EMBARGOED UNTIL DATE OF MEETING.

Greater Glasgow NHS Board

Board Meeting

18th March 2003 **Board Paper No. 03/19**

Dr H Burns

NHS HDL 2002 (82)

Recommendation:

Members are asked to:

Note the response sent to the Scottish Executive which is attached to this paper. This response was prepared by the Area Control of Infection Committee on behalf of Greater Glasgow NHS Board, in collaboration with all the Trusts in Greater Glasgow.

Background:

1. This HDL highlights recommendations from two reports for the management of health care associated infection.
    - Ministerial Action Plan on Health Care Associated Infection
    - Watt Group Report on the Outbreak of Salmonella Infection at Victoria Infirmary

    In addition, attached to this HDL was a questionnaire intended to help identify the extent of infection and related risk posed by the patient care environment in NHS hospitals and the work required to address the issue. The HAI and Patient Care Environment Questionnaires were completed by all Trusts in Glasgow and were returned to the Scottish Executive by 22nd November 2002. These questionnaires highlighted major issues in the loss of beds in hospitals to upgrade facilities. These need to be further discussed with the Trusts on how the consequences of this reduction in beds and other deficiencies in the patient care environment e.g hand washing facilities, patient handling equipment and side rooms etc can be addressed.

2. The Watt Group Report includes 47 recommendations for action by the NHS Trusts/Boards and other bodies including the Scottish Executive, to improve the efficiency and effectiveness of infection control arrangements and of hospital cleaning services. The Ministerial Action Plan contains further recommendations as well as endorsing the conclusions of the Watt Report. There is going to be a task force led by the Chief Medical Officer to look at how all these recommendations could be implemented. Meanwhile the Scottish Executive asked NHS Boards and Trusts to produce a report on how Boards/Trusts are going to respond to some of the key recommendations contained in the Watt Group Report.

3. We were asked to report to the Scottish Executive by 31st January 2003 and the attached document is the response from NHS Greater Glasgow. This response highlights the increasing emphasis on staff education, audit and updating of various outbreak plans, as well as progressive investment in infection control nursing staff. All the Glasgow Trusts, in response to the Watt Group Report, also requested additional resources to improve the infrastructure of their infection control teams including additional medical microbiology support, clerical support and surveillance nurse support. The Area Control of Infection Committee(ACIC) has agreed a standard formula based on international recommendations, on the number of ICN resources required per Trust. However, the ACIC has not completed its review of other resources required by Trusts in Glasgow for infection control infrastructure and once the ACIC has reviewed these, it will produce a further report for the Health Board to highlight any other deficiencies in infection control staffing in NHS Greater Glasgow.

RESPONSE TO THE NHS HDL(2002) 82
Ministerial Action Plan on Healthcare Associated Infection, Watt Group Report on the Outbreak of Salmonella Infection at Victoria Infirmary and HAI & Patient Care Environment Questionnaire.

Prepared by the Area Control of Infection Committee
on behalf Greater Glasgow NHS Board
January 2003

RESPONSE TO THE NHS HDL(2002) 82
Ministerial Action Plan on Healthcare Associated Infection, Watt Group Report on the Outbreak of Salmonella Infection at Victoria Infirmary.

(Numbers in column 1 relate to: Watt Group Report Conclusions & Recommendations Annex 2, p45. Nos. 1-5 and, Watt Group Recommendations For Immediate Implementation by NHS Trusts & Boards NHS HDL (2002) 82, Nos. 2-32)

1	A comprehensive implementation of Infection Control standards at ward / department level.	Optimal: All clinical areas would be visited and audited against set infection control standards once a year. Achievable: There will be a priority directed plan of all clinical areas to be audited developed in all Trusts. It would be expected that all clinical areas would be visited at least once every two years.
2	A properly developed and funded infection control infrastructure.	Optimal: 1 ICN: 250 beds. Currently the acute Trusts are funded for 1 ICN for 350 beds. The GGNHSB will plan to move towards the optimal level of ICN to bed ratio progressively over the next 2/3 years. In addition, there will be a specific review of the ICN requirements required within the Primary Care Trust.
3	A culture change in hand washing, underpinned by hand washing audits for all staff.	Audit of hand hygiene is the most time consuming audit of all. It needs to be done for sufficiently long to ensure that sufficient opportunities for hand hygiene are observed. In addition observation of the structural requirements is also required. The latest draft of the NHS Greater Glasgow Hand hygiene policy is accompanied by audits which cover the key criteria. However although it is of primary importance for all staff, the number of infection control staff allows only selective hand hygiene audits at present. All infection control teams within NHS Greater Glasgow will continuously emphasise the importance of hand hygiene amongst all grades of healthcare workers. A review of the employment contracts / conditions of service will be made to see whether inclusions on hand hygiene can be made which will emphasise to the employee responsibilities with regard to hand hygiene. It is recommended in the PCT that inclusions on hand hygiene should be part of the general Health & Safety policies / Staff handbooks which are attached to contracts of employment. All Trusts within NHS Greater Glasgow have or will

		implement teaching programmes on hand hygiene. At NHS Greater Glasgow we have produced a self-directed learning unit (SDLU) on hand hygiene. This tool or an equivalent programme will be mandatory for all staff. The proposal is that: - all students and agency staff will have satisfactorily completed a hand hygiene education programme in University or by Agency. - all new employees to the Trusts will be required to undertake the SDLU or equivalent programme. - all existing employees will be required to undertake the SDLU or equivalent programme within 12 months. - all ICTs within the Trusts will have access to a hand hygiene dye test machine. The EPIC guideline on hand hygiene has been made into an "Action Effect" chart: this will be accessible to staff. All staff within each Trust will be made aware of the importance of hand hygiene and how important NHS Greater Glasgow considers hand hygiene.
4	Implementation of a suggested Infection Control Outbreak / Episode Risk Matrix to allow consistent responses and communications across Scotland (Appx E)	The risk matrix has been added to the latest draft of NHS Greater Glasgow's Outbreak / Incident Plan. It will be used to assess future outbreaks with immediate effect. In addition we have produced an SDLU for initial outbreak management.
5	Proper emphasis on all aspects of communications in infection control and in outbreaks, including a culture of openness.	Work is ongoing to improve communication during incidents. Internal communication arrangements have already been strengthened to ensure that the Board Chair and Executive Team members are alerted at an early stage of any incident.
2	That cleaning specification in wards and departments should be set by the senior nurse responsible for the area and each ward / departmental manager in collaboration with the relevant ICT and DSM. Cleaning against this specification should be subject to rigorous monitoring and action to correct deficiencies. Failure to meet the specification subject to formal audit and review within each hospital and be subject to public disclosure.	Scot Meg frequencies will be the lowest level of service agreement in all Trusts. In addition clinical managers will be given the service level agreement for their clinical area and are aware of the procedure should there be any failure to maintain the specified agreements.
4	That audit Scotland reports are received and reviewed carefully by the	In future these will be discussed formally at ICCs, Trust Clinical Governance Committees and Risk

	management of trusts and that appropriate action is taken to respond to them.	Management Groups and a copy of the response plan sent to the ACIC.
6	That exposure of staff to faeces should be documented through incident reporting procedure as thoroughly as exposure to any other biological (body) fluids.	Healthcare workers will be required to report visible exposure to faeces through the incident reporting system. This will be stated in the Standard Precautions Policy. What has to be recognised is that many exposures to body substances are so small as not to be visible but are still significant. In the Trusts we are implementing the new Standard Precautions Policy as different from Universal precautions which for the first time recognises the importance of potential infection from patients with unrecognised infection. An SDLU has been prepared to accompany the policy and will be available as ward based learning. The SDLU or similar programme will be mandatory for all new staff, students will be required to undergo this SDLU or similar programme before coming to the wards.
7	That specific guidelines and facilities should be available in every hospital for the decontamination of staff who become grossly contaminated from body fluids.	The NHS Greater Glasgow Uniform policy makes provision for this. However it is very important to emphasise the importance of prevention of contamination. This is done through adherence to Standard Precautions and by the provision of gloves and aprons close to the point of use.
9	That nursing notes / care plans should clearly reflect the need for enteric precautions in individuals suffering from loose stools / diarrhoea.	A specific care plan for patients with diarrhoea – which may be infectious, is available to all staff. However we also emphasise the importance of Standard Precautions to prevent cross-infection. Proper adherence to Standard Precautions is essential in all situations, i.e. when infection is not proven.
11	That clear infection control guidance to all staff on how to nurse a patient with loose stools / diarrhoea should be provided within the infection control manual.	Care plans are available in all clinical settings for this in all clinical settings within the Trust.
18	That Agency / Bank Locum induction checklist should include explicit mention of infection control precautions in place.	Agency / Bank staff to do the SDLU or equivalent programme on hand hygiene and standard precautions.
23	That an OCT should always be chaired by someone with competence and authority in health care associated infection. The local CPHM should chair OCTs for major outbreaks.	This will be addressed through the NHS Greater Glasgow outbreak / incident plan. This plan is currently being updated in conjunction with colleagues in local Government and other key agencies. An updated plan will be brought to the NHS Board and the relevant Local Authorities for approval in May 2003.

	That there should be clear role definitions for the members of the OCT with clear responsibilities documented	This will be achieved with the approval of the NHS Greater Glasgow outbreak / incident plan.
	That a clear OCT should be agreed and implemented.	This will be addressed through the approval of the NHS Greater Glasgow outbreak / incident plan.
24	That senior management ED level of the trust should be fully engaged at an early stage in managing outbreaks either as full and active members of the OCT or as a separate support team to the OCT. Senior management support should include a senior communications manager who can ensure that staff, relatives and the public are timeously informed of the outbreak and are given appropriate public health messages.	This will be addressed through the approval of the NHS Greater Glasgow outbreak / incident plan.
25	That all OCT reports should provide sufficient details of key factors in the spread of infection to allow proper audit.	The Chair will write OCT reports within a deadline and the content of the report will be specified in the outbreak plan.
31	That in any outbreak that is considered at any stage to be foodborne, the Scottish Executive is informed in addition to the FSA	This is specified in the new outbreak plan.
32	That Trusts and Boards ensure that there are sufficient resources to appoint adequate levels of communication professions, but that press officer to press office communication is additional to, nor a substitute for professional communication.	A communication manager will always be a member of the outbreak / incident control team.