SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY
REPORT TO THE TRUST HEALTHCARE GOVERNANCE COMMITTEE

HELD ON 21 March 2011

Subject:	a) Infection Prevention and Control (IPC) Programme Progress Assessment 2010/2011 Quarter 3 (October – December) b) Ratification of 2011/12 IPC Programme
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Status[1]	

PURPOSE OF THE REPORT:

a) To highlight progress in quarter 3 of the 2010/11 IPC Programme.
b) To present the draft 2011/12 IPC Programme for comment and ratification

KEY POINTS:

2010/11 IPC Programme Q3 progress report:

- Overall progress has been made – Group/Department average score is 94.4% – (93.4% & 92.5% in Q2 & Q1 respectively)
- Overall areas within the Trust are showing at least an 84% compliance
- 12 areas have shown an improvement as regards progress against the Programme with eight of these areas improving sufficiently to move up a banding from either Green to Blue or Yellow to Green.
- 23 areas have seen a deterioration in their progress against the Infection Control Programme with four being sufficient to move banding from Blue to Green or Green to Yellow. The major reason for this reduction in compliance was the introduction of the Infection Control e-leaning package. Until this quarter Directorates were not required to declare compliance against this standard. All modules of this package are now available and staff have been requested to undertake the programme which can take 2-3 hours to complete. At present most areas have informed staff of the need to do this but few staff have as yet completed it.
- Progress is being made in updating the numerous IPC related policies and guidelines – see attached document
- 81 of 85 in-patient wards have Accredited at least once – 4 wards have only recently opened in their new configuration and are progressing well with the programme (CF Unit, MAU2, Firth 1, Huntsman 2)
- 53 of 91OPD/Day case areas/non-ward based departments have Accredited at least once. Progress is being made in particular Professional Services and Operating Theatres.

2011/12 IPC Programme

- The draft 2011/12 IPC programme has been developed by the IPC team and Approved by the IPC Committee on 15th March. The Healthcare Governance Committee is asked for comment and if possible to Ratify the Programme

IMPLICATIONS[2]

Achieve Clinical Excellence	Part of the Infection Control Assurance Framework
Be Patient Focused	An important area of patient experience
Engaged Staff	Staff need to be knowledgeable about Infection Prevention and Control

LINKS WITH CQC ESSENTIAL STANDARDS OF QUALITY AND SAFETY:

Outcome	Cleanliness and infection control (8)

RECOMMENDATION(S):

That the Healthcare Governance Committee notes the progress towards implementation of the IPC Programme for 2010/2011 and Ratifies the 2011/12 IPC Programme

APPROVAL PROCESS

Meeting	Presented	Approved	Date

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the three pillars (aims) of the STH Corporate Strategy 2008-2012

Sheffield Teaching Hospitals NHS Foundation Trust

INFECTION PREVENTION AND CONTROL PROGRAMME April 2011 - March 2012

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 2011 – March 2012. The Infection Prevention and Control Team (IPCT) takes the lead in developing the Programme. The Nurse Directors (or equivalent) and Clinical Directors are responsible for implementing the IPC Programme within their Groups/Departments/ Directorates 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 the updated Accreditation Programme
- Compliance with the Health and Social Care Act 2008
- Prevention and Control of Norovirus
- Prevention and Control of C.difficile
- Development and delivery of infection prevention and control education
- Optimising communication and the production of information for staff, patients and the public in respect of infection prevention and control issues
- Review the implications of the Trust assuming responsibility for management of Adult Community Services and other services previously provided by Sheffield PCT Provider Services and integrate these as appropriate

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
- Saving Lives Toolkit
- Health & Social Care Act 2008
- Ownership at Group/ Directorate/Ward level
- Audit and Review
- Surveillance
- Methicillin resistant *Staphylococcus aureus* (MRSA)
- *Clostridium difficile* (*C.difficile*)
- Influenza
- Norovirus
- Hand Hygiene
- Decontamination of Medical Devices
- Management of Peripheral and Central intravenous cannulae
- Environmental and Cleaning Issues
- Education and Training
- Communication and Information

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 Saving Lives 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 Those wards and departments that have not achieved initial Accreditation will report bi-monthly to the Chief Nurse/Chief Operating Officer until this is achieved.

1.5 All areas will use the most recent version of the Accreditation programme

1.6 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

1.7 All wards/departments will submit Accreditation audit scores to the IPCT on a monthly basis. Results for each month will be submitted by the end of the first week of the following month. The IPCT will upload the results onto a central database. This data will be used for the initiatives described in sections 1.8 to 1.12 and therefore it is extremely important that wards/departments submit data in a timely manner.

1.8 The IPCT will regularly review the progress being made by all wards and departments in respect of the Accreditation Programme. This will include progress towards initial Accreditation and annual Re-accreditation.
The IPCT will receive quarterly reports on wards/departments

a) That have not achieved initial Accreditation

b) Where last Accreditation/Re-accreditation was greater than 12, 15 or 18 months ago – these will be coloured coded white, green, amber or red as appropriate

1.9 The Chief Nurse/Chief Operating Officer and IPC Committee will receive a summary of these reports quarterly, as will Nurse Directors, Lead Nurses, Matrons, Ward Managers and IPC Leads in non-ward based departments

1.10 The IPCT will develop a system to highlight how each area is progressing in respect of the Accreditation Programme audit schedule.

1.11 Once the system in 1.10 has been developed, a process will be agreed as to how to respond to the results and how escalation of the results will take place if satisfactory progress is not being made.

1.12 The IPCT will continue to produce and distribute a ‘top performers’ list in respect of the Hand Hygiene and Cleanliness audits undertaken as part of the Accreditation Programme. This will be distributed quarterly to the IPC Team, the IPC Committee, Nurse Directors, Lead Nurses, Matrons, Ward Managers and IPC Leads in non-ward based departments

1.13 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 report

1.14 The IPCT will work with IT and other Trust departments to develop the system for submitting and downloading Accreditation data electronically rather than a partly paper based system.

1.15 The Accreditation status of the ward/area will continue to form part of the Trust annual Clinical Assessment Toolkit (CAT) review

1.16 The IPCT will update the Accreditation Programme to include a standard for drug preparation areas within wards/departments

1.17 The IPCT will update the Accreditation Programme to reflect any changes in the latest versions of the Saving Lives High Impact Intervention modules.

1.18 The IPCT will, in particular, review the peripheral cannula audit tool to determine if extra elements need to be included based on the results of audits carried out by IPC and Microbiology staff over the past few years

1.19 The IPCT will update the Accreditation Programme to include a commode and seat raiser audit module

1.20 The IPCT will review the Accreditation Programme audit schedule to determine if any new audits need to be added, if any can be removed and if the frequency of audits needs to be revised. In addition, the number of audits undertaken by the IPCT itself will be reviewed.

2. Saving Lives Toolkit

2.1 The Saving Lives toolkit will be applied at both a trust-wide & Directorate level

2.2 Application and audit of the High Impact Interventions will be via the Infection Control Accreditation Scheme

2.3 The current version of the balanced scorecard will be completed and reviewed by the DIPC, Deputy Chief Nurse and Lead Infection Control Nurse and reviewed at least annually. Issues highlighted by this review will inform the IPC Programme or interim Action Plans depending on the timing of the review in relation to the production of the Programme.

3. Health and Social Care 2008

3.1 One of the Trust objectives is to be fully compliant with the current version of the Health and Social Care Act 2008. Similarly, the Trust registration with the Care Quality Commission (CQC) requires compliance with Outcome 8 of the registration standards which relates to infection prevention and control.

3.2 The Deputy Chief Nurse, DIPC, the Lead Infection Control Nurse together with the IPCT will review the Health Act and Outcome 8 of the CQC standards 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 and community care colleagues to strengthen links between the various healthcare trusts within Sheffield, particularly in respect of infection prevention and control issues. This work will take into account changes necessitated by Department of Health initiatives in respect of Primary Care Trusts, Strategic Health Authorities, Community Services etc.

3.4 The action plan implemented following the review of ward/department linen handling, will continue to be implemented

3.5 Standards for storage facilities are included in the Accreditation Programme. Ongoing improvements in storage facilities, standards and strategy will take place via the Productive Ward programme.

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 TEG and DIPC will explore with the Human Resources Department how best to handle situations when staff (from whatever professional group) fail to comply with infection prevention and control requirements

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) Produce and implement as appropriate an annual IPC Programme/ Action Plan for all areas within their Group/Department, based on the requirements of this trust-wide Programme (in-house use only, does not need to be returned to the DIPC)
e) Review progress in respect of the Group/Department Infection Prevention and Control 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 4th July 11, 3rd October 11, 9th January 12 and 9th April 12. Generally these returns are submitted by the Nurse Director. However, the Clinical Director(s) should also agree and endorse these returns.
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 should include progress in relation to Infection Control Accreditation, MRSA and *C.difficile* Learning Points bulletins, issues raised from audits carried out in response to clusters of infection and areas for improvement detected by surveys, audits, complaints etc.
h) Ensure that the weekly 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. 'Lessons Learnt' 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 *C.difficile* occur. See section 6.11 and 6.14 below. MRSA bacteraemia data and data on clusters of infections occurring on wards e.g. *C.difficile*, norovirus etc. should be reported and discussed at the Directorate Healthcare Governance and Risk Management meetings

j) Ensure that the following infection prevention and control related polices, procedures and guidance are implemented in all wards/departments, as appropriate. The documents can be accessed via the Infection Control web-page. Each ward/department should review annually whether all relevant aspects of these documents are being followed in their area:

I. General Trust Infection Control Guidelines
II. Hand Hygiene Policy
III. Infection Control Patient Placement Guidelines
IV. MRSA Guidelines
V. GRE Guidelines
VI. Multi-resistant Gram negative Guidelines
VII. *C.difficile* Guidelines
VIII. Norovirus Guidelines
IX. Suspected infective diarrhoea Guidelines
X. SARS/Avian Influenza/SRINIA Guidelines
XI. CJD Guidelines
XII. Tuberculosis guidelines
XIII. Pandemic Influenza Plan
XIV. Hazard Group 4 Pathogens including Viral Haemorrhagic Fever Guidelines
XV. Legionella Control and Management including Tap Flushing
XVI. Birthing Pools
XVII. Hydrotherapy Pools
XVIII. Drinking Water Coolers
XIX. Ice machines
XX. Management of central IV line guidelines
XXI. Management of peripheral IV line guidelines
XXII. Management of urinary catheter guidelines
XXIII. Aseptic technique
XXIV. Guidelines for taking blood cultures
XXV. Care of the Deceased Patient
XXVI. Guidelines for completing death certification in respect of MRSA, *C.difficile* and other heath-care associated infections
XXVII. Linen Guidelines
XXVIII. Decontamination Policy
XXIX. Animals and Pets in Hospital
XXX. Computer keyboards and equipment cleaning guidelines
XXXI. Management of occupational exposure to blood borne viruses and post-exposure prophylaxis
XXXII. Guidelines for the Management of Healthcare Workers with Infections
XXXIII. Antibiotic prescribing policies
- Antibiotic prescribing guidelines
- Antibiotic review policy
- Restricted antibiotic policy
- Chest infection and Pneumonia guidelines

4.6 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 Infection Prevention and Control Programme. The DIPC will be notified of the name of this individual. These areas are:

- Pharmacy
- Medical Imaging
- Biomedical Engineering
- Professional Services
- Laboratory Medicine
- Estates
- Hotel Services
- Clinical Research Facility

5. Audit and Review

5.1 Progress in respect of the Infection Prevention and Control Programme will take place as follows:

a. Nurse Directors will complete a Performance Assessment form (Appendix A) on a quarterly basis (by 4th July 11, 3rd October 11, 9th January 12 and 9th April 12) and return this to the DIPC within two weeks of these dates

b. The Clinical Director(s) (or equivalent) should agree and endorse the quarterly returns

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 Infection Prevention and Control Team and 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 (Pharmacy, Medical Imaging, Biomedical Engineering, Estates, Professional Services, Laboratory Medicine, Hotel Services, Clinical Research Facility)

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/Chief Operating Officer's Office and DIPC in respect of strategic and corporate issues.

5.2 The Chief Nurse/Chief Operating Officer'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 Standards at the request of the Trust Healthcare Governance Department.

5.3 The Chief Nurse/Chief Operating Officer's Office, DIPC and IPCT will review the Trust position in relation to the infection prevention and control related standards within the NHS Litigation Authority standards at the request of the Trust Healthcare Governance Committee.

5.4 The DIPC will provide data as requested by the Healthcare Governance Team to inform the Trust monthly Governance Dashboard.

5.5 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) Cleanliness
d) Environment
e) Standard Precautions
f) Aseptic technique
g) Mattress audit
h) Linen handling audit
i) 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 as advised by the review mentioned in Sections 1.17 to 1.19 above

5.6 Audit of compliance with MRSA screening protocols.

a) The IPCT 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 a review of the MRSA screening audit programme. Wards will be assigned to one of the following groups: i) areas primarily functioning as admission units, ii) areas where a significant number of patients are admitted as direct admissions, iii) areas where few patients are admitted as direct admissions, iv) high risk areas e.g. critical care and v) others. The review will determine the frequency with which audits will be undertaken in each of these categories. It is expected that quarterly audits will take place for categories i) and iv). The results of the audits will be distributed to the areas audited and will be reviewed quarterly at the IPCT meeting. A summary will also be sent to the IPC Committee.

c) The IPCT will investigate participating in the national MRSA prevalence audit of MRSA screening being co-ordinated by UCL. This is due to take place during May.

5.7 The IPCT and Microbiology Department will undertake an annual audit of peripheral cannula use and documentation across the Trust. Further audit may be required, depending on the results of the *Staphylococcus aureus* bacteraemia surveillance schemes, see Section 6.2 below.

5.8 The IPCT will receive a quarterly report from the Healthcare Governance department regarding reports of ‘Facilities Not Available for IPC purposes’.

5.9 The IPCT will review progress in relation to the review and updating of infection prevention and control related polices at the monthly JICT meeting. Policies will be reviewed at least every two years although more frequent review will be undertaken as necessary.

5.10 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. This review will be completed by March 2012.

5.11 The IPCT will produce, review, approve and ratify infection prevention and control related policies/guidelines as per Trust requirements in this regard.

5.12 The IPCT will produce an Equality Impact Assessment (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. For documents not due for review for many months, EIAs will be written as & when possible.

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

5.13 All areas should ensure that patients are screened for MRSA as per the MRSA screening protocols within the Trust MRSA Guidelines, see Section 7.1-4 below.

5.14 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 below.

5.15 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

'Point of Access' areas are:

- A&E NGH
- MAU 1, 2 & 3 NGH
- AAU RHH
- Minor Injuries Unit RHH
- Infectious Diseases unit RHH

5.16 All areas should ensure that infrequently used water outlets are flushed daily, see section 14.23 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.

5.17 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

5.18 All areas should ensure that staff taking blood cultures do so as per the 'How to take a Blood Culture' guidelines

5.19 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.

6. Surveillance

6.1 The Trust will aim to achieve the MRSA bacteraemia and *C.difficile* diarrhoea operating framework targets. 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 Department of Health Mandatory Surveillance Schemes:

a) MRSA bacteraemia
b) MSSA bacteraemia
c) Glycopeptide resistant enterococcus (GRE) bacteraemia
d) *C.difficile* diarrhoea in patients 2 years of age or older

e) Wound infections in orthopaedic surgery
f) E.coli bacteraemia (when this is introduced)

6.3 The IPCT will enter data on to the HCAI Data Capture System as per Department of Health guidelines

6.4 The DIPC and Operational Infection Control Doctors will continue to develop systems to optimise the input of data into the HCAI Data Capture System in the absence of the DIPC.

6.5 The IPCT and IT Department will continue to progress the development of the bespoke Infection Control surveillance system

6.6 The IPCT will continue to work with the Trust to optimise the flagging of patients with MRSA, *C.difficile* etc on the Trust PAS/PFI/Patient Centre systems

6.7 The IPCT will continue to undertake surveillance of bacteraemia caused by Methicillin Sensitive and Resistant *Staphylococcus aureus* (MSSA & MRSA) and Extended Spectrum Beta–lactamase (ESBL) producing *E.coli* and participate in the South Yorkshire Infection Control Doctors project to collect this data on a sub-regional basis.

6.8 The Trust will continue to progress the Patient Safety First agenda including the central IV line and ventilator acquired pneumonia modules for Intensive Care Units and catheter associated urinary tract infection modules where appropriate

6.9 The IPCT will continue to produce a regular Infection Control Bulletin. This will include 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, Matrons, Ward Managers, Lead Nurses, the IPCT and the Central Nursing and Medical Director's Offices.

6.10 A review of the Infection Control Bulletin will be undertaken including the views of the end users. The format and frequency of distribution may be altered depending on this feedback.

6.11 Clusters of *C.difficile* diarrhoea and single episodes of MRSA bacteraemia will be investigated as appropriate by the IPCT; see Sections 8.17-22 and Section 7.23 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. The *C.difficile* cluster summary tool, developed by the IPCT, may be used.

6.12 The IPCT, DIPC and the Chief Nurse's/Chief Operating Officer's Office will determine an escalation process for the rare occasions where the reviews undertaken, and the advice given, by the IPCT are not followed by satisfactory improvement and progress

7. MRSA

The control of MRSA is an integral part of many infection control activities. The focus this year will be on the following issues:

Screening for MRSA:

7.1 The Trust protocols for screening reflect DH requirements.

7.2 All departments will ensure that patients are screened for MRSA as per these agreed 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.
7.4 The Trust will continue to progress the centralisation of pre-operative assessment on both campuses. One effect of this will be to aid standardisation and compliance of MRSA screening.

Decolonising patients:

Optimising MRSA decolonisation reduces the likelihood of an individual patient developing an infection and the ongoing spread of MRSA to other patients.

7.5 Patients found to be colonised or infected with MRSA will receive appropriate topical treatment
7.6 Topical treatment will be started within 24 hours of the IPCT advising clinical staff of the treatment required (including weekends and bank holidays)
7.7 Topical treatment will be applied thoroughly and consistently
7.8 The Infection Control Assistants will help and advise clinical staff in respect of how to appropriately apply topical treatment
7.9 The IPCT will continue to work with primary care and community colleagues to optimise decolonising patients in the community, where this is appropriate
7.10 In agreement with NHS Sheffield, the Trust will continue to develop 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 within the 18 week pathway.
7.11 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.

Management of intravenous lines:

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

7.12 Such lines must be managed as per the Trust Peripheral and Central Intravenous Line Care guidelines and DH Care Bundles at all times
7.13 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 Nursing Care Guidelines:

The Trust has MRSA Nursing Care Guidelines for managing patients colonised or infected with MRSA.

7.14 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

Patient placement

7.15 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
7.16 A Datix incident form will be completed whenever a single room is unavailable

Communication

7.17 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.

7.18 MRSA results will be communicated by the microbiology department to Infection Control and clinical staff in a timely manner as per agreed protocols

7.19 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.

7.20 The IPCT will work with NHS Sheffield IPCT colleagues to optimise the system for communicating information and making referrals between the Teams. The systems will take into account the need for confidentiality and information security.

7.21 The IPCT will work with NHS Sheffield to optimise the 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 Trust IPCT prior to discharge and those where this comes to light after discharge. Discussions will include allocation of responsibility for communication of the information to the patient and on-going care in respect of the MRSA colonisation/infection.

MRSA target

7.22 The Trust will aim to achieve the new MRSA target for Trust attributable MRSA bacteraemia episodes.

Management of episodes of MRSA bacterameia

7.23 Episodes of MRSA bacteraemia will be handled as Clinical Incidents and a review of the case held using the Department of Health Root Cause Analysis tool.

a) 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. Participation at these meetings is a priority strongly supported by the Chief Nurse/Chief Operating Officer and Medical Director.
b) Initial meetings should be held within 1 week of the blood culture result becoming known
c) Any actions identified should be acted upon within an agreed time frame. On the rare occasions where satisfactory improvement and progress does not occur, the escalation process mentioned in Section 6.12 will be followed.
d) 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 DIPC may produce MRSA Learning Points bulletins as appropriate. These will be sent to all Clinical Directors, Lead Clinicians and Nurse Directors plus the IPCT. The Learning Points will be placed on the Infection Control web-page.
e) MRSA bacteraemia episodes will be reported to the PCT on a weekly basis together with a summary of the root cause analysis results
f) The MRSA Learning Points will be sent by the DIPC to the PCT as and when they are produced

8. Clostridium difficile

The control of *C.difficile* is an integral part of many infection control activities. The focus this year will be on the following issues

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' document

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 Patients with diarrhoea should preferably be nursed in single rooms, unless an infective cause has been excluded. 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 unavailable

8.5 The Trust will continue to operate the *C.difficile* Enhanced Therapy unit on Robert Hadfield 4. Where clinically appropriate patients with *C.difficile* infection will be transferred to this unit.

8.6 The Microbiology department will continue to provide a 7 day a week *C.difficile* testing service for in-patient samples.

Communication

8.7 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.

8.8 *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

8.9 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.

8.10 The IPCT, Microbiology staff and the Antimicrobial Pharmacists will continue to develop options as to how this can be effectively achieved within the Trust. These include:

a. Reviewing on a rolling basis all trust-wide and Directorate specific antimicrobial policies
b. Implementing a rolling audit programme of compliance with antimicrobial treatment policies
c. Auditing the antibiotics prescribed to patients diagnosed with *C.difficile* infection (both in the community prior to admission and within the hospital)

d. Daily/weekly specialist review ward rounds of prescribing including the type, dose, duration and route of administration of the antimicrobials used.
e. Continuing review of the Restricted Antibiotic Policy
f. Investigating the possibility of changing the drug prescribing kardex to include a specific section for antibiotics
g. Rolling out the Saving Lives High Impact Intervention Antibiotic Prescribing Care Bundle – results would be sent to Directorates quarterly
h. Sending out quarterly reports of antibiotic usage to Directorates
i. Investigating methods of highlighting the need to review long or unusual antibiotic prescriptions – possible solutions could include pharmacists stamping notes highlighting these issues and advising referral to microbiology

8.11 The Trust will work with the NHS Sheffield 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.

<u>Cleaning and environment issues</u>

8.13 Details of general cleaning issues can be found in Section 14

8.14 The IPCT will explore further a range of initiatives and ideas designed to improve the cleaning and disinfection of the environment on an ongoing basis as well as in response to individual cases. These will require input and co-operation from a range of professionals including nursing, managerial and domestic services staff. These may include

a) Widening the area to be cleaned following the identification of a patient with *C.difficile* infection in a bay to include, not only the patient's bed space, but the rest of the bay, the ward toilets, commodes, seat raisers, sluice and nurses station
b) Being particularly vigilant for cases caused by the O27 strain and wherever possible use hydrogen peroxide misting of the areas listed in 8.14a). it is recognised that this may not always be possible.
c) Determining wards with higher than average numbers of *C.difficile* cases and undertaking a regular deep clean of these areas, ideally 1-2 times a year. This would include the Admission Units.
d) Senior nursing staff within the ward/Directorate affected,undertaking an IPC review of the ward after each case of *C.difficle*
e) The IPCT developing a modified IPC environmental tool to allow 8.14d) to take place
f) Training non-IPCT staff to be able them to undertake hydrogen peroxide vapour misting
g) Clarifying the cleaning of beds, including specialist beds, and ensuring all concerned are aware of whose role it is to undertake this task in various settings. Best practice should be rolled out across the Trust.
h) Estates undertaking checks on a number of bed pan washers to ensure they are reaching the required temperature
i) Systematic decluttering of wards to enable optimal cleaning
j) Storing commodes to enable better visualisation of hidden surfaces
k) Investigating alternative arrangements for the disposal of used/dirty water; this is generally poured down the hand washing sinks. The Nurse Directors will canvas users for ideas regarding feasible alternatives which address both the infection prevention and control and health and safety aspects of this activity

C.difficile target

8.15 The Trust will aim to achieve the *C.difficile* target for Trust attributable cases of *C.difficile* diarrhoea.

8.16 The IPCT will contact other trusts, whose performance in respect of reducing the number of cases of this infection, has outstripped that achieved by the Trust. The intention is to determine any lessons that can be learnt and any initiatives that might be considered for implementation within the STH.

Management of *C. difficile* clusters

8.17 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.

8.18 Samples from *C.difficile* clusters will be sent for ribotyping to aid investigation and management of the situation

8.19 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 using the *C.difficile* cluster summary tool.

8.20 The *C.difficle* cluster summaries will be sent by the DIPC to the Chief Nurse/Chief Operating Officer's Office each month.

8.21 On the rare occasions where these reviews are not followed by satisfactory improvement and progress, the escalation process mentioned in Section 6.12 will be used

8.22 *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' document.

9. Influenza

9.1 The Trust Clinical Operations and Pandemic Influenza Planning Officers will continue to lead the review of the Trust Influenza Plan including actions required to address both seasonal and pandemic influenza. Experience from both the 2009/10 and 2010/11 influenza 'outbreaks' will be taken into account. A multi-disciplinary approach will be taken based on the Pandemic influenza Operational Management Team (POMT) model.

9.2 A document covering all aspects of the management of seasonal and pandemic influenza will be produced

9.3 An Action Plan to address the fit testing for FFP3 masks will be developed and implemented

9.4 A review will take place in respect of staff uptake of influenza vaccination. An action plan will be developed to improve uptake rates.

9.5 Staff at all levels within the Trust will be involved in the planning and Action Plans described above, as appropriate

10. Norovirus

10.1 A review will be undertaken of the norovirus triage pathway introduce during the winter of 2010/11

10.2 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) Commencing cleaning throughout the Trust with Chlorclean even if areas do not as yet have cases of norovirus
b) All areas asking every patient admitted to them a set of norovirus screening questions
c) Severely restricting visitors

11. Hand Hygiene/Uniform/Dress Code

11.1 The Board of Directors, TEG, Chief Nurse/Chief Operating Officer's Office, DIPC, IPCT and staff at all levels within the Trust will continue to promote best practice in respect of hand hygiene by continued participation in the 'Cleanyourhands' Campaign and via the Infection Control Accreditation Scheme

11.2 Hand hygiene audits will be undertaken as per the Infection Control Accreditation Programme.

11.3 'Alert' floor motifs will continue to be installed on ward entrances to promote the use of hand hygiene products on entry to ward areas

11.4 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

11.6 Wards/Departments will ensure that patients have access to appropriate hand hygiene products/facilities before meals

11.7 The IPCT, Supplies, Occupational Health and other appropriate departments will work together to optimise the hand hygiene products available to staff and patients.

11.8 The Board of Directors, TEG, Chief Nurse/Chief Operating Officer's Office and DIPC will continue to support the Uniform and Dress Code policy. This includes the Department of Health's 'Bare Below the Elbow' guidance.

12. Decontamination of Medical Devices & Equipment

12.1 The Decontamination Group will continue to review and optimise the decontamination of medical devices.

12.2 The focus will continue to be on:

a) Progressing the Sterile Services Supercentre Project
b) Optimising decontamination of flexible endoscopes

12.3 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 Group. If decontamination is taking place without authorisation, these situations should be referred to the Decontamination Group for review

12.4 Decontamination of ward equipment will be audited via the appropriate module of the Accreditation Scheme

12.5 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.

12.6 The responsibility for maintenance and cleaning of wheelchairs will be clarified with the Medical Equipment Management Group and the Decontamination Group

13. Management of Peripheral and Central intravenous cannulae

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 review

   as per the Trust Management of peripheral cannula Guidelines and DH Care Bundles

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 The IPCT and Microbiology department staff will undertake an annual audit of peripheral cannula use and documentation, see Section 5.7 above.

13.9 The IPCT will review the Accreditation Programme peripheral cannula audit tool to determine if extra elements need to be included based on the results of audits carried out by IPC and Microbiology staff over the past few years

13.10 Further audit and actions may be required, depending on the results of the *Staphylococcus aureus* bacteraemia surveillance schemes, see Section 6.2 above.

14. Environmental and Cleaning Issues

14.1 The Board of Directors, TEG, Chief Nurse/Chief Operating Officer's office and DIPC will continue to optimise cleaning of the environment and to include the IPCT in decisions in this area.

14.2 The Patient Environment Group will continue to meet chaired by the Deputy Chief Nurse. The Group will oversee the deep clean programme, the refurbishment programme and the environmental cleaning standards and protocols for the Trust.

14.3 Requests by wards/departments for upgrades, refurbishments etc will be discussed and prioritised by the Patient Environment Group

14.4 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.

14.5 The IPCT will continue to participate as appropriate in the PEAT/PEAGs

14.6 The Trust will work towards compliance with the National Cleaning Standards

14.7 The rolling programme of audits that the Team undertakes of the cleanliness and state of repair of the commodes, will be replaced by a commode/seat raiser audit being included in the Accreditation Programme. Commode and

seat raiser audits will continue to form part of the reviews in response to C.difficile clusters

14.8 The IPCT, Hotel Services, Estates and clinical staff will continue to work together to agree protocols for
   a) the appropriate cleaning of radiators
   b) the appropriate cleaning of ventilation grills
   c) fans

14.9 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, surfaces etc are appropriately cleaned. Those responsible for each task should be aware of their role and undertake the tasks appropriately.
   c) Cleaning of commodes

14.10 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 taken place
   c) Each bed should have a full clean at least monthly – a label on the bed should indicate that this has taken place

14.11 The trolleys used to transport/store items from SSD to wards/departments will be cleaned monthly – a label on the trolley should indicate when cleaning last took place. This is the responsibility of the SSD department

14.12 The Bulk Store/exchange trolleys will be cleaned monthly – a label on the trolley should indicate when cleaning last took place. This is the responsibility of Bulk Stores staff.

14.13 Senior and supervisory staff will promote the protocols in 14.8, 14.9, 14.10, 14.11 and 14.12 amongst their staff

14.14 The IPCT will work with the Estates department to re-assess the cleaning protocols for Hospedia equipment and how compliance can be improved

14.15 The IPCT will continue to work with Hotel Services, Estates and clinical staff 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*, MRSA etc or individual rooms that have been vacated by patients with particular infections.

14.16 Domestic Services will ensure that disposable mops are not re-used

14.17 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.

14.18 The Estates department will determine the appropriate testing and maintenance schedules for all bed-pan washers within the Trust and develop a programme to undertake this.

14.19 The Estates department will ensure that all relevant Estates policies explicitly contain information regarding co-operation, communication and liaison with the IPCT.

14.20 Where available all computer keyboards in clinical areas should have keyboard covers.

14.21 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

14.22 String pulls in toilets should have a plastic cover

14.23 Infrequently used water outlets will be flushed daily for 5 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.

14.24 The Legionella and Water Quality Steering Committee will develop a programme for the audit of infrequently used outlet flushing and central recording the results

14.25 The Trust will aim to provide a hand washing station at all ward entrances. These will be installed during capital schemes or during ward refurbishment. The most appropriate option will be chosen depending on the ward and entrance layout.

14.26 Wards should use the standard Trust signage to indicate barrier precautions are required. Use of alternative signs should be agreed with the IPCT.

14.27 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 appropriate cleaned

14.28 The IPCT will continue to investigate ATP technology and how it might best be used within the Trust to optimise cleaning.

15. Education and Training

15.1 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.

15.2 This training will be part of the wider Trust mandatory training programme

15.3 Assurance of compliance with the standard in 15.1 will be by Directorates/ Departments reporting via the Healthcare Governance system plus e-learning and Central Induction records. Once fully rolled out the Electronic Staff Record will record training and education information

15.4 The induction IPC e-learning package is available on the Trust e-learning site and is available for all staff to access and use. The IPCT will

a) Continue to review and update the materially annually, as appropriate
b) Review the quiz questions and remove any that are ambiguous or open to interpretation
c) Assess which questions should be in the pool for different staff groups
d) Assess which modules are required for different staff groups
e) Clarify which sections different staff group should attempt

15.6 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 months given the amount of material and information contained within the package

15.7 All current staff should complete the induction e-leaning package before the end of March 2012. This can be used as their annual update.

15.8 The IPCT will produce material for an annual IPC e-learning update which will be available for staff to use after they have completed the full induction package above. This will become available 2012/13. This will be a shorter package than the induction version.

15.9 The IT and Education departments will work with the IPCT to facilitate the above goals.

15.10 Hand hygiene training will be undertaken at the generic Trust induction. training and 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.

15.11 The IPCT will investigate ways of optimising training of staff undertaking infection prevention and control audits. This issue will be included in the link worker training days.

15.12 A review will be undertaken of all the education and training provided by the IPCT to determine which should continue, which should cease and which should continue in a modified format.

16. Communication and Information

16.1 Infection prevention and control information will be displayed at both a ward/department level and also on the Trust web-site

16.2 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 noticeboards. The information will include results of some Accreditation audits e.g. hand hygiene, cleanliness scores and rates of certain organisms e.g. MRSA and C.difficile

16.3 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.

16.4 Review of the information available on the Trust internet site will continue

16.5 The latest Trust IPC Report and IPC Programme will be on the Trust internet site.

16.6 The Trust will continue to work with NHS Sheffield/PCT 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 dependant on both financial and personnel resource constraints.

16.7 The Trust will continue to liaise with NHS Sheffield/PCT with respect of case managing patients discharged into the community that have MRSA.

16.8 The Trust will continue to progress communication and information technology pathways so that information shared between STHFT, NHS Sheffield and Sheffield PCT is secure and efficient.

16.9 The Trust will review the infection prevention and control implications of the Trust assuming responsibility for management of Adult Community Services and other services previously provided by Sheffield PCT Provider Services.

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