INFECTION CONTROL ANNUAL REPORT

2006-07

Northern Devon Healthcare Trust

Dr David Richards

Director of Infection Prevention & Control

Abbreviations:

CDAD	*Clostridium difficile* Associated Disease
DIPC	Director of Infection Prevention & Control
GRE	Glycopeptide resistant enterococcus A form of the organism, enterococcus, which is resistant to the glycopeptide antibiotics, Vancomycin & Teicoplanin.
HCW	Healthcare worker
ICC	Infection Control Committee
ICN	Infection Control Nurse
ICT	Infection Control Team
MRSA	Meticillin resistant *Staphylococcus aureus* A form of the common organism *Staphylococcus aureus* which is resistant to penicillin and related antibiotics, but can usually be treated by a range antibiotics, both tablets and injection
NDHT	Northern Devon Healthcare NHS Trust
PEAT	Patient Environment Action Team
PPI forum	Patient & Public Involvement Forum
wte	whole time equivalent

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Executive summary:

Infection Control has continued to have a high priority with the Department of Health, the Strategic Health Authority and the public. Not only has MRSA been in the headlines but *Clostridium difficile* has now had similar, if not higher, profile.

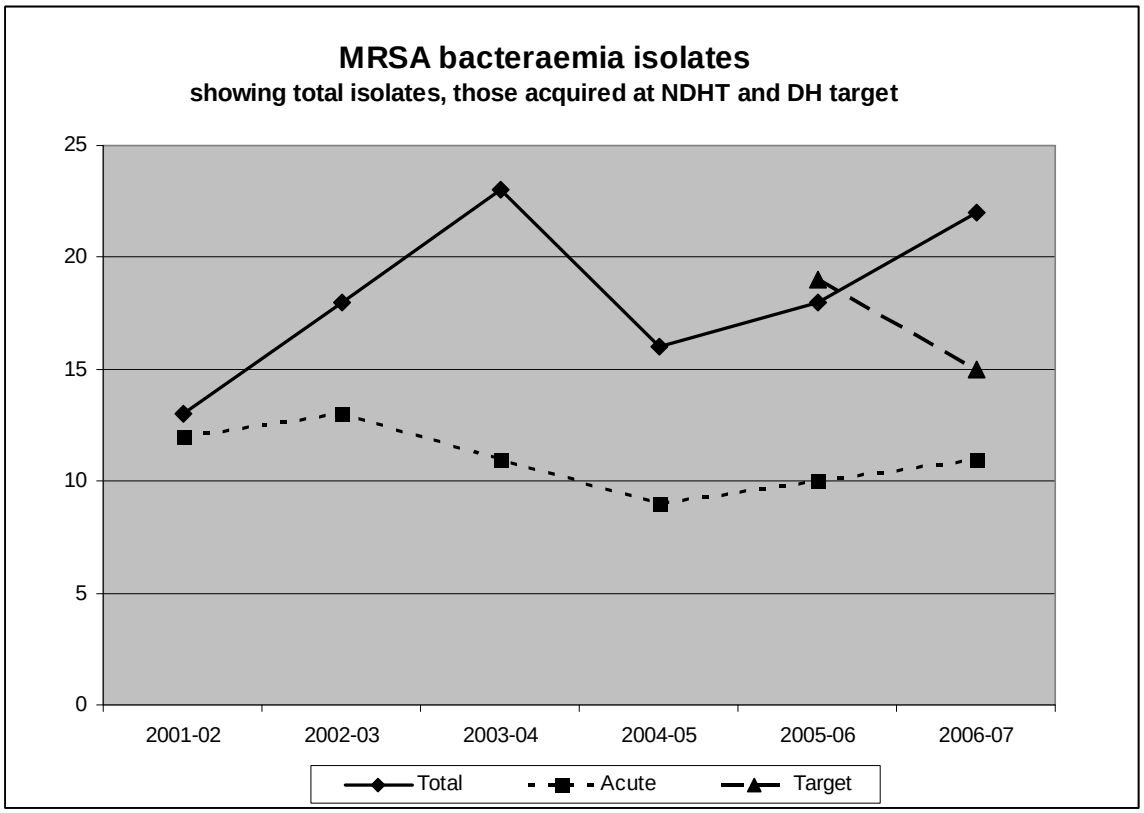
In summary the key points for 2006-07 are:

- A dramatic fall in the rate of *Clostridium difficile*. Levels have fallen dramatically by over 70% over 2006-07.
- A continued rise in the overall rate of hand hygiene compliance with also a good improvement in the compliance in doctors
- Rates of infection following hip surgery (hemiarthroplasty) are still well below the national average
- The Trust again declared compliant with the infection control element (Standard 4a) of the Standards for Better Health
- Funding for additional Infection Control Nurse posts and also for an Antibiotic Pharmacist
- The Trust failed to meet the MRSA bacteraemia target due, in part, to the large proportion of bacteraemias acquired outside the Trust
- Infection Control training is now included in all annual update training for staff
- The results of the Third Prevalence Survey of Healthcare Associated Infections in Acute Hospitals 2006 showed that the Trust had a rate of 10.7% compared to a national rate of 8.2%. The Trust had above average rates for urinary, skin and ear, nose & throat infections; and below average rate for pneumonia, bloodstream and post surgery infections.

MRSA

The Department of Health's target to reduce MRSA bacteraemias by 50% by 2007-08 has meant that the target for the Trust for this year was reduced to 15. The Trust failed to meet this challenging target: recording 22 bacteraemias for the year. 11 (50%) of these were related to infections acquired outside the Trust. This highlights the difficulty the Trust will have meeting the coming targets as, in common with other trusts, a large proportion of bacteraemias are from outside the Trust. The target for 2007-08 is 12 bacteraemias.

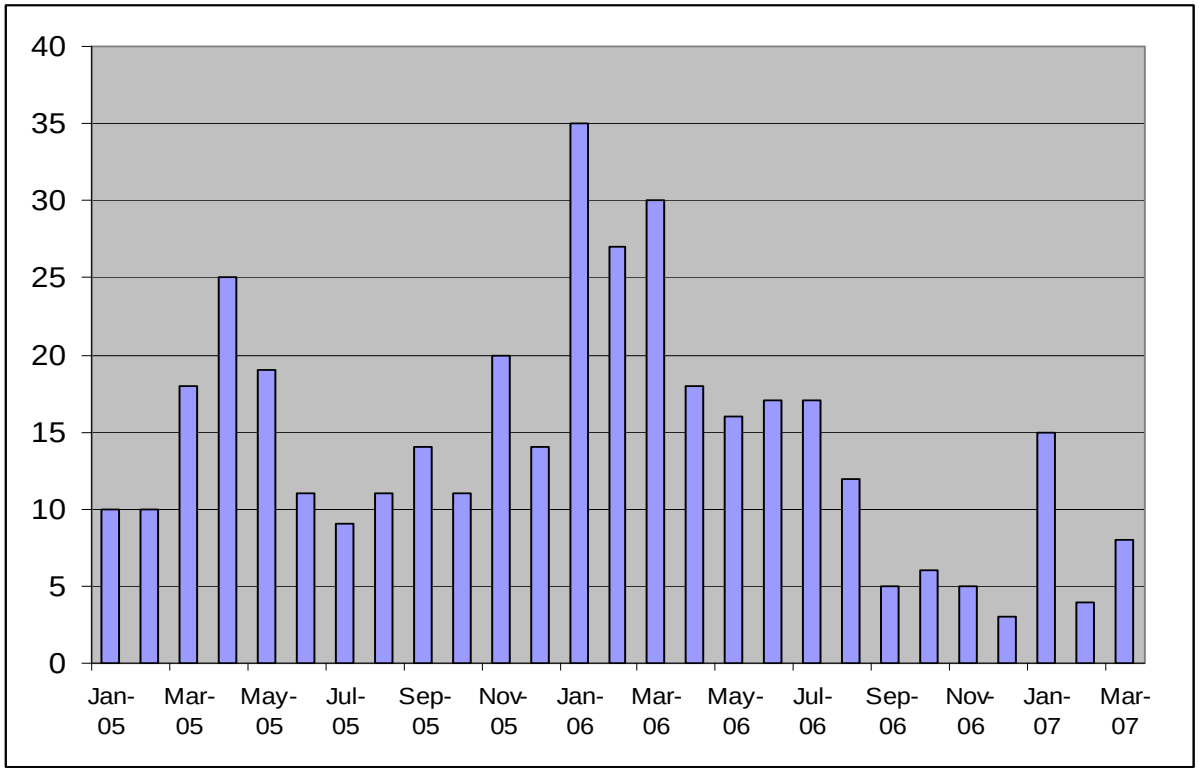
Of the bacteraemias related to infections acquired inside the Trust the largest numbers are related to infections of lines (both central and peripheral lines) and urinary catheters. The Trust will be implementing the Saving Lives programme to specifically address these areas.



Clostridium difficile

In the latter part of 2005-06 the Trust was experiencing the highest levels of *Clostridium difficile* that it had ever seen. A number of measures were introduced locally in April 2006; including a change to the recommended antibiotics for treating chest infections, guidance on treating suspected cases of *Clostridium difficile*, including starting treatment on suspicion rather than waiting until a positive result is received and emphasis on correct cleaning procedures.

Following the introduction of these measures the number of cases has fallen dramatically: 97 cases between January and March 2006 but with only 27 cases for the corresponding period in 2007. The significance of this success should be viewed against the national picture which shows an increase from 2006 to 2007.



Monthly numbers of *Clostridium difficile* toxin positive tests from North Devon Data from patients of all ages

The Third Prevalence Survey of Healthcare Associated Infections in Acute Hospitals 2006

The trust participated in this national survey and included all inpatients apart from the admission and children's wards. It measured all the infections that were present at the time of the survey and acquired more than 2 days after admission to hospital

23 patients were identified with an infection this corresponds to an overall rate of 10.7% compared to a national rate of 8.2%.

The highest rates of infection were for urinary, skin and eye, ENT & mouth infections. However the eye, ENT & mouth infections were mild and treated with creams (topical therapy).

The Trust had low and below average rates for pneumonia, bloodstream and post surgery infections.

Five of the 23 patients had MRSA infections, which equates to a rate of 2.3% compared to a national rate of 1.3%. One of these was a blood stream infection (MRSA bacteraemia), one was a urinary infection and three were soft tissue infections.

Standards for Better Health / Code of Practice

Infection Control activities are included under standard 4a of the Standards for Better Health and are assessed by the Healthcare Commission. The Trust self assess against these standards and reports to the Healthcare Commission. Towards the end of 2006-07 the Healthcare Commission changed the content of Standard 4a to include compliance with the 'Code of Practice for the Prevention and Control of Health Care Associated Infections' (part of the Health Act 2006). Following a gap analysis of compliance with the 'Code' and implementation of the actions the Trust self assessed as compliant (green) with this standard for 2006-07.

In June 2006 the Healthcare Commission published guidance on assessing compliance with the Code. The ICT has used this self assessment and has found a number of areas where actions can be taken to improve compliance. These will be taken forward over 2007-08. The self-assessment action plan and the Infection Control Annual Plan are included as appendices to this report.

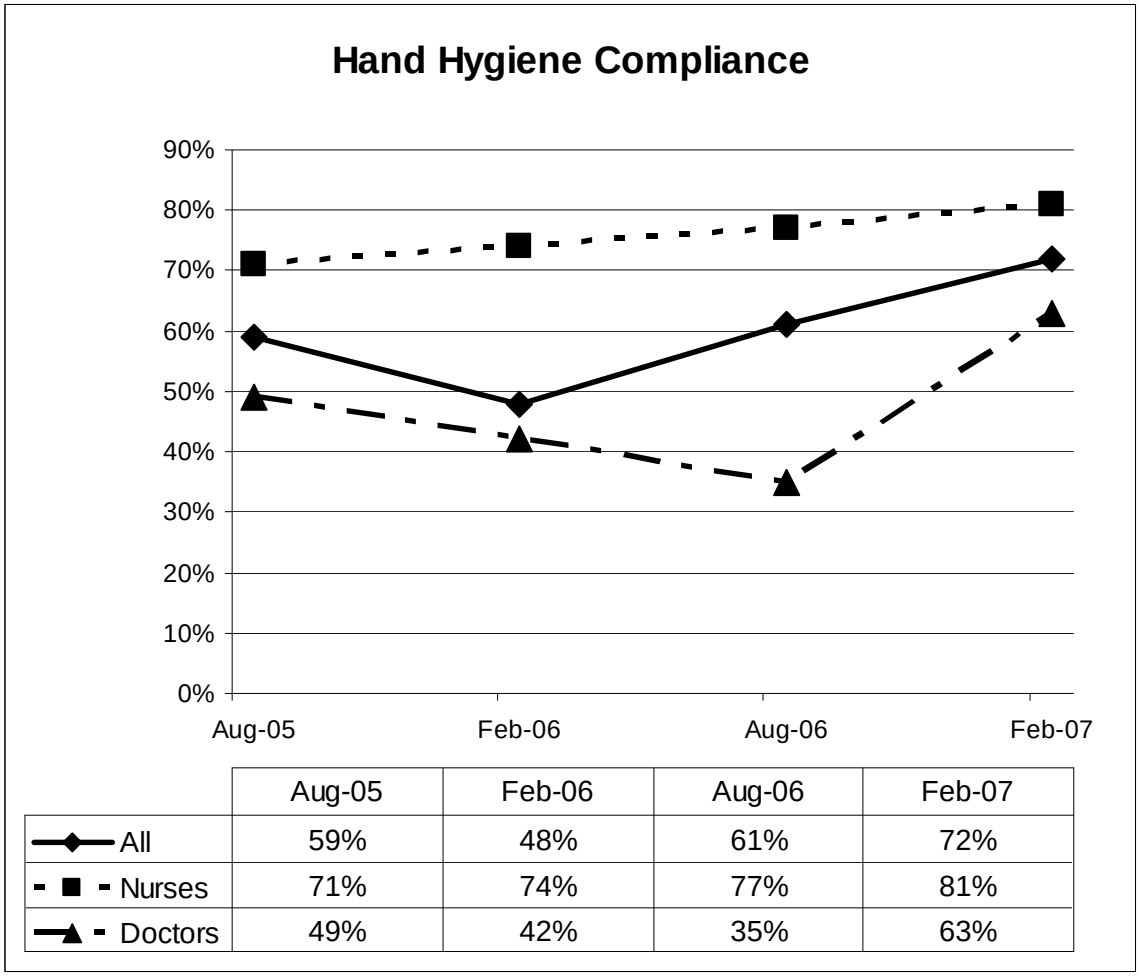
Orthopaedic surgical site infection

Hip hemiarthroplasty

The Trust is mandated to perform surveillance of surgical site infections for one type of orthopaedic surgery for at least one quarter each year. This year the procedure of hip hemiarthroplasty was chosen. One infection was detected in the 21 operations performed, which is an infection rate of 4.8%. If, however, all 96 operations studied since 2001 are considered the infection rate is only 2.1% which is significantly below the national rate of 4.3% for this procedure.

	No. of operations	No. of infections detected	Infection rate
Current surveillance 2006-07	21	1	4.8%
Total of all surveillance 2001-07	96	2	2.1%
National rate			4.3%

Hand Hygiene



	Aug-05	Feb-06	Aug-06	Feb-07
All	59%	48%	61%	72%
Nurses	71%	74%	77%	81%
Doctors	49%	42%	35%	63%

Hand hygiene compliance is one of the cornerstones of good infection control practice. The last annual report had shown that, although overall compliance was increasing, the rate amongst doctors was actually decreasing. This had been highlighted across the Trust and it is significant that this year the annual report can show that the total compliance and that for doctors has increased this year. The rate for doctors being the highest since this series of audits was commenced in August 2005. The Trust continues to implement the national cleanyourhands campaign, which is now entering its third year.

Staffing & Finance

In the latter part of 2006-07 approval to increase the staffing levels of the ICT was obtained. Early 2007-08 has seen the advertisements for additional members of the ICT at band 8b (0.7 wte) and band 7 (0.5 wte).

This year saw the approval of the funding of an Antibiotic Pharmacist at band 8a. An appointment has been made; the appointee will join the Trust in mid 2007-08.

In December 2006 the Department of Health announced additional funds for acute trusts. NDHT secured funding for £300,000. The ICT worked hard to submit the bid within a very short timescale and subsequently to arrange the spending of the funds.

The funding allowed:

- The replacement of the old ward macerators across the Trust
- The replacement of carpet by easily cleaned covering, such as lino, in clinical areas in NDDH and community hospitals
- Purchase of an e-learning package to permit infection control training of staff who can not easily attend routine training sessions
- Replacement of some conventional taps by sensor taps in ward areas across the acute hospital to aid hand hygiene
- Purchase of steam cleaners to improve cleaning across NDHT
- Purchase of additional ward equipment including commodes, linen skips, hoist slings and dispensers for gloves & gowns
- Installation of signage across the Trust to promote hand cleaning. The logo was designed by the ICT and used on wall and floor signs to show the location of hand washing facilities

'Are your hands clean?'
Trust Hand Hygiene Logo

Introduction

Infection Control has continued to have a high priority with the Department of Health, the Strategic Health Authority and the public. Not only has MRSA been in the headlines but *Clostridium difficile* has now had similar, if not higher, profile.

In summary the key points for 2006-07 are:

- A dramatic fall in the rate of *Clostridium difficile*. Levels have fallen dramatically by over 70% over 2006-07.
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- Funding for additional Infection Control Nurse posts and also for an Antibiotic Pharmacist
- The Trust fail to meet the MRSA bacteraemia target due in part to the large proportion of bacteraemias acquired outside the Trust
- Infection Control training is now included in all annual update training for staff

This report, unless otherwise stated, refers to the period April 2006 to March 2007.

The format of this report is based on a pro forma issued by the Inspector of Microbiology.

Description of infection control arrangements

Infection control team (ICT)

In North Devon the ICT operates very successfully as a combined team covering the Acute Trust, Primary Care Trust (PCT), Devon Partnership Trust (DPT) and the Health Protection Agency (HPA). Thus what would otherwise be four very small teams can combine their staff. This allows the combined team to be led by an experienced Band 8a ICN with lower grades in supporting roles. The larger team permits exchange of ideas and experience and prevents professional isolation as well as providing cover during periods of leave. The services for and income from the PCT, HPA & DPT are governed by service level agreements.

Currently, following the vertical integration of some of the responsibilities of the North Devon Primary Care Trust in mid 2006-07, notably that of the five community hospitals and the associated funding, the majority of the work of the ICT is concerned with the NDHT.

At the end of 2006-07 there were 3 ICNs (2.8 wte) in post for the whole ICT. There is additional funding to appoint 2 more ICNs (0.7 wte Band 8b & 0.5 wte Band7). These will be advertised in 2007-08.

There are two Consultant Medical Microbiologists who contribute medical input to the ICT. One of these is the Infection Control Doctor and Director of Infection Prevention & Control (DIPC) for the Trust. The DIPC is directly responsible to the Chief Executive for Infection Control issues within the Trust and reports directly to the Trust Board.

The Infection Control Team is available to provide advice 24 hours a day. The out of hours service is provided by the Consultant Medical Microbiologist on call.

Infection Control Team members (on 31/3/07):

Band 8a	1 wte	Lead Infection Nurse, Clinical Nurse Specialist Infection Control
Band 7	0.8 wte	Clinical Nurse Specialist Infection Control
Band 6	1 wte	Infection Control Nurse
Band 3	0.8 wte	Secretary
Medical	0.4 wte	Infection Control Doctor/ Director of Infection Prevention and Control/ Consultant Medical Microbiologist
Medical	0.1 wte	Consultant Medical Microbiologist

Currently advertising for additional:

Band 8b	0.7 wte	Clinical Manager/Clinical Nurse Specialist Infection Control
Band 7	0.7 wte	Clinical Nurse Specialist Infection Control

Infection Control Committee (ICC)

In December 2006 the Trust Board approved the Chief Executive taking the chair of the ICC. The ICC has also been strengthened by the inclusion of lead clinicians from medicine and surgery.

The ICC is a Special Advisory Group of and reports to the Clinical Governance Committee.

The minutes are sent to the Clinical Governance Committee and are available on the Trust intranet.

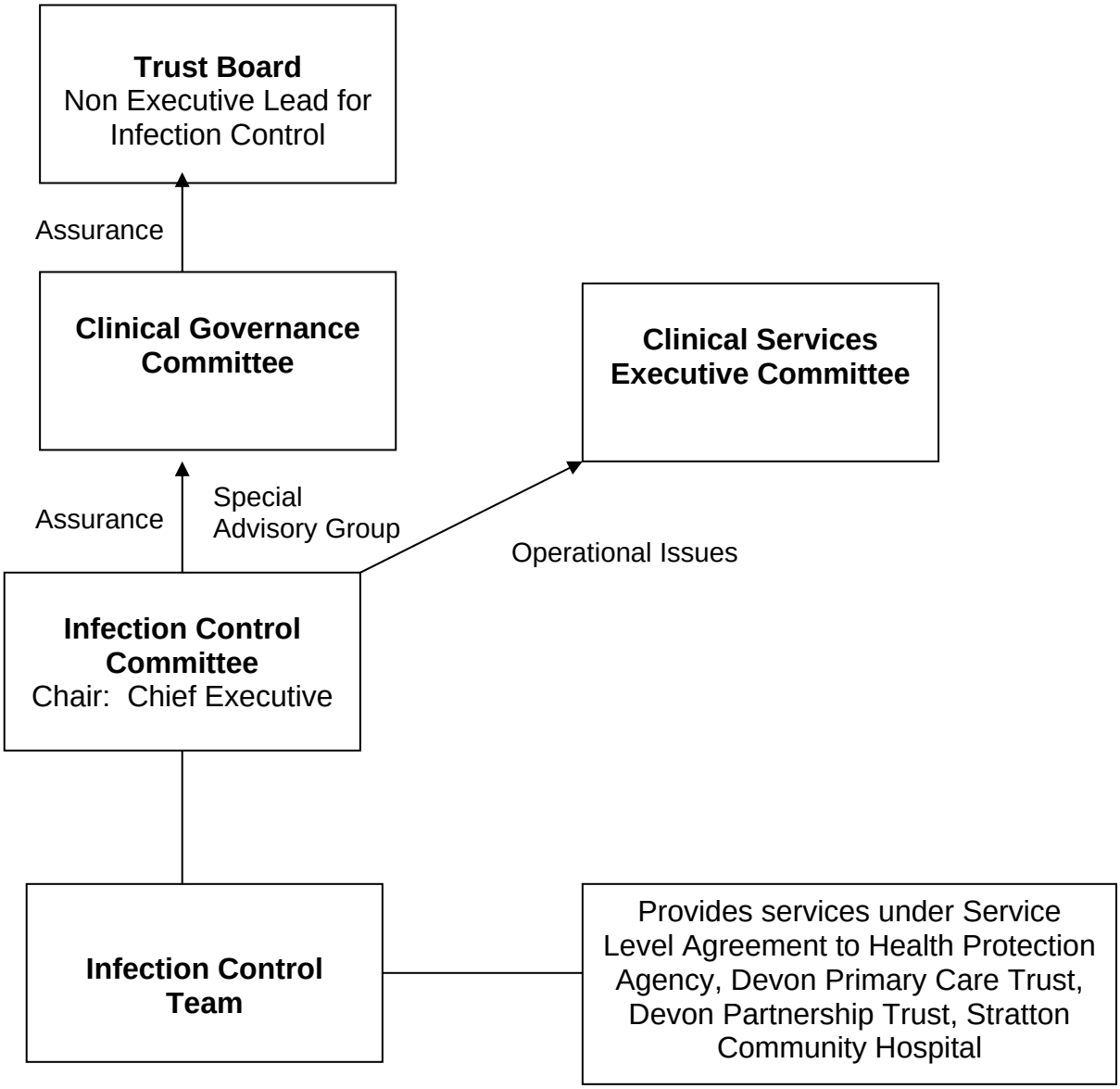
The ICC agreed changes to the format of the Annual Plan to indicate more clearly the key infection control activities for the coming year.

The annual report is sent to the Governance Committee, Trust Management Board and the Trust Board.

ICC membership:

- Chief Executive (Chair)
- Director of Operations
- Medical Director
- Director of Nursing
- DIPC
- Infection Control Doctor
- Lead ICN
- ICT
- Lead Clinician for Medicine
- Lead Clinician for Surgery
- Lead Nurse for Medicine
- Lead Nurse for Surgery
- Women & Children's Directorate representative
- Outpatient Services Representative
- Radiology Representative
- Community Directorate Representative
- Clinical Governance Representative
- Director of Pharmacy
- Occupational Health representative
- Decontamination Lead
- Estates & Facilities Representative
- Health & Safety Advisor
- Consultant in Communicable Disease Control (Health Protection Agency)

NORTHERN DEVON HEALTHCARE TRUST ORGANISATIONAL CHART OF INFECTION CONTROL ARRANGEMENTS



Director of Infection Prevention and Control:

- Reports directly to Trust Board and Chief Executive
- Member of Infection Control Committee and Clinical Governance Committee
- Leads Infection Control Team
- Is Infection Control Doctor

Reporting line to the Trust Board

The DIPC reports quarterly to the Trust Board. The Annual Report is presented to the Trust Board.

Links to Prescribing and Formulary Committee

The Director of Pharmacy is a member of both the Drugs and Therapeutics Committee and the ICC.
In 2006-07 an Antibiotic Working Group was formed. It is a subgroup of Drugs and Therapeutics Committee with authority to make decisions regarding antibiotic use in Trust. Its membership includes Consultant Medical Microbiologists (who are part of the ICT) and pharmacists (including the Director of Pharmacy and the antibiotic Pharmacist – not yet in post). Further details are given in Antimicrobial Prescribing section.

Links to Clinical Governance/Risk Management/Patient Safety

The ICC is a 'Special Advisory Group' of the Clinical Governance Committee and reports to it with respect to governance issues. The minutes, annual plan, annual report and terms of reference are all sent to the Clinical Governance Committee.
The DIPC is a member of the Clinical Governance Committee.
The lead ICN is a member of the Trust Health & Safety Committee.

Link Practitioners

Link Practitioners are HCWs, usually one per ward or department, who have a particular interest in Infection Control. They attend regular study days, participate in audit and act as an initial point of contact for Infection Control enquiries in the work area. The Link Practitioners represent an important resource which should be developed by requiring every ward and department to have one and to provide protected time for them to undertake their Infection Control duties.

DIPC reports to the Trust Board

Number and frequency

The DIPC has reported quarterly to the Trust Board since October 2004

Annual Action Plan

The Infection Control Annual Plan is agreed by the ICC and quarterly progress reports are made to the ICC.

Board decisions

The Board reports include details of MRSA and *Clostridium difficile* infections, hand hygiene audit results. These are all discussed in depth along with the Trust's approach to improving the figures. The Board has noted that the MRSA bacteraemia target for the Trust includes all bacteraemias identified at the Trust even though about half of these are acquired outside the Trust and are therefore not under the direct influence of the Trust. The Board approved the decision for the Chief Executive to chair the Infection Control Committee.

Outbreak reports

The Board received reports of outbreaks as part of the quarterly reports, the Annual Report and other times as required.

Budget allocation to infection control activities

The budget for the combined ICT is mainly from NDHT and also through income from the Devon Primary Care Trust, Health Protection Agency & Devon Partnership Trust as determined by service level agreements. As a result of the vertical integration of services from North Devon Primary Care Trust the budget available to the Trust increased and has allowed the advertisement of additional infection control nurse posts as mentioned in the staffing section.

The Infection Control budget covers pay for nurses and administrative staff but not medical staff who are funded from Pathology. The budget funds staff to the level indicated in the staffing structure. However the job plans of the consultant medical microbiologists do not specify the number of hours to be devoted to infection control activities.

Non-pay budget is £3,573 including travel expense payments. Some income is generated by an annual community study day organised by the ICT.

Additional Department of Health funding

In December 2006 the Department of Health announced additional funds for acute trusts to spend on capital projects. NDHT secured funding for £300,000. The ICT worked hard to submit the bid within a very short timescale and subsequently to arrange the spending of the funds.

The funding permitted:

- The replacement of the old ward macerators across the Trust
- The replacement of carpet by easily cleaned covering, such as lino, in clinical areas in NDDH and community hospitals
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- Installation of signage across the Trust to promote hand cleaning. The logo was designed by the ICT and used on wall and floor signs to show the location of hand washing facilities

'Are your hands clean?'
Trust hand hygiene logo

HCAI statistics including results of mandatory reporting

MRSA bacteraemia

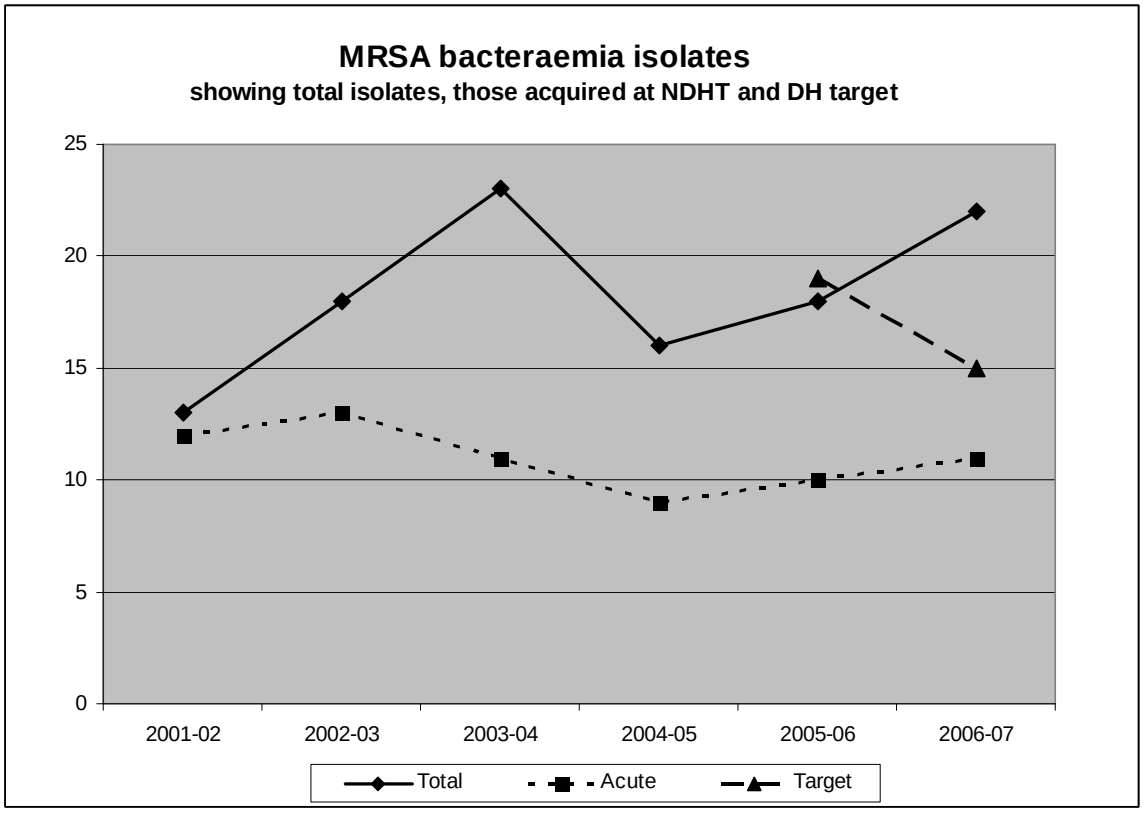
There were 22 MRSA bacteraemias identified by the Trust this year. This is an increase from a total of 18 for last year. 11 of the isolates were from infections acquired in the Trust, an increase from 10 for last year.

The sources of the infections, when identified, are similar to those seen in previous years being related to central lines (3), skin infection (1), urine infection (1) and prosthetic joint infection (1).

Target DH & SHA		Year		**Total**	NDHT	Outside NDHT	SMKU	Out area
		2001-02		**13**	12	1	0	0
		2002-03		**18**	13	5	0	0
		2003-04		**23**	11	8	1	3
		2004-05		**16**	9	4	2	1
19		2005-06		**18**	10	3	4	1
15		2006-07		**22**	11	11	0	0
		2006-07	Q1	6	4	2	0	0
			Q2	6	2	4	0	0
			Q3	5	2	3	0	0
			Q4	5	3	2	0	0

MRSA isolates from blood cultures by probable location of infection
SMKU – South Molton Kidney Unit

The Infection Control Team have been identifying the source of the bacteraemia where possible and reporting all bacteraemias to the Department of Health. From the middle of the year the Infection Control Team have been undertaking a more formal analysis of each case with the clinical team responsible for the patient's care. The results of this 'Root Cause Analysis' are reported externally to the Primary Care Trust and internally to members of the Infection Control Committee. Any additional actions that are identified through this process are incorporated into the Annual Plan.



Serious MRSA infections

Since 2005 the infection control team has been collecting data relating to the number of serious MRSA infections treated at NDDH. These include all the infections associated with MRSA bacteraemias but also those infections which did not result in a positive blood culture but were sufficiently serious to require intravenous antibiotics.

The table indicates the probable source of the infection and includes all of the MRSA blood culture isolates. Due to the surveillance techniques it is possible that not all serious infections will be identified.

		2005-06	2006-07
Acquired NDDH	Medicine	**19**	**19**
	Surgery	**20**	**19**
	Orthopaedic	**4**	**5**
	Women & Children	**0**	**1**
Total for NDDH		**43**	**44**
Total acquired outside NDDH		20	35

Serious MRSA infections in North Devon and their likely origin.

As the number of serious infections is higher than the number of bacteraemias it is possible to have a better indication of the areas within the Trust that require most attention in reducing the burden of MRSA infection. The data demonstrates that, as with the bacteraemias, a significant proportion of the serious MRSA infections are acquired outside the Trust.

MRSA colonisation

The ICT monitors the numbers and locations of patients newly diagnosed as colonised with MRSA. The figures are shown in the table. There are many difficulties in interpreting these data. Individuals may be found by screening to have MRSA, but not to have infection. The more screening that is carried out the more positive individuals will be found. The location of a patient when found to be positive does not necessarily relate to the location where the MRSA was acquired. MRSA could have been acquired at any time or location in the past. Indeed individuals are being recognised as MRSA positive that have had no contact with healthcare institutions in the past.

These figures show a fall in the numbers of colonised patients identified but should be interpreted with caution.

Numbers of patients newly identified as MRSA colonised

	2004-05	2005-06	2006-07
NDHT	229	212	149
Community	290	244	239
Total	519	456	388

Glycopeptide resistant enterococcus (GRE) bacteraemia

There were two reports of glycopeptide resistant enterococcus (GRE) bacteraemias for this year. These were isolated cases and occurred some months apart. The patients were not ill enough to require specific treatment for these organisms.

GRE are organisms that are resistant to many commonly used antibiotics, but can be treated with newer antibiotics. They do not usually cause serious infections unless the individual is severely immunocompromised. GRE bacteraemia is associated with renal and haematology units where there are immunocompromised patients and glycopeptide antibiotics are used frequently.

	2003-04	2004-05	2005-06	2006-07
GRE bacteraemia isolates	0	1	1	2

Data for GRE bacteraemia isolates reported to DH for NDHT

Clostridium difficile

The ICT monitors the numbers of isolates of *Clostridium difficile* associated disease (CDAD). These are individuals who have diarrhoea and have *Clostridium difficile* toxin (CDT) found in their stools. Since January 2004 NDHT has been required to report all such isolation from people over the age of 65 years.
Risk factors for acquiring CDAD include increasing age (especially over 65 years), other medical problems, bowel surgery and antibiotic use.

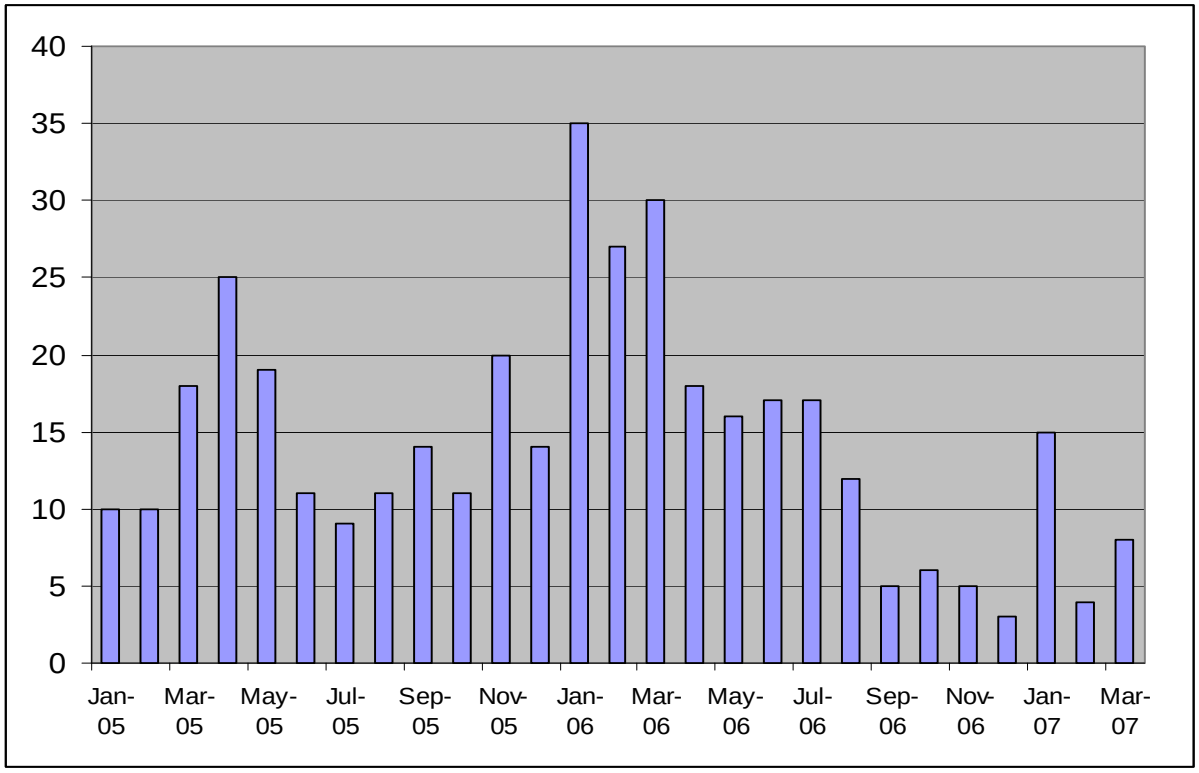
	2004	2005	2006
Number of episodes	56	157	176
Rate (per 1000 bed-days for patients aged over 65 years)	0.88	2.47	2.77
Average acute trusts in England	1.92	2.23	2.39

Data for *Clostridium difficile* reported by DH for NDHT for patients aged over 65 years.

All trusts are required to report all cases of CDAD detected by their laboratory whether they occur in their trust or in the community, but the denominator refers only to the beds in the trust.

Clostridium difficile numbers are usually highest in the January - March quarter in each year. However throughout 2005 there was an increase in the number of cases of *Clostridium difficile* resulting in a total of 97 cases in Jan-Mar 2006.
In April 2006 a range of specific measures were introduced locally to reduce the high number of *Clostridium difficile* cases. These included a change to the recommended antibiotics for treating chest infections and guidance on treating suspected cases of *Clostridium difficile*, including starting treatment on suspicion rather than waiting until a positive result is received.
Following the introduction of these measures the number of cases has fallen dramatically, from 97 in Jan-Mar 2006 to 27 cases for Jan-Mar 2007.
Nationally, outbreaks of *Clostridium difficile* have been associated with the new, more potent, 027 strain of *Clostridium difficile*. In common with many other

hospitals across the country this strain has been isolated from patients in North Devon.



Monthly numbers of *Clostridium difficile* toxin positive tests from North Devon
Data from patients of all ages

The achievement in reducing the *Clostridium difficile* numbers to, now, well below the national average is especially notable given the background of an increase in the national figures over this period.

The Department of Health has issued guidance that each Trust should be set a target to eventually achieve a rate of 1 case per 1000 bed-days for those over 65 years of age. The Devon Primary Care Trust has set NDHT a target of 174 cases for 2007-08. This equates to a rate of 2.73 cases per 1000 bed-days.

Mandatory surveillance of orthopaedic surgical site infection

Hip hemiarthroplasty

	No. of operations	No. of infections detected	Infection rate
Current surveillance 2006-07	21	1	4.8%
Total of all surveillance 2001-07	96	2	2.1%
National rate			4.3%

The Trust is mandated to perform surveillance of surgical site infections for one type of orthopaedic surgery for at least one quarter each year. This year the procedure of hip hemiarthroplasty was chosen. One infection was detected in the 21 operations performed, which is an infection rate of 4.8%. If, however, all 96 operations studied since 2001 are considered the infection rate is only 2.1% which is significantly below the national rate of 4.3% for this procedure.

Untoward incidents including outbreaks

In common with other trusts across the country NDHT experienced outbreaks of viral diarrhoea and vomiting. These were primarily caused by Norovirus and occurred mainly in the winter months. The virus affects many people in the community and occasionally the virus affects patients in the Trust. When this happens the virus can spread easily from patient to patient. To curtail the spread of the virus around the hospital wards or bays within the wards have to be ‘closed’. This means that patients can not be transferred out of or into that area until the infection has subsided. Patients can still be moved to another part of the hospital if their clinical condition warrants and can be discharged home. There are policies in place to cover such incidents and the Infection Control Team has developed an ‘outbreak pack’ to assist the wards in managing these cases of diarrhoea and vomiting. This pack has been in use for some years now and was

revised for 2006-07. The Infection Control Team is available 24 hours a day for advice and has authority to ‘close’ wards or bays to patient transfers. When Norovirus is prevalent in the local community floor-standing notices, developed by the Infection Control Team, are placed at the public entrances to hospitals in the Trust to inform visitors not to come if they have had, or been in contact with diarrhoea or vomiting.

The impact of Norovirus on the Trust was less this year than in 2005-06, however there was one occasion when the whole of South Molton Community Hospital was affected by Norovirus and a ‘Serious Untoward Incident’ was declared. Over a 14 day period in February 2007 diarrhoea and vomiting affected 18 patients and 26 staff. This required the ‘closing’ of the community hospital to new admissions.

Over the whole of 2006-07 there were a total of 23 clusters of diarrhoea and/ or vomiting affecting a ward resulting in the closure of at least a bay. Sometimes only one bay was closed, sometimes more than one bay was closed and occasionally the situation required the closure of a whole ward.

On average an area was affected for 8½ days. The majority of the closures were between January and March 2007. A total of 195 patients and 62 staff were reported as symptomatic and at least 442 bed-days were lost as a result. Norovirus was detected from 7 of the outbreak-episodes and *Clostridium difficile* from 5.

The Infection Control Team and the Bed Management Team worked hard to minimise the spread of infection and to arrange the admissions around the reduced number of available beds. Although a lot a patients and staff were affected the Trust staff were successful at reducing further spread of the disease thus limiting the impact on the Trust.

The Third Prevalence Survey of Healthcare Associated Infections in Acute Hospitals 2006

The trust participated in this national survey and included all inpatients apart from the admission and children's wards. It measured all the infections that were present at the time of the survey and acquired more than 2 days after admission to hospital

23 patients were identified with an infection this corresponds to an overall rate of 10.7% compared to a national rate of 8.2%. The infections are detailed in the chart

Infection Types	**Number of Infections**	**NDDH**	England	NDDH rate vs national
Bone and Joint	0	0.0 %	1.2%	
Cardiovascular System	0	0.0 %	1.1%	
Central Nervous System	0	0.0 %	0.3%	
Eyes, ENT or Mouth	6	24.0 %	2.9%	High
Gastrointestinal System	4	16.0 %	22.0%	
Lower Respiratory Tract (not pneumonia)	1	4.0 %	6.0%	
Pneumonia	1	4.0 %	13.9%	Low
Primary Bloodstream	1	4.0 %	6.8%	Low
Reproductive Tract	0	0.0 %	0.6%	
Skin & Soft Tissue	5	20.0 %	10.5%	High
Surgical Site	0	0.0 %	13.8%	Low
Systemic	0	0.0 %	1.2%	
Urinary Tract	7	28.0 %	19.7%	High

The highest rates of infection were for urinary, skin and eye, ENT & mouth infections. However the eye, ENT & mouth infections were mild and treated with creams (topical therapy).

The Trust had low and below average rates for pneumonia, bloodstream and post surgery infections.

Five of the 23 patients had MRSA infections, which equates to a rate of 2.3% compared to a national rate of 1.3%. One of these was a blood stream infection (MRSA bacteraemia), one was a urinary infection and three were soft tissue infections.

This ‘snap shot’ of the infections in the hospital provides useful confirmation of where the maximum infection control effort needs to be applied. All the activities of the infection control team are directed to reducing infections. The Saving Lives programme from the Department of Health specifically addresses the most important of these. The Trust will be implementing this initiative, which has been updated in early 2007-08 in the course of the coming year.

Antimicrobial resistance

MRSA and GRE data are mentioned elsewhere.

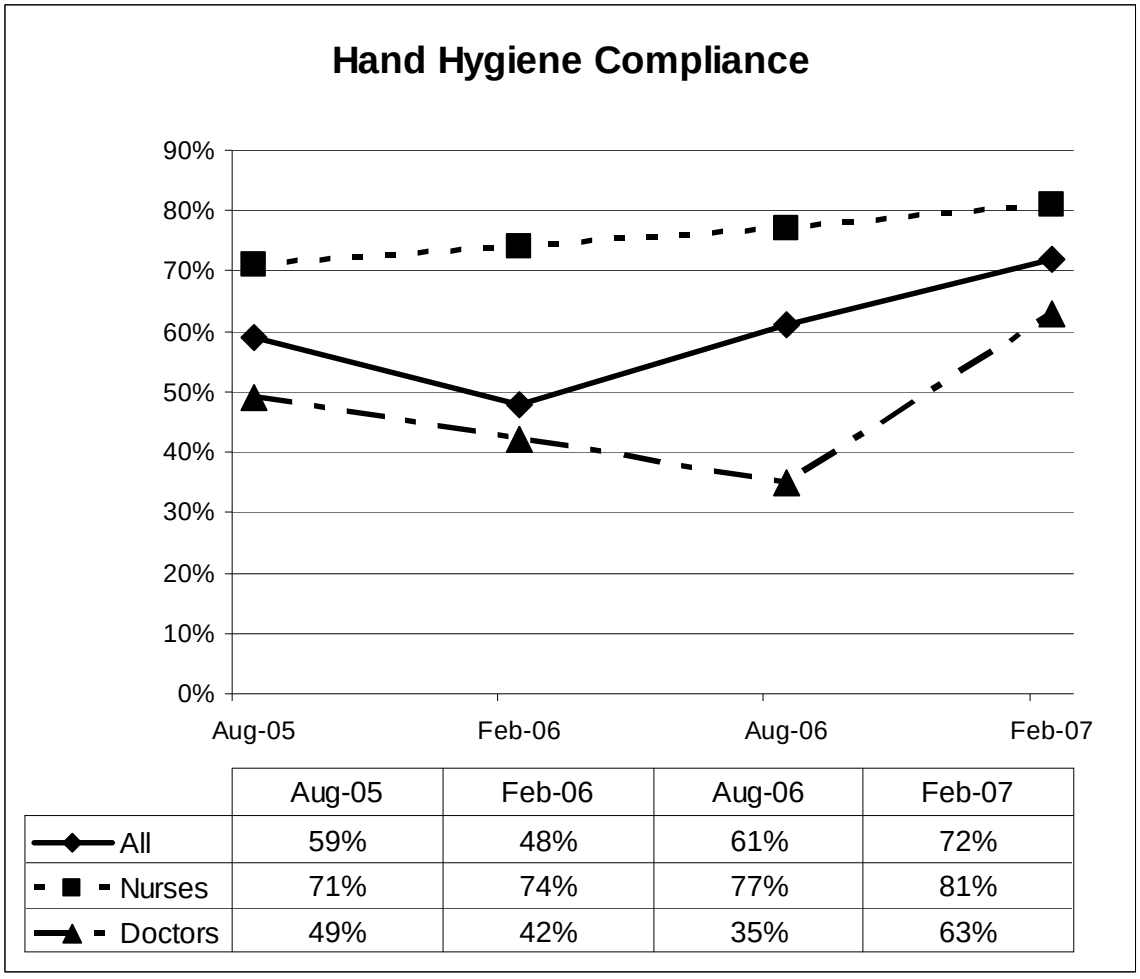
This year has seen a steady number of isolates of extended spectrum ßlactamase (ESBL) producing bacteria from patients in North Devon. The majority of these organisms detected in urine specimens from patients in the community. Characteristically the organisms are resistant to most oral antibiotics but remain susceptible to certain intravenous antibiotics. This can make treating simple urinary tract infections difficult as a patient may need admitting to treat an infection that could otherwise have been treated with tablets at home.
To date very few of these organisms have been identified from in-patients, but if the national trend is to be followed North Devon will see an increasing number of these organisms from in-patients. The spread of these organisms from person to person is prevented by the use of standard infection control precautions which are applied to every patient.

There have been a few isolates of multiresistant *Acinetobacter* species detected but these have not been associated with person-person spread nor the intensive care unit where these organisms have caused problems in other trusts.

Hand hygiene and Aseptic protocols

Implementation of 'cleanyourhands' campaign

The Trust is implementing the cleanyourhands campaign which was launched in January 2005. This includes the displaying of posters, changed monthly, in all hospital departments and the distribution of badges to staff. The Trust continues to place alcohol hand gel on all patient lockers and ward entrances where appropriate. In some areas, such as the paediatric ward, it was not appropriate to use bedside alcohol gel. These areas use personal dispensers which can be clipped to the clothing of staff.



	Aug-05	Feb-06	Aug-06	Feb-07
All	59%	48%	61%	72%
Nurses	71%	74%	77%	81%
Doctors	49%	42%	35%	63%

All wards and departments such as outpatients and theatres in the acute hospital are involved in the campaign. The campaign has been well received by staff, patients and visitors. The community hospitals are not presently included in the national campaign; there is the intention for the campaign to be extended to them in 2007-08.

The Trust is now participating in the third year of the campaign with a new selection of monthly posters and also posters showing local ‘champions’. These are members of the ward staff pictured on posters bearing the wording ‘we can, so can you’.

Other materials used this year included ‘point of use’ stickers (to promote alcohol gel usage), information cards sent to key trust personnel (Board members & consultants) and enamel badges.

Audits of hand hygiene compliance are undertaken every six months by the link practitioners in each area. It has been agreed at the Infection Control Committee to increase the frequency of these audits to 3 monthly. The results are fed back to the clinical areas and directorates concerned as well as to Trust Board.

The audit results show that overall compliance is above the national average of 40% and rises from 59% to 72%. However analysis of staff groups shows that the compliance of nurses is very good rising from 71% to 81% whilst that for doctors is poor and actually fell from 49% to 35%. This poor result was widely disseminated across the Trust with the message that hand hygiene is an important part of patient care and that it is applicable to all health care workers. The following audit showed that the compliance had risen considerably to 63%. This is a very encouraging result and needs to be consolidated and improved further. The aim is to demonstrate 100% compliance and to have continually improving results as the Trust approaches this goal.

Application of aseptic no-touch clinical protocols, IV catheters & urinary catheters

Policies are in place for these areas which take into account the EPIC guidance published in 2001 & 2007, they also comply with the requirements of the Health Act 2006 (The Code of Practice for the Prevention and Control of Health Care Associated Infections). The policies are regularly reviewed.

Decontamination

Arrangements

There is a central sterile services department situated next to the main theatre complex which processes all Trust items for sterile reprocessing. There are 3 double endoscope washer-disinfectors: one in CSSD and two in the endoscopy suite.

Discussions are underway to consider the formation of a 'super centre' which would serve several hospitals in the South West. Whilst there would be economies of scale there would be large set-up costs as more sets of instruments would be required and considerable risk as there would be a long road journey to the reprocessing centre. A full business case is planned to be presented to Trust Board in 2008.

Cleaning services

Management arrangements

Services are contracted out to Sodexho and monitored through a partnering agreement. There are regular twice-yearly meetings of the Partnering Board where the Trust and Sodexho formally discuss the cleaning arrangements. In addition there is a good and close working relationship between Trust staff including the ICT and the staff of Sodexho. There are 'zone co-ordinators' that liaise with ward managers concerning any local cleaning issues. The ICT liaise

with the Sodexho team should any increased cleaning be required, such as during outbreaks.

The new revised cleaning standards have been considered. As there would be considerable costs in implementing the standards in full a gap analysis was performed to identify areas where current cleaning did not comply with the new standards. A risk assessment was then performed and cleaning enhanced where it was defined to be of benefit.

PEAT/Patient forum inspection results

In assessments performed by the patient environment action teams (PEAT) in 2006 NDHT achieved scores of:

- **'Acceptable'** for the environmental assessment
- **'Excellent'** for the food assessment

The PEAT assessments are discussed at the Matron's Charter group where the actions arising from the report are taken forward.

The Patient & Public Involvement forum have worked with the Infection Control Team to develop an audit tool to be used for their ward inspections. The reports are fed back to the Trust and the recommendations considered and actioned by the Matron's Charter group. This year the forum conducted an inspection on the day surgery unit.

Audit

Infection control audits are coordinated by the Matron's Charter group on a rolling programme throughout the year. Audit results are discussed by the Matron's Charter group. Actions are agreed by the group and disseminated to individual areas and wider as appropriate. Most of the audits are undertaken by the link practitioners.

Audits undertaken this year include:

- Sharps audit – looking at availability and use of sharps bins. No major problems identified. Results fed back to staff.
- Hand hygiene audit – see Hand Hygiene section.
- Ward cleanliness audit – see Matron's Charter section
- Patient environment & equipment
- Declutter day
- Public & Patient Involvement Forum inspections
- Patient Environment Action Team (PEAT) cleanliness inspections

Antibiotic prescribing (report from Antimicrobial Pharmacist)

No report from Antimicrobial Pharmacist

The funds allocated for the antimicrobial pharmacist were withheld by the SHA and have therefore prevented this appointment. A business case for the Trust to fund an antibiotic pharmacist at band 8a has been accepted by the Trust. An appointment has now been made and the appointee will start work in mid 2007-8.

An Antibiotic Working Group has been formed this year. This is a sub-group of the Drugs and Therapeutics Group with the power to make decisions regarding antibiotic use within the Trust.

Membership of the Antibiotic Working Group is:

- Consultant Medical Microbiologist (chair)
- Director of Pharmacy
- Antibiotic Pharmacist
- Lead pharmacists
- Director of Infection Prevention & Control / Infection Control Doctor/Consultant Medical Microbiologist
- A&E consultant
- Medical consultant
- Others co-opted as required

The group's purpose is to promote the safe, effective, appropriate and economic use of antimicrobials within Northern Devon Healthcare Trust taking into account Department of Health Guidance. The group will ensure appropriate prescribing policies are in place, provide support for their implementation and audit compliance.

The minutes are sent to the Infection Control Committee.

Matron's Charter

Following the release of the Matron's Charter document in 2004 by the Department of Health, a group lead by the Acting Director of Nursing was set up. The group is chaired by the Director of Nursing and includes the ICT, senior nurses from the Trust, representatives from facilities and the Patient & Public Involvement (PPI) Forum.

The agenda of the group is set by the Charter and therefore has a strong emphasis on cleanliness. The group has taken many issues forward including the new cleaning standards, PEAT inspections, MRSA, the 'cleanyourhands' campaign and training of staff. Through the group the Trust organises an annual successful 'declutter weekend' when unwanted equipment and furniture is removed from wards.

There is a rolling program of audits which include decontamination, ward cleanliness, PPI forum cleanliness, PEAT, sharps and Sodexho's audit program. The results are discussed at the forum, actions decided and fed back to ward staff or wider, as appropriate.

In 2006-07 the group has initiated a monthly bulletin which follows each meeting and is distributed across the Trust. The bulletin includes key points from the previous meeting as well as other relevant information on cleanliness and infection control topics that need to be relayed to staff.

One of the outputs of the group this year was the production of an 'A to Z of cleaning ward equipment'. This guidance details the appropriate cleaning method and frequency of the various items of equipment that are found on the modern ward.

Targets and outcomes

MRSA

The DH has set a target to reduce MRSA bacteraemias in all Trusts by 50% by 2007-8 using the figures for 2003-4 as a baseline. This equates to a target of 19 in 2005-06, 15 in 2006-07 and 12 in 2007-08.
Although the Trust met the target for 2005-06 it failed to do so this year; registering 22 bacteraemias.

This is an extremely challenging target for a number of reasons. Firstly, the target relates to all bacteraemias identified in North Devon regardless of their origin. Thus, as mentioned in the MRSA section, 11 of the 22 bacteraemias this year were acquired outside the Trust. The causes of these infections are outside the direct control of the Trust. Secondly, some of the blood cultures are contaminated which means that the patient did not have an infection but through poor technique the MRSA organism was introduced into the culture bottle. The ICT is addressing this emphasising the importance of correct blood culture taking technique in training sessions.

The final challenge in reducing the number of MRSA bacteraemias is the prevention of actual MRSA infections within the Trust. Analysis of the causes of the bacteraemias shows that the commonest causes are related to vascular lines (plastic tubes inserted usually in the arm or neck used to inject drugs or fluids) and urinary catheters. As part of the Department of Health Saving Lives programme the ICT is promoting best practice in this area through education and audit. The majority of the ICT educational programme will, by improving practice of HCWs, work towards reducing MRSA colonisations and infections including bacteraemias.

Clostridium difficile

There is not a target pertaining to *Clostridium difficile* for 2006-07. The Department of Health has issued guidance that each Trust should be set a target to eventually achieve a rate of 1 case per 1000 bed-days for those over 65 years of age. The Devon Primary Care Trust has set NDHT a target of 174 cases for 2007-08 this equates to a rate of 2.73 cases per 1000 bed-days.

Standards for Better Health

Infection Control activities are included under standard 4a of the Standards for Better Health and are assessed by the Healthcare Commission. The Trust self assess against these standards and reports to the Healthcare Commission. Towards the end of 2006-07 the Healthcare Commission changed the content of Standard 4a to include compliance with the 'Code of Practice for the Prevention and Control of Health Care Associated Infections' (part of the Health Act 2006). Following a gap analysis of compliance with the 'Code' and implementation of the actions the Trust self assessed as compliant (green) with this standard for 2006-07.

In June 2006 the Healthcare Commission published guidance on assessing compliance with the Code. The ICT has used this self assessment and has found a number of areas where actions can be taken to improve compliance. These improvements will be actioned over 2007-08. The self-assessment action plan and the Infection Control Annual Plan are included as appendices to this report.

Training activities

Education of healthcare workers

Education of the Trust staff in the prevention and control of infection is a very important part of the Trust's strategy in containing the number of HCAIs. The ICT are pivotal in co-ordinating and providing the majority of this education.

Infection Control training at induction for staff

At induction every member of staff receives Infection Control training by a member of the ICT. This ensures that every new member of the Trust is aware of the basic principles of Infection Control. Bank and many agency nursing staff receive training before starting work. Most locum doctors however do not receive infection control training by the Trust. There is now a basic electronic learning package with compulsory question and answer section at the end. This is used for junior doctors prior to starting their posts. This will be developed and extended to other staff groups.

Annual Infection Control training for staff

From 2006-07 all staff have been receiving annual Infection Control updates which are given as part of their essential training. This has required a significant amount of time from the ICT which has impacted on the other activities that the ICT can perform but has been prioritised as it is one of the most important activities in raising awareness of infection control issues and reducing healthcare associated infections.

Monitoring of the attendance at these training sessions is undertaken by the education department. From 2007-08 this department will be providing attendance data to individual areas to ensure that all staff receive their training.

Other

Staff also receive education about particular aspects of Infection Control as for example part of training for venepucture / cannulation or IV drug administration. If a new policy is introduced then specific training is required to support this.

Delivery of 'Practice & Principles of Infection Control' course

The Infection Control Team deliver an Infection Control course at diploma and degree level in partnership with the University of Plymouth. The course, 'Practice & Principles of Infection Control', provides 20 credits at level 2 and 3. Although it was not offered in 2005-06 because of Trust restrictions on training it was provided this year to a total of 10 students. It is open to registered nurses in the public and private sectors but the majority of attendees are from the Trust, many of whom are, or become, Link Practitioners. This is providing a valuable resource of staff with enhanced infection control training to improve practice across the Trust.

Link Practitioners

Link Practitioners are HCWs, usually one per ward or department, who have a particular interest in Infection Control. They attend regular study days, participate in audit and act as an initial point of contact for Infection Control inquiries in the work area. The Link Practitioners represent an important resource which should be developed by requiring every ward and department to have one and to provide protected time for them to undertake their Infection Control duties.

Doctors represent a particular group with respect to their educational requirements. Despite its importance Infection Control has been poorly taught at medical school and doctors often not included in other teaching sessions

because of their work commitments and the short-term contract of many junior doctors. All junior doctors receive Infection Control training as part of their induction programme. Infection Control teaching occurs at regular departmental meetings and audit sessions. It is hoped to make this a regular part of the program. Infection Control is part of the mandatory training that all newly qualified doctors receive in their F1 & F2 years.

Education of the ICT

Members of the ICT attend educational events throughout the year. These include the Infection Control Nurses Association annual conference and DH events including those arranged specifically for DIPCs. The team are members of the South West Infection Control Forum which also provides regular meetings.
The ICNs are members of the regional Health Protection Nurse forum. The lead ICN has been elected vice-coordinator of the Southwest regional Infection Control Nurses Association and also gained a postgraduate certificate in education. Two of the ICNs have successfully completed the advanced food hygiene certificate and foundation Health Protection courses.

Appendix 1

NDHCT Infection Control Annual Plan 2007

Version	Date	Comment
1.	18 April 2007	1st draft to be discussed at ICC
2.	10 May 2007	Changes from ICC 18 April incorporated
3.	16 May 2007	Addition of section 15 MRSA screening as agreed at ICC 15 May 2007

NDHCT INFECTION CONTROL ANNUAL PLAN 2007

Problem / Issue	Goal	Intervention / Action	Evaluation	Progress
1. Surveillance				
Alert organism and condition and surveillance	To monitor trends and identify outbreaks promptly	ICNs to record and follow up alert organism and condition reports on a daily basis. ICT to review reports weekly	Daily Weekly	
Mandatory surveillance requirements	C.diff reporting	ICT to report monthly to trust and quarterly to region.	Monthly Quarterly	
	Monthly MRSA Bacteraemia reporting and RCA	ICT to undertake RCA of Bacteraemia using NPSA and SHA Tool. ICT to report RCA to PCT and to update DoH website	Within 5 days receipt of result	
	GRE reporting	ICT to report quarterly to region	Quarterly	
	Complete 1 module of SSISS Orthopaedics	ICNs and support nurses to undertake Orthopaedic surveillance of Hip or Knee replacements July – Sept	Oct 2007	
Serious untoward incidents associated with Infection	To report all serious untoward incidents (SUI) associated with infection	ICT to report all SUIs to region as they occur		
Feedback of surveillance data on MRSA and C.diff to board, ICC and clinical staff in appropriate format that facilitates interpretation	To contribute to reduction in HCAI including MRSA and C.diff.	ICT to produce easy to interpret data for clinicians and staff DIPC to report surveillance data to:	May 2007 Quarterly Quarterly	

		ICC Trust board Clinical staff	Quarterly	
Problem / Issue	Goal	Intervention / Action	Evaluation	Progress
2. <u>Delivery of National Targets re C diff and MRSA and reducing HCAI</u> DoH target for MRSA bacteraemia set at 12 for 2007/08 PCT target for C.diff set at 174 for 2007/08	To achieve national targets and to have in place systems and processes that will promote the reduction of C.diff, MRSA and all HCAIs	ICT to perform RCA of all MRSA Bacteraemia ICT to include resulting actions in MRSA action plan which is to be reviewed quarterly Monitor monthly compliance with target ICT to investigate clusters and target breaches, amending C.diff action plan which is to be reviewed quarterly Monitor monthly and quarterly compliance with target	 Quarterly Monthly Quarterly Monthly	
3. <u>Hand Hygiene Compliance</u> Improvement and maintenance of hand hygiene compliance amongst clinical staff. Provision of hand hygiene facilities and opportunities for patients. Provision of information and	To promote optimum levels of hand hygiene practice amongst staff, patients and visitors – that is evidence based and supported by NPSA cleanyourhands campaign.	ICT to implement year 2 of the cleanyourhands campaign as follows: ICNs to direct monthly poster changes in clinical areas by communication with ward / department managers and link practitioners. Hand hygiene audits to be performed by link practitioners and analysed, and feedback to clinical staff by ICNs 3	December 2008 Monthly June 07 September 07 December 2007 March 2008	

facilities for hand hygiene to visitors to the hospital to encourage safety of visitors and patients		monthly. Alcohol hand gel usage and availability to be monitored by ICNs. ICNs to implement near patient alcohol gel in community hospitals. ICNs to promote alcohol gel "point of use" element of campaign via link practitioners and targeting promotional materials. To achieve compliance at 75% in all staff groups ICT to promote the "power of one" and patient involvement "It's Ok to Ask" elements of campaign ICT to design and co-ordinate placement of corporate hand hygiene signage for sinks, walls and floors throughout the trust.	August 2007 February 2008 July 2007 October 2007 March 2008 October 2007 June 2007	
4. <u>Saving Lives</u> Implementation of DoH "Saving Lives" and "Essential Steps" programmes requiring engagement of clinical staff	To maximise reduction in HCAIs by prioritising implementation of the saving lives programme - targeting high impact interventions 1. Preventing microbial contamination 2. Insertion and care of central lines	ICT to introduce standard precautions policy as detailed below (see 5) which incorporates elements of high impact intervention 1 MD and DIPC to lead group developing protocols for insertion and care of central lines	June 2007 Evaluation date to be confirmed with MD	

	3. Urinary catheter care			
5. <u>Standard Precautions</u> Standard Infection Control Precautions policy ready to be launched – represents essential practice that is fundamental to achieving reduction in HCAIs (see 2,3, 4, 6 and 7) Clinical staff to be advised of policy Public to be able to access policy	Standard Infection Control Precautions will be embedded in clinical practice by March 2008	Policy to be ratified by ICC ICT to make policy available to staff via intranet and public by internet. ICNs to implement launch of policy ICT to educate clinical staff on policy and evaluate education by undertaking awareness audit. ICT to align this with Saving Lives / Essential Steps	April 2007 May 2007 June 2007 February 2008	
6. <u>S4BH</u> Standards C4a, C4c and C21 have been amended to include elements of the Code Of Practice	To declare compliance with S4BH core elements C4a, C4c and C21	Progress against standard to be monitored by ICT Evidence to be collated by ICT	Quarterly Quarterly	
Problem / Issue	Goal	Intervention / Action	Evaluation	Progress
7. <u>Code of Practice</u> 11 duties of code must be evidenced – HCC can issue improvement notices against individual duties. Forms part of S4BH and the annual health check	To demonstrate compliance with the code and to draw best practice and guidance information from it	Progress against Code to be monitored by ICT Evidence to be collated by ICT	Quarterly	
8. <u>Education</u>				

All trust staff require infection control training on induction and yearly updates All clinical staff that have a role in food handling are required to have food hygiene training by law. Increasing awareness to infection issues amongst patients and public	All staff will receive infection control training on induction and at statutory update days All clinical staff who require food hygiene training will receive a yearly update Opportunities to provide information / education to the public will be recognised	ICNs will deliver all planned induction and statutory training sessions Content of above sessions will be reviewed Accurate records of attendance at training to be developed with education and training to establish current attendance ICT will create and implement e-learning package with education and training Human resources to develop mechanism to address requirement that infection control training is included in job descriptions and personal development plans / appraisals.	Monthly May 2007 March 2008 August 2007 Evaluation date to be confirmed with CO	
9. <u>Patient and Public Involvement</u> Raised awareness in patients and public regarding infection – need for accurate and open communication	To work with PALS, PPI / links forum and media to ensure patients and public receive appropriate information and assurance	ICT to meet with PPI cleanliness subgroup as requested / required ICT and PPI rep to meet at Matron's charter group. ICT to work with PPI for IC week / visitors week	6 monthly Monthly Oct 2007	
10. <u>Policies</u> Majority of infection control policies in infection control manual require review in 2007	To review all policies before expiry date and to ensure updated policies are available on intranet, and that clinical staff are aware of policy updates	ICT to review / rewrite 9 policies by May 2007 for ratification by ICC. ICT to review / rewrite 6 policies for ratification by ICC by Dec 2007	May 2007 December 2007	

Problem / Issue	Goal	Intervention / Action	Evaluation	Progress
11. <u>Estates</u> Estates strategy for future of trust will have implications for Infection control	To ensure that infection control team is included in all service developments	ICT to respond formally to estates strategy ICT to review Infection control implications of all planned projects as they arise	April 2007	
12. **<u>Resources</u>** Expanding infection control agenda requires increased staffing to deliver plan	To increase nursing team by 2 members and to formalise role and support of link practitioners	Lead ICN to develop job descriptions as approved in new structure arrangements and submit for banding DIPC, DN and Lead ICN to carry out interviews and recruitment ICT to negotiate with DN and SNs possibility of protected time	March 2007 June / July 2007 July 2007	
13. <u>Audit / Monitoring</u> Increasing programme of practice and environmental audits	To fulfil all audit requirements and ensure appropriate feedback of results	ICT led inspections and audits to be completed as follows: PEAT inspections x 6 per year Hand Hygiene audits x 4 per year min Kitchen Inspections x 6 per year Environment audits x2 per year Patient equipment audits x 2 per year Sharps audit - annually Policy audit – 1 per year Saving Lives / Essential Steps -	 March 2008 " " " " " " "	
14. <u>CNST</u> NDHT will be assessed for compliance with CNST Level 1 on 28/29 November 2007	That NDHT is compliant with risk areas: 1.2.8 Hand Hygiene Training	ICT to review standards and develop, with Clinical Governance, a strategy for the Trust to achieve compliance	28 November 2007	

	1.3.6 Inoculation Incidents 1.4.9 Infection Control			
15. <u>MRSA Screening</u> Review required in line with Saving Lives and need to address MRSA bacteraemias	To ensure MRSA screening policy is appropriate for Trust	ICT to review MRSA screening strategy ICT to implement changes to MRSA screening strategy ICT to review MRSA screening strategy	May 2007 July 2007 December 2007	

Appendix 2

Code of Practice
for the Prevention and Control of Healthcare Associated Infections (HCAI)
Self Assessment Tool

Balanced Scorecard: Self Assessment Summary

Northern Devon Healthcare Trust, 17/08/07

Overall Status
66%

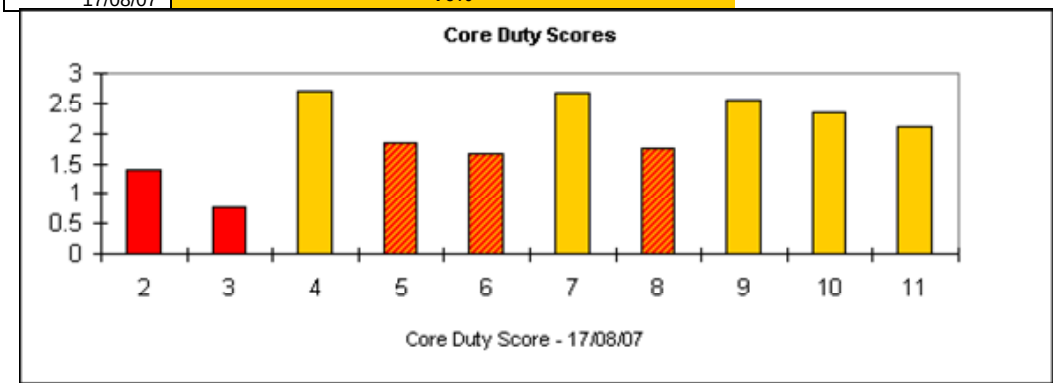
Key		
	100%	Full compliance
	71% - 99%	Action required
	50% - 70%	Urgent action required
	=< 49%	Trust priority

Core Duty 2: Duty to have in place appropriate management systems for infection prevention and control (IPC)		Core Duty 3: Duty to assess risks of acquiring HCAI and to take action to reduce or control such risks		Core Duty 4: Duty to provide and maintain a clean and appropriate environment for health care	
17/08/07	47%	17/08/07	26%	17/08/07	90%

Core Duty 5: Duty to provide information on HCAI to patients and the public		Core Duty 6: Duty to provide information when a patient moves from the care of one health care body to another		Core Duty 7: Duty to ensure co-operation	
17/08/07	61%	17/08/07	56%	17/08/07	89%

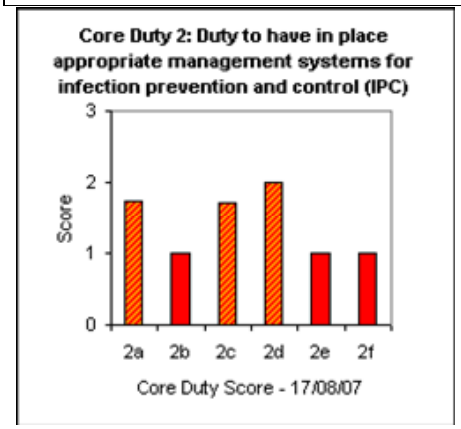
Core Duty 8: Duty to provide adequate isolation facilities		Core Duty 9: Duty to ensure adequate laboratory support		Core Duty 10: Duty to adhere to policies and protocols applicable to infection prevention and control	
17/08/07	58%	17/08/07	85%	17/08/07	78%

Core Duty 11: Duty to ensure that health care workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention/control of HCAI	
17/08/07	70%



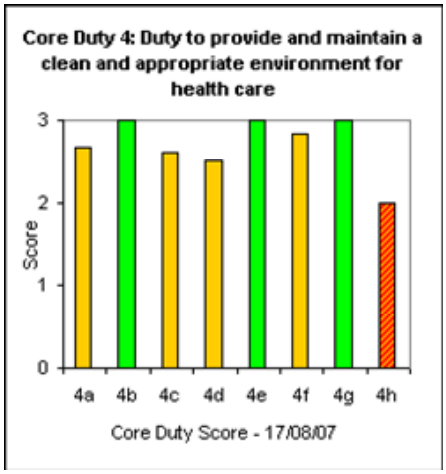
Individual Core Duty Compliance Charts

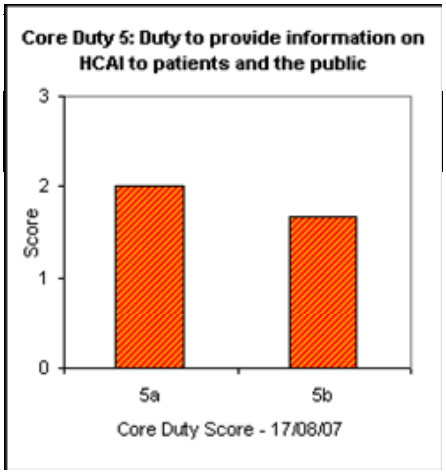
Bars indicate the scores for each assurance statement.
These scores range from 0 to 3 where 0 = "Not met", 1 = "Partly met", 2 = "Almost met" and 3 = "Fully met".



Overall % Score for Core Duty 2	47%

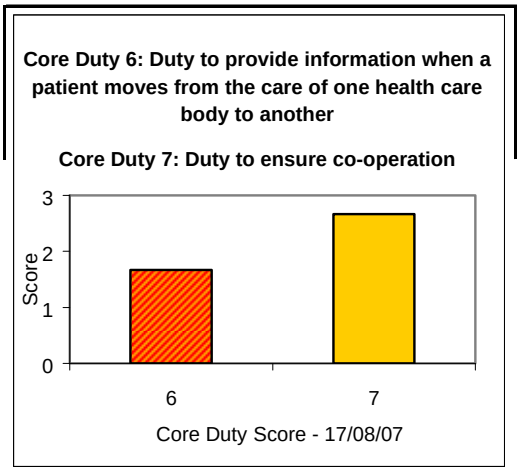
Overall % Score for Core Duty 3	26%



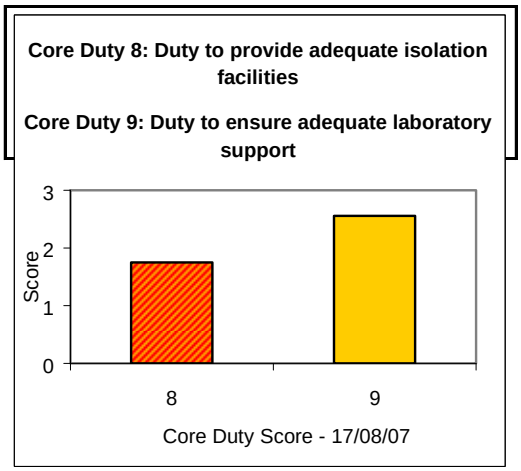


Overall % Score for Core Duty 4	90%

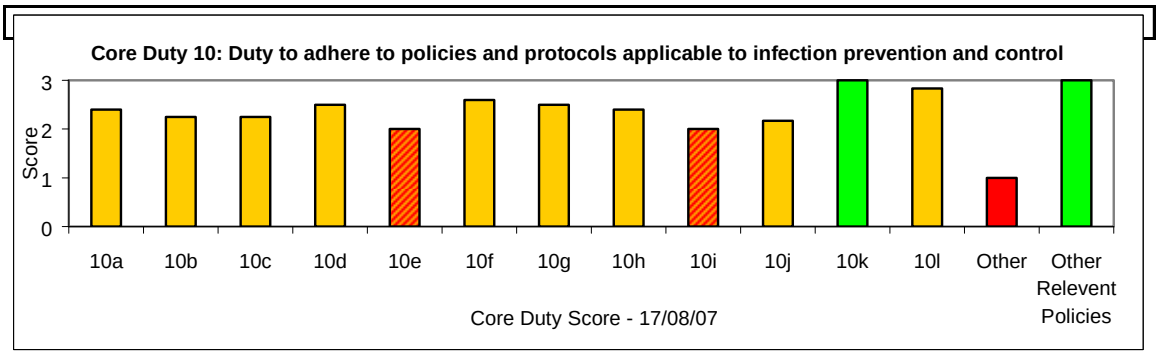
Overall % Score for Core Duty 5	61%



Overall % Score for Core Duty 6	56%
Overall % Score for Core Duty 7	89%

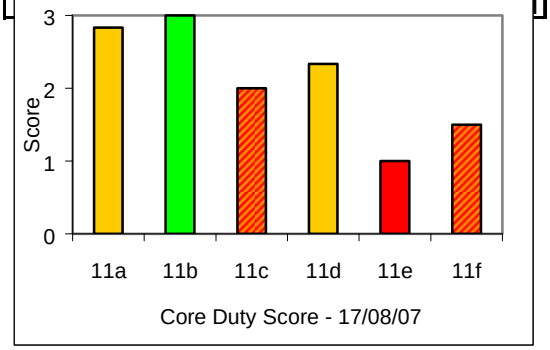


Overall % Score for Core Duty 8	58%
Overall % Score for Core Duty 9	85%



Overall % Score for Core Duty 10	78%

Core Duty 11: Duty to ensure that health care workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention/control of HCAI



Core Duty Score - 17/08/07

Overall % Score for Core Duty 11	70%