Trust name: Whittington Hospital NHS Trust

MRSA/Cleaner Hospitals Team : Achieving a 50% reduction of bacteraemias by March 2008

Date: 26th November 2007

Number	Issue/Findings	Situation before change (current situation)	Situation after change (way forward)	Action	Date of Implementation	List of individuals and departments involved in this change	Owner/Reviewer	Date of review	Evaluation/measures of success
1	**DIPC Role**	The DIPC did not communicate clearly the role and responsibilities required to effectively undertake the leadership role and recognised the need for additional administrative support	The DIPC role will be clearly defined and understood across the organisation with the relevant support structures in place	a. Review the DIPC role and job description and identify any additional support and guidance required to undertake the role effectively, including key objectives for the role. b. Review the administrative and analyst support required and take steps to address any unmet needs. c. Implement a communication strategy across the Trust as part of the existing infection control communication programme, outlining the responsibilities unique to the role of the DIPC. d. Appoint to the new Infection control matron post	**December-07**	**ICT, DIPC, DON, Directorate and ward leads**	**CEO**	**Jan-08**	DIPC in place with revised job descriptions and objectives for the coming 12 months Increased admin and analyst support to the DIPC evidence of trust-wide communication of DIPC role - staff demonstrate awareness Infection control matron appointed
2	**Audit Programme**	There is currently no annual audit plan/work schedule for infection control across the Trust incorporating all the relevant infection control and related practices	An audit programme will be developed and audit findings will be displayed and communicated to all staff	a. The IC and Governance teams to agree a robust audit programme which incorporates all the key infection control/related policies, High Impact Interventions, antibiotics policy etc. The regularity of the audits to be according to the hotspot areas and previous history of poor compliance. b. Audit findings must be communicated to clinical staff with action plans with timescales in order to gain ownership and commitment.	**December-07**	**IC team, CEAD, Directorate leads, Link practitioner, Matrons, all clinically based staff**	**DIPC**	**Jan 2008 March 08**	Audit programme will be in place and agreed, with prioritisation of HII audits Clear plan for clinical staff to produce action plans in response to audit findings March 2008 - evidence of completed audits and actions in place in response to findings
3	**Root Cause Analysis:**	Root cause analysis is currently undertaken but is not as robust as future requirements dictate.	RCA undertaken by the clinical teams supported by infection control, using a robust tool e.g. NPSA RCA tool. Actions are SMART after each case and actions are evidenced as closed within one month of the incident occurring. CDI cases have a RCA and actions to prevent reoccurrences.	a. root cause analysis (RCA) for all MRSA bacteraemias to be commenced within 24 hours of diagnosis. b. RCA to be undertaken by an individual within the relevant division who has the time, skills and status to investigate, action and follow up all cases, supported and challenged by the infection control team/DIPC and risk management team. c. RCA actions plans in place within 5 days of the incident and actions are followed through and evidenced as closed. d. monthly reports on RCA findings are disseminated to all wards and consultants, and reviewed at HMB and ICC e. Consider using RCA for CDI cases to understand issues and action plan to resolve.	**November-07**	**Asst Director of Nursing (Risk) Directorates, IC team**	**DIPC**	**Dec 08 and monthly**	RCA for every bacteraemia undertaken by clinical teams with infection control input using a robust tool within 24 hours of diagnosis actions plans SMART and within 5 days, actions evidenced as closed using audit such as HII. all wards aware of key findings from RCA across the hospital CDI cases have RCA and action plans
4	**Cleaning Schedule**	There was no evidence that the Matron Charter had been effectively embedded or implemented within some clinical areas. Previous audits of cleanliness had not been audited against the national standards. There was no clear schedule of cleaning in place and evidence of soiled equipment and clinical areas	Cleaning schedules will be in place and evidence that Matron's Charter has been embedded in all clinical areas. Evidence of complaince with minimum cleaning standards	a. Monthly audits using the national standard 49-point checklist to be undertaken in all areas by the Visible leadership team. b. All areas scoring less than 80% to be required to produce an action plan to rectify situation. c. Introduction of the Matron Charter in all clinical areas and monitoring of its effectiveness. d. Housekeeping to implement database to monitor response to all ad hoc calls. e. Ward based cleaning frequencies and schedules ratified at the September ICC and EFHG. To be rolled out in December following introduction of new national colour coding scheme. f. review management of domestics and give ward managers responsibliity for staff in their areas.	**November-08**	**matrons, Head of Nursing, facilities staff, ward managers**	**Director of Nursing**	**Jan-08**	evidence of monthly cleaning audits, with all areas achieving 80% implementation of the Matron's Charter is evident
5	**Training and appraisal**	Training needs analysis needed for ward managers. Need to train ward-based clinical leaders to address poor practice and hold staff to account through robust performance management	Evidence of consistent strong clinical leadership across the trust	a. All ward managers to be appraised by end of January 2008. b. Visible leadership programme to continue to focus on infection control. c. All ward link IC nurses to complete Middlesex University study programme and associated portfolio by December 2008. d. Monitor training provided to domestic staff and keep robust records - record on ESR when live in April 2008. e. monitor take-up of infection control training for all staff, and deal with non-attendance	**January-08**	**ward managers, matrons, IC link nurses, Asst Director of Education**	**Head of Nursing**	**Jan 2008 April 2008**	eKSF tool shows all ward managers appraised All ward IC nurses have registered for MU programme by March 2008 Minimum of 80% of staff have attended IC training in last 12 months by March 2008, with 90% by July 2008
6	**Information and data management**	information analysts should work more closely with ICT to carry out more detailed analysis of HCAI data, and support MESS data inputting. Performance data and information be provided for each board meeting, showing progress against trajectory, including three and 12 month rolling figures	Clear and accurate IC data is reported to all agencies and the Board	a. Appoint a full time information analyst to support ICT, including MESS data input. b. MRSA bacteraemia and C. diff rates are already reported to every Trust Board, Hospital Management Board and Infection Control Committee meetings - will be adjusted to include 3 and 12 month rolling totals, in addition to progress against trajectory. c. produce weekly tracking reports for MRSA and C.diff - monitor through Executive Team. d. produce weekly data by ward and specialty and share with managers and consultants. e. ICNet is technically implemented; complete verification of results daily to confirm transfer is comprehensive and accurate	**November 2008 - board reports March 2008 - analyst**	**IC team, IM&T, pathology**	**Head of IM&T**	**January 2008 April 2008**	data analyst in post by March 2008 revised reports taken to all committees - evidence from meeting papers competed implementation of ICNet

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7	**Communication**	A simple and consistent message needs to be communicated across the trust and its effectiveness monitored. Staff need to be able to identify key personnel with whom to discuss infection control concerns. Staff need to be aware of HCAI targets and show commitment to achieving them	Staff are clear about their responsibility for infection control. Staff attitude surveys will show increased scores in this area.	a. IC to be the focus of Chief Executive's briefing in November 2007, and Chief Executive's article in "The Link" in December. b. "Top 10 Tips" to be produced for all staff, outlining key responsibilities for infection control. Issue as pocket size cards to attach to ID badges & include details of ICT and how to contact. Distribute with January payslips. c. Use computer desktops to display a key message on IC each month, from December onwards	**Dec-07**	**IC team, Communications, IM&T**	**DIPC**	**Jan-08**	distribution of CEO briefing and article IC tips cards out with January payslips - sufficient stock to issue to all new starters desktop messages in place
8	**PCT involvement**	Build on the work with GPs to ensure the whole health economy is involved in lowering HCAI rates. Strengthen collaborative working on pre-48 hour bacteraemia RCAs with the PCT		a. Agreement with PCT on collaborative work to be taken through Primary Care Interface Group and reviewed in SLA monitoring meetings. b. Formal alert process already in place for pre-48 hour bacteraemia	**Jan-08**	**GPs, PCT,**	**Director of Primary Care**	**Mar-08**	Clear programme of work in place with PCT - incorporated into action plan once agreed evidence of reduction in pre-48 hour bacteraemia
9	**Surveillance**	provide a baseline report on compliance with the screening programme, and introduce ongoing monitoring, with timely feedback to departments	100% compliance with the surveillance policy	a. audit the current MRSA elective pre-admission screening programme - action plan to be put in place if less than 100% b. introduce screening for emergency admissions from December 2007, with full implementation by February 2008	**Feb-08**	**IC team, pathology, bed managers, ED, pre-admission team**	**DIPC**	**Feb-08**	evidence of full compliance with the MRSA elective screening policy screening of emergency admissions fully implemented by February 2008
10	**management of intravenous lines**	weekly monitoring of the iv lines tool needed, with individuals who are non-compliant performance managed	100% compliance with the IV lines policy	a. ward managers to complete weekly monitoring audits for their areas, with evidence of action taken for non-compliance. B. Visible leadership team will do a benchmarking audit of the tool on 17.12.07, for comparison	**Dec-08**	**ward managers, matrons**	**Director of Nursing**	**Jan-08**	evidence of 95% compliance with the peripheral cannula care plan and clinical policy
11	**hand hygiene**	Increase hand hygiene audits to weekly, and enlist other staff to take part. Give timely feedback and develop league tables. Increase the frequency of training for areas identified as hot spots	all areas will have 95% compliance	a. Visible leadership team to continue to undertake monthly audits as a benchmark. b. Ward managers and consultants to be asked to identify a rota of staff for weekly audits in their areas. c. Clinical audit team to produce league tables by ward and specialty	**Jan-08**	**ward managers, consultants, clinical audit team, matrons**	**Director of Nursing**	**Dec 08 and monthly**	evidence of 95% compliance with the policy in all clinical areas. Results displayed in all areas, showing performance against the 95% benchmark, and presented toi medical committee and ward managers committee Action taken against staff who persistently fail to comply
12	**Bed management and isolation of patients**	the electronic bed management system is not yet in all areas of the hospital. The trust needs to establish the number of beds needed for effective isolation/cohorting facilities. Incident reports are not completed when an HCAI patient is not isolated	Bedweb will be used in all wards. Patients with priority for isolation will be identified and the trust will have a plan for providing the optimum number of isolation facitlites.	a. Bedweb is curerntly live on 6 out of 22 wards, and will be rolled out into all wards by the end of December. b. Lewisham Isolation Priority System (LIPS) to be introduced in December, to support decisions about isolation of patients. c. Ward managers to complete incident forms when HCAI patient cannot be isolated. d. Scoping exercise on the number of isolation rooms required to be undertaken and a plan agreed for providing the optimum number of rooms. e. Monthly report on number of patients not placed in isolation rooms f. clear guidance in place on cohorting of patients, based on the LIPS score	**Dec-07**	**ward managers, bed management team, ICT, facilities**	**DIPC**	**Jan-08**	Bedweb fully implemented isolation of patients based on LIPS scores - reported to HMB and ICC monthly reports on appropriate isolation of patients to HMB and ICC

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13	**Antibiotic management**	Breaches in the antibiotic policy are tolerated. Monitoring of compliance with the policy is not adequate	95% compliance with the antibiotic policy	a. remove restricted antibiotics from ward stock. b. Enforce seven day stops on antibiotics, and transfer from iv to oral after 3 days. Agree local policies for specific areas, eg oncology. c. Audit areas of high impact for compliance - community acquired pneumonia and antimicrobial prohylaxis	**Jan-08**	**antimicrobial pharmacist, doctors, ward staff, pharmacists,**	**Consultant microbiologist**	**Jan 2008 March 2008**	evidence of compliance with trust antimicrobial policy reduction in expenditure on restricted antibiotics (proxy indicator for amounts presribed)
14	**environment**	There is no robust monitoring programme in place based on the national standards. Not all national policies about cleaning have been implemented. Equipment and furniture need to be monitored regularly	all national standards will be adhered to, with evidence of compliance in all areas	a. Business case to Business Planning Group for staffing of equipment library - aim to be operational by March 2008. b. Equipment checks carried out as part of Visible Leadership programme; ward managers to put daily checks of commodes in place. c. Observational audit of soap dispensers to be completed by December 2007 - all problems to be recitified by Jan 2008. d. protocols for cleaning beds to be reviewd and reinforced - discharge protocols to be reviewed by infection control committee. e. All staff lockers to be relocated out of clinical areas	**Mar-08**	**ward managers, facilities staff**	**Director of Facilities**	**Jan-08**	equipment library functioning by March 2008 audits demonstrate that all patient equipement is clean clear protocol in place for cleaning beds - evidenced through ward cleaning audit scores no staff lockers in clinical areas