# Q1 Infection Prevention Report 2011/12

**Report to**: Trust Board – 27th September 2011  
**Report from**: Graeme Jones, Director of Infection Prevention Unit  
Julie Brooks, Head of Infection Prevention  
Judy Gillow, Director of Nursing and Patient Services  
**Sponsoring Executive**:  
**Aim of Report**: This paper presents Trust Board with 2011-12 Q1 report on infection prevention within SUHT, and quarter 1 Matron reports.  
**Review History to Date**: TEC and Trust Board have received regular updates on infection prevention. Most recent updates have been:  
- Trust Board 26th January 2010  
- Trust Board 25th May 2010: Annual Report 2009-10  
- Trust Board 27th July 2010  
- Trust Board 23rd November 2010  
- Trust Board 24th February 2011  
- Trust Board 24th May 2011  
TEC and Trust Board also receive the corporate performance report monthly, which provides a numerical update on performance and progress against the national MRSA bacteraemia reduction trajectory, the Clostridium difficile infection reduction target, and the more detailed monthly Clinical Quality Report.

**Assurance Framework**  
**Strategic Objectives**  
Ref: SO1, SO1c  
Strategic Objectives 1 & 3: To be trusted on quality and excellence in healthcare.  
Specifically to ensure rates of healthcare-associated infection are below nationally set trajectory, and that the Trust develops a reputation for delivering clean, safe care thereby raising public confidence.

**Recommendations**: Members of Trust Board are asked to:  
1. Critically review the contents of this report to ensure it provides sufficient assurance on the actions in place to improve Trust performance in a sustainable way to achieve national targets  
2. Note the achievement of the Trust against the key Infection targets outlined.  
3. Recognise that leadership focus is still required to sustain high performance and achieve “best in class” status.  
4. Note the introduction of a Divisional accreditation scheme to encompass multiple aspects of infection prevention.
Introduction

The attached paper provides a summary report on work to reduce hospital-acquired infection including MRSA and Clostridium difficile within the Trust for Q1 2011-12, and also includes quarter 1 Matron Reports.

1.1 Summary of progress – Q1 2011/12

<table>
<thead>
<tr>
<th>Category</th>
<th>RAG</th>
<th>Action /Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA Bacteraemia reduction</td>
<td>Green</td>
<td>1 post 48 hr MRSA bacteraemia in Q1 against a performance limit for 2011/12 of 5 cases. SUHT is in the top performance quartile for acute teaching trusts.</td>
</tr>
<tr>
<td>MRSA screening</td>
<td>Green</td>
<td>99% of all elective and 99% of all emergency cases screened at patient level reporting. Matched census reporting &gt;100%. 25 patients acquired MRSA colonisation in SUHT in Q1.</td>
</tr>
<tr>
<td>Clostridium difficile infection reduction</td>
<td>Green</td>
<td>8 cases in Q1 against a national performance limit for 2011/12 of no more than 85 cases. SUHT is in the top performance quartile for acute teaching trusts.</td>
</tr>
<tr>
<td>Reduction of other post 48 hour bacteraemias e.g. MSSA.</td>
<td>Green</td>
<td>7 Post 48 hr MSSA BSI in Q1. Comparative data on inter-hospital performance is awaited.</td>
</tr>
<tr>
<td>Reduction of source related infections e.g. ventilated associated pneumonia, invasive device infections.</td>
<td>Green</td>
<td>100% compliance with VAP saving lives audits. 99% compliance with CVC saving lives audits.</td>
</tr>
<tr>
<td>CQC assurance framework</td>
<td>Green</td>
<td>Compliant with CQC outcome 8. The Trust continues to implement actions to improve performance relating to cleanliness and isolation risk assessments.</td>
</tr>
<tr>
<td>Hand hygiene and Saving Lives high impact interventions</td>
<td>Yellow</td>
<td>Amber status reflects sub-optimal Trust performance in cleanliness and decontamination and care to prevent surgical site infection, which are being addressed by review and education in poorly performing areas. Overall Trust performance is rated Green for other areas of practice.</td>
</tr>
<tr>
<td>Prudent antibiotic prescribing</td>
<td>Green</td>
<td>Data shows a stabilisation in use of antibiotics considered high risk for C difficile and MRSA and reduction in use of low risk agents over the last three months.</td>
</tr>
</tbody>
</table>

**NB:** MSSA – Meticillin Sensitive Staphylococcus aureus as opposed to Meticillin Resistant Staphylococcus aureus.
2. Prevention of Invasion of Infectious Agents – Position at end Q1

2.1 MRSA Bacteraemia:

Targets:
1. National performance limit of no more than 5 post-48 hr MRSA bacteraemias by end of 2011/12.
2. SUHT internal target to remain in the top quartile for published English hospital MRSA bacteraemia rates.

Progress:
In Q1 there was 1 post-48 hr case of MRSA bacteraemia which contributes to performance limit and 1 pre-48 hr MRSA bacteraemia case. An additional post-48h case was successfully appealed with commissioners and agreed as a non-trajectory case, not contributing to the performance limit. 1 post 48 hr MRSA bacteramia in Q2, currently under investigation.

Investigation of the trajectory post 48 hr MRSA bacteraemia from this quarter identified that important planned management actions were not reviewed to ensure that they had been completed and as a consequence were omitted. A new process is under development to perform a summative assessment of progress at intervals to ensure that outstanding actions are flagged as requiring action before patients move to a different ward.

Summary of actions:
Key actions to improve performance in 2011-12 are
1) Roll out of patient held MRSA record to improve health-economy awareness of MRSA status.
2) Enhanced surveillance of newly detected cases of MRSA colonisation within SUHT to identify and improve systematic issues with transmission of MRSA
3) Internal divisional target limits for prevention of transmission of MRSA within SUHT
4) Roll out of revised ANTT training to improve care of invasive devices
5) Regular feedback of prudent prescribing (HAPPI) audits to improve antimicrobial prescribing

SUHT is 6th best performing Trust of 27 Acute Teaching Trusts
2.2 MSSA Bacteraemias

SUHT Post-48h MSSA bacteraemia

*Staphylococcus aureus* is a bacterium that commonly colonises skin but may become a cause of serious infection in some individuals. *S. aureus* bacteraemia caused by organisms resistant to the antibiotic meticillin (MRSA) are formally reported and performance managed by DH. Most *S. aureus* bacteraemias are caused by organisms that are sensitive to the antibiotic meticillin – termed MSSA. Reporting of MSSA bacteraemia is now mandatory, and will be formally monitored at national level.

**Progress**

7 post-48h MSSA bacteraemias occurred in Q1. All post-48h MSSA BSI are reviewed by IPT to identify potential issues and RCA’s selectively commissioned to provide detail and learning.

MSSA bacteraemia data has been subject to mandatory reporting on MESS since February 2011 and comparative performance data for Trusts will be available when sufficient data are available.

**Summary of Actions**

Key actions to improve performance for 2011-12 include:

1. Roll out of new systems of Aseptic Non-Touch Technique to standardise approaches to invasive device care
### 2.3 E.Coli Bacteraemias

**SUHT post-48h E coli bacteraemia**

Reporting of *E. coli* bacteraemia is currently voluntary, but HPA have recommended mandatory reporting to DH. Most *E. coli* infections arise from patients own bowel flora and 100% of the population are colonised by *E. coli*.

13 post-48h *E. coli* bacteraemias occurred in Q1. Of the 8 cases in June, 5 (63%) were associated with urinary infection. All post-48h *E. coli* BSI are reviewed by IPT to identify potential CAUTI and RCA's selectively commissioned to provide detail and learning.

CQUIN requires reduction in number of patients who have been catheterised inappropriately as a means to reducing hospital-acquired urinary tract infection. The Trust CAUTI project has rolled out additional bladder scanners across the Trust to reduce the incidence of unnecessary catheterisation, during Q1. The catheter care record is being rolled out during July 2011.

**Summary of Actions:**

Key actions to improve performance for 2011-12 include:

1. Introduction of piloted catheter care documentation to ensure that continuing need for catheterisation is reviewed daily.
2. Enhanced and more frequent saving lives urinary catheter audit to capture appropriateness data. Q1 acts as baseline data for CQUIN.
3. Development of outcome measurements including reducing inappropriateness of catheterisation, reducing the number of catheter days and reducing *E. coli* bacteraemia resulting from catheter-associated UTI.
4. Investigation of post 48hr *E.Coli* bacteraemias that relate to urinary catheterisation.
2.4 Source Related Infections

Surgical Site Infections
Recent Dr Foster data indicate outlier performance on surgical site infection and this is under review to verify data integrity. HPA orthopaedic modules also indicate intermittent outlier performance.

SSI Saving Lives Audit
Saving Lives care bundle for SSI has been updated and includes standards for intraoperative care as well as preoperative and postoperative care. The revised SSI audit was carried out in June 2011. Results show 96% compliance against preoperative standards of care, 88% against intraoperative care and 96% compliance to postoperative care.

Summary of Actions:
Key actions to improve performance for 2011-12 include:
1. Review of Dr Foster data to verify integrity
2. IPT support and re-audit of practice in areas of sub optimal performance to reinforce compliance with standards.
2.4 Source Related Infections (cont….)

Ventilated Associated Pneumonia
Currently there is no national standard for measuring rates of Ventilator Associated Pneumonia. SUHT provides audit compliance data to commissioners.
Q1 audit results showed 100% compliance against local standards for VAP based on previous DH guidance. An updated DH saving lives care bundle included regular measurement of tracheal cuff pressure as a standard. Division A have challenged this as a valid national quality standard, because it is not widely practiced and may not be safe. This standard is to be removed from care bundle and validated at Infection Prevention Committee.
Next audit to be completed in Q3 2011/12.

Invasive Device Infections
Saving lives audit for Central Venous Catheter shows 99% and above compliance against insertion standards and 99% and above compliance against ongoing care. Next audit is to be completed August 2011.

During 2010/11 a Trust Aseptic Technique Steering Group was set up to review practices and standards relating to aseptic technique and agree the standardised technique to be adopted by the Trust. ANTT (aseptic non-touch technique) will be implemented throughout the Trust. ANTT is set of mandatory, nationally peer reviewed aseptic technique guidelines for core clinical procedures e.g. IV device care.
During Q1 2011/12 ANTT roll out across the Trust began and training of all clinical staff. Q1 audit of general aseptic practice was completed. Audit will be carried out twice a year.

2010/11 outcome data for CVC infection indicate 0.6 infections/1000 CVC days on GICU compared to a national average of 1.5 infections/1000 CVC days, and 3.6 infections/1000 parenteral nutrition days for the Intestinal Failure Unit, compared to 26 infections/1000 PN days locally in 2005-6. No national comparative data are available for PN.
2.5 Saving Lives

Target:
Clinical areas are required to achieve 95% and above compliance with saving lives audits.

Progress:
In 2010/11, peripheral line audit showed a decrease in compliance, with overall SUHT performance of 94% in December. Following independent audits of practice to reinforce compliance and IPT providing intensive support to areas of sub optimal performance, re-audits show an increase in compliance. Overall Trust performance is now at 98%. Next audit is due end July 2011/12.

For Q1 urinary catheter care audit was enhanced to identify inappropriate catheter use for CQUIN status. SUHT performance is at 95%. Next audit due August 2011.

In Q1 the overall Trust score for Cleanliness & decontamination was 94% showing a 1% improvement in compliance compared to January’11 audit.

Summary of actions
During 2011/12 IPT will continue to implement a Trust-wide rolling programme of infection prevention focus weeks to educate staff and raise staff awareness of key practice elements/initiatives and facilitate achievement and maintenance of high standards of infection prevention practice.
IPT continue to provide intensive support to areas of sub optimal compliance.

<table>
<thead>
<tr>
<th></th>
<th>SUHT</th>
<th>Division A</th>
<th>Division B</th>
<th>Division C</th>
<th>Division D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral Line Care</td>
<td>96</td>
<td>99</td>
<td>96</td>
<td>99</td>
<td>99</td>
</tr>
<tr>
<td>(Dec’10 Re-audits)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary Catheter Care</td>
<td>95</td>
<td>99</td>
<td>95</td>
<td>92</td>
<td>89</td>
</tr>
<tr>
<td>Care May ’11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>100</td>
<td>N/A</td>
<td>No patients</td>
<td>100</td>
<td>N/A</td>
</tr>
<tr>
<td>April’11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanliness &amp; Decont.</td>
<td>94</td>
<td>95</td>
<td>95</td>
<td>95</td>
<td>91</td>
</tr>
<tr>
<td>April’11</td>
<td></td>
<td></td>
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</tbody>
</table>
3. Prevention of Transmission of Infectious Agents – Position at end of Q1

3.1 MRSA Screening

Targets:
1. All emergency admissions and each relevant individual elective admission have been screened for MRSA.
2. All new MRSA positive inpatients are isolated within the 4 hour target.

Progress:
SUHT continues to achieve 99% screening success at individual patient level, for both emergency and relevant elective cases.
Matched census data (indicating number of screens divided by number of admissions) is > 400% and is accepted by SHA for assessment of achieving 100% target.

Enhanced Surveillance of MRSA
Infection Prevention Team now carry out enhanced surveillance on new MRSA positive inpatients, in order to review compliance with elements of the MRSA policy as well as isolation practice.
Isolation of new MRSA positive inpatients is at 89% for Q1. Delays in isolation are now included in the ward accreditation programme.

Summary of actions:
Key actions to improve performance in 2011-12 are
1. Introduction of internal target limits for MRSA acquisition,
2. Introduction of a formal programme of enhanced MRSA surveillance from 1st April 2011.
3. Incorporation of performance in isolation of MRSA positive inpatients in the ward accreditation programme from 1st April 2011.
3.2 Clostridium difficile

Targets:
1. National performance limit of no more 85 CDI cases by end of 2011/12.

2. SUHT internal target to be in the top quartile for Acute Teaching Hospital C. difficile Infection Rates.

3. To achieve a SUHT internal target of 100% success in isolating potentially infectious cases of diarrhoea within 4 hours.

Progress:
In Q1 there were 8 cases of C.dificile, with the Trust against a limit of 21. This shows a 38% reduction compared to Q4 in 2010/11.

SUHT remains within the top quartile of performance for Acute Teaching Trusts.

93% of cases were isolated within 4 hours in Q1 which is an improvement compared to Q4 of 83% isolated within the required time. Cohorting of confirmed C. difficile cases in key areas continues.

Summary of Actions
Key actions to achieve 2011-12 performance limit are:
1) Maintain current testing methodology until DH advises on national testing requirements and impact on performance limits
2) Continue use of ribotyping to target early intervention to prevent transmission
3) Continue focus on improving isolation using ward accreditation scores
4) RAG rating to ensure environmental cleanliness and clinical cleaning audit scores are achieved both across clinical areas and serially within clinical areas
3.3 Norovirus and Other Outbreaks

In Q1 there were 9 outbreaks in the Trust with approximately 264 bed days lost. Of these 9 outbreaks:

- 4 confirmed as Norovirus
- 1 confirmed as Rotavirus
- 4 D&V – likely viral cause

There was a period of increased incidence of C. difficile on F9 which was reported as a SIRI.

Graph shows number of all infectious outbreaks in the Trust and bed days lost.
### 3.4 Hand Hygiene

**Target:**
Clinical areas are required to achieve 95% and above compliance with hand hygiene audits.

**Progress:**
Clinical staff compliance to hand hygiene remains consistently above 95%. Medical staff compliance overall is above 95%, but inconsistent practice is still observed intermittently in some areas.

Infection prevention team carry out assurance audits on a random selection of areas scoring above 95%.

The Infection Prevention Team is currently following up % of staff that are up to date with Hand Hygiene training within the Divisions.

#### Hand Hygiene Audit:

**Clinical hand hygiene audit results % compliance:**

<table>
<thead>
<tr>
<th>Division</th>
<th>June 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUHT</td>
<td>99</td>
</tr>
<tr>
<td>A</td>
<td>97</td>
</tr>
<tr>
<td>B</td>
<td>98</td>
</tr>
<tr>
<td>D</td>
<td>99</td>
</tr>
</tbody>
</table>

**Medical hand hygiene audit results % compliance:**

<table>
<thead>
<tr>
<th>Division</th>
<th>May 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUHT</td>
<td>97</td>
</tr>
<tr>
<td>A</td>
<td>100</td>
</tr>
<tr>
<td>B</td>
<td>99</td>
</tr>
<tr>
<td>D</td>
<td>98</td>
</tr>
</tbody>
</table>
4. Minimising Consequences of HCAI – Position at end Q1

4.1 Prudent Antibiotic Prescribing

Antibiotic consumption data from the SUHT pharmacy system are presented in the graph opposite. Please note that classifications have changed, focusing on spectrum rather than *C. difficile* risk.

The proportional use of broad vs narrow spectrum antibiotics is stable, with no evidence of trends giving cause for concern.

Use of ultra-broad and specialist agents also remains relatively stable overall with no observable major trends at care group level.

**HAPPI audits (Hospital Antibiotic Prudent Prescribing Indicators)**

This second graph displays audit data collected by ward pharmacists representing compliance with SUHT antibiotic prescribing guidelines and policy. Trustwide compliance has declined recently to 70% with greater variability at care group level.

The electronic system to automate data analysis and reporting for HAPPI audits, using existing SUHT IM&T systems was user-tested in May and June and a number of changes have been made. Training for pharmacists is planned for 27th July and electronic reporting of results should begin from the month of August.

HAPPI audit scores will be incorporated into the dashboard of quality indicators for the Infection Prevention Ward Accreditation initiative.

**Smartphone App**

The SUHT adult pocket antibiotic prescribing guide has been developed into an App and approved by Apple for distribution via the iTunes website. It is hoped the App will be made available from 1st August pending insurance and contracts.

A paediatric antibiotic App is in development.
5. Environment – Position at end Q1

### 5.1 Infection Prevention Accreditation

During Q1 Divisional Infection Prevention Reviews were implemented. The first round of reviews were held in June/July 2011 within all Divisions. As part of these reviews the Infection Prevention Team developed Divisional scorecards using existing audit and performance data to provide a summative assessment of progress. Reviews will be held 6 monthly and data will be used in the Divisional Accreditation Scheme.

Data from the Divisional scorecards is shown below:

<table>
<thead>
<tr>
<th>Measures</th>
<th>Methodology</th>
<th>Division A Scores</th>
<th>Division B Scores</th>
<th>Division C Scores</th>
<th>Division D Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Accreditation</td>
<td>% wards maintaining full accreditation in last 6 months</td>
<td>96%</td>
<td>90%</td>
<td>96%</td>
<td>91%</td>
</tr>
<tr>
<td>Mandatory Infection Prevention Training</td>
<td>% staff maintaining mandatory training in last 12 months.</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Clinical Cleaning</td>
<td>% remaining above audit standard for entire assessment period</td>
<td>48%</td>
<td>63%</td>
<td>61%</td>
<td>61%</td>
</tr>
<tr>
<td>Medirest Cleaning</td>
<td>% remaining above audit standard (score not included in overall score as not under divisional control)</td>
<td>65%</td>
<td>59%</td>
<td>77%</td>
<td>78%</td>
</tr>
<tr>
<td>Mandatory Hand Hygiene Training</td>
<td>% staff reported as maintaining mandatory training in last 12 months.</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Hand Hygiene Compliance</td>
<td>Average % compliance in all clinical staff audits over last 6 months.</td>
<td>95%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Admission MRSA Screening</td>
<td>Average % compliance in all medical staff audits over last 6 months.</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>93%</td>
</tr>
<tr>
<td>Patients with new detection of MRSA colonisation in SUHT</td>
<td>No. of patients against calculated performance limits.</td>
<td>98%</td>
<td>97%</td>
<td>99%</td>
<td>98%</td>
</tr>
<tr>
<td>Patients acquiring C.difficile in SUHT</td>
<td>No. of patients against calculated performance limits.</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>ANTT Compliance</td>
<td>% staff with recognised competence in ANTT over last 6 months.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saving Lives Audits</td>
<td>Average % compliance in all Saving Lives audits over last 6 months.</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Post 48 hr MRSAMSSA bacteraemias</td>
<td>No. of patients against calculated performance limits.</td>
<td>100%</td>
<td>95%</td>
<td>88%</td>
<td>97%</td>
</tr>
<tr>
<td>Post 48 hr E.Coli bacteraemias</td>
<td>No. of patients against calculated performance limits.</td>
<td>98%</td>
<td>93%</td>
<td>93%</td>
<td>98%</td>
</tr>
<tr>
<td>Appropriate Antibiotic Prescribing (HAPPI)</td>
<td>Aim to audit 5-10 patients on every SUHT ward once per month. Pharmacists carry out audit. Target &gt;85%</td>
<td>71%</td>
<td>80%</td>
<td>76%</td>
<td>77%</td>
</tr>
<tr>
<td>Patients with unplanned admission to ICU for sepsis</td>
<td>Number of patients admitted to ICU for Sepsis &gt;48h after admission.</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Overall Infection Prevention Performance</td>
<td></td>
<td>91%</td>
<td>91%</td>
<td>91%</td>
<td>90%</td>
</tr>
</tbody>
</table>

This is the first iteration of compiled divisional data and acts as a baseline performance assessment to drive improvement in some areas. Mandatory hand hygiene and infection prevention training compliance data will be collated from the Divisions for future reports due to the inaccurate data pulled from Oracle Learning Manager (OLM). Red areas relate to aspects of performance new to assessment:

1) Clinical and Contract Cleaning. Inconsistencies remain across the Divisions with regards to standards of cleanliness. Issues around contract cleaning are picked up at the Medirest meeting. Divisions to focus on clinical cleaning and highlight the importance of joint monitoring between Matrons and Environmental Monitoring Team.

2) Individual bacteraemia performance limit targets. These are baseline figures to drive improvement. Individual units with the highest risk patients (e.g. NNU) will inevitably find this more challenging due to unavoidable BSI.

3) HAPPI audit data measure compliance with the process of prudent prescribing rather than assessing whether individual drug choices are correct. These have not previously been widely available to Care Groups/Divisions.

Data will now be disseminated to drive improvement.
## 5.2 Other Environmental Issues

**Legionella in SGH/PAH hospital water systems.**
This is subject to a separate report. Risk relating to acquiring Legionella infection documented on Corporate Risk Register number 1098 has been reviewed to document risk of patients and staff acquiring infection rather than risk of exposure to Legionella. This risk assessment is contingent on current control measures being maintained and remedial pipe work on C6L being completed by end September 2011. No hospital-acquired cases of Legionella infection have been identified.

**Pseudomonas in SGH/PAH hospital water system.**
Risk relating to acquiring Pseudomonas infection documented on Corporate Risk Register number 1219 has been reviewed to document risk of patients acquiring infection from the water system. This is a national problem, identified in July 2010, which relates to the introduction of no touch sensor taps and has affected SUHT patients on the neonatal unit. Work by Estates to replace sensor taps with manual taps appears to have solved the problem, but continued monitoring is required to manage the risk.
6. CQC Assurance Framework

Target:

Progress:
Overall, SUHT is compliant with Outcome 8. However areas for improvement have been identified. The Trust continues to implement actions to improve compliance against Criterion 2 and Criterion 7.

Exceptions are reported to the Infection Prevention Committee and Environmental Operational Steering Group.

Criterion 2 – Cleanliness and the Environment
Cleanliness issues have been highlighted through the environmental audits, Environmental Monitoring cleanliness audits, decontamination issues, and Matrons walkabouts.

Actions undertaken since last report:
• IPT Clinical Practice Facilitator carrying out spotlights and providing intensive support to areas of non-compliance with audits.
• ENT have all relevant risk assessments in place, although non-compliant, show suitable levels of controls to reduce the risk to an acceptable level. The care group is developing an action plan but await the result of the RSH move dates. The risk is on the corporate risk register.
• Clinical cleaning scores now included in the Ward Accreditation programme from 1st April 2011.
• IPT worked with EMT to develop data and report for EMT to show trends, exceptions, actions.
• Meeting held with JB/LW re waste bags. Awaiting national guidance.
• Biannual Divisional Infection Prevention Reviews set up. Divisional scorecards will include clinical cleaning and audit data and used in Divisional accreditation scheme.

Further actions required to achieve green:
• Continued monitoring through EMT cleanliness audits, Matrons walkabouts.
• Identify and report trends of clinical cleaning through EMT reporting.
• IPT to reinstate spotlights.
• Medirest ongoing monitoring and assurance via weekly cleaning meetings, Trust overview cleaning meeting, monitoring of contract KPI’s.
• Improvement of joint monitoring of cleanliness standards with EMT, Matrons.
• Trust Focus/awareness on clinical cleaning. KH/JB to discuss at NMG.

Criterion 7 – Isolation
Issues are ongoing around the failure to complete isolation risk assessments for infectious patients. There also remain issues around delays in isolation of C.difficile cases and newly acquired MRSA positive inpatients.

Actions undertaken since last report:
• Inclusion of delays in isolation of newly acquired MRSA positive inpatients in ward accreditation programme.
• IPT carrying out surveillance of isolation on MRSA positive inpatients to gain a better insight into isolation status and issues within the Trust.
• Reduction in number of delays in isolation occurred in Q1.

Further actions required to achieve green:
• Ongoing IPT C.difficile and MRSA surveillance.
• Monitoring of delays in isolation at Trust Weekly Delivery Group.
• Review isolation and produce action cards for staff.

Criterion 9 – Policies
Trust is reporting compliant against criterion 9; however there are a number of policies requiring review which are included in the exception report.

All out of date policies are currently under review.
7 Miscellaneous

Matrons Report – Summary of Key themes:

Matron’s reports continue to demonstrate a strong culture of ownership and engagement with the Infection Prevention agenda. The common themes identified include:

- Ongoing focus on improvements in clinical and environmental cleanliness including decontamination.
- Ongoing focus on compliance with clinical practice standards relating to infection prevention e.g. hand hygiene; saving lives care bundles, and recognition of this via the ward accreditation scheme.
- Ongoing focus on compliance of isolation of patients with diarrhoea and those newly acquired MRSA positive patients.

The reports also highlight the following key actions around sub optimal levels of performance:

- Focus and improvement in relation to other HCAI blood stream infections i.e. MSSA, E.Coli.
- Ongoing work around incidents of increased risk; Legionella and Pseudomonas.
- Estates and facilities issues that impact on infection prevention and control.
- Focused work around increased rates of SSI.
- Focus on infection prevention and hand hygiene training and actions around the discrepancies on OLM.

The full reports are included in Appendix A.

Financial Information:
The Dept of Health estimates that each MRSA bacteraemia costs approximately £10,000.

<table>
<thead>
<tr>
<th>Cost per case MRSA bacteraemia</th>
<th>Number of cases 2005-2006 in SUHT</th>
<th>Total estimated cost to SUHT 2005-2006</th>
<th>Actual number of cases 2010-2011</th>
<th>Total estimated cost to SUHT 2010-2011</th>
<th>Cost reduction achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>£10K</td>
<td>92</td>
<td>£920K</td>
<td>5</td>
<td>£50K</td>
<td>£870K</td>
</tr>
</tbody>
</table>

The cost per case of C.difficile was estimated to be £4K; based upon detailed economic evaluation published in 1996 (Wilcox 1996). This will now be a conservative estimate due to the impact of inflation.

<table>
<thead>
<tr>
<th>Cost per case Clostridium difficile diarrhoea</th>
<th>Number of cases 2006-2007 in SUHT</th>
<th>Total estimated cost to SUHT 2006-2007</th>
<th>Actual number of cases 2010-2011</th>
<th>Total estimated cost to SUHT 2010-2011</th>
<th>Cost reduction achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>£10K</td>
<td>741</td>
<td>£3.0 million</td>
<td>89</td>
<td>£356K</td>
<td>£2.6 million</td>
</tr>
</tbody>
</table>

The Trust has invested heavily in infection prevention via the core Infection Prevention Team and via clinical services, and the cost-reductions achieved through reduced infection rates demonstrate this investment to be cost-effective.

Risk Register Ref:
Risk number: 27 (corporate risk).

Legal Implications:
Continuing to exceed the MRSA bacteraemia target could be viewed by the Healthcare Commission as a breach of the Hygiene Code, and result in an improvement notice.

The Trust continues to take focussed action to reduce this risk, in collaboration with the Department of Health, the SHA and local PCTs, including implementation of a high-level MRSA Recovery Plan endorsed by all.

Carbon Management: Not specifically relevant
Appendix A Matrons Reports

Matron & CGCL Report for TEC/Trust Board
Division A

Matrons: Cancer Care: Liz Hall, Jacqui Swanston,
Critical Care: Amanda Barnes; Rachel Spreadborough, Linda Monk, Ruth Finney, Jenny Barltrop, Jon Stanger
Surgery: Vickie Purdie, Yvonne Strange
Care Group Clinical Lead: Cancer Care: Chris Baughan
Critical Care: Andrew Cone
Surgery: Jim Smallwood

Date of Report: 13 July 2011
Author: Mary Clunie

Top 3 Successes within the Division:

- Saving Lives audits compliance- continuing high scores across the Division, particularly in surgery
- Zero incidence of line sepsis in TPN patients this year, zero C.Diff, MRSA, MSSA or E.coli bacteraemias in Division, GICU continues to surpass Michigan standard
- Robust engagement with rollout of ANTT in all care groups

NB: Successful request to SHA that CICU MRSA bacteraemia be deflagged for SUHT

If Applicable, Issues (top 3 at most) To Bring To The Attention of IPC, TEC and Trust Board:

1) Need to ensure that external indicators for audit are evidence based, valid and in the patients best interest. eg HII No 5 ventilated patients – successful case presented to Trust infection prevention team by critical care team to record new metric for tracheal cuff pressure measurement as not applicable. Ongoing investigation into robustness of the criteria continues in collaboration with all clinical leads and DH.

Performance Update:
For the period 01/04/2011 – 30/06/2011

Outcome Data:

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MRSA Bacteraemia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>0</td>
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</tbody>
</table>

NB: Successful request to SHA that CICU MRSA bacteraemia be deflagged for SUHT
Outcomes for Other Infections e.g. MSSA Bacteraemia, SSI, E.Coli Bacteraemia:

4 cases of E.Coli Bacteraemia in June all likely to be HCAIs. 3 in surgery, 2 of whom were geriatric medicine transfers to 2 different wards. Both these patients had UTIs. The third surgical patient also had a UTI having had an indwelling urinary catheter. The 4th patient was in cancer care, had a wound ulcer and was neutropenic with a vascular access device but no indwelling urinary catheter. Investigation into the causes is continuing so increased awareness and preventative measures can be put in place.

Plan to start surgical site infection surveillance in October.

Infection Prevention Incidents/Outbreaks:

i) NICU has had four cases of pseudomonas fully investigated by microbiology. 2 patients were external transfers and 2 were possibly because of cross infection occurring before the diagnosis was made.

NB: Pre 48 hour MRSA bacteraemia in C6 (July 2011). Being investigated.

Actions to Address Sub-optimal Compliance with Outcome Performance Data:

ii) raised awareness for all staff with focus on hand hygiene, decontamination of equipment and disposal of water from ventilator tubing. No further incidents.

Process Data:

### Clostridium difficile – Isolation

<table>
<thead>
<tr>
<th></th>
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<tr>
<td>Critical Care &amp; Theatres</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate Isolation</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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<td></td>
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</tbody>
</table>

### Audit Results

<table>
<thead>
<tr>
<th>Audits</th>
<th>HII No 1 Central Venous Catheter Care</th>
<th>HII No 2 Peripheral Line Care</th>
<th>HII No 3 Renal Dialysis Catheter Care</th>
<th>HII No 4 Surgical Site Infection</th>
<th>HII No 5 Ventilated Patients</th>
<th>HII No 6 Urinary Catheter Care</th>
<th>HII No 8 Cleaning &amp; Decontamination</th>
<th>Hand Hygiene (Clinical)</th>
<th>Hand Hygiene (Medical)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>97</td>
<td>N/A</td>
<td>N/A</td>
<td>98</td>
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<td>100</td>
</tr>
<tr>
<td>Critical Care &amp; Theatres</td>
<td>99</td>
<td>97</td>
<td>N/A</td>
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<tr>
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<table>
<thead>
<tr>
<th>Date of Audit</th>
<th>Jan-11</th>
<th>Dec-10</th>
<th>Apr-11</th>
<th>Jun-11</th>
<th>Apr-11</th>
<th>May-11</th>
<th>Apr-11</th>
<th>May-11</th>
<th>Jun-11</th>
<th>May-11</th>
</tr>
</thead>
</table>
CQC Exceptions

<table>
<thead>
<tr>
<th>Criterion 2</th>
<th>Maintaining a clean and appropriate environment to facilitate the prevention and control of infection:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inconsistencies in clinical cleaning. Areas of non compliances identified through environmental audits, spot checks.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criterion 7</th>
<th>Provide adequate isolation facilities, includes completion of isolation risk assessments for infectious patients:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Delays in isolation of C.difficile patients, lack of completed isolated risk assessments.</td>
</tr>
</tbody>
</table>

**Actions to Address Sub-optimal Compliance with Process Performance Data:**

i) Critical care
   - HII No 4: SSI – was incorrect data entry pertaining to NICU, addressed by NICU team and resubmission has taken place.
   - HII No 5: As above - reference tracheal cuff pressure measurement now recorded as not applicable.

ii) Cancer Care
   - HII No. 8 - C6 Trolley in transplant room not labelled as cleaned – process now in place using labels and sign off sheet to be re audited August
   - HII No.6 –CMH figures on dashboard incorrect discussed with IP team and amended to 100%

**Exception Reporting of Wards without Full Ward Accreditation**

i) Critical care
   - Amber for E & F Level theatres – hand hygiene audits (amber); CQC cleaning sheets records inconsistently completed; 95% compliance for statutory & mandatory training

ii) Cancer Care
    - C6 : Amber due to issues included in the report – legionella in pipe work and trolley cleaning all have been addressed

**Hand Hygiene and Infection Prevention Mandatory Training:**

i) Cancer Care – focussed work has led to 2 wards being at 100% and significant improvement in the others. Doctor’s compliance remains an issue and it is planned to support work here when the Practice Educator post, now being recruited to, is filled.

ii) Robust HH figures in critical care and surgery with all wards >83% but needs focussed plan for doctors in latter

iii) Theatres - Hand hygiene practical is now 95% following targeting of out of date staff.

NB: the above figures are taken from local databases not OLM.

**Date this report will be an agenda item at Care Group Governance Meeting:**
- Cancer Care – 22nd July 2011
- Critical Care – 5 August 2011
- Surgery – 15 July 2011

**Date this report will be an agenda item at Divisional Governance Meeting:**
- 8 August 2011
Matrons: Emergency Medicine: Claire Rogers, Jill Young, Katie Ord, Mark Oakley, Erica Wallbridge
Specialist Medicine: Gina Winter-Bates, Clare Forsyth, Jagir Sahota
Radiology & Pathology: Lizete Pearson

Care Group Clinical Lead: Emergency Medicine: Jane Hazelgrove
Specialist Medicine: Jane Hazelgrove
Pathology: Bryan Green
Radiology: Ivan Brown

Date of Report: 15th July 2011
Author: Fiona Hoskins, Divisional Head of Nursing

Top 3 Successes within the Division:

1) HAPPI audit results – MOP over the Trust average
2) AUDIT COMPLIANCE - MRSA screening compliance 99.1% for Emergency admissions 99.4% for elective. Hand Hygiene compliance 98%. Saving Lives compliance 95%.
3) Ward G5 has shown a significant improving in all aspects of nursing care and been removed from the special measures programme.

If Applicable, Issues (top 3 at most) To Bring To The Attention of IPC, TEC and Trust Board:

1) Accreditation - AMU Downgraded on the infection control accreditation scheme – 31st May.
2) MRSA - Likely community acquired MRSA bacteraemia not identified on admission due to failure to acquire blood cultures – learning identified in both AMU and ITU.
3) Cleaning - Estate and capacity issues within Emergency Department continues to hinder domestic cleaning during busy times which is reflected in their environmental audits.

Performance Update:
For the period 01/04/2011 – 30/06/2011

Outcome Data:

<table>
<thead>
<tr>
<th>MRSA Bacteraemia</th>
<th>June 2011</th>
<th>Year to Date</th>
<th>Monthly Performance</th>
</tr>
</thead>
<tbody>
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<td>0</td>
<td>G</td>
</tr>
<tr>
<td>Ophthalmology</td>
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</tr>
<tr>
<td>Emergency Medicine</td>
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<tr>
<td>Medicine for Older People</td>
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</tr>
<tr>
<td>Pathology</td>
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</tr>
<tr>
<td>Radiology</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Clostridium difficile</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2011</td>
</tr>
<tr>
<td>DIVISION B</td>
</tr>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Emergency Medicine</td>
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<tr>
<td>Medicine for Older People</td>
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<tr>
<td>Medicine</td>
</tr>
<tr>
<td>Specialist Medicine</td>
</tr>
<tr>
<td>Pathology</td>
</tr>
<tr>
<td>Radiology</td>
</tr>
</tbody>
</table>
Outcomes for Other Infections e.g. MSSA

No MSSA.
Confirmed MRSA Bacteraemia – Outcome AMU

Infection Prevention Incidents/Outbreaks:

G8 Ward – D&V – 9th May 2011
D8 Ward – D&V – 13th May 2011
D5 Ward – D&V – 13th May 2011
G8 Ward – D&V – 16th May 2011
G9 Ward – D&V – 16th May 2011

Delay in isolation of newly acquired MRSA inpatient – G6 Ward – June 2011
G8 Ward D&V – June 2011

Actions to Address Sub-optimal Compliance with Outcome Performance Data:

1) On going audit of side room usage, isolation times, MRSA screening.
2) OLM data collection system in use, highlighting some training deficits within infection prevention for Medical staff and Allied Health Care Professionals. Divisional Education team is developing an action plan to tackle this.
3) A robust roll-out system for ANTT training is being developed within the Division to tackle all relevant clinical staff.
4) Action plan developed with regards to missed MRSA bacteraemia. New sticky label aid memoire being developed in AMU to ensure right bloods are taken and checked daily.
5) Ward leaders regularly reviewing CQD and discussing with teams.

Process Data

<table>
<thead>
<tr>
<th>Audits</th>
<th>HII No 1 Central Venous Catheter Care</th>
<th>HII No 2 Peripheral Line Care</th>
<th>HII No 3 Renal Dialysis Catheter Care</th>
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<th>Hand Hygiene (Clinical)</th>
<th>Hand Hygiene (Medical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
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<td>Hand Hygiene (Medical)</td>
<td>Hand Hygiene (Medical)</td>
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<td>Medicine for Older People</td>
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<tr>
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<td>Dec-10</td>
<td>Apr-11</td>
<td>Jun-11</td>
<td>Apr-11</td>
<td>May-11</td>
<td>Apr-11</td>
<td>Hand Hygiene (Medical)</td>
<td>Hand Hygiene (Medical)</td>
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</table>

Audit Results
## CQC Exceptions

<table>
<thead>
<tr>
<th>Criterion 2</th>
<th>Maintaining a clean and appropriate environment to facilitate the prevention and control of infection:</th>
<th>Inconsistencies in clinical cleaning. Areas of non compliances identified through environmental audits, spot checks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criterion 7</td>
<td>Provide adequate isolation facilities, includes completion of isolation risk assessments for infectious patients:</td>
<td>Delays in isolation of C.difficile patients, lack of completed isolated risk assessments.</td>
</tr>
</tbody>
</table>

### Actions to Address Sub-optimal Compliance with Process Performance Data:

**Criterion 2**
On going work within the Matrons team to ensure that staff are aware of their clinical responsibilities with regards to cleaning equipment. A significant improvement has been noted with regards to clinical cleaning. The Matrons and Ward Managers are continuing to work with medi-rest around domestic cleaning and in particular in high risk areas and kitchens. Escalation plans are being developed and actioned. CQD dashboard discussed with ward leaders by matrons at 1:1’s.

Roll-out of ANTT training.

**Criterion 7**
Matrons are fully investigating any reports of patients who are not isolated within the designated time frame. The divisional team has agreed a structure for reviewing the use of siderooms across the Division and not just in care groups. Matrons regularly review who is in siderooms and whether it is clinically justified.

### Exception Reporting of Wards without Full Ward Accreditation:
AMU Ward loss of accreditation due to delays in isolation. Incidents discussed with staff members involved and action plans developed and escalated out to ward teams.

### Hand Hygiene and Infection Prevention Mandatory Training:

**Date this report will be an agenda item at Care Group Governance Meeting:**
Insert Date

**Date this report will be an agenda item at Divisional Governance Meeting:**
Insert Date
Matron & CGCL Report for TEC/Trust Board
Division C

Matrons: Carol Purcell, Cath Battrick, Carol Woolridge, Carol Gosling, Julia Clark

Care Group Clinical Lead:

Date of Report: June 2011

Author:

Top 3 Successes within the Division:

**PHDU**
- Despite rota virus, MSSA and MRSA in an open ward there has been no cross infection.
- Good use of risk assessments and flow chart to manage infection prevention.
- Currently no infections in PHDU, patients now clear of MRSA, MSSA and rota virus

**Neonates**
- All taps changed in neonatal unit and the last two monthly water samples have been clear of pseudomonas.

**Maternity**
- Collaborative working to develop workable solutions for PPE in maternity services.

If Applicable, Issues (top 3 at most) To Bring To The Attention of IPC, TEC and Trust Board:

**PHDU**
- MSSA bacteraemia – see below
- No cubicles and only one hand basin in 4 bedded ward.
- PHDU is on the corporate risk register. Facilities had a formal review in May. Recommendations from the review soon to be published.

**Gynae**
- Issues with ventilation in theatres- temperature control a significant issue.

**Neonates**
- The neonatal unit suffered a compressed air failure. Investigation almost completed by estates team.
- The three babies with the MSSA bacteraemias were all involved in this incident and required transfer from incubators to transport systems.

**Child Health**
- Lack of Isolation facilities in PHDU affecting increased acute care within paediatric wards which are not resourced for the care these children and young people require and affects patient flow from PICU
- MRSA screening in child health now being established, indicating higher colonisation in paediatrics than initially thought. Policy widely available. Continue challenge to ensure all admissions screened
- Treatment rooms need refurbishment, sinks condemned areas in poor state of repair, new fridges now in place. G4S treatment room soon to be refurbished in 2011
- Lack of en-suite facilities with cubicles provides poor dignity for older children and young people and increases risk of cross infections
- New toileting and bathroom facilities being refurbished on G3

Performance Update:
For the period 01/04/2011 – 30/06/2011

Outcome Data:

<table>
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<tr>
<th></th>
<th>Target</th>
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</tr>
</tbody>
</table>

MRSA Bacteraemia
Outcomes for Other Infections e.g. MSSA Bacteraemia, SSI, E.Coli Bacteraemia:

One MSSA bacteraemia in PHDU.
- Child had cardiac surgery but due to his long term ventilation he was cared for on PHDU rather than E1.
- When patient needed further surgery he had not been prepared according to policy that is skin washes and nasal cream

Recommendations
- Staff education
- Cardiologists need to prescribeoctenisanwash andbactroban nasal cream before cardiac surgery as policy.
- When cardiac surgical patients are not on E1 ward cardiac nurse practitioners to ensure prescriptions are written and nurses are given pre-op care plan.
- Children undergoing cardiac surgery should be screened for MRSA and MSSA. If they have a tracheostomy in situ there needs to be specific discussion with cardiac surgeons in order to reduce the chance of a wound infection.

Neonates
- Three babies have had MSSA bacteraemias. All were successfully treated and are progressing well.

Child Health
- No Other infections reported

Infection Prevention Incidents/Outbreaks:

Neonates
- Increased incidence of MSSA infections within the maternity unit. Ongoing investigation involving IPT, estates and clinical team.

Child Health
- No outbreaks this quarter

Actions to Address Sub-optimal Compliance with Outcome Performance Data:

- General estates issues on the neonatal unit and in the PAH are on the corporate risk register.

Process Data:

Clostridium difficile – Isolation

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Immediate Isolation</td>
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<td>100</td>
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## Audit Results

<table>
<thead>
<tr>
<th>Audits</th>
<th>HII No 1 Central Venous Catheter Care</th>
<th>HII No 2 Peripheral Line Care</th>
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*(Non submission of urinary catheter audit by Therapies)*

## CQC Exceptions

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<tr>
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<td>Delays in isolation of C.difficile patients, lack of completed isolated risk assessments.</td>
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</table>

### Actions to Address Sub-optimal Compliance with Process Performance Data:

**Gynae**
- Cleaning and decontamination- an issue with staff walking through ward areas and not complying with Trust policy. This is to be discussed with specialist services.

**Child Health**
- Link nurses continue to liaise with medical colleagues to encourage submission of medical hand hygiene audits in agreed timescales.
- ...
- VIP scoring under review following clinical incident

### Exception Reporting of Wards without Full Ward Accreditation

- PICU, PHDU and E1 have full accreditation
- Neonates The Neonatal Unit has full accreditation.

**Child Health**
- Monthly 1:1 with ward leaders to discuss and action audit submissions and any issues not resolved

### Hand Hygiene and Infection Prevention Mandatory Training:

**Child Health**
- Active training and communication of infection control within care group continues.
- Link nurses given dedicated time

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**Date this report will be an agenda item at Care Group Governance Meeting:** Insert Date

**Date this report will be an agenda item at Divisional Governance Meeting:** Insert Date
Matron & CGCL Report for TEC/Trust Board
Division D

Matrons: Juliet Cox, Rachel Davies, Louisa Green, Sandra Palmer, Tina Raybould, Jo Smith, Pat Spacagna

Care Group Clinical Lead: Andy Cole, Paul Grundy, Gareth Morris

Date of Report: 4.7.11
Author: Helen Neary

Top 3 Successes within the Division:

- Full infection control and prevention accreditation @ Divisional level
- Consistent 99%-100% MRSA screening
- HPA modules; TOE, Hip Replacements, Knee Replacements, repair NoF, Spinal Surgery recommence 1.7.11.

If Applicable, Issues (top 3 at most) To Bring To The Attention of IPC, TEC and Trust Board:

Planned review for total knee category – Oct-Dec 2010 as >95% centile for infection.

Performance Update:
For the period 01/04/2011 – 30/06/2011

Outcome Data:

**MRSA Bacteraemia**

<table>
<thead>
<tr>
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<th>June 2011</th>
<th>Year to Date</th>
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<tr>
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<td>DIVISION D</td>
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<tr>
<td>Cardiothoracic</td>
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<tr>
<td>Neurosciences</td>
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**Clostridium difficile**

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Outcomes for Other Infections e.g. MSSA Bacteraemia, SSI, E.Coli Bacteraemia:

1 x MRSA bacteraemia under RCA.

T&O continue to work with theatres to reduce SSI for Hip Replacements.
**Infection Prevention Incidents/Outbreaks:**

No outbreaks.

Failure to isolate newly acquired MRSA patient in May 2011 on E3. (7 hour delay, hindered by the need for several bed moves, cleaning of side room and in support of 4 hourly ED targets and same sex accommodation. All infection control precautions met, no evidence of cross contamination. Ward team aware of need to escalate at an early point to Matrons.)

**Actions to Address Sub-optimal Compliance with Outcome Performance Data:**

Focus on Medical Hand Hygiene in T&O, currently on weekly audits.

Review of data entry for saving lives audits as disparity in central audit and ward/Care Group data.

Review of dressings within theatre achieved in T&O for Hip Replacements. Skin prep under discussions.

Theatre review and observations – Amber from Red, aiming for Green.

**Process Data:**

**Clostridium difficile – Isolation**

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**Actions to Address Sub-optimal Compliance with Process Performance Data:**

In discussions with IPCT, all data will be resubmitted as data entry errors found during review of red and amber results.

**Exception Reporting of Wards without Full Ward Accreditation**

None – all fully accredited.

**Hand Hygiene and Infection Prevention Mandatory Training:**

Discrepancy continues between OLM data and local records.

Date this report will be an agenda item at Care Group Governance Meeting: Insert Date

Date this report will be an agenda item at Divisional Governance Meeting

Insert Date: 8.7.11