

HPS REPORT – RECOMMENDATIONS AND ACTIONS

RECOMMENDATIONS	ACTIONS
<p>Prospectively, efforts should be directed at reducing numbers of cases of CDAD by a combination of both national and local surveillance, infection prevention and control procedures, and antimicrobial stewardship as set out in a range of current national guidance (model policies on Standard Infection Precautions and Transmission – Based Precautions, and policy on Antimicrobial Prescribing and Practice), which are currently being summarised in the Scottish National Guidance on CDAD and are due for completion in September 2008.</p>	<ul style="list-style-type: none"> • Chief Executive Letter to Boards regarding roles and responsibilities related to HAI, including infection control policies, procedures and antimicrobial prescribing. • A HAI reporting template will be developed for NHS Boards to use as the framework to report progress against the HAI agenda to all Board meetings and form the basis of the Boards Infection Control Managers HAI annual report that will be part of the Director of Public Health's Report. • NHS Boards to have 'zero tolerance' to non-compliance with hand hygiene • NHS Scotland hand hygiene policy clearly indicates what agents to use for hand hygiene and when they are indicated. • NHS Boards monitor and audit hand hygiene compliance (staff and visitors) and facilities • National; overview hand hygiene report produced 2 monthly on NHS Boards compliance • NHS Boards to implements requirements of CEL 30(2008): Prudent Antimicrobial Prescribing: The Scottish Action Plan For Managing Antibiotic Resistance And • Reducing Antibiotic Related Clostridium difficile Associated Disease, including: <ul style="list-style-type: none"> • Establishing Antimicrobial Management Teams • Funding for antimicrobial pharmacist to be provided by SGHD • Antimicrobial policy based on best practice prescribing guidance produced by Scottish Antimicrobial Prescribing Group and trends of use monitored
<p>Consideration should be given to extending the national surveillance system for CDAD to those aged between 15 and 64 years. This should be done in a way that does not disrupt the current surveillance programme for those aged 65 years and older so that trends can continue to be monitored.</p>	<ul style="list-style-type: none"> • Mandatory surveillance of Clostridium difficile associated disease revised to include surveillance of 15 year old and above and quarterly reports

RECOMMENDATIONS	ACTIONS
Local surveillance is an important part of infection control. The structure for this needs to be defined by the NHS Board to best reflect local reporting procedures for feedback of results. This should be by local hospital and by managerial arrangements.	<ul style="list-style-type: none"> NHS Boards local surveillance to include setting of control limits and trajectories for reduction of rates / incidence of HAI
A framework for local surveillance should be produced including guidance on how to identify figures and monitor improvement.	<ul style="list-style-type: none"> Standard template and guidance for local surveillance to developed and implemented by NHS Board's
Where an excess in cases or mortality are identified locally, the HPS Algorithm for validation (Appendix 3) should be adopted to examine the reasons for variation.	<ul style="list-style-type: none"> NHS Boards local surveillance to include setting of control limits and trajectories for reduction of rates / incidence of HAI
Prospectively, when there is a severe case of CDAD, such as a patient with pseudo membranous colitis, toxic megacolon or ileus; or who requires admission to intensive care for management of the infection; or who dies where CDAD is an underlying cause during an inpatient episode; further investigation (such as root cause analysis) is required. This should be undertaken by the clinical team responsible for the patients care in line with local Clinical Governance procedures to establish possible reasons, and to identify any actions necessary to minimise risk in the future.	<ul style="list-style-type: none"> Clostridium difficile Root Cause Analysis tool to be developed and used by Boards to investigate adverse outcomes
Routine national monitoring of CDAD mortality is unlikely to be productive in informing action to reduce the incidence of CDAD. However, if there is a decision to collect mortality data in relation to CDAD this should be carefully designed and planned, and consideration given to data definitions and data collection criteria. Further discussion should take place on the most appropriate national agency to undertake these reviews.	<ul style="list-style-type: none"> Clostridium difficile Root Cause Analysis tool to be developed and used by Boards to investigate adverse outcomes
It is outwith the scope of this exercise to comment on actions in relation to death certification.	<ul style="list-style-type: none"> Guidance on completing certificates to be reviewed and guidance issued NHS Boards policy / guidance on completing death certificates reviewed to include documenting death associated with HAI

INDEPENDENT REVIEW – RECOMMENDATIONS AND ACTIONS

RECOMMENDATIONS	ACTIONS
<p>That current infection control policies and procedures are reviewed to ensure that current best practice guidelines with respect to the prevention and control of <i>C.difficile</i> infection are implemented and monitored including relevant training and education. This should include <i>C.difficile</i> care Bundles to support audit, the <i>C.difficile</i> checklist and the Template for Local Surveillance produced by Health Protection Scotland. (Additional guidance from Health Protection Scotland) is expected in the Autumn 2008).</p>	<ul style="list-style-type: none"> • NHS Scotland policy guidance on prevention, control and management of Clostridium difficile to be available to NHS Boards, including: • CDAD care bundle • C.diff check list • Framework for local surveillance • Antimicrobial prescribing
<p>That current best practice for prudent antimicrobial prescribing guidelines are implemented and monitored both in the Acute and Community sectors and that the Hospital works towards compliance with the Scottish Management of Antimicrobial Resistance Action Plan (2008).</p>	<ul style="list-style-type: none"> • NHS Boards to implements requirements of CEL 30(2008): Prudent Antimicrobial Prescribing: The Scottish Action Plan For Managing Antibiotic Resistance And • Reducing Antibiotic Related Clostridium difficile Associated Disease, including: • Establishing Antimicrobial Management Teams • Funding for antimicrobial pharmacist to be provided by SGHD • Antimicrobial policy based on best practice prescribing guidance produced by Scottish Antimicrobial Prescribing Group and trends of use monitored
<p>That infection control roles, responsibilities, processes and committees must be aligned to clearly establish lines of professional and clinical responsibility, accountability and support clinical leadership.</p>	<ul style="list-style-type: none"> • Chief Executive Letter to Boards regarding roles and responsibilities related to HAI, including infection control policies, procedures and antimicrobial prescribing • A HAI reporting template will be developed for NHS Boards to use as the framework to report progress against the HAI agenda to all Board meetings and form the basis of the Boards Infection Control Managers HAI annual report that will be part of the Director of Public Health's Report.
<p>That a development plan to strengthen, support and empower the role of the Charge Nurse is put in place within an improved professional leadership structure.</p>	<ul style="list-style-type: none"> • All Boards will empower their Charge Nurses to deliver against their responsibilities and implement the recommendations in the Senior Charge Nurse Review

RECOMMENDATIONS	ACTIONS
That the process for communication with patients over infection control issues be improved in consultation with patient representatives.	<ul style="list-style-type: none"> • All patients to receive information on HAI • Board to review communication processes by clinical staff to patients and relatives, ensuring delivery of consistent accurate information. This should involve the Patient Focus Public Involvement lead
That the Board ensures a safe environment for patient care, develops a pre-planned maintenance programme for the Vale of Leven Hospital, and reviews current isolation facilities for patients with infectious diarrhoea, including CDAD to ensure that patients can be cared for safely.	<ul style="list-style-type: none"> • HAI SCRIBE (Healthcare Associated Infection System for Controlling Risk in the Built Environment) sections 3 &4 to be applied to all existing buildings to ensure fabric of healthcare facilities maintained to minimise risk of infection • Planned preventative maintenance programmes reflect requirements of prevention and control of infection • The Board to detail an investment programme to address outstanding maintenance and modernisation issues at the Vale of Leven Hospital. • The Board to review isolation facilities ensuring adequacy of numbers and facility at Vale of Leven
That the Board adopts a consistent approach through best practice and training in relation to death certification for Healthcare Associated Infection.	<ul style="list-style-type: none"> • Guidance on completing certificates to be reviewed and guidance issued • NHS Boards policy / guidance on completing death certificates reviewed to include documenting death associated with HAI
That an external and independent audit of the implementation of these recommendations should be conducted by the end of 2008 and that patient representatives should be included as part of the review team.	<ul style="list-style-type: none"> • Follow up review of actions from Independent Review Team report to be carried by end of year

INDEPENDENT REVIEW – PATIENTS’ AND RELATIVES’ RECOMMENDATIONS AND ACTIONS

RECOMMENDATIONS	ACTIONS
Better communication to improve the understanding about <i>C.difficile</i>	<ul style="list-style-type: none"> • All patients to receive information on HAI • Information leaflets to be available on: <ul style="list-style-type: none"> • HAI (general information) • Clostridium difficile (patients, relatives and staff) • Laundering of patients laundry at home • All information is available in a variety of formats that facilitates public understanding
Improved communication about infection control procedures for visitors, including laundry management	<ul style="list-style-type: none"> • All patients to receive information on HAI • Information leaflets to be available on: <ul style="list-style-type: none"> • HAI (general information) • Clostridium difficile (patients, relatives and staff) • Laundering of patients laundry at home • All information is available in a variety of formats that facilitates public understanding • Board to review communication processes by clinical staff to patients and relatives, ensuring delivery of consistent accurate information. This should involve the Patient Focus Public Involvement lead
More easily accessible wash hand basins	<ul style="list-style-type: none"> • Planned preventative maintenance programmes reflect requirements of prevention and control of infection
More investment in the fabric of the hospital	<ul style="list-style-type: none"> • NHS Boards to have identified budget for urgent repairs and replacement equipment available to Charge Nurses
On-going infection control training for <u>ALL</u> hospital staff	<ul style="list-style-type: none"> • All staff to have HAI objective in annual professional development plans • HAI Education and training programme for all disciplines of staff, to be developed and delivered at the Vale of Leven

RECOMMENDATIONS	ACTIONS
More education about antibiotic use	<ul style="list-style-type: none"> • NHS Boards to implements requirements of CEL 30(2008): Prudent Antimicrobial Prescribing: The Scottish Action Plan For Managing Antibiotic Resistance And • Reducing Antibiotic Related Clostridium difficile Associated Disease, including: • Establishing Antimicrobial Management Teams • Funding for antimicrobial pharmacist to be provided by SGHD • Antimicrobial policy based on best practice prescribing guidance produced by Scottish Antimicrobial
Improved surveillance both locally and nationally and a national alert system set up	<ul style="list-style-type: none"> • Standard template and guidance for local surveillance to developed and implemented by NHS Board's • NHS Boards local surveillance to include setting of control limits and trajectories for reduction of rates / incidence of HAI • All Boards will have web based test reporting for Clostridium difficile by end of October 2008. • A pilot of web based episode reporting with roll out to all diagnostic laboratories from March 2009
Staff should not wear their uniforms outside the hospital	<ul style="list-style-type: none"> • NHS Scotland dress code, applicable to all staff, hospital and community issued for implementation to NHS Board's • NHS Scotland uniform policy, includes changing into and from uniform and issued for implementation