

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

INFECTION CONTROL: HEALTHCARE ACQUIRED INFECTION

1. EXECUTIVE SUMMARY

This briefing paper provides an update on the current position in relation to healthcare acquired infections with particular reference to MRSA bacteraemias and Clostridium difficile. In particular, attention is drawn to progress with the Healthcare Acquired Infection Prevention and Control Action Plan.

2. RECOMMENDATION

To (i) receive the briefing (ii) and comment accordingly in relation to the effectiveness of the clinical and management actions being taken.

Dr. Alistair Gascoigne
Director of Infection Prevention and Control

Melanie Hornett
Nursing & Patient Services Director

13th November 2008

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

INFECTION CONTROL: HEALTHCARE ACQUIRED INFECTIONS

1. INTRODUCTION

This briefing paper provides an update on the current position in relation to healthcare acquired infections with particular reference to MRSA bacteraemia and Clostridium difficile. In particular, attention is drawn to progress with the Healthcare Acquired Infection Prevention and Control Action Plan.

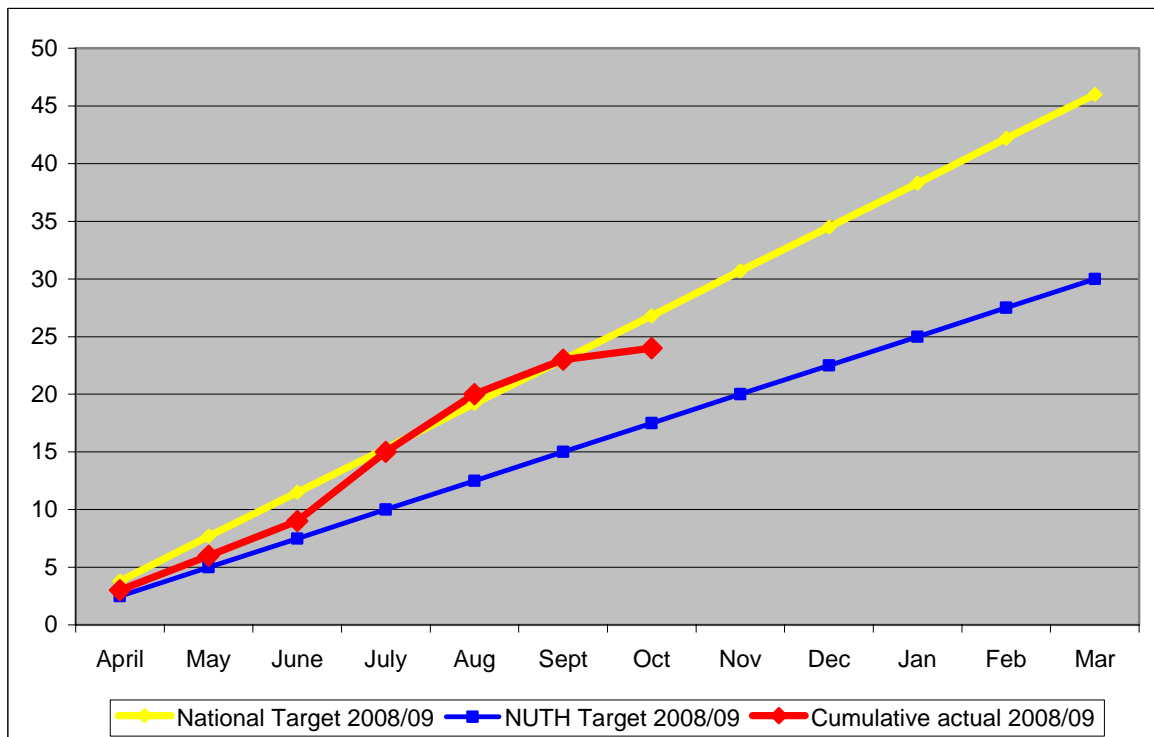
2. MRSA

2.1 MRSA BACTERAEMIA

In October one case was reported in Urology.
In November to date no cases have been reported.

Total cases to date are 24 against the national target year to date of 26.6.

MRSA Bacteraemia – Performance against Trajectory October 2008



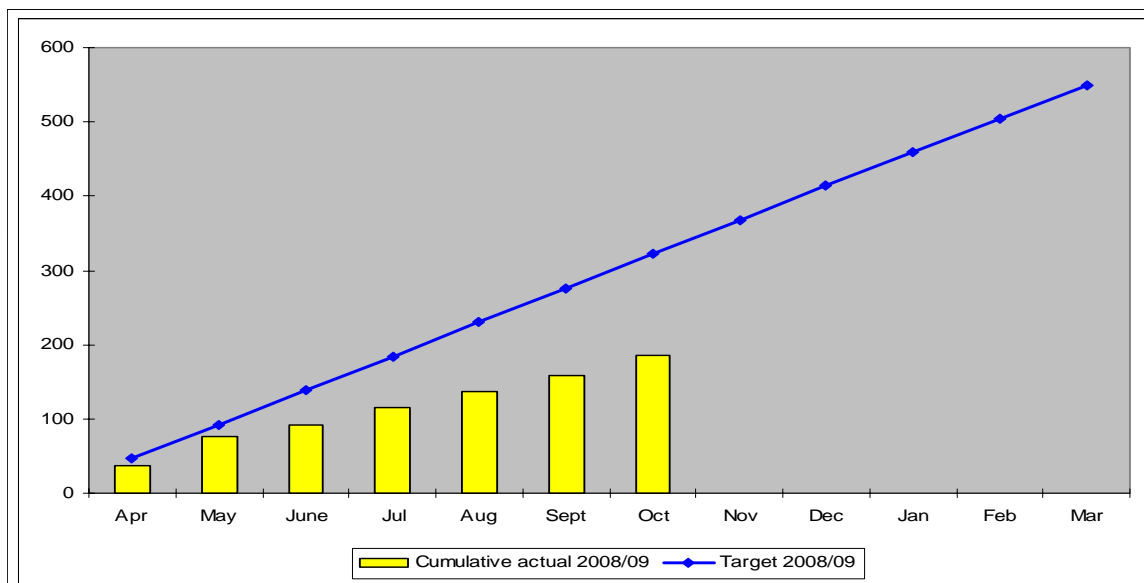
3. CLOSTRIDIUM DIFFICILE

In October 29 hospital acquired post 48 hours cases were reported.

In November to date 8 cases have been reported.

Total cases to end of October are 188 against the target of 550 year to date.

C difficile – Performance against Trajectory October 2008



4. TARGETS FOR 2008 - 09

As previously reported the Trust has agreed targets for C. difficile with the Commissioners but not for MRSA. The Chief Executive has now been informed of the arbitration process in relation to the MRSA bacteraemia targets. Further details will be given at the meeting.

5. OUTBREAK REPORT – October 2008

RVI Ward 44 26.09.08
MRSA isolated 0 bed days lost 10 patients, 0 staff symptomatic

Freeman Ward 13 07.10.08 – 11.10.08
No organism identified 13 bed days lost 9 patients, 2 staff symptomatic

NGH Ward 21 07.10.08 – 17.10.08
No organism identified 29 bed days lost 12 patients, 0 staff symptomatic

Freeman Critical Care 16.10.08 – 22.10.08
Multi-resistant klebsiella isolated 0 bed days lost 1 patient, 0 staff symptomatic

RVI Ward 52 20.10.08
MRSA isolated 17 bed days lost 13 patients, 3 staff symptomatic

6. ESTATES STRATEGY

The Infection Prevention and Control Team work closely with the Estates Department and the Transforming Newcastle Hospitals Team as a matter of routine

to ensure that any infection prevention and control issues are embedded in to work relating to new buildings and refurbishments.

In this regard a particular issue, highlighted by national regulation, is the provision of side rooms to enable isolation of infected patients. Within the Trust approximately 30 % of current beds are side rooms (although not all of these are en-suite). Within the new TNH buildings 50% of beds will be provided as en-suite side rooms.

The Board has supported the proposal that where ever possible current side rooms used for other purposes (such as offices) are reclaimed for clinical use and that, in future, planning for refurbishments and new builds explores the potential to increase en-suite side rooms in relation to clinical need, value for money and space availability. The Head of Estates will over see this process in collaboration with the Director for Infection Prevention and Control.

7. PROGRESS REPORT

The Healthcare Acquired Infection Prevention and Control Plan is attached *Appendix 1* indicating progress with the actions agreed by the Board in June 2008.

Progress with key objectives is noted below.

7.1 Our Target - 30 MRSA Bacteraemia cases maximum

This internal target, set by the Chief Executive, represents our ambition to drastically improve the current situation and equates to no more than 2.5 cases per month. In the year to date we have had 23 cases of MRSA bacteraemia against the year to date internal target of 15. This is very disappointing but the internal target remains as a clear marker of our ambition and the size of the task in hand.

7.2 Five Priorities

- **DH Saving Lives Care Bundle High Impact Interventions**

Phase Two of the campaign has now been completed. This focused on C. difficile, surgical site infections, renal dialysis catheters, and ventilators. The next three months will focus on urinary catheter care, peripheral cannula care and central line care with the practice improvement facilitators working in clinical areas along side staff to promote the translation of policy into practice. Monthly audit of these areas of practice is included in the Ward Accreditation Programme.

- **Ward Accreditation Programme**

Good progress continues to be made across all ward areas and further details are attached in *Appendix 2*

- **Clean Your Hands Campaign**

Progress with compliance in terms of opportunity for hand washing continues to improve and increased focus is now being brought to hand hygiene techniques.

A credit care size reminder of the “5 Moments of Care” will be attached to the payslips of all staff this month.

The public awareness campaign, led by Mr Maurice Harvey, Public Governor, is planned for launch at the beginning of December. Further details will be given at the meeting.

- **Strengthen the Role of Sisters and Charge Nurses**

The education and development programme for Sisters/Charge Nurses and Matrons is now well underway and receiving very positive evaluation. The Nursing and Midwifery Quality Improvement Strategy "I CARE 2" outlines how this work will be taken forward over the next two years.

- **Working with the Community**

A very positive meeting has now taken place with local nursing homes to establish ways of working together to improve patient care. The following work streams have been agreed:-

- Screening and Eradication
- Urinary Catheters
- Individual patient pathways
- Improving Communication

A range of resources (policies, guidelines, e learning packs) have already been shared and arrangements are being made to facilitate provision of a hand hygiene glow box.

- **Invite DH Observations of Care Team**

Following the visit in April by the DH Observation of Care Team the Board has previously agreed that a return visit should be arranged to give an objective view of progress. This visit is planned for the 10th and 11th of December and discussions in progress as to the format and scope.

To assess our own progress and in preparation for this visit a "mock inspection" took place on the 2nd of October. Results were mixed with issues persisting around the documentation of certain aspects of clinical care. A repeat inspection is planned for the end of this month.

8. SUMMARY

The position with C. difficile remains favourable. The position with MRSA bacteraemia remains fragile. Work continues to embed improvements into clinical practice.

9. RECOMMENDATION

To (i) receive the briefing (ii) and comment accordingly in relation to the clinical and management actions being taken.

Dr. Alistair Gascoigne
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13th November 2008

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

**Prevention and control of Healthcare acquired infections
Trust action plan – Updated October 2008**

Issue	Current Position	Aim	Action, Start/Finish Date & Resource implications	Lists of individuals & departments involved in change	Exec Lead Operational Lead	Indication of success	Progress/Comment
Practice	Robust system for follow through of the outcomes of RCA for MRSA bacteraemia at clinical level not in place. System for RCA of C.difficile not in place Standard of RCA varied. Learning from RCA limited.	Robust system for RCA and follow through of outcomes for MRSA bacteraemia and C.difficile in place at clinical level and across Trust Learning is detailed and widely shared	Review NPSA form. July 2008 ✓ Directorates to produce action plan In relation to each RCA with follow up mechanism via CGARD June 2008 ✓ Directorates to share learning in own Clinical Governance meetings June 2008 - ongoing ✓ Ensure all “investigators” have RCA training. September – December 2008 ✓ Quarterly Report on RCA outcome July 2008 – ongoing ✓	CGARD Clinical Directors Matrons Directorate Managers DIPC Medical Director Nursing &PS Director	DIPC Assistant Director Quality	Decreasing levels of infection Evidence of changes in practice post RCA Standardised RCA approach across Trust.	Actions complete but processes ongoing
	Standards of compliance with Aseptic technique Policy for Aseptic technique requires review. Education / Competency assessment not in place. Audit of policy not practice	High level of confidence in Aseptic technique practice and policy.	Review and update policy May 2008 ✓ Develop competency assessment. Develop and implement education programme. May 2008 ✓ Devise and implementation audit. Launch as part of Saving Lives Campaign June 2008 - ongoing ✓ Costs associated with production of educational material	DIPC Medical Director Nursing &PS Director Clinical Directors Matrons Directorate Managers All staff undertaking aseptic procedures	DIPC Senior Nurse Service Improvement	Decreasing levels of infection Improving results from Ward accreditation scheme	Asepsis policy and educational packages in place. Compliance audited through WAS. Audit commenced October 08 to assess compliance with education requirements.
	Seek & Destroy programme is in place for 80% of all admissions.	Seek & Destroy programme is in place for all admissions	Relocation of ICN Team June 2008 ✓ Extension of Lab facilities In progress – Completion August ✓ Start up of extended service September 2008 ✓ Cost = Estates/Staffing	DIPC Nursing &PS Director Nurse Consultant IPC IPC Nursing Team and admin support Estates	DIPC Lab Manager	Screening of all admissions in place by December 2008 Audit of compliance with seek and destroy	All areas with the exception of women having normal deliveries and day cases now screened on admission. Audit of S&D planned in Oct/Nov 08 with CGRD and matrons.

	Varied standards of care for patients with MRSA and C. difficile	Standardised approach to care to ensure patient safety	Develop patient pathways for MRSA positive patients and for patients with C. difficile July – September 2008 ✓	DIPC Nursing & PS Director Nurse Consultant IPC IPC Nursing Team Clinical Directors Matrons Sisters/Charge Nurses Consultants	DIPC Nurse Consultant IPC	Audit of patient care Increasing compliance with Ward Accreditation Scheme	To launch Trust wide with training from ICNs and link nurses after sign off at CPG Oct 08. Review Jan 09.
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Issue	Current Position	Aim	Action, Start/Finish Date & Resource implications	Lists of individuals & departments involved in this change	Exec Lead Operational Lead	Indication of success	Progress
	MRSA bacteraemias in 07/08 relate to the insertion of intravenous devices	No bacteraemias relating to the insertion of intravenous devices	Implementation of Peripheral and central cannulae policies June 2008 ✓ Compliance Audit July + Review ✓ IV to oral switch policy (see below)	All clinical staff involved in the insertion and care of intravenous access devices Patients Medical Director Nursing & PS Director Assistant Director Quality	DIPC Assistant Director Quality	Zero avoidable MRSA bacteraemias associated with insertion of intravenous devices	PIVC and CVC policy/guideline and educational packages in place. Compliance audited through WAS. Audit Nov 08 to assess compliance with education requirements. PIVC packs (without cannulas) will be available by November 08
Practice	Standardised Antibiotics polices in place as appropriate in non specialist areas, guideline compliance / appropriate prescribing not 100% Antibiotic Stop / Review and Indication Policy not fully implemented and compliance not 100% IV-oral switching policy in place Clinical Pharmacy	Increase guideline compliance Antibiotic Stop / Review and Indication Policy fully implemented across the Trust 100% and compliance 100% IV-oral switching policy 100% compliance Increase clinical	Audit of compliance September 2008 + Review ✓ Audit of compliance September 2008 + Review ✓ Audit of compliance September 2008 + Review ✓ Clinical pharmacy strategy	All prescribers All Clinical All Clinical staff Assistant Director of	Clinical Director of Pharmacy Antimicrobial Pharmacist	Decreased numbers of C.difficile cases Decreased number of MRSA bacteraemias Increasing compliance with antibiotics guidelines and or appropriate prescribing Increasing	Audit complete. Compliance varied. Action in progress Staff recruited to 1 st wave of posts.

	staff not available on all wards to support the appropriate use of antibiotics	pharmacy service provision to the wards	approved, First wave of staff to be in post by Autumn 2008 ✓	Pharmacy – Clinical Services All Clinical Pharmacy staff		compliance with IV-oral switching policy Increasing compliance with the Antibiotic Stop / Review and Indication Policy	
	Saving Lives High impact intervention care bundles not fully implemented across the Trust.	Saving Lives High impact intervention care bundles fully implement across the Trust	Programme to achieve full implementation with supporting policy, education, audit and information. Phase One July 2008 - Ongoing Phase Two September 2008 – Ongoing ✓ Costs associated with production of educational material	Nursing &PS Director Senior Nurse Service Improvement Practice Improvement Facilitators Head of Nursing Freeman Assistant Director Quality All clinical staff	DIPC Nursing &PS Director	Decreased number of MRS bacteraemias Decreased numbers of C.difficile cases Audit of compliance	
	Hand Hygiene audit indicates ongoing variation from expected standard.	All areas routinely achieve 95% compliance	Re launch Trust wide Hand Hygiene strategy Including peer audit and performance management mechanism Weekly audit from. May 2008 – Review August 2008 ✓	Trust wide/ all staff Matrons IPC Matron	DIPC Matron IPC	Decreasing rates of infection Achievement of 95% compliance Evidence in national patient survey feedback	Opportunity, technique and bare below elbow audited.
	Varying degrees of compliance with Saving Lives recommendations and expected environmental standards	All wards/departments 100% compliant with infection control Ward Accreditation Scheme	Development and implement the tool across the Trust Implementation April 2008 ✓ 100% compliance by March 2009	Sisters/CN, Matrons, Directorate Managers, Clinical Directors, Head of Nursing, Hotel Services, Estates	DIPC Nursing &PS Director	100% compliance Evidence in national patient survey feedback, PEAT Assessments, and random spot checks	

	<p>No evidence to confirm patients with infective diarrhoea are always isolated in a single room</p>	<p>Patients with infective diarrhoea are always isolated in a single room</p>	<p>Audit use of single rooms Audit movement of patients Review bed management policy. Establish plans for cohort bay/ward of necessary Review Estates Strategy to increase numbers of side rooms with ensuite facilities July - September 2008</p>	<p>IPC Team Patient Services Co-ordinators [PSCs] All wards Ward Nursing Staff Consultants and medical teams</p>	<p>Nursing & PS Director Emergency Care Lead Head of Estates</p>	<p>Decreasing numbers of patients acquiring C. difficile 100% compliance re: single rooms for patients with c. difficile Decreasing numbers of patient transfers Increasing numbers of side rooms year on year</p>	<p>Policy to be signed off at CPG Oct 08. Audit undertaken August 08. Work still in progress.</p>
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Issue	Current Position	Aim	Action, Start/Finish Date & Resource implications	Lists of individuals & departments involved in change	Exec Lead Operational Lead	Indication of success	Progress
People	<p>Scope for improved clinical engagement</p> <p>Lack of support for the DIPC</p> <p>Lack of high profile for IPC Nursing Team and Link Nurses</p>	<p>Improved clinical engagement</p> <p>Improved support for DIPC</p> <p>Highly visible/proactive IPC Nursing Team and Link Nurses across the Trust</p>	<p>Form site teams with IPC Lead Consultant, A Consultant, Head of Nursing and ICN.</p> <p>June 2008✓</p> <p>Clarify role and responsibilities of site team members</p> <p>June 2008✓</p> <p>Review roles/practice of IPC Nursing Team and Link Nurses</p> <p>October 08✓</p>	<p>CE, DIPC, Medical Director. Lead IC Director Nursing & PS Director Nurse Consultant IPC Matron IPC Link Nurses Directorate Management Teams Sisters/Charge Nurses</p>	<p>Medical Director</p> <p>DIPC</p> <p>Nursing & PS Director</p> <p>Matron IPC</p>	<p>Evidence of site based work.</p> <p>Increasing compliance with Ward Accreditation Scheme, Hand Hygiene Audits and Saving Lives Audits</p> <p>Increased clinical time for IPC Nursing Team</p> <p>Positive feedback from wards and departments</p> <p>Delegation of IPC Nursing Team duties to Link Nurses</p>	
	<p>Inadequate communication with GP's/community staff and nursing homes</p> <p>Inadequate communication between hospital wards and departments</p>	<p>Clear pathways of care and communication for all patients with HCAI's</p>	<p>Clarify issues and challenges in partnership with others and develop patient pathways and communication channels including pre admission assessment and post discharge by October 2008</p> <p>Develop and implement a robust system to ensure status of patient is clarified before any transfer/movement Oct 2008</p>	<p>GPs PCT Commissioners Nursing Homes Independent Providers Pharmacy IPC Nursing Team PAA Teams Consultants Ward Nursing Staff.</p>	<p>DIPC</p> <p>Nurse Consultant IPC</p>	<p>Improved communication re MRSA status of patients on admission, transfer and discharge</p>	<p>Work in progress.</p>

	No direct Ward to Board Communication	Feedback from Wards/Directorates to the Board	Implement process via CGARD to enable Matrons and Clinical Directors to provide direct feedback/comments re IPC issues June 2008 X Revised to November 2008	Matrons Clinical Directors Sisters/Charge Nurses Consultants Trust Board Council of Governors	DIPC Assistant Director Quality	Ongoing feedback to Board and Council of Governors from Wards and other clinical areas	IC newsletter, website and email to be developed to facilitate communication.
	Generic mandatory training in place Little opportunity for e learning, role specific training developing advanced knowledge/practice	Menu of education if training available specific to roles and responsibilities by staff group and in a variety of formats	Review of current educational programmes Development of e learning programmes Development of role specific training at basic, intermediate and advanced level by October 2008✓	All Staff including students and volunteers	DIPC Head of Education and Training IPC Nurse	100% compliance with mandatory training	Basic and intermediated training available via e-learning and classroom. Level 3 or advanced available in power point presentation and can be delivered by critical care staff. IPC Simulation training currently being developed to start March 09.

		<p>Ensure IPC of HCAI is standing item on key agendas. July 2008✓</p> <p>Refresh intranet/Internet site September 2008 Establish regular campaigns to highlight HCAI to patients, public and staff via the Infection Control Executive June 2008 onwards✓ Standardise IPC Notice Boards across the Trust by October 2008</p> <p>Leaflets focused on public/ patients eye catching brief and in other language formats by October 2008</p>	<p>RVI Matron IPC</p> <p>Business Director</p> <p>NC IPC</p> <p>Senior Nurse</p> <p>Service Improvement Deputy Director for N +PS</p>	<p>To do a spot check audit Jan 09.</p> <p>IPC on agenda's.</p> <p>Internet site reviewed. No site on intranet to be developed and a refreshed internet site January 09. Review of public and staff notice boards in progress. Translation instructions to be added to key patient leaflets.</p>
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Issue	Current Position	Aim	Action, Start/Finish Date & Resource implications	Lists of individuals & departments involved in change	Exec Lead Operational Lead	Indication of success	Progress
Performance	Compliance with the Code of Hygiene and Standards for Better Health [Healthcare Commission]	Compliance with the code of hygiene	Review current status/ evidence and develop action plans where required July 2008✓ Further review October 2008	DIPC Nurse Consultant IPC Nursing & PS Director Assistant Director Quality Trust wide / all staff Trust Board	DIPC Nurse Consultant IPC	Assurance to Trust Board and Council of Governors of compliance Successful outcome from HCC unannounced visits	
	Infection prevention and Control noted at all Directorate performance reviews but inconsistent in terms of KPIs and follow-up action. Infection prevention and Control noted at all Directorate Clinical Standards and Practice Reviews	Agreed KPI's at every Directorate performance review with documented action plan. Consistent review of HCAs within Trust Clinical Governance Framework	Develop KPI proforma for inclusion in performance reviews by September 2008 Clarify expectations at CSP Reviews re: Directorate review of risk / RCA outcome/ Directorate Plan to reduce HCAs/ evidence of shared learning September 2008✓	Executive Directors Assistant Director Performance Assistant Director Quality Directorate Management Teams	Operations Director Assistant Director Performance Medical Director Assistant Director Quality	Evidence of robust performance management Increased assurance to Trust Board and Council of Governors	Partially achieved. MT asked for date re inclusion of KPIs.
	IPC on corporate risk register but does not have own detailed risk log.	IPC on corporate risk register and has its own detailed register which is reviewed at the IPC Executive meeting and IPCC	Extract IPC risks from Trust Risk Register Quarterly Review at the IPC July 2008✓	IPC Executive meeting Infection Prevention and Control Committee	Medical Director Assistant Director Quality	Evidence of live risk register Evidence of regular review and follow up action	

NB: Completion date = Month end

Melanie Hornett
Nursing & Patient Services Director
Last update 16 October 2008

Ward Accreditation Audit (Infection Control)

Period Covered: September 2008

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 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 in-patient areas. There has been significant progress regarding the development of the Out Patients and Theatre tools which should be piloted within the next couple of months. It is envisaged that Directorate Managers and Matrons will take responsibility for ensuring weaknesses in compliance are improved upon and maintained.

This paper outlines the results of the sixth month's data collection of the ward accreditation programme. The results from each individual in-patient ward been combined to produce an overall Directorate score.

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 Ward Sister/Charge Nurse will ensure data is collected using the appropriate Ward Accreditation tool most appropriate to their area. The tools are comprised into the following sections: Environment, Decontamination & Waste Management, Source Isolation, Management of Surgical Patients, Aseptic technique, Urinary Catheters, Taking Bloods, Peripheral Cannulas, Central Lines, Renal Dialysis Catheters and Ventilators.

Where wards do not return a completed questionnaire, the ward automatically scores 0% in each of the questionnaire sections. Consequently, a nil return from one ward can adversely affect the score for the entire Directorate and the overall score for the Trust.

As a result of staff feedback, amendments were made to the audit tools at the end of the first five data collection periods.

Scoring

Throughout the tool a traffic light scoring has been utilised

100% compliance = Green

80-99% compliance = Amber

< 80% compliance = Red

Monitoring Performance

Red Scoring Sections:

If wards score red in one or more sections of the tool, action plans will have to be developed to address these deficits. The relevant matron will be sent a letter and proforma to complete from Melanie Hornett (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

inform the Matron and complete and forward an application form to Jo Coward (Nurse Specialist Patient Safety) in CGARD who will come and assess the ward within one month of receipt of the application.

Results

A total of 98 wards completed the ward accreditation tool this month, ten wards failed to return their audit data within the set time period, consequently an extension of four days was granted in the submitting of the data and one ward remained closed ward 3, Walkergate Hospital. The following chart depicts the overall compliance with each of the 12 sections of the tool by Directorate. The audits were undertaken from 29th September 2008 to 10th October 2008 and represent data for the month of September 2008.

Throughout all Directorates:

- The number of sections in which the standard was achieved (green rating) = **78/181 (43.1%)**
- The number of sections which achieved an amber rating = **97/181 (53.6%)**
- The number of sections which scored a red rating = **6/181 (3.3%)**

For the Trust

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

Chart 1 - Directorate totals by section for the month of September

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



	The Environment	Decontamination & 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 Score
Cancer Services	100.0%	98.5%	96.5%	NA	NA	78.5%	83.0%	100.0%	75.5%	100.0%	NA	NA	92.0%
Cardiothoracic Services	95.0%	98.8%	97.2%	98.1%	100.0%	90.1%	97.0%	98.3%	95.7%	96.8%	95.3%	96.0%	97.0%
Care of the Elderly	98.9%	99.0%	96.8%	100.0%	NA	86.9%	98.3%	100.0%	98.5%	NA	NA	NA	97.0%
Children's Services	98.1%	98.0%	97.1%	99.2%	83.5%	95.0%	95.8%	100.0%	98.2%	97.0%	76.7%	92.5%	94.0%
Dermatology	100.0%	100.0%	100.0%	100.0%	NA	100.0%	100.0%	100.0%	100.0%	NA	NA	NA	100.0%
ENT	93.0%	100.0%	96.5%	NA	100.0%	100.0%	100.0%	100.0%	95.0%	NA	NA	NA	98.0%
Internal Medicine	96.4%	98.7%	94.8%	96.9%	NA	89.8%	95.4%	98.7%	96.4%	100.0%	NA	NA	96.0%
MSU	98.3%	97.9%	97.1%	100.0%	100.0%	90.6%	95.9%	100.0%	98.7%	100.0%	NA	NA	98.0%
Neurosciences	95.2%	99.4%	97.4%	100.0%	100.0%	84.8%	86.2%	97.8%	89.6%	93.0%	50.0%	NA	90.0%
Ophthalmology	100.0%	100.0%	99.0%	100.0%	100.0%	85.5%	100.0%	100.0%	100.0%	NA	100.0%	NA	98.0%
Periop & Critical Care: FRH	100.0%	100.0%	96.0%	NA	NA	100.0%	94.5%	NA	91.0%	100.0%	100.0%	100.0%	98.0%
Periop & Critical Care: NGH & RVI	100.0%	98.5%	97.5%	86.0%	NA	91.0%	79.5%	100.0%	96.0%	95.0%	100.0%	100.0%	95.0%
Plastic Surgery	100.0%	100.0%	99.0%	NA	100.0%	95.5%	96.0%	100.0%	100.0%	NA	NA	NA	99.0%
Renal Services	96.0%	100.0%	95.3%	100.0%	100.0%	82.3%	92.5%	97.8%	94.0%	100.0%	92.5%	NA	95.0%
Specialist Haematology	100.0%	100.0%	98.3%	NA	NA	84.3%	100.0%	100.0%	86.7%	100.0%	NA	NA	96.0%
Surgical Services	97.2%	100.0%	95.0%	99.5%	100.0%	88.8%	95.3%	98.8%	96.5%	93.0%	100.0%	NA	97.0%
Urology	98.5%	100.0%	98.3%	100.0%	100.0%	100.0%	84.8%	100.0%	99.0%	NA	NA	NA	98.0%
Women's Services	97.7%	100.0%	96.0%	100.0%	77.7%	90.7%	98.9%	97.3%	97.7%	NA	NA	100.0%	96.0%
Bishop Ward	100.0%	100.0%	100.0%	NA	100.0%	100.0%	100.0%	100.0%	100.0%	NA	NA	NA	100.0%
TOTALS	98.0%	99.0%	97.0%	98.0%	97.0%	91.0%	94.0%	99.0%	95.0%	98.0%	89.0%	98.0%	97.0%

Chart 1 shows the Directorate totals by each section, the figures have been calculated to one decimal place to give a more explicit quantification of data. The figures depicting the totals of each section and Directorates will remain rounded to show comparisons from previous months clearly.

Possible reasons why 100% was not achieved in specific sections:

Urinary Catheters

- Within the urinary catheter section, failure to record the reason for insertion, batch number and date of insertion continues to be a problem this month. Several comments included no documentation available, particularly if the catheter had not been inserted on that specific ward, or if patients was admitted from theatres with a urinary catheter in place. This months individual Directorate reports will emphasis the importance of documentation of this information on admission, discharge and transfer of the patient between wards with a urinary catheter in place. Similarly, there is a problem with urinary catheter care plans and some wards have indicated that they are establishing their own care plans for urinary catheters. It is anticipated that the score within this section will improve as a new care plan for urinary catheters has been written and a sticker developed and they will be introduced during October to record insertion of urinary catheters and nursing observations when caring for these devices.

Aseptic technique

- The lack of treatment rooms in wards/departments continues to be a problem. Several wards/departments are going to be visited by the Clinical Governance and Risk Department to review and carry out a risk assessment regarding the geographical layout of the ward with the possibility of re-organisation of the ward/department. Some areas continues to use trolleys or and trays for dual purposes, all areas need to have an identified trolley or and tray that should be used for aseptic techniques only and this will be reiterated within the individual Directorate reports.

Renal Dialysis Catheters

- The red scores for the Renal Dialysis Catheter section particular within the Neuroscience Directorate are related to the questions regarding the site of the catheters being answered incompletely.
- Work within the Children's Directorate continues regarding the catheter site and single or multi lumen lines used.

Peripheral Cannulas

- Within the peripheral cannula section, documentation regarding the peripheral cannula assessment is poor, with several wards/departments finding the stickers incomplete. This months individual Directorate reports will emphasis the importance of documentation as per policy. The information regarding the knowledge based questions from both medical and nursing staff was incorrectly answered within some wards, highlighting the educational need regarding care of cannulas. Again this will be reflected in the individual Directorate reports.

Chart 2 - Trust total by section for the months of April to September inclusive.

NB: Due to audit tool changes the comparison has been provided as a guide to progress only.

SECTION	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
The Environment	80%	92%	95%	97%	98%	98%						
Decontamination & Waste Management	83%	95%	97%	99%	99%	99%						
Infection Control Practice	82%	92%	95%	95%	97%	97%						
Source Isolation Practice	93%	95%	96%	96%	98%	98%						
Management of Surgical Patients	88%	92%	97%	91%	97%	97%						
Aseptic Technique	65%	77%	80%	88%	89%	91%						
Urinary catheters	81%	90%	90%	93%	95%	94%						
Taking Blood	82%	96%	98%	99%	99%	99%						
Peripheral Cannulas	82%	86%	91%	93%	95%	95%						
Central Lines	72%	90%	92%	99%	99%	98%						
Renal Dialysis Catheters	61%	76%	92%	81%	97%	89%						
Ventilators	70%	94%	93%	97%	98%	98%						

Eight sections maintained the score that was attained from last months data collection period achieving scores in the mid to high nineties, with three sections having a reduction in the overall scores and only one section demonstrating an improvement.

The Renal Dialysis Catheter section had the lowest score of 89% with the questions regarding the site of the catheter not completed by one ward and lowering the score within the Neuroscience Directorate and the overall section. The concerns regarding the site and number of lumens used within the Childrens Directorate continues to influence the score in this section. The other lower scoring sections are Central Lines and Urinary Catheters, they had a small reduction in their overall scores by 1% when compared to last month, these appear to be related to documentation and poor labelling of these medical devices and the cleaning of lines.

The Aseptic Technique section has the penultimate score; however there is an improvement in the score when compared to the previous month. The concerns regarding not having a treatment room remains an ongoing issue throughout the Trust. Several wards/departments are going to be visited by the Clinical Governance and Risk Department to review and carry out a risk assessment regarding the geographical layout of the ward with the possibility of re-organisation of the ward/department. Wards within these Directorates that have planned visits include Peri-op and Critical Care, Specialist Haematology, Neurology, Care of the Elderly and Womens. The use of trolleys for the sole purpose of aseptic technique remains an ongoing issue with some wards continuing to use trolleys for dual purposes. The wards/departments where this is a problem have been advised that a specific trolley or tray needs to be identified for the purpose of aseptic technique only.

Several nursing and medical staff have not had their Aseptic Technique assessed in the last three years and the comments reflect there is a deficit in knowledge of how to ensure this is maintained. This months individual Directorate reports will address how to achieve this through the breeze online training programme and the location of the competency document, that are available on the intranet, emphasising the need for competence in performing aseptic procedures.

The following Bar Chart illustrates the Ward Accreditation results comparing sections from April to September

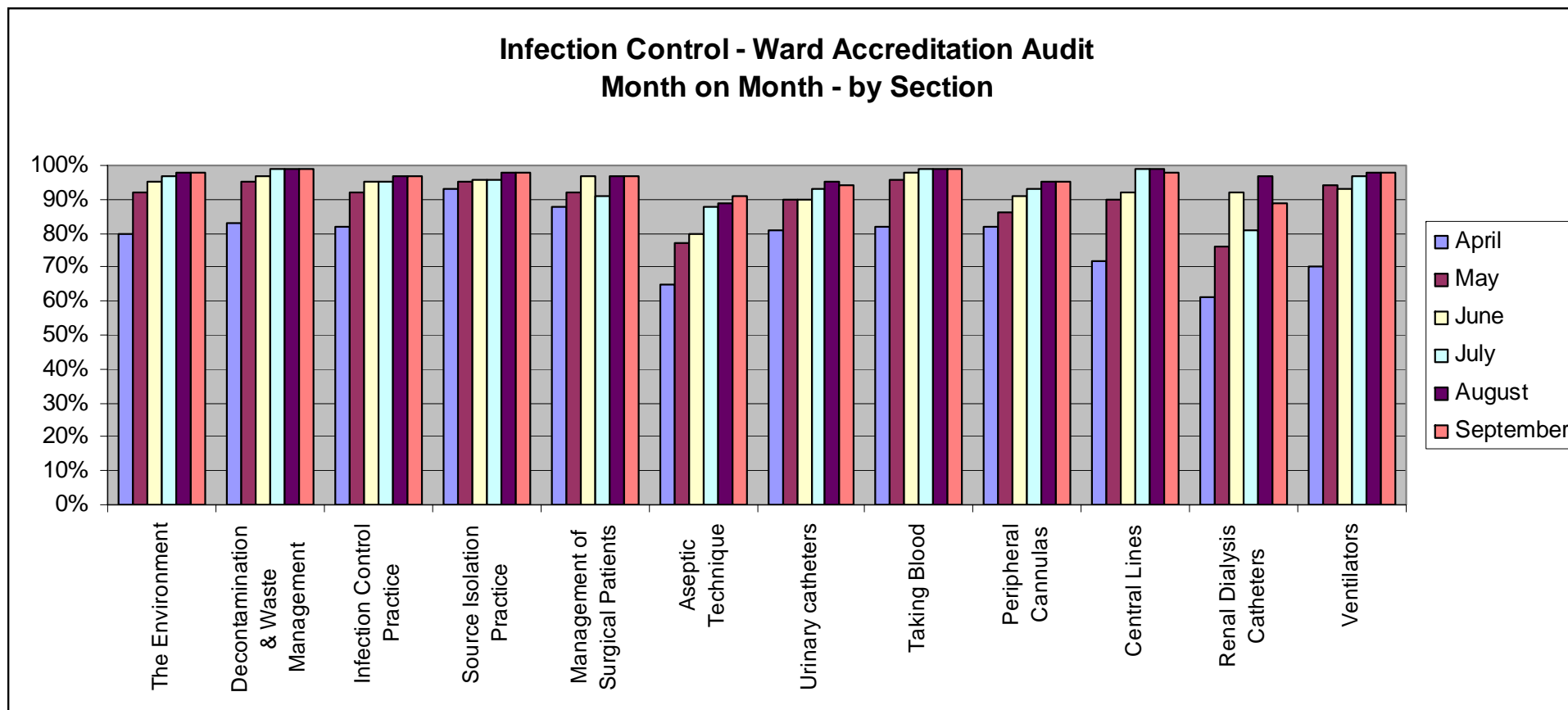


Chart 3 - Directorate scores for the months of April to September, inclusive.

NB: Due to audit tool changes the comparison has been provided as a guide to progress only.

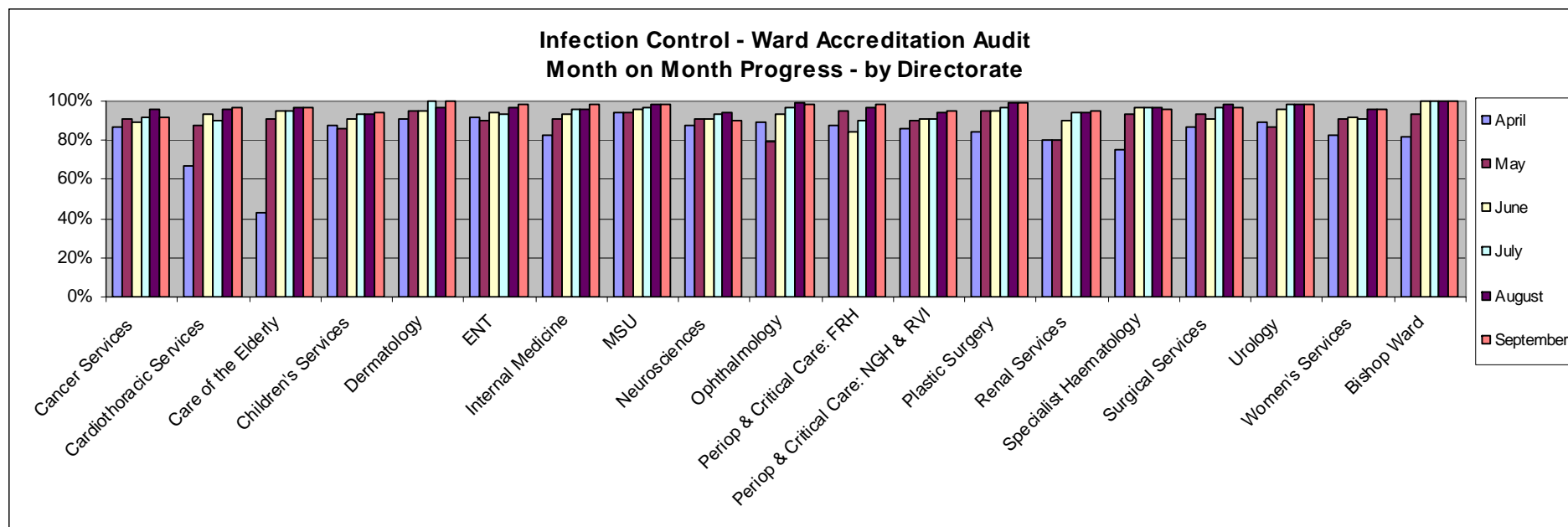
DIRECTORATE	April	May	June	July	August	September	October	November	December	January	February	March
Cancer Services	87%	91%	89%	92%	96%	92%						
Cardiothoracic Services	67%	88%	93%	90%	96%	97%						
Care of the Elderly	43%	91%	95%	95%	97%	97%						
Children's Services	88%	86%	91%	93%	93%	94%						
Dermatology	91%	95%	95%	100%	97%	100%						
ENT	92%	90%	94%	93%	97%	98%						
Internal Medicine	83%	91%	93%	96%	96%	98%						
MSU	94%	94%	96%	97%	98%	98%						
Neurosciences	88%	91%	91%	93%	94%	90%						
Ophthalmology	89%	79%	93%	97%	99%	98%						
Periop & Critical Care: FRH	88%	95%	84%	90%	97%	98%						
Periop & Critical Care: NGH & RVI	86%	90%	91%	91%	94%	95%						
Plastic Surgery	84%	95%	95%	97%	99%	99%						
Renal Services	80%	80%	90%	94%	94%	95%						
Specialist Haematology	75%	93%	97%	97%	97%	96%						
Surgical Services	87%	93%	91%	97%	98%	97%						
Urology	89%	87%	96%	98%	98%	98%						
Women's Services	83%	91%	92%	91%	96%	96%						
Bishop Ward	82%	93%	100%	100%	100%	100%						
Total	83%	90%	93%	95%	97%	97%						

Eight Directorates improved upon the previous months scores, with Dermatology returning to full compliance at 100%. Six Directorates maintained the same scores, including Bishop ward which maintained a score of 100% for the fourth month consecutively. Five Directorates demonstrated a decline in their score when compared to last month, Cancer, Neurosciences, Ophthalmology, Specialist Haematology and Surgery. Several of the Directorates submitted incomplete data, failing to answer some of the staff questions or give rationale for answers losing marks unnecessarily, and data from several Directorates was late so could not be returned for editing with comments and advise to the ward/departments. This highlights the need for meticulous attention to detail and careful consideration when answering questions and submitting data which will be reflected in the individual Directorate reports. Both Cancer and Neurosciences

Directorates had the largest drop in score from the previous months by 4% each, with Neuroscience scoring the lowest as 90%. Both Directorates submitted data late and scored poorly in Aseptic Techniques, Peripheral Cannula and Urinary Catheter sections. Reasons for this were staff used trolleys for multiple procedures rather than just aseptic ones, staff had not been assessed in their aseptic technique and there was poor documentation of peripheral cannulas and urinary catheters. Neurosciences scored only 50% for the Renal Dialysis Catheters as the data was incomplete.

The Children's Directorate score improved slightly to 94% however there is still concern within the peripheral cannula section and the policy regarding cannulas. From the data in areas where paediatrics are nursed, it appears that there is inconsistency in the documentation that is used regarding hourly checking of cannulas when infusions are in progress, or three times a day as per Trust policy. There is a need for all areas where paediatrics are nursed to utilise the same documentation as the rest of the trust until an amendment to the identified policy is made.

The following Bar Chart illustrates the Ward Accreditation results comparing Directorates from April to September



Conclusions

For the data collected all appropriate wards returned the ward accreditation tool audit this month.

The overall trust average score has been maintained at 97% with 14 Directorates improving or maintaining their previous months score, however only one section Aseptic Technique had an improvement in the overall score. Within the Asepsis Technique section, the concerns regarding not having a treatment room remain an ongoing issue that is continuously highlighted. Within the next month several wards/departments without a specific treatment room are going to be visited, reviewed and a risk assessment carried out by the Clinical Governance and Risk Department to assess the requirement of a treatment room. Additionally, it is anticipated that the scores for Urinary Catheters will improved due to the introduction of the new care plan and sticker into clinical practice.

Some of the data that has been submitted has questions that have been omitted or not completely answered and scores are unfavourably lower, and hence this may not be a true reflection on the ward or Directorate. It is encouraged that careful completion of the tool is performed to ensure that an accurate reflection of wards/departments can be evaluated.

The Ward Accreditation Scheme has been in place for six months now and there are some wards which require regular reminders to return the audit. Ten wards/departments required an extension from the original submission date, in future this will not be acceptable and the ward/department will score zero and this will reflect poorly within the Directorate.

Education and support will continue to all areas from the Clinical Governance and Risk Department to assist Sister's/Charge Nurses and Matrons in accurate completion of the tool.