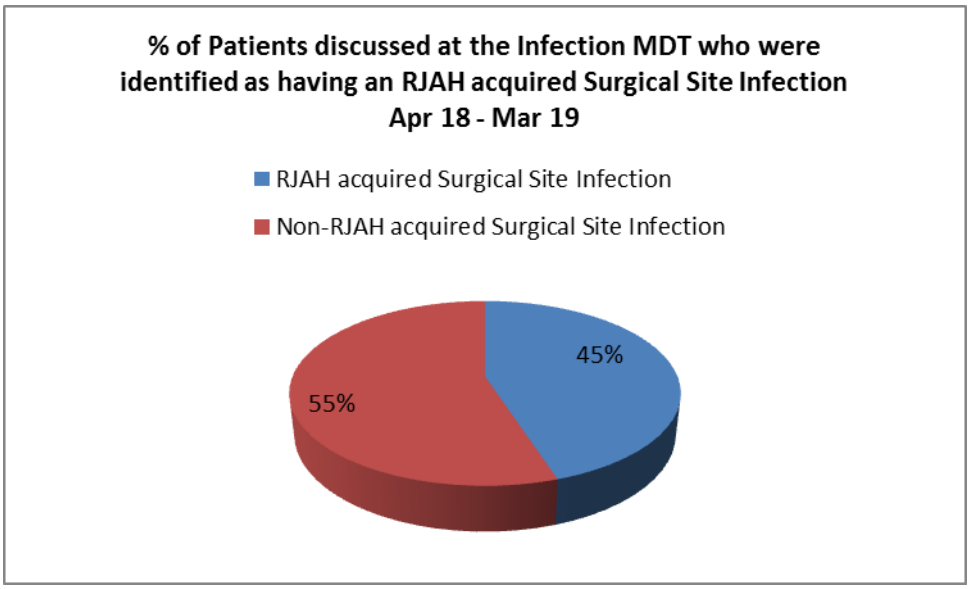

Deep/Superficial Infection:
Spinal Surgery Jan 2018 - Dec 2018
Deep incisional
Superficial incisional
40%
60%

Infection MDT

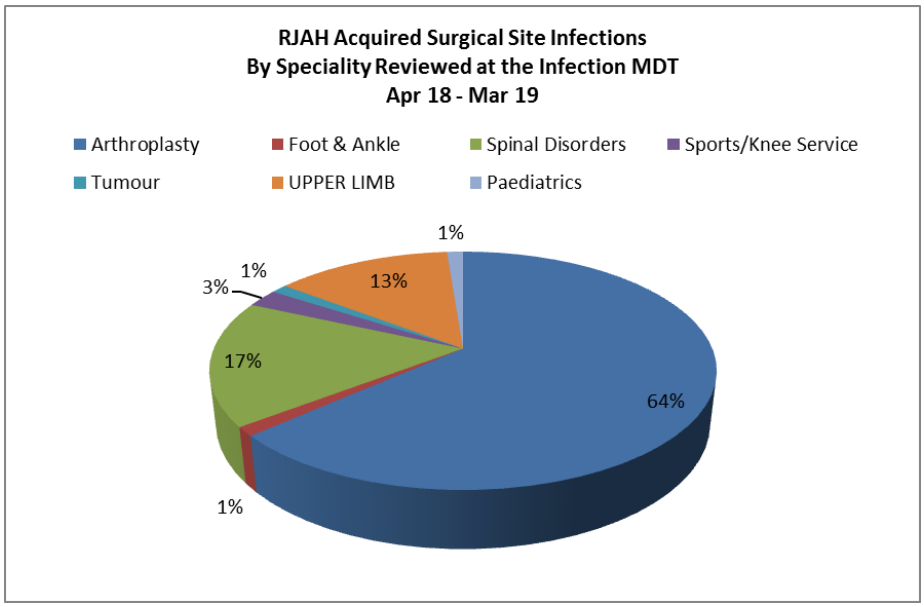
The Infection MDT commenced during October 2017, led by Consultant Surgeons within the Trust to review all patients who have been identified as having a surgical site infection. The purpose of the MDT is to discuss complex infections and to make recommendations for the surgeons' treatment plan. The Infection MDT is attended by the Consultant Microbiologist, Antimicrobial Pharmacist, the Infection Prevention & Control Team, Radiologist and Histopathologist. It is an opportunity for all surgeons to share learning and peer support.

There have been 189 patients reviewed during 2018/19, of which 85 (45%) were identified as having a surgical site infection which was acquired at RJAH. PHE's Surgical Site Surveillance System requirements are to report hips, knees and spines; the Infection MDT reviews patients from all orthopaedic specialities, e.g. upper limb, lower limb, sports & spinal injuries.

The pie chart below shows the split of RJAH and non-RJAH acquired SSIs during this reporting period:



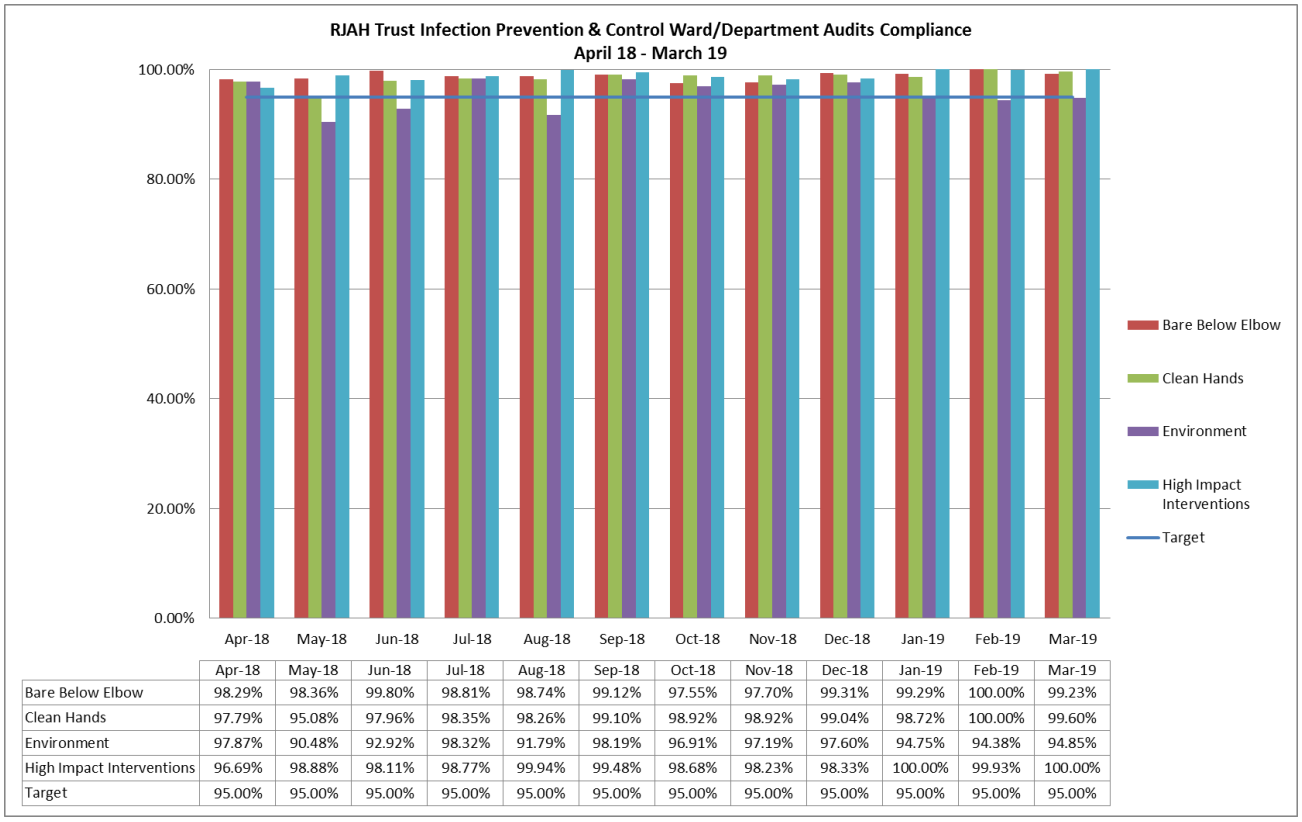
The chart below shows how the RJAH acquired surgical site infections are split by speciality during this reporting period:



Infection Prevention & Control Ward/Department Audits

Wards and departments complete a robust package of infection prevention and control audits across the year. The toolkit comprises of environmental auditing, which highlights patterns of non-compliance to be addressed, the hand hygiene audit tool includes bare below the elbows and a revised set of High Impact Interventions (Saving Lives) tool was implemented January 2018.

The graph below shows the Trust's compliance against each of the individual audits. The results show how the Trust consistently achieves the 95% target in all areas each month, with the exception of the Environment Audits..



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Bare Below Elbow	98.29%	98.36%	99.80%	98.81%	98.74%	99.12%	97.55%	97.70%	99.31%	99.29%	100.00%	99.23%
Clean Hands	97.79%	95.08%	97.96%	98.35%	98.26%	99.10%	98.92%	98.92%	99.04%	98.72%	100.00%	99.60%
Environment	97.87%	90.48%	92.92%	98.32%	91.79%	98.19%	96.91%	97.19%	97.60%	94.75%	94.38%	94.85%
High Impact Interventions	96.69%	98.88%	98.11%	98.77%	99.94%	99.48%	98.68%	98.23%	98.33%	100.00%	99.93%	100.00%
Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

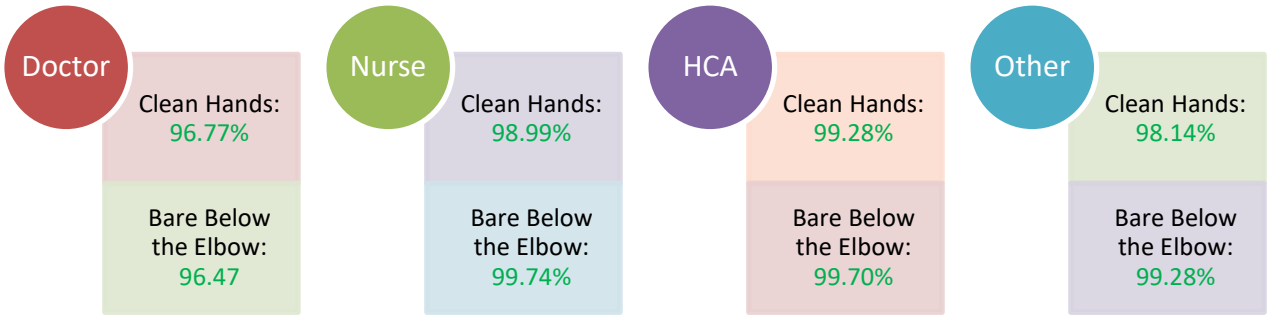
The most common areas of the Environment Audit non-compliance:

- Floors clean and in good state of repair
- Waste, bins are enclosed, foot operated and soft closing
- Waste, staff training is up to date
- Waste, bags are not tied to trolleys
- Sharps, temporary closure mechanisms are in use

Staff are encouraged to raise requisitions with the Estates department, waste and sharps awareness sessions have been held at Link meetings to support staff in raising awareness and educate staff within their departments.

Hand Hygiene & Bare Below the Elbows

The image below shows the hand hygiene and bare below the elbow compliance split by designation. The 'Other' category captures other members of the multi-disciplinary team, such as therapy support, pharmacists and students.



Changes have been made to the hand hygiene audit form to include an action taken section for completion on areas of non-compliance where the noting of the initials of indivuals are encouraged to enable specific feedback to be provided where necessary.

High Impact Interventions (Saving Lives)

During January 2018, a revised set of High Impact Interventions (Saving Lives) audits were implemented across the Trust. The aspects of care, volume and compliance of audits are shown in the following table:

High Impact Interventions	No. audits completed	% Compliance
Antimicrobial Prescribing	354	99%
Antimicrobial Secondary Care	164	98%
Central Venous Access Devices - Insertion Action	185	100%
Central Venous Access Devices – Ongoing Care	1758	100%
Chronic Wounds - Wound Care Phase	1265	100%
Peripheral Vascular Access Devices – Insertion Action	1965	100%
Peripheral Vascular Access Devices – Ongoing Care	9090	98%
Preventing Surgical Site Infections - Intra-Operative Phase	344	100%
Preventing Surgical Site Infections - Pre-Operative Phase	180	100%
Urinary Catheter - Insertion Phase	3372	100%
Urinary Catheter - Routine Maintenance	8892	99%

Quality Validation Auditing

The peer review audits are complemented by validation audits undertaken by the infection control team.

Areas reviewed in 2018/19 are shown below. All areas received copies of audits completed alongside action plan templates and suggestions for improvements in the clinical environment. Staff are encouraged to use the 'Planet FM' system to document environmental issues requiring estates attention.

Theatres

Areas of improvements adressed include:

- De Cluttering of the theatre corridors
- No clear responsibilities for cleaning
- Dust and dirty wheels on the stacks
- Betadine staining to the floors
- Dust and debris to the floors in the ladies changing rooms

TSSU

Areas of improvements adressed include:

- Build-up of scale on the washers
- Floors and walls damaged requiring attention
- Clutter and supplies stoed on the floor
- Difficulty in cleaning TSSU B due to time

Hydrotherapy Pool

Areas of improvements adressed include:

- Staff experiencing heat exhaustion during cleaning
- Cleaning rota not identifying cleaning responsibilities
- Shower chairs require replacement
- A Hydrotherapy Pool standard operating procedure required
- A Hydrotherapy Pool emergency plan required

Orthotics

Areas of improvements adressed include:

- No privacy curtain for when patients undergoing plaster application
- Build- up of scale in the plaster sink
- Cluttered shelves with open stored clinical equipment, recommend cupboard doors to be fitted to prevent collections of plaster dust
- Clinical equipment being stored in an office environment

Orthotics RSH

Areas of improvements adressed include:

- Limited storage for clinical equipment within clinical room
- Lack of hand hygiene facilities for office staff receiving soiled footwear
- Taping to floor mat damaged and unable to be cleaned effectively
- Poor access to sluice activities
- Poor ventilation

Gladstone

Areas of improvements adressed include:

- Lack of hand washing posters
- Extraneous items stored in the sluice
- Isolation signs not laminated
- Beds stored in corridors
- Linen cages uncovered stored in corridor
- Cluttered lockers
- Cluttered corridors

Alice

Areas of improvements adressed include:

- Wall ares around sinks in bays in poor state of repair
- Plugs in clinical hand wash basins
- No hand hygiene posters above the sinks
- Stained grout and poor finish in parents shower room
- Taps non compliant in sluice

Childrens OPD

Areas of improvements adressed include:

- Hand wash basins non compliant in the plaster room
- Paint peeling in the toilets
- Water pipes exposed in chidrens toilets
- No hand hygiene signs above the sinlks
- Bins not hard sided

Wrekin

Areas of improvements adressed include:

- Build-up of waste in the sluice
- Orange bags next to yellow bags (should be separated)
- Thick dust on the bottom of the observation machine (labelled as clean)
- Rust on floor in bathroom from old bin
- Dressing trolley cluttered and stained
- Cluttered lockers

Other Audits Undertaken include:

- Commode Audit
- Shower Chair Audit

Commodes *19	No. Compliant	% Compliance
Arm Rests Good Condition	14	74%
Back Rest Good Condition	15	79%
Foot Rest Visibly Clean	17	89%
Labelled as Clean	18	95%
Underneath of Seat Visibly Clean	18	95%
Arm Rests Visibly Clean	19	100%
Back Rest Visibly Clean	19	100%
Foot Rest Good Condition	19	100%
Frame Visibly Clean	19	100%
Frame Good Condition	19	100%
Top of Seat Visibly Clean	19	100%
Top of Seat Good Condition	19	100%
Underneath of Seat Good Condition	19	100%
Wheels Visibly Clean	19	100%
Wheels Good Condition	19	100%

Shower Chairs *15	No. Compliant	% Compliance
Labelled as Clean	8	53%
Top of Seat Visibly Clean	12	80%
Foot Rest Visibly Clean	13	87%
Foot Rest Good Condition	13	87%
Top of Seat Good Condition	14	93%
Underneath of Seat Visibly Clean	14	93%
Arm Rests Visibly Clean	15	100%
Arm Rests Good Condition	15	100%

Back Rest Good Condition	15	100%
Back Rest Visibly Clean	15	100%
Frame Visibly Clean	15	100%
Frame Good Condition	15	100%
Underneath of Seat Good Condition	15	100%
Wheels Visibly Clean	15	100%
Wheels Good Condition	15	100%

A rolling replacement programme continues and actions undertaken on individual wards.

A re-audit is scheduled for September 2019.

3.2.3. Criterion 2: Provide and maintain a clean and appropriate environment

The Trust understands the importance of a clean, appropriate environment and focuses on providing excellent outcomes.

Cleanliness

Cleaning is provided by the Trust's in-house team of cleaners and deep cleaners; the internal team is supported by external window cleaners and pest control operatives. Cleaning staff are allocated to their own area, giving them ownership of the standard; the number of hours for each area is determined by the Credits for Cleaning information system, with further input from local stakeholders, on a risk adjusted basis. The department has been supported by the infection control committee to recruit an extra member of staff for the theatre night shift, focusing on TSSU.

Outcomes for cleaning are monitored through several sources including internal monitoring, internal patient satisfaction surveys, the PLACE assessment and the CQC inpatient survey. Resources are dynamically moved around the Trust so that the best standard is achieved in all areas.

As part of the agenda for change band 1 closure, all new staff will be appointed to an enhanced role where they will take ownership of the environment, in reporting anything that prohibits them from effectively cleaning. All current staff have also been offered this opportunity.

Cleanliness – Deep Cleaning

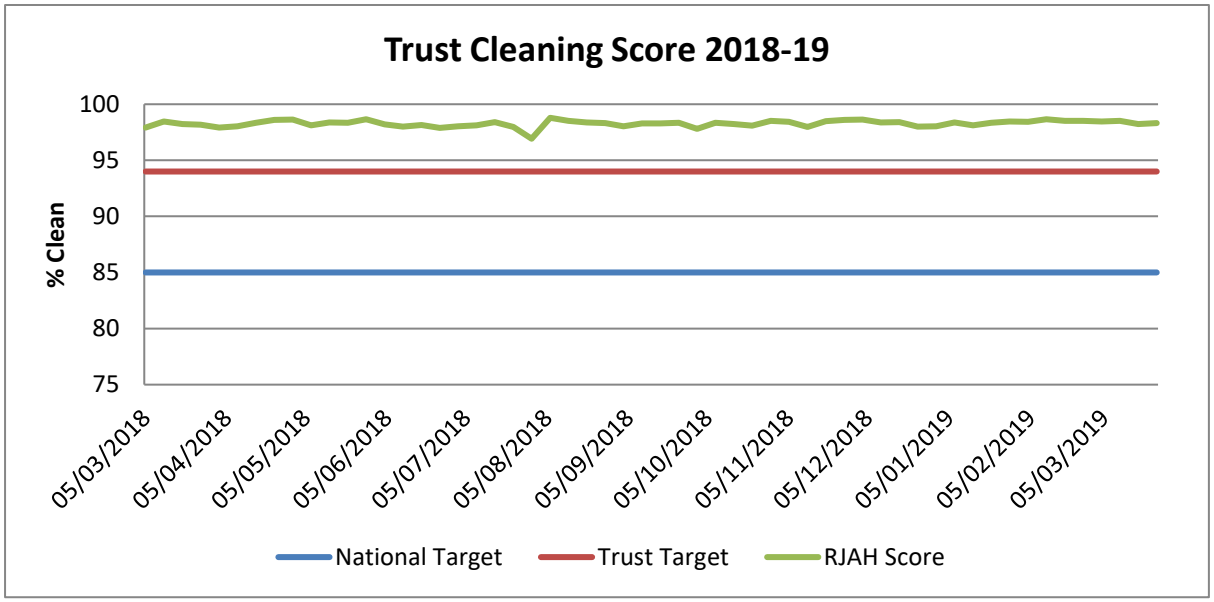
Whilst routine cleaning is completed in all areas on a daily basis, staff in high risk areas are supported with extra staff to complete a deep clean on a weekly basis. In the very high risk area of theatres there is a rolling deep clean programme that runs alongside the routine clean; cleaning in these areas is completed over night, when the theatres are not in use, to provide the most effective service.

In case of an outbreak, the Trust recognises the potential need to employ the use of technologies such as hydrogen peroxide vapour for the fogging of facilities and equipment. The Trust now also has a working relationship with Dewpoint Solutions, whose service can be called upon in less than 24 hours. Responses to date have been quick, effective and professional.

5 side rooms have undergone HPV fogging treatment in 2018/19; in each case a stringent process of isolation is undertaken by the estates team alongside a physical clean of the environment and equipment prior to completion.

Cleanliness – Internal Monitoring

The Housekeeping Department has devised an effective sign-off sheet that allows staff to easily demonstrate the work they have completed and alert the next person on shift to any outstanding requirements. Evidence of cleaning is retained by the department and is validated by supervisor monitoring and managerial spot checks.



Internal monitoring is carried out every day, visiting all areas on a weekly basis. Very high risk areas are monitored by a clinical team to ensure the broadest picture is seen. All required improvements identified by the audits are acted upon by the internal team and the results, along with the patient survey, go to the Infection Prevention & Control Committee on a quarterly basis.

The Trust has a risk based national cleanliness target of 85%, internally the Trust has set a 94% target, for the year 2018/19 the Trust achieved an average score of 98.27%.

Cleanliness – Patient Satisfaction – Internal

Feedback from service users is very important, internal monitoring very much aligns to the feedback PALS (Patient Advice and Liaison Service) receive from the patient. On a monthly basis an internal team speaks to patients one to one and also reviews feedback forms that the patient can fill in privately. The results are fed back to the Estates and Facilities team to act upon.

Further to the categorisation of cleanliness standards through the patient surveys, the department also reviews every comment as part of its 360° review and learns as a team from negative feedback but also highlights the numerous positive comments associated with the hard work of the cleaning team.

Overall comments in 2018/19 comments have been very positive, with no overarching negative themes.

Cleanliness and Environment - Kitchen

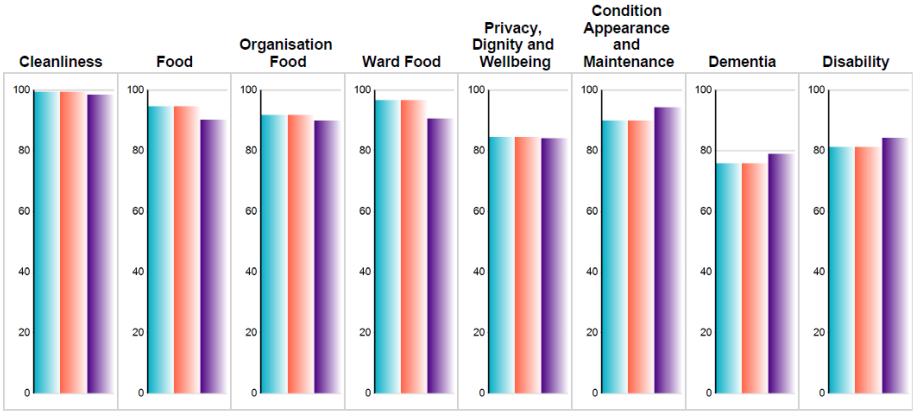
The Trust kitchen retained its 5 star food hygiene rating, undergoing an environmental health inspection in August 2018.

Supporting this inspection, the Trust procures a separate external food safety audit which produces a detailed action plan.

PLACE – Patient Led Assessment of the Care Environment

The 2018 PLACE assessment identified many positives for the Trust and also areas to work upon.

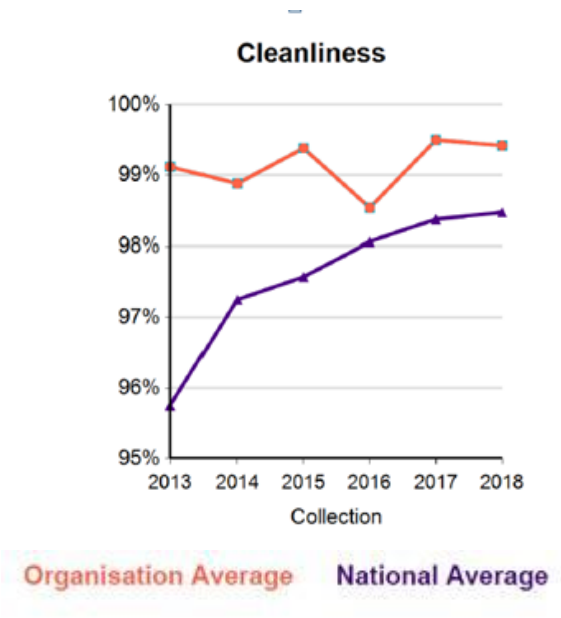
ROBERT JONES & AGNES HUNT ORTHOPAEDIC HOSPITAL- Collection: 2018



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3245.0000	268.7056	108.8275	159.8781	370.6666	1435.0000	681.3571	503.8697
Available Score (Actual)	3264.0000	283.9661	118.5880	165.3781	438.0000	1594.0000	898.8571	620.3697
Site Score	99.42%	94.63%	91.77%	96.67%	84.63%	90.03%	75.80%	81.22%
Organisation Average	99.42%	94.63%	91.77%	96.67%	84.63%	90.03%	75.80%	81.22%
National Average	98.47%	90.17%	89.97%	90.52%	84.16%	94.33%	78.89%	84.19%

In relation to cleanliness and the environment;

- The Trust has maintained high scoring feedback across cleanliness and food metrics, shown improvement on privacy, dignity, wellbeing and disability, but has marginally lower scores for condition/appearance and dementia.
- Some findings were easy to address with immediate actions, others raised debate regarding individual perception. Longer term solutions have been raised for consideration in Trust strategies and the department feels that technology will overtake the long term need to fulfil individual criteria.
- Cleanliness maintained its high standard, consistent with previous years and the internal reporting that goes to the Infection Control Committee quarterly. The few issues identified were mostly related to attention to detail, an example build slight build-up of dust in door well ledges; all issues were resolved within days following the report.



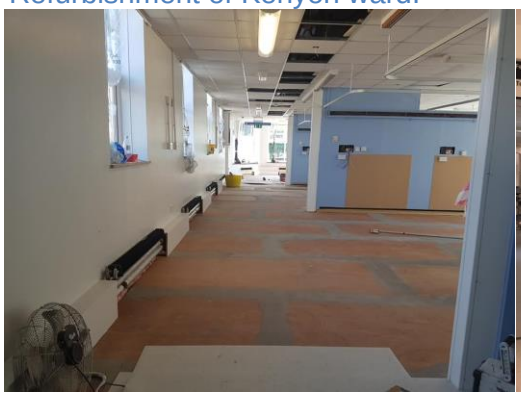
All PLACE elements are addressed through the quarterly Infection Prevention & Control Committee; these include elements that fall outside of Criterion 2; cleanliness and the environment.

In 2018/19; the Estates project team has moved forward with improvement identified through previous PLACE audits and areas picked up through internal & external audits. These have included:

- Refurbishment of Alice ward parent's facilities; including new shower room.

Infection Prevention & Control & Cleanliness Annual Report 2018/19

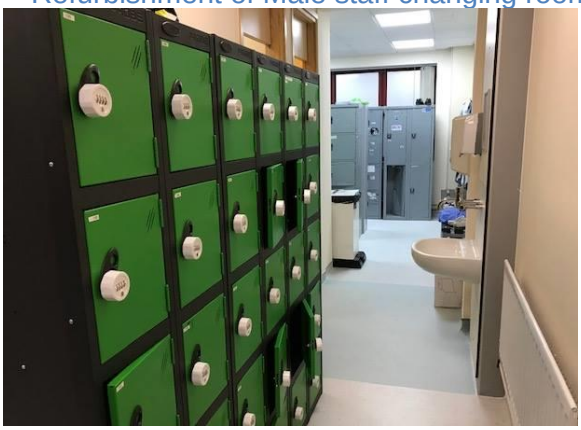
- Refurbishment of Kenyon ward.




- Addition of 2 additional bays on Powys & Clwyd ward.

- Redesign of Clwyd ward clinical areas to include a designated treatment room.


- Refurbishment of Male staff changing room for theatres.




- Refurbishment of the occupational therapy flat – used by patients on MCSI.


Linen

In 2018/19; quarterly review meetings continued to ensure standards relating to the provision of linen were monitored. This has included closing out of the action plan following a site audit and procuring bespoke washable covers for contingency linen supplies.

Estates Department Contribution to the Clean and Appropriate Work Environment

Estates department activity is essential in delivering the IPC agenda, and is delivered under the principles outlined in two main documents:-

1. Health Building Note 00-09 (Department of Health, 2013 -which supersedes and replaces all versions of Health Facilities Note 30) and covers the importance of a clean, safe environment for all aspects of Healthcare.

2. Health Technical Memorandum 04 01, The Control of Legionella, hygiene, “safe” hot water, cold water and drinking water systems.”

Part A: Design, installation and testing and

Part B: Operational management. (Department of Health (DOH) 2006). CWP’s ‘control of Legionella’ closely adopts the requirements of the above HTM.

Changes to the Estates’ management structure in Q3 18/19 has led to the appointment of an Estates Manager - Compliance and Sustainability, and substantial work has been undertaken since to increase the robustness of the department’s management of conformity to relevant legislation and guidance of such.

The Estates and Facilities helpdesk system, which also incorporates the planned maintenance tracker, has been recently upgraded with a rollout later in the summer. This will enable Estates and Facilities to monitor and report on progress of works and compliance.

Water

The control of water is covered by the legal requirements of the Health & Safety at Work Act 1974 concerning risks from exposure to legionella and guidance on compliance with the relevant parts of the Management of Health and Safety at Work Regulations 1999.

Water safety is managed and controlled by the estates department to guidance HSG274 and HTM 04. The Estates department continues to employ a third party contractor to provide technical advice for water services and undertake water risk assessments on Trust properties every two years, or where required following incidents or significant infrastructure changes. There is a written site specific scheme of control for each inpatient premises. Eurofins provide an internet based water testing database storage and reporting for statutory

test results. There is also a three monthly review of test results, control measures and procedures at the Water Safety Group to ensure compliance with current legislation and these results are published at the Infection Prevention Control Working Group.

The Trust have appointed an Authorising Engineer (Water) (AE(W)) in Q3 18/19. The AE(W) is a 'critical friend', a requirement of HTM 04-01b and offers technical advice to the Estates Engineers, auditing the management of water safety and increasing the Trust's resilience and bolsters the management of water hygiene.

Estates Operational Service continually undertake water tests throughout the Trust estate, this water testing is carried out under legislation and guidance set out by The Health & Safety Executive and the Department of Health. Testing is standard practice at RJAH to ensure robust control of waterborne infections such as leginaellosis; it is a method of using quantitative data to measure that our planned maintenance is successfully controlling growth of microorganisms in the potable water supply. During April 18 – March 19 at total of 975 water sample tests were undertaken, this is a greater frequency than required by guidance, the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

In response to these tests, thermal disinfection has been undertaken in some areas domestic water supplies – this process has increased efficacy and reduces costs as the works are now completed by the in house Estates' Mechanical Technicians. Disinfection is often employed to manage domestic water hygiene.

Decontamination Group

Decontamination covers the theatre and sterile services environment under the guidance of HTM 03-01.

Decontamination is led and monitored by the estates department supported by their third party accredited Authorising Engineer AE(D) .

Accredited third party contractors revalidates theatres on an annual basis, providing an inspection and reverification report. These reports are then reviewed by the AE(D)

The RJAH estates team maintain a local testing regime on a monthly basis to proactively manage any issues with compliance.

Further, there is a three monthly review of test results, control measures and procedures to ensure compliance with current legislation and these results are published at a sub-committee of the Infection Prevention & Control & Cleanliness Committee.

For the year 2018/19, all theatres passed their reverification based on their install specification. The Trust AE (Ventilation) has been sighted on all reports and any remedial works required.

Installation of a local Reverse Osmosis (RO) Plant was completed in Q4 18/19. This equipment increases patient safety by supplying pure water to the endoscope washer in line with HTM 01-01d and BSEN 15883.

Ultrasonic bath periodic testing and washer disinfector (endoscopy) periodic testing is being brought in house and will be completed by the Estates Technicians from Q1 19/20.

Best Practice Sharing

The Estates & Facilities team has actively participated in sharing of good practice – this year collaborating with Shrewsbury & Telford Hospitals, The Walton Centre and Cumbrian Partnership NHS Foundation Trust.

Key areas of discussion have included:

- Monitoring – systems, public signage and action allocation.
- Compliance – particularly in relation to the Premises Assurance Model (PAM).
- Water Safety – training, control measures and general awareness of the implications of water hygiene.

Clinical Waste

The Trust had to instigate its contingency plans with regards to disposal of clinical waste. The whole team pulled together to ensure that site and site user safety was maintained at all times. There have been no incidents relating to the management of waste on site, the Trust reports on a frequent basis to NHSi and no concerns have been raised.

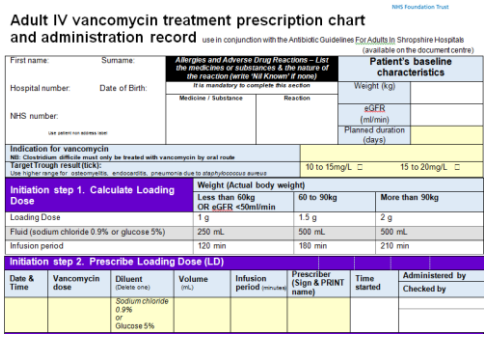
Whilst the situation has more control, the department is still working hard with its partners to ensure the smooth and compliant running of the waste service at the Trust.

3.2.4. Criterion 3: Ensure appropriate antimicrobial use

Pharmacy

Antimicrobial Stewardship 2018-19
At RJAH

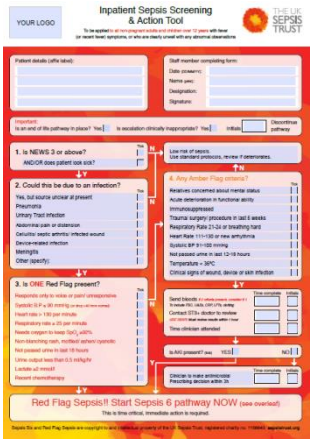
ANTIMICROBIAL STEWARDSHIP



Adult IV vancomycin treatment prescription chart and administration record

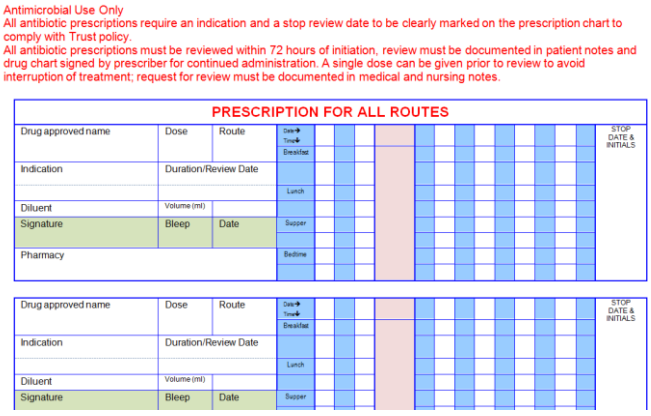
Trust wide implementation of vancomycin chart, improving vancomycin treatment dosing and patient safety.

Introduction of a Gentamicin calculator onto the RJAH intranet (Applications section), to improve gentamicin prescribing and patient safety.



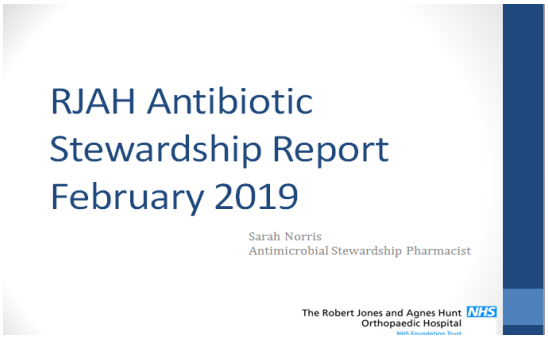
Achievement of CQUIN targets for first two quarters of the year for the review of antibiotic prescriptions for patients with sepsis

Review of current Trust drug chart to incorporate specific section for prescribing antimicrobials, to improve antimicrobial stewardship within the Trust.



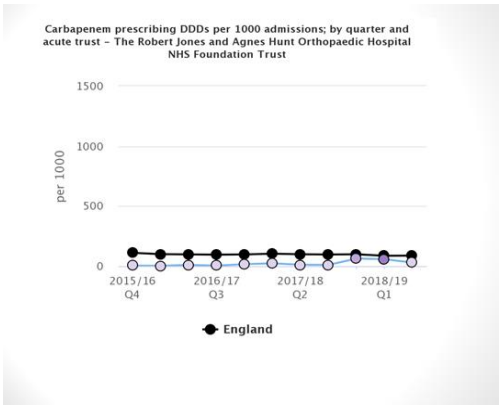
Antimicrobial Use Only
All antibiotic prescriptions require an indication and a stop review date to be clearly marked on the prescription chart to comply with Trust policy.
All antibiotic prescriptions must be reviewed within 72 hours of initiation, review must be documented in patient notes and drug chart signed by prescriber for continued administration. A single dose can be given prior to review to avoid interruption of treatment; request for review must be documented in medical and nursing notes.

PRESCRIPTION FOR ALL ROUTES



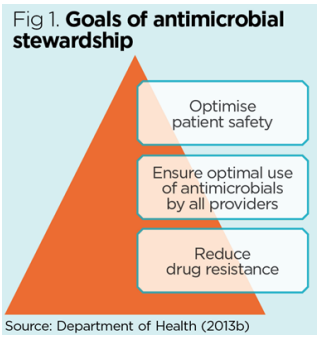
Continued contribution to the 'Local Health economy infection prevention and control and antimicrobial prescribing group' on a quarterly basis.

Continuation of ongoing programme of audit & feedback. Quarterly Point Prevalence Studies to monitor adherence to 'Start Smart- Then Focus' principles from PHE's Antimicrobial Stewardship toolkit



CQUIN payments received for total consumption of antibiotics and carbapenem usage based on low usage compared to use nationally.

Antimicrobial stewardship awareness presentation at LINK nurse meeting.



Antimicrobial Stewardship Pharmacist attendance and contribution at Infection MDT.

Pharmacist qualified as a non-medical prescriber in specific areas of antibiotic prescribing

Pharmacist attendance at The West Midlands Antimicrobial pharmacist's quarterly meeting. This aims to work collaboratively to improve standards & efficiency of antimicrobial pharmacy practice across the region, sharing best practice and innovation and bench marking regional practice.

The following are aspirations for 2019-20

Introduction of a box in the Emergency Drug Cupboard (EDC) containing antibiotics required if sepsis diagnosed in a person other than an inpatient e.g. a clinic attender or visitor.

Implementation of new drug card, incorporating specific sections for antibiotic prescribing.

To Dip or Not to Dip?

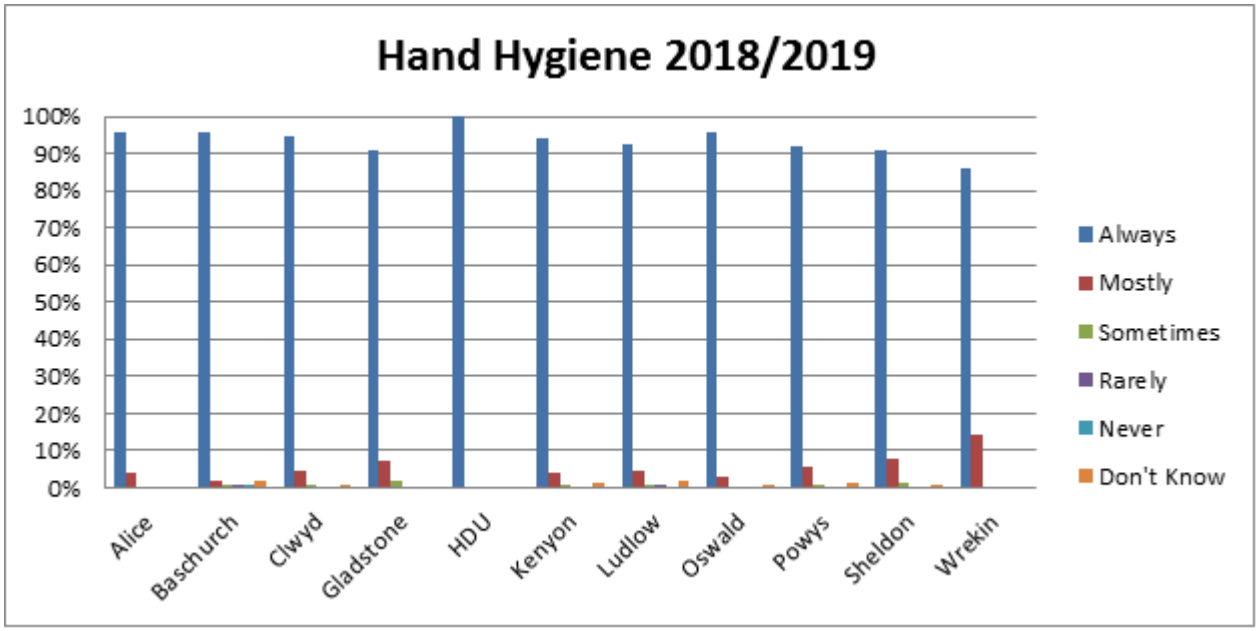
Achievement of Antimicrobial resistance CQUIN 2019/20: Lower urinary tract infection in over 65 year olds.

3.2.5. Criterion 4: Provide suitable accurate information on infections to service users

All patients with alert organisms are seen by the infection control nurse and information leaflets are provided. The microbiologist will also give advice and support to patients and their relatives upon request.

The Trust promotes best practice in infection prevention and control to its patients, relatives and visitors; highlighting the roles they can play in preventing infection through the website, targeted poster campaigns, and promotional events such as hand hygiene day.

The patient comment cards are used as a resource of data – including a specific question asking "Did the staff practice good hand hygiene". The results shown below provide encouraging feedback from a patient's perspective.

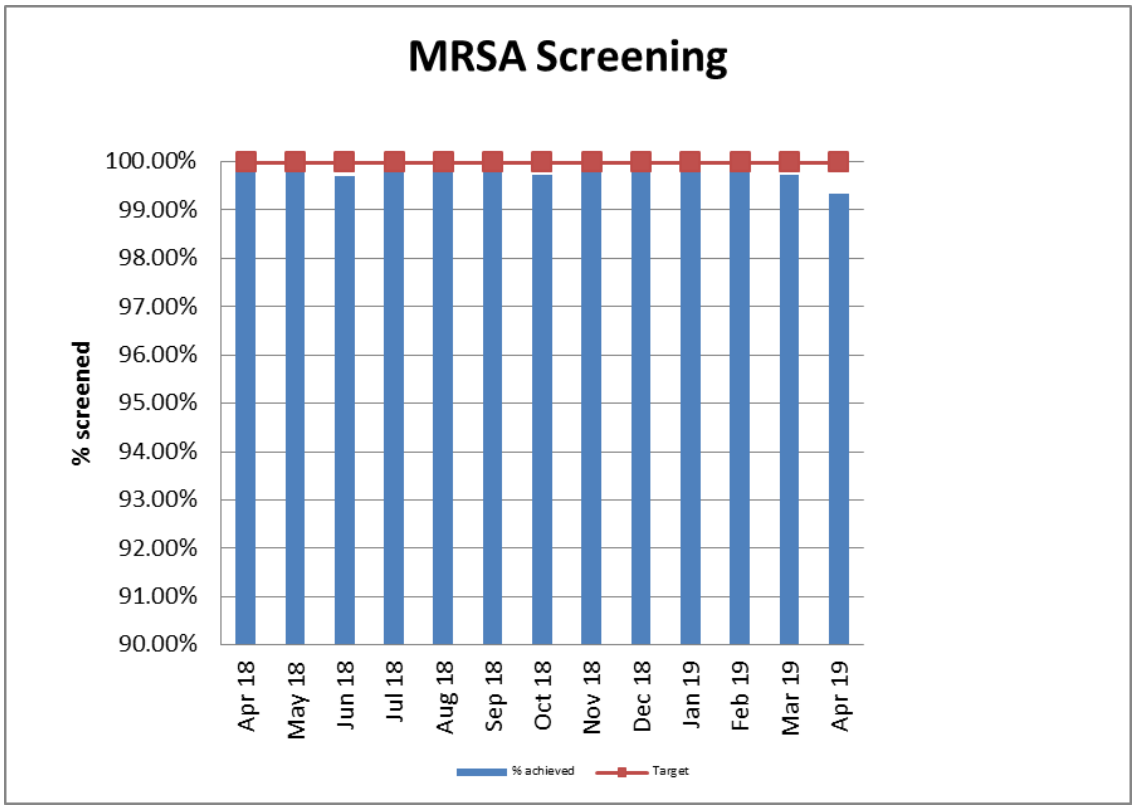


3.2.6. Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection

Patients who are at risk or require extra attention – this includes those unable to maintain high levels of hygiene standards, with poor quality skin or at risk of falls. Stakeholders receive an email with patient summaries and suggestions of actions to be in place in readiness for admission & surgery.

MRSA positive cases and ESBL infections are alerted to the IPCT daily as part of the lab reporting system, which are disseminated to the relevant departments; this ensures that positive cases can be decolonised within a timely framework preventing prolonged postponements of patient surgery.

The Infection Control Nurse/Surgical Site Surveillance Nurse provides advice and support to patients/relatives in the event of acquiring infection.



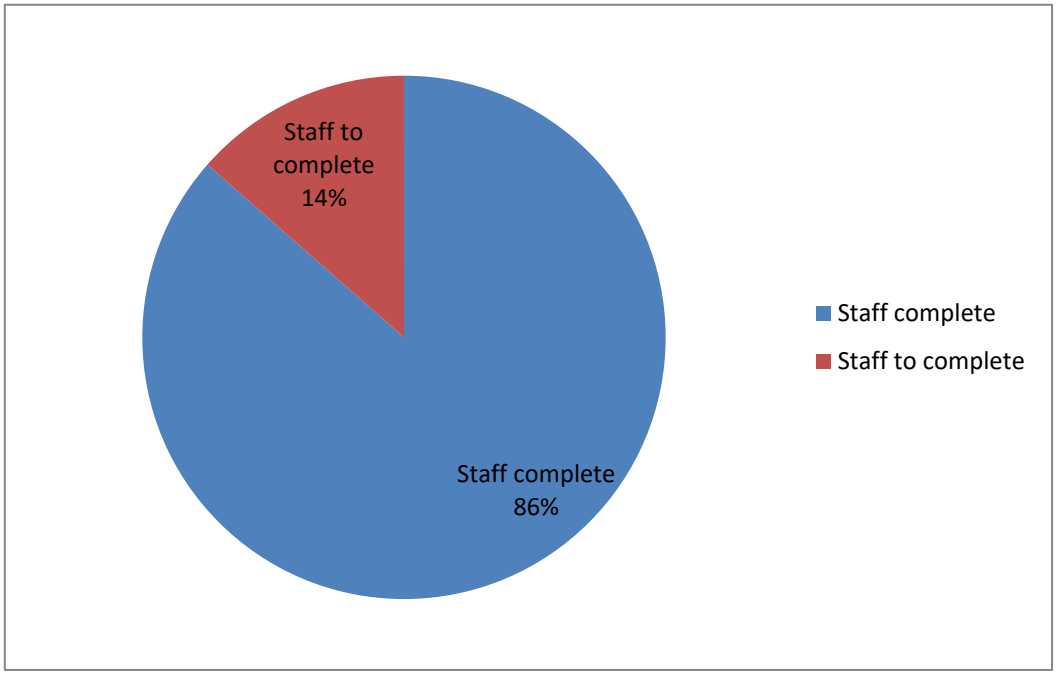
	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Eligible patients	835	1032	1049	1080	930	1025	1129	1145	895	1104	1007	1078
Screened for MRSA	835	1030	1046	1078	930	1025	1126	1145	894	1105	1005	1075
% achieved	100.00%	99.81%	99.71%	99.81%	100.00%	100.00%	99.73%	100.00%	99.89%	100.09%	99.80%	99.72%
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

The graph and table above demonstrates the MRSA screening compliance which is consistently above 99%, set against a Trust target of 100%.

CPE screening is performed on any patients who have been transferred from inner city hospitals or have been hospitalised abroad.

3.2.7. Criterion 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.

The provision of IPC training is met through provision of a mandatory e-learning package based on Department of Health evidence based infection control guidelines. In total, out of 1294 staff, 1119 have completed this training with 175 staff still to complete by the end 2018/19.



Additional training sessions provided by the IPCN include:

- Induction training of 45 minutes for all clinical and non-clinical staff (separate sessions for junior hospital doctors).
- All new/rotational doctors receive a short induction session provided by the IPCN.
- All volunteers receive a short training presentation and hand hygiene education.
- The team is part of the work experience programme run by the Trust on a quarterly basis.
- Provided 'train the trainer' education for link practitioners.
- Engage in the work experience programme based at RJAH
- Engage in the Trust preceptorship programme
- Provided workshop training sessions at ward training days
- Well received face to face training for groups of staff such as:
  - Catering
  - Porters
  - Domestics
  - Estates Maintenance staff

3.2.8. Criterion 7: Provide or secure adequate isolation facilities

The Trust has always been able to accommodate patient isolation with minimal disruption to the running of the wards. However, due to the increase of patients carrying antibiotic resistant organisms requiring siderooms for isolation, provisions have been made for the installation of additional doors to the bays on the spinal injuries unit to enable patients with the same carriage to be cohorted together in an isolated bay with the doors acting as a barrier as well as a reminder for staff to implement standard precautions.

3.2.9. Criterion 8: Secure adequate access to laboratory support as appropriate.

The management of prosthetic joint infection is challenging, the microbiology ward round is held once a week with the microbiologist, infection control nurse and the antimicrobial pharmacist. Each patient is reviewed and requires a tailored approach of antimicrobial prescribing due to the microorganisms grown on culture.

The microbiology lab sends a daily list of all positive samples including sensitivities. This enables all patients to receive the appropriate treatment/antibiotic therapy and prompt isolation if required.

3.2.10. Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

Infection Prevention & Control Policies & Standard Operation Procedures (SOP) are reviewed and agreed at the Infection Prevention & Control Committee.
IPC currently operates with 1 Infection Prevention & Control Policy, A framework of Infection Prevention & Control and 30 specific IPC SOP.

Policies Reviewed Published in 2018- 19	
Infection Control in the Built Environment Policy	Infection Prevention and Control Policy
Infection Control in the Built Environment Procedure	Infection Control Framework Strategy
Waste Policy	Scabies and Lice
Waste Procedure	

There has been a backlog of policies being reviewed as a result of other priorities, therefore a programme to review is set as a priority for 2019/20.

3.2.11. Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Team Prevent Occupational Health and Employee Wellbeing

Team Prevent is committed to the protection of all Trust employees as an essential part of Infection Control. In line with the Health and Social Care Act 2013 and Department of Health Guidelines, Team Prevent have arrangements in place for assessing the immunisation status of all Trust employees as well as regularly reviewing the immunisation status of existing healthcare workers and providing vaccinations as necessary and in accordance with the Green Book to reduce the risk and spread of vaccine-preventable disease.

Flu Campaign

Team Prevent support the Trust with their annual Seasonal Flu Immunisation Programme. The final submission results for 2018/19 season resulted in achieving 59% of all frontline healthcare workers having the flu vaccine.

Blood Borne Virus Exposure Incidents

Blood Borne Virus Exposure incidents or injuries may represent a significant risk to staff working in health care environments.

Under Health and Safety Legislation, Team Prevent work collaboratively with the Trust to ensure their responsibility for the health and safety of staff in relation to preventing, reducing and controlling the risks of healthcare associated infection and management of occupational exposure to blood-borne viruses and post exposure prophylaxis.

Team Prevent are responsible for the assessment and follow up of all Blood Borne Virus exposure incidents occurring during departmental opening hours and for the follow up of those exposure incidents occurring out of hours in Emergency Departments.

2018/19 exposure incidents reported to Team Prevent was 37 which is a slight increase from 2017/18 figures if 34. 87% were due to a percutaneous injury, 10% due to a mucotaneous injury and the remaining 3% were identified as being a low risk injury.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

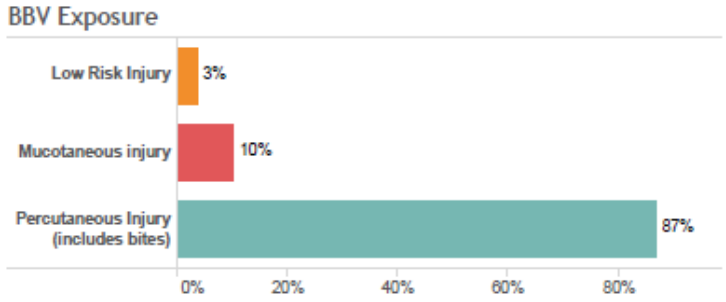
Team prevent

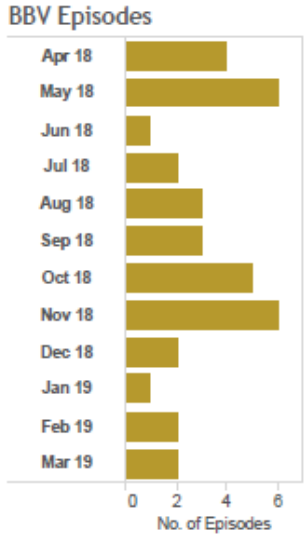
Monthly Dashboard - RJAH
Org Level 1 - RJAH
From 1 April 2018 to 31 March 2019

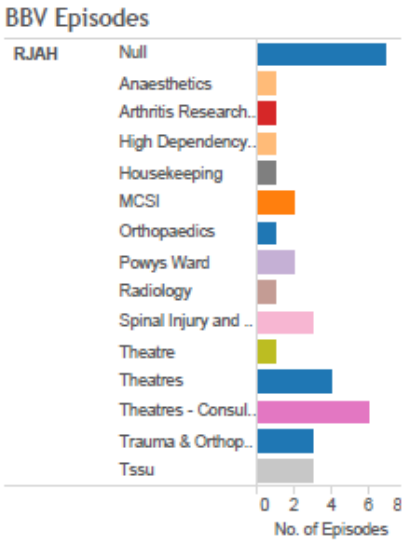
(months with zero data will not be displayed)

Innoculation/BBV Incidents

		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total
RJAH	Null	1			1		1		1	1			2	7
	Anaesthetics	1												1
	Arthritis Research Centre							1						1
	High Dependency Unit							1						1
	Housekeeping					1								1
	MCSI	1	1											2
	Orthopaedics									1				1
	Powys Ward		1								1			2
	Radiology						1							1
	Spinal Injury and Rehabilitation					1			2					3
	Theatre					1								1
	Theatres						1	1	1			1		4
	Theatres - Consultant Surgeons	1	1		1			1	2					6
	Trauma & Orthopaedics		1					1				1		3
	Tssu		2	1										3
	Total	4	6	1	2	3	3	5	6	2	1	2	2	37
Grand Total		4	6	1	2	3	3	5	6	2	1	2	2	37







The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Team prevent
Neddlestick Hospital Attended

Monthly Dashboard - RJAH
Org Level 1 - RJAH
From 1 April 2018 to 31 March 2019

(months with zero data will not be displayed)

		Month of Episode Start Date												
Question	Quest Answer	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Grand ..
Was the Injury reported out of hours and the individual obtained treatment or asse..	No	1	4	1	2	3	2	5	6	1	1	2	2	30

Classification Glossary

Low Risk Bodily Fluids - These fluids are not considered a risk UNLESS they are visibly blood stained: urine, vomit, saliva, faeces, nasal secretions, sputum, sweat, tears

Low Risk Injury - Splash on intact skin (there is no known risk of BBV transmission from exposures to intact skin)

Mucotaneous Exposure - is an exposure where there is direct contact of blood/body fluid with eyes, nose & mouth or broken skin e.g. uncovered cuts, abrasions or eczema not covered with waterproof dressing)

Percutaneous Injury (including bites) - is an exposure incident in which penetration of the skin occurs by a needle or other sharp object which may have been in contact with blood, tissue, or other body fluid before the exposure.

Safer Sharp Regulations

The Health and Safety (Sharp Instruments in Healthcare) Regulations came into effect in May 2013 requiring employers to use safer sharps which incorporate protection mechanisms to prevent or minimise the risk of accidental injury.

Following a recent review of safer sharps it was highlighted that there were non-safer sharps devices in use, therefore RJAH is failing to comply with above regulations.

An audit across all departments within the Trust has been planned for April 2019 and results to be fed back to the Innovation Committee.

3.3. Serious Incidents/ Periods of Increased Incidence

There were no Infection Prevention & Control Serious Incidents reported during 2018/19.

3.4. Conclusion

The year 2018/19 was another successful period in meeting the targets set by Public Health England and the Clinical Commissioning Group at RJAH Orthopaedic Hospital, with the exception of C.*difficile* and learning that the Trust has gained from these cases has increased staff awareness and effectiveness in the management of C.*difficile* infection.

The Infection prevention and control team have continued to provide an essential service to the Trust encompassing the Infection Prevention and Control service and surgical site surveillance service, microbiology ward rounds, post infection review/root cause analysis meetings and audit.

A highlight of 2018/19 was the recruitment of an additional 25hr Surgical Site Surveillance Nurse which will expand our surveillance capabilities within surgical site infections alongside increased tissue viability support for wards.

Bev Tabernacle: Director of Infection Prevention and Control

Sue Sayles: Infection Prevention and Control Nurse

June 2019

Key Areas of Focus for 18/19

- Achieving PHE National & CCG Infection targets
- PIR of all patients reported with positive blood cultures
- IT Solution for Infection Prevention & Control
- Improve website and intranet
- Participation of Getting It Right First Time
- Extend Tissue Viability Provision
- Introduce annual competencies for ANTT.
- Provide a 5 day Wound Clinic service
- Policy Review
- Additional surgical site surveillance for all Orthopaedic Specialities

Appendix 1: Acronyms

AE (D)	Authorised Engineer (D)
AMS	Antimicrobial Stewardship Committee
ANTT	Aseptic Not Touch Technique
CAUTI	Catheter-Associated Urinary Tract Infection
CCDC	Consultant in Communicable Disease Control
CCG	Clinical Commissioning Group
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DIPC	Director of Infection Prevention & Control
E.Coli	Escherichia coli
EPR	Electronic Patient Record
ESBL	Extended Spectrum Beta Lactamase
GIRFT	Getting It Right First Time
HCAI	Healthcare Associated Infection
HEE	Health Education England
HPV	Hydrogen Peroxide Vapour
HTM	Health Technical Memorandum
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IPCT	Infection Prevention & Control Team
ICD	Infection Control Doctor
IV	Intravenous
JAC	JAC – Electronic Pharmacy System
KPI's	Key Performance Indicators
MDT	Multi Disciplinary Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus
PALS	Patient Advice and Liason Service
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment

Appendix 1: Acronyms Continued:

RCA	Root Cause Analysis
RSH	Royal Shrewsbury Hospital
SATH	Shrewsbury and Telford Hospitals
SCCG	Shropshire Clinical Commissioning Group
SSI	Surgical Site Surveillance
SNAHP	Senior Nurse and Allied Health Professionals
SOP	Standard Operating Procedure
STAR	Sustaining Through Assessment and Review
TSSU	Theatre Sterile Services Unit
VIP	Visual Infusion Phlebitis
WTE	Whole Time Equivalent

Appendix 2: Glossary

Bacteraemia	The presence of bacteria in the blood without clinical signs or symptoms of infection
C. difficile	or C. diff is short for Clostridium difficile. It is a type of bacteria (germ) which less than 5% of the population carry in their gut without becoming ill. It is normally kept under control by the 'good' bacteria in the gut. However, when the good bacteria are reduced, e.g. by taking antibiotics, C. difficile can multiply and produce toxins (poisons) which can cause diarrhoea. The C. difficile bacteria form spores (germs that have a protective coating). These spores are shed in the diarrhoea of an infected person and can survive for a long time in the environment. C. difficile is highly infectious and can be spread from patient to patient unless strict hygiene measures are followed.
E coli	is an organism we all carry in our gut, and most of the time it is completely harmless. It is part of the coliform group of bacteria – often known as Gram Negative bacteria. Most strains do not cause any symptoms while being carried in the gut. Instead E coli forms part of our "friendly" colonising gut bacteria. However when it escapes the gut it can be dangerous. E coli is the commonest cause of blood stream infections (bacteraemia) in the community. The most frequent problem it causes is a urinary tract infection, but it can also cause infections in the abdomen such as gallbladder infections or following perforations of the bowel.
HCAI	Health Care Associated Infection. An infection acquired as a result of receiving treatment in a health care setting.
MRSA	or Methicillin Resistant Staph aureus, is a highly resistant strain of the common bacteria,Staph aureus. Bloodstream infections (bacteraemia) cases are the most serious form of infection where bacteria, in this case MRSA, escape from the local site of infection, such as an abscess or wound infection, and spread throughout the body via the bloodstream. All cases of MRSA detected in the blood are reported by the trust.
MSSA	or Methicillin Sensitive Staph aureus, is the more common sensitive strain of Staph aureus. Up to 25% of us are colonised with this organism. Mostly it causes us no problem but it is a frequent cause of skin, soft tissue and bone infections. As with its more resistant cousin, MRSA, sometimes the infection can escape into the bloodstream producing a "bacteraemia" i.e. bacteria in the blood. Unlike MRSA, the majority of the infections will be acquired in the community, and are not associated with health care. However, some may arise as a consequence of health care, and like MRSA, it can arise from infected peripheral and central intravenous lines and other health care interventions. We were asked by the Department of Health in 2011 to report all MSSA bacteraemia cases, whether acquired in the community or in hospital, so that we can review the sources and identify potentially avoidable cases. So far no targets have been set. However, we can compare ourselves with other trusts and put in interventions to further reduce infections.