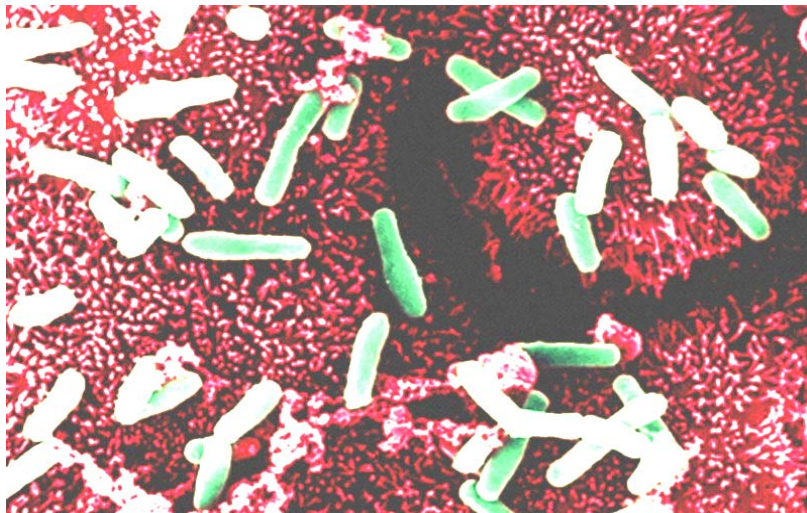


Camden Provider Services

Infection Prevention and Control Annual Report

1st April 2010 - 31st March 2011



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1 Executive Summary

The Infection Prevention and Control Annual Report provides detail on the activities and progress of the Camden Provider Services Infection Control Service for the year 1st April 2010- 31st March 2011.

- Between April 2009 and April 2012, all health care organisations that provide regulated activities are required by law to register with the Care Quality Commission.
- NHS Camden registered with the CQC prior to 1st April 2009. Following the Commissioning and Provider Services split, NHS Camden Provider Services have re-registered with the CQC.
- The CQC visit in 2010 deemed Camden NHS as compliant in the areas inspected (Inpatient Rehabilitation Service).
- Camden Provider Services has declared - Level Orange for Outcome 8 (CQC) for 2011-2012.
- Surveillance of alert organisms has continued as the Trust strives to reduce health care associated infections. Provider inpatient services had one MRSA bacteraemia in 2010-2011. MRSA acquisitions have slightly reduced, although the numbers of *Clostridium difficile* cases have increased as a consequence of an outbreak.
- Environmental and Clinical practice audits were undertaken during 2010/11 to assess compliance with policy and national standards. Findings from these audits will be used to inform the work programme for the coming year.
- *The Infection Prevention and Control Policy Manual* has been updated.
- Training has been provided to both clinical and non clinical staff, with an increase in the percentage of the clinical workforce receiving face to face training. The Infection Prevention and Control Team has also introduced practical training when appropriate e.g. isolation training.

2 Introduction

The Infection Prevention and Control Annual Report is produced by the Infection Control Nurse Lead and is a requirement under *The Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections (the Code of Practice)* and related guidance.

The report is intended to provide:

- An update on actions taken to ensure there is effective infection control provision across Camden Provider Services.
- Demonstrate the progress made towards achieving the Annual Infection Control Programme and Annual Audit Programme.
- The opportunity for the Trust Board to review the Infection Control Programme and identify priorities for the year ahead.

The Camden Provider Services is committed to ensuring there is a robust infection control function that supports the delivery of a high quality healthcare and protects the health of the population of Camden. Good infection prevention and control are essential to ensure that people who use Camden Provider Services receive safe and effective care. Therefore, the prevention and control of infection is integral in the delivery of high quality service. It must be part of everyday practice and applied consistently by everyone across the organisation.

This report provides assurances for the *Core Standards for Better Health C4a, C4c and C21* which link with the Trust's corporate objectives specifically objective 11 'to have an excellent performance on quality'.

3 Assurance Framework.

To inform Camden Provider Services of the progress towards the national standards, a working document was developed which incorporated all the actions required to comply with: *The Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control, Core Standards for Better Health C4a, C4c and C21* and NHS Litigation Authority standards. This was updated on a quarterly basis showing progress towards compliance and highlighting remaining gaps (refer to Appendix 1).

4 Registration with the Care Quality Commission

The profile of Infection Prevention and Control has been raised by the Government through the *Health Act (2008)* which consolidated previous guidance such as *Essential Steps to Safe, Clean Care (2006)*, *Standards for Better Health (DH 2004)*, *Winning Ways: Working Together to Reduce Healthcare Associated Infection in England (DH 2003)*, and *Infection Control Guidelines (NICE 2003)*.

Since 2006 all NHS provider Trusts have been legally required to observe the *Health Act 2008* and comply with the provisions of the *Code for the Prevention and Control of Health Care Associated Infection* (commonly referred to as *The Hygiene Code*).

The Hygiene Code outlines a Trust's duties to establish appropriate systems, assess and manage risks, implement clinical care protocols, ensure healthcare workers' access to occupational health services and provide induction and training. A revised and updated edition of *The Hygiene Code* was issued by the Department of Health in December 2009, and came into effect on 1st April 2010.

The Hygiene Code and related guidance aids providers of health and adult social care to plan and implement how they prevent and control infections. It also sets out the 10 criteria against which a registered provider will be judged. This is based on how it complies with this registration requirement, and

how it informs registered providers of what they should do to ensure compliance with the *Care Quality Commission (CQC)* registration requirement for cleanliness and infection control (Outcome 8).

Camden Provider Service declared green, full compliance for 2010 – 2011. In the previous year, the Infection Control Service had been provided by UCLH via a service level agreement. This SLA was dissolved and the infection control service was brought in-house. An independent gap analysis was undertaken and a number of areas of concern were identified.

Despite systematic improvement in the Infection Control Service and a CQC visit in 2010 (which deemed Camden NHS as compliant on the areas inspected), the Infection Control sub Committee has concluded from the evidence available at the time of assessment that Outcome 8, Regulation 12:

'is mostly met or there is not sufficient evidence to demonstrate the outcome is met. Impact on people who use services, visitors or staff is medium. Action required is moderate as opposed to compliant'¹

On assessment, Camden Provider Services fell between the Yellow and Orange compliance rating.² It was decided by the Infection Prevention and Control Sub Committee, and subsequently the Standards and Compliance Committee that in keeping with the Trusts reputation for honesty and transparency the lowest level of compliance rating should be declared Orange.

The areas of non compliance are broadly:

- Estates and Facilities policy and the monitoring of service provided
- the decontamination of medical devices
- embedding infection control policy and practice

The Infection Control Annual Programme 2011-12 (refer to Appendix 2) and the Assurance Framework Working Document (refer to Appendix 1) are included in this report. They are based on the relevant Care Quality Commission (CQC) registration requirement for cleanliness and infection control (*CQC Guidance about Compliance, Outcome 8*), NHSLA core standards, and they provide a record of evidence of working towards compliance with *Core Standards for Better Health C4a, C4c and C21* as specified by the Care Quality Commission.

5 Infection Control Arrangements

5.1 Organisational Arrangements

Good management and organisational processes are crucial to make sure that high standards of infection prevention and control are set up and maintained.

The Chief Operating Officer and the Provider Committee (Board) have a formal agreement (29/04/10) outlining their collective responsibility for minimising the risk of healthcare associated infections. The Provider Committee accepted responsibility for the systems in place for infection prevention and control, ensuring the protection of service users, their carers and families, and healthcare staff from infections. Strategies include making adequate resources available, inclusions of Infection Prevention and Control in corporate objectives, governance and risk management processes of the organisation, ensuring clear lines of accountability for Infection Prevention and Control from the CPS committee (board), appointing a board level lead for Infection Prevention and Control), and ensuring this role is satisfactorily fulfilled.

5.2 Director of infection Prevention and Control (DIPC)

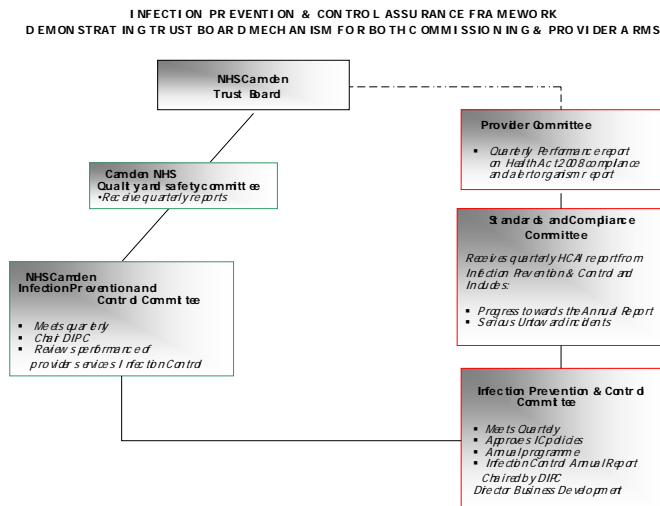
The designated Director of Infection Prevention and Control (DIPC), Caron Townsend, reported directly to the Chief Operating Officer and was responsible to the Board (up to 28/02/10) This role includes overseeing the Infection Control Agenda, challenging practice when necessary, and reporting directly to the Trust Board.

¹ *Compliance Assessment Outcome 8 (Regulation 12): Cleanliness and Infection Control*. NHS Provider Compliance Assessment: Outcome 8, p.3

² Ibid.

The DIPC chairs the Infection Prevention and Control Sub Committee (IPCsubC). The IPCsubC minutes are forwarded to the Standard and Compliance Committee. The DIPC Report is presented directly to the Provider Committee on a quarterly basis.

5.3 Reporting Mechanism



From the 1st April 2011 NHS Camden Provider service transfers to Central and North West Foundation Trust (CNWL), joining CNWL and Hillingdon Community Trust to become a single organisation. All Infection Control and Prevention data and documents were shared prior to the move of services, and an integration plan was presented as part of the CNWL's Infection Control and Prevention Annual Report. This integration plan was shared with *Monitor* for approval. The DIPC role will be undertaken by Peter Walsh (Director of Nursing CNWL). An Infection Control Executive Lead role was created within CPS. Wolfie Smith (Head of Allied Professionals) was appointed and will chair the local Infection Prevention and Control sub Committee.

5.4 Infection Prevention and Control sub Committee (IPCsubC)

The IPCsubC has met four times in the past 12 months. The committee has:

- approved and monitored the implementation of the Infection Control Programme and Policy Procedures.
- devolved Infection Prevention and Control responsibilities to all clinical services throughout the provider organisation
- supported the work of the Infection Control Team
- monitored the HCAI for inpatient services

Membership of the IPC sub Committee includes representation from all CPS business units. The terms of reference have been revised in line with current legislation.

5.5 The Infection Prevention and Control Service

Historically, CPS infection control and prevention services were provided via a Service Level Agreement with University College London Hospitals NHS Foundation Trusts (UCLH). Following a review of the SLA with UCLH in March 2009, NHS Camden Provider gave a period of six months notice to UCLH to terminate the contract with the intention to recruit to an in-house Infection Control Team. The Provider Services Infection Control Lead was appointed to provide cover to the NHS Camden Provider arm, commencing work in January 2010. From the beginning of November 2009 to the beginning of January 2010, the Infection Prevention and Control Service for NHS Camden Provider Services have been provided by Infection Control Solutions Ltd.

The control and prevention of infection and infectious disease in CPS is facilitated by the Infection Control Team, the IPCsubC and the Health Protection Agency (HPA) as appropriate. The Infection Prevention and Control Team provide support to Camden Provider Services staff. This includes policy development, training audit, surveillance and control of outbreaks, and ongoing strategy and planning. The Infection Prevention and Control Team assess and take actions to mitigate infection risks, and when necessary record outstanding risks on the CPS risk register. (refer to appendix 4)

An Infection Control Practitioner was funded for a fixed term of 6 months by the training and development department to support the Infection Control Lead.

Medical Microbiologist IC Dr. via SLA	O.1 WTE	April -March
Infection Control Lead 8b	1WTE	April- March
Infection Control Practitioner 7	1 WTE	Oct-March
Administration Assistant (Agency)	0.4 WTE	Oct-March

On-call advice and support is offered 24 hours a day, 365 days a year by the Infection Control Doctor or on call Microbiologist at UCLH. Monday to Friday from 9am to 5pm the team is contactable via e-mail, landline or mobile phone. Outside of office hours the Infection Control Doctor is contactable for incidents and outbreaks.

6 CQC Inspection (Unannounced)

The Care Quality Commission (CQC) established by the *Health and Social Care Act (2008)* is required to register, review, investigate and support all NHS bodies in improvements in the care provided to patients. A new registration system came into force on 1 April 2010 for NHS trusts (including primary care trusts as providers).

The CQC made an unannounced visit to South Wing at St. Pancras Hospital on the 12th May 2010 to inspect compliance against *The Hygiene Code*.

In brief the inspectors:

1. Analysed information on how the trust manages infection prevention and control, such as the results of audits and the frameworks used to assure the board that plans are happening in practice.
2. Examined policies and procedures.
3. Visited St. Pancras Hospital:
 - Continuing Care (Evergreen Ward)
 - Complex needs rehabilitation (Kingsdale Ward)
 - Rehabilitation (Rochester Ward)
 - Neuro-Rehabilitation (Oakwood Ward)
4. Had discussions with the Chief Executive Officer, the Associate Director GP & hospital services, the Clinical Services Manager, the Infection Control Lead, a clinical nurse specialist/modern matron, an admission & discharge co-ordinator, a junior doctor, a consultant, staff nurses, an infection control link nurse and health care assistants.

The inspectors had no concerns about the 14 measures inspected.

7 Alert Organism Surveillance 1st April 2010 – 31st March 2011

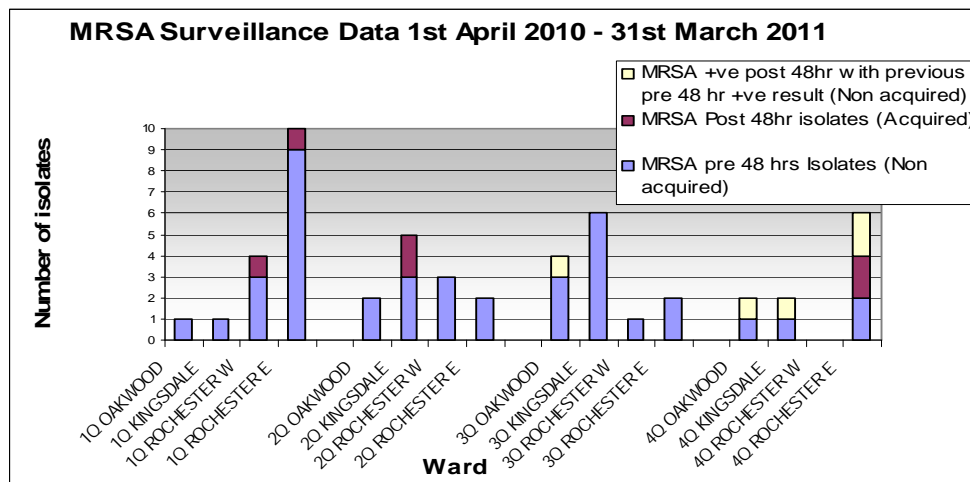
Surveillance of alert organisms was undertaken by the Infection Prevention and Control Team throughout the year. However, there are limitations as there are no electronic systems in place to review results. Therefore, the system is dependant on the Microbiologist reporting the result to either the ward or IC Lead. This has a consequential effect upon our ability to produce comprehensive data analysis (e.g. trend analysis).

7.1 Meticillin-Resistant Staphylococcus aureus (MRSA) Surveillance

SPH In-Patient Rehabilitation and Continuing Care Service screen all new admissions for MRSA. This allows for the identification of patients admitted to the unit with MRSA and those who acquire MRSA while they are in-patients. The total number of MRSA isolates from St Pancras In-Patient Rehabilitation Unit and Continuing Care Service patients per quarter for the year April 2010 - March 2011 is shown in the graph below. The data indicates a reduction in the total number of isolates.

Please note that 7 continuing care beds were decommissioned in September 2010. The total number of beds at St Pancras In-Patient Rehabilitation Unit therefore reduced from 76 to 69.

Graph 1: St. Pancras Hospital MRSA isolates for 1st April 2010 – 31st March 2011



- Nasal swabs are taken from all new admissions.
- Positive results from swabs taken 48 hours post admission are considered as acquired within the unit, unless the positive result is a weekly re screen with a positive admission screen already reported (revised protocol).
- The majority of patients recorded as MRSA positive were colonised rather than infected.

1st Quarter: 16 MRSA isolates at admission screen of which 2 cases were identified post 48 hrs, possible local acquisition.

2nd Quarter: 12 MRSA isolates in total, 10 detected on admission screening of which 1 was found to be Mupirocin resistant, suppression therapy reviewed.

2 MRSA isolates (post 48 hrs) on Kingsdale Ward: no obvious cross transmission between the two cases (one case had had a number of recent inter hospital transfers).

3rd Quarter: The post 48 hr MRSA case (Oakwood) was isolated from a repeat MRSA screen following suppression therapy, and therefore not considered a local acquisition.

4th Quarter: The number of post 48 hr positive isolates has increased. This is probably a consequence of the strict adherence to the revised MRSA screening protocol i.e. rescreening of all in-patients on a weekly basis. Of the 6 patients who were identified as MRSA positive post 48hrs, 4 who were previously positive remained positive following suppression therapy; 2 had previously negative results and were therefore local acquisitions.

The majority of MRSA cases (colonised) were positive on arrival at St. Pancras Inpatient Rehabilitation Unit. Of the 51 patients with MRSA positive isolates 88% (n45) were positive on admission screen (refer to Graph 1).

7.2 MRSA Isolates Data 2007-11

Table 1: MRSA Isolates Pre and Post 48 Hours Data Table, 2007-11

MRSA	2007-8		2008-9		2009-10		2010-11	
	Pre- 48 hrs	Post 48 hrs	Pre- 48 hrs	Post 48 hrs	Pre- 48 hrs	Post 48 hrs	Pre- 48 hrs	Post 48 hrs
	40	2	40	11	49	8	45	6

When comparing 2010-2011 MRSA pre 48 hrs and post 48 hrs isolate results with the previous 3 years data, there does not appear to be a significant change in the number of pre and post 48 hrs MRSA positive isolates.

7.3 MRSA Bacteraemia Data, 2007-11

St. Pancras In-Patient Rehabilitation and Continuing Care Service is not required to submit bacteraemia data to the Health Protection Agency's Mandatory Surveillance Programme, but the IPCT record all cases for surveillance and performance monitoring purposes. The table below details the number of MRSA bacteraemia recorded in SPH in-patient wards in the previous five years.

Table 2: MRSA Bacteraemia Data Table, 2007-11

MRSA Bacteraemia	2005-6	2006-7	2007-8	2008-9	2009-10	2010-11
	0	0	1	1	0	1

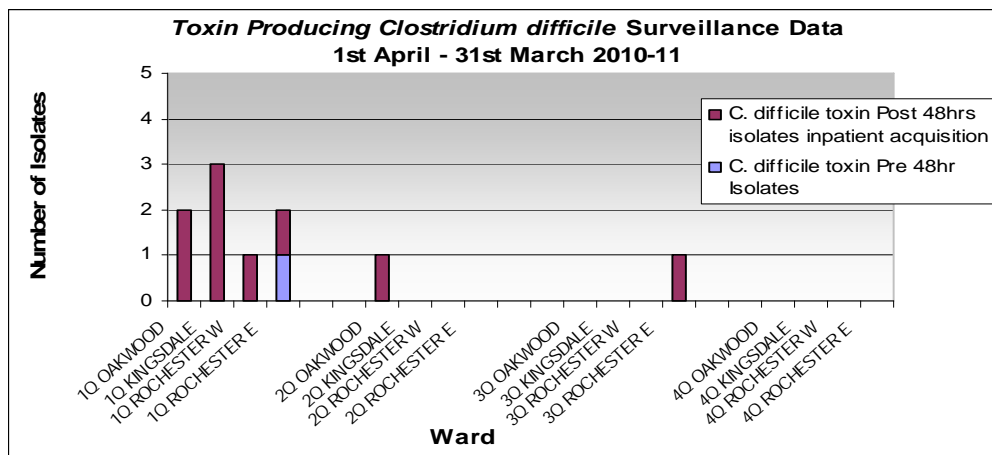
MRSA bacteraemia surveillance: 1 inpatient MRSA bacteraemia positive isolated 23/10/10 (for details refer to Incidents/Outbreaks section). A number of infection control measures and changes in clinical protocols have been implemented to reduce the risk of MRSA bacteraemia in the future.

7.4 Clostridium difficile (Toxin Producing) Surveillance

Patients admitted to the unit without a previous diagnosis of the alert organism are considered to have acquired the infection within the unit.

Antigen positive results are not part of mandatory surveillance.

Graph 2: St. Pancras Hospital Clostridium difficile (toxin producing) for the period of 1st April 2010 – 31st March 2011.



1st Quarter, an outbreak of toxin producing *C. difficile* infection affecting 4 of the wards (refer to Outbreak and Incidents section).

2nd Quarter, one case of toxin producing *C. difficile*. This patient had a recent history of *C. difficile* infection, probable relapse rather than a new case.

3rd Quarter, the patient had recently been treated with antibiotics in line with policy. No known previous *C. difficile* infection or contact with symptomatic case whilst an in-patient at St Pancras.

4th Quarter, no cases

7.5 *Clostridium difficile* Isolates Data Table, 2007-11

Table 3

	2007-8	2008-9	2009-10	2010-11
<i>Clostridium difficile</i>	12 (1 post 48hr)	0	6 post 48 hr	9 (8 post 48 hr)

Extensive infection control measures have been put in place to reduce the risk of *C difficile* infection such as isolation training, monthly *C. difficile* interventions audits, a *C. difficile* care pathway, prudent antibiotic prescribing and root cause analysis of all antigen and toxin producing isolates. There has been a marked reduction in positive isolates since the conclusion of the outbreak, i.e. one new case of toxin producing *C. difficile*.

7.6 Other alert organisms Surveillance

Alert organisms are those organisms that have Infection Prevention Control implications. The list below illustrates the total number of patients per quarter at SPH Rehabilitation and Continuing Care Unit who have been infected or colonised with an alert organism other than MRSA for the period April 2010 – March 2011.

1st Quarter: Extended Spectrum Beta lactamase (*ESBL*) *E. coli* isolated (pre 48 hour)

2nd Quarter: No cases

3rd Quarter: A case *Acinetobacter baumannii* post 48 hour infection; however please note the patient was colonised on admission.

A case Gentamicin resistant *E coli*, positive on admission (Pre 48hours)

4th Quarter: No cases

In 2010 -2011, there were two *E. coli* bacteraemias. Both were positive prior to transfer and one patient displayed symptoms of sepsis on admission. Enhanced surveillance for all *E. coli* bacteraemias will commence in June 2011. No targets are associated with this data in the near future.

8 Outbreaks and Incidents

8.1 Outbreak

There was one outbreak in the year 2010- 2011 at the St. Pancras, Inpatient Rehabilitation Unit. The causative organism was *Clostridium difficile*. This was a complicated outbreak which lasted from the 26th May 2010, to the 3rd August 2010 (last toxin positive case 30th June 2010). The outbreak affected 4 wards at the unit.

Introduction: *Clostridium difficile* infection (CDI) is the predominant cause of antibiotic-associated diarrhoea among hospitalised patients, and is of great importance as a healthcare-associated infection. Acquisition of *Clostridium difficile* may manifest as asymptomatic colonisation of the intestine, mild diarrhoea through to severe disease in the forms of pseudomembranous colitis and toxic megacolon. The risk of infection is higher in the healthcare setting due to a combination of risk factors, including the predominantly elderly population, antibiotic use, and the possibility of cross-infection.

Initial presentation: The suspected Index Case was symptomatic on admission and sample *Clostridium difficile* toxin positive within 48 hours. The onset of this outbreak was masked by simultaneous cases of Norovirus (dual infection). This may have increased environmental contamination and consequently the rate of transmission.

In the following week, there were 3 cases of Norovirus and an Outbreak meeting commenced. Two of the samples also isolated *Clostridium difficile*. Subsequent cases on different wards across the unit initiated a root cause analysis (RCA) of both antigen and toxin positive cases to examine the individual's risk and the possibility of this being an outbreak. All toxin positive cases were mild CDI, i.e. <3 stools of types 5-7 on the Bristol stool chart per day.

Root Cause Analysis: The findings of the RCA did not provide an obvious method of transmission. They did highlight factors influencing the increase in cases.

- Cases previously treated with Metronidazole / Vancomycin which would indicate a history of *Clostridium difficile* infection.
- due to recent cases of Norovirus, there was an increase in the number of faecal samples sent for testing.
- Recent changes to the *Clostridium difficile* testing regime at UCLH increased sensitivity.

In view of findings initially classified as a *period of increased incidence*, strict infection control measures were put in place and ribotyping requested (HPA laboratory) to establish if the cases were linked or coincidental. Results showed 4 of the 5 samples to be strain type 020, which comprises 5.4% of the strains in the UK. This indicates that transmission has taken place within the unit (South Wing). The Health Protection Agency were informed of the outbreak status on 6th July 2010. Outbreak meetings were held on 12/07/10, 19/07/10 & 03/08/10.

Overview of Cases and types: (1st case 26th May 2010)

There were twelve cases involved in this outbreak, of which eight were *Clostridium difficile* toxin positive and four were antigen positive but toxin negative.

Clostridium difficile infection toxin positive

The eight cases of *Clostridium difficile* toxin positive infection were as follows: 1 pre 48 hrs, 7 post 48 hrs. Seven were sent for ribotyping: four were typed as strain 020, one 023, one 014 and one non typable.

Clostridium difficile infection antigen positive (toxin negative)

Four samples were found to be antigen positive but toxin negative. One antigen positive sample on further laboratory testing was a non toxigenic type.

Table 4: Ribotyping results.

Toxin/ antigen	Cases	Ribotype
Toxin +ve Pre 48	1	020
Toxin +ve Post 48	7	(3x 020) 023, 014, non typable
Antigen +ve	4	(1 non toxigenic strain)
Total	12	

Serious Untoward Incident: This *Clostridium difficile* outbreak was managed within the capacity of Camden Provider Services with assistance from Microbiology at UCLH and the HPA specialist laboratory services.

As there were *two or more cases of C difficile in the same ward within the same week and/or third case within the same ward and month*, this outbreak was reported as a Serious Untoward Incident by the DIPC, via the Head of Governance & Risk Management to NHS London and NHS Camden Chief Executive. The risk was set as 16 (extreme).

Conclusion: The outbreak of *Clostridium difficile* infection was not closed until the 3rd August 2010. This was precautionary due to the risk of a second wave of infection, although ultimately this did not occur. Some in-patients had remained symptomatic and potentially could continue to excrete *C. difficile* spores, presenting the possibility of onward transmission.

A number of the infection control measures implemented during this outbreak are continuing and are being reviewed. The *Saving Lives* audit tool, 'High Impact Number 7, A care bundle to reduce the risk from *Clostridium difficile*,' is undertaken on a monthly basis (refer to audit section). To address the specific infection control and prevention issues at the Inpatient Rehabilitation Service, a local Infection Control *Saving Lives* Group has formed

CPS has provided investment monies to procure new commodes for all the wards. They are a better design, and can be dismantled to allow staff to clean the equipment more effectively.

8.2 Outbreak Planning

Camden Provider Services have developed policies and systems to prevent and control outbreaks in accordance with the *Health Act (2008)* which are incorporated in the *Infection Prevention and Control Policy Manual*. The Health Protection Agency (HPA) via the Local Health Protection Units (HPU) support NHS and non-NHS services regarding Infection Control, Notifiable Diseases, Health Care Associated Infections (HCAI's) and outbreaks.

The outbreak plan was tested in advance of the seasonal increase of norovirus. The area chosen to examine was communication. The exercise was called *Mistletoe*.

8.3 Exercise Mistletoe: Previous outbreak reviews found that the communication across organisations had been problematic. Therefore, an action of the winter outbreak planning meeting was to run a table top exercise. The exercise aimed to test the cascade of information in the initial stages of an outbreak, i.e. up to the point of the 1st outbreak meeting.

Method: A scenario was described to the nurse in charge on the ward and everyone was then asked to respond as they thought appropriate. Staff were asked to log actions taken / information received and to comment on decision making.

The data from the exercise was collected, and demonstrated that the outbreak plan had been effective. Communication took place in a timely manner across the organisation (i.e. ward to ward, bed manager and portering / domestic services) and vertically to director level and partner organisations (i.e. commissioners).

9 Root Cause Analysis (RCA)

Following DoH guidance, Acute Trusts are broadly considered in the first instance as accountable for all post 48 hour acquisitions of MRSA and *Clostridium difficile*, and those cases identified as community samples or within 48 hours of admission are considered as community acquired. The RCA process allows for a more comprehensive review of service activity and promotes learning across services for the common aim of reducing health care associated infections.

There were two cases of MRSA Bacteraemia in 2010-2011. One case was an inpatient St. Pancras South Wing Inpatient Rehabilitation Unit (post 48 hour) and the second was indentified as a pre 48 isolate at the Whittington Hospital with recent care from the Adult Community Nursing service. The RCA investigation, findings and conclusions for each of the cases are outlined below.

9.1 MRSA bacteraemia post 48 hour inpatient

Background: The patient was admitted to Kingsdale on 24/09/10 for rehabilitation. Admission screening for MRSA was reported as positive; the patient had already been transferred back to UCLH on 26/09/10 and readmitted to St Pancras on 29/09/10. A repeat swab was requested by Infection Control lead for culture (previous history of MRSA). The patient's condition deteriorated. A MRSA positive isolate from blood cultures was reported on the 23/10/10.

Outcome: A number of deficiencies were identified, primarily the absence of topical MRSA suppression therapy following the positive screening result. There were also communication problems between the laboratory and CPS around screening tests and in the reporting of alert organisms to the ward.

Conclusion: There may have been a benefit in reducing MRSA load by prescribing the suppression therapy. Taking into account the patient's long term colonisation with MRSA, a blood stream infection was possible. So on balance, this was considered a *true* bacteraemia. That said, given her difficult venous access and MRSA colonisation it remained possible that the positive blood culture was a contaminant.

Actions: The Camden Provider Services Inpatient has made extensive changes. The MRSA screening protocol has been reviewed and adapted to include a weekly rescreening regime and repeat MRSA suppression therapy if necessary. A MRSA care pathway has been developed and is commenced for every positive MRSA patient and this is audited. A web-based results service has been introduced which enables clinical staff to access results. This means that St. Pancras hospital staff are not solely reliant on

the UCLH alert organism notification system to find results. There are still potential risks around the telephone (verbal) reporting of alert organisms to clinical staff of the wards from UCLH. Ways to develop a more robust system are being worked on between the laboratory and St Pancras managers.

The equipment for taking blood cultures is now in line with national standard (EPIC 2 guidelines). The importance of standardised practice when taking blood culture samples is included in the new infection control session as part of all medical staff's orientation to South Wing.

9.2 MRSA bacteraemia Adult Community Nursing

Background: The patient was discharged from the Whittington Hospital on 26th January 2001. A referral was made to the Adult Community Nursing team at Gospel Oak for care of sacral pressure sore and stump wounds.

Outcome: From discharge to re-admission at the Whittington Hospital, daily dressings were carried out. Whilst the patient was under the care of Adult Community Nursing, there was no indication of deterioration in the condition of the wounds but healing was limited. The District Nurse visited the patient home on the 12th February 2011 and the patient was found to have deteriorated, resulting in emergency admission to the Whittington Hospital.

MRSA was isolated in blood cultures taken in A & E (pre 48 hours). The patient had a number of risk factors including: long-term MRSA colonisation since 2006 (hospital admission), unstable insulin dependent diabetes, recent surgery, chronic wounds, peripheral neuropathy, and lung disease.

The Root Cause Analysis highlighted areas for improvement in documentation, in particular detailed wound assessment.

Conclusion: The MRSA bacteraemia as a pre 48 result was attributable to primary care, but the bacteraemia was probably non-preventable. There was no indication the Adult Community Nursing services could have taken alternative actions in the circumstances which would have prevented the bacteraemia.

Actions: Adult Community Nursing are reviewing the documentation at the point of re-admissions to the service and photographs will be taken of all wounds. Root cause analysis training specific to MRSA bacteraemia has been proposed to the training and development department.

9.3 *Clostridium difficile* (toxin producing)

Root cause analysis (RCA) of all of toxin producing *Clostridium difficile* toxin isolates is standard practice in the NHS. In response to the increase in incidence of *Clostridium difficile*, this has been extended beyond the national standard to include all isolates of *Clostridium difficile* i.e. both toxin and antigen. The objective was to try and identify any patterns of transmission between cases. Following the outbreak there has only been one case.

Outcome: Findings of the RCA identified one potential risk factor; the patient had received a recent course of Co-amoxiclav for a suspected chest infection. The antibiotics were prescribed for 5 days, reviewed on day 3 and stopped in line with local antibiotic policy. IPCT experienced some difficulty isolating the patient quickly due to availability of single side rooms.

Actions: All appropriate infection control measures were taken, and the risks managed within the limitations of the building (number of isolation rooms). No further cases.

9.4 Incident Management

There was input into a number of separate water supply issues such as water discolouration, loss of pressure, water temperature at Mortimer Market & Margaret Pyke Centre.

9.5 Enquiries

There have been approximately 120 documented enquiries.

10 Audit

The Health Act (2008) Code of Practice for the Prevention and Control of Health Care Associated Infections requires that health care providers have in place a programme of audit to ensure that key policies and practices are being implemented appropriately (refer to Appendix 3)

10.1 Essential Steps to Safe Clean Care Audit

Background: *Essential Steps to Safe Clean Care*; Reducing Healthcare-Associated Infections in Primary Care Trusts; Mental Health Trusts; Learning Disability Organisations; Independent Healthcare; GP practices and Ambulance Services, is a framework issued by the Department of Health in June 2006 to support organisational use of best practice to prevent and manage the spread of infections and ultimately improve patient safety. The framework is composed of a number of interlinked tools and products and can be used on an organisation wide basis as well as by individual departments and teams. Participation with the *Essential Steps* programme will help demonstrate compliance with the *Code of Practice for the Prevention and Control of Health Care Acquired Infections* as set out in the *Health Act (DH 2008)* which is assessed by the Care Quality Commission as part of the registration criteria.

Introduction: Good hand hygiene, appropriate use of personal protective equipment, appropriate use of aseptic technique and the safe disposal of sharps are all important in minimising the risk of infection to patients, clients, staff and visitors.

Aims and Objectives: This project aimed to measure adherence to the following key Infection Control policies: Hand Hygiene; Use of Personal Protective Equipment; Aseptic Technique and Safe Disposal of Sharps.

Criteria and Standard: The criteria and standards used in this audit have been drawn from NHS Camden Provider Services policies on Infection Prevention and Control and the '*Essential Steps to clean, safe care*' programme (Department of Health, 2006).

Method: Staff undertook peer observation audits of clinical practice. 278 episodes of direct patient/client contact, which took place between 13th January and 3rd March 2011, were observed across Provider Services to determine whether essential steps were undertaken in accordance with current infection control policies. Data was requested from all service lines involved in delivering direct patient care, 27 teams took part in the audit.

Limitations: The requested number of observations was increased to 10 for each participating team / site this year (previously only 5 observations were requested from each team / site). Data was requested but not received from Mortimer Market Men's Clinic, although part of the audit period coincided with closure of the clinic for refurbishment.

Table 5: Results - Overall

Essential step	Results 2009/2010 (N=130)	Results 2010 /2011 (N=278)			
	% Compliance	Yes	No	N/A	% compliance
Hand hygiene	89	274	4	0	99
Personal Protective Equipment	96	115	6	157	95
Aseptic Technique	85	57	0	221	100
Sharps	98	95	0	183	100
TOTAL	92	541	10	561	98

Discussion: There has been a significant increase in the number of clinical observations undertaken (n 278) and an increase in the number of services taking part in the audit. This has been achieved despite limited opportunities for some staff to observe each other as they predominantly work alone.

All areas of the organisation reached the audit standard of 85%. The overall score for Camden Provider Services has improved when compared with the previous year.

The score has also improved for the essential steps elements, hand hygiene, appropriate use of aseptic technique and the safe disposal of sharps. The appropriate use of personal protective equipment PPE is

similar at 96% / 95%; this seems to be linked to a small number of staff not using gloves when handling sharps.

Conclusions: Camden Provider Services is compliant with *Essential Steps* to safe, clean care standard. There has been significant improvement to the overall standard and good engagement by services which has increased the number of observations undertaken when compared with 2009-2010.

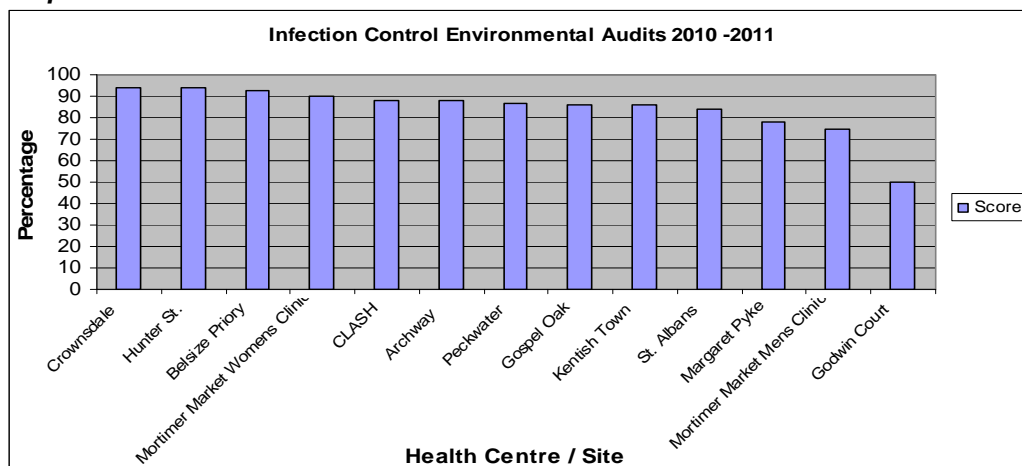
10.2 Health Centre Environmental Audits 2010 -2011

Aims and Objectives: This project aimed to assess the infection control standard in all sites where clinical care is delivered. The Infection Control National Association audit tool for a community setting was updated and adapted to address current practice. Although the purpose of the audit was to examine the environment, some basic infection control standards were also included (e.g. sharps safety, storage of vaccines).

Method: 13 sites were visited by the ICN accompanied by either the centre manager or a member of the clinical team, and the audit tool was completed.

Criteria and Standard: The standards used have been drawn from NHS Camden Provider Services policies on infection prevention and control, NICE guidance, and based upon the ICNA community audit tool.

Graph 4. Health Centre Environmental Audit



Conclusion: In general the standard is good. In many instances simple changes would improve the score significantly.

Actions: It was requested that responsibilities within the action plans would be divided between the managers of the clinic environment and managers of clinical practice. Action plans and ongoing progress against the site plans were reported through the IPCsubC as tabled reports by the service representative and the Head of Administration & Facilities.

Godwin court: Godwin Court scored poorly on the audit 50%. Godwin court a community hall which is being used as a site for a baby clinic twice a week. The baby clinic was moved from Crowndale Health Centre as an emergency measure at the request of commissioners. Infection Control has recommended that the site is not fit for purpose, and provided advice on the renovation necessary to reach the expected standard. The risks associated with this site have been entered on the Children’s Services risk register. CPS, and the commissioners are in ongoing negotiations to resolve the issue.

10.3 Rolling audit programme St. Pancras In-patients Rehabilitation Unit

South Wing has a rolling audit programme. Results of these audits are reported to the Infection Control *Saving Lives* Group, and tabled at the IPCsubC. Significant results are reported to the Provider Committee on a quarterly basis via the DIPC report.

- A weekly hand hygiene audit, compliance now between 90 – 100 %.
- Daily check list and weekly Matron/ Manager Audit undertaken on the *Thursday round*. Results indicate 90% compliance.
- A High Impact Intervention audit No7 (*Clostridium difficile*) was undertaken over the past 9 months. Areas examined include prudent antibiotic use, use of personal protective equipment, hand decontamination, isolation procedures, environmental decontamination. A target of 90% has been achieved in consecutive months and therefore the audit frequency has been reduced to quarterly.
- Monthly mattress audit which includes checks for tissue viability, infection control and fire safety continue.

10.4 Anti-Infective Prescribing Audit (excluding topical antibiotic preparations)

The Health Act 2008 states that procedures should be in place to ensure prudent antibiotic prescribing, and the Department of Health states that prescribing policies should be compliance-audited.

Introduction

Presently CPS refers to the UCLH antibiotic policy and protocol for guidance on antibiotic prescribing. To assure the Provider Service Committee of the prudent prescribing of antibiotics at the Inpatient Rehabilitation Service (South Wing), the pharmacy department provide information on the number of antibiotics dispensed quarterly. This data is used to indicate approximate antibiotic usage, and then augmented with antibiotic audits assessing practice (e.g. stop dates, clinical reason, and prompt switch from IV to oral).

Methods: An audit tool was devised and a point prevalence audit was initiated to look at compliance of all anti-infective prescriptions on the 3rd March 2011 to ensure they correspond to the UCLH guidelines. The audit was conducted by representatives from medicine, nursing, infection control and pharmacy.

The standard was set at 100% compliance with the anti-infective policy and generic good quality documentation standards.

Results: On the 3rd March, only 2 patients were currently receiving anti-infective treatment out of all the patients on the 4 wards. The antibiotic choice was judged appropriate in both cases. In one case the rationale to continue with IV antibiotics beyond 48 hours without an oral switch was not explicitly documented.

The short anti-infective guide available at St Pancras refers clinicians to the UCLH intranet for guidelines on treating complex Hospital Acquired Pneumonia. However, there is no facility to access these from St Pancras Hospital and so, although the audit team agreed that the antibiotic choice and duration was probably reasonable, these anti-infective prescriptions were judged to be not covered by the current policy.

Conclusions and Discussion

It is impossible to draw firm and meaningful conclusions surrounding the compliance with policy from the small sample. However it is clear that the 2 prescriptions were correctly charted.

Recommendations: Obtain access for clinicians to the full guideline on the UCLH intranet.

Add documentation standards to the anti-infective policy, including drawing the distinction between HAP and complex HAP

The audit planned in 2011 -2012 will use a prospective study design rather than a point prevalence survey, and the audit tool will be slightly altered to allow for free text, and include a question on catheterisation.

Author of original audit paper: Dr. Simon Green, Medical Registrar.

10.5 Waste Management Audit

In January 2010, an audit of Waste Management was commissioned by Provider Services. This was extended to include all sites. The audit was undertaken by Independent Safety Services Ltd. The auditors visited the remaining sites across provider services, auditing practice against Health Technical Memorandum 01:07: Safe Management of Healthcare Waste. Following the audit a report was presented outlining both recommendations and requirements to be implemented. In response Provider Services have initiated a waste sub group Chaired by The Head of Administration and Facilities to

address the recommendations made. The waste sub group meets bi-monthly, and has representation from clinical service leads, estates and facilities and risk. An action plan and risk register has been developed based on the recommendations.

Revision of the waste management contract and policy is required in order for it to reflect best current practice. It has not been possible to achieve this to date, partially due to the proposed changes in the provision of Estates and Facilities. This will need to be addressed in 2011 -12 when a new provider is in place.

10.6 Patient Environment Action Team Assessments (PEAT)

During May 2010, NHS Camden Provider Services participated in the annual PEAT inspections at St Pancras Hospital South Wing Inpatient Services. Scores have been submitted to the National Patient Safety Agency (NPSA). The site was graded as **good** for environment.

10.7 Patients Views.

User Satisfaction Questionnaire: On discharge a patient or a member family completes an exit questionnaire evaluating their experience as a patient in South Wing. Two of the fourteen questions asked relate to cleanliness in general ward and the bathroom / toilet area.

Chart 1 Patient satisfaction ward cleanliness

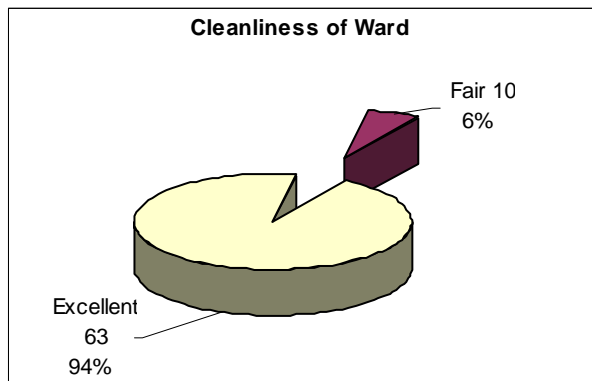
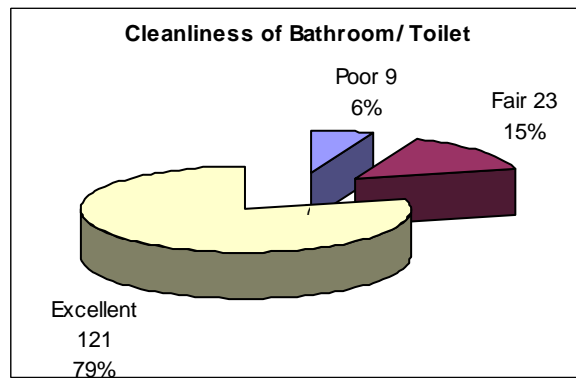


Chart 2 Patient satisfaction bathroom cleanliness



To provide an indication of the level of cleanliness at South Wing, information has been extracted from the user satisfaction questionnaire. Chart 1 and 2 illustrate the average percentage of views expressed over the year. The majority of patients found the cleanliness of the environment as excellent.

11 Learning and Development

Camden Provider Services has a statutory obligation to ensure that all staff receive appropriate education and training in IPC. The delivery of this training has remained of paramount importance. The *Hygiene Code* within the *Health Act (2008)* also requires that induction and training programmes for new staff and ongoing education for existing staff should incorporate the principles and practice of prevention and control of infection. *The Core standard C11* within *Standards for Better Health* refers to the participation of healthcare staff in mandatory training and also participation in further professional and occupational development.

All infection control education is designed to ensure that staff are able to work to the Camden Provider Services Infection Prevention and Control Policy, National standards and NICE guidelines in order to prevent, control and reduce infections for the public, patients and staff. Risk assessment and patient/staff safety are key messages in training delivered by the Infection Control Team.

The IPC Team have provided induction for all staff groups and annual infection control update for all clinical staff. In addition, *ad-hoc* training for individual wards/departments is provided if that area has specific requirements. The administration of routine infection control training is delivered by the Learning & Development Department. All education and training activity is monitored by the IPCsubC and training reports are produced by L&D quarterly for information and assurance.

Infection Control has trained domestic staff in E & F, although this service has been bought in under an SLA with E&F. A decision was made to offer free training because of the *C. diff* outbreak in South Wing.

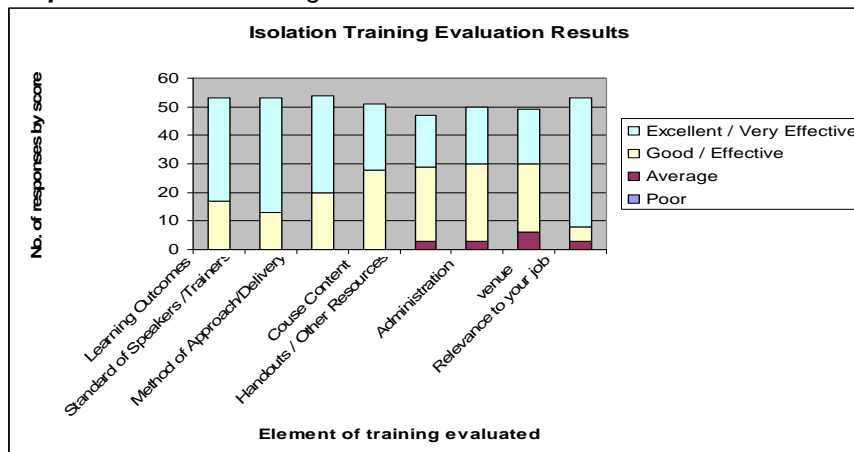
11.1 Mandatory Training

Between 1st April 2010 and 31st March 2011 there were a total of 29 Infection Control sessions. There were 11 induction sessions where 132 staff were trained, and 18 mandatory training updates where 301 people were trained. Therefore a total of 433 staff were trained in Infection Control (72% of Clinical Staff and 66% of Non clinical staff).

11.2 Isolation training

In response to the HII No7 audit results, isolation training includes correct use of personal protective equipment and hand hygiene training.

Graph 6: Isolation training results



A total of **161** staff were trained across all disciplines. Approximately 30% of participants completed evaluation forms, and of these over **90%** rated the training as **good or excellent** (refer to graph 6) This practical approach will be adopted for some aspects of clinical infection control training in 2011- 2012, specifically where changes have been made to clinical protocols or procedures.

11.3 Hand Hygiene

Following analysis of the weekly hand hygiene audits, it was decided that the focus this year on hand hygiene strategy would be the implementation of the *'Bare Below the Elbow'* campaign. This has been championed by the infection control link practitioners at South Wing where they ran an education day to raise awareness.

12 Policies / Documents

The joint IPC policy manual for Commissioning and Provider Services was completely revised, updated, and approved by the IPCC in 2009. However, the policies/protocols were reviewed as part of the gap analysis for Provider Services, and due to changes in requirements this highlighted a number of the policies and procedures which were not in line with current *EPIC 2*, *NICE guidance*, DoH MRSA screening requirements, and which were not specific to clinical requirements of the Provider Services.

Therefore, *The Infection Prevention and Control Policy Manual* has been updated as an interim measure and dated until the 1st of April 2012. It is available for reference on the Intranet. To see an overview of the revision and amendments made to the policy manual, please refer to table 6 below.

Table 6: Infection Prevention and Control Policy Manual amendments

Infection Prevention and Control Policy Manual Version 2	Amendments
A1: Hand Hygiene	Significant amendment
A2: Standard Precautions	Minor amendment
A3: Outbreak Management	Rewritten
A4: Notification of Communicable Disease	Rewritten to new legislation

A5: Isolation	Rewritten
A6: Schools and Other Childcare Settings	Rewritten
A7: Nosocomial Infection Surveillance	Minor amendments
A8: Uniform Policy	Minor amendments
A9: Glove Usage	Minor amendments
A10: Single Use Medical Devices	Rewritten
A11: Building & Renovation Healthcare Projects	Amended
A13: Use and Care of Invasive Devices	Replaced
A16: Aseptic Technique	Minor amendments
B1: Spillage Policy	Added Appendices
B2: Decontamination Equipment: Cleaning and Disinfection	New Document
B5: Specimen Collection and Transportation	Minor Amendments
B6: Healthcare Waste Management Policy	Rewritten
C1: MRSA	Rewritten
C4: Ectoparasites	Minor amendments
C9: Gastro Intestinal Infection, Food Poisoning	Renamed
C10: Antibiotic Associated Diarrhoea (<i>Clostridium difficile</i>)	Amended
C12: Norovirus Policy	Appendices added
D1: Blood borne Viruses Protection for Staff and Patients	Minor amendments
D2: Needlestick Injuries and Blood Exposure Incidents	Minor amendments
D4: Measles Vaccination of Healthcare Staff	New document
D5: Rubella: Staff Immunity and Immunisation	New document

13 Decontamination

The Decontamination Lead has responsibility for clinical decontamination issues within the Trust. The overall Lead for Decontamination lies at executive level. In 2010 -2011 this role was undertaken by the DIPC Caron Townsend. However, there has not been a nominated Decontamination Lead since 28th February 2011.

At present, day-to-day issues of decontamination in clinical areas and investigation of decontamination issues relating to infection control are undertaken by the Infection Control Lead.

The Infection Control Policy Manual, chapter B2: the Decontamination Equipment: Cleaning and Disinfection has been updated and revised, with a more comprehensive guide for the decontamination of frequently used medical devices.

Within the Trust there are no medical devices which fall in to the high risk category requiring sterilisation. These devices have been replaced by Single Use Items (e.g. podiatry instrumentation).

Decontamination of medical devices has been entered on the risk register and as such is a standing agenda item. CPS has formed a project group to address the management of medical devices. Infection control input has been requested to provide advice on the decontamination element of the management of medical devices. As decontamination forms only a part of the whole process for the management of medical devices, the decontamination agenda is dependant upon this project moving forward.

14 Estates and Facilities

It is a requirement that IPC is involved in the refurbishment and design of all new builds. The national and local policy stipulates that the IPC team are contacted when such works are being planned in order that appropriate advice is given at the correct time.

Currently there are no robust systems in place for ensuring IPC involvement prior to the sign off of all projects that occur across the PCT, although NHS Camden, Estates and Facilities capital projects do frequently involve Infection Control at an early stage.

Since April 2010, the IPC have been involved in the review of a number of projects these included projects for South Wing, Archway, Mortimer Market, Margaret Pyke, Cannonbury Project and Godwin Court.

There has been limited progress towards the *Health Act 2008* gap analysis with Estates and Facilities. Areas requiring attention are policies, procedures, training and audit. A new provider of Estates and Facilities services is being commissioned in partnership with Camden and Islington Foundation Trust. Compliance with the *Health Act 2008* is a requirement of the new contract agreement. Processes to monitor compliance with the *Health Act* will have to be integrated into the CPS infection control reporting mechanism (e.g. Legionella testing).

15 Partnership working

CPS Infection Control worked with the HPA, Islington PCT, Islington Council & Camden Borough Council, to raise the awareness and tools to assist Nursing Homes to meet the requirements of the *Health Care Act 2008*.

16 Conclusion

During the period of April 2010 to March 2011, Camden Provider Services continued to review their Infection Control service provision and compliance with Infection Prevention and Control standards. An unannounced visit to the Inpatient Rehabilitation Services from the CQC concluded that the CPS was compliant with the *Health Act 2008* in the areas inspected.

The assurance framework working document and DIPC reports outline the extensive improvements made to the Infection Control Service and its progress toward compliance with the *Health Act 2008*. There are now clear systems to manage and monitor the prevention and control of infection, with clear reporting mechanisms throughout the organisation to the Provider Committee.

Infection Control training was established as part of the Trusts essential training and the percentage of staff attending has increased.

The *Infection Control Policy Manual* has been updated to incorporate national standards, *NICE guidance* and *EPIC Guidelines*. Observational audit has been extended, showing an improvement in infection control standards in clinical practice.

Compliance against the *Hygiene Code*, as required by the Care Quality Commission, has been re-assessed and Camden Provider Services has declared partial compliance (Orange). This outlines the areas which require action and the priorities for the coming year. They are broadly estates and facilities policies, decontamination of medical devices and embedding the changes to policy into clinical practice, whilst progressing with the integration of infection control services with CNWL Foundation Trust.

References

Care Quality Commission (2009) Registration.

<http://www.cqc.org.uk/guidanceforprofessionals/nhsTrusts/registration.cfm>

Care Quality Commission (CQC) registration requirement for cleanliness and infection control (CQC *Guidance about Compliance, Outcome 8*)

Department of Health (2003) *Winning Ways: Working Together to Reduce Healthcare Associated Infections in England*. <http://www.dh.gov.uk>

Department of Health (2008) *The Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections*

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110288

Epic 2: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. Pratt RJ; Pellowe CM; Wilson JA; Loveday HP; Harper P; Jones SRLJ; McDougall C; Wilcox MH, **Journal of Hospital Infection** (2007) 65S, S1–S64

EU (2010) Directive 2010/32/EU - prevention from sharp injuries in the hospital and healthcare sector

<http://osha.europa.eu/en/legislation/directives/sector-specific-and-worker-related-provisions/osh-directives/council-directive-2010-32-eu-prevention-from-sharp-injuries-in-the-hospital-and-healthcare-sector>

NHS Litigation Authority, Risk Management Standards, acute, community, mental health and learning disability and independent sector standards 2011 - 2012 Infection control, Hand hygiene training standards 2.8

National Institute Clinical Excellence, NICE Guidance (2003), Prevention of Healthcare-Associated Infections in Primary and Community Care.

Occupational Health Service

Annual Infection Control Report for Camden Provider Service April 2011

Contents:

1. *Statement on Infected Health Care Workers with BBV*
2. *Sharps Update*
3. *New Entrant Screens / Staff Updates*
4. *Immunity Screens*
5. *Immunisations*
6. *Induction Training Session*
7. *Infection Control Related Audit Projects*
8. *Outbreak Management*
9. *Access to the Occupational Health Service*

Occupational Health Service Infection Control Report

1. Statement on Infected Health Care Workers with BBV

The Occupational Health Service confirms that it has not had any case that required the support / consultation with the UK Advisory Panel for Healthcare Workers Infected with Blood Borne Viruses between 01/04/10 – and 31/03/2011 on behalf of Camden Provider Services.

2. Sharps Update

From the 1st April 2010 – 31st March 2011 there have been **12** sharps injuries reported to OHS from Camden Provider Services

Summary information

Item	1st April 2010 - 31st March 2011	1st April 2009 - 31st March 2010
Number of Sharps Injuries	= 12	= 25
Donor BBV status	= 0 Hepatitis B = 0 Hepatitis C = 1 HIV * Not all Donors consented to blood being taken	= 0 Hepatitis B = 0 Hepatitis C = 0 HIV * Not all Donors consented to blood being taken
Recipient hepatitis B immunity	= 7 immune = 4 not immune = 1 declined to attend	= 17 immune = 8 not immune = 0 declined to attend
Recipient booster hepatitis B vaccine	= 8 given booster = 6 not needed / declined	= 12 given booster = 11 not needed / declined
PEP given	= 1	= 0
Occupation of recipient		
Doctor / Dentist	= 0	= 3
Nurse / Dental Nurse / Health visitor	= 10	= 16
HCA / Support worker / Admin	= 0	= 0
Manager	= 0	= 0
PAM's	= 2	= 3
Other information		
Preventable incident assessed by OHS	= 9 (75%)	14 (56%)

All staff have been offered followed up by OH in accordance with CPS policy where applicable to do so.

3. New Entrant Screens / Staff Updates

In the 2010 – 2011 financial year 293 Camden Provider Services (CPS) new starters were assessed in the OHS and a further 21 were up dated following change of post and 12 followed up post “sharps” injury. The vast majority of new starters required some form of up dating to meet protection standards. Immunity screens and immunisations were performed to meet infection control and health and safety standards. The activity conducted at New Entrant screening and the activity conducted “in” employment via staff up dates is summarised below.

4. Immunity Screens

All staff attending OHS for a new entrant screen / staff up date / sharps follow up will have their immune status for a range of communicable diseases assessed in relation to the nature of the referral and the requirements of their post.

In addition (and in accordance with CMO guidance) all staff are offered the opportunity to have Hepatitis C and HIV testing undertaken where they believe themselves to have been exposed to risk. The following provides a detailed breakdown of the number immunity screens conducted that were necessary to ensure documentary evidence of immunity in accordance with CPS policy. It can clearly be seen that a sizable number of staff entering the Trust continue to require immunity test or immunisations to meet the standard.

Hepatitis B.

86 Hepatitis B antibody screens and 50 Hepatitis B antigen screens have been undertaken over the financial year. 7 staff have required core antibody tests and 1 staff member required “e” markers.

HIV Test.

26 HIV antibody screens have been undertaken.

Hepatitis C.

27 Hepatitis C antibody screens and of these 1 Hepatitis C RNA PCR test has been undertaken.

Rubella.

69 Rubella antibody tests have been undertaken.

Measles.

55 Rubella antibody tests have been undertaken.

Varicella Zoster (Chicken Pox).

49 Varicella antibody tests have been undertaken.

Mantoux Screens.

All New staff are checked for evidence of a BCG scar. 1 member of staff had a Mantoux test and then required BCG vaccination – see below immunisations.

Immunity Screens		
<i>CPS 326 total cases (NE's, Updates including sharps)</i>		
<i>Type of Test</i>	<i>Number tests required</i>	<i>% who <u>required</u> screening.</i>
Hepatitis B Antibody	86	26%
Hepatitis B Antigen	50	15%
Hepatitis C Antibody	27	8%
HIV	26	8%
Rubella.	69	21%
Measles	55	17%
Varicella Zoster (Chicken Pox).	49	15%
Mantoux Screens.	1	0.3%

5. Immunisations

Hepatitis B.

72 doses of Hepatitis B vaccine have been administered this year. 18 members of staff were commenced on their first or second primary course; this represents 5.5% of those assessed as either new entrants or updated.

MMR.

18 doses of MMR vaccine have been administered. 12 members of staff were given the first dose and 6 have been given a second dose.

BCG.

1 staff have been administered a BCG, which is 0.3% of the total number of new entrant / updates.

Varicella Zoster (Chicken Pox).

8 doses of VZV vaccine have been administered. 5 member of staff was given the first dose and 3 has been given a second dose. This represents 0.1% of those assessed as new entrants.

Immunisations

CPS 326 total cases (NE's, Updates including sharps)

<i>Type of Vaccine</i>	<i>Total number of doses given</i>	<i>New / Repeat courses</i>	<i>% New staff / updates needing new / repeat course</i>
Hepatitis B	72	18	5.5%
MMR	18	12	3.6%
Varicella Zoster (Chicken pox)	8	5	1.5%
BCG	1	N/a	0.3%

Seasonal Flu vaccination uptake

Number of Doses Administered 2010 - 2011 (as extended beyond December)	Number of Doses Administered 2009
= 311	= 290
Outcome: A further 7.2 % increase in the number of staff receiving the seasonal flu vaccine this year	

The above table indicates flu vaccination uptake amongst staff in the 2010 season. This years seasonal flu campaign, was again affected by the prevalence of cases of H1N1 occurring in the wider population. Seasonal flu vaccine was offered in a manner that promoted convenience and accessibility and least disruption to frontline services.

This included numerous site visits and out of hours services both early morning and in the evenings. In addition the campaign continued well into the New Year with both repeat site visits and a continuation of the open access arrangements at the SPH site.

There was a 7.2% in the numbers of those vaccinated compared against last years figures and NHS Camden was fourth best PCT in London with an uptake of 44.6% (this is inclusive of GP practice data)

Data was regularly fed back via regular reports, flu groups and committees and to authorised officers. The OH service manager attended committees and working groups as requested by the organisation.

6. Communication and Induction Training Session

All New Entrants have been given written information to ensure that they are able to recognise and take action if they identify any area of risk to their health at work including what to do in the event of an accidental exposure to blood or body fluids / sharps injury.

Induction training is attended by OHS on a monthly basis. Sharps reporting and other important IC based information is included to reinforce the information given as part of the new entrant screening exercise.

7. Infection Control Related Audit Projects

A new Directive has been published by the EU. Its main aim is to prevent injuries and infections to healthcare worker from sharp objects such as needles, lancets and intravenous catheters. The new Directive must be translated into national Law by May 2013.

Key features:

- The Directive harmonises practice across Europe;
 1. It pulls together all the current UK legislation aimed at protecting staffs health at work as enshrined by the Health and Safety at work Act 1974 and its subsequent legislations.
 2. European Directives 89/391 and 2000/54 implemented in GB by the Management of Health and Safety at Work Legislation 1999 and the Control of Substances Hazardous to Health 2002
 3. Directive 89/655/EEC (Minimum safety and health requirements for the use of work equipment by workers at work) (implemented in GB by the Provision and Use of Workplace Equipment Regulations 1998)
 4. Directive 2000/54 from World Health Organisation that set out measures to eliminate Sharps injuries
- The new Directive requires that employers establish and integrated approach to risk assessment, risk prevention, awareness training and implementing response and follow-up procedures. {working with staff side reps}
 - Where a risk has been identified employers must eliminate them by:
 1. Specifying safety procedures for using and disposing of medical sharps
 2. Providing medical devices incorporating safety-engineered Protection mechanisms
 3. Banning the recapping of needles
 - Workers must be provided with:
 1. information on the different risks,
 2. existing legislation,
 3. good practice in preventing/recording incidents and support programmes
 - Receive training in policies and procedure to reduce their risk, including the correct use of sharp safe medical devices.
 - Where and how to report all incidents involving sharps

- Have policies and procedure in place when a sharps injury occurs, in accordance with national and regional legislation
- Care for injured workers by providing necessary immunisation and tests, post- exposure prophylaxis, counselling, rehabilitation, compensation and confidentiality.

Current practice in CPS:

Staff new to CPS are seen by occupational Health, immunisation status assessed and updated where required.

Verbal and Written Information is provided regarding the prevention of body fluid exposure and how to report these.

Policies are in place on the managing of these incidents and documented in section D of the infection control manual.

7 of 12 (58%) body fluid exposure in the past year was caused by used sharps medical devices and could have been prevented with the use of sharp safe equipment such as lancet and Diabetic needles. These are already available in the NHS catalogue. Further work is being undertaken by the Infection Control and OH teams to encourage the introduction of safer devices across CPS

8. Outbreak Management

The OH service has not had to participate in any serious outbreak management programmes in this financial year. Advice has been offered to staff as required where they have had queries about communicable disease and their fitness to work and staff immunity status has been checked and updated as required for minor events, such as, Shingles,

9. Access to the Occupational Health Service

On commencement of employment, all staff are informed of how they can access the OH service as self referrals and how they may be referred to the service. Sharps posters, sharps cards and OH booklet "Your health at work" are provided to all new entrants and units (as requested) All will be revised and updated with our new cooperate details in 2011.

All new entrants are given information according to hazard exposure and in line with new health and well being initiatives are encouraged to look after their health including making the most of all opportunities to remain up to date with the immunisations and immunity screens.

In addition to the contribution to infection control policy and protocols OH service maintains its own website where staff may find further information.

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INFECTION PREVENTION AND CONTROL ASSURANCE FRAMEWORK 2010 - 2011 (working document, final V7)								
Evidence and Action Plan to Demonstrate and Ensure Compliance with the Health and Social Care Act 2008								
Cross referenced with Standards for Better Health and NHS LA requirements.								
No	Criteria Standard Required	CQC Essential standards of quality and safety 2010 NHS LA requirements (2.4.9)	Assurance/Evidence required from Camden provider services	Current status of PCT	COMPLIANCE	Key Actions to be undertaken	Lead person (Including Role)	Time Scale
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them. Criterion 1								
1a	A board-level agreement outlining the board's collective responsibility for minimising the risk of infection and the general means by which it prevents and controls such risks	C04a; C07a&c refer to outcome 6 reg 24	Board Level Agreement in place outlining the Boards responsibility for reducing the risks of Infection.	Camden provider services has a Board Level Agreement in place outlining their responsibility for minimising risks infection control Infection Prevention and Control Strategy ratified by the board		Actioned	DIPC	01/04/2010
1b	The designation of an individual as Director of Infection Prevention and Control (DIPC) to be accountable directly to the Chief Executive and the Board	C04a; C07a&c NHSLA 2.4.9.	Name of Director for Infection and Prevention	Wolfie Smith chairs Infection Prevention and Control Sub Committee, included in job description		Actioned	DIPC	01/04/2010
			Reports directly to the Boards Chief Executive	Quarterly Reports to the Board on Infection Control progress are made by . (reporting mechanism established).		Actioned	Executive lead	01/04/2010
			Has the authority to challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions	Previous clinical practice, able to draw on microbiologist, infection control lead, Head pharmacist for advice. Clinical standards sub committee and IPCsC.		Actioned	link to pharmacy through clinical standards committee. antibiotic policy via UCLH and microbiological consultant advice via SLA	DIPC

		Responsible for Organisations ICT Monitors compliance with IPC agenda Training policy plans and outcomes to be audited and incorporated in the report.	Annual Report to be Training outcomes to be audited and measured in the report. meetings between ICL and DIPC to be established.	Actioned ICAR presented at Camden board by Jenny Gough	Rebecca Stretch ICL	01/09/2010	
		Oversees local infection control and related policies and their implementation	Director will review policies at Infection Prevention and Control Sub Committee refer to ToR . Programme of Audit will demonstrate all policies and procedures have been implemented.	ACTIONED, policies to be reviewed	. DIPC Rebecca Stretch ICL	01/02/2010	
1c	The mechanisms by which the Board intends to ensure that sufficient resources are available to secure the effective prevention and control of HCAI. These should include implementing and appropriate assurances framework, infection control programme and infection control infrastructure and information systems	C04a; C07a&c NHSLA 2.4.9.	Their should be a mix of both nursing and consultant experience. and links into all services	Infection Prevention and Control Sub Committee minutes demonstrate framework and structure to prevent and control infection. This includes nursing staff , lead practitioners and consultant on the committee.	Actioned	. DIPC Rebecca Stretch ICL	01/02/2010
			The ICT must be responsible for infection matters with specialist expertise.	Infection Control Annual Report includes programme of work aims and objectives).	Actioned	Rebecca Stretch ICL	01/05/2010
			Must be 24 hr access to nominated Infection Control Doctor.	Camden provider services have access to Out of Hours NE London Health Protection Agency. UCLH on-call microbiologist.	Actioned Contact details for the microbiologist/ HPU added to on-call pack. Formal SLA / contract with microbiologist at UCLH to provide 24 hour advice.	Rebecca Stretch ICL	01/04/2010 ongoing
			All new staff have access to Infection Control in their training programme.	Infection control including hand washing is available for all staff at induction	Actioned	Jane Canavan Head of L&D Rebecca Stretch ICL	01/04/2010 ongoing
			Infection Control Programme The infection Control programme must-: Set objectives identify priorities for action provide evidence that policies have been implemented report progress against objective of the programme in the DIPC report.	Objectives are set for the year, agreed by the IPCsC priority is based on risk, Actioned accordingly . agreed by provider services committee. Tabled IC progress reports to the ICP sub C / ICC NHS Camden and quarterly DIPC reports to the Provider Committee (Board)	ACTIONED agreed by provider services committee. Tabled IC progress reports to the ICP sub C / ICC NHS Camden and quarterly DIPC reports to the Provider Committee (Board)	Rebecca Stretch ICL Fiona Sutherland Quality Improvement Manager	01/05/10
	C04a; C07a&c Criterion 1		Clinical Champions (Infection Control Link Practitioners) to be identified in geographical areas Infection Control Link Practitioners roles and responsibilities identified.	Met. in services an ICL has been established	Modern Matrons Service Managers	01/02/10	

		Criterion 1		Identification of further Clinical Champions to undertake Essential Steps / observational hand hygiene audits / saving lives	South Wing have a group, establish meetings across provider services , TOR agendas and lines of communication to IPCsC. Service managers feedback so the IPCsubC	Modern Matrons Service Managers	01/09/2010
			Reports of progress and objectives are discussed with the DIPC and formalised in the Annual Report.	Recommendations are developed and discussed at Minted meeting between ICL and DIPC, IPCsC and PS Camden.	Actioned	. DIPC	01/04/2010
		Criterion 1	Information is available on Trend Analysis and compliance.	Monthly reports performance summary available for MRSA and C Difficile. RCA undertaken in south wing links in with UCLH and Camden PCT implemented across the community Reported to ICT for Analysis. Risk Assessments Report to the IPCsC.	Actioned Trend analysis initiated. reporting mechanism with UCLH pre 48 hour C. Diff MRSA Bacteraemia. No target set for provider services	Rebecca Stretch ICL	01/04/2010
1d	Ensuring that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient information on, and training and supervision in, the measure required to prevent and control risks of infection	Criterion 1	Infection Control Annual report discusses training of all staff.	Infection Control Annual Report 08-09 (includes training report and progress report for year end)	Actioned	. DIPC Rebecca Stretch ICL	01/02/10
			Report from the DIPC identifies training and monitors progress.	Training plan in place and up to date.50% of PSC staff have obtained Mandatory. IC is included at all induction.72% of PSC staff attended hand hygiene. Training Needs Analysis . Agreed IC training needs and incorporated into the Training Matrix.	Partially met some difficulty with numbers trained. ICsubC training report to be tabled quarterly by L&D	Rebecca Stretch ICL Jane Canavan Head of L&D	Ongoing
			Quarterly up dates to the Board.	Training plan in place audited and incorporated in to the Board Report. training matrix presented at workforce committee,	ACTIONED some difficulty with ESR accurate denominator ICsubC training report to be tabled quarterly by L&D	Jane Canavan Head of L&D	Ongoing
			Infection control training for all staff including contractors	Infection Control requirements included in all job descriptions for all contractors.	ACTIONED	Associate Director of HR	01/06/2010
			CPS training plan included IC mandatory training	Infection Control training to be given as per CPS training plan	ACTIONED	Jane Canavan Head of L&D	01/06/2010
			Records of infection control updates	recorded by individual department and Training and development.	Partially met L & D will review individual personal development plans as part of annual audit. Infection Control to be embedded within individual objectives in the PDP.	Service Managers Jane Canavan Head of L&D	01/02/2011

1e. A programme of audit to ensure that key policies are being implemented appropriately	C04a Criterion 1	A Programme of Audit is available to ensure that all policies and Procedures are implemented	Programme of Audits on going for 2010 refer to section 1 Audit programme ratified by PSC	Actioned	Service managers Fiona Sutherland Rebecca Stretch	01/04/2010 ongoing
		Audit results to be fed back to clinicians and Directorates. Action Plans and recommendations to be implemented	A Programme of Audits is in place. This incorporates monitoring compliance against key Infection Control policies and guidelines.	Environmental audits of all sites. Essential steps underway	Service managers Rebecca Stretch Fiona Sutherland	01/03/2011
			New Infection Control All Action Plans following audits will be fed back to IPCsC and Compliance and Standards sub Committee to review results of compliance Audits. These will be Incorporated into Continuing Improvement Plans. Criterion 1	Ensure engagement of PSC services in audits.	Service managers Fiona Sutherland Rebecca Stretch	01/07/2010
1f A policy addressing, where relevant, the admission, transfer, discharge and movement of patients between departments and within and between healthcare facilities	C04a NHSLA standard 4 2.4.5. & 2.5.10 refer to outcome 6 reg 24	Transfer policy to be in place.	Transfer Policy in place addressing admission transfer discharge and movement of patients between departments within healthcare facilities. Annex to the trust transfer policy	Inter transfer form in use / bed manager. To be rolled to across all sectors the PS.	Jason Lane Wolfie Smith	01/06/2010
			transfer form monitored as per audit plans at Directorate level for compliance to Fitness to Purpose.	Undertaken in intermediate care. To be repeated on a 3 monthly basis		01/09/2010
1g Designation of a decontamination lead	C04a; C4c Criterion 1	Named Decontamination Lead.	Name of Decontamination Lead	ACTIONED Decontamination lead to be identified Board Member.	DIPC Named lead required in CPS	01/04/2010
		Ensure that the programme is implemented in relation to the organisation and takes account of relevant National Guidelines	Policies in place B2: CLEANING AND DISINFECTING B3: CLEANING AND DISINFECTING (HOME LOAN EQUIPMENT) B4: DECONTAMINATION OF EQUIPMENT	Ensure Decontamination Programme is implemented takes account of current legislation. (National Decontamination Programme) Guidance followed e.g. HTM 2010 / HTM 2030 / HTM 01 01.	. DIPC Keith Davis Rebecca Stretch	01/0/2010
		decontamination of the environment is in line with policies and guidelines. Fabric, fixtures and fittings	Policies in place B2: CLEANING AND DISINFECTING B3: CLEANING AND DISINFECTING (HOME LOAN EQUIPMENT) B4: DECONTAMINATION OF EQUIPMENT	policy review Decontamination baseline risk assessment All staff to identify risk Action plans to be completed and recommendations for clinical practice. Decontamination action plan to be developed and monitored.	DIPC Keith Davis Rebecca Stretch	01/04/2010

		decontamination of reusable medical equipment is in line with policies and guidelines.	Policies in place B2: CLEANING AND DISINFECTING B3: CLEANING AND DISINFECTING (HOME LOAN EQUIPMENT) B4: DECONTAMINATION OF EQUIPMENT	policy review Decontamination assessment and action plan to be developed, monitored by the IPCsC. Progress to meet current legislation / best practice requirements is understood and has been shared with staff	DIPC	01/06/2010
		Staff are trained and assessed as competent in yes decontamination process.	Staff have received training in the principles of basic decontamination. (Training Plan) Personal Development Plan.	Training Records in place. Monitoring of	DIPC	01/06/2010
		Monitoring system in place to ensure that decontamination equipment is fit for purpose and meets the required standards.	Introduced at South Wing. For washer disinfectors. Clarity required on equipment across the trust. Wheelchair service have a contract with an external company to undertake cleaning and disinfection of some equipment. locally reprocessed equipment is undertaken in an area and with equipment (washing machine) which does not meet national standards. similar issues at the South Wing equipment store.	Monitoring device, installation commissioning / quarterly and annual planned preventative maintenance and testing schedule (i.e. washer disinfectors).	DIPC Service Managers Keith Davis	
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. Criterion 2					
2a	It has policies for the environment that make provision for liaison between the members of the ICT and the persons with overall responsibility for facilities management	C04a; C21 Criterion 2 refer to outcome 10 reg15	Environmental Audits are included in the audit programme. Tool is based on the national/local recognised audit tools. (Infection Control Nurse Association)	The environmental and cleanliness audits are complete by E&F domestic supervisors.	ACTIONED	Rebecca Stretch E & F manager 01/09/2010
		Estates Plan incorporate guidance from HTM Health Building Note across PCT Sites.	Draft Legionella policy. SLA with E&F	Evidence Requested All estates capital and minor works incorporate the requirements to comply with the relevant HTM or HBN.	Keith Davis E & F manager 01/04/2010	
		Performance Report to inform the Board of Cleanliness issues within the Trust.	monthly audit reports forwarded to ICL rarely accurate or complete. Annual PEAT inspections have an element of IC.	Evidence Requested Quarterly performance reports submitted to IPCsC and an annual performance report submitted to the Trust Board.	Keith Davis E & F manager 01/04/2010	
		Cleaning schedules and standards to include additional cleaning support and routinely required. Should include cleaning frequencies based on NHS (NPSA standard) Cleaning schedules. All staff have access to cleaning and	Lead operational person for cleaning identified E & F manager		Keith Davis E & F manager 01/04/2010	

	All staff have access to cleaning and decontamination policies	Cleaning schedules publicly available and monitored by facilities. information available at ward level at St. Pancras,		requested that the schedules are laminated cleaning schedules are not publicly available in the health centres. No monthly audits by E&F.	E & F manager Keith Davis	01/04/11 ongoing	
		Outcome of cleanliness audits are reviewed by ICT		Where possible. I.e.. If forwarded. Request for papers to be tabled at the IPCsubC C by the E&F representative	E & F manager Rebecca stretch	01/04/2010	
		Cleaning schedules are available at each site detailing cleaning frequencies and responsibilities. verbal confirmation		Evidence Requested information available at ward level at St. Pancras,	E & F manager Keith Davis	01/04/2010	
	Guidance / document action includes and is not restricted to		A13: FOOD HYGIENE POLICY,A12: BUILDING AND RENOVATION HEALTHCARE PROJECTS, A13: FOOD HYGIENE POLICY	Actioned	Audrey Catering Manager		
		Air handling System Policy	No policy	Policy required	E & F manager Keith Davis	01/04/2010	
		Potable - Non potable Water supplies Policy	No policy	Policy required	E & F manager Keith Davis	01/04/2010	
		Policies for the purchase and maintenance of all clinical equipment	MEDICAL DEVICES POLICY to be updated		A procurement group. IC involvement in purchase of equipment used in clinical areas	Jason Lane	01/04/2010
		Waste Management Policy.	Policy		Actioned requires updating to HTM 01 07 review date may 2010	E & F manager Keith Davis	01/05/2010
		Legionella Policy	Draft 9-2-10 (tabled at ICC)		Awaiting approved policy assurance/ schedules of work agreed	E & F manager Keith Davis	01/04/2010
		Terminal Cleaning Policy.	policy available		requires updating	E & F manager Keith Davis	01/05/2010
	Training records staff (and training slides IC& Waste).	verbal confirmation		Evidence Requested Training provided by ICL for domestic and Porter staff on principles of infection control and hand hygiene	E & F manager	01/05/2010	
	Audits waste transfer site/ stations.	verbal confirmation		written Evidence Requested under review	E & F manager Keith Davis	01/04/10 ongoing	

		Planned preventative maintenance Policy and schedules.	No policy	Policy required	E & F manager Keith Davis	outstanding
		Pest Control	No policy specification / schedule available, Evidence Requested	Policy required	E & F manager Keith Davis	outstanding
		Cleaning contract specification includes frequencies, cleaning methods statements and performance monitoring requirements.	Tender Document Domestic services 2002 has been amended to reflect guidance from the NPSA 2007,	SLA required outlining cleaning contract specification	E & F manager Keith Davis	outstanding
		Consultation with ICT on Cleaning Protocols when external and internal contracts are being met.	Previously consultation has taken place with ICT on cleaning protocols when external and internal contracts are being made. ICT authorise cleaning risks assessments and cleaning frequencies.	Evidence Requested to be specified as requirement in SLA. No assurance that the request has been included in the contract.	E & F manager Keith Davis	outstanding
			Cleaning and decontamination guidance available on Intranet B4: DECONTAMINATION OF EQUIPMENT B2: CLEANING AND DISINFECTING		Keith Davis	outstanding
		Audit performance of contracted services.	Trust hold quarterly meetings and reports via Performance /Contracts Reporting systems . Audit of performance of contracted services for buildings engineering and maintenance takes place annually.	Evidence Requested a reporting mechanism into the ICPsubC C to be developed	Keith Davis	outstanding
	Criterion 2	Protocol for Rapid response to unexpected occurrences and facilities management. Monitored by Infection Control.	Bodily Fluid Kits in place for spillage. 24 hour cleaning available, B1: SPILLAGE POLICY annual IC audit checks spillage kits. Incidents reported by staff through DATIX	no cover out - of hours	E & F manager	outstanding
2b	It designates lead managers for cleaning and *decontamination of equipment used in treatment (a single individual may be designated for both areas)	C04a; C4c Criterion 2	Designated lead for Infection Control is included in the job description.	The Decontamination Lead is . she has responsibility for ensuring decontamination programme is implemented in relation to National guidelines.	Lead person in the process of being identified . DIPC	01/04/2010
			Decontamination Lead responsible for ensuring that the programme is implemented in relation to the organisation. Takes proper account of the National Guidance.	Medical devices policy updating Procurement policy	Jason Lane	outstanding

			Procedures are followed for the acquisition and maintenance of decontamination of equipment	Procurement policy including consultation with ICT prior to purchase of medical devices, equipment. No sterilises used within PS. A11: SINGLE USE MEDICAL DEVICES		Procurement policy	Jason Lane	outstanding
			Audit compliance of decontamination standards and cleanliness. Decontamination audits take place	South Wing have schedule for maintenance of washer disinfectors		inventory of medical equipment and manufacturers recommendations, decontamination Audits required Audit results to be reported to IPCsC with recommendations and an action plan. Washer disinfectors maintained to standards HTM 0101 / HTM 2030 specification and award of contract completed with ICT involvement. Decontamination Audits required	. DIPC, Service Leads Keith Davis	outstanding
2c	Lead managers involve directors of nursing, matrons and the ICT in all aspects of cleaning services from contract negotiation and service planning to delivery at ward level	C21 Criterion 2	Consultation with Infection Control on Cleaning Protocols when internal and external contracts are being prepared and at ward level.	All cleaning audits are completed weekly, reported monthly		To be formalised. No current IC involvement when external contracts awarded. Insufficient assurance built into contract	Keith Davis service leads	01/04/2010
				verbal confirmation. Tender Document Domestic services 2002 has been amended to reflect guidance from the NPSA 2007		Evidence Requested policy implementation plan / tender doc	E & F manager	01/04/2010
2d	Matrons have personal responsibility and accountability for delivering a safe and clean care environment and that the nurse in charge of any patients area has direct responsibility for ensuring that cleanliness standards are maintained throughout that shift	C04a	All staff must adhere to the correct uniform policy and support good hygiene.	Uniform Policy in place implemented by managers. A9: UNIFORM POLICY		Actioned requires revision	Matrons service mangers all areas	01/04/09 ongoing
			Well publicised hand hygiene posters in all patient areas.	Clean <i>your</i> hands campaign hand wash posters at sites. A1: HAND HYGIENE		Actioned	Matrons Rebecca Stretch ICL	01/02/09 ongoing
			Matrons will be responsible for auditing the environment quarterly.	Thursday walk round at St. Pancras. B2: CLEANING AND DISINFECTING		To be formalised.	Matrons service mangers all areas	01/04/10 ongoing

		Access to policy on additional cleaning urgently and routinely. Rapid Response)	Arrangements in place on additional cleaning, urgently and routinely.		No policy, schedule available	Matrons service managers all areas	outstanding
			Well publicised cleaning routines in patient areas available.		Actioned St Pancras? All sites	E & F manager	outstanding
			Verbal confirmation of some aspects for the requirements		Refer to E & F policy section The physical condition is managed through detailed contract service specification, including planned maintenance, cleaning schedules, statutory compliance, waste management and best practice guidance.	Keith Davis	outstanding
2e All parts of the premises in which it provides healthcare are suitable for the purpose, kept clean and maintained in good physical repair and condition	C21	Sufficient resources have been dedicated to keep the environment fit for purpose	SLA estates and facilities		Evidence Requested Property appraisals to ensure the physical condition is maintained against specific requirements.	Keith Davis E & F manager	01/04/09 ongoing
			SLA estates and facilities		Evidence Requested Estates plan supports the HTM and HBN. Any required works are carried out in accordance with these requirements. Estates and facilities manages and maintains infection Control issues related to the associated functions in each of the trust premises.	Keith Davis E & F manager	01/04/09 ongoing
			PEAT assessments annually trust audit / Clean your hands campaign All hand wash facilities including staff toilets, have a wall mounted liquid soap Foot operated pedal bin and hand towels. Audits have been carried out to determine level of compliance.		Audits are undertaken in accordance with the appropriate standard. NOT CARTRIDGE LIQUID SOAP	Keith Davis E & F manager Rebecca stretch	01/04/09 ongoing
			There is a designated wash basin in all clinical areas and hand wash comply with HTM 64 i.e., no plugs, no overflow water from tap and not situated above the plug hole. A lidded foot operated bin is in close proximity to hand wash basins. Audit underway		Actioned trust audit completed Kingsdale and Oakwood ward require additional sinks at entrance /exit to wards	Keith Davis Rebecca stretch	01/02/2010

2f	The cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning facilities is publicly available	C04a C21	Cleaning schedules to be agreed and publicised.	verbal assurance Cleaning Standards meet those set by the National Specification for cleaning.	Actioned	E & F manager	01/04/09 ongoing
			Risk Assessments of premises in order to maintain standards of cleanliness	Premises are risk assessed appropriate action is taken and recommendations made.	Evidence Requested	Keith Davis E & F manager	01/04/09 ongoing
			Environmental audit undertaken Annually. PEAT assessment of inpatient facilities Cooper safety audit	peat results available	Keith Davis E & F manager	04/03/2010	
2g	There is adequate provision of suitable hand washing facilities and antibacterial hand rubs	C04a C21	All hand wash facilities including staff toilets contain the following requirements:	Hand washing audits needs compliance with Universal Precautions.	Partially met	Site Managers E&F	01/05/2010
			Wall mounted soap. Single use dispensers cartridge or pump dispensers.	Adequate hand washing facilities at all points of care	Single use dispensers cartridge Further Hand wash audits to be completed by clinical staff part of Essential Steps Audit.		outstanding
			Foot operated pedal bin	Hand wash basin in areas.	In place		01/04/09 ongoing
			Designated hand wash basin in all clinical areas	Compliant to regulation.	Actioned		01/04/09 ongoing
			To comply with HTM64, no plugs, no overflow water	Taps meet compliance.	Actioned problems with temperature and flow at St. Pancras SW		01/04/09 ongoing
			Taps not directly situated above plug hole	Meets compliance.	Actioned		01/04/09 ongoing
			Lidded foot operated bins are in close proximity to hand wash basins	Meets compliance.	Actioned, new bins required in areas (IC/ fire regs)		01/04/09 ongoing
2h	There are effective arrangements for the appropriate decontamination of instruments and other equipment - these should be incorporated within appropriate disinfection and decontamination policies	C04c	Reusable medical devices and other devices should be decontaminated in accordance with manufacturers guidelines.	All provider services use single use	Audit to be undertaken		01/07/2010
			Systems in place to allow re-usable medical devices to be tracked through decontamination process in order to ensure correct procedures have taken place.	Policy in place.	process required for decontamination of medical devices in services, e.g. mattresses, wheel chairs, syringe drivers		outstanding
			Policy for handling of instruments designated for single use.				01/02/2011
			Staff have access to up to date cleaning and decontamination guidelines and are compliant with decontamination guidance	policies in place	Staff have accesses to generic cleaning / decontamination guidance. Medical devices		01/02/2011

		Up to date cleaning and decontamination guidance		policy requires revision		01/02/2011
		Staff are Trained and competent in decontamination	IC training includes overview of decontamination processes. Training records	policy requires revision. Training record required to be in place by managers Monitoring system in place to assess that Decontamination processes are Fit for Purpose. An action plan updated and monitored by facilities department and reported to decontamination sub-group.		01/04/2010
		Monitoring system in place	Monitored and reported and is fully compliant to meet quality Standards.	Results of audit will identify that environment meets compliance		01/06/2010
2i	The supply and provision of linen and laundry supplies reflect Health Service Guidance (HSG) (%) 18, Hospital Laundry for uses and infected linen	CO4c	Policy for the supply of linen and laundry	ICT consulted at all stages of contract	Actioned	Rebecca Stretch ICL 01/04/09 ongoing
				Laundry policy with input from ICT B7: LINEN POLICY	Actioned	01/04/09 ongoing
2j	Uniform and work wear policies ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose	C4a	Uniform and work wear. Policy ensures clothing worn by staff carrying out their duties is clean and fit for their purpose. Uniform and dress policy to support good hygiene.	A9: UNIFORM POLICY	Actioned	01/04/09 ongoing
			Local policy to be in place for supply and laundering of staff uniforms clothing which reflects the assessments of risks associated with HCAI.	A9: UNIFORM POLICY	Actioned	01/04/09 ongoing
Provide suitable accurate information on infections to service users and their visitors. Criterion 3						
3a	General principle pertaining to the prevention and control of HCAI and key aspects of the provider's policy on infection prevention and control	C16 Criterion 3	Information is provided to patients and public about the organisations general system to prevent and control Health care Associated Infections. Policies, guidance Camden PS intranet .		Pending and information leaflets are available	Rebecca Stretch ICL 01/04/2010
					Policies in place, Sections of the infection control manual are revised in line with Department of Health recommendations, NICE and EPIC 2 guidance.	Rebecca Stretch ICL 01/02/2011

		Information is available to patients and the public relating to preventative measures to be taken in relation to Infection Control.		Pending ICT has produced infection control leaflets available on the Camden PS website for patients and visitors.	Rebecca Stretch ICL	01/06/2010
		Information system in place for surveillance and root cause analysis monthly.	Reviews take place and discussions with saving lives via Camden IPCsC.	Root Cause analysis summary in place for SHA Discussed at Clinical Leads and ICT. Action plans in place and recommendations given by ICT Risk assessments are completed and demonstrated in tables for discussion at meetings	Rebecca Stretch ICL	01/04/09 ongoing
			Information is available for visitors in the event of an outbreak MRSA and C difficile policy.	Review take place monthly	Rebecca Stretch ICL	
3b	The role and responsibilities of individuals in the prevention and control of HCAI, to support them when visiting patients	C16	Information is available in the event of an Outbreak in the management of Diarrhoea and Vomiting	A4: OUTBREAK MANAGEMENT, Outbreak meeting minuted outbreak reports reviewed by IPCsC and PS Committee. St Pancras outbreak resource pack for each ward.	Rebecca Stretch ICL	01/02/2011
			Information leaflets on Infection Control are available on the NHS Camden web page. Information to patients and visitors relating to their role in preventing the spread of HCAI.	Information leaflets on provider services Camden infection control intranet pages.	Rebecca Stretch ICL	01/04/2010
3c	Supporting vigilance in patients	Criterion 3	Information leaflets on Infection Control to be available to all staff.	Intranet information for staff, including leaflets for patients and visitors. Information on	Rebecca Stretch ICL	01/04/2010
			Joint pre-admission screening and post-operative wound information.	Screening in place all admissions MRSA included in the welcome pack Actioned: update of policy and audit programme introduced	Rebecca Stretch ICL savings lives group	01/04/2010
3d	The importance of compliance by visitors with hand hygiene and visiting restrictions	C04a; C16	Hand Hygiene by clinical matrons.	Hand hygiene Audits.	Actioned	01/05/2010
3e	Reporting breaches of hygiene and cleanliness	C04a; C1a	Reporting system in order to report cleanliness incidents via Audit Plan and Trend Analysis.	Reporting system for cleanliness incidents. Thursday walk round	Actioned	01/04/2010
3f	Explanation of incident / outbreak management	C04a; D13c; C16	Major incident Plan to be implemented.	Pandemic influenza plan (and Major Incident Plan) to be implemented.	limited involvement of ICT in PS. Lead within NHS Camden	business continuity lead
			Records of staff updates for all staff.	Staff Training in Major Incident Plan (See Training Plan)	emergency planning	business continuity lead

3g	Feedback that is focused on the patient pathway	C16		Contacts in Camden Link established.		Information should be developed with local service user representative organisations (LINKs) and Patient Advice and Liaison Services (PALS).	service managers ICL	
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion. Criterion 4							
	Provision across organisational boundaries, such as pre-admission screening and post-operative care	C04a Criterion 4 refer to outcome 6 reg 24	accurate information is communicated in an appropriate manner; information facilitates the provision of optimum care, minimising the risk of inappropriate management and further transmission of infection; and where possible, information accompanies the service user. Provision of relevant information across organisational boundaries is covered by the regulation requirement 'Co-operating with other providers'. Due attention should be paid to service user confidentiality as outlined in national guidance.	HCAI Information is provided across organisational boundaries e.g. pre-admission and post-op wound surveillance. inter health IC Transfer form SW audited		standard IC transfer form		01/11/2010
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people. Criterion 5							
		Criterion 5	National guidance and local data informs the local screening policy/guidance and mechanisms for assessing compliance are identified, and implemented. Infection Control risk assessments are a standing item on the Infection Control Committee, clinical governance/risk management/patient safety committee agenda.	Acute trusts have policies in place and undertake MRSA programme.		Inpatient facility has screening policy, Partnerships to be developed.		01/05/2010
		Criterion 5	Registered providers, should ensure that advice is received from suitably informed practitioners and local health protection agency of any outbreaks or serious infection occurrences.	Standing item on ICC, membership of the IPCsC		Actioned	Rebecca Stretch ICL	01/02/2010
		Criterion 5	Progress to be reviewed against Essential Steps Programme	Progress will be reviewed when Essential Step audit returned		Progress towards Implementation of Essential Steps PSC	Rebecca Stretch ICL	01/09/2010

		Criterion 5	Individual Treatment plans reflect the outcomes of HCAI risk assessments. Infection control risk assessments to be embedded in patient care.	Treatment plans are not reflecting outcomes of HCAI risk assessments.		Embedding Infection Control risk assessment into the patient transfer policy. Pilot in intermediate care facility taking place.	Rebecca Stretch ICL	01/09/2010
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection. Criterion 6							
	NHS Camden must ensure that they gain the cooperation of all staff, contractors and others in the provision of healthcare in preventing and controlling infection	C6; C21	Infection Control and Prevention should be included in all job descriptions of employees of the organisation.	All other job descriptions to have IPC discussed and incorporated during Personal Development Plans.		To be completed	HR assistant director	01/05/2010
Infection Control and Prevention is part of all the New Contracts as corporate objectives. ICT are providing Infection control input into the development of nursing and contract.					Actioned in all new contracts	Brian Benson Keith Davis	01/02/2010	
Infection Prevention and Control Sub Committee ToR					The terms of reference for these groups highlights the cooperation of services across the provider services and partnership working over the control and prevention of HCAI			
	Provide or secure adequate isolation facilities. Criterion 7							
7	A healthcare registered provider delivering in-patient care should ensure that it is able to provide, or secure the provision of, adequate isolation precautions and facilities, as appropriate, sufficient to prevent or minimise the spread of infection.		Isolation facilities consideration of the need of specialist negative pressure rooms available.	Transfer policy in place concerning allocation of patients to facilities based on local risk assessment. Criterion 6		Ensure compliance with patient transfer policy.		01/03/2010
Community MRSA, diarrhoea and vomiting, policies available on intranet. PSC has single room facilities.						Rebecca Stretch ICL	01/06/2010	
Information on isolation is available to all groups of staff, patients and visitors						Rebecca Stretch ICL	01/06/2010	
Limited Isolation facilities .No negative pressure rooms. (referral to specialist unit UCLH) not available within Camden PS					Actioned. Isolation facilities within intermediate care are insufficient .	Rebecca Stretch ICL	01/04/2010	
Evidence of Joint Planning between ICT and bed manager for planning patient admissions and transfer and discharge information and movements between departments.					Managed by the matrons of the PSC Intermediate care facilities, who seek specialist infection control advice as appropriate		Actioned	

			Policy to be in place on isolation facilities and include risk assessment. Also include the need for specialist ventilated isolation facilities.	Information leaflets A6: ISOLATION		Actioned ventilation NA		01/06/2010
Secure adequate access to laboratory support as appropriate. Criterion 8								
8	laboratories that are used to provide a microbiology service in connection with arrangements for infection prevention and control have in place appropriate protocols and that they operate according to the standards required for accreditation by Clinical Pathology Accreditation (UK) Ltd.	C04a	Microbiology Laboratory protocols should include.	SLA with UCLH Microbiology (offers advise and support for ICT)			Rebecca Stretch ICL	01/04/2010 Ongoing
			Standard operating procedure for the examination of specimens.	a microbiology laboratory policy for investigation and surveillance of healthcare associated infections; and standard operating procedures for the examination of specimens.		Actioned	Peter Wilson Rebecca Stretch ICL	01/04/2010 Ongoing
			Microbiology facilities must be CPA accredited.	CPA accredited. UCLH Labs.		Actioned	Peter Wilson Rebecca Stretch ICL	01/04/2010 Ongoing
Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections. Criterion 9								
9 9a	Standard (universal) infection control precautions	C04a NHSLA Standard 4 clinical care 1.4.9	Policy to be evidence based and accessible	IC MANUAL on intranet		policies reviewed		01/06/2010
				Implementing essential steps programme within PSC.		hand hygiene audits in place via PSC clean your hands clinical champions. rolling programme on south wing to be introduced	Rebecca Stretch ICL	01/06/2010
			Monitor compliance Audited by ICT and peer review	Awareness of Infection Control policies and how to contact ICT on induction programme.		Essential steps audit underway	Rebecca Stretch ICL	01/04/2010 Ongoing
			Training to be included to all induction staff	All training is updated on the training programme		Training completed	Rebecca Stretch ICL	01/04/2010 Ongoing
			All staff to attend training on Infection Control.	Training on the following:- Hand hygiene, standard universal precautions and aseptic technique All staff attendance will be recorded on database and regularly reported to managers and appropriate forums and board by learning and development training will be monitored on database by Learning and Development.			Rebecca Stretch ICL	01/04/2010 Ongoing
			Training and audit plan in place.	Further development of policies. Programme of Audits for all policies and procedures. MRSA surveillance C Diff under review		NHS staff to monitor compliance and staff Training. IC will report to PSC clinical Governance Committee.	Rebecca Stretch ICL	01/04/2010 Ongoing

9b	Aseptic Technique	C04a	Criterion 8	Clinical procedures are carried to promote principles of asepsis.	Training is available for all community staff for care of Central Venous Catheters including Aseptic technique. UCLH A23: ASEPTIC TECHNIQUE POLICY	saving lives group	Rebecca Stretch ICL	September 2010
				Training of all staff carrying out procedure takes place.	Competency check list drafted		Rebecca Stretch ICL	September 2010
				the technique should be standardised across the trust	A23: ASEPTIC TECHNIQUE POLICY.			September 2010
9c.	Outbreaks of communicable infections	C04a D13c		Policy to include at risk patients and clinical specialities	Policy in to be in place for major outbreaks to include initial assessment, communication management, organisation and control. Formal arrangement for outbreaks. A6: ISOLATION, A4: OUTBREAK MANAGEMENT	Actioned	Rebecca Stretch ICL	September 2010 see plan of audit
				Isolation policy in place for major outbreaks to include initial assessment communication management. Organisation and control.	Review contact detail of those involved in outbreak management A6: ISOLATION, A4: OUTBREAK MANAGEMENT	Actioned and tested	Rebecca Stretch ICL	01/09/2010
				Contact details for those involved in outbreak available.	A4: OUTBREAK MANAGEMENT	Actioned Policy to be amended	Rebecca Stretch ICL	01/04/2010
9d.	Isolation of service users with an infection	C04a D13c		Policy evidence based. Indications for isolation should be included in policy.	Isolation policy evidence is based and reflects local risk assessment of in-patients. A6: ISOLATION	Actioned	Rebecca Stretch ICL	September 2010
				Information on isolation accessible to the staff patients and visitors.	posters etc available with visitor information tool kit to be further developed	Actioned	Rebecca Stretch ICL Judith Greening Modern Matron	September 2010
9e	Safe handling and disposal of sharps	C04aC4bC4c		All staff to adhere to the policy.Audit compliance as per audit against the following:.	B10: SAFE USE AND DISPOSAL OF SHARPS Audit compliance.Included at all induction programmes for staff. Audit data available against HII no8 including isolation procedure. Tailored training provided to staff involved in care of isolated	Compliance within essential steps audit	Rebecca Stretch ICL .	01/09/2010
				Risk management and training and prevention of needle stick injuries	all needle stick injuries reported to the H & S committee.	Actioned	Jason Lane	Ongoing
9f.	Prevention of occupational exposure to blood-borne viruses, including prevention of sharps injuries	Co4a C4b		All staff to adhere to the policy. Audit compliance as per audit against the following:	D4: HEPATITIS B POLICY: PROTECTION OF STAFF AND PATIENTS Occupational Health Dept. reviewing needless devices	Actioned	Pam Duke Occ Health Lead Rebecca Stretch ICL	Ongoing
9g.	Management of occupational exposure to blood-borne viruses and post-exposure prophylaxis	CO4a		OH staff available to whom Healthcare workers can be referred.	Contract agreement in place within Camden OH.	Actioned	Pam Duke	Ongoing
				Provision of clear information to healthcare staff about potential exposure.	Body substance precautions policy. Sharps injury and bodily fluid exposure policy.	Actioned	Pam Duke	Ongoing

			Arrangements to be in place for post-exposure prophylaxis for blood borne viruses.	Contract agreement in place within Camden.D2: SHARPS INJURY POLICY AND POST EXPOSURE PROPHYLAXIS	Actioned	Pam Duke	Ongoing
9h	Closure of rooms, wards, departments and premises to new admissions	CO4a D13c	NHS Camden should have a system in place for the provision of advice by the DIPC to the Chief Executive.	Report from DIPC to Chief Operating Officer	Actioned	.	01/02/2010
			Policy to address the following: Management arrangements for redirecting admissions.	A6: ISOLATION, A4: OUTBREAK MANAGEMENT	Outbreak policy used for information on closure of unit	Rebecca Stretch ICL Judith Greening Modern Matron	01/02/2010
			Clear criteria for closure	A6: ISOLATION, A4: OUTBREAK MANAGEMENT	Outbreak policy used for information on closure of unit	Rebecca Stretch ICL Judith Greening Modern Matron	01/02/2010
			Policy to include the need for environmental decontamination prior to opening.	Criteria in policy.	Actioned	Rebecca Stretch ICL Judith Greening Modern Matron	01/02/2010
9i*	Environmental Disinfection Policy *	CO4c C21 Criterion 9	Local Policy on Disinfection which focuses on infection risk	Decontamination of clinical / non-clinical environment	Policy to be developed	E&F Decontamination Lead	01/09/2010
9j*	Decontamination of reusable medical devices*Decontamination involves a combination of processes and includes cleaning, disinfection and sterilisation, according to the intended use of the device. This aims to render a reusable item safe for further use on service users and for handling by staff.	CO4bCO4c	Re-usable medical devices are decontaminated in accordance with the manufacturers instruction and current guidelines.	Sterilisation policy guidance for re-usable medical devices.	Policy in place under review with HTM 0101.	Decontamination Lead	September 2010
			A system to protect service users and staff that minimises the risk of transmission of infection from medical devices. This requires that the device or instrument set can be clearly linked in a traceable fashion to the individual process cycle that was used to decontaminate, such that the success of that cycle in rendering the device safe for reuse can be identified.	medium risk as no equipment within CPS requiring sterilisation	general policy on decontamination and local policies on decontamination of equipment for patient loan	Decontamination Lead	September 2010
			decontaminated in accordance with manufacturers' instructions and current national or local best practice guidance. This must ensure that the device complies with the 'Essential Requirements' provided in the Medical Devices Regulations 2002.	medium risk as no equipment within CPS requiring sterilisation	general policy on decontamination and local policies on decontamination of equipment for patient loan	Decontamination Lead	September 2010

			Reusable medical devices employed in invasive procedures, are required to be individually identifiable, or identified to a set of which they are a consistent member, throughout the use and decontamination cycle in order to ensure subsequent trace ability.	Compliant, services using single use instruments	Compliant.	Decontamination Lead	September 2010
9k*	Single-use medical devices*	Criterion 9	Decon lead/ Policies should be in place for handling devices designed for single use only. Single-use medical devices should be used once and disposed of safely.			Decontamination Lead	31/03/ 2011
9l	Antimicrobial Prescribing	C04a	Local prescribing should, where appropriate, be harmonised with that in the British National Formulary. Guidelines to be in place to show information on the regimen and duration of drug.	Antimicrobial policy in place.	UCLH antibiotic prescribing policy. Quick guide available, however full UCLH policy cannot be accessed from SW site.	Jonathan Freedman	01/04/10
			Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update. In healthcare this is usually monitored by the antimicrobial management team.	prescribing. UCLH antibiotic prescribing policy adopted by CPS.	Surveillance of Antibiotic prescribing. Audit prudent antibiotic	ICL	01/04/2011
9m	Reporting HCAI to the Health Protection Agency (HPA) as directed by the Department of Health		mandatory surveillance requirement for NHS trust chief executives to report all cases of MRSA bacteraemia and all cases of Clostridium difficile infection in patients aged two years or older (as directed by the Department of Health).	Policy A5: NOTIFICATION OF COMMUNICABLE DISEASES	St Pancras , voluntary reporting of Norovirus outbreaks related policy review change to notification of comm. Dis. 2010	N/A	01/09/2010
9n	Control of outbreaks and infections associated with specific alert organisms	C04a D13c	PCT should ensure that they take into account local epidemiology and risk assessments.	Surveillance reports. Surveillance is taking place in order to monitor infection rates,/ alert organism	Policies reviewed , and monitoring	Rebecca stretch ICL. Dr Peter Wilson Local HPU	01/09/2010
			MRSA The policy should make provision for: screening of NHS patients on emergency or relevant elective admission to a unit that provides surgical, diagnostic or other medical care; decontamination procedures for colonised patients when appropriate; isolation of infected or colonised patients; transfer of infected or colonised patients within organisations or to other care facilities;	C1: MRSA D5: MANAGEMENT OF STAFF WITH MRSA	Policies reviewed, and monitoring	Rebecca stretch ICL. Dr Peter Wilson	

		Clostridium difficile The policy should make provision for: surveillance of Clostridium difficile infection; diagnostic criteria; isolation of infected service users and cohort nursing; environmental decontamination; antibiotic prescribing policies; and contraindication of anti-motility agents.	C10: ANTIBIOTIC ASSOCIATED DIARRHOEA (CLOSTRIDIUM DIFFICILE)		Policies reviewed, and monitoring	Rebecca stretch ICL. Dr Peter Wilson	
		Glycopeptides resistant enterococci (GRE) The policy should make provision for: identification of high-risk groups; isolation and prevention of cross-infection; and prophylaxis for surgical and invasive procedures.	unlikely alert organism for CPS infection control measures required can be implemented		No Policy to be developed	Rebecca stretch ICL. Dr Peter Wilson	outstanding
		Acinetobacter and other antibiotic-resistant bacteria The policy should make provision for: surveillance of identified patients at risk and of high-risk environments; and procedures for managing infected patients to prevent spread of infection.	unlikely alert organism for CPS infection control measures required can be implemented		No Policy to be developed	Rebecca stretch ICL. Dr Peter Wilson	outstanding
		Viral haemorrhagic fevers (VHF)The policy should make provision for:appropriate staff to be aware of the special measures to be taken for nursing VHF patients confirmed cases to be handled under full isolation measures in a high-security infectious diseases unit or equivalent;handling of patient specimens at the appropriate containment level;follow-up of all staff in contact with the patient at every stage of care; andspecial measures for the handling of all waste.	C6: VIRAL HAEMORRHAGIC FEVERS			Rebecca stretch ICL. Dr Peter Wilson	
9o	CJD / vCJD - handling of instruments and devices	refer to Outcome 11, Regulation 16 Safety Advice on the handling of instruments and devices in procedures on patients with known or suspected CJD/vCJD, or at increased risk of CJD/vCJD, including disposal/quarantine procedures, is provided in guidance from the Advisory Committee on Dangerous Pathogens (ACDP) TSE Working Group.	only single use instruments used			Rebecca stretch ICL	31/03/2011

9p	Safe handling and disposal of waste	Outcome 10, Regulation 15 Safety and suitability of premises	The risks from waste disposal should be properly controlled. In practice, in relation to waste, this involves: assessing risk; developing appropriate policies; putting arrangements in place to manage risks; monitoring the way in which arrangements work; and being aware of legislative change. Precautions in connection with handling waste should include; transport on-site and off-site; clear procedures for dealing with accidents, incidents and spillages; and appropriate treatment and disposal of such waste. Systems should be in place to ensure that the risks to service users from exposure to infections caused by waste	B9: WASTE DISPOSAL Audit of waste generated across sites and management of waste reviewed. Waste management Committee, which reports to the IPCsubC,		CPS in house clinical practice policy, however does not meet all the requirements of a waste policy remains the responsibility of E & F Policy review. Contract review. Updates in training. Audit plan	Keith Davis E & F manager	01/03/2011
9q	Packaging and handling and delivery of laboratory specimens		Biological samples, cultures and other materials should be transported in a manner that ensures that they do not leak in transit and are compliant with current legislation.				Rebecca stretch ICL. Dr Peter Wilson	
9r	Care of deceased person		procedures should include: risk assessment of potential hazards; the provision of appropriate facilities and accommodation; safe working practices; arrangements for visitors; information, instruction, training and supervision; and health surveillance and immunisation (where appropriate).	A20: LAST OFFICES		Policy require review		
9s	Use and Care of invasive devices	Refer also to Outcome 11, Regulation 16 Safety, availability and suitability of equipment	Policy should be based on evidence-based guidelines and should be easily accessible by all relevant care workers. Compliance with policy should be audited. Information on policy should be included in infection prevention and control training programmes for all relevant staff groups.	catheter care policy.		Continence advisor	clinical leads Maxine Hammond	31/03/2011

9t*	Purchase, cleaning , decontamination, maintenance and disposal of equipment *		Policies for the purchase, cleaning, decontamination, maintenance and disposal of all equipment should take into account infection prevention and control advice that is given by relevant experts or advisory bodies or by the ICT.	Medical devices policy B4: DECONTAMINATION OF EQUIPMENT		Policy require review		31/03/2011
9u	Surveillance and data collection		local surveillance and use of comparative data where available in order to monitor infection rates and to assess the risks of infection. This evidence should include data on alert organisms, and other infections where appropriate, alert conditions and wound infection per clinical unit or specialty.	surveillance St. Pancras SW		Actioned		01/04/2010
			Voluntary reporting to the Health Protection Agency of clinical laboratory isolates is recommended where the appropriate information technology is in place.	Norovirus outbreak reporting		Actioned		01/02/2010
			Timely feedback to clinical units, with a record of achievements and actions taken as a result of surveillance.	Clinicians involved in follow up.		Actioned, further improvements in trend analysis.		
9v	Dissemination of information	Outcome 6, Regulation 24 Cooperating with other providers	There should be a local protocol for the dissemination of information about infections between care organisations concerning an individual service user. facilitate surveillance and optimal management of infections in the wider community. Guidance on data protection legislation also needs to be observed.	Inter transfer forms initiated on south wing , annex to transfer policy				31/03/2011
9w	Isolation facilities		There should be a policy concerning the appropriate provision of isolation facilities. This should address: potential sources of infection; the use of protective measures and equipment; and the management of outbreaks.	A6: ISOLATION		Actioned. Further review planned		01/06/2010

9x	Uniform and dress code		Uniform and work wear policies ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose. Particular consideration should be given to items of attire that may inadvertently come into contact with the person being cared for. Uniform and dress code policies should specifically support good hand hygiene.	A1: HAND HYGIENE A9: UNIFORM POLICY	Actioned. Further review planned		31/03/2011
9y	Immunisation of service users		Registered providers should ensure that policies and procedures are in place in relation to the immunisation status of service users such that: there is a record of relevant immunisations; the immunisation status and eligibility for immunisation of service users are regularly reviewed in line with Immunisation against infectious disease ('The Green Book') and other Department of Health guidance; and all service users can access relevant health services that provide immunisation.	influenza vaccine offered to SW inpatients. Child health vaccination through HV and Sch Nursing services			01/4/2010 ongoing
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care. Criterion 9						
10a.	All staff can access relevant occupational health services.	C04a	All staff at NHS Camden have access to occupational health services.	Contract with occupational health provides Pre employment screening Management of exposure to HCAI. Emergency treatment policy. Arrangements of immunisation, reviews of staff in line with the Immunisation against Infectious Diseases and other DH Guidance.	Actioned	Pam Duke	01/04/09 ongoing
10b.	Occupational health policies on the prevention and management of communicable diseases in healthcare workers, including immunisation are in place.	CO4aC11aC11bC11c	Occupational Health Policies.	Body substances precautions policy.Sharps injury and body fluid exposure policy.	Actioned	Pam Duke	01/04/09 ongoing

10c. Prevention and control of infection is included in induction programmes for new staff and in training programmes for all staff.	C04a C11a C11b C11c Criterion 9 NHSLA Clinical care 4. 1.4.9	A training programme is in place up to date with relevant updated policies and procedures.	Infection Control is included in the induction of all new staff. Hand Hygiene is mandatory for all frontline staff refer to training matrix	Actioned	Rebecca Stretch ICL Jane Canavan L&D	01/04/09 ongoing
		Compliance with training plan and attendance at training must be monitored by Camden IPCSC.	Mapping of training taking place for all staff by PS ESR system Infection control including Hand Hygiene is mandatory for all frontline staff refer to training matrix	Further development is taking place in this area to monitor staff training. Compliance of all mandatory training is reported through workforce development. Ensure monitoring of staff attending infection control training.	Learning and Development	01/09/2010
10d. There is a programme of ongoing education for existing staff (including support staff, agency/locum staff and staff employed by contractors)	D5b NHSLA Clinical care 4. 1.4.9	All staff have ongoing training in infection control.	Infection control Annual Report (includes training report). Training needs analysis updated by L&D Infection control including Hand Hygiene is mandatory for all frontline staff Inclusion in training matrix	Further provision of infection control training (as per training plan) Contractors are invited to all Infection Control Training.	Ongoing Rebecca Stretch ICL	01/04/09 ongoing
			IC manual Policies, procedures guidance available on intranet	information leaflets on NHS Camden website	Rebecca Stretch ICL	
			Attendance at training is monitored. staff engagement in training and monitoring PS Camden staff attendance/DNA	Actioned		September 2010
10e. There is a record of relevant immunisation		Records of immunisation available.	Contract with Occupational Health Providers.	Actioned	Pam Duke	01/04/10 ongoing
10f. There is a record of training and updates for all staff	C11a C11b C11c NHSLA Clinical care 4. 1.4.9	Training Plan.	Infection Control Annual Report (includes training report). Training needs analysis updated by L&D Infection control / Hand Hygiene is mandatory for all frontline staff	Learning and development provide monthly reports of attendance and DNA to inform both PS Camden and NHS Camden governance / performance frameworks.		September 2010
10g. The responsibilities of each member of staff for the prevention and control of infection is reflected in their job description and in any personal development plan or appraisal	C11a C11b C11c	All job descriptions to include infection control.	All new contracts have infection control in the corporate objectives. Embed statement in all job descriptions and PDP.	Actioned		September 2010
			All other job descriptions infection control identified in PDP and Appraisal System.	Managers to complete PDP and appraisal system.		September 2010

Appendix 2

Infection Control Programme 2011-2012

The Infection Prevention and Control annual programme for 2011-2012 will be further developed with the Infection Control Leads at CNWL and Hillingdon PCT. Core priorities will be worked on primarily to progress the merging of the individual services. Alongside this plan a local CPS programme will be developed to meet specific organisational and service needs.

Task	Detail / Process	Indicator	Lead
1. Advise on the following policies.	<p>Advise on policies developed by other services where IC is relevant</p> <p>(i) Policies to be developed in collaboration with E&F</p> <ul style="list-style-type: none"> • Building and Renovation policy • Food Hygiene Policy • Policy on Management of potable and non-potable water supplies • Cleaning Policy – arrangements, standards, frequency schedule • Waste management policy (to comply with HTM 07-01) • Terminal clean/ disinfection policy • Legionella policy • Air Handling Systems Policy • Pest control Policy • Planned preventive maintenance • Laundry Policy • Decontamination of the environment policy including disinfection and terminal clean • Decontamination of medical devices policy 	<p>Up to date policies readily accessible to staff to facilitate evidence-based practice and risk reduction.</p> <p>Monitoring of policy implementation via audit</p> <p>Compliance with national requirements & standards</p> <p>Surveillance audits showing reduced incidence of infection</p> <p>Monitoring of policy implementation via audit.</p>	<p>Head of administration and facilities E&F</p> <p>Advice IC</p>
2. Risk management	<p>a. RCA to be carried out for cases of MRSA bacteraemia, infection, E. coli bacteraemia and toxin producing <i>C. difficile</i></p> <p>b. Report outbreaks as SUIs</p> <p>c. Maintain Assurance Framework Document, (incorporating Gap analysis and action plan for health & Social care Act 2008)</p> <p>d. ICT to advise and provide input into new builds, developments, renovations etc</p> <p>e. lead / assist in the Investigation of outbreaks of infection</p>	<p>RCA findings and action plan to address issue</p> <p>Incident report</p> <p>Reports to ICC as appropriate</p> <p>Minutes of outbreak committee meetings</p>	<p>Relevant multi-disciplinary team and ICT / Microbiologist.</p> <p>ICT</p>

<p>3.Audit</p> <p>Reports to be presented at IPCsubC.</p> <p>Outcomes to be disseminated to staff via IC training and via local team meetings.</p> <p>Outcomes and results to feed into work plan.</p>	<p>a. Policy audit to ensure that selected IC policies from CPS, CNWL and Hillingdon PCT) are assimilated within the year period</p> <p>b. Monitor staff uptake of vaccinations (service and data provided by Occ. Health).</p> <p>c. Occupational Health incidents e.g. Needle stick injury, PEP etc</p> <p>d. Audit of waste management processes (including transport of dangerous goods)</p> <p>e. Audit of staff compliance with Policy – particularly, adherence to standard precautions</p> <p>f. Regular audit of cleaning standards</p> <p>g. Audit of urinary catheter care – using High Impact Intervention tool in Essential Steps</p> <p>h. Audit of enteral feeding care - using essential steps</p> <p>i. Develop plan for implementing remaining high impact interventions / essential steps in community setting</p> <p>j. seek assurance, Due diligence visits to waste and laundry contractors</p>	<p>Audit results demonstrating level of compliance with policy/good practice.</p> <p>Risk reduction strategy/ identification of training needs as appropriate</p> <p>outstanding compliancy areas Safe waste management, handling & segregation</p> <p>Essential Steps to clean safe care Audit results demonstrating level of compliance with policy/good practice</p> <p>Establish action plans and cost implications for renovation/ refurbishment work</p> <p>Audit results demonstrating level of compliance with policy/good practice</p> <p>Establish action plans to address outstanding compliancy areas Audit results demonstrating level of compliance with policy/good practice</p>	<p>ICT</p> <p>OH ICT / Governance/ Service Leads Head of administration and facilities & E&F</p> <p>E&F</p> <p>ICT with L&D & Matron ICT E&F</p> <p>Head of administration and facilities & E&F</p>
<p>4.Promote compliance with hand hygiene amongst clinical staff and visitors</p>	<p>a. Audit of hand hygiene in clinical practice – including WHO's 5 moments for hand hygiene & bare below the elbows, review weekly hand hygiene audits.</p> <p>b. Display 6 step hand decontamination poster at all handwash basins and at all alcohol hand gel stations / Display of hand hygiene posters in all clinical rooms and in all waiting areas</p> <p>c. Examine reasons for below average score for staff survey around hand hygiene equipment.</p> <p>d. Set up an IP&C link network to facilitate good practice in IP&C in clinical areas.</p>	<p>Audit results demonstrating level of compliance with policy/good practice</p> <p>Increased hand hygiene compliance on re-audit</p> <p>Attendance record</p> <p>Evidence of education and work undertaken. Risk reduction</p>	<p>ICT & E&F</p> <p>ICT</p> <p>ICT and Site managers</p>

<p>5. Promote prevention of HCAI's through training, media and campaigns</p>	<p>a. Development of patient advice leaflets covering hand hygiene guidance and common HCAI's (Clostridium difficile, MRSA, norovirus)</p> <p>b. Infection control training ,an ongoing programme of updates is available to all provider staff and Infection Control included in each induction session</p> <p>c. Seasonal Influenza campaign, new approached to improve uptake amongst staff</p> <p>d. Dissemination of information and raising awareness of infection control issues and good practice through articles in '<i>PS</i>' staff magazine</p> <p>e. Target is 90% clinical staff to be trained by end Jan 2012.</p> <p>f. Provide an infection control</p>	<p>Leaflets & posters</p> <p>Training Policy & Programme</p> <p>Uptake of vaccination report</p> <p>New staff aware of IC Team and IC policies and how to access IC team</p> <p>Training record and evaluations.</p> <p>Increased awareness of infection control policies procedures improvement in clinical audit results Reductions in HCAI.</p>	<p>ICT</p> <p>L&D / ICT</p> <p>E&F</p> <p>OH</p> <p>L&D / ICT</p> <p>L&D / ICT</p>
<p>6. Provision of advice and review and report adverse incidents</p>	<p>a. Provide advice and maintain accurate record of advice given. Develop way to identify & monitor trends.</p> <p>b. Develop reports for and provide specialist information at e.g. waste , H&S committees, decontamination of medical devices, as required</p>	<p>Annual advice/incident log summary report to ICC</p> <p>Committee minutes</p>	<p>Governance ICT</p> <p>ICT Estates and Administration lead</p>
<p>7. Practice Development</p>	<p>a. Introduction of all remaining high impact interventions '<i>saving lives</i>' extend where possible to adult community nursing</p> <p>b. Extend essential steps to include Enteral feeding, urinary catheter care</p> <p>c. Ensure all EPIC and NICE guidance is in place, in particular invasive medical device management and aseptic technique.</p> <p>d. Decontamination is integrated into the management of medical devices.</p>	<p>Training Policy & Programme / Reductions in HCAI.</p> <p>Training & Policy Reductions in HCAI.</p> <p>Training & Policy</p> <p>Training & Policy</p>	<p>L&D / ICT/ service leads</p> <p>L&D / ICT/ service leads</p> <p>L&D / ICT/ service leads</p> <p>Risk, facilities and administration/ service leads ICT.</p>

Appendix 3

Camden Provider Services

Site	Audit	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In-patient Rehabilitation	Hand Hygiene												
	H117 <i>Clostridium difficile</i>												
	Antibiotic prescribing												
	MRSA screening												
	Transfer Policy												
	Peripheral Cannulae												
	Urinary Catheter												
	Decontamination												
Adult Community Nursing	Urinary Catheter												
	Decontamination				*								
	Enteral feeding												
All service Lines	Essential Steps to safe, clean care												
	Decontamination				*								
Health Clinics	Environmental Audits												

* Date maybe revised.

Infection Control and Prevention Audit Calendar 2011 -2012

Appendix 4

Ref.	No.	Principal Risks	Key controls	Assurances received	Gaps in control & risk management action plan	Gaps in assurance and action plan	Lead Director /Senior Manager	Group overseeing risk	Risk score (LxC)
Infection prevention and control Subcommittee (Local Risk Register)									
SP	1	Decontamination of medical devices: There is a failure to understand the current practice and the arrangements in place across all provider services in the decontamination of medical devices.		Project addressing the management of medical devices has begun. Which will involve a scoping exercise / gap analysis	The medical devices policy provides general guidance but may not be specific enough to either certain types of medical devices or areas where devices are used. A suitable document/s needs to be developed as part of an corporate project in the management of devices and equipment.	Local or corporate audit?	Decontamination lead	Infection prevention and control subcommittee	4x4=16
SP	2	Decontamination of medical devices: There is a risk that newly acquisitioned medical devices do not go through a process of checking that the device meets infection prevention and control requirements.		Project addressing the management of medical devices has begun.	At present it is not known if a process exists.		Decontamination lead	Infection prevention and control subcommittee	5x3=15
SP	3	Policy and procedures: There is a risk that estates and facilities documents have not been developed or those which exist are not ratified, suitable for use, and are not amended to reflect current or new guidance. Inc Legionella, potable and non potable water, plan preventative maintenance programme	Some of the policies within the infection control manual extend to policy expected to be provided by E&F e.g. Waste Management.	E &F have been made aware of the gaps in compliance. And aware of entry on risk register	Tender process with external consults and CIFT		Head of administration & facilities	Infection prevention and control subcommittee Health and Safety committee	5x3=15
SP	4	SLA E&F. The SLA in place has limited infection control input. Measures of compliance are not clearly defined and E&F do not consistently report progress towards 'the code', audit results, training records.	representation of E &F at the IPCsC and H&SsC, verbal feedback of progress, limited.	a new E &F provider is being sought	Tender process with external consults and CIFT			Infection prevention and control subcommittee Health and Safety committee	5x3 = 15

SP	5	Policy and procedures: There is a risk that the extensive revision/ amendment of infection prevention and control procedures have not been adopted fully in clinical practice	Interim infection control manual. Ratified review date 1st April 2012 . Mandatory infection control training. Access to infection control lead / microbiologist for advice	Annual audit programme.	ICPsubC decision, revision of some policies to reflect changes to current practice e.g. MRSA screening policy. Integration of CNWL Policies and Procedures	a) The agreement and ratification of new documents. b) Training and awareness of new documents required	Infection prevention & control lead	Infection prevention and control subcommittee	4x3=8
SP	6	isolation facilities: There is a risk of not controlling an outbreak effectively due to a lack of isolation rooms/facilities.	A range of measure are in place to control the risk of transmitting infection and include hand decontamination; the review of isolation room use: bed management; use of appropriate personal protective equipment (PPE); isolation /cohorting of symptomatic patients; MRSA surveillance of all admissions medical treatment of new cases. <i>Saving Lives High Impact Intervention (Clostridium difficile) No7 audits on a monthly basis</i>	The range of measures and the management of the outbreak are reviewed at regular ward and service meetings. Meetings include support from the Consultant Microbiologist; Infection prevention & control lead and the Health Protection Agency.			Infection prevention & control lead	Infection prevention and control subcommittee	4x3=12