

Board of Directors in Public

Item 2.2

Subject: DIPC (Director of Infection Prevention and control) Report Q1
Date of Meeting: 26th July 24
Prepared by: Nicola Best (Lead Infection Prevention and control nurse)
Presented by: Mr Manoj Kuduvali (Director of IP&C)

| BAF Ref | Impact on BAF |
|---------|---|
| BAF 1 | Assurance on the infection prevention and control measures in place |

1.0 Executive Summary

This paper provides information and an update on infection prevention and control issues for the 1st quarter of this financial year, 1st April until 31st June 24. Previous reports have covered the period up to the end of March 2024.

This paper provides assurances that surveillance systems, audit and governance programmes are in place to monitor and prevent healthcare associated infections. The rates of reportable infections remain relatively low. A number of audits have been performed across the Trust which have identified some issues which have been fed back to the relevant managers to address.

Working groups are in place to monitor and improve specific issues related to the prevention or management of infection including cleanliness, sepsis management, antimicrobial stewardship and surgical site infections.

2.0 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 and patient safety.

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.

3.0 Surveillance

There is a requirement that bacteraemias (blood stream infections) caused by certain bacteria and also Clostridioides difficile infections are monitored and reported to UKHSA (UK Health and Security Agency) on a monthly basis.

In addition to this, the Infection Prevention team continuously monitor and carry out surveillance on antibiotic resistant organisms or particular organisms of concern.

3.1 Mandatory Reporting – Bacteraemias (Blood cultures)

| | Attributable cases April to June 24 (Year to Date-Trust attributable) |
|---|--|
| Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemias | 1 (1) |
| Methicillin sensitive Staphylococcus aureus (MSSA) bacteraemias | 2 (2) |
| E coli bacteraemias | 0 (0) |
| Klebsiella sp. bacteraemias | 2 (2) |
| Pseudomonas aeruginosa bacteraemias | 0 (0) |

Post infection reviews have been undertaken for all these patients, in conjunction with relevant staff and any issues and actions required have been identified. (See below for summaries).

The relevant divisional governance meetings discuss these patient reviews and learning points and oversee any associated action plans that have been developed.

| Month | Bacteraemia | Summary | Learning points and comments |
|-------|----------------------|--|--|
| May | MRSA (Critical Care) | The patient developed a chest infection, whilst being ventilated on Critical Care and this was the probable source of the bacteraemia. No links to other patients with MRSA could be identified. | No specific learning points could be identified. |
| | MSSA (Critical Care) | The patient developed a surgical site infection following cardiac surgery, | |

| | | | |
|--|-----------------------|--|---|
| | | which was the cause of the bacteraemia. | No specific learning points identified. |
| | MSSA (Oak ward) | The patient developed a drain site infection post thoracic surgery, which was the probable cause of the bacteraemia. | Issues related to sampling and documentation of drain sites were identified. |
| | Klebsiella (Cedar) | The patient was discharged with a Hickman line in situ. Intravenous antibiotics were administered in the community but the patient was admitted to LHCH with a line related infection and signs of sepsis. | Issues related to management of the line in the community were noted and feedback provided to the community teams |
| | Klebsiella (Birch) | The cause of the bacteraemia could not be definitively identified. | |

3.2 Mandatory Reporting - Clostridioides difficile Infection

| | Attributable cases April – June 24 (Year to Date) |
|--|--|
| Clostridioides difficile infection (C. difficile toxin positive) | 0 (0) |

3.3 CPE cases

There were 12 new patients with CPE in this time period, 2 were attributable to the Trust. There was no identified connection between the patients and they appeared to be different strains of bacteria. The patients were isolated and cared for with the appropriate precautions, in accordance with Trust policy.

3.4 MRSA cases (all isolates)

19 patients were identified as MRSA positive in this time period, most were identified as positive prior to, or on admission. 1 was identified as Trust attributable (as above) and was isolated and treated in accordance with Trust policy.

3.5 Respiratory Viruses

SARSCoV2

An increased number of patients tested positive for SARS coV2 in this period, the breakdown of attribution is given below. The testing programme has significantly reduced and patients are only tested now if they develop symptoms of respiratory viral infection. These cases were reported to the national system.

All patients were isolated and cared for with the appropriate precautions, in accordance with guidelines.

| COVID 19 Patients April - June 2024 | Numbers of Patients |
|---|----------------------------|
| Community-Onset – First positive specimen date <=2 days after admission to trust. | 6 |
| Hospital-Onset Indeterminate Healthcare-Associated – First positive specimen date 3-7 days after admission to trust. | 3 |
| Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to trust. | 4 |
| Hospital-Onset Definite Healthcare-Associated – First positive specimen date 15 or more days after admission to trust. | 5 |

Influenza

There were 0 patients who tested positive for influenza during this time period.

4.0 Audit programme

An annual audit programme has been developed and a number of audits completed to provide assurance of compliance with national infection prevention and control standards. The following audits have been carried out by Infection prevention nurses, matrons and ward staff.

These include:

- MRSA screening programme and MRSA pathway and care
- CPE screening programme
- Hand Hygiene
- Peripheral Line care
- Urinary catheter care

5.0 Cleanliness

A new audit tool and programme to monitor cleanliness across the Trust has been developed in line with the National Standards for Cleanliness. A multi-disciplinary group including Infection prevention nurses, Matrons and Hygiene service supervisors have performed the audits in the clinical areas, ensuring a collaborative and standardised approach to monitoring cleanliness. The average scores across the Trust for each month are given below.

| | April | May | June |
|---------------|--------------|------------|-------------|
| Areas audited | 12 | 12 | 12 |
| Average score | 98.6% | 98.2% | 98% |

| | | | |
|--|--|--|--|
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|--|--|--|--|

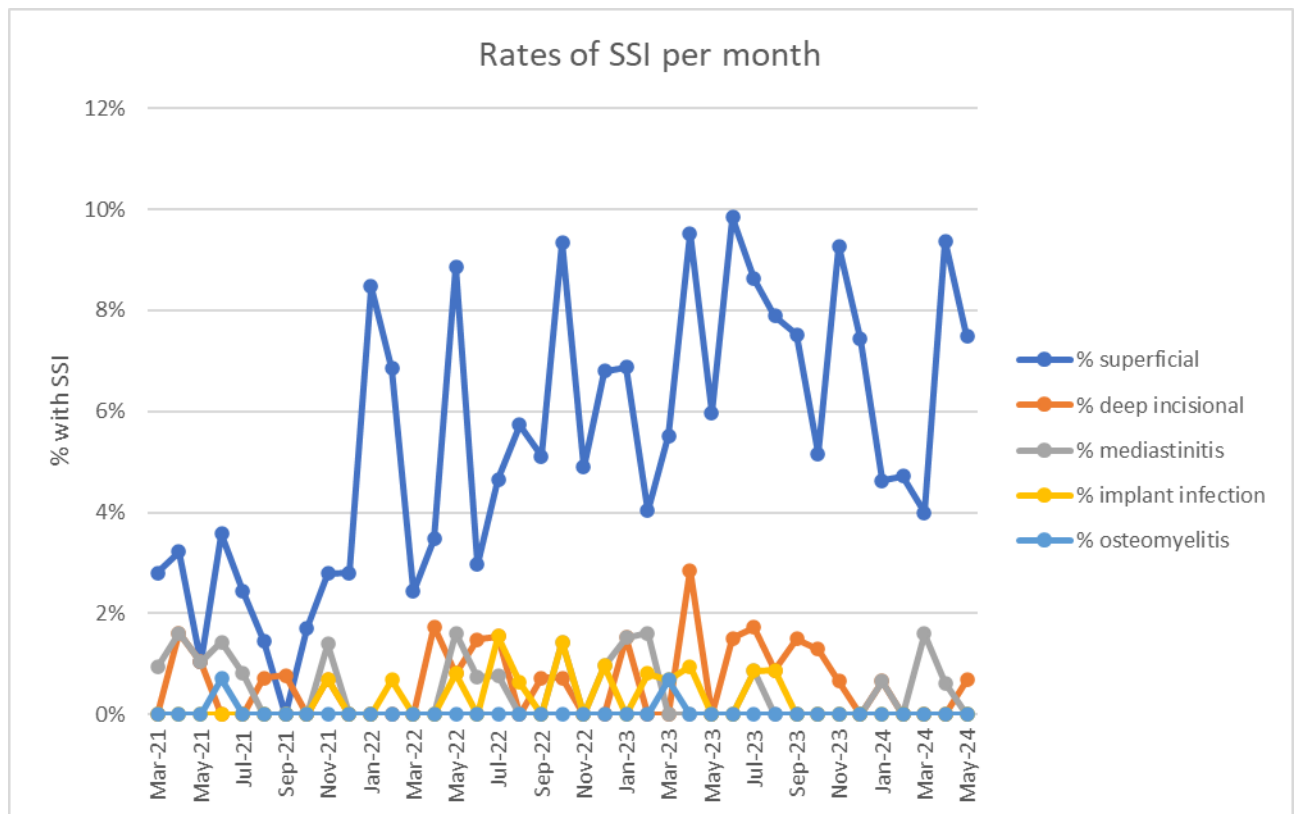
6.0 Surgical Site Infection (SSI)

The Infection prevention team have a robust surveillance system for the continuous monitoring of SSI following cardiac surgery. Data on all patients undergoing cardiac surgery is collated every month and categorised into different classifications of infections i.e. superficial, deep incisional, mediastinitis, implant infections, osteomyelitis. The graph is shown below.

The SSI prevention group meets regularly and has an ongoing action plan to improve SSI. Data is presented to the Infection Prevention Committee and the Surgical Governance Committee.

A number of audits have been undertaken to ensure compliance with infection prevention measures.

Reviews of the severe infections are undertaken to identify if there are any trends or learning points.



7.0 Antimicrobial Stewardship

The antimicrobial stewardship group meets quarterly. Antibiotic compliance audits have been performed and results fed back to relevant committees and to prescribers via the educational lead.

An educational programme is in place for prescribers.

8.0 Sepsis

A sepsis group meets quarterly to monitor compliance, identify areas of challenge, and aims to continually improve all aspects of sepsis management and care. There is ongoing monitoring of compliance with key performance indicators on a weekly basis. The overall average scores for the quarter are given below.

| Standard | Compliance April – June 24 |
|---|----------------------------|
| Blood cultures taken prior to antibiotics | 98.5 % |
| Antibiotics within 1hr of a screen that identifies a possible high risk of sepsis | 97.5% |
| Antibiotics within 3hrs of a possible high risk of sepsis | 100% |

Individual cases where targets aren't met are reviewed by the sepsis team with learning fed back to departments / individuals involved.

9.0 Summary

The surveillance of infections continue to be monitored and all reportable infections are reviewed to identify any trends or learning points, which are shared with relevant committees and groups. Work is on-going to ensure the infection prevention quality and safety plan is fulfilled and that a robust audit programme is in place.

A number of working groups have been established to oversee issues related to the prevention or management of infection including the Cleaning Group, Sepsis Group, Antimicrobial stewardship Group and Surgical Site infection Group. Each of these have their own audit schedule and action plans.

10.0 Recommendations

The Board of Directors is asked to note the contents of this report, the ongoing work and the continued low incidence of reportable infections.