University Hospitals Bristol NHS
NHS Foundation Trust

Infection Control Report 2012/13

Statement from the Executive Director

Name: **Helen Morgan**
Title/Position: **Acting Chief Nurse**

I am pleased to introduce the University Hospitals Bristol NHS Foundation Trust Annual Report on Infection Control for 2012/13.

Our focus on working to reduce the incidence of hospital acquired infections has not diminished over the years. This is especially important, not only because we have a duty to keep our patients free from harm, but also as patients and their families continue to tell us how important this is to them.

The Trust Board are fully committed to supporting staff as they strive to do their best for our patients and you will see throughout the report, evidence of work undertaken every day by staff across the Trust to minimise the risk of infections for patients in our care. Throughout the report there are also many examples of good practice and improvement, including hand hygiene, cleaning and antibiotic prescribing compliance.

It is encouraging to note that incidence of Clostridium Difficile reduced again during 2012/2013, which has been a year on year reduction since 2009/2010. However, we disappointingly failed to sustain a reduction in the incidence of Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemias seen over previous years. Following a thorough review of each case, a detailed recovery plan was quickly implemented to address the key issues identified.

We recognise that whilst we have made improvement in many areas, there is still much to do to keep our patients free from hospital acquired infections, which is reflected in our objectives for 2013/14.

I would like to take this opportunity to thank all the staff, whatever their role for the very important part they play. Thanks also go to Dr Richard Brindle and Jo Hamilton-Davies, Director and Deputy Director of Infection Control, who after taking up post in 2012 have played key roles during this year.

Helen Morgan
Acting Chief Nurse

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1. OVERVIEW OF PROGRESS FOR 2012/13

Our goal in 2012/13 was to ensure that patients who receive care within the organisation are assured that every effort is taken to reduce their risk of infection as well as to ensure the Trust meets statutory and national requirements related to healthcare associated infection. To achieve this we identified the following six objectives:

1. To comply with the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code)
2. To report and investigate cases and outbreaks of healthcare associated infection as mandated
3. Reduce further the incidence of infections, specifically Meticillin Resistant Staphylococcus Aureus (MRSA) and Meticillin Sensitive Staphylococcus Aureus (MSSA) blood stream infections and *Clostridium Difficile* (C. diff).
4. Develop the Infection Prevention and Control Master class Training Programme
5. To implement a programme for sharps injury prevention to meet requirements of Directive 2010/32/EU.
6. To develop a system in conjunction with Occupational Health and Human Resources (HR) for identifying members of staff who have been visiting (on annual leave/secondment) a high risk Pulmonary Tuberculosis (TB) country for more than 3 months or who have worked and lived with TB patients for more than one month

2. COMPLIANCE TO THE HYGIENE CODE

We said we would…

Have systems in place to manage and monitor the prevention and control of infection, using risk assessment to consider individual and environmental risks.

How did we do?

- We have a fully established infection control team that consists of an Infection Control doctor, seven infection control nurses, an antimicrobial pharmacist, an analyst and administrative support.
- The Director of Infection Prevention and Control leads the team and reports directly to the Chief Nurse and Medical Director.
- The Chief Nurse is the Executive Lead and chairs the Infection Control Group, which has met four times in 2012/13 and includes Governor and partner organisation representatives.
- The Trust Board has received monthly Infection Control reports within the Quality Report and a quarterly detailed report.
- The Infection Control Group has monitored all relevant risks at each meeting
- The Infection Control Group quarterly assessed compliance to the hygiene code.

Hygiene code and Care Quality Commission outcome 8 compliance.

Compliant	Minor concerns	Moderate concerns
50	2	3

We said we would...

Provide and maintain a clean and appropriate environment:

How did we do?

- Trust wide cleanliness audits continue on a monthly basis. If scores fall below 95%, audits are repeated weekly until the area returns to 95% for four consecutive weeks.
- Across all the Very High risk category areas in the Trust the average score has been 96% continuously for the past twelve months. All sites are averaging scores of 95% or above.
- Hand hygiene practice monitoring scores have achieved 97.7% against the 95% standard over the year.
- The implementation of alcohol hand gel that is effective against Norovirus has been completed.
- A new information leaflet has been developed for non-clinical staff, to inform them when to use alcohol hand gel and where alcohol hand gel needs to be sited.

We said we would...

Provide suitable and accurate information on infections to service users and their visitors.

How did we do?

- All patient and visitor Infection Prevention and Control Information leaflets have been updated as required.
- We invested in more entrance signage that provides up to date information on current ward closures.

We said we would...

Provide suitable and accurate information on infections to any person concerned with providing further support including nursing/medical care in a timely manner.

How did we do?

- Adult patients that have been discharged and have a positive Meticillin Resistant *Staphylococcus aureus* (MRSA) and positive *Clostridium difficile* result are informed by letter of their result. Their General Practitioners (GP) are also informed by letter about their patients result.
- The above system has now been implemented into the Children's hospital. Parents and carers of paediatric patients are now informed by letter regarding their infection status. The GP is also informed.

- An audit was undertaken looking at discharge summaries, to see that the infection status of patients was completed. This was to ensure that information was being shared with the nurses in the community when patients are discharged with infections.
  The ward areas and a diagnosed infection were the first factors identified. The results for each standard are as follows:

  Standard 1: All discharge summaries should include clinical information
  Of the 55 discharge summaries reviewed, 20 didn't have any clinical information recorded. Therefore, 67% (35/55) met this standard.

  Standard 2: All discharge summaries should include type of infection
  16 of the 55 discharge summaries did not have the patient information documented to indicate the presence or absence of infection. Therefore, 71% (39/55) met this standard.

  Standard 3: All discharge summaries should include specific instructions
  Of the 55 discharge summaries reviewed, 25 did not have specific instructions included regarding, further treatment or screening if this was required. Therefore, 55% (30/55) met this standard.

- The Trust recognises that there is more work to do to ensure compliance with electronic discharge summaries and there will be a focus on this. The audit will be repeated during 2013/14.

We said we would...

Ensure that people who have or develop an infection are identified promptly and receive appropriate treatment and care:

How did we do?

- An assessment for risk of infection is carried out for all patients when they are admitted
- We ensure the clinical teams are informed of any positive results.
- We follow up positive MRSA patients, ensuring appropriate treatment is commenced.
- Management of the cubicle tracker by the infection control team and clinical site team ensures patients are isolated appropriately.
- We screen elective and emergency patients before surgery for MRSA. Our target is 100% for elective patients and 90% for emergency patients.

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
MRSA Pre-Op Elective Screenings	100.0%	100.0%	100.0%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
MRSA Emergency Screenings	92.2%	93.8%	92.3%	93.9%	93.5%	95.3%	94.5%	94.1%	94.8%	95.4%	95.9%	95.7%

We said we would...

Ensure all staff are fully involved in the process of preventing and controlling infection

How did we do?

- All Divisions have leadership for infection control through the Heads of Nursing (for the Division of Diagnostics and Therapies it is the Divisional Director), a designated medical lead and Matrons. Divisions all have effective link nurse systems
- All Infection Prevention and Control mandatory and update training has been reviewed. All training includes staff responsibilities, for example, what action they are required to take if they are unwell or, suspect they have pulmonary Tuberculosis (TB).
- Training has been reviewed quarterly to reflect target requirements and achievements.
- The Link Practitioner system was reviewed in line with Supervisory ward sister role. Monthly link nurse meetings continue lead by the Matron from the Division.
- Monthly infection control operational meetings are held with the Matrons. Estates, facilities and Pharmacy representatives attend these meetings.

We said we would...

Provide adequate isolation facilities

How did we do?

- The isolation room on ward 54 has been upgraded to a negative pressure facility. This is the only negative pressure facility in the City at this time. This will be commissioned in July 2013.

- Isolation facilities have been planned into the new Bristol Royal Infirmary build; increasing isolation facilities from 12% to 33% these include areas with negative pressure facilities.

We said we would...

Secure adequate access to laboratory facilities

How did we do?

- Laboratory services are provided by Public Health England laboratory in line with the expected contract.
- The laboratory has implemented the new National *Clostridium difficile* testing regime from September 2012.

We said we would...

Have and adhere to policies that will prevent and control infection

How did we do?

- All Infection Prevention and Control policies have been monitored and updated with national guidelines and up to date evidence as required.
- The hand hygiene policy has been reviewed in line with NHSLA level 3 requirements.
- We have audited hand hygiene compliance monthly with a standard of 96.6% achieved at the end of year, against a target of 95%.
- The annual audit of sharps management has been completed by Daniel's, the company that supply the sharps bins to the Trust. The results are broken down into department, ward and area. Results and recommendations are fed back to the Divisions. The results can be obtained by contacting the infection control team.
- Environmental and equipment audits have been carried out by the infection control team Trust wide. Results and recommendations are fed back to each ward area. Results can be obtained from the infection control team.

We said we would...

Ensure that healthcare workers are free of and protected from exposure to infections and that all staff are suitably educated in the prevention of cross infection

How did we do?

- All staff are screened for infection when they begin work at the Trust and are offered appropriate vaccinations against infectious disease
- The Occupational Health department are introducing the eOPAS system (Occupational Health IT system) which will remind staff by letter when immunisation is required. This will go live from August 2013.
- We have worked with our occupational health service to review health screening and have introduced additional health screening for staff that spends long periods in specific countries abroad for either work of personal reasons.
- We have continued to place specific focus on providing infection control induction and update training for all staff with 88% of staff having attended within the three-year agreed timeframe, against a target of 95%.

3. STATUTORY AND NATIONAL REQUIREMENTS

We said we would...

Further reduce the incidence of infections, (specifically MRSA and MSSA blood stream infections and *Clostridium difficile.*

How did we do?

Clostridium difficile

2008/09	2009/10	2010/11	2011/12	2012/13
286	99	94	54	48

- The standard is measured by number of *Clostridium difficile* cases for patients in hospital for more than 3 days. The national reduction objective set centrally for 2012/13 was 54 cases in the year. Financial penalties are linked to the national target. The Trust achieved this target. 48 cases were recorded by the end of the year.
- The new National *Clostridium difficile* testing regime was introduced in September 2012.

MRSA Bacteraemia

Number of cases

2008/09	2009/10	2010/11	2011/12	2012/13
17	09	5	4	10

- The standard is measured by patients in hospital for more than 2 days. The target for 2012/13 was 2. This target has no financial penalties but does contribute to the Monitor compliance framework. By the end of March 2013 the Trust had 10 MRSA bacteraemias attributed to them. All cases were investigated and reported as per national requirement. The Root Cause Analysis showed that there were practice issues regarding intravascular access management and the timing of screening patients for MRSA.

A recovery plan was instigated:

- Training was developed for Doctors and Nurses for insertion and management of IV cannula. A total of 226 doctors were observed undertaking cannulation. Trainees are required to be signed off as competent by an appropriate person. This is in the form of a Directly Observed Procedure (DOP) or a Supervised Learning Event (SLE). This is an on-going process and is incorporated into the IV access coordinator role and is part of the infection control programme for 2013/14.

- Hand hygiene training was reinforced in clinical areas and extra training was undertaken by the infection control link practitioners.
- A daily checklist of patients with IV cannula was started. A 100% compliance was obtained in the ward areas.
- A post has been created in the Trust for an IV Access Co-ordinator. The post holder is now in post.

The recovery plan is on-going and is monitored through the Service Delivery Group, Infection Control Group, and Heads of Nursing and with the Chief Nurse and Medical Director.

We maintained the number of patients who were screened for MRSA at pre-operative assessment clinics at 100%

We have screened 94.3% of emergency patients for MRSA this is a 1% increase on the previous year.

MSSA Bacteraemia

The standard is measured by patients in hospital for more than 2 days. The Trust target was no more than 27 cases in the year. This target has no financial penalties and does not contribute to the Monitor compliance framework. The Trust exceeded its target and 36 cases were recorded; however this was less than the number of cases recorded in 2011/12. The actions to reduce MSSA are the same as for MRSA because both organisms are responsible for intravascular access and surgical site infections.

E. Coli

There has been no target set for E. coli bacteraemias. However we report these blood stream infections to Public Health England. This is a National requirement.

We said we would...

Report and investigate cases of healthcare associated infection and outbreaks as mandate.

How did we do?

- For some infections (e.g. chickenpox) staff or patients are infectious before they show any sign of the infection. When a staff member or patient develops such infections we look carefully at any patients or staff they have been in contact with, and may be at risk of getting the infection. In 2012/13 we did this once for chickenpox, twice for Pertusis (Whooping Cough) and once for Pulmonary Tuberculosis (TB).
- There was a raised incidence of *Pseudomonas aeruginosa* infection in babies in the Neonatal Intensive Care Unit at North Bristol Trust. In response to this a Trust wide Risk assessment was undertaken for assurance that all augmented care units within the Trust were working within the Department of Health guidelines. (Water sources and potential *Pseudomonas aeruginosa* contamination of taps and water systems. Advice for Augmented care units). The Health Protection Agency visited the Trust for assurance that the guidelines were being followed. The Trust was praised as the guidelines had

been implemented and were being adhered to. A water group has also been set up to monitor water quality throughout the Trust.

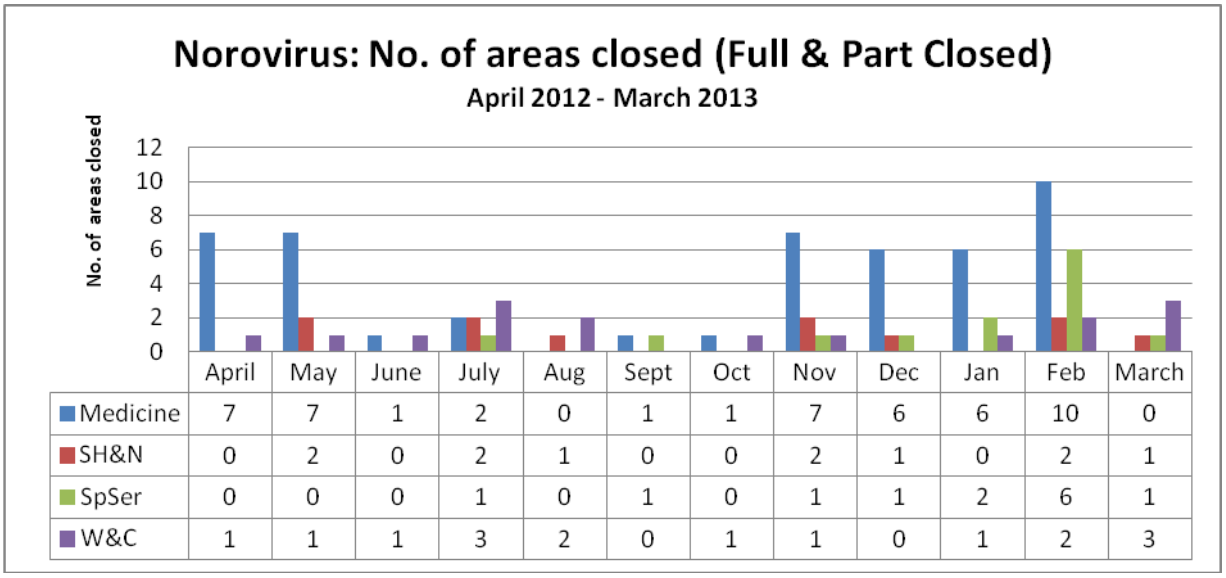
NOROVIRUS OUTBREAK ACTIVITY

April 2012 – March 2013

Between April 2012 and March 2013, 88 areas across the Trust were closed due to viral gastro-enteritis (Norovirus). In line with national guidance, closure was managed wherever possible by closing bays. Of the 88 areas closed, 30 were complete Wards and 58 involved bay closures. This shows good infection control practice by staff in the clinical areas and good management by the infection control team.

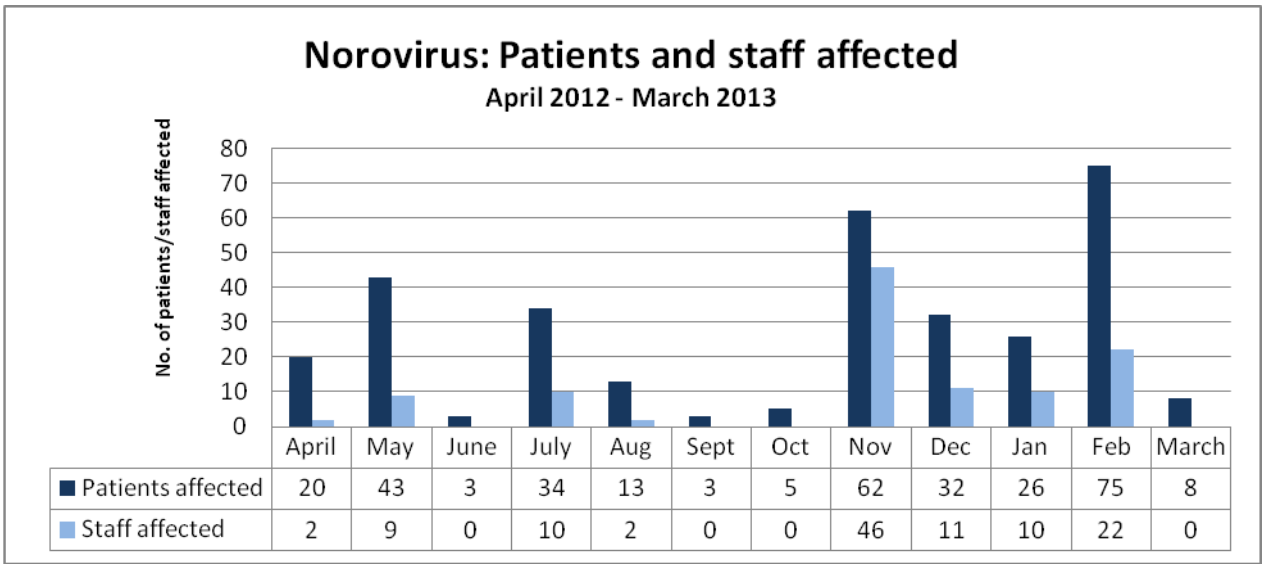
Fully closed areas were shut for 215 days and part-closed areas for 200 days; on average Wards were closed for a period of 7 days (2011/12 average was 9 days), and Bays for 3.5 days. 947 potential bed days were lost.

The table below shows a breakdown of closed areas by Division. Whilst there was increased incidence in May and November the peak was in February 2013.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Medicine	7	7	1	2	0	1	1	7	6	6	10	0
SH&N	0	2	0	2	1	0	0	2	1	0	2	1
SpSer	0	0	0	1	0	1	0	1	1	2	6	1
W&C	1	1	1	3	2	0	1	1	0	1	2	3

During this period 324 patients and 112 staff were affected. See table below.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Patients affected	20	43	3	34	13	3	5	62	32	26	75	8
Staff affected	2	9	0	10	2	0	0	46	11	10	22	0

Outbreak management followed Trust policies and included formal outbreak meetings as well as communication through standard operational meetings. Representatives from the Primary Care Trust (PCT) and Health Protection Unit (HPU) attended outbreak meetings and were kept appraised of situations.

Over the 12-month period and during the more intense outbreak period areas of good practice identified include:

- Prompt reporting of unexplained D&V by clinical staff/Clinical Site Team
- Prompt recognition of outbreaks
- Prompt Ward/Unit/Bay closures
- Ward staff were engaged and helpful in managing Norovirus effectively
- Improvement in the correct completion of monitoring paperwork and stool charts
- Prompt action by Deep Clean staff when re-opening areas and a high standard of cleaning
- Visiting restrictions were discussed at the outbreak meetings and implemented by the outbreak management group. Visiting was restricted to one hour a day.

4. DEVELOPMENTAL OBJECTIVES

We said we would...

Establish an in-house infection prevention and control master class training programme.

How did we do?

- In response to the number of MRSA and *Clostridium difficile* cases an in-house training programme was instigated focusing on these issues for all staff groups. The infection control team went to ward areas to deliver the training.

We said we would...

Implement a programme for sharps injury prevention

How did we do?

- A programme was introduced for sharps injury prevention to ensure the Trust is compliant with the EU safety devices Directive 2010/32/EU. A Trust wide group was set up to introduce the following:

European Biosafety Network – Toolkit for Implementation of the European Directive on the Prevention of Sharps Injuries

The five main recommendations from the directive are the group's main focus:

1. Elimination of unnecessary usage of sharps
2. Engineering controls
3. Safe Systems of Work
4. PPE (Personal Protective Equipment)
5. Vaccination

- The most recent development is the completion of the tender for safety cannula that is to be rolled out in all areas throughout the Trust (except Paediatrics) during May 2013. There needs to be further work within paediatrics due to the sizes of cannula that are available and the ones that are required for this patient group.
- The only outstanding area that the group has identified and are focusing on is the use of insulin needles and the patient's own insulin pens. There is currently a community trial underway with one device and UH Bristol are reviewing another with Procurement and the Trust diabetic team.

5. CLEANLINESS REPORT

Cleaning Services

- The Facilities department has made continual improvements to performance and working strategy to ensure the best patient environment experience. Actions and initiatives during 2012/13 included:
  - Successful completion of the departmental and clinical area cleaning rotas in the Old building and King Edward building, which provided a more efficient and consistent level of service.
  - Completion of the transfer of Cleaning and Food Services at Bristol Royal Children's Hospital's, Bone Marrow Transplant department from clinical to facilities ownership.
  - Introduction of 8 new Hydrogen Peroxide Gas machines, which has improved efficiencies and have considerably reduced the turnaround time of the room after the use of the machines. The new machines are located in the following areas: 4 at Bristol Royal Infirmary (BRI), 2 at Bristol Children's Hospital (BCH designed as a ladybird), 1 at St Michaels Hospital/Bristol Haematology and Oncology Centre, (STM/BHOC) 1 at South Bristol Community Hospital (SBCH).
  - Cleaning Strategy document has been updated and is based on the next 2 years.
  - Trial of a new ride-on machine for cleaning the floors in the corridors within the BRI/Bristol Heart Institute (BHI), this would improve efficiencies and enhance the cleaning standards.
  - Standardised the cleaning chemicals throughout the Trust which ensured a constant approach across the Trust and provided more flexibility in the workforce.
  - Successful completion of the new Patient Led Assessment of the Care Environment (PLACE) which has replaced the Patient Environment Action Team (PEAT).
- During 2012/13, Facilities have provided a prompt response to outbreak situations, appropriate management of high level cleaning and ward decontamination programmes together with meeting a growing expectation of our patients and staff to enjoy an environment that is always clean, well-organised and cared for. There is now evidence to support more appropriate cover at all times of the day and week to support the delivery of a prompt response to cleaning services. Facilities has improved the flexibility of our workforce by being able to cover more cleaning and food service shifts, by utilising our in-house relief team, this provides a more consistent level of service, and minimises our reliance on agency staff. The Patient Environment Operational group oversees the standards and protocol development and implementation and senior facilities representatives attend relevant infection control strategic and operational meetings.
- As set out in the NHS Cleaning Manual guidance cleaning schedules and frequencies are agreed and publicly displayed in each area. Regular audits of cleanliness are undertaken by facilities management and supervisory staff which are reported to the Ward Managers and Matrons with remedial actions agreed where needed.
- A programme of induction and on-going training is in place for Hotel Services Assistants (HAS's) with all new staff completing a programme of competencies.
- The facilities team continue to support infection prevention and control with deep cleans of bedspaces, cubicles, rooms and whole ward areas. This cleaning is in addition to regular cleaning and is carried out in response to individual cases of infection as well as outbreaks. The number of deep cleans performed in 2012/13 totalled 4,245 an increase of 1% from the previous year. During 2012/13 the deep clean team have used Hydrogen Peroxide Vapour machines for disinfection of an area 311 times, averaging up to 6 usages per week this is almost identical to usage during 11/12.

- Independent cleanliness monitoring audits are carried out around the Trust and a summary report tracks the scores achieved throughout the year. Ward areas of the Trust are audited on a monthly basis with weekly audits taking place in areas where patients are more vulnerable to infection, such as intensive care units. A green rating is applied when audit scores are 95% or over. When individual scores fall below 88% a remedial action plan is completed by the Hotel Services Management Team. During 20012/13 (April to March) the average cleanliness score across all risk categories (very high, high, significant and low) for the Trust was 95%, achieving an average score of 96% for very high and 95% for high risk category areas across the Trust.
- The 2013 a new programme of Patient Led Assessments of the Care Environment were completed. The assessments included clinical facilities and estates representatives whilst being led by patient representatives including governors, volunteers, trust members or local voluntary group representatives from Healthwatch and the Youth Council. Detailed action plans arising from the assessments have been disseminated to Heads of Nursing, Estates and Facilities for review and action. The master Action Plan for PLACE will be presented to Trust Service Delivery Group. A progress report in relation actions will be monitored and reported on by divisional leads with an update report submitted by Facilities to Service delivery group in December. For actions requiring funding a prioritisation process will be completed chaired by the Chief Nurse and this will feed into the master Action Plan.

  The format of results for the formal PLACE assessments has yet to be agreed at a national level however should be made available to Trusts by the autumn 2013.
- During 2013/14 in line with the Trust cleaning strategy we plan to build further on the improvements made in the standard of cleanliness achieved Trust wide. We will do this by:
  - Currently trialling 2 new mop systems on ward 17 and ward 53, which involve using the latest microfiber technology.
  - Review the market in identifying the best monitoring system for adenosine triphosphate (ATP). This is a method to assess the cleanliness of environmental surfaces in real time, and the system detects the presence of organism residue in addition to microorganisms which have been left on surfaces after cleaning.
  - To trial and implement an electronic cleanliness monitoring system using hand held devices for quicker inputting and downloading of data.
  - Reviewing the finishing times for the HSAs at BHI, with a proposal to bring the finishing times in line with the rest of BRI without affecting the current levels of cleaning and food service.
  - Review the HSA rotas in the Queens building to identify any more efficient ways of working.
  - To introduce Trust wide a programme of periodic mini PLACE assessments to include Ward/Department, Infection Control, Facilities/Estates personnel to ensure a continuous programme of monitoring and review.

UH Bristol Cleaning Audit Scores

RESULTS		2012										2013		
Risk Category	Area	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
VERY HIGH														
Areas include: Theatres, Intensive Care Units (Adult & Children), Emergency Departments, Oncology Wards etc.	B.R.I	96	97	97	97	97	97	97	98	97	96	97	97	96
	B.R.C.H	94	94	97	96	96	95	94	96	97	96	96	96	96
	S.M.H	96	96	96	96	96	95	96	94	95	93	93	96	96
	B.H.O.C	97	97	97	97	97	96	98	97	96	97	97	97	96
	B.E.H	97	97	97	95	98	96	95	96	97	97	98	97	96
	S.B.C.H				93	96	99	98	97	98	98	96	97	97
	Total Average	96	96	97	96	96	97	96	97	97	96	96	96	96
HIGH														
Areas include: All ward areas not covered above, Clinics X-ray Depts, etc. Sterile Services, Pharmacy etc	B.R.I	92	92	92	92	94	93	94	94	94	94	94	94	93
	B.R.C.H	96	97	97	96	96	96	92	92	94	96	93	96	93
	S.M.H	96	98	97	98	97	96	95	95	94	93	94	96	96
	B.H.O.C	98	97	92	95	95	96	95	96	96	97	96	97	96
	B.D.H	96	96	96	93	96	95	95	95	96	96	95	97	95
	B.E.H	97	97	97	97	96	96	97	97	97	98	97	98	96
	C.H.C	97	98	97	94	91	97	93	95	95	95	95	94	96
	S.B.C.H				93	94	95	96	96	96	96	95	97	95
	Total Average	96	96	95	95	95	96	95	95	95	95	95	96	95
SIGNIFICANT														
Areas include:- All Hospital Entrances, Levels and Stairwells, Public Toilets, Receptions Physiotherapy Departments,	B.R.I	92	89	90	93	92	93	92	94	90	92	95	91	88
	B.R.C.H	98		94	97	93	98	91	96	88	93	88	89	83
	S.M.H	99	98	97	97	98	96	96	98	96	97	93	98	98
	B.H.O.C			86		84	84		92	90		95		84
	B.D.H		93	92	96	96	95		94	95		95	96	92
	B.E.H					95	98	97	97	97	96	95	96	96
	C.H.C					100		96	88		87	96	100	91
	S.B.C.H				97	99		97	98		97	99	94	96
	Total Average	95	93	92	96	95	94	95	95	93	94	94	95	91
LOW														
Areas include:- Offices, Medical Records, Stores areas etc.	B.R.I			89		84				96				
	B.R.C.H													
	S.M.H		100	99	94	96		96						
	B.H.O.C						87							
	B.D.H						86		88					
	B.E.H					84	88							
	C.H.C		95		94	94	95							
	S.B.C.H				97	92					100	93		96
	Total Average		98	94	95	90	89	96	88	96	100	93		96
	TRUST SCORE	96	96	95	95	94	94	95	95	95	95	95	96	95

KEY	
	From 95% to 100%
	From 80% to 94%
	Under 80%

6. ANTIBIOTIC PRESCRIBING REPORT

Antibiotic lead structures

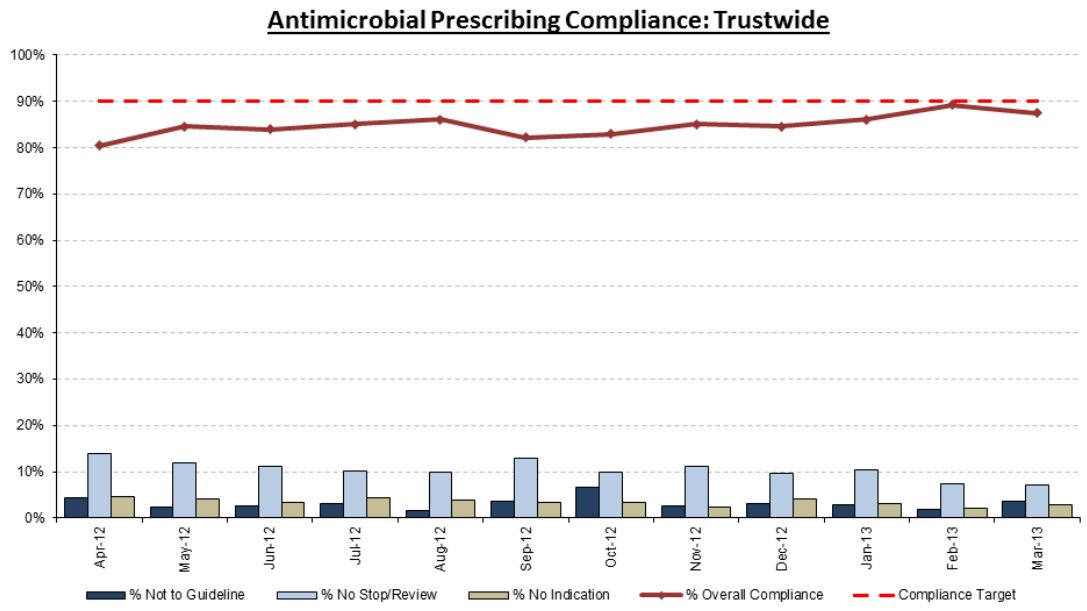
The Trust Anti-infective Committee has continued to meet under the leadership of Dr Sean O'Kelly with representatives from each division, microbiology and pharmacy. The Committee is responsible for the antibiotic stewardship within UHBristol, insuring policies and procedures are in place, reviewed as required and implemented in practice.

Antibiotic ward reviews

Antibiotic ward reviews continue across the trust. During the year there has been an increase in joint reviews with microbiology and pharmacy – 20 wards per week; with all other wards (excluding the Intensive Therapy Units) reviewed fortnightly by a pharmacist. On a weekly basis, Divisions receive a summary report of compliance by ward and monthly by specialist teams. .

The tables below summarise the Trustwide results.

Antibiotic prescribing compliance Trustwide 2012/13



The compliance with the antibiotic prescribing care bundle continued to rise during the year reaching 89% in February, just below the 90% target.

Work continues to ensure the 90% target is reached in 2013/14.

Antibiotic guidelines

A continued review of antibiotic guidelines has been undertaken, with all areas covered by a guideline or having a guideline under production.

7. DECONTAMINATION REPORT

The structures for assurance and management of decontamination were reviewed once again in the last 12 months and are as follows:

- Executive Manager/Lead – Chief Nurse (Helen Morgan).
- Decontamination Lead – Deputy Divisional Director, Head & Neck (Sarah Nadin).
- Designated Person CSSD & Trust Decontamination Manager – Head of Sterile Services (Annette Giles).
- Microbiologist Sterilizers – Consultant Microbiologist (Dr Richard Brindle).
- Senior Operational Manager – General Manager, Estates (Nigel Phillips).
- Authorised Person (Decontamination) – Estates Decontamination Officer (Clive Jenkins).
- Authorising Engineer (Decontamination) – Bob Kingston (External contracted service to provide independent assurance).
- Control of Infection Officer – (Deputy DIPC) Joanna Hamilton-Davies.

The strengthened governance and accountability structures monitor key performance indicators for all aspects of decontamination monthly, including Sterile Services. Investment in replacing and upgrading decontamination equipment across the Trust continues with new Reverse Osmosis plants in Bristol Royal Infirmary, Bristol Heart Institute, Bristol Children's and South Bristol Community Hospital.

Periodic testing continues to be provided by an external contractor (Audere) and now encompasses ALL on-site decontamination equipment – testing remains on schedule and thus means we are compliant. Community Dental Decontamination equipment is maintained and validated by a different external company (Eschmann) following a review of service and cost.

The Trust Estates Decontamination Engineers continue to provide an excellent responsive, day-to-day maintenance and repair service in addition to water sampling, problem solving and the weekly sanitisation of equipment.

The Authorising Engineer (Decontamination) annual inspection audit was carried out in April 2013. Like last year the report once again highlighted that a considerable amount of the Decontamination equipment for the Trust is or has approached the end of its economic life and that plans should be made for replacement in the near future. Capital monies have been secured in this financial year to replace equipment in Sterile Services Kingsdown and Queen's Day Unit.

Trust Wide Decontamination Service

Decontamination of medical devices occurs Trust wide every day by numerous teams of staff trained to clean and decontaminate equipment per manufacturer's and national guidelines. There are over 60 items of decontamination equipment on site that are used regularly by staff and maintained by the Estates Decontamination Engineering Team.

Challenges that face all the teams include acceptable water quality, machine reliability, medical device availability, service, maintenance and validation schedules and breakdowns.

During the last 12 months the Trust has commissioned 4 new Reverse Osmosis (RO) plants, installed two new Automated Endoscopic Reprocessors (AER) at SBCH and replaced an RO tank for Sterile Services.

A decontamination room for Radiology on Level E of St Michael's Hospital has been commissioned for use by Radiology and capital monies have been secured for a dedicated decontamination on Level C of St Michael's for use by Gynaecology.

Capital monies have also been secured for Sterile Service Department refurbishment, BRCH Theatres decontamination room up-grade, and QDU decontamination room/equipment up-grade.

A new steriliser has been purchased by University of Bristol for use in their labs in Bristol Dental Hospital following decommissioning of one earlier in the year.

Overall the water quality supplied to our machines has been within acceptable limits and there has been minimum service disruption due to high Total Viable Counts.

Up time of decontamination machinery availability has remained steady during the last 12 months due in part to the excellent maintenance and repair service provided by the Decontamination Engineering Team and also due to improved response times from the external companies we have service contracts with.

Ward 37 (renal) had to re-locate twice last autumn – firstly due to refurbishment of the ward and installation of a new RO plant and secondly due to further building works being required as part of the CSP works.

Key Performance Indicators for endoscopy and sterile services are monitored on a monthly basis and no major concerns about either service have been raised in the past year.

Future plans

Plans for 2013-14 are focused on building upon the improvements previously made to all aspects of decontamination across the Trust, continuing to invest in equipment and practice, and strengthening the management structures for decontamination. Specifically we will continue to:

- Review, update and finalise decontamination related Policies and Standard Operating Procedures in line with national guidance and legislation.
- Procure and manage decontamination equipment in line with best practice standards/guidance.
- Ensure that all decontamination carried out locally meets best practice standards and guidance.
- Monitor effectiveness and efficiency of all Trust wide decontamination equipment.
- Apply for capital monies in order to replace aging items of equipment.

Decontamination Programme 2013-14

Action	Lead	Target Date	Progress Report
Review of Decontamination Policy – including incorporating the Dental Decontamination Policy in order that there is one Trust wide.	Annette Giles	September 2013	
Up-grading of endoscopy decontamination room in Bristol Children's Theatres	Jim Sherlock	End of October 2013	Plans drawn up and agreed, contractors to be appointed, orders to be placed, works to commence
Implementation and completion of 1st phase of CSSD refurbishment programme	Annette Giles and CSSD team	End of March 2014	Plans being drawn up, equipment specifications being written
Up-grading of endoscopy facilities in Queen's Day Unit, Bristol Royal Infirmary	Annette Giles and QDU team	End of December 2013	Plans being drawn up, equipment specifications being written
Installation of RO plant and AER in new theatres of the new ward block	Annette Giles and Redevelopment Team	End of April 2014	Plans agreed, equipment specifications being drawn up, orders being placed.
Installation of decontamination facility on level C of SMH for gynae	Annette Giles	End of October 2013	Plans being drawn up, contractors being appointed
Purchase of automated reprocessing machines for use by radiology staff for the decontamination of ultrasound probes	Tina Stoyles	Autumn 2013	Paper to be presented to July's Decontamination Board meeting requesting sign off against proposed plans and product of choice.

8. MATRON REPORT

Quality in care tool

During the last year the Matrons infection control focus has been aimed at working alongside the Senior Nurse for Quality to input into the new quality in care tool and to ensure that the other metrics are being adhered to within the divisions. Particular focus has been upon the peripheral cannula daily audits which have seen an increased vigilance by staff in adhering to the new policies.

Innovation/activity linked to patient improvement.

The introduction of routine screening for MSSA for both elective and emergency patients in Specialised Services ensures all patients identified are treated appropriately either before or on admission.

Facilities issues

Matrons are working closely with facilities to team to ensure that cleaning score remain at acceptable levels, ensuring the 95% standard is maintained. There have been no major issues highlighted during 2012/13. The curtain supply is back to normal following a temporary issue with supply. There have been improved turnaround times for deep cleans with the introduction of new hydrogen peroxide machines.

Estates issues

With the high levels of building work around the Trust the matrons are working closely with the infection control, facilities and estates teams to minimise the amount of dust that is entering the buildings. This has included talking to estates teams, reminding workman to cover shoes before entering and requesting additional cleans when required. Response to priority issues remains good. The Estates forum that meets every two weeks is proving popular with the divisions in ensuring progress with works can be followed.

Patient Environment Operational Group

With the change in external visits from PEAT to PLACE this year matrons have been working with the Patient Environment Operational Group to ensure that the wards are ready for the forthcoming short notice inspections. The previous PEAT money that was allocated to Divisions has been used to prioritise any outstanding works.

Ward refurbishment activity

The work continues at a pace and Matrons continue to be involved at the essential stages of building.

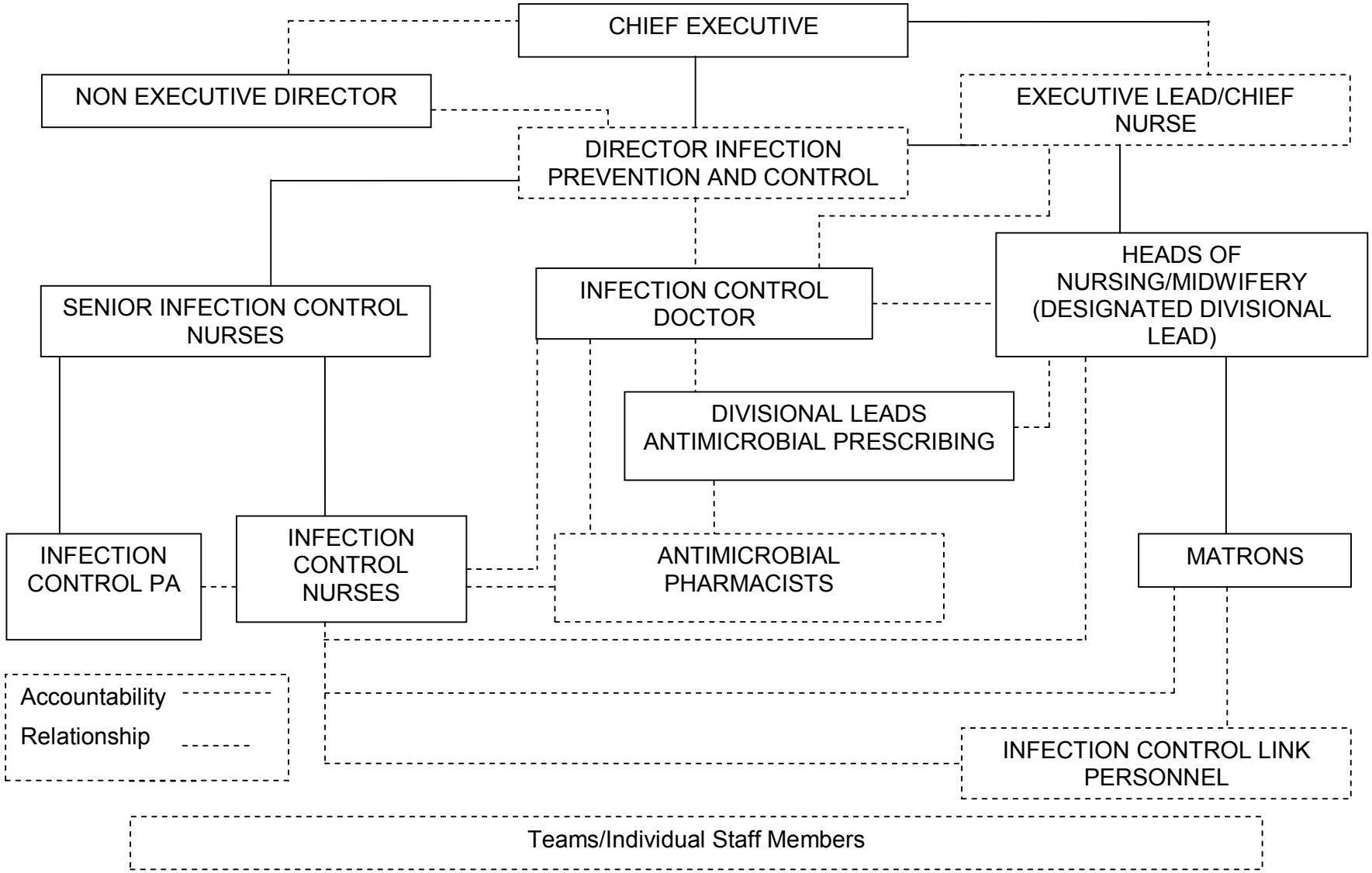
9. NEXT STEPS

Our goal in 2013/14 remains to ensure that patients who receive care within the organisation are assured that every effort is taken to reduce their risk of infection as well as to ensure the Trust meets statutory and national requirements related to healthcare associated infection. To achieve this we have identified the following five objectives:

1. We will comply with the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code).
2. We will report and investigate cases and outbreaks of healthcare associated infection as mandated.
3. We will reduce further the incidence of infections (specifically MRSA and MSSA blood stream infections and *Clostridium difficile*).
4. Develop a Surgical Site Infection programme.
5. Register interest in applying for Government funding to implement an IT system for Surgical Site Infection working with North Bristol NHS Trust.

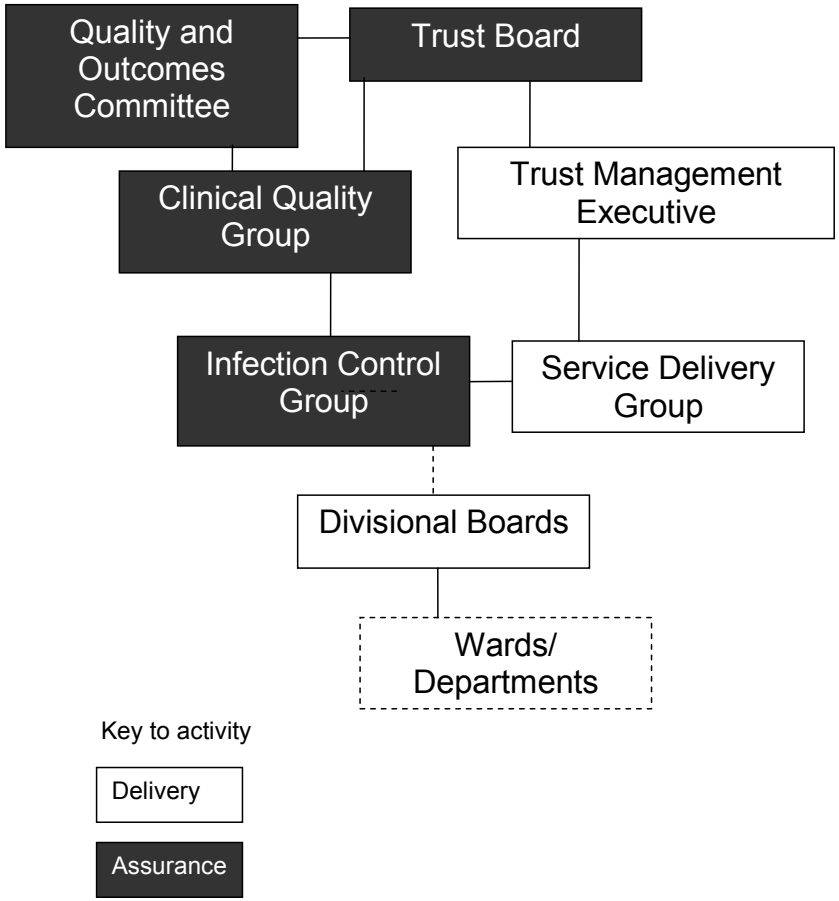
APPENDIX A

Infection Control Organogram



APPENDIX B

Infection Prevention and Control Reporting/Governance Structures



- The Chief Nurse is the Executive Lead and chairs the Infection Control Group, which has met four times in 2012/13 and includes Governor and partner organisation representatives.
- The Trust Board has received infection control reports within the quality report monthly and a detailed report quarterly.
- The Infection Control Group has monitored all relevant risks at each meeting and has assessed compliance to the hygiene code quarterly at each Infection Control Group meeting.