

EXECUTIVE SUMMARY
REPORT TO THE HEALTHCARE GOVERNANCE COMMITTEE –
23 MARCH 2015

Subject:	a) Infection Prevention and Control (IPC) Programme Progress Assessment 2014/2015 Quarter 3 (October – December) b) Ratification of 2015/16 IPC Programme
Supporting Director:	Professor H A Chapman, Chief Nurse
Author:	Dr C Bates, Consultant Microbiologist/Lead Infection Control Doctor/DIPC
Status ¹	N

PURPOSE OF THE REPORT:

- | |
|---|
| a) To highlight progress in quarter 3 of the 2014/15 IPC Programme
b) To present the proposed 2015/16 IPC Programme for comment and ratification |
|---|

KEY POINTS:

2014/15 IPC Programme Q3 (October – December) progress report:

- Overall good progress has been made – Group/Department average score is 97.1%
- Overall areas within the Trust are showing at least an 91% compliance
- All areas have coded as Green or Blue
- Issues that some areas need to address to improve compliance include a) all non-ward based areas achieving Accreditation for the first time, b) making regular antibiotic audit returns, c) reviewing all IPC related documents re local implementation and d) completing the sections re medical staff education.
- Progress continues in updating the numerous IPC related policies and guidelines – see attached document
- 78 of 78 in-patient wards have Accredited at least once
- 90 of 98 OPD/Day case areas/non-ward based departments have Accredited at least once. The majority of the outstanding areas have only commenced participation in the scheme during the past few months and therefore are not in a position to Accredit as yet. Good progress is being made by Community services in respect of phase 1, 2 and 3 of the pilot Accreditation scheme developed for this Group.
- The requirement to undertaken quarterly ward based antibiotic audits was included in the coding for this quarter. 55 of 64 wards completed the audit in November.

2015/16 IPC Programme

The proposed 2015/16 IPC Programme has been developed by the IPC team and was Approved by the IPC Committee members on 6 March

IMPLICATIONS

	Aim of the STHFT Corporate Strategy 2012-2017	Tick as Appropriate
1	Deliver the best clinical outcomes	√
2	Provide Patient Centred Care	√
3	Employ Caring and Cared for Staff	√
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	
	CQC Outcome	

RECOMMENDATION(S):

HGC is asked to note the progress towards implementation of the IPC Programme for 2014/2015 and ratify the 2015/16 IPC Programme

APPROVAL PROCESS

Meeting	Presented by	Approved	Date
TEG	Hilary Chapman	Y	11.3.15
HGC	Hilary Chapman		23.3.15

Sheffield Teaching Hospitals NHS Foundation Trust
INFECTION PREVENTION AND CONTROL PROGRAMME
April 2015 - March 2016

This document details the Sheffield Teaching Hospitals NHS Foundation Trust (hereafter referred to as the Trust) trust-wide Infection Prevention and Control (IPC) Programme for the year April 2015 – March 2016. The Infection Prevention and Control Team (IPCT) takes the lead in developing the Programme trustwide. The Nurse Directors (or equivalent) and Clinical Directors are responsible for implementing the IPC Programme within their Groups/Directorates/departments with assistance from the Matrons and Medical IPC Leads. It is important to remember that the IPCT can advise, monitor and educate, but it is the responsibility of each and every member of Trust staff to put infection prevention and control into practice, particularly those involved in direct patient care.

This IPC Programme describes the infection prevention and control activities that the Trust will focus on this year. All areas will continue to follow existing infection prevention and control activities, policies, protocols, procedures and guidelines unless specifically updated or superseded.

The Trust IPC Programme outlines the issues to be addressed this year. Each Group or department can produce their own programme/action plan detailing how the requirements in the Trust IPC Programme will be undertaken at a local level. A progress report should be returned to the Director of Infection Prevention & Control (DIPC) every quarter using Appendix A, B, C or D as appropriate. Progress in relation to the IPC Programme is the responsibility of the Clinical Directors and Nurse Directors (or equivalent).

The focus this year will be on:

- Trust-wide achievement of annual IPC Accreditation
- Prevention and Control of Norovirus
- Prevention and Control of *C.difficile*
- Prevention of meticillin sensitive *Staphylococcus aureus* and *E.coli* bacteraemia
- Prevention and Control of Category 4 pathogens e.g. Ebola
- Prevention and Control of carbapenemase resistant Gram negative organisms
- Update of infection prevention & control e-learning packages
- Development of the surgical site infection surveillance programme

Most of the other activities will relate to these issues by either being an integral part of them or via audit, ownership etc.

The IPC Programme is divided into the following Sections:

- | | |
|--|---|
| • Infection Control Accreditation | • Influenza & Other Respiratory Viruses |
| • Saving Lives Toolkit/NICE guidance/EPIC3 guidance | • Norovirus |
| • Health & Social Care Act 2008 | • Category 4 pathogens |
| • Ownership at Group/ Directorate/Ward level | • Hand Hygiene |
| • Audit and Review | • Decontamination of Medical Devices |
| • Surveillance | • Management of Invasive Devices: Peripheral and Central intravenous cannulae & Urinary catheters |
| • Meticillin resistant <i>Staphylococcus aureus</i> (MRSA) | • Environmental and Cleaning Issues |
| • Meticillin sensitive <i>Staphylococcus aureus</i> (MSSA) | • Education and Training |
| • <i>Clostridium difficile</i> (<i>C.difficile</i>) | • Communication and Information |
| • Gram Negative Organisms | • Research, Service Evaluations, Studies and Assessments |

1. Infection Control Accreditation

- 1.1 The Infection Control Accreditation scheme will continue to be the main means by which infection prevention and control practice is optimised and assessed throughout the Trust. The Accreditation standards include hand hygiene, cleanliness and application of the High Impact Interventions (HII)s within the Department of Health (DH) Saving Lives¹ toolkit, including appropriate audits and actions following external reviews.
- 1.2 All in-patient wards should achieve Accreditation initially and then keep up to date with the rolling programme of audits thereafter. Formal Re-accreditation should take place annually.
- 1.3 All non-ward based departments including inpatient, out-patient and day-case areas should achieve Accreditation initially and then keep up to date with the rolling programme of audits thereafter. Formal Re-accreditation should take place annually.
- 1.4 The Accreditation Programme will continue to include the High Impact Intervention on Prevention of Surgical Site Infection as a key element of the Trusts plan to reduce surgical site infections.
- 1.5 The IPCT and Community Services staff will continue to progress Phases 1, 2 and 3 of the Community Services Group Accreditation Programme and commence Phase 4 in late 2015
- 1.6 All areas will use the most recent version of the Accreditation Programme
- 1.7 Where wards/departments do not achieve compliance with any particular standard they will take action as appropriate and re-audit as required within the Accreditation Programme
- 1.8 All wards/departments will submit their Accreditation audit scores to the IPCT. The IPCT will upload the results onto a central database. This data will be used for the initiatives described in sections 1.13 to 1.16 and therefore it is extremely important that wards/departments submit data in a timely manner.
- 1.9 All audit scores should be submitted to the IPCT in as near to real time as possible i.e. within few days of the audit being undertaken
- 1.10 The results of all Accreditation audits should be submitted including the initial audits undertaken each month, which may or may not show optimal compliance, plus any follow up audits. This will help to show progression and that practice is being monitored appropriately and audit findings responded to.
- 1.11 The IPCT will undertake a six-monthly review of how wards/departments are progressing towards Re-accreditation. This will include a check of the completeness or otherwise of the submission of audit scores as detailed in sections 1.8 to 1.10 including submission of the quarterly Antimicrobial prescribing audits. The aim will be to undertake most of this activity outside of the busy winter period. Where a review falls during the busy winter period, some delay may occur but the review will be undertaken as soon as possible as work load allows.
- 1.12 The IPCT will develop an electronic database to record the Community Group Accreditation results similar to that used for the acute areas of the Trust.
- 1.13 The IPCT will receive quarterly reports on wards/departments. These reports will code wards/departments as follows:
 - White - 12 or less months since last accreditation
 - Green - 13-15 months since last accreditation, or only recently commenced Accreditation and making satisfactory progress
 - Amber - 16-18 months since last accreditation
 - Red - 19 or more months since last accreditation or having never accredited

- 1.14 The Chief Nurse and IPC Committee will receive a summary of these quarterly reports, as will Nurse Directors, Lead Nurses, Matrons, Ward Managers and IPC Leads in non-ward based departments
- 1.15 Areas not progressing satisfactorily will be subject to the agreed escalation process. This will involve reporting to the Lead IPC Nurse, Deputy Chief Nurse and Chief Nurse depending on the degree and persistence of non-compliance. Key stages of the escalation process are
- Where records suggest Accreditation is likely to lapse, there is contact with the Ward Manager from a named IPC Nurse Specialist at the time re-Accreditation is due, requesting an action plan within 10 days
 - Monitoring of progress against the proposed action plan
 - Contact with the Matron for an area from the Lead IPC Nurse at 15 months since last Accreditation, with an urgent request for an action plan for recovery
 - Contact with the Lead Nurse for an area from the Lead IPC Nurse at 16 months since last Accreditation, with an urgent request for an action plan for recovery
 - Meeting with the Trust Chief Nurse/Deputy Chief Nurse to discuss lack of progress and agree a clear action plan to achieve re-Accreditation.
 - Any concerns about progress with Antimicrobial Prescribing audits will be escalated by the Antimicrobial Therapy Team via the Directorate Medical Antibiotic Champions.
- 1.16 Where progress towards Accreditation is slow due to IPCT availability issues (either in undertaking audits or reviewing Accreditation paperwork), this will be brought to the attention of the Lead IPC Nurse by the area/department concerned. If problems persist the area/department can contact the DIPC or Deputy Chief Nurse.
- 1.17 When the IPCT undertakes reviews on wards following the detection of clusters of infection, the progress in respect of Accreditation will be investigated and form part of the outbreak report
- 1.18 The Accreditation status of the ward/area will continue to form part of the Trust annual Clinical Assessment Toolkit (CAT) review
- 1.19 The IPCT will publish the latest version of the Accreditation Programme which has been reviewed over the past 18 months
- 2. Saving Lives¹ Toolkit/NICE Infection Prevention & Control Guidance^{2,3,4} EPIC3 National Evidence Based Guidelines for preventing HCAI⁵**
- 2.1 The Saving Lives¹ and Essential Steps⁶ toolkits will be applied at both a trust-wide & directorate level, as appropriate
- 2.2 Application and audit of the High Impact Interventions will be via the Infection Control Accreditation Scheme
- 2.3 NICE infection prevention and control guidance^{2,3,4} will be implemented via the IPC Programme and Infection Control Accreditation scheme.
- 2.4 EPIC3 guidelines⁵ will be implemented via the IPC Programme and Infection Control Accreditation scheme
- 2.5 To strengthen continuous quality improvement and learning, the IPCT will include topical infection prevention and control issues, learning points from root cause analyses and feedback of audit and surveillance results as part of the monthly Infection Control Bulletin.
- 2.6 The review of patient information in respect of invasive devices will continue. This will include what information should be available, whether this currently exists or not, a review of the information itself, determining a system for

ensuring the information is readily available and ensuring staff are aware that such information should be given to patients and relatives, as appropriate.

- 2.7 Following the review of the EPIC3 guidelines⁵, the IPCT will update the Trust 'Infection Prevention and Control Standard Precautions, Prevention of Sharps Injuries and Prevention of Exposure to Blood and Body Fluids Policy' to clarify the use of gowns and the order of removal of personal protective equipment, as per EPIC3⁵ standards SP27 and 32.
- 2.8 The Trust will continue to progress the use of safer sharps devices. The prime responsibility for this lies with the 'Safer Sharps Group' within the Healthcare Governance department. All staff, including the IPCT will participate as appropriate in progressing and implementing this initiative.

3. Health and Social Care 2008⁷, Care Quality Commission

- 3.1 One of the Trust objectives is to be fully compliant with the current version of the Health and Social Care Act 2008⁷. Similarly, the Trust registration with the Care Quality Commission (CQC) requires compliance with their registration standards⁸ including those that relate to infection prevention and control; these mainly relate to Regulations 12 and 15 in the new 2014 standards.
- 3.2 The Deputy Chief Nurse, DIPC, the Lead Infection Control Nurse together with the IPCT will review the Health Act⁷ and the CQC standards⁸ and any issues/actions required to achieve the aforementioned objectives will inform the IPC Programme.
- 3.3 The Trust will continue to work with primary care colleagues to strengthen links between the various healthcare sectors within Sheffield, particularly in respect of infection prevention and control issues.
- 3.4 The Trust will consider the implications for infection prevention and control of the Duty of Candour requirements⁹

4. Ownership at Group/Directorate/Ward level

- 4.1 The Board of Directors, Trust Executive Group (TEG) and DIPC will continue to progress ownership of infection prevention and control at Group, directorate and ward level.
- 4.2 Clinical Directors and Nurse Directors (or equivalent) will ensure that all staff within their Group/Directorate are aware of their responsibilities and accountabilities in respect of infection prevention and control
- 4.3 Clinical Directors and Nurse Directors (or equivalent) will, where appropriate, report concerns they have in respect of infection prevention and control issues to TEG and the Board of Directors on a quarterly basis. The mechanism for this will generally be via the appropriate section of Appendix A or B, as appropriate, of the Performance Assessment form completed by each Group every quarter, see section 4.5e) below.
- 4.4. The IPCT will continue to work with Community Services staff in respect of infection prevention and control issues specific to the various services provided by the Group. This includes responsibility and accountability structures for the management of the estate, maintenance, decontamination, legionella control.
- 4.5 Clinical Directors and Nurse Directors (or equivalent) have responsibility for infection prevention and control at Group/department level. They should:
 - a) Ensure Leads for infection prevention and control at all levels throughout their Group.
 - b) Ensure the engagement of senior and junior medical staff within their area. To this end a consultant will be appointed as the Medical IPC Lead for each Directorate (and sub-directorate as appropriate)

- c) Ensure that infection prevention and control is integrated into the Healthcare Governance structure of the Group/Directorate/department
- d) Be aware of areas of non or partial compliance with the full Trust IPC Programme (not just Infection Control Accreditation) and have a mechanism for identifying these and regularly tracking progress towards addressing them. The quarterly returns may be used for this purpose or a standalone Directorate/department action plan may be appropriate depending on the department concerned and the issues that need addressing.
- e) Review progress in respect of the IPC Programme on a quarterly basis. A completed Performance Assessment form (Appendix A or B as appropriate) should be returned to the DIPC on a quarterly basis as follows: by 6th July 2015, 5th October 2015, 11th January 2016 and 4th April 2016. Generally these returns are submitted by the Nurse Director. However, the Clinical Director(s) should also agree and endorse these returns. The sections relevant to medical staff should be completed by an appropriate member of the medical staff e.g. the Clinical Director or the Medical IPC Lead(s) for the area(s) concerned.
- f) Where appropriate use the annual summary section of the performance assessment form as a Report of the Group/ department's activities and progress in respect of their IPC Programme and return this to the DIPC as part of the 4th quarter Performance Assessment Form – see final page of Appendix A or B respectively
- g) Ensure that infection prevention and control is a regular agenda item at Directorate Healthcare Governance and Risk Management meetings and that medical colleagues are included and active in this area of patient care. The issues discussed and minuted should include progress in relation to Infection Control Accreditation, issues raised from audits carried out in response to clusters of infection and areas for improvement detected by surveys, audits, RCAs, complaints etc.
- h) Ensure that the monthly MRSA and *C.difficile* data, sent out by the IPCT within the Infection Control Bulletin is reviewed at directorate and ward/department level and action taken where data shows that cases have arisen in those areas. News, alerts and lessons to learn should be noted and actioned, as appropriate.
- i) Ensure that all staff engage fully when the IPCT deem that reviews are required, in particular when episodes of MRSA bacteraemia or clusters of cases of MRSA or *C.difficile* occur. See sections 6.13, 7.21 to 22 and 8.15 to 19 below. MRSA bacteraemia data and data on clusters of infections occurring on wards e.g. *C.difficile*, MRSA, norovirus etc. should be reported and discussed at the Directorate Healthcare Governance and Risk Management meetings

4.6 Clinical Directors and Nurse Directors (or equivalent) should ensure that the following infection prevention and control related policies, procedures and guidance are implemented in all wards/departments, as appropriate. The documents can be accessed via the Infection Control web-page <http://www.sth.nhs.uk/NHS/InfectionControl/> and click on 'Clinical Guidelines and Polices' tab on the left hand side of the page.

As a minimum each ward/department should review the documents listed in section 4.8

- a) When the document is initially published and
- b) When the document is reviewed/updated and re-published – this is usually every 3 years. Some documents may be reviewed and updated within the three year time period if significant changes occur that necessitate an earlier update.

The Trust Controlled Documents Group will alert Groups/Directorates when a document has been published or updated. The IPCT will also bring these documents to the attention of staff via the monthly Infection Control Bulletins.

In addition to the official reviews mentioned above, a number of key infection prevention and control related documents should be reviewed annually to ensure ongoing full local implementation regardless of whether an official review/update has taken place – see section 4.7.

It is the responsibility of Clinical Directors and Nurse Directors (or equivalent) to ensure that all relevant aspects of the documents below are being followed in their area(s); how this is achieved is at their discretion. However, it would seem reasonable to suggest that a senior person within each Group/ Directorate reviews the document as a whole to note which aspects of the document are relevant to the wards/ departments in the Group and where action is needed to ensure full implementation at a local level. Merely noting any changes made to the documents at the three yearly review may miss the fact that key aspects of the documents have not been implemented previously, especially if services have changed or been reconfigured since the last review.

- 4.7 The following documents should be reviewed annually at Group/ Directorate level to ensure ongoing full local implementation in addition to being reviewed when initially published or re-published after an official review:
- I. Infection Prevention and Control Standard Precautions, Prevention of Sharps Injuries & Prevention of Exposure to Blood/Body Fluids
 - II. Hand Hygiene Policy
 - III. Infection Control Patient Placement Policy
 - IV. MRSA Policy
 - V. *C.difficile* Policy
 - VI. Carbapenemase-producing multi resistant Gram negative bacteria Policy
 - VII. Norovirus Policy
 - VIII. Suspected infective diarrhoea Policy
 - IX. Influenza information
 - X. Antibiotic prescribing policies
 - Antibiotic prescribing guidelines
 - Antibiotic review policy
 - Restricted antibiotic policy
 - Chest infection and Pneumonia guidelines/bundle
 - XI. Management of central IV line policy
 - XII. Management of peripheral IV line policy
 - XIII. Bladder management and Urinary Catheterisation policy
 - XIV. Aseptic technique
 - XV. Policy for taking blood cultures

4.8 i) The following documents should be reviewed to ensure local implementation when initially published and when re-published after an official review or if otherwise prompted by the IPCTm via the Infection Control Bulletins.

ii) Some of the policies/guidelines below may be particularly key for certain areas/ departments and Clinical and Nurse Directors may determine that these should also be reviewed annually (in addition to those in section 4.7) for their areas regardless of any official review:

- XVI. GRE Policy
- XVII. SARS/Avian Influenza/SRINIA Policy
- XVIII. CJD Policy
- XIX. Tuberculosis Policy
- XX. Chickenpox
- XXI. Hazard Group 4 Pathogens including Ebola/Viral Haemorrhagic Fever Policy
- XXII. Scabies
- XXIII. Lice, Fleas and Bed Bugs
- XXIV. Anthrax
- XXV. Smallpox
- XXVI. Legionella Control and Management including Tap Flushing
- XXVII. Birthing Pools
- XXVIII. Hydrotherapy Pools
- XXIX. Drinking Water Coolers
- XXX. Ice machines
- XXXI. Infection control policy for the Care of the Deceased Patient
- XXXII. Guidelines for completing death certification in respect of MRSA, *C.difficile* and other healthcare associated infections
- XXXIII. Statutory notification of Infectious diseases
- XXXIV. Linen Policy
- XXXV. Bed and Mattress Cleaning Protocol
- XXXVI. Decontamination Policy
- XXXVII. Animals and Pets in Hospital
- XXXVIII. Computer keyboards and equipment cleaning guidelines
- XXXIX. Management of occupational exposure to blood borne viruses and post-exposure prophylaxis
- XL. Guidelines for the Management of Healthcare Workers with Infections

4.9 For areas of the Trust not covered by the Clinical Groups e.g. do not have a Nurse Director, a senior individual e.g. the Lead for Healthcare Governance will be identified as the 'Lead for Infection Prevention and Control' and have responsibility for ownership, implementation and review of progress of the department in respect of the IPC Programme. The DIPC will be notified of the name of this individual. These areas are:

- Clinical Research Facilities
- Community Services
- Discharge Lounge
- Estates
- Hotel Services
- Laboratory Medicine
- Medical Imaging & Medical Physics
- Occupational Health
- Pharmacy
- Professional Services

5. Audit and Review

- 5.1 Review of progress in respect of the IPC Programme will take place as follows:
- a. Nurse Directors will complete a Performance Assessment form (Appendix A) on a quarterly basis (by 6th July 2015, 5th October 2015, 11th January 2016 and 4th April 2016) and return this to the DIPC within two weeks of these dates at the latest.
 - b. The Clinical Director(s) (or equivalent) should agree and endorse the quarterly returns. The sections relevant to medical staff should be completed by an appropriate member of the medical staff e.g. the Clinical Director or the Medical IPC Lead(s) for the area(s) concerned.
 - c. The DIPC will review the completed forms and code Group progress as Blue, Green, Yellow, Amber or Red. Progress will be reviewed quarterly at the IPCT and IPC Committee meetings. The DIPC will also report progress quarterly to the Healthcare Governance Committee.
 - d. Where Progress is coded as
 - Blue/Green/Yellow: No action will be taken; progress will continue to be monitored
 - Amber: Repeated Amber status will prompt one of the IPCT to meet with the appropriate Nurse Director to discuss the situation
 - Red: One Red status coding will prompt one of the IPCT to meet with the appropriate Nurse Director to discuss the situation
Two Red status codings will require the Nurse Director to report in person to the Infection Control Committee to explain the situation
 - e. A similar process using Appendix B will apply to non clinical areas (Clinical Research Facilities, Community Services, Discharge Lounge, Estates, Hotel Services, Laboratory Medicine, Medical Imaging & Medical Physics, Occupational Health, Pharmacy, Professional Services)
 - f. The Lead Infection Control Nurse will review progress in relation to the IPCT Programme quarterly and report the results to the DIPC using Appendix C. Similarly the DIPC will complete Appendix D on behalf of the Board of Directors, TEG, Chief Nurse's Office and DIPC in respect of strategic and corporate issues.
- 5.2 The Chief Nurse's Office, DIPC and IPCT will review the Trust position in relation to the infection prevention and control related standards within the Care Quality Commission Registration Standards⁸ at the request of the Trust Healthcare Governance department.
- 5.3 The DIPC will provide data as requested by the Healthcare Governance Team to inform the Trust Integrated Performance Dashboard.
- 5.4 Audits will be carried out as required within the revised Infection Control Accreditation Scheme. These include audit of:
- a) Hand hygiene
 - b) Dress Code
 - c) Commode cleanliness and repair
 - d) Cleanliness
 - e) Standard Precautions
 - f) Aseptic technique
 - g) Mattress audit
 - h) Linen handling audit
 - i) Antibiotic Prescribing

- j) MRSA screening
- k) High impact interventions as outlined in the Saving Lives toolkit
 1. Central venous catheter care
 2. Peripheral intravenous cannula care
 3. Renal haemodialysis catheter care
 4. Prevention of surgical site infection
 5. Care bundle to reduce ventilated associated pneumonia
 6. Urinary catheter care
 7. Reducing the risk of *Clostridium difficile*
 8. Cleaning and decontamination of clinical equipment

Audits may be added, removed or revised if significant changes become necessary during the year.

- 5.5 Audit of compliance with MRSA screening protocols.
 - a) The DIPC will review monthly the number of screens received by the Trust laboratories and relate this to the number of patients who should be being screened; patient episode data will be obtained from the information department. This information will be sent to commissioners as appropriate.
 - b) The IPCT will undertake MRSA screening compliance audits as per the agreed programme. High risk areas are audited twice a year and medium and low risk areas once a year. Where compliance is unsatisfactory repeat audits are undertaken in the following weeks. The results of the audits are distributed to the areas audited and reviewed monthly at the IPCT meeting. The aim will be to undertake most of this activity outside of the busy winter period. Where an audit falls during the busy winter period, some delay may occur but the audit will be undertaken as soon as possible as work load allows.
- 5.6 The IPCT and Microbiology department will undertake an annual audit of
 - i) peripheral cannula and ii) urinary catheter use and documentation across the Trust. The audits will be undertaken in a staggered manner over a one month period and be carried out in conjunction with members of the Catheter-Acquired Urinary Tract Infection (CAUTI) Group.
- 5.7 Audits of peripheral cannula use may also take place in response to clusters of MRSA/ MSSA infection or MRSA/MSSA bacteraemia depending on the circumstances of the incident. See section 7.30 below.
- 5.8 A review of the audit findings, mentioned in section 5.6, will be undertaken by the IPCT and CAUTI Group, respectively. Areas requiring educational input, more frequent audits etc. will be identified and appropriate interventions progressed.
- 5.9 The Trust (including certain services within the Community Services Group) will continue to participate in the NHS Safety Thermometer Programme¹⁰. This includes collecting information on patients who have a urinary catheter *insitu* and who are being treated for a urinary tract infection. Data will be collected by ward and Community Services staff. See also sections 13.15 and 13.16.
- 5.10 Internal audit will undertake an audit of Directorate compliance with the requirements of sections 4.5g) and 8.23 of this Infection Prevention and Control Programme
- 5.11 The IPCT will review progress in relation to the review and updating of infection prevention and control related policies/guidelines at the monthly JICT meeting. Policies/guidelines will be reviewed at least every three years although more frequent review will be undertaken as necessary.

- 5.12 The IPCT will continue the major review of the Infection Control Guidelines to separate out the many polices/guidelines within the existing single large document; the aim if for the review to be completed by March 2016.
- 5.13 The IPCT will produce, review, approve and ratify infection prevention and control related policies/guidelines as per Trust requirements in this regard.
- 5.14 The IPCT will produce an Equality Impact Analysis (EIA) for each of the infection prevention & control related policies/guidelines. This will generally be undertaken at the time of production/review of the document.

Particular actions/ issues within the above policies/protocols for wards/ departments to review this year and ensure are taking place:

- 5.15 All areas should ensure that patients are screened for MRSA as per the MRSA screening protocols within the Trust MRSA Guidelines, see sections 7.1-3.
- 5.16 All areas should ensure that patients with *C.difficile* diarrhoea are reviewed daily by their clinical teams and that where patients are deteriorating the IPCT is made aware of this, see section 8.2.
- 5.17 Appropriate 'Point of Access' areas should ensure that a SRINIA/SARS/Avian Influenza Personal Protective Equipment (PPE) box is readily available and that the contents are as listed in the SRINIA/SARS/Avian Influenza Policy. See Section 6 and Appendix L of the Trust SRINIA/SARS/Avian Influenza policy. These boxes can be used for any highly infectious pathogen as well as SARS etc. e.g. Cat 4 pathogens

Current 'Point of Access' areas are:

- A&E NGH
- MAU 1, 2 & Frailty Unit NGH
- SAC NGH
- Minor Injuries Unit RHH
- Infectious Diseases unit RHH

'Points of access' may be added or removed throughout the year, as the functions of these areas change

- 5.18 All areas should ensure that infrequently used water outlets are flushed daily, see section 15.24 below, and this is recorded and available for auditing purposes. The Estates department will develop a programme for auditing this activity and centrally recording the results.
- 5.19 All areas should ensure that patients who have a peripheral IV cannula *insitu*
 - a) Have the insertion documented
 - b) Have the cannula site reviewed at least daily
 - c) Have appropriate action taken in light of the daily review
as per the Management of peripheral cannula guidelines, see section 13.3.
- 5.20 All areas should ensure that staff taking blood cultures do so as per the 'How to take a Blood Culture' guidelines
- 5.21 All areas will ensure that patients are screened for CJD using the questions and process laid out in Section 2 of the Trust 'Creutzfeldt-Jacob Disease and Related Disorders: Safe Working and the Prevention of Infection' policy. This includes patients undergoing both elective and emergency procedures.

6. Surveillance

- 6.1 The Trust will aim to achieve the *C.difficile* diarrhoea target as set by NHS England. The Trust will participate in any other HCAI related DH/CQUIN objectives/modules as and when these are published.
- 6.2 The Trust will continue to participate in all DH Mandatory Surveillance Schemes:

- a) MRSA bacteraemia
 - b) MSSA bacteraemia
 - c) *C.difficile* diarrhoea in patients 2 years of age or older
 - d) Wound infections in orthopaedic surgery
 - e) *E.coli* bacteraemia
- 6.3 The IPCT will enter data on to the HCAI Data Capture System as per DH guidelines
- 6.4 The DIPC, Operational Infection Control Doctors and Chief Nurse's Office will continue to develop systems to optimise the input of data into the HCAI Data Capture System in the absence of the DIPC. This will include any necessary training should the updated database be introduced during 2015/16
- 6.5 The IPCT will continue to use the bespoke Infection Control surveillance (ICS) system
- 6.6 The IPCT and Trust will continue to optimise the ICS system as and when necessary.
- 6.7 The IPCT will continue to work with the Trust to optimise the flagging of patients with MRSA, *C.difficile* etc. on the Trust patient management systems e.g. Patient Centre, Electronic Patient Record
- 6.8 The IPCT will continue to undertake surveillance of bacteraemia caused by Meticillin Sensitive and Resistant *Staphylococcus aureus* (MSSA & MRSA), Glycopeptide resistant enterococcus (GRE) and Extended Spectrum Beta-lactamase (ESBL) producing *E.coli*
- 6.9 Each week the IPCT will review a 12 week rolling summary of all Trust attributable *C.difficile* episodes and MRSA acquisitions to help identify clusters of infection/colonisation at an early stage and enable pre-emptive action to be taken.
- 6.10 The IPCT will continue to produce the monthly Infection Control Bulletin. This includes important infection prevention and control messages and updates and a summary of MRSA colonisation/infection and *C.difficile* diarrhoea data. This will be sent out to all General Managers, Clinical & Nurse Directors, Medical IPC Leads, Matrons, Ward Managers, Lead Nurses, the IPCT and the Central Nursing and Medical Director's Offices, see also section 2.5.
- 6.11 The IPCT will undertake clinical reviews of patients as appropriate for the organisms concerned and the clinical situation of the patient. The frequencies the team aspires to work to is as follows:
- Active *C.difficile* infection - 3 x week
 - *C.difficile* infection where the patient has clinically recovered and finished treatment within the last 14 days - 2 x week
 - Previous *C.difficile* infection where the patient is asymptomatic but on antibiotics for whatever reason - 2 x week
 - Previous *C.difficile* infection where the patient is asymptomatic and not on any antibiotic treatment - 1 x week
 - Ongoing MRSA infection/colonisation and receiving MRSA treatment and considered at high risk of infection (i.e. critical care//infection, invasive devices *insitu*) - 2/3 x week
 - Ongoing MRSA infection/colonisation and receiving MRSA treatment - 2 x week
 - Previous MRSA infection/colonisation but less than 3 negative screens - 1 x week but may be seen more if the patient has invasive devices *insitu*, is in a critical care unit or if a visit is required to request rescreens are undertaken
 - Previous MRSA infection/colonisation but has had 3 negative screens, and has no intravenous lines in situ – 1x week

- Patients with other alert organisms or conditions e.g. Tuberculosis/ Group A Streptococcus/Campylobacter, CPE etc. - 1x week but this will be varied on a case by case basis
 - Norovirus outbreaks- daily
- 6.12 When clusters/outbreaks of infection occur within the Trust Intermediate Care facilities, IPCT member provide appropriate support in detecting, controlling and managing the incident. The Team aim, this year, to increase the on-site visits associated with this support.
- 6.13 Clusters of MRSA and *C.difficile* diarrhoea and single episodes of MRSA bacteraemia will be investigated as appropriate by the IPCT; see sections 8.15-19 and 7.21-22 below. Bacteraemia episodes caused by organisms other than MRSA or non-bacteraemia infections/clusters caused by any organism may also be investigated as determined by the IPCT. A summary of these episodes/ clusters will be recorded, as will the results of any reviews undertaken and actions advised. The format of these summaries will differ depending on the episode/cluster.
- 6.14 An escalation process similar to that detailed in section 1.15 will be enacted for the rare occasions where the reviews undertaken, and the advice given, by the IPCT are not followed by satisfactory improvement and progress.
- 6.15 The IPCT will continue to work with the Chief Nurse's Office to progress the Trust infection surveillance strategy, in particular the surveillance of surgical site infection (SSI). This will include possible expansion of the current surveillance team, as resources permit.
- 6.16 The IPCT will work with the Chief Nurse's Office to prioritise activities within SSI surveillance based on known or suspected infection rates/risks, within the resources made available to the Team.
- 6.17 The Infection Control Operational Group (ICOG) will meet at least monthly to review progress in respect of key infection prevention and control issues and ensure progress is being made and maintained. Membership of this Group consists of the DIPC, Deputy Chief Nurse, Lead IPC Nurse, Antibiotic Pharmacist, Hotel Services representative, Estates representative and the Operational Infection Control Doctors
- 6.18 The IPCT will continually be alert to and look out for infection prevention and control initiatives emanating from the DH and other professional bodies; in particular initiatives from the Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection¹¹ (ARHAI).

7. *Staphylococcus aureus* (MRSA and MSSA)

MRSA

Screening for MRSA:

- 7.1 The Trust protocols for screening reflect DH requirements taking into account local experience. The DH requirements regarding MRSA screening were updated during 2014¹². The updated guidelines allow trusts more freedom in determining their own screening protocols based on risk assessments and local experience. Following review of this guidance, the IPCT determined that STH protocols should remain largely unchanged, thereby exceeding the current DH requirements.
- 7.2 All departments will ensure that patients are screened for MRSA as per these STH protocols. Any changes to these protocols should be agreed with the IPCT. See Trust Guidelines for the Control of MRSA.
- 7.3 Audit of compliance with these protocols will be undertaken by the IPCT; see Audit Section above.

Managing patients colonised or infected with MRSA

- 7.4 The Trust has MRSA Nursing Care Guidelines for managing patients colonised or infected with MRSA. These Guidelines will be used to manage all patients colonised/infected with MRSA. Should any local variation to this pathway be necessary, this should be agreed with the IPCT
- 7.5 Patients found to be colonised or infected with MRSA will receive appropriate topical treatment, started within 24 hours of the IPCT advising clinical staff of the treatment required (including weekends and bank holidays) and be applied thoroughly and consistently
- 7.6 The IPCT will continue to develop and implement MRSA management pathways covering both the acute and community sectors of a patient's care
- 7.7 The IPCT will continue to work with primary care colleagues to optimise decolonising patients in the community, where this is appropriate
- 7.8 In agreement with NHS Sheffield, the Trust will continue to implement the pathway for managing patients found to have MRSA at pre-assessment to ensure the risk of infection is reduced to a minimum in these patients and where possible their treatment continues without unnecessary delay.
- 7.9 Patients with a history of MRSA who require quinolone (usually ciprofloxacin) therapy should have topical MRSA therapy until 48 hours after the quinolone has been stopped.
- 7.10 Patients with MRSA should preferably be nursed in single rooms. If this is not possible, the Infection Control Patient Placement guidelines will be followed e.g. patients with nasal carriage only may be managed with barrier precautions in a bay
- 7.11 A Datix incident form will be completed whenever a single room is required and is unavailable

MRSA Communication

- 7.12 Where a patient colonised/infected with MRSA is being transferred to, between or within a healthcare facility, their MRSA status will be communicated to the receiving party by the staff in the department sending the patient. This includes patients going to radiology, operating theatre etc.
- 7.13 MRSA results will be communicated by the microbiology department to Infection Control and clinical staff in a timely manner as per agreed protocols
- 7.14 Infection Control staff will communicate MRSA results, advice and paperwork to clinical staff in a timely manner. Discussions and the patient status will be clearly documented in patient and IPCT records, as appropriate.
- 7.15 The IPCT will continue to work with colleagues within the acute, community and primary care sectors to communicate information and make referrals between the Teams. The systems take into account the need for confidentiality and information security.
- 7.16 The IPCT will work with primary care colleagues to optimise communication of MRSA results for patients discharged with (or with a history of) MRSA colonisation or infection. This includes patients whose MRSA status was known to the IPCT prior to discharge and those where this comes to light after discharge. In this later situation, this will include sending a letter to both the patient and the patient's GP informing them of the results and the need for an assessment to be made to determine appropriate future management.

Management MRSA and intravenous lines:

Patients colonised with MRSA have an increased risk of bacteraemia if they have a peripheral, arterial or central intravenous catheter *insitu*.

- 7.17 Such lines must be managed as per the Trust Peripheral and Central Intravenous Line Care guidelines and DH Care Bundles at all times
- 7.18 See 'Management of Peripheral and Central intravenous cannulae' section below for MRSA screening of patients having central lines inserted and for topical therapy for patients with central lines *insitu* who also have MRSA.

MRSA target

- 7.19 There are currently no national targets/objectives for MRSA bacteraemia. However, the Commissioners can impose a £10k fine for episodes of care where a trust attributable MRSA bacteraemia occurs.
- 7.20 The Trust will continue to take, a zero tolerance approach to episodes of avoidable MRSA bacteraemia

Management of episodes of MRSA bacteraemia and MRSA clusters

- 7.21 Episodes of MRSA bacteraemia will be handled as Clinical Incidents and a review held using the DH Post Infection Review (PIR) tool.
- These meetings will involve one of the Infection Control Doctors and Infection Control Nurses plus a senior Nurse from the area looking after the patient and a senior clinician, preferably the patient's consultant or GP. Participation at these meetings is a priority strongly supported by the Chief Nurse and Medical Director.
 - Initial meetings/discussions should be held as soon as possible (within 48 hours) to ensure any urgent actions required are determined and undertaken. A PIR meeting should ideally take place within one week although attendance of appropriate senior personnel is more important than a quick meeting without them present.
 - Any actions identified should be acted upon within an agreed time frame. On the rare occasions where satisfactory improvement/progress does not occur, the escalation process mentioned in section 6.14 will be followed.
 - A report of the meeting should be sent to the DIPC and be reviewed by the IPCT as regards whether wider action across the Trust is required and to share learning in a constructive manner.
 - The Clinical Commissioning Group will be informed of episodes of MRSA bacteraemia, as they occur, and be provided with a summary of the PIR
 - PIR results will be uploaded onto the DH HCAI database as appropriate, when this is available
- 7.22 Clusters of hospital acquired MRSA infections or carriage will be logged by ward and the data reviewed at least every 2-3 days. Wards will be coded as Red if 4 or more new cases occur within an 8 week rolling period or if 2 cases occur within a 7 day rolling period. Wards will be coded as Amber if 2 or 3 new cases occur within an 8 week rolling period.

MRSA staff screening and management

- 7.23 The IPCT and Occupational Health staff will work together to update the Trust policy for the MRSA screening of staff and the management of staff found to be colonised or infected with MRSA.

MSSA

MSSA is carried by approximately 30% of the population and most infections are due to organisms already carried by the patient, although cross infection from other patients and staff can also occur. Preventing infection with MSSA therefore requires a variety of interventions many already mentioned elsewhere in this document.

However, all the planned actions/interventions are summarised in this Section to enable a complete picture to be gained of the activities designed to combat infection with this organism.

Optimising Infection Prevention and Control practice

- 7.24 All inpatient and operating theatre areas will gain and maintain Infection Control Accreditation. This includes compliance with the aseptic technique audit tool, hand hygiene audit tool and peripheral IV cannula care bundle – see Section 1

Monitoring

- 7.25 The likely source of cases of Trust Attributable MSSA bacteraemia episodes will be determined on a monthly basis by the Infection Control Doctors i.e. cannula, wound infection etc. Where trends or patterns are noted, the IPCT will discuss this with the appropriate Clinical Director and any necessary actions agreed. This information will also form part of the annual summary mentioned in section 7.38
- 7.26 MSSA bacteraemia is one of the Nurse Sensitive Indicators; this is to help identify areas having excess cases to enable actions to be taken to prevent further episodes.
- 7.27 The Trust will aim for an in-house target of 42 or less episodes of Trust attributable MSSA bacteraemia during 2015/16 – See section 6.2b)

Peripheral cannula care

- 7.28 All inpatient areas should aim to have fully completed peripheral cannula charts for 100% of their patients. Alternative documentation pathways are acceptable, as long as these are standardised, have at least the same level of detail as the charts, are readily available and are equally well completed.
- 7.29 Communication regarding the care of peripheral intravenous cannulae will be widely circulated as a reminder of good practice - see section 2.5.
- 7.30 The IPCT and Microbiology department will undertake an annual audit of peripheral cannula use and documentation across the Trust. The audits will be undertaken in a staggered manner over a one month period. Audits may also take place in response to clusters of MRSA/MSSA infection or MRSA/MSSA bacteraemia depending on the circumstances of the incident. See sections 5.6 to 5.8.

Central Lines

- 7.31 The patient safety programme to reduce central venous catheter infections will continue in General, Neurosciences and Cardiac Critical Care units
- 7.32 The use of TauroLock in the Renal unit will continue
- 7.33 The IPCT will continue to work with Haematology to investigate the benefits of peri-insertion decolonisation treatment in reducing the rate of catheter related sepsis in this patient group – see sections 13.11 and 18.2

Wound infections

- 7.34 The mandatory surveillance of surgical site infections within the Orthopaedic Directorate will continue – see section 6.2d).
- 7.35 Surgical site surveillance in other specialities e.g. neurosurgery, cardiothoracic surgery will continue as resources allow. Prioritisation of the available resource will be made by ICOG in conjunction with the surveillance team.

- 7.36 The surveillance of surgical site infections programme will continue and expand as and when possible – see section 6.15 and 6.16.

MSSA case follow through and actions

- 7.37 Cases of Trust attributable MSSA bacteraemia will be subject to a root cause analysis at the discretion of the appropriate Infection Control Doctor. This decision will be based on the circumstances of the case and any trends in MSSA infections in the area concerned.
- 7.38 The Infection Control Doctors will produce an annual e-mail summary of the number of MSSA bacteraemia cases recorded and a summary of actions required to prevent further cases. This will be sent to Clinical Directors, Medical IPC Leads, Nurse Directors, Deputy Nurse Directors and Matrons. This e-mail may be sent more frequently depending on the number and circumstances of cases detected each month.

Directorate specific actions

- 7.39 The IPCT will continually review all cases of MSSA bacteraemia and determine if there are Directorates where specific action needs to be taken. Appropriate discussions and action plans will be developed with these areas.
- 7.40 For surgical directorates the issues likely to be reviewed and addressed where necessary are:
- Standards of behaviour conduct and clinical practice within the theatre complex
 - Unnecessary clutter within the operating theatre
 - Ventilation parameters and air quality within the theatre
 - Antibiotic prophylaxis
 - Skin preparation
 - Strict control of entry of personnel into the theatre
 - Learning from colleagues in other similar trusts with lower rates of MSSA bacteraemia
 - Pre-operative screening for MSSA carriage and treatment where positive
 - Pre-emptive treatment for MSSA carriage for emergency cases whilst awaiting admission swab results
 - Practicalities of ensuring decolonisation treatment is prescribed and administered promptly
 - Post-operative wound care protocol
 - Wound closure protocol
 - Surgical site infection surveillance
- 7.41 For non-surgical directorates the issues likely to be reviewed and addressed where necessary are:
- Care of peripheral intravenous cannulae, in particular the documentation of insertion and on-going review – aim for 100% of peripheral intravenous cannulae in place to have fully completed peripheral intravenous cannula charts. Alternative documentation pathways are acceptable, as long as these are standardised, have at least the same level of detail as the charts, are readily available and are equally well completed.
 - The insertion location of any intravenous cannula implicated in an MSSA bacteraemia i.e. possible association with any particular clinical area or in ambulance prior to admission
 - Changing cannula if patients admitted from elsewhere

Screening for MSSA:

- 7.42 In some clinical situations MSSA screening may be part of an overall MSSA action plan. The IPCT will work with appropriate Directorates to determine if MSSA screening may be of benefit and options for progressing this.
- 7.43 For 2015/16, the IPCT and Renal Directorate will roll out MSSA screening for certain patient groups within this area.

8. *Clostridium difficile*

C.difficile Nursing Care Guidelines:

The Trust has *C.difficile* Nursing Care Guidelines for managing patients infected with *C.difficile*. These guidelines take into account the recommendations in the DH '*C.difficile* Infection; How to Deal with the Problem'¹³

- 8.1 These Guidelines will be used to manage all patients with *C.difficile* diarrhoea. Should any local variation to this pathway be necessary this should be agreed with the IPCT.
- 8.2 All areas should ensure that patients with *C.difficile* diarrhoea are reviewed daily by their clinical teams and that where patients are deteriorating the IPCT are made aware of this

Patient Placement

- 8.3 Unless an infective cause has been excluded, patients with diarrhoea should preferably be nursed in single rooms. If this is not possible, the Infection Control Patient Placement guidelines will be followed
- 8.4 A Datix incident form will be completed whenever a single room is required and is unavailable
- 8.5 The Trust will continue to operate the *C.difficile* Enhanced Therapy unit on Robert Hadfield 5. Where clinically appropriate patients with *C.difficile* infection will be transferred to this unit.

Communication

- 8.6 Where a patient infected with *C.difficile* is being transferred to, between or within a healthcare facility, their *C.difficile* status will be communicated to the receiving party by the staff in the department sending the patient. This includes patients going to radiology, operating theatre etc.
- 8.7 *C.difficile* results will be communicated by the microbiology department to the IPCT and or clinical staff in a timely manner as per agreed protocols
- 8.8 IPC staff will communicate *C.difficile* results, advice and paperwork to clinical staff in a timely manner.

Control of antimicrobial therapy

Control of the amount, type and duration of antimicrobial prescribing is known to be one of the key activities in controlling *C.difficile* infection and in reducing the likelihood of antibiotic resistance developing.

- 8.9 The IPCT, Microbiology staff and the Antimicrobial Pharmacists will continue to develop and implement initiatives aimed at effectively achieving this within the Trust. These include:
 - a. Reviewing on a rolling basis all trust-wide and directorate specific antimicrobial policies
 - b. Overseeing the rolling audit programme of compliance with antimicrobial treatment policies

- c. Auditing antibiotic prescribing on wards where a Red or Amber *C.difficile* cluster has been detected (see section 8.15 below) or as asked for by the IPCT.
 - d. Daily/weekly specialist review ward rounds of prescribing including the type, dose, duration and route of administration of the antimicrobials used e.g. ITUs, SCBU etc.
 - e. Continuing review of the Restricted Antibiotic Policy
 - f. Overseeing the quarterly Antibiotic Prescribing Care Bundle audits as part of the Accreditation Programme: Audits will take place quarterly on each ward and be undertaken by ward based medical staff. Results will be sent to the antibiotic pharmacists for review, analysis. Whether audits have been undertaken or not will be included in the assessment as to whether a ward can achieve Infection Control Accreditation or not. The DIPC will also take this into account when scoring Directorates for quarterly compliance against the IPC Programme
 - g. Giving feedback to wards on the results of the quarterly ward based audits
 - h. Sending out quarterly reports of antibiotic usage to Directorates
 - i. Uploading the aforementioned audit and usage data onto the Antibiotic web-site
 - j. Participating in the development and implementation of the e-prescribing system within the Trust. Amongst other benefits this should help highlight where long or unusual antibiotic prescriptions are being used.
 - k. Auditing compliance with the Chest Infection Guidelines/Bundle
- 8.10 The IPCT, Microbiology staff and the Antimicrobial Pharmacists will continue to investigate the appropriateness of advice given regarding the use of antibiotics for long term UTI prophylaxis and where this emanates from
- 8.11 The Trust will work with the primary care colleagues to optimise antimicrobial prescribing within the community
- 8.12 Where resources allow, audit of antibiotics prescribed in the community to patients who develop *C.difficile* infection will continue to be undertaken.

Cleaning and environment issues

- 8.13 Details of general cleaning issues can be found in Section 15
- 8.14 The following are specific initiatives aimed at preventing and controlling *C.difficile*. These will require input and co-operation from a range of professionals including nursing, managerial and domestic services staff.
- a) Following the identification of a patient with *C.difficile* in a bay, the area to be cleaned will include, not only the patient's bed space, but the rest of the bay, the ward toilets, commodes, seat raisers, sluice and nurse's station
 - b) Staff should be particularly vigilant when managing cases caused by the O27 strain and wherever possible hydrogen peroxide misting of the areas listed in section 8.14a) should be carried out. It is recognised that this may not always be possible.
 - c) The rolling programme of deep cleaning and hydrogen peroxide misting of wards and departments will continue. The frequency of this will be determined by the risk of *C.difficile* contamination and any clusters of cases associated with the area. The aim is to clean all wards at least once a year, and certain high risk wards/departments, two to three times a year.
 - d) Routine cleaning of the environment and patient equipment will be undertaken using a detergent/ disinfectant product; Chlorclean or Difficil-S depending on the ward concerned

- e) The programme of radiator cover removal and cleaning will take place annually on all wards prior to the heating being switched on in the autumn
- f) The IPCT will continue to undertake commode inspections as part of the Accreditation programme. More frequent inspections may be required should concerns be noted during Accreditation audits or at reviews undertaken by ward in response to individual *C. difficile* cases

Management of *C. difficile* clusters

- 8.15 Episodes of *C. difficile* diarrhoea will be logged by ward and the data reviewed at least every 2-3 days. Wards will be coded as Red if 4 or more new cases occur within a 28 day rolling period or if 2 cases occur within a 7 day rolling period. Wards will be coded as Amber if 2 or 3 new cases occur within a 28 day rolling period.
- 8.16 Samples from *C. difficile* clusters will be sent for ribotyping to aid investigation and management of the situation
- 8.17 Wards coded as Red or Amber will be reviewed at least weekly by the IPCT in respect of ward cleanliness, infection control and hand hygiene. A summary of the episode and review findings will be logged by the IPCT and distributed to staff responsible for the areas concerned, as well as to the DIPC and the Chief Nurse's Office.
- 8.18 On the rare occasions where these reviews are not followed by satisfactory improvement and progress, the escalation process mentioned in section 6.14 will be used
- 8.19 *C. difficile* clusters will be reviewed and monitored via the Trust's Serious Untoward Incidents process. Where appropriate these incidents will be escalated to the PCT and SHA. The definitions used for this process have been agreed and are based on those recommended in the DH '*C. difficile* Infection; How to handle the problem'¹³ document.

Other issues i.e. targets, testing, monitoring

- 8.20 The Trust will aim to achieve the *C. difficile* targets/objectives for STH attributable *C. difficile* episodes as determined by NHS England
- 8.21 The Microbiology department will continue to provide a 7 day a week *C. difficile* testing service
- 8.22 A root cause analysis (RCA) will be undertaken by the clinical teams for each Trust attributable *C. difficile* episode using the STH *C. difficile* RCA tool. The clinical teams should discuss the results of the RCAs at their healthcare governance and risk meetings and observations and any actions required should be noted in the meeting notes. Follow up of any actions required should be discussed and noted at following meetings.
- 8.23 The completed RCA should be returned to the Infection Control Doctor for the campus concerned to enable, where appropriate, wider lessons to be learnt. Feedback from the discussions held at the healthcare governance and risk meetings and on the actions required and undertaken should also be provided to the relevant Infection Control Doctor. The feedback to the Infection Control Doctors should occur even if no actual actions are required.
- 8.24 An assessment as to whether each Trust Attributable *C. difficile* episode was Avoidable or Unavoidable (Lapse of Care identified or No Lapse of Care identified) will be made by the appropriate Infection Control Doctor for the area concerned. The RCAs and feedback outlined in sections 8.22 and 8.23 will be key to this assessment. These assessments will be forwarded to Sheffield CCG on a quarterly basis and used as a key indicator within the CCG's performance management of the Trust.

- 8.25 A weekly e-mail will be sent out summarising the *C.difficile* situation for that week and the overall position for the reporting year. This will be sent to Clinical Directors, Medical IPC Leads, Nurse Directors, Matrons, Lead Nurses, the Chief Executive's Office, the Medical Director's Office, the Chief Nurse's Office and the IPCT.
- 8.26 The IPCT will continue the process for replacing the hydrogen peroxide misting machines, as appropriate based on their use and functionality
- 8.27 The Trust will participate in appropriate *C.difficile* related studies – see Section 18.

9. Gram Negative organisms

Pseudomonas

- 9.1 As recommended by the DH¹⁴, the Trust has a Water Safety Plan which covers various aspects of water quality including managing the risk of *Pseudomonas spp*. This Plan is overseen by the Water Quality Steering Group. See section 15.27 for details.
- 9.2 The DIPC will continue to monitor episodes of *Pseudomonas spp*. bacteraemia trust-wide plus pseudomonal respiratory infections on critical care units. This data will be used to determine if unusual patterns of infection are occurring and if action needs to be taken in any particular area.
- 9.3 The IPCT will produce a policy for the infection prevention and control management of resistant strains of *Pseudomonas species* and other Gram negative infections not covered by the policy mentioned in section 9.4.

Resistant Gram negative organisms

- 9.4 The IPCT will continue to progress implementation of the Trust policy for the Control of carbapenemase-producing multi-resistant Gram negative bacteria based on Public Health England guidance¹⁵. These organisms are variously known as carbapenemase –producing resistant organisms (CROs) or carbapenemase producing enterobacteriaceae (CPEs) – for the purposes of this document these terms are interchangeable and will be referred to as CPEs in the remainder of this document.
- 9.5 The IPCT will update the Infection Control Isolation Precautions and Patient Placement Policy to include
 - a) Appropriate prioritisation of patients colonised/infected with CPEs
 - b) Appropriate prioritisation of patients 'at-risk' of CPE colonisation and are awaiting screening results.
- 9.6 Admission screening for patients 'at-risk' of being colonised or infected with CPEs - as defined in the document referred to in section 9.4 - will continue to be rolled out across the Trust. The IPCT will highlight this requirement to clinical teams during the coming year.
- 9.7 Laboratory Medicine and the IPCT will continue to investigate the various methodologies available for CPE screening and the costs and benefits involved. The IPCT will discuss with the Chief Nurse's Office which method to use based on the funding made available for this purpose.
- 9.8 CPEs will be a standing item on the IPC Committee and Team meeting agenda
- 9.9 The Board will be kept appropriately informed in respect of CPEs by the Chief Nurse and by the DIPC.
- 9.10 The IPCT will explore ways of providing monthly data on the number of new cases of CPE colonisation/infection for inclusion in the monthly infection prevention and control report produced for the Board.
- 9.11 The 2015/16 IPC e-learning refresher course will include information on CPEs

SCBU

- 9.12 The IPCT and neonatal unit staff will continue to progress implementation of the national guidance on managing outbreaks of Gram negative infection in neonatal units¹⁶ and where necessary make amendments to how the Trust prevents and/or controls these situations.
- 9.13 Reporting of such infections will be undertaken via the national neonatal audit programme

10. Influenza and Other Respiratory Viruses

- 10.1 Planning for influenza will continue to be incorporated into the wider strategy for winter planning.
- 10.2 The role, function and membership of the Winter Planning Group (WPG) will be reviewed by Michael Harper. The need for Influenza planning will be taken into account in this review.
- 10.3 Areas where staff may reasonably be expected to wear FFP3 masks (for whatever reason) during the course of their normal duties should implement a fit testing programme for the staff concerned. This may be accessed via the Trust Education and Training department.
- 10.4 FFP3 mask fit testing may need to be expanded to a wider group of staff during outbreaks of certain respiratory viruses. Advice will be given by the WPG (or its replacement) as to which staff this should cover and where training can be accessed.
- 10.5 The WPG (or its replacement) will receive a report on staff uptake of influenza vaccination during 2014/15. An action plan will be developed to continue to improve uptake rates during 2015/16. The plan will take into account the impact of the relatively poorly protective 2014/15 vaccine, which may cause staff to feel there is little reason to be vaccinated.
- 10.6 Directorates will participate in the planning and implementation of the agreed influenza vaccination strategy
- 10.7 The Pandemic Influenza Guidance will be reviewed and updated as appropriate during the year led by the Emergency Planning Team.
- 10.8 The Seasonal Influenza Guidance will be reviewed and updated, taking account of any updated DH advice, in time for the anticipated 2015/16 influenza season i.e. by the end of October. This may need to change as the season progresses or further advice is forthcoming.
- 10.9 Guidance on the management of other respiratory viruses in units with high-risk patients e.g. haematology, renal will continue to be developed. This will be led by the consultant Virologists in conjunction with the IPCT and the clinicians for the areas concerned – see section 18.7
- 10.10 The IPCT will work with Community Services staff to clarify when masks are required, and if so which type should be used, in the various clinical scenarios faced by staff in this particular Care Group.
- 10.11 The Virology department will work with clinical colleagues to introduce a near-patient test for influenza in selected admissions departments for the 2015/16 season; see section 18.6
- 10.12 The Virology department will work with the IPCT to clarify, and where possible optimise, the communication of respiratory virus sample results to the IPCT to facilitate the infection prevention and control management of these infections
- 10.13 The Virology department will provide weekly influenza figures during the influenza season, which will be displayed on the Trust intranet page. This information is provided to staff so they are aware of influenza activity and can ensure they are up to date with influenza protocols and are vigilant in looking out for cases of this infection

11. Norovirus

- 11.1 Planning for norovirus will continue to be incorporated into a wider strategy for winter planning.
- 11.2 The role, function and membership of the Winter Planning Group (WPG) will be reviewed by Michael Harper. The need for Norovirus planning will be taken into account in this review.
- 11.3 The WPG (or its replacement) will undertake a review in April and May 2015 of the management of norovirus during 2014/15. This will be used to plan for the anticipated norovirus activity during 2015/16.
- 11.4 The Trust will take account of Public Health England norovirus¹⁷ management advice.
- 11.5 The IPCT will explore a range of initiatives and ideas designed to detect cases early and prevent spread wherever possible. These will require input and co-operation from a range of professionals including nursing, managerial and domestic services staff. These may include escalation procedures for:
 - a) Electronic flagging of patients arriving in A&E with symptoms of diarrhoea and vomiting
 - b) All areas asking every patient admitted to them a set of norovirus screening questions
 - c) On occasion, severely restricting visitors
- 11.6 The Virology department will provide weekly norovirus figures during the norovirus season, which will be displayed on the Trust intranet page. This information is provided to staff so they are aware of norovirus activity and can ensure they are up to date with norovirus protocols and are vigilant in looking out for cases of this infection

12. Hand Hygiene/Dress Code

- 12.1 The Board of Directors, TEG, Chief Nurse's Office, DIPC, IPCT and staff at all levels within the Trust will continue to promote best practice in respect of hand hygiene via the Infection Control Accreditation Scheme
- 12.2 Hand hygiene audits will be undertaken as per the Infection Control Accreditation Programme.
- 12.3 'Alert' floor motifs will continue to be installed on ward entrances to promote the use of hand hygiene products on entry to ward areas
- 12.4 Wards/departments will ensure that patients have access to appropriate hand hygiene facilities both in toilet areas and in bed spaces, particularly where patients need to use commodes
- 12.5 Wards/departments will ensure that patients have access to appropriate hand hygiene products/facilities before meals
- 12.6 The IPCT, Supplies, Occupational Health and other appropriate departments will work together to optimise the hand hygiene products available to staff and patients.
- 12.7 The Board of Directors, TEG, Chief Nurse's Office and DIPC will continue to support the Dress Code policy. This includes the DH's 'Bare Below the Elbow' guidance.
- 12.8 The IPCT will continue to work with the Communications department to develop and implement a campaign to once again highlight the importance of Hand Hygiene. This may include using the Trust's 'Facebook' page and the ward entrance TV screens (should these be introduced as part of the Trust's wider patient information strategy). Other initiatives may include ideas for encouraging patients and visitors to undertake good hand hygiene e.g. holograms at hospital and ward entrances.

13. Invasive Devices: Management of Peripheral and Central intravenous cannulae & Urinary Catheters

Intravenous Devices

Patients with peripheral, arterial or central intravenous catheters in situ are at increased risk of bacteraemia and localised site infections

- 13.1 Such lines must be managed as per the Trust Peripheral and Central Intravenous Line Care guidelines and DH Care Bundles at all times
- 13.2 All departments will ensure that staff handling any intravenous lines, whether at insertion or during on-going care, are appropriately trained
- 13.3 All patients who have a peripheral IV cannulae *insitu* should have
 - a) the insertion documented
 - b) the cannula site reviewed at least daily
 - c) appropriate action taken in light of the daily reviewas per the Trust Management of Peripheral Cannula Policy
- 13.4 Patients should be screened for MRSA either prior to, or within 24 hours of, a central line being inserted. Patients with non-tunnelled central lines in-situ should be re-screened every 7 days
- 13.5 Patients who have central lines insitu and who have a recent history of MRSA should have MRSA topical therapy until the central line has been removed. Such patients with long-term central lines insitu should be discussed with the IPCT on an individual basis.
- 13.6 Audit of compliance with these protocols will be undertaken by department staff as part of the Infection Control Accreditation Programme.
- 13.7 Directorates will consider undertaking line infection rate surveillance. This should be discussed with the IPCT.
- 13.8 Audits of peripheral cannula use and documentation will be undertaken across the Trust. See sections 5.6 to 5.8 and 7.30.
- 13.9 Management of intravenous lines and cannulae will be added to the topics discussed at the regular IPC course provided by the IPCT.
- 13.10 Clinical areas will ensure that staff inserting, accessing or managing intravenous lines are appropriately trained in using the various types of intravenous lines and accompanying accessories used within that area.
- 13.11 The IPCT will continue to work with Haematology to investigate the benefits of peri-insertion decolonisation treatment in reducing the rate of catheter related sepsis in this patient group – see sections 7.33 and 18.2.
- 13.12 For further actions see sections 7.28 to 33.

Urinary Catheter

Patients with urinary catheters in situ are at increased risk of urinary tract infections, bacteraemia and localised site infections

- 13.13 Such catheters must be managed as per the Trust 'Bladder Management and Urinary Catheterisation Policy for Adults' and DH Care Bundle at all times
- 13.14 All departments will ensure that staff handling any urinary catheter, whether at insertion or during on-going care, are appropriately trained
- 13.15 The Trust Safer Care Committee will continue to review the Safety Thermometer data in relation to Urinary Catheters. A sub group of the Committee was convened during 2012/13 to particularly look at reducing harm that may occur secondary to the use of urinary catheters; the Catheter-Acquired Urinary Tract Infection (CAUTI) Group. This will continue to meet during 2015/16.

- 13.16 The CAUTI Group will produce and monitor an action plan to optimise catheter management with the aim of
- a) Reducing the number of patients who inappropriately have a catheter *insitu* in both hospital and community settings – this will include issues around inserting the catheter in the first instance and regularly reviewing whether the catheter is still required.
 - b) Ensuring optimal technique during insertion and on-going management
 - c) Ensuring appropriate information as to catheter management is available for patients and their carers
- 13.17 Audits of urinary catheter use, management and documentation will be undertaken across the Trust. See sections 5.6 to 5.8.

14. Decontamination of Medical Devices & Equipment

- 14.1 The Decontamination Management Group will continue to review and optimise the decontamination of medical devices.
- 14.2 The focus will continue to be on:
- a) Monitoring performance of the Sterile Services Supercentre
 - b) Optimising decontamination of flexible endoscopes
- 14.3 Nurse Directors and Matrons should review whether decontamination of medical devices is taking place in their areas. All decontamination should take place in SSD unless specifically authorised by the Decontamination Management Group. If decontamination is taking place without authorisation, these situations should be referred to the Decontamination Management Group for review
- 14.4 Decontamination of ward equipment will be audited via the appropriate module of the Accreditation Scheme. This will include both acute and community settings.
- 14.5 Beds, commodes and patient equipment e.g. infusion pumps should be cleaned as per protocol. Each item should have a label clearly indicating that cleaning has taken place and when this last occurred.
- 14.6 Items designated as 'single use' by the manufacturer are not re-used/re-processed. This applies, not only to sterile items, but any piece of kit that the manufacturer deems to be single use.
- 14.7 The Trust Decontamination Policy will be reviewed and updated during 2015/16
- 14.8 The IPCT and Supplies will continue to work to rationalise the types of detergent/ disinfectants (including wipes), that are available within the Trust and clarify which types should be used for which tasks
- 14.9 The Decontamination Management Group will review and optimise the decontamination of ultrasound probes
- 14.10 The IPCT will work with Community Services staff to optimise the facilities available for the decontamination of items used by staff in community settings.
- 14.11 The IPCT will work with Community Services staff to identify appropriate kit bags for staff that can be easily cleaned and decontaminated.

15. Environmental and Cleaning Issues

- 15.1 The Board of Directors, TEG, Chief Nurse's Office and DIPC will continue to optimise cleaning of the environment and to include the IPCT in decisions in this area.

- 15.2 The Patient Environment Group will continue to meet chaired by the Deputy Chief Nurse. The Group will oversee the refurbishment programme and the environmental cleaning standards and protocols for the Trust.
- 15.3 The PEG will take note of issues raised at the PLACE inspections and take appropriate action.
- 15.4 Requests by wards/departments for upgrades, refurbishments etc. will be discussed and prioritised by the Patient Environment Group
- 15.5 A programme of essential maintenance will be developed by the Estates department. Whilst this work is being carried out cleaning and minor upgrade work will take place, as appropriate.
- 15.6 The IPCT will continue to participate as appropriate in the PLACE
- 15.7 The Trust will work towards compliance with the National Cleaning Standards
- 15.8 The IPCT will continue to review the cleanings standards and frequencies within the Community Services Group and agree standards for going forwards. It is recognised that setting and maintaining standards in areas that are shared by STH services with other providers is problematic.
- 15.9 The IPCT, Hotel Services, Estates and clinical staff will continue to use and promote the agreed protocols for
 - a) the appropriate cleaning of radiators
 - b) the appropriate cleaning of ventilation grills
 - c) fans
- 15.10 Hotel Services and clinical staff will continue to use and promote the agreed protocols for
 - a) Thorough cleaning of bed spaces vacated by patients with diarrhoea (especially *C.difficile* and norovirus). This should ensure that all items, surfaces etc. are cleaned appropriately and may include the use of steam cleaners
 - b) Daily, terminal and rapid response 'clean' to ensure that all items and surfaces are appropriately cleaned. Those responsible for each task should be aware of their role and undertake the tasks appropriately.
 - c) Cleaning of commodes
- 15.11 Patient beds will be cleaned as per protocol. In summary,
 - a) Each bed should have the visible surfaces cleaned after every discharge
 - b) Each bed should have a full clean after being used by a patient requiring barrier precautions; a label on the bed should indicate that this has occurred
 - c) Each bed should have a full clean at least monthly – a label on the bed should indicate that this has taken place
- 15.12 The trolleys used to transport/store items to and from the Synergy Sterile Services Facility (SSSF) to the Trust and onwards to wards/departments will be cleaned after each delivery cycle.
 - a) Trolleys used to transport items to and from the SSSF to the Trust are the responsibility of Synergy
 - b) Trolleys used within the Trust are the responsibility of the distribution team. Clarification will be made as to whose responsibility it is to ensure cleaning of these trolleys occurs
- 15.13 Where Bulk Store/exchange trolleys are used, these will be cleaned monthly – a label on the trolley should indicate when cleaning last took place. This is the responsibility of Bulk Stores staff.
- 15.14 The Domestic Services ward/department cleaning schedules include the cleaning of ceiling ventilation grills as per the agreed protocol
- 15.15 Wheelchairs should be decontaminated and maintained as follows:
 - a) Surface wiped with detergent wipes or chlorine-based/Difficil-S disinfectants between each patient
 - b) Have a full weekly clean using chlorine-based disinfectants e.g. Chlorclean, Trigene or Difficil-S

- c) annual service plus any maintenance required in between services
This is the responsibility of the Porterage service for pool chairs. Where wards/departments own or keep/store chairs within their ward/department the above becomes their responsibility
- 15.16 Senior and supervisory staff will promote the protocols in sections 15.9 to 15.15 amongst their staff
 - 15.17 The IPCT, Hotel Services, Estates and clinical staff will continue to work together to provide a hydrogen peroxide vapour misting service as and when necessary as determined by the IPCT. This may be required after areas have been refurbished or deep cleaned, post a cluster of cases of *C.difficile* or individual rooms that have been vacated by patients with particular infections.
 - 15.18 Domestic Services will ensure that disposable mops are not re-used and that re-usable mop-heads are laundered centrally; not at ward/department level.
 - 15.19 The monthly cleanliness audits undertaken by the Domestic Services department should include a senior nurse from the area being audited at least 50% of the time.
 - 15.20 The Estates department will ensure that all relevant Estates policies explicitly contain information regarding co-operation, communication and liaison with the IPCT.
 - 15.21 Where available all computer keyboards in clinical areas should have keyboard covers.
 - 15.22 Whether computer keyboards have a cover or not they should be cleaned as per the Trust guidelines. This also applies to computer mouse, card readers etc. Guidelines are available on Trust intranet
 - 15.23 String pulls in toilets should have a plastic cover
 - 15.24 Infrequently used water outlets will be flushed daily for two minutes in accordance with the Trust Legionella policy. This will be undertaken by Domestic Services staff but it is the responsibility of senior nursing staff in each area to ensure that this has been done and recorded.
 - 15.25 The Water Quality Steering Group will develop a programme for the audit of infrequently used outlet flushing and central recording the results
 - 15.26 The Trust will aim to provide a hand washing station at all ward entrances. These will be installed during capital schemes or ward refurbishment. The most appropriate option will be chosen based on the ward/entrance layout.
 - 15.27 As recommended by the DH¹⁴, the Trust has a Water Safety Plan which covers various aspects of water quality including managing the risk of *Pseudomonas spp.* This Plan is overseen by the Water Quality Steering Group. In summary the Water Safety Plan includes:
 - Plans to ensure that the water distribution system and outlets are appropriately maintained and managed to reduce the risk of stagnation and contamination
 - Local cleaning protocols for hand wash sinks to reduce the likelihood of outlet contamination i.e. taps are cleaned prior to the rest of the sink
 - An assessment of the risk of *Pseudomonas spp.* to various patient groups and this is used as a basis for advice on the issues below
 - Advice on the use of tap water for washing, bathing and showering patients i.e. in high risk units only water from outlets tested as pseudomonas free should be used for these tasks.
 - Advice on the use of hand-wash basins and disposal of used water i.e. hand wash sinks should not be used for any other tasks and used/dirty water should not be disposed of via hand wash sinks. Exceptionally, where a risk assessment has determined that water used to wash patients is best disposed of via the hand wash sinks, the sink must be cleaned each time this occurs

- Plans to monitor clinical isolates of *P.aeruginosa* as an alert organism
 - A programme for 6 monthly-testing of outlet water for *P.aeruginosa* on high risk units
 - Plans for managing patients and the water system in the event of pseudomonas positive water samples
 - IPCT, Estates, Microbiology and Clinical staff will undertake the various actions required of them within this Plan.
- 15.28 Wards should use the standard Trust signage to indicate barrier precautions are required. Use of alternative signs should be agreed with the IPCT.
- 15.29 All areas should determine who is responsible for the regular cleaning of patient trolleys used in their area and ensure these items are regularly and appropriately cleaned
- 15.30 The IPCT will use ATP technology as part of the quality assurance programme within Community Services in respect of the adequacy of cleaning
- 15.31 The IPCT will participate in the Total Bed Management Programme review to ensure infection prevention and control issues are considered.

16. Education and Training

- 16.1 All staff should receive appropriate, documented infection prevention and control training and education at induction and updates as determined within the Trust training needs analysis document. The update frequency will vary from 1 to 3 years depending on the role of the member of staff.
- 16.2 This training will be part of the wider Trust mandatory training programme
- 16.3 The IPCT will review the infection control training needs analysis documents, annually
- 16.4 Assurance of compliance with the standard in section 16.1 will be undertaken by the Education and Training department using the PALMS system
- 16.5 The IPC e-learning packages for induction and annual refresher are available on the Trust e-learning site and are available for all staff to access and use.
- 16.6 All new staff should complete the induction IPC e-learning material within six months after starting employment. Staff may wish to do this over a number of days/weeks given the amount of material and information contained within the package. Staff will generally undertake this via the e-learning site. However, the material can be presented by Educators in alternative formats to groups of staff as long as this is documented and added to ESR
- 16.7 All staff should complete the annual refresher IPC e-learning material within 2015/16 or at the frequency defined in the training needs analysis for the staff member's role. Staff will generally undertake this via the e-learning site. However, the material can be presented by Educators in alternative formats to groups of staff as long as this is documented and added to ESR.
- 16.8 The IPCT will review and update the annual refresher course annually, as appropriate and will also provide updated material for inclusion in the Central News Update
- 16.9 The IPCT will work with the Education and Training department as to how best to provide induction infection prevention and control information and education. This may include the use of nationally produced e-learning packages with appropriate local information added as necessary.
- 16.10 The IT and Education departments will work with the IPCT to facilitate the above goals.
- 16.11 Hand hygiene training will be undertaken at the generic Trust induction. Training will also be given on a risk assessment basis, as determined by audit and review results undertaken as part of the Accreditation Scheme or following identification of clusters of infection.

- 16.12 The IPCT will provide training for staff in how to undertake infection prevention and control audits. This issue will be included in certain Link Worker training days.
- 16.13 The IPCT will continue to provide Link Worker training days covering issues relevant to both experienced and less experienced staff
- 16.14 The IPCT continually review the education and training provided by the IPCT to determine which should continue, which should cease and which should continue in a modified format.

17. Communication and Information

- 17.1 Infection prevention and control information will be displayed at ward entrances and on the Trust web-site.
- 17.2 The IPCT will continue to work with the Patient Partnership department to produce regular infection prevention and control information and data for display on ward notice boards. The information will include results of some Accreditation audits e.g. hand hygiene, cleanliness scores, commode and linen audits and rates of certain organisms e.g. MRSA and *C.difficile*.
- 17.3 Any information displayed at ward/department level will be in dedicated enclosed display cabinets and be updated regularly. Information will be in a clearly visible format.
- 17.4 The Trust will continue to look into various options for optimising how information in general is made available to patients and the public at ward level. The option of have TV screens with rolling information being displayed will be considered. Infection prevention and control information, including that mentioned in section 17.2 will be included in any review.
- 17.5 The IPCT will work with those planning, developing and implementing the Trust Transformation Through Technology (T3) programme to ensure that, where possible, these developments will facilitate the infection prevention and control agenda
- 17.6 Review of the information available on the Trust internet site will continue
- 17.7 The latest Trust IPC Report and IPC Programme will be on the Trust internet site.
- 17.8 Hand Hygiene Campaign - see section 12.8
- 17.9 The Trust will continue to work with the Sheffield Clinical Commissioning Group and Sheffield Health and Social Care Trust IPC Teams to investigate the options for providing medical microbiology and infection prevention and control support to these areas. This will be dependent on both financial and personnel resource constraints.

18. Research, Service Evaluations, Studies and Assessments

- 18.1 The Trust will look to participate in infection prevention and control related research, service evaluations, studies and assessments as such opportunities arise, funding and personnel permitting.
- 18.2 The IPCT will continue to work with Haematology to investigate the benefits of peri-insertion decolonisation treatment in reducing the rate of catheter related sepsis in this patient group – see sections 7.33 and 13.11.
- 18.3 The Trust will continue to participate in a randomised controlled trial of adjuvant rifaximin versus placebo as adjunctive therapy in the treatment of *C.difficile* disease
- 18.4 The Trust will continue to participate as required in the EUCLID study comparing diagnostic results of *C.difficile* testing within local laboratories and reference laboratories

- 18.5 The Trust will continue to participate in the Longitudinal European *C difficile* Infection Diagnosis Surveillance Study (LuCID) which aims to investigate variability in *C.difficile* sampling, testing and positivity according to place and time across Europe.
- 18.6 The Virology department will work with clinical colleagues to introduce a near-patient test for influenza in selected admissions departments for the 2015/16 season. This will build on the pilot study that has taken place over the last two winter seasons – see section 10.11
- 18.7 The IPCT will continue to work with Haematology to optimise the diagnosis and management of respiratory viral infections in this group of patients – see 10.9

19. Ebola, Viral Haemorrhagic Fever and other Category 4 Pathogens

- 19.1 The Trust will continue to optimise plans for safely detecting, diagnosing and managing patients suspected or confirmed as being infected with Ebola virus or other Category 4 pathogens. The Trust plans will be based on Public Health England advice¹⁸.
- 19.2 The Ebola Task and Finish Group will lead this work during the current year. This is a multi-disciplinary group chaired by one of the Infectious Diseases consultants. Staff from the following departments are involved: Infectious Disease, IPCT, Emergency Planning, Laboratory Medicine, A&E. Emergency, Critical Care, Obstetrics, Supplies, Waste Management, Hotel Services, Mortuary and Occupational Health. Other staff are co-opted as required.

**Written by Dr C Bates on behalf of the Infection Prevention and Control Committee
March 2015**

References:

1. Saving Lives: A delivery programme to reduce Healthcare Associated Infection (HAI) including MRSA.
<http://webarchive.nationalarchives.gov.uk/20120118164404/http://hcai.dh.gov.uk/>
2. NICE (2011): Prevention and Control of Healthcare-associated Infections
<http://publications.nice.org.uk/prevention-and-control-of-healthcare-associated-infections-ph36>
3. NICE (2012) Infection Prevention and Control of healthcare-associated infections in primary and community care
<http://publications.nice.org.uk/infection-cg139>
4. NICE (2013) Infection Control NICE quality standard draft for consultation – no longer available on the intranet – update due in 2016
5. EPIC 3 National evidence based guidelines for preventing HCAs
http://www.his.org.uk/files/3113/8693/4808/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf
6. Essential steps to safe, clean care: reducing healthcare-associated infection. The delivery programme to reduce Healthcare associated infections (HCAI)
http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136212

7. Health and Social Care Act 2008: Code of Practice for the Prevention and Control of Infections and related Guidance
<https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance>
8. Care Quality Commission registration Standards
<http://www.cqc.org.uk/content/regulations-service-providers-and-managers>
9. Duty of Candour information <http://www.cqc.org.uk/content/fit-and-proper-persons-requirement-and-duty-candour-nhs-bodies>
<https://www.gov.uk/government/consultations/statutory-duty-of-candour-for-health-and-adult-social-care-providers>
10. Safety Thermometer Tool
<http://www.ic.nhs.uk/services/nhs-safety-thermometer>
11. Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI).
<https://www.gov.uk/government/groups/advisory-committee-on-antimicrobial-resistance-and-healthcare-associated-infection>
12. DH MRSA updated screening guidance
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/345144/Implementation_of_modified_admission_MRSA_screening_guidance_for_NHS.pdf
13. *Clostridium difficile* Infection: How to Deal with the Problem
<https://www.gov.uk/government/publications/clostridium-difficile-infection-how-to-deal-with-the-problem>
14. DH – Managing *Pseudomonas aeruginosa* in Healthcare Settings
<https://www.gov.uk/government/publications/addendum-to-guidance-for-healthcare-providers-on-managing-pseudomonas-published>
15. Public Health England guidance on detection, management and control of carbapenemase-producing Enterobacteriaceae
<https://www.gov.uk/government/collections/carbapenem-resistance-guidance-data-and-analysis>
16. Managing and preventing outbreaks of Gram-negative infections in UK neonatal units published in Archives of Diseases in Childhood Arch Dis Child Fetal Neonatal Ed. 2013 Nov;98(6):F549-53. doi: 10.1136/archdischild-2012-303540. Epub 2013 Jun 21. Review.
17. Public Health England guidance on Norovirus
<https://www.gov.uk/government/collections/norovirus-guidance-data-and-analysis>
18. Public Health England guidance on Ebola
<https://www.gov.uk/government/collections/ebola-virus-disease-clinical-management-and-guidance>