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20 January 2009

HEALTH AND SOCIAL CARE (COMMUNITY HEALTH AND STANDARDS) ACT 2003 as amended by the Health Act 2006

Healthcare Associated Infection (HCAI) Programme of Inspections

Dear Mr. Bain

I am writing to formally inform you of the outcome of an unannounced visit to East Kent Hospitals University NHS Trust by the Healthcare Commission on 9 and 10 December 2008. This was part of the annual programme of inspections to assess all NHS acute trusts' arrangements for the control and prevention of healthcare associated infections against the hygiene code.

We visited Kent & Canterbury Hospital, Queen Elizabeth the Queen Mother Hospital and William Harvey Hospital and assessed compliance with the following duties:

- **Duty 2** – to have in place appropriate management systems for infection prevention and control
- **Duty 4** – to provide and maintain a clean and appropriate environment for healthcare
- **Duty 8** – to provide adequate isolation facilities
- **Duty 10j** – to have in place an appropriate policy in relation to antimicrobial prescribing

I am pleased to inform you that the Healthcare Commission found no breaches of the hygiene code at East Kent Hospitals University NHS Trust. The Healthcare Commission will be taking no further action in relation to the hygiene code at this time.

The Healthcare Commission's full name is the Commission for Healthcare Audit and Inspection

Please find attached a copy of the summary report outlining the findings from the visit that will be published on our website. A copy of the full inspection report has been enclosed for your information.

Our findings have been subject to a quality assurance process within the Healthcare Commission. Please note this may have resulted in changes to the statements in the text or findings, therefore you are advised to check the summary report. If you have any comments please let us know within 2 working days of receipt.

The summary report will be published on the Commission's website on 23 January 2009.

Please contact me direct on 020 7448 9389 with any queries you may have.

Yours sincerely

Louisa Power
HCAI Business Delivery Manager

CC: Candy Morris – Chief Executive of South East Coast Strategic Authority
Ann Sutton – Chief Executive of Eastern and Coastal Kent PCT

Inspecting Informing Improving

Healthcare Commission

Evidence table for HCAI inspection programme 2008/09

Region/area	South East
Trust name & code	East Kent Hospitals University NHS Trust (RVV)
Hospital(s) inspected	Kent and Canterbury Hospital William Harvey Hospital Queen Elizabeth the Queen Mother Hospital
Duty(s) inspected	2, 4, 8 & 10j
Lead assessor	Paula J Mansell
Specialist assessor/ Expert adviser(s)	Lesley Meech Stuart Barnhill Cheryl Nankevill
Date(s) of inspection	9 & 10 December 2008
Report version	Post factual accuracy draft for National

Evaluation of evidence

Duty 2: Duty to have in place appropriate management systems for infection prevention and control

a) The trust has a Board level agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.	
I: Line(s) of enquiry	
2a(1)	**The trust has an appropriate board level agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks; and the trust has taken account of Annex 1.**
II: Evaluation of evidence	

The board-level agreement outlining its collective responsibility for infection prevention and control is reflected in a number of documents and was corroborated at interviews.

The trusts clinical governance assurance framework includes an objective with performance criteria for infection prevention and control (IPC). In addition the trust produced a framework for the management of risks associated with IPC in 2006, this was reviewed in October 2008. The framework states that:

- the trust board is responsible for providing as far as possible, suitable facilities and polices, that protect staff and patients from healthcare associated infection' and that it is responsible for ensuring that existing infection control management arrangements are effective in monitoring and controlling healthcare associated infection.

The arrangements for achieving this are detailed in the document. *(Framework for the Management of Risks Associated with Infection Prevention and Control in East Kent Hospitals University NHS Trust (EKHT) November 2006, Clinical Governance Assurance Framework August 2008)*

The trusts cleaning operational plan and subsequent review states that:

'The accountability for all aspects of cleanliness lies with the chief executive and the Trust board including:

- Listening to patients;
- Infection control;
- Developing, implementing and monitoring infection control policies; and learning from experience.
- Education and development;
- Monitoring'

- Whilst final accountability for all aspects of cleanliness lies with the chief executive, there are designated board members, the director of strategic development and capital planning and the director of nursing, midwifery and quality (DoNMQ) who are accountable for reporting to the chief executive and trust board and ensuring, in liaison with the director of infection prevention and control (DIPC), that proper systems and processes are in place to achieve high standards of cleanliness (via the infection control Leads Committee).

(EKHT Operational Plan June 2008, and review November 2008)

The line of accountability for infection control is directly to the chief executive and trust's board. The medical director and DoNMQ are joint executive leads for infection prevention and control. (J*ob description-medical director, director of nursing, midwifery and quality - job plan)*

The trust has appointed two non-executive directors (NEDs) with a lead for IPC, the chairman is one of these and has regular diarised meetings with the director of infection prevention and control (DIPC). The other is the chair of the trust's audit committee. We were told that the NEDs have received training from the DIPC on IPC during the board's afternoon training sessions. (*Interview notes - chairman, DIPC, DoNMQ)*

A handbook of information is provided to the NEDs of the trust. This contains a statement about the role of the NEDs with regard to IPC:

> External inspection bodies in particular, expect that NEDs will hold executives to account for the "quality" of service delivered and the patient experience, including, but not exclusively assurance on:
>
> - Clinical governance standards; safe equitable and consistent clinical practice; and the safety of the patient through systems that ensure staff are appropriately trained and skilled; the environment is clean and safe; and the opportunities for harm (e.g. through infection) are minimised.

(*NED Handbook, Interview notes - chairman, CEO)*

Interviews with the chief executive, DoNMQ and the trust's chairman confirmed the commitment of the board to IPC through receipt of monthly reports, executive walkabouts and integration of IPC measures into directorates' business and performance.

The trust's board formally agreed that a statement on accountability and responsibility for IPC should be included in all trust staff job descriptions and contracts of employment and that IPC be included by managers during staff appraisals. This was confirmed by staff interviewed and in staff job descriptions. IPC is a key component of the matrons' job descriptions. (*IC annual report 2007-2008, job descriptions, interview notes- ward staff, interview notes- executive and non-executive board members, appendix to all job descriptions*)

Every six weeks the chief executive meets with the 100 most senior managers and a member of their frontline staff, IPC is on the agenda for this meeting (*interview notes chief executive*). The DoNMQ, as part of her role as executive lead for IPC carries out infection control spot checks accompanied by IPC specialists and/or the head of soft FM services. (*Infection control spot checks: KC site-Aug 08, QEQM site-September 08, WHH-July 08)*

b) The trust has designated an individual as Director of Infection Prevention and Control (DIPC) accountable directly to the chief executive and the Board.

I: Line(s) of enquiry

2b(1)	**The trust has appropriately designated an individual as Director of Infection Prevention and Control (DIPC); and that person is accountable directly to the chief executive and the Board; and the trust has taken account of Annex 1.**

II: Evaluation of evidence

The trust's DIPC is a consultant medical microbiologist and is supported by a deputy who is the lead IPC nurse specialist. The DIPC is responsible for leading the trust infection prevention and control team (IPCT) and reports directly to the chief executive and the trust board.

The DIPC has a job description with defined HCAI responsibilities and outcome objectives, including all the responsibilities laid out in annex 1. The DIPC has protected time identified in the job plan for the post holder, currently equivalent to 3 programmed activities of time (*DIPC job description*)

The DIPC formally attends the trust's board quarterly and presents the infection control annual report to the board. He will attend additional board meetings as required and has diarised meetings with the chief executive and chairman of the board.

The DIPC chairs a number of meetings related to HCAI including the infection control committee (ICC), and the IPCT meetings and the IC leads meetings. In addition he is a member of the clinical management board (CMB) and patient safety board. (*ICC minutes, CMB minutes, EKUHT IC organisational arrangements, interview notes- DIPC*)

The DIPC has a high profile in the trust with the authority to challenge IPC practice, all senior staff (matrons, ward manager, sisters) interviewed knew who the DIPC was and what his role encompassed. He assesses the impact of IPC measures and policies and makes recommendations to the trust's board for change and improvement. (*Observation tools, interview notes- matrons, nurses, DIPC, IC annual report 2007-2008*)

c) The trust Board must have mechanisms in place to ensure that adequate resources are available to secure effective prevention and control of HCAI. These should include implementing an appropriate assurance framework, infection control programme and infection control infrastructure.

I: Line(s) of enquiry

2c(1)	**The mechanisms by which the trust Board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI include an appropriate assurance framework; and the trust has taken account of Annex 1.**

II: Evaluation of evidence

The trusts clinical governance assurance framework includes an objective with performance criteria for IPC. In addition the trust produced a framework for the management of risks associated with IPC in 2006, this was reviewed in October 2008. *(Framework for the Management of Risks Associated with Infection Prevention and Control in East Kent Hospitals University NHS Trust November 2006, Clinical Governance Assurance Framework, August 2008)*

The trust's ICC is chaired by the DIPC. The ICC meets quarterly (from January 2009 we were told that it will be meeting every other month) and is chaired by the DIPC. The ICC is comprised of the IPCT, the chief executive (or CE representative), the DoNMQ, nominated infection control leads from all clinical directorates and representatives from other relevant groups within the trust including:

- Hotel services
- Estates
- Pharmacy
- Occupational health
- Risk management

The ICC reports to the clinical governance steering group and is responsible for supervising the delivery of the annual infection control programme, including the programme of audit. (*Framework for the Management of Risks Associated with Infection Prevention and Control in East Kent Hospitals University NHS Trust, IC programme)*

The ICC receives reports on directorate performance and feeds into the CMB. The DIPC and CE are members of the CMB which receives minutes from the trust's ICC, regular infection control reports from the DIPC, and monthly summaries of the directorate reports. The CMB also receives monthly reports on directorates compliance performance relating to:

- hand hygiene, by directorate and staff group
- mandatory training compliance
- MRSA bacteraemia and *Clostridium difficile* data
- MRSA screening compliance
- Use of specified peripheral cannula packs and appropriate management
- Completion of IC RCA investigations within 5 days

The CMB receives results of IPC audit and monitors compliance with actions. The CMB feeds into the trust's board. The DIPC makes quarterly presentations to the trust's board and presents the infection control annual report. The board agreed the annual infection control programme for 2008-2009 at its June 2008 meeting. (*EKHUT Infection Control Organisational arrangements: August 2008, trust board minutes, TOR and minutes of the CMB, interview notes - board members*)

The trust's board monitors performance in relation to IPC through a number of reports. The DIPC formally reports to the trust's board quarterly, and annually presents the infection control report. He will attend additional board meetings as required and has diarised meetings with the chief executive. The trust's board receives monthly information via the DoNMQ's patient safety and quality report. The agreed HCAI key performance indicators (KPIs) are reported with assurance provided on a monthly basis internally to the CMB and externally to the PCT. This report details progress against the KPIs by directorate. (*EKHUT Infection Control Organisational arrangements, August 2008, Interview Notes - DIPC, DoNMQ, Chairman and CEO*, t*rust board minutes 2 May and June 2008, patient safety and quality report - Nov 08)*

The trust's matrons made a recent presentation to the board which included information about IPC (*interview notes* – c*hairman and chief executive*)

Infection control leads have been nominated for each clinical directorate and have responsibility for implementing specific IPC key performance targets for their directorate. The IC leads are responsible for implementing and monitoring infection control policies in their clinical areas. (*patient safety and quality report Nov 08, Annual Infection Control report, interview notes - director of nursing)*

The executives have a 'Walk the Floor' programme (*trust board minutes 2 May & June 2008*), supported by a proforma to guide questioning of staff about safety and environmental issues. All senior staff (matrons, ward manager, and sisters) stated that they had seen board members doing walk-arounds at some point and that this occurred about every 2-3 months. We were told that the board members talked to all grades of staff and reviewed cleanliness and processes on the ward in relation to HCAIs. The trust has two NED with lead roles for IPC (*observation tools, interview notes - board members*)

The IPCT report all MRSA bacteraemias (blood stream infections) to the Department of Health via the Strategic Health Authority/Health Protection Agency (HPA) notification and surveillance systems. RCA investigation reports following reported infections were provided and all contained the identified root causes and action plans to address the causes, all reports seen contained action plans and most had designated individuals and completion dates against the actions required to provide assurance that improvements were made. A summary of actions following RCA investigations is included in the DIPC's annual report to the board. The investigations are multi-disciplinary events, "owned" by the appropriate directorate and the RCA meeting is attended by the

following members of staff:

- Ward manager or senior nursing representative
- Matron
- Consultant or Registrar
- Infection prevention and control team
  (*MRSA policy September 2005/August 2008, RCA reports*)

There is evidence that the trust board receives information about infection outbreaks and that action is taken following assessment of the management of outbreaks. An example of this is the installation of automatic door openers in strategic areas across the worst affected site. (*IC annual report 2007-2008)*

I: Line(s) of enquiry

2c(2)	The mechanisms by which the trust Board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI include an infection control programme; and the trust has taken account of Annex 1.

II: Evaluation of evidence

The infection control annual programme for 2008/9 was agreed at the June meeting of the trust's board. (*minutes of the trust's board meeting June 27 June 2008*)

The programme sets out the objectives for the trust in relation to IP&C activity. Progress is monitored against the programme through action plans and key performance indicators for the clinical directorates by the ICC. The DIPC reports on progress against the programme in his annual report

The programme provides information on:

- MRSA bacteraemia and *Clostridium difficile* surveillance including frequency of reporting and feedback to wards/departments, Executive team and consultants
- Identification of risk areas e.g. the expansion of the haemodialysis facilities
- Incident reporting and investigation
- Performance management and audit of MRSA screening and decolonisation
- Key management aspects for IPC for *Clostridium difficile* including cleaning/hygiene practices
- Antibiotic management
- Surveillance of other alert organisms and post discharge surgical wound infection
- A review of policies and procedures contained in the IC manual and available on the trust intranet including:
  - Standard (universal) infection control precautions
  - Major Outbreak control policy
  - Isolation of patients
  - Safe handling and disposal of sharps
  - Management of occupational exposure to blood borne viruses
  - Admissions policy –including guidance on ward closure
  - Control of infection procedures for specific organisms including: MRSA, *Clostridium difficile* and TSE
- The programme of audit (not all have stipulated frequency)
- Implementation of Saving Lives High Impact Interventions
- Education in IPC
- Infection control link worker system
- Hand Hygiene campaign
- Management of invasive devices

- Aseptic technique
- Legionella management and monitoring
- Hospital Hygiene

(*Infection Control annual programme April 2008- March 2009*)

Prioritisation and monitoring of some activities detailed in the programme is undertaken via the directorate KPIs targets which include designated executive and operational leads, and timescales for improvement for each target. The KPIs have been developed to incorporate learning and action points from RCAs for MRSA and *Clostridium difficile* cases during 2007/2008. As a result, the programme states that the primary focus of the KPIs is on full implementation of key IPC policies related to the management of these infections and invasive devices.

Directorates report monthly on progress to the ICC. There is evidence that progress is monitored at the ICC and the CMB (*minutes of ICC and CMB*, *IPC performance monitoring, Key performance indicator targets for directorates (May 2008))*

I: Line(s) of enquiry	
2c(3)	**The mechanisms by which the trust Board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI include an infection control infrastructure; and the trust has taken account of Annex 1.**
II: Evaluation of evidence	

The IPCT consists of:

4 WTE microbiologists (1 vacancy), one of whom is the DIPC
5 clinical nurse specialists in IPC (1 vacancy) one of whom is the deputy DIPC
1 WTE administrative support

There is 24 hour a day access to an on call ICN and an on call consultant microbiologist via the trust's switchboard (*Infection Control annual programme 2008-2009, isolation policy, interviews with staff*)

At the June 2008 meeting of the trust board it was noted that additional microbiologist and specialist pharmacist resources had been agreed for the IPCT. (*board minutes- June 2008*) A further business case has been approved to increase the numbers and seniority of the ICN specialists to accommodate the increasing workload of the team. (*Infection Control annual programme 2008-2009, extract from minutes of CE's group 23 July 2008*). The trust has identified that the William Harvey site would benefit from increased IP&C presence and are trying to recruit to increase the team. (*interview notes- DIPC & Deputy DIPC*, *business case – undated)*

At the time of our visit two full time antimicrobial pharmacists had been recently appointed. This is in addition to the existing antimicrobial technician.

It is the responsibility of the IPCT to review progress with the annual infection control programme, to be responsible for the day to day operation of the infection control service including maintenance of up to date polices, provision of advice to clinical and management colleagues, monitoring of infection risks in clinical areas, monitoring of compliance with infection control policies and response to outbreaks of hospital infection. (*IC annual report 2007-2008, framework for the management of IPC risks, Infection Control annual programme 2008-2009)*

The IPCT also provide IPC advice to a small private hospital at Hythe, this was not considered by the team to cause undue burden on the resources of the team. (*IP&C annual report, interviews with the IPCT*)

The ICC includes external representation from the HPA. It oversees the activity of the IPCT and supervises the implementation of the IPC annual programme.

The IPCT team meet monthly, the ICC has met quarterly, but from January 2009 it will meet every other month. The clinical governance steering group and the CMB receive the ICC meeting minutes. (*interview notes- DIPC, minutes of the ICC*)

Since 2006, the trust's directorates have had IPC clinical leads, the roles were reviewed and revised in 2008. The leads had been meeting monthly, chaired by the DIPC, this meeting has recently been amalgamated with the ICC. Each clinical area has at least one link nurse/worker including the five renal satellite areas. The link nurses are provided with training and information to cascade to the clinical teams. (*Infection Control annual programme 2008-2009, minutes of the ICC and directorate leads meeting minutes*)

The trust's infrastructure for IPC is described in the EKHT infection control organisational arrangements (August 2008). This document outlines the committees and reporting arrangements for IPC through committees and reports from clinical areas to the trust board.

d) The trust must ensure that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection.

I: Line(s) of enquiry

2d(1)	All relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, on the measures required to prevent and control risks of infection

II: Evaluation of evidence

Training in IPC is mandatory for all staff. The IPCT provide most of the IPC training and cover the chain of infection, key IPC principles, accountability and responsibilities and key policies.

Details of IPC training are laid out in the annual IC programme as follows:

- All clinical staff should have a one hour session on IPC at induction.
- Mandatory training is available as an e-learning package on the trust's intranet.
- Junior doctors have a short induction session supported by handouts on IPC practices. In addition all junior doctors should undergo mandatory training and assessment of competency on the insertion of peripheral venous cannulae, and phlebotomy skills provided by the practice development team
- All clinical staff involved in blood culture collection will be required to undertake the relevant training and education provided by the practice development team and complete an e-learning competency assessment.
- Participation in the F1 junior doctor programme should include the principles of IC, antibiotic prescribing and utilizing the microbiology laboratory
- Mandatory annual IC education programme for contracted domestic and portering staff
- Ad hoc sessions for specialist areas
- IC management of the highly dependent patient
- Management of urinary catheters for HCAs
- Completion of the Saving Lives programme for mandatory education for senior nurses in high risk areas
- Additional training for IC link workers including an annual IC link worker conference

Induction
IPCT provide training at induction for all new staff once a fortnight as part of the clinical awareness component of the induction. Failure to attend is followed up by a letter to staff managers from human resources (*interviews notes- IPCT, induction and mandatory training policy)*

Induction for medical staff includes a twenty minute session on IPC provided by the IPCT and a section on prescribing with a sub-section on antibiotic prescribing; this is undertaken as a sign-posting session so that staff know where to go for further information, advice and support. At induction the doctors are given the pocket sized prescribing guidance. (*interview notes-DIPC, pharmacists, presentations*)

Mandatory training
Mandatory training for clinical staff is provided in the form of an e-learning package, the annual report for 2007-08 shows that 4,277 staff completed the training. The trust's human resources department monitors attendance at mandatory training monthly and recorded that 77% of clinical staff had completed the mandatory e-learning session on IP&C during the year to 1st October 2008. Mandatory training is monitored by the board. (*IC annual report 2007-2008, interview with HR, education and training recorded rates for mandatory training*).

The trust has an induction and mandatory training policy, written to include both medical and non medical staff. All staff interviewed had completed infection control training within the last year. All were aware that it was mandatory to attend annually. The clinical decisions unit on the William Harvey site had had some difficulties in relation to getting all staff trained and were below the expected trust agreement so have employed a Band 5 'return to practice nurse' whose responsibility is to review training and ensure all relevant staff attend with the support of the ward manager. A training database was seen on ward computers. Staff confirmed that the ward manager would check that the mandatory training was completed and if not done the staff would receive a letter. Any additional study leave requested is not granted if the mandatory training has not been completed. The human resources department obtains figures, from their work force planning department, which show the percentage of completion of mandatory training within directorates. This information is passed onto directorate leads who then have the responsibility of ensuring line managers work to complete all mandatory training requirements within their ward or department. Directorate leads who head up directorates with poor mandatory training records may be at risk of disciplinary proceedings or financial penalties. (*Induction and mandatory training policy-undated, observation tools, interview notes- nurses, HR, Induction and mandatory training policy- undated*)

The pharmacists provide training on antibiotic prescribing for Foundation Year 2 (FY2) medical staff. The IPCT provide three sessions for FY1 junior doctors, this includes the principles of IPC and high impact interventions. The post graduate department follow up non-attenders junior medical staff are also provided with training on insertion of intravenous devices and aseptic blood culture collection. (*IC annual report interviews with pharmacists, interviews IPCT*).

A number of presentations were provided that were used for the medical staff training including : sensible and practical prescribing - junior doctors induction, antimicrobial prescribing FY1 & 2, antibiotic multiple choice questions, infection control & patient safety. (*PowerPoint training Presentations*)

Contractors and temporary staff
We were told that agency nursing and medical staff are employed through NHS Professionals (NHSP) who have received IP&C training through that organisation. Local inductions are carried out by ward staff and any temporary staff working at the trust for longer than three months are expected to attend the trust induction programme including IPC. (*Induction and mandatory training policy-undated, interview notes*)

IC is covered in the induction for contracted cleaning staff. They also receive a two week on the job

induction following the initial corporate induction and this includes the use of appropriate products and cleaning standards. Annual IC training is provided in an hour session onsite in conjunction with the IPCT. There is a training needs analysis matrix which is regularly reviewed to ensure all staff are up to date. The training is monitored and the IC annual report 2007-08 states that 510 contract cleaning staff attended IPC training. (*interviews notes- on site Manager and operation manager for cleaning contractors, IC annual report 2007-2008*)

Additional training
The IPCT provided other training sessions during 2007-08 as reported in the infection control annual report, including sessions on preventing infection - Saving Lives, two hour sessions for Link nurses/workers, HCA induction and development programme and practical hand washing sessions. Many of these were attended by different grades of medical staff. (*interviews IPCT, IC annual report 2007-2008*)

Compliance with mandatory training is included as an appendix to the IP&C annual report. (*IC annual report 2007-2008*)

I: Line(s) of enquiry	
2d(2)	**All relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient information, on the measures required to prevent and control risks of infection**

II: Evaluation of evidence

Staff interviewed on the wards all referred to the ward IP&C manual as the main source of information, together with the IPCT. Staff asked were aware of their key contact in the IPCT. The IPCT link nurses also cascade information to the clinical teams from the IPCT. The inspection team were also advised by staff that IP&C elements are included at appraisal. (*interviews with nurses and matrons*)

The IPCT will provide information to clinical areas regarding changes to practice for example the introduction of new skin preparation prior to insertion of peripheral cannulae was circulated via an e-bulletin and the IC&PT attended the directorate cluster groups, matrons meetings and ward/team meetings to inform staff of the new practice. In addition the team have produced a number of wipe clean notices containing '10 important points' for a variety of subjects, these include: hand washing, peripheral cannula care, central line care, management of *Clostridium difficile* infections, and urinary catheter care, these are delivered to clinical areas where the team discuss the contents with clinical staff and decide where the notices should be displayed. These notices were seen in most wards, where they were not seen it was following deep cleaning and they had been temporarily removed. A staff nurse interviewed cited the '10 important points' as useful information. (*interview notes- IP&CT, observation tools, interviews with staff*)

A recent review of the trust's IP&C policies has been undertaken and issued to all clinical areas and are available on the intranet. (*IC annual report 2007-2008, interviews with staff*)

MRSA bacteraemia and *Clostridium difficile* epidemiological data are reported on a monthly basis to all wards/departments, matrons, ward/department managers, consultants and junior doctors. (*Infection Control annual programme 2008-2009, interviews with staff*)

Information is available in the format of leaflets (seen but not retained) providing information on *Clostridium difficile,* MRSA and hand hygiene, posters on wards, the trust intranet and in ward folders which are regularly updated by the IC Link nurses. These folders have up to date information and also ward specific information relating to HCAI – for example issues specific to neonates in SCBU and surgery in orthopaedics. Link nurses are expected to give feedback at handover and at

ward meetings. Minutes of ward meetings were seen and all contained a standing agenda item for IC.

Contractors are provided with the contractors information booklet, this informs them that when working in patient areas, that they must report to the head of department to receive instruction on the relevant infection control procedures and includes information on hand washing procedures when working in patient or risk areas, as well as being able to see the posters displayed. (*observation tools, contractors information booklet 2005 ,updated July 2007*)

The trust's IC annual programme states that the IPCT will provide support and advice to hotel services and contractors as required as well as advising on day to day issues. Contractors and visitors are provided with an IP&C leaflet containing information on hand hygiene, needle stick injuries, and signs of ill health, they have to sign the leaflet on receipt (*infection prevention and control guidance for contractors, interviews with IPCT*).

Junior doctors are provided with a pocket size copy of the guidelines for the use of antibiotics. In addition there is an interactive web based antibiotic policy which provides advice based on information submitted and useful links, such as the BNF. (*interviews with pharmacists*)

I: Line(s) of enquiry

2d(3)	**All relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient supervision, on the measures required to prevent and control risks of infection**

II: Evaluation of evidence

Supervision is carried out through direct observation, audits and practical sessions in clinical areas. Each ward has at least one IPCT link nurse/worker. Those interviewed confirmed that new staff 'shadowed' more experienced staff and were clear on their role and carry out supervision of hand hygiene in the clinical areas. There is a preceptorship programme in place for new staff. (*interviews notes*)

The IPCT undertake regular rounds of the clinical areas on their site and undertake spot checks on IPC processes. The IPCT and link nurses/workers carry out practical sessions and observations on hand hygiene and directorates provide monthly figures on compliance with hand hygiene and use and management of specified peripheral cannula packs. (*interviews with IPCT, directorate monthly reports, interviews notes*)

The DoNMQ, as part of her role as executive lead for IPC carries out infection control spot checks accompanied by IPC specialists and/or the head of soft FM services. This spot check includes checks on equipment cleaning, MRSA and *Clostridium difficile* management plans, and uniform and Bare Below the Elbows (BBE) guidance (*Infection control spot checks: KC site, Aug 08, QEQM site, September 08, WHH July 08)*

Contractor supervisors regularly visit wards and review cleaning standards. Each individual has sign off sheets which are checked and counter signed by senior staff on duty and checked by supervisors. Any issue is brought to their attention by ward staff. Cleaners are included in ward meetings where cleaning audits and performance are discussed. Other contractors are expected to report to the senior staff on the ward and are observed in relation to use of antibacterial hand rub. In addition they report on completion of the job and any concerns are raised with IPCT and Estates (*interviews notes- ward staff, estates management*)

e) The trust has a programme of audit to ensure that key policies and practices are being implemented appropriately.	
I: Line(s) of enquiry	
2e(1)	**The trust has a programme of audit to ensure that key policies and practices are being implemented appropriately**
II: Evaluation of evidence	

Audit programme
The trust's annual IC programme contains a programme of audit aligned to the programme of IPC work. The programme includes audits to be carried out by directorates as well as those carried out by the IPCT and others. All listed audits have designated leads and most detail the frequency of audit required. (*Infection Control annual programme 2008-2009)*

Environmental Audit
The IPCT undertake environmental audits every 12-18 months with the link worker or senior nurse in the clinical area. The IPCT report on the findings of the audit and the ward manager is responsible for producing and action plan. The ICPT check progress against the action plan in eight weeks. If problems are identified the area is re audited. The results are included as part of the directorates KPI report. (*interviews notes- IPCT, environmental audits*)

Antimicrobial prescribing audit
Four directorates completed antimicrobial prescribing audits during 2007/2008 as reported in the DIPC's annual report. Antibiotic usage is monitored monthly. (*antibiotic usage summary)*

The CMB received the report of an antibiotic prescribing audit on the QEQM site in August 2008 there were 13 recommendations to improve prescribing following analysis against the standards derived from the trust's antimicrobial guidelines. The committee agreed action and monitoring to be undertaken as a result of the recommendations. (*minutes of the CMB August 2008*)

Commode audit
Commode audit audits are undertaken weekly since September 2008. Following an audit of the cleaning of commodes during 2008 the IPCT initiated twice daily cleaning of commodes by the domestic staff using a chlorine based cleaning solution. Evidence of this twice daily cleaning was seen during the visits to the wards, checklists for the twice daily clean had been signed on that day by the domestic staff. (*IC annual report 2007-2008, observation tools, interviews notes, commode audit tool, commode audits*)

Cleaning audits
Cleaning audits are undertaken by the contracted cleaners with clinical staff. Areas are risk assessed from very high to low and audit frequencies are based on this. (*interview notes - on site manager and operation manager for cleaning contractors*)

Invasive device audits
The IC annual programme details plans to introduce software in December 2008 to facilitate trust wide participation and compliance monitoring of HII. At present only specialist areas such as ITU have implemented the HIIs. The trust is in the process of purchasing software to support the implementation of HIIs throughout the organisation. The new software will allow data to be collected simply, resulting in a customised dashboard showing percentage compliance levels at trust site and ward levels. Senior nurses throughout the trust have received Saving Lives training in preparation for the roll-out of the new software and implementation of the audits. (*IC programme, Implementation of Synbiotix Saving Lives for High Impact Interventions document - undated)*

The following trust-wide audits of invasive devices were carried out in May 2008, including

comparison of results with previous audits:

An audit of peripheral cannula was carried out to assess compliance with the standards of best practice set out in the trust's clinical guideline '*Venous cannulation management and removal (adults) (2006)'* and to determine whether there has been an improvement in the achievement of the standards since the previous audit. The audit findings and the headline key messages were circulated (*peripheral cannula audit, peripheral cannula audit flyer 2008)*

An audit of central venous cannula was carried and the results, comparison of results to previous audits and actions to improve practice were circulated to matrons and ward managers (*CV audit September 2008*)

An audit or urinary catheters was carried out and the results of the audit and an eye-catching key messages was produced (*Urinary catheter audit 2008 flyer*)

Following RCA investigation reports citing peripheral cannula as the site of MRSA infections and results of audit, the trust has instigated a number of actions including the use of standard peripheral cannula packs across the trust and weekly audits of compliance (*trust wide MRSA bacteraemia action plan – September 2008*) The directorate invasive devices audits consist of visual inspection phlebitis (VIP) scores and catheter days rather then processes. (*Observation tools, interview notes*). One of the matrons on the ward confirmed that peripheral cannula audits were carried out weekly and discussed at the weekly cluster meetings where the staff discuss results, share good practice and audit other areas to avoid bias. (*Interview notes - matron*). An intravenous access group was established in 2006 to ensure that practice, equipment and policies across the trust are standardised. (*IC annual report 2007-2008*)

Weekly audits
Weekly audits in place are for hand hygiene, commode cleaning, environmental cleaning, also for MRSA screening and decolonisation. (*Commode audit tool and audits, Directorate reports, Infection Prevention and Control Key Performance Indicator Targets for Directorates – Performance Metrics 2008 – 2009)*

The trust is also part of the Feedback Intervention Trial (FIT); with seven wards taking part in this national study of ways of improving hand hygiene (*IC annual report 2007-2008*)

There is evidence of compliance monitoring at the monthly CMB meetings for example at the September meeting the board asked for the three directorates with hand washing compliance below 90%, to provide their action plans to improve performance. (*CMB minutes September 2008*)

Audit results
Audit results are sent via email and to ward managers and matrons and discussed at 'cluster meetings' – which consist of matrons and senior staff from the directorate. Information is then expected to be cascaded during ward meetings and handover. Link nurses are expected to take any concerns back to the IPCT. This was corroborated by interviews with nurses on the wards. *(interview notes-ward staff)*

Training on audit
Various levels of staff do the audits from senior to junior all have had some form of training from the IPCT in relation to documentation to use and expectations. However on the William Harvey site one nurse stated that the training was cascaded by senior staff who did not know if the initial information that they had been given was sufficient. (*interviews with staff, observation tools*)

Action following outbreaks
The trust assessed the impact of a Norovirus outbreak which most severely affected the William Harvey site. Following this assessment the trust installed automatic door openers in strategic areas

across the site *(IC annual report 2007-2008, interviews notes)*

f) The trust has an appropriate policy that addresses, where relevant, admission, transfer, discharge and movement of patients between departments, and within and between health care facilities.

I: Line(s) of enquiry

2f(1)	**The trust has an appropriate policy that addresses where relevant, admission, transfer, discharge and movement of patients between departments, and within and between health care facilities**

II: Evaluation of evidence

The trust has policies for the admission and discharge of patients that are linked to the trust's transfer of patients policy and the policy for the admission, movement/transfer and discharge of patients with an infection / infectious disease. (August 2008)

The **trust's transfer of patients policy** includes internal transfers between departments and sites, patients transferring to or from other hospitals, transferring patients home or to nursing/residential home by hospital transport.

The policy contains a paragraph about information to be provided about a patient's infection status prior to transfer. It also states that if a patient has an infection requiring isolation staff should refer to the infection control policy and contact the infection control nurse. The policy includes a patient transfer **risk assessment tool** which includes a link to the infection control policy and a checklist for transfer which includes information about HCAI. (*transfer of patients policy, January 2008*)

The **Policy for the Admission, Movement/Transfer and Discharge of Patients with an Infection / Infectious Disease** is appropriately referenced to other key policies including the Policy for the Isolation of Patients with Infectious Diseases. The policy states that in the event of any uncertainty, the Infection Prevention and Control Team must be contacted for advice.

The policy states that the allocation of single rooms to patients with suspected/confirmed infections must be a priority and take precedence over bed management / capacity issues. If there is no side room available, the Bed Manager / Site Co-Coordinator must ensure that the patients currently in side rooms are reviewed and patients who do not require a side room for isolation purposes are moved. It is the responsibility of the ward sister or manager to ensure that the Bed Manager / Infection Prevention and Control Team are contacted if there is difficulty allocating a side room. The IPCT provide advice on the movement of patients with infections and liaise with the bed managers, or site managers out of hours, regarding side room usage and the isolation ward on the William Harvey site. **(***Policy for the Admission, Movement/Transfer and Discharge of Patients with an Infection / Infectious Disease, August 2008)*

The trust's isolation policy clearly states that where there are competing demands for single rooms, bed managers in conjunction with the IPCT should jointly agree on the appropriate placement of patients. The isolation policy also includes an appendix 'admissions guidance for bed managers/matrons/site coordinators' including advice on 'high risk' categories of patients. The guidance states that the IPCT must be contacted for advice. The policy also includes guidelines for admission to the isolation ward which are coordinated via the clinical decisions unit and the IPCT. (*isolation policy*)

Side room usage is monitored on the Kent and Canterbury site, the smallest of the three main sites, by the bed managers/site managers who update the use of side rooms following calls to all wards. On the two larger sites a review of isolation rooms is conducted daily with a breakdown of side room

usage across all sites (*interview notes DIPC, DDIPC, transfer of patients policy, January 2008, Policy for the Admission, Movement/Transfer and Discharge of Patients with an Infection / Infectious Disease, August 2008, Isolation policy, Aug 2008, interview notes- ward staff and the IPCT*)

All nursing staff that were asked were aware of relevant policies for transfer, discharge and movement of patients. Adverse incident forms are completed when patients diagnosed with infections cannot be isolated on confirmation of diagnosis. Staff were aware of the importance of involving the IPCT if any concerns arise at an early stage. Support is sought from matrons if concerns are raised in relation to movement of an infected or suspected infected patient. (*interviews notes- ward staff)*

The trust has an operational escalation plan which includes managing infectious patients with limited bed capacity and managing a significant outbreak. At times of bed pressure, with no side rooms available, the need for patient isolation will be risk assessed on a patient by patient basis. This will be done in accordance with the 'Infection Control Admission Guide for Bed Managers', which provides advice on the priority of patients for isolation. The infection control team, through the hospital manager / site management team will be kept informed and contacted for advice as necessary. (*operational escalation plan 2006*)

Duty 4: Duty to provide and maintain a clean and appropriate environment for health care

a) The trust must have policies for the environment which make provision for liaison between the members of any infection control team ("the ICT") and the persons with overall responsibility for facilities management, with a view to minimising the risk of HCAI.

I: Line(s) of enquiry

4a(1)	**The trust has policies for the environment, which make provision for liaison between the members of any infection control team ("the ICT") and the persons with overall responsibility for facilities management; The trust has taken Annex 1 into account in forming its policies.**

II: Evaluation of evidence

A statement is included in the annual infection control programme that the IPCT will advise on all new developments/reconfiguration projects relating to service and buildings within the trust based on national guidance and best practice (*annual infection control programme 2008-2009*)

The trust's provision for liaison between members of the ICPT and the staff with responsibility for facilities management is described in the trust's policy document for **environmental policies and infection control** developed in December 2008, it is still in draft but states that:

- the aim of the document is to ensure that all policies for the environment make provision for liaison between the Infection Prevention and Control Team (IPCT) and individuals with overall responsibility for facilities management.
- The objective of the policy is to ensure liaison with the IPCT in all environmental policies. The document states that when policies are reviewed, revised or developed this liaison with the IPCT will be incorporated, until such time this policy will provide the overarching assurance that this is occurring. (*Environmental policies and infection control December*

2008 Draft)

In addition the following documents further describe the provision for liaison with the IPCT:

Cleaning Operational Plan (June 2008)
This plan states that there must be the involvement of a board nominee who has a significant influence on combating healthcare associated infections and that the close involvement of matrons and patients in the setting and monitoring of standards is crucial to delivering consistently high levels of service. The plan states that:

a) IPCT, facilities and the service provider must be consulted in relation to the types of surface finishes suitable for trust premises and specific to the activity.
b) Introducing cutting edge innovation in consultation with IPCT, where appropriate within the cleaning regime, including the full use of information technology and systems.
c) The DIPC to liaise with the director of strategic development and capital planning and the DoNMQ to ensure that proper systems and processes are in place to achieve high standards of cleanliness.

(Cleaning Operational Plan – June 2008, East Kent Hospitals University NHS Trust Strategic Cleaning Plan Review November 2008)

Ward kitchens and food policy 2008 (including pest control)
The policy forms part of the infection control manual available in all clinical areas with details of how to contact the IPCT. The policy contains a section on pest control. The policy states that the infection control nurse will routinely inspect the ward kitchen as part of the ward audit. *(Ward kitchens and food policy 2008)*

Waste Strategy 2008

- providing all staff with explicit guidance (e.g. education, training, waste procedures etc) in the safe handling and disposal of all wastes in line with health and safety and infection control requirements;
- Waste management policy
- Waste management procedures
- Soft facilities management services waste specification

It will be monitored by a steering and working group to reflect all interested parties' views, this group includes the DIPC. *(Waste Strategy 2008)*

Legionella Policy (including Air Conditioning Systems and Air Handling Units and planned preventative maintenance)
The policy includes liaison with the IPCT in the event of a suspected outbreak or incident. (*Legionella Policy)*

Infection control in building and refurbishment policy December 2008
This is a draft document produced in December 2008 awaiting ratification. The policy makes provision for the involvement of the IPCT in any building or refurbishment work. It states that it is imperative that buildings are designed and refurbished with IPC in mind and that the team are contacted in the earliest stages of planning. (*Infection control in building and refurbishment policy December 2008)*

The aim of the policy is to ensure that the trust manages the infection risks associated with building construction and renovation. There is timely collaboration between estates and infection prevention and control with regard to any new build, renovation or repairs to trust buildings. The policy includes sections on the responsibilities of the estates department and the issues to be addressed by the

IPCT at different stages of any building or refurbishment work.

The policy includes an infection control risk assessment to be used during construction and/or refurbishment.

Discussions with staff and documentation regarding recent work confirms that this liaison between estates, facilities and the IPCT happens in practice The head of hotel services is a member of the IPC leads meetings and the ICC. The ICPT are members of the PEAT group and the cleaning standards group. The estates strategy was discussed at the ICC. (*interview notes with estates, facilities, IPCT, emails regarding recent building work, minutes of ICC meetings*)

b) The trust must designate lead managers for cleaning and decontamination of equipment used for treatment (a single individual may be designated for both areas), with a view to minimising the risk of HCAI.

I: Line(s) of enquiry

4b(1)	**The trust has designated lead managers for cleaning and decontamination of equipment used for treatment (a single individual may be designated for both areas); and has taken account of Annex 1.**

II: Evaluation of evidence

The acting head of facilities is the trust's lead for cleaning. The head of soft FM services is the interim post holder currently in this role. This post reports to the director of strategic development and capital planning. The post holder is responsible for the day to day management of hotel services, transport, laundry and accommodation. The roles and responsibilities of this post are detailed in the job description and include:

- To assist in the development of a cleaning strategy and facilitate links with the DIPC and the DoNMQ in respect of cleanliness and the reduction of HCAI's
- To act as the facilities lead on the ICC.

(*Head of soft FM services job description)*

The decontamination lead was the director of facilities who left the trust at the beginning of November 2008. The trust has started the recruitment process for a new post: trust decontamination lead. The job description covers the roles and responsibilities as detailed in Annex 1 of the hygiene code. The post holder will report to the DoNMQ (*Job description - trust decontamination lead, November 2008)* In the interim, we were told that the DoNMQ has asked the DDIPC to cover elements of this role alongside the endoscopy matrons and the sterile services manager leading on decontamination in their areas, overseen by the decontamination working group which reports into the risk and clinical governance group. (*minutes of Decontamination of medical devices working Group 8 Dec 08*)

There is no equipment library at the trust, all wards and departments have their own equipment with clear schedules of cleaning. All patient equipment is registered with the trust's electronics and medical engineering (EME) department.

There is also a transition team that meets monthly and reports to the decontamination working group to oversee the planned move to the centralised decontamination facility during the summer of 2009.

(interview notes- head of patient safety, SSD manager, acting head of facilities, head of estates, head of soft FM support, minutes of the medical devices decontamination group 10 Oct 2008)

The DoNMQ undertakes spot checks on all sites that include checks on equipment cleaning, commode cleaning and mattress cleaning & soiled mattresses any failures to meet required standards are reported with actions for improvement. (*Infection control spot checks: KC site, Aug 08, QEQM site, September 08, WHH July 08)*

c) The trust must ensure that all parts of the premises in which it provides health care are suitable for the purpose, are kept clean and are maintained in good physical repair and condition, with a view to minimising the risk of HCAI.

I: Line(s) of enquiry

4c(1)	**The trust ensures that all parts of the premises in which it provides health care are suitable for the purpose, are kept clean and are maintained in good physical repair and condition.**

II: Evaluation of evidence

The trust's cleaning services are contracted to an external provider.

The trust has a cleaning operational plan and cleaning specification as documented under 4a, and cleaning is monitored by the directorates monthly, by the IPCT as part of the environmental audits and by the routine maximiser audits carried out by the cleaning contractor. *(cleaning operational plan 2008, maximiser audits, environmental audits*)

The cleaning specification details the cleaning service including:
scheduled and reactive cleaning;

- Planned cleaning
- Vacation cleaning
- Hydrotherapy pool cleaning
- Exceptional cleans
- Rapid response team cleaning

The schedule includes the categories of areas as defined in the NHS Estates National Standards of Cleanliness (August 2003) e.g., very high risk, high risk, significant risk and low risk functional areas.

The inspection team visited 13 clinical areas in three different hospitals within the trust. Overall the areas visited were clean, tidy and well maintained.

Areas visited were:

- Queen Elizabeth the Queen Mother Hospital: Fordwich Stroke Unit, Special Care Baby Unit, Endoscopy, ENT Endoscopy, Sea Bathing (emergency orthopaedic), Clinical Decision Unit (CDU)
- William Harvey Hospital: CDU, King C1, Cambridge J2, Endoscopy, Oxford (isolation ward)
- Kent and Canterbury: Emergency Care Centre, St Lawrence ward, Harvey ward

The on-site manager and the operation manager for the contracted cleaning services were interviewed on the QEQM site and outlined the arrangements for training of the cleaning staff and monitoring of the training. The managers have daily contact with the IPCT. They are involved in any outbreak meetings and undertake cleaning audits with the clinical staff with frequency of audit based on a risk assessment from very high risk to low risk. The managers stated that although they manage the contract the ward sister/manager needs to be in agreement in relation to processes and practices that best suit the individual wards*. (Staff interviews)*

The trust risk register identifies that providing an environment that is fit for purpose is constrained by the age of some parts of the estate (*trust corporate risk register 2008/09*)

The overall impression of the areas visited on the QEQM and Kent and Canterbury site were extremely positive, the clinical areas were clean and well maintained all patient equipment seen was clean. On the William Harvey site the general standard of cleanliness was still reasonably good however there was some evidence of less attention to detail, with some isolated issues identified including:

- Plastic boxes containing blood glucose testing equipment on two wards were spattered with blood. One was particularly bad and was immediately disposed of.
- Storage of items is an issue and lots of 'clutter' and old equipment that is no longer used was seen in some wards.
- Clean blood pressure cuffs stored under wet slipper pans.

More generally the inspection team noted that many of the domestic waste bins examined on the QEQM and WH sites contained used gloves and aprons that should have been disposed of in clinical waste bins. Staff interviewed were all aware of proper processes and the fact that the trust could be penalised for incorrect waste disposal. In addition bins clearly had labels stating 'No Gloves and No Clinical waste'. This was brought to the attention of the trust who indicated that immediate action would be taken (*observation tools, interviews with staff*)

A bath with jets was observed on one ward on the Kent and Canterbury site, staff were unaware how the jets were cleaned. This was brought to the attention of the IPCT who were aware of the bath through a recent environmental audit, and confirmed that they have requested information regarding specific arrangements for cleaning the jets. They had recently contacted the estates team for clarification and were awaiting the outcome. (*observation tool and interview with nurses and IPCT, IPC environmental audit November 2008*)

The team observed that eye catching and informative cleaning schedules were available as were floor and wall signs to improve compliance with hand hygiene

Staff interviewed were able to confirm the following:

- 24 hour cleaning staff
- 24 hour 'Blitz' team for post infection clean
- Good awareness of responsibilities for cleaning

d) The trust must ensure that cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available, with a view to minimising the risk of HCAI.

I: Line(s) of enquiry

4d(1)	**The trust ensures that <u>cleaning arrangements detail the standards of cleanliness required</u> in each part of its premises and that a <u>schedule of cleaning frequencies is publicly available</u>; and has taken account of Annex 1.**

II: Evaluation of evidence

Contract cleaners provide the cleaning services for the trust. There is a cleaning (domestic) services and associated services output specification which contains key objectives and processes for cleaning services. This specification makes reference to the trust's IPCT as one of the 'key

customers and contains other references to the IPC manual (*Cleaning (Domestic) Services and Associated Services output specification*)

In all clinical areas visited, there was a very clear schedule of cleaning responsibilities and frequencies in pictorial form in public areas. All staff were aware of their responsibilities for cleaning: what to clean and the products to use. It was clear that there is an effective relationship between the IPCT and the contract cleaning managers. (*observation tools, interviews with staff*)

There are designated toilet cleaning teams who clean all toilets at regular intervals. They are also responsible for thorough clean of commodes twice a day in each area.

Charts were present in every cleaning cupboard for products and processes. There is also a schedule for stripping and cleaning of floors, vents, radiators, etc. (*planned schedule for cleaning*)

Domestic staff are invited to ward meetings and feel an integral part of the team. (*interview notes on-site manager and operational manager of the contract cleaning service*)

Following use by patients with infections the contract cleaners perform a ‘vacation clean’ with hot water and a chlorine based cleaning solution (*interviews with staff, isolation policy*)

The trust’s IC annual programme stipulates the cleaning/hygiene practices for the management of *Clostridium difficile.* These include:

- the use of a sodium hypochlorite product
- the frequency of cleaning of isolation rooms and equipment used by patients infected with *Clostridium difficile* such as commodes, dynamic mattress systems

(*IC annual programme 2008/2009*)

The trust’s ‘Raising the bar’ project was introduced in February 2008 with the specific aim of improving cleanliness and patient feeding standards across the Trust. This was a three month project undertaken between March and May 2008 where 65 ward managers across all 3 sites, were visited by the facilities department, accompanied by a cleaning contract representative, and on some occasions a matron, with the following objectives discussed:

- Explain what their expectations should be with regards to the content and standards as laid out in the cleaning and catering specifications.
- The monitoring regime.
- What an output specification is.
- The payment mechanism.
- Escalation.
- Rectification and response times.
- A walk round of their ward area (for 10 minutes) to spot check on the cleaning standards and to demonstrate how thorough the cleaning and monitoring should be.

(Raising the bar project document May2008, interviews with staff)

The DoNMQ undertakes spot checks on all sites that include checks on general cleanliness, clinical room/area and tidiness & clutter any failures to meet required standards are reported with actions for improvement. (*Infection control spot checks: KC site, Aug 08, QEQM site, September 08, WHH July 08)*

It was clear from interviews with staff that the IPCT have been involved with the development of cleaning standards and schedules

The cleaning contractors monitor the results of maximiser audits against infection control environmental audits. *(maximiser audits, environmental audits, interviews with DIPC and DDIPC)*

e) The trust must ensure that there is adequate provision of suitable hand wash facilities and antibacterial hand rubs, with a view to minimising the risk of HCAI.	
I: Line(s) of enquiry	
4e(1)	**The trust ensures that there is adequate provision of suitable hand wash facilities and antibacterial hand rubs.**
II: Evaluation of evidence	

The trust has assessed its provision of hand washing facilities on most wards on the three inpatient trust sites against the following standard: There are sufficient numbers of hand wash basins available in accordance with national and local guidelines. Hand wash basins conform to HTM 64. Comments were included where improvements are needed. (*Hand wash basin audits*)

Staff interviewed generally felt that hand wash facilities were adequate with the exception of Fordwich Stroke Unit where they have identified the need for a basin in the clinical room, this has been requested and should be in place within the next fortnight and the DVT clinic in the Kent and Canterbury emergency care centre, again this has been raised with estates who are investigating the waste pipes available. Some areas would like basins moved for easier access but have stated that this has been raised and is under review with the refurbishment plans. The new build at QEQM has been designed with consultation with the IPCT and facilities will be in line with recognised best practice. From observation it appears that there are suitable facilities and appropriate access to antibacterial hand rub in all areas visited. (*observation tools and interviews with staff, audits of hand wash basins*)

Antibacterial hand rub was seen to be readily available at the point of patient care and at entrances to wards and departments. (*Observation tools)*

Notices were seen above bed spaces encouraging hand hygiene and the use of wet wipes for individual patients to promote optimum hand hygiene (*observation tools, IC annual programme 2008/2009*)

The IC annual programme describes the IPCT promotion of effective hand hygiene including:

- Supporting phase 3 of the cleanyourhands campaign
- Seven ward in the trust are part of a national campaign (FIT study) to improve hand hygiene amongst ward staff
- Regular hand hygiene sessions on wards

Staff observed during the site visits were seen to be washing their hands and using the antibacterial hand rub provided. Floor and wall notices were in place to encourage hand hygiene compliance (*observation tools)*

f) The trust must ensure that there are effective arrangements for the appropriate decontamination of instruments and other equipment.

I: Line(s) of enquiry	
4f(1)	**The trust ensures that there are effective arrangements for the appropriate decontamination of equipment; and has taken account of Annex 1.**

II: Evaluation of evidence

East Kent Hospitals is part of the Kent cluster project for the centralisation of sterile services provision to an off site location. This project is in line with the national strategy and is due for completion in August / September 2009. Currently there are sterile services provided at the trust. A BSI (British Standards) audit was undertaken in December which we were told concluded that it was a well run unit with all appropriate training for staff. The unit is CE marked because the unit provides sterile supplies to the PCT. Quality meeting minutes with actions signed off were seen but not retained. The trust's hygiene code action plan states that the steam piping is non-compliant and will be addressed in the new facility due to be functional by September 2009, in the meantime regular monitoring is providing assurance on maintenance of quality. (*steam test purity reports, interview with head of patient safety and SSD manager*)

Endoscopy services have recently undergone a Joint Accreditation Group (JAG) review at the Kent and Canterbury site, there were no action points about the processing or decontamination of equipment raised. All washer disinfectors in the endoscopy units have either been replaced or are in the process of being replaced. The endoscopy unit at QEQM has been redeveloped and is about to open. This unit has a 'pass through' design with complete separation of dirty to clean. A reverse osmosis water plant has been installed and all of the commissioning tests have been completed. The ENT outpatient clinic is not HTM 20/30 compliant or JAG accredited, however a risk assessment has been completed and there is an appropriate work process in place to manage the identified risks. Training records were seen in both units and the lead from each area discussed the training and supervision of staff undertaking processing of endoscopes. The relevant daily testing records were viewed in the ENT department. (*observation tools, interviews with head of patient safety, JAG visit report 30 Sept 08)*

We were told that the ICPT audit the three endoscopy units every 12-18 months using the environmental audits and adapted ICNA tools, these are reported at the decontamination working group. Previous audits and completed action plans were provided but there were none for 2008. In addition the audit of endoscopy facilities and practice takes place bi-annually by the Authorised Person (sterilisers), DDIPC, endoscopy lead nurse and steriliser engineer. The trust's policy for the decontamination of reusable medical devices outside the sterile services department contains an appendix for the processing of flexible endoscopes. (*policy for the decontamination of reusable medical devices outside the sterile services department August 2008, Audit of Endoscopy department KCH 12 December 2007*)

The trust's decontamination policy states that the IPCT must sign off the purchase of any new equipment that requires decontamination outside SSD. (*policy for the decontamination of reusable medical devices outside the sterile services department August 2008*)

The trust's cleaning specification makes clear that contractors are responsible for cleaning all medical and patient equipment not being used or attached to patients under the direct instruction of ward staff unless specifically excluded. (*cleaning specification*)

We observed equipment storerooms that were generally clean and tidy. Most of the equipment inspected was clean. Staff interview were all very clear regarding their responsibilities for the decontamination of patient equipment in ward areas. Patient equipment is cleaned following use by nursing staff and the cleaners also ensure that it is cleaned daily when in the storage areas. Hoist slings were seen to be disposable. Plastic bags were covering patient fans to denote they had been cleaned. There were some isolated incidents of dust on blood pressure machines and the blood pressure cuffs were seen to be marked on one ward, this was brought to the attention of senior staff during observation round. (*observation tools*)

The trust's annual IC programme states that the IPCT will organise the annual commode audit. The audit for 2008 resulted in a change to include twice daily cleaning of commodes by the domestic staff using a chlorine based cleaning solution, in addition to the clean after use undertaken by the nursing staff. Commodes are left with the seat upturned and with tape applied to denote that they have been cleaned and are ready for use. All commodes seen during the inspection on all three sites were clean, apart from two old style commodes on one ward on the William Harvey site which were stained. Checking forms were available and signed to denote that the twice daily cleans were being undertaken. (*annual report, interviews with staff, observation tools)*

The trust has a policy for mattresses, including the management of dynamic mattress systems. The policy outlines the cleaning processes and solutions to be used. The trust uses a label to identify dynamic mattress systems used by patients with infections. The isolation and mattress policies states that it is the nurses responsibility to contact the tissue viability nurses to arrange for the external cleaning of dynamic mattress systems used by patients with infections. Interviews with staff confirmed that specialist mattresses are cleaned externally. (*IC annual programme 2008/2009, label observed on visit, not retained, Mattress policy August 2008, Isolation policy*).

g) The trust must ensure that the supply and provision of linen and laundry supplies reflects Health Service Guidance HSG (95)18, Hospital Laundry Arrangements for Used and Infected Linen, as revised from time to time, with a view to minimising the risk of HCAI.

I: Line(s) of enquiry

4g(1)	**The trust ensures that the supply and provision of linen and laundry supplies reflects Health Service Guidance HSG (95) 18, Hospital Laundry Arrangements for Used and Infected Linen, as revised from time to time.**

II: Evaluation of evidence

Linen services are provided in-house and comply with HSG95(18). Calibration checks are carried out and monitored monthly. Evidence is kept at East Kent linen services on: soaps and bleaches, machine temperatures and UV whiteness checks. Monitoring records for independent checks were provided for September, October and November 2008. No issues were raised by staff in relation to collection and delivery, however there are some storage issues for dirty linen bags and this is to be reviewed as part of the refurbishment at QEQM and WH.(*email form linen and accommodation manager 9 Dec 08, Laundry technology reports*)

h) The trust must ensure that uniform and workwear policy ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose.

I: Line(s) of enquiry

4h(1)	**The trust ensures that uniform and workwear policy ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose.**

II: Evaluation of evidence

The trust has a uniform policy, updated in April 2008. The policy includes guidance on the 'bare below the elbows' (BBE) initiative, action to be taken if uniforms become soiled and laundering arrangements. The policy covers the requirements for personal protective equipment (PPE) the uniform policy makes reference to HCAI and cross infection. (*uniform policy, updated April 2008*)

All staff were aware of the uniform policy and requirements. BBE is required for direct patient

contact and this was observed on all the wards visited. Medical staff in clinical areas with wrist watches were seen to remove these when approaching a patient. All staff seen were wearing uniforms that were clean, tidy and fit for purpose. (*observation tools*)

Duty 8: Duty to provide adequate isolation facilities

a) The trust must ensure that it is able to provide or secure the provision of adequate isolation facilities for in-patients sufficient to prevent or minimise the spread of HCAI

I: Line(s) of enquiry

8a(1)	The trust ensures that it is able to provide or secure the provision of adequate isolation facilities for in-patients sufficient to prevent or minimise the spread of HCAI; and has taken account of Annex 1.

II: Evaluation of evidence

The trust has assessed the available provision for isolation and has recently opened four negative pressure isolation rooms, two at the William Harvey Hospital and two at Queen Elizabeth the Queen Mother Hospital. The IPCT were involved throughout the process. The trust has not identified a need for positive pressure facilities due to the nature of its work, however there is guidance for staff contained in the isolation policy to be followed if a patient does require protective isolation, the policy states which side rooms on designated wards should be used. (*IC annual report 2007-2008, email re progress on isolation ward – September 2008, interview with DIPC, isolation policy, updated Aug 08*)

The trust has an isolation ward on the William Harvey site. The trust have identified that further investment is required to provide more isolation facilities. This is addressed as part of the estates strategy which will provide 50% side rooms.

Current availability of side rooms is as follows:
Surgery: 330 beds, 18% side rooms, of which 43% are ensuite
Medicine: 617 beds, 16% side rooms, of which 54% are ensuite
Maternity/paediatrics: 176 beds, 23% side rooms of which 59% are ensuite
ITU: 24 beds, 33% side rooms, none of which are ensuite

The isolation policy states that if a patient has been diagnosed with an infection or an infection is suspected the IPCT should be informed. The policy advises that the most effective form of isolation is a single room and this should always be the first choice for the placement of an infected/colonised patient. However there is a contingency for cohorting (grouping of patients with one particular infection to isolate them from other patients) patients if required and for ward closures.

The policy provides guidance on action that must be taken by staff if there is no availability of a side room, including consultation with the IPCT and the policy contains an appendix 'guidance for bed managers/matrons/site coordinators' on the management of 'high risk' patients and guidelines for admission to the isolation ward which is coordinated via the clinical decisions unit and the IPCT. *(Isolation Policy – reviewed August 2008)*

The isolation policy is referenced to and supplemented by the MRSA policy, this includes more detailed guidance for staff and has as an appendix a management plan to be followed if a patient has confirmed MRSA colonisation/infection and a MRSA risk assessment tool for placement of

patients within the ward area. (*MRSA policy September 2005/August 2008*)

The trust also has a *Clostridium difficile* policy that contains an appendix: medical guidelines for patient management which lays out the nursing and medical management required, a *Clostridium difficile* patient management plan and a RCA tool designed for investigating *Clostridium difficile* cases. (*Clostridium difficile policy*)

Included in the trust's infection control manual are a number of other policies providing information on various types of infection and their management. The policy for the admission, movement/transfer and discharge of patients with an infection / infectious disease contains a patient transfer risk assessment tool. This is to be applied to all patients being transferred to departments or clinical area within the trust and to all inter and intra hospital transfers and is completed by the registered nurse / midwife responsible for the patient's care or the nurse in charge of the ward. The risk assessment includes information about HCAI and isolation requirements. *(IC Manual and transfer policy)*

Directorates are required to audit compliance with cohorting in line with directorate KPI targets (*Isolation policy*)

An audit of isolation of 64 patients with confirmed *Clostridium difficile* within six hours was undertaken between July and November 2008 showing that nearly all patients were isolated within the target. One patient was over the target time and for seven there was no data. (*audit of isolation of patients with Clostridium difficile)*

All staff interviewed were aware of the policies for isolation and the need to liaise with IPCT. Decisions to isolate patients are based on policy guidance and discussed with the IPCT if any concerns are identified. All areas have co-hort plans in place if the need arises and this is only instigated with discussion with IPCT. (*interview notes with staff)*

All staff are aware of relevant precautions and processes to follow if patient is isolated for infection. Different isolation notices are available depending on the type of infection present, for example one notice requests staff to use antibacterial hand rub, another, for *Clostridium difficile* infections requires personnel to wash hands with soap and water. (*Observation tools, copies of notices and interviews with staff*)

Gloves and aprons were seen to be readily available outside bays and single rooms. (*observation tools)*

Isolation audit
The planned audit of the trust's isolation wards was planned but not undertaken due to demands on the team. (*IC annual report 2007-2008)*

Duty 10: Duty to adhere to policies and protocols applicable to infection prevention and control

j) The trust must have in place an appropriate policy in relation to antimicrobial prescribing, which is monitored via the trust's Clinical Governance System. There must be evidence of a rolling programme of audit, revision, and update, and the policy must be marked with a clear review date.	
I: Line(s) of enquiry	
10j(1)	**The trust has in place an appropriate policy on antimicrobial prescribing. The policy is monitored via the trust's Clinical Governance System, and there is evidence of a rolling programme of audit, revision, and update, and the policy is marked with a clear review date. The trust has taken account of Annex 2 in forming its policy.**
II: Evaluation of evidence	

The trust's document: guidelines on the use of antimicrobial drugs are dated September 2003 but have been regularly updated, the last update in July 2007, the guidelines have an expiry date of June 2009. (*guidelines on the use of antimicrobial drugs*)

The trust's annual infection control programme details the trust's antibiotic management:

- The trust's drugs and therapeutic committee are to receive reports on antibiotic prescribing from directorates and from pharmacy staff carrying out surveillance at ward level
- Continuing close monitoring and control of the use of antibiotics known to present a higher risk of *Clostridium difficile* infection
- Improved systems for escalating and acting on non-compliance with the antibiotic policy
- Removal of broad spectrum cephalosporin from ward stock in surgical units
- The development of a pocket size antibiotic policy to be issued to all junior medical staff together with an interactive web based antibiotic policy rolled out during August 2008

(Infection control annual programme April 2008-March 2009)

Interviews with staff confirmed that these initiatives were in place. All junior doctors are provided with a pocket size copy of the guidelines for the use of antibiotics. The interactive web based antibiotic policy provides advice based on information submitted and useful links, such as the BNF. The antimicrobial pharmacist will be monitoring the usage of the web based policy. (*interview notes-pharmacists*)

The pharmacists stated that they had been limited by the amount of audit that they had been involved in due to lack of resources in their team. This has now been addressed with the recent appointment of two full time antimicrobial pharmacists. (*interview notes pharmacists*)

In spite of the above, antibiotic use by directorate and by site is collected monthly to monitor usage. In addition, four directorates completed antimicrobial prescribing audits during 2007/2008. There is routine monitoring of compliance with the policy by pharmacy and microbiology staff with microbiology conducting retrospective audits on the medical admission wards and point of prevalence studies on all general surgical and orthopaedic wards. (*IPC annual programme, IC annual report 2007-2008*). The pharmacy technician monitors antibiotic usage for each directorate by site. The information is then provided to the clinical directors and the stewardship group for monitoring. The information is updated monthly, if required the information can be broken down to individual prescribers and poor performance can be escalated via the clinical director to the medical director. These reports have resulted in the removal of some high risk antibiotics from clinical areas

e.g. cefuroxime has been removed from wards. (*antibiotic usage spreadsheets, interview notes - pharmacists, drugs and therapeutic committee minutes*)

The inspection team were shown a new prescription chart, currently in final print stage, with a number of pages, which has been designed so that whichever page is being used the patient details, including allergies are visible. The new chart has a separate page for antibiotic prescribing which provides triggers to prompt compliance with best practice, such as requiring a doctor's signature after five days, and microbiology approval at 10 days of antibiotic use. (*new prescribing policy, interview with pharmacists, prescription chart*)

Numerous presentations were provided that are delivered at medical staff training by pharmacists, microbiologists and the DIPC outlining best practice regarding antimicrobial prescribing and usage. (*PowerPoint presentations)*

Staff interviewed during the visits to the wards were aware of the antimicrobial prescribing policies and stated that it was part of their role to query prescriptions if they were concerned. Staff showed us the pharmacy intervention record form which is used if there is a problem identified with any prescription to provide details of the problem to the prescribing clinician and a range of outcomes to be documented. (*staff interviews, Pharmacy Intervention Record Form*)

Pharmacists visit the wards daily Monday to Friday and are available on Saturday morning and on-call at other times. Any concerns are raised with the DIPC/microbiologist and/or IPCT. The pharmacist places a 'Yellow Label' (seen but not retained) on any prescription chart that raises any concerns and information is copied to the microbiologist and clinical lead. Pharmacy monitors the use of anti- infectives. *(interview notes – pharmacists)*

Supporting evidence

Staff interviewed (list job titles)

- Director of Nursing, Quality and Midwifery
- Chairman
- Chief Executive
- Trust Sterile Services Manager and Head of Patient Safety (interviewed together)
- Head of Facilities and Head of Estates (interviewed together)
- Head of Human Resources and Workforce Planning (interviewed together)
- Chief Operating Officer
- Head of Pharmacy, Antimicrobial Pharmacist and Antimicrobial Technician (interviewed together)
- DIPC and deputy DIPC (interviewed together)
- Infection prevention and control team: three x ICN, and consultant microbiologist
- interviewed during observation visits:

  Matrons x 4
  Ward manager x 2
  Sister x 4
  Nurses x 22
  HCA x 8
  Domestic staff x 13
  Domestic supervisor x 1
  Contract cleaners on site manager x 2
  Doctors x 12
  X-ray technician x 1
  Physiotherapists x 3
  Porters x 4
  Pharmacist x 1

Areas where observations were conducted (Note: this is relevant to duty 4)

Kent and Canterbury

- Emergency Care Centre
- St Lawrence (medical ward)
- Harvey ward (medical)

Queen Elizabeth the Queen Mother

- Fordwich Stroke Unit
- SCBU
- Endoscopy
- ENT endoscopy
- Sea Bathing ward
- Clinical Decisions Unit

William Harvey

- CDU
- King C1
- Cambridge J2

- Endoscopy
- Oxford (isolation ward)

Documents reviewed

Reference	Document title	Date of document
HCAI RVV 001	Job description – Medical director	
HCAI RVV 002	Job description - DIPC	
HCAI RVV 003	Director of Nursing – Job plan	
HCAI RVV 004	EKHUT Infection Control Organisational arrangements	August 2008
HCAI RVV 005	Interview notes - DIPC	10 December 2008
HCAI RVV 006	Interview notes - chairman	9 December 2008
HCAI RVV 007	Interview notes - CEO	9 December 2008
HCAI RVV 008	NED handbook	
HCAI RVV 009	IPC Annual Report	April 2007-March 2008
HCAI RVV 010	Appendix to all job descriptions	January 2008
HCAI RVV 011	Job Description - DoNMQ	undated
HCAI RVV 012	Job description - Lead Nurse Head of Nursing	September 2007
HCAI RVV 013	Job Description - Matron	
HCAI RVV 014	Job description - Registered nurse band 5	
HCAI RVV 015	Minutes - ICC	
HCAI RVV 016	Interview notes matron	
HCAI RVV 017	Framework for the management of risks associated with IPC in EKHUT	November 2006
HCAI RVV 018	Clinical Governance assurance framework	August 2008
HCAI RVV 019	Infection control programme	April 2008 – March 2009
HCAI RVV 020	EKHUT Infection control organizational arrangements	August 2008
HCAI RVV 021	TOR Clinical Management Board	
HCAI RVV 022	Minutes – Clinical Management Board	
HCAI RVV 023	Minutes – Trust Board	May 2008
HCAI RVV 024	Minutes – Trust Board	June 2008
HCAI RVV 025	Patient Safety and quality report	November 2008
HCAI RVV 026	RCA investigation reports	various
HCAI RVV 027	MRSA policy September 2005/August 2008	
HCAI RVV 028	IPC performance monitoring	
HCAI RVV 029	Key Performance indicator targets for directorates	May 2008
HCAI RVV 030	Isolation Policy	August 2008
HCAI RVV 031	Business case	undated
HCAI RVV 032	Interview notes IPCT	10 Dec 2008
HCAI RVV 033	Minutes directorate leads meetings	
HCAI RVV 034	Induction Policy	
HCAI RVV 035	Interviews - Pharmacists	10 Dec 2008
HCAI RVV 036	Training PowerPoint presentations	
HCAI RVV 037	Interview – HR and Workforce planning	
HCAI RVV 038	Education and training recorded rates for mandatory training	
HCAI RVV 039	Induction and Mandatory training policy	undated
HCAI RVV 040	Interviews – onsite manager and operations manager for cleaning contractors	
HCAI RVV 041	Contractors information booklet	Updated July 2007
HCAI RVV 042	IPC guidance for contractors	
HCAI RVV 043	Interview – estates manager	
HCAI RVV 044	Environmental audits	November 2008

HCAI RVV 045	Antibiotic usage summary	
HCAI RVV 046	Commode audits	
HCAI RVV 047	Commode audit tool	
HCAI RVV 048	Implementation on Synbiotix Saving Lives for High Impact Interventions document	
HCAI RVV 049	Venous cannulation management and removal (adults)	2006
HCAI RVV 050	peripheral cannula audit,	
HCAI RVV 051	peripheral cannula audit flyer	2008
HCAI RVV 052	CV audit	September 2008
HCAI RVV 053	Urinary catheter audit flyer	2008
HCAI RVV 054	Transfer of Patients policy	January 2008
HCAI RVV 055	Transfer risk assessment tool	
HCAI RVV 056	Policy for the Admission, Movement/Transfer and Discharge of Patients with an Infection / Infectious Disease	August 2008
HCAI RVV 057	operational escalation plan 2006	
HCAI RVV 058	Draft policy document for environmental policies and infection control	December 2008
HCAI RVV 059	Cleaning Operational Plan	June 2008
HCAI RVV 060	cleaning specification	
HCAI RVV 061	East Kent Hospitals University NHS Trust Strategic Cleaning Plan Review	November 2008
HCAI RVV 062	Ward kitchens and food policy	2008
HCAI RVV 063	Waste Strategy	2008
HCAI RVV 064	Legionella Policy	
HCAI RVV 065	Infection control in building and refurbishment policy	December 2008
HCAI RVV 066	emails regarding recent building work	
HCAI RVV 067	Job description - trust decontamination lead	November 2008
HCAI RVV 0068	Job description - Head of soft FM services	
HCAI RVV 069	Minutes of Decontamination of medical devices working Group	8 Dec 08
HCAI RVV 070	Minutes of Decontamination of medical devices working Group	October 2008
HCAI RVV 071	JAG visit report	30 Sept 08
HCAI RVV 072	Maximiser audits	various
HCAI RVV 073	Email from linen and accommodation manager	9 Dec 08
HCAI RVV 074	Trust corporate risk register	2008/09
HCAI RVV 075	Cleaning (Domestic) Services and Associated Services output specification	
HCAI RVV 076	Planned schedule for cleaning	
HCAI RVV 077	Raising the bar' project document	
HCAI RVV 078	Hand wash basin audits	
HCAI RVV 079	Steam test purity reports	
HCAI RVV 080	Policy for the decontamination of reusable medical devices outside the sterile services department	August 2008
HCAI RVV 081	Mattress policy	August 2008
HCAI RVV 083	Monitoring records for independent checks (linen)	October and November 2008
HCAI RVV 083	Uniform Policy	Updated April 2008

HCAI RVV 084	Email re progress on isolation ward –	September 2008
HCAI RVV 085	MRSA policy September	2005/August 2008
HCAI RVV 086	*Clostridium difficile* policy	
HCAI RVV 087	Audit of isolation of patients with Clostridium difficile	July – November 2008
HCAI RVV 088	Isolation notices	
HCAI RVV 089	Minutes drugs and therapeutic committee	
HCAI RVV 090	JAG Action Plan	December 2008
HCAI RVV 091	Observation tools	
HCAI RVV 092	Guidelines on the use of antimicrobial drugs	Updated July 2007
HCAI RVV 093	Infection Prevention and Control Key Performance Indicator Targets for Directorates – Performance Metrics)	2008 – 2009

Appendix 3

East Kent Hospitals University NHS
NHS Trust

Deep Clean Assurance

In response to the request from the SHA, this comprehensive update highlights EKHUT's approach to the continuing 'Deep Clean' programme, based on (at the very least):

- the latest national guidance/advice on cleaning
- an assessment of what worked well and not so well from the 07/08 Deep Clean
- an assessment of the level of decanting to enable a proper Deep Clean processes (especially where decanting may not have been carried out in the previous Deep Clean)
- a thorough needs assessment of the current position - e.g. prioritising areas using infection rates, cleanliness and public confidence scores
- agreed measures to be used to assess how well the plan has been implemented
- reporting of performance against these measures to the PCT

The update includes all relevant reports, action plans, a longer term approach to achieving excellent cleaning standards and improvement plans.

- There is on going review of the deep cleaning programme as indicated in the assurance document. The current cleaning specification (July 2004 – June 2011) meets the operational cleaning requirements of 'The national specifications for cleanliness in the NHS'

- The 'Deep cleaning programme' resulted in the 'Raising the Bar' initiative, to ensure continuity in improving the standard of cleanliness achieved and to reinforce awareness at ward level of the contract specification which included the standards to be maintained and escalation by the local managers in the event of default.

- The deep cleaning programme also resulted in the initiative to fully review cleaning services to ensure our service provider, Medirest, is adhering to the contract specification and a drive to achieve consistent excellence throughout in cleaning standards. A cleaning action plan was developed with identified time frames. Progress is monitored weekly (using red, amber, green indicators) with our service provider.

- In addition senior Trust representatives met with senior Medirest management, Medirest. From this an action plan was drawn up with identified time frames, with a commitment to improving consistent standards of excellence, and to identify areas of weakness in the delivery of the cleaning service.

- A comprehensive cleaning schedule has been produced with the involvement of senior nurses and IP&C. This will shortly be prominently displayed on all wards

and departments. The ward cleaning SLA's have been signed off across the Trust and there is evidence to support the ward managers increased awareness of the specification particularly in respect of their expectations from the cleaning. The Medirest supervisors are carrying out daily spot checks and are focused on the 49 cleaning elements.

- A further piece of work is that of bringing together all the strands around cleaning by identifying action points from relevant legislation and guidance and initiatives which is being coordinated and led by the Deputy Director of Nursing.

- A review of the cleaning strategy (approved by the Risk Committee- Trust board sign off imminent) and the cleaning operational policy plan has been undertaken.

- There has been a full review of mattress storage and segregation in accordance with the enhanced cleaning programme to ensure compliance with all relevant local and national guidance.

- Commode audits are carried out an ongoing monthly basis by Medirest in addition to the Infection Prevention and Control commode audits.

PEAT

The results for this year did not reflect the full effect of the deep cleaning programme as the assessments were undertaken during the on going activity of the programme. As a consequence of the results a report 'Life after PEAT' identified possible solutions which are being taken forward as part of the coordination of the cleaning strands with nursing.

Task lists were issued as a consequence of the exercise.

Annual Monitoring Programme (AMP)

There is an AMP for each site which is reviewed and agreed by Infection Prevention and Control. Medirest have specific site monitoring officers who monitor the 49 elements utilising Maximiser to this programme involving both Matrons and ward managers. There is consistent review of the scores as part of the Medirest monthly report with identification of those areas that do reach the specified standard of 95% and also the highlighting the 10 most common failures identified for targeting by the supervisors over the next month. The 13 week review is compiled in accordance with the National Cleaning specification and submitted to ERIC. The monitoring results, its associated risk category, along with patient cleaning survey results and patient complaints help to determine areas requiring a deep clean.

Public surveys.

Medirest carry out quarterly reviews to ascertain patient feedback and perception of the cleaning service.

- Introduction of more comprehensive audit trails. For barrier room cleaning, curtain changing programme, floor maintenance schedules, radiator cleaning

Environment

An Estates strategy is being developed to encompass the requirements as prioritised on each site by an identified representative group.

Things that did not go so well:

- Not being able to decant at the KCH, therefore the cleaning took place while patients were in the beds or wherever possible, one bay at a time! It did cause disruption and the cleaning generally could not be as thorough as we would have wanted.
- The initial hours submitted by our service provider (Medirest) were reduced, therefore this impacted on time available spent on wards to physically clean, leading to some ward managers being dissatisfied with the outcome. The time allocated for the wards to be thoroughly deep cleaned was insufficient taking into account that they were occupied, which meant that areas had to be revisited several times to complete the clean.
- The timescale imposed for such a large Trust, put unnecessary pressure on ward and cleaning staff, through working overtime.
- There was a lack of bed spaces to move patients at the WHH on areas where Norovirus was present. This created some confusion in March 2008 when the plan was changed around in Kings wards, Betherseden and CDU at WHH.
- Where major building works were being undertaken, these areas had to be re-visited, examples being, Endoscopy, Oxford, Outpatients and Maternity.
- The wards which were unable to decant gave Medirest operational issues as only 1 bay at a time could be cleaned and then patients had to be moved thus extending the time frame of deep cleaning these wards.
- It became apparent during the process that although we had originally allowed 3 days to fully deep clean a ward, Estates department were also instructed to complete minor repairs at the same time therefore in practice we only has 1.5 or 2 days to complete the task.
- There was also an expectation from the wards that when they returned to their ward from the decant that the ward would have had a “Make over”.
- Unfortunately there were a number of departments were the lack of co-operation and interest in the programme made it difficult for the team to carry out their work to the required standard.

Things that did go well:

- Being able to decant at the WHH and QEQM. The wards which were decanted gave Medirest the best opportunity to deep clean as we were able to use the high pressure steam cleaners to ensure that we got into all areas of the ward.
- Many of the different disciplines worked together to deliver the programme i.e. good examples of team working.
- It gave the opportunity for a structured process, led by hospital managers, for cleaning areas in greater depth e.g. storage areas.
- There was an opportunity to carry out minor building works, resulting in improved cleanliness (fabric easier to clean).
- There was a great deal of de-cluttering that took place which improved the tidiness of many areas and has enabled Medirest to complete cleaning since then with more accessibility.

- It gave an added focus on cleaning and the importance of it. It re-emphasised that cleaning is everyone's responsibility.
- The ward managers had the ability to formally sign off the deep clean and were therefore able to determine whether the standards had been achieved or not. This formal process was welcomed by many of the ward managers as they were able to ensure the required standards were met.
- Medirest rose to the challenge very well, especially at such short notice and were very supportive in the whole process.
- It enabled the Trust to purchase specialist equipment, e.g. dry steam pressure cleaners, which are still used on an ongoing basis all year round, leading to more effective cleaning.
- There was positive feedback from certain departments who were very pleased at having a thorough deep clean.

As a suggestion, the sum of money spent on the one off 'Deep Clean' potentially would be better employed on permanent deep clean teams all year round. I have attached the scoping document for 'Specialist Infection Control Clean teams' which describes our approach to assisting in the ongoing programme.

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Appendix 4

FIRST DOMAIN: SAFETY Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.			
Core Standards		Declaration 2007/08	Draft Declaration 2008/09
C1a	Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents and make improvements in practice based on local and national experience and information derived from the analysis of incidents	**Compliant**	**Compliant**
C1b	Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.	**Compliant**	**Compliant**
C2	Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.	**Compliant**	**Compliant**
C3	Healthcare organisations protect patients by following National Institute for Health and Clinical Excellence (NICE) interventional procedures guidance.	**Compliant**	**Compliant**
C4a	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA.	**Compliant**	**Compliant**
C4b	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.	**Compliant**	**Compliant**
C4c	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and the risks associated with decontamination facilities and processes are well managed.	**Compliant**	**Compliant**
C4d	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely.	**Compliant**	**Compliant**

C4e	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment. **Commentary**: Following on from recommendations contained within correspondence from the Environment Agency in late February 2008, good progress has been made with the action plan to address these. 44 of the 54 recommendations have been achieved with the remaining 10 on target for completion before the end of March 2009. The Trust must be able to demonstrate that the standard has been fully met for the whole year to declare compliance, which will not be possible for 2008-09.	**Not met**	**Insufficient Assurance**
SECOND DOMAIN: CLINICAL AND COST EFFECTIVENESS **Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes.**			
Core Standards		**Declaration 2007/08**	**Draft Declaration 2008/09**
C5a	Healthcare organisations ensure that they conform to National Institute for Health and Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivery treatment and care.	**Compliant**	**Compliant**
C5b	Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership.	**Compliant**	**Compliant**
C5c	Healthcare organisations ensure that clinicians' continuously update skills and techniques relevant to their clinical work.	**Compliant**	**Compliant**
C5d	Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.	**Compliant**	**Compliant**
C5d	Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.	**Compliant**	**Compliant**
C6	Healthcare organisations cooperate with each other and social care organisations to ensure those patients' individual needs are properly managed and met.	**Compliant**	**Compliant**

THIRD DOMAIN: GOVERNANCE **Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.**			
Core Standards		**Declaration 2007/08**	**Draft Declaration 2008/09**
C7a	Healthcare organisations: apply the principals of sound clinical corporate governance.	**Compliant**	**Compliant**
C7b	Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.	**Compliant**	**Compliant**
C7c	Healthcare organisations undertake systematic assessment and risk management.	**Compliant**	**Compliant**
C7d	Healthcare organisations ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources.	**Separate Assessment**	**Separate Assessment**
C7e	Healthcare organisations challenge discrimination, promote equality and respect human rights.	**Compliant**	**Compliant**
C7f	Healthcare organisations meet the existing performance requirements.	**Separate Assessment**	**Separate Assessment**
C8a	Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.	**Compliant**	**Compliant**
C8b	Healthcare organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under representation of minority groups.	**Compliant**	**Compliant**
C9	Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.	**Compliant**	**Compliant**

THIRD DOMAIN: GOVERNANCE **Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.**			
C10a	Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.	**Compliant**	**Compliant**
C10b	Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice.	**Compliant**	**Compliant**
C11a	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake.	**Compliant**	**Compliant**
C11b	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes.	**Compliant**	**Compliant**
C11c	Healthcare organizations ensure that staff concerned with all aspects of the provision of health care participate in further professional and occupational development commensurate with their work throughout their working lives.	**Compliant**	**Compliant**
C12	Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.	**Compliant**	**Compliant**
C13a	Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.	**Compliant**	**Compliant**
FOURTH DOMAIN: PATIENT FOCUS **Healthcare is provided in partnership with patients, their carers and relatives respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.**			
C13b	Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information.	**Compliant**	**Compliant**
C13c	Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where	**Compliant**	**Compliant**

	authorised by legislation to the contrary.		
C14a	Healthcare organisation have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services.	**Compliant**	**Compliant**
C14b	Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made.	**Compliant**	**Compliant**
C14c	Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.	**Compliant**	**Compliant**
C15a	Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice that it is prepared safely and provides a balanced diet.	**Compliant**	**Compliant**
C15b	Where food is provided, healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.	**Compliant**	**Compliant**
C16	Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care.	**Compliant**	**Compliant**

FIFTH DOMAIN: ACCESSIBLE AND RESPONSIVE CARE **Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway.**			
Core Standards		**Declaration 2007/08**	**Draft Declaration 2008/09**
C17	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.	**Compliant**	**Compliant**
C18	Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.	**Compliant**	**Compliant**

C19	Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.	**Separate Assessment**	**Separate Assessment**
SIXTH DOMAIN: CARE ENVIRONMENT AND AMENITIES **Healthcare services are provided in environments which promote effective care and optimise health outcomes by being: a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation – Not a Domain Outcome**			
Core Standards		**Declaration 2007/08**	**Draft Declaration 2008/09**
C20a	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property and the physical assets of the organisation.	**Compliant**	**Compliant**
C20b	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.	**Compliant**	**Compliant**
C21	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.	**Compliant**	**Compliant**
SEVENTH DOMAIN: PUBLIC HEALTH **Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.**			
Core Standards		**Declaration 2007/08**	**Draft Declaration 2008/09**
C22a	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by cooperating with each other and with local authorities and other organisations.	**Compliant**	**Compliant**
C22b	Healthcare organisations promote, protect and demonstrably improve the health of the community served and narrow health in equalities by ensuring that the local Director	**Compliant**	**Compliant**

	of Public Health's annual report informs their policies and practices.		
C22c	Healthcare organisations promote, protect and demonstrably improve the health of the community served and narrow health in equalities by making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.	**Compliant**	**Compliant**
C23	Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Framework and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.	**Compliant**	**Compliant**
C24	Healthcare organisations protect the public by having a planned, prepared and, where possible, practiced response to incidents and emergency situations which could effect the provision of normal services.	**Compliant**	**Compliant**

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Appendix 5

Waste Management Issues Briefing

Introduction

There is a distinct HCC core standard for waste management C4e as follows:

"Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment".

The Trust declared not met against this standard for 2007/2008 as a result of findings contained within the Environment Agency (EA) hazardous waste inspection report of the Medway Maritime Hospital issued in late February 2008. Both our Trust and Medway NHS Trust are members of the Kent and Medway 'Total Waste Management' consortium (a collaborative contract agreement of three acute Trusts, Mental Health Trusts and PCT's, over a seven year period, starting in November 2005, with a single service provider-Polkacrest Ltd). This report contained a number of legal requirements to be met (30), as well as a number of recommendations (24).

In addition the Trust were audited by South Coast Audit (November 2007) on its waste management practices and compliance with Health Technical Memorandum (HTM) 07-01 "Safe Management of Healthcare Waste". This report contained a number of recommendations (16).

As a number of the Medway Maritime Hospital requirements applied to this Trust, coupled with the South Coast Audit (SCA) report findings a 'not met' declaration was made. Examples of the main non compliance issues were as follows:

- The healthcare organisation should ensure that waste is properly segregated/stored:
  - Waste compounds do not meet the specification as laid in HTM 07-01 (Safe Management of Healthcare Waste).
  - Offensive waste stream (plaster casts, sanitary towels, nappies etc) not introduced. These were being disposed of in the infectious clinical waste stream.
  - Anatomical/sharps waste not correctly classified for transport i.e. wrong codes being used.
  - Incorrect coloured bags were being used in certain departments.
  - Incorrect disposal of saline bags.
  - Incorrect disposal of pathology waste.
  - Incorrect disposal of general waste in clinical waste.

- The Healthcare organisation should ensure that staff are properly trained and informed in their responsibilities and legal obligations:

    - The Trust Waste policy produced in April 2006 was not updated in line with HTM 07-01 issued in December 2006.

    - Although waste procedures had been updated they had not been issued)

    - The Trust did not have a training package developed for all it's staff e.g. e-learning, induction training.

    - The Trust does not have a dedicated waste manager for act as a single point of contact for all waste management.

In light of the 'not met' declaration the then Deputy Head of Hotel Services led on an initial three month project (later extended) to achieve 'part met' for 2008/2009 and to prepare for the impending EA inspection of the QEQM hospital in July 2008. A detailed waste management action plan was produced to ensure that the tasks and timescales were met. Initially there were a significant number of gaps but by the end of November 2008 the action plan reported a significant improvement in waste management compliance, enabling the Trust to declare 'part met' for 2008/2009. On the 19 December 2008 the Trust received the July 2008 EA report for the QEQM. Within this were 32 requirements and 8 recommendations to be met, the majority by the 31 January 2009 and the remainder by the 31 March 2009. A revised waste management action plan has been produced (attached) to ensure full compliance. The acting Head of Hotel services is leading on delivering to this plan and there is confidence that it will be delivered in the required timeframe.

It is important to note that **all** outstanding action points from the EA and SCA reports must be achieved by the end of March 2009 to enable the Trust to declare a 'fully met' declaration for 2009/2010 (as the criteria within any core standard is compliance for the full financial year). The major challenge is to complete the upgrading of our three waste compounds at the three acute sites (primarily due to planning applications and funding being made available).

APPENDIX 6

Red =Not compliant
Amber =progress being made
Green =complete

Environment Agency Requirements (Absolute Legal Compliance Issue must be complied with)	Location	Issue	Detail of Action	Person Responsible	Comment	Actual Completion Date	Required completion Date
1	Facilities	EA advised of some errors in waste procedures	Ensure EKHUT waste procedures are updated as detailed	Deputy Head of Soft FM	Completed and revised in December 2008. Issued to wards in December 2008 and January 2009.		31st January 2009
2	Pharmacy	Pharmacy staff unclear on disposal of sharps	Pharmacy - Ensure that a procedure is implemented for disposal of unused, out of date sharps and that this is disseminated	Deputy Head of Soft FM/ Pharmacy	Posters were in place along with procedural guidance at time of inspection. There was a lack of consistent understanding by staff of use of sharps bins that can easily be addressed		31st January 2009
3	Ward - Cheerful Sparrows / Trust wide	Syringes were being placed in pharmi bins which are for medicines only	Wards - Ensure that a procedure is implemented for disposal of unused, out of date sharps and that this is disseminated	Deputy Head of Soft FM / Nursing/Medical Director/ all ward staff	Posters were in place by sharps bins . The issue appeared to be due to doctors not adhering to the posters		31st January 2009
4	Ward - Cheerful Sparrows / Trust wide	EA advise disposal of empty alcohol gels in general waste (or orange clinical waste bags) is illegal.	The hospital should review their procedures for disposal of alcohol gel bottles and ensure that these are followed	Deputy Head of Soft FM / Nursing/Medical Director/all ward staff	Waste procedures around alcohol gel disposal are being revised		31st January 2009
5	Ward - Cheerful Sparrows / Trust wide	Disposal of non-infectious clinical waste in orange bags	The hospital should review their procedures for disposal of intravenous products and ensure that these are followed	Deputy Head of Soft FM	An offensive waste stream has been introduced at QEQM since the EA inspection and waste procedures revised and updated.		31st January 2009
6	Ward - St Augustine's / Trust wide	General waste (card, paper) placed in labelled clinical waste bins	The hospital should ensure that their procedures for segregating different categories of hazardous waste and non-hazardous waste	Deputy Head of Soft FM / Nursing/Medical Director/ all ward staff	99% of all bins are labelled as to use and have been for over 5 years. They are also colour coded. Written procedures have been in place regarding disposal of clinical waste.		31st January 2009
7	Radiology	Silver cartridges are removed by staff to KCH without waste consignment note or licence	Ensure that silver cartridges are transferred with an accompanying hazardous waste consignment note to an appropriately permitted site	Deputy Head of Soft FM/ Radiology	Future collections will be made directly from the QEQM.		31st January 2009
8	Radiology	Glass bottles that contained medicines were being recycled. EA advice is illegal.	The hospital should review their procedures for the disposal of medicinally contaminated glass bottles and ensure that these are followed	Deputy Head of Soft FM/ Radiology	Waste procedures have been updated.		31st January 2009
9	Radiology - Trustwide	General waste (sweet wrappers) placed in sharps bins	The hospital should ensure that their procedures for segregating different categories of hazardous waste and non-hazardous waste	Deputy Head of Soft FM/ Radiology/all staff	Staff not adhering to waste procedures		31st January 2009
10	A&E	No evidence of list of Cytotoxic and cytostatic medicines	Ensure that Cytotoxic and cytostatic pharmaceuticals are readily identifiable and disposed of correctly	Deputy Head of Soft FM/ Pharmacy/A&E	Pharmacy advised lists were provided to all departments prior to inspection		31st January 2009
11	A&E	Syringes were being placed in pharmi bins which are for medicines only	Pharmacy - Ensure that a procedure is implemented for disposal of sharps and that this is disseminated	Deputy Head of Soft FM / Nursing/Medical director/all A&E staff	Posters on wards. E-mail communication. Written waste procedures and policy provided prior to inspection.		31st January 2009
12	A&E	General waste (sweet wrappers and syringe wrappers) placed in sharps bins	The hospital should ensure that their procedures for segregating different categories of hazardous waste and non-hazardous waste	Deputy Head of Soft FM / Nursing/Medical director/all A&E staff	Bins are labelled. Waste Procedures were issued		31st January 2009
13	Dentaline	How do they dispose of amalgam waste?	Establish how waste from Dentaline is managed and disposed of and report this to the Environment Agency. Ensure that procedures are in place to correctly identify, classify and segregate these wastes.	Deputy Head of Soft FM	Dentaline to be contacted and their waste procedures and documentation sourced.		31st March 2009

14	Theatres	Small items of anatomical waste are placed in orange clinical waste bags which are sent for alternative treatment	Ensure all anatomical waste is correctly segregated for incineration.	Deputy Head of Soft FM	EA to be contacted with regard to Trust waste procedures which requires all recognisable anatomical waste to be placed in rigid containers for incineration.		31st January 2009
15 and 17	Theatres	General waste (hair net and paper towels, wrappers) placed in sharps bins	The hospital should ensure that their procedures for segregating different categories of hazardous waste and non-hazardous waste	Deputy Head of Soft FM / Nursing/Medical director/all Theatres staff			31st January 2009
16	Theatres	No evidence of list of Cytotoxic and cytostatic medicines	Ensure that Cytotoxic and cytostatic pharmaceuticals are readily identifiable and disposed of correctly	Deputy Head of Soft FM/ Pharmacy/Theatres	Pharmacy advised lists were provided to all departments prior to inspection		31st January 2009
18	Pathology	Chemical bottles incorrectly disposed	Ensure chemical bottles are correctly segregated into correct containers	Deputy Head of Soft FM/ Pathology			31st January 2009
19	Pathology	Flammable and corrosive chemicals kept less than 3 metres apart	Keep all incompatible chemicals separate, and store them appropriately.	Deputy Head of Soft FM Services/Pathology	A collection of unwanted chemicals was organised in September 2008 including QEQM Pathology	Sep-08	31st January 2009
20	Clinical waste Compound	Bins with inoperable locks	Waste bins need working locks to ensure that there is no general access to their contents while in public areas. Containers and bags should be clearly labelled and properly sealed. Unused packaging should be disposed of in general waste with labels removed or obliterated.	Deputy Head of Soft Fm services/Medirest	Written memo to Medirest Contract Manager. Medirest contract PMPM. Key Performance Indicators. Bin tagging		31st March 2009
21	Clinical waste Compound	Loose unbagged clinical waste	Waste should not be placed loose into bins – it should always be placed inside a bag or box first.	Deputy Head of Soft Fm services/all staff/Medirest	Written waste procedures		31st January 2009
22	Battery waste storage container	Lead acid and non hazardous batteries mixed	Hazardous and non-hazardous batteries must be kept segregated. Lead/acid batteries should be stored upright to minimise the risk of spills, even if in a secondary container.	Deputy Head of Soft FM			31st January 2009
23	Light bulbs storage	Fluorescent tubes mixed with non-hazardous light bulbs	Hazardous and non-hazardous lighting must be kept segregated.	Estates Manager/ deputy Head of Soft FM Services			31st January 2009
24	Segregation of electrical waste		Waste electrical equipment should be checked to determine if it contains any hazardous components which will make the complete item hazardous waste. Disposal arrangements for IT equipment and its transfer to HIS need	Deputy Head of Soft FM Services/ HIS	Review of electrical waste storage into hazardous and non-hazardous. Discuss with HIS regarding disposal arrangements		31st March 2009
25	Spencer Wing	Disposal of non-infectious clinical waste in orange bags	The hospital should review their procedures for disposal of intravenous products and ensure that these are followed	Deputy Head of Soft FM / Spencer Wing	An offensive waste stream has been introduced at QEQM since the EA inspection and waste procedures revised and updated.		31st January 2009
26	Spencer Wing	alcohol gel disposed of with general waste	The Spencer Wing should assess whether of not the Hydrex hand gel is a hazardous waste and make appropriate arrangements for disposal if necessary.	Deputy Head of Soft FM / Spencer Wing	Waste procedures around alcohol gel disposal are being revised		31st March 2009
27	Spencer Wing	Fluorescent tube found in general waste	Facilities are required for keeping different categories of hazardous waste, such as fluorescent tubes, separate from other waste.	Deputy Head of Soft FM / Spencer Wing	Waste procedures have been issued to Spencer Wing		31st January 2009
28	Consignment Notes	Forms used by contractors not always compliant	Staff managing hazardous waste contracts should ensure that the format of the consignment notes used for each contract meets the requirements of the Hazardous Waste Regulations.	Deputy Head of Soft FM			31st March 2009
29	Consignment Notes	Training of staff	All staff supervising waste collections should be familiar with the format of hazardous waste consignment notes and only sign them when they are sure that all the required details have been completed and are correct.	Deputy Head of Soft FM / Medirest			31st March 2009

30	Consignment Notes	Notes are held at Ross House	Arrangements need to be in place for continuous access at the hospital to the producer copies of the hazardous waste consignment notes for at least three years from the date raised. The Environment Agency now accepts electronic access if there is still a requirement to hold the original copy at another location.	Acting Head of Facilities/ Deputy Head of Soft FM			31st March 2009
31	Consignment Notes	Dual registration of hospital as a hazardous waste producer	Staff disposing of waste should be aware of the hazardous waste arrangements to avoid registering the hospital more than once as a produce	Deputy Head of Soft FM	Deputy Head of Soft FM to discuss with EA as believed companies are dual registering		31st March 2009
32	Consignment Notes	Correct completion of paperwork and correct number of documents	The member of the hospital staff supervising the waste collections should ensure that all details are correct and there are the correct number of copies (3 for hazardous waste) in respect of duty of care or hazardous waste transfer notes before signing them. Care should be taken to ensure that confusion is avoided by only using one	Deputy Head of Soft FM / Medirest	Three part copies of consignment notes in use at QEQM, KOCH and WHH		31st March 2009

Environment Agency Recommendation (Best Practice)			Detail of Action	Person Responsible	Comment	Actual Completion Date	
1	Trust wide	Cytotoxic / cytostatic drugs are not labelled. Nurses have to refer to a list to identify	Consider implementing a procedure where the pharmacy identifies and labels all cytostatic drugs that are used in the hospital	Director of Pharmacy			
2	Viking Day	One bin was found without a label identifying its purpose	Ensure all bins are labelled to aid correct waste segregation	Deputy Head of Soft FM Services	The clinical waste bin without the label in Viking Day was relabelled. 99%+ of bins in the Trust are labelled. It has to be borne in mind that Medway maritime did not label any bins at the time of their inspections whereas this has been standard practice in our Trust for a number of years.	Jul-08	
3	A&E	Outside parties dispose of their waste in A&E	Ensure that procedure are in place to manage waste that may be brought into A&E by external parties (such as paramedics and police) and that those parties are made to follow those procedures	?	Posters are on site and bins are labelled. There is a major risk with the needle exchange scheme. There have been three sharps incidents since September (1 at WHH A&E, 2 at Buckland minor Injuries due to drug users misdisposing of sharps in sani bins resulting in a needle stick injury at Buckland		
4	Pathology	Clean cardboard boxes are disposed of in general waste	Segregate uncontaminated packaging for recycling wherever possible	Deputy Head of Soft FM Services/Pathology	Extra recycling bins were provided subsequent to the inspection	Jul-08	
5	Pathology	EA advise that Pathology should not be requiring incineration of their clinical waste as it is already autoclaved	Treated laboratory waste could be disposed of as offensive/hygiene waste (tiger bags) if the autoclave meets STAATT level IV no further treatment of waste should be required.	Deputy Head of Soft FM Services/Pathology	EA to be invited to discuss with Pathology		
6	Pathology	Pathology use yellow lidded sharps boxes for phlebotomy waste	Please ensure that internal procedures are all updated - alternative treatment (i.e. orange sharps boxes) is suitable for phlebotomy sharps.	Deputy Head of Soft FM Services/Pathology	Deputy Head of Soft FM to discuss with Senior Biomedical Scientist		Orange for phlebotomy
7	Pathology/ trust wide	Unwanted/unused chemicals	Dispose of any unused/unwanted chemicals to an appropriately authorised site as soon as possible.	Deputy Head of Soft FM Services	A collection of unwanted chemicals was organised in September 2008 including QEQM Pathology	Sep-08	
8	QEQM Hospital	Separate clinical waste collections for Spencer Wing and Thanet Mental Health Unit	It may be more efficient if all the waste from the different units at the site could be bulked up by type and a single collection made for each type.	Deputy Head of Soft FM Services/ Spencer Wing. Kent & Medway Waste Manager	Discussion with Spencer Wing already underway prior to report		

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Green =complete