Homerton University Hospital NHS
NHS Foundation Trust

HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

Director of Infection Prevention & Control (DIPC) & Infection Prevention & Control Team (IPCT)

Annual Report

April 2012 - March 2013

Author:

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On behalf of the:
Homerton University Hospital Infection Prevention & Control Team (IPCT)

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1 Executive Summary

a) Healthcare Associated Infection (HCAI) Objectives 2012-2013:

- The 2012-2013 MRSA Objective target for the Trust was 1 Homerton-attributable (Post-48h) MRSA bacteraemia. The end of year total was 2 cases.
- The 2012-2013 *C.difficile* Objective target for the Trust was 7 Homerton-attributable cases. The end of year total was 13 cases.

b) Hygiene Code compliance 2012-2013:

- A Klarient software programme is used to assess compliance and store evidence.
- There have been no concerns or issues regarding Hygiene Code Compliance at the Trust raised by the Care Quality Commission during any of their visits in 2012-13.
- The Infection Prevention & Control Team (IPCT) and the Employee Health Medical Services (EHMS) have completed a joint project to ensure that the Trust is compliant with the new EU directive (Council Directive 2010/32/EU) requiring all member states to introduce further protection of health care workers exposed to the risk of sharps injuries. The implementation of safer needle devices as recommended by this project and the updated infection control policy on 'Protection against Blood Bourne Viruses and Needlestick Injuries' gives compliance against Criterion 9 of the Hygiene Code.

c) Infection Prevention and Control (IPC) arrangements 2012-13:

- The following Infection Prevention and Control (IPC) assurance framework from ward level to Trust Board of Directors is currently in place:
  - Homerton Hospital Clinical Directorates (SWSH, CSDO, IMRS) report on their IPC performance and governance via the Infection Prevention and Control Lead Nurse Group and Decontamination Monitoring Committee. These Infection Prevention & Control sub groups report to the Infection Control Committee on a quarterly basis as does the IPCT, Estates & Facilities and Employee Health Medical Services (EHMS). The IPCT reports to the ICC consist of the IPCT quarterly report, the IPC risk register update and the IPC Balanced Score Card.
  - The ICC is chaired by the DIPC. The DIPC then presents a quarterly report to the Trust Board of Directors (in person on request) providing IPC performance and governance updates to assure the Board of the effectiveness of IPC measures at the Trust. The DIPC also presents an Annual Report on behalf of the DIPC and IPCT to the Trust Board in person.
  - IPC measures approved by the ICC and Board of Directors are cascaded back down to ward level by the Directorate Leads for action and audit and IPC improvements are reported back to the ICC.
  - The DIPC also reports directly to the CEO and the Chief Nurse and Director of Governance.

- The Divisions discuss IPC incidents, HII results and IPC issues at local Governance meetings and report on these at the Division Performance meetings with the Executive Team.
- The Senior Nurse for each Directorate also presents their IPC reports to the Quality Improvement Committee (QIC) as part of their Divisional reports. The QIC, on which the DIPC sits, reports to the Risk Committee which reports to the Board of Directors.

d) DIPC/ICT Annual Programmes 2012-2013 and 2013-2014

- The DIPC and IPCT annual programmes for 2011-2012 and 2012-2013 are presented as part of this DIPC and IPCT annual report.

e) HCAI statistics 2012-2013:

- Homerton University Hospital NHS Foundation Trust has had 2 Trust-attributable MRSA bacteraemias against a target of 1 Trust-attributable MRSA bacteraemias for 2012-2013.
- Homerton University Hospital NHS Foundation Trust has had 13 Trust-attributable Clostridium *difficile* infections (CDI) against a target of 7 for 2012-2013.
- In line with mandatory DH requirements, the Trust IPCT also collects and submits data on the number of Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias, *E.coli* bacteraemias and Glycopeptide Resistant *Enterococci* (GRE) bacteraemias processed by the Trust Microbiology laboratory. There are no targets set for these bacteraemias.
  In 2012-13 the Microbiology laboratory processed blood culture samples on:
  MSSA bacteraemias: 20
  E.coli bacteraemias: 61
  GRE bacteraemias: 0
- The Surgical Site Infection (SSI) rates for April 2012 – March 2013 for Total Hip Replacements (THR) is 4.1% compared to all hospitals rates of 1.2% and for Total Knee Replacements (TKR) there have 4.9% infected compared to 1.7% nationally. Although these statistics may be a reflection of the relatively small number of THR and TKR operations performed at the Trust, the orthopaedic clinical governance arrangements are under review to ensure that there is a robust process for investigating all Orthopaedic SSIs.
- A summary of outbreaks, other Serious Incidents (SIs) and incidents is presented in this report.

f) IPC audit programme 2012-2013:

- The IPC audit programme for 2012-2013 was completed and all action points were followed up.
  This programme included the:
- Infection Control Nurse-led Infection Prevention Society (IPS) audits of 49 clinical areas (CSDO: 9 audits; IMRS: 22 audits; SWSH: 18 audits).
- Ward-based High Impact Interventions (HII) audits:
  Central Venous Catheter care

Peripheral Venous Catheter care
Prevention of surgical site infections (theatres only)
Urinary catheter ongoing care
Hand hygiene audits
MRSA screening audits

- Audit of compliance with key policies:
  Isolation Policy Compliance Audit
  Sharps Disposal
  Antimicrobial prescribing
  Blood culture contamination

g) IPC education programme 2012-2013:

- Induction training - all staff attend the Trust induction. Infection Prevention & Control is also part of junior medical staff induction arranged by medical staffing on a monthly basis.
- In June 2012 a Trust Statutory and Mandatory Training booklet which included a section on Infection Prevention & Control was sent out to all staff as a Level 1 update.
- By the end of the 12/13 financial year, 97% of staff had received an IPC level 1 annual update.
- IPCT and DIPC training activities – the IPCT and DIPC continue to attend postgraduate education and other courses to ensure ongoing professional development.

h) Cleaning Services IPC arrangements 2012-2013:

- The cleaning services for the Hospital acute site are contracted out to Medirest and, for the community sites, the East London Consortium provide and monitor the cleaning services. Monitoring within the Trust's premises is undertaken as prescribed within The National Specifications for Cleanliness in the NHS (2007), Revised Guidance on Contracting for Cleaning (2004), current legislation, codes of practice and best practice.
- Cleaning service performance is formally audited by technical audits & monitoring and validation audits. Cleaning service performance is informally audited by the Hotel Services Monitoring Officer's report to the Cleaning Review Group and the Hotel Services Manager's report to the Infection Prevention and Control Lead Nurse Group.
- No major issues were reported in the cleaning services audits in 2012-13.
- PEAT is now replaced with PLACE (Patient Led Assessment of the Clinical Environment). The inspection took place in June 2013.

i) Estates and Facilities reports 2012-2013:

- The ICC receives quarterly reports on the Trust's decontamination monitoring, ventilation planned preventative maintenance programme and Legionella planned preventative maintenance programme.

- The Department of Health document 'Sources and potential *Pseudomonas aeruginosa* contamination of taps and water systems. Advice for augmented care units' was published in March 2012. As a result a 'Water Safety Plan' has been developed by Estates and the IPCT and endorsed by the ICC and there is ongoing surveillance both by the Estates team and IPCT to ensure environmental and clinical monitoring of pseudomonas on the Trust's augment care units (adult and neonatal ICUs).

j) Employee Health Medical Services (EHMS) IPC reports 2012-2013:

- An Employee Health Management Service (EHMS) balanced scorecard including details of compliance with the Exposure Prone Procedure (EPP) register and measles, rubella, chickenpox and tuberculosis screening register is reported to the ICC quarterly.
- In 2012/13, the EHMS department led the Trust's Flu Staff Vaccination Campaign. Almost 40% of frontline staff were vaccinated by the EHMS team (Doctors: 60%; Nurses/Midwives: 31%; AHPS: 46%; Support to clinical staff: 40%).
- During 12/13 EHMS & the IPCT have completed a joint project to ensure that the Trust is compliant with the new EU directive (Council Directive 2010/32/EU) requiring all member states to introduce further protection of health care workers exposed to the risk of sharps injuries.

k) IPC policies endorsed by the ICC in 2012 -2013:

The following IPC policies have been reviewed and endorsed by the ICC in 12/13:

- Policy for prevention and contact management of measles, mumps and rubella in health care staff (EHMS) VZV (review)
- Dress Code (review)
- Group A Streptococcus (new policy)
- Multi-resistant Gram Negative policy (review)
- Endoscopy decontamination (review)
- Rabies policy (review)
- IPC operational policy including ICC terms of reference (review)
- TB policy (review)
- Norovirus diarrhoea and vomiting policy (review)
- Protection against BBV and NSI (review in line with EU directive on safer sharps, SICP and BBV policies merged)
- Policy for Hepatitis B immunisation and Occupational health clearance for hepatitis B, C and HIV in health care staff (review)
- *C.difficile* policy (reviewed in line with introduction of laboratory PCR testing)

l) Influenza – Winter 12/13 update:

- Over the winter months influenza activity was low with very few admissions to the acute hospital and critical care. There was no adverse impact on bed or isolation capacity.

m) Other IPC updates:

- This DIPC/ICT annual report 2012-2013 will be presented to the Board of Directors and then made available to the public on the Trust internet site in accordance with the requirements of the Code of Practice for reducing HCAI.
- Dr Daniel Krahé, the Microbiology Laboratory Director and Clinical Lead Microbiology Consultant and member of the IPCT has retired due to illness. We gratefully acknowledge his contribution to IPC at the Trust over the past 6 years.
- The DIPC & IPCT also gratefully acknowledge the contribution that Dr Maysoon Al-Zahawi, Dr Krahe's locum, has made to IPC at the Trust since her appointment in July 2012.
- In addition to ongoing Service Level Agreements (SLAs) to provide IPC cover for Mildmay and St Joseph's Hospice, the IPC team has been awarded the contract to provide IPC services for the East London Foundation Trust (ELFT). The ELFT contract started on the 17th September 2012.

2 Healthcare Associated Infection Objectives 2012- 2013

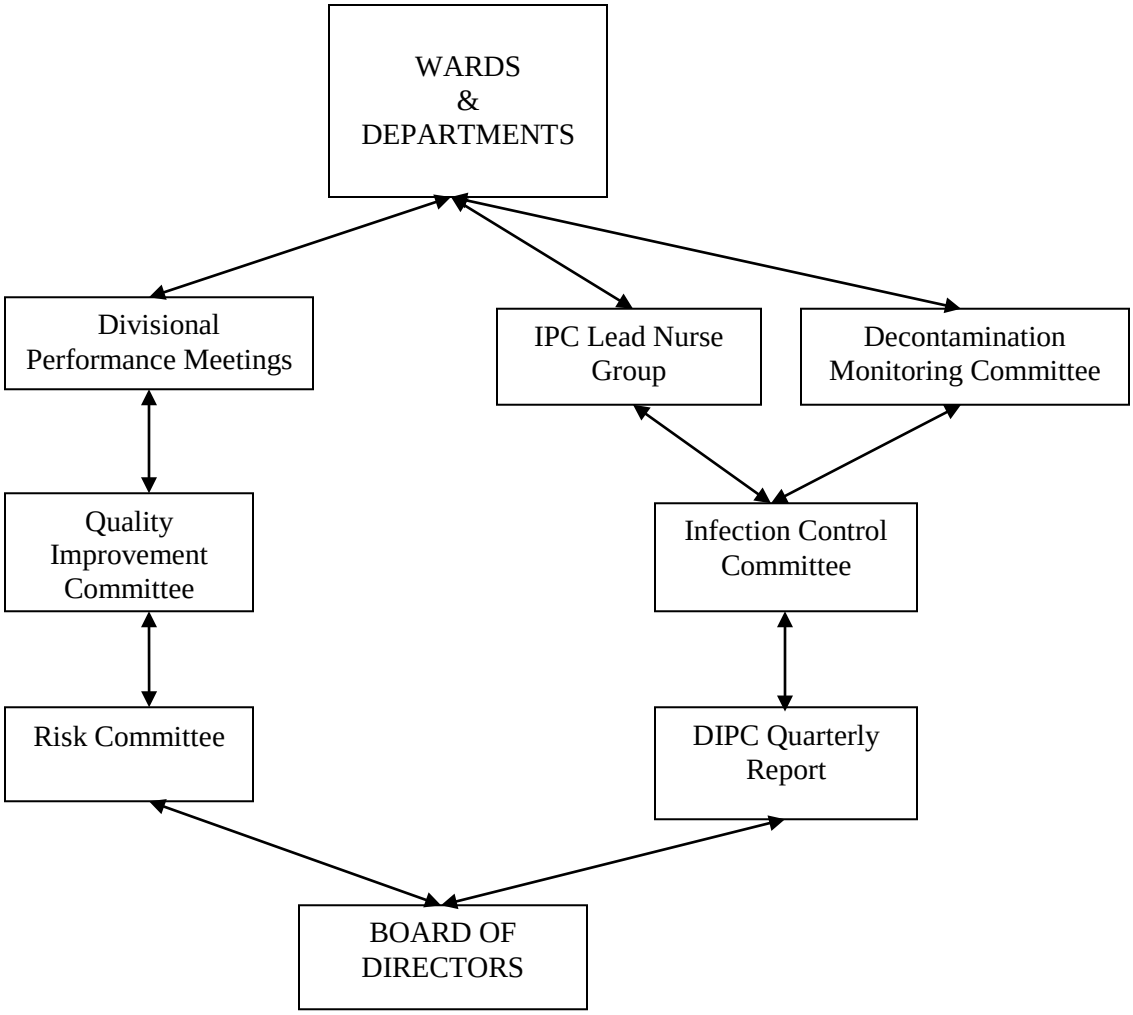
- The 2012-2013 MRSA Objective target for the Trust was 1 Homerton-attributable (Post-48h) MRSA bacteraemias. The end of year total was 2 cases.
- The 2012-2013 *C.difficile* Objective target for the Trust was 7 Homerton-attributable cases. The end of year total was 13 cases.
- All HUH-attributable MRSA bacteraemias and are automatically Serious Incidents and all Non-HUH-attributable (pre-48h) MRSA bacteraemias and C.difficile cases have an RCA completed.

3 Hygiene Code Compliance 2012-2013

- A Klarient software programme is used to assess compliance and store evidence.
- There have been no concerns or issues regarding Hygiene Code Compliance at the Trust raised by the Care Quality Commission during any of their visits in 2012-13.
- The Infection Prevention & Control Team (IPCT) and the Employee Health Medical Services (EHMS) have completed a joint project to ensure that the Trust is compliant with the new EU directive (Council Directive 2010/32/EU) requiring all member states to introduce further protection of health care workers exposed to the risk of sharps injuries. The implementation of safer needle devices as recommended by this project and the updated infection control policy on 'Protection against Blood Bourne Viruses and Needlestick Injuries' gives compliance against Criterion 9 of the Hygiene Code.

4 Infection Prevention and Control Arrangements

4.1 IPC Accountability and Assurance Framework



4.2 Summary table of IPC accountability and assurance framework

Regularity	Information Tree	Reporting	Response to Variance
Quarterly	Trust Board	DIPC report – surveillance data, incidents and outbreaks, SIs, audit programme, antimicrobial prescribing, IPC Lead Nurse group, education programme, IPC BSC, risk register, cleaning standards, estates and facilities reports (Legionella, ventilation, decontamination) and employee health reports	Frequency of meetings may be increased or decreased in response to specific situations such as an outbreak. This would be reflected in IPC reports and DIPC reports to the Board.
Quarterly	Infection Control Committee	Surveillance data, incidents and outbreaks, SIs, audit programme, antimicrobial prescribing, IPC Lead Nurse group, education programme, IPC BSC, risk register, cleaning standards, estates and facilities reports (Legionella, ventilation, decontamination) and employee health reports	
Quarterly	Health and Safety Committee	Needlestick injuries, latex allergy	
Quarterly	Decontamination Monitoring Committee	Decontamination of equipment, SSD audits and compliance, endoscopy audits and compliance	
Quarterly	IPC Lead Nurse Group	Ward/clinical area IPC issues	
Monthly	Quality Improvement Committee	IPC issues in the Divisional reports	
Monthly	Catering and Domestic Operational Review Group	Performance against National Standards of Cleanliness and Trust KPI	
Monthly	Patient Safety Committee	RCAs, SIs	
Monthly	Infection Control Team meetings	Surveillance data, SIs, policy review programme, audit programme, antimicrobial prescribing, education	
Monthly	Divisional Governance/Performance meetings	HII, audit, cleanliness, decontamination, SIs and education	
Weekly	DIPC and ICN meetings	Key issues Instant reporting of HCAI issues	
Monthly Daily Ad hoc	Wards	HII, audit, C.difficile, MRSA and cleaning	

4.3 Infection Prevention & Control Team overview

4.3.1 Membership of the IPCT

The Infection Prevention & Control Team (IPCT) comprises of:

a) One full-time Consultant Microbiologist, Dr Alleyna Claxton, who is also the Infection Control Doctor (ICD) & Director of Infection Prevention and Control (DIPC).
b) One full-time Infection Control Nurse Consultant (ICNC) and Deputy DIPC, Ms Victoria Longstaff.
c) Four full-time Band 7 Infection Control Nurses, Ms Gema Martinez-Garcia, Ms Marcia Andrews, Ms Monique Laberinto and Ms Mo Farish (ICN for ELFT).
d) One part time administrator, Ms Sheila Martin.
e) During 12/13 Dr Daniel Krahé's role in the IPCT has been provided by his locum Dr Maysoon Al-Zahawi.
f) One full-time Microbiology Specialist Registrar (in 12/13 Dr Michael Murphy - Micro/ID LATS)
g) One full-time antibiotic pharmacist, Ms Luisa Cabrero-Moreno.

4.3.2 IPCT team monthly meetings

- The IPCT meets monthly on the second Thursday of every month. The IPCT (as above) and Health Protection Unit Nurse Consultant attend.
- The regular agenda items for meetings are:

  Clinical items:
  MRSA cases (bacteraemia, infected, colonised)
  C. difficile infections
  MSSA bacteraemias
  E.coli bacteraemias
  GRE bacteraemias
  Pseudomonas in NICU/SCBU/ITU
  Invasive and maternity cases of invasive Group A Strep

  Incidents and outbreaks
  Policy review programme
  Antimicrobial prescribing
  Infection control audit programme – IPC, ICNA & HII
  Education programme
  HPU update
  Divisional update
  ELFT update

- Issues discussed at the IPCT meetings may be included on the Infection Control Committee agenda as necessary.

4.3.3 Responsibilities of the IPCT

- The DIPC provides a report to the Board quarterly.
- The Nurse Consultant/Infection Control Nurse attends the Trust Health and Safety and Patient Safety Committee meetings
- The IPC team provides specialist advice, formulates, monitors and evaluates the implementation of policies.
- The use of evidence-based practice is supported and used in the writing and reviewing of policies.
- The IPC team are responsible for the daily management and advice on infection control clinical cases and incidents. They also advise the Trust at a strategic level on service and building developments which will have an impact on IPC and required remedial actions.
- The IPC team develop and provide education to all Trust staff on infection prevention and control.
- The IPC team develop and complete a programme of audit relating to infection prevention and control.
- An Annual Report is produced by the DIPC and Deputy DIPC and presented to the Trust Board.
- An Infection Prevention and Control Team Annual Programme is produced by the ICNC and DIPC and presented to the ICC for agreement.
- All members of the IPC team are registered for and fulfil Continuing Professional Development requirements.
- The IPC team will identify requirements for additional resources to support and promote infection control practices and present these to the ICC.
- The IPC team will fulfil the requirements of any SLA for a service with outside organisations. Currently SLAs are held with the East London and City Mental Health Trust, St Joseph's and Mildmay Hospital.
- The IPC team report to the Infection Control Committee.

4.3.4 IPCT technical support

- The IPCT is supported by the in-house Microbiology laboratory and the Virology laboratory situated at Royal London Hospital.
- In 2012-2013, the IPCT has used the web-based Klarient Hygiene Code self-assessment tool to enhance the accessibility of the portfolio of evidence required to demonstrate compliance with the Hygiene Code.
- In 2012-2013, the IPCT has used a web-based Infection Prevention Audit System (IPAS) to assist with local data collection for ward based monitoring of High Impact Interventions.

4.3.5 IPCT reports to the ICC

4.3.5.1 IPCT Quarterly report

The IPCT present a quarterly summary report to the ICC which details surveillance data (MRSA bacteraemias, *C.difficile* infection, MSSA

bacteraemias, *E.coli* bacteraemias, GRE bacteraemias, Pseudomonas in augmented care units, orthopaedic surgical site infections), incidents and outbreaks, SIs, audit programme, education programme, policy review programme and Service Level Agreements.

4.3.5.2 IPC Risk Register

At the end of 2012-13, the following risks remain on the IPC Risk Register as ongoing risks requiring further acute action after review by the ICC. Those risks that, after discussion at the ICC, have been confirmed as ongoing risks for which no further acute actions can be identified have been closed on the risk register with the proviso that they may be put back on at any time should their risk profile change.

There are 2 ongoing IPC risks on the risk register:

- Risk 413 Pseudomonas in tap water in NICU – SOP required from unit on control measures. The risk will then be reviewed at the July 2013 ICC and if water system testing results continue to be negative, the risk will be closed.
- Risk 144 Legionella and pseudomonas in Trust water supplies – remains on risk register with current score of 5. The Trust's Water Safety action plan is to be developed following Dr Lee's external audit and presented to the next ICC in July 2013. The risk will then be reviewed in light of the recommendations and actions.

The following risks have been closed on the risk register in 12/13:

- Risk 11 Provision of hand washing sinks
- Risk 38 Neonatal infection risk
- Risk 150 Segregation of surgical elective and emergency cases
- Risk 23 Training
- Risk 230 MRSA target
- Risk 328 *C.difficile* target
- Risk 396 Negative pressure isolation
- Risk 366 Planned maintenance in theatres

4.3.5.3 IPC Balanced Score Card

The IPC balanced Score Card (BSC) is used to summarise Trust wide IPC data and is presented to the ICC quarterly.
The IPC BSC comprises of summary statistics of the following:

- DH Indicators (MRSA bacteraemias, Trust-attributable *C.difficile* infections, GRE bacteraemias)
- SIs (Trust-attributable MRSA-related deaths, *C.difficile*-related deaths, other SIs)
- 'Alert organism' trigger events (MRSA, CDI)
- National Standards Monitoring tool (cleaning)
- Outbreaks (Diarrhoea & Vomiting, other)
- Audits completed (ICNA, Trustwide, HIIs)

- IPC training completed

4.4 Infection Control Committee overview

Authority

The Infection Control Committee has been established to evaluate and report on all aspects of infection prevention and control and compliance with the Health and Social Care Act on behalf of the Board of Directors. The committee is a subcommittee of the Trust Board and reports directly to the Board via the DIPC Quarterly reports and Annual Report.

Purpose

The purpose of the committee is to ensure that there is a managed environment within the Trust that minimises the risk of infection to patients, staff and visitors. The committee provides the Board of Directors with assurance that it has control of the HCAI agenda through compliance with HCAI regulatory requirements.

Duties

- To ensure strategic and operational infection prevention and control risks are identified, assessed, evaluated and managed according to the risk management and assurance frameworks.
- To provide strategic direction and guidance to facilitate the development and implementation of infection prevention initiatives Trustwide.
- To promote a culture in which infection prevention and control will continue as an integral and seamless component of the healthcare process.
- To receive and approve the Infection Prevention and Control annual programme and audit programme ensuring the programme has clearly defined objectives.
- To monitor progress against Infection Prevention and Control performance key performance indicators using the balanced score card.
- To consider and respond to reports on:
  - Incidence and prevalence of alert organisms and important infectious disease
  - Serious Incidents
  - Infection prevention and control education and training
  - Infection prevention and control practice and hospital hygiene
  - Outbreaks of infection
  - Audit
- To ensure structures and processes are in place that enable hygiene code self-assessment and compliance.
- To define priorities based on current risk ratings detailed in the Infection Prevention and Control risk register.
- To review and endorse Trust policies for infection prevention and control, procedures and guidance and monitor their implementation through an annual programme of audit.
- To review and monitor outbreak management plans and monitor their implementation.

- To review other infection control issues as necessary, including those relating to catering, decontamination, engineering, ventilation and water services, employee health, pharmacy, procurement, capital strategy etc.
- To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection.
- To monitor the performance of the IPCT and make suggestions for improvement.
- To review the performance of the committee.

Membership

Director of Infection Prevention and Control (DIPC) - CHAIR
Chief Nurse/Executive Director for IPC – DEPUTY CHAIR

Medical Director
Clinical Risk Manager
Consultant Microbiologist
Employee Health Lead
Infection Control Nurse Consultant/Deputy DIPC
Senior Nurse Children's services, diagnostics & outpatients
Senior Nurse Integrated medical & rehabilitation services
Senior Nurse Surgery, women's and sexual health services
Head of Midwifery
Infection Control Nurses
Director of Environment (Trust Decontamination Lead)
Health Protection Team representative (nurse or CCDC)
Non-Executive Director

The Terms of Reference are reviewed annually and were reviewed and agreed in January 2013

4.5 DIPC reports to the Trust Board

- Dr Alleyna Claxton, the current DIPC, Infection Control Doctor (ICD) and Microbiology Consultant is accountable to and reports directly to the Chief Executive Officer (CEO). The Trust's longstanding CEO, Ms Nancy Hallett, retired in December 2012 and Ms Tracey Fletcher is the new CEO.
- The DIPC presents a Quarterly DIPC report to the Trust Board (in person on request). The DIPC quarterly reports summarises the minutes of the ICC and any other issues of importance to the Trust Board.
- Board decisions regarding Infection Prevention & Control issues are recorded in the minutes of the Board meetings.
- Incident, outbreak and SI reports are presented to the Board in the Quarterly DIPC reports.
- The DIPC quarterly reports are available on request.
- The DIPC/IPCT annual programme is approved by the ICC.
- The DIPC/IPCT annual report is presented to the Board in person by the DIPC and ratified by the Board.

- The DIPC/IPCT annual report is then made available to the public on the Trust internet web site in accordance with the requirements of the Health and Social Care Act.

4.6 IPC reports to other Trust assurance frameworks

4.6.1 Quality Improvement Committee

- The DIPC sits on the Trust's Quality Improvement Committee.
- Each Division submits regular reports to the Quality Improvement Committee which include Infection Prevention & Control reporting.

4.6.2 Patient Safety Committee

- The Trust's Patient Safety Committee meets monthly and reports to the Risk Committee which reports to the Board of Directors.
- The Deputy DIPC sits on the Patient Safety Committee and reports all IPC-related SIs, outbreaks and other relevant IPC issues to the committee.

5 DIPC/ICT Annual Programme 2012-2013

Objective	Actions	Leads	Timescale
Complete a programme of audit for Community Health Services using the Infection Prevention Society audit tool.	• Audit programme developed to cover 6 department and 17 service based audits • Ensure that key findings and recommendations from IPC audits and progress on IPC audit programmes are reported to the ICC via the ICT quarterly report and Trust Board via the DIPC quarterly report for action	IPC team	Ongoing during 2012-2013 Quarterly review at ICC (via ICT quarterly report)
Implement high impact (HII) intervention monitoring in Community Services (Chronic wounds, IV lines, Urinary catheters, enteral feeding)	• Provide training on HII to community staff involved in practices • Provide training on HII monitoring to key staff members • Produce monthly reports on HII compliance results and disseminate to matrons and community service leads • Results will be reported to the ICC via the ICT quarterly report and Trust Board via the DIPC quarterly report for action	IPC team	Ongoing during 2012-2013 Monthly Quarterly review at ICC (via ICT quarterly report)
Set up an Out-patient Parental Antibiotic Therapy framework	• Prescribing protocol and care pathway for patients to be developed in conjunction with the pharmacy and community services • Admission avoidance pathway to be developed with A&E	IPC team/antibiotic pharmacist	March 2013 Community OPAT service development - in progress. Pathway for cellulitis & pyelonephritis admission avoidance developed with A&E.
In conjunction with paediatric and neonatal teams develop an antimicrobial prescribing policy	• Develop antimicrobial prescribing guidelines for neonatal and paediatric patients which will be available on the	DIPC/antibiotic pharmacist/neonatal and paediatric lead	March 2013 Guidelines available on the Trust intranet developed by

	Trust intranet		paediatricians and approved by Dr Krahé in 2011
Safer needle devices to be implemented as appropriate	• Safer needle devices to be reviewed and implemented as necessary in accordance with the European Directive published in 2010 (Council Directive 2010/32/EU)	IPC team EHMS	March 2013
Surveillance for Extended-spectrum-beta-lactamases (ESBL) producers and other multi-resistant gram negative organisms	• Develop a surveillance system for ESBL and other multi-resistant gram negative organisms • Report and act on resistance markers in relation to IPC practices and antimicrobial prescribing • Report surveillance data and any actions required to the ICC via the ICT quarterly report and Trust Board via the DIPC quarterly report	IPC team	Ongoing during 2012-2013 Quarterly review at ICC (via ICT quarterly report)
Perform Root Cause Analyses (RCA) on the MSSA and *E.coli* bacteraemias to identify any preventative actions	• Develop a system for performing RCA on the MSSA and E.coli bacteraemia cases • Report findings and any actions required to the ICC via the ICT quarterly report and Trust Board via the DIPC quarterly report	IPC team	Ongoing during 2012-2013 Quarterly review at ICC (via ICT quarterly report)
Ongoing Objectives			
Review infection prevention and control initiatives that require additional financial resources to inform the annual budget setting process at Divisional level	• Review IPC practice and initiatives and priorities those which will have the greatest impact on reducing HCAI and improve patient safety • Present the above to the ICC and include in the relevant DIPC report	IPC team DIPC	September 2012 September 2012
Complete a programme of audit and ensure findings are acted on	• Surgical prophylaxis audit (annual) • Antimicrobial prescribing compliance audit (to include duration of treatment and IV to oral switch audit) (6 monthly) • IPC policy compliance • IPS department audits	Antibiotic pharmacist	Ongoing throughout 2012/13 Reported to the ICC and to the Board of Directors via the DIPC report

	• HII audits		
Ensure Trust is compliant with Care Quality Commission (CQC) registration criteria	• Review all 10 criteria of The Health and Social Care Act (2008) at quarterly ICC. • Ensure that progress on the ICT annual programme is reported quarterly to the ICC (via ICT quarterly report) and Trust Board (via DIPC quarterly report)	Chief Nurse DIPC IPC team	Quarterly review at ICC meetings Quarterly review by Board of Directors via DIPC quarterly report
Ensure Trust has measures in place to minimise the risk of MRSA bacteraemias and *C.difficile* infections	• Continue to review clinical practices in response to RCA findings and audit results • Continue to report findings and progress against MRSA bacteraemia and *C.difficile* infections action plans to ICC via IPC quarterly reports and Board via DIPC quarterly reports and to monthly Patient Safety Committee meetings and share across the health economy as required	Chief Nurse DIPC IPC team	Ongoing during 2012-2013 Quarterly review at ICC meetings Quarterly review by Board of Directors via DIPC quarterly report
Continue to embed evidence based practice for blood culture taking	• Provide training and support for staff on the implementation of the Blood Culture taking policy • Monitor practice and feedback results on contamination rates via quarterly IPC team report to ICC	IPC team IPC team	Ongoing during 2012-2013 Quarterly review at ICC meetings
Maintain awareness of hand hygiene in community and acute clinical staff	• Continue to monitor hand hygiene compliance as part of the IPC audit programme	IPC team	Ongoing during 2012-2013
Education	• Continue to provide induction lecture for all new staff; annual IPC updates for all clinical staff; junior doctors teaching; Infection Control/IV/urinary catheterisation study days • Ensure that proportion of Trust staff receiving annual IPC training are reported to the ICC via the IPC Balanced Scorecard and Trust Board via the DIPC quarterly report for action	IPC team	Ongoing during 2012-2013

	• Continue to develop education programme for IPC link practitioners with continued Trust commitment to 3 protected study days/year • Consultants and SpR training programme on antimicrobial prescribing to be developed	Antibiotic pharmacist	December 2012 Antimicrobial Management Group established in March 2013 – remit includes medical education
Surveillance & Reports i) 'alert organism' ii) 'alert condition' iii) Incidents/RCAs/SIs iv) Orthopaedic surgical site surveillance v) Provision of comparative data to clinicians on HCAIs vi) Quarterly ICT reports to ICC vii) Quarterly IPC Balanced Scorecard viii) Monthly HPA Enhanced Surveillance website reports (MRSA BSI, CDI, MSSA and *E.coli* bacteraemia) & quarterly GRE bacteraemia and laboratory denominator data returns	• Continue to identify and respond promptly to all incidents and clusters/outbreaks of infection in the hospital • Continue to update & disseminate MRSA bacteraemia/colonisation and *C.difficile* infection data to all doctors and lead nurses on a monthly basis • Use findings from incidents/RCAs/SUIs to inform practice development priorities • Continue to return all mandatory reports promptly • Ensure that key findings and recommendations from surveillance data and incidents are reported to the ICC via the ICT quarterly report and Trust Board via the DIPC quarterly report for action	IPC team	Ongoing during 2012-2013
Communication	• Ensure there are robust systems of communication in place between the ICT and all Trust staff via: email updates; monthly infection control newsletter; up-to-date ICT policies on intranet • Ensure there are robust systems of communication in place between the ICT	IPC team	Ongoing during 2012-2013

	and Public and patients via: patient information leaflets; prompt response to all Freedom of Information and other enquiries through the Communications and Information Governance departments • Develop a patient information leaflet for patients on antimicrobials	Antibiotic pharmacist	June 2012
Review of policies	• Review all IPC policies due for revision and update • IPC policies due for revision and update in 2012-2013: 1. Varicella zoster due September 2012 2. Rabies due (April 2013) 3. IPC operational policy 4. Infection control section of Pandemic flu plan 5. Antimicrobial prescribing policy	IPC team	All IPC policies revised and updated on 3-year rolling basis All IPC policies due for revision & update in 2012-2013 to be completed by March 2013 Antimicrobial prescribing policy will be reviewed in 2013/14
Cleanliness & Decontamination issues	• ICT members to continue to sit on and contribute expert advice to the Decontamination Monitoring Group; Cleaning Service Review Group • Facilitate the reporting of cleanliness scores to the ICC via the IPC Balanced Score • Advise the Trust Lead for Decontamination on decontamination issues both at the regular Decontamination Monitoring Group meetings and on an ad hoc basis	IPC team	Ongoing during 2012-2013

6 DIPC/ICT Annual Programme 2013-2014

Objective	Actions	Leads	Timescale
Establish an Outpatient Parental Antibiotic Therapy (OPAT) framework	• Prescribing protocol and care pathway for patients to be developed in conjunction with the pharmacy and community services • Admission avoidance pathway to be implemented with A&E	IPC team/antibiotic pharmacist/ IMRS lead nurse	March 2014
Safer needle devices to be implemented as appropriate and to ensure compliance with EU directive	• Safer needle devices to be reviewed and implemented as necessary in accordance with the European Directive published in 2010 (Council Directive 2010/32/EU)	IPC team/ EHMS	May 2013
To provide infection prevention & control and microbiology input to the extraordinary vascular group	• Provide advice on referral pathways for patients requiring central vascular access (in-patients and OPAT patients) • Provide infection prevention advice on line insertion and ongoing care protocols	IPC team	March 2014
To maintain good practice in *C.difficile* management strategies	• Provide induction training for all staff on *C.difficile* management • Provide regular training updates to clinical staff on *C.difficile* management • Provide training and information to clinical staff on patients with suspected infectious diarrhoea • Review practices as a result of RCA findings and new evidence as required	IPC team	March 2014
To review and update the infection prevention and section for the 7th edition of the Antibiotic Policy	• Update the infection prevention and control chapter in the Antibiotic policy • Update infection prevention and control advice in the various sub-sections of the Antibiotic policy	IPC team	March 2014
To establish an Antimicrobial	• To establish group membership	DIPC/Medical	July 2013

Management Group	• Develop group Terms of Reference and remit of the group • Engage with stakeholders in all clinical specialties	director	
To establish new methods of communicating with staff and service users	• Develop social media communication tools (e.g. Twitter feeds, Facebook) • Work with Trust project manager on development of Trust new website and intranet	IPC team/ Communication project manager	July 2013 March 2014
To set up the new Infection Prevention and Control service to ELFT as part of a new contract	• Ensure that service requirements as per contract are met • Ensure adequate staffing resources available to provide the service	IPC	March 2014
Ongoing Objectives			
To continue surveillance for Extended-spectrum-beta-lactamases (ESBL) producers and other multi-resistant gram negative organisms	• Assess effectiveness of screening all admission on NICI/SCBU for Multi-resistant gram negatives • Report and act on resistance markers in relation to IPC practices and antimicrobial prescribing • Report surveillance data and any actions required to the ICC via the ICT quarterly report and Trust Board via the DIPC quarterly report	IPC team	Ongoing during 2013-2014 Quarterly review at ICC (via ICT quarterly report)
To continue to perform Root Cause Analyses (RCA) on the MSSA and *E.coli* bacteraemias to identify any preventative actions	• Develop a system for performing RCA on the MSSA and *E.coli* bacteraemia cases • Report findings and any actions required to the ICC via the ICT quarterly report and Trust Board via the DIPC quarterly report	IPC team	Ongoing during 2013-2014 Quarterly review at ICC (via ICT quarterly report)
Complete a programme of audit and ensure findings are acted on	• Surgical prophylaxis audit (annual) • Antimicrobial prescribing compliance audit (6 monthly) • IPC policy compliance • IPS department audits	Antibiotic pharmacist	March 2014 Reported to the ICC and to the Board of Directors via the DIPC report

	• HII audits		
Ensure Trust is compliant with Care Quality Commission (CQC) registration criteria	• Review all criteria of The Health and Social Care Act (2008) at quarterly ICC. • Ensure that Trust compliance is reported quarterly to the ICC (via ICT quarterly report) and Trust Board (via DIPC quarterly report)	Chief Nurse DIPC IPC team	Quarterly review at ICC meetings Quarterly review by Board of Directors via DIPC quarterly report
Ensure Trust has measures in place to minimise the risk of MRSA bacteraemias and *C.difficile* infections	• Continue to review clinical practices in response to RCA findings and audit results • Continue to report findings and progress against MRSA bacteraemia and *C.difficile* infections action plans to ICC via IPC quarterly reports and Board via DIPC quarterly reports and to monthly Patient Safety Committee meetings and share across the health economy as required	Chief Nurse DIPC IPC team	Ongoing during 2013-2014 Quarterly review at ICC meetings Quarterly review by Board of Directors via DIPC quarterly report
Education	• Continue to provide induction lecture for all new staff; annual IPC updates (including hand hygiene training) for all clinical staff; junior doctors teaching; Infection Control/IV/urinary catheterisation study days • Provide training and support for staff on the implementation of the Blood Culture taking policy • Ensure that proportion of Trust staff receiving annual IPC training are reported to the ICC via the IPC Balanced Scorecard and Trust Board via the DIPC quarterly report for action • Continue to develop education programme for IPC link practitioners	IPC team	Ongoing during 2013-2014
Surveillance & Reports ix) 'alert organism' x) 'alert condition'	• Continue to identify and respond promptly to all incidents and clusters/outbreaks of infection in the hospital	IPC team	Ongoing during 2013-2014

xi) Incidents/RCAs/SIs xii) Orthopaedic surgical site surveillance xiii) Provision of comparative data to clinicians on HCAIs xiv) Quarterly ICT reports to ICC xv) Quarterly IPC Balanced Scorecard xvi) Monthly HPA Enhanced Surveillance website reports (MRSA BSI, CDI, MSSA and *E.coli* bacteraemia) & quarterly GRE bacteraemia and laboratory denominator data returns	• Continue to update & disseminate MRSA bacteraemia/colonisation and *C.difficile* infection data to all doctors and lead nurses on a monthly basis • Use findings from incidents/RCAs/SUIs to inform practice development priorities • Continue to return all mandatory reports promptly • Ensure that key findings and recommendations from surveillance data and incidents are reported to the ICC via the ICT quarterly report and Trust Board via the DIPC quarterly report for action		
Communication	• Ensure there are robust systems of communication in place between the ICT and all Trust staff via: email updates; monthly infection control newsletter; up-to-date ICT policies on intranet • Ensure there are robust systems of communication in place between the ICT and Public and patients via: patient information leaflets; prompt response to all Freedom of Information and other enquiries through the Communications and Information Governance departments	IPC team	Ongoing during 2013-2014
Review of policies	• Review all IPC policies due for revision and update • IPC policies due for revision and update in 2013-2014: 6. Rabies due (April 2013)	IPC team	All IPC policies revised and updated on 3-year rolling basis All IPC policies due for revision & update in 2013-2014 to be completed by March 2014

	7. IPC operational policy (Jan 2014) 8. CJD/TSE (Nov 2013) 9. Death of infectious patient (Nov 2013) 10. Environment and isolation room cleaning (Mar 2014) 11. Hand hygiene (Mar 2014) 12. Isolation policy (Nov 2013) 13. Laundry (new guidelines published) 14. Major outbreak (Mar 2014) 15. Norovirus (Nov 2013) 16. Notification of infectious diseases (Sep 2013) 17. Safe handling of body fluid spills (Mar 2014) 18. Single use medical devices (Mar 2014) 19. Specimen collection (Mar 2014) 20. Surgical site infection (Mar 2014) 21. Surveillance and reporting of HCAI (Mar 2014) 22. TB policy (Nov 2013) 23. Tunneled CVC/Hickman line (Nov 2013) 24. ANTT (Mar 2014) 25. MRSA (Mar 2014)		
Cleanliness & Decontamination issues	• ICT members to continue to sit on and contribute expert advice to the Decontamination Monitoring Group; Catering and Domestic Operational Review Group • Facilitate the reporting of cleanliness scores to the ICC via the IPC Balanced Score • Advise the Trust Lead for Decontamination on decontamination issues both at the regular Decontamination Monitoring Group meetings and on an ad hoc basis	IPC team	Ongoing during 2013-2014

7 HCAI Statistics: 2012-2013

7.1 Results of Mandatory Surveillance Reporting: 2012-2013

7.1.1 MRSA bacteraemias 2012-2013

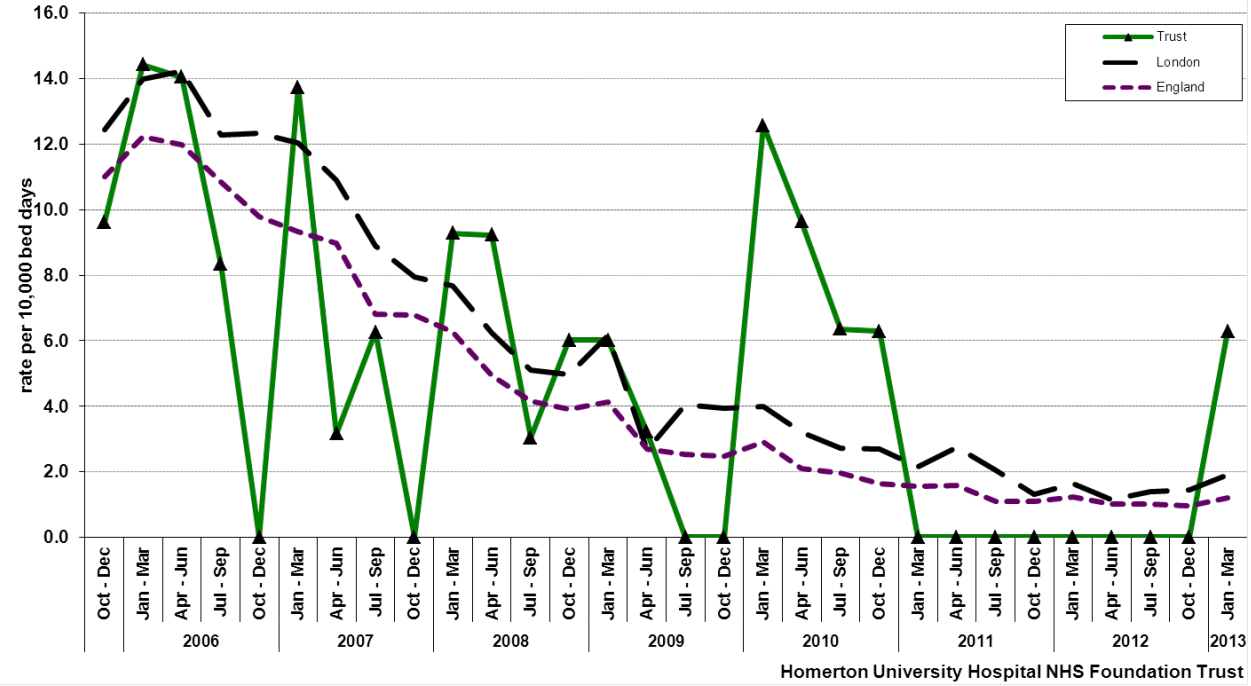
- The HUH Objective for the financial year 12/13 was 1 Trust-attributable MRSA bacteraemias (taken 48 hours or more after admission).
- At the end of the financial year 12/13, there have been 2 Trust-attributable MRSA bacteraemias.

- Summary of HUH-attributable MRSA bacteraemias for FY 12/13:

Date and place of specimen	Comments
11/01/2013 Graham	The source of the bacteraemia is unknown as examination and further investigation has not revealed any foci of MRSA-related sepsis. The patient had a clinical picture of a UTI which is a rare focus for an MRSA-related bacteraemia
21/01/2013 Edith Cavell	The source of the bacteraemia was the patient's central line which he required for parental nutrition as he could not tolerate enteral nutrition. The patient could not have another type of (short term) line inserted which may have reduced the risk of infection as the service is not currently available at the Homerton.

- Graph of HUH MRSA bacteraemia rate, London region and national rates from 2006-13

Figure 5: Trust-apportioned MRSAb rate, with Trust-apportioned national & regional rate



- Summary of Non HUH-attributable MRSA bacteraemias for FY 12/13:

Date and place of specimen	Comments
01/12/2012 A&E	The source of bacteraemia was a total knee replacement (surgery in October and November 2011) infection.
18/02/2013 A&E	The source of the bacteraemia is a lesion at C2 and associated osteomyelitis. The patient had no risk factors for MRSA acquisition. The MRSA isolate was sent to the reference laboratory where it was found to be Panton-Valentine Leukocidin (PVL) positive. It is presumed there was community acquisition although how or where this occurred could not been determined.

7.1.2 CDI (*Clostridium difficile* infections) 2012-2013

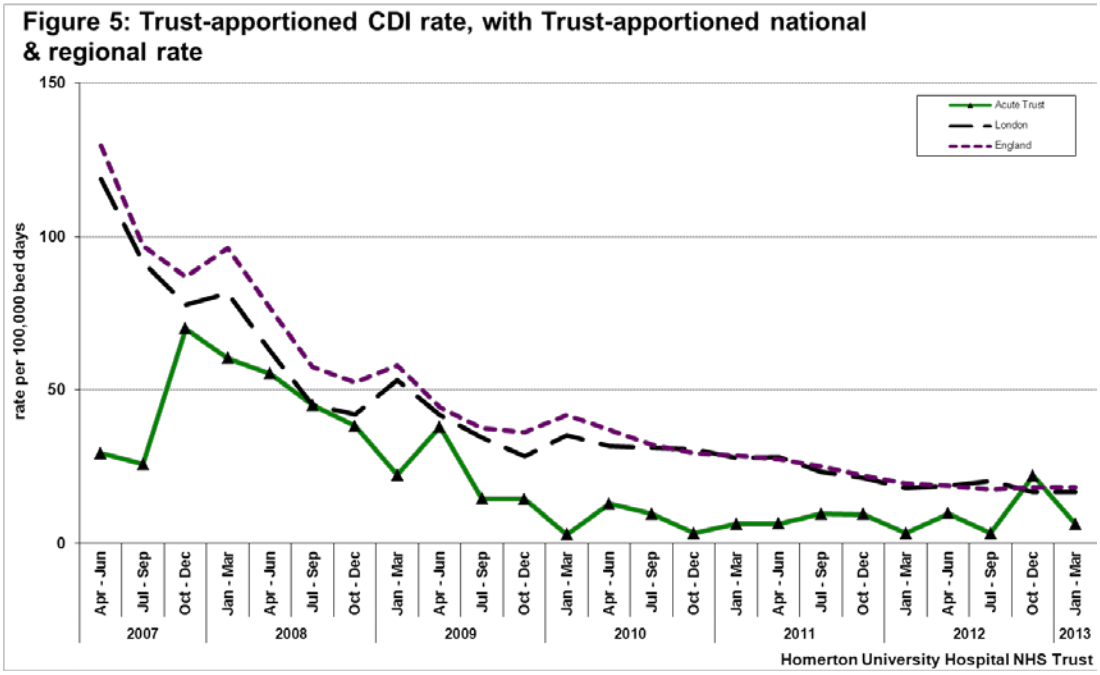
- The HUH target for the financial year 12/13 was 7 hospital-attributable cases (defined as all *C. difficile* toxin positive stool sample from patients admitted to the Trust, except those collected during the first 3 days of admission).
- At the end of the financial year 12/13, there have been a total of 13 Trust-attributable cases.

- Summary table of Trust-attributable CDI cases FY12/13:

Date and place of specimen	Comments
06/05/2012 ECU	The acquisition of the *C.difficile* infection is unclear. There were no cases of *C.difficile* infection identified on wards from the patient's previous admissions nor the current one. The antibiotic prescribing was compliant with the prescribing policy but still could have contributed to the patient developing *C.difficile* diarrhoea.
07/06/2012 Graham	The reason for the *C.difficile* associated diarrhoea is probably a recurrence as the patient was at high risk and had been *C.difficile* positive in another Trust.
11/06/2012 Edith Cavell	The root cause is difficult to ascertain as the patient was not exposed to any other patients on this admission with *C difficile* infection. The patient was a complex case with multiple potential causes of diarrhoea with a subsequent diagnosis of ulcerative colitis with possible superimposed and cytomegalovirus (CMV) and *C.difficile* infections. Also, the patient previously had a stool sample result that was *C.difficile* GDH positive and toxin negative which implied that the patient had *C.difficile* carriage.
23/08/2012 ECU	It is not possible to determine where the patient acquired the *C.difficile* carriage. The patient developed diarrhoea which could have been attributable to antibiotics which started on the 18th July as an in-patient on Priestley ward and finished on the 1st July as an out-patient (4 weeks later). The stool result on admission could have been a false toxin negative result.
04/10/2012 ECU	The acquisition of the *C. difficile* infection is unclear. The antibiotic prescribing was compliant with the prescribing policy and required but could have contributed to the patient developing *C.difficile* diarrhoea.

07/10/2012 ECU	There is no clear root cause to determine where the patient acquired the *C. difficile* infection. One of the patient's presenting complaints to A&E was diarrhoea and this could have been associated with antibiotic use from the previous two admissions in July and August, superseded by the antibiotics used during the current admission. The patient was also discharged with ciprofloxacin for six days on 10th September 2012 as well as trimethoprim for fourteen days. However the antibiotics were appropriately used and in line with the antibiotic policy.
16/10/2012 Thomas Audley	There was possible exposure to *C.difficile* on the ward although this is unlikely due to the other case being another bay and using separate toilet facilities. The patient was at high risk of *C.difficile* infection due to the underlying cancer, bowel surgery and antibiotic treatment for the rectal collection.
04/11/2012 Thomas Audley	Root cause of *C.difficile* acquisition: There was possible exposure to *C. difficile* on the ward as the patient in B5 had a positive CDT specimen on the 16/10/2012. Both samples were sent for typing and the results suggested they could be related. Root cause of *C.difficile* toxin-mediated infection: This is likely to be related to the prolonged IV antibiotic use and the patient's multiple co-morbidities.
27/11/2012 Graham	The acquisition of *the C.difficile* infection is unclear. There was one patient on the ward diagnosed with *C.difficile* colonisation (toxin negative) but this patient was isolated promptly. The antibiotics received were compliant with the prescribing policy but the patient did have repeated and prolonged courses of antibiotics that may have contributed to the patient developing *C.difficile* diarrhoea. Inappropriate stool specimens were sent for *C.difficile* toxin testing on a patient receiving laxatives for faecal impaction.
29/11/2012 Delivery suite	The source of the acquisition is not clear as the patient had no exposure to other patients with diarrhoea or *C.difficile* during her Homerton admission. She was on antibiotics for a UTI which were indicated and appropriate and these could have precipitated the *C.difficile* diarrhoea.
31/12/2012 ECU	The patient was admitted with diarrhoea which could have been laxative induced as she was laxatives at home. The diarrhoea continued despite the laxatives being stopped and a specimen sent 7 days after admission was *C.difficile* positive. There was a delay in sending the specimen once the laxatives had been stopped.
03/01/2013 Priestley	The patient was started on antibiotics which were appropriate for a post-op hospital acquired pneumonia. The patient was not isolated when the diarrhoea started.
09/02/2013 Edith Cavell	The patient was admitted with a CAP. He was started on IV antibiotics and started having diarrhoea on the 05/02/2013. The antibiotic prescribing was complaint with Trust policy. A stool specimen was sent on the 09/02/2013 showing a delay in sending the specimen. The result was confirmed *C.difficile* toxin positive on the 10/02/2013. He was moved a side room as he was not isolated when the specimen/diarrhoea started.

- Graph of HUH CDI rate, London region and national rates from 2007-13



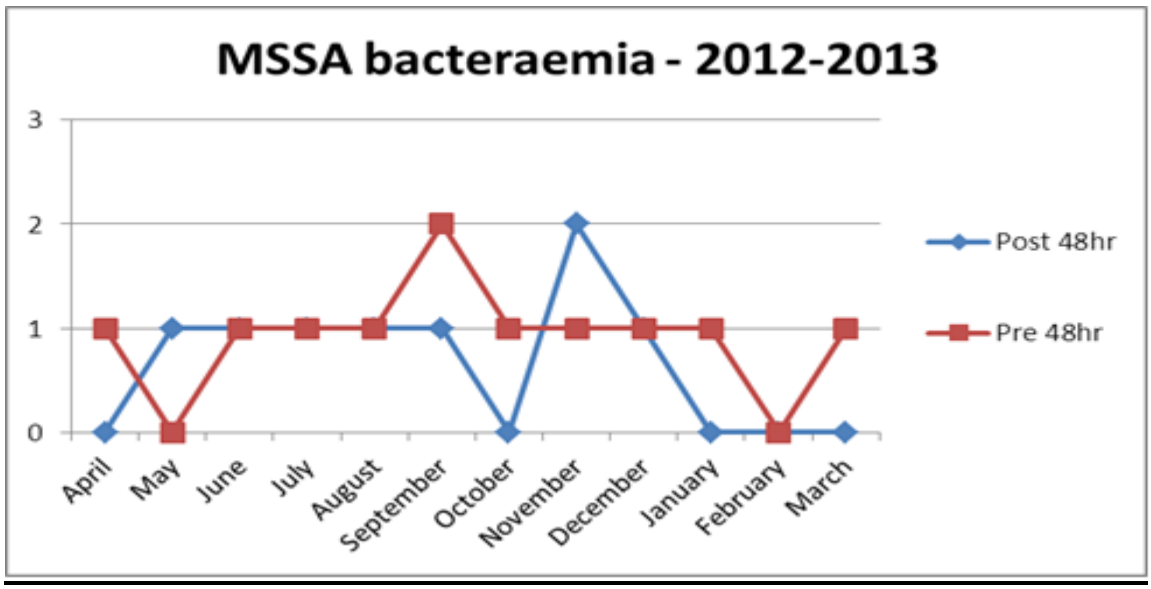
- Summary table of Non-attributable CDI cases FY12/13:

Date of specimen	Comments
04/05/12	The root cause is difficult to ascertain as the patient was not exposed to any other patients on this admission or the previous one with *C difficile*. Important to note is the patient's underlying illness. The previous prolonged admission where the patient had gastrointestinal surgery, developed a hospital acquired pneumonia and was treated with antimicrobials as well as being on omeprazole, may have contributed to the patient developing *C difficile* related diarrhoea.
22/06/12	The reason for the reoccurrence of *C.difficile* associated diarrhoea is unclear as the patient did not have any PPIs or antibiotics administered after her discharge from North Middlesex Hospital on the 13/06/2012. However, reoccurrence of C.difficile infection is common and occurs in approximately 25% of cases and is probably related to host factors.
31/07/12	The root cause is difficult to ascertain as the patient was a complex case with multiple potential causes of diarrhoea and a diagnosis of ulcerative colitis in addition to their *C.difficile* infection.
26/10/12	The acquisition of the *C.difficile* infection is unclear. The antibiotic prescribing on the patient's previous A&E attendance was compliant with the prescribing policy and required but could have contributed to the patient developing *C.difficile* diarrhoea.
20/11/12	The acquisition of the *C.difficile* infection is unclear. The cause of diarrhoea is probably multifactorial as she was previously diagnosed with Salmonella and had a flare up of chronic colonic pseudo-obstruction secondary to infection.

	The antibiotic prescribing was compliant with the prescribing policy and required but could have contributed to the patient developing *C.difficile* diarrhoea.
22/11/12	It is difficult to identify where the *C.difficile* acquisition occurred as there were no *C.difficile* cases on Lloyd or ward 13C at the Royal London and there had not been any cases for a number of months. The likely cause of the *C.difficile* diarrhoea is the antibiotic treatment for the infected diabetic foot ulcer. However the antibiotics were required and appropriate. The patient's foot ulcer was secondary to poorly controlled diabetes due to non-adherence with treatment.
07/01/13	The reason for the CDI is a recurrence of infection. Recurrent CDI occurs in about 20% of patients treated initially with either oral Metronidazole or Vancomycin (Teasley et al.1983; Bartlett, 1985; Wenisch et al., 1996).
16/02/13	The CT scan performed on this admission showed metastatic pancreatic cancer. The patient did not have any previous admissions to hospital or antibiotic treatment recently and no contact with any *C.difficile* positive patients.
19/02/13	The root cause is difficult to ascertain as the patient was a complex case with multiple potential causes of diarrhea. However the patient had previously had an episode of CDI in Jan 13 and this was a recurrence of infection.
04/03/13	The patient has an extensive past medical history. The patient had antibiotic treatment for soft tissue infection, cellulitis, infected right total knee replacement, hospital acquired pneumonia in previous admissions. The antibiotic prescribing on previous admissions was compliant with the prescribing policy and required but could have contributed to the patient developing *C. difficile* diarrhoea.

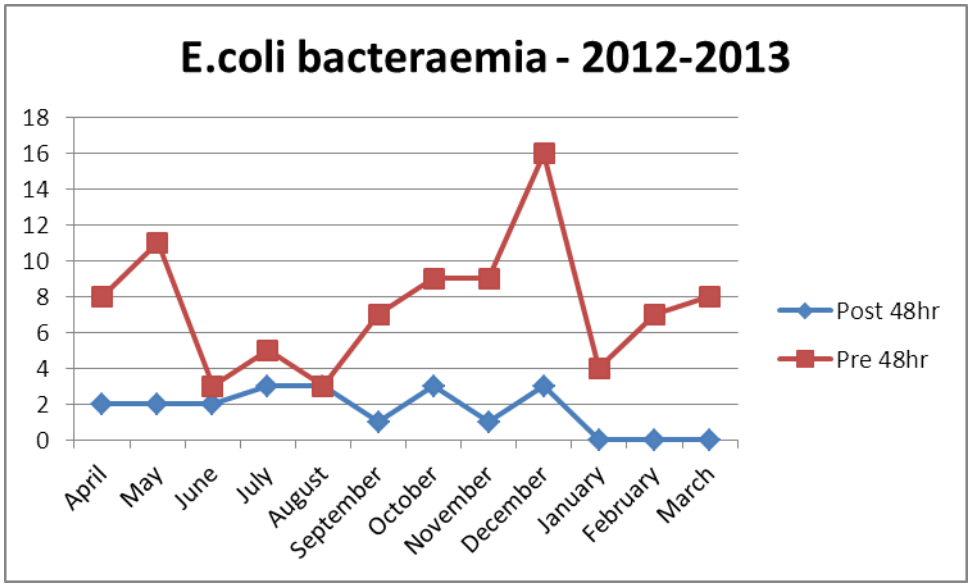
7.1.3 MSSA Bacteraemia 2012-13

Mandatory surveillance of MSSA bacteraemia started in January 2011. No objective has been set. The source of each post 48h bacteraemia is investigated by the IPCT and presented to the ICC in the IPCT quarterly report.



7.1.4 E.coli Bacteraemia 2012 - 2013

Mandatory surveillance of E. coli bacteraemia started in June 2011. No objective has been set.



The source of each bacteraemia was investigated by the IPCT and presented to the ICC in the IPCT quarterly report over a 6 month period. No preventable issues were identified over this 6 month period therefore routine investigation of all *E.coli* bacteraemias has stopped. However if any issue of concern is identified by the Microbiologists the case is discussed with the IPCT and investigated as appropriate.

- Resistance rates in E.coli bacteraemias are discussed in section 7.3 below.

7.1.5 GRE bacteraemias 2012-2013

- Although the reporting of Glycopeptides Resistant Enterococci (GRE) bacteraemias is mandatory, currently there are no targets set.
- GRE bacteraemias are usually an HCAI issue for tertiary referral centres with large renal or oncology units and are unusual in the acute hospital setting.
- In 2012-2013 the Trust had no cases of GRE bacteraemia.

7.1.6 Orthopaedic surgical site infections 2012-2013

- Surgical Site Infection (SSI) data is collected on Total Hip Replacements (THR) and Total Knee Replacements (TKR) as part of the national SSI Surveillance programme. The summary data, with national comparisons, is available c. 6 months after the time period for which the data is collected.
- The SSI rates for April 2012 – March 2013 for HUH THR is 4.1% compared to all hospitals rates of 1.2% and for HUH TKR there have been 4.9% infected compared to 1.7% nationally. Although these statistics may be a reflection of the relatively small number of THR and TKR operations performed at the Trust, the orthopaedic clinical governance arrangements are under review to ensure that there is a robust process for investigating all Orthopaedic SSIs.

7.2 Incidents and outbreaks (non-MRSA bacteraemia or CDI) 2012-2013

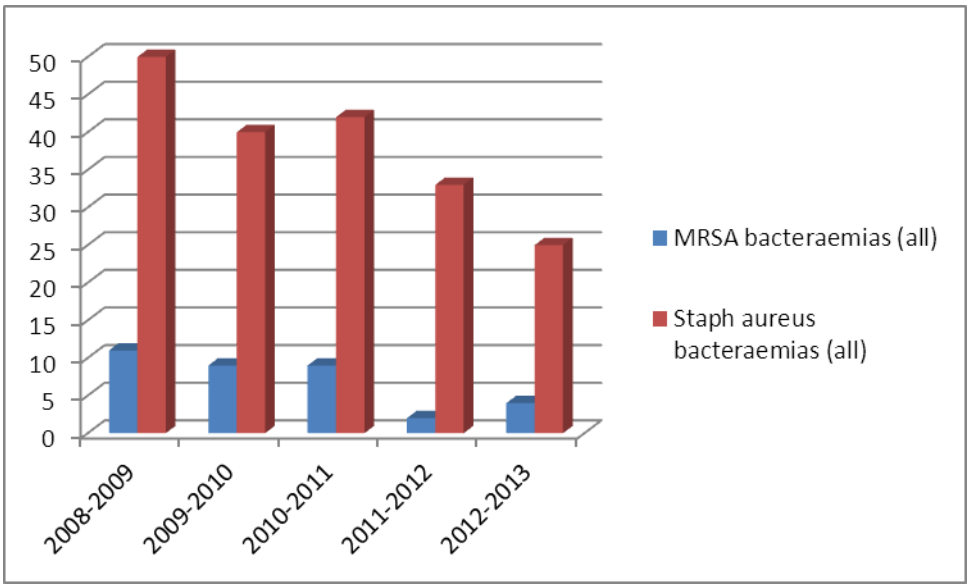
- In 2012-2013 the following other incidents, outbreaks and SIs were managed by the IPCT in liaison with the relevant ward-based and other teams:

Month	Incident
April 12	Measles in CEA
May 12	Nil
June 12	Nil
July 12	Burkholderia cepacia in Endoscopy
Aug 12	Nil
Sep 12	Nil
Oct 12	TB on open ward (ACU/ECU)
Nov 12	Nil
Dec 12	Nil
Jan 13	Cluster of GRE cases on ITU Cluster of parainfluenza cases on SCBU
Feb 13	Nil
Mar 13	Nil

- Further details of all incidents, outbreaks and serious incidents are documented in the Infection Prevention & Control Team's Quarterly Reports to the ICC 2012-2013 which are available on request.

7.3 Antimicrobial resistance 2012-2013

- There have been no new local antimicrobial resistance issues identified by the Microbiology laboratory in 2012-2013 although there have been cases of Carbapenem Producing Enterobacteriacea (CPE) in the London region which are widely viewed to be the major antimicrobial resistance threat in the coming decade.
- MRSA bacteraemia cases (all i.e. both Trust-attributable and non-attributable) account for 16% of all Staph aureus bacteraemias.



- Extended spectrum β- lactamase (ESBL) - producing *E.coli* account for 13% (8 of 61) of *E.coli* bacteraemias in 2012-13.

- From 2005-2010, E.coli bacteraemia cases accounted for 11% of all significant positive blood cultures at the Trust and the proportion of likely ESBL +ve E.coli isolated in blood cultures at the Trust remained stable at c.10% year on year over this period in contrast to national data submitted to the Health Protection Agency (HPA) which showed that, from 2004-8, E.coli bacteraemia cases had risen by 33% and accounted for 23% of all significant bacteraemias.

8 IPC audit programme 2012-2013

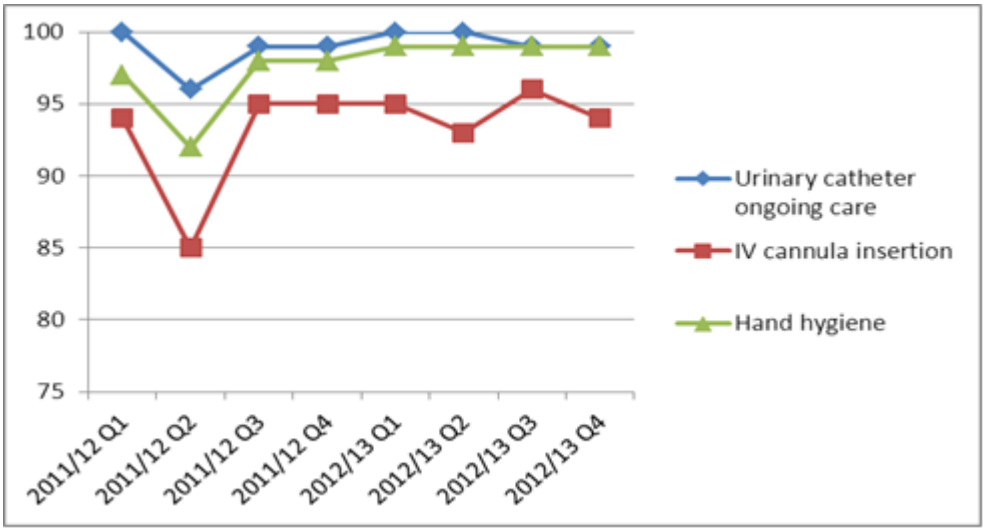
- The IPC audit programme for 2012-2013 was completed and all action points were followed up.
  This programme included the:

  - Infection Control Nurse-led Infection Prevention Society (IPS) audits of 49 clinical areas (CSDO: 9 audits; IMRS: 22 audits; SWSH: 18 audits)

  - Ward-based High Impact Interventions (HII) audits:
    Central Venous Catheter care
    Peripheral Venous Catheter care
    Prevention of surgical site infections (theatres only)
    Urinary catheter ongoing care
    Hand hygiene audits
    MRSA screening audits

  - Audit of compliance with key policies:
    Isolation Policy Compliance Audit
    Sharps Disposal
    Antimicrobial prescribing
    Blood culture contamination

A summary of the HII and hand hygiene monitoring Trustwide results for 2010-2013 is detailed in the graph below:



8.1 Antibiotic prescribing compliance audits 2012-2013

The antibiotic pharmacist monitors antimicrobial prescribing practice in order to ensure safe and appropriate prescribing of antimicrobials by:

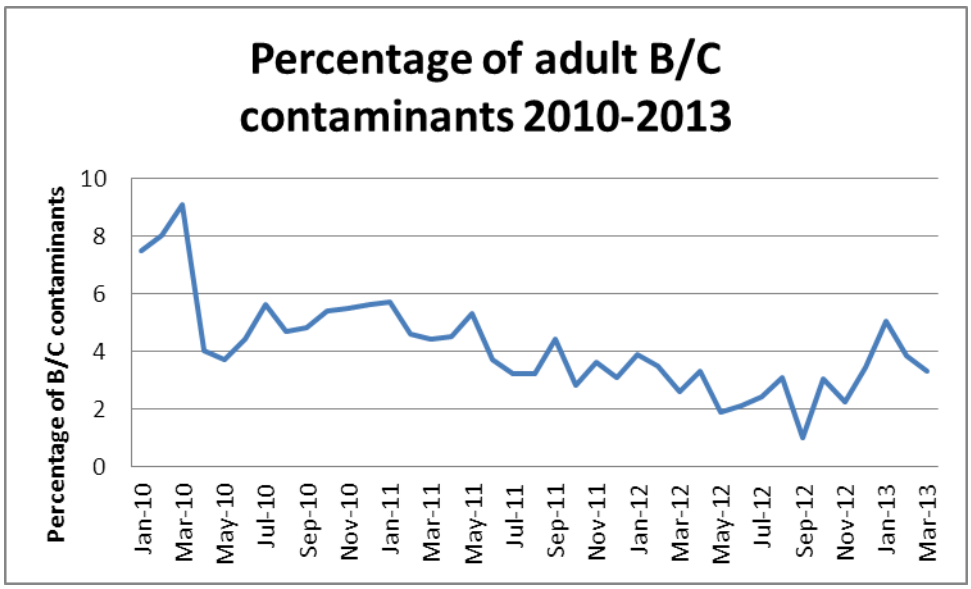
- Daily liaison with the Microbiology/IPCT teams
- Interaction with other pharmacists and prescribers to enhance prudent antibiotic prescribing
- Compiling evidence-based responses to antibiotic queries
- Compiling and editing each new edition of the Trust Antibiotics policy in liaison with the Trust's Antibiotic Lead Microbiologist (Dr Claxton, who is also the DIPC)
- Carrying out the Antibiotic Policy Compliance Audit

- The results of the quarterly audits up to December 2010 and now bi-annual antibiotic compliance (defined as correct choice, route, dose and duration not exceeding HUH policy recommendation) audits for 12/13 are detailed in the table below:

	Audit Jan 13	Audit Jul 12	Audit Dec 11	Audit Jun 11	Audit Dec 10	Audit Sep 10	Audit Jun 10	Audit Mar 10
Total patients	311	317	288	234	138	113	267	186
Patients on antibiotics	100 (32%)	77 (25%)	86 (30%)	87 (37%)	45 (33%)	31 (32%)	83 (31%)	66 (36%)
Compliance:								85.0%
Compliant	84%	86%	79%	92%	82%	79%	74%	
Non-compliant	10%	13%	15%	8%	12%	12%	15%	
Off-policy	6%	1%	6%	3%	6%	9%	11%	2%
Indication	97%	98%	97%	97%	97%	93%	92%	91.6%
Indication on drug chart	94%	85%	70%					
Stop/Review	72%	77%	68%	N/A	62%	46.5%	42%	46.7%

8.2 Blood Culture Contamination audits: 2012-2013

In 2010 the Trust introduced a specific pack for blood culture collection, a training programme and training film available on the Trust intranet and YouTube. The blood culture contamination is monitored as an indicator for blood culture taking practice due to the difficulty of monitoring through observation of practice. The presence of coagulase negative staphylococci or diphtheroids is used as evidence of contamination. In March 2010 9.1% of blood cultures were contaminated using the above definition and in March 2013 3.3% indicating that good practice in blood culture collection continues.



8.3 Patient isolation audits 2012-2013

- No issues of concern were identified in either of the patient isolation audits in 12/13.

9 IPC education programme 2012-2013

9.1 Induction Training

- All staff attended the Trust induction. Infection prevention & control is also part of junior medical staff induction arranged by medical staffing on a monthly basis.

9.2 Annual Update Training

- Infection prevention and control is included in the Trust Mandatory Training policy and all clinical staff are required to attend annual update.
- In June 2012 a Statutory and Mandatory Training booklet which included a section on Infection Prevention & Control was sent out to all staff as a level 1 update.
- By the end of the 12/13 financial year 97% of staff had received an IPC level 1 annual update.

9.3 IPCT and DIPC training activities & presentations 2012-2013

- The Infection Control Nurse Consultant attended the Health Protection Conference in September 2012 and Florence Nightingale Nursing Conference in February 2013.
- One of the ICNs attended the Infection Prevention Society Conference in September 2012.
- The ICNs have attended Infection Prevention Society Professional Development Forums, Health Protection Agency one day forums/conference and Reducing HCAI one day conferences as part of CPD.
- One of the ICNs has recently become the secretary for the North London Infection Prevention Society Branch.
- One of the ICNs is in the process of completing her BSc in Infection Control.
- The ICD/DIPC attended the following conferences:

  - April 2012 UK OPAT workshop
  - May 2012 – Managing Water Safety in Healthcare
  - May 2012 – 3rd National Orthopaedic Infection Forum
  - July 2012 – HCAI Operational Guidance Workshop
  - Nov 12 – Joint BSAC/HIS/BIA Skin & Soft tissue infection workshop
  - Nov 12 – Managing Infections: Current & Future Trends

10 Cleaning Services IPC arrangements 2012-2013

- The cleaning services for the Hospital acute site are contracted out to Medirest and, for the community sites, the East London Consortium provide the and monitor the cleaning services. Monitoring within the Trust's premises are undertaken as prescribed within The National Specifications for Cleanliness in the NHS (2007), Revised Guidance on Contracting for Cleaning (2004), current legislation, codes of practice and best practice.
  Specific guidance has been provided to all those required to undertake monitoring & auditing through the Board approved Policy 'Cleaning Standards Monitoring Policy'.

- The formal auditing arrangements to measure service performance are:

  - Technical Audits & Monitoring:
    - Technical monitoring is carried out by the cleaning service provider and relevant ward/department head using the 49 element audit score sheet contained within the National Specification for cleanliness in the NHS.
    - The frequency for formal audit is at least in accordance with risk category agreed with the infection control team and as stated in National Specification for cleanliness in the NHS, which are as follows:
      - Very high-risk functional areas (main theatre, ITU, NICU, etc) at least once a week.
      - High-risk functional areas (general wards, A&E, public areas, etc) at least once a month.
      - Significant -risk functional areas (pathology, outpatient, etc) at least once every 3 months.

- Low- risk functional areas (offices, stores, etc) at least twice a year.

- Failure reports arising from technical monitoring are agreed between the cleaning service provider and ward/department head with sign off of rectification being undertaken within one day/week of the initial audit, depended on risk category.

- Validation Audits:
  - Recognising the need for validation the Trust has resourced a full time monitoring officer whose role it is to undertake at least 20% of all audits undertaken.
  - These audits are based on the 49 element audit tool contained within National Specification for cleanliness in the NHS. This audit review process validates a sample of audit information arising from the technical audits on a quarterly basis. The key purpose of these audits is to assess the accuracy of the routine auditing by the cleaning service provider, to address issues raised by ward/department managers and infection control and to ensure that service provision meets the requirements of the relevant ward or department.

- The National Standards Monitoring Tool audit quarterly results for 12/13 are detailed in the table below. The scores are RAG rated 'green' in all areas.

National Standard Monitoring Tool	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2012/13 total
CSDO	96.0%	97.0%	97.2%	98.2%	97%
IMRS	94.0%	96.0%	96.5%	97.5%	96%
SWSH	96.0%	97.0%	97.3%	97.9%	97%
Trust	95.0%	96.7%	97.1%	97.9%	97%

- Cleaning service performance is formally audited by technical audits & monitoring and validation audits. Cleaning service performance is informally audited by the Hotel Services Monitoring Officer's report to the Cleaning Review Group and the Hotel Services Manager's report to the Infection Prevention and Control Lead Nurse Group (which has replaced the matrons' Monitoring Group.
- No major issues were reported in the cleaning services audits in 2012-13.
- PEAT is now replaced with PLACE (Patient Led Assessment of the Clinical Environment). The inspection took place in June 2013.

11 Estates and Facilities reports 2012-2013

The ICC receives quarterly reports on the Trust's decontamination monitoring, ventilation planned preventative maintenance programme and Legionella planned preventative maintenance programme.

11.1 Decontamination Monitoring Committee

Scope/Aim of the Committee
The committee is required to manage all elements of the Trust's Decontamination Policy in relation to national guidance / performance criteria and report the progress on actions and issues to the Trust's Infection Control Committee. It is a multidisciplinary professional group with members from all relevant stakeholder disciplines across the Trust.

The committee aims to underpin the Trust requirements to fulfill its role in delivering first class Healthcare services across Hackney and the City of London and to ensure appropriate compliance against the UK Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Part 4 – Quality and Safety of Service Provision in Relation to Regulated Activity (or such other legislation as it is updated).

Terms of Reference
- To apply relevant national guidance to the areas of decontamination practice across the Trust.
- To manage and monitor all risks and incidents associated and identified with the decontamination of medical devices within the Trust.
- Establish and oversee regular compliance auditing programmes for all decontamination processes and facilities within the Trust and all other facilities not within the Trust but, that which are used by Trust Staff.
- Advise on all documentation used to record decontamination across the Trust.
- Review and approve existing and new systems and methods of the decontamination of medical devices.
- To advise the Trust, Divisions and Departments on any necessary action; and support the same in the development of investment needs as appropriate e.g. upgrading decontamination facilities where improvements from sources of national / best practice guidelines suggest are required.
- The Decontamination Committee will have responsibility for the consultation, development, implementation, on-going monitoring, compliance and review of the Trust's Decontamination Policy for Re-Usable Medical Devices and the Trust's Decontamination Policy for Flexible Endoscopes and, procedural sub documents as listed within the policies. This will include all national guidance sources as listed within those policies.

- The committee will suggest necessary action to the Divisions and other departments as appropriate.
- These 'Terms of Reference' will be reviewed on an annual basis, and as required by the influence or compliance requirements or national guidance.

Governance Arrangement

- In accordance with Choice Framework for Local Policy and Procedures (CFPP) 01-01 Part A, Management and Decontamination of Surgical Instruments used in Acute Care, the Trust's Director of Estates and Facilities is the Designated Lead for Decontamination.
- The Decontamination Committee reports to the Trust Infection Control Committee, which in turn reports to the Trust Board.
- The Decontamination Committee will report to the Director of Infection Prevention and Control (DIPC) via the Infection Control Committee on relevant issues.
- The Decontamination Committee will seek advice from the Infection Control Committee on actions where progress on issues is deemed to be insufficient or inappropriate.

- Membership of the Trust Decontamination Committee shall comprise of:

Senior representatives from the following areas:
Director of Environment (Committee Chairman)
Director of Infection Prevention and Control (DIPC)
Infection Control Nurse Consultant
Operative Services Manager
Trust Decontamination Manager
Quality and Risk Management Representative
Estates Management Representative
Medical Electronics & Physics Manager (TBC)
Divisional Director Representatives
Endoscopy Dept. Representatives
Synergy Health, Sterile Services Department Manager.

Frequency of meetings
Meetings of the Trust Decontamination Committee will take place on a regular basis with a minimum of 4 meetings per year. Other meetings may be required and will be arranged as and when required. The meetings will take place at least 1 month in advance of all Trust Infection Control Committee Meetings.

Responsibilities
All roles and responsibilities for decontamination are contained within individual Job Descriptions of Trust staff.
Designated lead managers are in place across the Trust to complement requirements of national Codes of Practice such as those provided by The Department of Health's - CFPP (Choice Framework for Local Policy and Procedures) 01-01 Series.

- The Decontamination KPI quarterly reports for 12/13 have all RAG rated all areas 'green' and no major compliance-related issues have been reported to the ICC.

11.2 Ventilation planned preventative maintenance programme

- The Director of Environment also submits reports on the ventilation programme of planned preventative maintenance to the ICC and covers the maintenance, sampling and testing of the Trust's negative pressure room facilities and theatre facilities. There were no major IPC issues of concern in 12/13.

11.3 Legionella planned preventative maintenance programme

- The Director of Environment also submits the Legionella prevention report which covers the Legionella policy; sampling and testing arrangements; risk assessment; general engineering works and training arrangements. Ashland is employed by the Trust as the expert contractor for sampling and testing. There were no major issues identified in the Legionella prevention programme in 2012-2013.
- The Department of Health document 'Sources and potential Pseudomonas aeruginosa contamination of taps and water systems. Advice for augmented care units' was published in March 2012. As a result a 'Water Safety Plan' has been developed by Estates and the ICT and endorsed by the ICC and there is ongoing surveillance both by the Estates team and IPCT to ensure environmental and clinical monitoring of pseudomonas on the Trust's augmented care units (adult and neonatal ICUs).

12 Employee Health Medical Services IPC reports 2012-2013

- An Employee Health Management Service (EHMS) balanced scorecard has been developed and is presented to the ICC. This document includes details of compliance with the Exposure Prone Procedure (EPP) register and measles, rubella, chickenpox and tuberculosis screening register.
- In 2012/13, the EHMS department led the Trust's Flu Staff Vaccination Campaign. Almost 40% of frontline staff were vaccinated by the EHMS team (Doctors: 60%; Nurses/Midwives: 31%; AHPS: 46%; Support to clinical staff: 40%).
- During 12/13 EHMS & the IPCT have completed a joint project to ensure that the Trust is compliant with the new EU directive (Council Directive 2010/32/EU) requiring all member states to introduce further protection of health care workers exposed to the risk of sharps injuries.

13 IPC policies endorsed by the ICC in 2012-2013

The following IPC policies have been reviewed by the ICC in 12/13:

- Policy for prevention and contact management of measles, mumps and rubella in health care staff (EHMS) VZV (review)
- Dress Code (review)
- Group A Streptococcus (new policy)
- Multi-resistant Gram Negative policy (review)
- Endoscopy decontamination (review)
- Rabies policy (review)
- IPC operational policy including ICC terms of reference (review)
- TB policy (review)
- Norovirus diarrhoea and vomiting policy (review)
- Protection against BBV and NSI (review in line with EU directive on safer sharps, SICP and BBV policies merged)
- Policy for Hepatitis B immunisation and Occupational health clearance for hepatitis B, C and HIV in health care staff (review)
- *C.difficile* policy (reviewed in line with introduction of laboratory PCR testing)

14 Influenza – winter 12/13 update

- Over the winter months influenza activity was low with very few admissions to the acute hospital and critical care. There was no adverse impact on bed or isolation capacity.

15 Other IPC updates 2012-2013

- This DIPC/ICT annual report 2012-2013 will be presented to the Board of Directors and then made available to the public on the Trust internet site in accordance with the requirements of the Code of Practice for reducing HCAI.
- Dr Daniel Krahé, the Microbiology Laboratory Director and Clinical Lead Microbiology Consultant and member of the IPCT has retired due to illness. We gratefully acknowledge his contribution to IPC at the Trust over the past 6 years.
- The DIPC & IPCT also gratefully acknowledge the contribution that Dr Maysoon Al-Zahawi, Dr Krahe's locum, has made to IPC at the Trust since her appointment in July 2012.
- In addition to ongoing Service Level Agreements (SLAs) to provide IPC cover for Mildmay and St Joseph's Hospice, the IPC team has been awarded the contract to provide IPC services for the East London Foundation Trust (ELFT). The ELFT contract started on the 17th September 2012.

16 Appendix 1 - Glossary of terms

Bacteraemia	blood stream infection; blood poisoning
CDI	*Clostridium difficile* infection
CQC	Care Quality Commission
DIPC	Director of Infection Prevention & Control
GRE	Glycopeptide Resistant Enterococci
HCAI	Healthcare Associated Infections; 'any infection by any infectious agent acquired as a consequence of a person's treatment by the NHS or which is acquired by a healthcare worker in the course of their NHS duties'
HCW	Healthcare Worker
HII	*Saving Lives* High Impact Interventions
HPU	Health Protection Unit; 'Public Health'
HUH	Homerton University Hospital NHS Foundation Trust
ICC	Infection Control Committee
ICD	Infection Control Doctor
ICN(C)	Infection Control Nurse (Consultant)
IPCT	Infection Prevention and Control Team
IV line	Intravenous line
IPC	Infection Prevention and Control
MRGNR	The term 'multi-resistant gram negative rods' (MRGNR) covers the laboratory finding of GNRs resistant to gentamicin and a 3rd generation cephalosporin. These include both those GNRs who are multi-resistant due to the production of extended spectrum ß-lactamases (ESBL-producers) e.g. multi-resistant *E.coli*, multi-resistant *Klebsiella* and those GNRs who are multi-resistant due to other resistance mechanisms e.g. multi-resistant *Acinetobacter*
MRSA	Meticillin Resistant *Staphylococcus aureus*
NPSA	National Patient Safety Agency
RCA	Root Cause Analysis
SI	Serious Incident

Infection Prevention & Control Scorecard

Homerton University Hospital NHS
NHS Foundation Trust

		2011/12						2012/13							
	Units	Q1	Q2	Q3	Q4	2011/12 Out-Turn	2012/13 Target	Q1	Q2	Q3	Q4	2012/13 Out-Turn	Target Status		
													Red	Amber	Green
DH Indicators															
IC Indicators (Reported to DH)															
MRSA Bacteraemia (MRSAB)	Cases	0	0	0	0	0	1	0	0	0	2	2			
CDT (HUH Attributable)	Cases	2	3	3	1	9	7	3	1	7	2	13			
VRE Bacteraemia	Cases	1	0	0	0	1	0	0	0	0	0	0			
Serious Untoward Incident (SUI)															
C-Diff Deaths	Cases	0	1	1	0	2	0	0	0	0	0	0			
MRSA Deaths	Cases	0	0	1	0	1	0	0	0	0	0	0			
Other SUIs	Cases	0	0	0	3	3	0	0	0	1	0	1			
Alert Organisms Trigger Events															
MRSA	Number	1	1	0	0	2	0	0	0	0	0	0			
CDT	Number	0	0	0	0	0	0	0	0	1	0	1			
National Standard Monitoring Tool															
Cleaning Service															
CSDO	%	98.0%	96.9%	95.5%	93.4%	96%	95%	96.0%	97.0%	97.2%	98.2%	97%			
IMRS	%	96.9%	96.4%	95.2%	92.4%	95%	95%	94.0%	96.0%	96.5%	97.5%	96%			
SWSH	%	97.0%	95.4%	96.9%	95.6%	96%	95%	96.0%	97.0%	97.3%	97.9%	97%			
Trust	%	97.0%	96.8%	95.0%	93.8%	96%	95%	95.0%	96.7%	97.1%	97.9%	97%			
Outbreaks															
Diarrhoea and Vomiting	Number	1	1	0	0	2	0	0	0	0	0	0			
Other	Number	0	0	0	0	0	0	0	0	0	0	0			
Audits Completed															
ICNA Audits	%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Trustwide Audits	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			
HII Audit Compliance															
IV line ongoing care															
CSDO	%	92%	94%	96%	98%	95%	95%	98%	100%	100%	100%	100%			
IMRS	%	95%	96%	98%	94%	96%	95%	99%	97%	97%	98%	98%			
SWSH	%	100%	99%	100%	99%	100%	95%	100%	99%	100%	98%	99%			
Urinary catheter ongoing care															
IMRS	%	99%	99%	100%	100%	100%	95%	100%	100%	97%	100%	99%			
SWSH	%	94%	100%	98%	98%	98%	95%	100%	100%	100%	100%	100%			
IV cannula insertion															
CSDO	%	100%	99%	100%	97%	99%	95%	93%	84%	88%	100%	91%			
IMRS	%	96%	93%	95%	97%	95%	95%	97%	94%	100%	95%	96%			
SWSH	%	89%	86%	91%	98%	91%	95%	95%	94%	99%	95%	96%			
Hand hygiene															
CSDO	%	99%	98%	99%	100%	99%	95%	100%	99%	98%	99%	99%			
IMRS	%	96%	97%	99%	99%	98%	95%	99%	99%	100%	99%	99%			
SWSH	%	96%	96%	97%	98%	97%	95%	99%	97%	98%	97%	98%			
MRSA screening															
IMRS	%	92%	91%	92%	92%	92%	95%	96%	97%	97%	95%	96%			
SWSH	%	95%	97%	90%	94%	94%	95%	99%	99%	99%	98%	99%			
IC Training Completed															
CSDO	%	51.3%	100.0%	99.5%	96.5%	96%	80%	92.1%	99.6%	97.9%	96.0%	96%			
IMRS	%	49.2%	100.0%	99.4%	96.2%	96%	80%	91.6%	99.7%	97.4%	97.0%	96%			
SWSH	%	59.0%	100.0%	99.3%	97.0%	97%	80%	94.0%	99.8%	98.8%	97.0%	97%			
Environment	%						80%	96.3%	100.0%	98.8%	99.0%	99%			
Workforce	%	90.1%	100.0%	100.0%	98.5%	99%	80%	90.0%	94.7%	98.5%	98.0%	95%			
Corporate	%	81.2%	100.0%	100.0%	97.8%	98%	80%	93.1%	100.0%	98.2%	98.0%	97%			
Trust	%	57.2%	100.0%	99.5%	96.8%	97%	80%	92.5%	99.6%	97.9%	97.0%	97%			

49 out of 49 audits for the year
4 out of 4 audits for the year