

CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

Report of:	Director of Patient Services/Chief Nurse/Director of Infection Prevention & Control
Paper prepared by:	Nurse Consultant Infection Prevention and Control
Date of paper:	April 2009
Subject:	Annual Report of Infection Prevention and Control Team
Purpose of paper:	To inform the Trust Board of the activities and progress of the infection prevention and control team for 08/09

Introduction

The Board is asked to receive the annual Infection Prevention and Control report for 2008/09.

Executive Summary

2008/9 has been a successful year for Infection prevention and control within the Trust. For the second successive year there has been a sustained improvement in meeting performance standards set out by the Department of Health and the Hygiene Code in the Health Act of 2006 (revised 2008).

1. Key Achievements

- 1.1 The addition of a Surveillance Officer to the Trust-wide Infection Prevention and Control Team was a significant appointment facilitating the ability of the team to collate, analyze and distribute data and therefore develop a more proactive response to infection prevention and control
- 1.2 The actual number of incidents of MRSA bacteraemia was 17 compared to the target of 24. The number of incidents of *Clostridium difficile* infection was 19.9% under target (242 compared to a target of 302) and there were only two incidents of Glycopeptide resistant *Enterococci* in the year to date (31/03/09).
- 1.3 This is the third consecutive year that the Trust has demonstrated a year on year reduction in the number of incidents of infection. Data compared between infection rates for 2006/7 and 2008/9 shows the following reductions: The incidents of MRSA bacteraemia reduced by 70.7%, *Clostridium difficile* infection by 47.7% and Glycopeptide resistant *Enterococci* by 94.9%. This is due to a combination of interventions driven by a dynamic approach to infection prevention and control from all levels of the organisation
- 1.4 The Trust activity and throughput of patients was maintained despite a total of 19 unpredicted outbreaks of Noro-like virus with a loss of 538 bed days and ward closures.

- 1.5 The Dress Code Policy has been processed through the Human Resources Department and will set the Trust-wide standard for the implementation of 'Bare Below the Elbows' in accordance with the Health Act.
- 1.6 The Trust received national and international recognition for work undertaken in relation to the implementation of Aseptic non –Touch Technique. Locally the Policy for ANTT has been reviewed and updated and training and assessment extended to all new junior medical staff.
- 1.7 The Decontamination and Sterilization Department transferred to the new hospital development halfway through the year. There has been a review of the use of laryngoscopes, and new equipment has been purchased to improve the quality of decontamination between each patient use.
- 1.8 The transfer of cleaning services to Sodexo Healthcare occurred in October 2008. The Annual Patient Environment Action Team (PEAT) assessment scores for the environment were rated good for all sites Trust-wide. (an improvement on previous year)
- 1.9 An extended clinical audit programme was developed and successfully established in the Division of Medicine. It is currently being rolled out across the other Divisions. There was also a demonstrable improvement in the annual audit of antibiotic prescribing guidelines.
- 1.10 The Trust Infection Prevention & Control Team has developed a research and innovation programme in partnership with both the Department of Health Showcase Hospitals Project and TrusTECH.
- 1.11 Trust staff presented nationally and internationally on the management and control of infection as well as welcoming a number of international visitors
- 1.12 In October 2008, The Healthcare Commission (HCC) made an unannounced visit to the Trust to assess compliance with four duties from the Hygiene Code. The Trust was assessed as compliant in three of the four duties assessed. The HCC assessment team identified breaches in relation to Core duty 4. The Trust implemented an action plan to address the issues identified which was successfully completed by March 2009
- 1.13 The Trust successfully registered with the newly established Care Quality Commission from 1st April 2009. Assessment included cross-referencing with performance information including the Healthcare Commission's Hygiene Inspection (October 2008), the Trust's declaration against the core standards for Infection Control and rates of infection.

2. Future Work Programme

The Trust continues to improve the quality and performance in standards of infection prevention and control and has set new challenges, which are reflected in the Corporate Infection Prevention and Control Action Plan for 2009/2010. Zero tolerance of all hospital acquired infections remains our goal.

3. Conclusion

This was a successful year for infection prevention and control activities within CMFT. The Board is asked to note the report and Infection Prevention and Control Action Plan for 2009/2010.



Central Manchester University Hospitals



NHS Foundation Trust

**INFECTION PREVENTION &
CONTROL ANNUAL REPORT
2008/09**

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Introduction

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SECTION 2: INFECTION PREVENTION & CONTROL ARRANGEMENTS

2.1 The Director of Infection Prevention and Control (DIPC)

Mrs Gill Heaton, Director of Patient Services/Chief Nurse is the DIPC for the Trust.

2.2 The Infection Prevention & Control Team

2.2.1 The addition of a Surveillance Officer to the Trust-wide Infection Prevention and Control Team was a significant appointment that will facilitate the ability of the team to collate, analyze and distribute data and therefore develop a more proactive response to Infection prevention and control. There is now a fully established team which is constantly developing to provide Trust-wide advice and support. The team comprises of the following personnel (whole-time equivalent (WTE) unless otherwise stated):

- Dr Andrew Dodgson, Microbiologist and Infection Prevention & Control Doctor (Central Site)
- Dr Bobby Sanyal, Microbiologist and Infection Prevention & Control Doctor (Children's Hospitals)
- Mrs Julie Cawthorne Nurse Consultant, Infection Prevention & Control
- Mrs Jo Rothwell, Lead Nurse, Infection Prevention & Control
- Ms Jo Clubb (0.93 WTE) Infection Prevention & Control Nurse Specialist.
- Miss Janice Streets Infection Prevention & Control Nurse Specialist.
- Mrs Michelle Worsley Infection Prevention & Control Nurse Specialist.
- Mrs Melanie Phillips Infection Prevention & Control Nurse Specialist
- Mr Federico Tabios Junior (0.6 WTE) Infection Prevention & Control Nurse Specialist
- Miss Rachel Soutar Surveillance Officer
- Dr Kirsty Dodgson, Consultant Clinical Scientist, Microbiology
- Ms Ann France Secretary

Please see the Infection Prevention & Control Action Plan, appendix 6, for planned development of the Infection Prevention & Control Nursing Team service in 2009/10

2.3 The Infection Control Committee (formerly The Winning Ways Committee)

2.3.1 The Winning Ways Committee was reconstituted as the Infection Control Committee (ICC) in December 2008 forming part of the Trust assurance framework. It is chaired by the DIPC and meets every two months. The Committee has corporate responsibility for all Infection Prevention & Control issues and monitoring the implementation of the annual Infection Prevention & Control plan. The Committee has the following sub-committees:

- Infection Prevention & Control Expert Group
- Medical Devices Committee
- Modern Matron Facilities Committee
- Medicines Management (Antibiotics) Committee

2.3.2 The Trust Strategy for Infection Prevention and Control was updated in 2007/8 and defines the structure and activities of Infection prevention and control within CMFT. It can be found alongside all Trust-wide Infection Prevention and Control Policies on the Trust Intranet, Infection Control website.

The Terms of reference for the ICC can be found in Appendix 1.

2.4 Infection Prevention & Control Structure within the Divisions

Each Division addresses Infection Prevention & Control issues either as a standing item on the Divisional Clinical Governance Meeting or, through a separate Divisional Infection Prevention & Control Committee/Group. This has been agreed with the DIPC on the basis of a risk assessment.

2.5 The Infection Prevention & Control Link Practitioners (ICLP's)

There are ICLP's across all the Divisions within the Trust who act as a conduit from the Infection Prevention & Control Team to the clinical environment. The ICLP's receive regular education and training on issues pertinent to Infection Prevention & Control and their role is to undertake audits and local training, for example, hand hygiene in their areas. Meetings have been consistently well attended however, divisional representation has been variable. Please see the Infection Prevention & Control Action Plan, appendix 6 for planned development of the Link nurse programme for 2009/10.

SECTION 3: BUDGET ALLOCATION TO INFECTION PREVENTION & CONTROL ACTIVITIES

3.1 Funding for Infection Prevention & Control

There is a fully funded Infection Prevention and Control Team

- Funding for Microbiology laboratory services (including outbreaks of infection) is covered by the Service Level Agreement (SLA) between the Trust and the Health Protection Agency.
- Funding for outbreaks of infection (excluding laboratory costs) are funded locally by the Divisions.
- The Service Level Agreement (SLA) with the Manchester Mental Health and Social Care Trust (MMH&SC) remains in place. This equates to 0.4 (FTE) Band 7. The SLA includes all key Infection Prevention & Control activities for services based at the Central site.
- Recurrent funding for ICNet (electronic Infection Prevention & Control surveillance database) is met from the Divisions.

SECTION 4: HEALTHCARE ASSOCIATED INFECTION

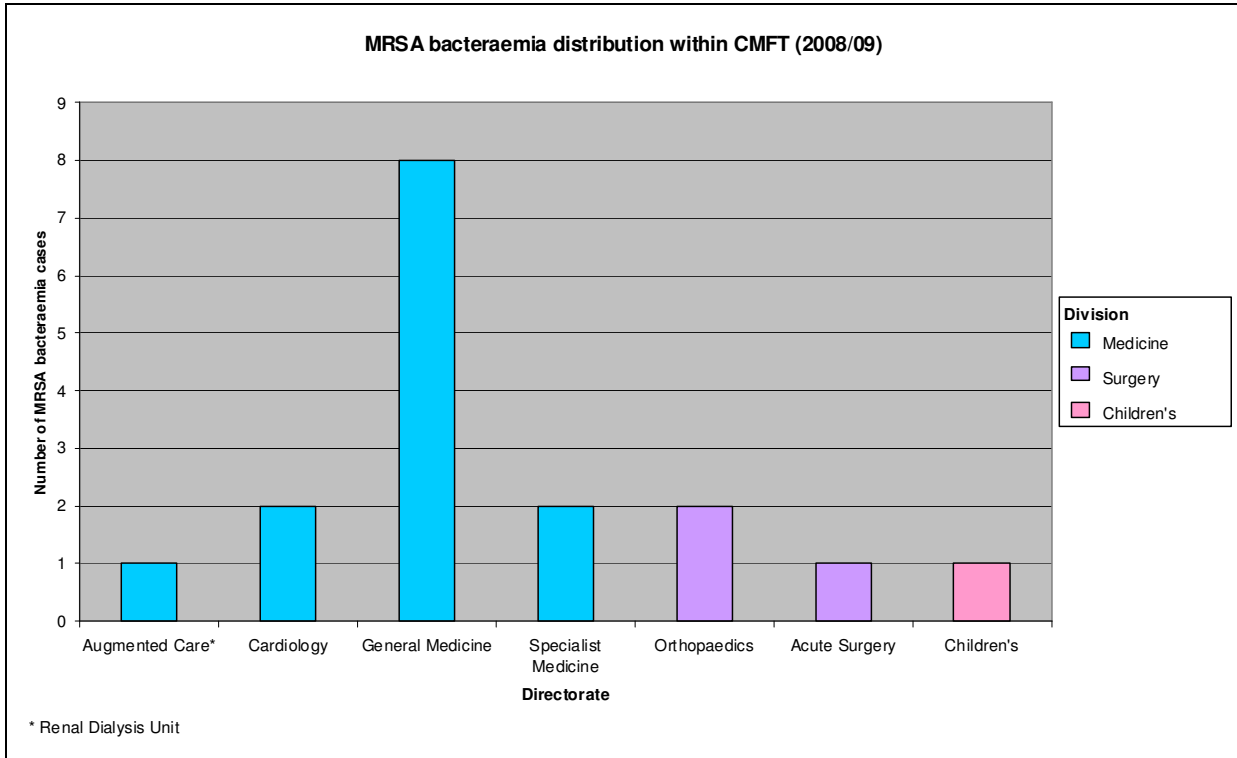
4.1 Methicillin Resistant *Staphylococcus aureus* Bacteraemias

The Department of Health provided all acute trusts a target to reduce the incidence of MRSA bacteraemias by 50% over a three year period (April 2005 – March 2008). The national target was achieved in March 2008 and the target for 2008/9 and 2009/10 as agreed with Manchester PCT is to maintain the current position. The annual targets and actual results for CMFT can be seen below:

Year	Target	Actual Number
April 2005 – March 2006	47	54
April 2006 – March 2007	35	59
April 2007 – March 2008	24	21
April 2008 – March 2009	24	17

4.1.1 Overview of Root Cause Analysis of MRSA bacteraemias

Each incident of MRSA bacteraemia is investigated using a Root Cause Analysis (RCA) tool, and presented to the weekly Infection Prevention & Control meeting, chaired by the DIPC. A summary of the 17 incidents of MRSA bacteraemia for this year can be found below.



Incidents of MRSA bacteraemia by Division/Directorate in which they occurred

4.1.2 Performance against the Target

The Trust has maintained a year on year improvement in the number of incidents of MRSA bacteraemia for 2007/8 and 2008/9. This is considered to be due to a combination of interventions including the introduction of aseptic non touch technique (ANTT) and increasing awareness and compliance with hand hygiene policy which were introduced trust-wide three years ago.

4.1.3 There are now new challenges. In the year 2008/09 there were seventeen incidents of MRSA bacteraemia amongst fifteen patients. Eleven of these patients were known to be colonised with MRSA prior to the bacteraemia (this may be due to the extended screening for MRSA, please see below). A review of the data from the RCA's suggested that there needs to be continued focus on raising awareness and compliance with antibiotic prophylaxis and MRSA topical eradication therapy.

4.1.4 In response, the Infection Prevention & Control Team revised the Trust MRSA Policy and included more detail regarding antibiotic prophylaxis, screening and decolonisation procedures. This Policy has been widely disseminated across the Trust amongst those staff with responsibility for direct patient care. Adherence to the policy continues to be monitored through audit.

4.1.5 Extended Screening for MRSA

Guidance from the Department required all acute Trusts to be compliant with the following actions by March 2009:

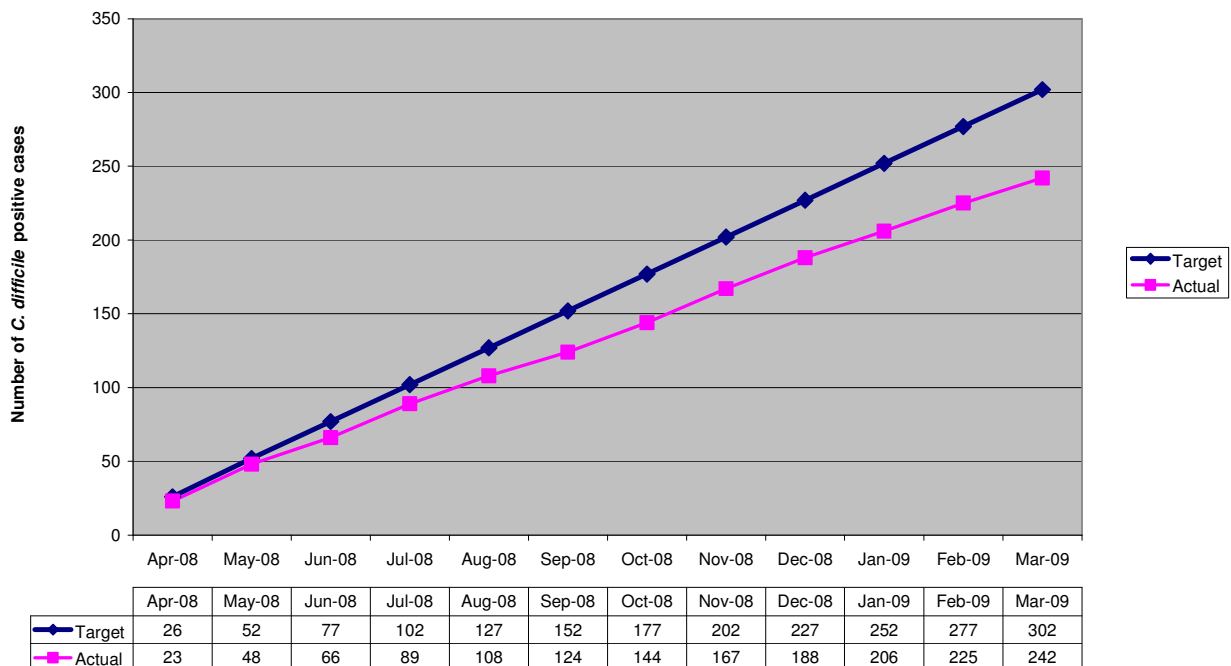
- Screening of all elective admissions. (This has been extended to include all remaining emergency admissions by no later than 2011).
- Provide assurance on the screening programme by submitting monthly reports to their commissioners on numbers of MRSA screens and numbers of admissions.
- Make publicly available their MRSA screening policy

4.1.6 The Trust was compliant with the above guidance and worked in partnership with Manchester PCT to ensure that elective patients who are identified as MRSA positive receive appropriate re-screening and decolonisation therapy prior to admission.

4.1.7 Future plans include meeting the target for screening the remaining emergency admissions by 2011. (Please see the Infection Prevention & Control Action Plan 2009/10), appendix 6

4.2 Clostridium difficile Infection (CDI)

Cumulative Clostridium difficile Infection 2008/09



4.2.1 Target for 2008/9

The Trust had an agreed target with the PCT of 302 cases of CDI in all patients over the age of two for the year 2008/09. This was based on the baseline data of 380 cases in 2007/08.

4.2.2 The total number of cases was 242 in 08/09 which is 19.9% under the agreed target of 302 cases.

- 4.2.3 The Department of Health reviewed all data submitted on CDI in December 2008 and redefined attributable and non-attributable cases. Cases classed as non-attributable (from April 1st 2009) include GP specimens, samples taken within 2 days of the date of admission and certain non-admitted patients.
- 4.2.4 Based on these calculations CMFT reviewed the CDI targets for 2009/10 and 2010/11 to achieve a national target of 3.22 cases per 1000 ordinary admissions or a 10% reduction which ever is the least.
These are
- 2009/10 – 245 attributable cases
 - 2010/11 – 231 attributable cases

4.3 Revised National Guidelines for the Management of Patients with *Clostridium difficile* Infection

There is national evidence of increased mortality and morbidity associated with *Clostridium difficile* infection. New national guidelines were issued that are currently being reviewed by the Infection Prevention and Control Team

4.4 Glycopeptide (Vancomycin) resistant Enterococci (GRE)

At present no target has been set in relation to GRE however, the Trust reported all incidents of GRE bacteraemia to the Health Protection Agency. The total number of incidents for this year to date (31/03/09) is two (annual totals run from September - October). Both of these occurred in the Division of Medicine. This continues to demonstrate a sustained decrease from 32 in Sept 06 –Oct 07, to 5 in Sept 07-Oct 08

4.5.1 Review of Figures for MRSA Bacteraemia, *Clostridium difficile* Infection and VRE Bacteraemia for 2006/7 – 2008/9

The Trust has demonstrated a consistent year on year reduction in the number of incidents of the above. The following table represents reductions in these infections when data has been compared between rates of 2006/7 and 2008/9. (Please see appendix 2 for bar chart)

Infection type	Percentage Reduction
MRSA Bacteraemia	70.7%
<i>Clostridium difficile</i> Infection*	47.7%
VRE Bacteraemia	94.9%

* Excludes GP and other hospitals samples

The Trust is committed to the principle of ‘zero tolerance’ towards healthcare Associated Infection. Please see Infection Prevention & Control Action Plan for 2009/10, Appendix 6, for further actions to reduce infections caused by specific organisms.

4.6 Mandatory Surgical Site Infection (SSI) Surveillance for Joint Replacement

4.6.1 The Trust participated in the mandatory SSI surveillance for knee replacement surgery. The orthopaedic directorate completed all four quarters for the year ending March 2009 however; the data from the last quarter will not be returned from Colindale until May 2009.

4.6.2 Until recently SSI surveillance only included the in-patient period this was extended to include post discharge surveillance from July 2008. This additional data will provide a more accurate reflection of the incidence of SSI in the future.

Quarter	Total number of records submitted	Number of SSI during in-patient period
April – June 2008	56	0
July – Sept 2008	42	0
Oct – Dec 2008	55	1
Totals	153	1

4.6.3 The incidence of SSI amongst patients receiving knee replacement surgery for this nine month period is 0.6%. The national average for the same category is 0.5%

4.7 Report of MRSA Panton - Valentine Leukocidin (PVL) Outbreak on Ashby Ward RMCH August – December 2008

4.7.1 In August 2008 three patients who were known to be MRSA positive were found to have a PVL strain. Control measures were instigated and all patients were successfully treated. Following genotyping at Colindale all three isolates were found to be indistinguishable

4.7.2 In November 2008 a fourth patient was identified as having MRSA PVL strain, (found to be indistinguishable from the isolates typed in August). Prompt action included screening of all staff whose work- load involved time spent on the ward.

4.7.3 Following staff screening two members of staff were found to be MRSA positive.

- One of them had a PVL strain indistinguishable from that isolated from the patients and was treated with appropriate antibiotic therapy.
- The other member of staff was successfully treated with appropriate decolonisation therapy and was subsequently found to be colonised with a strain unrelated to the one implicated in the outbreak.

4.7.4 Patients on the ward were also re-screened for MRSA on a regular basis to monitor the course of the outbreak and as a measure of the effectiveness of the control measures instigated. No further cases were identified and the ward was re-opened in January 2009.

4.8 Outbreak of MRSA amongst patients on ward 26

4.8.1 Between 7th-18th February 2009 eight patients acquired MRSA whilst in-patients on ward 26. The ward was closed to admissions on 16th February 2009, and control measures instigated by the outbreak team.

4.8.2 Following re-screening two more patients were identified as MRSA positive over the week-end of 21st- 22nd February 2009. The progress of the outbreak was assessed and progress reviewed on a daily basis. The Ward re-opened on 1st

March 2009 as no new cases had been identified from two consecutive MRSA screens.

- 4.8.3 Results from genotyping of isolates identified the transmission of three different strains of MRSA involved during the outbreak.

4.9 Outbreaks of Noro-Like Virus (Viral Gastroenteritis)

All outbreaks of Noro- like virus are reported to Manchester Health Protection Agency. Below is a summary of the outbreaks of confirmed/suspected Noro-like Virus that occurred in CMFT for 2008/9

Ward	Dates of closure	Number of patients affected	Number of staff affected	Bed days lost
NNMU	18.04.08 – 24.04.08	11	1	0
Borchardt	12.04.08 – 14.04.08	6	0	12
WMU	23.06.08 – 25.06.08	4 (plus1 parent)	0	2
9	18.07.08 – 23.07.08	8	2	44
Wrigley	08.10.08 – 12.10.08	11 (plus1 visitor)	2	47
Heywood	01.11.08 – 05.11.08	12	3	28
Borchardt	19.11.08 – 25.11.08	7	3	43
15	22.11.08 – 30.11.08	12	1	55
Liebert	02.12.08 – 05.12.08	5 (plus 4 visitors)	0	22
Heywood	18.12.08 – 22.12.08	7	1	38
Heywood	26.12.08 – 02.01.09	9	2	37
AM1	15.01.09 – 20.01.09	11	0	14
6	11.01.09 – 16.01.09	15	1	15
33	12.01.09 – 18.01.09	14	1	46
Victoria	17.01.09 – 21.01.09	8 (plus 3 visitors)	3	40
6	28.01.09 – 06.02.09	13	2	50
NNSU	29.01.09 – 02.02.09	7 (plus 2 parents)	1	8
Borchardt	23.03.09 – 25.03.09	6	2	17
Borchardt	31.03.09 – 03.04.09	8	3	20
Totals		174 (plus 11 others)	28	538

4.9.1 Comments

- 4.9.2 The Trust responded promptly to each outbreak, closing the affected ward and instigating the guidance in the Trust Viral Gastro-enteritis Policy
- 4.9.3 The activity of throughput of patients was maintained despite a total of 19 outbreaks and subsequent ward closures.
- 4.9.4 The Health Protection Agency set up the national voluntary reporting system for noro-like virus from 22nd December 2008. The Trust began participating from March 2009

SECTION 5: HAND HYGIENE AND ASEPTIC NON TOUCH TECHNIQUE

5.1 Raising awareness and increasing compliance with Hand Hygiene Policy across the Trust

- 5.1.1 The Trust continues to participate for the fourth consecutive year in the national Clean~~your~~hands campaign.
- 5.1.2 All clinical areas undertake monthly audits of hand hygiene opportunity and frequency (see section 8.1). The audit tool was revised and updated and made more accessible by attaching it to the Trust hand hygiene policy, on the Infection control website on the Trust intranet

5.2 Dress Code Policy

The Dress Code Policy has been progressed through Trust Negotiation and Consultative Committee. This Policy sets the standard for the implementation of 'Bare Below the Elbows' in accordance with The Health Act.

5.3 Aseptic Non Touch Technique (ANTT)

- 5.3.1 The Trust has received national and international recognition for work related to the implementation of ANTT (please see section 10.3)
- 5.3.2 The Trust Policy for ANTT was been reviewed and updated and is available on the Trust intranet on the Infection control website.
- 5.3.3 This year ANTT training and assessment was extended to include all new junior doctors who commence employment within the Trust.
- 5.3.4 The Trust changed supplier of sharps disposal bins in order to facilitate compliance with national guidelines for near side disposal of sharps during an ANTT procedure.

SECTION 6: DECONTAMINATION SERVICES

The Trust appointed Lead for Decontamination is David Pearson, Acting Director for Clinical and Scientific Services.

6.1 External Review

A full external review of decontamination was completed in October 2008 by a recognized expert which highlighted many areas of good practice and also a number of recommendations for improvement.

6.2 Transfer of services and move to New Hospital Development

The Decontamination and Sterilization Department (DSD) transferred to the new hospital development half way through the year. This provided state of the art bespoke equipment and accommodation and has increased the capacity of the department. The move enabled the service to expand and the department was awarded the contract for Salford PCT from March 2009. Services at Booth Hall Children's Hospital will transfer in June 2009.

6.3 Review of Usage of Intubation Equipment (Laryngoscopes)

The Trust review of decontamination of laryngoscopes was brought forward following the report of the Healthcare Commission in January 2009. (Please see section 10).

6.3.1 All laryngoscopes on resuscitation trolleys have now been replaced with single use equipment.

6.3.2 The Trust has purchased additional re-useable laryngoscopes to enable all other areas, where applicable, to re-process instruments through DSD between each patient use. This is currently being rolled out across the Trust.

6.4 Review of Local Re-processing of Endoscopes

Local re-processing of endoscopes occurs in several departments within the Trust.

6.4.1 The Endoscopy Unit was reviewed by the Joint Accreditation of Gastroenterologists and will be accredited following implementation of suggested recommendations.

6.4.2 Following a review of current service provision in other areas of the Trust a dedicated Decontamination Group has been convened to develop a trust-wide standard for decontamination of endoscopes

SECTION 7: CLEANING SERVICES

7.1 Management Arrangements for Cleaning Services

7.1.1 The Trust has contracted out cleaning services since October 2008 to Sodexo Healthcare as part of the PFI Project Agreement. This contract is managed and monitored by the Facilities Monitoring Team who report to the Associate Director of Estates and Facilities who in turn reports to the Director of Nursing (Adults).

- 7.1.2 The contract is managed in accordance with the Project Agreement, with specific reference to Schedule 14 which provides the Trust specification requirements and the method statements which are to be followed by Sodexo Healthcare. The Facilities Monitoring Team has developed a Contract Monitoring Procedure that sets out monitoring arrangements and contract management procedures to ensure that the required standards are met.
- 7.1.3 The cleaning services for the Children’s Hospitals is contracted out to Medirest and transfers to Sodexo Healthcare in June 2009 as part of the above.
- 7.1.4 Sodexo Healthcare provide a monthly performance report which summarises their performance, based on their self monitoring regime, by service against agreed performance standard indicators and this is analysed and where appropriate challenged by the Facilities Monitoring Team. The analysis undertaken is based on information collation from a number of sources to confirm that the data provided reflects the experience of the Trust.
- 7.1.5 The performance standard indicators report on service delivery against specific measures looking at quality standards or response times. Any areas of non-performance incur financial penalties applied as a percentage of the monthly payment.

7.2 Annual Patient Environment Assessment Team (PEAT) Assessment – March 2009

The outcomes of the PEAT assessments for 2009 are as illustrated in the table below. It should be noted that there has been an improvement on scores and outcomes when compared with the 2008 PEAT results, which are included in brackets.

Table to illustrate CMFT PEAT Assessment outcomes 2009

Site	Environment	Food	Privacy and Dignity
Booth Hall	Good (Good)	Excellent (Good)	Good
RMCH	Good (Good)	Good (Acceptable)	Acceptable
Saint Mary’s	Good (Good)	Good (Good)	Good
MRI / REH	Good (Good)	Good (Acceptable)	Acceptable

It is pleasing to note comparative improvements in several categories, this at a time where significant building and construction works are on-going within Trust Healthcare Facilities.

SECTION 8: AUDIT

The Health Act 2006: Code of Practice for Prevention and Control of Healthcare Associated Infection’s (HCAI’s) states that ‘Effective prevention and control of HCAI’s has to be embedded into everyday practice and applied consistently by everyone.’ The Act requires that NHS organisations audit key policies and

procedures for infection prevention and control in order to provide assurance that clinical practice is effective in the prevention of HCAI's.

8.1 CMFT Clinical Practice Audit Programme

Two of the principle elements of safe clinical practice are:

- Hand hygiene
- Aseptic non-touch technique (ANTT).

8.2 Hand Hygiene Frequency Audit

The Trust has a well established monthly observational hand hygiene audit programme. The annual results for each Division can be seen in appendix 3, Figure 1

8.3 Aseptic Non-Touch Technique (ANTT) and Peripheral Cannulae Audits

- 8.3.1 The Trust-wide implementation of ANTT in 2006 has been supported by annual observational audits of practice.
- 8.3.2 In October 2008, following twelve incidents of MRSA bacteraemia in six months within the Division of Medicine it was decided to increase frequency of auditing ANTT procedures and maintenance of peripheral cannulae audits to monthly.
- 8.3.3 Results from these audits are collated by the Clinical Audit Department and reports are fed back to the Division (Please see Appendix 3, Figure 2, for results of ANTT audits and Figure 3 for results of peripheral cannulae audits).
- 8.3.4 Following the implementation of the above, there were no further incidents of MRSA bacteraemia within the Division of Medicine from October 2008 – March 2009. This is attributable to a range of factors including the implementation of the audit programme.
- 8.3.5 In January 2009, the clinical practice audit programme was rolled out into the Division of Surgery and will be extended to all remaining Divisions, by the end of December 2009 (Please see the Infection Prevention & Control Action Plan, appendix 6).

8.4 Antibiotic Policy / Prescribing Guidelines

- 8.4.1 The Trust-wide guidelines were updated in August 2008, and comply with Department of Health recommendations regarding minimising ciprofloxacin & cephalosporin use, and on prudent antibiotic prescribing.
- 8.4.2 Guidance on the treatment and management of *C.difficile* infection has been updated, and additionally a summary guidance chart that has been developed to assist clinicians. Also, the antibiotic prophylaxis section was updated, notably for patients who are, or have been MRSA positive. Antibiotic prophylaxis against infective endocarditis reflects the NICE Guidance issued in March 2008

8.5 Audit of Antibiotic Prescribing Guidelines

- 8.5.1 The Trust wide (Central and Children's sites) point prevalence audit was performed in December 2008 to assess compliance with the antibiotic guidelines.
- 8.5.2 For the purpose of the audit 1031 inpatients were reviewed. The significant improvement in compliance noted in the previous years audit has been sustained.
- 8.5.3 A comprehensive audit report with actions was discussed at the Trust Infection Control Committee. The results for each Division were circulated to the relevant Clinical Directors, Divisional Directors and pharmacists to take forward the recommended actions.
- 8.5.4 An audit of antibiotics restricted to Microbiology recommendation / approval was undertaken in September / October 2008. 93% of prescriptions were approved by Microbiology (n = 29).

8.6 Audit of Hand washing Facilities in Phase 2

- 8.6.1 An audit of hand wash basins (HWB's) in phase 2 was undertaken using current national standards. Twenty three areas were audited including wards, A&E and outpatients departments
- 8.6.2 The purpose of the audit was to provide information for the Trusts' Property and Estates Development department that can be used to prioritise plans for upgrading of facilities in 2009/10

8.7 Findings - The standard requirement is the provision of dedicated hand washing facilities

- 8.7.1 14 areas did not have access to a separate HWB as well as equipment cleaning sink in the sluice room, hence equipment and hands are washed using the same facility. 14 areas do not have separate HWB and an equipment cleaning sink in the treatment (clinical) room.
- 8.7.2 12 areas do not currently comply with national recommendations for the ratio of HWB's to number of beds (1:1 critical care area, 1:4 acute elderly and long term settings, 1:6 in low dependency areas).

8.8 Outcome

Work on upgrading hand hygiene facilities occurred across the Trust in 07/08 and 08/09. Funding has been secured to upgrade these remaining facilities in the capital project scheme for 2009/10

8.9 MRSA Integrated Care Pathway (ICP) Documentation Audit

A trust- wide audit was performed to assess the completeness of documentation of the MRSA Integrated Care Pathway (ICP). A total of 41 ICPs were audited. The ICP has different sections, one of which includes cycles of eradication treatment.

8.10 Findings

Overall the results showed varying degrees of compliance between each section of the ICP. Only two were correctly completed. 19 forms were correctly completed for patients receiving cycle one of eradication treatment. 28 forms had prescriber's details correctly completed. Limitations to the audit tool were identified.

8.11 Recommendations

In view of the issues identified with compliance of MRSA eradication treatment a new tool will be developed which will facilitate more frequent audit.

A power point presentation on the revised Trust Policy on MRSA screening, decolonisation and isolation was developed by the Infection Prevention and Control Team and presented to clinical staff in a variety of settings.

SECTION 9: EDUCATION & TRAINING ACTIVITIES

- 9.1 The Infection Prevention & Control Team (ICT) deliver training on the key principles of Infection Prevention & Control at corporate induction and corporate clinical and non-clinical mandatory training. The content of the training is in accordance with the core care policies identified within the Health Act
- 9.2 In August of this year all new medical staff received Infection Prevention & Control training during induction including the principles of ANTT. Each doctor was then ANTT competency assessed in their clinical environment.
- 9.3 The team have collaborated with the Trust Organisational Development and Training department to develop 'e' learning packages. The corporate mandatory is currently being piloted. The clinical mandatory programme is in progress.
- 9.4 The Anaesthetic Directorate in collaboration with colleagues in the Manchester Heart Centre have made a DVD to specifically highlight training issues for Anaesthetists and Surgeons when conducting their clinical practice. The DVD was sponsored by the Department of Health.

SECTION 10: RESEARCH AND INNOVATION

10.1 The Showcase Hospitals Project

- 10.1.1 The Showcase Hospitals Project was launched in April 2008. It is led by the NHS Purchasing and Supplies Agency as part of the Department of Health Healthcare Associated Infection Technology Programme. CMFT were one of seven hospitals across England to be chosen as a Showcase Hospital.
- 10.1.2 The focus was on the in-use value of HCAI technologies with the aim of developing technical and economic business cases for each of the technologies. The Trust gained invaluable knowledge about the practical aspects of using the products in real situations that we will be able to share with other Trusts in the Region in the second year of the project. (Please See Infection Prevention & Control Corporate Action Plan, Appendix 6)

10.1.3 As a participant in the Showcase Project, The Trust was commissioned to develop a bespoke Hand Hygiene DVD for training purposes which will be launched nationally at the Chief Nursing Officers Meeting in April 2009

10.2 Working in Partnership with TrusTECH

10.2.1 In collaboration with TrusTECH, the infection Prevention & Control Team instigated two research projects. The aim of these projects was to assess the performance of novel infection control related products in a real world healthcare setting. Both of these projects were fully funded by their manufacturers. Full ethical approval was sought for both projects prior to their initiation. The largest of these projects is an evaluation of a novel disinfectant product, the efficacy of which is being compared with hypochlorite (bleach) on the Acute Medical wards. The project yielded some interesting results to date and will continue to May 2009. Interim results have been presented as posters at major conferences (Appendix 4). The Infection Prevention and Control Team in collaboration with TrusTECH has also evaluated the antibacterial efficacy of a silver coating for hospital mattresses.

10.2.2 It is anticipated that this successful collaboration with TrusTECH will continue in 2009-10, with a number of projects already under discussion. Please see corporate Infection Prevention and control Plan for 2009/10 (Appendix 6).

10.3 National, International Paper Presentations and Poster Presentations 2008/9

The DIPC and other members of the Infection Prevention and Control Team were invited to present at a range of national and international conferences (Please see Appendix 4). The focus of the presentations was to share our success in reducing HCAI rates and the methods used to achieve this and also our preliminary research findings from our work with Byotrol (see section 10.2 above). The Trust also welcomed international visitors.

SECTION 11: TARGETS AND OUTCOMES

11.1 The Healthcare Commission Assessment

On 22 & 23 October 2008, The Healthcare Commission (HCC) made an unannounced visit to the Trust to assess compliance with four duties from the Hygiene Code. The Trust was assessed as compliant in three of the four duties assessed (Duty 2, Duty 8 and sub-duty 10j).

The HCC assessment team identified breaches in relation to Core duty 4 sub duties 4c, 4d, 4f and 4g. The Trust implemented an action plan to address the issues identified (See Appendix 5).

11.2 Registration with the Care Quality Commission (CQC)

On April 1st 2009 the Trust successfully registered with the Care Quality Commission. In accordance with national guidance the Trust undertook a self assessment of compliance against The Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections. This was cross-checked by the CQC with other performance information, including patient and staff surveys, findings from the Healthcare Commission's hygiene inspection, the

Trusts' declarations against core standards for infection control, and rates of MRSA and *Clostridium difficile* infection.

11.3 NHS Litigation Authority (NHSLA) Risk Management Standards for Acute Trusts

The Trust achieved Level 2 compliance with the above assessment which included the following Infection prevention and control standards:

- Hand Hygiene training
- Managing the risks associated with infection prevention and control

11.4 The Annual Plan for infection Prevention and Control

The Annual Plan for Infection Prevention and Control for 2009 -10 can be found in appendix 3

SECTION 12: CONCLUSION

This report confirms the commitment and drive for infection prevention and control at all levels of the organisation. Key factors to our success have been sustained effort including a clear accountability framework, effective leadership, improvements in clinical practice and performance and a clear focus on the environment of care. There is a zero tolerance approach towards Healthcare Associated Infection and a developing culture of quality improvements in infection prevention and control that is clearly demonstrated by our year on year reductions in infection. The Trust will continue to work in partnership with colleagues across the health economy to maximise the health benefit for the communities we serve. Our challenge is to sustain and improve on our achievements during 08/09 which is reflected in the work plan for 09/10.

Julie Cawthorne
Nurse Consultant Infection Prevention and Control



APPENDIX 1 – Infection Control Committee Terms of Reference

INFECTION CONTROL COMMITTEE TERMS OF REFERENCE

1. CONSTITUTION

The Infection Control Committee is a sub committee of the Clinical Effectiveness Committee. The Infection Control Committee is chaired by the Director of Infection Prevention and Control who is the Chief Nurse/Director of Patient Services

2. MEMBERSHIP

- Director of Infection Prevention and Control/Director of Patient Services/Chief Nurse
- Consultant Microbiologist/Infection Control Doctor (Central sites)
- Consultant Microbiologist/Infection Control Doctor (Children's Hospitals)
- Nurse Consultant, Infection Prevention and Control
- Lead Nurse, Infection Prevention and Control
- Consultant Virologist
- Director of North West Regional Health Protection Agency Laboratory
- Consultant Microbiologists
- Consultant Physician Occupational Health
- Antimicrobial Pharmacist
- *Director of Nursing (Adults)
- Director of Nursing (Children)
- Consultant Physician for Respiratory Medicine
- Associate Director of Clinical governance
- Head of Patient safety and Risk Management
- Head of Clinical Audit
- Trust Decontamination Lead/representative for CSS Division
- Head of Nursing for Division of Medicine
- Associate Director of Estates and Facilities
- Consultant Communicable Disease Control
- PCT Infection Control Lead
- Manchester Mental Health Services

* Representative for Surgery Division/Eye/Dental Division/Saint Mary's

- Other Members of the Trust or partner organisations may be co-opted to the Infection Control Committee at the invitation of the Chairwoman
- A quorum shall be eight members including the Director of Infection Prevention and Control (or a nominated deputy), and two representatives from the Infection Control Team



3. ATTENDANCE AT MEETINGS

- The Infection Control Committee may require from time to time, the attendance of any Trust employee (or agent of the Trust) to attend the committee at the request of the Chairwoman

4. FREQUENCY OF MEETINGS

- The Infection Control Committee will meet every two months (six times a year)

5. OVERVIEW

- The purpose of the Infection Control Committee is to provide a two-way communication channel between the Trust Board and Infection Control.
- The Infection Control Committee is authorised to formulate recommendations for Infection prevention and control within the Trust and to convey these to the Trust Board.

6. SCOPE AND DUTIES

- To ensure the infection control strategy and all infection control policies, procedures and guidelines are in place, relevant and up to date with noted guidance.
- To provide advice and support on the implementation of the strategy and policies
- To collaborate with the Infection Control Team to produce guidance on the Trust's Annual Infection Control objectives, from which the Divisions create an Infection Control Plan and the Infection Control Team a Corporate Action Plan.
- To monitor progress of the objectives described in the Corporate Infection Prevention and Control Action plan
- To monitor Trust wide trends of alert organisms and alert conditions and advise the Divisions, PFI and Infection Control Team on actions.
- To consider reports on infections and infection control problems
- To ratify the Annual Infection Control Board Report
- To draw the attention of the Chief Executive, through the Director of Infection Prevention and Control, to any serious problems or hazards relating to infection prevention and control



- To describe, review and monitor the principle and significant risks related to infection control on behalf of the Trust and present these with the plan of controls to the Trust Significant Risk Review Group and Risk Advisory Committee at least annually.
- Members will disseminate relevant information to their clinical areas
- To receive for information the Divisional performance reports against their Action Plans

7. AUTHORITY

The Infection Control Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

8. REPORTING

- The Infection Control Committee reports to the Clinical Effectiveness Committee (see CMMC Clinical Governance Organisational Chart appendix 1)
- There are four sub-groups of the Trust Infection Control Committee (See Infection Control Committee structure appendix 2). The Chair persons from each of the sub-groups, (Or their nominated deputy), provide a verbal report at each Infection Control Committee meeting

9. REVIEW

These Terms of Reference will be reviewed in April 2010.

10. KEY PERFORMANCE INDICATORS

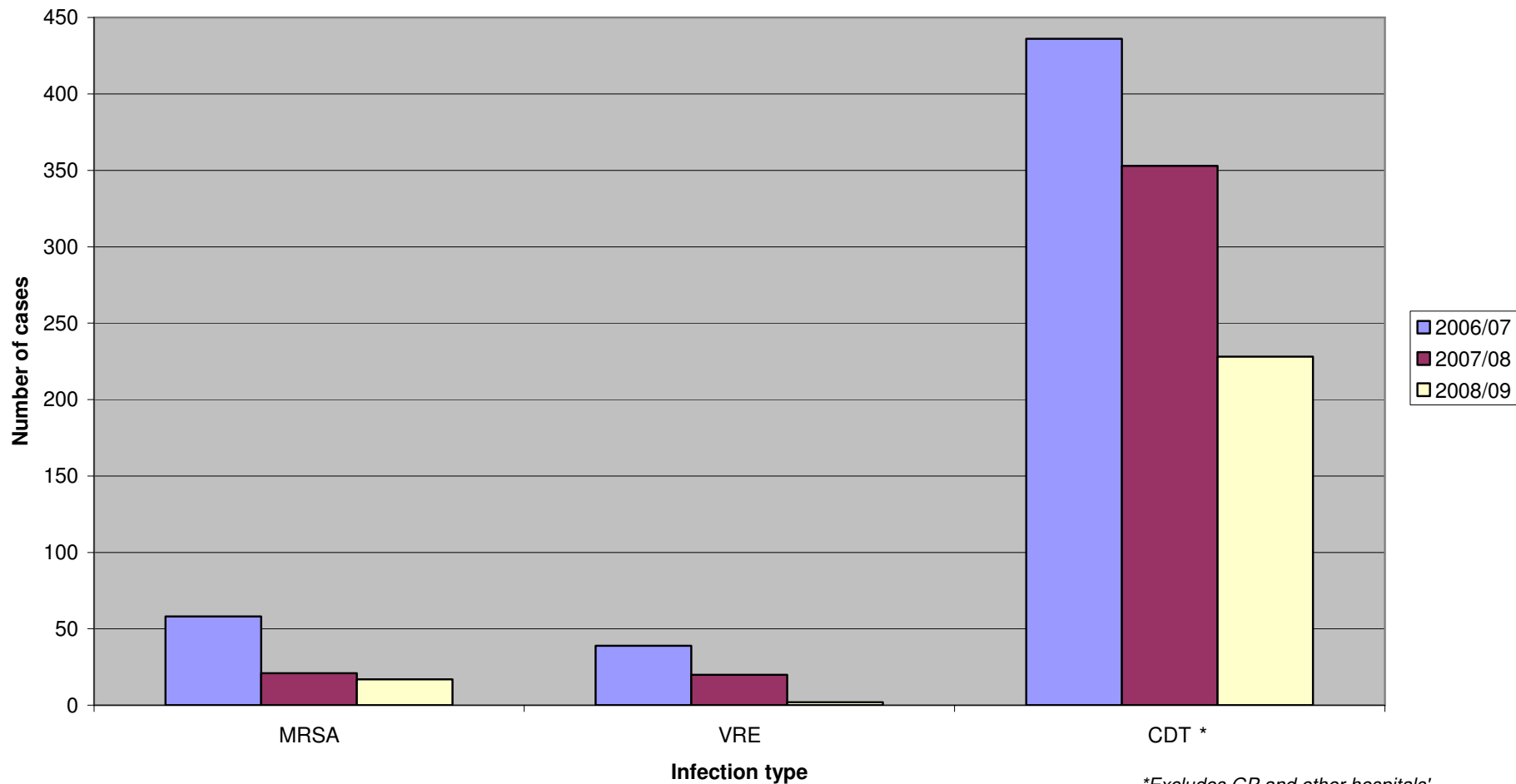
- Attendance of the Infection Control Committee will be audited annually, members are expected to attend (or send a nominated Deputy) to a minimum of four out of six meeting per year.
- Minutes and reports of the Infection Control Committee
- The Annual Infection Control Report will demonstrate the key activities and performance made Trust wide in infection control
- Healthcare Commission annual assessment of compliance against the Health Act (2006)
- Terms of Reference for Infection Control Committee reviewed annually



APPENDIX 2

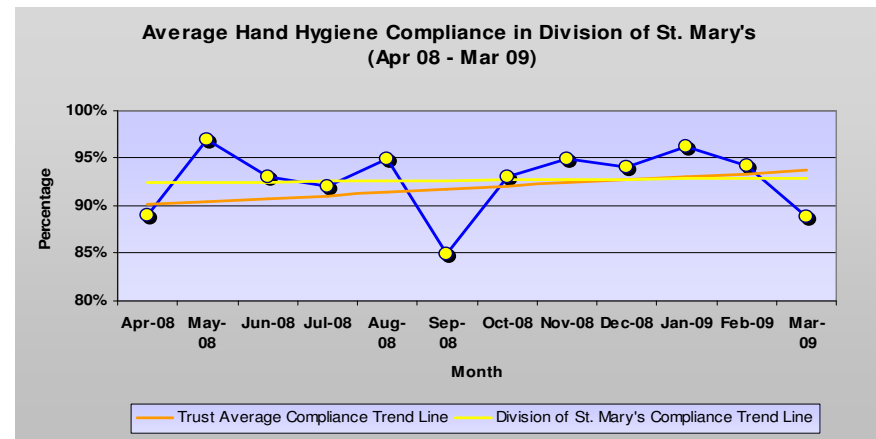
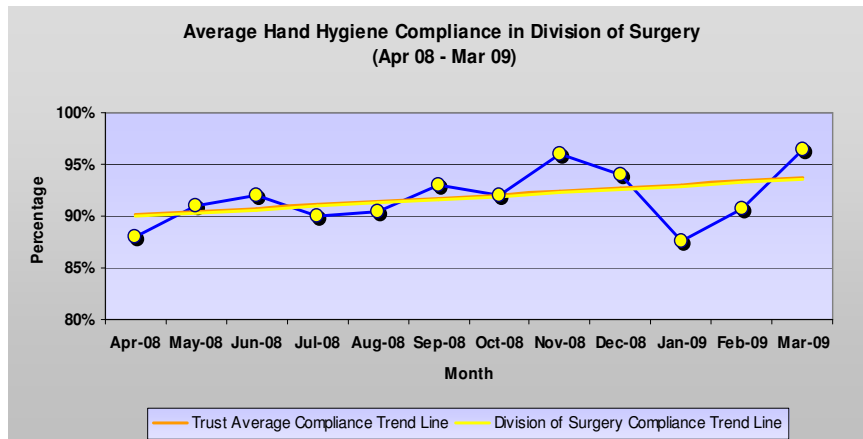
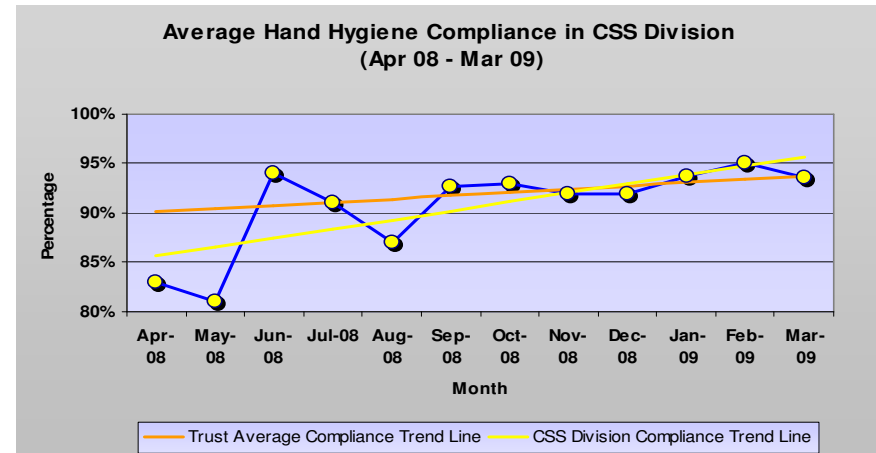
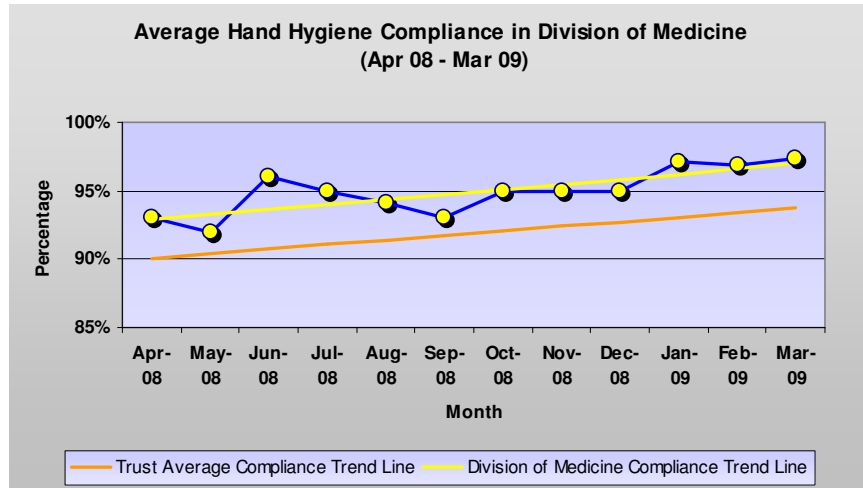
MRSA bacteraemia, VRE bacteraemia and CDT infections within CMFT 2006/07/08/09

Please note graphs are representative of CDT samples processed within the Trust's laboratories, so may not represent the total number of cases allocated to the Trust through the HPA mandatory reporting system



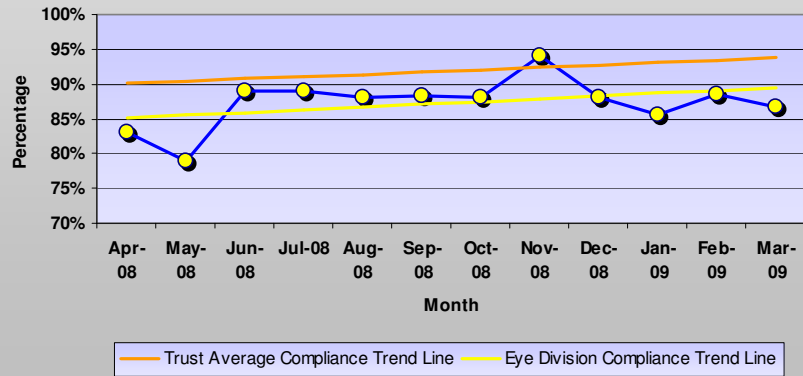


APPENDIX 3 – Audit
Figure 1: Audit of Hand Hygiene Practice

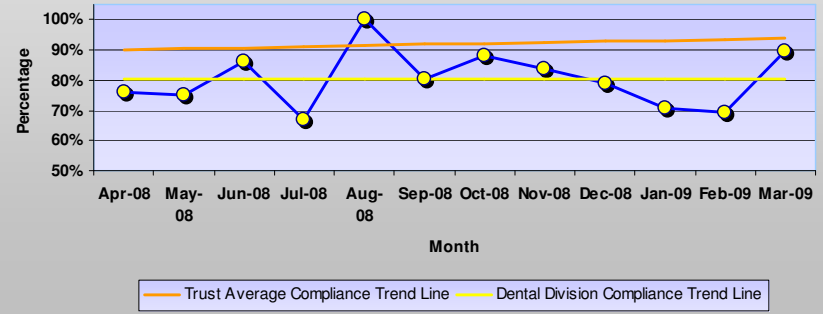




**Average Hand Hygiene Compliance in Eye Division
(Apr 08 - Mar 09)**



**Average Hand Hygiene Compliance in Dental Division
(Apr 08 - Mar 09)**



**Average Hand Hygiene Compliance in Childrens Division
(Apr 08 - Mar 09)**

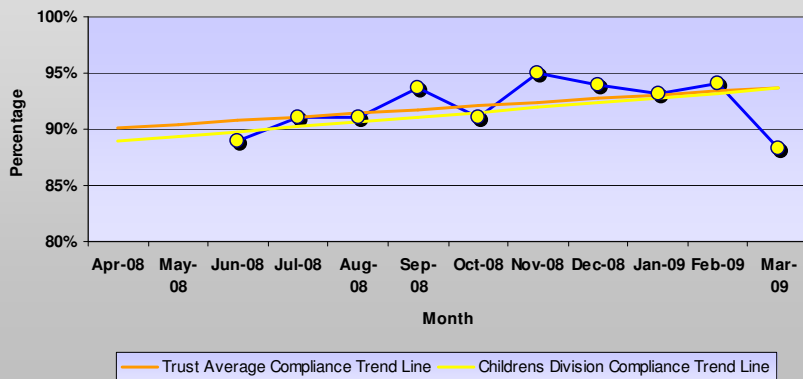




Figure 2: Audit of ANTT Trends in Division of Medicine

ANTT TRENDS- Medicine

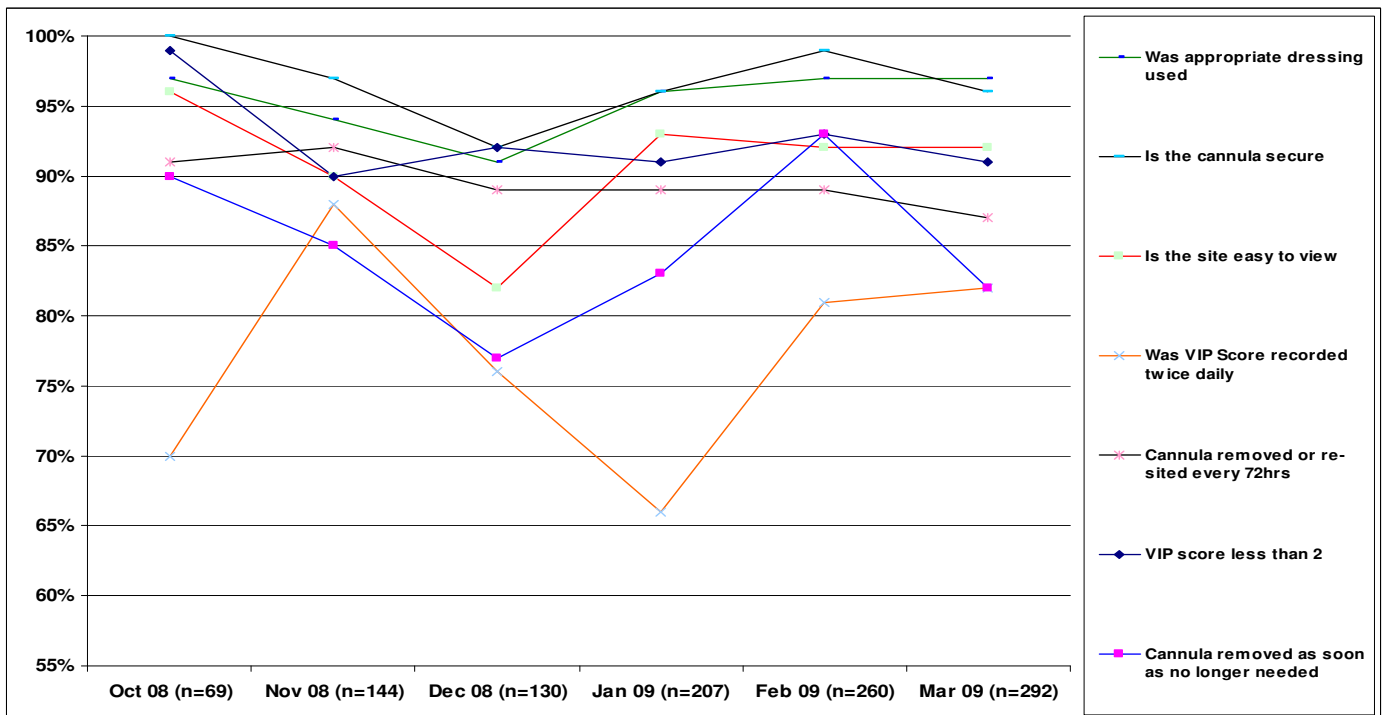
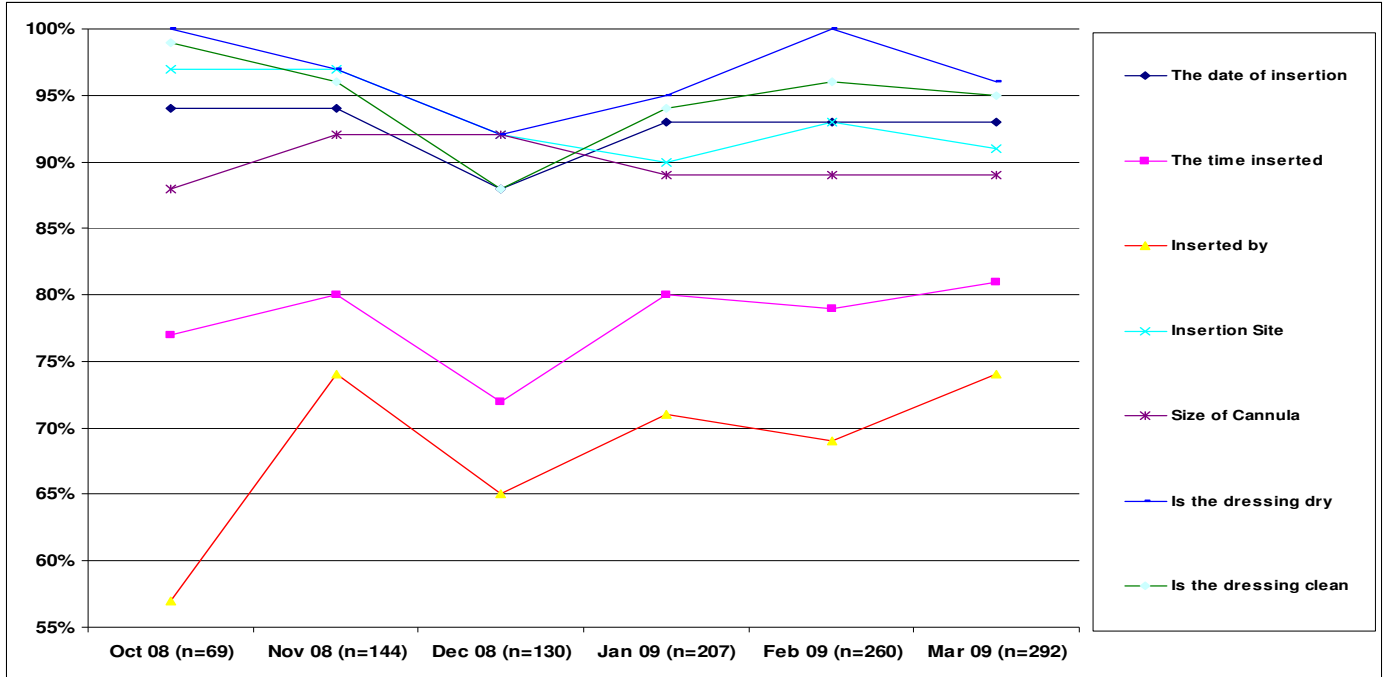
No of forms		34	70	56	65	77	72
	Standard	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Hands decontaminated		97	100	100	100	97.4	98.6
Explain rationale for hand decontamination		100	98.6	100	98.5	96.1	100
Appropriate aseptic field selected		100	100	100	100	94.8	100
Aseptic field cleaned correctly		100	100	100	100	93.5	98.6
All equipment gathered correctly		100	98.5	100	98.5	96.1	97.2
PPE worn		100	98.6	100	96.9	93.5	98.6
Individual able to articulate		100	98.5	100	98.5	96.1	98.6
Individual protects key parts in preparation phase		97	98.6	98.2	96.9	97.4	98.6
Patient identification confirmed		100	98.6	100	98.5	97.4	97.2
Key parts protected /prepared during procedure		100	97.1	98.2	95.4	93.5	98.6
If key parts contaminated did individual stop procedure		87	na	100	100	78.6	89
Hands decontaminated at end of procedure		97	97	100	98.5	96.1	100
Hands decontaminated at all times during procedure		94	97.1	100	100	97.4	97.2
Appropriate documentation completed		97	100	98.2	100	96.1	98.6
Disposal of all waste undertaken in accordance with policy		97	100	100	98.5	94.8	98.6

KEY

	95-100%
	90-94%
	<89%
(blank)	No data entered



Figure 3: Trends for the Criteria Relating to VIP (Peripheral Cannulae) for the Division of Medicine





APPENDIX 4 – Research & Innovation

Paper and Poster Presentations 2008/9

- ANTT our Journey from Board to Ward
 - Paper Presentation at National ANTT Conference, London, September and October 2008
 - Poster Presentation at IHI International Quality and Safety Conference (Berlin) March 2009
- ANTT our Journey at CMMC, Infection Prevention Society, National Conference, Harrogate, September 2008
- Preliminary Results of an In-Use Efficacy Trial of AzoMax Active Cleaning Products in an Acute Medical Environment. Federation of Infection Societies, Cardiff, Dec 2008.
- Reduction in Nosocomial Bacteraemia by a Standardized Aseptic Care Protocol. Society for Healthcare Epidemiology of America, San Diego, March 2009.
- Interim Analysis of an In-Use Efficacy Trial of a Novel Disinfectant in an Acute Medical Environment and Evidence of Residual Activity. Society for Healthcare Epidemiology of America, San Diego, March 2009.



APPENDIX 5 – Healthcare Commission Action Plan

Attachment 6: (Agenda Item 6)

**CMFT Action Plan in response to Unannounced HCC visit (22nd – 23rd October 2008)
January 2009**

	Comment	Action	Responsibility	Completion date
1	<p>Duty 4 c All parts of the premises in which it provides health care are suitable for the purpose, kept clean and maintained in good physical repair and condition</p> <p>“The trust has a multi-disciplinary, integrated approach to environmental cleanliness and associated risk assessment to ensure required standards are adhered to, maintained and improved as necessary. However, we visited four wards and there were a number of areas of concern identified during these observations. There were issues surrounding the cleanliness of all the wards inspected. Dust and dirt was seen at low and high levels, such as the curtain tracks and ventilation grilles in the patients’ areas. We observed that there were items stored inappropriately on more than one occasion. In some storerooms there were items stored on the floor, such as sterile intra-venous fluids, making it difficult to clean the area effectively. This is evidence that the trust does not meet this sub-duty.” <i>(HCC Hygiene Code Inspection Report January 2009)</i></p>	<ol style="list-style-type: none"> 1. Action plan developed with Sodexo 2. Joint monitoring to commence from January 09 3. Matrons ward rounds to support monitoring arrangements 4. Assurance provided to divisions and Trust Board through both contract performance management and matrons ward rounds 	<ol style="list-style-type: none"> 1. ADE&F/S odexo 2. ADE&F 3. ADNS 4. DoN 	<ol style="list-style-type: none"> 1. January 23rd Completed 2. January 31st Completed February 28th Completed March 31st Completed <p>And Ongoing</p>
2	<p>Duty 4 d The cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available</p>	<ol style="list-style-type: none"> 1. Cleaning Schedules to be publicly available in all areas with immediate effect 	<ol style="list-style-type: none"> 1. ADE&F/S odexo 	<p>January 31st 2009 Completed</p>



<p>“The trust has cleaning policies and contracts that aim to ensure full compliance with the national specifications for cleanliness. The cleaning arrangements detail the standards of cleanliness required in each part of the premises and include a schedule of frequencies for cleaning. Roles and responsibilities relating to duties are clearly specified. However, during ward visits we observed that cleaning schedules were not publicly available on any of the wards inspected. This is evidence that the trust does not meet this sub-duty.” <i>(HCC Hygiene Code Inspection Report January 2009)</i></p>			
<p>3 Duty 4 f There are effective arrangements for the appropriate decontamination of instruments and other equipment – these should be incorporated within appropriate disinfection and decontamination policies “The trust has a decontamination policy that outlines the decontamination programme. It has a decontamination manager with overall responsibility for the decontamination of equipment used for treatment. During visits to wards, we identified failures in the effective decontamination of laryngoscopes (medical instruments used to examine the vocal folds and glottis) that are used on the emergency resuscitation trolleys. We saw clean linen delivered and stored in an inappropriate manner. The trust’s system for identifying clean and contaminated equipment was ineffective, whereby green tags should be wrapped around equipment to signify that it is clean</p>	<ol style="list-style-type: none"> 1. Laryngoscopes for use on resuscitation trolleys will be replaced with disposable single use laryngoscopes immediately 2. A longer term plan to consider single use across the Trust is on going 3. review areas of non compliance with decontamination policy and ensure practice is addressed 4. procedure for decanting linen 	<ol style="list-style-type: none"> 1. DD CSS 2. DD CSS 3. DD CSS 4. NC IC/ADNS 	<ol style="list-style-type: none"> 1. January 09 Completed February 09 Completed 2. January 09 Completed January 09 Completed



	and ready for use. It was seen that this system has not been implemented in all the wards inspected and there was variation in its use. This is evidence that the trust does not meet this sub-duty." <i>(HCC Hygiene Code Inspection Report January 2009)</i>	provided to clinical areas and audited as part of ward rounds		
4	<p>Duty 4 g</p> <p>The supply and provision of linen and laundry supplies reflect Health Service Guidance (HSG) (95)18, <i>Hospital laundry arrangements for used and infected linen, as revised from time to time</i></p> <p>The trust's policy for the supply of linen and laundry is based on HSG (95)18 guidance. The policy for used and infected linen is reviewed with the ICT. The laundry facilities meet quality-assurance standards that are externally assessed. However, we observed that linen was inappropriately stored and distributed in the sites inspected. This practice does not comply with HSG (95)18. This is evidence that the trust does not meet this sub-duty." <i>(HCC Hygiene Code Inspection Report January 2009)</i></p>	1. The Trust has agreed the actions to address the transport of linen in accordance with the guidance. In addition the Trust infection control team has issued guidance to wards regarding the decanting of linen supplies in clinical areas	1. NC IC/ADE& F/Sodexo	1. January 09 Completed 31/03/09

Key

- DoN Director of Nursing
- ADNS Assistant director of Nursing
- ADE&F Associate Director of estates and Facilities
- Sodexo Site Director Health Care Services
- DD CSS Divisional director Clinical Scientific Services
- NC IC Nurse Consultant Infection Control



APPENDIX 6: Infection Prevention & Control Corporate Action Plan 2009/10

OBJECTIVE	ACTION	LEAD	DATE of COMPLETION
To continue to update Infection Control Policy Manual	Continue systematic update of Infection Control Policy Manual	Jo Rothwell	March 2010
To standardize corporate image of Staff working within the Trust to increase public confidence	Implement Dress Code Policy	Julie Cawthorne	October 2009
Consider flexible working hours of the ICN team to meet service needs	Review ICN cover	Jo Rothwell	July 2009
To reduce the incidence of MRSA infections and facilitate Policy for MRSA screening and decolonisation of all elective admissions	1. To develop standard protocol for MRSA screening and eradication therapy for patients prior to admission	1. Julie Cawthorne	June 2009
	2. Collaborate with Manchester PCT to implement Trust standard	2. Julie Cawthorne	August 2009
To extend MRSA screening to remaining emergency admissions	Review service provision	Andrew Dodgson	March 2010
To reduce the incidence of CDI	1. Review national guidelines	1. Andrew Dodgson	May 2009



and to implement new national guidelines for management of patients with <i>Clostridium difficile</i> infection	2. Develop and implement action plan	2. Andrew Dodgson	July 2009
To provide assurance of compliance with Core Clinical Procedures	Extend audit framework of ANTT practice and management of vascular devices to all Divisions	Julie Cawthorne	December 2009
To ensure all staff groups within the Trust access training in infection control core policies	1. All junior doctors to receive IC training during their induction in August 2009 and February 2010.	1. Dawn Pike/ Julie Cawthorne	August 2009 February 2010
	2. ICT to deliver training at Trust Induction and Mandatory Training sessions	2. Jo Rothwell	March 2009
	3. Agree programme of training and monitoring of PFI staff with Sodexo	3. Julie Cawthorne	June 2009
	4. Develop an 'e' learning package for clinical mandatory training	4. Janice Streets	June 2009
To enhance the role and function of ICLP	1. Increase numbers of ICLP to include more AHP's	1. Michelle Worsley	December 2009
	2. Update Role specification and training programme	2. Michelle Worsley	
To Continue to develop New technologies for HCAI	1. Continue to participate in Showcase hospitals Project 2. Continue work with TrusTech	1&2. Andrew Dodgson / Julie Cawthorne	March 2010