Yeovil District Hospital NHS
NHS Foundation Trust

Infection Prevention and Control Policy

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Policy Owner	Director of Infection Prevention and Control		
Author	Nurse Consultant Infection Control/Deputy Director Infection Prevention and Control		
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Staff/Groups Consulted	Infection Control Doctor Medical Director Director of Infection Prevention and Control Matrons Infection Prevention Control team Chief Pharmacist Director Estates and Facilities Hotel Services Manager		
Discussed at IPCC	September 2020 – via email		
Next Review Due	September 2022		
Equality Impact Assessment Completed		Yes	

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1. RATIONALE

1.1 The Hygiene Code 2008 (revised 2010) Code of Practice for the Prevention and Control of Healthcare Associated Infection requires all Trusts to have clear processes in place for the effective prevention, detection and control of Healthcare Associated Infections (HCAI). Infection Control surveillance is undertaken on alert organisms as determined by local and national trends. Surveillance provides information for identifying patients that present with infectious conditions that could pose a risk to others.

The Trust is required to undertake mandatory surveillance for reporting HCAI to Public Health England (PHE) as directed by the Department of Health (DH).

2. AIM

2.1. This policy details the mechanisms for effective management of infection prevention and control (IPC) across the Trust.

- It defines the Assurance Framework for reassuring the Board of Directors of effective management of IPC.
- Identifies key individual responsibilities.
- Defines the performance monitoring and surveillance framework for IPC with specific reference to key performance indicators and individual responsibilities and accountabilities.

3. DEFINITIONS

3.1. Hygiene Code: references within this Policy to the Hygiene Code refer to “Part 2: The Code of Practice” contained within The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

3.2. Key Performance Indicators: quantifiable measurements to reflect the success of the organisation in relation to IPC.

3.3. Alert Organisms: specified organisms that are reported by the microbiology laboratory to the Infection Prevention and Control Team (IPCT) that may give rise to outbreaks and transmission of infectious conditions to others.

3.4. Saving Lives High Impact Interventions: DH programme for reducing infection based on care bundles and audit of practice.

3.5. Mandatory Surgical Site Infection Surveillance (SSIS): The Public Health England Programme of mandatory reporting of orthopaedic surgical site infections (SSI) that are healthcare associated.

3.6. Infection Control Assurance Framework: contains activities to demonstrate that IPC is an integral part of the organisational plan (activities are included in roles and responsibilities).

3.7. The Annual Programme of Work identifies the objectives to be met for the year, and is displayed on the Trust Infection Control YCloud site.

3.8. Surveillance: surveillance is a comprehensive method of obtaining information on HCAI and is essential for monitoring progress, investigating underlying causes and applying prevention and control measures.

3.9. Period of increased incidence (PII): a period of time in which 2 or more cases of HCAI are identified in a clinical area.

3.10. Serious Untoward Incidents (SUI): an incident of infection that can have serious consequences. CHECK

4. ROLES AND RESPONSIBILITIES

4.1. **Chief Executive** is responsible for:

- Ensuring that appropriate systems and resources are in place to manage IPC across the organisation in relation to The Hygiene Code.
- Appointing an individual as the Director of Infection Prevention and Control with designated time to fulfil this role.
- Ensuring an appropriate Infection Control Assurance Framework is in place for reviewing incidence of alert organisms, outbreaks, SUIs and compliance/ performance against infection control audit programme in clinical areas.

4.2. **Director of Infection Prevention and Control (DIPC), with support from the Deputy DIPC** is responsible for:

- IPC within the Trust, monitoring performance and compliance against the Hygiene Code.
- Chairing the Infection Prevention and Control Committee (IPCC).
- Ensuring the development and implementation of strategies to prevent avoidable HCAI at all levels of the Trust.
- Providing assurance to the Board of Directors that systems are in place and correct policies and procedures are adhered to across the Trust to ensure safer and effective healthcare, and to comply with The Hygiene Code.
- Production of reports and presentations to the Trust's Board of Directors against IPC Annual Programme of Work.
- The sign off (lock down) of the monthly surveillance data reported to the Public Health England on behalf of the Chief Executive. The DIPC reports surveillance activities and data to the Trust's Board of Directors.

4.3. **Director of Estates & Facilities** is responsible for:

- Ensuring that the Trust's Estate Strategy and any future developments take account of good infection control practice.
- Ensuring IPC representation in the design of new facilities and the refurbishment of existing ones.
- Ensuring that the Trust has appropriate standards of cleanliness, decontamination and waste management.

4.4. **Chief Medical Officer**

- The Chief Medical Officer is the professional lead for the medical profession and has responsibility for the standards of care delivered. The post holder is responsible for reinforcing expectations, outlining actions required and evaluating progress made in relation to IPC.

4.5. **Chief Nurse**

- The Chief Nurse is the professional lead for Nursing and Allied Health Professionals and has professional responsibility for the standards of care delivered. The post holder is responsible for reinforcing expectations, outlining actions required and evaluating progress made in relation to IPC.

4.6. **Infection Control Doctor (ICD)**

The ICD reports directly to the DIPC and is a core member of the IPCC group. The post holder is responsible for:

- Providing expert specialist advice on IPC in line with The Hygiene Code.
- Advising and supporting the IPCT.
- Advising and supporting the DIPC on all aspects of infection control in the hospital and on implementation of agreed policies.
- Supporting and contributing to the training of medical students, medical and nursing staff and other health workers of all grades.
- Being involved in strategic planning and development of hospital services and facilities.

Nurse Consultant for IPC is responsible for:

- Implementing and leading on all aspects of compliance against the Hygiene Code in line with the Infection Control Assurance Framework (Appendix A).
- Providing nursing leadership within the IPCT and across the Trust, delivering expertise and advice on IPC.
- Producing and implementing the IPC Annual Programme of Work in collaboration with the DIPC and the ICD.

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4.7. **IPCT** will:

- Implement all aspects of compliance against the Hygiene Code in line with the Infection Control Assurance Framework (Appendix A).
- Be core members of the IPCC.
- Visibly promote good IPC practice.
- Work with Clinical Site Managers to ensure appropriate placement of patients to minimise the risk of infection.
- Implement the IPC Annual Programme of Work in collaboration with the Nurse Consultant for IPC.

- Undertake national mandatory Surgical Site Infection (SSI) surveillance. Results will be used to drive improvement and be reported to the Board of Directors and to the relevant clinicians at regular intervals as appropriate.

- The IPCT is responsible for reporting alert organisms in line with the Infection Control Assurance Framework (Appendix A).

4.8. **Matrons** are responsible for:

- Maintaining standards of IPC practice within wards and departments in line with The Hygiene Code.

- Ensuring each clinical area has an IPC Link Practitioner and Hand Hygiene Champion.

- Ensuring HCAI or infection control risks are on the appropriate risk register.

- Undertaking root cause analysis investigations in respect of IPC incidents in conjunction with the appropriate multi-disciplinary team and IPC representative.

4.9. **Ward Sisters/Managers and Heads of Department** are responsible for:

- Ensuring all staff attend induction and mandatory updates in IPC.

- Ensuring that local induction includes the dissemination of IPC Trust policy and guidelines to all staff, including agency and service providers.

- Monitoring compliance with Trust policy and identifying and responding to incidents related to breaches of IPC standards.

4.10. **IPC Link Practitioners** are responsible for:

- Being a champion for good IPC practice in their area, ensuring that the latest IPC practices and guidance are disseminated to the clinical team.

4.11. **All Staff** will:

- Understand the impact of IPC practice to enable them to act responsibly to patients, other staff, visitors and themselves.

- Make themselves aware of and follow Trust policies/guidelines and procedures in relation to IPC that affect them.

- Attend Trust induction/mandatory training sessions relating to IPC.

- Failure by any member of staff to comply with this policy or any of its associated procedures will result in consideration of the use of disciplinary action. Responsibilities for this are defined in the Trust's Disciplinary Policy.

4.12. **The IPCC** is:

- mandated by the Hygiene Code and forms an integral part of Trust governance arrangements, reporting to the Board of Directors via the DIPC, with membership, authority, reporting arrangements, roles and responsibilities defined in its Terms of Reference (refer to Appendix B).

- Responsible for providing strategic direction for IPC to the Trust, in line with best practice, and ensuring that there is a strategic response to new legislation and national guidance.

5. INFECTION PREVENTION AND CONTROL TRAINING

5.1. On commencement in the Trust all staff must be trained in IPC procedures appropriate to their role. This will be delivered as part of the Trust induction training programme. Local induction will be provided by the Ward Sister / Charge Nurse / Head of Department.

5.2. All staff will receive regular updates in IPC procedures appropriate to their role. This is a mandated training requirement. For individual staff training requirements and methods of delivery please refer to the IPCT.

5.3. Attendance at IPC induction and mandatory training will be recorded through the Yeovil Academy, and monitored through the Human Resources dashboard procedure.

5.4. Requirement for training and regular update in IPC will be part of all staff job descriptions/job plans/Knowledge Skills Framework outlines, included in the Training Needs Analysis held by the Yeovil Academy and appraisal process.

6. INFECTION PREVENTION AND CONTROL POLICIES, GUIDANCE AND PATIENT INFORMATION LEAFLETS

6.1. IPC policies, guidelines and patient information leaflets will be produced in consultation with the IPCC and relevant staff groups.

6.2. Policies will be approved by the IPCC and Hospital Management Team

6.3. IPC policies, guidelines and patient information leaflets will be available on the Trust YCloud.

7. CORE CLINICAL CARE GUIDELINES

7.1. The Trust applies evidence based clinical care guidelines required by the Hygiene Code which are detailed on the Trust intranet (YCloud). The Standard IPC Precautions are a set of standards that must be met to ensure best practice when implementing and maintaining robust IPC practices.

The Standards are:

7.1.1 **Principal Hand Hygiene techniques** (Hand Hygiene Policy)

7.1.2 **Skin Care** (Staff Health Guidelines)

7.1.3 **Personal Protective Equipment (PPE)** (PPE Guidelines)

7.1.4 **Blood and Body Fluid Spillages** (Blood and Bodily Fluid Guidelines)

7.1.5 **Sharps Management** (Sharps Safety Policy)

- Management of Contamination Injuries Involving NHS health Care Workers policy (Contamination Injuries policy)
- Prevention of occupational exposure to blood-borne viruses (Immunisation and Employment Policy)

7.1.6 **Laundry Handling** (Linen and Laundry Policy)

7.1.7 **Waste Management** (Facilities Services Policy)

7.1.8 **Animals** (Pets in Hospital Guidelines) – For specific guidance on animals visiting hospital, including Assistance Dogs.

7.1.9 **Food Hygiene** (Food Hygiene Policy)

7.1.10 **Aseptic technique** (Aseptic Non Touch Technique Guidelines)

- In addition to the above guidelines, information can be found in the Royal Marsden Manual. This identifies that clinical procedures are carried out in a manner that maintains the principles of asepsis. Staff undertaking these procedures are trained and assessed in aseptic technique.

7.1.11 **Major outbreaks of communicable disease** (Hospital Outbreak Management Guidelines)

7.1.12 **Isolation of patients** (Isolation Guidelines)

- This policy includes an A to Z of Disease Specific Precautions, Isolation guidelines and Paediatric Isolation procedures.
- The Infection Control Guidance for Care of the Deceased should be used when there has been a notified or suspected infection risk.

7.1.13 **Decontamination/Disinfection** (Decontamination of Hospital Equipment and Medical Devices)

- The procedures for cleaning and disinfecting patient equipment and the healthcare environment are provided in the Cleaning Procedure Manual.
- The above guidelines and policies should be read in conjunction with the Medical Devices Management Policy and manufacturers specific instructions.
- The Standing Operating Procedure for Decontamination of Endoscope Equipment is held by the Sterile Services Department.

7.1.14 **Antimicrobial prescribing** - the Trust's Antimicrobial Prescribing Policy identifies procedures in place to ensure prudent prescribing to reduce the risk of antibiotic associated diarrhoea.

8. MANDATORY REPORTING

8.1. Surveillance Schemes – the Trust will participate in all DH mandatory surveillance schemes for HCAI and with Getting It Right First time data collection. Data will be entered onto the Public Health England (PHE) database no later than one week of cases being reported to the IPCT with submissions to national audit and GIRFT compliant with individual scheme requirements.

8.2. Blood Stream Infection (BSI) reporting

- Information regarding all MRSA, MSSA, E Coli, Kleibsiella, and Pseudomonas BSI such as patient information, source and risk factors will be downloaded to PHE via the HCAI data capture system website.

- All BSI's will be reported to the Clinical Commissioning Group (CCG). The standard reporting process will be followed.

8.3. *Clostridium difficile* associated diarrhoea

- Information on all *Clostridium difficile* isolates will be entered on the HCAI data capture system website.

- Any incident where more than 2 cases of *Clostridium difficile* are identified on the same ward within a 30-day period will be investigated as a PII.

- All cases will be investigated resulting in an RCA and results feedback via the IPCC in accordance with latest contractual obligations and national reporting requirements.

8.4. Mandatory SSIS

- Mandatory SSIS will be conducted for a minimum of 3 months each year, selecting one of four categories. SSI activities will extend to non-mandated categories as part of the annual work plan and as directed by local incidence of infection or risks.

8.5. Summaries of all mandatory surveillance data will be reported to the Trust's Board of Directors on a monthly basis, and to the IPCC, Governance and Quality Assurance Committee (GQAC), and in the Trust's Annual Report. Ad hoc reports will be made available at departmental Clinical Governance meetings as indicated by local surveillance activities ie Covid19.

8.6. Duty of Candour – in the event of a patient's infection being deemed avoidable through the PIR process, the Trust is required to:

- Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity

- Tell the relevant person as soon as reasonably practicable after becoming aware that a 'notifiable safety incident' has occurred and provide support to them in relation to the incident, including when giving the notification

- Provide an account of the incident which, to the best of the Trust's knowledge, is true of all the facts the body knows about the incident as at the date of the notification:

- Advise the relevant person what further enquiries the Trust's believes are appropriate:
- Offer an apology:
- Follow this up by giving the same information in writing, and providing an update on enquiries.
- Keep written record of all communication with the relevant person.

This would be led by the Consultant managing the patients care at that point in time and in accordance with the Trust Serious Incident Reporting and Investigation policy.

9. ALERT ORGANISM AND ALERT CONDITION SURVEILLANCE

9.1. The microbiology department will inform the IPCT of any alert organisms that are likely to cause outbreaks of infection and/or are multi drug resistant. This is supplemented by alerts and reporting via ICNet (countywide electronic IPC reporting and record system)

9.2. Clinical ward staff, the Consultant microbiologists and microbiology staff have a responsibility to report clinical conditions to the IPCT that are likely to cause outbreaks of infection and/or are notifiable diseases. The implementation of control measures will minimise the risk of an outbreak. Control of infections with specific alert organisms

9.3. Guidelines are provided for the provision of the following:

- *Clostridium difficile* (C diff)
- Control of Tuberculosis including multi-drug resistant tuberculosis (TB)
- Respiratory conditions (ie Covid19)
- Diarrhoeal infections (management of Hospital Outbreaks)
- Multi-Resistant Gram-Negative Organisms (MRGNO)
- Glycopeptide Resistant Enterococci (GRE)
- Legionella Management
- Methicillin Resistant *Staphylococcus aureus* (MRSA guidelines)
- Transmissible Spongiform Encephalopathies (CJD)
- Viral haemorrhagic fevers (VHF).
- Guidelines for the management of Scabies and Varicella (Chickenpox)

10. ASSURANCE FRAMEWORK / PERFORMANCE MONITORING

10.1. The infection control Assurance Framework is designed to build upon the systems and structures that already exist to maintain best practice and ensure high standards

of IPC. This framework provides the Trust with the necessary monitoring and reporting systems to enable the standards to be maintained.

10.2. Internal Assurance Framework:

- Root cause analysis on all mandatory HCAI
- Surveillance of other HCAI using ICNet
- Surveillance and audit programme reporting to clinical divisions
- Published annual DIPC Infection Control report

10.3. External Assurance Framework:

- Reporting of clusters/outbreaks of infection to PHE.
- Reporting of serious incidents of HCAI to the PHE, and CCG.
- Published quarterly reports on HCAI from PHE

10.4. Implementation, evaluation and monitoring of this policy will be in accordance with the IPC audit programme and Trust Performance in relation to IPC.

11. APPLICABILITY

11.1. This policy applies to all staff employed by the Trust, whether on a permanent or temporary basis.

12. EQUALITY IMPACT ASSESSMENT

12.1. This policy has been assessed and implemented in line with the policy on procedural documents and an equality impact has been carried out to ensure the policy is fair and does not discriminate against any staff groups. A completed Equality Impact assessment can be found at Appendix A

13. REFERENCES

13.1. The following references have been used:

- The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (revised 2010).
- Infection prevention and control (2014) NICE quality standard 61
- 2014/15 NHS Outcomes Framework
- Surgical site infection (2013) NICE quality standard 49
- Patient experience in adult NHS services (2012) NICE quality standard 15
- Saving Lives: a delivery programme to reduce Healthcare Associated Infection including MRSA. DH 2006.
- Freedom of Information Act 2000. Office of Public Sector Information.

- The Hygiene Code (see “Part 2: The Code of Practice” of The Health and Social Care Act 2008 above).

- Winning Ways: working together to reduce Healthcare Associated Infection in England. DH 2003.

- epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England (2014).

APPENDIX A –

14. ANNEX A – EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Somerset Equality Impact Assessment			
Before completing this EIA please ensure you have read the EIA guidance notes – available from your Equality Officer			
Organisation prepared for	**Yeovil District Hospital NHS Foundation Trust**		
Version	**7**	**Date Completed**	**2020**
Description of what is being impact assessed			
Infection Control Policy			
Evidence			
What data/information have you used to assess how this policy/service might impact on protected groups? Sources such as the Office of National Statistics, Somerset Intelligence Partnership, Somerset's Joint Strategic Needs Analysis (JSNA), Staff and/ or area profiles,, should be detailed here			
Reviewed by Infection Control Committee members			
Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?			
As above			

Analysis of impact on protected groups				
The Public Sector Equality Duty requires us to eliminate discrimination, advance equality of opportunity and foster good relations with protected groups. Consider how this policy/service will achieve these aims. In the table below, using the evidence outlined above and your own understanding, detail what considerations and potential impacts against each of the three aims of the Public Sector Equality Duty. Based on this information, make an assessment of the likely outcome, before you have implemented any mitigation.				
Protected group	**Summary of impact**	**Negative outcome**	**Neutral outcome**	**Positive outcome**
Age	• Positive outcome	☐	☐	☐
Disability	• Positive outcome	☐	☐	☐
Gender reassignment	• Positive outcome	☐	☐	☐
Marriage and civil partnership	• Positive outcome	☐	☐	☐

Pregnancy and maternity	• Positive outcome	☐	☐	☐
Race and ethnicity	• Positive outcome	☐	☐	☐
Religion or belief	• Positive outcome	☐	☐	☐
Sex	• Positive outcome	☐	☐	☐
Sexual orientation	• Positive outcome	☐	☐	☐
Other, e.g. carers, veterans, homeless, low income, rurality/isolation, etc.	• Positive outcome	☐	☐	☐

Negative outcomes action plan Where you have ascertained that there will potentially be negative outcomes, you are required to mitigate the impact of these. Please detail below the actions that you intend to take.				
Action taken/to be taken	**Date**	**Person responsible**	**How will it be monitored?**	**Action complete**
	Select date			☐
	Select date			☐
	Select date			☐
	Select date			☐
	Select date			☐
	Select date			☐
	Select date			☐
	Select date			☐
If negative impacts remain, please provide an explanation below.				

Completed by:	**Rachael Grey**
Date	**September 2020**

Signed off by:	**Infection Control, Commitee**
Date	**September 2020**
Equality Lead/Manager sign off date:	
To be reviewed by: (officer name)	
Review date:	