THE STATE HOSPITALS BOARD FOR SCOTLAND

# Infection Control Annual Report for

# Clinical Governance Group

# 1 April 2020 – 31 March 2021

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| Approval Group | Clinical Governance Committee | |
| Effective Date | 6th May 2021 | |
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| Responsible Officer (eg SMT lead) | Director of Nursing and AHPs | |

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## 1. Core Purpose of Committee

The State Hospitals Board is responsible for the infection prevention and control (IPC) within its services to minimise the risk of healthcare associated infections to patients, staff, carers, volunteers and visitors. The State Hospital is not considered to be high risk for infection or cross infection; however the employment of evidence based protocols to assist clinical practice to ensure a clean and safe environment is an integral part of our overall clinical governance agenda. In the event of an outbreak regardless of the virus the attack rate is viewed to be significant given the 'closed' environment.

The Infection Control Committee (ICC) promotes the highest standards of practice within the organisation for infection prevention and control, ensuring compliance with the Healthcare Improvement Scotland (HIS) Healthcare Associated Infection (HAI) 2015 standards. The ICC supports the development, implementation and ongoing monitoring of infection control activity throughout the State Hospital in line with the Infection Control Programme of Work.

## 2. Current Resource Commitment

There is one Senior Nurse for Infection Control to oversee all aspects of infection control within The State Hospital.

## 3. Summary of Core Activity for the last 12 months

A full list of audits can be found within the quality assurance section.

### i. Antimicrobial Management

Inappropriate use of antibiotic medication can have a negative impact on individual levels of resistance and vulnerability.

The State Hospital continues with its Service Level Agreement with NHS Lanarkshire for the provision of sessional input from an Antimicrobial Pharmacist (who is also a member of the State Hospital Infection Control Committee).

The NHS Lanarkshire Empirical First Line Antibiotic Policy for Primary Care has been adopted for use by the State Hospital. The Infection Control Committee monitors the results of the audits led by the Antimicrobial Pharmacist in conjunction with members of the Clinical Effectiveness Department.

The State Hospital is represented in the Lanarkshire Antimicrobial Management Committee by our Antimicrobial Pharmacist.

Currently the Hospital is compliant with all National / Local Antimicrobial Prescribing Policy and Guidance, with a sustained minimal spend per quarter on such drugs. Antimicrobial use within The State Hospital is monitored by quarterly retrospective analysis and biennial audit of compliance with national guidance.

### ii. Outbreaks / DATIX Incidents

The State Hospital uses the DATIX reporting system to monitor and examine infection control incidents; this will highlight concerns and emerging trends.

Infection Control Incidents – 01/04/2020 to 31/03/2021

| Infection Control Incidents = Total 55 | | |
|---|---|---|
| Type | Number | Percentage of Total |
| Clinical Waste | 40 | 71.4% |
| Exposure to Bodily Fluids | 2 | 3.6% |
| Needle stick | 0 | - |
| Outbreak | 1 | 3.6% |
| Patient Suspected Contagious Illness | 9 | 16.1% |
| Staff Suspected Contagious Illness | 1 | 1.7% |
| Other | 2 | 3.6% |

Of the Clinical Waste Incidents, there was 36 related to laundry. The remaining 4 were split between PPE (Covid PPE slippage) and medication waste (inappropriate items in medicinal waste bin).

Both incidents of Exposure to Bodily Fluids were by spit.

The outbreak incident related to physical distancing within ward systems.

All Patient Suspected Contagious Illness incidents were related to either vomiting, diarrhoea or both.

The one incident for Staff Suspected Contagious Incident was COVID-19 related.

Other incidents were surrounding PPE and social distancing not being followed.

### iii. Seasonal Flu Vaccination Programme

The State Hospital continues to offer seasonal flu vaccination to both patients and staff. This year due to Covid restrictions and the impracticality of holding drop-in clinics, a peer vaccinator model was introduced. Anecdotal feedback indicated that this model enabled more staff to avail themselves of the vaccine as they didn't have to leave their ward. However, it could also be argued that the reason for the increase in uptake was due to COVID and the associated risks. The vaccinators were from all hubs which meant that they were able to vaccinate at various times throughout the day, including night shift and weekends.

No individual letters were sent and there was no raffle which was attributed to the increase in uptake last year.

| | **2017/2018** | **2018/2019** | **2019/2020** | **2020/21** |
|---|---|---|---|---|
| Total staff vaccinated | 243 (36.5%) | 231 (35.8%) | 290 (43.9%) | 380 (56.1%) |
| Direct patient care | 31.8% | 31.3 % | 186 (45.7%) | 227 (52.9%) |
| Nursing staff | 25.4% | 26.8% | 140 (41.8%) | 160 (45.7%) |
| Non Direct Clinical care | 40.4% | 42.5% | 103 (40.7%) | 153 (61.7%) |

The population of patients at the time the flu vacs were given out was 110.

The percentage of vaccinations among patients has shown a slight increase from 66% (2019) to 69% (2020), 70 patients. We have 32 patients who fall into the additional “at risk” group, of this 24 patients (75%) consented to flu vaccination. There were 5 patients over 65, of which 4 patients (80%) consented to flu vac. The under 65 group who are in the “at risk” population is 27 patients, of which 20 consented to flu vac (74%).

### iv. Review / Development of Policies and Guidance

The State Hospital Board continues to use the NHS National Infection Control Manual supplemented by its own electronic infection control policies and guidance which manages local issues. Policies are influenced by those developed and approved by NHS Lanarkshire Infection Control Committee (which the SNIC attends) and emerging information received from Health Protection Scotland. In light of the Vale of Leven recommendations all infection control policies are reviewed biennially or earlier if legislation / emerging guidance dictate. An Equality Impact Assessment & Data Protection Impact Assessment (DPIA) for the suite of infection control policies was approved in March 2021 and will be reviewed annually and as policies renew. There are two policies which have passed their review period. Formal extensions have been agreed both by the ICC and Policy Approval Group. The rationale being that there have been changes in Covid practice which impact on policy developed and this guidance is in consultation at present (Control of Infection in Dentistry and the Safe Management of Waste (including clinical waste).

### v. COVID19 Activity

The last 12months have been challenging due to Covid19. In March 2020 (first wave) a Covid support team was established consisting of:

- **i.** Senior Nurse for Infection Control
- **ii.** Risk Management Team Leader (full time until position became vacant in December 2020)
- **iii.** Human Resources advisor
- **iv.** Admin support (5days)
- **v.** Operational Nursing resources

The Covid19 support team provided a 7day support service with the Senior Nurse for Infection Control and Risk Management Team Leader providing an on call service. The on call and 7day service provided by the Senior Nurse for Infection Control and Risk Management Team Leader was in place until October 2020. From January 2021 the Risk Management Team Leader position has been vacant. This has proved to be a considerable deficit in the support team.

**State Hospital Covid-19 Testing data**

The Covid19 support team act on symptoms rather than wait until a positive result is obtained. This has enabled quick identification of contacts and interventions which has contributed to low infection rates.

Of all State Hospital staff (N=650), 265 staff tests have now been conducted. 42 staff have tested positive for Covid-19, with 223 testing negative.

**State Hospital staff tests by result, and as percentage of total staff population**

| | Number | % of Total Staff population (n=650) |
|---|---|---|
| Staff tests | 265 | 38% |
| Positive test results | 42 | 6% |

| | | |
|---|---|---|
| Negative test results | 223 | 32% |

It should be noted that staff testing figures are only disaggregated to directorate level, rather than department given the very small staff numbers in some departments, and the subsequent possibility of staff members being identified through the data provided.

**Staff tests and positive test results by directorate**

| Directorate | Covid-19 tests undertaken | Positive Covid-19 test results |
|---|---|---|
| Nursing incl. Clinical Admin, AHPs and Skye Centre | 157 | 31 |
| Security, Estates & Facilities | 73 | 5 |
| Medical, Psychology & Forensic Network | 9 | 0 |
| Other | 25 | 6 |
| Total | 265 | 42 |

It is interesting to note that there were no positive staff cases from April – August 2020. There was a gradual increase from August to December with the peak in January/February, this is representative of the national presentation.

**Number of patient tests, positive and negative results by month with cumulative total.**

| Month/Week | Mar | April | May | Jun | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | Tot |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Tests | 11 | 10 | 4 | 7 | 17 | 7 | 8 | 10 | 14 | 9 | 57 | 60 | 28 | 4 | 246 |
| Asymptomatic tests | 2 | 2 | 2 | 7 | 14 | 4 | 6 | 5 | 12 | 8 | 52 | 59 | 26 | 4 | 215 |
| Positive results | 7 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 2 | 0 | 0 | 14 |
| Negative results | 4 | 9 | 4 | 7 | 17 | 7 | 8 | 10 | 14 | 9 | 53 | 58 | 28 | 4 | 232 |

There has only been 1 patient who has required to be treated out with The State Hospital due to complications of Covid19.

In January 2021 voluntary lateral flow device testing was introduced for staff who have direct/social interactions with patients. The turnaround time from request by the Scottish Government and implementation was 4 weeks which coincided with Christmas holidays and the staff vaccination program. The uptake of the lateral flow device testing is monitored on a weekly basis by the Scientific and Technical Advisory Group (STAG).

**Covid Vaccinations**

In December 2020 The State Hospital embarked on the Covid vaccination programme as per JCVI priority groups. This was co-ordinated by the SNIC supported by Lead Pharmacist, Senior Charge Nurse and Business Support Manager. A cohort of experienced vaccinators (5 State hospital staff plus 2 staff from Occupational Health).

**Staff and Patient Covid-19 Vaccination**

| | |
|---|---|
| Staff Vaccinated – 1st Dose | 553 |
| Percentage (from 630 eligible staff) | 87.8% |
| Number of staff declined vaccine | 51 (+22 outstanding and 4 vaccinated elsewhere) |

| | |
|---|---|
| Patients Vaccinated – 1st Dose | 13 (Pfizer) 87 (AZ) |
| Number of patients declined vaccine | 2 (Pfizer) 13 (AZ) |
| | |
| Staff Vaccinated – 2nd Dose | 498 |
| Percentage (from 553 eligible after 1st dose) | 90% |
| Number of staff declined vaccine | 48 |
| Patients Vaccinated – 2nd Dose | 10 (Pfizer) |
| Number of patients declined vaccine | 2 (Pfizer) |

This vaccination program was an intense program of work which relied on staff flexibility as the date of vaccine receipt changed almost daily.

**Covid outbreaks**

During March/April 2020 there were 5 outbreaks identified in the following wards

- Arran 1
- Arran 2
- Iona 3
- Lewis 2
- Mull 1

With 8 patients confirmed as positive at this time.

In January 2021 there was an outbreak in

- Lewis 3 (4 positive patients)
- Iona 2

There were another 2 patients who subsequently tested positive in February 2021 (Iona 2 and Iona 3).

The last positive patient was identified 15 February 2021.

**Face Fit Testing**

The State Hospital had undertaken a Face Fit testing program from April – October 2020, which enable staff to undertake AGPs safely. Primarily these activities are CPR (specifically airway management as part of the CPR continuum) and some dental procedures. Staff would also be required to wear FFP3 masks if they are in the presence of an AGP.

Advice received from the previous Risk Management Team Leader and Health & Safety Advisor is that the masks that are currently in use within the NHS Scotland are reaching an expiry date (March 2021) and that there is no replenishment of this stock. In addition the 3M 1873v will expire in June 2021.

The FFP3 masks that are effected are the 3M 1863 (118 staff fitted) and 3M 8833 (59 staff fitted). A re-fit program for the above masks commenced in February (3 weeks) and then April (1 week), at time of writing 49 staff are outstanding.

**Lateral Flow Testing**

## 4. Comparison with Last Year's Planned QA/QI Activity

The table below indicates progress made against the future areas of work for 2020/21.

| Recommendation | Timescale | Progress |
|---|---|---|
| To improve on hand hygiene audit submission and improve compliance | Partial completion | Hand hygiene submission and compliance has been sporadic throughout the year. A Covid audit tool has been developed and implemented from November 2020; however, monitoring of this has been poor due to the resource pressures on the SNIC.<br><br>From March 2021 the Clinical Effectiveness Department have agreed to monitor audit submissions. Activity will be noted at the quarterly ICC. |
| To increase the seasonal flu vaccinations among front line staff | Completed | A significant improvement in vaccination uptake on previous year. The introduction of peer vaccinators may have been attributed improvement. |

## 5. Performance against Key Performance Indicators

The 2 key indicators to support the high infection control standards

- The overall level of cleanliness of the Hospital (as indicated by National Compliance for Domestic Monitoring and by HEI inspections)
- No significant outbreaks in routine IC organisms

The State Hospital's current record on both indicators suggests that staff are responding positively and complying with policy and guidance.

## 6. Quality Assurance Activity

### i. Audit

Clinical audit is a proven method of quality improvement. It gives staff a systematic way of reviewing their practice and making improvements in patient care using quality improvement methodology. Our audit results demonstrate sustained improvement in practice and motivate staff and patients to maintain this improvement.

The State Hospital used a local audit database which enabled all infection control audit activity to be held centrally and action plans to be published. However, as the migration and update to the IT systems a new database has yet to be developed.

The Infection Control audits managed by the SNIC (Appendix 3) are predominately dictated by the National Standard Infection Control Precautions (SICPs) Audits. In 2017, the HIS Improvement Team (HISIT) for HAI assisted the SNIC to review the audit program to ensure that a robust audit system was in place that complied with the HAI Standards. This review followed the Quality Improvement model using small tests of change, and involved incorporating Infection Control audits with the Health and Safety eControl Book, namely the Healthcare Waste and the Workplace Inspection Checklist. Both of these audits are now undertaken by the Senior Charge Nurse (Control Book Holder) or their deputy with quality

assurance check by the SNIC on a quarterly basis. Due to additional pressure on the SNIC quality assurance checks have not been completed during this period.

There have been no unannounced inspections from the Healthcare Environment Inspection Teams or Environmental Health Officer during this time period. The last inspections being 2016 and 2019 respectively.

The main activities from the audit programme include:

***Clinical Waste and Sharps Audit***
The SNIC continues to work alongside the Risk Management Team Leader to ensure that these audits are submitted and reviewed by the eControl book holder.

In quarter 3 the wider use of face masks was introduced across the hospital which requires all areas to now hold clinical waste. Communication has been sent to the eControl book holders to advise them of the need to complete this checklist and Risk Management department will continue to monitor the completion.

| Timeframe | % audit submitted on time |
|---|---|
| Quarter 1 | 66% |
| Quarter 2 | 94% |
| Quarter 3 | 78% |
| Quarter 4 | 78% |

***Infection Control Environmental Audits & Cleaning Services***
In addition to the changes to the healthcare waste audits the infection control environmental audits were merged with the Health and Safety eControl book. This merge has proven to be successful with minimal non completions. The Risk Management Team will continue to report on non submissions with the SNIC reviewing compliance data.

The outstanding actions pertaining to the Skye Centre (PLC) & Islay relate to estates issues that have been outstanding from last year. The Estates department are aware of the issues. The significant water leaks and subsequent water damage caused by heavy rain was a result of latent defects. Attempts to rectify the defects in the PLC have been made however the problem of water leaks is still present. There is some outstanding remedial damage to paintwork etc which requires attention. The Infection Control Committee continues to monitor the situation on a quarterly basis. No update as non-essential work has be delayed due to restricted access to the hospital during the last 12months.

The housekeeping department continue to undertake the NHSScotland National Cleaning Services Specification monitoring which provides the assurance that every room (as a minimum requirement) is audited not only for cleanliness but also estates and user issues on an annual basis. The audit results are submitted to Health Facilities Scotland monthly and the Infection Control Committee quarterly. The quarterly audits results have continued to be in the ‘green’ which indicates a result of 90% or above. These audit scores are the consistent with last year. On investigation it would appear that staff sickness has been the cause for drops in performance. The SNIC and the Housekeeping and Linen service manager undertook risk assessment in 2020 which enable the hospital to focus in the clinical areas to ensure that these areas are prioritised for cleaning. Cleaning frequencies have been increased to twice daily cleans with Actichlor as an additional control measure for reducing the risk of Covid19 within the hospital.

Acknowledgement should be given to the Housekeeping department who have responded effectively and positively to the additional cleaning requirement throughout the last year.

HAI SCRIBE documentation was reviewed by Health Facilities Scotland in 2015 and we will continue to use this for any new or remedial structural or maintenance actions that are identified within the hospital. HAI SCRIBE has been completed as part of the installation of the internal security cameras.

***Bed Mattress Audit***

It is known that damaged mattresses can harbour micro-organisms and be a potential cause of cross-infection. The SNIC continues to undertake an annual quality assurance audit of all mattresses across the hospital.

The bed mattress audit is undertaken to ensure compliance with national guidance from the Medicines and Healthcare products Regulatory Agency (MHRA) relating to all types of bed mattresses (MDA/2010/002). The condition of patient mattresses is also a key area of inspection by the HEI team.

There is a guidance document which was produced by the SNIC and in conjunction with the Housekeeping and linen services manager in 2018 which outlines the procedure for both housekeeping and nursing staff; to ensure that the bedroom is fit to receive a new patient. This appears to be working well with no complaints received from patients, housekeeping, ward staff or SNIC

The mattress audit was due to be undertaken in March 2020; however due to the Covid19 this has been deferred on several occasions.

***Blood Borne Virus (BBV) Audits***

**BBV Admission Assessment**

When a patient is admitted to The State Hospital a BBV Admission Risk Assessment should be completed on the day of admission. The information can either be obtained directly from the patient or from past notes. From 1 August 2019 to 31 July 2020, 34 patients were admitted to The State Hospital.

From the table below we see an 8.5% decrease in the number of BBV admission assessments being carried out. Of the 5 completed (x4 Iona 1; x1Mull 2).

| Was BBV Admission Assessment carried out | 16/17 | | 17/18 | | 18/19 | | 19/20 | |
|---|---|---|---|---|---|---|---|---|
| Yes | 28 | 87.5% | 25 | 92.6% | 30 | 93.8% | 29 | 85.3% |
| No | 4 | 12.5% | 2 | 7.4% | 2 | 6.3% | 5 | 14.7% |

On the 29 occasions where the BBV Admission Assessment was completed 19 (65.5%) were completed on the day of admission, this is an increase of 22.2%.

| Number of days after admission the BBV assessment was carried out | 16/17 | | 17/18 | | 18/19 | | 19/20 | |
|---|---|---|---|---|---|---|---|---|
| Day of admission | 18 | 64.3% | 15 | 60.0% | 13 | 43.3% | 19 | 65.5% |
| 1 day after admission | 5 | 17.9% | 5 | 20.0% | 7 | 23.3% | 4 | 13.8% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 2 days after admission | 4 | 14.3% | 2 | 8.0% | 2 | 6.7% | 1 | 3.4% |
| >2 days after admission | 1 | 3.6% | 3 | 12.0% | 8 | 26.7% | 5 | 17.2% |
| Total | 28 | | 25 | | 30 | | 29 | |

The patients whose assessments were carried out >2 days after admission were as follows

| | | |
|---|---|---|
| Patient 1 | Arran 1 | 3 days |
| Patient 2 | Arran 1 | 9 days |
| Patient 3 | Arran 2 | 3 days |
| Patient 4 | Lewis 1 | 4 days |
| Patient 5 | Mull 2 | 5 days |

**BBV Annual Assessment**

Each year the BBV Annual Assessment should be completed for each patient. The information can either be obtained directly from the patient or from past RiO entries.

On 27 August 2020 each patient's BBV information was checked on RiO. At the time of the audit there were 119 patients in The State Hospital. The audit shows that 64% of patients had an Annual BBV Assessment form completed on RiO – this is a 14% decrease on the period 18/19. This drop can partly be explained by the increase in not applicable – this is due to a larger number of patients having shorter admissions to TSH. In 8 cases the patient did not have an Annual BBV Assessment form and 35 were not applicable as their admission BBV assessment was still in date.

| Has the Annual BBV Assessment form completed on RiO | 16/17 | | 17/18 | | 18/19 | | 19/20 | |
|---|---|---|---|---|---|---|---|---|
| Yes | 66 | 59.5% | 67 | 63.2% | 78 | 78% | 76 | 64% |
| *Yes with inapplicable stripped out | 66 | 77.6% | 67 | 75.3% | 78 | 91.8% | 76 | 90.5% |
| No | 19 | 17.1% | 22 | 20.8% | 7 | 7% | 8 | 7% |
| Inapplicable (admissions/discharge) | 26 | 23.4% | 17 | 16.0% | 15 | 15% | 35 | 29% |
| Total | 111 | | 106 | | 100 | | 119 | |

The audit also showed that of the 119 patients 24 (20.2%) of patients did not have an up to date BBV Assessment – Annual or Admission. This is an increase from 19% for the period 18/19.

BBV bloods now form part of the patient's annual health check. The audit shows that currently 69% of patient's have had their BBV bloods tested – this is a 22% decrease on the period 18/19

| Has patient been tested? | 16/17 | | 17/18 | | 18/19 | | 19/20 | |
|---|---|---|---|---|---|---|---|---|
| Yes | 82 | 73.9% | 96 | 90.6% | 91 | 91% | 82 | 69% |
| No | 24 | 21.6% | 10 | 9.4% | 7 | 7% | 36 | 30% |
| Patient declined | 5 | 4.5% | - | - | 2 | 2% | 1 | 1% |
| Total | 111 | | 106 | | 100 | | 119 | |

### *Hand Hygiene Compliance Audits*

The hands of staff are the principal method by which micro-organisms are transmitted to patients. Hand washing is widely acknowledged as being one of the most important ways of preventing the spread of infection within healthcare settings.

Although hand hygiene audits are to be completed on a monthly basis this has not been actively monitored by the SNIC. In November 2020 a covid practice audit was developed and implemented. This was to be undertaken in conjunction with the existing hand hygiene audits. From 01 March 2021 the clinical effectiveness department have agreed to support the monitoring of this until additional resources are in place to support the SNIC.

### ii. Education and Communication

Staff education in the general principles of infection control is of great importance. The hospital aims to sustain the low incidence of HAI and manage BBV Infection effectively and ensure safe working practices. The Training & Professional Development Manager reports to the ICC quarterly on all infection control training. Infection Control training is monitored by the Learning Centre and reported directly to line managers. Quarterly reports are presented to the Infection Control Committee.

An introduction to Infection Control continues to feature as part of the corporate Health and Safety Training Programme for clinical / non clinical staff, due to Covid there were no courses delivered as this is a face to face method of teaching. The topics covered include the infection control structure, BBV awareness, hand hygiene, the management of patients with loose stools the management of clinical waste and Safe Management of Linen.

Education continues to be an essential part of the role of the SNIC by the development and review of online learning material and the provision of an informal in-service education whenever there is a clinical need; this often follows a request from wards or departments. During the last year the focus has been on the correct use of PPE

There have been minimal IC campaigns during the year; the main focus has been promoting safe practice during covid and the uptake of the vaccination program.

### Scottish Infection Prevention and Control Education Pathway (SIPCEP)

The Senior Management Team, in August 2017 requested that all staff must complete four core modules.

| Module | Completions | | | |
|---|---|---|---|---|
| | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| Why Infection Control Matters | 301 (44.9% of target) | 264 (39.3%) | 105 (15.8%) | 68 completed in year 95.9% of target |
| Breaking the Chain of Infection | 362 (54% of target) | 233 (34.7%) | 84 (12.6%) | 67 completed in year 96.7% of target |
| Hand hygiene | 315 (47% of target) | 266 (39.6%) | 96 (14.4%) | 68 completed in year 97% of target |
| Respiratory and Cough hygiene | 308 (45.9% of target) | 263 (39.2%) | 103 (15.5%) | 66 completed in year 96.4% of target |

| Module | Completions | | | |
|---|---|---|---|---|
| | 2017/18 | 2018/19 | 2019/20 | 2021/21 |
| Safe disposal of waste (inc Sharps) | 165 (35.9% of target) | 179 (37.4% of target) | 104 (21.6%) | 91.4% of target 47 completed in year |
| PPE | 174 (38.9% of target) | 183 (38.2% of target) | 96 (20.4%) | 91.8% of target 43 completed in year |
| Prevention and Management of Occupational Exposure (inc Sharps) | 166 (36.1% of target) | 182 (38% of target) | 104 (21.7%) | 91.6% of target 44 completed in year |
| Blood and body fluid spillages | 201 (45.2% of target) | 176 (36.7% of target) | 82 (17.9%) | 93.7% of target 33 completed in year |
| Safe Management of Care Environment | 120 (30.9% of target) | 155 (32.4% of target) | 87 (23.2%) | 88.8% of target 40 completed in year |
| Safe Management of Care Equipment | 88 (26% of target) | 146 (30.5% of target) | 85 (24.4%) | 88.1% of target 38 completed in year |
| Safe Management of Linen | 120 (30.9% of target) | 161 (33.6% of target) | 83 (20.81%) | 89.3% of target 44 completed in year |
| Patient Placement/ Infection Risk | 92 (27.9% of target) | 140 (29.2% of target) | 84 (24.6%) | 87.9% of target 31 completed in year |

***Royal Environment Health Institute of Scotland (REHIS) Elementary Food Hygiene Training***

Poor hygiene during food preparation and handling procedures can put patients and staff at risk. Harmful bacteria that cause food poisoning can spread very easily and can lead to serious illness or even death.

The ICC approved (supported by the Training and Professional Development Manager) a tailored approach to Food Hygiene Training. This approach will ensure that staff will be trained to a level commensurate with their role.

Occupational Therapists, those in a position of responsibility i.e. Senior Charge Nurses, Charge Nurses and those who are directly involved in food preparation i.e. Catering staff will still require to be trained to the REHIS Elementary Food Hygiene standard. Those who are responsible for the service of food at ward level will be required to complete the online module. In previous years a combination of both face to face and online training sessions depending on the level of need was the preferred method for training; however due to Covid restrictions we introduced a completely online accredited training package. This has been underway from January 2021. Anecdotally this appears to be well received with a good uptake.

| **Module** | **Completions** | | | |
|---|---|---|---|---|
| | **2017/18** | **2018/19** | **2019/20** | **2020/21** |
| Food Safety Module Completions | 38 | 52 | 38 | 24 completions in the year 97% compliance of target group |
| Staff (in target group) who have not completed | 23 | 6 | 13 | 14 |
| REHIS Elementary Food Hygiene | 2 courses scheduled and 0 delivered | 0 Scheduled and 0 delivered | 2 courses scheduled and delivered | 0 courses scheduled, however introduced online in 2021 and 19 staff have completed and passed exam. |
| REHIS Elementary Food Hygiene (total overall) | 44 completions (55.6%) - AHP = 10, Catering = 12, Skye Centre = 2, Nursing = 20 | 37 Completions (46.8% - AHP=6, Nursing=20, Catering=11 | 49 completions (58.3%) - AHP = 11, Nursing = 23, Catering = 10, Skye Centre = 3, PCIT = 2 | Target group is 73 staff<br>17 not completed<br>**76.7% compliance**<br>AHP – 4 completed<br>Nursing – 15 completed<br>Catering - 0<br>Skye - 0 |
| REHIS Elementary Food Hygiene not yet completed | 35 staff still to complete | 42 staff still to complete | 35 staff still to complete | 17 staff still to complete |

***Blood Borne Viruses (BBV) Training Module***

The module is open to all staff but is of particular relevance to clinical staff involved in direct patient care. This is a mandatory module for clinical staff with refreshers being undertaken biennially.

Staff education in the general principles of infection control is of great importance. The hospital aims to sustain the low incidence of HAI and manage BBV Infection effectively and ensure safe working practices. The Training & Professional Development Manager reports to the ICC quarterly on all infection control training. Infection Control training is monitored by the Learning Centre and reported directly to line managers. Quarterly reports are presented to the Infection Control Committee.

An introduction to Infection Control continues to feature as part of the corporate Health and Safety Training Programme for clinical / non clinical staff of which there were 0 courses scheduled due to the pandemic. The topics covered include the infection control structure, BBV awareness, hand hygiene, the management of patients with loose stools, the management of clinical waste and the safe management of linen. Inductions for new staff including students have continued.

| Module | Completions | | | |
|---|---|---|---|---|
| | **2017/18** | **2018/19** | **2019/20** | **2020/21** |
| ***Blood Borne Viruses (BBV)*** | 201 completed this year<br><br>52 staff have never complete | 180 completed this year<br><br>43 staff have never completed.<br><br>70 are overdue their refresher | 228 completed this year<br><br>23 staff have never completed.<br><br>69 are overdue their refresher | 175 completed this year<br><br>20 staff have never completed<br><br>75 staff overdue their refresher. |

***iii. Person Centred Improvement Team/Patient Partnership Group***

The SNIC previously attended the Patient Partnership meetings as required to discuss any Infection Control issues that patients may have. There has been no face to face/video interactions during the last 12 months. Written communication has been developed in conjunction with the Person Centred and Improvement Lead to appraise patients of Covid, the limitations/restrictions in place and also the Covid vaccinations.

***iv. Infection Control Updates***

Infection control updates continue to be disseminated throughout the year. These updates provide information on infection control news and developments, both locally and nationally.

The information is conveyed via the hospital intranet, staff bulletins, Vision magazine and through internal e-mails.

## 7. Quality Improvement Activity

The main focus of the year has been to minimise the risk of Covid transmission therefore some of the improvement activities projected for the year were on hold. However, one area of improvement was:

- Increase in the uptake of flu vaccinations for nursing staff

## 8. Planned Quality Assurance/Quality Improvement for the next year

Although not specifically identified throughout the review period 2020/2021, it has noted through the **Covid-19 Pandemic** that having a single Infection Control Nurse poses a lack of resilience in this is area. In particular, managing routine IC practice and audit. This is not unique to The State Hospital and in other health board's audit activity has decreased. Recruitment this department will be a future service development.

## 9. Identified issues and potential solutions

Challenges for incoming year

- To improve on hand hygiene audit submission and compliance across the organisation
- To improve on Covid/PPE audit submission and compliance across the organisation
- To sustain an increase in the seasonal flu vaccination uptake among front line staff
- To consider innovative ways to increase compliance with infection control training
- To monitor DATIX with specific attention being placed on items being coded as clinical waste
- To review all audit tools for infection control over the next two years.

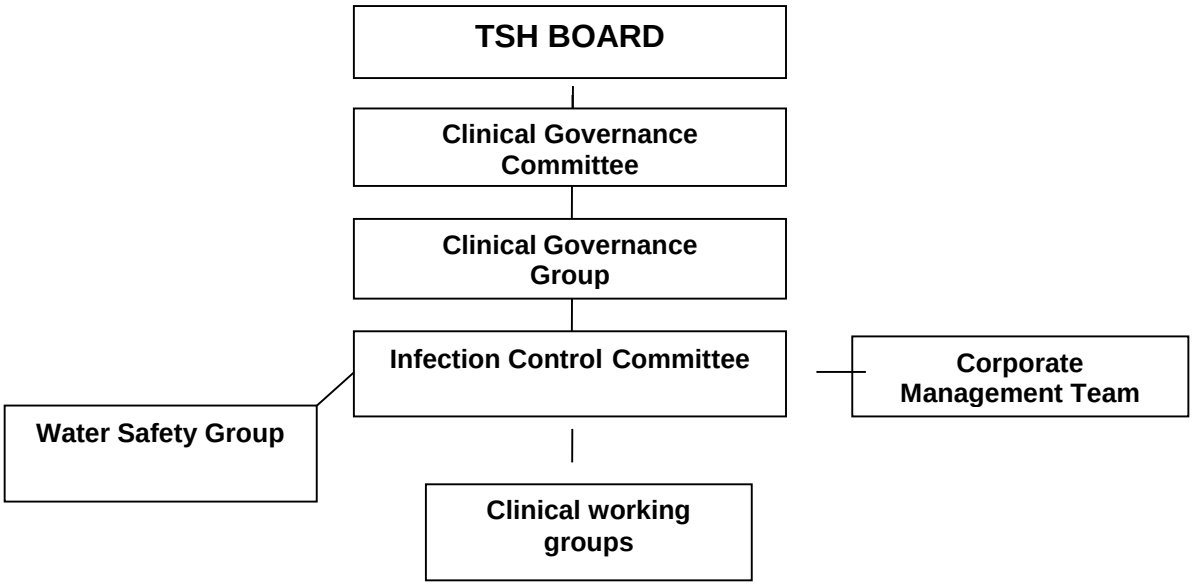
## 10. Next Review Date

The next Infection Control Annual Report will be submitted to the Infection Control Committee and Clinical Governance Committee in May 2021.

**Acknowledgements**
The last 12months have been extremely challenging for us all and it is important to take this opportunity to recognise the commitment to staff in protecting our patients. I would like to express a special thanks to Dr Gillespie, the Procurement Department, Estates and Housekeeping Services and the Vaccination team who have been an invaluable support throughout this time.

## 1. Governance Arrangements

The Annual Report and Programme of Work highlight the activities and accomplishments relating to infection prevention and control. This is submitted to the ICC for approval and forwarded to the Chief Executive via the Corporate Management Team (CMT), and Clinical Governance Committee (CGC). The document is also available to all staff via the intranet: http://adsp02/Departments/Nursing%20Practice%20Development/InfectionControl/Pages/default.aspx




- **Decontamination**
- **Housekeeping/estates & Infection Control (IC)**
- **Procurement & IC**

### i. Committee Membership

Members are appointed by the ICC as indicated in the Scottish Infection Control Manual. Attendance will be reviewed biannually with the terms of reference biennially; these will be reported as part of the normal monitoring mechanisms.

**Internal**
Director of Nursing and AHPs / IC Manager (Chair)
Consultant Forensic Psychiatrist
Head of Estates & Facilities
Senior Nurse for Infection Control
Procurement Manager
Risk Management
Senior Charge Nurse (ward)
Staff-side Representative
Practice Nurse /Skye Centre Representative
Learning & Development Representative

**External**
Consultant Microbiologist / Infection Control Doctor
Anti-microbial Pharmacist
Public Health (as required)
Occupational Health Physician / Occupational Health Advisor

Additional members may be invited to attend as required by the agenda, where available a deputy may be appointed to attend.

### ii. Role of the Committee

**The State Hospitals Infection Control Committee will:**

1. Monitor audit compliance and advise on best practice
2. Direct policy, procedure and protocol development and review
3. Agree local policies before submission to the Policy Approval Group (PAG)
4. Consider and action, where appropriate, relevant reports
5. Act as the Outbreak Control Team in the event of major outbreaks of infection
6. Advise the Hospital Board on Infection Control matters and escalate areas of concern
7. Advise on resources and agreed programme of work
8. Set out the Hospitals objectives in the area of Infection Control
9. Produce and agree the annual infection control report and annual programme of work and monitor compliance with same
10. Oversee any required action/improvement as a consequence of any Healthcare Environment Inspection (HEI)
11. Contribute to the State Hospital's resilience arrangements as it relates to planning for pandemic influenza

At the request of the NHS Board or CMT, the ICC may also be called up to perform one or more of the following functions:

To investigate and take forward particular issues on which clinical input is required on behalf of the Hospital and /or CMT, taking into account the evidence base, best practice, clinical governance etc and make proposals for the resolution;

The ICC will manage its business through the Infection Control Program of Work, agreed by the Chair of the Committee. This will ensure that the full remit is covered on a rolling basis.

The role of the Senior Nurse for Infection Control (SNIC) has expanded during the year as a consequence of the increase complex physical healthcare and palliative care needs of the patient population. When nursing patients with indwelling devices there is the high risk of infection. It was identified that there was a gap in the

skill set of staff and it was felt that the SNIC would be best placed to address this. It should be noted that excellent nursing care and adherence to SICPs meant that the patients involved did not acquire an HAI.

iii. **Meeting Frequency and dates met**

Meetings are held quarterly. There were 0 meeting held from April – July due to the first wave of Covid19. Infection Control/Covid19 practice was closing monitored through Incident Command Structure. Infection Control activity in relation to Covid was discussed at the weekly Scientific and Technical Advisory Group, at which the Consultant Microbiologist / Infection Control Doctor and Public Health Consultant attend.

Dates of meeting held are below.

24 July 2020
23 October 2020
05 January 2021

**iv. Strategy and Work plan**

The implementation and management of the Infection Control Programme will be supported, monitored and reviewed quarterly by the Infection Control Committee. The Infection Control Programme of Work for 2021 – 2022 is below:

**Appendix 2**

**THE INFECTION CONTROL PROGRAMME (ICP) OF WORK & AUDIT PROGRAMME**
**1 APRIL 2021 – 31 MARCH 2022**

This programme has been developed on behalf of the State Hospital by the Senior Nurse for Infection Control (SNIC). It is subsequently endorsed by the Infection Control Committee (ICC), Corporate Management Team (CMT) and Clinical Governance Committee. The implementation and management of the ICP will be supported, monitored and reviewed quarterly by the ICC.

The Committee relies on all professions working together to promote good prevention and control of infection. Progress on this work plan will be provided at quarterly ICC meetings and areas of concerns to CMT meetings.

Infection Prevention and Control (IPC) does not rest solely within the domains of the ICC, everyone has prevention and control of infection responsibilities. The ICC will co-ordinate the delivery of ICP. Local managers must take a lead in ensuring interventions are implemented and monitored at a departmental level to ensure a safe environment for patients staff and visitors.

The content of the programme has been influenced by:

- HIS HAI Standards (2015)
- HEI Self Assessment and Action Plan
- Leading Better Care -Senior Charge Nurse Framework
- Scottish Patient Safety Programme
- Hand Hygiene Campaign CEL (2009)5
- National Cleaning Services Specifications (HFS)
- Vale of Leven Recommendations / QEUH unannounced inspection report

The annual ICP details the main activities of the ICC during the incoming year April 2021 – March 2022. These include:

- Ensuring that appropriate resources are made available to support infection control activities.
- Having in place policies and guidance for management of infection control across the organisation.
- Reviewing and improving infection control arrangements where necessary.
- Ensuring that staff receive relevant training in infection prevention and control
- Communicating infection control information to all relevant parties.
- Working with other stakeholders to improve surveillance.

All healthcare workers must be aware of infection prevention and control issues in order to take responsibility both individually and as part of a team for the maintenance of excellent standards of care.

**IMPLEMENTATION OF THE INFECTION CONTROL PROGRAMME**

The SNIC plays a major role in the implementation of the ICP. Any areas of concern will be brought to the attention of the ICC. An analysis of any potential resource implications in the development and delivery of the Programme will be submitted to the CMT.

**CONCLUSION**

Infection prevention and control is a high priority for The State Hospital and will continue to be monitored through the Board's Risk and Governance Structure. Infection Prevention and Control can only be successful through the employment of an active organisation wide programme with the commitment of all staff in The State Hospital.

**INFECTION CONTROL PROGRAMME**

The timescales identified for activities outlined in this programme may be subject to change depending on unscheduled work and clinical activity. Any deviations from the programme will be monitored by the Infection Control Committee.

# INFECTION CONTROL PROGRAMME OF WORK 2021 - 2022

| | Standard 1: Leadership in the prevention and control of infection | | | |
|---|---|---|---|---|
| | **Aims for delivery 2021/22** | **Progress to date** | **Review** | **Issues / Challenges / Actions Planned** |
| **1.1** | Recruit to additional Infection Control Support | | | |
| **1.3** | Assurance - Participation in leadership walk rounds by Senior Management and members of the Hospital Board | | | |

| | Standard 2: Education on Infection Prevention and Control is provided and accessible to all healthcare teams to enable them to minimise infection control risks that exist in care settings | | | |
|---|---|---|---|---|
| | **Aims for delivery 2021/22** | **Progress to date** | **Review** | **Issues / Challenges / Actions Planned** |
| **2.1** | Monitor and report quarterly to the ICC infection control training uptake on SIPCEP, Food Hygiene and BBV modules | | | |
| **2.2** | Continue to support the further education / development of the SNIC and other members of the Infection Control Committee | | | |
| **2.3** | Continue to support ward based nursing staff in the management of indwelling devices to reduce the risk of HAI | | | |
| **2.4** | Review the delivery of REHIS Elementary Food Hygiene courses for staff and if appropriate to patients within the State Hospital | | | |

| | | | | |
|---|---|---|---|---|
| 2.5 | Ensure compliance with the education framework for domestic assistants and other training determined by the Housekeeping & Linen Services Manager and Head of Estates and Facilities | | | |

| Standard 3: The organisation has effective communication systems in place to enable continuity of care and infection prevention and control throughout the patients journey | | | | |
|---|---|---|---|---|
| | **Aims for delivery 2021/22** | **Progress to date** | **Review** | **Issues / Challenges / Actions Planned** |
| 3.1 | Develop and publish an Infection Control Annual Report and Programme of Work | | | |
| 3.2 | Continue with the publication of Infection Control bulletins (minimum of 2 per year) | | | |
| 3.3 | Prepare and send quarterly reports with interpretation to Infection Control Committee and briefings to the CMT when appropriate. | | | |
| 3.4 | Monitor the HAIRT activity and present areas of concern to the Infection Control Committee and Corporate Management Team | | | |

| Standard 4: The organisation has a surveillance system to ensure a rapid response to HAI | | | | |
|---|---|---|---|---|
| | **Aims for delivery 2021/22** | **Progress to date** | **Review** | **Issues / Challenges / Actions Planned** |
| 4.1 | Weekly Norovirus and Influenza Activity (seasonal) reporting to Health Protection Scotland and review of National Data. | | | |
| 4.2 | Maintain surveillance of alert organisms such as HIV, HBV, and HCV. In addition look for trends for diarrhoea and vomiting, flu etc | | | |

| | | | | |
|---|---|---|---|---|
| 4.3 | Continue to review all Infection Control related DATIX and escalate where appropriate | | | |

| Standard 5: The organisation demonstrate effective antimicrobial stewardship | | | | |
|---|---|---|---|---|
| | **Aims for delivery 2021/22** | **Progress to date** | **Review** | **Issues / Challenges / Actions Planned** |
| 5.1 | Undertake biennial audit of Antimicrobial use and follow up on any actions. | | | |

| Standard 6: The organisation demonstrates implementation of evidenced based infection prevention and control measures | | | | |
|---|---|---|---|---|
| | **Aims for delivery 2021/22** | **Progress to date** | **Review** | **Issues / Challenges / Actions Planned** |
| 6.1 | All IPC polices are reviewed within a 2 year time frame | | | |
| 6.2 | Undertake Infection Control Audits as per programme<br><br>Collate audit results, feedback and actions plans to key stakeholders | | | |
| 6.3 | Review HACCP manual for the main kitchen | | | |
| 6.4 | Review the Food Safety Manual for the Therapeutic Kitchen in line with Food Hygiene Regulations / Standards | | | |
| 6.5 | Continue to support ward based /Skye Centre staff to undertake Hand Hygiene audits monthly and action shortfalls | | | |

| | | | | |
|---|---|---|---|---|
| 6.6 | Review operational Pandemic Influenza Plan in light of COVID 19 for the State Hospital and present to the Resilience Group | | | |

| Standard 7: Systems and processes are in place to ensure the safe and effective use of invasive devices | | | | |
|---|---|---|---|---|
| | **Aims for delivery 2021/22** | **Progress to date** | **Review** | **Issues / Challenges / Actions Planned** |
| 7.1 | Ensure national catheter associated urinary tract infection (CAUTI) bundles are utilised (when appropriate) | | | |
| 7.2 | Investigate any infection pertaining to an invasive device & report to the Infection Control Committee and Patient Safety Group | | | |

| Standard 8: The environment and equipment (including reusable medical devices) used are clean, maintained and safe for use. Infection risks associated with the built environment are minimised | | | | |
|---|---|---|---|---|
| | **Aims for delivery 2021/22** | **Progress to date** | **Review** | **Issues / Challenges / Actions Planned** |
| 8.1 | Review cleaning schedules and risk assessments in line with the NHSScotland NCSS, ensuring compliance with NCSS or deviation is risk assessed. | | | |
| 8.3 | Ensure the monthly domestic monitoring tool is signed off and feedback is provided to SCNs | | | |
| 8.4 | Ensure an annual peer and public review is undertaken | | | |

| | | | | |
|---|---|---|---|---|
| **8.5** | Continue with bimonthly meetings between SNIC and Housekeeping and Linen Services Manager to share information and discuss pertinent issues. | | | |
| **8.6** | Continue bimonthly meetings between ICM, SNIC, Housekeeping & Linen Services Manager and the Estates & Facilities Manager as per HDL (2005) 8 and HDL (2001) 10 | | | |
| **8.7** | Review the decontamination SLA between Falkirk Sterilising Unit and the State Hospital | | | |
| **8.8** | Implement HAI SCRIBE and SHFN 30 for any new build or renovation within the Hospital | | | |
| **8.9** | Continue to ensure compliance with SHTM 04-01 – Legionella / Water | | | |

# INFECTION CONTROL AUDIT PROGRAMME 2021/22

| AUDIT | SOURCE | AUDIT TOOL USED | AGREED FREQUENCY | PERSON RESPONSIBLE | Comments |
|---|---|---|---|---|---|
| **Respiratory Hygiene and Cough Etiquette *** | National Infection Control Manual – SICPs Audit. | SICPs Tool | As directed by ICC. | SNIC (or deputy) | Observe 3 staff members in each clinical area |
| **Management of Care Equipment** | National Infection Control Manual - SICPs Audit. | SICPs Tool | Annually | SNIC (or deputy) | Inspect 2 pieces of patient equipment in each clinical area |
| **Cleanliness Monitoring** | HFS and SGHD | HFS Audit Tool | Monthly 2021/22 | **Monthly:** Housekeeping<br><br>**Bi Annual:** SNIC (or deputy) | As directed by National Monitoring Tool |
| **Hand Hygiene** | NHS HIS HAI Standards (2015), National Hand Hygiene Campaign. | TSH Audit Tool | 10 x opportunities Monthly audits per hub throughout 2020/21 | **Monthly**: Ward / Skye Centre Staff<br><br>**Bi Monthly:** SNIC (or deputy) | 4 Hubs, Health Centre and Skye Centre. |
| **Personal Protective Equipment (PPE)** | SGHD National Infection Control Manual - SICPs Audit. | SICPs Tool | Monthly | SCN<br><br>SNIC | 55 observations (5 per ward/Skye centre per week) |
| **Mattress Audit** | MHRA Medical Device Alert – Mattresses and MDA/2010/002 | TSH Audit Tool | February & March 2022 | SNIC and Housekeeping & Linen Services Manager | 36 mattresses across site |
| **Healthcare Waste Audit (incorporating Safe Management of Linen and Safe Disposal of Waste) +**<br><br>**Management of Blood and Body Fluid Spillages and Environmental Cleaning** | NHS HIS HAI Standards (2015) and National Infection Control Manual - SICPs Audit | eControl Book Tool | Monthly | Control Book Holder<br><br>**Annual:** SNIC (or deputy) | Each ward, Health Centre, Sports & Fitness and Occ Health |

| | | | | | |
|---|---|---|---|---|---|
| **Workplace Inspection (incorporating environmental audit ) including status of ABHR** | NHS HIS HAI Standards (2015) and National Infection Control Manual - SICPs Audit | eControl Book Tool | Monthly | Control Book Holder<br><br>**Annual:** SNIC (or deputy) | All patient areas across the site over a 24 month period |
| **BBV initial assessment completion** | Initial Admission VAT | TSH Audit Tool | August 2021 | Clinical Effectiveness | Review RiO notes for patients admitted during previous 12months. |
| **Management of loose stools & completion of NEWS** | The Management of Patients with Loose Stools Policy | TSH Audit Tool | November 2021 | Clinical Effectiveness | Review RiO notes for patients who have been identified as experiencing symptoms |
| **Audit of main kitchen against HACCP manual** | Food Safety Act | TSH Audit Tool | November 2021 | SNIC and Catering Manager | Carry out a visual inspection main kitchen and review the HACCP manual |
| **Food Safety Manual Therapeutic Kitchen / Skye Centre** | Food Safety Act | TSH Audit Tool | November 2021 | SNIC, Catering Manager and Occupational Therapist | Carry out a visual inspection of 2 therapeutic kitchens & review the Food Safety Manual |
| **Occupational Exposure Management** | SGHD National Infection Control Manual - SICPs Audit | SICPs Tool | February 2022 | SNIC (or deputy) | Ask 5 staff members throughout Hubs and Skye Centre |
| **Water Safety** | Water Safety | TSH Audit Tool | October 2021<br>February 2022 | SNIC & Facilities | Review water flushing recording documents in 6 areas across the hospital. |
| **Antimicrobial Usage Audit** | ScotMARAP 2008 | TSH Audit Tool | July 2022 | Clinical Effectiveness | |
| **HEI and HAI Self Assessment updates** | SGHD and HIS | National Tool | As per external direction | Clinical Effectiveness and SNIC | |

*As required when clinical activity dictates

Any deviation from audit activity will be reported to the ICC.