Stockport NHS
NHS Foundation Trust

INFECTION CONTROL
ANNUAL REPORT 2006/2007

FOREWORD

This report describes the activities covering the period of April 2006 till March 2007 appertaining to infection prevention and control. It provides data on rates of healthcare acquired infections (HCAI). Through participation in the Mandatory Enhanced Surveillance (MES) the Trust has robust information on the local pattern of HCAI and most of the data provided in this document has been forwarded to the Health Protection Agency.

It is important to recognise that over the past 4 years there has been a series of reports and directives setting the agenda for NHS Trusts with regards to reducing risk of HCAI. These include Winning Ways (DoH 2003), National Audit Report (July 2004), Saving Lives (DoH June 2005), CNO and HCC Clostridium Difficile Reports (2006) and more recently Health Act 2006 (DoH 2006). The Trust has ensured that the approach to tackling HCAI is based on the advice and guidance incorporated in these documents and thereby ensuring that it meets its statutory obligations.

In the previous annual report I made reference to the need of using data intelligently so as to focus appropriately quality initiatives. This annual report provides evidence of such activity, highlighting the reduction in MRSA bacteraemias in certain cohort patients as a result of proactive interventions. We have developed a comprehensive strategy for screening of MRSA in acute admissions.

I also emphasised that whole system engagement is crucial. The past year has seen a lot of effort in achieving this. Quality dashboards have been developed. These ensure that infection control targets e.g. MRSA and C. Difficile rates are discussed monthly at the Board of Directors and Clinical Effectiveness Committee meetings. A specific comprehensive Infection Control Dashboard has been introduced and is discussed monthly at meeting between Infection Prevention and Control Team and Senior Professional Managers. We have also continued to develop the link nurses who provide a vital link with ward staff. Directorates have supported the release of these nurses for half a day a week thereby ensuring education and support to staff.

The past year has seen a significant investment including Consultant Microbiology post, introduction of the ‘Hot Team’, and the bringing in-house the portering and domestic services. Over 500 hours extra have been funded for cleaning as part of the new arrangements. The Trust in ‘adopting zero tolerance’ to HCAI recognises that it has set itself a challenging aspiration but the issue of HCAI is at the heart of patient safety.

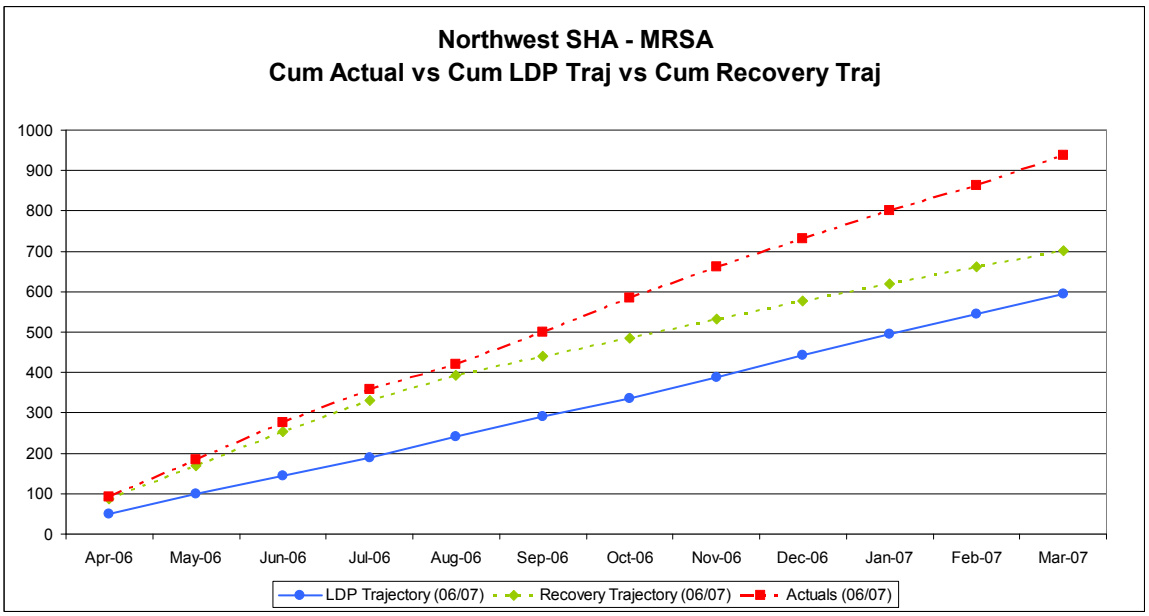
James Catania
Medical Director / Director of Infection Prevention and Control

MRSA

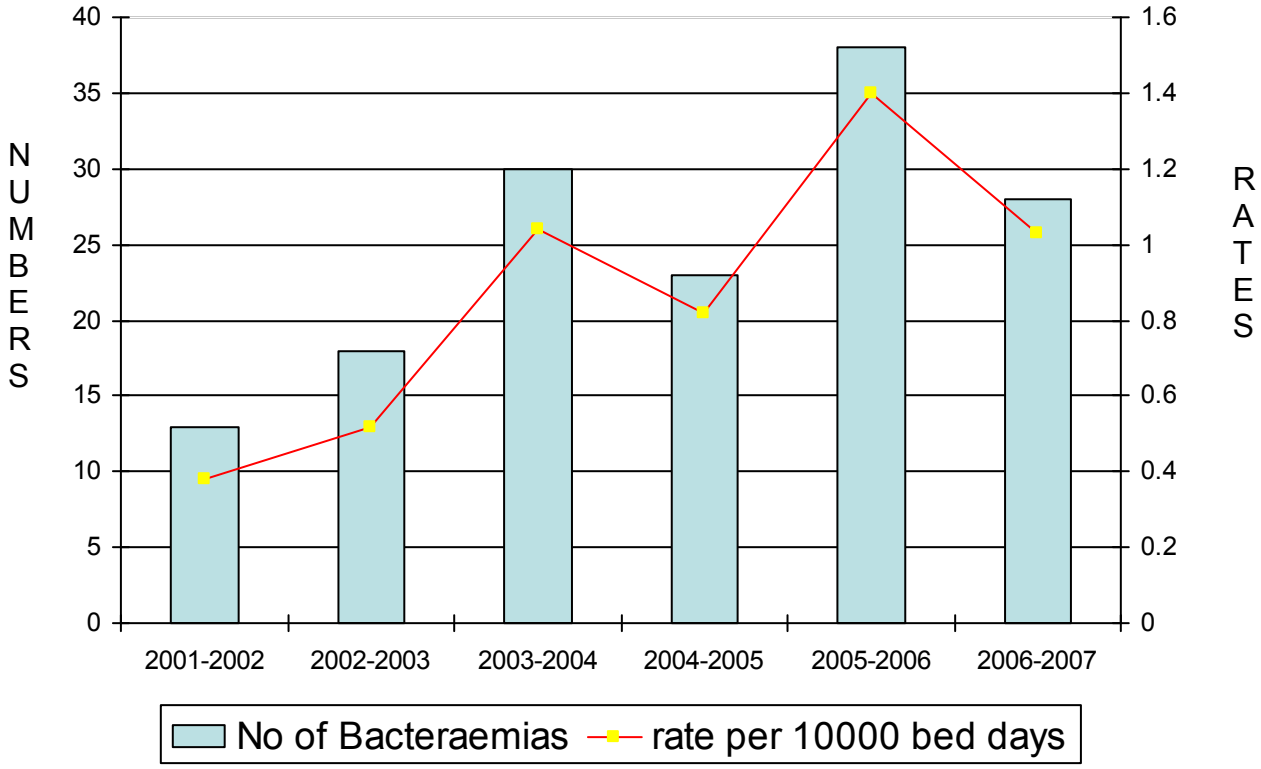
In interpreting MRSA data one has to take the following into account:

- MRSA bacteraemia report is made when MRSA is detected in a blood sample.
- The data does not include MRSA colonisation
- Suspected contaminated blood cultures still have to be reported
- Trusts may import MRSA from other hospitals or from the community
- MRSA bacteraemia rates are calculated using bed occupancy that only includes overnight admissions. This may be affected by the configuration of hospital beds e.g. day case beds.

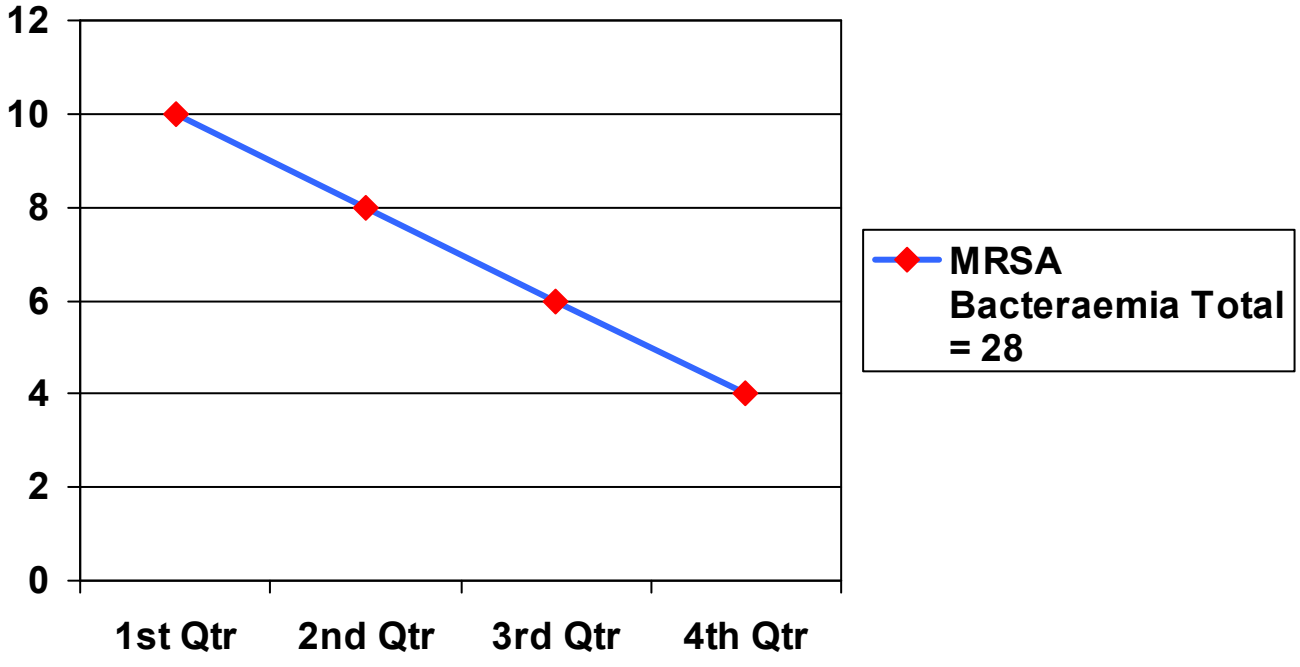
The Trust has achieved a reduction of MRSA bacteraemias from 38 (05-06) to 28 (06-07), although it has not met the trajectory target of 24 for the year. This achievement has got to be put in the context of an upward trend in MRSA bacteraemias nationally as well as in the Northwest, with the latest data indicating that this region has not met the trajectory target for MRSA bacteraemia.



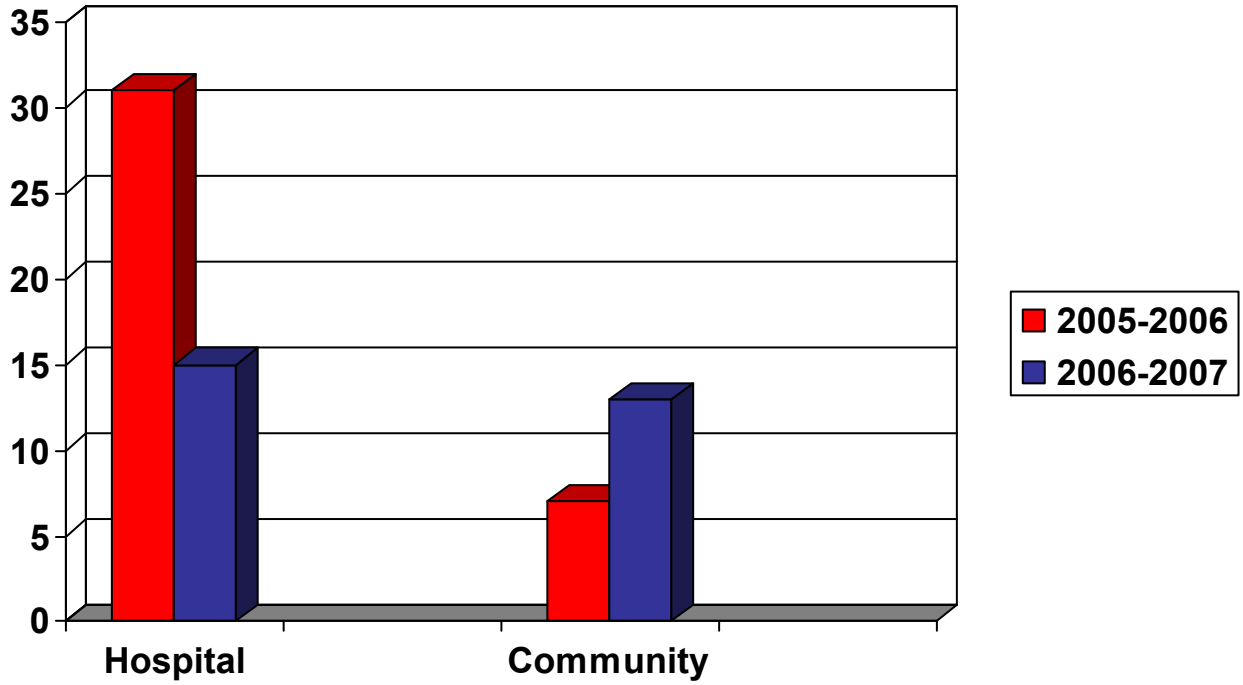
MRSA bacteraemias rates are also measured as rate per 10,000 bed days and the following chart demonstrates the Trust's performance over the past 7 years



The performance by quarter over the year suggests that the robust approach to tackling this problem is bearing fruit as the Trust has experienced a reduction in numbers quarter by quarter.



According to the current mandatory reporting arrangements any bacteraemias that are detected within 48 hours of admission are classified as community (C) and the rest deemed hospital acquired (H). The year's breakdown is highlighted in the next chart with last year's comparative figures included:



The Health Protection Agency reports that at national level 27% of MRSA cases are diagnosed within 48 hours. Of these a higher than average level of MRSA bacteraemia appear to occur in elderly patients in the community, particularly those with a chronic illness, frequent admission and/or those who reside in nursing and care homes. Close collaboration across the health economy is therefore essential to identify ways of reducing the spread of infection and to minimise risk. Locally 15 (54% of total) were previously known to be colonised with MRSA before episode of bacteraemia. 5 (18% of total) were admitted from residential care.

Source of infection

Last year's annual report included a breakdown of potential causes of infection and two major contributors were identified: central lines (12) and nephrostomy tubes (5). These two interventions were therefore highlighted as requiring particular focus with an approach based on care bundle (in the case of central lines as per Saving Lives) and blanket decolonisation in the other group. These measures appear to have produced the desired outcome:

Comparison of source of MRSA bacteraemia

	2005-2006	2006-2007
Chest	9	4
Central Lines	**12**	**1**
Soft tissue*	4	9
Nephrostomy	**5**	**0**
Catheter	2	2
Contaminant	2	3
Miscellaneous / Unknown	8	9
*wounds/pressure sores/cellulitis		

The significant emerging group this year is that associated with pressure sores, wounds and cellulitis. Of the 9 in this group 4 were classified as community acquired.

This year the approach to MRSA bacteraemia has been based on targeting the high risk groups as identified following a review of the first 15 cases. Two basic steps underpin the local approach:

- Every admission must be checked against Patient centre/PAS/Wardlinks to identify if patient has had a history of MRSA (colonisation or bacteraemia)
- SCREEN,TREAT, STOP (if negative)

All patients:

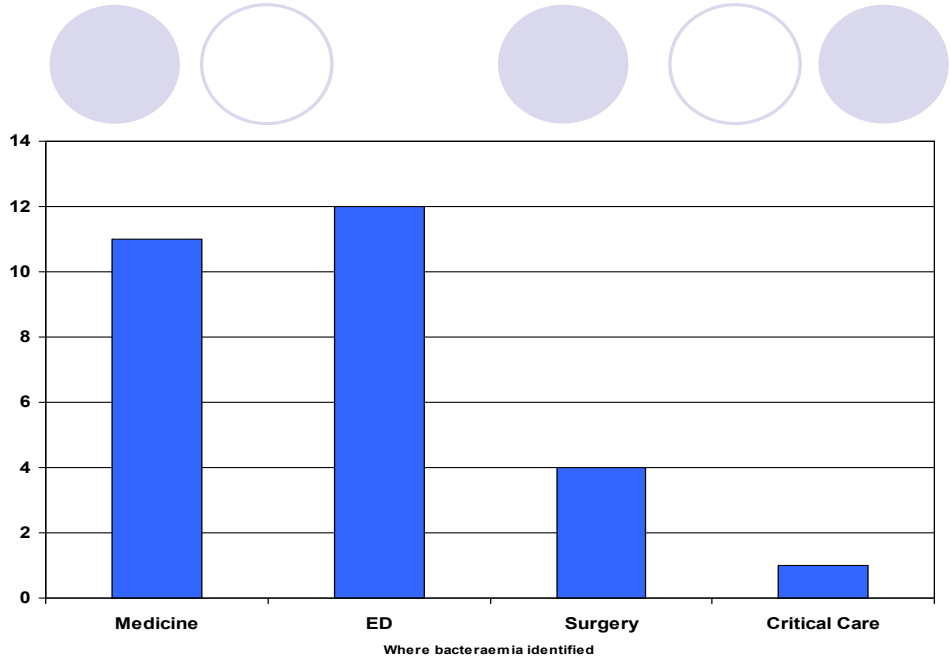
- With a history of MRSA
- With a history of recent admissions to this or another hospital
- Transferred from another hospital
- With a fractured neck of femur
- For cardio-oesophagectomy/gastrectomy
- Admitted from residential/nursing homes

- are screened for MRSA colonisation on admission and eradication therapy is commenced and continued unless the screening proves negative (SCREEN, TREAT, STOP if negative). Furthermore all patients admitted with any of the following are also included in this approach:

Urinary catheter	Intravenous line	PEG tubes
Leg ulcers	Existing wounds	Pressure sores
Suprapubic catheter	Tracheostomies	
Skin conditions such as psoriasis dermatitis or eczema		

In practice a significant proportion of acute admissions, particularly medical, fall within this policy.

The 'hot spots' nationally and locally for MRSA bacteraemias are predominantly Medical/Elderly care units and augmented care. This is the case for the majority of Northwest Trusts.



The above chart identifies the source of bacteraemia with 23 out of 28 having been within the Division of Medicine (Medicine and Emergency Department) who deal with all the acute medical/elderly admissions.

Root Cause Analysis

It is accepted from biological principles that not every case of infection can be prevented and the concept of 'unavoidable' infections recognises this. However each MRSA bacteraemia (particularly in the group of high risk patients in augmented care) should be reviewed in detail by a root cause analysis (RCA) or equivalent approach and identify any factors in the patient's care that were not done optimally and may have resulted in the infection.

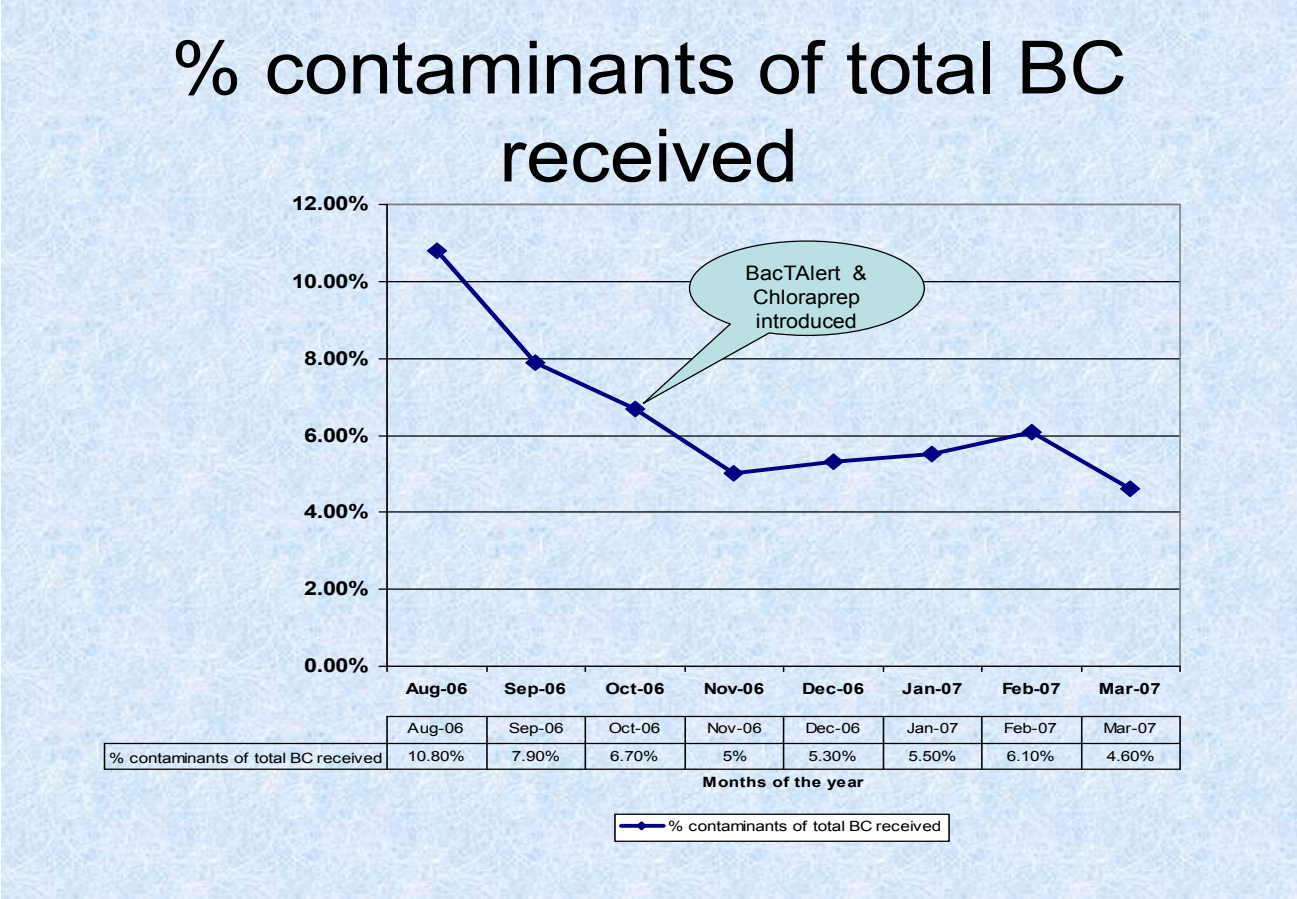
Over the year root cause analysis was applied to MRSA bacteraemias. The main themes identified with corrective response (in red) included:

- Staff not checking Patient Centre/PAS for MRSA flag
- Risk alert sent out via Risk department
- Patients not being screened as per protocol
- New screening protocol introduced and disseminated
- Not taking blood cultures according to policy
- Introduction of BactAlert and chloroprep, development of blood culture pack with documentation sticker
- Failure to document IV therapy care
- Development of IV therapy Care Plan

Contamination of Blood Cultures:

Blood culture is an important diagnostic tool in diagnosis of serious infections. False positives due to contamination can lead to inappropriate/delayed treatment/increase length of stay/increase cost of health care. Adherence to an aseptic technique at the venepuncture site is known to reduce contamination rates.

In order to reduce the rate of contamination an extensive educational programme was undertaken to ensure that blood cultures are obtained under aseptic technique. To facilitate this, BacT Alert Blood collection system was introduced. Also chloroprep was introduced for skin preparation. The impact of these interventions is highlighted in the chart below which identifies a significant drop in the rate of contamination. In real terms there has been a drop from 10.8% contamination rate in total blood cultures taken to 4.6% in the latter half of the year. This has had a noticeable positive impact on the workload of the microbiology laboratory staff. **It is also important to bear in mind that 3 of this year's bacteraemias were considered to have been contaminants.**



Alert Organisms isolated from significant Blood Cultures (excludingMRSA)

The notable trend in the bacteraemia rates (excludingMRSA) is that the number of MSSA (Methicillin Sensitive Staph Aureus) of hospital detected bacteraemias has decreased in 2006-2007 compared to the previous year (a reduction from 23 to 15). This decrease is mainly due to less S.Aureus bacteraemia associated with IV lines compared to the previous year. This encouraging trend could be linked to the implementation of the Saving Lives care bundle approach to the insertion of IV lines.

For all organisms there were 43 bacteraemias documented to be associated with IV lines compared to 50 the previous year. On the other hand 32 bacteraemias this year were documented to be associated with urinary catheters compared to 13 last year. It is difficult to make comparison as documentation of insertion and care of medical devices, especially IV lines and urinary catheters, was not robust in the previous year.

Alert organisms isolates from blood cultures

Organism	No	Hospital	Community
MSSA	48	23	25
GRE*	1	1	0
ESB1's**	9	4	5
Strep. Pneu.	43	5	38
Gr. A Strep	10	0	10
N. Meningitis	2	0	2
Yeast	11	11	0
*Glycopeptide Resistant Enterococci			
** Extended Spectrum B Lactamase producing organism			

There were 11 bacteraemias associated with yeasts in 2006/7 compared with 2 in 2005/6. This may reflect that increasingly very sick patients with extensive co-morbid conditions are receiving aggressive medical interventions.

Clostridium Difficile

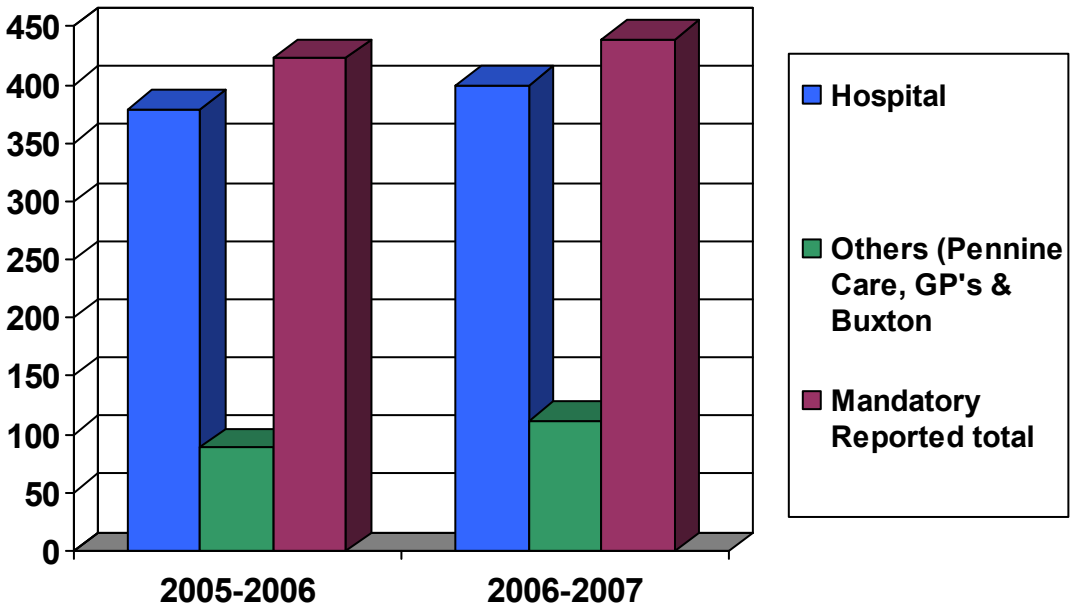
Up till March 2007 the mandatory surveillance scheme required all NHS acute trusts in England to report all cases of CDAD (Clostridium Difficile associated diarrhoea) in people aged 65 years and over. The scheme began in January 2004. Cases reported included infections contracted in the community and those that develop while a patient is in hospital. This might be the acute trust hospital itself, or other hospitals (such as community hospitals) for which the acute trust hospital processes specimens. Even patients who are not admitted to hospital, but have a positive stool submitted by their GP or from another NHS-run healthcare facility is reportable. Under this system cases are therefore assigned to the reporting laboratory's trust regardless of where the patient came from.

The following table breaks down the reportable figures for this trust to highlight the numbers stemming from sources other than hospital for the

period April06 to March 07. The data emphasise that the preponderance of the reportable cases are deemed to be hospital acquired.

Month	Total C.Diff (all locations)	C.Diff (Foundation Trust)
Apr	35	32
May	41	38
June	45	41
July	33	31
Aug	40	37
Sept	31	29
Oct	43	37
Nov	42	35
Dec	39	32
Jan	53	46
Feb	54	48
March	56	45

The diagram below illustrates a breakdown of CDAD figures into three groups (Hospital: **H**;Others:**O**;Reported Total:**R**).



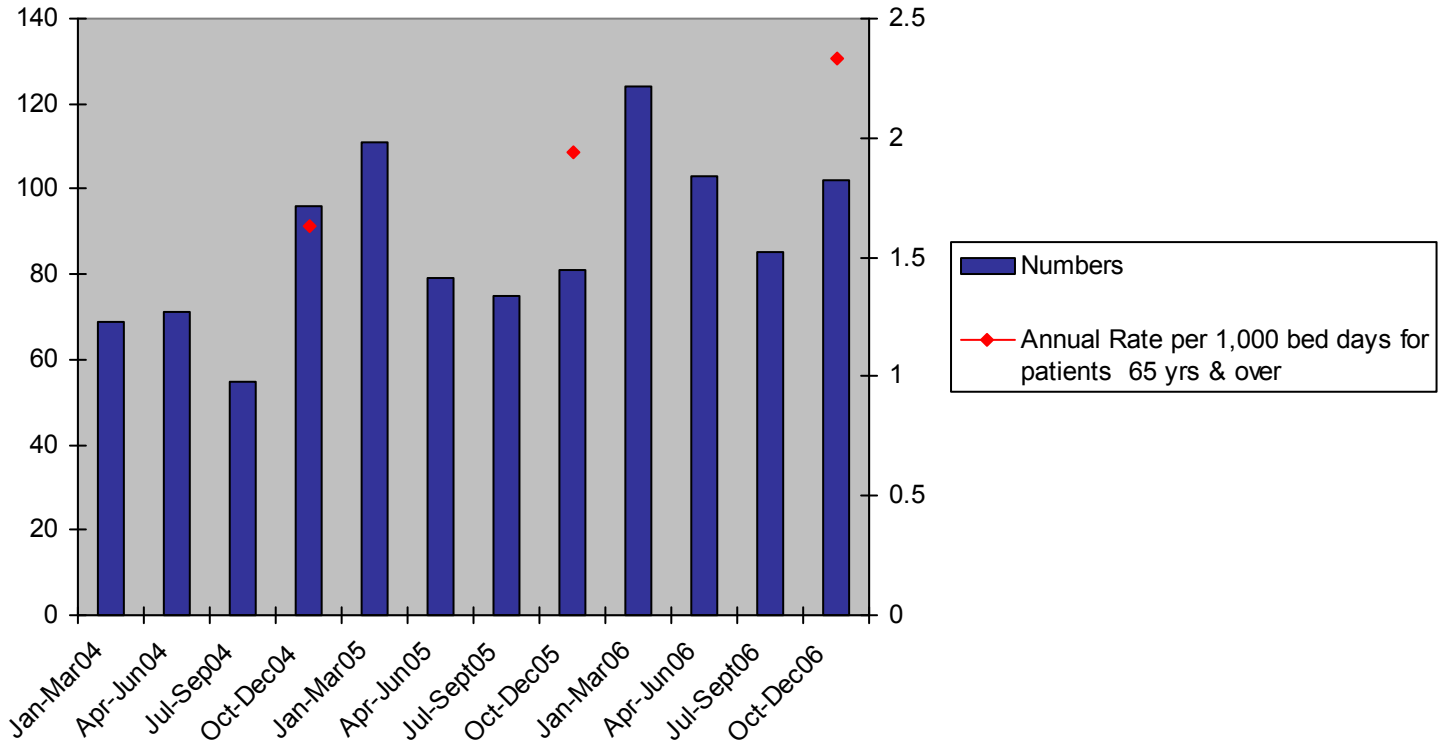
The Health Protection Agency (HPA) has developed a new system based on the enhanced MRSA surveillance system which has been available from April 2007. **Under these new arrangements, all cases over 2 years old are to be reported**. The other data, apart from date of birth, to be collected include sex; specimen date; reporting laboratory **and location of the patient at the time the specimen was taken.**

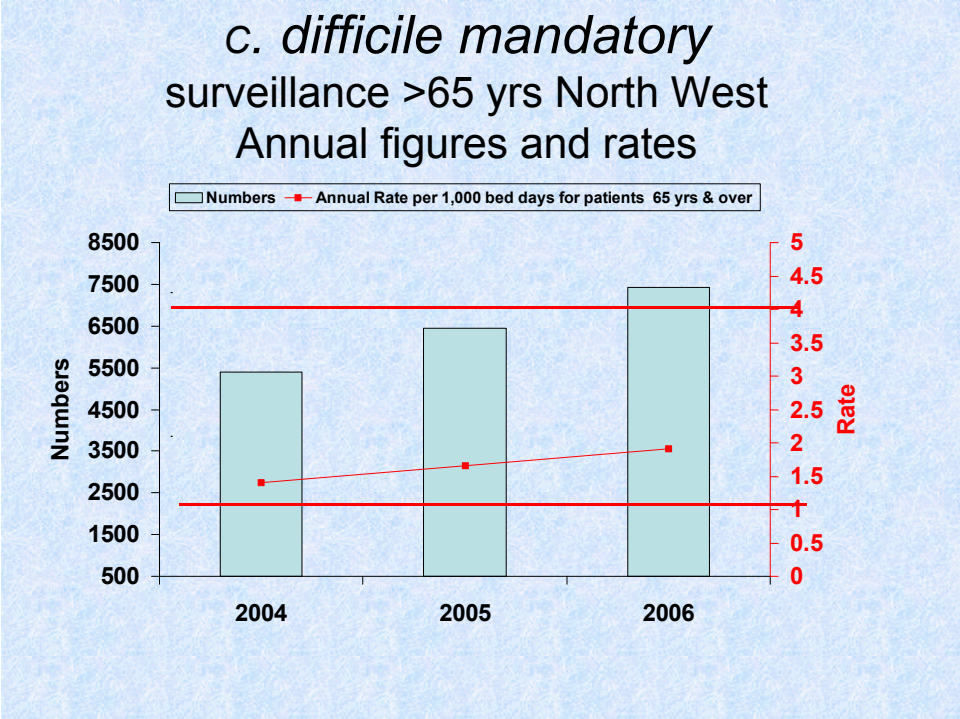
Hospital rates are calculated by the number of C.difficile reports for the period divided by the total number of bed days for patients 65 years and over for the time period multiplied by 1000.

As the next diagram confirms, this Trust has experienced a rise in cases of C.Difficile over the past two years

STOCKPORT FOUNDATION TRUST

ANNUAL FIGS: 2004 = 291; 2005 = 346; 2006 = 414





The figure above shows a similar trend over the same period for the Northwest.

This upward trend has been experienced at national level with the HPA reporting a 5.5% increase from 2005 to 2006. Comparison between Trusts needs to be done with caution in view of different patient and hospital types. Trusts are divided into 5 types. The table below shows the rates for each type for January-September 2006:

Trust Type	**Rate (cases per 1000 bed days in people aged 65 and over)**
Small acute	2.87
Medium Acute	2.46
Large Acute	2.29
Acute specialist	0.85
Acute Teaching	2.55

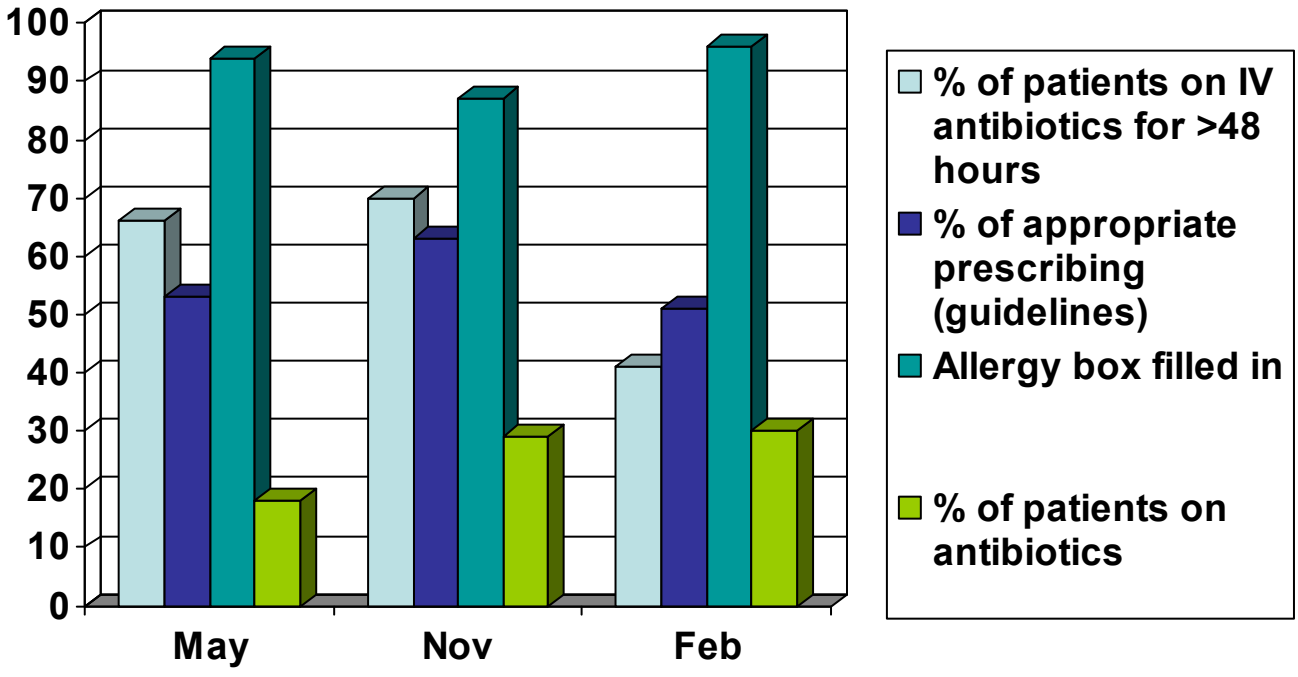
Stockport NHS Foundation Trust is classed as Medium Acute and for the same period its rate has been calculated as 2.35. The rate of C.Difficile is of concern and the Trust needs to ensure that it has effective measures in place to reduce the rates.

The Code of Practice (Health Act 2006) requires Trusts to have specific policy on the prevention and control of C.difficile infections. Effective measures include:

1. **Prudent use of Antibiotics**:
   Under the terms of the Code of Practice (Health act 2006), all Trusts are required to have an antibiotic prescribing policy. The policy should include the control of the prescription of commonly used broad-spectrum antibiotics, to include specifically extended spectrum cephalosporins and fluoroquinolone antibiotics. Control in this circumstance refers to ensuring that these antibiotics are only used when indicated by the clinical condition of the patient and/or in association with the results of microbiological investigation. Their empiric overuse must be avoided both to reduce the risk of unnecessary side effects, and to reduce the likelihood of emergence of antibiotic resistant organisms which will compromise their future use.

   Taking into account that patients must receive the medicines they need in a timely manner, the policy should restrict prescription of IV antibiotics to a maximum of 48 hours in the first instance; this may include automatic stop dates on prescription charts and a requirement for re-prescribing if needed for longer. There should be guidance on switching from IV to oral administration as soon as possible and oral antibiotics may be restricted to five days, with longer use requiring re-prescription.

   Over the last year 3 antibiotic audits were performed. The sample size in the last two audits involved a review of 465 and 507 charts respectively. The main findings of the audits are highlighted in the chart below:



Encouraging Trends :

- Percentage of patients being given IV antibiotics for longer than 48 hours has shown a dramatic reduction. This indicates that IV antibiotics are being regularly reviewed and changed to oral
- Percentage of patients on appropriate antibiotics has continued to improve, although a lot of antibiotics used were not according to the guidelines even though they were appropriate to the patients' condition.
- High compliance rate in filling allergy boxes, although we should strive for 100% compliance consistently.
- The percentage of patients on antibiotics has remained the same over the last two audits (one must bear in mind that audits conducted during the winter months are bound to identify a higher proportion of inpatients on antibioics).

Areas of Concern:

- The recording of course lengths is still low even though it has improved from the previous audit.
- It is Trust policy that every inpatient with documented allergy should wear a red wristband. The figures revealed in these audits are therefore disappointing

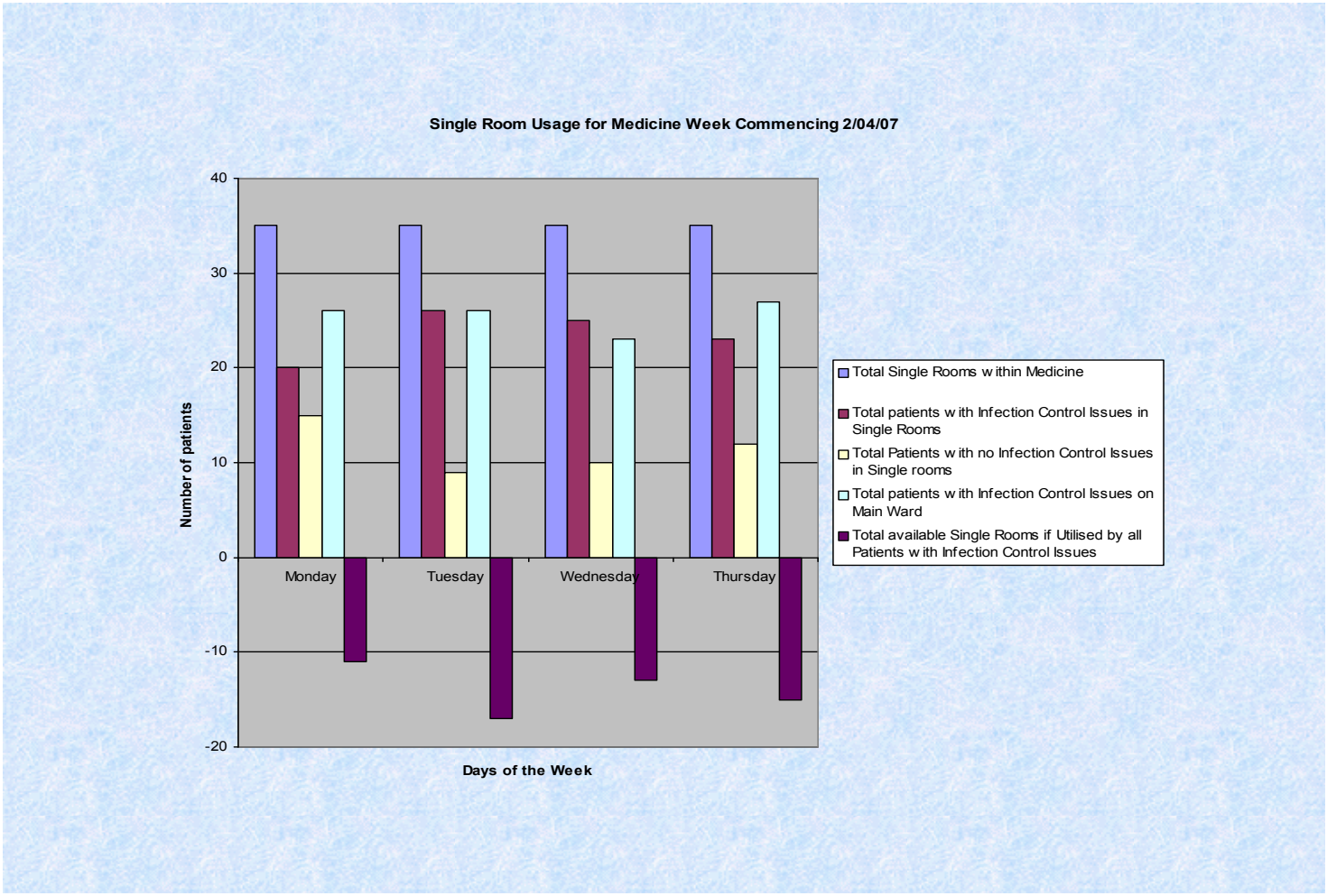
The challenge is therefore to sustain the encouraging trends and to improve the compliance in the areas of concern. Antibiotic audits are now being performed every 3 months and feedback to staff. These audits are also discussed at various forums including Infection Prevention and Control Committee, Clinical Effectiveness Committee and Drugs and Therapeutics Committee. There are also arrangements in place that trigger an automatic antibiotic audit in those clinical areas that are experiencing increase in new cases of C. Difficile.

2. **Diagnosis of CDAD**

The Trust has prompt access to laboratory diagnosis of CDAD by toxin tests on stool specimens that detect toxin A and B. This facility is available 6 days out of 7 with a turnaround time of under 0.6 of day. **The Trust is required to extend this facility to 7 days a week**.

3. **Isolation/segregation/cohort nursing**

Ideally patients with a communicable HCAI should be isolated in a single room. Patients with the same HCAI may be nursed together in an enclosed environment, for example in a typical 4/5 bedded bay. The Trust faces a major constraint in so far there are only 74 single rooms available from a bed complement of 860. The extent of the challenge is highlighted in a week survey of utilisation of single beds in the Division of Medicine



With this in mind, guidelines for the use of single rooms that were previously published in 2005 were re-enforced and education at ward level given on an informal basis to increase awareness. Two surveys were performed to evaluate the use of single rooms for infection control. The April 2006 study identified 62% of single rooms being occupied by patients with infection control issues. The February 2007 repeat survey identified 59% of single rooms being used for infection control purposes. These results are disappointing. Increase education occurred over the year to emphasise the priority of the use of single rooms for infection control. As a result of enhanced surveillance of patients with C.Difficile positive feacal samples, datix forms were completed if patients were not placed into a single room. In total 40 incident forms were completed between October 2006 and March 2007 due to inappropriate placement of patient with active C.Difficile.

The challenge that the Trust faces in its capacity to ensure appropriate isolation of patients for control of infection can be addressed in the short term by the opening of an isolation ward (i.e. conversion of one of the current wards). In the medium and long term the ongoing major ward upgrade will improve the Trust's capacity in this area. The upgrade which involves a capital investment of approximately £2.5 million pounds will increase the number of single rooms, number of bays and bed space area. These measures will enhance the ability to isolate and cohort patients.

4. **Hand Hygiene**

Since November 2004 the trust has provided facilities for hand decontamination at point of care through the installation of alcohol hand rub dispensers. Participation in the NPSA sponsored clean your hands (CYH) campaign continued over the year with regular delivery of official posters to wards via Supplies Department. This will continue into this year with education through Induction and Mandatory Training sessions. This year saw the installation of yellow floor mats and backing plates behind alcohol gel dispensers at entrances to departments to encourage staff, patients and visitors to clean hands before entering and on leaving clinical areas .

A new National Soap Contract was developed under the guidance of the Purchasing and Supplies Agency (PASA). This contract standardised the presentation and dispensing format of the soap. The Infection Prevention and Control Team opted to provide a complete hand care system (soap and moisturiser). Installation began on the 12th February 2007 and lasted 2 weeks. It is important to point out that as regards to C.Difficile, the appropriate hand washing is to use soap and water rather than alcohol gel.

5. **Environmental cleaning**

During this year the Trust introduced an enhanced environmental cleaning team. This team attends level two cleans in ward areas, and endemic areas of infection whereby they increase the level of cleaning of equipment. Wards that are considered to be showing higher prevalence of C. Difficile are also cleaned with Actichlor Plus (bleach based product).

This year the Trust also took the decision to bring in-house the portering and domestic staff. Infection Control was one of the primary motivating factors for this decision.

The ward upgrade referred to will also enhance environmental cleaning by improving the quality of fixtures and fittings which will make it easier for the domestics to clean and the quality of the Dirty Utility areas

Mandatory Orthopaedic Surgical Site Surveillance Infection (SSSI)

The mandatory requirement of the Health Protection Agency (HPA) is to survey one orthopaedic procedure for a period of 3 months. This year our surveillance targeted hip hemiarthroplasties over a period of the statutory 3 months (January to March 2007).

Report:

Quarter	No of Operations	No of Surgical site Infections	% infection rate
Jan-March	40	1	2.5%

The national average % infection rate for this cohort of patients for 2005-2006 was reported as 3.63% (SSSI in Orthopaedic Surgery Report April2004-March 2006). It is important to point out that rates of SSI in this orthopaedic intervention tend to be higher compared to others e.g. elective hip replacements. This is partly explained by patients having to undergo these procedures being at greater risk of infection and having longer post-operative stay in hospital, increasing the chance that SSI's will be detected.

Flu Vaccination Programme

The breakdown of staff who were vaccinated are shown in the table below. The uptake was lower than 2005 (45%). This is probably related to the difficulties encountered in supplies of the vaccine resulting in significant delays. This was a national problem.

	TOTAL STAFF IN POST	TOTAL VACCINATED	PERCENTAGE VACCINATED
Doctors	276	59	21%
Nurses (incls N/A & HCA)	1905	560	29%
All other professional groups allied to medicine (eg physios, radiographers, pharmacists, laboratory staff)	591	247	42%
Anciliary staff (cleaners, porters, caterers etc)	222	66	30%
Admin & clerical (ward clerks, office staff , managers etc)	852	266	31%
TOTAL	**3846**	**1198**	**31%**

DIRECTORATE/DIVISION	NUMBER EMPLOYED	NUMBER VACCINATED	OVERALL PERCENTAGE
CRITICAL CARE	326	110	34
CENTRAL ADMIN	90	38	42
CLINICAL SUPPORT	328	147	45
DIAGNOSTIC	240	125	52
FINANCE	222	16	7
HR	68	20	28
MEDICINE	883	452	51
OPERATIONS	412	93	23
SURGERY	530	231	44
WOMENS & CHILDREN	470	286	60
TOTAL	**3569**	**1518 + 95 = 1613**	**45%**

Needlestick statistics.

These are attached in Appendix 1, including figures for 2005 for comparison.

Education

Development of the Intranet Site of Infection Prevention and Control continued throughout the year. The site has achieved 5 star status. More guidelines and policies have been made available on this site so that staff are able to access up to date evidence based information. Every week a news update is added.

E-Learning package of Infection prevention and Control Training was launched.

This year's Infection prevention and Control week (20-24th November 2006) was launched with a successful conference concentrating on C.Difficile and MRSA and how staff could become engaged in the process of reducing these healthcare associated infections. Various publicity stands were placed throughout the hospital to highlight topics such as hand hygiene and asepsis. Sale Sharks team member, Mark Taylor, visited the hospital during the week to help publicise the infection control campaign and launch the 'Stockport vs Superbugs' campaign. During the same week the patient cleanliness hotline was set up and hand hygiene stations given a higher profile with the installation of bright yellow mats. One of the educational activities included giving the opportunity to staff to have their hands 'sampled' by having their fingers wiped on an agar plate and were then able to view photographs of their plates to see what was grown.

Health Act 2006

This Act gave the secretary of state the power to issue a Code of Practice for the Prevention and Control of Health care Associated Infections connected with NHS healthcare. The code does not introduce new measures but brings together existing guidance that NHS bodies should already be compliant with. However a crucial change is that it identifies 11 core duties and sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment where the risk of healthcare associated infections is kept as low as possible. The Code Duties include:

1. General duty to protect patients, staff and others from HCAI
2. Duty to have in place appropriate management systems for infection prevention and control
3. Duty to assess risks of acquiring HCAI and to take action to reduce or control such risks
4. Duty to provide and maintain a clean and appropriate environment for health care
5. Duty to provide information on HCAI to patients and public
6. Duty to provide information when a patient moves from the care of one health care body to another
7. Duty to ensure co-operation
8. Duty to provide adequate isolation facilities
9. Duty to ensure adequate laboratory support
10. Duty to adhere to policies and protocols applicable to infection prevention and control

11. Duty to ensure, so far as reasonably practicable, that health care workers are free of and are protected from exposure to communicable infections during the course of their work and that all staff are suitably educated in the prevention and control of healthcare associated infections.

Action plans are in place to ensure that the Trust is and remains compliant with the above duties and responsibilities.

Saving Lives Balance Score Card

In the annual report 05-06, reference was made to this toolkit which was launched by the DoH in June 2005 to assist Trusts to reach and maintain their MRSA trajectory targets. The toolkit makes use of a self-assessment to improve patient safety and reduce infection rates. This focuses on 9 areas of challenge ranging from organisation wide components such as the environment to front line clinical practice. Scores for each challenge are used to generate a balanced score card with red, amber and green ratings. Red rating is allocated to those challenges that are deemed to have less than 70% compliance and green rating if the Trust is fully compliant (100 %).

In last year's score card (05-06) all challenges apart from 2 were assessed as amber. Challenge 2 was assessed as red. This year's (06-07) re-assessment has identified a challenge that is green (1) but two assessed as red (8 and 9). The scorecard is attached.

Challenge 8 is in relation to environment and effectiveness of facilities management. There are 11 questions incorporated in this challenge and target has been met in 3. Areas where target has not been met include: integration into clinical teams, induction training and ongoing training for staff, approval of cleaning strategy by Board and involvement of Infection Control team in design buildings and contracting processes. Challenge 9 deals with decontamination policies specifically regarding to re-useable instruments. Target has not been met in 2 out of 6 questions, in relation to the lack of a central flexible endoscopy decontamination unit and compliance with HTM 2030 for disinfectors and dishwashers.

These issues would have to be addressed this year but in part are already part of an action plan in progress e.g. the in-house contracting will resolve most of the issues in challenge 8.

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Appendix 1

FINANCIAL YEAR ANNUAL FIGURES
01.04.2006 to 31.03.2007

EMPLOYER

	2006/7	2005/6
Stockport NHS Trust	114	116
Pennine Care Trust	15	3
Initial Hospital Services	3	3
Other	12	9
TOTAL	**144**	**131**

OCCUPATIONAL GROUP

	2006/7	2005/6
Trained nurse	52	57
Midwife	7	7
Medical staff	31	23
Healthcare Assistant	19	15
Nursing auxiliary	13	5
Support worker	0	2
Trainee assistant practitioner	2	2
Student nurse/medical	6	7
Agency nurse/NHS professionals	3	1
Domestic/porter	3	3
Assistant Practitioner	1	-
Physiotherapist	0	0
Podiatry (chiropody)	0	0
HSDU	1	1
X-ray staff	1	1
Phlebotomist	1	1
Laboratory staff	3	4
Admin/clerical	0	1
Volunteer	0	0
Laundry	0	1
EBME	1	0
TOTAL	**144**	**131**

How Injury Occurred 2006/7		
Type of sharp	**Sharp used for:**	**Circumstance of injury**

Cannula	16	Inserting iv line	19	During use	45
Hollow needle	46	Arterial blood gas sampling	5	Disassembling device	8
Suture needle	12	Sampling other tissue/fluid	3	Re-sheathing	7
Scalpel	3	Venepuncture	22	Before disposal – in transit	24
Other surgical instrument	8	Finger/heel sample	5	Putting sharp in box	11
Lancet	5	Suturing	12	Item protruding from box	3
Butterfly	5	Other surgical procedure	10	Sharp left in wrong place	11
Bone	1	Injection iv/im/sc	28	Sharp left in wrong container	2
Scratch/bite	21	Other/not applicable	40	Attack by patient	20
Splash	18			Other	13
Other	9				
TOTAL	**144**		**144**		**144**

Hepatitis B vaccination status at time of injury	
	2006/7
Vaccinated and immune	124
Vaccinated no serology done	8
Not vaccinated	1
Vaccination in progress	3
Incomplete vaccination	4
Vaccinated but no protective immunity Gained	4
Vaccinated no serology available	0
TOTAL	**144**

Saving lives: Reducing HCAI including MRSA

Balanced Score Card: Self-assessment summary for infection control

STOCKPORT NHS FOUNDATION TRUST

Challenge 1	Challenge 2	Challenge 3
Engage senior management (clinical and non clinical) in order to secure the implementation of best practice in the prevention and control of infection	Appoint infection control leaders at each level in the organisation to ensure the promotion of good clinical practice and challenge inappropriate behaviour	Implement a local surveillance programme in order to identify in real time the infection status throughout the Trust by the provision of reports to each ward/unit at least quarterly
Challenge 4	**Challenge 5**	**Challenge 6**
Adopt national evidence based guidance in order to ensure that patients are treated according to best practice	Ensure the effective auditing of infection control practices throughout the Trust through monitoring and implementation.	Ensure that all Trust employees have a programme of education and training on the prevention and control of infection in order to understand their responsibility for infection control and the actions they must personally take.
Challenge 7	**Challenge 8**	**Challenge 9**
Review the patient journey for emergency and planned patients in order to reduce the risk of transmission of infection by minimising the movement of potentially infected patients.	Review the status of the built environment and the effectiveness of the facilities management services, including cleaning, in order to provide a safe and clean environment for patient care.	Implement robust Trust-wide policies for decontamination in order to ensure that patients will not get infected by inadequately decontaminated re-usable instruments, including surgical instruments and endoscopes.

Overall Status

Key		
	100%	Full compliance
	71%-99%	Review required
	=>70%	Trust priority