Infection Prevention & Control

Nursing Report

April 2022– March 2023

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Summary

This report covers the period April 2022 – March 2023.

The Infection Prevention and Control (IPC) Committee at New Victoria Hospital (NVH) includes the following

- Director of Clinical Services – Gill Welch (reporting directly to the Chief Executive, Medical Advisory Committee and the Hospital Board of Directors)
- Consultant Microbiologist –Dr Jim Stephenson (available 24/7)
- Infection Control Nurse (ICN) – Jane Harris
- Theatre Manager – Sarah Feeley
- Theatre Sterile Services Unit (TSSU) coordinator – Barbara Duffy
- Operations Director – Katalin Kovacs replaced Donna Gibbs in October 2022
- Other representatives would be invited onto the committee if their expertise is required e.g. OPD, Ward, Pharmacy and Housekeeping managers, or a CNS from the Gender Dysphoria Surgical Service (GDSS) – from January 2023.

COVID19 infection continued to affect the organisation with government guidance and advice being updated and followed by staff, patients and their visitors.

The IPC Standards were audited throughout the year by the ICN and link practitioners in six departments:

- Alexandra Wards A and B
- Day Unit
- Physiotherapy
- Imaging
- Outpatients
- Catering

Theatres followed their own audit programme which included the IPC standards.

Pathology services remained outsourced to South West London Pathology (SWLP).

COVID – 19

COVID-19 continued to circulate among the population.
Government guidelines, published on 24 August 2022, reviewed the requirement for Covid-19 testing for patients undergoing elective procedures and planned care as prevalence in the community fell and remained at a comparatively low level meaning that the likelihood of individuals being infectious had also reduced.

Most asymptomatic screening for both staff and patients ceased; with only some continuing, to protect the most vulnerable patients.
Wearing masks for patients, staff and visitors became optional.

Changes in Business

NVH continued to provide surgical gender affirmation procedures for patients on the female to male transitioning pathway. 431 procedures were carried out during this period.

NVH continued to offer MYA theatre time and 352 procedures have been done.
NVH continued to support Kingston Hospital NHS Foundation Trust, particularly with pain lists, general and breast surgery.

One DIEP procedure has been completed during the last quarter.

Departmental Audits

See Appendix 1 for the results of the annual audit programme for 2022-23.

The ICN and team have continued to use the following audit tools:

- The Quality Improvement Tools (QIT) produced and validated by The Infection Prevention Society (IPS) and The Infection Control Nurses' Association (ICNA) audit tools have been amalgamated into one audit tool to simplify its use, covering:
  - Personal protective equipment (PPE)
  - Hand hygiene
  - Safe management of patient equipment
  - Management of blood and body fluids
  - Respiratory and cough hygiene
  - Safe management of environment
  - Safe management of linen
  - Disposal of waste (including sharps)
- In-house audit tools, (urinary catheter care, aseptic technique and care of IV cannulae) designed and reviewed by the ICN and link practitioners, are located on G Drive (as denoted on the annual audit plan).

Figure 1 compares the IPC standards audited throughout the Hospital. The total audit score for IPC 2022-23 was 97.42% (2021-22 was 97.5%), an agreed score of 90% and above indicates compliance.

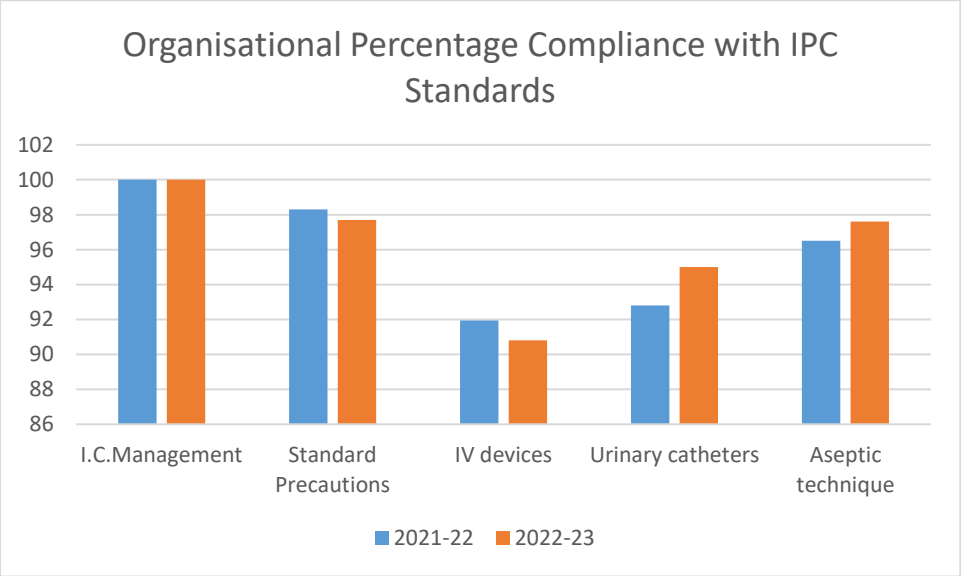

Figure 1

The management standard remained fully compliant. All other standards remained compliant. Individual departments have remained compliant as shown in figure 2.

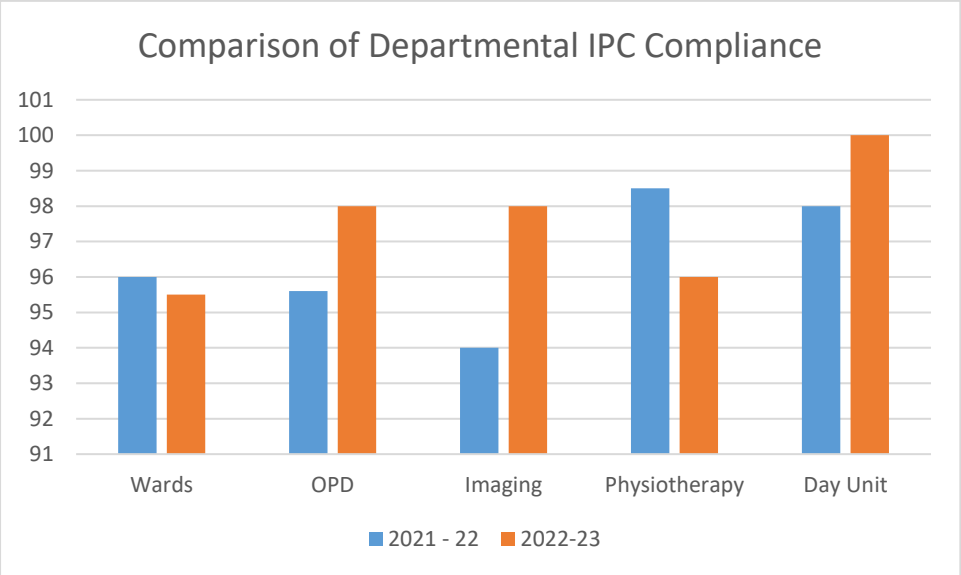

Figure 2

There is no score for the catering audit as this was written as a report with accompanying action plan.

There is no score for Theatres as their audits were not all completed.

Microbiologically, there were no reports of MRSA, MSSA, E. coli, or Pseudomonas bacteraemia or C. difficile infections at NVH during the period, however, NVH did report one case of Klebsiella bacteraemia. Mandatory reporting continued via Public Health England's Data Capture System by the ICN, with the IT Director being the local administrator.

The Hospital acquired infection rate for the inpatient population was 0.22% (0.3% in 2021-22)
The surgical site infection rate for 2021-22 was 0.22% (0.46% in 2021-22).
Attendance at infection control training for all staff remained mandatory.

Departmental Audits

The aim of audit is to assess compliance against set standards with a comprehensive IPC audit tool of the clinical departments, and to make recommendations for any improvements required.

Theatres

Operating Theatres are critical in providing excellent surgical care for patients. This should be a controlled environment, meeting or exceeding infection control standards.

It was agreed that the theatre staff would undertake their own audits for the year and from that a total of 14 IPC audits were planned. Due to lack of available staff, these were not all completed. By June 2022 a Deputy Theatre Manager had been appointed and part of his role was to be responsible for undertaking the audits.

Excluding Endoscopy, a total of 8 IPC audits were completed – Theatre asepsis (100%), Hand Hygiene (minor issues addressed during audit), WHO 5 steps to safer surgery, an environmental audit (with an action plan of recommendations), Theatre Practice, management of sharps (after which a new audit tool has been designed to incorporate handling sharps in theatre), flushing IV cannulas and the management of Normothermia using the 'One Together' audit tool.
This final audit has required some changes to practice - NICE recommend that all patients should be assessed for their risk of perioperative hypothermia and have their temperature monitored at specified times to enable the appropriate warming to be undertaken to maintain the patient's temperature above 36 degrees Celsius in order to minimise their risk of infection and enhance their recovery.
This audit was undertaken in 3 parts: pre-operative, intra-operative & post-operative warming. 5 patients' care was reviewed to determine their pre-op assessment information given, temperature assessment, any warming aids given and their temperature record. A number of recommendations were made:

- The POA team should provide verbal and written information about the importance of keeping warm prior to an elective admission
- The risk of hypothermia should be assessed preoperatively
- The patient's temperature should be measured within one hour before procedure
- The patient's core temperature should be measured and recorded before the induction of anaesthesia
- Any patient with a temperature below 36 degrees are at high risk of hypothermia and should be warmed immediately
- Training in the use of warming devices should be provided to all relevant staff
- The patient's core temperature should be assessed every 15 minutes in recovery, if a core temperature is less than 36 degrees, the patient should be actively warmed with forced-air, until they reach the normothermia level
- If a patient's core temp is less than 36 degrees, they should not be discharge from Recovery.

The theatre audit schedule for the next year has been reviewed and amended.

Endoscopy was compliant with its audit schedules as it is preparing for JAG accreditation.

The general impression of theatres remained one of a busy but still cluttered environment e.g. lack of storage space and relying on regular agency staff to fill vacancies.

Decontamination of equipment continued to take place off site at Parkside Hospital. There were a couple of incidences where the outer coverings of the 'heavy' sets were found to be damaged possibly through handling and when more than one set was being transported, this seemed to have been resolved during the last quarter..

There were no infection control issues with the endoscopy washer disinfectors.

The theatre department passed a medical air sampling test in January 2023.

Wards

The Standard Infection Control Precautions (SICPs) were audited on the wards by the ICN and the Ward Manager.
The audit also consisted of spot checks/observation of practice where members of staff were asked to describe procedures and explain their knowledge regarding infection control.

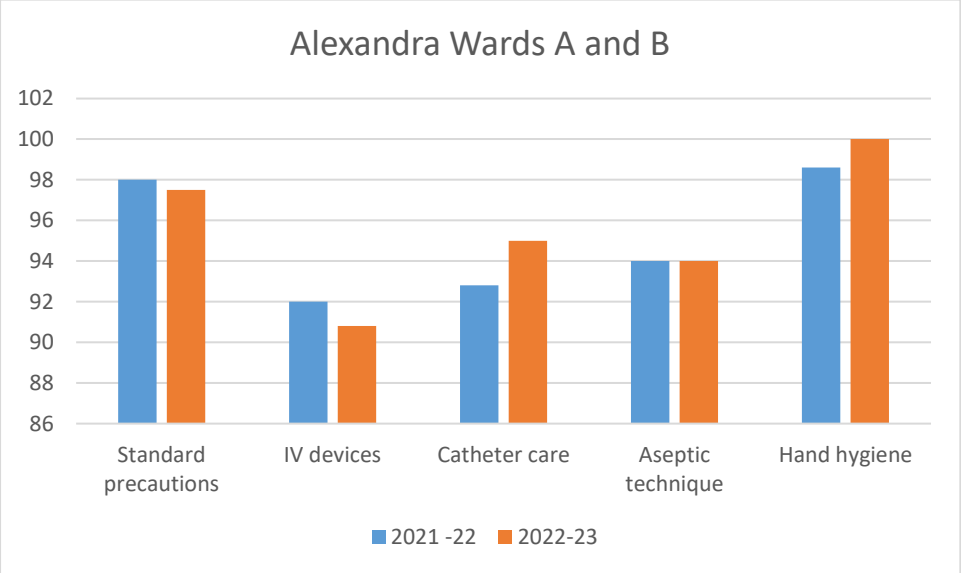

Figure 3

The ward was fully compliant with the management of linen, waste, sharps, PPE and hand hygiene facilities, as well as the staff knowing how to practice safely (figure 3). The environmental issues lowered the overall result and will be addressed over the following year during a planned decorating programme and the replacement of patient room windows.

Mattress testing
Hospital mattresses which are not routinely checked for wear or damage may be associated with increased Infection Prevention and Control risks. Poor maintenance of foam mattresses and their covers may lead to staining of the foam or inner surfaces of the mattress covers. This damage can promote the growth of micro-organisms, which are a potential cause of cross infection.

All mattress covers were routinely visibly inspected for small holes by housekeeping staff (at a patient's discharge) and when nurses were making beds, in line with guidance.
During August, the mattress covers were checked for: zipper integrity, stains, tears and unpleasant odours as well as performing the leakage test using the Infection Prevention Society's recommendation in the Patient Equipment Audit Tool:

Standard- mattress covers are in good state of repair- Select a bed at random and undertake a mattress test (Mattress Test: examine the mattress- there should be no staining visible and the mattress should be impermeable to fluids –Place paper beneath cover and press down for 10 seconds. Pour 30mls of water onto area and press for 30 seconds. Remove and examine paper towel for signs of leakage beneath cover).

19 mattress covers (out of 19) were checked, 6 had lost their integrity and 1 had visible holes in the cover, the covers were replaced. 10 of the mattresses were beginning to lose their foam integrity and the Ward Manager is awaiting approval for their replacement.

This test is repeated yearly.

All joint replacement patients, and those identified as being at risk of developing a pressure ulcer, had a pressure relieving mattress ordered for them, via Huntleigh Healthcare, prior to admission or on admission if they had not had a pre-op assessment. The mattress is decontaminated prior to use by the company and cleaned by NVH staff before returning.

Catheter Care

This audit was undertaken twice during the year using inpatient notes alongside observation of practice in order to assess the compliance of staff looking after patients with an indwelling urinary catheter and their associated documentation in line with the NICE clinical guideline for Healthcare-associated infections: prevention and control in primary and community care (CG139) and the NICE Quality Standard 61 for Infection control and prevention. Figures 4, 4A and 4B demonstrate the results.

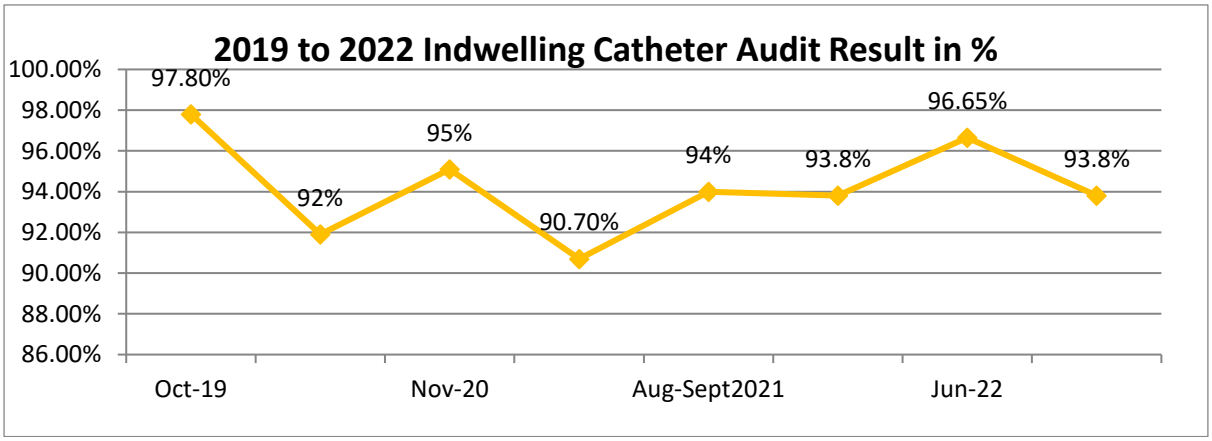

Figure 4

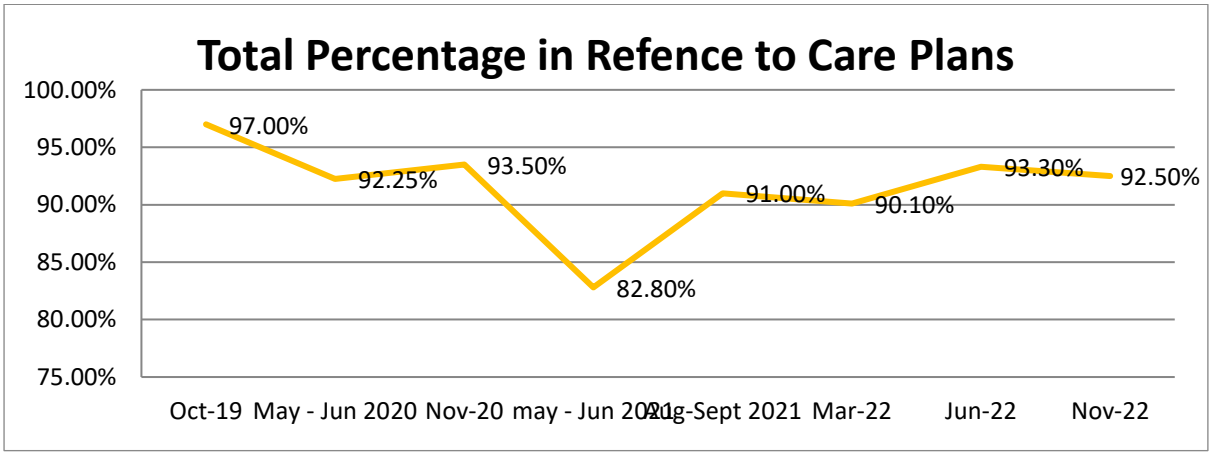

Figure 4A - Trend Score (in Percentage %) per Audit Event in Reference to Care Plans

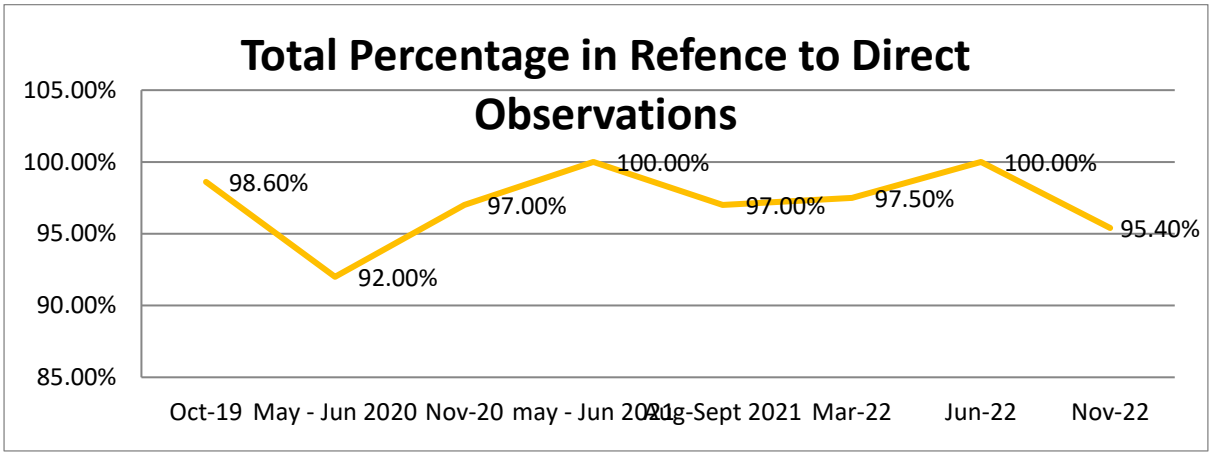

Figure 4B - Trend Score (in Percentage %) in Reference to Direct Observations

Catheter-associated urinary tract infections (CAUTI) comprise a large proportion of healthcare-associated infections, and can occur whether a person has either a short-term or a long-term catheter in situ. The two main concerns around the development of CAUTI are unnecessary urinary catheterisations and prolonged catheter days.
With the introduction of the GDSS at NVH, there are more in-patients with an indwelling catheter which are in for a longer period of time (more than 72 hours). Hence, high standards in the care of urinary catheters must be maintained at all times to avoid the occurrence of CAUTIs.
From these audits, attention to detail was raised again within the documentation and the importance of securing catheters with a retaining strap (observed in patients having a phalloplasty). More patients returned to NVH to have their catheters removed and in May 2022, a new combined day case care plan for trial without catheter was trialled and adopted.

IV Cannula Audit
Peripheral Access Cannula Devices (PACD) or Peripheral IV Cannula (PIVC) are designed to facilitate the administration of appropriate short-term (3-5 days) IV therapy infusions, such as IV antibiotics, chemotherapy, and parenteral nutrition, as well as for bolus intravenous injections or short infusion times and blood sampling (RCN Standards for infusion therapy, 2016).

The audit was carried out using the audit tool found on G-drive by the Ward Infection Control Link Nurse with the results charted below (Figures 5, 5A, 5B):

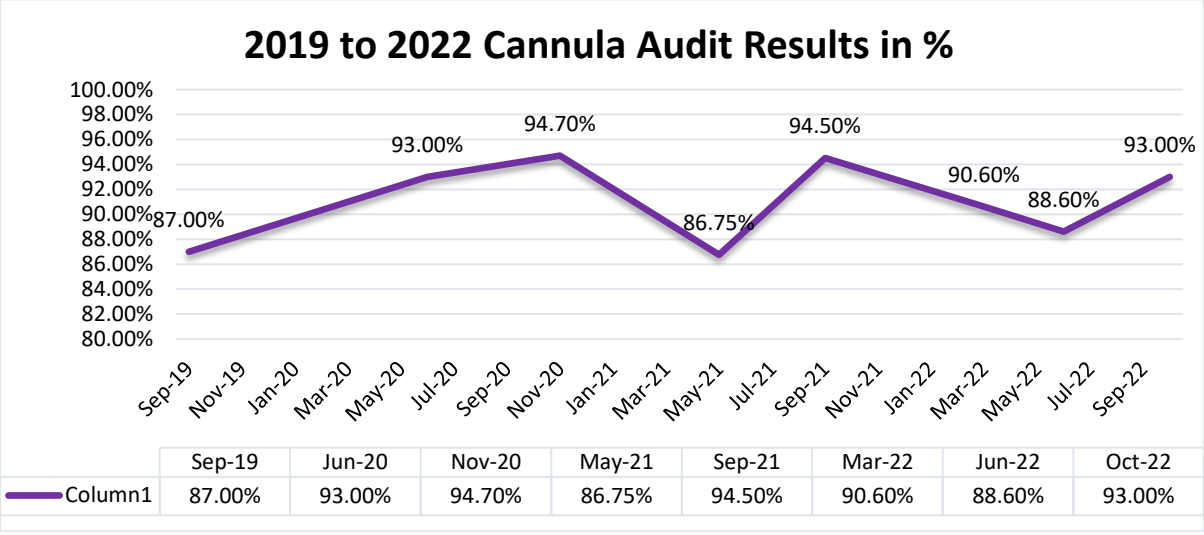

Figure 5

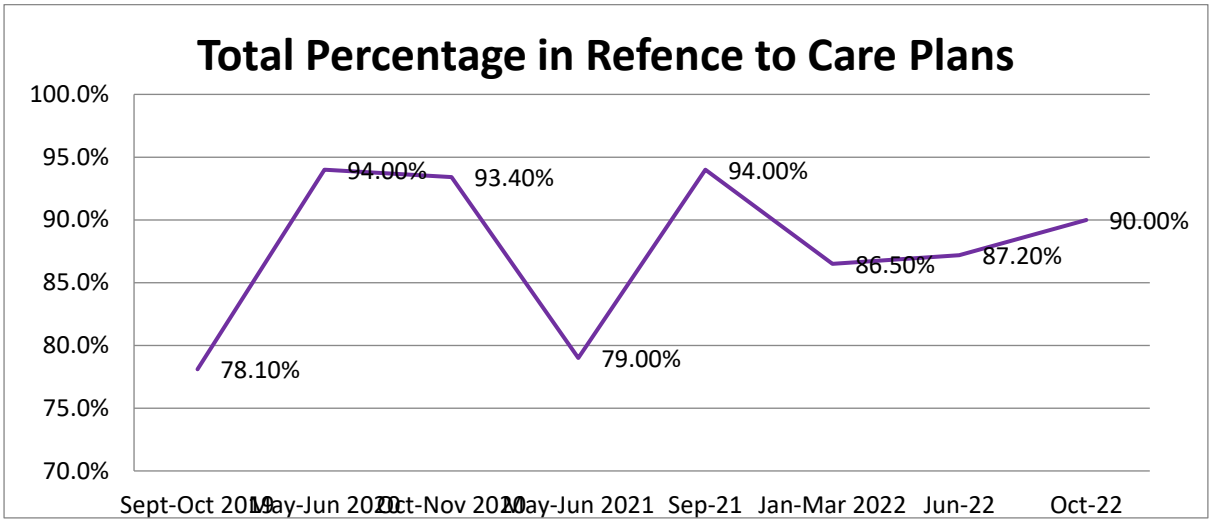

Figure 5A - Trend Score (in Percentage %) per Audit Event in Reference to Care Plans

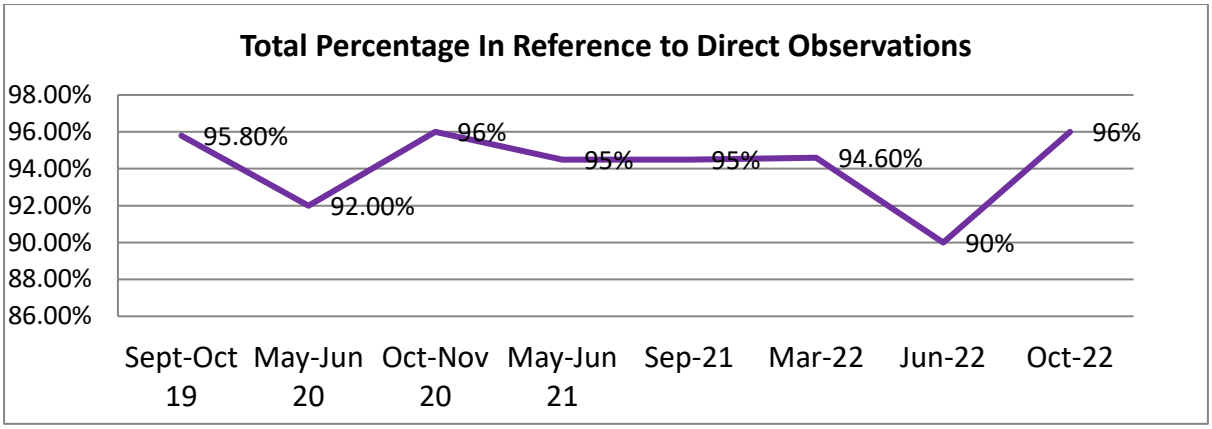

Figure 5B - Trend Score (in Percentage %) in Reference to Direct Observations

Following a slight fall in compliance at the beginning of this audit timeline, there was an improvement in nursing practices in the care of IV cannula. Staff became fully compliant in instigating care plans; decontaminating hands prior to handling cannulas, cleaning the port with appropriate solution prior to accessing them and using impregnated hubs when cannulas are not in use.

Central vascular access devices were not audited during 2022-23 as in previous years, there were not enough inserted to carry out a meaningful audit.

<u>Hand Hygiene</u>

Everyone has an important role to play in keeping patients safe from infection – and hand hygiene is the key. Up to 80% of Infectious Diseases are transmitted by touch. With COVID still ravaging the population and the global pandemic still prevalent, correct and timely hand hygiene practice underpins the importance of preventing the spread of infection.

Health-care workers should clean their hands:

1. before touching a patient,
2. before clean/aseptic procedures,
3. after body fluid exposure/risk,
4. after touching a patient, and
5. after touching patient surroundings.

The ward achieved 100% compliance.

Outpatients

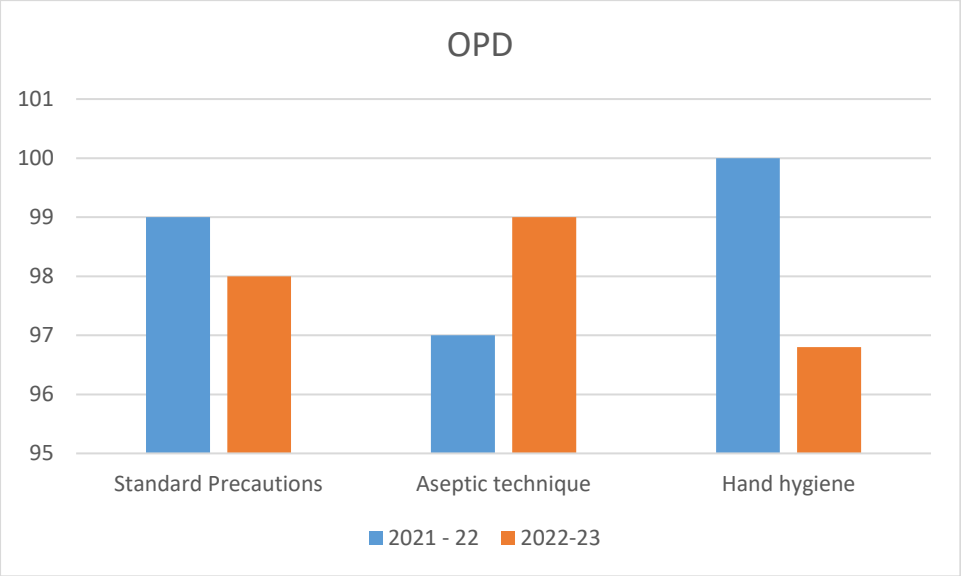

Figure 6
Standard precautions were audited in the department (consulting rooms 6, 8, 11, the three treatment rooms, dirty utility rooms, storage rooms, phlebotomy and Pre-op assessment 2) using an adapted audit tool based on the ICNA audit tools and the IPS Quality Improvement tools for standard precautions. The department was found to be clean, tidy and well organised. The HCAs are to be commended for keeping the gratnells trollies clean and well stocked with no expired items found on them. The issues identified from the previous audit had all been resolved with only three minor issues found and two recommendations which were rectified shortly after the audit.

Aseptic Technique
Proper aseptic technique is one of the most fundamental and essential principles of infection control in the clinical and surgical setting. The word “aseptic” is defined as “without microorganisms,” and aseptic technique refers to specific practices which reduce the risk of post-surgical infections in patients by decreasing the likelihood that infectious agents will invade the body during clinical procedures. These practices also are designed to help surgical teams avoid being exposed to blood, body fluids, tissue and other potentially infectious material during surgical/invasive procedures.
Continual assessment of the evidence base and comprehensive evaluation of practice represent important components in further developing a strong and solid aseptic technique among the team members.
Ten observations of aseptic technique were made during minor surgical procedures and during wound dressings in OPD in March and August 2022 using the Aseptic Audit Tool found on G drive, no major issues were identified.
The IPC link nurse in OPD ensured that all care givers in OPD had completed a competency assessment in aseptic technique and confirmed competency at their yearly appraisal.

Hand Hygiene
OPD staff were observed to be compliant with hand hygiene practices both during their standard precautions audit, observation of hand hygiene audit and the organisational hand hygiene audit.

Imaging

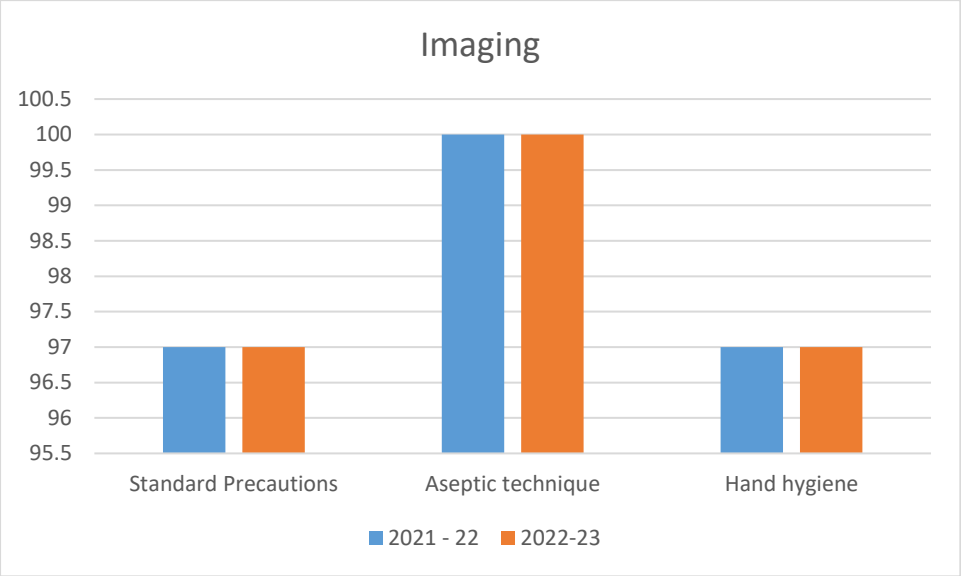

Figure 7

The annual audit of IPC standards in the Imaging Department used an adapted Clinical Practice Process Improvement Tool (IPS) and combined Infection Control Audit Tools from ICNA (2004) designed by the ward Infection Control Link Nurse and found on G drive. It involves hand hygiene, personal protective equipment, patient equipment, the environment, sharps, linen and waste.
The auditors looked at the reception areas Interventional room, X – Ray room, Ultra sound rooms 1 and 2, mammography, CT and MRI.

This busy department has outgrown its environment. There are plans to upgrade throughout. It was visibly clean, no issues were found concerning high and low dusting.

Aseptic Technique
The Radiographers scored 100% compliance in April and 3 HCAs, who were audited for their technique by the IPC Link Practitioner, were also 100% compliant.
In September two NHS pain lists were followed, looking at the aseptic technique of the anaesthetist and maintenance of the sterile field by the theatre nurse for one audit by the IPC Nurse, the main issue concerned the environment i.e. lack of space for carrying out hand hygiene, preparing the sterile field and gowning and gloving.

Hand Hygiene
Imaging staff were observed to be compliant with hand hygiene practices both during their standard precautions audits, observational audit and the organisational hand hygiene audit. Two Consultants had to be reminded to be ‘bare below the elbows’ when carrying out aseptic techniques during one audit.

Physiotherapy

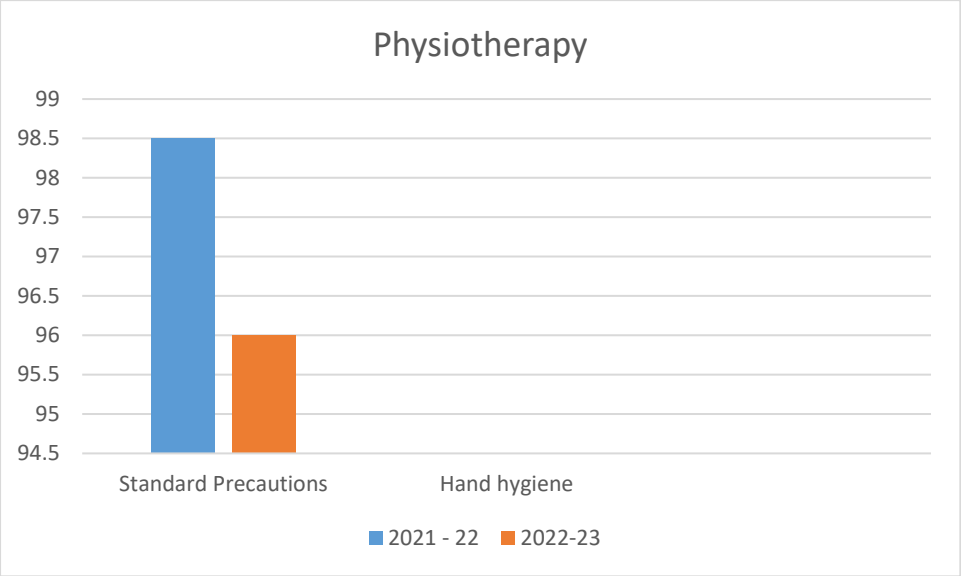

Figure 8

The department was audited for IPC standards in June and was found to be generally clean and tidy with the main issue concerning the management of sharps bins (not being labelled or closed). No further issues were found when the department was targeted during regular sharps and waste walk-abouts.

Hand Hygiene

This audit was carried out in November.

The overall result was positive (not scored), however, areas for improvement were physiotherapists needed to be bare below the elbow, not wear jewellery and to ensure hands were wetted prior to using hand hygiene products. This was discussed and addressed with the offending staff members.

Day Unit

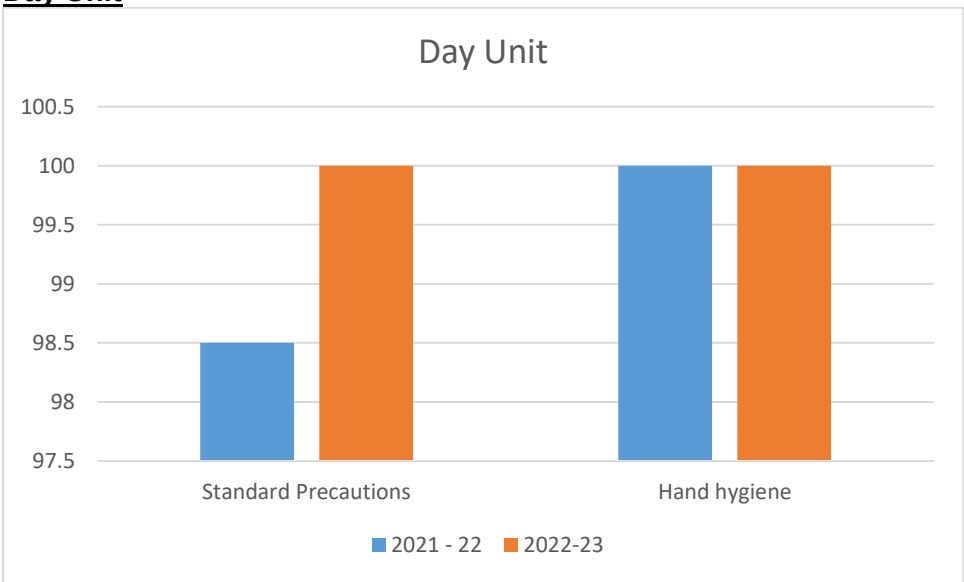

Figure 9

The Day Unit was compliant with the IPC standards (figure 9) and was audited once during the year using an adapted Clinical Practice Process Improvement Tool (IPS) and the combined Infection Control Audit Tools from ICNA (2004) designed by the I.C Link practitioner. The audit consisted of spot checks/observation of practice where members of staff were asked to describe procedures and explain their knowledge regarding infection control. No issues were identified.

Hand Hygiene

This audit was carried out twice during the year by the DU receptionist and the ICN. No hand hygiene issues were identified by the auditors.

Catering Department

Hospital catering services are an essential part of patient care, given that good quality and nutritious food plays a vital part in a patient's rehabilitation and recovery. Effective catering services are dependent on a range of processes which involve menu planning, procurement, food production and distribution of meals to patients and staff.

NVH has a legal obligation to comply with the provisions and requirements of food hygiene regulations since 1987 and there are now several pieces of legislation governing food safety, including the requirement to have a food safety management system based on Hazard Analysis Critical Control Point (HACCP) principles.

The kitchen and pantries are audited once a year by the Infection Control Nurse to include the environment, staff and to ensure policies and procedures are being followed.

The department was audited in October with only the minor issue of ensuring all records were signed, dated or commented as to why not complete.

The Environmental Health Officer visited in September 2022 and made some minor recommendations, NVH received a 5 star rating.

Pathology Services

SWLP maintained the contract for processing the majority of pathology samples, except for Histology, with a small amount still being processed by The Doctor's Laboratory (TDL).

Blood for cross match and group and save continued to be sent to Kingston Hospital Blood Transfusion Laboratory with a SLA finally being agreed in March 2023.

The blood fridge was serviced and mapped by Kingston Hospital (DEVA) and is centrally alarmed via the Medicare system.

Organisational Hand Hygiene

This audit used the WHO self-assessment framework to see if compliance had been maintained. The Framework is a tool with which to obtain a situation analysis of hand hygiene promotion and practices within an individual health-care facility, according to a set of indicators.

This survey was carried out using the QIT hand hygiene environment tool (IPS). All departments were visited (covering 32 areas). The Infection Control Nurse and Day Unit staff nurse visited each department and looked at the provisions for hand hygiene. In addition they asked staff to demonstrate their hand hygiene technique.

Individual infection control link practitioners covertly observed hand hygiene practices amongst clinical staff throughout the year. The observation of practice is difficult to do in this organisation as the auditors are recognised for what they are doing which accounts for the high compliance.

To complete this audit, the Infection Control Nurse carried out an assessment for the provision of hand hygiene in the organisation using the WHO Self-Assessment Framework (2010).

Summary of Findings

Results:

Observation - No issues concerning hand hygiene identified from the clinical departmental audits.

40 members of staff were observed. Many non-clinical staff were not wetting their hands before applying liquid soap.

No hand cream present in 3 departments

WHO Self-assessment

Component	**Subtotal % (2022(2021)**
System change (sinks, gel, soaps)	100 (100)
Training and education	100 (100)
Evaluation and feedback (audit feedback)	85 (80)
Reminders in the workplace	70 (80)
Institutional safety climate	75 (60)
Total score	**430 (340)**

Total Score (range) Hand Hygiene Level 0 - 125 Inadequate
126 - 250 Basic
251 - 375 Intermediate (or Consolidation)
376 - 500 Advanced (or Embedding)

This audit identified the need to change the hand hygiene posters which was completed via Marketing in March 2023. It also highlighted the need for the appointment of a Hand Hygiene Champion to help teach new members of staff (particularly non-clinical). An HCA with an interest in infection control has taken on this role.

Waste and Sharps Walk-About

The Housekeeping Manager and the ICN continued to carry out regular (monthly) walk round mini audits of waste and sharps compliance throughout the Hospital. Minor issues were found in all departments, e.g. mixed waste in recycling, open sharps bins, unlabelled pharmaceutical waste bins (porters) which were addressed immediately.

Due Diligence visit to Albus Environmental (August 2022)

Under the Environmental Protection Act 1990 anyone who produces, imports, keeps, stores, transports, treats or disposes of waste has a duty to take all reasonable steps to keep it safe. Therefore, it is important to carry out Duty of Care checks in **order to demonstrate compliance with legislation and help avoid prosecution and/or fines**. NVH has a legal responsibility to track and trace its waste to ensure that it is being transferred, treated and disposed of appropriately.

Albus will be collecting the clinical waste from 30 June 2023 in the future and they will subcontract Veolia to remove household, recyclable and glass waste.

The auditors (who were able to compare with the Grundon sites) were shown a clean, tidy and well run operation.

Grundon visited NVH in November 2022 and found no issues; NVH was compliant with waste handling and segregation.

MRSA Screening

MRSA screening of 'at risk' identified patients continued throughout 2022-23 in line with the recommendations issued initially by the Association of Independent Healthcare Organisations and following publication of the NOW study (National One Week prevalence study of MRSA) and Department of Health Advice August 2014.

The numbers of positive patients identified remained small.

CRE Screening

CRE screening of 'at risk' identified patients continued throughout 2021-22, with none being reported.

Surveillance of Hospital Acquired Infections

Surveillance of HAIs enables the organisation to provide feedback to surgeons and the surgical team about the quality of infection prevention in the operating theatre.
All infections (medical/surgical) were reported to the ICN via the daily bed meeting and were presented at the Infection Control Team meetings for discussion as to whether they were Hospital acquired. All patients were assessed for signs of infection on admission and all discharged patients were encouraged to report signs of infection and seek advice from the organisation. An unknown number of superficial wound infections and urinary tract infections still went unreported as patients reported directly to their Consultant or General Practitioner. It is also thought that a number of GDSS patients sought help either from their GP or via their local NHS hospital.
In summary: -

- There were no outbreaks among patients
- Some departments continued to have issues with staff absences due to Covid.
- There were no MRSA healthcare acquired infections
- One Klebsiella blood stream related infection was reported to PHE via Data Capture System (DCS). A root cause analysis was carried out on the patient following a Millin's prostatectomy with lessons learnt being disseminated to the relevant departments and consultant concerned.
- During the period April 2022 - March 2023, there were no MRSA, MSSA and pseudomonas bacteraemia or C. difficile infections reported by the Hospital to Public Health England via the Data Capture System
  National results can be found at:
  http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI/LatestPublicationsFromMandatorySurveillanceMRSACDIAndGRE/
- There were 13 reported surgical site infections: 5 NVH, 1 MYA and 7 GDSS
- There were no reported healthcare acquired chest infections
- One infection was reported from procedures carried out in OPD (removal of a sebaceous cyst).

The surgical site infection rate for 2022-23 was 0.22% (2021-22 =0.46%)
Excluding Medical, MYA and GDSS patients, the SSI rate was 0.098% (0.24%)
MYA – 0.28% (0.8%)
GDSS – 1.6% (2%)
The Hospital infection rate for all inpatients was 0.22% (0.3% - 2021-22).

Prophylactic Antibiotics

It is important to understand the current use of antibiotics within the Hospital in order to improve patient care while minimising the development of antibiotic resistance. Surgical site infections are a major source of hospital-acquired infections, causing significant morbidity and mortality. In appropriate cases, surgical antibiotic prophylaxis is essential in preventing such infections; however, this comes with increased risks of antibiotic resistance and antibiotic-associated diarrhoea. On the other hand, the unnecessary use of antibiotics can expose patients to avoidable side effects and increase antibiotic resistance.
The Hospital's prophylactic antibiotic audit was carried out in September using the Kingston Hospital's "Empirical Antibiotic Guidelines for the Management of Common Infections, 2018".

The standard compliance for antibiotic prophylaxis should be 90% or more, NVH achieved a 90.6% (92.9%) compliance.

Needlestick Injury

There were 8 needlestick injuries during the year with no trends being identified.
Staff were able to access Occupational Health at Kingston Hospital, who provide and counsel if Post Exposure Prophylaxis is needed for needlestick injuries when the risk assessment has indicated a high risk of HIV transmission.

Flu

The flu vaccine was offered to all 'frontline' staff; 90 members of staff received it.

Training

All new members of staff continued to meet with the ICN during their induction program. All staff had access to annual Infection Control training via e-learning. The training compliance for March 2022 was 90.5% (85% 21-22).

All clinical staff have had training as to what to expect from caring for patients undergoing GDSS and DIEP procedures.

The ICN is a member of the Infection Prevention Society, which provides valuable updates in practice and guidance. She has access to yearly external training and updates. She was also in regular contact with the ICN at KHFT. During the Hospital's contract with MYA to perform cosmetic surgery, the ICN has had contact with their ICN when needed.

The ICN has regular contact with the Consultant Microbiologist as well as chairing the quarterly IPC Committee and IPC Link nurses' meetings.

Innovations

- Appointment of a Hand Hygiene Champion
- The Deputy Theatre Manager leading the Theatre audits

Aims and Objectives for 2023- 24

To continue:

- Compliance with The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance http://www.legislation.gov.uk/ukpga/2008/14/contents
- Compliance with The Health and Social Care Act 2012 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
- Ensuring that the organisation remains compliant with the CHKS and CQC standards
- With planned departmental IPC audits using the appropriate audit tools
- Completing an annual Hospital pre-acceptance waste audit in conjunction with the porter and housekeeping managers with a representative from Grundon and carry out a duty of care visit
- Offering face to face IPC training with staff where needed
- Monitoring effectiveness of housekeeping activities through their audit activity and as part of each departmental environmental audit
- Reporting MRSA, MSSA, E. coli, Pseudomonas and Klebsiella bacteraemia and C. difficile infections to Public Health England via the Data Capture System
- Providing data to the organisation as a requirement of PHIN
- Maintaining links with KHFT and IHCA Infection Control Team
- Developing the link infection control practitioners within each department
- Assisting in the completion of the prophylactic antibiotic audit with the pharmacy manager

In addition:

- To encourage and assist the IPC Link nurse (Hand Hygiene Champion) with training
- To assist with Theatre audits if needed

References

Coronavirus – Guidance and Support
https://www.gov.uk/coronavirus?gclid=EAIaIQobChMIx-udmL_97wIVz9rVCh0nJQVLEAAYASAAEgJeb_D_BwE
NICE (2014) Infection Prevention and Control Quality Standard 61
Department of Health. (2004). *Audit Tools for Monitoring Infection Control Standards.* Infection Prevention Society.
Infection Prevention Society, *Quality Improvement Tools*. - http://www.ips.uk.net/professional-practice/quality-improvement-tools/quality-improvement-tools/#.Ut0MMmdFBMs
Department of Health (2008) *The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of Healthcare associated infections and related guidance* (revised 2015)
The National One Week Prevalence Audit of MRSA Screening (NOW study team Jan 2013).
Implementation of modified admission MRSA screening guidance (Department of Health 2014)
EU Council Directive 2010/32/EU on the prevention of sharps injuries in the hospital and healthcare sector found at http://www.hse.gov.uk/healthservices/needlesticks/eu-directive.htm
Surgical site infections: prevention and treatment - NICE guideline [NG125] Published date: April 2019 https://www.onetogether.org.uk/home/
Alexandrou E et al (2018) Use of short peripheral intravenous catheters: characteristics, management, and outcomes worldwide. *Journal of Hospital Medicine*; 13: 5.
Alexandrou E (2014) The one million global catheters PIVC worldwide prevalence study. *British Journal of Nursing*; 23: 8, 16-17.

NHS Improvement - https://www.england.nhs.uk/patient-safety/urinary-catheter-tools/)

Appendix 1 - Infection Control Audit Plan – Results April 1st 2022 – March 31st 2023

Audit Tool	Standard	%compliance 2021-22 97.5	Dept	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Avg 97.42
G Drive	**Management**	100	**Organisation**	**100**												100
G Drive	**Catering**	Completed Oct 21 Compliant	**Kitchen/Pantries**							**Completed Compliant**						√
QIT (IPS) (sharps/cleanliness/PPE/hand hygiene, patient equipment)	**Standard Precautions (PPE, Environment, waste, linen, sharps, spills, pt equipment)**	98.4	**Ward**											**97.5**		97.5
		99	**OPD**		**98**											98
		97	**X-ray**												**97**	97
		98.5	**Physio**			**96**										96
		98.5	**Day Unit**				**100**									100
Observation	**Hand Hygiene**	98.6	**Ward**				√				**100**					100
		100	**OPD**					**93.75**			**100**					96.8
		Compliant	**X-ray**						**98**						**96.5**	97.25
		Compliant	**Physio**							**Compliant**						**Compliant**
		100	**Day Unit**		**100**					**100**						100
G Drive WHO (self-assessment)	**observation**	Compliant	**Organisation**								**Completed**					**Compliant**
External Auditor	**Waste audit (organisational)**	Compliant									**Completed**					**Compliant**
QIT (G Drive)	**IV Devices**	91.95	**Ward**			**88.6**							**93**			90.8
QIT (G Drive)	**Catheter**	92.8	**Ward**		**96.65**								**93.8**			95
QIT (ANTT- G Drive)	**Aseptic technique**	94	**Ward**						**96**						**92.3**	94
		Compliant	**X - Ray**					**100**							**100**	100

		97	**OPD**					**98**						**100**		99

Compliance in 4 audits, not scored.

Theatre Audits – 8 IPC audits completed
Total IPC compliance score (excluding Theatres) = 97.42%