Pwyllgor Iechyd a Gwasanaethau Cymdeithasol

HSS(2)-10-05(p.3c)

Dyddiad: Dydd Mercher 5 Hydref 2005
Lleoliad: Ystafelloedd Bwyllgora 3&4, Cynulliad Cenedlaethol Cymru
Teitl: Haint a Gafwyd yn yr Ysbyty: Tystiolaeth gan Dr D Nicholas Looker, Microbiolegydd Ymgynghorol Anrhydeddus/Meddyg Rheoli Heintiau Ymddiriedolaeth GIG Siroedd Conwy a Dinbych

Crynodeb Gweithredol

Ehangder y Broblem

Asesir ehangder y broblem o heintiau a ddelir mewn ysbytai a heintiau eraill yn ymwneud â gofal iechyd (HCAI) gan y broses o wyliadwriaeth. Gwneir hyn mewn dwy ffordd yn Ymddiriedolaeth GIG Siroedd Conwy a Dinbych.

1. Gwyliadwriaeth Orfodol

Mae'n rhaid i Ymddiriedolaethau GIG gymryd rhan mewn 4 maes allweddol o ofal iechyd gorfodol sy'n gysylltiedig â gwyliadwriaeth heintiau gan Lywodraeth Cynulliad Cymru, sef:

- Heintiau llif *gwaed Staph aureus* (Atodiad 1)
- Heintiau safleoedd llawfeddygol orthopedeg (Atodiad 2)
- Adroddiadau dechreuol (Atodiad 3)
- Haint *Clostridium difficile* (Atodiad 4)

2. Astudiaeth Pwynt Cyffredinolrwydd (Atodiad 5)

Fel rhan o weithredu Strategaeth Haint Cysylltiol Gofal Iechyd Cymru, mae'r Ymddiriedolaeth wedi ymgymryd ag astudiaeth pwynt cyffredinolrwydd. Mae hyn yn darparu ciplun o'r heintiau sydd wedi digwydd ymysg cleifion mewnol Ymddiriedolaeth Conwy a Dinbych ar ddiwrnod penodol ac yn galluogi gwahaniaethiad rhwng heintiau a ddelir mewn ysbytai a heintiau a ddelir yn y gymuned ar gyfer bob cyfarwyddiaeth glinigol, ynghyd â gwybodaeth syml ar ffactorau risg.

Yn ogystal â hyn, mae'r Adran Microbioleg yn monitro data ar ddiagnosis labordy o heintiau. Mae defnyddio dulliau safonol yn galluogi monitro tueddiadau dros amser. Mae Atodiad 6 yn dangos y cynnydd mewn arwahanu labordy o haint a chytrefiad Metisillin Ymwrthol *Staphylococcus aureus* (MRSA) ers 1994.

Mesurau sy'n cael eu cymryd i fynd i'r afael â'r haint a ddelir mewn ysbytai

Mae gan Ymddiriedolaeth GIG Siroedd Conwy a Dinbych hir hanes o reolaeth haint ysbyty effeithiol gyda Thîm Rheoli Haint a Phwyllgor Rheoli Haint wedi'i sefydlu yn gynnar yn yr 1980au. Ar hyn o bryd, mae gan yr Ymddiriedolaeth sawl ymyrraeth strategol a gynlluniwyd i leihau heintiau sy'n gysylltiedig â gofal iechyd.

- Gweithredu Safonau Sicrwydd Rheoli Cronfa Risg Cymru (gweler Atodiad 7).
- Gweithredu Strategaeth Haint Gofal Iechyd Cymru Gysylltiol (gweler Atodiad 8).
- Mae'r Ymddiriedolaeth wedi cytuno bydd bob cyfarwyddiaeth yn ymrwymo i 3 ymyrraeth strategol craidd
    - Ymgyrch Glanhewch eich Dwylo, Asiantaeth Cleifion Diogelach (http://www.npsa.nhs.uk/cleanyourhands)
    - Strategaeth Hylendid Ysbytai Llywodraeth Cynulliad Cymru (http://howis.wales.nhs.uk/doclib/whc-2003-059-pt2-e.pdf)
    - Hyfforddiant mandedol i'r holl staff.

Ymrwymodd yr Ymddiriedolaeth yn ddiweddar fel un o 4 safle llywio yn y DU ar gyfer y Blaengaredd Cleifion Diogelach ac mae'n y broses o weithredu bwndeli gofal monitro ac ymyrraeth fel rhan o'r blaengaredd. Mae hyn yn cynnwys heintiau Uned Gofal Dwys, heintiau llif gwaed MRSA a heintiau clwyfau orthopedig.

Yn amlwg, mae gan y Tîm Rheoli Heintiau ran allweddol wrth reoli a lleihau heintiau sy'n gysylltiedig â gofal iechyd. Darperir hyn mewn sawl ffordd. Yr pwysicaf yw cyngor ynghylch rheolaeth cleifion unigol ar gyfer cleifion sy'n dioddef o, neu mewn perygl o gael haint. Mae'r Tîm hefyd yn gyfrifol am lawer o'r wyliadwriaeth a nodir yn yr adran uchod, ac yn ogystal â hyn yn ymgymryd ag archwiliadau adroddiadau labordai dyddiol.

Ychwanegir at hyn gan adroddiadau anffurfiol o glystyrau clefydau ymddangosiadol gan staff clinigol ar wardiau i'r Tîm Rheoli Heintiau. Mae'r ddwy agwedd yn cael eu tanategu gan system meddalwedd masnachol o'r enw ICNet a brynwyd gan Ymddiriedolaeth GIG Siroedd Conwy a Dinbych i'w defnyddio gan y Tîm Rheoli Heintiau. Mae hyn yn galluogi monitro ac adrodd ar dueddiadau o organebau a chyflyrau rhybuddion allweddol. Mae esiampl wedi'i amgáu yn Atodiad 9.

Mae'r Tîm Rheoli Heintiau yn gyfrifol am ddarparu hyfforddiant mandedol ac mae ganddynt ran allweddol i ddatblygu ac adolygu nifer o bolisïau rheoli heintiau (Atodiad 10). Mae hyn yn golygu bod angen i'r Tîm fod yn hollol gyfarwydd ynghylch ymchwil a chanllawiau.

Beth arall y mae'n rhaid ei wneud

Amcangyfrifodd adroddiad y Swyddfa Archwilio Genedlaethol ar heintiau'n gysylltiedig â gofal iechyd, gellir osgoi rhwng 15 a 30% o HCAI. Credaf gellir gwneud gwelliannau arwyddocaol mewn sawl maes.

1. Gwyliadwriaeth a Thechnoleg Gwybodaeth

Nid yw systemau TG presennol ysbytai yn effeithiol iawn i gynorthwyo gwyliadwriaeth heintiau. Mae mynediad at wybodaeth ynghylch digwyddiadau o heintiau yn wael, yn ogystal â gwybodaeth ynghylch ffactorau risg; felly mae'r rhan fwyaf o'r data a ddarperir ar hyn o bryd mewn Ymddiriedolaethau wedi'u casglu, dadansoddi a'u hadrodd â llaw gan y staff rheoli haint. Mae hyn yn cymryd llawer o amser a gallai fod yn llawer hawddach gyda datblygiad systemau TG sy'n cymryd i ystyriaeth anghenion gwyliadwriaeth. Gobeithir bydd hyn yn rhywbeth a fydd yn derbyn sylw gan Hysbysu Gofal iechyd.

Byddai cyflwyno'r wybodaeth yn cyfiawnhau datblygiad pellach, fel mae'r esiamplau yn yr atodiadau'n dangos. Tra bod gennym wybodaeth eithaf da ynghylch digwyddiadau rhai heintiau, mae'n bosib iddi fod yr eithaf anodd i gyfarwyddiaethau clinigol a Thimau Rheoli Heintiau i ddeall sut i ddefnyddio'r wybodaeth i leihau'r graddau o heintiau sy'n gysylltiedig â gofal iechyd. Gall gweithio'n agosach ag adrannau gwybodaeth ac archwilio ac eraill helpu hyn.

Dylid ehangu gwyliadwriaeth strwythedig i gynnwys llawer o'r gweithrediadau a'r ymyriadau cyffredin er mwyn cymharu perfformiad ac yn fwy pwysig, i roi gwybodaeth i drafod â chleifion. Ar hyn o bryd mae'r rhan fwyaf o wyliadwriaethau'n seiliedig ar gleifion mewnol yn unig. Oherwydd bod llawer o heintiau'n digwydd yn y gymuned, mae angen ehangu hyn i gynnwys casglu data o'r gymuned, ond mae'n rhaid cydnabod byddai hyn yn cymryd cryn amser a byddai'r gost yn uchel. Rhaid deall mewn sawl achos bod systemau gwyliadwriaeth yn cael eu rhoi yn eu lle'r un amser ag ymyriadau neu safonau newydd a gynlluniwyd i leihau'r gyfradd haint ac felly, mae'n bosibl na fyddai cynlluniau gwyliadwriaeth fel hyn eu hunain ddangos unrhyw welliannau mewn cyfraddau haint, ond byddent o gymorth i glinigwyr i roi gwybodaeth well i gleifion.

2. Hyfforddiant

Mae'r Ymddiriedolaeth hon wedi bod yn eithaf effeithiol wrth ddarparu hyfforddiant mandedol i staff a dangoswyd bod y broses hon yn gwella gwybodaeth staff. Fodd bynnag, dangoswyd ei fod wedi bod yn llai llwyddiannus yn trosi'r wybodaeth hon i newid ymddygiad. Gobeithir bydd y gweithredu cynlluniedig o becyn hyfforddiant Cymru gyfan o gymorth i'r perwyl hwn, ynghyd ag unrhyw ddatblygiadau a fyddai'n annog a gwobrwyo arferion da drwy ddarparu atborth gadarnhaol.

3. Gwasanaethau Ysbyty

Cydnabyddir bod cydberthynas groes rhwng lefelau staffio a rheoli heintiau'n effeithiol. Oherwydd nad yw lefelau staffio wedi cynyddu yn unol â gweithgareddau ysbyty, mae hyn yn rhoi cryn bwysau ar staff o ran cynnal safonau yn y meysydd allweddol megis hylendid dwylo a glanhau amgylcheddol. Mae bylchau yn y ddarpariaeth gwasanaethau domestig ar wardiau ar amserau penodol o'r dydd yn amlwg o ddim cymorth. Yn ogystal â hyn, cynlluniwyd y lefel bresennol o ddarpariaeth gwasanaethau domestig i ymdrin â chyfraddau arferol o heintiau a gall fod yn annigonol i ymdrin â phwysau uwch sy'n gysylltiedig â digwyddiadau o gastro-enteritis firaol. Byddai o gymorth i Ymddiriedolaethau fod â staff sgwad sgwrio sy'n ychwanegol at y ddarpariaeth safonol o wasanaethau domestig dan yr amgylchiadau hyn. Mae hyn yn fecanwaith a ddefnyddir yn effeithiol yn sector deithio ac eraill i ymdrin â phroblemau fel hyn.

Ymgymerwyd â'r astudiaeth cyffredinolrwydd yn Ymddiriedolaeth GIG Siroedd Conwy a Dinbych i amlygu'r diffyg cyfleusterau ystafelloedd sengl i gleifion gydag MRSA a heintiau trosglwyddadwy. Mae Strategaeth Ystadau'r Ymddiriedolaeth yn mynd i'r afael â'r diffyg hwn ar hyn o bryd. Mae profiad yn y gaeaf wedi dangos nad oes gan y GIG y gallu ymchwydd i ymdrin â chynnydd mewn derbyniadau ysbyty oherwydd un ai heintiau llwybr resbiradu , y ffliw neu gastro-enteritis firaol. Mae bodolaeth targedau aros D&A er enghraifft, yn cynyddu'r pwysau ar dderbyn cleifion i fannau nad ydynt yn ddelfrydol ar gyfer eu gofal neu cyn y gellir glanhau a dilygru'n ddigonol. Mae trosglwyddo cleifion rhyng-wardiau cysylltiedig â'r broblem o ddefnydd gwelyau yn cymhlethu'r broblem o symud heintiau o amgylch yr ysbyty.

4. Cefnogaeth y Tîm Rheoli Heintiau

Nid oes adnoddau digonol un pwrpas ar gyfer y Tîm Rheoli Heintiau, sydd ar hyn o bryd yn gorfod blaenoriaethu eu gweithgareddau, gan ganolbwyntio'n benodol ar wasanaethau cleifion mewnol llym er anfantais gwasanaethau eraill a ddarperir gan yr Ymddiriedolaeth. Mae'r data a ddarparwyd yn yr adroddiad hwn yn nodi nad yw'r wyliadwriaeth yn gyflawn gydag ychydig neu dim gwyliadwriaeth ar ôl rhyddhau.

Darperir hyfforddiant mandedol yn bennaf mewn lleoliad dosbarth yn groes i ddarpariaeth pwynt gwasanaeth, lle cydnabyddir bod ymyriadau hyfforddiant yn fwy tebygol o fod yn effeithiol. Mae'n anodd rhyddhau staff o'u dyletswyddau clinigol i gymryd rhan mewn hyfforddiant.

Mae'r ysbytai'n gweithredu ar sail 7 diwrnod yr wythnos, fodd bynnag dim ond ar sail 5 diwrnod yr wythnos mae cefnogaeth nyrs rheoli heintiau ar gael ar hyn o bryd - dydd Llun i ddydd Gwener. Mae darpariaeth cyngor a chefnogaeth ar gyfer cychwyniadau mawr ar sail ewyllys da yn hytrach na meddu ar wasanaeth cefnogol digonol. Yn ogystal â hyn mae'r lefel bresennol o wasanaeth yn annigonnol i ddarparu cyngor rheoli heintiau

effeithiol o ran bob datblygiad newydd. Mae cyngor ar hyn o bryd yn cael ei gyfyngu i ddatblygiadau cyfalaf mawr.

5. Cynhwysiad adrodd am HCAI difrifol mewn cynllun adrodd am ddigwyddiadau critigol yr Ymddiriedolaeth

Ar hyn o bryd nid oes safoni ymagwedd ar gyfer casglu heintiau cysylltiedig â gofal iechyd difrifol neu farwol yn y cynllun adrodd am ddigwyddiadau critigol, ac oherwydd hyn, ni ellir ei ystyried yn integredig gyflawn yn system lywodraethu'r Ymddiriedolaeth.

6. Gwybodaeth i gleifion

Mae'r ymgynghoriad diweddar wedi nodi'n hollol glir bod cleifion a'r cyhoedd yng Nghymru yn disgwyl mwy o wybodaeth o ran gofal iechyd sy'n gysylltiedig â heintiau, pan mae'n digwydd, sut gellir ei leihau a chamau mae Ymddiriedolaethau'n eu cymryd i'w lleihau. Mae llawer o waith y gellir ei wneud i ddarparu gwybodaeth mewn ffordd ystyrlon a chynorthwyol i gleifion, ond un o'r pethau pwysicaf ganddynt yw derbyn gwybodaeth ddibynadwy a phriodol gan staff y Gwasanaeth Iechyd sy'n gyfrifol am eu gofal. Bydd angen ymdrech addysgol fawr ar gyfer hyn yn unigi sicrhau bod y neges a drosglwyddir gan staff clinigol yn gyson ac yn seiliedig ar ffeithiau.

Dr D Nicholas Looker
Microbiolegydd Ymgynghorol Anrhydeddus/Meddyg Rheoli Heintiau
Ymddiriedolaeth GIG Siroedd Conwy a Dinbych

Mae'r farn uchod yn eiddo'r awdur ac nid yw'r cynrychioli polisi'r Ymddiriedolaeth.

National Public Health Service for Wales
Gwasanaeth Iechyd Cyhoeddus Cenedlaethol Cymru

NPHS Communicable Disease Surveillance Centre

Conwy & Denbighshire NHS Trust

Staphylococcus aureus bacteraemia Surveillance Report

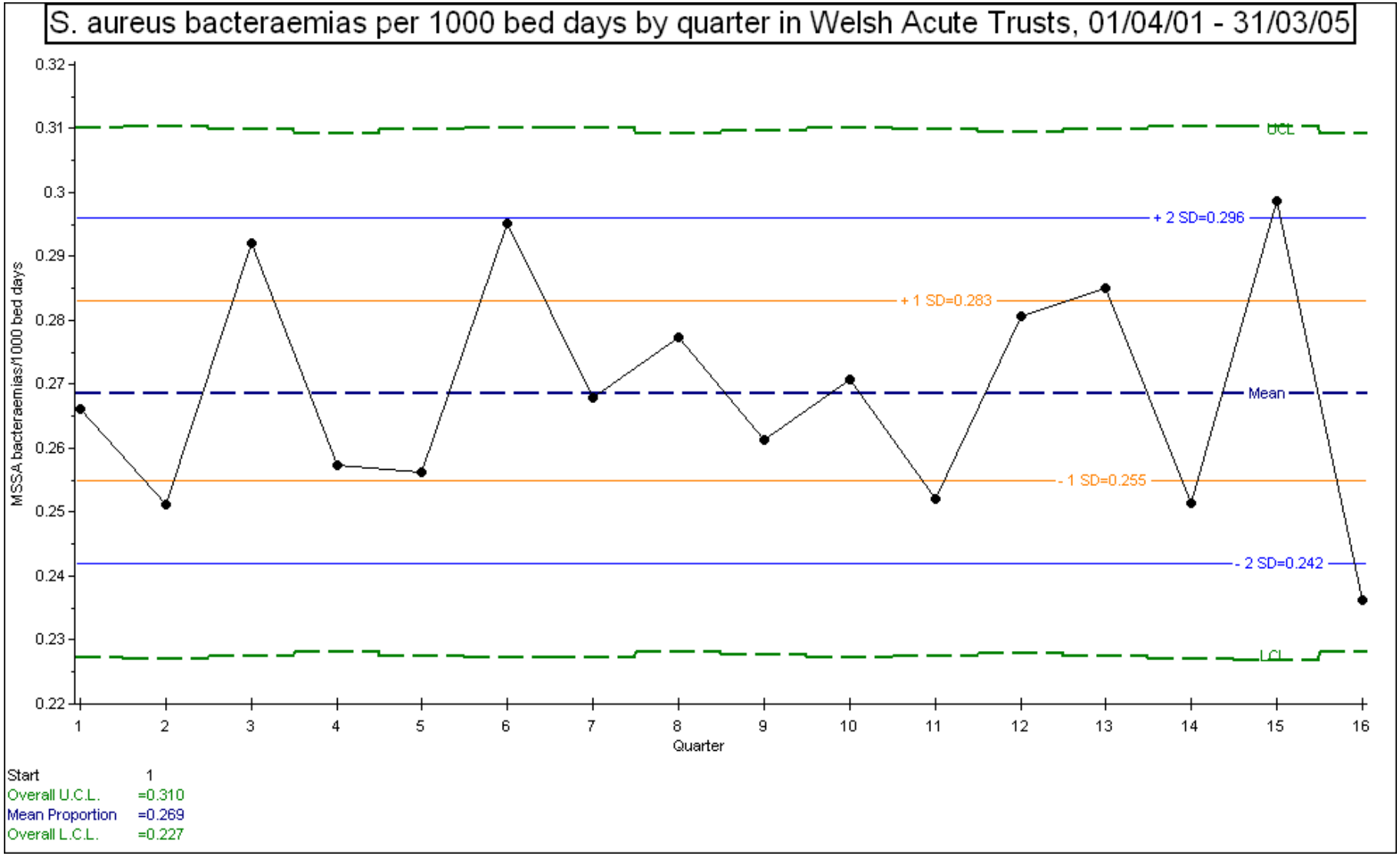
16th Report 01/04/04 – 31/03/05

Including Quarterly and Annual Trend Data 01/04/01– 31/03/05

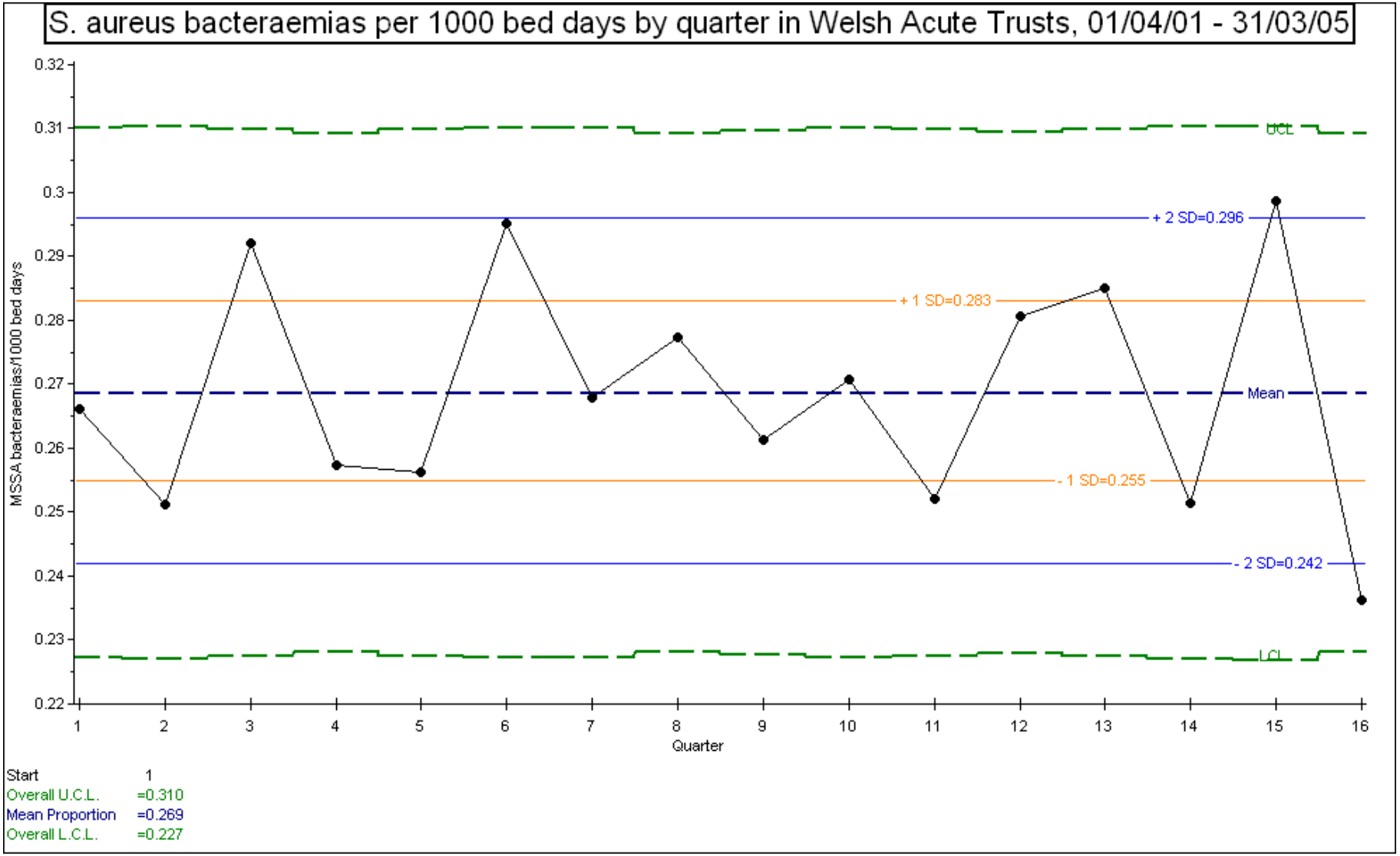
July 2005

Abton House, Wedal Road, Cardiff, CF14 3QX
Ty Abton, Ffordd Wedal, Caerdydd, CF14 3QX
DX 6070102 Cardiff 90 CF
Tel/Ffôn 029 2052 1997 Fax/Ffacs 029 2052 1987

Atodiad 1


S. aureus bacteraemias per 1000 bed days by quarter in Welsh Acute Trusts, 01/04/01 - 31/03/05
MSSA bacteraemias/1000 bed days
0.32
0.31
0.3
0.29
0.28
0.27
0.26
0.25
0.24
0.23
0.22
UCL
+ 2 SD=0.296
+ 1 SD=0.283
Mean
- 1 SD=0.255
- 2 SD=0.242
LCL
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
Quarter
Start 1
Overall U.C.L. =0.310
Mean Proportion =0.269
Overall L.C.L. =0.227

Atodiad 1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MSSA bacteraemias/1000 bed days
0.32
0.31
0.3
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0.27
0.26
0.25
0.24
0.23
0.22
UCL
+ 2 SD=0.296
+ 1 SD=0.283
Mean
- 1 SD=0.255
- 2 SD=0.242
LCL
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
Quarter
Start 1
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Mean Proportion =0.269
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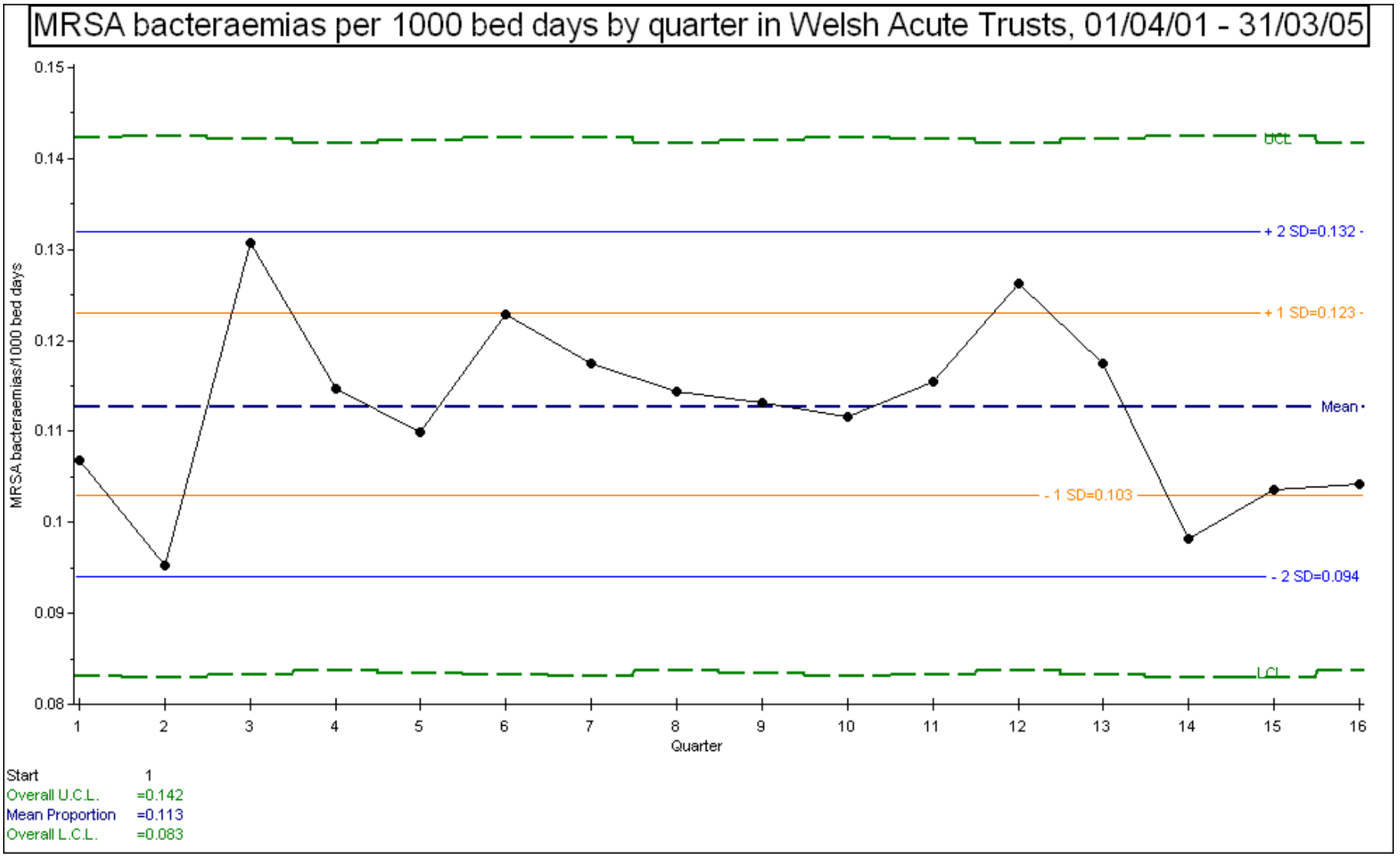
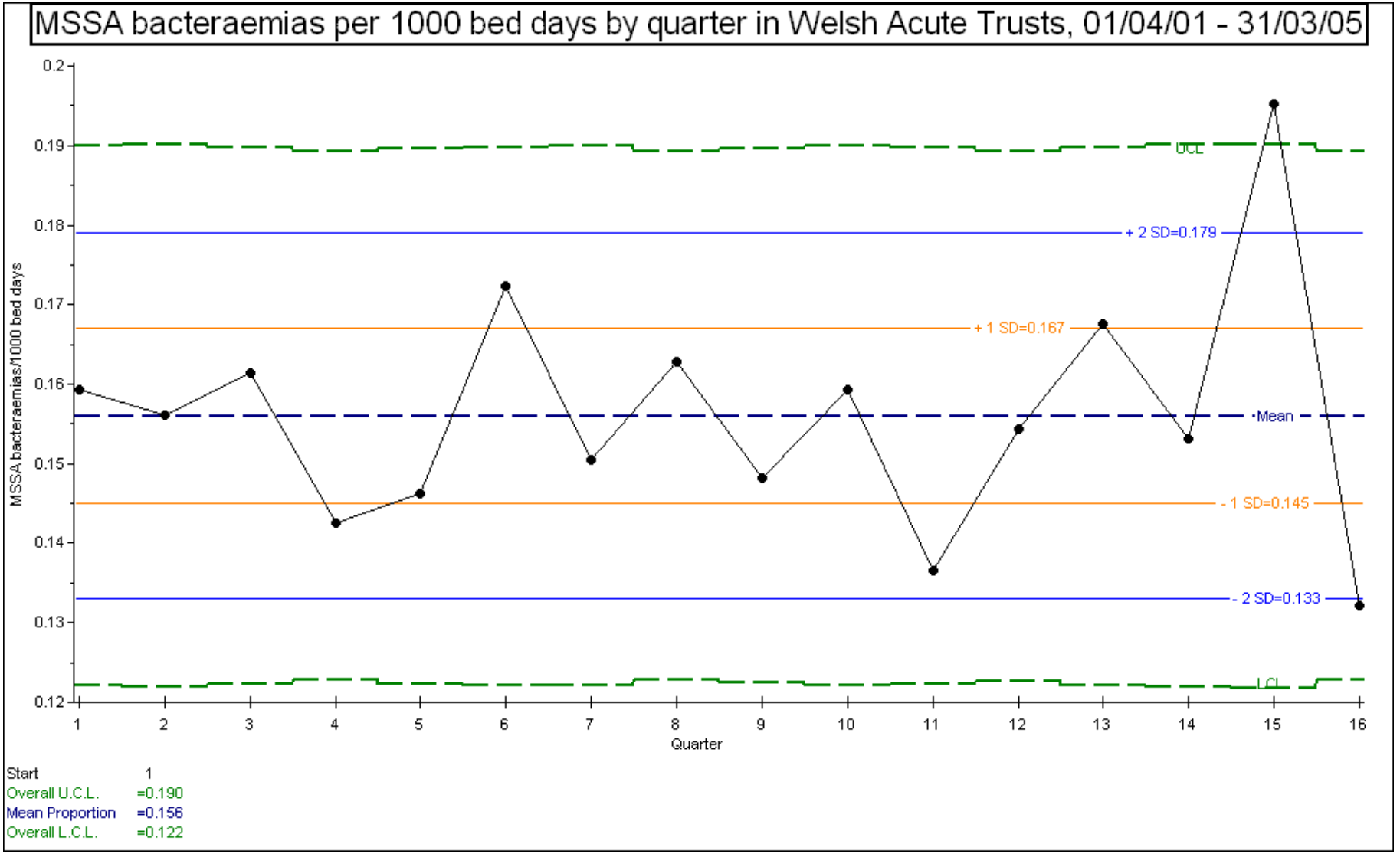
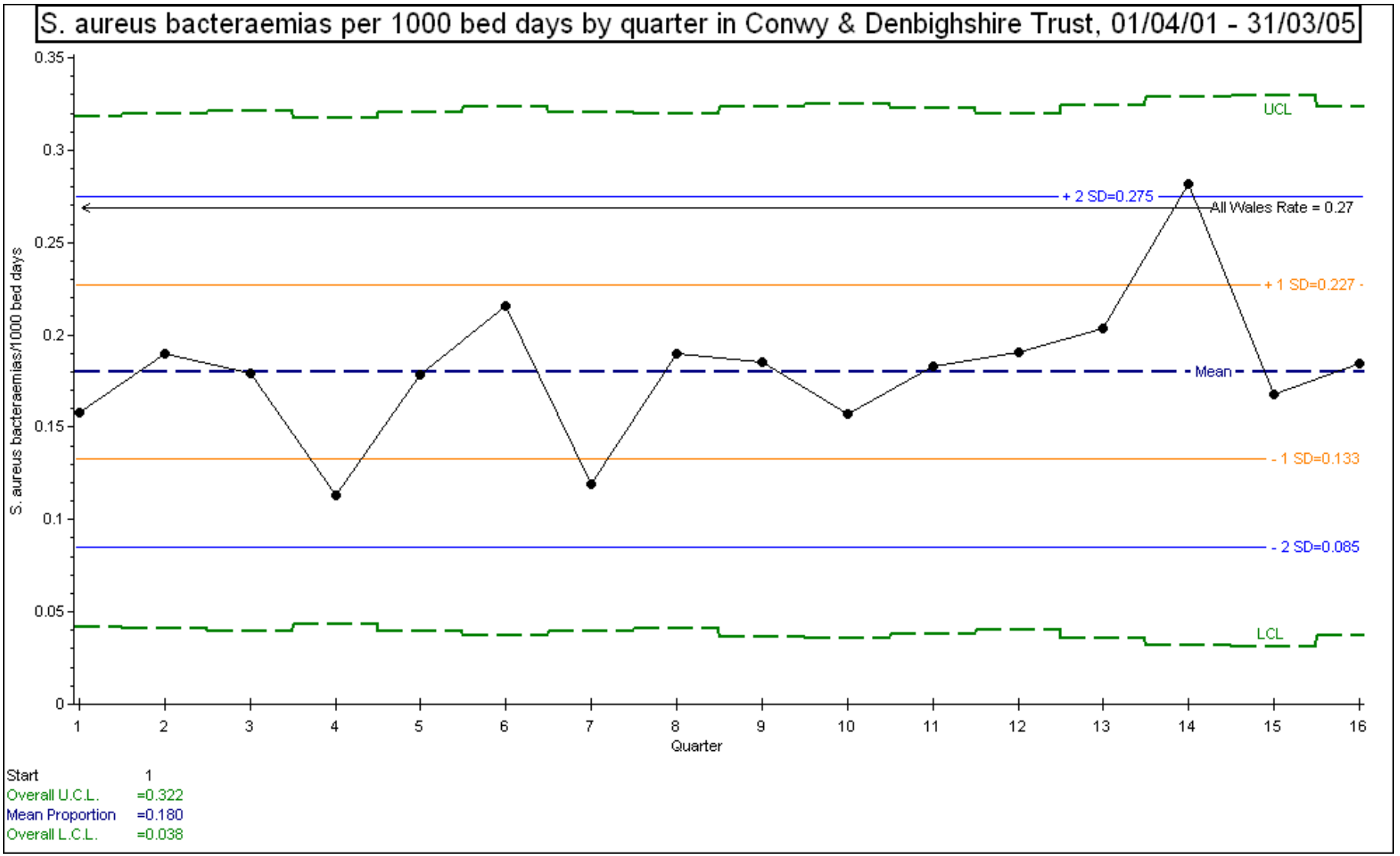
Atodiad 1


MRSA bacteraemias per 1000 bed days by quarter in Welsh Acute Trusts, 01/04/01 - 31/03/05
MRSA bacteraemias/1000 bed days
0.15
0.14
0.13
0.12
0.11
0.1
0.09
0.08
UCL
+ 2 SD=0.132
+ 1 SD=0.123
Mean
- 1 SD=0.103
- 2 SD=0.094
LCL
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
Quarter
Start 1
Overall U.C.L. =0.142
Mean Proportion =0.113
Overall L.C.L. =0.083

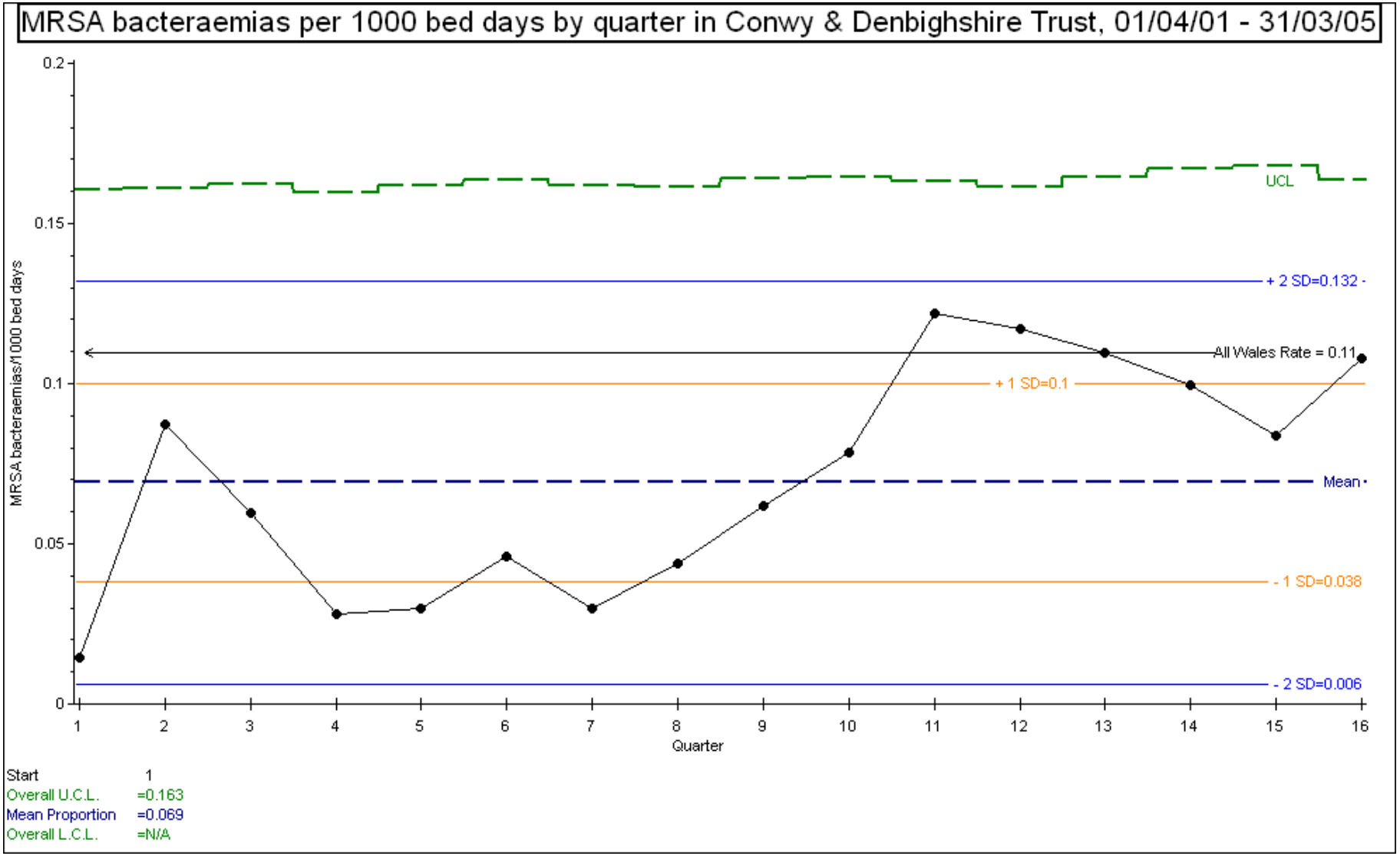
Atodiad 1


MSSA bacteraemias per 1000 bed days by quarter in Welsh Acute Trusts, 01/04/01 - 31/03/05
MSSA bacteraemias/1000 bed days
0.2
0.19
0.18
0.17
0.16
0.15
0.14
0.13
0.12
UCL
+ 2 SD=0.179
+ 1 SD=0.167
Mean
- 1 SD=0.145
- 2 SD=0.133
LCL
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
Quarter
Start 1
Overall U.C.L. =0.190
Mean Proportion =0.156
Overall L.C.L. =0.122

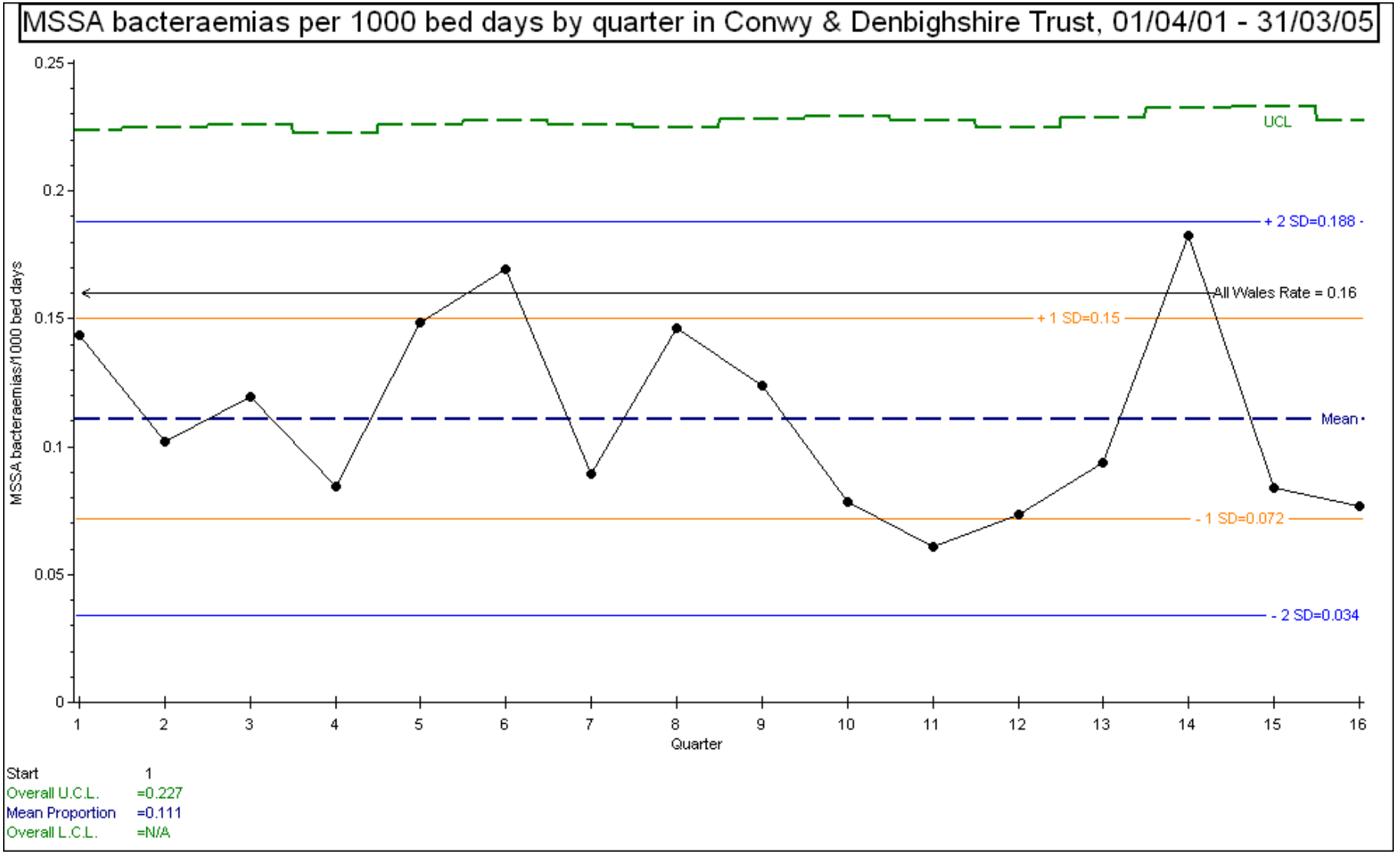
Atodiad 1


S. aureus bacteraemias per 1000 bed days by quarter in Conwy & Denbighshire Trust, 01/04/01 - 31/03/05
S. aureus bacteraemias/1000 bed days
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
UCL
+ 2 SD=0.275
All Wales Rate = 0.27
+ 1 SD=0.227
Mean
- 1 SD=0.133
- 2 SD=0.085
LCL
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
Quarter
Start 1
Overall U.C.L. =0.322
Mean Proportion =0.180
Overall L.C.L. =0.038

Atodiad 1


MRSA bacteraemias per 1000 bed days by quarter in Conwy & Denbighshire Trust, 01/04/01 - 31/03/05
MRSA bacteraemias/1000 bed days
0.2
0.15
0.1
0.05
0
UCL
+ 2 SD=0.132
All Wales Rate = 0.11
+ 1 SD=0.1
Mean
- 1 SD=0.038
- 2 SD=0.006
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
Quarter
Start 1
Overall U.C.L. =0.163
Mean Proportion =0.069
Overall L.C.L. =N/A

Atodiad 1


MSSA bacteraemias per 1000 bed days by quarter in Conwy & Denbighshire Trust, 01/04/01 - 31/03/05
MSSA bacteraemias/1000 bed days
0.25
0.2
0.15
0.1
0.05
0
UCL
+ 2 SD=0.188
All Wales Rate = 0.16
+ 1 SD=0.15
Mean
- 1 SD=0.072
- 2 SD=0.034
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
Quarter
Start 1
Overall U.C.L. =0.227
Mean Proportion =0.111
Overall L.C.L. =N/A

National Public Health Service for Wales
Gwasanaeth Iechyd Cyhoeddus Cenedlaethol Cymru

NPHS Communicable Disease Surveillance Centre

Orthopaedic Surgical Site Infection Surveillance
Conwy & Denbighshire Trust

Summary Report
January – December 2004

- This is a summary of the second national report on surgical site infections (SSI) following orthopaedic procedures in Wales.
- It is provided to complement data that is regularly fed back to NHS Trusts from the Welsh Healthcare Associated Infection Programme to assist units in maintaining low infection rates.
- A full report is available on the WHAIP website (http://howis.wales.nhs.uk/whaip).
- Data is available from 7 Trusts in Wales for January to December 2004. 10 Trusts are undertaking this surveillance in 2005.
- The report is restricted to the surveillance of the 4 mandatory surveillance procedures: arthroplasty of the hip, arthroplasty of the knee, hemiarthroplasty and internal fixation of trochanteric fractures of the femur (#NOF).
- From analysis of hospital activity data, it is clear that a large number of procedures are not being reported via this surveillance scheme. Results should therefore be treated with caution.

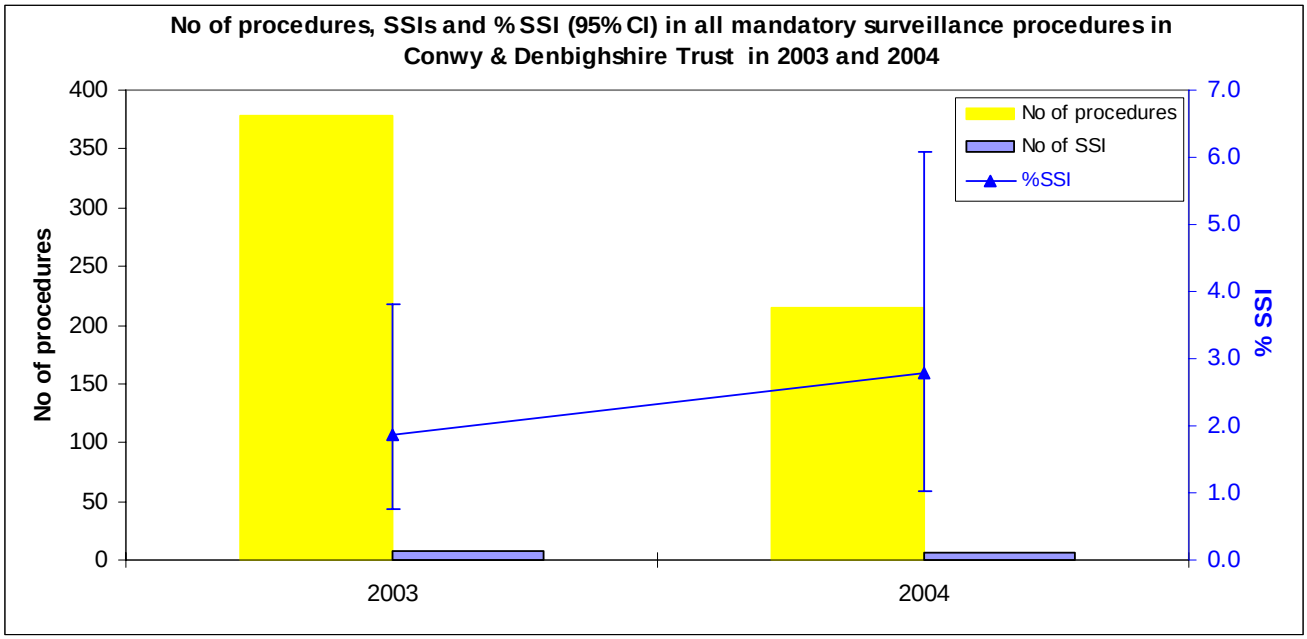
Results Summary

Table 1. Incidence of SSI by Category of Orthopaedic Surgical Procedure in Wales in 2004

Procedure Category	No. procedures	No. SSI	No. pre-discharge SSI	% SSI (95% CI)	% pre-discharge SSI (95% CI)
All mandatory procedures	1211	38	17	3.1 (2.2-4.3)	1.4 (0.8-2.3)
Hip arthroplasty	527	11	7	2.1 (1.0-3.7)	1.3 (0.5-2.7)
Knee arthroplasty	453	14	4	3.1 (1.7-5.2)	0.9 (0.2-2.3)
Hemiarthroplasty	96	6	2	6.3 (2.3-13.6)	2.0 (0.3-7.5)
#NOF	135	7	4	5.2 (2.1-10.7)	3.0 (0.8-7.6)

Table 2. Incidence of SSI and pre-discharge SSI in all mandatory orthopaedic procedures in Wales in 2004 by Trust

Trust	No. Procedures	% with post-discharge update	No. SSI	No. pre-discharge SSI	% SSI (95% CI)	% pre-discharge SSI (95% CI)
9	292	98%	14	5	4.8 (2.6-8.0)	1.7 (0.6-4.0)
10	25	24%	0	0	0 (0-14.8)	0
11	306	42%	10	4	3.3 (1.6-6.0)	1.3 (0.4-3.3)
25	117	13%	2	2	1.7 (0.2-6.2)	1.7 (0.2-6.2)
34	67	79%	2	0	3.0 (0.4-10.8)	0
C&D	235	0	6	6	2.6 (0.9-5.6)	2.6 (0.9-5.6)
39	169	64%	4	0	2.4 (0.6-6.1)	0



Key Messages

- There were no significant differences between Trusts within Wales in the rates of SSI for all mandatory procedures.

- The pre-discharge rates of surgical site infection in Wales are comparable to those reported for Scotland and Northern Ireland (eg Hip prosthesis: Scotland = 1.6%; Northern Ireland = 0.9%).
- There is no significant difference between the overall rates of SSI in Conwy & Denbighshire Trust in 2003 and 2004.

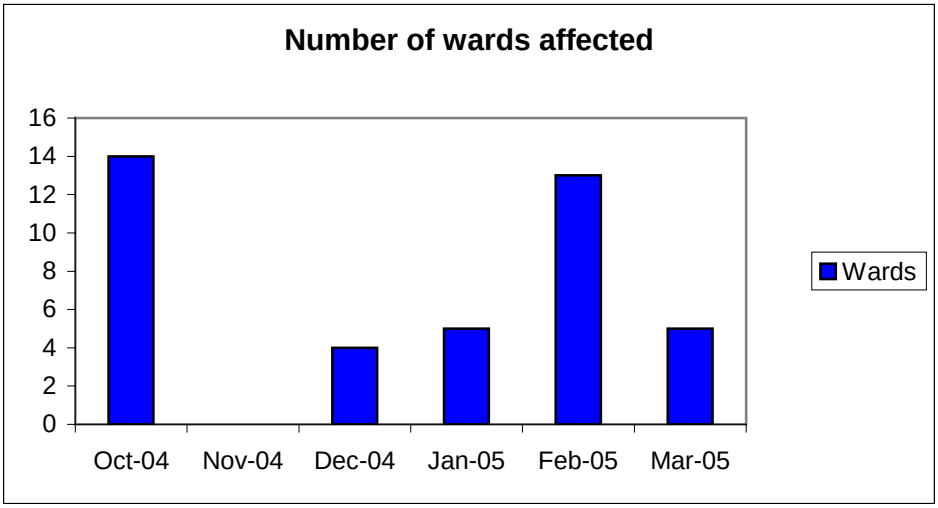
Atodiad 3

OUTBREAKS OF VIRAL GASTROENTERITIS 2004/05

Summary

There have been a number of viral gastroenteritis outbreaks (Norovirus) within the Conwy & Denbighshire Trust from October 2004 continuing into March 2005. The trend within the Trust for these outbreaks reflects the significant background level of viral gastroenteritis in the community that has occurred over the winter period.

The most significant areas affected were Care of the Elderly and Medical wards and a small number of Community hospitals. There was a much smaller impact on other divisions. However due to closure of beds in affected areas these outbreaks have had a significant affect on the Trust in respect of resources and lost bed days and necessitated the Trusts major outbreak policy being invoked.



In total there were 543 cases identified in patients and staff, it is estimated that in excess of 50% were community acquired, with the rest as a consequence of in hospital transmission. Ward and bed closures were estimated at 3502 lost bed days.

It was difficult to ascertain the reasons for the continuing length of the outbreaks, however it would seem to be multifactorial:

- Staff working, and visiting within those areas affected, failing to adhere to control measures.
- Inter ward transfer of patients from affected areas to unaffected areas.
- Reductions in staffing due to illness.
- Reintroduction of cases from the community.
- Visitors and staff entering ward areas whilst symptomatic.
- Insufficient single rooms for patient isolation
- Insufficient provision of domestic services to allow timely cleaning of bays/rooms consistent with admission demands

Atodiad 3

A series of recommendations for improvements were made to the Trust Board.

Atodiad 4

National Public Health Service for Wales
Gwasanaeth Iechyd Cyhoeddus Cenedlaethol Cymru

NPHS Communicable Disease Surveillance Centre

Conwy & Denbighshire NHS Trust

C.difficile Data

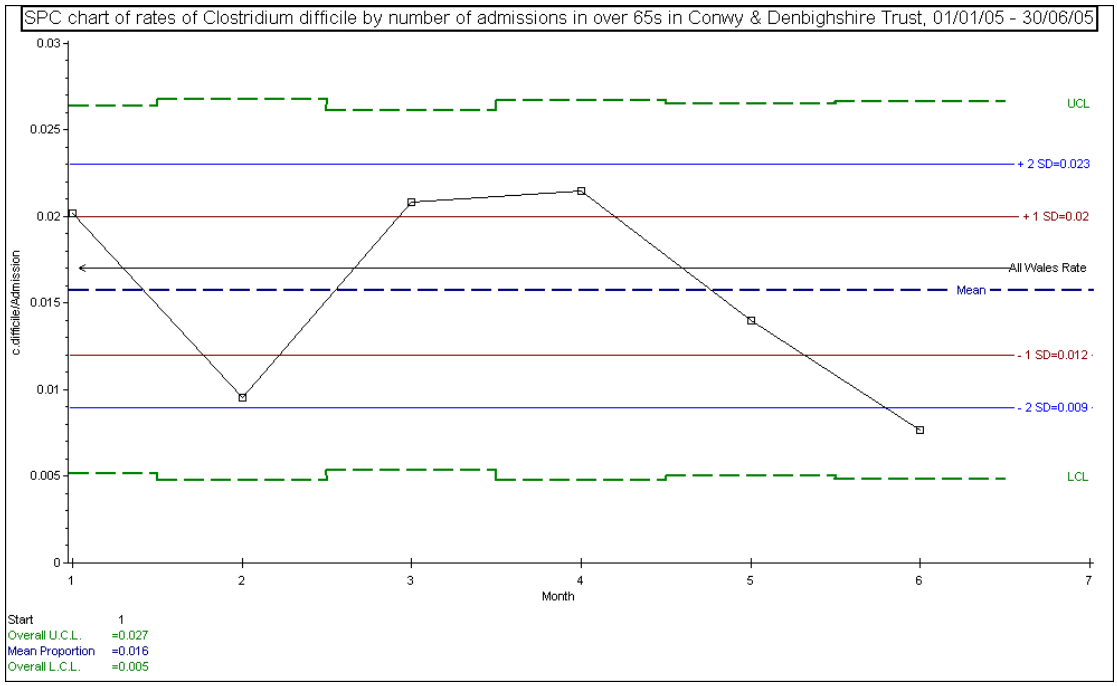
01/01/05 – 30/06/05

Abton House, Wedal Road, Cardiff, CF14 3QX
Ty Abton, Ffordd Wedal, Caerdydd, CF14 3QX
DX 6070102 Cardiff 90 CF
Tel/Ffôn 029 2052 1997 Fax/Ffacs 029 2052 1987

Atodiad 4

Conwy & Denbighshire Trust *C. difficile* Data

Month	No. C. difficile	Admissions	Rate/1000 admissions
Jan	25	1237	20.21
Feb	11	1154	9.53
Mar	27	1294	20.87
Apr	25	1162	21.51
May	17	1214	14.00
Jun	9	1172	7.68



Annex 5

Prevalence of Infection Survey
Conwy & Denbighshire NHS Trust

1st February 2005

Prepared by:

Joanne Hogan
Conwy & Denbighshire NHS Trust

Dafydd Williams
Welsh Healthcare Associated Infection Team

Introduction

The prevalence survey was a new venture by the trust, and is designed to assess the overall prevalence of infection of patients in hospitals. The survey would also assess their associated risk factors and sites of infection. A prevalence survey measures the proportion of patients infected at a given time. *Improving Health in Wales – A Plan for the NHS and It's Partners* emphasised the importance of good information to plan service delivery, evaluate progress and demonstrate improvement. Two other Trusts in Wales have also performed a similar study.

Under the current political climate, infection control teams are under enormous pressure to tackle healthcare associated infections (HAI). To reduce the burden of HAI there is a requirement for good, representative baseline data, in order to assess the impact of the measures which have been put in place, and act as focus for future interventions. Each individual directorate within the Trust will receive a directorate specific report. (Appendix4)

Method

An adaptation of the *Hospitals in Europe Link Infection Control Surveillance* HELICS protocol was used for the survey. The Performa was adapted for use with the Eyes and Hands optical mark reader.

A nominated nurse from each ward within the Trust undertook the data collection. The nominated nurse had undergone training on the definitions of the data set and the definition of infection. The aim of the study was to collect the data over a period of one working day using agreed definitions from the Centre for Communicable Disease (CDC) Atlanta. Identified infections were further validated by the infection control team and the nurse specialist from the Welsh Healthcare Associated Infection Programme. 69 identified infections were excluded following validation.
The forms were scanned at the Communicable Disease Surveillance Centre, Cardiff and reported using an Excel spreadsheet which was further analysed by the infection control team locally.

Data was also collected in relation to General Risk Factors associated with the development of infection and the source of patients' admission to the clinical area (Appendix1)

An evaluation of the day was then conducted and reported on in order to inform any future prevalence studies. (Appendix 2)

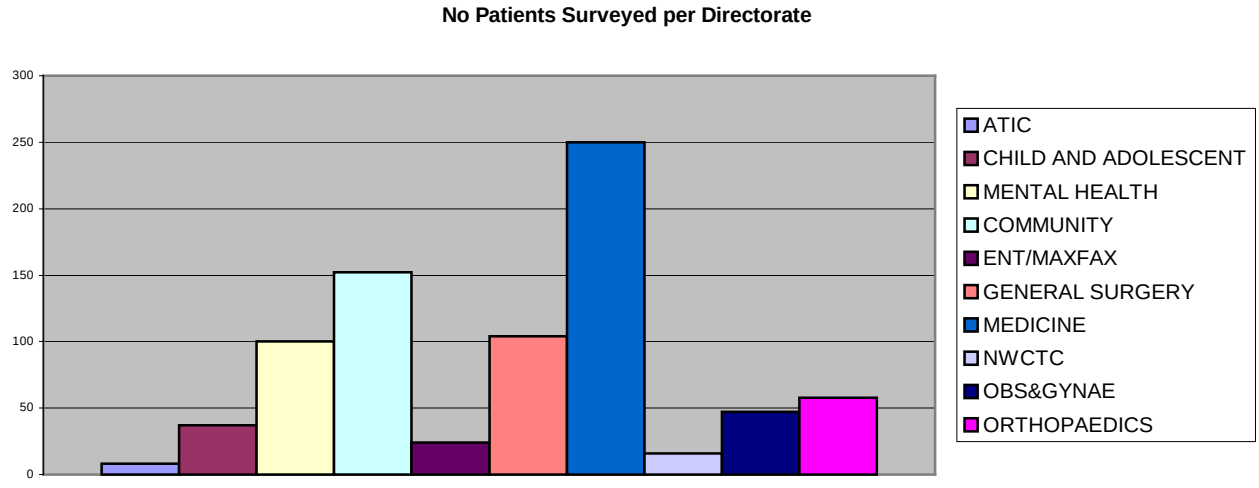
Atodiad 5

Results

Patient demographics

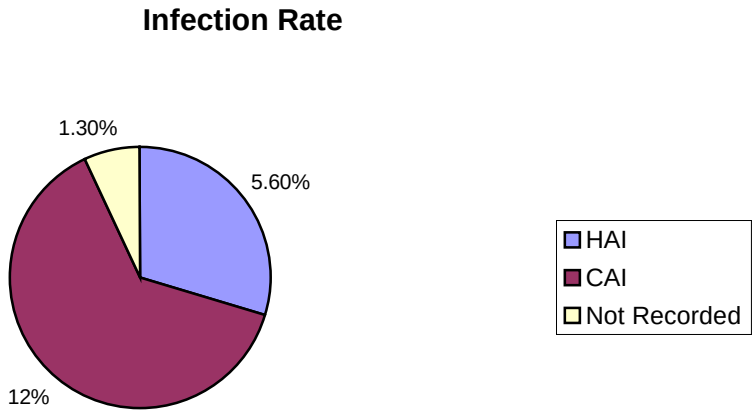
There were 796 patients included in the survey. Males represented 43.2%(n=344) of the population, females 54.1% (n=431), 21 forms did not have gender recorded.

Ten Clinical Directorates were included in the survey. A breakdown on the number of patients surveyed in each directorate is given below.

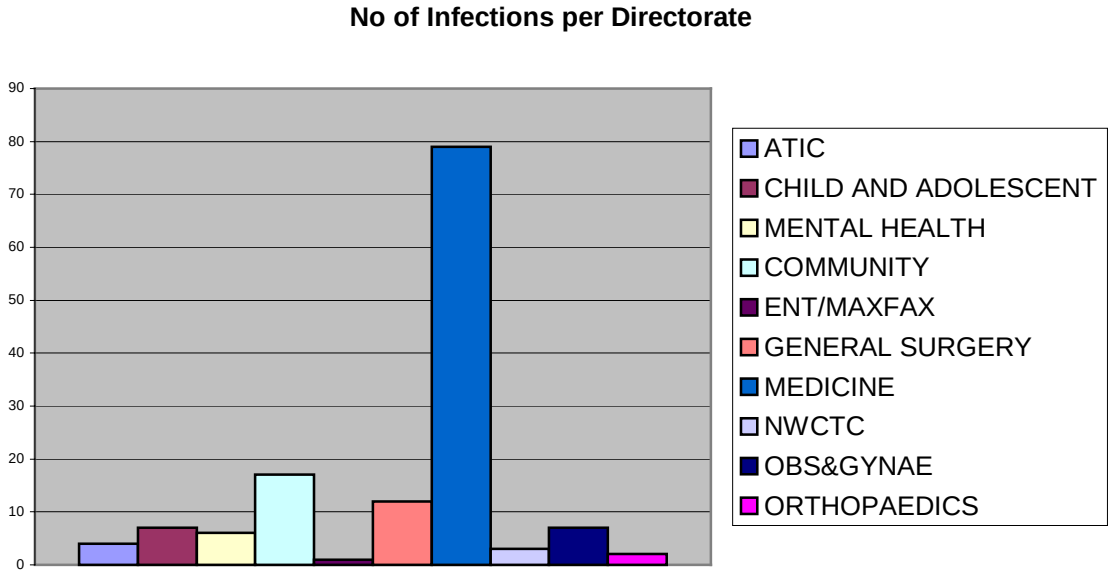


System Infections

The overall burden of infection for the Trust on February 1st 2005 was 17.9% (n= 143). The infections were identified as hospital acquired infection (HAI) and community-acquired infection (CAI). Overall hospital acquired infection accounted for 5.6% (n= 45) and community acquired 12% (n=96). Two forms did not record HAI or CAI.



138 patients (17.3%) were identified on the day of the survey as having an active infection present. Some patients were identified as having more than one system infection resulting in the number of infections being recorded as 143. The chart below gives a breakdown of the number of patients infected in each directorate.



A comparison can be made in relation to number of patients surveyed in each directorate and no of patients identified as having an infection (Appendix 3)

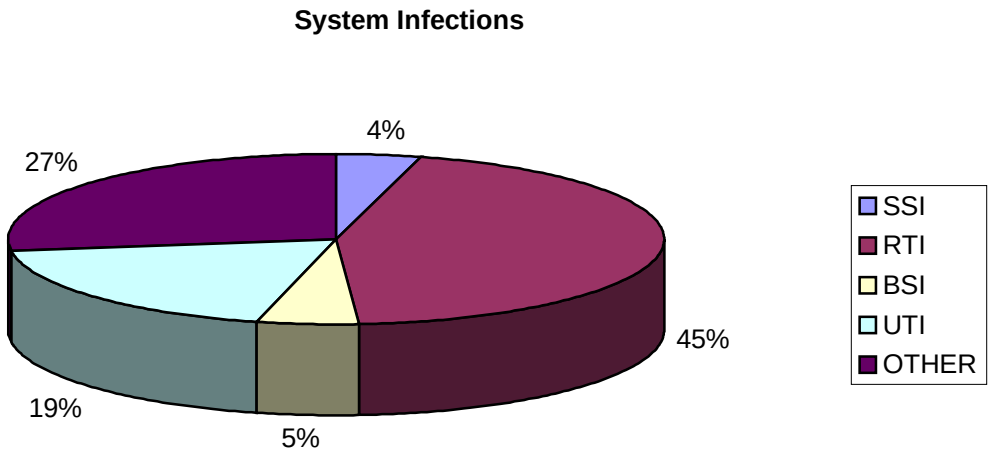
The following table provides a summary of the number of patients surveyed and associated infections per directorate with a breakdown of HAI and CAI.

Conwy and Denbighshire NHS Trust Point Prevalence Study Data 2005

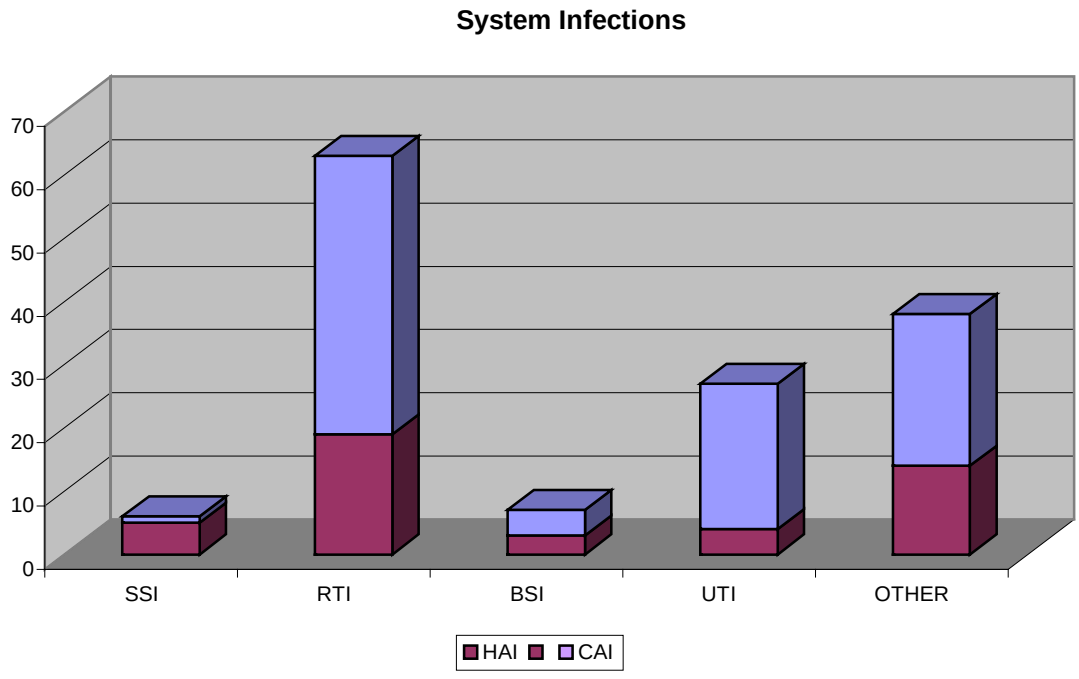
	No Patients Surveyed	No patients with an infection	Overall %	HAI %	CAI %
Anaesthetics, Theatres and Intensive Care	8	4	50%	25%	25%
Child & Adolescent Health	37	7	18.9%	2.7%	16.2%
Mental Health	100	4	4%	2%	1%
Community	152	19	12.5%	5.4%	4.2%
ENTand Oral/Maxillofacial Surgery	24	1	4.1%		4.1%
General Surgery and Urology	104	12	12.5%	4.8%	7.7%
Medicine	250	79	31.6%	6.8%	26.9%
North Wales Cancer Treatment Centre	16	3	18.7%	6.25%	12.5%
Obstetrics & Gynaecology	47	7	14.8%	10.6%	4.2%
Orthopaedics	58	2	4.2%	2.1%	2.1%

System Infections

Type of infection was categorised as Surgical Site, Respiratory Tract, Bloodstream, Urinary Tract and Other (which includes skin and soft tissue, gastric illness, bone and joint).



The chart below identifies a comparison of system infections, and whether they are Hospital or Community acquired.



The tables below present the overall prevalence of HAI for Conwy & Denbighshire NHS Trust and compare the study with the results of 1980 and 1994 National Prevalence Survey

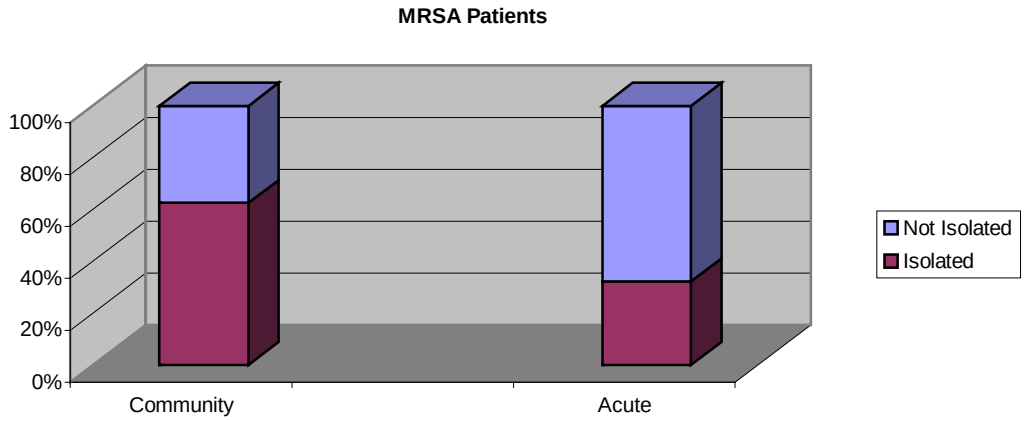
	1980 National Prevalence	1994 National Prevalence	Conwy and Denbighshire NHS Trust
Urinary Tract Infection	2.79	2.41	0.50
Respiratory Tract Infection	1.55	2.38	2.51
Surgical Site Infection	1.78	1.11	0.63
Bloodstream Infection	0.1	0.63	0.38

Another Trust in Wales who also conducted a point prevalence study, using similar data sets and a comparison of the rates of infection are tabled below.

	Conwy &Denbighshire NHS Trust	Another Trust in Wales
Overall Infection Rate	17.9%	18.6%
HAI	5.6%	5.56%
CAI	12%	13.1%

MRSA

4.5% (n=36) of patients were identified in the survey as being carrier of MRSA. Of this figure only 61% (n=22) were isolated in a single room. A comparison can be made between isolated patients in community hospitals and the acute sector.

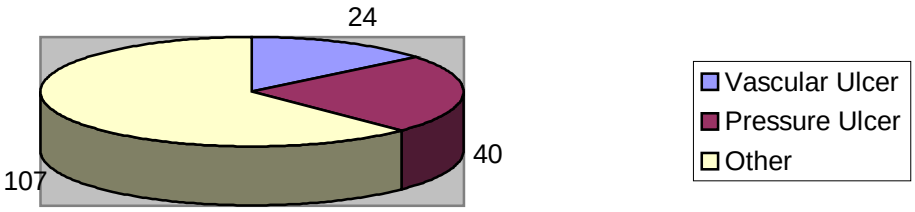


Break in skin

Each patient was assessed for a break in the skin including surgery. A non-surgical break in the skin was recorded in 20.9% (n=167) patients. 4 patients had 2 different types of non- surgical break. Non-surgical breaks were classified as Vascular Ulcer, Pressure Ulcer and Other, including cuts, abrasions and skin lesions.
Summary of the type of break in the skin is detailed below.

Conwy & Denbighshire NHS Trust	% number of patients
Vascular Ulcer	14.3
Pressure Sore	23.8
Other	64.0
N = 167	

Non- Surgical Skin Breaks



Surgery

18.9% patients (n=151) had undergone surgery during this admission period. Data on type of surgical intervention was collected.

Conwy & Denbighshire NHS Trust	% number of patients
Emergency Surgery	58.3%
Elective Surgery	39.7%
Not Recorded	1.9%
N = 151	

Of these figures:
5.2% (n=23) had undergone multiple surgical interventions
9.2% (n=14) had undergone endoscopic surgical procedures

Invasive Procedures

A further 35.3% (n=281) patients had undergone other invasive procedures during this admission. Data on patient exposure to an invasive procedure was collected.

Conwy & Denbighshire NHS Trust	%-number of patients
Percutaneous Drainage	2.5
ERCP	1.1
Other	75.1
Other Endoscopy	9.3
Not Recorded	12.0

N = 281

Antibiotic Therapy during admission

Antibiotic Therapy was prescribed to 418 patients (52.5%) on the day of the survey.

Use of Antibiotics

Part of the survey was to determine the number of patients receiving antibiotic during their current admission. Prescribing was divided into prophylaxis and therapy.

- Those used for prophylaxis (a definition for prophylaxis in that any antibiotic prescribed for more than 24 hours was deemed to be therapy not prophylaxis),
- Those used for therapy.

Conwy & Denbighshire NHS Trust	%
Prophylaxis alone	22.9%
Treatment Alone	63.3%
Prophylaxis & Treatment	7.4%
Use not stated/Unknown	3.8%

N = 418

Conclusions

The survey has provided valuable information that will enable each of the Clinical Directorates to develop their own targeted infection control programme, thus facilitating compliance with the Welsh Assembly Governments recent publication: 'Healthcare Associated Infections: A Strategy for Hospitals in Wales'. The data sets collected will also inform directorates about many other pre-disposing factors which may impact on a patient's susceptibility to developing infection. Directorates should look critically at their individual prevalence data and relate this to their infection reduction plans.

As a Trust Conwy and Denbighshire's Hospital Acquired Infection rate is 5.6%, however it must be emphasised that this is a prevalence figure, and does not imply that 5.6% of patients admitted to the Trust will develop infection. An incidence figure is likely to be lower.
The overall Infection Rates (excluding respiratory tract) are lower than those conducted in previous national survey 1994, however these were calculated from the average taken from 157 centres which included teaching hospitals.

The preliminary results have identified the same major system infections as previous surveys. The most prominent system infection identified is Respiratory Tract Infection, however consideration must be taken into account for seasonal variation (as the study was performed during the winter) and that 68.7% of these were identified as Community Acquired. This high prevalence figure does imply that further investigation is required into the opportunities available to prevent the development of respiratory tract infection within the community and the opportunities for prevention of hospital admission.

A major finding of the study related to antibiotic use. Although only 138 patients were identified as having system infections, 264 were receiving antibiotics for therapy. This information should be critically reviewed by individual directorates, which may identify a need for further audit or investigation into the use of therapeutic antibiotics.

From the data collected it appears that the Trust's Hospital Acquired Rate is far lower than the rate quoted from previous prevalence studies. Limitations to the study however are that the results are reliant on the quality of data collected from the documentation that exists, that some directorates with small numbers of patients surveyed may be misleading, and finally some infections identified in directorates may have originated whilst the patient was in another clinical area.

There are currently plans for a national prevalence study in 2006, and the evaluation report (Appendix2) has identified avenues in which the data can be collected more efficiently.

Appendix 1

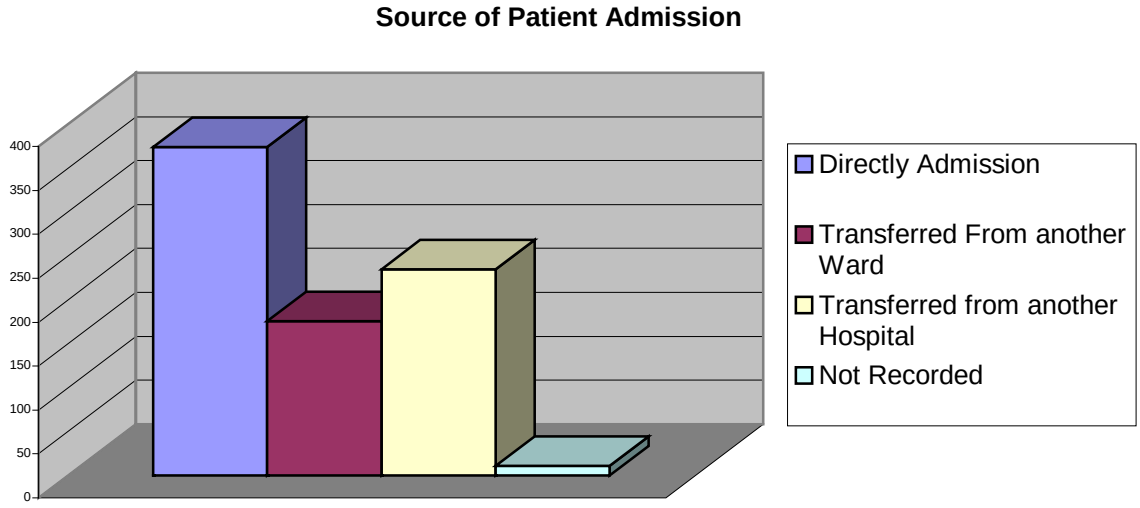
General Risk Factors

General risk factor data was collected on each patient.

Conwy & Denbighshire NHS Trust	%
Urinary Catheter	16.32
Peripheral Venous Catheter	28.33
Central Venous Device	4.27
Parenteral Nutrition	4.27
Mechanical Ventilation	1.75
Immunodeficiency	3.51
Neutropenia	1.00

N = 796

Data was collected about interhospital/ward transfers



Conwy & Denbighshire NHS Trust	%
Admitted directly to clinical area	46.9%
Transferred from another ward in the same hospital	29.5%
Transferred from another hospital	22.1%
Not Recorded	1.3%
N = 796	

Appendix 2

Evaluation of Point Prevalence Study 1st February 2005

Methodology

In identifying a process for data collection, clinical directors and leaders were invited to attend a meeting four weeks before the proposed study to explain the process of data collection and request their support, which would involve releasing a member of staff from each clinical area to collect the data. Prior to this meeting support was also gained from the Director of Nursing. All areas offered their support, which proved difficult in some instances due to staff shortages.

Nominations were received promptly and training sessions for the nominated nurses were arranged. The training sessions lasted approximately half an hour and consisted of:

- Disseminating the Point Prevalence Pack
- Explaining each question
- Giving a brief overview of definitions of infection
- Explaining the role of the data collector on the study day

By the day of the study 37 out of 43 data collectors had attended a training session.
The study day was structured to allow a brief overview of the study form and an opportunity for questions. Lunch was provided (again allowing for informal questions) and the study commenced at 1300hrs. Each data collector was allocated an infection control nurse as a point of contact for any queries.

Conwy and Denbighshire Trust also had 14 peripheral hospitals that were included in the study. In order to meet the needs of data collectors in these peripheral areas, training was arranged for them within their areas and they were given a point of contact on the study day for any queries. A small number of data collectors from peripheral sites were able to attend the briefing session on the study day.

The data collection process was completed by 1930 hours on the same day. On average it took 9 minutes to survey each bed however in Mental Health where the patients clinical condition is less complex it only took 5 minutes.

Following the study, the infection control team with the assistance of an ICDS specialist nurse visited each area (including community sites) and validated all forms where an infection had been identified. 208 infections were identified initially and following validation 139 were confirmed as meeting the agreed definitions.

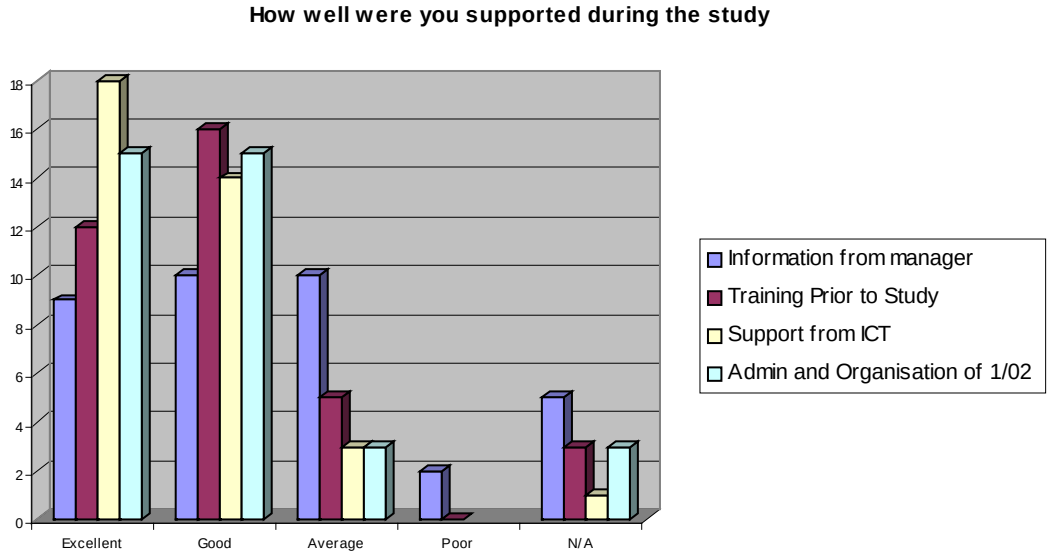
All data collectors were sent Thank you letters together with an evaluation form during the week following the study.

Atodiad 5

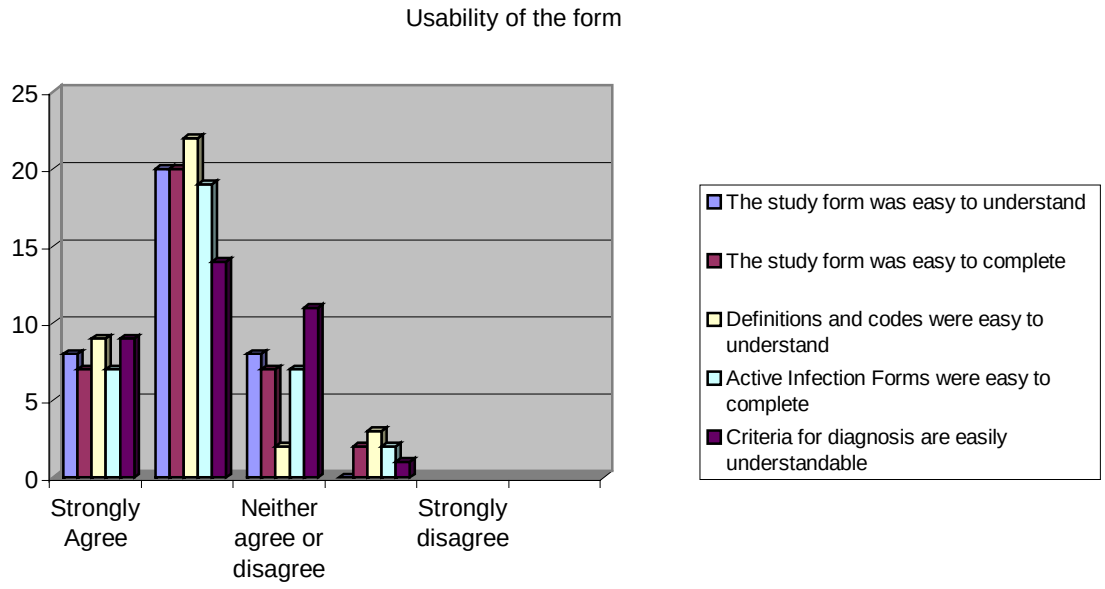
Evaluation

36 Evaluation Forms were returned, from 43 Data Collectors. (83%)

In relation to the support the data collectors received during the study, they were asked to comment of the information received from managers, the training received prior to the study, the support received from the Infection Control Team on the day and the administration and organisation of the day.



The data collectors were also asked to evaluate the data collection form. They were asked to evaluate how easy the form was to understand and complete. They were also asked how easily understandable the definitions were.



Additional Comments received from the data collectors were positive, negative and constructive and included

"Enjoyable and interesting"
"Clear and informative training made answering the questions easy"
" Too much work for 1 person"
"Criteria for Respiratory Infection difficult to understand – needed separate criteria for Chest Infection"
" Use of case scenarios during training sessions"
" To be performed overnight or at the weekend so that disruptions are reduced and notes are readily available"
"More Time Required"
"Support easily available to community hospitals"
"Initially appeared overwhelming but with practice got easier"
"Time consuming for one person – two people made the process easier"

Conclusion

Overall the study was a success. Despite staffing problems each area nominated a data collector. Communication from the infection control team with managers was well structured however the information was not clearly disseminated to the data collectors. The training prior to the study empowered the data collectors to work independently although support from the infection control team was readily available and utilised.

The data collection forms were easy to understand and complete although upon validation it became apparent that that there was some misinterpretation about the presence of infection.

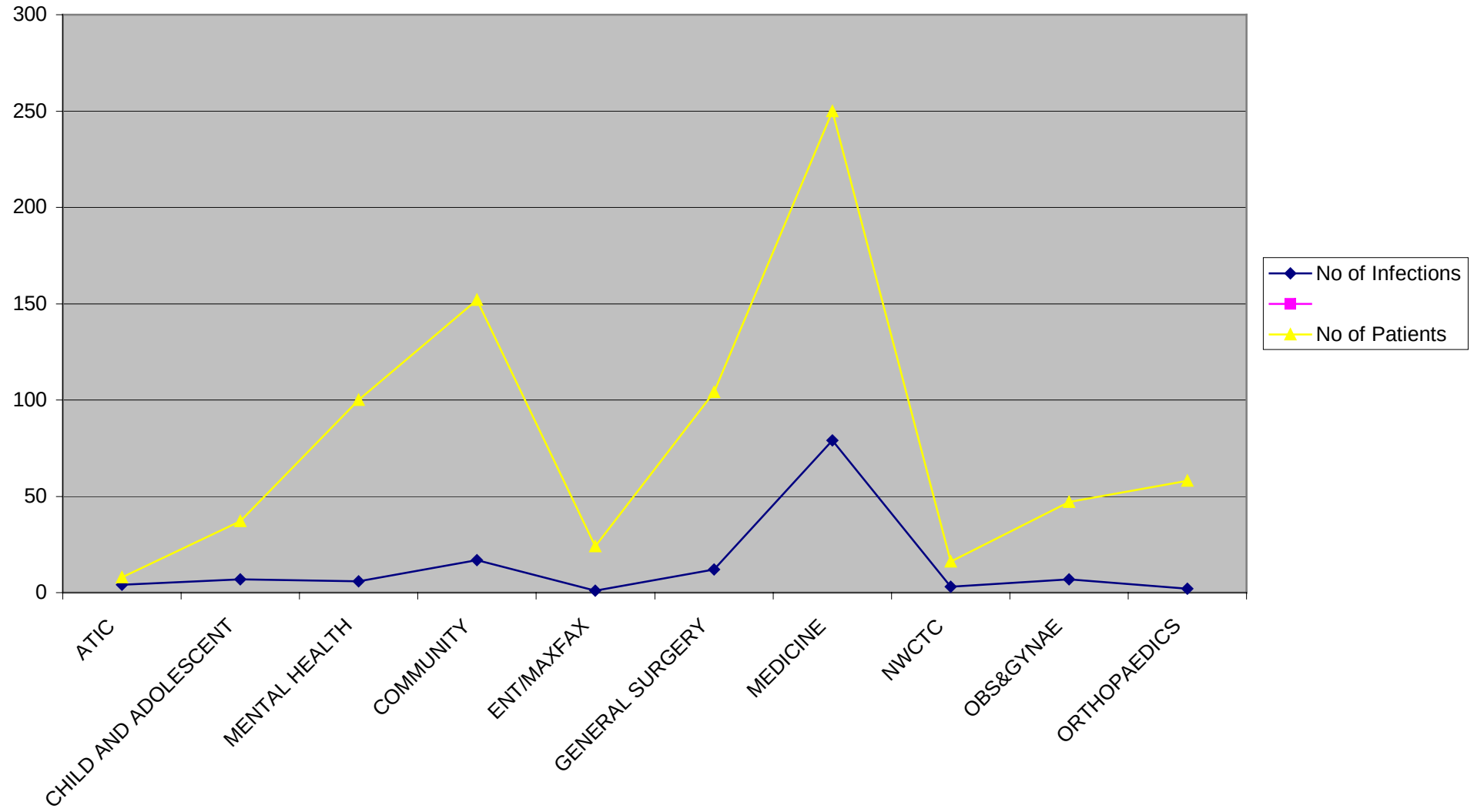
Recommendations

If the study were to be repeated the following recommendations would ease the burden to data collectors

- Longer Training sessions to include case scenarios and increased education about the definition of infection
- More than 1 data collector per acute ward
- Assess the implications of performing the study during a quieter period e.g. early evening or overnight

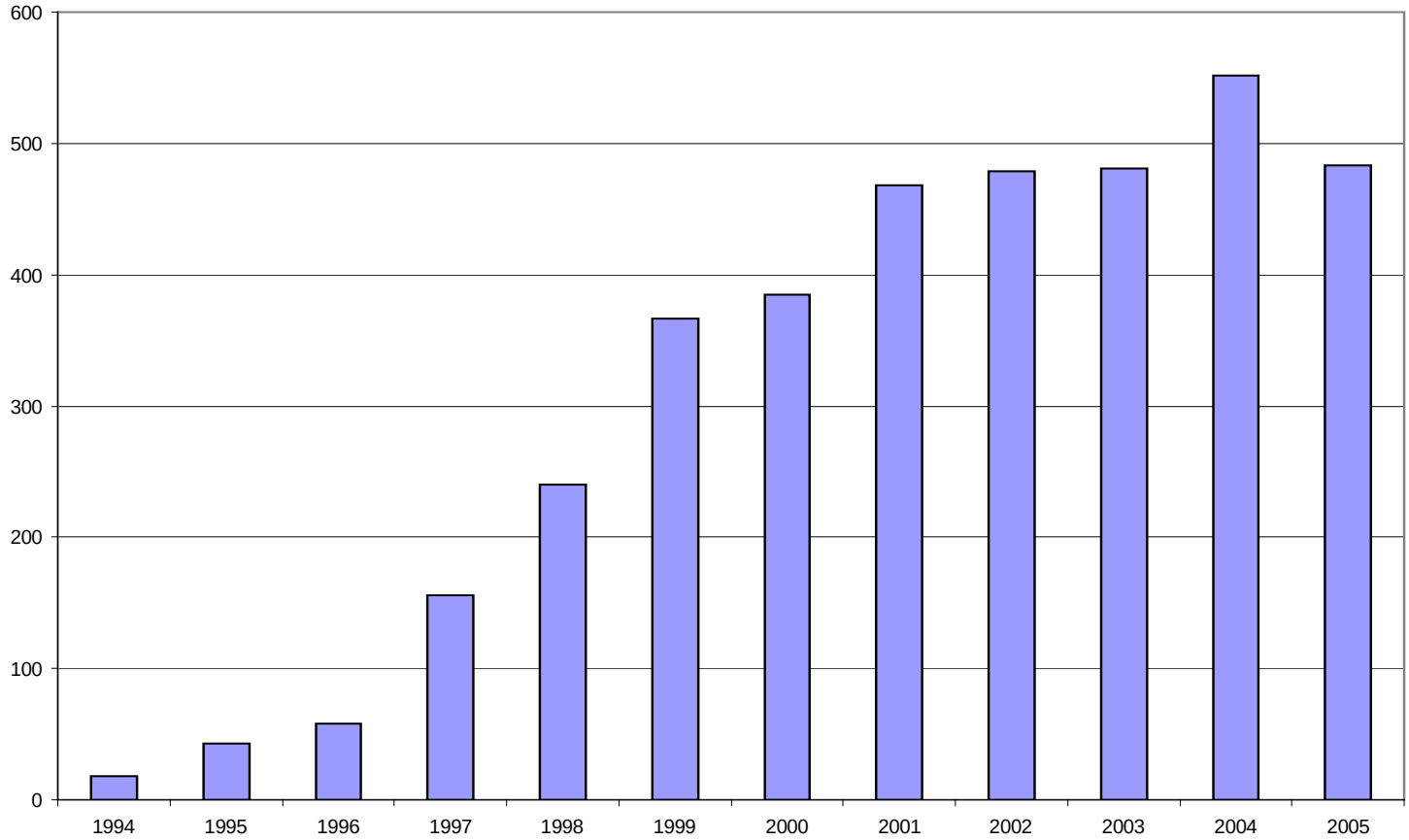
Atodiad 5

Appendix 3



Atodiad 6

New MRSA Isolates, NPHS Microbiology Rhyl, 1994-2005



The dramatic rise in occurrence of new laboratory isolations of meticillin resistant *Staphylococcus aureus* is demonstrated. The data set includes patients with asymptomatic colonisation, superficial infection and serious infection, including bloodstream infections. Currently approximately 40% of new cases are detected in the community, although it is believed that most of these are healthcare associated.

Standard 14: Infection Control

Purpose of Standard:	**There is a management environment, which minimises the risk of infection to patients, staff and visitors.**

Rationale and Risk:	Inadequate infection control has very significant health care and financial implications that can severely affect the effective functioning of the Trust. Prevention and control of infection is part of the overall risk management strategy within the healthcare environment and an integral part of the management of antibiotic resistance. A proportion of hospital-acquired infection is preventable. Evolving clinical practice presents new challenges in infection prevention and control, which need continual review and assessment.

REFERENCES:

1. WHC (2000) 13 – Risk Management and Organisational Control
2. WHC (99) 158 – Variant Creutzfeld-Jakob Disease (vCJD): Minimising the Risk of Transmission
3. WHC (99) 157 – Controls Assurance in Infection Control: Decontamination of Medical Devices
4. WHC (98) 56 – The Interdepartmental Working Group on Tuberculosis – The Prevention and Control of Tuberculosis in the UK, 1996
5. WHC (99) 04 – AIDS/HIV Infected Health Care Workers: Guidance on the Management of Infected Health Care Workers and Patient Notification: Recommendations of the Expert Advisory Group on AIDS
6. National Priorities Guidance for 1999/00 – 2001/02 [and 2000/01 – 2002/03 update]
7. Guidelines on Post-Exposure Prophylaxis for Health Care Workers Occupationally Exposed to HIV: Recommendations of the Expert Advisory Group on AIDS 1997 (under revision)
8. "Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection" (Advisory Committee on Dangerous Pathogens (ACDP)/Spongiform Encephalopathy Advisory Committee (SEAC), April 1998
9. AS/NZS 4360:1999 Risk management
10. Internal Control – Guidance for Directors on the Combined Code of Practice on Good Corporate Governance (The "Turnbull" report)
11. HSC 1999/178 – Variant Creutzfeld-Jakob Disease (vCJD): Minimising the Risk of Transmission
12. HSC 1999/179 – Controls Assurance in Infection Control: Decontamination of Medical Devices
13. HSC 1998/063 – Guidance for Clinical Health Care Workers: Protection against Infection with Blood-borne viruses. Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis
14. HSC 1998/226 - AIDS/HIV Infected Health Care Workers: Guidance on the Management of Infected Health Care Workers and Patient Notification: Recommendations of the Expert Advisory Group on AIDS
15. HSC(91)33 – Decontamination of Equipment, Linen and Other Surfaces Contaminated with Hepatitis B and/or Human Immunodeficiency Viruses
16. HSC 1999/123 – Risk management and organisational controls
17. EL(96)51 – The Interdepartmental Working Group on Tuberculosis – Guidance on Tuberculosis Control, 1996
18. HSC 1998/196 – The Interdepartmental Working Group on Tuberculosis – The Prevention and Control of Tuberculosis in the UK, 1996
19. HSC 1998/025 – The Management and Control of Viral Haemorrhagic Fevers. Summary of the Guidance from the Advisory Committee on Dangerous Pathogens

20. HSG (95) 10 – Hospital Infection Control: Guidance on the control of infection in hospitals prepared by the joint DH/PHLS Hospital Infection Working Group
21. HSG (93) 40 – Protection of Health Care Workers and Patients against Hepatitis B (under revision)

Area for Assessment 1:	**Accountability** **Board level responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters throughout the organisation, leading to the board.**
Guidance:	The Chief Executive is responsible for ensuring that there are effective arrangements for infection control within the hospital. Clear lines of accountability throughout the organisation should be established defining the relationships between the Risk management Committee, Clinical Governance Committee, Infection Control Committee and Infection Control Team. The following specific arrangements should be in place. • ✓The infection control programme is developed with the support of the board and approved by it. • ✓The Chief Executive and Risk Management Committee receive the annual report on the infection control programme which is presented to the board. • ✓The Chief Executive, or a deputy with authority to make appropriate decisions on the Chief Executive's behalf, works closely with the Infection Control Team within the hospital. • ✓Senior management support is provided for infection control emergencies out of hours. The Chief Executive and the Risk Management Committee are informed of any serious problems or issues relating to infection control issues.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
1.1	The above arrangements are recorded within the board minutes. *Example of evidence:* ➢ *Board minutes.*	✓			Clinical governance meetings minutes Risk Management Committee
1.2	**The minutes of the risk management committee record that the board has accepted its responsibility for overseeing effective infection control arrangements.** ***Example of evidence:*** ➢ ***Risk management committee minutes.***	✓			

1.3	**An accountability chart or diagram exists, showing that clear lines of accountability exist for infection control issues.** ***Example of evidence:*** ➢ ➢ ***Accountability chart.***	✓			Organisational charts, reflecting structural changes

Overall Evaluation:	**Compliance**			**Score**
	Yes ✓	**No**	**Partial**	100%

General Comments on Area for Assessment 1:

Area for Assessment 2: 	**Accountability** **There is an infection control committee that endorses all infection control policies, procedures and guidance, provides advice and support on the implementation of policies, and monitors the progress of the annual infection control programme to develop, endorse and communicate all infection control policies and act as a central resource for guidance and support in relation to all infection control matters.**
Guidance:	The membership of the Infection Control Committee (ICC) should include: • ✓the Infection Control Team (ICT) • ✓the Chief Executive or a nominated senior manager with authority to represent him or her; • ✓the Consultant in Communicable Disease Control (CCDC) for the Health Authority in which the hospital is situated; • ✓the Occupational Health Physician and the Occupational Health Nurse or manager; • ✓an Infectious Disease Physician where there is one; • ✓Nurse Executive Director or nominated representative(s); • ✓senior clinical representatives nominated by the Medical Director; • ✓other identified representatives from, for example, Sterile Services Department, Estates Department, Facilities Management, etc. The structure of the ICC should be appropriate to the organisation. Some organisations have found that smaller, operational ICCs reporting to the main ICC work well. The ICC should have agreed Terms of Reference and Accountability arrangements and should meet at least twice a year. Minutes of the ICC should be circulated to all clinical Directors/managers and relevant committees, for example, clinical governance and risk management committees. The ICC should provide advice and support to the ICT.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
2.1	There are clear terms of reference for the infection control committee with a broad membership. *Example of evidence:* ➢ *Terms of reference.*	✓			Terms of reference
2.2	**Detailed minutes are taken at all infection control committee meetings and circulated to all relevant staff.** ***Examples of evidence:*** ➢ ***Minutes.*** ➢ ***Circulation lists.***	✓			Control of infection Committee meetings Distribution list

Overall Evaluation:	Compliance			**Score**
	Yes ✓	**No**	**Partial**	**100%**
General Comments on Area for Assessment 2:				

Area for Assessment 3: 	**Accountability** **There is an appropriately constituted and functioning Infection Control Team (ICT).**
Guidance:	The Infection Control Team (ICT) includes: • ✓the infection control doctor(s) (ICD); • ✓the infection control nurse(s) (ICN); • ✓a consultant medical microbiologist if the ICD is from another speciality. The ICT should be supported, as appropriate, by adequate secretarial, IT and audit staff. The responsibilities of each member of the ICT are clearly defined and the contracted sessions per week for the ICD are defined and agreed. Members of the ICT must have appropriate training in infection control and provide evidence of relevant continuing professional development (CPD). The ICT liaises with the Trust occupational health department(s) when dealing with: • ✓infection control advice relating to the health and safety of Health Care Workers; • ✓infection control advice relating to the transmission of infection from Health Care Workers to patients, other members of the organisation's staff and visitors. The ICT should ensure that advice on infection control is available on a 24-hour basis. The ICT liaises with the local Consultant in Communicable Disease Control when dealing with: • ✓outbreaks within the acute and community settings; • ✓issues relating to infection within primary care settings; • ✓areas of work requiring the involvement of environmental health officers.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
3.1	There is an Infection Control policy referring to the membership of this team. *Example of evidence:* ➢ *Policy.*	✓			Infection Control Standard, in date
3.2	**There is a document setting out membership and roles of the ICT.** ***Example of evidence:*** ➢ ***Constitution.***	✓			

Overall Evaluation:	Compliance			Score
	Yes ✓	No	Partial	100%
General Comments on Area for Assessment 3:				

Area for Assessment 4:	**Processes** **Prevention and control of infection is considered as part of all service development activity.**
Guidance:	Infection control advice should be provided by the Infection Control Team (ICT), particularly in relation to the following: • the development of policies relating to engineering and building services for the Trust and to the purchase of medical devices/equipment; • early stage planning for advice relating to engineering and building works and the purchase of medical devices/equipment; • all stages of the contracting process for hotel and other services that have implications for infection control, eg cleaning, laundry, clinical waste.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
4.1	There is a written procedure detailing how infection control advice/assistance is sought, at an early stage, prior to any significant building development/change in utilisation. *Example of evidence:* ➢ *Procedure.*	✓			Health & Safety management policy, Estates department, details Infection control liaison
4.2	**Infection control input is built in to the procurement process (ie evidence of correspondence with infection control specialist on purchase documentation) for new medical equipment purchases/trialling and in respect of any other changes in contracts such as disposal of clinical waste.** ***Examples of evidence:*** ➢ ***Procurement procedure.*** ➢ ***Sample procurement.***	✓			Procurement process EBME, in date Infection control inclusion evident on procurement form Waste management policy, in date

Overall Evaluation:	**Compliance**			**Score**
	Yes ✓	**No**	**Partial**	**100%**

General Comments on Area for Assessment 4:

Area for Assessment 5: 	**Processes** **An organisation wide annual infection control programme with clearly defined objectives is produced by the infection control team.**
Guidance:	The ICT should develop and produce an annual infection control programme in full consultation with relevant key stakeholders, including the Infection Control Committee, health professionals and senior managers. The programme should include reference to audit of the implementation of, and compliance with, selected infection control policies. The annual infection control report should outline the progress of the infection control programme.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
5.1	There is a documented infection control programme covering all relevant areas of the Trust developed in full consultation with relevant professionals. *Example of evidence:* ➢ *IC programme.*	✓			Annual report, shows plan in retrospect, 2004 within objectives in annual report
5.2	**There are local level business plans that reflect the infection control programme objectives and agreed local education and audit activity.** ***Example of evidence:*** ➢ ***Sample business plans.***	✓			Operational plans selection of directorates [medicine, cancer services, dental, A&E, T&O, facio-max, community]
5.3	**There is a written audit programme for infection control activity.** ***Example of evidence:*** ➢ ***Audit programme.***	✓			Audit rolling programme

Overall Evaluation:	**Compliance**			**Score**
	Yes ✓	**No**	**Partial**	**100%**

General Comments on Area for Assessment 5:

Area for Assessment 6: WRP WELSH RISK POOL • CRONFA RISG CYMRU	**Processes** **Written policies, procedures and guidance for the prevention and control of infection are implemented and reflect relevant legislation and published professional guidance.**
Guidance:	There should be a core of infection control policies, approved by the ICC, available for all relevant staff. Each directorate, department or service should have a current copy of the approved policies, procedures and guidelines pertinent to its activities. Key policies should be in place, including: • ✓Universal infection control precautions; • ✓Handwashing; • ✓Major outbreaks of communicable infections; • ✓Isolation of patients; • ✓Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries; • ✓Management of occupational exposure to BBVs and post exposure prophylaxis; • *Antimicrobial prescribing; **within medicines management policies** • ✓Control of MRSA, VRE and other antimicrobial resistant micro-organisms; • ✓Control of tuberculosis, including multi-drug resistant tuberculosis; • ✓Safe handling and disposal of clinical waste; • ✓Single use and single patient use devices and other health care products; • ✓Decontamination and reprocessing of re-usable medical devices; • ✓Ward closure; • ✓Packaging, handling and delivery of laboratory specimens; within Microbiology policy • ✓Occupational health policies for prevention and management of communicable infections in health care workers, including those infected with BBVs; • *Handling of medical devices in procedures carried out on known/suspect CJD patients and on patients in risk categories for CJD as defined in the ACDP/SEAC guidance (including disposal/quarantining/procedures). In draft All policies should be included in an annual audit programme.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
6.1	All relevant staff have received/have easy access to infection control policies. ***Examples of evidence:*** ➢ *Distribution lists.* ➢ *Distribution systems.*			✓	On intranet Specific yellow folders in clinical areas Updates distributed for hard copies via Infection control library Policy distribution lists

6.2	Annual audit reports on compliance with these policies. ***Example of evidence:*** ➢ *Annual report.*	✓			Audit reports re compliance and response Annual report re audit
6.3	Evidence of name of the author, ratification and review dates, and relevant reference information. ***Examples of evidence:*** ➢ *Policy on policy control.* ➢ *Sample policies.*	✓			

Overall Evaluation:	**Compliance**			**Score**
	Yes	**No**	**Partial✓**	**90%**

General Comments on Area for Assessment 6:

Area for Assessment 7: 	**Processes** **There is an annual programme for the audit of the infection control policies and procedures.**
Guidance:	There should be a written programme for the audit of infection control policies and procedures. The annual programme should include a timetable stating which key infection control policies, procedures and guidance are to be reviewed or written that year. The audit should check that all policies are clearly marked with a review date. Audit results should be included in the infection control annual report.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
7.1	There should be a written audit programme. *Examples of evidence:* ➢ *Audit programme document.* ➢ *Annual report.* ➢ *Sample policies.*	✓			Audit programme Audit tool template

Overall Evaluation:	**Compliance**			**Score**
	Yes ✓	**No**	**Partial**	**100%**

General Comments on Area for Assessment 7:

Area for Assessment 8: 	**Processes** **Specialist microbiological support is provided in a timely and effective manner.**
Guidance:	The microbiology laboratory should be CPA accredited and should support the infection control service via processing, data provision, surveillance and specialist testing. There should be access to and provision for timely specialist microbiology support, including the interpretation of results either on-site or via reference centres, eg Public Health Laboratory Service (PHLS). Written procedures should be available relating to specimen collection, handling and disposal. There should be a written procedure for the reporting of results on each test. The ICT should have appropriate access to laboratory results via an effective computer system. Microbiology services should be available on a 24-hour basis. Funding for outbreaks of infection should be agreed in advance. Appropriate arrangements should be in place for meeting all laboratory costs arising from outbreaks of infection.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
8.1	A Microbiology Laboratory policy document, which details the level of support to the infection control function. *Example of evidence:* ➢ *Policy.*	✓			CPA accreditation Microbiological policies, in date
8.2	**Written procedures on specimen collection handling and disposal and on the reporting of test results.** ***Example of evidence:*** ➢ ***Procedures.***	✓			

Overall Evaluation:	**Compliance**			**Score**
	Yes ✓	**No**	**Partial**	**100%**

General Comments on Area for Assessment 8:

Area for Assessment 9:	**Processes** **There is a defined surveillance method in place in accordance with centrally agreed objectives, specified in the annual infection control programme.**
Guidance:	There should be agreed objectives and priorities for targeted surveillance of infection, developed by the ICT and endorsed by the ICC. Methods of surveillance should be defined and in place. There should be continuous "alert organism" and "alert condition" surveillance covering the whole hospital to prevent and rapidly detect outbreaks of infection. Confidentiality for patients and staff should be maintained at all times. Results of the analysis of surveillance with interpretation and recommendations should be reported to the ICC, clinicians, nurses and others who need to know regularly. Any appropriate action should be agreed with the ICT.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
9.1	Surveillance policy in force, which is reviewed on a regular basis with a minuted record to this effect within the infection control committee meetings. *Examples of evidence:* ➢ *ICC minutes.* ➢ *Surveillance report.*			✓	Infection Control minutes Annual report detailing Surveillance Bacteraemia surveillance report Orthopaedic surveillance survey report
9.2	**The surveillance programme makes reference to the means of prevention of specific infections.** ***Example of evidence:*** ➢ ***Surveillance programme.***			✓	

Overall Evaluation:	**Compliance**			**Score**
	Yes	**No**	**Partial✓**	**80%**

General Comments on Area for Assessment 9:

Area for Assessment 10:	**Processes** **A comprehensive infection control report is produced by the Infection Control Team on an annual basis, reviewed by the Risk Management Committee and presented to the board.**
Guidance:	The annual infection control report should contain, as a minimum, information on the following: • progress of the infection control programme; • a review of reported adverse incidents; • any recommendations made on measures taken to prevent recurrence of incidents; • surveillance data; • education and training undertaken; • results of audit. The report should be submitted to the Risk Management Committee for review. The Risk Management Committee, which includes in its membership the Chief Executive, should present the report to the board, bringing to the board's attention any significant risks or other issues.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
10.1	There is an annual Infection Control Report covering the issues in the area for assessment. *Example of evidence:* ➢ *Annual report.*	✓			
10.2	The minutes of the Risk Management Committee record receipt and review of the report. *Example of evidence:* ➢ *Risk management committee minutes.*	✓			

Overall Evaluation:	**Compliance**			**Score**
	Yes ✓	**No**	**Partial**	**100%**

General Comments on Area for Assessment 10:

Area for Assessment 11: 	**Capability** **The Infection Control Committee and Infection Control Team have access to up-to-date legislation and guidance relevant to infection control.**
Guidance:	There are many sources of information on legislation and infection control guidance, including books and, through subscriptions to specialist information providers, CD-ROMs containing the full text. Up-to-date NHS Wales guidance can be accessed on HOWIS (http://howis.wales.nhs.uk/) and NHS Executive guidance can be accessed on the Internet on the Department of Health COIN database. The Health and Safety Executive's website (http://www.hse.gov.uk) contains up-to-date information on legislation and guidance. Full text copies of all legislation issued from 1 January 1997 can be downloaded from (http://www.official-documents.co.uk) which contains information on UK official documents.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
11.1	There is an Infection Control Library of documents/journals/books/ CD-ROMs. *Example of evidence:* ➢ *Library.*	✓			Trust library with infection control section Infection control library for Lab staff and IC Team Library resources list
11.2	The team have direct Internet access. *Example of evidence:* ➢ *See above.*	✓			

Overall Evaluation:	**Compliance**			**Score**
	Yes ✓	**No**	**Partial**	**100%**

General Comments on Area for Assessment 11:

Area for Assessment 12:	**Capability** **Education in infection control is provided to all health care staff, including those employed in support services.**
Guidance:	All staff, including those employed by support services, should receive training in prevention and control of infection. Infection control should be included in induction programmes for new staff, including support service staff. There should be a programme of ongoing education for existing staff, including update of policies, feedback of audit results and the action needed to correct deficiencies. Junior doctors and specialist registrars should receive training in infection control and antimicrobial prescribing as part of their continuing professional development (CPD). Records should be kept of attendance of all staff on infection control education programmes.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
12.1	Documented induction and training programme for staff (including medical, locum and agency personnel). *Example of evidence:* ➢ *Annual risk management report.*	✓			Induction programmes Junior doctors handbook Training records
12.2	There is a system for identifying staff working in high-risk clinical environments, for whom ongoing infection control training is provided. *Example of evidence:* ➢ *Board minutes.*	✓			Training records Focus groups with nominated link members who have attained diploma level module on infection control
12.3	Training records of attendance of staff in high-risk areas having received such training. *Example of evidence:* ➢ *Board minutes.*	✓			Focus group minutes Training records across the board

Overall Evaluation:	**Compliance**			**Score**
	Yes ✓	**No**	**Partial**	**100%**

General Comments on Area for Assessment 12:

Area for Assessment 13:	Outcomes **Key indicators capable of showing improvements in infection control and/or providing early warning of risk are used at all levels of the organisation, including the board, and the efficacy and usefulness of the indicators is reviewed regularly.**
Guidance:	The organisation should develop indicators that demonstrate the performance of infection control and the risk management process. One indicator is degree of compliance with this standard. Ideally the indicators should be designed to demonstrate improvement in the performance of control of infection services over time. The number of indicators devised should be sufficient to monitor the infection control service and the risk management process. It is not necessarily the case that all the indicators will be used by the board. The board should select those that are useful for ensuring that the internal controls are working satisfactorily and infection control services are meeting their objectives. The National Assembly for Wales will review the actual indicators used by organisations to identify best practice in indicator use. This will inform the development of a set of national indicators for benchmarking and monitoring purposes.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
13.1	A list of indicators has been developed. *Example of evidence:* ➢ *Infection control indicators.*	✓			Outbreaks, infection rates, specialist infection data rates, quarterly reports
13.2	**There is evidence that information is gathered, used at all levels and reported to the Infection Control Committee.** ***Example of evidence:*** ➢ ***Minutes of ICC.***	✓			Annual report Quarterly reports to Directorates and focus groups Control of Infection Committee minutes

Overall Evaluation:	**Compliance**			**Score**
	Yes ✓	**No**	**Partial**	**100%**

General Comments on Area for Assessment 13 :

Area for Assessment 14: 	**Monitoring and review** **The system in place for control of infection is monitored and reviewed by management and the board in order to make improvements to the system.**
Guidance:	It is the responsibility of the Chief Executive and the board to monitor and review all aspects of the infection control system, including: • accountability arrangements; • processes, including risk management arrangements; • capability; • outcomes; • internal audit findings. The Infection Control Committee will review the detailed issues surrounding infection control. Risk Management Committee will play a significant role in monitoring and reviewing all aspects of the system as a basis for establishing significant information that should be presented to, and dealt with by, the board. The Clinical Governance Committee may also play a significant role in monitoring and reviewing control of infection as it impacts on the quality of clinical service provision. The Audit Committee should review internal audit findings.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
14.1	Internal Audit undertake reviews of the infection control systems. *Example of evidence:* ➢ *Internal audit reports.*	✓			Rolling programme ICT audit results
14.2	Reports detailing monitoring and review activity undertaken, with evidence that any shortcomings have been satisfactorily addressed. *Examples of evidence:* ➢ *Action plans.* ➢ *Reports.*	✓			
14.3	Specific action taken is recorded within the risk management committee meeting minutes and/or Infection Control Committee minutes. *Example of evidence:* ➢ *Minutes of ICC/risk management committee.*	✓			

Overall Evaluation:	Compliance			Score
	Yes ✓	No	Partial	100%
General Comments on Area for Assessment 14:				

Area for Assessment 15: 	**Audit** **The Internal Audit function carries out periodic audits to assure the Board that a system of infection control is in place conforming to this standard.**
Guidance:	Internal auditors, in collaboration with the ICC and ICT, should periodically verify that a system of internal control exists with respect to infection control. The level of independent audit should be carried out should be based on risk, which will be determined principally by reference to assurances given by the ICC and ICT. Reports should be presented to the Audit Committee and copied to the Risk Management Committee and any other relevant board sub-committee (eg Clinical Governance Committee). An annual internal audit statement should be provided to the Chief Executive which sets out the audit work carried out for the year. Where the system in place for infection control has been audited, this should be referred to in the statement.

No.	Check for evidence that :	Yes	No	Partial	Comments (including cross reference to evidence)
15.1	Internal Audit provides report(s) and statement to Chief Executive. *Example of evidence:* ➢ *Reports/statements.*	✓			Audit reports, on rolling programme
15.2	Minutes confirming receipt – ICC, Risk Management Committee, Clinical Governance Committee. *Examples of evidence:* ➢ Minutes of ICC, risk management committee, clinical governance committee.	✓			

Overall Evaluation:	**Compliance**			**Score**
	Yes ✓	**No**	**Partial**	**100%**

General Comments on Area for Assessment 15:

INSTRUCTIONS FOR DETERMINING SCORE

1. Any 'Areas for Assessment' which are thought to be Not Applicable should, in the case of standards 1-21, be agreed by the Welsh Risk Pool in advance. In such cases or in standards 22-35 where the NHS body believes an Area of Assessment is Not Applicable a line should be drawn through the whole standard on the Summary Score table.
2. After completing the standard, enter the scores in the Y, N and P boxes in the Score Table. Award 100 for "full" (f) response. Award 0 for "non" (N) response. Enter a score between 1 and 99 to demonstrate the extent of partial compliance (see scoring rationale table)
3. Multiply the 'Area for Assessment' weighting by the relevant score given in either of the Y, N, or P columns and record the result in the Weighting (W) x Score (S) column
4. Sum up the weightings for all the applicable Areas for Assessment and record the value in the Total Weightings (A) box.
5. Sum up the values in the W x S column and record the result in the Total Scores (B) box.
6. Calculate the overall % score (B divided by A) and record in the Total % Score box.
7. Model Elements are indicated in the text next to the Area for Assessment within each standard. They include: Accountability, Process, Capability, Outcomes, Monitoring/Review, and Audit. This is to assist with performance management.

			Scoring				
Area for Assessment	**Model Elements**	**Weighting**	**Y**	**N**	**P**	**N/A**	**W x S**
1	Accountability	25					
2	Accountability	50					
3	Accountability	50					
4	Processes	50					
5	Processes	50					
6	Processes	100					
7	Processes	50					
8	Processes	50					
9	Processes	100					
10	Processes	10					
11	Capability	50					
12	Capability	50					
13	Outcomes	25					
14	Monitoring and review	50					
15	Audit	10					
	TOTAL WEIGHTINGS (A)					**TOTAL SCORES (B)**	68500

Total % Score (B divided by A)	**95%**

INSTRUCTIONS FOR ACTION PLANNING

1. Identify the 'Area for Assessment' number to which the action relates. Enter the action number and a brief description of the action.
2. Identify a simple priority for the action. This could be high, medium or low, or could relate to time-scale for implementation, e.g. immediate action; action within 1 month; etc.
3. Identify any costs associated with the action. Where appropriate, identify both non-recurring (e.g. capital) and recurring (e.g. revenue) costs.
4. Identify the due date for the action and enter the date when the action is complete (Date Comp).

PAGE ___ OF ___

AREA FOR ASSESSMENT	ACTION No.	DESCRIPTION	PRIORITY	RESPONSIBILITY	COST (£)	DUE DATE	DATE COMP

Atodiad 8

Welsh Healthcare Associated Infections Strategy
Accident and Emergency

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Improvement in Hand Hygiene		Implement the NPSA 'clean your hands' campaign	Clinical Lead, ICT and Ward Champions		Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness	Clean Hospitals Group, Clinical Lead and Domestic Services		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed	Action Plans addressed Internal audit cycle established with results being fed back to CHG	
All staff will receive training on infection control	Red	Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

Safe Management of Infectious Patients within A&E		Development of local policies for the management of infectious patients	Clinical Lead	December 2005	Policy Not Developed	Policy developed and agreed with Infection Control	Policy Ratified and staff aware of procedures required	
Prevention of Infection Associated with insertion of IV cannula		Observational Audit	Clinical Lead and Clinical Director	March 2006	No action taken	Nominated person developing audit tool	Audit completed and results presented to directorate	

Atodiad 8

Welsh Healthcare Associated Infections Strategy
Cancer Services

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Improvement in Hand Hygiene		Implement the NPSA 'clean your hands' campaign	Clinical Lead, ICT and Ward Champions		Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness	Clean Hospitals Group, Clinical Lead and Domestic Services		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed	Action Plans addressed Internal audit cycle established with results being fed back to CHG	
All staff will receive training on infection control	Red	Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

Atodiad 8

Surveillance of Central Venous Devices		Data set to be decided Nominated Lead for facilitation of surveillance	Clinical Lead PICC Nurse Specialist		Surveillance form not completed.	Nominated nurse identified Surveillance form accepted	Structured Surveillance trailed with proposed commencement date	
Review Burden of Disease in relation to MRSA		Case Note Review			No identified person to commence audit	Junior Doctor identified to undertake short audit and case note review	Case Note Review completed Results fedback to directorate	

Atodiad 8

Welsh Healthcare Associated Infections Strategy
Community Directorate

Objective	Current Status	Action Points	By Whom	By When	Progress Criteria			Date achieved/Comments
					Red	**Amber**	**Green**	
Improvement in Hand Hygiene	Green	Implement the NPSA 'clean your hands' campaign	Clinical Lead, ICT and Ward Champions		Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness	Clean Hospitals Group, Clinical Lead and Domestic Services		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed	Action Plans addressed Internal audit cycle established with results being fed back to CHG	
All staff will receive training on infection control	Red	Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

Identify the pressure sore prevalence and the impact on DN services		Identify research studies for monitoring prevalence Develop audit tool to monitor and assess impact		March 2006	Research studies not identified Audit Tool not developed	Research Studies identified Audit Tool developed	Audit being performed by Community Nursing Teams	
Monitor Rates of Infection of PEG Sites		Identify research studies in order to develop mechanisms for data capture Develop audit criteria to monitor trends		September 2005 March 2006	Research Studies not identified Audit Tool not developed	Research Studies identified Audit Tool developed	Audit being performed by Community Nursing Teams	
Identify Infection Control Issues for Community Nursing		Baseline assessment undertaken Action Plan to be developed	Deputy CSM's to work with G Grades	September 2005	Base Line Assessment not undertaken	Baseline Assessment undertaken Action Plan not developed	Action Plan developed identifying Infection Control Issues for Community Nursing	

Atodiad 8

Welsh Healthcare Associated Infections Strategy
Directorate of Clinical Support Services

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Improvement in Hand Hygiene		Implement the NPSA 'clean your hands' campaign locally following release of recommendations from NPSA in relation to Primary Care	Clinical Lead, ICT and identified Champions	May 2006	Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness	Clean Hospitals Group, Clinical Lead and Domestic Services		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed	Action Plans addressed Internal audit cycle established with results being fed back to CHG	
All staff will receive training on infection control		Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

To review and where necessary write infection control policies for each department in line with Trust Guidelines for infection control		Set up divisional group with leads from each department to review local policies	Stuart Harmes – Head of Podiatry	2005 -2006	Divisional Leads not identified.	Leads identified, and divisional group formed	Policies reviewed and where necessary updated	

Atodiad 8

Welsh Healthcare Associated Infections Strategy
ENT and Maxillofacial Surgery

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Improvement in Hand Hygiene		Implement the NPSA 'clean your hands' campaign	Clinical Lead, ICT and Ward Champions		Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness	Clean Hospitals Group, Clinical Lead and Domestic Services		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed	Action Plans addressed Internal audit cycle established with results being fed back to CHG	
All staff will receive training on infection control		Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

Atodiad 8

Trial of Pre-operative Screening for patients undergoing major surgical procedures		Protocol to be devised Swabbed patients to be tracked to identify if there are any benefits to preoperative screening	Ward Sister, Nurse Practitioner and ICT	Commenced September 2005	Protocol not devised Screening not commenced	Protocol devised Screening commenced	6 month trial completed and assessed	

Atodiad 8

Welsh Healthcare Associated Infections Strategy
Intensive Care

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Improvement in Hand Hygiene		Implement the NPSA 'clean your hands' campaign	Clinical Lead, ICT and Ward Champions		Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness	Clean Hospitals Group, Clinical Lead and Domestic Services		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed	Action Plans addressed Internal audit cycle established with results being fed back to CHG	
All staff will receive training on infection control		Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

Atodiad 8

Monitoring and Reduction of ITU Acquired MRSA		Compliance with Barrier Nursing Policy and Procedures Monthly feedback of MRSA rates to clinical director	Clinical Lead and all staff Infection Control Team	Monthly	ITU acquired MRSA increasing. Poor compliance with barrier nurse policies and procedures	ITU acquired MRSA remains static Compliance with Policies and Procedures	ITU Acquired MRSA reducing Compliance with Policies and Procedures	
Surveillance of Ventilator Associated Pneumonia		Implement surveillance software Identify process for data collection	Dr G Bugelli		Surveillance System not in place	Surveillance system in place. Data collected No reporting mechanism,	Surveillance system in place. Reporting mechanism in place	

Atodiad 8

Welsh Healthcare Associated Infections Strategy
Directorate of Medicine

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Improvement in Hand Hygiene		Implement the NPSA 'clean your hands' campaign	Clinical Lead, ICT and Ward Champions		Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness	Clean Hospitals Group, Clinical Lead and Domestic Services		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed	Action Plans addressed Internal audit cycle established with results being fed back to CHG	
All staff will receive training on infection control	Red	Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

Atodiad 8

Audit of Compliance with Isolation Precautions		Observational Audit of all clinical areas	ICT, Lead Nurse		Audit tool not developed No Audits performed	Audit Tool developed Audit ongoing	Identified Areas audited and report presented to directorate	
Reduction of Staphylococcal Bacteraemias		Collection of mandatory surveillance data Standardise practice for the insertion and care of peripheral venous catheters Audit compliance with standards	Dr M Kumwenda	(Forms part of the Trust's Infection Reduction Strategy)	Surveillance in place	Baseline Audit completed. Standard for insertion and care developed	Practice standardised Compliance audited	

Atodiad 8

Ophthalmic Directorate (DRAFT)

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
All staff will receive training on infection control	Red	Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training
Improvement in Hand Hygiene	Green	Implement the NPSA 'clean your hands' campaign	Clinical Lead, ICT and Ward Champions		Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness	Clean Hospitals Group, Clinical Lead and Domestic Services		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed	Action Plans addressed Internal audit cycle established with results being fed back to CHG	

Monitor infection rates following ophthalmic surgery		Data collection in relation to the no of infections identified post operatively	Clinical Lead		Data Collection not implemented	Data Collection in progress	Data collection in progress and results fed back to Head of Nursing and Clinical Audit with any increases notified to ICT	

Atodiad 8

Welsh Healthcare Associated Infections Strategy
Orthopaedic Directorate

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Improvement in Hand Hygiene		Implement the NPSA 'clean your hands' campaign	Clinical Lead, ICT and Ward Champions		Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness	Clean Hospitals Group, Clinical Lead and Domestic Services		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed	Action Plans addressed Internal audit cycle established with results being fed back to CHG	
All staff will receive training on infection control	Red	Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

Atodiad 8

Improve compliance with Surgical Site Surveillance		Follow pathway of an SSI form and identify barriers to compliance Nominate responsible person for collating forms Quarterly compliance report for directorate	Clinical Lead nurse Infection control Team		Barriers to compliance not identified No nominated person for collating forms No improvement in compliance	Barriers identified Nominated person collecting forms No improvement in compliance	Barriers resolved and compliance improved Improvement in Quarterly compliance reports	
Consider pre op screening to identify MRSA carriers		Review National Guidelines for MRSA when released and implement any changes	Clinical Director and Infection Control Team		Guidelines released but not reviewed	Guidelines reviewed and decision regarding changes discussed	Changes in practice identified and implemented if required	

Atodiad 8

Welsh Healthcare Associated Infections Strategy

Pathology

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Review Phlebotomy Practices	Green	Audit compliance with Trust standards for hand hygiene and management of clinical waste	ICT	June 2005	External audits not carried out	Partial completion of audits	Audits completed	
Review Policies and develop, where required, new policies and procedures for Phlebotomy	Amber	Review policies against national or evidence based practices	Phlebotomy and ICT	September 2005	No review of policies carried out	Partial review of policies carried out	All policies reviewed and Ratified	
All staff will receive training on infection control	Red	Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

Atodiad 8

Review and Audit Mortuary Practices and Procedures in relation to Infection Control	Red	Audit compliance with local policies and national standards for infection control	ICT and Histopathology Manager	September 2005	No audits carried out	Audit cycle commenced but not completed	Audit cycle completed	
Review policies and procedures for mortuary	Red	Policies and procedures to conform to Local and National guidelines or evidence based practices	Histopathology manager	November 2005	No reviews or development of policies or procedures	Partial review of policies and procedures	Policies reviewed and all new policies ratified.	
Review the receipt of high risk specimens	Yellow	Identify number of specimens received as high risk Identify number of specimens identified as high risk that had bee wrongly classified	Health & Safety reps in Pathology and ICT	December 2006	No review of high risk specimens carried out	Review work has began	Review completed and report submitted	

Atodiad 8

Welsh Healthcare Associated Infections Strategy

Pathology

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Review Phlebotomy Practices	Green	Audit compliance with Trust standards for hand hygiene and management of clinical waste	ICT	June 2005	External audits not carried out	Partial completion of audits	Audits completed	
Review Policies and develop, where required, new policies and procedures for Phlebotomy	Amber	Review policies against national or evidence based practices	Phlebotomy and ICT	September 2005	No review of policies carried out	Partial review of policies carried out	All policies reviewed and Ratified	
All staff will receive training on infection control	Red	Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

Atodiad 8

Review and Audit Mortuary Practices and Procedures in relation to Infection Control	Red	Audit compliance with local policies and national standards for infection control	ICT and Histopathology Manager	September 2005	No audits carried out	Audit cycle commenced but not completed	Audit cycle completed	
Review policies and procedures for mortuary	Red	Policies and procedures to conform to Local and National guidelines or evidence based practices	Histopathology manager	November 2005	No reviews or development of policies or procedures	Partial review of policies and procedures	Policies reviewed and all new policies ratified.	
Review the receipt of high risk specimens	Yellow	Identify number of specimens received as high risk Identify number of specimens identified as high risk that had bee wrongly classified	Health & Safety reps in Pathology and ICT	December 2006	No review of high risk specimens carried out	Review work has began	Review completed and report submitted	

Atodiad 8

Welsh Healthcare Associated Infections Strategy
Diagnostic Services - Radiology

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Improvement in Hand Hygiene		Implement the NPSA 'clean your hands' campaign	Clinical Lead, ICT and Champions		Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness Radiology Group formed to ensure clean environment maintained	Clean Hospitals Group, Radiology Group and Domestic Services		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed Radiology Group meeting on a monthly basis	Action Plans addressed Internal audit cycle established with results being fed back to CHG	

Atodiad 8

All staff will receive training on infection control	Red	Staff to attend infection control mandatory training session every 2 years Directorate to identify key trainer	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training. Key Trainer not identified	Staff have access to training but attendance low Key Trainer identified but not 'trained'	Greater that 75% staff are up to date with training	ICT currently not offering training
Standardise Practice in relation to ultrasound probes		Observational Audits Protocol to be developed and discussed at directorate meeting	Dr Byrne Dawn Brough	August 2005	Base line Audit not performed Protocol not developed	Audit completed Protocol being developed	Protocol in place Practice standardised and audited	

Atodiad 8

Welsh Healthcare Associated Infections Strategy
Surgical Directorate

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Improvement in Hand Hygiene		Implement the NPSA 'clean your hands' campaign	Clinical Lead, ICT and Ward Champions		Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness	Clean Hospitals Group, Clinical Lead and Domestic Services		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed	Action Plans addressed Internal audit cycle established with results being fed back to CHG	
All staff will receive training on infection control		Staff to attend infection control mandatory training session every 2 years	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

Audit burden of Infection Associated with Central Venous Devices		Audit Central Venous Lines in the surgical unit	Clinical Lead Nurse	December 2005	Audit Tool not developed	Audit Tool developed and Audit underway	Audit completed and results fed back to directorate	

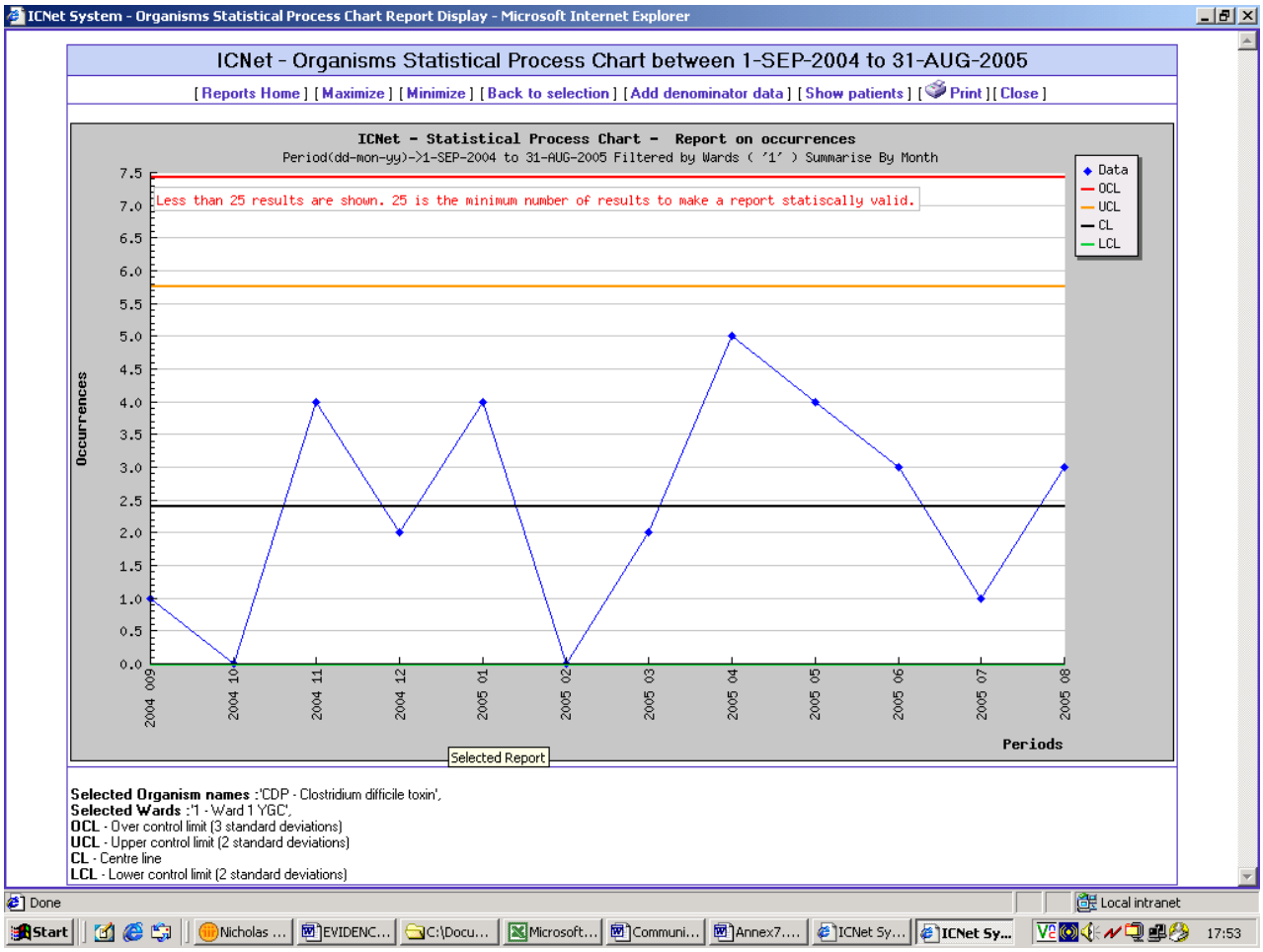
Atodiad 8

Welsh Healthcare Associated Infections Strategy
Theatres - YGC

Objective	**Current Status**	**Action Points**	**By Whom**	**By When**	**Progress Criteria**			Date achieved/Comments
					Red	**Amber**	**Green**	
Improvement in Hand Hygiene		Implement the NPSA 'clean your hands' campaign	Clinical Lead, ICT and Ward Champions		Alcohol Hand Gel not available at point of care. Poor Hand Hygiene Compliance Scores	Alcohol Hand Gel available at point of care with baseline Hand Hygiene Audits in completed	AHG available at point of care. Regular hand hygiene audits being performed which identify improved practice	
Monitoring of Environmental Cleanliness		Adhere to National Standards of Cleanliness for Wales by ensuring external and internal audits are completed in order to monitor environmental cleanliness	Clean Hospitals Group, Theatre Manager and Clean Theatres Group		External and Internal Audits not performed	External Audits performed in majority (>50%) areas and action plans addressed	Action Plans addressed Internal audit cycle established with results being fed back to CHG	
All staff will receive training on infection control		Staff to attend infection control mandatory training session every 2 years 'Scrub' staff to receive training and awareness sessions	Manager to ensure staff have time to attend training and staff to attend when sent	Ongoing	Staff unable to access training.	Staff have access to training but attendance low	Greater that 75% staff are up to date with training	ICT currently not offering training

Atodiad 8

Safe Evidence Based Preoperative Practice in relation to infection control		Review Local Policies and Procedures	Theatre Manager	Annually	Policies and procedures not reviewed annually	Policies and Procedures reviewed but not implemented	Policies and Procedures Reviewed and Implemented	
All Staff competent at scrub technique		'Scrub' staff to receive training and awareness sessions Audit of Scrub Technique			No training sessions available. Audit not commenced	Audit performed. Training Available	Ongoing audit identify high levels of competence.	



This is an example of a standard report derived from the ICNet infection surveillance system. The example shows the occurrence of *Clostridium difficile* infection on a Care of the Elderly ward over a 12-month period. It automatically applies statistical parameters to highlight control failures.

Conwy & Denbighshire NHS Trust
Yellow Policies

Policy No	Policy Title	Date Written and Validated	Date Last Updated	Date Reviewed
Yellow 01	Infection control standards	June 1996	August 2003	**August 2003**
Yellow 02	Handwashing procedure and use of protective clothing PDF Version	January 2000	August 2003	**April 2005**
Yellow 03	Universal blood and body fluid precautions	June 1996	August 2003	**August 2003**
Yellow 04	Blood spillage policy	April 1996	August 2003	**August 2003**
Yellow 05	Isolation/barrier nursing policies PDF Version	June 1996	September 2004	**September 2004**
Yellow 06	The nursing and midwifery management of patients with HIV/AIDS PDF Version	June 1996	August 2003	**April 2005**
Yellow 07	Staff sharps/body fluid incident policy PDF Version	June 1996	November 2002	**April 2005**
Yellow 08	Major outbreak of infection policy	June 1996	August 2003	**August 2003**
Yellow 09	Policy for antiseptics and disinfectants PDF Version	September 2000	August 2003	**April 2005**
Yellow 10	Management of patients with Methicillin Resistant Staphylococcus Aureus (MRSA) PDF Version	June 1996	September 2004	**September 2004**

Yellow 11	Food safety and hygiene for non catering food handlers PDF Version	June 1998	August 2003	**April 2005**
Yellow 12	Ward and departmental kitchen policy PDF Version	June 1996	August 2003	**April 2005**
Yellow 13 WITHDRAWN 16.12.04 (now part of Yellow 10)	The policy on the inter hospital/tertiary centre transfer of patients			
Yellow 14	Waste management policy appendix 2	September 2000	January 2003	**January 2003**
Yellow 15	Policy for Varicella Zoster virus infection control PDF Version	July 1997	November 2004	**November 2004**
Yellow 16	Methicillin Resistant Staphylococcus Aureus (MRSA) - The policy on the admission of patients from nursing/residential homes	July 1997		**Withdrawn - no longer available**
Yellow 17	Hepatitis B policy	March 1998	August 2003	**June 2005**
Yellow 18	Policy on the protection of health care workers against infection with blood borne viruses	September 2000	September 2004	**September 2004**
Yellow 19	Management of used/soiled CSSD equipment and instruments	January 2000	August 2003	**August 2003**
Yellow 20	Management of used and soiled/infected linen	January 2000	August 2003	**August 2003**
Yellow 21	Feeding autologous stem cell transplant (immunosuppressed) patients who require a "clean" diet policy PDF Version	January 2000	July 2004	**July 2004**
Yellow 22	Policy for the decontamination of equipment PDF Version	September 2000	August 2003	**April 2005**

Yellow 23	Bloodborne virus infected health care worker - patient notification plan PDF Version	September 2000	August 2003	**April 2005**
Yellow 24	Policy for rubella infection control	July 2001	August 2003	**June 2005**
Yellow 25	Hepatitis C Policy	December 2002	December 2002	**December 2002**
Yellow 26	Staff Immunisation & Screening	September 2002	September 2002	**September 2002**
Yellow 27	Policy for Severe Acute Respiratory Syndrome (SARS) PDF Version	April 2004		**New Policy**

The policies can be accessed at http://nww.cd-tr.wales.nhs.uk/polproc/2003/yellow/yellow_contents.htm