Ava Lake washing her hands.
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11. Summary
I am delighted to present the Director of Infection Prevention and Control’s annual report for 2012-13. Preventing infection is a team effort and I would like to recognise the work of staff throughout the Trust in delivering safe, effective care.

Cleanliness and not taking away an infection you didn’t bring into the healthcare service are essential to the patient experience. In years gone by we had almost come to accept that picking up infections was an inevitable part of the healthcare experience. I hope when you read our achievements this year you will see our culture is that we most certainly do not accept this and we are relentless in our quest to eliminate the spread of infection.

In this Trust we always say that behind every figure is a patient and even one avoidable infection is one too many. To see the stark truth of the Trust’s performance last year makes me proud not only of the medical and nursing team but the many, many people in front of and behind the scenes who understand that this is such a crucial aspect of care.

While it is excellent to have an end of year report which shows the sustained improvements that we are making, there is no room for complacency. Unfortunately, despite delivering a reduction in the number of patients who acquired Clostridium difficile in our hospitals, we failed to achieve the challenging target set by our commissioners during the year. We would like to assure our patients that we are absolutely committed to reducing opportunity for infection and we will not rest until we’re the best in terms of tackling infection. Good enough just isn’t good enough for us or, more importantly, for the patients we look after.

Patients place their lives in our hands. We can and we will do everything humanly possible to protect patients from infection. However I would make one plea. We will play our part but we ask one thing of those visiting and caring for patients; please play your part. More patients acquire infection at home than they do in hospital so we all need to work together to reduce infection. Please help and protect the person you care about by cleaning your hands when you come in to visit. Please stay at home if you’re ill yourself and please keep isolation doors closed. If we all work together we can continue to fight against the spread of infection both in hospital and at home.

I would like to thank everyone who has contributed to the results we have achieved this year. I commend this report to you.

Sue Smith
Director of Nursing and Patient Safety
Director of Infection Prevention and Control
GP registrar Thomas Bielby.
1. Infection Prevention and Control (IPC) Arrangements

1.1 Structure

The Chief Executive holds overall responsibility for infection prevention and control in the Trust. The Executive Director of Nursing and Patient Safety is the designated Director of Infection Prevention and Control (DIPC) for the Trust and reports directly to the Chief Executive and Board of Directors. The Infection Prevention and Control Team (IPCT) provide specialist advice on matters relating to the identification, prevention and management of infections in the Trust. The team works to an agreed annual programme approved by the Infection Control Committee which is chaired by a non executive director and includes two non executive members and representatives from clinical departments and corporate services. The team includes a Consultant Microbiologist/Infection Control Doctor, Assistant Director of Nursing and Infection Prevention and Control, Assistant Matrons, Infection Prevention and Control Nurses, Healthcare Assistants and clerical staff and covers activity in hospital and community settings. The IPCT is supported by an antimicrobial pharmacist and a biomedical scientist link in the microbiology laboratory. The DIPC also works closely with the IPCT.

1.2 Reporting arrangements

The reporting arrangements for the IPCT are shown in Fig 1 below. The operational Group for IPC is the Healthcare Associated Infection Operational Group which meets monthly and reports to the Infection Control Committee (ICC). The ICC meets quarterly and receives assurance on infection prevention in the Trust via directorate reports, audit reports and updates on the annual programme. The IPCT is also represented on various forums across the Trust including Patient Safety and Quality Standards Committee, Patient Safety Committee, Health and Safety Committee, Routine Cleaning Group, Uniform and Personal Appearance Committee, Drug and Therapeutics Committee, Estates Capital Projects Group, Decontamination Group and new hospital planning.

Fig 1 Reporting arrangements
The IPCT has a budget which covers pay and non-pay expenses. Additional costs relating to outbreaks and investigations requiring testing of samples at reference laboratories are separately funded. Service Level Agreements with local hospices, an independent hospital and a community network are in place and generate a small income.

2. Summary of reports to the Board

The DIPC provides a full report on IPC related matters at each Board meeting. Issues such as performance against mandatory surveillance targets, hand hygiene, audits, outbreaks, incidents and new initiatives or reporting requirements are included in the reports.

3. Healthcare Associated Infection Statistics

The IPCT carries out a programme of surveillance to meet both mandatory and local requirements. The Department of Health requires mandatory surveillance of:

- Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia (blood stream infection)
- Clostridium difficile diarrhoea
- Methicillin sensitive Staphylococcus aureus (MSSA) bacteraemia
- Escherichia coli (E coli) bacteraemia
- Glycopeptide resistant enterococcus (GRE) bacteraemia
- Surgical Site Infection

3.1 Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia

MRSA is a strain of Staphylococcus aureus that is resistant to a number of antibiotics and is capable of causing a wide range of infections, including blood stream infections (bacteraemia). MRSA is carried on the skin or in the nose of a number of people without causing them any harm, but under the right circumstances the bacteria can enter the body and lead to infection. In previous years the Trust has been responsible for all MRSA bacteraemia regardless of whether they were hospital or community attributed. From April 2010 a new MRSA objective was introduced, with acute Trusts being responsible only for reducing those cases which were identified two or more days after the day of admission, whilst still being responsible for reporting all cases processed by their laboratories.
In 2012-13 unfortunately two Trust attributed cases were reported against a target of one. Six community attributed cases were also reported. Each case is thoroughly investigated to ensure lessons are learned and errors are not repeated. The outcome of the root cause analysis investigation is shared with the Executive Team, directorate, commissioners and wider Trust staff. Table 1 shows the number of cases per year since 2007-8 and also the rate per 10,000 bed days. Fig 2 shows the cases per quarter since 2006 and demonstrates a significant improvement made overall.

Table 1. MRSA bacteraemia cases annual numbers and rates

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No of bacteraemia reported (Trust attributed cases only)</td>
<td>16</td>
<td>9</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Rate of infections per 10,000 occupied bed days</td>
<td>0.75</td>
<td>0.37</td>
<td>0.23</td>
<td>0.19</td>
<td>0.00</td>
<td>0.09</td>
</tr>
</tbody>
</table>

Fig.2 Quarterly MRSA bacteraemia (trust attributed cases) 2006-13

**3.2 Clostridium difficile diarrhoea**

Clostridium difficile is an organism that causes diarrhoea, usually following antibiotic usage in vulnerable patients. This can cause complications such as pseudomembranous colitis which is a severe inflammation of the bowel, and can be life threatening. A reduction target for Clostridium difficile infection (CDI) has been in place since 2007.

Although this was a reduction on the previous year it was disappointing to fail the target given the effort and focus on prevention. Each Trust attributed case is subject to investigation using root-cause analysis carried out by the multidisciplinary team within 3-working days. Findings and trends are reported quarterly at the ICC with verbal reports provided to the executive team on a weekly basis. Table 2 shows the rate of cases per 10,000 bed days since 2007-8. Fig 3 shows the monthly cases since April 2007.
Table 2. Clostridium difficile cases annual numbers and rates

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No of hospital attributed C difficile cases reported</td>
<td>210</td>
<td>158</td>
<td>136</td>
<td>53</td>
<td>68</td>
<td>61</td>
</tr>
<tr>
<td>Rate of infections per 10,000 occupied bed days</td>
<td>9.93</td>
<td>6.63</td>
<td>6.05</td>
<td>2.59</td>
<td>3.50</td>
<td>2.99</td>
</tr>
</tbody>
</table>

An external review by Professor Brian Duerden and Professor Janice Stevens was commissioned by the Trust in August 2012. The review team made recommendations in relation to antibiotic prescribing and stewardship, isolation practices and clinical leadership, all of which have been incorporated into an extensive action plan which is reviewed monthly and shared with Clinical Commissioning Groups (CCGs) and with Monitor.

An extensive review of all actions and data relating to C difficile was carried out in January 2013. The review identified that:

- The Trust tests more stool samples for C difficile than several other larger Trusts in the North East and therefore may be expected to have a greater number of cases to report
- The age profile of cases is high with the majority of patients being in the 75+ age group
- Evidence from ribotyping suggests that cross infection is rare
- High bed occupancy in wards correlates with increased risk of infection

Fig. 3 Trust attributed C difficile cases 2007-13
### 3.3 Methicillin sensitive Staphylococcus aureus (MSSA) bacteraemia

Staphylococcus aureus is a bacterium commonly found on human skin which can cause infection if there is an opportunity for the bacteria to enter the body. In serious cases it can cause blood stream infection. MSSA is a strain of these bacteria that can be effectively treated with many antibiotics. The Trust has been carrying out voluntary surveillance of MSSA bacteraemia cases since mid 2007 however the organism became part of the mandatory surveillance programme from April 2011. No reduction target is set for this infection. Root cause analysis is carried out for all Trust attributed cases. In 2012-13 a total of eleven Trust attributed cases were reported showing an increase of two cases on the previous year. Table 3 shows the rate of cases per 10,000 bed days since 2008 and Fig 4 shows the monthly cases since January 2009.

<table>
<thead>
<tr>
<th>Year</th>
<th>2008-9</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Trust attributed cases reported</td>
<td>20</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>No. of infections per 10,000 occupied bed days</td>
<td>0.83</td>
<td>0.51</td>
<td>0.49</td>
<td>0.46</td>
<td>0.54</td>
</tr>
</tbody>
</table>

**Fig. 4 Trust attributed MSSA bacteraemia cases 2009-13**
3.4 Escherichia coli (E coli) bacteraemia

Escherichia coli are a very common bacterium found in the human gut which can cause serious infections such as blood poisoning. From 1st June 2011 these bacteraemia cases became part of the national mandatory surveillance programme. We began our data collection in April 2011. Both hospital and community cases are entered into the data capture system following enhanced data collection. A total of 225 cases were recorded during 2012-13, of which 31 were trust attributed and 194 were acquired in the community. This gives a rate per 10,000 bed days of 1.52 and represents a 25% reduction on the previous year. There is no reduction target allocated to this infection. Fig 5 shows the Trust and community attributed cases by month since April 2011.

![Fig. 5 E coli bacteraemia 2011-13](image)

3.5 Glycopeptide resistant enterococcus (GRE) bacteraemia

The Trust has been required as part of the mandatory surveillance programme to report bacteraemia cases where glycopeptide resistant enterococci (GRE) is isolated. Enterococci are a group of bacteria that are commonly found in the bowel of healthy individuals and can cause a range of infections, including bloodstream infections. GRE is a type of enterococci which is resistant to a particular group of antibiotics, and is more of a risk to hospital patients who have procedures and invasive devices such as catheters and intravenous lines. GRE does not spread easily however it is more difficult to treat than other infections. In 2012-13 no cases of GRE bacteraemia were reported by the Trust. This organism was removed from the mandatory surveillance programme from 1st April 2013 however any infections will continue to be reported on a voluntary basis via the laboratory reporting system CoSurv. The Trust continues to contribute to this.

3.6 Surgical site infection

The Trust has participated in the mandatory surveillance of surgical site infections entering information on hip replacements and long bone fractures for two quarters. However the most recent published data is for 2011-12 (published by Health Protection Agency in December 2012). During that period the Trust did not report any infections. Data for 2012-13 will be published in late 2013.
3.7 Outbreaks

Each year there are a number of outbreaks of diarrhoea and/or vomiting which affect patients and staff in the community and in our hospitals. The cause of these outbreaks is usually Norovirus (also known as winter vomiting bug) and this reflects a similar picture in the community, in care homes, schools, nurseries and peoples own homes. Outbreaks can have an adverse impact on the business of the Trust because wards can be closed for a number of days, reducing beds available for new patients to be admitted to. This is a serious concern for the Trust and a significant amount of work has gone into reducing the length of time that wards are closed, and providing a timelier and efficient post outbreak cleaning programme. Table 4 below shows the number of outbreaks and staff/patients affected in our Trust during 2012-13, which reflected a large number of outbreaks in community settings. This year we saw fewer outbreaks but more patients affected. This reflects a number of prolonged outbreaks with over 20 patients being affected on two occasions.

Table 4 Outbreak numbers and rates

<table>
<thead>
<tr>
<th>Year</th>
<th>2008-9</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of outbreaks</td>
<td>22</td>
<td>21</td>
<td>14</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>No of patients affected</td>
<td>253</td>
<td>211</td>
<td>163</td>
<td>251</td>
<td>314</td>
</tr>
<tr>
<td>Rate per 10,000 occupied bed days</td>
<td>10.62</td>
<td>9.39</td>
<td>7.98</td>
<td>12.92</td>
<td>15.43</td>
</tr>
<tr>
<td>No of staff affected</td>
<td>56</td>
<td>51</td>
<td>51</td>
<td>110</td>
<td>79</td>
</tr>
<tr>
<td>Total number affected</td>
<td>309</td>
<td>262</td>
<td>214</td>
<td>361</td>
<td>393</td>
</tr>
</tbody>
</table>

Have you cleaned your hands when entering and leaving the wards?

Have you made sure your loved one has no more than two visitors at their bed?

Help us to keep your loved ones safe from infection.
4. Infection Prevention and Control Initiatives

4.1 Hand hygiene promotion

Although the National Patient Safety Agency (NPSA) ceased to exist under the reorganisation of arms length bodies in 2011 we continue to promote hand hygiene in the Trust using the principles of cleanyourhands. We continue to utilise the tools provided by the World Health Organisation such as the 5 moments for hand hygiene. Each year we hold a hand hygiene day on or around 5th May to coincide with World Hand Hygiene Day which is very successful and is supported by non-executive directors and clinical staff. Staff are encouraged to carry out hand hygiene competency assessments and prizes are awarded to competition winners. Any opportunity to promote hand hygiene to staff, patients and the public is utilised with enthusiasm.

In 2013 public awareness events have been carried out in local health centres and supermarkets with great success. Specific materials relating to hand hygiene were developed for the events and the programme will be further extended in 2013-14.
Monthly observations of hand hygiene practice are carried out in all wards, departments and services. The Trust has consistently achieved a score of over 90% compliance in self assessment reviews (Table 5). In 2011 we moved to peer-assessment of hand hygiene. We believe that this adds rigor to the process and provides additional assurance. Independent observation of hand hygiene compliance is also carried out on each ward by the infection prevention and control team as part of an unannounced visits programme with all high risk wards receiving a minimum of monthly observation visits.

**Table 5 hand hygiene compliance 2012-13**

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score</td>
<td>92.62</td>
<td>87.21</td>
<td>98.91</td>
<td>94.44</td>
<td>95.48</td>
<td>96.46</td>
<td>95.84</td>
<td>98.13</td>
<td>96.85</td>
<td>99.89</td>
<td>98.41</td>
<td></td>
</tr>
</tbody>
</table>

### 4.2 Saving Lives/Essential Steps

Saving Lives and Essential Steps are Department of Health initiatives that support Trusts to audit best practice in relation to hand hygiene, use of personal protective equipment, safe handling of sharps, intravenous line care, urinary catheter care, surgical site infection, ventilator care, *Clostridium difficile* and cleanliness of equipment. The Trust has continued to participate in the Saving Lives Programme in our hospitals and the Essential Steps Programme in our community settings. Audits are performed monthly and results reported to the Board in the regular DIPC reports. Results are also discussed and challenged at the Healthcare Associated Infection Operational Group.
4.3 Infection Prevention and Control Dashboard

A dashboard approach has been taken to reporting performance information related to infection prevention and control. Information including infection numbers for wards, hand hygiene compliance, cleaning scores, antibiotic audit results and training are all brought together in one place with a clear visual aspect to the front page and an option to access more in depth information behind it. The dashboard is used to monitor progress at the Healthcare Associated Infection Action Group and Infection Control Committee and will eventually be available to directorate teams. Data from the dashboard feeds into the nursing dashboard which is used to monitor achievement of key performance indicators for ward matrons.

4.4 Infection Control Week

Once again infection control week was very successful with displays and competitions on both hospital sites. This year the theme for the week was Clostridium difficile, featuring an innovative training resource to help staff identify when to send stool samples.

4.5 Patient Experience and Quality Standards (PEQS) panel

Each month the senior nurses of the Trust hold a PEQS panel to review standards in the patient environment, nursing documentation and patient experience. This is held in hospital and community settings and the assessment of the patient environment includes cleanliness of equipment, including commodes, compliance with ‘bare below the elbows’ and first impressions of the environment. Immediate feedback is given to the nurse in charge and each department/clinic lead receives a letter from the Director of Nursing and Patient Safety highlighting the positive aspects of the visit, any opportunities for improvement and offering support if needed. Governors and directors join the panel and speak to patients to ask about their experience. A total of 224 ward visits have taken place this year and over 1,000 patients have been asked about their care across hospital and community settings. Unannounced PEQS panels take place during the out-of-hours periods and there have been 3 such visits this year. One of the night time reviews was undertaken by members of the board of directors.

4.6 Link Worker Programme

Our well established link worker programme has continued this year and there are in excess of 300 link workers across the organisation, including nurses, healthcare assistants, pharmacy technicians, physiotherapists, podiatrists, dieticians, speech therapists and care home staff. Link workers are responsible for audit, training and cascade of information in their own areas as well as raising issues with the IPCT at quarterly meetings and the programme has been very successful. Each meeting has an educational session on a current topic included. This year the sessions have included C difficile, hand hygiene competence assessment and root cause analysis/action planning.

A full day study event on urinary catheter insertion and care was held in June 2012 and was well attended and very successful judging by participant evaluation. A further event is planned for 2013.
5. Policies

The Trust has a programme for revision of core infection prevention and control policies as required by the Health and Social Care Act 2008. All policies are available on the Trust Intranet site. Key policies are available to the public on the Trust public website. Policies are audited where appropriate and overall compliance scores are shown in the table below:

Table 6. Policies

<table>
<thead>
<tr>
<th>Policy Code</th>
<th>Policy Title</th>
<th>Status</th>
<th>Audit compliance and comparison with previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>IC1</td>
<td>Outbreak Policy</td>
<td>For review March 2014</td>
<td>N/A</td>
</tr>
<tr>
<td>IC2</td>
<td>Hand Hygiene Policy</td>
<td>Under review in 2013</td>
<td>98% ↑</td>
</tr>
<tr>
<td>IC3</td>
<td>Infection Control Policy</td>
<td>Under review in 2013</td>
<td>N/A</td>
</tr>
<tr>
<td>IC5</td>
<td>CJD Policy</td>
<td>For review July 2014</td>
<td>N/A</td>
</tr>
<tr>
<td>IC6</td>
<td>MRSA Policy</td>
<td>For review May 2014</td>
<td>70% ↓</td>
</tr>
<tr>
<td>IC7</td>
<td>Viral Haemorrhagic Fevers Policy</td>
<td>For review October 2013</td>
<td>N/A</td>
</tr>
<tr>
<td>IC11</td>
<td>Tuberculosis Policy</td>
<td>For review October 2014</td>
<td>N/A</td>
</tr>
<tr>
<td>IC12</td>
<td>Disinfection and Sterilisation Policy</td>
<td>Under review in 2013</td>
<td>N/A</td>
</tr>
<tr>
<td>IC13</td>
<td>Urethral Catheter Management Policy</td>
<td>Under review in 2013</td>
<td>N/A</td>
</tr>
<tr>
<td>IC14</td>
<td>Clinical Specimen Policy</td>
<td>Under review in 2013</td>
<td>N/A</td>
</tr>
<tr>
<td>IC15</td>
<td>Patient Isolation Policy</td>
<td>For review April 2014</td>
<td>86% ↑</td>
</tr>
<tr>
<td>IC16</td>
<td>Scabies Policy</td>
<td>For review February 2015</td>
<td>N/A</td>
</tr>
<tr>
<td>IC17</td>
<td>Standard Precautions Policy</td>
<td>For review February 2015</td>
<td>Sharps safety 97% ↑</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Environmental cleanliness 96% ↑</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PPE 97% ↓</td>
</tr>
<tr>
<td>IC18</td>
<td>Peripheral Cannulation Policy</td>
<td>For review May 2014</td>
<td>68% ↓</td>
</tr>
<tr>
<td>IC19</td>
<td>Clostridium difficile Policy</td>
<td>For review February 2015</td>
<td>90% ↑</td>
</tr>
<tr>
<td>IC20</td>
<td>MRSA screening</td>
<td>For review December 2013</td>
<td>Elective 85% ↑</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Emergency 83% ↔</td>
</tr>
<tr>
<td>IC21</td>
<td>Theatre Policy</td>
<td>For review August 2015</td>
<td>N/A</td>
</tr>
<tr>
<td>IC22</td>
<td>Surveillance Policy</td>
<td>For approval May 2013</td>
<td>N/A</td>
</tr>
<tr>
<td>C56</td>
<td>Antibiotic Strategy</td>
<td>For review December 2013</td>
<td>N/A</td>
</tr>
</tbody>
</table>
6. Infection Prevention and Control Incidents

6.1 Tuberculosis

Tuberculosis (TB) is a curable infectious disease caused by bacteria that usually affects the lungs. People with TB can infect others if there is prolonged contact. There were a small number of patients identified as having tuberculosis during 2012-13. In some cases this prompted contact tracing of patients and staff that had been in contact with cases prior to diagnosis. All contacts have either received information letters or been offered follow up appointments depending on the level of contact in each case.

6.2 Measles

An increase in cases of measles in children and adults across Teesside was noted during 2012-13. Working with primary care colleagues our community services teams were involved in an immunisation programme for children. Our occupational health team carried out screening of staff and our infection prevention and control team advised when cases of measles were cared for in hospital. The Director of Nursing and Patient Safety volunteered to have her measles vaccination in order to set an example to staff.
7. Decontamination

Decontamination is a process which removes or destroys infectious agents from medical equipment. Cleaning is always the first step in this process, which is then usually followed by disinfection or sterilisation depending on the circumstances in which the equipment is used. The Trust provides an in house sterile services department, reprocessing reusable medical devices. This is a fully validated and monitored service. Decontamination audits are carried out annually in departments where local decontamination is delivered, and the IPCT for part of the audit team.

The podiatry department moved away from reusable equipment several years ago and now have 100% disposable items.

The endoscope (flexible tube used to look inside the body) decontamination facilities on the endoscopy units on both sites are fully compliant and providing a much improved service following a comprehensive modification programme to improve dosing and reduce failure rates. The Authorising Engineer (Decontamination) has validated the annual / re-commissioning reports as suitable for service. In addition the Endoscope washer disinfectors within central sterile services department provide contingency support to the endoscopy unit facilities.
8. Providing a clean and safe environment for our patients

8.1 Cleaning

The provision of cleaning services continues to be delivered by in house staff and external contractors (some community premises). Performance management systems are in place with monitoring staff making checks of the environment and patient equipment in line with national standards. Both of our hospital sites achieved ‘Good’ ratings for the environment in the 2012 Patient Environment Action Team (PEAT) assessment. The Trust cleaning group meets monthly to review monitoring scores, with representation from IPCT and senior clinical matrons. A programme of cleaning and ‘fogging’ with Hydrogen Peroxide Vapour (HPV) is in place on both Trust sites and a project to provide the same level of cleaning in some care homes was funded by commissioners in 2012-13. The project has been successful in improving cleaning of rooms of residents suffering from C difficile and along with additional input from the Infection Prevention and Control Nurse covering care homes has been responsible for reducing the risk of recurrent episodes of infection in high risk residents. The project was the winner of the Nursing Times Infection Control Award in 2012.
8.2 In patient Survey results 2012

The Trust results from the National Inpatient Survey for 2012 show that the patient perceptions of cleanliness and hand hygiene are good and are in line with the majority of other Trusts. See Figure 6 below.

Fig. 6 In patient survey results

8.6/10 Cleanliness of rooms and wards
for describing the hospital rooms or wards as clean

8.4/10 Cleanliness of toilets and bathrooms
for describing the toilets and bathrooms as clean

9.4/10 Availability of hand-wash gels
for hand-wash gels being available for patients and visitors to use

8.3 Our new hospital

A proposal for a single site hospital with a significant increase in ensuite single room accommodation is under development. This will provide a state of the art environment, designed to be safe and easy to clean. The IPCT have been involved in the early stages of the bidder dialogue process and will continue to be integral members of the design process. Until the new hospital is built there is a programme of refurbishment of Trust premises to constantly improve the healthcare environment for our patients and staff. The IPCT are involved in all building and refurbishment projects and are represented at the Capital Projects Group.
Patient John Powell using hand wipes.
9. Antibiotic prescribing

Antibiotics are substances that kill or slow down the growth of bacteria. Junior doctors in each clinical directorate are required to carry out antibiotic kardex audits every 4 months. These audits capture data such as whether stop and review dates are recorded at the time of prescribing, whether allergy boxes are completed, whether indication is recorded on the drug kardex and what the length of therapy has been. These results are then collated by the clinical effectiveness team and fed back to directorates.

A temporary pharmacy technician post has enabled an increased number of audits of compliance with antibiotic guidelines to be carried out during October 2012 – March 2013 and an automatic reporting process developed to provide timely feedback to clinicians.

A weekly ward-round by the Consultant Microbiologist, Infection Prevention and Control Nurse (IPCN) and Antibiotic Pharmacist to review all the current Clostridium difficile cases within the hospital is routine practice. Any issues that are raised by the IPCN can then be actioned by either the Consultant Microbiologist or Antibiotic Pharmacist as appropriate. The Antibiotic Pharmacist also carries out antibiotic histories for the previous 3 month period for any hospital acquired cases of Clostridium difficile. These are then added to the RCAs and trends examined as part of the overall RCA analysis.

Induction training on antibiotic prescribing is delivered to all new junior doctors starting at the Trust by the Consultant Microbiologist/ Antibiotic Pharmacist. This session covers the basic principles of antibiotic prescribing within the trust and what is expected of the prescribers.

The antibiotic guidance was reviewed and re-circulated in December 2012 with easy reference guides being displayed on all wards and credit card sized reference guides produced for medical staff.

Antibiotic consumption data is now available in the form of daily defined dose (DDD) data. This is reported monthly on the Pharmacy intranet site and enables us to monitor usage of individual antibiotics and groups of antibiotics to note and act upon any changes seen.
10. Training

The IPCT contribute to the Trust mandatory training programme and have provided input into:

• Large numbers of drop in sessions
• Trust induction
• Junior doctor induction
• Blood culture sampling competency assessment which has now been widened to include nursing as well as medical staff
• Student nurse induction
• Ward/department specific sessions
• Specific training on Clostridium difficile

11. Summary

Staff at every level across the Trust have worked hard during the year to deliver a reduction in hospital acquired infections. It is unfortunate that although the Trust continues to deliver a sustained overall trend of reduction, that we failed to achieve the target set for Clostridium difficile during the year. Staff are committed to achieving the infection performance targets set by commissioners for 2013-14. Whilst recognising that it is not possible to prevent every case, staff will continue to work to reduce risk and to ensure that patients do not acquire avoidable infection whilst in our care.