The Shrewsbury and Telford Hospital NHS Trust

# Board of Directors' Meeting
# 12 May 2022

| | | | | |
|---|---|---|---|---|
| **Agenda item** | 083/22 | | | |
| **Report** | Quarterly Report from the Director of Infection Prevention & Control | | | |
| **Executive Lead** | Director of Nursing | | | |
| | **Link to strategic pillar:** | | **Link to CQC domain:** | |
| | Our patients and community | √ | Safe | √ |
| | Our people | | Effective | √ |
| | Our service delivery | √ | Caring | √ |
| | Our partners | | Responsive | √ |
| | Our governance | √ | Well Led | √ |
| | **Report recommendations:** | | **Link to BAF / risk:** | |
| | For assurance | √ | | |
| | For decision / approval | | **Link to risk register:** | |
| | For review / discussion | | 2077,2158,1749,1456 1359,1847,1994,1809 | |
| | For noting | | | |
| | For information | | | |
| | For consent | | | |
| **Presented to:** | Trust Board | | | |
| **Dependent upon** (if applicable)**:** | NA | | | |
| **Executive summary:** | This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC in Quarter 4 and a summary for the financial year 2021/2022.<br><br>Overall performance in relation to many of the IPC KPIs was positive, with the national targets being achieved for E.Coli, Pseudomonas Aerguinosa, Klebsiella Bacteraemia and C diff. The Trust also achieved its local stretch improvement targets for MSSA and Pseudomonas.<br><br>The number of COVID 19 cases cared for in the Trust has increased considerably in Q4.There have been a number of outbreaks seen on wards, which exceeded those seen previously in 2020/2021. | | | |
| **Appendices** | Appendix 1: IPC BAF | | | |
| **Lead Executive** |  | | | |

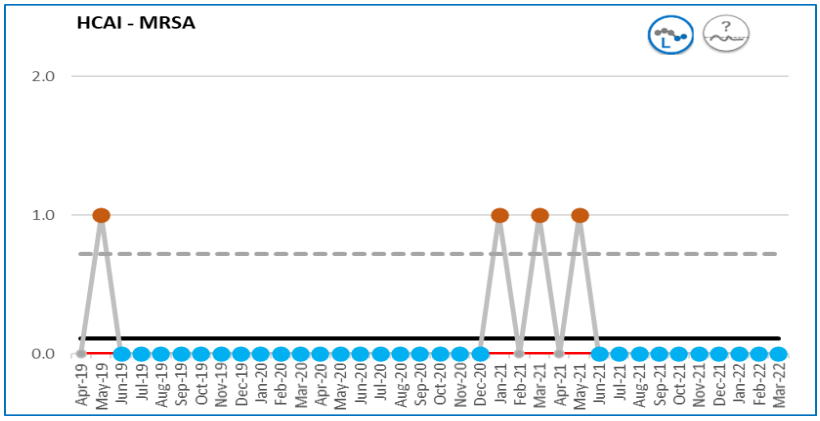
## 1.0 Introduction

This paper provides a report for Infection Prevention and Control for Quarter 4 (January to March 2022) against the 2021/2022 objectives for Infection Prevention and Control. An update on hospital acquired infections: Methicillin-Resistant *Staphylococcus aureus* (MRSA), Clostridioides Difficile (CDI), Methicillin-Sensitive Staphylococcus (MSSA), Escherichia Coli (E.Coli), Klebsiella and Pseudomonas Aeruginosa bacteraemia for January to March 2022 is provided and a summary of performance throughout 2021/22. An update in relation to Covid-19 is also provided. The report also outlines any recent IPC initiatives and relevant infection prevention incidents. The updated IPC BAF is also included.

## 2.0 KEY QUALITY MEASURES PERFORMANCE

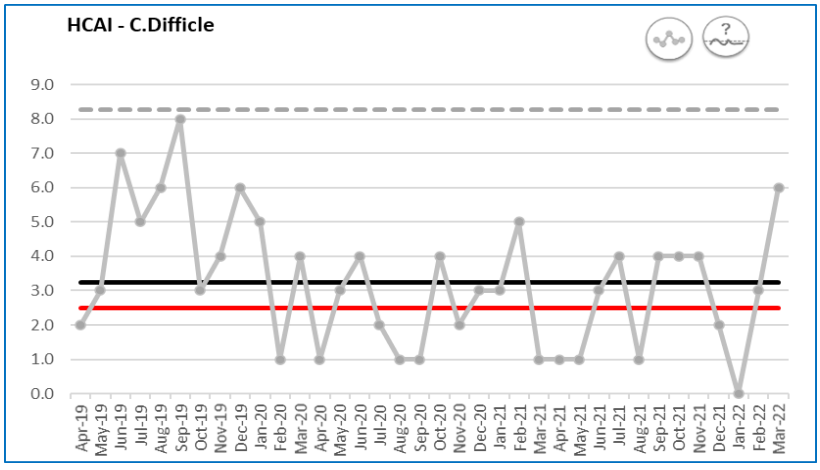
### 2.1 MRSA Bacteraemia

The target for MRSA bacteraemia remains 0 cases for 2021/22. There was one case of MRSA bacteraemia reported in May 2021, but no further cases in 2021/22.




### 2.2 Clostridium Difficile

The Trust trajectory for C diff cases in 2021-22 is no more than 49 cases. Total number of C-Diff cases reported per month is shown:



There were 9 cases of C.diff attributed to the Trust in Quarter 4 (January – March 2022). 7 of these cases were post 48 hours of admission and 2 cases had been inpatients in the 28 days prior to their positive sample.

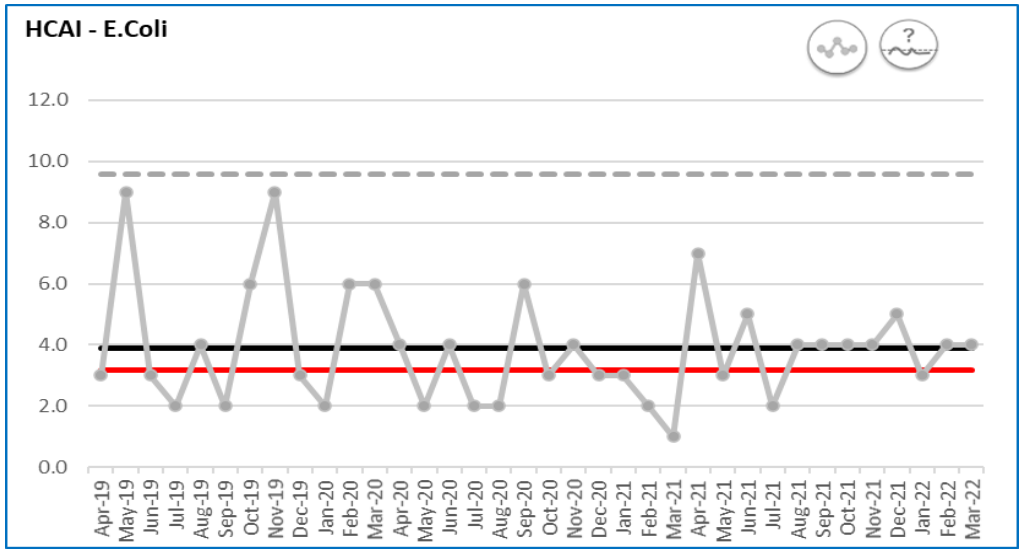
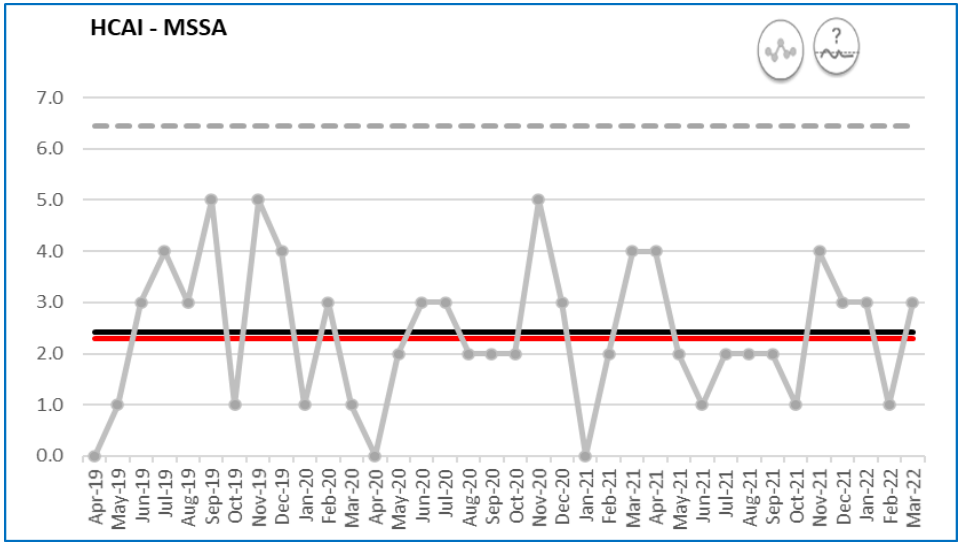
In total there were 33 cases of C diff in the financial year 2021/22, against a local target of no more than 30 cases and a nationally set target of no more than 49 cases.

Root cause analysis investigations are undertaken on all C.diff cases. During this quarter there were 9 cases reviewed.

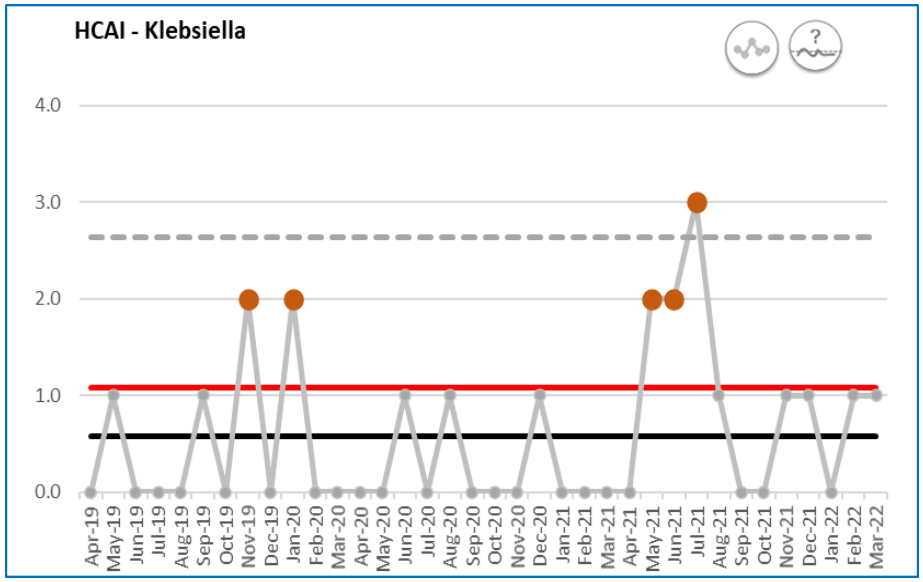
Common themes being identified and reported were:

- The timely manner of isolating a patient who was experiencing 2 or more episodes of unexplained type 5, 6, or 7 stool.
- The isolation on admission of a patient who is admitted with type 5, 6 or 7 stool and the sending of a sample.
- There was evidence of appropriate antibiotic prescribing in a majority of cases, however, there were cases where the choice of antibiotic had not been clear and on occasion no discussion recorded with the Consultant Microbiologist, from discussions at the RCA meetings it was often made clear that the patient's complex clinical condition had often determined the choice of antibiotics.
- There was a delay in commencing a stool chart at the time of a second episode of an unexplained type 5,6, or 7 stool, and lack of documentation in nursing notes regarding the patient's current bowel habit.

As part of the RCA process, action plans for each case include sharing of the cases with the relevant clinical division in their governance meetings. This is normally undertaken by the consultant attending the RCA meeting so that lessons learnt can be shared and findings of practise which could be done better and good practise can be identified and shared with other clinicians. Learning from the RCA's are also shared as part of the divisional reports in IPCOG.

| **2.3 E.Coli Bacteraemia** | **2.4 MSSA Bacteraemia** |
|---|---|
| The Number of E.Coli cases are shown:<br>  | The number of MSSA cases are shown:<br>  |
| The nationally agreed target for 2021/2022 was no more than 122 cases. There have been 49 cases at the end of the financial year. This is significantly below the target of no more than 122 cases but above the Trust improvement target of no more than 38 cases in 2021/22.<br><br>All cases which are deemed to be device related or in which the source cannot be identified have an RCA completed. In the majority of cases the source of the infection was not considered to be device related, however in 11 cases (year total) the source was considered to be a catheter associated urinary tract infection (CAUTI), 1 was considered to be related to biliary stents, 1 was due to a post-operative infection, and 1 was thought to be a HCAI with an unknown source. | There has been no national target set for MSSA bacteremia cases in 2021/22. There have been 28 cases of post 48 hour MSSA bacteremia at the end of the financial year against a Trust improvement target of no more than 28 cases.<br><br>All cases deemed to be device or intervention related have an RCA completed. Of the 28 cases of post 48 hour MSSA bacteremia, 8 were considered to be device or intervention related, and 1 is still under investigation. 6 were considered to be line infections, 1 was a fracture of a prosthetic and 1 was a fractured PEG tube. |

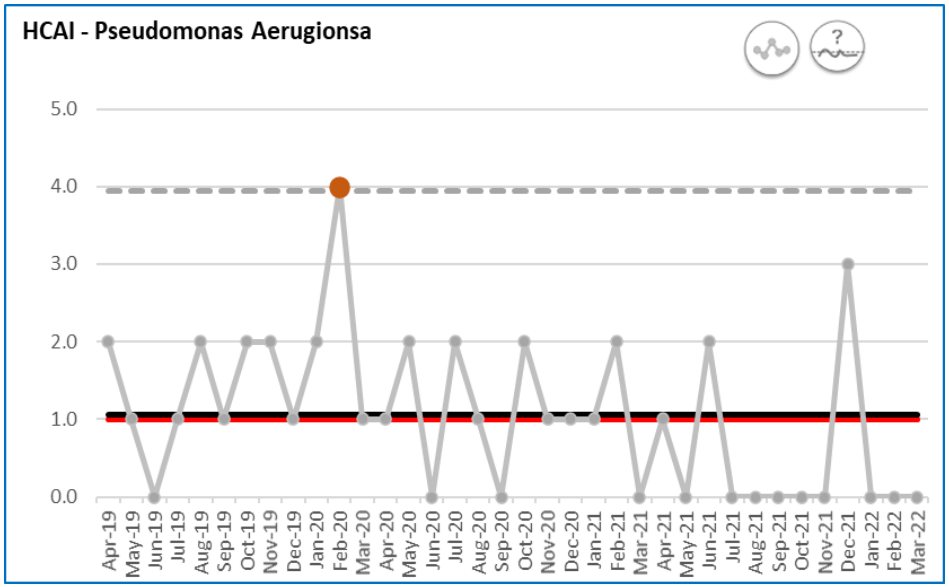
## 2.5 Klebsiella Bacteraemia (Post 48 Hours):




The nationally agreed target for 2021/2022 was no more than 24 cases. There was a total of 12 cases of post 48 hour Klebsiella Bacteraemia at the end of the financial year meaning the Trust achieved the national target but did not achieve the local improvement target.

Of these 5 were considered to be device or intervention related, with 2 cases deemed to be catheter associated urinary tract infections (CAUTI), 2 were line infections (1 central line and 1 PICC line), and 1 case was sepsis post procedure.

## 2.6 Pseudomonas Aeruginosa Bacteraemia (Post 48 Hours):




The target for 2021/22 was no more than 10 cases. There have been 6 cases of Pseudomonas Aeruginosa at the end of the financial year. The Trust achieved both its internal and national target for Pseudomonas bacteraemia in 2021/2022.

Of the 6 post 48 cases, 4 were considered to be device or intervention related with one relating to a CAUTI, 1 was a ventilator associated pneumonia, and 2 were line related infections.

## 2.7 Root Cause Analysis Infections for MSSA and E.Coli Bacteraemia

All MSSA and E.coli post 48 hour bacteraemia are reviewed by the microbiology team, those deemed to be device related or where the source of infection cannot be determined are expected to have a Root Cause Analysis (RCA) completed.

Learning from completed RCAs include:

- Management of urinary catheters including documentation and plans for removal is inconsistent
- Lapses in management of peripheral cannula including recording of VIP scores identified in MSSA bacteraemia
- Appropriate clinical specimens are not sent in a timely manner to enable correct antibiotic prescribing choices
- Consistent practice in relation to undertaking blood cultures

Actions implemented in relation to improvements include:

- The sharing and discussion of the RCA and its findings through the relevant clinical governance teams and at IPC Operational Group (IPCOG).
- Discussion and practice during IPC and induction training with FY1's regarding blood culture best practice. Blood culture 'top tips' poster distributed to all clinical areas to highlight best practice
- Ward managers monitor the VIP scores and compliance monitored at monthly nursing metrics meetings, these being reported by division through their IPCOG reports
- Urology specialist nurses linked in with clinical practice educators to provide catheter care training as part of the statuary training requirement.

## 2.8 MRSA Screening

MRSA Elective screening compliance has been above the 95% target throughout Q4, (average 96.7%, and achieved 97.6.4% for the year)

MRSA Emergency Screening for Q4 2021/2022 was below the 95% target being at 94.56%. but overall for the year compliance was 95.5%.

MRSA screening compliance is reported via the ward dashboards monthly and monitored via IPCOG and the monthly Nursing Quality Metrics meetings.

# 3.0 PERIODS OF INCREASED INCIDENCE/OUTBREAKS

During January, February and March of 2022, 40 COVID outbreaks have been declared within the Trust.

The most common issues identified during the outbreak management are:

- Non-compliance with PPE and hand hygiene practices
- Plastic curtains not being closed around bed spaces
- Inappropriate patient transfers between bays and wards

- Patients seeing their relatives on the corridors and car parks without wearing masks.
- Missed routine and contact COVID screens

1 VRE outbreak has also been declared in January 2022, for which the typing was unique.

The periods of increased incidence/outbreaks are shown for Quarter 4 2021/2022 in the table below.

| | Ward | Infective Organism | Typing | Learning |
|---|---|---|---|---|
| **January 2022** | T7 | COVID | NA | Lapses in good IPC practice. Non-compliance with PPE. Missed routine and alternate day COVID swabs |
| | T10 outbreak A | COVID | NA | Plastic curtains not closed around bed spaces. LFT compliance poor, Due to nature of ward positive patients are not always able to socially distance or wear masks. |
| | TED staff | COVID | NA | Staff outbreak. Incorrect use of PPE, LFT compliance very low, Staff room small, social distancing difficult |
| | T8 H&N | COVID | NA | Patients should not be moved from an outbreak ward unless it is for clinical need. |
| | T4 | COVID | NA | Plastic curtains not closed around bed spaces, issues with PPE. LFT compliance very low. Asymptomatic staff picked up on an outbreak screen |
| | T Day Ward | COVID | NA | Index case was moved from outbreak ward while being asymptomatic |
| | S21 | COVID | NA | Delay in isolation of the positive patient, non-compliance with PPE |
| | S27 (Outbreak A) | COVID | NA | Staff should be encouraged to record their LFT compliance twice a week to enable prompt identification of positive staff. |
| | S22T&O | COVID | NA | A staff member had attended work and developed symptoms during shift, this staff member worked with the two staff that latterly become positive. |
| | S26 | COVID | NA | The two initial cases were together in a bay. Curtains were not closed correctly. LFT compliance was identified as low therefore staff are actively encouraged to undertake their screening and record it twice a |

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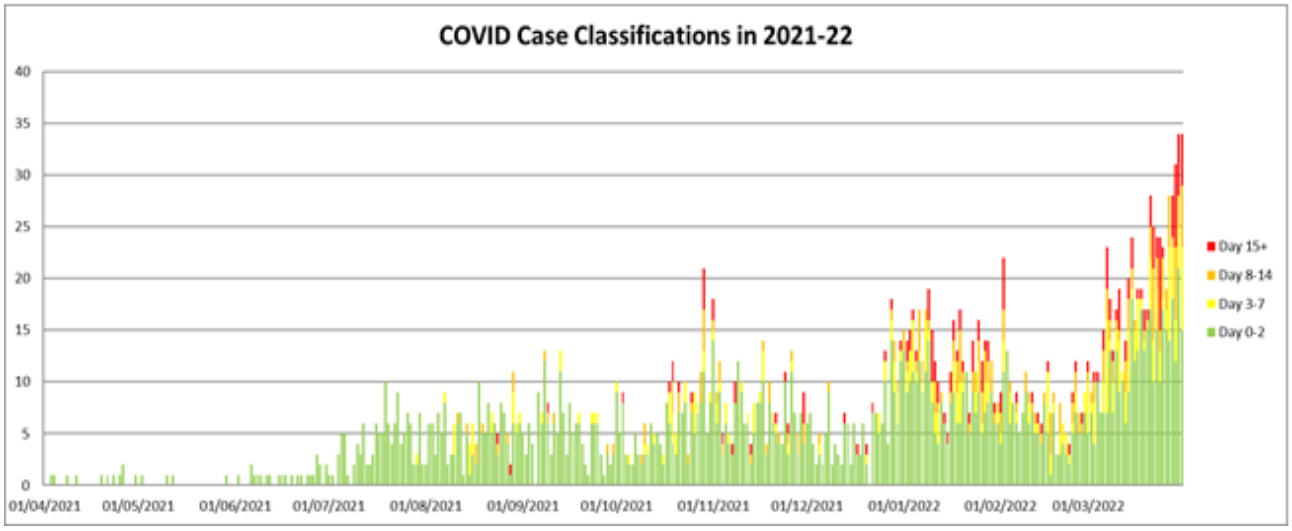
| | | | | week. Missed COVID screening was also identified as contributing factor. |
| | S24 | COVID | NA | Patient in the Bay who due to their cognitive state made it difficult for staff to ensure they remained in their bedspace area |
| | S25 | COVID | NA | There was also a patient in the Bay who due to their cognitive state made it difficult for staff to ensure they remained in their bedspace area |
| | S23OH | VRE | Typing result: Unique | Action plan completed. No issues identified. |
| | Ludlow Renal Unit | COVID | NA | 3 dialysis patients were identified as COVID positive. The dialysis chairs are 2 metres apart and windows were kept open however the nature of Omicron variant has concluded that there is an increase transmission. |
| **February 2022** | T6 | COVID | NA | Bay A is small, social distancing difficult. 1 contact delinked to compliance with mask wearing. |
| | T7 cluster B | COVID | NA | Delay in isolation due to capacity issues. |
| | T15 | COVID | NA | Visitor is thought to be the index case that infected a patient and caused creation of contact. Missed COVID screening was also identified as contributing factor. |
| | T10 | COVID | NA | Patient positive on admission screen created bay of contacts. Plastic curtains not closed around bed spaces. Incorrect use of PPE |
| | T9 | COVID | NA | PPE and Hand hygiene issues identified. |
| | S25G | COVID | NA | The index case was a very social patient who insisted on helping other patients. Staff to remind patients to socially distance. |
| | S22RE | COVID | NA | Staff to be encouraged to complete their LFT and to be aware of the PPE requirements. |
| | S27 (outbreak B) | COVID | NA | Ward advised to ensure processes are in place to keep the plastic curtains closed around bed spaces. Screening |

| | | | | |
|---|---|---|---|---|
| | | | | of contacts was identified as not done as per policy. Contact patients not to be moved out of isolation before their last screen result is available. |
| | S28 | | NA | Missed COVID screen was identified as contributing factor. |
| **March 2022** | T17 | COVID | NA | Staff not wearing visors while with positive patients. |
| | T6/7 | COVID | NA | Plastic curtains not closer around bed spaces. Incorrect use of PPE. |
| | T Day Ward | COVID | NA | The Day Surgery area was used for medical escalation Large bays creating risk of multiple contacts. |
| | T10 | COVID | NA | Patient being moved before the screen result available. |
| | T15 (Outbreak B) | COVID | NA | Plastic curtains not closed around bed spaces. Confused patient wondering taking off her mask. PPE issues identified with staff members. |
| | T11 | COVID | NA | Index case positive on day 3 creating a bay of contacts. One of the positive patients had carers through their stay. Non-compliance with PPE and hand hygiene identified |
| | T9 | COVID | NA | Non-compliance with PPE. |
| | T Renal Unit | COVID | NA | Positive patients were dialysing on the same shift and were looked after by the positive staff member. |
| | S Renal Unit | COVID | NA | The patient thought to be an index case was a known contact of a relative who had been attending the renal unit to give translation assistance. |
| | S34SAU | COVID | NA | Patients being placed in a bay before their COVID status is known is creating a risk of generating contacts. |
| | S32 Respiratory | COVID | NA | Staff outbreak. RIDDOR reportable. Recurrent PPE non-compliance identified. |
| | S21 | COVID | NA | Positive patients created bays of contacts who became positive. |
| | S23OH | COVID | NA | Symptomatic patient has been moved from side room on AMU to the bay on ward 23. Ensure that Covid screen result is available and documented prior patient's transfer. |

| | | | | |
|---|---|---|---|---|
| | S22T&O cluster A&B | COVID | NA | Missed COVID screening. |
| | S26 | COVID | NA | Issues with PPE use.<br>Symptomatic staff member attending work |
| | S27 | COVID | NA | Lapses in PPE use<br>Lack of evidence of required cleaning and ventilation |
| | S35 | COVID | NA | To ensure that the swab result is accessed and documented before any decision of patient transfer is made. |

## 4.0 COVID 19 UPDATE

The number of Covid-19 cases in the Trust in Quarter 4 (January 2022 to March 2022) has continued to increase throughout the financial year. The graph below demonstrates the increase in cases seen in the Trust in 2021/2022




In October 2020 NHSEI provided definitions of apportionment of COVID 19 in respect of patients diagnosed within hospitals as below:

**Community Onset** – Positive specimen date <=2 days after hospital admission or hospital attendance
**Hospital-Onset Indeterminate Healthcare-Associated** – Positive specimen date 3-7 days after hospital admission
**Hospital-Onset Probably Healthcare-Associated** – Positive specimen date 8-14 days after hospital admission
**Hospital-Onset Definite Healthcare-Associate** – Positive specimen date 15 or more days after hospital admission

For the financial year there were 202 cases that were considered to be 202 'Probable' Healthcare-Associated and 161 'Definite' Healthcare-Associated cases. Most of these cases have been involved in COVID outbreaks on the wards, however any case that tests positive after day 8 of admission that is not involved in an outbreak will have an RCA completed.

Ongoing actions to reduce any transmission in the hospital remain in place and include:

- Ongoing patient screening on admission, Day 3, Day 5-7, Day 13 then every 7th day of admission after this.
- Plastic curtains around bed spaces
- Ensuring PPE compliance and social distancing by all staff
- Encouraging patients to wear face masks at all times but particularly when mobilising to the bathroom
- Robust cleaning of the ward environment with Tristel twice daily

In response to the "Living with Covid" Guidance issued by NHSE/I in April 2022 the Trust has implemented the following changes:

- For patients who are a Covid contact, the duration of isolation has been reduced to 7 days from 10 (91% of contact patients in our convert within 7 days or before). The exceptions to this are Oncology, Haematology and Renal, where the timescale will stay at 14 days.
- Staff with household contacts no longer need PCR or to complete a risk assessment to be considered the daily Covid Decision Making Group, they are required to do a twice weekly Lateral Flow test (LFT).
- Outbreaks will be closed at 10 days instead of 14 internally (they will continue to be reported online as per current practice until Day 28)

**Staff Lateral Flow Testing**

There is an expectation that staff will undertake lateral flow tests twice weekly and report the results through on the Trust lateral flow app. The results are shown below and highlight there is further work required across all staff groups to encourage compliance with this.

| Lateral Flow Test Compliance January to March 2022 (Average) | | | |
|---|---|---|---|
| **Division** | **% Yes Reporting Results** | **% No Not Reporting Results** | **Total Frontline Headcount** |
| **Trust** | **21%** | **79%** | **5714** |
| Medicine and Emergency Care | 20% | 80% | 1637 |
| Surgery, Anaesthetics and Cancer | 22% | 78% | 1977 |
| Women and Children's | 15% | 85% | 852 |
| Clinical Support Services | 27% | 73% | 935 |
| Corporate | 18% | 82% | 313 |
| Bank Workers | 8% | 92% | 991 |

Managers now receive this information weekly. This has been discussed at the weekly senior nurses meeting and escalated to the Covid-19 Silver meeting for discussion and escalation to the Covid-19 Gold meeting.

## 5.0 SERIOUS INCIDENTS (SI) RELATED TO INFECTION PREVENTION & CONTROL

There were no IPC serious incidents reported in Quarter 4 of 2021/2022.

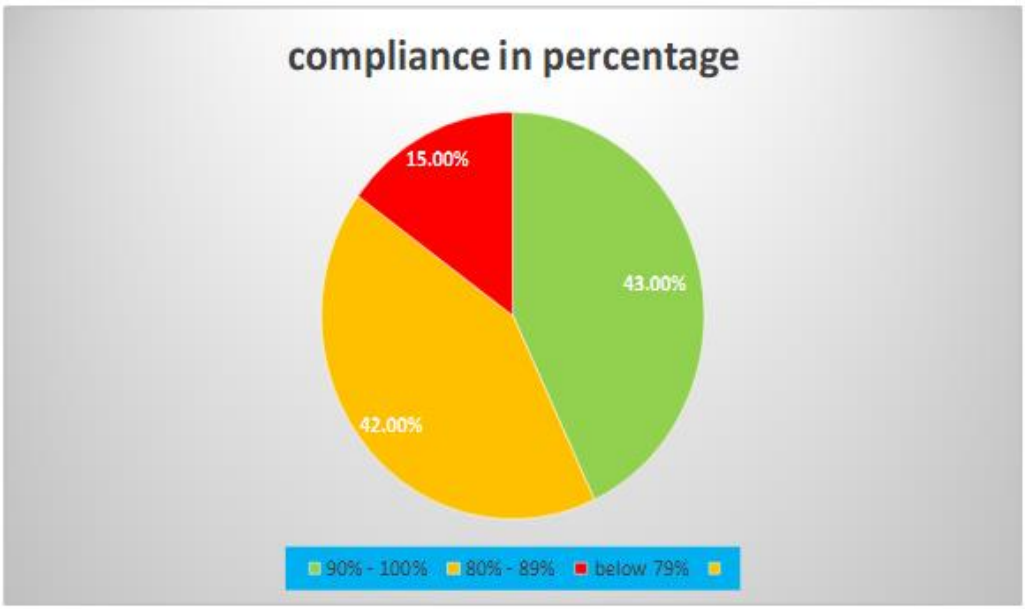
## 6.0 IPC INITIATIVES

The IPC team conducted 46 full QWW in Q4 (January to March 2022).

The accepted standard is for QWW compliance of 90% and above. If compliance is between 100% and 90% the area will be re-audited quarterly in line with current schedule and the action plan should be returned to the IPC team within two weeks. If the compliance achieved is between 80-89%, the area will be reviewed in 1 month, and the action plan should be returned to the IPC team within a week. If an area scores less than 80%, a repeat audit will be completed in a week and action plan should be returned immediately.

Compliance scores ranged from 73% - 100%.

Of the 46 QWWs completed, 20 areas were over 90% compliant, 19 audited areas scored between 80% - 89% and 7 areas achieved a score below 80%.




During the same period, the IPC team has also completed 198 QWW as part of the outbreak investigations, of which 194 were related to Covid-19 Outbreak and 4 were connected to a C diff outbreak.

The 6 most frequent non-compliant elements were:

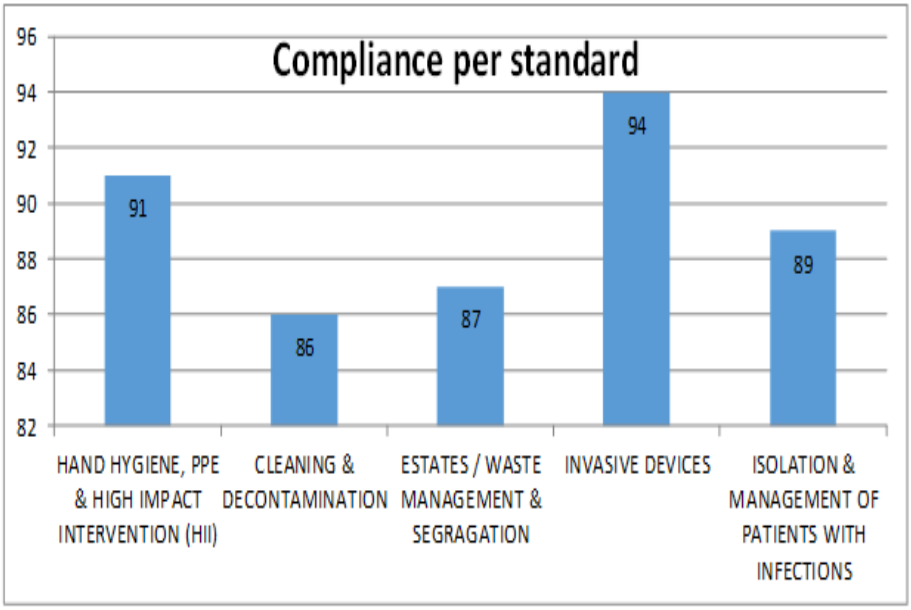
- Estates issues,
- Cleanliness of the general ward environment
- Compliance with patients wearing face masks and supporting documentation
- Appropriate storage of equipment, supplies and linen
- Cleanliness of sanitary equipment including commodes, toilet seat frames& bed pans

- PPE not being worn according to current guidelines

These issues have also been identified as part of outbreak investigations.

The IPC QWW tool is sectioned into 5 standards

- Hand hygiene, PPE & high impact intervention (HII)
- Cleaning & decontamination
- Estates / waste management & segregation
- Invasive devices
- Isolation & management of patients with infections.




In all cases it was observed that the following elements were compliant

- Patients were confident that staff were decontaminating their hands
- Staff needing to use FFP3 masks were fit tested.
- Waste was segregated as per policy
- Correct signage was in place for patients who were isolated in a side room
- Clinical staff are able to articulate to correct procedure for patients with Diarrhoea
- Clinical staff are able to articulate the symptoms of COVID-19 and are able to describe the process when onset occurs in hospital
- Clinical staff are aware that patients require rescreening for COVID-19 at day 3, day 5-7 and day 13 of admission
- All patients requiring isolation were isolated
- All COVID 19 contacts identified and flagged on SEMA

## 7.0 IPC NHSE/I REVIEW

NHSE/I visit was completed in January 2022, at this visit the Trust retained its Green IPC status. Issues identified at the visit were included in the overarching IPC action plan and continue to be monitored at the IPC Operational Group.

The next NHSE/I visit is being undertaken on the 5th July 2022.

## 8.0 RISKS AND ACTIONS

The Risk register for IPC is held by the Director of Nursing as the DIPC. The Risk register is updated monthly. There are 8 risks on the register, 1 risk remains red after mitigating controls have put in place as outlined below:

***Risk 2077: Decontamination assurance for medical devices***
There is ongoing work being led by the Head of Estates as the Trust Decontamination lead for the Trust. Work is focusing on ensuring the implementation of all recommendations from the Decontamination review undertaken by University Hospitals Birmingham and includes the appointment of a Decontamination Clinical Lead, robust Standard Operational Procedures for all services undertaking decontamination and the revision of the Decontamination Policy to ensure this reflects national best practice.

There were no new risks added in the last month reporting period.

## 9.0 IPC BOARD ASSURANCE FRAMEWORK

This Prevention and Control Board Assurance Framework (IPC BAF) was last updated by NHSE/I in December 2021 and consists of 10 domains and 130 key lines of enquiry (See Appendix 1). The Trust is RAG rated green for 119 of the key lines of enquiry, amber for 11 items.

| | | |
|---|---|---|
| 1.1a | That includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs prevalence, and care services | Amber |
| 1.2 | Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone. | Amber |
| 1.3a | Based on the measures as prioritized in the hierarchy of controls, including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concer4n in the local area | Amber |
| 1.8 | Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services. | Amber |
| 2.13 | A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways | Amber |
| 3.1 | arrangements for antimicrobial stewardship are maintained | Amber |
| 4.1 | Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors | Amber |
| 6.2 | Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning and doffing) PPE safely | Amber |
| 6.3 | All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it | Amber |
| 9.3 | Safe spaces or staff break areas/changing facilities are provided | Amber |
| 10.6 | Where there has been a breach in infection control procedures, staff are reviewed by occupational health who will:<br>• Lead on the implementation of systems to monitor for illness and absence<br>• Facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce<br>• Lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID 19<br>• Encourage staff vaccine uptake | Amber |

The Trust is awaiting the new NHSE/I IPC BAF which is due to be published in May 2022.

## 10.0 HYGIENE CODE UPDATE

The Health and Social Care Act (2008) Code of Practice on the prevention and control of infections, applies to all healthcare and social care settings in England. The Code of Practice sets out the 10 criteria with 243 elements against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements, which is set out in regulations. To ensure that consistently high levels of infection prevention (including cleanliness) are developed and maintained Trusts complete a self-assessment.

The Hygiene Code is reviewed monthly by the IPC team and presented at the IPC Operational Group. The Trust is 96.9% compliant, being RAG rated 'Green' for 233 elements, 'Amber' for 9 and RAG rated 'Red' for 1 (this relates to decontamination as highlighted in risk section of this report).

The Trust self-assessment compliance against each of the 10 domains and the current gaps and actions are shown:

| | What the Trust must demonstrate | Current compliance | Current Gaps | Actions Required/Target date |
|---|---|---|---|---|
| 1 | Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them. | 97% | IPC arrangements & responsibilities policy in place and found in every JD. All staff should receive Mandatory update & induction training. Contractors receive IPC training via estates (part of their induction to the Trust) | Continue to monitor attendance and report quarterly to IPCOG<br>Care Groups to report compliance with training on report to IPCOG monthly |
| 2 | Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. | 95% | Decontamination of the environment – including cleaning and disinfection of the fabric, fixtures and fittings of a building (walls, floors, ceilings and bathroom facilities) or vehicle. | This is currently not in the remit of the Decontamination Group and therefore Decontamination Lead (AD Estates). The TORs have been agreed to exclude these items which remain in the remit of IPC group. |
| | | | a record-keeping regime is in place to ensure that decontamination processes are fit for purpose and use the required quality systems | Following TRUS probe investigation (following outbreak) an audit is underway of all invasive devices requiring all departments to ensure they have adequate decontamination records, SOPs and training records. |

| | What the Trust must demonstrate | Current compliance | Current Gaps | Actions Required/Target date |
|---|---|---|---|---|
| | | | | The responsibility is with the departments to ensure they have adequate processes and share information with the Decontamination group to ensure satisfactory assurance is provided. |
| 3 | Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance | 94% | All antibiotic prescriptions are reviewed by a pharmacist. Overall antibiotic usage is lower than average see Fingertips Portal. No e-Prescribing system<br>Proactive work being undertaken relating to sepsis with appointment of sepsis nurse and development of sepsis boxes to speed up access to critical antibiotics. | Sepsis<br>E-prescribing system required |
| 4 | Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion. | 100% | None | None |
| 5 | Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people. | 100% | None | None |
| 6 | Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the | 100% | None | None |

| | What the Trust must demonstrate | Current compliance | Current Gaps | Actions Required/Target date |
|---|---|---|---|---|
| | process of preventing and controlling infection. | | | |
| 7 | Provide or secure adequate isolation facilities. | 83% | The Trust has a relatively low percentage of side rooms such that patients requiring isolation may exceed the numbers of side rooms available. Patients may need to be cohort nursed if demand is high for example at outbreaks of norovirus or influenza during high activity periods. On risk register risk level 12. | Long term solution = Isolation facilities to be considered as part of planning regarding "Future Fit" and moving to possibly 50% of capacity being side rooms.<br>April 2022 risk register score 15 lack of pressure isolation rooms. Estates currently looking at the feasibility of having drop in pod to ITU & also side room capacity.<br>Bioquell Pods installed in ITU and redirooms in use . |
| 8 | Secure adequate access to laboratory support as appropriate. | 100% | None | None |
| 9 | Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. | 99% | The Trust has a relatively low percentage of side rooms such that patients requiring isolation may exceed the numbers of side rooms available.<br>Require assurance from CPE's that competency based assessments for aseptic technique are in place | None |
| 10 | Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection | 100% | None | None |

## 11.0 CONCLUSION

This IPC report has provided a summary of the performance in relation to the key performance indicators for IPC in Quarter 4 and a summary for the financial year 2021/2022. Overall performance in relation to many of the IPC KPIs was positive, with the national targets being achieved for E.Coli, Pseudomonas Aerguinosa, Klebsiella Bacteraemia and C diff cases. The Trust also achieved its local stretch improvement targets for MSSA and Pseudomonas.

The number of COVID 19 cases being seen in the Trust has increased considerably in Q4 (January to March 2022). There have been a number of outbreaks seen on wards, which exceeded those seen previously in 2020/2021. Outbreak meetings are held twice weekly, with the involvement of PHE and NHSEI. Lateral flow testing compliance for staff still requires improvement.