Wye Valley NHS
NHS Trust

Infection Prevention & Control

DIPC Annual Report 2011/12

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1 Introduction

Infection Prevention and Control is a national priority, both politically and by the general public. Public opinion polls year on year demonstrate that hospital cleanliness and patient safety remain critical regarding the NHS from a patient's perspective. Prevention of healthcare associated infection remains central to the operating framework of the NHS and Wye Valley NHS Trust.

All NHS organisations must ensure that they have effective systems in place to control healthcare associated infection. The prevention and control of infection is part of Wye Valley NHS Trust's overall risk management strategy. Evolving clinical practice presents new challenges in infection prevention which need continuous review.

The Trust puts infection prevention and cleanliness at the heart of good management and clinical practice, and is committed to ensuring that appropriate resources are allocated for effective protection of patients, their relatives, staff and visiting members of the public. In this regard, emphasis is given to the prevention of healthcare associated infection, the reduction of antibiotic resistance and the sustained improvement of cleanliness in the hospital.

The issues that the Trust must consider include:

- The number and type of procedures carried out across the Trust and the systems in place to support infection prevention, cleanliness and decontamination.
- The different activities of staff in relation to the prevention and control of infection.
- The policies relating to infection prevention and control and decontamination.
- The staff education and training programmes.
- An appropriately resourced and managed audit programme.
- The accountability arrangements for infection prevention and control.
- The infection prevention and control advice available to the Trust.
- The microbiological support for the Trust.
- The integration of infection prevention control into all service delivery and development activity.

April 2011 saw the formation of Wye Valley NHS Trust bringing together three organisations into one, with acute, community and adult social care services with the opportunity to implement a single high quality standardised approach for the prevention and control of infection across Herefordshire.

The Trust has a proactive infection prevention team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that infection prevention and control is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients across Herefordshire.

This report summarises the key infection prevention and control initiatives and activities of the Trust for the year April 2011 up until March 2012. It also provides an assessment of performance against national targets for the year and with the Health Act (2008) criteria compliance.

There is continuing national focus on trajectory objectives for the reduction of MRSA blood stream infection rates and *Clostridium difficile* rates and these are monitored by the Health Protection Agency. Mandatory reporting of Meticillin – Sensitive *Staphylococcus Aureus* (MSSA) commenced in January 2011 with currently no trajectory assigned. In June 2011, mandatory reporting of *Escherichia coli* bacteraemias was also introduced.

- In 2011/12 the year ended without a single case of MRSA bacteraemia being acquired either in Wye Valley NHS Trust or within Herefordshire as a whole. Wye Valley NHS Trust is one of only two Trusts in the West Midlands who have been without an MRSA bacteraemia for the whole year.

- In 2011/12 the year ended with 38 cases of *Clostridium difficile* against a final trajectory limit set at 38 cases. During the year the trajectory was adjusted due to an outbreak of *Clostridium difficile* 027, discussed further in to the report and to reflect the introduction of an enhanced PCR testing method. The Community hospitals ended 2011/12 at 7 cases exceeding a separate trajectory of 5 cases
- Since the mandatory reporting of MSSA bacteraemia was introduced, the Trust has identified 6 cases diagnosed more than 2 days after admission.
- In a national point prevalence study of Healthcare Associated Infections (HCAI) undertaken in 2011 the Trust had a rate of 2.5% almost a third of the national rate of 6.4% HCAI's in English Hospitals. This study was last undertaken in 2006 when the Trust had a rate of 12%.

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 improved in elective screening through 2011/12 with a year round average of 85% and excellent sustained compliance has been maintained in emergency screening with a year round average of 100%.

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 2011/12 the Trust maintained its Infection Prevention Committee (IPC) structure with broadened membership to reflect the revised service unit structure of the new organisation. In February 2012 the Terms of Reference were revised to increase strategic direction and oversight. The committee is chaired by the Director of Infection Prevention & Control and reports to the Quality Committee to move forward the agenda across the new organisation.

The Trust Director of Infection Prevention and Control (DIPC) position was held by the Medical Director until January 1st 2012 when the position transferred to the Director of Nursing and Transformation, the DIPC is accountable directly to the Chief Executive and Trust Board.

The Service Delivery Manager for Theatres, Anaesthetics, Critical Care and Endoscopy is the designated lead for decontamination and chairs the Decontamination Committee. 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 advice and support.

The Infection Prevention Team (IPT), reporting to the DIPC, consisted of an Infection Control Doctor 0.4 whole time equivalent, Lead Infection Prevention Nurse and 4 Infection Prevention Nursing staff.

2.2 Compliance assessment and assurance

On April 1st 2010 the Care Quality Commission (CQC) subsumed the functions of the Healthcare Commission. Declaration of compliance is an ongoing process and the CQC can arrive unannounced or request a compliance assessment document and supporting evidence to be provided within 3 working days. The Trust has declared ongoing compliance with all criteria of the Health Act through 2011/12.

2.2 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 2011/12 the Trust identified no MRSA bacteraemias in blood cultures. The last case of MRSA bacteraemia was identified in January 2011. There were no MRSA bacteraemias in Herefordshire in 2011/12.

Blood culture sampling

Throughout 2011/12 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 2011/12 there has been a sustained reduction in blood culture contaminants to an average contaminant rate within a nationally recognised minimum 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 the County Hospital site there was a 50% reduction in these cases of MRSA with 5 cases. The Community hospitals had 10 cases identified more than 2 days after admission in 2011/12.

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 Key Performance Indicator (KPI). The average monthly compliance of non-elective admission MRSA screening in A&E at the acute Trust was 100%, in the Community hospitals this was an average during the first 6 months of 93% and in the last 6 months of 2011/12 increased to an average of 98%.

Elective MRSA screening.

The Trust continued through 2011/12 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 an improvement in compliance data for all Elective surgical screening including all surgical categories in the County site, including Maternity screening and Podiatric surgery at Belmont, with a year round average of 85 % and specifically 100% for Podiatric surgery.

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 2011/12 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 2011/12 there have been 6 cases identified more than 2 days after admission. 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 introduced the most sensitive test for *C .difficile* – the Polymerase Chain Reaction (PCR) test, in November 2011. It is a powerful technique which amplifies specific DNA fragments from minute quantities of source DNA material, to rapidly identify infectious organisms. In line with DH guidance, from January 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 2011/12 the County Hospital reported 38 cases against the externally set limit of 38 cases for the year and the Community Hospitals reported 7 cases against an externally set limit of 5 cases, totaling 45 across inpatient areas.
An increase in cases is managed with a formalised procedure referred to as a period of increased incidence with enhanced surveillance, cleaning and audit where there are 2 or more cases within a 28 day period.

In the first quarter of 2011/12 the Trust experienced an outbreak of *Clostridium difficile* 027; this will be detailed further in the report under Outbreaks.

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 2011/12 there were no cases of GRE identified in the Trust.

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 2011/12 the IPT undertook a 3 month surveillance period in January – March 2012. The surveillance was undertaken whilst the patients are inpatients and then looks at readmissions for infection in the year after the operation. The outcomes of the orthopaedic surveillance so far are as below:

Type of Surgery	**January – March 2012** (preliminary data)
Hip replacements	1% (1/94 patients)
Knee replacements	0% (0/98 patients)

National comparative data will be available in July 2012 but, in general, infection rates after hip and knee replacement surgery should be 1% or less.

2.3.6 Point Prevalence Survey 2011

In 2011 WVT participated in a national point prevalence study of healthcare associated infection. Overall, in the period studied, 2.5% of patients in the County Hospital had a healthcare associated infection. This compares favourably with the national figure of 6.4%, reflecting very well on the united effort of staff in focused infection prevention methods, delivering greater patient safety and supporting the ongoing need for infection prevention to be at the centre of all Trust activities, despite the intense and increasing pressure on beds during this period.

2.4 Audit programme to ensure key policies are implemented

Audit projects for 2011/12 completed by the IPT were:

- Annual performance audit against Infection Prevention Society (IPS) performance improvement tool audit criteria.
- Cleanliness of commodes on a monthly basis with weekly follow up if non compliance 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.
- Rapid Improvement tool audits in areas with particular performance concerns.
- Observation and practice audits.
- Cannula prevalence and practice compliance quarterly.

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.

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.

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

There have been no MRSA Bacteraemias in 2011/12 necessitating RCA,

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.

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 Infection Prevention Initiative 2011 – Pull Together to Prevent infection

Following the creation of Wye Valley NHS Trust and the provision of infection prevention services across the new organisation from a single infection prevention team, a need was identified to develop a set of core principles which apply to all Wye Valley staff regardless of role or location. Out of this a campaign was developed and rolled out entitled 'Pull together to Prevent Infection'. The campaign focuses on 5 elements of prevention, the elements if applied consistently by everyone all of the time regardless of where they work in the Trust will ensure patients are protected from avoidable healthcare associated infection.
The campaign will see the roll out of staff posters and educational resources and is represented by the Pull Together linked hands logo. The IPT intends to develop the campaign further through 2012/13. (See appendix 1)

2.7.2 Staff training

The team continues to have a strong training role. Infection prevention training and education programmes during 2011/12 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 Professionals, Sodexo and voluntary staff. There is an established Link Nurse training programme for clinical and non clinical 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 was 61%.
A robust plan for increasing compliance with attendance at mandatory training is underway for 2012/13. Compliance data will be closely monitored monthly by the service units and Trust Board.

2.7.3 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 for staff.

2.8 Staff supervision

Infection Prevention Team:
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.
Infection Prevention and Control Team Personal Development and Training:
During 2011/12 members of the team have attended relevant/ required study days plus one of the team members has attended the National Infection Conference.

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 were involved in updating and reviewing this policy during 2011. 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.

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 Centers providing auditing and advice with regards to local decontamination and compliance with the HTM01-05 regulation.

The Trust subcontracts an independent authorised engineering compliance with HTM 01-01, provides independent auditing and advice to oversee Endoscopy and ENT decontamination requirements with plans to broaden this through 2012/13 to Dental and Podiatric services.
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 are externally audited twice a year by a notified body.

3.2 Patient Environment Action Team inspection

PEAT inspections were completed in January and February of all the acute and community inpatient sites, with external validation for Ross community hospital. The results were favorable and full outcome data is awaited from the Information center for Health and Social Care.

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

During 2011/12 there have been extensive building works which have improved the fabric, layout and environment which supports good infection prevention practice and care delivery, of a number of Trust locations, primarily within community locations, below is an overview summary of these. The IP lead has been closely involved with all projects from conception through completion, with further projects for 2012/13 planned.

Location	Infection Prevention Team Involvement in New Build/ Refurbishment
Radiology	• Extensive IPT involvement in planning and work for replacement of CT Scanner and refurbishment of environment.
Radiotherapy Unit	• Extensive IPT involvement in enabling works for the new Radiotherapy unit
Theatres	• Planning and facilitating safe execution of installation of new air handling unit in Theatres 6.
Location	**Environmental Refurbishment undertaken to support infection prevention practice**
Leominster Community Hospital	• Improvements in bed spacing • Installation of handwash basins throughout the clinical areas • Creation of en-suite bathrooms for all patient areas • Refurbishment of dirty utility and installation of bedpan macerators. • Refurbishment of clean utility • Improved storage • Redecoration of environment to support cleaning.
Hillside Community Hospital	• Installation of clinical handwash basins in all single rooms • Refurbishment of storage room. • Purchase of new patient lockers to ease cleaning • Redecoration of environment to support cleaning.
No.1 Ledbury Rd	• Refurbishment of facility to create a dedicated laundry, decontamination room and domestics area.
Ross Community Hospital	• Refurbishment of Endoscopy unit including installation of handwash basins, improved decontamination facility to support dirty to clean flow, procedure and recovery rooms.

All clinical areas have worked very hard to support this works completion and the improvements in infection prevention practices are evident throughout.

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

4.1 Communications programme

During 2011/12 there have been a range of initiatives aimed at patients and the public to support infection principles. The Pull Together to Prevent Infection campaign was developed with a public arm linked to the principles of prevention. This has been rolled out through all patient/public areas of the Trust and will be further developed through 2012/13. See appendix 1.

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 supported the Trust Members Forum throughout 2011/12. 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.

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.

5.2 Managing outbreaks of infection

5.2.1 Outbreak of Clostridium difficile 027 – April – July 2011

The following summarises an outbreak that occurred in the Trust of *Clostridium difficile* 027. The outbreak involved a total of sixteen patients, involving a total of 3 wards at Hereford County Hospital and one ward at Leominster Community Hospital.

An outbreak was declared on 26th April 2011 and an outbreak meeting was held the same day due to a 5th case of *Clostridium difficile* 027 in the Trust. The initial 4 cases across 2 wards had been isolated, identified and managed up until that time under the period of increased incidence policy, with enhanced cleaning, environmental/practice monitoring and enhanced antibiotic stewardship in place. On the 26th April the outbreak team met and developed a strategy to

manage the outbreak with a detailed action plan with managerial and senior medical leadership. Subsequently there were twelve further cases of *Clostridium difficile* 027 across the Trust including Leominster Community Hospital. The last case of *Clostridium difficile* 027 was diagnosed on 14th June 2011. The outbreak was declared over on the 31st July 2011.

The outbreak was subject to internal and external Strategic Health Authority (SHA) review and there were 2 separate SHA assurance visits to the County Hospital and Leominster Community Hospital. A debrief was held on 30th June 2011 followed by a root cause analysis meeting, the root causes were developed into an action plan with all necessary outcomes completed.

Key changes for management of *Clostridium difficile* 027 since the outbreak:

- Revised *Clostridium difficile* policy
- Enhanced testing for all diarrhoeal specimens with a more sensitive PCR test.
- Revised management plan for *Clostridium difficile* 027 cases.
- Introduction of routine hydrogen peroxide fogging of environments in contact with patients positive with *Clostridium difficile* 027.

Since the last case of *Clostridium difficile* 027 there have been no further cases of *C. difficile* 027identified more than 3 days after admission in the Trust.

5.2.2 Norovirus

During 2011/12 the Trust saw a significant an increase in Norovirus outbreaks in comparison to 2010/11 although average duration has reduced in comparison to outbreaks in previous years.

Location & Date	Patients Affected	Staff Affected	No. of days closed
Arrow 22/6/11 – 28/6/11	13	1	7
Dore 23/11/11 – 26/11/11	5	0	4
Dore 7/12/11 – 11/12/11	4	0	5
Peregrine, Ross CH 6/12/11 – 7/12/11	3	0	2
Arrow 9/12/11 – 20/12/11	31	8	12
Lugg 11/12/11 – 18/12/11	36	0	8
Frome 11//12/11 – 14/12/11	17	0	4
Leominster CH 16/12/11 – 23/12/11	18	2	8
Leadon 6/3/12 – 9/3/12	7	3	4

The Trust has revised its outbreak procedure following on from revised HPA guidance for management of Norovirus outbreaks.

The Trust continued to have the Inov8 air disinfection units in the majority of the County hospital inpatient areas with plans to roll out their installation into Community hospital sites through 2012/13.

5.2.3 Influenza

2011/12 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. In 2012 the Trust was subject to an external SHA visit.

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 isolation 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 clinical management is appropriate.

9. Compliance Criterion 8: Ensure adequate laboratory support

The IPT is supported by a fully accredited Microbiology Department.

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10. Compliance Criterion 9: Policies and protocols

9.1 Antimicrobial stewardship

Quantitative and qualitative data is being used monthly to monitor and audit antimicrobial prescribing.
Antimicrobial consumption is monitored through reporting of daily defined doses (DDD), at an organisational, service unit and ward level, and by monthly monitoring of usage data for restricted agents.
Qualitative data regarding antimicrobial prescribing is obtained from a monthly antimicrobial prescribing point prevalence study, carried out across the Acute Trust. 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 DoH guidance for antimicrobial stewardship in hospitals. Overall compliance for the Acute Trust is between 61 and 70%.

In addition this audit provides quantitative information which can be used to benchmark against regional data regarding the percentage of in patients receiving antimicrobial therapy and the duration of both intravenous and oral antimicrobial treatment courses.

9.2 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 the Health@Work services to support the flu vaccination campaign and needle stick injury prevention programme. Compliance is monitored through the IPC.

12. Conclusion

Over the last year there has been significant improvements made in rates of healthcare associated infection across Herefordshire, most notably with MRSA bacteraemias, the Trust has a broadened surveillance programme to ensure known and emerging organisms are identified and acted upon quickly, ensuring policy, practice and facilities are under constant review for ongoing compliance with the Health and Social Care Act 2008.

The development of the Wye Valley NHS Trust and its integration of Health and Social Care provide a platform to further improve and standardise infection prevention understanding, practice and facilities to support safe high quality care, with organisms not adhering to organisational boundaries an infection prevention strategy that works seamlessly through acute and community settings is essential. Wye Valley is committed to a zero tolerance strategy to prevent all avoidable healthcare associated infections and embraces the delivering of the strategy through 2012/13 to support our commitment to improving the health and well-being of the people we serve in Herefordshire and the surrounding areas

Wye Valley NHS Trust

PULL TOGETHER TO PREVENT INFECTION

Universal Standard Precautions
Ensure you and your patients are protected with universal precautions.

Infection Management
Understand and adhere to infection prevention policies.

Cleaning and Decontamination
Ensure your patient's environment and equipment is clean, safe and decontaminated to the appropriate level.

Hand Hygiene
Clean hands are safe hands - are yours clean?

ANTT
Aseptic Non Touch Technique for all interventions.

Wye Valley NHS Trust

PATIENTS & VISITORS

HELP US PULL TOGETHER TO PREVENT INFECTION

Follow the guidance given to you by staff or displayed on posters.

Visitors – Sickness / Diarrhoea in the last 48hours Please stay at home.

Help us keep the environment clean by taking excess personal belongings home and reporting any concerns about cleanliness standards.

Perform hand hygiene prior to and following contact with patients and their surrounding environment. Wash hands with soap and water if visibly soiled or if in contact with a patient with diarrhoea, use alcohol hand gel on visibly clean hands.

Patients Invasive drips, lines or wounds must not be touched by the patient or visitors to help prevent infection.