THE STATE HOSPITALS BOARD FOR SCOTLAND

Infection Prevention and Control 12 Month Report
1st April 2023 – 31st March 2024

Lead Author	Senior Nurse for Infection Control
Sponsoring Director	Director of Nursing and Operations
Date	09 April 2024

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1. Core purpose of Committee

The State Hospitals Board is responsible for infection prevention and control (IPC) within its services, ensuring that the risk of healthcare associated infections to patients, staff, carers, volunteers, and visitors is minimised. The employment of evidence-based protocols will assist clinical practice to ensure a clean and safe environment is an integral part of our overall clinical governance agenda. The State Hospital is a high-risk environment with predominately low risk patients, which means 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 Department promotes the highest standards of practice within the organisation for infection prevention and control, ensuring compliance with the Healthcare Improvement Scotland (HIS) Infection Prevention and Control Standards (2022). 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 (SNIC) to oversee all aspects of infection control within The State Hospital.

There is one Clinical Quality Improvement Facilitator (CQIF) for Infection Control to oversee the Quality Improvement (QI) agenda for infection control; however, this post became vacant in February 2024. It is hoped that this post will be replaced with a clinical role. The recruitment process is underway.

3. Summary of Core Activity for the last 12 months

The Senior Nurse for Infection Control will present IPC activity under the headings outlined in the HIS Infection Control Standards (2022).

Standard 1: Leadership and Governance

The organisation demonstrates effective leadership and governance in IPC.

The Infection Control Committee meets on a quarterly basis (4 meetings have occurred) and this is Chaired by the Director of Nursing and Operations. The terms of reference were last reviewed in March 2024.

The Infection Prevention and Control Group meet monthly and this is Chaired by the Associate Nurse Director (9 meetings have occurred).

The Infection Control Risk register is reviewed prior the Infection Control Committee. There are 9 risks identified with 8 graded a low and 1 medium risk (safe management of Linen).

No escalation required.

Standard 2: Education and Training

Staff are supported to undertake IPC education and training, appropriate to their role, responsibilities and workplace setting, to enable them to minimise infection risks in care settings.

All staff are required to complete 4 core Infection Control Modules within 3 months of starting employment of those that have completed the core modules 100% has been completed within the timescale.

Chart 1 below shows the hospitals compliance with the core SIPCEP modules.

Chart 1: SIPCEP Core Module Compliance

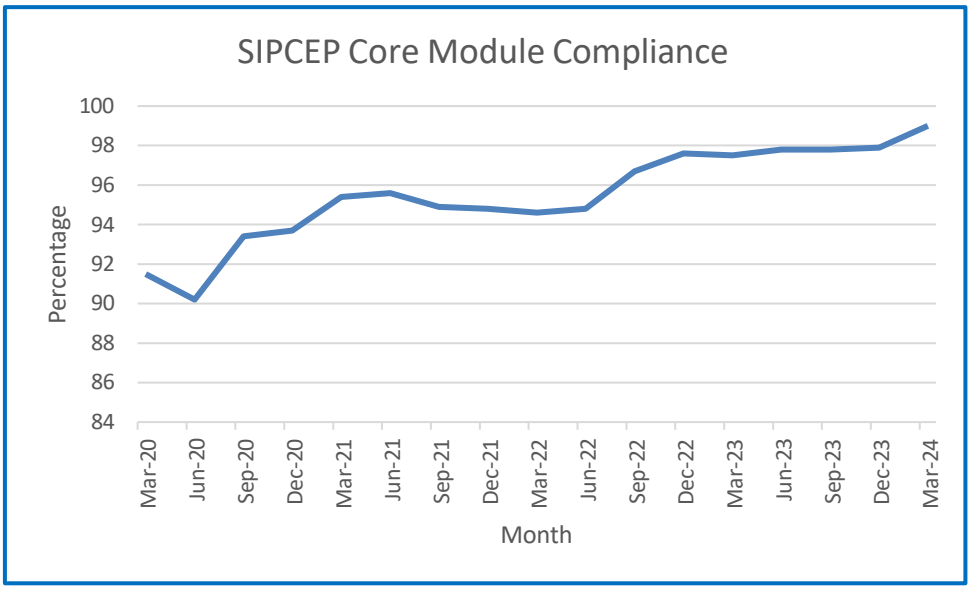
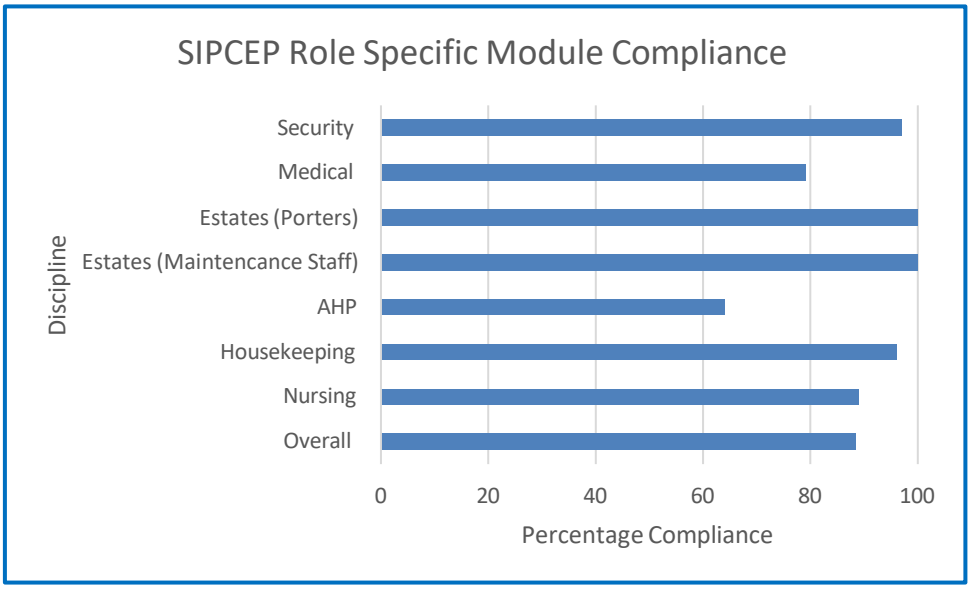


Chart 2 below shows the compliance with the role specific SIPCEP modules. These modules are to be completed within 6 months of starting employment. Reminders are sent to individual line managers to promote & monitor compliance.

Chart 2: SIPCEP Role Specific Module Compliance



The compliance for REHIS Elementary Food Hygiene training is 88.2%, this is also delivered online.

A general IPC education session is a standing item on the corporate induction with a tailored induction for student nurses, clinical and housekeeping staff. The corporate induction and the tailored induction for housekeeping staff, introduced in the last 12months has had positive feedback.

No areas require escalation.

Standard 3: Communication

The organisation implements robust communication systems and processes to enable person-centred decision making, continuity of care and effective IPC throughout a person's care experience.

There are regular communications published by the Infection Control Team via the Staff Bulletins/Special Bulletins. These bulletins provide updates on infection control activity (including vaccinations), reinforcement of good infection control practice, covid19 updates and any pertinent information arising for the ICC.

The Senior Nurse for Infection Control attends the PPG bimonthly to respond to infection control questions.

It was hoped to use a telecommunication method to communicate with staff and patients at ward level via the ONELAN system however, due to the monitors requiring to be updated this was not possible.

No escalation required.

Standard 4: Assurance and monitoring systems

T*he organisation uses robust assurance and monitoring systems to ensure there is a co-ordinated and rapid response to reduce the risk of infections and to drive continuous quality improvement in IPC.*

Autum/Winter vaccination

100% of patients were offered the Covid and Flu vaccines in autumn 2023, additional letters were sent to patients (January 2024) who initially refused the vaccines. However, the uptake was poor in comparison to last year. As of the 31 March, there are 36 patients who have been vaccinated against Covid19 and 39 patients who have been vaccinated against flu.

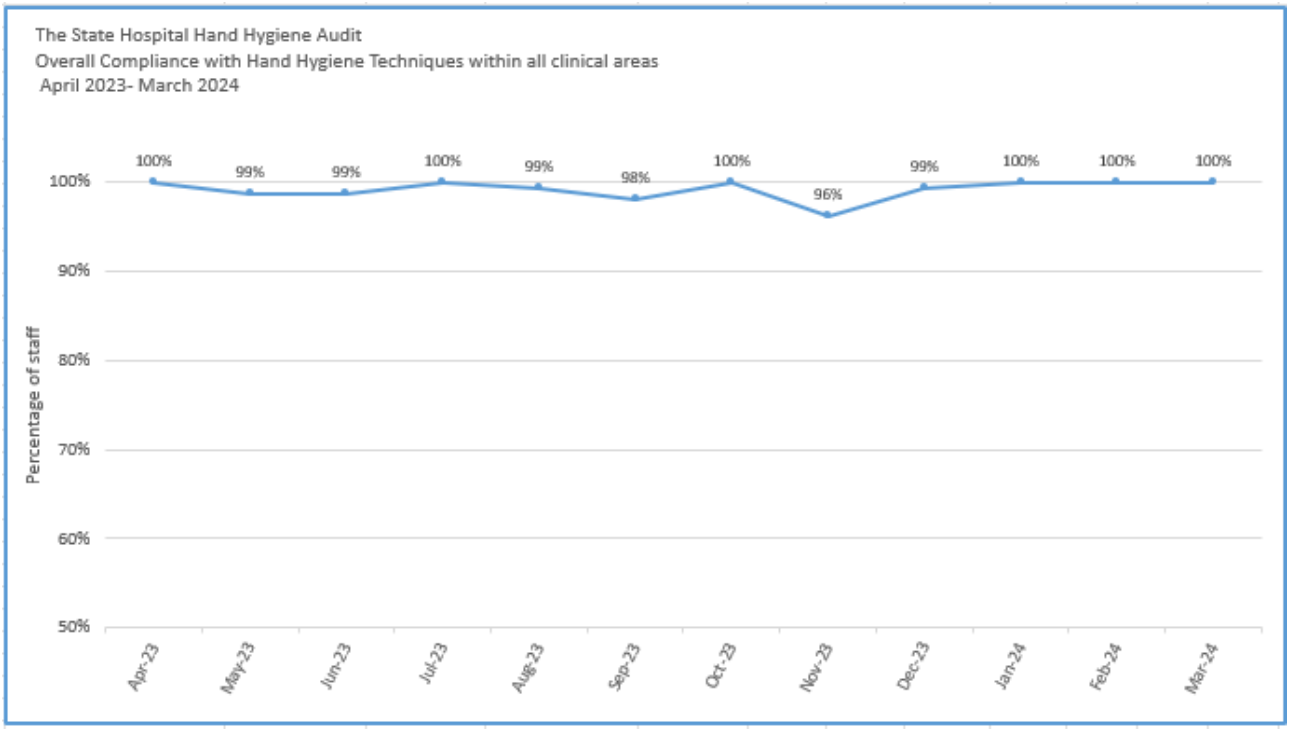
The Infection Control Department facilitated staff autumn winter vaccination clinics supported by Occupational Health and Peer Immunisers.

Hand Hygiene

Hand hygiene remains the single most important activity to reduce the spread of infection. This was even more paramount in the height of the pandemic and was reinforced through Scottish Government.

Chart 3 below shows the hospitals overall hand hygiene compliance in clinical areas (all disciplines across the site).

Chart 3: Overall Hand Hygiene Compliance

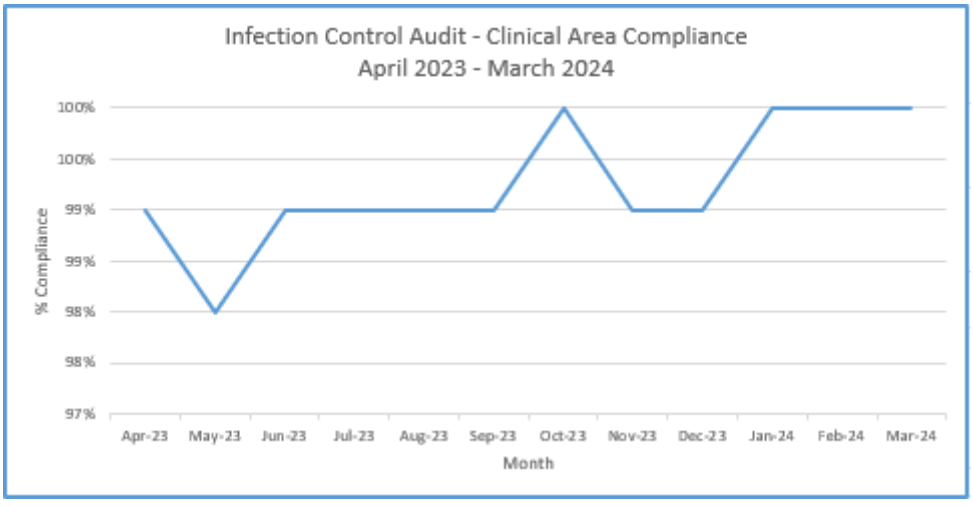


Individual clinical areas have remained high, with 4 areas falling below 100% compliance. The CQIF worked with the staff and heads of service within these areas and compliance increased.

Infection Control Audits

The IC audits were introduced during Covid as a crude measure of general IC practice. These have evolved to incorporate wider IC practice such as adherence to HR40 Standard of Dress and Uniform Policy that are not captured within SIPS audits. The results of which can be viewed in the chart 4 below.

Chart 4: Infection Control Audit of Clinical Areas



There are common themes of non-compliance namely long hair not being tied up, staff having long nails/wearing false nails/nail varnish. The CQIF worked with the staff within these areas and compliance increased.

The Senior Nurse for Infection Control continues to undertake infection control walk rounds with the Lead Nurses. The walk rounds have been successful in demonstrating a united approach to Infection Control.

BBV audits

The audit is for the period of 1st August 2022 to 31st July 2023.

BBV Admission Risk Assessment

Between the 1st of August 2022 and the 31st of July 2023, there were at total of twenty-four patients admitted to the hospital over the period identified, of which twenty-one were still in-patients at the time of audit.

Table 1 shows that the total number of admission risk assessments completed was 76%, showing a decrease of 19% on 21/22 data. This has also been the lowest percentage since data started to be collected in 2016/17.

Table 1: **The number of BBV admission risk assessments undertaken**

Was BBV Admission Risk Assessment carried out. (n=number of admissions still inpatients at time of audit)	2016/17 (n=32)		2017/18 (n=27)		2018/19 (n=32)		2019/20 (n=34)		2020/21 (n=32)		2021/22 (n=21)		2022/23 (N=21)	
Yes	28	87.5%	25	92.6%	30	93.8%	29	85.3%	31	96.9%	20	95%	16	76%
No	4	12.5%	2	7.4%	2	6.3%	5	14.7%	1	3.1%	1	5%	5	24%

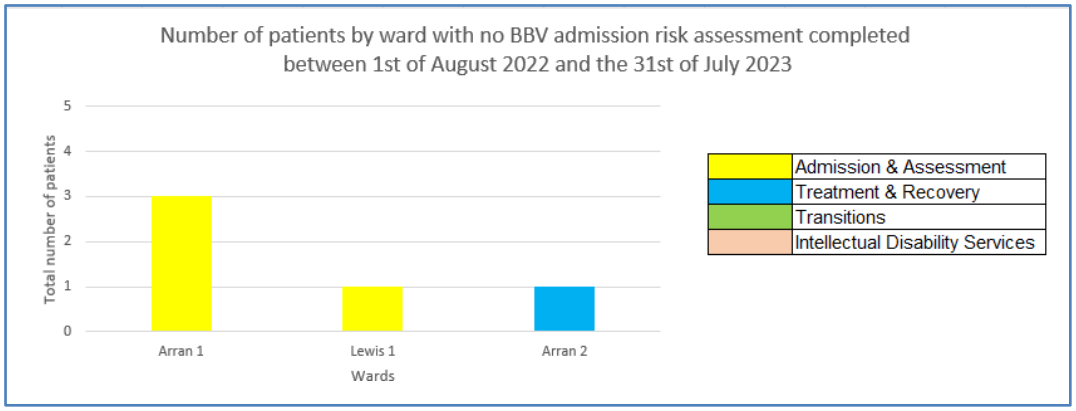
Table 2 shows from the sixteen completed BBV admission risk assessments, 75% of these were conducted on day of admission, showing a 40% increase from 21/22 figures.

Table 2: The number of days between patient admission and BBV assessment completed

Number of days after admission the BBV assessment was carried out	2016/17		2017/18		2018/19		2019/20		2020/21		2021/22		2022/23	
Day of admission	18	64.3%	15	60.0%	13	43.3%	19	65.5%	17	54.8%	7	35%	12	75%
1 day after admission	5	17.9%	5	20.0%	7	23.3%	4	13.8%	5	16.1%	6	30%	1	6%
2 days after admission	4	14.3%	2	8.0%	2	6.7%	1	3.4%	0	0%	1	5%	0	0
>2 days after admission	1	3.6%	3	12.0%	8	26.7%	5	17.2%	9	29.0%	6	30%	3	19%
Total	28		25		30		29		31		20		16	

Chart 5 shows the clinical areas in where a BBV admission risk assessment has never been completed by the keyworker over the period identified under point two of this report.

Chart 5: The clinical area where no BBV assessment has been completed



BBV Annual Continual Care Risk Assessment

Table 3 shows that during the audit period, eighty-five patients required a BBV annual continuing care risk assessment. Four of the eighty-five patients had been discharged from the hospital at the time of the audit. From the eighty-one patients audited, 69% of these patients had their risk assessment completed correctly showing a decrease of 13% from 2021/22 data. However, this has also been the lowest percentage completed since data being was collected in 2016/17.

Table 3: The number of Annual BBV risk assessments conducted

Table 3

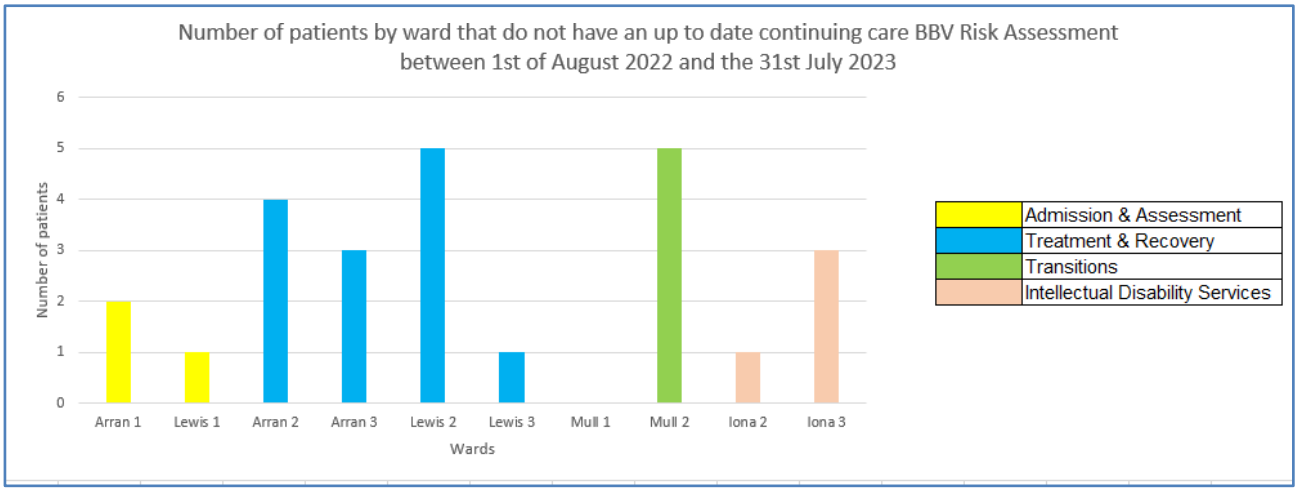
Has the Annual BBV Risk Assessment form completed on RiO	16/17		17/18		18/19		19/20		20/21		21/22		22/23	
Yes	66	77.6%	67	75.3%	78	91.8%	76	90.5%	77	93.9%	71	82%	56	69%
No	19	17.1%	22	20.8%	7	7%	8	7%	5	6.1%	16	18%	25	31%
Total	85		89		85		84		82		87		81	

Table 4 shows the reasons for the non-compliances for the 31% of patients who did not have an annual risk assessment completed within the timescales identified within point two this report.

Table 4: Reasons for noncompliance with BBV annual risk assessment

Reasons	Number	Percentage
Assessment Out of Date	18	72%
Never had one since admission	7	28%
Patient refused	0	0

Chart 6: Areas of annual BBV risk assessment non-compliance.



The CQIF worked very closely with the Senior Charge Nurse and ward staff to promote compliance and the expectation was that this would be re-audited in August 2024. The Infection Control Team will be reviewing the BBV risk assessment process in the incoming year.

Close monitoring by the IPCG with escalation to the ICC if required.

BBV Blood Testing

BBV bloods are taken at the Health Centre, as part of the patients admission and their annual health check. Approximately 98% of patients BBV status is known.

Mattress Audits

Mattress audits have not been undertaken for 2 years. Initially this was due to Covid and minimising footfall within the ward and then the clinical model movement of patients. During the clinical model moves mattresses were inspected prior to new patients moving into bedrooms.

The CQIF for HAI was working alongside Housekeeping and nursing staff to review the existing mattress audit tool. However, this progress has been halted due to the vacant post.

Mattress audit activity is being monitored by the IPCG and will be escalated to the ICC if this cannot be resolved.

Covid19 Activity

Cases of novel coronavirus (nCoV) were first detected in China in December 2019, with the virus spreading rapidly to other countries across the world. This led World Health Organisation (WHO) to declare a Public Health Emergency of International Concern (PHEIC) on 30 January 2020 and to characterize the outbreak as a pandemic on 11 March 2020.

On 5 May 2023, more than three years into the pandemic, the WHO Emergency Committee on COVID-19 recommended to the Director-General, who accepted the recommendation, that given the disease was by now well established and ongoing, it no longer fit the definition of a PHEIC. This does not mean the pandemic itself is over, but the global emergency it caused is – for now.

Within the previous 7days (31 March 2024) the UK reported 1400 cases of Covid19 to the WHO. Worldwide the Covid19 cases has increased by 62,925 in the previous 7 days to 31 March 2024 (111,791)

From March 2020 the State Hospital has recorded 182 cases of covid19; 30 of which have been during the reporting period and contributed to 8 outbreaks.

Table 5 shows the number of Covid19 outbreaks during this reporting period and the location of same.

Table 5: The number of outbreaks per month and location.

Month	Number of Outbreaks	Location
April*	2	Iona 3 (2) & Arran 1 (2)
August	1	Lewis 2 (5)
September	1	Arran 3 (2)
October	1	Arran 1 (7)
December	1	Lewis 1 (2)
February	1	Mull 1 (4)

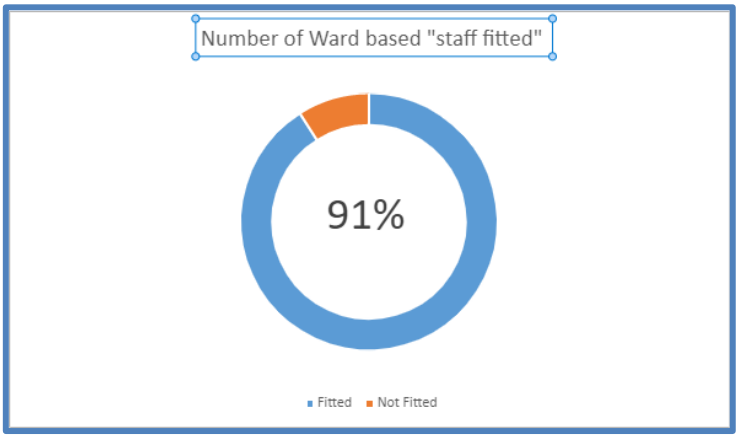
*these outbreaks were prior to the clinical moves therefore staff, patient group and services were different.

Arran 1 outbreak was not attributed to new admitted patients and the individuals who contracted Covid had off ward activities with a lot of social contact out with Arran 1. There is no obvious rationale regarding locations. Peaks replicate the Covid activity within community. From the beginning of September there was no requirement for the public or NHS staff to test for Covid.

Face fit testing
The State Hospital had undertaken a Face Fit testing program from April 2020 which enables 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. In May 2022 an additional six members of staff were trained to become Face Fit Testers. It was agreed by the ICC that these would be non-clinical staff as from previous experience it is difficult to release clinical staff from their duties in order to complete this role.

The accepted threshold in relation to the number of staff who are face fit tested is 85% therefore we exceed this threshold as per chart 7.

Chart 7: The percentage of staff who are face fit tested.



There is consultation occurring at a national level regarding Transmission Based Precaution which may impact/influence this going forward.

Datix Incident Summary

An area of concern was noted in the Clinical Governance Committee annual report pertaining to the high number of Clinical Waste incidents recorded. Within the last 12 months DATIX categories have been reviewed and re-classified. Laundry issues have now been removed from the clinical waste category.

Each individual Infection Control DATIX incidents are reviewed by the Senior Nurse for Infection Control.

Table 6: Infection Control DATIX incidents 2023/2024

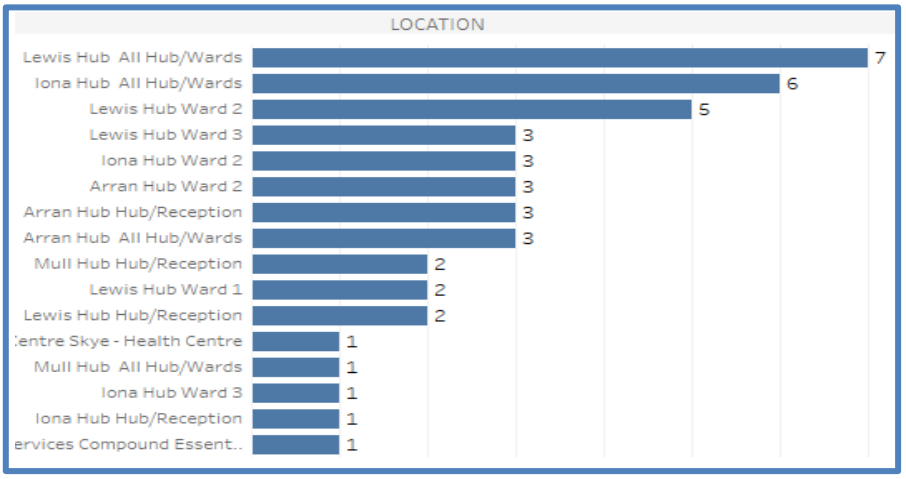
Laundry Packed Incorr..	21
Laundry Bag Untagged	18
Other Laundry Issue	3
Urine	1
Other	1
Exposure to Blood	1

From the table above the safe manamgent of linen remains high in respect to the number of infection control incidents although a decrease in 7 from previous year.

From November 2023 data has been collected on the total number of laundry bags produced, this euqates to 2060. The DATIX incidents pertaining to laundry for this period is <1%.A decrease from previous year refer to Table 7

The incidents which relate to urine and exposure to blood (table 6) relate to incorrect practice when transporting specimens. On further investigation is was highlighted that there wasn't an SOP for transporting specimens from the wards to the main reception. This has since been addressed.

Chart 7: Location of DATIX incidents



From chart 7 above the majority of all incidents are located within Lewis hub collectively. The CQIF for Infection Control worked alongside the Senior Charge Nurses and Lead Nurses within the hub to resolve the issues. Progress and monitoring of this thorugh the IPCG on a monthly basis.

No escalation required.

<u>Standard 5: Optimising antimicrobial use.</u>

The organisation demonstrates reliable systems and processes for antimicrobial stewardship to support optimal antimicrobial use.

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). This contract has been extended to 31st March 2026.

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 Quality Department. This will be audited in autumn/winter 2024.

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 on such drugs.

No escalation required.

Standard 6: Infection Prevention and Control Policies, procedures and guidance.

The organisation uses evidence-based IPC policies, procedures and guidance.

There are no Infection Control Policies that require updating. All DPIAs and EQIAs are up to date. No escalation required.

Standard 7: Clean and Safe Care Equipment

The organisation ensures that care equipment is cleaned, maintained and safe for use.

Patient care equipment such as commodes, mobility aids and manual handling aids are allocated for individual patients use. There are cleaning schedules in place for each of these items. Audits have been scheduled to take place regarding compliance with the cleaning schedules.

An audit of the shared patient care equipment will take place following the review of the audit tool and will be undertaken by members of the IPCG.

Cleaning schedules pertaining to patient equipment will be updated and rolled out across the site.

Further development is required in relation to the information populated on the Synbiotix system to consider “user issues”. These are areas that require action at ward level and cannot be attributed to domestic or estates fails.

Activity is being monitored by the IPCG and will be escalated to the ICC if this cannot be resolved.

Standard 8: The Built Environment

The organisation ensures that infection risks associated with the health and care built environment are minimised.

The cleanliness and fabric of the hospital is monitored by the housekeeping supervisors and reported through the Facilities Monitoring Tool (FMT) Synbiotix.

In 2024/25 members of the IPCG will undertake assurance audits.

Chart 8 shows the trend throughout the year for domestic monitoring against the National Cleaning Specifications. It can be noted that throughout the last 12months that the State Hospital has ahcieve the national target of 90%.

Chart 8: Domestic Audit Report

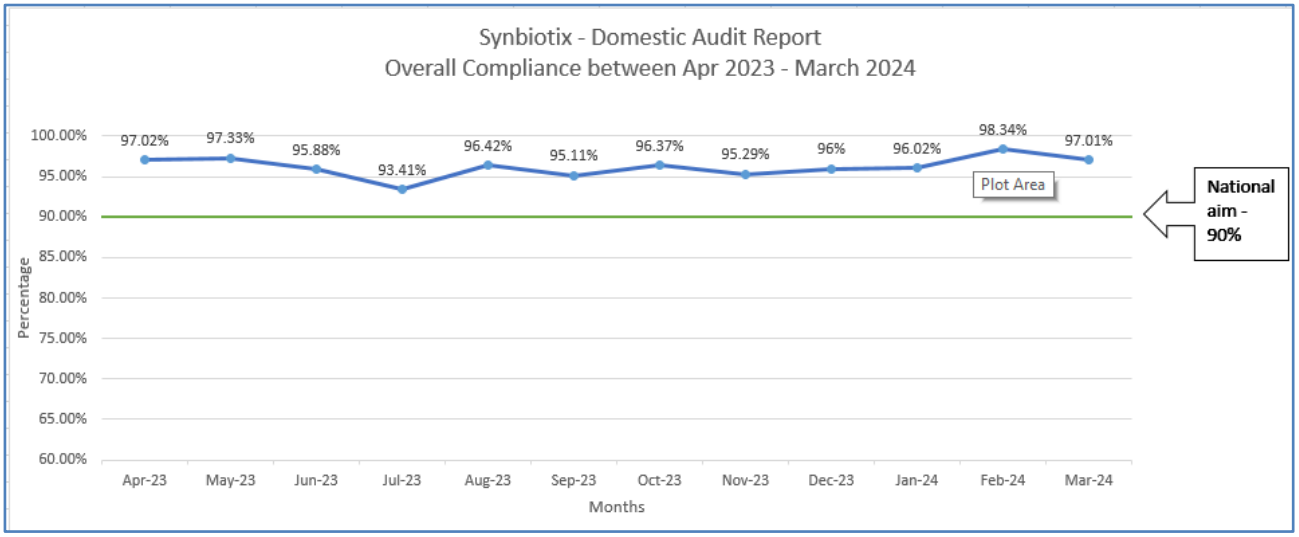
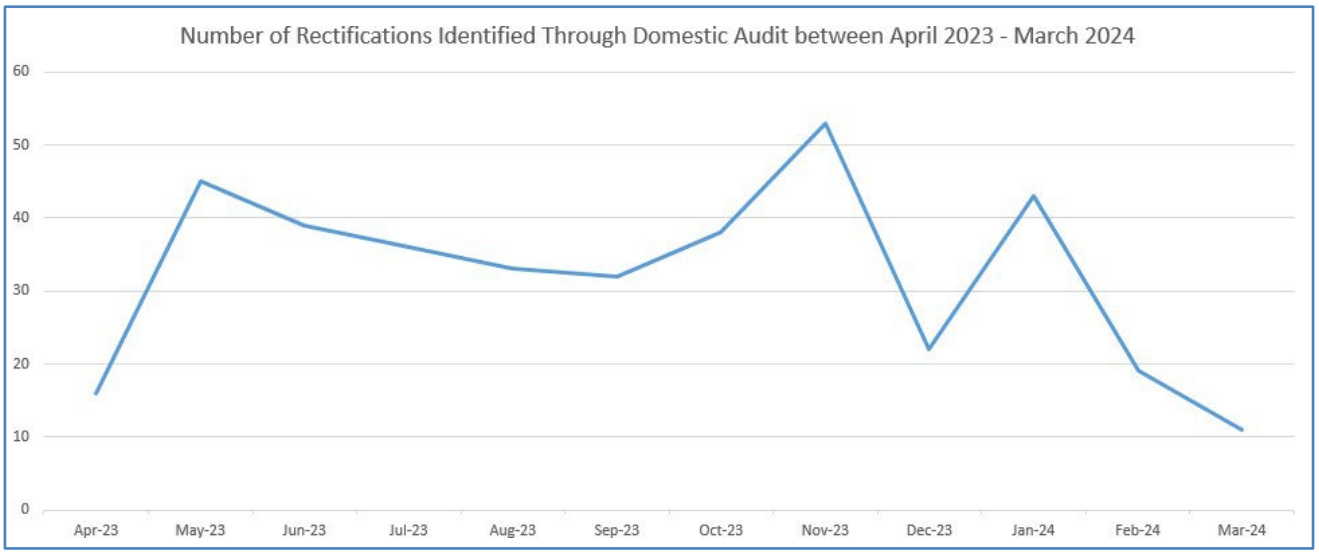


Chart 9 below shows the number of rectifications that have been identified during the domestic audit. It can be noted that there has been a decrease since January.

Chart 9: Domestic Retifications identified during 2023-2024.



The Infection Control Team and the Housekeeping department worked closely to ascertain how the information gleaned from Synbiotix can be presented to the wards/Senior Charge Nurses in a meaningful manner in order to promote ownership of the data and areas of compliance/noncompliance. This work will continue in the incoming year to address “user” issues. User issues are areas which cannot be cleaned by the housekeeping team as a direct consequence of actions from service users.

Outstanding action from Clinical Governance updated in November 2023 pertaining to remedial work within the Patient Learning Centre (Water ingress).

Skanska carried out an environmental assessment on site 08/06/23 to complete a pre-work assessment with Estates. A further site visit has been arranged 19.04.2024 to discuss the issues and agree a plan to undertake the works.

Activity is being monitored by the IPCG and will be escalated to the ICC if this cannot be resolved.

Standard 9: Acquisition and provision of equipment

The organisation demonstrates the acquisition and provision of equipment that is safe for use in health and social care settings.

A new process has been established to ensure that all products used in patient areas has been approved for this environment. This process ensures that key stakeholders e.g. Infection Control, Housekeeping, manual handling, security etc are involved from the initial stages. There have been 4 new products which have gone through this process.

No escalation required.

4. Comparison with last years Planned QA/QI Activity

Progress on previous years activity

- To consider innovative ways to increase compliance with infection control training – **achieved**

- To continue to monitor DATIX with specific attention being placed on items being coded as clinical waste – **achieved**
- To review DATIX coding with risk management department – **achieved**
- Introduction Hand Hygiene Peer audits – **not achieved**
- Roll out new Cleaning Schedules across the site and commence audits – **achieved**

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 (Healthcare Environment Inspectorate) inspections)
- No outbreaks in IC organisms (excluding Covid19)

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

6. Planned Quality Assurance/Quality Improvement for the next year

The Clinical Quality Improvement for Infection Control post will not be recruited to following vacancy. It is anticipated that this vacancy will move to a clinical post, the remit of which has yet to be finalised.

7. Identified issues and potential solutions

Activities for incoming year

- Recruit to vacancies within Infection Control Team
- Introduction Hand Hygiene Peer audits within ward areas and broaden hand hygiene audits to other areas of the hospital such as security reception
- Establish a shared timetable among members of the Infection Prevention and Control Team to undertake assurance audits.
- To review and implement mattress audit tool
- Review the BBV annual risk assessment process
- To introduce a greater use of "user issues" when undertaken the Domestic Services Monitoring as this will provide greater ownership at ward level.
- To review the information gleaned from the Synbiotix system and how this is interpreted at ward level.
- Review clinical cleaning schedule for patient equipment and undertake audits to ensure compliance with said cleaning schedules.

8. Next review date

The next Infection Control Update Report will be submitted to the Clinical Governance Committee in November 2024.