PURPOSE OF PAPER

To present the Board with a six monthly Annual Infection Prevention & Control Report for 2010/11.

EXECUTIVE SUMMARY

The Board acknowledges its collective responsibility for minimising the risks of infection and reviews and monitors the controls of such risks via the DIPC reports.

Infection prevention and control is a key risk that has been identified on the Trust’s Assurance Framework. The DIPC Report provides significant assurance to Board members that all areas of infection prevention and control are being managed effectively.

The Report specifically highlights the following:

- Progress against the Action Plan for 2010/11
- Healthcare associated infection (HCAI) rates for the Trust and required root cause analyses (RCA)
- Changes and learning as a result of RCA investigations
- Details of HCAI management
- Progress with education, training and audit, including hand hygiene compliance
- The updated positions for cleaning services, decontamination and antimicrobial practices

ACTION REQUIRED BY THE BOARD

The Board is asked to:

1. Note the report and how its content relates to Board assurance.
2. Minute that the Board continues to acknowledge their collective responsibility as described above.

Tracey Nutter
Director of Nursing
Director of Infection Prevention and Control

November 2010
Director of Infection Prevention & Control (DIPC)

Six Monthly Report for 2010/11

Tracey Nutter
DIPC

November 2010
1. Introduction

The Trust Board recognises and agrees their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is designated to the Director of Infection Prevention & Control (DIPC).

The DIPC bi-annual Report, together with the monthly Key Quality Indicator (KQI) Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively and that the Trust remains registered with the Care Quality Commission (CQC) without conditions.

The purpose of the DIPC Report is to inform the Trust Board of the progress made against the 2010/11 Action Plan, to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices for 2010/11.

The Action Plan focuses on ‘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 (December 2009), which identifies criteria to ensure that patients are cared for in a clean environment, where the risk of HCAI is kept as low as possible. This document includes references to other national strategy initiatives in infection control including –

- ‘Clean, safe care: reducing infections and saving lives’
- ‘Essential steps to safe clean care: reducing healthcare associated infections’
- ‘Saving lives: reducing infection, delivering clean and safe care’
- ‘Winning ways: working together to reduce healthcare associated infection in England’

The CQC has used the Code as a key feature of registration. Failure to observe the Code may either result in an improvement notice being issued to the Trust by the CQC following an inspection, or in it being reported for significant failings and placed on “special measures”.

All NHS organisations must be able to demonstrate that they are complying with the Code. The Trust continues to be registered with the CQC, without conditions. The Annual Action Plan for 2010/11 (Appendix 1) highlights how the Trust is continuing to maintain compliance.

2. Overview and Action Plan

The review of the Annual Action Plan 2010/11 (Appendix 2) shows the progress made towards achieving the infection prevention and control objectives over the last six months. This work is monitored via the Infection Prevention and Control Working Group (IPCWG) which reports to the Infection Prevention & Control Committee (IPCC) and onto the Clinical Governance Committee (CGC).

3. Infection Control Arrangements

A comprehensive infection prevention and control service is provided Trust-wide. The Infection Prevention & Control Team (IP&CT) provides a ward liaison and telephone consultation service with on-call arrangements for outbreaks of Norovirus.

The IP&CT currently comprises of an Infection Control Doctor (ICD), 3.0 whole time equivalent (w.t.e) Infection Control Nurses (ICNs) and 0.8 w.t.e secretarial post, with a vacancy existing for an ICN (0.6 w.t.e). In discussion with the DIPC, the IP&CT have reformulated the vacancy role to provide a Vascular Access Nurse (Appendices 3 & 4).
4. **DIPC reports to the Board**

The IPCC monitors the action plan on behalf of the Trust Board. The IPCC also provides regular progress reports to the Clinical Governance Committee (CGC).

The publication of the Department of Health (DH) guidance ‘Improving Cleanliness and Infection Control’ (Appendix 5), recommends that the DIPC provides the Trust Board with quarterly updates on standards of cleanliness. The first report was presented to the Trust Board in April 2008 and will continue to be included in the DIPC report.

5. **Budget Allocation**

The total budget for Infection Prevention & Control is £180.5K comprising:

**Staff**
- Nursing £138K
- Administrative £19K
- Medical (2 PA’s/week) £20.5K

**Support**
- Non-pay £3K

**Training**
Training budgets are held centrally in the Trust.

6. **HCAI Statistics**

6.1 **Outbreak Management**

The investigation and management of communicable and nosocomial infections in the hospital environment is the role that is most often associated with infection control and this is certainly an important and visible function of the service. Some areas in which the IP&CT have been particularly involved with include:

**Viral Gastro-enteritis**

Noroviruses are the group of viruses formerly known as Norwalk-like viruses (NLV) or small round structured viruses (SRSV). These viruses have long been associated with outbreaks of a relatively short-lived form of gastroenteritis, often referred to as ‘winter vomiting disease’. Appendix 10 provides additional information.

Although there were no declared outbreaks of Norovirus during quarters 1 & 2 of 2010/11, three unrelated cases of Norovirus were identified from inpatient samples. Two of these were from patients admitted from the community with symptoms of diarrhoea and vomiting on admission.

The Trust Norovirus Major Outbreak Plan Policy provides information and guidance on Salisbury NHS Foundation Trust’s operational response to a major outbreak of Norovirus. The aims and objectives of this document are to ensure a procedure is in place to deal with the command and control of Norovirus issues that might affect the operational running of the Trust. By ensuring that an agreed system of response is in place to manage a major outbreak of Norovirus it will help minimise disruption to the Trust, whilst it continues to operate effectively without the need to cancel elective admissions. The policy identifies appropriate areas for isolation nursing and the management of patients presenting with symptoms of viral gastro-enteritis direct from the community.
**Clostridium difficile (C. difficile)**

Clostridium difficile is a spore forming bacterium, which is present as one of the 'normal' bacteria in the gut of up to 3% of healthy adults. It is much more common in babies - up to two thirds of infants may have C. difficile in the gut, where it rarely causes problems. People over the age of 65 years are more susceptible to contracting infection. Appendix 10 provides additional information.

Following on from quarter 4 of 2009/10, when a C. difficile outbreak was declared on a ward within the medical directorate, the IP&CT compiled a report which was presented to the IPCWG during quarter 1 of 2010/11. The ward was closed to admissions during the period and full terminal (post infection) cleaning of the area was completed prior to reopening the ward.

A period of increased incidence (PII) of C. difficile was identified during quarter 2 of 2010/11, on a ward within the surgical directorate, when cases of C. difficile were geographically linked to two bays on the ward. In accordance with DH ‘best practice’ guidance and Trust policy, a series of measures were instigated. These included an additional antibiotic therapy review for all patients on the ward, full terminal (post infection) cleaning of the area, additional monitoring of practices and ribotyping of the available faecal samples. The terminal cleaning was expanded to include a neighbouring ward area, as service facilities were shared across both areas.

**Staphylococcus aureus**

Staphylococcus aureus is a bacterium that is a common coloniser of human skin and mucosa. This bacterium can cause disease, particularly if there is an opportunity for it to enter the body. Illnesses such as skin and wound infections, urinary tract infections, pneumonia and bacteraemia (blood stream infection) may then develop. Staphylococcus aureus is mainly spread by direct person-to-person contact, or indirect contact from touching contaminated objects or equipment.

Most strains of the bacterium are sensitive to many antibiotics and infection can be effectively treated. The term Methicillin Sensitive Staphylococcus aureus (MSSA) refers to the antibiotic sensitive strains of the bacterium. Some strains of the bacterium are resistant to the antibiotic Methicillin, and are termed Methicillin Resistant Staphylococcus aureus (MRSA). Appendix 10 provides additional information.

**Invasive Group A Streptococcus**

Group A streptococcus (GAS) is a bacterium, often found in the throat and on the skin. This organism can be carried in the throat and on the skin, and there is no outward sign of illness. Most GAS infections are relatively mild illnesses, such as ‘strep throat’ or a skin infection, such as impetigo. On rare occasions, these bacteria can cause other severe and even life-threatening diseases, e.g. invasive streptococcal disease.

During quarter 1 of 2010/11 there was one case of invasive GAS disease recorded within the medical directorate. Patients are initially isolated in a side room until they have received adequate antibiotic therapy. The IP&CT maintain close liaison with the Health Protection Agency (HPA) who follow up household contacts, and Occupational Health & Safety Services (OHSS) if there has been staff members identified at risk.

**Acinetobacter baumannii**

Acinetobacter is a gram-negative bacterium that is readily found throughout the environment including drinking and surface waters, soil, sewage and various types of foods. Acinetobacter is also commonly found as a harmless coloniser on the skin of healthy people and usually poses very few risks. Acinetobacter infections acquired in the community are very rare and most strains found outside hospitals are sensitive to antibiotics.

Acinetobacter poses few risks to healthy individuals; however a few species, particularly Acinetobacter baumannii, can cause serious infections, mainly in very ill hospital patients. The most common Acinetobacter infections include pneumonia, bacteraemia (blood stream infection), wound infections, and urinary tract infections. ‘Hospital-adapted’ strains of Acinetobacter are sometimes resistant to antibiotics and are increasingly difficult to treat. Patients identified to have
multi-drug resistant Acinetobacter are isolated in a side room for the duration of their hospital admission. There have not been any new inpatient cases multi-drug resistant Acinetobacter identified.

**Chicken Pox (Varicella Zoster)**

Chicken pox is a common illness, which does not normally cause complications in children. The likelihood of complications can increase in adults and especially if they are immuno-suppressed because of disease (e.g. leukaemia), and having high doses of steroids or chemotherapy. Non-immune women in the early or late stages of pregnancy are also potentially at risk.

For cases identified within the Trust, potential patient and staff contacts are followed up where appropriate, by the IP&CT and OHSS respectively. There have not been any new inpatient cases of chicken pox identified.

**Extended Spectrum Beta Lactamase**

One of the most common ways that bacteria become resistant to antibiotics is by the production of enzymes. The most common enzymes produced are beta-lactamases, which breakdown beta-lactam antibiotics, such as penicillin and cephalosporins.

Gram-negative micro-organisms have now started to produce extended spectrum beta lactamases (ESBLs), spread by hand contact, contaminated items or the faecal oral route. The significance of this is that ESBL is only responsive to a small number of antibiotics, so strict contact precautions are required. The Trust continues to manage cases of ESBL, most commonly isolated in urine. Patients are isolated within the clinical areas as appropriate, and in line with the Isolation policy.

**High Count of Legionella**

Legionellas are bacterium that are widely distributed within the environment, and have been found in ponds, hot and cold water systems and water in air conditioning cooling systems. The organisms are spread through the air from a water source. Breathing in aerosols from a contaminated water system is the most likely route of transmission. Person to person spread does not occur. The early symptoms can include a ‘flu-like’ illness that can develop into pneumonia. Deaths can occur in 10 – 15% of otherwise healthy individuals and may be higher in some groups of patients.

During quarter 4 of 2009/10, routine water testing returned a positive count from a staff shower room on Level 3 of SDH North. The outlet was managed in accordance with Trust policy. Follow up sampling identified the need for further flushing and resampling during quarter 1 of 2010/11. These confirmed negative results, and the outlet was returned to normal service.

During quarter 2 of 2010/11 there were no known Legionella colonisation episodes identified. All results are feedback immediately to the relevant personnel and the appropriate action taken. Quarterly result updates are formally reported to the IPCC.

**Respiratory Syncytial Virus**

Respiratory Syncytial Virus (RSV) is a viral infection that causes upper and lower respiratory infections, commonly affecting babies and young children. It is spread by aerosol droplets or by contact with contaminated surfaces. Although those affected usually present with mild symptoms, infants under 6 weeks old or premature babies are more at risk and the impact can be devastating, with an increased mortality rate. RSV is more prevalent during the winter months and the Trust has a policy for the management of RSV in the Neonatal Intensive Care Unit (NICU). There have been no outbreaks of RSV on NICU.

**Tuberculosis**

Tuberculosis (TB) is a disease caused by a germ (called the tubercle bacterium or *Mycobacterium tuberculosis*). TB usually causes disease in the lungs (pulmonary), but can also affect other parts of the body (extra-pulmonary). Only the pulmonary form of TB disease is infectious. Transmission occurs through coughing of infectious droplets, and usually requires prolonged close contact with
an infectious case. TB is curable with a combination of specific antibiotics, but current treatment must be continued for at least six months.

Multi-drug resistant tuberculosis (MDRTB) describes strains of TB that are resistant to certain first line treatment drugs. These cases can still be successfully treated with different medications.

The IP&CT have worked closely with the Respiratory Department, OHSS, and the HPA following the identification of a staff member with pulmonary TB during quarter 1 of 2010/11. Meetings were held to establish the risk factors for this individual and the required actions in light of this result. It was agreed that active screening should be undertaken for all patients nursed on the ward from the time that the staff member became symptomatic. Letters were sent to the General Practitioners for these patients, with an enclosed patient letter offering them the opportunity to attend the hospital for further TB screening. Patient contacts who remained as inpatients were identified and followed up by the Respiratory Nurses.

The follow up of staff contacts was undertaken by OHSS. This involved an ‘inform and advise’ approach, completion of a questionnaire, with further blood sampling/tests and chest x-ray undertaken.

During quarter 1 of 2010/11, an inpatient was identified to have pulmonary TB and was appropriately isolated in a sideroom within the medical directorate. Staff and patient contacts were identified and the require contact tracing and follow up completed.

In July 2010, the Director of Nursing commissioned a Serious Incident Inquiry (SII) in response to the management of TB. This report is near completion and will be presented to the Chief Executive and the Trust Board.

**Vancomycin Resistant Enterococcus (VRE)**

Enterococci are bacteria that are found in the faeces of most humans and some animals. Infections caused by enterococci are commonly urinary tract and wound infections. VRE cause the same types of infections, but the range of antibiotics available for treatment is limited and treatment is dependent upon the antibiotic sensitivities. There has been 1 case of VRE identified within the Trust, and this patient was isolated in a side room.

### 6.2 Surveillance

The IP&CT collects ‘alert organism’ and ‘alert condition’ surveillance data within the Trust. This data is used in the detection of outbreaks and monitoring of trends. The IP&CT co-ordinates data collections for the National Surgical Site Infection Surveillance (NSSIS) programme and within this there are twelve surgical procedures that are applicable to the Trust. The surveillance categories completed during quarters 1 and 2 of 2010/11 are as follows:

- Hip replacement surgery commenced in quarter 1 of 2010/11, and was completed during the this time as an acceptable cohort number of cases was achieved.
- During quarter 2 of 2010/11 the IP&CT completed data collection and follow up for patients who had undergone hip replacement surgery during the previous quarter. The data was submitted to the HPA within the required time frame.

**Methicillin Resistant Staphylococcus aureus (MRSA)**

The Department of Health (DH) Mandatory MRSA Bacteraemia Surveillance scheme has been used to measure the effectiveness of infection prevention & control practices in all NHS Trusts. The rationale behind this scheme is that it is sometimes difficult to distinguish between colonisation and true infection caused by MRSA, but culture of the bacterium from blood almost always represents significant infection. In accordance with current guidance from the HPA, results from this scheme are as given in the summary below, and cite the definitions of ‘Trust apportioned’ cases and ‘non-Trust apportioned’ cases.
MRSA Bacteraemia Trust apportioned cases: include patients who are –

1. Inpatients, day patients and emergency assessment patients; **AND**
2. have had a specimen taken at an acute Trust; **AND**
3. specimen is **3 or more** days after date of admission (admission date is considered day ‘1’).

Non-Trust apportioned cases: These include all cases that are **NOT** apportioned to the acute Trust.

Breakdown of total number of Trust cases recorded – April 2010 to September 2010

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>April</td>
<td>May</td>
<td>June</td>
<td>July</td>
<td>Aug</td>
</tr>
<tr>
<td><strong>Total patients</strong></td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Non-Trust</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>apportioned cases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(The Table 1)

The Trust's MRSA target for 2010/11 is no more than 12 cases. As can be seen from Table 1, the total reported for quarters 1 and 2 of 2010/11 is 3, and these were all non-Trust apportioned cases. The Annual Action Plan is key to achieving the Trust MRSA target. However, the Trust continues to act to ensure absolute minimum occurrence, with an obvious preference of zero.

A root cause analysis (RCA)/investigation has been performed for the 3 cases and communication with the relevant Primary Care Trusts/Community Teams has taken place.

The DH published ‘Clean, safe care: Reducing infections and saving lives’ in January 2008, which identified a number of initiatives to support continued improvement. One of these improvements was for each Trust to introduce MRSA screening for all elective admissions by March 2009, which has been achieved. The Trust MRSA screening steering group monitors compliance rates. Further work has been undertaken by this group to introduce screening for all emergency admissions to the Trust by 31st December 2010.

**Clostridium difficile (C.difficile)**

The control of this infection has been through the combination of sound infection control practices, environmental cleaning and prudent antibiotic prescribing. From April 2007, all patients over the age of two have been included for mandatory reporting of C.difficile to the HPA. Previously only patients over the age of 65 years of age were reported. In accordance with current guidance from the HPA results from this scheme are as given in the summary below, and cite the definitions of ‘Trust apportioned’ cases and ‘non-Trust apportioned’ cases. Table 2 relates to the breakdown of all inpatient cases of C.difficile identified, and Table 3 contains the total cases of C.difficile recorded by the Trust.

C.difficile Trust apportioned cases: include patients who are –

1. Inpatients, day patients and emergency assessment patients; **AND**
2. have had a specimen taken at an acute Trust; **AND**
3. specimen is **4 or more** days after date of admission (admission date is considered day ‘1’).

Non-Trust apportioned cases: These include all cases that are **NOT** apportioned to the acute Trust.

Breakdown of cases recorded for inpatients – April 2010 to September 2010

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>April</td>
<td>May</td>
<td>June</td>
<td>July</td>
<td>Oct</td>
</tr>
<tr>
<td>Total Inpatients</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Non-Trust apportioned cases</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Trust apportioned cases</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

(Table 2)

Breakdown of total number of Trust cases recorded – April 2010 to September 2010

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>April</td>
<td>May</td>
<td>June</td>
<td>July</td>
<td>Oct</td>
</tr>
<tr>
<td>Inpatients</td>
<td>2</td>
<td>3</td>
<td>6*</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Community Hospitals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>General Practitioners</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Residential/Nursing Home</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other (including Coroner, A&amp;E, Private Hospital)</td>
<td>0</td>
<td>0</td>
<td>1**</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>6</td>
<td>11</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

(Table 3)

*depicts one Day patient case
**depicts one Outpatient Department patient case which the HPA website classifies as an ‘acute Trust’ sample

These are the numbers of positive episodes. In a single patient, a positive test occurring after a previous positive test is considered a new episode only after 28 days. For each inpatient episode a RCA investigation is performed by the IP&CT in conjunction with staff from the clinical area concerned and the Lead Antimicrobial Pharmacist.
A multidisciplinary C. difficile ward round (as recommended in the DH document ‘C. difficile – How to deal with the problem’), has also been piloted. The aim being for this to be a regular occurrence.

A report from the HPA last year, highlighted poor performance from the kits that were being widely used to detect C. difficile infection by hospital laboratories, leading to uncertainty as to how to best test for the infection. The Salisbury Microbiology Laboratory performed a trial of a new diagnostic algorithm for detection of C. difficile infection in February, March and April 2009. The trial found similar results to that from recent published trials in the literature, with improved sensitivity and specificity. The new testing method was accepted by the IP&CWG.

The laboratory continue to use polymerase chain reaction (PCR) testing which has greater sensitivity for detecting C. difficile compared to older toxin detection kits. This may increase the number of reported positive results because of improved laboratory detection.

**Methicillin Sensitive Staphylococcus aureus (MSSA)**

From April 2008 the IP&CT commenced voluntary surveillance of MSSA bacteraemia detected from blood cultures and reported figures to the DH via the HCAI Data Capture System. MSSA bacteraemia has the potential to become resistant and develop in to MRSA bacteraemia.

Prior to April 2008, the IP&CT were not routinely informed or held a record of this data. Although currently voluntary, participating in this surveillance has been beneficial. It has heightened awareness of practices regarding the insertion and care of intravenous vascular devices.

**MSSA Bacteraemias figures recorded for blood cultures from inpatients, and blood cultures taken in outpatient areas and the Emergency Department – April 2010 to September 2010**

<table>
<thead>
<tr>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2010/11</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

The IP&CT undertake a RCA for every inpatient MSSA bacteraemia. Where indicated this includes generating an action plan with the involvement of staff in the relevant clinical area.

From the RCA process, none of these cases could be related to the presence of an invasive device and none of the cases could be linked. Five samples were taken from patients admitted to the Trust with signs and symptoms of infection. The remaining two patients, had pre-existing conditions and became unwell. It is important to emphasise the need for continued monitoring of invasive devices and maintaining the required care documentation. The IP&CT will continue to produce an annual MSSA incidence report for presentation to the IPCC.

The Trust recognises that there is a requirement to sustain improvement and maintain safety across all aspects of invasive vascular device management. To ensure a reduction in 2010/11 HCAI figures, KQI reports will continue to monitor local targets set by the DIPC.

### 7. Hand Hygiene

All inpatient and outpatient clinical areas are required to undertake monthly hand hygiene audits. Compliance rates continue to be calculated, and individual tables for each area within the
directorates are produced by the IP&CT. These are feedback direct to the clinical leaders, DMTs and DIPC via the monthly Matrons Monitoring meetings.

In additional support of this practice, a robust Uniform Policy and Workwear Guidance including ‘Bare below the elbow’ (BBE) policy remains in place, and compliance is monitored by the Directorate Management Teams (DMTs) and findings feedback directly to the DIPC.

The Trust target for hand hygiene compliance rates is 100%. This target is reflected in the Clinical Leaders and Directorate Senior Nurses (DSNs) personal objectives. An improvement has been achieved however further work is required by the DMTs to sustain this improvement. Part of this has involved the IP&CT training the Infection Control Link Professionals (ICLPs) to undertake hand hygiene assessments for staff in their own areas. This is proving to be successful and is a useful method to further raise the profile of hand hygiene behaviour and compliance with bare below the elbow. It also provides an alternative opportunity for staff to complete their annual mandatory hand hygiene assessment. Appendix 6 shows hand hygiene compliance summary tables for each directorate.

The requirement to complete an annual hand hygiene assessment has been added to each staff member’s Learning Plan on the Managed Learning Environment (MLE). From the record/signature sheet completed when a hand hygiene assessment takes place, the IP&CT are able to record the assessment on the MLE for the relevant staff member. It is aimed that this facility will act as a reminder to individual staff and will assist line managers to identify and follow up staff who have not completed their annual hand hygiene assessment. The IP&CT have undertaken hand hygiene assessment ‘drop-in’ sessions for departments/staff to attend who are unable to access an ICLP. These commenced during quarter 2 of 2010/11 and will continue. Figures for completed hand hygiene assessments during quarters 1 and 2 of 2010/11 are shown in Appendix 9.

The IP&CT are keen to continue to improve hand hygiene compliance amongst visitors including relatives, to the Trust and have performed adhoc hand hygiene promotion sessions for the public and visitors. This involves the use of the ultra violet (UV) hand hygiene inspection cabinet (‘light box’) and training gel, to assess hand hygiene technique. This activity remains very popular and is an extremely useful exercise. The IP&CT have continued to review the hand hygiene posters and signage across the Trust site during 2010/11.

The alcohol hand rub gel dispenser stations with the brightly coloured background boards have been a successful Trust project. However the challenge will be to continue to raise the profile and public awareness of hand hygiene practices. The ArtCare Department have been commissioned to implement a maintenance programme to ensure the upkeep of these gel dispenser stations.

8. Decontamination

The Trust Decontamination Group continues to meet quarterly, chaired by Peter Wells, Decontamination Lead & Sterilisation & Disinfection Unit (SDU) Manager. The Chair gives formal feedback to the IPCC & IPCWG. The Decontamination Group membership and ‘Terms of Reference’ were reviewed in April 2010.

Progress against Decontamination Strategy
The Decontamination Strategy remains in place, with key objectives reviewed at each quarterly meeting. Risk assessments have recently been updated/completed for outstanding areas of non compliance. Progress against these objectives is as follows:

1. Ensure fully compliant decontamination practice Trust-wide.
   The latest guidance for variant Creutzfeldt Jakob Disease (CJD) has been considered and meetings have been held attended by the relevant personnel. The vCJD policy is being amended in response to a review of the local systems currently in place.
The consolidation of single use items remains an ongoing process, with the involvement of representatives from Theatres and the Day Surgery Unit to assist in the pursuit of other single use alternatives to enable standardisation and economical solutions. The Medical Devices Management Centre (MDMC) has been involved to support this process and assist with product evaluations.

The national information technology (IT) training package for decontamination is still available in the Trust and is supported by a seconded team leader from SDU. Pressure of workload in some areas is still causing a delay in completion of training. Training files are being compiled showing competencies of all those staff undertaking any decontamination and is the responsibility of the line manager.

Bar codes for patient wrist bands have been implemented, although problems with the interface between the proposed tracking system and patient electronic records has caused a delay. The system has been consolidated in the SDU, and when the electronic patient record issue is resolved, it is planned to be rolled out across the Trust commencing in quarter 3 of 2010/11.

The Bedpan Washer Replacement & dirty utility room upgrade programme has continued during quarters 1 and 2 of 2010/11. Bedpan washer facility options are still to be finalised in the Radiology Department, and the future for the remaining macerators in the Trust will be considered by the group overseeing this project, along with the use of dishwashers within clinical areas.

2. **Ensure all endoscopy decontamination takes place in fully compliant washers and is in line with MDS DB2002 (05).**

   The project flexi-scope reprocessing into SDU with the contractor Lancer UK Limited is completed. The old facilities in the Endoscopy Department have been decommissioned, and SDU has processed scopes from all three Endoscopy Department Treatment Rooms, the Cardiac Suite and the DSU.

   The flexi-scope reprocessing has now been audited and registered to the SDU accreditation system and will be audited bi-annually by an external notified body. All correct testing procedures are undertaken and relevant results will now be presented to the IPCC.

   The 2 flexi endoscope washers in Ear Nose and Throat (ENT) Outpatient Department (OPD) continue not to be used after prolonged delays due to the reverse osmosis (RO) water quality and testing issues. The Estates and Technical Services (ETS) and Procurement Department have met with the company, and are working with the company to remove the equipment and reinstate costs. Staff have received training for the use of new flexi-nasoendoscopes which will be processed in SDU, the issue of labour processing costs remain unresolved.

3. **Maintain a fully compliant SDU until at least 2017.**

   The SDU continues to maintain its compliance and accreditation to the latest European Standards in Sterile Services. The next external audit is due in January 2011.

4. **Marketing the SDU services to increase the external customer base.**

   This continues to be an ongoing piece of work with any opportunities taken to expand our customer network and income channels. The following has been achieved:
   - The new Ministry of Defence (MOD) three year contact continues to progress well.
   - The tray service for South Wiltshire Podiatry Service continues.
   - Contracts are in place with Wiltshire Community Health Services and some GP practices to decontaminate their minor operations instrumentation.
   - Further external work has been obtained by SDU to provide a service to the Royal Navy in Portsmouth.
The Decontamination Group continues its work to ensure all these objectives are met. A copy of the Decontamination action plan against strategy is available from the Chair of the Decontamination Group.

9. Cleaning Services

**Patient Environment Action Team (PEAT) – Programme of In-House PEAT audits**
During April – September/October 2010, in-house PEAT teams completed 10 audits, during which 33 visits were made to wards/Units and public areas. PEAT audits remain well supported by Foundation Trust Governors and the IP&CT. Individual ward/departmental PEAT reports are sent to Ward Leaders immediately following an inspection and presented each month at the Matrons Monitoring Meeting.

**Terminal Cleaning**
Additional cleaning undertaken to manage infection is carried out by a rapid response team (Monday to Friday) reducing but not removing, the requirement to use cleaning staff assigned to other duties (i.e. ward cleaning).

### Terminal Cleans

<table>
<thead>
<tr>
<th>Month</th>
<th>2009/10</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>239</td>
<td>218</td>
</tr>
<tr>
<td>May</td>
<td>218</td>
<td>196</td>
</tr>
<tr>
<td>June</td>
<td>256</td>
<td>192</td>
</tr>
<tr>
<td>July</td>
<td>285</td>
<td>164</td>
</tr>
<tr>
<td>August</td>
<td>238</td>
<td>192</td>
</tr>
<tr>
<td>September</td>
<td>194</td>
<td>237</td>
</tr>
<tr>
<td>October</td>
<td>254</td>
<td></td>
</tr>
<tr>
<td>November</td>
<td>272</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>487</td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>395</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>379</td>
<td></td>
</tr>
</tbody>
</table>

The average of 168 terminal cleans per month (2005 baseline) is used by the Housekeeping Department to measure service pressure against. An audit trail for each terminal clean is provided via the Housekeeping Department decontamination certificate. These figures relate to the cleaning of individual bedspaces **not** wards/bays.

**Fan Cleaning**
To further support environmental cleanliness in August (2010), the Housekeeping and ETS teams delivered a cleaning programme for electrical fans within out-patient areas and for in-patient areas during September (2010).

**Matrons Monitoring Meeting**
To support the ongoing programme around hospital cleanliness, Clinical Leaders, Facilities Managers, the Facilities Director and Director of Nursing meet monthly to monitor standards of environmental cleanliness and to receive directorate reports. The group provides an opportunity to ensure effective communication between Clinical Leaders and Facilities Managers and is used to ensure continuous improvement.

**Housekeeping Auditing System (Credits for Cleaning)**
From March 2008 the Housekeeping Department has audited environmental cleanliness using software developed by the Department of Health, using the national specifications of cleanliness (NPSA, 2007) to identify the frequency of audits and risk categories.

In accordance with DoH recommendations:
- Cleanliness scores by risk category, are expressed as a 13 week average
- External validation of the Trusts cleanliness standards was undertaken in December (2009) by Avon & Wilts Mental Health Partnership NHS Trust.

### Cleanliness scores by risk category

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Areas (examples)</th>
<th>NPSA (2010) Target Score</th>
<th>Trust Target Score</th>
<th>Trust Score @ 25/10/10</th>
<th>+/-*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very High Risk</td>
<td>Main Theatres, Radnor, ED, Pembroke Ward/Suite</td>
<td>98%</td>
<td>98%</td>
<td>99%</td>
<td>+1%</td>
</tr>
<tr>
<td>High Risk</td>
<td>Main Entrance, In-Patient wards, SDU, DSU.</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
<td>+1%</td>
</tr>
<tr>
<td>Significant Risk</td>
<td>Wessex rehab, Rheumatology, Spinal Pool, Sight Centre</td>
<td>85%</td>
<td>85%</td>
<td>90%</td>
<td>+5%</td>
</tr>
<tr>
<td>Low Risk</td>
<td>Education Centre, Chapel, Offices.</td>
<td>75%</td>
<td>85%</td>
<td>88%</td>
<td>+3%</td>
</tr>
</tbody>
</table>

*This score is reflective of the Trust target score

### Overall Trust Cleanliness Score

The Trusts cleanliness audit score, as measured against the National Specifications for Cleanliness (NPSA, 2007) for the 13 weeks ending 25th October (2010) is 92%. The overall cleanliness score is calculated by weighting cleaning scores by the occupied square metre.

<table>
<thead>
<tr>
<th></th>
<th>NPSA 2010 Target Score</th>
<th>Trust Target Score</th>
<th>+/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 weeks to 02/09/10</td>
<td>92%</td>
<td>92%</td>
<td>-</td>
</tr>
</tbody>
</table>

### Cleaning Schedules

In accordance with the Health and Social Care Act 2008, in January 2009 revised cleaning schedules were published, and publically displayed from April 2009. To provide assurance Cleaning Task lists were put into place in February 2010, these have been reviewed by a multi disciplinary team and will be presented for approval to the Matrons Monitoring Group during quarter 3 of 2010/11.

### Ward Kitchen Audits

Monthly ward kitchen hygiene audits are undertaken by the Catering Manager and reported monthly to the Matrons Monitoring Meeting. Capital bids for the replacement of damaged kitchen units and ineffective, domestic type, ward refrigeration have been approved, work has commenced and is due for completion by the end of quarter 3 (2010/11).

### 10. Audit

In line with the requirements of the Health and Social Care Act 2008, a programme of infection prevention & control audits is illustrated in the Audit programme (Appendix 7). The programme ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust.
During quarters 1 & 2 of 2010/11, the IP&CT have undertaken Trust wide audits against the following key infection control policies, with the following outcomes:

- **MRSA Prescription, Treatment and Monitoring Pathway – full reaudit completed.**
  - Sustained compliance (82.5%) with the use of the MRSA Pathway, and patients being screened correctly. The challenge remains to improve compliance and ensure that nursing staff commence an MRSA Pathway for every patient meeting the policy criteria, and that the tool is used appropriately to treat and screen patients.

- **Isolation policy – full reaudit completed.**
  - Improved compliance from 60% to 74%. All patients were being isolated appropriately and no patients were found to be in isolation unnecessarily.

- **Bare Below the Elbow (BBE) policy and Uniform and Workwear guidance – reaudit completed.**
  - Achieved 100% compliance for staff in uniform with no sleeve or garment being worn below the elbow.

- **Use of 2% Chlorhexidine Gluconate in 70% alcohol – first audit completed.**
  - Established that these wipes were available in all inpatient clinical areas and this product is consistently used for skin preparation, prior to insertion of a peripheral vascular device.

The IP&CT have facilitated a reaudit of commode cleanliness with an external company representative, and established a monthly audit programme for the safe use of mattresses. The latter work is being led by the MDMC.

**10.1 Changes and Benefit as a Result of Auditing Trust policies**

As a result of the monthly hand hygiene audits, there continues to be a raised awareness of the effects of poor hand hygiene through all staff groups within the Trust. Work to increase compliance with good hand hygiene practices continues and this is led by the directorates, with support from the DIPC and IP&CT.

Following the key infection control policies audits, the following areas for improvement were identified:

- Increase directorate compliance to ensure all appropriate patients have an MRSA Prescription, Treatment and Monitoring Pathway, in accordance with Trust policy
- Increase directorate compliance to ensure all appropriate patients have an Isolation Risk Assessment Tool and score completed, in accordance with Trust policy

Reaudits completed by the IP&CT have confirmed that there has been an increase in compliance with use of both the MRSA Prescription, Treatment and Monitoring Pathway and the Isolation Risk Assessment Tool. The challenge for the directorates has been to sustain the level of improvement and further increase compliance towards the target of 100%.

The Bare Below the Elbow (BBE) policy and Uniform and Workwear guidance audit demonstrated overall adherence to the Trust policy. However, there is a need for directorates to continue monitoring and challenging non-adherence to the policy.

**11. Antibiotic Prescribing**

**Overview**

The Antibiotic Reference Group (ARG) is a sub group of the Drugs and Therapeutics Committee (DTC) which meets monthly and provides a focus for all work linked with antibiotics, advising and promoting good practice and optimal antibiotic prescribing across the Trust. The work of the ARG is aimed at delivering the Government agenda to minimise the development of anti-microbial resistance and to reduce healthcare associated infection as set out in the ‘Winning Ways’ document. Continued support for this work is documented in the 2007 Saving Lives Document: Antimicrobial Prescribing: A Summary of best practice. The Lead Antimicrobial Pharmacist is a member of the IPCWG and reports monthly at the IPWCG and quarterly at the IPCC.
Key work areas for quarters 1 and 2 of 2010/11 have included:

1. Guideline development/review
   This year has seen the development/review of the following guidelines:
   - Vancomycin management guidance (update)
   - Urology guidance (new)
   - Ear, Nose and Throat Treatment guidance (new)
   - Genito-urinary Medicine guidance (new)

2. Antimicrobial ward sessions
   These are organised with each pharmacist, so that competency in practice can be assessed by the Lead Antimicrobial Pharmacist. Training is provided as appropriate, to ensure adherence with the Antibiotic Care Bundle (essential standards) and compliance with Trust antibiotic guidelines in general.

3. Audit
   Regular Antimicrobial Stewardship Audits
   A rolling programme of antibiotic stewardship audit has been introduced. The aim is to audit one ward every fortnightly to provide a snapshot of antimicrobial prescribing practice. The audit takes the form of 5 brief questions focusing on:
   - Restricted antibiotic use
   - Documentation of allergy status, indication and course length
   - Use of antibiotics implicated in C.difficile, e.g. cephalosporins, ciprofloxacin

   Audits are carried out by the Lead Antimicrobial Pharmacist and Consultant Microbiologist/ICD and therefore also allow multidisciplinary review of antimicrobial prescribing with interventions made as necessary.

   The information gathered is converted into a percentage performance score for the ward in question which is fed back to the team within 7 days of the audit; results are also presented at medical and surgical teaching sessions.

   Results have shown that areas for attention are the documentation of the indication for antibiotic prescribing and the specification of a course length/review date. This is being addressed by the feedback at the time of audit and the aforementioned teaching sessions.

   Plans are in place for each ward to be audited every 6 months, thus allowing us to ensure that improvements in these areas are being made.

   Following almost a year of auditing practice in this way the current system has been reviewed and two key changes are:
   1) Inclusion of all microbiologists in the audit process
   2) Revision of the way in which data is used and feedback to staff. The new plan is as follows:
      a. Continue to feedback to staff on ward (usually juniors) at time of audit
      b. Present results in a tabular format at each ARG/IPCWG (to ensure any concerning reductions in quality are noted)
      c. The ICD and Chair of the Drug and Therapeutics Committee will write to all consultants during quarter 3 of 2010/11 and every six months thereafter, with a summary of the trends identified by the audit and advice on how to improve practice.

   Defined daily doses
   A regional audit of antibiotic usage in terms of ‘defined daily doses’, has commenced. This is a recommendation that has been made by the DH and HPA and is necessary to ensure cost effective use of antimicrobials which is clearly of paramount importance in the current economic climate. It is as yet still unclear how data should be utilised to best benefit the trust. This will be raised with members of the ARG and the Drug and Therapeutics committee to canvas opinion and devise a plan regarding how to move forward with this important work stream.
Point prevalence audit
We are awaiting a regional decision on what form of point prevalence study to conduct for 2010/11. A consensus on this should be reached following the regional antibiotic pharmacists meeting at the end of October 2010.

12. Training Activities

It is widely recognised that ongoing education activity in infection control is required in order to improve health care worker compliance with infection prevention and control practices. The IP&CT undertakes a number of induction and educational updates to a wide range of key staff within the Trust. The IP&CT keeps attendance data from these sessions and supports the Trust in its delivery of mandatory education for all staff. Appendix 8 identifies the figures for the IP&C Computer Based Learning (CBL) modules completed via the intranet site for 2010/11.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments and also to study sessions organised by:
- Education Department
- Respiratory Department
- Intensive Care Unit (ICU)
- Facilities Directorate (Housekeeping, on-site contractors)
- Maternity Unit
- Personnel, for work experience students

The IP&CT invite representatives from all departments across the Trust to the Infection Control Link Professional (ICLP) formal meetings. These are held monthly and give the opportunity to discuss infection control matters, in relation to individual areas and Trust wide. Topics covered have included:
- Review of the Infection Control Link Professional role, including the responsibility for providing an infection control induction for new staff members in their areas
- Discussion of the monthly hand hygiene audit results
- Hand hygiene assessments using the UV light box
- Preliminary discussion of the initial findings from the external Trust wide Commode Audit, and the planned commode workshops
- Use of 2% chlorhexidine gluconate in 70% alcohol for skin disinfection and accessing hubs and ports and feedback from the completed audit
- Discussion of hand decontamination for patients and the provision of hand wipes
- Following detergent cleaning, the use of Actichlor solution to disinfect equipment
- Feedback regarding a free on-line learning resource for Royal College of Nursing members
- Presentation by the external company representative from GoJo (Purell Alcohol Gel) about hand washing methodology and hand care post hand washing.
- A review of health promotion issues including tick awareness, rabies, advice for travelling overseas and safety for children/adults when visiting animal petting farms
- Food poisoning and related aspects of food hygiene practices
- Discussion of a Health Protection Agency press release concerning Legionnaires disease and the preventative measures in place within the Trust
- Presentation and discussion of completed audit/reaudit reports
- A workshop surrounding the management of patients with diarrhoea, with scenarios relevant to inpatient and outpatient areas

A study morning was also arranged by the IP&CT for the ICLPs during quarter 2 of 2010/11. The format consisted of seminar sessions and workshops, with access to company representatives for further information of products, currently used within the Trust.
The infection prevention & control CBL programme is accessible for all staff on the MLE via the Trust intranet site. This enables the Trust to ensure non-participants are followed up according to National Health Service Litigation Agency (NHSLA) standards by the relevant line manager.

13. Summary

This bi-annual Report has provided the Trust Board with evidence of improvements in infection prevention & control practices across the Trust, and assurance with regard to registration without conditions with the CQC ‘Standard for cleanliness and infection control’ (Outcome 8).

The Report has detailed the continuing progress against the Action Plan for 2010/11 in significantly reducing and sustaining HCAI rates for the Trust. These achievements include –

- A sustained focus on identified key learning and changes as a result of RCA investigations facilitated by the IP&CT.
- Continued involvement and feedback to staff groups, which has further raised the profile of infection prevention and control.
- Progress with education, training and audit, which has improved compliance for hand hygiene and policy adherence.
- Maintaining a clean and safe environment for our patients.
- Continued provision of cleaning services, decontamination and antimicrobial practices.

Continued implementation of the Infection Prevention and Control Annual Action Plan 2010/11 (Appendix 1), is key to ensuring a reduction in MRSA bacteraemia and C.difficile rates, and to maintain widespread sound practice in the prevention and control of infection.
### Infection Prevention & Control

#### Annual Action Plan 2010/11

<table>
<thead>
<tr>
<th>Domain and Key Actions</th>
<th>Who</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Management, Organisation and the Environment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.1 General duty to protect patients, staff and others from HCAIs</strong></td>
<td>Chief Executive</td>
<td>Continuous</td>
</tr>
<tr>
<td><strong>1.2 Duty to have in place appropriate management systems for Infection Prevention and Control</strong></td>
<td>Chief Executive, DIPC</td>
<td>Continuous</td>
</tr>
<tr>
<td>Continue to promote the role of the DIPC in the prevention &amp; control of HCAI.</td>
<td>DIPC</td>
<td>In place</td>
</tr>
<tr>
<td>DIPC as Chair of the Infection Prevention and Control Committee.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead infection prevention &amp; control in the Trust and provide a six monthly public report to the Trust Board.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor and report uptake of mandatory training programme.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue contribution to implementation of the Capacity Management policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure a programme of audit (incorporating Saving Lives) is in place to systematically monitor &amp; review policies, guidelines and practice relating to infection prevention &amp; control.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review staffing levels via Workforce Planning.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete bedpan washer replacement and dirty utility upgrade programme.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks</strong></td>
<td>Chief Executive</td>
<td>Continuous</td>
</tr>
<tr>
<td>Maintain the role of DIPC as an integral member of the Trust’s Clinical Governance &amp; risk structures (including Assurance Framework).</td>
<td>DIPC/IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Active Surveillance &amp; Investigation:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue implementation of mandatory Surveillance Plan for HCAI &amp; produce quarterly reports for ICC.</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Review implementation of ‘alert organism’ &amp; ‘alert condition’ system.</td>
<td>JH/SC</td>
<td>Continuous</td>
</tr>
<tr>
<td>Use comparative data on HCAI &amp; microbial resistance to reduce incidence &amp; prevalence.</td>
<td>JH</td>
<td>In place</td>
</tr>
<tr>
<td>Promote liaison with the HPA for effective management &amp; control of HCAI.</td>
<td>JH/IP&amp;CT</td>
<td>Continuous</td>
</tr>
<tr>
<td>Domain and Key Actions</td>
<td>Who</td>
<td>When</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>1.4 Duty to provide and maintain a clean and appropriate environment for health care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit. Review schedule of cleaning frequency and standards of cleanliness, making them publicly available. Ensure adequate provision of suitable hand washing facilities, hand rubs and continued implementation of ‘CleanYourHands’ Campaign. Continue IP&amp;C involvement in overseeing all plans for construction &amp; renovation. Ensure effective arrangements are in place for appropriate decontamination of instruments and other equipment. Ensure the supply and provision of linen and laundry adhere to health service guidance. Ensure adherence to the uniform and BBE policies and workwear guidance.</td>
<td>DIPC/RP/IR/SS</td>
<td>Monthly</td>
</tr>
<tr>
<td>DIPC/RP/IR/SS/ Matrons IP&amp;CT GA DIPC/PW GP DIPC/DSNs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.5 Duty to provide information on HCAIs to patients and the public</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure publication of DIPC report via the Trust website. Review Capacity Management policy &amp; documentation to ensure communication re an individual’s risk, nature and treatment of HCAI is explicit. Include obligations under the Code to appropriate policy documents.</td>
<td>DIPC</td>
<td>6 monthly</td>
</tr>
<tr>
<td>DIPC DIPC DIPC</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td><strong>1.6 Duty to provide information when a patient moves from one health care body to another</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.7 Duty to ensure co-operation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.8. Duty to provide adequate isolation facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue implementation of the Isolation policy.</td>
<td>DSNs/IP&amp;CT</td>
<td>Ongoing</td>
</tr>
<tr>
<td><strong>1.9. Duty to ensure adequate laboratory support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation.</td>
<td>SC/JH/MS</td>
<td>Continuous</td>
</tr>
</tbody>
</table>
### Domain and Key Actions

**1.10 Duties to adhere to policies and protocols applicable to infection prevention and control**

<table>
<thead>
<tr>
<th>Core policies are:</th>
<th>Who</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard infection control precautions</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Aseptic technique</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Major outbreaks of communicable infection (Outbreak policy)</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Isolation of patients</td>
<td>JH</td>
<td>In place</td>
</tr>
<tr>
<td>Safe handling and disposal of sharps</td>
<td>GL</td>
<td>In place</td>
</tr>
<tr>
<td>Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Management of occupational exposure to BBVs and post exposure prophylaxis.</td>
<td>TA</td>
<td>In place</td>
</tr>
<tr>
<td>Closure of wards, departments and premises to new admissions (Outbreak &amp; Capacity Management)</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Disinfection policy</td>
<td>SS</td>
<td>In place</td>
</tr>
<tr>
<td>Antimicrobial prescribing</td>
<td>JH/ET</td>
<td>In place</td>
</tr>
<tr>
<td>Mandatory reporting HCAIs to the HPA</td>
<td>JH</td>
<td>In place</td>
</tr>
<tr>
<td>Control of infections with specific alert organisms; MRSA and C. difficile</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Additional policies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transmissible Spongiform Encephalitis (TSE)</td>
<td>JH</td>
<td>In place</td>
</tr>
<tr>
<td>Glycopeptide Resistant Enterococcus (GRE)</td>
<td>JH</td>
<td>Included in Isolation Policy</td>
</tr>
<tr>
<td>Acinetobacter species</td>
<td>JH</td>
<td></td>
</tr>
<tr>
<td>Viral Haemorrhagic fever (VHF)</td>
<td>JH</td>
<td>Policy</td>
</tr>
<tr>
<td>Diarrhoeal infections.</td>
<td>JH</td>
<td>In place</td>
</tr>
<tr>
<td>Surveillance.</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Respiratory viruses (RSV)</td>
<td>SK</td>
<td>In place</td>
</tr>
<tr>
<td>Infection control measures for ventilated patients.</td>
<td>MF</td>
<td>In place</td>
</tr>
<tr>
<td>Tuberculosis.</td>
<td>JH</td>
<td>In place</td>
</tr>
<tr>
<td>Legionella.</td>
<td>GA</td>
<td>In place</td>
</tr>
<tr>
<td>Strategic Cleaning Plan &amp; Operational Policy</td>
<td>IR</td>
<td>In place</td>
</tr>
<tr>
<td>Building &amp; Renovation – Inclusion of Infection Control within Building Change, Development &amp; Maintenance</td>
<td>GA</td>
<td>In place</td>
</tr>
<tr>
<td>Waste Management Policy</td>
<td>GA/PJ</td>
<td>In place</td>
</tr>
<tr>
<td>Linen Management Policy</td>
<td>GP</td>
<td>In place</td>
</tr>
<tr>
<td>Decontamination of medical devices</td>
<td>PW</td>
<td>In place</td>
</tr>
</tbody>
</table>
### Domain and Key Actions

| 1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs. |
|---|---|---|
| Ensure staff can access relevant occupational health services. Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place. Continue the provision of infection prevention and control training at induction. Continue the provision of ongoing infection prevention and control training for existing staff. Continue recording and maintaining training records for all staff. Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and PDPs of all staff. Enhance and monitor the role of the Link Nurses. | Alan Denton | Continuous |
| Tony Andrews | In progress |
| IP&CT | Continuous |
| IP&CT | Continuous |
| IP&CT | Continuous |
| DIPC | In place |
| IP&CT | Continuous |

#### KEY

- **DIPC**: Tracey Nutter, Director of Infection Prevention & Control
- **DDIPC**: Lorna Wilkinson, Deputy Director of Infection Prevention & Control
- **PW**: Peter Wells, Trust Decontamination Lead and SDU Manager
- **JH**: Julian Hemming, Consultant Microbiologist & Infection Control Doctor
- **SC**: Stephen Cotterill, Consultant Microbiologist
- **RP**: Ron Perry, Facilities Director
- **IR**: Ian Robinson, Hotel Services Manager
- **SS**: Sue Stickland, Housekeeping Contracts Manager
- **GA**: George Atkinson, General Manager, Facilities
- **GP**: Gregory Park, Laundry Manager, Facilities
- **DSNs**: Directorate Senior Nurses
- **MS**: Maggie Skyrme, Laboratory Manager, Microbiology
- **GL**: Geoff Lucas, Safety Advisor
- **TA**: Tony Andrews, OHSS Manager
- **ET**: Emma Taylor, Lead Antimicrobial Pharmacist
- **SK**: Shirley Kinsey, Neonatal and Postnatal Services Manager
- **MF**: Maria Ford, Nurse Consultant in Critical Care
- **PJ**: Paul Jackson, Energy and Waste Manager
- **AD**: Alan Denton, Director of Human Resources
Appendix 2

Annual Action Plan Review 2010/11

Please note: The numbering does not depict the order of priority for the Trust, but reflects the numbered duties within the Hygiene Code.

<table>
<thead>
<tr>
<th>Domain and Key Actions</th>
<th>Who</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Management, Organisation and the Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 General duty to protect patients, staff and others from HCAIs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Duty to have in place appropriate management systems for Infection Prevention &amp; Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue to promote the role of the DIPC in the prevention &amp; control of HCAI.</td>
<td>Chief Executive</td>
<td>Continuous</td>
</tr>
<tr>
<td>DIPC as Chair of the Infection Prevention and Control Committee (IPCC).</td>
<td>Chief Executive</td>
<td>In place</td>
</tr>
<tr>
<td>Lead infection prevention &amp; control in the Trust and provide a six monthly public report to the Trust Board.</td>
<td>DIPC</td>
<td>In place</td>
</tr>
<tr>
<td>Monitor and report uptake of mandatory training programme.</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Continue contribution to implementation of the Capacity Management policy.</td>
<td>DIPC</td>
<td>In place</td>
</tr>
<tr>
<td>Ensure a programme of audit (incorporating Saving Lives) is in place to systematically monitor &amp; review policies, guidelines and practice relating to infection prevention &amp; control.</td>
<td>IPCWG/IPCC</td>
<td>Monthly</td>
</tr>
<tr>
<td>Review staffing levels via Workforce Planning.</td>
<td>DDIPC</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Ensure correctness of death certification and classification.</td>
<td>JH/MF</td>
<td>Reviewed</td>
</tr>
<tr>
<td>Complete bedpan washer replacement and dirty utility upgrade programme.</td>
<td>PW/RE/FM</td>
<td>In progress</td>
</tr>
</tbody>
</table>

1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks

Maintain the role of DIPC as an integral member of the Trust’s Clinical Governance & risk structures (including Assurance Framework). | Chief Executive | Continuous |
<p>| Ensure active maintenance of principle risks relating to infection prevention &amp; control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these. | DIPC/IP&amp;CT | In place |</p>
<table>
<thead>
<tr>
<th>Domain and Key Actions</th>
<th>Who</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Active Surveillance &amp; Investigation:</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue implementation of mandatory Surveillance Plan for HCAI &amp; produce quarterly reports for IPCC.</td>
<td>IP&amp;CT, SC/JH, JH, IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Review implementation of ‘alert organism’ &amp; ‘alert condition’ system.</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>Use comparative data on HCAI &amp; microbial resistance to reduce incidence &amp; prevalence.</td>
<td></td>
<td>Continuous</td>
</tr>
<tr>
<td>Promote liaison with the HPA for effective management &amp; control of HCAI.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.4 Duty to provide and maintain a clean and appropriate environment for health care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit.</td>
<td>DIPC/RP/IR/SS, DIPC/RP/IR/SS/Matrons</td>
<td>Monthly</td>
</tr>
<tr>
<td>Review schedule of cleaning frequency and standards of cleanliness, making them publicly available.</td>
<td></td>
<td>Continuous</td>
</tr>
<tr>
<td>Ensure adequate provision of suitable hand washing facilities, hand rubs and continued implementation of ‘CleanYourHands’ Campaign.</td>
<td>IP&amp;CT, IR/PU/IP&amp;CT GA</td>
<td>Continuous</td>
</tr>
<tr>
<td>Implement new gel dispenser design in public areas.</td>
<td>DIPC/PW, DDIPC/GP, DDIPC/DSNs</td>
<td>In place</td>
</tr>
<tr>
<td>Continue IP&amp;C involvement in overseeing all plans for construction &amp; renovation.</td>
<td></td>
<td>Continuous</td>
</tr>
<tr>
<td>Ensure effective arrangements are in place for appropriate decontamination of instruments and other equipment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure the supply and provision of linen and laundry adhere to health service guidance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure adherence to the uniform and BBE policies and work wear guidance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.5 Duty to provide information on HCAIs to patients and the public</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.6 Duty to provide information when a patient moves from one health care body to another</strong></td>
<td>DIPC</td>
<td>6 monthly</td>
</tr>
<tr>
<td><strong>1.7 Duty to ensure co-operation</strong></td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>Domain and Key Actions</td>
<td>Who</td>
<td>Update</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----</td>
<td>--------</td>
</tr>
<tr>
<td><strong>1.8 Duty to provide adequate isolation facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue implementation of the Isolation policy.</td>
<td>IP&amp;CT/DMTs</td>
<td>Continuous</td>
</tr>
<tr>
<td>Introduce en-suite facilities on Redlynch and Farley Wards, and assess impact.</td>
<td>DDIPC</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>1.9 Duty to ensure adequate laboratory support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation.</td>
<td>SC/JH/MS</td>
<td>Continuous</td>
</tr>
<tr>
<td><strong>1.10 Duty to adhere to policies and protocols applicable to infection prevention and control</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core policies are:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard infection control precautions</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Aseptic technique</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Major outbreaks of communicable infection (Outbreak policy)</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Isolation of patients</td>
<td>JH</td>
<td>In place</td>
</tr>
<tr>
<td>Safe handling &amp; disposal of sharps</td>
<td>GL</td>
<td>In place</td>
</tr>
<tr>
<td>Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Management of occupational exposure to BBVs &amp; post exposure prophylaxis</td>
<td>TA</td>
<td>In place</td>
</tr>
<tr>
<td>Closure of wards, departments and premises to new admissions (Outbreak &amp; Capacity Management)</td>
<td>IP&amp;CT/JG</td>
<td>In place</td>
</tr>
<tr>
<td>Disinfection policy</td>
<td>SS</td>
<td>In place</td>
</tr>
<tr>
<td>Antimicrobial prescribing</td>
<td>JH/ET</td>
<td>In place</td>
</tr>
<tr>
<td>Mandatory reporting HCAIs to the HPA</td>
<td>JH</td>
<td>In place</td>
</tr>
<tr>
<td>Control of infections with specific alert organisms; MRSA &amp; Clostridium difficile</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
</tbody>
</table>

*Additional policies:*
- Transmissible Spongiform Encephalitis (TSE)
- Glycopeptid Resistant Enterococcus

JH/PW In place

JH Included in Isolation policy
<table>
<thead>
<tr>
<th>Domain and Key Actions</th>
<th>Who</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acinetobacter species</td>
<td>JH</td>
<td>Included in Isolation policy</td>
</tr>
<tr>
<td>Viral Haemorrhagic Fever</td>
<td>JH</td>
<td>In place</td>
</tr>
<tr>
<td>Diarrhoeal infections</td>
<td>JH</td>
<td>Included in Isolation policy</td>
</tr>
<tr>
<td>Surveillance</td>
<td>IP&amp;CT</td>
<td>In place</td>
</tr>
<tr>
<td>Respiratory viruses (RSV)</td>
<td>SK</td>
<td>In place</td>
</tr>
<tr>
<td>Infection control measures for ventilated patients.</td>
<td>KD/MF</td>
<td>In place</td>
</tr>
<tr>
<td>• Tuberculosis (TB)</td>
<td>JH</td>
<td>In place</td>
</tr>
<tr>
<td>• Legionella</td>
<td>GA</td>
<td>In place</td>
</tr>
<tr>
<td>Strategic Cleaning Plan &amp; Operational Policy</td>
<td>IR</td>
<td>In place</td>
</tr>
<tr>
<td>Building &amp; Renovation – Inclusion of Infection Control within Building Change, Development &amp; Maintenance</td>
<td>GA</td>
<td>In place</td>
</tr>
<tr>
<td>Waste Management Policy</td>
<td>GA/PJ</td>
<td>In place</td>
</tr>
<tr>
<td>Linen Management Policy</td>
<td>GP</td>
<td>In place</td>
</tr>
<tr>
<td>Decontamination of medical devices</td>
<td>PW</td>
<td>In place</td>
</tr>
</tbody>
</table>

**1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs.**

- Ensure staff can access relevant occupational health services.
- Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place.
- Continue the provision of infection prevention and control training at induction.
- Continue the provision of ongoing infection prevention and control training for existing staff.
- Continue recording and maintaining training records for all staff.
- Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and PDP of all staff.
- Enhance and monitor the role of the Link Nurses.
IMPROVING CLEANLINESS AND INFECTION CONTROL

Dear Colleagues

As you are aware, the Prime Minister and Secretary of State recently announced a series of measures aimed at improving hospital cleanliness, including increasing the number of Matrons and giving more powers to nurses. This letter gives more detail.

Increasing the number of Matrons to 5000

We expect to have 5000 Matrons in acute services by May 2008. This will allow hospital Matrons to devote a substantial amount of time to the delivery of a safe and clean environment for patient care. To make sure the additional numbers of Matrons make a difference, Trusts should focus the role of the Matron on

- Providing a clean environment for care
- Ensuring best practice in infection control
- Improving clinical care standards
- Treating patients with dignity and respect


In setting up implementation plans, Trust Directors of Nursing will need to introduce any necessary changes to ensure that all Matrons have personal responsibility for these actions.

We will be collecting the number of Matrons in post through the ESR on a monthly basis, by SHA. We will provide information on current and indicative numbers for each SHA directly to SHA Directors of Nursing and Workforce.

The financial allocation for this development will be reflected in PCT allocations and in the tariff from 2008/9.

From the Chief Nursing Officer and Director General of NHS Finance, Performance and Operations

Professor Christine Beasley CBE RN

Mr David Flory

Richmond House
79 Whitehall
London
SW1A 2NS

PL/CNO/2007/6

For action

- Chief Executives of NHS Trusts and NHS Foundation Trusts
- Chief Executives of Strategic Health Authorities
- Directors of Nursing of NHS Trusts and NHS Foundation Trusts
- Directors of Estates and Facilities of NHS Trusts and NHS Foundation Trusts
- Strategic Health Authorities Directors of Workforce
- Strategic Health Authorities Directors of Performance Management

For information

- Strategic Health Authorities Directors of Nursing
- Strategic Health Authorities Estates and Facilities advisors

Authorised by the Department of Health
Gateway No. 8977
Reporting on cleanliness

Matrons and Clinical Directors are required to report quarterly to Trust Boards on cleanliness and infection control. These reports will focus on compliance with statutory obligations and will increase the ability of senior clinical staff to raise concerns over cleanliness and infection control with Trust Boards directly.

The Code of Practice for the Prevention and Control of Healthcare Associated Infections will be amended to reflect this new requirement. This will mean that the Healthcare Commission (and, in due course, the new regulator who will be able to impose fines, halt new admissions or cancel a provider’s registration entirely) can consider these issues when checking compliance with the standards.

If NHS staff have concerns about cleanliness and infection control, they can report these to the regulator. However, in the first instance they should raise their concerns within their organisation. Reporting to Boards and to the regulator should be seen as an escalation process, rather than as two independent initiatives.

Directors of Nursing should work with Directors of Estates and Facilities to prepare and publicise a local system of escalation for nursing staff.

Enhancing the nursing role in cleaning

At ward level, we expect Sisters and Charge Nurses to take overall responsibility for standards of cleanliness in their own clinical areas. We expect Matrons to be involved in setting initial service quality and standards and in the monitoring of contracts and service level agreements. Trusts will need to ensure staff are empowered to do this and have access to, and understand, the contract’s provisions, and may have to agree changes to the contract. Trusts can already give Matrons the authority to withhold payments from cleaning contractors and, ultimately, the right to recommend termination of the contract.

The Healthcare Commission found that a higher frequency of meetings between nurses, cleaning staff and infection control staff was related to lower rates of both MRSA and C. difficile infection. To embed this more firmly in everyday practice, we will revise the Code of Practice so that the Healthcare Commission (and ultimately the new regulator) can monitor implementation.

Trust Directors of Nursing will need to work with Directors of Estates and Facilities to:

1. Instigate any necessary changes to ensure that all Matrons have personal responsibility and accountability for delivering a safe and clean care environment.
2. Make clear that the nurse in charge of any patient area is directly responsible for ensuring that cleanliness standards are maintained throughout the shift.
3. Involve Directors of Nursing, Matrons and Infection Control Nurses in all aspects of cleaning services, from contract negotiation and service planning, to delivery at ward level.
4. Require cleaning providers (if they have not already done so) to set out how nurses can request additional cleaning, both urgently (e.g. spills or discharge cleaning) and routinely (e.g. where standards are persistently below expectations).

Deep cleaning the NHS

Funding has been identified at SHA level to deliver a major deep clean of all NHS hospital services. This will be commissioned locally and Trust Directors of Nursing will need to work with Directors of Estates and Facilities to agree jointly what is needed and how it will be evaluated. Trust plans should be costed fully and include timescales to ensure delivery before year-end.
Attached at Annex A is broad guidance on what might be included within a deep clean. Deep cleaning is not meant to, nor should replace, the regular and on-going cleaning that Trusts have in place.

As part of this process Directors of Estates and Facilities should assure the Board that cleaning staff are appropriately trained.

Performance monitoring

Performance management of all four action points will be incorporated into the existing reporting mechanisms, through a mixture of self-declaration and audit. Further details will be advised. SHA Directors of Performance Management will need to consider this with their contacts in the Recovery and Support Unit.

For further information, please contact:

Increasing the number of Matrons
Lyn Simpson (performance)
llyn.simpson@dh.gsi.gov.uk

Debbie Mellor (workforce)
Debbie.Mellor@dh.gsi.gov.uk

Giving nurses control over cleaning
Liz Jones
elizabeth.jones@dh.gsi.gov.uk

Reporting hygiene concerns to the Board and the regulator
Kevin Guinness
kevin.guinness@dh.gsi.gov.uk

Deep cleaning the NHS
Liz Jones
elizabeth.jones@dh.gsi.gov.uk

Professor Christine Beasley
Chief Nursing Officer

David Flory
Director General of Finance, Performance and Operations
Annex A

Deep cleaning

The details of the deep clean will be finalised locally. SHA estates and facilities advisors can help PCTs and SHAs to commission deep cleans that meet the needs of the site and deliver tangible outcomes by year-end.

The following list shows some of the ways in which we expect the deep cleaning to be carried out:

<table>
<thead>
<tr>
<th>Dismantling/cleaning beds/bedrails</th>
<th>Curtain changing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaning equipment e.g. commodes</td>
<td>Window washing</td>
</tr>
<tr>
<td>Cleaning ductwork</td>
<td>Cleaning soft furnishings</td>
</tr>
<tr>
<td>Steam cleaning</td>
<td>De-cluttering</td>
</tr>
<tr>
<td>Ultrasonic cleaning</td>
<td>Cleaning cupboards/storage space</td>
</tr>
<tr>
<td>Hydrogen peroxide fogging</td>
<td>Cleaning kitchens/food prep areas</td>
</tr>
<tr>
<td>Restoration of surfaces</td>
<td>Cleaning trolleys/trolley wheels</td>
</tr>
<tr>
<td>Wall-washing</td>
<td>Cleaning entrances/common areas</td>
</tr>
<tr>
<td>High cleaning</td>
<td>Doors and door furniture</td>
</tr>
<tr>
<td>Cleaning behind radiators, fitments</td>
<td>Light fittings</td>
</tr>
<tr>
<td>Floor scrubbing</td>
<td>Telephones/IT equipment</td>
</tr>
</tbody>
</table>

In some instances it may be more appropriate to replace items that cannot be satisfactorily cleaned, or to replace damaged finishes to make subsequent cleaning easier. Some Trusts may wish to use the fund to invest in equipment in this context, in addition to the cleaning of existing equipment where it need not be replaced.

The money can be spent in any hospital setting but priority should be given to areas where an impact on healthcare associated infections or on patient and public confidence can be clearly demonstrated. This is revenue funding which, under normal finance rules, can include non-capitalised equipment purchases.

Deep cleaning is disruptive and time consuming and it would be advisable for public confidence for Trusts to explain that a deep clean is in progress through appropriate signage.

Accessing funding

Proposals will be commissioned locally. They must be signed off by Trust Directors of Nursing and include confirmation that this will be truly additional expenditure and will lead to clear improvements in cleanliness and/or infection control.
### Directorate Hand Hygiene Mean Compliance by month for April to September 2010

<table>
<thead>
<tr>
<th>Directorate</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>Overall Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support &amp; Family Services</td>
<td>94.76%</td>
<td>96.67%</td>
<td>92.07%</td>
<td>70.61%</td>
<td>86.67%</td>
<td>84.5%</td>
<td>87.55%</td>
</tr>
<tr>
<td>Medicine</td>
<td>93.79%</td>
<td>91.27%</td>
<td>86.22%</td>
<td>92.82%</td>
<td>96.43%</td>
<td>95.65%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Surgery</td>
<td>69%</td>
<td>93.91%</td>
<td>75%</td>
<td>79.1%</td>
<td>94.49%</td>
<td>96.68%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Musculo-Skeletal</td>
<td>90.48%</td>
<td>93.45%</td>
<td>82.55%</td>
<td>79.81%</td>
<td>94.73%</td>
<td>97.69%</td>
<td>89.79%</td>
</tr>
</tbody>
</table>

**Directorate Mean Monthly Compliance Scores**

Audits undertaken by the ICLPs or Lead Nurses
Any month where an area does not complete an audit, is recorded as a nil return (0%)
## Annual Audit Programme 2010/2011

<table>
<thead>
<tr>
<th>No</th>
<th>Aim</th>
<th>Audit</th>
<th>When By/How</th>
<th>Who</th>
</tr>
</thead>
</table>
| 1. | Active surveillance & investigation. | • Mandatory SSI – Orthopaedics  
• Root Cause Analysis-  
  • Mandatory alert organisms (MRSA & C Diff)  
  • Outbreaks  
  • Targeted others e.g. TB  
• ‘Saving Lives: High Impact Interventions (HII)’ | • Monthly  
• As required | • IP&CT  
• Led by IP&CT including key personnel from affected areas |
|   | Reduction of infection risk from the use of catheters, tubes, cannulae, instruments & other devices | | | |
| 2. | Reduce the reservoirs of infection | • Environmental & equipment cleanliness  
• PEAT | • Annual rolling programme; priorities & timescales agreed with DIPC, using the Clinical Leader’s Audit Toolkit (CLAT)  
• Plus, targeted audits | • IP&CT  
• Clinical Leaders/DSNs assisted by IP&CT |
|   | | | | |
|   | | | | |

---

Appendix 7

33
<table>
<thead>
<tr>
<th>No</th>
<th>Aim</th>
<th>Audit</th>
<th>When By/How</th>
<th>Who</th>
</tr>
</thead>
</table>
| 3. | High standards of hygiene in clinical practice | • Hand hygiene  
• Isolation & PPE | • Both within the annual rolling programme; priorities & timescales agreed with DIPC, using the Clinical Leader’s Audit Toolkit (CLAT)  
• Plus, targeted audits | • Clinical Leaders/DSNs assisted by IP&CT  
• IP&CT |
| 4. | Prudent use of antibiotics | Antibiotic prescribing & usage. | • Action Plan agreed & monitored by the Antibiotic Reference Group (ARG) | • Chief Pharmacist & Anti-microbial Pharmacist |
| 5. | Management & organisation  
Policy, guideline & information development & review programme | Pt info leaflet - Acinetobacter Alerts  
Aseptic technique  
C.difficile  
Pt info leaflet – C.difficile  
Contractors info leaflet – Infection Control  
CJD  
Decontamination  
Pt info leaflet – Diarrhoea  
Pt info leaflet – ESBL  
Glove Usage policy & chart  
Pt info leaflet - Group A Strept  
Staff info leaflet – Hand Hygiene  
Infection Control policy  
Inclusion of Infection Control within Renovation & Construction  
Isolation (including diarrhoeal infections & other alert organisms)  
Hand Hygiene  
Pt info leaflet – Invasive Group A Strept Disease  
Linen policy | Review October 2011  
Review October 2010  
Review April 2012  
Review January 2011  
Review September 2012  
Review March 2012  
Review February 2012  
Review December 2010  
Review August 2011  
Reviewed June 2010  
Reviewed December 2010  
Reviewed June 2010  
Review July 2011  
Review October 2010  
Review September 2011  
Review February 2011  
Review October 2012  
Reviewed July 2010  
Review December 2011 | Deputy DIPC/Senior Nurse  
Peter Wells  
Laundry Manager |
<table>
<thead>
<tr>
<th>No</th>
<th>Aim</th>
<th>Audit</th>
<th>When By/How</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Legionellosis</td>
<td>Reviewed June 2009</td>
<td>Estates Technical Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical Management of MRSA</td>
<td>Under review from May 2010</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pt info leaflet - MRSA</td>
<td>Review November 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pt info leaflet – MRSA Contact Bay</td>
<td>Under review from June 2010</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pt info leaflet – MRSA screening</td>
<td>Review December 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outbreak Management</td>
<td>Review October 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outbreak Management of Norovirus</td>
<td>Review April 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pt info leaflet – Norovirus</td>
<td>Review July 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pt info leaflet – ‘Now That I am in Isolation’</td>
<td>Reviewed August 2010</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pt &amp; visitor info leaflet – Information and Advice to Patients</td>
<td>Review February 2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pt info leaflet – Peripheral IV cannula (drips)</td>
<td>Review October 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prevention of Occupational Exposure to BBVs</td>
<td>Under review from July 2010</td>
<td>Shirley Kinsey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respiratory Syncytial Virus (RSV)</td>
<td>Review August 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Standard precautions</td>
<td>Review September 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surveillance</td>
<td>Review February 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tuberculosis</td>
<td>Review December 2011</td>
<td>Julian Hemming</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Viral Haemorrhagic Fever</td>
<td>Review July 2013</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 9

Hand Hygiene Assessments

Number of staff

April  | May  | June | July | August | September

Bank Nurses | Chief Executive | Clinical Support & Family Services | Consultants/Doctors | Contractors/Other | Corporate | Facilities | Finance & Procurement | Human Resources | Medicine | Musculo-Skeletal | Nursing | Musculo-Skeletal | Other | Students/Work Experience | Surgery
FREQUENTLY ASKED QUESTIONS

_Clostridium difficile_

Q. What is _Clostridium difficile_?
_C. difficile_ is a spore forming bacterium which is present as one of the 'normal' bacteria in the gut of up to 3% of healthy adults. It is much more common in babies - up to two thirds of infants may have _C. difficile_ in the gut, where it rarely causes problems. People over the age of 65 years are more susceptible to contracting infection.

Q. How do you catch it?
_C. difficile_ can cause illness when certain antibiotics disturb the balance of 'normal' bacteria in the gut. Its effects can range from nothing in some cases to diarrhoea of varying severity, which may resolve once antibiotic treatment is stopped, through to severe inflammation of the bowel which can sometimes be life threatening.

It is possible for the infection to spread from person to person because those suffering from _C. difficile_ -associated disease shed spores in their faeces. Spores can survive for a very long time in the environment and can be transported on the hands of health care personnel who have direct contact with infected patients or with environmental surfaces (floors, bedpans, toilets etc.) contaminated with _C. difficile._

Q. What are the symptoms of _C. difficile_ infection?
The effects of _C. difficile_ can vary from nothing to diarrhoea of varying severity and much more unusually to severe inflammation of the bowel.

Other symptoms can include fever, loss of appetite, nausea and abdominal pain or tenderness.

Q. How do doctors diagnose _C. difficile_ infection?
It is difficult to diagnose _C. difficile_ infection on the basis of its symptoms alone; therefore the infection is normally diagnosed by carrying out laboratory testing which shows the presence of the _C. difficile_ toxins in the patient's faecal sample.

Q. Who does it affect? Are some people more at risk?
The elderly are most at risk, over 80% of cases are reported in the over 65-age group. Immuno-compromised patients are also at risk. Children under the age of 2 years are not usually affected. Repeated enemas and/or gut surgery increase a person's risk of developing the disease. _C. difficile_ infection occurs when the normal gut flora is altered, allowing _C. difficile_ to flourish and produce a toxin that causes watery diarrhoea. Antibiotics may also alter the normal gut flora and increase the risk of developing _C. difficile_ diarrhoea.

Q. How can it be treated?
_C. difficile_ can be treated with specific antibiotics. There is a risk of relapse in 20-30% of patients and other treatments may be tried, including pro-biotic (good bacteria) treatments, with the aim of re-establishing the balance of flora in the gut. Most cases of _C. difficile_ diarrhoea make a full recovery. However, elderly patients with other underlying conditions may have a more severe course. Occasionally, infection in these circumstances may be life threatening.

Q. What should I do to prevent the spread of _C. difficile_ to others?
If you are infected you can spread the disease to others. However, only people that are hospitalised or on antibiotics are likely to become ill. In order to reduce the chance of spreading the infection to others: it is advisable to wash hands with soap and water, especially after using the restroom and before eating; keeping surfaces in bathrooms, kitchens and other areas clean and cleaning these on a regular basis with household detergent/disinfectants.
Q. How can hospitals prevent the spread of *C. difficile*?
Unfortunately patients with diarrhoea, especially if severe or accompanied by incontinence, may unintentionally spread the infection to other patients, which may lead to outbreaks of *C. difficile* in hospitals. In addition, the ability of this bacterium to form spores enables it to survive for long periods in the environment (e.g. on floors and around toilets) and disseminate in the air e.g. during bed making. Staff should wear disposable gloves and aprons when caring for infected patients and affected patients may be segregated from others. Rigorous cleaning with warm water and detergent is probably the most effective means of removing spores from the contaminated environment, whilst staff should observe good hand washing practice. Alcohol gels should be used routinely by healthcare staff between treating patients, but only if their hands are not visibly soiled. When hands are visibly soiled, they must always be washed with soap and water first. In an outbreak situation, the Infection Control Team may introduce special measures for staff, patients and visitors to follow.

Q. I have heard that some patients are at increased risk for *Clostridium difficile*-associated disease. Is that true?
That is true – the risk for disease increases in patients with the following:
- antibiotic exposure
- gastrointestinal surgery/manipulation
- long length of stay in healthcare settings
- a serious underlying illness
- immuno-compromising conditions
- advanced age

Q. Has a new type of *C. difficile* infection been detected recently?
The HPA has initiated a sampling scheme to detect new types of *C. difficile* infection. A new type of *C. difficile* closely related to one previously found in North America has recently been detected in the UK, including at Stoke Mandeville Hospital.

Q. How common is this strain in the UK?
It is not possible to make an assessment of how prevalent this is in the UK because data have not been collected in sufficient quantities to give us a true picture of the current position.

Q. Is this strain more difficult to treat?
This strain of *C. difficile* can be treated with antibiotics, in the same way as other types.

Q. Is this hospital infection caused by *C. difficile* any more difficult to remove from the environment than other hospital infections?
*C. difficile* are types of bacteria that produce resistant spores that are able to persist in the environment longer than other bacteria. Although they will not be killed by alcohol hand gels, they can be removed with soap and water. Staff, patients and visitors need to wash hands with soap and water in addition to using alcohol hand gels. Disinfectants containing bleach need to be used on surfaces and floors to ensure that the spread of infection is controlled.

*Staphylococcus aureus*

Q. What is *Staphylococcus aureus*?
*Staphylococcus aureus* is a bacterium that is commonly found on human skin and mucosa (lining of mouth, nose etc). The bacterium lives completely harmlessly on the skin and in the nose of about one third of normal healthy people. This is called colonisation or carriage. *Staphylococcus aureus* can cause actual infection and disease, particularly if there is an opportunity for the bacteria to enter the body e.g. via a cut or an abrasion.

Q. What illnesses are caused by *Staphylococcus aureus*?
*Staphylococcus aureus* causes abscesses, boils, and it can infect wounds — both accidental wounds such as grazes and deliberate wounds such as those made when inserting an
intravenous drip or during surgery. These are called local infections. It may then spread further into the body and cause serious infections such as bacteraemia (blood poisoning). *Staphylococcus aureus* can also cause food poisoning.

**Q. How is *Staphylococcus aureus* infection treated?**

Infections caused by many antibiotic-sensitive varieties of *Staphylococcus aureus* are usually successfully treated with antibiotics such as some types of penicillin and erythromycin. Some *S. aureus* bacteria are resistant to the antibiotic methicillin, and they are termed methicillin-resistant *Staphylococcus aureus* (MRSA). They tend to be more complicated to treat and require the use of other antibiotics.

**MRSA**

**Q. What is MRSA?**

MRSA stands for methicillin-resistant *Staphylococcus aureus*. They are varieties of *Staphylococcus aureus* that are resistant to methicillin (a type of penicillin) and usually to some of the other antibiotics that are normally used to treat *Staphylococcus aureus* infections.

**Q. Is MRSA treatable?**

It is not generally necessary to treat MRSA colonisation or carriage. MRSA infection is no more dangerous or virulent than infection with other varieties of *Staphylococcus aureus*, but it is more difficult to treat depending on whether it is resistant to any other antibiotics. Some of the antibiotics used to treat MRSA however can on occasion be more difficult to use or may cause side effects.

**Q. Who is at risk of MRSA infection?**

MRSA infections usually occur in hospitals and in particular to vulnerable or debilitated patients, such as patients in intensive care units, and on surgical wards. Some nursing homes have experienced problems with MRSA. MRSA does not normally affect hospital staff or family members (unless they are suffering from a severe skin condition or debilitating disease). In general, healthy people are at a low risk of infection with MRSA.

**Q. What is the prevalence of MRSA in the UK?**

MRSA are one of the most prevalent micro-organisms involved with healthcare-associated infections worldwide. Most patients who are colonised with MRSA do not go on to develop an infection. The surveillance of MRSA in the UK is a mandatory scheme run by the Department of Health and measures the number of blood-stream infections reported by Acute NHS Trusts.

**Q. What is the cause of the rise in MRSA infections in the UK?**

The rise in MRSA infections in the UK is likely to be multi-factorial. The new strains that emerged in the 1990s may be more virulent (i.e. more likely to cause infections) than some of their predecessors, or more easily spread on the hands of healthcare workers, equipment, and perhaps via the environment. There are also a number of factors that aid in the spread of MRSA in hospitals such as: patient transfers within and between hospitals, the increasing number of very ill patients seen in hospital and the difficulty in isolating some patients with MRSA. The increasing complexity of healthcare and medical intervention also add to the risk of acquiring MRSA.

**Q. How is MRSA spread?**

MRSA is most commonly spread via hands, equipment, and sometimes the environment. It is important that healthcare workers and visitors wash their hands before and after visiting a patient. Provided hands are not soiled (when they should be washed with soap and water), rapid acting alcohol and other hand hygiene solutions are now advocated in healthcare: they are easier and faster to use than hand washing. Equipment should also be cleaned after use.
Q. What happens if I get an MRSA infection?
There will be precautions put into place to prevent the spread of the organism from patient to patient. Ways of limiting the spread include hand washing, cleaning equipment after use and keeping the environment clean. The hospital may need to move the patient into a single room, or in with other affected patients, to reduce the risk of spread to another patient.

Q. Can a patient with MRSA have visitors?
Hospital strains of MRSA do not normally cause harm to healthy people, including pregnant women, children and babies. Visitors should ensure they wash their hands before and after visiting the patient.

Q. How do you measure MRSA bacteraemia rates?
Some people carry MRSA most commonly in the nose and occasionally on the skin without it causing harm to themselves or others. This is known as colonisation or carriage. When a person has an MRSA bacteraemia (bloodstream infection) this means that MRSA has gained access to tissues and bloodstream and is multiplying and causing harm. MRSA rates are measured by dividing the number of patients with MRSA isolated from blood specimens in a hospital by the activity level within the hospital which provides a 'rate'. This enables one hospital to gauge itself against other similar hospitals and investigate possible causes for differences.

Q. Is there any value in screening new patients to ensure they are not bringing MRSA into the hospital with them?
Carriage of MRSA should not be a reason for stopping admission to hospitals, nursing or residential homes or for discharge to their home. However sometimes hospitals screen upon admission e.g. for planned elective surgery. This enables treatment e.g. special washes or ointments to be given to reduce or clear MRSA before surgery.

Q. Can MRSA be passed on by cleaning teams?
If equipment and wards are not cleaned properly there is a possibility of a contaminated environment contributing to the spread of infection. However dirty areas of hospitals do not necessarily have high MRSA rates or, clean ones low MRSA rates.

Q. Can it be carried on cutlery, plates, clothing, curtains, sheets, cushions etc?
Good hygiene particularly in the form of simple everyday precautions such as hand washing is an effective method in the prevention of MRSA spread. If cutlery and plates are washed using soap and water (preferably hot) this will remove MRSA. The risk of acquiring MRSA through contact with curtains, sheets and cushions etc is very low.

Q. What decontamination methods can be used on people, wards, clothing etc?
Thorough hand washing and drying between caring for people, and whenever necessary, has been shown to be the single most important measure in reducing cross-infection. Healthcare workers use antiseptic solutions, including alcohol hand rubs. The environment must be kept clean and dry. Whilst in hospital, patients may have to be nursed in a special ward and visitors may be asked to wear gloves and aprons if having direct patient contact. Before going home visitors may be advised to wash their hands.

Community-acquired MRSA

Q. What is community-acquired MRSA?
Community-acquired MRSA infection (C-MRSA) is when an MRSA infection occurs in a previously healthy individual who has no recognised risk factors associated with MRSA - for example, no previous hospitalisation, surgical procedures or prolonged antibiotic treatment. The term community-acquired MRSA may refer to infections in residential homes caused by hospital strains of MRSA.
Q. Is C-MRSA a different infection than Hospital acquired MRSA?
Yes, ‘true’ C-MRSA infections are different from the hospital acquired MRSA, notably C-MRSA is more sensitive to antibiotic treatment than hospital acquired MRSA, and therefore a wider range of antibiotics can be used to treat them.

Q. How common is C-MRSA?
There have been no systematic studies to establish how common C-MRSA infection is in the UK, but S. aureus isolates referred to the HPA's reference laboratory are routinely tested to identify whether they are C-MRSA. Through this surveillance of MRSA isolates, the Health Protection Agency has identified approximately 100 cases over the last three years.

Q. Who is more at risk of contracting C-MRSA?
It is believed that personal contact is the principal risk factor, particularly where the skin is likely to be broken.

Q. How is C-MRSA treated?
Treatment of C-MRSA infection is easier than for hospital acquired MRSA as C-MRSA are more susceptible to antibiotic treatment. C-MRSA is universally sensitive to the antibiotics vancomycin, rifampicin, gentamicin, and linezolid.

Norovirus

Q. What are Noroviruses?
Noroviruses are a group of viruses that are the most common cause of gastroenteritis (stomach bugs) in England and Wales. In the past, Noroviruses have also been called 'winter vomiting viruses', 'small round structured viruses' or 'Norwalk-like viruses'.

Q. How does Norovirus spread?
The virus is easily transmitted from one person to another. It can be transmitted by contact with an infected person; by consuming contaminated food or water or by contact with contaminated surfaces or objects.

Q. What are the symptoms?
The symptoms of Norovirus infection will begin around 12 to 48 hours after becoming infected. The illness is self-limiting and the symptoms will last for 12 to 60 hours. They will start with the sudden onset of nausea followed by projectile vomiting and watery diarrhoea. Some people may have a raised temperature, headaches and aching limbs. Most people make a full recovery within 1-2 days, however some people (usually the very young or elderly) may become very dehydrated and require hospital treatment.

Q. Why does Norovirus often cause outbreaks?
Norovirus often causes outbreaks because it is easily spread from one person to another and the virus is able to survive in the environment for many days. As there are many different strains of Norovirus, and immunity is short-lived, outbreaks tend to affect more than 50% of susceptible people. Outbreaks usually tend to affect people who are in semi-closed environments such as hospitals, nursing homes, schools and on cruise ships.

Q. How can these outbreaks be stopped?
Outbreaks can be difficult to control and long-lasting because Norovirus is easily transmitted from one person to another and the virus can survive in the environment. The most effective way to respond to an outbreak is to clean and disinfect contaminated areas, to institute good hygiene measures including handwashing and to provide advice on food handling. Those who have been infected should be isolated for a minimum of 48 hours after their symptoms have ceased.
Q. How is Norovirus treated?
There is no specific treatment for Norovirus apart from letting the illness run its course. It is important to drink plenty of fluids to prevent dehydration.

Q. If I’m suffering from Norovirus, how can I prevent others from becoming infected?
Good hygiene is important in preventing others from becoming infected – this includes thorough hand washing before and after contact. Food preparation should also be avoided until 48 hours after the symptoms have subsided.

Q. Who is at risk of getting Norovirus?
There is no one specific group who are at risk of contracting Norovirus – it affects people of all ages. The very young and elderly should take extra care if infected, as dehydration is more common in these age groups.

Outbreaks of Norovirus are reported frequently in semi-closed institutions such as hospitals, schools, residential and nursing homes and hotels. Anywhere that large numbers of people congregate for periods of several days provides an ideal environment for the spread of the disease. Healthcare settings tend to be particularly affected by outbreaks of Norovirus. Outbreaks are shortened when control measures at healthcare settings are implemented quickly, such as closing wards to new admissions as soon as possible at the beginning of the outbreak and implementing strict hygiene measures.

Q. How common is Norovirus?
Norovirus is not a notifiable disease so reporting is done on a voluntary basis. The HPA only receives reports of outbreaks and see anywhere between 130 and 250 outbreaks each year. It is estimated that Norovirus affects between 600,000 and a million people in the UK each year.

Q. Are there any long-term effects?
No, there are no long-term effects from Norovirus.

Q. What can be done to prevent infection?
It is impossible to prevent infection however, taking good hygiene measures (such as frequent handwashing) around someone who is infected is important. Certain measures can be taken in the event of an outbreak, including the implementation of basic hygiene and food handling measures and prompt disinfection of contaminated areas, and the isolation of those infected for a minimum of 48 hours after their symptoms have ceased.