

**Agenda item 10f**

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| **TITLE:** | **BOARD/GROUP/COMMITTEE:** | |
| **Infection Prevention & Control**  **Annual Report** | **Quality & Safety Committee** | |
| **1. PURPOSE:** | **REVIEWED BY (BOARD/COMMITTEE)** | |
| For approval | Infection Prevention & Control Committee | |
| **2. DECISION REQUIRED:** | **CATEGORY:** | |
| For approval | **X□ NATIONAL TARGET**  **X□ ASSURANCE FRAMEWORK**  **X CQUIN/TARGET FROM**  **COMMISSIONERS**  **X CORPORATE OBJECTIVE**  **X□ OTHER (PATIENT SAFETY )** | |
| **AUTHOR:**  Glynis Bennett  Lead Nurse/Deputy Director of Infection Prevention & Control  **PRESENTER**  Glynis Bennett  Emma Hardwick  Director of Infection Prevention and Control | |
| **DATE: 08/05/2017** | |
| **3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:** | | |
|  | | |
| **4. DELIVERABLES** | | |
|  | | |
| **5. KEY PERFORMANCE INDICATORS: C. difficile national target (53) not breached (22); MRSA Blood Culture Positive target (0) breached (0).** | | |
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| **AGREED AT \_\_\_\_\_\_\_\_\_\_MEETING**  **OR**  **REFERRED TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |



**Infection Prevention and Control (IP&C)**

**Annual Report**

**April 1st 2016 – March 31st 2017**

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**8th May 2017**

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1. **Executive Summary**

* Over the last year the trust has made significant improvements in Prevention and Control of Hospital Acquired Infections. IP&C practice across the Trust has shown improvements and rates of reported infections have fallen.
* The Trust has fallen well within the trajectory of 53 cases of Hospital Acquired C *difficile* set by NHS England with an end of year total of 22 cases. A significant improvement on the previous year 2015/6 where 39 cases were recorded.
* Trajectory for Hospital Acquired MRSA Bacteraemia of 0 cases has been met this year. Significantly less numbers of Hospital Acquired MRSA colonisation were also noted, with improved screening rates and the introduction of Octenisan body wash for all inpatients.
* A reduction in the number of ward closures due to Norovirus outbreaks and control measures for management of cases within a bay showing improvements in control of community acquired patients.
* Improvements made in IP&C practices and standards of cleanliness across the Trust. Auditing of Hand hygiene, PPE usage, cleaning of the environment and commode cleaning has shown consistent improvements in practice.
* Education and training in IP&C and clinical practice including ANTT across the trust and targeted in areas of concern by use of a Supportive Measures Programme for these areas of concern.

1. **Introduction**

Preventing infections is a key priority for the Trust; every effort is made to ensure no patient develops an avoidable infection.

The objectives and strategy for IP&C are based on criteria within the health and social care Act 2008 Code of Practice on the prevention and control of infections and related guidance (Dept of Health 2010). It draws upon previous and current guidance from the Dept of Health and Care Quality Commission including:

* Prevention and Control of Healthcare – associated infections overview. (NICE Feb 2017)
* Healthcare Associated infections – QS113 (NICE Feb 16)
* Infection Prevention and Control - QS61 (NICE April 2014)
* Antimicrobial stewardship “Start-Smart” – Then Focus” Guidance for antimicrobial stewardship in hospitals (England) (DH 2011)
* Saving Lives :reducing Infection delivering clean and safe care (DH 2007)
* Care Quality Commission The Fundamental Standards (CQC Jan 2015)

1. **Management Structure for Infection Prevention & Control**

The Chief Executive has overall responsibility for the prevention and control of infection within the Trust. During 2016/7 the role of Director of Infection Prevention and Control (DIPC) was held by the Associate Medical Director.

The Hospital Infection Control Committee (HICC) is chaired by the DIPC and at the beginning of the year was meeting monthly but in since October has meet bi monthly. Chairs key issues are escalated to the Trust Executive Committee and Board. Minutes of the meeting are widely circulated.

The day to day co-ordination of IP&C activities are undertaken by the IP&C Team. The IP&C team reports to HICC. Leadership of the team is from the DIPC, and the IP&C Nurses in the Team are managed by the Lead IP&C Nurse. The team consists of Lead Nurse for IP&C, three IP&C Nurses including one with surveillance nurse duties. Secretarial Support is shared with Consultant Microbiologists and the DIPC. There are two Consultant Microbiologists; one is the Infection Control Doctor and the other Leads on Antimicrobial issues.

**4.0 Mandatory Surveillance**

Trajectories for each Acute Trust (2016/7 by NHS England) for the numbers of cases of Hospital Acquired C. *difficile* and Blood stream infections due to Methicillin-resistant *Staphylococcus aureus* (MRSA). West Norfolk CCG oversee these numbers and are involved in Root Cause Analysis Investigations into cases.

Methicillin-sensitive *Staphylococcus aureus* (MSSA) and *Esherichia coli* (E Coli) blood stream infections have no HCAI trajectory set but national surveillance and reporting of these cases is required.

**5.0**  **MRSA Bloodstream Infection (Trajectory = 0)**

There were 0 cases of MRSA blood stream infection associated with the Trust. This is an improvement on the previous year’s performance when the trajectory was breached with 1 case.

There have been notably less cases of Hospital acquired MRSA colonisation this year also. In the previous year several clusters or Periods of Increased Incidence (PIIs) of MRSA colonisation have been identified.

A number of processes have assisted in reducing cases of both MRSA colonisation and BSI. Admission and weekly screening of all inpatients for MRSA has improved with compliance at 95% for both. This identifies patients that are colonised allowing prompt decolonisation treatment and the correct IP&C precautions to be put in place.

Since November 2016 all inpatients (excluding admission areas) have been offered Octenisan body wash and if patients have wounds they are also cleaned with Octenalin wound solution. These products reduce the amount of bacteria on patient’s skin/wounds thus preventing invasion into bloodstream, wounds or lines. Compliance with the use of this has improved and an education programme for staff still continues. Outcomes of this initiative are being presented locally at the Infection Prevention Society (IPS) East of England Conference and nationally at the IPS National Conference. An article has also been accepted for publication in the June issue of Clinical Service Journal.

The IP&C team also follow up on all patients who screen positive for MRSA and ensure that decolonisation treatment is prescribed and administered. Compliance with policy and patients receiving a full course is steadily improving across the Trust.

**MSSA BSI (no trajectory – mandatory reporting of all cases)**

The measures outlined above are also used to prevent the acquisition of MSSA BSI also, Octenisan wash and good IP&C clinical practices prevent invasion of MSSA to the blood stream.

**6.0 Clostridium *difficile* (Trajectory = 53)**

The Trust reported 22 cases of C.*difficile* for 2016/7 an improvement on the previous two years when 39 cases were reported.

A number of measures have been put in place to maintain and improve on this performance, and learning from all Root Cause Analysis (RCAs) is fed back to clinical areas to improve practice.

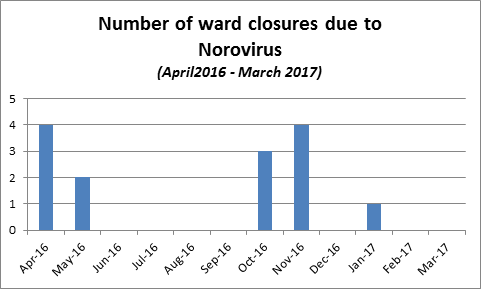
Learning from RCAs from the 22 cases this year included delay and lack of assessment in samples being sent, incomplete documentation (stool charts) and delay in isolation of patients.

To improve in these areas the IP&C team have been working with clinical areas to aid in the assessment of patients with loose stools, the use of an assessment tool and raising awareness around documentation continues as an education programme led by the IP&C Nurses. The use of isolation precautions for patients nursed in bays either through lack of single rooms or safety issues continues to be successful with audits showing improved compliance with IP&C practices around this.

Earlier in 2017 Public Health England raised concerns that a higher than average numbers of C *difficile* cases were reported across Norfolk, both Hospital and Community acquired. West Norfolk has higher than average numbers than the rest of the East of England. A subcommittee to look into this has been formed and the Lead IP&C Nurse will be part of this committee.

**7.0**  **Norovirus**

2016/7 has shown an improvement in the number of ward closures and control measures for Norovirus. Bay control has been used successfully and less ward closures have been seen in comparison to previous years.



Assessment of patients admitted with symptoms of D&V and communication with the wider health community has helped identify patients requiring isolation on admission. Wards and clinical areas have been given action cards with instructions for isolation and equipment required to manage Norovirus. A greater awareness of the spread of the virus and IP&C precautions required has assisted with this improvement.

**8.0 Reduction in Gram Negative BSI**

The introduction of a reduction target for E Coli BSI in the form of a quality premium for CCG will be introduced for the year 2017/8. The previous year E Coli BSI was reported on the mandatory surveillance system.

The IP&C team are now undertaking full investigation into E Coli BSI, and working closely with the CCG to ensure that information is shared. A Trust wide audit is planned around urinary catheters and clinical practice, to identify any education needs. A catheter passport is in use to aid communication with community colleagues and the use if this will also be audited.

**9.0 Carbapenemase Producing** **Enterobacteriaceae (CPE)**

To date no patients screened at QEH have been identified as either colonised or infected with CPE. A Policy is in place including current screening recommendations from PHE. Work within the EPA Microbiology laboratory has ensured that resources and methods are available for screening. Other Trust’s locally have reported cases of CPE.

The IP&C Team are planning further education and support for admission areas and maternity services to assess and identify those patients who may require screening. A process of alerts is planned for those patients who have screened positive or who are high risk is planned when an update to the ICE system allows requests to be made via the system.

**10.0 Hand Hygiene & Personal Protective Equipment**

In the past year Hand Hygiene has shown an improvement with standards for medical and surgical inpatient areas (including A&E) above 90%. On-going work aims to push results to a sustained position of 95% focusing on areas of poor compliance.

An awareness campaign has been on-going in the correct use of PPE, focusing mainly on glove usage. Follow up audits have shown better compliance and gloves use is still the main area of poor compliance. This is covered in Hand Hygiene auditing.

**11.0 Environmental Cleaning and Decontamination**

The domestic team undertake Cleaning 4 Credits (C4C) audits as per a new cleaning policy ratified March 2017. Data from these are triangulated in the IP&C dashboard along with Infection Rates, Hand Hygiene and other KPIs for IP&C.

All cleaning requested from clinical areas requires a “sign off” form to ensure standards are met, records are held by the cleaning team.

IP&C are undertaking a trial with new cleaning wipes to replace existing wipes. New wipes include a universal wipe effective in norovirus and MRSA and a sporicidal wipe that is effective against C *difficile.* A business case is being formulated with potential cost savings.

Bi weekly audits of commodes, bed pans and ward items are undertaken by the IP&C team and reported on the IP&C and quality dashboard. Matrons and Ward managers undertake environmental audits also as part of a Matrons assurance tool.

**12.0 Aseptic Non Touch Technique**

The QEH implemented a programme of ANTT in 2015 and to date 40% of clinical staff are “signed off” as competent in ANTT. The aim of this is to standardise practice around IV administration, Cannulation, Urinary catheterisation and Phlebotomy. A business case for new cannulation packs has been passed and implementation is planned from June 2017, along with ANTT training for all clinical staff. A Pre and Post introduction audit is planned, to ensure standards are met and show quality improvements.

In Dec 2016 an audit of cannulas across the Trust was undertaken, checking from documentation as well as clinical practice around the management of cannulas.

**13.0 Surgical Site Infections**

Mandatory reporting is required on all orthopaedic SSIs and voluntary reporting is undertaken on colorectal SSIs. The audit and surveillance dept, work alongside relevant departments to identify and report SSIs. The last data set for Orthopaedic infections has shown the QEH is an outlier with higher than expected numbers of SSIs. The Medical Director is leading on a review of this.

**13.1 Priorities for 2017/8**

1. Continue in improvements made in reduction of HAI C *difficile* infections.
2. Continue with programme to maintain zero tolerance for MRSA bacteraemia cases, by continuing with screening and decolonisation improvements.
3. QEH to assist with 10% reduction target from E Coli BSI across local health economy, and comply with new reporting and data collection methods.
4. Ensure a robust screening programme for CPE in line with guidance.
5. Maintain IP&C practice to control and manage Norovirus.
6. Work closely with clinical teams to improve Hand Hygiene practices and PPE usage across the Trust.
7. Formulate business case for introduction of new wipes to aid environmental cleaning.
8. Introduce new cannulation pack and ANTT education programme to ensure all clinical staff are competent.
9. Ensure a robust process in for reporting and investigating cases of SSI.
10. Continue building and supporting relationships with all clinical areas to ensure robust IP&C practice across the whole Trust, providing education, clinical knowledge and implementation of practices/procedures to protect patients from HAI.