

1. Purpose

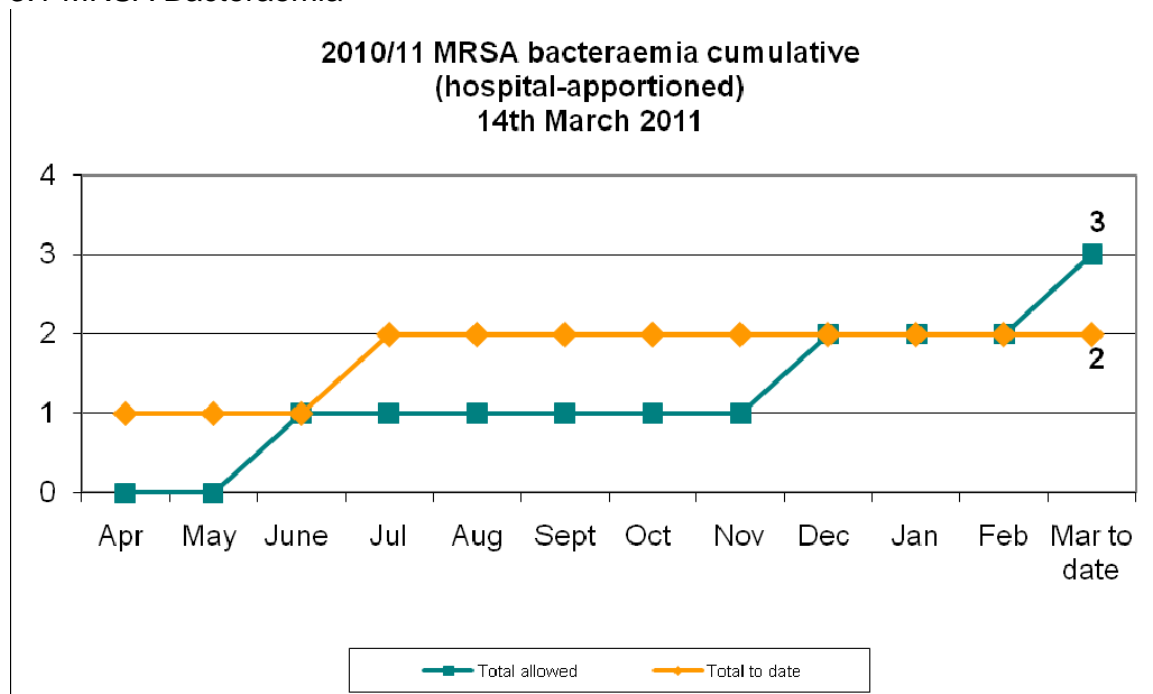
1.1 The purpose of this paper is to inform on the position of the Trust in relation to infection prevention and control during February 2011.

2. New Developments

2.1. Serious Incident. We reported as a serious incident a possible outbreak of gastroenteritis on Reginald Hart ward. This commenced on 11th March 2011 and at time of writing, is ongoing.

3. Performance

3.1 MRSA Bacteraemia

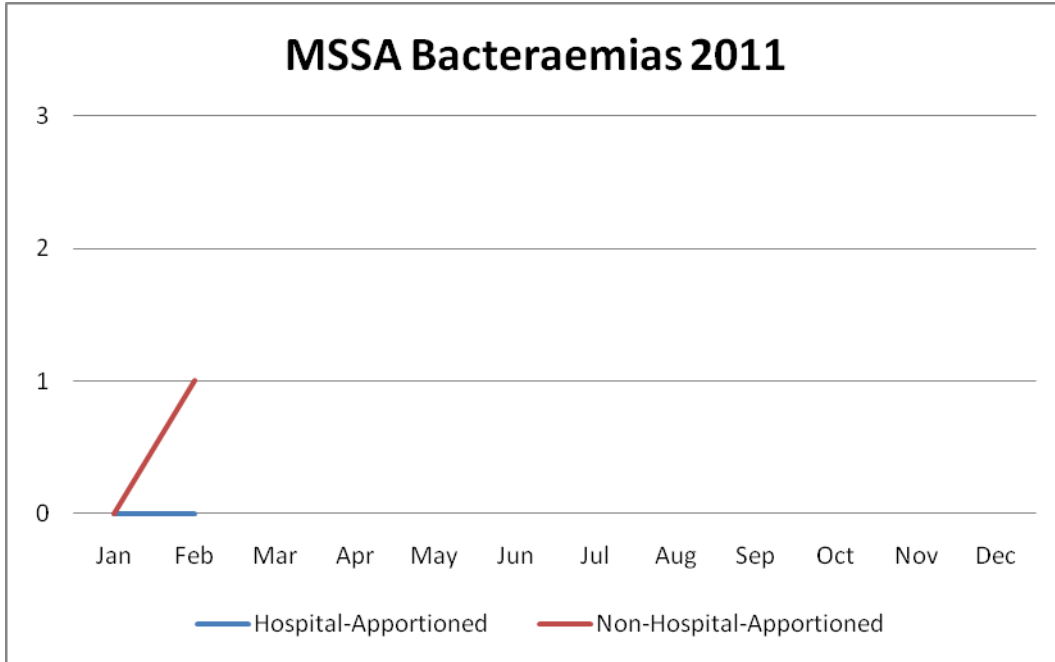


We have now had seven months with no hospital-apportioned MRSA bacteraemia.

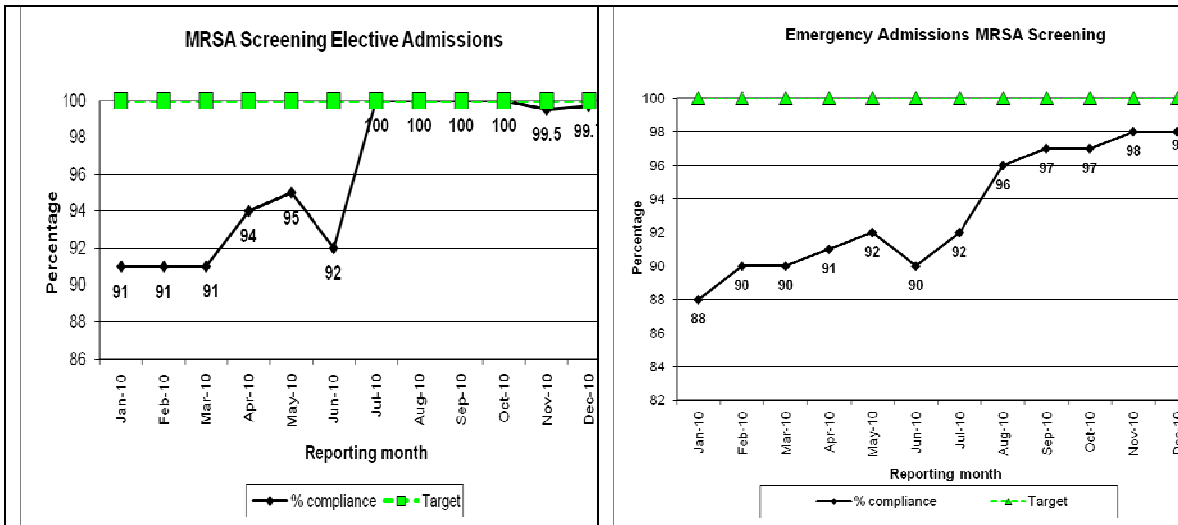
3.2 MSSA bacteraemia

This is for information only, and reporting of these bacteraemias has been mandatory since January 1st 2011. For ease of comparison, we have applied the

same date parameters for determining as for MRSA whether the bacteraemia onset was in hospital or elsewhere.



3.2 MRSA screening.

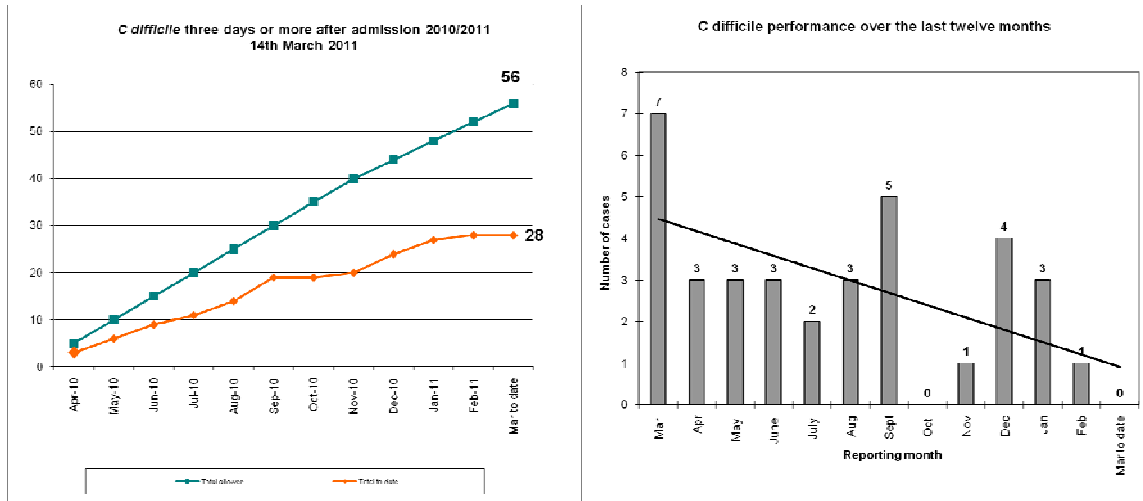


Data from January and February are yet unverified and will be reported next month.

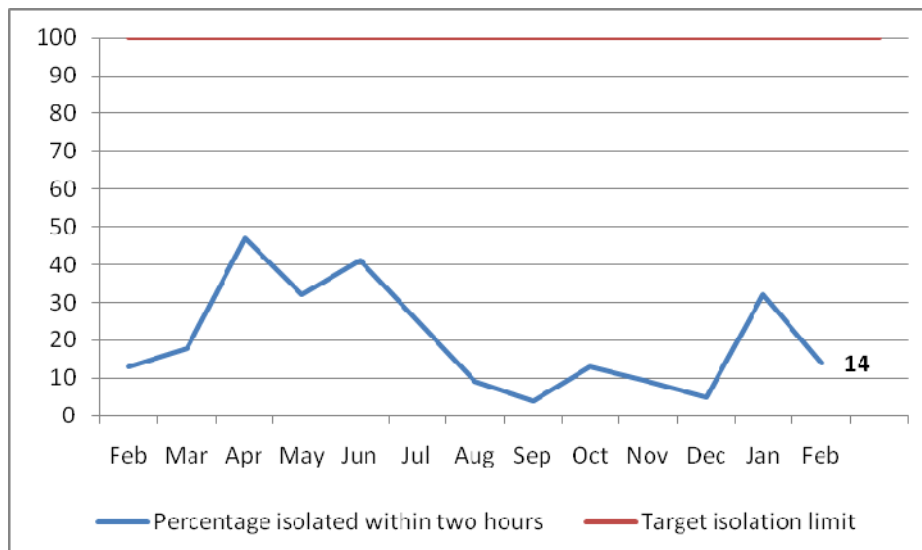
3.3 *Clostridium difficile*

Our incidence of patients developing *Clostridium difficile* associated disease has fallen significantly so far this year. We have a ceiling of **56** cases for 2010/11, and until the end of February, we had recorded **28** cases against a ceiling of 52. Our twelve-month projection, based on the last twelve months, is **35** cases.

There does tend to be seasonality with *Clostridium difficile*, with higher numbers during the winter months. This is probably due to a combination of an increase in antibiotic use for treatment of chest infections, overcrowding/high bed occupancy, and the likelihood of outbreaks of viral gastroenteritis, which increases sampling, and will identify a higher proportion of colonised patients. Comparatively low viral gastroenteritis activity thus far is likely to have had an advantageous effect on the number of people diagnosed as having *Clostridium difficile* associated disease.

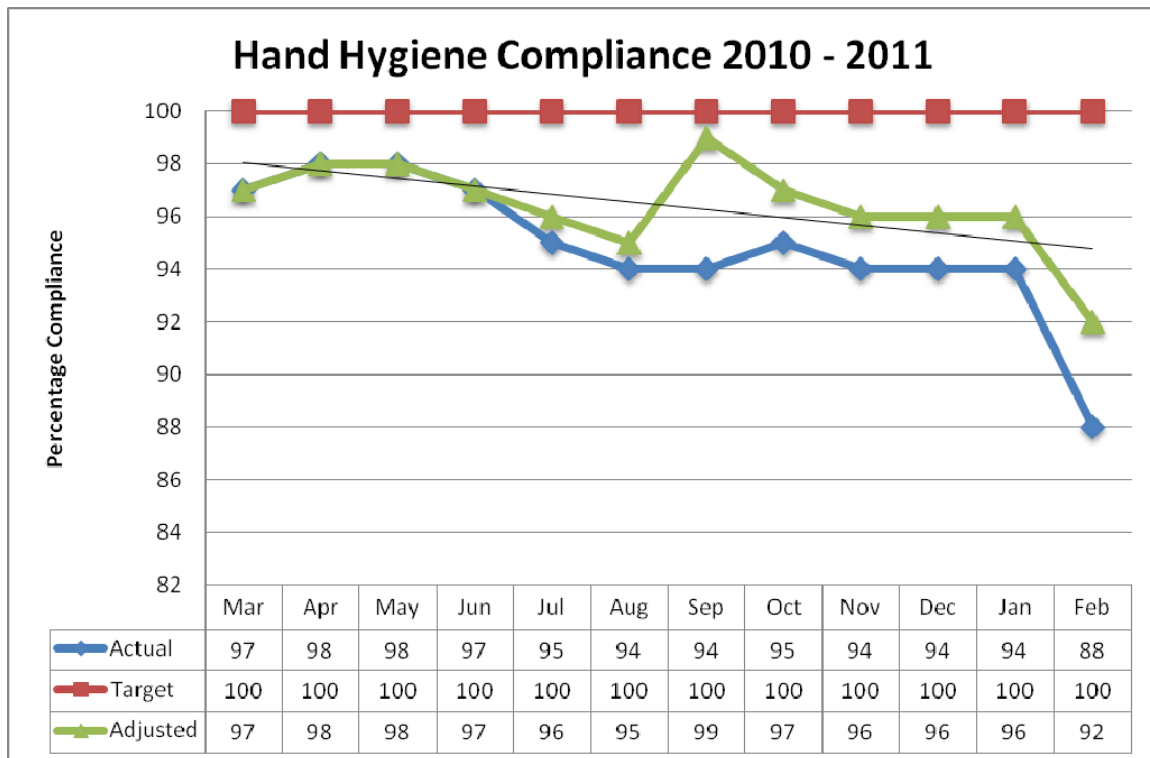


Time to isolation

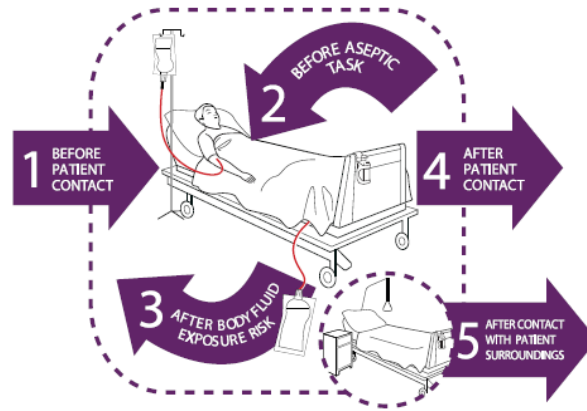


The plan to improve isolation times is in place in the medical division. The division requires both support and challenge to improve both time to isolation and data quality with regard to the timing.

3.4 Hand Hygiene

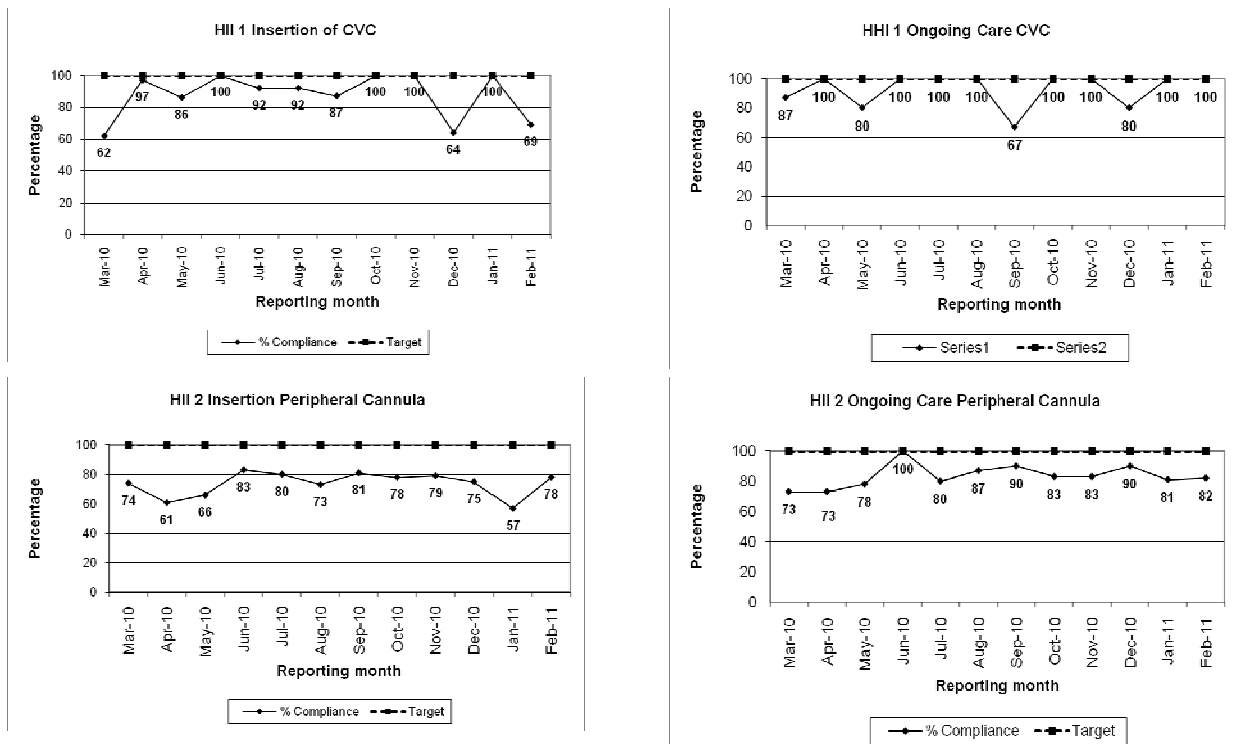


The drop in compliance in February reflects the auditing undertaken by the infection control nurses to check the audit quality and Hawthorn effect (when people know that they are being watched and behave differently). The main learning points picked up from this audit were people putting gloves on without cleaning their hands first (moment one), and not cleaning their hands after contact with a patient's surroundings (moment 5). The infection control nurses are repeating this audit in March and will report to the Trust Board next month.

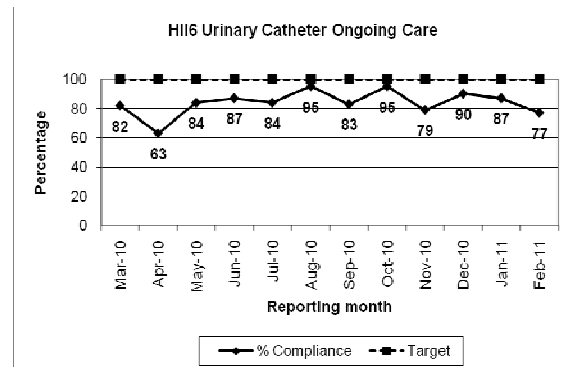
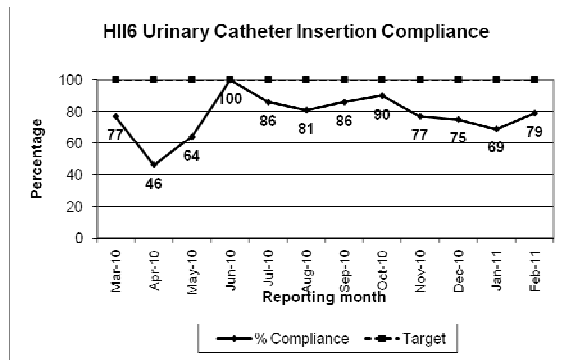


1	BEFORE PATIENT CONTACT	WHEN? Clean your hands before touching a patient when approaching him/her WHY? To protect the patient against harmful germs carried on your hands
2	BEFORE AN ASEPTIC TASK	WHEN? Clean your hands immediately before any aseptic task WHY? To protect the patient against harmful germs, including the patient's own, from entering his/her body
3	AFTER BODY FLUID EXPOSURE RISK	WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal) WHY? To protect yourself and the healthcare environment from harmful patient germs
4	AFTER PATIENT CONTACT	WHEN? Clean your hands after touching a patient and her/his immediate surroundings when leaving the patient's side WHY? To protect yourself and the healthcare environment from harmful patient germs
5	AFTER CONTACT WITH PATIENT SURROUNDINGS	WHEN? Clean your hands after touching any object or furniture in the patient's immediate surroundings when leaving - even if the patient has not been touched WHY? To protect yourself and the healthcare environment from harmful patient germs

4. High Impact Interventions



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 Infection Prevention and Control
 March 2011



Some improvement has been made in insertion documentation this month. This should generally be completed by medical staff, and is a challenging area to improve. Ongoing care documentation should generally be completed by the nursing staff. Both areas must be addressed by the divisions in order to effect significant improvement.

The infection control team is considering other outcome measurements that will give a clearer picture of the care of invasive devices. The High Impact Intervention monitoring was originally introduced as an educational tool and has since been adopted regionally as a key performance indicator. Whilst they give some indication about the quality of documentation, itself a concern, they do not give a comprehensive overview of quality of care.