The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

# Infection Prevention and Control Annual Report 2012/13

## Contents

## 1. Executive Overview

This report outlines the activities of the Trust relating to infection prevention and control for the year April 2012 to March 2013. The aim of the report is to present infection prevention and control activity within Trust and review accountability arrangements, policies and procedures relating to infection control, audit, surveillance and education.

The report demonstrates the continued high standards maintained in RJAH's performance in infection prevention and control and how the Trust has sustained its position year on year.

During 2012/2013 the Trust has maintained excellent healthcare associated infection (HCAI) rates. There were no cases of MRSA bacteraemia, only *two* cases of Clostridium difficile infection and surgical site infection surveillance continues to show rates of infection lower than the national average.

In recognition of the role all staff play in infection prevention and control, education has been delivered at all levels across the organisation. This report will show that programmes in infection prevention have been delivered for all staff groups from hand hygiene, cleaning standards, outbreaks and many other topics.

Recognising the importance of Infection prevention and control, the Trust has continued to undertake surveillance of all infections which is supported by the availability of a regular wound clinic for all patients as required in order to support and review post-operative wound management

The Trust has responded positively throughout the year to new national guidance ensuring compliance and continued monitoring as required. This has included the development of a multi-disciplinary water group following the recommendations made as a result of an outbreak of Pseudomonas in Belfast. Although the guidance related to augmented care units such as ITU the Trust decided to take a proactive approach and undertook a comprehensive review of all sink areas and developed an action plan which is monitored through the water group, a sub group of the infection control committee

This annual report 2012/13 will demonstrate the in house surveillance carried out, including high impact intervention audits and hand hygiene audits , that both demonstrate the improvements to the clinical service and offers assurances, from board to ward and most importantly to patients.

The Trust Board fully recognises the importance and positive impact that good infection prevention performance has on the patient experience and their safety. The Trust has made patient safety its number one priority having infection prevention as its founding principle.

The challenge for 2013/14 remains to maintain low rates of HCAI and to continue to improve practice to ensure the best care for all patients.

## 2. Key Achievements 2012-2013

| Key Achievements at RJAH 2012-2013 |
|---|
| **For the 6th consecutive year the Trust has had no MRSA bacteraemia.** |
| **The Trust achieved MRSA elective and emergency screening compliance of 99.82% for the year, above the threshold set by Shropshire CCG.** |
| **The Trust has achieved all mandatory targets for C *d*ifficile and MRSA.** |
| **The Trust has had no major outbreaks of infection in year.** |
| **The Trust reported only 2 isolated episodes of infection due to Clostridium difficile.** |
| **The IPC Team have begun the process of reviewing and auditing infection control policies against standards for NHSLA** |
| **The IPCT have taken steps to minimise the risks of Pseudomonas infection throughout the Trust** |
| **The IPC Team have significantly supported major capital developments that have improved patient experience.** |
| **The IPC Team have worked with the Facilities Manager and the domestic services to ensure continued high standards of cleanliness.** |
| **Domestic service staff continue to achieve 100% attendance at Infection Control Training** |
| **A water group has been developed and has actioned improvements in the swimming pool, water testing and risk of pseudomonas throughout the Trust.** |
| **A full year of surgical site surveillance has been undertaken, and the Trust has consistently achieved infection rates below the national average in hip & knee replacements.** |
| **The Trust has offered a wound clinic service throughout the year.** |
| **An Antimicrobial Stewardship Group has begun.** |
| **The Trust is a part of the Local Health Economy task and finish group for C *difficile* reduction.** |
| **The Infection control team has secured a 16 hour post for administration.** |

## 3. Infection Prevention and Control Team 2012-2013

*Jayne Downey*
Director of Infection Prevention and Control

*Dr Graham Harvey*
Consultant Microbiologist, 1 programmed activity (4 hours/week) is agreed with Shrewsbury and Telford Hospital Trust for provision of this service.
24h infection control advice is available from the on-call consultant microbiologist (3 programmed activity sessions cover in hours and on call)

*Sue Sayles*
Infection Prevention and Control Sister (1 WTE) Band 7

*Mary Offland*
Surgical Site Surveillance Nurse (0.8 WTE) Band 5

*Sian Evans*
Infection Control Administrator (0.43 WTE) Band 2

The Infection Prevention and Control Team (IPCT) are represented at the following Trust meetings:

| | |
|---|---|
| Infection Control Committee | Quarterly |
| Infection Control & Tissue Viability Link | Monthly |
| Clinical Effectiveness Committee | Monthly |
| Medicines Management Committee | Quarterly |
| NHSLA Leads Meeting | Monthly |
| SNAHP Forum | Monthly |
| Band 6 Forum | Monthly |
| Water Group | Quarterly |
| PLACE Team | Monthly |
| Medicine Divisional Meeting | Monthly |
| Health and Safety Committee | Quarterly |
| Root Cause Analysis | Ad-Hoc |

The IPCT is also represented at the following external meetings:

| | |
|---|---|
| DIPC Lit (Local Implementation Team) | Monthly |
| Clinical Quality Review (CQR) | Monthly |

## 4. The Role of the Infection Control Team

The following roles are undertaken by the IPC Team:-
· Education
· Surveillance of hospital infection
· Investigation and control of outbreaks
· Development of infection control policies
· Implementation and monitoring of infection control policies
· Audit
· Assessment of new items of equipment
· Assessment and input into service development and buildings / estate works
· Reference source for hospital personnel

Infection control advice is available during office hours (09.00 – 17.00) from the Infection Prevention & Control Team and 'on-call' via the duty Microbiologist at SaTH.

## 5. Infection Control Committee

The Infection Control Committee (ICC) meets quarterly and is chaired by the DIPC. A much wider group of key stakeholders including theatre representation attend this meeting to discuss future issues and solutions around infection prevention and control, cleanliness and wider environmental improvements and policies.

Table 1 shows the attendance at the ICC 2012 -13

| | 11/04/12 | 10/07/2012 | 09/10/12 | 08/01/12 |
|---|---|---|---|---|
| Infection control Sister | ✓ | ✓ | ✓ | ✓ |
| Director Nursing, Governance and DIPC | ✓ | ✓ | ✓ | ✓ |
| Consultant Microbiologist | ✓ | ✓ | ✓ | ✓ |
| Medical Director | | | | |
| Clinical director, medicine | ✓ | ✓ | ✓ | ✓ |
| Consultant Surgeon | | | | |
| HPA representative | | ✓ | | |
| Facilities Manager | ✓ | ✓ | ✓ | ✓ |
| Estates | | | | ✓ |
| Pharmacy | | | | |
| Theatres | | ✓ | | |
| CSM Medicine & Rehabilitation | | ✓ | | |
| CSM Surgery | ✓ | ✓ | ✓ | |
| G grade Surgery | | | | |

## 6. Infection Prevention and Control Links

The Infection prevention and control nurse has a monthly meeting with the Director of nursing (DIPC) to discuss any issues and to keep the DIPC informed of infection rates within the trust.
The Infection control Link group meet monthly to discuss issues, share good practice and to update on evidence based practice.
The IPCN attends the SNAHP meetings monthly. This forum is used to feedback additional information to the wards and departments, and receives information to inform the priorities and actions of the Infection Prevention team
The IPCN has weekly support from the microbiologist, who visits the Trust and completes a full ward round to address issues on site.
The IPCN attends the PCT/SaTh IPC Nurses meeting quarterly.
The IPCN attends the DIPC LIT meetings monthly.
The DIPC sits on the Medicines Management Committee and receives regular feedback on antibiotic usage throughout the Trust.
The IPCN attends monthly site 'walkabouts' as part of the PLACE team where environmental issues pertaining to IPC can be raised and addressed.

## 7. Microbiology support

Working arrangements in the Microbiology laboratory have been established to facilitate seven-day testing and reporting for *Clostridium difficile* toxin*,* Methicillin resistant *Staphylococcus aureus* (MRSA), and *Norovirus.*
There are good communications systems between the laboratory the IPC team, ward staff, from the Microbiology laboratory attending outbreak meetings to provide current detection information & the regular IPCT meetings. The information on ward issues is then communicated to staff in the laboratory to enable better prioritisation. The use of real-time information about alert organisms allows the epidemiological and surveillance data to be effectively managed.

## 8. Reports

During the year the DIPC has produced quarterly reports which update the Infection Control Committee as well as the Trust Board in Infection Control and Cleanliness matters. The DIPC reports directly to the Chief executive.

## 9. Budget Allocation

Whilst the Trust has no separate budget allocation for infection control, it has utilised appropriate budgets and funding to support ongoing improvements.
Funding for specialist training and attendance at required external meetings is provided for specialist practitioners/ clinicians as well as ward staffing.

## 10. Progress against the Annual Programme

The annual programme for 2012/13 identifies the planned activities of the Infection Prevention and Control Team for 2012. It was originally based on both local and national priorities in relation to The Health Act, "Saving Lives" and Department of Health recommendations.
Programme activities were undertaken in addition to the routine work of the infection control team, which included clinical advice, delivery of education to all groups of staff, policy review and updating audit and surveillance.
For the full programme of work see Appendix 2.

## 11. NHSLA

Relevant IPC polices have been agreed and audited and the Trust is now working towards NHSLA Level 2.

## 12. Education

Mandatory training in infection prevention and control is a requirement for all Trust staff including clinical, non clinical staff and contractors.
The Trust uses an e-learning system to deliver consistent annual training to staff, and the IPCN provides induction training to all new-starters. Medical staff also have quarterly updates from the Infection Control Nurse.
The Training figures for 2012 – 2013 are shown in table 2.

Table 2:

| **Completion of Infection Control from 1st April 2012 to 31 March 2013** | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Courses require completion annually | Total number of staff overall to complete based on organisational TNA | Number of staff completing module each month | | | | | | | | | | | | Total no Completed Training | Total as a % |
| Module Name | | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Nov-12 | Dec-12 | Jan-13 | Feb-13 | Mar-13 | | |
| Infection Control | 1059 | 90 | 72 | 69 | 46 | 43 | 39 | 56 | 71 | 25 | 62 | 89 | 84 | 746 | 70% |

A rolling programme undertaken by HR and ward/department managers emphasises the importance of all staff members' attending mandatory training.

## 13. Policy

During 2012-13, a programme of review for IPC policies has been updated. Policies updated and agreed at the Infection Control Committee during the year were:

- Standard Precautions Policy
- Management of Occupational Exposure to Blood Borne Virus
  - This Policy was updated in line with NHSLA standards, and has been divided into a policy and specific SOP's
- Ward Control Measures for Legionnaires Disease

The IPC team has also participated in the development of the Urinary Catheterisation Policy.

## 14. Healthcare Associated Infections – Statistics

The Department of Health requires mandatory surveillance of the following types of infection:

- Clostridium difficile
- MRSA bacteraemia
- MSSA bacteraemia
- E-coli bacteraemia
- Glycopeptide Resistant Enterococcal (GRE) bacteraemia's
- Surgical Site Infections (Orthopaedics)
- Pseudomonas Aeruginosa
- Norovirus

### 14.1 Clostridium Difficile

*Clostridium difficile* is the main cause of antibiotic associated diarrhoea. As a HCAI, these cases are monitored by the Department of Health, through mandatory surveillance data supplied by on a monthly basis by all Trusts.
Extensive work is ongoing to reduce the incidence of *Clostridium difficile* Infection (CDI) across the local health economy and a task and finish group for Shropshire and Telford has been formed and an action plan produced. This includes: education of medical staff around antibiotic prescribing, the instigation of antibiotic ward rounds, increased cleaning frequencies when there is a case of *C.difficile*, rapid isolation of these patients and the emphasis on the use of the *C.difficile* care plan in the hospital.

There is a robust reporting mechanism and Root Cause Analysis (RCA) process around *C.difficile*. All cases of patient's with *C.difficile* are visited by the Infection Prevention Control Nurse (IPCN) on a daily basis to ensure the correct infection control measures are in place in

hospital. In addition the Microbiologist reviews the patient to ensure they are on the correct treatment regime and all the necessary precautions are in-place.
The RCA is then instigated to ensure all staff involved are aware of actions to be taken in order to complete the RCA. Information from staff is collated in order to try and identify key themes. The clinical team, the Infection Control Nurse and the pharmacist will then meet with the Director of Nursing to review the case. All the key themes are shared with the ward managers and recommendations taken to the Infection Control Committee (ICC).
Key issues from the RCA feedback process over the last 12 months indicate that the two patients have been prescribed Cephalosporin antibiotics that were identified as a causative factor. As a consequence, the medical director requested a review of antibiotic practise on MCSI. A meeting took place involving the lead clinician, the consultant microbiologist and the clinical director. An audit was undertaken and it was agreed from the findings that antibiotics would not be prescribed to asymptomatic patients on MCSI.

### 14.2 MRSA bacteraemia

The Trust participates in the Mandatory Enhanced Surveillance Scheme (MESS) and has accumulated robust information on the local pattern of this HCAI. The data covers MRSA detected in blood cultures only and does not include MRSA carriage rates.
For the surveillance year April 2012 – March 2013 there have been no cases of MRSA bacteraemia. Our trajectory for the year was 0 cases of MRSA bacteraemia.

MRSA Screening Compliance
The Trust achieved an overall annual compliance of 99.82%.
There is an expectation from the DoH for 100% MRSA screening compliance. However, by having this as a target, the Trust is setting an unrealistic goal. Hence, the Shropshire clinical commissioning group have advised a threshold of 95%.
For MRSA screening compliance data, see appendix 1.

### 14.3 MSSA Bacteraemia

Since January 2011, Trust's have had to report their Methicillin Sensitive Staphylococcus Bacteraemia (MSSA) cases via the MESS system on a monthly basis. It was anticipated that targets will be set for individual Trusts for MSSA bacteraemia; however, we have been informed by the SHA/CCJ that for the present time we are just to continue to report numbers and no trajectories will be set for the forthcoming year.

4 cases of MSSA bacteraemia were identified at RJAH during 2012/13. Following root cause analysis, all 4 infections were identified pre-48 hours and therefore none were categorised as Trust attributable.

### 14.4 *E. coli* Bacteraemia

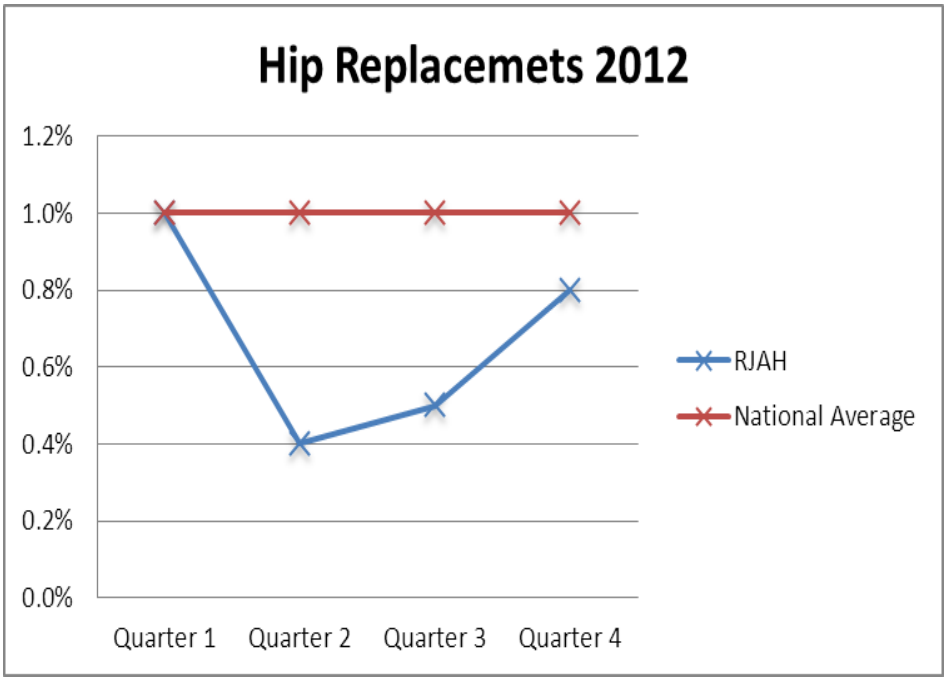
From 1st June 2011, the IPCT have reported all cases of *E. coli* bacteraemia identified within the Trust via the MESS system. No trajectories have been set by the DoH for these cases, monitoring by monthly cases will continue to be recorded.

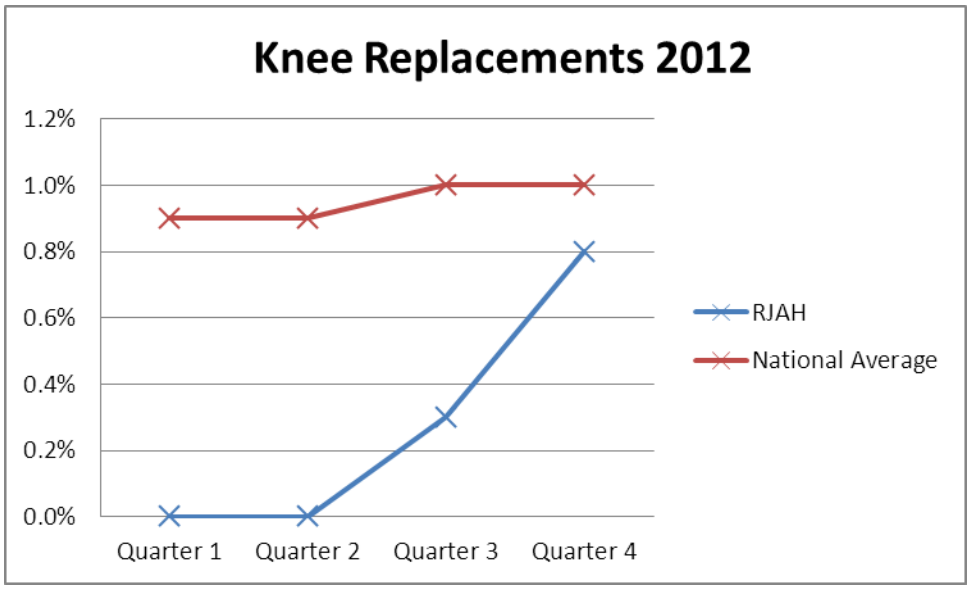
There were 6 cases of *E. coli* bacteraemia identified during 2012/13. RCAs of the cases were undertaken. The infections occurred more than 48 hours after admission to RJAH and are therefore attributed to the Trust for the purposes of National monitoring. However the review did not identify any Trust attributable factors leading to acquisition. It is possible (but remains unproven) that these were of urinary source.

### 14.5 Glycopeptide Resistant Enterococcus (GRE)

There have been no cases of GRE bacteraemia at RJAH Orthopaedic Hospital in surveillance period April 2012 – March 2013.

**14.6 Surgical Site Surveillance**




In a surgical hospital the most common infective adverse event is likely to be infection of the surgical site. The IPCT consider the collection of robust data on this form of infection as fundamental to the assurance of the quality of care delivered.

The Trust continues to perform constant surgical site surveillance for hip and knee replacements for the 4 quarters. This enables the Trust to gain a true picture of its infection rates year to year, and gives the ability to benchmark accurately against other specialist orthopaedic Trusts.

As in the above graphs, RJAH remains in line, or below the national average, which is consistent with the rates achieved in 2011.

Spinal Surveillance: October – December 2012

| | RJAH | National average |
|---|---|---|
| Spinal Surveillance:<br><br>2 Infections Identified in 105 Procedures | 1.9% | 1.4% |

There were 2 identified spinal surgical site infections during October – December. This positions RJAH slightly above the national average for this category of procedure. As it is only a snapshot in time this does not reflect a true picture of the trusts performance in spinal surgery over the year. To enable meaningful data the aim for the next financial year is to do continuous spinal surveillance.

### 14.7 Pseudomonas Aeruginosa

Following an outbreak of pseudomonas in a neo-natal unit in Belfast, new guidance has been published by the DoH Water sources and potential pseudomonas aeruginosa contamination of taps and water systems advice. The guidance outlines best practice for hand-wash stations in augmented care. The guidance emphasises that these stations must only be used for hand-washing, stipulates how and when water testing in these units should be carried out and also recommends that each Trust has a nominated person who is responsible for water management.

At RJAH Orthopaedic Hospital, a multi-disciplinary water group has been set up and meets four times a year to address the new guidance. Although the Trust does not have augmented care units apart from HDU, it was decided to take a pre-emptive and proactive approach and undertake a comprehensive trust wide review of all sinks. An action plan had been devised and reviewed on a regular basis within estates and clinical teams.

### 14.8 Norovirus

This winter (October 2012 – February 2013) saw two ward closures due to outbreaks of norovirus. This is higher than the previous year however this is in line with a national increase in the number of norovirus outbreaks reported to the HPA.

Lessons learned from previous years and enhanced teaching around outbreak management have meant that all staff are far more responsive in dealing with cases of unexplained diarrhoea and vomiting in their area and ensure that;

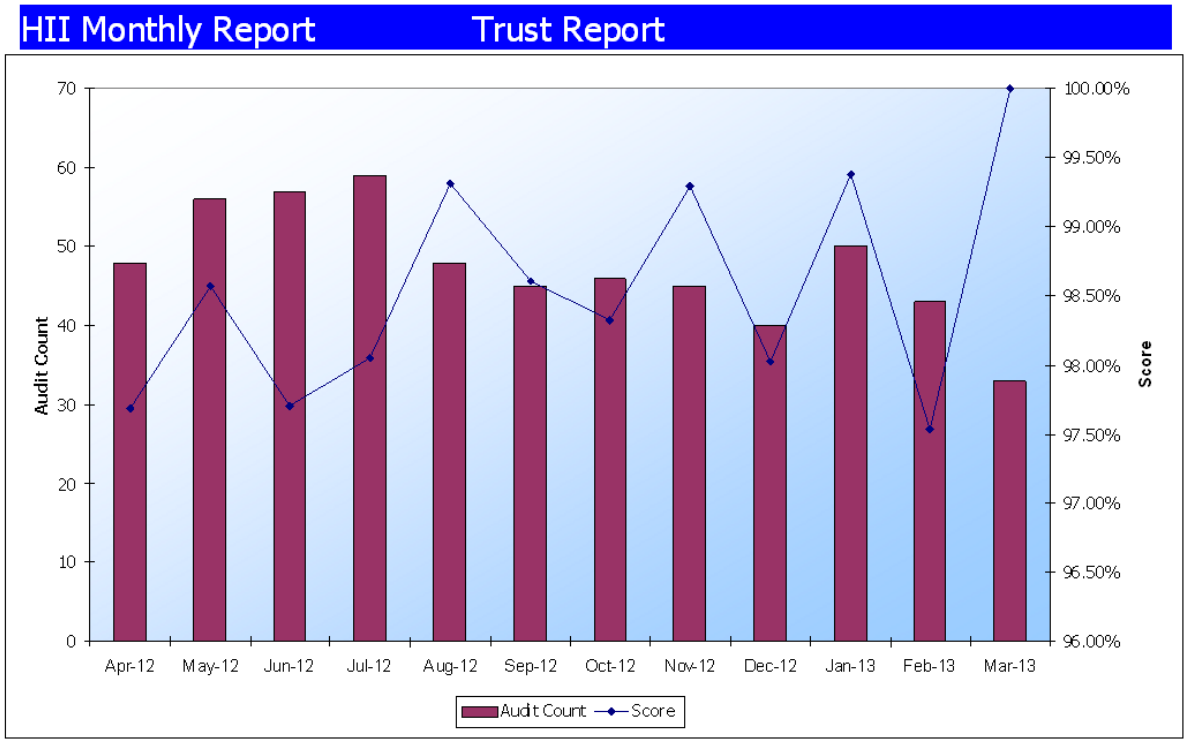
- Patients are isolated more quickly (if possible); in most cases this is immediate.
- The movement of patients is restricted as much as possible
- Staff collate information in relation to patients symptoms more readily
- The Bristol stool chart is utilised so that reporting is more robust.
- Specimens are collected promptly so rapid detection of infective causes
- Concentration on increased frequencies of cleaning
- All wards use Tristel solution at the onset of any outbreak.
- Immediate outbreak meetings involving relevant staff that then feed into the regular bed meetings at the hospital

All the above actions have together have had a huge impact on the effective management and impact on the control of outbreaks this year.

The IPCT contributes to a regional Norovirus reporting scheme through the Health Protection Agency. All wards in the hospital that are closed to admissions due to an outbreak of diarrhoea and vomiting that is clinically suspected of being Norovirus are reported through this scheme and regular reports are published and distributed to the participating Trusts.

## 15. Audit

High Impact Interventions

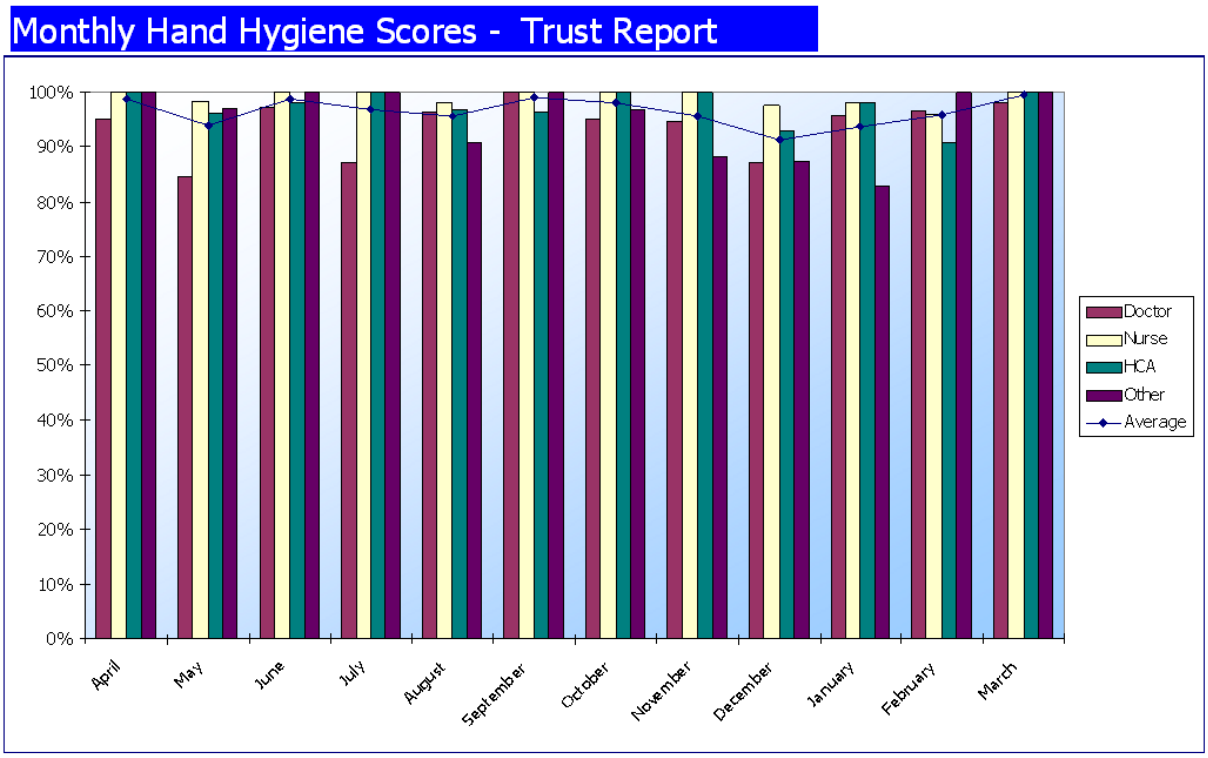



The audit results demonstrate that the overall compliance of the High Impact Interventions, which include:

- Peripheral Line Insertion/Ongoing care
- Central Line Insertion/Ongoing care
- Urinary Catheter Insertion/Ongoing care
- Reducing the risk of C difficile infection
- MRSA screening
- Cleaning and Decontamination

Have remained on average above 97% during the year, this is refelcted in our low levels of line associated infections.

Hand Hygiene

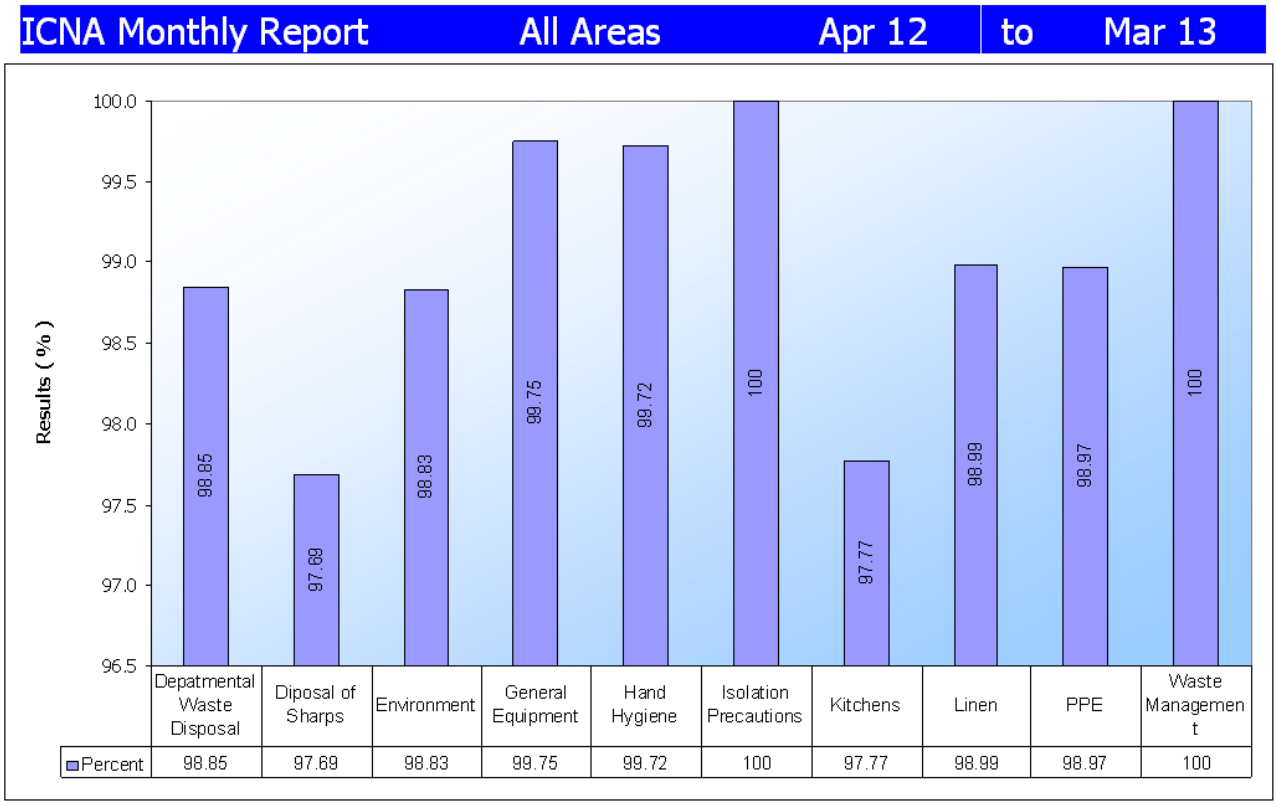



| Staff Group | | Score | Audits Completed |
|---|---|---|---|
| Doctor | Overall | 93.16% | 819 |
| HCA | Overall | 97.44% | 507 |
| Nurse | Overall | 98.71% | 1006 |
| Other | Overall | 94.55% | 367 |

Hand hygiene audits continue to be undertaken on a monthly basis, which incorporates nurses, doctors and health care assistants. The other category is for other healthcare workers, i.e. physiotherapists, occupational therapists. Overall the Trusts compliance has been above 93%. During periods of increased incidence of infection within the Trust, hand hygiene audits are performed on a more regular weekly basis.

The Trust achieved 96.29% hand hygiene compliance over the year, a 0.71% increase on last year.

ICNA Audit Tool




ICNA audit compliance consistently remains above 97% in all areas. In order to verify these results, a peer review audit calendar has been developed, in which infection control links staff complete an audit on another ward/department. 12 areas have had a peer review audit undertaken.

**16. Antimicrobial report**

An antimicrobial committee is now taking place 4 times a year.
Activities have included the following:

- Preparation, update and implementation of antibiotic treatment guidelines in conjunction with the consultant microbiologist and relevant lead clinicians and senior pharmacists.
- A review of antimicrobial prescribing following urodynamics and cystoscopy/spincterotomy is currently being formalised

**17. On-going Developments**

**Construction/Building Works**

The IPCT have being working closely with Estates in the last year particularly with regard to building work. The completed schemes include:

- The completion of the main entrance and conference suites
- The refurbishments in the x ray department
- Rolling plan of main corridor refurbishment
- Deep clean of the swimming pool and installation of new locker system

Schemes currently in progress are:

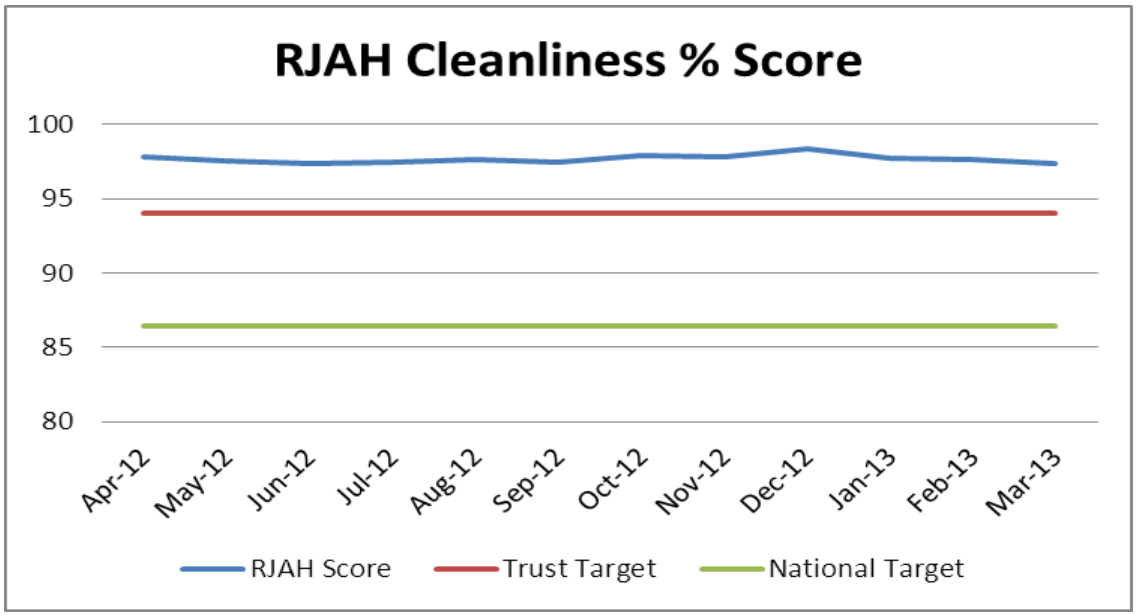
- ADOS and DAART
- The New Tumour Unit

IPCT involvement includes:

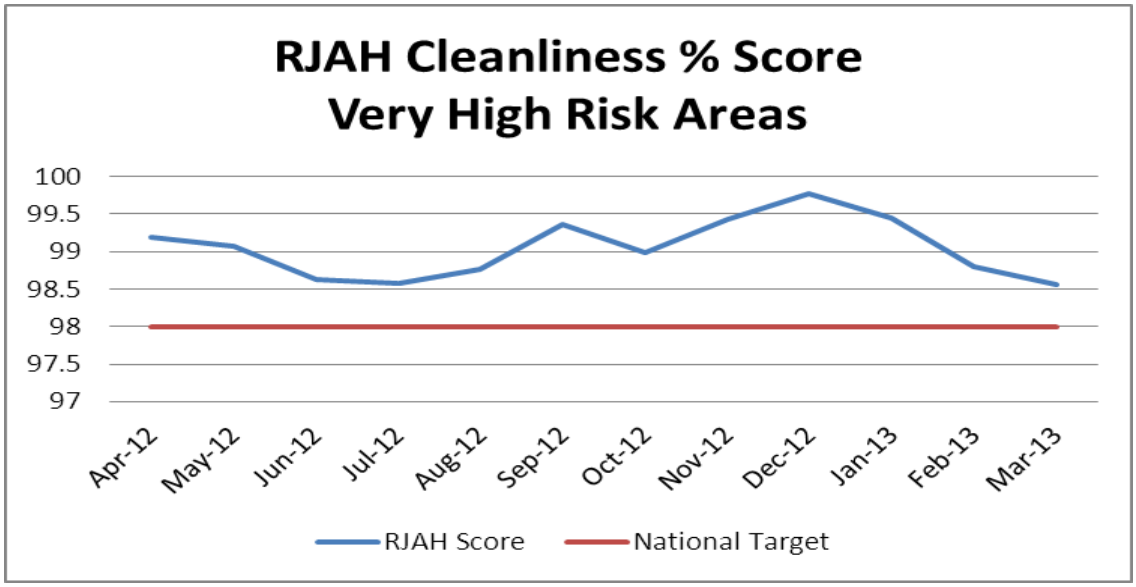
- Ensuring that current infection prevention guidance is considered at the design stage
- Comments at the design stage for the location of hand wash facilities, storage, single rooms and in more recent developments the addition of doors on bays.
- Visiting building areas to assess control measures in place from contractors
- Attendance at all progress meetings and raising any concerns
- When work is completed- an assessment from infection will assess if work is completed to a suitable standard

## 18. **Cleanliness**

18.1 Measured cleanliness has been maintained above the National calculated target (86.4%) and Trust target (94.0%) over the course of the year, achieving an overall average for the year of 97.7%.




18.2 Measured standards in the Very High Risk areas including Main Theatres, HDU and Menzies consistently exceeded the National Target of 98%. Very close monitoring of each area, by clinical and non-clinical staff, was utilised to bolster the assurance in these important departments.



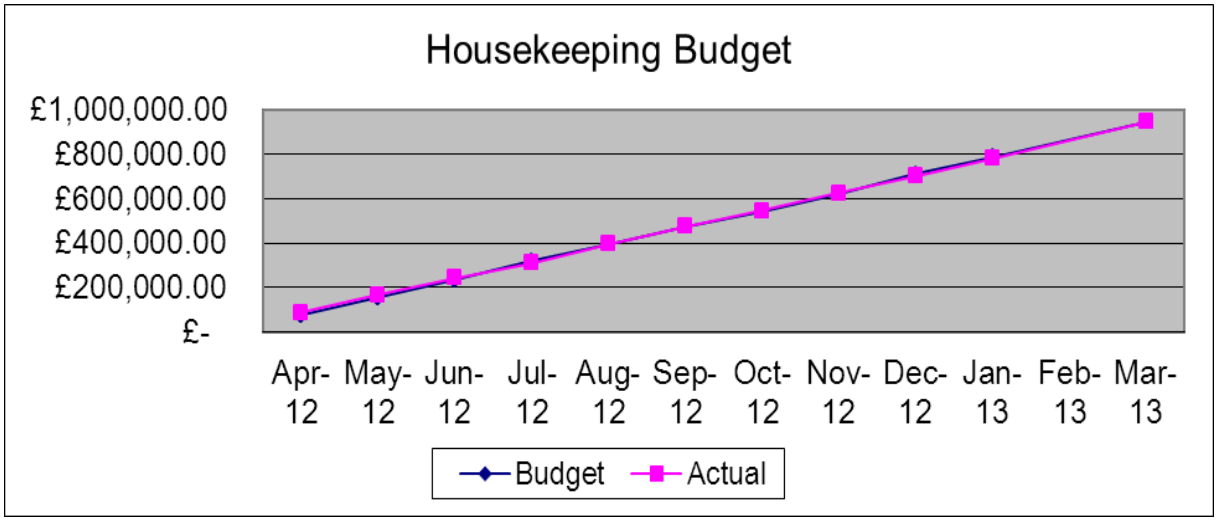

18.3 For the second year running the department took control of the deep clean programme in Theatres. By bringing this service back in-house the department is able to introduce a rolling programme, this has led to an increase in the frequency, a reduction in the cost and the overall result has been improved standards, as captured in the above graph.

18.4 Staff followed the departments training programme which ensured the target was met for all statutory training by year end. 100% of Information Governance training was achieved by year end and good progress has been made on the training programmes that run over 2/3 years.

Training in date as of 31/03/2013
HOUSEKEEPING

| | Course Name | Department Headcount | Number of new employees within period | Number of employees on Maternity / Adoption Leave | Total number of people not required to complete training based on TNA | Total number of employees required to complete training based upon TNA | Number of employees who have completed training | % of employees who have completed training | Number of employees still to complete training |
|---|---|---|---|---|---|---|---|---|---|
| Statutory Training (KPI Training data) | Fire Awareness Training (Practical/Theory) | 57 | 4 | 0 | 0 | 53 | 48 | 91% | 5 |
| | Health & Safety (e-learning) | 57 | 4 | 0 | 0 | 53 | 53 | 100% | 0 |
| | Manual Handling Theory (e-learning) | 57 | 4 | 0 | 0 | 53 | 53 | 100% | 0 |
| | COMPLETED ALL ELEMENTS | 57 | 4 | 0 | 0 | 53 | 48 | 91% | 5 |
| | Information Governance | 57 | | 0 | 0 | 57 | 57 | 100% | 0 |
| | Incident Reporting | 57 | 4 | 0 | 0 | 53 | 53 | 100% | 0 |
| | Infection Prevention and Control Training | 57 | 4 | 0 | 0 | 53 | 52 | 98% | 1 |
| | Moving and Handling Training Practical | 57 | 4 | 0 | 0 | 53 | 48 | 91% | 5 |
| | Fraud Prevention Awareness Training | 57 | 4 | 0 | 0 | 53 | 53 | 100% | 0 |
| | Equality & Diversity Training | 57 | | 0 | 0 | 57 | 48 | 84% | 9 |
| | Child protection Level 1 | 57 | 4 | 0 | 0 | 53 | 53 | 100% | 0 |
| | Safeguarding Vulnerable Adults Training | 57 | | 0 | 0 | 57 | 9 | 16% | 48 |
| | Slips, trips and falls training | 57 | | 0 | 0 | 57 | 0 | 0% | 57 |
| | Making Every Contact Count | 57 | | 0 | 0 | 57 | 1 | 2% | 56 |
| | Prevent Training | 57 | | 0 | 0 | 57 | 0 | 0% | 57 |
| | Waste Management | 57 | | 0 | 0 | 57 | 53 | 93% | 4 |

18.5 The Housekeeping department hit its target for the financial year, with spend matching budget each month.




18.6 Patient feedback stayed at a consistently high level, with Excellent and Good feedback accounting for 98.2% of all feedback over the year. Written feedback provided numerous positive comments for cleanliness, and the cleaning staff. Only one comment raised a concern regarding cleanliness but an investigation, including visual inspections and a review of the auditing data, found no issue.

18.7 An annual PEAT (Patient Environment Action Team) inspection was not carried out in 2012/13, owing to it being replaced by PLACE – Patient Led Assessment of the Caring Environment. The first annual audit of the PLACE programme did not fall in 2012/13, with it being programmed for 20th of May 2013.

Staff from the Trust attended the National training programme for PLACE, following which a mini PLACE programme was instigated. The PLACE assessment includes aspirational standards and heavily involves patient assessors, who make up half the auditing team.

18.8 Further developments within Housekeeping included the introduction of disposable curtains for most wards, all wards will soon have the curtains when the appropriate alterations have been made. The advantages of the curtains include; the ease with which they can be changed, improved patient dignity and respect signage and they also give wards a fresh clinical and healthy appearance.

**19. Conclusion**

The year 2012/13 was another successful period in maintaining low levels of healthcare acquired infection (HCAI), and meeting all the targets set by the DoH and the CCG's at RJAH Orthopaedic Hospital NHS foundation Trust.

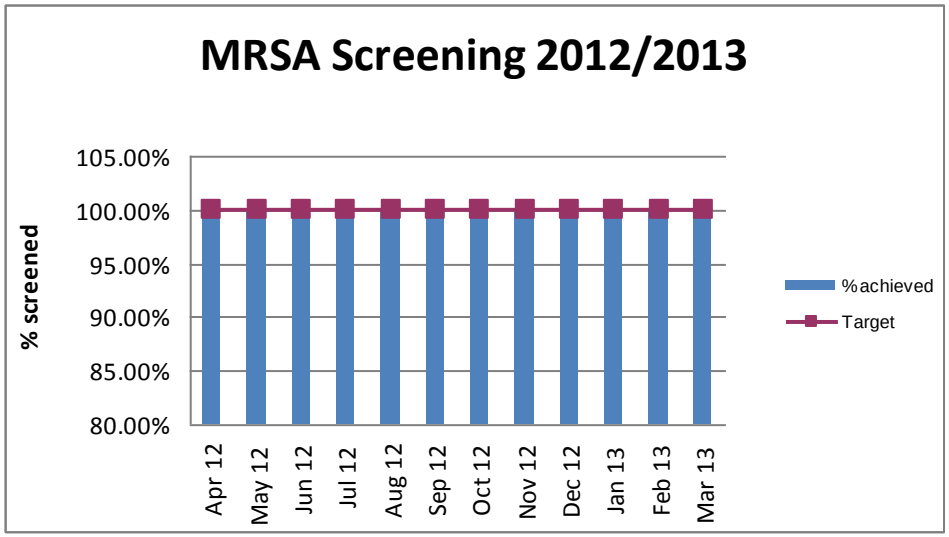
For 2013/14, RJAH strives to keep infection prevention and control high on the agenda at all levels of the Trust in order to continue to put our patients care first.

**Jayne Downey**
**Director of Infection Prevention and Control**
**June 2013**

Appendix 1

**MRSA Screening Compliance 2012-13**

| | Apr 12 | May 12 | Jun 12 | Jul 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Eligible patients | 903 | 931 | 793 | 1071 | 1020 | 1004 | 1131 | 1119 | 864 | 1081 | 1046 | 1034 |
| Screened | 898 | 931 | 790 | 1068 | 1019 | 1003 | 1130 | 1118 | 864 | 1081 | 1043 | 1031 |
| % achieved | 99.45% | 100.00% | 99.62% | 99.72% | 99.90% | 99.90% | 99.91% | 99.91% | 100.00% | 100.00% | 99.71% | 99.71% |
| Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |



Appendix 2

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

# Infection Control Programme of Work 2012/13

| **Criterion 1- Have in place and operate effective management systems for the prevention and control of HCAI which are informed by risk assessments and analysis of infection incidents** | **Responsibility** | **RAG** |
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| ***Laboratory reporting system*** | | |
| ▪ Surveillance of alert organisms of MRSA and Clostridium Difficile<br>▪ Surveillance of CAUTI's<br>▪ Mandatory reporting of MRSA, MSSA and E-coli bacteraemia<br>▪ Mandatory reporting of C-difficile infections<br>▪ Root cause analysis completed for cases of alert organisms<br>▪ Monitor MRSA screening and report compliance figures to the committee and DIPC Lit meetings. | IPCN<br>Microbiologist | On target |
| ***Surgical Site Surveillance*** | | |
| ▪ Continuous surgical site surveillance of all Hip and Knee replacements to the HPA<br>▪ Increase spinal surgery surveillance to continuous<br>▪ Commence post discharge surveillance<br>▪ Report the figures to the IC committee | IPCN<br>SSSN | Hip & Knee replacements surveillance continuous.<br>Only 1 quarter of spinal surveillance undertaken.<br>Post discharge surveillance not yet commenced.<br>Unfortunately due to a change in job description in IPCT this form of prospective surveillance could not be sustained.<br>Figures reported at all committee meetings. |
| ***Audit*** | | |
| ▪ Monthly hand hygiene audits and completion of action plans for areas of low compliance<br>▪ Weekly high impact intervention audits and completion of action plans for areas of poor compliance<br>▪ Monthly ICNA audits performed by ward/departmental staff, validation audits to be performed by ICN<br>▪ Provide surveillance data for all infections as a baseline profile for wards and departments | IPCN | On target |
| **Criterion 2- Provide and maintain a clean and appropriate environment which facilitates the prevention and control of HCAI** | | |

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| ***Cleanliness monitoring*** | | |
| ▪ Mini PEAT inspections monthly with ICN, facilities and Matrons<br>▪ Monthly ICNA audits of wards and departments<br>▪ C4C weekly audits<br>▪ Spot checks on ward/dept clinical cleaning schedules<br>▪ Action plans produced to capture areas for improvement and reports to be created on a monthly basis<br>▪ Report compliance figures to the IC Committee | IPCN<br>FM<br>FS | On target |
| **Criterion 3- Provide suitable accurate information on infections to service users and their visitors** | | |
| ***Shared Governance*** | | |
| ▪ Correlate an infection control information pack on the intranet<br>▪ Display results from the Hand Hygiene and High Impact Intervention audits on wards/departments<br>▪ Regular ward rounds of isolated patients | IPCN<br>IC Link Nurses<br><br>SSSN | Packs correlated but awaiting upload to intranet.<br>Results displayed on wards/departments.<br>Weekly ward rounds completed. |
| **Criterion 4- Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion** | | |
| ▪ Monitor the hospital transfer form in line with SATH and PCT to ensure consistency throughout trusts<br>▪ Patient transfer checklist to be implemented. | IPCN<br><br>Matron | On target |
| **Criterion 5- Ensure that people who 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** | | |
| ▪ Develop a flagging system on EPR for patients previously positive of MRSA, C Diff<br>▪ Implement checklist for isolation procedure<br>▪ Ensure immediate alert organism reporting from RSH Laboratory | IPCN<br>IT Department | Flagging system awaiting next phase of 'Bluespier'<br>Isolation policy under review, awaiting approval |
| **Criterion 6- Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing infection** | | |
| ***Education*** | | |
| ▪ Further development of the infection control link nurses- attendance of annual infection prevention conference<br>▪ Launch bare below the elbows campaign (Lord Darzi) 'Our NHS Our Future'<br>▪ Attendance of health and safety meetings to ensure IPC representation<br>▪ IPCN to develop a programme of working on the wards/departments | IPCN | All links attended conference at SaTH.<br>Executive lead required to launch campaign.<br>H&S meetings attended as required.<br>IPCN has worked on wards on ad-hoc basis. |
| ***Training*** | | |

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| ▪ Induction and mandatory training to all staff on hand hygiene, aseptic technique and correct waste and sharps disposal<br>▪ ICN to attend relevant local and national infection control study days and conferences<br>▪ Infection control link nurses to attend local and national study days<br>▪ Devise a rolling programme of education for link nurses. This will include specialist practice speakers | IPCN | On target. |
| **Criterion 7- Provide or secure adequate isolation facilities** | | |
| ▪ Review isolation policy<br>▪ Develop isolation checklist | FM, IPCN Matrons | Isolation policy under review, awaiting approval |
| **Criterion 8- Secure adequate access to laboratory support as appropriate** | | |
| ▪ Further develop database to analyse trends in infections<br>▪ See criteria 1 | IPCN Microbiology | On target. |
| **Criterion 9- Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections** | | |
| ▪ Microbiologist to work with ICN to continue a programme of updating polices in line with guidelines and best practice<br>▪ Develop a quick reference guide for infection control policies for each department | IPCN Microbiology | On target. |
| **Criterion 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** | | |
| ▪ Improve Blood Borne Virus awareness including sharps and needle stick injury policy<br>▪ Continuous PPE monitoring<br>▪ Refer to criteria 6 | IPCN | On target. |

Key - IPCN : Infection Prevention and Control Nurse, FM : Facilities Manager, FS : Facilities Supervisor, SSSN: Surgical Site Surveillance Nurse