Provide

Quality and Safety Committee

Subject	Infection Prevention and Control Annual Report
Presented By	Gerdalize Du Toit, Interim Deputy Director of Operations

Date	01/05/2018

Current RAG Rating:
(Select Rating)

Assured ✓
Mostly Assured □
Not Assured □

PPO	**Executive Summary:** The report from the Director of Infection Prevention and Control (DIPC) is the annual report to the Board on healthcare associated infections (HCAIs) and a summary of the progress of the 2017.18 infection prevention annual plan. The report informs the Board of all ongoing processes to control healthcare associated infections, including the implementation of all national initiatives during the reporting period from April 1st 2017 to March 31st 2018. The report highlights the excellent performance for infection prevention and control. To ensure that the Board is compliant with the Health and Social Care Act, 2015 the report will be made available to the public. **Summary of key successes of the infection prevention annual plan:** • Provide achieved both MRSA bacteraemia and *Clostridium difficile* improvement objectives set by MECCG. • Provide maintained its commitment to an effective infection prevention audit programme. • The infection prevention team worked closely with medicines management team to develop a new (AMR) antimicrobial strategy. • The practice of effective hand hygiene remains consistently high; monthly audits achieved above 95% (audits completed by Infection Prevention Link Practitioners). • The infection prevention team worked closely with facilities and estates in the planning and refurbishment of estates.

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Contents

1. Introduction

The infection prevention annual report to the Board is an account of the infection prevention annual plan for 2017.18 and reports on the key infection prevention quality standards for the period. The Board acknowledges and agrees their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The delivery of quality services is a priority across Provide and infection prevention is a key factor in the delivery of safer services. The annual plan meets Provide's Clinical Strategic Objectives for 2017.18. Our vision is to provide a range of outstanding services that care, nuture and empower individuals and communities to live better lives.

The annual plan is monitored and progress against each objective is reviewed at every Infection Prevention Group meeting. The annual report seeks to assure the Board that progress has been made against the 2017.18 annual plan.

The annual plan complies with all national priorities for infection prevention; The Health & Social Care Act, 2015: Care Quality Commission; regulatory requirement 12(2)(h) ,assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated. NHS in England: 2017.18 NHS Outcomes Framework indicator 5.2 (MRSA and *C difficile*).

2. Management Arrangements

Provide is locally performance monitored by mid Essex Clinical Commissioning Group (MECCG) and Essex County Council. Provide Board assurance is maintained by the continuing risk assessments of services through each quarterly infection prevention report. This is monitored at the Quality and Safety Committee, the Infection Prevention Group and the Board.

During the year the infection prevention team participated in the North Essex CCG infection prevention meetings and worked closely with the infection prevention and control teams from Mid Essex Hospital Services NHS Trust and Colchester Hospital University NHS Foundation Trust.

Provide is monitored by the following organisations:

- The Care Quality Commission (CQC)
- Mid Essex Clinical Commissioning Group (MECCG)
- Essex County Council

2.1 The Director of Infection Prevention and Control

The Director of Infection Prevention & Control (DIPC) is the Executive Clinical & Operations Director. As a Board member, the Director reports on all matters to do with infection prevention, directly to the Board.

2.2 The Infection Prevention Team

The Infection Prevention Team comprises of 1 full-time Head of Infection Prevention, 1 part-time Infection Prevention Nurse, supported by the Director of Infection Prevention & Control and an Infection Control Doctor.

2.3 Infection Prevention Accountability

The Director of Infection Prevention & Control has responsibility for the delivery of the infection prevention programme. All services have nominated infection prevention link practitioners. All ward managers, integrated community team managers, department managers and team leaders are

accountable for ensuring all clinical practices comply with agreed infection prevention protocols and guidelines. They are responsible for taking ownership for infection prevention and control within their clinical environments and services.

The infection prevention team provides advice and support to each service. The team is responsible and accountable for providing the annual infection control plan.

2.4 Infection Prevention Meetings

Infection Prevention Group

The group meets quarterly to monitor the progress of the infection prevention plan and to discuss new local and national initiatives. The primary responsibility of the group is the supervision of the infection prevention annual plan, policy and guideline approval and monitoring infection prevention related incidents, outbreaks, risks and gaps in regulatory compliance.

Infection Prevention Link Practitioner Forum

The infection prevention link practitioners meet regularly to discuss current practices and invite external speakers to discuss current topics of interest. Each clinical service within Provide has a nominated infection prevention link practitioner. The infection prevention team hold regular link practitioner forums which include educational sessions to give updates on national and local development in practice. This year's forum topics included a presentation on the treatment of Tuberculosis (TB) from the regional TB nurse specialist, a presentation on new subcutaneous engineered stabilisation devices for PICCs and training on hand hygiene.

3. Outbreaks, Incidents, Serious Incidents, Risks and Complaints relating to Infection Prevention and Control

3.1 Infection Prevention Outbreaks

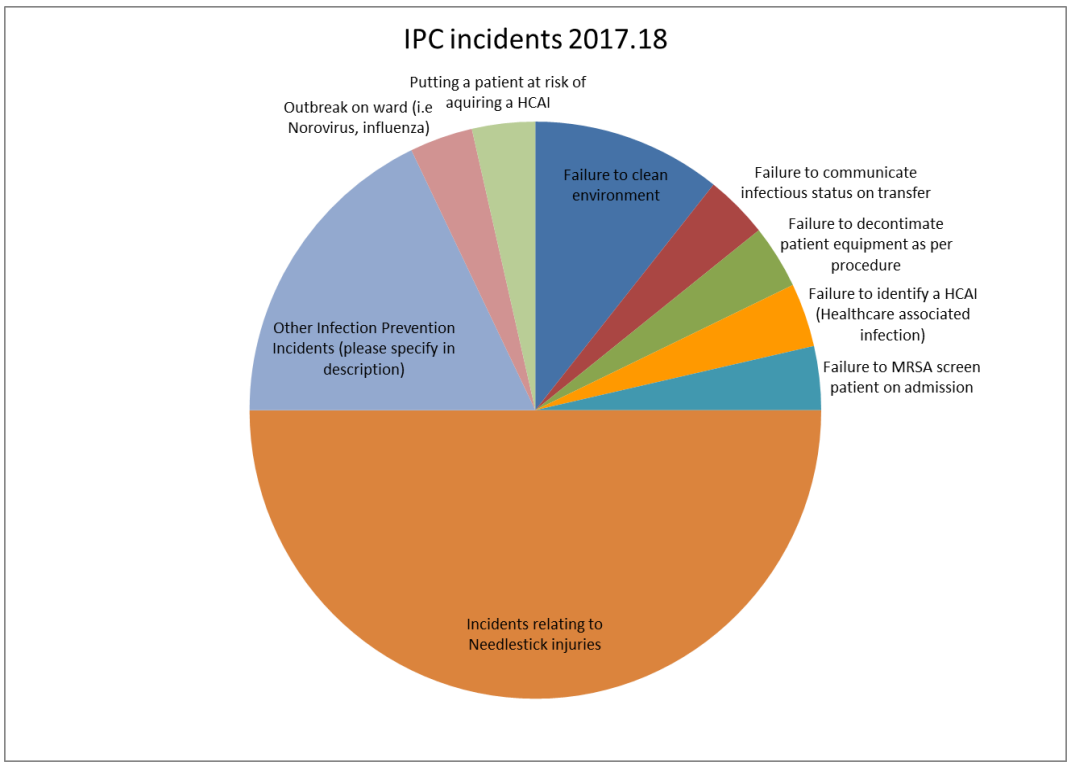
There was one norovirus outbreak on Courtauld ward in September 2017. Two confirmed patient cases, 2 further suspected cases and 3 staff members affected. The ward was closed to new admissions for two days between 29th September and 2nd October; Mid Essex Clinical Commissioning Group (CCG) were notified of the outbreak which was successfully contained. The outbreak was well managed and effectively minimised the number of bed days lost to norovirus this winter.

3.2 Infection Prevention Incidents /Serious Incidents (SI) & Complaints involving Infection Prevention

In the 2017.18 there were no serious incidents declared relating to infection prevention and control. Additionally, there were no complaints relating to infection prevention and control.

All incidents were reported via Datix (web-based incident reporting); overall there were 28 reported incidents reported as either minor harm or no harm. The largest percentage of these incidents were related to needle stick/sharp incidents (50%, 14 incidents). All infection prevention incidents reported on Datix during 2017.18 are summarised by category in figure 1 below; none of these were reportable as serious incidents. As well as monitoring through the Quality and Safety Committee, they are reported to the quarterly Infection Prevention Group; the most common categories of infection prevention incidents relate to diabetic insulin pens in the community.

Figure 1



3.3 Risks

There was one significant infection prevention risk to the organisation in 2017.18. The risk related to clinical sinks on St Peters ward which did not meet current regulations (Outcome10, regulations15, Safety & Suitability of Premises no7, provision of suitable hand washing facilities). The risk has been closed on the risk register following the replacement of the clinical hand washing sinks in January 2018.

4. Surveillance & Alert Organisms

Healthcare associated infections (HCAIs) are infections that occur either as a result of a person's treatment or from contact with any part of the health care system. Assessing all patients for their risk of acquiring an HCAI is a requirement of the Health and Social Care Act 2008 (revised, 2015). The infection prevention team uses a risk assessment form (HCAI alert form) which is available for all teams to access on systmOne.The infection prevention team reviews all alert forms daily to identify abnormal trends and to investigate to see if there are any underlying reasons and if additional support is required. Clinicians are responsible for following up all laboratory samples and advice should be sought from the infection prevention team as required, if colonisation or new infection is identified during the patient's stay or concerning admission to a ward.

MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemia (infections in the blood stream), when identified within 48 hours of admission to hospital is considered to have already been present and is reported as a 'community acquired infection'. Infections that are identified 48 hours after admission are considered to be acquired in hospital.

In *Clostridium difficile* infection, the period is 72 hours from hospital admission, to the time the specimen was taken.

Provide reports on the incidence of Healthcare-Associated Infections for MRSA bacteraemia and *Clostridium difficile* as part of national data collection (2017-18 NHS Outcomes Framework indicators 5.2). Mid Essex Clinical Commissioning Group is responsible for determining whether identified cases should ultimately be assigned to the above targets on the bases of completed root cause analyses (RCAs) and audit feedback.

Public Health England's Data Capture System (HCAI Data Capture System) provides an integrated reporting and analysis system for the mandatory surveillance of *Staphylococcus aureus*, *Escherichia coli* bacteraemia and *Clostridium difficile* infections.

4.1 MRSA Bacteraemia

Mandatory surveillance 2017.18: MRSA Bacteraemia: **target** = **zero: outcome zero** (*Community wards 0 > over 48hrs following admission/ as per operational standards/national standards/MECCG).* As part of the national reporting surveillance programme, all MRSA bacteraemias BSI (infections in the blood stream) must be reported. During 2017.18 targets for MRSA bacteraemia were set at zero for Provide by MECCG. The year-end cumulative total, achieved 100% compliance for zero infections attributable to Provide.

4.2 Clostridium difficile

Clostridium difficile is a major cause of antibiotic-related diarrhoea, particularly in elderly patients. In line with Department of Health guidance, Provide assures the public of its commitment to the prevention of *Clostridium difficile* by an explicit patient care pathway stating clear antibiotic prescribing, strict isolation, the use of chlorine-dioxide disinfectant and hydrogen peroxide fogging as part of a terminal clean.

Mandatory surveillance 2017.18: *Clostridium difficile* new isolates: target = **zero; outcome zero** *(> over 72 hrs following admission, as per Clostridium difficile mandatory reporting/operational standards/national contract/MECCG).*

The assessment of Provide figures by MECCG did not identify any cases in 2017.18 where an improvement in care could potentially have prevented the development of *Clostridium difficile.* All reported cases refer to toxin positive results for *Clostridium difficile* that are detected by the Trust in which the laboratory processed the specimen. It is important to note that Provide, as a community provider, reports into MECCG who reports all community providers collectively.

4.3 Escherichia coli (E.coli) bacteraemia; Zero:

Outcome zero: no reported cases.

4.4 Surgical site infection surveillance (Minor Surgery & Podiatric Surgery)

Provide undertakes a voluntary post-discharge surveillance for its minor surgery and podiatry surgery units based at Braintree Community hospital.

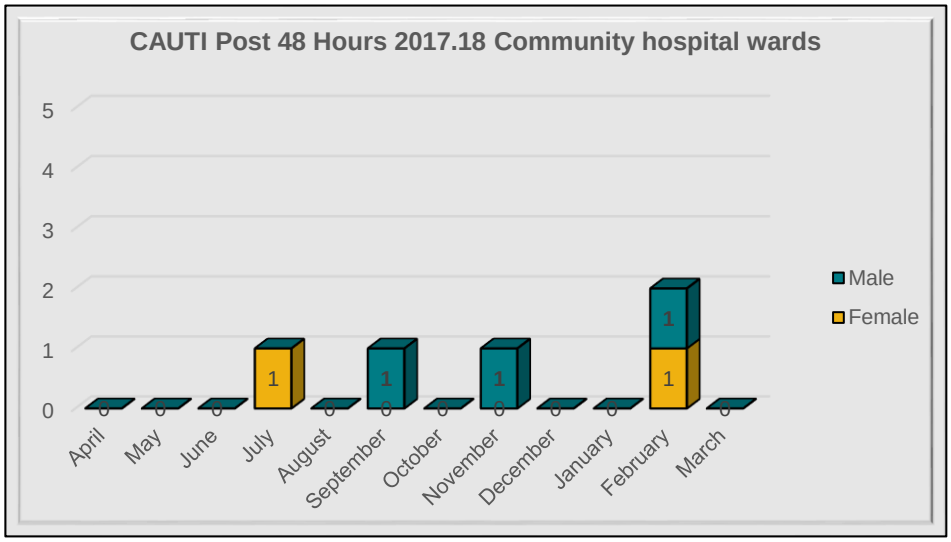
4.5 Catheter Associated Urinary Tract Infections (CAUTIs)

Catheter associated urinary tract infections are very common infections acquired as a result of healthcare. Provide infection prevention team have continued to monitor all pre-and post 48hrs CAUTIs to improve the management of urinary catheters on community wards. NHS England published an ambitious strategy to reduce E coli and other gram negative bacteraemia infections by 10% in 2017.18 and a further 50% by 2020. The majority of these infections occur in the community and the reduction target sits with the CCGs; as part of supporting Mid Essex CCG and NHS England, Provide has a detailed 3-year AMR strategy to reduce gram negative infections.

The overall total number of CAUTIs (per 1,000 bed days) 2017.18 = **0.7.**

Figure 2 illustrates the total number of reported post 48hr CAUTIs and shows that the numbers remain very low across all three wards.

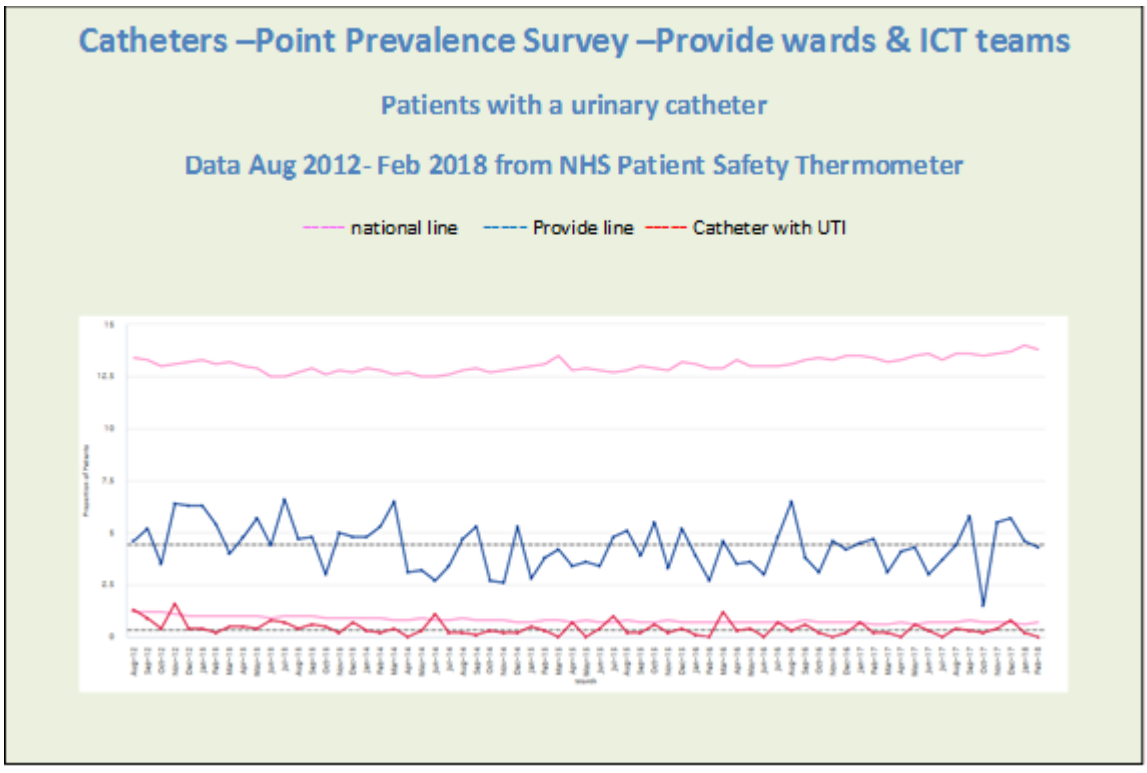
Figure 2



4.6 NHS Safety Thermometer dashboard: Harm Free Care/Patients with urinary catheter

Provide participates in the national NHS Patient Safety Thermometer. This is a national measurement tool to support patient safety improvement. It is used to record patient harms at the frontline, and to provide immediate information and analyses for teams to monitor their performance in delivering harm free care. Data is collected through a point of care survey on a single day each month on 100% of patients. Analysis of the data enables us to understand the prevalence of catheter harms at Provide so that we can focus on making improvements in patient care. Figure 3 demonstrates that Provide remains below the national average.

Figure 3



4.7 Antimicrobial Resistance Strategy-AMR (Community Wards)

Antimicrobial resistance is a global public health issue driven by the over-use of antimicrobials and inappropriate prescribing, making these agents less effective and contributing to infections which are hard to treat. The strategy forms part of evidence for CQC on compliance with the Health and Social Care Act 2015, to include compliance criterion3: ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Provide is committed to the strategic development of antimicrobial stewardship to ensure antimicrobials are used safely and effectively, thus raising awareness of the judicious use of antimicrobial agents and appropriate prescribing. The infection prevention team have signed up to assist with the implementation of the following:

- Ensuring IP&C is an integral part of good patient centred care
- Ensuring all staff are trained/educated in standard precautions (hand hygiene ,PPE ,decontamination of equipment, waste management ,linen management and sharps disposal)
- Maximise vaccination programme for all clinical staff (i.e. Influenza vaccine-staff uptake)
- Improve surveillance and reporting mechanisms for HCAIs
- Target campaign for Gram –negative BSIs –prevention (indwelling vascular devices, catheters and wound management)

The annual antimicrobial audit report for 2017.18 shows that overall antimicrobial prescribing is in line with local formularies with penicillin's accounting for 40% of all antimicrobial prescribing on the wards.

4.8 Annual Influenza Campaign

The infection prevention team worked closely with the Human Resources team to promote the 2017.18 Influenza campaign in August 2017 with links to the on-line booking system and a campaign in clinical matters dispelling the five common myths about Flu.

The key messages in team brief were;

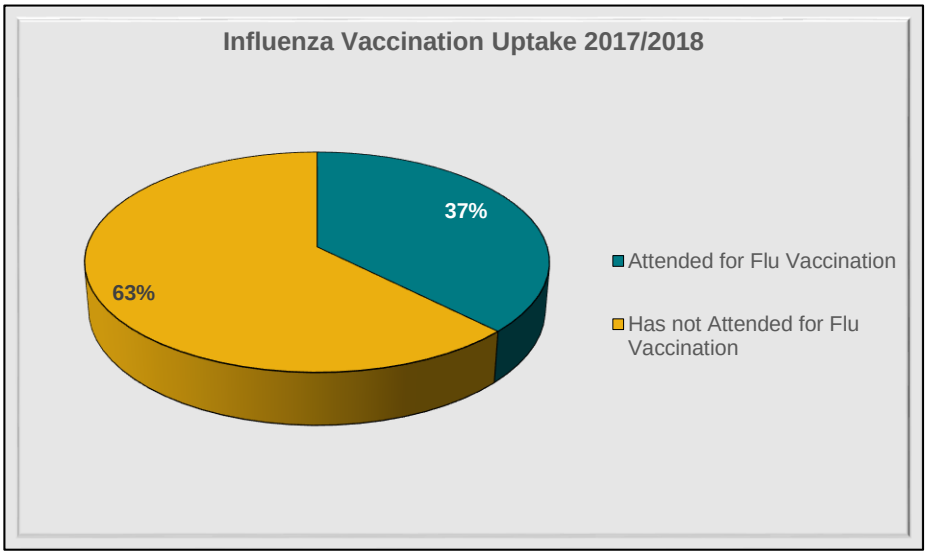
- Getting your flu vaccination will help keep you well, and reduce the risk of you passing anything on to your family, your work colleagues and - most crucially – our patients

- Like other healthcare organisations, Provide faces significant challenges around maintaining staffing levels during times of increased sickness. In having a flu vaccination you will help protect your patients and will be less likely to get sick yourself

- Please help us reduce the risks to patient health and your own health; and help Provide to avoid the financial pressures associated with flu-related illness and staff shortages

However, despite good marketing and multiple locations the uptake remained similar to previous years at around 37% of staff taking up the offer a free vaccination.

Figure 4



5. Environmental Cleanliness

5.1 Monthly Cleaning Audits

All Provide community hospitals are audited monthly using the 'National Specification for Cleanliness in the NHS', audit tool. All hospital sites have maintained their levels of cleanliness on the wards, consistently over the past twelve months. The results for the year are summarised below in figure 5:

Figure 5: Annual Cleaning Scores (NPSA audit template)

Wards	Annual scores
Halstead ward	96%
St Peters ward	97.3%
Braintree Community Hospital ward	99%

5.2 PLACE Assessment

A patient-led assessment of the care environment (PLACE) assesses the quality of the hospital environment. PLACE assessments put patient views at the centre of the assessment process, and use information gleaned from patient assessors to report how well a hospital is performing in the areas assessed – privacy and dignity, cleanliness, food and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or staff behaviours. The assessment of cleanliness covers all items commonly found in healthcare premises including patient equipment, baths, toilets, showers and fixtures and fittings. Figure 6 illustrates the PLACE results in 2017.18.

Figure 6: PLACE Scores

PLACE Scores 2017/18		
Wards	**Cleanliness**	**Condition , appearance and maintenance**
National Average	**98.38%**	**94%**
Halstead	**100%**	**95%**
Braintree Community Hospital	**100%**	**95.5%**
St Peters	**99%**	**91%**

6. Infection Prevention Audit Programme and Surveys

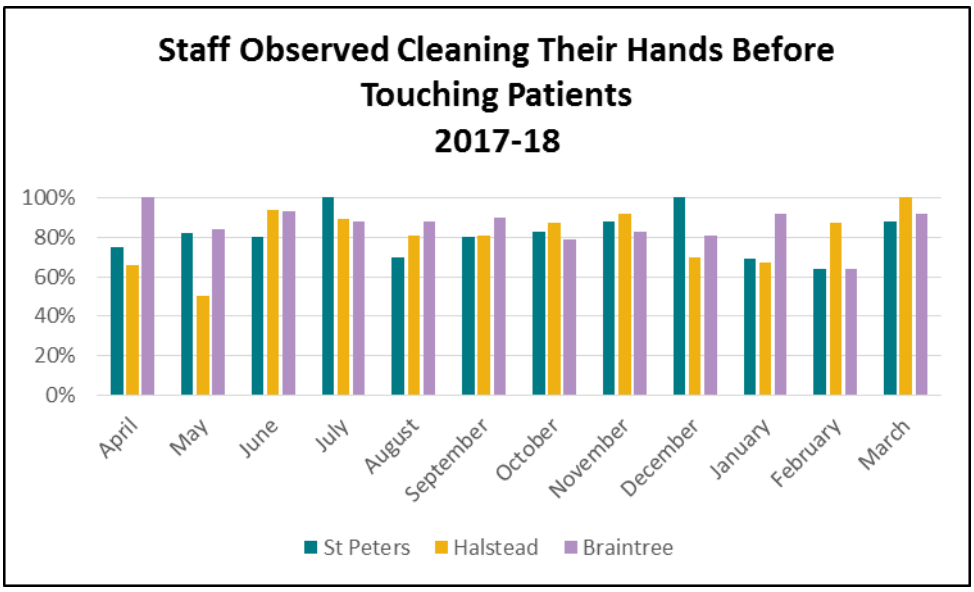
6.1 Patient Experience Surveys: Hand Hygiene Compliance

We ask our patients to audit our hand hygiene compliance. As part of the patient experience surveys undertaken by Provide during 2017.18, where relevant to the client/patient, a question is asked in relation to the performance of Provide staff in relation to hand washing. This is a component of all relevant surveys irrespective of the service involved. Patient /clients are asked a specific question about the performance of the staff in hand washing and are asked to rate what they felt the performance of the staff member was.

Patients were asked; As far as you know are staff washing or cleaning their hands between touching patients?

a) Yes, all of the time
b) Yes sometimes
c) Not sure/can't remember
d) Not really
e) No, not at all
A= *'yes, all of the time'*.

Figure 7: Patient experience hand hygiene survey results: 2017.18



The patient surveys (figure 7) demonstrate that patients' perceive that hand hygiene is not always carried out by staff all of the time. Whereas, the hand hygiene audits performed monthly by the link practitioners record compliance at 100% all of the time. While the patient hand washing survey is helpful it can be subjective as clinical staff may wash their hands out of sight of patients. The audit and training provided by an external company demonstrated overall good compliance but that some staff are applying too much soap.

6.2 High Impact Interventions

The high impact interventions are evidence-based care bundles designed by the Department of Health to reduce the risk of infection. They have been adopted locally as an improvement tool and include wound management, catheter care, and hand hygiene, decontamination of equipment and peripheral line care. Each service, undertakes monthly audits which are recorded onto a performance dashboard and monitored by the Infection Prevention Group. Figure 8 below illustrates the overall results in 2017.18.

Figure 8: High Impact Intervention monthly audits

High Impact Intervention (HIIs)	Audit actions	Performance target	Number of audits	Overall compliance achieved
HII Preventing Peripheral line infection	Insertion	100%	70	100%
	On-going care	100%	94	100%
HII Preventing Urinary Catheter Infection	Insertion	100%	77	100%
	On-going care	100%	88	100%
HII Cleaning & Decontamination of equipment	Infected	100%	25	100%
	Non-infected	100%	231	100%
HII Safe Clean Care/Hand Hygiene Audits	Observations	100%	307	100%
HII Wound Care	Wound phase	100%	77	100%

6.3 Annual Audit Programme

The infection prevention team audits and evaluates clinical practice by undertaking annual clinical audits with feedback reports, action plans, progress and compliance monitoring. The audits review patient care to ensure best practices are taking place. When necessary, actions are identified to improve practice and these actions are monitored and reported to the local team, Quality and Safety meeting and the Board.

As part of the overall risk assessment process the infection prevention team undertake environmental audits using the Infection Prevention Society's (IPS) audit tool or the infection prevention and control compliance tool (short report) for low risk areas.

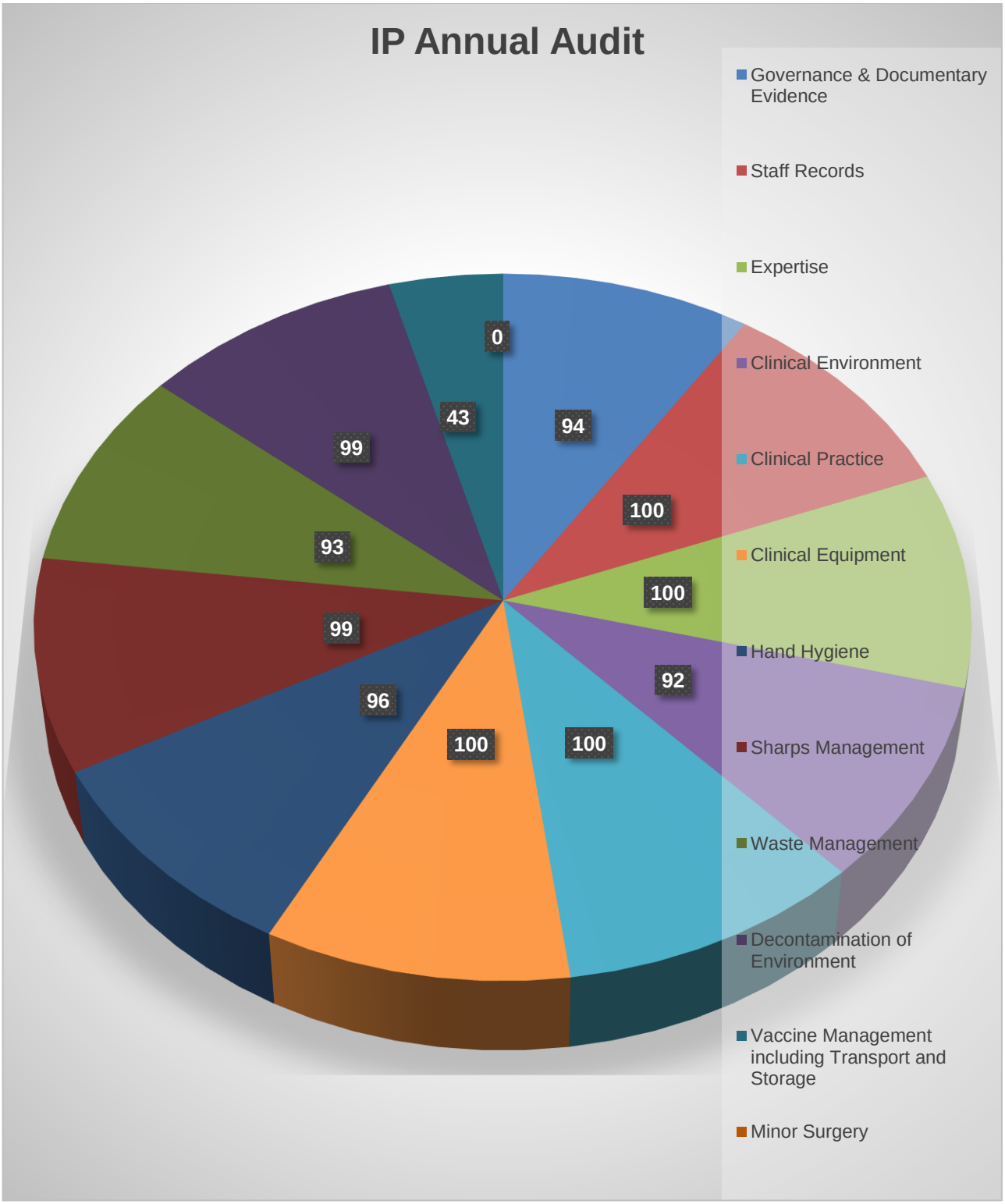
Overall the scores were good,but the audits did highlight that shared premises with other service providers often had issues with maintenance, cleanliness or inappropriate fixtures and fittings . All areas have submitted detailed action plans which are monitored by the relevant Assistant Director of Service. The action plans are reported at the Quality and Safety committee.

The audit programme included visits to the following services:

- Bartams Wheelchair services
- BCH-Endoscopy unit
- BCH-Courtauld ward
- BCH-Minor operations unit
- Burnham clinic
- Chelmsford ICT team (Kestrel house)
- DGT-Wheelcair services
- Essex Sexual Health Services (ESHS) (Rayleigh, Stow, South Woodham Ferrers)
- Halstead ward
- Moulsham Lodge clinic
- Pendrill Court
- Springfield clinic
- Spinks Lane clinic
- St Peters ward
- Steeple Bumpstead GP Practice
- Wood Farm : Wheel chair services

Figure 9 demonstrates overall compliance scores for infection prevention environmental audits
The high compliance scores relate to good clinical enviroments ,clean equipment and hand hygiene;
The lower score relates to accessing policy in two of the clinics. Staff can access all policies on MyCompliance.

Figure 9 Infection Prevention Annual Audit compliance scores



The reports identified key patterns in infection prevention non-compliances:

- In a couple of clinics the environmental cleaning schedules had not been signed
- In older premises there was evidence of physical damage to the walls
- Sharps bins had not been signed and dated

Several recommendations were identified in the report to improve standards.

- Infection prevention and control training on the importance of signing off cleaning schedules
- Infection prevention and control training on the management of sharps bins and waste
- Facilities and Estates team to check that all general maintenance requests which have not been signed off and actioned as complete, should be reported to the Facilities and Estates Group to be followed up.

7. Infection Prevention Policies and Policy Development

Infection prevention policies are continually being updated on a three year rolling programme; several were reviewed over the past year by the infection prevention group. The following were approved by the Infection Prevention Group this year;

- IPPOL27: CPO-The management of patients with Carbapenemase-Producing Organisms (including CPE) in non-acute community settings
- IPPOL19: MRSA screening policy for Podiatric day case surgery.
- IPPOL 02 : *Clostridium difficile* policy

8. Infection Prevention Education and Training

Mandatory training for infection prevention and control is a compulsory component of Provide's learning and development programme in 2017.18. As part of the annual programme the infection prevention team mapped infection prevention training with the core skills training framework to deliver training to a recognised standard and to align with other healthcare providers. This will ensure the educational relevance, consistency and quality of the training provision. As part of the mapping process changes have been made to the infection prevention induction programme and to the latest version of the Green card version 8.

As part of the core mandatory training, staff have infection prevention training at induction and all clinical staff are required to complete the infection prevention training booklet called 'the green card'. All clinical staff complete the e-learning module 'the principles of infection prevention' every 2 years or complete the green card version 8. The NHS-eLearning portal covers infection prevention, sepsis and antimicrobial resistance. Figure 10, illustrates the percentage of staff compliant in infection prevention training.

Figure10

2017.18	Q1	Q2	Q3	Q4
Infection Prevention and Control Clinical staff|	**88%**	**91%**	**92%**	**93%**

9. Infection Prevention Plan for 2017.18

The annual infection prevention plan sets out national and locally agreed initiatives. It is reviewed quarterly at the Infection Prevention Group. The plan includes innovative projects that balance healthcare quality and competence to ensure staff are equipped with the right skills, knowledge and abilities for effective practice.

In 2017/18 the infection prevention team were involved in several quality improvement projects all relating to reducing healthcare associated infections (HCAIs) linked to national initiatives.

9.1Infection Prevention Quality Improvement Project - Leg Ulcers

This project looked at ways to improve the management of leg ulcers in the community .The team completed a point prevalence survey and made recommendations based on the results. One of the recommendations was to work with the tissue viability team and develop a leg ulcer passport which is now used by community services.

9.2 Infection Prevention Quality Improvement Project - CAUTIs (catheter associated urinary tract infections)

This project monitored the number of CAUTIs on community wards. The project aims to reduce the infection rates and improve catheter management. The infection prevention team are using the information gathered in this project to improve training and ensure best practice is delivered.

9.3 Hand hygiene –improvements with compliance

The infection prevention team launched a new hand hygiene initiative in August 2017 to encourage clinical staff to remove their jewellery. This was adapted from work undertaken at the Norfolk and Norwich University Hospital, aiming to make potentially challenging conversations simpler during hand hygiene audits; it was found to be a very useful tool with a positive impact. The idea is simple, staff are given a safety pin to be able to remove any non-compliant jewellery and pin it into their uniform pocket for safe keeping whilst at work.

10. External Inspections of Services

MECCG

There were some exemplary episodes of care observed during the visit. Staff were well informed and were well aware of who the infection prevention team were within the organisation and all areas were clean with evidence of equipment being cleaned and maintained.

11. Summary

Infection prevention and control is the responsibility of all staff and Provide has a commitment to infection prevention at all levels throughout the organisation. Provide has continued to implement a robust infection prevention plan and support a strong network of link practitioners and associate nurses. This is evidenced by the low number of infection prevention incidents, outbreaks and the excellent results for MRSA bacteraemia and *Clostridium difficile*. The annual infection prevention and control site audits have seen improvements to clinical environments undertaken on behalf of the facilities and estates team.

12. Looking Forward 2018.19

- As Provide moves towards delivering more patient care in patients' homes and acquires new community services it must continue to ensure that IP&C is fully embedded within all the new services.
- Changes to the reporting processes for MRSA and *Clostridium difficile*
- Infection prevention team to work closely with mid and south Essex sustainability transformation partnership (STP).
- Infection prevention team to work closely with NELFT infection prevention team to support safer services.

13. Appendix

Abbreviations

- AMR- Antimicrobial Resistance
- DIPC –Director of Infection Prevention and Control
- HCAI –Healthcare Associated Infection
- HCW –Health Care Worker
- CQRG-Care Quality Review Group.
- CQC-Care Quality Commission
- BCH – Braintree Community Hospital
- ANTT-Aseptic Non touch Technique
- PLACE-Patient-Lead Assessments of the Care Environment
- MECCG- Mid Essex Clinical Commissioning Group
- RCA –Root Cause Analysis
- UTI- Urinary Tract Infection
- CAUTI- Catheter Associated Urinary Tract Infection

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June 2018