

ANNUAL REPORT OF THE DIRECTOR OF INFECTION PREVENTION & CONTROL

April 2010 – March 2011

Blitz the Bugs.....

The Trust takes Infection Prevention & Control very seriously

We are committed to ensuring that our staff, patients and visitors are protected from healthcare associated infections

Please help us to maintain our high standards by:

- ✓ Washing your hands or using alcohol hand gel on entering and before leaving wards and departments
- ✓ Helping us to keep our hospital clean and tidy
- ✓ Not visiting patients if you are unwell with signs of an infection (such as diarrhoea, vomiting, fever or flu like symptoms)
- ✓ Letting us know if you have any questions or concerns regarding infection prevention and control or standards of cleanliness



..... It's in all our hands

**Birmingham Women's NHS Foundation Trust
Working together to beat infection**

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PART 1: INTRODUCTION

EXECUTIVE SUMMARY

- ❑ For the eighth year in succession no infections in two of the three categories subject to Department of Health mandatory surveillance.
- ❑ There has been one case of Clostridium Difficile in July 2010.
- ❑ Active programme of Infection Control Audit, focusing on areas of high risk to this Trust.
- ❑ Active programme of environmental inspections has been enhanced
- ❑ Improved performance in hand hygiene audits.
- ❑ Provision of hand hygiene facilities at the Point of Care throughout the Trust.
- ❑ MRSA screening of elective and emergency Gynaecology patients, all admissions to the Neonatal Unit, and high-risk Maternity cases maintained.
- ❑ Excellent rating on Patient Environment maintained.
- ❑ Training programme in Infection Prevention & Control successfully delivered, including extensive hand hygiene training.
- ❑ No breaches identified during our unannounced visit by South Birmingham PCT in 2010
- ❑ Trust compliant with Code of Practice for the prevention and control of healthcare associated infections contained in The Health and Social Care Act 2008.

INTRODUCTION

Birmingham Women's NHS Foundation Trust has always been committed to protecting patients from healthcare-associated infections (HCAIs). Once again we are pleased to report evidence of continuing high standards of Infection Prevention and Control at all levels within the Trust, together with the successful achievement of almost all objectives set for the Infection Control Team (ICT). In November 2010 we underwent an unannounced inspection by South Birmingham PCT of our performance against the Hygiene Code. No breaches of the Hygiene Code were found,

For the eighth consecutive year there were no MRSA bacteraemia infections subject to Department of Health mandatory surveillance. However for the first time in over 5 years, the trust reported one case of Clostridium Difficile in July 2010. A full review of the case was undertaken and lessons have been learnt and shared. The trust continues to implement a range of stringent infection prevention measures that have been in place for many years. Mandatory infection surveillance encompasses only a small proportion of the overall burden of healthcare associated infections (HCAIs), and it is important to note that our much more extensive internal infection surveillance continues to show satisfactory performance in preventing a much broader range of HCAIs. This excellent performance is no reason for complacency. We continue to raise awareness of specific risks around HCAIs with our staff, and to promote and monitor good clinical practice to minimise the risk of HCAI for our patients.

We believe that this report underlines our success and ongoing commitment in providing excellent standards of infection control and environment cleanliness.

DESCRIPTION OF INFECTION CONTROL INFRASTRUCTURE

All staff members at Birmingham Women's Hospital have a responsibility to themselves, patients, visitors and other staff to maintain high standards of Infection Control. However some staff have specific responsibilities defined in their job descriptions, and they are recorded here.

The Infection Control Team

Jane Owen, Director of Infection Prevention & Control

Julie Suviste, Infection Control Nurse Specialist

Samantha Bullingham, Infection Control Nurse

Charlotte King, Infection Control Lead for Neonatal and Maternity Services

Jim Gray, Consultant Microbiologist

Mitul Patel, Consultant Microbiologist

Matrons

Jenny Henry, Head of Midwifery

Justine Jeffrey, Clinical Manager, Delivery Suite

Michele Emery, Head of Nursing, Neonatal Services

Jacky Cotton, Head of Nursing, Gynaecology Directorate

Other Clinical Services

Emily Hartwell, Pharmacy

Louise Hopton, Occupational Health Nurse

Gael Peters, Operating Theatre Manager

Corporate Services

Pam Cooper, Head of Facilities

Gail Alexander, Hotel Services Coordinator

Roger Bengough, Assistant Estates Manager

Rosey Monaghan, Decontamination Lead

Cath Roper, Risk Manager

STATEMENT BY THE BOARD OF DIRECTORS

The Board of Directors is committed to maintaining the Trust's excellent reputation and rating in relation to the prevention and control of healthcare-associated infections (HCAIs). Effective prevention and control of HCAIs has to be embedded into everyday practice and applied consistently by everyone. The Board recognises it has an important role in ensuring that appropriate and adequately resourced arrangements for infection prevention and control are in place, and in monitoring standards through an assurance framework and knowledge of the annual infection control programme.

As part of the regular reporting and assurance to the Board the Director of Infection Prevention and Control (DIPC) presents an annual report and programme of work as well as quarterly Directorate reports from the matrons.

These reports provide information and assurance on issues affecting infection prevention and control across the Directorates and demonstrate the infection control is an integral part of the Directorate's activities.

In January 2010, a weekly patient safety report, produced by the medical director, was introduced. Two of the nine metrics reported are MRSA and Clostridium Difficile. The "Friday metrics" are circulated to all staff, the PCT and our governors. This has raised the profile of the trust's performance against these indicators.

The Trust's strategic objective of improving the quality, reputation and safety of our services is underpinned by infection prevention and control.

Objective: To maintain infection control standards and compliance with the Hygiene Code.

An assurance framework exists for each principal objective of the Trust that includes assessment of the principal risks, key controls, assurances on controls and arrangements for Board reporting (including provision for reporting gaps in controls and/or assurance).

By this means the Board of Directors takes collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks, and is assured that sufficient resources are available to secure the effective prevention and control of HCAI.

ACHIEVEMENTS OF THE INFECTION CONTROL TEAM

PRIZES & AWARDS

MEMBERSHIP OF NATIONAL COMMITTEES

Jim Gray

- Expert Adviser, British National Formulary for Children (BNF-C)
- Member, Guidelines Development Group, National Institute for Health & Clinical Excellence: Donor breast milk banking short clinical guideline
- Member, NETSCC, HTA Pharmaceuticals Panel
- Member, Guidelines Development Group, National Institute for Health & Clinical Excellence: Antibiotics for early onset neonatal infection

Mitul Patel

- Member, Guideline Development Group, The management of acute bloody diarrhoea potentially caused by VTEC (E coli O: 157) in children. Health Protection Agency, RCPCH and RCGP

EDITORSHIPS

Jim Gray

- Associate Editor, Journal of Paediatric Infectious Diseases
- Paediatric Section Editor, International Journal of Antimicrobial Agents
- Assistant Editor, Journal of Hospital Infection

PUBLICATIONS

Peer-reviewed publications

1. Daniels J, **Gray J**, Pattison H, Gray R, Khan KS on behalf of the GBS Collaborative Group. Intrapartum tests for group B streptococcus: accuracy and acceptability of screening. Br J Obstet Gynaecol 2011;118:257-65.
2. **Gray J**, Patwardhan SC, Martin W. MRSA infections in obstetrics: a review. J Hosp Infect 2010;75: 89-92.
3. Kaambwa B, Bryan S, **Gray J**, Milner P, Daniels J, Khan K, Roberts TE. Cost-effectiveness of rapid tests and other existing strategies for screening and management of early onset group B streptococcus during labour. Br J Obstet Gynaecol 2010; 117:1616-27.
4. **Gray J**, Ali O, Dawood R, Robertson S, Strauss R, Walton S. Consensus guideline for the management of common bacterial skin infections in primary care. Guidelines 2010; 51: 437-41.
5. **Gray J, Patel M**, Turner H, Reynolds F. MRSA screening on a Paediatric ICU. Arch Dis Child. Doi:10.1136/adc.2010.185785.
6. Ismail AQ, **Gray J**, Anthony. M. An investigation of possible routes of transmission of group B streptococci to humans outside the neonatal period. J Hosp Infect 2011;77:184-5.
7. **Gray J**, O'Donoghue B. Bacteraemia with meticillin-sensitive *Staphylococcus aureus* in an English children's hospital. J Hosp Infect. doi: 10.1016/j.jhin.2011.02.006.
8. **Gray J, Patel M**. Management of antibiotic resistant infection in the newborn. Arch Dis Child Fetal Neonatal Ed. In press.

9. **Gray J.** GUM_02_001 Interpreting Laboratory Tests. In Department of Health e-Learning for Healthcare. E-HIV-STI. 2010.

Book chapters

1. **Gray J,** Hextall A. Vaginitis. In: Cardozo L, Statskin D (eds.) Textbook of female urology and urogynecology, 3rd edn. Informa UK, London.2010, pp.544-53.
2. **Gray JW.** POCT for infectious diseases. In Price CP, St John A, Kricka LJ (eds.) Point-of-care testing. Needs, opportunity and innovation, 3rd edn. Washington DC: AACC Press 2010, pp. 447-65.
3. **Gray J,** Robinson D. Lower urinary tract infections: simple and complex. In: Cardozo L, Statskin D (eds.) Textbook of female urology and urogynecology, 3rd edn. Informa UK, London.2010, pp.530-43.

PRESENTATIONS AT SCIENTIFIC MEETINGS

1. **Gray J,** Bullingham S, Dyer N, Room J. Rapid root cause analysis to investigate the sources of cases of hospital-acquired rotavirus (HARV). Poster presentation at the 28th Annual Meeting of the European Society for Paediatric Infectious Diseases, Nice, 5-8 May 2010.
2. **Gray J,** Sime M, Sahni M, Rasiah SV. MRSA on a neonatal unit (NNU): admission screening or surveillance cultures? Poster presentation at the 28th Annual Meeting of the European Society for Paediatric Infectious Diseases, Nice, 5-8 May 2010.
3. Lyttle M, **Gray J,** Berry K. Assessment of potential benefits in the paediatric population with point of care testing in pandemic H1N1 influenza. Oral presentation at the 28th Annual Meeting of the European Society for Paediatric Infectious Diseases, Nice, 5-8 May 2010.
4. Room J, **Gray J.** Elective Surgical MRSA Screening in a Paediatric Hospital. Poster presentation at the 3rd Congress of the European Academy of Paediatric Societies, Copenhagen, October 23-26 2010.
5. Room J, **Gray J, Patel M,** Thomas C. PVL-producing US 300 MRSA Outbreak on a Paediatric Burns Unit. Poster presentation at the 3rd Congress of the European Academy of Paediatric Societies, Copenhagen, October 23-26 2010.
6. Lyttle M, **Gray J,** Berry K. Assessment of potential benefits in the paediatric population with point of care testing in pandemic H1N1 influenza. Poster presentation at the College of Emergency Medicine Conference, Learning from Each Other. Civilian and Military Emergency Care, Birmingham, September 13-15 2010.
7. Patwardham S, **Gray J,** Martin W. MRSA Screening in Obstetrics. Poster presentation at the 30th annual meeting of the Society for Maternal-Fetal Medicine, San Francisco, February 7-12 2011.
8. Lyttle M, **Gray J,** Berry K. Assessment of potential benefits in the paediatric population with point of care testing in pandemic H1N1 influenza. Poster presentation at the 1st Annual West Midlands CEM Conference, Birmingham, 19th January 2011.
9. **Gray J.** *Clostridium difficile*: can we be better at diagnosis? Invited lecture at Society for Applied Microbiology Spring Meeting, Stratford upon Avon, 16 April 2010.
10. **Gray J.** Microbiology of Donor Milk Banking. Invited lecture at UKAMB Milk Banking Conference, Solihull, 8 October 2010.

11. **Gray J.** Infection Prevention & Control on the Burns Unit. Now & into the Future. Invited lecture at the 7th International Conference of the Hospital Infection Society, Liverpool, 10-13 October 2010.
12. **Gray J.** European strategies to contain antibiotic resistance & promote appropriate antibiotic prescribing in paediatric care. Invited lecture at the 3rd Congress of the European Academy of Paediatric Societies, Copenhagen, 23-26 October 2010.
13. **Suviste J. Bullingham S,** Coley C, King C. Blitzing Bug's at Birmingham Women's Hospital. Poster presentation at the International Forum on Quality and Safety in Healthcare, Amsterdam 5-8 April 2011.
14. **M Patel.** Neonatal infections: Learning from each other's experience. Invited presentation. P.S. Medical College, Gujarat, India. May 2010
15. **M Patel.** Making sense of antifungal guidelines. Presentation at West Midlands Microbiology Meet, Oct 2010
16. Johansen L, Sharif K, Mirza DF, **Patel M et. al.** CMV PCR is indicated in symptomatic children whereas routine EBV PCR screening is necessary in effective management of post-intestinal transplant patients. British Society for Paediatric Gastroenterology, Hepatology and Nutrition annual meeting. Jan 2011

AWARDS

Julie Suviste

- Regional winner (Central/East of England) - Cepheid Infection Control Nurse Award 2010

INFECTION SURVEILLANCE

1. ALERT ORGANISM-BASED SURVEILLANCE

BACKGROUND

The Infection Control Team prospectively records all new laboratory isolates of key alert organisms (that is microorganisms that are important causes of healthcare associated infections).

Staphylococcus aureus is an important cause of HCAI in all groups of patients. Meticillin-resistant *S. aureus* (MRSA) are strains that are resistant to flucloxacillin and other commonly-used antibiotics. They are especially important because infections with MRSA are inconvenient and expensive to treat, and because in hospitals where MRSA is prevalent it tends to add to the overall burden of healthcare associated infections.

Klebsiella and *Enterobacter* are usually the most common hospital-associated opportunistic nosocomial Gram-negative pathogens seen on our NNU. Although the majority of cases detected are asymptomatic, their occurrence is a useful measure of patient-to-patient transmission of a wide range of bacteria.

Pseudomonas and *Acinetobacter* are Gram-negative bacteria that are important because they are often multiply antibiotic-resistant and they occur almost exclusively as healthcare-associated pathogens. These bacteria have a different epidemiology to *Klebsiella* and *Enterobacter* in that they can be

associated with deficiencies in environmental cleanliness, as well as direct patient-to-patient spread.

In recent years the range of potentially important Gram-negative bacteria on NNUs has increased: during 2010/11 we introduced enhanced screening of neonates to monitor the acquisition of these bacteria and to facilitate earlier intervention in the event of a possible outbreak. One impact of this approach is that surveillance will have detected more babies on the NNU colonised with Gram-negative bacteria, and therefore numbers are not directly comparable with previous years.

METHODS

Alert organism-based surveillance is undertaken by prospective collection of Microbiology laboratory data by the Infection Control Team.

In the case of MRSA, the ICT makes a thorough assessment of each new case. This includes determining the likely origin of the MRSA using the following definitions:

- Originating at BWNFt: Patient admitted to BWH at least 48 hours before MRSA first identified *and* no risk factors for prior colonisation with MRSA or previous negative microbiology results from the affected site(s).
- Originating elsewhere: Patient already known to be colonised with MRSA or patient transferred from, or employed in, a hospital where MRSA is prevalent *and* no previous negative microbiology results from the affected site(s). Infections in babies judged to be vertically transmitted are categorised according to the origin of the maternal infection.
- Uncertain origin: Cases that do not fulfil either of the above definitions.

MRSA cases are also assessed on the reason why swabs were collected (screening or because infection is suspected).

RESULTS

Annual numbers of cases of colonisation or infection with *S. aureus* for the past five years are shown in Table x.1. Numbers of cases in babies were lower than in previous years, whilst cases in adults women were comparable to recent years.

Table 1: Annual numbers of cases of colonisation or infection with *S. aureus* according to patient group over the past four years

	No. of cases of colonisation or infection with <i>S. aureus</i> in:			
	NNU	Other babies	Obstetric mothers	Gynaecology
2010/11	63	44	73	32
2009/10	77	66	57	28
2008/09	123	57	50	36
2007/08	106	83	74	46
2006/07	68	68	100	46
2005/06	105	85	114	54

The evolution of screening for MRSA means that numbers of cases of colonisation or infection detected in 2010/11 are not fully comparable with those in previous years. Results are presented in the same format as last year, but note that the Gynaecology results will be skewed as a result of introduction of screening of emergency admissions during the last year (Table x.2). It is also noted that rationalisation of the screening programme for Maternity services has, as predicted, had no effect on case ascertainment.

Again, no cases of MRSA were considered to have been definitely acquired at BWH in 2010/11: 34 were deemed to have been acquired elsewhere, and in two cases a source could not be assigned with certainty.

Table 2: Occurrence of various epidemiological categories of MRSA colonisation and infection during the past three years

Reason for test	No. of cases in patient category								Total nos. of cases	
	NNU babies		Other babies		Maternity		Gynaecology			
	2009 /10	2010 /11	2009 /10	2010 /11	2009 /10	2010 /11	2009/10	2010 /11	2009 /10	2010 /11
Routine screen	0	1	0	0	9	6	16	19	25	26
Non-routine screen	0	0	3	1	0	1	0	0	3	2
Suspected infection	0	0	1	3	3	4	2	1	6	8
TOTALS	0	1	4	4	12	11	18	20	34	36

The numbers of cases of infection or colonisation with *klebsiella* and *enterobacter* in NNU babies were comparable to the previous year (Table x.3): these results were unaffected by the change in screening procedure referred to earlier. The number of cases of *P. aeruginosa* was substantially increased. This was partly due to enhanced surveillance, but the specific matter of *pseudomonas* being found in taps and water is discussed in the Untoward Incidents chapter.

Table 3: Occurrence of *Klebsiella* and *Enterobacter* spp. in NNU patients in the past three years

	No of isolates of:			
	<i>Klebsiella</i>	<i>Enterobacter</i>	<i>Acinetobacter</i>	<i>Pseudomonas</i>
2010/11	12	9	1	37
2009/10	16	2	1	18
2008/09	21	22	3	9
2007/08	26	16	2	8

Numbers of cases of colonisation or infection with *P. aeruginosa* are also recorded for Maternity and Gynaecology patients. There were 15 isolates of *P. aeruginosa* in Gynaecology patients in 2010/11, which is comparable to previous years: 10, 7, 22, and 14 cases in the years 2009/10 to 2006/07. Amongst Maternity patients *P. aeruginosa* was isolated from 6 mothers and no babies in 2010/11, compared with 8 mothers and 2 babies in the previous year.

CONCLUSIONS

Although far more comprehensive than many hospitals' programmes, the limitations of our surveillance programme in that denominator data are not used to determine rates of infection have been noted in previous Annual Reports. Nevertheless it can be concluded that:

- MRSA remains tightly controlled in our hospital.
- MRSA screening has made it easier to identify whether MRSA was acquired within or outside the Trust. However, it has had little effect on overall case ascertainment: in particular extension of the screening programme to include emergency gynaecology admissions has had minimal impact.
- Numbers of cases of colonisation or infection with *Staphylococcus aureus* remain at a lower level.
- The most important change detected by organism surveillance has been increased numbers of previously unusual Gram-negative bacteria on the NNU.

RECOMMENDATIONS

- Revised MRSA screening strategy is working well, although case ascertainment rates remain low: there may be an opportunity to rationalise screening further once the results of the national audit planned for May 2011 are available.
- Work is ongoing to investigate and control Gram-negative bacteria on the NNU.

2. CONDITION-BASED SURVEILLANCE

2.1 National surveillance through mandatory reporting to the Health Protection Agency

BACKGROUND

The Department of Health mandatory infection surveillance schemes encompass three infections:

- Bacteraemia with meticillin-resistant *Staphylococcus aureus* (MRSA)
- Bacteraemia with glycopeptide-resistant enterococci (GRE)
- *Clostridium difficile*-associated diarrhoea in over-2 year olds

RESULTS

For the eighth consecutive year there were no bloodstream infections with either MRSA or GRE. We did however report one case of presumed *C. difficile*-associated diarrhoea in July 2010. The patient had self-limiting diarrhoea and was *C. difficile*-positive by PCR, but toxin-negative by enzyme immunoassay. A root cause analysis (RCA) was undertaken on this case, which identified some issues with movement of patients with possible infectious diarrhoea and around antibiotic stewardship. All actions arising from this RCA have been completed.

ENHANCED SCREENING FOR GNB USING RECTAL SWABS ON NNU

BACKGROUND

Gram negative organisms resistant to commonly used antibiotics are a growing threat to hospitalised patients globally. We have seen more instances of colonisation with Gram-negative bacteria with unusual antibiotic resistances on the NNU in recent months. There are anecdotal reports of other local NNU having same problem.

A screening programme using oropharyngeal secretions (OPS) and endotracheal secretions (ETS) is already in place on the NNU.

An enhanced screening programme for screening for resistant gram negative organism using rectal swab has been implemented on the new NNU.

METHOD

Rectal swabs are collected at the time of admission to the unit and once in a week throughout the patient's in-patient stay. The target organisms are: gentamicin resistant *Enterobacteriaceae*, ESBL producing *Enterobacteriaceae* and *Serratia marcescens* (GNB of interest: **GNBi**)

RESULT

Table: 1 GNBi isolated from screening specimens including rectal swabs during the first 6-month period (1st Sept 10 to 28th Feb 11) on the new NNU

Organism	From any specimen	First isolated in rectal swab	Isolated only from rectal swab	Isolated from other specimen
Gent R <i>E coli</i>	6	3	1	2
Gent R <i>Klebsiella</i>	2	2	2	0
Gent R <i>Morganella</i>	1	1	0	1
ESBL <i>E coli</i>	4	2	2	0
<i>Serratia marcescens</i>	8	3	2	1
TOTAL	21	11	7	4

- A total of 21 GNBi were isolated from 21 cases from all clinical and screening specimens during the first 6 months period.
- Rectal swab was the first specimen to grow GNBi in 11 cases.
- In 7 out of these 11 patients, rectal swab was the only positive specimen that was growing the GNBi during their in-patient stay.
- In 4 out of the 11 cases, the same organism was isolated from other specimens e.g. ETS/ OPS, including one blood culture, later during their in-patient stay.
- In addition to above organisms, *P. aeruginosa* colonisation was also identified in 9 cases; a detail of which has been discussed in 'untoward incidents'.

CONCLUSION

- Rectal screening enabled early recognition of colonisation with GNB in 11 out of 21 cases.
- Seven of those 11 cases, where rectal swab was the only positive specimen, would have passed through the NNU without notice.
- Enhanced screening has helped monitor the changing epidemiology of GNB on NNU

RECOMMENDATION

- To continue rectal screening and keep under review

INFECTION CONTROL AUDITS

BACKGROUND

In order to comply with the duties detailed in the Health and Social Care Act (2008) *Code of Practice for the Prevention and Control of Health Care Associated Infections and related guidance* Trusts need to ensure that they have an active audit programme in place to monitor compliance with key infection prevention and control policies. Audits are a useful measure of general compliance with clinical practices and can also help to identify where further action, resources or education may be required. However it is important to note that audits can only reflect the practice observed at the time and observational audits can be subject to bias by the auditor or those being audited.

The audit programme for 2010/2011 was identified in the Trust Infection Control Annual Programme and agreed by the Infection Control Committee.

Audits have continued to focus on key clinical practices and environmental standards. This year clinical departments have taken the lead in undertaking monthly audits of cleanliness and environmental standards, hand hygiene compliance and the Department of Health Saving Lives – High Impact Interventions.

Audits completed this year include:

Clinical Practices

- Hand Hygiene Compliance
- Safe Sharps Practice
- Standard Precautions
- Isolation Practices
- Aseptic Practice
- High Impact Interventions

Environmental Standards

- Multidisciplinary Environment Inspections
- Hand Hygiene Facilities
- Department led Environmental Audits
- Department led Medical Equipment Cleanliness Audits

- Mattress & Pillow Audits
- Ward and Main Kitchen Inspections

METHODS

The majority of audit tools used are based on the Infection Control Nurses Association (ICNA) *Audit tools for monitoring infection control standards* or nationally recognised audit tools i.e. Department of Health Saving Lives – High Impact Interventions. The ICNA defines scores of 85% and above as compliant, whilst scores of 80-84% are partially compliant.

Collation of audit results is either undertaken by the Infection Control Nursing Team or by individual Departments, this is dependent upon the audit. The responsibility for dissemination of results and follow-up of any issues identified remains the responsibility of Heads of Nursing and Midwifery or designated Infection Control Leads. Audit results and actions taken are detailed in the Directorate Matron Reports to the Infection Control Committee.

RESULTS

An overview of the audit results is provided below.

Hand Hygiene Compliance

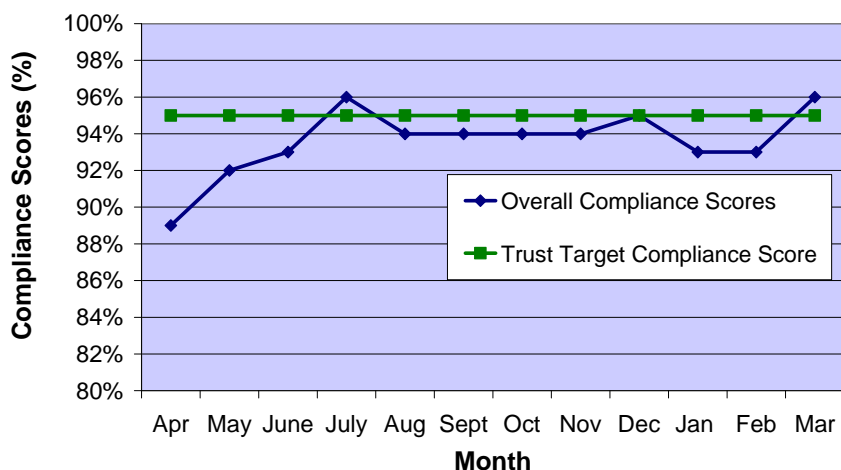
Clinical areas undertake monthly observational audits of hand hygiene compliance which focus on the World Health Organisations “Five moments of hand hygiene” and the key elements of “Bare Below the Elbows”. Compliance scores are entered into an electronic database and overall scores are generated for each Directorate, Department and individual staff disciplines.

Scores are displayed in clinical areas on dedicated Infection Control notice boards for staff and public information.

The Trust compliance target is 95% and above. Overall compliance scores have continued to increase this year with scores consistently at or above 93% for the majority of months this year, a score of 96% was recently achieved in March. High standards of hand hygiene compliance remains a priority for the Trust with Clinical Directorates being responsible for ensuring actions are undertaken to improve and sustain compliance in their areas. Hand Hygiene training is included in all Infection Control education sessions for all relevant staff and is promoted as part of Infection Control awareness days and ad hoc sessions throughout the year, which are aimed at staff, patients and the public.

Overall Trust Compliance Scores

Hand Hygiene Compliance 2010-2011



Hand Hygiene Facility Audit

An audit of hand hygiene facilities was undertaken in all clinical areas throughout the Trust. The overall compliance score was 92% compared to 88% in 2009/2010.

Key issues identified related to non-intact sealant, evidence of build up of alcohol gel or soap residue around nozzles of dispensers, or missing drip trays. All issues have been addressed and are monitored locally during department level environmental audits.

Hand Hygiene Facilities – Inpatient Departments									
Dept/Ward	1	3	4	7	8	TC	NNU	DS	BC
Score	91%	95%	95%	91%	91%	91%	100%	95%	82%

Hand Hygiene Facilities – Outpatient Departments										
Dept	ACU	EPAU	FM	Rad	Physio	Wd 2	ANC	Gynae OPD	Colp	DAU
Score	82%	91%	82%	95%	95%	96%	86%	100%	95%	100%

Safe Handling and Disposal of Sharps

Safe handling and disposal of sharps is key to preventing inoculation injuries. Compliance with practice was assessed in 19 areas during Quarter 3. Scores were above 90% in 17 areas and the overall Trust compliance score was 95%. The main themes identified were:

- Lack of use of the temporary closure mechanism on sharps containers when not in use.
- Visual posters detailing the correct management of inoculation injuries were not displayed in all areas, however on questioning staff knowledge was very good.

Safe sharps practice and management of inoculation injuries continues to be included in all infection control training sessions at induction and during annual Infection Control updates. It was also targeted during our Infection Control awareness week in June.

Standard Precautions

Standard precautions are key principles of infection prevention and control practice and encompass several different aspects (including hand hygiene, use of personal protective equipment, decontamination processes, management of blood and bodily fluids and management of linen and waste). Compliance with practice was audited in 19 areas in Quarter 2 with outpatient clinical areas also included this year. 5 areas scored lower than 85%, key areas that required further action included:

- Ensuring that all staff know where to locate personal protective equipment in their areas; including protective eye wear and disposable face masks.
- Ensuring all staff are knowledgeable about the products used for all decontamination processes.
- Ensuring spillage kits are available and within use by dates in all clinical areas.

Isolation Practices

Compliance with isolation policy was undertaken in Quarter 2. Due to the low number of patients often requiring isolation, the audit was undertaken over a 6 week period, to gain a sufficient number of observations to reflect practice. The audit focused on all key elements of the Trust Isolation Policy.

Compliance with policy was observed to be very good, with patients being isolated promptly, appropriately and with key isolation practices in place.

Throughout the year capacity of isolation facilities has been observed to be sufficient within the Trust. The isolation facilities available in the Neonatal Unit have now increased and are usually sufficient for demand. However following risk assessments involving the ICT, cohort nursing has still been necessary on occasion due to the numbers of babies colonised with specific organisms, patient dependency or staffing.

Department of Health – Saving Lives: High Impact Interventions

High Impact interventions (HII's) are audit compliance tools (Care Bundles) which relate to key clinical procedures and aim to reduce any variation in practice. They are based on the latest evidenced based guidance and provide a means for clinical staff to measure local compliance of clinical procedures against nationally agreed standards.

Participation in the individual auditing programmes by clinical areas has improved this year and a central electronic database has been produced by Informatics and the Infection Control Nursing Team to improve collation and dissemination of results.

Compliance with the individual Care Bundles is generally very good, however some individual departments need to focus on ensuring that documentation records for the care of peripheral venous devices are fully completed.

Aseptic Practice

Elements of aseptic practice are monitored via the audit of High Impact Interventions. In addition clinical areas were requested to undertake more detailed audits of aseptic non-touch technique practice throughout Quarter 4, using an audit tool based on the policy for Aseptic and Aseptic non-touch technique.

64 completed audit forms were returned from 9 clinical departments. Compliance with policy was reported to be very good with individual department scores ranging between 86% and 100%. Key issues identified by the audit will be reinforced during ongoing education programmes delivered by the Infection Control Nursing Team.

Environmental Audits

Department based audits that assess environmental standards and cleanliness of medical equipment continue to be led by Department Managers. Performance and any unresolved issues are included in the Quarterly reports to the Infection Control Committee produced by the Heads of Nursing and Midwifery (Matrons).

Formal mattress and pillow audits are also completed in all clinical areas, these are performed quarterly in Delivery Suite and the Birth Centre and a minimum of 6 monthly in all other clinical areas.

Environmental Inspections 2010/11

BACKGROUND

The Health and Social Care Act (2008) *Code of practice for the NHS on the prevention and control of health care associated infections and related guidance* Criterion 2 identifies the need to: *“Provide and maintain a clean and appropriate environment which facilitates The prevention and control of healthcare associated infections”*.

In July 2010 an environmental Inspection framework was developed and agreed by members of the Infection Prevention and Control Committee. This is now the standard proforma that is used and applied to all the Environmental Inspections done in clinical areas.

METHOD

An Environmental Inspection visit is carried out in all clinical areas on an annual basis (as a minimum) by the Environmental Inspection Team. This consists of:

- Lead
- Matron
- Infection Control Nurse

- Facilities/housekeeping Lead

The audit tool '*Observational Tool for Quality Walkabout Patient Environment*' is used as a framework for the visits.

RESULTS

The Environmental Inspection Team determines the outcome of the inspection dependent on the findings. Results are deemed as:

1. EIT inspection visit reveals no problems
2. EIT inspection visit reveals problems NOT deemed to be putting patients at immediate risk
3. EIT inspection visit reveals problems THAT ARE deemed to be putting patients at immediate risk

Where the EIT visit reveals problems that are deemed to be putting patients at immediate risk this information is escalated to the DIPC on the same day and a decision will be made on precautions to be put in place i.e. special measures.

Since July 2010 there have been 17 inspections that have been undertaken. Two inspection visits were found deemed to be putting patients at immediate risk. Following the inspections the issues/problems identified were escalated to all team members including the DIPC an action plan was formulated and a revisit to both areas was scheduled. These areas are now in process of rectifying any outstanding issues raised during the visits.

RECOMMENDATIONS

Recommendations for 2011/12 are:

- To develop a robust system to enable common themes/problems that are occurring across the Trust
- Review the current observational audit tool.
- Develop the tool to make it more specific for use in the out-patient areas and Theatre settings.

Ward Kitchen Audits

Quarterly unannounced inspections are undertaken by the Infection Control Nursing Team and the Facilities Manager. The main aim is to monitor environmental standards within ward kitchens and assess compliance with the Food Hygiene policy.

Results have continued to be good throughout the year with overall compliance scores ranging between 84% in Quarter 1 to 90% in Quarter 4. Areas of non-compliance can vary but in general relate to cleanliness of areas that are difficult to access, i.e. beneath and behind appliances, storage of inappropriate or surplus items in the kitchen, and lack of labelling of food items stored in ward based refrigerators. Department Managers are responsible for ensuring action is taken in response to any issues identified.

Ward Kitchen Compliance Scores 2010/2011				
Quarter	Q1	Q2	Q3	Q4
Score	89%	83%	78%	90%

The Infection Control Team also participate in quarterly inspections of the Trust main kitchen in conjunction with the Catering Manager to monitor practice and environmental standards. The main and ward kitchens are also subject to annual inspections undertaken by Environmental Health, the ICT are normally invited to accompany them during their visits.

CONCLUSIONS

A robust proactive audit programme has continued throughout the Trust this year, encompassing the monitoring of environmental standards and individual clinical practices. In general audit scores remain very good and reflect the high standards of practice in all clinical areas. The Multidisciplinary Environment Inspections have continued to be extremely useful and effective in maintaining and further improving our high standards throughout the Trust. The reporting mechanisms in place help to ensure that prompt action is taken if any areas of concern are identified.

RECOMMENDATIONS

- To review our audit programme to ensure that this continues to reflect the requirements of the Health and Social Care Act 2008.
- To incorporate the new national Quality Improvement Tools within our audit programme following their launch which is expected in April this year.
- To review auditing of the High Impact Interventions and incorporate any of the newly published tools which are relevant to our Trust.

ANTIMICROBIAL PRESCRIBING

BACKGROUND

Good antimicrobial stewardship depends on a number of factors, including:

- Selection of agents that give effective and reliable cover against the expected pathogens.
- Selection of agents that are safe for our group of patients: this is an especially important consideration in this Trust, where a large proportion of our patients fall into groups that are at high risk of harm from drugs, such as pregnant, breastfeeding, and neonates.
- Selection of agents that minimise the risks of antibiotic resistance and nosocomial infections such as *Clostridium difficile* and MRSA.
- Antibiotics prescribing for the shortest effective time.

The antimicrobial prescribing policy for neonates in this Trust fulfils all the above criteria.

The antimicrobial prescribing policy for adults has to strike a balance between patient safety and promotion of antimicrobial resistance. As a result, we place fewer restrictions on use of cephalosporins during the antenatal period; however, new guidelines promote reduced use of cephalosporins in every other group.

METHODS & RESULTS

Updated antibiotic prescribing policies for Maternity Services, Gynaecology and the Neonatal Unit were approved last year.

This year an A4 size laminated and coloured 'quick reference' guide has been published and put on every ward for easy access. This has been well received by medical staff, with positive feedback and encouraging audit results.

The pharmacist's role includes the monitoring of the antimicrobial prescribing across the trust. This is based on current antibiotics guidelines.

An annual audit was carried out and the results showed that in the majority (93%) of cases the antibiotics were prescribed appropriately, guidelines were followed where possible; microbiologist was contacted when needed and record keeping, especially for duration of treatment, was somehow poor.

Antimicrobial prescribing is now a regular feature of junior doctors' induction program.

CONCLUSIONS & RECOMMENDATIONS

An early audit, straight after the introduction of the new guidelines showed good results, however antibiotic prescribing ought to be reassessed during the year to ascertain compliance.

In addition, further training has been put together by the pharmacist and the microbiologist, for nurses and midwives, to help understanding infectious diseases and antibiotic drugs use.

If well attended and received the training should result in better prescribing, monitoring and health outcomes for patients.

INFECTION CONTROL POLICIES

BACKGROUND

The Trust has in place all the core Infection Control Policies identified in The Health & Social Care Act 2008, as well as additional policies specific to the needs of this Specialist Trust. All Infection Control Policies are available for any staff member to view on the Trust intranet.

OUTCOMES

The following Infection Control Policies were reviewed, and updated as required:

- Policy for the control of *Clostridium difficile*
- MRSA screening policy
- Policy for the control of infections with varicella zoster virus (chickenpox and shingles)
- Guidelines for the management of needlestick injuries and mucous membrane exposures to blood & body fluids (inoculation injuries)

- Cleaning, disinfection & decontamination policy
- Isolation policy
- Aseptic and aseptic non-touch technique policy
- Introduction to infection control and arrangements for reporting of infections
- Policy for the prevention & control of tuberculosis
- Policy for the control of MRSA
- Marking of patient's case notes who represent an infection control hazard
- Procedure for handling used linen
- Notes on the control of individual of individual infections diseases

In addition the following new Infection Control Policies were produced and approved:

- Policy for the control of respiratory viruses in the hospital
- Policy for the control of diarrhoea and vomiting in the hospital
- Policy for the Laboratory Investigation & Surveillance of Healthcare Associated Infections

RECOMMENDATIONS

That the Infection Control Team continues to ensure that existing Infection Control Policies are in date, and that new policies in response to local or national demands are produced in a timely manner.

PART 3: THE REPORTS OF OTHER KEY SERVICES

FACILITIES

BACKGROUND

Cleaning services are provided by the Hotel Services function, which forms part of Facilities Directorate. Cleaning is undertaken by an extremely dedicated in house team of Housekeepers and Housekeeping Supervisors. The majority of cleaning is undertaken between 07.30 and 20.00 hours, however a 24 hour service is provided to the Delivery Suite and Birth Centre.

The Trust now employs 48.6 wte Housekeepers and 3.4 wte Housekeeping Supervisors.

The Hotel Services Department have successfully grown a team of bank workers that can be called upon to cover staff shortages

All Housekeepers assist with meal and beverage services, as a result they are trained to the basic food hygiene standard; they receive annual hand hygiene/infection control training and undertake the NVQ level two Basic Cleaning course.

METHODS

Cleaning services are provided throughout the hospital, the level and frequency of service is documented in work schedules which are on public display. All work schedules are compliant with the National Cleaning standards.

The Trust adopts the National Colour Coding system for cleaning cloths, mops etc and all waste is segregated and stored in designated areas away from public view.

In addition to scheduled work the Housekeeping department undertake special cleans, usually as part of a refurbishment or building programme where the entire area receives a thorough deep clean prior to re-occupation.

All clinical areas have disposable curtains and the Housekeeping team change as necessary or upon the date of the annual change.

Standards of cleanliness and general environment are monitored on a daily basis by Housekeeping Supervisors. Room cleaning checklists are completed for high risk; high turnover areas like Birth centre and Delivery Suite to ensure standards are maintained despite the quick turnover.

Ward cleanliness checklists are completed on a weekly basis for specific pieces of equipment such as Ice makers and beds

A new contract has been established for monthly deep cleaning of Ice makers in line with EHO recommendations

Each clinical area has an Infection Control/Housekeeping notice board specifically designated for the display of Infection Control and Housekeeping information, relating to that specific ward or department.

Monthly quality control reports are completed by the Housekeeping Supervisors, these are then sent to the relevant Ward manager or Department head for comment/action as required and a copy is displayed on the Infection Control/Housekeeping notice board.

The Facilities team are actively involved in the design and development of all building work and refurbishment programmes, this provides an excellent opportunity to influence the design and layout of areas and to ensure cleaning, storage and waste handling services are included in any design.

The Facilities team are active members of the Infection Control Committee and Infection Control Task Force participating in regular site inspections. This team has proved to be invaluable as a means of maintaining good communication/access to Ward Managers, Service heads, Director for Infection, Prevention and Control and the Infection Control team.

RESULTS

- Deep clean and maintenance programme for all Delivery rooms implemented
- New Neo natal unit opened and cleaning processes adjusted to meet manufacturers recommendations for the new floors and other furnishings
- Dedicated storage space created for clean linen, consumables and cleaning equipment in the new Neo natal unit and also designed into the new Midwifery unit plans
- Further patient bathrooms converted to wet rooms and hands free taps installed
- Water birth room refurbished
- Improved waste segregation and introduction of new waste stream for offensive waste
- Ceiling tiles replaced on an on going basis, and patch painting undertake
- Junk removal and general de cluttering throughout.
- Waste traps and shower wastes cleaned out on a regular basis by dedicated member of staff.
- Waste hold area on Delivery suite refurbished, floor and wall surfaces replaced to reduce infection control risks from damaged surfaces
- Changing facilities for Catering staff and Housekeeping staff refurbished.

CONCLUSIONS

The general standard of cleanliness and the condition of the patient environment has been maintained over the last 12 months. However there are some patient areas in need of upgrade and redecoration ante natal clinic in particular

Working relationships across clinical and non clinical teams have been strengthened and the relationship between Facilities and Infection Control continues to be extremely healthy and supportive.

RECOMMENDATIONS

- To maintain the current level of investment in Housekeeping and maintenance services.
- To maintain an on going programme of re upholstering of patient furniture and removal of clutter
- To maintain the programme of Infection Control/Environmental inspections in all patient areas
- To consider increasing the level of painting and redecoration service provided to patient areas in order to maintain the appearance of the environment and ensure surfaces are in a good condition to clean and maintain.

MATERNITY SERVICES DIRECTORATE

BACKGROUND

The Directorate team, with the support of local link workers and the ICT, has made good progress against the objective set for this period.

Objectives for 2010/2011

- To secure resources to ensure a bed/mattress replacement programme is in place
- To maintain resource for housekeeping services
- To continue with the quarterly audits and regular environment inspections
- To continue to fund link midwives within the clinical area
- To monitor the adherence of compliance for all high impact interventions
- To provide targeted hand hygiene education
- To improve compliance with MRSA screening

METHOD

Hand hygiene audits and environmental audits continue within all clinical areas. Changes to cleaning systems and reallocation of tasks to specific staff groups have been implemented. Targeted teaching for hand hygiene has improved compliance amongst staff groups that had consistently lower levels of compliance.

Environmental inspections provided disappointing results for the intrapartum areas. New systems for cleaning each of the areas have been implemented

regular weekly spot checks are carried out by the leads for IC to ensure that standards are maintained.

A maintenance programme for the intrapartum area was organised to address some minor estate issues that were identified during environmental inspections. Delivery beds were also serviced and repairs carried out in the last quarter of this year. Disposable curtains continue to be successfully utilised within the directorate.

MRSA screening compliance continued to challenge the Directorate for the majority of this period. Targeted teaching and a new system implemented in the post natal area have provided assurance to the Trust during the last quarter.

Mattress audits have been completed bi-annually and replacement bed, cot and resuscitaire mattresses are available within the Directorate to ensure rapid replacement. Intrapartum bed mattresses are audited quarterly.

Collating evidence for the high impact interventions has been challenging. Documentation changes in the labour and birth record and a new HDU booklet were introduced in December 2010 to address audit requirements. A review of equipment has begun and financial support for changes to consumables will be explored to improve compliance with catheterisation.

Housekeeping has been maintained and is currently being reviewed with a plan to increase the resource during the forthcoming financial year.

Monthly directorate meetings continue and are attended by the ward managers and/or the link midwife. The monthly audit results are discussed at this meeting and problems/actions to address poor levels of compliance are explored. Infection control remains a standing item on the agenda for the Maternity Managers meeting.

RESULTS

- Hand hygiene compliance has improved in all areas
- All mattresses are audited and replaced promptly
- Financial support to maintain the use of disposable curtains was secured.
- New cleaning systems to provide assurance have been implemented and are proving highly effective.
- Compliance with high impact interventions is improving, in particular documentation.
- Maintenance programme for the intrapartum areas was completed.
- Feedback from the patient tracker units regarding the cleanliness of the environment is positive
- Compliance with MRSA screening has been achieved.
- Delivery beds serviced and repaired.
- Local meeting with link midwives/managers continue.

CONCLUSIONS

The Directorate has continued to perform well against the audit targets.

MRSA screening compliance is now achieved and the Directorate has continued to provide financial support for all of the identified projects.

The IC links have continued to raise the profile of infection control within the Directorate and the Directorate are pleased to report that all of the objectives set have been achieved.

RECOMMENDATIONS

- To maintain resources to ensure a bed/mattress replacement programme is in place
- To increase resource for housekeeping services
- To maintain compliance with all IC audits
- To maintain the funding for link midwives within the clinical area
- To provide an additional Midwife IC link for the Directorate
- To monitor the adherence of compliance for all high impact interventions
- To provide targeted hand hygiene education if levels of compliance fall
- To maintain compliance with MRSA screening

NEONATAL SERVICES DIRECTORATE

BACKGROUND

The Neonatal Directorate has had a challenging year ensuring that the highest standards of infection control and prevention were maintained. We have continued to work very closely with the Infection Control Team to monitor and limit any incidence of infection.

The Neonatal Unit relocated to our brand new purpose built space on the 8th September 2010. The environment is modern, clean and spacious. However there have been on going concerns following the isolation of pseudomonas aeruginosa from the automatic taps.

We now have six single rooms where we can isolate babies with organisms that cause concern. This has been helpful as we have seen an increase in gram negative multi resistant organisms this year.

Throughout the past year considerable activity has been undertaken to monitor and improve all areas with the potential to cause infection. Hand Hygiene continues to be at the top of our infection control agenda. Training is mandatory and regular sessions are held by Charlotte King, Neonatal Infection Control Lead, to ensure that staff is up to date. Mattress audits have been completed, on a six monthly basis, both of adult and cot/incubator mattresses.

Antibiotic prescribing continues to be closely monitored within the Directorate on daily ward rounds and also by Dr M Patel, Consultant Microbiologist who attends weekly grand ward rounds on Mondays. There is a Neonatal Formulary, which was reviewed in February 2011, available on the intranet which gives antibiotic prescribing advice. Changes to antibiotic policy have been made throughout the year in response to incidents concerning babies.

Other audits have been completed in compliance with the yearly audit programme including aseptic non touch technique, assessing the environment, high impact interventions, medical equipment cleanliness, waste management, sharps management and standard precautions.

New initiatives

Plastic reusable injection trays are now in use to provide a clean area for the making up and administration of intravenous antibiotics. Each baby has his/her own tray to prevent cross infection. The trays are cleaned with a detergent wipe before and after use. They replace disposable cardboard trays which were not fit for purpose.

Disposable sterile packs for the insertion of long intravenous lines have been purchased. These have been a huge success with medical and nursing staff as everything is in one sterile pack saving time and reducing the risk of cross infection. We are now investigating cost effectiveness of similar packs for umbilical arterial and venous line insertion.

In October 2010 Dr Patel commenced a weekly rectal swab screening programme for all babies on the Neonatal Unit specifically to look for gram negative organisms. This has been successful and has now been incorporated into our routine screening programme.

Following review of practice and the literature between neonatologists and microbiologists our practice of screening oropharyngeal secretions in babies requiring oxygen was stopped. There has also been a reduction in screening endotracheal secretion to three times per week instead of daily. In both these cases it was felt that the rectal screening programme had superseded them. Assessed competency based training in Aseptic Non Touch Technique (ANTT) has commenced for all members of the medical and nursing staff to ensure that our practice is of the highest standard.

Results or outcomes

There have been no cases of MRSA bacteraemia or C Dificile in the Directorate this year. There was one baby with asymptomatic colonisation of MRSA detected on routine screening. This baby was isolated to prevent the spread to other patients.

All babies admitted to the Directorate are routinely screened for MRSA. Mothers admitted to Transitional Care are also routinely screened for MRSA. All new members of staff are also screened.

Results of Hand Hygiene Audits have been variable. Although we have had some excellent hand hygiene audit results we have failed to consistently achieve the benchmark of 95% compliance. Numerous interventions have been put in place this year to achieve the benchmark. We have now launched an on line infection control power point presentation that clinical staff can undertake at the cot side. This has a video of correct hand washing technique embedded within it. This is then followed by a compulsory questionnaire which is returned to the Infection Control Lead. We hope this will highlight any problem areas of compliance and understanding.

Results of Environmental Audits have raised minor issues but are not showing cause for concern. Settlement cracks have developed in some of the internal walls.

Medical equipment audits have been disappointing with equipment found to be dusty. A new system is now in place where damp dusting of equipment is carried out at night. A more robust cleaning schedule for clinical trolleys has also been instigated.

High Impact Intervention Audits have been undertaken and show good results many achieving 100% compliance. However, achieving the required number of observations for each audit has proved to be challenging. These audits have to be undertaken in the clinical area when a procedure is occurring and nurses have expressed difficulty in completing them. Next year we are piloting a self assessment audit in an attempt to increase the number of observations achieved.

CONCLUSIONS

Good progress has been made this year but this will be accelerated in 2011 - 2012 to ensure all audit results are compliant with targets.

RECOMMENDATIONS

- To continue to actively support the prevention and control of infection within the Directorate
- To support the Infection Control Audit Programme.
- To continue to develop robust action plans within the multidisciplinary team to improve the hand hygiene audit results to achieve and maintain a minimum of 95% compliance.
- To continue to work with the nurses and Infection Control Team to develop High Impact Intervention Audits.

GYNAECOLOGY SERVICES DIRECTORATE

BACKGROUND

Cleanliness and monitoring of infection control and prevention measures have continued to be a high priority during 2010-11 within the Gynaecology Directorate. No areas were required to relocate during the year so staff have been able to consolidate practice within existing areas. Ward and departmental managers and their staff have worked extremely hard during the year to maintain a clean and pleasant environment for patients and to ensure regular audits are undertaken to provide assurance.

Ward and departmental managers have prioritised the maintenance and enhancement of the clinical environment. Disposable curtains are replaced either as required or as a minimum annually and window blinds are used in all areas. Furniture used in patient areas has been regularly maintained and is either recovered or replaced if any damage is noted which could compromise adequate cleaning. A system has been implemented on the inpatient wards to identify when equipment has been cleaned and is ready for use and also when bed spaces have been cleaned and prepared for the next patient.

All patients admitted to the wards are now screened for MRSA isolates. Patients for elective procedures are screened at their preoperative assessment visit and patients admitted as an emergency are screened on admission. This latter procedure was implemented from April 2010 in advance of the National requirement for all patients to be screened by December 2010.

Hand hygiene continues to be very high profile and is audited regularly. Results of the audits are publically displayed on designated infection control notice boards in ward areas. Hand gel is available at point of care.

Assurance of the standards of cleanliness and actions taken to reduce the risk of infection is provided through an annual audit programme developed by the Infection Control Nurse Specialist. It has continued to be challenging for ward managers to ensure all required audits are undertaken in a timely manner. A particular challenge is monitoring of High Impact Interventions relating to peripheral venous cannulae and catheters and ensuring sufficient numbers of observations have been undertaken. The majority of peripheral venous cannulae are inserted in other departments prior to arrival on the ward and so target figures have been adjusted accordingly.

The role of link nurse in clinical areas has strengthened and many of the audits are now led by these nurses.

Senior nursing staff actively participate in the Infection Control Committee and the Infection Control Taskforce which has ensured infection prevention and control maintains a high priority. The Head of Nursing provides quarterly Directorate reports to the Infection Control Committee, summarising audit activity and results, any concerns and relevant action plans.

Staff within Gynaecology are required to attend annual mandatory training in Infection Prevention and Control Updates provided by Infection Control Nurse Specialists and attendance is monitored closely by Ward and Departmental managers.

A revised antibiotic formulary for the Directorate has been implemented by microbiologists and pharmacists.

Infection control is a standing item on the agenda of Gynaecology Clinical Improvement Group which meets every 6 weeks.

METHODS

The Infection Control taskforce now undertake regular Environment Inspections. A timetable is developed for the year and each clinical area is inspected by a team from the Taskforce at least annually. In addition, senior nurses in the Directorate undertake additional inspections using the same format and audit tool on a quarterly basis.

Ward and departmental managers ensure that the many audits as described in the Infection Control Annual Audit Programme are undertaken in a timely manner and the Head of Nursing collates all the results in the quarterly Directorate reports. . Action plans have been developed where compliance does not meet the agreed standard. The following methods have been implemented

- Hand hygiene audits are undertaken on inpatient wards on a monthly basis.
- Antibiotic usage is closely monitored. On a weekly basis any patients who have been an inpatient for over 6 days or are known to have required therapeutic antibiotics or who have been readmitted with potential wound or other infection are reported to the Infection Control Team. A Consultant microbiologist then assesses the patient's care to ensure the antibiotic prescription is timely and appropriate.
- Readmission of any patients with a wound infection is reported on the Datix incident reporting system. The Infection Control team are informed and they will under a review of the patient's care to see if there were any preventable factors identified.
- Nursing staff complete forms monitoring peripheral venous cannulation from insertion to removal and this is filed in the patient's healthcare records.
- Nursing staff also monitor and record specific interventions relating to care of catheters
- Mattress and pillow audits are completed 6 monthly and if any defects are identified either during the audit or during routine checking whilst bed making, covers or the actual mattresses are replaced as required.
- Ward managers ensure regular audits of cleanliness of medical equipment and the patient environment undertake.
- Senior nursing staff undertake an environment inspection on a quarterly basis
- Audits have been undertaken with Facilities and Infection control staff on sharps management, waste management, standard precautions and environment.

RESULTS

There were no cases of Clostridium difficile or MRSA, MSSA, Eschericia Coli bacteraemias in the Directorate during the year. Several incidences of MRSA isolates were detected on routine screening of patients.

Hand hygiene audits showed generally good levels of compliance, particularly amongst nursing staff and compliance figures have improved during the year. Ward 8 achieved 95% compliance on 4 occasions, 90% compliance on 4 occasions, 85% compliance on 2 occasions and 80% compliance on 2 occasions .

Ward 7 achieved 95% compliance on 2 occasions, 90% compliance on 5 occasions and 85% compliance on 3 occasions. The other 2 months were below 85%

This was due mainly to non compliance by medical staff including anaesthetists on ward rounds, particularly preoperatively. Two particular ongoing issues identified here were ensuring staff are "bare below the elbow" particularly during ward rounds and ensuring that clinicians clean their hands after being in contact with patient bed space even if they have not been in direct contact with the patient. Consultant medical staff are regularly reminded of their responsibilities at Consultant Education Meetings.

Results of both Environmental audits and Standard Precautions Audit reflect the hard ongoing work of staff with only minimal areas of non-compliance which are addressed by the ward/departmental managers as soon as they are noted.

CONCLUSIONS

It is evident that staff continue to take great pride in maintaining the cleanliness and appearance of the patient environment in the Gynaecology Directorate.

Formal monitoring and reporting mechanisms within the Directorate have been consolidated and this has supported all staff in maintaining this as a high priority.

Results in hand hygiene audits, whilst generally improving, have not been as consistent as the Directorate would wish. In 2008/09, the agreed standard of 95% compliance overall was only achieved on one occasion. During 2009/10 it was achieved on 5 occasions and in 2010/11 it was achieved on 6 occasions. Ward managers are continually working with staff to challenge any non-compliance observed on an ongoing basis to ensure further improvements in the forthcoming year.

RECOMMENDATIONS

- Continue to feedback results of hand hygiene audits to all staff groups
- Nursing staff to challenge other clinicians who are noncompliant with "bare below the elbows"
- Continued education about hand hygiene responsibilities to all staff groups.
- Raise awareness of staff of results and need to comply with policy for hand hygiene.
- Continue current monitoring processes to provide assurance of effective infection prevention.
- Continue close working relationship with Infection Control Team.

CLINICAL SUPPORT SERVICES DIRECTORATE
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BACKGROUND

The Associate Director for Clinical Support and the Operating Theatre Manager have lead responsibility for infection control in the Clinical Support Directorate. They work very closely with department managers and the Infection Control Team to ensure high standards of cleanliness within clinical areas are maintained.

Over the past year the directorate has continued to manage the decontamination service provided by BBraun. Monthly service review committee meetings are held to ensure service delivery is effective and an internal BBraun user group are held to discuss non-conformances.

The areas of focus for this financial year have included:

- Hand hygiene compliance

- Standards of environment and equipment cleanliness
- High impact intervention

OUTCOMES

Results in hand hygiene audits, whilst generally improving, have not been as consistent as the Directorate would wish. The Directorate achieved an overall compliance of 93.4%. Radiology achieved 100% on 6 occasions and was below 90% on 3 occasions. Theatres achieved 95% and above on 3 occasions and achieved 90% and below on 3 occasions. Results of these audits are fed back to staff at staff meetings and audit information is displayed on designated infection control notice boards.

Following the Environmental Audits and Medical Equipment Audits, robust cleaning rotas have been developed and are being closely monitored. Storage rooms have been re-organised, and alternative shelving has been erected for the storage of sterile fluids in Theatres.

High Impact Intervention Audits have also been undertaken in Theatres although it is not a true reflection of overall activity for PVC insertion (currently undertaken using 2 individuals).

Urinary catheter insertion audits consistently achieve 100%.

Turnaround times for the decontamination service have been reviewed and adjusted from 8 to 24 hours for most sets.

CONCLUSION

Despite audits being inconsistently completed at the beginning of the year, departmental managers have worked hard to ensure standards of cleanliness are maintained and appropriate action has been taken to reduce the risk of infection.

Further work is required in the forthcoming year to ensure staff compliance and to ensure audits are consistent and meet target levels.

RECOMMENDATIONS

- To continue to improve the consistency of hand hygiene audits to ensure results achieve and maintain a minimum of 95% compliance.
- To progress all Environmental and Equipment action plans ensure all results are compliant with targets.
- To continue to work with the Infection Control Team to develop additional High Impact Intervention Audits.
- Continue with current monitoring processes to provide assurance of effective decontamination.
- Educate medical staff in the advantages of wearing PPE within the anaesthetic area.

- Implement stricter controls for audit process of PVC insertion by introducing daily snapshot of activity. Named individual will take responsibility for this role.
- Support training for 2 members of theatre staff to undertake infection control link nurse course.

MICROBIOLOGY DEPARTMENT

The Microbiology Department has unconditional accreditation with CPA (UK) Limited. It underwent a full inspection in March 2011 at which feedback from the Assessor was positive.

The Department has Standard Operating Procedures describing the communication and investigation of hospital infection control-related issues. There is also an infection control policy entitled *Laboratory Investigation & Surveillance of Healthcare associated Infections Policy* that defines the role of the Microbiology Department in the investigation and surveillance of healthcare-associated infections.

PART 4: OUR STAFF

OCCUPATIONAL HEALTH

BACKGROUND

The Occupational Health service is provided to Birmingham Women's Hospital by a Service Level of Agreement with the University Hospital Birmingham. The purpose of the service is to promote and protect the health and well being of staff in the workplace. This contributes to the protection of patients and staff from the acquisition and transmission of some infectious diseases.

METHODS

Health Assessment prior to employment (previously known as Pre-employment screening)

This is undertaken for all new staff. It includes screening and when indicated immunisation for the following infectious diseases.

Screening	
EPP workers (practitioners of invasive procedures)	All Health Care Workers
Hepatitis B	Hepatitis B
Hepatitis C	Measles
HIV	Rubella
	Varicella
	TB

Immunisation Clinics

Clinic sessions have been provided for in employment testing and immunisation.

Seasonal flu (which included H1N1)

16 sessions were provided across the Trust including some dedicated clinics for high risk areas. 304 employees were immunised against seasonal flu, this was an increase from the previous year. The initial uptake was poor however when the number of flu cases in the population became high more staff members took up the opportunity to be vaccinated.

Doctors	Nurses & Midwives	Prof & Tech	Snr Mgt	A & C	Ancillary	AHP	Total
35	76	70	13	62	36	12	304

Inoculation/splash Injuries

Advice on the management and follow-up of inoculation/splash injuries is provided on a daily basis and during the induction of all staff members. Occupational Health and Control of Infection ran an inoculation injuries awareness day in June, staff were given information and advice about inoculation injuries, a short quiz identified knowledge gaps.

60 injuries were reported in the Trust. There is also evidence of other unreported and untraceable incidents.

Doctors and Surgeons reported 45% (27) of incidents and were the largest reporting staff group

Nurse and Midwives reported 36% (22) of the incidents

Delivery Suite & Delivery suite Theatres reported 55% (33) of injuries

Gynae Theatres reported 21% (13) of injuries.

The causes of injuries were

Hollow bore needles 31%

Non – hollow needles 26%

Splash Injuries 13%

Surgical Instruments 23%

Others 7%

CONCLUSIONS

- More incidents were reported this year; this may be due to a better reporting system and a better awareness of the importance of reporting injuries.
- Occupational Health and the Control of Infection team have carried out an audit of injuries; this has been report elsewhere in the report.
- Evidence gathered from the reported injuries indicates that the implementation of sharp safe devices could reduce nearly one third of the injuries.
- Improved use of personal protective equipment particularly eye protection could reduce a number of the splash injuries.
- Injuries caused by suture needles and surgical instruments may indicate that there is a training issue that needs to be addressed.

RECOMMENDATIONS

1. Prevention of injuries should continue to be a priority; this may be achieved by:

- ❖ Continue to ensure displays of information at Ward and Department level are appropriate and up to date
- ❖ A further focus week in conjunction with Control of Infection
- ❖ Review of Inoculations Injury audit, issues raised from this should be actioned.

2. Uptake of flu vaccinations

- ❖ Frontline staff need to be encouraged to take up the flu vaccination
- ❖ High risk areas need to be targeted with dedicated sessions
- ❖ Staff should be encouraged to take up the vaccination at the first possible opportunity

TRAINING & EDUCATION

BACKGROUND

Training and education in infection prevention and control is central to the effective prevention and control of healthcare associated infections. It is also necessary to ensure compliance with the NHSLA standards and requirements of the Health and Social Care Act 2008. The Health Act places key emphasis on ensuring that prevention and control of health care associated infection (HCAI) is embedded into everyday practice, with staff demonstrating consistent high standards and awareness of infection control.

RESULTS

The Infection Control Team (ICT) continues to contribute to a comprehensive training programme to all disciplines of staff throughout the Trust. We continue to adopt a multi-faceted approach to deliver education, which includes formal presentations, informal training in clinical areas, infection control awareness weeks and regular staff newsletters. The Infection Control Training Needs Analysis (TNA) defines levels of training for all disciplines of staff and is part of the Trust Mandatory and Statutory Training policy.

All training sessions are updated at least annually to reflect national and local policy or initiatives and also include feedback of audit results or emphasis on individual policies as required.

Attendance is recorded centrally on the education database (OLM system), quarterly reports are provided by Human Resources to Directorate Leads who are responsible for monitoring the uptake of training and ensuring that all staff attend relevant training sessions in line with the Infection Control TNA.

Our Infection Control awareness week was held in June 2010, this involved the launch of our '*Blitz the Bugs It's in all our hands*' campaign. Staff participated in quizzes based on key infection control practices, with safe management of sharps and inoculation injuries targeted during the week. Representatives from Occupational Health and Synergy Healthcare were also available throughout the week to provide advice and education to staff.

All Departments now have identified link practitioners, who have taken on increased responsibility this year in leading the locally led audit programmes. Forums have now been established in both Maternity and Gynaecology Directorates, which provide an opportunity for the Infection Control Nurses and the link practitioners to meet on a regular and more formal basis.

CONCLUSIONS

A comprehensive training programme continues to be provided by the Infection Control Team, providing a wide range of educational activities. Hand hygiene continues to be a key element in all Infection Control training sessions at induction, as part of update training programmes and in response to local audit results.

RECOMMENDATIONS

To further develop the structure of the Maternity and Gynaecology forums to provide an informative and educational framework for the link practitioners.

PART 5: OUR PUBLIC

REPORT OF INFORMATION PROVIDED TO THE PUBLIC

BACKGROUND

The Trust is committed to providing information on healthcare-associated infections to the people we serve. This is included in public displays throughout the hospital, Infection Control awareness days and an information leaflet which describes what the Trust is doing to prevent and control healthcare associated infections, which is sent out to patients with all appointment or booking information.

OUTCOMES

Throughout the year a number of initiatives have been completed to provide information and raise awareness of Infection Prevention and Control:

- Launch of our 'Blitz the Bugs' campaign to reinforce and communicate key Infection Control messages to the public.
- Regular update of the Infection Control information board which is displayed in main reception for public access.
- Continued display of information at Ward and Department level on Infection Control notice boards, including key Infection Control messages and audit results of hand hygiene compliance, environmental cleanliness standards and High Impact Interventions.
- Production of an abbreviated version of the Trust Annual Report, highlighting the key points from the full report that would be of interest to our staff and our public.
- Our Infection Control Focus Week took place in June 2010. This involved displays, quizzes, an opportunity to test individual hand hygiene technique using the 'Glo & Tel' hand inspection unit and a chance for the public to meet the Infection Control Nurses and Infection Control Leads.
- Updates on Infection Prevention and Control in the Trust newsletter – Women's Progress.
- Further development of our sections on the Trust Internet site and Intranet pages.

RECOMMENDATIONS

Continue to develop and update the information that is displayed throughout the Trust.

Ensure our patient information leaflets meet the requirements of the Health and Social Care Act 2008, and the needs of our users.

PART 6: ASSURANCE

COMMITTEES & REPORTING

INFECTION CONTROL COMMITTEE

The Infection Control Committee met on the following dates:

22 April 2010
22 July 2010
21 October 2010
13 January 2011

INFECTION CONTROL TASK FORCE

This group operated regularly throughout the year, with the focus more on environmental inspection than on meetings. A new Observation Tool and Action Report Form were introduced in June 2010, and a more detailed report of the inspection programme is included elsewhere in this report.

CLINICAL GOVERNANCE GROUP

Quarterly reports were made to the CGG in April 2010, July 2010, October 2010 and January 2011.

THE CARE QUALITY COMMISSION AND COMPLIANCE WITH THE HYGIENE CODE

The Care Quality Commission (CQC) has registered, and therefore licensed, Birmingham Women's NHS Foundation Trust to provide services. The essential standards of quality and safety that must be met for registration include a requirement that patients are cared for in a clean environment where they are protected from infection (that is that we comply with the Hygiene Code).

This Annual Report of the Director of Infection Prevention & Control provides evidence of compliance against each of the ten criteria of the Hygiene Code.

RESPONSES TO GUIDANCE & DIRECTIVES FROM THE DEPARTMENT OF HEALTH & OTHER BODIES

- *The Health & Social Care Act 2008 (Revised December 2010)*
A further revised Hygiene Code again contained few changes that were relevant to the acute sector. As in recent years, the Annual Programme for Infection Control 2010-11 follows the format of the Hygiene Code, and includes actions that have been identified to ensure ongoing compliance with the Code.

- *Department of Health Water Sources and Potential for Infection from Taps and Sinks Gateway 14720 27 August 2010*
 This alert highlighted the risks associated of bacteria being transmitted from taps and sinks, a matter that became of importance following the opening of the new Neonatal Unit in September 2010 (see Untoward Incidents chapter).
- *NHS West Midlands Serious Incidents (SI) reporting Policy and Procedure*
 Infection-related incidents are managed and reported in accordance with this document.
- *NHS West Midlands minimum data set toolkit for healthcare associated infections*
 The Infection Control Team began reporting these data in November 2010.
- *Extension of DH Mandatory Surveillance of bloodstream infections to include meticillin-sensitive Staphylococcus aureus (MSSA) and E.coli*
 The Infection Control Team has had arrangements in place to report bloodstream infections with MSSA on the national hcai website since January 2011. Guidance on reporting of *E. coli* infections is still awaited. The Trust has decided that all bloodstream infections with MSSA and *E. coli* will be investigated by root cause analysis. All clinical staff have received a letter outlining their responsibilities in preventing and responding to these infections.

PROGRESS AGAINST INFECTION CONTROL PROGRAMME 2009-2010

Criterion 1

Systems to manage & monitor the prevention & control of infection

Subject	Objective	Priority	Lead individual	Target date	Status at end of Q4
Decontamination Lead	See under Criterion 2				
Audit programme	Undertake audit of key infection control policies & practices <ul style="list-style-type: none"> • Standard Precautions • Isolation Policy • Safe Handling & Disposal of Sharps • Hand Hygiene Facilities • Aseptic Technique 	HIGH	JS Matrons	March 2011	Completed
	Undertake audits to ensure environmental standards are maintained: <ul style="list-style-type: none"> • Medical equipment cleanliness • Environmental and cleanliness standards • Ward Kitchens • Mattress & Pillows • Waste Management 	HIGH	Matrons/ HoN's/HoM's GA/PC	On-going	Completed
Multidisciplinary Environment Audits (IC Task Force)	Agree a programme of audits for the year	HIGH	JO	April 2010	Completed
Hand Hygiene Compliance	Establish a working group to lead on improving and sustaining hand hygiene compliance at all clinical areas	HIGH	JO & Matrons	May 2010	Completed
	Implement actions at local level and provide exception reports where compliance falls below 95%	HIGH	Dept Managers/ Matrons	On-going	

High Impact Interventions	Continue to undertake audits of high impact interventions. <ul style="list-style-type: none"> • Central venous devices • Peripheral venous devices • Urinary catheters • Ventilator Care 	HIGH	Matrons/JS	On-going	Completed
	Improve ownership of programme in clinical areas	HIGH	Matrons		
	Review Care Bundle for Cleaning & Decontamination & incorporate into audit programme		Matrons/JS		Completed
Audit feedback and action plans	Develop ownership at Department/Directorate level . Ensure systems are in place to feed back/review audit results, produce action plans & re-auditing where required.	HIGH	Matrons/ Ward & Dept Managers	July 2010	Completed
	Explore the use of IT systems to support collation and feedback of Trust wide audit data	Moderate	JS/IT Dept	July 2010	
Infection Control Resources at Department Level	Establish a system to provide support and education to department based IC Link practitioners	Moderate	JS/ Dept Managers	June 2010	Completed.
Local infection surveillance	Continue to participate in mandatory MRSA bacteraemia surveillance	HIGH	JG	Ongoing	Completed
	Continue to participate in mandatory <i>C. difficile</i> surveillance				
	Continue to participate in mandatory GRE bacteraemia surveillance				
Infection Prevention & Control Committee	Undertake annual review of membership & terms of reference	Moderate	JG/JO	July 2010	Completed
MRSA screening	Review experience of screening of obs screening	HIGH	JG	April 2010	Completed
	Introduce screening of emergency Gynaecology admissions	HIGH	JC	April 2010	Completed

Criterion 2**Clean & appropriate environment**

Subject	Objective	Priority	Lead individual	Target date	Status at end of Q4
Decontamination	Review the management of decontamination, taking account of three roles defined in the Hygiene Code: <ul style="list-style-type: none"> • Decontamination Lead • Lead for Cleaning • Lead for Decontamination 	HIGH	JO	June 2010	Completed
	Review cleaning, disinfection and decontamination policy to ensure that requirements under 2.1, 2.5 and 2.6 of the Hygiene Code are addressed.	HIGH	JG/JS	May 2010	Completed
	Mattresses Ensure that Ward Managers understand and execute their responsibilities in relation to: <ul style="list-style-type: none"> • Ensuring staff awareness of the Mattress Policy • Having in place a system for local regular mattress checking 	HIGH	Matrons	Sept 2010	Completed
Hand hygiene & uniform policy	Reinforcement of key messages via the Trust ' Blitz the Bugs' campaign <ul style="list-style-type: none"> • Hand Hygiene • 'Bare below the elbows' 	HIGH	JS	June 2010	Completed

Criterion 3**Suitable & accurate information on infections to service users and their visitors**

Subject	Objective	Priority	Lead individual	Target date	Status at end of Q4
Patient & public information	Launch 'Blitz the Bugs campaign'	HIGH	JS	May 2010	Completed
	Develop promotional material for display at hospital and ward entrances promoting as part of 'Blitz the Bugs' campaign	HIGH	JS	June 2010	Completed
	Review and update the information on the IC information Board in main reception	Moderate	JS	August 2010	Completed
	To have at least one Infection Control Focus week throughout the year	Low	JS/CK	Sept 2010	Completed
Ward notice boards	Review information displayed at ward level to ensure that it is consistent and reflects requirements	Moderate	JS/ Matrons	July 2010	Completed
System for reporting breaches of hygiene & cleanliness	Review current process for collating & reporting of information on cleanliness breaches	Moderate	JO	September 2010	Completed
	Implement any actions arising from the above review	Low	GA	December 2010	Completed
Website & Trust Intranet	Ensure all information is renewed and updated as required	Moderate	JS	On-going	Completed

Criterion 9**Infection Control Policies**

Subject	Objective	Priority	Lead Individual	Target date	Status at end of Q4
Antibiotic prescribing	Develop and implement systems for monitoring and reporting antimicrobial use	HIGH	MP	September 2010	Completed
<i>C. difficile</i> diagnosis	Monitor impact of changes to laboratory methods for <i>C. difficile</i> testing via quarterly reporting to ICC	HIGH	JG	Ongoing	Completed
Policy on control of acinetobacter & other antibiotic-resistant Gram-negative bacteria	Produce new Infection Control Policy	Low	JG	September 2010	Completed
Policies on control of respiratory viruses and diarrhoeal infections	Produce new Infection Control Policies	Moderate	JG	June 2010	Completed

Criterion 10**HCWs are free of, and protected from exposure to, infections, and that staff are suitably trained**

Subject	Objective	Priority	Lead individual	Target date	Status at end of Q4
Medical staff training	Develop and implement new means of training in infection control	HIGH	JG	June 2010	Completed
	Develop and implement new means of training in antimicrobial prescribing	HIGH	MP	June 2010	
Training & development of IC Nurses	Ensure that ICNSs have appropriate PDPs	HIGH	JO	March 2011	Completed
Monitoring of training	Ensure training uptake is monitored	HIGH	Matrons	July 2010	Completed
Reduction of sharps injuries	Undertake an appraisal of the feasibility, likely effectiveness and costs of using Safety-Engineered Sharp Devices at Birmingham Women's Hospital	Moderate	JG/JS	January 2011	Completed

INFECTION CONTROL RISKS

BACKGROUND

The infection control risk register was successfully transferred onto the Trust's new Datix Risk Register during 2009/10.

RESULTS & CONCLUSIONS

There are currently 13 infection control risks on the risk register, with no risk scoring greater than 12. 8 risks were closed during the year, and 2 risks were added.

All infection control risks are reviewed on a quarterly basis by the Infection Control Committee, which reports to the Clinical Governance Committee. Any important risk-related matters can also be brought to the attention of the Clinical Governance Committee via the quarterly Infection Control Report.

RECOMMENDATIONS

Although there has been progress in ensuring that the infection control risk register remains a 'live' document, further work is required to ensure that it reflects the current risks with respect to HCAI.

APPENDIX 1: TABLE REFERENCING THIS REPORT AGAINST THE HEALTH & SOCIAL CARE ACT 2008: CODE OF PRACTICE

Code of Practice criterion	Section of Report						
	Part 1	Part 2	Part 3	Part 4	Part 5	Part 6	Appendix 2
1: Have in place & operate effective management systems for the prevention & control of HCAI	√	√	√	√		√	√
2: Provide and maintain a clean and appropriate environment		√	√				
3: Provide suitable and sufficient information on HCAI to the patient, the public, and other service providers					√		
4: Ensure that patients with an infection are identified promptly and managed appropriately		√	√			√	√
5: Gain the cooperation of staff, contractors & others in preventing & controlling infection				√			
6: Provide adequate isolation facilities		√	√				
7: Secure adequate access to laboratory support							
8: Have and adhere to policies for the prevention of HCAI		√	√	√		√	
9: Staff are free of, and protected from, infection and are suitably educated				√			