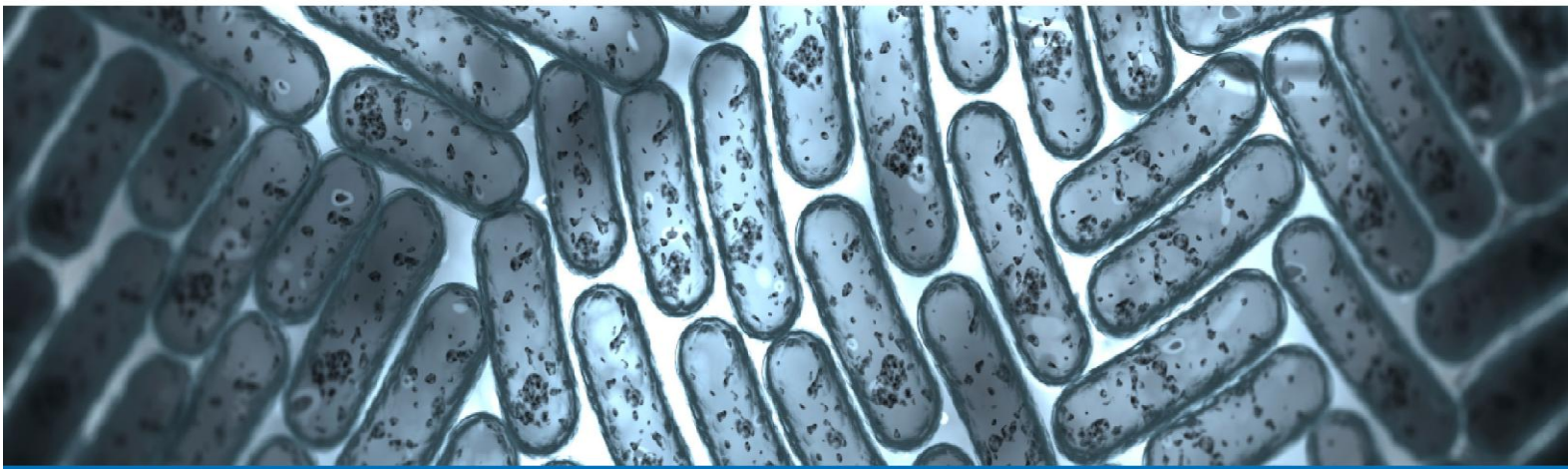
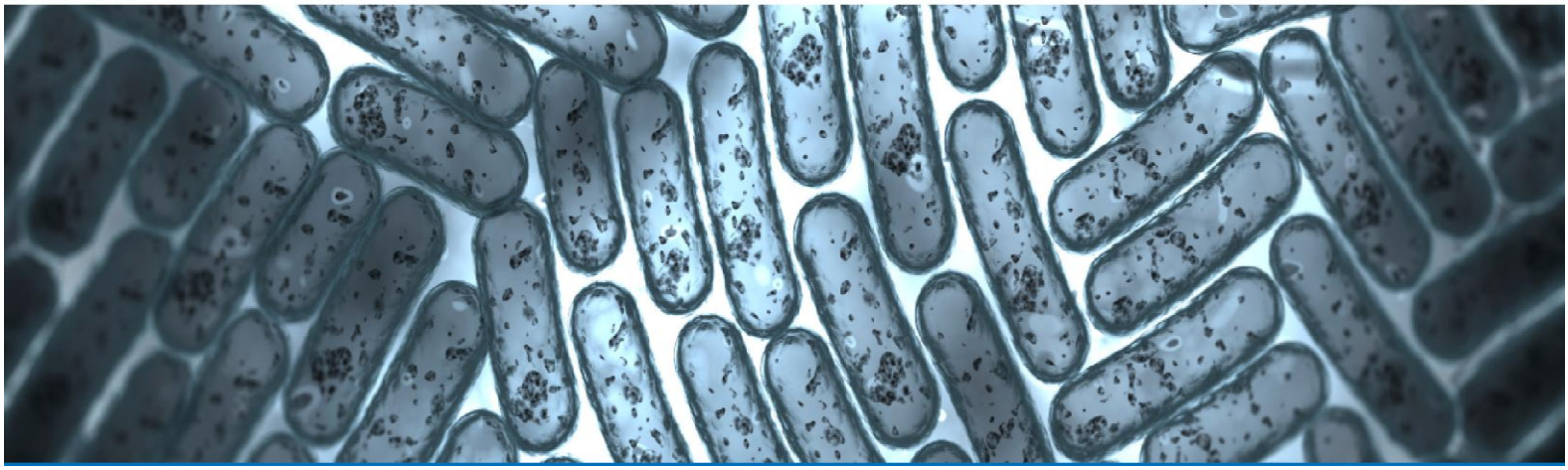
Wye Valley NHS
NHS Trust



# Director of Infection Prevention Control Annual Report

## 2012/13



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## 1. Introduction

The purpose of this report is to inform patients, public, staff, the Trust Board and Herefordshire Clinical Commissioning Group of the infection prevention work undertaken in 2012/13, the management arrangements, the state of infection prevention and control within Wye Valley NHS Trust (WVT) and progress against performance targets.

Healthcare associated infection (HCAI) remains a top priority for the public, patients and staff. Avoidable infections are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources. Investment in infection prevention and control is therefore both necessary and cost effective. The resources committed by WVT to infection prevention and control can be appreciated in the contents of this report.

Over the last 12 months the Infection Prevention Team (IPT) has continued to be actively involved in managing the risk of infection.

WVT provides county wide opportunities to improve infection prevention policies, practices, education and compliance ensuring continuity across the health economy. The IPT has worked with service units and departments in ensuring that infection prevention and control are everybody's responsibility and ownership can be demonstrated at all levels of the organisation.

In December 2010 a revised code of practice was introduced for the prevention and control of health care associated infections: The Health Act (2008), Code of Practice on the Prevention and Control of Infections and Related Guidance. The code of practice is also referred to as the Hygiene Code and is regulated by the Care Quality Commission. The Trust remains fully compliant with the Hygiene Code.

The Hygiene Code requires the Director of Infection Prevention and Control (DIPC) to produce an annual report on the state of healthcare associated infections in the organisation. This report covers the period from April 2012 to the end of March 2013 and outlines the progress being made to reduce HCAI. The drive to reduce HCAI is also aligned to the Trust's objective to enjoy a reputation for and be able to demonstrate exceptional quality, safety and customer service, providing a quality of care we would want for ourselves, our families and friends

There is continuing national focus on trajectory objectives for the reduction of Meticillin Resistant Staphylococcus aureus (MRSA) blood stream infection rates and *Clostridium difficile* rates and these are monitored by the Health Protection Agency. In addition mandatory reporting of Meticillin – Sensitive *Staphylococcus Aureus* (MSSA) and *Escherichia coli* bacteraemias continues with no nationally set trajectory at present.

- In 2012/13 the year ended at 3 cases of MRSA Bacteraemia (2 of the cases were repeated samples on the same patient) this was against a limit of 1 case set for 2012/13.
- In 2012/13 the year ended with 10 cases of *Clostridium difficile* against a final trajectory limit set at 21 cases demonstrating a significant reduction in cases from 2012/13. The Community hospitals ended 2012/13 at 6 cases exceeding a separate trajectory of 5 cases, although this exceeded the trajectory limit, this was a reduction on the previous year cases of 7.
- In 2012/13 the year ended at 3 cases of MSSA bacteraemias identified greater than 2 days after admission
- In 2012/13 the year ended at 14 cases of E.Coli Bacteraemia identified greater than 2 days after admission, there is no nationally set trajectory for E.Coli Bacteraemia

The Trust has continued with its zero tolerance approach to avoidable HCAIs and its proactive MRSA screening of all elective and emergency admissions to the Trust. Compliance against this is monitored monthly and acted on through the service delivery units. Compliance has significantly improved in elective screening through

2012/13 with a year round average of 96% and excellent sustained compliance has been maintained in emergency screening with a year round average of 98%.

The Trust has made significant improvements in the numbers of staff receiving infection prevention training with a year-end compliance figure of 100% of staff trained in 2012/13. The training programme has been devised to be interactive and has consistently received positive feedback for learning outcomes.

There has been continuing progress made with sustaining the Department of Health Saving Lives programme to ensure compliance with relevant 'High Impact Interventions'. These are summarized monthly on the infection prevention performance dashboards in the clinical areas and compliance is monitored through the Infection Prevention Committee.

Hand hygiene compliance remains a priority and there are continuing high compliance rates across the Trust. These are demonstrated in the monthly audit results fed back through the performance dashboard.

The activity in the report is described in the context of the Health Act 2008 Code of Practice for the Prevention and Control of Healthcare Associated Infections, so that it can be seen how the work of the Trust relates to its statutory responsibility to maintain compliance with the Code.

## 2 Compliance Criterion 1: Effective management systems for prevention and control of HCAI informed by risk assessments and analysis of infection

### 2.1 Committee structures and assurance processes

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for infection prevention and control. Trust executive job descriptions incorporate a statement detailing their responsibility for infection prevention issues.

In 2012/13 the Trust maintained its Infection Prevention Committee (IPC) structure with broadened membership to reflect the revised service unit structure of the new organisation. The committee is chaired by the Director of Infection Prevention & Control and reports to the Quality Committee.

The Trust Director of Infection Prevention and Control (DIPC) position is held by the Director of Nursing and Quality, the DIPC is accountable directly to the Chief Executive and Trust Board.

The Service Delivery Manager for Theatres, Anaesthetics, Critical Care and Endoscopy has been the designated lead for decontamination ,with Director level leadership provided by the Director of Service Delivery, and has chaired the Decontamination Committee through 2012/13. Minutes from the decontamination committee are received at the IPC.

The infection prevention service is provided via a structured programme of delivery against reactive requirements and a proactive annual programme of surveillance, education, audit, policy development and review with 24 hour access to expert Microbiological advice and support.

The Infection Prevention Team (IPT), reporting to the DIPC, consisted of an Infection Control Doctor 0.4 whole time equivalent, a Lead Infection Prevention Nurse 0.8wte and 3.4 wte Infection Prevention Nursing staff.

### 2.2 Compliance assessment and assurance

The Health and Social Care Act 2008 (DH, 2010) published by the DH provides Trusts with a code of practice for the prevention and control of healthcare associated infections and makes clear their statutory responsibilities. Each Trust is expected to have sufficient systems in place to apply evidence based protocols and to comply with the relevant provisions of the act so as to minimise risk of HCAI to patients, staff and visitors.

Wye Valley NHS Trust has continued to declare compliance against the 10 criterion as outlined below through 2012/13.

| Compliance criterion | What the registered provider will need to demonstrate |
|---|---|
| 1 | Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them. |
| 2 | Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. |
| 3 | Provide suitable accurate information on infections to service users and their visitors. |
| 4 | Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion. |
| 5 | Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people. |
| 6 | Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection. |
| 7 | Provide or secure adequate isolation facilities. |
| 8 | Secure adequate access to laboratory support as appropriate. |
| 9 | Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections. |
| 10 | Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care. |

The Infection Prevention strategy, IPC, DIPC and IPT set the standards by which the risks of HCAI are minimised. This is achieved through the following proactive measures:

- Improving infection prevention and control capability and capacity in Service Units
- Facilitating programmes of education
- Undertaking audit and targeted surveillance
- Formulating policies and procedures
- Providing advice on all aspects of infection prevention and control
- Interpreting and implementing national guidance at a local level
- Involvement with new building and equipment projects
- Managing outbreaks of infection

## 2.3 Surveillance of Healthcare Associated Infection (HCAI)

### 2.3.1 Meticillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia, infection and colonisation.

**MRSA Bacteraemia**

The Department of Health (DH) began mandatory surveillance of MRSA bloodstream infections (bacteraemias) in 2001. This includes all bloodstream infections with MRSA, whether acquired in the hospital or in the community and whether considered to be contaminants or not. Data is reported to the DH (via the Health Protection Agency) monthly and quarterly.

In 2012/13 the Trust identified 3 MRSA Bacteraemias, the first case was subject to a full multidisciplinary root cause analysis which identified areas for improvement, these formed a Trust action plan and all actions from this have been implemented and are complete. The 2nd and 3rd cases were samples taken on the same patient due to ongoing infection; a full multidisciplinary root cause analysis was undertaken, no issues were identified requiring action.

**Blood culture sampling**

Throughout 2012/13 the Trust has continued to utilise blood culture packs to support best practice. All blood culture contaminants are followed up by the IPT. The individual taking the blood culture is notified of the contaminant by a Consultant Microbiologist and then competency assessed by a member of the IPT. During 2012/13 there has been a sustained reduction in blood culture contaminants. Contaminant rates are a service unit and Trust Key Performance Indicator and are challenged through the IPC. The average blood contaminant rate for 2012/13 has been 2.8%, better than the recommended rate of 3%.

**MRSA Infection/ Colonisation**

Rates of MRSA cases identified more than 2 days after admission have continued to reduce with the Trust's universal MRSA screening programme. The MRSA screening programme is applied to all elective and emergency adult admissions to the Trust. In 2012/13 there were 20 cases in the County site and 8 cases in the community hospital sites. In 2012/13 the IPT introduced a strategy entitled the enhanced review period for MRSA. When 2 or more cases of MRSA identified as post admission cases are identified within a clinical setting, an enhanced programme of audit, education and review is implemented. This is reviewed weekly by a member of the IPT and there is a weekly IP audit until the department has achieved 3 weeks of compliant audit scores and no further cases.

**Non-Elective MRSA screening.**

All patients admitted to the Trust via Accident & Emergency are screened for MRSA using an efficient cost effective test methodology known as the Universal broth method. Compliance with this is monitored and reported monthly to the IPC and monitored as a Service Unit KPI. The average monthly compliance of non-elective admission MRSA screening in A&E at the acute Trust was 98% and the Community hospitals also at 98%. Data is fed back to the units for review and improvement.

**Elective MRSA screening.**

The Trust continued through 2012/13 with its elective screening programme aligned to the national guidance for MRSA screening. Compliance is monitored monthly and fed back to the service units to monitor performance by individual surgical category.

There has been a significant improvement in compliance data for all elective surgical screening including all surgical categories in the County site and Maternity screening and Podiatric surgery at Belmont, with a year round average of 96% and specifically 100% for Podiatric surgery undertaken at Belmont Podiatric theatres.

**Management of MRSA cases.**

All MRSA positive cases are followed up by the IPT to ensure their management and treatment is appropriate as per policy. All MRSA positive cases are flagged on the Trust Patient Administration System, This enables the clinical teams to isolate, screen and commence decolonisation therapy on admission of any previous positive MRSA patients to minimize any risk of potential spread prior to screening results being available.

### 2.3.2 Meticillin Sensitive Staphylococcus Aureus (MSSA).

Through 2012/13 the Trust has continued to monitor and report all MSSA bacteraemia cases. Each case of MSSA is investigated to establish potential causative factors with full root cause analysis and action plans to address issues if identified. In 2012/13 there have been 3 cases identified more than 2 days after admission, a 50% reduction on the previous year. There is currently no externally set reduction objective for post MSSA cases. These are monitored by the IPC.

### 2.3.3 *Clostridium difficile* infection (CDI).

WVT uses the most sensitive test, (the Polymerase Chain Reaction (PCR) test), as its frontline diagnostic test for *C .difficile.* In line with DH guidance, from April 2012, only cases which are positive by 2 tests are reported to the Health Protection Agency but WVT continues to treat patients and take infection prevention precautions if patients are *C. difficile PCR* positive only.

In 2012/13 the County Hospital reported 10 cases against the externally set limit of 21 cases for the year, a significant reduction (74%) on the 38 cases diagnosed in 2011/12. The Community Hospitals reported 6 cases against an externally set limit of 5 cases, although exceeding the limit, this represented a reduction on cases of 7 identified in the previous year.

An increase in cases is managed with a formalised procedure referred to as a period of increased incidence with enhanced surveillance, cleaning and audit when there are 2 or more cases within a 28 day period in a clinical area.

### 2.3.4 Glycopeptide Resistant Enterococcus (GRE) Bacteraemia

Enterococci are bacteria commonly found in the bowel and GRE are enterococci that have become resistant to vancomycin and similar antibiotics. Reporting of bacteraemia caused by GRE has been mandatory for NHS acute trusts in England since September 2003. In 2012/13 there was 1 case of GRE identified.

### 2.3.5 National Nosocomial Infections Surveillance (NNIS) System

**Orthopaedic NNIS**

All Trusts are mandated to undertake a minimum of 3 months orthopaedic NNIS. During 2012/13 the IPT undertook 2, 3 month surveillance periods in July-September 2012 and October – December 2012. The surveillance was undertaken whilst the patients are inpatients. The outcomes of the orthopaedic surveillance so far are as below use inpatient data only.

| Type of Surgery | July - September 2012 | October – December 2012 |
|---|---|---|
| **Hip replacements** | 1.7%<br>1 out of 58 operations had reportable SSI's. | 0%<br>0 out of 64 operations had reportable SSI's. |
| **National Rate for SSI Period** | 1.0% | 0.9% |
| **Knee replacements** | 3.4%<br>2 out of 58 operations had reportable SSI's. | 1.5%<br>1 out of 67 operations had reportable SSI's. |

| | | |
|---|---|---|
| **National Rate for SSI Period** | 0.9% | 0.9%. |

In order to attain greater denominator data and year round review and assurance of infection rates the orthopaedic department has commenced continuous orthopaedic surveillance supported by the infection prevention team.

## 2.4 Audit programme to ensure key policies are implemented

Audit projects for 2012/13 completed by the IPT were:

- Annual performance audit against Infection Prevention Society (IPS) performance improvement tool audit criteria.
- Specific HTM 01-05 Dental practice audits in the dental access centres.
- Cleanliness of commodes on a monthly basis with weekly follow up if noncompliance was identified, compliance improved month on month during the year.
- *C. difficile* follow up. If an area experiences two or more cases of *C. difficile,* identified more than 48hrs after admission within a 28 day period, they are placed in a special measures period with weekly follow up. They remain in this period until they score 90% on a specific audit tool for 3 consecutive weeks and there are no further concerns or cases.
- Enhanced Review Period audits where 2 or more cases of MRSA are identified as outlined earlier.
- Rapid Improvement tool audits in areas with particular performance concerns.
- Observation and practice audits.
- Cannula prevalence and practice compliance quarterly.
- Urinary Catheter prevalence audits.

All audit data is fed back to the department managers with action plans where issues requiring action are identified.

Audit data is available from the infection prevention team on request. Audit action plans are fed into service unit improvement plans for monitoring and action through service unit governance meetings.

### Ward/ Department led infection prevention audits

All wards and departments undertake the infection prevention audits below. The results of these are reported in the Infection Prevention Trust dashboard monthly.

- Clinical Environment Audit Review – Monthly
- Hand Hygiene – Monthly
- Saving Lives audits – Monthly
- Mattress audit – Monthly

Audit data is monitored through the estates and facilities performance meeting and infection prevention committee.

Audit data is available for individual areas on request.

### Saving Lives audits

Ensuring we know what to do to avoid infection and actually doing this every time are two crucial components of delivering safe, clean care. Undertaking clinical procedures such as line insertion or wound or catheter care

requires all relevant healthcare professionals to perform evidenced-based practice consistently. Saving Lives High Impact Intervention audits support this requirement.

All relevant Saving Lives High Impact Intervention (HII) audits are rolled out throughout appropriate areas of the Trust.

Results are fed in to and displayed in the department infection prevention dashboards.

## 2.5 Root Cause Analysis

Root cause analysis (RCA) is a set of problem solving methods aimed at identifying the root causes of problems or events. The practice of RCA is predicated on the belief that problems are best solved by attempting to address, correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. By directing corrective measures at root causes, it is more probable that problem recurrence will be prevented.

### RCA MRSA Bacteraemia

RCAs have been performed on the 3 episodes of MRSA Bacteraemia as outlined earlier.

### RCA for *Clostridium difficile*

The Trust undertakes RCA on all *C. difficile* deaths where it is on part one of the death certificates as per Strategic Health Authority requirement. All cases of *C. difficile* were subject to a full root cause analysis with action planning for lessons learnt. RCA is undertaken in conjunction with the medical and nursing teams to ensure the RCA is thorough and lessons where identified are learnt and embedded. There were no deaths in 2012/13 attributable to *C. difficile* on part one of the death certificate.

## 2.6 Risk assessment and action

The IPC reviews the risk register for all infection prevention risks logged in the Trust, the IPT are regularly involved in risk assessment recording.

## 2.7 Staff information, training and supervision

### 2.7.1 Staff training

The team continues to have a strong training role. Infection prevention training and education programmes during 2012/13 included a programme of mandatory sessions and training to all staff on induction days. Annual training is also delivered to all Medical staff, Nursing staff, Allied Health Professionals, Sodexo and voluntary staff. Training is delivered through formal and informal methods.

Training data is reviewed by the service unit leads and Trust Board. Compliance for the year end improved significantly to 100%.

### 2.7.2 Staff information

Ward Dashboards: Infection prevention data is collated on to dashboards. These summarize performance against key criteria including surveillance data, audit compliance, antibiotic prescribing & sharps injury data; these are locally displayed and monitored at service unit governance meetings.

Notice Boards: A Trust wide communications initiative is in place in the form of infection control notice boards for each ward, enabling staff to review their own performance.

Intranet: Infection prevention continues to make use of the intranet for providing staff with an easy access portal for information, policy guidance and team contact details.

### 2.8 Staff supervision

The IPT is deployed to provide training and expert advice, and monitor compliance by wards and departments with expected standards. In this way, the work of staff in the trust is subject to scrutiny and supervision.

IPT Personal Development and Training:
During 2012/13 members of the team have attended relevant/ required study days; one of the team has undertaken degree level training in infection control, resulting in all team members being formally trained in infection prevention.

### 2.9 Policy on admission, transfer, discharge and movement of patients

The Trust bed management policy addresses the admission, transfer and discharge of patients within and between healthcare facilities. The IPT maintain a daily database of all side rooms in the Trust to ensure they are being correctly and effectively managed and patients are isolated, if required, appropriately. The IPT liaises with bed management staff and operational managers daily, supporting compliance with this policy. This works successfully in ensuring there is a daily strategic overview of cases of suspected or diagnosed infection and their management.

## 3. Compliance Criterion 2: A clean and appropriate environment for healthcare

### 3.1 Committee structures and monitoring processes

In addition to the Infection Prevention Committee already outlined there are the following committees to address individual issues:

#### Cleanliness Committee

The Trust has a cleanliness committee chaired by the DIPC with representation from the Service units, meeting monthly to monitor and deliver against a cleanliness strategy and report in to the Quality Committee. Estates issues are managed through the Estates and Facilities Performance group which meets monthly.

#### Water Management Group

The Trust has a water quality group chaired by the Trust Engineer which meets three monthly to review monitoring data and compliance with standards. This reports in to the IPC.

#### Decontamination

The Decontamination Committee is responsible for monitoring decontamination arrangements and compliance overall and reports directly to the IPC.

The committee meets bi-monthly and is chaired by the Trust Decontamination Lead who reports to the Trust Executive lead.

The IPT works closely with the Dental Access Centre's providing auditing and advice with regards to local decontamination and compliance with the HTM01-05 regulation.

The Trust subcontracts with an independent authorised engineer in order to ensure compliance with HTM 01-01. They provide independent auditing and advice to oversee Endoscopy, ENT, Dental and Podiatry decontamination requirements.

The Sodexo managed Hospital Sterilisation and Decontamination Unit, which reprocesses all surgical and other invasive reusable instruments, conducts internal audits to ensure compliance with ISO9001/2000, ISO13485 and the Directive 93/42/EEC + 2007/47/EC and is externally audited twice a year by a notified body.

### 3.2 Patient Environment Action Team inspection

PEAT inspections were completed in 2012/13 of all the acute and community inpatient sites. The results were favourable and full outcome data is awaited from the Information Centre for Health and Social Care. 2013/14 will see the Trust launch the revised national Patient Led Assessment of the Care Environment (PLACE) auditing scheme with greater public involvement in the review of Trust services.

### 3.3 IPT involvement in service development including reprovision and new build projects

During 2012/13 there have been extensive building works which have improved the fabric, layout and environment of a number of Trust locations, primarily within the community. These changes support good infection prevention practice and care delivery. The IP lead has been closely involved with all projects from conception through completion, with further projects for 2013/14 planned.

## 4. Compliance Criterion 3: Provide information to patients, the public and between service providers on HCAI

### 4.1 Communications programme

During 2012/13 the infection prevention team has continued with the Pull Together to Prevent Infection campaign across the organisation utilising campaign materials to support training and infection prevention initiatives. The latter part of 2012/13 has seen the development of new campaigns to be rolled out in 2013/14 to ensure the messages are refreshed.

### 4.2 Trust website and information leaflets

The Trust website promotes infection prevention for patients and visitors and includes details on the MRSA screening programme and information for patients and visitors for use prior to admission or visiting. There is a dedicated Infection Prevention section in the hospital handbook available to all patients. Patient information leaflets related to specific conditions/ infections are available from the Trust intranet site.

### 4.3 IPT meetings with stakeholders

The Trust continued to support the Public Members Forum throughout 2012/13. The meetings were supported by the Infection Control Doctor and Lead Infection Prevention Nurse and delivered presentations and facilitated discussion about the HCAI prevention strategy. Sessions were also delivered at the Herefordshire LINK meetings.

### 4.4 Providing information when patients move between providers

As part of assessment of the Trust's compliance with the Hygiene Code, it is necessary that patient transfer information is shared by recording HCAI status on discharge summary letters and thereby GP notification and transfer documentation. Trust documentation supports the flow of this information. In addition the Infection Prevention nurses notify appropriate providers of infective status information as appropriate.

## 5. Compliance Criterion 4: Promptly identify, manage and treat infected patients

### 5.1 MRSA screening

The Trust has continued with its successful Universal MRSA screening strategy ensuring all emergency and elective admissions to the Trust are screened so that positive cases can be identified within 24hrs of admission for appropriate management and treatment. Compliance with the MRSA screening programme is monitored for both emergency and elective categories monthly and fed back to the IPC and forms a Trust Board KPI for review and action where required. There have been significant improvements in both Emergency and Elective Screening compliance through 2012/13 as outlined earlier in this report.

### 5.2 Managing outbreaks of infection

#### 5.2.1 Norovirus

There was a reduction in the numbers and duration of Norovirus outbreaks in 2012/13 in comparison to 2010/11, the Trust continues with its robust outbreak management policy with timely closure, robust management and support and rigorous review on reopening times and post outbreak cleaning regimes.

| Location & Date | Patients Affected | Staff Affected | No. of days closed |
|---|---|---|---|
| **Frome 23/4/12 – 2/5/12** | 24 | 13 | 10 |
| **Wye 24/6/12 – 30/6/12** | 37 | 23 | 7 |
| **Frome 11/8/12 – 14/8/12** | 8 | 2 | 4 |
| **Leo CH 16/12/12 – 23/12/12** | 21 | 13 | 8 |
| **Ross/Bromyard/Leadon/Arrow 3/2/13 – 9/2/13** | 52 | 24 | 7 |

#### 5.2.2 MRSA Outbreak SCBU

In November 2012 MRSA was isolated from a baby on the special care baby unit. The rest of the babies were screened and one further baby was found out to be an MRSA carrier. Neither baby was unwell at that time. One of the baby's parents was found to be an MRSA carrier also. An outbreak meeting was held, no direct causes for the outbreak were identified but various interventions including review of laundry provision and personal protective equipment quality were completed.

#### 5.2.3 Influenza

2012/13 was a very quiet year for influenza. H1N1 (swine flu) is now one of the seasonal strains of flu that circulate each winter and was included in the annual influenza vaccine.

## 6. Compliance Criterion 5: Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

The Trust has access to specialist advice with the resource of the Infection Prevention Team and Consultant Microbiologist, advice is available 24hrs a day. Regular communication with the Health Protection Agency and Strategic Health Authority is well established with robust systems in place to escalate issues where appropriate, such as outbreaks or serious incidents. The Trust has a well embedded ethos of infection prevention being the responsibility of all.

## 7. Compliance Criterion 6: Co-operation within and between healthcare providers

### 7.1 Health Economy working

The Trust participates in a health economy HCAI Forum chaired by the Director of Public Health with Trust membership from the DIPC, Infection Control Doctor and Lead Infection Prevention Nurse. The forum has membership from provider and commissioning organisations and reviews the health economy outcomes and strategies for infection prevention.

The Trust IPT meets regularly with the Primary Care Trust IPT to undertake joint working and share strategies for preventing infection across both organisations.

## 8. Compliance Criterion 7: Provide adequate isolation facilities

The Trust has en-suite rooms for the isolation of patients identified to have diagnosed or undiagnosed infection. These isolation rooms are reviewed daily by the IPT and a dedicated database shared with the clinical site managers is updated then colour coded to manage isolation rooms optimally. This system has worked very effectively in ensuring appropriate patients are isolated and enables the IPT staff to review all isolated patients daily to ensure their infection related management is appropriate.

## 9. Compliance Criterion 8: Ensure adequate laboratory support

The IPT is supported by a fully accredited Microbiology Department.

## 10. Compliance Criterion 9: Policies and protocols

### 10.1 Antibiotic Stewardship

Key developments for this 2012-13

- Launch of antibiotic stewardship strategy document
- Implementation of a quarterly audit plan
    - Iv to oral step down
    - Use of second line antibiotics
    - Vancomycin and gentamicin monitoring
    - Surgical prophylaxis
- Introduction of a dedicated antimicrobial section to the inpatient medication chart

In addition monthly quantitative and qualitative antimicrobial prescribing data is being collated and reported to the IPC and service unit leads.

Antimicrobial consumption throughout 2012-13 has been comparable with the previous years, whilst overall expenditure on antibiotics has reduced by £25,000 from £297,978 to £273,380.

Qualitative data regarding antimicrobial prescribing is obtained from a monthly antimicrobial prescribing point prevalence study. Four criteria are audited, documentation of allergy status, adherence to local antimicrobial guidelines, documentation of a duration or review date, and documentation of indication. These are taken from the antimicrobial "care bundle" and the latest DH guidance for antimicrobial stewardship in hospitals. Overall compliance for the acute element of WVT is between 69-73%, a slight improvement on the previous year (61 - 70%).

### 10.2 Policies and Procedures

The areas of the work programme described in this annual report are relevant to the policy areas listed in the Hygiene Code. The Trust is confident it has policies to support Trust practices as required. These are available through the Trust intranet site. Policies are updated and approved by the IPC according to review dates or changing practices. Policies were compared with peer performance and national guidance to ensure best practice was promoted.

## 11. Compliance Criterion 10: HCAI prevention among healthcare workers

Roles and responsibilities guidance, available on the intranet and circulated to wards and departments, are available for all staff groups explaining their particular responsibilities around infection prevention. Job descriptions include infection prevention responsibility. The IPT participates in induction training and mandatory updates for all staff groups. Health@Work services are provided as required within the Trust. The IPT work with Health@Work services to support the flu and MMR vaccination campaigns and needle stick injury prevention programme. Compliance is monitored through the IPC.

## 12. Conclusion

Eliminating avoidable healthcare associated infection remains a top priority for the public, patients and staff. In response, a robust annual programme of work has, yet again, been implemented over the last year which has been led by an experienced and highly motivated Infection Prevention Team. Particularly notable successes include:

- A significant reduction in the number of cases of *Clostridium difficile*.
- A reduction in the number and duration of norovirus outbreaks
- Completion of all audits across the WVT sites.
- Significant increased improvement in annual training compliance to 100%.

Challenges remain and, next year, efforts will be focused on further reduction of *Clostridium difficile* infection and elimination of all avoidable MRSA bacteraemias, as well as optimal care of invasive devices like catheters and central lines.

Infection Prevention and Control is the responsibility of all Trust staff and the Infection Prevention and Control Team do not work in isolation. The considerable successes over the last year have only been possible due to the commitment to infection prevention and control that is demonstrated at all levels within the organisation. Such commitment will be crucial to maintain high standards into the future.