

## Board of Directors (in Public)

### Item 2.3

**Subject:** Director of Infection Prevention and Control (DIPC) Quarterly Report  
**Date of Meeting:** Tuesday 27<sup>th</sup> July 2021  
**Prepared by:** Nicola Best, Infection Prevention Nurse Specialist  
**Presented by:** Dr Raphael Perry, Medical Director  
**Reason for Report:** To Note

BAF Reference	Impact on BAF
BAF1	Assurance regarding processes for infection prevention and control

Level of assurance (please tick one)					
To be used when the content of the report provides evidence of assurance					
✓	<b>Acceptable assurance</b> Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input type="checkbox"/>	<b>Partial assurance</b> Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	<b>Low assurance</b> Evidence indicates poor effectiveness of controls

### 1. Executive Summary

This paper provides information and an update on infection prevention and control issues for the 1<sup>st</sup> quarter of this financial year, 1<sup>st</sup> April till 30<sup>th</sup> June 2021. Previous reports have covered the period up to 31<sup>st</sup> March 2021.

This paper provides assurances that surveillance systems and audit programmes are in place to monitor and prevent healthcare associated infections.

A number of audits have been performed across the Trust which identified some issues which have been fed back to the relevant managers to address.

### 2. Background

High standards of infection prevention and control are essential to ensure that people who use health care services receive safe and effective care. The *Health and Social care Act 2008: Code of Practice on the prevention and control of infections* identifies that good organisational processes and a robust assurance framework are essential to ensure effective infection prevention.

In order to demonstrate that infection prevention is integrated into the assurance framework one recommendation is that the Board of Directors receives regular updates from the

infection prevention and control team, including information on alert organisms, outbreaks, cleanliness standards and audit information. This report provides such an update.

### 3. Issues

#### 3.1 Surveillance

##### 3.1.1 Mandatory reporting of Bacteraemias and C Difficile infections

There is a requirement that bacteraemias (blood stream infections) caused by certain bacteria and also Clostridium difficile infections are monitored and reported to Public Health England on a monthly basis. These cases are also reported to the Clinical Commissioning Group monthly.

		<b>April 2021- June 2021 (Year to Date)</b>	<b>Target 2021/22</b>
1.	Trust attributable MRSA (Methicillin Resistant Staphylococcus aureus) bacteraemias	0 <b>(0)</b>	0
2.	Trust attributable MSSA (Methicillin Sensitive Staphylococcus aureus) bacteraemias	3 <b>(3)</b>	Internal target = 9
3.	Trust attributable E coli bacteraemias	0 <b>(0)</b>	Internal Target for the total of all these Gram negative bacteraemias = 9
4.	Trust attributable Klebsiella species bacteraemias	0 <b>(0)</b>	
5.	Trust attributable Pseudomonas aeruginosa bacteraemias	0 <b>(0)</b>	
6.	Trust attributable Clostridium Difficile infection	3 <b>(3)</b>	4

## Trust attributable MSSA Bacteraemias

Probable cause	Summary & issues Identified	Actions
Infected hip replacement	Urgent admission for TAVI. Patient had hip replacement in the transferring Trust. Some time after admission here the wound became red & inflamed and the patient was diagnosed with infection at the surgical site	The patient was transferred back to the referring hospital for orthopaedic treatment.
Peripheral venous cannula (PVC)	Emergency admission following out of hospital cardiac arrest. Cannula inserted prior to admission, removed when VIP score raised.	To rewrite Peripheral cannula policy to incorporate new practice in relation to emergency admissions. (31/7/21)
Surgical Site Infection (SSI)	ACHD patient scheduled for elective surgery which was cancelled twice over 6 months. Decolonisation given first time of scheduled surgery but not repeated and no outpatient appointment when surgery rescheduled.  Sternal wound was positive for S aureus.	The ACHD team to review pathways for elective ACHD patients (31/7/21).  Decolonisation audit to be performed and action plan forwarded to SSI group  (Completed 30/6/21)

### 3.1.2 Clostridium difficile

The numbers of patients with C difficile infection are above the trajectory required to meet the annual target of 4 cases. 3 patients were identified in this time period. Patient reviews were completed with the relevant wards for all these patients some issues related to documentation and administration of laxatives were noted but no significant lapses in care were identified.

Patient reviews and actions have been sent to the governance committees for discussion. The patients were not linked to each other in either time or space and so no incidence of cross infection could be identified.

### 3.1.3 Total LHCH attributable MRSA cases

Cases of MRSA in the Trust are closely monitored to identify any increased incidence or outbreaks. This includes all patients and all isolates, including colonised and infected patients.

A number of patients were identified as MRSA positive in this time period, but all were already known to be positive, or tested positive on admission, 0 were Trust attributable.

### 3.1.4 Carbapenemase Producing Enterobacteriaceae

There has been 1 case of Trust attributable CPE, the patient was colonised and did not have an infection.

### 3.1.5 SARS-CoV2 (COVID-19)

COVID 19 Patients April – June 21 –Attribution	Number of positive patients

<b>Community-Onset</b> - First positive specimen date <=2 days after admission to trust.	3
<b>Hospital-Onset Indeterminate Healthcare-Associated</b> - First positive specimen days 2-7 days after admission to trust,	2
<b>Hospital-Onset Probable Healthcare-Associated</b> – First positive specimen date 8-14 days after admission to trust,	0
<b>Hospital-Onset Definite Healthcare-Associated</b> – First positive specimen days 15 or more days after admission to trust.	0

### 3.2 Hand Hygiene

Clinical areas carry out a monthly observational audit of hand hygiene in their area, in addition to another audit in a peer review ward each month. The audit system has moved to an electronic system “Perfect Ward” however not all areas are currently using this and so there have been some difficulties with data collection. Further work is ongoing to address this and to ensure all audits are performed and submitted in a timely manner

	April	May	June
<b>Results of Compliance Audits</b>	100%	100%	99%
<b>No. of Observations</b>	156	159	131

Although audits performed by the wards show good compliance audits separately performed by the infection prevention nurse showed that not all staff were compliant with the hand hygiene and “bare below the elbows” policy, this has been fed back to individual staff members, ward managers and the Infection Prevention Committee.

### 3.3 Cleanliness

The standard monitoring tool used by the Hygiene supervisors to assess environmental cleanliness has continued to be used. The target is an overall Trust score of 95%, with an individual score for clinical areas of 95% or above.

Hygiene services have been under renewed pressure because of the increased frequency of cleaning and the number of areas requiring deep cleaning. Also additional cleaning has been required in certain areas due to building works and capital planning projects.

	April	May	June
<b>Results overall of Compliance Audits</b>	97%	99%	99%

A group has been established to introduce the new National Standards for Cleanliness across the Trust.

#### 4. Audits

An audit programme has been developed and audits have been performed by the Infection prevention team within this quarter including:

- Decolonisation prior to surgery
- COVID- 19 swabbing compliance
- Infection prevention standards and PPE (Personal protective equipment)
- Diagnosis and treatment of urinary tract infections
- Critical Care screening

Results and action plans have been feedback to wards and through the Infection Prevention committee

#### 4. Sepsis

The 20/21 annual sepsis report was presented at Quality Committee on 20<sup>th</sup> July 2021. There has been an improvement in the management of sepsis with the principal KPIs either achieved or significantly improved.

There has been a review of the service and systems by MIAA and action plan agreed. This table outlines ongoing work and as part of the annual sepsis report.

##### On-going Sepsis Improvement work

	Key issues to highlight to Board
1	The new appointment of critical care microbiology and sepsis specialist nurse. This development in service will enhance education and training in ensuring correct and timely treatment of sepsis in LHCH.
2	Restart of direct individual feedback system for clinicians involved in sepsis treatment. This programme will congratulate staff for delivery of successful treatment according to Trust sepsis guidelines and provide education for those involved in incomplete sepsis treatment. This will be an ongoing programme to maintain high level of compliance and mitigate against the effect of rotation of medical staff through LHCH.
3	Delivery of actions highlighted by the MIAA report. This includes formalisation of the sepsis group with TORs, minutes and an ongoing action log. Also drive to improve levels of sepsis screening, provide patient information leaflets on sepsis and continued education and training.
4	Sepsis group meetings will be reinstated now after the new specialist nurse appointment to ensure involvement of sepsis first responders in further development of sepsis care in LHCH.
5	Development of a new sepsis training video to include key educational material, blood culture acquisition, delivery of life saving treatment and correct documentation on EPR.

	Action Required	Timeframe for completion
1	Review of sepsis trigger system on Critical Care (SOFA).	September 2021
2	Restart of sepsis group meetings.	July 2021
3	Sepsis data provision and validation – Amit Malik left the Trust, transition of role to Sophie Barwise.	July 2021

4	Sepsis video to be included in the mandatory training with update to current sepsis educational material on the Trust's E-Learning platform.	September 2021
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	Key Risks Identified	Action to Mitigate
1	Regular change of junior medical staff.	Education through induction programme.
2	Sepsis data provision and validation.	Currently being developed by audit team and sepsis specialist nurse.
3	Non acceptance to feedback from incomplete sepsis treatment.	Divisions support of individual feedback system.

There is a continued education programme:

- To deliver teaching sessions for junior doctors' outreach and hospital coordinators.
- Trust wide reminders through screen savers and desktop backgrounds continue.
- There is an updated sepsis eLearning package which is included in mandatory training for clinical staff.
- A new narrated video detailing diagnosis, management and documentation of sepsis treatment has been developed and currently in use during the induction programme for junior doctors. The sepsis group will discuss potential distribution of this learning material to a wider group of staff in LHCH.

There is continued optimisation of EPR workflow in sepsis. This includes pop up reminders for the screening tool. When trying to prescribe sepsis antibiotics off bundle; a tick box for MEWS greater than 5 to eliminate the need for the screening tool; automatically opening the sepsis bundle on completion of high-risk screening. In addition, there will be improvements in visibility of data such as start times for antibiotics. Facilities boards will include a column for sepsis next to MEWS with colour coding to indicate the need for and completion of the screening tool.

## 5. Summary

The surveillance of infections and routine audit data continue to be monitored and work is on-going to ensure the infection prevention quality and safety plan is fulfilled and a robust audit programme is in place.

## 6. Recommendations

The Board of Directors is asked to note the contents of this report.