Appendix 3

The Whittington Hospital NHS
NHS Trust

Director of Infection Prevention and Control

Annual Report 2010/11

Dr Julie Andrews, Consultant Microbiologist and Director of Infection Prevention and Control

(1st April 2010 – 31st March 2011)

1.0 Executive Summary and Overview

1.1 Organisation

The Whittington Hospital NHS Trust takes the prevention and control of all infection seriously. It is a key corporate objective to deliver clean, safe care to all patients. Infection prevention and control is everyone's' business, regardless of discipline or grade.

1.2 Activities

The activities of the Infection Prevention and Control team (IPCT) and the wider community have continued to focus on further reductions in incidence of healthcare associated infections (HCAI), in particular MRSA bacteraemia, *Clostridium difficile* diarrhoea, diarrhoea/vomiting outbreaks and surgical site infections. Ensuring that all our staff have the necessary knowledge and skills to achieve this reduction in HCAI incidence has also been an ongoing activity.

The trust has been below trajectory for MRSA bacteraemia episodes since 1st July 2009 so no additional support from the Department of Health's (DoH) MRSA Improvement Support Team (IST) has been required.

Since the arrival of the novel Influenza strain H1:N1 (swine flu) in the UK in April 2009, the IPCT have continued to be key members of the Swine flu co-ordinating committee. The remit of this committee has been to ensure the organisation has a robust crisis management plan to deal with possible rising patient numbers.

In collaboration with the Microbiology team, the IPCT review ward patients with infection related problems Monday-Saturday. An on call Infection prevention service is available 24 hours a day 7 days a week through a joint Microbiology Speciality Registrar and Consultant rota. Outpatients and community patients are discussed with relevant healthcare workers directly or via telephone or email. Rapid diagnosis of infection, prudent antimicrobial prescribing and reduction in transmission of infection are the main focus of management.

1.3 Infection Prevention and Control (IPC) Action Plan

The 2010/11 IPC annual plan is outlined in Appendix A. The IPC plan focuses on continued zero tolerance to MRSA bacteraemia, enhanced clinical ownership, practical skills training and introduction of a ward based Infection prevention and control performance scheme presented as an IPC dashboard.

Progress of the actions contained within the plan has been monitored more closely over the year by the development of a small IPC implementation group consisting of the Director of Infection prevention and control (DIPC) and three senior nurses. This year each action area had a named lead from the senior nursing, medical or management team and an IPC team member to act as support to ensure deliverability in a timely manner.

Every MRSA bacteraemia and other significant HCAI events were reviewed using Root cause analysis (RCA) methodology and the HCAI RCA ongoing action plan was reviewed at regular intervals in conjunction with the annual IPC plan.

2.0 Infection Prevention and Control Arrangements

2.1 Infection Prevention and Control Team

At the Whittington Hospital the IPC agenda is led by the DIPC, who reports to the Trust Board quarterly. The Medical Director and Director of nursing also have key roles in ensuring that high standards of clinical care are delivered to patients, and they support the DIPC in her role.

The IPCT is directly managed by the DIPC, and during 2010–11 comprised of a Matron, two specialist nurses, one antimicrobial pharmacist, a surveillance co-ordinator and a full time support officer. The IPCT also works closely with the Microbiology team, all clinical teams, facilities staff, bed management team, practice development team and Health and Work centre.

A team of ward based link practitioners, who receive additional training in infection prevention and control and liase with the IPCT, also support ward and clinic staff.

During 2007, the previous Director of Nursing established the Visible Leadership team (VLT). The team includes Matrons and Assistant Directors of nursing, who work on the wards in uniform every Monday. A major focus for this team is education of staff and auditing practice around infection control guidance, including hand hygiene, peripheral cannula care, urinary catheter care, environment cleaning standards and isolation practice. The VLT work in collaboration with the IPCT to ensure Saving lives audits are covered regularly and findings are fedback. The current Director of Nursing has boosted the membership of this group and encouraged ward managers and other staff to take a more active part in Saving lives audits in collaboration with their Matrons.

In May 2010 the DIPC Dr Julie Andrews was a finalist in the British Medical Association Group awards in the "Clinical leadership" category. From November 2010 the DIPC has been on maternity leave and the post has been covered on a day-to-day basis by the IPC matron Patricia Folan and strategically by Bronagh Scott, Director of Nursing. The DIPC will return to her role on a part time basis in September 2011.

2.2 Infection Control Committee

The Infection Control Committee is currently chaired by the Director of Nursing and meets bi-monthly. During 2010/11 it reported to the Clinical Governance Committee, which received regular updates on progress against the infection control targets and monitors progress with both the IPC action plan and the HCAI RCA action plan.

Membership of the ICC includes key directors, directorate representatives, the IPCT, Microbiology team, Health Protection Agency representative, an Occupational Health Consultant and an Islington PCT representative.

2.3 Reporting Line to the Trust Board

The ICC reported directly to the Trust Board until the end of 2007, when a review of the Trust Board structures was undertaken. The current reporting line of the ICC is below:

Trust Board
↓
Audit Committee
↓
Clinical Governance Committee
↓
Infection Control Committee

The DIPC reports directly to the Trust Board via a quarterly report.

2.4 Links to Drugs and Therapeutics Committee

During the period of this report the Drugs & Therapeutics committee (DTC) and ICC both report to the CGC, which is co-chaired by the Medical Director and the Director of nursing & clinical development. Continuity is assured as the DIPC and head of pharmacy are both members of the CGC and provide regular updates from their areas.

An antimicrobial steering group (ASG), chaired by the DIPC, was set in April 2009 and meets quarterly. The ASG reviews antimicrobial policies, expenditure and audits and plans further work as required. All directorates are represented and a pharmacist from Islington PCT attends. The ASG reports directly both to the DTC and ICC.

2.5 Links to Risk Management

The IPCT have a close working relationship with the risk management team, which is headed by the Assistant Director of nursing (risk management). The ADN is also a member of the CGC and is the RCA HCAI lead for the Trust.

3.0 DIPC reporting to Trust Board

The trust's performance against the targets for MRSA bacteraemia and *Clostridium difficile* and MRSA screening are reported to the Trust Board every month, as part of the trust's performance dashboard report.

The DIPC also provides detailed quarterly infection control updates to Trust Board that are presented by the Director of nursing. The report includes as standard the trust's performance for the previous month against the national targets for MRSA bacteraemia and *Clostridium difficile*, work being planned and undertaken to improve performance, including root cause analysis reports, and results of the IPC audits.

Where applicable, reports are also provided on any infection outbreaks and from external visits and resultant actions planned, for example following the visits from Healthcare commission inspections.

All Trust Board decisions are recorded in the minutes and then taken to CGC and ICC for further action.

4.0 Budget allocation for Infection Prevention and control activities

4.1 Staff

The DIPC is a Consultant Microbiologist, who has one programmed activity designated for this role.

The infection prevention and control team had the following staff in 2010/11:
1 wte matron (band 8a) appointed in February 2008
1 wte antimicrobial pharmacist (band 8a)
2 wte specialist infection control nurses (band 7)
1 wte surveillance co-ordinator (band 5, new post from January 2009)
1 wte support officer (band 4, new full time post from April 2009)

The allocated budget for infection control in 2010/11 was £289,253 pay and £2145 non-pay. This excludes the salary of the DIPC whose role is funded from within the microbiology budget. There was a limited allocated training component (£50) for the 6 non-medical members of the IPCT within the annual IC budget.

4.2 Support

The IPCT have support from a designated analyst within the IM&T department, who produces their weekly monitoring graphs, and undertakes other data analysis e.g. MRSA screening audits as requested. The weekly monitoring IC flash report from 31st March 2011 is shown as appendix B.

4.3 Training

The trust does not have a separate budget for consumables and other overheads required to deliver infection prevention and control training to all staff.

5.0 IPC training

The IPCT provides an extensive range of training as part of their role, both through individual IC practitioner study days and as part of the trust's regular induction and mandatory refresher training days. An additional programme of mandatory training for non-clinical staff commenced in September 2009 and sessions are delivered by the IPCT.

Training is also provided for junior doctors by the DIPC through their regular education programmes, with a focus on prescribing antimicrobials, managing

common infection scenarios and infection prevention. A practical procedures course was introduced for the Foundation year one Doctors focusing on aseptic technique for basic procedures such as insertion of peripheral cannulae, blood cultures and urinary catheterisation.

The antimicrobial pharmacist and DIPC provide training support for ward pharmacists and pharmacy students. The DIPC delivers departmental IPC training to individual departments 1-2 times a month and gives IPC updates to the full Consultant body formally twice a year.

Training and competency assessment on the care and insertion of urinary catheters was delivered to over 800 members of staff in May 2010 based on Trust policy. The training was delivered by the IPCT in collaboration with the practice development nurses and the Urology clinical nurse specialist. The IPCT were nominated for and shortlisted as finalists for the National Patient Safety Awards 2011 in recognition of this innovative work.

6.0 HCAI rates and other IPC surveillance

6.1 Results of Mandatory HCAI Reporting

- **MRSA Bacteraemia**: For the period April 1st 2010 until 31st March 2011 there were 2 trust attributable MRSA bacteraemia episodes against an agreed target of 4. They were fully investigated using RCA process with wide sharing of learning. Each RCA and actions identified were kept as an ongoing HCAI RCA action plan discussed at CGC and ICC. There has been a marked improvement from performance in 2009/10 and 2008/9 when there were 8 and 23 episodes respectively. There were 3 PCT attributable MRSA bacteraemia episodes within the 2010/11 period investigated by the relevant primary care Trusts.

- **GRE Bacteraemia:** The trust reported 1 case of glycopeptide resistant enterococci (GRE) bacteraemia in the period 2010/11.

- ***Clostridium difficile*:** From 1st April 2010 until March 31st 2011 the trust reported 37 cases of trust attributable *C. difficile* diarrhoea against an Islington PCT set target of 79.

  There has been a 25% reduction in the total number of cases of *C. difficile* between 2009/10 and 2010/11. . Each post 48-hour case was reviewed and action for improvements rapidly dealt with. The *C. difficile* objective for 2011/12 is 34.

  From April 2010 it became compulsory to report and complete full NHS London STEIS investigations into *C. difficile* related deaths (part 1a/b). During 2010/11 2 patients died with *C. difficile* recorded in part 1a of their death certificate and full investigations were completed and actions raised added to the HCAI action plan.

- **Orthopaedic Surgical Site Infections**: In the three reporting periods up to 31st December 2010 the Trust entered surgical site infection surveillance

data for hip replacements, knee replacements and surgical repair of fractured neck of femur. The hip replacement infection rate at the Whittington was 3.8% (3 out of 78 operations) compared to the national benchmark of 1.7%. The knee replacement infection rate was 1.0% (1 out of 96) against the national benchmark of 2.7%. For patients having hip hemiarthroplasties and dynamic hip screws for fractured neck of femur the infection rate was 4.3% (5 out of 117) against a national benchmark of 2.0%.

In order to ascertain whether there were any avoidable causes for the recorded higher infection rates in patients undergoing emergency and elective hip procedures the Medical Director set up a joint working group headed by the Clinical Director of Surgery with representation from the Orthopaedic surgeons, nursing staff and IPCT.

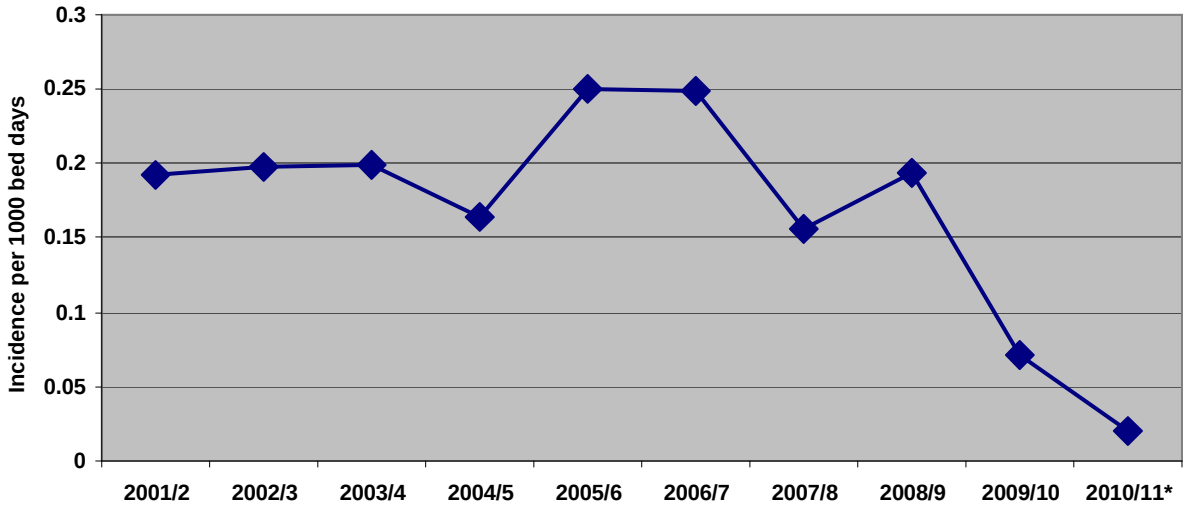
6.2 Trends in HCAI Statistics

A summary of the monthly performance in the management of MRSA bacteraemia and *Clostridium difficile* is attached as IPC flash report, Appendix B. The trust takes its responsibilities for reducing HCAI very seriously; these figures are monitored weekly by Executive committee and reported to Trust board.

The following charts show the trends in HCAI rates from year to year since mandatory surveillance commenced.

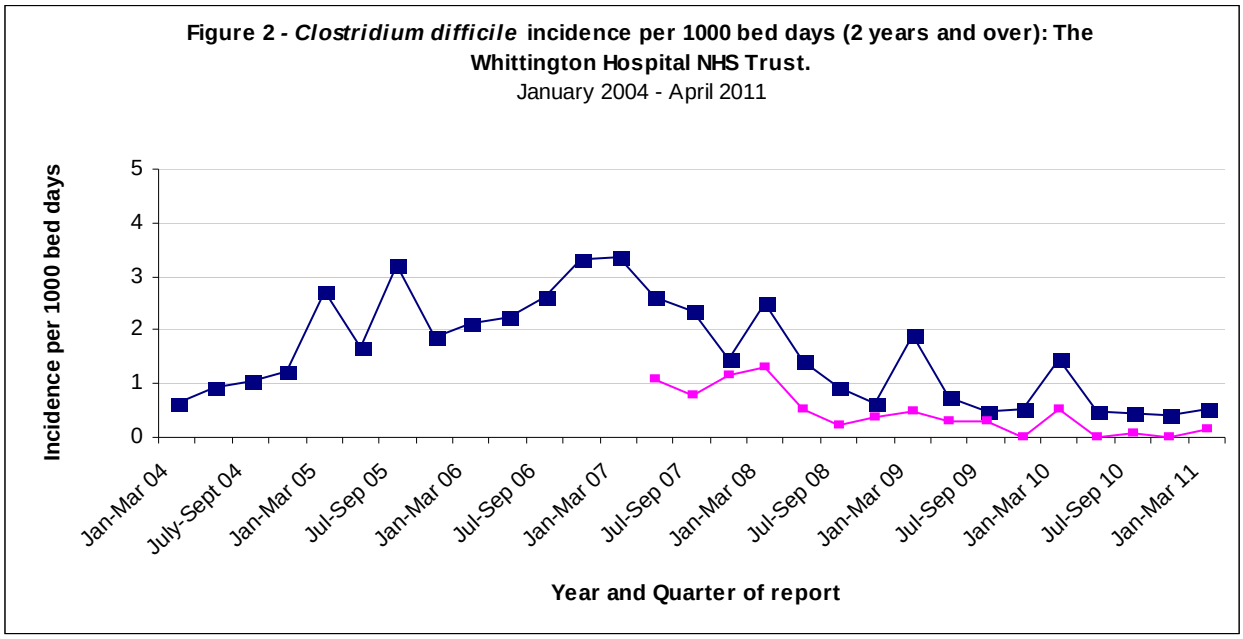
Figure 1 - MRSA bacteraemia episodes per 1000 bed days at the Whittington NHS trust

*2010/11 trust attibutable data only



Source: Health Protection Agency

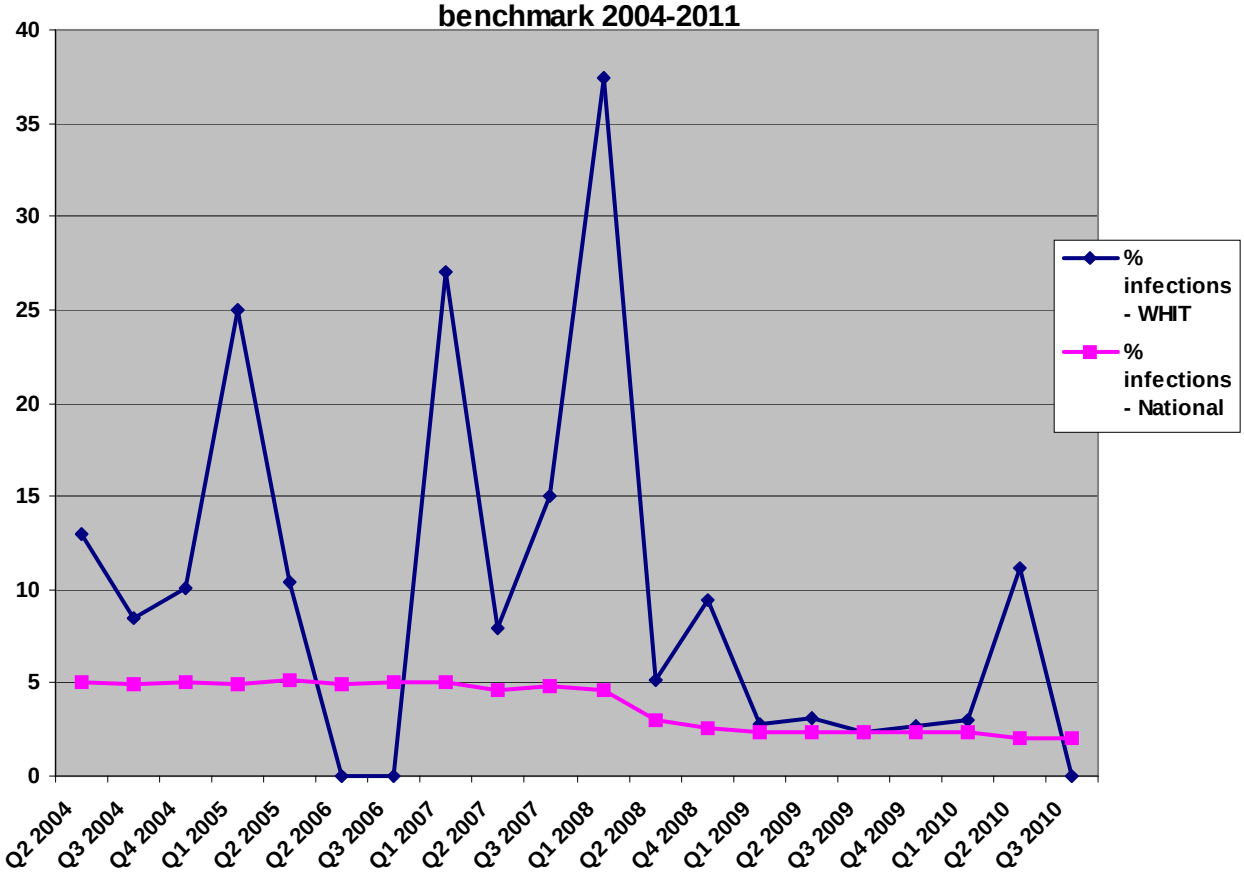
As shown in Figure 1, MRSA bacteraemia rates per 1000 bed days reached a peak in 2005/6; in 2010/11 the rates were the lowest recorded since mandatory reporting started in 2001/2.
The Trust has been below trajectory for MRSA bacteraemia since 1st July 2009.



Source: Health Protection Agency

Incidence of *Clostridium difficile* cases in patients aged 65 years and over (shown in the blue lines) peaked in late 2006/early 2007 as shown in Figure 2. Recently we have seen a return to incidence per 1000 bed days figures last seen in 2004 when mandatory surveillance commenced. The pink line shows the incidence of *C. difficile* cases seen in 2-64 year olds; this data collection became mandatory from April 2007. The incidence of cases in this younger age group has also significantly decreased recently.

Figure 3 - Percentage of Hemiarthoplasty (and DHS from Q2 2008) surgical site infections at the Whittington compared to National benchmark 2004-2011



The infection rates in patients undergoing hemiarthoplasty or dynamic hip screw procedures for neck of femur fractures as shown in Figure 3 have been above national benchmark figures during Q2 2010/11 and the IPCT have been working in collaboration with the Orthopaedic department to ensure this is urgently addressed. An orthopaedic surgeon represents the surgical directorate at the ICC and reports regularly on progress.

New guidelines and teaching around them for all orthopaedic medical, nursing and theatre staff were introduced in 2009 based on National Institute of Clinical Excellence (NICE) guidance for reducing the risks of surgical site infection. This work is being regularly audited and recent infection rates since Quarter 1 2009 have been more encouraging. Figure 3 shows the infection rates at the Whittington in Q1-4 2009/10 and Q1 2010/11 at the national benchmark figure for the first time since Q3 2006. This area will be a continued area of focus for the IPCT in collaboration with the orthopaedic department in future years.

6.3 Other surveillance work

The trust invested in the IPCT to fund a fulltime surveillance co-ordinator in 2008/9. The IPCT have been able to expand the number of surveillance schemes that the Trust contributes to. In quarter 3 2010/11 the IPCT and General Surgical department carried out surgical site infection surveillance for colorectal and vascular procedures. The infection in colorectal surgery was 7.2% compared to the national

benchmark of 10.5%. The infection rate in vascular surgery was 0% against national benchmark of 4.4%.

Universal MRSA screening for all emergency adult admissions was introduced on 1st January 2009. Audits have shown that between 92-98% of patients were screened within 48 hours of their admission. Universal screening of all elective surgical and haematology-oncology patients was introduced on 1st April 2009. Compliance with this screening has been more difficult to introduce in the Trust but latest figures March 2011 showed a compliance rate of 97%.

6.4 Serious Untoward Incidents, including Outbreaks

There were no SUI panel inquiries related directly to clinical Infection prevention and control in the period 2010/11. An SUI related to a decontamination issue is discussed in section 8.4.

Investigations were carried out and reported through the NHS London incident reporting scheme on two patients who died from *C. difficile* diarrhoea. The findings from these were incorporated within the HCAI action plan.

There were 5 outbreaks of diarrhoea and/or vomiting in the period 2010/11 that were associated with ward closures. Most of the outbreaks occurred on medical wards and were rapidly dealt with through the implementation of an outbreak management group.

6.5 Healthcare worker exposure to blood borne virus

The number of needlestick and bloodsplash injuries (potentially exposing staff to blood borne viruses such as HIV and Hepatitis C) reported to Health and work centre was 11 and 70 respectively in 2010/11. There has been a significant reduction in the number of needlestick injuries from a high of 104 in 2004/5.

The trust moved to safety products, in 2009 for peripheral line cannulation following recommendations by the Code of practice (Health Act 2006). Procurement is involved in a tripartite tendering project for other needle free access devices but the tendering process has been greatly delayed. It is important that all safety products are introduced rapidly into the Trust. Sharps refresher training forms part of all induction and mandatory refresher sessions.

7.0 Hand Hygiene and aseptic technique protocols

During the last 5 years, the trust made a concerted effort to ensure that hand hygiene was a high priority across the trust. The trust had previously signed up to the National Patient Safety Agency's Cleanyourhands campaign. This campaign was disbanded in April 2010 but the lessons learnt from it have been incorporated into Trust policy and practice. Locally designed posters have been used to maintain hand hygiene as a high profile topic.

The trust rolled out mandatory hand hygiene refresher training for every employee in 2009. The success of this programme resulted in a decision to provide this yearly as part of clinical and non-clinical staff mandatory training.

Compliance is monitored through monthly hand hygiene audits across all clinical areas. The results have shown consistent improvements since their introduction with most clinical areas having hand hygiene compliance scores over 95%. The results are presented monthly as part of a ward IPC performance dashboard, see Appendix C.

With regard to aseptic protocols, the trust agreed to follow the guidance set out in the Saving Lives High Impact Interventions. This includes the management of central venous catheters, peripheral cannulae, renal dialysis catheters, urinary catheters and tracheosotomies, and the prevention of surgical site infection and *Clostridium difficile*. Up to date evidence based guidelines for all these areas are found on the Clinical guidelines section of the intranet. Compliance with these guidelines forms part of the ward IPC dashboard. Compliance has improved steadily since the introduction of the Saving lives and is now at a high level. For example, 100% of staff carried out all 8 steps of the central line insertion bundle and 97% of staff carried out all 7 steps of the peripheral line care bundle when audited in 2010.

Saving lives audits undertaken are also presented at ICC, CGC as well as to relevant user groups and departmental meetings.

8.0 Decontamination

8.1 Arrangements

The Director of Estates & Facilities is responsible for decontamination at board level. The Trust Decontamination Advisor, who is also the designated lead manager for decontamination, supports him. The Director of Estates & Facilities is a member of the infection control committee. The trust's decontamination arrangements are in line with the duties of the Hygiene Code, and are supported by a number of policies, which are available on the hospital's intranet.

8.2 Committee Activities

The trust's decontamination committee meets quarterly. The committee agenda is arranged to ensure that over a 12-month cycle all aspects of decontamination governance and operational performance monitoring and are reviewed. Each meeting covers of the following;

- Performance Indicators; dashboard, incident reporting
- Compliance Framework; equipment validation and process audits
- Exception Reports; progress update on incident action plans
- Training report
- Policy updates

8.3 Audit

Audits are carried out and reported to committee at every meeting. The following audits are carried out, and results reported to the decontamination committee;

- Endoscope Processing Unit (EPU)
- Equipment Decontamination Unit (EDU)

- Mop Washing Room
- Mattress Decontamination Room
- Pathology Autoclave Room

Matters arising are identified and tracked through subsequent meetings.

8.4 Incidents or Failures Investigated

The 12 months to March 2011 marked the first full year that the decontamination of reusable surgical instruments was carried out at an offsite facility run by IHSS. This first 12 months were not without difficulty. There were a number of process failures that had an impact upon trust business. Failures ranged from breach of the sterile field due to poor quality wrap through to severe contamination of instruments. The impact of these ranged from the need to use more than one pack to carry out a procedure through to the cancellation of operations.

Recording and reporting of these incidents was not always carried out in accordance with trust policy. There was certainly underreporting in the first 10 months of the reporting period (April 2010 to March 2011).

At the end of March 2011 a total of 53 incidents had been recorded for the year 2010/11 (up 31 on the previous year). Of these, 15 were rated as 'low risk' (up 5 on the previous year), 35 were rated as 'medium risk' (up 28 on the previous year), and 3 were as 'high risk' (down 2 on the previous year). There was considerable under reporting of incidents in the summer and autumn of 2010 due to theatre staff being unfamiliar with the Datix system; this was overcome by additional training towards the end of 2010. The perceived level of risk has also changed over the period from Feb 2010. Incidents prior to this date were rare and labelled as high risk. As they began to occur with frequency the perceived level of risk fell as staff became more familiar with the reporting system and there was greater understanding of risks. Four operations were cancelled in the year as a direct result of service failure. There were however many alternative procedures performed to avoid cancellation.

For each of the incidents reported, an incident form was completed and an investigation carried out by the theatre matron, with support from the trust Decontamination Advisor as appropriate. The committee monitors progress with any action plan arising until all actions are complete.

During the latter part of the year three significant operational incidents were reported. One became the subject of an SUI, and two required investigation and an action plan to address the issues raised.

Trust response to MHRA advice on sigmoidoscopes: During the year, the trust received and advice from the MHRA regarding potential difficulties in following manufacturers instructions for the decontamination of the sigmoidoscopes. On review, it was found that non-disposable sigmoidoscopes could not be decontaminated following manufacturers instructions. Further, elements that were intended to be disposable within the sigmoidoscope were being reused. The level of risk arising from this was deemed to be low, however an action plan was developed with the aim of introducing more robust measures to deal with the matter of decontamination. In addition a fully disposable sigmoidoscope was sourced and introduced as a trial to the trust. The matter remains ongoing at the end of March, and is due for review at the next decontamination committee meeting scheduled for

July.

Failure of the offsite service provider to decontaminate reusable surgical instruments; In March of 2011 a Gamma Tray Nailer was returned to the trust by IHSS as decontaminated and ready to use. During the operation it was discovered that the instrument was heavily contaminated with biological debris. With no suitable alternative available and with the patient already anaesthetised the operation proceeded after the surgical team carried out improvised decontamination procedure. This decision was taken on a fully risk assessed basis. The matter was declared as a serious untoward incident and a full investigation and STEISS report completed and submitted to the SHA. An action plan was developed arising from the root cause analysis. During the course of the investigation, it became apparent that certain instruments used by the trust were difficult to decontaminate, even following manufacturers instructions. Where instruments were so identified, the matter was reported to the MHRA for further investigation. Where there was no clear solution, disposable items were introduced. Talks with instrument manufacturers have commenced to address this problem in a more pro-active manner The majority of recommendations were implemented before the end of March, however this action plan remains ongoing and it is due for review at the next decontamination committee meeting scheduled for July.

Endoscope washer rinse water failure: In March 2011 rinse water testing, carried out as part of routine operational procedures for the endoscope washers, recorded elevated counts of colony forming units (CFUs) which exceeded limits identified in the operating procedures. This happened in all three machines simultaneously. The processing facility was closed whilst sanitation of the machines and the pipework leading to the machines was carried out. This caused some operational difficulties and business continuity issues. An investigation was carried out, and an action plan developed to reduce the risk of this happening in future. This action plan has largely been completed and is due for review at the next decontamination committee meeting scheduled for July.

8.5 A review of the priorities for 2010/11

- To complete the transfer of the decontamination of reusable surgical instruments to an off site service provider
- Increase the capacity of the EPU by 50%
- To audit ward based staff to establish competence to decontaminate medical equipment in situ and between patient use
- Introduce a new design of commode suitable for use in the EDU

Decontamination of reusable surgical instruments: The transfer of decontamination of reusable surgical instruments to an offsite provider has not been without difficulty. Over the course of 12 months problems that were identified with the process at the outset remained unresolved as the service approached its anniversary in February 2011.

From the trust's point of view, it failed to adapt to the new service provision. The recording of service failures on the trust's Datix system was not completed rigorously meaning that the opportunity to escalate low-level failures was lost, even though these were being dealt with through the contract project agreement.

The incident of the Gamma Tray Nailer bought matters to a head and the trust spent some time and resources in dealing with this matter with IHSS. Service delivery has improved, but remains under constant review

Increase the capacity of the EPU by 50%: When the new endoscope processing unit was opened in September 2010 it was understood that due to the increasing workload, and the increased complexity of the washers, additional capacity would be required to ensure that sufficient scopes could be processed to meet the needs of the day treatment centre. During the year, a new sink, scope washer and storage cabinet were installed in the endoscope-processing unit, commissioned and validated.

Audit of ward based staff: The trust spends a considerable amount of money on high tech equipment and services to decontaminate complex medical devices. However, at the other end of the scale there was recognition that local decontamination at the point of use of medical equipment had not been assessed on a formal basis by the trust.

In recognition of this, the Trust Decontamination Advisor developed a programme and undertook a regular series of ward based observational audits inspecting medical equipment and observing how staff on the wards decontaminated these devices between patient use.

Approximately 6 months of audits were carried out, and the results bought to the decontamination committee. Early indications were that ward staff were not always diligent in their approach to the decontamination of medical equipment, but that the constructive nature of the audits was leading to an improvement in standards

Introduction of a new design of commodes: A regular feature of feedback from the visible leadership team ward audits was the poor condition of ward commodes. It was regularly identified that commodes could not be cleaned because they were in a poor condition, and their design precluded effective cleaning even when processed through the equipment washer.

The Infection Control Committee resolved that all of these older style commodes would be withdrawn from service and replaced with a modern design developed as part of the NHS "Design Bugs Out" programme.

55 commodes were purchased and introduced to wards during the course of the year. Access to order codes for the old style commodes were withdrawn from Eros.

8.6 Priorities for 2011/12

- Integration of the community and acute decontamination processes
- Stabilisation of the in health contract for the decontamination of reusable surgical instruments such that the level of reported failures reduces to levels achieved by the trust service in the 12 months preceding relocation offsite.

9.0 Audit

9.1 Extent of Audit Programme

Audit of infection prevention control practice is conducted as part of the trust's main clinical audit programme, as part of the IPCT work and by the VLT, as follows: -

- Infection Prevention and Control Team
    - Saving Lives audits
    - Surgical site infection surveillance scheme
    - Compliance with antimicrobial policies
    - MRSA screening and interventions

- Visible leadership Team
    - Hand hygiene
    - Environmental cleanliness including commodes
    - Compliance with isolation and personal protective equipment policies

All results are presented immediately at ward level as part of the IPC dashboard, see Appendix C. Wards were awarded prizes in July 2010 for best performance (Montuschi), most improved (Meyrick) and best feedback of results (Coyle).

9.2 Reasons for audit focus

The reason for carrying out all the above audits was to help the trust to reduce the incidence of MRSA bacteraemia, *Clostridium difficile*, surgical site infections and other HCAI. Audits help to raise awareness, measure performance and enable focused actions to be taken to improve.

As the same principles of best practice apply whatever the infection type, by raising performance in these two key areas, performance should improve the prevention and control of all infections.

10.0 Report from the Antimicrobial Pharmacist

The antimicrobial audit programme is divided into core and targeted audits.

The core programme comprised of quarterly targeted ward audits by the DIPC and antimicrobial pharmacist. Each ward was audited quarterly and results of the audit fedback to the respective ward or team in the form of a balanced scorecard. Wards were able to benchmark their prescribing practices against Trust average and identify improvement strategies.

The targeted programme focuses mainly on priority areas including NPSA reports, antimicrobial surgical prophylaxis and specific treatment guidelines. The programme depends largely on the continued support and contribution from clinical teams and pharmacy.

Results of the core audit for 2010/11 showed that trust targets were achieved in regards to the appropriateness of IV administration, choice of therapy and use of restricted antimicrobials. However, documentations were reported to be below the trust target; with only half of prescribed antimicrobials accompanied with a documented indication and stop/review date on the drug chart.

The antibacterial expenditure for 2010/11 was £587,000, with a £31,000 saving compared to the previous year.

The DIPC and antimicrobial pharmacist won first prize in the Trust Clinical audit awards in 2010 for the ward targeted antimicrobial audits.

11. Conclusions

The Whittington Trust has again maintained a high focus on reducing the burden of Healthcare associated infections (HCAI's) during 2010/11 despite ongoing challenges such as increased bed pressures, staff vacancies and additional IPC training commitments. There again has been a consistent and co-ordinated input from the IPCT and associated teams. The ethos of "Infection control being Everybodys' business" is more embedded within the culture of the Trust.

This success is evidenced by achievements such as being below trajectory for MRSA bacteraemia episodes within the Trust since July 2009 and a further 25% reduction in *Clostridium difficile* diarrhoea cases.

The main objective going forward in 2011/12 will be the continued zero tolerance approach to HCAI outlined in detail within the current IPC plan. There will be no room for complacency.

The area of HCAI that acceptable performance not yet been achieved is in the area of orthopaedic surgical site infections and this is and will continue to be a major priority for the Trust working closely with the Orthopaedic department. It has been a difficult year for decontamination issues within the Trust but due to hard work from the Director of Facilities and his team there are clear outlined priorities for 2011/12 and onwards.

There have been local and national successes for the IPCT team this year in leadership, audit and patient safety awards that help maintain enthusiasm and drive going forward into the new financial year.

There are a number of new mandatory HCAI statistics that require collecting in 2011/12 such as Meticillin sensitive *Staphylococcus aureus* and *Escherichia coli* bacteraemia episodes and it is likely that enhanced surgical site infection surveillance will be required.

The major challenges ahead of combining acute and community Infection control and prevention services within the current climate of financial constraints will require patience, innovation and enthusiasm. Policies, guidelines and practices will require aligning along with a rapid training programme to ensure all staff are aware of any changes. However the new Whittington Health alliance and the amalgamation of staff will potentially make the follow up of patients with infection more streamlined.