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Date	13.07.23	Agenda item	Bo.7.23.9

INFECTION PREVENTION AND CONTROL REPORT: JANUARY – MARCH 2023 (QUARTER 4, 2022/23)

Presented by	Professor Karen Dawber, Chief Nurse		
Author	Muhammad Yaseen, Director Infection Prevention and Control		
Lead Director	Professor Karen Dawber, Chief Nurse/Executive Lead Infection Prevention and Control		
Purpose of the paper	<p>This report summarises progress against the infection prevention and control work plan for 2022/23 and sets out the Trust's infection control activities and performance between January and April 2023. This is the Quarter (Q) 4 report for 2022/23 and provides the fourth of 4 reports which comprises the annual report.</p> <p>To provide assurance on compliance with:</p> <ul style="list-style-type: none"> NHS Outcomes Framework– domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (commonly known as The Hygiene Code). 		
Key control	This paper is a key control for the Board Assurance Framework		
Action required	For approval		
Previously discussed at/ informed by	Infection Prevention and Control Committee		
Previously approved at:	Infection Prevention and Control Committee	Date: 28/04/2023	
	Quality and Patient Safety Academy	24.05.23	

Key Options, Issues and Risks

This is the quarterly infection prevention and control report which is required by the Quality and Patient Safety Academy to demonstrate progress against the annual infection prevention programme and in achieving compliance with:

- The Health and Social Care Act (H&SCA) 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.
- Regulation 12(2) (h) and 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This is the Q4 report for 2022/23 and provides the fourth of 4 reports which comprises the annual report.

Analysis

The report presents assurances for progress against the annual infection prevention work programme. The report also highlights and provides an escalation summary of key risks in systems and processes which impact on the prevention of healthcare associated infections.

Recommendation

The report provides assurance to the Quality Academy by monitoring the activity of infection prevention and control annual work programme and is requested to confirm the actions arising from the

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recommendations identified are appropriate.

The Academy is requested to note the risks identified and approve the further actions and mitigations as detailed in the main report.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for our patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors						
Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Equality Diversity and Inclusion implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Performance Implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Regulation, Legislation and Compliance relevance	
NHS England: (please tick those that are relevant)	
<input type="checkbox"/> Risk Assessment Framework	<input checked="" type="checkbox"/> Quality Governance Framework
<input type="checkbox"/> Code of Governance	<input checked="" type="checkbox"/> Annual Reporting Manual

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Care Quality Commission Domain: Safe
Care Quality Commission Fundamental Standard: Safety
NHS England Effective Use of Resources: Clinical Services
Other (please state): NICE [QS61] Infection prevention and control

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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INFECTION PREVENTION AND CONTROL REPORT: JANUARY - MARCH 2023 (QUARTER (Q) 4)

1 PURPOSE/ AIM

- 1.1 The purpose of this report is to demonstrate progress against the annual infection prevention programme and in achieving compliance with national standards and performance indicators. The report provides assurance by monitoring the activity of infection prevention and control and identified key issues are noted. The Committee is asked to note the report in relation to:
- Corporate objectives: strategic objective 1 - To provide outstanding care for our patients.
 - NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.
 - Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.
 - NICE [QS61] Infection prevention and control.

2 BACKGROUND/CONTEXT

- 2.1 Section 21 of the Health and Social Care Act (H&SCA) 2008 contains statutory guidance about compliance with the registration requirement relating to infection prevention (regulation 12(2) (h) and 21(b) (Regulated Activities) Regulations 2014. It should also be noted that Regulation 15 is also relevant.
- 2.2 Care Quality Commissions (CQCs) guidance about compliance with the above regulations includes a reference to the 'premises and equipment' regulation (regulation 15) as CQC considers this code to be relevant for the purposes of meeting that regulation.
- 2.3 The 'Code of Practice' on the prevention of infections under The Health and Social Care Act 2008 sets out the 10 criteria. Criterion 1 requires that systems to manage and monitor the prevention and control of infection and require the Director of Infection Prevention and Control (DIPC) to provide oversight and assurance on infection prevention (including cleanliness) directly to the Trust Board and produce an annual report. This report therefore provides assurance to meet the requirements set out above.

3 PROPOSAL

- 3.1 This report will confirm continued assurance systems for compliance against the statutory requirements which will support assurance with corporate strategic objective 1 - To provide outstanding care for our patients.
- 3.2 This is the Q4 report for 2022/23 and provides the fourth of 4 reports which comprises the annual report.

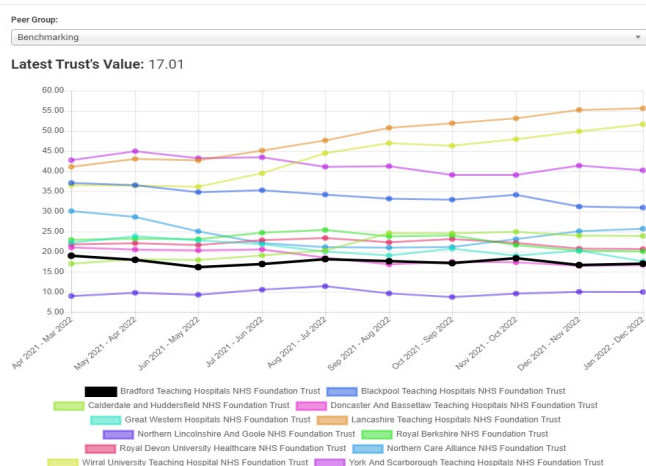
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4 BENCHMARKING IMPLICATIONS

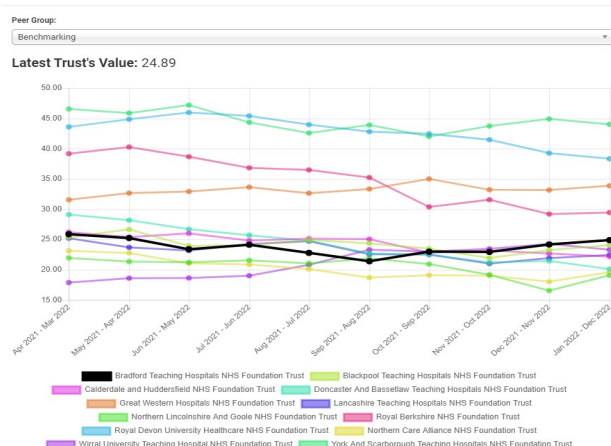
4.1 The latest information available on Healthcare Evaluation DATA (HED) in relation to infection rates is included in the section below. It shows the Trusts position for MRSA and MSSA bacteraemia, Clostridioides difficile (CDI), Klebsiella Spp, Pseudomonas aeruginosa and E. coli, in relation to the national distribution for each of these infections as of March 2023. The arrows in the graph below indicate the position of BTHFT in relation to National and Regional data.

Standard Indicator Set: Clinical Quality	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
Infection rate - C. diff, HOHA & COHA (12 mth rolling) PHE C. Diff Infection Rates, HES Inpatients (Mar 2023)	17.96 (Feb 2022 - Jan 2023)	16.85 (Jan 2022 - Dec 2022)	1.11 ↑	-	25.42	
Infection rate - MRSA, HOHA & COHA (12 mth rolling) PHE MRSA Infection Rates, HES Inpatients (Mar 2023)	6.94 (Feb 2022 - Jan 2023)	6.99 (Jan 2022 - Dec 2022)	-0.05 ↓	-	5.05	
Infection rate - MSSA, HOHA & COHA (12 mth rolling) PHE MSSA Infection Rates, HES Inpatients (Mar 2023)	25.31 (Feb 2022 - Jan 2023)	24.66 (Jan 2022 - Dec 2022)	0.65 ↑	-	24.47	
Infection rate - E. coli, HOHA & COHA (12 mth rolling) PHE E. coli Infection Rates, HES Inpatients (Mar 2023)	20.82 (Feb 2022 - Jan 2023)	22.19 (Jan 2022 - Dec 2022)	-1.37 ↓	-	20.93	
Infection rate - Pseudomonas, HOHA & COHA (12 mth rolling) PHE Pseudomonas Infection Rates, HES Inpatients (Mar 2023)	3.27 (Feb 2022 - Jan 2023)	3.29 (Jan 2022 - Dec 2022)	-0.02 ↓	-	6.42	
Infection rate - Klebsiella, HOHA & COHA (12 mth rolling) PHE Klebsiella Infection Rates, HES Inpatients (Mar 2023)	7.35 (Feb 2022 - Jan 2023)	8.63 (Jan 2022 - Dec 2022)	-1.28 ↓	-	14.57	

Infection rate - C. diff, HOHA & COHA (12 mth rolling)



Infection rate - MSSA, HOHA & COHA (12 mth rolling)



5 RISK ASSESSMENT

5.1 The paper provides assurance for compliance with:

- Corporate objectives: strategic objective 1 - To provide outstanding care for our patients.
- NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

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- Health and Social Care Act 2008: Code of Practice for the prevention and control of healthcare associated infections and related guidance.
- NICE [QS61] Infection prevention and control.

5.2 Gaps in compliance during January - March 2023 that have been identified are highlighted below and within the main report (Appendix 1).

6 RECOMMENDATIONS

- 6.1 The report provides assurance to the Quality Academy by monitoring the activity of infection prevention and control annual work programme is requested to confirm the actions arising from the recommendations identified are appropriate.
- 6.2 The Academy is requested to note the risks identified and approve the further actions and mitigations as detailed in the main report.

7 Appendices

Appendix 1: Infection Prevention and Control: Main Report

1. Introduction

- 1.1 The following report demonstrates progress against the annual infection prevention programme and in achieving compliance with national standards and performance indicators. The report provides assurance by monitoring the activity of infection prevention and control and identified key issues are noted.

2. Strategic Context

- 2.1 This report summarises progress against the work plan for 2022/23 and sets out the Trust's infection control activities and performance. This is the Q4 report for 2022/23 which comprises the annual report.
- 2.2 The infection prevention programme of work continues to be delivered. The progress is monitored through the Infection Prevention and Control Committee (IPCC), which meets 6 times a year and has been chaired by the Director Infection Prevention and Control. Reports are submitted at each committee on progress against the annual plan and key performance objectives.

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3. Healthcare Associated Infections

The NHS Standard Contract 2022/23 includes quality requirements for NHS trusts and NHS foundation trusts to minimise rates of both *Clostridioides difficile* (C. difficile) and of Gram-negative bloodstream infections to threshold levels set by NHS England and NHS Improvement. Trusts are required under the NHS Standard Contract 2022/23 to minimise rates of both *Clostridioides difficile* (C. difficile) and Gram-negative bloodstream Infections so that they are no higher than threshold levels set by NHS England and Improvement. The following table sets out the threshold levels for each trust.

- The classification of healthcare acquired infection cases is split into defined groups:
 - Hospital-onset, healthcare associated (HOHA) - Date of onset is ≥ 3 days after admission (where day of admission is day 1).
 - Community-onset healthcare-associated (COHA) - Date of onset is ≤ 2 days after admission and the patient was admitted to the trust in the 28 days prior to the current episode days (where day 1 is date of discharge).
 - Community-onset, community associated (COCA) - Date of onset is ≤ 2 days after admission and the patient had not been admitted to the trust in the previous 28 days prior to the current episode.
- During August 2020 the Public Health England (PHE) Data Capture System (DCS) started to report cases of MSSA, E.Coli, Pseudomonas sp. and Klebsiella sp. bacteraemias in a similar way to CDI. The classification of cases is split into the defined groups:
 - Hospital-onset, healthcare associated (HOHA) - Date of onset is ≥ 3 days after admission (where day of admission is day 1).
 - Community-onset healthcare-associated (COHA) - Date of onset is ≤ 2 days after admission and the patient was admitted to the trust in the 28 days prior to the current episode days (where day 1 is date of discharge).
 - Community-onset, community associated (COCA) - Date of onset is ≤ 2 days after admission and the patient had not been admitted to the trust in the previous 28 days prior to the current episode.
- Therefore, the surveillance reporting of HCAs for all reportable organisms has aligned with the same categories as CDI.
- Consequently, there has been transference in numbers of cases that are trust assigned, particularly as healthcare associated cases will include those with recent (last four weeks) hospitalisation. The SPC charts presented in this report reflect this change to indicate the re-assignment.
- The PIRs are presented at monthly Planned Care and Unplanned care IPC sub-group meetings and action plans to correct any lapses of care are approved and monitored for completion through these meetings, with final assurance provided by the Assistant Directors of Nursing reports to the Trust IPCC.

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Trust Target for 2022/23

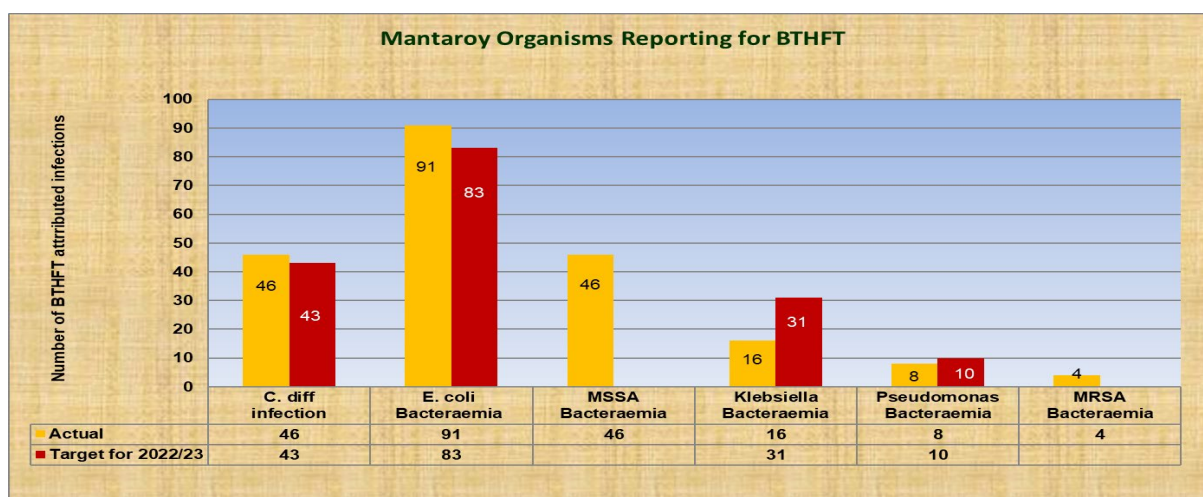


Figure 1

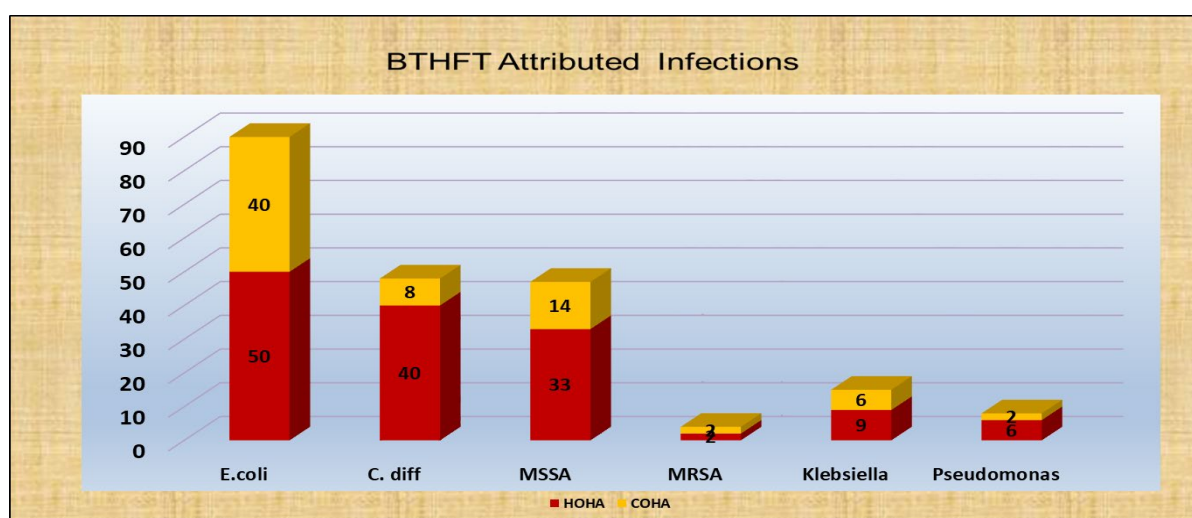


Figure 2

3.1 MRSA bacteraemia

The Trust has reported 4 cases of MRSA bacteraemia during 2022/23. Figure 3 statistical process (SPC) chart highlights the Trust allocated cases from April 2021 to March 2023.

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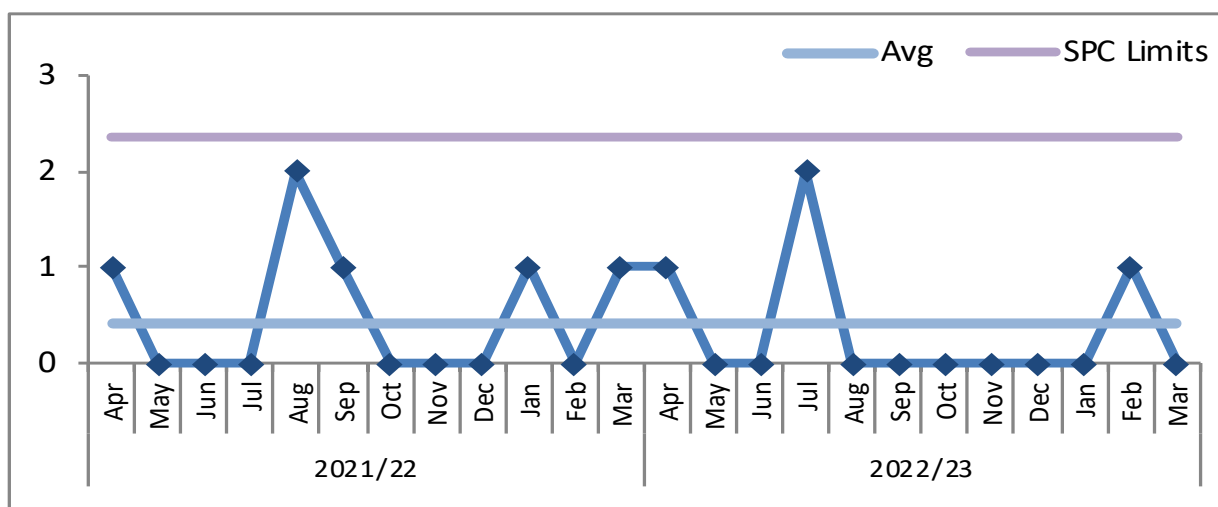


Figure 3

3.2 MSSA Bacteraemia

- The Trust has reported 46 hospital attributed MSSA bloodstream infections from April 2022 to 31st March 2023. There is no National objective for MSSA.
- Figure 4 statistical process (SPC) chart shows Trust allocated cases from April 2021 to March 2023.
- The SPC chart indicates an increase in the cases of MSSA bacteraemia in the months of December 2022 and January 2023. However actions were taken to reduce the incidence and the graph indicates that the number of cases were reduced in February and March 2023 as a result of those actions.

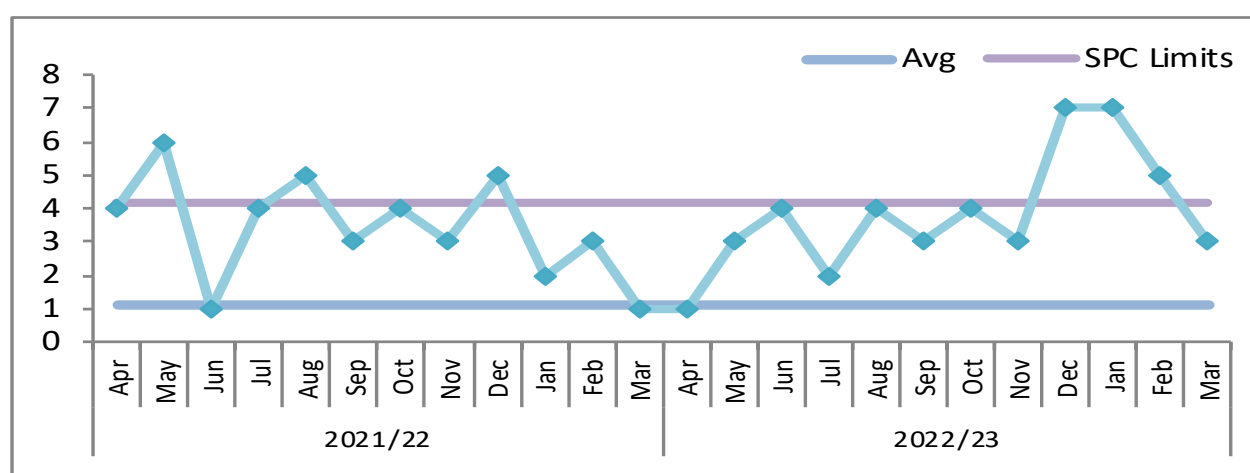


Figure 4

3.3 E. coli Bacteraemia

- Figure 5 SPC chart highlights the Trust attributed *E.coli* BSI cases per month from April 2021 to March 2023.

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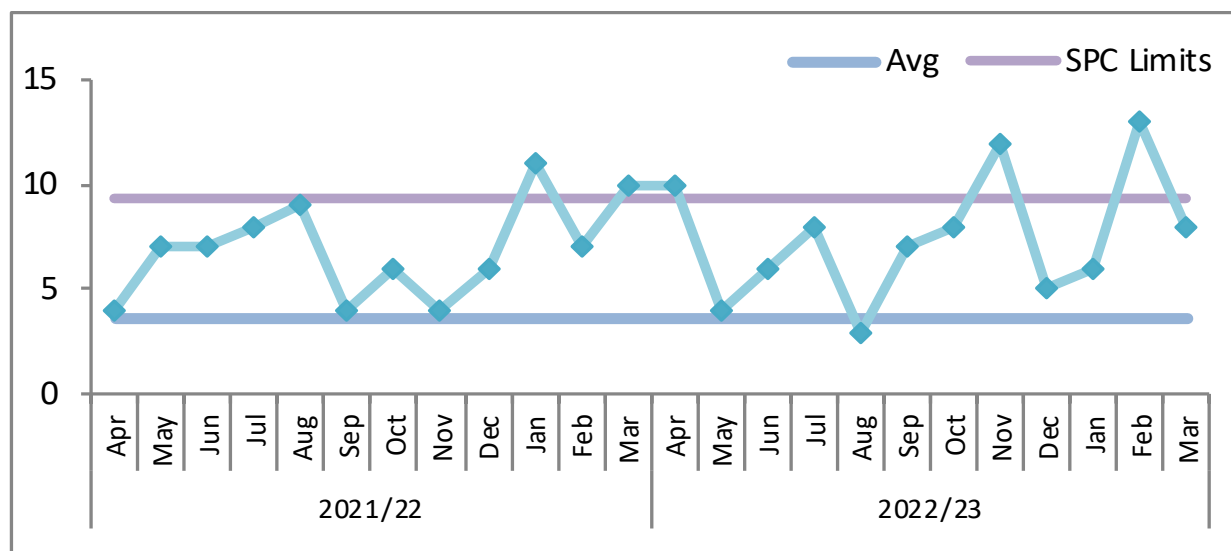


Figure 5

- There have been 91 cases of E.Coli bacteraemias attributed to the Trust from April 2022 to 31st March 2023 against an annual trajectory of 83.
- The majority of patients appeared to be admitted unwell and developed E.Coli sepsis as part of their ongoing clinical condition. Whether these patients are attending hospital much later than pre-Covid and therefore more advanced in their disease severity is being explored with Medical Specialist support through the PIR process.

3.4 Klebsiella Bacteraemia

- Figure 6 SPC chart highlights the Trust attributed *Klebsiella Spp.* BSI cases per month from April 2021 to March 2023.
- There have been 16 cases of Klebsiella Spp. bacteraemias attributed to the Trust from April 2022 to 31st March 2023 against an annual trajectory of 31.

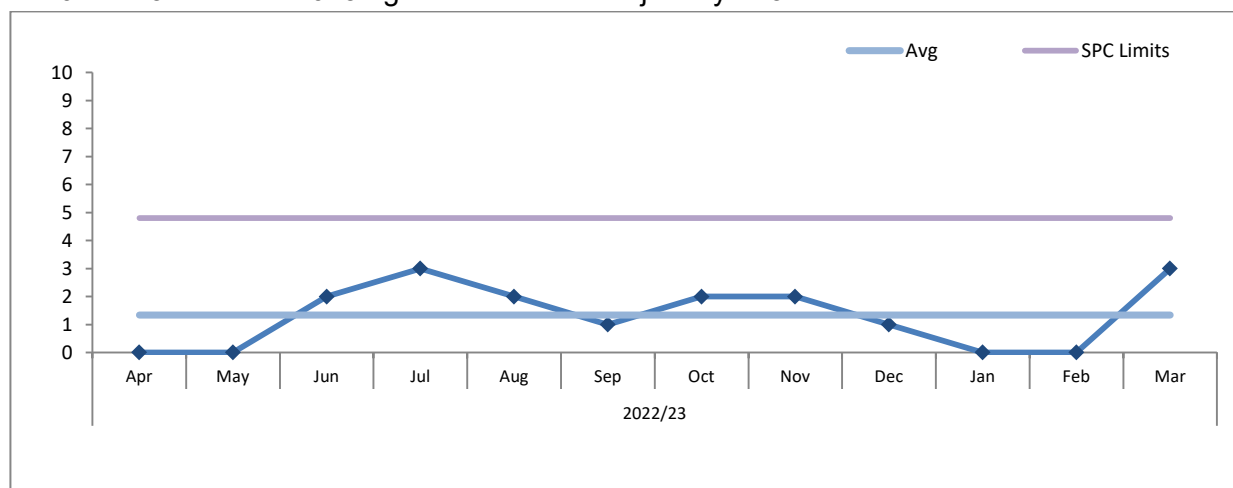


Figure 6

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3.5 Pseudomonas aeruginosa Bacteraemia

- Figure 7 SPC chart highlights the Trust attributed *Pseudomonas aeruginosa* BSI cases per month from April 2021 to March 2023.
- There have been 8 cases of *Pseudomonas aeruginosa* bacteraemias attributed to the Trust from April 2022 to 31st March 2023 against an annual trajectory of 10.

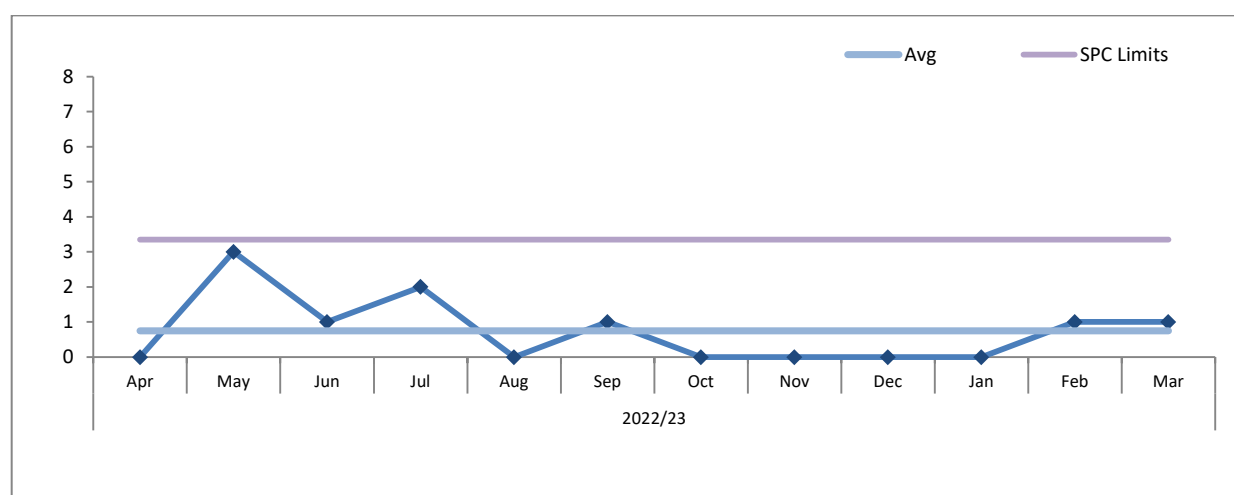


Figure 7

Bacteraemia Reduction Measures

- Octenisan antibacterial body wash implemented. Additional amendments made for documentation in EPR.
- Audits of Octenisan compliance (datix on non-compliance).
- Blood Culture Group.
- Biopatch posters for training and awareness.
- Hydration improvement project.
- ANTT – collaboration with L&OD Team to restart as mandatory training (93 ANTT assessors).
- Follow up by IPC Team of MRSA colonised pts to ensure topical treatment is prescribed.
- PIRs are carried out for all bacteraemias with required actions.
- Special CLABSI reduction project at Meadows.
- Audit for cannulas.

3.6 Clostridioides difficile infection (CDI)

- Figure 8 statistical process (SPC) chart shows Trust allocated cases.
- There have been 46 cases of CDI attributed to the Trust from April 2022 to 31st March 2022 against an annual trajectory of 43.

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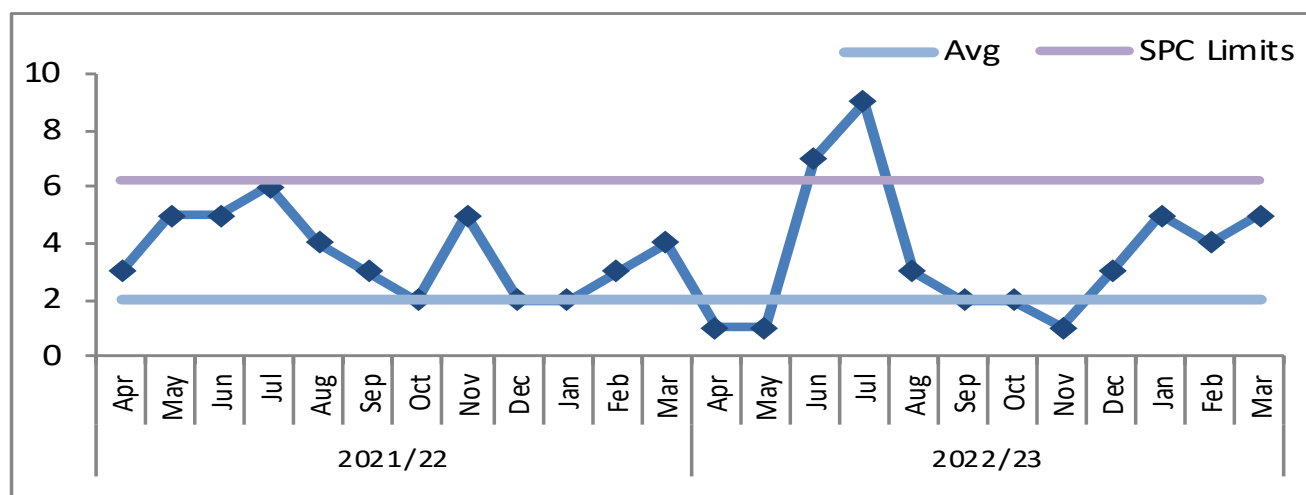


Figure 8

- Each CDI case is sent to a UKHSA (previously PHE) reference laboratory for typing; 25 subtypes of *Clostridioides difficile* have been reported during 2022/23 at BTHFT. Where there are any similar typing results, a search is undertaken to identify any potential risks for cross transmission (for example, the same ward either at the same time or at different times). No evidence of cross transmission has been identified.
- Cleaning and decontamination, including hydrogen peroxide vapour (HPV) fogging for any side room following the discharge or transfer of a patient with CDI has continued and clinical wards and departments have maintained their audit programme for hand hygiene and PPE compliance.

CDI Reduction Measures

- Post Infection Review (PIR) for each new case with implementation for learning from PIRs.
- CDI Improvement plan in place with regular updates.
- Adhoc and regular environmental audits.
- Commode audits with datix on non-compliance.
- Dedicated antimicrobial Stewardship pharmacist.
- Data collection on compliance to Start Smart and Focus.

4. COVID-19 Outbreaks and COVID-19 Preventive measures

All COVID-19 outbreaks at BTHFT (2022/23) are summarised in Appendix. 2.

- Board Assurance Framework.
- Masks in clinical areas. Mandatory for staff. Visitors encouraged to wear mask and not to visit patients if symptomatic.
- Testing of all symptomatic patients and staff.
- Isolation/cohorting of positive patients.

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- Admission screening for immunocompromised and respiratory patients.
- Early detection and management of outbreaks with closure of wards/bays for new admissions.

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Appendix 2. COVID-19 Outbreaks at BTHFT in 2022/23

Record of IMarch Submissions to NHS England												
Outbreak Code	Ward Name	1st IMarch Submiss	2nd IMarch Submissi	3rd IMarch Submiss	4th IMarch Submissi	5th IMarch Submissi	6th IMarch Submiss	7th IMarch Submiss	Submission	Submission	Submission	Submission
19972	Ward 6 D&C b	28.03.2022	07.04.2022	19.04.2022	26.04.2022	03.05.2022	05.05.2022					
19103	Ward 28	30.03.2022	07.04.2022	16.04.2022	26.04.2022	02.05.2022						
19400	Ward 3	17.4.22	2	22	22							
19514	Ward 3	2	2	22	22							
20122	Ward 29	17.05.2022	24.05.2022	06.06.2022								
20542	Ward 26	17.06.2022	24.06.2022	01.07.2022	07.07.2022	19.07.2022						
21517	Ward 16 - link	19.7.2022	25.7.2022	11.08.2022								
22978	Ward 19	09.10.2022	16.10.2022	23.10.2022	28.10.2022							
22979	Ward F6	09.10.2022	16.10.2022	23.10.2022	30.10.2022	02.11.2022						
23223	Ward 6 C&D b	16.10.2022	16.10.2022	23.10.2022	30.10.2022	07.11.2022	10.11.2022					
23224	Ward 27	16.10.2022	23.10.2022	30.10.2022	04.11.2022							
23665	Ward 24	30.10.2022	07.11.2022	13.11.2022	20.11.2022							
23852	F6	20.11.2022	27.11.2022	04.12.2022	12.12.2022	19.12.2022						
24436	33	22.12.2022	30.12.2022	08.01.2023	16.01.2023							
24609	28	03.01.2023	09.01.2023	16.01.2023	23.01.2023	30.01.2023						
24776	26	09.01.2023	16.01.2023	24.01.2023	02.02.2023							
24895	F5	17.01.2023	Completed	023 closed								
24897	29	17.01.2023	Completed	Complete	Completed	Closed 13.02.23						
24956	6	Complete	30.01.2023	3.02.2023	13.2.23	Closed						
25112	16	Complete	Completed	13.02.23	13.2.23	Closed						
25130	17	Complete	Completed	Completed	Completed	Closed 2.3.23						
25143	23	Complete	Completed	Completed	Completed	Closed 5.3.23						
25292	F6	Complete	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Closed 13.4.23	
25890	29	Complete	Completed	Completed	Completed	Closed 5.04.2023						
26072	F5	Complete	Completed	Completed	Completed	Completed	Closed 20.4.23					
26073	27	Complete	Completed	Completed	Completed	Closed 17.4.23						
26339	28	Complete	Completed	Completed	Completed	Closed 10.05.23						
26631	F5-Bay 2	Complete	due 18.05.23									

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Appendix 3: Improvement plan to reduce the incidence of *Clostridioides difficile* infection (CDI) (Updated March 2023)

Rationale: This improvement plan has been developed following an increase in patients being diagnosed with *Clostridioides difficile* resulting in the Trust being above trajectory in quarter 1 2022 / 23 a total of 18 patients have been diagnosed with *Clostridioides difficile*; have been reported against a trajectory of 43 for the year (10 per quarter).

Status:	
O	Open
OC	Open and to be completed
C	Closed
OD	Overdue

Control Objective		1 Reduce the incidence of <i>Clostridioides difficile</i> infection (CDI)					
No.	Description	Action	Lead	Scheduled completion	Status	Date Completed	Progress Comments:
1	Inconsistent timings in staff obtaining samples from patients experiencing loose stools	1.1 Clarify standards required when stool samples must be obtained – Develop poster to support ward teams	IPC Team	30.9.22	C	1.12.2022	The posters have been distributed; supported with verbal update at time of delivery.
		1.2 Develop a 'push report' to alert staff to stool sample compliance. Increase awareness to all staff of the correct time to take samples using different communication strategies.	EPR Team	30.11.22	OC		Awaiting confirmation for EPR team if Push report or alert messaging is feasible
2	Delays in isolating patients with unexplained diarrhoea, those diagnosed with CDI and CD toxin gene positive results due to competing requirements	2.1 Strengthen communications and escalation processes when isolation is delayed – delays are escalated to Clinical Site Team and reported at daily site Ops meetings/action log and notified to IPC Team.	Ward Managers/ Matrons/ Clinical Site Team	30.9.22	C	10.11.2022	Escalation process is being followed and Datix completed where applicable.

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Control Objective		1 Reduce the incidence of <i>Clostridioides difficile</i> infection (CDI)					
No.	Description	Action	Lead	Scheduled completion	Status	Date Completed	Progress Comments:
	for single rooms						Side room priority posters have been reprinted and currently being provided to the clinical areas
		2.2 Provide refreshed Side room priority Poster	IPC Team	30.11.22	C	31.01.2023	Side room priority posters have been reprinted and currently being provided to the clinical areas
		2.3 Inform developments in CapMan to ensure that side room usage (based on priority criteria available) is reflected in long term solutions	IPC Lead Nurse/EPR Team	31.12.2022	OC		Feasibility escalated to Dr Southern and EPR team
3	There are discrepancies with ward based hand hygiene and PPE audits and IPC spot-checks – an over use of gloves has been observed	3.1 Increase / raise awareness of hand hygiene requirements for all health care professionals and staff at the point of patient care – Reintroduce “The Gloves are off” campaign and hand hygiene promotion	IPC Team	30.11.22	C	30.11.2022	Posters have been delivered to clinical areas. Awareness raising on concourse held on 24.11.2022 . clinical areas also provided with order codes for end of bed gel holders
4	Ensure MDT Review completed of CDI PIRs including compliance with antibiotic protocols	4.1 Ensure there is a Medical review of CDI PIRs is completed; Antibiotic Pharmacist review and comments and forwarded completed document to PIR review panel.	DADNs	30.8.22	C	13.09.2022	PIR process embedded and all cases reviewed by ABP and lessons learnt shared through IPCC and Governance meetings.
5	Intelligence is needed to understand the Trust use of Cephalosporins (e.g. Co-amoxiclav) and compliance with protocols	5.1 Antibiotic Pharmacist to share data to IPCC on antibiotic usage and compliance with antibiotic protocols – Any high risk prescribing to be escalated to Clinical Teams and DIPC.	Antibiotic Pharmacist	30.9.22	C		Antimicrobial pharmacist provides report to IPCC

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Control Objective		1 Reduce the incidence of <i>Clostridioides difficile</i> infection (CDI)					
No.	Description	Action	Lead	Scheduled completion	Status	Date Completed	Progress Comments:
		5.2 Lessons learnt from CDI PIRs where antibiotic prescribing concerns highlighted to be shared with CSU Governance meetings, the relevant clinical team and Drugs & Therapeutics meetings.					Reporting and feedback process is in place
6.	Evidence identified of need for Infection clean programme for those wards with identified CDI cases during June/July	6.1 Agreed programme of cleaning/decontamination (including HPV/UV light of ancillary areas and side rooms) for all wards where a case of CDI was reported – priority given to those wards with >1 cases	Facilities Manager/Ward Matrons	30.9.22	C	13.09.2022	Agreed programme completed for wards 6,15,18 22, 26 and continues for any ward area where > 1 case identified
7.	Infection clean standards may not always be achieved prior to an HPV cycle due to competing demands/ communication issues	7.1 Review the current standard and develop a sign off procedure for with Facilities Team to ensure that the environment and any equipment is visibly clean prior to commencing the HPV and that this is consistent trust wide. 7.2 Ensure bedspace checklist is completed as per cleaning policy	Facilities Manager/Ward Managers/ Matrons	30.8.22	C	30.09.2022	Areas concerned were recleaned followed by ATP testing prior to and HPV decontamination
8.	Evidence of the need to improve understanding of how to clean a commode and improve compliance for cleaning	8.1 How to clean a commode poster to be re-issued to all wards; commode cleaning training to be provided to wards identified with concerns.	IPC Team/Ward Managers	30.9.22	C	31.01.23	Posters have been delivered to the wards and departments
		8.2 Focus on commode cleaning during August/September: Commode cleaning checks to be included in the ward managers daily checklist and all nursing	Ward Managers/ Matrons	30.9.22	C	30.11.22	Assurance received from matrons at local IPC meeting that staff have reviewed the video

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Control Objective		1 Reduce the incidence of <i>Clostridioides difficile</i> infection (CDI)					
No.	Description	Action	Lead	Scheduled completion	Status	Date Completed	Progress Comments:
		staff to watch to "how to clean a commode" video.					
		8.3 IPC Team/Matrons to undertake spot-checks of commode cleaning and escalate to DADNs and areas of concern	IPC Team/Matrons	30.8.22	C	30.09.2022	Spot-checks completed and escalation to Local IPC meeting via Datix
9.	Need to understand any lessons learnt, key themes and areas for improvement from Post infection reviews	9.1 Review of all completed CDI PIRs during June/July 2022 and share any lessons learnt/key themes via IPCC and CSU Governance meetings.	DADNs/ DIPC/Lead Nurse IPC	18.9.22	C	10.11.2022	Lessons learnt shared at local IPC meetings.
10.	It is not known if patients are consistently being offered hand hygiene at essential moments during the day (especially after using the toilet)	10.1 Ascertain current practice and report to IPCC with recommendations for improvement. IPC to repeat previous QI project regarding the importance of patients' hand hygiene - before meals and after using the toilet.	IPCN Team	30.1.23	OC		Patient hand hygiene audit of 10 clinical areas completed
11.	How can we determine if our mattresses across the trust are clean and fit for use	11. Ensure mattress ingress and damage checks are part of (1) ward accreditation audit (2) Matron/IPC audits (3) annual mattress audit reinstated	IPCN Team/Matrons/ Chief Nurse Team	30.11.22	C	30.10.2022	Audit question added to the matron and IPC audit; assurance audit and IPC unannounced ward audit

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Appendix 4: MRSA & MSSA Bacteraemia Improvement plan 2021/22/2023 (Updated March 2023)

Status:	
O	Open
OC	Open and to be completed
C	Closed
OD	Overdue

Control Objective		Reduction in MRSA / MSSA Bacteraemia					
1							
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
1	Octenisan antimicrobial body wash to be prescribed for all acute inpatients at the time of admission	DIPC	1.3.2022	01.12.2022	OC		SOP, patient information leaflet and screensaver developed and previously circulated. EPR team have created a new SOP. A task alert on EPR for the nursing staff to activate the decolonisation care plan. The IPC team are monitoring compliance on a weekly basis Datix completed for areas of non-compliance and escalation to Local IPC care group meetings
2	Upload peripheral line screensaver to computer network across all hospital's sites <ul style="list-style-type: none"> ○ Circulate peripheral line newsletter ○ Finalise Biopatch poster and launch in conjunction with tool box sessions to areas using the product 	Lead IPCN	1.4.2023	01.07.2023	O		Draft screensaver created in by IPCT; medical illustration to finalise prior to upload to the computer network. Biopatch poster drafted by manufacturer; await final version following feedback by IPCT.
	All patients admitted to the trust must have an IPC risk assessment correctly completed in EPR for their	Matron/IPCT	27/03/2021	01.10.2022	C	14.6.2022	Non-compliance continues to be reported via Datix SOP in

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Control Objective		Reduction in MRSA / MSSA Bacteraemia					
	1						
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
	current admission with non-compliance being reported via the Clinical Datix reporting system						EPR developed, staff training in progress on SDEC using PDSA cycle. Point prevalence audit completed and will be repeated again following training followed by wider roll out to clinical areas
	All admission wards to use the MRSA screening Protocol	Matron/IPCT	27/03/2021	01.10.2022	C	14.6.2022	
3	All new inpatients with MRSA will receive a IPC review (Monday-Friday)	Lead IPCN	15/03/2021	01.10.2022	C	14.6.2022	Daily reviews continue to support clinical teams checking compliance with <ul style="list-style-type: none"> VIPS /Clips Decolonisation suppression treatment commenced and prescribed according to protocol
4	Antibiotic prescriptions within EPR are in line with prescribing policy or agreed variation with ID or Consultant Microbiologist	Antimicrobial Pharmacist	22/03/2021		C	1.4.2022	Audit compliance will be reported to Drug and therapeutic committee and IPCC
6	All patients admitted to the trust must have an IPC risk assessment correctly completed in EPR for their current admission with non-compliance being reported via the Clinical Datix reporting system	Matron/IPCT	27/03/2021	01.10.2022	C	14.6.2022	<ul style="list-style-type: none"> Body was continues for duration of stay if greater than 5 days Referral to TV team if required Urinary catheter care Datix completed for non-compliance

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Control Objective		Reduction in MRSA / MSSA Bacteraemia					
1							
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
7	All clinical areas must be <ul style="list-style-type: none"> o supplied o Use peripheral cannula packs for insertion of cannula and FREPP available for skin cleansing 	Head of Procurement / Director of Pharmacy	27/04/2021	1/07/2022	C	01.05.2022	Frepp discontinued by manufacturer but substituted by Cloraprep containing 4% CHG 70%IPA
8	Blood cultures must be taken using <ul style="list-style-type: none"> o closed system SAFETY Blood collection set o aseptic technique 	Education Team	22/03/2021	1/07/2021	C	14.06.2022	Staff members are taught using safety blood collection sets and ANTT
9	Concentrate initial ANTT refresher training in areas with high patients acuity i.e. ward 29, ward 22, ICU, ward 6 & AED	IPCT	22/03/2021	1/09/2021	C	14.06.2022	93 ANTT assessors in place and trained. Focus training completed on ICU, NICU, The meadows, ward 26 Training and assessment being led by the Education team supported practice educators supported by IPC team
10	Peripheral cannula\CVC to be reviewed by clinical team <ul style="list-style-type: none"> o 3 times daily o VIPS\CLIPS assessment will be recorded on the patients EPR VIPS/CLIPS care plan within EPR 	Matron	27/04/2021	01/11/2022	C	31.10.2022	Discussed at local care group IPC meetings and will be supported by IPC team to ensure VIPs recorded at least daily and then focus on achieving 3 times daily . IPC continue to monitor VIP scores during matron/IPC assurance audits. Wards continue to audit insertion and ongoing care of cannula's monthly.
11	Explore feasibility of creating MRSA care plan in EPR	IPCT	20/04/2021	01/12/2022	C	31.10.2022	Awaiting confirmation from CHFT IPC team as joint agreement required. No replies from CHFT and not able to proceed

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Control Objective		Reduction in MRSA / MSSA Bacteraemia					
	1						
No.	Description	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Progress Comments:
12	All peripheral cannula to be removed within 72 hours of insertion or 96 hours if venous access is limited and VIPS recorded as Zero	IPCT/ matron	27/04/2021	01/12/2022	C	31.10.2022	Audit compliance against Vascular access device policy. VIP audits restart March 22 and audit results reviewed at local IPC meetings. Wards continue to audit insertion and ongoing care of cannulas monthly. IPC/Matron audit 6 monthly auditing VIPS/CLIPS.
13	Remove peripheral cannula within 24 hours of cannula being inserted in emergency situations where aseptic technique cannot be assured	IPCT	22/03/2021	01/07/22	C	01/07/2022	VIP audits restarted March 22 and audit results discussed at care group IPC meetings
14	Relaunch the 'Gloves are off Campaign' to support hand hygiene compliance and reduce unnecessary glove use	IPCT	27/04/2021	1/10/2021	C	05.05.2022	Relaunched on 05.05.2022, stall on concourse with good staff engagement; tool box exercises delivered to clinical areas with revised posters and inclusion in 'Let's talk'
15	Restart matron IPC audit programme; results and actions to be monitored by the individual care groups at local IPC meeting and included in report to IPCC	Matron/ ADNs	27/04/2021	1/8/2022	C	1.5.2022	Audit has resumed, action plan created for areas of non-compliance and monitored at local IPC meeting. Summary included in care group report to IPCC