The Royal Wolverhampton NHS Trust

IP08
Infection Prevention Operational Policy

Attachments:

1.0 Policy Statement (Purpose / Objectives of the policy)

The prevention and control of infection in the Royal Wolverhampton NHS Trust has a high priority as part of the Trust's Integrated Governance and Patient Safety Strategies. This is monitored by the adherence to standards set out by the NHS Resolution, the Care Quality Commission and the Health Act 2022. Therefore, arrangements for the organisation of infection prevention and control within the Trust need to be clear. This policy must be read in conjunction with the joint Royal Wolverhampton and Walsall Healthcare Trusts Infection Prevention delivery plan.

The policy will

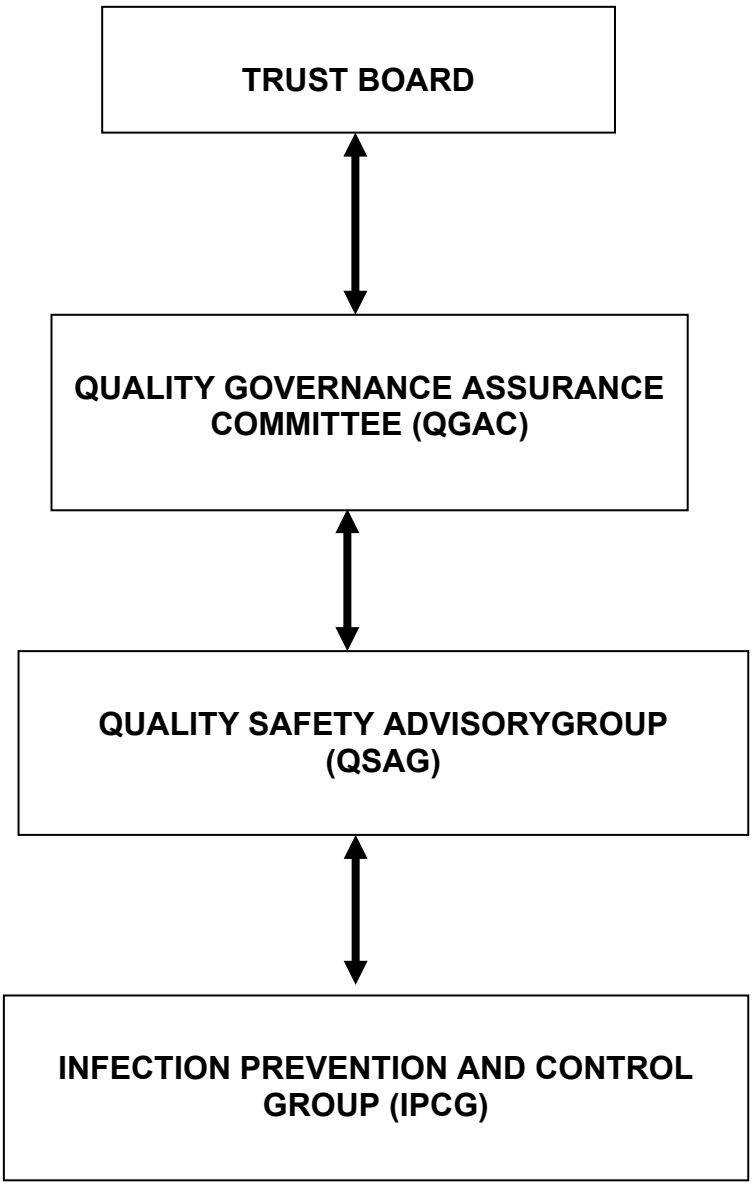
- Identify the position of the infection prevention and control function within the organisational structure and the operational systems and assurances which are in place in order to ensure that infection prevention and control is facilitated and communicated within the Trust.
- Outline surveillance priorities for the Trust and ensure that an annual programme of work is developed that includes an audit programme and an educational plan.
- Identify the process of management of healthcare associated infections (HCAI)

statistics available to the general public and identify the investigation process for specific infections.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy (OP109) must be considered and addressed. In the case of any inconsistency, the Conflicts of Interest Policy is to be considered the primary and overriding Policy.

2.0 Infection Prevention in the Organisational Structure

IPCG / COMMITTEE STRUCTURES



Ref: Trust Committee structure July 2023

3.0 Accountabilities

Infection Prevention Infrastructure

3.1 There is an Infection Prevention and Control Group (IPCG) which is accountable to QSAG, QGAC and the Trust Board. This group oversees the annual infection prevention programme of work, NHS Standard Contract for Healthcare Associated Infections (HCAI) and provides advice and support to the Infection Prevention Team. The Chief Medical Officer (CMO) chairs the Infection Prevention and Control Group, which meets monthly (see Attachment 1 for membership and Terms of Reference **3.2.** There is an Infection Prevention Team which meets weekly and is directly accountable to the Director for Infection Prevention and Control (DIPC) (see Attachment 2 for full membership and Terms of Reference) including provision of an infection prevention service for Primary Care operating under Service Level Specifications.

3.3 The Trust's core Infection Prevention Team consists of:

3.3.1 Director of Infection Prevention and Control

3.3.2 Head of Nursing – Corporate Support Services

3.3.3 Senior Matron Infection Prevention

3.3.4 Matron Infection Prevention – Operational

3.3.5 Matron Infection Prevention – Education and Innovation

3.3.6 Band 7 Infection Prevention Nurses

3.3.7 Band 6 Infection Prevention Practitioners

3.3.8 Band 4 Healthcare Support worker

3.3.9 Infection Control Doctor (programmed activities (PAs) for infection prevention).

3.3.10 Surveillance Data Analyst

3.3.11 Administrator/PA.

In addition:

3.3.12 There are additional Consultant Medical Microbiologists with infection prevention PAs in their Job Plans

3.3.13 Other staff members may be co-opted into the team as required. These may include laboratory staff, secondments or project leads

3.3.14 Head of Nursing Corporate Support Services strategically directs Infection Prevention, Continence, Intravenous Resource and TB Teams

3.4 Individual Responsibilities

3.4.1 Chief Executive

The Chief Executive is responsible for establishing and maintaining IPC. arrangements across the organisation. This responsibility is delegated to the Director of Infection Prevention & Control and the person with the lead responsibility is the Executive Director of Nursing and Allied Health

Professions/Chief Executive.

3.4.2 Director of Nursing

Infection Prevention is in the portfolio of the Director of Nursing therefore they have lead executive director responsibility and will delegate local operational responsibility to Heads of Nursing and Midwifery, Matrons and Senior Sisters and Charge Nurses and Department Managers.

3.4.3 Chief Medical Officer (Chair of IPCG)

Will chair the IPCG meetings, oversee implementation of the IP Delivery Plan within Trust services and will delegate local operational responsibility to Clinical Directors via the Divisional Directors. The Chair will ensure areas of concern or non-compliance with statutory requirements for IP are escalated to the Chief Executive and the Board.

3.4.4 Chief Operating Officer

Has responsibility for the Trust performance framework and will delegate local operational responsibility to Clinical Directors via the Divisional Directors.

3.4.5 Chief People Officer

Will ensure that all Trust staff job descriptions (JDs) contain explicit reference to infection prevention and where appropriate Occupational Health and Wellbeing policies and procedures support the Infection Prevention Delivery Plan.

3.4.6 Chief Finance Officer

Will ensure that resources are available centrally to finance the management and control of outbreaks of infection and will oversee opportunities for clinical engagement between Finance and Infection Prevention and Control.

3.4.7 Head of Estates & Developments/ Divisional Manager Estates and Facilities

Will ensure that timely, efficient and effective communication systems are in place to alert the Infection Prevention Team to forthcoming developments, external contract reviews, refurbishments and changes to services at all stages of development.

Will also ensure close liaison regarding environmental hazards and screening of potable and non-potable water and will also advise on decontamination and lead on legionella, ventilation waste management.

3.4.8 Director of Infection Prevention and Control

Has lead director responsibility for Infection Prevention and Control and will delegate operational responsibility and works in close collaboration with the Head of Nursing – Corporate Support Services, Consultant Microbiologists and senior IP staff incorporating national guidance into local policy, monitoring KPIs and compliance with the Infection Prevention Annual Programme of Work, Infection Prevention Board Assurance Framework, IP Delivery Plan and Code of Practice for HCAI action plan, reporting directly to the Trust Board.

Key roles are to: oversee local infection prevention policies and related policies including their implementation; be responsible for the Infection Prevention Team; report directly to the Trust Board; have the authority to challenge inappropriate clinical hygiene practices and antibiotic prescribing decisions;

assess the impact of existing and new policies and plans on infection and make recommendations for change; be an integral member of the organisation's clinical governance and patient safety structures; monitor, report and make recommendations on key performance indicators and produce an annual report on the state of healthcare associated infection in the organisation and release this publicly.

3.4.9 Head of Nursing – Corporate Support Services

Reports to the Chief Nurse and DIPC and has responsibility for strategic planning and development of the Infection Prevention Delivery Plan and the ongoing development and evaluation of communication and educational strategies across the health economy, Trust and Divisional levels aimed at the facilitation of prevention of avoidable infection.

3.4.10 Matrons – Infection Prevention

Report to the Head of Nursing – Corporate Support Services and manages the Infection Prevention Team and associated teams within the structure on a daily basis. They facilitate the divisional activity in the implementation of infection prevention policy, guidance and practice. They assist in the development of the annual programme of work and in the implementation of the annual programme of work across the health economy, including CQC compliance.

3.4.11 Infection Prevention Nurses and Practitioners

Responsible for facilitation of infection prevention initiatives, policy and guidance at divisional and directorate level; ensuring that a high standard of communication is maintained with matrons, leads and ward managers; identifying the need for and implementation of projects, surveillance, policy and guidance; develop, collate and report on the findings of all investigations; provide an advice service on the management of clinical infections and outbreaks. Also, Quality (Audit etc), building and refurbishment works to name some.

3.4.12 Divisional Heads of Nursing & Midwifery and Divisional Medical Directors

Accountable for local performance management and receipt and action on HCAI in their area of responsibility. This will be achieved using the Trust Governance Framework and regular reporting to IPCG.

Responsible for the development and communication of divisional infection prevention action plans, regular communication with the IPTeam, dissemination of information within the division and challenging poor practice. Identify and monitor Divisional priorities for the prevention of infection addressing key areas of concern linked to Trust priorities, monitor action plans resulting from investigations and ensure that all infection prevention issues are discussed at Governance meetings.

3.4.13 Directorate Managers & Matrons

Responsible for local performance management regarding infection prevention outcome measures and ensuring local uptake of infection prevention strategies; ensuring that the IP Team are fully involved with plans for reconfiguration and changes in services and regular communication within the division regarding progress on action plans.

Are key role models for exemplary infection prevention practice and have

responsibility for maintaining standards of infection prevention practice; implementation and communication of infection prevention initiatives and surveillance results; ensuring the clinical environment is safe and maintained to a high standard and the facilitation of risk assessment and route cause analysis for HCAI as directed by the IP Team within their designated clinical areas. Rates of organisms identified in the key indicator data form part of the Matrons performance monitoring framework.

3.4.14 Professional Clinical Leads/Consultant Medical Staff

Are key role models for exemplary infection prevention practice and have responsibility for maintaining standards of infection prevention practice; preventing avoidable infection in their patient group, implementation and communication of infection prevention initiatives and surveillance results, particularly to non-consultant grade doctors who form part of their clinical team. They must ensure that the clinical environment is safe and maintained to a high standard and communicate concerns about the clinical environment and practices appropriately. They must facilitate risk assessment and route cause analysis for HCAI within their designated clinical areas and their patients. Rates of organisms identified in the key indicator data form part of the Matrons performance monitoring framework.

3.4.15 Senior Sisters/Charge Nurses/Department Managers

Responsible for ensuring that systems are in place to ensure that infection prevention policies, practices and guidance are carried out reliably within their area of responsibility; local investigation of HCAI and highlighting areas of practice or the environment which present a risk to patient safety, implementation and communication of priorities.

3.4.16 Departmental Leads/Link Practitioners for Infection Prevention

Responsible for setting a good example of infection prevention practice; challenging poor practice; regular communication with the local area manager on matters relating to infection prevention and involvement in the roll out of infection prevention initiatives locally.

3.4.17 All Staff

Staff have a responsibility to comply with infection prevention policies and procedures, this includes:

- Completing mandatory and role specific infection prevention education and training.
- Challenging poor infection prevention and prevention practices.
- Ensuring their own compliance with Trust Infection Prevention policies and procedures.
- Being good role models.

4.0 Policy Detail

4.1 Ratification and Review of Infection Prevention Policies and Clinical Care protocols

See Policy guidance in OP01 and OP03 for policy writing, revision and ratification. The Committee to approve IP policies is identified as the Infection Prevention and Control Group.

4.2 Developing the Annual Infection Prevention Programme of Work

The IP Annual Work Programme is developed in conjunction with the DIPC, Head of Nursing – Corporate Support Services and the Infection Prevention Matrons each year. The annual programme of work will run in accordance with the financial year. The content of the annual programme of work will be influenced by the following.

4.2.1 IP Delivery Plan

4.2.2 Trust priorities.

4.2.3 Recommendations from audits performed by the Infection Prevention Team, Clinical Teams, Internal Audit Department or National Audit Office or professional bodies.

4.2.4 Feedback and recommendations from external inspections.

4.2.5 Local, regional or national surveillance.

4.2.6 Recommendations from local, regional or national incidents or outbreaks.

4.2.7 The results and recommendations of national Confidential Enquiries.

4.2.8 New or revised Department of Health directives and guidance.

4.2.9 New or revised expert advice.

4.2.10 Lessons learned from incidents, outbreaks and complaints.

4.3 Progress on the annual programme of work will be monitored quarterly by IPCG.

4.4 The Infection Prevention Annual Report will detail achievements from the annual programme of work and will be produced each May and presented to the Trust Board no later than July each year.

4.5 The annual programme of work will include assurance that the Code of Practice implementation is sustained and includes audit, education and policy revision as standard.

4.6 Selection process for the Annual Infection Prevention Audit Programme

The annual infection prevention audit programme is based on ensuring that relevant Infection Prevention policies are audited at least once every 3 years. Individual practices may be audited more frequently. In accordance with recognised best practice and national guidelines key policies will be audited at increased frequencies. These key policies are subject to frequent review due to their representing a higher risk to patient care if they are not implemented and include the following.

4.6.1 Clostridioides *difficile* via data collected on an electronic surveillance system (IC Net).

4.6.2 Antibiotic Resistant Organisms.

4.6.3 Sharps in collaboration with Health & Safety and Occupational Health and Wellbeing.

4.6.4 Decontamination - Environmental Cleanliness (Monthly via a Trust electronic dashboard).

4.6.5 Decontamination - Commode audit (annually).

4.6.6 Hand hygiene (Monthly via a Trust electronic dashboard).

A full list of infection control policies, frequency of audit and rationale for timescale is provided in (Attachment 3).

4.7 Performance Monitoring

4.7.1 The Trust's Infection Prevention Annual Programme of Work will be monitored by the Infection Prevention and Control Group by the following mechanisms:

- Regular exception reports based on the Annual Programme of Work.

4.7.2 The Trust's Annual Infection Prevention Programme will be monitored by the Trust IPCG by way of:

- Regular presentation of data (minimum quarterly).
- Receipt of an annual report.
- Compliance with infection prevention and control aspects of the NHS Litigation Authority Standards and Code of Practice for the Prevention of HCAI.
- Achievement of National objectives and targets.
- Compliance with the Care Quality Commission Standards for Better Health.
- Results of independent reviews.
- Results of Key Performance Indicators (see Attachment 4).

4.7.3 Key Performance indicators will be communicated to Divisions monthly as per the Surveillance protocol (see Attachment 5) using statistical process control charts and run charts.

4.7.4 Divisional performance on alert organisms will be reported to the Divisional Directors, Matrons and Divisional leads monthly. Monitoring of progress will be though monthly reports to the Infection Prevention and Control Group using an agreed format which will include:

- *Clostridioides difficile* will be monitored on a weekly basis on a *Clostridioides difficile* ward round with a Microbiologist leading the review.
- *Clostridioides difficile* will be managed using a standard operating procedure (SOP) (Attachment 6);
- An internal review for methicillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia requirements and RCA through the use of (Attachment 7);
- Monitoring of Hand Hygiene using 5 moments.
- Monitoring the monthly Environmental Audit results.
- Monitoring of C*arbapenemase-Producing Enterobacterales.*
- Monitoring of Gram negative bacteraemia.
- Monitoring of respiratory illnesses
- Reporting and Investigation of device related bacteraemia will be in line with Attachment 8 and Attachment 8a;
- The protocol for Serious Incident (SI) required for reporting HCAI is outlined in Attachment 9;
- The protocol for Periods of Increased Incidence (PII) required for reporting HCAI is outlined in Attachment 10;
- Management of a suspected or confirmed case of Viral Haemorrhagic Fever including Ebola Virus Disease is outlined in 1;
- The protocol for reporting COVID-19 HCAI and outbreak management Attachment 12 and Attachment 12a;

- Problems identified within the Division and the plan to resolve them.
- Results of audits undertaken by the Infection Prevention Team
- IP Incident Review meetings attended as requested on a fortnightly basis to discuss incidents and determine lessons learnt.

4.8 Leads and Infection Prevention Link Practitioners

4.8.1 Heads of Nursing will be the main focus of communication of infection prevention statistics, information and audit results to the divisions.

4.8.2 Each professional lead will agree with the Divisional Management Team a robust communication network through which to communicate information to with a suitable audit trail.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Doe the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

6.0 Equality Impact Assessment

It is not anticipated that this policy will have any impact on race equality and equality and diversity.

7.0 Maintenance

This policy will be reviewed as part of the Infection Prevention Annual Programme of Work at least 3 yearly and at the same time as the Infection Prevention Delivery Plan.

8.0 Communication and Training

8.1.1 Infection Prevention will be a feature of job descriptions for clinical staff and those support / administrative staff that access clinical areas as a key part of their role. All other staff will be also required to undergo mandatory training as part of their requirement to comply with Trust policy.

8.1.2 The Infection Prevention Team will ensure provision of training on infection prevention to all staff relevant to their role / needs of the Trust. This will be provided through the production and annual review of an Education and

Training Plan available on the Intranet and include as a minimum:

8.1.3 Induction training will be provided to new staff on the key principles of infection, and the infection prevention arrangements within the Trust.

8.1.4 Annual training will be provided to staff either through face-to-face presentations from the Infection Prevention Team or via other means approved / developed by the Team. Publication of these will be via the Trust Training and education MyAcademy site (see OP41 Mandatory Training Policy).

8.1.5 New training will be influenced by the outcomes of Trust training needs analysis, priorities and new or revised national guidance or local policy.

8.1.6 Feedback on key issues and audit will be undertaken by use of the Divisional Leads communication systems, Clinical Governance structure, existing committees / training venues, the Intranet, displays and/or awareness campaigns.

8.1.7 Mandatory training will be monitored via the Trust's Education and Training Database.

8.1.8 Training and education delivered will be accompanied by an appropriate means of evaluation.

8.1.9 Full reports of infection prevention training and education will be included in the annual report.

8.2 Communication of Infection Prevention Information

8.2.1 Information will be generated through surveillance data and the results of the investigations and findings at IP incident review meetings (Attachment 13).

8.2.2 Infection Prevention information will be communicated through Trust wide communications and Divisions and Directorates as appropriate.

8.2.3 Matrons must meet with an Infection Prevention Nurse to discuss local issues and performance at regular agreed intervals.

8.2.4 Communication with Divisional Medical Directors will occur regularly though the membership of the Infection Prevention and Control Group.

8.2.5 Information requiring dissemination through the divisions (e.g., new policies / guidelines / recommendations etc.) will be sent to divisional leads in a format which can be presented at local Governance meetings or emailed.

8.2.6 Divisional leads will, in conjunction with the Divisional Director and Heads of Nursing / Midwifery develop a robust system of communicating infection prevention information.

8.2.7 Surveillance data will be communicated via email monthly to - Service leads Divisional Directors, Heads of Nursing / Midwifery, Matrons.

8.2.8 Outbreaks will be communicated and managed as per the Outbreak of Communicable Infection Policy IP13.

8.2.9 Feedback of HCAI statistics and local progress to patient groups will feature annually on the Infection Prevention Annual Programme of work. Mandatory information will also be available to the general public via the UKHSA web site.

8.2.10 Where relevant press releases will be agreed prior to the release of information.

8.2.11 Press enquiries must be referred to the Head of Communications, or out-of-hours the on-call executive director, prior to response.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
IP 08 Operational Policy components	Matron Operational IP	Individual policy components	See individual policies	IPCG

10.0 References - Legal, professional or national guidelines

- Care Quality Commission; 2014; https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-12-safe-care-treatment
- NHS Standard Contract for Healthcare Associated Infections (HCAI) - PRN00150-NHS-Standard-Contract-202324-Minimising-Clostridioides-difficile-and-Gram-negative-bloodstream-infect-1.pdf (england.nhs.uk)
- Department of Health 2012; (Updated 2022) The Health and Social Care Act Code of practice for adult health and social care on the prevention and control of infections and related guidance; DH London Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)
- Syndromic surveillance: systems and analyses - GOV.UK (www.gov.uk)
- NHS Resolution; Home - NHS Resolution
- IP13 Outbreaks of Communicable infection / Infection Serious Untoward Incident Policy;
- OP41 Mandatory Training Policy
- OP10 Reporting of Serious incidents [SIRI]-Serious incidents requiring investigation.
- OP01 Development and Control of Trust policies
- IP06 *Clostridioides difficile* Policy
- IP03 MRSA, VRE and other antibiotic resistant organisms Policy

Part A - Document Control

Policy number and Policy version: IP08 Version 7.0	**Policy Title** **Infection Prevention Operational Policy**	**Status:** Final		**Author: Nurse Manager Infection Prevention** **Director Sponsor: Chief Nurse**
Version / Amendment History	Version	Date	Author	Reason
	V1	Nov 2006	Lead Nurse IP	Original Policy
	V2	July 2009	Lead Nurse IP	Reached stated review date
	V3	September 2012	Lead Nurse IP	Review and reformat required following TCS
	V3.1	October 2013	Lead Nurse IP	Review to add reporting protocols
	V4	November 2014	Nurse Manager IP	Addition of another protocol and review of existing content
	V6	October 2020	Kim Corbett	Reached date of review
	V6.1	December 2020	Kim Corbett	Inclusion of attachment 14 – COVID-19 Outbreak Protocol
	V6.2	April 2021	Kim Corbett	Minor update to Attachment 13 – COVID-19 HCAI
	V6.3	September 2021	Kim Corbett	Minor updates to Attachments 8, 9, 10,11 and 13

	V7.0	July 2023	June Cooper	Minor updates to the policy and attachments

Intended Recipients: All staff groups employed by RWT	
Consultation Group / Role Titles and Date: IPCG 28th July 2023	
Name and date of Trust level group where reviewed	Trust Policy Group - October 2023
Name and date of final approval committee	TMC November 2023
Date of Policy issue	November 2023
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)	October 2026 every 3 years

Training and Dissemination: The approved policy can be found on the Trust intranet.

Managers and Matrons will be informed of the launch.

Mandatory training provided through Trust induction and annual training requirement.

Further training in response to audit findings

To be read in conjunction with: Infection Prevention Delivery Plan

Infection Prevention suite of policies available on the Trust Intranet

Initial Equality Impact Assessment (all policies): Completed Yes Full Equality Impact assessment (as required): Completed NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator8904

Monitoring arrangements and Committee	Infection Prevention and Control Group

Document summary/key issues covered. The prevention and control of infection in the Royal Wolverhampton NHS Trust has a high priority as part of the Trust's Integrated Governance and Patient Safety Strategies. This is monitored by the adherence to standards set out by the NHS Litigation Authority, the Care Quality Commission and the Health Act 2008 (updated 2022). Therefore, arrangements for the organisation of infection prevention and control within the Trust need to be clear. This policy must be read in conjunction with the current Infection Prevention Delivery Plan.
The policy will identify the position of the infection prevention and control function within the organisational structure and the operational systems and assurances which are in place to ensure that infection prevention and control is facilitated and communicated within the Trust. The policy will outline surveillance priorities for the Trust and ensure that an annual programme of work is developed that includes an audit programme and an educational plan. The policy will identify the process of management of HCAI statistics available to the general public and identify the investigation process for specific infections.

Key words for intranet searching purposes	Infection Prevention
High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g., contains detailed images of means of strangulation.	**No**

• References to individually identifiable cases. • References to commercially sensitive or confidential systems. If a policy is considered to be high risk, it will be the responsibility of the author and director sponsor to ensure it is redacted to the requestee.	

Part B Ratification Assurance Statement

Name of document: Infection Prevention Operational Policy

Name of author: June Cooper Job Title: Infection Prevention Matron

I, the above named author confirms that:

- The Strategy/Policy/Procedure/Guidelines (please delete) presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.
- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.
- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines(OP01).
- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.
- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.
- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.
- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author: JM Cooper

Date: 24/07/2023

Name of Person Ratifying this document (Director or Nominee):
Job Title:Chief Nurse
Signature:

- I, the named Director (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval

Policy number and policy version IP08 V7.0	**Policy Title Infection Prevention Operational Policy**	
Reviewing Group	Trust Policy Group	**Date reviewed: October 2023**
Implementation lead: Print name and contact details		
Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.	n/a	
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form	All IP Policies are included in Mandatory training	
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed	Leaflets available for alert organisms	
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?	All IP policies available on Intranet	
Financial cost implementation Consider Business case development	None	
Other specific Policy issues / actions as required e.g. Risks of failure to implement, gaps or barriers to implementation		

IP 08 Attachment 1

TERMS OF REFERENCE

Name of Meeting	Infection Prevention and Control Group
Trust/local Strategic Objectives (as applicable)	1. The Group will have a broad overview of infection risks and advise on the prioritisation of action within the Trust while taking an active role in ensuring that infection risks are minimised within the broader population of Wolverhampton and Cannock. 2. The Group will monitor performance against national and local ambition to reduce healthcare associated infection (HCAI). 3. The Group will gain assurance that the risk of healthcare associated infection is minimised to the lowest possible level taking into account international, national and local risks to public health. 4. The Group will test clinical accountability and assurance to directorate level to ensure that the risk of healthcare associated infection is minimised to the lowest possible level. 5. The Group will steer the infection prevention agenda within the organisation and, where relevant, the wider Wolverhampton area, through the delivery of the infection prevention annual programme of work based on the following specific objectives: a. Wolverhampton will continue to grow its reputation as a centre of excellence for infection prevention. b. The Trust will be a lead site for research, development and innovation in infection prevention linking with academic institutions, industry and the Department of Health whenever possible to fund further development. c. There will be no avoidable blood stream infection. d. Wolverhampton will build on its robust surgical site infection surveillance to establish the irreducible minimum. e. The risk of emerging multi-resistant organisms will be minimised. f. *Clostridioides difficile* Infection will be reduced to an irreducible minimum and the actions necessary to sustain this understood. g. The risk of outbreaks and subsequent organisational disruption will be reduced to a minimum through local surveillance and detections of organisms. h. Health and social care systems will work jointly to identify and reduce the risk of spread of tuberculosis. i. The Code of Practice on the prevention and control of infection is fully implemented and monitored within RWT and independent contractors are supported to implement and monitor where relevant. j. Education will be available to all Trust staff, patients, visitors and the general public.
Risks title and number	**5452 - PPE** Supply and Distribution during Covid 19 Pandemic

Meeting Purpose/Remit	1. Provide strategic direction for the prevention and control of Healthcare Associated Infection (HCAI) for the organisation. 2. Contribute to the strategic direction for the control of tuberculosis. 3. Provide a key role in monitoring the organisation's performance against the Trust's Infection Prevention and Control Strategy including external objectives/targets and compliance with the Health and Social Act 2008: Code of Practice on the Prevention and Control of Infections (2015). 4. Ensure there is a strategic response to emerging infections, antimicrobial resistance, new legislation and national guidelines. 5. Ensure there is adequate learning from local, national and international incidents and health economy issues to minimise impact on patient safety/Trust business. 6. Ensure that the use of resources is maximised in order to achieve the most efficient methods to achieve excellence in practice.
Responsibilities	1. The Group will receive monthly reports from each Clinical Division on performance against the HCAI key performance indicators using the agreed assurance framework. 2. The Group will receive quarterly summaries of IP risks on the divisional risk register. 3. The Group will receive quarterly summaries of the TB position and risks in Wolverhampton. 4. The Group will accept reports from Task and Finish Groups as necessary. 5. The Group will receive monthly reports from the Infection Prevention Team including actions against specific priorities, progress against the Code of Practice on the Prevention and Control of Infections (2015) and National Guidance. 6. The Group will receive monthly performance reports from the Director of Infection Prevention and Control (DIPC) including surveillance data and performance against national and local HCAI targets. 7. The Group will receive quarterly Antimicrobial Prescribing Reports from the Director of Pharmacy Services regarding antibiotic prescribing audits, antimicrobial prescribing policy compliance, use of antimicrobials with a high risk for specific infections as required (e.g., *Clostridioides difficile* acquisition) and recommendations from

	the Trust Antimicrobial Stewardship Group and related projects. 8. The Group will receive a quarterly report from the Hotel Services Manager on compliance with the National Specifications for Cleanliness (2007) and from the Trust Environmental Sub-Group. 9. The Group will receive quarterly reports from the Decontamination Lead on compliance with decontamination guidance and decontamination risks in the Trust. 10. The Group will receive quarterly reports from the Occupational Health and Wellbeing Manager on matters relating to prevention and control of infection including flu vaccination rates, inoculation injuries and incidents requiring post exposure prophylaxis. 11. The Group will receive and approve the Infection Prevention Annual Report in the first quarter of the following year prior to submission to the Trust and ICB Boards. 12. The Group will approve, review and monitor the Infection Prevention Team's Annual Programme of Work/ Annual Report/Code of Practice on the Prevention and Control of Infections (2015) compliance. 13. The Group will receive advice from the Infection Prevention Team on new national policy and guidance and its implementation within the organisation, highlighting potential areas of non-compliance. 14. The Group will work collaboratively with the Wolverhampton UKHSA & ICB Teams to ensure there is an interface of the Infection Prevention Strategy and Policy, considering the impact of decisions on the health economy and maintaining the health economy approach to the prevention of HCAI. 15. The Group will receive regular updates on current infection-related issues of international or national priority and local impact/action from the UKHSA team. 16. The Group will receive issues for escalation or concern from regular reports or interim exception reporting. 17. The Group will monitor the Trust's risk register in relation to infection prevention and control of infection risks and receive associated action plans. 18. The Group will ratify infection prevention policies prior to submission to the Trust Policy Group and Trust Management Committee. 19. The Group will address outstanding areas of non-compliance with

	national accreditation schemes (e.g. NHSLA, CQC) and advise the Trust Management Committee as appropriate.
Authority & Accountabilities	Accountable for the steering of the priorities to prevent infection and thus contribute to the improved patient safety. The Group will oversee advice and support the Trust on next steps and remedial actions to reduce infection.
Reporting Arrangements	Reports to Compliance Oversight Group (COG). Receives reports from Environment Group, Decontamination Group, Antimicrobial Stewardship Group, and Task and Finish Groups. Also receives individual reports from Head of Nursing for Corporate Support Services - Infection Prevention (progress on annual programme of work), DIPC (performance), Occupational Health and Wellbeing (Inoculation incidents/staff vaccination and incidents), and Estates (water risks, risks associated with the built environment).
Membership	Medical Director (Chair) Chief Nurse (Deputy Chair) Director of Infection Prevention & Control Head of Nursing for Corporate Support Services Senior Matron – Infection Prevention Consultant in Public Health UKHSA Representative for Wolverhampton ICB Divisional Medical Director Division 1 Head of Nursing Division 1 Divisional Medical Director Division 2 Head of Nursing Division 2 Divisional Medical Director Division 3 Head of Nursing Division 3 Clinical Director of Pharmacy Head of Hotel Services Estates and Facilities Manager/Legionella Lead Occupational Health & Wellbeing Service Manager (Quarterly attendance) Decontamination Lead (Quarterly attendance) Volunteer (patient representative) Council of Members representative IP Matron Representative
Attendance	Clinical Directors, Matrons, Ward Sisters, Group/Directorate Managers, Education Leads, and others as appropriate.
Chair	Medical Director
Quorum	Minimum of 6 representatives of which 1 will be Executive Director from the Trust and one member of the Infection Prevention Team. Each division must be represented.

Frequency of meetings	Monthly, last Friday of the month 1000-1200hours.
Administrative support	Infection Prevention Secretary
Standards worked to	Code of Practice for Healthcare Associated Infection CQC Key Lines of Enquiry NHSLA
Standard Agenda	Standing Reports Division 1 Report Division 2 Report Division 3 Report Performance Report Head of Nursing (Corporate Support Services) Infection Prevention Report Divisional/Directorate Risk Registers (Quarterly) Antimicrobial Prescribing Report (Quarterly) Environment Report (Quarterly) Estates report (including water safety) (Quarterly) Occupational Health & Wellbeing Report (Quarterly) Decontamination Report (Quarterly) Public Health update (as required)
Subgroup reports	Environment Group Water Safety Group Antimicrobial Stewardship Group Decontamination Group Inoculation Injury Group
Date Approved	August 2023
Date Review	August 2024

IP 08 Attachment 2

TERMS OF REFERENCE

Name of Meeting	Infection Prevention Surveillance Meeting
Trust/local Strategic Objectives (as applicable)	1. The Infection Prevention Team (IPT) has a primary responsibility for, and reports to the Infection Prevention and Control Group on all aspects of surveillance, prevention and control of infection within the Trust and Health Economy 2. The Team will minimise infection throughout the Trust, to provide a safe environment for patients, staff and visitors.
Risks title and number	5648 Currently unable to achieve CPE screening as recommended in updated CPE toolkit. 5682 The Trust is at risk of increased incidence of Healthcare Acquired Infections (HCAI) as there are a limited number of side rooms per se and a limited number of side rooms with ensuite facilities.
Meeting Purpose/Remit	The IPT Surveillance meeting is where the day-to-day operational aspects of infection prevention will be discussed and monitored by the IP Team and Consultant Microbiologists.
Responsibilities	Oversee the development and maintenance of an effective system of integrated governance, risk management and infection prevention across the Health Economy that supports the achievements of the healthcare providers' objectives through: 1. Ensuring that this system is designed to promote a learning organisation and culture, which is open and transparent, supportive of patients, staff and stakeholders, to minimise unnecessary duplications. 2. Taking overall responsibility for the strategic planning and performance monitoring of compliance with the Care Quality Commission and the Code of Practice 3. Ensure learning and any appropriate action is taken relating to external enquiries and national guidance. 4. Reviewing the effectiveness of the meeting to ensure members receive the appropriate support and training

	to undertake their roles as members of the Infection Prevention Team 5. Reviewing individual incidents and trends 6. Ensure effective links with the following committees/groups/projects: • Waste Management • Environmental • Clinical Practices, Policies and ratification • Building Projects • Matron's, , Midwifery & health visiting and allied health professionals' groupHealth and Safety • Water Safety group • Ventilation Safety group • Medical Devices • Sharps Management • Decontamination 7. Agree and monitor performance related to surveillance. 8. Produce an annual programme of work, education and training plan and audit programme. 9. Produce an annual infection prevention report.
Authority & Accountabilities	The IPT and Director of Infection Prevention and Control are accountable to Infection Prevention and Control group (IPCG). A service level specification is in place with the Black Country Integrated Care Board (ICB) to provide an Infection Prevention service for Primary Care Community Projects is jointly funded by the local UK Health & Safety Agency (UKHSA) and the Black Country ICB, this provides a place for innovation and improvement to raise the quality of the IP services.
Reporting Arrangements	• The IPT will report via the Infection Prevention monthly report to the Infection Prevention and Control Group, the Divisional Clinical Governance, the Matrons, Senior Nurse's, Midwifery, health visiting and allied health professional's meeting. • The report will include a summary report of IPT activities, issues which the IPT cannot resolve, or which have constituted a significant risk or untoward incident. • IPT Primary Care will report quarterly. Community outbreak information will be reported monthly to IPCG.

	• Ensure the minutes/notes of the meetings are formally recorded. Any items of specific concern, or which requires the Infection Prevention and Control Group approval will be included in the monthly IPT report to IPCG. • The IPT will produce a Health Economy Annual Infection Prevention report for Primary Care to include Community Projects and will be reported through IPCG. This will be signed off at Trust Management Committee
Membership	Director of Infection Prevention & Control Head of Nursing for Corporate Support Services Senior Matron Infection Prevention Matron Infection Prevention Operational Matron Infection Prevention Education and Innovation Consultant Microbiologists Infection Prevention Nurses and Practitioners Healthcare Assistants Infection Prevention Administration Support Data Analyst
Attendance	Other Clinicians, Managers, Company representatives will be invited to attend for specific items, and they will be advised accordingly
Chair	The Director of Infection Prevention and Control or a nominated deputy in their absence.
Quorum	Minimum of at least 4 members of the IPT, including the Chair or nominated deputy.
Frequency of meetings	Fortnightly for a duration of 1 hour and there must be no less than 24 meetings per year. If circumstances dictate, the meeting will be held more frequently
Administrative support	Infection Prevention Administration support will be responsible for: • Attending to take minutes/notes of the meeting. • Keeping a record of matters arising and issues to be carried forward. • Providing appropriate support for the Chair • Agreeing the agenda with the Chair • Collating papers for the meeting

Standards worked to	Code of Practice for Healthcare Associated Infection CQC Key Lines of Enquiry Infection Prevention Board Assurance Framework
Standard Agenda	*Clostridioides difficile* Meticillin Resistant *Staphylococcus aureus* (MRSA) Meticillin Sensitive *Staphylococcus aureus* (MSSA) Carbapenemase Producing Enterobacteriaceae (CPE) Device related Bacteraemia (DRB) Gram Negative Bacteraemia Outbreaks and Incidents High Risk MRSA patients Water Safety Ventilation Safety Respiratory Illnesses including COVID-19
Date Approved	
Date Review	August 2024

IP 08 Attachment 3

Policy Reference: IP 08

Document Title: Infection Prevention Policy Review/Audit Schedule

Policy	Evidence base	Maximum Review	Audit Frequency	Responsibility
Hand Hygiene IP01	EPIC Guidelines IPS* Hand Decontamination Guidelines Code of Practice for HCAI NICE Guidance 0139 (2012 updated 2017) WHO 5 Moments of Hand Hygiene	3 yearly	Monthly 5 moments via Trust electronic dashboard Senior Sisters/Charge Nurses/Department Managers	IPCG Matrons and Senior Nurse Meeting
Preventing infection associated with the Built Environment IP02	Health Building Note 00-09 (2013) Code of Practice for HCAI	3 yearly	During works	IPCG
Prevention of MRSA, VRE and Other antibiotic resistant organisms IP03	DH Guidelines Professional Bodies (IPS/HIS)	3 yearly	Monthly audit of MRSA screening compliance IP Team	IPCG
Transportation of clean and contaminated instruments, equipment and specimens IP04	HSE Guidance Health and Safety at work (1974) Code of Practice for HCAI	3 years	Biennial – IP Team	IPCG
Linen Policy IP05	HSE Guidance	3 yearly	Annual – IP Team	IPCG
Prevention, Management and Control of *Clostridioides difficile* IP06	Code of Practice for HCAI NHS England Guidance	3 yearly	Monthly via ICNet, dashboard and DIPC Performance Report	IPCG
Viral Haemorrhagic Fever IP07	DH Guidance		Following a case – IP Team	IPCG

Operational IP08	DH Guidance Operating frameworks Code of Practice for HCAI	3 yearly	Monthly update by Matron Infection Prevention	IPCG
Gloves IP09	EPIC Guidelines Code of Practice for HCAI NICE guidance O139 (2012 updated 2017)	3 yearly	Biennial External Company	IPCG
Isolation IP10	Hospital Infection Society Guidance	3 yearly	Annual IP Team	IPCG
Management of patients affected by common UK parasites IP11	PHE Guidance		Post outbreak – IP Team	IPCG
Standard Precautions IP12	EPIC Guidelines Code of Practice for HCAI	3 yearly	Annual - IP Team PPE audit monthly via Trust electronic dashboard – Senior Sisters/Charge Nurses/Department Managers	IPCG Matrons and Senior Nurses Meeting
Management of Communicable disease/Infection Prevention/Serious Incident Policy IP13	DH / PHE guidelines Code of Practice for HCAI	3 yearly	Post outbreak of infection RCA report - IP Team	IPCG Commissioning
Norovirus IP18	DH / PHE guidelines Code of Practice for HCAI		Post Norovirus outbreak RCA report - IP Team	IPCG

Blood and body fluid spillage management IP19	DH Guidance Health & Safety at Work (1974) COSHH (2002) NHS Executive (2000)	3 yearly	Biennial -IP Team	IPCG
Urinary Catheter Policy IP20	DH Guidance		Quarterly via electronic system and Matron Infection Prevention Report	IPCG
Transmissible Spongiforming Encephalopathies (TSE) IP21	DH Guidance	3 yearly	Report RCA/if a case is reportable.	IPCG Commissioning
Sharps HS03	EPIC Guidelines IPS Reducing sharps injury. Code of Practice for HCAI NICE guidance O139 (2012 updated 2017)	3 yearly	Annual External Company	IPCG Sharps Safety Group
MP05 Antimicrobial Prescribing		Annual	Quarterly audit – Pharmacy Prescribing Lead	IPCG Antimicrobial Stewardship Group

IP 08 Attachment 4

Policy Reference: IP 08

Key Performance Indicator Data Reporting and Frequencies

The Infection Prevention and Control Group receive all of the key performance indicators below in a set paper format at least quarterly. In addition, ward, matrons and Divisions are all monitored on the data below. The currently KPI detail is circulated annually through Divisions.

Data	Frequency	Report to	Presentation
Hand Hygiene Training compliance	Monthly	IPCG via Divisional Reports	Numbers of staff compliant with mandatory training
Antibiotic prescribing Training compliance	Monthly	IPCG via Microbiologist Report	Numbers of staff identified compliant with attendance of training
Environmental standards audit compliance	Monthly	Environment Group which reports to IPCG	Percentage and compliance rating by Ward/Department, Directorate and Division
Clostridioides difficile Infection (over 2 years of age)	Monthly	IPCG Trust Management Committee (TMC) / Trust Board –	Exact figures pre and post 48hour
New patients with MRSA (acquisition)	Monthly	IPCG via Microbiologist report Trust Management Committee (TMC) / Trust Board – through IQPR report	Exact figures and run chart overall Trust performance. Exact figures and SPC chart by Division/Department
MRSA Screening compliance in Emergency Portals	Monthly	IPCG	Compliance data for AMU, Stroke Unit, Cardiology, Paediatrics, Surgical Emergency Unit > 90%
MRSA Screening compliance for elective admissions	Monthly	IPCG	All elective admissions >90%
MRSA Bacteraemia	Monthly	IPCG TMC through performance report	Exact figures and run chart overall Trust performance. Exact figures and run chart

		Individual Wards / Units Trust Management Committee (TMC) / Trust Board – through IQPR report	per Division
MSSA bacteraemia	Monthly	IPCG Individual wards / Units Trust Management Committee (TMC) / Trust Board – through IQPR report	Exact figures and run chart overall Trust performance. Exact figures and run chart per division
CPE Positive Patients	Monthly	IPCG	Exact figures and run chart overall Trust performance. Exact figures and run chart per Division
Gram Negative bloodstream infections	Monthly	IPCG	Exact figures and run chart overall Trust performance. Exact figures and run chart per Division

Policy Reference: **IP 08**

Document Title: **Surveillance Protocol**

1. Introduction

Healthcare associated infection (HCAI) remains at an estimated prevalence of 8% nationally (Public Health England (PHE) 2016) . HCAI remains a threat to NHS Trusts in terms of finance, quality of services and reputation. Since 2000 there has been a recommendation that all UK trusts undertake regular and co-ordained surveillance programmes. This refers to surveillance on surgical sites and alert organisms and conditions.

In 2018 the mandatory programme of surveillance was reviewed by UK Health Security Agency (formerly PHE) , this now includes the following;

- All cases of *Staphylococcus aureus* including Meticillin Sensitive (MSSA) and Meticillin Resistant (MRSA) bacteraemia;
- All cases of *Clostridioides difficile* Infection in the over 2 year age groups;
- Serious incidents (SI);
- Certain Surgical site infections;
- *Escherichia coli;*
- *Klebsiella spp.;*
- *Pseudomonas aeruginosa;*
- Gram negative bacteraemia.

2. Aim / Purpose

The aim of this protocol is to identify the surveillance of infection required in order to provide adequate intelligence on which organisms require specific control measures, the identification of period of increased incidence, and early warning systems for outbreaks through the systematic collection of data over a period of time. ICNet is the electronic surveillance system purchased by the organisation to ensure prompt detection and a secure paper free system. This data will then inform the Infection Prevention Team (IPT) and IPCG as to the effect of the current Infection Prevention strategies and their need for modification.

The following policies must be referred to when operating this protocol:

- Outbreak of Communicable Disease IP13
- Antibiotic Resistant Organisms IP03
- Norovirus IP18
- *Clostridioides difficile* Infection IP06

3. Alert organism surveillance

3.1. The IPTwill identify alert organisms from the laboratory using an electronic system on a continuous basis and advise on their prevention of spread.

3.2. The alert organisms will include as a minimum:

3.2.1. New patient isolates of MRSA;

3.2.2. MRSA isolated from any blood culture;

3.2.3. MSSA isolated from any blood culture;

3.2.4. New patients identified with *Clostridioides difficile* infection (and those with a previous positive result of more than 28 days since the last).

3.2.5. Multi-resistant Gram-negative organisms including ESBL producing organism and multi-resistant *Acinetobacter* spp;

3.2.6. Group A Streptococci isolates;

3.2.7. Organisms producing gastroenteritis e.g. Rotavirus, Norovirus etc.;

3.2.8. Glycopeptide resistant Enterococci;

3.2.9. Penicillin resistant Pneumococci;

3.2.10. *Mycobacteria tuberculosis;*

3.2.11. *E. coli* bacteraemia;

3.2.12. *Klebsiella spp.* bacteraemia;

3.2.13. *Pseudomonas* bacteraemia;

3.2.14. Listeria;

3.2.15. Candida albicans;

3.2.16. Candida auris;

3.2.17. Mycobacterium Chimaera;

3.2.18. *Carbapenemase producing Enterobacteriaceae* (CPE);

3.2.19. Influenza, RSV,COVID-19;

3.2.20. All other statutory notifiable organisms, new and emerging organisms as required and other non-notifiable organisms with the potential to cause outbreaks (e.g., Legionella spp) or which indicate lapses in infection prevention and control practice.

3.3. Outbreaks identified through alert organism surveillance will be managed in accordance with the Outbreak of Communicable Infections Policy IP13

3.4. Alert organisms monitored through the trust's key performance indicators will be provided monthly by the DIPC in the form of run charts or statistical process control charts. This data will be circulated widely amongst divisions and directorates monthly and presented and discussed routinely at IPCG

3.5. Where statistical process control charts are used an escalation plan will be followed if numbers exceed control limits.

4. Alert Condition Surveillance

4.1. Alert conditions will usually be identified on a clinical level (and the Infection Prevention Team will be notified by clinical staff) and will be recorded on the electronic surveillance system ICNet.

4.2. Outbreaks of alert conditions will be managed according to the Outbreak of Communicable Infection Policy IP13.

4.3. Alert conditions will consist of the following as a minimum:

4.3.1. Diarrhoea and / or vomiting with no clinical reason other than a probable infectious organism;

4.3.2. Device related healthcare acquired bacteraemia (DRHABS);

4.3.3. Ventilated Associated Pneumonia (VAP);

4.3.4. Confirmed or suspected case of the following: chickenpox, Tuberculosis, influenza, shingles, measles, mumps, rubella, meningitis or Legionella.

NB This list is not exhaustive.

5. Surgical Site Infection Surveillance

5.1. The Trust routinely undertakes surgical site infection surveillance on knife-to-skin procedures. Information is fed back to appropriate Clinical Directors via the Divisional Medical Director for Division 1.

5.2. All communication of reports from the UKHSA SSISS data and the Surgical Site Infection Surveillance Team will be directed to the Infection Prevention Team and DIPC, who will hold confidential data on surgeon codes. The data will be forwarded immediately to the Clinical Director who will take responsibility or the feedback of data to the relevant clinical teams.

5.3. The Infection Prevention Team/Surgical Site Infection Surveillance Team (SSI) will provide support in the education, development, analysis and action planning to reduce/implement surgical site infections to all areas undertaking surgical site infection surveillance. The SSI Team will undertake further surgical site surveillance in response to urgent need for specified time periods an in accordance with the priorities of the Trust. This prioritisation, where required will be debated through the IPCG.

6. References

Healthcare associated infections (HCAI): guidance, data and analysis - GOV.UK (www.gov.uk) Updated September 2023

Policy Reference: IP 08

Document Title:

Standard Operating Procedure for *Clostridiodes difficile* to be used in conjunction with *Clostridiodes difficile* policy IP06

1. Laboratory informs of *Clostridioides difficile* (CDI) positive result for an in-patient or a patient in the community. Result available promptly on ICNet surveillance system for IP Team to action.

- Phone call to wards during weekends.
- ICNet data transfer from laboratory.

2. Following a positive result, the IPN/Practitioner within the relevant team will implement this SOP for management (Mon – Sun 9-5pm).

Locations include:

A RWT, West Park Hospital and Cannock Chase Hospital;
B Primary care – Wolverhampton GP sample;
C Over - border patient;

Locations A and B: IPN within relevant team to follow SOP.

Location C: Over border patient – IPN/Practitioner within relevant team to contact neighbouring Trust's IP team and document referral if discharged.

IN-PATIENT – RWT

Contact the ward and inform of *Clostridioides difficile* positive result to enable patient isolation and a clinical decision for treatment based upon RWT CDI treatment and referral algorithm (IP06). The team IPN/Practitioner e-mails Senior Sister/Charge Nurse/Department Manager and agreed email cascade with patient notification to include: Consultant, Divisional Head of Nursing and Divisional Managers, Matron for area relevant Divisional IP team and Governance lead.

Ward area to be visited by IPN/Practitioner within 2 hours of result or next working day if late results are reported, and to complete the following:

- IPN would expect to see the patient in isolation within 2 hours of result;
- IPN to observe that treatment has been written up and is on the ward and ready to administer within 2 hours of result;
- Complete XP's on ICNet.
- Patients to be monitored at least twice weekly to ensure isolation, treatment and condition is reviewed.

IN-PATIENT – West Park/Cannock Hospital

Contact the ward and inform of *Clostridioides difficile* positive result to enable patient isolation and a clinical decision for treatment based upon RWT CDI treatment and referral algorithm (IP06). The team IPN/Practitioner e-mails Senior Sister/Charge Nurse/Department Manager and agreed email cascade with patient notification to include Consultant, Divisional Head of Nursing and Divisional Managers, Matron for area relevant Divisional IP team and Governance.

Ward area to be visited by an IPN/Practitioner at the earliest opportunity to discuss the patient with nursing and medical staff, and to complete the following:

- IPN/Practitioner would expect to see the patient in isolation within 2 hours of result.
- IPN/Practitioner to observe that treatment has been written up and is on the ward and ready to administer within 2 hours of result.
- Complete XP's on ICNet.

PRIMARY CARE – Wolverhampton GP

The IPN from the relevant team must contact GP and patient within 24hrs to arrange treatment and ensure patient is well in themselves.
Weekly phone calls to the patient for up to four weeks to ensure that they are improving.

For **ALL** *Clostridioides difficile* cases the IPN/Practitioner must complete ICNet extended properties/questions on the day of isolate or next working day and complete the enhanced CDI audit tool to ensure environmental standards are maintained. This can be located under Results on ICNet.

NB: The enhanced environmental audit must be completed on the ward where the patient is and also if the incident is attributable to a different ward/department then the enhanced environmental audit must be completed on that area.

Speak to the patient to reiterate information given by ward staff. A patient information leaflet must be provided for patients and their family if one has not been given already.

Letter to patient's GP informing them of CDI sent by Infection Prevention admin. staff if out of area or e mail if Wolverhampton GP and uploaded to Clinical Portal.

Clostridioides difficile ward round scheduled weekly to include

IPN with Microbiologist and representative from the clinical or ward team This will be documented in the medical record.
Patients who are asymptomatic or recovered will be reviewed and discharged from the CDI ward round.

NB: At West Park Hospital and Cannock Chase Hospital, a time will be agreed when the Microbiologist can telephone and discuss the patient with an IPN and Clinician.

1. CDI investigation findings to be shared with clinical teams for information and on-going management. Report any issues to nurse in charge at time of ward round.
   Following identification of CDI, the patient is to be moved from the single room and relocated into a clean side room on a weekly basis whilst they remain symptomatic, if capacity allows.
   The single room transfer is to include clean equipment, bed, locker chair etc. to reduce potential for re-infection for the patient where the environmental bio burden will potentially remain within the single room. Hydrogen Peroxide Vapour (HPV) must be used for the vacated room for decontamination.

2. At the point of transfer/discharge or resolution of symptoms the patient will be discharged from the IP caseload following risk assessment on a case by case basis by
   the IPT. Monitoring and recording of bowel habits and high risk antibiotic use must continue until discharge.
   When patient has been discharged, check the Discharge Summary on Clinical Portal to ensure that CDI has been documented.
   The relevant IP Team where the patient is being discharged from must continue to follow them up in the Community for at least 4 weeks (if patient registered with a Wolverhampton GP).

   Routine environmental cleaning for patients with CDI requires a freshly prepared combined detergent and hypochlorite solution for each room.

   Following discharge or transfer from single room the vacated room must be cleaned as per Trust policy IP06 using HPV as the preferred method /first choice for environmental decontamination, where CDI is confirmed or suspected.
   A combined detergent and hypochlorite solution remains the next level of recommended decontamination following CDI and must take place prior to use of the single room for another patient. If HPV was not possible this must be completed as quickly as possible either by moving the newly admitted patient to a new single room or to arrange for HPV following this discharge if the patient is potentially a short-term admission.
   Failure to decontaminate with HPV must be reported to the IPT with rationale for why.
   this was not achieved. This data must be recorded on ICNet and will be reported.
   monthly to IPCG via the CDI dashboard.
   Where confirmed or suspected CDI patients are nursed in an open bay

and
subsequently isolated or discharged (including retrospective laboratory confirmation of
CDI) the method of cleaning of that area will need to be discussed with the IP team on
a case-by-case basis and a decision will be made based on risk. Where there are
concerns regarding duration and frequency of diarrhoea in a bay then HPV must be
considered.

5. Incidence of *Clostridioides difficile* to be reviewed monthly at Infection Prevention Surveillance meetings to identify IP actions, and any trends, actions or learning points to be reported and fed into IPCG.

6. Periods of Increased Incidence (PII) involving 2 possibly related positives by any method within a 28 day period will be subject to the Escalation Plan as outlined in the *C. difficile* Policy **[IP 06 Attachment 9]**. PII must be managed by the Clinical Lead, Matron, and senior ward sister/charge nurse/departmental manager with support from the Infection Prevention Team and progress fed back via the Divisional report to the IPCG.

   If transmission is confirmed via enhanced ribotype and fine typing, an SI should be raised Outbreaks must be managed in line with Trust Policy and will be guided by the IP Team.

7. Fine typing for historical cases of CDI to identify any transmission – do not need to be reported as an SI if more than 3 months ago as this is enhanced surveillance and wouldn't be reported by other Trusts.

8. Ward teams, where possible, or the bereavement office must notify the IPT where CDI appears as part 1 or 2 of the Death certificate to enable a review of the circumstances related to the patient's death and initiate the incident reporting process & RCA if required OR the Team IPN must ring bereavement office to ask if CDI is on any part of the Death certificate.

   Part 1a
   Cases where death is attributable to *Clostridioides difficile* and recorded as **part 1a** on the death certificate will automatically be graded as a RED incident and be reportable to UKHSA and ICB as a Serious Incident as per Trust policy. The SI will require a Datix report, 48 hour report, a Post Incident Review meeting and an investigation led by the clinical area and supported by Infection Prevention. A 30-day report and action plan will need to be produced for internal learning purposes and will need submitting to Commissioners by Governance within the specified timeframe.

The Datix should include: ***Clostridioides difficile*** **has been recorded as Part 1a on the death certificate as a contributory cause of death. This decision has been agreed with the Consultant Microbiologist and therefore an investigation is required.**

Where the Consultant Microbiologist disagrees with the decision, a Datix will be completed and the following should be stated: ***Clostridioides difficile*** **has been recorded as Part 1a on the death certificate as a contributory cause of death. Consultant Microbiologist disagrees with Part 1b decision and does not concur that *Clostridioides difficile* was a contributory cause of death, therefore an investigation is required.**

Part 1b

Cases where death is attributable to *Clostridioides difficile* and recorded as **part 1b** on the death certificate and has been **agreed as appropriate recording with the medic involved and following discussion with the Consultant Microbiologist** will require a Datix report, 48hr report and an investigation led by the clinical area and supported by Infection Prevention. A 30-day report and action plan will need to be produced for internal learning purposes. This will need to be submitted to Divisional Governance meeting for lessons learnt to be implemented.

The Datix should include: ***Clostridioides difficile*** **has been recorded as Part 1b on the death certificate as a contributory cause of death. This decision has been agreed with the Consultant Microbiologist and therefore an investigation is required.**

Where the Consultant Microbiologist disagrees with the decision, a Datix will be completed, and the following should be stated: ***Clostridioides difficile*** **has been recorded as Part 1b on the death certificate as a contributory cause of death. Consultant Microbiologist disagrees with Part 1b decision and does not concur that *Clostridioides difficile* was a contributory cause of death, therefore an investigation is not required.**

Part 1c

Cases where death is attributable to *Clostridioides difficile* and recorded as **part 1c** on the death certificate and has been **agreed as appropriate recording with the medic involved and following discussion with the Consultant Microbiologist** will require a Datix report, 48hr report and an investigation led by the clinical area and supported by Infection Prevention. A 30-day report and action plan will need to be produced for internal learning purposes. This will need to be submitted to Divisional Governance meeting for lessons learnt to be implemented.

The Datix should include: ***Clostridioides difficile*** **has been recorded as Part 1c on the death certificate as a contributory cause of death. This decision has been agreed with the Consultant Microbiologist and therefore an investigation is required**

Where the Consultant Microbiologist disagrees with the decision, a Datix will be completed, and the following should be stated:
Clostridioides difficile **has been recorded as Part 1c on the death certificate as a contributory cause of death. Consultant Microbiologist disagrees with Part 1c decision and does not concur that *Clostridioides difficile* was a contributory cause of death, therefore an investigation is not required**

Death in community

Where there is a death of a patient in a Wolverhampton community setting, including residential and nursing care homes, and *Clostridioides difficile* has been recorded as **Part 1a, 1b, 1c or 2** on the death certificate, an incident will be raised with the ICB for reporting purposes and an investigation will be undertaken where it is deemed appropriate by the Consultant Microbiologist.
Infection Prevention will liaise with the GP involved for information on death certificate details.

Avoidable/Unavoidable cases

CDI Toolkits are generated at the beginning of every month from data from the previous month by the Data Analyst.
The training compliance data is generated by the Data Analyst and manually added to the Toolkits.
The IPN responsible for the CDI Toolkits will request environmental results from Hotel Services and manually add to the Toolkits.
Trust attributed CDI cases will be reviewed at the second Infection Prevention Surveillance meeting of every month to determine avoidable/unavoidable cases.
Monthly e mail to be sent out to Senior Management and relevant areas regarding attribution and avoidable/unavoidable of Trust attributed cases.
Toolkits are sent quarterly to the ICB bcicb.pqtwolverhampton@nhs.net outlining any lapses in care and avoidable/ unavoidable outcomes for further discussion at ICB level

Protocol 1

Policy Reference: **IP 08**

Document Title:

Meticillin Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

Post 48 hours after admission (internal reporting)

E mail to be sent to:
Ward Senior Sister/Charge Nurse
Matron
Divisional Head of Nursing
Group Manager
Consultant
Infection Prevention generic e mail
Relevant IP Team
Matron – IP
Head of Nursing – Corporate Support Services
Microbiologists

Infection Prevention Team
DATIX Incident immediately linking incident to appropriate ward/department and to Matron - IP who will then assign Handler as Sister/Charge Nurse/Department Manager

↓

Infection Prevention Team
rwh-tr.InfectionPrevention@nhs.net
E mail request for 30 day report to appropriate staff (Ward Senior Sister /Charge Nurse /Matron etc.) and give information regarding DATIX.
Attach 48hr completed report and 30 day MSSA report template

↓

Infection Prevention Team
Complete 48 hour report; send to Matron IP who will attach to Datix and to Sister/Charge Nurse/Department Manager for information
IP to complete XPs on ICNet
IPN to visit ward to complete a short observational audit around ANTT, Catheter Management, Devices as appropriate and report immediate findings to nurse in charge

↓

Ward Senior Sister/Charge Nurse/Department Manager
Complete 30-day MSSA report and return ahead of IP incident review meeting for

Ward Senior Sister/Charge Nurse/Department Manager/Matron
Present 30 day MSSA report & findings at Local Governance meeting
Attend IP incident review meeting as per invitation to present report.
Decision to made re harm of patient and Datix updated accordingly

↓

Infection Prevention Team
Collate actions following IP incident review meeting and present at IPT Surveillance meeting and agree actions for IP Team

Matron
Final 30 day Report/Action Plan completed and presented at Divisional Governance for formal sign off
Duty of Candour to be issued as required

↓

Divisional Lead
Present 30 day report and Action Plan at IPCG as part of the Divisional Report

Protocol 2

Policy Reference: **IP 08**

Document Title: **Device Related Bacteraemia (DRB) (internal reporting)**

(not including MSSA Bacteraemia as this is captured in Protocol 1)

E mail to be sent to

Ward Senior Sister/Charge Nurse
Matron
Divisional Head of Nursing
Consultant
Infection Prevention generic e mail
Relevant IP Team
Matron IP

IV Team
DATIX Incident immediately linking incident to appropriate ward/department and Lead Nurse – IVRT who will assign Handler as Sister/Charge Nurse/Department Manager

↓

IV Team
E mail request for RCA to appropriate staff (Ward Sister/Charge Nurse/Matron etc) and inform re DATIX
Attach DRHAB Tool

↓

IP Team
rwh-tr.InfectionPrevention@nhs.net
Member of the IP to visit the ward to complete a short observational audit around ANTT, Catheter Management, Devices as appropriate and report immediate findings to nurse in charge.
Invite ward team to an IP incident review meeting

↓

Ward Senior Sister/Charge Nurse/Department Manager
Complete RCA within 30 working days and return to IP ahead of IP Incident Review meeting

↓

Infection Prevention Team
Collate actions from IP incident review meeting and present findings at IPT Surveillance meeting with actions.
Decision to made re harm of patient and Datix updated accordingly

Matron
Final RCA Report/Action Plan completed and presented at Divisional Governance and formal sign off
Learning shared with relevant clinical team Duty of Candour to be issued as required

↓

Divisional Lead
Present RCA report and Action Plan at IPCG as part of the Divisional Report

Protocol 2

Policy Reference: **IP 08**

Document Title:

Device Related Community Acquired Bacteraemia (DRCAB)
Ulcer Related Community Acquired Bacteraemia (URCAB)
(internal reporting)

(not including MSSA Bacteraemia as this is captured in Attachment 8)

E mail to be sent to

Community Team Manager
Matron for ACS
Divisional Head of Nursing
Consultant
Infection Prevention generic e mail
Relevant IP Team
Community IP Team
Matron IP

Infection Prevention Team
Contact Senior Matron for Adult Community Services (ACS) by email to confirm attribution (cc Microbiologist & IVRT)
DATIX Incident linking to appropriate Community Team and Lead Nurse – IP Matron will assign Handler as Community Team Manager

Infection Prevention Team
E mail request for an investigation to appropriate staff (Community Team Manager, Matron etc) and inform re DATIX
Attach DRCAB/URCAB document
Enter on to ICNet under "conditions"

Infection Prevention Team
rwh-tr.InfectionPrevention@nhs.net
If the patient is a resident from a care home, Community IP Team to be informed and to arrange a visit to complete a short observational audit around ANTT, Catheter Management, Devices as appropriate and report immediate findings to Care Home Manager and Community Team Manager

Community Team Manager
Complete document within 30 working days and return to IP ahead of the Incident Review meeting

Infection Prevention Team
Collate actions from IP Incident Review meeting and present findings at IPT Surveillance meeting with actions.
Decision to made re harm of patient and Datix updated accordingly

Matron
Final RCA Report/Action Plan completed and presented at Divisional Governance and formal sign off
Learning shared with relevant clinical team Duty of Candour to be issued as required

Divisional Lead
Present RCA report and Action Plan at IPCG as part of the Divisional Report

Protocol 3

Policy Reference: IP 08

Document Title: Healthcare Associated Infections (HAI) - Serious Incident (SI)

(external reporting)

Trust attributable MRSA Bacteraemia
Clostridioides difficile on 1A of death certificate

2 *Clostridioides difficile* with same Ribotype and fine typing Outbreaks
HAI on 1a of death certificate
CPE Positive result with evidence of transmission following contact screening
COVID-19 Outbreak *(see Attachment 12a)*

E mail to be sent to
Director of Nursing
Senior Sister/ Charge Nurse
Matron
Divisional Head of Nursing
Deputy Chief Operating Officer
Group Manager
Consultant
Pharmacist
Microbiologists
UKHSA (West Midlands)
Wolverhampton ICB
Hotel Services
Infection Prevention generic e mail
Director – Chair
Senior Matron – IP or Representative
Head of Nursing – Corporate Support Services
Relevant IP Team

Infection Prevention Team
Collate findings/ actions from IP incident review meeting and present at IP Surveillance

Disseminate Lessons Learnt to the Trust by including it in planned education and ad hoc sessions

Policy review if required

Take any findings to Matron Group

Infection Prevention Team
rwh-tr.InfectionPrevention@nhs.net
DATIX Incident immediately linking incident to appropriate ward/department and to Matron IP who will then assign Handler as Sister/Charge Nurse/Department Manager
Senior IPN to inform Governance via rwh-tr.SUIReporting@nhs.net to raise incident on STEIS as an SI
E mail request for 30 day report/RCA to appropriate staff and give information regarding DATIX and SI.
Complete 48 hour report and return to Matron IP who will attach to DATIX and rwh-tr.SUIReporting@nhs.net
IPN to visit the ward to complete a short observational audit around ANTT, Catheter Management, Devices as appropriate and report immediate findings to nurse in charge

↓

Infection Prevention Team/IP Admin
Incident meeting to be arranged
A meeting Chair **must** be identified (Director Led)
Directorates must be represented – if no representation then meeting should be rearranged
Consultant Microbiologist **must** be in attendance

↓

Director/Matron/Ward/Department Manager/IP/Clinician
Attend the Post Incident Review (PIR) Meeting, review incident and assign a Lead Investigator.
Agree Action Plan following PIR Meeting
Ensure completion of the RCA and 30 working days report and return to Governance

↓

Directorate Representative
Present 30 day report/RCA/Action Plan at Local Governance and IP incident meeting as invited
Decision to made re harm of patient and Datix updated accordingly

↓

Matron/Ward/Department Manager
Final 30 day report/RCA/Action Plan completed and presented at Divisional Governance and formal sign off.
Duty of Candour to be issued as required

↓

Divisional Lead
Present RCA/findings and Action Plan at IPCG as part of the Divisional Report

The Royal Wolverhampton NHS Trust

IP Attachment 10

Protocol 4

Policy Reference: IP 08

Document Title: Period of Increased Incidence (PII)

(internal reporting)

2 cases of a specific organism in a ward within a 28 day period e.g., CDI, MRSA Acquisition,
COVID-19
2 DRHABs in a ward within a 28 day period

E mail to be sent to
Director of NursingSenior Sister/ Charge Nurse
Matron
Divisional Head of Nursing
Deputy Chief Operating Officer
Group Manager
Consultant
Pharmacist
Microbiologists
UKHSA (West Midlands)
(TB only)
Wolverhampton ICB (TB only)
Hotel Services
Infection Prevention generic e mail
Director – Chair
Senior Matron – IP or Representative
Head of Nursing – Corporate Support Services
Relevant IP Team

Infection Prevention Team

Collate findings/ actions from scrutiny meeting and present at IP Surveillance

Disseminate Lessons Learnt to the Trust by including it in planned education and ad hoc sessions

Policy review if required

Take any findings to Matron Group

Infection Prevention Team
rwh-tr.InfectionPrevention@nhs.net
DATIX Incident immediately linking incident to appropriate ward/department and to Nurse Manager IP who will then assign Handler as Ward/Department Manager
E mail request for 30 day report to appropriate staff (Ward Manager/Matron etc.) and give information regarding DATIX
Complete 48 hour report and return to Matron IP who will attach to DATIX
IPN to visit the ward to complete a short observational audit around ANTT, Catheter Management, Devices as appropriate and report immediate findings to nurse in charge

↓

Infection Prevention Team/IP Admin
Incident meeting to be arranged
A meeting Chair **must** be identified
Directorates must be represented – if no representation then meeting should be rearranged
Consultant Microbiologist **must** be in attendance

↓

Director/Matron/Ward/Department Manager/IP/Clinician
Attend the PII Meeting, review incident and assign a Lead Investigator.
Agree Action Plan following Meeting
Ensure completion of the RCA and 30 working days report and return to Governance

↓

Directorate Representative
Present 30 day report/Action Plan at Local Governance
Attend IP incident review meeting as invited and present RCA and action plan
Decision to made re harm of patient and Datix updated accordingly

↓

Matron/Ward/Department Manager
30 day Report/Action Plan completed and presented at Divisional Governance and formal sign off.
Duty of Candour to be issued as required

↓

Divisional Lead
Present RCA/findings and Action Plan at IPCG as part of the Divisional Report

The Royal Wolverhampton NHS Trust

IP Attachment 11

Suspected/ Confirmed case of Viral Haemorrhagic Fever (VHF) including Ebola Virus Disease (EVD)

Infection Prevention Team informed by Microbiology or clinical area if a suspected case of EVD

EVD is a viral haemorrhagic fever (VHF), characterised by sudden onset of fever, intense weakness, muscle pain, headache and sore throat

This is often followed by vomiting, diarrhoea, and sometimes internal and external bleeding

Initial symptoms are generic and can be misdiagnosed (esp. malaria)

The incubation period is 2-21 days

There is currently no effective treatment or vaccine for Ebola that is commercially available

Spread: Direct contact with blood or body fluids incl. droplet sprays (through broken skin or mucous membranes) and indirect contact via contaminated environments

↓

Infection Prevention Team

IMMEDIATE ADVICE for clinical area:

1) **IMMEDIATE** strict single room isolation requirements (including en suite facility/ dedicated commode)
2) **Source PPE pack from Emergency Department.** Standard precautions for direct and indirect contact, to include fluid repellent gown, plastic apron, double gloves, eye protection, FFP3 respirators and leg/feet protectors. This includes domestic staff who will undertake the terminal clean. PPE **MUST** be donned and removed according to policy to avoid contamination of clothing/hands during removal.
3) **ALL waste must be disposed of into orange clinical waste stream and MUST NOT be removed from the patients room until IP advise otherwise**
4) Advise to restrict staff entering the patients room to a core group only
5) **Please refer to IP07** and Inform the Infection Prevention Matron/ Head of Nursing Corporate Support Services of the incident

↓

Infection Prevention Team/ Microbiology

1) Liaise with Microbiology to discuss case, history and signs & symptoms to determine if suspected case or improbable
2) Microbiologist/ Lead Consultant to discuss possible transfer to an appropriate Infectious Disease Unit

↓

Clinical areas

Record and monitor all Health Care Worker contact with EVD patients, especially those who have unprotected contact

↓

Infection Prevention Team

Ensure environmental decontamination occurs using:

1) Manual clean using hypochlorite solution, at a concentration of 10,000ppm where blood is evident
2) Hydrogen Peroxide Vapour (HPV) to include **all medical equipment/ bagged clinical waste/ sharps** which **MUST** remain in the room until decontamination has been completed
3) Waste must be disposed of in line with National Policy
4) **Refer to Policy IP12 Appendix 1** for instruction on how to apply and remove PPE appropriately http://intranet.xrwh.nhs.uk/pdf/policies/IP_12_Appendix1.pdf
5) Ensure incident is recorded on ICNet for data capture purposes

COVID-19 HCAI and Outbreak Protocol

Definition of COVID HCAI

Hospital-onset probable/definite healthcare-associated – first positive specimen date 8 days or more after admission to the Trust

Definition of COVID outbreak

2 or more cases in an area at a period of time, 1 of which is an HCAI.

(See also Attachment 12a)

E mail and invite to meeting to be sent to:

Director of Nursing
Senior Sister/ Charge Nurse
Matron
Divisional Head of Nursing
Divisional Medical Director
Deputy Chief Operating Officer
Group Manager
Consultant
Microbiologists
Infection Prevention (generic email)
Matron – IP
Head of Nursing – Corporate
Relevant IP Team
Occupational Health & Wellbeing
Antimicrobial Pharmacist
Hotel Services
Public Health Wolverhampton
Wolverhampton ICB
NHS E/I
Health & Safety
Emergency Planning
Communications

Infection Prevention Team

IIMARCH form to be completed for 28 days and returned by 11am to england.mids-incident@nhs.net

Collate findings/ actions from meeting and present at IP surveillance.

Infection Prevention Team

rwh-tr.InfectionPrevention@nhs.net

DATIX incident immediately linking incident to appropriate ward/department and to IP Matron who will then assign ward/department manager as Handler

Complete 48 hour report for outbreak only and send to IP Matron to upload to Datix and appropriate staff (Sister/Charge Nurse/Matron etc.) Include 30 day report template

IPN to visit the ward to complete environmental, PPE, social distancing and hand hygiene audits and report findings to the nurse in charge

Contact PHE/HPT of outbreak via email wm.2019cov@phe.gov.uk and obtain reference number.

Complete IIMARCH form and send to england.mids-incident@nhs.net

Infection Prevention Team/IP Admin – For outbreak only

meeting to be arranged

IP to confirm a list of invitees

Chair identified

Ward must be represented – if no representation then meeting should be rearranged

Consultant Microbiologist **must** be in attendance

Agenda and 48 hour report to be sent to invitees

Matron/Ward/Department Manager/Clinician/IP

Attend the Teams meeting to review the incident and agree if any adverse effects on patient and if so a 30 day report is requiredIf a 30 day report is requested it should completed and returned to IP and Governance

Ward Representative

Present exception at IP meeting

Ensure Duty of Candour requirements are met, if required

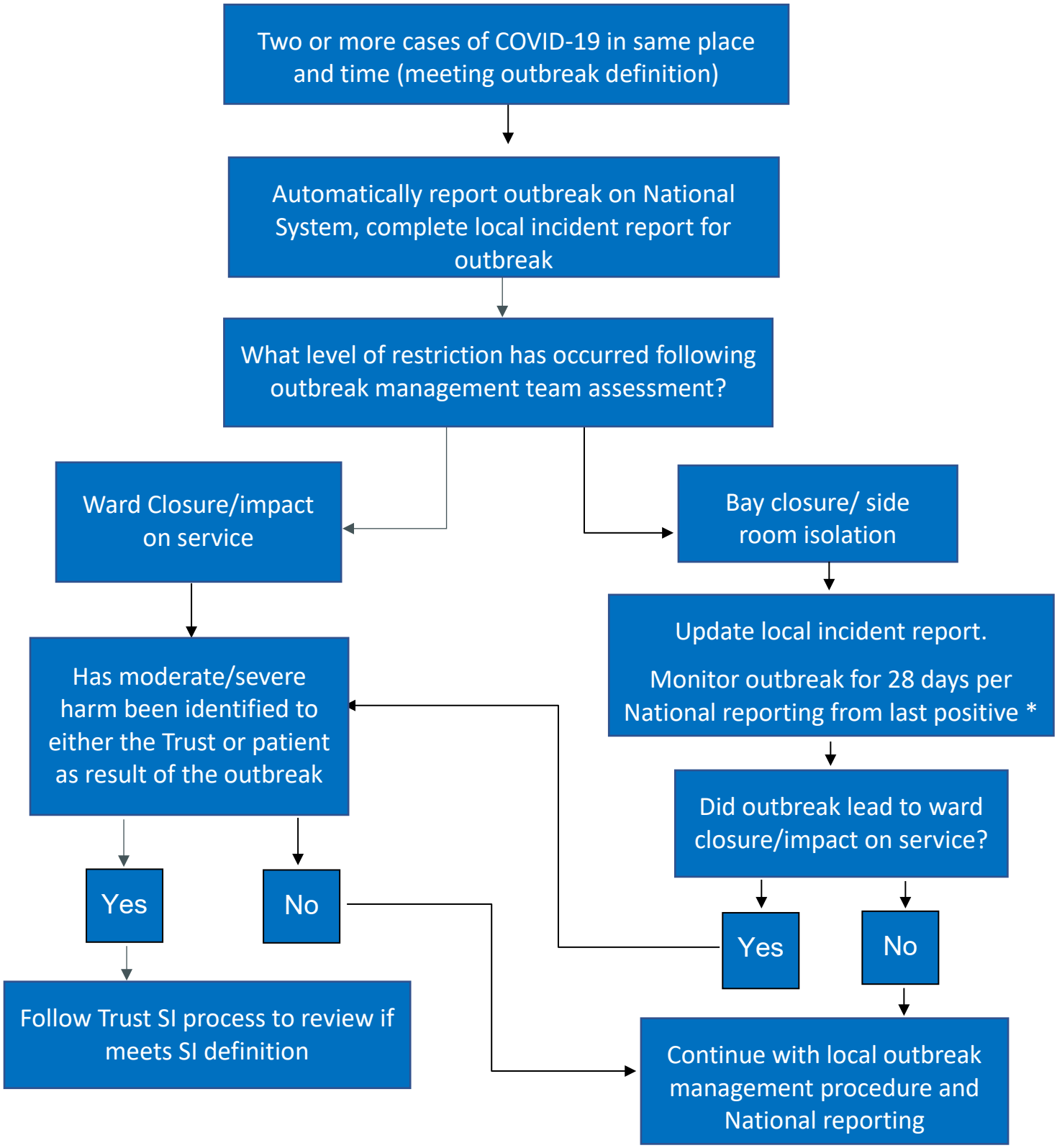
Matron/Ward/Department Manager

If a 30 day report is requested it should be completed and presented at Divisional Governance for formal sign off

Divisional Lead

Present report/findings and action plan at IPCG as part of the Divisional Report

COVID-19 Outbreak Serious Incident (SI) reporting process for the Black Country System



***Outbreak may be closed earlier as per local risk assessment and supported by NHSE/UKHSA. Positive case(s) identified post outbreak closure but within 28 days would require assessment of true link between time and place.**

IP 08

Lessons Learnt and sharing best practice.

1. Introduction

Like surveillance, reviewing incidents has proven to be useful in developing an understanding of specific infections and action planning against both their recurrence and strategic planning against consistent cause of infection. The processes explained in this protocol assist ensuring patient safety is optimised; the organisation is assured that avoidable infections are not repeated, and patients have confidence in the organisation as infections are minimised. A resulting fall in infections results in the appropriate use of resources and improved quality of services.

1.1 Currently 48hr and 30-day reports are used at Royal Wolverhampton NHS Trust for the following Infection incidents:

1.2 MSSA bacteraemia.

1.3 *Clostridioides difficile* where CDI is part 1 on the death certificate (Part 1a as standard, Parts 1b and 1c where the Consultant Microbiologist agrees with the recording on the death certificate).

1.4 Outbreaks and incidents as directed by the IPCG, or Serious incident policy OP10;

For MRSA bacteraemia a Post Infection Review (PIR) document is completed by the IP team in conjunction with the clinical teams

For Device Related Healthcare Associated Bacteraemia (DRHAB) a specific document has been designed and sent out for the clinical teams to complete

2. Principles for investigation

Three principles - React, Record and Respond.

2.1 React

- Immediate care needs must be identified.
- Commence immediate treatment and management of the infection.
- Action is taken immediately on any identified problems.

2.2 Record

- Data must be captured in a timely manner.
- The patient's journey must be mapped.

- Problems, contributory factors and root causes must be identified.

2.3 **Respond**

- The lessons learnt and best practice shared at the IP incident review meeting
- Organisational themes and trends must be acted on.