

## Board of Directors (Public)

### Item 2.4

**Subject:** Infection Prevention and Control Quarterly report  
**Date of meeting:** 26<sup>th</sup> July 2016  
**Prepared by:** Nicola Best (Infection Prevention nurse specialist)  
**Presented by:** Dr Raph Perry (Director of Infection Prevention and Control)

BAF Ref	Impact on BAF Risk Rating?
2,3	Nil

## 1. Executive Summary

This paper provides information and an update on infection prevention and control issues for the time period 1<sup>st</sup> April - 30<sup>th</sup> June 2016. Previous papers have covered the period up to the end of March 2016.

## 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 and Alert organisms

#### 3.1.2 Mandatory reporting

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.

	Number of cases April – June 16	Target for 2016/17	Comments
MRSA bacteraemias (Bloodstream)	0	0	
Staphylococcus aureus (MSSA) bacteraemias	1	Mandatory reporting but no targets assigned	Review indicates the probable source of the bacteraemia is a wound

			infection post cardiac surgery
E. coli bacteraemias	0	Mandatory reporting but no targets assigned	
Clostridium difficile infection (i.e. C. difficile toxin positive)	0	≤ 4	

Information on patients who develop infections post cardiac surgery has been collected and will be analysed to identify risk factors and any common themes.

### **3.1.3 MRSA – all cases (Non- bloodstream)**

All cases of MRSA in the Trust, including infected and colonised patients, are closely monitored to identify any increased incidence or outbreaks.

Although there have been a significant number of patients in the Trust with MRSA during this time period these were identified before or on admission and only 1 case was identified as Trust acquired.

### **3.1.4 Carbapenemase Producing Enterobacteriaceae (CPE)**

2 patients not previously known to be CPE positive were identified in May. The first patient had been transferred from another Trust and was screened on admission. When the results were received additional screening was performed on contact patients from POCCU. This identified another positive patient. However further tests showed that these were actually 2 different types of bacteria. This indicated that cross infection had not taken place between these patients. Both of the patients were isolated when the positive results were received, both of the patients were colonised only.

Another patient became positive for CPE in June (colonised). There was no contact identified with the previous positive patients.

No further positive patients were identified however, as previously identified, there are difficulties when attempting to identify and trace contact patients and a significant number of patients had already been discharged prior to the results being returned and so could not be screened.

### **3.1.5 Vancomycin Resistant Enterococcus (VRE)**

23 patients were identified with isolates positive for VRE in this time period. 6 of these were classified as not LHCH acquired because they had been identified previously as positive in another Trust or the samples were taken within 3 days of admission. The majority of the patients were colonised only.

The majority of the new isolates were from patients on Critical Care. However this is the only area that routinely tests for colonisation with VRE as part of a weekly screening regime. Therefore it is not always possible to identify where and when the patients acquired VRE.

However there were 2 patients who had had negative screens and then later became positive, thus indicating probable transmission within the unit. This has been discussed with the managers and a more robust cleaning schedule and monitoring schedule have been introduced.

### **3.1.6 Surveillance software system**

An updated software system is now in place for surveillance and reporting of infection, although this is not fully functional as yet because interfaces are required with the Trust's patient administration systems. Work is ongoing to resolve this.

## **3.2. Audits**

### **3.2.1 Hand Hygiene**

Clinical areas carry out weekly observational audits of hand hygiene in their area, with 1 audit in a peer review ward each month. Some areas have not submitted all the audits, including the peer audits, but this has been raised with the relevant managers and the results have been forwarded to the Heads of Nursing so they can monitor that the audits are performed according to the schedule.

	<b>April</b>	<b>May</b>	<b>June</b>
<b>Results of Compliance Audits</b>	100%	100%	100%
<b>No. of Observations</b>	593	706	651

### **3.2.2 Other audits**

An audit of antibiotic surgical prophylaxis has been performed by the antibiotic pharmacist which showed significantly improved compliance compared with previous audits.

Audits of the screening regimes for patients on Critical Care and patients transferred into the Trust have been performed by the infection prevention nurses. The results show improvement from previous audits although further work is being undertaken to increase compliance further. All action plans will be monitored by the Infection Prevention Committee.

## **3.3. Cleanliness**

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

The overall monitoring scores for the Trust were:

	<b>April</b>	<b>May</b>	<b>June</b>
<b>Results</b>	97.3%	97.5%	Data not available

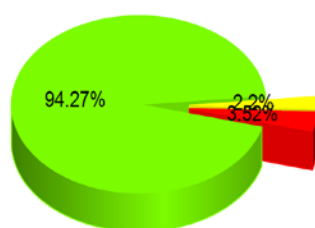
1 Clinical area did not meet the required standard but this was rectified immediately.

### **3.3.1 Cleanliness of equipment/patient environment**

The Clean trace system is now being used throughout the Trust. This provides an objective measurement of cleanliness in the clinical area using a swabbing system and is used to monitor equipment cleanliness rather than the general environment.

Combined results for the Trust are given below:

Pass Caution Fail



Measurements:454. Pass:428. Caution:10. Fail:16

When a problem is identified i.e. the expected standard of cleanliness has not been reached this is rectified immediately. Results are fed back to ward managers and the relevant Heads of Nursing in a monthly report so that they can identify any trends.

#### **4.0 Conclusion**

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

#### **5.0 Recommendations**

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