THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

HEALTHCARE ASSOCIATED INFECTIONS

EXECUTIVE SUMMARY

This paper provides the regular monthly update on the Trust's position in relation to Healthcare Associated Infections, highlighting reported levels of MRSA Bacteraemias and cases of C.Difficile against the challenging targets for the current year.

The paper also highlights actions within the Trust since the last report and highlights the introduction of public reporting of MRSA Bacteraemias and C.Difficile on a weekly basis. This raises issues of concern for the Trust and the paper highlights actions taken to mitigate these.

RECOMMENDATION

To (i) note the content of this report (ii) comment accordingly.

Helen Lamont
Nursing & Patient Services Director

Dr. Alistair Gascoigne
Director of Infection Prevention and Control

9th July 2010

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

HEALTHCARE ASSOCIATED INFECTION

1. INTRODUCTION

This briefing provides an update on the current position in relation to healthcare associated infections (HCAI) and related activity within the Trust. Changes regarding national reporting of HCAI information are also highlighted.

2. INFECTION UPDATES

MRSA Bacteraemia

(As previously advised the Trust's MRSA Bacteraemia target for 2010/11 is for no more than 12 post 48 hour cases).

Appendix 1 illustrates performance against trajectory for 2009/2010, and comparison with previous year's performance.

It can be seen that 3 MRSA Bacteraemias were reported within the Trust during May 2010, however 2 of these were identified 'pre 48hrs', and therefore do not 'count against' the Trust. However one of these patients is a longstanding patient of the trust with a recognised history of chronic MRSA colonisation. Two previous cases are the subject of on-going appeals (i) the relapsed infection previously reported to Trust Board which is under discussion with the Queen Elizabeth Hospital in Gateshead, (ii) A case which occurred within 48 hours of admission, but occurred on the third calendar day of admission, and there is some dispute regarding whether this should be allocated to the Trust or not.

Clostridium Difficile

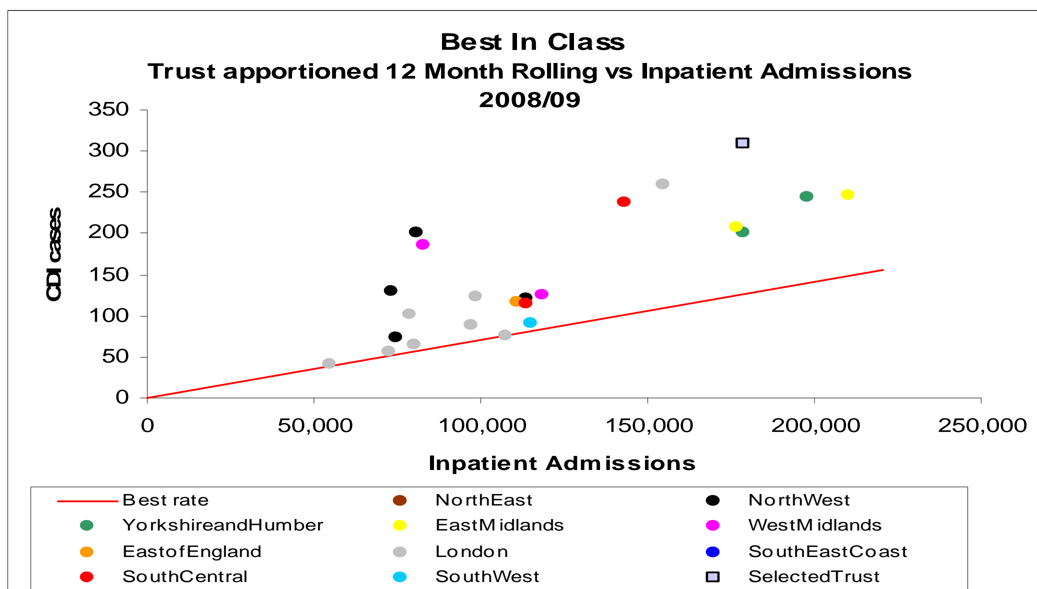
(As previously reported Target for 2010/11 a 30% reduction on the 2007/08 baseline, is for no more than 296 cases).

(Appendix 1) illustrates performance against trajectory, and comparisons with the previous year's performance, and identifies 13 cases in May against the monthly external target of 24 cases per month.

Reducing C.difficile rates within this Trust is a high priority for 2010/11 and the previous report described in detail the work which is underway within the Trust.

However this has come much more critically into focus with the recently introduced weekly reporting of MRSA and C.Difficile cases in the public arena. The first set of data published during the week commencing 31st May 2010 suggested that the Trust was an 'outlier' and extremely poor performer in this regard. In large part this is due to the way in which the data is reported ie. in terms of absolute numbers and not as a percentage of bed days. However, (Whilst the Trust has achieved the defined targets, it has not made the same degree of progress as others in reducing the incidence in our patient population)

The following scatter graph shows the Trust's position in relation to numbers of admissions, in comparison to other organisations.



When comparisons are made with other similar trusts, in terms of % bed days it can be seen that, although not the best performer, the Trust's position is improved.

Acute trust counts/Rates (per 1,000 bed days) 2 years plus	2008/09	
Royal Liverpool and Broadgreen University Hospitals NHS Trust	1.1	***Worst***
Leeds Teaching Hospitals NHS Trust	1.09	
University Hospitals Bristol NHS Foundation Trust	1.04	
University Hospitals of Birmingham NHS Foundation Trust	1.02	
Cambridge University Hospitals NHS Foundation Trust	0.82	
Southampton University Hospitals NHS Trust	0.7	
King's College Hospital NHS Foundation Trust	0.68	
Imperial College Healthcare NHS trust	0.65	
Barts and the London NHS Trust	0.65	
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	0.64	
University Hospital of South Manchester NHS Foundation Trust	0.58	
Central Manchester University Hospitals NHS Foundation Trust	0.55	
Salford Royal NHS Foundation Trust	0.47	
University Hospitals of Leicester NHS Trust	0.47	
University Hospitals Coventry and Warwickshire NHS Trust	0.42	
Sheffield Teaching Hospitals NHS Foundation Trust	0.42	
Nottingham University Hospitals NHS Trust	0.4	
Chelsea and Westminster Hospital NHS Foundation Trust	0.34	
Guy's and St Thomas' NHS Foundation Trust	0.28	
St George's Healthcare NHS Trust	0.28	
Royal Free Hampstead NHS Trust	0.25	
University College London Hospitals NHS Foundation Trust	0.15	
Oxford Radcliffe Hospitals NHS Trust	0.08	***Best***
23 trusts		
NuTH 14/23		

There has been much additional emphasis on addressing C.Difficile since the last report to Trust Board including.

i) A formal reminder to all Matrons of the need to ensure full application of standards of cleanliness and hand hygiene in their areas of responsibility.

ii) A extraordinary Matrons' Forum was convened on 10th June 2010 at which presentations were made regarding the weekly reporting arrangements, the Trust's C.Difficile action plan, and revised arrangements for C.Difficile testing which have been introduced with immediate effect, to reduce the number of 'false positive' tests recorded in the organisation.

   Matrons are required to cascade this information to staff throughout their clinical areas in order to ensure best practice is enforced.

iii) Definitive written advice has been produced to confirm when stool specimens should be tested for C.Difficile. These will be enshrined in Policy but will also be widely displayed within all clinical areas.

iv) The issue is also being addressed at Clinical Policy Group on 15th June 2010.

Weekly Publication of HCAI Data

As referred to above, on 2nd June 2010 a letter was sent, by Andrew Lansley, Secretary of State for Health, to Chairs of all Trusts and to Monitor. This letter outlined the Government's intervention to open up data to the public as part of their drive to improve the information available to patients and the public about healthcare providers.

As part of the NHS contribution to this the Department of Health is arranging for weekly data on MRSA bacteraemias, and Clostridium Difficile, for each hospital site, to be available on data.gov.uk Initially monthly data will be used but they will move to more timely, weekly reporting from 5th July 2010.

This publication will be made alongside the official statistics on the HPA website, and requires the Trust to ensure that relevant figures are uploaded on a weekly basis. In order to further increase access to data the Department of Health are also looking to explore other options, for example through publication on NHS Choices. They are also considering the potential, over a longer period, to include the non acute setting and to include surveillance on other Healthcare Associated Infections.

Ongoing Actions within the Trust

In addition to the routine Hand Hygiene Audits, and Matrons' cleanliness checks the following initiatives/issues have been addressed since the last report.

(i) Estates Issues

a. RVI Leazes Wing West

Following the replacement of all main valves within the Leazes Wing West, and the main circulating pump an increase in flow temperatures on the domestic hot water have been achieved. Where counts of legionella have been recorded immediate action has taken place of changing of shower heads and hoses, increased daily flushing of hot and cold water outlets, extensive temperature checking and re-testing of areas.

In May 2010 a specialist in chlorine dioxide completed an audit of all chlorine dioxide plants in the RVI. The subsequent report identified a shortfall in chlorine dioxide in the water systems. The company responsible for providing the service of chlorine dioxide will now be contacted to carry out a thorough review of their installation.

Estates will also be carrying out a re-commissioning exercise of all the water systems in the RVI Leazes Wing to ensure the correct water flow rates are being achieved.

b. Great North Children's Hospital

Estates have worked closely with Senior Consultants and reported on a weekly basis on all findings. Where counts of legionella have been identified immediate action has been taken of flushing with additional resources, weekly chlorination of shower heads and tabulation of all results with trend analysis.

Estates have pursued this issue with HS(N) Limited using the Project Agreement and they have now agreed to re-design the GNCH domestic hot water system and separate this from the New Victoria Wing system. The design options are being discussed and a decision will be made by Friday 11th June on the preferred option. HS(N) have stated that all remedial work will be completed by September 2010.

(ii) Matching Mitchigan

The ICUs are continuing to implement the NPSA Matching Michigan interventions to improve rates of CVC-BSI. This Quality Improvement project involves three key interventions:

(a) Data collection and monitoring of infection rates: All units collect and submit data monthly (see table below). From July 2010 the NPSA national reporting tool will provide reporting back to units on rates of infections benchmarked against all English ICUs and compared to ICUs of the specialty.

(b) Technical Interventions: implementing evidence based care for every patient with a central venous catheter in ICU. This includes a CVC trolley with contents inventory, and an observer/inserter CVC checklist. The Trust CVC clinical guideline is under review and will set out the recommended practices in line with Matching Michigan. Units have been working towards implementing a number of these recommendations.

(c) Non-technical Interventions: implementing ways to improve safety culture in ICU. This includes the completion of a baseline culture survey, implementing daily goals for effective communication, investigating and learning from any CVC infection, executive:clinician partnership and staff education on the science of safety. Units have been working towards implementing a number of these recommendations.

A joint North of England Critical Care Network and NPSA sharing event was held on 10th June 2010. This event shared a number of case studies where Matching Michigan had been implemented effectively and provided an update on national progress and data. Good representation of ICU staff was achieved.

Unit	May-Jul 3/12	Aug-Sept 2/12	5 months Baseline	Quarter Oct- Dec 2009	Jan	Feb	Mar	Quarter Jan-Mar	6 months Post interventions	April
RVI Wd 38cc	0	0	0	0	15	0	0	5.7	2.6	7.4
NGH ITU	2.9	0	2.2	0	0	0	0	0	0	0
FH ICCU	4.1	1.8	3.3	1.2	3.2	3.3	0	2.3	1.7	0
FH Wd 26	9.9	7.6	8.9	4.7	3.2	0	0	1.1	2.8	0
Trust Adult Critical Care	5	3.7	4.5	1.9	5.5	1.2	0	2.3	2.1	1.2
RVI PICU	8.7	0	7	6.5	0	0	0	0	3.4	
NGH PICU	7.2	0	4.7	0	0	0	0	0	0	0
FH PICU	3.7	8.3	5.5	1.8	0	10.3	9.8	6.6	4.2	6.2
Trust Paediatric Critical Care	5.7	5.3	5.6	2.2	0.0	7.2	6.8	4.2	3.2	

(iii) WARD ACCREDITATION SCHEME

The monthly completion of this scheme continues and a full copy of the May report is attached at *Appendix 2*. Ongoing assessment and accreditation of wards continues, with a further 1 ward having achieved the required standard. This brings the total number of accredited wards across the Trust to 24.

It will be noted that there has been an increase in the number of 'red scores' in this month's report. However it is stressed this is as a consequence of a revision to the scoring system, to achieve consistency across all the audit initiatives. In effect this has 'raised the bar' in terms of targets to be achieved; it is not as a consequence of falling standards.

The following chart indicates the previous thresholds, and the inconsistencies these produced and the final column shows the new and consistent thresholds which are applied.

	Quarterly Inspection	Ward Accreditation	Hand Hygiene Opportunity	Hand Hygiene Technique	Matrons Weekly Checks	Saving Lives Results	Agreed Thresholds to be applied from April 2010
RED	< 85%	< 80%	< 90%	< 90%	>95%	Not previously traffic lighted	<90%
AMBER	85% to 95%	88% to 99%	90% to 94%	90% to 94%			90-97%
GREEN	> 95%	100%	> 95%	> 95%			>98%

(iv) Quarterly Cleanliness Audit

The first of this year's quarterly Trust wide cleanliness audits was undertaken during May highlighting much good practice and also opportunities for improvement. The Heads of Nursing are working actively with Matrons to secure improvements in forthcoming months (summary of results at Appendix 3).

3. SUMMARY

Monthly updates will continue to be provided to Trust Board to demonstrate the Trust's position.

4. RECOMMENDATION

To (i) note the content of this report (ii) comment accordingly.

Helen Lamont
Nursing & Patient Services Director

Dr. Alistair Gascoigne
Director of Infection Prevention and Control
9th July 2010

Accreditation Audit (Infection Control)

Period Covered: May 2010

Section 1: Introduction: The Ward Accreditation Scheme was introduced in April 2008 with the purpose of securing the prevention and control of Healthcare Acquired Infections (HCAIs) and will enable individual Inpatient wards to monitor their own practices as well as Directorates to benchmark themselves against each other. In order to achieve this, on a monthly basis each ward is required to assess themselves using a specifically designed data collection tool. The tool has been devised and amended for all adult and paediatric Inpatient areas. Out Patient and Theatre tools have been piloted in March and are in use from April 2009. It is envisaged that Directorate Managers and Matrons will take responsibility for ensuring weaknesses in compliance are improved upon and maintained.

Aims & Objectives

- To identify good practice and allow the dissemination of good practice throughout the Trust.
- To identify areas of practice not attaining specified standards.
- To ensure targeted action where standards are weak.

Standards

The standards indicated in the tool have been developed from the Department of Health's, 'Saving Lives' tool kit and specific Trust policies. 100% compliance must be achieved in all sections.

Methodology

On a monthly basis, each Sister/Charge Nurse will ensure data is collected using the Accreditation tool most appropriate to their area. The tools are comprised of a maximum of twelve sections based on Environmental, Cleanliness and Clinical Practice evidence based standards.

Where departments do not return a completed questionnaire, the ward automatically scores 0 in each of the sections. Consequently, a nil return from one department can adversely affect the score for the entire Directorate and the overall score for the Trust. Overall Trust data will be presented for Inpatient, Out Patient and Theatre tools.

Scoring

Throughout the tool a traffic light scoring system has been utilised
≥ 98% compliance = Green
97-91% compliance = Amber
≤ 90% compliance = Red

Monitoring Performance
Red Scoring Sections:

If wards and departments score red in one or more sections of the tool, action plans should be developed to address these deficits. The relevant Matron will receive a letter and pro forma to complete from Helen Lamont, Director of Nursing and Patient Services with a specific timeframe for completion and an action plan to be returned to the relevant Head of Nursing who will monitor progress.

Accreditation Process;

Where a ward/department is achieving 100% compliance in all sections and the area is confident in its performance, they are encouraged to apply for accreditation. The Ward Sister/Charge Nurse should apply directly to the Matron who will consult with the Directorate Manager and Clinical Director and agree that an application for accreditation should be made to Helen Lamont, Director of Nursing and Patient Services. A team will then visit your ward/department to validate the award of Accreditation.

Accreditation Reports are presented on the following pages:

Tool	Page Number
Inpatient	2-7
Theatre	8-10
Out Patient	11-13

The audits were undertaken between 12 May and 7th June and represent data for the month of May 2010.

<u>Section 2: Inpatient Accreditation Tool</u>: A total of 86 Inpatient wards completed the Inpatient accreditation tool this month. The following chart depicts the overall compliance with each of the 12 sections of the tool by Directorate.

Throughout all Directorates:

- The number of sections in which the standard was achieved (green rating) = **145/162 (89.5%)**
- The number of sections which achieved an amber rating = **16/162 (9.9%)**
- The number of sections which scored a red rating = **1/162 (0.6%)**

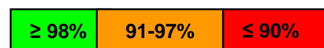
For the Trust

- The number of sections in which the standard was achieved = **12/12 (100%)**
- The number of sections which achieved an amber rating = **0/12 (0%)**
- The number of sections which scored a red rating = **0/12 (0%)**

Table 2.1 - Directorate totals by section for the month of May

Additionally, the chart provides a Directorate score which is derived from the average percentage of the totals achieved in each section

Legend:



	The Environment	Decontamination and Waste management	Infection Control Practice	Source Isolation Practice	Management of Surgical Patients	Aseptic Technique	Urinary catheters	Taking Blood	Peripheral Cannulas	Central Lines	Renal Dialysis Catheters	ventilators	Directorate scores
Cancer Services	100.0%	100.0%	96.0%	100.0%	NA	100.0%	100.0%	100.0%	100.0%	100.0%	NA	NA	**99.6%**
Cardiothoracic Services	97.7%	99.5%	99.5%	100.0%	100.0%	100.0%	99.7%	100.0%	99.5%	100.0%	100.0%	96.0%	**99.3%**
Care of the Elderly	99.0%	99.7%	98.2%	100.0%	NA	97.0%	99.6%	100.0%	99.3%	NA	NA	NA	**99.1%**
Children's Services	99.5%	99.8%	97.7%	98.0%	100.0%	100.0%	98.9%	100.0%	99.5%	99.6%	100.0%	100.0%	99.3%
Dermatology	100.0%	100.0%	100.0%	100.0%	NA	100.0%	95.0%	NA	100.0%	NA	NA	NA	**99.3%**
ENT	100.0%	100.0%	100.0%	NA	NA	100.0%	NA	100.0%	100.0%	NA	NA	NA	**100.0%**
Internal Medicine	99.4%	99.3%	98.0%	100.0%	NA	100.0%	97.6%	100.0%	99.0%	100.0%	NA	NA	**99.3%**
MSU	100.0%	100.0%	99.7%	100.0%	100.0%	94.0%	99.3%	100.0%	99.7%	100.0%	NA	NA	**99.3%**
Neurosciences	100.0%	100.0%	99.5%	100.0%	NA	90.2%	95.8%	100.0%	98.0%	NA	NA	NA	**97.9%**
Ophthalmology	100.0%	100.0%	100.0%	NA	NA	100.0%	100.0%	100.0%	100.0%	NA	100.0%	NA	**100.0%**
Periop & Critical Care: FRH	100.0%	100.0%	98.5%	NA	NA	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**99.9%**
Periop & Critical Care: NGH& RVI	100.0%	100.0%	100.0%	NA	NA	90.0%	100.0%	100.0%	98.5%	100.0%	100.0%	NA	**98.7%**
Plastic Surgery	100.0%	100.0%	97.0%	100.0%	NA	96.5%	100.0%	100.0%	100.0%	NA	NA	NA	**99.2%**
Renal Services	100.0%	100.0%	100.0%	NA	100.0%	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%	NA	**99.7%**
Specialist Haematology	95.0%	97.0%	100.0%	NA	NA	100.0%	100.0%	100.0%	100.0%	100.0%	NA	NA	**99.0%**
Surgical Services	99.5%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	NA	**99.9%**
Urology	100.0%	100.0%	100.0%	100.0%	NA	100.0%	100.0%	100.0%	100.0%	NA	NA	NA	**100.0%**
Women's Services	98.0%	100.0%	97.8%	NA	100.0%	98.4%	100.0%	100.0%	100.0%	NA	NA	100.0%	**99.4%**
TOTALS	**99.3%**	**99.9%**	**99.0%**	**99.8%**	**100.0%**	**98.1%**	**99.0%**	**99.9%**	**99.6%**	**99.96%**	**100.0%**	**99.0%**	**99.5%**

Figure 2.2 – Directorate scores by section for the months April 2010 to March 2011

Figure 2.2 demonstrates an increase in seven sections of the tool when comparing the data from last month. Three sections remained the same. The most notable increase was for the Renal Dialysis Catheters section which saw an increase from 93.8% to 100%.

Sections where scores are achieving less than 98%
All 12 sections achieved the 98% compliance mark this month.

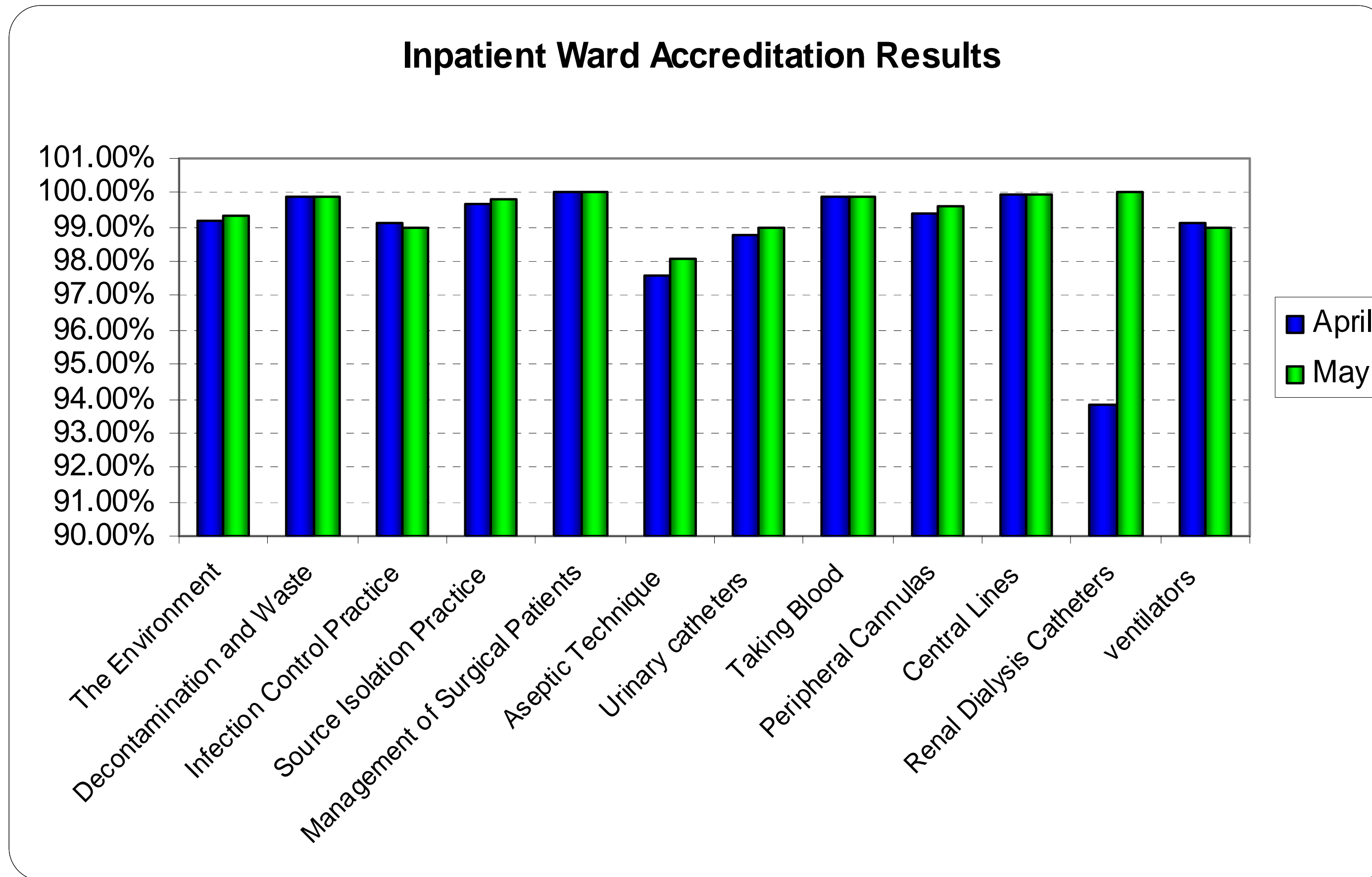


Table 2.3 – Directorate scores by month for April 2010 to March 2011

DIRECTORATE	April	May
Cancer Services	99.60%	99.60%
Cardiothoracic Services	99.30%	99.30%
Care of the Elderly	93.90%	99.10%
Children's Services	99.30%	99.30%
Dermatology	97.30%	99.30%
ENT	100.00%	100.00%
Internal Medicine	99.30%	99.30%
MSU	98.80%	99.30%
Neurosciences	97.90%	97.90%
Ophthalmology	100.00%	100.00%
Periop & Critical Care: FRH	99.70%	99.90%
Periop & Critical Care: NGH & RVI	98.90%	98.70%
Plastic Surgery	98.70%	99.20%
Renal Services	99.50%	99.70%
Specialist Haematology	99.60%	99.00%
Surgical Services	99.80%	99.90%
Urology	99.80%	100.00%
Women's Services	98.50%	99.40%

Table 2.3 shows the Directorate scores for the month of May. This table highlights that there is one directorate that has not made the 98% compliance mark.

Neurosciences: The scores were reduced in this directorate mainly because of the lack of separate treatment rooms (Aseptic Technique). The scores were also affected by not all nursing staff having completed their mandatory infection control training and not all antimicrobial prescriptions including a stop and review date.

One Directorate also scored **less than 90%** in one area:

Periop & Critical Care: NGH& RVI - Aseptic technique: The low score is the result of aseptic technique not being documented in the notes of a patient who has had a dressing changed on an HDU ward – resulting in a score of 80%.

Summary for Inpatient Accreditation Tool

ENT, Ophthalmology and Urology have all achieved 100% compliance in all sections for the month of May.

This month only one directorate, Neurosciences, did not reach the 98% compliance mark (reasons discussed above).

There is also continuing evidence of missing answers and also of reports not being checked before being submitted, running the risk of marks being lost unnecessarily, affecting Directorate and Trust scores. Education and support will continue to all areas from the Patient Services Department to assist Sisters/Charge Nurses and Matrons in accurate completion of the tool, however Directorates are strongly encouraged to take ownership of the process and to check the tools prior to submission, and indeed that tools from all areas have been submitted ahead of the deadline.

<u>Section 3: Theatre Accreditation Tool:</u> A total of 15 theatres completed the theatre accreditation tool this month. All appropriate theatres returned the theatre accreditation tool audit this month. The following chart depicts the overall compliance with each of the 12 sections of the tool by Directorate.

Throughout all Directorates:
- The number of sections in which the standard was achieved (green rating) = **44/56 (78.6%)**
- The number of sections which achieved an amber rating = **10/56 (17.9%)**
- The number of sections which scored a red rating = **2/56 (3.6%)**

For the Trust
- The number of sections in which the standard was achieved (green rating) = **9/12 (75%)**
- The number of sections which achieved an amber rating = **3/12 (25%)**
- The number of sections which scored a red rating = **0/12 (0%)**

Table 3.1 - Directorate totals by section for the month of May

Table 3.1 shows the Directorate totals by each section with the latter section showing an overall average.

	The Environment	Decontamination & Waste Management	Infection Control Practice	Management of patients in the Perioperative Department	Aseptic Technique	Urinary Catheters	Taking Blood	Peripheral Cannulas	Central Lines	Renal Dialysis Catheters	Anaesthetic Machines	Reprocessing and storage of flexible endoscopes	Average
Cardiothoracic Services	97.96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**99.8%**
Dermatology	100.0%	100.0%	100.0%	100.0%	100.0%	NA	NA	100.0%	NA	NA	NA	NA	**100.0%**
Peri Op RVI/NGH	97.0%	99.7%	99.5%	95.5%	100.0%	100.0%	100.0%	99.3%	NA	100.0%	100.0%	98.3%	**99.0%**
Peri Op FH	91.8%	97.6%	89.8%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**98.0%**
Surgery	98.9%	95.7%	96.7%	NA	100.0%	NA	NA	98.4%	NA	NA	NA	100.0%	**98.3%**
Radiology	91.1%	100.0%	96.8%	NA	100.0%	100.0%	100.0%	100.0%	NA	100.0%	83.3%	NA	**96.8%**
Totals	**96.1%**	**98.8%**	**97.1%**	**98.9%**	**99.4%**	**100.0%**	**100.0%**	**99.6%**	**100.0%**	**100.0%**	**95.8%**	**99.6%**	**98.8%**

Figure 3.1 – Theatre scores by section for the months April 2010 to March 2011

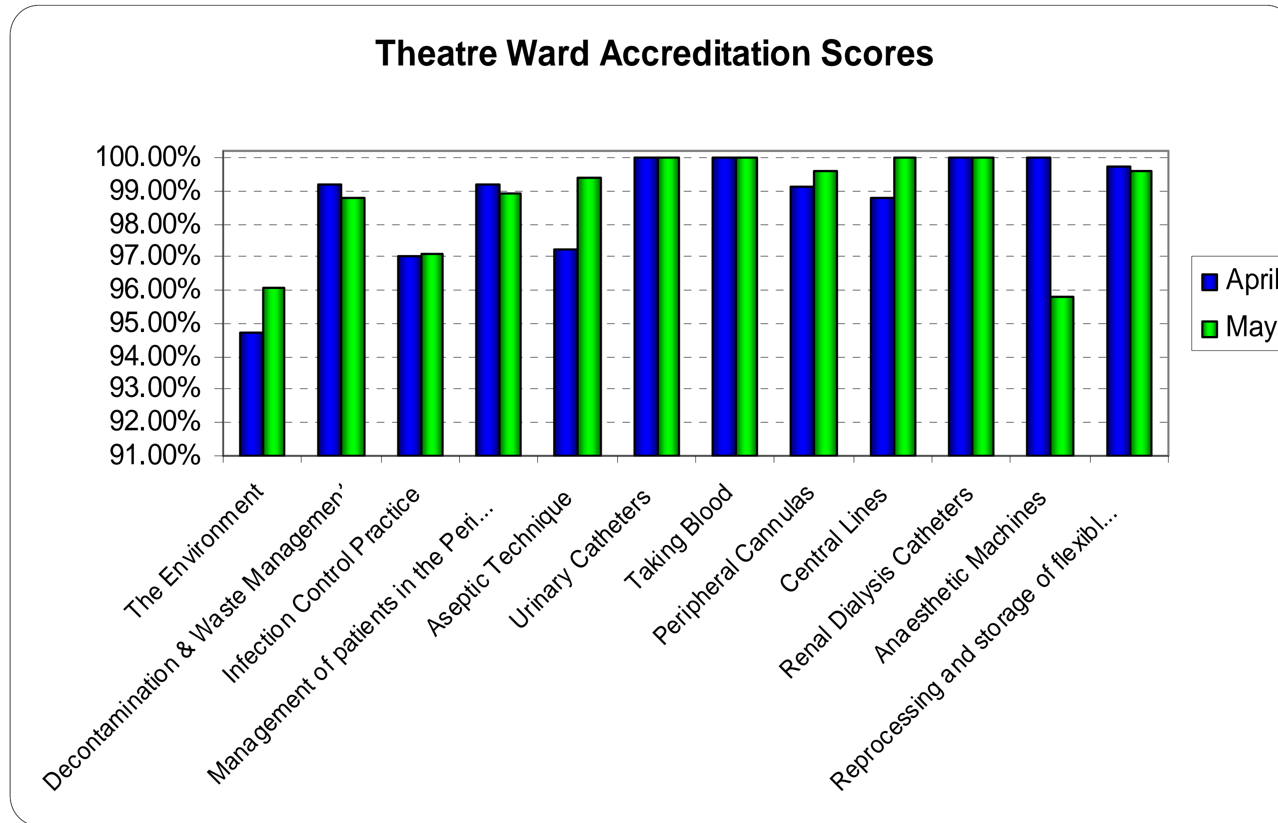


Figure 3.1 shows the Directorate scores for the month of May. The graph demonstrates an increase in 5 sections of the tool when comparing the data from last month. Three sections remained the same. There was a decrease in four sections – the most notable of which was Anaesthetic Machines which saw a decrease from 100% to 95.8%.

Table 3.2 – Directorate scores by month for April 2009 to March 2010

DIRECTORATE	April	May
Cardiothoracic Services	99.80%	99.80%
Dermatology	96.40%	100.00%
Periop RVI & NGH	99.10%	99.00%
Periop FH	98.10%	98.00%
Surgery	99.10%	98.30%
Radiology	97.80%	96.80%
Totals	**98.70%**	**98.80%**

Table 3.2 shows the Directorate scores for the months of April and May. When comparing the May results to the previous month 1 Directorate improved, 1 remained the same and the remaining four decreased. One directorate did not achieve the 98% compliance mark.

Radiology: The scores for the Radiology Department were affected by an anaesthetic log book not being checked and signed and a lack of storage facilities at the Freeman resulting in untidy corridors and storage rooms**.**

Two departments also achieved a score of **less than 90%** in two individual sections:

Peri-op FH – Infection Control Practice: In this case the scores were affected by not all staff members having completed their mandatory infection control training and also some jewellery being worn.

Radiology – Anaesthetic Machines: As mentioned above the score here were affected by an anaesthetic log book not being checked and signed.

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Summary for Theatre Accreditation Tool

All 15 departments returned data for the theatre accreditation this month. All but 1 Directorates achieved the 98% compliance mark and on average an improvement can been seen from the previous month.

<u>Section 4: Outpatient Accreditation Tool:</u> A total of 40 outpatient departments completed the tool this month. All appropriate outpatient departments returned the outpatient accreditation tool audit this month. The following chart depicts the overall compliance with each section of the tool by Directorate.

Throughout all Directorates:

- The number of sections in which the standard was achieved (green rating) = **98/116 (84.5%)**
- The number of sections which achieved an amber rating = **16/116 (13.8%)**
- The number of sections which scored a red rating = **2/116 (1.7%)**

For the Trust

- The number of sections in which the standard was achieved = **6/8 (75%)**
- The number of sections which achieved an amber rating = **2/8(25%)**
- The number of sections which scored a red rating = **0/8 (0%)**

Table 4.1 - Directorate totals by section for the month of May

Table 4.1 shows the Directorate totals by each section with the latter section showing an overall average.

	The Environment	Decontamination & Waste Management	Infection Control Practice	Infection Status	Aseptic Technique	Urinary Catheters	Taking Blood	Peripheral Cannulas	Central Lines	Renal Dialysis Catheters	**Directorate Scores**
Business & Development	100%	100%	100%	NA	100%	NA	100%	100%	NA	NA	**100%**
Cardiothoracic Services	94%	100%	100%	NA	97%	NA	67%	100%	NA	NA	**93%**
Childrens	100.0%	100.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	NA	100.0%	**100%**
Cancer	95.7%	100.0%	97.7%	NA	100.0%	NA	95.4%	100.0%	100.0%	NA	**98%**
Care of the Elderly	100.0%	100.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**100%**
ENT	97.0%	97.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**99%**
Main OP	92.0%	97.0%	98.5%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**98%**
Medicine	99.2%	99.4%	99.4%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**100%**
MSU	100.0%	98.5%	100.0%	NA	100.0%	NA	50.0%	100.0%	NA	NA	**91%**
Neurosciences	100.0%	100.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**100%**
Ophthamology	100.0%	100.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**100%**
Patient Services	100.0%	100.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**100%**
Radiology	95.0%	100.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**99%**
Renal	97.0%	97.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**99%**
Regional Medical Physics	97.5%	96.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**99%**
Specialist Haemotology	99.2%	99.4%	99.4%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**100%**
Surgery	100.0%	100.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**100%**
Womens	97.7%	100.0%	99.0%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**99%**
Urology	93.0%	100.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	NA	NA	**99%**
Totals	**97.9%**	**99.1%**	**99.6%**	**NA**	**99.8%**	**NA**	**94.8%**	**100.0%**	**100.0%**	**100.0%**	**98.6%**

Table 4.2 – Outpatient scores by section for the months from April 2010 to March 2011

SECTION	April	May
The Environment	98.1%	97.9%
Decontamination & Waste Management	99.2%	99.1%
Infection Control Practice	99.7%	99.6%
Infection Status	100.0%	NA
Aseptic Technique	98.0%	99.8%
Urinary Catheters	NA	NA
Taking Blood	99.7%	94.8%
Peripheral Cannulas	99.2%	100.0%
Central Lines	NA	100.0%
Renal Dialysis Catheters	100.0%	100.0%
Totals	**99.0%**	**98.6%**

Sections where scores are achieving less than 98%:
This month 2 areas failed to achieve the 98% compliance mark on average.

The Environment: A total of 6 Directorates failed to reach the 98% compliance mark in the Environment section. Common reasons include untidy corridors and rooms and general lack of storage facilities. Also problems with fridges arise frequently.

Taking Blood: This section was affected by two very low scores in Cardio and MSU. The low scores were a result of needle stick injuries to two members of staff and in both cases this was the only relevant question in this section and so they scored zero.

Table 4.3 –Directorate scores by month for April 2009 to March 2010.

	April	May
Business & Development	100%	100%
Cardiothoracic Services	98%	93%
Children's	100%	100%
Cancer	100%	98%
Care of the Elderly	100%	100%
ENT	99%	99%
Main OP	98%	98%
Medicine	98%	100%
MSU	100%	91%
Neurosciences	100%	100%
Ophthalmology	100%	100%
Patient Services	96%	100%
Radiology	99%	99%
Renal	98%	99%
Regional Medical Physics	99%	99%
Specialist Haematology	100%	100%
Surgery	100%	100%
Women's	100%	99%
Urology	99%	99%
Totals	**99.20%**	**98.60%**

Table 4.3 shows the Directorate scores for the months of April and May.

In May two Directorates failed to achieve the 98% compliance mark:

Cardiothoracic Services: This score was affected by a very low scoring in the 'Taking Blood' section of the tool. The reasons for this have been explained previously.

MSU: This score was affected by a very low scoring in the 'Taking Blood' section of the tool. The reasons for this have been explained previously**.**

Summary for Outpatient Accreditation Tool

All appropriate Outpatient Departments have returned data this month, with 37 departments submitting data. 9 outpatient departments from a range of Directorates have achieved 100% compliance in all sections. All but 2 Directorates, Cardio and MSU, achieved 98% compliance and the reasons for this have been discussed above.

Quarterly Cleanliness Audit Trust Totals

Directorate	Score			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Burns/Plastic/Ophthalmology	92%			
Cardiothoracic	93%			
Children's Services	97%			
Care of Elderly	96%			
Dental Hospital	92%			
Dermatology	90%			
ENT	100%			
Specialist Haematology/NCCC	96%			
MSU	98%			
Medicine	91%			
Neurosciences	96%			
Peri Op/Critical Care Freeman	93%			
Peri Op/Critical Care RVI/NGH	92%			
Renal/Urology	94%			
Surgery	99%			
Women's Services	100%