

Calderdale and Huddersfield



NHS Foundation Trust

WORKING DOCUMENT

**TRUST INFECTION PREVENTION AND
CONTROL ACTION PLAN**

**‘A strategy to reduce healthcare
associated infections’**

APRIL 2008-2009

VERSION 1

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1. Background

The reduction of Healthcare Associated Infections (HCAI) is a high priority for all parts of the NHS, the Department of Health and for the Trust. The Department of Health has produced a number of documents over the last few years as guidance to reduce HCAI: *Getting Ahead of the Curve*, *Winning Ways: working together to reduce health care associated infection in England* and *Towards Cleaner Hospitals and Lower Rates of Infection: a summary of action*. The most recent publications, *Saving Lives: a delivery programme to reduce health care associated infection including MRSA* and *Essential Steps to Safe Clean Care: reducing health care associated infection*, provide guidance on moving towards compliance with these policies, best practice and evidence based care.

There are also requirements within the Healthcare Commission *Standards for Better Health* Core Standard C4(a) that state "Health care organisations keep patients, staff and visitors safe by having systems to ensure that the risk of HCAI to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA".

Whilst these publications have given guidance on the practice of infection control it has been the Health Act 2006 that has provided the legislative basis for enforcement of high standards of infection control practice. The Health Act (2006): A Code of Practice to Prevent and Control Healthcare Associated Infections helps NHS bodies to plan and implement how they can prevent and control health care associated infections. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment and where the risk of health care associated infections is kept as low as possible. The Trust's uses the Health Code as the framework for the Annual Infection Prevention and Control Plan.

Following the visit from the Department of Health HCAI Improvement team in November 2007 a comprehensive short term action plan was developed, implemented and monitored weekly to ensure all parts of the organisation were engaged with the plan and an increase in the pace of change. This approach saw the successful implementation of the short term actions but acknowledges some actions are ongoing and a few are longer term actions. These have been carried over into this years plan.

The Trust will communicate to all members of staff, using the current communication channels including Executive Board team Brief, Trust Intranet, Divisional Communication Structures, Trust Newsletters the high priority to reduce healthcare associated infections including MRSA and C.difficile and the a zero tolerance will be given to those staff who do not comply with good infection control practice.

2. Objectives for 2008/09

- To provide assurance to patients, the public, Board of Directors, Healthcare Commission and Monitor that there are robust control measures for the prevention of healthcare associated infections.
- To ensure that the targets associated with the reduction of healthcare associated infections, including MRSA bacteraemia and Clostridium difficile infections are met.
- To ensure compliance with the Health Act (2006) is both maintained and strengthened.
- To use a zero tolerance approach to avoidable infection and non compliance with infection control policies.
- To ensure the Trust maintains compliance with the 'Standards for better health'.
- To provide a training programme to meet the needs of the healthcare staff within the organisation.

- To provide the trust with infection prevention and control guidelines and policies for best and safe practice for patient care and monitor compliance with these policies.
- To provide timely and accurate data regarding the state of healthcare associated infections and compliance with hand hygiene and infection control practices outlined in 'Saving Lives' to clinical staff and management.

3. The Key Message for all Staff

The key message for all staff will be that the MRSA target will be achieved by the compliance with practice as outlined in the priority areas (see table below) and there will be a zero tolerance approach for staff that are not compliant with the trust policies and procedures.

Priority area	Focus
1 Hand hygiene	The principal weapon in combating HCAI and in increasing patient confidence. Staff to comply with Trust policy. Hand hygiene compliance will be monitored in each clinical area. Patients and visitors to be encouraged to practice good hand hygiene
2 Cleaning	Cleaning is high profile (i.e. is <i>seen</i> to be carried out) and visibly reported (i.e. cleaning schedules are published in patient areas). Staff to report/action poor cleanliness. All areas need to be kept tidy and free from clutter for effective cleaning.
3 Challenging practice	Staff, patients and visitors are to be encouraged and empowered to challenge poor practice with regard to hand hygiene, uniform policy, clinical practice and cleaning.
4 Antibiotic prescribing	To comply with local guidelines and best practice standards. Microbiology and pharmacy colleagues to act as 'champions' and proactively support other colleagues with information, expert advice and positive feedback.
5 Indwelling devices	A major potential source of HCAI. Clinical colleagues to consider non-invasive alternatives, hygiene at entry point, and removal at earliest opportunity. Compliance with practice will be monitored in clinical areas using the 'Saving Lives' toolkit.
6 Communication	Infection Risks including MRSA, C Difficile and invasive devices must be communicated at staff handover and to other healthcare professionals when transferring patients both internally and externally.

4. Communications and Engagement Strategy – (Appendix 1)

The prevention of Healthcare Associated Infections (HCAI) is a very high priority for the trust staff, patients and visitors alike. Infection prevention and control activity is supported by a communications and engagement strategy

5. Monitoring of the Action Plan

This annual action plan provides the overarching assurance framework for Infection Prevention and Control.

The reduction of HCAIs will be achieved through the existing performance management framework. This system will be reviewed to ensure that at a Divisional level HCAIs are prioritised alongside other key organisation objectives.

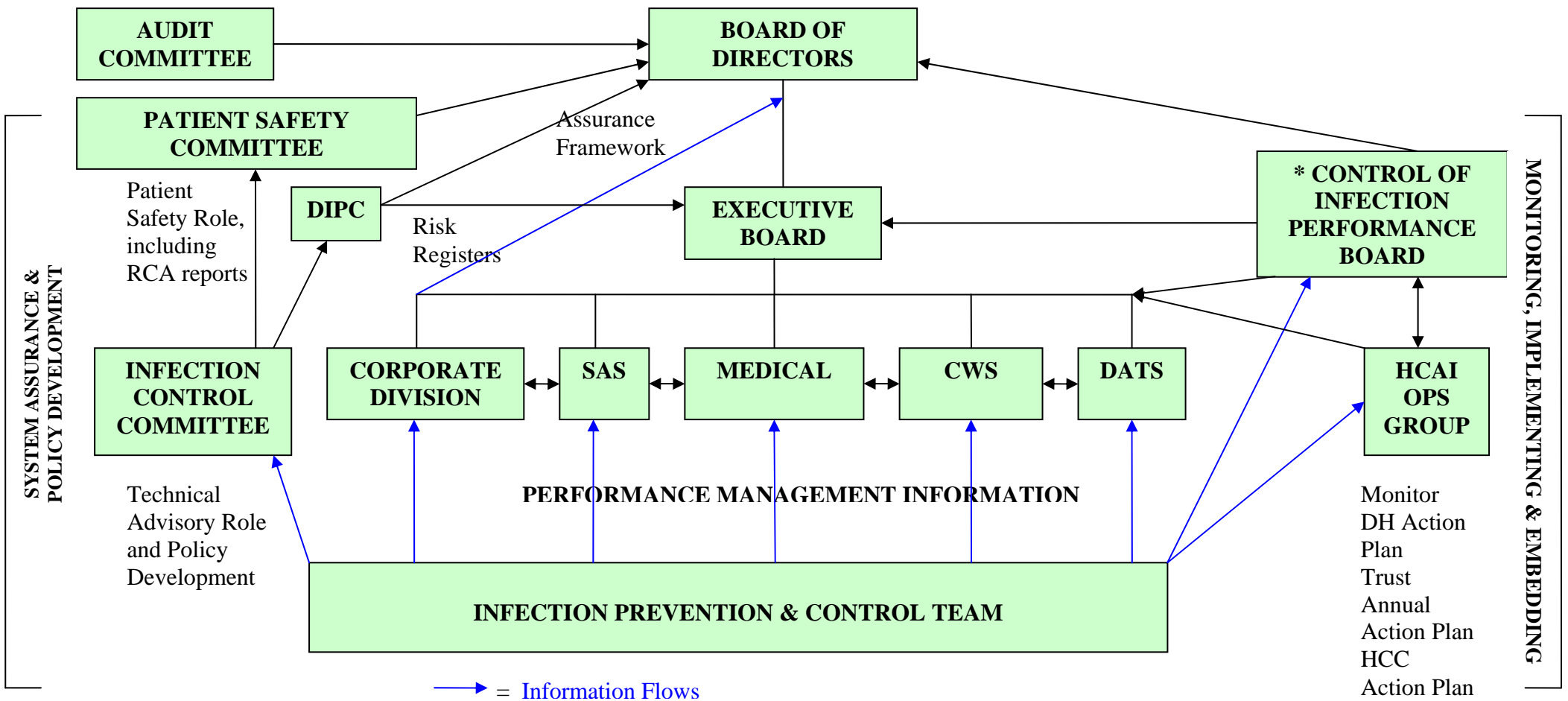
The annual action plan will be implemented and monitored by the HCAI Operational group who will meet regular, weekly initially. The HCAI Operational group will report on the progress of the action plan to the HCAI Strategy Group.

The HCAI will work alongside the Divisional Management teams to ensure the development of divisional plans that reflect the trusts strategy, and to prioritise the key actions required during 08/09. They will monitor this through their divisional performance management arrangements.

The Operational group will monitor the following

- Compliance with Saving Lives
- Compliance with Hand hygiene
- Learning from RCAs
- MRSA bacteraemias
- Clostridium difficile
- Rapid escalation
- Key actions related to the 6 key priorities

TRUST GOVERNANCE ARRANGEMENTS FOR THE PREVENTION & CONTROL OF HEALTHCARE ASSOCIATED INFECTION



The Trust treats the prevention and control of infection as a core and integral part of its day to day business. The Trust's Performance Management and Clinical Governance frameworks both have an important part to play, with additional assurance provided by the Audit Committee. The Performance Management framework is currently reinforced with the creation of the Control of Infection Performance Board which monitors, on behalf of the Board of Directors, performance against the HCAI action plans.

* Also provides assurance and information to the Health Economy Wide (HEW) Steering Group overseeing the implementation of the HEW Action Plan.

Preventing Healthcare associated Infections- Annual Plan 2008-09

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
Core Duty 2: Duty to have in place appropriate management systems for Infection Prevention and Control							
2.1	The Chief Executive will explicitly advise staff using Divisional Communication structures that there will be a zero tolerance approach to those staff who are not compliant with Trust Policies and Procedures. Developing a strong culture throughout the organisation to challenge poor practice.	CEO	Board of Directors		Implemented - Letter sent to all staff		DOH 1.5.1 HA1A
2.2	There is a designated Director of Infection Prevention and Control	CEO	CEO	Job description	Implemented	DIPC appointed in 2004	HA2b
2.3	There is a designated non executive director lead 'champion' for infection control who will provide a further link to the board		Board of Directors		Implemented		HCC Hygiene Code inspection report 08 2.8.3. DOH
2.4	Infection control is included in the Trust's assurance framework and approved by the Board of Directors	Director of Nursing	Board of Directors	Minutes of BOD and Assurance framework	Annually	Implemented and ongoing	HA2C
2.5	Personal responsibility for compliance with Infection Control policies is identified in the job descriptions of all staff	Director of Personnel & Development	Board of Directors	Random selection of 5 job descriptions and letter sent to existing staff outlining their responsibility.	June 2008	A statement regarding infection control is now included in all job descriptions.	2.6.1. DOH 7.3.2 DOH HCC Hygiene Code inspection report 08 2.8.5. DOH
2.6	Infection Control is included in individual appraisals of all clinical staff	Director of Personnel & Development	Board of Directors	Random selection of 5 appraisals of clinical staff	June 2008		2.6.1. DOH 7.3.1 DOH

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
2.7	There should be a named clinical lead for Infection Control for each clinical area/ward	Medical Director	IPC Performance Board	List of named clinical leads and a job description	August 2008		7.4.1 DOH
2.8	There will be a named senior infection control nurse for each clinical division	Director of Nursing	IPC Performance Board	List of named Senior ICNs and job descriptions	May 2008		
2.9	There is an audit programme to measure compliance with the key infection control policies <ul style="list-style-type: none"> • Hand hygiene • Standard precautions • Management of sharps • Care of invasive devices 	DIPC	Infection Control committee	Audit reports	March 2009		CNST 4.1.1 DOH
2.10	Compliance of the High Impact Interventions will be monitored monthly and where performance is poor immediate actions will be taken to rectify the problems. Information regarding compliance will be incorporated into Board of Director Reports.	Director of Nursing	IPC Performance Board				6.2.1DOH HA1A
2.11	Where clinical areas are consistently achieving 95% compliance with hand hygiene these will be used as exemplar areas and opportunities to share good practice will be utilized.	Director of Nursing	IPC Performance Board				6.2.2 DOH
2.12	Where there are deficiencies in compliance immediate action plans are developed and implemented to increase compliance to 100%	Director of Nursing	IPC Performance Board	Action plans and minutes of divisional meetings	Immediate		HA1A
2.13	There will be a divisional lead for infection control who will ensure compliance with infection control policies	Divisional Directors	IPC Performance Board	Job descriptions of divisional leads	August 2008		HA1A
2.14	There is a strong culture throughout the organisation to challenge poor practice	CEO	IPC Performance Board	Leadership walk rounds and high compliance with infection control practice including hand hygiene and Saving Lives audits	Immediate and ongoing	Immediate and ongoing	1.1.1.DOH HA1A

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
2.15	A zero tolerance approach will be adopted, areas where poor practice is identified will be performance managed to ensure improvement	CEO	HCAI Performance Board				2.6.2. DOH HA1A
2.16	The DIPC will provide regular reports to the Trust Board, at least quarterly, reporting the cases of MRSA and <i>Clostridium difficile</i> , areas of concern and progress with the Annual Plan for preventing HCAI	DIPC	Board of Directors	Minutes of the BOD and DIPC reports to the BOD	Implemented and ongoing	Implemented and ongoing	HA1B
2.17	The Trust will report all cases of MRSA and VRE bacteraemia and Clostridium difficile in the over 2 year olds using the HPA reporting system in a timely manner to ensure the CEO can 'lock down' by the 15 th of each month.	DIPC	Board of Directors	National reporting database	Implemented and ongoing		11.4.1. DOH 11.4.2 DOH
2.18	Directorate and Ward based targets for MRSA and C difficile will be established and allocated to Divisions. Reports will be made to Exec Board on a monthly basis. These will be managed using existing performance management arrangements.	DIPC	IPC Performance Board				11.1.1 DOH
2.19	Data sets are reported to wards including summary information on RCAs and rates of C.difficile, MRSA bacteraemia and MRSA acquisitions. These will continue to be returned to wards on a monthly and quarterly basis and be on display to promote ownership and behavioural changes.	DIPC	IPC Performance Board				11.1.2 DOH
2.20	Antibiotic audits are undertaken to review the use of specified antibiotics.	DIPC	IPC Performance Board				11.2.2 DOH
2.21	Rolling ward based audits of antibiotic prescribing compliance with policy will be instituted	DIPC	IPC Performance Board				11.2.3 DOH
2.22	Mandatory surgical site surveillance will be performed for a minimum of 3 months	Divisional Director for Surgery	IPC Performance Board	Surgical Site Surveillance report	December 2008		

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
2.23	Link practitioners should have 'ring fenced' time to perform the role of audit, training and feedback and to attend training workshops.	Director of Nursing	IPC Performance Board	Register of attendance at workshops	July 2008		
2.24	Work with York Trust (SPI partner) to peer review Infection Prevention and Control and antimicrobial prescribing	Medical Director	IPC Performance Board	Letter to invite	Immediate	First meeting held 2 nd May	11.4.8 DOH
2.25	New antibiotic guidelines to be distributed and communicated to GPs and Primary Care Practitioners.	DIPC	IPC Performance Board				10.1.3 DOH
2.26	Feedback of results from appropriate Trust antibiotic audits to PCTs	DIPC	IPC Performance Board				10.1.4 DOH
2.27	The communications Strategy for HCAI will be further developed to support the trusts management of HCAI	Director of OD	IPC Performance Board				
2.28	SPI and Saving lives will work in tandem	Director of Nursing	IPC Performance Board				
2.29	The trust will utilise its communication channels to communicate the message that reduction of MRSA bacteraemia is achievable	CEO	IPC Performance Board				DOH
Core Duty 3:Duty to assess risks of acquiring HCAI and to take action to reduce or control such risks							
3.1	There is a policy for the risk assessment of patients to prevent HCAI	DIPC	Infection Control Committee	Infection control bed management policy (section W) and minutes of the ICC	Implemented and ongoing	Policy reviewed Jan 2008	HA1b HA2F HA3A HA3B
3.2	Incidents where patients have been identified as an infection risk but cannot be isolated will be reported as a clinical incident	Director of Nursing	IPC Performance Board	Datix risk management reports	Implemented and ongoing		HA3B 2.7.1.DOH
3.3	Audit of compliance with the bed management policy will be carried out quarterly	Director of Nursing	IPC Performance Board	Audit report and minutes of ICC	June 2008		HA2E
3.4	The corporate risk register will include the risks of HCAI including MRSA	Director of Nursing	Board of Directors	Minutes of the BOD and corporate risk register	Implemented and ongoing		DOH2.1.1 HA3C
3.5	Divisional and departmental risk registers will be reviewed and include risks of HCAI	Divisional Directors	Risk, Assurance and Compliance Committee	Divisional Board minutes and risk registers	Implemented		DOH 2.1.1 HA3C
3.6	MRSA screening is performed in high risk areas as per policy	Director of Nursing	IPC Performance Board	Audit of compliance with screening, Divisional Board and ICC minutes	Implemented and ongoing		2.2.1.DOH

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
3.7	A proposal for MRSA screening for all admitted patients should be made through the normal business planning process	DIPC	IPC Performance Board	Business plan and minutes of the Performance and Finance Group	April 2008		2.2.2 DOH
3.8	The Surgical Division will carry out regular audit of compliance of screening.	Divisional Director for SAS	IPC Performance Board				2.2.3 DOH
3.9	Screening of medical patients will continue to be monitored on a monthly basis and results will be fed back to wards.	Divisional Director for M&E	IPC Performance Board				2.2.4. DOH
3.10	MRSA bacteraemias and other serious HCAI are reported as 'red' clinical incidents	Director of Nursing	Patient Safety Committee	Datix system reports	Implemented and ongoing		
3.11	Root Cause Analysis is performed as a formal investigation for all MRSA bacteraemias within 5 days.	Director of Nursing	Patient Safety Committee	RCA reports	Implemented and ongoing		2.3.1.DOH HA3E
3.12	Actions and Learning from the RCA is managed through Divisional Risk Committees, Divisional Boards, ICC and the Clinical Audit meetings	Director of Nursing	Patient Safety Committee	Minutes of the Divisional Risk Committees, Divisional Boards, ICC and the Clinical Audit meetings	Implemented and ongoing		2.3.4 DOH HA3E
3.13	Learning from RCAs is reported in the Learning from Experience report.	Director of Nursing	Patient Safety Committee	Learning from Experience report	Implemented and ongoing		2.3.5.DOH HA3E
3.14	Alert organism (MRSA and Clostridium difficile) data will be provided to ward managers, matrons and Divisional leads on a monthly basis.	DIPC	IPC Performance Board	Alert organism reports	Implemented and ongoing		
3.15	The trust will continue to work with the PCTs for all pre-48 hour bacteraemias cases and disseminate learning from RCAs	DIPC	IPC Performance Board				2.3.6.DOH
3.16	Analysis of the incidence of alert organisms, bacteraemias and compliance with hand hygiene and Saving Lives High Impact Interventions will be made to identify 'hot spot' areas.	DIPC	IPC Performance Board	Minutes of the Divisional Boards, EB and ICC.	April 2008		2.4.1.DOH
3.17	Action plans for 'hot spot' areas to be developed and implemented	Divisional Directors	IPC Performance Board	Action plans and minutes of the Divisional Boards, EB and ICC.	May 2008		2.4.1.DOH

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
3.18	All new cases of MRSA to be investigated.	DIPC	IPC Performance Board	Matrix of adverse events and minutes of the Divisional Infection Control groups	Implemented and ongoing		
3.19	All new cases of C.difficile investigated using enhanced surveillance form.	DIPC	IPC Performance Board	Surveillance data	Implemented and ongoing		
3.20	A risk assessment of HCAI should be performed on all patients on admission.	Director of Nursing	IPC Performance Board	A random selection of 5 patients	June 2008		
3.21	A CJD risk assessment will be performed on all patients requiring surgery and/or endoscopy	Director of Nursing	Infection Control Committee	A random selection of 5 patients	Implemented and ongoing		
3.22	Invasive devices CNS will investigate methods to reduce the risk of infection with IV devices and urinary catheters, including packs PVC insertion and keep the Director of Nursing informed of new initiatives.	DIPC	IPC Performance Board	Reports	Immediate and ongoing.		3.1.1 DOH
3.23	Invasive Devices - Audit of current practice across all clinical areas to be completed and returned to wards, DDs, Medical Director, DIPC and the Director of Nursing. Remedial action to be implemented with immediate effect	Director of Nursing	IPC Performance Board	Audit reports			3.1.2 DOH
3.24	Invasive device specialist nurses to check all areas are using VIP scores and report back to Divisional Directors. Where this is not in use, the DIPC and Medical Director and Director of Nursing must be informed.	Director of Nursing	IPC Performance Board	VIP score audits Clinical incident reports - DATIX			3.1.3 DOH
3.25	Appropriate use of Chlorhexidine 2% and alcohol with venous lines to be reinforced at IV Strategy Group for cascade to all clinical areas.	DIPC	Infection control committee	Snapshot audit			3.2.2 DOH
3.26	Prepared packs including Chlorhexidine wipes will be available for peripheral line insertion to ensure all that is required to perform the cannulation is provided. Specific trays will be used for the insertion of central venous catheterization to ensure standardization of practice.	DIPC	Infection control committee	Procurement of packs – SOP for line insertion			3.2.3 DOH

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
3.27	Clean your Hand Campaign posters will be used as the Trust standard. The Infection Control Team will audit with the Matrons the use of signage and correct as appropriate	DIPC	HCAI Performance Board	Audit results			5.1.2DOH
3.28	'Stop, Gel Go' posters to be placed at the entrance to all clinical areas.	Director of Estates and Facilities	HCAI Performance Board	Minutes of HCAI performance and operational board meetings			5.1.3 DOH
3.29	Trust will consider through business planning the placement of embossed floor signs regarding hygiene at strategic points throughout the Trust.	Director of Estates and Facilities	IPC Performance Board	Minutes of the Cleaning Strategy Forum			5.1.4DOH
Core Duty 4: Duty to provide and maintain a clean and appropriate environment for healthcare							
4.1	The Cleaning Strategy is reviewed bi-annually and approved and monitored by the BOD	Director of Estates and Facilities	Board of Directors	Cleaning Strategy and minutes of the BOD	May 2008		HA 4a HCC Hygiene Code inspection report 08 2.8.4 DOH
4.2	The cleaning standards and frequencies should be publicly available in each clinical area	Director of Estates and Facilities	Strategic Cleaning Forum	Minutes of the Cleaning Strategy Forum and cleaning schedules	July 2008		HA 4d
4.3	Review of cleaning and hygiene will include the assessment of need for an out of hours service/rapid response and annual deep cleaning and this will be managed through the normal business planning process	Director of Estates and Facilities	Strategic Cleaning Forum	Minutes of the Cleaning Strategy Forum and business plan	May 2008		4.2.2 DOH 4.4.1 DOH
4.4	Ward managers and matrons will be required to assess compliance with cleanliness standards with a sign off process of cleanliness audits	Director of Estates and Facilities	Strategic Cleaning Forum	Cleanliness audit reports	June 2008		4.2.1 DOH
4.5	Clear signage for hand hygiene will be used through out the trust	Director of Estates and Facilities	IPC Performance Board	Minutes of the Hygiene and PEAT group	May 2008		
4.6	Monthly PEAT visits are performed and reports are provided to the Divisional teams	Director of Estates and Facilities	Executive Board	PEAT reports	Implemented and ongoing	Implemented and ongoing	HA 4c 4.2.3 DOH

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
4.7	Action plans are developed with matrons where required to ensure that the patient environment meets the PEAT standards and these are monitored within the Divisions	Director of Estates and Facilities	Strategic Cleaning Forum	Action plans and minutes of divisional meetings	May 2008		4.3.1 DOH
4.8	Matrons will inspect wards on a weekly basis to ensure adequate standards of hygiene are met. Areas of concern are reported to the Director of Estates and facilities, DIPC, ADD and Director of Nursing.	Director of Nursing	Strategic Cleaning Forum	Weekly ward visit reports	April 2008	Implemented and ongoing	4.2.4 DOH
4.9	A minimum of 2 staff from each clinical area should attend the 'Masterclass training for cleaning equipment'	Director of Nursing	IPC Performance Board	Training records	March 2009	Commenced	4.3.2 DOH
4.10	Produce a simple poster for the available cleaning products and their intended use.	Director of Estates and Facilities	Strategic Cleaning Forum				4.3.3 DOH
4.11	There is a written policy for the management of laundry and linen supplies which reflects the HSG (95)18	Director of Estates and Facilities	Infection Control Committee	Written policy and EB minutes re approval	September 2008		HA 4g
4.12	There should be plans for a centralised endoscope decontamination unit on both hospital sites and the processes should be compliant with HTM 2030	Director of Estates and Facilities	IPC Performance Board	Minutes of the endoscopy project board and Capital ??	March 2008		HA 4f CNST
4.13	All staff adhere to the uniform policy and their compliance is monitored by monthly audits	Director of Nursing	IPC Strategy Board	Audit results	September 2008		HA 4g, 4h 2.6.1 DOH
4.14	Review and update the policy for the management of water related systems in line National Guidelines for preventing Legionella	Director of Estates and Facilities	Infection Control Committee	Updated policy	June 2008		
4.15	Review and update the Estates policy for Disinfection and Sterilisation	Director of Estates and Facilities	Infection Control Committee	Updated policy	July 2008		
4.16	Review and update of the Aspergillus Estates policy	Director of Estates and Facilities	Infection Control Committee	Updated policy	May 2008		
4.17	There is a planned preventative programme for maintenance	Director of Estates and Facilities	Infection Control Committee	Policy			
4.18	Review and update policy for ventilation (including air handling units)	Director of Estates and Facilities	Infection Control Committee	Updated policy	July 2008		

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
Core Duty 5: Duty to provide information on HCAI to patients and the public							
5.1	The Annual DIPC report is made available via the Trust website	DIPC	Infection Control Committee	Annual DIPC report downloaded from the website	July 2008	Annual report for 2007/08 is available at present	HA 5a
5.2	At the public entrances to the hospital sites a large, highly visible poster will be displayed informing the public of the importance of hand hygiene. 'Clean Your Hands' Campaign visitor and public information will be available in the vicinity of the poster.	Director of Estates and Facilities	IPC Performance Board				5.1.1 DOH
5.3	The Infection Control annual programme and policies are available for the public on the trust website	DIPC	IPC Performance Board	Information downloaded from the website	May 2008	Annual programme for 2007/08 is available at present	HA 5a
5.4	Outbreak signage to be reviewed and approved by the Infection Control Team.		IPC Performance Board				5.1.5 DOH
5.5	Clear signage will be displayed on ward entrances when the ward is affected with viral gastroenteritis informing visitors of the risk and the required actions.	DIPC	IPC Performance Board	Door signage and outbreak policy	Immediate and ongoing		5.1.6 DOH
5.6	Clear signage will be displayed on side room doors when patients are isolated due to infection risk providing visitors with the required actions	DIPC	IPC Performance Board	Door signage and isolation policy	Immediate and ongoing		
5.7	Patient information leaflets are provided to patients with MRSA and Clostridium difficile.	DIPC	IPC Performance Board	Patient information leaflets	Immediate and ongoing		
5.8	Patient information leaflets are available to patients regarding MRSA screening	DIPC	IPC Performance Board	Patient information leaflet	Immediate and ongoing		
5.9	Patient information leaflets are available regarding reducing the risk of infection	DIPC	IPC Performance Board	Patient information programme	Immediate and ongoing		
Core Duty 6: Duty to provide information when a patient moves from the care of one healthcare body to another.							
6.1	Patients with a history of MRSA and other multi resistant organisms are flag with an alert message on the PAS system	Director of THIS	IPC Performance Board	A page from the PAS system	Implemented and ongoing		
6.2	All staff accessing the PAS system should know when and who to inform if they are made aware of the alert message	Director of Nursing	IPC Performance Board	Bed management policy	Implemented and ongoing		

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
6.3	Patients transferred to other healthcare providers should have a inter-healthcare risk assessment discharge form (as found in the Bed Management Policy) completed by the discharging area	Director of Nursing	IPC Performance Board	Bed management policy (section W)	Implemented and ongoing		
6.4	The medical team must inform the GPs of patients with a history of MRSA and include this in the discharge letter after they are discharged home.	Medical Director	IPC Performance Board	Discharge letter	June 2008		
6.5	The medical team must inform the GPs of patients with a history of Clostridium difficile and include this in the discharge letter after they are discharged home.	Medical Director	HCAI Performance Board	Discharge letter	June 2008		
Core Duty 7: Duty to cooperation							
7.1	The need to adhere to the infection control policies is included in the job descriptions of all staff	Director of Personnel & Development	IPC Performance Board	Evidence as per 2.4	Implemented and ongoing		
7.2	Contractors are provided key information regarding good infection control before commencing work.	Director of Estates and Facilities	Infection Control Committee	Information leaflet	Immediate and ongoing		
7.3	There is an audit programme to measure compliance with the key infection control policies <ul style="list-style-type: none"> • Hand hygiene • Standard precautions • Management of sharps • Care of invasive devices 	DIPC	Infection Control committee	Evidence as per 2.	March 2009		CNST
7.4	Where there are deficiencies in compliance immediate action plans are developed and implemented to increase compliance to 100%	Divisional Directors	IPC Performance Board	Evidence as per 2.	Immediate		
7.5	The trust will meet regularly with the PCTs to ensure a whole healthcare approach to reduce HCAs. Ensuring that all healthcare providers are compliant with Saving Lives and Essential Steps.	CEO	IPC Performance Board	Minutes of the meetings	Implemented and ongoing		10.1.1 DOH
7.6	The trust will work with the PCTs for all pre-48 hour bacteraemias, ensure prompt reporting and shared learning from the RCA	DIPC	IPC Performance Board	Infection Control Committee minutes			10.1.2 DOH

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
Core Duty 8: Duty to provide adequate isolation facilities.							
8.1	Audit of isolation facilities and infection risk patients will be performed to ensure there is adequate capacity	Director of Nursing	HCAI Performance Board	Audit report, minutes of ICC	October 2008	Last audit performed April 2008	8.1.2 DOH
8.2	The trust will ensure that there is a robust system in place for recording all instances where a lack of facilities for isolation leads to bed management policy being breached	Director of Nursing	HCAI Performance Board				HCC Hygiene Code inspection report 08 2.8.2.DOH
8.3	Patients with infectious diarrhoea are not admitted via MAU but are risk assessed and admitted to siderooms as appropriate. Regular monitoring of the appropriate usage of siderooms will be carried out by the infection control nurses	Director of Nursing	IPC Performance Board				8.2.1 DOH
8.4	No commissioned side rooms will be taken out of current use without consultation with the infection control team and the Director of Nursing	Director of Operations	IPC Performance Board	Isolation Audit report	May 2008		
8.5	Infection Control Advice will be sought at the earliest opportunity on all refurbishment and new build schemes	Director of Estates and Facilities	Infection Control Committee	Minutes of refurbishment or new build schemes.	Immediate and ongoing		
8.6	The doors of all isolation rooms must be kept closed. Where there is a risk to an individual patient extra staff should be requested and documented in the patient's notes.	Director of Nursing	IPC Performance Board	Audit of isolation practice Clinical Incident reports	Immediate and ongoing		8.1.1 DOH
Core Duty 9: Duty to ensure adequate laboratory support.							
9.1	The microbiology laboratory has protocols in place and operates in accordance with the standards required for accreditation by the Clinical Pathology Accreditation (UK) Ltd.	Divisional Director DATS	Infection Control Committee	Current accreditation certificate	Implemented	Due for renewal ?	
9.2	An assessment of need for rapid testing of MRSA should be undertaken	DIPC	IPC Performance Board	Assessment report	July 2008		
9.3	Testing for Clostridium difficile toxins should be available 7 days a week and results available within 24 hours	DIPC	Infection Control Committee	Standard Operating procedure			

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
9.4	Where there are two or more related Clostridium difficile cases in an area the specimens must be sent for typing	DIPC	Infection Control Committee	C.difficile policy	Implemented and ongoing		
Core Duty 10: Duty to adhere to policies and protocols applicable to infection prevention and control.							
10.1	There is a policy for standard precautions	Director of Nursing	Infection Control Committee	Section C, Infection Control Policies	July 2008	Due for review	HA 10a
10.2	There is a policy for aseptic technique	Director of Nursing	Infection Control Committee	Section , Infection Control Policies	Implemented	Review date March 2010	HA 10b
10.3	There is a policy for major outbreaks of Infection and including the closure of wards and departments to new admissions.	Director of Nursing	Infection Control Committee	Section E, Infection Control Policies	July 2008	Due for review	HA 10c, 10h
10.4	The trust should review its isolation policy	Director of Nursing	Infection Control Committee				HCC Hygiene Code inspection report 08 2.8.1. DOH
10.5	There is a policy for Isolation	Director of Nursing	Infection Control Committee	Section , Infection Control Policies	Implemented	Review date March 2010	HA 10d
10.6	There is a policy for management of occupational exposure to blood borne viruses (BBVs), including the prevention of sharps injuries, safe handling and disposal of sharps and the management of occupational exposure to BBVs and post exposure prophylaxis	Director of Nursing	Infection Control Committee	Section M, Infection Control Policies	implemented	Review date October 2009	HA 10e, 10f, 10g
10.7	There is a disinfection policy	Director of Estates and Facilities	Infection Control Committee	Section F, Infection Control Policies	Implemented	Review date ?	HA 10i
10.8	There is an antimicrobial prescribing policy	Divisional Director DATS	Infection Control Committee	Antimicrobial policy	implemented	Review date October 2009	HA 10j
10.9	There is a policy for the reporting of HCAI to the HPA	Director of Nursing	Infection Control Committee	Section A, Infection Control Policies	July 2008	Needs to be included in the IC arrangements policy	HA 10k
10.10	There is a policy for the management of multi-resistant organism including MRSA	Director of Nursing	Infection Control Committee	Section , Infection Control Policies	Implemented	Review date March 2010	HA 10l
10.11	There is a policy for the management of Clostridium difficile	Director of Nursing	Infection Control Committee	Section Y, Infection Control Policies	Implemented	Review date October 2009	HA 10l
10.12	There is a policy for Transmissible Spongiform Encephalopathies	Director of Nursing	Infection Control Committee	Section , Infection Control Policies	implemented	Review date ?	HA 10l

Key area	Action	Lead	Who will measure progress	How will it be measured	By when	Progress	Reference
10.13	There is a policy for TB	Director of Nursing	Infection Control Committee	Section , Infection Control polices	July 2008	Review due	
10.14	There will be an audit programme to ensure compliance with Infection control policies.	DIPC	Infection Control Committee	Audit programme and reports	October 2008		HA2e
Core Duty 11: Duty to ensure that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAI.							
11.1	Infection control training is provide to all new staff at Induction training	Director of Organisational Development	Training & Education Strategy Group	Training records	Implemented and ongoing		HA2d HA11c HCC C11b
11.2	Infection control update training is provided to all staff on a two yearly basis	Director of Organisational Development	Training & Education Strategy Group	Training records	Implemented and ongoing		HA11d HCC11b HA2d 7.1.1 DOH
11.3	Mandatory & Induction training will include the following keys areas <ul style="list-style-type: none"> • Hand hygiene • Standard precautions • Isolation policy • Management of sharps • Results of key audits 	Director of Organisational Development	Training & Education Strategy Group	Training presentations	Implemented and ongoing		NHS LA 1.2.8 1.3.6 1.4.9 HCC 11b 8.1.3.DOH
11.4	Staff who fail to attend mandatory or induction training in a timely manner will be identified and their line manager notified.	Director of Organisational Development	Training & Education Strategy Group	Training records	Implemented and ongoing		NHS LA 1.2.8 1.3.6 1.4.9 7.1.2 DOH
11.5	The training department will provide quarterly reports on attendance at mandatory training for divisional managers	Director of Organisational Development	Training & Education Strategy Group	Quarterly reports	July 2008		HA 11e 7.1.3 DOH
11.6	Specific mandatory infection control Masterclass will be provided for the on-call managers, bed team and matrons	Director of Organisational Development	Training & Education Strategy Group	Training records	Immediate	First session delivered?	7.1.2.DOH HCC C11b
11.7	All staff can access occupational health services	Director of Personal & Development	Board of Directors	Attendance figures for Occupational Health Services	Implemented and ongoing		
11.8	Occupational health policies are available on the prevention and management of communicable disease	Director of Nursing	Infection Control committee	Review of documentation			
11.9	Training on antibiotic prescribing is provided to all prescribing staff.	Medical Director	Medicine Management Committee	Training records	March 2009		

Key

DOH = Trust's HCAI Action Plan in response to Department of Health's recommendations

HCC = Healthcare Commission

HA = Health Act (2006)

NHS LA = NHS Litigation Authority

Appendix 1

HCAI –COMMUNICATIONS & ENGAGEMENT STRATEGY

Summary

The prevention of Health Care Associated Infections (HCAI) is a very high priority for Trust staff, patients and visitors alike. Infection prevention and control activity is supported by a communications & engagement strategy.

Purpose

This strategy is intended to act as an overarching framework for all Calderdale & Huddersfield Foundation Trust (CHFT) communications relating to the fight against HCAI. The strategy is designed to support the Trust objective of zero tolerance of HCAI.

Aims

The aims of the strategy are to:

- **Raise awareness** – both internally and externally, of the importance of the infection prevention and control agenda, and of the actions necessary to eradicate HCAI
- **Raise confidence** – of patients, visitors and other stakeholders that the Trust is taking seriously the infection prevention and control agenda, and that hospital services are effective and safe.
- **Change behaviour** – through clear and accessible messages that encourage best practice
- **Inform & educate** – staff, patients, visitors and other stakeholders about the facts, myths, prevalence, prevention and treatment of HCAI
- **Celebrate success** – of positive activity, and of the creativity and dedication of staff in their work to prevent HCAI
- **Seek feedback** – from all stakeholders including concerns, questions and suggestions in order to enhance the fight against HCAI

Core principles

Communications activity will be governed by a number of core principles:

1. Communications will be open, honest, accessible and timely
2. Communications activity will be informed by involvement, consultation, creativity and feedback from staff and stakeholders (including other partners in the healthcare community)
3. Communications activity will centre on clear and consistent messages, capitalising on existing promotional materials e.g. the National Patient Safety Agency campaign 'Clean Your Hands'
4. Communications will support a leadership culture of positive challenge, the pursuit of excellence and zero tolerance of HCAI

Messages

The report by the Healthcare Commission 'Healthcare associated infection – what else can the NHS do?' (July 2007) stated that *'the evidence suggests that patients and the public consider that the risk of being infected by MRSA, if admitted to hospital, is high. Many claim to know someone to whom this has happened, and some are being deterred from seeking treatment or are seeking treatment in the private sector'*.

In light of this, it is suggested that the key messages of this strategy are:

- ❖ CHFT recognises the concerns of patients and visitors and has made HCAI a top priority
- ❖ CHFT is working hard to prevent and control infection by improving both clinical and housekeeping practice
- ❖ Patients, visitors and staff can help prevent and control infection by taking simple measures and following the advice given by the Trust
- ❖ CHFT has a 'zero tolerance' to unacceptable practice and behaviours concerning HCAI

These key messages are to be underpinned by activity in 5 priority areas:

Priority area	Focus
Hand hygiene	The principal weapon in combating HCAI and in increasing patient confidence. Staff to comply with Trust policy. Patients and visitors to be encouraged to practice good hand hygiene
Cleaning	Cleaning is high profile (i.e. is <i>seen</i> to be carried out) and visibly reported (i.e. cleaning schedules are published in patient areas). Staff to report/action poor cleanliness
Challenging practice	Staff, patients and visitors are to be encouraged and empowered to challenge poor practice with regard to hand hygiene, uniform policy, clinical practice and cleaning.
Antibiotic prescribing	To comply with local guidelines and best practice standards. Microbiology and pharmacy colleagues to act as 'champions' and proactively support other colleagues with information, expert advice and positive feedback
Indwelling devices	A major potential source of HCAI. Clinical colleagues to consider non-invasive alternatives, hygiene at entry point, and removal at earliest opportunity. The practice standard is the 'Saving Lives Toolkit'.

Target Audiences

Audience	Significance	Desired outcomes
Patients	<ul style="list-style-type: none"> • Partners in the task of infection prevention & control • Primary group affected by failure to prevent and control infection • Dissatisfaction and poor communication around HCAI typically reach the media through this audience 	<ul style="list-style-type: none"> • To see evidence of HCAI as a Trust high priority • To understand their responsibility in combating HCAI • To understand what to do (i.e. use of alcohol gel) • To feel empowered to challenge staff
Visitors & carers	<ul style="list-style-type: none"> • Partners in the task of infection prevention & control • Secondary group affected by failure to prevent & control infection • Potential sources of infection • Dissatisfaction and poor communication around HCAI typically reach the media through this audience 	<ul style="list-style-type: none"> • To see evidence of HCAI as a Trust high priority • To understand their responsibility in combating HCAI • To understand what to do (i.e. use of alcohol gel) • To feel empowered to challenge staff
Staff	<ul style="list-style-type: none"> • ‘Guardians’ of patient and public information • Role models for best practice • Advocates of best practice • Advisors to patients and their visitors on prevention and control of infection 	<ul style="list-style-type: none"> • To understand their responsibility in complying with Trust policies • To understand what to do (i.e. use of alcohol gel, soap and water) • To educate patients/visitors/carers in basic hand hygiene techniques • To feel empowered to challenge colleagues on poor practice • To understand the public confidence issue around HCAI and act accordingly
Other Healthcare Partners (e.g. GPs, PCTs, Nursing homes)	<ul style="list-style-type: none"> • ‘Guardians’ of patient and public information • Role models for best practice • Advocates of best practice • Advisers to patients and their visitors on prevention & control of infection 	<ul style="list-style-type: none"> • To see evidence of HCAI as a Trust high priority • To work as partners with the Trust in combating HCAI • To educate patients/visitors/carers in basic hand hygiene techniques • To feel empowered to challenge colleagues on poor practice • To understand the public confidence issue around HCAI and act accordingly
Media	<ul style="list-style-type: none"> • Disseminators of information across all audiences • Persuaders of opinion across all audiences • Separate and competing local media across area served by CHFT 	<ul style="list-style-type: none"> • To become partners in the fight against HCAI • To disseminate accurate information • To help the Trust celebrate success

Channels

Various Trust meetings and fora receive regular reports on the status and occurrence of HCAI, and these have been mapped elsewhere (see appendix A). In addition, there is a range of communications channels available for the dissemination of agreed messages about HCAI. This includes:

Trust News Team briefings Roadshows	Trust wide emails Payslip attachments/messages One to one briefings	Posters Point of use displays Noticeboards	Hospital radio Patient support groups CEO/Directors briefings Hospital volunteers	Local media Patient letters Website Trust membership
Trust intranet	Leaflets	Speaking noticeboards		

An updated communications & engagement plan will be created to deploy these various channels across the audiences as described above.

Resources

The delivery of the communications & engagement strategy and subsequent plan relies upon appropriately identified resources (both human and financial). A budget for print and materials will be required together with the approval of dedicated time for those individuals working as part of the HCAI Task Force.

Risks & Constraints

The communications & engagement strategy may not positively affect the number of reported bacteraemias and cases

A heightened awareness of HCAI through publicity material may heighten the fear of patients of poor care

Demand and capacity pressures may inhibit staff's ability to focus on preventing HCAI

Significant improvement in reported cases of HCAI is reliant upon a cultural shift and 'sea change' in attitudes across the entire Trust and beyond.

Evaluation

Whilst it is difficult to measure the actual causative effect of such a strategy, the effectiveness of the communications & engagement strategy and plan will be measured by an increased compliance in hand hygiene standards; staff and visitors expressing satisfaction in the increased visibility of HCAI messages; positive media reports; and ultimately, the reduction in reported cases of HCAI.