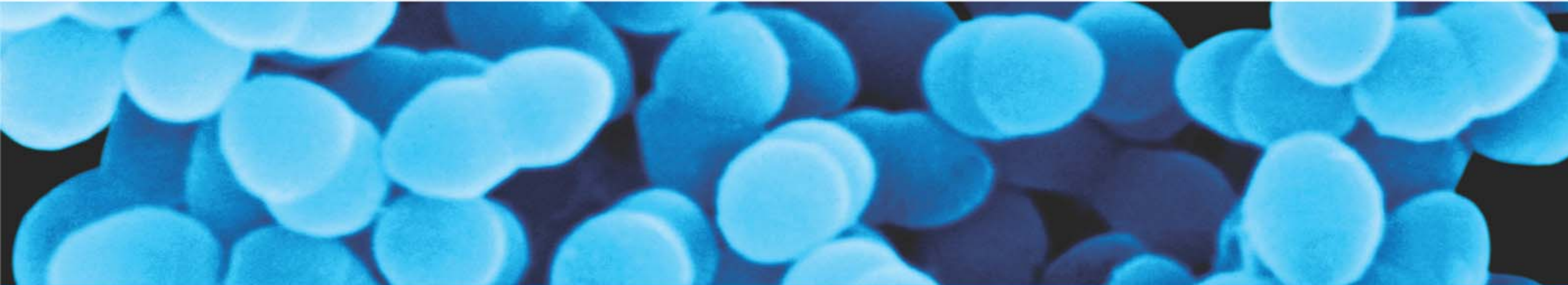
NHS



Caroline Trevithick

Department of Health

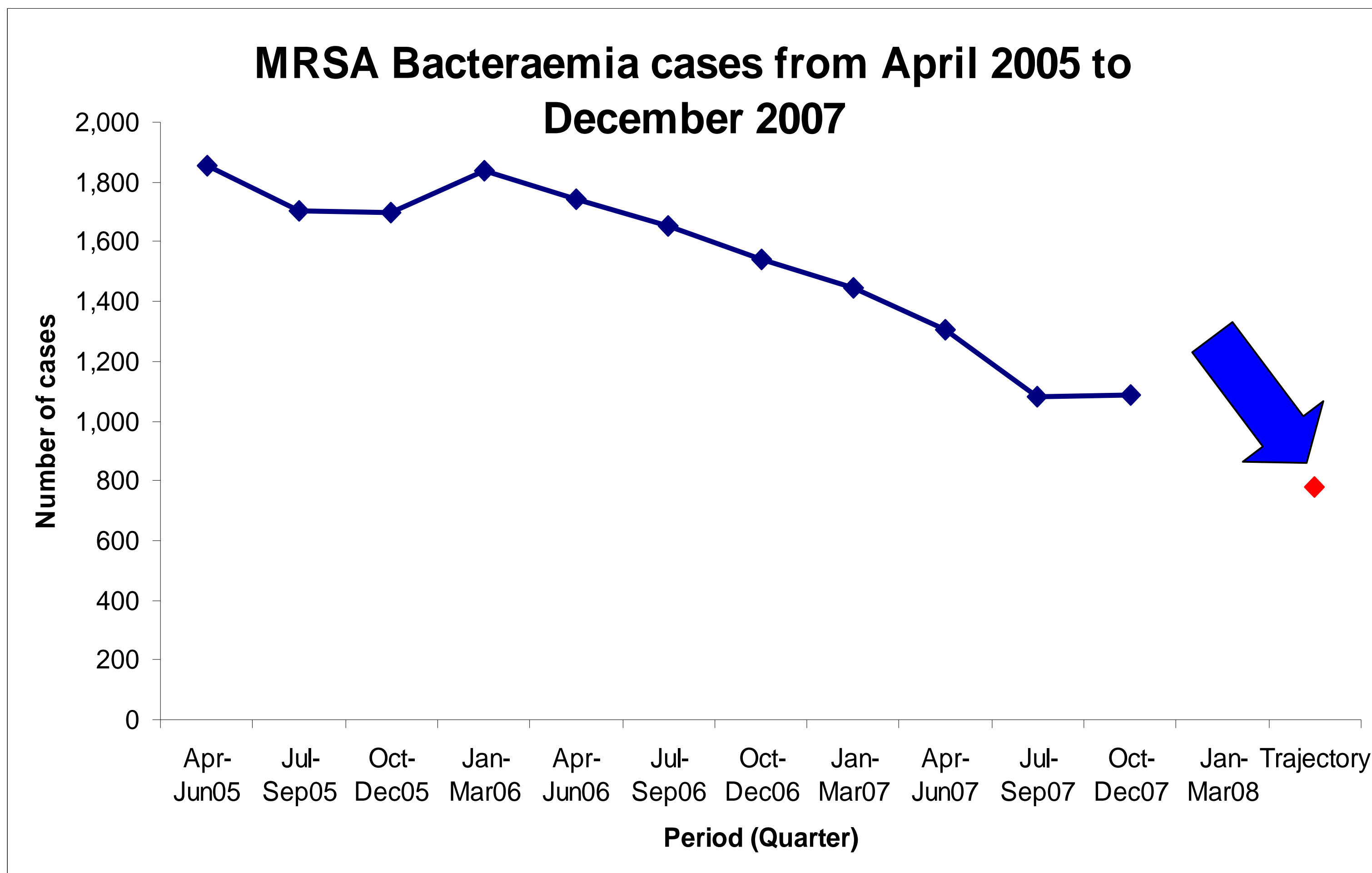
DH Department of Health

Aim of today……………

To

- Share progress nationally
- Describe how progress has been made
- Share features of differing organisations
- Describe the elements that drive improvement and how they translate into any health care setting

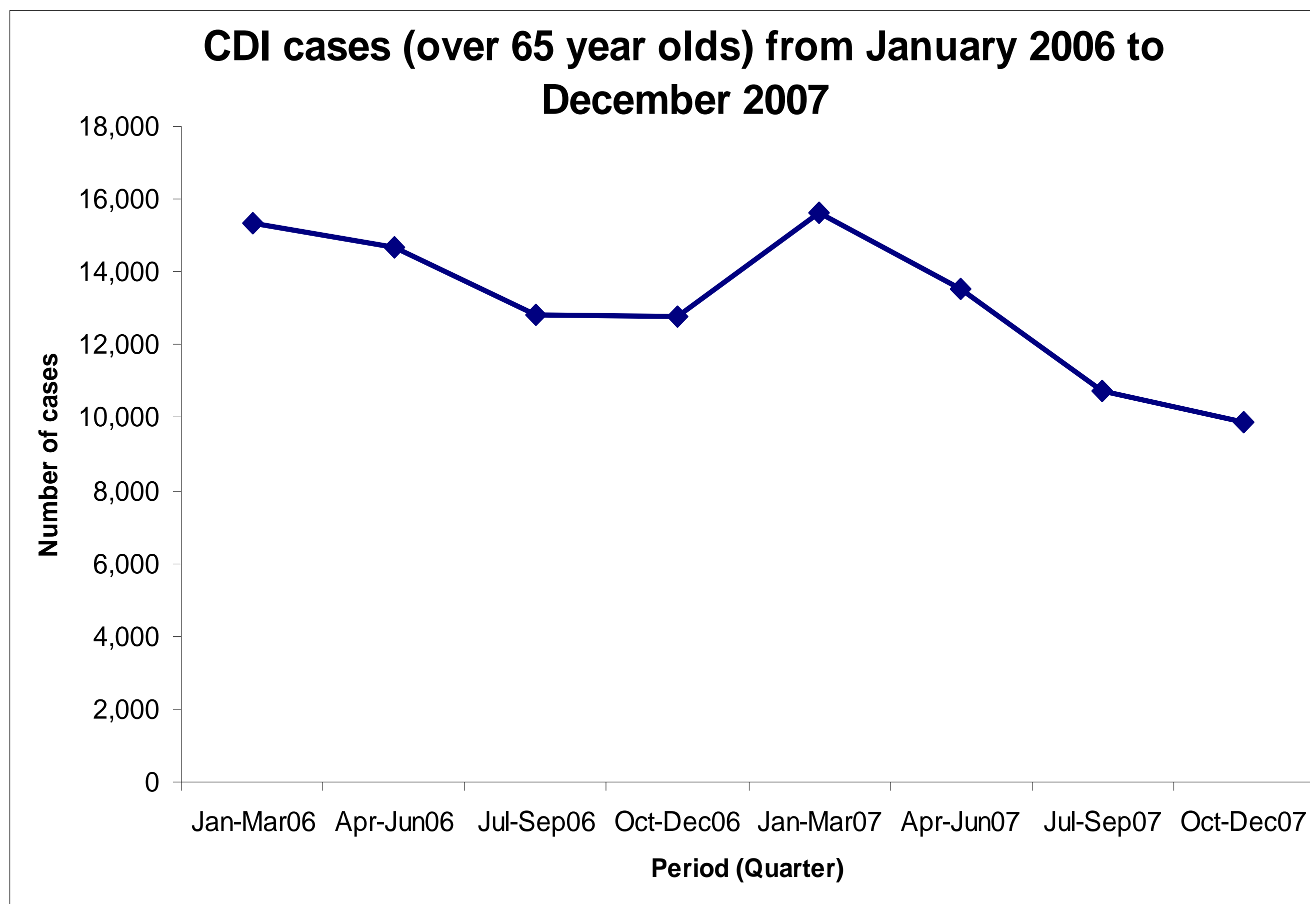
Quarterly national MRSA bacteraemia cases April 2005 to December 2007



As at December 2007 the national quarterly number of MRSA bacteraemia cases was still higher than the national Local Delivery Plan trajectory reduction

Source: Published HPA data and SHA Local Delivery Plans

National quarterly *C. Difficile* (CDI) cases April 2006 to December 2007



The national quarterly number of CDI cases indicated a further reduction for October to December 2007, although reductions should be treated with caution at this early stage of monitoring

Source: Published HPA data

Looking back – to move forward

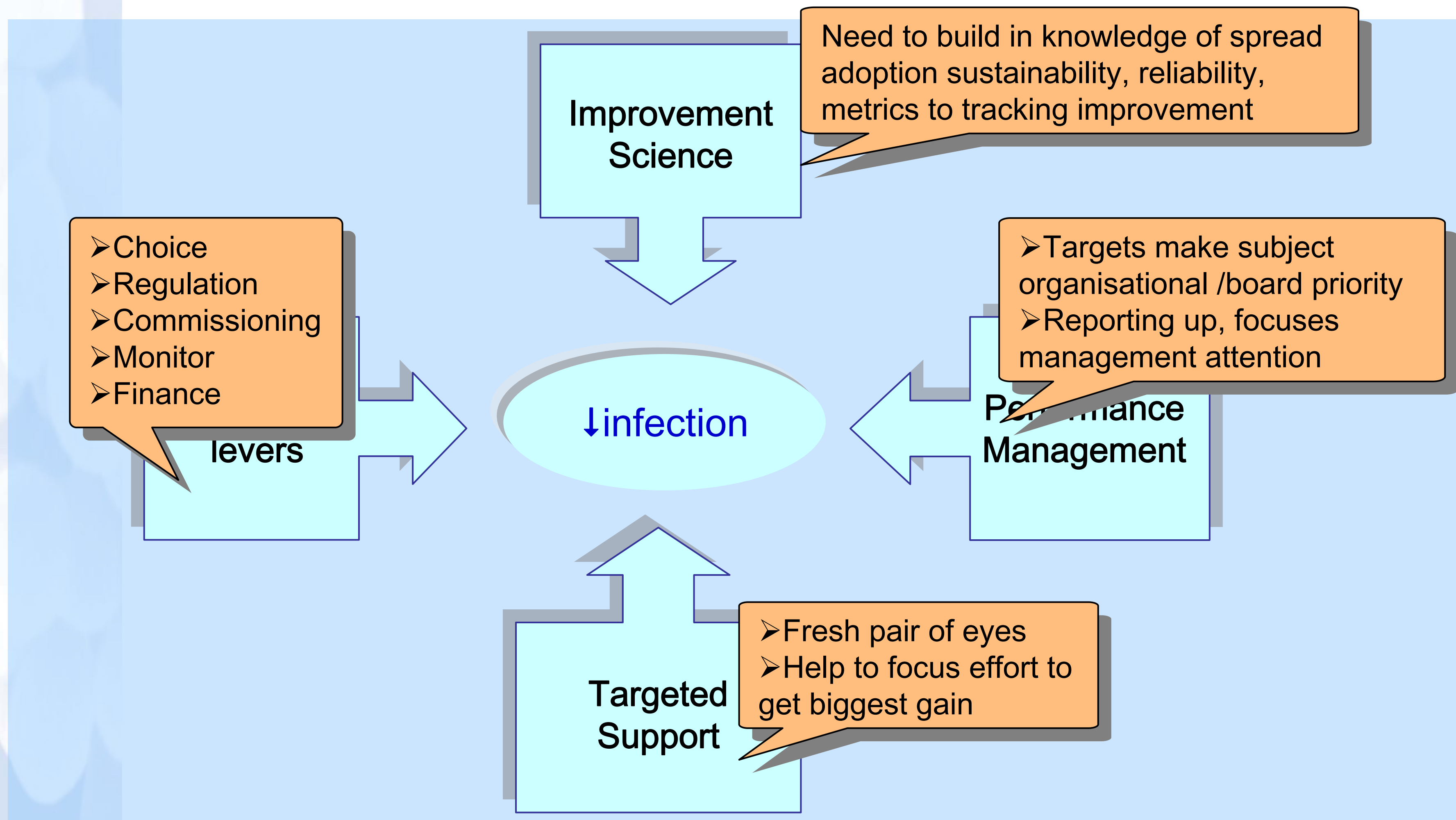
- HCAI domain of IC teams
- Infection happens….
- Over use of antibiotics – hence resistance & rise of C.diff
- Lack of recognition of impact on quality
- Clinical training not focussed on IC for years
- Lack practical skills training with assumed competence
- Belief it is just a clinical issue

- Reducing HCAI requires major cultural, organisational and behavioural change – so plan has to be multi -faceted

A National Strategy – England

- High Profile Leader – CNO – number one priority
- Government endorsement
- Made a national target
- National Board – key senior stakeholders
- Legislation - Hygiene Bill Code of Practice
- Regulation – Health Care Commission
- Monitor
- Visits/conferences/launches across country
- Communications Strategy

Action for Improvement - A multifaceted approach



Essential steps to safe, clean care

Reducing healthcare-associated infections in Primary care trusts; Mental health trusts; Learning disability organisations; Independent healthcare; Care homes; Hospices; GP practices and Ambulance services.

Health economy wide issue

Shared approach to RCA & collaboration to implement findings

Understand causes of infection and plan to prevent in the future

Good clinical practice across the whole system

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SO…………….WHAT HAVE WE LEARNED?

The Power of Three……….

BELIEF

BEHAVIOUR

BE SURE

Why are some Trusts still struggling

- Belief system – ‘this is impossible’
- Still arguing about unfairness of target rather than impact on patients
- Not part of ‘strategic intention’ or perceived by staff as a priority
- Senior leadership have not properly gripped agenda
- Implementation plans without clear outputs, outcomes, timescales, lead
- Accountability not devolved – still heavy reliance on IPC teams to ‘sort out’
- There are no consequences for non-compliance
- Benefits of Root Cause Analysis not understood or exploited
- IPC Team – ‘not out there!’ – not rethought how role[s] might need to be different.

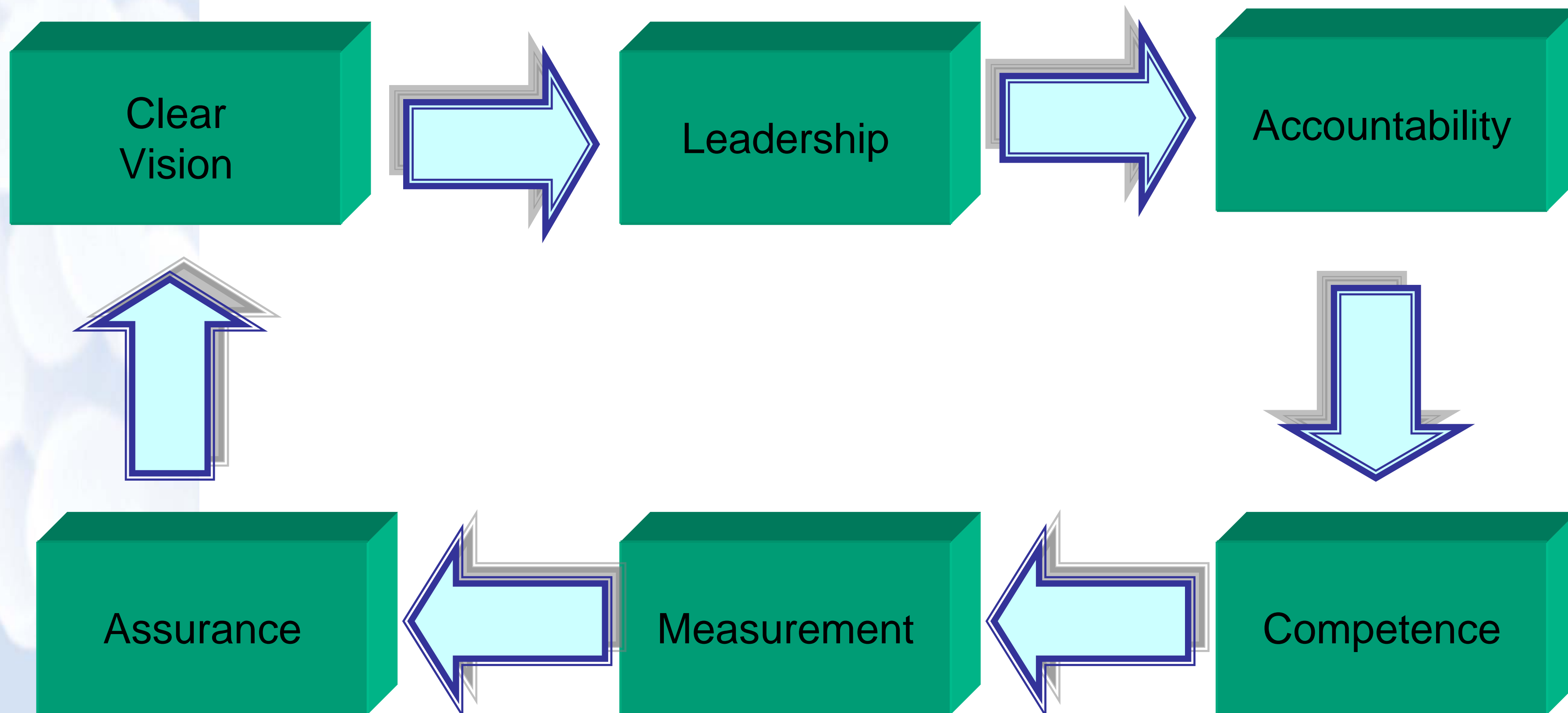
Features of successful organisations

- Belief system – ‘we can do this’
- Absolute priority – ‘zero tolerance’ philosophy & message
- Led and championed by CEO and execs
- Board see how HCAI fits with quality, effectiveness and efficiency
- Core Value to reduce harm
- High profile microbiologist and Infection Prevention team
- Effective use of information and data with action plans – ‘focus, pace, grip’
- Every case is used to learn, feedback & improve
- Clear accountability with consequences at every level

Clinical Practice

- Often mismatch between intention and action!
- Variation in compliance to protocols / guidelines
- Lots of training, less assurance about competence
- Assumed level of competence to perform 'basic procedures' e.g. hand hygiene aseptic technique, wound & line care, …
- Staff 'too embarrassed' to ask about 'basic care'
- Staff reluctant to give feedback & challenge colleagues
- 'Rose-tinted' compliance data

The journey to safe clean care



Clear Vision

- Part of intention to delivering good quality safe care
- Culture of ‘zero tolerance’ & belief achievable
- Avoidable infections insult our patients
- Plan that shows what you intend to improve (the outputs)

Leadership

- Owner, manager, matron,
- Implementation lead for delivery plan
- Identify champions!
- From Infection Control Committee to Infection Prevention

Accountability

All staff

- Understand what is expected of them;
- What they will be held responsible for;
- Will have the authority to drive improvement

This will require

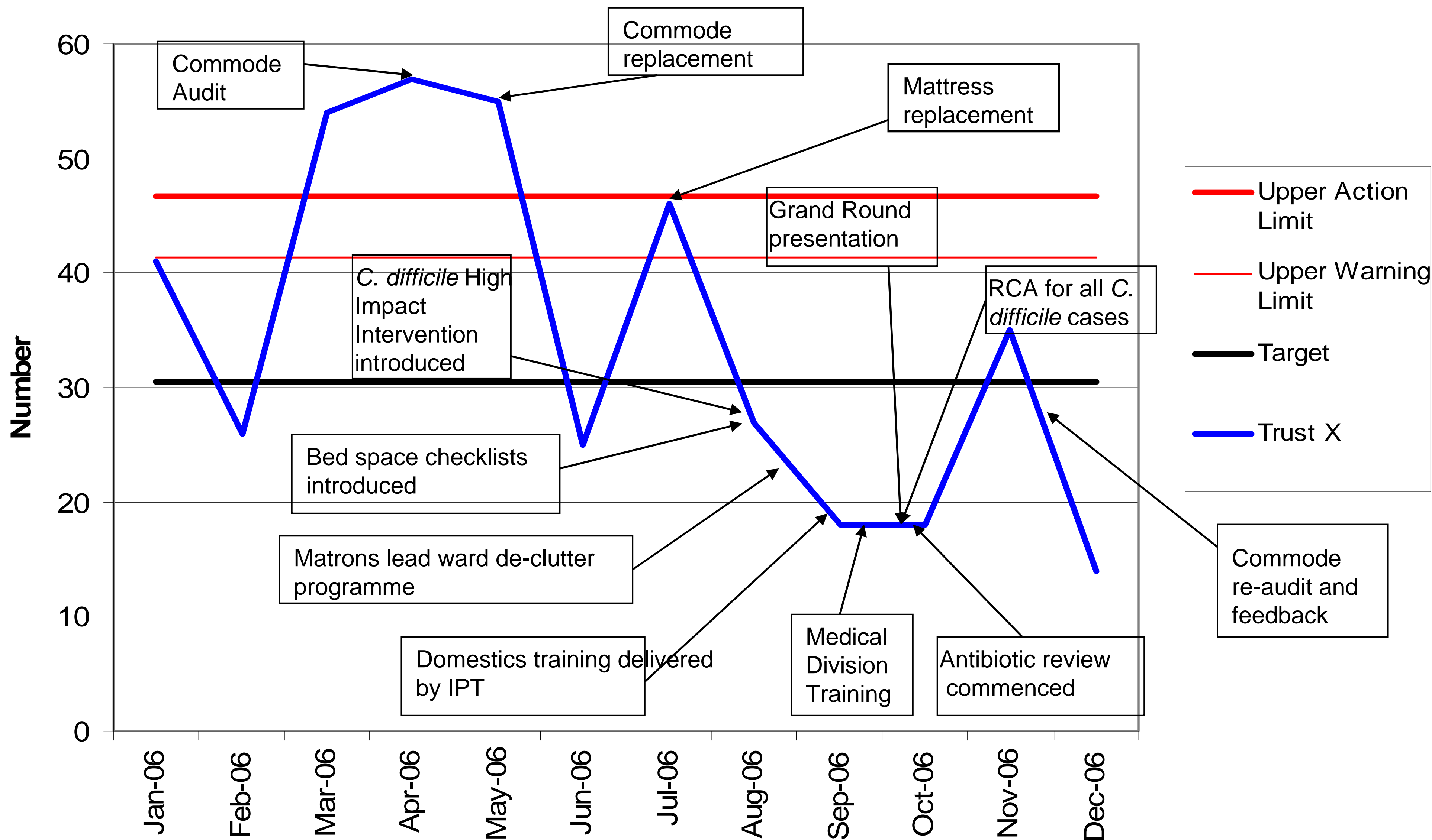
- Responsibility for HCAI prevention explained clearly in
  - job descriptions
  - personal objectives (which are agreed and monitored)
  - discussed at appraisal
- Consequence of non-delivery understood and acted upon
- Observe and feedback on what they see

Competence

- Training
  - induction for all
  - included in mandatory updates for all staff
  - delivered in different ways (e-learning)
- Assessment of competence
  - Don't assume / check staff skills regularly re aseptic technique, line care, wound care

Measurement

- If you can’t measure it – you might still improve but you wont know for sure
- Compliance data - use of care bundles in Essential Steps
- Root Cause Analysis done well, used to focus action and training
- Use information and analysis visually track progress


SPCC Trust X C. difficile Toxin Positives
Number
60
50
40
30
20
10
0
Jan-06
Feb-06
Mar-06
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Sep-06
Oct-06
Nov-06
Dec-06
Commode Audit
Commode replacement
Mattress replacement
Grand Round presentation
C. difficile High Impact Intervention introduced
RCA for all C. difficile cases
Bed space checklists introduced
Matrons lead ward de-clutter programme
Domestics training delivered by IPT
Medical Division Training
Antibiotic review commenced
Commode re-audit and feedback
Upper Action Limit
Upper Warning Limit
Target
Trust X
DH Department

Assurance

- Be confident that systems, policies and people are doing what you need them to do
- Integral to risk & clinical governance
- Clear about risks to both business and patients with plans to mitigate
- Effective systems in place to improve reliability.

Headlines…..

MRSA

- Hand hygiene
- Colonisation
  - Screening
  - decolonisation,
- Indwelling devices
- Wounds
- Antibiotics

Questions

- Are staff cleaning hands every time they should & doing it correctly?
- How do you know?
- Do staff understand colonisation, risks and what to do.
- How are indwelling devices cared for
- How are leg , pressure ulcers managed
- Who is tracking antibiotic usage

C.difficile

- Hand washing
- Antibiotics
- Prompt Isolation
- Cleaning

Questions

- How clean is your equipment – commodes toilets, bed areas
- What cleaning regimes are in place
- How do you care for patients with suspected infection
- Do staff understand the causes of infection, know what to do, have skills
- How do you know?

Department of Health

Moving forward……………

- Have you got the right policies & procedures?
- Have staff got the knowledge, skills to do the right things right every time?

More fundamentally

- Is reducing infection seen as important?
- Are staff motivated to "play their part?"
- Have you the tools to move forward?
  - Essential steps, nursing home guidance, bundles
- Are you clear about what you need to do?
  - Plan – outputs, timescales

- How can you "raise the focus?" in your care facility

Launched in June

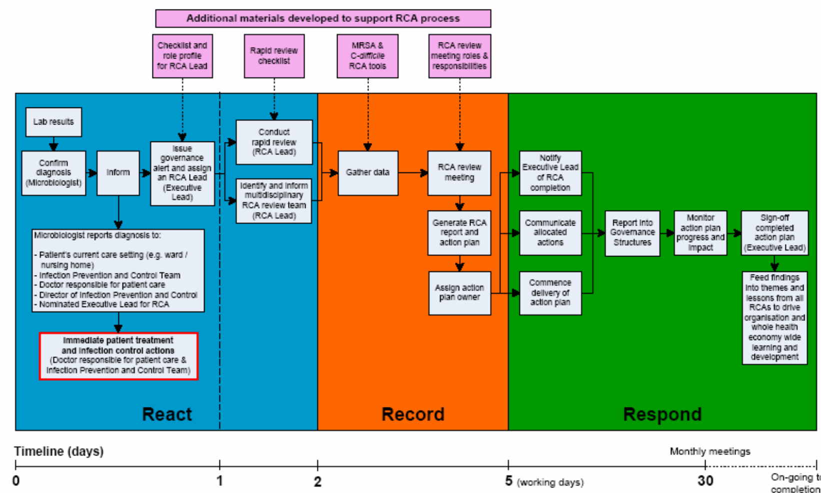
Board to Ward

how to embed a culture of HCAI prevention in acute trusts

Going Further **Faster II**: applying the learning to reduce HCAI and improve cleanliness

Draft for pilot

Healthcare Associated Infections Root Cause Analysis (RCA) Process



www.clean-safe-care.nhs.uk

The front line of communication

All staff have a duty to provide clean, safe and reliable care. The Clean, Safe Care website is an information resource designed to enhance your knowledge of good practice and give you access to the latest research and available tools.

What's online?

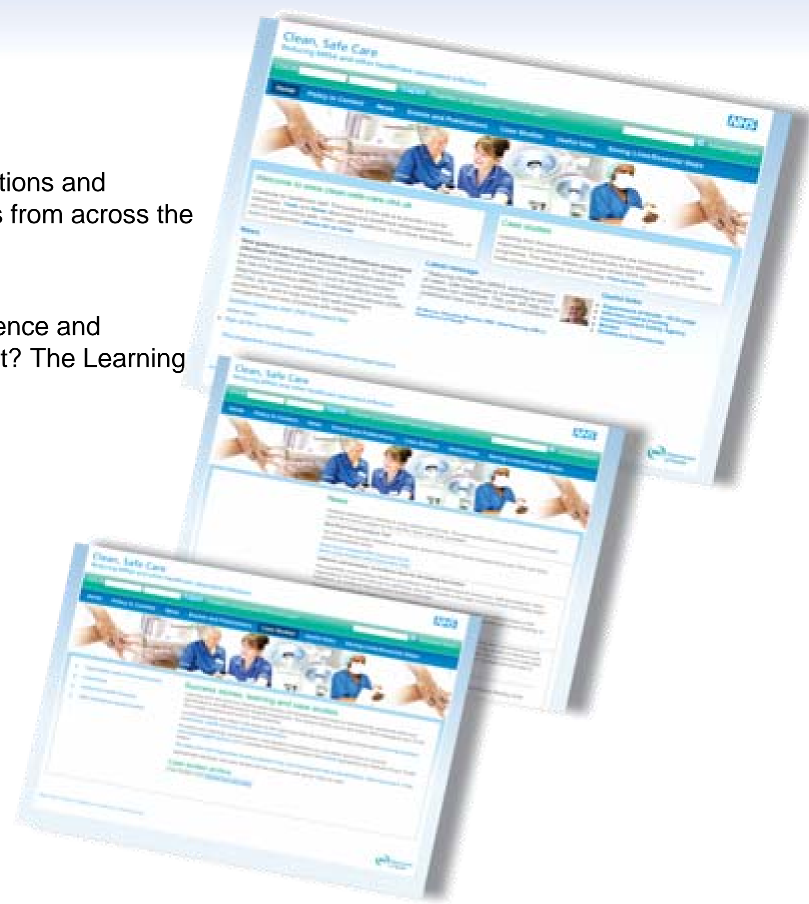
Information on reducing HCAI
For use from Board to ward.

Shared learning
From colleagues across England and beyond.

Monthly e-bulletins
Sign up to receive the official HCAI news bulletin, packed with the latest information on how to reduce infection.

Community forum
Talk about the latest policies, ask questions and broaden your expertise with colleagues from across the NHS.

Case studies
How are other trusts using their experience and knowledge? What works? What doesn't? The Learning Zone is packed with examples.



Get involved

Online
Want to make a difference to the healthcare policies that affect your trust and its patients? You can upload case studies and information from your trust at **www.clean-safe-care.nhs.uk** as well as view other examples of good practice.

In person – Performance Improvement Network (PIN) meetings
The Performance Improvement Network meets quarterly to discuss and share information on reducing healthcare associated infections and improvements in best practice.

If you would like to be part of the PIN, please email **reducingmrsa@dh.gsi.gov.uk** to register and receive event information.

www.clean-safe-care.nhs.uk