

**CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS
FOUNDATION TRUST**

Report of:	Director of Patient Services/Chief Nurse/Director of Infection Prevention & Control (DIPC)
Paper prepared by:	Consultant Nurse Infection Prevention and Control
Date of paper:	April 2011
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 10/11

Introduction

The Board is asked to receive the Annual Infection Prevention and Control report for 2010/11

Executive Summary

2010/11 has been another impressive year for Infection Prevention and Control within the Trust in which we have continued to sustain and improve performance in the reduction of Healthcare Associated Infection (HCAI) rates.

Building on this success the Trust implemented an end of year review of the incidence of HCAI in order to refocus and regenerate infection prevention and control practices, with the aim of taking the Trust nearer towards our aim of zero avoidable health care acquired infections

Challenges during the year have included the unusual and unprecedented emergence of multi-resistant coliforms, which were proactively managed and controlled across the Trust and the management of patients admitted with seasonal influenza during the peak period of winter.

Key Achievements

- 1 The actual number of MRSA bacteraemias attributed to the Trust was seven. This is the second successive year in which the Trust has achieved less than ten incidents of MRSA bacteraemia
- 2 The total number of incidents of *Clostridium difficile* infection (CDI) attributable to inpatients at CMFT was 106. This was 54% below the agreed target of 231 cases and a 14% reduction in comparison to 2009/10. This was facilitated by sustained monitoring of antibiotic prescribing.
- 3 The trend for hand hygiene indicated an increased compliance from 97% to 98% for 2010/11 compared to 94% to 97% for last year.
- 4 Auditing compliance with Aseptic Non Touch Technique (ANTT) and Visual Inspection of Phlebitis (VIP) scores which originated in the Divisions of Medicine and Surgery in 2009/10 have been successfully rolled out across the Trust this year.
- 5 This year saw the emergence of a unique and unprecedented incidence of multi-resistant coliforms (carbapenemase producing coliforms (CPC) amongst patients

in CMFT. Between August and December in order to proactively manage the outbreak the decision was taken to close a ward to new admissions. Whilst this resulted in a number of patients having their surgery delayed it was considered best practice by the Health Protection Agency who we liaised with throughout the outbreak. In the months of January 2011 – March 2011, the Trust continued to proactively screen high risk wards and departments and whilst the numbers of patients with CPC's did not diminish, it is notable that most patients identified were colonised with the organism as opposed to being infected.

- 6 H1N1 became the seasonal influenza virus. This year, in line with previous years, influenza activity in the North West started to increase in week 47 (the week beginning 22 November 2010), peaking in week 51 (the week beginning 20 December 2010). At CMFT, the peak occurred in the last week of 2010. Local staff vaccination clinics commenced on 20th December and continued into the first two weeks of 2011. In all 2,700 staff were vaccinated.
- 7 The rise in influenza activity this season was much higher than any increases seen in recent years and caused significant pressures on hospitals and laboratory services including CMFT, resulting in the cancellation of non-urgent Surgical work for two weeks.
- 8 The Trust Decontamination Group made considerable progress in improving existing decontamination services for re-processing of endoscopes. The business case for centralisation has also moved forward. A variation enquiry was submitted to Project Co for the works in order that the costs can be included in the final business case which will be presented to Trust Management Board in 11/12
- 9 As part of the work to ensure continuous improvement to the cleanliness of the environment; the Trust in partnership with Sodexo launched a programme called Cleaning Matters. The programme aim was to develop team working in clinical areas through joint training. The main objective was to facilitate local ownership and local action to improve the patient experience and remove delays which can occur when issues are escalated through the contractual process; this work continues.
- 10 The Infection Prevention and Control Team organised its second annual Infection Prevention & Control Study Day for all staff in September 2010. The event was well attended and included a range of topics delivered by both internal and external speakers.
- 11 The Trust continued as the North West representative for the Showcase Hospitals Project for the third successive year. This included; a trial of new patient furniture, a system for monitoring cleaning and an in house evaluation of a new test for *Clostridium difficile* Infection
- 12 The Trust was successful in unconditional registration with the Care Quality Commission following self assessment against the standards in the Health and Social Care Act (2008): Code of practice for health and adult social care on the prevention and control of infections and related guidance (the Hygiene Code)
- 13 The Trust internal audit reports on the effectiveness of infection control processes reported significant assurance



Central Manchester University Hospitals



NHS Foundation Trust

**INFECTION PREVENTION &
CONTROL ANNUAL REPORT
2010/2011**

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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, continued her tenure as the Director of Infection Prevention and Control (DIPC) for the Trust.

2.2 The Infection Prevention & Control Team (IPCT)

The current IPCT was established in 2007/8. This year there were some changes to the team. The IPC Lead Nurse was initially seconded to a post as a matron in the Division of Specialist Medicine in June 2010. An appointment of an IPC Nurse specialist was made on a fixed – term contract to cover the secondment. The IPC Lead Nurse was appointed to a substantive post in the Division of Specialist Medicine from April 1st 2011.

The post of Healthcare Associated Infections (HCAI) Surveillance Officer became vacant in August 2010. Following a team review this post has been recently re-advertised. The IPCT have received support from the Informatics Directorate to report mandatory surveillance data during this vacancy period.

Over the past year one team member has unfortunately been on long-term sickness leave from October 2010.

The team comprised of the following personnel (whole-time equivalent (WTE) unless otherwise stated):

- Dr Andrew Dodgson, Microbiologist and Infection Prevention & Control Doctor (IPCD)
- Mrs Julie Cawthorne, Consultant Nurse, Infection Prevention & Control
- Mrs Jo Rothwell, Lead Nurse, Infection Prevention & Control (April 2010 – June 2010)
- 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
- Ms Amanda Pagett Infection Prevention & Control Nurse Specialist (temporary fixed-term contract from June 2010)
- Mr Federico Tabios Junior (0.6 WTE), Infection Prevention & Control Nurse Specialist
- Miss Rachel Soutar, Surveillance Officer (April 2010 – July 2010)
- Ms Ann France, Secretary (retired October 2010)

2.3 The Infection Control Committee

The Infection Control Committee (ICC) was chaired by the DIPC and met every two months. The Committee had corporate responsibility for all Infection Prevention & Control issues and monitoring the implementation of the Annual Infection Prevention & Control plan. The Committee had the following sub-committees which each provided regular reports to the committee meetings:

- Infection Prevention & Control Expert Group
- Medical Devices Committee
- Antibiotics Group
- The Patient Environment and Patient Experience Group
- Trust Decontamination Group

The Infection Control Committee reports to the Trust Clinical Effectiveness Committee

The Trust Strategy for Infection Prevention and Control defines the structure and activities of infection prevention and control within CMFT. It was updated this year and 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 addressed Infection Prevention & Control issues at a local level either as a standing item on the Divisional Clinical Governance meeting or through a separate Divisional Infection Prevention & Control Committee/Group. These meetings included representatives of the IPCT and provided an excellent forum for discussion and resolution of local issues.

2.5 The Infection Prevention & Control Wednesday Weekly Meetings

The Infection Prevention and Control Wednesday Weekly Meetings were a forum to present and discuss incidents of HCAI including; Meticilin resistant *Staphylococcus aureus* (MRSA) bacteraemias and Periods of Increased Incidence of *Clostridium difficile* Infection. The meetings were an opportunity for staff to share experiences and lessons learned were incorporated into action plans that were monitored and reviewed at Divisional Infection prevention and control meetings.

SECTION 3: BUDGET ALLOCATION TO INFECTION PREVENTION & CONTROL ACTIVITIES

3.1 Funding for Infection Prevention & Control Services

The infection prevention and control team provided a trust – wide service. Funding is located with in the Division of Clinical and Scientific Services. In accordance with the Trusts wider organizational financial objectives the IPCT funded establishment was reviewed and the following adjustments were made:

The post of HCAI Surveillance Officer has been reviewed in accordance with agenda for change and as there are no managerial responsibilities associated with the post it was re-banded from Band 6 to Band 5.

3.2 Microbiology Laboratory Services

- Funding for Microbiology Laboratory services (including outbreaks of infection) was covered by the Service Level Agreement (SLA) between the Trust and the Health Protection Agency.
- Additional funding was resourced this year for extended MRSA screening.
- Financial supports for outbreaks of infection (excluding laboratory costs) were sourced locally by the divisions.

3.3 Service Level Agreement

- The Service Level Agreement of 0.4 (WTE) Band 7 with the Manchester Mental Health and Social Care Trust continued this year. It includes all key Infection Prevention & Control activities for services based at the Central site.

3.4 Electronic surveillance System

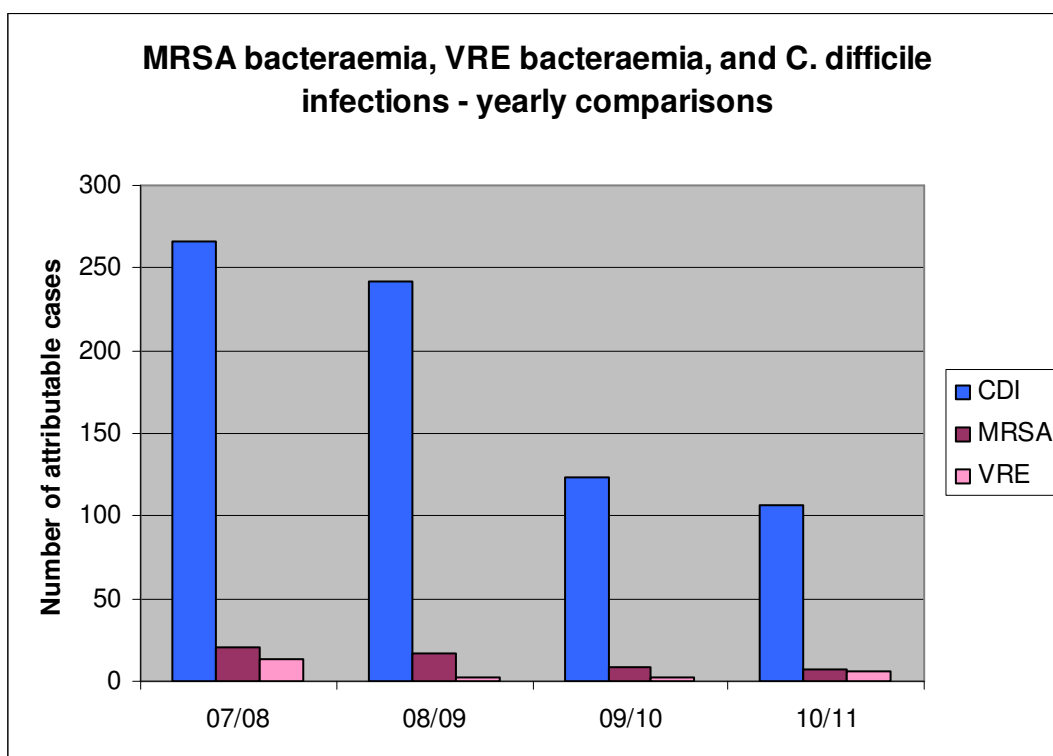
- Recurrent funding for ICNet (electronic Infection Prevention & Control surveillance database) was met from the divisions.

SECTION 4: HEALTHCARE ASSOCIATED INFECTION (HCAI)

4. HCAI Performance Targets

National performance targets for HCAI's began in April 2005. This year the Trust has continued to sustain and improve performance as can be seen in Fig. 1 below.

Fig. 1 Incidence of HCAI in CMFT April 2007 – March 2011



Building on this success the Trust implemented an end of year review of the incidence of HCAI in order to refocus and regenerate infection prevention and control practices, with the aim of taking the Trust nearer to our aim of zero avoidable health care acquired infections

4.1 Meticilin Resistant *Staphylococcus aureus* (MRSA) Bacteraemias

The annual targets and actual results for CMFT from 2005/6 to 2010/11 can be seen below in Fig 2. The MRSA bacteraemia trajectory for 2010/11 for Vital Signs for CMFT was six.

This year the Department of Health introduced a new system for attributing incidents of MRSA bacteraemia. Incidents that counted towards the Trust trajectory were those that occurred to patients 48 hours or more after their admission. Incidents of MRSA bacteraemia that occur within 48 hours of admission were attributed to the Primary Care Trust (PCT).

Fig. 2 Incidents of MRSA bacteraemia reported to the Department of Health

Year	Target	Actual Number Reported
April 2005 – March 2006	47	54
April 2006 – March 2007	35	59
April 2007 – March 2008	24	21
April 2008 – March 2009	24	17
April 2009 – March 2010	24	8
April 2010 - March 2011	6	7 + 4 *

* There were 7 post 48 hour incidents of MRSA bacteraemia and 4 pre-48 hour incidents reported to the Department of Health.

Each incident of MRSA bacteraemia was investigated using a Root Cause Analysis (RCA) tool, and presented to the weekly Infection Prevention & Control meeting, chaired by the Director of Infection Prevention & Control (DIPC) or her deputy.

4.2 Extended Screening for MRSA

The Trust was compliant with national guidance on extended screening for all elective/emergency admissions as of December 2010.

General Practitioners in some practices across Manchester PCT (and other PCT's), however have remained resistant to providing appropriate re-screening and decolonisation therapy for MRSA positive patients prior to their admission. The IPCT has worked with other colleagues in acute services across Manchester to address this issue. In the interim some patients have returned to CMFT for follow-up decolonisation therapy and re-screening prior to admission.

4.3 Reporting of Meticilin Sensitive *Staphylococcus aureus* (MSSA) Bacteraemias

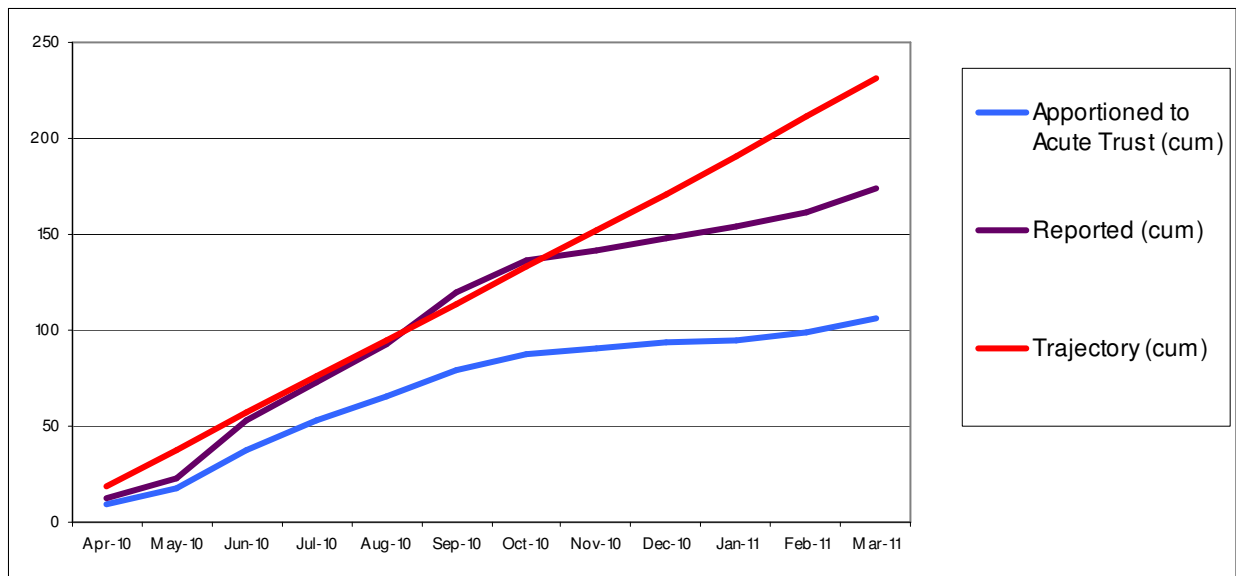
The Department of Health added MSSA bacteraemias to the mandatory reporting of HCAI's in January 2011.

Trust-wide there were eight incidents of MRSA bacteraemia last year (09/10) where as there were 99 incidents of MSSA bacteraemia for the same period. To date no target has been set for reducing the incidence of MSSA bacteraemia.

4.4 Clostridium difficile Infection (CDI)

The Trust had an agreed target with the PCT of 231 attributable cases of CDI in all patients over the age of two for the year 2010/11. The distribution of these cases can be seen in the graph below. Similarly to MRSA bacteraemia the cases of CDI that were attributable are those which occurred three days after admission.

Fig. 3 Incidence of CDI in CMFT April 2010 – March 2011



The total number of cases attributable to CMFT was 106 in 2010/11. This was a 54% under the agreed trajectory of 231 cases; this was a remarkable achievement and was primarily attained through antibiotic stewardship.

4.4.1 CDI Periods of Increased Incidence (PII's)

In accordance with national guidance, CMFT introduced monitoring of 'Periods of Increased Incidence' (PII) from July 2010. The definition of a PII was two or more new cases of CDI occurring greater than 48 hours post admission (not including relapses), in a rolling 28 day period on the same ward.

All ward/departments identified as having a PII initiated audit processes in order to identify any issues facilitating ongoing transmission and provide assurance that infection prevention and control measures were being implemented.

4.5 Vancomycin Resistant Enterococci (VRE)

The Trust reported all incidents of VRE bacteraemia to the Health Protection Agency (HPA). The total number of incidents for this year to date is five (annual totals run from October – September). Two occurred in the Division of Medicine, two in the Division of Surgery and one in the Critical Care Directorate. This is an increase from last year (October 2009– September 2010), when the total number of incidents was four it is however difficult to draw any conclusions at the time of this report.

4.6 Review of Figures for MRSA Bacteraemia and *Clostridium difficile* Infection

The following table compares annual incidence of infection rates over the last two surveillance periods.

Infection type	2009/10	2010/11	% reduction
MRSA Bacteraemia ¹	8	7	12.5
Clostridium difficile Infection ²	123	106	14

^{1and 2} Trust-apportioned cases

4.7 Surgical Site Infection (SSI) National Surveillance Scheme

The Trust participated in both mandatory (orthopaedic) and voluntary (coronary artery bypass graft (CABG) reporting of SSI to the Health Protection Agency (HPA).

4.7.1 Knee Replacement Surgical Site Infection (SSI) rates

The Trust is required to submit a minimum of one quarter of data per year to comply with mandatory reporting for orthopaedic implant surgery.

This year the surveillance period was quarter three (July – September 2010). Data was collected from 67 patients who underwent knee replacement surgery. The results fed back from the HPA can be found in fig 4 below. The figures include the previous year's data (during which data was gathered for three quartiles) in order to provide some comparison.

Two patients developed a wound infection. One of these patients had a revised knee replacement and developed an infection that subsequently healed. The second patient received a course of antibiotics as an out patient for a minor wound infection.

Fig. 4 SSI rates for Knee replacement surgery

Overall SSI rate

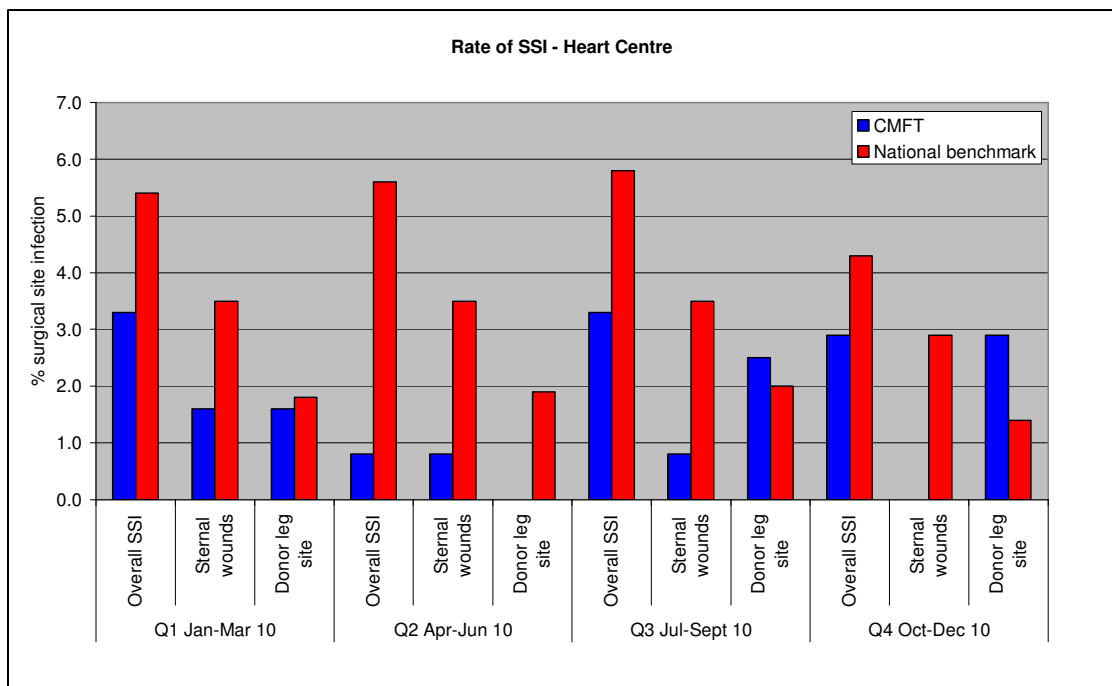
Quarter	Time period	CMFT (%)	National benchmark (%)
Q1	Jan-Mar 09	0.0	1.0
Q2	Apr-Jun 09	5.6	1.0
Q4	Oct-Dec 09	0.0	1.1
Q3	Jul-Sep 10	1.5	0.6

4.7.2 Coronary Artery Bypass (CABG) Surgery SSI

The Manchester Heart Centre participated voluntarily in the national SSI scheme. The overall results from the surveillance demonstrate that performance is better than the national benchmark (Please see Fig 5. graph below).

This is a significant improvement on last year's results when the results for CMFT were above the national benchmark for the first three quartiles of the year. This improvement has been due to changes overseen by a multi-disciplinary cardio-thoracic SSI group which has included members of the IPCT.

Fig. 5 Graph to show rates of SSI in Coronary Artery Bypass Graft Surgery for Manchester Heart Centre



4.8 Outbreaks of Infection

4.8.1 Carbapenemase Producing Coliforms (CPC's)

Coliform organisms such as *Klebsiella* producing carbapenemase enzymes (particularly the KPC enzyme) are recognised as an emerging threat worldwide. These organisms have been infrequently identified in the UK; however CMFT became the first trust to experience an issue with these pathogens. Evidence obtained by the HPA suggests that the KPC enzyme is transmitted between strains via a mobile piece of DNA (called a plasmid), though plasmids are a very common method used by the bacteria to transmit antibiotic resistance the one implicated in the current problem at CMFT appears to be unique to the Trust.

The first CPC was identified at CMFT during 2009-10, and the numbers increased considerably during 2010-11. In order to manage the situation and limit spread the Trust adopted a proactive response. This included;

- Liaison with the Health Protection Agency on a national and local level
- Development of a Policy for the identification and management of patients with these organisms
- Strict monitoring of hand hygiene practices particularly on those wards where there were patients who were positive
- Screening of the wider population of in-patients to identify carriage.
- Information for patients
- Reviewing antibiotic guidelines to reduce the use of carbapenems
- Additional cleaning of the environment with disinfectant
- Developed methods for screening for CPC's.
- DIPC and Medical Director closely involved & monitored the situation

Despite this responsive approach additional measures were required to control the situation. The following wards were closed for a period of time between August and December 2010. On each occasion the decision to close a ward was made following due consideration in respect of the potential adverse effect on patient throughput and delays to admission. The situation was reviewed by the HPA, the Infection Prevention & Control Doctor and Medical Director and it was agreed the Trust's approach to the situation was broadly appropriate, a number of recommendations were made primarily relating to investigating the epidemiology of the problem, these are currently being worked on by the IPCT in conjunction with the HPA.

Ward Closures due to CPC August – December 2011

Ward	Date closed	Date opened	Total days	Bed days lost
Ward 7	27/08/10	03/09/10	8	224
Ward 12	15/10/10	29/10/10	14	392
Ward 12	11/11/10	05/12/10	24	672
Ward 11	29/10/10	03/11/10	6	168
Ward 32	25/10/10	2/11/10	9	144
TOTALS			61	1600

As an additional control measure the Trust commissioned a one month managed service contract, during December 2010, with Bioquell to enhance environmental decontamination using Hydrogen Peroxide Vapour (HPV).

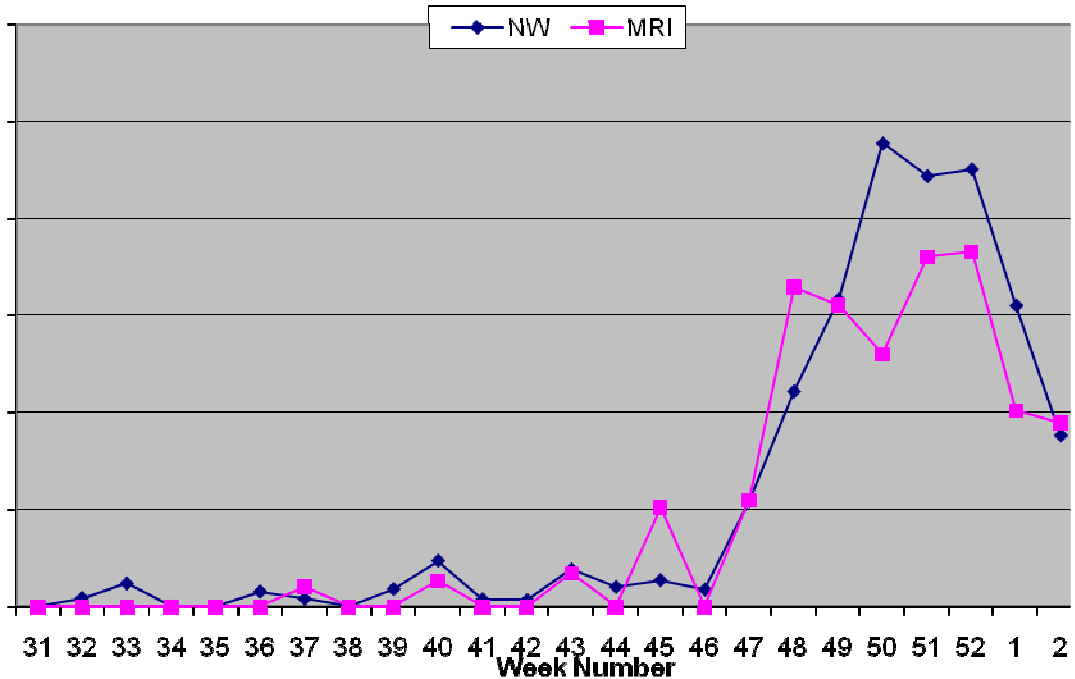
In the months of January 2011 – March 2011, the Trust continued to proactively screen high risk wards and departments and whilst the numbers of patients with CPC's did not diminish, it is notable that most patients identified were colonised with the organism as opposed to being infected.

4.8.2 Seasonal Influenza

H1N1 became this season's predominant influenza virus. This year, in line with previous years, influenza activity in the North West started to increase in week 47 (the week beginning 22 November 2010), peaking in week 51 (the week beginning 20 December 2010).

At CMFT, the peak occurred in the last week of 2010, when 36.5% of samples were positive for influenza (please see Fig 6). According to the North West Health Protection Agency, the rise in influenza activity this season was much higher than any increases seen in recent years and caused significant pressures on hospitals and laboratory services including CMFT.

Fig. 6: Samples positive for influenza (A and B), North West and CMFT (% samples tested) - Data from North West (HPA)



4.8.3 Influenza Vaccination for Staff

Additional measures were taken to increase access to vaccination for staff using a similar model to the previous year. Each division set up local vaccination clinics in addition to the 'drop in' sessions organized by the Occupational Health Department.

Local vaccination clinics commenced on 20th December, (four weeks after activity started to increase and the week that activity peaked regionally, although a week before it peaked at CMFT). Local divisional staff vaccination clinics ceased in the second week of January 2011 however 'drop in' sessions continued through the Occupational Health Department. In all 2,700 staff were vaccinated.

4.8.4 Outbreaks of diarrhoea and vomiting

There has been seven outbreaks of Norovirus and one outbreak of Rota virus during 2010/11 (please see table below). Appropriate control measures were implemented and all outbreaks were promptly resolved.

Ward	Date of Closure	Number of days closed	Number of patients affected	Number of staff affected	Number of cases confirmed by PCR	Bed days lost
AM2	10/04/10	7	16	0	5	196
AM1	13/04/10	13	12	0	1	392
Ward 16 Trafford	28/04/10	8	5	2	0	144
Ward 84	02/05/10	5	17	0	7	100
Ward 1 Trafford	27/09/10	5	7	4	3	85
Ward 85	16/09/10	6	9	10	9	120
Ward 83	30/03/11	6	5	9	3	49
TOTALS			71	25	28	1086

SECTION 5: DECONTAMINATION SERVICES

5.1 The Trust appointed Lead for Decontamination was the Associate Director of Estates and Facilities.

5.2 Trust Decontamination Monitoring Group

The Trust Decontamination Monitoring Group met four times this year and reported to the Trust Infection Control Committee on Decontamination matters. A review of the Trust Decontamination Policy was completed in December 2010.

5.3 Staff Decontamination Training – Principles of Decontamination Training

Managers, supervisors and staff received training in the principles of decontamination. This best practice, theory and awareness training was bespoke and targeted all managers and staff in areas that undertake decontamination of re-usable medical as a specific part of their work role.

5.4 Adverse Total Viable Count (TVC) Results

In accordance with national guidance the Trust has developed a system for monitoring the quality of water used in the automated decontamination process for endoscope washer disinfectors. This year significant investment was made to address adverse testing results. Work completed to date has included:

- Development of a Trust management protocol
- Chemical treatments of endoscopy equipment and systems
- Implementation of engineering solutions (e.g. stainless steel ring mains; increased maintenance regimes)
- Review by multi-agency, multi-disciplinary teams
- Trust Renal Technicians were trained in the correct methods for water sampling in March 2011.

5.5 Review of Local Re-processing of Endoscopes

Local re-processing of endoscopes occurred in several departments within the Trust including the Endoscopy Unit. The Endoscopy Unit was reviewed by the Joint Accreditation of Gastroenterologists (JAG) and will be accredited following implementation of suggested recommendations.

5.6 Business Case for Centralization of Endoscope Re-processing

The Trust wide group set up to review options for the centralization of endoscope re-processing made excellent progress. Options were reviewed, designs drafted and a procurement open day took place, where companies had the opportunity to present their decontamination equipment solutions. A 'variation' enquiry was submitted to Project Co for the works so that the costs can be included in the final business case which will be presented to Trust Management Board in 2011/12.

SECTION 6: CLEANING SERVICES

6.1 Management Arrangements for Cleaning Services

Since October 2008 the Trust has sub contracted cleaning services through the PFI contract; these are provided by Sodexo. This contract was 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).

The contract was managed and monitored 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.

The Trust worked closely with Sodexo to ensure that acceptable standards of cleanliness were delivered and that any cause for concern was escalated through the agreed contract rectification and escalation processes.

6.2 Monitoring Performance

In line with the contract schedule, Sodexo operated a self monitoring regime, against agreed performance standard indicators and the Trust received a monthly report which was analysed and where appropriate challenged by the Facilities Monitoring Team with input as required from the Infection Prevention and Control team. The analysis undertaken compared information collation from a number of sources to confirm that the data provided from Sodexo Healthcare was reflected in the experience of the Trust. Areas of non-performance, or where performance did not meet required standards, were formally addressed through contractual remedies including financial deductions and through agreed action plans which were monitored by the Trust.

6.3 Cleaning Matters

As part of the work to ensure continuous improvement the Trust, in partnership with Sodexo, launched a programme called Cleaning Matters. The programme aim was to develop team working in clinical areas through joint training. The main objective was to facilitate local ownership and local action to improve the patient experience and remove delays which can occur when issues are escalated through the contractual process.

The roll out of this programme commenced in December 2010 and initial results have shown improved standards of cleanliness and responsiveness to service delivery and associated patient care. This work continues.

6.4 Annual Patient Environment Assessment Team (PEAT) Assessment January 2010

The outcomes of the PEAT Assessment for 2010 are illustrated in the table below, although it should be noted that these have not yet been confirmed by the National Patient Safety Agency (NPSA). These results demonstrate an improvement from the results in 2009.

In previous years the Trust has completed four separate assessments for Booth Hall and Royal Manchester Children's Hospitals, St Marys Hospital and the Manchester Royal Infirmary and Royal Eye Hospitals. In 2010, due to the centralisation of all Hospitals onto a single site one single assessment was undertaken.

Environment	Food	Privacy & Dignity
GOOD	GOOD	GOOD

SECTION 7: AUDIT

In accordance with the Health Act (2008) all NHS organisations are required to audit key policies and procedures for infection prevention and control to provide assurance that practice is effective in the prevention of Health Care Associated Infections (HCAI's).

7.1 Audit of Clinical Practice

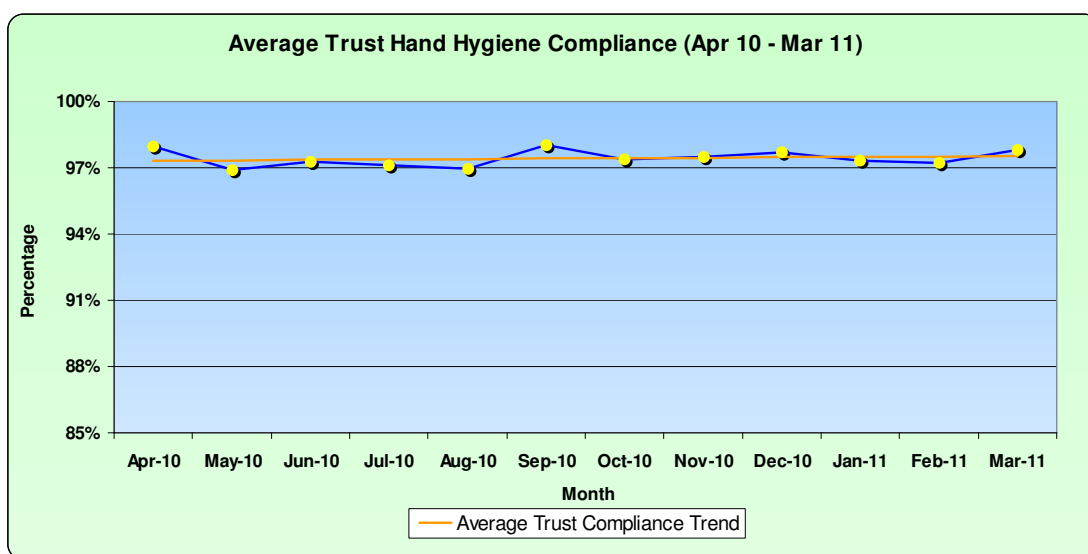
The key practices that reduce the risk of HCAI include; hand hygiene, asepsis during clinical procedures and monitoring of in-dwelling intravenous catheters.

7.1.1 Audit of Hand Hygiene Practice

Hand hygiene is the single most important method of preventing cross infection. All clinical areas undertook weekly audits of opportunities for hand hygiene. These results were submitted online via the Trust Intranet site. The audit department analysed the results and a monthly report was produced which was disseminated to the DIPC and the divisions.

Compliance with hand hygiene remained constant across the Trust at 97-98%. This is an improvement from the previous year (2009/10) when compliance was 94-98%. The results for the year 2010/2011 can be seen below in Fig 1.

Fig.1 Average Trust Hand Hygiene Compliance 2010/11



The audits for hand hygiene compliance in individual divisions can be found in Appendix 2

7.2 Aseptic Non-Touch Technique (ANTT) and Visual Inspection of Phlebitis (VIP) Score Audits.

ANTT and VIP audits were reported quarterly and were extended to include all clinical divisions (with the exception of the Dental Hospital) in a rolling programme during April 2010/March 2011.

7.2.1 Audit of Aseptic Non-Touch Technique

The ANTT audit comprised of 14 components and all clinical wards/departments submitted a sample size of 20 per quarter. Results (below) demonstrate the percentage compliance rate where all 14 standards were met. Results indicate a high level of compliance. (The audit results for individual divisions can be found in Appendix 3)

Division	Q1	Q2	Q3	Q4
Medicine	98.2%			
DARES	N/A	99.2%	97.9%	92%
SMS	N/A	98.4%	98.4%	98%
Surgery	99.1%	99.1%	98.9%	95%
Children's	88.4%	90.7%	92.2%	92%
CSS	N/A	90.0%	85.0%	82%
Eye	N/A	92.8%	100.0%	75%
St Marys	N/A	88.8%	96.7%	98%

(Note, the Division of Medicine was replaced in Quarter 2 by the Division of Acute, Rehab and Emergency Services (DARES) and Specialist Medical Services (SMS)).

7.2.2 Audits of Visual Inspection of Phlebitis (VIP) Score

The VIP audit consisted of 14 questions. Clinical areas that participated submitted a maximum sample size of 20 per quarter although in some wards/departments this was variable as there were insufficient numbers of patients with peripheral intravenous devices.

The results are tabled below. Overall the results improved over the year however; on investigation it was found that there were inconsistencies in documentation of indwelling intravenous catheters as the patient moved from one department to another. The IPCT continue to work with the divisions to address this issue. (The audit results for individual divisions can be found in Appendix 4)

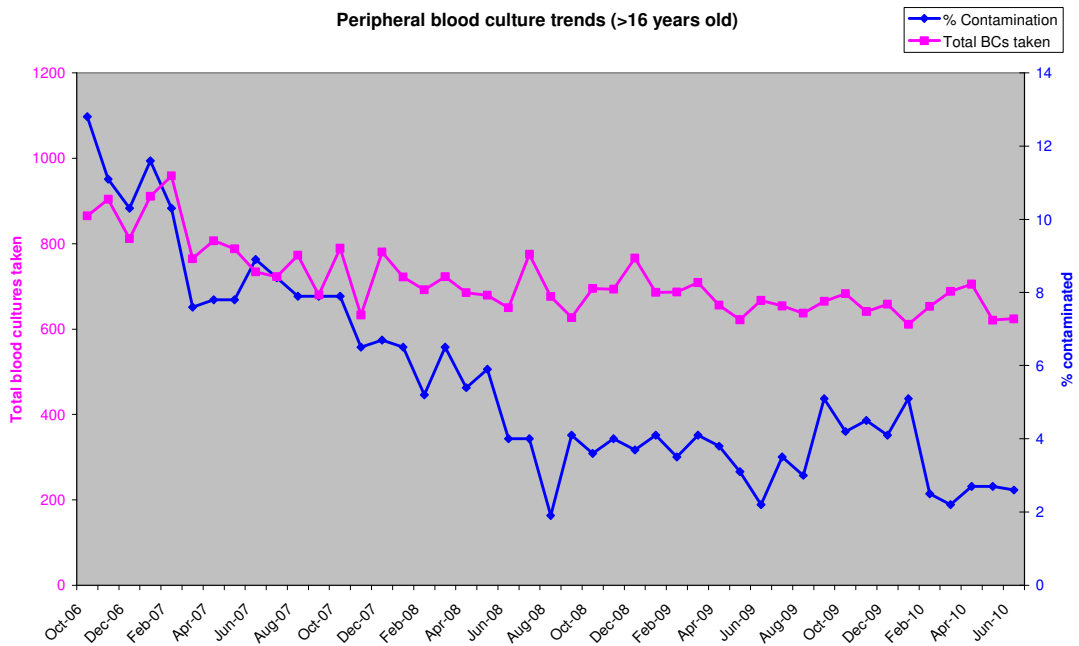
Division	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Medicine	69.90%			
DARES	N/A	55.60%	68.30%	63%
SMS	N/A	70.30%	71.60%	74%
Surgery	59.40%	60.00%	56.50%	59%
Children's	13.40%	20.00%	28.70%	21%
CSS	N/A	43.30%	20.00%	30%
Eye	N/A	85.00%	66.70%	95%
St Marys	N/A	76.90%	59.40%	86%

7.3 Audit of Blood Culture Contamination Rates

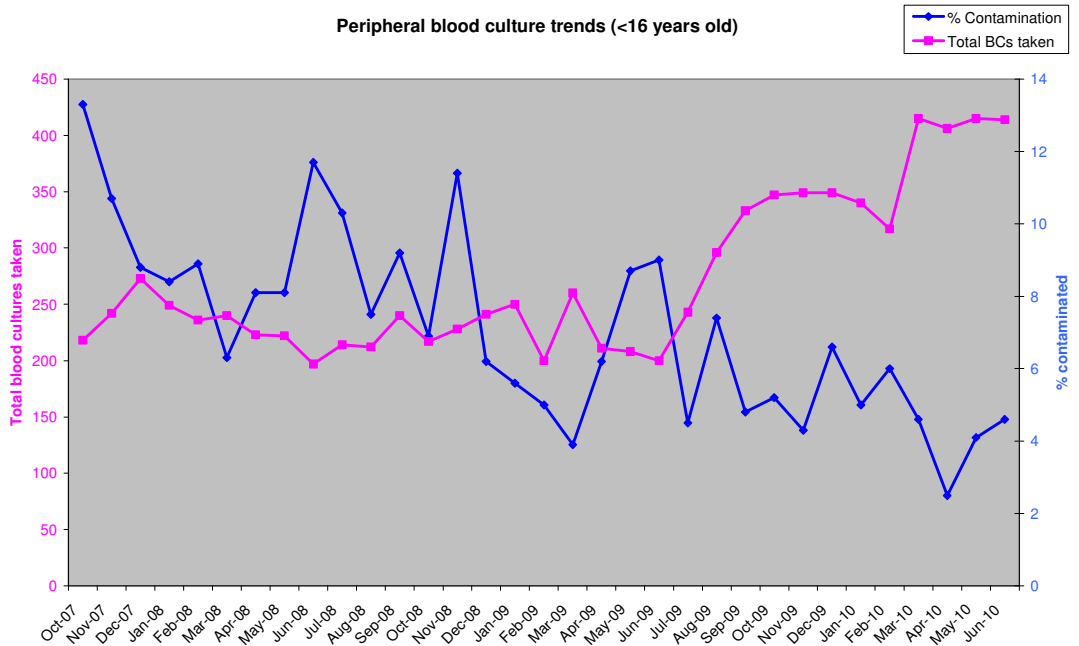
Trust wide the trend in blood culture contamination rates has declined since the start of data collection.

The data is separated into two groups by patient age (those less than 16 years old, and those greater than 16 years old please see graphs below). Contamination rates for both groups was 13% in December 2007 where as the average for 2010 was between 2-6%.

Peripheral blood culture contamination rates for patients greater than 16 years of age



Peripheral blood culture contamination rates for patients less than 16 years of age



Please note that monitoring of blood culture contamination rates and monthly reports were disseminated trust wide until June 2010 and have since been suspended pending the appointment of a new Surveillance Officer

7.4 Antibiotic Prescribing Guidelines, Restricted Antibiotic Agents and MRSA Theatre Pathway

7.4.1 Audit of Antibiotic Prescribing Guidelines

A number of audits were undertaken to assure compliance with Trust guidelines and policies for antibiotic prescribing.

The Trust wide point prevalence audit was performed in February 2011. Overall compliance with the guidelines improved since the last audit in 2009.

	2006	2007	2008	2009	2011
Compliant	56%	79%	75%	74%	77%
Justified deviation / NA	23%	12%	13%	14%	13%
Non-Complaint	21%	9%	12%	12.8%	9%

The Trust Anti-infective Guidelines for Adults and Children were updated in October 2010 and January 2011 respectively.

The updated guidance further restricted the prescription of carbapenem antibiotics to minimise selection pressure for resistance

7.4.2 Audit of Restricted Antibiotic Agents

An audit of procedures for prescribing antibiotic agent restricted to microbiology approval demonstrated compliance of 86%. Although this is a reduction in compliance since 2009, all incidences of non-compliance were isolated cases that have been investigated. No further actions for the system of restricting agents have been identified.

7.4.3 Audit of MRSA Theatre Pathway

The MRSA Checklist for Surgery was introduced in May 2009 to ensure that all patients undergoing surgery receive appropriate antibiotic prophylaxis according to their MRSA status. Completion of the pathway was audited in September 2010.

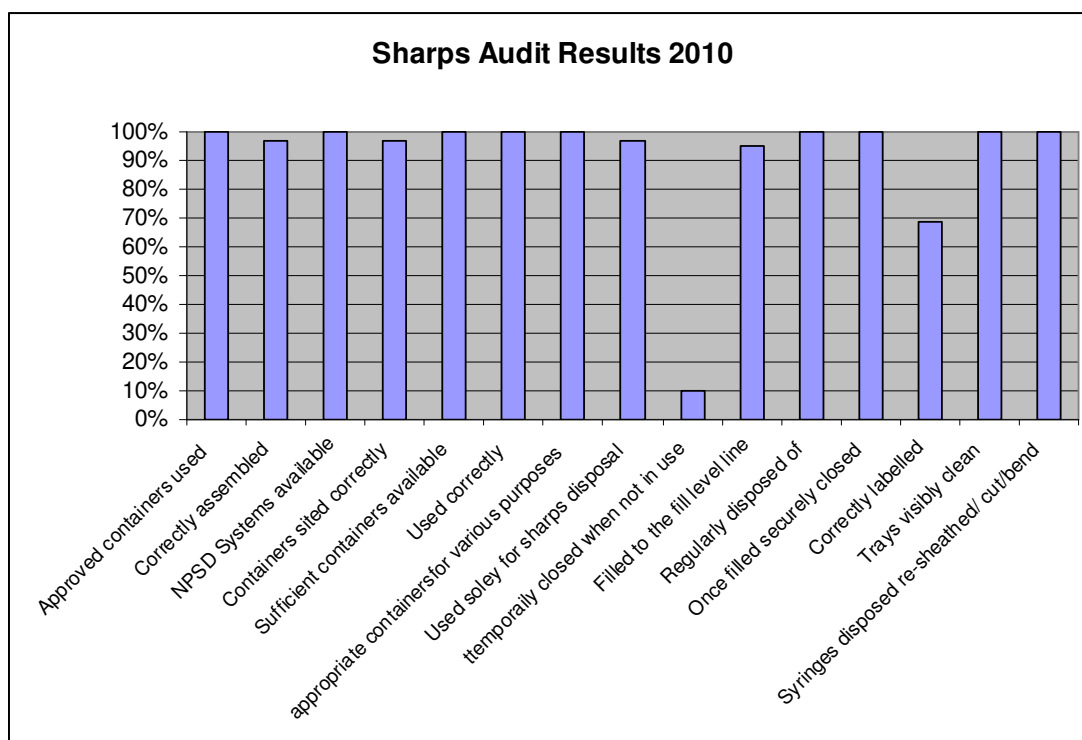
In 87% of cases the MRSA theatre checklist was used. Completion of the MRSA surgical checklist by ward staff (questions 1 to 3) was >85%. Question 4 was completed by medical staff in only 38% of cases.

In all 4 cases where teicoplanin was indicated, antibiotic prophylaxis for MRSA was administered. Despite all patients having received correct antibiotic prophylaxis, action was required to ensure better completion of the documentation and that the process was robust. The Surgical Division developed an action plan to address issues identified.

7.5 Audit of Disposal of Sharps

A Trust wide audit of the disposal of sharps was undertaken in September 2010. The IPCT commissioned Frontier Medical (current providers of sharps disposal equipment), to undertake the audit. Overall the audit found that the practice had improved from the 2009 audit. Frontier Medical has undertaken additional training for staff in those areas where compliance was sub-optimal.

Audit of sharps disposal practice



7.6 Audit of Documentation of the MRSA Integrated Care Pathway (ICP)

A trust wide audit was undertaken in April 2010 to measure compliance with the MRSA ICP. A total of 46 documents were audited. Findings indicated poor compliance with documented evidence of administration of decolonisation therapy. The Report was fed back to all clinical divisions and each area developed local action plans. In addition the IPC Nurses Team undertook spot checks in their areas of responsibility. Non-compliance was dealt with at the point of care with the nurse in charge of the patient/ward

7.7 Audit of Central Venous Catheters (CVC) within ward areas (non-critical care)

A trust wide audit was undertaken in August 2010 by the Critical Care Team. The findings of the audit were presented and discussed at the Trust Infection Control Committee.

In previous years the audit of CVC lines had been restricted to Critical Care, Renal services and Haematology. This year the audit was extended to include all other relevant wards and departments.

65 patients were found to have a CVC line. The results indicated variations in practice across the Trust including; documentation relating to the insertion, placement and maintenance care. The Critical Care Team are leading developments to standardise practice trust-wide.

7.8 Internal Audit

The Internal Audit Department undertook an annual assessment of Infection prevention and Control. This year the assessment focussed on assurance on the systems and procedures adopted by the Trust to ensure compliance with criterion 2 of the Hygiene Code – ‘to provide and maintain a clean and appropriate environment which facilitates the prevention and control of healthcare associated infections (HCAI)’.

The Report indicated that there was a significant level of assurance regarding the adequacy and operating effectiveness of controls in place in relation to hygiene and cleanliness.

SECTION 8: EDUCATION & TRAINING ACTIVITIES

8.1 Induction and Mandatory Training

The Infection Prevention and Control Team (IPCT) delivered training on the key principles of Infection Prevention & Control at all Corporate Induction and Corporate Clinical and non-Clinical Mandatory training days. In addition the team formatted on-line training for staff who undertook “e” learning. The content of the training is in accordance with the core care policies identified within the Health Act.

The IPC Nurses also contributed to other training sessions including; Asepsis in intravenous therapy.

8.2 Infection Prevention and Control Training for Junior Medical Staff

In August and February this year the IPCT co-ordinated and delivered a series of induction sessions for all new medical staff including the basic principles of hand hygiene and ANTT

Medical staff were subsequently expected to seek assessment of their competency to undertake ANTT procedures in their own clinical area of practice.

8.3 Additional Education Sessions as a Proactive Response to Emerging Multi-resistant Micro-organisms

Following the emergence of carbapenem producing coliforms (CPC) amongst patients the IPCT co-ordinated a series of education sessions for medical and nursing staff across the Trust. The purpose of the sessions was to inform staff of the risks to patients of acquiring a CPC and the prevention and management of these incidents. The sessions were very well received particularly by medical colleagues.

8.4 Annual Infection Prevention and Control Study Day

The IPCT organised its second annual Infection Prevention & Control Study Day for all staff in September 2010. The event was well attended and included a range of topics delivered by both internal and external speakers. The day was a great success with positive feedback. In view of the transfer of community services in April 2011, both our community and hospital based staff will be invited to attend future study days.

SECTION 9: THE DEPARTMENT of HEALTH SHOWCASE HOSPITALS PROJECT

The Trust has been the North West representative for the Department of Health Showcase Hospitals Project for the past three years. Activities this year included:

- A trial of 'design bugs out' patient furniture which has been well evaluated.
- A system for monitoring cleaning including feed back of weekly cleanliness reports to wards and departments.
- An in house evaluation of a new test for *Clostridium difficile* Infection

In addition the Trust also hosted two very successful national showcase hospitals conferences which was well attended and evaluated.

SECTION 10: EXTERNAL ASSESSMENT

10.1 Compliance with the Hygiene Code

The Trust is required to annually register with the Care Quality Commission (CQC). Assessment is based on compliance with the ten criterion in the Health and Social Care Act (2008): Code of practice for health and adult social care on the prevention and control of infections and related guidance (the Hygiene Code).

The Trust submitted evidence of a self assessment against the prevention of healthcare associated infection standards and registered unconditionally with the CQC.

10.2 Compliance with NHSLA level 3

The NHSLA standards for 2011/12 contained significant changes, including the removal of the standard on infection prevention and control.

To achieve level 3 for Standard 2 – Criterion 8: Hand Hygiene Training the following actions were agreed:

- Monitoring attendance at hand hygiene training was designated as the responsibility of the Trust Organisational Development and Training department as part of monitoring for induction and mandatory training.
- The Infection Prevention and Control team remained responsible for outlining the training requirements and delivery of the training.

SECTION 11: CONCLUSION

This has been another impressive year for Infection Prevention and Control in CMFT. The Trust has sustained and improved performance against HCAI targets as well as proactively meeting the challenges of new and emerging multi-resistant micro-organisms such as carbapenemase producing coliforms.

The scope of infection prevention and control has also continued to expand to encompass specific local issues such as decontamination of endoscopes.

These achievements reflect the hard work and commitment of all staff groups within the organization to providing safe standards of care for patients at CMFT.

Julie Cawthorne
Consultant Nurse, Infection Prevention & Control
Central Manchester University Hospitals NHS Foundation Trust



Central Manchester University Hospitals **NHS**

NHS Foundation Trust

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. CORE MEMBERSHIP

- Director of Infection Prevention and Control/Director of Patient Services/Chief Nurse (Chair)
- Consultant Microbiologist/Infection Control Doctor
- Nurse Consultant, Infection Prevention and Control
- Lead Nurse, Infection Prevention and Control
- Consultant Virologist
- Consultant Microbiologists
- Antimicrobial Pharmacist
- Director of Nursing (Adults)
- Associate Director of Clinical Effectiveness
- Head of Patient Safety and Risk Management
- Head of Clinical Audit
- Trust Decontamination Lead
- Trust Medical Devices Lead (CSS Representative)
- Show Case Hospitals Lead Nurse
- Medical Division representative
- Surgery Division representative
- Children's Hospital representative
- Eye/Dental Division representative
- Saint Mary's Division representative
- PCT Infection Control Lead

ADDITIONAL MEMBERSHIP

- Consultant Physician Occupational Health
- Consultant Physician for Respiratory Medicine
- Consultant Communicable Disease Control
- Other Members of the Trust or partner organisations may be co-opted to the Infection Control Committee at the invitation of the Chair
- A quorum shall be eight members including the Director of Infection Prevention and Control (or a nominated deputy), and one representative from the Infection Prevention and Control Team (i.e. Infection Control doctor/Consultant Nurse/Lead Nurse).

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 Prevention and Control Team to produce guidance on the Trust's Annual Infection Control objectives.
- 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 (annually)

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 CMFT Clinical Effectiveness Organisational Chart appended)

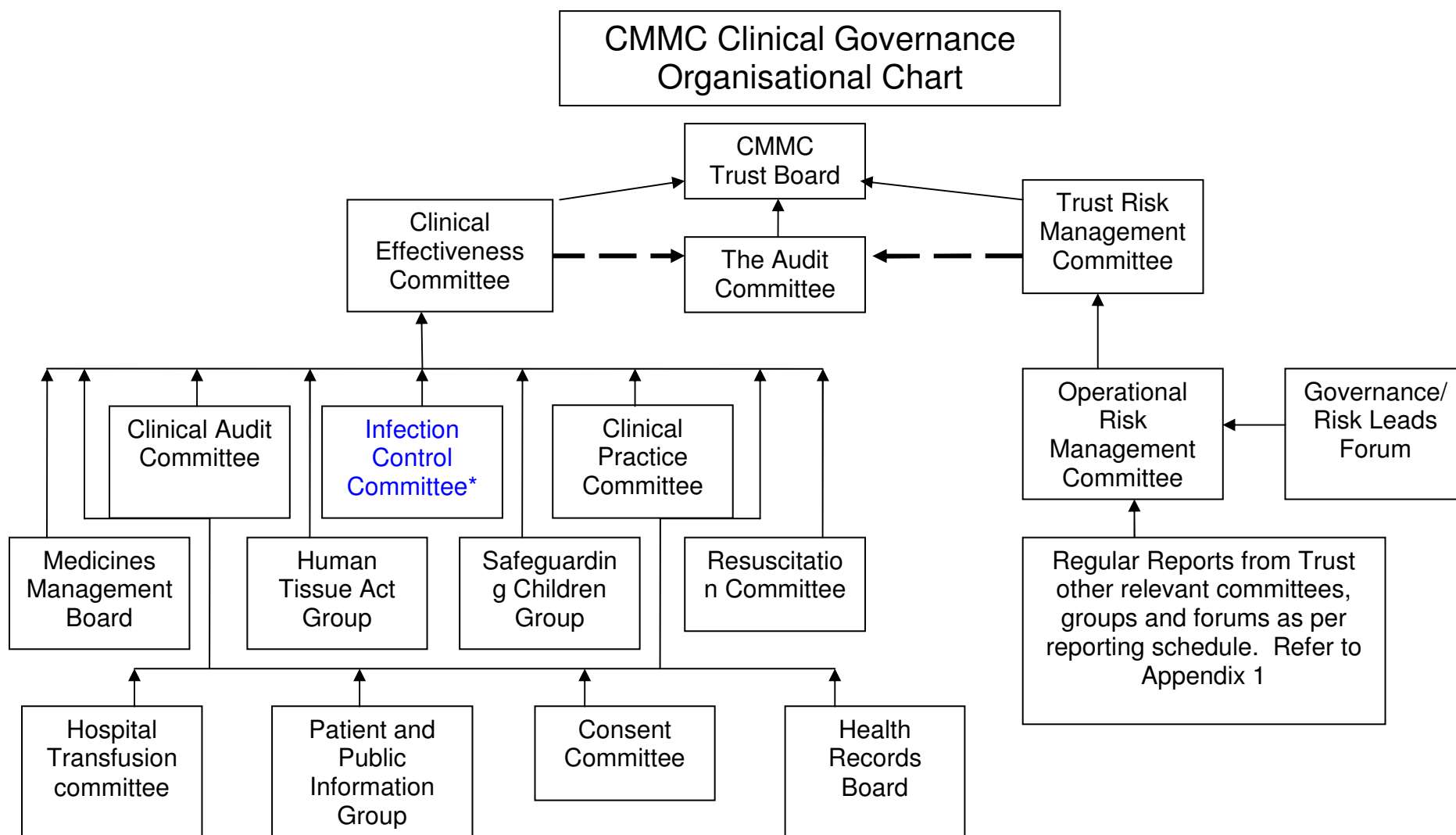
- 9.** There are five sub-groups of the Trust Infection Control Committee (See Infection Control Committee structure appendix 2). The Chair persons from each of the sub-groups, (Or their nominated deputy), provide a verbal report at each Infection Control Committee meeting

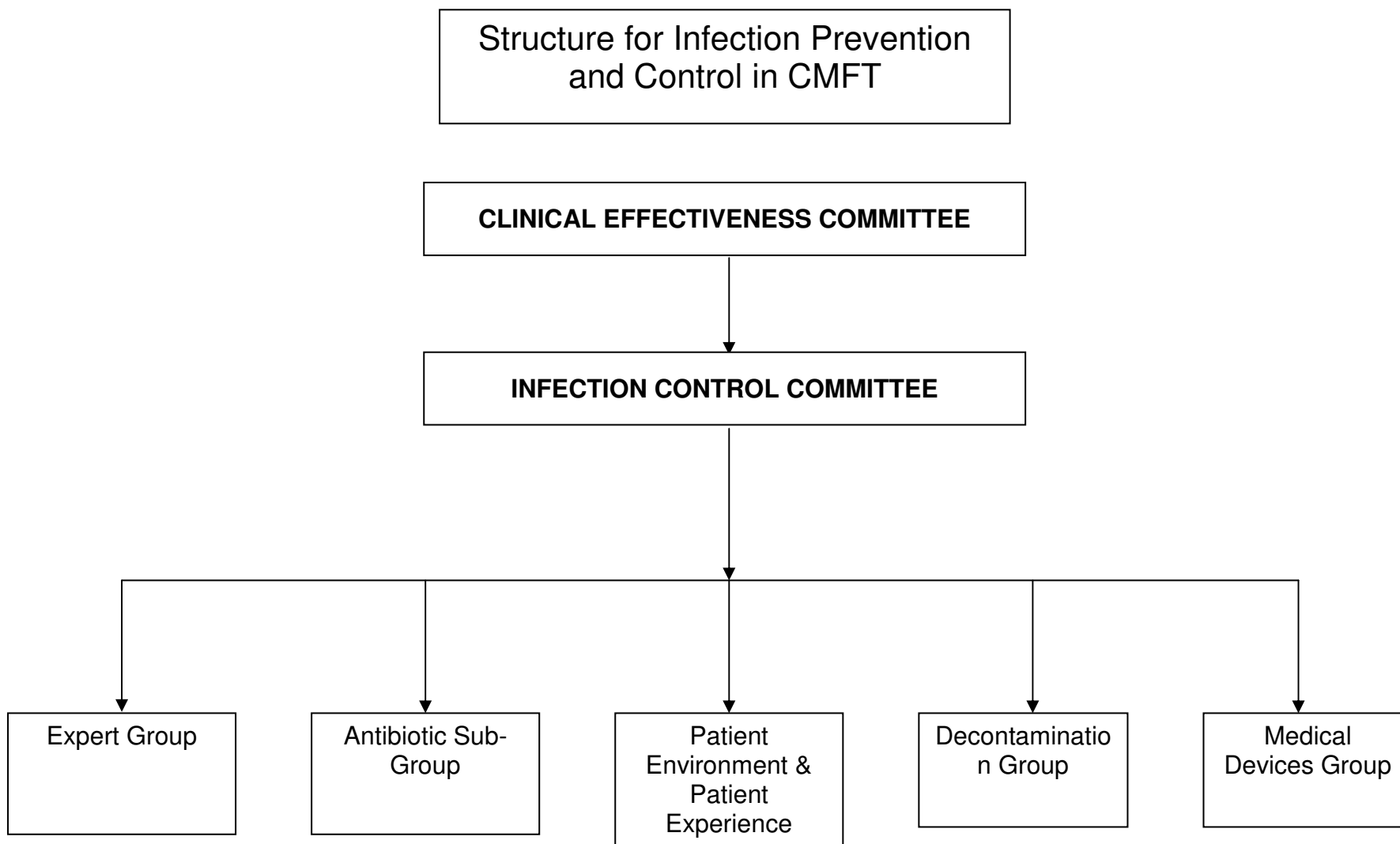
10. REVIEW

These Terms of Reference will be reviewed in April 2011

11. KEY PERFORMANCE INDICATORS

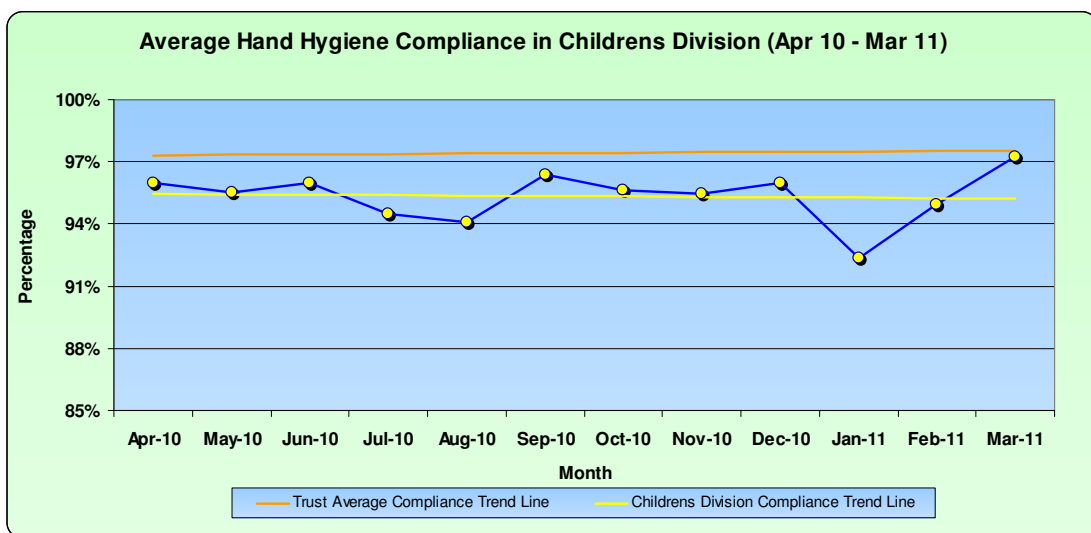
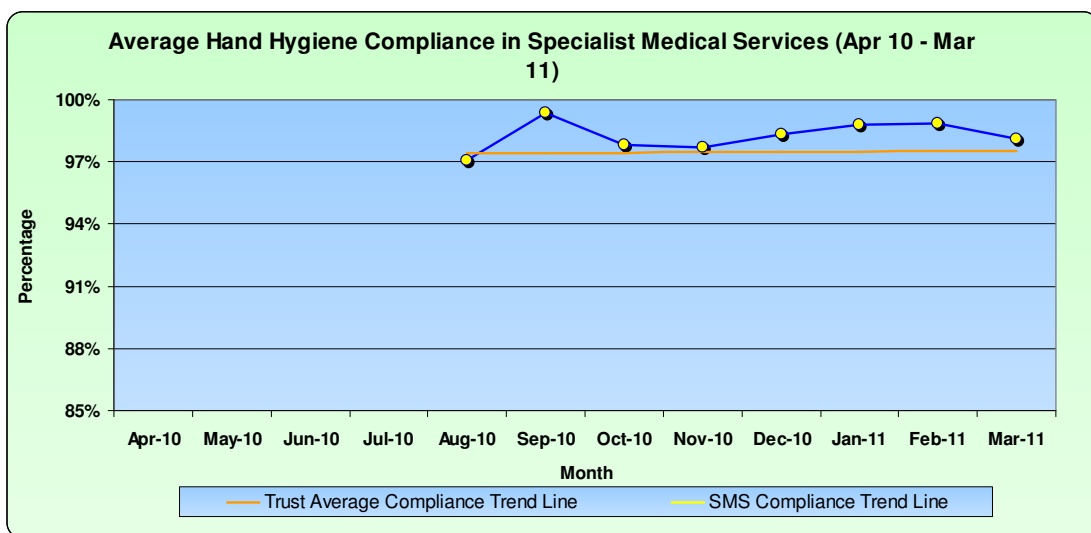
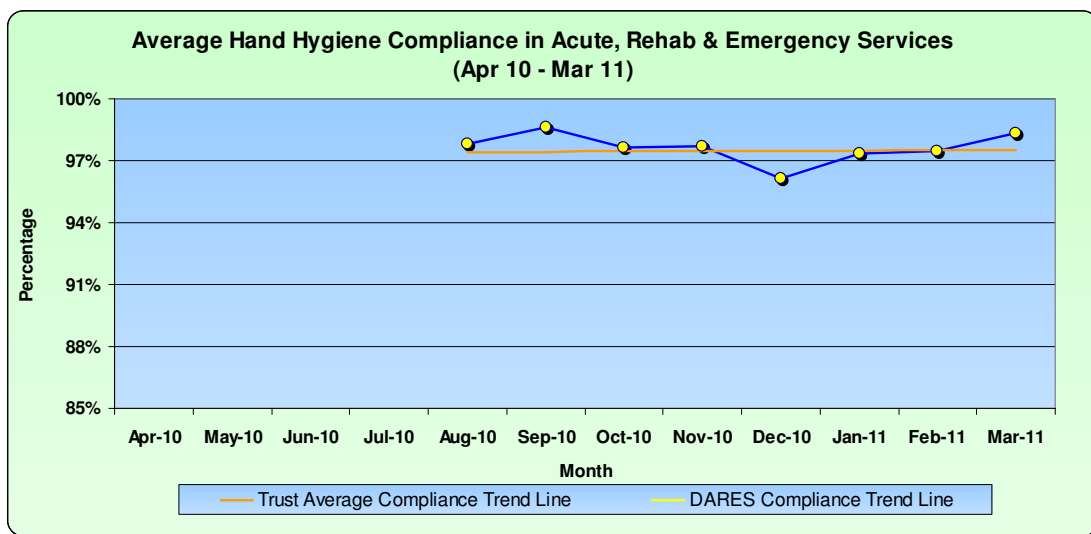
- Attendance of the Infection Control Committee will be audited annually, core members are expected to attend (or send a nominated, named Deputy) to a minimum of four out of six meeting per year. Additional members are expected to attend in person a minimum of two out of six meetings per year.
- Minutes and reports of the Infection Control Committee
- The Annual Infection Control Report will demonstrate the key activities and performance made Trust wide in infection prevention and control
- Care Quality Commission annual assessment of compliance against the Health and Social Care Act (2008)
- Terms of Reference for Infection Control Committee reviewed annually

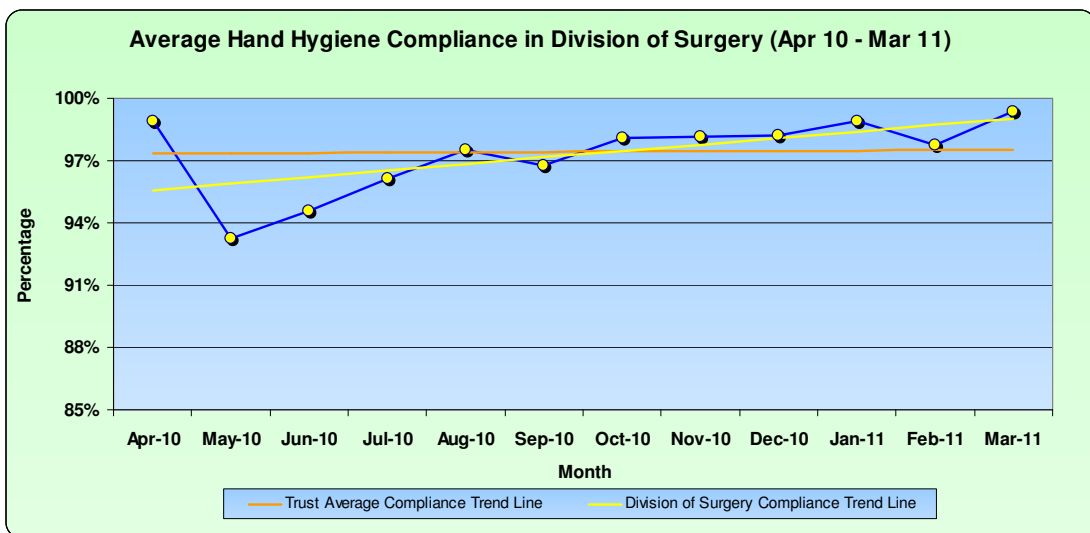
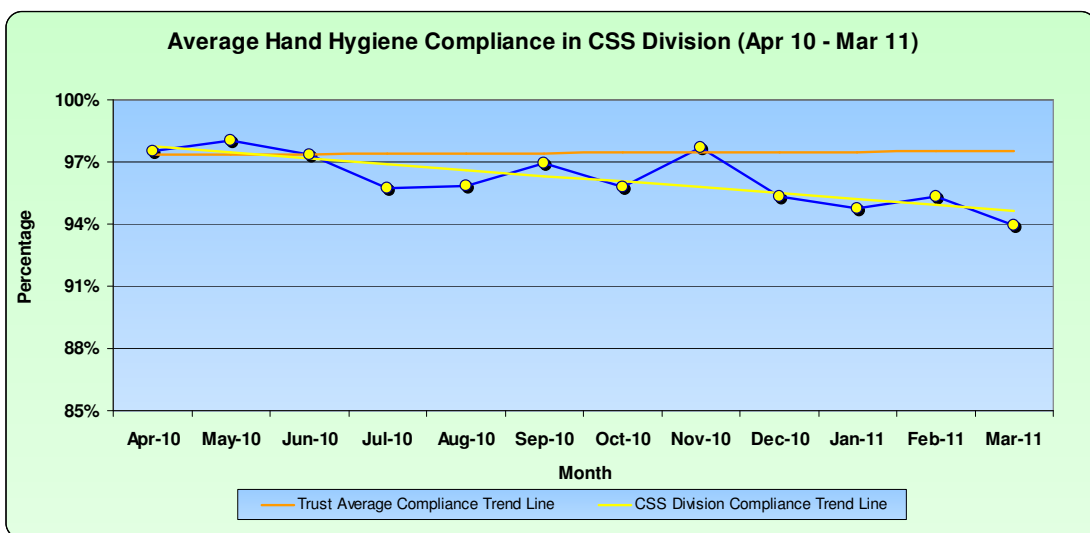
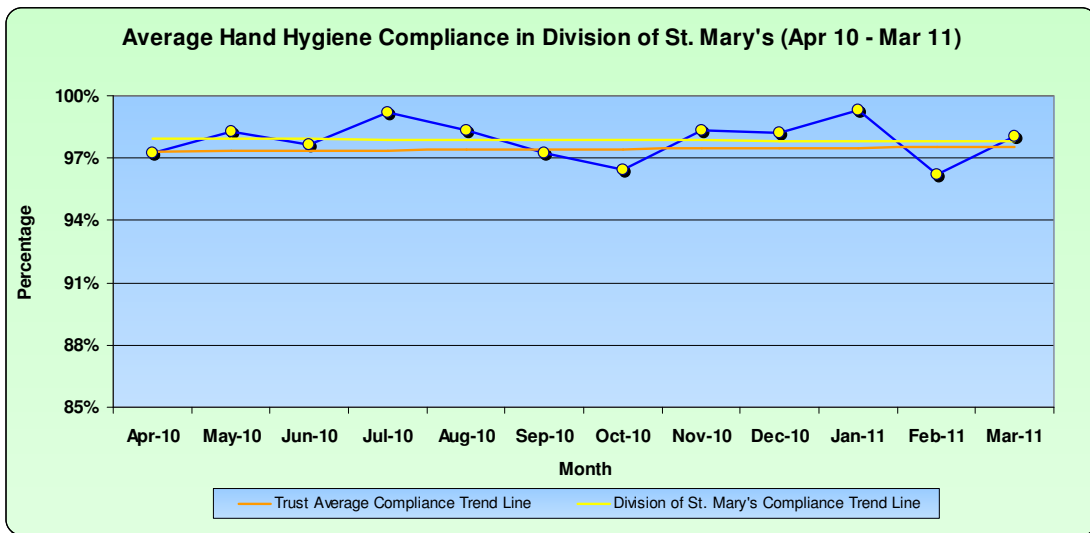


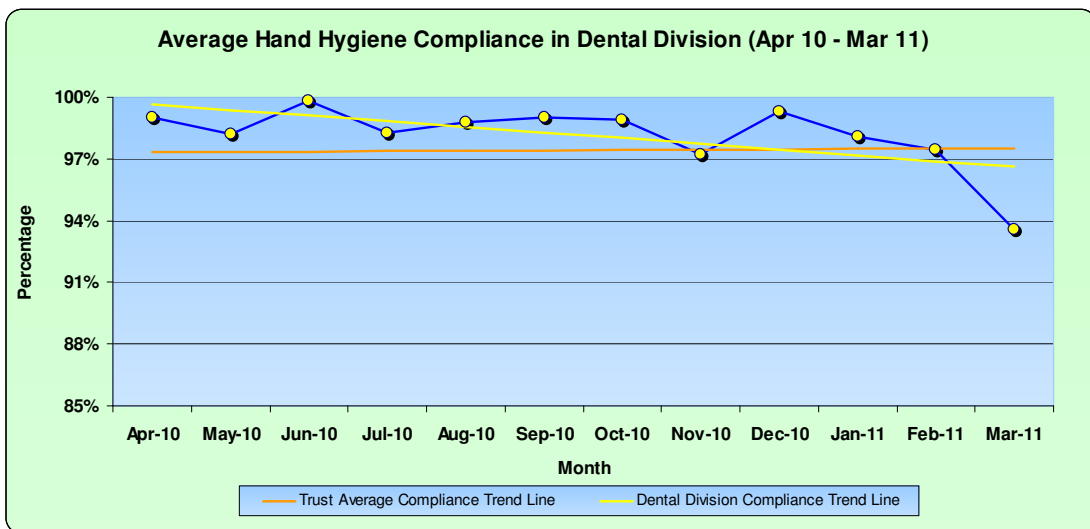
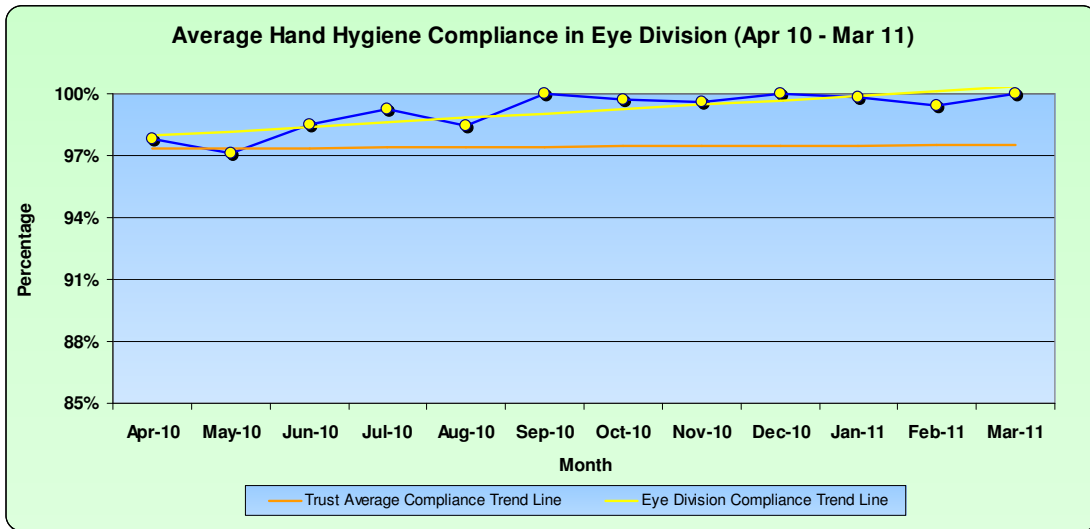


AUDIT APPENDICES FOR ANNUAL REPORT

Figure 1: Audit of Divisional Compliance of Hand Hygiene Practice







ANTT TRENDS**ANTT key**

KEY

	95-100%
	90-94%
	<89%

Divisional ANTT Tabular trends**ANTT TRENDS- Medical Division 2010**

Standard	Quarter1
Hands decontaminated at start of procedure	99.5
Appropriate aseptic field selected	99.7
Aseptic field cleaned correctly	99
All equipment gathered correctly	100
PPE worn	99.5
Individual protects key parts in preparation phase	100
Patient identification confirmed and pt consent sought	99.5
Key parts protected /prepared during procedure	100
Hands decontaminated at end of procedure	99.4
Hands decontaminated at all times during procedure	99.5
Appropriate documentation/ labelling completed	99.8
Disposal of all waste undertaken in accordance with policy	99.8
Individual can explain rationale for hand decontamination	100
Individual able to articulate what key parts are	100

ANTT TRENDS- DARES Division 2010-2011

Standard	Quarter 2	Quarter 3	Quarter 4
Hands decontaminated at start of procedure	99.2	100	100
Appropriate aseptic field selected	100	100	100
Aseptic field cleaned correctly	100	99.6	100
All equipment gathered correctly	100	100	100
PPE worn	100	98.3	100
Individual protects key parts in preparation phase	100	100	100
Patient identification confirmed and pt consent sought	100	99.6	100
Key parts protected /prepared during procedure	100	100	100
Hands decontaminated at end of procedure	100	100	100
Hands decontaminated at all times during procedure	100	100	100
Appropriate documentation/ labelling completed	100	100	100
Disposal of all waste undertaken in accordance with policy	100	100	100
Individual can explain rationale for hand decontamination	100	100	100
Individual able to articulate what key parts are	100	100	100

ANTT TRENDS- Specialist Medical Division 2010-2011

Standard	Quarter 2	Quarter 3	Quarter 4
Hands decontaminated at start of procedure	100	100	99.8
Appropriate aseptic field selected	100	100	99.8
Aseptic field cleaned correctly	99.8	99.8	99.6
All equipment gathered correctly	99.8	100	99.2
PPE worn	99.4	99.3	99.6
Individual protects key parts in preparation phase	100	99.8	100
Patient identification confirmed and pt consent sought	100	100	100
Key parts protected /prepared during procedure	100	100	100
Hands decontaminated at end of procedure	100	100	99.6
Hands decontaminated at all times during procedure	99.8	100	99.8
Appropriate documentation/ labelling completed	99.8	99.6	100
Disposal of all waste undertaken in accordance with policy	100	100	99.8
Individual can explain rationale for hand decontamination	100	100	99.8
Individual able to articulate what key parts are	99.8	100	99.4

ANTT TRENDS- Children's Division 2010-2011

Standard	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Hands decontaminated at start of procedure	99	100	99	100
Appropriate aseptic field selected	99	99	99	100
Aseptic field cleaned correctly	97	98	98	99
All equipment gathered correctly	96	98	98	100
PPE worn	96	98	98	97
Individual protects key parts in preparation phase	98	100	99	100
Patient identification confirmed and pt consent sought	98	99	99	100
Key parts protected /prepared during procedure	100	98	100	100
Hands decontaminated at end of procedure	98	98	98	98
Hands decontaminated at all times during procedure	99	99	98	99
Appropriate documentation/ labelling completed	99	97	98	98
Disposal of all waste undertaken in accordance with policy	100	100	100	100
Individual can explain rationale for hand decontamination	100	100	100	100
Individual able to articulate what key parts are	99	100	100	100

ANTT TRENDS- CSS Division 2010-2011

Standard	Quarter 2	Quarter 3	Quarter 4
Hands decontaminated at start of procedure	100	100	96.1
Appropriate aseptic field selected	100	100	96.1
Aseptic field cleaned correctly	100	100	94
All equipment gathered correctly	100	95	100
PPE worn	100	100	98
Individual protects key parts in preparation phase	100	100	100
Patient identification confirmed and pt consent sought	100	90	94
Key parts protected /prepared during procedure	100	100	100
Hands decontaminated at end of procedure	90	95	96
Hands decontaminated at all times during procedure	100	100	92.2
Appropriate documentation/ labelling completed	100	95	100
Disposal of all waste undertaken in accordance with policy	100	100	100
Individual can explain rationale for hand decontamination	100	100	100
Individual able to articulate what key parts are	100	100	100

ANTT TRENDS- St Marys- 2010-2011

Standard	Quarter 2	Quarter 3	Quarter 4
Hands decontaminated at start of procedure	99	99	100
Appropriate aseptic field selected	96	99	100
Aseptic field cleaned correctly	94	99	100
All equipment gathered correctly	100	100	100
PPE worn	95	99	99
Individual protects key parts in preparation phase	100	100	99
Patient identification confirmed and pt consent sought	100	100	99
Key parts protected /prepared during procedure	100	100	99
Hands decontaminated at end of procedure	99	99	99
Hands decontaminated at all times during procedure	98	99	99
Appropriate documentation/ labelling completed	99	99	100
Disposal of all waste undertaken in accordance with policy	100	100	100
Individual can explain rationale for hand decontamination	99	100	100
Individual able to articulate what key parts are	99	100	100

NB

Quarter 2 Gynaecology only

Quarter 3 Obstetrics and Gynaecology combined

ANTT TRENDS- Surgery 2010- 2011

Standard	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Hands decontaminated at start of procedure	100	100	100	99.5
Appropriate aseptic field selected	100	100	99.5	100
Aseptic field cleaned correctly	100	100	99.5	100
All equipment gathered correctly	100	99.6	99.5	99.5
PPE worn	99.6	100	99.5	99
Individual protects key parts in preparation phase	100	100	100	100
Patient identification confirmed and pt consent sought	100	100	100	100
Key parts protected /prepared during procedure	100	100	100	100
Hands decontaminated at end of procedure	99.6	99.1	100	96.9
Hands decontaminated at all times during procedure	99.6	99.6	100	99.5
Appropriate documentation/ labelling completed	100	100	100	100
Disposal of all waste undertaken in accordance with policy	100	99.6	99.5	100
Individual can explain rationale for hand decontamination	100	100	100	100
Individual able to articulate what key parts are	100	100	100	100

ANTT TRENDS- Royal Eye Hospital 2010-2011

Standard	Quarter 2	Quarter 3	Quarter 4
Hands decontaminated at start of procedure	96.4	100	100
Appropriate aseptic field selected	100	100	100
Aseptic field cleaned correctly	97.6	100	100
All equipment gathered correctly	100	100	100
PPE worn	98.1	100	100
Individual protects key parts in preparation phase	100	100	100
Patient identification confirmed and pt consent sought	94	100	100
Key parts protected /prepared during procedure	100	100	100
Hands decontaminated at end of procedure	97.6	100	100
Hands decontaminated at all times during procedure	100	100	100
Appropriate documentation/ labelling completed	100	100	100
Disposal of all waste undertaken in accordance with policy	100	100	100
Individual can explain rationale for hand decontamination	100	100	100
Individual able to articulate what key parts are	100	100	100

VIP TRENDS

VIP key

KEY

	95-100%
	90-94%
	<89%

VIP TRENDS - Medicine 2010

Standard	Quarter 1
The date of insertion	97
Size of Cannula	96
The time inserted	89
Inserted by	84
Insertion Site	97
Cannula secure	100
Is the dressing dry	100
Is the dressing clean	100
Was appropriate dressing used	100
Is the site easy to view	100
Was VIP Score recorded twice daily	92
Cannula removed or re-sited every 72hrs	92
VIP score less than 2	94
Cannula removed as soon as not needed	92

VIP TRENDS- DARES 2010- 2011

Standard	Quarter 2	Quarter 3	Quarter 4
The date of insertion	95	96	97
Size of Cannula	94	96	96
The time inserted	87	91	91
Inserted by	85	89	85
Insertion Site	97	96	96
Cannula secure	100	99	100
Is the dressing dry	100	100	100
Is the dressing clean	100	99	99
Was appropriate dressing used	100	99	100
Is the site easy to view	100	100	100
Was VIP Score recorded twice daily	88	90	88
Cannula removed or re-sited every 72hrs	92	94	96
VIP score less than 2	88	93	92
Cannula removed as soon as not needed	91	88	88

VIP TRENDS- Specialist Medicine 2010- 2011

Standard	Quarter 2	Quarter 3	Quarter 4
The date of insertion	98	97	98
Size of Cannula	95	98	98
The time inserted	92	93	95
Inserted by	86	93	93
Insertion Site	98	98	100
Cannula secure	100	100	100
Is the dressing dry	100	99.6	100
Is the dressing clean	100	99.6	100
Was appropriate dressing used	100	100	100
Is the site easy to view	100	99.6	100
Was VIP Score recorded twice daily	92	91	89
Cannula removed or re-sited every 72hrs	92	94	92
VIP score less than 2	96	95	98
Cannula removed as soon as not needed	95	93	94

VIP TRENDS- Children's Division 2010 2011

Standard	Quarter 1	Quarter 2	Quarter 3	Quarter 4
The date of insertion	77	80	74	74
Size of Cannula	48	56	45	47
The time inserted	37	53	53	43
Inserted by	29	43	48	39
Insertion Site	76	76	75	75
Cannula secure	100	100	100	100
Is the dressing dry	100	100	100	100
Is the dressing clean	99	99	100	100
Was appropriate dressing used	100	100	99	100
Is the site easy to view	100	100	100	100
Was VIP Score recorded twice daily	77	58	66	54
Cannula removed or re-sited every 72hrs	81	87	83	87
VIP score less than 2	95	84	89	89
Cannula removed as soon as not needed	95	91	93	93

VIP TRENDS- Royal Eye Hospital 2010-2011

Standard	Quarter 2	Quarter 3	Quarter 4
The date of insertion	95	100	100
Size of Cannula	90	95	100
The time inserted	90	100	100
Inserted by	90	100	100
Insertion Site	100	100	100
Cannula secure	90	100	100
Is the dressing dry	95	100	100
Is the dressing clean	90	100	100
Was appropriate dressing used	90	100	100
Is the site easy to view	90	100	100
Was VIP Score recorded twice daily	100	60	100
Cannula removed or re-sited every 72hrs	100	100	100
VIP score less than 2	100	90	100
Cannula removed as soon as not needed	95	100	95

VIP TRENDS- St Marys Division 2010-2011

Standard	Quarter 2	Quarter 3	Quarter 4
The date of insertion	97	100	99
Size of Cannula	89	97	96
The time inserted	92	94	94
Inserted by	92	99	96
Insertion Site	97	100	97
Cannula secure	100	100	100
Is the dressing dry	100	100	100
Is the dressing clean	100	100	100
Was appropriate dressing used	100	100	100
Is the site easy to view	100	100	100
Was VIP Score recorded twice daily	81	70	94
Cannula removed or re-sited every 72hrs	98	100	100
VIP score less than 2	83	91	99
Cannula removed as soon as not needed	88	93	97

NB Quarter 2 Gynaecology only

Quarter 3 Obstetrics' and Gynaecology combined

VIP TRENDS- CSS Division 2010-2011

Standard	Quarter 2	Quarter 3	Quarter 4
The date of insertion	100	100	85
Size of Cannula	100	85	90
The time inserted	60	65	48
Inserted by	53	50	53
Insertion Site	100	100	88
Cannula secure	100	100	100
Is the dressing dry	100	100	100
Is the dressing clean	100	100	90
Was appropriate dressing used	100	100	100
Is the site easy to view	100	100	100
Was VIP Score recorded twice daily	87	80	79
Cannula removed or re-sited every 72hrs	87	85	85
VIP score less than 2	100	100	98
Cannula removed as soon as not needed	83	65	63

VIP TRENDS- Surgery 2010- 2011

Standard	Quarter 1	Quarter 2	Quarter 3	Quarter 4
The date of insertion	96	96	95	99
Size of Cannula	98	99	96	98
The time inserted	76	77	77	83
Inserted by	73	73	75	77
Insertion Site	98	99	95	98
Cannula secure	100	100	100	100
Is the dressing dry	100	100	100	100
Is the dressing clean	99	99	99	99
Was appropriate dressing used	100	100	100	100
Is the site easy to view	100	100	100	100
Was VIP Score recorded twice daily	90	93	91	85
Cannula removed or re-sited every 72hrs	94	95	93	95
VIP score less than 2	97	99	100	96
Cannula removed as soon as not needed	89	86	92	91