

Birmingham Women's   
NHS Foundation Trust

**ANNUAL  
REPORT OF THE  
DIRECTOR OF  
INFECTION  
PREVENTION &  
CONTROL**

**April 2008 – March 2009**

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## PART 1: INTRODUCTION

### EXECUTIVE SUMMARY

- ❑ For the sixth year in succession no infections in any of the three categories subject to Department of Health mandatory surveillance.
- ❑ Active programme of Infection Control Audit, focusing on areas of high risk to this Trust.
- ❑ Improved performance in hand hygiene audits.
- ❑ Provision of hand hygiene facilities at the Point of Care throughout the Trust.
- ❑ MRSA screening of elective Gynaecology patients, all admissions to the Neonatal Unit, and high-risk Maternity cases introduced.
- ❑ Green rating on Patient Environment maintained.
- ❑ Successful transition to new provider of Sterile Supplies.
- ❑ Training programme in Infection Prevention & Control successfully delivered, including extensive hand hygiene training.
- ❑ No breaches identified during our unannounced visit by the Healthcare Commission.
- ❑ 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 December 2008 we underwent a two-day unannounced inspection by the Healthcare Commission of our performance against the Hygiene Code. No breaches of the Hygiene Code were found, and our practices around production and dissemination of our Annual Report were highlighted as an example of good practice.

For the sixth consecutive year there were no infections in any of the categories subject to Department of Health mandatory surveillance. While this success is partly down to the nature of the activity of the Trust, the contribution of stringent infection prevention measures that have been in place for many years should not be overlooked. 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.

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## 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

Jim Gray, Consultant Microbiologist

### **Matrons**

Jenny Henry, Head of Midwifery

Justine Jeffrey, Clinical Manager, Delivery Suite

Michele Emery, Head of Nursing, Neonatal Unit

Charlotte King, Infection Control Lead for Neonatal and Maternity Services

Jacky Cotton, Head of Nursing, Gynaecology Directorate

### **Other Clinical Services**

Emily Hartwell, Pharmacy

Linda Waterhouse, Occupational Health Nurse

Gael Peters, Operating Theatre Manager

### **Corporate Services**

Pam Cooper, Head of Corporate Services

Gail Alexander, Hotel Services Coordinator

Roger Bengough, Assistant Estates Manager

Gary Cockayne, 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.

Two of the principal objectives of the Trust relate directly to infection prevention & control:

**Objective 2:** To ensure all HCAI targets are met

**Objective 4:** To ensure the organisation maintains excellent standards of infection control and clean environment

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.

## PART 2: THE REPORT OF THE INFECTION CONTROL TEAM

### INFECTION SURVEILLANCE

#### 1 ALERT ORGANISM-BASED SURVEILLANCE

##### BACKGROUND

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

*S. aureus* is an important cause of HCAI in all groups of patients. Methicillin-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 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.

##### 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.

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## RESULTS

Annual numbers of cases of colonisation or infection with *S. aureus* for the past four years are shown in Table 1. The number of cases on the NNU increased in 2008/09. No single explanation for this was identified, but one likely contributory factor was the large number of babies transferred to us from other units, and who were noted to be colonised on arrival.

Numbers of cases of *S. aureus* in all other patient groups declined in 2008/09. It is likely that improved standards of hand hygiene and environmental cleanliness have been important factors in the sustained improvement seen in these areas.

**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
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 total number of new cases of colonisation or infection with MRSA remains low (Table 2). As in previous years most cases were detected through routine screening of Gynaecology patients. However, despite the fact that routine screening of all Gynaecology elective admissions commenced in September 2008 the number of cases of MRSA amongst Gynaecology patients was lower than in previous years. A greater number of mother and baby pairs were found to have MRSA than in previous years: it will be interesting to see whether the roll-out of MRSA screening to high-risk mothers will reduce this.

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

Patient group	No. of cases considered to have originated:									Total no. of cases		
	In this hospital			Outside this hospital			Uncertain					
	08/09	07/08	06/07	08/09	07/08	06/07	08/09	07/08	06/07	08/09	07/08	06/07
Neonatal Unit	-	-	-	5	1	3	1	2	-	6	3	3
Obstetric (mothers)	1	-	1	6	2	3	1	3	2	8	5	6
Obstetric (babies)	2	-	-	4	1	2	1	-	1	7	1	3
Gynaecology	-	-	1	13	16	18	-	2	3	13	18	22
Total	3	-	2	28	20	26	3	7	6	34	27	34

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Numbers of cases of infection or colonisation with Gram-negative bacteria in NNU babies were comparable to the previous year (Table 3).

**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>
2008/09	21	22	3	9
2007/08	26	16	2	8
2006/07	18	21	1	3

Numbers of cases of colonisation or infection with *P. aeruginosa* are also recorded for Maternity and Gynaecology patients. There were only 7 isolates of *P. aeruginosa* in 2008/09, compared with 22 in 2007/08 and 14 in 2006/07. Amongst Maternity patients *P. aeruginosa* was isolated from 11 mothers and 1 baby, compared with 7 women and 1 baby during 2007/08 and 8 women and 3 babies in 2006/07.

## CONCLUSIONS

Although far more comprehensive than many hospitals' programmes, the limitations of our surveillance programme have been noted in previous Annual Reports. Nevertheless it can be concluded that:

- MRSA remains tightly controlled in our hospital. We look forward to witnessing the impact of the roll-out of screening to high-risk maternity cases from the beginning of the 2009/10 financial year.
- Numbers of cases of colonisation or infection with *Staphylococcus aureus* outside the NNU are at an all-time low, possibly reflecting ongoing general improvements in standards of infection prevention and control.
- None of the alert organisms are occurring at a frequency that gives cause for concern.

## RECOMMENDATION

- More detailed infection surveillance on the NNU should be introduced to determine the impact of babies being transferred into the Unit from other institutions as part of our Level 3 role and function.

## 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:

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

## RESULTS

For the sixth consecutive year there were no infections in any of the three categories encompassed by this scheme.

### 2.2 Surgical site infection surveillance (including post-discharge surveillance)

## BACKGROUND

Surgical site infections are one of the most common types of HCAI in patients undergoing surgery. During 2007/08 we used Department of Health Funds to Improve Patient Safety & Healthcare Infection Performance to undertake a surgical site infection surveillance project in both Maternity Services and Gynaecology. This project was completed during 2008/09.

## METHODS

Women undergoing elective or emergency gynaecological surgery or Caesarean section were followed-up until at least 10 days post-discharge by a Surveillance Nurse and Midwife assigned to the project.

## RESULTS

15 out of 80 women developed a surgical site infection, giving an infection rate of 18.8%. All infections presented post-discharge, between 5 and 38 days (median 12 days) post-operatively.

22 out of 160 (13.8%) women who could be followed-up developed a surgical site infection following Caesarean section. Infections presented between 2 and 17 days post-operatively (median 8 days). Only one infection presented before discharge from hospital.

## CONCLUSIONS

The wound infection rates were not appreciably different to published rates. The majority of infections presented several days after discharge, indicating: a) that wound care at home may have been a contributory factor, and b) there is potential for a delay in treatment of infections through lack of women's awareness of the early signs of infection.

## RECOMMENDATIONS

- ❑ The reports of the projects recommended that better verbal and written information should be given to all women before discharge/transfer home concerning wound care and what to do should signs of a wound infection develop. This action has since been completed.

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- There are opportunities for further training of community midwives on the early recognition and management of surgical site infections.

## INFECTION CONTROL AUDITS

### INTRODUCTION

In order to comply with the duties of The Health Act 2006 - Code of Practice for the Prevention and Control of Health Care Associated Infections, trusts need to ensure that they have an audit programme in place to monitor compliance with key infection control policies. Infection Control audits provide a useful measure of general compliance with policy and good infection control practice. Individual audits also provide an opportunity to identify where further resources or education may be required to improve clinical standards. It is important to note however, that they only reflect the standards observed at the time of the audit, and observational audits can be subject to bias either by the auditor or by those being audited. This year's Infection Control audit programme was agreed at the start of the year and communicated to the Heads of Nursing and Midwifery. The audit programme was facilitated by the Infection Control nursing team, but many audits benefited from multidisciplinary involvement, including department staff, representatives from Facilities and external companies as appropriate. Collation and analysis of results was predominantly undertaken by the Infection Control nursing team, with the dissemination of results and follow-up of individual action plans being the responsibility of the Heads of Nursing & Midwifery (Infection Control Leads). Audit tools used were based on the Infection Control Nurses Association (ICNA) 'Audit tools for monitoring infection control standards'. The ICNA define scores of 85% and above as compliant. Individual audit scores are detailed in Figures 1 and 2.

### ENVIRONMENTAL AUDITS

#### BACKGROUND

The Health Act 2006 places a statutory duty on NHS trusts to provide and maintain a clean and appropriate environment which facilitates the prevention and control of infection. It is therefore important to ensure that high standards are continually maintained in the clinical environments throughout the Trust. Routine multidisciplinary environmental inspections are performed each quarter to assess standards of cleaning and identify any environmental issues. Ward and Department managers also have a responsibility to ensure that their clinical environments are clean and fit for purpose.

#### METHODS

In addition to the multidisciplinary inspections, Ward and Department managers were asked to complete an environment audit in their areas during the last quarter of the year. The main aim was to identify any outstanding environmental issues, requiring further resource or action which may need to be identified in this year's annual plans /annual programme of work. The audit tool used was based on an environment tool produced by the ICNA, but had additional criteria relating to a number of relevant issues including point of

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care availability of hand hygiene products and cleaning and decontamination of items of medical equipment.

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## RESULTS

*Completed audits were received from six ward areas by the target date agreed.*

Audit scores ranged between 84% - 97%. The Neonatal Unit scored 84%, however the unit has since moved to Ward 6 and many of the environmental issues identified have been resolved. Investment in refurbishment and redecoration in clinical areas has contributed to the higher scores achieved this year. Areas of non-compliance were communicated to individual Heads of Nursing and Midwifery for action and monitoring in their individual areas.

## CONCLUSIONS

The patient environment and the standards of cleaning throughout the trust continue to remain high. The regular multidisciplinary inspections provide the ideal opportunity for continuous monitoring of cleanliness and environmental standards and support the audits undertaken locally by Ward and Department managers and Facilities.

## RECOMMENDATIONS

In addition to the multidisciplinary inspections Ward and Department managers should continue to monitor environmental standards in their individual clinical areas. Any issues identified should be communicated promptly to Facilities or Estates to ensure that they are rectified in a timely manner. Environmental standards and any unresolved issues should be included in the quarterly reports produced by the Heads of Nursing and Midwifery.

## HAND HYGIENE

### BACKGROUND

Effective hand hygiene is widely acknowledged to be a one of the key single effective activities in reducing the spread of infection and can therefore contribute to preventing healthcare associated infections. The point of care is also considered to be a particularly crucial time for performing hand hygiene. The importance of providing hand hygiene products at the point of care and the key times to perform hand hygiene (World Health Organisations – Five Moments of Hand Hygiene) were emphasised in the NPSA Alert – Clean Hands Saves Lives (NPSA 2008). Directorates also have a trust performance target of 95% hand hygiene compliance.

### METHOD

As part of the annual audit programme each Directorate is asked to perform observational hand hygiene audits in their in-patient clinical areas. The results of the audits are collated by the Infection Control Nursing team and communicated to the Heads of Nursing and Midwifery each quarter. The Heads of Nursing and Midwifery take responsibility for dissemination of results and taking the lead on any action required in response to results achieved.

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The observational audit tool used is based on the World Health Organisations (WHO) "Five Moments of Hand Hygiene". Each audit includes a minimum of twenty observations and assesses compliance by Medical Staff, Nursing and Midwifery Staff and Allied Health Professionals and others. Data collected also focuses on some key elements of the Hand Hygiene and Uniform policies, including the wearing of stoned rings / watches and non-compliance with short sleeves/ rolled up sleeves ("Bare below the Elbows").

Individual audits assessing hand hygiene facilities and provision of alcohol hand gel have also been undertaken this year.

## RESULTS

Overall trust compliance scores which take into account the total opportunities observed in all areas audited, have varied between 82% and 91% throughout the year. Data for individual clinical areas and individual disciplines are also collated and disseminated. Compliance by Nursing and Midwifery staff has continued to be high with scores of 94% achieved in quarters 3 and 4. Compliance scores achieved by Medical staff and Allied Health Professionals have been more variable, Medical staff varied between 61% and 86% and Allied Health Professionals & others between 81% and 100%. Action is taken in individual areas in response to lower scores, including raising awareness of policy and increasing the frequency of observational audits.

Scores of the hand hygiene facility audits ranged between 76% and 96% with an overall average score of 89%.

## DEVELOPMENTS

In response to the NPSA Alert – Clean Hands Saves Lives and the audit of provision of alcohol hand gel products, alcohol hand gel is now provided at patient bed spaces or treatment areas enabling staff to decontaminate their hands at the point of care.

## CONCLUSIONS

High standards of compliance with hand hygiene remains a priority for the trust. Overall, general compliance with hand hygiene continues to be very good, however audit scores reported quarterly do vary between individual areas and disciplines of staff. Some individual wards have met the performance target of 95% compliance but this is not consistent across all areas and disciplines of staff. Scores achieved by Nursing and Midwifery staff have improved each quarter but those achieved by other disciplines have been more variable. The current audit programme only provides limited data which may explain the variable scores achieved. Hand hygiene continues to be included in all infection prevention and control training sessions at induction, as part of update training and during planned and ad hoc awareness sessions. Audit results are also discussed within training sessions and are communicated to all staff in the routine Infection Control newsletters. The trust has also continued to participate in the NPSA Clean Your hands campaign.

## RECOMMENDATIONS

In order to provide more consistent data the frequency of hand hygiene audits should increase in all areas. The hand hygiene audit programme and high standards of compliance also needs to be fully owned by the Directorates. The Infection Control Team should also work with Directorates to develop the auditing of hand hygiene compliance in Outpatient areas of the trust.

## SAFE HANDLING AND DISPOSAL OF SHARPS

### BACKGROUND

Protecting staff, patients and visitors against inoculation injuries is a fundamental principle of infection prevention and control. Ensuring that sharps are handled and stored safely is key to the prevention of inoculation injuries. The audit of safe handling and disposal of sharps is a key duty of the Health Act 2006.

### METHOD

A routine annual audit was undertaken by a representative from Synergy Health the supplier of our sharps containers. An audit tool based on a tool published by the ICNA was used, which assessed compliance and knowledge of safe sharps practice and management of inoculation injuries.

### RESULTS

The scores ranged between 68% and 96% with an overall trust average score of 82%.

Knowledge base amongst staff questioned regarding management of inoculations was high throughout all areas. Areas of non-compliance varied between individual areas and were communicated to Heads of Nursing and Midwifery for action and monitoring in their individual areas of responsibility.

### CONCLUSIONS

Background knowledge regarding management of inoculations injuries and safe sharps practice continues to remain high in all clinical areas. However all Wards and Departments need to ensure that continued compliance is maintained in all areas of safe sharps management. Safe sharp practice continues to be included in Infection Control training at induction and during update sessions to ensure awareness and knowledge of policy remains up to date.

### RECOMMENDATIONS

Regular training and audit should continue to ensure high standards of compliance and awareness are maintained. The audit tool should be reviewed to ensure that it reflects local policy and national requirements.

## **STANDARD PRECAUTIONS**

### **BACKGROUND**

Standard Precautions are key principles of infection prevention and control practice. They encompass several different aspects including hand hygiene, safe handling of sharps, handling of linen, waste management, use of personal protective equipment and management of blood and body fluids. Auditing of compliance with standard precautions is also a key requirement of the Health Act 2006.

### **METHOD**

An audit tool was designed by the Infection Control Team to assess compliance with standard precautions. It did not include hand hygiene and safe sharps practice as these areas are addressed by separate audit tools and are audited separately. The audit was undertaken in seven in-patient clinical areas by the Infection Control nursing team. The audit tool was also made available to outpatient areas, to assess their own individual compliance locally.

### **RESULTS**

Scores ranged between 78% and 90%. Knowledge base regarding appropriate use of protective clothing and equipment, correct disposal of linen and waste and management of blood spillages was very good. The main areas that required action included improving the availability of eye protection/goggles and improving staff knowledge regarding the use of decontamination products and appropriate dilutions. These areas have since been addressed where appropriate.

### **CONCLUSION**

The standard precautions audit was useful in assessing knowledge and compliance with policy. The results identified the limited availability of eye protection, and some poor understanding and knowledge of decontamination processes and products in some areas. Action has been taken in the relevant clinical areas to ensure compliance at future audits. The importance of standard precautions are reinforced during Infection Control training sessions at induction and during training updates.

### **RECOMMENDATIONS**

Adherence with standard precautions should continue to be practised by all staff at all times in all clinical areas. Compliance will be audited as part of the Infection Control audit programme.

## **WARD KITCHEN INSPECTIONS**

### **BACKGROUND**

In order to monitor compliance with food hygiene policy and cleanliness and environmental standards, routine unannounced multidisciplinary inspections are undertaken throughout the trust each quarter. The inspection team includes representatives from the Infection Control Team, Facilities and Estates.

### **METHODS**

An audit tool published by the ICNA is used to monitor compliance with policy. Issues identified during the audit that relate to clinical practice are fed back locally at the time of the audit. Overall and individual results are detailed in a summary report produced by the Infection Control Team which is communicated to the Heads of Nursing and Midwifery.

### **Results**

Throughout the year audit scores ranged between 76% and 96% with an average score of 86%. Some lower scores achieved were due to the condition of fixtures and fittings in some areas, which have since been addressed as part of the Trust refurbishment process.

### **CONCLUSIONS**

Compliance with food hygiene policy remains high in clinical areas. Regular auditing is useful to raise awareness and reinforce the need for high standards of practice. Ward and Department managers need to continue to reinforce trust policy and monitor standards of compliance all ward kitchen areas throughout the Trust.

### **RECOMMENDATIONS**

Explore the possibility of devolving the responsibility for undertaking quarterly ward kitchen audits to ward and department level. The multidisciplinary team should continue to undertake an objective audit at least annually.

## **SAVING LIVES - HIGH IMPACT INTERVENTIONS**

### **BACKGROUND**

High Impact Interventions (HII's) are audit compliance tools (care bundles) and are part of the Department of Health Saving Lives: reducing infection, delivering clean and safe programme (DOH 2007). Seven individual HII's are currently available and relate to key clinical procedures which can increase the risks of infection if they are not performed correctly. Each HII includes key actions which are evidence based.

### **DEVELOPMENTS**

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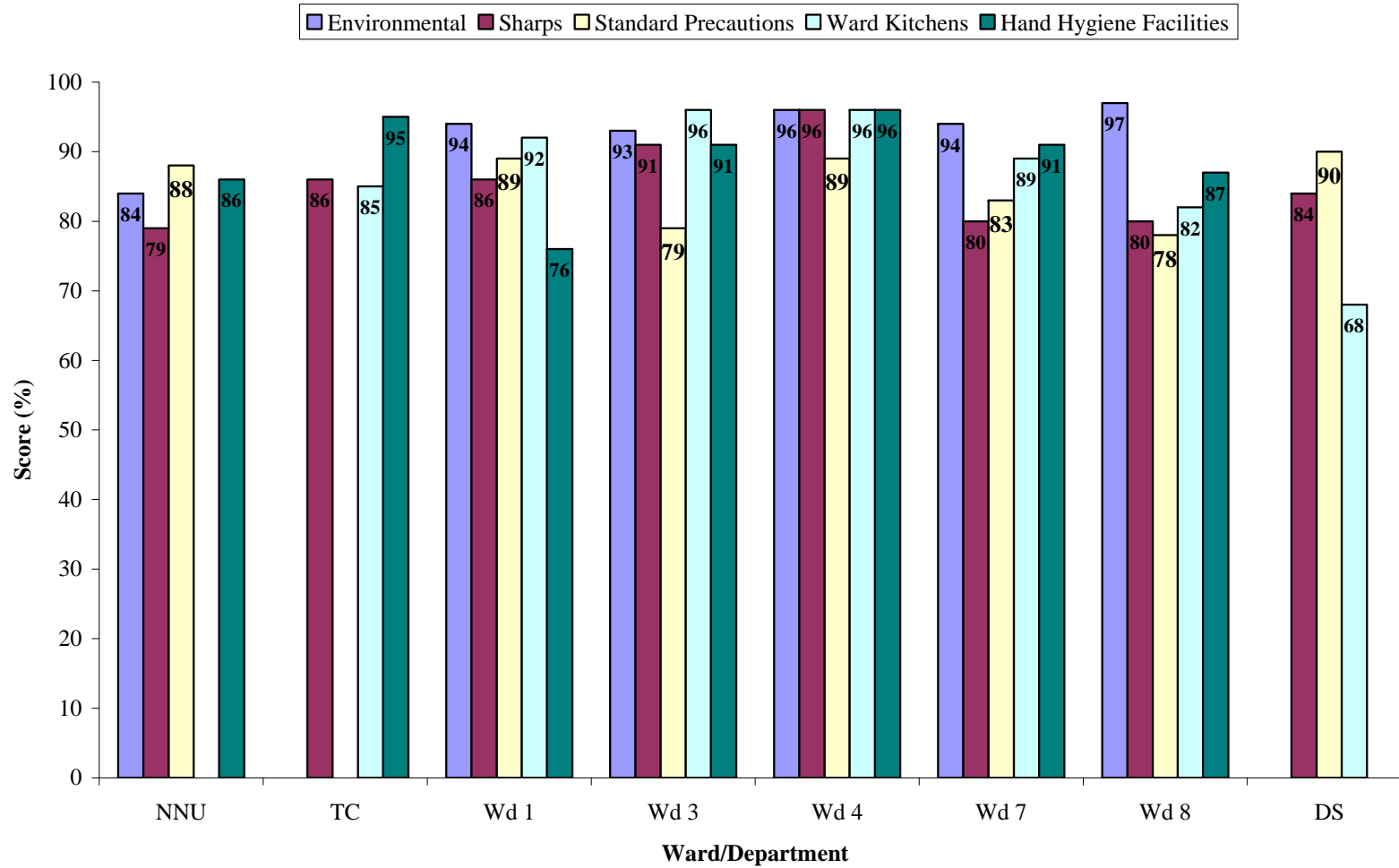
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High Impact Interventions (HII) relating to insertion and care of peripheral and central venous devices have been introduced to relevant clinical areas across the trust. Specific audit tools for insertion and care of intravenous devices based on the HII's have also been developed for use in the Neonatal Unit. A documentation record for improving the recording of insertion and on-going care details for peripheral venous devices has also been implemented in clinical areas.

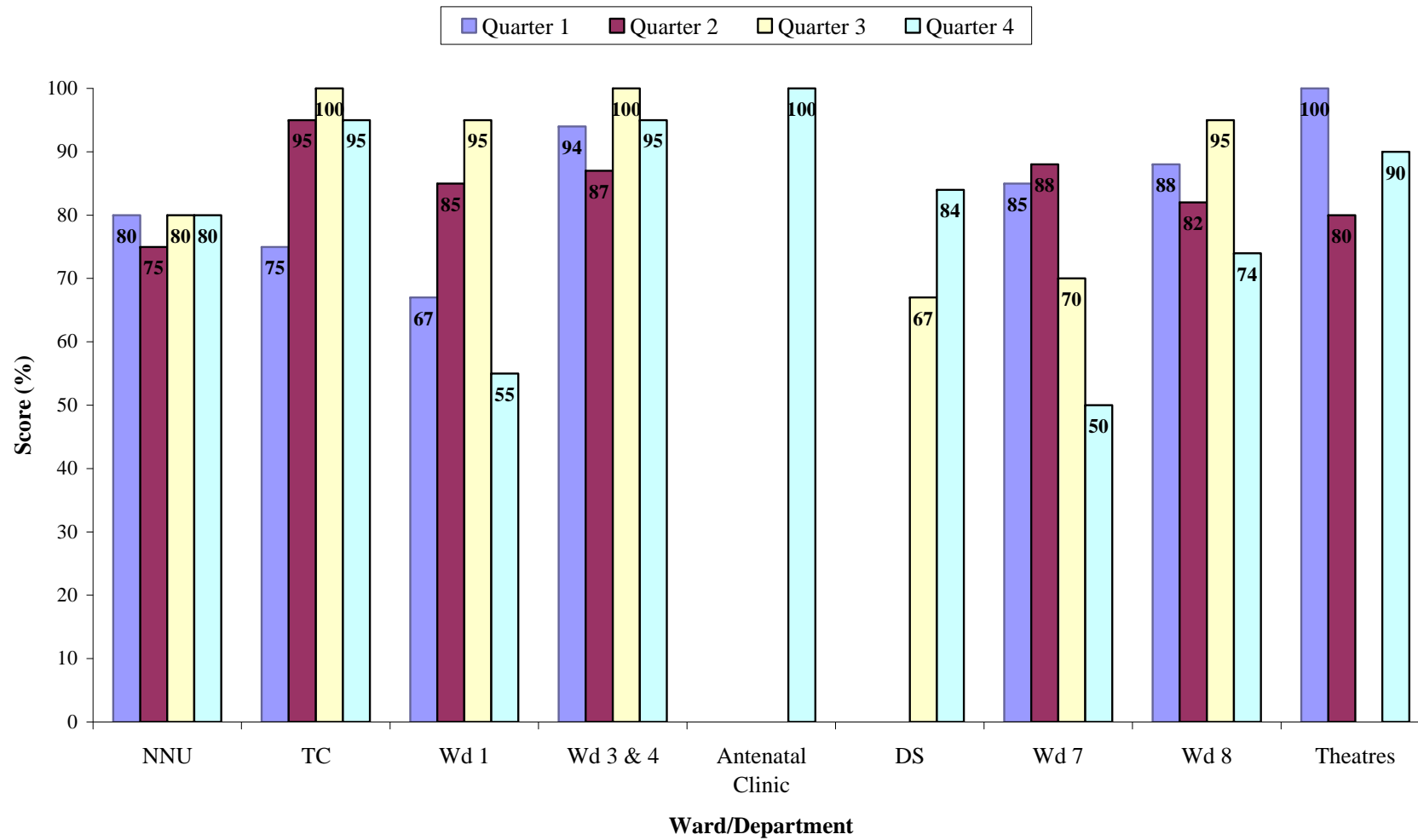
## **RECOMMENDATIONS**

Additional HII's should be fully implemented in relevant clinical areas throughout the forthcoming year.

**Figure. 1 - Infection Control Audits 2008-2009**



**Observational Hand Hygiene Audit Results 2008-2009**



## ANTIMICROBIAL PRESCRIBING

### BACKGROUND

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

- Selection of agents that give reliable cover against the expected pathogens.
- Selection of agents that are safe for the patient: this is an especially important consideration in this Trust, where a large proportion of our patients fall into groups that are at special risk of harm from drugs, that is pregnant or breastfeeding mothers, and neonates.
- Selection of agents that minimise the risks of selection of antibiotic resistance and of promoting healthcare associated infections such as *Clostridium difficile* and MRSA.
- Giving antibiotics for the shortest possible time period.

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

The antimicrobial prescribing policy for adults has to strike a balance between patient safety and promotion of antimicrobial resistance. It is recognised that we place fewer restrictions on use of cephalosporins than is that case in most general hospitals. However, this decision is based on a risk assessment that for our patient population a change in antimicrobial prescribing policy could do more harm than good.

### METHODS

In June 2008 the Trust received a report from the West Midlands Antibiotic Audit Group of its performance in the West Midlands Antimicrobial Prescribing Audit 2004-2007. The findings were shared with the Infection Control Committee and presented to the Clinical Governance Committee.

Since August 2008 a system has been in place where the Consultant Microbiologist is notified of patients who have been Gynaecology in-patients for 6 days or more. The drug charts of all such patients are reviewed to ensure that any antibiotic treatment that they have been prescribed is appropriate.

An audit of vancomycin prescribing on the NNU was completed, and the results analysed and reported during 2008/09.

### RESULTS

The West Midlands Antimicrobial Prescribing Audit confirmed that our Trust had a low overall antibiotic expenditure. It also showed that we were high users of cephalosporins, an antibiotic group whose use is now restricted in

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many general hospitals. However the year-on-year trends in pattern of usage of these agents did not differ from other Trusts.

In the 7 months that the Gynaecology antimicrobial prescribing review has been in place only one intervention has been made to discontinue antibiotic therapy.

The audit of vancomycin prescribing resulted in recommendations around dosing to ensure that adequate serum concentrations are achieved: these have been implemented.

## CONCLUSIONS

There is evidence that local antibiotic prescribing policies are being complied with. However, there are opportunities to undertake more detailed analysis of antimicrobial prescribing within the Trust, and to review current policies, especially with respect to cephalosporin use.

## RECOMMENDATIONS

That the Trust builds Antibiotic Pharmacist support into the existing Pharmacy SLA. This resource would allow the Trust to monitor antibiotic prescribing more effectively, to review prescribing policies and to provide more training to prescribers.

## 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. These are all available electronically to ensure the most up to date version is in circulation.

### OUTCOMES

During the year the following Infection Control Policies were reviewed, and updated as required:

- Introduction to Infection Control and Arrangements for Reporting Infections
- General Principles to Minimise the Infection Risk from Use of Catheters, Cannulae, Tubes & Other Indwelling Devices
- Infection Control Guidance on the Admission, Movement Within the Hospital, Transfer Between Hospitals & Discharge of Patients
- Policy for the Prevention of Transmission of Infection to and from Hospital Visitors
- Policy for the Use of Cadaver Bags
- Policy for the Use of Latex and Non-Latex Gloves in the Clinical Area
- Procedures for the Collection, Handling & Transport of Specimens
- Policy for the Management of Suspected or Proven Severe Acute Respiratory Syndrome (SARS)
- Policy for the Prevention of Infection with Transmissible Spongiform Encephalopathy Agents
- Guidelines for the Management of Needlestick Injuries and Mucous Membrane Exposures to Blood & Body Fluids (Inoculation Injuries)
- Policy for the Management of Risks Associated with Needlestick Injuries and Mucous Membrane Exposures to Blood & Body Fluids (Inoculation Injuries)
- Managerial Arrangements for Infection Prevention & Control

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

- Policy for the Control of PVL-associated *Staphylococcus aureus* (PVL-SA) Infections
- Policy for the Control of Extended-spectrum  $\beta$ -lactamase-producing Gram-negative Bacteria
- MRSA Screening Policy
- Infection Prevention and Control Training Policy
- Policy for the Care, Maintenance and Decontamination of Mattresses and Covers

# **ENCLOSURE 6**

**June 2009**

## **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**

Within the Facilities Directorate, cleaning services form part of the Hotel Services function and are provided by a dedicated in house team.

At present there are 44 WTE housekeepers in post, 1 WTE manager and 2.75 WTE Supervisors

All Housekeepers are trained to basic food hygiene standard; they receive annual hand hygiene/infection control training and undertake the NVQ level one Basic Cleaning course.

#### **METHODS**

Cleaning services are provided throughout the hospital and the level and frequency of service is documented in work schedules which are on public display.

The level of cleaning service varies according to the type of area. The service is based on the National Cleaning Standards, however the schedules are not fully compliant, for example the recommended frequency of high dusting is weekly and at present this task is undertaken on a monthly basis.

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 as they go about the hospital Quality control inspection sheets are completed on a monthly basis by the Housekeeping Supervisors, these are then sent to the relevant Ward manager or Department head for comment/action as required.

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.

# ENCLOSURE 6

June 2009

The Facilities team are active members of the Infection Control Committee and Infection Control Task Force with good communication/access to Ward managers, Service heads, Director for Infection, Prevention and Control and the Infection Control team.

## RESULTS

During 2008 a significant amount of resource was invested to improve the standard of cleanliness and the general condition of the patient environment, the result of which culminated in a very successful HCC inspection in December 2008.

In addition to the scheduled cleaning programme, the following tasks were undertaken as part of the preparation process;

- Fabric covered furniture in patient areas replaced with easy clean vinyl
- Mattress covers replaced along with sections of delivery mattresses.
- Kitchens replaced
- Sluices refurbished
- Improved dirty and clean utilities provided
- Improved housekeeping and waste storage areas
- Painting and re decoration
- Improved ward level storage
- Service ducts professionally cleaned
- Ceiling tiles replaced
- Steam cleaner purchased and used to clean beds, radiator grills etc
- Additional apron, glove and gel dispensers provided throughout
- Special cleans to all patient areas
- Junk removal and general de cluttering throughout.
- Waste traps and shower wastes cleaned out
- Deep cleans and wall washing to high risk areas

## CONCLUSIONS

The general standard of cleanliness and the condition of the patient environment has improved considerably over the last 12 months.

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.

The HCC preparation process did identify a number of 'grey' areas where essential tasks did not appear to be assigned to any one individual and there was confusion at times over lines of responsibility between clinical and non clinical staff however this has now been resolved as a result of the closer working and improved communication.

# ENCLOSURE 6

June 2009

## RECOMMENDATIONS

To maintain the standard expected by the HCC we must increase the level and frequency of dusting, in particular high dusting, throughout the hospital.

There are still 'grey' areas, those tasks that do not appear to be anyone's job such as cleaning out shower traps, replacing damaged ceiling tiles, grouting and re-sealing around sinks, replacing damaged shelves, etc. To address this shortfall the appointment of a 'handyman' to undertake these basic tasks on an on going basis, would ensure the standard is maintained and avoid any need for sudden investment prior to any future inspections.

## MATERNITY SERVICES DIRECTORATE

### BACKGROUND

Within the Maternity Directorate the lead responsibility of infection control sits with the Head of Midwifery and her senior team i.e. the Clinical Manager for Delivery Suite and the Specialist Midwife for Fetal Medicine. Prevention of infection control is everyone's responsibility and in 2008-09 the directorate saw significant improvement in the clinical environment both in maintenance, cleanliness and in general hygiene standards. The directorate works very closely with the Infection Control Team in all matters relating to prevention and treatment of infection.

Most clinical areas within the directorate have named staff who are responsible for infection control in their areas.

The main areas of concern during this period was results from a bed and mattress audit which identified that most of the beds in maternity need to be replaced, and the general standard of the bathroom and shower areas in some of the wards and some areas on delivery suite. Housekeeping services for the directorate has been stretched and has identified the need for more resources to maintain the cleanliness of the directorate.

There has been significant investment which has meant the purchasing of a large number of inpatient beds and delivery suite beds and mattresses which have been replaced.

Routine screening for MRSA in elective and high risk women commenced in March 2009 with no reported cases of screen positive women for that month.

### METHOD

Regular audits of hand hygiene, the environment, bed and mattress audits are undertaken on a regular basis using an agreed proforma any non compliance or concerns identified are notified to the ward and department manager and to the Head of Midwifery. An action plan is developed to address the areas identified.

Infection control is a standing item on the agenda of the maternity managers meeting which is chaired by the Head of Midwifery this is to ensure actions have been completed. The meeting also gives managers the opportunity to share any joint concerns which can then be raised at the Trust Infection Control Committee.

Maternity has introduced the Dr Foster Patient Tracker units to receive real-time patient feedback on their experiences in maternity services. One area explored is the cleanliness of the environment. The units are being used in Delivery suite, the postnatal floor and 2 teams in the community.

## RESULTS

- Adherence to the Trust' Work wear' Policy has seen an overall improvement in maternity with medical and midwifery staff.
- Hand hygiene has improved significantly in all clinical areas with gel readily available in all clinical areas and at the end of all inpatient beds
- All delivery suite and birth centre mattresses have been replaced
- Most of the inpatient beds in maternity have been replaced
- All fabric curtains have been replaced in all clinical areas to disposable curtains
- Cleaning schedule in delivery suite (triage) has improved significantly
- Completion of monitoring forms for peripheral venous cannulation has been disappointing
- Significant investment has improved the bathroom and shower facilities on the wards and delivery suite.
- Commencement of the replacement of windows on delivery suite
- Early feedback from the patient tracker units regarding the cleanliness of the environment are encouraging

## CONCLUSIONS

Maternity directorate has had significant investment in the clinical areas and has seen a continued marked improvement within the environment. Early feedback from the women confirms that cleanliness and has been maintained.

There are no reported cases of MRSA.

Vigilance must be maintained to ensure that the standard of cleanliness and prevention of infection is maintained at all times.

## RECOMMENDATIONS

- To secure resources to ensure a bed replacement programme is in place
- To agree increased resources for housekeeping services
- To continue with the quarterly audits and regular environment inspections
- To identify infection control leads for all areas in maternity
- To monitor the adherence of compliance in using the peripheral venous cannulation

## NEONATAL SERVICES DIRECTORATE

### BACKGROUND

The Neonatal Directorate has had a challenging year ensuring that the highest standards of infection control and prevention were maintained.

The main cause for concern was the environment and fabric of the Neonatal Unit itself which had been raised as a Red Risk on the Trust Risk Register. The majority of concerns were centred around poor flooring, the need to replace sinks and tiling and a lack of clinical space. We have, however, worked very closely with the Infection Control Team, Housekeepers and Estates to maintain the environment and patient safety. On the 18<sup>th</sup> March 2009 the Neonatal Unit moved into refurbished accommodation on ward 6 whilst a new 'State of the Art' Neonatal Unit and Out Patients' facility is built. Although ward 6 is only a temporary facility it provides an excellent clean new environment with substantially more clinical space to prevent cross infection.

Throughout the past year considerable activity has been undertaken to monitor and improve all areas with the potential to cause infection.

- Matrons and shift leader carry out weekly environmental checks, particularly examining areas of high dusting.
- Hand Hygiene continues to be at the top of our infection control agenda. Training is mandatory and regular sessions are held by Charlotte King to ensure that staff is up to date.
- Intravenous monitoring charts have been introduced in order to record the position and condition of all intravenous lines, peripheral and central.
- In line with the 'clean your hands' campaign, alcohol gel has been introduced in all areas at point of use.
- 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 J Gray, Consultant Microbiologist who attends weekly grand ward rounds on Mondays. There is a Neonatal Formulary available on the 'G' drive which gives antibiotic prescribing advice.
- Audits have been completed assessing the environment, hand hygiene, Gentamicin prescribing, bed and cot mattress integrity, waste management, sharps management and standard precautions.

### RESULTS OR OUTCOMES

There have been no cases of MRSA bacteraemia in the Directorate this year. There have, however, been occasional cases of asymptomatic colonisation detected on routine screening of babies and subsequently their mothers on the NNU and Transitional Care. These patients were isolated or cohort nursed to prevent spread of colonisation to other patients.

# ENCLOSURE 6

June 2009

Results of Hand Hygiene audits have been variable Transitional Care have improved their performance and have achieved 95% compliance in their latest audit. Results from the NNU are inconsistent and fail to achieve 95% compliance.

## CONCLUSIONS

Progress is being made but needs to be accelerated and maintained.

## RECOMMENDATIONS

- To continue to actively support the prevention and control of infection within the Directorate
- To support the Infection Control Audit Programme.
- To develop a robust action plan 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 Infection Control Team to develop and instigate 'High Impact Interventions' particularly peripheral and central venous 'Care Bundles'.
- To request extra funding within the annual plan to allow more frequent high dusting.

## GYNAECOLOGY SERVICES DIRECTORATE

### BACKGROUND

Within the Gynaecology Directorate during 2008-09 cleanliness and monitoring of infection control and prevention measures has continued to be a high priority. In addition to maintenance of standards in existing areas, several clinical outpatient departments have been required to move location as part of the Neonatal Unit Project and there has been close liaison with the Infection control Team to ensure new areas are fit for purpose.

Ward and clinical departmental managers have undertaken evaluation of the clinical environment and as a result, many changes have been implemented to support the continued successful prevention of infection in the Directorate. Furniture used in patient areas has been regularly maintained and either recovered or replaced if cleaning to reduce the risk of infection is compromised. Disposable curtains are now used for bed areas in all clinical departments and new window blinds have been installed to eliminate the problems encountered by curtains and regular cleaning programmes.

Patients assessed as high risk of carrying MRSA were screened at their preoperative assessment visit and several cases of MRSA isolates were detected through this route. From mid-September, routine screening of all elective patients was introduced. A robust system for monitoring this is being developed with the Infection Control Team.

There were no cases of MRSA bacteraemia or Clostridium Difficile in the Directorate during the year.

Hand hygiene continues to be very high profile and is audited regularly. Hand gel has been introduced at point of care on wards in line with NPSA Safety Alert Clean Hands Saves Lives.

Senior nursing staff actively participate in the Infection Control Committee and the Infection Control Taskforce which has improved multidisciplinary working between clinical and non-clinical Directorates and ensured infection prevention and control maintains a high priority. The Head of Nursing provides quarterly Matron reports to the Infection Control Committee which summarise activity, any concerns and relevant action plans on a timely basis.

Staff within Gynaecology are required to attend annual mandatory training in Infection Prevention and Control Updates. Although leads were identified in clinical areas, separate bespoke sessions have been implemented by Infection Control Nurses to provide more in-depth and consistent information.

## METHODS

Ward managers and Head of Nursing undertake regular inspections. Ward managers had undertaken many audits and action plans have been developed where compliance does not meet the agreed standard. The following methods have been implemented

- Hand hygiene audits are undertaken by the Ward Managers on a quarterly basis.
- Antibiotic useage is closely monitored and a system was introduced in October which monitors on a weekly basis patients who may have been on antibiotics. The Consultant microbiologist undertakes case assessment to ensure the antibiotic prescription is timely and appropriate.
- Nursing staff now complete forms monitoring peripheral venous cannulation from insertion to removal and this is filed in the patient's healthcare records.
- Mattress and pillow audits have been completed and any such equipment which may compromise effective infection prevention replaced.
- Audits have been undertaken with Facilities and Infection control staff on sharps management, waste management, standard precautions and environment.

## RESULTS

As reported previously there have been no cases of MRSA bacteraemia or Clostridium Difficile in the Directorate during the year.

Hand hygiene audits have showed generally good levels of compliance, particularly amongst nursing staff. However Ward 8 was the only ward to achieve the required 95% compliance during one quarter. Compliance appeared to decrease during Quarter 4, notably with compliance by medical staff. A multidisciplinary action plan is being developed by the Ward Managers and Directorate Management Team to address this.

Both Environmental audits and Standard Precautions Audit have shown minimal areas of non-compliance and these have been addressed through the ward managers.

## CONCLUSIONS

The cleanliness and appearance of the patient environment in the Gynaecology Directorate has improved over the past 12 months.

There has been a considerable increase in formal monitoring and reporting mechanisms within the Directorate and this has supported all staff in maintaining this as a high priority.

# ENCLOSURE 6

June 2009

Results in hand hygiene audits have not been as consistent as the Directorate wish and the agreed standard of 95% compliance overall has only been achieved on one occasion. Further work is required here particularly with medical staff to improve this in the forthcoming year.

## RECOMMENDATIONS

- Multidisciplinary action plan to be finalised by Directorate Management Team to improve compliance with hand hygiene audits.
- 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

### BACKGROUND

The Clinical Support Directorate encompasses a diverse range of disciplines, both supporting Clinical Directorates and as lead providers in their own right. All areas have made a valuable contribution by investing time and effort into improving the standards of cleanliness around the trust. Environmental walkabouts of all areas had a positive effect on ensuring cleaning schedules were on display and decontamination policies were reviewed and updated.

The Trust is a member of the Pan Birmingham Decontamination Project (PBDP) who has collaborated to procure decontamination services from BBraun. This is under the auspices of the National Decontamination Project whose main aim is to reduce the potential for HCAI and to ensure that sterile services are standardised in terms of quality of service and delivery. The planning and migration to this service in October 2008 was managed by the directorate. All in house decontamination within the Operating Department has subsequently been eliminated.

### ACTIONS

- The directorate introduced the role of matron who has a key responsibility for infection control in 2008.
- The Trust decontamination manager (as required under the health act) is the Director of Clinical Support
- A collaborative approach was introduced throughout the directorate reviewing techniques and cleaning schedules and updating policies to maintain and improve local decontamination procedures on a daily basis.
- The Trust uniform policy has consistently been enforced with a zero tolerance on hospital grounds and in any of the food outlets.
- The directorate manages decontamination and as such, chaired the Local Pan Birmingham Decontamination Group to make certain the decontamination requirement of the Trusts met the needs of every department.
- Improvements have been introduced with cold disinfect areas having new sterilised instrumentation.
- Investment in new instrumentation and good storage areas have had a positive impact on staff and maintained a smooth service delivery.
- The introduction of Instrument Management System assists the Trust with maintaining adequate and constant supplies of sterile instrumentation to meet service delivery.

### OUTCOMES

1. Introduction of new instrument sets has cut surgery time by 30 minutes (Gynae) and reduced frequency of opening additional sets (Obstetrics).

# ENCLOSURE 6

June 2009

2. Turnaround time for sterile instrumentation reduced from 24 to 8 hours with an instrument management system to track and trace instrument sets.
3. Successfully negotiated to track supplementary items (only trust within PBDP).
4. Trust has a representative on the PDPB Service review committee (PBP) to maintain and improve service delivery and who also acts as customer advisor for other Trusts.
5. Removal of Tristel machine and Little Sister Autoclaves from the Operating Department.
6. Increased awareness of roles and responsibilities within the directorate of standards of cleanliness and the health act.

## CONCLUSIONS

A very successful Health Care Commission visit in December has had a positive impact on patients, staff and visitors to the Trust.

The migration of decontamination to BBraun went smoothly and service delivery has improved as a result of this.

Increased awareness of Infection control amongst all staff throughout the directorate, with a clear understanding of roles and responsibilities.

## RECOMMENDATIONS FOR 09/10 AND BEYOND

Expand Environmental and Hand Hygiene audits to all areas of the directorate.

Investigate shoe washing facilities for Obstetric theatres (via BBraun or independently)

Decontamination role to be strengthened and a decontamination programme implemented

Strengthen infection control links around the directorate and develop dissemination protocol.

# ENCLOSURE 6

June 2009

## **MICROBIOLOGY DEPARTMENT**

The Microbiology Department has unconditional accreditation with CPA (UK) Limited. It underwent a surveillance visit in January 2009 at which feedback from the Assessor was positive.

The Department has Standard Operating Procedures describing the communication and investigation of hospital infection control-related matters.

During 2008/09 a selective indicator chromogenic medium was introduced to improve the speed of MRSA detection in screening samples. Using this medium most results are available within 24 hours, compared with 72 hours or more with the previous method.

## 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 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

##### Pre-employment screening

This is undertaken for all new staff. It includes screening and when indicated immunisation for the following infectious diseases. The predicted number of screenings is 440 for 2008/9.

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

##### Immunisation Clinics

80 clinic sessions have been provided for in employment testing and immunisation. In addition 4 extra sessions were provided in which 220 employees were immunised against Flu.

##### Inoculation Injuries

Advice on the management and follow-up of inoculation injuries is provided on a daily basis and during the induction of all staff members. 56 injuries were reported in the Trust. There is also evidence of other unreported and untraceable incidents. Doctors and Surgeons reported 25% of incidents with Nurse and Midwives (23%) being the second largest reporting staff group. The use of hollow bore (HB) needles (25%) was cited as the most frequent cause of injury. Maternity Services was the directorate reporting the majority (37%) of incidents. The recipient of one high risk incident required immediate post exposure prophylaxis

#### CONCLUSIONS

# **ENCLOSURE 6**

**June 2009**

Evidence gathered from the reported injuries indicates that the implementation of sharp safe devices would reduce one quarter of the injuries. Improved use of personal protective equipment could reduce a further 10% of splash injuries.

## **RECOMMENDATIONS**

The cost of introducing sharp-safe devices should be investigated. The NHS is challenged to improve the uptake of Flu vaccination during 2009 which will require enhanced Trust wide promotion of the programme.

## TRAINING & EDUCATION

### BACKGROUND

Provision of a regular training and education programme is central to the effective prevention and control of infections. It is also necessary to ensure compliance with the NHSLA standards and duties in the Health Act 2006. The Health Act places a key emphasis on ensuring that prevention and control of health care associated infection (HCAI) is embedded into everyday practice and applied consistently by everyone.

### RESULTS

An Infection Control Training Policy was developed and approved this year, which defines the Mandatory training requirements for all disciplines of staff and provides the supporting background for the Training Needs Analysis.

A training programme to meet the training requirements of the Gynaecology Directorate has also been introduced this year and has been well attended. A regular electronic Infection Control Newsletter for staff includes feedback of audit results and relevant infection control topical educational or regional/national issues.

Training programmes have also been undertaken to support Department of Health guidance/initiatives including the introduction of High Impact interventions and elective MRSA screening.

A report produced for the Health Commission in January of this year showed that attendance figures were generally very good, showing good compliance with the Infection Control Training Policy and Training Needs Analysis.

### CONCLUSIONS

A comprehensive training programme continues to be provided by the Infection Control Team, including both formal and ad hoc training sessions and awareness events. Hand hygiene continues to be included in all Infection Control training sessions at induction, as part of update training programmes and in response to audit results.

### RECOMMENDATIONS

To review the current role, training and support network for link practitioners as part of next years programme of work.

## PART 5: OUR PUBLIC

### REPORT OF INFORMATION PROVIDED TO THE PUBLIC

#### BACKGROUND

The *Strategic Goals and Core Values* of the Trust emphasise its commitment to providing safe and high quality care. Within this, we have a longstanding commitment to providing information on healthcare-associated infections to the people we serve, including public displays throughout the hospital and a leaflet on healthcare associated infections that is sent out with all appointment letters.

#### OUTCOMES

During the year the following initiatives were completed:

- Provision of more information on Ward Infection Control Notice Boards
- Production of an abbreviated version of last year's Annual Report, highlighting the key points from the full report that would be of interest to our staff and our public. This initiative was identified by the Healthcare Commission as an example of good practice.
- The leaflet *What we are doing to prevent and control healthcare associated infections* was updated
- Production of new patient leaflets on MRSA.
- Publication of information about our MRSA screening strategy on the Trust website.
- Displays during Infection Control week and at the Trust Annual General Meeting. There was an opportunity to view Infection Control information and also meet with the Infection Control nursing team.
- Production of an Infection Control newsletter which is available on the trust intranet site.

#### RECOMMENDATIONS

Although the Trust website already contains a large amount of information about infection control and healthcare associated infections, there are opportunities to develop this further. It is also recommended that the performance of individual wards and departments in infection control audits should be displayed on the publicly-accessible infection control notice boards. That a new Trust website is updated in date, and that new policies in response to local or national demands are produced in a timely manner.

## **PART 6: ASSURANCE**

### **COMMITTEES & REPORTING**

#### **INFECTION CONTROL COMMITTEE**

The Infection Control Committee met on the following dates:

- 17<sup>th</sup> April 2008
- 17<sup>th</sup> July 2008
- 16<sup>th</sup> October 2008
- 15<sup>th</sup> January 2009

#### **INFECTION CONTROL TASK FORCE**

An Infection Control Task Force was initially established in October 2008 to oversee preparations for the unannounced Healthcare Commission Hygiene Code Inspection. The group is chaired by the DIPAC, and membership includes the Infection Control Team, clinical representatives from all parts of the hospital and Estates and Hotel Services staff. The long-term value of this group as a forum for communication between these groups is recognised, and the group now convenes eight times per year, alternately meeting and undertaking environmental inspections.

#### **CLINICAL GOVERNANCE COMMITTEE**

Quarterly reports were made to the CGC in July 2008, October 2008 and January 2009.

## RESPONSES TO NHS GUIDANCE & DIRECTIVES AND OTHER INFECTION CONTROL ISSUES

- *National Patient Safety Agency Patient Safety Alert, 2<sup>nd</sup> edition (2 September 2008): Clean Hands Save Lives*  
This Alert required us to undertake an audit to review availability of hand hygiene products at point of care, and to ensure that policies, processes and programmes prioritised hand hygiene at the point of care. An action plan was produced in response to this document, focusing on the provision of alcohol gel at each bed space. All actions were completed by January 2009.
- *Department of Health Operation Guidance on MRSA Screening (Published 31 July 2008 & 31 December 2008)*  
MRSA screening in accordance with this guidance was phased in between September 2008 and March 2009. Our MRSA Screening Policy is publicly available on the Trust website, and systems are in place to assure compliance with the policy.

- *The Health & Social Care Act 2008*  
This act includes a revised Hygiene Code, compliance with which has been declared by the Trust in its application for Registration with the Care Quality Commission. The Annual Programme for Infection Control 2009-10 is based largely on those duties that have been identified as being necessary to provide assurance of ongoing compliance with the Code.

- *Initiation of enhanced surveillance of severe group A streptococcal infections in England (19 February 2009)*

In response to an increased number of reports of invasive group A streptococcus infections (iGAS) nationally the Health Protection Agency National Incident Management Team initiated enhanced surveillance via the above letter. We had already recognised the increased risk, and had pre-emptively alerted our Maternity Services staff about iGAS via a briefing note on 19 January.

- *Clostridium difficile* infection: how to deal with the problem.  
HPA/Department of Health, January 2009  
This document provides advice on many aspects of controlling *C. difficile* infection. Although this infection is very uncommon at the Women's Hospital, the document had been considered in detail by the Trust, and recommendations in relation to prevention of infection through antibiotic prescribing will be taken forward in the coming months.

## HEALTHCARE COMMISSION UNANNOUNCED VISIT

During 2008/09 the Healthcare Commission undertook an annual programme of unannounced inspections to assess all NHS acute Trusts' arrangements for the control and prevention of healthcare associated infections against the Hygiene Code [Health & Social Care (Community Health & Standards) Act 2003 as amended by the Health Act 2006]. Birmingham Women's NHS Foundation Trust was visited on December 30 and 31 2008, when compliance was assessed against:

- ❑ **Duty 2:** to have in place appropriate management systems for infection prevention and control
- ❑ **Duty 4:** to provide and maintain a clean and appropriate environment for healthcare
- ❑ **Duty 8:** to provide adequate isolation facilities
- ❑ **Duty 10j:** to have in place an appropriate policy in relation to antimicrobial prescribing

The Healthcare Commission found no breaches of the hygiene code, and highlighted as an example of good practice our processes for publicising our Annual Report of the Director of Infection Prevention & Control, including the production and distribution of a smaller 'user friendly version'.

The summary report is published on the Healthcare Commission's website at the following address:

[http://www.bwhct.nhs.uk/hcc\\_dec\\_08\\_birmingham\\_women\\_s\\_hcai\\_summary\\_report.pdf](http://www.bwhct.nhs.uk/hcc_dec_08_birmingham_women_s_hcai_summary_report.pdf)

## PROGRESS AGAINST INFECTION CONTROL PROGRAMME, 2008-09

Health Act ref	General area	Objectives	Lead individual(s)	Target date	Progress at year-end
1	General duty to protect patient, staff and others	Introduce a new infection prevention ethos for the organisation along the lines of the US <i>Protecting 5m lives from harm</i> campaign	JG	March 2009	This is an ongoing objective. During the year a publicity campaign increased awareness of staff about the importance of Infection prevention & Control. Improvements in care demonstrated through improved audit performance, infection rates, etc.
2	Appropriate management systems	Programme of audit of compliance with infection control policies	JS	July 2009	Quarterly audit timetable produced, disseminated and completed on schedule
		Implement agreed increase in Infection Control Nurse hours	JG/JO	September 2008	Achieved
		Work with Directorate Management Teams towards achieving 95% compliance in at least some audits of clinical practice by year-end. Neonatal Services will be prioritised.	JG/JS	March 2009	Achieved
		Establish regular formal communication & reporting between Infection Control Team and Directorate Management Teams	JG/JS	September 2008	Achieved: Infection Control Task Force established
3	Assess risks of acquiring HCAs	Review clinical practices to obtain further assurance that risks of HCAI are minimised. This may include observational audits to try to streamline practices, implementation of care bundles, etc.	JS	March 2009	High impact interventions introduced, together with audits of compliance
		Complete and report on current Maternity & Gynaecology surgical site infection surveillance projects	JG	June 2008	Achieved
		Continue laboratory-based organism-based surveillance	JG	Ongoing	Ongoing
		Produce recommendations for, & commence implementation of, enhanced infectious condition-based surveillance on the NNU	JG	September 2008	Delayed because of lack of staff time. However, an extension of the existing surveillance scheme to including noting the origin of patients with alert organisms will be introduced in April 2009

# ENCLOSURE 6

## June 2009

Health Act ref	General area	Objectives	Lead individual(s)	Target date	Progress at year-end
4	Clean & appropriate environment	Review of the adequacy and visibility of hand hygiene facilities and hand hygiene promotional material	JS	September 2008	Completed
		Implement any required changes identified by the above review		October 2008	Completed
5	Information to patients & the public	Develop an infection prevention & control section for the Trust website	JG	November 2008	Key information on website (Healthcare Commission noted this as an example of good practice).
		Review provision of written information for patients on avoiding surgical site infections after discharge from hospital	JG	August 2008	Completed
10	Policies & protocols	Develop & implement a plan for MRSA screening of elective & emergency admissions	JG	March 2009	Screening policy was completed, made available to the public, and complied with by March 20, 2009
		Ensure all relevant IC policies are reviewed on time	JG	Ongoing	All policies remain in date
11	Healthcare workers	Improve communication about prevention of HCAI, e.g. through newsletters, local displays, awareness campaigns, etc.	JS	March 2009	Achieved

## INFECTION CONTROL RISKS

### BACKGROUND

Recognising the importance of assessing the risks to patients with respect to HCAI (Hygiene Code Duty 3) a separate infection control risk register was established in September 2008. This has now been successfully transferred onto the Trust's new Datix Risk Register.

### RESULTS & CONCLUSIONS

There are currently 27 infection control risks on the risk register. Of those, the highest scoring risk is Hand Hygiene compliance (score = 9).

Risks of 15 or above would be reported to both the Management Board and Board of Directors at least bimonthly. 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

Ensure that infection control risk register remains a 'live' document that 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				√			

# **ENCLOSURE 6**

**June 2009**