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NHS DORSET CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

Date of the meeting	21/05/2014
Author	J Campbell, Infection Control Nurse Specialist M Wain, Head of Patient Safety and Risk
Sponsoring Board Member	T Goodson, Chief Officer
Purpose of Report	The IPC annual report provides an overview of Infection Control activity of the CCG during 2013/14
Recommendation	The Governing Body is asked to **Note** the report.
Stakeholder Engagement	All health partners sit on the post infection review group and lay members sit on the Quality Group to represent the CCG population.
Previous GB / Committee/s, Dates	N/A

Monitoring and Assurance Summary

This report links to the following Assurance Domains	• Quality • Outcomes • Governance • Partnership-Working

I confirm that I have considered the implications of this report on each of the matters below, as indicated:	**Yes** [e.g. ✓]	**Any action required?**	
		Yes Detail in report	**No**
All three Domains of Quality (Safety, Quality, Patient Experience)	✓		✓
Board Assurance Framework / Risk Register	✓		✓
Budgetary Impact	✓		✓
Legal / Regulatory	✓		✓
People / Staff	✓		✓
Financial / Value for Money / Sustainability	✓		✓
Information Management &Technology	✓		✓
Equality Impact Assessment	✓		✓
Freedom of Information	✓		✓

Initials : JC

1. Introduction

1.1 This report provides a summary of infection, prevention and control (IPC) activity for the Dorset Clinical Commissioning Group for the 2013/14 financial year.

1.2 The report comprises a short overview report and detailed appendices can be found at the end of the report relating to:

- 2013/14 work plan found as appendix A;
- root cause analysis (RCA) overview found as appendix B;
- healthcare associated infection (HCAI) data 2013/14 found as appendix C.

1.3 Monitoring of infection rates, both in providers and the wider community was carried out by members of the Quality Improvement and Patient Safety teams, following the retirement of the Infection Control Specialist Nurse in the second quarter. Support was also provided to investigate reported community acquired MRSA bacteraemia, C-Difficile cases and outbreaks. Root causes identified and subsequent learning was shared with partners across the health community to reduce the risk of future occurrence. The team has now been recruited to establishment with a new IPC nurse commencing in post in February and a senior IPC nurse in March 2014.

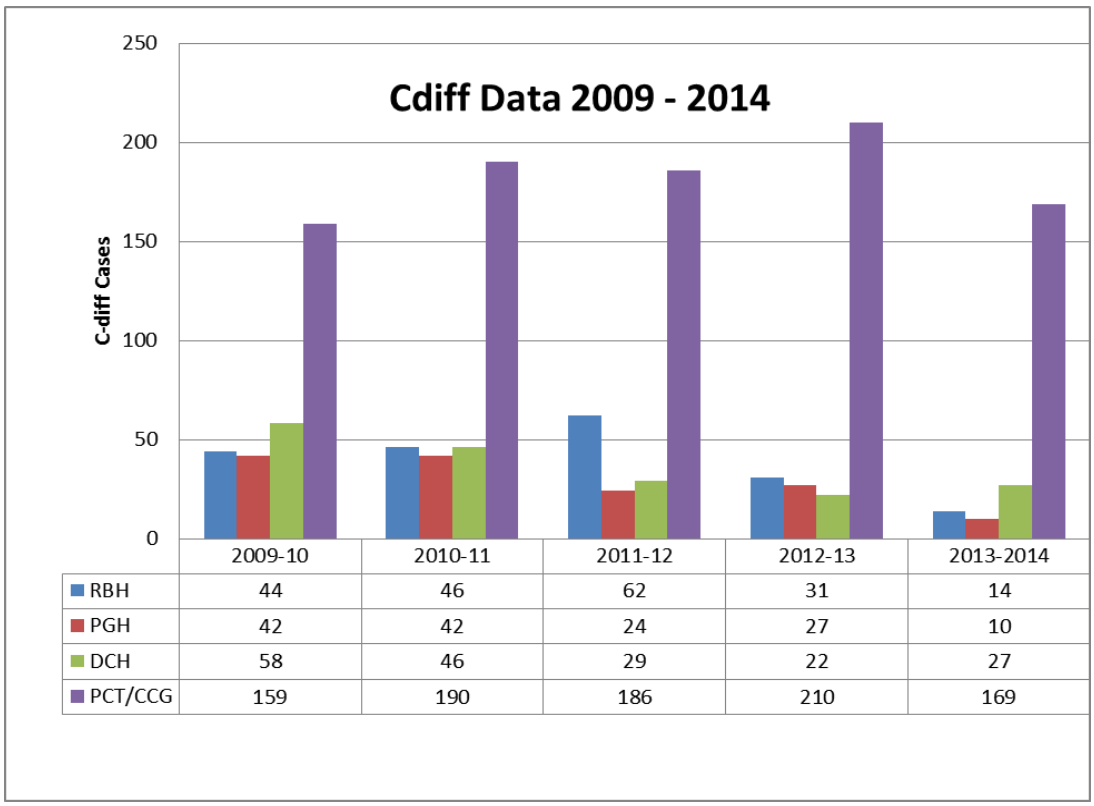
1.4 The IPC and Patient Safety teams continued to provide and advice and support service to health and social care providers including:

- General Practices;
- Care Homes;
- Nursing Homes;
- Local Authorities;
- Safeguarding Teams;
- Care Quality Commission.

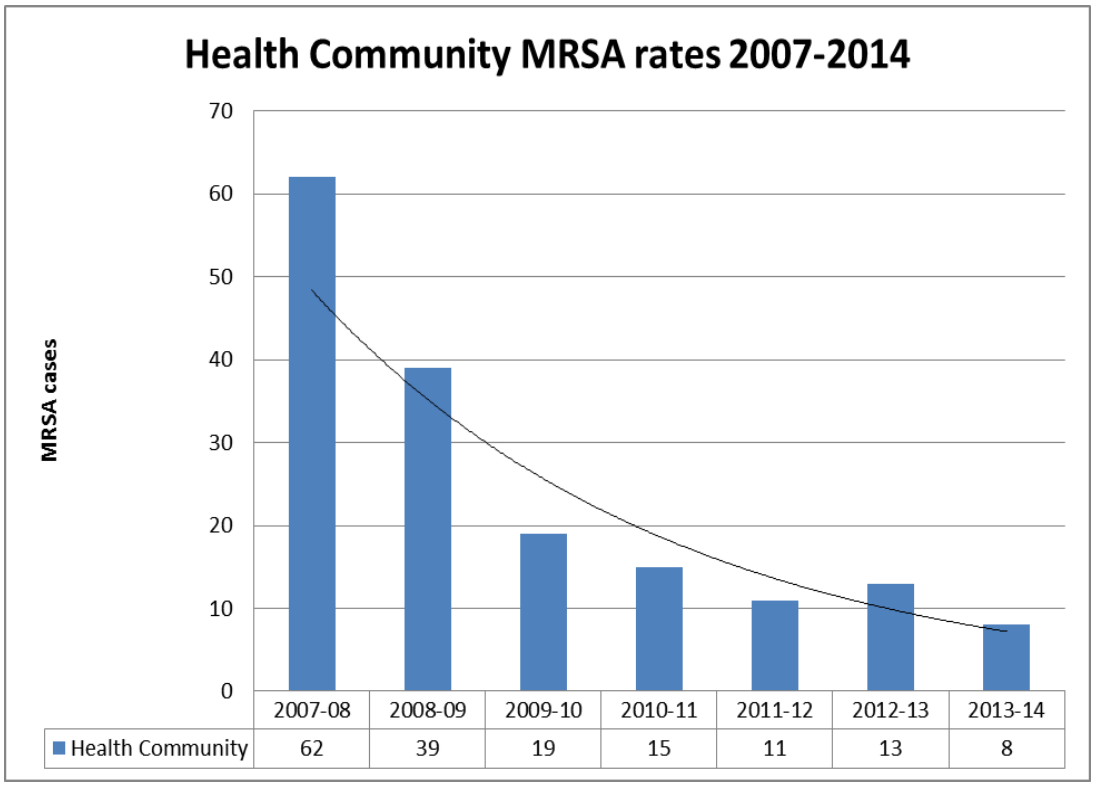
2. Overview

2.1 The health community continues to perform well against infection rates, achieving below trajectory for *Clostridium difficile*. MRSA bacteraemias are reported following the 'zero tolerance' approach and remain low as the graph demonstrates. Dorset County Hospital NHS Foundation Trust (DCHFT) exceeded the attributed *Clostridium difficile* target by nine cases (although three of these were agreed to be non-preventable), however their reporting and investigations have been thorough and shared through established health

community links. The targets for 2014/15 have again been reduced all local trusts, other than DCHFT which has been set at 22.



	2009-10	2010-11	2011-12	2012-13	2013-2014
RBH	44	46	62	31	14
PGH	42	42	24	27	10
DCH	58	46	29	22	27
PCT/CCG	159	190	186	210	169



	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Health Community	62	39	19	15	11	13	8

2.2 Quality assurance visits continued to be undertaken to assess compliance with quality standards in relation to IPC and patient safety across community and acute providers. Reports were produced and fedback to enable improvements where required.

2.3 Assessment visits to care homes were undertaken following referral from the Care Home Quality Improvement Team and Local Authorities where expert assessment was required. The aim of the visits is to improve quality and safety of services by identifying IPC deficiencies and make recommendations for change in practice the environment. Follow-up visits were undertaken to ensure agreed improvements had been made.

2.4 Visits to other providers, including general practices and hospital trusts, were also undertaken. Where potential risks to patients were identified actions were taken to reduce or remove the risk e.g. compliance with decontamination of reusable instruments in accordance with national guidance.

2.5 The team also had an input into a number of new building projects and refurbishments to ensure IPC standards were considered during the planning stage. Assessments were also made on completion of building works to ensure compliance with national building standards and environmental guidance.

2.6 Training and support continued throughout the year to a range of provider groups. These sessions covered dissemination of national guidance, best practice and learning from infection reviews. A number of events were held for practice nurses, care homes and domiciliary care providers.

2.7 To reduce the impact of winter pressures and infection outbreaks the IPC team developed 'Getting Ready of Winter' programme. This was initially developed within Poole Hospital and adapted for Care Homes and General Practice. Information CDs, training tools and posters were developed and sent to relevant areas including care homes, domiciliary care agencies, general practices, dental practices, schools, libraries and pharmacies to raise awareness amongst the public. During the winter no acute trust reported unnecessary attendance of admission due to Norovirus type illness.

3. Root Cause Analysis

3.1 Dorset CCG leads a group spanning the health community to ensure that incidence of healthcare associated infections receive robust review and that any learning is widely disseminated.

3.2 Through the Root Cause Analysis process information was reported and shared in relation to Meticillin Resistant Staphylococcus Aureus (MRSA), Clostridium difficile (C-Diff) and other specific infections and out breaks to inform on learning and prevention.

3.3 The Pan-Dorset HealthCare Associated Infection (HCAI) Group continues to meet, supported by Dorset Clinical Commissioning Group to provide a framework for sharing information and learning to inform on improvements and prevention of preventable HCAIs and outbreaks.

4. Pan-Dorset IPC Network

4.1 The network meet bi-annually to ensure a multiagency approach to IPC, overseeing and supporting the work of the IPC teams. The network was attended by all Directors of Infection, Prevention and Control and microbiologists from the heath community. The group also reviewed national guidance to ensure consistent local implementation.

4.2 During this year new guidance in relation to C-Diff including testing algorithm was published and a local process was agreed.

5. Conclusion

5.1 The role of IPC within the CCG prioritises monitoring and surveillance of healthcare associated infections, develops links with partners in Public Health England (PHE), local public health teams and other CCG members within Wessex.

5.2 National and local links are being strengthened and roles and responsibilities being discussed. Local specialist forums remain in place to ensure specialist knowledge and skills are maintained and shared.

5.3 The Dorset HCAI group has been reviewed and terms of reference revised in line with national guidance on post infection reviews of MRSA and Clostridium difficile cases. The group has established a protocol for deciding if C-Diff cases are to be considered trajectory or non-trajectory, which is led by the Consultant Medical Microbiologists on a rotational basis.

5.4 IPC in Dorset remains focused on ensuring people are cared for in a safe environment and are protected from avoidable harm.

Author's Name and Title: Jacqui Campbell
Infection Control Nurse Senior Nurse
Matthew Wain
Head of Patient Safety and Risk

Telephone Number: 01305 368944

Appendices

Appendix 1	**IPC Work Program**
Appendix 2	**HCAI RCA overview report**
Appendix 3	**HCAI Data**

APPENDIX 1

Infection Prevention and Control Work Programme 2013-2014

No	Objective	Programme of Work	Progress
1	To provide board assurance on the management systems for Infection Prevention and Control	HCAIS Data Reports including MRSA, CDiff, MSSA and EColi. Data reports on Norovirus and any other outbreak within the acute of community trusts and care homes	Data collated and reported monthly through RCA meeting and Head of patient safety
		Quality Assurance Visits to provider service including acute and community hospitals	Quality assurance visits undertaken - reports and feedback to services to enable improvements and recognise areas of good and best practice
		RCA/PIR establish reporting and review process	Terms of reference revised following group review to incorporate non trajectory consideration.
		RCA on all community C.diff & MRSA Bacteraemias	RCAs completed and lessons learned shared across the health community. End of year RCA overview report completed. Process for general practice under development.
2	To ensure IPC is based on current legislation and best practice guidance	Review legislation and guidance as published and disseminate through organisation via local web systems	Uploaded onto Primary web all relevant documents and links.
		Maintain and update database on reference documents	On-going review and inclusion of relevant documents onto database
		Raise IPC awareness across health and social care and other organisations as identified	Pan Dorset Practice Nurse forums held as planned. Information provided for care homes as required.
3	To provide specialist advise on Infection Prevention and Control including the clean environment to health and care providers within Dorset	Respond to enquiries and offer advice and support Undertake visits and assessments following invitation Undertake assurance visits in response to safeguarding, CQC and Care Home facilitator request.	Referrals from boroughs and CQC led to care home visits where assessment were undertaken and advice given to enable improvements. Reports were shared with the homes and the referring organisations. Follow up visits undertaken to ensure improvements made and on-going actions continued. Primary Care - Practice nurse Forum meetings held to offer advice and information to inform staff on audits and practice improvements. Sessions also included IPC update for staff. Primary care visits undertaken when requested to offer support and advice and when required taken action to ensure safe care for patients
4	To ensure new commissioned services have IPC practices in place to ensure patient safety in relation to HCAIS	Assess new services as required to ensure national guidance in followed Undertake Assessments as required and report findings	Advised of some primary care new builds and refurbishments and offered advice and support to ensure completed works met national IPC standards. Assessments carried out as required and reports completed and disseminated.

Dorset IPC Work Programme 2012/13 continued

No	Objective	Programme of Work	Progress
5	Care Home Teams	Develop links and working relationship with care home team.	Training day for Care Home teams held.
6	Care Homes	With care home team deliver a IPC Training Programme to Dorset Care Homes	One day event held in November focusing upon Quality of Care
		Assess Care home against IPC standards as required and requested by boroughs and safeguarding leads	Assessments carried out as required.
		RCA following outbreaks or incidents Identify role for undertaking RCA following outbreaks or incidents relating to IPC with links to HPA as required	Links with Public Health England and PHDorset confirmed. Members attend the joint HCAI meeting where outbreaks and learning are discussed.
7	PVL MRSA screening residents in Nursing Home	To review the incidence of resident colonisation within a nursing home implicated in increase reported cases following MRSA PVL Bacteraemia death with the aim: To prevent further PVL MRSA infections	Screening completed supported by CCG. Further discussions took place at the joint meetings regarding

APPENDIX 2

HCAI Root Cause Analysis Overview 2013.2014

HCAI	Date	Focus	History / Root Cause	Learning/issues Identified
MRSA PVL Pneumonia Death Part 1 **Acute and Community**	April 13	**Familial contact Unpreventable**	• Patient, previously healthy, died of necrotising pneumonia from PVL MRSA. Her husband, living in a nursing home, was found to be PVL positive.. • Concern was expressed that the HPA had decided not to screen all staff and patients in the nursing home. The HPA had followed guidance, which suggests screening when there are four PVL positive cases. • The HPA asked that the nursing home assess patients and screen when they think it is necessary. Public Health consultant RP supported the advice from the HPA. Members of the RCA group expressed concern over the HPA guidance. • The acute trust reported that another resident of the same nursing home had tested positive for with the same sensitivities as the first patient	• The learning from the previous MRSA in the community project was used to plan the screening of the nursing home. • No further cases of PVL were identified. The nursing home felt supported by the CCG and had learned from the process. • A deep clean, building works and repairs have been undertaken at the home.
Clostridium difficile **Acute**	April 13	**Non trajectory case**	• This patient was admitted on 29 January. The patient had colangitis and a blocked stent. They were treated with IV antibiotics with advice from Consultant Microbiologist. • On 20th February the patient tested C-diff positive, toxin positive. • The patient had a long standing rectal prolapse with complicated management. The patient was prescribed 125mg qdsVancomycin. • On 10 April, the patient was admitted with diarrhoea and tested Norovirus negative. This was a recurrence of C-diff and was treated with Vancomycin and Rapamycin. On 18 April the patient was started on Fidaxomicin. The	• It was agreed that this was a non-trajectory case

HCAI	Date	Focus	History / Root Cause	Learning/issues Identified
			patient had a type 4/5 stool. • This case was not prompted by inappropriate antibiotics	
Norovirus Outbreak **Acute**	June 13	**Significant spread across wards. Community presence reported.**	• Norovirus outbreak at PGH in April. A multi-disciplinary review meeting was held, co-ordinated by the chief operating officer and attended by Dorset ambulance. • The events were time-lined. There was evidence that there was spread within the hospital, 11 wards were affected. • It was noted that at the time there was a high occupancy with a high number of outliers.	•
CDiff Death Part 1b **Acute**	June 13		• Patient who died with C-diff being recorded on part 1B of the death certificate. • Admitted via outpatients on the colorectal pathway. The referral stated that they had anaemia, severe weight loss and change of bowel habit. • Underlying conditions of polymyalgia, diverticulitis and hypertension. A bladder tumour was found in December 2012. • PCR positive in January, received **Metronidazole** and the C-diff resolved. The patient had a fairly uneventful recovery and was discharged to the community hospital, where they had cellulitis and was given a 7 day course of **Amoxicillin.** • Following discharge home bowel problems under the care of h the GP. • Prescribed Ciprofloxacin after having a cystoscopy. • readmitted on 30.4.13. No other stool sample was taken. The patient was treated for diverticulitis. • A stool sample was taken on 7.5.13 and this was found to be toxin positive	• The learning from the case was that there was no alert system in place to say that the patient had previously had C-diff, this has been rectified • The patient was offered a bowel re-section but **declined,** suffered a perforated bowel and died. • The discharge letter contained the information that the patient previously had C-diff, however this was not picked up and flagged by the GP. • The diagnosis of diverticulitis was accepted and the patient wasn't tested for C-diff. • When patients have a history of C-diff the hospital pharmacy is emailed so that their medicines are monitored.

HCAI	Date	Focus	History / Root Cause	Learning/issues Identified
Outbreak of diarrhoeal illness **Community Hospital**	July 13	**Increased incidence**	• Diarrhoeal outbreak on 2 wards in a Community Hospital. Two patients had diarrhoea over the weekend, on 12.6.13 three patients in one bay and two members of staff were symptomatic. There was no causative organism identified.	• The outbreak was managed by bay closure. • There were no identified practice issues
Outbreak of Norovirus **Community Hospital**	July 13	**Increased incidence**	• Three patients in a twenty five bedded ward and one member of staff became symptomatic. A second member of staff then became unwell.	• This was managed very well by bay closure and bay management. • There were no identified practice issues • 9 bed days were lost during the 10 day closure.
Two *Clostridium difficile* cases in care home residents **Community**	August 13	**Awareness of significance of faecal infections and IPC requires**	• CCG informed of a C-diff case in a care home. This was the second C-diff case within 28 days. • The care home did not understand the implications of C-diff. • The first case was only reported to the home as a bowel infection and therefore no precautions had been put in place. There was some concern about wandering patients.	• The care home undertook a deep clean of the home, trained and assessed all staff in hand hygiene and followed outbreak management guidance. • Lessons learned from the incident by care home.
Clostridium difficile **Acute**	August 13	**Non trajectory case**	• Patient with previous CDI in March 2013. The patient was re-admitted to the Trust on 15 May 2013. • IDDM a history of alcohol use, secondary opiate use and bowel problems. On CPAP, diarrhoea was on-going. • Clinically not considered to have a CDI infection and not treated, known to have pancreatic insufficiency but compliance with medication was poor, including intermittent compliance with medication Creon and therefore had persistent diarrhoea. • The patient was given the medication whilst at the Trust and the diarrhoea stopped. The carriage of C.Diff was unavoidable.	• As the patient was not actively treated for CDI, has been reported as CD toxin positive – agreed non trajectory. .

HCAI	Date	Focus	History / Root Cause	Learning/issues Identified
Clostridium difficile **Acute**	August 13	**Non trajectory case**	• An elderly patient with dementia, admitted to the Trust with faecal overflow. During initial admission period nursing staff sent a specimen which was C.Diff toxin positive. There were no markers for CDI the patient received no treatment. The diagnosis of faecal overflow was confirmed and when treated for this the diarrhoea stopped. The patient was discharged back to the care home. There was no other case at the care home.	• Agreed non trajectory.
MRSA Death Part 1 **Acute**	Sept 13	**Cannula site and pressure sore possible sources of infection**	• The patient had renal problems, poor cardiac function and a large hernia. The Consultant's overview was that the patient was at end stage organ failure with confirmed severe heart failure. The patient was unlikely to survive. • Screened MRSA negative on admission, but a positive result confirmed during inpatient episode • Report from the patient's relatives that the patient had an inflamed cannula site; the cannula was possible source for the bacteraemia. • Grade 2 pressure sore which may also have contributed to risk.	• The ward had been assessed for hand hygiene in the preceding months and had been validated 100%, however non-compliance with hand hygiene by a non-clinical member of staff was reported and an action plan for improvement was initiated. • Housekeeping was below expected standards and had not shown improvement on inspections. • Noted weekly MRSA screening had not taken place of other patients as per policy, within the time frame expected. There had been some hand hygiene issues with a ward hostess • Learning from this case indicated that it may have been preventable if the patient had not had so many cannulations.
Missed communication of infectious case **Acute**	Sept 13	**Communication lapse**	• Patient transferred from the IOW ITU to local trust ITU Trust was found to be C.diff positive. • Local Trust failed to advise the transferring hospital of the infection risk which was discovered by the ICD after a period of 4 months • Good practice is to inform the transferring hospital of any patients transferred with HCAI.	• The receiving trust amended the database to include notice within the system to indicate notification to the transferring hospital of an HCAI

HCAI	Date	Focus	History / Root Cause	Learning/issues Identified
MRSA **Acute**	Sept 13	**Infected Cannula site**	• Case of MRSA relating to a patient who had been undergoing radiotherapy for cancer of the prostate and was experiencing 'oozing' from one of the injection sites. • The patient was quite dehydrated. • The patient had a cannula and was screened for MRSA which proved negative. • The patient was transferred to one of the surgical wards and the cannula became infected. • On reviewing the case, the cannula was removed and then in a couple of days the area had become sceptic and the patient developed MRSA bacteraemia. • The patient was transferred to ITU. • On further investigation, the patient had metastatic cancer.	• There was some concern regarding the recording of the cannula site. As a result of this there was a trust-wide cannula audit. • There is a task and finish group was established to improve compliance. • Some staff screening was also undertaken. • The action plan was been completed. • A review of IV cannulas has taken place.
Clostridium difficile **Acute**	Nov 13	**Non trajectory case**	• Patient was transferred from Community Hospital with an acute GI bleed and large amount of melaena. • The patient passed a large loose stool, which was tested and found to be toxin positive for C-diff. • No any antibiotics and no treatment for C-diff was given as no further symptoms. CDI excluded. • Treatment was provided for GI bleed.	It was agreed that this case was non-trajectory.
Clostridium difficile **Acute**	Nov 13	**Non trajectory case**	• Admitted for reversal of stoma. • The patient was unwell post operatively and had no bowel actions for 7 days. • Type 1 stool was passed and tested for C-diff. This was found to be C-diff toxin positive. • Bowel actions then settled back to normal. The stool was tested as per protocol	It was agreed that this case was non-trajectory.

HCAI	Date	Focus	History / Root Cause	Learning/issues Identified
			and the patient was on Lulworth Ward which previously had a period of increased incidence.	
Clostridium difficile **Acute**	Nov 13	**Non trajectory case**	This patient was transferred from Spain and admitted on 28.8.13. The patient had loose stools on admission and tested PCR positive for C-diff and later tested toxin positive. The patient was treated for C-diff.	It was agreed that this case is non-trajectory as acquired before admission
Clostridium difficile **Community Hospital**	Nov 13	**Non trajectory case**	Admitted to Community Hospital and had no previous antibiotics for three months. The patient was on laxatives. The patient passed a mucus stool and this tested toxin positive for C-diff. No CDI treatment given.	It was agreed that this case is non-trajectory.
Clostridium difficile **Acute**	Nov 13	**Non trajectory case**	• This patient was admitted for an investigation, and deemed fit for discharge. • The patient was on Creon, which is a pancreatic enzyme replacement. If a dose is missed then the patient can get diarrhoea. • The patient tested positive for C-diff on the day of discharge. • The patient's GP was contacted and it was reported that the patient had intermittent diarrhoea, but was non-compliant with medication and no further symptoms of C Diff.	It was agreed that this case is non-trajectory.
CDiff Death Part 1 **Acute**	Nov 13	**Not considered preventable**	• A case was reported relating to a patient with a fractured neck of femur. • The patient was suffering from caecal carcinoma. Due to have a colonoscopy but had diarrhoea and tested toxin positive for C-diff. • The patient was treated for C-diff. • The colonoscopy was not done. The patient died and C-diff infection was entered on part 1b of the death certificate.	• Two caring medical teams led to missed opportunity to carry out investigation. • This would not have prevented death.

HCAI	Date	Focus	History / Root Cause	Learning/issues Identified
CDiff Death Part 1 **Acute**		**Antibiotic prescribing implicated but unlikely preventable**	• A case was reported relating to a patient who had been suffering from numerous foot ulcers treated in the community with antibiotics. • The patient had been visited by the district nurses to dress the foot. The patient was admitted with a chronic foot ulcer, cellulitis developed and became more confused than normal. • The patient was admitted to the elderly care ward and treated with Flucloxacillin and Benzylpenicillin, however they deteriorated quickly. • The patient passed a type 6 stool, which tested positive for C-difficile. Oral vancomycin was given but the patient's death was considered to be unpreventable. It was agreed that elderly patients who receive frequent antibiotics are at high risk of C-difficile.	
MRSA **Acute**	Nov 13	**Likely preventable**	MRSA bacteraemia in patient admitted to Emergency Department from home with acute exacerbation of chronic lung disease. Initial admission to critical care days 0 to 9 was followed by transfer to older peoples ward. Blood culture taken following deterioration on day 18. Continued deterioration and discussion with family progressed care to end of life care-pathway. Patient died day 22. Blood culture positive on day 23. Key points: • MRSA on part 2 of death certificate • MRSA negative on admission and during critical care admission • Blood culture positive in one bottle after 5 days, possible	• Formal investigation and report produced. • Staff health review to identify potential carriers. • Additional training to domestic and nursing staff. • User friendly posters on key cleaning standards and disinfectant use.

HCAI	Date	Focus	History / Root Cause	Learning/issues Identified
			• contaminant. • Investigative re-screen of all ward patients identified two further first isolates in same bay and 1 PCR positive another bay. • Isolates from case and two direct contacts have same genetic fingerprint therefore indicating cross colonisation. • Deficiencies in domestic cleaning identified. • Inconsistencies in cleaning of near patient equipment.	
Clostridium difficile **Acute**	Nov 13	**Non trajectory case**	• Patient with no previous history of C-difficile, diagnosis of discitis and needed 3 months treatment with antibiotics which raised the risk of contracting C-difficile. • Difficulty passing urine (E coli resistant to Trimethoprim /sensitive to Gentamicin). Flucloxacillin was commenced intravenously – changed to Teicoplanin and PICC line was inserted. • The PICC line became infected and was removed. Teicoplanin changed to Ceftriaxone on microbiologist advice reinserted • 3 months later the patient had a fall and was admitted to acute trust, transferred to community hospital the same day. • Returned to acute care commenced IV Tazocin for pneumonia. Tazocin discontinued after 5 days. • BSC Type 5 stool recorded at 2 days later. • Transferred back to community hospital. • In view of the time line the case would not be considered for acute care.	It was agreed that this case would be allocated to community hospital, and that it would be considered non trajectory as it is not possible to determine where acquisition occurred.

HCAI	Date	Focus	History / Root Cause	Learning/issues Identified
Outbreak of Norovirus **Acute**	July 13	**Increased incidence**	• The elderly care ward closed due to a Norovirus outbreak. • The acute renal unit also affected, but this unit has an annexe, which can be used for urgent cases. • The stroke unit also affected with an outbreak of Norovirus.	No practice issues identified. Management by staff followed policy.
Adneovirus outbreak in SCBU **Acute**	January 14	**Suspected Increased incidence - excluded**	Infants tested positive for adenovirus but later as part of the outbreak management plan, samples were sent to a reference laboratory for more detailed analysis. This showed negative results. The SCBU was closed. It was agreed that the test is not reliable in neonates. All cases will now have a PCR test	Lessons learned and recommendations included: • Structured communication plans for physical segregation or cohorting of babies needs to be implemented as part of outbreak meetings. • A Standard Operating Procedure (SOP) for managing samples for adeno/rotavirus in neonates is required for testing neonates (defined as babies less than 28 days old) with diarrhoea. The Trust will continue to use the same assay. • Any positive samples will be sent to the reference laboratory at Bristol for confirmation before a result is issued. Negative results will be accepted as negative and reported accordingly.
Respiratory syncytial virus **Acute**	January 14	**Increased incidence resulting in closure**	• Baby identified and isolated. • Within 3 days there were 2 more cases. • 2 nurseries were subsequently closed and 2 single rooms were identified and used for new admissions. • After 9 days another new case was identified but this was considered incidental and not connected.	• All babies recovered. Unit was closed for 8 days. • No practice issues identified
MRSA Bacteraemia **Community**	March 13	**Wrist abscess**	• Admitted to the acute unit with pyrexia and confusion. • Cared for in own home by family • Repeated falls, co morbidities, septic arthritis and skin friable • Did not respond to treatment and died	• Reported as unlikely to be preventable in view of limited healthcare input. • Previous wounds tended by Community Nursing team

HCAI	Date	Focus	History / Root Cause	Learning/issues Identified
MRSA Increased incidence of acquisition **Acute**	March 13	**Practice issues**	• 4 cases over 3 months higher than normal prevalence. • Practice issues identified included wound exposure, use of inappropriate pads for bed protection, use of fans during exposure.	• IPC team carried out audits of practice and environmental cleanliness • Changes to wound management put in place • IPC lead established on the ward to lead initiatives and improvements. • Ongoing actions.

Appendix 3 – HCAI data Apr 13 – Mar 14

MRSA performance (Provider)

Trust	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Year end performance
RBCHFT	0	0	0	0	1	0	0	0	0	0	0	0	1
PHFT	0	0	0	0	0	0	1	0	0	0	0	0	1
DCHFT	0	0	0	1	0	0	0	0	0	0	0	0	1
SFT	0	0	0	0	0	1	0	1	0	0	0	0	2
Yeovil	0	0	0	0	0	0	0	0	0	0	0	0	0

MRSA (commissioner based)

Trust	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Year end performance
Dorset CCG	0	0	0	1	1	0	1	1	1	2	0	1	8

C-diff performance (Provider)

Trust	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Year end performance
RBCHFT	2	2	3	0	1	2	2	1	1	1	1	2	14
3 cases agreed as non-trajectory													
PHFT	2	0	1	1	0	0	0	1	0	2	2	1	10
DCHFT	1	3	1	5	3	4	0	1	3	3	0	3	27
3 cases agreed as non-trajectory													
SFT	1	2	3	2	0	1	2	2	0	6	1	1	21
Yeovil	1	1	0	1	1	1	2	0	0	1	1	tbc	tbc

C-diff (Attributable to Community)

Trust	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Year end performance
RBCHFT Community	7	3	3	1	6	4	3	0	5	1	4	tbc	37
PHFT Community	5	1	4	2	6	5	2	2	1	2	1	tbc	31
DCHFT Community	5	1	6	4	7	6	4	6	4	5	3	tbc	51
SFT Community	2	1	2	3	3	3	2	3	2	2	1	tbc	24
Yeovil Community	1	1	0	1	3	0	3	4	0	0	1	tbc	14

C Diff (Commissioner based Provider and Community)

Trust	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Year end performance
Dorset CCG	19	9	17	14	24	22	10	12	16	14	12	tbc	169